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TRIP REPORT TO PERU.

FROM: MARIA DE TANCO

DATES: October 23, 1982 - November 13, 1982.

PURPOSE: To evaluate the progress of Project OPG No. 527-0228.

OBJECTIVE: Evaluate the Progress of the Project OPG No. 527-0228

Evaluate the Instituto Marcelino performance.

A. Project OPG No. 527-0228.

Background.

In 1979 a project extension for family planning services of Instituto Marcelino was designed to cover two areas outside of Lima.

The project included the establishment of two gynecological and family planning service clinics outside of Lima and the organization of a community based distribution program.

Chiclayo and Arequipa were chosen in view of the fact that family planning services were not available in those cities at the ~~present~~ time and because there are areas of geographical influence.

The project objectives were to provide family planning education and services as well as to demonstrate to the government and other private organizations the feasibility of carrying out CBD projects. At the same time, the creation of a national level infrastructure to offer services outside of Lima was contemplated to further motivate and extend the project to other areas.

The Instituto Marcelino project should be completed with a technical assistance component to improve the administration and, in this way, strengthen the institution, which at the time of project inception did not have an efficient administrative structure to handle different projects. We will refer again to this point later in the report.

The project started in November 1980 with the contracting of a coordinator, Teresa Watanabe, nurse and sociologist, who was selected for her efficient organization and management of a health center, which had a great community component.

The steps taken for the implementation of the clinic and the distribution component are described in the report presented to AID by the project coordinator, and some of its problems are mentioned in my technical assistance report of July 1980.

In short, the project had several problems during its implementation:

a) Difficulty in finding personnel willing to collaborate, especially physicians and social workers.

b) Lack of knowledge of project methodology on the part of the coordinator and failure to request technical assistance at the beginning of the project.

c) The inefficient administrative organization of the Institute and their incapacity to reorganize resulted in the absorption by the coordinator alone of the whole project implementation.

d) Time devoted to administrative tasks, such as obtaining the license to operate, customs, etc.

e) Opposition found among officials from the Ministry, journalists and community leaders in Arequipa and Chiclayo.

f) Difficulties in entering the equipment and contraceptives methods which are still in customs.

All the above mentioned obstacles resulted in a delayed project implementation (6 months later than scheduled). Therefore, the clinics started operations in April 1981 in Arequipa and in May 1981 in Chiclayo. With regard to the CBD component, the promoters were trained as late as July and the first training course for distributors was held in August.

In view of the above, in evaluating the project, consideration should be given to the fact that the project was totally implemented in October 81.

FINDINGS.

1. Arequipa Clinic: The clinic is located in a central area near the hospital and other clinics. It has easy access from any other zone.

. The site is large and has a clinic implemented with the necessary equipment to offer gynecological and family planning services. It opens to the public from 1:30 to 7:30. It has 4 hours of medical attention. Personnel includes two nurses trained in IUD insertion at the Marcelino Institute in Lima.

The attention received by patients is reported to be good, although some complain that the doctor is not always as communicative as they would like.

Clinical histories and reporting system are well organized, nevertheless, it can be simplified when the number of patients increases.

Personnel knows the project and is well motivated, with the exception of the physician who seems to have lost interest and apparently has not identified himself as the project director.

The clinic offers gynecological and family planning services, including PAP smears and cauterizations, which has become really necessary in view of the high percentage of women with cervix ulcers.

Methods used at present include Noriday, condoms, Lippes loops, Copper-T and Nova-T. There is a great demand for Copper-Ts, but the price is high because it is bought from Schering. They do not have other local methods or injections, which limits the number of methods offered.

In 1981, the demand at the clinic raised from 9 in April to 279 in November and 310 in December, i.e. an increase of 344%. (See Table 3). Of the total medical consultations in this year, only 25% were family planning. This percentage increased to 32% in 1982.

The number of IUD users also increased from one in April to 23 in December. (The four ALAFARPE clinics in Lima, after 4 years operation, have at the present time an average of 33 new IUD users per month).

However, as of January 1982, the number of medical consultations decreased and does not continue to show the increment of 1982. In the 9 months of this year (Table No. 3), only a 4% increase is evidenced compared with 1981. New IUD users show a decrease of 24% in comparison with 1981.

The above mentioned situation can be explained as follows:

1) Decrease in quantity and quality of promotion and educational activities within the community.

When the CBD program is analyzed later in this report, it will be noted that these activities show a

diminished level in 1982.

2) Initiation of a family planning program by the Health Region as of February, offering IUD insertions and pills at no cost. It should be noted that there are many health centers in Arequipa's pueblos jóvenes, which distribute Noriday and insert IUDs free of charge.

However, we believe this project does not account for the low demand during the first months of this year, in view of its moderate impact in the community. We were informed confidentially that the number of new IUD users is approximately 1,330 and 300 pill users, which, in our opinion, is not of such a magnitude as to seriously affect the Marcelino project.

In Arequipa there is another F.P. clinic paid by INPPARES. In conversations with INPPARES, I found out they are going to start a CBD in Arequipa and improve their project.

