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EVALUATION OF
A.I.D. POPULATION ASSISTANCE
TO BRAZIL

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Evaluation conducted by:

Barbara Kennedy
Howard Helman
Maura Brackett
Samuel Carlson

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I. EXECUTIVE SUMMARY

Brazil has been a high priority country for A.I.D. population assistance for a number of years. Since there has been no bilateral program, the majority of support has come from A.I.D.'s central Office of Population with contributions from the Latin America Bureau's regional funds. In 1986, 14 centrally funded cooperating agencies (CAs) provided approximately 6 million U.S. dollars of support to Brazil and estimations for 1987 and 1988 are between 6 to 8 million dollars for each year. Given the long history of A.I.D. support, it was decided to conduct a comprehensive evaluation of the population program for the following reasons:

Brazil has made substantial progress in family planning as evidenced by a recent national Demographic and Health Survey which indicated 65.8 percent of couples in union practicing family planning;

There was a need to assess progress, redefine priorities and justify continued A.I.D. support, especially as overall population funding available to Brazil will likely decrease as program support is shifted to Africa;

Within the past few years, there has been interest on the part of the Government to introduce family planning services within the proposed Integrated Health System (AIS); and

The Agency is developing a strategy for Advanced Developing Countries (ADC) which includes Brazil, and this evaluation offered an opportunity to contribute to the design of criteria for ADC country programs.

The evaluation was conducted during a three week period in July - August 1987 and the team included the new USAID Representative to Brazil and A.I.D. Washington Population Specialists. The team traveled to eight states and met with the heads of the major private family planning organizations to observe programs and discuss future strategies. Meetings were also held with Secretaries for Health at federal, state and municipal levels.

The findings and recommendations of this report will be used to define a specific 2-3 year A.I.D. population assistance strategy which will guide Brazilian private voluntary organizations (PVOs) and A.I.D. supported cooperating agencies (CA) in design of technical assistance and support efforts.

Covering 3.3 million square miles, Brazil is the fifth largest country in the world. With a population of 141 million and an estimated growth rate of 2.1 percent, it is the world's sixth most populous nation and one of the fastest growing countries among those with over 100 million people. Brazil is larger than the continental United States and comprises roughly 50 percent of the total area and population of South America.

The Brazilian population is young, with 50 percent of the population under age 20. This implies that, even given the decline in the total fertility rate from 6.28 in 1960 to 4.35 in

1980, the population will continue to increase and exceed 200 million within the next 13 years because of the large cohorts that will reach reproductive age.

Population growth is taking place in an unbalanced fashion, resulting in rapid urbanization. Urban population has grown from 36 percent of the total population in 1950 to 72 percent in 1986. For example, Sao Paulo experiences an increase of 600,000 new residents annually which results in urban slums, poverty and serious health and nutritional problems for these groups. The estimated population of the cities of Rio de Janeiro and Sao Paulo will reach 13 and 20 million respectively by the turn of the century.

Brazil's economy, while the eighth largest in the free world, has experienced problems within the past few years. Medium term prospects for improvement seem doubtful, however in the long run, Brazil's large internal market and abundant natural resources bode well for continued economic development.

After 21 years of military rule, in 1985, a democratic government was installed. The President, Mr. Jose Sarney, has struggled to earn the support of Brazil's politicians and people and the transition to democracy has included the writing of a new constitution which should be complete by the end of 1987.

In 1986, the first nationally representative survey on family planning and fertility was conducted. The survey showed an extremely high 65.8 percent of women in union using family planning. While this overall rate compares favorably to that found in the United States, prevalence varies dramatically by

region, area of residence, age, educational level and total number of children. For example, in the states of Rio de Janeiro, Sao Paulo and in the southern region more than 70 percent of couples were practicing family planning, yet in the northeast region only 53 percent were using a family planning method. Even though contraceptive use is high, there are currently at least 2.5 million fecund women who do not want to become pregnant, yet are not using any form of contraception. In addition, 25 percent of women aged 15-24 reported having had a premarital sexual experience yet only 15 percent used contraception at first sexual exposure. Major survey findings demonstrate that notable characteristics of the Brazil program include:

The program is dominated by two methods which are female sterilization and the pill;

Ninety-two percent of pill users and 98 percent of condom users obtain their supplies and/or information from a pharmacy. Sterilizations were obtained equally from private doctors and Social Security hospitals or institutions reimbursed by Social Security;

The survey showed an extremely high percentage of caesarean section delivery, approximately 32 percent of all hospital births nationwide and 72 percent in Rio de Janeiro and Sao Paulo;

Forty-nine percent of unmarried young adults aged 15-19 years reported having had sexual relations the month prior to the survey, with only 28 percent using any

contraceptive method; and

male methods account for only 2.5 percent of all users.

The results of this survey will greatly assist in understanding the unique characteristics of the family planning program and should form the a basis for future strategic program planning.

For its level of development, Brazil has an unusually high infant mortality rate reported at 71 per 1000 live births. Estimates for the northeast are as high as 124 per 1000 live births. Although abortion is illegal, abortion estimates are quite high and point to the continued need for family planning information and services.

There has been no Federal Government-sponsored family planning program in Brazil. It has been largely the commercial sector, and to a lesser degree the non-profit private sector, which have played a critical role in making family planning available. Locally-manufactured pills and condoms distributed and sold throughout a large number of commercial outlets nationwide greatly facilitate easy access to family planning supplies. In fact, Brazil ranks among the top five countries in the world in volume of local pill production. This coupled with price controls, which make pills affordable, have contributed to the pill's wide use and success.

As in the great majority of most Latin American countries, the private non-profit sector has played a leading role in

initiating access to and acceptance of family planning. In part as a result of their efforts, the Brazilian Federal Government has recently shown increased interest in initiating family planning information and services.

In 1984 the Ministry of Health announced the Integrated Womens Health Program (PAISM) which included family planning services. In 1987, the ministry developed written family planning guidelines which include all methods except sterilization. Even though these and other Government actions are certainly positive, little progress has been made so far in providing family planning services within public sector supported programs. The next few years will demonstrate how far the Government will progress in implementing family planning services and the extent to which public and private sector institutions can collaboratively work together in this area.

The recently developed government family planning guidelines have two major problems. First, there is no mention of sterilization which is currently Brazil's most popular and widely used method; and second there are restrictive elements in the guidelines which for example, require a doctor's exam before new clients can be given services. These guidelines, if implemented could result in limited access to family planning, especially for poor rural women where there are a shortage of doctors or competing demands on their time. Therefore, while the concept of PAISM is sound in terms of providing quality comprehensive services to women, family planning services delivered according to these guidelines could cause serious cost and administrative problems for public sector and private voluntary programs.

Even though the Demographic and Health Survey showed a high percentage of women know about and use the pill, a number of special studies suggest that not only are a high percentage of women incorrectly using pills, but they may also have contraindications to pill use. There is a need to improve education efforts for pill and other method users so that couples can correctly use a method, understand side effects, and know where to go for medical referral. Since the majority of couples obtain their supplies from pharmacies, the challenge will be how to improve and provide this information to those who use these commercial outlets.

