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PRIVATE SECTOR COMMUNITY BASED DISTRIBUTION AND COMMERCIAL SOCIAL MARKETING STRATEGIES IN COLOMBIA

SUBORDINATE AGREEMENT Nos. IA84.20A AND IA86.32A

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FINAL REPORT

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PROFAMILIA
AND
THE POPULATION COUNCIL

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BOGOTA, COLOMBIA - AUGUST, 1988

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EXECUTIVE SUMMARY

PROFAMILIA, a private, non-profit family planning organization in Colombia, conducted six operations research projects with the general objective of improving the cost-effectiveness of its contraceptive marketing programs. In addition, six other studies explored different subject areas using the project's survey data.

The first operations research (OR) study tested the cost-effectiveness of replacing PROFAMILIA's community-based distribution (CBD) program with a contraceptive social marketing (CSM) strategy in rural and marginal urban areas with high contraceptive prevalence. In the Department (state) of Santander, PROFAMILIA discontinued the CBD program and enlarged the CSM program to include rural and semi-rural areas. In the Department of Cundinamarca, the CBD and CSM programs continued operating as usual. After two years, the CSM strategy achieved a net profit per couple year of protection (CYP) of US$1.18, compared with a cost per CYP of US$4.20 for the CBD program in Cundinamarca. Contraceptive knowledge and prevalence did not decrease in either case. However, PROFAMILIA was forced to cancel its CSM program due to a number of factors, including government regulations regarding the sale of donated contraceptives, a price freeze on sales of pharmaceutical products, and increased competition from local contraceptive manufacturers.

Given the successes and shortcomings of the first OR project, and operating under what was possible given the Colombian contraceptive market situation, a second OR project tested the cost-effectiveness of a novel community marketing (CM) strategy that incorporated the main features of both CSM and CBD. The objective was to allow PROFAMILIA to market contraceptives through a more commercial network and with increased coverage, while maintaining the network of CBD posts and some streamlined elements of the educational campaign. Like the first OR project, this study was conducted in the Departments of Cundinamarca and Santander. In Cundinamarca, a cost of US$1.52 per CYP was achieved, which was an improvement over the results observed in the first study. The cost per CYP in Santander was US$0.43, lower than in Cundinamarca, but less favorable than the profit per CYP observed in the first study. In both Departments, contraceptive knowledge remained at approximately the same levels, and contraceptive prevalence increased. Based on the results of this study, PROFAMILIA extended the CM strategy to the remainder of the country, reasoning that it allows the organization to fulfill its social objectives with increased cost-effectiveness.

The third OR study used two national sample surveys to measure CBD distributors' knowledge of contraception and to assess the effectiveness of a training program to improve knowledge. In the three year interval between the surveys, PROFAMILIA was able to train about half of the distributors in one to three-day courses, and most of the rest in briefings during resupply visits. Improvements in knowledge of contraception were correlated with training, but no significant differences were found between distributors trained in courses and those trained in briefings. There were large improvements in the knowledge of certain critical items regarding oral contraceptive use, but knowledge of other important items, including counterindications for pill use, remained low. Knowledge of barrier method use was high. Vasectomy was the least known method.

The fourth OR study sought to determine the long-term effects of a 1984-1985 generic condom radio advertising campaign. To do this, PROFAMILIA conducted a survey in 1987 among men in the city of Cali to measure knowledge, use and purchases of condoms. Results were compared with baseline and endline surveys of 1984 and 1985 to measure long-term impact. The results suggest that the pool of condom users remained approximately the same size after three years, but that condom use increased because of more frequent use by condom ever-users. The most important long-term effect of the radio advertising campaign was apparently to increase the frequency of repeat purchases.

The fifth study obtained basic information on contraceptive marketing to allow PROFAMILIA to compete more effectively in the commercial drugstore market. The services of A.C. Nielsen de Colombia S.A. were hired to do this. The information included market size, market share, inventory levels, average prices and stock-outs in drugstores. The results show that PROFAMILIA holds over 50% market share in pills and condoms, that their distribution network covers a large majority of drugstores in Colombia, and that they achieve social objectives by selling the least expensive contraceptives in the commercial market.

In order to have better cost-effectiveness information, the sixth OR study determined an accurate distribution among service programs of the indirect costs of central administration and of the shared costs of assets and services. By taking these costs into account, the community marketing program's cost per CYP increased by 59.7%, and the clinical program's cost increased by 17%. The surgical program was the least affected, with the cost per CYP increasing by only 7.3%.

Besides collecting basic data to achieve project objectives, PROFAMILIA used the surveys to explore other issues that have important implications for program management and design. The

report presents results of six subject area studies that used survey data from this project, including IEC and marketing in CBD programs, quality of care in CBD programs, contraceptive information needs of women, perception of condoms and condom brands, knowledge of AIDS, and perception of sources of supply and reasons for use and non-use of contraception.

The general conclusions of the project are that program self-sufficiency is within the reach of family planning organizations in programs which sell spacing methods of contraception, if they fully adopt the practices followed by private sector companies, and that family planning managers are capable to meet the challenges faced in this new environment. However, if family planning organizations stop receiving subsidies through donations, they would in all likelihood be forced to discontinue their more costly services, such as sterilizations and IUD insertions. Their existence would be endangered because their limited product line (contraceptives) makes them less competitive than other pharmaceutical wholesalers and leaves them vulnerable to sudden changes in demand or supply of those products. In addition, they would not be able to pursue the social objectives that justify their existence. Therefore, it is recommended that family planning organizations endeavor to become more cost-effective in all service programs, with an aim of self-sufficiency or small profits in sales of pills, condoms and vaginal spermicides. In this way, international donations could be focused on more costly services requiring medical supervision, like sterilization and IUDs, and on helping the organizations meet social objectives.

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I. INTRODUCTION

This document is the final narrative report of the project "Private Sector Community Based Distribution and Commercial Social Marketing Strategies in Colombia," implemented by the Asociación Pro-bienestar de la Familia Colombiana (PROFAMILIA) with the assistance of The Population Council and funded under Cooperative Agreement No. AID/DPE-3030-A-00-4050-00.

This final report presents the background, objectives, methodology and principal results and conclusions of six studies carried out as part of this project. The studies were the following:

- an operations research (OR) project that tested whether a contraceptive social marketing (CSM) program could replace a community based distribution (CBD) program in rural and marginal urban areas where contraceptive use prevalence was already high. In this report we will refer to this as the Phase I study.

- an operations research that tested the cost-effectiveness and impact of a mixed CBD-CSM program that has been named community marketing (CM) by PROFAMILIA. This is referred to as the Phase II study in this report.

- a survey among CBD distributors to measure changes in their knowledge of contraceptive use since a similar survey three years earlier. We refer to this as the distributors' survey.

- a survey to determine the long term effects of generic condom radio advertising. This is referred to as the condom survey.

- an audit in urban drugstores to determine the size of Colombia's contraceptive market and PROFAMILIA's market share. This is called the Nielsen or the drugstore study.

- a cost study to determine how indirect and shared costs due to central administration and shared assets and services should be distributed among PROFAMILIA's service programs. We refer to this as the cost study.

The report also presents results of six other studies that used survey data from this project. The studies included such subjects as IEC and contraceptive marketing, quality of care in CBD programs in Colombia, contraceptive information needs of women, perception of condoms and condom brands, knowledge of AIDS and sources and reasons for use and non-use of contraception.

Additional results and information can be found in the seven progress reports that have been presented to AID as follows:

-1st report dated May 1985 (September 1984 - April 1985)
-2nd report dated January 1986 (April - September 1985)
-3rd report dated May 1986 (October 1985 - March 1986)
-4th report dated November 1986 (April - September 1986)
-5th report dated May 1987 (October 1986 - March 1987)
-6th report dated November 1987 (April - September 1987)
-7th report dated May 1988 (October 1987 - March 1988)

II. BACKGROUND

2.1 General Characteristics of Project Areas

Colombia is located in northwest South America, where it is the only country having coasts on both the Atlantic and Pacific Oceans. Although Colombia covers an area of 1,138,914 square kilometers (439,828 square miles), 97% of her 28 million inhabitants live in the Andean and Atlantic Coastal regions which make up less than half of the total land area (DANE, 1986). Sixty seven percent of the population lives in urban areas. Most of the activities documented in this report either had a national focus or took place in the Departments ([1]) of Cundinamarca and Santander, both of which are located in the highlands of the eastern range of the Andes Mountains. A survey was also conducted in the city of Cali, in the southern end of a valley that runs between the eastern and central ranges of the Andes. Figure 1 presents a map of Colombia where project areas are identified.

According to the 1985 census, the Department of Cundinamarca had a total of 1,382,360 inhabitants, of which 54.2% lived in rural areas. There was a total of 283,589 dwellings, with an average of 4.8 people living in three rooms per living area. There was electricity in 71.4% of the houses, 56.6% had running water, and 45.5% were equipped with sewage services. The illiteracy rate for people ten years or older was 11.7%, and the labor-force participation rate was 69.1% for males and 33.1% for females. Women had an average number of 3.75 children. It should be noted that although Bogotá, the capital of Colombia, is technically a special district of the Department of Cundinamarca, it has not been included in these figures. Excluding Bogotá, the largest cities in Cundinamarca are Soacha (pop. 99,000), Girardot (pop. 66,000) and Zipaquirá (pop. 46,000).

The census also showed that the Department of Santander had 1,438,226 inhabitants in 1985, of which 38% were residents of rural areas. There was a total of 269,506 dwellings, with an average of 5.3 people living in 3.6 rooms per living area. There was electricity in 71% of the houses, 67.2% had running water, and 58.8% were equipped with sewage services. The illiteracy rate for those ten years or older was 12.6%, and the labor-force participation rate was 71.4% for males and 36.7% for females. Women had an average number of 2.67 children. The three largest

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[1]/ A Colombian Department is a geo-political division equivalent to an American State.

cities in Santander are Bucaramanga, the capital, with 341,500 inhabitants in 1985, Floridablanca with 138,000 residents, and the oil-producing town of Barrancabermeja, also with a population of 138,000.

The city of Cali is the third largest metropolitan area in Colombia, with 1.3 million inhabitants. Cali is characterized by a relatively low unemployment rate and a large industrial base, most notably in the agrobusiness that takes advantage of the fertile cropland in the surrounding Cauca Valley.

2.2 Contraception and Family Planning in Colombia

According to the 1986 National Demographic and Health Survey (CCRP et al, 1988) , knowledge of contraceptives in Colombia is almost universal with 98% knowing at least one method and 96%, 91% and 98% knowing the pill, female sterilization and the IUD, respectively. Contraceptive use is also high, with 63.2% of currently married women using some kind of method. Prevalence among urban residents (70.2%) remains higher than among rural inhabitants (53.6%). There are also large differentials between educational groups, but even among women with no formal schooling, 50% used contraceptives, compared with approximately 60%, 70% and 80% of women with some primary, secondary or college education. The three most popular methods were female sterilization, the pill and the IUD, which were used by 17.4%, 16.5% and 10.3% respectively of currently married women. Condoms were known by only 71% and used regularly by only 1.7% of currently married women. In the eastern region of Colombia, where both Cundinamarca and Santander are located, contraceptive prevalence was 65%, with female sterilization used by 18% of currently married women, and the pill and the IUD by 13% each.

The DHS survey also showed that 36.1% of all current family planning users had used PROFAMILIA as their most recent source of service or supply. Other relevant sources were drugstores (33.3%) and the Ministry of Health's (MOH) public hospitals and health posts (15.1%). PROFAMILIA provides nearly 75% of sterilization and 45% of IUD services, while drugstores are the main suppliers of pills (75%), injectable contraceptives (73%), vaginal tablets and suppositories (89%) and condoms (65%). It is worth pointing out, however, that PROFAMILIA is the major source of supply for approximately 80% of those drugstores. PROFAMILIA's CBD posts supplied 7% of all pill and condom users (Table II-1).

PROFAMILIA, the IPPF affiliate in Colombia, was founded in 1965 as an outgrowth of the private practice of its president, Dr. Fernando Tamayo. Although early service delivery efforts were largely clinic based, in 1970 PROFAMILIA began offering temporary contraceptives through a CBD program. Since then, PROFAMILIA has remained the largest supplier of family planning

services in Colombia. In 1987, PROFAMILIA opened its forty-third clinic, provided 339,000 medical consultations and offered a record total of 1,422,285 couple years of protection (CYP). Nearly 60,000 sterilizations were provided and 4.8 million pill cycles, five million condoms and 1.8 million vaginal tablets were sold through 10,000 sales points located in 185 counties.

The second largest provider of services, the Colombian government's Ministry of Health, does not emphasize family planning but has included a population policy in the National Development Plans since 1970. The policy stresses the need for making information and services available so that couples may make informed decisions and exercise their right to determine family size. In practice, this has meant that the Ministry of Health has provided family planning services in its 600 hospitals and 2,400 health posts and has not interfered with private sector efforts.

With regard to the commercial sector, both Schering and Wyeth produce pills and injectable contraceptives locally. Norwich and other smaller pharmaceutical companies locally produce vaginal suppositories. Condoms are not manufactured locally, but they are imported from the USA and Korea by a number of large commercial wholesalers.

2.3 PROFAMILIA's Organization and Programs

PROFAMILIA is governed by a Board of Trustees presided by Dr. Fernando Tamayo. The Executive Director oversees all operations and reports to the Board of Trustees. Currently, seven directors report directly to the Executive Director: Management and Finance, Resource Development, Industrial Relations, Director's Assistance, the Pilot Clinic in Bogotá, the Training Center, Planning and Evaluation, and Community Marketing. In addition, all of PROFAMILIA's clinic directors report to the executive director. The directors are responsible for carrying out one or more of PROFAMILIA's programs.

Currently, PROFAMILIA is subdivided into three service programs (Clinical, Surgical and Community Marketing) and seven support programs (Local Training, International Training, Planning and Research, Information, Education and Communication (IEC), Resource Development, Family Legal Counselling and Volunteer Women). However, this is the end result of a continuously evolving organization. At the beginning of this project, PROFAMILIA was subdivided into four service programs (Clinical, Surgical, Social Marketing and Community-Based Distribution) and three support programs (Local Training, Research and IEC). In what follows, we present a brief account of the development of PROFAMILIA's CSM and CBD service programs because all of the studies presented in this report were

conducted in order to help them become more efficient. Since these studies do not relate to the Clinical and Surgical Programs, we do not present a detailed description of them. We will only mention that both of these programs are mostly clinic based. The Clinical Program provides all medical services, including IUD insertions and family planning consultations. Lately, in several of the largest clinics, PROFAMILIA has begun offering other medical services, such as general medicine, gynecology and ultrasound. The Surgical Program performs all sterilizations, including those performed by mobile units and vasectomies provided in PROFAMILIA's three male clinics.

2.3.1 The Contraceptive Social Marketing Program

The CSM program was initiated in 1973 in order to help PROFAMILIA subsidize its CBD program while increasing access to contraception in Colombia. For this reason, the prices of contraceptives sold through the CSM program were set from the beginning at nearly commercial levels. In contrast to CSM programs in other countries (AID, 1986) PROFAMILIA's program was never independent from the parent organization. PROFAMILIA never sold repackaged contraceptives under an owned brand and, thus, never made brand-specific advertisements on mass media. For reasons that will be explained later, PROFAMILIA's CSM program came to an end in 1986.

In the beginning, the CSM program relied on four (later six) salesmen to sell contraceptives to drugstores in large urban areas. These salesmen were paid a small wage plus sales commissions. They sold Schering and Wyeth pills and Norform vaginal suppositories bought in bulk from local producers, and Noriday pills, Neo-sampoon tablets, Emko foams, and Tahiti and Conture Condoms, all of which were donated. In 1979, the CSM program accounted for nearly 25% of PROFAMILIA's total income (Plata, 1981).

By the time the present project started, PROFAMILIA had appointed five distributors with exclusive rights to market contraceptives in seven Departments each. These distributors were wholesalers of pharmaceutical products who were already reaching most of the drugstores in urban areas and who could introduce contraceptives in their line of products at little or no extra cost to them. Since PROFAMILIA was only responsible for delivering the products to the distributors' warehouses, and the distributor was paid only a small wage plus commissions, the organization benefitted from greatly reduced administrative responsibilities, while being virtually guaranteed a profit.

2.3.2 The Community Based Distribution Program

PROFAMILIA began its CBD program in the coffee growing areas of Western Colombia in 1971. The program was the first of its kind in the Western Hemisphere, and perhaps in the world. In the early PROFAMILIA program, volunteers selected by their communities sold pills, condoms and spermicides at subsidized prices from their homes or work places. These distributors were trained and supervised by an instructor, who supplied the distribution posts with contraceptives and collected sales money and statistical data every month. The instructors also devoted a large amount of time to IEC activities in their communities to increase knowledge of contraception and to generate demand for the service posts run by the volunteers. These activities included a large number of home visits, as well as educational talks to the community in which family planning and contraception were discussed within a social development framework (Echeverri, 1975). The program achieved excellent use-continuation rates, at a cost of US $10.84 per couple-year-protection (CYP) sold (Bailey and Correa, 1975).

Over the last ten years, different components of this service model have been extensively tested by operations research projects to produce a more cost-effective CBD program. The results of these projects have led to several changes in the system: the price of contraceptives has been raised to nearly commercial levels; resupply visits are now made every three months instead of every month; home visits have been reduced and group educational activities increased; the elaborate statistical system has been simplified to keep only information on sales and stock levels of each brand; the number of distribution posts per instructor and their density have been increased; almost all posts are now in small rural retail stores instead of in private homes; and, finally, the supervision pattern of the instructors has been changed to allow for a decreased frequency of supervision and a larger number of instructors per supervisor (Townsend and Ojeda, 1986).

In addition, alternatives to the basic CBD model have been tested, including the extended medical supervision (EMS) model, the IEC team system and wage incentives to supervisors. In the EMS model, a group of 15 instructors (under one supervisor and 3 coordinators) walked or travelled by public transportation and promoted family planning in a Department for three years. A mobile medical team followed the instructors, providing sterilizations and IUD insertions. After three years, the Department was left on maintenance. In the team approach, two instructors (supervised by a regional supervisor in Bogota) travelled by jeep to the communities and promoted family planning with the aid of a movie projector, films, portable generator, IEC manuals, flipcharts and other audiovisual aids. Finally, in the

incentives model, no additional personnel were added, but the existing instructors received incentives for contraceptive sales above goals. Depending on the characteristics of the area in which these systems were tested, the cost-effectiveness ranged from US $ 3.32 to $8.80 per CYP when significant number of sterilizations by mobile units were added to CBD sales (Townsend and Ojeda, 1986; Townsend et al, 1986). However, in areas where few sterilizations were performed, the cost per CYP was as high as US $37.71 (Townsend and Ojeda, 1986). Of these three alternatives, only the EMS was never widely used because it was too difficult to find doctors willing to travel for long periods in rural areas. Both the IEC and Incentives models continued to be used in certain areas of the country at certain times before the CBD program evolved into community marketing in 1987.

2.3.3 The Community Marketing Program

In 1986, as a consequence of a price freeze on all pharmaceutical products and of new government regulations on retail sales of donated products, PROFAMILIA was forced to terminate the CSM program as an independent service program. In order to avoid losing sales of its products in the drugstores which had been serviced by the CSM program, PROFAMILIA decided to create a new Community Marketing (CM) Program, in which the instructors (or field workers) of the CBD program reduced their IEC activities, kept selling contraceptives through CBD posts and small drugstores, and began selling contraceptives to large drugstores and wholesalers in urban areas. A more detailed description of this mixed CBD-CSM strategy will be found in section 5.2, since it was first tried in the field as part of the Phase II study in Cundinamarca and Santander of this project.

III. OBJECTIVES

The project's objectives were the following:

3.1 General Objective

To obtain information to help PROFAMILIA improve the cost-effectiveness of their programs which market temporary contraceptives.

3.2 Specific Objectives

The specific objectives of each of the studies conducted under this project were the following:

3.2.1 Objective of the Phase I Study

To test the cost-effectiveness of replacing PROFAMILIA's Community-Based Distribution Program with a CSM strategy in marginal urban and rural areas of Colombia.

3.2.2 Objective of the Phase II Study

To test the cost-effectiveness of a Community Marketing strategy that incorporated the main features of the CSM and CBD strategies, to allow PROFAMILIA to market contraceptives through a more commercial network and with increased coverage.

3.2.3 Objective of the Distributor's Survey

To assess the progress made in improving CBD distributors' knowledge of contraception, and to see whether the distributors recruited to reestablish CBD posts in Santander for the Phase II study were adequately trained.

3.2.4 Objective of the Condom Survey

To determine the long term effects of generic condom radio advertising.

3.2.5 Objective of the Nielsen's Drugstore Study

To obtain basic information on the marketing of contraceptives in the commercial drugstore market, including size

of market, market share, inventory levels, average prices and stock-outs in drugstores.

3.2.6 Objective of the Cost Study

To determine an accurate distribution among service programs of the indirect costs of central administration and of the shared costs of assets and services.

IV. SOURCES OF INFORMATION

The main sources of information that were used in this project were the following:

4.1 PROFAMILIA's Accounting System

All data on revenues and costs in this report come from PROFAMILIA's accounting system. The basic records of the accounting system are revenue and expenditure receipts. The accounting system considers three revenue items (sales, services and donations) and 12 expenditure entries (personnel -broken into wages, legal benefits and benefits-, travel and perdiem, fees, public services, rent, insurance, drugs and fungibles, publicity, office, taxes, depreciation and maintenance and repairs). PROFAMILIA's accounting department assigns all revenue and expenditure receipts to these accounting entries (or "accounting centers" in the parlance of the accounting department). In each of these accounting entries, there are three additional pieces of information which are coded: the program, the project or donor and the clinic to which the entry is charged. PROFAMILIA currently has three service programs (clinical, surgical and community marketing) and seven support programs (Local Training, International Training, Planning and Research, IEC, Resource Development, Family Legal Counselling and Volunteer women). Each project funded by an international donor is assigned a code. Finally, each of the 43 clinics is assigned a code. PROFAMILIA's central administration is treated in the accounting system as another clinic. Whenever a given expenditure is shared by two or more programs, clinics or donors, the expenditure is distributed and two or more entries are made for it. This accounting structure has allowed PROFAMILIA to estimate the cost-effectiveness of its service programs and clinics, since service statistics are also kept for both.

4.2 Service Statistics Information System

PROFAMILIA's service statistics information system yields data on all contraceptive sales and medical services offered by each clinic and service program. Contraceptive sales, IUD insertions and sterilizations are converted into CYP by standard IPPF equivalencies (100 condoms or vaginal tablets or 13 pill cycles are equal to one CYP; one IUD inserted is equal to 2.5 CYP; one sterilization is equal to 12.5 CYP).

In the case of sales of contraceptives, the sales invoice is the basic record of the information system. Whenever a sale is made, the instructor gives the original invoice to the client and sends copies to the community marketing and accounting

departments. Appendix 1 shows a copy of an invoice and the instructions for completing it. In the case of drugstores, the instructors record only the quantities of each contraceptive sold, whereas in the case of CBD posts, they record the quantities left on consignment, the stocks found in the CBD post and the amounts sold during the period. PROFAMILIA's systems unit has a master record of CBD posts and drugstores that is updated every month. Sales statistics are produced every three months, so each instructor can see the trends observed in each sales outlet in her or his assigned area.

In the case of medical services, the clinical history is the basis of the information system. At the end of each day, an assistant records the number of services provided by kind of service and by medical office in a daily record. At the end of each month, daily records are added up to produce a monthly summary of services provided. These in turn are sent to the evaluation department, where the data is entered into computers and processed. Appendices 2-4 present copies of a clinical history, a daily record and a monthly record of clinical activities.

4.3 Baseline, Midpoint and Endline Surveys in Cundinamarca and Santander

Three surveys were conducted in Cundinamarca and Santander to assess changes in the knowledge, use and unmet need for contraception. The baseline surveys took place in April 1984, before the service strategies tested in the Phase I study were implemented. The Midpoint surveys were conducted in June, 1986, when the CSM strategy had been stopped and the CM strategy was being initiated in Santander. The midpoint surveys were really endline surveys for the Phase I study and baseline surveys for the Phase II study. Finally, the endline surveys took place in the last months of service delivery in the Phase II study, in November/December, 1987.

The sample frame used was the same in all the surveys, and in each case a representative multistage stratified sample was obtained. In each survey, 12 municipalities of each Department were randomly selected from the 31 municipalities in Santander and 50 in Cundinamarca that comprised the project areas. Segments of each selected municipality were randomly selected in both urban and rural sectors. These segments were outlined on maps and a sampling fraction assigned to each one. Households were selected according to the sampling fractions, and all ever-married women of fertile age (15-49 years old) in each selected household were interviewed.

Table IV-1 shows that 1,491, 1,512 and 1,206 complete individual interviews were made in the baseline, midpoint and endline surveys in Santander, compared with 1,627, 1,094 and 966 interviews in Cundinamarca. In the second and third surveys in both Cundinamarca and Santander, about 60% of the interviews were made in urban areas. In the first survey, the proportion of interviews conducted in urban areas was about 42% in Cundinamarca and 51% in Santander. The rate of individual interviews completed varied from 90% to 96%. The most frequent cause for not completing individual interviews was absence of the eligible respondent in the three visits made to the household. The number of individual interviews made in the different surveys represented between 39,000 and 70,000 ever-married women in project areas.

The respondents of the three surveys in each Department were similar in terms of their age, years of schooling, marital status and number of children. The age distribution was approximately rectangular from 20 to 40 years of age in all surveys. Between 30 and 40% of the women interviewed in the three surveys had less than three years of schooling, and around 60% had three or more living children (Table IV-2).

Appendices 5-7 show the questionnaires used in the first, second and third surveys in Cundinamarca and Santander. In addition to the basic information needed to evaluate the performance of the service delivery strategies, these surveys explored other topics to help PROFAMILIA design other projects. The baseline survey explored reasons for non-use of contraceptives and perceptions of the respondents' husbands. The midpoint survey explored satisfaction with methods and sources, and contraceptive continuation rates. The third survey explored knowledge of correct contraceptive use and knowledge of AIDS.

4.4 Distributors' Survey

In March 1987, PROFAMILIA conducted a national CBD Distributor Survey to assess the distributors' knowledge of contraception and to see if the distributors recruited to reestablish the CBD program in Santander had received adequate training.

A random sample of distribution posts was selected from the 3,456 posts considered active in PROFAMILIA's files as of December, 1986. The counties included in the sample frame were the same as those included in a survey conducted in 1984 for the same purposes. To reduce costs, only counties with three or more

posts were part of the sample frame of the two surveys. The 1987 survey also included all the CBD posts that had been opened in Santander, regardless of their location or number of posts in each county.

The 1987 sample included a total of 723 CBD posts. Table IV-3 shows that 21% of the interviews were not completed, mainly because PROFAMILIA's lists of distributors and CBD posts were outdated. 6.9% of the 723 posts were no longer distributing PROFAMILIA products, 3.6% were only occasional buyers who had been billed but had never been regular distributors, and 4.6% had some problem with the address. One distributor refused to be interviewed, and 20 distributors were away from their posts at the time of the visit.

The characteristics of the distributors interviewed in 1987 were similar to those surveyed in 1984, but in 1987 they were slightly better-educated and less likely to be using contraceptives at the time (Table IV-4). In 1987, there was still a small proportion (1.8%) of illiterate distributors. Also, a larger proportion reported that they were distributors for social service reasons. Finally, the proportion of posts in private homes had decreased since 1984, while those in public places such as small stores, and "other" places like beauty parlors, shoe stores, etc. had increased (Table IV-5).

The characteristics of distributors in Santander were similar to distributors elsewhere, but they tended to be slightly older and less likely to be currently married or using contraceptives. About half of the 27 distributors in Santander had been recruited after the end of Phase I. The remainder had been supplied during Phase I by the CSM wholesale distributor, who had retained a few CBD posts which he felt were commercially promising. (Table IV-6).

The questionnaire used in the distributors' survey is presented in Appendix 8. In addition to obtaining the basic data on the distributors' knowledge of contraceptive use, the survey also explored the distributors' perception of PROFAMILIA's IEC activities, as well as their marketing experiences.

4.5 Cali Condom Survey

In May 1987, PROFAMILIA conducted a survey to determine the long-term effects of generic condom radio advertising in the city of Cali. This survey used the same sample frame that a 1984 pretest and a 1985 post test had used to evaluate the effects of a radio campaign to promote condom use. This sample frame comprised the most updated list of national, state and local government organizations, and of manufacturing companies with 10 or more employees in Cali, elaborated by the National Statistics

Department. In addition, in each survey about 200 unemployed males over 17 years old were interviewed in the streets in different parts of the city.

The samples themselves were probability, cluster bietapic samples for the business and government workers, and nonrandom in the case of street interviews. In the first survey, 1,767 interviews were conducted in August, 1984 in 18 governmental and 40 private business organizations. In the second survey, 2,669 interviews were conducted in May, 1985, using the same organizations as in 1984 plus 17 new governmental and 40 new private enterprises, and a new sample fraction. In the 1987 survey, 1,519 interviews were made in 16 governmental and 41 business organizations that were selected from the updated sample frame.

The people interviewed in 1987 were somewhat younger and more educated than the people interviewed in 1984 and 1985. In 1987, there was also a larger proportion of single men employed in the private sector (Table IV-7). Similarly, the men interviewed in 1987 were less likely to know of most contraceptive methods, but were almost as likely to have ever-used them than those interviewed in 1984 and 1985 (Tables IV-8 to IV-10).

In addition to the questions on knowledge, use and purchases of condoms, exposure to mass media and radio message recall, the 1987 survey questionnaire explored knowledge and perception of brands, perception of condoms, and knowledge of AIDS. The 1987 survey questionnaire is presented as Appendix 9.

4.6 Nielsen's Retail Index Service

Starting in November, 1987, PROFAMILIA hired for one year A.C. Nielsen de Colombia Retail Index Service to better understand the characteristics of the contraceptive market in large urban drugstores. The Nielsen's Retail Index audits every two months a representative sample of the 4,465 drugstores and 457 supermarkets located in Colombian cities with populations over 20,000 inhabitants. In each audit, Nielsen checks inventory levels and invoices for sales and purchases for a two-month period. This allows them to provide their clients with bimonthly information on sales, purchases, inventory levels, average prices, stock-outs and other crucial marketing information for a given class of products (like pills, condoms, etc.), and the more important brands in each class (like Microgynon, Noriday, etc., in the case of pills).

The Retail Index Bimonthly Report includes 60 tables. Fifteen of these are devoted to contraceptive products in general and 15 to contraceptive brands: pills (Noriday, all Schering

brands, all Wyeth brands, and others), condoms (Tahiti, Majestic, Rosetex, Orquidea, and others) and vaginal tablets and suppositories (Norforms, Neosampoon, Farma 12, and others). In each case, seven tables present data by geographical region and eight tables by type of outlet and geographical region. The geographical regions analyzed in the report are Colombia, the Atlantic Coast, Antioquia, the Eastern Region, Bogota, the Central Region, and the Pacific Region. At the national level, outlets are broken down into four categories: all supermarkets, private supermarkets, cooperative supermarkets and drugstores. At the regional level, data on all supermarkets and drugstores are presented for Bogota and the rest of the country. It should be pointed out that sales in supermarkets always refer to drugstores located within supermarkets.

A more detailed description of the marketing data generated by the Retail Index may be found in section 5.5.2, where the layout of the tables included in Nielsen's reports is explained.

4.7 Clinics' Survey

To distribute the cost of fixed assets and services of PROFAMILIA's clinics among service programs, it was necessary to obtain information on the area occupied by each service program in the clinics, as well as the number of telephones, faucets and energy consuming equipment in these areas. Because the costs of visiting 38 clinics would have been prohibitive, this information was obtained by studying a representative sample of the clinics. To account for the wide variety of clinic sizes and volume of services provided, the clinics were classified in four stratified groups: (a) new clinics, of which there were seven, (b) small clinics, of which there were 13, (c) medium-sized clinics, of which there were 14, and (d) large clinics, of which there were four. Of these, 15 clinics were included in the final sample in order to keep the standard error for average sales (which was the only variable well known in each clinic) below 10%. The importance of the four large clinics led to their inclusion in the sample. In addition, two new clinics, four small clinics, and five medium-sized clinics were selected. These clinics were visited in November and December of 1987 by two researchers who measured the relevant variables of the study. Results of the survey are presented in section 5.6.

V. CHARACTERISTICS AND MAIN RESULTS OF THE SIX STUDIES

5.1 Phase I Study

5.1.1 Introduction

The main question that this study sought to answer was whether a contraceptive social marketing (CSM) strategy could replace a community based distribution (CBD) strategy in rural and marginal urban areas where relatively high contraceptive prevalence had been achieved.

The results of this project have vast implications for the funding and management of family planning programs in low and middle income countries. Although CBD programs have been very successful in promoting contraceptive use in rural and semi-rural areas of low availability, knowledge and use of contraceptives, they have traditionally been a costly component of family planning programs. This is due to the need for salaried field workers who carry out IEC activities, the creation of low volume, independent distribution posts in isolated and difficult to reach areas, and the need for fieldworkers to resupply those posts on a frequent basis. CSM programs, on the other hand, should be less expensive than CBD programs because they rely on fewer salaried personnel and sell the contraceptives through pharmacies and other commercial outlets in areas with higher population densities and higher knowledge and use of contraception. Thus, theoretically it should be possible to increase the overall cost effectiveness by switching from one program type to the other once the objectives of CBD programs of raising contraceptive knowledge and use have been achieved. In this case, family planning agencies would be best advised to rely more extensively on established commercial distribution channels and to turn their IEC fieldworkers into salespersons.

5.1.2 Design and Implementation of the Study

To test these ideas, PROFAMILIA selected two Departments where the traditional CBD and CSM programs had coexisted for the last decade (a detailed description of the evolution and characteristics of these programs can be found in sections 2.3.1 and 2.3.2 of this report). In one of the Departments, PROFAMILIA discontinued the CBD program and extended the CSM program to include rural and semi-rural areas. In the second Department, the CBD and CSM programs continued operating as usual. The only change was the introduction of incentives to the CBD instructors for sales above goals. PROFAMILIA decided that if the cost effectiveness improved significantly with the CSM strategy, and

if this improvement was not accompanied by decreased contraceptive knowledge and use levels or by an increase in the unmet need for family planning in project areas, then the CSM strategy would be extended to the rest of the country and would replace the CBD program.

The Department selected to test the CSM strategy was Santander. To begin the Phase I project there, the nearly 150 CBD posts were discontinued and replaced by an enlarged CSM program in which PROFAMILIA's wholesale dealer began supplying small rural drugstores in addition to his regular urban clients. In order to make the experiment attractive to the wholesaler, the project paid him a monthly fixed amount (about US $500) for wages and travel expenses of a salesman, who devoted his time to contraceptive sales in urban and rural areas of Santander. In addition to the rural and urban pharmacies, the salesman serviced a few former CBD outlets which he considered commercially profitable. The salesman's product line included Schering and Noriday pills, Norform and Neosampoon vaginal tablets, and Tahiti and Sultan condoms. The only promotional activity that took place during the project was the distribution of a pamphlet on contraceptive methods that was placed in drugstores. In addition, 46 pharmacists attended four three-day seminars that were meant to increase their knowledge of contraception and to help them guarantee quality services to their customers. The salesman covered 35 counties with a total population of 946,493 inhabitants, of which 352,000 were urban residents in the capital city of Bucaramanga. The remaining 594,493 inhabitants resided in semi-urban and rural areas of small towns. Excluding Bucaramanga, the proportion of the rural population was 51%. The salesman traveled by public transportation and made only cash sales. In an average month, he was able to visit about 80 outlets in some 18 counties, out of approximately 400 drugstores in the area.

In the Department of Cundinamarca, as elsewhere in the country, PROFAMILIA's regular CSM program coexisted with the CBD program and continued supplying wholesalers and large urban drugstores with contraceptives. The only difference between the CBD program in Cundinamarca and those of other Departments was that the three CBD instructors in Cundinamarca began receiving commissions for contraceptive sales above goals set for them by PROFAMILIA. Sales goals were set according to the population of the assigned area and the desired coverage levels. At the beginning of the project, commissions equaled about 10% of each method's value. Since the commissions were not adjusted by the inflation rate in Colombia, these incentives were nearly 50% smaller in real terms by the end of the project. The instructors walked or traveled by public transportation and visited each distribution post at least every three months to resupply them, collect money and statistics and provide training. They also opened new CBD posts and devoted about two-thirds of their time to educational activities. The three instructors serviced an

average of 70 CBD posts in 50 counties with a total population of 585,500 persons, with a range of 3000 to 56,800 inhabitants per county and a proportion of rural inhabitants of about 55%. In addition, they also made sales to small drugstores in the rural areas of these counties.

5.1.3 Cost Effectiveness and Contraceptive Prevalence Analysis

To calculate the efficiency of the strategies, all the costs were subtracted from the revenues of contraceptive sales, and the result was divided by the total CYP sold in each area. In the case of the CSM program, costs included those incurred from the purchase of contraceptives and the fixed amount given to the wholesaler for the salesman's expenses, as well as the cost of the pamphlets. However, the expense of training the pharmacists was not included because it was thought that this activity would not normally be part of a commercially oriented strategy. In order to make the CSM cost-effectiveness data comparable to those of Cundinamarca, two sets of revenue/cost figures are presented for the CSM experiment, one total for the entire department, including the large city of Bucaramanga, and one total for just the rural and semi-urban regions(i.e., excluding Bucaramanga). To arrive at the latter figures, income from sales in Bucaramanga was subtracted, as were the costs from the purchase of the contraceptives sold there. Operating costs were recalculated to exclude travel and perdiem in Bucaramanga, and to include the pro-rated cost of the leaflets, a base salary for the salesman equal to 1.2 times the legal minimum wage in Colombia at the time, plus 3% of sales (excluding Bucaramanga) paid as commissions. This was recalculated in this way because the wholesaler paid his other salespersons according to that formula.

In the case of the CBD strategy, costs included contraceptives, instructor wages and benefits, travel and perdiem, and educational materials such as brochures and manuals for the distributors. CYP was calculated using conventional IPPF methods (13 pill cycles, 100 condoms, or 100 vaginals equal one CYP). As in Santander, referrals for sterilizations or sterilizations actually performed in the clinics were not included.

To test the effectiveness of the strategies, baseline and endline (i.e., midpoint) sample surveys were carried out among ever-married women between 15 and 49 years of age living in rural, semirural and marginal urban areas serviced by the projects. These surveys provided information on changes in contraceptive knowledge and use, and in unmet need for family planning. In the case of the CSM strategy, it was decided that if knowledge or use levels decreased, or if unmet need increased,

the strategy should not be used to replace CBD in project areas, even if it proved to be more cost-effective. The surveys were conducted in July 1984 and June 1986.

5.1.4 Results

Cost-effectiveness figures for each strategy are presented in Table V.1-1. The CSM strategy was the only one that yielded a net profit, achieving an impressive net income of $1.18 US per CYP for the two year period. Even when the area covered by the salesman was restricted to rural and semi-urban areas, the CSM strategy still achieved a net profit of $0.20 US per CYP, compared to a cost per CYP of $4.20 in Cundinamarca. The figures show that the main reason for this discrepancy was in the operating costs of each strategy, rather than their revenues. Whereas $16,225 were spent in two years to service Santander under CSM, the expenditures in Cundinamarca for the same period were $69,004, mainly due to personnel costs. The large proportion of sales in Santander that were made in Bucaramanga (83% of all CYP sold) should also be noticed, because it has important implications for the analysis.

Table V.1-1 obscures the fact that during the life of the project, a negative sales trend was observed for the CSM experiment, while the CBD strategy showed a positive trend over time (Appendices 10 and 11 present semestral cost effectiveness results for Cundinamarca and Santander, respectively). These trends were due in part to a government price freeze on pharmaceutical products, and in part, to increased competition from commercial distributors. With the retail price of pills frozen in Colombian pesos and their cost of acquisition denominated in dollars by the pharmaceutical companies, the devaluation of the peso progressively shrunk PROFAMILIA's and the dealer's profit margins. Further, another decree had forbidden the sale of donated pharmaceutical products at more than 10% of their free on board (FOB) value, and the sale of those products through intermediaries or persons not belonging to the organization that had directly obtained the donation. This made it impossible to make a profit on sales of those products and to legally sell donated products like Noriday Pills and Tahiti condoms through the CSM program (PROFAMILIA considered that CBD distributors were associates rather than intermediaries and that they could continue selling donated products through the CBD posts). Due to these problems, PROFAMILIA was forced to cancel its contracts with its CSM dealers in April, 1986. Another consequence of the decreasing profit margins was that the pharmaceutical companies began to limit contraceptive sales to PROFAMILIA in order to keep the wholesale market to themselves and to force PROFAMILIA to confine marketing activities to the CBD program.

Regarding IEC activities carried out by instructors in Cundinamarca, Table V.1-2 shows that they addressed over 21,000 persons in educational meetings and around 5,600 in household visits, as well as leading 434 training sessions with distributors. Assuming that all people were addressed by the instructors only once, we can conclude that the instructors reached approximately 42% of the women aged 15-44 in the rural project areas of Cundinamarca.

Like most family planning associations, PROFAMILIA is a non-profit organization that seeks to promote knowledge and use of contraceptives. There would be no sense in changing service strategies to become more self-sufficient if as a consequence those social objectives could not be achieved. CBD educational activities are meant to increase contraceptive knowledge and use, and provide increased accessibility through contraceptive distribution posts. Family planning agencies generally assume that the increased coverage of these programs justifies the added financial burden they imply. However, do IEC activities need to continue once high levels of contraceptive knowledge and use have been achieved? Would a reduction in the number of CBD distribution posts reverse the progress achieved by CBD in marginal urban and rural areas?

Table V.1-3 shows that IEC activities carried out by CBD instructors in Cundinamarca did not increase the level of contraceptive knowledge in those areas. The proportion of people that knew of at least one, two, three, four or five modern contraceptive methods between the baseline and midpoint surveys remained the same in statistical terms. The same results were observed in Santander, the CSM area where no IEC activities took place. Similarly, contraceptive use remained virtually unchanged in both the CSM and CBD regions two years after the beginning of Phase I, even though one region maintained the CBD network and elaborate IEC activities while the other had none. The unmet need for modern contraceptive methods declined by 18% in the CSM area, which was somewhat less than in Cundinamarca (23%).

Finally, Table V.1-4 shows that discontinuing the CBD program in Santander did not mean transferring large numbers of users (and subsidies) from the private sector to the public sector. The proportion of current users served by PROFAMILIA decreased marginally, and there was a slight increase in the proportion served by all other sources, both private and public. Although CSM sales declined during the period, other commercial suppliers were able to close most of the supply gap. In Cundinamarca, there was an important increase in the proportion served by drugstores, and a decrease in the proportion going to PROFAMILIA and the MOH for contraceptive supplies. Thus, the increase in sales by the CBD program in Cundinamarca seems to have taken place through the small drugstores served by the instructors.

5.1.5 Conclusions

The results of this OR project indicate that once relatively high levels of knowledge and use of contraceptives have been achieved in rural and semi-urban areas, CSM programs can replace CBD programs with no decline in contraceptive knowledge or use. Nor will there be an increase in the unmet need for modern contraceptive methods. To be more precise, the evidence presented here shows that the transition from one program type to the other can take place when 55-65% of ever-married women are using contraceptive methods, or when 45-50% are using modern methods.

Even though the transition from CBD to CSM almost certainly implies financial gains, family planning organizations should carefully assess the benefits of fully commercializing their service delivery systems. PROFAMILIA's experience has been that once commercial practices are adopted, the organization is more susceptible to political and economic factors such as price freezes, exchange rates, etc. Also, when family planning organizations are supplied with contraceptives by local commercial producers and the two subsequently compete for sales in the commercial contraceptive market,the pharmaceutical companies will probably try to push the family planning organizations out of the market to increase their own profits. It could be argued that in such a case, the existence of the family planning organization would be irrelevant, since the commercial distributors would continue to supply contraceptives to consumers. However, it is unlikely that a commercial operation would sacrifice some of its profits to supply remote areas where costs exceed sales, which is a routine practice of CSM programs carried out by family planning organizations. Also, such a position ignores the fact that family planning CBD fieldworkers and salespeople, unlike purely commercial salesmen, are instrumental in making clinic-based methods (like the IUD, sterilization and Norplant (R)) available to consumers through referrals to clinics. Also, they contribute to the achievement of other legitimate social objectives of family planning agencies, like providing better quality care to contraceptive users through the training of service providers, increasing information and choices available to consumers, and delivering more user-oriented services. Therefore, it would appear that family planning agencies would achieve greater stability and acceptable levels of cost-effectiveness by maintaining their field workers and captive network of distribution posts, enlarging the areas and number of outlets serviced by each instructor, supplying small rural and large urban drugstores (but not other wholesalers), and substantially reducing the amount of time dedicated to IEC activities. In this way, because of their strong sales force, the family planning agency would remain an attractive customer to

the local commercial producers rather than a competitor. Thus, the agencies would continue to pursue their social objectives while becoming more financially self-sufficient at the same time.

5.2 Phase II Study

5.2.1 Introduction

According to the project proposal, if Phase I results showed that CSM was a cost effective strategy in rural and semi-rural areas, then PROFAMILIA would extend the strategy to other areas during Phase II of the project. On the other hand, if Phase I showed that CSM was not cost effective, or if it led to decreased knowledge and use of contraception in project areas, then Phase II would be used to reestablish the CBD program in Santander. Phase I proved that the CSM strategy was financially more efficient than CBD in rural areas with high contraceptive use, and that the increased efficiency was not achieved at the cost of decreased knowledge and use of contraception or of increased unmet need for family planning. However, because of the problems mentioned earlier (difficulties with local companies in the supply of contraceptives for the CSM program, the peso devaluation and a governmental price freeze on all pharmaceutical products that eroded profit margins, and a governmental decree forbidding the sale of donated pharmaceutical products at a price over 10% the FOB price of the product and the sale of these products through intermediaries), PROFAMILIA was forced to terminate the CSM program in all of Colombia in 1986. Thus, Phase II of the project was used to test a new strategy that would allow PROFAMILIA to continue selling through commercial channels while increasing the cost effectiveness of the traditional CBD strategy.

5.2.2 Design and Implementation of the Study

Based on the results of the Phase I study, PROFAMILIA decided to test in Cundinamarca and Santander a mixed CBD-CSM strategy that is now called community marketing (CM). Under the new strategy, CBD instructors were trained as sales people and started selling contraceptives to commercial outlets that had previously been supplied through CSM. In addition, the instructors were still responsible for many of their traditional duties such as opening new CBD posts and visiting existing posts every three months to resupply them with contraceptives, to collect sales revenues and statistics, and to carry out IEC activities in the communities. The only difference between the strategies tested in Cundinamarca and Santander was that the

instructors in Cundinamarca continued receiving the same incentives for sales above goals that they had received during Phase I.

In Santander, three CBD instructors who had been working for PROFAMILIA in other projects were given the task of rebuilding the CBD program there, selling contraceptives to large drugstores and wholesalers in urban areas and engaging in IEC activities in the communities.

To allow the instructors in both Cundinamarca and Santander to absorb the responsibility for CSM sales in their areas and to maintain PROFAMILIA's sales levels, some of these activities were given a new emphasis and others were de-emphasized. The instructors were told to insist on cash sales to distributors and reduce to a minimum leaving contraceptives in consignment; to decrease the amount of IEC activities; to always address groups rather than making household visits; and to attempt larger sales to reduce the frequency of resupply visits.

The instructors were assigned zones with roughly the same population, except for an area that included the city of Bucaramanga. The instructors in Cundinamarca were posted in the small towns of Pacho, Guaduas and Fusagasugá, whereas the instructors in Santander were posted in the largest urban area in their zones: Bucaramanga, San Gil and Barbosa. Sales goals in Santander were initially the same as sales in each zone reported in 1986 by the CSM distributor. In Cundinamarca, goals were established by summing the 1986 CSM and CBD sales in each zone.

In both Cundinamarca and Santander, the instructors delivered contraceptives to their customers on the spot. The instructors in Santander kept a stock of contraceptives in their homes which they replenished each month when they visited PROFAMILIA's clinic in Bucaramanga to collect their salary. Occasionally, when they made a very large sale which they could not cover with their stock, or when they ran out of contraceptives, they arranged with the warehouse in Bucaramanga or Bogota the direct delivery to their customers by means of a regular parcel delivery service.

The instructor discussed their monthly workplans with PROFAMILIA's regional supervisor. The workplan detailed the counties to be visited during the month, the distribution posts to be established, and the IEC activities to be carried out. The regional coordinator spent a couple of days with each instructor every other month. In these visits, the coordinator verified that the reported activities had taken place, accompanied the instructors to provide on-the-job training and checked the distributor's knowledge on contraception.

5.2.3 Cost Effectiveness and Contraceptive Use Analysis

As in phase I, project statistics were obtained from PROFAMILIA's routine information system. The efficiency of the strategies was calculated by subtracting all costs from contraceptive sales revenues, and by dividing the result by the total number of CYPs sold in each area. The costs included those of contraceptives, instructors' and supervisors' wages and benefits, travel and perdiem, and educational materials.

To test the effectiveness of the strategies, surveys at the beginning (midpoint survey) and the end (endline survey) of field activities were carried out among ever-married women of reproductive age. These surveys provided information on changes in contraceptive knowledge and use, and changes in unmet need for family planning in project areas. The surveys were conducted in June 1986 and November 1987.

5.2.4 Results

Table V.2-1 presents the results of the cost effectiveness analysis of the community marketing strategy tested in Cundinamarca and Santander. In Cundinamarca, a cost of US $1.52 per CYP was achieved, which was a large improvement over the US $4.25 per CYP observed during the Phase I study under the CBD strategy. In Santander, the cost per CYP was US $0.43, lower than that in Cundinamarca, but considerably less favorable then the US $1.22 profit per CYP observed in the Phase I study under the CSM strategy. The differences in the cost effectiveness between Cundinamarca and Santander seemed to be due to the large city of Bucaramanga being included in the Santander project area, and the smaller number of CBD posts in Santander, rather than the fact that incentives were paid to the Cundinamarca instructors for sales above goals. Therefore, the instructors in Santander were able to sell more contraceptives under lower operating costs than the instructors in Cundinamarca. However, comparing the results with those of Phase I, we see that the switch from CBD to CM in Cundinamarca led to an increase in contraceptive sales from 10,436 to 16,050 CYPs, while in Santander the switch led to a decrease in sales from 33,689 to 18,868 CYPs. In Appendices 10 and 11 we see again that incentives accounted for a very small portion of operating costs in Cundinamarca, and that the cost per CYP of the CM strategy tended to increase over time in both Departments, mostly as a consequence of increases in the cost of contraceptives to PROFAMILIA.

One of the advantages of the CM strategy is that fieldworkers can still engage in IEC activities in the communities they serve. As the transition towards high contraceptive prevalence in rural areas becomes complete,

fieldworkers should decrease activities aiming to recruit new users and should increase activities that result in improved use of contraceptives through more information on choices that achieve particular family planning goals, and more convenient supply posts. In practice this would mean a proportional increase in training of contraceptive retailers, talks to groups and referrals for female sterilization, and to decrease the number of household visits and, perhaps, but not necessarily, the number of talks to adolescents who are not sexually active. Overall, there should be a substantial decrease in the total amount of IEC activities to allow the instructors to absorb the increased work load of making contraceptive sales to large drugstores and wholesalers. Table V.2-2 shows that these objectives were not completely met by the instructors in Cundinamarca and Santander. It seems that when they were instructed to decrease IEC activities, they decided mostly to reduce the number of household visits. An unanticipated consequence of this in Santander was a reduction in the number of referrals to PROFAMILIA's clinics for female sterilization, which was a concern to the executive director, who places a high priority on that method. Likewise, talks to adolescents were basically cut to zero, and there was a decline over time in the number of training sessions to contraceptive retailers and in the number of talks to groups. This was especially true in the last semester of the project, when there was heavy pressure on the instructors to achieve sales goals. However, when we compare the IEC activities in Cundinamarca in Phases I and II, we see that the trends were according to the instructions provided to the instructors: there were increases in training sessions and female sterilizations, a slight increase in talks to groups of adults, and a large decrease in the number of household visits.

Even though there was a decreasing trend in the amount of IEC activities in Cundinamarca, contraceptive use increased substantially and the unmet need for family planning continued to decline. These same results were observed in Santander, where IEC activities were begun again after two years of Phase I CSM activities with no IEC. Likewise, awareness of contraceptive methods remained essentially the same between the midpoint and endline surveys in both Cundinamarca and Santander. The only relevant result regarding knowledge of contraceptive methods was that a larger proportion of people in Cundinamarca reported knowing or having heard of at least seven methods, which was brought about by an increase in the number of women who were aware of vasectomy in the endline survey (Table V.2-3). Since no differences between the baseline and midpoint surveys were observed in knowledge or use in either Department during Phase I (when there were IEC activities in Cundinamarca, but not in Santander), and since similar increases in contraceptive prevalence and decreases in unmet need occurred in both departments between the midpoint and endline surveys (despite the fact that more IEC activities occurred in Cundinamarca than in

Santander), it is difficult to claim that IEC activities in and of themselves had much influence on contraceptive knowledge or use in the target areas.

Finally, Table V.2-4 shows the changes in contraceptive sources observed in project areas between the beginning and end of Phase II activities. If we consider only the contraceptive sources of women using methods sold in drugstores and CBD posts, we see that in Cundinamarca there was an increase in the number of women going to Ministry of Health (MOH) outlets and a decrease in the number going to PROFAMILIA and drugstores. If we include users of the IUD, we see that the proportion served by PROFAMILIA remained constant, and the gains of the MOH outlets were less pronounced. In Santander, nearly opposite results were obtained: if we include only nonclinical methods, there was a decrease in the proportion served by the MOH, an increase in those served by PROFAMILIA, and an equal proportion served by drugstores; including the IUD, the proportion that went to PROFAMILIA decreased and the proportions going to private physicians and drugstores increased. There is no clear explanation for this last result.

5.2.5 Conclusions of Phase II Study

Well before the end of the Phase II study, PROFAMILIA decided to extend the CM strategy to all areas where there were CBD programs in place. From this perspective, the operations research project should be considered a success, even though the truth is that the nationwide adoption of CM was more a result of circumstance than of the particular merits of CM as revealed by the project. Be that as it may, the new CM strategy allowed PROFAMILIA to recover its preeminent place in the national contraceptive market after declines observed during 1985 and 1986 caused by CSM sales losses.

From a more theoretical perspective, the CM strategy seems to be an adequate response of non-profit family planning organizations to survive and prosper once their main objective of making contraception available to nearly the whole population in need has been achieved. The CM strategy has the advantage of being less costly than traditional CBD approaches while preserving an infrastructure of field workers that allows the organization to promote other family planning objectives. These include the introduction of new contraceptive methods, the referral of users interested in methods like Norplant (R), the IUD and sterilization to family planning clinics, and better education of consumers for proper use of contraceptives. It may also allow family planning organizations to expand and diversify their range of interests to other social development areas, such as marketing oral rehydration salts and antihelmintics, that would seem to fit well within the services of an organization

involved in social marketing of reproductive health products. On the other hand, it has the disadvantage of not producing a profit (or perhaps producing only a very small profit) that could help offset the costs of other programs. For example, PROFAMILIA performs nearly 75% of all sterilizations in Colombia at low cost, and is able to do so mostly by virtue of international donations. Without such donations it would have to raise its prices and thus limit sterilizations to women in the upper income segments. Thus, the need for continued donations for clinical services is a must, but because such donations may be harder to come by in the future, the need for profits or at least self-sufficiency in CM programs would also seem to be an urgent task.

This project also highlighted the difficulties involved in transforming CBD programs into more commercially oriented marketing programs. Even though the instructors were ordered to substantially reduce the amount of time devoted to IEC activities, the results showed that they did so in a limited way. Further, although no data was collected on the topic, it seems that the contents and strategies of IEC activities continued to be the same as under the CBD program, and that they were not re-focused to achieve new objectives as mentioned earlier. Only after 12 to 18 months were substantial changes observed, and these required both training in new skills, such as how to sell in a commercial market, and heavy pressure from PROFAMILIA directors to achieve sales goals. Thus, organizations wishing to change their marketing strategies should be aware that such transitions take time, and they require the intense involvement of management and the extensive retraining (almost re-programming) of fieldworkers.

5.3 Distributors' Survey

5.3.1 Introduction

In 1984 PROFAMILIA conducted a national survey of community-based distributors to measure their knowledge of contraceptive methods. This was done because it was learned from supervisory visits to distributors (part of a separate Population Council project) that they could not always describe how to use the methods correctly, and that, in many cases, incorrect information was given. These observations, plus other survey results which showed that many users of oral contraceptives did not know how to use the method correctly, raised questions regarding the distributors' training and their ability to provide quality services to their communities (Townsend and Ojeda, 1985).

Since the results of the 1984 survey showed that there were indeed some weak spots in the distributors' knowledge of contraceptives, PROFAMILIA organized several short term courses

for them between 1984 and 1987, and also insisted that the instructors refresh the distributors' knowledge every time they made a resupply visit.

In March 1987, PROFAMILIA conducted a new CBD Distributor Survey which tested the distributors' knowledge of contraception. The survey also tested the knowledge of distributors in the new CBD posts in Santander which were opened as part of the Phase II study. The results of the survey are presented in this section.

5.3.2 Results of Distributors' Survey

Table V.3-1 illustrates the strong effort made by PROFAMILIA between 1984 and 1987 to train its community-based distributors. Although the proportion who had received some training decreased from 85.9% to 82.8%, by 1987 about half of the distributors had participated in a short one-to-three-day course on contraception sponsored by PROFAMILIA. In 1984, by contrast, practically all distributor training was simply a series of short briefings or talks given by the instructors during resupply visits. In any case, a very large increase in personal talks (59%) and group sessions (31%) was also observed.

The proportion of distributors in Santander who had received training was below the national average, but only by 5 percentage points. Both personal and group talks by the instructors were more prevalent in Santander than in other regions, even though there were basically no training activities there in 1984/1985 because of the CSM experiment. Almost all the distributors thought the instructors had taught them contraception either well (72.1%) or very well (27.1%) (Table V.3-2).

In both surveys, distributors were asked a battery of questions regarding the use of each contraceptive method. It was evident that training had a significant effect on a distributor's knowledge. Although short-term courses produced the most desirable effects, the cumulative effect of this training style over other styles is not as strong as might be expected. Translating the results of Table V.3-3 to a 0 to 10 scale, we see that those distributors who had not received training received a grade of 5.5 in pills, compared to 7.3 for those who had received training. For barrier methods, the difference was 8.7 vs. 9.7; for female sterilization, it was 7.2 vs 8.7; for vasectomy, it was 5.4 vs 7.8; and for the IUD, it was 5 vs 6.

Table V.3-4 shows that the longer a person had been a contraceptive distributor, the more knowledgeable he or she was regarding contraceptive use. This is particularly true in the case of knowledge of pills and knowledge of female sterilization.

Tables V.3-5 to V.3-10 present the results obtained for each item of the battery of questions for each contraceptive method.

Table V.3-5 shows that there were large improvements in knowledge about such crucial items as when to start taking the pill, when a woman should resume taking 21-pill cycles after one cycle has been finished, what should be done when a woman forgets to take the pill one day, and whether it is advisable for a woman who is lactating to take the pill. On the other hand, knowledge of these last two items continues to be low. Knowledge of when to resume taking a pill after finishing a 28 pill cycle, what women should do if they feel nauseous in the first two weeks of using the pill, and whether it is advisable for women over 35 to take the pill, were also very low. Table V.3-6 shows that not only did knowledge of counter-indications for pill use remain very low, but that there was no improvement since 1984. Only about half of the distributors identified high blood pressure and varicose veins as counter-indications. Cardiovascular disease was mentioned by around 30%, and liver disease and cancer by less than 15%.

According to Tables V.3-7 and V.3-8, knowledge about condoms, vaginal tablets and female sterilization was much higher than knowledge about pills. There appears to have been continued progress in those areas. The only point that remained difficult for distributors was the possibility that sterilization could fail, which about 28% do not know. Also, about 15% thought that women could have children after a sterilization and around 10% that sterilization could change a woman's character.

Although vasectomy continued to be the least known method, Table V.3-9 shows that PROFAMILIA made large advances in this area since 1984, when only about 45% of distributors could give an adequate description of the method. In 1987, 76% could do so. However, by 1987 still one fourth believed that vasectomy was similar to castration and 15% thought that the operation could change a man's sexuality and his character and behavior.

Although the IUD was known as a method by 99.6% of the distributors, Table V.3-10 suggests that their detailed knowledge about where it should be placed and how long an IUD can be used was far from universal: only 60% could tell correctly where in a woman's body are IUDs placed, and only about one third knew for how long women could safely use a Copper-T or a Lippes Loop. Similarly, Table V.3-11 indicates that the distributors would be very poor advisers regarding the rhythm method, since less than 50% knew that pregnancy is more likely when there is sex at the middle of the menstrual cycle. Other distressing results were that only 66.4% understood that family planning is having the number of children wanted when they are wanted, and that 55% did not realize that PROFAMILIA is a private institution.

5.3.3 Conclusions of Distributors' Survey

Although a strong effort has been made in recent years to provide basic training in contraception to the distributors, there were still nearly 17% in 1987 who had not received appropriate training, perhaps because of high turnover among distributors (that could be over 20% a year considering the number that has been in the program less than a year). Training had a significant effect on contraceptive knowledge levels, but there are many areas which remain weak. If we consider the expense involved, perhaps bringing the distributors together for short-term courses is not the most cost-effective strategy. The currently implemented strategy of instructor-to-distributor delivery of information may be the best system to pursue. Also, since seniority as a distributor is directly related to knowledge, and there are high costs involved in drafting and training distributors, PROFAMILIA could consider providing monetary incentives for those who become distributors for longer periods of time. Although there has been a definite improvement in contraceptive knowledge, there are still many weak spots that should be emphasized in information-delivery programs by PROFAMILIA's instructors in the near future, especially regarding use of the pill (including side effects and dangers), vasectomy, the IUD, and other general points such as the meaning of family planning and how fecundity is related to the menstrual cycle. Finally, it should be pointed out that the distributors in Santander still seemed to be slightly less knowledgeable about contraception than their colleagues elsewhere. However, the differences were not large, and project instructors in Santander should be congratulated for providing such good training to their distributors while reestablishing the whole CBD program in the area and absorbing CSM sales.

5.4 Cali Condom Survey

5.4.1 Introduction

In 1984 and 1985, PROFAMILIA carried out an OR project in collaboration with Somarc and Johns Hopkins University in the city of Cali to test the effectiveness of generic radio advertising campaigns to increase the knowledge, use and sales of condoms. PROFAMILIA used a before-and-after research design in which surveys were conducted among a sample of males 15-60 years old in August, 1984, and May, 1985. The radio campaign itself included five different radio spots that were aired between October 1984 and March 1985. The spots were aired on seven different stations at a rate of 10 spots per day, for about five months. All spots were conversational in nature, one taking place

in a drugstore, one in a clinic, one in a factory work place, one between male friends, and one between a couple. All ended with the message that loving responsibly is also a duty of men. Appendix 12 shows examples of the script of the spots.

In May, 1987, this project conducted a follow-up survey in Cali to determine the long-term effects of generic condom radio advertising. Using data from all three surveys, impact was measured as changes in ever-use and recent use of condoms. Because there was no control group, the evaluation consisted in cross-tabulating condom use with various measures of message recall and analyzing the differential patterns of use. The results of this study are presented in this section.

5.4.2 Results of Cali Condom Survey

We first explore in Tables V.4-1 to V.4-4 the exposure to condom advertising and the recall of the radio campaign, and then show in Tables V.4-5 to V.4-7 the effect that exposure had on knowledge, use and purchase of condoms among the men interviewed in 1987.

Table V.4-1 shows the degree of exposure to condom advertising. The radio campaign reached about 80% of the people in Cali, and even after two years about 53% still remembered having heard radio ads, indicating significant long-term recall. Of those who remembered the spots in 1987, about half said they could remember their content, compared to 60% who said they could do so in 1985. A surprising result was the increased recognition of printed promotional materials, such as posters, stickers, brochures and mobiles. By 1987, 27.3% of those surveyed reported having seen some of these materials, up from 21.2% in 1985 and 7.6% in 1984.

The lower the age and the greater the education of the respondents, the more likely they were to remember the content of the radio spots in 1987. However, exposure to the radio campaign did not depend at all on the working sector. The quality of exposure to the campaign was high: when asked to verbalize what they remembered, over 85% gave responses consistent with the messages that PROFAMILIA had aired two years earlier. Only a few respondents said they also remembered condom brands being mentioned in the spots, and almost always the brand remembered was Tahiti. In view of the fact that PROFAMILIA did not mention brands in the spots, and since PROFAMILIA is the sole distributor of Tahiti in Colombia, those people were probably associating other messages with the radio spots (Table V.4-2).

Table V.4-3 shows that about 38% of those who heard the campaign learned something from it, and that more educated men and men under 30 years of age were more likely to have learned.

The facts most commonly learned were that condom use is a matter of responsibility (33%), that it is a safe and practical method (13.3%), and the way condoms should be used (13.7%). About 17.9% of those who remembered the content of the radio messages reported that the ads had strongly motivated them to use condoms, and this was especially true among the unemployed.

Finally, about 31% of those who knew about condoms in 1987 had seen a poster, a sticker, or a mobile. The study showed that younger and more educated respondents were more likely to recall printed promotional materials. These materials had mainly been seen in brochures or magazines (34.9%), in drugstores (22.4%) and in PROFAMILIA's clinic (17.3%). Although very few people remembered any brand or institution associated with these messages, most of those who did mentioned either PROFAMILIA (14%) or Tahiti (7.7%) as the sponsor of the printed message (Table V.4-4).

Table V.4-5 presents the main results observed regarding trends in knowledge, use and purchase of condoms in Cali since the 1984 baseline survey. The results are somewhat contradictory, because even though 1987 knowledge levels were substantially lower than in the 1984/1985 surveys, condom use increased among the respondents. Although the proportion of men who had ever-used the condom in 1987 was similar to that observed before the radio campaign, they were more likely in 1987 to have used the condom as their most recent method (11.3%) than they were just after the campaign (8.6%). Similarly, they were as likely to have used the condom in the last six months (40.1%) as those interviewed in 1985 immediately following the campaign (42.4%).

The proportion of men who had ever purchased condoms remained around 45% across time. However, the radio campaign appeared to generate an increase in the number of men who had purchased condoms in the last six months, and though this proportion decreased slightly in 1987, it continued to be 30% higher than the observed pre-campaign levels. Even more important, over 50% of those who had bought a condom in the last six months of 1987 had also bought a condom in the previous month. Overall, the results suggest that there was a significant short-term increase in the pool of ever-users and recent users. In the long-term, the most important impact was that overall condom use continued to increase because of increased frequency of use among ever-users.

The lack of a control group did not allow us to arrive at a decisive conclusion regarding the long-term effects of condom radio advertising. However, Table V.4-6 shows that, in 1987, those who remembered having heard the radio spots and those who remembered their message were more likely to have used the condom than those who could not remember the ads or their contents.

This was true regardless of whether our dependent variable was ever-use of condoms, use of condoms as the most recent method or use of condoms in the most recent six months. Those who remembered the radio spots and their message were also more likely to report that they had seen a condom, or that they knew how to use condoms, but were not more likely to describe correctly how condoms are used. However, the greatest differences in ever-use, use of condoms as the most recent method and use in the most recent six months were observed between those who said they had been motivated to use the condom by the advertisements and those who said the ads had made no difference. In contrast, exposure to printed materials made no difference in any of the condom use variables. Overall, the results suggest that the radio campaign had a substantial and lasting impact on those who listened to it.

Table V.4-7 shows the long-term effect that exposure to the radio campaign and message recall had on knowledge of sources and condom purchase habits. Recall of the campaign had a very slight effect on knowledge of condom sources, and remembering the content of the messages, learning something or having been motivated to use condoms by the campaign, or exposure to printed materials had no effect upon knowledge of condom sources. On the other hand, there was a strong correlation between recalling the content of the radio campaign and having purchased a condom at some point, in the last six months or in the last month. As in the case of use of condoms, the best predictor of condom purchase was the self-reported influence of the radio spots on condom use. Exposure to printed propaganda did not appear to affect purchase of condoms.

5.4.3 Conclusions of Condom Survey

In conclusion, the data indicate that though the pool of condom users remained essentially the same size from 1984 to 1987, condom use increased substantially because of more frequent and continuous use by those who had used condoms at some point. While one of the short term effects of the radio advertising seemed to be an increase in the number of people who tried the method, the number of current purchasers tended to decrease over time to original levels. However, after two years, the proportion of recent purchasers remained about 30% higher than pre-campaign levels. The most important long term effect of the radio advertising campaign was therefore to increase the frequency of repeat purchases as indicated by the proportion who reported having bought a condom in the last six months or in the last month. A completely external factor which could explain some of the increases in condom purchases and use is increased concern about AIDS. It was learned in a separate part of the 1987 survey (see Section 6.5) that almost 80% of the respondents knew that AIDS could be sexually transmitted, and about 23% knew that

condoms serve as some form of protection against the disease. More research is needed, however, before drawing definitive conclusions on this point.

Other possible conclusions from the study are that a radio campaign need not be directed to any particular working sector, that it could probably best be directed to the poorer sections of the target population, that although elderly listeners have more to learn from radio advertisements than young people, the latter tend to have better recall and to learn more from them, and that radio campaigns may be preferable to campaigns which use printed materials. Further, it might be worthwhile exploring the effectiveness of brand specific advertising in comparison with generic campaigns.

5.5 Drugstore Study

5.5.1 Introduction

A potential problem of replacing CBD with CSM strategies could be decreased quality of contraceptive information provided by pharmacists. Thus, the second year work plan originally proposed that a national mini-survey of pharmacists be conducted to assess their knowledge of contraception. If the CSM strategy tested in Santander during Phase I had been extended to other areas, PROFAMILIA would then have been able to design a training program for pharmacists. However, the organization finally adopted the community marketing strategy, where the instructors-turned-salespeople could give feedback on the knowledge of pharmacists and provide them with in-service training. For this reason, PROFAMILIA decided to conduct a study that would give them basic information on new commercial markets where they would start to compete against established firms. After a detailed analysis of the alternatives, PROFAMILIA decided to hire the Retail Index Services (Indice Nielsen de Detallistas) of A. C. Nielsen of Colombia, S.A. for a one-year period.

The Retail Index provides producers and distributors of consumer products constantly updated information on the performance of their own and their competitors' brands in national and regional markets. The Retail Index audits every two months a representative sample of drugstores and supermarkets in cities with over 20,000 inhabitants. In each audit, Nielsen checks inventory levels and invoices for sales and purchases for a two-month period. Nielsen then provides its clients with bimonthly information on sales, purchases, inventory levels, average prices, stock-outs and other marketing information that will be described in detail in the following section. Thus, the Index is a tool that allows an organization to interact more

intelligently with the market place by receiving a wider range of market indicators than its own sales data.

