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Final Narrative Report

For the Period: October 1978 to October 1981

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FINAL NARRATIVE REPORT

AID/Pha-C-1199

INTRODUCTION

This is the final narrative report covering the period October 1978 to October 1981 for the project Rural Health Services carried out in the department of Boyacá, by the MCH Division of the Colombian Ministry of Health, FES¹, the Population Council and the Agency for International Development. The purpose of this project has been to (1) determine the impact of the household delivery of oral contraceptives by rural MCH promoters on contraceptive use prevalence levels and (2) measure the effect of household distribution by these same promoters of a wide-spectrum anthelmintic on the nutritional status of children under two years of age. The report will focus only on the results of first objective and will describe the changes in contraceptive use which occurred. They will be shown by contrasting the results from two Censuses, the first of which was carried out in February and March of 1979, before project services were initiated, and the second, implemented in those same months of 1981. As well an analysis of project costs is included. A final report on the second objective is being prepared by the MCH and the project's research director.

BACKGROUND

In Colombia, the public sector, through the institutions of the Ministry of Health, is the main supplier of health services, especially for the low income population both in the rural and urban areas. The provision of services follows a four level pyramidal pattern. The two upper levels include university hospitals and the regional hospitals, where there is specialized medical care. The third level is conformed by local hospitals and health centers having both out-patient clinic, diagnosis, and general and emergency hospitalizations.

¹ Fundación para la Educación Superior.

The fourth level includes the rural health posts, where there is only an auxiliary nurse and a doctor who attends the post once or twice a week. Ascribed to the health centers, and under the direct supervision of the auxiliary nurse, is the rural health promoter, the key agent of service delivery in the Boyacá project.

The first attempts to include community elements in the provision of health services in Colombia were made in 1958. In 1968 and 1969, this work pattern was strengthened with the establishment of the rural health promoter in the MCH programs. These promoters were first appointed by the community and then given a brief training course; they worked as volunteers four hours a day, and received a small monetary reward to compensate them for transportation expenditures.

Today, there are approximately 4,500 rural promoters in the country, working as full-time employees, who receive the minimum legal salary plus fringe benefits¹ and work eight hours a day. Promoters are now selected by the State health officials in cooperation with the community. One of the most important requirements to select the promoter is that she is a full time resident of the area in which she will be working. A promoter must attend a twelve week training course previous to the initiation of activities in her area. The supervision of her work is the responsibility of an auxiliary nurse who works in the village health post.

The activities which are ordinarily assigned to the promoter can be grouped under the following three areas: (1) health education (2) health promotion and (3) patient referrals. These are primarily preventive responsibilities. Up until the Boyacá project, the promoter was not trained to provide curative services and as such she handled few medical supplies. Under the usual work schedule promoters are supposed to disseminate information on family planning and make referrals to the nearest health post or hospital for methods. However, no program target for this activity had been set before the implementation of this project and in practice very little supervision occurred.

¹ Monthly cost by promoter is estimated at \$150.00 dollars.

Considering the low priority family planning activities were given within the promoter delivery system, the differences between the urban and rural areas in Colombia with regards to Colombia's now well documented fertility decline, and the gaps in knowledge and practice of family planning between the two sectors, the Boyacá project was developed to assist the Colombian Ministry of Health to improve its family planning services. This project was intended to determine: (1) if it was possible for the promoter to distribute oral contraceptives without prescription following a set of instructions developed by the MOH and (2) the impact of initial home delivery of contraceptives by the promoter without prescription on increasing the prevalence of use of contraceptive methods.

At the same time, it was estimated that in Colombia 88% of the population was suffering from a mild infestation of three different kinds of parasites (ascaris, trichuriasis, uncinarias) and that little action was being taken to treat this problem on a large scale basis. It was decided, then, to design the project so that it would test the impact of promoter delivery of anthelmintics on improving nutritional status of rural children aged 1 to 5 by reducing the severity and prevalence of intestinal parasites for those children and if integrated health service delivery increases contraceptive use.

Project Sites

Because of its proximity to Bogotá (120 kilometers northeast) and given the socio-economic conditions of the State of Boyacá, it was decided to implement the project in 4 areas of that department. Most of the inhabitants of Boyacá are mestizos who are descendents of the early indigenous population. The predominant economic activity was and still is agriculture as can be seen in Table 1. This table shows the percentage distribution of the gross internal production by activity sector comparing Boyacá with the national level. As can be observed by 1975, 50.3 percent of the production in Boyacá was generated in the primary sector while the statistic for the country was only 26.3 percent. With the exception of the construction industry where, in 1975, percent of the total production in Boyacá

TABLE 1.- Percentage distribution of the gross internal production by activity sectors for 1960 and 1975: Boyacá and National level

	<u>B O Y A C A</u>		<u>NATIONAL</u>	
	<u>1960</u>	<u>1975</u>	<u>1960</u>	<u>1975</u>
<u>PRIMARY</u>	51.6	50.3	33.7	26.3
Agriculture	48.1	45.0	31.2	25.1
Mining	13.5	5.3	2.5	1.2
<u>SECONDARY</u>	15.8	19.4	21.1	23.7
Manufacturing	11.2	13.4	17.3	19.2
Construction	4.6	6.0	3.8	4.5
<u>TERCIARY</u>	32.6	30.3	45.2	50.0
Commercial	4.9	10.1	16.6	16.7
Transportation	2.7	3.3	5.6	6.1
Communications	0.4	0.7	0.6	1.3
Electricity and gas	0.1	0.6	1.0	1.6
Banks and insurance	0.9	2.7	2.4	4.6
Rental agencies	4.0	4.8	5.0	5.7
Personal service	6.0	5.0	7.7	7.5
Government service	3.6	3.1	6.2	6.3

occurred as compared to 4.5 percent at the national level, the participation of the secondary and tertiary sector activities in the gross internal production in Boyacá is quite inferior to that in the national production.

Besides Boyacá being one of the least well developed states in Colombia economically, it is also underdeveloped socially (see table 2 on page 5). Table 2 shows some selected indicators of social development for that department comparing them with the national level.

According to the 1973 national population and housing census in Colombia, Boyacá covers an area of 25,134 kilometers and is divided into 120 municipalities. Of these, only seven have 20,000 or more inhabitants and 31 have less than 5,000. There are 25 hospitals in Boyacá, 9 of which are regional and 16 local. As such, most of the

TABLE 2.- Selected indicators of social development in Boyacá and at the national level: 1970-1975

<u>I T E M</u>	<u>BOYACA</u>	<u>NATIONAL</u>
<u>Demographic (1970-1975)</u>		
Mortality	12.1	8.8
Infant mortality	91.0	80.0
Birth rate	40.1	34.6
Life expectancy	55.7	59.0
Percent urban	29.6	61.5
<u>Public Services (1973)¹</u>		
Aqueducts	37.6	58.3
Sewage	20.6	42.2
Energy	23.5	52.7
<u>Schooling (1971-1975)²</u>		
Urban	3.3	3.6
Rural	1.7	1.3

¹ Percent of houses with these services.

