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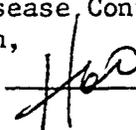
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Public Health Service
Centers for Disease Control**Memorandum**

Date February 25, 1982

From Leo Morris, Ph.D., M.P.H., Chief, and Mark Oberle, M.D., M.P.H., Program Evaluation Branch (PEB), Family Planning Evaluation Division (FPED), Center for Health Promotion and Education (CHPE)

Subject Foreign Trip Report (AID/RSSA): Guatemala, January 11-19, 1982

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

SUMMARY

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SUMMARY

FPED/CDC provided technical assistance to APROFAM in conducting the 1978 Contraceptive Prevalence Survey (CPS) in Guatemala. Because of the incompleteness of service statistics and lack of contraceptive prevalence data since 1978, and to obtain data that could supplement the evaluation of the Ministry of Health (MOH) contraceptive distribution program, the USAID Mission has proposed a follow-up survey in 1982 with APROFAM as the local agency again responsible for field operations. Preliminary discussions concerning the 1982 Guatemala Family Planning and Maternal-Child Health Survey took place in Guatemala in October 1981 and at the Contraceptive Prevalence Survey Regional Workshop in Lima in November 1981. During this consultation, objectives and specifications of the survey were defined and a preliminary budget completed as well as a draft questionnaire discussed. A proposed timetable was also agreed upon, with field work proposed for September-December 1982. Total field work costs are estimated to be \$50,201.

APROFAM's Direct Distribution Program experienced a decline in contraceptives distributed in 1981. However, the decline in distribution is artificial, chiefly attributable to two factors: the fact that 11 of 22 departments are now supplied by the Ministry of Health (MOH), and an increase in distribution early in 1981 required to restock facilities which had not provided family planning services in 1979-1980 resulted in artificially high distribution figures in the first quarter.

Although the MOH's National Pharmacy (DN) had agreed to a mixed allocation/requisition formula for the last quarter of 1981, only 45 percent of health centers and 20 percent of health posts under their responsibility received contraceptives in the fourth quarter. Among recommendations discussed, to improve performance, the most important was that the DN, the Direccion General, and AID hold brief, weekly meetings to monitor the DN's progress. Other recommendations included (1) a medical supervisor would visit clinics that failed to send in a requisition for contraceptives, (2) a survey to determine inventory levels and (3) an improved monitoring system.

If the MOH is to assume responsibility for contraceptive distribution in the entire country, APROFAM will need to know by early June 1982, in order to provide 30 days notice for APROFAM employees whose jobs would be abolished. The Tripartite Agreement calls for an evaluation to be conducted before transfer to the MOH. At a meeting of the Tripartite Agreement Committee on January 15, Dr. Oberle suggested that the evaluation consist of three parts: 1) a questionnaire survey of all health posts and health centers to determine contraceptive inventory; 2) a review of DN shipments to health centers and health posts; and 3) site visits to a sample of clinics. The questionnaire survey should be conducted in mid-April, approximately 2 weeks after the last scheduled shipment from the DN to a department to allow for delivery from the departments to the clinics. CDC facilities are available to process the survey. However, because CDC has provided technical assistance to this project, the review of DN records and site visits ideally should be performed by an observer from another agency.

Since 1979 the Pathfinder Fund has assisted an APROFAM program for contraceptive distribution by private physicians. The program aims to increase acceptance of family planning by private physicians especially in rural areas, and increase the number of distribution points available to potential family planning acceptors. Pathfinder requested CDC assistance in establishing an evaluation procedure for the private physician programs that might be used for current and future programs.

After a review of the APROFAM private physician program, CDC recommends that Pathfinder consider these evaluation approaches for future private physician-programs: (1) performing pre-program and post-program surveys of physician attitudes, (2) comparing physicians participating to the target population of physicians, and (3) distinguishing contraceptives distributed at initial visits from those distributed at re-visits.

I. PLACES, DATES, AND PURPOSE OF TRAVEL

Guatemala, January 11-19, 1982, at the request of AID/POP/FPSD, and the USAID Mission/Guatemala (1) to provide technical assistance to the Asociacion Pro-Bienestar de la Familia de Guatemala (APROFAM), in the planning of a 1982 Guatemala Contraceptive Prevalence Survey, (2) to review the status and progress of the Ministry of Health contraceptive distribution system, and (3) to review evaluation procedures in APROFAM'S Pathfinder-funded private physician distribution program. Travel was performed in accordance with the Resource Support Services Agreement (RSSA) between the Office of Population/AID/ Washington and CDC/CHPE/FPED.