One of the characteristics of the Retail Index Service is the emphasis that Nielsen places on the usefulness of the data and the effort it makes to present the main results to its clients. In addition to the reports, Nielsen prepares every two months a presentation for PROFAMILIA's staff. The Executive, Financial, Community Marketing and Evaluation Directors have always attended the presentations, as have the members of their staffs who have marketing responsibilities. The presentations emphasize trends in the main marketing variables, sales potential in different regions, and opportunities arising from competitor weaknesses or temporary conditions caused by recent events. Therefore, these presentations have been followed with great interest by PROFAMILIA's staff, especially with regard to the condom market, where the competition from commercial wholesalers has seriously eroded PROFAMILIA's profits. Nielsen also provides training on the analysis and use of data to interested staff members.

5.5.2 Data Generated by the Retail Index and Uses of the Data

The best way to fully understand the extent and usefulness of the information provided by Nielsen is to look at the bimonthly reports and presentations. Table V.5-1 explains the basic layout of the tables normally included in the Nielsen reports, which are divided into 13 columns.

Column 1 shows the products or brands for which the service was requested. The products shown in Table V.5-1 are contraceptives: pills, vaginals, condoms and others. In the case of a given product such as pills, the brands of these product are displayed in this column.

Columns 2 and 3 show sales to consumers of each product or brand, in thousands of pesos and units respectively. The market share of each product or brand is presented in the second figure in each cell. For example, Table V.5-1 shows that around 1.4 million pill cycles were sold in the first two-months of the year, and that these sales represented about 183 million pesos, or 47.2% of all contraceptives sold on the market.

Column 4 presents data on purchases by retailers during the two-month period as well as the distribution of these purchases by product or brand, while Column 5 shows the total number of units in stock at drugstores at the time of the last audit, as well as the stock share of each product or brand.

Columns 6, 7 and 8 present data that are more complicated since they represent figures that are grouped together for analysis. Column 6 shows stock levels in terms of the average number of months that this stock would last at current sales levels. The second figure in Column 6 shows the distribution of those products or brands that are on public display at the drugstores. The first figure in Column 7 shows the average monthly stock levels for drugstores handling each product during the two-month period (i.e., any drugstore that purchased, sold or kept a given product or brand in stock for the two-month period). The second figure in Column 7 shows average monthly purchases per drugstore handling the product or brand. The first figure in Column 8 present monthly average sales to consumers per drugstore. In the second figure of Column 8 the average price of each contraceptive unit or brand to the consumer is presented.

Columns 9 to 12 present numerical and weighted distributions of different variables. The numerical distribution shows the proportion of drugstores relative to the universe. The weighted distribution shows the proportion of contraceptive sales made by the drugstores included in the numerical distribution. For example, the first figure in Column 9 of Table V.5-1 shows the proportion of drugstores handling a given product during the period (87% in the case of vaginal tablets and suppositories), whereas the second figure shows the proportion of sales of all contraceptives in pesos made by those 87% of drugstores (99% of all contraceptive sales). Similarly, Column 10 presents the number of drugstores that were out of stock for a given product or brand at the time of the last audit, and Columns 11 and 12 show the proportion of drugstores that bought and sold a given class or brand of contraceptives during the period, as well as the proportion of contraceptive sales made by those stores in each case.

The Bimonthly Report presents 15 tables devoted to contraceptive products and 15 tables on brands of each of the contraceptive products sold by PROFAMILIA: pills, condoms, and vaginal tablets and suppositories. In each case, seven tables present data by geographical region and eight tables by type of outlet and geographical region. These data allow organizations to take full advantage of the opportunities offered by the market by manipulating these merchandizing variables. For example, in terms of pricing, PROFAMILIA can use the data to set prices low enough to achieve its social objectives but high enough to maximize profits without reducing its market share. Likewise, in terms of sales strategies, PROFAMILIA can take advantage of low stock levels in drugstores to make promotions and fill the drugstores' inventories, thus blocking shelves to the competitors, or PROFAMILIA could decide to become more competitive in geographical regions where they are weak, or to modify their marketing policy to achieve a larger presence in certain kinds of outlets. The Nielsen data allow the evaluation of point-of-

purchase communication campaigns and of the reach of the distribution efforts, an especially important variable for a socially oriented organization committed to increasing access to contraceptives in Colombia. In conclusion, opportunities for improved management that are made possible by the Retail Index data are almost unlimited.

5.5.3 Results of the Drugstore Study to Date

Since the wealth of data produced by Nielsen's Retail Index is far more than can be analyzed in a short report such as this, only the most important results will be included here. In most cases, an effort was made to extrapolate the results of the three two-month reports available at the time of this writing to a yearly basis. Readers interested in the two month reports developed by Nielsen are referred to the Seventh Progress Report.

Table V.5-1 shows that drugstores normally have inventory levels of about 1.5 months for all methods (see column 6). Individual drugstores sell an average of 122 pill cycles, 180 vaginals and 208 condoms per month. Vaginal tablets cost 129 Colombian pesos or US$ 0.43, about half as much as condoms and pill cycles (Column 8). The 94% of drugstores that sell pills also sell 100% of all other contraceptives. Condoms are unavailable at 28% of drugstores, but these drugstores account only for 11% of total contraceptive sales (Column 9). Between 3 and 4% of drugstores handling pills, condoms or vaginals were out of stock for these materials at the time of the audit. Stock outs seem to be much more frequent for injectables and other contraceptives (Column 10).

Table V.5-2 shows estimated annual sales extrapolated from the November 1987/April 1988 data for pills, vaginals, condoms and other contraceptives. According to these figures, the temporary contraceptive market for drugstores in urban areas in Colombia is estimated to be on the order of seven million dollars per year and 893,597 couple years of protection (including only pills, condoms and vaginals). Bogota is the largest market for vaginals and condoms, and the Pacific Region is the largest market for pills. Table V.5-3 shows that 12-15% of sales of any given contraceptive take place in drugstores located within supermarkets. Table V.5-4 shows that sales of condoms increased very strongly between the three two-month periods for which data is available. Sales of vaginal tablets and suppositories were unstable as a consequence of declining sales in Bogota and erratic trends in the Atlantic Coast and Pacific Regions. Perhaps the most noteworthy points were the strong and unexplained upsurge in sales of all contraceptives on the Atlantic Coast and the continuing decline of sales in supermarkets.

Table V.5-5 presents a copy of the March/April Table for Condoms at the national level, which includes data on condom brands. PROFAMILIA is the sole importer of Tahiti, which for a long time was the only brand available nationally, and Majestic, an ultra thin condom which was introduced on the Colombian market in December/January 1988. Rosetex, a striped condom, and Orquidea, a regular lubricated condom, are brands that were first imported by a commercial wholesaler because he perceived a chance to make a profit. At that time, Tahiti was the only brand available and PROFAMILIA had just raised its prices in an effort to obtain higher profits. Tahiti then started losing sales to the competition, so PROFAMILIA lowered prices to a level well below Orquidea and Rosetex. Currently, about 40% of all condoms sold in drugstores in Colombia are Tahiti, but those sales represent only 34.3% of total revenues from condom sales, compared to 17% and 16.8% for Orquidea and Rosetex, respectively.

For the sake of clarity, Table V.5-6 highlights some of the most interesting merchandizing variables from Table V.5-5. Stock sizes are important in merchandizing because they influence a retailer's willingness to purchase a product. If a retailer has very large stock sizes for a given brand, he or she will be reluctant to buy more condoms, regardless of the brand, until those in stock have been sold. From this perspective, Tahiti and Majestic are doing quite well, because drugstores have stock levels for at least a month at current sales levels, and because Tahiti has the largest stock share by far and Majestic has been able to occupy a large proportion of shelf space compared to its market share.

Regarding PROFAMILIA's social service goals and demographic and health objectives, Table V.5-6 shows that PROFAMILIA's condoms are at least 17% cheaper than any other brand in Colombia. In addition, since only 81% of drugstores are selling condoms and only 57% of them carry Tahiti, there exists the possibility of increasing condom accessibility substantially. Likewise, accessibility could be improved by bettering the distribution system so as to reduce the proportion of drugstores that experience Tahiti stock-outs. In fact, Figure 2 shows that in the Central and Eastern Regions there was a semestral decline in the proportion of drugstores handling Tahiti (numerical distribution), and that in the Atlantic Coast, Antioquia and the Eastern Region there were important decreases in the number of drugstores with high sales potential that were handling Tahiti (weighted distribution). The Majestic brand is only beginning to sell in Bogotá and in the Central and Pacific Regions, where positive distribution trends are observed.

Table V.5-7 shows that Tahiti sales are strong on the Atlantic Coast, in Antioquia and in the Pacific Region, though they are relatively weak in the Central Region and even weaker in the Eastern Region, where Rosetex and Orquidea are making great

inroads. The two latter brands are also challenging Tahiti in Bogotá and Antioquia. Thus, the strategy of the competition seems to be to concentrate their efforts in the largest cities with the largest markets. Lastly, Table 4.7 shows that PROFAMILIA is not directing enough efforts toward supermarkets, since Tahiti holds only the third largest market share for these outlets. Rosetex sells nearly twice as many condoms as Tahiti in supermarket drugstores, whereas in regular drugstores it sells less than half. PROFAMILIA is currently reviewing its commercial policies in order to compete more effectively in supermarkets. These outlets are expected to increase their proportion of sales over time and are perceived as important because of greater exposure to the products due to the large numbers of customers who frequent supermarkets.

In addition to Tahiti and Majestic condoms, PROFAMILIA is the sole distributor of Noriday pills and Neosampoon vaginal tablets, and a major distributor of Schering pills. Table V.5-8 shows that the four most popular brands of pills, all of which are produced by Schering, hold a 53.8% share of the market. By comparing these figures with institutional sales data, we estimate that PROFAMILIA sells over 50% of all Schering pills. PROFAMILIA holds an additional 6.5% of the market with Noriday, which has one of the most favorable stock sizes and sells at the lowest market price. Noriday is available in only 64% of all drugstores, however, compared with 83%-89% for the Schering brands marketed by PROFAMILIA. The large number of drugstores that were out of stock for any given brand by the end of February was striking. One possible explanation for this could be that the number of brands of pills available on the market causes retailers to be conservative in their purchases of any one brand, while they are careful to maintain an adequate overall supply of pills. Pill stock outs are rare.

Lastly, Table V.5-8 shows that Norforms is the leading brand by far in the vaginals market. This brand accounts for 76% of all units sold, and its price is at least 50% lower than the next cheapest product. Much to PROFAMILIA's chagrin, Neosampoon holds only a 14.7% share of the market and sells at nearly four times the price of Norforms. This is a consequence of several factors, including the devaluation of the dollar against the yen, which has more than doubled the cost of Neosampoon to PROFAMILIA, and difficulties in obtaining government import permits.

5.5.4 Conclusions of Drugstore Study

The Retail Index data show that PROFAMILIA is the main marketer of temporary contraceptives in Colombia: about 50% of all pills and condoms, and about 15% of vaginal tablets sold in drugstores and supermarkets are marketed by PROFAMILIA.

PROFAMILIA is facing strong competition in the condom market and is heavily dependent on A.C. Schering of Colombia for marketing pills, since Noriday, the only brand for which PROFAMILIA is sole distributor, accounts for only 6% of total pill sales. In the long run, this could lead PROFAMILIA into a situation like the current one in the vaginal tablet market, where their market share declined to only 15% after Norwich stopped selling Norforms to PROFAMILIA.

To avoid losing ground, PROFAMILIA should review its commercial practices in order to compete more effectively in supermarkets, where its market share is smaller than in the drugstore market, and where contraceptive sales are likely to increase in the future. Likewise, PROFAMILIA has to be more aggressive in marketing condoms in the Central and Eastern regions, where their competitors are overtaking them as the most important distributor. Finally, since the contraceptive market in Colombia is now a mature market with many brands, PROFAMILIA might safely and successfully introduce new pill and condom brands. As new brands are introduced by other competitors, Tahiti and the Schering brands will have an increasingly difficult time holding their market share. Thus, if these brands are to lose market share, the best solution would be to lose it to other brands distributed by PROFAMILIA, preferably to those for which PROFAMILIA is the exclusive distributor. The recent introduction of Majestic brand condoms was a good example of the benefits of this strategy, since it is quickly gaining market share from all the other brands, including Tahiti.

Regarding PROFAMILIA's social objectives, the Nielsen data show that it sells the least expensive pills and condoms in Colombian drugstores and supermarkets. However, it is obvious that there is still more than enough room for improvement regarding other social objectives, like increasing the availability of contraceptives in areas which may not be profitable. Tahiti condoms are available in only 58% of all drugstores, and Noriday in only 52% of all outlets. Likewise, reducing stock-outs in outlets selling PROFAMILIA's brands is another way to increase contraceptive availability, although this is not such a pressing problem, since less than 10% of the outlets managing PROFAMILIA's brands had stock-outs of those brands in any of the two-month periods analyzed so far. Finally, the need for PROFAMILIA to market another vaginal contraceptive is obvious, since currently they are serving only the upper-income segment of the market.

5.6 Cost Study

5.6.1 Introduction

In the near future, it is likely that international agencies will begin to reduce the amount of financial aid they direct

toward Colombia, preferring instead to devote those resources to countries they consider to be more in need of family planning assistance. In view of this, PROFAMILIA undertook the studies presented in this section, designed to provide information on the real costs of PROFAMILIA's different service programs to allow for a more efficient management of the organization's financial resources.

PROFAMILIA considers programs that offer contraceptive services and information directly to the community to be service programs. These include: (a) the clinical program, which provides medical services and IUD insertions, (b) the surgical program, which provides female sterilization and vasectomy, and (c) the community marketing program, which sells pills, condoms, vaginal tablets and suppositories.

The availability of reliable cost-effectiveness data for service programs is a vital part of the decision-making process in the management of family planning programs. Unfortunately, one of the obstacles noted in prior studies (Ojeda et al, undated; Castro and Girón, 1985) that makes it difficult to arrive at a precise calculation of cost-effectiveness is the distribution of indirect and shared costs, that is, costs which are shared in differing proportions by all service programs. Such costs can be divided into two groups: (a) indirect costs of central administration, including the areas of accounting, evaluation and statistics, industrial relations, general services, systems, resource development, grants, program direction, treasury and auditing, and (b) the shared costs of the assets and services such as rent, security, electricity, etc. among service programs.

The objective of this study was to determine an accurate distribution of these costs. Thus, in what follows, we present results of the distribution of the central administration's support group costs among all service groups, and of the distribution of the costs of assets and services shared among the various service programs.

5.6.2 Distribution of Costs of Central Administration

The distribution of costs of central administration was performed in two phases: the construction of a distribution model and its application.

In order to assign costs proportionally to each support group among the service programs, it was necessary to select a series of indicators that would facilitate an accurate measurement of the amount of work that each support group contributed to service programs and to other support groups. Since the main costs of support groups are related to the

personnel working for each group, these indicators had to be representative of both the amount of time spent and of the wide variety of activities performed by personnel from each group on behalf of other related areas. In addition, it was important to ascertain that the criteria selected fulfilled the requirements of simplicity, unobstrusiveness, completeness, and long-term efficiency. In keeping with these stipulations, the following measurement units were selected to determine the distribution of support group costs:

Accounting: The proportion of all accounting entries made over the previous 18-month period for a given support or service unit was considered the best measure of the efforts made by the accounting department on behalf of the other service and support programs.

Evaluation, Statistics and Planning: The number of projects carried out in 1987 for each service program as well as the number of people involved, including the percentage of their time devoted to each project was used to distribute evaluation and planning costs. Whenever a project involved two or more service programs, the costs were assigned to those programs in equal proportions. Statistical costs were distributed in equal parts to all service units.

Systems: The proportion of records entered on the computer on behalf of each service unit with respect to all records entered was calculated to distribute 60% of systems costs. The remaining 40% was distributed proportionately according to the number of software programs developed for each group.

Industrial Relations: Costs were distributed in proportion to the number of employees in each unit.

General Services: Costs were distributed proportionately according to purchases made by general services on behalf of each organizational unit. There were three main kinds of purchases: (a) drugs and fungibles, which constituted 65% of all purchases, (b) office supplies and advertising costs, which constituted 25%, and (c) those expenses related to fixed assets, which represented 10%. Costs for drugs and fungibles were distributed proportionately according to purchases made by each unit with respect to total purchases made. Office supplies and advertising costs were distributed proportionately according to the amount spent by each unit. Finally, fixed asset costs were apportioned proportionately, depending on the number of acquisitions made by each group.

Resource Development: This is the unit responsible for soliciting all contributions and donations for PROFAMILIA. Since most contributions are received without stipulations as to how they should be allocated, they are normally used to cover

financial deficits. Resource development costs were distributed according to the proportional size of the deficit covered for each support unit or service group with respect to the total deficit covered.

Grants: Three main criteria were used to determine the proportional allocation of the costs incurred in 1987 by the grants office: (a) the number of projects covered, (b) the number of reports made, and (c) a weighting factor for each grant, depending on the specific stipulations made by the donors for each project (e.g., the requirements for the format of reports vary for each donor).

Financial Assistance: The four types of activities that make up the core of the responsibilities of the assistant to the financial director are imports, insurance, investments in stocks and securities, and foreign currency exchange services. According to calculations employed here, the assistant spends 25% of his time on each of the activity types. Costs were distributed proportionately according to the number of discrete payments made on account for the other organizational units.

Treasury: Costs were distributed proportionately according to revenue and expenditure entries made by each unit in those bank accounts that were managed by treasury.

Auditing: Costs were determined proportionately, depending on the number of hours employed by personnel to auditing particular organizational units. Audits involving more than one unit were accounted for by distributing costs proportionately according to the total expenditures due for each particular unit.

Presidency: One third of the costs of the presidency were assigned to each of the service program divisions: clinical, surgical and community marketing.

To handle complications arising from the fact that each support group normally provides services both to the different service program divisions as well as to other support programs, the distribution model was applied in two phases. The first phase was devoted to the distribution of service group costs among service and support groups. The second phase consisted of a redistribution by iteration of costs to the appropriate service programs to ensure that all costs incurred had been assigned to one of the three service program divisions. Methodological details of the iteration process by means of matrix algebra can be found in the sixth progress report.

Table V.6-1 contains the final results of the implementation of the distribution model. The final item, Weighed Average, indicates that the community marketing program is the service area that absorbs the highest percentage of work performed by

PROFAMILIA support groups (41.37%). This is due in great part to the number of tasks performed by the division of evaluation, statistics and general services on behalf of this program.

5.6.3 Distribution of Fixed Asset and Service Costs by Area

In order to distribute the cost of fixed assets and shared services among service programs it was necessary to measure the proportional area they occupied in the clinics. To do this, areas were measured in 15 of PROFAMILIA's 38 clinics, selected in a stratified sample.

The only asset costs measured in this part of the study were rental costs of the clinics. Depreciation of vehicles, furnishings and office equipment had already been assigned to each service program by accounting. It is important to note that the accounting department assigns a rental cost to all PROFAMILIA clinical units, even when those units are housed in buildings owned by the institution.

The services that are shared by all programs in PROFAMILIA clinics are cleaning services, security, electricity, telephone, water, sewage services, and garbage collection. The costs of these services, were distributed proportionally in a variety of ways.

Rent, and the costs of cleaning and security services were distributed according to the total area occupied by service programs in the clinics. Communal areas (like hallways, administrative offices, stairways, general storage rooms, employees' cafeteria, rest rooms in administrative areas and in reception, etc.) were not measured since it would have been difficult to determine the proportional share of each service program's use of such areas.

Areas that were considered part of the clinical program included display cases, areas where information is given to users, medical offices, laboratories, bathrooms and hallways with direct access to medical offices, pharmaceutical storage rooms, and the files and office of the medical director.

The areas assigned to the surgical program were the operating rooms, recovery rooms, waiting rooms for surgery, sterilization areas, the doctors' and patients' dressing rooms, storage areas for anesthesia and surgical medications, and kitchens in those clinics where the area was used to sterilize surgical tools.

The areas assigned to the community marketing program were the instructors' rooms and storage areas as well as all areas dedicated to IEC activities, like betamax rooms and conference halls.

To distribute the costs of electricity, telephone, water and sewage services, more specific indicators were chosen. Electrical costs were determined by the number of electrical appliances in each service program's area as well as the energy consumption of these appliances and the amount of time each was used. Telephone costs were determined according to the number of people working for each program in a clinic. Finally, water and sewage service costs were distributed according to the number of faucets in each program's area within a clinic.

Tables V.6-2 and V.6-3 show the proportional area occupied by each service program in the sample's four stratified clinic groups. In Table V.6-2, it can be seen that the surgical program occupies about 50% of the area in most clinics. The clinical program tends to occupy approximately 25% of the area in most clinics, except in the largest ones, where it tends to occupy a larger share. Table V.6-3 shows 90% confidence intervals of the proportional area occupied by service programs in the clinics of each stratified group. The spread in these confidence intervals demonstrate a rather high standard error in the calculations. As may be remembered, sample size was determined according to the only well known variable - contraceptive sales of each clinic, but there does not seem to be a direct correlation between sales and clinic size.

Table V.6-4 provides a breakdown of the distribution of faucets, employees, and total electrical consumption in kilowatts for the different service programs in the clinic sampling strata.

5.6.4 Conclusions: Implications of the Results for the Determination of Cost-Effectiveness and Cost Benefits

Tables V.6-5 to V.6-8 present the results of an exercise that used data from 1986 to determine the influence of the distribution of costs of support groups obtained in this study in the calculation of the cost-effectiveness and financial self-sufficiency of PROFAMILIA's service programs.

The first section of Table V.6-5 presents PROFAMILIA's income from sales of products and services as well as the net direct operating cost of service programs. This last figure subtracts from the revenues of each program its direct costs (including the shared cost of services as are currently distributed by PROFAMILIA) without including administrative and support expenses.

In the second section of the Table, the direct costs of the support groups (net indirect costs) are distributed among service programs according to the results of this study to obtain the net operating cost of each service program. The final section of the Table shows the changes in the financial self-sufficiency observed by including indirect costs. By considering these costs, the revenues of the community marketing program covered only 42.4% of all program costs, compared with 54.2% self-sufficiency as previously estimated. Although less drastic, there were also substantial decreases in the estimated self-sufficiency of the clinical program (from 53.5% to 49.6%) and the surgical program (from 29.6% to 27.5%), when the new method of cost distribution was used.

In Table V.6-6, cost-effectiveness indicators were calculated by taking into account only the direct operating costs of the service programs, and adding to them the indirect costs determined in this study. The program most affected by including indirect costs was the community marketing program, whose cost per CYP rose from US$ 1.74 to US$ 2.78 (an increase of 59.7%). For the clinical program, there was a 17% increase in the cost per CYP, from US$ 6.92 to US$ 8.09. The surgical program was least affected, with cost per CYP increasing only 7.3%, from US$ 2.17 to US$ 2.33. The increases in the gross cost per CYP after incorporating indirect costs were smaller but still considerable: 27.4% for the community marketing, 7.8% for the clinical, and 6.0% for the surgical programs. Table V.6-6 also shows that the clinical program's gross cost per office visit increased by $0.48, while the gross cost per sterilization increased by US$1.86, when the new system of cost measurement was used.

A similar exercise to the one above was performed to distribute the costs of public services proportionately according to the results obtained in Section 5.6.3 of this report. Table V.6-7 presents the 1986 costs of the different programs distributed according to the usual practice of the accounting department and to the results obtained in this study. Table V.6-8 shows that while there was an increase in the cost per CYP for the surgical program, such costs decreased for the clinical and community marketing programs. This indicates that the costs currently charged to the clinical and community marketing programs for public services, security and cleaning services are inflated.

VI. OTHER SUBJECT AREAS EXPLORED

Besides collecting basic data to achieve project objectives, PROFAMILIA used the surveys which were part of this project to explore several other issues of interest to them. In other cases, special survey analyses were made and presented as focused papers at professional meetings and conferences. In this chapter, we present the results of six such studies which were conducted as part of this project but were not included in the project proposal. The discussion is brief because the studies were subordinate to the six main studies discussed earlier. The studies were the following: IEC and marketing in CBD programs; quality of care in CBD programs; contraceptive information needs of women; perception of condoms and condom brands; knowledge of AIDS; and perception of sources and reasons for use and non-use of contraception.

6.1 IEC and Marketing of Contraceptives in CBD Programs

The second distributors' survey had the secondary objective of studying the distributors' needs and their perceptions of IEC activities and contraceptive marketing in their communities. This was to find ways in which PROFAMILIA could support them more effectively. As will be seen in section 6.2, most of the topics explored are also considered to be essential issues in the quality of care provided by CBD programs.

Regarding the promotion of family planning activities, the distributors were asked about three aspects of IEC activities: activities that were performed by PROFAMILIA's instructors, promotional activities of the distributors' themselves, and PROFAMILIA's mass-media campaigns.

Except in Santander, where the instructors were told not to make household visits, a large proportion of distributors (37,5%) reported that such visits had been made in their communities at some point. Similarly, 41% also reported that at least one group session or talk had taken place in their communities, and in about half of these communities there had been at least three talks. About two thirds of the distributors attended at least one of the talks, where they heard the instructor provide information on available contraceptive brands and the location of CBD posts. However, only about 32% reported a sales increase after these talks. IEC activities by instructors seem to be less common in Santander and in the Eastern Region, but the effect of talks on sales in these areas seems to be stronger than elsewhere (Table VI.1-1).

The CBD distributors' main responsibility is contraceptive sales. In addition, PROFAMILIA expects them to deliver information to their clients and to engage in occasional promotional activities in their communities. Although distributors should have a PROFAMILIA sign advertising the place as a CBD post and a contraceptive method showcase to let their customers see the contraceptives, only 82.3% had the sign and 59.7% displayed the showcase. Also, only 57.1% offered brochures explaining contraceptives and only 22.6% had posters on display in their stores. Since the project had paid for some brochures for the CSM wholesale distributor and some were left over, CBD posts in Santander were more apt to display them than posts elsewhere. On the other hand, very few posts in Santander had the contraceptive showcase on display, which helped sales "a lot" according to 66.9% of all interviewees. They considered it second in importance only to PROFAMILIA's sign, which was thought to help sales "a lot" by 82.1% of those interviewed. The showcase was used by 76.4% of the respondents to explain how contraceptives are used (second only in this respect to the brochure on contraceptive methods). When the answers are combined to calculate a "perceived importance rating" of each promotional tool, both brochures and contraceptive showcases come out in first place, with posters having a substantially lower rating. (Table VI.1-2).

Finally, Table VI.1-3 shows the extent of coverage of PROFAMILIA's mass-media messages. Nearly half of the respondents recalled hearing a PROFAMILIA radio spot at some point in the last year, and they said that what they remembered of the content was information on contraceptive methods or an invitation for people to come to PROFAMILIA and take advantage of the services. Although very few (14.9%) said the spots had had a positive effect on their sales, the distributors were almost equally divided in their preference of printed advertisements (45.7%) and radio spots (41.3%) as promotional means.

Regarding the marketing of contraceptives, Table VI.1-4 shows that pills were sold in all CBD posts, but that condoms (81.1%) and vaginals (48.9%) were not as widely available, especially on the Atlantic Coast. PROFAMILIA's contraceptive-distribution system seems to be reliable, since nearly 62% of the distributors said they had never been out of stock. Those who had found themselves in that situation usually advised their customers to go to some other source for their contraceptives, rather than to change to a different method which was in stock (2.5%), or to avoid sex until the store was resupplied (2.7%). In most communities where there were CBD posts, there was at least one other contraceptive source, usually a drugstore (74.4%) or health post (41.9%).

Except in Santander, where a large proportion of posts were newly opened, most distributors perceived themselves to be the main suppliers of pills and condoms in their communities. The distributors were usually able to influence their customers' brand choice in the case of condoms and, to a lesser extent, in the case of pills, where brand loyalty seemed to be lower than is usually assumed (Table VI.1-5). According to Table VI.1-6, distributors felt that their most important advantages as pill retailers were lower prices (35.7%), the fact that they were the only contraceptive source in the area (19.4%), their closeness to their clients (17.7%) or the fact that they offered better, more personal service (11.7%). The perceived advantages of drugstores were: the greater variety of brands available (29.5%), (drugstores sell Wyeth pills and several brands of vaginal suppositories and condoms), better trained personnel (in Latin American small towns drugstore owners and attendants have high credibility for prescribing drugs), or lower prices. By far the major perceived advantage of government health posts and hospitals was that they give contraceptives to their clients almost free of charge.

Finally, Table VI.1-7 shows that Noriday was considered the best pill brand by 23.5% of respondents, second only to Neogynon 28 (26.1%) and preferred over Neogynon 21 (14.2%). This shows how brand-specific marketing can create a favorable image of a given brand. Since PROFAMILIA is the sole distributor of Noriday in Colombia and they are able to sell the product at reduced prices with larger profit margins, PROFAMILIA instructors usually go out of their way to explain at length the advantages of that brand to distributors. Among condoms, Tahiti was by far the most widely known brand, and most distributors also considered it to be the best. However, this was not a very strong conviction, since one third of the distributors said they thought all brands were the same, and two thirds believed that the brands they sold were no better than those sold by others in their communities. About 20% had received complaints about condoms, most of which were that they break or slip off (88.6%), or that they are uncomfortable (8%) (Table not shown.)

In conclusion: PROFAMILIA's CBD instructors seem to do their best to support CBD distributors by carrying out extensive IEC activities. About 40% of the distributors reported that they knew of talks to groups given by the instructors in their communities. Furthermore, the large attendance of the distributors at those talks showed that there was good coordination between instructors and distributors. Although the instructors tried to promote their distributors' sales by mentioning methods, brands and contraceptive sources of supply in their talks, they did not seem to be effective since few distributors reported larger sales after the talks. The CBD posts were readily identifiable by the PROFAMILIA sign, but about half of the distributors lacked essential educational materials like contraceptive show cases and

brochures, and of those who had them, several reported not using them, perhaps because their concern was limited to sales. CBD posts also seemed to have problems with the availability of condoms and vaginal tablets, which made them refer clients to other sources of supply. In most of the communities included in the sample, there were other sites where people could purchase contraceptives, usually a drugstore. This suggests that PROFAMILIA could afford to close some of the posts and to rely more on commercial channels. Even though the distributors face extensive competition, they believe they are the most important contraceptive source in their community, given their advantages in price, proximity to clients and personal service. Another important advantage that was sometimes mentioned was that they were the only contraceptive source available in the community.

PROFAMILIA should make an effort to promote brand preference among CBD distributors, since they seem to be able to influence the preferences of their customers. Currently, the distributors believe that most condom brands are the same. If PROFAMILIA could associate resistance, lubrication and softness as superlative attributes of the Tahiti and Majestic brands, sales of those brands would probably increase, since many consumers seem to feel that those are the most important condom characteristics (see Section 6.4).

6.2 Quality of Care in CBD Programs in Colombia

6.2.1 Introduction

Considerable efforts have been devoted recently to analyzing of quality of care in family planning programs and its effects on the acceptability of services in less-developed countries. Rogow (1986) has pointed out that although quality of care standards have been spelled out in great detail in Title X Federal Regulations as well as in a number of state regulations which govern the funding of family planning programs in the U. S., such standards have eluded formal definition and contract language for international family planning programs. This seems partly a consequence of the perception that such standards would be logistically and culturally unrealistic for the Third World, and partly due to a lack of research that could facilitate decision-making. Nonetheless, it has been suggested that funding of international family planning programs should be linked to their adoption of quality of care standards (Rogow, 1986).

Since standard implementation is expensive and requires strong managerial skills that are seldom found in public service organizations in less-developed countries, researchers have sought to identify basic elements that might help define the minimum quality of care standards that should be met by medical,

over-the-counter and community-based distribution (CBD) programs in less developed countries. Briefly, those elements encompass four main areas: (a) choice of methods: including accessibility in terms of cost, time and distance to a meaningful choice of safe and acceptable methods which are intrinsically varied along several dimensions; (b) information for the implementation of choice: sufficient information presented in an understandable form to make relevant choices. Such information includes expectations of trial use, information to recontact provider and to allow method switching if necessary; (c) provider competence: including proper screening of users of each method, certification of the effects of training and staff competence, as well as user confidence in supplier technical skills, and (d) client/provider relationship: meaning that clients respect and trust the providers (Bruce, 1987; Rogow, 1986). In addition, some researchers have proposed improved follow-up mechanisms, adequate physical facilities, and complementary health services designed to meet women's reproductive health needs beyond fertility control as an integral part of family planning services (IWHC and TPC, 1986).

Although these elements address an ideal model of family planning programs, several qualifications seem to depend on environmental constraints and the particular kind of family planning program observed. Townsend (1987), for example, has pointed out that in several countries there is a limited choice of both methods and brands. Choice is also affected by the number of contraceptive sources in communities and by factors such as hours of operation of family planning centers or suppliers. Regarding the kind of program, CBD programs can offer only a limited choice of methods to large populations, whereas clinic-based programs can offer all methods to a restricted population. Townsend concludes that, in the broadest sense, quality of care -including competence of providers- should be examined at the level of program management, as well as the level of service suppliers, since "problem-driven managers have active field programs with a concern for quality, whereas managers who have poorly organized field services with low coverage rarely have time to look at quality because their programs are so chaotic."

In this section, we explore the effect that enforcing the adoption of some quality of care standards may have on the acceptability of services of CBD programs in less developed countries. In order to provide program managers with an initial check list of the quality of care elements that need to be looked into to improve program performance, we explore the relative contribution of choice of methods, information to users, and the relationship between client and provider in explaining the distributors' contraceptive sales and knowledge of contraception, which would seem to be an essential aspect of quality of care in CBD programs.

To do this, we used the data collected as part of the CBD Distributors' Survey and created a knowledge scale in which the number of correct responses to questions regarding method use was employed as an index of knowledge of how each method was used. Nine questions were asked on pill use, 4 on barrier methods, 6 on female sterilization, 5 on vasectomy, one on the IUD and one on rhythm. In addition, the survey explored the distributors' training, their perception of PROFAMILIA's IEC activities, and their marketing experiences. For the purposes of this section, we classified survey items according to three levels at which there might be program intervention and four quality of care dimensions.

The three levels of variables for which there might be program intervention were defined as: the individual distributor, the CBD post and PROFAMILIA's program support, and the communities where CBD posts are located. From a management perspective, the individual level deals with program norms and selection procedures of CBD distributors, whereas community level variables are related to the communities selected for CBD posts. CBD post and program variables are those that are directly implemented and controlled by program management.

The four quality of care dimensions were selected from those identified by Bruce (1987), specifically (1) choice of methods, including items on program choice (items on the availability of contraceptive methods at CBD posts), and community choice (items on the availability of contraceptive sources in the community); (2) information, including items on the availability of mass communications in the community, printed materials in the CBD posts, the use of these materials, and interpersonal communication of IEC program activities; (3) client/supplier relationship, which includes items on the distributors' willingness to communicate with their clients and the influence that this communication may have on contraceptive purchases of their clients; and (4) provider competence, including knowledge on the use of each contraceptive method as described before and training (including items on training as well as knowledge of PROFAMILIA's private character and the commitment to PROFAMILIA, as measured by the number of years as a distributor). Finally, to assess the effect of quality factors on the acceptability of services, the distributors' sales of pill cycles, condoms and vaginal tablets according to PROFAMILIA's January-June 1987 sales statistics were appended to the survey data, as well as their implied couple-years of protection. Likewise, the 1985 population of the counties where CBD posts were located was appended to the distributor's socio-demographic survey data. The set of items that were used to construct the quality of care variables at each level of analysis can be found in Figure 3.

6.2.2 Results

The effect of quality of care variables on knowledge of contraception and contraceptive sales was tested by means of regression analysis. The model considers that the distributors' knowledge of contraception is a function of socio-demographic characteristics as well as the variables of choice, information, client/provider relationship and training. Contraceptive sales are considered to be a function of all these variables and the distributors' knowledge of contraception. In the regression analysis we considered the sets or blocks of items displayed in Figure 3 as variables. All sociodemographic, information and client/provider relationship items presented in Figure 3 were entered as single blocks of variables. Choice of method items were entered in two separate blocks, one representing the program choice variable and the other the community choice variable. The items on training were also entered as a single block.

The regression analysis consisted of three steps. In the first step, we eliminated from the model the socio-demographic and quality of care items that did not have a statistically significant predictive value for knowledge and sales. In the second step, we assessed the relative change in the explained variance of knowledge and sales achieved by each quality of care variable over and above the sociodemographic items. In the third step, we used all significant socio-demographic and quality of care items to predict knowledge and sales and observed which items remained significant. Finally, we noted the amount of variance explained by the model.

In the first step we were able to detect the statistically significant items that had been included in each quality of care variable by means of backward elimination. Table VI.2-1 presents the results items of each variable that had a significant effect explaining the variance of at least one of the dependent knowledge variables (knowledge of pills, barrier methods, female sterilization, vasectomy and all methods) and sales variables (sales of pills, condoms, barrier methods and couple years of protection). To simplify the analysis, Table VI.2-1 discriminates between "consistent" and "inconsistent" predictors. Consistent predictors proved to be statistically significant at the .05 probability level for more than half the knowledge or sales variables. Inconsistent predictors were statistically significant for less than half of them. All items that showed no significance at the .05 level were eliminated from further analysis. These items can be determined by comparing Figure 3 with Table VI.1-1.

Two major conclusions can be drawn from the results presented in Table VI.1-1. The first is that only a small number of items of each quality of care variable were significant predictors of knowledge and sales. The second is that the items

of each quality of care variable which predicted knowledge and sales were different.

Regarding the first fact, by comparing Figure 3 and Table VI.1-1 we see that all socio-demographic, training and client/supplier relationship items were significant and consistent predictors for either knowledge or sales variables. However, of the information items, only the use of educational materials and the reception of PROFAMILIA's radio spots in the community had any predictive value. Likewise, of the program choice items, only the number of methods sold in the community and the perception of the post as the main pill or condom source in the community were relevant. When the distributors' knowledge of each contraceptive was used to predict their contraceptive sales, only knowledge of pills, vasectomy and female sterilization proved to be consistent predictors, with a negative correlation observed between knowledge of female sterilization and sales.

Regarding the second observation that can be made from the results in Table VI.1-1, the socio-demographic variables of sex, years of schooling and ever-use of contraceptives were consistent predictors of knowledge. In contrast, population, living in union, age, current contraceptive use and receiving help for sales at the CBD post were consistent predictors of sales. The distributors' use of educational materials helped predict knowledge but not sales. Similarly, community choice items helped explain sales but not knowledge. Of the training items, training and knowledge that PROFAMILIA is a private institution helped predict knowledge, while the number of years as a distributor explained sales. Finally, the percent of women who the distributor advised predicted knowledge of contraception, but not contraceptive sales. Thus, the results suggest that different management strategies should be followed to maximize either the acceptability of services (sales) or the competence of providers (knowledge).

In the second step of the regression analysis, all consistent items were simultaneously entered to test the increase in the explained variance of knowledge and sales when each quality of care variable (i.e., set of items) were added to socio-demographic items. Table VI.2-2 shows that socio-demographic items explained between 5.7% and 17.1% of the variance of knowledge items. When each quality of care variable was added to socio-demographic items, training was observed to be the most powerful predictor of knowledge variables, increasing their explained variance by between 5.0% and 14.1% over and above the variance explained by socio-demographic items. Client/supplier relationship items produced the second largest r square change of knowledge of methods sold at the CBD post (7.0%), whereas information was the second strongest predictor of knowledge of sterilization methods (3.9%). Program choice

variables, which included items on the different contraceptives available at the CBD post, were the least powerful predictor of knowledge variables.

Table VI.2-3 shows that program choice items increased the explained variance of most sales variables by nearly 100% over the variance explained by socio-demographic items. In the case of pill sales, training was the second most powerful predictor (3.5%), whereas community choice and client/supplier relationship were the second most powerful predictors for sales of condoms and vaginals. Overall, for CYP, the most important predictors were program choice (7.1%), training (5.0%) and the distributors' knowledge of contraception.

The third step of the regression analysis involved entering into single equations all consistent socio-demographic and quality of care predictors of either knowledge or sales variables. Tables VI.2-4 and VI.2-5 show that all socio-demographic and quality of care consistent variables were able to explain between 12.4% and 34.9% of the variance of knowledge variables and between 12.2% and 19.1% of the variance of sales variables. In the case of knowledge of methods sold at CBD posts, only a few items remained significant when all were entered into regression equations. These were part of the socio-demographic set (ever-use of contraceptives, sex and years of schooling), of the training set (training and knowledge that PROFAMILIA is a private institution) and of the client/supplier relationship variable (clients' purchase of condom if own brand was unavailable and percent of women advised). This last variable was not a significant predictor of knowledge of female sterilization or vasectomy, but information items were (use of brochures and exposure to PROFAMILIA's radio spots).

When all items identified in Table VI.2-1 as consistent predictors of contraceptive sales variables were entered into regression equations, only socio-demographic items (mainly the county's population and the distributors' age), program choice items (the number of methods sold at the post and the perception of the post as the main pill source in the community) and training items (the number of years as a distributor) were consistent predictors of most sales variables. The number of contraceptive sources available (a community choice item) was also related to pill sales. Curiously enough, the only knowledge variables that were significant predictors of sales were knowledge of methods not sold at the CBD post. Even more interesting, knowledge of female sterilization had a very significant negative correlation with pill sales.

6.2.3 Conclusions

The evidence that has been presented here suggests that CBD distributor training can have a significant impact on distributors' knowledge of contraceptives, but that this measure of distributor competence does not significantly affect sales. Furthermore, even though both socio-demographic and quality of care variables influence the providers' knowledge and sales, the particular items that do so are different and lead to contrasting implications for program management. It would seem that if CBD program managers wished to maximize distributors' knowledge of contraception, they should draft educated females who have used contraceptives and who like to give advice. They should also train them and provide them with educational materials to use with their clients. On the other hand, if the main interest of program managers is to increase sales, increase contraceptive use and reduce fertility, the results of this study suggest that they should establish CBD posts in rural and semi-rural communities, select middle-aged distributors, provide them with the largest variety of contraceptives possible and keep them well stocked, and provide them with sufficient motivation so they continue as distributors for as long as possible.

These descriptions in fact suggest that the linking of funding to a given quality of care standard is an inadvisable strategy which could lead to undesirable results. For example, linking funding to providers' knowledge of contraception could lead to a reduced choice of contraception for consumers and cut-off the organizations who most need the funds, perhaps to improve their quality of care. Rather than viewing quality of care as a single program characteristic, international organizations should recognize it as a multidimensional concept that includes different service qualities, levels of analysis and outcome measures (Baldwin, 1988). In order to allow program managers to improve the quality of care of CBD programs, an effort should be made to further determine the more desirable service qualities at the different levels of analysis that were considered in this paper, and to identify outcome measures and goals to be pursued at discrete intermediate and final steps in the chain of events leading to the delivery of services to consumers. In practice, this would allow the setting of standards for a wide range of program activities, such as selecting and training CBD distributors, supplying contraceptives and IEC materials to CBD posts, and other factors related to a program's quality of care.

Because the scope of the work is enormous, international agencies should design policies to encourage the long-term commitment of family planning organizations to improving the quality of care of their programs. Such policies should take into account that such improvements make take time, and they may be costly and difficult to achieve. For example, in section 5.3 it

was shown that even large training efforts over long periods of time can achieve only modest improvements in the distributors' knowledge of contraception. Thus, the commitment, motivation and persistence of program managers and family planning workers is crucial if quality of care standards are to be achieved in the long-term. Perhaps the best lead for the design of such policies is provided by modern day industry, where quality control is considered to be a process (as opposed to an outcome) that requires the active collaboration of all workers involved in the production of a good or the delivery of a service. Such collaboration includes monitoring the quality of all inputs and outputs of intermediate and final steps, keeping basic statistics that help identify trends and problems in each step, and suggesting new and better ways to accomplish a given task.

Prudence in the choice of short-term policies to influence the quality of family planning care in less-developed countries should also be advised. If we consider that family planning services are always provided in the context of a contraception market, the "invisible hand" of such a market would seem to maximize quality of care along the different dimensions that are part of that concept. In areas with low contraceptive use, the simple availability and accessibility of contraceptives should outweigh any other quality of care consideration. On the other hand, in areas of high prevalence where several contraceptive outlets are available, the outlets can be tailored to meet individual needs and expectations of consumers. The CBD distributors we interviewed in Colombia thought that consumers go to different sources because of important differences in outlet characteristics. Consider Table VI.1-6. According to distributors, people go to health posts because the pill is available almost without cost to the user, though everybody knows that there is a price to be paid in waiting time; drugstores have a large variety of brands, and drugstore attendants are perceived as knowledgeable, while other CBD posts are closer to the consumer's home. In other words, consumers are able to choose according to the quality of care concept which is most important for them. Thus, it is unlikely that a policy designed to improve in the short-term one or a few factors of a single source of supply would have much effect on the overall quality of care provided to contraceptors. Rather, the challenge would be to gradually let consumers choose from increasingly better services provided by different sources, an objective feasible only in the long term.

Finally, the results show that there is a need for operations research to help clarify several issues that may have a strong impact on the adoption of a quality of care perspective in family planning programs. One such issue is that of the cost involved. Although undoubtedly there are several low cost measures that could greatly improve some programs, raising the quality of care of some components of CBD programs can be an

expensive venture. Therefore, the cost-effectiveness of different measures to improve quality of care factors should be analyzed. For example, in section 5.3 it was shown that the cost-effectiveness of brief talks by CBD instructors may be almost as effective for improving the distributors' knowledge as much more expensive short-term courses. A second issue would be the adoption of other measures that have an impact on quality of care and acceptability of services. For example, lowering the distributor turnover rate can be an effective way to reduce training expenses and increase contraceptive sales, though there is very little information on what strategies could be followed to accomplish that goal, nor is there information on the likely effects of such strategies. A third issue would be to study the interaction patterns between CBD distributors and their clients. Although this paper has shown that such patterns are important, we lack information on what strategies could be followed to change them and what kind of materials could help facilitate such a change.

6.3 Contraceptive Information Needs of Colombian Women

6.3.1 Introduction

Section 5.1 showed that awareness of contraceptive methods is very high in Cundinamarca and Santander. PROFAMILIA has obtained the same basic results in several surveys conducted all over Colombia, and the 1986 Demographic and Health Survey confirmed that the number of methods that respondents claim to know of or to have heard about is very high in Colombia. On the other hand, recent studies have discovered some disturbing facts that indicate that contraceptive users do not possess the minimum information needed to use methods correctly and, consequently, do not use them properly (Vernon and Rocuts, 1986; Prada, 1986. As was shown in section 5.3, even trained CBD post distributors lack knowledge on some essential facts and, hence, can not orient potential users adequately.

Since the information needs of contraceptive users have far-reaching implications for the design and management of family planning programs, PROFAMILIA took advantage of the endline survey in Cundinamarca and Santander to explore the knowledge of ever-married women regarding use of each contraceptive. To do so, women were presented with most of the questions asked in the CBD distributor survey. These included 12 questions on the pill, five questions on vaginal tablets and suppositories, six questions on the condom, six questions on the IUD, 12 questions on vasectomy and eight questions on female sterilization. The questions were asked only to women who "knew or had heard" of each method. In addition, the first question in the pill, condoms and vaginals sections of the questionnaire was whether the woman knew how to use that method. Only women answering that they did were asked the other questions on that method.

6.3.2 Results

Table VI.3-1 displays the number of selected questions used to construct the knowledge scales for each method. In all cases, correct answers were given a score of one and incorrect or void answers a score of zero. Thus, women who declared not "knowing or having heard" of a given method, or not knowing how it was used, automatically scored zero in all items. The final score was obtained by adding the number of correct answers. The mean number of correct answers was quite low. Transforming the scores to a 0 to 10 scale, women in Cundinamarca had mean scores of 3.9 for the pill, 2.4 for barrier methods, 4.2 for the IUD, 2.1 for vasectomy, 6 for female sterilization and 2 for natural family planning (NFP). The mean score for knowledge of all methods according to this scale was 3.6. Scores in Santander were similar.

Table VI.3-2 presents the percentages of women answering correctly to each question about pill use. Although 97% of women knew or had heard of the pill, only 57% declared that they knew how to use it. This explains why the mean scores presented above were so low, since nearly half of all women were assigned a score of zero to start with. Even so, if we look only at answers given by women who claimed to know how to use the method, we see that there is a high level of confusion about such critical items as when women should start taking the pill or whether it is advisable to stop using the pill for brief periods without sexual relations. The least known items were how long women should wait to start a new 21 or 28-pill cycle, and whether it is advisable for lactating women or women over 35 years of age to use the pill. The best known items were the frequency of pill intake and when to start taking the pill. Table VI.3-3 shows that most counterindications for pill use were known by less than 20%.

Either the items asked in the case of barrier methods were easier to answer or knowledge of their use is more widespread. Over 90% could tell that condoms and tablets should be placed before the sexual relation starts, and that one condom or tablet is good only for one relation. However, less than 30% knew about important items for effective contraceptive use, such as the time when the vaginal tablet must be put in place and the moment when a man using a condom should withdraw. Likewise, only about 22% knew that douches should not be performed just after sexual relations with vaginal tablets. Local researchers think that this is probably a social desirability answer rather than a reflection of actual practices, since running water is often unavailable in rural Cundinamarca and Santander. However, even if that theory is correct, the answers show important knowledge deficiencies. (Table VI.3-4).

Since there is nothing that IUD users must absolutely know for effective use, the items on Table VI.3-5 perhaps tell more about the effects of counseling and IEC campaigns than about contraceptive use effectiveness. It was surprising to see that over 80% and 70% were aware of the Lippes loop and the TCU's, and that nearly 70% knew that it is advisable to insert an IUD during menstruation. On the other hand, those items about practices that could possibly interfere with the effectiveness of the method were poorly known, such as the length of time that IUD's are effective, the way to check if an IUD is in place, and the correct frequency of follow-up check-ups.

Because the ability to make an informed choice in favor of female sterilization has far reaching implications for the respect and freedom of women, it is discouraging to see in Table VI.3-6 that knowledge levels about the nature of this operation were quite low. For example, only about 53% of the women in Santander and 72% in Cundinamarca knew that female sterilization is permanent. One would like to think that this confusion was due more to the wording of the question than to a lack of knowledge about the definitive character of surgical contraception. However, the low correct response rates to questions on the possibility of a contraceptive failure of sterilization and on changes in the sexual desires and character of women due to sterilization clearly indicate a need for adequate counseling in clinics offering this method.

Knowledge on vasectomy as a contraceptive method was the last area explored in the endline survey. It also was the least familiar method to most women: only 39% of those surveyed in Cundinamarca and 44% in Santander had heard of it. Around half of those women knew that vasectomized men could still ejaculate and that vasectomy had no effect on a man's sexual desires, character or behavior. A larger percentage knew that vasectomy was not the same as castration and that the operation involved is not painful. However, less than a third knew of specific details related to the operation itself, such as the time that a patient must spend at the hospital or the recovery time before returning to work. Finally, about 70% in Cundinamarca and 28.2% in Santander thought that their husbands knew about vasectomies, but only 10% or less thought that their husbands would ever get one. Surprisingly, about the same number said that they knew someone who had had a vasectomy, a large proportion considering that vasectomy is used only by about 1.5% of couples practicing contraception (Table VI.3-7).

Table VI.3-8 shows that there is a correlation between the knowledge scores for the different methods, usually yielding coefficients higher than .30 and occasionally above .40. However, the highest correlations observed (with coefficients around .70) were between knowledge scores for each method and the sum score of all individual methods ("knowledge of all methods"). This

suggests that individuals with high level of knowledge about a given method are more likely to have a high level of knowledge about other methods. Table VI.3-9 also shows that there are high correlations between ever-use of a given contraceptive method and knowledge about that particular method. The exception is the pill, where low correlations may be caused by the greater difficulties involved in pill use. This suggests that the results shown before may have a less drastic effect on use-effectiveness than might otherwise be believed.

Table VI.3-10 shows that the largest differences observed in the mean knowledge scores for each method are achieved by comparing those who have ever-used a modern contraceptive method and those who have not. In the case of knowledge scores for the pill, this difference was sometimes as large as three full points (or correct answers), whereas in the case of the IUD and barrier methods, the differences were on the order of 1.8 and 1.4 points. Perhaps the easiest way to measure the full impact of each variable is to look at the global scores for all methods, where the differences between ever-users and non-users were greater than eight correct answers. There are basically no differences between women who have an unmet need for contraception and women who do not, which suggests that women who do not want more children and who risk becoming pregnant do not use contraceptives for reasons other than lack of knowledge about them. Finally, Table VI.3-10 explores the knowledge of current users of modern contraceptives according to their contraceptive supply source. In the case of pills and barrier methods, drugstore and CBD post users have the higher scores, while public hospital and health post users have below-average knowledge levels. In the case of clinical methods (IUD, vasectomy and female sterilization), users of PROFAMILIA clinics and CBD posts and of private physicians have high scores, while users of public health facilities have average scores. Thus, the results seem to be mediated by the relationship between ever-use and knowledge of a particular method, since drugstores and CBD posts supply temporary methods and PROFAMILIA, public hospitals and private physicians supply clinical methods.

In order to see the main determinants of knowledge of contraceptive use, sociodemographic variables were regressed on knowledge scores. Table VI.3-11 presents the main results of this analysis. In general terms, sociodemographic variables explain around 20% of the variance of the knowledge scores of any given method. Years of schooling and ever-use of a modern contraceptive method are the most powerful predictors of knowledge scores. Urban residence also has some effect. It is interesting to note that the only exceptions to the trend of ever-use and schooling as joint powerful predictors of knowledge of use are pills, vasectomy and NFP. In the case of pills, ever-use is a stronger predictor, and in the case of vasectomy and NFP, schooling is the most important predictor. Also, it should be noted that in the

case of knowledge of all methods, sociodemographic variables are useful for explaining a greater proportion of the observed variance, 37% in Cundinamarca and 42% in Santander.

6.3.3 Conclusions

Although awareness of most modern contraceptive methods is very high in Colombia, knowledge of their specific characteristics and requirements for effective use is much lower. PROFAMILIA should develop a basic informational curricula for acceptors of different methods in different sources of supply, and should test strategies for the effective delivery of the minimum information needed to use the methods correctly. Because of the potential health hazards, the complexity of the behavior involved, and the variety of sources of supply, this exercise should focus first on pills. However, it is also urgent to disseminate adequate information on barrier methods, because of their low contraceptive reliability (due mostly to improper use). It is also imperative to find better ways to inform clients about the permanent nature of female sterilization and to raise the awareness of vasectomy among the general population. Finally, an effort should be made to determine whether the differences in knowledge of contraceptives among users of different sources of supply is a consequence of the characteristics of the sources or of the counseling practices in each of these sources.

6.4 Perception of Condoms and Condom Brands in Colombia

In addition to the effects of the condom radio advertising campaign (see Section 5.4 for details of the campaign and the survey), the survey conducted in Cali explored knowledge and use of condoms and condom brands, as well as preferences and satisfaction with their use.

Table VI.4-1 presents data regarding knowledge of how condoms are used. About 77.9% of the respondents who knew condoms also said they knew how to use them. Of these, 86.5% were able to give a correct description of the procedure involved. Most were aware that condoms should be worn prior to sexual contact. Knowledge of condom use is negatively correlated with age, which shows that PROFAMILIA should not try to carry out educational campaigns targeted to the younger population.

Table VI.4-2 shows that most of those who had used condoms were aware of both the advantages and disadvantages of the method. The most important perceived advantages were the safety or reliability of the condom as a contraceptive (41.6%), that they are prophylactics (33%), that they are practical (13.3%), and that they do not have any harmful side effects (14.3%). The principal disadvantages mentioned were that they are

uncomfortable (25.6%), that they have a variety of negative psychological effects (20.8%), and that they are unsafe in terms of contraceptive reliability (17.1%).

Regarding condom brands, Tahiti is by far the best known and has the highest market share. Most of those who had heard of a given brand had purchased it at one time or another. Though there were no strong perceived differences between brands, Tahiti was thought to be among the most resistant and high quality condom on the market (Table VI.4-3). These perceptions are important because consumers considered resistance, lubrication and "softness" to be the most desirable characteristics in a condom. Thus, PROFAMILIA should seek to strengthen the association between these attributes and the brands it sells. Consumers seemed to be equally divided in their preferences for the container, with 33% preferring boxes and 28.6% preferring individual units. Most preferred to buy condoms in small quantities and reported indifference to brands. This suggests the need to work on brand loyalty. (Table VI.4-4).

Most men reported using condoms as contraceptives, though the proportion that used them for both contraceptive and prophylactic reasons increased substantially between 1984 and 1987, perhaps as a consequence of the AIDS scare. (Table VI.4-5). Table VI.4-6 shows that the proportion of men who had used condoms at some point and felt satisfied with them increased substantially from 28% in 1984 to 46.9% in 1987. This increase in satisfaction was observed uniformly across different age and income brackets. Curiously enough, both increased sensitivity and decreased sensitivity were given as the main reasons for satisfaction or dissatisfaction with the condom. Other reasons for satisfaction similar in nature but coded separately were reliability as a contraceptive (21.5%) and the fact that they are effective contraceptives (13.4%). Additional reasons for dissatisfaction were that condoms are uncomfortable (26.2%) and that they eliminate the possibility of direct ejaculation (4%). Finally, people were asked about problems they had had with condoms. Only 15.7% reported having had problems, and in 69.9% of those cases, the problem was that the condom had broken (Table VI.4-7).

The results presented above suggest that organizations should carry out brand-specific advertising campaigns rather than the generic campaigns required when US AID funds are used due to existing regulations. This is because family planning organizations have a difficult time expanding and maintaining their condom market share without stimulating brand loyalty among their customers. Furthermore, such advertising should be targeted more to middle-aged and older males, since they are less well informed about most aspects of condom use. Campaigns should use resistance and lubrication as selling points, along with other attributes of PROFAMILIA's brands like low prices, since

consumers consider those the most important characteristics. In addition to the responsibility message that has already been successfully used by PROFAMILIA (see Section 5.4 and Appendix 12), other possible mass media messages could deal with the prophylactic use of condoms, since this kind of use has increased and widespread knowledge of AIDS may increase it further, as the results presented in Section 6.5 suggest.

6.5 Knowledge of AIDS in Colombia

6.5.1 Introduction

Since the use of condoms is perhaps the most effective measure for preventing AIDS while still engaging in sexual relations, and since this fact has significant implications for PROFAMILIA as a social-service organization which also markets condoms, PROFAMILIA has added AIDS awareness questions to a number of its surveys. In the 1987 Cali condom survey, all people who knew of condoms were also asked about AIDS. Knowledge of AIDS was also tested in the endline surveys in Cundinamarca and Santander. Thus, this project was able to test AIDS awareness among males in a large city and among ever-married women in rural and semiurban areas in Colombia. Partly as a consequence of these surveys, PROFAMILIA decided to develop an operations research project under the INOPAL program that is currently testing if CM instructors can provide information on AIDS to members of high risk groups (such as homosexuals, prostitutes, prison inmates, adolescents and clients of VD clinics), and if they can establish condom and brochure distribution posts in the meeting places of those groups (such as gay bars, brothels, detention centers, barracks, VD clinics and sauna baths).

Included in the surveys were batteries of questions on AIDS, forms in which it is transmitted and ways in which it can be prevented.

6.5.2 Results

Very large proportions of respondents had heard of AIDS. In large cities such as Cali, awareness of the disease was almost universal; in rural and semi urban areas such as those surveyed in Cundinamarca and Santander, about 90% had heard of it. Awareness was high across all age groups, and even among those with three years of education or less over 80% were aware of AIDS (Table VI.5-1).

The importance given to AIDS by the mass media has also helped disseminate information regarding more specific knowledge than the mere existence of the disease. Answering an open

question on how AIDS was transmitted, 79% of males in Cali mentioned sex with an infected person, 27.2% mentioned blood transfusions and 11.6% mentioned sharing needles. Answering direct questions on whether each of these behaviors could help transmit AIDS, over 85% of the women in Cundinamarca and Santander answered correctly (Table VI.5-2).

However, there was a large amount of confusion regarding other ways in which AIDS is transmitted. In the open ended question in the Cali survey, 41.9% of the respondents mentioned behaviors that are generally held to be incorrect by the medical community. In Cundinamarca and Santander, where direct questions were asked on each form of transmission, over 60% of the women said that AIDS could be transmitted by insect bites, animal bites, shaking hands with an infected person or breathing his or her air (Table VI.5-3). Also in Cundinamarca and Santander, only about half of the respondents knew that there were ways to know if a person was infected with the AIDS virus (HIV), that AIDS can not be cured, and that there is not a vaccine against AIDS. A higher proportion knew that a person can look healthy and be infected with the HIV. Also, less than 2% said that they knew someone who had had AIDS, which suggests that respondents were doing their best to answer truthfully (Table VI.5-4).

Respondents were also asked to mention all the things they knew that could help prevent AIDS. In general, the responses showed that there was very little awareness of preventive behaviors. In Cali, only 22.9% of the males mentioned the use of condoms, and less than 15% mentioned abstinence, having a single partner, avoiding transfusions or avoid homosexual relations. The most frequent answer was to avoid sex with prostitutes, given by 36.8% of the respondents. Women in Cundinamarca and Santander were more likely to mention having a single partner, avoiding transfusions and avoiding homosexual relations (Table VI.5-5).

In the case of the Cundinamarca and Santander data, an AIDS knowledge score was determined by adding up the number of correct responses to 11 questions on AIDS. If the respondent answered that she did not know or had not heard of AIDS, she was not asked any further questions and was assigned a score of zero. Table VI.5-6 shows that the mean score was 4.5 correct answers in Cundinamarca and 4.4 in Santander. Knowledge of AIDS seemed to be slightly correlated with years of schooling and the degree of exposure to radio, television, newspapers and magazines. Several tables in the sixth and seventh progress reports show that this was also true for most of the particular items explored regarding knowledge of AIDS.

6.5.3 Summary of Results

Awareness of AIDS is widespread in Colombia, even among women in rural areas. Although most people seem to know that sex and exposure to contaminated blood through needles or transfusions can transmit AIDS, large proportions of the population also believe that AIDS may be transmitted by insect and animal bites, and by touching or breathing the air of an infected person. Most people are also uncertain about ways to detect AIDS, whether it can be cured, and whether there is a vaccine against the disease. Finally, mass media information on AIDS has been so pervasive that there are only slight differences in the knowledge of AIDS across age, education and degree of exposure to mass media.

6.6 Perception of Sources and Reasons for Use and Nonuse of Contraception

The last subject areas that were explored in the baseline, midpoint and endline surveys in Cundinamarca and Santander were the sources of supply of contraceptives and reasons for using or not using family planning. Regarding the former subject, it was thought that replacing the CBD program in Santander with CSM would probably make it more difficult for women in that area to obtain contraceptives, because of increased distances to their supply source, or because they would have to switch to new sources. Reasons for use and non-use of contraception were explored because PROFAMILIA wanted to explore ways of reaching the few remaining pockets of unmet demand for family planning in Colombia. In what follows, we present some of the most important results obtained in the studies. Additional information can be found in the second, fifth and seventh progress reports.

6.6.1 Sources of Supply of Contraceptives

Table VI.6-1 shows the distribution of current contraceptive users of each method observed in the midpoint survey by their usual source of supply. As can be seen, the users tended to go to different supply outlets depending on the method used. In rural and semiurban areas of both Cundinamarca and Santander, most women using temporary, non-clinical methods obtained their supplies in drugstores, while most users of the IUD and sterilization got their methods in MOH hospitals or health posts. PROFAMILIA's CBD posts in Cundinamarca were an alternative source for less than 10% of those respondents using condoms, pills or vaginals, which made them slightly more important sources than the MOH posts and promoters. In Santander, drugstores and MOH posts and promoters seemed to have taken most of the clientele

that was serviced before by PROFAMILIA's CBD posts. In both Cundinamarca and Santander, PROFAMILIA was the second most important source for IUDs and sterilization.

Users of the IUD were asked several questions that explored their satisfaction with the sources they had used and the quality of care they obtained. Except for women in Cundinamarca who had had their IUD inserted in PROFAMILIA or with a private physician, only about 10% had gone for follow-up visits to a different outlet from where they had the IUD inserted. A large proportion of the women reported that they had not received an explanation of how the insertion was made or how to check if the IUD was in place. Except for the 17.7% of women who had gone to PROFAMILIA in Santander, very few said the service and attention was slow. In all, women who had had their IUD inserted in a private clinic or by a private physician seemed more satisfied with the service, whereas those who had gone to MOH outlets or to PROFAMILIA in Santander were more likely to complain. However, over 90% of the women reported that the service they had received was good or very good (Table VI.6-2).

Users of pills, injectables, condoms and vaginals were also asked about their service sources. Nearly all said that they planned to return to their usual source to obtain their next supply. However, large proportions of the users of all sources reported that they had found their contraceptives out of stock at least once in their normal source of supply. (Table VI.6-3). Table VI.6-4 provides further evidence of the consistency of source used. Current users who had switched methods were asked if they had switched sources while using the previous method. In almost all cases, less than 10% had done so. In the case of current users, distance from the source had been an important reason for switching from MOH and PROFAMILIA to other sources, while in drugstores the price of contraceptives was the most important reason. In Santander, contraceptive stock-outs were an important reason to switch from many sources, particularly from MOH outlets and, understandably, from PROFAMILIA's CBD posts (Table VI.6-5).

In order to estimate the satisfaction of contraceptive users according to sources of supply, contraceptive use continuation rates of the method used before the current one were obtained for each source. Continuation rates were lower for the MOH outlets and higher for PROFAMILIA outlets. In the case of drugstores, the one year continuation rates were high in Cundinamarca and low in Santander. Considering the large use of the IUD at MOH outlets, the low continuation rates were somewhat surprising (Table VI.6-6). Similar results were obtained when the continuation rates of the last method used by pregnant women were estimated (Table VI.6-7).

In the endline survey, some questions were included to obtain information on the satisfaction and accessibility of the sources of supply of contraceptives. As in the midpoint survey, some items were not very useful because the answers obtained were almost universal and constant. Such was the case with questions on whether the user of a given contraceptive method planned to return to her usual supply source (all did) and what she thought of the attention she received there (almost all thought that it was good or very good). However, other items provided interesting information, such as the decline in the proportion that had experienced stock-outs of their method (only 28% had done so). Unfortunately, for CBD posts this proportion rose to 42.7% in Cundinamarca and 58.5% in Santander.

The accessibility of sources was studied in detail in the endline survey. Table VI.6-8 shows that more than 45% of temporary, nonclinical contraceptive users take less than ten minutes to get to their supply source, and about three-fourths of all users take half an hour or less. Similarly, around 70% of all users can walk to their supply source, with an additional 17% going there by bus. Thus, there seemed to be easy access to contraception in Cundinamarca, where users took an average of 25 minutes to get to their source, and in Santander, where the mean travel time to the supply source was 35.8 minutes. Table VI.6-9 shows that those who walked to their supply source used less than half the time as those who traveled by bus or car. Also, CBD post users took the shortest time to get to their source, while hospital and health post users in Cundinamarca and drugstore users in Santander took the longest time. Likewise, users of vaginal contraceptives seemed to need more time to get to their supply source than users of other methods. Finally, users who had experienced stock-outs at their supply source generally took more time to get there than those who had not experienced stock-outs, suggesting that stock-outs are more frequent in rural, out-of-the way areas.

In conclusion: all the evidence presented in this section shows that women are consistent in their choice of contraceptive source of supply and are apt to be faithful clients, regardless of the source. When they change sources it is more because events force them to do so than because of the perception of bad service or other considerations. Since most of the population in rural Cundinamarca and Santander now have easy access to contraception, one must conclude that the elimination of a preferred contraceptive source causes some amount of hardship. In the case of the discontinuation of CBD posts, such as was done in the Phase I study, the hardship would probably be increased because CBD posts tend to be used because of their proximity. However, the evidence presented also shows that women could probably find an acceptable alternative source of supply within a reasonable distance of their homes.

6.6.2 Reasons for Use and Nonuse of Contraception

As higher prevalence rates are achieved in Colombia, it becomes more difficult to reach those women with unmet need of family planning. Given the wide accessibility of contraception in the country, it is puzzling to find an unmet need for modern family planning methods in areas such as Cundinamarca and Santander. Under these circumstances, family planning organizations need to question whether they should continue to direct their efforts to increasing the availability of contraceptives and information on family planning, or whether their efforts should be complemented with other strategies to reach what in the diffusion of innovations literature are called the "laggards". For this reason, PROFAMILIA included in the surveys questions on reasons for nonuse of contraception.

In the baseline survey, it was observed that only around one percent of all ever-married women did not know at least one modern contraceptive. Of the approximately 40% of women who did not use contraceptives, about half had used them at some point in the past and about half had not (Table VI.6-10). Thus, we start this study by looking at the continuation rates of the different contraceptive methods. As can be seen in Table VI.6-11, less than half of all the current users in the midpoint survey who had used a method before did so for more than one year. Abandonment of methods was more frequent among users of injectables, but it was also high among pill and barrier method users. In the case of injectables, pills and the IUD, the most important reason for discontinuing use was the side effects, while in the case of barrier methods, the major reasons were unreliability, the difficulties associated with their use, and other reasons such as the lack of collaboration of the partner (Table VI.6-12). If we concentrate our attention on those women who had used contraceptives but were not using them at the time of the survey, we see that failure of the contraceptives to avoid a pregnancy, the absence of sexual relations and the desire of a child were also important reasons for nonuse (Table VI.6-13). Lastly, if we restrict ourselves to those who had never used contraceptives, we see that social factors such as traditionalism, ignorance, lack of information, opposition of the husband, and opposition to family planning on different grounds were reasons for nonuse in over 50% of the cases (Table VI.6-14).

There seem to be several conclusions from this study. The first is the need to continue improving existing contraceptive methods and to continue developing new ones. In the case of family planning programs in less developed countries, this would seem to be more a responsibility of international donors than of the family planning programs themselves. While some programs could incorporate a larger variety of methods, large programs such as PROFAMILIA are already using all those that are available

at low cost. For various reasons, family planning programs are not able to or not allowed to take advantage of new advancements in contraception, such as Norplant (too expensive for programs aimed at poor women), the Today vaginal sponge, the triphasic pills or IUDs such as the Multiload. The second conclusion is the need for adequate counseling. If one of the most important reasons for nonuse is the difficulty women face with the methods they choose, they should have information to evaluate if the difficulty is temporary or permanent, and, in this case, they should be aware of all available alternatives. Fortunately, most family planning programs have already incorporated a large amount of counseling into their clinical programs. However, few make a strong effort to guarantee access to relevant information in commercial or quasi-commercial CSM and CBD programs. Since this project has shown that a likely trend of these programs in the long run may be towards more commercial strategies, family planning organizations should begin experimenting with mechanisms that allow them to provide this sort of information to clients of commercial outlets. Finally, the question of social factors needs to be better studied. Although PROFAMILIA suspected that husbands could be an important reason for lack of use and included questions to explore the issue (see Table VI.6-15), the large number of responses on traditionalism, ignorance and opposition to family planning was unsuspected. Thus, it would be advisable to study both the true meaning of these responses as well as the ways in which they can be addressed.

