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CENTER FOR POPULATION AND FAMILY HEALTH

COLUMBIA UNIVERSITY

Semi-Annual Report to the  
Agency for International Development

Contract AID-pha-C-1107

January 1, 1978 - June 30, 1978

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## AID Semi-Annual Report

January 1, 1978 - June 30, 1978

### 1. Background

The Center for Population and Family Health (CPFH), established at Columbia University in 1975, is made up of experts in a variety of disciplines including medicine, public health, sociology, law, demography, anthropology, economics, and management. The objectives of the Center are as follows:

- A. To provide technical assistance to developing country family planning programs in the development, implementation and evaluation of operational research projects and in development and operation of research and evaluation units. Particular emphasis is placed on innovative methods of delivering services, e.g., community-based distribution of contraceptives and wider use of paramedical personnel.
- B. To apply and evaluate innovative approaches to reproductive and sexual health care in the community surrounding Columbia University.
- C. To conduct research studies relating to the causes and consequences of adolescent fertility.
- D. To carry out teaching obligations as a Division in the School of Public Health, with particular responsibility for the Masters and Doctoral level Population and Family Health track.

It should be observed that although each of these objectives are self-sufficient, taken together they are mutually reinforcing. For example, findings from applied research in innovative delivery methods overseas can be utilized in the domestic reproductive health care program and then become a case study in the teaching program.

## 11. International Activities

### A. Project Objectives as Stated in the Contract (c-1107)

#### 1. General

To develop and implement operational research projects to assist family planning program managers in overcoming operational impediments. To develop new operational research techniques. To support these efforts by indexing, storing, and searching population literature and updating the fertility control thesaurus.

#### 2. Specific Tasks

- a. Develop, implement, and provide technical assistance to operational research projects in LDCs, particularly Latin American countries. Provide short-term training for host country personnel and also consultative support for research at operational level.
- b. Develop and maintain contacts with professionals and population officers in LDCs. Travel overseas to develop new projects or implement previously designed operational protocols.
- c. Provide short- and long-term consultancies to support local operational research efforts.
- d. Thailand - to assist the head of the Research and Evaluation of the Thai National Family Planning Program in:
  - 1) the collection, processing and analysis of routine service statistics data, with a particular emphasis given to the application of the data findings to assist in the improvement of program management through the development of appropriate indicators;
  - 2) research projects being developed under the auspices of the Unit, both those to be conducted directly by the Unit and

those to be carried out in conjunction with other resources within the country;

- 3) planning for future activities of the Unit;
- 4) analysis of data presently available but not yet analyzed which could be of use to the program;
- 5) training, on-the-job, of personnel within the Unit;
- 6) various R&E-related activities at provincial level; and
- 7) activities outside the Ministry of Public Health, as designated by the Director of the Family Health Division.

The CPFH will provide the above-mentioned assistance by furnishing one resident advisor, working under the Director of the Family Health Division of the Department of Health, and supported by short-term visits by CPFH staff members based in New York.

- e. Mexico\* - The CPFH shall assist the Government of Mexico to carry out projects which demonstrate that paramedical and nonmedical personnel (e.g., traditional practitioners) are safe, effective and cost-efficient agents for the delivery of family planning services in rural and urban slum areas. Assistance is also provided to the Ministry of Health and the National Coordinator in the general areas of evaluation, research, and training.
- f. Colombia - Assist Profamilia to compare the effectiveness of paramedical and medical personnel in delivering family planning services and particularly in inserting intrauterine devices.

\*A separate contract - c-1200 - provides for Center assistance to the National Family Planning Coordinating Council and the Maternal-Child Health and Family Planning Directorate in Mexico. Under this contract a large scale operational research project will be carried out applying different models of community-based MCH and family planning services in rural areas of three states and in four semi-urban slum areas of Mexico City.

Note: Other objectives, specified in the original contract, have been met and are listed and discussed in other semi-annual reports.

## B. Accomplishments

### I. Latin America and the Caribbean

#### a. Guatemala

The Center's relationship with APROFAM/Guatemala is twofold. First, the Center provides technical and financial assistance to APROFAM in carrying out an operational research project with FECOAR, a federation of agricultural cooperatives and with a cotton growers association; second, the CPFH provides, at APROFAM's request, technical assistance on APROFAM's CBD projects in general.

#### FECOAR

Peggy McEvoy has provided technical assistance on supervision and training to APROFAM's CBD unit. She assisted the Director of the Unit, Sara Molina, to develop forms for supervisors at all levels; these forms gave detailed itineraries for the supervisors at all levels and also provided a record of contraceptives distributed. In addition, Ms. McEvoy provided assistance in the design of curriculum for the pre-service training of promoters and distributors. Additional technical assistance was provided by Stephen Isaacs on both program and administrative aspects. Some of the specific areas in which Mr. Isaacs provided assistance were the following:

a. Duration and Financing. The project is currently scheduled to end on November 30, 1978 with an evaluation to take place in September. However, since the project really got going in January, 1978, a September evaluation would be premature. Hence, in separate conversations with Roberto Santiso, Sara Molina, and Scott Edmonds, AID Population Officer, it was decided to hold the evaluation early in 1979, after the project has had a chance to run 12 to 15 months. Also, it was agreed that Columbia would finance the project through December 31, 1978 and that AID would, through its bilateral agreement, continue its funding between January 1, 1979 and December 31, 1979.

b. Transportation. It is obvious that promoters have to have vehicles if the project is to be properly supervised. Accordingly, it had been decided previously that APROFAM would loan money to the promoters to buy motorcycles. The promoters would then repay the loan out of their monthly salaries. However, most felt that they were losing money under this arrangement by having to pay for gas and oil out of their own pockets, so that it was decided to pay the promoters an extra amount each month to cover these costs.

c. Rebudgeting. After reviewing expenditure patterns, the Administrative Director and Mr. Isaacs agreed upon a revised budget which would take the project through the end of December, 1978.

d. Problem Areas. Several problem areas were noted and discussed with APROFAM's Executive Director, Dr. Roberto Santiso, and Ms. Sara Molina. These include: problems in sending supplies to the field, which can be resolved by hiring an additional person solely responsible for the logistics of APROFAM's CBD projects and a failure to give sufficient attention to the distribution of simple medicines, which is part of the project design.

Notwithstanding the problems mentioned above, the project appears to have started smoothly with a considerable degree of motivation and enthusiasm at all levels.

#### Cotton Growers

The subcontract for the Cotton Growers project was signed in May. Although the subcontract stipulates a beginning date of June 1, 1978, APROFAM has already trained some promoters and distributors. As currently envisioned, the project will take place on 14 cotton plantations ("fincas"). There will be four promoters (paid by the plantation owners) and nine distributors. The objective is to provide family planning services to the migrant workers who pour into Esquintla department by the thousands for the cotton harvest.

This is a very interesting project, well worth trying on an experimental basis. The difficulties in succeeding should, however, be recognized at the outset. These difficulties relate to serving a population of migrant workers who are at the finca only several months before returning to their homes. During these several months, they work in the fields from morning to night, running a risk of chemical asphyxiation from excessive spraying, and spend their nights in crowded dormitories. Thus, the concepts of a "depot" or even "household distribution" are not applicable. Follow-up is difficult, if not impossible. There must be an intensive motivation and service effort for a

few months, followed by a relatively long hiatus. Because the people disperse after the harvest, evaluation becomes difficult. Conceptually, then, this project is quite different from CBD projects in stable communities.

How to overcome, or at least minimize, these inherent difficulties? With regard to services, one way is to provide 12 months of protection for each acceptor. If a person did not want to buy 12 months' worth of pills (or condoms), then perhaps the finca owners could pay the cost. Or perhaps they could be provided free. Another way is to find "leaders" who can be trained to be distributors in their home areas. And those who return to a place near an already existing distribution post can be referred to that post for resupplies. With reference to evaluation, since it appears that in general the same families return to the same fincas year after year, it appears logical to conduct an evaluation during the 1979 harvest season, one year after services were initially provided. Another possibility that we discussed was to follow-up some of the acceptors in their homes. This is based on the assumption that large numbers of the migrant workers come from the same community.

In discussions with Scott Edmonds, it was agreed that AID would pick up the funding of this project in 1979. Since our subcontract expires July 31, 1979, we agreed that AID funding would commence on August 1.

Other APROFAM Activities. APROFAM recently sent project proposals for CBD with coffee growers and sugar growers to FPIA. They are similar to the cotton growers' project discussed above. Peggy McEvoy provided assistance in the design of these projects.

b. Haiti

The Center is providing assistance to the Family Hygiene Division (DHF) of Haiti's Ministry of Health in the design, implementation, and evaluation of an operational research project. Dr. Robert Hanenberg is stationed in Port-au-Prince as the Center advisor to the DHF.

In the project, three areas are to be covered on a door-to-door basis, 2,000 households in each area. There are five or six villages in each area. Three visits are to be made each year at four-month intervals. There is to be one distributor per village, who is to visit five or six households a day. The distributor lives in the village in which he works. He receives a six-week training course in which he learns how to use the contraceptives he distributes (pills, condoms and foam) and under what circumstances they should not be distributed.

A six-week training course for the five distributors in Fond Parisien, the first of the three areas, was conducted in November-December 1977. Fieldwork began on January 9, 1978 and as of this writing all 2,000 households have been visited for the first time. The data analyzed below refer to the first 746 households.

The unit of analysis is the physical dwelling. Each time this unit is visited, the distributor fills out a short pre-coded questionnaire on each person who spent the previous night in that dwelling. The questionnaire design is such that a respondent can be followed throughout the year if he remains in the same dwelling.

Even if people tend not to remain in the same dwellings, however, the experimental design still will give the desired results, although not with the same precision. The population of the survey is to be regarded as the 2,000 physical structures in each area. The dependent variable is the level

of use of contraceptives among the people living in those structures at given times. In order to measure differences in these levels, it is not necessary to follow individuals through time, although following them through time can substantially reduce estimates of the variances of those differences.

Each village will receive two different kinds of treatment. In 1,000 of the 2,000 households, contraceptives are left only with people who express a desire for them. In the second thousand, contraceptives are left everywhere, unless there are specific objections to them, or evident contra-indications.

#### The Fond Parisien Area

The first project area is made up of parts of five separate villages in an arid rural area about two hours northeast of Port-au-Prince by jeep. Village 1 has had a family planning program since 1966, and Village 2 since 1969. There is a full-time clinic in Village 1 where pills, condoms, IUDs, foam and contraceptive injections are available. In Villages 1 and 2 women can be resupplied (but not initially supplied) with contraceptives by "agents sanitaires" (health agents) who make regular visits to certain households. The other three villages in the Fond Parisien area are within a day's travel by foot to the clinic in Village 1. These three villages are serviced by mobile clinics.

The areas included in the project were chosen in order (1) to avoid areas already serviced by the health agents (although in the end there was some overlap) and (2) to make a contiguous group of 400 households in each of the five villages. Rough boundaries of territory were delineated with reference to streams and roads, and a starting point designated. The distributors were told to start at this point and to visit each dwelling so that no dwelling

was omitted, that is, so that the project area was contiguous, until a total of 400 households per distributor were covered. Thus the project areas were purposively selected, not randomly sampled, and do not represent the population of Fond Parisien as a whole.

The area of Fond Parisien was itself chosen because some of its villages have been receiving family planning services for many years. If the rate of the use of contraceptives increases appreciably in Fond Parisien, this will be evidence that a door-to-door system meets the demand of villagers for contraceptives better than a clinic system.

