

AUG 24 1979 195 p.

## ACTION MEMORANDUM FOR THE ASSISTANT ADMINISTRATOR (LAC)

FROM : LAC/DR, Marshall D. Brown *Marshall D. Brown*

SUBJECT: Authorization of the Panama Population II project  
(\$3.250 million grant)

Discussion: The project proposes to expand delivery of family planning information and services to a higher proportion of the fertile age group. In particular, the project will concentrate on extending outreach to a greater number of fertile age women in rural areas and low-income sections of metropolitan Panama and to two new target groups, adolescents and men. Thus, the project will build upon the success of the terminating population project and continue to support the GOP's integrated approach to the delivery of family planning services through the Ministry of Health in coordination with a UNFPA program. The project will also encourage new avenues of outreach by assisting nonhealth sector institutions to extend family planning through sex education and family planning information and education activities. These latter activities will be implemented through the Ministry of Education, the Panamanian Institute for Special Education (I.P.H.E.), the Asociacion Panamena para el Planeamiento de la Familia (APLAFa), and the Ministry of Labor.

The total cost of the project is \$9.54 million, of which \$3.250 million will be financed by an A.I.D. grant. A.I.D.'s contribution will finance commodities, including contraceptives, equipment and vehicles (\$616,300); centrally procured commodities (\$820,000); printed materials and mass media coverage (\$682,000); training (\$691,700); technical assistance (\$166,000); and evaluation and studies (\$274,000). The GOP will finance salaries, vehicles and equipment, maintenance and repair costs (\$4,976,600). Other donor contributions amount to \$1,313,000 and will finance commodities, training, and information education and communication activities.

The DAEC reviewed and approved the proposed project on July 25, 1979. The following modifications were made in the project as a result of the review:

1. Additional funds were included in the project to ensure that adequate logistic management support will be available for providing sufficient and timely supplies of drugs and contraceptives in the dispensing facilities.
2. An indepth study will be conducted during the first 2 to 3 years of the project to determine the effect of the sex education program and whether adequate family planning services are being provided to meet the demand created by this education program. At the same time the review will analyze whether project reprogramming will be required in order to meet the possible increased demand.

3. A summary of the proposed national sex education program, including a general outline of the curriculum, was included in the PP.

4. The Mission is being requested during project implementation to explore possibilities of encouraging in country sterilization training and to establish a systematic interchange mechanism for coordinating the project with the UNFPA, the MOH and the National Commission on Sex Education. The Mission is also being requested to include in the project agreement a covenant to the effect that an individual can not be issued laproscopy equipment without appropriate training in its use.

This project does not appear in the FY 79 CP, although \$505,000 was included for this activity under the previous Health and Population Grant, 525-0142. A Congressional Notification has, therefore been transmitted requesting \$1,430,000 for FY 79 funding. This amount provides 3 years of funding for this project. The waiting period expired on August 24, 1979. An Initial Environmental Examination recommending a negative determination was approved by the AA/LAC.

Recommendation: That you sign the attached Project Authorization and Request for Allotment of Funds (PAF) for the Panama Population II project, as well as the attached cable transmitting the DAEC results to the Mission.

Attachment:  
a/s

**DEPARTMENT OF STATE**  
**AGENCY FOR INTERNATIONAL DEVELOPMENT**  
WASHINGTON, D. C. 20523

**ASSISTANT  
ADMINISTRATOR**

**PROJECT AUTHORIZATION AND REQUEST FOR ALLOTMENT OF FUNDS**

Name of Country: Panama  
Name of Project: Population II  
Number of Project: 525-0204

Pursuant to Part I, Chapter 1, Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize a Grant to the Republic of Panama, the "Cooperating Country" of not to exceed One Million Three Hundred Seventy Four Thousand United States Dollars (\$1,374,000) and to the Asociacion Panamena para el Planeamiento de la Familia (APLafa) of not to exceed Fifty-Six Thousand United States Dollars (\$56,000), subject to registration of APLafa with AID as a private voluntary organization. The total amount hereby authorized to be granted to the Cooperating Country and to APLafa is One Million Four Hundred Thirty Thousand United States Dollars (\$1,430,000), the "Authorized Amount", which will help in financing certain foreign exchange and local currency costs of goods and services required for the Project as described in the immediately following sentence. The Project consists of (1) extension of contraceptive coverage; (2) expansion of family planning information, education and communication outreach activities; and (3) introduction and institutionalization of sex education for Panama's fertile age group (hereinafter referred to as the "Project").