VII. INSTITUTIONALIZATION OF OPERATIONS RESEARCH, DISSEMINATION OF RESULTS AND OTHER PROGRAM INPUTS

As part of the project, a strong effort was made to institutionalize operations research as a routine management tool in PROFAMILIA, and to disseminate the most relevant results of the studies among professionals involved in the design, management, funding and research of family planning projects. There were four main kinds of institutionalization and dissemination activities: workshops and seminars, presentation of papers at professional meetings, publications in professional journals and support of research activities.

7.1 Workshops and Seminars

There were three seminars on operations research and management funded by this project. In attendance at these seminars were all of PROFAMILIA's clinic directors and the central staff. The purpose of the seminars was to encourage the regional directors to use financial and service data from operations and from operations research projects to help them better administer their regions. In each of the seminars, at least one day was devoted to analyzing the results of the studies conducted under this project and of other financial and operations research conducted by PROFAMILIA. In each seminar, the participants worked through exercises designed to make clear how they could best use financial and research data. The evaluation of all three seminars was highly positive. The first seminar took place in March, 1985 in Melgar, the second in Cartagena in March, 1986, and the third in Medellin in March, 1987. In addition to these seminars, most of the final results of the studies conducted under this project were presented in the 1988 annual meeting of PROFAMILIA's directors which took place in Cali.

Also, the experiences gained during this project were used as exercises and reference materials at the international workshop on operations research that was held at PROFAMILIA's headquarters in Bogotá, March 7-11, 1988. Gabriel Ojeda, the principal investigator of this project and head of PROFAMILIA's Evaluation Department, and Ricardo Vernon, The Population Council's resident technical advisor to the project, organized and lectured at the workshop. The workshop was evaluated highly by the participants.

7.2 Presentations at Professional Meetings

Several papers on operations research conducted under this and previous PROFAMILIA/Population Council projects were prepared for presentation at professional meetings. The papers presented were the following:

- Townsend, John; G. Ojeda and M. Townsend. "Alternative Strategies to Improve the Cost-Effectiveness of the PROFAMILIA CBD Program in Colombia: Wage incentive vs Specialized IEC Teams." Paper presented at the PAA Annual Meeting in San Francisco, California, April 3-5, 1986. (Presentation of results of a previous OR project conducted by PROFAMILIA and The Population Council).

- Townsend, Marcia and G. Ojeda. "Community Based Distribution by Mobile Teams in Colombia: Policy Implications and Alternative Strategies." Paper presented at the Annual Meeting of the American Public Health Association in Las Vegas, Nevada, September 28 - October 3, 1986. (Presentation of results of a previous OR project conducted by PROFAMILIA and The Population Council).

- Vernon, Ricardo and G. Ojeda. "Comparación de la Distribución Comunitaria y el Mercadeo Social de Anticonceptivos en Colombia." Paper presented at the V International Congress of the World Federation of Public Health Associations in Mexico City, Mexico, on March 22-27, 1987. (Presentation of Phase I results).

- Ojeda, Gabriel and R. Vernon. "Contraceptive Social Marketing vs Specialized Community Based Distribution Programs in Colombia." Paper presented at the annual meeting of the Population Association of America in Chicago, Illinois on April 30 - May 2, 1987. (Presentation of Phase I results).

- Vernon, Ricardo and G. Ojeda. "CBD vs. CSM programs in Colombia." Paper presented at the Annual Meeting of the National Council for International Health in Washington, D.C. on June 14-17, 1987. (Presentation of Phase I results and comparison with an specialized IEC team strategy that was tested in the Department of Huila in an operations research funded by UNFPA).

- Vernon, Ricardo; G. Ojeda and A. Vega. "Quality of Care in CBD Programs in Colombia." Paper presented at the annual meeting of the Population Association of America (PAA) in New Orleans, Louisiana on April 21 - 24, 1988. (Presentation of Quality of Care study included in section 6.2 of this report).

- Ojeda, Gabriel; R. Vernon and T. Williams. "Long Term Effects of Generic Condom Radio Advertising in Colombia." Paper presented at the annual meeting of the National Council for

International Health (NCIH) in Washington, D.C., May 19-22, 1988. (Presentation of the Cali Condom Survey results presented in section 5.4 of this report).

- Vernon, Ricardo and G. Ojeda. "Knowledge and Prevention of AIDS in Colombia." Paper presented at the annual meeting of the National Council for International Health (NCIH) in Washington, D.C., May 19-22, 1988. (Presentation of results presented in section 6.5 of this report and of the design of an AIDS OR project funded under the INOPAL program).

- Vernon, Ricardo, G. Ojeda and R. Murad. "How Family Planning Organizations Can Help Prevent AIDS in Colombia." Poster presentation at the IV International Conference of AIDS in Stockholm, Sweden, June 12-16, 1988. (Presentation of results of section 6.5 and preliminary results of the INOPAL AIDS OR project).

7.3 Publications in Professional Journals

In order to reach a larger professional audience, papers were submitted or will be submitted in the near future to professional journals to have them published as articles or summaries. The papers are the following:

- "PROFAMILIA Examines Contraceptive Social Marketing in Colombia." Summary of the 1987 PAA paper published in the Digest section of International Family Planning Perspectives 13, 2 (June 1987). p. 62-63.

- "PROFAMILIA Estudia la Eficacia de los Programas de Comercialización de Anticonceptivos en Colombia." (English title same as above). Summary of the 1987 PAA paper published in the Compendio section of Perspectivas Internacionales en Planificación Familiar (Número Especial de 1987). p. 39-40.

- Vernon, Ricardo; G. Ojeda and M. Townsend: "Contraceptive Social Marketing and Community-Based Distribution Systems in Colombia." Studies in Family Planning (December/January 1989, forth coming).

A copy of the paper on long-term effects of condom radio advertising presented at the 1988 NCIH annual meeting has been submitted for publication at the Digest section of International Family Planning Perspectives. In addition, we expect to submit in the near future a modified version of the quality of care study presented in section 6.2 of this report to Studies in Family Planning, and a modified version of the study on contraceptive information needs of Colombian women included in section 6.3 of this report to either of the two journals mentioned above.

7.4 Support of Research and Program Activities

This project helped consolidate PROFAMILIA's Research and Evaluation Division by funding the salaries of the principal investigator, Gabriel Ojeda, who is also the Director of the Division, and of three full time research assistants. All the survey expenses, research expenses such as Nielsen's Retail Index and presentation of results at international conferences were also funded by the project. Other personnel funded partially or totally included the CSM salesperson, the CBD and CM instructors and supervisors, and the director of the CSM project during the Phase I and Phase II studies.

To improve PROFAMILIA's data analysis capability, the project purchased two microcomputers, one IBM AT and one IBM XT. Training in the use of microcomputers was also provided to all the project's research assistants. The Research and Evaluation Division's personnel have become so proficient in the use of microcomputers that they have since bought several more and continuously provide help in data analysis to other institutions, such as the Asociación Colombiana de Estudios de Población (ACEP), the Departamento Nacional de Estadísticas (DANE) and the Instituto Colombiano de Bienestar Familiar (ICBF).

During the course of the project, The Population Council maintained a resident technical project advisor in Bogotá. This advisor continuously monitored all research activities, including the design of data collection instruments, training of survey interviewers, data analysis and preparation of progress reports. This had the advantage of exposing the project's research assistants to new techniques and procedures and of helping them become more proficient researchers. As a consequence of the development of these research assistants, PROFAMILIA's Research and Evaluation Department has increased its talent pool.

Finally, the project helped services at project areas by designing a brochure on contraceptive methods and printing 30,000 copies, which were distributed in the Santander project zones at the beginning of Phase I activities. The project also funded four seminars on contraception for pharmacists in Santander. The seminars took place in the cities of San Gil, Barbosa and Bucaramanga, and they lasted for three days. A total of 46 persons attended the seminars.

VIII DISCUSSION: MARKETING OF CONTRACEPTIVES BY FAMILY PLANNING ORGANIZATIONS

The subject area explored by this project was the potential for non-profit family planning organizations to market contraceptives in societies where high contraceptive prevalence has been achieved. Since the particular conclusions and implications of the studies conducted as part of this project have been presented in earlier sections of this report, we take the opportunity here to discuss the general conclusions and themes that have been covered by the project as a whole.

One of the main themes explored was the cost-effectiveness of different strategies in marketing contraceptives. The underlying assumption of several of these studies was that contraceptive marketing programs need to become more self-sufficient in order to survive in the long term, and that self-sufficiency depends in large part on the contraceptive distribution strategies used by the organization. The Phase I and Phase II studies showed that self-sufficiency is within the reach of family planning organizations which fully adopt the practices followed by commercial private sector companies. In addition, the Nielsen drugstore study showed that family planning program managers are capable not only of gearing their organizations to meet the challenges faced in this new environment, but that they can also adopt sophisticated marketing strategies to compete effectively with private sector contraceptive distributors. However, the Phase I study also showed that if family planning organizations become another actor in the commercial contraceptive market place and stop receiving subsidies through donations, they will likely face new challenges that would endanger their survival as commercial enterprises. This is so because government regulations and the relationships with contraceptive suppliers are also important determinants of program cost-effectiveness, perhaps just as important as the service delivery strategies that are adopted. Compared to commercial wholesalers, family planning organizations have the disadvantage of marketing only a limited set of pharmaceutical products (contraceptives). This makes them more exposed to regulations that may affect only that particular set of products and to pressures from their commercial suppliers. This dependance also makes them less competitive in the market place, because although the costs involved in visiting a retailer are similar for pharmaceutical wholesalers and family planning organizations, the former obtain larger profits from each visit because the volume of products sold per visit is larger than in the case of the latter. Thus, as long as family planning organizations remain exclusively contraceptive retailers, they will not be able to compete effectively on a purely commercial basis or to remain viable organizations on the long term.

The corollary to the above conclusions is that if funding to contraceptive marketing programs was to be cut in countries where high contraceptive prevalence has already been achieved, family planning organizations would first have to be helped to become more commercially oriented wholesalers of a larger line of pharmaceutical products and, perhaps, to tap new funding sources within their own countries, a strategy that has been pursued by PROFAMILIA with little success. If this strategy were to be followed, the Phase I study showed that at least in the short term, knowledge and use of contraceptives would not likely decrease. However, even if successful, this course of action would be undesirable because family planning organizations would be forced to behave like other commercial wholesalers, and the social purposes that justify their existence would no longer be within their reach. In addition, the long term consequences of such a strategy would be unpredictable, since the decreased accessibility of contraceptives in remote areas that cannot be serviced profitably would probably cause contraceptive prevalence to remain at current or even lower levels at a time when demand for contraception is likely to increase. Regarding clinical and sterilization programs, which are the more costly components of family planning programs, stopping donations would mean abandoning the programs or making available these methods only to higher income women.

The second issue that was implicitly explored in this report was what social objectives should be pursued by family planning programs. As higher contraceptive levels are achieved in a society, the traditional objectives of increasing contraceptive use and contraceptive accessibility begin to be more difficult to achieve and less socially relevant. The study on reasons for non-use of contraception showed that there is still a small but significant proportion of women who are still not cognitively prepared to realize the benefits of family planning, and certainly it will continue to be one of the responsibilities of family planning programs to provide these women and their husbands with this information. But the information that most women need is how to correctly use the various contraceptive methods available. In section 6.3 we saw that many women do not know how to use even their own contraceptive method correctly and are not aware of the counterindications for their methods' use. In section 6.6.2 it was also seen that difficulties with a given method are an important cause for stopping use and that women should therefore be well acquainted with the different available alternatives. Furthermore, section 5.3 showed that even if sufficiently motivated to go to their contraceptive suppliers, women would find it difficult to obtain reliable information because even trained retailers lack knowledge on several important aspects of contraceptive use. Thus, it seems that family planning organizations could benefit by changing the content of their IEC campaigns and exploring new ways to educate the public on these topics. Within a larger framework, section

6.2 showed that there is also a need to explore the quality of care of contraceptive marketing programs, since several factors related to this concept seem to have an important effect on the acceptability of services and, perhaps, on the continuity of contraceptive use.

The final main issue that was explored in this report was the use of mass media to back up marketing programs. The results shown in sections 5.4 and 6.1 suggest that in areas with high contraceptive prevalence of several methods, short term mass media campaigns will probably not raise contraceptive prevalence of a given method in the long run. However, such campaigns will likely be good educational measures because they motivate large segments of the public to try the contraceptive method and obtain first hand knowledge of it, and because they probably motivate more continous and responsible use of that contraceptive by those who used it occasionally. It should be pointed out that the authors believe that the results obtained by these advertising campaigns were determined in large part by their generic, as opposed to brand-specific, character. Even if the overall prevalence of a given method is not increased by advertising campaigns, perhaps they could be cost effective if they were brand specific and the campaign was able to increase the market share of the brand sold by the family planning organization. Thus, family planning organizations would be well advised to engage in brand specific advertising. Likewise, international donors should encourage the use of brand specific advertising whenever possible, and should encourage this to happen in the case of donated contraceptives by not switching the brands of the donated products. Perhaps this could be accomplished by packaging contraceptive products under a single owned brand. In that case, even if the supplier of the donor was changed, the contraceptive method could continue to be sold under the same name.

IX. REFERENCES

AID. 1986. AID's Experience with Contraceptive Social Marketing. A Synthesis of Project Evaluation Findings. AID, Washington, D.C.

Bailey, Jerald. and J. Correa. 1975. "Evaluation of the PROFAMILIA Rural Family Planning Program." Studies in Family Planning 11, No. 6 (June): 148-155.

Baldwin, Wendy, 1988. Remarks made at her discussion of the Quality of Care in Family Planning in the Third World Session at the 1988 Population Association of America annual meeting in New Orleans, Louisiana, April 21-23.

Bruce, Judith, 1987. Internal The Population Council Memorandum to IP Associates and Field Staff, New York, The Population Council, March 12.

Castro, Rodrigo and N. Girón, 1985. Estudio de Costos Quirúrgicos. PROFAMILIA, Bogotá, Colombia.

Corporación Centro Regional de Población (CCRP), Ministerio de Salud de Colombia and Institute for Resource Development/Westinghouse, 1988. Colombia. Encuesta de Prevalencia, Demografía y Salud. CCRP, Bogota, Colombia.

DANE, 1986 (Departamento Administrativo Nacional de Estadística). XV Censo Nacional de Población y IV de Vivienda. Volumen 1. DANE, Bogotá, Colombia, 1986.

Echeverri, Gonzalo. 1975. "Development of the PROFAMILIA Rural Family Planning Program in Colombia." Studies in Family Planning 6, No.6 (June): 142-147.

Foreit, J.R. et al. 1978. "Community-Based and Commercial Contraceptive Distribution: An Inventory and Appraisal." Population Reports, Series J.

International Women's Health Coalition and The Population Council (IWHC & TPC). 1986. "Rapporteurs'Report." In The Contraceptive Development Process and Quality of Care in Reproductive Health Services, New York, IWHC & TPC, 1986: 5-28.

Ojeda, Gabriel and R. Vernon, 1987. "CSM vs CBD programs in Colombia." Paper presented at the 1987 annual meeting of the Population Association of America, Chicago, April 1987.

Ojeda, Gabriel; J.M. Amadeo and A. Monroy. Cost per Couple Year of Protection. The Case of Profamilia, 1977-1980. Undated Monograph published by the International Planned Parenthood Federation (IPPF) Western Hemisphere Region, New York, N. Y.

Plata, Santiago. 1981."Colombia: El Programa Comercial de PROFAMILIA." In Alcides Estrada (ed) Planificación Familiar en América Latina: Programas Comunitarios y Comerciales. (no press) Bogotá.

Prada , Elena, 1986. Estudio sobre Continuidad y Uso Adecuado de Anovulatorios en el Departamento del Magdalena. Grupos Focales. Unpublished Monograph. Family Health International/Colombian Ministry of Health, Bogotá.

Rogow, Deborah, 1986. "Quality of Care in International Family Planning: A Feminist Contribution" pps 72-102 in IWHC & TPC, The Contraceptive Development Process and Quality of Care in Reproductive Health Services. IWHC & TPC, New York.

Townsend, John and G. Ojeda, 1985. "Community Distribution of Contraceptives in Rural Areas." Final Narrative Report of Project AID/DSPE-C-0084. New York, The Population Council.

Townsend, John; G.Ojeda and Marcia Townsend. 1986. "Alternative Strategies to improve the Cost-Effectiveness of the PROFAMILIA CBD Program in Colombia: Wage incentive vs Specialized IEC Teams." Paper presented at the PAA Annual Meeting. San Francisco, California, April 3-5.

Townsend, John, 1987. Internal Population Council Memorandum to Tomas Frejka. Mexico City, The Population Council, October 5.

Townsend, Marcia and G.Ojeda. 1986. "Community Based Distribution by Mobile Teams in Colombia: Policy Implications and Alternative Strategies." Paper presented at the Annual Meeting of the American Public Health Association. Las Vegas, Nevada, September 28 - October 3.

Vernon, Ricardo and K. Rocuts, 1986. The Provision of Natural Family Planning Through Comprehensive Health Care Systems. Sixth Progress Report to AID of Cooperative Agreement No. DPE-3005-A-00-3003-00. Fundación Santa Fe de Bogotá and the Population Council, Bogotá/New York.

Vernon, Ricardo and G. Ojeda, 1987. Private Sector Community Based Distribution and Commercial Social Marketing Strategies in Colombia. Sixth Narrative Report to AID. Bogotá, The Population Council.

TABLE II-1

PERCENT DISTRIBUTION OF CURRENT CONTRACEPTIVE USERS BY MOST RECENT SOURCE OF SUPPLY AND METHOD
DHS, 1986

SOURCE OF SUPPLY	METHOD								
						STERILIZATION			
	PILL	IUD	INJECTABLE	VAGINALS	CONDOM	FEMALE	MALE	TOTAL	NUMBER OF WOMEN
HOSPITAL, HEALTH CENTER	9.7	35.5	8.3	0.0	3.3	11.9	0.0	15.1	257
HEALTH PROMOTOR	0.3	0.0	2.4	0.0	0.0	0.0	0.0	0.2	4
PROFAMILIA CLINIC	1.8	45.2	1.8	2.4	10.0	71.7	100.0	36.1	614
CBD POST PROFAMILIA	7.1	0.0	1.3	3.4	7.0	0.0	0.0	2.6	44
PRIVATE CLINIC	0.4	4.7	3.7	0.0	0.0	11.2	0.0	5.2	89
PRIVATE PHYSICIAN	0.2	9.3	6.7	0.0	1.7	0.3	0.0	2.5	42
DRUGSTORE	75.3	0.6	73.4	88.9	65.0	0.2	0.0	33.3	566
FAMILY COMPENSATION SERVICE	4.0	4.1	1.1	3.3	0.0	4.7	0.0	3.9	67
OTHER	0.5	0.6	0.0	1.1	1.8	0.0	0.0	0.4	4
DOES NOT KNOW	0.8	0.0	1.3	0.9	11.2	0.0	0.0	8.7	6
TOTAL	100.0	100.0	100.0	00.0	100.0	100.0	100.0	100.0	100.0
NUMBER OF WOMEN	526	360	78	84	54	590	11	1,702	1,702

TABLE IV-1

NUMBER OF COMPLETE AND INCOMPLETE HOUSEHOLD AND INDIVIDUAL SURVEYS IN BASELINE, MIDPOINT AND ENDLINE SURVEYS IN CUNDINAMARCA AND SANTANDER

		NUMBER OF INTERVIEWS											
		HOUSEHOLDS						INDIVIDUAL					
DEPARTMENT	ZONE	COMPLETE	NO ADULTS	UNINHABITED	REJECTIONS	NOT A HOUSEHOLD	OTHER	COMPLETE	INCOMPLETE	REJECTION	ABSENT	OTHER	WEIGHTED INDIVIDUAL INTERVIEWS
CUNDINAMARCA 1st. SURVEY	URBAN	954	101	46	9	76	21	681	-	3	82	3	20,028
	RURAL	1,195	77	47	5	13	13	946	-	2	84	-	49,553
	TOTAL	2,149	178	93	14	89	34	1,627	-	5	166	3	69,581
CUNDINAMARCA 2nd. SURVEY	URBAN	934	73	40	18	114	26	657	-	8	48	-	20,493
	RURAL	619	33	27	1	6	4	437	-	1	59	1	23,639
	TOTAL	1,553	106	67	19	120	30	1,094	-	9	107	1	44,132
CUNDINAMARCA 3rd. SURVEY	URBAN	921	94	51	-	-	14	566	-	-	61	-	18,212
	RURAL	539	43	24	-	-	9	400	-	-	18	-	21,158
	TOTAL	1,460	117	75	-	-	23	966	-	-	79	-	39,370
SANTANDER 1st. SURVEY	URBAN	1,057	43	45	6	98	14	758	-	10	68	1	26,062
	RURAL	920	27	23	4	7	4	733	2	-	69	1	27,163
	TOTAL	1,977	70	68	10	105	18	1,491	2	10	137	2	47,225
SANTANDER 2nd. SURVEY	URBAN	1,180	59	59	5	130	14	949	2	1	30	-	30,859
	RURAL	645	11	9	1	9	3	563	2	-	14	-	24,366
	TOTAL	1,825	70	68	6	139	17	1,512	4	1	44	-	55,225
SANTANDER 3rd. SURVEY	URBAN	1,223	93	48	2	-	7	718	-	-	34	1	23,178
	RURAL	652	54	60	1	-	1	488	-	-	27	-	19,570
	TOTAL	1,875	117	108	3	-	8	1,206	-	-	61	1	42,748

TABLE IV-2

CHARACTERISTICS OF THE WOMEN INTERVIEWED IN THE BASELINE, MIDPOINT AND ENDLINE SURVEYS IN CUNDINAMARCA AND SANTANDER

CARACTERISTIC	BASELINE SURVEY		SECOND SURVEY		THIRD SURVEY	
	CUNDINAMARCA	SANTANDER	CUNDINAMARCA	SANTANDER	CUNDINAMARCA	SANTANDER
AGE						
15-19	3.9	5.9	4.8	4.7	4.5	5.2
20-24	19.3	19.9	20.2	15.2	15.6	17.3
25-29	18.3	18.7	19.2	18.7	19.4	19.7
30-34	17.0	16.5	15.9	15.1	18.9	17.9
35-39	15.3	16.5	16.1	18.4	15.9	15.3
40-44	13.9	12.8	11.9	12.6	12.6	12.1
45-49	12.2	9.9	11.9	15.5	13.0	12.5
YEARS OF SCHOOLING						
0-3	*	*	43.3	42.4	32.7	39.2
4-5	*	*	28.1	27.6	31.4	24.6
6-9	*	*	19.6	14.8	22.6	20.7
10 +	*	*	9.0	15.1	13.3	15.4
MARITAL STATUS						
MARRIED	56.7	66.2	58.2	71.0	61.8	71.9
IN UNION/NOT MARRIED	30.7	22.5	29.5	15.5	26.0	18.4
WIDOW	3.1	2.8	3.2	2.3	2.9	2.8
SEPARATED/DIVORCED	9.5	8.5	9.1	11.2	9.3	6.9
% HAVE HAD CHILDREN	96.8	95.3	95.3	94.7	95.4	94.7
No. CHILDREN						
0	3.2	4.7	4.7	5.3	4.6	5.3
1	14.2	14.6	17.2	12.9	16.1	14.7
2	19.2	20.1	21.0	20.1	22.5	22.6
3-4	30.9	25.9	29.4	29.0	32.2	29.2
5 +	32.5	34.7	27.7	32.5	24.5	28.1
% DESIRE AN ADDITIONAL CHILD	21.3	18.4	22.8	15.3	19.5	19.2
% CURRENTLY USING CONTRACEPTION	64.3	57.1	63.4	57.6	72.7	66.7
TOTAL CASES	1,626	1,491	1,094	1,512	966	1,206

* Not Available

TABLE IV-3

COVERAGE OF THE 1987 CBD DISTRIBUTORS STUDY

I T E M	No.	%
TOTAL NUMBER OF DISTRIBUTION POSTS	3456	-
NUMBER OF DISTRIBUTION POSTS INCLUDED IN SAMPLE	723	100
INTERVIEWS COMPLETED, SAMPLE FRACTION	571	79
COVERAGE (INTERVIEWS COMPLETED/ CBD POSTS IN SAMPLE)	571/723	79
INTERVIEWS NOT COMPLETED	152	21
- HAVE CEASED TO BE DISTRIBUTORS	50	6.9
- OCCASIONAL CONTRACEPTIVE BUYERS WHO ARE NOT REGULAR CBD DISTRIBUTORS	26	3.6
- DISTRIBUTOR WAS ABSENT	20	2.8
- NON-EXISTENT ADDRESS	15	2.1
- ADDRESS EXISTS BUT THERE WAS NO CBD POST THERE(DRUGSTORES, INSTRUCTORS, ETC)	10	1.4
- ADDRESSES REPEATED	8	1.1
- REJECTIONS	1	0.1
- ADDRESS IS LOCATED IN A COUNTY NOT INCLUDED IN SAMPLE FRAME	22	3.0

TABLE IV-4

CHARACTERISTICS OF PROFAMILIA'S CBD DISTRIBUTORS BY DATE OF SURVEY. COLOMBIA, 1984-1987.

CHARACTERISTICS OF CBD DISTRIBUTORS	DATE OF SURVEY 1984	DATE OF SURVEY 1987
NUMBER OF CASES:	530	571
AGE:		
LESS THAN 20	1.3	1.1
20 - 29	13.9	13.1
30 - 39	36.9	39.9
40 OR OLDER	47.9	45.9
SCHOOLING:		
- ILLITERATE	2.5	1.8
- SOME ELEMENTARY	51.9	47.4
- SOME SECONDARY	43.3	47.5
- SOME COLLEGE	2.3	3.5
HAVE HAD CHILDREN:		
- YES	87.8	89.5
- NO	12.2	10.5
CURRENT USE OF CONTRACEPTIVES:		
- YES	75.9	71.2
- NO	24.1	28.5

TABLE IV-5

CHARACTERISTICS OF CBD DISTRIBUTORS AND CBD POSTS BY DATE OF SURVEY. COLOMBIA, 1984-1987.

CHARACTERISTICS OF CBD DISTRIBUTORS AND POSTS	DATE OF SURVEY 1984	1987
NUMBER OF CASES:	531	571
CIVIL STATUS OF DISTRIBUTOR		
SINGLE	11.5	10.0
MARRIED OR IN UNION	75.9	75.3
SEPARATED/DIVORCED/WIDOWED	12.7	14.6
No. OF YEARS AS DISTRIBUTOR:		
0 - 1 YEARS	30.0	28.0
2 - 3 YEARS	23.4	23.7
4 - 5 YEARS	17.2	16.1
6 OR + YEARS	29.4	32.3
MOST IMPORTANT REASON TO BE A DISTRIBUTOR:		
- COMMUNITY SERVICE/ HELP WITH DEMOGRAPHIC AND FAMILY PLANNING OBJECTIVES.	67.5	81.5
- INCREASE PROFITS/ INCREASE SALES/ HAVE MORE PRODUCTS.	9.0	10.2
- OTHER.	23.5	8.3
KIND OF POST:		
- HOME	36.8	28.9
- SMALL RETAIL STORE	44.9	34.7
- OTHER COMMERCIAL SITE	18.3	36.4
% GETTING HELP TO SELL CONTRACEPTIVES:	61.0	50.1
- SPOUSE	34.3	44.6
- CHILDREN	37.0	48.4
- PARENTS	7.4	7.2
- OTHER RELATIVES	22.7	17.9
- EMPLOYEES	3.4	6.9
NUMBER OF CASES:	324	286

TABLE IV-6

CHARACTERISTICS OF CBD DISTRIBUTORS AND POST BY GEOGRAPHICAL REGION. COLOMBIA, 1987.

CHARACTERISTICS OF CBD POSTS AND DISTRIBUTORS	REGION						
	TOTAL	ATLANTIC	SANTANDER	EASTERN	PACIFIC	CENTRAL	BOGOTA
AGE:							
< THAN 20	1.1	1.6	0.0	1.5	1.0	1.1	0.0
20 - 29	13.1	12.9	3.7	19.4	20.6	10.9	6.5
30 - 39	39.9	42.7	51.9	37.3	35.3	41.4	36.4
40 OR OLDER	45.9	42.7	44.4	41.8	43.1	46.6	57.1
SEX:							
- MALE	12.6	18.5	14.8	11.9	10.8	12.1	6.5
- FEMALE	87.4	81.5	85.2	88.1	89.2	87.9	93.5
SCHOOLING:							
- ILLITERATE	1.8	1.6	3.7	0.0	2.9	2.3	0.0
- ELEMENTARY	47.4	48.4	48.1	41.9	51.0	47.6	45.5
- SECONDARY	47.5	45.9	48.1	50.7	44.1	47.1	52.0
- COLLEGE	3.5	4.0	0.0	7.5	2.0	2.8	2.6
CAN READ CONTRACEPTIVE METHODS MANUAL:							
- YES	85.6	73.7	100.0	90.9	77.8	92.0	91.7
- NO	14.4	26.3	0.0	9.1	22.2	8.0	8.3
NUMBER OF CASES:	90	19	5	11	18	25	12
HAVE HAD CHILDREN:							
- YES	89.5	88.7	96.3	91.0	94.1	83.9	93.5
- NO	10.5	11.3	3.7	9.0	5.9	16.1	6.5
CURRENT USE OF CONTRACEPTIVES:							
- YES	71.2	71.3	66.7	73.2	76.8	75.0	55.6
- NO	28.5	28.7	33.3	25.0	23.2	25.0	44.4
NUMBER OF CASES:	452	94	21	56	82	136	63
CIVIL STATUS:							
- SINGLE.	10.0	12.1	11.1	10.4	6.9	12.1	5.2
- MARRIED OR IN UNION.	75.3	79.1	66.7	73.2	77.4	74.7	72.7
- SEPARATED/DIVORCED/WIDOWED.	14.6	8.9	22.2	16.4	15.6	13.2	20.8
NUMBER OF CASES:	571	124	27	67	102	174	77

TABLE IV-7

CHARACTERISTICS OF RESPONDENTS BY DATE OF SURVEY. CALI, 1984-1987.

WORKING SECTOR, AGE, CIVIL STATUS AND EDUCATION	DATE OF SURVEY		
	AUGUST 1984	MAY 1985	MAY 1987
WORKING SECTOR:			
PRIVATE	44.4	43.5	56.1
OFFICIAL	44.3	49.0	30.7
UNEMPLOYED	11.3	7.5	13.2
A G E:			
15 - 19	1.8	1.1	2.9
20 - 24	13.7	12.9	16.8
25 - 29	22.4	21.1	25.8
30 - 34	19.4	19.4	19.0
35 - 39	14.5	16.4	13.2
40 - 44	10.2	12.6	9.3
45 - 49	6.9	7.6	4.9
50 or +	11.1	8.8	8.0
AVERAGE:	34.7	34.8	32.7
CIVIL STATUS:			
SINGLE	25.2	22.7	32.4
MARRIED	53.0	54.0	45.3
CONSENSUAL UNION	20.3	20.3	17.4
OTHER	1.6	3.0	4.9
EDUCATION:			
NONE	1.0	0.9	0.3
SOME ELEMENTARY	30.0	24.9	16.4
SOME SECONDARY	49.6	54.8	54.5
SOME COLLEGE	19.4	19.4	28.8
AVERAGE YEARS OF SCHOOLING:	8.4	8.8	10.2
T O T A L	100.0	100.0	100.0
NUMBER OF CASES:	1,767	2,669	1,519

TABLE IV-8

PROPORTION OF MALES KNOWING EACH FAMILY PLANNIG METHOD BY DATE OF SURVEY. CALI, 1984-1987.

CONTRACEPTIVE METHOD	DATE OF SURVEY		
	AUGUST 1984	MAY 1985	MAY 1987
PILL	98.9	99.3	95.0
IUD	91.9	96.1	87.6
FEMALE STERILIZATION	95.5	97.5	86.3
MALE STERILIZATION	81.4	85.0	76.0
CONDOM	99.4	99.6	86.9
INJECTABLE	78.1	82.8	77.7
VAGINALS	90.5	95.3	87.0
RHYTHM	86.2	92.4	86.2
WITHDRAWAL	80.6	93.2	76.0
OTHER	50.0	3.6	5.2

TABLE IV-9

PROPORTION OF MALES WHO HAD EVER USED EACH FAMILY PLANNING METHOD BY DATE OF SURVEY. CALI, 1984-1987.

METHOD EVER USED	DATE OF SURVEY		
	AUGUST 1984	MAY 1985	MAY 1987
PILL	63.9	73.2	65.7
IUD	22.9	34.7	30.3
STERILIZATION*	15.7	17.6	12.5
CONDOM	41.8	50.6	43.1
VAGINALS	28.8	54.1	47.7
OTHER**	50.5	53.6	49.3

* Including Vasectomy.
** Including Injectables, Rhythm, Withdrawal and Other.

TABLE IV-10

DISTRIBUTION OF MALES ACCORDING TO LAST CONTRACEPTIVE METHOD USED BY DATE OF SURVEY. CALI, 1984-1987.

LAST METHOD USED	DATE OF SURVEY		
	AUGUST 1984	MAY 1985	MAY 1987
PILL	31.6	30.1	34.1
IUD	13.8	14.0	12.9
FEMALE STERILIZATION	14.0	14.3	10.0
VASECTOMY	1.8	1.2	0.6
CONDOM	7.7	8.6	11.3
INJECTABLE	4.9	5.0	5.1
VAGINALS	8.5	7.4	8.5
RHYTHM	12.4	12.5	12.6
WITHDRAWAL	4.7	6.3	4.4
OTHER	0.6	0.8	0.5
T O T A L	100.0	100.2	0.0

TABLE V.1-3

KNOWLEDGE, USE AND UNMET NEED FOR CONTRACEPTION AMONG EVER-MARRIED WOMEN IN FERTILE AGE IN PROJECT AREAS BY STRATEGY AND BY SURVEY

KNOWLEDGE, USE AND UNMET NEED FOR CONTRACEPTION	STRATEGY			
	C S M		WAGE-INCENTIVES	
	Baseline	Midpoint	Baseline	Midpoint
KNOWLEDGE: % KNOWING OF AT LEAST:				
1 modern method \1\	98.6	97.3	99.5	97.1
2 modern methods	98.6	96.9	98.7	95.4
3 modern methods	93.5	94.8	95.2	93.9
4 modern methods	87.0	90.2	87.6	88.4
5 modern methods	76.1	80.4	75.1	78.8
PREVALENCE OF USE: % USING:				
Contraceptive methods	57.1	57.5	64.2	63.4
Modern methods	44.6	46.7	47.6	47.3
UNMET NEED \2\ for:				
Contraceptive methods	15.5	12.8	12.4	7.3
Modern methods	23.9	19.6	24.5	18.8
NUMBER OF CASES:	1491	1512	1629	1094

\1\ Including the pill, condom, IUD, female sterilization, vasectomy, injectables and vaginals.

\2\ Percent of currently married women who are not pregnant, are not sterile, not desire another child and (a) are not using any contraceptive method ; or (b) are not using a modern contraceptive method.

TABLE V.1-4

SOURCE OF CURRENT TEMPORARY CONTRACEPTIVE METHOD USED
(INCLUDING AND EXCLUDING THE IUD)
BY SURVEY AND DEPARTMENT

SOURCE OF CURRENT CONTRACEPTIVE USED	CUNDINAMARCA				SANTANDER			
	BASELINE		MIDPOINT		BASELINE		MIDPOINT	
	1*	2**	1*	2**	1*	2**	1*	2**
HOSPITAL/HEALTH POST	-	31.5	7.0	28.6	-	33.3	14.1	34.8
DRUGSTORE	-	44.0	83.7	51.9	-	44.0	83.5	44.4
PROFAMILIA	-	16.6	7.5	14.9	-	12.3	1.2	11.5
PRIVATE CLINIC/PHYS.	-	4.4	0.3	3.3	-	6.2	0.0	6.7
OTHER	-	3.5	1.3	1.3	-	4.2	1.2	2.6
NUMBER OF CASES	-	22077	8883	14340	-	15778	8506	15988

* Includes pill, condom, vaginal and injectable.
** Includes IUD, pill, condom, vaginal and injectable.

TABLE V.2-1

CONTRACEPTIVE SALES, REVENUES, EXPENDITURES AND COST-EFFECTIVENESS UNDER THE CM AND CM WAGE-INCENTIVE STRATEGIES (US DOLLARS) APRIL 86/MARCH 88

COST-EFFECTIVENESS INDICATORS	CM WAGE INCENTIVES	CONTRACEPTIVE MARKETING
	CUNDINAMARCA	SANTANDER \2\
SALES		
Pill cycles	173,701	192,145
Condoms	165,514	234,960
Vaginals	103,339	173,782
CYP	16,050	18,868
REVENUES	70,905	91,082
COSTS	95,247	99,153
Merchandise	43,034	60,624
Operating costs \1\	52,214	38,529
NET PROFIT (+) OR COST (-)	-24,342	- 8,071
COST OR PROFIT PER CYP	- 1.52	- 0.43

\1\ Includes: wages, benefits, travel and perdiem, IEC materials and incentives (where applicable).

\2\ Including all project areas (i.e., including Bucaramanga).

TABLE V.2-2

IEC ACTIVITIES IN CUNDINAMARCA AND SANTANDER BY SEMESTER

	CUNDINAMARCA					SANTANDER				
	ABR./86 SEPT/86	OCT./86 MARCH/87	ABR./87 SEPT/87	OCT./87 MARCH/88	TOTAL	ABR./86 SEPT/86	OCT./86 MARCH/87	ABR./87 SEPT/87	OCT./87 MARCH/88	TOTAL
1. DISTRIBUTORS TRAINED	183	305	199	128	815	82	55	90	42	269
2. MEETINGS	174	114	165	64	517	76	143	108	40	367
-ADULTS ATTENDING	4,934	3,188	4,819	2,232	15,173	2,032	3,830	2,709	1,017	9,588
-YOUTHS ATTENDING	1,118	466	0	3	1,587	685	286	28	0	999
3. HOUSEHOLD VISITS	1,564	1,547	106	83	3,300	481	270	106	9	866
-PERSONS VISITED	2,243	1,686	186	152	4,267	1,002	482	114	9	1,607
4. REFERRALS FOR FEMALE STERILIZATION	198	107	19	68	392	81	270	65	6	422

TABLE V.2-3

CONTRACEPTIVE KNOWLEDGE, PREVALENCE, AND UNMET NEED \1\ AMONG EVER-MARRIED WOMEN OF FERTILE AGE IN PROJECT AREAS BY DEPARTMENT: MIDPOINT AND ENDLINE SURVEYS

KNOWLEDGE: % KNOWING	CM WAGE INCENTIVES CUNDINAMARCA		CONTRACEPTIVE MARKETING SANTANDER	
AT LEAST:	CBD Midpoint	CSM-CBD Endline	CSM Midpoint	CSM-CBD Endline
1 modern method \2\	97.1	98.6	97.3	99.3
2 modern methods	95.4	97.3	96.9	97.5
3 modern methods	93.9	95.2	94.8	94.3
4 modern methods	88.4	90.5	90.2	88.9
5 modern methods	78.8	81.7	80.4	79.0
6 modern methods	59.2	63.3	61.2	64.2
7 modern methods	29.2	36.4	35.6	37.8
USE: PERCENT USING:				
Contraceptive methods	63.4	72.2	57.5	66.7
Modern methods \2\	47.3	52.1	46.7	52.1
UNMET NEED FOR:				
Contraceptive methods	7.3	3.8	12.8	7.5
Modern methods \2\	18.8	17.8	19.6	17.3
NUMBER OF CASES				
INTERVIEWS	1094	966	1512	1204
WEIGHTED	43949	38266	55671	42811

\1\ Percent of currently married women who are not pregnant, not sterile, do not want another child and (a) do not use a contraceptive method; or (b) do not use modern contraceptive method.

\2\ Modern methods include pills, condoms, IUD, female sterilization, vasectomy, injectables and vaginal tablets and suppositories.

TABLE V.2-4

SOURCE OF CURRENT TEMPORARY CONTRACEPTIVE METHOD USED (INCLUDING AND EXCLUDING THE IUD) BY SURVEY AND DEPARTMENT

SOURCE OF CURRENT CONTRACEPTIVE USED	CUNDINAMARCA				SANTANDER			
	MID POINT		ENDLINE		MID POINT		ENDLINE	
	1*	2**	1*	2**	1*	2**	1*	2**
HOSPITAL/HEALTH POST	7.0	28.6	15.6	31.6	14.1	34.8	9.2	27.6
DRUGSTORE	83.7	51.9	78.5	47.3	83.5	44.4	84.2	52.6
PROFAMILIA	7.5	14.9	4.8	14.8	1.2	11.5	4.0	7.4
PRIVATE CLINIC/PHYS.	0.3	3.3	0.0	5.1	0.0	6.7	0.6	9.9
OTHER	1.3	1.3	1.1	1.2	1.2	2.6	2.0	2.5
NUMBER OF CASES	8883	14340	7789	12667	8506	15988	8457	13989

* Includes pill, condom, vaginal and injectable.
** Includes IUD, pill, condom, vaginal and injectable.

TABLE V.3-1

CHARACTERISTICS OF THE TRAINING OF CBD DISTRIBUTORS BY DATE OF SURVEY. COLOMBIA, 1984-1987.

CHARACTERISTICS OF TRAINING	DATE OF SURVEY	
	1984	1987
% WHO HAD RECEIVED TRAINING IN USE OF CONTRACEPTIVES:	85.9	82.8
NUMBER OF CASES:	531	571
KIND OF TRAINING RECEIVED: \1\		
- SHORT TERM COURSES WITH OTHER DISTRIBUTORS:	1.3	47.3
- PERSONAL TALKS	45.6	72.7
- GROUP TALKS	36.2	47.3
- OTHER	2.6	1.5
- VARIOUS	14.3	0.0

\1\ For 1984, the distribution of answers to a direct question is presented. For 1987, the percent who had received each kind of training is presented.

TABLE V.3-2

CHARACTERISTICS OF DISTRIBUTOR TRAINING BY REGION. COLOMBIA, 1987.

CHARACTERISTICS OF TRAINING	REGION						
	TOTAL	ATLANTIC	SANTANDER	EASTERN	PACIFIC	CENTRAL	BOGOTA
% WHO HAD RECEIVED TRAINING IN USE OF CONTRACEPTIVES:	82.8	80.6	77.8	85.1	87.3	83.9	77.9
NUMBER OF CASES:	571	124	27	67	102	174	77
KIND OF TRAINING RECEIVED:							
- SHORT-TERM COURSES WITH OTHER DISTRIBUTORS:	47.3	30.0	42.9	56.1	58.4	55.5	33.3
- PERSONAL TALKS:	72.7	65.0	80.9	68.4	88.7	76.7	53.3
- GROUP TALKS:	47.3	61.0	57.1	36.8	47.2	42.5	43.3
- OTHER	1.5	2.0	0.0	0.0	1.1	1.4	3.3
HOW WELL DID THE INSTRUCTOR TEACH ABOUT METHODS:							
- VERY WELL	27.1	15.0	9.5	24.6	27.0	38.4	28.3
- WELL	72.1	84.0	90.5	75.4	71.9	61.0	70.0
- BADLY	0.2	1.0	0.0	0.0	0.0	0.0	0.0
- POORLY	0.6	0.0	0.0	0.0	1.1	0.7	1.7
YEAR OF LAST TRAINING FROM PROFAMILIA:							
- 1986/1987	80.3	80.0	80.9	94.8	88.8	81.5	51.7
- 1984/1985	15.7	18.0	4.8	5.3	10.1	15.7	33.3
- 1983 OR BEFORE	3.8	2.0	14.3	0.0	1.1	2.8	13.4
NUMBER OF CASES:	473	100	21	57	89	146	77

TABLE V.3-3

CBD DISTRIBUTORS' AVERAGE KNOWLEDGE OF CONTRACEPTIVE METHOD USE BY TRAINING AND KIND OF TRAINING. COLOMBIA, 1987.

KNOWLEDGE OF METHODS	HAD RECEIVED TRAINING			KIND OF TRAINING				
	YES	NO	TOTAL	SHORT TERM COURSE	PERSONAL TALKS	GROUP TALKS	OTHER	TOTAL
KNOWLEDGE OF PILLS \1\	6.6	5.0	6.4	6.9	6.6	6.7	7.1	6.6
KNOWLEDGE OF BARRIER METHODS \2\	3.9	3.5	3.8	3.9	3.9	3.9	3.7	3.9
KNOWLEDGE OF STERILIZ.\3\	5.2	4.3	5.1	5.4	5.2	5.4	5.6	5.2
KNOWLEDGE OF VASECTOMY\4\	3.9	2.7	3.7	4.2	4.0	4.0	4.0	3.9
KNOWLEDGE OF IUD'S \5\	0.6	0.5	0.6	0.6	0.6	0.6	0.6	0.6
NUMBER OF CASES:	473	98	571	224	344	224	7	473

\1\ Out of a possible 9 correct answers.
\2\ Out of a possible 4 correct answers.
\3\ Out of a possible 6 correct answers.
\4\ Out of a possible 5 correct answers.
\5\ Out of a possible 1 correct answer.

TABLE V.3-4

CBD DISTRIBUTORS' AVERAGE KNOWLEDGE OF CONTRACEPTIVE METHOD USE BY YEARS OF BEING DISTRIBUTORS. COLOMBIA, 1987.

KNOWLEDGE OF METHODS	YEARS OF BEING A DISTRIBUTOR				
	LESS THAN A YEAR	1 - 2 YEARS	3 - 4 YEARS	5 OR MORE YEARS	T O T A L
KNOWLEDGE OF PILLS \1\	5.8	6.2	6.6	6.6	6.4
KNOWLEDGE OF BARRIER METHODS \2\	3.7	3.8	3.8	3.9	3.8
KNOWLEDGE OF FEMALE STER.\3\	4.9	4.9	4.9	5.3	5.1
KNOWLEDGE OF VASECTOMY \4\	3.2	3.7	3.7	3.9	3.7
KNOWLEDGE OF IUD \5\	0.5	0.6	0.6	0.6	0.6
NUMBER OF CASES:	85	144	109	233	571

\1\ Out of a possible 9 correct answers.
\2\ Out of a possible 4 correct answers.
\3\ Out of a possible 6 correct answers.
\4\ Out of a possible 5 correct answers.
\5\ Out of a possible 1 correct answer.

TABLE V.3-5

CBD DISTRIBUTORS' QUALITY OF KNOWLEDGE OF PILL USE.
PERCENT ANSWERING EACH QUESTION CORRECTLY BY DATE OF SURVEY.
COLOMBIA, 1984-1987 AND SANTANDER, 1987.

QUESTIONS ON QUALITY OF KNOWLEDGE	DATE OF SURVEY		
	1984	1987	
	NATIONAL	NATIONAL	SANTANDER
WHEN SHOULD A WOMAN BEGIN TO TAKE THE PILL?	67.8	80.6	66.7
HOW LONG SHOULD A WOMAN WAIT BEFORE STARTING A NEW CYCLE, WHEN SHE FINISHES A 21-PILL CYCLE?	29.8	84.2	85.2
HOW LONG SHOULD A WOMAN WAIT BEFORE STARTING A NEW CYCLE, WHEN SHE FINISHES A 28-PILL CYCLE?	49.9	48.8	59.3
HOW OFTEN SHOULD PILLS BE TAKEN?	98.3	98.2	100.0
WHAT SHOULD A WOMAN DO IF SHE FORGETS TO TAKE THE PILL ONE DAY?	49.2	72.0	63.0
WHAT WOULD YOU ADVISE TO A WOMAN WITH NAUSEA DURING FIRST TWO WEEKS?	0.0	30.5	25.9
IF A WOMAN IS BREAST FEEDING, IS IT ADVISABLE FOR HER TO TAKE THE PILL?	48.4	59.0	46.0
IF A WOMAN IS NOT HAVING SEXUAL RELATIONS FOR ONE WEEK, CAN SHE STOP TAKING THE PILL?	87.4	88.3	85.5
WOULD YOU RECOMMEND THE PILL TO A WOMAN OVER 35 YEARS OF AGE?	74.0	74.4	81.5
NUMBER OF CASES:	531	571	27

TABLE V.3.6

PERCENT OF CBD DISTRIBUTORS MENTIONING EACH COUNTERINDICATION FOR PILL USE BY DATE OF SURVEY. COLOMBIA, 1984-1987, AND SANTANDER, 1987.

COUNTERINDICATION MENTIONED	DATE OF SURVEY		
	1984	1987	
	NATIONAL	NATIONAL	SANTANDER
HIGH BLOOD PRESSURE:	45.2	49.6	48.1
VARICOSE VEINS:	50.8	53.8	66.7
CARDIOVASCULAR DISEASE:	31.3	26.6	29.6
LIVER DISEASE:	12.4	14.0	22.2
CANCER:	7.3	5.4	7.4
OTHER:	37.5	25.9	18.5
NUMBER OF CASES:	531	571	27

TABLE V.3.7

CBD DISTRIBUTORS' QUALITY OF KNOWLEDGE OF BARRIER METHOD USE. PERCENT ANSWERING EACH QUESTION CORRECTLY BY DATE OF SURVEY. COLOMBIA, 1984-1987, AND SANTANDER, 1987.

QUESTIONS ON QUALITY OF KNOWLEDGE	DATE OF SURVEY		
	1984	1987	
	NATIONAL	NATIONAL	SANTANDER
HOW MANY MINUTES BEFORE SEX SHOULD A VAGINAL TABLET BE PUT IN PLACE?	NA	94.0	100.0
FOR HOW MANY SEXUAL RELATIONS CAN A VAGINAL TABLET BE USED?	92.3	95.6	100.0
NUMBER OF CASES:	531	567	27
WHEN SHOULD A MAN PUT A CONDOM IN PLACE?	87.6	95.4	96.3
FOR HOW MANY SEXUAL RELATIONS CAN A CONDOM BE USED?	95.5	98.4	100.0
NUMBER OF CASES:	531	569	27

NA: Not available.

TABLE V.3-8

CBD DISTRIBUTORS' QUALITY OF KNOWLEDGE OF FEMALE STERILIZATION. PERCENT ANSWERING EACH QUESTION CORRECTLY BY DATE OF SURVEY. COLOMBIA, 1984-1987, AND SANTANDER, 1987.

QUESTIONS ON FEMALE STERILIZATION	DATE OF SURVEY		
	1984	1987	
	NATIONAL	NATIONAL	SANTANDER
HOW IS A FEMALE STERILIZATION DONE?	86.3	94.2	100.0
CAN A WOMAN HAVE CHILDREN AFTER A STERILIZATION?	89.1	84.9	92.3
CAN A STERILIZATION FAIL?	67.7	71.9	65.4
DOES THE STERILIZATION CAUSE SEXUAL CHANGES IN A WOMAN?	76.8	86.3	88.5
DO WOMEN KEEP HAVING MENSTRUATIONS AFTER A STERILIZATION?	90.2	95.5	96.2
DOES THE STERILIZATION CAUSE CHANGES IN THE WOMAN'S CHARTACTER?	79.3	89.7	88.5
NUMBER OF CASES:	531	556	26

TABLE V.3-9

CBD DISTRIBUTORS' QUALITY OF KNOWLEDGE ON VASECTOMY.
PERCENT ANSWERING EACH QUESTION CORRECTLY BY DATE OF SURVEY.
COLOMBIA, 1984-1987, AND SANTANDER, 1987.

QUESTIONS ON VASECTOMY	DATE OF SURVEY		
	1984	1987	
	NATIONAL	NATIONAL	SANTANDER
HOW IS A VASECTOMY DONE?	45.4	76.3	76.0
IS VASECTOMY THE SAME AS CASTRATION?	66.4	75.4	68.0
DOES A VASECTOMIZED MAN EJACULATE?	74.2	80.7	84.0
DOES VASECTOMY CHANGE A MAN'S SEXUALITY?	72.4	85.4	88.0
DOES VASECTOMY CHANGE A MAN'S CHARACTER OR BEHAVIOR?	72.3	85.2	88.0
NUMBER OF CASES:	530	528	25

TABLE V.3-10

CBD DISTRIBUTORS' QUALITY OF KNOWLEDGE OF IUD USE.
PERCENT ANSWERING EACH QUESTION CORRECTLY BY DATE OF SURVEY.
COLOMBIA, 1984-1987, AND SANTANDER, 1987.

QUESTIONS ON QUALITY OF KNOWLEDGE	DATE OF SURVEY		
	1984	1987	
	NATIONAL	NATIONAL	SANTANDER
WHERE IN A WOMAN'S BODY IS AN IUD PLACED?	60.1	60.4	55.6
FOR HOW LONG CAN A WOMAN USE AN IUD?			
-TCu (3 - 5 YEARS)	NA	31.5	55.0
-LIPPES (UNTIL MENOPAUSE)	NA	22.1	16.1
NUMBER OF CASES:	531	561	27

NA: Not available.

TABLE V.3-11

CBD DISTRIBUTORS' GENERAL KNOWLEDGE ABOUT FAMILY PLANNING AND PROFAMILIA BY DATE OF SURVEY. COLOMBIA, 1984-1987, AND SANTANDER, 1987.

GENERAL KNOWLEDGE ABOUT FAMILY PLANNING AND PROFAMILIA	DATE OF SURVEY		
	1984	1987	
	NATIONAL	NATIONAL	SANTANDER
% KNOWING THAT IT IS EASIER TO GET PREGNANT IN THE MIDDLE OF THE MENSTRUAL CYCLE.	49.5	42.7	40.7
% WHO UNDERSTOOD THAT FAMILY PLANNING MEANS "HAVING THE DESIRED NUMBER OF CHILDREN WHEN THEY ARE WANTED":	62.1	66.4	59.3
% WHO KNEW THAT PROFAMILIA IS A PRIVATE INSTITUTION:	42.8	45.0	40.7
NUMBER OF CASES:	530	571	27

TABLE V.4-1

EXPOSURE TO CONDOM ADVERTISING BY DATE OF SURVEY
CALI, 1984-1987.

EXPOSURE TO CONDOM ADVERTISING	DATE OF SURVEY		
	AUGUST 1984	MAY 1985	MAY 1987
OF THOSE WHO KNEW CONDOMS:			
% WHO HAD HEARD RADIO ADVERTISEMENTS	*16.9	79.4	52.8
% WHO REMEMBERED THE CONTENT OF THE SPOTS	58.7	60.6	49.9
% WHO HAD SEEN POSTERS, STICKERS AND MOBILES	7.6	21.2	31.5

* Had heard or seen some information.

TABLE V.4-2

RADIO CONDOM ADVERTISING AND MESSAGE RECALL BY AGE, EDUCATION AND WORKING SECTOR. CALI, 1987.

AGE, EDUCATION AND WORKING SECTOR	% WHO HAD HEARD CONDOM RADIO ADVERTISEMENTS		% WHO RECALLED MESSAGE CONTENT		% WHO REMEMBERED MESSAGE OF PROFAMILIA CAMPAIGN		% WHO REMEMBERED BRAND BEING MENTIONED		BRAND MENTIONED			
	No.	%	No.	%	No.	%	No.	%	TAHITI	LOVE	ELEPHANT	DID NOT KNOW/ DID NOT REMEMBER
AGE:												
15 - 19	20	62.5	13	65.0	12	92.3	1	5.0	0.0	0.0	100.0	0.0
20 - 24	107	48.2	63	58.9	51	81.0	5	4.7	40.0	20.0	0.0	40.0
25 - 29	90	53.2	100	52.6	91	91.0	9	4.7	33.3	0.0	0.0	66.7
30 - 39	241	55.7	115	47.7	98	85.2	14	5.8	14.3	0.0	0.0	85.7
40 - 49	101	52.9	45	44.6	36	80.0	7	6.9	28.6	0.0	0.0	71.4
50 or +	38	44.7	12	31.6	8	66.7	1	2.6	0.0	0.0	0.0	100.0
YEARS OF SCHOOLING:												
0 - 3	14	35.9	3	21.4	3	100.0	0	0.0	0.0	0.0	0.0	0.0
4 - 5	63	45.7	21	33.3	18	85.7	3	4.8	33.3	0.0	0.0	66.7
6 - 8	140	53.6	55	39.3	48	87.3	7	5.0	14.3	0.0	0.0	85.7
9 or +	478	54.3	269	56.3	227	84.4	27	5.6	25.9	3.7	3.7	66.7
WORKING SECTOR:												
PRIVATE	370	50.2	191	51.6	166	86.9	20	5.4	25.0	0.0	5.0	70.0
OFFICIAL	244	57.5	118	48.4	92	78.0	10	4.1	10.0	0.0	0.0	90.0
UNEMPLOYED	83	52.2	39	47.0	38	97.4	7	8.4	42.9	14.3	0.0	42.9
ENTIRE SAMPLE	697	52.8	348	49.9	296	85.0	37	5.6	9	1	1	26

TABLE V.4-3

LEARNING AND MOTIVATION TO USE CONDOMS DUE TO RADIO ADVERTISING, BY AGE, EDUCATION AND WORKING SECTOR. CALI 1987.

AGE, EDUCATION AND WORKING SECTOR	LEARNING AND MOTIVATION FROM RADIO MESSAGE									
	% WHO LEARNED SOMETHING FROM MESSAGE		CONTENT LEARNED:						% MOTIVATED TO USE BY MESSAGE	
	No.	%	ITS CALLED A CONDOM	RESPON-SIBILITY	PROFILAXIS STD/AIDS	HOW TO USE IT	SAFE/ PRACTICAL	OTHER	No.	%
AGE:										
15 - 19	9	45.0	11.1	0.0	11.1	22.2	22.2	33.3	2	10.0
20 - 24	55	51.4	3.6	32.7	16.4	10.9	12.7	23.6	27	25.2
25 - 29	78	41.0	0.0	44.9	5.1	9.0	20.5	19.2	36	18.9
30 - 39	82	34.0	6.1	32.9	7.3	17.1	7.3	28.0	36	14.9
40 - 49	31	30.7	3.2	19.4	19.4	22.6	9.7	22.6	21	20.8
50 or +	8	21.1	0.0	12.5	37.5	0.0	12.5	37.5	3	7.9
TOTAL	263	37.7	3.4	33.1	11.0	13.7	13.3	24.3	125	17.9
YEARS OF SCHOOLING:										
0 - 3	3	21.4	0.0	33.3	0.0	33.3	0.0	0.0	2	14.3
4 - 5	19	30.2	0.0	26.3	15.8	21.1	15.8	21.1	17	27.0
6 - 8	59	42.1	0.0	39.0	8.5	10.2	18.6	22.0	23	16.4
9 or +	182	38.1	4.9	31.9	11.5	13.7	11.5	25.8	83	17.4
TOTAL	263	37.7	3.4	33.1	11.0	13.7	13.3	24.3	125	17.9
WORKING SECTOR:										
PRIVATE	154	41.6	3.2	35.7	9.1	13.0	15.6	22.7	60	16.2
OFFICIAL	79	32.4	3.8	32.9	17.7	12.7	10.1	20.3	40	16.4
UNEMPLOYED	30	36.1	3.3	20.0	3.3	20.0	10.0	43.3	25	30.1
T O T A L	263	37.7	3.4	33.1	11.0	13.7	13.3	24.3	125	17.9
NUMBER OF CASES:	697	100.0	9	87	29	36	35	64	697	100.0

TABLE V.4-4

EXPOSURE TO CONDOM MESSAGES IN PRINTED MEDIA AND MESSAGE RECALL BY AGE, EDUCATION AND WORKING SECTOR. CALI, 1987.

AGE, EDUCATION AND WORKING SECTOR	% WHO HAD SEEN POSTERS, STICKERS OR MOBILES	PLACE WHERE SEEN:					BRAND OR INSTITUTION MENTIONED			
		BROCHURE/ MAGAZINE	DRUG-STORE	PROFA-MILIA	CLINC,HOSP. H.POST	OTHER	PROFA-MILIA	TAHITI	STIMULA	OTHER
AGE:										
15 - 19	40.6	59.2	7.7	15.4	0.0	7.7	23.1	0.0	0.0	0.0
20 - 24	39.6	37.5	23.9	15.9	4.5	18.2	10.2	6.8	1.1	2.3
25 - 29	29.1	24.0	22.1	19.2	15.4	13.5	20.2	8.7	0.0	2.9
30 - 39	33.5	35.9	26.2	18.6	9.7	7.6	13.1	11.0	1.4	4.1
40 - 49	24.1	39.1	10.9	15.2	15.2	17.4	13.0	2.2	2.2	2.2
50 or +	22.4	42.1	26.3	10.5	10.5	5.3	0.0	0.0	0.0	5.3
YEARS OF SCHOOLING:										
0 - 3	17.9	28.6	42.9	0.0	0.0	14.3	0.0	28.6	0.0	0.0
4 - 5	17.4	33.3	29.2	4.2	12.5	16.7	4.2	4.2	0.0	0.0
6 - 8	29.5	32.5	23.4	16.9	9.1	18.2	15.6	5.2	0.0	2.6
9 or +	34.8	35.9	21.2	19.0	10.5	10.5	14.7	8.2	1.3	3.6
WORKING SECTOR:										
PRIVATE	31.5	37.9	24.1	15.1	6.5	14.2	12.9	8.6	0.4	2.6
OFFICIAL	30.9	29.8	18.3	20.6	17.6	9.9	13.7	8.4	2.3	3.8
UNEMPLOYED	32.7	34.6	25.0	19.2	9.6	9.6	19.2	1.9	0.0	3.8
T O T A L	31.4	34.9	22.4	17.3	10.4	12.3	14.0	7.7	1.0	3.1
NUMBER OF CASES:	415	145	93	72	43	51	58	32	4	13

TABLE V.4-5

KNOWLEDGE, USE AND PURCHASES OF CONDOMS
BY DATE OF SURVEY. CALI, 1984-1987.

	DATE OF SURVEY		
	AUGUST 1984	MAY 1985	MAY 1987
KNOWLEDGE AND USE:			
OF THOSE WITH KNOWLEDGE:			
% WHO KNOW THE CONDOM.	99.4	99.6	86.9
% WHO HAD EVER USED	41.8	50.6	43.1
% USING CONDOM AS LAST METHOD.	7.7	8.6	11.3
OF EVER USERS, % WHO USED THE CONDOM IN THE LAST 6 MONTHS.	27.9	42.4	40.1
PURCHASES OF CONDOMS:			
OF THOSE WITH KNOWLEDGE:			
% WHO HAD EVER PURCHASED.	44.3	47.3	46.1
OF THOSE WHO HAD EVER PURCHASED:			
% WHO PURCHASED IN THE LAST SIX MONTHS.	24.9	38.8	32.2
% WHO PURCHASED IN THE LAST MONTH.	*	*	18.4

* Not available.

TABLE V.4-6

USE OF CONDOMS AMONG THOSE KNOWMING THE METHOD BY EXPOSURE TO CONDOM ADVERTISING AND MESSAGE REC
CALI, 1987.

EXPOSURE TO CONDOM ADVERTISING AND MESSAGE RECALL	USE OF CONDOM					
	% WHO HAD EVER-USED	% USING AS LAST METHOD	% USING IN LAST SIX MONTHS	% WHO HAD SEEN A CONDOM	% WHO REPORTED KNOWING HOW TO USE	% DESCRIBI CORRECT U
REMEMBERED CONDOM ADVERTISING BY RADIO:						
YES	53.8	13.4	42.1	96.7	81.3	86.2
NO	44.8	10.9	37.3	93.6	74.0	86.8
NUMBER OF CASES:	654	157	262	1,257	1,028	889
RECALLED MESSAGE OR CONTENT OR ADVERTISEMENT:						
YES	58.6	15.1	45.1	97.7	85.9	87.3
NO	49.0	11.7	38.6	95.7	76.8	85.1
NUMBER OF CASES:	375	91	158	674	567	489
LEARNED SOMETHING FROM ADVERTISEMENT:						
YES	58.9	12.1	38.1	96.6	84.0	84.2
NO	50.6	14.0	45.2	96.8	79.7	87.5
NUMBER OF CASES:	375	91	158	674	567	489
ADVERTISEMENT MOTIVATED CONDOM USE:						
YES	76.8	23.2	64.6	96.8	86.4	88.0
NO	48.7	11.2	34.5	96.8	80.4	85.9
NUMBER OF CASES:	375	91	158	674	567	489
HAD SEEN POSTERS OR OTHER PRINTED MATERIALS ON CONDOMS:						
YES	51.1	12.0	40.6	97.3	81.9	85.9
NO	48.8	12.2	39.7	94.2	76.0	86.8
NUMBER OF CASES:	654	157	262	1,257	1,028	889

TABLE V.4-7

KNOWLEDGE OF SOURCES AND PURCHASES OF CONDOMS AMONG THOSE KNOWING THE METHOD BY EXPOSURE TO CONDOM ADVERTISING AND MESSAGE RECALL CALI, 1987.

EXPOSURE TO CONDOM ADVERTISING AND MESSAGE RECALL	KOWNLEDGE AND USE BY SOURCES AND PURCHASE OF CONDOMS											
	% KNOWIG WHERE TO GET CONDOMS (SOURCE)	% MENTIONING AS SOURCE					% WHO HAD PURCHASED			MOST FREQUENT SOURCE		
		DRUG-STORE	PROFA-MILIA	TRAVELLING SALESMEN	SUPER-MARKETS	OTHER	EVER	LAST 6 MONTHS	LAST MONTH	DRUG-STORE	PROFA-MILIA	OTHER
REMEMBERED CONDOM ADVERTISING BY RADIO:												
YES	98.3	96.6	18.4	3.2	4.4	1.0	50.9	34.9	60.5	91.0	2.8	5.6
NO	94.9	97.1	15.1	1.5	4.6	1.2	40.6	28.5	51.4	90.1	3.6	5.5
NUMBER OF CASES:	1,276	1,235	215	31	57	14	608	196	112	551	19	34
RECALLED MESSAGE OR CONTENT OF ADVERTISEMENT:												
YES	98.6	97.1	20.7	2.6	4.1	1.2	56.3	36.2	64.8	93.4	2.0	4.1
NO	98.0	96.2	16.1	3.8	4.7	0.9	45.6	33.3	54.7	88.1	3.8	7.5
NUMBER OF CASES:	685	662	126	22	30	7	355	124	75	323	10	20
LEARNED SOMETHING FROM ADVERTISEMENT:												
YES	99.2	97.3	20.7	2.3	2.7	1.1	54.8	36.1	53.8	93.1	2.8	3.5
NO	97.7	96.2	17.0	3.8	5.4	0.9	48.5	34.3	65.3	89.5	2.9	7.1
NUMBER OF CASES:	685	662	126	22	30	7	355	124	75	323	10	20
ADVERTISEMENT MOTIVATED CONDOM USE:												
YES	98.4	95.9	21.1	2.4	4.9	0.8	72.0	55.6	64.0	88.9	1.1	8.9
NO	98.2	96.9	17.5	3.4	4.3	1.1	46.2	28.4	58.1	92.0	3.1	4.6
NUMBER OF CASES:	685	662	126	22	30	7	355	124	75	323	10	20
HAD SEEN CONDOM POSTERS:												
YES	98.1	96.3	18.0	1.5	5.7	0.7	47.7	35.4	61.4	85.9	4.5	9.1
NO	96.0	97.1	16.4	2.9	3.9	1.3	45.2	30.6	55.2	93.2	2.4	3.7
NUMBER OF CASES:	1,276	1,235	215	31	57	14	608	196	112	551	19	34

TABLE V.5-1

SALES, PURCHASES, STOCKS AND MERCHANDIZING VARIABLES OF CONTRACEPTIVES BY CONTRACEPTIVE METHOD. EXAMPLE OF TABLES PREPARED BY NIELSEN'S RETAIL INDEX

JANUARY/FEBRUARY 1988 - COLOMBIA

Nielsen Marketing Research

UNIDADES -000.0- ENE/FEB 1988 TOTAL
PESOS -000- COLOMBIA

1	2	3	4	5	6	7	8	9	10	11	12	13
METHOD	SALES		PURCHASES	INVENTORY	ROT.INVENT.	Ø INVENTAR.	Ø SALES	MANA-	OUT-	BUY-	SELL-	
	PESOS	UNITS	UNITS	UNITS	PART.INV.ACT.	ØPURCHAS.	Ø PRICE	GING	STOCK	ING	ING	
TOTAL CONTRACEPTIVES	387391	5469.7	5204.4	4117.1	1.5	705.9	468.9	94		94	94	
	100.0%	100.0%	100.0%	100.0%	100.0%	446.7	70.83	100		100	100	
TOTAL PILLS	182910	1414.4	1505.5	1197.1	1.7	214.1	121.8	94	3	92	94	
	47.2%	25.9%	28.9%	29.1%	30.9%	132.6	129.32	100	1	100	100	
TOTAL SPERMICIDES	45937	1951.6	1764.1	1390.9	1.4	265.4	180.5	87	3	74	85	
	11.9%	35.7%	33.9%	33.8%	38.7%	193.4	23.54	99	3	90	98	
TOTAL OTHERS	75999	261.5	274.0	189.6	1.5	39.6	24.9	85	8	71	83	
	19.6%	4.8%	5.3%	4.6%	3.5%	31.1	290.62	96	4	88	95	
TOTAL CONDOMS	82546	1842.1	1660.7	1339.5	1.5	321.7	207.7	72	4	56	70	
	21.3%	33.7%	31.9%	32.5%	26.9%	238.2	44.81	89	2	73	89	

TABLE V.5-2

ESTIMATED ANNUAL \1\ SALES PER REGION IN COLOMBIA \2\ BY CONTRACEPTIVE METHOD

METHOD	TOTAL UNITS SOLD (000)	TOTAL SALES IN DOLLARS (000)	DISTRIBUTION OF SALES IN UNITS BY REGION						
			COLOMBIA	ATLANTIC	ANTIOQUIA	EASTERN	BOGOTA	CENTRAL	PACIFIC
PILLS	8,566.6	4,093.1	100	13.3	19.4	11.4	15.8	13.4	26.7
VAGINALS	12,303.6	1,089.4	100	10.0	9.0	11.1	41.4	11.7	16.9
CONDOMS	11,159.2	1,886.6	100	7.8	13.9	14.1	39.5	7.4	17.3

\1\ Extrapolated from data for the November 87/ April 88 period.
\2\ Including only sales in drugstores and supermarkets located in cities over 20.000 inhabitants.

SOURCE: A.C. Nielsen de Colombia Retail Index.

TABLE V.5-3

ESTIMATED ANNUAL \1\ SALES IN THOUSANDS OF UNITS BY CONTRACEPTIVE METHOD AND KIND OF OUTLET

METHOD	TOTAL UNITS SOLD (000)	DISTRIBUTION OF SALES BY KIND OF OUTLET		
		COLOMBIA	DRUGSTORES	SUPERMARKETS
PILLS	8,566.6	100	87.9	12.1
VAGINALS	12,303.6	100	85.0	15.0
CONDOMS	11,159.2	100	87.3	12.7

\1\ Extrapolated from data for the November 87/ April 88 period.