II. PRINCIPAL CONTACTS

A. USAID/Guatemala

1. Mr. Paul Cohn, Chief, Public Health Division
2. Mr. Neil Woodruff, Health and Population Officer
3. Mr. Carlos Andriano, Health and Population Assistant

B. Asociacion Pro-Bienestar de la Familia (APROFAM)

1. Dr. Roberto Santiso, Executive Director
2. Lic. Antonieta Pineda, Chief, Department of Studies and Evaluation
3. Mr. Rolando Sanchez, Chief, Direct Distribution Program

C. Ministry of Economics

1. Dr. Martin Carranza Orillana, Director General, Direccion General de Estadistica (DGE)
2. Lic. Josefina Antillon, Chief, Survey Section, DGE
3. Lic. Gaston Ormena, United Nations Advisor, Survey Section, DGE

D. Ministry of Health

1. Dr. Angel Paz Cojulun, Director General
2. Dr. Leonel Barrios, Assistant Director General
3. Dr. Jorge Chang Quan, Medical Supervisor

III. FAMILY PLANNING--MATERNAL CHILD HEALTH SURVEY

A. Background

In 1978, APROFAM, with technical assistance from FPED, CDC, conducted the first Maternal and Child Health/Family Planning Survey in Guatemala. Results showed an overall prevalence of 18 percent of married women using contraception (RG Santiso, MA Pineda, L Morris, C Chen, and JE Anderson: Encuesta Nacional de Fecundidad, Planificacion Familiar y Comunicacion de Guatemala--Primera Parte: Fecundidad y Planificacion Familiar. APROFAM, Guatemala, CA., 1980). Prevalence ranged from 40 percent of married women in the Department of Guatemala to 22 percent of Ladino women in the Interior to 4 percent of Indian women in the Interior.

Nineteen percent of most recent pregnancies, almost one of five, were reported to be unplanned, and data from the survey showed that 35 percent of married women were in need of family planning services--30 percent of Ladino women and 44 percent of Indian women (need for family planning services was defined as women not currently pregnant and not desiring a pregnancy, who were sexually active and fecund but not using contraception).

For Ladino women, a strong association between accessibility to contraceptive source and contraceptive use was found (C Chen, RG Santiso and L Morris: Impact of Accessibility to Contraceptive Source on Contraceptive Prevalence in Guatemala. In preparation). Also, if Indian women had the same accessibility to contraceptives as did Ladino women, it was estimated that their use of reversible methods which needed re-supply would more than double from 2.0 percent to 5.2 percent.

The crude birth rate was estimated to be 45 per 1,000 with a lower level of 35 per 1,000 in the mostly urban Department of Guatemala, compared with 46 per 1,000 in the Interior (JE Anderson, L Morris, A Pineda, and R Santiso: Determinants of Fertility in Guatemala. Social Biology 27(1):20-35,1981). While Ladinos had a much higher rate of contraceptive use than did Indians, the two groups had similar birth rates in the Interior. The lack of difference in fertility appears to be due to the pattern of prolonged breastfeeding among Indians.

Since 1978, updated data on service statistics and private-sector involvement have been incomplete. In addition, the Tripartite Agreement involving USAID, APROFAM, and the Guatemalan MOH called for APROFAM to transfer responsibility for contraceptive distribution to health centers and posts in 11 of 22 departments to the MOH in 1981. Details of this plan's evolution are documented in four previous reports (CDC/AID/RSSA Trip Reports on Guatemala dated March 3, 1980, January 2, 1981, January 13, 1981, and July 8, 1981). The most recent consultation on the integration of contraceptive supplies into the MOH's logistics system documented that the MOH had not begun contraceptive distribution until the third quarter of 1981, and only distributed minimum quantities in the 11 departments under its responsibility (Oberle AID/RSSA Report dated October 27, 1981). Thus, the evaluation to determine whether the MOH should have responsibility for expansion of contraceptive distribution to the remainder of the country in 1982 has been delayed.