While most methods are available in Brazil, 80 percent of all current use is by two-methods, half of which is sterilization and the other half the pill. Part of the reason for this is due to the limited availability of other methods and the lack of trained workers to provide a full range of services. Government and private sector officials feel the need to increase the availability and use of other reversible methods, such as the condom, IUD, vaginal and natural methods.

Brazil has the highest caesarean section delivery rate in the world and the recent Demographic and Health Survey reported that one-third of hospital births are delivered by caesarean. Female sterilization is the single most popular method in Brazil and 65 percent of all female sterilizations were carried out in conjunction with a caesarean delivery and this high rate has also been documented in state surveys. Health officials and medical leaders need to review these current caesarean practices, acknowledge sterilization as an acceptable permanent

method of family planning and develop guidelines to train and reimburse physicians for voluntary surgical contraception in response to the high demand for these services.

A.I.D. has supported family planning activities in Brazil for a number of years and sustained technical assistance and support has enabled the private sector to make considerable progress. Even though results of the recent Demographic and Health Survey show a remarkably high percentage of women using contraceptives, there is still need for continued and focused A.I.D. population support. Reasons include the need to:

Insure the private sector network supported by A.I.D. over the years develops sustainable programs before A.I.D. phases out;

Focus attention on the northeast, which is still in need of family planning information and services, along with the large unserved "favela" populations on the outskirts of Rio de Janeiro and Sao Paulo; and

Establish links and impart expertise between the private sector and Government as the public sector moves to implement a family planning program.

A.I.D.'s population strategy for Brazil will include:

- * Family planning for underserved areas and populations
- * Policy and program changes for improved quality
- * Promotion of sustainable programs.

1. Family Planning for Underserved Areas and Populations

The strategy to increase access to voluntary quality family planning information and services will focus on underserved areas and populations, which include:

1.1 Areas with low contraceptive prevalence in the northeast region, the state of Minas Gerais and the "favela" slum populations surrounding Rio de Janeiro and Sao Paulo metropolitan areas.

1.2 Programs which reach groups in special need of information and services, to include:

- * men and
- * young adults

2. Policy and Program Changes for Improved Quality

To improve the quality of existing family planning programs, the following activities will be supported which could lead to significant policy and program changes:

2.1 Provide better quality information to couples who receive their supplies through commercial channels, such as:

- 2.1.1 Training retailers, pharmacists and doctors;
- 2.1.2 Developing simple family planning informational materials to be provided or sold over the counter; and

- 2.1.3 Other media informational efforts which include sexually transmitted diseases such as AIDS.
- 2.2 Support the training of health workers to provide a wide range of family planning services, through:
 - 2.2.1 Strengthening family planning skills in basic training curricula for health personnel.
 - 2.2.2 Supporting in-service family planning service delivery training.
- 2.3 Test alternative approaches to the delivery of family planning and conduct research activities which could impact on family planning services delivery, such as:
 - 2.3.1 The role of nurses in delivery of services.
 - 2.3.2 The cost and benefits of providing integrated services, including the physicians' role in service delivery and the potential impact that AIDS may have on family planning programs.
- 2.4 Develop targeted informational materials and programs to enable couples to make informed family planning choices, which among other things, would:
 - 2.4.1 Focus on correct method use and continuation.
 - 2.4.2 Emphasize the importance of family planning as an integral reproductive health care intervention.
 - 2.4.3 Dispell false information and rumors about family planning.

- 2.4.4 Encourage male involvement in programs through condom use and surgical contraception.

3. Promotion of Sustainable Programs

As A.I.D. support decreases, it is critical to assist private family planning organizations to better manage their programs and enable them to become more financially self-sufficient. This is not limited to but can include:

- 3.1 Improve linkages between private organizations and government programs.
- 3.2 Identify ways for private organizations to increase local financial support (fees for service, fund raising, etc.).
- 3.3 Assist private organizations in developing focused and clearly defined program strategies.
- 3.4 Improve the management and efficiency of programs.
- 3.5 Establish international training networks, where appropriate.
- 3.6 Encourage private sector investment in family planning.

4. Other

- 4.1 Due to the large number of local private organizations and U.S. cooperating agencies (CAs) working in Brazil and the redirection of efforts within the context of

this new strategy, there will be a need to closely coordinate all A.I.D. population efforts. This will be achieved by:

- 4.1.1 Conducting an annual coordination meeting in Brazil of all major Brazilian organizations, CAs and A.I.D./W and USAID personnel to discuss progress and develop specific workplans.
 - 4.1.2 Sharing A.I.D. program documents and reports among local organizations and CAs.
- 4.2 AIDS can have a major and negative impact on the provision of family planning services, however, population funds are extremely limited to support AIDS activities. Therefore, within the context of this strategy support will only be considered for:
- 4.2.1 Provision of condoms.
 - 4.2.2 Development of simple information materials on AIDs and family planning for information and training programs.
 - 4.2.3 Selected AIDS operations research activities which would have a direct impact on family planning service delivery.

II. COUNTRY OVERVIEW

Brazil is an advanced developing country; national statistics are commonly compared to developed and developing countries. Yet Brazil is also a country of contrasts, where national figures often camouflage large disparities among its five geographically distinct regions, such as differences in socio-economic development, between rich and poor, rural and urban, and culturally diverse populations.

A. Demographic Situation

The population density in Brazil averages 14 persons per square kilometer. It is important to recognize, however, that many rural and jungle areas have a very low population density (1-3 persons per square kilometer), while urban areas such as the city of Rio de Janeiro has 625 persons per square kilometer, accounting for nearly 50 percent of the total population of the state of Rio de Janeiro. In fact, as can be seen in Table 1, the two regions of the northeast and southeast have 72 percent of the total population.

Furthermore, population growth is taking place in an imbalanced fashion, resulting in rapid urbanization and a decline in the rural population. Urban population has grown from 36 percent of the total population in 1950 to 72 percent in 1986. In the state of Rio de Janeiro for example, the population living in slums increased 318 percent between 1965 and 1979, while the non-slum population increased just 10 percent. The imbalanced

distribution of land resources leading to high rural poverty, high infant mortality and continued high birth rates in the northeast, had resulted in migration to urban areas. Sao Paulo experiences an increase of 600,000 new residents annually which results in urban slums, poverty and serious health and nutritional problems for these groups. The estimated population of the cities of Rio de Janeiro and Sao Paulo will reach 13 million and 20 million respectively by the turn of the century.