During the first half of 1978, baseline data gathered during the first visit were analyzed. The first visit to the first 743 households yielded the following conclusions:

-- The levels of the variables measured were consistent with results obtained in other good surveys in the same or similar areas. Despite the low level of education of the distributors, the computer turned up very few errors of consistency. There is thus every reason to believe that the evaluation of the project will not only be possible, but will embrace an unusually high degree of accuracy.

-- If the evaluation of the project is successful, it will be due to the extreme simplicity of the experimental design, and the decision made at the beginning of the project to rely on complete enumerations rather than on samples.

-- The percentage of women ages 15-49 using the four common efficient contraceptives (pills, condoms, IUDs and foam) at the time of the interview was 5.2.

-- Kinds of contraceptives used:

60 percent of the users of these four methods were using pills

23 percent IUDs

13 percent condoms

4 percent foam

-- The level of current use was highest in Village 1 (9.3 percent), where a family planning program has been in effect since 1966, and next highest (6.6 percent) in Village 2, where a program has been in effect since 1969 (Table 3).

-- 14 percent of women ages 15-49 accepted contraceptives, mainly pills and foam, as a result of the distribution.

-- 62 percent of these women accepted pills, and 38 percent foam.

During the period covered by this report the CPFH made two visits to Haiti. Joanne Revson, CPFH, and Gary Merritt, USAID/Washington, visited Haiti in March and Joanne Revson returned again in June. Several actions were taken by Dr. Bordes, the Chief of the DHF, in order to assist the distributors in their work. 1) inservice training programs have been initiated in order to provide refresher courses for the knowledge the distributors acquired in November 1977; 2) DHF will arrange meetings between the distributors, and Area 1 clinic staff in order to a) better coordinate family planning services for this area and b) have the clinic staff participate in the distributor refresher courses.

The project is soon to be extended to Area II, the St. Marc Area. Presently the distributors for this area are being selected by the local community councils and the DHF. The distributors will be trained in July and the distribution should begin in August.

The household distribution project had been funded through a subcontract between the DHF and the CPFH, with funding provided by AID agreement PHA-C-1107. During the visit to Haiti details were finalized for a tripartite agreement between the DHF, AID/Haiti and the CPFH to cover the period January 1, 1978 through June 30, 1981. The major responsibilities of the parties are summarized as follows:

DHF The DHF agrees to implement the household distribution project and agrees to provide the personnel and administrative resources.

CPFH The CPFH agrees to provide technical assistance and consultation for project implementation. CPFH also agrees to procure one project vehicle and data processing from non-Haitian sources as required. These responsibilities are subject to continued availability of funds under contract AID/pha-C-1107.

AID/Haiti AID/Haiti agrees to provide up to \$160,000 in support of authorized local expenditures.

### c. Peru

The Center has been working with INPROMI (Institute for Maternal and Neonatal Care), Ministry of Health, which has responsibility for establishing norms, standards and guidelines for the delivery of maternal-child health and family planning services, for training and supervising Ministry personnel in MCH/family planning, and for developing new approaches for the delivery of MCH/family planning services. The actual responsibility for delivering services lies with each one of the regional health directorates. Thus, INPROMI experiments in its own facilities, provides assistance and, in some cases, financing of innovative projects which are implemented by one of the regional health directorates. The Center's involvement with INPROMI takes three forms: (1) technical assistance in the planning, implementation and evaluation of two pilot community-based health and family planning projects, one in an urban slum and the other in a mountainous rural setting; (2) assistance in a study to identify and measure risks of pregnancy, delivery and puerperium both to the mother and the baby; and (3) assistance in the design and implementation of training courses for delivery of primary health and family planning services and evaluation of projects.

The politics of family planning in Peru might be characterized as conservative from a United States vantage point. Although the Peruvian population policy states that the government should make family planning services available, at the moment no governmental services are being offered. In fact, the establishment of a private family planning association is still prohibited. However, with the change to civilian rule in 1980, the prospects for the future are considered brighter. At present, the appointment of a new Deputy Director of Health, in the Ministry, who supports population-related activities and a recent Ministry reorganization, both appear to strengthen the role of INPROMI in this area.

Given this environment, the plan is to develop two small pilot projects in which community agents or promoters will provide health services, including family planning, to their neighbors. With these as a demonstration that services, including contraception, can be safely and effectively delivered by nonphysicians, INPROMI plans to sponsor a larger project in the mid-south region of Ayacucho, which has a population of approximately 700,000 people. This, in turn, might serve as a national model if health policies become more liberalized after 1980.

Dr. Walter Torres and Mr. Stephen Isaacs visited Peru in January, Dr. Torres again in February, and Drs. Krishna Roy and Torres (again) visited in June to help INPROMI prepare the pilot projects in Chimbote, an urban area, and Chivay, a rural area. (USAID/Peru is providing funding for the projected with the Center furnishing technical assistance.) These visits were supplemented by a visit of Dr. Rene Cervantes, Director General of INPROMI to the CPFH in early July.

The pilot project in Chivay has been drawn up by the Arequipa Health Region (an important step given its key role in implementation) with the assistance of Dr. Cervantes and the abovementioned CPFH personnel. The sites of the project are the villages of Chivay, Achoma, Yanque, and Caporaque. The total population of these villages is approximately 9,000 people. Chivay is located about three hours from Arequipa, Peru's second largest city. Chivay is served by a health center staffed by a nurse, a sanitarian, and a "secigrista" (a medical student in his last year serving an obligatory year in the countryside before graduating). Two of the smaller villages have small health posts, served by a sanitarian or part time nurse. All of the health facilities are underequipped. As currently envisioned, health promoters or community agents will be trained to deliver health care under the general supervision of a sanitarian or nurse and under the overall supervision of

secigrista. The agents will make a circuit of the houses in the assigned area. They will offer a variety of services including, according to the proposal prepared by the health region, family planning. However, for political reasons family planning might not be offered at the initiation of the project, but would be made available therefore within the first 3-4 months.

As of June, a collaborative sample survey of the nutritional status of the population of the four project areas under the jurisdiction of Chivay was completed by the Arequipa health region, the Nutrition Institute of the Ministry of Health and INPROMI and will serve as base-line information for the integrated MCH-Family Planning Project as well. The results are being tabulated by the Nutrition Institute. Eight health promoters have been selected. Training of the medical and paramedical personnel will start as soon as the data collection and service statistics forms are finalized by INPROMI and INFORMATICA, which is responsible for service statistics.

The Chimbote project was being completed by the health region and will essentially follow the Chivay model discussed above.\*

#### High-Risk Study

With the technical assistance of Dr. Roy, the high-risk study was completed as scheduled. Dr. Kanashiro, of INPROMI, spent several weeks in New York working under Dr. Roy's supervision prior to the final tabulations. A final report, based on the tabulations, is currently being drafted, and will be presented by Dr. Cervantes at the October meeting of the Fifth American Obstetrics/Gynecology Congress. It is expected that the presentation at this meeting, plus publications of the results (particularly the health risks of pregnancy to older, younger, and multiparous women and for short-interval pregnancies) in professional and popular journals will have an influence

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\*The CPFH received a copy of the Chimbote project on July 25.

in moderating the now restrictive family planning practices of the Peruvian government.

The longitudinal study is based on a sample of 47,600 cases of women who delivered in 33 different public sector facilities in Peru in the period 1 June 1976 to 31 May 1977. Predictive variables in the study include demographic, socioeconomic, ethnic and pathological. The four most important phases for grouping of predictive variables are:

- (a) antecedents - includes demographic, socioeconomic, ethnic and earlier pregnancy information
- (b) first 12 weeks of current pregnancy - pregnancy evolution
- (c) from 12 weeks to 28 weeks of pregnancy - evolution
- (d) from 28 weeks to 41 weeks of pregnancy - besides maternal certain fetal characteristics are also included
- (e) delivery - conduct and outcome
- (f) puerperium - some morbidity variables of the mother and several status and morbidity variables of the perinatal, neonatal and post-neonatal stages of the baby.

The seven most important dependent variables that have been used to determine the influence of each one of the predictive variables partially and jointly, are:

- (i) Maternal mortality
- (ii) Fetal mortality (including still births)
- (iii) Neonatal mortality
- (iv) Maternal morbidity
- (v) Fetal and neonatal morbidity
- (vi) Birth-weight ratio with the duration of pregnancy
- (vii) Apgar count at three different intervals after birth.

Variables (iv), (v) and (vii) were created on the basis of a factor analysis of a number of characteristics that served as different dimensions of the same main variable and were then combined in a nominal or interval scale as the original factors permitted.

On the basis of a multiple-partial correlation analysis of all the predictive variables (risk factors) with the seven dependent variables (outcomes) seven sets of partial beta coefficients were determined which together served as the basis for determining the weight of each one of them. The final weight of each factor was a weighted average of these partial beta coefficients. This process was carried out for each one of the phases of the study referred to above in order to determine the weight of each risk factor at every phase so that an evaluation of pregnant women right from the first three months of pregnancy until after birth can be done and each case can be classified as no risk, medium risk and high risk on the basis of the total score obtained from the factors by the patient.

This study is expected to serve two main objectives:

- (1) to help rationalize scarce public sector MCH facilities whereby on the basis of the total risk borne by each patient she can be classified for either institutional care, just obstetrician's office care or home delivery
- (2) to help build up a clinical family planning programme based on the risk a subsequent pregnancy is likely to produce for the mother and the baby.

### Training

Walter Torres provided assistance on the design of a training course for personnel with teaching responsibilities in the Ministry of Health. The workshop on educational methodology and program evaluation was held for 25

people in March under the direction of two Chilean professors arranged by Dr. Torres. A followup to this workshop is tentatively planned for September 18 with Center assistance.

Ninety-one scholarship holders (nurses and midwives) who have undergone training in family planning in INPROMI have been surveyed in their places of work through a questionnaire. The salient results of this study suggest that 76% of them are involved in some MCH activity, that is, a fifth of them are not involved in MCH and only two of them are doing family planning work privately. However, 85% of the people who received training have wanted to work in family planning.

d. Brazil

(1) BEMFAM

In the last semi-annual report we summarized the course of our involvement in Brazil (funded by the Ford Foundation) from 1974 through 1977. This ended with a preliminary analysis of a subsample of respondents from a follow-up survey of acceptors in the BEMFAM sponsored community-based distribution (CBD) program in the state of Rio Grande do Norte. The last of the data tapes from the follow-up survey were received in New York on 22 June 1978 and a full report of the survey will be prepared immediately. This will be facilitated by use of computer programs and analytical techniques developed in the analysis of the subsample (a preliminary report is now available).

In May 1978, Drs. Gorosh and Ross visited Brazil (for the first time under our USAID contract) to begin an assessment of BEMFAM's current activities and future plans in order to lay a foundation for future collaborative activities between BEMFAM and the CPFH.

Tentatively, the proposed scope of collaborative activities flows from the analysis of the continuing and new workloads of the evaluation department. Specifically:

- 1) To review and improve CBD and clinic program information systems with particular emphasis to be placed on feedback of information and findings for management and program improvement.
- 2) To design, plan, and implement a community "before" survey (including the measurement of the prevalence of contraceptive practice) for use as a baseline prior to the launch of a new CBD program in the state of Piauí. This state program will employ all contraceptive methods from the start and will include a parasite

control component as well.

- 3) To design, plan and implement operational research studies aimed at looking at different innovative approaches to the delivery of family planning and simple health services, particularly in the rural areas. Two such approaches have been identified: the first involves a trial of all methods (in addition to orals) in 4 states and the second involves pricing trials in one state).
- 4) To design, plan and implement approaches to measuring the impact of family planning programs in other areas of Brazil.
- 5) To design, plan and implement strategies for the evaluation of BEMFAM's training and information programs.