Under these circumstances there are three alternatives:

1. Close Marcelino project
2. Close INPPARES project
3. Join efforts and do only one project.

Dr. Ramos, INPPARES Executive Director favors having only one project. Unfortunately Dr. Larrañaga was out of Lima, but the project coordinator agrees.

Next week they plan to have a meeting with AID as an intermediary, and it is very important they reach an agreement on the way Arequipa should be continued.

With regard to the capacity to generate its own resources, the same tendency as in the case of medical consultations is shown, a strong increment in 1981 and a standstill in 1982. Comparing the recuperation rates in September 1981 and September 1982, we find the difference is only 8% more for the last year.

The percentage which would permit financing of the clinic as of October 82, is only 23%. If a cash budget is made and supposing a strong increase in demand takes place, it would only finance 58% at the end of 1983.

Community Based Distribution.

The CBD component is managed by a social worker who attended a training course in Guatemala.

Fifteen promoters were trained at the beginning of the project. They were considered as volunteers and received a bonus. Unfortunately, this arrangement did not work out and little by little the number of promoters was reduced to reach only two, that remain at the present time.

With reference to the social worker, it was found that she was not really able to create a community distribution program. She had developed a poor relationship with the promoters and tried to exercise an excessive control over them, thereby limiting their task. The relationship with the distributors was not good either.

For example, the promoters indicated that until December 1981, their work was going very well, but after that time they could not develop their initiative, as they were asked to do only what the supervisor demanded, mainly concentrating on coordination, i.e. inspection visits to a pueblo joven. She transferred the promoters from one zone to another, thus preventing them from carrying out an intensive task in a given zone. The supervisor did not allow the promoters to make motivation visits which, in the promoters' opinion, is of great assistance in their work. This fact is evidenced in the decline of educational activities, such as talks and motivation visits, and the increase in the number of coordination visits (Table 8).

The promoters also commented on the arrogant attitude and poor empathy displayed by the social worker in her relations with the people at the pueblos jovenes.

The promoters are leaders with authority in their pueblos jovenes. They show a positive attitude towards family planning and the project, but unfortunately have not been given the opportunity to perform at a higher level of capacity.

These deficiencies in the educational and promotional activities coincide with the decrease in demand, which may indicate a relation between these two factors.

On the other hand, the IE & C performance lacked initiative in looking for support from other organizations or media, as radio, press, etc. Furthermore, the project does not have educational materials.

The project has at the present time only 23 distributors working in their homes. After a supervision visit, it was found that they had not received an adequate motivation towards family planning, are not identified with the Institute, there exists a poor relationship with the supervisor, and only a few had received attention at the Institute. They indicated that the lack of sales was due to the fact that the Health Centers were distributing contraceptives free of charge and also that Noriday was not well tolerated by women.

At this moment the project only has Noriday and condoms at a community level, which offers women a very limited choice.

As to the recording system, the promoters and distributors found great difficulty in filling out the forms. It has now been reduced to a notebook where they write down the name of the user and whether she is new or active. In the personnel's point of view, the carrying out of this system proved to be troublesome.

In viewing the number of new and active users (Table 6), a strong reduction can be noted from one year to another. While in 1981, during a four month period there were 79 new users, in the first nine months of this year there were only 35.

Finally, it is worth mentioning that the CBD component was limited to the urban area.

The CBD component could only finance 0.4% in October 81, but if goals are accomplished, it can support 58%.

In general, it can be concluded that even though the project shows deficiencies, especially in the community-based distribution component, a medical service was established, the organization is well known, there is an infrastructure, and there are some motivated individuals that can fulfill their objectives, provided changes stated in the recommendations are made, not only to offer IE & C and education in Arequipa, but possibly to serve as a base center to introduce this type of service in rural areas.

Although the project did not comply with its objectives, we have to consider family planning private programs within the Peruvian context, handled by different small organizations, without administrative personnel, with little or no technical assistance, and limited funds for educational and

promotion materials. These institutions have to start with the creation of an image and confidence within the community. Generally, one person acts as messenger, secretary, educator, and also has to elaborate the technical norms. Under these circumstances, it cannot be expected that the results be the same as in countries where family planning is managed by organizations which for years have been working on the creation of an image, have administrative personnel, technical assistance, etc.

In view of the above, I believe this project should not be deprived from support, but, on the contrary, full consideration must be given to support this effort and take advantage of the effort that has been made.

CHICLAYO

Clinic

The Chiclayo Clinic is very well located in a new building in the center of the city. It has large rooms and an adequate display.

It has only one room for medical attention with the necessary equipment to offer gynecological and family planning services.

The clinic opens from 2 to 8 with 5 hours medical attention. It has an auxiliary nurse and a secretary, both of them very well motivated, offering a very good attention to patients. They are being trained to do IUD control, but do not make insertions.