² Mean years of formal education.

medical care is centered in the small health posts and health centers where paramedical attention is given. Medical doctors generally visit these outlets once or twice a week.

For the project's purposes, the rural areas of 4 municipalities in Boyacá were selected: Tunja, Sogamoso, Duitama and Moniquirá. The total target population in all four municipalities was estimated to be around 60,000 rural inhabitants or 12,000 families. These families were then divided into 4 groups of 3,000 each and the basic promoter health services were supplied to each one. Since the project was divided into two phases, in the first phase two of the groups were to receive initial household delivery of an oral contraceptive and subsequently be resupplied in their homes by the pro-

moters. Promoters attending the other two groups referred all persons interested in using a method to a health post or hospital and all re-supply was through MOH outlets. Each group was serviced by 25 promoters. At the same time, one-half of both the referral and the initial delivery groups were given a wide spectrum anthelmintic in the home by the promoter. This design can be seen in the following table.

TABLE 3.- The Boyacá service delivery module

Anthel- mintic / Contra- ceptives	Initial and re-supply + Basic Ser- vices	Referral + Basic Services
Delivery	<u>GROUP I</u> 25 promoters 3,000 families	<u>GROUP II</u> 25 promoters 3,000 families
No Delivery	<u>GROUP III</u> 25 promoters 3,000 families	<u>GROUP IV</u> 25 promoters 3,000 families

RESULTS

Promoter Training

Normally, in order for the promoter to carry out her activities, she attends 12 week training course at a State School of Auxiliary Nurses. This training is provided by the staff of the school and personnel from the State Health Department. The course includes the following aspects: the promoter as part of the health system (26 hours); family and community (35 hours); environmental sanitation (38 hours); medical care, MCH and first aids (235 hours); delivery of drugs and supervision (40 hours); other activities (45 hours). This training is carried out through lectures, movies, audiovisual aids, and practicums.

For this project the promoters received the above training in Tunja plus an additional one week course which treated the specific aspects of the project: census taking techniques, identification of the population exposed to the risk of pregnancy, recognition of symptoms and adverse conditions to oral contraceptive use, correct use of oral contraceptives and condoms, and on completing project record-keeping and report forms. All promoters learned to administer oral contraceptives to first-time users through a check list categorizing women by risk and to supply the population with the wide-spectrum anthelmintic. All auxiliary nurses in the project attended a similar course of the same duration in Tunja but with the addition of training in supervision of promoters in accordance with the project's objectives. Area Supervisors, as registered nurses, participated in both promoter and auxiliary nurse courses as part of their training.

Once the training phase was completed, promoters were randomly assigned into four experimental groups. The first group distributed both antiparasite drugs and contraceptives. The second group only distributed anthelmintics, and the third group contraceptives. The fourth group did not distribute drugs, and only operated as a control group. Both the second and fourth groups referred individuals who desired to use family planning methods to MOH outlets.

Service Delivery

Before initiating the household distribution of contraceptives, a list of contraindications was prepared and given to the promoters who would distribute methods. Each time a user requested an oral contraceptive, the promoter reviewed this list. If the promoter was still unsure if the health of the potential users might be affected, she referred them for a medical examination in an MOH outlet. The promoter visited each month all the users of contraceptives and provided them a month's supply. During the first year only Noriday was distributed, but in the second year the list was increased to include other brands of oral contraceptives and, as well, the promoter began to distribute Neo-rampoon and condoms.

Anthelmintic distribution was initially carried out twice a year but due to the high re-infestation rate in these areas where there was little environmental control, it was decided to increase distribution from two to three times a year.

Censuses and Information System

Preceding service delivery in 1979 all promoters made an initial visit to each of the households they were assigned. From the population of 12,000 households on this initial contact visit a census was taken to establish baseline data of all the women 15-44 years of age: age, number of living children, literacy, civil status, pregnancy, desire for more children, current use of contraceptives, and source of contraceptive supplies. For children 1-4 years of age, information on height and weight was gathered and a stool sample was taken of 700 children in this age group to analyze the prevalence of parasites. At the same time the Ministry of Health's evaluation system required information on the total number of inhabitants of the households and the sanitary conditions of each house. This information was collected every year for three consecutive years, and similar questionnaires were used to report the promoter monthly activities. With this information a computer program to establish longitudinal records for each woman was developed. As it turned out, this program was impossible to administer because of the promoter's reporting errors made with regards to the household and individual identification number of each respondent. Because of this, it was decided to analyze the project's impact only by comparing the 1979 and 1981 Censuses. The monthly reports were used to monitor the program and to guide the supervision.

In Table 4 the number of women 15 to 44 interviewed in the 1979 and 1981 Censuses and some characteristics of these women by intervention group are shown. There is little difference between the mean ages of the women in each of the four groups both in 1979 and in 1981. As well, the 1979 mean ages are similar to those found in 1981. Most of the women interviewed in the Census of 1979 and in that of 1981 are literate and in the group where only the anthelmintic was distributed in 1981, only 3 percent reported they are illiterate. It is likely that either the question on literacy was poorly

TABLE 4.- Characteristics of women 15 to 44 according to intervention group: 1979 and 1981 censuses (Boyacá)

CHARACTERISTICS	1 9 7 9 C E N S U S				1 9 8 1 C E N S U S			
	Oral + Anthel.	Anthel. Only	Oral Referral Only	Referral Only	Oral + Anthel.	Anthel. Only	Oral Referral Only	Referral Only
Total number of women interviewed	2477	2617	2636	2651	2665	1904	2475	2269
Mean age	27.1	26.7	26.8	26.9	27.7	27.3	27.6	27.2
EDUCATION								
Literate	85	90	87	84	89	97	89	90
Illiterate	15	10	13	16	11	3	11	10
Total percent	100	100	100	100	100	100	100	100
EXPOSURE STATUS								
Currently pregnant	9	7	7	10	6	6	6	7
Non pregnant, widowed, divorced separated, single	45	59	55	49	44	46	50	39
Non pregnant, in union	46	34	38	41	50	48	44	54
Total percent	100	100	100	100	100	100	100	100

administered, or the concept not understood by the interviewer because the levels of illiteracy appear to be more similar to urban levels in Colombia. In the 1980 Use Prevalence Survey the percent of women 15 to 49 reported illiterate in the rural areas of the Eastern Region where Boyacá is located is 19 percent.

The category Exposure Status is used in Table 4 to identify the women most exposed to the risk of pregnancy and most in need of family planning services. They are the non-pregnant currently in union women which in 1979 represented 40 percent of all women 15 to 44 in all four groups and in 1981, 49 percent. The percent of exposed women by intervention group varies between groups in each Census with the lowest statistics being found in the 1979 Census for each group. There is about a 14 percentual point difference between the 1979 and 1981 Censuses for the Anthelmintic Only (AO) and Referral Only (RO) groups.