With respect to items 2 and 4 above, the CPFH has been in close touch with IFRP regarding their prevalence study in Sao Paulo. They have shared information such as sampling approaches and instrument design.

Studies undertaken in this collaborative activity should be designed to produce results that may be compared with similar surveys in Brazil. To this end provision should be made for using IFRP technical staff as consultants in prevalence survey development.

Further, to facilitate the field administration of the surveys and to avoid overloading the department of evaluation, the feasibility of contracting with Brazilian survey research organizations to conduct these studies should be explored.

Finally, with reference to both survey research and to the overall review of BEMFAM's information systems, the CPFH would assist in the selection of a computer processing service bureau.

BEMFAM requested that a two person mission be sent from the CPFH to spend the month of July 1978 working closely with BEMFAM staff to prepare an up-to-date status report on CBD in Brazil and a detailed work plan (including budget and timetable) for collaborative activities covering a two year period. This would be based on rather extensive field visits to different states in which BEMFAM works. CPFH staff have already made numerous field observations of BEMFAM activities over the past six years. These include observations of both the clinic program and the CBD program. CBD observations have been extensive involving establishment of records and service statistics systems and conducting acceptor follow-up research. (A detailed report of this visit is available).

A major theme of these collaborative activities would be increased use of evaluation findings for program and management improvement. While data have been collected, analyzed and reported in the past and while various special studies have been conducted, it is agreed that much more emphasis should be placed on linking information and findings to the managerial processes of program operation. Monthly and quarterly reports which are detailed and comprehensive are not sufficient. These reports must also contain signals for headquarters, state and local managers about areas that require their attention. Survey findings must contain specific suggestions for action (for example, distributor training, revised screening procedures, and information and training program changes as well as for the ongoing management of the program).

#### CPAIMC

In addition to our work with BEMFAM, Drs. Gorosh and Ross also touched base for the first time with CPAIMC (Centro de Pesquisa Assistencia Integrada a Mulher E A Crianca). This organization is currently developing and

Implementing a model for delivery of comprehensive MCH/FP services for the metropolitan areas of Brazil. In brief, the model developed by Dr. Aquinaga of the Hospital Sao Francisco is aimed to serve an urban area containing his hospital and a population of about 100,000. using a full range of integrated prenatal, delivery, postpartum, family planning and child health services. In concept, there is to be a four-level delivery system including 1) the central hospital and its specialized in and out-patient facilities, 2) an ambulatory MCH/FP clinic already established next door to the hospital, 3) nine new satellite units dispersed in the community, each one having six trained auxiliary workers to provide the front line of primary care, and 4) home services provided by visits of these auxiliaries, 3 going out to the homes and 3 staying in the unit.

A six month start up period has already been funded (UNFPA via PAHO, and the Ford Foundation). This period is coming to a close and one satellite unit (adjacent to the hospital) has been established. To date, the major new program development has been in the area of family planning services. The full development of the nine satellites and the full range of services is embodied in a two and one-half year 1.5 million dollar proposal submitted to the UNFPA.

For the longer run Dr. Aquinaga expects to refine and extend this urban model to other metropolitan areas of Brazil, using existing medical school-hospital-health center complexes supplemented by development of satellite units and home visiting. He has involved the RENUMI group of medical centers in other cities, and this will help to justify the large UN request. In addition to this major activity, there are two other programmatic areas which were mentioned especially by Dr. Leslie Scofield of his staff as items for future development. The first was a major postpartum family planning

thrust for all of Rio which emphasizes postpartum services delivered by those health facilities near to women's homes and not requiring return to the central hospitals at which they were delivered. The second calls for the creation and development of a Population Training and Research Center oriented to service, not to academic demography, etc. Plans for this are still quite tentative but the numbers of foreign faculty resources mentioned in casual conversations suggest that this might become an impressively large undertaking.

The mission of Drs. Ross and Gorosh with respect to CPAIMC was fairly narrowly focussed to review progress in developing service statistics and evaluation systems for the CPAIMC program. They reviewed all forms and records developed to date, information flow and processing in relation to service delivery, etc. In connection with this work, they offered to be available for further technical assistance, and to help get CPAIMC started on the more complex parts.

The CPAIMC is preparing a proposal for longer term funding of its operational research and evaluation activities and this proposal will include active collaboration with the CPFH. In terms of the history of family planning program development, urban MCH/FP services using satellite units staffed by auxiliaries, postpartum programming, and developing Institutional research and training capabilities barely rank as innovative undertakings. For Brazil, however, these are important new directions and coupled with the existing rural CBD programs offer the first real possibility for a nationwide network of family planning services. We believe that by working collaboratively with BEMFAM and CPAIMC we will be able to have an important role in the development of family planning services in Brazil.

e. Mexico

The primary focus of the CPFH in Mexico at present is to assist the Directorate of Maternal-Infant Care and Family Planning (DGAMMIPF), Ministry of Health, in the New Strategies Project (described in more detail in the Semi-Annual Report under Contract AID/pha-C-1200). The CPFH continued to furnish general assistance, upon request, in a variety of activities of both DGAMMIPF and the Coordinacion in such areas as operational research and evaluation, training and program planning. Ms. Michele Shedin continued to spend approximately two weeks every six weeks at DGAMMIPF, where she serves as a staff member within the Rural Programs Unit. She provides general technical assistance, particularly focusing on anthropological aspects of the rural programs. She has also provided assistance in the developing of norms for a variety of personnel based, in part, on her experiences in the San Pablo Autoban Project. In addition, she has provided some assistance in the evaluation of that project. In the future, the majority of her efforts will be directed towards the New Strategies Project.

Dr. Walter Torres, who moved from Bogota, Colombia to the New York Office of the CPFH, also continues to have major involvement in the Mexican program. He has been named as Project Coordinator of the New Strategies Project by the Center and will be giving increasing amounts of time over the coming year to that project. In addition, he has spent a great deal of time providing assistance to the DGAMMIPF's Information, Communication and Education Unit, the unit responsible for training. He assisted in an overall administrative restructuring of the unit and in a review of the needs of the rural and urban health center, which was then used to assist in a planning document for improvements in this unit. In conjunction with the unit's staff, a master plan for the selection of

MCH/family planning subjects was developed, following which educational norms and regulations were prepared. Based on the objectives then developed, a variety of courses were designed. An additional component for evaluating the effectiveness of the training was built in, and included before, during and after tests, as well as mechanisms to evaluate both the instructors and the administrators. The courses will include a variety of self-instruction materials. Significant personnel changes took place within the unit during the year which has somewhat slowed the progress that had been developing.

Dr. Henry Elkins visited Mexico to provide general research and evaluation assistance to the Coordinacion and also consulted with Ing. Luis de la Macorra on the proposed commercial distribution of contraceptives and on facilitating the involvement of private physicians in family planning through training and the subsidized sale to physicians of equipment and contraceptives. In addition, he has worked with the Evaluation Unit of DGAMMIPF in the development of the evaluation plan for both the urban and rural components of the New Strategies Project.

Finally, Stephen Isaacs was in Mexico twice during the period, primarily in regard to the New Strategies Project, but also reviewing overall CPFH collaboration. Dr. Rosenfield also made a brief visit in an attempt to short-cut the obstacles to moving the New Strategies Project forward more rapidly, as well as to discuss the general collaboration between CPFH and the government of Mexico.

f. Clustered Projects

During the period covered by this report, a small task force was established to look at clustered health or family planning service delivery at the community level. It included representatives from AID, IPPF, Battelle, and the CPFH (Dr. Henry Elkins and Mr. Stephen Isaacs). Ms. Jeanne Stillman, working for the Center as a consultant, prepared a compedium of over 150 interpreted community-based projects with a family planning or health component currently active in Latin America. Many of these projects are supported by church groups or by the International Planned Parenthood Federation.

The original purpose of the survey was to prepare the ground for a series of regional conferences, or dialogues, on successful community-based projects. To this end, Battelle will attempt to coordinate on-site visits of experts to assess some of the more promising projects and Development Associates might provide funding for the dialogues.

## 2. Asia

### a. Thailand

#### (1) Assistance to the Thai National Family Planning Program

Mr. Anthony Bennett, the Center's representative in Thailand, continues to provide technical assistance to the Research and Evaluation Unit of the Ministry of Public Health's Family Health Division (which is the unit with primary responsibility for the Thai National Family Planning Program). He is involved in providing assistance in a wide range of activities including the planning and implementation of an improved management-oriented services statistics systems for the national program, evaluation of a continuation rate survey for pill and IUD acceptors over a three year period, 1974-1976, planning and implementation of a study to follow cervical cancer screening (PAP smears) among DMPA users and controls, the evaluation of the AID-supported CBFPS 80 district CBD project, and an auxiliary midwife IUD insertion study. In addition, he consults with the Family Health Division Director on most research and evaluation-related issues that arise within the Division. Attached to this report as an appendix are a number of tables produced by the R&E unit, both from the routine services statistics system and from the pill and IUD follow-up study.

The Thai program continues to be an exciting one that is providing leadership for the family planning field in a number of areas. The final number of new acceptors for 1977 totalled a surprising 829,000. Pills continue to lead the way with almost 500,000 new acceptors for the year. In addition, there were 107,000 female sterilization procedures, 19,000 vasectomies, 70,000 DMPA acceptors (in the first year as a national program method) and 75,000 IUD acceptors. In addition, there were 70,000 condom acceptors. Early figures for the first few months in 1978 suggest that

these acceptance figures will be matched this year. The "free" pill policy has resulted in a remarkable increase in pill acceptance and this increase has continued at approximately 50% above earlier levels. The sterilization program is expanding with new mobile units, the continued cost-subsidy and a new AVS-supported project to encourage sterilizations by physicians in their private practices.

Mr. Bennett attended an important meeting in Chiangmai on DMPA (Asian Regional Conference on the Injectable Contraceptive). The meeting was attended by over 40 participants from 11 Asian countries. Increasing numbers of countries in the region are now using DMPA, with positive experiences being reported by most. Thailand, of course, continues to have the most remarkable DMPA record, particularly due to the pioneering work of the McCormick Hospital group in Chiangmai.

The National Family Planning Program held the First International Training Course in Family Planning Management for middle level family planning personnel from five Asian countries. This was a four week program and Mr. Bennett played an active role in helping plan and conduct the program. He also participated in a Workshop on Demographic Estimates in Thailand, sponsored by the National Academy of Sciences' Committee on Demographic Estimates. Among the important conclusions to come out of this very fruitful meeting were the following: agreement of the remarkable consistency of totally independent sources of fertility data (all indicating substantial decline); slight upward adjustment of WFS-SOFT findings and slight downward adjustment of SPC estimates; agreement to simplify vital registration and improve completeness, and recognition of the need to analyze regional fertility differentials, particularly in the northeast and southern regions. Mr. Bennett assisted in the preparation of a paper by the Research and Evaluation

Unit of the NFPP for this meeting on the conformity of NFPP service statistics with the findings of the national sample surveys.

Among the studies with which Mr. Bennett and the R&E staff will be involved during the coming year are a nationwide abortion survey, a logistics study of injectables, a DMPA continuation rate survey and the 80 district CBFPS study.

(2) The Community-Based Family Planning Services

The Center is developing a close relationship with the Community-Based Family Planning Services Program run by Mr. Mechai Viravaidhya. Mr. Mechai spent a week in New York having discussions with CPFH staff, elaborating on the plans for collaboration between the Center and CBFPS. Mr. Mechai will formally become a member of the CPFH staff, serving as Senior Asian Coordinator based in Bangkok. Funding will be provided by IPPF and the Population Crisis Committee. He will continue to work primarily as Director of the CBFPS, but also will be available for consulting assignments in the Asian region and in other parts of the world, as well.

