PD-AAA-665-E1

5150105 (4)

AIRGRAM

DEPARTMENT OF STATE

UNCLASSIFIED
CLASSIFICATION

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TO - AID/Washington TOAID A 93 X

973 SEP 11 PM 4 35

A.I.D.

DATE SENT. Sept. 6, 1973

FROM - USAID/SAN JOSE
E.O. 11652: N/A
SUBJECT - PROP Submission Family Planning Project 515-11-580-105
Attn: AS/PR Room B-930
REFERENCE -

Transmitted herewith are two (2) copies of subject PROP revision/extension.

Three errors have been corrected in this copy of subject PROP:

1. P. 1. Block 4 should read "Ends FY 76"

2. The date of signature of the AID Affairs Officer is August 21, 1973.

3. P. 6 tenth line on second paragraph the word "last" is substituted for the word "first".

YAKY

PAGE 1 OF 1 PAGES

DRAFTED BY	OFFICE	PHONE NO.	DATE	APPROVED BY
PO:ASayegues:jrv	Population	Ext. 324	8-31-73	AAO:PMKreis

AID AND OTHER CLEARANCES

UNCLASSIFIED
CLASSIFICATION

AID-5-40 (9-62) W/O HECTO (Do not type below this line) PRINTED 9-6

AID 1025-1 (7-71), (FACE SHEET)

NONCAPITAL PROJECT PAPER (PROP)

I. PROJECT IDENTIFICATION

1. PROJECT TITLE: Population/Family Planning

APPENDIX ATTACHED: [X] YES [ ] NO

2. PROJECT NO. (M.O. 1095.2): 515-11-580-105

3. RECIPIENT (specify)
[X] COUNTRY: COSTA RICA
[ ] REGIONAL _____ [ ] INTERREGIONAL _____

4. LIFE OF PROJECT
BEGINS FY 68
ENDS FY ~~76~~

5. SUBMISSION
[ ] ORIGINAL
[X] REV. NO. 2 August 17,7
DATE
CONTR./PASA NO. _____

II. FUNDING ($000) AND MAN MONTHS (MM) REQUIREMENTS

A. FUNDING BY FISCAL YEAR	B. TOTAL $	C. PERSONNEL (1) $	C. PERSONNEL (2) MM	D. PARTICIPANTS (1) $	D. PARTICIPANTS (2) MM	E. COMMODITIES $	F. OTHER COSTS $	G. PASA/CONTR. (1) $	G. PASA/CONTR. (2) MM	H. LOCAL EXCHANGE CURRENCY RATE: $ US ____ (U.S. OWNED) (1) U.S. GRANT LOAN	(2) COOP COUNTRY (A) JOINT	(2) COOP COUNTRY (B) BUDGET
1. PRIOR THRU ACTUAL FY	1,617	185	60	96	197	328	936	72	30			
2. OPRN FY 73	378	33	12	11	25	86	248	--	--			
3. BUDGET FY 74	395	35	12	--	--	56	204	100	24			
4. BUDGET +1 FY 75	998	35	12	--	--	160	803	--	--			
5. BUDGET +2 FY 76	378	40	12	--	--	55	283	--	--			
6. BUDGET +3 FY	--	--	--	--	--	--	--	--	--			
7. ALL SUBQ. FY	--	--	--	--	--	--	--	--	--			
8. GRAND TOTAL	3,766	328	108	107	222	685	2,474	172	54			

9. OTHER DONOR CONTRIBUTIONS

(A) NAME OF DONOR	(B) KIND OF GOODS/SERVICES	(C) AMOUNT

III. ORIGINATING OFFICE CLEARANCE

DRAFTER: Thomas F. McMahon	TITLE: Population Officer	DATE: August 17,73
2. CLEARANCE OFFICER: Peter M. Kreis	TITLE: AID Affairs Officer	DATE: 8/21/73