Contraceptive Use Prevalence

Item I in Table 5 on page 11 shows the percent of exposed women by intervention group who were currently using a contraceptive method at the time of the 1979 and 1981 Censuses. In all four groups use prevalence more than doubled by 1981 with the greatest increase occurring in the RO Group where neither the oral nor the anthelmintic were delivered and where referrals were made for family planning services. It must be kept in mind, however, that the initial contraceptive use rate in the Oral + Anthelmintic Group (OA) (20 percent) was higher than for the other three categories and it is in the OA Group, as well, where prevalence continues to be highest (49 percent).

If the 1979 Boyacá Census prevalence rates for exposed rural women are compared with those for exposed rural women from the 1978 Use Prevalence Study¹ and the 1978 PROFAMILIA Posttest², it can be seen that contraceptive use in the project areas in Boyacá was unusually low before the project began. Thirty-nine percent of the currently married, non-pregnant women in the rural areas of the Eastern Region were using family planning methods in 1979³. The Posttest shows that in the coffee growing areas of North Santander and Santander in 1978 contraceptive use prevalence was 42 and 59 percent respectively⁴. The 1981 Boyacá Census use percentages are more similar to those found in the two studies cited above for the year 1978 and, if the 1980 CPS is consulted, it is clear now that contraceptive use in these 4 areas in Boyacá have now reached use levels similar to or slightly above those found for rural exposed women in the Eastern Region (43 percent)⁵.

¹ CCRP, MOH, Westinghouse Health Systems, Encuesta nacional de prevalencia de uso de anticoncepción: Colombia, 1978, Resultados Generales.

² Marcia Townsend, Changes in Contraceptive Use Prevalence and Knowledge in Three Rural Profamilia CBD Service Areas of Colombia. Policy Implications.

³ CCRP, op. cit., p. 63.

⁴ Townsend, op. cit., pp.7,8.

⁵ CCRP, MOH, Westinghouse Health Systems, 1980 CPS Unpublished Preliminary Tables, 4.1.

TABLE 5.- Percentage of currently married non-pregnant women who are currently using a contraceptive method (including sterilization) by age, number of living children and level of education according to intervention group: 1979 and 1981 censuses (Boyacá)

I T E M	1 9 7 9 C E N S U S				1 9 8 1 C E N S U S			
	Oral + Anthel.	Anthel. Only	Oral Only	Referral Only	Oral + Anthel.	Anthel. Only	Oral Only	Referral Only
ALL	20	17	15	12	49	46	45	38
AGE								
15-19	3	11	8	6	21	23	16	25
20-24	10	11	13	11	39	31	45	33
25-29	20	19	13	14	51	42	47	39
30-34	29	25	14	15	54	54	43	40
35-39	25	18	20	12	54	52	45	43
40-44	21	14	15	8	49	54	48	36
NUMBER OF LIVING CHILDREN								
0	3	2	6	8	3	15	9	9
1	11	7	7	7	39	29	31	30
2	15	15	11	16	52	44	45	37
3	15	21	16	17	46	50	49	46
4	26	25	18	12	54	53	50	42
5	30	20	20	11	53	52	47	37
EDUCATION								
Literate	23	17	16	13	52	46	45	40
Illiterate	8	18	12	6	29	44	45	22

In Table 5 the level of contraceptive use in each intervention category by age group and number of living children is presented for both Censuses. As well, the percent of literate and illiterate women using a method can be found.

Age.-- Looking at contraceptive use by age group for the 1979 Census, comparing each of the 4 interventions, well defined patterns across groups cannot be observed. Although lower rates are shown for those women 15 to 19 than in most of the other age groups, a low 6 percent of the respondents 40 to 44 were currently using in the Referral Only category. While the highest percent contracepting in the OA Group were the women 30 to 34 (29 percent) both the OO and RO Groups are an exception to that. The intervention group where both the oral and anthelmintic were distributed is the group where the widest range of prevalence rates was found: from 3 percent of the women 15 to 19 currently using to 29 percent of the women 30 to 34.

The substantial increment in the use of birth planning methods found in the 1981 Census occurred among all of the age groups. However, the pattern of use by age still remains slightly different for each intervention category. It is most noteworthy to point out the sharp rise since 1979 in use for women 15 to 19 and 20 to 24 in the category Oral plus Anthelmintic and among women 15 to 19 and 40 to 44 in the RO Group. Across all four intervention categories major change occurred in the age group 20 to 24.

Number of Living Children.-- As expected, contraceptive use tends to increase as the number of children goes up in all four intervention groups for both Censuses.¹ Except for those women exposed to the anthelmintic treatment only where use rose from 2 to 15 percent, little change was observed between 1979 and 1981 for women with no children in the other three intervention groups. While considerable change occurred for women in all 4 groups in all of the other categories (1 to 5 living children), contraceptive use quadrupled among the women with 1 child in the AO, OO and RO Groups and for women with 2 children in the category OO (Oral Only). It appears from this that family planning methods were being adopted during these two years particularly for spacing reasons since the greatest in-

¹ This pattern is not so well defined for Group IV in the 1979 Census where the percent using with 4 and 5 or more children declines appreciatively.

crease in use was found for women with 1 to 2 children and among women 20 to 24 years of age.

Education.-- Most of the information on contraceptive use in Colombia indicates that higher prevalence is accompanied by higher levels of formal education. This pattern is observed in both the 1978 and 1981 Censuses in Boyacá for all intervention categories except the Anthelmintic Only Group in 1979 where nearly the same percent of literates (17 percent) as illiterates (18 percent) were using. Between the two Censuses the lowest increment in use was found for the Oral plus Anthelmintic literate women (23 to 52 percent). It was this Group, however, where the highest contraceptive prevalence rate was reported for both 1979 and 1981. It was among the illiterate women in the Groups OA, OO and RO where the most gains in family planning use were made.

Type of Method

Table 6 on page 14 shows the percentage distribution of the exposed women who reported using a method in 1979 and 1981 in each intervention group by method in use and efficiency of method. For all 4 groups in 1979, the IUD was the most popular method. Of the 12 percent in the Referral Only Group who were currently using, nearly half (45 percent) were IUD users. The oral was the second most used method in all of the intervention categories except where both the oral and the anthelmintic were distributed. There the second most popular method was rhythm: 24 percent reported practicing that method.

By 1981 the IUD was replaced by the oral as the method most used in the OA and OO Groups where the oral was distributed by the promoter. However, instead of the IUD moving to second place in the OA Group, its use was diminished so that it became the method most used after female sterilization (19 percent) and rhythm and withdrawal (16 percent). For the women in the Oral Only category, after the oral, female sterilization followed (19 percent) and then the IUD (16 percent).