The CPFH is assisting Mr. Mechai's program in establishing an international training center on village-based programs. Initial funding support for this program will come from the Population Crisis Committee and the Pathfinder Fund. It is anticipated that this training center will play a major role in training personnel from Asia and other parts of the world on approaches to the delivery of services at the village level. One- and two-week courses will be developed for individuals involved in planning and running such programs, with shorter one- to three-day seminar sessions for political and national program directors.

It is hoped that the training center will develop collaborative relationships with other community-based programs which have been developed in other

parts of the world. It is anticipated that agencies such as IPPF, USAID, UNFPA, WHO, and others will be supportive in the future in sending participants to the training courses, so that in time it will become self-sufficient. JOICP of Japan has provided assistance in renovating space to serve as classrooms.

The CBFPS is engaged in a number of other interesting and exciting activities, including collaboration with the government's national family planning program in which CBFPS will work at the village level, cooperating with the clinic-based programs run by the Ministry of Public Health. It is also developing projects to attempt to integrate family planning-related activities with other development activities at community level. It is expected that the collaboration between the CPFH and Mr. Mechai's program will be a most rewarding one.

b. Bangladesh

Dr. Henry Elkins made two trips to Bangladesh, in January and June, and consulted on three projects (funded outside this contract).

(1) Assessment of the Bangladesh Contraceptive Social Marketing Program in cooperation with the Institute of Statistical Research and Training (ISRT) of Dacca University

The assessment has utilized three instruments: a population survey, a survey of retailers, and a purchasing experiment. The retail survey, completed in July 1977, showed that retailers judged both Raja condoms and Maya pills to be priced correctly. They liked the Raja display box but were critical of the Maya display box, which was not suitable for wall hanging. The population survey, reported in June 1978, demonstrated that purchasers of Raja and Maya were disproportionately more rural and less literate than consumers of other brands. Surprisingly, the purchasing experiment found no direct evidence of retailers' substituting government pills for Maya.

(2) An experimental combined delivery system for rural areas of initial household delivery and commercial resupply in cooperation with the Bangladesh Contraceptive Social Marketing Program and the Institute of Statistical Research and Training of Dacca University

Dr. Elkins has helped to design and experiment for household distribution and commercial resupply of Raja condoms and Maya pills. Rural but educated female canvassers in company with a respected woman from the local area will visit eligible couples to offer a free one month supply of Raja or Maya. For half the area the canvassers will make

a second visit to reinforce the education and motivation. The canvassers will encourage the users to purchase resupplies from local retail outlets and traditional medical practitioners. To facilitate the purchase of the first month of resupply users may obtain discounts at the retail outlets or from the medical practitioners by presenting coupons distributed by the canvassers at the time of the first visit. The first experimental area will be Shibaloy Thana, where ISRT has conducted a baseline prevalence survey and plans a subsequent survey in early 1979.

- (3) A pilot training and service program for traditional medical practitioners in rural areas for the provision of oral contraceptives, injections, menstrual regulation, and condoms, in collaboration with the Bangladesh Family Planning Association

The Bangladesh Family Planning Association will train approximately 100 traditional medical practitioners in Shibaloy Thana. These practitioners will collaborate in the sale of Raja and Maya condoms for resupplies in the household distribution project described above. In addition the practitioners will offer injectable contraceptives, and some will offer menstrual regulation. The Bangladesh Family Planning Association will resupply the practitioners, supervise their activities, and provide facilities for referrals for abortion, sterilization, and IUD insertion.

c. India

In Bombay Dr. Henry Elkins consulted with Dr. D.N. Pai on two ICARP-sponsored projects: 1) a training project for testing the feasibility of involving private physicians and licensed medical practitioners

In intensified family planning services with a greater variety of methods (pills, male and female sterilization, and abortion); and 2) a motivation study using the postal system to attract pill and sterilization acceptors from among selected women.

In Calcutta, Dr. Elkins consulted with Dr. B. Mullick on a feasibility study for post-menstrual regulation insertion of Copper T IUD's, on a Bengali language publication for family planning workers, and on a project for adolescents. With Dr. C. S. Dawn, Dr. Elkins discussed plans for a family planning publication for physicians.

d. Adolescent Studies in Asia

In Thailand, Dr. Allan Rosenfield and Dr. Henry Elkins consulted with Dr. Debhanom Muangman of the School of Public Health of Mahidol University on an ICARP-sponsored survey of adolescents in the Bangkok area. The survey includes both males and females and focuses on factory employees and secondary school students. The Ministry of Education participated in the design of the questionnaire, and staff there have indicated interest in the results for planning secondary school curriculums. The survey is also intended to answer questions regarding the need for expanded family planning services for adolescents.

In the Philippines, Drs. Ross, Elkins and Rosenfield have consulted with the Population Center Foundation (PCF) and Consumer Pulse, Inc. on the design of an ICARP-sponsored survey of adolescents in the Metropolitan Manila area, and on an experiment involving counseling and family planning services for low income areas. In addition Ms. Aurora Silayan-Go, in charge of special programs at the PCF spent a few days in New York having discussions with the Center's Adolescent Social

Science Research Unit and visited clinical programs for adolescents at Columbia and at the D00R. The experiment will compare two types of clinics: a family planning clinic for patients of all ages versus a clinic for adolescents only.

In Indonesia, Dr. Elkins consulted on a project design to provide services for adolescents employed in factories and carried out preliminary discussions regarding a project for adolescents in Calcutta, India.

### 3. Africa

#### a. Nigeria

Dr. O.A. Ladipo, Senior Lecturer in the Department of Obstetrics and Gynecology, University of Ibadan, visited CPFH during May to continue discussions of, planning for, and the drafting of a preliminary project proposal for an integrated health and family planning CBD project in the rural region near Ibadan. Dr. James Heiby of AID came to CPFH to participate in this effort. Center staff primarily involved were Ms. Joanne Revson and Drs. Nick Cunningham, Allan Rosenfield, and Walter Watson. A visit was also made to Washington to discuss the project further with Mr. William Bair and Drs. Gary Merritt and James Heiby.

Mrs. G.E. Delano, another key staff member of the Department of Obstetrics and Gynecology, and the proposed field director of the CBD project, visited CPFH in June to follow-up the May meeting and to initiate plans for the forthcoming visit of a joint CPFH-AID team to Ibadan in the fall to finalize project planning in cooperation with Dr. Ladipo and other Nigerians. Revson, Watson, and Dr. Martin Gorosh of CPFH also consulted with Dr. Dixon Despommier, a Columbia University parasitologist on mebendazole and on some of the common problems of parasitic disease control likely to be encountered in the rural Nigerian setting.

Building upon a document drafted previously by Dr. Heiby in Nigeria, a preliminary proposal has been prepared in collaboration with Dr. Ladipo, which will serve as the basis for the final project proposal to be prepared in Ibadan for formal submission to CPFH and AID. A visit is planned by a CPFH-AID team in the early fall to help in this process. The preliminary document can be used by Dr. Ladipo in acquainting key Nigerians with the proposed project. CPFH staff stressed the importance of political

acceptance of CBD concepts in Nigeria and emphasized dimensions of the project related to broad replication, if it is successful, at state, regional, and national levels in Nigeria.

### Objectives

The basic objectives of the proposed project include:

1. To develop and test the feasibility of a safe, effective, low cost, potentially broadly replicable model (adapted to the social, cultural, political, and economic conditions of the region) for the door-to-door delivery of basic MCH and family planning services in rural Nigeria through local community agents (e.g. TBAs and other nonmedical volunteers).
2. To develop and test an appropriate training program for the UCH staff to administer to midwife-supervisors.
3. To develop and test an appropriate training program for the midwife-supervisors to administer to TBAs and other community agents.
4. To test the effectiveness as primary supervisory personnel for these community agents of the existing network of paramedical workers (i.e. registered midwives).
5. To assess the effectiveness of varying levels of intensity of supervision.
6. To assess community acceptance of various MCH and family planning services at varying consumer prices.
7. To determine which individual and/or community characteristics distinguish effective from ineffective TBAs and other community agents.
8. To assess the individual contents of the service delivery package to determine community receptivity to, and the feasibility of door-to-door vs. referral to health/maternity center delivery of, each individual drug, contraceptive, or service provided with a view toward developing the ideal

service package.

9. To assist in replication of the successful aspects of the project at state and for federal level.

The project will build upon the existing networks of government midwives and local health/maternity centers, both probably somewhat better developed in the rural region near Ibadan than in the rural areas of the nation as a whole. Nationally in 1972 there were some 16,000 registered midwives. In the Ibadan region the rural midwives work singly or in pairs to staff and supervise small health/maternity centers which typically also have one dispensary assistant and one (female) aide. Services are limited, but include care prior to referral; simple preliminary health care; and prenatal and postpartum check-ups, and normal deliveries, with referral of cases involving high risks or complications to the nearest specialist units such as government or teaching hospitals. The orientation of the midwives and of the medical system in general is toward a Western-style institutional care and not toward service delivery extension and local community involvement. Given this orientation and given that most of the deliveries still take place in the homes, attended by untrained TBAs, it is clear that the existing medical system is not beginning to realize its potential for the delivery of basic preventive health care and family planning services to the people. This project marks a sharp break with the present medical system; consequently, the training and reorientation of the midwives becomes a very crucial step. Training and supervising TBAs in the household provision of basic MCH and family planning services will be a new experience for them. If the project is successful, the implications for traditional midwifery training and for the entire medical system could be profound.

Approximately 12 grade one government midwives with a minimum of five

years of experience will be selected to participate part-time in the project. Most of them have already been contacted and have agreed to do so, as noted above. They will be brought to UCH for a two week training course as outlined below.

Each midwife will train and supervise 3-5 TBAs or other local community influentials who will be responsible for the door-to-door delivery of information, supplies, and services. There will be two general types of supervisory relationships: internal supervision in which the midwife supervises community agents working within her own community where a health/maternity center is located and external or extended supervision in which at least some of the community agents live and work in communities beyond the one where a health/maternity center and the midwife supervisor are situated. The latter type represents the more radical break with the traditional clinical orientation of the medical system.

TBAs and other community agents will provide free information/education on health, nutrition, and family planning, but there will be a nominal charge for supplies and services, from which the agents will receive a small commission. Agents will also receive a nominal monthly salary, and, if they have achieved target distributional levels, a periodic bonus.

Charges for supplies and services will obviously have to be kept within the limited economic capabilities of the rural population to be served, but will be varied in different communities to test community reaction.

b. Sudan

Dr. Walter Watson visited Khartoum in January to confer with Dr. Fatma Abdel Mohmoud, Minister of Social Affairs of the Sudan, about organizing an experimental CBD project in the Sudan. Drs. Watson and Martin Gorosh subsequently went to Washington to brief Drs. David Mutchler and Duff Gillespie on CBD prospects in that country. Dr. Fatma in turn visited CPFH in May. It is proposed that the CBD effort be carried out by the Department of Community Health at the University of Khartoum under the direction of Dr. Abdul Rahman El Tom, head of the Department, in cooperation with Dr. Fatma.

Details of the proposed CBD project have yet to be worked out, but it is clear that it would involve the distribution of both contraceptive and simple medical supplies/services. Preliminary discussions concerned the following concepts: The population to be served should probably number about 10,000 households or more, with a total population of approximately 100,000. This would be large enough in scale to be a credible demonstration, but still modest enough to be manageable from both the administrative and research points of view. While it would be possible to conduct the project in one contiguous rural area, there seemed to be greater interest in a project that would serve different communities in several parts of the country. Possibly some of the participating communities or areas might be urban in character.