IV. PROJECT AUTHORIZATION

1. CONDITIONS OF APPROVAL

2. CLEARANCES

BUR/OFF.	SIGNATURE	DATE	BUR/OFF.	SIGNATURE	DATE

3. APPROVAL AAs OR OFFICE DIRECTORS

SIGNATURE _____ DATE _____

TITLE _____

4. APPROVAL A/AID (See M.O. 1025.1 VI C)

SIGNATURE _____ DATE _____

ADMINISTRATOR, AGENCY FOR INTERNATIONAL

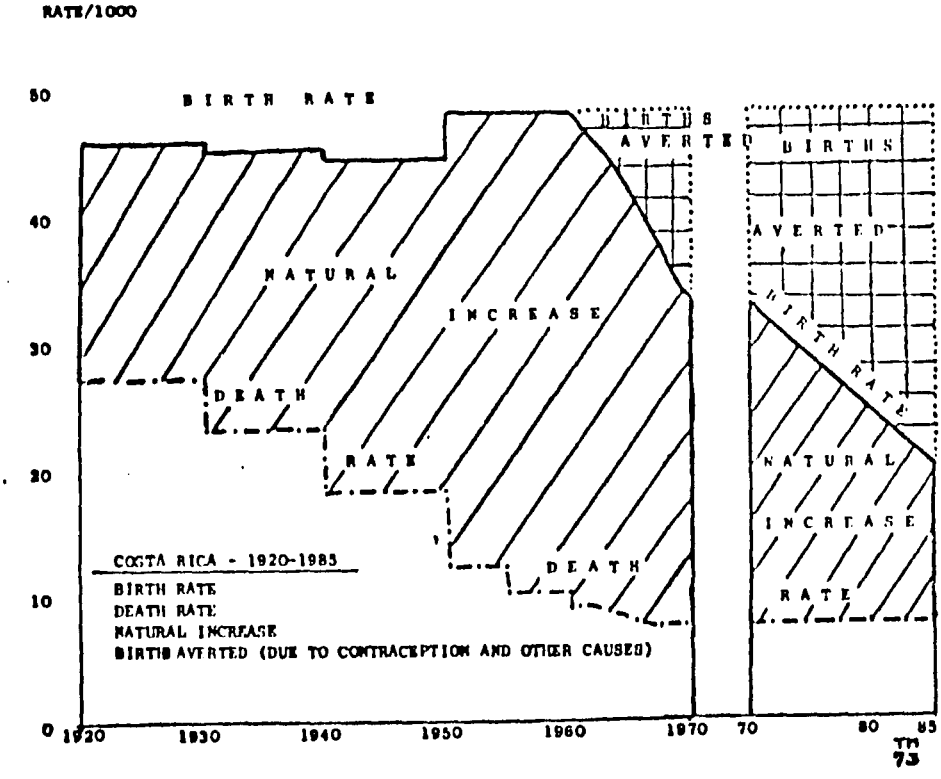
Revision - AID H-93

I. BACKGROUND

POPULATION - THE KEY LONG-TERM DEVELOPMENT VARIABLE

No development activity is more central and critical to long-term objectives than a population program which actually reduces excessive growth rates. The CR POP/FP program has contributed to the decline in birth rate from 46/1000 to 34/1000 in a ten year period and has already created a situation where more favorable economic dependency ratios exist than would have been the case if the unrestricted high birth rates of the late 50's had continued.

TABLE 1



The actual population of Costa Rica in 1972 was 143,500 fewer than it would have been if contraception, later marriage and family planning counseling services had not caused a reduction in birth rate during the 1960's. This means that the actual population of Costa Rica at the end of 1973 will be close to 2,000,000 which is 7.% lower than it would have been without the use of contraception.

Lower birth rates favorably affect the health sector almost immediately by improving maternal/child health. This is evident to recent health statistics of the MOH and CCSS. Infant mortality in 1950 was 89.3, in 1963 it was 69.8 and in 1972 it was 56.5. Part of this decline can be attributed to the reduction in birth rates.