SOURCE: A.C. Nielsen de Colombia Retail Index.

TABLE V.5-4

TRENDS IN SALES OF CONTRACEPTIVE UNITS BY REGION, OUTLET AND CONTRACEPTIVE METHOD
NOV/DEC 1987 - JAN/FEB 1988 AND JAN/FEB 1988 - MAR/APR 1988

REGION AND OUTLETS	METHOD							
	ALL		PILLS		VAGINALS		CONDOMS	
	N/D-J/F	J/F-M/A	N/D-J/F	J/F-M/A	N/D-J/F	J/F-M/A	N/D-J/F	J/F-M/A
COLOMBIA	1.4	9.0	0.4	3.3	-10.1	4.0	19.4	19.2
ATLANTIC	13.1	75.8	0.7	47.2	-20.2	88.7	215.5	115.1
ANTIOQUIA	10.1	1.1	-6.3	12.9	12.3	4.9	28.5	-11.7
EASTERN	32.8	-5.1	31.8	-15.1	13.6	21.3	52.8	-18.7
BOGOTA	-12.3	2.7	-9.8	-0.2	-26.9	-6.4	10.6	14.0
CENTRAL	-0.9	-1.1	2.1	-5.6	-3.5	-8.7	-9.0	33.2
PACIFIC	2.3	10.2	-0.9	-6.5	20.7	-10.2	-7.8	56.0
SUPERMARKETS	-2.0	-11.5	1.3	6.1	-6.3	-19.7	-0.4	-11.5
DRUGSTORES	1.9	12.3	0.3	2.9	-10.8	8.7	23.1	23.7

SOURCE: A.C. Nielsen de Colombia Retail Index.

TABLE V.5-5

CONDOM SALES, PURCHASES, STOCKS AND MERCHANDIZING VARIABLES
BY BRAND. TABLE PREPARED FOR THE MARCH/APRIL 1988 RETAIL INDEX REPORT

Nielsen Marketing Research

CONDONES PROFAMILIA , INDICE - ASEO PERSONAL 001

UNIDADES -000.0- MAR/ABR 1988 TOTAL
PESOS -000- COLOMBIA

1	2	3	4	5	6	7	8	9	10	11	12	13
BRAND	SALES PESOS	SALES UNITS	PURCHASES UNITS	INVENTORY UNITS	ROT. INVENT. PART. INV. ACT.	Ø INVENTAR. Ø PURCHAS	Ø SALES PRICE	MANAGING	OUT-STOCK	BUY-ING	SELL-ING	ACT. PRO. NUM. POND.
TOTAL CONDOMS	103400	2195.3	2390.2	1477.0	1.3	314.8	218.3	81	5	68	81	4
	100.0%	100.0%	100.0%	100.0%	100.0%	284.5	47.10	92	2	82	92	4
TAHITI	35427	882.0	787.8	428.6	1.0	136.8	125.7	57	6	38	55	3
	34.3%	40.2%	33.0%	29.0%	34.9%	168.8	40.17	60	5	44	59	2
MAJESTIC	3200	85.8	140.2	82.3	1.9	124.0	58.0	12	1	8	11	2
	3.1%	3.9%	5.9%	5.6%	7.1%	133.5	37.28	12	1	10	11	1
ROSETEX	17328	354.0	358.1	183.5	1.0	217.4	133.0	21	8	14	21	*
	16.8%	16.1%	15.0%	12.4%	12.6*	200.7	48.95	34	11	22	34	*
ORQUIDEA	17589	327.1	376.3	155.7	1.0	138.9	138.5	19	1	14	18	*
	17.0%	14.9%	15.7%	10.5%	10.3*	213.5	53.77	24	1	20	24	*
OTHER	29857	546.3	727.8	627.0	2.3	352.1	121.0	36	8	26	36	1
	28.9%	24.9%	30.5%	42.5%	35.0%	223.3	54.65	56	16	38	55	2

TABLE V.5-6

CONDOM MERCHANDIZING VARIABLES BY BRAND: SIZE OF STOCK, BRAND STOCK SHARE, AVERAGE PRICE TO PUBLIC, PROPORTION OF OUTLETS WHERE BRAND IS AVAILABLE, PROPORTION OF OUTLETS THAT HAD A STOCKOUT. MARCH\APRIL 1988.

MERCHANDIZING VARIABLE	BRAND					
	ALL	TAHITI	MAJESTIC	ROSETEX	ORQUIDEA	OTHER
SIZE OF STOCK (In months at current sales levels)	1.3	1.0	1.9	1.0	1.0	2.3
BRAND STOCK SHARE	100.0	34.9	7.1	12.6	10.3	35.0
AVERAGE PRICE TO PUBLIC (US$)	0.17	0.15	0.14	0.18	0.20	0.20
PROPORTION OF OUTLETS WHERE BRAND IS AVAILABLE	81	57	12	21	19	36
PROPORTION OF OUTLETS THAT HAD A STOCKOUT	5	6	1	8	1	8

SOURCE: A.C. Nielsen de Colombia Retail Index.

TABLE V.5-7

ESTIMATED ANNUAL \1\ CONDOM SALES IN THOUSANDS OF UNITS
BY BRAND, REGION AND OUTLET

REGION	ANNUAL SALES	BRAND MARKET SHARE (%)				
		TAHITI	MAJESTIC	ROSETEX	ORQUIDEA	OTHER
COLOMBIA	11,159	42.1	1.4	19.3	12.3	24.8
ATLANTIC	943	55.4	3.1	0.0	6.1	35.4
ANTIOQUIA	1,526	53.8	1.2	22.8	8.5	13.7
EASTERN	1,556	23.7	0.4	33.7	22.7	19.4
BOGOTA	4,375	42.5	0.6	23.6	18.1	15.2
CENTRAL	821	36.8	3.2	12.8	0.7	46.4
PACIFIC	1,938	46.6	2.1	5.7	0.1	45.6
UNIT SALES BY OUTLET						
SUPERMARKETS	1,375	22.5	0.4	37.9	23.3	15.8
DRUGSTORES	9,784	45.1	1.5	16.6	10.8	26.0

\1\ Extrapolated from November/April sales.

SOURCE: A.C. Nielsen de Colombia Retail Index.

TABLE V.5-8

ESTIMATED ANNUAL SALES \1\, SIZE OF STOCK, AVERAGE PRICE AND AVAILABILITY OF PILLS AND VAGINALS BY BRAND. MARCH/APRIL 1988

CONTRACEPTIVE/ BRAND	ANNUAL SALES (000) AND BRAND MARKET SHARE \1\		STOCK IN MONTHS	AVERAGE PRICE TO PUBLIC	% OF OUTLETS W/BRAND	% OF OUTLETS W/ STOCKOUTS
	DOLLARS	UNITS				
PILLS	4,093.1	8,566.6	1.6	135.0	92	0
MICROGYNON 21	13.0	17.4	1.0	105.0	89	20
NEOGYNON 21	14.2	15.5	1.5	127.5	89	12
MICROGYNON CD	8.4	10.3	2.4	115.8	83	8
NEOGYNON CD	12.5	10.6	2.2	167.4	85	9
NORAL 21	8.6	9.0	1.4	130.7	79	16
NORDETTE 21	6.9	8.6	0.8	109.2	75	21
NORIDAY	4.7	6.5	2.2	94.0	64	15
OTHER	31.6	22.2	-	-	-	-
VAGINALS	1,089.4	12,303.6	1.5	25.5	86	3
NORFORMS	50.6	76.0	1.3	15.8	82	6
NEOSAMPOON	36.3	14.7	2.2	64.6	47	8
FARMA 12	12.1	8.7	1.4	33.2	45	7
OTHER	1.1	0.6	10.6	26.1	5	-

\1\ Considering November 1987/April 1988 sales.

SOURCE: A.C. Nielsen de Colombia Retail Index.

TABLE V.6-1

DISTRIBUTION OF WORK EFFORT OF SUPPORT GROUPS AMONG SERVICE PROGRAMS

SUPPORT GROUPS	SERVICE PROGRAMS			
	CLINIC & LABORATORY	SURGICAL	COMMUNITY MARKETING	CCAPP
ACCOUNTING	61.20%	21.07%	17.41%	0.32%
EVALUATION	12.63%	6.47%	80.90%	0.00%
INDUSTRIAL RELATIONS	54.17%	21.97%	23.08%	0.78%
GENERAL SERVICES	20.59%	26.99%	51.50%	0.92%
SYSTEMS	44.87%	11.32%	43.62%	0.19%
RESOURCE DEVELOPMENT	58.59%	11.47%	29.55%	0.39%
GRANTS	36.86%	22.83%	26.52%	13.79%
EXECUTIVE ASSISTANCE	43.67%	40.49%	14.25%	1.59%
FINANCIAL ASSISTANCE	29.86%	29.11%	40.91%	0.12%
TREASURY	66.16%	18.42%	14.26%	1.16%
AUDITING	45.83%	19.89%	33.96%	0.32%
PRESIDENCY	33.33%	33.33%	33.33%	0.00%
WEIGHTED AVERAGE	36.10%	21.56%	41.37%	0.97%

TABLE V.6-2

MEAN PROPORTION OF THE CLINICS' AREA OCCUPIED BY SERVICE PROGRAMS BY CLINICS' SAMPLING STRATA

CLINICS STRATA	NUMBER OF CLINICS	SERVICE PROGRAM: C B D MEAN	C B D STD.DEV.	CLINICAL MEAN	CLINICAL STD.DEV.	SURGICAL MEAN	SURGICAL STD.DEV.
NEW	2	27.00%	0.005	25.00%	0.040	48.00%	0.040
SMALL	4	18.70%	0.029	26.00%	0.011	55.30%	0.027
MEDIUM	5	24.80%	0.043	24.20%	0.014	51.00%	0.047
LARGE	4	15.25%		45.25%		39.5%	
BOGOTA		18.00%		38.00%		44.00%	
CALI		23.00%		31.00%		46.00%	
MEDELLIN		7.00%		60.00%		33.00%	
PEREIRA		13.00%		52.00%		35.00%	

TABLE V.6-3

90% CONFIDENCE INTERVALS OF THE MEAN PROPORTION OF AREA OCCUPIED BY SERVICE PROGRAMS IN CLINICS ACCORDING TO CLINICS' SAMPLING STRATA

CLINICS SAMPLING STRATA	SERVICE PROGRAM		
	CBD	CLINICAL	SURGICAL
NEW	(25.91% , 28.08%)	(16.29% , 33.70%)	(39.29% , 56.70%)
SMALL	(11.57% , 25.80%)	(23.29% , 28.70%)	(48.66% , 59.94%)
MEDIUM	(13.00% , 36.50%)	(20.36% , 28.04%)	(38.11% , 63.80%)
ALL	(16.23% , 29.72%)	(20.82% , 25.04%)	(41.47% , 62.56%)

TABLE V.6-4

MEAN PROPORTION OF FAUCETS, ELECTRICITY USE AND EMPLOYEES IN THE CLINICS BY SERVICE PROGRAMS AND CLINICS' SAMPLE STRATA

SERVICE PROGRAM/ INDICATOR OF USE OF COMMON SERVICES	CLINICS' SAMPLING STRATA				
	ALL	NEW	SMALL	MEDIUM	LARGE
COMMUNITY MARKETING					
• MEAN PROPORTION IN CLINICS OF:					
Faucets	14.18	18.48	9.38	18.33	10.53
Electricity use	2.85	1.22	2.17	3.97	3.57
Employees	18.13	16.83	18.53	20.51	13.54
CLINICAL					
• MEAN PROPORTION IN CLINICS OF:					
Faucets	38.22	27.58	40.51	38.28	46.50
Electricity use	79.73	95.06	90.64	74.92	62.28
Employees	58.91	69.68	62.84	58.75	37.50
SURGICAL					
• MEAN PROPORTION IN CLINICS OF:					
Faucets	47.60	53.94	50.11	43.39	42.97
Electricity use	17.42	3.72	7.19	21.12	34.15
Employees	22.96	13.49	18.62	20.74	48.96

TABLE V.6-5

OUTPUT UNITS (SALES), REVENUES, EXPENDITURES, NET DIRECT, INDIRECT AND TOTAL OPERATING COSTS AND DEGREE OF FINANCIAL SELF-SUFFICIENCY OF SERVICE PROGRAMS. PROFAMILIA, 1986. IN US DOLLARS \1\

ITEM	SERVICE PROGRAM		
	CLINICAL & LABORATORY	SURGICAL	COMMUNITY MARKETING
OUTPUT UNITS: PRODUCTS AND SERVICES SOLD			
Couple-years-protection (CYP)	155,214	773,537	309,643
Medical visits	380,533	-	-
Sterilizations	-	61,882	-
TOTAL REVENUES FROM SALES OF PRODUCT AND SERVICES	1,238,317	496,813	635,084
TOTAL DIRECT EXPENDITURES BY SERVICE PROGRAMS	2,312,922	2,174,559	1,172,489
NET DIRECT OPERATING COST	1,074,605	1,677,746	537,404
NET OPERATING COST DUE TO SUPPORT GROUPS (NET INDIRECT COSTS)	181,506	127,623	324,283
NET TOTAL COSTS	1,256,111	1,805,369	861,687
FINANCIAL SELF-SUFFICIENCY CONSIDERING DIRECT COSTS ONLY	53.5%	29.6%	54.2%
FINANCIAL SELF-SUFFICIENCY CONSIDERING ALL COSTS	49.6%	27.5%	42.4%

\1\ Considering an exchange rate of $196.1 Col. cy. per US Dollar.

TABLE V.6-6

NET AND GROSS COST PER OUTPUT UNIT (COST-EFFECTIVENESS) OF SERVICE PROGRAMS CONSIDERING ONLY DIRECT COST AND ALL COSTS, BY SERVICE PROGRAM AND KIND OF OUTPUT UNIT. PROFAMILIA, 1986. IN US DOLLARS \1\

OUTPUT UNIT/ KIND OF COST	SERVICE PROGRAM					
	CLINICAL & LAB.		SURGICAL		COMMUNITY MARKETING	
	DIRECT	ALL COSTS	DIRECT	ALL COSTS	DIRECT	ALL COSTS
COUPLE-YEARS-PROTECTION						
Net	6.92	8.09	2.17	2.33	1.74	2.78
Gross	14.90	16.07	2.81	2.98	3.79	4.83
MEDICAL VISIT						
Net	2.82	3.30	-	-	-	-
Gross	6.08	6.56	-	-	-	-
STERILIZATION						
Net	-	-	27.11	29.17	-	-
Gross	-	-	35.14	37.20	-	-

\1\ Based on an exchange rate of 196.1 pesos per US dollar.

TABLE V.6-7

REVENUES AND DIRECT EXPENDITURES OF SERVICE PROGRAMS BY DISTRIBUTING SERVICE EXPENDITURES

I T E M	CLINICAL & LABORATORY	SURGICAL	COMMUNITY MARKETING
TOTAL REVENUES	1,238,317	496,813	635,084
EXPENDITURES:			
AD HOC (CURRENT) DISTRIBUTION:			
- Water & sewage	7,246	1,459	3,035
- Electricity	16,329	3,076	6,599
- Telephone & telex	14,582	3,888	7,094
- Security	24,525	4,244	10,749
- Cleaning	11,965	3,054	5,745
OTHER EXPENDITURES	2,238,274	2,158,837	1,139,266
DIRECT EXPENDITURES	2,312,922	2,174,559	1,172,489
NEW DISTRIBUTION:			
- Water & sewage	4,487	5,589	1,665
- Electricity	20,731	4,529	741
- Telephone & telex	15,060	5,870	4,635
- Security	9,880	20,558	9,081
- Cleaning	5,191	10,801	4,771
OTHER EXPENDITURES	2,238,274	2,158,837	1,139,266
TOTAL DIRECT EXPENDITURES	2,293,623	2,206,183	1,160,160
DIRECT NET OPERATING COST:			
AD HOC DISTRIBUTION	1,074,605	1,677,746	537,404
NEW DISTRIBUTION	1,055,305	1,709,370	525,075

TABLE V.6-8

NET DIRECT COST AND NET DIRECT COST PER OUTPUT UNIT (COST-EFFECTIVENESS) BY DISTRIBUTING SECURITY, CLEANING, TELEPHONE, ELECTRICITY AND WATER & SEWAGE COSTS BY AD-HOC CURRENTLY USED PROPORTIONS AND BY THE NEW PROPORTIONS OBTAINED IN THIS STUDY BY SERVICE PROGRAM. PROFAMILIA, 1986. IN US DOLLARS \1\

ITEM	SERVICE PROGRAM					
	CLINICAL & LAB.		SURGICAL		COMMUNITY MARKETING	
	AD HOC	NEW	AD HOC	NEW	AD HOC	NEW
NET DIRECT OPERATING COST	1,074,605	1,055,305	1,677,746	1,709,370	537,404	525,075
NET COST PER CYP	6.92	6.80	2.17	2.21	1.74	1.70
NET COST PER MED. VISIT	2.82	2.77	-	-	-	-
NET COST PER STERILIZATION	-	-	27.11	27.62	-	-
GROSS COST PER CYP	14.90	14.78	2.81	2.85	3.79	3.75
GROSS COST PER MED. VISIT	6.08	6.03	-	-	-	-
GROSS COST PER SURGERY	-	-	35.14	35.65	-	-
FINANCIAL SELF-SUFFICIENCY	53.5%	54.0%	22.8%	22.5%	54.0%	54.6%

\1\ Based on an exchange rate of $196.1 Col. pesos per US Dollar.

TABLE VI.1-1

DISTRIBUTORS' PERCEPTIONS OF THE ACTIVITIES OF CBD INSTRUCTORS DURING LAST YEAR
BY REGION. COLOMBIA, 1987.

PERCEPTIONS OF THE ACTIVITIES OF INSTRUCTORS DURING LAST YEAR	REGION						
	TOTAL	ATLANTIC	SANTANDER	EASTERN	PACIFIC	CENTRAL	BOGOTA
% WHO KNEW OF HOUSEHOLD VISITS IN THEIR COMMUNITIES:	37.5	41.1	18.5	25.4	34.3	42.0	42.9
% WHO KNEW OF FAMILY PLANNING TALKS IN THEIR COMMUNITIES:	41.0	54.8	25.9	17.9	45.1	40.8	39.0
NUMBER OF CASES:	571	124	27	67	102	174	77
NUMBER OF TALKS:							
1	24.0	22.1	16.7	33.3	30.4	23.9	16.7
2	27.0	23.5	16.7	33.3	32.6	23.9	33.3
3 OR +	49.0	54.4	66.6	33.4	37.0	52.2	50.0
% WHO ATTENDED ONE OF THE INSTRUCTOR'S TALKS:	67.1	67.6	57.1	66.7	78.3	69.0	46.7
- SUGGESTED A PARTICULAR METHOD:	41.4	30.4	50.0	62.5	41.7	46.9	42.9
- GAVE INFORMATION ON BRANDS:	88.5	87.0	100.0	87.5	88.9	93.9	71.4
- POINTED OUT SOURCES OF SERVICE:	96.8	97.8	100.0	100.0	97.2	95.9	92.9
NUMBER OF CASES:	157	46	4	8	36	49	14
% MENTIONING INCREASE IN SALES AFTER TALKS AND VISITS:	32.5	32.4	42.9	41.7	34.8	38.0	10.0
NUMBER OF CASES:	234	68	7	12	46	71	30

TABLE VI.1-2

AVAILABILITY AND USE OF PROMOTIONAL MATERIALS IN CBD POSTS
BY REGION. COLOMBIA, 1987.

AVAILABILITY AND USE OF MATERIALS	REGION						
	TOTAL	ATLANTIC	SANTANDER	EASTERN	PACIFIC	CENTRAL	BOGOTA
% WHO HAD:							
- BROCHURES ON METHODS:	57.1	51.6	70.4	52.2	50.0	60.3	67.5
- POSTERS:	22.6	29.0	14.8	31.3	6.9	20.1	33.8
- PROFAMILIA'S SIGN IN VISIBLE PLACE:	82.3	72.6	77.8	88.1	85.3	83.9	87.0
- CONTRACEPTIVE SHOW-CASE:	59.7	66.9	18.5	67.2	52.0	63.2	58.4
% WHO THOUGHT THAT SALES WERE HELPED BY HAVING:							
- BROCHURES ON METHODS:	55.8	53.1	42.1	57.1	60.8	61.9	46.2
- POSTERS:	39.3	47.2	25.0	33.3	28.6	45.7	29.1
- PROFAMILIA'S SIGN:	82.1	75.6	52.4	83.1	92.0	89.1	71.2
- CONTRACEPTIVE SHOW-CASE:	66.9	68.7	60.0	53.3	60.4	78.2	57.8
% WHO SAID THEY EXPLAINED CONTRACEPTIVE USE WITH THE AID OF:							
- BROCHURES ON METHODS:	89.2	89.1	89.5	94.3	86.3	87.5	92.3
- CONTRACEPTIVE SHOW-CASE:	76.4	74.3	100.0	84.4	73.6	73.1	80.4
AVERAGE PERCEIVED IMPORTANCE:							
- BROCHURES ON METHODS:	20.6	18.8	7.4	28.4	19.6	23.2	16.9
- POSTERS:	5.8	10.7	0.0	1.5	6.9	3.5	7.8
- PROFAMILIA'S SIGN:	49.2	44.2	40.7	53.7	58.8	47.6	46.8
- CONTRACEPTIVE SHOW-CASE:	19.0	21.3	44.4	11.9	11.8	20.9	18.2
NUMBER OF CASES:	567	122	27	67	102	172	77

TABLE VI.1-3

DISTRIBUTORS' PERCEPTIONS OF RADIO ADVERTISING BY REGION. COLOMBIA, 1987.

PERCEPTIONS OF RADIO ADVERTISING	REGION						
	TOTAL	ATLANTIC	SANTANDER	EASTERN	PACIFIC	CENTRAL	BOGOTA
% WHO HAD HEARD A PROFAMILIA RADIO SPOT DURING THE LAST YEAR	47.6	45.2	22.2	35.8	49.0	54.0	54.5
NUMBER OF CASES:	571	124	27	67	102	174	77
RADIO SPOT CONTENT:							
- INVITATION TO PROFAMILIA AND INFORMATION ABOUT METHODS.	30.7	26.8	0.0	20.9	42.0	31.6	31.0
- INVITATION TO PROFAMILIA AND SERVICES OFFERED.	22.7	21.5	0.0	33.3	10.0	28.5	23.9
- INVITATION TO PROFAMILIA AND INFORMATION ON FAMILY PLANNING.	12.5	17.9	33.3	12.5	16.0	9.5	4.8
- IMPORTANCE AND ADVANTAGES OF FAMILY PLANNING.	21.8	25.1	50.0	16.7	18.0	20.0	23.7
- DID NOT REMEMBER.	12.1	8.9	16.7	16.7	14.0	10.5	14.3
- NO ANSWER.	0.4	0.0	0.0	0.0	0.0	0.0	2.4
% REPORTING INCREASE IN SALES WHILE SPOTS WERE BROADCAST:	14.9	22.2	0.0	8.3	12.0	16.1	11.9
NUMBER OF CASES:	272	56	6	24	50	94	42
% PREFERRING							
- PRINTED MATERIALS:	45.7	53.2	44.4	46.3	45.1	42.5	41.6
- RADIO SPOTS:	41.3	42.7	44.4	38.8	41.2	41.4	40.3
- BOTH:	11.6	1.6	11.1	11.9	13.7	15.5	15.6
- NEITHER:	1.2	1.6	0.0	3.0	0.0	0.6	2.6

TABLE VI.1-4

DISTRIBUTORS' PRACTICES AND PERCEPTIONS OF CONTRACEPTIVE MARKETING BY REGION. COLOMBIA, 1987.

PRATICES & PERCEPTIONS	REGION						
	TOTAL	ATLANTIC	SANTANDER	EASTERN	PACIFIC	CENTRAL	BOGOTA
PERCENT SELLING:							
- PILLS	99.6	100.0	100.0	98.5	99.0	100.0	100.0
- CONDOMS	81.1	56.5	81.5	85.1	86.3	90.8	88.3
- INJECTABLES	2.6	3.2	7.4	3.0	1.0	2.3	2.6
- VAGINALS	48.9	30.6	51.9	58.2	37.3	54.6	71.4
DISTRIBUTORS' SUGGESTIONS TO USERS IF THEY ARE OUT OF STOCK:							
- GO TO PROFAMILIA OR ANOTHER POST.	15.9	14.5	7.4	23.9	10.8	16.1	20.8
- HAVE NEVER BEEN OUT OF STOCK	62.2	62.1	74.1	55.2	96.6	64.4	49.4
- BUY FROM ANOTHER OUTLET.	16.2	20.9	14.8	7.5	14.7	13.1	24.7
- WAIT UNTIL RESUPPLIED/ AVOID SEX.	2.7	1.6	0.0	7.5	1.0	4.0	0.0
- CHANGE METHOD.	2.5	0.0	3.7	3.0	2.9	2.3	5.2
- NO RECOMMENDATION.	0.7	0.8	0.0	3.0	1.0	0.0	0.0
% OF COMMUNITIES WITH AN ALTERNATIVE CONTRACEPTIVE SOURCE:							
- PROFAMILIA CLINIC:	10.7	1.6	14.8	22.4	12.7	12.1	7.8
- OTHER PROFAMILIA CBD POST:	42.7	41.9	11.1	37.3	49.0	46.6	42.9
- DRUGSTORE:	74.7	62.9	88.9	68.7	73.5	77.6	87.0
- PRIVATE CLINIC/PHYSICIAN:	1.1	0.0	0.0	0.0	1.0	0.6	5.2
- SOCIAL SECURITY:	6.1	1.6	0.0	4.5	2.0	9.2	15.6
- HOSPITAL OR HEALTH POST:	41.9	39.5	40.7	35.8	45.1	45.4	39.0
- OTHER:	1.1	2.4	0.0	0.0	1.0	1.1	0.0

TABLE VI.1-5

CBD DISTRIBUTORS' MARKETING PRACTICES AND PERCEPTIONS OF PILLS AND CONDOMS. COLOMBIA, 1987

MARKETING PRACTICES AND PERCEPTIONS	CONTRACEPTIVE METHOD	
	PILLS	CONDOMS
PERCEIVED SOURCE WITH HIGHEST METHOD SALES		
- Own CBD post	61.3	47.1
- Other PROFAMILIA CBD post	4.7	4.4
- PROFAMILIA clinic	0.4	0.4
- Hospital/health post	11.6	2.1
- Drugstore	13.7	20.0
- Did not know	0.4	26.1
IF CLIENT ASKS FOR A PARTICULAR BRAND AND YOU DO NOT HAVE IT, DOES CLIENT BUY ANOTHER BRAND?		
- Yes, buys brand available	58.7	95.2
- Does not buy	41.1	4.8
- Other	0.2	-
NUMBER OF CASES	569	457

TABLE VI.1-6

CBD DISTRIBUTORS' PERCEPTIONS OF WHY PILL USERS BUY FROM THE VARIOUS SOURCES AVAILABLE IN THEIR COMMUNITIES. COLOMBIA, 1987.

REASONS FOR MORE PILL SALES	SOURCE			
	DISTRIBUTORS'S CBD POST	HOSPITAL/ HEALTH POST	DRUGSTORE	OTHER PROFAMILIA CBD POST
- LOWEST PRICE:	35.7	90.9	10.3	14.8
- MORE VARIETY OF BRANDS:	1.7	0.0	29.5	3.7
- SOLD IN BOXES:	0.0	0.0	1.3	0.0
- NEVER OUT OF STOCK:	3.2	0.0	3.8	7.5
- OPEN MORE OFTEN:	5.7	0.0	5.1	11.1
- CLOSER TO HOMES:	17.7	0.0	7.7	37.0
- BETTER PERSONAL SERVICE:	11.7	0.0	0.0	0.0
- BETTER QUALITY OF PILLS:	0.9	0.0	5.1	0.0
- BETTER TRAINED PERSONNEL:	1.4	7.6	20.5	0.0
- ONLY SOURCE AVAILABLE:	19.4	1.5	2.6	0.0
- OTHER:	2.6	0.0	14.1	22.2
- NO RESPONSE	0.0	0.0	0.0	3.7
T O T A L	100.0	100.0	100.0	100.0
NUMBER OF CASES:	350	66	78	27

TABLE VI.1-7

CBD DISTRIBUTORS' PERCEPTIONS OF PILL AND CONDOM BRANDS BY REGION
COLOMBIA, 1987

PERCEPTION OF BRANDS	TOTAL	REGIONS					
		ATLANTIC	SANTANDER	EASTERN	PACIFIC	CENTRAL	BOGOTA
BEST PILL BRAND							
- Neogynon 28	26.1	29.0	37.0	31.3	33.3	21.3	14.3
- Noriday	23.5	29.8	18.5	26.9	17.6	17.8	32.5
- Neogynon 21	14.2	15.3	11.1	7.5	11.8	19.0	11.7
- Microgynon 28	7.4	4.8	18.5	10.4	3.9	7.5	9.1
- Microgynon 21	5.3	7.3	0.0	1.5	3.9	5.2	9.1
- All are the same	15.4	3.2	3.7	14.9	23.5	20.1	18.2
- Other	8.1	10.6	11.2	7.5	6.0	9.1	5.1
% WHO KNEW EACH CONDOM BRAND:							
- Tahiti	88.8	74.2	96.3	88.1	90.2	96.0	92.2
- Sultan	9.8	11.3	18.5	10.4	10.8	5.7	11.7
- Stimula	2.8	3.2	7.4	6.0	1.0	1.1	3.9
- Rosetex	2.5	3.2	0.0	4.5	1.0	1.7	3.9
NUMBER OF CASES	571	124	27	67	102	174	177
OF THOSE WHO KNEW BRANDS, % NAMING THE FOLLOWING AMONG BEST THREE							
- Tahiti	61.0	78.4	92.3	65.1	35.7	62.5	53.5
- Stimula	1.4	2.0	7.6	3.3	0.0	0.6	0.0
- Sultan	5.4	11.4	19.2	5.0	2.0	3.0	2.8
- Rosetex	0.6	1.0	0.0	1.7	0.0	0.0	1.4
- All are the same	33.3	9.3	3.8	31.7	57.1	32.7	46.5
NUMBER OF CASES	520	97	26	60	98	168	71
ARE THE CONDOMS YOU SELL BETTER OR WORSE THAN THOSE SOLD BY OTHERS?							
- Better	28.6	38.0	34.8	33.9	21.8	26.8	25.0
- The same	66.4	53.5	60.9	62.5	69.0	70.1	73.5
- Worse	0.9	2.8	0.0	1.8	0.0	0.6	0.0
- DK/NR	4.1	5.6	4.3	1.8	9.2	2.5	1.5
NUMBER OF CASES	462	71	23	56	87	157	68

TABLE VI.2-1

QUALITY OF CARE CONSISTENT\1\ AND INCONSISTENT PREDICTORS OF KNOWLEDGE AND CONTRACEPTIVE SALES VARIABLES

QUALITY OF CARE VARIABLES	PREDICTOR VARIABLES OF KNOWLEDGE AND SALES OF CONTRACEPTIVES			
	KNOWLEDGE		SALES	
	MOST CONSISTENT	INCONSISTENT	MOST CONSISTENT	INCONSISTENT
SOCIO-DEMOGRAPHIC ITEMS	-Sex (-)(female) -Schooling -Contracep. method -Ever use	-Civil status -Urbanization	-Population -Civil status(-) (Single or separated) -Help in sales -Age -Current use	-Schooling
INFORMATION ITEMS	-Use of brochure -Use of showcase -Sign -Radio spot	Instructors': -IEC talks (-) Distributors': -Attendance talks -Other motive active (-)	None	-Availability of sign -Radio spot
TRAINING ITEMS	-Training -Knowledge of PROFAMILIA	None	-Years as distributor	None
PROGRAM CHOICE ITEMS	-Number of methods sold -Sale of condoms -Main pill source	None	-Number of methods sold in post -Main pill source -Main condom source	Availability in CBD post of: -Pill -Condoms
COMMUNITY CHOICE ITEMS	None	None	-Number of sources available -Private phys/ clinic -Drugstore	-Availability of social security
CLIENT/SUPPLIER RELATIONSHIP ITEMS	-% Women advised by instructor -Client purchases of condoms if regular brand unavailable	None	-Client purchases of condom if regular brand unavailable	None
PROVIDER COMPETENCE ITEMS			Knowledge of: -Pill -Sterilization(-) -Vasectomy	Knowledge of: -Vaginals

\1\ Significant predictors for more than half the knowledge or sales items on which they were regressed (knowledge of pills, barrier, female sterilization, vasectomy, all methods).

TABLE VI.2-2

INCREASE IN THE EXPLAINED VARIANCE (ADJUSTED R SQUARE) OF KNOWLEDGE VARIABLES BY INTRODUCING CONSISTENT QUALITY OF CARE PREDICTORS OVER CONSISTENT SOCIODEMOGRAPHIC PREDICTORS

QUALITY VARIABLES	KNOWLEDGE OF					
	PILL	BARRIER\1\	METHODS SOLD\2\	FEMALE STERIL.	VASEC-TOMY	ALL METHODS\3\
SOCIO-DEMOGRAPHIC Adj r^2	.136	.059	.150	.057	.088	.171
INFORMATION Adj r^2	.036	.009	.037	.039	.042	.058
TRAINING Adj r^2	.115	.050	.126	.065	.072	.141
PROGRAM CHOICE Adj r^2	.023	.013	.028	.010	.008	.024
CLIENT/PROVIDER RELATIONSHIP Adj r^2	.057	.038	.070	.024	.029	.067

\1\ Condom + vaginal
\2\ Pill + Barrier
\3\ Methods sold plus sterilization, vasectomy, IUD and rhythm.

TABLE VI.2-3

INCREASE IN THE EXPLAINED VARIANCE (ADJUSTED R SQUARE) OF SALES ITEMS BY INTRODUCING CONSISTENT QUALITY OF CARE PREDICTORS OVER CONSISTENT SOCIODEMOGRAPHIC PREDICTORS

QUALITY OF CARE VARIABLES	SALES OF				
	PILL	CONDOMS	VAGINALS	BARRIER	C Y P
SOCIO-DEMOGRAPHIC Adj r^2	.052	.070	.047	.086	.053
INFORMATION Adj r^2	.017	.002	.003	.000	.011
TRAINING Adj r^2	.035	.001	.016	.009	.050
PROVIDER COMPETENCE Adj r^2	.029	.005	.003	.007	.034
PROGRAM CHOICE Adj r^2	.060	.060	.050	.080	.071
COMMUNITY CHOICE Adj r^2	.010	.019	.039	.020	.012
CLIENT/PROVIDER RELATIONSHIP Adj r^2	.017	.024	.009	.026	.018

TABLE VI.2-4

CORRELATIONS AND EXPLAINED VARIANCE (ADJUSTED R SQUARE) FOR KNOWLEDGE OF EACH CONTRACEPTIVE METHOD REGRESSED ON CONSISTENT SOCIODEMOGRAPHIC AND QUALITY OF CARE VARIABLES

KNOWLEDGE OF	CORRELATION (R) AND EXPLAINED VARIANCE (R^2)		Sociodemographic and quality of care items that remained significant (p<.05) all consistent predictors were entered into equation
	r	Adj r^2	
PILL	.541	.275	Ever use* sex*, years of schooling*, knowledge of PROFAMILIA*, training*, clients' purchase of condoms if own brand unavailable
BARRIER (CONDOM + VAGINALS)	.381	.124	Ever'use*, sex*, years of schooling*, training*, proportion of women advised
METHODS SOLD (PILL + BARRIER)	.568	.306	Ever use*, sex*, years of schooling*, client purchases condoms if regular brand unavailable, knowledge of PROFAMILIA*, training*
FEMALE STERILIZATION	.410	.147	Ever use*, sex*, years of schooling, post main pill source in community, radio spot*, use of brochures, training*
VASECTOMY	.449	.181	Ever use*, years of schooling*, knowledge of PROFAMILIA, training*, use of brochure*
ALL METHODS (METHODS SOLD PLUS STERILIZATION, VASECTOMY, IUD, AND NFP)	.604	.349	Ever use*, sex*, years of schooling*, knowledge of PROFAMILIA*, training*, use of brochure, radio spot*, percent of women advised

*P<.01

TABLE VI.2-5

CORRELATIONS AND EXPLAINED VARIANCE FOR CONTRACEPTIVE SALES ITEMS REGRESSED FOR CONSISTENT SOCIODEMOGRAPHIC AND QUALITY OF CARE VARIABLES

SALES OF	CORRELATION (R) AND EXPLAINED VARIANCE (adj r^2)		Socio-demographic and quality of care variables that remained significant (p<.05) when all consistent predictors were entered into equation
	r	adj r^2	
PILL CYCLES	.441	.167	Population (-), civil status (-), help from others, age, current use*, number of available sources in community*, radio spot, post perceived as main pill source*, years as distributor*, knowledge of female sterilization* (-) and of vasectomy
CONDOMS	.417	.146	Population*, civil status (-), current use, post perceived as main condom source, number of methods sold in post*, knowledge of vasectomy, availability of private clinic/physician
VAGINAL	.398	.122	Population*, years as distributor, number of methods sold at post*, availability of private clinic/physician
BARRIER (CONDOMS + VAGINALS)	.467	.191	Population*, post perceived as main condom source*, number of methods sold*, availability of private clinic/physician in community*
COUPLE-YEARS OF PROTECTION	.469	.189	Population (-), civil status (1), help from others, age, current use*, knowledge of female sterilization* (-_ and vasectomy, years as distributor*, CBD post perceived as main pill source*, number of available sources*, number of methods sold

* p<.01

TABLE VI.3-1

KNOWLEDGE OF CONTRACEPTIVE USE AMONG EVER-MARRIED WOMEN: MEAN NUMBER OF CORRECT ANSWERS TO QUESTIONS ON EACH CONTRACEPTIVE METHOD BY DEPARTMENT

CONTRACEPTIVE METHOD	TOTAL NUMBER OF QUESTIONS	CUNDINAMARCA			SANTANDER		
		MEDIAN	MEAN	STD DEVIATION	MEDIAN	MEAN	STD DEVIATION
PILLS \1\	8	4	3.1	2.9	3	2.7	2.6
BARRIER \1\	8	2	1.9	2.2	0	1.9	2.2
I U D \2\	9	4	3.8	2.3	4	3.8	2.2
VASECTOMY \2\	8	0	1.7	2.5	0	1.5	2.3
FEMALE STERILIZATION\2\	6	4	3.6	1.6	3	3.3	1.7
NATURAL FAMILY PLANNING	1	0	0.2	0.4	0	0.4	0.5
ALL METHODS	40	14	14.5	8.1	13	13.6	8.0

\1\ Questions asked to those who said they knew how to use the method.
\2\ Questions asked to those who knew or had heard of the method.

TABLE VI.3-2

KNOWLEDGE OF PILL USE: PERCENT OF EVER-MARRIED WOMEN ANSWERING EACH QUESTION CORRECTLY, CUNDINAMARCA AND SANTANDER, 1987

QUESTIONS ON QUALITY OF KNOWLEDGE	CUNDINAMARCA		SANTANDER	
	All sample	Knew use of pills	All sample	Knew use of pills
KNEW OR HAD HEARD OF THE PILL	96.9	-	97.6	-
REPORTED KNOWING HOW TO USE THE PILL	57.1	100.0	56.5	100.0
• WHEN SHOULD A WOMAN BEGIN TO TAKE THE PILL?	47.5	83.2	33.5	59.3
• HOW LONG SHOULD A WOMAN WAIT BEFORE STARTING A NEW CYCLE, WHEN SHE FINISHES A 21-PILL CYCLE?	37.7	66.0	23.3	41.2
• HOW LONG SHOULD A WOMAN WAIT BEFORE STARTING A NEW CYCLE, WHEN SHE FINISHES A 28-PILL CYCLE?	19.9	34.8	15.5	27.4
• HOW OFTEN SHOULD PILLS BE TAKEN?	54.6	95.6	55.1	97.5
• WHAT SHOULD A WOMAN DO IF SHE FORGETS TO TAKE THE PILL ONE DAY?	40.3	70.6	40.2	71.1
• IF A WOMAN IS BREAST FEEDING, IS IT ADVISABLE FOR HER TO TAKE THE PILL?	31.3	54.8	34.6	61.2
• WHY SHOULD BREAST FEEDING WOMEN NOT TAKE THE PILL?	9.4	16.5	10.4	18.4
• IF A WOMAN IS NOT HAVING SEXUAL RELATIONS FOR ONE WEEK, CAN SHE STOP TAKING THE PILL?	37.7	66.0	38.5	68.1
• WOULD YOU RECOMMEND THE PILL TO A WOMAN OVER 35 YEARS OF AGE?	27.6	48.3	27.4	48.5
NUMBER OF CASES	38266	21198	42811	24198

• Questions were asked only to women who reported they knew how to use the pill.

TABLE VI.3-3

PERCENT OF EVER-MARRIED WOMEN MENTIONING EACH COUNTERINDICATION FOR PILL USE. CUNDINAMARCA AND SANTANDER, 1987

COUNTERINDICATION MENTIONED:	CUNDINAMARCA		SANTANDER	
	All sample	Knew pill use	All sample	Knew pill use
HIGH BLOOD PRESSURE	14.5	26.2	12.0	21.2
VARICOSE VEINS	20.7	37.4	20.2	35.7
CARDIOVASCULAR DISEASE	5.8	10.5	5.9	10.4
LIVER DISEASE	4.2	7.6	6.0	10.6
CANCER	4.4	7.9	2.9	5.1
OTHER	6.6	7.2	9.4	16.6
NUMBER OF CASES	38266	21198	42811	24198

TABLE VI.3-4

KNOWLEDGE OF BARRIER METHOD USE. PERCENT OF EVER-MARRIED WOMEN ANSWERING EACH QUESTION CORRECTLY, CUNDINAMARCA AND SANTANDER, 1987

QUESTIONS ON QUALITY OF KNOWLEDGE	CUNDINAMARCA		SANTANDER	
	All sample	Knew use of method	All sample	Knew use of method
KNEW OR HAD HEARD OF VAGINALS	81.3	-	78.4	-
KNEW HOW TO USE VAGINALS	45.2	100.0	42.6	100.0
• WHEN SHOULD THE TABLET BE PUT IN PLACE: BEFORE, DURING OR AFTER SEX?	44.8	99.1	41.5	97.4
• HOW MANY MINUTES BEFORE SEX SHOULD A VAGINAL TABLET BE PUT IN PLACE?	7.4	16.4	11.0	25.8
• FOR HOW MANY SEXUAL RELATIONS CAN A VAGINAL TABLET BE USED?	40.8	90.3	38.4	90.1
• WHEN USING VAGINALS, IS IT NECESSARY TO DOUCHE JUST AFTER RELATIONS?	10.0	22.1	9.1	21.4
NUMBER OF CASES	38266	17313	42811	18245
KNEW OR HAVE HEARD OF CONDOMS	65.0	-	72.4	-
KNEW HOW CONDOM IS USED	25.7	100.0	30.1	100.0
• WHEN SHOULD A MAN PUT A CONDOM IN PLACE?	25.0	97.3	28.6	91.7
• FOR HOW MANY SEXUAL RELATIONS CAN A CONDOM BE USED?	24.1	93.8	28.4	94.3
• WHEN SHOULD A MAN WITHDRAW WHEN USING A CONDOM?	6.8	26.5	8.4	27.9
• SHOULD THE CONDOM BE TIGHT OR LEAVE SPACE IN THE TIP?	15.9	61.9	18.1	60.1
NUMBER OF CASES	38266	9844	42811	12883

• Questions were only asked to women who reported they knew how vaginals or condoms were used.

TABLE VI.3-5

KNOWLEDGE OF IUD USE. PERCENT OF EVER-MARRIED WOMEN ANSWERING EACH QUESTION CORRECTLY, CUNDINAMARCA AND SANTANDER, 1987

KNOWLEDGE	CUNDINAMARCA		SANTANDER	
	All sample	Knew I U D	All sample	Knew I U D
KNEW OR HAD HEARD OF IUD	88.7	100.0	90.9	100.0
• WHERE IN A WOMAN'S BODY IS AN IUD PLACED?	35.2	39.7	44.3	48.7
• KNEW LIPPES LOOP	72.5	81.7	74.2	81.6
• KNEW FOR HOW LONG LIPPES MAY BE USED	11.5	13.0	21.9	24.1
• KNEW TCu	61.0	68.8	62.7	69.0
• KNEW FOR HOW LONG TCu MAY BE USED	27.9	31.4	23.8	26.2
• IS THE IUD PLACED DURING OR AFTER MENSTRUATION	57.1	64.4	61.8	68.0
• HOW DOES A WOMAN KNOW IF IUD IS IN PLACE	14.8	16.7	12.2	13.4
• WHEN SHOULD A WOMAN GO FOR A CHECK-UP AFTER INSERTION?	56.7	63.9	62.3	68.5
• HOW OFTEN SHOULD A WOMAN HAVE CHECK-UPS AFTER THE FIRST ONE?	31.1	35.1	28.2	31.0
NUMBER OF CASES	38266	33944	42811	38895

• Questions were only asked to women who had heard of the IUD.

TABLE VI.3-6

KNOWLEDGE OF FEMALE STERILIZATION. PERCENT ANSWERING EACH QUESTION CORRECTLY, CUNDINAMARCA AND SANTANDER, 1987

QUESTIONS ON FEMALE STERILIZATION	CUNDINAMARCA		SANTANDER	
	All sample	Knew sterilization	All sample	Knew sterilization
KNEW OR HAD HEARD OF FEMALE STERILIZATION	92.1	100.0	94.3	100.0
• HOW IS A FEMALE STERILIZATION DONE?	71.9	78.1	61.5	65.2
• IS STERILIZATION A PERMANENT OR TEMPORARY METHOD?	66.6	72.3	50.3	53.3
• CAN A STERILIZATION FAIL?	39.4	42.8	51.9	55.0
• DOES THE STERILIZATION CHANGE SEXUAL DESIRES IN A WOMAN?	46.5	50.5	39.8	42.2
• DO WOMEN KEEP HAVING MENSTRUATIONS AFTER A STERILIZATION?	79.3	86.1	80.8	85.7
• DOES THE STERILIZATION CAUSE CHANGES IN THE WOMAN'S CHARACTER?	48.2	52.3	50.9	54.0
NUMBER OF CASES	38266	35258	42811	40365

• Questions asked only to women who had heard of female sterilization.

TABLE VI-3-7

KNOWLEDGE OF VASECTOMY. PERCENT ANSWERING EACH QUESTION CORRECTLY, CUNDINAMARCA AND SANTANDER, 1987

QUESTIONS ON VASECTOMY	CUNDINAMARCA		SANTANDER	
	All sample	Knew vasectomy	All sample	Knew vasectomy
KNEW OR HAD HEARD OF VASECTOMY	39.3	100.0	43.9	100.0
• HOW IS A VASECTOMY DONE?	17.9	45.5	17.9	40.8
• IS VASECTOMY THE SAME AS CASTRATION?	26.5	67.4	27.4	62.4
• DOES A VASECTOMIZED MAN EJACULATE?	20.1	51.1	24.8	56.5
• DOES VASECTOMY CHANGE A MAN'S SEXUALITY?	20.9	53.2	19.5	44.4
• DOES VASECTOMY CHANGE A MAN'S CHARACTER OR BEHAVIOR?	20.4	51.9	20.2	46.0
• HOW MANY NIGHTS DOES A MAN HAVE TO STAY AT THE HOSPITAL FOR A VASECTOMY? (0)	13.2	33.6	12.3	28.0
• HOW PAINFUL IS A VASECTOMY? (A LITTLE OR NOT PAINFUL)	23.4	59.5	27.5	62.6
• AFTER HOW MANY DAYS CAN A MAN GO BACK TO WORK (1 or 2)	9.5	24.2	7.9	18.0
• THOUGHT HUSBAND KNEW ABOUT VASECTOMY	27.5	70.0	28.2	64.2
• THOUGHT HUSBAND WOULD GET A VASECTOMY	4.0	10.2	3.2	7.3
• KNEW SOMEONE THAT HAD A VASECTOMY	4.4	11.2	5.9	13.4
NUMBER OF CASES	38266	15041	42811	18815

• Questions were only asked to those who had heard of vasectomy.

TABLE VI.3-8

CORRELATION MATRIX OF KNOWLEDGE OF EACH CONTRACEPTIVE
(INCLUDING COEFFICIENTS > .40)*
SANTANDER AND CUNDINAMARCA, 1986

	CUNDINAMARCA							
SANTANDER	PILLS	BARRIER	I U D	VASECTOMY	FEMALE STERILIZATION	N F P	ALL METHODS	NUMBER METHODS KNOWN
PILLS	1						.680	
BARRIER		1	.435	.519			.749	.485
IUD			1				.715	.560
VASECTOMY		.523		1			.717	.533
FEMALE STERILIZATION			.405	.448	1		.580	.508
N F P						1		
ALL METHODS	.672	.744	.713	.756	.632	.455	1	.688
NUMBER OF METHODS KNOWN		.497	.585	.558	.497		.703	1

*All other correlation coefficients are > .24, most are > .30.

TABLE VI.3-9

CORRELATIONS OF EVER-USE OF EACH METHOD WITH KNOWLEDGE OF THAT METHOD BY DEPARTMENT

CORRELATES: EVER USE AND KNOWLEDGE OF:	CORRELATION	
	CUNDINAMARCA	SANTANDER
PILLS	.183	.171
IUD	.557	.565
FEMALE STERILIZATION	.620	.518
VASECTOMY	.797	.782
CONDOM/BARRIER	.430	.432
VAGINAL/BARRIER	.370	.409

TABLE VI.3-10

MEAN KNOWLEDGE OF EACH METHOD ACCORDING TO UNMET NEED AND EVER-USE OF MODERN METHODS, AND SOURCE OF CURRENT CONTRACEPTIVE BY DEPARTMENT CUNDINAMARCA AND SANTANDER, 1987

	CONTRACEPTIVE METHOD													
	PILLS		BARRIER		IUD		VASECTOMY		FEM. STERILIZATION		ALL METHODS		NO. OF CASES	
	CUN/MARCA	SANTANDER	CUN/MARCA	SANTANDER	CUN/MARCA	SANTANDER	CUN/MARCA	SANTANDER	CUN/MARCA	SANTANDER	CUN/MARCA	SANTANDER	CUN/MARCA	SANTANDER
UNMET NEED														
YES	3.3	2.8	1.9	1.9	3.9	3.8	1.8	1.5	3.5	3.1	14.6	13.5	440	527
NO	2.9	2.6	1.9	1.8	3.7	3.8	1.7	1.6	3.8	3.5	14.3	13.8	526	679
EVER USE OF MODERN METHOD														
YES	3.9	2.5	2.3	2.2	4.3	4.3	2.0	1.8	3.9	3.6	16.7	15.9	702	879
NO	0.9	1.7	0.9	0.8	2.6	2.5	1.1	0.7	2.9	2.4	8.6	7.6	264	327
SOURCE OF CURRENT METHOD	3.8	3.4	2.3	2.1	4.4	4.4	2.0	1.9	4.1	3.8	16.9	16.0	508	628
HOSP/H.POST	3.3	2.8	2.0	1.7	4.3	4.3	1.6	1.3	4.2	3.9	15.6	14.4	227	239
DRUGSTORE	4.6	4.3	2.5	2.5	3.8	4.1	2.0	1.6	3.6	3.2	16.8	16.2	157	206
CBD POST	5.8	4.6	2.6	2.6	4.6	4.2	1.8	2.8	3.9	5.0	19.0	19.6	9	5
PROFAMILIA CLINIC	3.7	2.7	3.0	2.0	5.3	4.7	3.3	3.0	4.5	4.5	20.0	17.3	85	97
PRIVATE CLINIC PHYSICIAN	2.2	3.5	2.6	3.0	5.3	5.1	2.6	3.2	4.2	4.3	17.3	19.6	30	57
ENTIRE POPULATION	3.1	2.7	1.9	1.9	3.8	3.8	1.7	1.5	3.6	3.3	14.5	16.0	966	1206

TABLE VI.3-11

EXPLAINED VARIANCE FOR KNOWLEDGE OF EACH CONTRACEPTIVE METHOD REGRESSED ON SCHOOLING, MARITAL STATUS, UNMET NEED, AGE, ZONE, EVER-USE AND NUMBER OF LIVING CHILDREN. EVER-MARRIED WOMEN IN CUNDINAMARCA AND SANTANDER, 1987

DEPENDENT VARIABLES	ADJUSTED R SQUARE		PREDICTORS WITH LARGEST BETA WEIGHTS		
			PREDICTOR	BETA	
	C/MARCA	SANTANDER		C/MARCA	SANTANDER
KNOWLEDGE OF PILLS	.276	.255	Ever use	.47	.43
			Zone	.11	.07
			Schooling	.11	.13
			Num. of children	-.09	-.10
KNOWLEDGE OF BARRIER METHODS	.215	.247	Ever use	.26	.22
			Schooling	.32	.38
			Zone	.10	.06
			Num. of children		-.09
KNOWLEDGE OF IUDS	.206	.249	Ever use	.31	.33
			Schooling	.24	.27
			Zone	.12	.11
KNOWLEDGE OF VASECTOMY	.203	.242	Schooling	.40	.47
			Ever use	.11	.17
			Age	.07	.12
			Zone	.09	
KNOWLEDGE OF FEMALE STERILIZATION	.127	.170	Ever use	.21	.28
			Schooling	.17	.23
			Children	.16	
			Desire more child.		-.16
KNOWLEDGE OF NATURAL FAMILY PLANNING	.031	.137	Schooling	.18	.34
			Zone		.07
KNOWLEDGE OF ALL METHODS	.374	.420	Ever use	.40	.41
			Schooling	.35	.42
			Zone	.15	.08
NUMBER OF METHODS KNOWN	.191	.287	Ever use	.24	.28
			Schooling	.26	.37
			Zone	.15	.10
KNOWLEDGE OF AIDS	.196	.225	Schooling	.30	.38
			Ever use	-	.07
			Zone	.17	.12

TABLE VI.4.1

KNOWLEDGE OF CONDOM USE BY AGE, YEARS OF SCHOOLING AND WORKING SECTOR. CALI, 1987.

AGE AND YEARS OF SCHOOLING	KNOWLEDGE OF CONDOM USE		
	% WHO KNEW HOW TO USE	% CORRECTLY DESCRIBING FORM OF USE	% KNOWING IT IS PUT IN PLACE BEFORE SEX
AGE:			
15 - 19	65.6	81.0	75.0
20 - 24	72.5	87.0	87.4
25 - 29	77.6	86.6	85.7
30 - 39	79.7	87.2	85.0
40 - 49	80.1	86.3	84.8
50 or +	83.5	83.1	90.6
YEARS OF SCHOOLING:			
0 - 3	66.7	84.6	82.1
4 - 5	60.9	82.1	80.4
6 - 8	70.9	84.3	79.7
9 or +	83.1	87.6	88.4
TOTAL	77.9	86.5	85.7
NUMBER OF CASES:	1,028	889	1,131

TABLE VI.4-2

PERCEPTION OF THE MAIN ADVANTAGES AND DISADVANTAGES OF CONDOMS BY AGE AND YEARS OF SCHOOLING. CALI, 1987.

ADVANTAGES AND DISADVANTAGES	AGE AND YEARS OF SCHOOLING										TOTAL	
	AGE						YEARS OF SCHOOLING				No.	%
	15-19	20-24	25-29	30-39	40-49	50 or +	0-3	4-5	6-8	9 or +		
ADVANTAGES:												
NO HARMFUL EFFECTS	0.0	11.3	15.9	17.7	12.8	4.4	8.3	4.1	9.3	16.6	93	14.3
PRACTICAL	9.1	14.4	13.4	12.4	13.8	15.6	33.3	8.2	14.8	13.0	87	13.3
SAFE	54.5	49.5	45.7	38.9	32.1	42.2	25.0	57.1	47.2	39.1	271	41.6
PROPHYLACTIC	63.6	29.9	26.2	32.3	40.4	42.2	16.7	32.7	33.3	33.3	215	33.0
OCCASIONAL	9.1	5.2	6.1	4.9	7.3	8.9	0.0	2.0	5.6	6.6	39	6.0
ECONOMIC	9.1	4.1	6.1	3.5	3.7	4.4	8.3	6.1	4.6	4.1	29	4.4
OTHER	0.0	4.1	2.4	2.7	5.5	0.0	0.0	2.0	1.9	3.5	20	3.1
NUMBER OF CASES:	11	97	164	226	109	45	12	49	108	483	652	100.0
DISADVANTAGES:												
NOT EFFECTIVE	36.4	16.8	20.4	16.6	14.8	8.9	0.0	10.2	12.3	19.3	110	17.1
INCOMFORTABLE	18.2	20.0	30.9	28.3	21.3	17.8	16.7	24.5	21.7	26.8	165	25.6
PSYCHOLOGICAL EFFECTS	36.4	14.7	14.2	22.4	30.6	22.2	33.3	12.2	16.0	22.4	134	20.8
PHYSICAL EFFECTS	18.2	14.7	21.0	13.9	14.8	6.7	0.0	10.2	11.3	17.4	100	15.5
OTHER	27.3	37.9	29.6	29.1	26.9	26.7	33.3	22.4	32.1	30.2	193	30.0
NUMBER OF CASES:	11	95	162	223	108	45	12	49	106	477	644	100.0

TABLE VI.4-3

KNOWLEDGE, USE AND PERCEPTION OF BRANDS AMONG THOSE WHO KNEW AND HAD PURCHASED CONDOMS, BY BRAND. CALI, 1987.

BRAND	KNOWLEDGE, USE AND PERCEPTION OF BRANDS								
	% WHO HAD HEARD OF BRAND		OF THOSE WHO KNEW BRAND, % WHO HAD EVER PURCHASED IT	PERCEIVED STRENGTH			PERCEIVED QUALITY		
	No.	%		A LOT	LITTLE	NONE	VERY GOOD	GOOD	FAIR/BAD
TAHITI	293	45.0	94.2	80.4	18.2	1.4	24.4	60.8	14.8
STIMULA	64	9.9	95.3	70.3	25.0	4.7	25.0	50.0	25.1
SULTAN	43	6.6	88.1	62.5	35.0	2.5	17.5	47.5	35.0
PRIME	19	2.9	88.9	66.7	22.2	11.1	11.1	61.1	27.8
ROSETEX	52	8.0	92.3	70.6	15.7	13.7	29.4	45.1	25.5
NUDA	16	2.5	87.5	40.0	33.3	26.7	20.0	26.7	53.3
CONTURE	24	3.7	87.0	72.7	13.6	13.6	13.6	59.1	27.3
JELLIA	30	4.6	93.1	67.9	25.0	7.1	25.0	57.1	17.9
MILLION	12	1.8	75.0	81.8	9.1	9.1	18.2	63.6	18.2
LOVE	50	7.7	93.8	73.5	16.3	10.2	20.4	49.0	30.6
PARADISE	30	4.6	78.6	72.0	24.0	4.0	28.0	48.0	24.0
OTHER	17	2.8	93.8	43.8	43.8	12.5	31.3	18.8	50.0

TABLE VI.4-4

PERCEIVED CHARACTERISTICS OF A GOOD CONDOM AND PREFERENCES IN CONDOM PACKAGE

PERCEIVED CHARACTERISTICS AND PACKAGING PREFERENCES	PERCENT MENTIONING	NUMBER OF CASES
PERCEIVED CHARACTERISTICS		
STRONG	24%	146
LUBRICATED	14.3	87
SOFT	13.3	81
THIN	5.8	35
PREFERRED PACKAGE		
BOXES	33.2	202
STRIPS	3.6	22
UNITS	28.6	174
OTHER	0.4	2
INDIFFERENT	34.2	208
NUMBER OF UNITS PREFERRED		
1-2	46.2	184
3-4	41.5	165
5-6	8.4	33
7-+	3.9	15
MISSING	-	211
BRAND PREFERENCES		
PURCHASE BY BRAND	15.1	92
BRAND NOT IMPORTANT	84.9	516
TOTAL	100.0	608

TABLE VI.4-5

DISTRIBUTION OF MALE CONDOM EVER-USERS AND USERS IN THE LAST SIX MONTHS BY TYPE OF USE AND DATE OF SURVEY. CALI, 1984-1987.

TYPE OF USE	DATE OF SURVEY			
	AUGUST 1984	MAY 1985	MAY 1987	
	EVER-USERS	EVER-USERS	EVER-USERS	LAST 6 MONTHS
TYPE OF USE:				
AS CONTRACEPTIVE	84.3	84.5	81.5	79.0
AS PROPHYLACTIC	2.6	3.1	3.2	3.1
BOTH WAYS	10.6	8.1	14.2	17.9
OTHER	2.5	4.3	1.1	0.0
TOTAL	100.0	100.0	100.0	100.0
NUMBER OF CASES:	888	1,348	654	262

TABLE VI.4-6

PERCENT OF MALES WHO HAD USED CONDOMS AND FELT SATISFIED, INCOME, AGE AND DATE OF SURVEY. CALI, 1984-1987.

INCOME AND AGE	DATE OF SURVEY		
	AUGUST 1984	MAY 1985	MAY 1987
INCOME:			
LESS THAN $ 15.000	28.4	32.6	100.0
$15.001 - $ 30.000	30.8	39.6	43.0
$30.001 - $ 60.000	26.5	37.4	44.4
$60.001 - $100.000	20.0	38.9	45.8
MORE THAN $100.000	16.7	36.4	56.7
A G E:			
15 - 19	8.3	9.1	36.4
20 - 24	26.0	37.4	41.2
25 - 29	29.2	38.5	45.1
30 - 34	25.1	39.3	45.7
35 - 39	30.8	37.7	44.3
40 - 44	31.3	35.1	50.7
45 - 49	30.3	40.4	56.4
50 or +	26.8	40.4	63.0
TOTAL	28.0	38.0	46.9
NUMBER OF CASES:	249	513	307

TABLE VI.4-7

REASONS FOR SATISFACTION AND DISSATISFACTION WITH CONDOM USE, AND PROBLEMS WITH CONDOM USE

SATISFACTION AND PROBLEMS	PERCENT	NUMBER OF CASES
SATISFACTION WITH CONDOMS		
Y E S	46.7	302
- Does not affect sensibility	56.7	174
- Contraceptive safety	21.5	66
- It is a contraceptive	13.4	41
- Other reasons	6.8	21
N O	53.3	344
- Loss of feeling	54.8	190
- Uncomfortable	26.2	91
- No direct ejaculation	4.0	14
- Other reasons	14.1	49
T O T A L		
HAVE HAD PROBLEMS WITH USE		
	15.9	103
- Has broken	69.9	72
- Too tight	4.9	5
- Slips off	6.8	7
- Other reasons	18.4	19
TOTAL	100.0	646

TABLE VI.5-1

PERCENT OF RESPONDENTS WHO HAD HEARD OF AIDS BY AGE AND YEARS OF SCHOOLING. MALES IN CALI AND EVER-MARRIED WOMEN IN CUNDINAMARCA AND SANTANDER, 1987

AGE AND YEARS OF SCHOOLING	GEOGRAPHIC REGION		
	CALI	CUNDINAMARCA	SANTANDER
AGE			
15-19	97.7	86.0	85.7
20-29	99.3	95.0	89.5
30-39	99.2	94.7	89.0
40-49	98.6	88.3	84.5
YEARS OF SCHOOLING			
0-3	89.7	85.8	78.2
4-5	97.8	93.4	89.6
> 6	98.2	98.6	97.7
ENTIRE SAMPLE	99.0	92.8	87.9

TABLE VI.5-2

PERCENT OF THOSE WHO HAD HEARD OF AIDS WHO CORRECTLY MENTIONED DIFFERENT BEHAVIORS AS MEANS OF TRANSMISSION OF AIDS, BY KIND OF BEHAVIOR. MALES IN CALI AND FEMALES IN CUNDINAMARCA AND SANTANDER, 1987

	GEOGRAPHICAL REGION		
BEHAVIOR	CALI \1\	CUNDINAMARCA \2\	SANTANDER \2\
SEX WITH INFECTED PERSON	79.3	-	-
HOMOSEXUAL SEX	-	95.3	96.0
HETEROSEXUAL SEX	-	91.5	94.2
TRANSFUSIONS	27.2	85.3	86.6
SHARING NEEDLES	11.6	94.1	95.5
BIRTH	1.6	-	-

\1\ Open ended question.
\2\ Direct questions.

TABLE VI.5-3

PERCENT OF THOSE WHO HAD HEARD OF AIDS WHO INCORRECTLY MENTIONED DIFFERENT BEHAVIORS AS MEANS OF TRANSMISSION. MALES IN CALI AND FEMALES IN CUNDINAMARCA AND SANTANDER, 1987

BEHAVIOR	GEOGRAPHIC REGION		
	CALI \1\	CUNDINAMARCA \2\	SANTANDER \2\
INSECT BITES	-	72.0	71.4
ANIMAL BITES	-	68.1	64.6
BREATHING AIR OF INFECTED PERSON	-	73.8	73.2
TOUCHING OR SHAKING HANDS WITH INFECTED PERSON	-	63.9	65.2
ANY INCORRECT ANSWER	41.9	-	-

\1\ Open ended question.
\2\ Direct question.

TABLE VI.5-4

PERCENT OF THOSE WHO HAD HEARD OF AIDS WHO KNEW OTHER BASIC FACTS ON AIDS. EVER-MARRIED WOMEN IN CUNDINAMARCA AND SANTANDER, 1987

BASIC FACTS	DEPARTMENT	
	CUNDINAMARCA	SANTANDER
THERE ARE WAYS TO KNOW IF PERSON IS INFECTED WITH HIV	47.3	58.6
MENTIONED LAB EXAM	30.9	44.0
A PERSON CAN LOOK HEALTHY AND BE INFECTED WITH HIV	64.1	82.4
AIDS CANNOT BE CURED	53.9	54.4
THERE IS NO VACCINE AGAINST AIDS	56.2	50.7
REPORTED KNOWING SOMEONE WITH AIDS	0.9	1.8

TABLE VI.5-5

PERCENT OF THOSE WHO HAD HEARD OF AIDS WHO MENTIONED DIFFERENT PREVENTIVE BEHAVIORS OF AIDS \1\ MALES IN CALI AND FEMALES IN CUNDINAMARCA AND SANTANDER, 1987

	GEOGRAPHIC REGION		
BEHAVIOR	CALI	CUNDINAMARCA	SANTANDER
USE OF CONDOMS	22.9	5.8	7.1
SINGLE PARTNER	15.0	36.4	33.9
ABSTINENCE	7.8	8.7	14.7
AVOID TRANSFUSIONS	9.1	34.5	16.4
AVOID SHARING NEEDLES	5.9	5.9	18.2
AVOID HOMOSEXUAL RELATIONS	3.4	26.3	12.6
AVOID SEX WITH PROSTITUTES	36.8	8.1	19.5
OTHER NOT CORRECT	35.3	-	-

\1\ Open ended question.
\2\ Incorrect answers were field coded only in Cali.

TABLE VI.5-6

MEAN AIDS KNOWLEDGE SCORE AMONG EVER-MARRIED WOMEN OF FERTILE AGE IN CUNDINAMARCA AND SANTANDER BY SOCIODEMOGRAPHIC VARIABLES AND EXPOSURE TO MASS MEDIA

SOCIODEMOGRAPHIC VARIABLES AND EXPOSURE TO MASS MEDIA	DEPARTMENT			
	CUNDINAMARCA		SANTANDER	
	N	X*	X*	N
AGE				
15-19	43	4.0	4.0	63
20-29	338	4.7	4.5	446
30-39	337	4.6	4.5	400
40-49	248	4.1	4.1	297
YEARS OF SCHOOLING				
0-3	316	3.9	3.6	473
4-5	303	4.4	4.4	297
> 6	346	5.1	5.2	426
RADIO				
0 DAYS/WEEK	84	4.0	3.6	180
1-6 DAYS/WEEK	110	4.1	4.0	131
7 DAYS/WEEK	772	4.6	4.6	894
TELEVISION				
0 DAYS/WEEK	229	3.6	3.3	366
1-6 DAYS/WEEK	73	4.7	4.5	97
7 DAYS/WEEK	664	4.8	4.9	739
NEWSPAPERS				
NEVER READS	464	4.0	3.7	554
READS 1-5 DAYS/MONTH	363	4.8	4.8	443
READS > 5 DAYS/MONTH	139	5.3	5.2	207
MAGAZINES				
NEVER READS	555	4.1	3.9	733
READS 1-2/MONTH	194	5.0	5.0	222
READS > 2/MONTH	217	5.2	5/2	251
ENTIRE SAMPLE	966	4.5	4.4	1206

* Out of a possible 11 correct answers.