The clinic has moved three times since its inception, mainly due to problems with the landlords, whose economic demands the Institute was not able to meet. These changes have evidently upset the clinic's activities. This has also represented additional efforts to inform the community of these changes.

On the other hand, the clinic had problems with the doctors, since it is very difficult to find in Chiclayo a doctor without a heavy schedule, who is willing to work and is able to accept criticism against the Institute. They hired obstetricians, but this presented problems of a technical nature, i.e. indiscriminate insertion of IUDs, deficient insertions, etc.

At the present time, they have two doctors working 2 and 3 hours, respectively. During the supervision visit, the first of them was late on two occasions and did not show up one day.

The clinic offers the same services as the one in Arequipa and also gives pregnancy attention in order to attract patients during pregnancy. They also have an arrangement with a pediatrician to refer patients to the clinic.

It offers the same methods as in Arequipa, plus the injection because of its great demand. They buy it from Schering.

Demand for medical attention at this clinic had a result opposite to that in Arequipa. During the first year the demand was low, the second year it increased gradually. In 1981 the number of medical consultations was 624 while in 1982 it reached 1,900, i.e. an increment of 208%. This increase is maintained throughout the months. In October it shows a 6% increase in relation to September.

Of the total medical services offered in 1981, 33% were family planning, while in 1982 it went up to 52%, which indicates that the family planning objective was met.

With reference to the number of new users, there has also been a 71% increment in 1982, as compared with 1981. However, it is interesting to note the differences in the number of new users month to month, depending on the doctor in charge, which may indicate the level of conservatism on the part of doctors with respect to IUD insertions.

Own resources generated by the clinic amounted to S/.191,808 in 1981, compared with S/.1,309,135 in 1982.

Comparing income with expenditures, 52% of total operation costs could be financed in October.

Supposing the clinic reaches an objective of 500 medical consultations, estimating an average of 5 per hour, and provided the forecast proves to be accurate, 65% of the expenses could be financed at the end of the period.

The promoters and distributors considered the medical attention cost to be reasonable for the community.

Competition with the Ministry of Health, which also has an IUD insertion program and distributes pills free of charge, was not reported to be a great obstacle to fulfill the objectives, except in some cases.

Community Based Distribution.

The CBD component is handled at present by a sociologist who started her duties in July. This position has been filled by several individuals that have resigned for different reasons. As a result of this, the promoters have been without supervision for a period of time.

There are now three promoters who initiated the project and attended a training course in Lima in July 1981. The three are excellent, with a good attitude towards the Institute and family planning, know the different methods and have continued in-service training.

A very good IE & C task has been accomplished thanks to which the Institute is well known and has good standing in Chiclayo. For example, taxi drivers would know perfecly the place on our request. The promoters have a radio program every Sunday. Leaflets prepared by themselves are distributed, bearing a rubber stamp in view of lack of educational materials in the project.

At present they have 53 posts. These are located in small shops, dressmakers' workshops, or at home, that offer injection services, although no announcement or propaganda of the project or family planning was found at those places. Identification and respect for the Institute was observed in the distributors, as well as a very positive attitude towards family planning. They all seem to have the characteristics necessary to make a good distributor. None of them reported Noriday's problems among women.

The number of new users is modest. There is an increase from one year to another (Table 6) but in reviewing each month, there has been a drop in the last months. However, the number of active users increases every month.

On the other hand, the number of pill cycles and condoms sold has increased 50% from one year to another and continues to increase every month. (Table 4).

It is difficult to have an explanation on the low demand for contraceptives from distributors, given the quality of the project. We believe the distributors need more reinforcement to start selling in a more aggressive fashion.

Methods available are the same as in Arequipa, condoms and Noriday only; some have injections but these are very expensive.

As for the reporting system, it has also proved difficult to teach promoters to keep a register of new and active users.

B. Instituto Marcelino - Lima.

As mentioned before, Instituto Marcelino did not have an organization capable of observing more activities than the clinic they run in Lima. For this reason, along with the project, the Instituto received a technical assistant in administration to refashion the whole organization.

The idea was to strengthen an organization that could be a leader for the F.P. private sector. Because the FP projects in Perú are developed for many small organizations or even for individuals, that makes projects expensive, low coverage and not self-supporting.

Unfortunately, the reorganization failed for many reasons:

1. The technical assistant did not offer follow-up to Instituto.

2. An observation trip requested for two persons from the Instituto to visit FP organization in LA never was given.

3. The difficulties posed by the MOH to get equipment and contraceptives out of customs and the lack of help in this regard from AID.

This last point was very important in discouraging Dr. Larrañaga in two projects, one to distribute contraceptives to private doctors and the other, a sterilization center, where it was impossible to start activities.

The Marcelino continued as it was and the OBG was handled by the coordinator completely independently and isolatedly. During this visit, one of the tasks was to integrate the Central Marcelino with the affiliates and make them feel responsible too for the project progress.