After a delay of five years, lower birth rates influence the demand for education because fewer children require schooling. The educational sector in CR is already experiencing this phenomenon, although it should be understood that this decline is based on the percentage decline of the increased number and not and absolute decline. By 1980 nearly 200,000 more young people would be of school age had not the birth rate declined during the 60's and 70's. This means that the education sector will be spared the drain required by nearly a quarter million students who would have required classrooms, teachers, equipment, etc.

The GOCR is publicly committed to expansion of its FP program to the point where every citizen will have easy access to such services. This will enable all citizens to act on their choice to have fewer children. The GOCR has not determined what the ideal growth rate for CR should be in the light

of its development goals; although most observers are hopeful of a continuing decline to a 2.0% rate by 1980.

The GOCR continues to support the POP/FP program with funds and personnel. It has also shown new interest in including the demographic variable in its long term planning.

Success in Costa Rica to date may be attributed to a number of key factors:

1. The GOCR has supported a broad Population/Family Planning (POP/FP) program with substantial funds (more than $350,000 in FY/72-73) which includes an integrated sex education program in the school system with direction from the Ministry of Education as well as the creation of a Department of Population in the Ministry of Health to manage the FP services in all Ministry hospitals and clinics. Most of these facilities are in urban areas or larger towns.

2. All seven institutions both public and private -- Costa Rica Demographic Association (CRDA), Center for Family Integration (CIF) of the Catholic Church, Center for Family Orientation (COF) of the Protestant Church, Center for Population and Social Studies (CESPO), Ministry of Education, Ministry of Public Health, Social Security Institute -- are members of the National Coordinating Committee for Population and Sex Education (CONAPO) which meets regularly each week to discuss policy, programs and future plans.

3. Costa Rica has an operative country FP program and has assigned them to responsible organizations. Information/education is carried out by CRDA, COF, CIF, materials production by MOH and CRDA, FP service by MOH and SSI, research, evaluation and non-medical training by CESPO, planning

and fund raising from international non-governmental organizations by CRDA, medical training by Medical Faculty of the UCR and SSI.

4. The relatively high CR literacy and educational level has contributed to the effectiveness of information/education programs.

5. The vigorous involvement of the private sector and Churches has strengthened the total program and prevented dysfunctional opposition.

A recent commitment by the Social Security Institute (SSI) to rapidly expand its MCH/FP services to all currently eligible citizens (54% of the total population in 1972) will reduce pressure on the already overburdened Ministry of Health MCH/FP program during the next two years. The challenge of reaching the isolated rural population with the highest birth rates and greatest need for MCH/FP services, however, has only recently been given top priority by the MOH. Some of these communities have birth rates at the upper biological limit.

A rural health pilot project in San Ramón is currently testing the feasibility of using specially trained auxiliary nurses to visit isolated families in teams to bring them preventive health care and MCH/FP service. These specially trained rural health workers offer many services in the home which were previously restricted to the clinic. Preliminary data after one year indicates that this approach, modeled after similar projects in Cali, Colombia, and Israel, may be sufficiently cost-effective to warrant expansion. A special nine-month course for 20 additional rural health auxiliaries is scheduled to begin in July, 1973. This course is being supported by the USAID.

Health and FP service in Costa Rica should improve in urban areas with the expansion of the SSI; but the willingness of the MOH to provide innovative preventive/community health services to the population which is not covered by Social Security will be the principle determinant for the future in reducing population growth in an increasing urban-rural dichotomy.

A critical problem in the MOH is a weak program/manpower planning function. This is especially true of the MOH Department of Population. Recent expansion of the UCR Medical School and increased nurse training courses hold out promise for increasing health care over the long haul. However, significant expansion of FP services in the near future can come in only one of three ways: (1) decrease in service standards - number of clients attended per health team hour - (2) the increase of health personnel in each FP service facility or (3) the introduction of new technique and/or manpower categories to provide services. The most acceptable solution within the present Costa Rica context is the ~~first~~ last alternative. This is difficult in the short run but possible in a longer time-frame. The Medical School increased entering enrollment from 40 in 1970 to 100 in 1973. The nursing schools trippled entering enrollment to 150 in 1971. Nonetheless, the propensity of medical personnel to live in the city will further skew the proportion of such services provided to the urban areas.