TABLE 6.- Percentage distribution of non-pregnant currently married women according to current use and type of method being used by intervention group: 1979 and 1981 censuses (Boyacá)

METHOD	1 9 7 9 C E N S U S				1 9 8 1 C E N S U S			
	Oral + Anthel.	Anthel. Only	Oral Only	Referral Only	Oral + Anthel.	Anthel. Only	Oral Only	Referral Only
<u>EFFICIENT</u>	66	73	82	96	68	74	74	83
Oral	15	21	22	25	33	17	36	18
IUD	25	33	38	45	13	28	16	32
Female sterilization	23	16	20	23	19	22	19	26
Injection	2	3	0	-	1	3	0	4
Suppository	1	0	2	3	2	4	3	3
<u>INEFFICIENT</u>	34	27	18	4	32	26	26	17
Rhythm	24	11	9	3	16	23	10	7
Withdrawal	10	16	9	1	16	3	16	10
<u>PERCENT TOTAL</u>	100	100	100	100	100	100	100	100
<u>NUMBER OF CASES</u>	221	154	149	127	652	412	476	448

In the other two intervention categories, where the IUD remained the method of most use (AO and RO), the percentage of women practicing that method actually declined: 5 percentual points in the AO Group and 13 percentual points in the Group RO. During the two years between the Censuses in the areas where only the anthelmintic was distributed, the pill was replaced by the rhythm method as the second most used form of birth planning. The percent of women practicing rhythm doubled from 11 to 23 percent. Withdrawal declined from 16 to 3 percent and sterilization rose by 6 percentual points (16 to 22 percent).

In the RO Group, the percent of exposed women sterilized (26 percent) was the highest percent found for that method in any of the groups and sterilization replaced the oral as the method most used after the IUD. Both rhythm and withdrawal increased in use

from 1979, however given the percent of current users practicing withdrawal in the other three intervention groups, the 1 percent reported using that method in 1979 appears unusually low.

Finally, it is noteworthy to examine by the changes in methods from the 1979 Census to that of 1981 according to efficiency of method (Table 6). In 1979 the highest percent of current users practicing an efficient method was found for the Referral Only Group (96 percent) and the lowest (66 percent) in the group to receive both the oral and anthelmintic. By 1981, even though the percent of exposed women currently using dramatically increased, in all 4 intervention groups increased use of efficient methods over inefficient methods was only observed for the OA and AO Groups and that change was only in the range of 1 or 2 percentage points (66 to 68 percent for the OA women and 73 to 74 percent for the AO Group). Greater use of inefficient methods was actually detected among those current users in the group where the oral was distributed by the promoter (OO Group) and where Referrals were made (RO).

Source of Family Planning Services

As can be seen in Table 7, (on page 16) the 1979 Census data does not discriminate among the different family planning services of current users other than to indicate if the promoter was supplying the method or the user was getting it from some other source. Exposed women who were using rhythm or withdrawal were classified as users of non-service dependent methods. It was not expected that even one percent of the women would obtain their method from the promoter in 1979 because at that time the promoter was not delivering family planning services.

Because of the deficiencies in the 1979 Census data, the 1981 information in Table 7 serves primarily to help describe the situation in 1981 and to observe changes which occurred in supply by the promoter and the percent not requiring service dependent methods. In the group where both the anthelmintic and oral were distributed by the promoter, thirty-three percent of the current users in 1981 were being serviced by the promoter. Nearly the same statistic was found for the OO Group. Despite the offer at the household level

TABLE 7.- Percentage distribution of non-pregnant currently in union women who are currently using a contraceptive method by source of service and intervention group: 1979 and 1981 census (Boyacá)

SOURCE	1979 CENSUS				1981 CENSUS			
	Oral + Anthel.	Anthel. Only	Oral Only	Referral Only	Oral + Anthel.	Anthel. Only	Oral Only	Referral Only
MOH Health Promoter	1	1	0	1	33	1	36	0
MOH Health Post./Center					33	62	34	74
Uses non-service dependent methods	34	27	18	4	32	28	27	19
Other	65*	72	82	95	2	9	3	7
Percent Total	100	100	100	100	100	100	100	100

The only information on source of service for the 1979 Census is whether the user received service from the promoter or from some other source. The 65 percent reported in the category "other" represents all users who depend on supplies (oral, IUD, sterilization, injection and suppositories) but it is not known if the source is PROFAMILIA, the MOH, drugstore, etc.

of contraceptives in both of these groups, the percent of women using a method that requires no supplies remained nearly the same in the OA Group (32 percent) and rose by 9 percentage points in the OO Group. For those current users who resided in the Referral Group zone of the project, the percent not requiring a specific source, more than quadrupled (4 to 19 percent).

Unmet Need

Although family planning methods rose substantially over the two year period in all intervention zones of Boyacá, the percentage of exposed women 15 to 44 years of age in each group not desiring more children increased (See Table 8 on page 17). Item 1 in Table 8 indicates that for the women in the Referral Only category where the increment in use was greatest, the percent not wanting more

TABLE 8.- Estimates of unmet need of family planning services: 1979 and 1981 censuses (Boyacá)

I T E M	1 9 7 9 C E N S U S				1 9 8 1 C E N S U S			
	Oral + Anthel.	Anthel. Only	Oral Only	Referral Only	Oral + Anthel.	Anthel. Only	Oral Only	Referral Only
	I	II	III	IV	I	II	III	IV
(1) Percent of exposed women who want no more children	90	95	93	94	95	96	94	97
(2) Percent of exposed women not using								
Any method	80	83	85	88	51	54	55	62
Efficient method	87	87	88	89	66	66	67	69
(3) Of exposed women who want no more, percent not using								
Any method	78	82	84	87	49	52	52	62
Efficient method	85	87	86	87	65	64	65	68

children (97 percent) is the highest. This indicates that even though gains have been made by this group in contraceptive use there still exists a considerable unmet need. That is to say, it is expected that as use would increase in the RO Group, the desire for more children would decline but that is not the case. Similarly, the OA Group where half of the exposed women are currently using a method, still 95 percent do not desire more children. These statistics found for Item I for both 1979 and 1981 are high when compared to the PROFAMILIA Baseline and Posttest studies where in Santander about 75 percent of the exposed women do not want another child.

Item 3 in Table 8 presents statistics on use for those women who are of particular programmatic interest: the currently married non-pregnant who desire no more children. The percent for each intervention group not using any method is high if it is compared to the PROFAMILIA 1976 Baseline for the two Santanders. In that study, for the

rural exposed women who want no more children, the percent not using any method was 45 in Santander and 66 in North Santander. After nearly three years of a family planning intervention in Santander the statistic declined to 36 percent which is still quite inferior to the Boyacá 1981 Census results. In North Santander where no CBD activities were carried out, by the end of 1978 43 percent were not using any method. These 1981 Boyacá percentages for all 4 intervention categories are more similar to the data on unmet need of the rural exposed women in Cesar (50 percent) and Cauca (69 percent) in 1981 before CBD services were introduced. It is clear, then, that although considerable change in contraceptive use occurred among the exposed women who desire no more children, around half are still not using any method and about two thirds are not using any or are using an inefficient method.