TABLE VI.6-1

METHOD CURRENTLY USED BY SOURCE OF SUPPLY AND DEPARTMENT
MIDPOINT SURVEY. CUNDINAMARCA AND SANTANDER, 1986

METHOD USED AND DEPARTMENT	SOURCE OF SUPPLY						
	HOSPITAL/ HEALTH POST/ PROMOTER	DRUGSTORE	PROFAMILIA CBD POST/ CLINIC	PRIVATE CLINIC OR PHYSICIAN	OTHER	TOTAL No.	TOTAL %
CUNDINAMARCA:							
- PILL	9.8	80.3	9.0	0.0	0.9	6,011	100.0
- CONDOM	4.3	88.6	7.1	0.0	0.0	905	100.0
- INJECTABLE	0.0	91.2	0.0	2.7	6.1	1,051	100.0
- VAGINALS	0.0	92.9	7.1	0.0	0.0	916	100.0
- IUD	63.6	0.0	26.8	8.2	1.4	5,458	100.0
- STERILIZATION	78.5	0.0	16.0	5.5	0.0	6,432	100.0
SANTANDER:							
- PILL	14.0	82.9	1.7	0.0	0.5	5,468	100.0
- CONDOM	0.0	83.4	0.0	0.0	16.6	440	100.0
- INJECTABLE	30.8	69.2	0.0	0.0	0.0	1,125	100.0
- VAGINALS	6.0	93.4	0.6	0.0	0.0	1,524	100.0
- IUD	58.2	0.0	23.3	14.4	4.1	7,482	100.0
- STERILIZATION	60.0	0.0	21.8	12.8	5.4	9,935	100.0

TABLE VI.6-2

DISTRIBUTION OF IUD USERS ACCORDING TO PLACE OF INSERTION, DEPARTMENT AND DIFFERENT INDICATORS OF QUALITY OF CARE. MIDPOINT SURVEY CUNDINAMARCA AND SANTANDER, 1986

QUALITY OF CARE INDICATORS	PLACE OF INSERTION OF IUD					
	HOSPITAL/ HEALTH POST		PROFAMILIA		PRIVATE CLINIC OR PHYSICIAN	
	C/MARCA	SANTANDER	C/MARCA	SANTANDER	C/MARCA	SANTANDE
HAVE GONE TO OTHER PLACE FOR SUBSEQUENT FOLLOW UPS:	8.9	7.5	18.1	9.9	19.8	9.7
WERE NOT EXPLAINED HOW INSERTION WAS MADE:	41.8	30.7	23.6	34.8	16.2	25.5
WERE NOT ATTENDED QUICKLY:	2.6	7.1	8.4	17.7	0.0	5.8
WERE NOT EXPLAINED HOW TO CHECK IF IUD WAS ON PLACE:	45.4	39.4	41.3	51.4	28.3	39.6
THE SERVICE SEEMED:						
- VERY GOOD	8.7	14.1	17.5	9.4	7.6	29.3
- GOOD	84.2	75.8	79.8	82.3	92.4	69.5
- FAIR	6.1	10.1	2.7	8.4	0.0	0.0
- BAD	1.0	0.0	0.0	0.0	0.0	1.1
T O T A L	100.0	100.0	100.0	100.0	100.0	100.0
NUMBER OF CASES	3474	4358	1461	1742	445	1077

TABLE VI.6-3

SATISFACTION AND ACCESSIBILITY OF SOURCE OF SUPPLY FOR CURRENT CONTRACEPTIVE USERS (EXCLUDING IUD AND STERILIZATION) BY CONTRACEPTIVE SOURCE AND DEPARTMENT. MIDPOINT SURVEY

	HOSPITAL/ HEALTH POST	MOH PROMOTER	DRUGSTORE	PROFAMILIA/ CBD POST	PRIVATE CLINIC/ PHYSICIAN
% WHO PLANNED TO RETURN TO SOURCE					
CUNDINAMARCA	100.0	100.0	95.9	90.9	100.0
SANTANDER	100.0	100.0	99.6	100.0	100.0
% WHO HAD FOUND STOCK-OUTS					
CUNDINAMARCA	40.2	100.0	41.5	55.6	100.0
SANTANDER	45.6	50.0	31.2	0.0	0.0
NUMBER OF CASES					
CUNDINAMARCA	570	59	7482	668	28
SANTANDER	1103	100	7104	142	27

TABLE VI.6-4

CONTRACEPTIVE SOURCE SWITCHING BY METHOD USED BEFORE CURRENT METHOD AND BY DEPARTMENT. MIDPOINT SURVEY. CUNDINAMARCA AND SANTANDER, 1986

SOURCE SWITCHING	METHOD USED PREVIOUSLY BEFORE CURRENT METHOD				
	PILL	CONDOM	IUD	INJECTABLE	VAGINALS
CUNDINAMARCA:					
- NEVER SWITCHED	93.4	100.0	90.7	100.0	100.0
- SWITCHED SOURCE	6.6	0.0	9.3	0.0	0.0
- NUMBER OF CASES	1,724	113	1,266	447	571
SANTANDER:					
- NEVER SWITCHED	93.3	100.0	89.5	91.9	100.0
- SWITCHED SOURCE	6.7	0.0	10.5	8.1	0.0
- NUMBER OF CASES	2,732	105	1,324	619	741

TABLE VI.6-7

CONTINUITY OF USE OF LAST METHOD USED BEFORE PREGNANCY OF LAST CHILD BY SOURCE OF SUPPLY OF LAST METHOD. MIDPOINT SURVEY. CUNDINAMARCA AND SANTANDER, 1986

	CONTINUITY OF USE OF LAST METHOD BEFORE LAST CHILD						
	1 MONTH	3 MONTHS	6 MONTHS	9 MONTHS	12 MONTHS	2 YEARS	No.
CUNDINAMARCA:							
SOURCE OF SUPPLY OF LAST METHOD:							
- HOSPITAL/HEALTH POST/ PROMOTER	90.7	68.0	66.9	58.9	49.2	37.5	2,208
- DRUGSTORE	95.5	81.2	74.5	65.5	49.6	30.9	6,061
- PROFAMILIA CLINIC/ CBD POST	100.0	88.7	75.5	58.6	45.1	27.7	711
- PRIVATE CLINIC OR PHYSICIAN	100.0	78.3	78.3	78.3	51.9	41.1	314
- FRIEND OR NEIGHBOR/ OTHER	100.0	83.9	33.0	33.0	33.0	0.0	118
SANTANDER:							
SOURCE OF SUPPLY OF LAST METHOD:							
- HOSPITAL/HEALTH POST/ PROMOTER	98.8	92.1	87.7	80.2	62.3	33.8	1,805
- DRUGSTORE	93.0	80.7	66.5	62.3	50.9	29.1	6,187
- PROFAMILIA CLINIC/ CBD POST	93.3	86.1	82.0	82.0	72.8	31.5	1,056
- PRIVATE CLINIC OR PHYSICIAN	100.0	84.8	84.8	50.0	40.0	25.1	529
- FRIEND OR NEIGHBOR/ OTHER	59.1	59.1	31.8	4.5	4.5	4.5	66

TABLE VI.6-8

SATISFACTION AND ACCESSIBILITY OF SOURCE OF SUPPLY OF CURRENT CONTRACEPTIVE USERS, PILL, CONDOM, VAGINAL AND INJECTABLES BY DEPARTMENT. ENDLINE SURVEY

	DEPARTMENT	
	CUNDINAMARCA	SANTANDER
% WHO PLANNED TO RETURN TO SOURCE	100.0	97.2
% WHO HAD RECEIVED VERY GOOD OR GOOD ATTENTION IN SOURCE	98.5	98.8
% WHO FOUND STOCK-OUTS IN SOURCE	27.9	27.5
TRAVEL TIME FROM HOUSE TO SOURCE:		
0-10 minutes	45.3	47.8
11-20 minutes	17.2	11.9
21-30 minutes	14.2	14.4
31-60 minutes	14.6	10.8
61-120 minutes	7.2	10.4
> 120 minutes	1.5	4.7
MODE OF TRAVEL TO SOURCE		
Walking	69.3	70.0
Bus	16.6	17.0
Car/taxi	8.0	10.2
Other	6.1	2.8
NUMBER OF CASES	7798	8357

TABLE VI.6-11

CONTINUITY OF USE OF PREVIOUS METHOD BEFORE CURRENT METHOD BY METHOD PREVIOUSLY USED AND BY DEPARTMENT. MIDPOINT SURVEY. CUNDINAMARCA AND SANTANDER, 1986

METHOD USED PREVIOUSLY	CONTINUITY OF USE OF PREVIOUS METHOD						
	1 MONTH	3 MONTHS	6 MONTHS	9 MONTHS	12 MONTHS	2 YEARS	No.
CUNDINAMARCA:							
- PILL	86.7	75.8	55.7	47.2	38.1	23.4	1,891
- CONDOM	57.5	57.5	57.5	57.5	57.5	0.0	113
- IUD	82.3	75.4	60.5	54.6	48.1	32.9	1,334
- INJECTABLE	100.0	73.6	59.7	44.5	28.2	17.7	447
- VAGINALS	76.5	41.2	36.3	36.3	13.8	9.2	571
SANTANDER:							
- PILL	93.3	88.9	76.8	70.6	46.3	32.5	2,717
- CONDOM	100.0	52.4	41.0	41.0	41.0	41.0	105
- IUD	91.8	82.2	71.0	70.1	61.1	51.1	1,324
- INJECTABLE	100.0	88.3	70.7	70.7	30.6	9.4	619
- VAGINALS	93.1	73.9	73.9	70.3	50.7	33.5	741

TABLE VI.6-12

REASONS FOR STOPPING USE OF PREVIOUS METHOD BY METHOD PREVIOUSLY USED AND DEPARTMENT. MIDPOINT SURVEY. CUNDINAMARCA AND SANTANDER, 1986.

REASONS FOR STOPPING USE	METHOD USED PREVIOUSLY				
	PILL	CONDOM	IUD	INJECTABLE	VAGINALS
CUNDINAMARCA:					
- LACK OF CONTRACEPTIVE PROTECTION	3.8	23.0	15.7	7.6	37.7
- OPPOSITION OF HUSBAND	0.0	0.0	0.0	0.0	0.0
- MEDICAL REASON	0.7	0.0	4.3	19.9	0.0
- SECONDARY EFFECTS	78.2	0.0	69.5	53.2	4.9
- METHOD NOT AVAILABLE	0.0	0.0	0.0	0.0	10.9
- DIFFICULT TO USE	0.0	24.8	2.5	0.0	16.5
- HEALTH PROBLEMS	2.7	0.0	0.0	7.8	2.1
- OTHER	14.5	52.2	7.9	11.4	28.0
T O T A L	100.0	100.0	100.0	100.0	100.0
NUMBER OF CASES	1891	167	1334	447	571
SANTANDER:					
- LACK OF CONTRACEPTIVE PROTECTION	1.4	59.0	16.2	0.0	33.9
- SEX INFREQUENT	0.8	0.0	0.0	0.0	0.0
- OPPOSITION OF HUSBAND	0.0	0.0	0.0	0.0	16.3
- MEDICAL REASON	5.2	0.0	16.2	9.5	0.0
- SECONDARY EFFECTS	71.2	0.0	36.7	58.0	9.6
- METHOD NOT AVAILABLE	0.8	0.0	0.0	0.0	2.8
- EXPENSIVE	0.0	0.0	0.0	9.5	0.0
- DIFFICULT TO USE	3.1	41.0	0.0	14.9	13.8
- HEALTH PROBLEMS	5.5	0.0	22.8	8.1	0.0
- PREGNANCY	1.0	0.0	0.0	0.0	17.5
- OTHER	11.1	0.0	8.1	0.0	6.1
T O T A L	100.0	100.0	100.0	100.0	100.0
NUMBER OF CASES	2732	105	1324	619	741

TABLE VI.6-13

REASONS FOR STOPPING USE OF LAST METHOD, BY DEPARTMENT. CURRENT NON-USERS, BASELINE SURVEY, 1984

REASONS	DEPARTMENT	
	CUNDINAMARCA	SANTANDER
PREGNANCY/FAILURE	24.8	21.8
SIDE EFFECTS	15.1	24.4
HEALTH PROBLEMS	5.6	0.2
MENOPAUSE	3.8	2.5
NO SEX	14.2	13.9
ECONOMIC REASONS	3.0	0.3
WANTED ANOTHER CHILD	15.9	20.5
MEDICAL REASONS	3.6	3.1
UNCOMFORTABLE/DID NOT LIKE	4.1	8.0
RELIGION	3.5	0.2
OTHER	6.4	5.1
TOTAL	100.0	100.0
NUMBER OF CASES	14629	10901

TABLE VI.6-14

REASONS FOR NEVER HAVING USED AND NOT CURRENTLY USING CONTRACEPTIVE METHODS BY DEPARTMENT BASELINE SURVEY, 1984

REASONS FOR NEVER HAVING USED	DEPARTMENT	
	CUNDINAMARCA	SANTANDER
FEAR OF SIDE EFFECTS	9.1	13.3
DESIRES FOR CHILD	24.9	23.1
THEY WERE NOT USING BEFORE (Traditionalism)	9.9	8.4
IGNORANCE	11.2	10.9
LACK OF INFORMATION	7.9	8.0
OPPOSITION OF HUSBAND	7.0	7.1
JUST MARRIED	7.1	9.5
INFERTILITY	6.9	2.3
OPPOSES FAMILY PLANNING	11.4	12.0
OTHER	4.6	5.4
TOTAL	100.0	100.0
NUMBER OF CASES	10072	11929

TABLE VI.6-15

HUSBANDS' PERCEPTION OF FAMILY PLANNING USE BY DEPARTMENT. BASELINE SURVEY, 1984

HUSBANDS' PERCEPTION OF FAMILY PLANNING USE	DEPARTMENT			
	CUNDINAMARCA		SANTANDER	
	N	%	N	%
WAS HUSBAND AWARE OF USE?				
Yes	32130	96.2	21777	97.1
No	900	2.7	640	2.9
Did not know	376	1.1	-	-
DID HUSBAND AGREE WITH USE				
Yes	29433	88.1	21185	94.5
No	3047	9.1	1080	4.8
Did not know	926	2.8	152	0.7
TOTAL	33406	100.0	22417	100.0
REASONS FOR NOT AGREEING				
Fear of side-effects	980	32.2	405	37.5
Wanted another children	375	12.3	149	13.8
Not safe	160	5.3	53	4.9
Incomprehensive	269	8.8	142	13.1
Lack of satisfaction	12	0.4	52	4.8
Feared unfaithfulness	341	11.2	12	1.1
Disagreed with methods	577	18.9	188	17.4
Other	333	10.9	79	7.3
TOTAL	3047	100.0	1080	100.0

FIGURE 1

MAP OF COLOMBIA WITH PROJECT AREAS IDENTIFIED

FIGURE 1

MAP OF COLOMBIA

U.S. DEPARTMENT OF COMMERCE Bureau of the Census

Names and boundary representation are not necessarily authoritative

BEST AVAILABLE COPY

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FIGURE 2

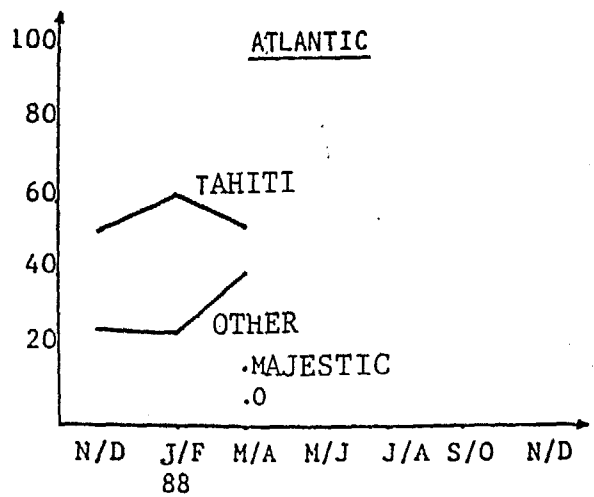
CONDOMS: COMPARATIVE DISTRIBUTION ANALYSIS BY REGION
NOVEMBER 1987/APRIL 1988

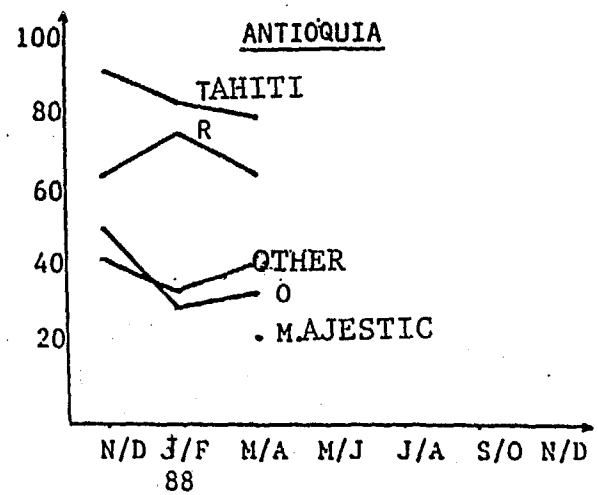
FIGURE 2

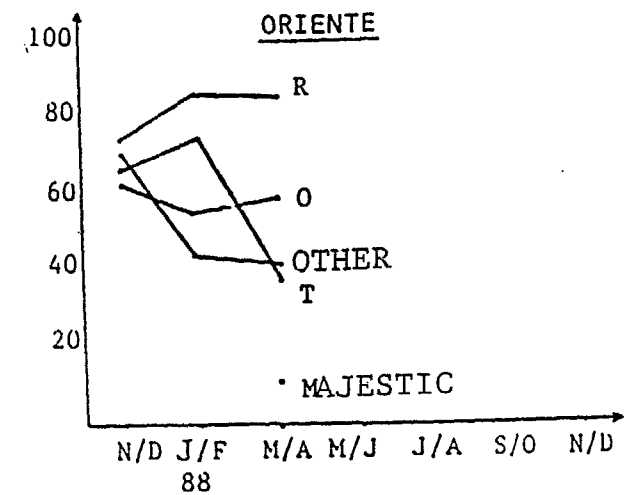
CONDOMS: COMPARATIVE DISTRIBUTION ANALYSIS BY REGION

November 1987/April 1988

WEIGHTED







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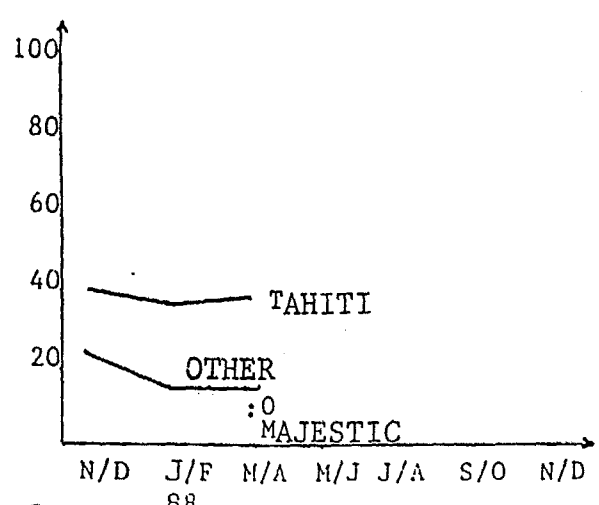
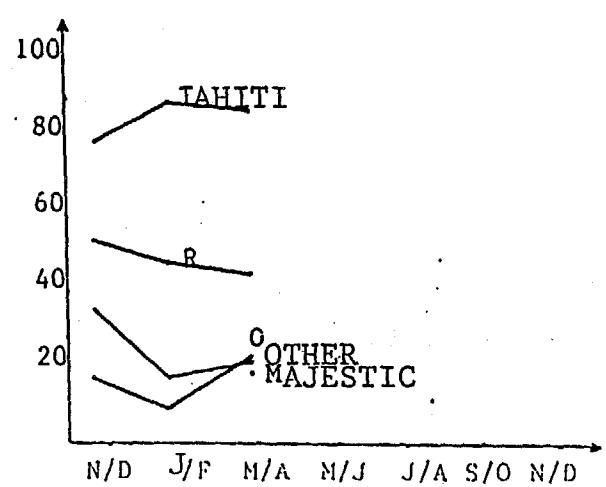




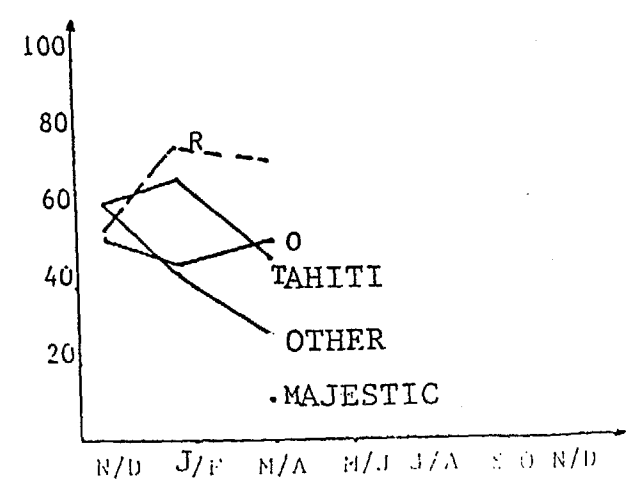


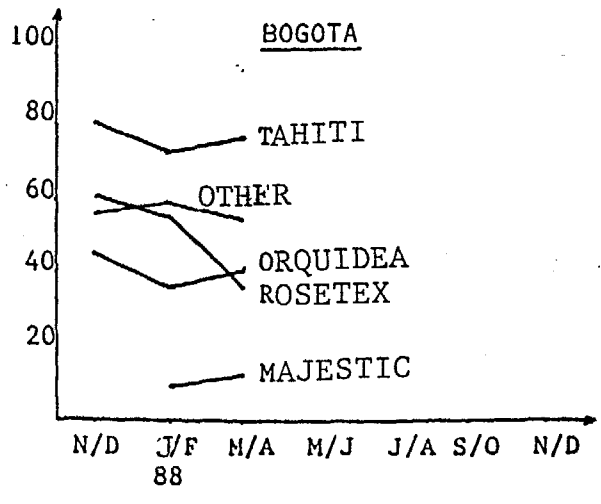
FIGURE 2

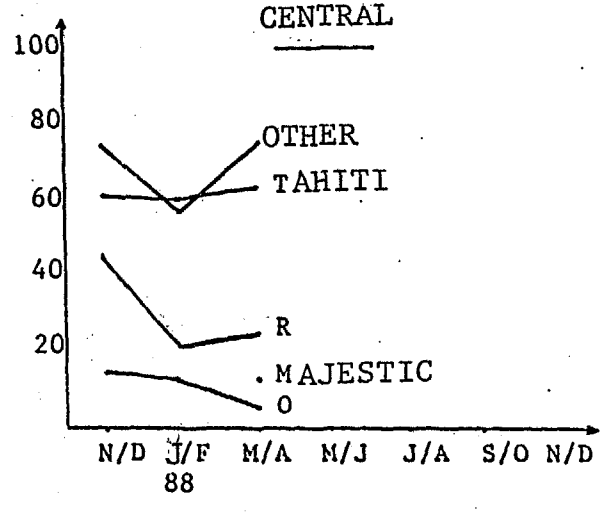
(CONTINUATION)

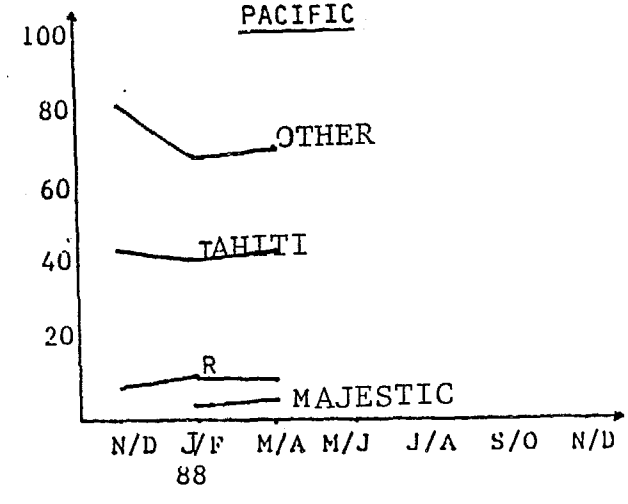
CONDOMS: COMPARATIVE DISTRIBUTION ANALYSIS BY REGION

November 1987/April 1988

WEIGHTED







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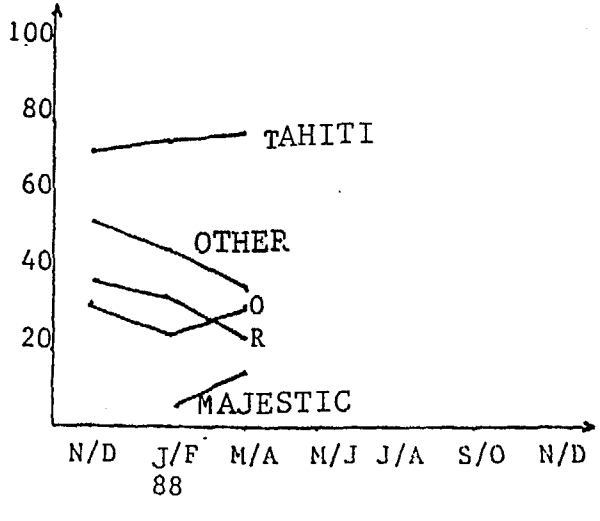

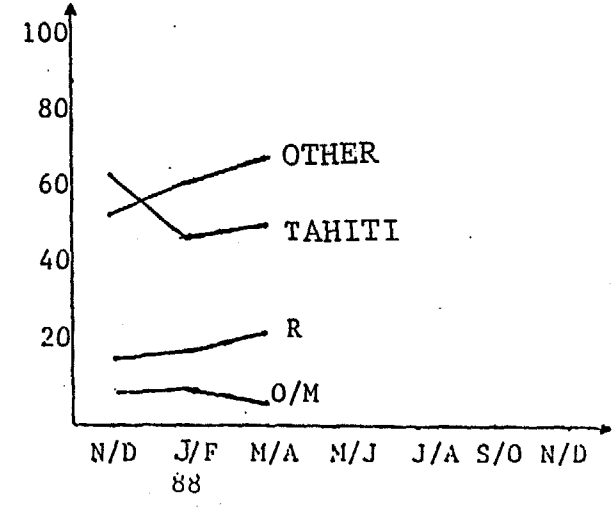

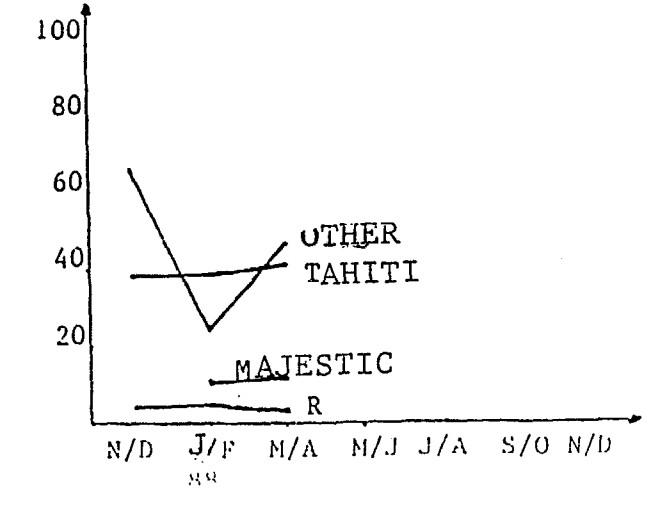

FIGURE 3

QUALITY OF CARE ITEMS TESTED AS PREDICTORS OF SUPPLIER COMPETENCE AND ACCEPTABILITY

FIGURE 3

QUALITY OF CARE ITEMS TESTED AS PREDICTORS OF SUPPLIER COMPETENCE AND ACCEPTABILITY OF CBD PROGRAM SERVICES

QUALITY OF CARE VARIABLES

LEVEL OF ANALYSIS	SOCIO-DEMOGRAPHIC	CHOICE OF METHOD	INFORMATION	CLIENT/PROVIDER RELATIONSHIP	PROVIDER COMPETENCE	ACCEPTABILITY
PERSONAL	Age, sex, marital status, years of schooling, with children, current and ever use of contraceptives.		+ Use of brochure and showcase to explain contraception. + Other motivational activities in community.	+ Proportion of clients advised by distributor + Purchase of different brand of pill and condoms if clients brand is unavailable.	Knowledge of contraceptive use: pills, condoms, female and male sterilization, IUD, rhythm.	
CBD POST/PROGRAM	Help from others to sell contraceptives.	+ Number of contraceptives sold + Availability of pills, condoms, vaginals, injectables at post + Perception of post as most important source for pills and condoms.	+ Availability of brochure, Profamilia sign and contraceptive show case on display at post. + Engagement of instructor in-house visits and educational talks in community. + Perceived reception of Profamilia radio spots in community.		Has had training. Years as distributor. Knowledge of Profamilia.	Sales of pills, condoms, vaginals, couple-years of protection.
COMMUNITY	Urbanization, population.	- Availability of Profamilia clinic, other CBD post, drugstore, hospital/health post, private physician/clinic, Social Security, other. - Number of alternative sources available in community				

APPENDIX 1

INVOICE FOR CONTRACEPTIVE SALES

PROFAMILIA

NIT 60 013.779

FACTURA No. 68850

2. Centro: _____ 3. Fecha: Año Mes Día 4. Puesto No. _____

5. Nombre Distribuidor/Comprador: _____ C.C. o NIT. _____

6. Dirección: _____ Barrio: _____ Municipio: _____

Tel. _____ Corregimiento: _____ 7. Clase de Establecimiento: _____

8. Tipo de Cliente: 8.1. Pto. Distrib. Consignación ☐ Contado ☐

8.2. Otros ☐ Forma de Pago: _____ Vencimiento: _____

9.

a			b	c	d	e	f	g	h	i
PRODUCTOS			Exist. Ant.	Inventario	Ventas	V/r. Unit.	V/r. Venta	Nva. Entrg.	Reintegro	Nva. Existen
01015801	EUGYNON	02								
01015802	MICROGYNON CD	05								
01015803	MICROGYNON 21	06								
01015804	NEOGYNON 21	03								
01015805	NEOGYNON CD	04								
01016201	NORIDAY	01								
01017001	NORAL 21	08								
01017002	NORAL 28	07								
01017003	NORDETTE 21	17								
01017004	NORDETTE 28	18								
01020602	TAHITI - TIRAS	09								
01020603	TAHITI-EMPACADO	20								
01020604	SULTAN	19								
01032402	NEO-SAMPOON - TUBOS	11								
01032403	NEO-SAMPOON - TABLE.	12								
10274501	PIRANTEL	16								
10274503	GAMAX	13								

10. TOTAL $ _____

12. Cancelado en: Efectivo $ _____

Cheque $ _____

11. NOTA: Por ventas de contado utilizar columnas d e f

Recibo de Caja No. _____

13. La presente FACTURA CAMBIARIA DE COMPRAVENTA se asimila a una LETRA DE CAMBIO conforme a lo dispuesto en el Numeral 6 del Artículo 774 del Código de Comercio.

En caso de mora nos comprometemos a pagar y reconocemos en favor de PROFAMILIA un interés del 3% mensual. Expresamente declaramos que las firmas que aparecen en este título valor son auténticas, representan legalmente al comprador por autorización del mismo y obligan el pago del valor de las obligaciones contraídas en el mismo.

14. Observaciones: _____

15. Recibí Distribuidor/Comprador

16. Nombre Instructor(a)

1.200X20X5-3-87

CLIENTE

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APPENDIX 2

CLINICAL HISTORY

CENTRO | NUMERO
1 2 3 4 5 6 7

PROFAMILIA
HISTORIA BASICA

DATOS BASICOS

DIA (8 9) MES (10 11) AÑO (12 13)

Nombre (s)_____ 1er. Apellido_____ 2o. Apellido (o de casada) _____

Dirección _____ Ciudad _____ Teléfono _____

Edad (años cumplidos) (14 15) Escolaridad (años aprobados) (16 17) Número de Hijos actualmente vivos (18 19)

Uso Anticonceptivo Previo: Si 1 → Ultimo Método Usado (ver código métodos) (21); No 2 (20)

Desea más Hijos: Si 1; No 2 (22)

Zona de Residencia: Urbana 1; Rural 2 (23)

HISTORIA CLINICA

Método deseado (Ver código) (24) Método Adoptado (ver código) (25) Atendida por (ver código) (26)

Tensión Arterial Máxima / Mínima

Examen Ginecológico: No Efectuado ☐ Normal ☐ Anormal ☐ Especifique: _____

Peso (en Kilogramos)

Fecha última menstruación (DIA MES AÑO) Fecha último parto / aborto (DIA MES AÑO)

CONTRAINDICACIONES: D. I. U. ☐ Píldora ☐ Esterilización ☐ Especifique: _____

ANTECEDENTES: _____

ESTERILIZACION

Dirección: _____ Ciudad: _____ Teléfono: _____

Cédula

Edad (años cumplidos) (27 28) Escolaridad (años aprobados) (29 30) Número Total de Embarazos (35 36)

Número de Hijos actualmente vivos (31 32) Número de Abortos (33 34)

Fecha Intervención (DIA MES AÑO 37 38 39 40 41 42) Método Quirúrgico (ver código) (43)

Nombres:
Cirujano _____
Anestesista _____
Alumno _____

Accidentes Quirúrgicos _____

Accidentes Anestésicos _____

Observaciones _____

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40

CODIGOS

METODOS:
1 Diu
2 Píldora
3 Ovulos, Jaleas, Espumas
4 Esterilización Masculina
5 Esterilización Femenina
6 Condón
7 Coito Interrupto
8 Ritmo
9 Inyección
0 Otro

ATENDIDA POR:
1 Médico
2 Enfermera
3 Auxiliar Enfermería

METODO QUIRURGICO:
1 Laparoscopia Bandas
2 Laparoscopia Cauterio
3 Laprocator
4 Minilaparatomía Ligadura
5 Minilaparatomía Bandas
6 Post-Parto
7 Otro Femenino
8 Vasectomía

EV - 002

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Controles

FECHA Día	Mes	Año	* Motivo Consulta (ver código)	* Anticonceptivo en uso. (ver cód. Métodos)	* Atendida por (ver código)	OBSERVACIONES	* Anticonceptivo con que sale (ver cod. Métodos)	* Citología	FECHA DE PROXIMA VISITA	SELLO DE LA PERSONA QUE LA ATENDIO.

CODIGO MOTIVO CONSULTA: 1 - Control Planificación Familiar 2 - Consulta Médica 3 - Otros

APPENDIX 3

DAILY CLINICAL RECORD

PROFAMILIA

INFORME DIARIO DE ACTIVIDADES

CENTRO	AÑO	MES

CONCEPTOS		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTALES
PRIMERA VEZ PLANIFICACION	D. I. U.																																
	ORALES																																
	ESTERILIZACION MASC.																																
	ESTERILIZACION FEM.																																
	OTROS METODOS																																
TOTAL PRIMERA VEZ																																	
CONTROLES PLANIFICACION	D. I. U.																																
	ORALES																																
	ESTERILIZACION MASC.																																
	ESTERILIZACION FEM.																																
	OTROS METODOS																																
TOTAL CONTROLES																																	
CIRUGIAS	VASECTOMIA																																
	MINILAPARATOMIA																																
	LAPAROSCOPIA																																
	OTRO METODO																																
TOTAL CIRUGIAS																																	
CITOLOGIAS	USUARIA																																
	PARTICULAR																																
TOTAL CITOLOGIAS																																	
PRUEBAS EMBARAZO	USUARIA																																
	PARTICULAR																																
	ESTERILIZACION																																
TOTAL PRUEBAS EMBARAZO																																	
OTROS:																																	

I. V. 006

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APPENDIX 4

MONTHLY CLINICAL RECORD

PROFAMILIA

INFORME MENSUAL DE ACTIVIDADES

Centro: _____ Mes ____ Año: ____

CONSULTAS DE PLANIFICACION	PRIMERA VEZ	CONTROL
Dispositivos		
Píldoras		
Esterilización Fem.		
Esterilización Masc.		
Otros Métodos		
TOTALES		

ESTERILIZACIONES	CENTRO	MOVIL
Laparoscopias		
Minilaparotomías		
Post-Parto		
Otros: _____		
Vasectomías		
TOTALES		

OTRAS CONSULTAS	NUMERO
Ginecología	
Infertilidad	
Prenatal	
Medicina General	
TOTAL	

LAPAROSCOPIAS DIAGNOSTICAS	

PRUEBAS DE EMBARAZO	NUMERO
Usuarias	
Particulares	
De Esterilización	
TOTAL	

OTRAS ACTIVIDADES	NUMERO
Frotis Vaginal Usuaria	
Frotis Vaginal Particular	
Biopsias	
Cauterizaciones	
Otras Cirugías	
Otras: _____	
Otras: _____	

CITOLOGIAS TOMADAS	NUMERO
Usuarias	
Particulares	
TOTAL	

INFORME DE CITOLOGIAS LEIDAS						
I-II	III	IV	V	Sin Grado	Otro	Total

OBSERVACIONES: _____

ELABORO _____ FECHA _____ Vo. Bo. DIRECTOR _____

EV-005 EVALUACION Lito 2001 - 60 L 50x2 - 26 - VIII/86

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APPENDIX 5

BASELINE SURVEY QUESTIONNAIRE

PROFAMILIA	PRIMERA ENCUESTA: SANTANDER, CUNDINAMARCA Y HUILA 1984 CUESTIONARIO DE HOGAR	CONFIDENCIAL FINES CIENTIFICOS

I. IDENTIFICACION DEL CUESTIONARIO

(101) Número del Cuestionario [ ][ ][ ][ ] 1 2 3 4

(102) Municipio _____ [ ][ ] 5 6

(103) Departamento [ ] 7

(104) Segmento [ ][ ] 8 9

(105) Zona 1. Urbana 2. Rural [ ] 10

(106) Número de Hogar [ ][ ][ ] 11 12 13

(107) Vereda _____ NOMBRE

(108) Encuestadora _____ NOMBRE 14 [ ][ ] 15 CODIGO

(109) Fecha de Entrevista Día Mes [ ][ ][ ][ ] 16 19

(110) Cuestionario [ ] de [ ]

II. PARA TODOS LOS MIEMBROS DEL HOGAR — 15 AÑOS y MAS

NUMERO DE ORDEN DE LA PERSONA	NOMBRES Y APELLIDOS	PARENTESCO	SEXO	EDAD	ESTADO CIVIL		ELEGIBILIDAD
	Por favor me puede decir el nombre de las personas que normalmente viven en este hogar, aunque no hayan dormido aquí anoche.	Cuál es el parentesco de (cada persona) _____ con el jefe del hogar? Jefe [1] Esposa [2] Hijos [3] Parientes [4] Otros [5]	Es hombre o mujer? Hombre [1] Mujer [2]	Cuántos años cumplidos tiene?	Ha estado casado o unido alguna vez? SI [1] (CONTINUE) NO [2] (PASE A LA SIGUIENTE PERSONA)	Cuál es su estado civil actual? Casado [1] Conviviente [2] Viudo [3] Separado o divorciado [4]	Numere la mujer elegible para la entrevista individual en orden consecutivo.
(201)	(202)	(203)	(204)	(205)	(206)	(207)	(208)
20-21		22	23	24-25	26	27	28
01							
02							
03							
04							
05							
06							
07							
08							
09							
10							
11							
12							
13							
14							
15							

(209) Número de personas en el hogar 29-30 [ ][ ]

(210) Número de mujeres elegibles 31 [ ]

(211) RESULTADO DE LA VISITA [1] Completa [2] Ningún adulto en casa [3] Casa desocupada [4] Rechazo [5] No es vivienda [6] Otro 32 [ ]

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PROFAMILIA	PRIMERA ENCUESTA: SANTANDER, CUNDINAMARCA Y HUILA 1984 CUESTIONARIO INDIVIDUAL	CONFIDENCIAL FINES CIENTIFICOS

A. IDENTIFICACION DEL CUESTIONARIO

CODIGOS

(101) Número de identificación — 1 [ ][ ][ ][ ][1] 5

(102) Municipio _____ — 6 [ ][ ] 7

(103) Departamento _____ — 8 [ ]

(104) Segmento [ ][ ] — 9 [ ][ ] 10

(105) Zona — Urbana [1] Rural [2] — 11 [ ]

(106) Número del hogar [ ][ ][ ] — 12 [ ][ ][ ] 14

(107) Nombre y número de orden de la mujer _____ [ ][ ] — 15 [ ][ ] 16

B. RESULTADO DE LA ENTREVISTA

CODIGOS

(108) Visita	(109) Fecha		(110) Hora de iniciación	(111) Hora de terminación	(112) Resultado	
	día	mes				
1o.						17 [ ]
2o.						18 [ ]
3o.						19 [ ]

CODIGO DE RESULTADO DE LA VISITA (S)

1. Completa
2. Incompleta
3. Rechazo
4. Ausencia de la mujer
5. Otro

C. CONTROL DE SUPERVISION Y PROCESAMIENTO

CODIGOS

(113) Nombre de la encuestadora _____

Observaciones _____

_____ — 20 [ ]

(114) Nombre del supervisor _____

Observaciones _____

_____

(115)

	SUPERVISOR	CRITICA	CODIFICACION
Fecha			
Nombre			

II. CARACTERISTICAS DE LA ENTREVISTADA

CODIGOS

(201) En qué mes y año nació usted? [ ][ ] Mes [1][9][ ][ ] Año No Sabe [ ] — Pase a 203 — 21 [ ][ ][ ][ ] 24

(202) Entonces cuántos años cumplidos tiene usted? [ ][ ] — 25 [ ][ ] 26

(203) Cuál es su estado civil (conyugal) actual?

Casada [1] Viuda [3]

Conviviente [2] Divorciada/Separada [4]

[ ] 27

(204) Cuál fué el curso ó año más alto que usted aprobó?

> ENCIERRE EN UN CIRCULO EL NIVEL MAS ALTO ALCANZADO Y EL ULTIMO AÑO APROBADO EN ESTE NIVEL. SI LA ENTREVISTADA NUNCA FUE A LA ESCUELA, O COLEGIO, MARQUE PRIMARIA CERO.

NIVEL	AÑOS
1 Primaria	0 1 2 3 4 5
2 Secundaria	1 2 3 4 5 6
3 Universitario	1 2 3 4 5 6 7 o más

[ ] 28 [ ] 29

(205) Ha tenido Ud. hijos alguna vez?

SI [1] NO [2]
(PASE A 207)

[ ] 30

(206) Ha estado embarazada alguna vez?

SI [1] NO [2]
(PASE A 212) (PASE A 215)

[ ] 31

(207) En total en toda su vida cuantos hijos nacidos vivos ha tenido?

NUMERO [ ][ ]

[ ][ ] 32 33

(208) Ha tenido hijos que nacieron vivos pero murieron después, aunque hayan vivido solo unos minutos?

SI [1] NO [2]

[ ] 34

(209) En total, en toda su vida, cuantas veces ha estado embarazada?

NUMERO [ ][ ]

[ ][ ] 35 36

(210) ENTREVISTADOR (A) RESTE DE 209 (TOTAL EMBARAZOS) 207 (NACIDOS VIVOS) Y ANOTE EL RESULTADO AQUI Y AHORA DIGA A LA ENTREVISTADA: ES DECIR, UD. HA TENIDO ABORTOS Y/O NACIDOS MUERTOS. ES ESTO CORRECTO?

SI [1] NO [2] (CORRIJA DONDE SEA NECESARIO)

[ ][ ] 37 38

(211) Dígame ahora en qué mes y año tuvo su último hijo nacido vivo?

[ ][ ] MES [1][9][ ][ ] AÑO

(PASE A 213)

[ ][ ][ ][ ] 39 42

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CARACTERISTICAS DE LA ENTREVISTADA (Continuación)	CODIGOS
(212) Cuántas veces ha estado embarazada? ☐ Número	☐ 43
(213) Está Ud. embarazada actualmente? SI [1] NO [2] NO SABE [3] → (PASE A 216)	☐ 44
(214) Desea Ud. tener otro hijo fuera del que está esperando? SI [1] NO [2] NO SABE [3] → (PASE A (301)	☐ 45
(215) Hasta donde ustedes saben, usted y su marido son capaces de tener un hijo si así lo desearan? SI [1] NO [2] (PASE A 301) NO SABE [3]	☐ 46
(216) Desea Ud. tener un (otro) niño? SI [1] NO [2] NO SABE [3]	☐ 47

III. CONOCIMIENTO Y USO DE METODOS	CODIGOS
LAS PREGUNTAS 301 HASTA LA 306 DEBEN DILIGENCIARSE EN EL ESQUEMA DE LA PAGINA SIGUIENTE.	
(301) Hay varias formas, maneras o métodos para que una pareja pueda demorar o evitar un embarazo o un hijo si no lo desean. Conoce Ud. o ha oído hablar acerca de alguna forma, manera o método de planificación familiar o método para evitar un embarazo? SI [1] NO [2] (PASE A 304)	☐ 48
(302) Qué métodos de planificación familiar o medio para evitar un embarazo conoce Ud.?	
COLOQUE UN CIRCULO EN "1" DE LA COLUMNA A1 DEL CUADRO POR CADA METODO MENCIONADO POR LA ENTREVISTADA.	
(303) POR CADA METODO MARCADO DENTRO DE UN CIRCULO EN LA COLUMNA "A 1" PREGUNTE: Ha usado Ud. o su esposo (compañero) alguna vez _____ METODO	
COLOQUE UN CIRCULO EN LA RESPUESTA APROPIADA EN LA COLUMNA A 3 DEL ESQUEMA	
(304) POR CADA METODO QUE NO ESTE MARCADO DENTRO DE UN CIRCULO EN LA COLUMNA "A 1" PREGUNTE: Para estar bien segura ha oído hablar de _____ METODO O MEDIO	
MARQUE UN CIRCULO EN "2" DE LA COLUMNA "A 2" DEL CUADRO SI LA RESPUESTA ES AFIRMATIVA Y SEGUIDAMENTE HAGA LA PREGUNTA 305 ANTES DE PASAR AL OTRO METODO. SI LA RESPUESTA ES NEGATIVA MARQUE UN CIRCULO EN "3" DE LA COLUMNA "A 2" Y PASE AL PROXIMO METODO.	

CONOCIMIENTO Y USO DE METODOS (Continuación) | CODIGOS

(305) Ha usado Ud. o su esposo (compañero) alguna vez _____ METODO

MARQUE UN CIRCULO EN LA RESPUESTA APROPIADA EN LA COLUMNA "A 3" DEL CUADRO.

(306) Actualmente usted (es) está (n) usando o ha (n) usado durante el último mes algún método de planificación familiar para evitar un embarazo?

[1] SI ——→ Cuál? _____ [ ] 49

SI LA RESPUESTA ES AFIRMATIVA ESCRIBA EL METODO DE USO A CONTINUACION DE "CUAL" Y MARQUE EN UN CIRCULO EL CODIGO CORRESPONDIENTE EN LA COLUMNA "A 4". SI LA RESPUESTA ES MAS DE UN METODO PREGUNTE CUAL ES EL DE USO MAS FRECUENTE Y HAGA LAS ANOTACIONES RESPECTIVAS. PASE A 307. [ ][ ] 50 51

[2] NO ——→ (PASE A 401)

ESQUEMA DE CONOCIMIENTO Y USO

METODOS DE PLANIFICACION FAMILIAR	A. 1 (302) Sin ayuda SI	A. 2 (304) Con ayuda SI	A. 2 (304) Con ayuda NO	A. 3 (303) Ha usado Alguna vez SI	A. 3 (305) Ha usado Alguna vez NO	A. 4 (306) Método que usa actualmente		
01 Píldora	1	2	3	1	2	01 Píldora	52 [ ]	[ ] 53
02 DIU	1	2	3	1	2	02 DIU	54 [ ]	[ ] 55
03 Esterilización femenina	1	2	3	1	2	03 Esterilización femenina	56 [ ]	[ ] 57
04 Esterilización masculina	1	2	3	1	2	04 Esterilización masculina	58 [ ]	[ ] 59
05 Condón	1	2	3	1	2	05 Condón	60 [ ]	[ ] 61
06 Inyección	1	2	3	1	2	06 Inyección	62 [ ]	[ ] 63
07 Vaginales	1	2	3	1	2	07 Vaginales	64 [ ]	[ ] 65
08 Ritmo	1	2	3	1	2	08 Ritmo	66 [ ]	[ ] 67
09 Retiro	1	2	3	1	2	09 Retiro	68 [ ]	[ ] 69
10 Otros	1		3	1	2	10 Otros	70 [ ]	[ ] 71
Ninguno	96			97		98		

(307) Cuándo comenzo a usar este método? [ ][ ] Mes [ ][ ][ ][ ] Año 72 [ ][ ][ ][ ] 75

No recuerda, no sabe [ ]

200

IV. CONOCIMIENTO Y USO DE FUENTES DE INFORMACION Y SERVICIO DE PLANIFICACION FAMILIAR

CODIGOS

(401) Sabe Ud. en dónde le pueden dar información y servicios (métodos) de planificación familiar?

SI [1] NO [2] (PASE A 403) — 76

(402) Dónde le pueden dar información y servicios (métodos) de planificación familiar? — 1 [ ] [ ] [ ] [ ] [2] 5

	INFORMACION	IDENTIFICACION SERVICIOS, METODOS SUMINISTROS
Hospital o puesto de salud.	1	1
Droguería	2	2
PROFAMILIA	4	4
Médico Particular	8	8
Amiga o vecina	16	16
Otro _____ (ESPECIFIQUE)	32	32
No sabe	00	00

[ ] [ ] [ ] [ ] 6 9

(403) MARQUE LA CASILLA APROPIADA

ACTUALMENTE USA NO ESTERILIZADA [1] — NO USA ACTUALMENTE [2] (PASA A 501) — ESTERILIZADA [3] — 10 [ ]

(404) A dónde va con más frecuencia (normalmente) a solicitar servicios o a comprar métodos de planificación familiar?

Hospital, puesto de salud, promotora del Ministerio de Salud.	1
Droguería ó farmacia	2
PROFAMILIA	3
Médico Particular	4
Otro _____ (ESPECIFIQUE)	5

(405) Volverá usted a este servicio?

SI [1] NO [2] → (Pase a 512)

(406) Dónde le hicieron la Operación? _____ — 11 [ ] (404)

(407) Quién le remitió para ésta operación? _____ — 12 [ ] (405)

(408) Está satisfecha con la operación? _____ — 13 [ ] (406)

(PASE A 517) — 14 [ ] (407) — 15 [ ] [ ] 16 (408)

V. OPINION DE SERVICIOS Y METODOS

CODIGOS

VERIFIQUE CON ESQUEMA DE CONOCIMIENTO Y USO

(501) Han usado usted o su esposo (o compañero) alguna vez algún método de planificación familiar?

SI [1] NO [2] (PASE A (506) — 17 [ ]

V. OPINION DE SERVICIOS Y METODOS (Continuación).			CODIGOS
MARQUE EN UN CIRCULO LAS RESPUESTAS PERTINENTES			
(502) Qué métodos ha (n) usado? (NO LEA LAS RESPUESTAS)			
	SI	NO	
01 Píldoras	1	2	18 ☐
02 Condón	1	2	19 ☐
03 Diu	1	2	20 ☐
04 Esterilización Femenina	1	2	21 ☐
05 Esterilización Masculina	1	2	22 ☐
06 Inyección	1	2	23 ☐
07 Vaginales	1	2	24 ☐
08 Ritmo	1	2	25 ☐
09 Retiro	1	2	26 ☐
10 Otros_____ Especifique	1	2	27 ☐
(503) Cuál fué el último método que usaron?			
Píldora 01	Inyección 06		
Condón 02	Vaginales 07		
Diu 03	Ritmo 08		28 ☐☐ 29
Ester Femenina 04	Retiro 09		
Ester Masculina 05	Otros 10		
(504) Cuándo dejó (aron) de usarlo?	AÑO 1 9 ☐☐		30 ☐☐ 31
(505) Por qué dejó (aron) de usarlo? _____			32 ☐☐ 33
(PASE A LA 507)			
(506) Por qué nunca han usado métodos de planificación familiar? _____ _____			34 ☐☐ 35
(507) Por qué no está (n) planificando actualmente? _____ _____			36 ☐☐ 37
(508) Ha (n) pensado usar algún método de planificación familiar en el futuro?			
SI 1 ↓	NO 2 (PASE A 511)		38 ☐

202

V. OPINION DE SERVICIOS Y METODOS (Continuación)	CODIGOS
(509) Qué método han pensado o cuál les gustaría usar?	
Píldora [01] Inyección [06]	
Condón [02] Vaginales [07]	
Diu [03] Ritmo [08]	39 [ ][ ] 40
Este. Femenina [04] Retiro [09]	
Este. Masculina [05] Otro [10]	
(510) Sabe (n) usted (s) en dónde podría (n) obtener dicho método?	
Hospital o centro de salud [01] Médico particular [08]	
Droguería [02] Otro [16]	41 [ ][ ] 42
Profamilia [04] No sabe [00]	
(PASE A 517)	
(511) Por qué no han pensado usar algún método de planificación familiar en el futuro?	
_____	43 [ ][ ] 44
(PASE A 517)	
(512) Sabe su esposo (compañero) que usted usa actualmente métodos anticonceptivos?	
SI [1] NO [2] NO SABE [3]	45 [ ]
(513) Está su esposo (compañero) de acuerdo con que usted use métodos anticonceptivos?	
SI [1] NO [2] NO SABE [3]	
(PASE A 517) (PASE A 517)	46 [ ]
(514) Por qué su esposo (o compañero) no está de acuerdo	
_____	47 [ ][ ] 48
(515) Usted o su esposo (compañero) ha (n) tenido molestias con el método que están usando actualmente?	
SI [1] NO [2]	49 [ ]
(PASE A 517)	
(516) Cuáles molestias ha (n) tenido?	
_____	50 [ ][ ] 51
(517) Conoce usted otras usuarias de planificación familiar en su comunidad?	
SI [1] NO [2]	
AGRADEZCA A LA ENTREVISTADA POR SU COLABORACION Y TERMINE LA ENTREVISTA	52 [ ]
(518) Cómo llegó a conocerlas?	
_____	53 [ ][ ] 54
AGRADEZCA A LA ENTREVISTADA POR SU COLABORACION Y TERMINE LA ENTREVISTA	

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APPENDIX 6

MIDPOINT SURVEY QUESTIONNAIRE

PROFAMILIA	SEGUNDA ENCUESTA SANTANDER, CUNDINAMARCA Y HUILA 1986 CUESTIONARIO DE HOGAR	CONFIDENCIAL FINES CIENTIFICOS

I. IDENTIFICACION DEL CUESTIONARIO

(101) Número del Cuestionario: [ ][ ][ ][ ] 1

(102) Municipio _____ [ ][ ] 2

(103) Departamento: [ ] 3

(104) Segmento: [ ][ ] 4

(105) Zona: 1. Urbana 2. Rural [ ] 5

(106) Número de Hogar: [ ][ ][ ] 6

(107) Vereda _____ Nombre

(108) Encuestadora: _____ Nombre

(109) Fecha de Entrevista: [ ][ ] 7 Día [ ][ ] 8 Mes

(110) Cuestionario: [ ] de [ ]

II. PARA TODOS LOS MIEMBROS DEL HOGAR

NUMERO DE ORDEN DE LA PERSONA	NOMBRES Y APELLIDOS	PARENTESCO	SEXO	EDAD	15 AÑOS Y MAS ESTADO CIVIL		ELEGIBILIDAD 15 y 49 AÑOS
	Por favor me puede decir el nombre de las personas que normalmente viven en este hogar, aunque no hayan dormido aquí anoche.	Cuál es el parentesco de (cada persona) _____ con el jefe del hogar? Jefe [1] Esposa [2] Hijos [3] Parientes [4] Otros [5]	Es hombre o mujer? Hombre [1] Mujer [2]	Cuántos años cumplidos tiene?	Ha estado casado o unido alguna vez? SI [1] (CONTINUE) NO [2] (PASE A LA SIGUIENTE PERSONA)	Cuál es su estado civil actual? Casado [1] Conviviente [2] Viudo [3] Separado o Divorciado [4]	Numere la mujer elegible para la entrevista individual en orden consecutivo.
(201)	(202)	(203)	(204)	(205)	(206)	(207)	(208)
9		10	11	12	13	14	15
01							
02							
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(209)	Número de personas en el hogar	16 [ ][ ]
(210)	Número de mujeres elegibles	17 [ ]
(211)	Este hogar fué entrevistado por PROFAMILIA en 1984? SI [1] NO [2]	18 [ ]
(212)	RESULTADO DE LA VISITA: [1] Completa [3] Ningún adulto en casa [5] Casa desocupada [2] Rechazo [4] No es vivienda [6] Otro	19 [ ]

205

PROFAMILIA	SEGUNDA ENCUESTA SANTANDER, CUNDINAMARCA Y HUILA 1986 CUESTIONARIO INDIVIDUAL	CONFIDENCIAL FINES CIENTIFICOS

I.A. IDENTIFICACION DEL CUESTIONARIO — CODIGOS

(101) Número de identificación — 1 ☐☐☐☐

(102) Municipio _____ ☐☐ — 2 ☐☐

(103) Departamento _____ ☐ — 3 ☐

(104) Segmento ☐☐ — 4 ☐☐

(105) Zona: 1 Urbana 2 Rural ☐ — 5 ☐

(106) Número del hogar ☐☐☐ — ☐☐☐ 6

(107) Nombre y número de orden de la mujer _____ ☐☐ — ☐☐ 7

B. RESULTADO DE LA ENTREVISTA — CODIGOS

(108) Visita	(109) Fecha		(110) Resultado
	Día	Mes	
1a.			
2a.			
3a.			

☐☐ 8

☐ 9

CODIGO DE RESULTADO DE LA VISITA

1. Completa
2. Incompleta
3. Rechazo
4. Ausencia de la mujer
5. Otro _____

C. CONTROL DE SUPERVISION Y PROCESAMIENTO

(111) Nombre de la encuestadora _____

Observaciones: _____

(112) Nombre del supervisor _____

Observaciones: _____

(113)

	SUPERVISOR	CRITICO	CODIFICADOR
Fecha			
Nombre			

206

II. CARACTERISTICAS DE LA ENTREVISTADA

PREG. No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS
201	A usted la entrevistó PROFAMILIA en 1984?	SI.....	1	10
		NO.....	2	
202	En qué mes y año nació usted?	MES.....	→204	11
		AÑO.....		12
		NO SABE 9 8		
203	Entonces, cuántos años cumplidos tiene usted?	AÑOS CUMPLIDOS		13
204	Cuál es su estado civil (conyugal) actual?	CASADA.....	1	14
		CONVIVIENTE	2	
		VIUDA.....	3	
		SEPARADA/DIVORCIADA	4	
205	Cuál fue el curso o año de escolaridad más alto que usted aprobó?	PRIMARIA 0		15
		SECUNDARIA 1		
		UNIVERSIDAD 2		
206	Ha estado embarazada alguna vez?	SI.....	1	16
		NO.....	2→212	
207	Cuántas veces ha estado embarazada?	TOTAL EMBARAZOS		17
208	Ha tenido hijos nacidos vivos?	SI.....	1	18
		NO.....	2→210	
209	En total en toda su vida, cuántos hijos nacidos vivos ha tenido?	TOTAL NACIDOS VIVOS		19
210	En total cuántos abortos y/o nacidos muertos ha tenido?	TOTAL ABORTOS Y/O NACIDOS MUERTOS		20
	ENCUESTADORA: VERIFIQUE SI 207 ES LA SUMA DE 209 Y 210. CORRIJA DONDE SEA NECESARIO. Nota: SI EL UNICO EMBARAZO QUE HA TENIDO ES EL ACTUAL, PASE A 212.			
211	En qué mes y año tuvo su último hijo nacido vivo?	MES.....		21
		AÑO.....		22
212	Está usted embarazada actualmente?	SI.....	1	23
		NO.....	2	
		NO SABE	3 →214	
213	Desea usted tener otro hijo fuera del que está esperando?	SI.....	1	24
		NO.....	2 →301	
		NO SABE	3	
214	Hasta donde usted sabe, usted y su marido pueden tener (más) hijos si así lo desearan?	SI.....	1	25
		NO.....	2 →301	
		NO SABE	3	
215	Desea usted tener un (otro) hijo?	SI.....	1	26
		NO.....	2	
		NO SABE	3	

207

III. CONOCIMIENTO Y USO DE METODOS ANTICONCEPTIVOS Y FUENTES DE INF. y SERVICIOS

CODIGOS

301 Existen varios métodos de planificación familiar que las parejas pueden usar para evitar los embarazos si no los desean. Qué métodos conoce o de cuáles ha oído hablar?

METODOS	(302 Ha oído de este método? SI Sin ayuda	SI Con ayuda	NO	(303) Ha usado alguna vez _____? (Método) SI	NO	(304) Mencione dos sitios en donde le pueden suministrar este método. * 1o.	2o.	CODIGOS
Píldora	1	2	3	1	2			27 28 29 30
Condón	1	2	3	1	2			31 32 33 34
DIU	1	2	3	1	2			35 36 37 38
Esteril. femenina	1	2	3	1	2			39 40 41 42
Esteril. masculina	1	2	3	1	2			43 44 45 46
Inyección	1	2	3	1	2			47 48 49 50
Vaginales	1	2	3	1	2			51 52 53 54
Ritmo	1	2	3	1	2			55 56
Retiro	1	2	3	1	2			57 58
Otros	1	2	3	1	2			59 60

VEA 302 y 303

HA USADO ALGUN METODO	NO HA USADO METODOS NINGUN SI EN 303	NO CONOCE NINGUN METODO
1	2	3
↓	(PASE A 401)	TERMINE LA ENCUESTA

61

305 En los últimos tres años, de los siguientes lugares, a cuáles ha ido a solicitar información o a comprar métodos anticonceptivos?

LUGAR	HA IDO	NO HA IDO	CODIGOS
Hospital o Puesto de Salud	1	2	62
Promotora Minsalud	1	2	63
Droguería o farmacia	1	2	64
Puesto distribución Profamilia	1	2	65
Clínica de Profamilia	1	2	66
Clínica/médico particular	1	2	67
Amiga o vecina	1	2	68
Otro	1	2	69

* Códigos para pregunta 304:

Hospital o puesto de salud	1
Promotora Minsalud	2
Droguería o farmacia	3
Puesto distribución de Profamilia	4
Clínica de Profamilia	5
Clínica/médico particular	6
Amiga o vecina	7
Otros	8
No sabe	0

208

PREG. No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS
306	VEA PREGUNTAS 212 y 303:			
	ELLA O EL ESTERILIZADO [1]	NO ESTERILIZADA (O). [2]		
		EMBARAZADA [1] (PASE A [redacted])		70
		NO EMBARAZADA [2] (PASE A 313)		71
307	En qué mes y año le hicieron a usted (o a su esposo) la operación para no tener más hijos?	MES..... [ ][ ] AÑO..... [ ][ ]		72 [ ][ ] 73 [ ][ ]
308	En qué sitio le practicaron la operación?	HOSPITAL/PUESTO SALUD 1 CLINICA PROFAMILIA .. 2 CLINICA/MEDICO PRIVADO 3 OTRO..... 4		74
309	Quién la(o) remitió para esa operación?	_____ _____		75 [ ][ ] Anexo
310	Está satisfecha(o) con la operación?	SI..... 1 NO..... 2	→312	76
311	Por qué está satisfecha(o)? (DILIGENCIE 313 Y 314 SIN FORMULAR LAS PREGUNTAS).	_____ _____ _____	→313	77 [ ][ ] Anexo
312	Por qué no está satisfecha(o)? (DILIGENCIE 313 Y 314 SIN FORMULAR LAS PREGUNTAS).	_____ _____ _____		78 [ ][ ] Anexo
313	Actualmente está(n) usando algún método para no quedar embarazada?	SI..... 1 NO..... 2	→341	79
314	Qué método está(n) usando? (NO HAGA PREGUNTA PARA ESTERILIZACION UNICAMENTE ENCIERRE CODIGO 4 ó 5 SEGUN EL CASO).	PILDORA ..... 01 CONDON ..... 02 DIU 03	→322	80
		ESTERIL. FEMENINA ... 04 ESTERIL. MASCULINA .. 05	→332	
		INYECCION ..... 06 VAGINALES..... 07 RITMO ..... 08 RETIRO ..... 09 OTROS_____ 10 (Especifique)	→331	
315	A dónde va con más frecuencia a comprar_____ (método actual)?	HOSPITAL/PUESTO SALUD 1 PROMOTORA MINSALUD 2 DROGUERIA/FARMACIA 3 PUESTO DE DISTRIBUCION DE PROFAMILIA .. 4 CLINICA PROFAMILIA .. 5 CLINICA/MEDICO PARTICULAR ..... 6 AMIGA O VECINA..... 7 OTRO_____ 8 (Especifique)		81

209

PREG. No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS
316	Volverá usted a este servicio?	SI.....	1	☐
		NO.....	2	82
317	Cómo le ha parecido la atención que ha recibido cuando va a comprar el anticonceptivo?	MUY BUENA.....	1	
		BUENA.....	2	
		REGULAR	3	☐
		MALA.....	4	83
		MUY MALA.....	5	
318	En alguna ocasión al ir a comprar el anticonceptivo lo ha encontrado agotado?	SI.....	1	☐
		NO.....	2	84
319	Cuánto pagó por el anticonceptivo la última vez que lo compró? (ESPECIFIQUE UNIDADES)	$ ☐☐☐		☐☐☐
		POR UNIDAD:_____ (Ciclos, condones, óvulos, tabletas, etc.)		Anexo 85
320	Antes de comprar sus anticonceptivos en (sitio al que acude actualmente), en dónde compraba con más frecuencia?	HOSPITAL/PUESTO SALUD	1	
		PROMOTORA MINSALUD	2	
		DROGUERIA/FARMACIA	3	
		PUESTO DE DISTRIBUCION DE PROFAMILIA ..	4	☐
		CLINICA DE PROFAMILIA	5	86
		CLINICA/MEDICO PARTICULAR	6	
		AMIGA O VECINA.....	7	
		OTRO_____ (Especifique)	8	
		NUNCA HA COMPRADO EN OTRO SITIO.....	9→331	
321	Por qué dejó de ir a este lugar a comprar sus anticonceptivos?	LE QUEDA LEJOS.....	1	
		CAMBIO DE DOMICILIO..	2	
		SON MAS CAROS LOS ANTICONCEPTIVOS	3	
		LA ANTIENDEN MAL ...	4 } 331	☐
		SE ACABABA LA DROGA	5	87
		DEJARON DE VENDER ANTICONCEPTIVOS	6	
		CERRARON EL LUGAR..	7	
		OTRO_____ (Especifique)	8	
322	En dónde le insertaron el dispositivo que está usando?	HOSPITAL/PUESTO SALUD	1	
		PROFAMILIA	2	☐
		CLINICA/MEDICO PARTICULAR	3	88
		OTRO_____ (Especifique)	4	
323	A dónde ha ido para controles posteriores?	MISMO LUGAR DONDE SE LO PUSIERON	1→325	☐
		LUGAR DIFERENTE A DONDE SE LO PUSIERON	2	89
		NUNCA HA IDO A CONTROL	3→325	
324	Por qué prefiere ir a otro lugar a control?	_____		90☐☐
		_____		Anexo
		_____		
		_____		

210

PREG. No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS
325	CUANDO LE INSERTARON EL DISPOSITIVO: Le explicaron cómo se lo iban a poner?	SI.....	1	☐
		NO.....	2	91
326	Le pidieron que regresara al mes para control?	SI.....	1	☐
		NO.....	2	92
327	La atendieron rápidamente?	SI.....	1	☐
		NO.....	2	93
328	Le explicaron cómo podía ver si el dispositivo estaba en su lugar?	SI.....	1	☐
		NO.....	2	94
329	Cómo le pareció la atención que le dieron?	MUY BUENA.....	1	
		BUENA.....	2	
		REGULAR	3	☐
		MALA.....	4	95
		MUY MALA.....	5	
330	A dónde le recomendaría a una amiga que fuera a ponerse el dispositivo?	HOSPITAL/PUESTO SALUD	1	
		PROFAMILIA	2	☐
		CLINICA/MEDICO PARTICULAR	3	96
		OTRO_____ (Especifique)	4	
331	Por cuánto tiempo ha estado usando (Método actual) continuamente (sin haberlo dejado de usar)?	MESES	☐☐	☐☐☐
		AÑOS.....	☐☐	97
		DESDE ULTIMO PARTO	☐ →350	
332	(Desde el nacimiento de su último hijo nacido vivo) Alguna vez usó otro método diferente al___(método actual) para evitar el embarazo?	SI.....	1	☐
		NO.....	2 →350	98
333	Qué método usó antes de_____(Método actual)?	PILDORA	1	
		CONDON	2	
		DIU.....	3	
		INYECCION	4	☐
		VAGINALES.....	5	99
		RITMO	6	
		RETIRO	7	
		OTRO_____ (Especifique)	8	
334	Por cuánto tiempo usó este método en forma continua hasta que dejó de usarlo (la última vez)?	MESES	☐☐	☐☐☐
		AÑOS.....	☐☐	100
335	Cuál fue la razón principal para dejar de usar (el método antes de método actual) en ese entonces?	INSEGURIDAD METODO .	01	
		SEXO INFRECUENTE ...	02	
		OPOSICION MARIDO....	03	
		MOTIVOS MEDICOS.....	04	
		EFECTOS COLATERALES	05	☐☐
		METODO NO DISPONIBLE	06	101
		COSTOSO	07	
		DIFICIL DE USAR	08	
		PROBLEMAS DE SALUD .	09	
		DESEABA EMBARAZO...	10	
		OTRO_____ (Especifique)	11	
		NO SABE	98	

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PREG. No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS
336	VERIFIQUE 333:			
	[1] PILDORA, CONDON, DIU, INYECCION, VAGINALES	[2] RITMO, RETIRO, OTROS (PASE A 350)		102
337	A dónde iba con más frecuencia a comprar_____? (Método)	HOSPITAL/PUESTO SALUD PROMOTORA MINSALUD DROGUERIA/FARMACIA PUESTO DISTRIBUCION DE PROFAMILIA..... CLINICA PROFAMILIA .. CLINICA O MEDICO PARTICULAR ..... AMIGA O VECINA..... OTRO_____ (Especifique)	1 2 3 4 5 6 7 8	103
338	Mientras usó este método siempre lo compró en el mismo lugar o primero iba a un lugar y después cambió a otro?	SIEMPRE COMPRO EN EL MISMO LUGAR ..... CAMBIO DE LUGAR	1→350 2	104
339	A dónde iba antes a comprarlo?	HOSPITAL/PUESTO SALUD PROMOTORA MINSALUD DROGUERIA/FARMACIA PUESTO DISTRIBUCION DE PROFAMILIA..... CLINICA PROFAMILIA .. CLINICA/MEDICO PARTICULAR ..... AMIGA O VECINA..... OTRO_____ (Especifique)	1 2 3 4 5 6 7 8	105
340	Por qué cambió de lugar en el que compraba ese anticonceptivo?	LE QUEDABA LEJOS.... CAMBIO DE DOMICILIO.. SON MAS CAROS LOS ANTICONCEPTIVOS .... LA ATENDIAN MAL .... SE ACABABA LA DROGA DEJARON DE VENDER ANTICONCEPTIVOS .... CERRARON EL LUGAR.. CAMBIO DE METODO Y NO LO CONSEGUIA AHI .... OTRO_____ (Especifique)	1 2 3 4 5 6 7 8 0 } →350	106
341	VEA 208 y 209: ALGUN HIJO NACIDO VIVO [1] NINGUN HIJO NACIDO VIVO [2] (PASE A 343)			107
342	Desde el nacimiento de su último hijo nacido vivo ha usado algún método para no quedar embarazada?	SI..... NO.....	1 2→364	108
343	Cuál fue el último método que usó?	PILDORA ..... CONDON ..... DIU ..... INYECCION ..... VAGINALES..... RITMO ..... RETIRO ..... OTRO_____	1 2 3 4 5 6 7 8	109

212

PREG. No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS
344	Por cuánto tiempo usó (Ultimo método) hasta que dejó de usarlo (la última vez)?	MESES ..... ☐☐ AÑOS ..... ☐☐		☐☐☐ 110
345	Cuál fue la razón principal para dejar de usar (último método)?	INSEGURIDAD METODO . 01 SEXO INFRECUENTE ... 02 OPOSICION MARIDO .... 03 MOTIVOS MEDICOS..... 04 EFECTOS COLATERALES 05 METODO NO DISPONIBLE 06 COSTOSO ..... 07 DIFICIL DE USAR ..... 08 PROBLEMAS DE SALUD . 09 OTRO_____ 10 NO SABE 98		☐☐ 111
	(PARA RITMO Y RETIRO PASE A 350)			
346	A dónde iba con más frecuencia a comprar_____?	HOSPITAL/PUESTO SALUD 1 PROMOTORA MINSALUD 2 DROGUERIA/FARMACIA 3 PUESTO DISTRIBUCION DE PROFAMILIA..... 4 CLINICA PROFAMILIA .. 5 CLINICA O MEDICO PARTICULAR ..... 6 AMIGA O VECINA..... 7 OTRO_____ 8		☐ 112
347	Mientras usó este método ¿Siempre lo compró en el mismo lugar, o primero iba a un lugar y después cambió a otro?	SIEMPRE COMPRO EN EL MISMO LUGAR 1	→350	☐ 113
		CAMBIO A OTRO..... 2		
348	A dónde iba antes de comprarlo?	HOSPITAL/PUESTO SALUD 1 PROMOTORA MINSALUD 2 DROGUERIA/FARMACIA 3 PUESTO DISTRIBUCION DE PROFAMILIA..... 4 CLINICA PROFAMILIA .. 5 CLINICA O MEDICO PARTICULAR ..... 6 AMIGA O VECINA..... 7 OTRO_____ 8		☐ 114
349	Por qué cambió de lugar en el que compraba el anticonceptivo?	LE QUEDABA LEJOS.... 1 CAMBIO DE DOMICILIO.. 2 SON MAS CAROS LOS ANTICONCEPTIVOS..... 3 LA ATENDIAN MAL .... 4 SE ACABABA LA DROGA 5 DEJARON DE VENDER ANTICONCEPTIVOS..... 6 CERRARON EL LUGAR.. 7 CAMBIO DE METODO Y NO LO CONSEGUIA AHI .... 8 OTRO_____ 0		☐ 115
350	VERIFIQUE 305:			
	HA COMPRADO ANTICONCEPTIVOS EN MAS DE UN SITIO → 1 (CONTINUE)	NO HA COMPRADO ANTICONCEPTIVOS EN LOS ULTIMOS TRES AÑOS O LOS HA COMPRADO EN UN SITIO SOLAMENTE. → 2 (PASE A 357)		☐ 116

213

PREG. No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS

351 De los lugares a los que ha ido a comprar anticonceptivos en los últimos tres años, por favor infórmeme lo siguiente:

LUGAR	(352) En dónde la atienden mejor?	(353) En dónde son más baratos los anticonceptivos?	(354) En dónde son de mejor calidad los anticonceptivos?	(355) Cuál le queda más cerca de su casa?	(356) A dónde le recomendaría a una amiga que fuera?	CODIGOS
Hospital/Puesto de Salud	1	1	1	1	1	117 118 119 120 121
Promotora Minsalud	2	2	2	2	2	122 123 124 125 126
Droguería/Farmacia	3	3	3	3	3	127 128 129 130 131
Puesto Distribución Profamilia	4	4	4	4	4	132 133 134 135 136
Clínica Profamilia	5	5	5	5	5	137 138 139 140 141
Clínica o médico particular	6	6	6	6	6	142 143 144 145 146
Amiga o vecina	7	7	7	7	7	147 148 149 150 151
Otro_____	8	8	8	8	8	152 153 154 155 156

357	Usted conoce o llegó a ver en los últimos años que vendieran métodos anticonceptivos en una tienda pequeña o en casa de alguna persona cerca de este lugar (un puesto de Profamilia)?	SI..... 1 NO..... 2→364		157
358	Alguna vez pidió consejo o compró anticonceptivos en este lugar?	SI..... 1 NO..... 2		158
359	En esta tienda o casa siguen vendiendo anticonceptivos o dejaron de vender hace tiempo?	SIGUEN VENDIENDO ... 1→362 DEJARON DE VENDER .. 2 NO SABE ..... 9→362		159
360	Le causó algún problema que dejaran de vender anticonceptivos ahí?	SI..... 1 NO..... 2→362		160
361	Qué problemas le causó? INSISTA: Qué otros problemas le causó?	_____ _____		161 Anexo
362	Qué le parece el servicio que dan (daban) estos puestos de venta de anticonceptivos?	MUY BUENO..... 1 BUENO..... 2 REGULAR ..... 3 MALO..... 4 NO LO HA UTILIZADO .. 5→364		162
363	Por qué le parece_____?	_____		163 Anexo

VEA 211, 212 y 313

364 HA TENIDO HIJO NACIDO VIVO DESDE ENERO DE 1981 O EMBARAZADA ACTUALMENTE. [1] → NINGUN HIJO NACIDO VIVO DESDE ENERO DE 1981 Y NO EMBARAZADA ACTUALMENTE [2]

- USA METODOS [1] (PASE A 405)
- NO USA METODOS [2] (PASE A 402)

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165

Ahora quisiera tener más información sobre (su embarazo y) los hijos que tuvo desde Enero de 1981.