The last barrier that remains to be surmounted is the introduction of the isolated rural family into the MCH/FP program.

This effort cannot be carried out separately from other rural health activities. Scarce human and budget resources eliminate the feasibility of

developing a separate corps of medical personnel for FP. Morover, clinical space and mobile units are not sufficiently numerous to consider a duplicate FP system. What is needed is a methodology that can integrate FP with general health services for rural families.

There is also the important maintenance task of convincing the more resistent, traditionally-minded, families in urban areas that FP and smaller family size is the more desirable norm. It is a well-documented phenomenon that after the easily persuaded "first acceptors" have enrolled in the FP program the task of motivating the more resistent women in the fertile age cohorts becomes progressively more difficult and costly.

This task has been assigned in part to the sex education program within the MOE.

The MOE objective is that within three to five years sex education instruction will be introduced into the entire curriculum of the school system, both public and private, from first grade of primary school to the last year of secondary school. Teachers continue to be enthusiastic about the program.

The Catholic Church is intimately connected with the National Population/Sex Education Program through the Center for Family Integration (CIF) of the Christian Family Movement. CIF organizes 12-hour, pre-matrimonial courses for Catholic couples who plan to marry. It also has youth groups organized throughout the country. In many parishes, the CIF course is the official pre-matrimonial instruction required by the Catholic Church in preparation for marriage. Both, family planning and responsible parenthood are discussed

along with all the available contraceptive methods. While the Church does not officially recognize all types of contraceptives, CIF tells the couples that they should follow their personal convictions in this regard. Rapid expansion of CIF's activities is spreading FP information to more and more families, emphasizing the advantages of smaller size.

Each member organization of CONAPO has its general overall goals and objectives well in hand. Several serious problems exist in two institutions; the MOH and CESPO. The MOH requires technical assistance in health system planning and its Department of Population lacks a program coordinator which has caused inefficient management practices and prevented timely scheduling of important activities. Solutions are being sought jointly with the officials involved.

CESPO continues to have funding problems mainly because it has not generated sufficient managerial expertise to coordinate the activities of its research, evaluation and training divisions and lacks a planning capability.

Important international donors to the program are listed below with their FY/72 inputs:

Inputs in Thousands of Dollars	
AID (bilat.)	313
IPPF	233
Ford Foundation	85
PAHO	250
PPFA	56
SIDA	27

UNFPA	9
WORLD EDUCATION	8
	981

The Mission will focus its primary attention on assisting the MOH and CONAPO in developing an integrated rural health delivery system with MCH/FP the major focus. It will also continue to support salary supplements for program supervisors to bolster overall supervision which has been inadequate in the past. New agreements with member organizations of CONAPO will also be focused on the principal thrust -- bringing FP service to the rural population.

DISTRIBUTION OF POP/FP FUNCTIONS

ACCORDING TO AGENCIES OF CONAPO

	MOH	SSI	CRDA	CESPO	MOE	COF	CIF
Information	xx	x	xxxx	x	x	xx	x
Training	x	x	xx	xxxx	xx	xx	x
FP Services	xxxx	xxxx	xx	0	0	0	x
Research & Education	x	x	xx	xxxx	x	x	xx
Sex Education				xxx	xxxx	xxx	xxx
Distribution of Contraceptives	xx	xx	xxx	0	0	0	0

Key: Principal activity - xxxx
Important " - xxx
Secondary " - xx
Minor " - x

II. IDENTIFICATION OF PROBLEM

The major health problem facing Costa Rica with a rural population of about 60% is how to provide maternal child health/family planning (MCH/FP) services that are integrated with community health services to the large number of families that live beyond practical access to existing health facilities.