The main activity of Marcelino is a family planning clinic located in a populous low income suburb in Lima. The clinic is self-supporting. It attended an average of 2,789 consultations a month and 298 new users in 1981; 2,946 consultations and 212 new users in 1982. The clinic was reorganized during the visit in October but still needs some changes especially in the quality of attention given to patients. They do not carry out any IE & C activities or promotion in communities.

Besides the clinic, Marcelino runs other special projects:

1) For two years they received a grant from Pathfinder to train doctors and midwives from MOH or private doctors. The project was well organized and accomplished the goals. The follow-up visit shows that many of the doctors are doing F.P., for example, Mr. Danart from AID in his recent visit to Ica mentioned that many doctors were trained at Marcelino and commended the high quality of the training they received.

2) The other project is to loan films and books donated by AID, to different organizations. The film loan is very high and going on well. They ran out of books a long time ago and asked AID for more, but they have to present a report in order to get them.

3) As a consequence of projects carried out with persons, Pathfinder had a FP clinic in Chimbote with Dr. Gilberto Arias, who one day decided to move to Lima and pack the clinic. After that experience, Pathfinder transferred the project to Marcelino, who is trying to revive it.

Luckily during the meeting with INPPARES we found out they were going to start a CBD project in Chimbote. One example of lack of coordination between FP groups is that INPPARES did not know about Marcelino clinic in Chimbote, but now they should work together.

4) Sterilization Service. The whole place is fully arranged for doing ambulatory sterilization but the MOH has not given the authorization yet after one year, for unknown reasons. Dr. Larrañaga is afraid to go on without MOH license.

5) Contraceptive distribution to private doctors, a project approved by Pathfinder, could not start because MOH did not permit the contraceptives to get into the country. Dr. Larrañaga is not interested in the project any longer.

At this moment Dr. Larrañaga needs to appoint an Assistant Director to help him in the administrative task. Dr. Larrañaga is a poor administrator. The Assistant Director could be Dr. Hurtado who has been some kind of a coordinator.

Dr. Hurtado is a good administrator but has poor human relations. In conversations with him he said that he wants to revive the organization project made one year ago and is willing and very enthusiastic to go ahead. The problem is Dr. Larrañaga, who is not very enthusiastic about going ahead with the plans, so what we can try to get out of Marcelino is just that he run well the projects they have now.

Recommendations:

1. Extend the project support for 12 months more using the money left. Marcelino would receive the same amount in soles for the 12 months and the salary and cost increases should be covered by the project to encourage the personnel according to the income generated.

2. AID should have a strategy to work in FP in private sectors, and coordinate, support or eliminate some of all the isolated efforts going on.

3. AID might try to help Marcelino to get the equipment and contraceptives out of customs.

4. Supervise the project progress monthly and give continued technical assistance to project and to Marcelino-Lima.

5. In the coordination between Marcelino and INPPARES for the Arequipa projects, AID should be the third party. in order to to decide if the join efforts or other way of cooperation

6. Make an amendment to the Contract and recognize the Coordinata and rent payments.

7. Recommendations to Marcelino:

   a) Appoint an assistant director and try to implement the reorganization plan designed last year.

   b) In order to integrate the OBG into Marcelino, Teresa Watanabe, OBG, Project coordinator, should have an office in Marcelino and not in her house. She should cooperate, besides the project, in the IE & C and community work in Marcelino Lima and direct the films and movie center.

c) In order to improve the films and movie center, Watanabe should make an inventory of the films:

- Send a letter to different organizations offering service.

- Charge a small amount.

- Present the report to AID

- Request more publications.

d) A doctor from Marcelino Lima should supervise the regional clinics twice.

e) Marcelino should delegate the different project administration tasks in one person and not each project coordinator be the secretary, clerk, etc.

f) Marcelino has to push the Minister in order to get permission to start sterilization projects.

g) Teresa Watanabe should spend three weeks in Arequipa and two in Chiclayo before 1982 ends.

h) Improve the quality of information and attention to patients in Lima clinic.

8. Recommendations for Arequipa:

Community Based Distribution:

a) Meet with INPPARES to study the way the two projects can join, or another way of cooperation.

b) Replace the supervisor with the nurse who is presently working at the clinic.

c) Have the nurse come to Lima to observe existing CBD programs.

d) See that three well-motivated promoters are given uniform and social security.

e) Change working system in the community, so that promoters have flexible working hours, assignments by zones, motivation visits, talks, etc.

f) Open at least 45 posts, 20 in Arequipa and the rest in rural areas near the city.

These posts can be small shops, nurses and midwives' homes, or first aid posts,near or in front of factories.

Posts must be far from Ministry of Health centers.

Personnel must receive adequate motivation towards family planning so that they identify themselves with the Institute, are accepted in their communities and hopefully are contraceptive users.

The promoters must encourage and develop a special relationship with the distributors to obtain their full identification and a "love" attitude for the Institute.

g) Offer free medical attention to the distributors so that they get first hand experience and can recommend it.

h) Training of distributors must be made through frequent visits by the promoters. Once a well-motivated group is gathered, which have previously received family planning information, training can take place in one afternoon.

i) Increase the number of methods offered by distributors through Neosampoon which the Instituto Marcelino has in Lima. Talk to Schering and explore the possibility of buying Neogynon and injections to sell at the posts.

j) Set up goals for cycles sold: Example: 5 cycles per month by post. The following months increase 5 by 5.