MARQUE SI ESTA EMBARAZADA ACTUALMENTE Y ANOTE LOS NOMBRES DE LOS HIJOS NACIDOS VIVOS DESDE ENERO DE 1981. DESPUES DILIGENCIE VERTICALMENTE LAS PREGUNTAS PARA CADA CASO.

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(365)	EMBARAZADA ACTUALMENTE SI [1] NO [2] →	ULTIMO NACIDO VIVO NOMBRE _____	ANTERIOR NACIDO VIVO NOMBRE _____	ANTERIOR NACIDO VIVO NOMBRE _____	CODIGOS
					[ ] 166
(366) Antes de que usted quedara embarazada de _____ (NOMBRE) (pero después del nacimiento de _____) había hecho algo o había usado algún método aunque fuera por poco tiempo para no quedar embarazada?	SI ..... 1 NO ..... 2→ (REPITA PREGUNTA PARA ULTIMO NACIDO VIVO)	SI ..... 1 NO ..... 2→ (REPITA PREGUNTA PARA ANTERIOR NACIDO VIVO)	SI ..... 1 NO ..... 2→ (REPITA PREGUNTA PARA ANTERIOR NACIDO VIVO)	SI ..... 1 NO ..... 2 (PASE A 405)	[ ] 167 [ ] 168 [ ] 169 [ ] 170
(367) Cuál fue el último método que usó entonces?	PILDORA ..... 01 CONDON ..... 02 DIU ..... 03 ESTERIL. FEMENINA 04 ESTERIL.MASCULINA 05 INYECCION ..... 06 VAGINALES ..... 07 RITMO ..... 08 RETIRO ..... 09 OTROS _____ 10	PILDORA ..... 01 CONDON ..... 02 DIU ..... 03 ESTERIL. FEMENINA 04 ESTERIL.MASCULINA 05 INYECCION ..... 06 VAGINALES ..... 07 RITMO ..... 08 RETIRO ..... 09 OTROS _____ 10	PILDORA ..... 01 CONDON ..... 02 DIU ..... 03 ESTERIL. FEMENINA 04 ESTERIL.MASCULINA 05 INYECCION ..... 06 VAGINALES ..... 07 RITMO ..... 08 RETIRO ..... 09 OTROS _____ 10	PILDORA ..... 01 CONDON ..... 02 DIU ..... 03 ESTERIL. FEMENINA 04 ESTERIL.MASCULINA 05 INYECCION ..... 06 VAGINALES ..... 07 RITMO ..... 08 RETIRO ..... 09 OTROS _____ 10	[ ][ ] 171 [ ][ ] 172 [ ][ ] 173 [ ][ ] 174
(368) Por cuánto tiempo estuvo usando (último método) en esa oportunidad?	MESES [ ][ ] AÑOS [ ][ ]	MESES [ ][ ] AÑOS [ ][ ]	MESES [ ][ ] AÑOS [ ][ ]	MESES [ ][ ] AÑOS [ ][ ]	[ ][ ] 175 [ ][ ] 176 [ ][ ] 177 [ ][ ] 178

215

					CODIGOS
(369) Estaba usando (último método) cuando quedó embarazada?	SI..... 1 (PASE A 371) NO..... 2	SI..... 1 (PASE A 371) NO..... 2	SI..... 1 (PASE A 371) NO..... 2	SI..... 1 (PASE A 371) NO..... 2	☐ 179 ☐ 180 ☐ 181 ☐ 182
(370) Cuál fue la razón principal por la que dejó de usar el método en esa oportunidad?	EMBARAZARSE ... 01 INSEGURIDAD METO 02 SEXO INFRECUENTE 03 OPOSICION MARIDO 04 MOTIVOS MEDICOS. 05 EFECTO COLATERAL06 MET.NO DISPONIBLE 07 COSTOSO ..... 08 DIFICIL DE USAR .. 09 OTRO_____10	EMBARAZARSE .. 01 INSEGURID.METODO 02 SEXO INFRECUENTE 03 OPOSICION MARIDO 04 MOTIVOS MEDICOS 05 EFECTO COLATERAL06 MET. NO DISPONIBLE07 COSTOSO ..... 08 DIFICIL DE USAR . 09 OTRO_____10	EMBARAZARSE ... 01 INSEGURID.METODO 02 SEXO INFRECUENTE 03 OPOSICION MARIDO 04 MOTIVOS MEDICOS 05 EFECTO COLATERAL 06 MET.NO DISPONIBLE 07 COSTOSO ..... 08 DIFICIL DE USAR .. 09 OTRO_____10	EMBARAZARSE ... 01 INSEGURID.METODO 02 SEXO INFRECUENTE 03 OPOSICION MARIDO 04 MOTIVOS MEDICOS. 05 EFECTO COLATERAL 06 MET.NO DISPONIBLE 07 COSTOSO ..... 08 DIFICIL DE USAR .. 09 OTRO_____10	☐☐ 183 ☐☐ 184 ☐☐ 185 ☐☐ 186
(371) A dónde iba a comprar este método hasta que lo dejó de usar? (NO PREGUNTE PARA RITMO Y RETIRO)	HOSP PUESTO SALUD 1 PROMOT.MINSALUD 2 DROGUERIA..... 3 PUESTO PROFAMILIA 4 CLINICA PROFAMILIA 5 CLINICA O MEDICO PARTICULAR .... 6 AMIGA O VECINA .. 7 OTRO_____8	HOSP.PUESTO SALUD 1 PROMOT. MINSALUD 2 DROGUERIA..... 3 PUESTO PROFAMILIA 4 CLINICA PROFAMILIA 5 CLINICA O MEDICO PARTICULAR ... 6 AMIGA O VECINA . 7 OTRO_____8	HOSP.PUESTO SALUD 1 PROMOT. MINSALUD 2 DROGUERIA..... 3 PUESTO PROFAMILIA 4 CLINICA PROFAMILIA 5 CLINICA O MEDICO PARTICULAR .... 6 AMIGA O VECINA .. 7 OTRO_____8	HOSP.PUESTO SALUD 1 PROMOT. MINSALUD 2 DROGUERIA..... 3 PUESTO PROFAMILIA 4 CLINICA PROFAMILIA 5 CLINICA O MEDICO PARTICULAR ..... 6 AMIGA O VECINA .. 7 OTRO_____8	☐ 187 ☐ 188 ☐ 189 ☐ 190
(372) Usó algún otro método antes de (último método)? (VEA CODIGO EN 367)	ANTERIOR ☐☐ NO USO 9 6	ANTERIOR ☐☐ NO USO 9 6	ANTERIOR ☐☐ NO USO 9 6	ANTERIOR ☐☐ NO USO 9 6	☐☐ 191 ☐☐ 192 ☐☐ 193 ☐☐ 194

(PASE A 405)

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IV. USO FUTURO DE PLANIFICACION FAMILIAR, APROBACION MARIDO Y EXPOSICION AL FOLLETO

PREG. No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS
401	Por qué nunca ha usado métodos de planificación familiar?	_____		195 [ ][ ] Anexo
402	Ha(n) pensado usar algún método de planificación familiar en el futuro?	SI..... 1 NO..... 2	→404	[ ] 196
403	Qué método ha(n) pensado o cuál le(s) gustaría usar?	PILDORA..... 01 CONDON..... 02 DIU..... 03 ESTERIL. FEMENINA... 04 ESTERIL. MASCULINA.. 05 INYECCION..... 06 VAGINALES..... 07 RITMO..... 08 RETIRO..... 09 OTROS_____ 10 (Especifique)	408	[ ] 197
404	Por qué no ha(n) pensado usar un método de planificación familiar?	_____	408	198 [ ][ ] Anexo
405	Sabe su esposo que usted usa (ha usado) métodos anticonceptivos?	SI..... 1 NO..... 2		[ ] 199
406	Está su esposo de acuerdo con que usted use métodos anticonceptivos?	SI..... 1 NO..... 2 NO SABE..... 3	→408 →408	[ ] 200
407	Por qué su esposo no está de acuerdo?	_____		201 [ ][ ] Anexo
408	FILTRO: SANTANDER [1] → DE LOS AGRADECIMIENTOS POR LA COLABORACION Y TERMINE LA ENCUESTA. CUNDINAMARCA Y HUILA [2] → DE LOS AGRADECIMIENTOS POR LA COLABORACION Y TERMINE LA ENCUESTA.			[ ] 202
409	Durante el último año vió usted alguna vez un folleto sobre planificación familiar?	SI..... 1 NO..... 2	→413	[ ] 203

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PREG. No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS
410	En qué sitio lo vió?	DROGUERIA O FARMACIA OTRO_____ _____ (Especifique)	1 2	☐ 204
411	De qué institución era ese folleto?	PROFAMILIA ..... OTRO_____ _____ (Especifique) NO SABE	1 2 3	☐ 205
412	Cómo le pareció el folleto?	MUY BUENO..... BUENO..... REGULAR ..... MALO..... MUY MALO..... NO LO OBSERVO	1 2 3 4 5 6	☐ 206
413	↓ DE LOS AGRADECIMIENTOS POR LA COLABORACION Y TERMINE LA ENCUESTA.			

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APPENDIX 7

ENDLINE SURVEY QUESTIONNAIRE

PROFAMILIA	TERCERA ENCUESTA SANTANDER Y CUNDINAMARCA CUESTIONARIO DE HOGAR, 1987	CONFIDENCIAL FINES CIENTIFICOS

I. IDENTIFICACION DEL CUESTIONARIO

101. Número del Cuestionario: [ ][ ][ ][ ] 1

102. Municipio: _____ [ ][ ] 2

103. Departamento: _____ [ ] 3

104. Segmento: [ ][ ] 4

105. Zona: 1. Urbana 2. Rural [ ] 5

106. Número del Hogar: [ ][ ][ ] 6

107. Vereda: _____

108. Encuestadora: _____

109. Fecha de la Entrevista: 7 [ ][ ] Día [ ][ ] Mes 8

110. Cuestionario: [ ] de [ ]

II. PARA TODOS LOS MIEMBROS DEL HOGAR.

No. DE ORDEN DE LA PERSONA	NOMBRES Y APELLIDOS	PARENTESCO	SEXO	EDAD	15 AÑOS Y MAS ESTADO CIVIL		ELEGIBILIDAD 15 A 49 AÑOS
	Por favor, me puede decir el nombre de las personas que habitualmente viven en este hogar, aunque no hayan dormido aquí anoche.	Cuál es el parentesco de (cada persona) con el jefe del hogar Jefe [1] Esposa [2] Hijos [3] Parientes [4] Otros [5]	Es hombre o mujer? Hombre [1] Mujer [2]	Cuántos años cumplidos tiene?	Ha estado casado o unido alguna vez? SI [1] → NO [2] ↓	Cuál es su estado civil actual? Casado [1] Conviviente [2] Viudo [3] Separ/Divorc. [4]	Numere la mujer elegible para la entrevista individual en orden consecutivo.
201	202.	203.	204.	205.	206.	207.	208.
9		10	11	12	13	14	15
01							
02							
03							
04							
05							
06							
07							
08							
09							
10							
11							
12							
13							
14							
15							

209 Número de personas en el hogar. [ ][ ] 16

210 Número de mujeres elegibles. [ ] 17

211 Este hogar fue entrevistado por PROFAMILIA en 1986? SI [1] NO [2] [ ] 18

212. RESULTADO DE LA VISITA: [1] Completa [3] Rechazo [5] Casa desocupada [2] Incompleta [4] Ningún adulto en casa [6] Otro [ ] 19

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PROFAMILIA

TERCERA ENCUESTA SANTANDER, CUNDINAMARCA
1987
CUESTIONARIO INDIVIDUAL

CONFIDENCIAL
FINES
CIENTIFICOS

IA. IDENTIFICACION DEL CUESTIONARIO.

CODIGOS

101. Número de identificación. 1 ☐☐☐☐

102. Municipio. _____ ☐☐ 2 ☐☐

103. Departamento. _____ ☐ 3 ☐

104. Segmento. ☐☐ 4 ☐☐

105. Zona: 1. Urbana 2. Rural ☐ 5 ☐

106. Número del hogar. ☐☐☐ 6 ☐☐☐

107. Nombre y número de la mujer. _____ ☐☐ 7 ☐☐

B. RESULTADO DE LA ENTREVISTA.

108. Visita	109. Fecha		110. Resultado
	Día	Mes	
1a.			
2a.			
3a.			

8 ☐☐

CODIGO DE RESULTADO DE LA VISITA:

1. Completa 3. Rechazo 5. Otro _____
2. Incompleta 4. Ausencia de la mujer

9 ☐

C. CONTROL DE SUPERVISION Y PROCESAMIENTO

111. Nombre de la encuestadora: _____
Observaciones: _____

112. Nombre del supervisor: _____
Observaciones: _____

113.

Fecha	SUPERVISOR	CRITICO	CODIFICADOR
Nombre:			

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II. CARACTERISTICAS DE LA ENTREVISTADA

PREG No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS
201.	A usted la entrevistó PROFAMILIA en 1986?	SI . . . . . 1 NO 2		10 ☐
202.	Cuántos años cumplidos tiene usted?	AÑOS CUMPLIDOS . . . . . ☐☐		11 ☐☐
203.	Cuál es su estado civil (conyugal) actual?	CASADA . . . . . 1 CONVIVIENTE . . . . . 2 VIUDA . . . . . 3 SEPARADA/DIVORCIADA . . 4		12 ☐
204.	Cuál fue el último curso o año de escolaridad más alto que usted aprobó?	PRIMARIA . . . . . 0 SECUNDARIA . . . . . 1 UNIVERSITARIA . . 2		13 ☐☐
205.	Ha tenido hijos nacidos vivos?	SI . . . . . 1 NO . . . . . 2 →	208	14 ☐
206.	En total en toda su vida, cuántos hijos nacidos vivos ha tenido?	TOTAL NACIDOS VIVOS . . . ☐☐		15 ☐☐
207.	En qué mes y año tuvo su último hijo nacido vivo?	MES . . . . . ☐☐ AÑO . . . . . ☐☐		16 ☐☐ 17 ☐☐
208.	Está usted embarazada actualmente?	SI . . . . . 1 NO . . . . . 2 NO SABE 3	210	☐
209.	Desea usted tener otro hijo fuera del que está esperando?	SI . . . . . 1 NO . . . . . 2 NO SABE 3	301	19 ☐
210	Hasta donde usted sabe, usted y su marido pueden tener (más) hijos si así lo desearan?	SI . . . . . 1 NO . . . . . 2 → NO SABE 3	301	20 ☐
211.	Desea usted tener un (otro) hijo?	SI . . . . . 1 NO . . . . . 2 NO SABE 3		21 ☐

III. CONOCIMIENTO Y USO DE METODOS ANTICONCEPTIVOS, FUENTES DE INFORMACION Y SERVICIOS

CODIGOS

301. EXISTEN VARIOS METODOS DE PLANIFICACION FAMILIAR QUE LAS PAREJAS PUEDEN USAR PARA EVITAR O DEMORAR LOS EMBARAZOS SI NO LOS DESEAN.
Qué métodos de Planificación Familiar conoce o de cuáles ha oído hablar?
(ENCUESTADORA: EXPLIQUE CLARAMENTE LOS METODOS Y SEÑALE LAS RESPUESTAS EN EL CUADRO)

METODOS	(302) Ha oído de este método?			(303) Han usado alguna vez este método?		(304) En qué sitio se puede obtener este método?*	(305) Ha ido allí a obtener este método?		(306) Cómo le ha parecido el servicio?				CODIGOS
	SI Sin ayuda →	SI Con ayuda →	NO ↓	SI	NO	SITIO	SI →	NO ↓	MUY BUENO	BUENO	REGULAR	MALO	
01. PILDORA	1	2	3	1	2	☐	1	2	1	2	3	4	22 23 24 25 26
02. CONDON	1	2	3	1	2	☐	1	2	1	2	3	4	27 28 29 30 31
03. DIU	1	2	3	1	2	☐	1	2	1	2	3	4	32 33 34 35 36
04. ESTE. FEM.	1	2	3	1	2	☐	1	2	1	2	3	4	37 38 39 40 41
05. ESTE. MAS.	1	2	3	1	2	☐	1	2	1	2	3	4	42 43 44 45 46
06. INYECCION	1	2	3	1	2	☐	1	2	1	2	3	4	47 48 49 50 51
07. VAGINALES	1	2	3	1	2	☐	1	2	1	2	3	4	52 53 54 55 56
08. RITMO	1	2	3	1	2								57 58
09. RETIRO	1	2	3	1	2								59 60
10. OTRO, cuál? _____	1	2	3	1	2								61 62

307. VEA PREG. 302 _____

CONOCE METODOS [1] (CONTINUE) ↓

NO CONOCE METODOS [2] (PASE A PREG. 501)

☐ 63

PREG. No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.
308.	Actualmente está(n) usando algún método para no quedar embarazada?	SI . . . . . 1 NO 2	→ 401

☐ 64

* Códigos para pregunta 304:
- Hospital/Puesto de salud 1
- Droguería/Farmacia 2
- Puesto Distribución PROFAMILIA 3
- Clínica PROFAMILIA 4
- Clínica/Médico particular 5
- Caja compensación/Supermercado 6
- Otros 7
- No sabe 8

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III. CONOCIMIENTO Y USO DE METODOS DE INFORMACION Y SERVICIO — Continuación

PREG No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS
309.	Qué método está(n) usando?	PILDORA . . . . . 01 CONDON . . . . . 02 DIU . . . . . 03 ESTER. FEMENINA . . . . . 04 ESTER. MASCULINA . . . . . 05 INYECCION . . . . . 06 VAGINALES . . . . . 07 RITMO . . . . . 08 RETIRO . . . . . 09 OTRO, cuál? 10	311 401	65 ☐☐
310.	A dónde va con más frecuencia a comprar _____(método actual?)	HOSPITAL/PUESTO SALUD . . . . . 1 PROMOTORA MIN/SALUD . . . . . 2 DROGUERIA/FARMACIA . . . . . 3 PTO. DIST. PROFAMILIA . . . . . 4 CLINICA PROFAMILIA . . . . . 5 CLIN/MEDICO PARTICUL . . . . . 6 AMIGA O VECINA . . . . . 7 OTRO, cuál? _____ 8	312	66 ☐
311.	DIU: A qué sitio fue para que le insertaran el DIU? ESTERILIZACION: En qué sitio le practicaron la operación?	HOSPITAL O PTO SALUD . . . . . 1 CLINICA PROFAMILIA . . . . . 2 CLIN/MEDICO PARTICUL . . . . . 3 OTRO, cuál? _____ 4	401	67 ☐
312.	Volverá usted a comprar en este sitio?	SI . . . . . 1 NO 2		68 ☐
313.	Cómo le ha parecido la atención que ha recibido cuando va a comprar el anticonceptivo?	MUY BUENA . . . . . 1 BUENA . . . . . 2 REGULAR . . . . . 3 MALA . . . . . 4 MUY MALA 5		69 ☐
314.	En alguna ocasión al ir a comprar el anticonceptivo lo ha encontrado agotado?	SI . . . . . 1 NO 2		70 ☐
315.	Normalmente, cuánto tiempo gasta en llegar de su casa a ese lugar?	HORAS . . . . . ☐☐ MINUTOS . . . . . ☐☐		71 ☐☐☐
316.	Qué medio de transporte utiliza generalmente para llegar a ese lugar?	A PIE . . . . . 1 BUS . . . . . 2 CARRO/TAXI COLECTIVO . . . . . 3 LANCHA/CANOA . . . . . 4 CABALLO/MULA . . . . . 5 OTRO, cuál? _____ 6		72 ☐

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IV. CONOCIMIENTO DE METODOS

PREG No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS
401.	VEA PREGUNTA 302	HA OIDO DE LA PILDORA [1]	NO HA OIDO DE LA PILDORA [2] (PASE A PREG. 414)	73 ☐
402.	Sabe usted cómo se usa la píldora?	SI . . . . . 1 NO . . . . . 2 →	414	74 ☐
403.	En que día de la menstruación comienza a tomar la píldora al iniciar el uso de este método?	AL 5o. DIA DE COMENZADA LA MENSTRUACION . . . . . 1 5 DIAS DESPUES DE PASADA LA MENSTRUACION . . . . . 2 1 SEMANA DESPUES DE PASAR LA MENSTRUACION . . . . . 3 CUALQUIER DIA DEL MES . . . . . 4 OTRO, cuál? _____ 5 NS/NC 8		75 ☐
404.	Cuando una señora termina un ciclo o cartón de 21 píldoras, cuántos días debe esperar para comenzar uno nuevo?	AL DIA SIGUIENTE . . . . . 1 A LOS 7 DIAS . . . . . 2 OTRO, cuál? _____ 3 NS/NC 8		76 ☐
405.	Cuando una señora termina un ciclo o cartón de 28 píldoras, cuántos días debe esperar para comenzar uno nuevo?	AL DIA SIGUIENTE . . . . . 1 A LOS 7 DIAS . . . . . 2 OTRO, cuál? _____ 3 NS/NC 8		77 ☐
406.	Cada cuánto se debe tomar la píldora?	TODOS LOS DIAS . . . . . 1 CADA VEZ QUE TIENE RELACIONES SEXUALES . . . . . 2 OTRO, cuál? _____ 3 NS/NC 8		78 ☐
407.	Qué debe hacer una mujer cuando se le olvida tomar una píldora?	TAN PRONTO SE ACUERDA SE LA TOMA Y SIGUE EL CICLO NORMAL . . . 1 TOMA 2 SIMULTANEAS AL DIA SIGUIENTE . . . . . 2 TOMA SOLO UNA AL DIA SIGUIENTE . . 3 OTRO, cuál? _____ 4 NS/NC 8		79 ☐

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IV. CONOCIMIENTOS Y METODOS

Continuación

PREG No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS
408.	Si una señora tiene ocasionalmente náuseas, durante las dos primeras semanas del uso de la píldora, usted que le recomendaría?	CONTINUAR EL USO . . . . . 1 SUSPENDER DEFINITIVAMENTE USO . 2 CAMBIAR LA MARCA DE PILDORA . . . 3 CONSULTAR AL MEDICO . . . . . 4 OTRO, cuál? _____ 5 NS/NC 8		80 ☐
409.	Si una señora está lactando (dando pecho) a un niño, puede tomar píldoras anticonceptivas?	SI . . . . . 1 NO . . . . . 2 NS/NC 8	→ 411 → 411	81 ☐
410.	Por qué no?	ACABA CON LA LECHE . . . . . 1 LE HACE DAÑO AL NIÑO . . . . . 2 OTRO, cuál? _____ 3 NS/NC 8		82 ☐
411.	Si una señora no va a tener relaciones sexuales durante una semana, puede suspender el uso de píldoras durante ese período?	SI . . . . . 1 NO . . . . . 2 NS/NC 8		83 ☐
412.	En cuáles enfermedades o alteraciones de salud una mujer no debe usar la píldora? (PUEDE MARCAR VARIAS RESPUESTAS)	PRESION ARTERIAL ALTA . . . . . 01 VARICES MUY PRONUNCIADAS . . . . . 02 ENFERMEDADES CARDIOVASCULARES. 04 ENFERMEDADES HEPATICAS (Ictericia, hepatitis) . . . . . 08 CANCER . . . . . 16 OTROS, cuáles? _____ 32 NS/NC 88		84 ☐☐
413.	Es aconsejable que las mujeres con más de 35 años usen la píldora?	SI . . . . . 1 NO . . . . . 2 NS/NC 8		85 ☐

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IV. CONOCIMIENTOS DE METODOS

Continuación

PREG No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS
414.	VEA PREGUNTA 302	HA OIDO DE VAGINALES [1] ↓ / NO HA OIDO DE VAGINALES [2] ↓ (PASE A PREG. 420)		86
415.	Sabe cómo se usan los óvulos y tabletas vaginales?	SI . . . . . 1 NO 2	→420	87
416.	En qué momento de la relación una señora se debe colocar la tableta vaginal?	ANTES DEL ACTO SEXUAL . . . . . 1 DESPUES DEL ACTO SEXUAL . . . . . 2 DURANTE EL ACTO SEXUAL . . . . . 3 ANTES Y DESPUES DEL ACTO SEXUAL. 4 OTRO, cuál? _____ 5 NS/NC 8	418	88
417.	Cuánto tiempo antes de la relación se debe colocar la tableta vaginal u óvulo?	MENOS DE 10 MINUTOS . . . . . 1 ENTRE 10 Y 60 MINUTOS . . . . . 2 MAS DE 60 MINUTOS . . . . . 3 NS/NC 8		89
418.	Para cuántas relaciones sirve cada tableta vaginal?	UNA . . . . . 1 MAS DE UNA . . . . . 2 NS/NC 8		90
419.	Cuando se usan tabletas u óvulos, es necesario hacerse una ducha vaginal poco después de la relación?	SI . . . . . 1 NO . . . . . 2 NS/NC 8		91
420.	VEA PREGUNTA 302	HA OIDO DE CONDONES [1] ↓ / NO HA OIDO DE CONDONES [2] ↓ (PASE A PREG. 427)		92
421.	Sabe usted cómo se usan los condones?	SI . . . . . 1 NO 2	→427	93
422.	En qué momento de la relación se debe colocar el hombre el condón?	ANTES DE INTRODUCIR EL PENE EN LA VAGINA . . . . . 1 DURANTE LA RELACION SEXUAL . . . 2 DESPUES DE TERMINADA LA RELACION SEXUAL . . . . . 3 OTRO, cuál? _____ 4 NS/NC 8		94
423.	Para cuántas relaciones sirve cada condón?	UNA . . . . . 1 MAS DE UNA . . . . . 2 NS/NC 8		95
424.	Cuándo se debe retirar el hombre que usa condón de la mujer: Cuando el pene está todavía erecto o cuando ya está flácido?	ERECTO . . . . . 1 FLACIDO . . . . . 2 NS/NC 8	426	96

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IV. CONOCIMIENTOS DE METODOS

Continuación

PREG No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS
425.	Por qué?	NO SE DERRAMA EL SEMEN/MENOR RIESGO DE EMBARAZO/MAYOR EFECTIVIDAD. (RPTA. SIMILAR) . . 1 OTRA RESPUESTA . . . . . 2 NS/NC 8		97 ☐
426.	Cómo debe quedar el condón en la punta del pene: Bien ajustado o con un poco de espacio?	AJUSTADO . . . . . 1 CON ESPACIO . . . . . 2 NS/NC 8		98 ☐
427.	VEA PREGUNTA 302 HA OIDO DEL DIU ☐1 ↓	NO HA OIDO DEL DIU ☐2 (PASE A PREG. 436)		99 ☐
428.	Dónde se coloca el DIU (anillo, T Dorada, aparato, churrusco) en la mujer?	UTERO O MATRIZ . . . . . 1 VAGINA . . . . . 2 ABDOMEN . . . . . 3 OTRO, cuál? _____ 4 NS/NC 8		100 ☐
429.	Por favor dígame qué clases de Dispositivos intrauterinos conoce o de cuáles ha oído hablar?			

DISPOSITIVOS	430. Ha oído de este DIU? SI SIN AYUDA Pase a 431	SI CON AYUDA Pase a 431	NO ↓	431. Cuánto tiempo protege este DIU contra el embarazo? ENTRE 2 Y 5 AÑOS	6 AÑOS O MAS	OTRA RESP. Cuál?	NS/ NC.	CODIGOS
ASA DE LIPPES, CHURRUSCO, ANILLO'	1	2	3	1	2	3 _____	8	101 ☐☐ 102
T DE COBRE, T DORADA, ETC.	1	2	3	1	2	3 _____	8	103 ☐☐ 104
OTRO, cuál? _____	1	2	3	1	2	3 _____	8	105 ☐☐ 106

432.	El DIU se debe colocar con la menstruación o sin ella?	CON LA MENSTRUACION . . . . . 1 SIN LA MENSTRUACION . . . . . 2 NS/NC 8	107 ☐
433.	Cómo puede saber la mujer si su DIU está bien colocado?	TOCANDO LOS HILOS CON LOS DEDOS O RESPUESTA SIMILAR . . 1 OTRA RESPUESTA . . . . . 2 NS/NC 8	108 ☐

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PREG No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS
434.	Después de la inserción, al cuánto tiempo debe ir la mujer a control médico?	TRES MESES O ANTES . . . . . 1 CUATRO A SEIS MESES . . . . . 2 OTRA RESPUESTA . . . . . 3 NS/NC 8		109 ☐
435.	Después del primer control, cada cuánto debe ir la mujer a sus siguientes controles?	CUALQUIER RESPUESTA ENTRE 9 Y 18 MESES . . . . . 1 OTRA RESPUESTA . . . . . 2 NS/NC 8		110 ☐
436.	VEA PREGUNTA 302	HA OIDO DE LA VASECTOMIA [1] ↓	NO HA OIDO DE LA VASECTOMIA [2] ↓ (PASE A PREG.449)	111 ☐
437.	En qué consiste la vasectomía o Esterilización Masculina?	LIGAR O CORTAR LOS CONDUCTOS DEFERENTES . . . . . 1 QUITAR LOS TESTICULOS . . . . . 2 QUITAR EL PENE . . . . . 3 QUITAR LOS TESTICULO Y EL PENE . . . . . 4 OTRO, cuál? _____ 5 NS/NC 8		112 ☐
438.	Vasectomía es lo mismo que castración?	SI . . . . . 1 NO . . . . . 2 NS/NC 8		113 ☐
439.	Tiene eyaculaciones un hombre vasectomizado?	SI . . . . . 1 NO . . . . . 2 NS/NC 8		114 ☐
440.	Produce cambios en los deseos sexuales del hombre la vasectomía?	SI . . . . . 1 NO . . . . . 2 NS/NC 8		115 ☐
441.	Produce cambios en el carácter o comportamiento del hombre la vasectomía?	SI . . . . . 1 NO . . . . . 2 NS/NC 8	443	116 ☐
442.	Cuáles cambios?	MAL GENIO . . . . . 01 MAS SERIOS . . . . . 02 DECAIMIENTO ESTADO DE ANIMO . . 04 TRAUMATISMO PSICOLOGICO . . . . . 08 TRANQUILIDAD/SERENIDAD . . . . . 16 OTRO, cuál? _____ 32 NS/NC 88		117 ☐☐

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IV. CONOCIMIENTOS DE METODOS

Continuacion

PREG No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS
443.	Cuántas noches cree usted que tiene que pasar en la clínica u hospital un hombre que se mande vasectomizar?	0, NINGUNA 1 - 2 NOCHES 3 O MAS NOCHES NS/NC	1 2 3 8	118 ☐
444.	Cuánto diría que le duele la operación a un hombre: Mucho, poco o nada?	MUCHO POCO NADA NS/NC	1 2 3 8	119 ☐
445.	A los cuántos días después de la operación puede trabajar el hombre?	AL DIA SIGUIENTE A LOS 2 DIAS A LOS 3 DIAS A LOS 4 O MAS DIAS NS/NC	1 2 3 4 8	120 ☐
446.	Su marido o pareja sabe de la vasectomía?	SI NO VASECTOMIZADO NS/NC	1 2 3→449 8	121 ☐
447.	Usted cree que su marido o pareja se haría la vasectomía, cuando ustedes ya no quieran tener más hijos?	SI NO NS/NC	1 2 8	122 ☐
448.	Usted conoce a alguien que se haya hecho la vasectomía?	SI NO NS/NC	1 2 8	123 ☐
449	VEA PREGUNTA 302.	HA OIDO DE LIGADURA DE TROMPAS [1] ↓	NO HA OIDO DE LIGADURA DE TROMPAS [2] ↓ (PASE A PREG. 457)	124 ☐
450.	En qué consiste la ligadura de trompas o esterilización femenina?	LIGAR O CORTAR LAS TROMPAS DE FALOPIO SACAR LA MATRIZ SACAR LOS OVARIOS SACAR MATRIZ Y OVARIOS OTRO, cuál? _____ NS/NC	1 2 3 4 5 8	125 ☐
451.	Puede fallar la esterilización femenina?	SI NO NS/NC	1 2 8	126 ☐

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IV. CONOCIMIENTOS DE METODOS

Continuación

PREG No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS
452.	La ligadura de trompas es un método definitivo o temporal. (irreversible o reversible)	DEFINITIVO . . . . . 1 TEMPORAL . . . . . 2 NS/NC 8		127 ☐
453.	Produce cambios en los deseos sexuales de la mujer, la ligadura de trompas?	SI . . . . . 1 NO . . . . . 2 NS/NC 8		128 ☐
454.	Después de la ligadura de trompas o esterilización femenina una mujer sigue teniendo reglas o menstruación?	SI . . . . . 1 NO . . . . . 2 NS/NC 8		129 ☐
455.	Produce cambios en el carácter o comportamiento de la mujer la ligadura de trompas?	SI . . . . . 1 NO . . . . . 2 NS/NC 8	457	130 ☐
456.	Cuáles cambios?	MAL GENIO . . . . . 01 MAS SERIAS . . . . . 02 DECAIMIENTO ESTADO DE ANIMO . . 04 TRAUMATISMO PSICOLOGICO . . . . . 08 TRANQUILIDAD/SERENIDAD . . . . . 16 OTRO, cuál? . . . . . 32 NS/NC 88		131 ☐☐
457.	En qué momento dentro del ciclo menstrual cree usted que una mujer tiene mayor riesgo de quedar embarazada?	CUANDO TIENE LA REGLA . . . . . 1 EN LA PRIMERA SEMANA DESPUES DE LA REGLA . . . . . 2 EN LA MITAD DEL CICLO . . . . . 3 UNA SEMANA ANTES DEL COMIENZO DE LA REGLA . . . . . 4 EN CUALQUIER MOMENTO . . . . . 5 OTRO, cuál? _____ 6 NS/NC 8		132 ☐

V. CONOCIMIENTO Y USO DE MEDIOS DE COMUNICACION

PREG No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS
501.	Cuántos días a la semana escucha radio?	DIAS . . . . . ☐		133 ☐
502.	Cuántos días a la semana ve televisión?	DIAS . . . . . ☐		134 ☐
503.	Cuántos días lee periódicos en un mes?	DIAS . . . . . ☐☐		135 ☐☐

V. CONOCIMIENTO Y USO DE MEDIOS DE COMUNICACION

Continuación

PREG No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	CODIGOS
504.	Cuántas revistas lee en un mes?	NUMERO DE REVISTAS AL MES ..... ☐☐	136 ☐☐
505.	En el último año, ha asistido usted a alguna charla de PROFAMILIA?	SI ..... 1 NO ..... 2 NS/NC 8	137 ☐
506.	En el último año, ha asistido usted a una charla de alguna promotora de salud?	SI ..... 1 NO ..... 2 NS/NC 8	138 ☐
507.	Alguna vez le han practicado una Citología Vaginal?	SI ..... 1 NO ..... 2→601	139 ☐
508.	Con qué frecuencia?	1 a 6 MESES ..... 1 CADA 6 MESES ..... 2 6 MESES A 1 AÑO ..... 3 CADA AÑO ..... 4 1 A 2 AÑOS ..... 5 CADA 2 AÑOS ..... 6 MAS DE 2 AÑOS 7	140 ☐
509.	A dónde va con más frecuencia a mandarse practicar la Citología Vaginal?	LIGA CONTRA EL CANCER ..... 1 PROFAMILIA ..... 2 HOSPITAL/CENTRO SALUD ..... 3 MEDICO/LAB. PARTICULAR ..... 4 CAJA COMPENSACION/ISS ..... 5 OTRO, cuál? 6	141 ☐

VI. CONOCIMIENTO SOBRE EL SIDA (AIDS)

AHORA ME GUSTARIA HACERLE UNAS PREGUNTAS SOBRE UN TEMA DIFERENTE:

601.	Ha oído usted de una enfermedad llamada SIDA (o AIDS, SINDROME DE INMUNO-DEFICIENCIA ADQUIRIDA)	SI ..... 1 NO ..... 2→TERMINE	142 ☐

602.	Usted cree que se pueda contagiar el SIDA:	SI	NO	NS/NC	
602A	Por transfusión de sangre?	(1)	2	3	143 ☐
602B	Por picaduras de insectos o zancudos?	1	(2)	3	144 ☐
602C	Por mordeduras de animales?	1	(2)	3	145 ☐
602D	Por relaciones homosexuales entre hombres?	(1)	2	3	146 ☐
602E	Por relaciones sexuales de un hombre con una mujer?	(1)	2	3	147 ☐
602F	Por respirar el aire de una persona infectada?	1	(2)	3	148 ☐
602G	Por darle la mano/tocar personas que tengan el virus?	1	(2)	3	149 ☐
602H	Por inyectarse con aguja contaminada y/o que han usado varias personas?	(1)	2	3	150 ☐

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VI. CONOCIMIENTO SOBRE EL SIDA (AIDS)

Continuación

PREG No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS
603.	Hay alguna manera en que se pueda saber si una persona tiene el virus del SIDA?	SI ..... 1 NO ..... 2 NS/NC 8	605	151
604.	De qué maneras? (PUEDE MARCAR VARIAS RESPUESTAS)	EXAMEN LABORATORIO ..... 01 SE VE ENFERMO ..... 02 OTRA, cuál .... 04 NS/NC 88		152
605.	Puede alguien estar sano y tener el virus del SIDA?	SI ..... 1 NO ..... 2 NS/NC 8		153
606.	Cómo se puede prevenir el contagio del SIDA? INSISTA: Hay alguna otra manera? (PUEDE MARCAR MAS DE 1 RESPUESTA)	USANDO CONDONES ..... 01 UN SOLO COMPAÑERO ..... 02 ABSTINENCIA ..... 04 EVITAR TRANSFUSIONES ..... 08 NO AUTOINYECTARSE Y NO COMPARTIR JERINGAS ..... 16 NO TENER RELAC. HOMOSEXUALES .. 32 NO TENER RELACIONES CON PROSTITUTAS ..... 64 OTRA, cuál .... 128 NS/NC 888		154
607.	EL SIDA se puede curar?	SI ..... 1 NO ..... 2 NS/NC 8		155
608.	Hay vacuna contra el SIDA?	SI ..... 1 NO ..... 2 NS/NC 8		156
609.	Sabe de algún amigo, conocido o vecino que tenga o haya tenido SIDA?	SI ..... 1 NO ..... 2 NS/NC 8		157

DE LOS AGRADECIMIENTOS Y TERMINE LA ENCUESTA

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APPENDIX 8

1987 DISTRIBUTORS SURVEY QUESTIONNAIRE

PROFAMILIA	SEGUNDA ENCUESTA DE DISTRIBUIDORES 1.987	CONFIDENCIAL FINES CIENTIFICOS

I.A. IDENTIFICACION DEL CUESTIONARIO

CODIGOS

101 Número del cuestionario: 1

102 Clínica: _____ 2

103 Departamento: _____ 3

104 Municipio: _____ 4

105 Zona: URBANA 1 RURAL 2 5

106 Nombre Distribuidor: _____ 6

107 Dirección Distribuidor: _____

_____

B. RESULTADO DE LA VISITA

VISITA	(108) FECHA		(109) RESULTADO				
	Día	Mes	Completa	Incompleta	Rechazo	Ausencia	Otros
1a.							
2a.							

7 8 9

C. CONTROL DE SUPERVISION Y PROCESAMIENTO

110 Nombre de la encuestadora: _____

111 Observaciones de la encuestadora: _____

_____

_____

112 Nombre del Supervisor: _____

113 Observaciones: _____

_____

114

	SUPERVISOR	CRITICO	CODIFICADOR
FECHA			
NOMBRE			

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II. CARACTERISTICAS DEL (A) DISTRIBUIDOR (A).

PREG. No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS
201	Cuántos años cumplidos tiene usted?	AÑOS CUMPLIDOS		10
202	Sexo:	MASCULINO ..... 1 FEMENINO 2		11
203	Cuál es su estado civil (conyugal) actual?	CASADO (A) ..... 1 CONVIVIENTE ..... 2 SEPARADO (A) DIVORCIADO (A) 3 VIUDO (A) ..... 4 SOLTERO (A) 5		12
204	Cuál fue el curso o año de escolaridad más alto que usted aprobó?	PRIMARIA ..... 0 SECUNDARIA ..... 1 UNIVERSITARIA 2		13
	SI EL ENTREVISTADO DICE HABER ESTUDIADO HASTA TERCERO DE PRIMARIA O MENOS, HAGALE LA SIGUIENTE PREGUNTA, DE LO CONTRARIO PASE A 206			
205	Puede usted leer el manual de métodos de planificación familiar correctamente?	SI ..... 1 NO 2		14
206	Ha tenido usted hijos alguna vez?	SI ..... 1 NO 2		15
207	Qué métodos de planificación familiar conoce usted o de cuáles ha oído hablar?			

METODOS	208 Ha oído hablar de este método? SI	208 NO	209 Ha usado alguna vez este método? SI	209 NO	CODIGOS
PILDORA	1	2	1	2	16 17
CONDON	1	2	1	2	18 19
DIU	1	2	1	2	20 21
ESTERILIZACION FEMENINA	1	2	1	2	22 23
ESTERILIZACION MASCULINA	1	2	1	2	24 25
INYECCION	1	2	1	2	26 27
TABLETAS VAGINALES	1	2	1	2	28 29
RITMO	1	2	1	2	30 31
RETIRO	1	2	1	2	32 33
OTRO, Cuál?	1	2	1	2	34 35

210	VEA 209:	HA USADO ALGUN METODO 1	NUNCA HA USADO METODOS 2 (PASE A 213)	36
211	Está usando actualmente un método de planificación familiar?	SI ..... 1 NO ..... 2 → 213		37

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PREG. No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	CODIGOS
212	Qué método está usando?	PILDORA ..... 01 CONDON ..... 02 DIU ..... 03 ESTERIL. FEMENINA ..... 04 ESTERIL. MASCULINA ..... 05 INYECCION ..... 06 TABLETAS U OVULOS ..... 07 RITMO ..... 08 RETIRO ..... 09 OTRO, Cuál?_____ 10	38 [ ][ ]
213	Cuántos años hace que usted es distribuidor (a) de Profamilia?	AÑOS ..... [ ][ ]	39 [ ][ ]
214	Cuál es la razón más importante por la que usted es distribuidor de Profamilia?	_____ _____ _____ _____	40 [ ][ ] (ANEXO)
III. CONOCIMIENTO DE METODOS			
301	VEA PREGUNTA 208:	HA OIDO DE LA PILDORA [1] ↓ / NO HA OIDO DE LA PILDORA [2] (PASE A 314)	41 [ ]
302	Cuándo se comienza a tomar la píldora al iniciar el uso de este método?	AL 5o. DIA DE COMENZADA LA MENSTRUACION ..... 1 5 DIAS DESPUES DE PASADA LA MENSTRUACION ..... 2 UNA SEMANA DESPUES DE PASAR LA MENSTRUACION .. 3 CUALQUIER DIA DEL MES ... 4 OTRO, Cuál?_____ 5	42 [ ]
303	Cuando una señora termina un ciclo o cartón de 21 píldoras, cuántos días debe esperar para comenzar uno nuevo	AL DIA SIGUIENTE ..... 1 A LOS 7 DIAS ..... 2 OTRO, Cuál?_____ 3	43 [ ]
304	Cuando una señora termina un ciclo o cartón de 28 píldoras, cuántos días debe esperar para comenzar uno nuevo?	AL DIA SIGUIENTE ..... 1 A LOS 7 DIAS ..... 2 OTRO ,Cuál?_____ 3	44 [ ]
305	Cada cuánto se debe tomar la píldora?	TODOS LOS DIAS ..... 1 CADA VEZ QUE TIENE RELACIONES SEXUALES .... 2 OTRO, Cuál?_____ 3	45 [ ]
306	Qué debe hacer una mujer cuando se le olvida tomar una píldora?	TAN PRONTO SE ACUERDA SE LA TOMA Y SIGUE EL CICLO NORMAL ..... 1 TOMA DOS AL DIA SIGUIENTE EN FORMA SIMULTANEA .... 2 TOMA SOLO UNA AL DIA SIGUIENTE ..... 3 OTRO, Cuál?_____ 4	46 [ ]

PREG. No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS
307	Si una señora tiene ocasionalmente náuseas durante las primeras dos semanas del uso de la píldora, usted qué le recomendaría?	CONTINUAR EL USO A NO SER QUE EMPEORE LA SITUACION 1 SUSPENDER DEFINITIVAMENTE EL USO DE LA PILDORA 2 CAMBIAR LA MARCA DE PILDORA ..... 3 CONSULTAR CON URGENCIA AL MEDICO ..... 4 OTRO, Cuál? _____ 5		47 ☐
308	Si una señora está lactando (dando pecho) a un niño puede tomar píldoras anticonceptivas?	SI ..... 1 NO..... 2	→ 310	48 ☐
309	Por qué no?	ACABA CON LA LECHE ..... 1 LE HACE DAÑO AL NIÑO .... 2 OTRO, Cuál ?_____ 3 _____	311	49 ☐
310	Qué píldora recomendaría usted a una mujer que está lactando (dando pecho)?	NORAL ..... 1 NORDETTE ..... 2 NEOGYNON ..... 3 MICROGYNON ..... 4 TODAS LAS ANTERIORES ... 5 OTRA, Cuál?_____ 6 NO SABE 7		50 ☐
311	Si una señora no va a tener relaciones sexuales durante una semana, puede suspender el consumo de píldoras durante ese período?	SI ..... 1 NO..... 2		51 ☐
312	En cuáles enfermedades o alteraciones de salud una mujer no debe usar la píldora? (PUEDE MARCAR VARIAS RESPUESTAS)	PRESION ARTERIAL ALTA .. 01 VARICES MUY PRONUNCIADAS O INFLAMADAS ..... 02 ENFERMEDADES CARDIOVASCULARES ..... 04 ENFERMEDADES HEPATICAS (ICTERICIA, HEPATITIS) ..... 08 CANCER ..... 16 OTROS, Cuáles?_____ 32 _____		52 ☐☐
313	Usted recomendaría el uso de la píldora a una mujer de más de 35 años de edad?	SI ..... 1 NO 2		53 ☐
314	VEA PREGUNTA 208: HA OIDO DE VAGINALES [1] ↓ NO HA OIDO DE VAGINALES [2] (PASE A 317)			54 ☐
315	En qué momento una señora se debe colocar la tableta vaginal?	DESPUES DEL ACTO SEXUAL 1 DURANTE EL ACTO SEXUAL 2 ANTES DEL ACTO SEXUAL .. 3 ANTES Y DESPUES DEL ACTO SEXUAL ..... 4 OTRO, Cuál?_____ 5 NO SABE 6		55 ☐
316	Para cuántas relaciones sirve cada tableta vaginal?	UNA ..... 1 MAS DE UNA 2		56 ☐

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PREG. No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS
317	VEA PREGUNTA 208: HA OIDO DE CONDONES [1] ↓	NO HA OIDO DE CONDONES [2] (PASE A 320)		57 [ ]
318	Cuándo se debe colocar el hombre el condón?	ANTES DE INTRODUCIR EL PENE EN LA VAGINA ..... 1 DURANTE LA RELACION SEXUAL ..... 2 DESPUES DE TERMINADA LA RELACION SEXUAL ..... 3 OTRO, Cuál? _____ 4		58 [ ]
319	Para cuántas relaciones sirve cada condón?	UNA ..... 1 MAS DE UNA 2		59 [ ]
320	VEA PREGUNTA 208: HA OIDO DE LIGADURA DE TROMPAS [1] ↓	NO HA OIDO DE LIGADURA DE TROMPAS [2] (PASE A 328)		60 [ ]
321	En qué consiste la ligadura de trompas o esterilización femenina?	LE LIGAN O CORTAN LAS TROMPAS DE FALOPIO ..... 1 LE SACAN LA MATRIZ ..... 2 LE SACAN LOS OVARIOS .... 3 LE SACAN LOS OVARIOS Y MATRIZ ..... 4 OTRO, Cuál? _____ 5		61 [ ]
322	Después de la ligadura de trompas o esterilización femenina una señora puede volver a tener hijos?	SI ..... 1 NO 2		62 [ ]
323	Puede fallar la ligadura de trompas o esterilización femenina en algunas raras ocasiones?	SI ..... 1 NO 2		63 [ ]
324	Produce cambios en la sexualidad de la mujer la ligadura de trompas o esterilización femenina?	SI ..... 1 NO 2		64 [ ]
325	Después de la ligadura de trompas o esterilización femenina una mujer sigue teniendo reglas o menstruaciones?	SI ..... 1 NO 2		65 [ ]
326	Produce cambios en el carácter o comportamiento de la mujer la ligadura de trompas?	SI ..... 1 NO ..... 2 → 328		66 [ ]
327	Cuáles cambios?	_____ _____ _____ _____ _____		67 [ ][ ] (ANEXO)

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PREG. No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS
328	VEA PREGUNTA 208:	HA OIDO DE VASECTOMIA [1] ↓ / NO HA OIDO DE VASECTOMIA [2]	(PASE A 334)	68 [ ]
329	En qué consiste la vasectomía o esterilización masculina?	SE LIGAN O CORTAN LOS CONDUCTOS DEFERENTES ..... 1 LE QUITAN LOS TESTICULOS . 2 SE LE QUITA EL PENE ..... 3 SE LE QUITAN LOS TESTICULOS Y EL PENE AL HOMBRE ..... 4 OTRO, Cuál? _____ 5 NO SABE 6		69 [ ]
330	Vasectomía es lo mismo que castración?	SI ..... 1 NO 2		70 [ ]
331	Tiene eyaculaciones un hombre vasectomizado?	SI ..... 1 NO 2		71 [ ]
332	Produce cambios en la sexualidad del hombre la vasectomía?	SI ..... 1 NO 2		72 [ ]
333	Produce cambios en el carácter o comportamiento del hombre la vasectomía?	SI ..... 1 NO 2		73 [ ]
334	VEA PREGUNTA 208:	HA OIDO DEL DIU [1] ↓ / NO HA OIDO DEL DIU [2]	(PASE A 337)	74 [ ]
335	Dónde se coloca el DIU (anillo, T dorada, aparato, churrusco) en la mujer?	EN EL UTERO O MATRIZ .... 1 EN LA VAGINA ..... 2 EN EL ABDOMEN ..... 3 OTRO, Cuál? _____ 4 NO SABE 5		75 [ ]
336	Mencione tres clases de Diu que conozca y diga cuánto tiempo puede durar una mujer con él. (CONVIERTA LA RESPUESTA A MESES)	1._____ _____ 2._____ _____ 3._____ _____		76 [ ] [ ] 77 78 [ ] [ ] 79 80 [ ] [ ] 81 (ANEXOS)
337	En qué días dentro del ciclo menstrual cree usted que una mujer puede quedar embarazada más fácilmente?	DURANTE LA REGLA O MENSTRUACION ..... 1 EN LA PRIMERA SEMANA DESPUES DE LA REGLA ..... 2 EN LA MITAD DEL CICLO .... 3 UNA SEMANA ANTES DE LA REGLA O AL FINAL DEL CICLO ..... 4 AL PRINCIPIO Y AL FINAL DEL CICLO ..... 5 OTRO, Cuál? _____ 6		82 [ ]

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IV. PLANIFICACION FAMILIAR Y PROFAMILIA

PREG. No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS
401	Qué entiende por planificación familiar?	TENER MENOS HIJOS ..... 1 TENER LOS HIJOS QUE SE QUIERE EN EL MOMENTO QUE SE DESEE ..... 2 ES NO TENER HIJOS ..... 3 OTRO, Cuál? _____ 4		83
402	Profamilia es una Institución u organización privada, oficial o del gobierno o mixta?	PRIVADA ..... 1 OFICIAL O DEL GOBIERNO .. 2 MIXTA 3		84
403	La instructora le ha enseñado el uso de los métodos, o ha recibido alguna otra capacitación de Profamilia?	SI ..... 1 NO 2	→ 407	85
404	Qué tipo de capacitación ha recibido de Profamilia? (PUEDE MARCAR VARIAS RESPUESTAS)	CURSILLO CON OTROS DISTRIBUIDORES ..... 01 CHARLAS DOMICILIARIAS PERSONALES ..... 02 CHARLAS COLECTIVAS .... 04 OTRO, Cuál? _____ 08		86
405	Qué tan bien diría usted que la instructora le ha enseñado sobre métodos: Muy bien, bien, mal o muy mal?	MUY BIEN ..... 1 BIEN ..... 2 MAL ..... 3 MUY MAL 4		87
406	En qué año recibió la última capacitación de Profamilia?	AÑO 1 9		88
407	En el último año supo usted que la instructora de Profamilia hiciera visitas domiciliarias en esta comunidad o barrio?	SI ..... 1 NO 2		89
408	En el último año dió la instructora de Profamilia charlas sobre planificación familiar en esta comunidad o barrio?	SI ..... 1 NO ..... 2 NO SABE 3	416	90
409	Como cuántas charlas sobre planificación familiar diría usted que dió la instructora en esta comunidad?	NUMERO DE CHARLAS		91
410	Ha asistido a alguna de estas charlas de la instructora?	SI ..... 1 NO 2	→ 415	92
411	Recomendó la instructora algún método en especial?	SI ..... 1 NO 2	→ 413	93
412	Cuál?	PILDORA ..... 01 CONDON ..... 02 DIU ..... 03 ESTERILIZACION FEMENINA . 04 ESTERILIZACION MASCULINA 05 INYECCION ..... 06 TABLETAS U OVULOS ..... 07 RITMO ..... 08 RETIRO ..... 09 OTRO, Cuál? _____ 10		94
413	La instructora dió información sobre las marcas y la disponibilidad de los anticonceptivos?	SI ..... 1 NO 2		95
414	Mencionó a qué sitios podía irse a adquirir anticonceptivos o servicios?	SI ..... 1 NO 2		96

241

PREG. No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS
415	Después de estas charlas y visitas domiciliarias sus ventas de anticonceptivos aumentan, disminuyen o quedan igual que antes?	AUMENTAN ..... 1 SIGUEN IGUAL ..... 2 DISMINUYEN 3		97 [ ]
416	De cada 10 mujeres que le compran anticonceptivos como a cuántas les ha aconsejado cómo usarlas?	NUMERO DE MUJERES... [ ][ ]		98 [ ][ ]

417 Cuáles de los siguientes materiales de publicidad tiene usted?

MATERIALES	(418) Lo tiene? SI	NO	(419) Qué tanto ayuda a vender? MUCHO	POCO	NADA	(420) Lo utiliza para explicar el uso? SI	NO	(421) Cuáles serían los tres más importantes?			
1. FOLLETOS METODOS ANTICONCEPTIVOS	1	2	1	2	3	1	2	1	2	3	99 [ ][ ][ ] 101
2. AFICHES PROFAMILIA	1	2	1	2	3			1	2	3	102 [ ][ ][ ] 104
3. LISTA DE ANTICONCEPTIVOS EN LUGAR VISIBLE	1	2	1	2	3			1	2	3	105 [ ][ ][ ] 107
4. AVISO DE PUESTO DE DISTRIBUCION VISIBLE	1	2	1	2	3			1	2	3	108 [ ][ ][ ] 110
5. MUESTRARIO DE ANTICONCEPTIVOS	1	2	1	2	3	1	2	1	2	3	111 [ ][ ][ ] 113 114 [ ][ ][ ] 116

PREG. No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS
422	Aparte de vender anticonceptivos qué otras actividades realiza para motivar a la comunidad?	VISITAS DOMICILIARIAS .... 1 CHARLAS O REUNIONES .... 2 OTRO, Cuál?_____ 3 NINGUNA ACTIVIDAD 4		117 [ ]
423	En el último año ha llegado usted a oír en el radio una cuña de Profamilia?	SI ..... 1 NO 2	→ 426	118 [ ]
424	De qué cosas hablaba o qué decía esa cuña?	_____ _____ _____ _____		119 [ ][ ] (ANEXO)
425	Cuando estaban pasando estas cuñas por radio se elevaron sus ventas de anticonceptivos o continuaron igual?	SUBIERON LAS VENTAS..... 1 SIGUIERON IGUAL..... 2		120 [ ]
426	Si usted tuviera que escoger, qué preferiría tener: folletos, afiches y otros impresos o que hubiera cuñas por radio?	MATERIALES IMPRESOS .... 1 CAMPAÑAS POR RADIO ..... 2 LAS DOS COSAS ..... 3 NINGUNA DE LAS DOS 4	→ 428 → 428	121 [ ]
427	Mencione tres métodos de mayor a menor importancia que sea más fácil promover por radio:	1o._____ 2o._____ 3o._____		122 [ ][ ] 123 [ ][ ] 124 [ ][ ] (ANEXO)
428	Cree usted que sería correcto enseñar el uso de los métodos por radio o no?	SERIA CORRECTO ..... 1 SERIA INCORRECTO 2		125 [ ]
429	Por qué cree usted esto?	_____ _____ _____ _____		126 [ ][ ] (ANEXO)

242

PREG No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS
430	Es correcto anunciar por radio el nombre o marca de los anticonceptivos?	SI ..... 1 NO 2		127 ☐
431	Por qué?	_____ _____ _____ _____		128 ☐☐ (ANEXO)
V.	**MERCADEO**			
501	Qué clase de establecimiento es éste?	VIVIENDA ..... 1 TIENDA ..... 2 OTRO, Cuál? _____ 3		129 ☐
502	Qué metodos de planificación familiar está vendiendo actualmente? (PUEDE MARCAR VARIAS RESPUESTAS)	PILDORA ..... 01 CONDON ..... 02 INYECCION ..... 04 TABLETAS U OVULOS ..... 08 OTRO Cuál? _____ 16 NINGUNO 00		130 ☐☐
503	Le ayuda otra persona en la venta de anticonceptivos?	SI ..... 1 NO 2	→505	131 ☐
504	Quiénes le ayudan? (PUEDE MARCAR VARIAS RESPUESTAS)	CONYUGE ..... 01 HIJOS ..... 02 PADRES ..... 04 OTROS FAMILIARES ..... 08 EMPLEADOS 16		132 ☐☐
505	Cuando a usted se le agotan los anticonceptivos que vende, qué le recomienda a sus usuarias?	_____ _____ _____		133 ☐☐ (ANEXO)
506	A qué otros establecimientos va la gente de esta comunidad o barrio a comprar anticonceptivos?	SI NO CLINICA DE PROFAMILIA 1 2 OTROS PUESTOS DE PROFAMILIA ..... 1 2 DROGUERIA-FARMACIA . 1 2 CLINICA / MEDICO PARTICULAR ..... 1 2 ISS/CAJAS COMPENSACION ..... 1 2 HOSPITAL/PUESTO DE SALUD ..... 1 2 OTRO, Cuál? _____ 1 2		134 ☐ 135 ☐ 136 ☐ 137 ☐ 138 ☐ 139 ☐ 140 ☐
507	Quién cree que vende más pastillas a la gente en esta comunidad o barrio?	ESTE PUESTO DE DISTRIBUCION ..... 1 OTROS PUESTOS DE PROFAMLIA ..... 2 CLINICA DE PROFAMILIA .... 3 HOSPITAL/PUESTO DE SALUD . 4 DROGUERIA/FARMACIA ..... 5 OTRO, Cuál? _____ 6		141 ☐

243

PREG. No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS

508 Por qué cree usted que la gente que compra sus pastillas en _____ prefiera comprar ahí? (Respuesta anterior)

MOTIVOS	(509) ESTE PUESTO	(510) CLINICA PROFAMILIA	(511) HOSPITAL PTO. SALUD	(512) DROGUERIA FARMACIA	(513) OTROS DIST. PROFAMILIA	CODIGOS
PRECIO MAS BARATO	01	01	01	01	01	
MAYOR VARIEDAD DE MARCAS	02	02	02	02	02	142
PRESENTACION EN CAJITAS	03	03	03	03	03	143
NUNCA SE AGOTAN	04	04	04	04	04	
ESTA ABIERTO MAS TIEMPO	05	05	05	05	05	144
CERCANIA A SUS DOMICILIOS	06	06	06	06	06	
MEJOR TRATO PERSONAL	07	07	07	07	07	145
MEJOR CALIDAD DE PASTILLAS	08	08	08	08	08	146
PERSONAL MAS CAPACITADO	09	09	09	09	09	
ÚNICO PUNTO DE VENTA	10	10	10	10	10	
OTRO, Cuál?	11	11	11	11	11	

514 Qué cosas se le ocurren que se podrían hacer para aumentar la venta de pastillas en este puesto?

_____
_____
_____
_____

147 (ANEXO)

515 Si un cliente le pide una marca de pastillas y usted no la tiene que hace el cliente: compra la que usted tiene o no?

COMPRA LA QUE USTED TIENE 1
NO COMPRA..... 2
OTRO, Cuál?_____ 3

148

516 Para usted cuáles son las tres mejores pastillas?

	1o.	2o.	3o.
01. NORIDAY.....			
02. EUGYNON.....	—	—	—
03. NEOGYNON 21...	—	—	—
04. NEOGYNON 28...	—	—	—
05. MICROGYNON 21.	—	—	—
06. MICROGYNON 28.	—	—	—
07. NORAL 21.....	—	—	—
08. NORAL 28.....	—	—	—
09. NORDETTE 21....	—	—	—
10. NORDETTE 28....	—	—	—
11. OVRAL.....	—	—	—
12. OTRA, Cuál?_____	—	—	—
13. TODAS SON IGUALES	—		

149 150 151

517 Ha escuchado usted algún tipo de cosas negativas o quejas sobre alguna marca de pastillas?

SI 1
NO ..... 2 → 520

152

518 Qué cosas ha escuchado?

_____
_____
_____

153 (ANEXO)

519 De cuáles pastillas?

_____

154 (ANEXO)

520 En condones, Quién cree que vende más en esta comunidad o barrio?

ESTE PUESTO 1
OTROS PUESTOS DE PROFAMILIA . . 2
CLINICA DE PROFAMILIA ... 3
HOSPITAL/PUESTO DE SALUD 4
DROGUERIA/FARMACIA 5
OTRO, Cuál?_____ 6

155

244

PREG. No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS

521 Por qué cree usted que la gente que compra sus condones en _____ prefiera comprar en este lugar? (Respuesta anterior)

MOTIVOS	(522) ESTE PUESTO	(523) CLINICA PROFAMILIA	(524) HOSPITAL PTO. SALUD	(525) DROGUERIA FARMACIA	(526) OTROS DIST. PROFAMILIA	CODIGOS
PRECIO MAS BARATO	01	01	01	01	01	156
MAYOR VARIEDAD DE MARCAS	02	02	02	02	02	
PRESENTACION EN CAJITAS	03	03	03	03	03	157
NUNCA SE AGOTAN	04	04	04	04	04	
ESTA ABIERTO MAS TIEMPO	05	05	05	05	05	158
CERCANIA A SUS DOMICILIOS	06	06	06	06	06	
MEJOR TRATO PERSONAL	07	07	07	07	07	159
MEJOR CALIDAD DE CONDONES	08	08	08	08	08	
UNICO PUNTO DE VENTA	09	09	09	09	09	160
OTRO, Cuál?	10	10	10	10	10	

527 Qué cosas se le ocurren que podría hacer usted o Profamilia para aumentar la venta de condones en este puesto?

_____
_____
_____
_____

161 (ANEXO)

528 Si un cliente le pide una marca de condones y usted no la tiene, el cliente compra la que usted tiene o prefiere no comprar?

COMPRA LA QUE USTED TIENE. 1
NO COMPRA 2
OTRO, Cuál? _____ 3

162

529 Por favor dígame el nombre o marca de los condones que usted conoce:

	SI	NO	CODIGOS
TAHITI	1	2	163
STIMULA	1	2	164
SULTAN	1	2	165
PRIME	1	2	166
ROSETEX	1	2	167
NUDA	1	2	168
CONTURE	1	2	169
JELLIA	1	2	170
MILLION	1	2	171
LOVE	1	2	172
PARADISE	1	2	173
OTRO, Cuál? _____	1	2	174

530 Usted cree que los condones que usted vende son mejores o peores que los que venden en otros lugares?

MEJORES 1
IGUALES 2
PEORES 3

175

531 Para usted cuáles son las tres mejores marcas de condones?

	1o.	2o.	3o.
01. TAHITI	—	—	—
02. STIMULA	—	—	—
03. SULTAN	—	—	—
04. PRIME	—	—	—
05. ROSETEX	—	—	—
06. NUDA	—	—	—
07. CONTURE	—	—	—
08. JELLIA	—	—	—
09. MILLION	—	—	—
10. LOVE	—	—	—
11. PARADISE	—	—	—
12. OTRO, Cuál? _____	—	—	—
13. TODAS SON IGUALES —			→ 533

176 177 178

245

PREG. No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS
532	Por qué piensa que estos condones son los mejores?	_____		179 [ ][ ] (ANEXO)
533	Ha escuchado cosas negativas o recibido quejas sobre alguna marca de condones?	SI ..... 1 NO 2	→ 536	180 [ ]
534	Qué cosas ha escuchado?	_____		181 [ ][ ] (ANEXO)
535	De cuáles condones?	_____		182 [ ][ ] (ANEXO)
536	En resumidas cuentas, cuáles cree usted que son sus principales ventajas sobre los otros para la venta de anticonceptivos?	_____		183 [ ][ ] (ANEXO)
537	Cuáles son sus principales desventajas respecto a los otros lugares que venden anticonceptivos?	_____		184 [ ][ ] (ANEXO)

DE LOS AGRADECIMIENTOS POR LA COLABORACION
Y TERMINE LA ENCUESTA

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APPENDIX 9

1987 CALI CONDOM SURVEY QUESTIONNAIRE

PROFAMILIA	TERCERA ENCUESTA ESTUDIO PRESERVATIVOS (CALI) 1.987	CONFIDENCIAL FINES CIENTIFICOS

I. DATOS ADMINISTRATIVOS

A. IDENTIFICACION DEL CUESTIONARIO

CODIGOS

101 Número de identificación del cuestionario 1 [ ][ ][ ][ ]

102 Institución o empresa: _____ 2 [ ][ ][ ]

103 Sector:
- [1] Privado
- [2] Oficial
- [3] Desempleado

3 [ ]

B. RESULTADO DE LA VISITA

(104) VISITA	(105) FECHA		(106) RESULTADO *				
	DIA	MES	COMPLETA	INCOMPLETA	RECHAZO	AUSENTE	OTRO
1a.							
2a.							