Costa Rica with 15 FP acceptors per 1,000 inhabitants ranks second highest of all Latin American countries behind Trinidad. It also ranks second after Jamaica with one FP clinic for every 20,000 inhabitants. Its well coordinated population/sex education program has been responsible, together with private sector initiatives, in significantly reducing the birth rate from 47.8 in 1960 to 33.3 in 1970. But most of these accomplishments in lowering birth rates and providing much improved health services has come about in the urbanized areas where access to clinics and hospitals is relative easy.

Despite the wide acceptance and utilization of FP services the most needy families, those with the highest fertility and morbidity, remain beyond the outreach of existing health delivery for many reasons:

-- Shortage of doctors and medical personnel in rural areas.

-- Budgetary limitations.

-- Traditional physician-centered and curative approach to health delivery.

-- Insufficient numbers of para-medics.

-- Unrealistic restrictive professional regulations which reserves even very simple procedures for doctors.

-- Cumbersome administration and planning deficiencies.

However these obstacles can be overcome, since many leaders of the health community are progressive, anxious to adopt new, more effective delivery systems and revolutionize the concepts of medicine and the delivery of community medical service to the entire CR people.

Costa Rica has nearly doubled enrollment in the University Medical School. If current doctors' training proceeds on schedule, Costa Rica should have reached the minimum set by the WHO of 1 doctor for 1200 population by 1985. Recently the schools of nursing have doubled enrollment to 150 graduates per year.

An innovative pilot project in San Ramon is currently underway to determine how effective specially trained auxiliary nurses working in health teams in isolated rural areas can be in improving services. In particular, emphasis is placed on maternal child health care and FP education. Preliminary statistics after one year indicate that dramatic reductions in morbidity have resulted in those communities which have been served by this new health delivery system.

The Ministry of Health has organized a second one-year course for 20 additional auxiliary nurses which will extend the San Ramon experiment to more communities.

The Medical Faculty of the University is currently reforming the entire curriculum and teaching methodology which aims at making instruction relevant to the basic needs of Costa Rica and its communities. Students will begin learning medicine in newly developed modules which focus on specific indigenous health problems such as disorders of the gastro-intestinal

tract. In this module all necessary aspects of anatomy, physiology,, microbiology, pharmacology will be studied along with practical clinical experience in both urban and rural clinics.

Two years of experimentation with this new approach indicates that students:

-- Learn faster.

-- Work in small teams facilitates practical research.

-- Use more resource material.

-- Become more proficient in medical practice.

-- Receive higher grades in some material.

-- Are more motivated to public health medicine.

The greatest difficulty encountered thus far lies in the area of student evaluation and the development of grading system acceptable to the entire faculty.

The Ministry of Health has recently established an Office of Rural Medicine to coordinate and begin planning a more comprehensive approach to these new initiatives; this includes the development of a training facility. Given the open nature of the Costa Rica medical community to such advances to a total health program there is every indication that a major grant program to address MCH/FP needs in isolated rural communities will produce outstanding results.

III. USAID/CR PROGRAM IN POPULATION AND INTEGRATED HEALTH SERVICE

The Mission plans to support the CR/FP program at the levels indicated in Table II.

TABLE II

FY/74

	Other Costs	Commodities	Total
CONAPO (Rural Program)	- 0 -	- 0 -	100,000*
CRDA	69,000	6,000	75,000
MOH	65,000	35,000	100,000
CIF	35,000	5,000	40,000
CCSS	15,000	10,000	25,000
DIRECT HIRE	35,000	- 0 -	35,000
LOCAL CONTRACT	6,000	- 0 -	6,000
SHORT-TERM TRAINING	14,000	- 0 -	14,000
TOTAL	239,000	56,000	395,000