Due to the incompleteness of service statistics and lack of contraceptive prevalence data since 1978, and to obtain data that could supplement the evaluation of the MOH contraceptive distribution program, the USAID Mission has proposed a follow-up survey in 1982 with APROFAM as the local agency again responsible for field operations. Preliminary discussions concerning the survey took place in Guatemala in October 1981 and at the Contraceptive Prevalence Survey Regional Workshop in Lima in November 1981. During this consultation, objectives and specifications of the survey were defined and a preliminary budget completed as well as a draft questionnaire discussed. A proposed timetable was also agreed upon.

B. Objectives and Specifications of the Survey

Following discussions with local officials, the following principal objectives were agreed upon, and the survey was entitled, "Encuesta de Planificacion Familiar y Salud Materno Infantil en Guatemala." This survey would measure changes in fertility, contraceptive use and other program variables since the 1978 survey:

1. Estimation of the crude birth rate and total fertility rate in each of 3 strata:
 - a. The Department of Guatemala
 - b. Interior-Ladino population, and
 - c. Interior-Indian population
2. Estimate knowledge, past use, and current use of contraception in all three strata by age group, educational level, marital status and other demographic variables.

3. For women currently using contraception, describe the method and source of contraception. For women not currently using contraception, investigate the reason why they are not using contraception. And for those women who want to space or limit their families, determine what method of contraception they prefer, whether they know where to go for contraceptive services and their knowledge of availability of those services.
4. Define the percentage of women 15-44 years of age that are in need of contraception (not currently pregnant and not desiring pregnancy but not using contraception for reasons not related to sexual activity or fecundity) and the proportion of women with unwanted pregnancy, by parity.
5. The proportion of women who do not desire any more children and would consider surgical contraception as a permanent method of limiting fertility will be determined, as well as the proportion of women that would use contraceptives distributed through a community-based distribution program.
6. Determine the proportion of women with a history of abortion, including the percentage of women needing medical care and hospitalization following abortion.
7. Determine the proportion of ever-pregnant women who have used maternal-child health services and document the place of birth for their last child.
8. Measure breastfeeding prevalence and duration.
9. Determine the immunization status of children less than 5 years of age.
10. Evaluate the family planning mass media campaign and obtain data for future planning of family planning information and education programs (the latter portion of the questionnaire that deals with the evaluation and planning of family planning mass media campaigns was designed by Dr. Jane Bertrand of Tulane University, who will work with APROFAM and CDC in the analysis of this data). Supplemental questions on this topic were requested by local officials.

Specifications of the survey include:

1. An independent multi-stage probability sample of approximately 1,500 households in each of 3 strata: the Department of Guatemala, Interior-Ladino population, and Interior-Indian population--a total of 4,500 households. The sampling frame for the Interior of the country includes all departments outside of the Department of Guatemala with the exception of the Department of Peten. It is estimated that 1,500 households are necessary in

order to obtain completed interviews with 1,000 women 15-44 years of age in each strata. With 1,000 women of fertile age, the 95 percent confidence interval, including design effect, will be plus or minus 6 percent for the variable, actual use of contraception. For the entire country, the confidence interval, including design effect, will be plus or minus 5 percent.

2. For Indian areas, the questionnaire will be translated into five languages: Quiche, Cachiuel, Keckchi, Pocomchi, and Mam, and, of course, in these areas bilingual interviewers will be necessary.

C. Timetable

During this visit a draft questionnaire based on the instruments used in 1978 in Guatemala and the Family Planning-Maternal/Child Health survey conducted in southern Brazil in late 1981, was discussed with APROFAM and the USAID/Mission. The questionnaire was modified based on these discussions and a revised draft will be typed reflecting these changes and will be returned to APROFAM and USAID/Guatemala by the end of February for their review.

The proposed timetable for the survey is shown below. Preliminary discussions in October 1981 included the possibility that field work would be carried out during the months of May through July. However, field work has been re-scheduled for September through early December for the following reasons:

1. The rainy season will be over, facilitating field work in rural areas.
2. For comparison purposes and measurement of trends, it will be the same time period as the 1978 survey.
3. Elections take place in March and the new government installed in July. Field work between elections and the installation of the new government may encounter problems in certain areas. Also, there will be an additional time period to judge possible security problems in certain departments.
4. As mentioned in Section III.A. of this report, there have been delays in implementation of the MOH contraceptive distribution program in 11 Departments, with a subsequent delay in any formal evaluation of this project. Although the survey is not meant to be the principal evaluation of the MOH project, by delaying field work from May to September, the MOH project would have 6-8 months of full implementation for evaluation purposes.
5. Sampling frame availability has been delayed from January to February.