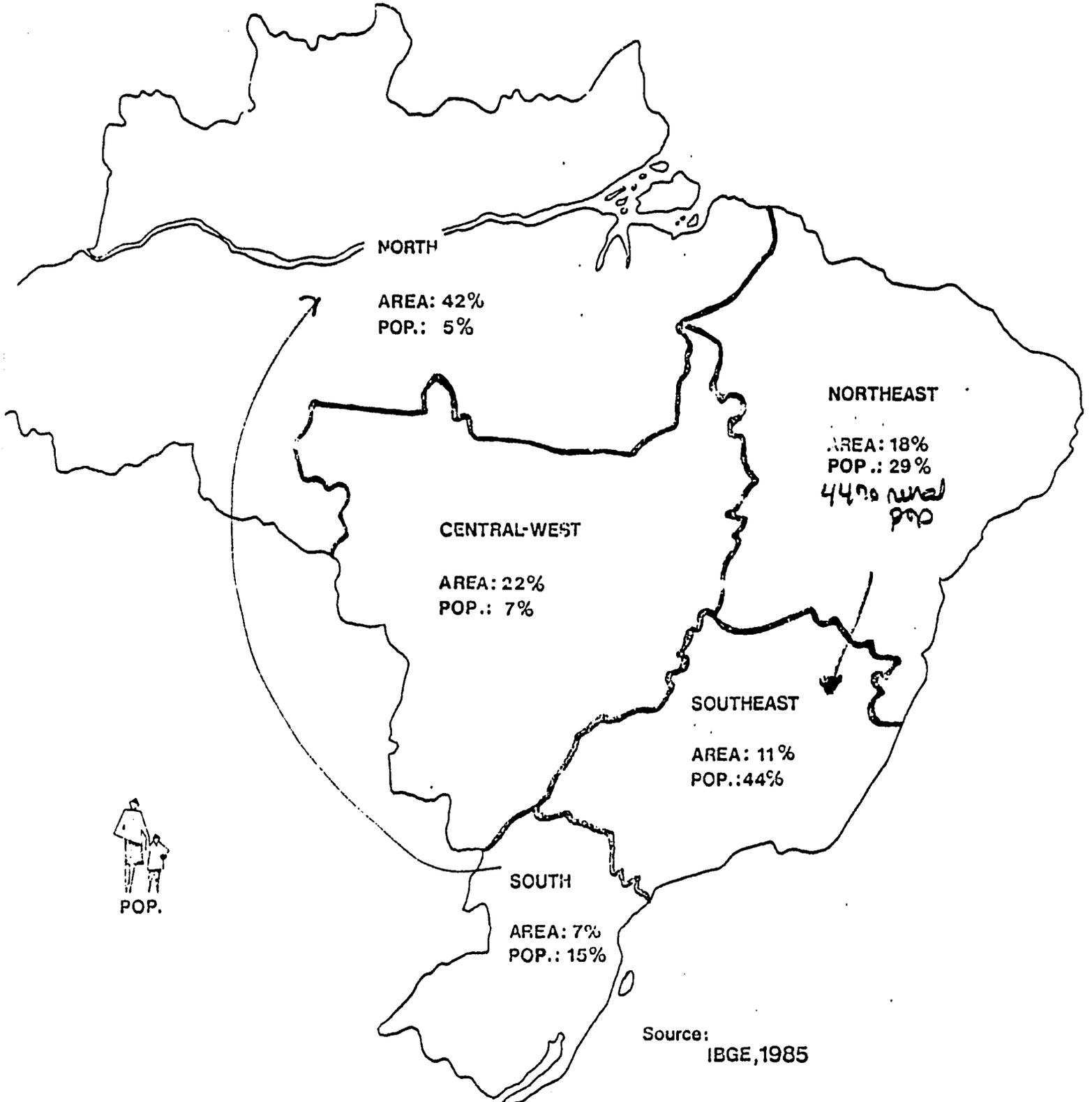
B. The Economy

Brazil's economy, the eighth largest in the free world, grew at the astonishing rate of 11 percent per year between 1968-1973. This was a time of rapid industrialization and infrastructure development. The 1973 oil crisis handicapped the economy but Brazil was still able to expand at 6 percent annually between 1974-1980. However in 1982, the country registered zero growth in GNP because of the surge in world oil prices and interest rates, the fall of commodity prices, and the slackening in world trade as a result of the global recession. There was rampant inflation and devaluation and Brazil's foreign debt became the largest of any developing country.

By 1985, Brazil had recovered and posted a GNP growth rate of 8.3 percent. Economic growth continued buoyant during 1986, at 8.2 percent, but the trade surplus dropped sharply. Total GNP for 1986 was \$280 billion. However in early 1986, runaway inflation prompted President Sarney to decree the Cruzado Plan. The effects of this plan were to freeze all prices, end wage indexation, and create a new currency, the Cruzado. The Cruzado Plan stimulated a consumer spending boom at the same time that

TABLE I

PERCENT DISTRIBUTION OF POPULATION AND AREA BY REGION, BRAZIL



were cutting back because of squeezed profit margins. Exports declined and imports rose considerably. By February 1987, foreign exchange reserves had dropped to levels low enough to force the suspension of interest payments on Brazil's \$112 billion external debt.

Medium term prospects for improvement seem doubtful given (1) Brazil's large external debt; (2) its relations with commercial banks and the IMF, the need to attract investment capital if there is to be a longer term solution; and (3) the squeeze which proposed austerity measures will place on the fragile, lower-middle class. In the long run, however, Brazil's large internal market (less than 10 percent of GDP is exported) and abundant natural resources bode well for continued economic development.

C. Political Changes

In January 1985, after 21 years of military rule, a democratic Government was introduced through the Electoral College's selection of Tancreo Neves as President. Unfortunately, Mr. Neves fell ill and died before he could take office and his Vice-President, Jose Sarney, acceded to the Presidency.

As part of a transition to democracy a Constituent Assembly, composed principally of members of Congress, was appointed to write a new Constitution. This has been an arduous process with lengthy debates and discussions and drafts produced so far have been long. The principal disputes have been over the adoption of a presidential or parliamentary system of Government, the

length of the presidential mandate, the degree of foreign participation in the economy, and the role of the Armed Forces. Special concerns to A.I.D. population staff are the creation of a unified health system and avoidance of excess regulation over private groups working in health and family planning. The final text should be ready by the end of 1987.

Although Brazil is considered an advanced developing country, it is not advanced in terms of social consciousness, income distribution, or political development. Most certainly there is an overwhelming lack of dialogue between the public and private sectors concerning both Brazil's economic growth and its social agenda.

III. STATUS OF FAMILY PLANNING

A. 1986 Demographic Health Survey and Other Statistics

In 1986 a Demographic and Health Survey was conducted which was the first nationally representative survey on fertility and family health undertaken in Brazil. The survey demonstrated that 65.8 percent of married women or women in union by consent were using some method of family planning. In fact, this contraceptive prevalence rate is comparable to that found in the United States. At the same time, rates within Brazil vary dramatically by region, area of residence, age, educational level and total number of children. For example, in the states of Rio de Janeiro, Sao Paulo and in the southern region, more than 70 percent of couples were practicing family planning, yet in the northeast region only 53 percent were using a family planning method (only 40 percent in rural areas).

The survey showed that the total fertility rate for 1983-1986 was 3.5 births per woman which, when compared to independent estimates of 5.8 in 1970 and 4.4 in 1980, demonstrates a dramatic decline in fertility of approximately 25 percent in a ten year period. An important factor which contributed to this decline is the high level of awareness and use of all methods of family planning. Yet even though contraceptive use is high, there are currently at least 2.5 million fecund women who do not want to become pregnant, yet are not using any form of contraception. In addition 25 percent of women 15-24 reported having had premarital sexual relations and only 15 percent used contraception at first sexual experience. In fact one-third of marital first births were premaritally conceived.