*Contract Services with U.S. and/or third country nationals

FY/75

	Other Costs	Commodities	Total
CONAPO (Rural Program)	600,000	100,000	700,000
CRDA	65,000	5,000	70,000
MOH	90,000	30,000	120,000
CIF	30,000	5,000	35,000
CCSS	- 0 -	20,000	20,000
DIRECT HIRE	35,000	- 0 -	35,000
LOCAL CONTRACT	6,000	- 0 -	6,000
SHORT-TERM TRAINING	12,000	- 0 -	12,000
TOTAL	838,000	160,000	998,000

FY/76

	Other Costs	Commodities	Total
CONAPO (Rural Program)	150,000	20,000	170,000
CRDA	60,000	- 0 -	60,000
MOH	35,000	30,000	65,000
CIF	20,000	5,000	25,000
CCSS	- 0 -	- 0 -	- 0 -
DIRECT HIRE	40,000	- 0 -	40,000
LOCAL CONTRACT	8,000	- 0 -	8,000
SHORT-TERM TRAINING	10,000	- 0 -	10,000
TOTAL	323,000	55,000	378,000

Assistance to MOH during the next two fiscal years will be concentrated on introduction of more efficient methods of manpower utilization through use of qualified para-medical personnel and on maintenance of on-going clinical FP services by inputs to critical areas of planning and supervision.

CONAPO working closely with the Ministry of Health plans to develop a para-medical program as follows:

Phase I - Undertake a study of current health services available in rural areas and plot relative needs by areas.

Phase II - Design a rigorous para-medical training course to confront CR rural health problems described in Phase I.

Phase III - Select candidates from target rural communities and begin a pilot one-year course to test the feasibility of training up to 250 para-medics who can provide basic health/family planning services and identify individuals requiring higher level care. These para-medics will also assume an important community leadership role by introducing modern attitudes toward health, family planning and sanitation standards conducive to much improved overall levels of community health.

Assistance to CRDA will continue to support part of its administration costs which has enabled CRDA to provide the leadership for CONAPO as well as family planning promotion and support services.

Assistance to CIF will continue with an aim to phase out in FY/76. Assistance to the CCSS will be for costs which CCSS will assume after new program innovations have been operative and can be included in the subsequent CCSS budget.

The Mission will continue to offer training for key managers of the program for short study visits to neighboring countries and the U.S. to observe and study techniques and programs that may show promise in Costa Rica.

The Mission is coordinating its plan to finance a large-scale rural health delivery system using specially trained para-medical personnal with MOH and CONAPO. There is general agreement in the MOH that such a plan should be pushed ahead quickly and that FP would be the key element.

The CR/FP program has had remarkable success. At this stage of development, improved management and better means to attract new acceptors are critical problems. Evaluation has become essential and is being carried out slowly. Longer term planning must be incorporated into all institutions to achieve continuous guaranteed support and program continuity. The 5-year UNFPA/CONAPO plan is a first step.

Each element in the AID plan for FY's 74-76 is a continuation of support for previous activities but with increased concentration on innovative methods of bringing health/FP services to rural Costa Rica.

The USAID believes that continued support of the Costa Rica FP program is crucial. Significant progress has been made to the point where its national acceptance has been achieved. This presents a golden opportunity to strengthen the actual provision of services. However, Costa Rica faces a major obstacle in the maintenance of the momentum already achieved in reducing family size, namely, the problem of bringing FP service to the isolated rural family with high fertility. External assistance will be relied on to study and fund innovative health delivery systems using para-medical personnel to perform

many of the tasks traditionally assigned to physicians. Such assistance should pay important dividends that can be applied to other countries facing similar problems of introducing modern health delivery concepts.