Condoms: 15 the first month by post, and after that increase 5 by 5.

If Neosampoon is available, it must be 3 by post, increasing monthly 1 by 1.

k) Promoters must contact doctors and midwives in zones where distribution is made and encourage them to buy contraceptives at the Institute. In order to implement this, it is necessary to have Copper Ts, which may be obtained through Pathfinder.

l) Monthly evaluation to determine if goals have been reached, and to take necessary measures otherwise.

m) An AID evaluation must be carried out after 6 months. Suspend the project in case objectives have not been met.

n) A time schedule was elaborated, which in accordance with activities must be completed in November.

n) Increase IE & C activities.

o) Change the statistics systems and only control number of cycles distributed and other methods.

Clinic.

a) Study the possibility to open the clinic in the mornings. This can be worked out with a doctor offering him to keep for himself part of the fees charged.

b) Goals were set up on the basis of 6 hours, 4 doctors and 2 nurses. This represents 25 medical consultations daily, 500 per month, 55% of which is obtained at present. Of these 50% are gynecological and 50% family planning, with a goal of 40 IUD users per month.

c) Reduce the amount charged for services at the clinic, so that it would be accessible for pueblo joven users.

d) Leave two rates, one for urban people and the other for pueblos jóvenes.

e) Offer pregnancy control services, according to recommendation made by MOH to Marcelino Lima.

8. Recommendations for Chiclayo.

Community Based Distribution.

1. Schedule more working hours for each promoter, so that they reach a minimum of 8 hours.

2. Increase number of distributors to 60. An evaluation of distributors presently working must be made first to leave only the best. Of the total of distributors 40 must be assigned to Chiclayo and 20 to nearby areas.

3. Demand more from distributors through the setting of goals. For example: Pill cycles: 10 by distributor, increase from 5 to 5, starting in November.

   Condoms: 20 increasing from 10 to 10 in November.
   Injections: 3
   Neosampoon: 2

4. Coordinator's visit to Lima to observe CBD projects.

5. Monthly evaluation of goals. Make wall poster to be seen by all personnel.

6. Give free medical attention to distributors.

7. Selective supervision every 2 months in accordance with distributor performance.

8. Users recording will be limited to the writing down of the number, the name of user and the method purchased.

9. Make a sample set of the different methods and a poster for distributors.

10. Detect doctors and midwives. Offer them contraceptive methods.

11. Eliminate follow-up visits. Give greater emphasis in motivating the woman when she requires the service, so that she continues to be an active user.

12. Coordinate with factories, unions, cooperatives, etc. to give talks and offer services to these groups.

CLINIC

1. Delegate IUD control to auxiliary nurse.

2. Study possibility to open clinic in the morning.

3. Set up goals at the clinic:

   500 medical consultations - of these 60% must be family planning. A goal of 40 new users by month.

4. Give training charging a fee.

5. Make arrangements with institutions to offer medical services to their employees.

6. The Marcelino Institute in Lima must make a supervision visit to define technical norms.

7. Do not make follow-up visits. Give greater emphasis to the motivation and information given the woman when she approaches the clinic, so that she does not leave the method.

8. Pay doctors a percentage on medical service fees.

TABLE No. 1

New users in Clinic by year.

Year	Arequipa					Chiclayo				
	IUD		Pills/ other		Total	IUD		Pills/ other		Total
	No.	%	No.	%	No.	No.	%	No.	%	No.
1981	150	80	38	20	188	89	77	26	23	115
1982	119	93	8	7	122	180	91	17	9	197

TABLE No. 2.

Consultations by clinic and year

Year	Arequipa Consultations					Chiclayo Consultations				
	F.P.		Gynecol.			F. P.		Gynecol.		
	No.	%	No.	%	Total	No.	%	No.	%	Total
1981	400	25	1197	75	1,597	210	34	414	66	629
1982	527	32	1134	68	1,661	982	52	236	48	1,900

TABLE No. 3.

Consultations by quarter by clinic in Arequipa and Chiclayo

	Arequipa		Chiclayo	
	No.	%	No.	%
2nd qrt.81	167	-	65	-
3rd qrt.81	655	+ 192	182	+ 180
4th qrt.81	775	+ 18	377	+ 107
1st qrt.82	607	- 22	595	+ 58
2nd qrt.82	504	- 17	557	- 6
3rd qrt.82	550	+ 9	748	+ 34

TABLE No. 4

Pills and IUDs distributed by quarter in Arequipa and Chiclayo.