COSTS

Table 9 on page 19 has been prepared to illustrate some estimated costs of the Boyacá service delivery activities according to intervention group for 1979 to 1981. The first category in this table shows the expenditures in US dollars incurred during this time period while the second category presents the family planning yield. In order to determine the cost/effectiveness, the expenditures were divided by the family planning yield to give Categories 3 and 4 in Table 9.

Expenditures.-- For analysis purposes it was decided to organize the project costs into three groups of expenditures: variable, fixed and experimental. Variable costs are those which include training, supervision, commodities (anthelmintic, oral contraceptives), and the scales to weigh children. Even though the project paid full-time salaries and related expenditures of the supervisors, only 50 percent of those costs have been included in this analysis since only about half of their time was actually spent on project activities. Because no records were kept on the number of oral contraceptives distributed by the promoter, an estimate has been made for the OA and OO groups of US\$2,000 each.¹ Expenditures made on the anthelmintic are based

¹ Since AID provided Norinyl at 17 cents a cycle to the project this cost was multiplied by the project duration (36 months) times the estimated maximum number of possible users in the AO and OO group (400 in each). Then the amount received from sales was subtracted from the total. Each cycle was sold for \$2.00 Colombian pesos which is roughly 3 US cents.

TABLE 9.- Cost estimates in U.S. dollars for the period 1979-1981 by analysis group: Boyacá

Category	Oral & Anthel.	Anthel. Only	Oral Only	Referral. Only
(1) EXPENDITURES				
<u>Variable Costs</u>				
Training	1,310	1,040	1,130	1,040
Supervision	8,590	8,590	8,590	8,590
Anthelmintic	14,080	14,080	-	-
Oral contraceptives	2,000	-	2,000	-
Scales	650	650	650	650
TOTAL	26,630	24,360	12,370	10,280
<u>Fixed Costs</u>	17,880	14,181	15,414	14,181
<u>Experimental Costs</u>	46,517	46,517	46,517	46,517
<u>Total Costs</u>	91,027	85,058	74,301	70,978
(2) FAMILY PLANNING YIELD				
<u>Number of New Acceptors</u>	394	-	335	-
<u>Number of Additional New Users</u>	300	195	191	173
(3) COST PER NEW ACCEPTOR				
<u>Variable Costs</u>	67.59	-	36.93	-
<u>Fixed Costs</u>	45.38	-	46.01	-
<u>Total Costs (Variable + fixed)</u>	112.97	-	82.94	-
(4) COST PER ADDITIONAL USER				
<u>Variable Costs</u>	88.77	124.92	64.76	59.42
<u>Fixed Costs</u>	59.60	72.72	80.70	81.97
<u>Total Costs (Variable + fixed)</u>	148.37	197.65	145.47	141.39

on the number of units purchased for the project, not the number of units actually distributed for that is not known.

Fixed costs are the salaries and other expenditures of the promoter, all of which were paid by the Boyacá Health Service. However, since only a portion of the promoters' time was spent on project activities (family planning and intestinal parasites), the figures in Table 9 on Fixed Costs refer to only that portion of time. It was

estimated by the Boyacá Health Service that approximately 15 percent of the promoter's time was dedicated to family planning and parasite control activities.¹ That estimate has been employed here so that the total fixed costs in Table 9 represent 15 percent of the amount spent by the MCH on promoter salaries and related costs.

Experimental costs refer to funds paid to the project director, the principal investigator, a research assistant, a secretary, paper, computer time, laboratory analyses and other research related costs. Although these expenditures are shown in Category 1, they have been excluded from the cost calculations made in Categories 3 and 4.

As expected the Total Costs in Category 1 are highest for the OA group (US\$91,027) and lowest for the RO group (US\$70,978). Expenditures are higher where the anthelmintic was distributed as reflected clearly in the Variable Costs.

Family Planning Yield.-- Two family planning yield measurements have been selected (Category 2) for the cost analysis: the number of new oral acceptors which is available only for the OA and OO groups and the net increase of users of all methods which was calculated for all four groups. The number of new oral acceptors was taken from the project's service statistics records while the net increase of new users of all methods was determined by subtracting the total number of users by group according to the 1981 Census from the total number of existing users in the same groups reported in the 1979 Census.

Cost per New Acceptor.-- The total cost per new acceptor was US\$ 112.97 for the OA group and US\$82.94 for the OO group. This difference in cost was due primarily to the variable expenditures which in the OA group were more than double the amount in the OO group (US\$26,630 v; US\$12,370).

Cost per Additional User.-- From the time of the initial pre-service Census in 1979 to the 1981 Census the increase in the number of women contracepting was greatest in the OA group where, as shown in

¹ No specific documentation was kept on the amount of time each promoter dedicated to family planning and/or parasite control.

Category 2, 300 more women were using a contraceptive by 1981. This fact caused the OA group to be a less expensive service modality (US\$148.37) than that of the AO group (US\$197.65) and nearly the same as that of the OO and RO service forms.

Although these costs are high, it must be remembered that the project was not specifically designed to develop a favorable cost/effective service modality and that rural CBD programs in Colombia have been costly. During 1977 to 1978 the PROFAMILIA rural CBD program in Santander cost US\$69.27 per new acceptor. At the same time it is useful to point out that the MCH promoter is assigned a relatively small number of families to cover (200 households) which in turn affects the potential number of users a promoter can recruit. In Boyacá where the project was implemented, each promoter covered on the average about 108 women in fertile age out of whom only 59 were in union and only 52 at risk of pregnancy. Of those at risk, some were already using a family planning method when the project began. The number of possible users then for each promoter was small affecting the cost per new acceptor or active user.

Furthermore it is useful to remember that 15 percent of the promoter's salary and expenditures were charged to the project but this is an estimate. It is thought that this is probably an over-estimation and that, in fact, the MOH did not have any additional cost, related to promoter activities, because of this program. Promoters continue receiving the same salary, and this project helped to envision a more logic work schedule for this personnel.

Since the MOH already has established a primary health care system in Colombia before the project began which utilizes full-time salaried promoters in rural areas, the additional costs of the Boyacá project activities which the MOH would have to assume to expand the program (training) are not considered problematic. In the case where a Ministry wished to organize and implement a promoter dependent system, the costs of family planning services plus all other health care provided by this personnel should be examined in terms of whether the returns warrant the expenditures.