IV. PROJECT SUPPORT JUSTIFICATION

This PROP replaces the previous PROP, dated August 17, 1970 in its entirety. The USAID believes that the FP program in Costa Rica is one of the best in the LA Region and deserves continuing AID support. Justification for its continuation at least through FY 76 is based on (a) exceptional progress to date, (b) the inability of other international assistance agencies to finance a greater share of the activities under this national program, (c) the innovative, sometimes experimental nature of the proposed inputs which implies the type of costs consistent with Title X criteria which the GOCR would be unable to finance without proven experience, (d) the already heavy percent of Costa Rican public sector expenditures going to the health sector and (e) the importance of following through with sufficient financial support to implement a major attempt at providing FP services to isolated rural communities which is the primary constraint to population rate decline to 2.0% by 1980.

The Mission believes that Costa Rica has made a concerted, self-help effort in reducing population presures and that continuation of AID assistance will have the needed catalytic effect toward successful realization of the program's objectives.

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project From FY 74 to FY 76
Total U. S. Funding -
Date Prepared:

Project Title & Number: Costa Rica Population Family Planning

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Program or Sector Goal: The broader objective to which this project contributes: (A-1) That Population/Family Planning programs contribute to general socio-economic development	Measures of Goal Achievement: (A-2) 1. Development indicators: a. Lower dependency ratio b. Better educational opportunity c. Reduced morbidity d. Less malnutrition (Cont. page 2, A-2)	(A-3) 1. Official Government economic data and indicators 2. Census and health statistics	Assumptions for achieving goal targets: (A-4) 1. That Government include demographic projections in its economic planning 2. That Government adopt an integrated population policy (Cont. page 2, A-4)
Project Purpose: (B-1) To achieve healthful reproductive patterns among citizens, concentrating on rural families with high mobidity and to adjust birth rates downword to a level conducive to sustained socio-economic development.	Conditions that will indicate purpose has been achieved: End-of-Project status. (B-2) 1. Birth rate decline over -time Costa Rica Birth Rates: 1952 - 48.1 56 - 48.2 60 - 47.8 (Cont. page 2, B-2)	(B-3) 1. Statistics a. Census Department b. CESPO c. CELADE 2. Demographic studies: a. CESPO (Cont page, B-3)	Assumptions for achieving purpose: (B-4) 1. That GOCR increase support of population/family planning program 2. That GOCR not enact legislation and support public programs that will be (Cont. page 2, B-4)
Project Outputs: (C-1) Integrated POP/FP Program consisting of: a. FP Services of MOH & SSI b. Education, Information & Communication program (EIC) c. Research and evaluation (Cont. page 2, C-1)	Magnitude of Outputs: (C-2) 1. Rural Community Medicine Program: a. Train 60 para-medics/yr. 1975-76 b. Staff 100 rural health posts by 1976. c. Introduce FP to 20% (Cont. page 2, C-2)	(C-3) Health institution reports. Evaluation statistics	Assumptions for achieving outputs: (C-4) 1. That FP services and EIC programs be extended to remote rural areas. 2. That GOCR and SSI budget support continue to increase to meet demand. 3. That emphasis be concentrated on improved administra.
Project Inputs: (D-1) Total AID Grant Funds: FY/74 - 395,000 FY/75 - 998,000 FY/76 - 378,000	Implementation Target (Type and Quantity) (D-2) CONAPO Rural Program: FY/74 - 100,000 FY/75 - 700,000 FY/76 - 170,000 CRDA FY/74 - 75,000 FY/75 - 70,000 FY/76 - 60,000 (Cont. page 2, D-2)	(D-3) 1. Recipient institution monthly reports. 2. Monthly reimbursement vouchers 3. Project manager reports	Assumptions for providing inputs: (D-4) That Costa Rica institutions continue to accept assistance from international sources.