There might be a two- or three-year timetable, with the first 6 months or so allocated to overall planning and design, training, and a pre-action survey or census (which might be related to your 4 community survey), an action or service phase of about a year (services might continue in the action area thereafter, if successful), and a final phase of about 6 months

for a post-survey or census analysis, writing, and broad dissemination of project results within the Sudan. The concept is that the project should be kept simple enough, involve a limited range of activities and services (at least at first), and be feasible to deliver, so that, if successful, there would be a good chance for large scale replication of the action or service phase of the project. The replication might be nationwide, or at least in broad regions of the country and should, of course, be appropriately modified in light of experience. The service costs in the pilot phase should not exceed modest magnitude, so that if successful the large scale replication suggested would be financially feasible in light of Sudanese budgetary resources, as well as feasible in the context of Sudanese managerial and personnel resources.

The service package to be delivered would obviously have to fit the Sudanese context. Preliminary ideas were that it might involve such elements as oral rehydration for diarrheal diseases, particularly of children, anti-parasitic medications, vitamins or other nutritional supplementation (with care that the population not become dependent upon an exogeneous program for their basic food supply), other simple medications, immunizations (depending upon what vaccines are provided by WHO) and family planning, specifically oral pills, condoms and vaginal methods such as foams and spermicides. There should probably be referral for IUD acceptance, and, at least ideally, for sterilization. Such a service package could be delivered within the village, preferably at the doorstep by paramedical workers or by local lay people residents in the village with limited special training.

It is hoped that arrangements can be made for a team from CPFH to visit Khartoum late in 1978 to follow-up discussions to date and to work with Drs. El Tom and Fatma and others in the Sudan in the preparation of a CBD proposal and budget for submission to AID.

#### 4. Library Information Program

The library has continued to collect and to disseminate information on family planning program development and program evaluation, and related topics. The main part of the library is its files of published and unpublished documents on family planning programs which are indexed in depth and entered into the Columbia University file of the POPINFORM data base, a cooperative collection of citations and abstracts in population. This material is used in answering our library's reference requests, and is the major part of the Population Information Program's citations on family planning program development and evaluation and related concepts, including such subjects as fertility behavior, attitudes toward contraception, population policy, the value of children. The Center's collection is unique in this subject area and continues to be updated on a regular schedule.

During this six month period the Center has assumed the responsibility for maintaining the complete computer stored POPINFORM data base. This has involved financial support to keep the files available and provision of information services. The latter has consisted of conducting bibliographic searches and handling requests for information

ordinarily answered by the Population Information Program in addition to the usual Center reference activities. Susan Pasquariella, as a representative of the Center, assisted AID in organizing a system to route PIP bibliographic search requests to our library. This activity was undertaken to ensure uninterrupted access to the POPINFORM data base. Added to the Center staff was one part-time member located at AID to handle routing of the material.

An object of CPFH is to broaden the usefulness of POPINFORM by increasing access to it. The National Library of Medicine's (NLM) literature retrieval program is heavily used, both in this country and overseas, through satellite centers with terminals that query the system in an online mode (MEDLINE). Not only medical literature is available, there are also other data bases on related subjects (cancer: CANCERLINE; bioethics: BIOETHICSLINE). Now that NLM's director has approved the POPLINE file concept as a data base in the MEDLINE system work has proceeded in converting POPINFORM into a section of POPLINE. NLM's Medical Subject Section has been mapping thesaurus terms from the Center's Fertility Modification Thesaurus and George Washington University's Population/Fertility Control Thesaurus to NLM's Medical Subject Headings (MeSH). The Center library staff has been involved in assisting NLM with both thesauri. Another component in the development of POPLINE is the conversion of our computer formatted entries into the NLM format. Judith Wilkinson and Kathryn Speert met with the appropriate members of the NLM staff to explain our system of entries and output so that an orderly work plan can be pursued. Fortunately, our subcontractor for computer input, Informatics, Inc. also works

for NLM which should simplify the design of conversion programs.

The Center library staff continues to play an active part in the Association for Population/Family Planning Libraries and Information Centers - International (APLIC). Ms. Pasquariella, Editor and Compiler, and Ms. Wilkinson, Assistant Editor have produced the first location directory of population and family planning periodicals. The Union List of Population/Family Planning Periodicals: A Serial Holdings List of 36 North American APLIC Member Libraries and Information Centers covers over 2,000 serial titles listing library holdings for each. The U.S. Library of Congress and the National Library of Canada have cooperated by assigning codes to any of the 36 libraries not already coded by them. Since many of the periodical titles have never been listed in a standard bibliographic source the Union List should be valuable outside of the population field as well as within it.

In 1973, Ms. Speert took part in an APLIC, Carolina Population Center, ESCAP (then ECAFE) sponsored seminar in Bangkok to train population/family planning librarians and information specialists. In 1977, she obtained, for APLIC, NGO status with UNFPA. As a result of that status, UNFPA is contributing the major funding for Bangkok II, a seminar to meld these libraries and information centers into a network of mutually supportive agencies to increase the flow of population/family planning information across national boundaries. She is now actively involved in planning this meeting scheduled for the latter part of November and which will receive assistance not only from UNFPA, but IPPF and ESCAP as well.

C. Statistical Summary

1. Project Title: Operational Research for Family Planning  
Contract Number: AID/pha-C-1107
2. Principal Investigator: Allan Rosenfield  
Contractor: Columbia University  
Mailing Address: Center for Population and Family Health  
60 Haven Avenue  
New York, New York 10032
3. Contract Period: July 1, 1975-September 30, 1978
4. Period Covered by Report: January 1, 1978-June 30, 1978
5. Total AID Funding of Contract through September 30, 1978: \$2,570,290
6. Total estimated expenditures: July 1, 1975-June 30, 1978: \$2,231,035
7. Total estimated expenditures: January 1-June 30, 1978: \$532,860

## D. Statement of Estimated Expenditures, January 1, 1978 - June 30, 1978\*

\$ <u>205,165</u>	Salaries
<u>42,262</u>	Fringe Benefits
<u>-0-</u>	Consultants
<u>2,395</u>	Supplies
<u>-0-</u>	Publications
<u>2,580</u>	Services
<u>41,463</u>	Communications
<u>-0-</u>	Mexico Subcontract
<u>21,500</u>	Guatemala Subcontract
<u>13,972</u>	Haiti Subcontract
<u>37,024</u>	Travel
<u>2,882</u>	Rental of Equipment
<u>7,307</u>	Informatics Subcontract
<u>6,127</u>	Computer
<u>          </u>	Profamilia Subcontract
<u>1,649</u>	Overseas Expenses
<u>3,835</u>	Other:
<u>\$ 388,160</u>	TOTAL DIRECT COST
<u>144,700</u>	Indirect Cost (Mixed)
<u>\$ 532,860</u>	TOTAL EXPENDITURES

"The official statement of expenditures is submitted by Columbia University's Controller's Office.

E. International Travel by CPFH Staff, 1/1/78 - 6/30/78

<u>Name</u>	<u>Place</u>	<u>Dates</u>	<u>Reason</u>
Doty	Guatemala	1/1 - 6/30	Advise APROFAM on CBD. Travelled from El Salvador to Guatemala on weekends.
Elkins	Dacca	1/2 - 1/26	Consult with Dacca University on commercial program assessment and Bangladesh F.P.A. on training of traditional healers.
	Mexico	3/12 - 3/17	Consult with DGAMMIP on New Strategies Project and National Coordination on research and evaluation, private physicians.
Gorosh	Rio	5/7 - 5/16	Technical consultation to BEMFAM and development of 2-year proposal for collaboration with BEMFAM (for submission to AID/W).
Isaacs	Lima	1/24 - 1/29	Technical assistance to INPROMI, Peru.
	Guatemala	5/22 - 5/29	Assistance to APROFAM, Guatemala.
	Mexico	5/30 - 6/3	Establish administrative and financial reporting procedures re: sub-contract.
Revson	Haiti	2/14 - 2/28	Consult with members of Div. of Family Hygiene.
	"	6/11 - 6/16	Consult with members of Div. of Family Hygiene.
Rios	Mexico	5/30 - 6/4	Establish financial/administrative procedures re: sub-contract.
Rosenfield	Mexico	1/29 - 1/31	Discussion with Ministry of Health.
Ross	Rio	5/7 - 5/16	Technical consultation to BEMFAM and development of 2-year proposal for collaboration with BEMFAM (for submission to AID/W).
Roy	Lima	3/5 - 3/22	Followup activities on pilot projects; assist IMPROMI in developing research studies and completing high-risk study.
Shedlin	Mexico	1/30 - 2/23	Work with DGAMMIPF.
	"	2/28 - 3/11	Attend meeting at CIESS on social science.
	"	4/3 - 4/24	WHO meeting and work at DGAMMIPF.
Torres	Lima	1/23 - 2/15	Assist IMPROMI in training, developing pilot projects

### III. CPFH Program for Reproductive Health Care Services in New York City

The Center, as part of its overall commitment to the design and implementation of family planning services as a means toward fertility decline and improved reproductive and sexual health, has opened a Young Adult Clinic(YAC) in October, 1977, in conjunction with the Obstetrics and Gynecology Service of Presbyterian Hospital. Through increased support by the Department of Health, Education and Welfare, the initiation of this clinic is the first program initiative to specifically address the lack of access to contraceptive services for adolescents in the community with the unmet reproductive and sexual health care needs of this high risk group. Medical and counseling services are provided by bi-lingual staff in the late-afternoon and evening in order to accommodate the schedules of this predominantly school-age population.

While data for only the first six months of this clinic has been tabulated, the following is a clear indication of the growth and the need for this service. There were 600 visits during the period to the one evening session per week. This number was almost matched in the past three months since a second evening clinic was opened in May, to allow for the growing numbers of teenagers seeking services. Fourteen percent of the clinic population is male, and since outreach efforts focus on their involvement, this percent should continue to increase.

Almost all of the young people are 16 or over. This is likely to reflect both the prevalence of sexual activity in the older age groups, but also the present focus of outreach which has been largely concentrated in high schools. Half of the YAC patients are black

and about two-fifths are Hispanic, which reflects the ethnic composition of the Washington Heights community. Although three-quarters of patients come from Manhattan, some travel longer distances from the Bronx or other areas to receive services.

Three-quarters of the patients are in school. This percentage too is likely to reflect the presently school-based outreach program. Sixty percent had never been to a birth control clinic before and 50 percent had never used a birth control method. Of those who had used a method before, only two-thirds had used the pill and an additional 22 percent had used an IUD. But, nearly half of those who previously had used methods, were not using one at the time of their first visit to the YAC. Two-fifths of the patients had already experienced a pregnancy, and of these, nearly two-thirds had given birth to at least one child.

These data help substantiate the teenage pregnancy figures for 1976 in Washington Heights in which one in eight female teenagers had a pregnancy, which rate is 25 percent higher than the national. In fact, between 1972 and 1975, the birth rate increased in Washington Heights, while there was a decline in Manhattan and adjoining districts. In 1976, Washington Heights had only 16 percent of the population of Manhattan, yet 23 percent of the live births, 17 percent of abortion, 25 percent of spontaneous fetal deaths and 20 percent of total pregnancies.

In an effort to attract increasing numbers of individuals to our services and to make the community more sensitive and supportive of the need, we have developed and continue to work on the expansion

of a strong community network system. An Adolescent Advisory Council composed of professionals and community leaders has been formed to assist in the further development of the program and to monitor its progress. Preliminary discussions are currently taking place to adopt some of the more successful aspects of our international work in a community-based distribution model, by the use of indigenous personnel such as espiritistas who have a large following in this community.