Major survey findings (Table 2) demonstrate that notable characteristics of the Brazil program include:

Of the 65.8 percent of all current use 80 percent is by two methods divided equally between; female sterilization and the pill;

Ninety-two percent of pill users and 98 percent of condom users obtain their supplies and/or information from a pharmacy. Sterilizations were obtained equally from private doctors and Social Security hospitals or those reimbursed through the Social Security System;

The survey showed an extremely high percentage of caesarean section delivery, approximately 32 percent of all hospital births nationwide and 42 percent in Rio de Janeiro and Sao Paulo;

Forty-nine percent of sexually experienced unmarried young adults aged 15-19 years reported having had sexual relations the month prior to the survey, with only 28 percent using any contraceptive method; and

male methods account for only 2.5 percent of all users.

The results of this survey will greatly assist in understanding family planning program success and should form the a basis for future strategic program planning.

Table 2
1986
Brazil Demographic and Health Survey
Summary of Findings

| | |
|---|----------------------|
| *Total Fertility Rate | 3.5 births per woman |
| Rio de Janeiro | 2.6 |
| Northeast | 5.2 |
| More than primary education | 2.5 |
| No Education | 6.5 |
| Currently Using Contraception | 65.8% |
| Rio de Janeiro, Sao Paulo and South Region | 71-74% |
| Northeast | 53.0% |
| Current Use | |
| Female Sterilization | 26.9% |
| Oral Contraceptives | 25.2% |
| Withdrawal | 5.0% |
| Periodic Abstinence | 4.3% |
| Condom | 1.7% |
| IUD | 0.9% |
| Male Sterilization | 0.8% |
| Vaginal Methods | 0.5% |
| Not Using | 34.2% |
| Source of Supply | |
| Pills obtained from pharmacy | 92% |
| Female sterilizations from; Social Security hospitals, | 43.3% |
| Doctors, Private Hospitals | 42.0% |
| Condoms obtained from pharmacies | 98.6% |
| Births occurred in hospitals | 79% |
| Births delivered by Caesearan Section | 31.7% |
| Rio de Janeiro, Sao Paulo | 72% |

*Statistics reported on fertility refer to all women aged 15-44; all other statistics in the survey refer to currently in union women aged 15-44.

Sociedade Civil Bem-Estar No Brasil - BEMFAM Demographic and Health Survey - DHS Institute for Resource Development, Westinghouse.

For its level of development, Brazil has an unusually high infant mortality rate (IMR), reported at 71 per 1000 live births. In 1983 the IMR began increasing, especially in the Northeast where it rose from 93 per 1000 live births in 1982 to 124 per 1000 live births in 1986 (Jaguaribe et al., 1986). Most likely the recent recession, which began in 1981, has had a major impact on health status through indicators such as malnutrition, anemia, premature weaning and low birth weight babies, especially in the Northeast.

Although abortion is illegal, high abortion rates cause serious health problems for women. While exact figures are unknown, it has been estimated by Brazilian experts that each year there is an abortion for each child born, or approximately 3 million annually. Data furnished by DATAPREV indicated that in 1986, 151,847 abortion complications were treated in hospitals, 79 which resulted in death. These high figures are a clear indication of the continuing need to make a wide range of effective family planning information and services available to all couples in Brazil.

B. Role of the Private Sector

There has been no Federal Government-sponsored family planning program in Brazil. It has been largely the commercial sector, and to a lesser degree the non-profit private sector, which have played a critical role in making family planning services and supplies available. Three of the largest private non-profit family planning organizations in the country are the Civil Society for Family Welfare BEMFAM; the Integrated Maternal and

Child Care Research and Development Center (CPAIMEC); and the Brazilian Association of Family Planning Organizations (ABEPF). Each has played a major role in family planning in Brazil.

BEMFAM, founded in 1965, is affiliated with the International Planned Parenthood Federation and concentrates its efforts on the support of community-based family planning information and service programs on a national scale. It carries out its activities through cooperative agreements with states and city health programs, particularly in the Northeast. With a budget of approximately 3.5 million U.S. dollars in 1986, BEMFAM provided family planning services at 2,382 state and county health centers and 63 cooperative clinics, handling 1,700,000 client visits. BEMFAM also trained 4,476 health professionals and performed several research projects, including the 1986 National Demographic and Health Survey.

CPAIMEC, founded in 1975, has been active in the training of family planning personnel and in developing a model for the delivery of family planning within maternal and child health care services, which has been adopted by over 300 organizations throughout Brazil. With a budget of 1 million U.S. dollars in 1986, 75,300 low-income women, men and children received primary health care services. This year, its hospital headquarters as well as 12 health units, have been a source of training for 480 health professionals as well as sites for five operations research projects.

ABEPF, created in 1981, is an association of more than 140 family planning organizations, established in universities, hospitals, clinics and health centers, each operating autonomously and having freedom to organize and carry out programs. One of the most important activities undertaken by ABEPF was the establishment of norms and procedures for family planning services based upon sound scientific information. Having a budget of approximately 1 million U.S. dollars in 1986, through its affiliates ABEPF handled 1,400,000 family planning visits and provided training to 400 health professionals, organized by its central office. Directors of ABEPF affiliates also occupy key positions in prestigious organizations in the area of human reproduction, such as the Brazilian Society of Human Reproduction (SBRH), the Brazilian Federation of Gynecology and Obstetrics (FEBRASGO) and the Brazilian Society of Anthropology (SBA).

Locally-manufactured pills and condoms, distributed and sold throughout a large number of commercial outlets nationwide, greatly facilitate the easy access of family planning supplies to couples in all regions of the country. In fact, Brazil ranks among the top five countries in the world in the volume of local production of oral contraceptives.

As in the great majority of most Latin American countries, the private sector in Brazil has played the leading role in initiating access to family planning. In part as a result of their efforts, the Brazilian Federal Government has recently shown increased interest in initiating family planning information and services within their health service programs.

C. Recent Government Interest

For 20 years the absence of a Government policy and family planning program led couples to seek these services primarily through pills purchased in pharmacies and by arranging for voluntary sterilizations performed during a Caesarian section delivery by private physicians and in public institutions. Government price-controlled pills made this method an affordable and easy option for many couples. However in 1984, the Government began to show more favorable interest in family planning through a number of events:

- At the Mexico City Population Conference in 1984 the Government proclaimed access to family planning as a basic human right;
- That same the year, the Ministry of Health announced the Integrated Women's Health Program (PAISM) and in June 1985, stated its expansion to 11 states. In 1987, the Ministry issued written guidelines on family planning, which included all methods except sterilization;
- In February 1986, the Ministry of Social Welfare adopted family planning as part of their PAISM program of the Social Security System (INAMPS). This marked the Government's first national effort to implement what it had stated as a human right;

- At this same time, the Ministry of Health included oral contraceptives on their basic drug list which would essentially make supplies free to the majority of the population through the public health system;
- A month after the INAMPS statement, the Brazilian Legion Assistance (LBA) agreed to distribute informational materials on family planning to parents who have children in LBA's 28,000 day care centers throughout the country;
- In June 1986, The Human Reproductive Rights Commission, designated by the Ministry of Health, produced a report which included the following on family planning:

A couple has the right to decide the number of children they want;

Family planning should be offered in an integrated health care setting;

The Government does not seek demographic change through its family planning program;

The Ministry of Health should provide close and continued monitoring of contraceptive research programs; and

The commission strongly favors periodic abstinence and vaginal methods including the diaphragm, over other methods such as the pill, IUD and sterilization.