Summary of Findings

This report has focused on the results of the family planning interventions in the Boyacá project. It does not treat the impact of anthelmintic distribution on the nutritional status of children. As such, the interest here has been to determine through an analysis of the 1979 and 1981 Censuses, if the household delivery of oral contraceptives by MCH rural promoters is a service modality which increases contraceptive use over and above the traditional referral system. At the same time, the project was implemented to test the impact on use of a promoter distributed wide-spectrum anthelmintic along with the delivery of the oral, the hypothesis being that this modality would be even more effective than the household delivery of orals.

The project was implemented in four geographical areas of Boyacá; each area was assigned a specific intervention. As shown in the preceding tables, the first group received both the anthelmintic and the oral contraceptive (OA) while the second was exposed to the anthelmintic only (AO) and the third, only the oral (OO). Women who wished to plan their families referred to MOH outlets (the fourth group) are identified in this document as the RO Group. They received no parasite treatment as well.

Contrary to what was expected, contraceptive use among the currently married, non-pregnant women increased most for the control group (RO). Their prevalence rose 217 percent. A change nearly as strong was found for the OO Group: 200 percent. The least gain was found among those women exposed to both the anthelmintic treatment and delivery of the pill (145 percent).

At the same time, it should be pointed out that use more than doubled in each one of the four groups between 1979 and 1981. The percentage of exposed women currently using in 1981 is similar to the current regional levels while the 1979 Census percentages were exceptionally inferior to regional statistics.

Of the change that did occur, it appears that the demand for family planning methods during this period has been for child spacing. It was found that for all the intervention categories the percent of exposed women currently using increased most in the 20 to 24 age group and among women with one and two children.

While the IUD was the most popular method in 1979 among all four intervention models, by 1981 it was replaced by the oral in the two groups where the oral was distributed by the promoter. In the other two categories (AO and RO), the IUD continued to be the preferred method.

It was expected that the household delivery of the oral would influence the mix of methods in such a way that the percent of current users practicing inefficient methods would decline. In fact this was what occurred in the OA group where the pill was offered. However, the change was only minimal. Now 32 percent of OA current users reported practicing inefficient methods as compared to 34 percent in the 1979 Census. For those women who were exposed to the Oral Only treatment the use of inefficient methods actually increased by 8 percentual points.

At the same time, even though the RO Group underwent the most change in contraceptive prevalence and the use of efficient methods almost tripled, (see Table 10) use of inefficient methods rose 13 times above the 1979 level as shown in Table 10 (0.5 to 6.6).

TABLE 10 .- Percentage distribution of non-pregnant currently married women according to current use and type of method being used by intervention group: 1979 and 1981 censuses (Boyacá)

METHOD	1 9 7 9 C E N S U S				1 9 8 1 C E N S U S			
	Oral + Anthel.	Anthel. Only	Oral Only	Referral Only	Oral + Anthel.	Anthel. Only	Oral Only	Referral Only
<u>NO METHOD</u>	80.2	82.7	85.1	88.1	50.9	53.7	55.3	62.6
<u>EFFICIENT</u>	15.0	12.6	12.1	11.4	33.5	34.5	33.1	30.8
Oral	3.0	3.6	3.3	3.0	16.4	8.1	16.2	6.7
IUD	5.0	5.6	5.6	5.3	6.5	12.8	7.0	11.8
Female sterilization	4.6	2.7	2.9	2.7	9.3	10.3	8.3	9.5
Injection	2.3	0.6	-	-	0.3	1.3	0.1	1.5
Suppository	0.1	0.1	0.3	0.4	1.0	1.9	1.5	1.3
<u>INEFFICIENT</u>	6.8	4.7	2.8	0.5	15.6	11.8	11.6	6.6
Rhythm	4.7	1.9	1.4	0.4	7.8	10.6	4.3	2.8
Withdrawal	2.1	2.8	1.4	0.1	7.8	1.2	7.3	3.8
<u>PERCENT TOTAL</u>	100.0	100.0	100.0	100.1	100.1	100.0	100.0	100.0

It is estimated that around 45 percent of the change in use of all contraception for this group is due to the increase which occurred in the use of inefficient methods.

The statistics presented on the source of service by intervention category for 1981 indicate the important role the promoter now plays as a family planning source in those areas where she delivered supplies: around one-third of all users in OA and OO Groups obtain their method from this service agent. The cost per new acceptor reached US\$67.59 in the OA group and US\$36.93 in the OO group.

CONCLUSIONS

Since 1969 the Colombian Government has been implementing its programs of primary health care and employing community agents to provide basic services, promote health education and refer patients. This personnel is required to attend a twelve week course before initiating services and must reside in the area of work. Promoters earn the minimum wage and are part of the official health personnel structure. Even though the work plan of the promoter has traditionally included motivational activities in family planning and in the treatment of intestinal parasites, in practice, almost none of these actions are carried out for several reasons. In the case of family planning, no official objectives have been established by the MOH. Until the Boyacá project, the promoter's work in family planning was not evaluated. These have caused the promoter to place little emphasis on an activity which at times may create problems with certain community groups. With regards to intestinal parasites, there is little that the promoter has been able to do besides education, since she has not had the necessary drugs. The Boyacá program was designed as a pilot project to improve this situation. Promoters were trained to distribute oral contraceptives and an antiparasite drug in conjunction with some of the elementary measures of nutritional care of children between 1 and 4 years of age and by a series of annual censuses an evaluation of these interventions was made.

In a comparative analysis of the family planning information from two of the censuses, it was found that the use of contraceptives increased in all of the areas of the project and in two years Boyacá shifted from a low rate according to Colombian standards, to similar rates of other rural areas. This increase in the use of contraceptives was attained in different ways. In the group where the promoter was authorized to distribute oral contraceptives a great increase in the use of orals was achieved and in the groups where oral contraceptives were not distributed, the use of intrauterine devices and female sterilization was increased.

It is surprising that the increase of effective methods has been almost the same for all the groups. It was expected to achieve greater changes in use in the group that distributed the anthelmintic along with contraceptives, followed by the group that only distributed contraceptives and finally, the group where none of these actions were carried out. As the project was designed, the data collected does not tell us why. However, there are several possible explanations:

1. Before initiating services, the experimental nature of the project was contaminated since all the promoters received the same training, had the same supervision, filled in the same forms, and attended the same programming meetings. It is possible that all of these actions made the promoters feel that family planning had great importance, when they realized that it was an official program of the Ministry and that they would receive the support of health authorities in case of any problem with the community.
2. As a consequence of the latter, a sense of competition may have developed among promoters in all the groups which may have encouraged the promoters who did not distribute contraceptives to increase referral of patients to health centers and hospitals.
3. The third possibility leads us to perhaps one of the most fundamental aspects of the experience obtained during the execution of the project. As it has been emphasized, the project was developed based on an existing structure over which it did not have any operative control. Thus, it was

impossible to maintain the minimum experimental conditions. Thus, for example, the program of the Ministry started to provide tubal occlusion services in the hospitals of the area in which the promoter was working. On the other hand, there were several administrative changes regarding cancelling promoters, replacements and work to carry out those changes that individually analyzed do not affect the design, but lead to results that are difficult to analyze on the whole. For this reason, we think that it is very difficult to arrive at conclusive research results when experimental designs of the scale of the Boyacá project are dependent on such complex and fixed structures. It is recommended that if experimental designs are to be implemented when the control is limited, that the research question be simple and not so complex.