* Marque una X en la casilla correspondiente

4 [ ][ ]
5 [ ][ ]

C. CONTROL DE SUPERVISION Y PROCESAMIENTO

107 Nombre del encuestador: _____

Observaciones del encuestador: _____

108 Nombre del supervisor: _____

Observaciones del Supervisor: _____

109

	CRITICO	CODIFICADOR	SUPERVISOR
FECHA			
NOMBRE			

248

II. INFORMACION BASICA

PREG. No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS
201	Fué entrevistado por Profamilia en 1.984 o 1985?	SI ..... 1 NO 2		6
202	Nivel salarial mensual:	MENOS DE $15.000 ..... 1 DE $15.001 A $30.000 ..... 2 DE $30.001 A $60.000 ..... 3 DE $60.001 A $100.000 ..... 4 MAS DE $101.000 ..... 5 DESEMPLEADO 6		7
203	Cuántos años cumplidos tiene usted?	AÑOS CUMPLIDOS		8
204	Cuál es su estado civil (conyugal) actual?	SOLTERO ..... 1 CASADO ..... 2 CONVIVIENTE ..... 3 VIUDO/SEPARADO 4		9
205	Cuál fué el curso o año de escolaridad más alto que usted aprobó?	PRIMARIA ..... 0 SECUNDARIA ..... 1 UNIVERSITARIA 2		10
	SI EL SEÑOR DICE HABER ESTUDIADO HASTA TERCERO DE PRIMARIA O MENOS HAGALE LA SIGUIENTE PREGUNTA, DE LO CONTRARIO PASE A 207.			
206	Puede usted leer correctamente?	SI ..... 1 NO 2	→213	11
207	Lee usted periódicos?	SI ..... 1 NO 2	→210	12
208	Como cuántos días lee el periódico en una semana cualquiera?	DIAS		13
209	Cuáles periódicos lee con más frecuencia?	1._____ 2._____ 3._____		14 15 16
210	Lee usted revistas?	SI ..... 1 NO 2	→213	17
211	Como cuántas revistas lee en un mes cualquiera?	REVISTAS AL MES		18
212	Cuáles revistas lee con más frecuencia?	1._____ 2._____ 3._____		19 20 21
213	Oye usted radio?	SI ..... 1 NO 2	→217	22
214	Como cuántos días oye radio en una semana cualquiera?	DIAS		23
215	Cuáles emisoras prefiere oír?	1._____ 2._____ 3._____		24 25 26

PREG No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG	CODIGOS
216	De qué horas a qué horas escucha generalmente el radio?	DE_____A_____ DE_____A_____		27 ☐☐ ☐☐ 27A 28 ☐☐ ☐☐ 28A
217	Ve usted televisión?	SI ..... 1 NO 2	→ 301	29 ☐
218	Como cuántos días vé televisión en una semana cualquiera?	DIAS ..... ☐		30 ☐
219	Qué programas ve más frecuentemente?	1._____ 2._____ 3._____		31 ☐☐ 32 ☐☐ 33 ☐☐
220	De qué horas a qué horas suele usted ver televisión?	DE_____A_____ DE_____A_____		34 ☐☐ ☐☐ 34A 35 ☐☐ ☐☐ 35A

III. CONOCIMIENTO Y USO DE METODOS DE PLANIFICACION FAMILIAR

301 Existen varios métodos de planificación familiar que las parejas pueden usar para evitar los embarazos. Qué métodos conoce o de cuáles ha oído hablar?

METODOS	(302) Ha oído de este método? SI sin ayuda	SI con ayuda	NO	(303) Ha usado alguna vez_____? (método) SI	NO	(304) Ultimo método usado	
01. PILDORA	1	2	3	1	2	01	36 ☐☐ 37
02. DIU	1	2	3	1	2	02	38 ☐☐ 39
o3. EST. FEMENINA	1	2	3	1	2	03	40 ☐☐ 41
04. EST. MASCULINA	1	2	3	1	2	04	42 ☐☐ 43
05. CONDON	1	2	3	1	2	05	44 ☐☐ 45
06. INYECCION	1	2	3	1	2	06	46 ☐☐ 47
07. VAGINALES	1	2	3	1	2	07	48 ☐☐ 49
08. RITMO	1	2	3	1	2	08	50 ☐☐ 51
09. RETIRO	1	2	3	1	2	09	52 ☐☐ 53
10. OTROS	1	2	3	1	2	10	54 ☐☐ 55
							56 ☐☐

SI NO CONOCE NINGUNO TERMINE LA ENCUESTA.

305 VEZ 303: HA USADO METODOS [1] (PASE A 401) — NUNCA HA USADO METODOS [2] ↓ — 57 ☐

306 Por qué nunca ha usado métodos de planificación familiar? _____ — 58 ☐☐ (ANEXO)

250

IV. CONOCIMIENTO Y COMPRA DEL CONDON

PREG No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG	CODIGOS
401	VEA 302: CONOCE EL CONDON [1] ↓	NO CONOCE EL CONDON [2] (TERMINE LA ENCUESTA)		59
402	Usted dijo anteriormente que conoce el condón. Cómo supo de la existencia de los condones? (MARQUE UNA SOLA ALTERNATIVA DE RESPUESTA)	UN AMIGO ..... 01 UNA AMIGA ..... 02 ESPOSA O COMPAÑERA ..... 03 UN FAMILIAR ..... 04 UN MEDICO ..... 05 PROFAMILIA ..... 06 REVISTAS ..... 07 CINE ..... 08 PERIODICO ..... 09 COLEGIO-UNIVERSIDAD ..... 10 OTRO_____ 11 NO RECUERDA 12		60
403	Ha visto usted un condón?	SI ..... 1 NO 2		61
404	Sabe usted cómo se usa el condón?	SI ..... 1 NO 2	→406	62
405	Me puede describir cómo se usa el condón?	_____ _____ _____ _____		63 (ANEXO)
406	En qué momento de la relación sexual debe colocarse el hombre el condón?	ANTES DE INTRODUCIR EL PENE EN LA VAGINA ..... 1 DURANTE LA RELACION SEXUAL 2 DESPUES DE LA RELACION SEXUAL. 3 OTRO, Cuál?_____ 4 NO SABE 9		64
407	Sabe usted en dónde se consiguen los condones?	SI ..... 1 NO 2	→409	65
408	En dónde? (PUEDE MARCAR VARIAS ALTERNATIVAS DE RESPUESTA)	DROGUERIA ..... 01 PROFAMILIA ..... 02 VENDEDORES AMBULANTES Y/O SAN ANDRESITOS ..... 04 SUPERMERCADOS/COOPERATIVAS . 08 OTRO SITIO_____ 16		66
409	Alguna vez ha comprado usted condones?	SI ..... 1 NO 2	→501	67
410	Ha comprado condones en los últimos seis meses?	SI ..... 1 NO 2	→412	68
411	Ha comprado condones en el último mes?	SI ..... 1 NO 2		69
412	De qué marca compró la ultima vez?	_____		70 (ANEXO)

PREG No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS
413	En dónde compra los condones generalmente?	DROGUERIA ..... 1 PROFAMILIA ..... 2 VENDEDORES AMBULANTES / SAN ANDRESITOS ..... 3 SUPERMERCADOS/COOPERATIVAS. 4 OTRO SITIO_____ 5 NO RECUERDA 6		71 ☐
414	Al comprar condones cuál es la forma de empaque que prefiere?	EN CAJAS ..... 1 EN TIRAS ..... 2 EN UNIDADES ..... 3 OTRA FORMA_____ 4 ES INDIFERENTE 5	416	72 ☐
415	De cuántas unidades?	UNIDADES ☐☐		73 ☐☐
416	Al comprar condones el vendedor le ha sugerido alguna vez alguna marca?	SI ..... 1 NO 2	→ 418	74 ☐
417	Qué marca le ha sugerido?	TAHITI ..... 01 STIMULA ..... 02 SULTAN ..... 03 PRIME ..... 04 ROSETEX ..... 05 NUDA ..... 06 CONTURE ..... 07 MILLION ..... 08 LOVE ..... 09 PARADISE ..... 10 JELLIA ..... 11 OTRO:_____ 12		75 ☐☐
418	Cuando compra condones pide usted una marca en especial o le es indiferente la marca?	PIDE MARCA ..... 1 LE ES INDIFERENTE 2	→ 420	76 ☐
419	Qué hace usted cuando no encuentra la marca que pide?	COMPRA OTRA ..... 1 BUSCA EN OTRO SITIO ..... 2 OTRO, Cuál? 3		77 ☐
420	Para usted qué características hacen un buen condón?	1._____ 2._____ 3._____ 4._____		78 ☐☐ (ANEXO)

V. USO DEL CONDON

501	VEA PREGUNTA 303:	HA USADO CONDON [1] (PASE A 503)	NO HA USADO CONDON [2] ↓	79 ☐
502	Por qué nunca ha usado el condón?	_____ _____ _____ _____	701	80 ☐☐ (ANEXO)
503	Con qué fines ha usado el condón la mayoría de las veces?	COMO ANTICONCEPTIVO ..... 1 COMO PROFILACTICO ..... 2 COMO ANTICONCEPTIVO Y PROFILACTICO ..... 3 OTRA, Cuál?_____ 4		81 ☐

252

PREG No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS
504	Lo ha usado en el último medio año?	SI ..... 1 NO 2	→506	82
505	Por qué ha dejado de usarlo?	_____		83 (ANEXO)
506	En general cuando usted ha usado el condón se ha sentido satisfecho con él?	SI ..... 1 NO 2	→508	84
507	Por qué se ha sentido satisfecho con él?	_____	509	85 (ANEXO)
508	Por qué no se ha sentido satisfecho con él?	_____		86 (ANEXO)
509	Al usar el condón ha tenido algún problema?	SI ..... 1 NO 2	→511	87
510	Qué problemas ha tenido?	_____		88 (ANEXO)
511	Comparando con otros anticonceptivos, cuáles son las principales ventajas que tiene el condón?	_____		89 (ANEXO)
512	Cuáles son las principales desventajas que tiene el condón?	_____		90 (ANEXO)

VI. PERCEPCION DE MARCAS

601 Ahora quisiera que me dijera que marcas de condones conoce usted?
(DILIGENCIE PREGUNTAS 603 A 605 SOLO PARA MARCAS CONOCIDAS)

MARCA	(602) Ha oído de esta marca?		(603) Ha comprado alguna vez?		(604) Qué tan resistentes son estos condones?			(605) Qué le parece la calidad de estos condones?				
	SI	NO	SI	NO	MUCHO	POCO	NADA	MUY BUENA	BUENA	REGULAR	MALA	
TAHITI	1	2	1	2	1	2	3	1	2	3	4	91 94
STIMULA	1	2	1	2	1	2	3	1	2	3	4	95 98
SULTAN	1	2	1	2	1	2	3	1	2	3	4	99 102
PRIME	1	2	1	2	1	2	3	1	2	3	4	103 106
ROSETEX	1	2	1	2	1	2	3	1	2	3	4	107 110
NUDA	1	2	1	2	1	2	3	1	2	3	4	111 114
CONTURE	1	2	1	2	1	2	3	1	2	3	4	115 118
JELLIA	1	2	1	2	1	2	3	1	2	3	4	119 122
MILLION	1	2	1	2	1	2	3	1	2	3	4	123 126
LOVE	1	2	1	2	1	2	3	1	2	3	4	127 130
PARADISE	1	2	1	2	1	2	3	1	2	3	4	131 134
OTRO, Cuál?	1	2	1	2	1	2	3	1	2	3	4	135 138

PREG No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG.	CODIGOS
606	VEA PREGUNTA 602; CONOCE MARCAS [1]	NO CONOCE NINGUNA MARCA [2] (PASE A 701)		139 [ ]
607	Qué tan sensibles le parecen los condones?	MUY SENSIBLES ..... 1 SENSIBLES ..... 2 POCO SENSIBLES 3		140 [ ]
608	Qué tan profilácticos le parecen los condones?	MUY PROFILACTICOS ..... 1 PROFILACTICOS ..... 2 POCO PROFILACTICOS 3		141 [ ]
609	Qué tan cómodos de usar le parecen los condones?	MUY COMODOS ..... 1 COMODOS ..... 2 INCOMODOS ..... 3 MUY INCOMODOS 4		142 [ ]
VII. EXPOSICION A MEDIOS MASIVOS				
701	Recuerda usted haber oído alguna información o propaganda del condón por la radio?	SI ..... 1 NO 2	→710	143 [ ]
702	Hace cuántos meses diría usted que fué la última vez que oyó por radio algo del condón?	MESES ..... [ ][ ]		144 [ ][ ]
703	Recuerda usted el mensaje o contenido de dicha información o propaganda?	SI ..... 1 NO 2	→705	145 [ ]
704	Cuál era el mensaje o contenido?	_____ _____ _____		146 [ ][ ] (ANEXO)
705	Este mensaje mencionaba alguna marca?	SI ..... 1 NO 2	→707	147 [ ]
706	Qué marca mencionaba?	_____		148 [ ][ ] (ANEXO)
707	Usted aprendió algo de esta propaganda?	SI ..... 1 NO 2	→709	149 [ ]
708	Qué aprendió?	_____ _____ _____		150 [ ][ ] (ANEXO)
709	Lo motivó a usar el condón esta propaganda?	SI ..... 1 NO 2		151 [ ]
710	Ha visto afiches, calcomanías o móviles relacionados con el condón?	SI ..... 1 NO 2	→713	152 [ ]
711	Dónde?	_____ _____		153 [ ][ ] (ANEXO)
712	Qué marca o empresa se mencionaba ahí?	_____ _____		154 [ ][ ] (ANEXO)

VIII. CONOCIMIENTO SOBRE SIDA (AIDS)

PREG. No.	PREGUNTAS Y FILTROS	CODIGOS Y CATEGORIAS	PASE A PREG	CODIGOS
801	Ha oído usted de una enfermedad llamada SIDA (o AIDS)? (Síndrome de inmuno deficiencia adquirida)	SI ..... 1 NO 2	→807	155 ☐
802	Cómo piensa usted que se transmite el SIDA (o AIDS)? (ENCUESTADOR: Trate de ampliar la información. PREGUNTANDO: Existen otras formas?")	CONTACTO SEXUAL CON UNA PERSONA INFECTADA ..... 01 TRANSFUSION SANGUINEA .... 02 INYECTARSE CON LA MISMA JERINGA VARIAS PERSONAS ... 04 INSECTOS, ZANCUDOS ..... 08 MORDEDURAS ..... 16 POR SALIVA ..... 32 POR LACTANCIA ..... 64 DURANTE EL PARTO DE MADRE A HIJO ..... 128 RESPIRAR AIRE DE UNA PERSONA INFECTADA ..... 256 OTRA RESPUESTA ..... 512 ESPECIFIQUE:_____ NO SABE 00		156 ☐☐☐☐
803	Cómo se puede disminuir el riesgo del contagio del SIDA (o AIDS)? (ENCUESTADOR: Trate de ampliar la información. PREGUNTANDO: "Existen otras formas"?)	USANDO CONDONES EN CONTACTOS SEXUALES ..... 01 UN SOLO COMPAÑERO ..... 02 ABSTINENCIA SEXUAL ..... 04 EVITAR TRANSFUSIONES ..... 08 NO AUTO INYECTARSE O NO COMPARTIR JERINGAS ..... 16 NO TENER RELACIONES SEXUALES CON PROSTITUTAS ..... 32 OTRA RESPUESTA ..... 64 ESPECIFIQUE:_____ NO SABE 00		157 ☐☐☐
804	Sabe de algún amigo, conocido o vecino que tenga SIDA (o AIDS)?	SI ..... 1 NO 2	→807	158 ☐
805	Por favor dígame la edad y el sexo de todos los conocidos que tengan actualmente SIDA (o AIDS)	EDAD / H / M PERSONA 1 ☐☐ 1 2 PERSONA 2 ☐☐ 1 2 PERSONA 3 ☐☐ 1 2 PERSONA 4 ☐☐ 1 2		159 ☐☐ 160 161 ☐☐ 162 163 ☐☐ 164 165 ☐☐ 166
806	Sabe de algún amigo, conocido o vecino que haya muerto de SIDA (o AIDS)?	SI ..... 1 NO 2		167 ☐

807

DE LOS AGRADECIMIENTOS Y TERMINE LA ENCUESTA

APPENDIX 10

CUNDINAMARCA: PHASE I AND PHASE II SEMESTRAL COST-EFFECTIVENESS DATA

APPENDIX 10

CUNDINAMARCA: SALES, COUPLE YEARS OF PROTECTION (CYP), REVENUES AND COSTS.
AND NET COST OR PROFIT PER CYP BY PROJECT PHASE AND SEMESTER
(US DOLLARS)

	REFERENCE*		PHASE I				PHASE II			
	ABR./83 SEPT/83*	OCT./83 MARCH/84*	ABR./84 SEPT/84	OCT./84 MARCH/85	ABR./85 SEPT/85	OCT./85 MARCH/86	ABR./86 SEPT/86	OCT./86 MARCH/87	ABR./87 SEPT/87	OCT./87 MARCH/88
	CBD	CBD	CBD	CBD	CBD	CBD	CBD-CSM	CBD-CSM	CBD-CSM	CBD-CSM
1. SALES										
PILLS	22,084	23,398	25,523	27,260	31,022	34,960	41,553	44,124	44,283	43,741
CONDOMS	7,107	6,443	6,071	6,525	11,360	16,514	34,400	38,413	58,404	34,297
VAGINALS	24,268	24,512	26,942	20,593	21,014	20,980	46,422	28,989	4,388	23,540
2. CYP	2,013	2,109	2,293	2,368	2,710	3,064	4,005	4,068	4,034	3,943
3. REVENUES			12,727	13,944	11,981	11,715	19,152	17,036	17,045	17,672
4. COSTS			26,223	24,258	24,336	19,948	21,804	18,620	27,107	27,101
-MERCHANDIZE			6,904	5,550	5,667	7,078	10,117	5,922	12,786	14,209
-OPERATION			19,319	18,708	18,668	12,870	11,687	12,699	14,931	12,898
PERSONNEL			15,776	11,945	14,500	10,883	10,183	10,148	13,068	10,981
PERDIEM-TRAVEL-OTHER			3,425	6,665	4,057	1,848	1,142	2,322	1,621	1,752
INCENTIVES			117	98	111	139	362	229	242	165
5. NET PROFIT OR LOSS			(13,497	(10,314)	(12,355)	(8,233)	(2,651)	(1,584)	(10,062)	(9,435)
6. PROFIT OR LOSS PER CYP			(5.88)	(4.36)	(4.56)	(2.69)	(0.66)	(0.39)	(2.49)	(2.39)

* No accounting data available for Oct/83-Mar/84.

APPENDIX 11

SANTANDER: PHASE I AND PHASE II SEMESTRAL COST-EFFECTIVENESS DATA

APPENDIX 11

SANTANDER: SALES, COUPLE YEARS PROTECTION (CYP), REVENUES AND COSTS
AND NET COST OR PROFIT PER CYP BY PROJECT PHASE AND SEMESTER
(US DOLLARS)

	REFERENCE						PHASE I				PHASE II			
	ABR/83-SEP/83			OCT/83-MAR/84			ABR/84-SEP/84	OCT/84-MAR/85	ABR/85-SEP/85	OCT/85-MAR/86	ABR/86-SEP/86	OCT/86-MAR/87	ABR/87-SEP/87	OCT/87-MAR/88
	CBD	CSM	TOTAL	CBD	CSM	TOTAL	CSM	CSM	CSM	CSM	CBD-CSM	CBD-CSM	CBD-CSM	CBD-CSM
1. SALES														
PILLS	22,922	84,361	107,283	18,947	72,863	91,810	125,730	85,655	76,387	55,489	38,001	49,963	47,326	56,855
CONDOMS	16,941	174,877	191,818	11,896	376,948	388,844	72,035	35,150	152,979	58,016	31,240	60,616	66,032	77,072
VAGINALS	29,081	70,072	99,153	22,647	91,816	114,463	151,743	129,499	83,944	63,072	33,460	83,120	3,200	54,002
2. CYP	2,223	8,939	11,162	1,803	10,292	12,095	11,909	8,235	8,245	5,479	3,570	5,281	4,333	5,684
3. REVENUES	11,435	47,418	58,853	9,938	43,565	53,503	49,467	38,637	36,245	20,791	16,591	25,363	21,206	27,922
4. COSTS	18,920	27,654	46,575	17,704	27,303	45,007	36,278	26,617	25,211	15,799	12,904	25,136	28,352	32,762
-MERCHANDIZE	5,691	27,654	33,345	5,025	27,303	32,328	31,483	22,383	21,840	13,002	8,073	13,067	16,089	23,395
-OPERATION	13,229	0	13,229	12,679	0	12,679	4,795	4,234	3,370	2,797	4,830	12,069	12,263	9,367
PERSONNEL											4,091	9,818	10,381	8,283
PERDIEM-TRAVEL-OTHER											739	2,251	1,882	1,083
5. NET PROFIT OR LOSS	(7,486)	19,764	12,278	(7,766)	16,262	8,496	13,189	12,021	11,034	4,992	3,688	227	(7,146)	(4,840)
6. PROFIT OR LOSS PER CYP	(3.37)	2.21	1.10	(4.31)	1.58	0.70	1.11	1.46	1.34	0.91	1.03	0.04	(1.65)	(0.85)

APPENDIX 12

SCRIPTS OF CALI CONDOM RADIO SPOTS

1. DRUGSTORE

Juan: Hi, Victor
How's the drugstore?

Victor: Good, Juan.
How's life in the repair shop?

Juan: Oh, I'm making out all right.
When you know what you're doing, everything works out well.

Victor: That's great.
Now what can I do for you?

Juan: I'd like some condoms... because when you have something good in life, you have to take care of it... So, I'm careful.

Victor: Miss, can you please reach some condoms.
Juan, that's a nice way to think. There aren't many men like you.

Helper (female): Here you are, sir.

Juan: Thanks. See you later.

Helper: That sure is a man of character, wouldn't you say, Victor?

Victor: He sure is.

SPEAKER: It's true. Loving responsibly is also for men.

A MESSAGE OF PROFAMILIA

2. DOCTOR'S OFFICE

Speaker 1: Doctor, is there something a man can use that's safe and practical so he can love responsibly?

Speaker 2: Why of course! The condom.
Besides being safe and practical, it's also inexpensive and easy to use.

I always recommend it to men like yourself who want to love responsibly, and who are in control of what they do.

Speaker 3: The condom.
Ask for it in any drugstore or in PROFAMILIA.

Because loving responsibly is also for men.

A MESSAGE OF PROFAMILIA

3. A MAN OF CHARACTER

Woman 1: Look, Clarita! Isn't that Juan?

Woman 2: Yes. What a great guy, don't you think?

Woman 1: His wife says he just knows exactly what he's doing and what he wants, and everything turns out perfectly.

Woman 2: With a guy like that, responsible, dependable, a man in every respect... who could ask for more? Lucky his wife.

Man 1: Hey Juancho. Where are you headed?

Juan: To the drugstore.

Man 1: Hey, you know... those girls were just talking about you. They said you were so wonderful and so responsible....

And Clarita never even looks at me!

Juan: Oh, it's just a question of character..
... and knowing what they want.

Well, here we are...
Good morning.
Can you give me a few condoms, please?

SPEAKER: Ask for them like anything else... Condoms.

Because loving responsibly is also for men.

A MESSAGE OF PROFAMILIA

4. "I LIKE THE WAY YOU ARE"

Woman: You know, Juan, I like the way you are....
... because just yesterday I was talking with a friend, and she told me how hard it is for her, carrying all the responsibility of the household, even including responsibility in love.

Man: Who would possibly think that there are still men who think responsibility is something for women.

Woman: ... And especially in love where everything is shared.

Man: That's why I decided to use the condom.
What better way to show how much I love you.

Woman: You know, Juan, I like the way you are.

SPEAKER: That's right ... Responsible men love responsibly.

Because loving responsibly is also for men.

A MESSAGE OF PROFAMILIA

5. FACTORY

Man 1: Hey Juancho ... They told me you're going for some training.

Juan: That's right ... Because to move ahead you have to know really well what you're doing.

Man 1: I try, but my wife says I'm not responsible.

Juan: She may have her reasons...
... A real man has to be responsible in everything: at work, with his wife, and in love.

Man 1: You know... she may be right.
But, what does one do to be responsible in love?

Juan: Simple... Understand the woman. Love her responsibly, using a condom.

Man 1: Of course... I didn't know before.
But where can you buy them?

Juan: In any drugstore or in PROFAMILIA.
And besides, they're cheap.

SPEAKER: That's right. Loving responsibly is also for men.

A MESSAGE OF PROFAMILIA

APPENDIX 13

LIST OF PROGRESS REPORTS

APPENDIX 13

LIST OF PROGRESS REPORTS OF PROJECT "PRIVATE SECTOR COMMUNITY-BASED DISTRIBUTION AND COMMERCIAL SOCIAL MARKETING STRATEGIES IN COLOMBIA"

Cooperative Agreement No. DPE-3030-A-00-4050-00
Subordinate Agreement IA84.20A

AUTHORS	NUMBER OF PROGRESS REPORT	PERIOD	DATE
Wilde, Norman and G. Ojeda	First	September 84/March 85	May, 1985
Ojeda, Gabriel and J. Townsend	Second	April/September 1985	January, 1986
Vernon, Ricardo and G. Ojeda	Third	October 85/March 1986	May, 1986
Vernon, Ricardo and G. Ojeda	Fourth	April/September 1986	November, 1986
Vernon, Ricardo and G. Ojeda	Fifth	October 86/March 1987	May, 1987
Vernon, Ricardo and G. Ojeda	Sixth	April/September 1987	November, 1987
Vernon, Ricardo and G. Ojeda	Seventh	October 87/March 1988	May, 1988

APPENDIX 14

LIST OF PROJECT PARTICIPANTS

APPENDIX 14

LIST OF PROJECT PARTICIPANTS

Project Director:	Miguel Trías, M.D.
Principal Investigator:	Gabriel Ojeda, Ph.D.
Research Coordination and Data Processing:	Ana Vega
Service Statistics:	Myriam Hernández and Mercedes Sánchez
Survey Sampling:	Leonel Castillo
Survey Fieldwork and Coordination:	Carmenza Castro
Data Entry:	Rocío Barbosa and Martha de Leyva
Data Cleaning and Coding:	Clara Inés Ortiz
Researchers for Cost Study:	Juan Pablo Varela and Rocío Murad
Drugstore Study:	A.C. Nielsen de Colombia, S.A.
Coordination of Service Delivery Activities:	Lily de Bucheli and Luisa de Murillo
Supervision of Service Delivery Activities:	Lola de Betancour and Gloria I. Avila
Instructors in Cundinamarca and Santander:	Omar Alonso, Celmira Anzola, Jose Fidelo Camelo, Rosalba Cortez, Dora Luz Díaz, Mercedes Martín, Patricia Ospina, Betty Ortiz, Rosa Oliva Palacios, Hilda Ramírez

APPENDIX 14

LIST OF PROJECT PARTICIPANTS (CONTINUATION)

Technical Assistance from The Population Council:

Project Design:	Marcia Townsend
Baseline Survey and Second Year Workplan:	John Townsend
First Progress Report:	Norman Wilde
All Other Activities:	Ricardo Vernon
AID Project Supervision:	Jim Smith, AID/Bogotá Marcia Townsend, AID/Washington Jerald Bailey, AID/Washington
Technical and Editorial Review of Reports:	Tim Williams
Typing of Reports	Lucia V. Conti

The Population Council

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New York, New York 10017
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Telephone (212) 644-1300
Telex: 234722 POCO UR

Recipient (Name and Address)

Asociacion Pro-Bienestar de la
Familia Colombiana
Calle 34, No. 14-52
Bogota, Colombia

Population Council
Subordinate Agreement
No. IA84.20A
Amendment No. 1

The purpose of this amendment is to modify the Scope of Work, the project calendar and the budget, at no additional cost. Changes in the agreement are as follows:

Cover Page

Delete the contents of the second paragraph in its entirety and substitute in lieu thereof, the following:

"Commencing September 4, 1984 and continuing to completion, not later than September 3, 1987, the Recipient shall perform the work outlined in the revised proposal dated February 1985 entitled 'Private Sector Community Based Distribution and Commercial Social Marketing Strategies in Colombia'." (Attachment 1).

Schedule

Article I - Scope of Work

Delete the contents of this paragraph in its entirety and substitute in lieu thereof, the following:

"The Recipient shall perform the Scope of Work outlined in the revised proposal dated February 1985 entitled 'Private Sector Community Based Distribution and Commercial Social Marketing Strategies in Colombia,' incorporated herein by reference and attached as Attachment 1."

Article VI - Budget

Delete the contents of this Article in its entirety and substitute in lieu thereof, the following:

"Within the funds obligated, the Recipient may adjust line item amounts as reasonably necessary for the performance of work under this agreement.

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The Population Council

*The fixed value of this subordinate agreement is the U.S. dollar amount shown and cannot be exceeded. The U.S. dollar amount above results in a local currency budget of 10,243,448 Colombian Pesos translated using an estimated rate of exchange of 95 Colombian Pesos/US$ for Year 1. The local currency budget for Years 2 and 3 will be provided prior to the beginning of those years. The local currency budget may change depending on exchange rate fluctuations at the time payments are made by the Council. Actual expenditures should be reported in local currency and translated into U.S. dollars at the actual rate of exchange realized on the U.S. payment received or average actual rate, if more than one payment is received.

**To be procured by the Population Council (includes both hardware and software)"

Except as amended herein, all terms and conditions of Subordinate Agreement No. IA84.20A remain unchanged and in full force and effect.

For the Population Council:

Signature
James J. Bausch
Vice President
and Secretary
Name and Title

Date

For the Asociacion Pro-Bienestar de
la Familia Colombiana:

Signature of Authorized Individual

Name and Title (Print or Type)

Date

The Population Council

One Dag Hammarskjold Plaza
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Schedule

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Article VI - Budget

Delete the contents of this Article in its entirety and substitute in lieu thereof, the following:

"Within the funds obligated, the Recipient may adjust line item amounts as reasonably necessary for the performance of work under this agreement.

The Population Council

Subordinate Agreement No. IA84.20A
Amendment No. 1

Line Item	Year 1 U.S.$	Year 1 Local Currency*	Year 2 U.S.$	Year 3 U.S.$
I. PERSONNEL				
Regional Coordinator	$ 3,981	P 378,225	$ 5,156	$ ---
Instructors (3x18 mos)	14,088	1,338,327	8,063	---
Salesperson (1x36 mos)	4,872	462,870	6,000	5,752
Team (2x18 mos)	---	---	6,111	11,718
Marketing Director	5,190	493,000	---	---
Subtotal	28,131	2,672,422	25,330	17,470
II. TRAVEL AND PER DIEM				
Regional Coordinator	3,298	313,340	4,512	---
Instructors	5,566	528,737	4,007	---
Salesperson	2,391	227,175	3,660	3,508
Team	---	---	9,531	18,288
Subtotal	11,255	1,069,252	21,710	21,796
III. DISSEMINATION				
Seminar on Operations Management				
Air transportation	2,463	234,000	---	---
Local Transportation	210	20,000	---	---
Per Diem (40 persons x 2 days x $85/day)	6,800	646,000	---	---
Meeting Costs	865	82,175	---	---
Supplies & Materials	844	80,180	---	---
Publication	2,568	244,000	---	---
Subtotal	13,750	1,306,355	---	---
Total (I + II + III)	53,136	5,048,029	47,040	39,266
IV. OVERHEAD (15%)	7,970	757,204	7,056	5,890
V. ADDITIONAL COSTS				
IEC Materials	5,158	490,000	4,750	4,554
Training Courses	2,895	275,000	500	---
IBM PC (Model AT)**	15,000	NA	---	---
Maintenance Services	968	92,000	968	968
Evaluation	37,697	3,581,215	110,413	90,435
Subtotal	61,718	4,438,215	116,631	95,957
GRAND TOTAL	$122,824	P10,243,448	$170,727	$141,113

The Population Council

*The fixed value of this subordinate agreement is the U.S. dollar amount shown and cannot be exceeded. The U.S. dollar amount above results in a local currency budget of 10,243,448 Colombian Pesos translated using an estimated rate of exchange of 95 Colombian Pesos/US$ for Year 1. The local currency budget for Years 2 and 3 will be provided prior to the beginning of those years. The local currency budget may change depending on exchange rate fluctuations at the time payments are made by the Council. Actual expenditures should be reported in local currency and translated into U.S. dollars at the actual rate of exchange realized on the U.S. payment received or average actual rate, if more than one payment is received.

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For the Population Council:

Signature

James J. Bausch
Vice President
and Secretary

Name and Title

Date

For the Asociacion Pro-Bienestar de la Familia Colombiana:

Signature of Authorized Individual

Name and Title (Print or Type)

Date

PRIVATE SECTOR COMMUNITY BASED DISTRIBUTION AND COMMERCIAL SOCIAL MARKETING STRATEGIES IN COLOMBIA

REVISED

PROFAMILIA

THE POPULATION COUNCIL

Bogota, February 1985

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SUMMARY

This is a proposal to determine the need to continue PROFAMILIA's family planning community based distribution (CBD) program in Colombia. Thirty-six months will be required to complete the project, divided into two phases. During the first phase, which will last 18 months, this objective will be experimentally tested in one department of Colombia (Santander) by implementing a commercial social marketing (CSM) strategy in replacement of a promoter CBD delivery system. If, at the end of the first phase, it is found that contraceptive use prevalence rates and the unmet need for family planning remain stable and that delivery system costs reach a self-maintenance level, then the CSM strategy will be expanded into an additional province during the second phase. The purpose of the second phase expansion is to reinforce the findings from the initial experiment and to initiate a process of discontinuation at the national level of the CBD program. On the other hand, if a decline in contraceptive knowledge and use is detected, whether delivery costs are at the self-maintenance level or not, the CSM strategy will be abandoned after the first phase and the second 18 months will be utilized to remount the CBD program in Santander. The design of the CBD model to be applied in Santander, if prevalence rates decline, will be decided upon taking into consideration the cost-effect results of (1) the Cesar-Cauca mobile team experiment tested during 1981 and 1982 by PROFAMILIA and (2) a commission scheme to be tested simultaneously with the CSM experiment but in another province (Cundinamarca) during the first phase of the project being proposed here. It is expected at the end of the three years to be able to state whether the cost of a private sector community based distribution program is still warranted in a country like Colombia where contraceptive knowledge rates are high and multiple family planning service sources exist. If in fact the private sector effort is still required, the project will have identified a CBD system that can substantially raise contraceptive prevalence rates at a low near self-maintenance cost.

BACKGROUND

Since 1971 PROFAMILIA has supported a family planning community based distribution program in the rural areas of Colombia. This program has represented a private sector effort to increase accessibility of isolated populations to a health service which had traditionally been clinic and medical doctor dependent.[1] From the late 1970's to date, however, the cost of these services have sharply risen as Colombian labor legislation on employee benefits became more protective and inflation and local currency devaluation problems hightened. Yet at the same time external funds for development activities in Colombia have suffered serious cut-backs raising questions regarding (1) the continued support by external agencies of costly CBD service delivery models and (2) official sector approval to utilize external funds on private sector family planning activities.

Throughout the past 8 years various experimental CBD models have been tested by PROFAMILIA and the Population Council with the financial support from the Agency for International Development to reduce the costs of these services and, in turn, the amount of institutional dependency on external funds to support them. Most of these experiments have focused on how to lessen expenditures incurred to support a core group of personnel (supervisors, promoters and distributors) considered necessary to implement a CBD program.[1]

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[1]Before 1971 rural populations were practically excluded from any family planning program since no organized health services existed in these isolated areas at that time.

[2]That is because personnel expenditures are the most costly components of a program. They are comprised of (1) base salary (2) fringe benefits which now represent more than 75 percent of the base salary and (3) travel and perdiems. The latter implies considerable expense depending of the service model, i.e. if promoters are permanent agents in their communities or if they cover various counties and whether they are assigned a permanent or mobile home base.

The experimental strategies selected have been designed taking into account the increasingly almost universal contraceptive knowledge levels of the Colombian population.[1] As Colombians have become more knowledgeable about contraceptive methods the content of the promoter's IE & C messages have been streamlined leaving aside such themes as reproductive physiology and community development issues. With a population where over 90 percent of the ever married women in fertile age can name a contraceptive method, the promoter now can work with large groups rather than individual household visits once utilized to gain the community's confidence and to explain an unknown theme. Both of these factors speed up the coverage process and demand less personnel resources thereby reducing costs.

One of the more recent efforts to reduce CBD costs tested a male-female two member team mobilized in a jeep equiped with loud speakers and audio-visual equipment.[2] Through this model contraceptive knowledge and use levels were significantly raised at a record low cost. Currently PROFAMILIA and The Pop-

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[1]According to the 1980 Contraceptive Prevalence Survey, 96 percent of the ever married women in fertile age could name at least one contraceptive. By place of residence, the statistics are 98 percent urban and 91 percent rural have knowledge of a contraceptive. (Ministerio de Salud de Colombia and the Corporación Centro Regional de Población, Segunda Encuesta Nacional de Prevalencia del Uso de Anticoncepción, Colombia, 1980, p. 47).

[2]Differing from the promoter, a team could cover an area much more quickly because it did not depend on public transportation. Furthermore team members worked with large mixed groups (50 or more men and women) instead of household visits with women and they utilized group dynamic techniques. They only visited a community once every 3 months after a distributor(s) was selected and trained and services were initiated. After 1 year of service delivery through the team model in 6 counties in the department of Cauca, contraceptive use significantly rose from 24 percent to 54 percent of the exposed women. The costs per new acceptor and couple year protection were US$14.05 and US$1.44 respectively. These costs compare favorably with previous CBD models which have estimated costs per new acceptor as high as US$75.00.

ulation Council are experimenting with a service delivery strategy which pays a small fee (a commission) to promoters for every contraceptive unit sold over and above a fixed goal. Initial findings indicate that this strategy is the least costly up to now.[1]

Despite the low cost of the team and the current commission strategy, some major issues still remain to be answered. Perhaps the most critical is that unless a CBD program actually represents no cost (reaches self-sufficiency), then PROFAMILIA will continue to depend on external financial aid.[2] Whether this dependency is justified or not depends on whether the need for family planning in the marginal urban and rural areas is being met. Need in this project refers to meeting the contraceptive demand so that current use prevalence levels and the unmet need for family planning remain stable and do not decline.[3] Ordinarily the expectation would be to increase use and reduce the unmet need. However, given the issue of financial dependency and the hypothesis that IE & C campaigns (which are personnel dependent) are necessary to increase use and drop

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[1]The cost per couple year of protection after 6 months of the experiment is US$0.63 cents. Under the commission scheme promoters are paid a base salary, benefits and perdiems. They then are given an additional amount of money for each cycle of orals and unit of vaginals and condoms sold exceeding a base level set for them for each method. Contraceptive sales may be transmitted in small pharmacies and stores for cash besides the usual distribution posts where contraceptives are generally left on consignment. The cost of each contraceptive to all outlets is fixed by PROFAMILIA and to the consumer when they are sold through the distributors. When purchased through commercial outlets, PROFAMILIA cannot set the sales cost to the buyer.

[2]Self-sufficiency occurs when income from contraceptive sales and other family planning services covers expenditures.

[3]The unmet need for family planning is measured by the proportion of women in a population who are exposed to the risk of pregnancy, are fertile, do not want another child or who wish to space yet are not contracepting.

unmet need levels, the project questions if use rates and unmet need levels can be at least sustained through the adoption of a commercial social marketing strategy by the private sector agency.[1] It is expected that this can result since (1) alternative supply sources to the PROFAMILIA distribution posts exist (2) Colombians can identify one or more methods and supply sources and (3) the Ministry of Health (MOH) now provides orals and condoms to rural Colombians at the household level through its rural health promoter.[2] Whether contraceptive use increases and unmet need for family planning declines depends on the importance of IE & C campaigns to promote and inform about contraception to gain new acceptors, the willingness of the Colombian population to travel to drugstores and MOH outlets and certain characteristics of the MOH program (i.e. adequate and timely contraceptive re-supply through the rural health promoter). These factors will also play an important role in assuring maintenance of the current use rates as other sources will need to substitute for PROFAMILIA's distribution posts.[3]

PROJECT OBJECTIVES

It is the purpose of this project to test the cost-effectiveness of a commercial social marketing contraceptive delivery strategy to replace PROFAMILIA's community based distribution program

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[1] A CSM strategy theoretically represents a self-sufficient system since it does not support an IE & C component, nor are distribution posts established, requiring a large number of personnel to implement it.

[2] The Ministry of Health (MOH) through its county health posts and rural health promoter program, offers a range of contraceptive methods at very little cost to the user. Over half of all rural ever married women reside within 37 minutes of an MOH health center and 44 percent within that same time from a drugstore. In most departments the MOH promoter now re-supplies rural users of non-surgical methods with contraceptives at the household level and when necessary can initiate new acceptors.

[3] In Appendix I is a description of MOH family planning activity in Santander.

in urban marginal and rural areas of Colombia. Given that a CSM system might prove ineffective or effective but expensive, the project will also test for the cost-effectiveness of a CBD model based on commission payments to promoters for contraceptive sales carried out in semi-rural and rural areas.

METHODOLOGY

In order to complete the project's objectives, thirty-six months will be required divided into two phases. Each phase will last 18 months as shown in the calendar on page 6.

First Phase

During the first phase a commercial social marketing system (initiated in July, 1984 following a baseline KAP survey) similar to PROFAMILIA's country-wide CSM program will continue to be implemented in at least 31 counties in the department of Santander where 429,475 inhabitants reside (94,483 WFA). The counties and their population are shown on page 7.[1]

PROFAMILIA's commercial social marketing program, initiated in 1973, functions in 22 departments of Colombia grouped into 5 zones.[2] Distribution of the oral, condom and spermicides to commercial outlets through the program is the responsibility of 5 distributors, one for each zone. Distributors are indepen-

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[1] These 32 counties are currently being serviced through PROFAMILIA's CBD program. They will be covered by the new strategy and other counties will be selected as well. A map of Santander and a list of all of the counties in that department can be found in Appendix I.

[2] They are:

ZONE	DEPARTMENT
1	Bogotá, Cundinamarca, Huila, Meta, Tolima
2	Antioquia
3	Atlántico, Bolivar, Córdoba, Guajira, Magdalena, Sucre
4	Caldas, Cauca, Nariño, Quindío, Risaralda, Valle
5	Santander, Norte de Santander, Boyacá, [illegible]

dent business persons who have the exclusive rights to sell PROFAMILIA's products. These rights and distributor obligations are outlined in a contract signed by both PROFAMILIA and the distributor (see Appendix II for a copy of a contract). Distributors, then, are not salaried employees of PROFAMILIA as promoters are.

Through local drug companies and The International Planned Parenthood Federation, PROFAMILIA obtains contraceptives at discount prices. Once a distributor is fully trained by PROFAMILIA in the management of those contraceptives and a contract is signed, the distributor purchases from PROFAMILIA a quantity of each product up to the total value of 3 million pesos (US$35,300). The price for each drug to the distributor is slightly higher than the cost to PROFAMILIA to cover administrative expenditures (importation taxes, storage, transportation). PROFAMILIA sets the quantity of each product which the distributor must sell yearly and the prices at which contraceptives can be sold by the distributor to druggists. The distributor is permitted 90 days to pay PROFAMILIA for the products he/she purchases from them and is responsible for the storage of those contraceptives once they are transported to him/her from PROFAMILIA's warehouse in Bogotá. PROFAMILIA pays for the transportation of the shipment to a distributor.

In the work zones assigned to the distributor by PROFAMILIA, the distributor functions independently from PROFAMILIA in that he/she designs and implements his/her own work strategy. PROFAMILIA's commercial marketing department helps by providing technical assistance when needed and promotion in the work area (i.e. newspaper advertisments). PROFAMILIA also supervises the distributor's activities, usually through unannounced field visits to the distributor's clients.

Although distributors work directly in the sales of their products to commercial retailers, they frequently employ sales

personnel to assist them. These individuals are contracted and paid by the distributors and represent no labor relationship with PROFAMILIA. They are trained and supplied with drugs by the distributor.

Since the distributor and his/her sales personnel depend on commissions from contraceptive sales, they rely on selling in large quantities and on the prompt payment by buyers. Certain precautions are taken by the distributor before a sale is transacted to assure that the buyer is reliable. A minimum order of $5,000 pesos (about US$60 dollars) of contraceptives by the buyer in urban areas and $10,000 pesos (US$120) in rural areas is required before an order can be filled by the distributor (or sales persons). This is to insure the income estimated necessary to cover the distributors administrative costs and expected earnings. Buyers set their own prices to the public on the drugs purchased from the distributor. They are not controlled by either PROFAMILIA nor the distributor but rather by the presence of other outlets which sell contraceptives such as the MOH and PROFAMILIA distribution posts. Druggists are given a 30 day credit to pay the distributor for the products purchased. Neither the distributor nor PROFAMILIA have a fixed limit on the maximum amount of contraceptives (or monetary value) a druggist may buy however the volume sold each month by the druggist and his/her payment cumplicity influence the top level permitted. If the druggist pays in cash upon receipt of purchase he/she is given a 5 percent discount off the total sales price.

Currently PROFAMILIA's commercial social marketing program supplies 65 percent of Colombia's pharmaceutical outlets with contraceptives. The table on page 10 shows the trends in contraceptive sales from 1977 to 1982 by method for the program. As can be seen, oral contraceptive sales have increased steadily since 1977, condoms have remained fairly stable while substantial increases have been found in the sales of Emko and Norforms. Perhaps more importantly is to note that 66 percent of all orals

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COMMERCIAL SOCIAL MARKETING PROGRAM BY SALES OF CONTRACEPTIVES

1 9 7 7 - 1 9 8 2

METHOD	1 9 7 7	1 9 7 8	1 9 7 9	1 9 8 0	1 9 8 1	1 9 8 2
Pill (Cicles)	1,189,354	1,548,354	1,862,926	2,769,207	2,921,570	3,311,780
Condoms (Units)	4,328,462	4,188,130	5,665,613	5,380,875	5,261,642	5,292,292
Norforms (Boxes)	20,958	65,677	114,023	246,076	79,937	322,591
Emko (Tubes)	9,453	9,291	1,829	404	-o-	4,419
Neo-Sampoon (Units)	883,860	1,238,060	1,529,780	659,780	1,793,600	1,823,344

and 86 percent of all condoms distributed by PROFAMILIA in Colombia during January-June 1983 was through the commercial social marketing system.

The CSM model being tested in Santander is similar to the system just described except that PROFAMILIA's distributor assigned to Santander has contracted one salesperson funded by the project (salary, transportation and per diem) rather than paid from commissions on sales.[1] The second major difference is that the CSM program is to function in the small towns and semi-rural areas where PROFAMILIA previously maintained distribution posts. In the past the CSM program in Santander sold contraceptives only to druggists located in Bucaramanga (the capital city of Santander) and 5 principal counties in the department.[2] By extending the model to less densily populated areas, current regulations regarding the minimum monetary amount a druggist must receive need to be reviewed. This decision will depend on (1) the capacity of the druggists in these counties to pay on a cash or 30 day credit basis and (2) the cost to the CSM distributor to deliver and re-supply these druggists.

Because of this, the first service-related activity initiated before starting service delivery in July was an on-site visit by the distributor to the 32 counties where PROFAMILIA maintained CBD distribution posts. Each CBD distributor was evaluated by the CSM distributor in terms of commerical utility. Perhaps the most important requisite considered was the CBD distributor's economic capacity to buy in sizeable quantities and to pay in cash rather than on consignment as CBD distributors do. Results of this activity are not yet available but will be described in the first 6-month narrative report.

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[1]The reason for paying this person is that the project is experimental in that the CSM will expand to smaller counties than where it is now functioning and therefore represents a risk to the CSM distributor.

[2]They are: San Gil, Socorro, Barbosa, Vélez, and Puente Nacional.

[3]Between 10 and 15 units of each contraceptive (orals, vaginals and condoms) are supplied to a distribution post by a promoter

It is likely, however, that most if not all CBD distributors are unable to meet the CSM requisites and therefore will be phased out. In these counties the CSM distributor will search for alternative sources (generally drugstores) to supply.

Once the CSM distributor determines the appropriate CSM outlets, he will work with PROFAMILIA's CSM and Evaluation departments to organize a more specific work plan and calendar than is presented here. Special project-specific service statistics forms will be designed and printed to document the volume of sales and monetary amount by contraceptive method, service outlet and county.

Also during the first phase a commission strategy (also begun in July, 1984 after a baseline KAP survey) designed to pay 3 project funded promoters a small commission for every unit of contraceptives sold over a fixed goal will continue to be implemented in 50 counties where about 500,000 inhabitants reside (109,800 WFA) in the department of Cundinamarca. (A list of those counties can be found on page 13). This strategy differs from the current PROFAMILIA-Population Council project in that it will be applied only in semi-urban and rural areas, excluding Bogota. Under the current commission model, promoters cover the capital cities of the departments[1] which may have influenced the low-cost per couple year protection estimated for the first 6 months of the project.

The prices established by PROFAMILIA for each product to the CBD distributor, druggist and to the public are shown in Appendix III. Although specific sales goals by promoter according to drug have not yet been fixed, the commission a promoter can earn for each unit by method has been (see Appendix III).

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[1]Refer to footnote number 1 on page 3 for other information regarding the current incentive scheme.

TABLE 2.- Counties, population number of women in fertile age to be covered by commission system and number of existing CBD posts in each county:

CUNDINAMARCA

COUNTY	TOTAL POPULATION	NUMBER OF WFA	NUMBER OF DISTRIBUTION POSTS
Albán	4,774	1,050	1
Anolaima	11,901	2,618	1
Arbeláez	7,135	1,570	1
Bituima	3,302	726	1
Cabrera	5,193	1,142	-
Caparrapí	18,214	4,007	-
Cogua	8,630	1,899	-
Colegio	14,110	3,104	1
Chaguani	5,612	1,235	1
El Peñón	6,825	1,502	1
Fusagasugá	35,383	7,784	5
Guaduas	16,478	3,625	1
Guayabal de Siquim	4,333	953	1
Icononzo	8,707	1,916	2
La Mesa	10,204	2,245	1
La Palma	13,198	2,904	2
La Peña	6,187	1,361	-
La Vega	5,915	1,301	1
Melgar	13,466	2,963	2
Nemocón	6,622	1,457	1
Nimaima	3,536	778	1
Nocaima	4,714	1,037	1
Pacho	12,845	2,826	2
Paime	4,634	1,019	1
Pandi	5,099	1,122	1
Pasca	9,458	2,081	2
Pulí	4,773	1,050	1
Quebrada Negra	4,966	1,093	2
Quipile	9,548	2,101	1
Rioseco	9,828	2,162	1
San Antonio	6,331	1,393	1
San Bernardo	8,322	1,831	-
San Cayetano	6,931	1,525	1
San Francisco	5,450	1,199	-
Sasaima	4,856	1,068	1
Sibaté	18,076	3,977	-
Silvania	11,592	2,550	3
Supatá	4,543	999	1
Tena	3,520	774	-
Tenjo	6,733	1,481	1
Tibacuy	4,041	889	1
Tocancipá	4,465	982	-
Topaipi	5,676	1,249	1
Utica	5,212	1,147	1
Vergara	10,646	2,342	1
Viani	3,469	763	1
Villeta	12,876	2,833	1
Viotá	13,356	2,938	1
Yacopí	48,146	10,592	4
Zipaquirá	39,386	8,665	2
	[illegible]	10[illegible],828	57

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Evaluation: First Phase

The purpose of this project is to measure the cost-effectiveness of the CSM and CBD incentive schemes so that policy decisions may be made with regards to (1) whether PROFAMILIA should continue supporting a community based distribution program and (2) if so, which model should be adopted nationally.

CSM Scheme.-- For this model effectiveness is defined in terms of meeting the need for family planning services. Whether the need for contraception is being met or not will be detected through the behavior of the contraceptive use prevalence rates and the unmet need for family planning among the ever married women in fertile age in the target counties of Santander after delivery by the CSM approach has been in effect for 12 months. By means of a comparison between pre-intervention (baseline) sample survey findings on use prevalence and the unmet need and post-intervention (post-test) survey results on the same indicators, the stability of prevalence rates and unmet need levels will be documented. The CSM model will be considered effective if contraceptive use remains at the same level before the experiment was initiated or if it increases after the 12 month delivery period.

The model's costs will be measured by subtracting project expenditures (salesperson's salary, benefits, travel and per diems plus expenditures on purchase, storage and transportation of drugs and an estimate in monetary terms of the distributor's time spent on service delivery) from contraceptive sales income. The degree to which the result shows that income from contraceptive sales is sufficient to pay for expenditures will indicate the model's capacity for self-sufficiency. Complete self-sufficiency is reached when expenditures are covered by income. Expenditure records will be kept by PROFAMILIA and the distributor while sales data will be recorded by the distributor and the salesperson.

CBD Commission Scheme.-- In order to be able to compare this model with that tested in Cesar and Cauca (team approach), and in turn select the CBD model to be adopted if the CSM approach is unacceptable, effectiveness will be measured in terms of changes in contraceptive method and source knowledge, use prevalence, and the unmet need for family planning among the ever married women 15 to 49 in the study areas of Cundinamarca after 12 months of service delivery under this system. As in the CSM project zone, pre and post-intervention sample surveys findings will be compared to indicate if contraceptive knowledge and use increase and the unmet need for family planning declines. The model will be considered effective if this occurs.

The baseline surveys in Cundimanarca and Santander dealing with knowledge and use of contraceptive methods were conducted by PROFAMILIA in June-July, 1984. (See Appendix IV for copy of survey instrument). During this first phase, work will continue on the cleaning and processing of the data. Documentation will be prepared on this sample and files developed during analyses. A report will be prepared of preliminary findings, prior to the preparation for the second survey in year two.

It is not expected that a CBD scheme reach self-sufficiency as the commercial social marketing strategy may since it is characterized by personnel dependent IE & C campaigns and distributor re-supply activities. As such, and to compare with previous CSM strategies, the commission scheme costs will be estimated by cost per couple year protection calculations. The numerator of the ratio, program costs, will incorporate salaries, benefits, per diems and travel of the 3 promoters plus those same expenditures for the Regional Coordinator who will act as a field supervisor.

Other Activities

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A. Seminar on Operations Management

PROFAMILIA is interested in the integration of operations research techniques with the management of its service programs. In service of this goal, the institution plans to organize an operations management seminar with its directors of programs, projects, centers and clinics. The objective, is through a simulation excercise, to give management personnel practical experience and provide strategies for decision making based upon data generated by their units. Working in small groups, they will identify problems in service delivery, define the need for more information and propose potential solutions, specifying where possible their implications in terms of costs, human resource requirements and timeframe for implementation. A report will be prepared summarizing the benefits and problems encountered in this effort. This activity will be the responsibility of Miguel Trías in coordination with his program directors.

B. Cost Study

One of the objectives of this subagreement is to identify the cost-effectiveness of different strategies for service delivery. The proposed activity will complement this effort by defining costs for all operating centers of PROFAMILIA. Concretely this study will analyze fixed and variable costs for all service models (Clinical, Surgical, Community and Social Marketing). Reviewing the relationship of these costs to income and couple years of protection provided will assist the administration in developing guidelines for cost control and identifying the need for better program management. This study will be completed during the period January-June, 1985 under the direction of Guillermo Cerna, administrative assistant to the executive director.

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C. Computer Operations

In support of the research activity, PROFAMILIA will be acquiring a micro computer IBM/AT with software adequate for the in-house processing of operations research data. In order to increase the immediate utility of the effort, the Director of the Evaluation Division and two assistants will receive training in the use of IBM personnel computers through DATA CLUB, a Bogotá based training center, for a period of one year. The training provided includes the use of all software acquired by PROFAMILIA as well as its installation, care and documentation. In addition, PROFAMILIA is requesting basic materials (i.e. diskettes) and maintenance for a period of two years. Finally, during year one PROFAMILIA will design and test a computerized service statistics system for both service strategies.

Second Phase: Activities and Evaluation

Utilizing the results from the first phase, pre- and post-intervention surveys and the cost analysis for the commercial social marketing department PROFAMILIA will determine its policy regarding the continuation of its CBD programs in Colombia. If the CSM proves to be effective (contraceptive use prevalence rates do not decline) and it represents a self-sufficient delivery strategy, then the second 18 months of the project will be utilized to expand the system into another department. Expansion into a second department will serve to reinforce the first phase's results and to begin the phasing out at the na-

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tional level of the CBD program. However, if the CSM proves ineffective (use prevalence rates decline), even though it may be self-sufficient, it will be cancelled in Santander and a cost-effective CBD system will be re-mounted in that province during the second phase of this project.[1]

Mini sample-surveys will be carried out in the second phase preceeding and following a 12 month service delivery period in the department to which the CSM model is expanded, if the CSM policy is adopted. Their purpose is to reinforce the results from the first phase and as such will measure changes in contraceptive use and the unmet need. Only a post-intervention survey will be implemented in Santander in the second phase if a CBD system is applied there, to detect if contraceptive use increases again after having dropped.

PROJECT CALENDAR AND REPORTS

On page 6 a calendar is presented showing an estimated time schedule for implementing the activities proposed in this document. The 36 month period would begin September, 1984 and terminate in September, 1987. During the first seven months of the First Phase, the new service statistics forms will be drawn up and printed.[2] The commercial social marketing and commission delivery strategies in Santander and Cundinamarca will continue

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[1]The CBD strategy selected will be either the team or incentive model depending on the results from the incentive experiment during the first phase. Since this is not yet known, personnel budgeted for the second phase may change. Right now one team is budgeted.

[2]These forms will be tested in Cundinamarca. They will be computerized service statistic reports intended to improve the quality of reporting of contraceptive sales and program movement for CBD systems. Appendix IV shows the current report form. Item 2 (Existencia Anterior) will be automatically printed out by the computer. Each promoter will fill in the amount provided to the distributor (item 7). When this information is remitted to the Evaluation Unit in Bogotá, it will be fed into the computer which will then calculate monetary

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through month 16 of the First Phase. These delivery strategies will be supported in these zones until that time even though the second survey will be fielded after 12 months of service (month 13). This extension of service delivery three additional months past the second survey occurs because no policy decisions can be made with regard to Second Phase activities (personnel cannot be moved) until the comparative results of the First Phase surveys are available.

During months 13 and 14 the baseline mini-survey in the Second Phase service areas will be carried out. By the 17th month of the project field work for this survey will be terminated and the Second Phase delivery strategies will have been designed. Service activities will then begin and run until the 36th month. Six months before the project is over, the second mini-survey will be carried out.

Service statistics will be collected every third month once services are implemented in each phase. Financial and narrative reports will be prepared every 6 months to be submitted to the Population Council.

Project Personnel

The following personnel will participate in the implementation of the project.

Project Director.-- This person is the Executive Director of PROFAMILIA and is responsible for assuring the implementation of both the service and research components of the project as described in this protocol. As well, the Project Director is responsible for the timely submission of all financial and narrative progress reports to the Population Council. Time dedicated to the project by the Executive Director is considered PROFAMILIA's financial counter-contribution and as such is not budgeted into funds requested from the Population Council. A total of 25% of the administrative assistant's time in year one is allocated for the cost study.

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Project Division Heads.-- Both the Heads of the IE & C and Commercial Marketing Departments will be responsible before the Project Director for the budgeting, organization, planning and supervision of the corresponding project strategies and personnel required to implement those strategies. Although these individuals are usually considered PROFAMILIA's financial counterpart, 25% of the time of the head of the Commercial Marketing Department will be paid by the project so that the operation of the marketing strategy can be well documented.

Evaluation Personnel.-- PROFAMILIA's Director of Evaluation and statistics will be funded half-time by the project as well as two research assistants and one auxiliary full-time to (1) design and implement new service statistics forms (2) process and report contraceptive sales and sterilization statistics by county every 3 months for Santander and Cundinamarca (3) design and implement in collaboration with the Population Council technical advisor the four surveys (4) analyze survey results and prepare reports on policy implications of survey data, contraceptive sales and cost estimates for Second Phase design along with the Population Council Advisor and (5) prepare final policy recommendations with the Population Council Advisor regarding the future of PROFAMILIA's CBD program in Colombia. Evaluation personnel will also be responsible for the reporting on contraceptive sales by method (totals not by county) for 1981 to 1983 for both Santander and Cundinamarca and the statistics for these departments for 1984-1985 for comparative purposes. Specifically one research assistant will be devoted to the documentation of data collected by the Division, including raw data, output and archives, as well as setting up a control system for a questionnaire item bank, cleaning and variable formation procedures and the Division data bank.

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Regional Coordinator.-- This person will be stationed in Bogotá and is responsible to the Director of IE & C. Her responsibilities during the first 12 months are those related to the supervision of the promoters employed in the commission zone. The Regional Coordinator will be funded half-time by the project and spend 7 out of every 10 days a month in Cundinamarca working with the promoters.

Promoters.-- Three promoters will be paid full-time by the project to work under the commission scheme in those counties selected in Cundinamarca as described in the protocol.

Distributor and Salesperson.-- PROFAMILIA's commercial social marketing distributor will be responsible for hiring and contracting one salesperson to supply commercial outlets in the counties selected in Santander. Although the distributor will not receive any payment for his participation in the project, he will benefit financially from any profits earned on the sales of contraceptives in the project counties and he will have no expenditures for the salesperson as these will be paid by the project. Although it is not known which system will be employed during the Second Phase, the salesperson has been budgeted for the entire 3 years.

Team.-- Costs for one male-female team for 18 months have been included in the budget anticipating that the Second Phase delivery strategies will include a team model.

Technical Advisor.-- The Population Council will provide technical assistance and project monitoring through its Technical Advisor in Bogotá who will dedicate 40 percent of his/her time to these activities. This person is to collaborate with the Director of Evaluation and Statistics in the design, implementation and analysis of the four Surveys. He/she will participate in the calculations of cost per CYP and work with PROFAMILIA in the programmatic interpretation of all data generated by the project. As part of the Technical Advisor's monitoring responsibilities, this person will make 4 field site visits during each phase and will prepare reports on those visits. He/she will be in charge of preparing Population Council 6 month and final narrative reports to AID and will collaborate with the project Director in the implementation of the service component.

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APPENDIX I

DESCRIPTION OF MOH FAMILY PLANNING ACTIVITIES IN SANTANDER AND MAPS AND LISTS OF COUNTIES IN SANTANDER AND CUNDINAMARCA

MOH FAMILY PLANNING SERVICES IN SANTANDER

In Santander the Ministry of Health provides family planning services through its 28 health posts, 9 health centers, 12 local hospitals and 2 regional hospitals located in 45 counties in the department. (These are listed on the attached chart from the MOH.) Methods offered in these outlets are Copper-T and Lippes IUD's, condoms, and orals. Female sterilization can be obtained in the hospitals. There are currently 274 MOH rural health promoters who sell oral contraceptives for $5.00 pesos (US$0.06 cents) to women registered in an MOH health outlet on a re-supply basis. Twelve of the proposed CSM counties are currently serviced by the MOH leaving 20 uncovered. The residents of these 20 counties will be most affected by the phasing out of PROFAMILIA's CBD program.

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REPUBLICA DE COLOMBIA
MINISTERIO DE SALUD

INFORMACION GENERA DE LA EXTENS
DE SALUD CON ATENCION PRIMARIA PAR

1.983

ELABORACION NIVEL LOCAL ☐

ELABORACION NIVEL REGIONAL ☐ CONSOLIDADO REGION

SERVICIO SECCIONAL DE SALUD DE SANTANDER CONSOLIDADO SECCION

IDENTIFICACION			MUNICIPIO	LOCALIDAD SEDE DE LA U. P. A.	HOSPITAL DE APOYO			UNIDAD PRIMARIA DE AT (O MAC)		
No DE ORDEN	TIPO DE ORGANIGRAMO SEDE DE LA U.P.A.	IDENTIFICACION POR FUENTE DE FINANCIACION			NOMBRE	TIPO H.L.	TIPO H.R.	EN FUNCIONAMIENTO	No. Promotores	
1	2	3	4	5	6	7	8	9		
1	P.S.	PNSR/S.S.	Sabana de Torres	Popayal	Integ. Sabana de Torres	X		1.976	6	
2	P.S.	DRI	Hato	Hato - Palmar	S. Juan de Dios		X	1.976	6	
3	P.S.	PNSR/S.S.	San Vicente	Cantadorio	S. Juan de Dios		X	1.977	6	
4	P.S.	PNSR/S.S.	San Vicente	Agua Blanca	S. Juan de Dios		X	1.978	4	
5	P.S.	DRI	Ocamonte	Ocamonte	S. Roque - Charalá	X		1.978	7	
6	P.S.	PAN	Pinchote	Pinchote	S. Juan de Dios		X	1.979	5	
7	P.S.	PNSR/S.S.	Zapatoca	La Fuente	La Merced - Zapatoca	X		1.979	4	
8	P.S.	PNSR/S.S.	Charalá	Riachuelo	S. Roque - Charalá	X		1.979	6	
9	P.S.	PAN	Molagavita	Suarez Cruz	S. Antonio - Bucaramanga	X		1.979	2	
10	P.S.	PAN	Tona	Vegas	H. R. Gonzalez Valencia		X	1.979	6	
11	P.S.	PNSR/PAN	Guapotá	Guapotá	H. S. Rosal - Cubo	X		1.979	6	
12	P.S.	DRI	Molagavita	Molagavita	Sto. Domingo - Molagavita		X	1.979	6	
13	P.S.	DRI	Enciso	Enciso	Sto. Domingo - Molagavita		X	1.979	6	
14	P.S.	DRI	Cerrogi	Cerrogi	Hno. Bro. Remedios	X		1.979	6	
15	P.S.	DRI	San Andrés	Pangote	S. José - San Andrés	X		1.977	6	
16	P.S.	DRI	Palmas del Socorro	Palmas del Socorro	S. Juan de Dios		X	1.977	6	
17	P.S.	DRI	Suaita	Olival	Caicedo y Flórez	X		1.977	4	
18	C.S.	PNSR	Contratación, Guacamayas	Contratación - Guacamayas	San Roque	X		1.977	6	
19	P.S.	DRI	Suaita	San José de Suaita	Caicedo y Flórez	X		1.977	6	
20	P.S.	DRI	San Benito	San Benito	Caicedo y Flórez	X		1.977	4	
21	C.S.	DRI	Gambita	Gambita	Caicedo y Flórez	X		1.977	6	
22	P.S.	PNSR/S.S.	La Paz	La Paz	S. Juan de Dios		X	1.977	5	
23	C.S.	PNSR/S.S.	Chipatá	Chipatá	S. Juan de Dios		X	1.977	6	
24	P.S.	PNSR/S.S.	Guavatá	Guavatá	S. Juan de Dios		X	1.977	6	
25	P.S.	DRI	Jesús María	Jesús María	San Antonio - Pla. Nal.	X		1.977	5	
26	P.S.	DRI	Guepsa	Guepsa	S. Bernardo	X		1.976	4	
27	H.L.	DRI	Bolívar	Bolívar	S. Antonio - Pla. Nal.	X		1.977	6	
28	H.R.	DRI	Vélez	Lomo Alto	S. Juan de Dios		X	1.978	4	
29	P.S.	DRI	Jesús María	Floridas	S. Antonio - Pla. Nal.	X		1.977	6	
30	P.S.	PNSR	Albania	Albania	S. Antonio - Pla. Nal.	X		1.978	5	

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ICA DE COLOMBIA
STERIO DE SALUD

INFORMACION GENERA . DE LA EXTEN
DE SALUD CON ATENCION PRIMARIA PAF

1.983

ELABORACION NIVEL LOCAL ☐

ELABORACION NIVEL REGIONAL ☐ CONSOLIDADO REGION

SERVICIO SECCIONAL DE SALUD DE SANTANDER CONSOLIDADO SECCIO

IDENTIFICACION			MUNICIPIO	LOCALIDAD SEDE DE LA U. P. A.	HOSPITAL DE APOYO			UNIDAD PRIMARIA DE A (O MAC)		
No DE ORDEN	TIPO DE ORGANIS MO SEDE DE LA U.P.A.	IDENTIFICACION POR FUENTE DE FINANCIACION			NOMBRE	TIPO		EN FUNCIONA - MIENTO	Número Promotores	
						H.L.	H.R.		A Diciembre	
1	2	3	4	5	6	7	8	9		
31	H.L.	PNSR/Sec	Matanza	Matanza	San Rafael - Matanza	x		1.981	9	
32	P.S.	PNSR/Sec	Charta	Charta - Suratá	San Rafael - Matanza	x		1.981	6	
33	C.S.	PAN.	Rionegro	Playón	San Antonio - Rionegro	x		1.981	3	
34	C.S.	PNSR	Piedecuesta	Piedecuesta	S. Juan de Dios - Pie	x		1.981	8	
35	P.S.	PNSR	Los Santos	Los Santos	S. Juan de Dios - Pie	x		1.982	3	
36	C.S.	PNSR	Capitanejo	San Miguel	Sto. Domingo - Malaga		x	1.981	6	
37	P.S.	PNSR	Macaravita	Macaravita	Sto. Domingo - Malaga		x	1.978	6	
38	H.L.	PNSR/Sec	Valle San José	Valle San José	Valle de San José	x		1.981	6	
39	H.R.	PNSR/Sec	San Gil	San Gil	S. Juan de Dios - S. Gil		x	1981	6	
40	H.L.	PNSR/Sec	Mogotes	Mogotes	S. Pedro Claver - Mogotes	x		1.981	8	
41	H.L.	PNSR/Sec	Onzaga	Onzaga	S. Vicente de Paul	x		1.981	5	
42	H.L.	DEL.	Simacota	Simacota	S. Roque - Simacota	x		1.982	6	
43	H.L.	PAN.	San Joaquín	San Joaquín	H. de Caridad	x		1.981	5	
44	C.S.	PNSR.	Barichara	Los Cerrajos - Barichara	S. Rafael - Barichara		x	1.981	4	
45	C.S.	PAN.	Bucaramanga	Kennedy	H. R. González Valencia		x	1.981	6	
46	U.I.	PNSR	Bucaramanga	Comuneros	U. I. H. L. Sto Tomás			1.981	6	
47	C.S.	PAN/Sec	Bucaramanga	San Cristóbal	H. R. González - Valencia		x	1.981	6	
48	H.L.	PNSR/Sec	Rionegro	Rionegro	S. Antonio - Rionegro	x		1.980	3	
49	H.L.	PAN.	S. José de Miranda	S. José de Miranda	Hna. Sta. de los Ángeles	x		1.981	6	
50	H.L.	PNSR	Aratoca	Capitá	S. Rafael - Aratoca	x		1.981	3	
51	H.L.	[illegible]	GALAN	GALAN	S. Juan Dios	x		1.983	2	

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300

PROFAMILIA
ASOCIACIÓN PRO-BIENESTAR DE LA FAMILIA COLOMBIANA

C 0228

Bucaramanga noviembre 30 de 1.983

Señor Doctor
GABRIEL OJEDA
Dirección de Evaluación Y Estadística
PROFAMILIA
Calle 34 Nº 14-52
BOGOTA

Muy apreciado doctor Ojeda:

Con relación a la información solicitada por Ud. sobre el Programa de Planificación Familiar desarrollado por el Ministerio de Salud en el Departamento de Santander, me permito informarle lo siguiente:

1º.- Número de Puestos, Centros de Salud y Hospitales:
Están minuciosamente detallados en el gráfico que le acompaño.