The timetable is as follows:

<u>Month</u>	<u>Activities</u>
January	1) Sample design and discussions with Direccion General de Estadistica (DGE) concerning sampling frame 2) Discussion of draft questionnaire 3) Preliminary budget
February	1) Sample selection (1st stage) 2) Revision of questionnaire
March/April	1) Request maps of sampled census sectors from DGE 2) Pretest questionnaire
May/June	1) Finalize questionnaire 2) Translate questionnaire 3) Sample selection (2nd stage) using DGE maps of census sectors (1st stage)
June/July	1) Write Interviewer's Manual 2) Plan field work
September/December	1) Training (Sept. 6-11) 2) Field work (Sept. 12 - December 16)

D. Proposed Budget

A preliminary budget was developed in collaboration with Lic. Pineda who directed the 1978 contraceptive prevalence survey. The 1978 survey costs for field work, coding, and keypunching was \$37,518. Four years later, with a slightly expanded questionnaire and an additional 600 households to be included in the sample, the preliminary budget estimate is \$50,201. The increase is concentrated in transport: There have been substantial increases in both vehicle rental costs and gasoline costs over the 4-year period. Per diem and salaries have also increased in line with inflation. The budget's principal line items are:

<u>Personnel</u>		\$17,280
1 field coordinator at \$600/mo. x 5 mo.	\$3,000	
3 team supervisors at \$400/mo. x 3 1/2 mo.	4,200	
9 interviewers at \$200/mo. x 2 mo.	3,600	
15 bilingual interviewers at \$10/day x 270 person days	2,700	
3 drivers at \$200/mo. x 3 1/2 mo.	2,100	
1 secretary at \$200/mo. x 2 mo.	400	
Social Security (8 percent)	1,280	
<u>Per Diem</u>		\$14,151
Department of Guatemala: \$3/day x 308 person days	\$ 924	
Interior: \$15/day x 835 person days	12,525	
Indian guides: \$3/day x 234 person days	702	
<u>Transport</u>		\$10,800
Car rental (4-wheel drive), gasoline and maintenance at \$48/day x 225 vehicle days		
<u>Material</u>		\$2,580
Census maps at \$3 x 360 maps	\$1,080	
Paper and printing	1,000	
Office supplies	500	
<u>Coding and Keypunching</u>		\$2,000
<u>Other</u>		\$3,390
Translation and verification of questionnaire	\$1,000	
Indirect costs	\$2,390	
TOTAL		\$50,201

IV. CONTRACEPTIVE LOGISTICS

A. Direct Distribution Program

During calendar year 1981, APROFAM's Direct Distribution Program (DDP) experienced a decline in commodity distribution, but this decline is somewhat misleading for two reasons (Table 1). First, early in 1981 the DDP was still restocking clinics that had refused to accept family planning supplies until mid-1980 when the Minister of Health permitted the resumption of services (see FPED/CDC report dated July 8, 1981). Thus, distribution of orals jumped from 17,805 cycles in the third quarter of 1980 to 55,461 in the first quarter of 1981, so that first quarter figures are artificially high. The second reason for the overall decline in DDP deliveries was the turnover of responsibility for contraceptive distribution in 11 of 22 departments to the MOH in the second quarter. These 11 MOH departments had accounted for 22 percent of orals distributed in the first quarter of 1981.

B. MOH National Pharmacy Distribution

As documented in earlier reports, the MOH National Pharmacy (DN) was unable to begin contraceptive distribution in the 11 departments for which they are responsible in the second quarter of 1981. Consequently, the DN agreed to a simple allocation plan for the third quarter only. The DN failed to carry out the plan. The few contraceptives distributed in the third quarter were by requisition. On October 5, the DN agreed that in the fourth quarter, contraceptive requisitions would be filled for clinics that returned the new requisition form, and a fixed allocation would be sent out to those clinics that failed to return the requisition. However, once again, the only contraceptives dispatched in the fourth quarter were in response to requisitions.