	Arequipa				Chiclayo			
	IUDs		Pills		IUDs		Pills	
	No.	%	No.	%	No.	%	No.	%
2nd qrt. 81	15	-	24		14		8	
3rd qrt. 81	67	+346	73	+204	32	+128	114	+1325
4th qrt. 81	68	+1.5	249	+241	48	+ 50	294	+ 158
1st qrt. 82	51	- 25	181	- 27	94	+ 96	397	+ 35
2nd qrt. 82	28	- 45	139	- 23	57	- 39	497	+ 25
3rd qrt. 82	35	+ 25	105	- 24	32	- 44	628	+ 26

TABLE No. 5.

Condoms distributed by quarter in Arequipa and Chiclayo

	Arequipa		Chiclayo	
	No.	%	No.	%
2nd qrt. 81	138		12	
3rd qrt. 81	51	- 63	268	+ 2,133
4th qrt. 81	1,494	+ 2829	1452	+ 442
1st qrt. 82	1,016	- 32	952	- 32
2nd qrt. 82	836	- 18	1354	+ 42
3rd qrt. 82	804	- 4	1717	+ 27

TABLE No. 6.

New users of all methods by quarter

by Clinic and C.B.D. in Arequipa and Chiclayo.

	Arequipa				Chiclayo			
	Clinic	CBD			Clinic		CBD	
	No.	%	No.	%	No.	%	No.	%
1981 1st.qt.	188	-	79	-	115	-		
1982 2nd.qt.	51		18		95		79	
1982 3rd.qt.	34	- 33	16	- 11	62	- 53	101	- 28
1982	35	+ 3	1	- 94	37	- 40	59	- 42

TABLE No. 7

Income*generated by quarter in Arequipa and Chiclayo

	Arequipa		Chiclayo	
Quarters.	No.	%	No.	%
2nd qt. 1981	80,000		33,800	
3rd qt. 1981	378,350	+ 373	127,050	+ 276
4th qt. 1981	709,825	+ 88	306,150	+ 141
1st. qt.1982	608,000	- 14	583,025	+ 90
2nd. qt.1982	651,425	+ 7	525,275	- 10
3rd. qt.1982	738,225	+ 13	875,855	+ 67

* Gross Income

TABLE No. 8

I. E. & C. Activities by quarter in Arequipa and Chiclayo.

Period	Arequipa				Chiclayo			
	Motivation		Talks		Motivation		Talks	
	No.	%	No.	%	No.	%	No.	%
2nd.qrt. 81	-	-	10		-		22	
3rd qrt. 81	857		43	+ 330	1501		60	+ 173
4th qrt. 81	1232	+ 44	68	+ 58	3457	+130	88	+ 47
1st qrt. 82	848	- 45	11	- 84	2389	- 31	7	- 92
2nd qrt. 82	4045	+377	17	+ 55	1714	- 28	3	- 57
3rd qrt. 82	649	- 84	33	+ 94	4086	+137	16	+ 81

* Promoters think they report as motivation visit only distributing publicity.

TABLE No. 9.

PROJECT BUDGET FLOW - NOV. 1982 - OCT. 1983.

AREQUIPA	1st. qrt.	2nd qrt.	3rd. qrtr.	4th qrtr.
Income	905,775	1,681,200	3,205,500	3,911,000
Expenditure	4,232,730	5,180,076	6,043,907	7,042,421
Deficit	(3,326,955)	(3,498,876)	(2,838,407)	(3,131,421)
% Self support	12.5%	32.4%	53.%	55%
CHICLAYO				
Income	1,610,676	2,584,500	3,561,000	3,876,000
Expenditure	3,875,014	4,875,555	5,623,584	6,275,447
Deficit	(2,264,338	(2,291,055)	(2,062,584)	(2,399,447)
	3,743,013	3,743,013	3,743,013	3,743,013
% Self support	41.5%	53%	63%	62%

TABLE No. 10

BUDGET FLOW FOR AREQUIPA - COMMUNITY BASED DISTRIBUTION

November 1982 - October 1983.

INCOME	October	Nov-Dec-Jan.	Feb.-Mar-Apr.	May-Jun-Jul.	Aug-Sep-Oct.
Orals	1,200	101,250	286,875	870,000	1,125,000
Condoms	2,800	49,875	95,625	210,000	270,000
Other		76,500	76,500	126,000	126,000
Total	4,000	304,125	459,000	1,206,000	1,521,000
EXPENDITURE.					
Salaries	382,700	1,148,100	1,377,720	1,584,378	1,822,035
Benefits	114,810	344,430	413,316	475,313	546,610
Transport.	24,000	72,000	86,400	103,680	124,416
Educ.Mater.		60,000	72,000	86,400	103,680
Total	520,810	1,624,830	1,949,436	2,249,771	2,596,741
	(516,810)	(1,320,705)	(1,490,436)	(1,043,771)	(1,075,741)
	0.76%	22.9%	24%	54%	58%