In the middle of 1986, the Minister of Education spoke in favor of family planning and stated the Ministry's intention to create sex education and family planning programs for young adults in schools.

Even though these actions are positive and indicate Government interest in family planning, little progress has been made on the implementation of programs. However, the Government has signed agreements with both the World Bank and UNFPA which include the provision of family planning services. There are a small number of continuing vocal opponents to family planning, but this opposition generally does not focus on the issue of family planning, but rather on how it should be delivered. There is also some concern over the role of international organizations in funding private family planning organizations.

In summary, over the past three years, the Government has taken positive steps in initiating family planning through the Integrated Womens Health Delivery System and the INAMPS health delivery system. Guidelines for family planning services have also been developed, oral contraceptives have been included on the list of essential drugs, and all methods except sterilization have been approved by the Ministry of Health. At the same time, politically motivated women activists continue

to express concern that private family planning organizations are accepting funding from international organizations, but these concerns seem to be politically motivated. The next few years will show Government progress in implementing family planning services, and how private sector family planning programs can collaboratively work with Government.

IV. SUMMARY OF A.I.D. SUPPORT

A. Historical Summary

Since 1983, the U.S. Government has been restricted from providing direct assistance to the Government of Brazil because of delinquency and default on payments to the U.S. Government and because Brazil has not signed the Nuclear Non-Proliferation Treaty. However, Section 123(e) of the Foreign Assistance Act of 1961, permits assistance to private and voluntary organizations assisted by A.I.D. at the time of or prior to the 1983 prohibition. As family planning assistance in 1983 was extensive and included many U.S. and local PVO's, the latitude for continuing assistance, while restricted, is still broad.

Brazil has been a high priority country A.I.D. for population assistance. As there has been no program funded by USAID/Brazil, the majority of support has come from the central Office of Population with contributions from the Latin America Bureau's regional funds. As can be seen from Table 3, support has ranged from \$2.6 to \$6.4 million dollars in the period 1983-1986. In FY 1987 and 1988, it is estimated that approximately 6-8 million U.S. dollars will be programmed each

Table 3

Population Funding Levels
and Numbers of Projects
for Brazil FY 1983 - FY 1987
(\$000)

| <u>ITEM</u> | <u>YEAR</u> | | | | |
|--------------------------|-------------------|-------------------|-------------------|----------------|------------------|
| | <u>FY 1983</u> | <u>FY 1984</u> | <u>FY 1985</u> | <u>FY 1986</u> | <u>FY1987 1/</u> |
| S&T/POP | \$4,396 | \$3,445 | \$2,577 | \$5,832 | \$7,792 |
| NUMBER OF SUBPROJECTS | 46 | 64 | 52 | 69 | |
| LAC REGIONAL | <u> </u> | <u> </u> | <u> </u> | <u> \$585</u> | <u> \$300</u> |
| | \$4,442 | \$3,509 | \$2,629 | \$6,417 | \$8,092 |

1/ Estimates based on S&T/POP
Cooperating Agency Projections

year through approximately 14 centrally-funded cooperating agencies. (See Annex 2 for complete list and summary.) In FY 1986 and FY 1987, \$858,000 dollars were obligated by the Latin America Bureau to the Pathfinder Fund to strengthen private sector family planning service delivery in Brazil.

Table 4 shows the breakdown of the \$7.792 million of central FY 1987 funds for Brazil and it can be seen that the majority of support will go for services and information/training.

B. Justification for Continued Support

A.I.D. has supported family planning activities in Brazil for a number of years and sustained technical assistance and support has enabled the private sector to make considerable progress. Even though results of the recent Demographic Health Survey show a remarkably high percentage of women using contraceptives, there is still need for continued and focused A.I.D. population support. Reasons include the need to:

Insure the private sector network supported by A.I.D. over the years has developed more self-sustainable programs before A.I.D. phases out;

Focus attention on the northeast, which is still in need of family planning information and services, along with the large unserved "favela" populations on the outskirts of Rio de Janeiro and Sao Paulo; and

Establish links and impart expertise between the private sector and Government as the public sector moves to implement a family planning program.

Table 4

TOTAL ESTIMATED EXPENDITURES
S&T/POP FOR BRAZIL
FY 1987

| | |
|--------------------------|------------------|
| Policy | \$150,000 |
| Research | 902,000 |
| Services | 5,200,000 |
| Information and Training | <u>1,540,000</u> |
| | \$7,792,000 |

V. ISSUES IN FAMILY PLANNING

A. Integrated Womens Health Services

Guidelines for Integrated Health Services (PAISM) were established by the Ministry of Health in 1985 and guidelines on family planning methods and norms were issued in 1987.

Components of the PAISM program include:

- gynecological services including treatment of sexually transmitted diseases;
- prenatal, delivery and post-partum care;
- infertility, diagnosis and treatment;
- cancer detection and screening; and
- family planning services.

These family planning guidelines do not mention the most popular method in Brazil which is sterilization. They also require that the first family planning consultation be performed by a doctor, after the client has received educational activities no matter what method is chosen. Although less clear, it also seems to be a requirement that a woman receive a pelvic exam and pap smear before being given oral contraceptives. Most private sector family planning organizations are in the process or have already

expanded their family planning service programs to include PAISM interventions in response to Government guidance. In some cases reflects a departure from the way in which services were provided in the past.

In 1986 BEMFAM expanded their clinical services to include PAISM interventions and also began to implement the physician exam requirement for new family planning users. This has caused BEMFAM to change their Community-Based Distribution (CBD) Program. These workers are no longer able to provide initial supplies and re-supply depots are being moved from community-based posts to clinics. There is an urgent need to clearly redefine the role of these workers, and what activities they are to perform within these new PAISM guidelines. These family planning requirements may work well in urban areas which have good medical coverage, but it is doubtful there will be enough doctors to work in rural health posts. Also, women may not want to come to clinics for pills if they know that a pelvic exam is required. This is not an uncommon phenomenon in many parts of the world and in a family planning clinic in Fortaleza a 70 percent drop in pill use was reported in 1986, in part as a result of the doctor/pelvic requirement.

These requirements will also affect the numbers that can be seen for family planning in social security clinics or those programs reimbursed by INAMPS because of competing demands. That is, even where there are doctors available and present, INAMPS sets the standard for the number of patients to be seen per clinic session. For example, if 20 women come for family planning, and the doctor is only required to see 17 clients, the rest will have to return to be seen by the doctor, who will be equally busy providing other related services.

While the concept of the PAISM program is sound in terms of providing quality comprehensive services to women, the implementation as presently planned could result in serious cost and administrative problems for public and private sector programs.

B. Quality of Services

1. Correct Method Use

Even though the Demographic and Health Survey showed a high percentage of women know about and use the pill, an important question that needs to be asked is, "exactly what do women know?" Ninety-one percent of current pill users obtain their supplies from pharmacies, and only 54 percent had a prescription when they purchased the pill for the first time. This means that almost half of women who purchased pills received little if any advice on how to correctly take the pill, contraindications to pill use, or where to go if problems occur.