#### IV. Adolescent Social Science Research

In September of 1977 the Center established an Adolescent Social Science Research Unit with the following goals:

1. To generate research which addresses the important and practical questions involved in delivery of clinical services to adolescents.
2. To provide assistance for adolescent studies in countries which are part of the Center's international program of technical assistance.
3. To generate and maintain a broad and general program of research on adolescent sexuality, contraceptive use, and pregnancy behaviors.

The Unit is staffed by four professionals with a combination of clinical and research expertise. In the first few months of Unit operation they have identified a number of research projects, provided assistance to the adolescent family planning clinic and begun international technical assistance. Some of these activities are listed below:

1. A Ford Foundation project on the impact of population education in U.S. schools. In particular this project examines the impact of contraceptive and sex education on young people. A simulation gaming device has been developed to measure adolescent decision-making with regard to intercourse and use of contraception. This instrument and others will be utilized in data collection in several model and prototypic school programs beginning in the fall of 1978.
2. Implementation of research to define and measure quality of parenting and return to school among adolescent mothers. Data are being collected over the summer of 1978 from some 600 mothers who bore their first children in 1975. Teen mothers will be compared with older ones in terms of the quality of their parenting, the development of their children, and their return to school and/or work after childbearing.
3. Development of a proposal to provide technical assistance in survey research, operational evaluation and services design in countries where there is interest in developing adolescent family planning programs.
4. Assistance to Preterm, Inc. in the analysis of abortion and family planning service statistics.
5. Preliminary discussions with family planning personnel in the Philippines and in Juarez, Mexico, regarding the development of adolescent research and services.

6. Development of a proposal to study contraceptive continuation among adolescents.

.V. Academic Program\*

The program's overall objectives are to provide students with:

- general grounding in the practice and principals of public health
- acquisition of broad perspectives on population and family health issues
- knowledge and skill in defining major population, MCH, and family-related problems, developing solutions and analyzing strategies and programs
- ability in techniques of administration and management
- competence in effective decision-making at policy, administrative, and service levels
- a critical awareness of research methods and their selective application to population and family health questions

The need for public health professionals who are equipped in orientation, interest and skills for programs in the area of population/ family planning and maternal, child and family health is great. As expansion of innovative service programs becomes possible, well-trained health professionals with varying kinds of expertise in these fields will be required. This special Population and Family Health program is designed to meet this evolving need, as well as to respond to market demands of transitional periods.

\*A more detailed description of this activity was presented in the previous semi-annual report.

As of January 1978, 96 students had entered and 62 MPH degrees had been awarded in the Population and Family Health Division. The table below displays all available data on the students' year of entry, status while doing coursework (full-time or part-time), practicum, whether MPH degree has been received and whether employed after finishing academic requirements. Some students, particularly those who studied part-time, are still finishing their practicum work or have not completed all of the coursework requirements.

Outcome of Degree Candidates	Year of Entry											
	1973		1974		1975		1976		1977		TOTAL	
	#	%	#	%	#	%	#	%	#	%	#	%
a. Entered	13	14	18	19	22	23	21	22	22	23	96	100
b. Changed track	0	0	0	0	2	9	0	0	1	5	3	3
c. Part-time	8	62	3	17	3	14	5	24	4	18	23	24
d. Practicum waived	10	77	13	72	9	41	13	62	15*	68*	60	63
e. Practicum undertook	2	15	5	28	11	50	8	38	6*	27*	32	33
f. Coursework or practicum incomplete	1	8	0	0	2	9	7	34	22	100	32	34
g. Received degree	12	92	18	100	18	82	14	67	0	0	62	65
h. Reported employment status and graduate school enrollment (% of those receiv- ing degree)	12	92	17	94	12	67	14	100	n.a.	n.a.	n.a.	n.a.

\*anticipated

The following table illustrates in general the pre-MPH professional orientation of each entering class. The students who fall into category (c) are those who complete the MPH with a practicum; a proportion that overs around 30 percent. The class entering in 1975 may have been unusual in containing 59 percent in category (c). It should be noted that those classes which had a more solid professional background did better on employment after graduation.

Pre-entry Professional Background	Year of Entry											
	1973		1974		1975		1976		1977		TOTAL	
	#	%	#	%	#	%	#	%	#	%	#	%
a. Health-related post-B.S. professional training and/or two years or more of exper- ience	8	61	6	33	6	27	10	48	8	36	38	40
b. Other than health- related post-B.S. training and/or two years or more of exper- ience	2	15	6	33	3	14	4	19	8	36	23	30
c. No post-B.S. train- ing and/or less than two years post-B.S. ex- perience	<u>3</u>	<u>23</u>	<u>6</u>	<u>33</u>	<u>13</u>	<u>59</u>	<u>7</u>	<u>33</u>	<u>6</u>	<u>27</u>	<u>35</u>	<u>36</u>
TOTAL	13		18		22		21		22		96	

Among the 96 enrollees are 8 students with "Vista" or "Peace Corps" back-grounds and 61 with over 2 years experience in administration, research, or other service activities. This multi-disciplinary mix of students was anticipated and meets the program's expectations.

To date, there have been 10 students from developing countries in the M.P.H. program and 3 in the Dr.P.H. program. The class accepted for entry in September 1978 includes 7 foreign Masters students and 2 doctoral applicants. This entering class has considerably fewer entry level students (14%), more health professionals (57%), and approximately the same number with other than health related post-Bachelors professional experience (28%).

The Division currently has information on the employment status of 56 of the program's 62 graduates as of January 1978. Four of these 56 are engaged in full-time graduate study. The remaining 52 can be divided as to their area of work as follows: 32 in domestic health care delivery, family planning research or service organizations and 20 working in internationally oriented agencies of the same type, or in the case of some of the foreign graduates, in their home countries.

The doctoral program in the Division of Population and Family Health has graduated one Dr.P.H. who is now employed by the State of New York. Four who have completed coursework are currently employed, while five who have passed the qualifying examination are preparing dissertation topics. Four of these are also employed. One Dr.P.H. candidate is now in the process of completing her coursework.

<u>Student</u>	<u>Area of Research</u>	<u>Status</u>
Beebe, J.	Relationship between professional education socialization and the quality of professional care	Qualifying exam passed
Doty, M.	Follow-up study of sterilization acceptors	Qualifying exam passed
Foreit, J.	Community-based distribution in Korea	Qualifying exam passed
Kellner, E.	Undecided	Coursework incomplete
Khipple, K.	Undecided	Qualifying exam unsatisfactory
Krasae, C.	Rural health delivery in Thailand	Qualifying exam passed
Montague, J.	Undecided	Coursework completed; on leave of absence
Murphy, J.	Undecided	Coursework completed; changing area of interest outside population
Nguyen, M.	Nutritional status of Korean orphans adopted in the U.S. and later development	Dr.P.H. awarded
Plaskon, V.	Adolescent male sexuality and contraceptive use	Coursework complete
Revson, J.	Evaluation of household distribution of contraceptives in Haiti with and without medicaments	Qualifying exam passed

The following courses were offered by the Division during the Spring 1978 semester. Students enrolled include not only those in the Center's program, but interested students from other Divisions of the School of Public Health and graduate programs at Columbia University.

- Health care delivery systems - MCH
- Reproductive physiology and contraception
- Seminar on special issues in MCH
- Human growth, development and sexuality
- Applied concepts of family health
- Population law and policy
- Family planning program development, administration and evaluation
- Methods of demographic analysis
- Tutorials in population and family health
- Independent studies in international health

During the Summer 1978 term, the following courses are being taught. Those marked (8) are newly developed and being offered for the first time this year.

- Adolescence and fertility\*
- Population, socialization and education\*
- Population policy\*
- Economic development and population change
- Sociobiological determinants of fertility
- Overview of family planning services in the U.S.
- Issues in population and socioeconomic development

During the Spring of this year, the entire School of Public Health undertook a comprehensive self-study of all its educational, research and service activities in preparation for the scheduled review of its accreditation by the Council on Public Health Education. The Division of Population and Family Health developed a detailed report on its own programs, reviewing activities of the past five years and addressing specific strengths and weaknesses of the Division.

The Division was awarded a \$20,000 grant to provide fellowships for M.P.H. students during the 1978-79 academic year. The award was made by the Jessie Smith Noyes Foundation, and is the first time a division of the School of Public Health has successfully secured non-governmental support for students in its educational programs.

The teaching program is viewed as a vital part of the Center's activities with both staff and students benefitting from the interaction and exchange of the classroom experience and collaboration in service and research projects.

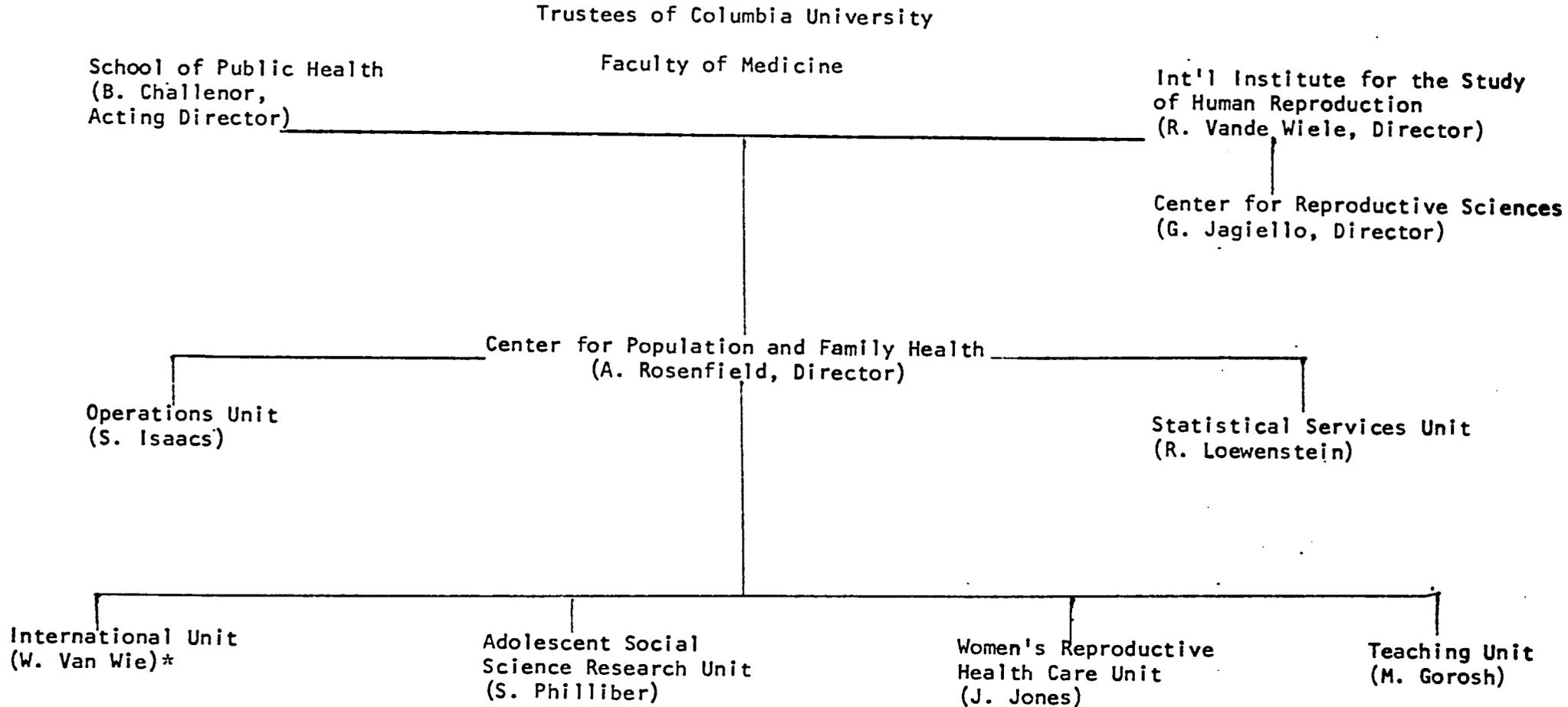
VI. Center Staff Bibliography, January 1 - June 30, 1978