At first glance, the total contraceptives distributed in the fourth quarter may not seem particularly low. However, none of these departments had received contraceptives for the preceding 6 months, and if anything, the DN's fourth quarter shipments probably should have been larger. Only 41 health centers (45 percent) and 68 health posts (20 percent) in the 11 MOH departments received contraceptives in the fourth quarter. Most of the remaining facilities failed to send in a requisition. Twenty-six facilities returned the requisition blank. Auxiliary nurses at two health posts replied that they do not offer family planning because no physician or medical student was available. In other words, the district medical supervisors had not adequately explained that auxiliary nurses can now provide family planning services without a physician's presence.

To improve the DN's sluggish performance, a number of steps were agreed upon at a meeting of the Tri-partite Agreement Committee on January 15, and at a subsequent meeting between myself and the DN's administrator:

1. The DN agreed to provide, each quarter, a list of those clinics that failed to send in a contraceptive requisition or claimed that they were not offering family planning services. The Direccion General (DG) would then send a medical supervisor to investigate the reasons for non-performance.

2. Dr. Jorge Chang of the DG office planned to distribute a questionnaire to all health centers and posts during the last week of January to determine which facilities were offering family planning services; what their contraceptive inventory was; and which health centers had clinicians skilled in IUD insertion or requiring training in IUD insertion.
3. On January 19, the DN's administrator agreed to send an allocation of contraceptives to those facilities that had failed to send in their first quarter requisition. In subsequent quarters, only requisitions would be filled, but hopefully, by then, the medical supervisors will have been able to resolve the problem of clinics failing to participate.
4. To monitor the DN's performance, a series of additional forms was devised: a quarterly warehouse summary, a quarterly list of contraceptives delivered to each health center and post by department, and a list of dates to compare scheduled and actual deliveries of DN shipments to each area chief.
5. The Health and Population Officer plans to meet weekly with Dr. Chang (DG) and Mrs. de Palma (DN) to facilitate operations.

If the MCH is to assume responsibility for contraceptive distribution in the entire country, APROFAM will need to know by early June 1982, in order to provide 30 days' notice for those employees whose DDP jobs will be abolished. At the Tripartite Agreement Committee meeting, Dr. Oberle suggested that the evaluation of MOH performance consist of three parts: 1) a questionnaire survey of all health posts and health centers to determine contraceptive inventory, 2) a review of DN shipment records for each health center and health post, and 3) site visits to a sample of clinics. The questionnaire survey should be conducted approximately 2 weeks after the last scheduled shipment from the DN to area chiefs to allow for delivery from the departments to the clinics. The current schedule calls for the last shipment to Santa Rosa Department on March 31. Thus, the survey should be conducted in mid-April. CDC facilities are available to assist in processing the data. However, because CDC has provided technical assistance to this project, the review of DN records and site visits ideally should be performed by an independent observer.

V. APROFAM PRIVATE PHYSICIAN PROGRAM

Since 1979 the Pathfinder Fund has assisted an APROFAM program for contraceptive distribution by private physicians. The program aims to increase acceptance of family planning by private physicians especially in rural areas, and increase the number of distribution points available to potential family planning acceptors. Pathfinder requested CDC assistance in establishing an evaluation procedure for the private physician programs that might be used for current and future programs.

In order to evaluate changes in physicians' attitudes a survey before and after the program began would be necessary. It is too late for that sort of evaluation in Guatemala. APROFAM did conduct a survey of 560 physicians enrolled in the program during its first year. Field work was completed in July 1981, but results are not yet available. However, the APROFAM survey focused on the performance of the distributor and the physician's attitude toward the program, not toward family planning. Pathfinder should consider a pre and post test of physician attitudes in future programs.

A second evaluation criterion might be the proportion of private practitioners in the target area reached by the program. Unfortunately, the denominator for such a calculation is very uncertain in Guatemala. The Guatemala College of Physicians lists 3,782 physicians in the country of whom 30 percent, or 1,045, are thought to be practicing in the interior. However, an unknown number of physicians have emigrated from rural areas because of political violence. Thus, this estimate is probably high. In its first year and one-half of operation, the private physician program contacted 597 private doctors in rural areas (57 percent of the rural MDs). Subsequently, 253 (24 percent of rural MDs and 42 percent of those contacted) became distributors. The actual percentage of participation in Guatemala is probably higher due to rural-urban migration. Where denominators are available, comparing physicians participating to the "population at risk" is a useful evaluation tool.