A number of studies support the idea that not only are a high percentage of women incorrectly using pills, but many who do so have contraindications to pill use.

In a 1982 CPAIMC study of 1,188 women in Rio de Janeiro using the pill, findings showed that:

- 21 percent of the women did not know what to do when forgetting to take one pill;

- 92 percent did not know what to do when forgetting to take two pills; and
- 85 percent of the women incorrectly quoted when to start a new cycle of pills.

In a state survey of 4,000 women in Sao Paulo in 1978, 50 percent of the pill users had relative or major contraindications to pill use. One half of pill users received their supplies from physicians and the other half from pharmacies. Similar findings in a 1987 AMICO study of Health Maintenance Organizations showed 61 percent of all pill users were classified as having at least one medical contraindication to pill use. The frequency of these medical conditions among pill users was similar to frequencies in the population at large (e.g. 30 percent of pill users smoked vs 34 percent of the population at large, 12 percent suffered from high blood pressure vs 13 percent in the general population). The DHS Survey also showed that 12.2 percent of married women aged 35-44 (or 670,000 women) were currently using the pill when, due to age considerations they should have probably been using another method.

The results of these studies all demonstrate the need to improve education efforts for women using the pill so that they can correctly use the method and be aware of side effects. As the majority of women and men obtain their supplies from pharmacies, this presents a challenge to provide correct information on use and medical back-up to couples who purchase their supplies in pharmacy outlets. There is also the need to assure that appropriate training programs reach all health workers,

including pharmacists, so that they know how to correctly provide and advise couples on a wide range of family planning methods.

2. Method Mix

While most methods are available, the Brazil program is actually a two method program and 80 percent of all current use is female sterilization and the pill.

While the recent DHS Survey showed that 64.3 percent of women have heard of the IUD, only 2.3 percent had ever used this method and only 0.9 percent were currently using IUDs at the time of the survey. Condom use was only 1.8 percent and vaginal methods 0.5 percent. Therefore, even though overall prevalence is high, there is a heavy dependence on two methods.

Indications are that the Government and private sector feel the need to increase the availability and use of other reversible methods such as the condom, IUD, vaginal, and natural methods.

Part of the reason for this reliance on the pill and sterilization is due to the limited availability of other reversible methods and the lack of trained health workers to provide the full range of family planning services. Even though the Commission on Reproductive Rights approved the use of the IUD in 1985, they require that it be inserted by a doctor. The end result is that the Ministry of Health and INAMPS will not approve of its use until doctors are trained in insertion techniques.

A simple reason that pills are a popular and widely used method is that they are available and affordable in commercial outlets. Due to Government import restrictions, pills must be purchased on the local market and each trademark has strictly enforced price controls set by the Government. These controlled prices are far below inflation and are internationally competitive and among the cheapest in the world at 19 - .21 cents per cycle.

3. Caesareans and Sterilization

Brazil has the highest caesarean section delivery rate in the world and the recent DHS reported that one-third of hospital births are delivered by caesarean. This rate varies and in Sao Paulo up to 72 percent of all deliveries in private hospitals covered by health insurance are caesarean births. Some of the cultural and social reasons given for this practice are:

- The convenience of the physician;
- There are no trained midwives and doctors would have to wait through long labors;
- Physicians are not well experienced in how to perform vaginal deliveries;
- While INAMPS reimburses the same for caesareans as vaginal deliveries, they do not reimburse for any analgesia (local, epidural) unless there is a caesarean;

- Women believe that a vaginal delivery will leave their vagina stretched and undesirable to their partners; and
- Women choose it to obtain a sterilization.

According to the DHS, female sterilization is the single most popular method in Brazil and 65 percent of sterilizations were carried out in conjunction with a caesarean delivery. This high rate has also been corroborated by previous state level surveys as shown in Table 5.

Table 5

Percentage of Births by Caesarean Delivery and
Percentage of Women Having Sterilization
Combined with Caesarean Delivery

| <u>Conbined</u> <u>State-Survey Year</u> | <u>Percentage Births by</u> <u>Caesarean Delivery</u> | <u>Percentage Sterilization</u> <u>With Caesarean Delivery</u> |
|---|--|---|
| Amazonas-1982 | 43.4 | 73.7 |
| Paraiba-1980 | 20.3 | 71.0 |
| Bahia-1980 | 33.5 | 63.1 |
| Pernambuco-1980 | 43.5 | 71.4 |
| Rio Grande do Norte-1980 | 22.5 | 66.7 |
| Piaui-1982 | 29.9 | 72.6 |
| South Region-1981 | 26.6 | 74.6 |

SOURCE: DEPEs-BEMFAM

Since 1975 sterilization has been authorized under Brazil's medical code for "medical reasons", requiring two doctors approval. A revised medical code in 1984, does not specifically prohibit or legally restrict sterilization.

In practice, physicians are not reimbursed for sterilization by the Ministry of Health and INAMPS. Moreover, since the largest employer/employee health insurance schemes in the country rely on Government schedules to determine rates for compensation for physician services, they also omit payments for sterilization.

As a result, women choose a caesarean for which insurance schemes will reimburse and have the sterilization done at the same time. There has been no Government action to either acknowledge sterilization as an acceptable method of family planning or to recognize that these services, half of which are being conducted in Government facilities or federally reimbursed through INAMPS. Until the Government takes positive action, the high rate of caesarean delivery to obtain a voluntary sterilization will continue.

While sterilization is a popular method, access to voluntary sterilization is not equally available to all women. Women who have had previous caesarean birth become medically high risk when they undergo their third caesarean and are frequently given the choice of sterilization for medical reasons. It could be difficult for a woman who has never had a caesarean to qualify for a sterilization unless she can meet other "medically indicated criteria". In other words, women who deliver by caesarean are 16 times more likely to obtain a sterilization than those women who deliver vaginally.

The Ministry of Health and medical leaders need to review these current caesarean practices and set up guidelines to train and reimburse physicians for voluntary surgical contraceptive services in response to the high demand for these services.

VI. A.I.D. POPULATION STRATEGY FOR BRAZIL

A.I.D.'s population strategy for Brazil will include:

- * Family planning for underserved areas and populations
- * Policy and program changes for improved quality
- * Promotion of sustainable programs.

1. Family Planning for Underserved Areas and Populations

The strategy to increase access to voluntary quality family planning information and services will focus on underserved areas and populations, which include:

1.1

Areas with low contraceptive prevalence in the northeast region, the state of Minas Gerais and the "favela" slum populations surrounding Rio de Janeiro and Sao Paulo metropolitan areas.

1.2

Programs which reach groups in special need of information and services, to include:

*men and

*young adults

2. Policy and Program Changes for Improved Quality

To improve the quality of existing family planning programs, the following activities will be supported which could lead to significant policy and program changes:

2.1

Provide better quality information to couples who receive their supplies through commercial channels, such as:

- 2.1.1 Training retailers, pharmacists and doctors;
- 2.1.2 Developing simple family planning informational materials to be provided or sold over the counter; and
- 2.1.3 Other media informational efforts which include sexually transmitted diseases such as AIDS.