2º.- Número de Promotoras Rurales de Salud por municipio, Puesto de Salud y Hospitales:
Están relacionadas en hojas anexas.

3º.- Métodos de Planificación Familiar ofrecidos por Minsalud en Sder:
a) Dispositivos intrauterinos (Tou y Lippes)
b) Preservativos
c) Anovulatorios orales
d) Esterilización Femenina.

4º.- Actividades de Minsalud en Santander a través de Promotoras:
Hacen divulgación con folletos y afiches por medio de charlas en Hospitales, Centros y Puestos de Salud. También realizan visitas domiciliarias y distribuyen los anavulatorios orales a la pacientes inscritas en los sitios de atención ya mencionados. Hacen tambien visitas de seguimiento a domicilio y reabastecen a las usuarias. Los anovulatorios orales son vendidos a $5,oo y en algunos pocos casos se regalan.

Es de hacer notar que se exige una inscripción de la usuaria en el Hospital , Puesto o Centro de Salud, la cual es gratuita y luego se lleva cabo el seguimiento y reabastecimiento correspondiente.

./.

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PROFAMILIA
ASOCIACIÓN PRO-BIENESTAR DE LA FAMILIA COLOMBIANA

C 0228

Dr. Ojeda.

Espero con estos datos tenga una visión completa y más o menos detallada del Programa de Planficación Familiar de Minsalud en Santander.

Con sentimientos de consideración y aprecio, me repito de Ud. muy cordialmente,

DR. FABIO DURAN VELASCO
DIRECTOR

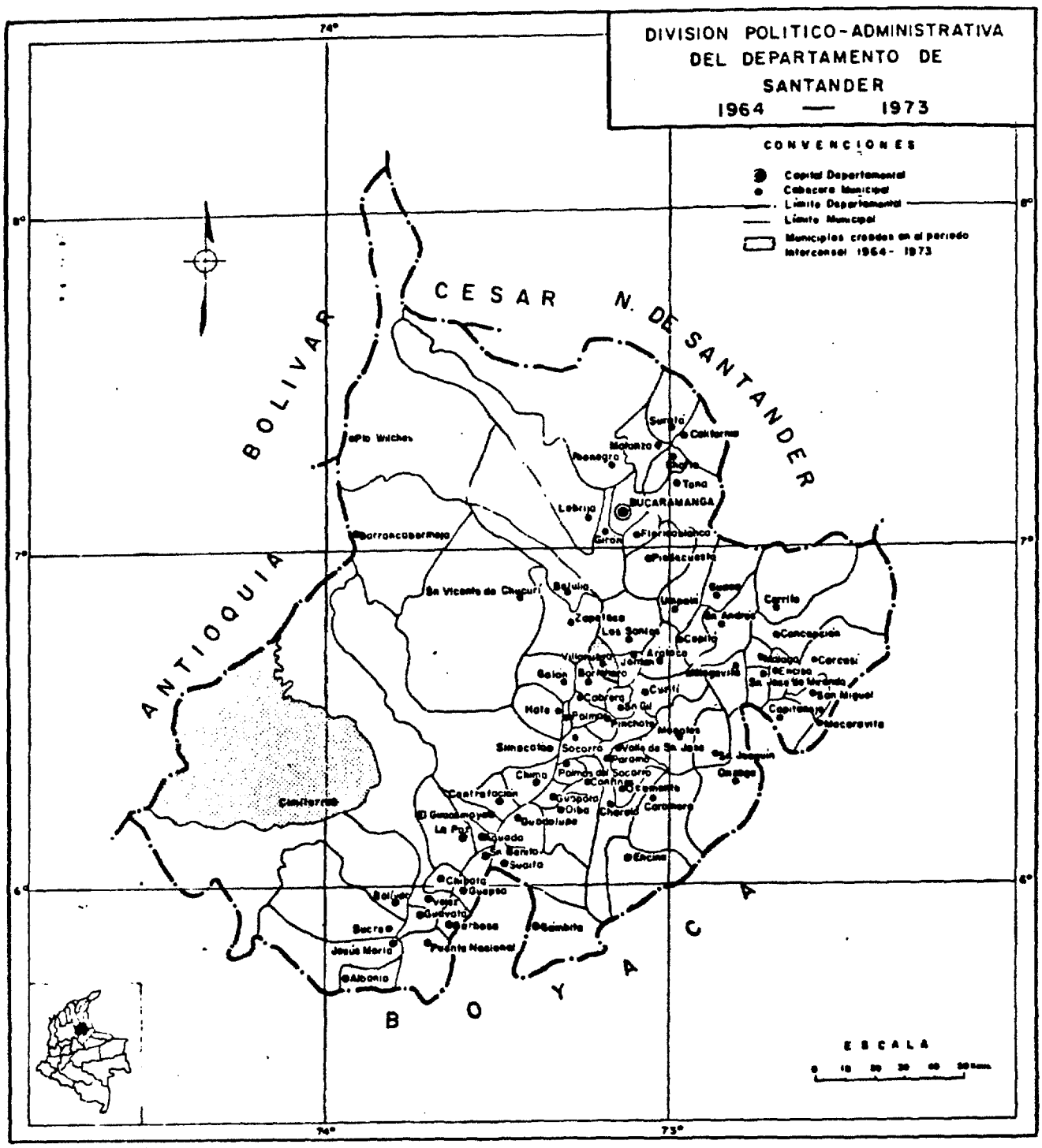
Anexo: Lo anunciado.

A.deDP.-

PROFAMILIA 7222
Fecha XII.1/83
Enviar a:
...ado con
... en código

Carrera 28 No. 37-86 - Teléfono. 25611 - Bucaramanga

302


DIVISION POLITICO-ADMINISTRATIVA
DEL DEPARTAMENTO DE
SANTANDER
1964 — 1973
CONVENCIONES
Capital Departamental
Cabecera Municipal
Límite Departamental
Límite Municipal
Municipios creados en el periodo
Interconsol 1964 - 1973
CESAR
N. DE SANTANDER
BOLIVAR
ANTIOQUIA
BOYACA
Pto Wilches
Barrancabermeja
San Vicente de Chucurí
Sucre
Jesús María
Albania
Puente Nacional
Sambita
Cimitarra
Bolívar
Vélez
Guavatá
Barbosa
Chipatá
Guepsa
Suaita
San Benito
La Paz
Guadalupe
Oiba
Guapotá
Cerrito
Charalá
Coromoro
Encino
Capitanejo
Macaravita
San Miguel
San Joaquín
Gambita
Simacota
Socorro
Palmas del Socorro
Valle de San José
Paramo
Chima
Contratación
Guadalupe
Mogotes
Pinchote
Cabrera
San Gil
Hato
Palmar
Galán
Barichara
Jordan
Villanueva
Aratoca
Curití
Oiba
Cepita
Los Santos
Zapatoca
Betulia
Piedecuesta
Floridablanca
Girón
Lebrija
BUCARAMANGA
Tona
Rionegro
Matanza
California
Suratá
Cerrito
Concepción
Cácota
Chitagá
Silos
Mutiscua
Pamplona
Pamplonita
Cucutilla
Gramalote
Lourdes
Salazar
Santiago
Arboledas
Bochalema
Chinácota
Ocaña
Abrego
La Esperanza
Hacaritama
Convención
El Carmen
Teorama
San Calixto
Tibú
ESCALA
0 10 20 30 40 50 Kms
74°
73°
8°
7°
6°

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Población del departamento de Santander en los censos de 1964 y 1973, según municipios

1964		1973		Area medida sobre la cartografía censal de 1973 Kms2
Municipios correspondientes a los vigentes en 1973	Población	Municipios vigentes en 1973	Población	
Totales	1.001.213		1.127.999	30.889
Bucaramanga	229.748	Bucaramanga	296.657	153
Aguada	2.747	Aguada	2.272	61
Albania	8.351	Albania	7.208	242
Aratoca	6.015	Aratoca	6.093	168
Barbosa	9.892	Barbosa	10.973	55
Barichara 1/	13.417	Barichara 1/	8.207	145
Barrancabermeja	71.096	Barrancabermeja	98.218	1.171
Betulia	5.524	Betulia	5.344	339
Bolívar	29.411	Bolívar	23.294	1.806
Cabrera	3.322	Cabrera	3.177	68
California	2.759	California	2.680	140
Capitanejo	6.895	Capitanejo	6.448	90
Carcasí	7.643	Carcasí	7.119	260
Cepitá	2.590	Cepitá	2.414	115
Cerrito	6.337	Cerrito	5.945	430
Charalá	13.377	Charalá	17.724	405
Charta	4.318	Charta	4.263	126
Chima	3.654	Chima	3.951	148
Chipatá	8.003	Chipatá	7.281	87
		Cimitarra 2/	13.940	2.891
Concepción	9.364	Concepción	8.150	333
Confines	2.314	Confines	2.611	73
Contratación	4.644	Contratación	4.642	162
Coromoro	6.250	Coromoro	5.779	583
Curití	6.615	Curití	6.734	240
El Guacamayo	6.881	El Guacamayo	6.741	281
Encino	2.686	Encino	2.549	380
Enciso	6.511	Enciso	5.590	70
Floridablanca	14.720	Floridablanca	43.870	98
Galán	5.030	Galán	4.236	230
Gámbita	5.905	Gámbita	4.816	527
Girón	17.247	Girón	21.272	878
Guaca	8.707	Guaca	8.847	305
Guadalupe	7.434	Guadalupe	6.857	142
Guapotá	2.737	Guapotá	2.594	65
Guavatá	7.322	Guavatá	6.304	58
Güepsa	3.891	Güepsa	3.127	42
Hato	2.336	Hato	2.041	195
Jesús María	15.493	Jesús María	14.782	477
Jordán	1.756	Jordán	1.499	40
La Paz	8.291	La Paz	7.473	277
Lebrija	15.806	Lebrija	17.291	909
Los Santos	7.590	Los Santos	8.273	310
Macaravita	6.029	Macaravita	4.821	105
Málaga	15.417	Málaga	14.850	56
Matanza	7.379	Matanza	7.030	240
Mogotes	12.848	Mogotes	11.775	470
Molagavita	8.611	Molagavita	8.022	180
Ocamonte	4.150	Ocamonte	3.953	75
Oiba	8.161	Oiba	7.688	280
Onzaga	10.787	Onzaga	9.595	487
Palmar	1.954	Palmar	1.713	21
Palmas del Socorro	2.310	Palmas del Socorro	2.322	60

Población del departamento de Santander en los censos de 1964 y 1973, según municipios

1964		1973		Area medida sobre la cartografía censal de 1973 Kms^2
Municipios correspondientes a los vigentes en 1973	Población	Municipios vigentes en 1973	Población	
Páramo	3.386	Páramo	2.773	75
Piedecuesta	22.624	Piedecuesta	26.020	380
Pinchote	3.738	Pinchote	3.418	55
Puente Nacional	16.495	Puente Nacional	17.820	265
Puerto Wilches	22.285	Puerto Wilches	25.798	2.300
Rionegro	29.525	Rionegro	31.405	1.515
San Andrés	15.891	San Andrés	14.806	288
San Benito	3.668	San Benito	2.870	59
San Gil	26.019	San Gil	28.643	155
San Joaquín	5.277	San Joaquín	4.240	145
San José de Miranda	7.111	San José de Miranda	6.853	73
San Miguel	5.801	San Miguel	4.795	64
San Vicente de Chucurí	32.019	San Vicente de Chucurí	35.695	2.028
Simacota	9.537	Simacota	8.168	1.280
Socorro	18.806	Socorro	21.393	130
Suaita	13.600	Suaita	10.734	315
Sucre	12.383	Sucre	12.412	860
Suratá	6.455	Suratá	5.933	368
Tona	6.447	Tona	5984	350
Umpalá	3.962	Umpalá	3.507	320
Valle de San José	4.630	Valle de San José	3.436	80
Vélez 2/	34.115	Vélez 2/	33.199	1.740
		Villanueva 1/	5.529	115
Zapatoca	15.164	Zapatoca	11.513	380

1/ El municipio de Villanueva fue creado por Ordenanza 026, de noviembre 26 de 1966, segregado del municipio de Barichara.

2/ El municipio de Cimitarra fue creado por Ordenanza 025, de noviembre 26 de 1966, segregado del municipio de Vélez.

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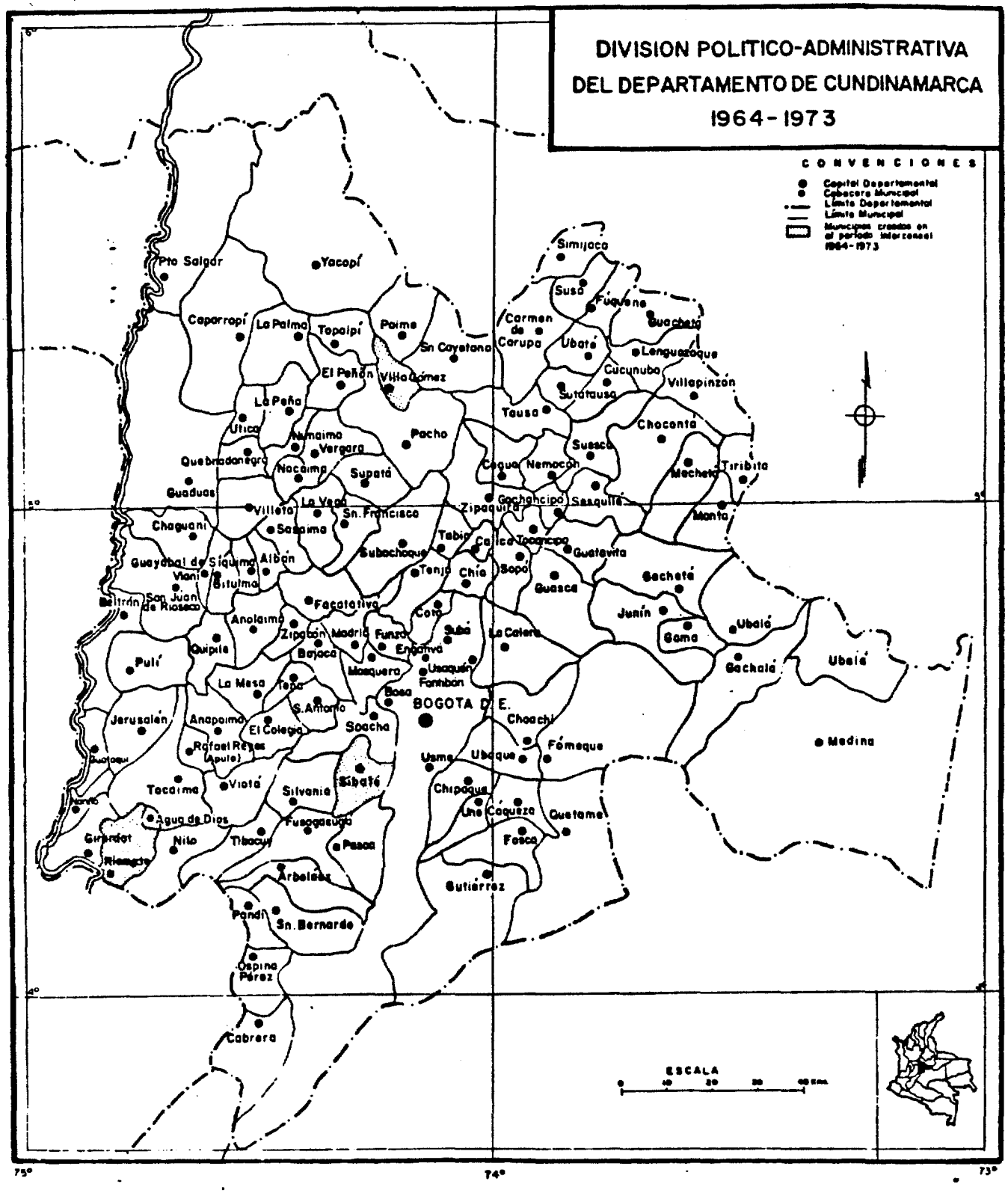
DIVISION POLITICO-ADMINISTRATIVA
DEL DEPARTAMENTO DE CUNDINAMARCA
1964-1973
CONVENCIONES
Capital Departamental
Cabecera Municipal
Límite Departamental
Límite Municipal
Municipios creados en el período intercensal 1964-1973
Pto Salgar
Yacopí
Caparrapí
La Palma
Topaipí
Paime
Sn Cayetano
El Peñón
Villa Gómez
La Peña
Útica
Nimaima
Vergara
Quebradanegra
Nocaima
Supatá
Guaduas
Villeta
La Vega
Sn. Francisco
Chaguaní
Sasaima
Guayabal de Siquima
Albán
Viani
Bituima
San Juan de Rioseco
Beltrán
Anolaima
Facatativá
Zipacón
Madrid
Funza
Bojacá
Mosquera
Engativá
Usaquén
Fontibón
Quipile
Pulí
La Mesa
Tena
S. Antonio
Bosa
BOGOTA D. E.
Soacha
Jerusalén
Anapoima
El Colegio
Rafael Reyes (Apulo)
Tocaima
Viotá
Silvania
Sibaté
Agua de Dios
Girardot
Nilo
Tibacuy
Fusagasugá
Pasca
Arbeláez
Pandi
Sn. Bernardo
Ospina Pérez
Cabrera
Simijaca
Susa
Fúquene
Guachetá
Carmen de Carupa
Ubaté
Lenguazaque
Cucunubá
Villapinzón
Sutatausa
Tausa
Choconta
Suesca
Cogua
Nemocón
Mechetá
Tiribita
Zipaquirá
Cachipay
Sesquilé
Manta
Tabio
Cajicá
Tocancipá
Guatavita
Subachoque
Tenjo
Chía
Sopó
Guasca
Sachetá
Junín
Gama
Ubalá
La Calera
Cota
Suba
Usme
Ubaque
Chipaque
Une
Cáqueza
Fómeque
Choachí
Fosca
Quetame
Gutiérrez
Medina
Gachalá
ESCALA
75°
74°
73°
6°
5°
4°

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Población del departamento de Cundinamarca en los censos de 1964 y 1973, según municipios

1964		1973		Area medida sobre la cartografía censal de 1973 Kms^2
Municipios correspondientes a los vigentes en 1973	Población	Municipios vigentes en 1973	Población	
TOTALES	1.122.213		1.125.642	22.223
Agua de Dios	8.462	Agua de Dios	12.431	85
Albán	6.769	Albán	6.048	56
Anapoima	6.868	Anapoima	5.324	118
Anolaima	23.885	Anolaima	20.536	178
Arbeláez	11.207	Arbeláez	8.685	152
Beltrán	2.044	Beltrán	2.785	196
Bituima	4.653	Bituima	3.887	60
Bojacá	2.617	Bojacá	2.982	83
Cabrera	4.796	Cabrera	5.062	404
Cajicá	10.049	Cajicá	12.439	51
Caparrapí	14.369	Caparrapí	16.217	604
Cáqueza	15.656	Cáqueza	14.178	105
Carmen de Carupa	9.428	Carmen de Carupa	8.467	238
Chaguaní	6.657	Chaguaní	6.073	168
Chía	15.793	Chía	20.602	78
Chipaque	8.874	Chipaque	8.267	123
Choachí	11.677	Choachí	10.805	229
Chocontá	13.332	Chocontá	13.232	329
Cogua	8.146	Cogua	8.630	136
Cota	4.048	Cota	4.827	54
Cucunubá	4.798	Cucunubá	5.157	109
El Colegio	15.367	El Colegio	14.845	114
El Peñón	9.346	El Peñón	8.246	131
Facatativá	25.565	Facatativá	34.348	161
Fómeque	11.524	Fómeque	11.410	465
Fosca	7.166	Fosca	6.511	130
Funza	10.659	Funza	17.660	70
Fúquene	4.137	Fúquene	3.863	76
Fusagasugá	30.328	Fusagasugá	39.426	226
Gachalá	9.875	Gachalá	8.559	435
Gachancipá	2.526	Gachancipá	2.625	43
Gachetá	16.106	Gachetá	13.892	277
Gama	6.045	Gama	5.452	98
Girardot 1/	76.990	Girardot 1/	61.232	132
Guachetá	8.773	Guachetá	7.782	177
Guaduas	18.018	Guaduas	17.256	754
Guasca	7.142	Guasca	6.996	119
Guataquí	2.450	Guataquí	2.423	92
Guatavita	5.447	Guatavita	4.781	246
Guayabal de Síquima	4.210	Guayabal de Síquima	4.555	61
Gutiérrez	4.737	Gutiérrez	5.066	660
Jerusalén	3.392	Jerusalén	3.358	204
Junín	16.916	Junín	10.955	345
La Calera	10.933	La Calera	11.807	358
La Mesa	17.796	La Mesa	14.794	162
La Palma	16.577	La Palma	14.935	191
La Peña	6.955	La Peña	6.187	136
La Vega	9.877	La Vega	7.595	135
Lenguazaque	6.421	Lenguazaque	6.729	156
Machetá	11.475	Machetá	8.668	205
Madrid	11.850	Madrid	18.099	122
Manta	8.201	Manta	7.219	108
Medina	15.138	Medina	17.010	1.938
Mosquera	7.396	Mosquera	7.660	113
Nariño	2.416	Nariño	2.365	55
Nemocón	5.821	Nemocón	6.208	108
Nilo	8.910	Nilo	4.975	220
Nimaima	4.762	Nimaima	4.040	59
Nocaima	7.397	Nocaima	5.738	70

Población del departamento de Cundinamarca en los censos de 1964 y 1973, según municipios

1964		1973		Area medida sobre la cartografía censal de 1973 Kms²
Municipios correspondientes a los vigentes en 1973	Población	Municipios vigentes en 1973	Población	
Ospina Pérez	5.181	Ospina Pérez	4.753	156
Pacho 2/	31.469	Pacho 2/	18.018	401
Paime	10.092	Paime	6.617	187
Pandi	5.099	Pandi	4.618	94
Pasca	11.953	Pasca	10.557	237
Puerto Salgar	11.019	Puerto Salgar	10.232	526
Pulí	5.645	Pulí	4.773	168
Quebradanegra	5.754	Quebradanegra	4.966	79
Quetame	7.709	Quetame	8.999	414
Quipile	11.788	Quipile	10.680	106
Rafael Reyes 3/	9.575	Rafael Reyes	8.335	124
		Ricaurte 1/	5.277	127
San Antonio de Tena	9.879	San Antonio de Tena	7.845	81
San Bernardo	9.742	San Bernardo	9.246	191
San Cayetano	8.117	San Cayetano	8.038	281
San Francisco	6.847	San Francisco	6.069	110
San Juan de Rioseco	13.634	San Juan de Rioseco	11.460	313
Sasaima	6.248	Sasaima	5.901	104
Sesquilé	4.669	Sesquilé	4.490	138
		Sibaté 4/	14.037	116
Silvania	11.953	Silvania	11.882	157
Simijaca	6.208	Simijaca	6.704	100
Soacha 4/	32.600	Soacha 4/	37.753	183
Sopó	4.187	Sopó	5.852	110
Subachoque	10.075	Subachoque	9.614	298
Suesca	8.824	Suesca	7.643	179
Supatá	6.161	Supatá	5.176	150
Susa	5.855	Susa	5.441	113
Sutatausa	2.798	Sutatausa	2.566	60
Tabio	5.274	Tabio	7.094	73
Tausa	4.039	Tausa	4.484	201
Tena	5.187	Tena	4.220	53
Tenjo	6.077	Tenjo	6.733	113
Tibacuy	5.076	Tibacuy	4.613	84
Tibirita	5.221	Tibirita	5.286	55
Tocaima	17.998	Tocaima	16.724	248
Tocancipá	3.312	Tocancipá	4.465	71
Topaipí	9.163	Topaipí	7.115	129
Ubalá	16.467	Ubalá	13.810	742
Ubaque	8.634	Ubaque	8.547	117
Ubaté	14.486	Ubaté	15.129	100
Une	7.262	Une	6.664	96
Utica	4.959	Utica	5.093	91
Vergara	11.450	Vergara	10646	145
Vianí	5.081	Vianí	4.190	68
		Villagómez 2/	3.916	67
Villapinzón	11.259	Villapinzón	11.890	231
Villeta	13.836	Villeta	13.395	107
Viotá	16.042	Viotá	14.786	204
Yacopí 5/	13.830	Yacopí	23.793	971
Zipacón	3.932	Zipacón	3.767	53
Zipaquirá	27.775	Zipaquirá	39.836	193

1/ El municipio de Ricaurte fue suprimido como municipio por ordenanza 024 de diciembre 30 de 1955; pero el Tribunal de lo Contencioso Administrativo declaró nula esa ordenanza, y el Consejo de Estado confirmó esta nulidad según Providencia de julio 29 de 1967. Por esta razón Ricaurte fue censado en 1964 como corregimiento de Girardot.

2/ El municipio de Villagómez fue creado por ordenanza 002 de octubre 18 de 1965, segregado del municipio de Pacho.

3/ En el Censo de 1964 se le denominó Rafael Reyes–Apulo; por Decreto No. 1336 de diciembre 19 de 1949 este municipio fue formado por el territorio del corregimiento de Apulo.

4/ El municipio de Sibaté fue creado por Ordenanza 040, de noviembre 24 de 1967 segregado del municipio de Soacha.

5/ En el censo de 1964 se le denominó Yacopí–San Antonio, se desconoce la disposición por medio de la cual se cambió de nombre.

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APPENDIX II

COMMERCIAL SOCIAL MARKETING PROGRAM AND
DISTRIBUTOR CONTRACT

P R O F A M I L I A

AMALFRE. LTDA. ZONA 5

MINIMA CANTIDAD DE COMPRA PARA 1983 POR PRODUCTO

P R O D U C T O		M E T A A N U A L 1 9 8 3	P R O M E D I O M E N S U A L
NORIDAY	= Caja x 60 Ciclos	818	68
SCHERING	= Caja x 100 Ciclos	2.387	199
WYETH	= Caja x 100 Ciclos	1.260	105
NEO-SAMPOON TUBOS	= Caja x 20 Tubos	681	57
NEO-SAMPOON TIRAS	= Gruesa	210	18
NORFORMS	= Caja x 12 Ovulos	40.115	3.343
EMKO 40 Gms.	= Unidades	480	40
EMKO BECAUSE	= Unidades	237	20
STIMULA	= Gruesa	845	70
ROUGH RIDER	= Gruesa	196	16
TAHITI EMPACADO	= Gruesa	3.524	294
TAHITI TIRAS	= Caja x 100 Unid,	602	50
PRIME TIRAS	= Caja x 100 Unid,	450	38
TERRAMICINA	= Caja x 100 Unid.	2.580	215
AGUA 2 Cms..	= Caja x 100 Unid.	138	12
AGUA 5 Cms.	= Caja x 100 Unid.	156	13
T O T A L E S	$	19.600.000	1.633.333

DIRECCION DE MERCADEO

Bogotá, Enero de 1983

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LISTA DE PRECIOS ESPECIALES

P R O D U C T O	Cajas de Compensación y Cooperativas	Distribuidores de Profamilia y Somefa
Noriday (Caja x 60 ciclos)	1.620.oo	17.40 1.044.oo
SCHERING (Caja x 100 ciclos)	2.700.oo	24.50 2.450.oo
WYETH (Caja x 100 ciclos)	2.700.oo	24.50 2.450.oo
NEO-SAMPOON TUBOS (Caja x 20 tubos)	3.200.oo	130.oo 2.600.oo
NEO-SAMPOON TABLETAS (Caja x 144 Unds.)	1.728.oo	10.oo 1.440.oo
NORFORMS (Caja x 12 óvulos)	73.oo	67.oo
EMKO 40 GRAMOS (Tubo)	300.oo	236.oo
EMKO BECAUSE (Tubo)	315.oo	250.oo
NUDA (Gruesa)	4.550.oo	78.75 3.780.oo
CONTURE (Gruesa)	4.500.oo	78.12 3.750.oo
STIMULA (Gruesa)	2.960.oo	52.08 2.500.oo
ROUGH RIDER (Gruesa)	3.540.oo	62.50 3.000.oo
TAHITI EMPACADO (Gruesa)	1.550.oo	24.58 1.180.oo
TAHITI TIRAS (Caja x 100 Unds.)	880.oo	7.oo 700.oo
PRIME EN TIRAS (Caja x 100 Unds.)	480.oo	4.oo 400.oo
AGUA DESTILADA 2cms. (Caja x 100 Unds.)	280.oo	240.oo
AGUA DESTILADA 5cms. (Caja x 100 Unds.)	420.oo	360.oo

Bogotá, 1°de septiembre de 1983 31

PROFAMILIA
ASOCIACION PRO BIENESTAR DE LA FAMILIA COLOMBIANA

DMV- 117

Bogotá, octubre 14 de 1983

DE : Dirección de Mercadeo

PARA : Distribuidores Profamilia

ASUNTO : Precios y escalas para Preservativos y Emko

Según lo acordado con ustedes en nuestra reciente reunión me permito confirmarles las nuevas escalas para los productos anotados en la referencia, a partir del 15 de octubre/83:

P R E S E R V A T I V O S :

NUDA : Precio por gruesa

1 - 5 gruesas	6 - 20 gruesas	21 o más gruesas
$5.530,oo gruesa	$5.040,oo gruesa	$4.550,oo gruesa

CONTURE : Precio por gruesa

1 - 5 gruesas	6 - 20 gruesas	21 o más gruesas
$5.480,oo gruesa	$4.990,oo gruesa	$4.500,oo gruesa

ROUGH RIDER : Precio por gruesa

1 - 5 gruesas	6 - 20 gruesas	21 o más gruesas
$4.350,oo gruesa	$3.960,oo gruesa	$3.540,oo gruesa

TAHITI EMPACADO : Precio por gruesa

1 - 10 grs.	11 - 25 grs.	26 - 100 grs.	101 o más grs.
$1.680,oo gr.	$1.610,oo gr.	$1.550,oo gr.	$1.480,oo gr.

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PROFAMILIA

Precios y escalas Preservativos y Emko

TAHITI TIRAS : Precio por caja de 100 unidades

1 - 10 cjs.	11 - 50 cjs.	51 - 150 cjs.	151 o más cj
$970.oo cja.	$920.oo cja.	$880.oo cja.	$840.oo cja

EMKO ESPUMA 40 GRAMOS CON APLICADOR : Precio por unidades

1 - 12 unidades	13 - 24 unidades	25 o más unidades
$330.oo tubo	$300.oo tubo	$270.oo tubo

EMKO BECAUSE : Precio por unidades

1 - 12 unidades	13 - 24 unidades	25 o más unidades
$345.oo tubo	$315.oo tubo	$280.oo tubo

Cordialmente,

Gustavo Merizalde S.
Sub-Director de Mercadeo

man.-

LISTA DE PRECIOS

Apreciados señores :

A continuación nos permitimos relacionar los productos que tenemos a su disposición con sus precios y descuentos los cuales empezaron a regir a partir del 1o. de septiembre de 1983 :

O R A L E S

S I N T E X

NORIDAY

1 - 2 Cajas	3 - 6 Cajas	7 ó más Cajas
$1.800.oo caja	$1.620.oo caja	$1.380.oo caja

SCHERING : Caja x 100 Ciclos - Precio para cualquier cantidad

Neogynón 21	$ 3.000.oo
Neogynón CD	3.000.oo
Eugynón	3.000.oo
Microgynón 21	3.000.oo
Microgynón CD	3.000.oo

WYETH : Caja x 100 Ciclos - Precio para cualquier cantidad

Noral 21	$ 3.000.oo
Noral 28	3.000.oo
Nordette 21	3.000.oo
Nordette 28	3.000.oo
Ovral 21	3.000.oo

V A G I N A L E S

NEO-SAMPOON TUBOS : Precio por caja de 20 tubos

1 - 2 Cajas	3 - 5 Cajas	6 - 10 Cajas	11 o más Cajas
$3.300.oo caja	$3.200 caja	$3.100.oo caja	$3.000.oo caja

NEO-SAMPOON TABLETAS : Precio por Gruesa

1 - 5 Gruesas	6 - 19 Gruesas	20 o más Gruesas
$1.822.oo Gruesa	$1.728.oo Gruesa	$1.584.oo Gruesa

NORFORMS : Precio por Caja de 12 óvulos

1 - 99 Cajas	100 - 299 Cajas	300 - 499 Cajas	500 o más Cajas
$76.oo caja	$74.oo caja	$ 73.oo caja	$ 72.oo caja

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PROFAMILIA

Lista de Precios

P R E S E R V A T I V O S :

NUDA : Precio por Gruesa

1 - 10 Gruesas	11 - 50 Gruesas	51 o más Gruesas
$5.530.oo Gruesa	$5.040.oo Gruesa	$4.550.oo Gruesa

CONTURE : Precio por Gruesa

1 - 10 Gruesas	11 - 50 Gruesas	51 o más Gruesas
$5.480.oo Gruesa	$4.990.oo Gruesa	$4.500.oo Gruesa

ROUGH RIDER : Precio por Gruesa

1 - 10 Gruesas	11 - 50 Gruesas	51 o más Gruesas
$4.350.oo Gruesa	$3.960.oo Gruesa	$3.540.oo Gruesa

STIMULA : Precio por Gruesa

1 - 10 Gruesas	11 - 50 Gruesas	51 o más Gruesas
$3.640.oo Gruesa	$3.300.oo Gruesa	$2.960.oo Gruesa

TAHITI EMPACADO : Precio por Gruesa

1 - 10	11 - 25	26 - 100	101
1 - 25 Gruesas	26 - 100 Gruesas	101 - 250 Gruesas	251 o más GRS.
$1.680.oo Gruesa	$1.610.oo Gruesa	$1.550.oo Gruesa	$1.480.oo Gr.

TAHITI EN TIRAS : Precio por Caja de 100 unidades

1 - 10	11 - 25	26 - 100	101
1 - 50 Cajas	51 - 200 Cajas	201 - 500 Cajas	501 o más Cajas
$970.oo Caja	$920.oo Caja	$880.oo Caja	$840.oo Caja
	11 - 50	51 - 150	151

PRIME EN TIRAS : Precio por Caja de 100 unidades

1 - 50 Cajas	51 - 200 Cajas	201 - 500 Cajas	501 o más Cajas
$500.oo caja	$490.oo Caja	$480.oo Caja	$460.oo Caja

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EMKO ESPUMA 40 GRAMOS CON APLICADOR : Precio por Unidades

1 - 35 Unidades	36 - 71 Unidades	72 o más Unidades
$330.oo Tubo	$300.oo Tubo	$270.oo Tubo

EMKO ESPUMA BECAUSE : Precio por Unidades

1 - 35 Unidades	36 - 71 Unidades	72 o más Unidades
$345.oo Tubo	$315.oo Tubo	$280.oo Tubo

O T R O S

AMPOLLAS AGUA DESTILADA : Ciclo Proceso Ltda.

Precio por Caja de 100 Unidades $ 280.oo de 2 cms.
Precio por Caja de 100 Unidades $ 420.oo de 5 cms.

Cordialmente,

GUSTAVO MERIZALDE S.
Sub-Director de Mercadeo

man.-

Conste por el presente documento que, entre nosotros, por una parte la ASOCIACION PRO-BIENESTAR DE LA FAMILIA COLOMBIANA -PROFAMILIA, entidad sin ánimo de lucro y representada en este documento por el dr. FERNANDO TAMAYO O. identificado con la Cédula de Ciudadanía No.2.865.099 de Bogotá, mayor y de esta vecindad y que en adelante se llamará, PROFAMILIA, y por la otra DISTRIBUCIONES AMALFRE LTDA., domiciliada en Bucaramanga y representada en este contrato por su gerente, AMANDA PERILLA DE MOLANO y su sub gerente LUIS ALFREDO MOLANO CASALLAS, identificados con las Cédulas de Ciudadanía Nos.41.551.040 de Bogotá y 17.146.944 de Bogotá respectivamente, mayores y vecinos de la ciudad de Bucaramanga, que en adelante se llamarán DISTRIBUCIONES AMALFRE LTDA., hemos celebrado el CONTRATO DE DISTRIBUCION de acuerdo a las siguientes cláusulas: PRIMERA.- DISTRIBUCIONES AMALFRE LTDA., se compromete a adquirir todos los productos de que dispone PROFAMILIA para la venta y a vender y distribuír dichos productos en los Departamentos de Santander, Norte de Santander, Cesar y Boyacá, en las poblaciones asignadas y relacionadas en el Anexo No. 1 de este contrato, el cual hace parte del mismo y se considera parte integrante de este documento. DISTRIBUCIONES AMALFRE LTDA., no podrá efectuar ventas en poblaciones distintas a las que se relacionan en el citado Anexo, pero de común acuerdo y por escrito, las partes podrán variar las poblaciones relacionadas.-- SEGUNDA.- DISTRIBUCIONES AMALFRE LTDA., adquirirá en PROFAMILIA los artículos que deberá distribuír en las poblaciones y departamentos a que se refiere la cláusula anterior, por los precios que se indican en el Anexo No. 2 de este contrato, el cual se considera incorporado a este documento y los venderá a los precios que se indican en el mismo citado Anexo No. 2. DISTRIBUCIONES AMALFRE LTDA., no podrá vender los productos anticonceptivos que adquiere a PROFAMILIA, a precios menores, ni mayores, de los indicados en el Anexo No. 2. DISTRIBUCIONES AMALFRE LTDA., entregará mensualmente a PRO-

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FAMILIA una copia de la lista de precios que ésta utilice para e-- fectuar las ventas. TERCERA.- PROFAMILIA se reserva el derecho de modificar los precios de venta a DISTRIBUCIONES AMALFRE LTDA., sin previo aviso. Las modificaciones de precio se notificarán por es-- crito y con esa comunicación se modifica el Anexo No. 2 de este contrato. CUARTA.- PROFAMILIA facturará a DISTRIBUCIONES AMALFRE LTDA artículos hasta por un cupo máximo de TRES MILLONES DE PESOS MONEDA CORRIENTE ($ 3.000.000.oo) y con plazo de 90 días para su cancelación. Las partes podrán, de común acuerdo y por escrito, variar la cuantía del cupo y el plazo del pago. El simple retardo en el - pago de las facturas en la fecha de su vencimineto, es causal suficiente, para dar por terminado el presente contrato y exigir el pago inmediato de todas las obligaciones que tenga DISTRIBUCIONES AMALFRE LTDA., a favor de PROFAMILIA. QUINTA.- Las poblaciones y departamentos a que se refiere este contrato, en su cláusula primera, y de acuerdo con el Anexo No. 1, no son exclusivos por parte de PROFAMILIA para con DISTRIBUCIONES AMALFRE LTDA., pero, mientras DISTRIBUCIONES AMALFRE LTDA., compre a PROFAMILIA, los mínimos asignados para cada producto, PROFAMILIA utilizará preferentemente a DISTRIBUCIONES AMALFRE LTDA., como distribuidor en las zonas asignadas y en las condiciones a que se refiere este contrato. SEXTA.- PROFAMILIA se reserva el derecho de visitar a los clientes de DISTRIBUCIONES AMALFRE LTDA., cuantas veces lo estime conveniente, con el - objeto de verificar la atención dada a los clientes y verificar los precios dados, así como también investigar todo lo que estime conveniente en desarrollo de este contrato, o para los fines que se - propone PROFAMILIA, a través del presente contrato de distribución. SEPTIMA.- DISTRIBUCIONES AMALFRE LTDA., se compromete a adquirir a PROFAMILIA, para su distribución y en desarrollo del presente contrato, todos los productos que tiene a su disposición PROFAMILIA - para la venta, en las cantidades mínimas a que se refiere el Anexo No. 3, el cual hace parte integrante de este contrato y se considera incorporado a él. OCTAVA.- DISTRIBUCIONES AMALFRE LTDA., podrá -

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vender y distribuir productos diferentes a, los que tiene a su disposición PROFAMILIA, y a que se refiere el Anexo No. 2 ya citado. Sin embargo, si los productos que fuera a vender DISTRIBUCIONES AMALFRE LTDA., no están disponibles en PROFAMILIA, DISTRIBUCIONES AMALFRE LTDA.7 deberá obtener una autorización previa de PROFAMILIA donde conste que - PROFAMILIA no tiene a disposición de DISTRIBUCIONES AMALFRE LTDA., ese producto y que no tiene objeciones para que DISTRIBUCIONES AMALFRE LTDA., los distribuya. DISTRIBUCIONES AMALFRE LTDA., sólo podrá vender productos aduciendo que son de PROFAMILIA cuando éstos hayan sido comprados a esa entidad. NOVENA.- DISTRIBUCIONES AMALFRE LTDA., se compromete para con PROFAMILIA a visitar las zonas asignadas como distribuidor en el presente contrato,,por lo menos una vez cada tres meses. El incumplimiento de esta obligación dá derecho a PROFAMILIA para dar por terminado el presente contrato en forma inmediata, y declarar de plazo vencido todas las obligaciones a cargo de DISTRIBUCIONES AMALFRE LTDA., y a favor de PROFAMILIA. DECIMA.- PROFAMILIA en desarrollo del presente contrato, se compromete a entregar a DISTRIBUCIONES AMALFRE LTDA., productos de igual calidad y presentación a los que utiliza en sus diversos programas. Una vez recibidas las mercancías por DISTRIBUCIONES AMALFRE LTDA., de conformidad, quedan de exclusiva propiedad de ésta, debiendo responder a PROFAMILIA por su valor y no se aceptará ninguna clase de reclamos por ninguna causa, tales como faltantes, deterioros, etc. DECIMA PRIMERA.- Son de cargo de DISTRIBUCIONES - AMALFRE LTDA., todos los gastos que sean necesarios en desarrollo del presente contrato de distribución. En consecuencia serán de cargo de DISTRIBUCIONES AMALFRE LTDA., todos los salarios y prestaciones sociales de sus trabajadores, de las oficinas, de arrendamientos, vehículos, y en general de todos los gastos que estime conveniente hacer, y sin que PROFAMILIA adquiera ninguna responsabilidad para con ninguna persona o entidad con quien contrate DISTRI-

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BUCIONES AMALFRE LTDA.,DECIMA SEGUNDA.- PROFAMILIA no podrá ser -- comprometida por DISTRIBUCIONES AMALFRE LTDA., en ninguna obliga-- ción, civil, comercial, o laboral, que haya celebrado, con anterioridad o posterioridad, al presente contrato, como tampoco adquirirá ninguna responsabilidad de ningún carácter frente a terceros. DECIMA TERCERA.- DISTRIBUCIONES AMALFRE LTDA., hará las compras a PROFAMILIA, en desarrollo del presente contrato de distribución a través de las oficinas de Mercadeo de PROFAMILIA y nó podrá intervenir en dichas operaciones ningún representante de ventas de PROFAMILIA, ya que los precios a que se refiere el presente contrato han sido fijados teniendo en cuenta que PROFAMILIA hace la venta directa-- mente y por consiguiente no reconoce comisiones sobre estas operaciones. DECIMA CUARTA.- Cuando PROFAMILIA hiciere ventas en promoción de uno o varios de sus productos, DISTRIBUCIONES AMALFRE LTDA. gozará de esos precios,en cuanto lo sean más favorables, a los convenidos en el presente contrato. DECIMA QUINTA.- La variación por - parte de DISTRIBUCIONES AMALFRE LTDA., de los precios de venta a - que se refiere el presente contrato, son causal suficiente para dar por terminado inmediatamente el presente contrato y exigir el pago de todas las obligaciones a cargo de DISTRIBUCIONES AMALFRE LTDA., y a favor de PROFAMILIA. DECIMA SEXTA.- El presente contrato es a término indefinido pero las partes se reservan el derecho de darlo por terminado, en cualquier momento dando aviso por escrito a la - otra parte, con anticipación no inferior de dos meses. En este caso, las facturas a plazo serán exigibles a su vencimiento. DECIMA SEPTIMA.- Las partes se reservan el derecho de modificar el presente contrato, de común acuerdo y por escrito. Ninguna de las partes podrá alegar ninguna modificación en forma verbal. DECIMA OCTAVA.- Las diferencias que se presentan entre las partes, en desarrollo - del presente contrato, deberán ser resueltas por los contratantes en forma amigable y directamente. Si ello no fuere posible, se constituirá un Tribunal de Arbitramento integrado por un representante - por cada una de las partes y un tercero elegido de común acuerdo -

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por los dos ya nombrados. Si éstos no se pusieron de acuerdo, el tercero lo designará la Cámara de Comercio de Bogotá. En desarrollo de este artículo se aplicarán las disposiciones pertinentes del Código del Comercio y del Código del Procedimiento Civil. DECIMA NOVENA.- Se establece como domicilio contractual del presente contrato a la ciudad de Bogotá .D.E. En consecuencia se firma el presente documento en Bogotá, a los dos días del mes de Febrero de 1982.x.x.x.x.x.x.x

ASOCIACION PRO-BIENESTAR DE LA FAMILIA COLOMBIANA -PROFAMILIA.-

FERNANDO TAMAYO OGLIASTRI
c.c. No. 2.865.099 de Bogotá

DISTRIBUCIONES AMALFRE LTDA.

AMANDA PERILLA DE MOLANO
c.c. No. 41.551.040 de Bogotá

LUIS ALFREDO MOLANO CASALLAS
c.c. No. 17.146.944 de Bogotá

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APPENDIX III

PROMOTER RESPONSIBILITIES AND INCENTIVE STRATEGY DESCRIPTION

PROFAMILIA

Bogotá. Agosto 8 de 1983

FUNCIONES Y ACTIVIDADES DE LA INSTRUCTORA

Area de Incentivos:

Actividades I.E.C. :

1. Informar. Motivar y Capacitar a Líderes de la comunidad hacia la Planificación Familiar.

2. Contactar, Seleccionar. Motivar. Capacitar y Evaluar a personas de la comunidad que se encarguen de los Puestos de distribución.

3. Informar. Motivar y Capacitar a las personas y familias sobre Planificación Familiar haciendo énfasis en aquellas de menores recursos económicos.

4. Efectuar la divulgación de los puestos de distribución y de los centros de Planificación Familiar más cercanos.

5. Motivar las usuarias para que utilicen los servicios de los Centros Clínicos y hacer las respectivas remisiones.

6. Programar y dictar conferencias. charlas y cursillos sobre Planificación Familiar a diferentes grupos e Instituciones.

7. Realizar una labor de consejería individual y de grupo - que dé una buena imagén de Profamilia y colaborar al logro de los objetivos de la Entidad.

8. Informar mensualmente los resultados del trabajo realizado; Informe I.E.C. e Informe Ventas y Existencias PC. 002

Administración Programa Comunitario:

1. Visitar a lo largo del mes los puestos asignados de acuerdo con el sistema de recolección que rige para el país. - practicar el inventario; recoger dineros y entregar droga de acuerdo a procedimientos establecidos.

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2. Entregar oportunamente a la responsable de la Caja los dineros recolectados durante la recolección.

3. Elaborar el resumen mensual de ventas y existencias de los puestos a su cargo teniendo en cuenta los procedimientos y normas establecidas.

4. Instalar Puestos de distribución y hacer la respectiva reinstalación cuando las circunstancias así lo requieran.

5. Tener en cuenta las indicaciones generales que Profamilia ha establecido para la modalidad de Incentivos.

6. Informar mensualmente a su Jefe inmediato el funcionamiento administrativo del Programa y de cualquier sugerencia para su mejoramiento en todos los campos.

7. Velar porque todos los puestos a su cargo martengan los elementos necesarics para su buen funcionamiento. aviso de precios visible al público.

LILY DE BUCHELI
Directora División I.E.C.

PROGRAMA COMUNITARIO

EXPERIMENTAL

OBJETIVOS: Aumentar las ventas del Programa Comunitario.

METAS : Cuadro Anexo No. 1

ZONIFICACION: Cuadro Anexo No. 1

CENTROS SEDES:
- Barrancabermeja
- Barranquilla
- Bogotá
- Cartagena
- Girardot
- Santa Marta
- Villavicencio

INDICACIONES GENERALES:

I. COMISION

I.1

Píldoras	$	3.00	Ciclo
Condones	$	1.00	Unidad
Neosampoon	$	0.50	Tabletas
Norforms	$	0.20	Unidad
Pirantel	$	0.50	Tableta
Sales de Rehidratación	$	0.50	Sobre

I.2 Estos valores se revisarán periodicamente y podrán modificarse.

I.3 La comisión se liquida sobre el excedente de la Meta base, (Metas cuadro anexo).

I.4 Se entrega la Comisión contra dinero recaudado.

I.5 La Comisión se liquida y cancela trimestral o semestralmente luego de comparar las metas año con los resultados a la fecha de la liquidación.

Con lo anterior se excluyen las metas y resultados fraccionados por trimestres, bimestres o meses para efecto de comisiónes.

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Forma PC. 003 Factura de Ventas de Contado a Droguerías, Botiquines y otros que no son puestos de distribución.

Forma PC. 004 Devolución de Droga
Forma PC. 006 Rendición de Gastos de Viaje
Forma PC. 007 Solicitud de Anticipo para viaje
Forma PC. 008 Auxiliar de Puestos de Recolección

c. A través de la forma PC. 005 Libretas de los Puestos de Distribución, Profamilia podrá verificar el número de Puestos y las Existencias de droga en los mismos.

d. En ningún caso se autoriza dejar droga en consignación en Droguerías.

e. La Instructora queda autorizada para dejar droga en consignación únicamente en los Puestos de Distribución Comunitaria.

f. En cualquier momento Profamilia hace supervisión con base en las libretas Forma PC. 005 y si se encuentran existencias en droguerías o no se ajusta a la verdad, se considera motivo de despido con justa causa.

g. Puede efectuar ventas de Contado en los Puestos de distribución Comunitarios, droguerías o cualquier otro lugar y no hay suma límite. Con este sistema se deja libertad de precio al público.

III. 4. La Instructora se compromete a recolectar cada puesto, mínimo una vez en el trimestre.

III. 5. Precios:

PRODUCTOS	Precio ventas de Contado a Distribuidor y Mini-droguería	Consignación en Puestos de Disbución.	Al Público
Noriday	$ 29.00	$ 30.00	$ 40.00
Shering y Otras	$ 29.00	$ 30.00	$ 40.00
Condones	$ 9.00	$ 10.00	$ 13.00
Norforms	$ 75.00	$ 80.00	$ 90.00
Neosampoon	$ 155.00	$ 165.00	$ 180.00
Pirantel	$ 5.00	$ 6.00	$ 7.00
Sales de Rehidratac.	$ 10.00	$ 11.00	$ 12.00

Appendix IV

Questionnaire

PROFAMILIA	PRIMERA ENCUESTA: SANTANDER, CUNDINAMARCA Y HUILA 1984 CUESTIONARIO DE HOGAR	CONFIDENCIAL FINES CIENTIFICOS

I. IDENTIFICACION DEL CUESTIONARIO

(101) Número del Cuestionario [ ][ ][ ][ ] 1 2 3 4

(102) Municipio _____ [ ][ ] 5 6

(103) Departamento [ ] 7

(104) Segmento [ ][ ] 8 9

(105) Zona 1. Urbana 2. Rural [ ] 10

(106) Número de Hogar [ ][ ][ ] 11 12 13

(107) Vereda _____ NOMBRE

(108) Encuestadora _____ NOMBRE 14 [ ][ ] 15 CODIGO

(109) Fecha de Entrevista Día Mes [ ][ ][ ][ ] 16 19

(110) Cuestionario [ ] de [ ]

II. PARA TODOS LOS MIEMBROS DEL HOGAR — 15 AÑOS y MAS

NUMERO DE ORDEN DE LA PERSONA	NOMBRES Y APELLIDOS	PARENTESCO	SEXO	EDAD	ESTADO CIVIL		ELEGIBILIDAD
	Por favor me puede decir el nombre de las personas que normalmente viven en este hogar, aunque no hayan dormido aquí anoche.	Cuál es el parentesco de (cada persona) _____ con el jefe del hogar? Jefe [1] Esposa [2] Hijos [3] Parientes [4] Otros [5]	Es hombre o mujer? Hombre [1] Mujer [2]	Cuántos años cumplidos tiene?	Ha estado casado o unido alguna vez? SI [1] (CONTINUE) NO [2] (PASE A LA SIGUIENTE PERSONA)	Cuál es su estado civil actual? Casado [1] Conviviente [2] Viudo [3] Separado o divorciado [4]	Numere la mujer elegible para la entrevista individual en orden consecutivo.
(201)	(202)	(203)	(204)	(205)	(206)	(207)	(208)
20-21		22	23	24-25	26	27	28
01							
02							
03							
04							
05							
06							
07							
08							
09							
10							
11							
12							
13							
14							
15							

(209) Número de personas en el hogar 29-30 [ ]

(210) Número de mujeres elegibles 31 [ ]

(211) RESULTADO DE LA VISITA [1] Completa [2] Ningún adulto en casa [3] Casa desocupada [4] Rechazo [5] No es vivienda [6] Otro 32 [ ]

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2

PROFAMILIA	PRIMERA ENCUESTA: SANTANDER, CUNDINAMARCA Y HUILA 1984 CUESTIONARIO INDIVIDUAL	CONFIDENCIAL FINES CIENTIFICOS

A. IDENTIFICACION DEL CUESTIONARIO — CODIGOS

(101) Número de identificación — 1 [ ][ ][ ][ ][1] 5

(102) Municipio _____ — 6 [ ][ ] 7

(103) Departamento _____ — 8 [ ]

(104) Segmento [ ][ ] — 9 [ ][ ] 10

(105) Zona — Urbana [1] Rural [2] — 11 [ ]

(106) Número del hogar [ ][ ][ ] — 12 [ ][ ][ ] 14

(107) Nombre y número de orden de la mujer _____ [ ][ ] — 15 [ ][ ] 16

B. RESULTADO DE LA ENTREVISTA — CODIGOS

(108) Visita	(109) Fecha		(110) Hora de iniciación	(111) Hora de terminación	(112) Resultado	
	día	mes				
1o.						17 [ ]
2o.						18 [ ]
3o.						19 [ ]

CODIGO DE RESULTADO DE LA VISITA (S)

1. Completa
2. Incompleta
3. Rechazo
4. Ausencia de la mujer
5. Otro

C. CONTROL DE SUPERVISION Y PROCESAMIENTO — CODIGOS

(113) Nombre de la encuestadora _____

Observaciones _____

_____ — 20 [ ]

(114) Nombre del supervisor _____

Observaciones _____

_____

(115)

	SUPERVISOR	CRITICA	CODIFICACION
Fecha			
Nombre			

II. CARACTERISTICAS DE LA ENTREVISTADA	CODIGOS
(201) En qué mes y año nació usted? [ ][ ] Mes [1][9][ ][ ] Año — No Sabe [ ] → Pase a 203	21 [ ][ ][ ][ ] 24
(202) Entonces cuántos años cumplidos tiene usted? [ ][ ]	25 [ ][ ] 26
(203) Cuál es su estado civil (conyugal) actual? Casada [1] Viuda [3] Conviviente [2] Divorciada/Separada [4]	[ ] 27
(204) Cuál fué el curso ó año más alto que usted aprobó? ENCIERRE EN UN CIRCULO EL NIVEL MAS ALTO ALCANZADO Y EL ULTIMO AÑO APROBADO EN ESTE NIVEL. SI LA ENTREVISTADA NUNCA FUE A LA ESCUELA, O COLEGIO, MARQUE PRIMARIA CERO. NIVEL — AÑOS 1 Primaria 0 1 2 3 4 5 2 Secundaria 1 2 3 4 5 6 3 Universitario 1 2 3 4 5 6 7 o más	[ ] 28 [ ] 29
(205) Ha tenido Ud. hijos alguna vez? SI [1] NO [2] (PASE A 207)	[ ] 30
(206) Ha estado embarazada alguna vez? SI [1] NO [2] (PASE A 212) (PASE A 215)	[ ] 31
(207) En total en toda su vida cuantos hijos nacidos vivos ha tenido? NUMERO [ ][ ]	[ ][ ] 32 33
(208) Ha tenido hijos que nacieron vivos pero murieron después, aunque hayan vivido solo unos minutos? SI [1] NO [2]	[ ] 34
(209) En total, en toda su vida, cuantas veces ha estado embarazada? NUMERO [ ][ ]	[ ][ ] 35 36
(210) ENTREVISTADOR (A) RESTE DE 209 (TOTAL EMBARAZOS) 207 (NACIDOS VIVOS) Y ANOTE EL RESULTADO AQUI Y AHORA DIGA A LA ENTREVISTADA: ES DECIR, UD. HA TENIDO ABORTOS Y/O NACIDOS MUERTOS. ES ESTO CORRECTO? SI [1] NO [2] (CORRIJA DONDE SEA NECESARIO)	[ ][ ] 37 38
(211) Digame ahora en qué mes y año tuvo su último hijo nacido vivo? [ ][ ] MES [1][9][ ][ ] AÑO (PASE A 213)	[ ][ ][ ][ ] 39 42

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IV. CONOCIMIENTO Y USO DE FUENTES DE INFORMACION Y SERVICIO DE PLANIFICACION FAMILIAR

CODIGOS

(401) Sabe Ud. en dónde le pueden dar información y servicios (métodos) de planificación familiar?

SI [1] NO [2] (PASE A 403) — 76

(402) Dónde le pueden dar información y servicios (métodos) de planificación familiar?

1 [ ][ ][ ][ ][2] 5

	INFORMACION	IDENTIFICACION SERVICIOS, METODOS SUMINISTROS
Hospital o puesto de salud.	1	1
Droguería	2	2
PROFAMILIA	4	4
Médico Particular	8	8
Amiga o vecina	16	16
Otro _____ (ESPECIFIQUE)	32	32
No sabe	00	00

[ ][ ][ ][ ] 6 9

(403) MARQUE LA CASILLA APROPIADA

ACTUALMENTE USA NO ESTERILIZADA [1] — NO USA ACTUALMENTE [2] (PASA A 501) — ESTERILIZADA [3] — 10 [ ]

(404) A dónde va con más frecuencia (normalmente) a solicitar servicios o a comprar métodos de planificación familiar?

Hospital, puesto de salud, promotora del Ministerio de Salud.	1
Droguería ó farmacia	2
PROFAMILIA	3
Médico Particular	4
Otro _____ (ESPECIFIQUE)	5

(406) Dónde le hicieron la Operación? _____ — 11 [ ] (404)

(407) Quién le remitió para ésta operación? _____ — 12 [ ] (405) — 13 [ ] (406)

(408) Está satisfecha con la operación? _____ — 14 [ ] (407)

(PASE A 517) — 15 [ ][ ] 16 (408)

(405) Volverá usted a este servicio?

SI [1] NO [2] → (Pase a 512)

V. OPINION DE SERVICIOS Y METODOS

CODIGOS

VERIFIQUE CON ESQUEMA DE CONOCIMIENTO Y USO

(501) Han usado usted o su esposo (o compañero) alguna vez algún método de planificación familiar?

SI [1] NO [2] (PASE A (506)) — 17 [ ]

V. OPINION DE SERVICIOS Y METODOS (Continuación).	CODIGOS

MARQUE EN UN CIRCULO LAS RESPUESTAS PERTINENTES

(502) Qué métodos ha (n) usado? (NO LEA LAS RESPUESTAS)

	SI	NO	
01 Píldoras	1	2	18 ☐
02 Condón	1	2	19 ☐
03 Diu	1	2	20 ☐
04 Esterilización Femenina	1	2	21 ☐
05 Esterilización Masculina	1	2	22 ☐
06 Inyección	1	2	23 ☐
07 Vaginales	1	2	24 ☐
08 Ritmo	1	2	25 ☐
09 Retiro	1	2	26 ☐
10 Otros _____ Especifique	1	2	27 ☐

(503) Cuál fué el último método que usaron?

Píldora	01	Inyección	06
Condón	02	Vaginales	07
Diu	03	Ritmo	08
Ester Femenina	04	Retiro	09
Ester Masculina	05	Otros	10

28 ☐☐ 29

(504) Cuándo dejó (aron) de usarlo? AÑO 1 9 ☐☐ — 30 ☐☐ 31

(505) Por qué dejó (aron) de usarlo? _____ — 32 ☐☐ 33

(PASE A LA 507)

(506) Por qué nunca han usado métodos de planificación familiar? _____ _____ — 34 ☐☐ 35

(507) Por qué no está (n) planificando actualmente? _____ _____ — 36 ☐☐ 37

(508) Ha (n) pensado usar algún método de planificación familiar en el futuro?

SI 1 ↓ NO 2 — 38 ☐

(PASE A 511)

332

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V. OPINION DE SERVICIOS Y METODOS (Continuación)	CODIGOS
(509) Qué método han pensado o cuál les gustaría usar?	
Píldora [01] Inyección [06]	
Condón [02] Vaginales [07]	
Diu [03] Ritmo [08]	39 [ ][ ] 40
Este. Femenina [04] Retiro [09]	
Este. Masculina [05] Otro [10]	
(510) Sabe (n) usted (s) en dónde podría (n) obtener dicho método?	
Hospital o centro de salud [01] Médico particular [08]	
Droguería [02] Otro [16]	41 [ ][ ] 42
Profamilia [04] No sabe [00]	
(PASE A 517)	
(511) Por qué no han pensado usar algún método de planificación familiar en el futuro?	
_____	43 [ ][ ] 44
(PASE A 517)	
(512) Sabe su esposo (compañero) que usted usa actualmente métodos anticonceptivos?	
SI [1] NO [2] NO SABE [3]	45 [ ]
(513) Está su esposo (compañero) de acuerdo con que usted use métodos anticonceptivos?	
SI [1] NO [2] NO SABE [3]	
(PASE A 517) (PASE A 517)	46 [ ]
(514) Por qué su esposo (o compañero) no está de acuerdo	
_____	47 [ ][ ] 48
(515) Usted o su esposo (compañero) ha (n) tenido molestias con el método que están usando actualmente?	
SI [1] NO [2]	49 [ ]
(PASE A 517)	
(516) Cuáles molestias ha (n) tenido?	
_____	50 [ ][ ] 51
(517) Conoce usted otras usuarias de planificación familiar en su comunidad?	
SI [1] NO [2]	
AGRADEZCA A LA ENTREVISTADA POR SU COLABORACION Y TERMINE LA ENTREVISTA	52 [ ]
(518) Cómo llegó a conocerlas?	
_____	53 [ ][ ] 54
AGRADEZCA A LA ENTREVISTADA POR SU COLABORACION Y TERMINE LA ENTREVISTA	

yellow

AID 1350-1 (10-79)

PIO/T

UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT IMPLEMENTATION ORDER/TECHNICAL SERVICES

1. Cooperating Country: Colombia

Page 1 of Pages

2. PIO/T No.: 936-3030-

3. [X] Original or Amendment No. _____

4. Project/Activity No. and Title: 936-3030
Private Sector Community-Based Distribution and Commercial Marketing Strategies in Colombia

DISTRIBUTION

5. Appropriation Symbol: 72-1141021.4

6. Allotment Symbol and Charge: DDAA-84-13600-BG11/444-36-099-00-81-41

7. Obligation Status: [X] Administrative Reservation [ ] Implementing Document

8. Project Assistance Completion Date (Mo., Day, Yr.): 6/30/87

9. Authorized Agent: AID/W

10. This PIO/T is in full conformance with PRO/AG: n/a _____ Date _____

11a. Type of Action and Governing AID Handbook: [ ] AID Contract (HB 14) [ ] PASA/RSSA (HB 12) [ ] AID Grant (HB 13) [X] Other: Cooperative Agreement

11b. Contract/Grant/PASA/RSSA Reference Number (If this is an Amendment): _____

12. Estimated Financing (A detailed budget in support of column (2) is attached as attachment no. _____)

		(1) Previous Total	(2) Increase	(3) Decrease	(4) Total to Date
Maximum AID Financing	A. Dollars		479,444		479,444
	B. U.S.-Owned Local Currency				

13. Mission References

14a. Instructions to Authorized Agent

The purpose of this PIO/T is to request SER/CM to negotiate a 36-month cooperative agreement, "Private Sector Community-Based Distribution and Commercial Marketing Strategies in Colombia," based on the Population Council's unsolicited proposal at an estimated total cost of $728,865. This PIO/T authorizes project funds in the amount of $479,444 for the first two years of the project. The scope of work is attached.

Contract No.:
Project:
Project Office: ST/POP/R
Obligation No.:

14b. Address of Voucher Paying Office
FM/PAD
Room 607 SA-12

15. Clearances—Include typed name, office symbol, telephone number and date for all clearances.

A. The project officer certifies that the specifications in the statement of work are technically adequate: ST/POP/R, JBailey — Phone No. — Date

B. The statement of work lies within the purview of the initiating and approved agency programs: ST/POP, DGGillespie — Date

C. ST/POP/R, JDShelton
ST/POP, BCase — Date

D. Funds for the services requested are available: FM/PAD, BWilliams

E. ST/POP, SWSinding
ST/PO, HDestler — Date

16. For the cooperating country: The terms and conditions set forth herein are hereby agreed to

Signature _____ Date _____

Title

17. For the Agency for International Development

Signature _____ Date _____

Title Robert Meehan, Chief, ST/PO

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I. Statement of Work

A. Project Objective

The objective of this project is to search for more cost-effective family planning delivery strategies to serve the rural population in Colombia. Both a social marketing strategy and a commission scheme for field workers will be tested by Profamilia and the Population Council for their cost-effectiveness. Results of the research will indicate whether a mature CBD program should be replaced by a social marketing approach.

B. Scope of Work

The grantee shall provide technical assistance and funding to Profamilia to carry out the following tasks as more fully described in the unsolicited proposal entitled "Private Sector Community-Based Distribution and Commercial Marketing Strategies in Colombia," dated January 6, 1984, incorporated herein by reference and attached hereto as Appendix A.

In general, the plan of action will consist of (1) conducting a baseline sample survey among ever-married women 15 to 49 years of age to measure contraceptive use, prevalence and unmet need rates in two provinces of Colombia, (2) establishing a social marketing system in at least 31 counties of one of those provinces, (3) implementing a compensation scheme for promoters in 50 counties of the second province, (4) providing family planning services through both strategies for 12 months, (5) documentation during the 12 months expenditures for service delivery, income from contraceptive sales and number of contraceptives sold by method according to county for each province, (6) conducting a post-test sample survey in the same provinces among the ever-married women 15 to 49 years of age to detect changes in contraceptive use and the unmet need for family planning, (7) decide in cooperation with A.I.D. and Profamilia whether to expand the social marketing strategy to new areas the second half of the project or to reinitiate CBD activities in the experimental province where CBD was cancelled and replaced by the social marketing program, (8) carry out pre- and post-mini sample surveys in the area where the social marketing strategy is expanded, if the decision is made to cancel Profamilia's CBD program, to detect changes in contraceptive use and the unmet need, (9) conduct a post survey in the state where the CBD program is reinitiated if the social marketing strategy was not cost-effective, and (10) design and test computerized service statistics reports to improve the quality of reporting of contraceptive sales and IE&C activities.

The grantee will work with Profamilia to estimate and analyze the cost-effectiveness of both the social marketing and motivation schemes and recommend policy decisions to Profamilia regarding (1) whether Profamilia should continue supporting a CBD program and (2) if so, which model should be adopted nationally.

1. During the first 18 months of the project, the grantee will fund and provide technical assistance to Profamilia to conduct the pre and post surveys, implement the social marketing and motivational delivery schemes, carry out the analysis plan and decide which delivery strategy should be tested in the second 18 months.

2. During the last 18 months the grantee will fund and provide technical assistance to Profamilia to implement the delivery strategy selected from the first phase results and carry out appropriate research as described in the proposal in Appendix A.

3. The grantee shall coordinate project activities with the AID/Washington Cognizant Technical Officer (CTO).

4. As per General Provision No. 30, entitled "Rights in Data," the grantee shall disseminate, in coordination with Profamilia, the AID/W CTO and the appropriate USAID officer (1) the results of the surveys and cost-effective analysis, (2) documentation of the implementation of the service delivery strategies, and technical assistance given by the grantee, (4) service statistics and (5) project expenditure information.

5. As required in General Provision No. 16 entitled "Reports," the grantee shall submit three (3) copies of the following reports to AID/W within 45 days of completion of each specified period:

a. Six- (6) month progress report
b. Twelve- (12) month progress report
c. Second Phase Plan to be submitted at the end of the 17th month
d. Eighteen- (18) month progress report
e. Twenty-four- (24) month progress report
f. Thirty- (30) month progress report

II. Key Personnel

A. The key person which the grantee shall furnish for the performance of this contract is as follows:

John W. Townsend, Technical Advisor - 40%

III. Period of Cooperative Agreement

This agreement shall cover a period of three years.

IV. Budget

The following budget sets forth estimated amounts of dollar costs for individual line items. Within the total amount obligated set forth below, the grantee may adjust line item amounts as reasonably necessary for the performance of work under this contract.

	1984	1985	1986	TOTAL
Salaries	$ 16,000	$ 17,120	$ 18,318	$ 51,438
Fringe Benefits	4,568	4,888	5,230	14,686
Indirect Costs	31,352	36,996	33,162	101,510
Travel & Transportation	4,845	3,195	2,094	10,134
Allowances	7,780	7,780	7,780	23,340
Subcontract	131,817	161,734	141,113	434,664
Audit fees	-	-	15,000	15,000
General and Administrative Expenses	23,563	27,806	26,724	78,093
TOTAL	$219,925	$259,591	249,421	$728,865

V. Logistical Support

Neither AID/Washington nor any USAID Mission is expected to provide logistical support to the grantee or grantee personnel.

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Regional Coordinator.-- This person will be stationed in Bogotá and is responsible to the Director of IE & C. Her responsibilities during the first 12 months are those related to the supervision of the promoters employed in the commission zone. The Regional Coordinator will be funded half-time by the project and spend 7 out of every 10 days a month in Cundinamarca working with the promoters.

Promoters.-- Three promoters will be paid full-time by the project to work under the commission scheme in those counties selected in Cundinamarca as described in the protocol.

Distributor and Salesperson.-- PROFAMILIA's commercial social marketing distributor will be responsible for hiring and contracting one salesperson to supply commercial outlets in the counties selected in Santander. Although the distributor will not receive any payment for his participation in the project, he will benefit financially from any profits earned on the sales of contraceptives in the project counties and he will have no expenditures for the salesperson as these will be paid by the project. Although it is not known which system will be employed during the second phase, the salesperson has been budgeted for the entire 3 years.

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Team.-- Costs for one male-female team for 18 months have been included in the budget anticipating that the Second Phase delivery strategies will include a team model.

Technical Advisor.-- The Population Council will provide technical assistance and project monitoring through its Technical Advisor in Bogotá who will dedicate 40 percent of his/her time to these activities. This person is to collaborate with the Director of Evaluation and Statistics in the design, implementation and analysis of the four Surveys. He/she will participate in the calculations of cost per CYP and work with PROFAMILIA in the programmatic interpretation of all data generated by the project. As part of the Technical Advisor's monitoring responsibilities, this person will make 4 field site visits during each phase and will prepare reports on those visits. He/she will be in charge of preparing Population Council 6 month and final [illegible] will [illegible] with the project