- Brinkley-Carter, C. "Demographic and sociological determinants of black fertility: a causal analysis." in L. Rose (ed.) The Black Woman: Current Research and Theory. Urbana, Ill.: University of Illinois Press (in press)
- Brinkley-Carter, C. "The economic impact of the new immigration on 'native' minorities." In Proceedings of the Conference, "The New Immigration." Washington, D.C., November 1976. Washington, D.C.: Smithsonian Institution, Research Institute and Ethnic Studies (in press).
- Cervantes, R.B., and K. Roy, "Study of socio-economic-demographic and clinic factors related to toxemia among mothers that delivered babies in 33 hospitals of Peru." Revista del Colegio Medico del Peru (in press).
- Darabi, K., K. Roy, and R.M. Richart. "Collaborative study of hysteroscopic sterilization procedures: final report." in John J. Sciarra (ed.) Risks, Benefits and Controversies in Fertility Control (in press).
- Darabi, K., and R.M. Richart. "Female sterilization: an overview." in Roy O. Greep, Marjorie A. Koblinsky and Frederick S. Jaffe (eds.) Reproduction and Human Welfare: a Challenge to Research, Vol. II.
- Elkins, H., V. Matthews, and J. Pomeranz. "Experience and recommended principles for the development of software for processing statistical data in the third world." In D. Hogben and D.W. Fife (eds.) Computer Science and Statistics: Tenth Annual Symposium on the Interface; Proceedings of the Tenth Annual Symposium held at the National Bureau of Standards, Gaithersburg, Md., April 14-15, 1975. Gaithersburg, Md.: National Bureau of Standards, 1978, pp. 14-18. National Bureau of Standards Special Publication No. 503)
- Foreit, J.R., M.E. Gorosh, D.G. Gillespie, and C.G. Merritt. "Community-based and commercial contraceptive distribution: an inventory and appraisal." Population Reports, Series J, No. 19:J1-J29, 1978
- Gorosh, M.E. "Management Improvement through evaluation in family planning and MCH programs." Studies in Family Planning (in press)
- Gorosh, M.E., and D. Wolfers. "Standard couple-years of protection." In Manual on Methods of Measuring the Impact of Family Planning Programs on Fertility. New York: United Nations (in press).
- Hale, C., and S.G. Philliber. "The subtle points of controversy: a case study in sex education." Journal of School Health (in press).
- Isaacs, S. "Major consideration in planning community-based distribution." UNFPA Newsletter 4(1):4, January 1978.

- O'Brien, P.J., C.A. Heuther, and S.G. Philliber. "Teacher knowledge and use of population education materials: reports from national surveys." Science Education (in press).
- Pasquariella, S.K., and J.M. Wilkinson (eds.) Union List of Population/Family Planning Periodicals: a Serial Holdings List of 36 APLIC Member Libraries in North America. Clarion, Pa.: Association for Population/Family Planning Libraries and Information Centers - International, 1978.
- Philliber, S.G. "Who's offering sex education: data and implication." Family Planning Perspectives (in press)
- Rosenfield, A.G. (Chairman, Panel on Population, Health and Nutrition), and W.B. Watson (writer and editor for the Panel), "Heath, nutrition, and population." In Study on Science and Technology for Development. Washington, D.C.: National Academy of Sciences (in press).
- Rosenfield, A.G. "Development world family planning programs: status 1976." Advances in Planned Parenthood 12(3):149-155, 1978
- Rosenfield, A.G. "Oral and intrauterine contraception: a 1978 risk assessment." American Journal of Obstetrics and Gynecology (in press).
- Ross, J.A., and J.D. Forrest. "The demographic assessment of family planning programs: a bibliographic essay." Population Index 44(1):8-27, January 1978.
- Ross, J.A., and H.Y. Kwon. "Post-abortal immediate IUD insertion: further experience and a controlled comparison of three devices." Contraception 17(3):237-246, March 1978.
- Rothenberg, P.B. "Employment patterns of male methadone patients." American Journal of Drug and Alcohol Abuse (in press).
- Rothenberg, P.B. "Mother-child communication about sex and birth control." Population: Behavioral, social and Environmental Issues (in press).
- Roy, K., R. Cervantes, and B.A. Kanashiro. "Identification and weighting of high risk factors for mothers' and/or babies' life and health during pregnancy, delivery and puerperium in 33 hospitals of Peru: a longitudinal study." In Proceedings of the 4th Latin American Congress of Obstetricians and Gynecologists (in press).
- Som, R.K., G. Perez, K. Roy, et al. Methods of Demographic Evaluation: Adjustment and Analysis of Census Data. New York: United Nations (in press).

VII.

CPFH ORGANIZATION CHART



\*as of September 1, 1978

## VIII. Professional Staff

### A. General Comments

During the period some staff changes took place. Carol Valentine, who had major involvement in the teaching program, but who also was involved in some international activities in French-speaking areas completed her contract with the Center in June.

Mr. Jairo Rios, recruited recently as the Business Manager, resigned to accept a position overseas with FPIA. He will be replaced as Business Manager in August by Ms. Dee Blomstadt, who has had extensive administrative experience within Columbia University.

Dr. Giorgio Solimano, a well-known Chilean pediatrician and nutrition expert, who has been full time on the staff of Columbia's Institute of Human Nutrition (IHN), will now be shared equally between the CPFH and the IHN, with Dr. Solimano having an active involvement in the CPFH's programs abroad, bringing extensive experience in the delivery of nutrition and health services to rural and urban slum populations.

Dr. Tequalda Monreal, A Chilean epidemiologist has joined the staff on short term contract, with the possibility of extending this to a full time position in the future. She brings extensive experience in developing world epidemiological studies, as well as involvement in the delivery of health and family planning services. She is particularly well known for her studies on the epidemiology of abortion in Chile.

After a long period of recruitment, the CPFH has identified and recruited Dr. William Van Wie to serve as Assistant Director in charge of international programs. Dr. Van Wie, who has a Dr.P.H., has spent the last several years working with the Population Council, first in a

rural project in the Philippines and then in an administrative and technical assistance role in the New York office. He brings much experience and interest in the types of the programs in which the CPFH is involved and will be a strong addition to the staff. He will join the CPFH on September 1, 1978

Also during this period, Dr. Walter Torres, the CPFH regional representative for Latin America returned to the New York office for approximately one year. Discussions are underway with authorities in Mexico concerning the possible full time assignment of Dr. Torres to Mexico in the future to assist the Ministry of Health's DGAMMIPF in its New Strategies program, as well as in other activities of the DGAMMIPF.

#### B. Staffing Pattern

Director - A. Rosenfield, M.D.

##### Assistant Directors

M. Gorosh, Dr.P.H.	(Teaching)
S. Isaacs, J.D.	(Operations) (Acting International)
J. Jones, B.A.	(Women's Health Care)
S. Philliber	(Adolescent Research)

##### International

###### Program Staff

A. Bennett, MPH  
 N. Cunningham, M.D., Dr.P.H.  
 K. Darabi, M.A.  
 P. Doty, MPH  
 H. Elkins, Ph.D.  
 M. Gorosh, Dr.P.H.  
 R. Hanenberg, Ph.D.  
 S. Isaacs, J.D.  
 T. Monreal, M.D.  
 J. Revson, MPH  
 A. Rosenfield, M.D.  
 J. Ross, Ph.D.  
 K. Roy, Ph.D.  
 M. Shedlin, M.A.  
 G. Solimano, M.D.  
 W. Torres, M.D.  
 W. Watson, Ph.D.

Information Services/Library

S. Pasquariella, M.S.  
 K. Speert, M.S. (Head Librarian)  
 J. Wilkinson, M.S.  
 R. Oettinger, M.S.

Adolescent Social Science Research

C. Brinkley-Carter, Ph.D.  
 K. Karabi, M.A.  
 S. Philliber, Ph.D.  
 P. Rothenberg, Ph.D.

Women's Reproductive Health Care

L. Crockett, M.D.  
 P. Jencks, MPH  
 J. Jones, B.A.  
 A. Rosenfield, M.D.  
 G. Green, R.N., M.W.  
 K. Blount-Skeet, R.N., M.W.  
 Counselors, Physicians and Other Clinic Personnel

Statistical Services

R. Loewenstein, M.A. (Head)  
 P. Ting

Teaching

J. Bongaarts, Ph.D.  
 C. Brinkley-Carter, Ph.D.  
 R. Brown, M.D., MPH  
 N. Cunningham, M.D., Dr.P.H.  
 J. Dryfoos, M.A.  
 T. Frejka, Ph.D.  
 R. Friedman, M.D.  
 A. Galen, M.A.  
 M. Gorosh, Dr.P.H.  
 S. Isaacs, J.D.  
 R. Loewenstein, M.A.  
 S. Pasquariella, M.S.  
 S. Philliber, Ph.D.  
 A. Rosenfield, M.D.  
 J. Ross, Ph.D.  
 P. Rothenberg, Ph.D.  
 K. Roy, Ph.D.  
 A. Sear