A third evaluation goal might be the number of women served or couple years of protection provided. Private physicians are notoriously uncooperative in providing statistics on clients, whether they be family planning users or hepatitis patients. The APROFAM questionnaire mentioned above attempted to estimate clients served by asking physicians directly how many clients they served and by calculating contraceptives distributed to users by comparing an inventory with delivery receipts. The latter approach did not work well because many physicians lost their receipts. However, we may still be able to estimate distribution to users by comparing each physician's contraceptive inventory with the deliveries to him, as recorded in program records. The difference should be the amount distributed to users and can be standardized as couple years of protection. Total contraceptives distributed to physicians would overestimate contraceptives passed on to clients (Table 2). Thus, we tried two other approaches utilizing logistics data. In the first approach, we separated commodities distributed to MDs at the first visit from those distributed at re-visits. The assumption here is that physicians who accept contraceptives more than once are more likely to be distributing contraceptives.

Of note is the fact that 78 percent of orals were distributed to physicians at re-visits while only 19 percent of Lippes loops were distributed at re-visits. This suggests that Lippes loops were not being distributed from physicians to users as actively as orals. Of further note is the popularity of Copper-T's relative to Lippes loops. Although 426 more Copper T's were distributed to physicians during the history of the program, the totals of IUDs distributed probably underestimate the relative popularity of Copper T's. When only resupply visits are considered, more than 4 times as many Copper T's were distributed than Lippes loops, despite the greater cost of the Copper T's. In short, although active user counts are not available to

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independently confirm actual use, it would be helpful to include a line on APROFAM's program report to Pathfinder for contraceptives distributed to physicians at resupply visits.

In the second approach, we reviewed logistics records for each physician excluding the last shipment of each commodity on the assumption that a physician would be close to using up previous lots of a contraceptive if he has re-ordered. This approach not only gave a much lower estimate of use, but is also a time consuming and possibly confusing calculation. We do not recommend its use.

Pathfinder should consider these approaches for future private physician-programs: performing pre-program and post-program surveys of physician attitudes; comparing physicians participating to the target population of physicians; and distinguishing contraceptives distributed at initial visits from those distributed at re-visits.



Leo Morris, Ph.D.



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

TABLE 1

Contraceptive Distribution--MOH National Pharmacy and
 APROFAM Direct Distribution Program
 Guatemala, CY 1981

	<u>Orals</u> (Cycles)	<u>Condoms</u> (Dozens)	<u>Cream, Foam</u> (Tubes)	<u>Neosampoon</u> (Tubes)
<u>APROFAM</u>				
First Quarter	55,461	5,107	35	1,343
Second Quarter	33,471	2,016	0	655
Third Quarter	33,390	2,203	349	1,269
Fourth Quarter	28,710	1,964	73	920
<u>National Pharmacy</u>				
Second Quarter	0	0	--	0
Third Quarter	5,280	744	--	296
Fourth Quarter	15,060	1,800	--	2,980

TABLE 2

Three Ways of Expressing Contraceptives Distributed
 APROFAM's Private Physician Distribution Program
 Guatemala, 1979-81

	<u>Orais</u> <u>(Cycles)</u>	<u>Condoms</u> <u>(Dozens)</u>	<u>Lippes Loops</u> <u>(Units)</u>	<u>Copper T's</u> <u>(Units)</u>	<u>Emko</u> <u>(Tubes)</u>
Total distributed to MDs	13,673 (100.0)*	1,631 (100.0)	788 (100.0)	1,214 (100.0)	189 (100.0)
Contraceptives distributed at resupply visits only	10,720 (78.4)	1,153 (70.7)	151 (19.2)	660 (54.4)	21 (11.1)
Contraceptives distributed minus last lot of each method	6,510 (47.6)	680 (41.7)	90 (11.4)	844 (69.5)	8 (4.2)

*Numbers in parentheses are the percentage of the total distributed to physicians during the 3 years of the program.