However, based upon the results presented in the previous sections, it can be affirmed that after being trained, and backed up with the support of the health authorities, the rural health promoters can distribute contraceptives. It was demonstrated in this project that prevalence rates significantly increased during this period.

The authorities of the Ministry of Health consider that the results of the project are enough evidence of the capacity of the promoters to carry out these actions and of the acceptance at the community level. Thus, the Mother and Child Division of the Ministry of Health, which is in charge of directing all the activities of the promoters, has distributed the communication 03242 of February 4, 1982 (see Appendix), whereby authorization has been granted to Health Centers to delegate family planning activities to health promoters. On the other hand, plans and financial arrangements are being made to train promoters according to the methodology designed in this project.

A P P E N D I X

REPUBLICA DE COLOMBIA
MINISTERIO DE SALUD

Calle 16 número 7-39
BOGOTÁ D. E.
TELEGRAMAS Y CABLES: "MINSALUD"

Al contestar esta nota
mencione el número y la
sección de procedencia
e indique su dirección.

DIVISION: **Materno Infantil**

NUMERO

SECCION:

Fogotá, D. E.

Doctor

**Jefe Sección Materno Infantil
Servicio Seccional de Salud de**

Estimado doctor :

De acuerdo a las proyecciones del Programa Materno Infantil, sobre la asignación de funciones para el equipo de salud, que presta servicios en la población de madres y niños en el país y basados en investigaciones operativas periódicas, se ha definido distribuir las actividades de Planificación Familiar, en la siguiente forma :

- a- Personal médico : será responsable de las actividades quirúrgicas, de la prescripción de métodos no quirúrgicos que ameriten su formulación, manejo de complicaciones y patología asociada a los métodos que se le remitan y supervisión de las funciones delegadas en el personal de enfermería.**
- b- Personal de Enfermeras : a este personal se le asigna (luego de ser prescrito por el médico), la aplicación y control de dispositivos intrauterinos, previa capacitación, así como el control de los demás métodos de planificación familiar, delegados por el médico. Tendrá también la responsabilidad de supervisión y asesoría a Auxiliares y Promotoras de Salud.**
- c- Auxiliares de Enfermería : donde no se cuente con enfermeras o donde la enfermera no tenga el tiempo disponible para realizar las actividades anteriormente mencionadas, las auxiliares cumplirán con las funciones asignadas a la enfermera. Realizará además la supervisión y asesoría de las Promotoras de Salud.**

- d- **Promotoras de Salud** : a este personal se se asigna la distribución y control casa a casa, de tabletas anticonceptivas orales prescritas por el médico y la oferta de métodos locales, con remisión posterior al organismo de Salud en caso de identificación de nuevas aceptantes que ameriten prescripción de un método.

Además realizará un seguimiento a las usuarias de los otros métodos anticonceptivos.

Para dar cumplimiento a este plan propuesto, se hace indispensable capacitar a cada persona en la función asignada: a los médicos actualmente se les dió capacitación en laparoscopia y está en curso la capacitación en Minilaparotomía.

Al personal de enfermeras y auxiliares de enfermería, se les ha iniciado la capacitación en inserción y control de dispositivos intrauterinos, y supervisión y asesoría en distribución de anticonceptivos orales por promotoras. Por lo tanto, los cursos de 5 días hábiles para este efecto, deben contener como mínimo los siguientes temas e intensidad horaria :

1. Información básica general sobre el Programa Materno Infantil, donde énfasis en Planificación Familiar, en los diferentes niveles del Sistema Nacional de Salud (Nivel Nacional, Seccional, Regional y Local) - 2 horas.
2. Reproducción humana (anatomía, fisiología, etc.) - 2 horas.
3. Métodos anticonceptivos, disponibles (quirúrgicos, ritmo, métodos locales). - 1 hora.
4. Dispositivos intrauterinos :
 - a- Motivación e información a la pareja sobre el método teoría sobre mecanismos de acción, tipos disponibles en el Ministerio de Salud (con énfasis en Lippes I oop), indicaciones, contraindicaciones, ventajas, desventajas, pasos necesarios para la inserción, control periódico, indicaciones de retiro, forma de retiro, complicaciones - 2 horas.

- b- Práctica sobre modelos pélvicos y en pacientes, utilizando como centros de entrenamiento hospitalares, centros y puestos de salud del Sistema; que garanticen un adecuado volumen de pacientes, así como centros de Profamilia, previamente coordinados. Se calcula que cada enfermera o auxiliar debe aplicar bajo práctica supervisada 20 dispositivos en modelos pélvicos y 10 en pacientes como mínimo. Se sugiere que en caso de no alcanzar el número en pacientes durante el curso, se coordine con la institución a donde pertenece el funcionario para que bajo supervisión médica continúe su capacitación.

Recomendamos que a partir del segundo día del curso, se programen las prácticas con el propósito de cumplir lo anteriormente recomendado, además que se le solicite a los centros de práctica, la acumulación de pacientes para los días del curso, bien sea para inserción o para control de usuarias antiguas, charlas educativas, etc.

5. Anticonceptivos Orales :

Motivación e información a la pareja sobre el método. Tipos disponibles en el programa, mecanismos de acción, indicaciones, contraindicaciones, ventajas, desventajas, complicaciones. Seguimiento y manejo de usuarias por Promotoras. Supervisión y asesoría a Promotoras. Manejo administrativo en el suministro a Promotoras - 2 horas.

3. Estadísticas y Registro de la Información :

Formas sistemáticas (SIS-130), manejo de los formularios de Riesgo y formularios de Esterilización e historia clínica de Planificación Familiar. Práctica en el manejo de formularios - 2 horas.