TABLE No. 11

BUDGET FLOW FOR AREQUIPA - CLINIC

November 1982-October 1983

INCOME	October	Nov-Dec-Jan.	Feb-Mar-Apr.	May-Jun-Jul.	Aug-Sep-Oct.
Consultations	107,900	191,100	525,000	1,015,000	1,200,000
Citologies	47,700	257,550	367,200	450,000	540,000
Biopsies					
Cauterizations	21,800	93,000	210,000	362,500	450,000
Methods	20,800	60,000	120,000	172,000	200,000
Total	197,200	601,650	1,222,200	1,999,500	2,390,000
EXPENDITURE					
Salaries	351,000	1,053,000	1,263,960*	1,453,554**	1,671,587**
Soc.benefits	105,300	315,900	379,080	435,942	501,333
Rent	216,000	648,000	777,600	933,120	1,100,600
Services					
Cleaning	129,000	387,000	464,400	556,800	668,160
Methods	14,500	--	--	--	--
Citologies	34,200	204,000	345,600	414,720	504,000
Total	850,000	2,607,900	3,230,640	3,794,136	4,445,680
Deficit	(653,000)	(2,006,250)	(2,008,440)	(1,794,636)	(2,055,680)
% self support	23.2%	23%	38%	53%	54%

* Everything increased 20%
**Salaries increased in 15%.

Table No. 12

BUDGET FLOW FOR CHICLAYO CLINIC

November 1982 - October 1983

INCOME	October	Nov-Dec-Jan.	Feb-Mar-Apr.	May-Jun-Jul.	Aug-Sep-Oct.
Consultations	207,500	705,870	1,000,500	1,245,000	1,245,000
Papanicolau	72,000	295,200	504,000	576,000	576,500
Cauterizations	12,000	90,000	255,000	324,000	324,000
Methods	38,200	128,106	150,000	165,000	165,000
Total	330,320	1,219,176	1,909,500	2,310,000	2,310,000
EXPENDITURE					
Salaries	357,194	1,071,582	1,285,898	1,431,750	1,646,512
Social benefits	107,158	321,474	385,769	443,634	510,179
Rent	100,000	300,000	300,000	370,000	370,000
Services					
Cleaning	66,885	200,655	240,786	288,943	346,732
Papanicolau	57,600	296,000	432,000	504,000	504,000
Methods	22,000	660,000	90,000	103,500	103,500
Pediatric Consult.	7,000	--	--	--	--
Total	717,837	2,205,711	2,734,453	3,141,827	3,480,923
Deficit	(387,517)	(986,535)	(824,953)	(831,827)	(1,170,923)
% Self support	46%	55%	70%	73%	66%

Table No. 13

BUDGET FLOW - CHICLAYO COMMUNITY BASED DISTRIBUTION

November 1982-October 1983

INCOME	October	Nov.-Dec-Jan.	Feb-Mar-Apr.	May-June-July	Aug-Sept-Oct.
Sales:					
Orals	27,795	202,500	405,000	810,000	1,125,000
Condoms		81,000	162,000	315,000	315,000
Neo Sampoon		54,000	54,000	7,200	72,000
Injections		54,000	54,000	54,000	54,000
Total	27,795	391,500	675,000	1,251,000	1,566,000
EXPENDITURE					
Salaries	340,334	1,021,002	1,225,202	1,408,983	1,620,330
Social benef.	102,100	306,300	367,500	422,694	486,098
Transportation	24,000	72,000	86,400	103,680	124,416
Rent	100,000	300,000	300,000	370,000	370,000
Educ. Material	30,000	150,000	162,000	176,400	193,680
Total	596,100	1,849,303	2,141,102	2,481,757	2,794,524
Deficit	(568,305	(1,849,303)	(1,466,102)	(1,230,757)	(1,228,524)
% Self Support	4.66%	21%	32%	50%	56%

CHICLAYO GOALS - NOVEMBER 1982-OCTOBER 1983.

Month	Pills	Condoms	Neosam.	Inject.	Consult.	Pap.	Caut.	IUD
Nov.	600	1,200	120	180	315	75	10	15
Dec.	900	1,800	120	180	350	84	10	20
Jan.	1,200	2,400	120	180	360	87	10	25
Feb.	1,500	3,000	120	240	450	120	25	30
March	1,800	3,600	120	240	500	120	30	35
April	2,100	4,200	120	240	500	120	30	40
May	2,400	4,200	120	240	500	120	30	40
June	2,700	4,200	120	240	500	120	30	40
July	3,000	4,200	120	240	500	120	30	40
Aug.	3,000	4,200	120	240	500	120	30	40
Sept.	3,000	4,200	120	240	500	120	30	40
Oct.	3,000	4,200	120	240	500	120	30	40

Unit Price $\bar{x}$ Consult.	Nov.-April	s/ 690
	May - Oct.	830
Papanicolau - Cost per	Nov-Jan.	1200
	Feb.-Apr.	1400
	May-Oct.	1600
Cauterization - Cost per	Nov-April	3000
	May-Oct.	3600
IUD -	Nov-May	1000
	May-Oct	1300
Cost per cycle	Nov.-Apr.	150
condoms	do.	30
Neosampoon	do.	300
Injection	Nov-Oct.	200 plus unit cost.
Cost per cycle	May to July	200
condoms		50
Neosampoon	May to Oct.	400
Cycles	July to Oct.	250
Condoms	July to Oct.	60

AREQUIPA GOALS - NOVEMBER 1982-OCTOBER 1983.