2.2 Support the training of health workers to provide a wide range of family planning services, through:

- 2.2.1 Strengthening family planning skills in basic training curricula for health personnel.
- 2.2.2 Supporting in-service family planning service delivery training.

2.3 Test alternative approaches to the delivery of family planning and conduct research activities which could impact on family planning services delivery, such as:

- 2.3.1 The role of nurses in delivery of services.
 - 2.3.2 The cost and benefits of providing integrated services, including the physicians' role in service delivery and the potential impact that AIDS may have on family planning programs.
- 2.4 Develop targeted informational materials and programs to enable couples to make informed family planning choices, which among other things, would:
- 2.4.1 Focus on correct method use and continuation.
 - 2.4.2 Emphasize the importance of family planning as an integral reproductive health care intervention.
 - 2.4.3 Dispell false information and rumors about family planning.
 - 2.4.4 Encourage male involvement in programs through condom use and surgical contraception.

3. Promotion of Sustainable Programs

As A.I.D. support decreases, it is critical to assist private family planning organizations to better manage their programs and enable them to become more financially self-sufficient. This is not limited to but can include:

- 3.1 Improve linkages between private organizations and government programs.
- 3.2 Identify ways for private organizations to increase local financial support (fees for service, fund raising, etc.).

- 3.3 Assist private organizations in developing focused and clearly defined program strategies.
- 3.4 Improve the management and efficiency of programs.
- 3.5 Establish international training networks, where appropriate.
- 3.6 Encourage private sector investment in family planning.

4. Other

- 4.1 Due to the large number of local private organizations and U.S. cooperating agencies (CAs) working in Brazil and the redirection of efforts within the context of this new strategy, there will be a need to closely coordinate all A.I.D. population efforts. This will be achieved by:
 - 4.1.1 Conducting an annual coordination meeting in Brazil of all major Brazilian organizations, CAs and A.I.D./W and USAID personnel to discuss progress and develop specific workplans.
 - 4.1.2 Sharing A.I.D. program documents and reports among local organizations and CAs.
- 4.2 AIDS can have a major and negative impact on the provision of family planning services, however, population funds are extremely limited to support AIDS activities. Therefore, within the context of this strategy support will only be considered for:

- 4.2.1 Provision of condoms.
- 4.2.2 Development of simple information materials on AIDs and family planning for information and training programs.
- 4.2.3 Selected AIDS operations research activities which would have a direct impact on family planning service delivery.

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S&T/POP
ESTIMATED FY 1987
EXPENDITURES FOR BRAZIL

POLICY

- 1. Technical Information on Population for the Private Sector (TIPPS) Project 932-3035.2

TIPPS will work with Health Maintenance Organizations (HMOs) such as ABRAMGE and AMICO to conduct cost benefit analyses for family planning.

Estimated Expenditures FY 1987 \$50,000

- 2. Demographic and Health Surveys (DHS) Project 936-3023

Plans are to finalize the report for the 1986 Contraceptive Prevalence Survey, conduct limited secondary analysis and hold a seminar to disseminate the results.

Estimated Expenditure FY 1987 \$50,000

- 3. Resources for the Awareness of Population Impact on Development (RAPID II) Project 936-3017

Use computer simulations to explain impact of population growth on development with O Segundo Brazil

Estimated Expenditures FY 1987 \$50,000

TOTAL POLICY \$150,000

RESEARCH

- 1. Family Health International (FHI) Project 936-3041

Continue with research to develop new and improved methods of fertility regulation with various research organizations

Estimated Expenditures FY 1987 \$200,000

- 2. Population Council Program Project 936-3005

Support activities towards the development and introduction of new contraceptive methods along with technical assistance in service delivery systems research, evaluation and training with organizations such as CEMICAMP and the University of Campinas

Estimated Expenditures FY 1987 \$250,000

3. Strategies for Improving Service Delivery Project (Population Council) 936-3030

Support operations research to improve family planning service delivery with BEMFAM and ABEPF

Estimated Expenditures FY 1987 \$300,000

4. Natural Family Planning Project 936-3040

Improve natural family services and research with CENPLAFAM

Estimated Expenditures FY 1987 \$52,000

5. Contraceptive Research and Development (CONRAD) Project 936-3044

Will support first two phases of clinical trials of new contraceptive methods, particularly reversible sterilization for men and an injectable contraceptive for women with Propater and the Federal University of Bahia

Estimated Expenditures FY 1987 \$100,000
TOTAL RESEARCH \$902,000

SERVICES

1. Family Planning International Assistance (FPIA) Project No 932-0953

FPIA will provide continued and phase out support for 10 on going service support projects.

Estimated Expenditures FY 1987 \$1,300,000

2. Contraceptive Social Marketing (SOMARC) Project 936-3028

SOMARC will conduct special studies on improving point of purchase materials and training of distributors and pharmacists to improve both the volume and sale of contraceptives through commercial channels.

Estimated Expenditures FY 1987 \$500,000

3. Program for Voluntary Surgical Contraception (AVSC) Project 932-0968

Supports the training and provision of voluntary surgical contraception through assistance to ABEPF, BEMFAM, PROPATER and SAMEAC

Estimated Expenditures FY 1987 \$1,000,000

4. Family Planning Services (The Pathfinder Fund) Project
932-3042

Supports a number of private sector family planning organizations which carry out a wide range of family planning activities.

Estimated Expenditures FY 1987 \$500,000

5. Family Planning Enterprise Project 936-3034

Assistance to ABEPF to help improve financial and human resource planning and make cost effective use of resources.

Estimated Expenditures FY 87 \$200,000

6. Expansion of Family Planning Programs (IPPF/WHR) Project
936-3043

WHR provides support to BEMFAM's CBD training and service program geared to the Northeast

Estimated Expenditures FY 1987 \$1,600,000

7. Family Planning Logistics Management (John Snow) Project
936-3038

John Snow will assist BEMFAM and CPAIMC to develop an improved management information system for commodities.

Estimated Expenditures FY 1987 \$100,000
=====

TOTAL SERVICES \$5,200,000

INFORMATION AND TRAINING

1. Training in Reproductive Health Project 932-0604 I and Project 936-3045 II (JHPIEGO)

Support short term educational programs for health personnel in reproductive health with a focus on pre-service education working with SAMEAC, BEMFAM and CPAIMC

Estimated Expenditures FY 1987 \$1,070,000

2. Population Communication Services (PCS) Project 936-3004

Assist ABEPF with development of printed and audio visual materials on family planning

Estimated Expenditures FY 1987 \$150,000

3. Paramedical, Auxiliary and Community Workers Training (PAC II) - Develoment Associates (DA) Project 936-3031

Support non physician training of health workers, specifically with BEMFAM, CPAIMC and CAEMI

Estimated Expenditures FY 1987 \$320,000
=====

TOTAL TRAINING \$1,540,000

Strategies for Improving Service Delivery (SISD), Project No. 936-3030, 1984-1988.

Estimated expenditures for FY 1988 are \$150,000.

Natural Family Planning (NFP), Project No. 936-3040, 1985-1990.

Estimated expenditures for FY 1988 are \$25,000.

Contraceptive Research and Development (CONRAD), Project No. 936-3044, 1986-1990.

Estimated FY 1988 expenditures are \$87,000.