Operations

B. Graves, B.A.  
S. Isaacs, J.D.  
J. Rios, B.A.

Special Assignments

J. Bertrand, Ph.D.  
B. Folger, B.A.

Appendix I

National Family Planning Program  
Ministry of Public Health  
Bangkok, Thailand

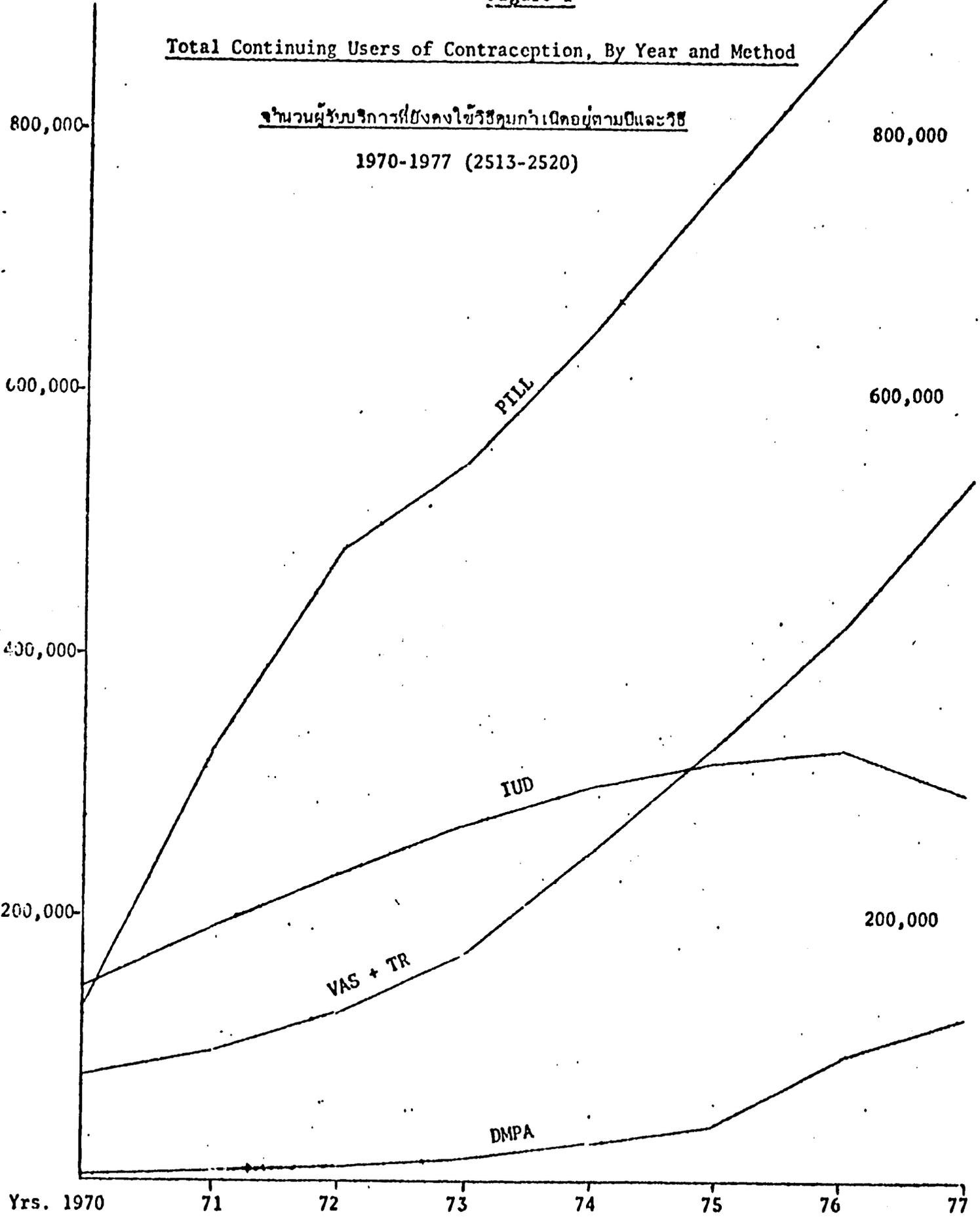
1. Service Statistics Data
2. Data Summary, Contraceptive Followup Study

Figure 1

Total Continuing Users of Contraception, By Year and Method

จำนวนผู้ใช้บริการที่ใช้คุมกำเนิดอยู่ตามปีและวิธี

1970-1977 (2513-2520)



Note: Mid year users.

Table 1

Number of New Family Planning Acceptors By Method By Month - 1977

จำนวนผู้รับบริการใหม่เป็นรายเดือนตามวิธี - ๒๕๒๐

Month Method	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Whole Year
IUD	7,541	6,615	6,305	5,289	6,158	6,920	5,532	5,688	5,904	5,525	6,611	6,706	74,794
Pill	44,872	41,870	39,548	34,326	43,513	41,291	34,074	37,833	40,496	38,345	42,313	50,284	488,765
Female Steriliz.	9,070	8,981	9,085	7,771	8,699	9,757	7,898	9,559	9,654	8,456	7,189	10,697	106,816
Vasectomy	747	1,152	1,543	928	1,040	2,053	950	1,280	1,329	2,451	2,116	3,534	19,123
DMPA	5,660	6,052	5,773	4,703	5,779	6,088	5,201	5,560	6,294	6,037	5,564	6,043	68,714
Condom	4,112	4,533	5,700	5,329	5,926	5,715	5,930	6,748	6,267	5,899	5,959	7,275	69,393
Total	72,191	69,332	68,075	58,507	71,267	72,007	59,662	66,809	70,050	66,774	69,951	84,780	829,405

Note: Total includes acceptors of methods other than those listed.

รวม: รวมจำนวนผู้รับบริการรายใหม่ที่รับบริการวิธีอื่น ๆ ด้วย

Table 2-BSELECTED CHARACTERISTICS OF NEW FAMILY PLANNING ACCEPTORS, 1971-1977

	<u>71</u>	<u>72</u>	<u>73</u>	<u>74</u>	<u>75</u>	<u>76</u>	<u>77</u>
<u>Average</u>							
Age	29.2	28.9	28.7	28.3	28.3	28.2	28.1
No. of Living Children	3.8	3.5	3.3	3.3	3.1	2.9	2.8
No. of Living Sons	-	-	-	1.7	1.6	1.5	1.4
No. of Living Daughters	-	-	-	1.6	1.5	1.4	1.4
Length of Open Interval (months)	14.3	12.7	12.3	12.1	12.7	12.7	12.4
<u>Per Cent</u>							
Choosing the Oral Pill	-	-	65.7	63.5	62.7	58.8	61.5
"    the IUD	-	-	22.0	17.9	13.7	11.2	9.7
"    Female Sterilization	-	-	9.1	14.2	14.8	13.7	13.2
"    Vasectomy	-	-	0.5	1.0	1.4	2.0	2.4
"    the Condom	-	-	-	0.0	2.3	3.7	4.0
"    Other (includes DMPA)	-	-	-	3.0	4.3	7.5	9.1
From Rural Areas	72.2	74.1	74.9	71.5	69.6	69.5	67.2
From Urban Areas	12.4	13.0	12.4	13.9	13.9	12.2	13.4
With no Prior Practice of Contraception	-	-	85.5	78.2	76.0	73.3	73.2
Who are New to the Government's NFPP	-	-	-	84.1	83.7	79.9	79.1
Who Changed Method Only*	-	-	3.2	3.3	4.0	4.5	4.2
Who Changed Clinic Only*	-	-	6.1	6.5	7.0	5.9	6.1
Who Changed Method and Clinic*	-	-	5.2	5.9	5.3	6.7	7.0

These data are obtained from a sample of the F.P. 01 new acceptor form which is drawn in the various proportions:

IUD acceptors	1:60
pill acceptors	1:60
injectable acceptors	1:60
female sterilization acceptors	1:10
vasectomy acceptors	1:1

\* These percents refer to new acceptors who were already in the government system but are counted as new acceptors again due to change of method or clinic.

Table 4

## New Acceptors By Method and Region 1976-1977

จำนวนผู้รับบริการรายใหม่แยกเป็นรายวิธีและภาค ปี ๒๕๑๙-๒๕๒๐

แยกตามวิธี	By Method	Number of New Acceptors จำนวนผู้รับบริการรายใหม่		Percent of MWRA % ต่อหญิงในวัยเจริญพันธุ์ ที่แต่งงานแล้ว	
		1976	1977	1976	1977
ยาเม็ดคุมกำเนิด	Pill	376,707	488,765	7.4	9.3
ห่วงอนามัย	IUD	71,894	74,794	1.4	1.4
ผ่าตัดทำหมันหญิง	Female Sterilization	95,131	106,816	1.8	2.0
ผ่าตัดทำหมันชาย	Vasectomy	10,150	19,123	0.2	0.4
ยาฉีดคุมกำเนิด	DMPA	73,357	68,754	1.4	1.3
ถุงยางอนามัย	Condom	37,656	69,393	0.7	1.3
รวม*	TOTAL*	664,895	827,605	13.0	15.8
* Excludes "Other" * ไม่รวมวิธีอื่น ๆ					
แยกตามภาค	By Region	Number of New Acceptors		Estimated Growth Rate	
		1976	1977	1976 <sup>+</sup>	1977 <sup>+</sup>
กรุงเทพมหานคร	Bangkok	73,004	91,417	2.8 %	2.7 %
ภาคกลาง	Central	128,558	173,096	2.7 %	2.7 %
ภาคตะวันออกเฉียงเหนือ	Northeast	206,086	276,078	3.6 %	3.6 %
ภาคเหนือ	North	166,856	205,429	1.3 %	1.2 %
ภาคใต้	South	52,705	83,385	3.1 %	3.1 %
รวม	TOTAL	627,239	829,405	2.8 %	2.7 %

<sup>+</sup> Extrapolation From "Survey of Population Change" Data - N.S.O.

Table 5

New Acceptors Target Achievement By Method 1976-77

	1976 (2519)			1977 (2520)		
	Acceptors (ผู้รับบริการรายใหม่)	Target (เป้าหมาย)	% of Target (% ต่อเป้าหมาย)	Acceptors (ผู้รับบริการรายใหม่)	Target (เป้าหมาย)	% of Target (% ต่อเป้าหมาย)
Pill ยาเม็ด	376,707	280,000	+ 34.5	488,765	350,000	+ 39.6
IUD ห่วงอนามัย	71,894	90,000	- 20.1	74,794	95,000	- 21.3
Female and Male Sterilization ผ่าตัดทำหมัน	105,281	40,000	+ 163.2	125,939	90,000	+ 39.9
DMPA ยาฉีด	73,357			68,754	40,000	+ 71.9
Total รวม	553,882*	410,000	+ 135.1	758,252	575,000	+ 31.9

\* Does not include DMPA

ไม่รวมของยาฉีดคุมกำเนิด

Table 6

% Distribution of New Acceptors by Method and Region 1965-1977

% ผู้รับบริการรายใหม่แยกตามวิธีและภาค ปี ๒๕๐๘-๒๕๒๐

Method Year	IUD	Pill	Female Steril. and Vasectomy	DMPA	Condom and Other
1965 - 1971	35.5	53.4	11.1	-	-
1972	20.0	72.7	7.3	-	-
1973	22.7	66.3	12.0	-	-
1974	18.1	61.7	14.9	-	5.3
1975	13.4	61.4	14.7	4.4	6.1
1976	10.8	56.7	14.3	11.0	7.2
1977	9.0	58.9	15.2	8.3	8.6

Region Year	Bangkok	Central	Northeast	North	South
1965 - 1971	23.4	18.3	27.0	23.8	7.5
1972	10.1	20.1	36.1	26.2	7.6
1973	12.6	20.5	34.8	24.6	7.5
1974	13.5	19.7	36.5	22.7	7.6
1975	12.3	20.1	34.2	25.8	7.6
1976	11.6	20.5	32.8	26.6	8.4
1977	11.0	20.9	33.3	24.8	10.1

Recent Continuation Rate Data for Thailand

Method	Year	Organiza	Cumulative Continuation Rate				Total Starting first ordinal month	
			Sample	6 mos.	12 mos.	18 mos.		24 mos.
Pill	1971	NFPP	Nat'l	79	69	-	55	1,495
Pill	1974	NFPP	Nat'l	68	54	43	35	1,506
Pill	1975	IPSR	Bangkok	77	66	54	48	720
Pill	1977	NFPP	Nat'l	82	72	62	56	1,043
IUD	1971	NFPP	Nat'l	85	76	-	65	1,087
IUD	1972	NFPP	4 Bangkok hospitals	-	77	-	-	1,180
IUD	1975	IPSR	Bangkok	75	62	48	36	277
IUD	1977	NFPP	Nat'l	82	75	68	65	520
DMPA	1975	NFPP	15 (m.d.'s) provinces	75	50	-	-	550
DMPA	1975	NFPP	15 (midwives) provinces	86	69	-	-	555
DMPA	1975	McCormick	Chicupmai Province	84	73	65	57	4,876
<u>Pregnancy Rates</u>								
Pill	1974	NFPP		-	2.7			1,151*
Pill	1975	IPSR		1.8	2.9			720
IUD	1971	NFPP		-	1.0			664
IUD	1972	NFPP		-	1.1			1,180
IUD	1975	IPSR		1.5	3.1			277
DMPA	1975	McCormick		0.6	1.0	1.1	1.4	-
<u>Overall Pregnancy Rate (method of initial acceptance)</u>								
Pill	1974	NFPP		12.6	24.9	40.4	52.5	1,151*
Pill	1975	IPSR		8.5	15.2			720
IUD	1975	IPSR		4.6	11.7			277

\*Interviewed group only, hence total does not reach 1,506 in the data for cumulative continuation rates.