AID-28 (1-72)
SUPPLEMENT B

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

(INSTRUCTION: THIS IS AN OPTIONAL FORM WHICH CAN BE USED AS AN AID TO ORGANIZING DATA FOR THE PAR REPORT. IT NEED NOT BE RETAINED OR SUBMITTED)

Life of Project:
From FY 74 to FY 76
Total U.S. Funding
Date Prepared:

Project Title & Number: Costa Rica Population Family Planning

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Program or Sector Goal: The broader objective to which this project contributes: (A-1)	Measures of Goal Achievement: (A-2)	(A-3)	Assumptions for achieving goal targets: (A-4)
	e. Increased life expectancy. Death Rates: 1950 - 12.3 1963 - 9.4 1972 - 5.9 1976 - 5.2 Infant Mortality Rates: 1950 - 89.3 1963 - 69.8 1972 - 56.5 1976 - 50.0 2. Increase number of women in work force		

AID 1020-28 (11-73)
SUPPLEMENT 1

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY 74 to FY 76
Total U.S. Funding
Date Prepared:

Project Title & Number:

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Purpose: (B-1)	Conditions that will indicate purpose has been achieved: End-of-Project status. (B-2) 1962 - 45.1 64 - 42.9 66 - 40.5 68 - 35.9 70 - 33.3 76 - 31.0 2. General awareness among all socio-economic groups that reduced fertility is desirable for individual and general welfare 3. The numbers of women and men in the reproductive age group practicing family planning. Cumulative percentage of women in fertile age group registered in FP official programs 1968 - 3.2% 69 - 6.9% 70 - 12.4% 71 - 19.7% 72 - 26.9% 73 - 35.1% (extrapolated) 74 - 42.3% 75 - 49.2% (estim.) 76 - 54.1% 76 - 58.9%	(B-3) b. CELADE 3. Health Statistics a. Ministry of Health b. Social Security Institute	Assumptions for achieving purpose: (B-4) dysfunctional to birth rate decline. vg. Family Assistan Program. 3. That Church continue to supp general program goals. 4. That CONAPO accept a vigorou rural health delivery system which permits non-physician distribution of conventional and oral contraceptives. 5. That sterilization be offere to all women and men who s request.

AID 1020-28 (1-72)
SUPPLEMENT 1

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY 74 to FY 76
Total U.S. Funding
Date Prepared:

PAGE 3

Project Title & Number: Costa Rica Population Family Planning

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Outputs: (C-1)	Magnitude of Outputs: (C-2)	(C-3)	Assumptions for achieving outputs: (C-4)
. Sex education program in school system.	of fertile women reached by health posts. 2. F.P. Program Maintenance a. Ministry of Health by 1976 85 clinics 7 mobile units 10 hospitals b. Social Security Institute by 1976 15 clinics 7 hospitals 3. Information, communication and education program per year. (1) Demographic Association: 30,000 radio programs broodcast 250,000 booklets published 11 series of slides produced 250 flip charts produced 1840 inches of newstories 1 Experimental information Center (Limón) 4. Research and Evaluation CESPO Evaluation Unit: 2 Major studies per year to 1977 3 Minor studies per year to 1977		

(Cont. page 3, C-2)

AID 1020-25 (1-730)
SUPPLEMENT B

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY 74 to FY 76
Total U.S. Funding
Date Prepared:

Project Title & Number: Costa Rica Population Family Planning

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Outputs: (C-1)	Magnitude of Outputs: (C-2)	(C-3)	Assumptions for achieving outputs: (C-4)
	5. Sex Education Program CESPO Cumulative Teachers Trained: 1973 - 1,700 1974 - 2,400 1975 - 3,000 1976 - 3,500		

1020-28 (1-73)
ELEMENT 5

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY 74 to FY 76
Total U.S. Funding
Date Prepared:

Project Title & Number: Costa Rica Population Family Planning

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Inputs: (D-1)	Implementation Target (Type and Quantity) (D-2) MOH FY/74 - 100,000 FY/75 - 120,000 FY/76 - 65,000 CIF FY/74 - 40,000 FY/75 - 35,000 FY/76 - 25,000 CCSS FY/74 - 25,000 FY/75 - 20,000 FY/76 - - 0 - SHORT-TERM TRAINING FY/74 - 14,000 FY/75 - 12,000 FY/76 - 10,000	(D-3)	Assumptions for providing inputs: (D-4)