Family Planning Services

Family Planning International Assistance (FPIA), Project No. 932-0955, 1971-1987.

Estimated FY 1988 expenditures are \$905,000.

Family Planning Services, The Pathfinder Fund, Project No. 932-3042, 1968-1990.

Estimated expenditures for FY 1988 are \$600,000.

Program for Voluntary Sterilization, Project No. 932-0968, 1972-1988.

The project end date was extended from June 1987 to June 1988.

Estimated expenditures for FY 1988 are \$595,000.

Contraceptive Social Marketing, Project No. 936-3028, 1984-1988.

Estimated expenditures for FY 1988 are \$500,000.

Family Planning Enterprise, Project No. 936-3034, 1985-1989.

Estimated expenditures for FY 1988 are \$200,000.

Expansion and Improvement of Family Planning Programs, Project No. 936-3043, 1985-1992.

The project end date was extended from September 1987 to September 1992.

Estimated expenditures for FY 1988 are \$1.2 million.

Family Planning Logistics Management, Project No. 936-3038, 1986-1992.

Estimated expenditures for FY 1988 are \$34,000.

Information and Training

Training in Reproductive Health, Project No. 932-0604, 1973-1987.

Estimated expenditures for FY 1988 using FY 1986 funds are \$150,000.

Training in Reproductive Health II, Project No. 936-3045, 1987-1992.

Estimated expenditures for FY 1988 are \$350,000.

Population Service Information Program (PIP), Project No. 936-3032, 1984-1992.

The project end date was extended from August 1987 to August 1992.

Estimated expenditures for FY 1988 are \$95,000.

Population Communication Services (PCS), Project No. 936-3004 1983-1991.

Estimated expenditures for FY 1988 are \$250,000.

Paramedical Auxiliary and Community Family Planning Personnel Training II, (PAC II), Project No. 936-3031, 1984-1988.

Estimated expenditures for FY 1988 are \$160,000.

Family Planning Management Training, Project No. 936-3039, 1985-1990.

Estimated expenditures for FY 1988 are \$300,000.

Family Planning Worldwide Training Funds, Project No. 932-0651, 1972-1988.

This project has been extended from 1987 to 1988.

Estimated expenditures for FY 1988 are \$40,000.

RIO DE JANEIRO

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BENFAM- Sociedade Civil Bem-Estar Familiar do Brasil
Society of Family Welfare in Brazil

Dr. Marcio Schiavo, Executive Director
Dr. Jose Maria Arruda, Coordinator of Research Division
Dr. Carmen Gomez, Coordinator of Program Planning Department

ABEPF- Associacao Brasileira de Entidades de Planejamento Familiar
Brazilian Association of Family Planning Agencies

Denise Chagas Leite, General Coordinator
Rosele Ciccone Paschaolick, Project Coordinator
Ilka Maria Rondinelli, Training Project Coordinator

CPAIMC- Centro de Pesquisas de Assisstencia Integrada a Mulher e
a Crianca
Center for Research in Integrated Assistance to Women and
Children

Dr. Helio Aguinaga, Director and President
Dr. Lia Kropsch, General Coordinator
Dr. Maria Goncalves, Coordinator of Planning

O SEGUNDO BRASIL

Dr. Manoel Costa, Director

AMERICAN CONSULATE

Alfonso Arenales, Consul General
Jack Gilbride

SAO PAULO-

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SECRETARY OF HEALTH FOR SAO PAULO MUNICIPALITY

Dr. Fernando Mauro

FONTOURA-WYETH LABORATORIES

Dr. Luiz Osorio Nogueiria, Director of Marketing Planning

EDITORIA ABRIL

Dr. Roberto Civita, Director

CENTER FOR FAMILY PLANNING

Dr. Milton Nakamura, Director

JOHNSON & JOHNSON

Rubens Occhine, Chief of Pharmaceutical Contraceptive Marketing

ASSISTANT SECRETARY OF HEALTH FOR THE STATE OF SAO PAULO

Dr. Enio Duarte (The Secretary is Dr. Aristodemo Pinotti)

PROPATER-

Dr. Marcos Castro, President
Ms. Bernadete Castro, Assistant

SCHERING (BERLIMED)

Dr. Stefan Seeger, Director

CLNPLAFAN (Natural Family Planning)

Sister Martha Silvia Bhering

AMERICAN CONSULATE-

Stephen Dachi, General Consul
Donna Hrinak, Political Officer

CAMPINAS

CEMICAMP

Dr. Anibal Faundes, Director
Ms. Laura, Head Nurse

CAEMI

Dr. Conceicao Resende, Director

LONDRINA-

CLAM- Conselho Londrinense de Assistencia a Mulher
Londrina Council for Women's Assistance

Dr. Joao Fernando Goes, Medical Director
Dr. Margarida Goes, Executive Administrator

BELO HORIZONTE-

CEPECS-

Dr. Antonio Neto, Supervisor of FPIA program
Dr. Roberto Peixota, Coordinator of FPIA program
Dr. Delzio Bicalho, President

SOFIA FELDMAN-

Dr. Ivo de Oliveira Lopes, Director
Dr. Lili Lopes, Assistance Director

SALVADOR

PATHFINDER

Dr. Jose de Codes, Pathfinder Representative

CPARH

DR. Elsimar Coutinho, Director (and President of ABEPF)

RECIFE-

BENFAM/CAISM- Centro de Assistencia Integral a Saude da Mulher
Center of Women's Integrated Health Assistance

Denise ZP Barbosa, Executive Coordinator
Aida El Deir, Assistant Coordinator
Dr. Carlos Carneiro, Resident Physician

HUMAN REPRODUCTION INSTITUTE OF PERNAMBUCO-

Dr. Weydson Leal, President, BENFAM associate

FEDERAL UNIVERSITY OF PERNAMBUCO, CENTER OF HEMOTOLGY AND HEMOTHERAPY

Dr. Belarmino de Siqueira Carneiro, Professor of Infectious Disease
Dr. Aderson Araujo, Director of hematology laboratories
Dr. Paulo Loureiro, Coordinator of Hemophiliacs with AIDS program

AMERICAN CONSULATE

Donald Stader, General Consul
Ed Bakota, Head of USIS

FORTALEZA-

BENFAM branch

Dr. Aldamara de Souza Costa, Director
Angela Dias de Macedo, Director of Health Foundation
Dr. Antonio Jose, BENFAM physician

PROJECT HOPE-

Dr. Jay MacAuliffe, Director of HOPE/Fortaleza
Dr. Marilyn Nations, Assistant Professor of Medical Anthropology,
Project Hope researcher

SAMEAC-

Dr. Sylvia Bonfim, President of SAMEAC and Second Secretary
of ABEPF

FEDERAL UNIVERSITY OF CEARA-

Dr. Helio Leite, Rector of university
Dr. Malbio Roblim, Coordinator of PROAIS project
Dr. Claudio, Director of Health Services Center

BRASILIA-

PROFAMILIA-

Ana Maria Mendonca, Director

UNICEF-

Cesare de La Rocca, Deputy Representative
John Donohue, Representative

MINISTRY OF HEALTH

Dr. Joao Bosco Renno Salomon, Coordinator for
International Programs