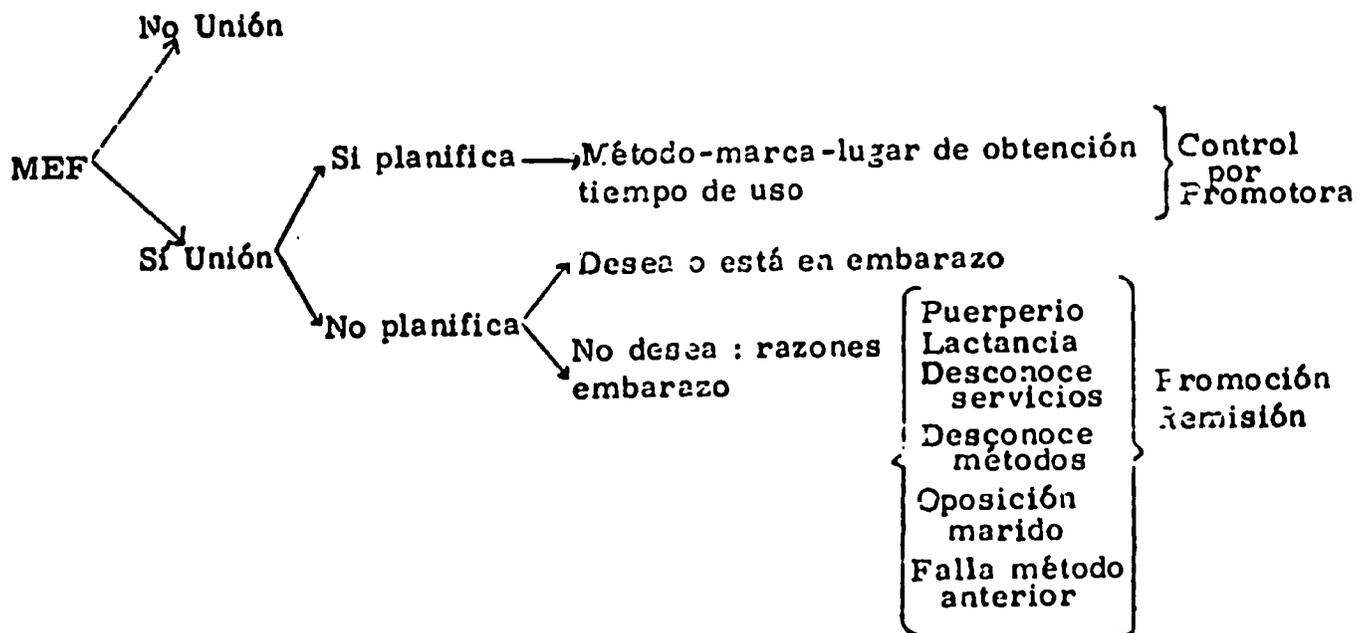
NOTA : Se sugiere realizar mesas redondas para discusión en los temas de mayor importancia, para reforzar conceptos y aclarar dudas.

Al personal de Promotoras de Salud, para la distribución y control de

anticonceptivos orales y métodos locales, la capacitación debe contener los siguientes temas :

1. Información básica general sobre el programa Materno Infantil, dando énfasis en Planificación Familiar, en los diferentes niveles del Sistema Nacional de Salud (Nacional, Seccional, Regional Local -) - 2 horas.
2. Salud Reproductiva Básica : Anatomía, fisiología, educación sexual, otros.
3. Métodos de Planificación Familiar (métodos naturales, dispositivos intrauterinos, quirúrgicos) : En este tema se dará una información sucinta y general sobre ventajas y desventajas, formas de acción, necesidad de controles y posibles complicaciones que ella debe conocer para remitir al médico. Se debe hacer énfasis en sitios, horarios y en lo posible nombre del médico o personal de enfermería que está desarrollando esta actividad - 2 horas.
4. Tabletas anticonceptivas orales y métodos locales :
 - a- Aspectos Teóricos : Considerando que estos son los métodos que va a manejar la Promotora, el mayor tiempo del curso, estará dedicado a este tema. Se les explicará ampliamente la marca de tabletas que se tienen en el programa, mecanismos de acción, indicaciones, contraindicaciones, ventajas, desventajas, complicaciones, detección precóz de patología asociada al método, conociendo signos y síntomas que se han fijado en las normas del programa para este personal, promoción, motivación y seguimiento de usuarias tanto nuevas como antiguas, remisión de usuarias con patología o para cambio y retiro del método - 4 horas.
 - b- Sociodramas sobre promoción, motivación y oferta de anticonceptivos orales y métodos locales control de usuarias para detección de patología asociada, remisión de pacientes, cambio de método - 5 horas - 8 horas.
 - c- Censo de mujeres en edad fértil (15-49 años) en la unidad de cobertura atendido por cada promotora (ve anexa

En reunión que se debe hacer, mínimo 15 días antes del curso de capacitación en la asignación de nuevas funciones, se debe explicar el formato censal, que se aplicará a cada mujer entre 15 y 49 años, el cual una vez esté elaborado se llevará al curso para su análisis. Determinado el grupo de mujeres en edad reproductiva, se pretende llegar al siguiente esquema:



Una vez obtenido este censo se podrá determinar el número de mujeres en edad Reproductiva en Riesgo de Embarazo y que necesitan ser protegidas con métodos efectivos de Planificación Familiar (Población Blanco). Además se puede determinar las que están planificando, estableciendo el tipo de método y la marca que están usando.

Conocido el número de usuarias de anticonceptivos orales y métodos locales (óvulos, jaleas, espumas, otros), se podrá hacer el cálculo de necesidades de elementos anticonceptivos que debe tener la promotora, agregando un número de elementos racionalmente mayor, de acuerdo a las proyecciones que se calculen en captación de nuevas usuarias, asegurando un suministro a la usuaria, permanente y adecuado.

Este censo se repetirá cada 3 meses, para conocer los incremen-

tos de nuevas usuarias, retención de antiguas usuarias y cambio de métodos. Al mismo tiempo nos permite evaluar el trabajo de la promotora dentro de este subprograma.

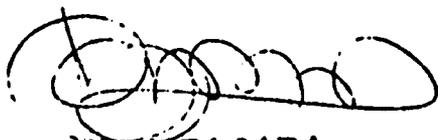
Durante el curso de promotoras, se revisará cuidadosamente el censo de cada unidad de cobertura, con el fin de detectar errores en el diligenciamiento, orientar las actividades a realizar la promotora, aclarar dudas, calcular elementos que debe tener la promotora para suministro, ubicación de las usuarias por método en el mapa de la unidad de cobertura, preparación y programación de la visita domiciliaria. Intensidad horaria : tiempo requerido.

5. Otros Registros : Se explicará el registro diario-mensual que debe llevar la promotora referente a usuarias nuevas y antiguas y movimiento de elementos anticonceptivos.

Se recomienda incluir como docentes dentro de los cursos, al personal médico y de enfermería de los niveles Regional y Local, con el fin de responsabilizarlos posteriormente en la supervisión y asesoría.

Esperamos que estas explicaciones hayan sido lo suficientemente claras, en caso de dudas les solicitamos comunicarse con esta División.

Atentamente,



LUIS DAZA PARADA
Jefe División Materno Infantil

Copia : Jefe Servicio Seccional de Salud - Coordinador Técnico.
Jefe de Atención Médica - Enfermera Programa M.I.

/mdg.