Month	Pills	Condoms	Neosam.	Inject.	Consult.	Pap.	Caut.	New IUD
Nov.	225	675	90	90	180	72	18	10
Dec.	450	1,125	90	135	208	83	20	15
Jan.	675	1,525	90	135	249	100	24	20
Feb.	975	2,025	90	135	300	120	30	25
March	1,275	2,100	90	135	350	120	35	35
April	1,575	2,250	90	135	400	120	40	40
May	2,700	2,400	120	180	450	120	45	40
June	3,000	3,000	120	180	500	120	50	40
July	3,000	3,000	120	180	500	120	50	40
Aug.	3,000	4,200	120	180	500	120	50	40
Sept.	3,000	4,200	120	180	500	120	50	40
Oct.	3,000	4,200	120	180	500	120	50	40

Cost- CBD - Same as in Arequipa.

			IUD
Cost per Consultation	Nov-Jan -	S/300	200
	Feb-April	500	400
	May-July	700	600
	Aug.-Oct.	800	800
Cost per Pap.	Nov.-Jan.	850	
	Feb.-April	1,020	
	May - July	1,250	
	Aug - Oct.	1,500	
Cost per Cauter.	Nov-Jan.	1,500	
	Feb-Apr.	2,000	
	May-July	2,500	
	Aug-Oct.	300	

PROJECT BUDGET IN US$

FOR NOVEMBER 1982 - OCTOBER 1983

	1st (1) quarter	2nd(2) quarter	3rd(3) quarter	4th(4) quarter	Total
Salaries:					
Arequipa	2,498	2,172	1,889	1,644	8,203
Chiclayo	2,375	2,066	1,796	1,563	7,800
Coordinat.	1,200	600	600	600	3,600
	150	150	150	150	600
Total					20,203
Fringe Benefits					
Arequipa	750	652	567	493	2,462
Chiclayo	713	620	539	469	2,341
Total					4,803
Rent					
Arequipa	735	640	556	484	2,416
Chiclayo	681	592	515	448	2,236
Total					4,652
Supervision					
Arequipa	100	87	87	87	225
Chiclayo	100	87	87	87	225
Lima	1,000	670	480	480	2,630
Total					3,080
Other Exp.					
Arequipa	507	442	384	334	1,667
Chiclayo	296	258	224	195	973
Total					2,640
Print.Mater.	2,000				2,000
Equipment	700				700
Total					2,700
		Grand Total			38,078

(1) US$ rate: 1 = S/881
(2) US$ rate: 1 = S/1,013.15
(3) US$ rate: 1 = S/1,165.00
(4) US$ rate: 1 = S/1,339.00

PROJECT BUDGET IN SOLES

PER QUARTER

Salaries		
Arequipa	2,201,100	
Chiclayo	2,092,584	
Total		4,293,684
Fringe Benefits		
Arequipa	660,330	
Chiclayo	600,000	
Total		1,260,330
Rent		
Arequipa	648,000	
Chiclayo	600,000	
Total		1,248,000
Supervision		
Arequipa	88,100	
Chiclayo	88,100	
Total		176,200
Other Expenses.		
Arequipa	447,000	
Chiclayo	260,655	
Total		707,655
Total		S/7,685,869

PERSONS CONTACTED

Flor Cardozo
Director

Dr. Cesar Guzman, Director Centro Médico Carmen de la Legua.

Tania Tagle Educator
Centro Médico Carmen de La Legua.

Irma de Subiría
ADIFAM

Malena Cáceres,
Arequipa Distributor.

Margarita Perez
Arequipa Distributor

Dr. Percy Chavez,
Medical Director Arequipa.

Consuelo Choque
Nurse Arequipa.

Rosa Yañez
Nurse Arequipa

Celina Pachama
Arequipa Promotor

María Arcata
Arequipa Promotor

Gloria Rodríguez
Social Worker

Ayme Huaman
Supervisor CBD Chiclayo.

Rosa Cerna
Auxiliary Chiclayo Clinic

Alba Montes
Auxiliary Chiclayo Clinic

Juana Vidaurre
Chiclayo Promoter

Lola Chumioque
Chiclayo Promoter

Elvira Flores
Chiclayo Promoter

Elencith del Aguila
Doctor

Juan Gutierrez
Doctor

Marlene Perez
Marco Rojas
Cecilia Ipayanqui
Carmen Arana
Rosa Pinto
Distributors.

Dr. Alfredo Larrañaga, Director
Instituto Marcelino.

Dr. Hilario Hurtado, Subdirector
Instituto Marcelino.

Dr. Miguel Ramos, Executive Director
INPPARES.

Mrs. Gabriela Perez Alvela,
Administrative Director INPPARES

Dr. Alfonso Loli
Director San Alfonso Clinic.