I approve the total level of AID appropriated funding planned for this Project of not to exceed Three Million Two Hundred Fifty Thousand Dollars (\$3,250,000), all of which will be Grant funded, including the funding authorized above, during the period FY 1979 through FY 1983. I approve further increments during that period of Grant funding up to One Million Eight Hundred Twenty Thousand United States Dollars (\$1,820,000), subject to the availability of funds in accordance with AID allotment procedures.

I hereby authorize the initiation of negotiation and execution of Project Agreements by the officer to whom such authority has been delegated in accordance with AID regulations and Delegations of Authority subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as AID may deem appropriate:

A. Source and Origin of Goods and Services

Goods and services, except for ocean shipping, financed by AID under the Project shall have their source and origin in the Cooperating Country or in the United States, except as AID may otherwise agree in writing. Ocean shipping financed under the Grant shall be procured in the United States, except as AID may otherwise agree in writing.

B. Conditions Precedent to Disbursements by Implementing Institutions

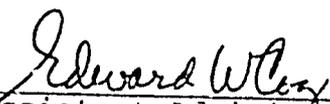
Prior to disbursement under the Grant, or to the issuance by AID of documentation by which disbursement will be made by each implementing institution, for any purpose other than to finance (i) training of trainers in sex education or (ii) extension of media contracts, the Cooperating Country will, except as AID may otherwise agree in writing, furnish to AID or cause to be furnished to AID, in form and substance satisfactory to AID, evidence that a Project Coordinator mutually acceptable to AID and the Cooperating Country has been named by each such implementing institution.

C. Condition Precedent to Disbursement for Training by Each Implementing Institution

Prior to any disbursement under the Grant, or to the issuance by AID of any documentation by which disbursement will be made by each implementing institution which will carry out, under the Grant, training activities other than training of trainers in sex education, the Cooperating Country will, except as otherwise agreed in writing by AID, furnish to AID, or cause to be furnished to AID, in form and substance satisfactory to AID, a training plan for each such implementing institution.

D. Covenants

The Cooperating Country shall covenant that, except as AID may otherwise agree in writing, the Cooperating Country shall provide adequate budget for continuation of the program of family planning and sex education for five years beyond the final disbursement under the Grant.

  
Assistant Administrator  
Bureau for Latin America  
and the Caribbean

8-24-79  
Date

Clearances:

GC/LAC, J. Kessler JK/YW date 8/22  
LAC/DR, R. Mathia DMD date 8/17/79

LAC/DR, M. Brown MB date \_\_\_\_\_

Drafted:GC/LAC:<sup>SRW</sup>SWhitman:ec:8/15/79:x29182

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| AGENCY FOR INTERNATIONAL DEVELOPMENT<br><br><b>PROJECT PAPER FACESHEET</b> | 1. TRANSACTION CODE<br><input type="checkbox"/> A ADD<br><input type="checkbox"/> C CHANGE<br><input type="checkbox"/> D DELETE | PP |
|  | 2. DOCUMENT CODE<br>3   |    |

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| 3. COUNTRY/ENTITY<br>Panama | 4. DOCUMENT REVISION NUMBER<br><input type="checkbox"/> |
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| 5. PROJECT NUMBER (7 digits)<br><input type="text" value="525-0204"/> | 6. BUREAU/OFFICE<br>A. SYMBOL <input type="text" value="LA"/> B. CODE <input type="text" value="05"/> | 7. PROJECT TITLE (Maximum 40 characters)<br><input type="text" value="POPULATION II"/> |
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| 8. ESTIMATED FY OF PROJECT COMPLETION<br>FY <input type="text" value="84"/> | 9. ESTIMATED DATE OF OBLIGATION<br>A. INITIAL FY <input type="text" value="79"/> B. QUARTER <input type="text" value="3"/><br>C. FINAL FY <input type="text" value="83"/> (Enter 1, 2, 3, or 4) |
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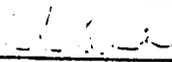
| A. FUNDING SOURCE      | 10. ESTIMATED COSTS (\$000 OR EQUIVALENT \$1 - ) |         |          | LIFE OF PROJECT |           |           |
|------------------------|--|---------|----------|-----------------|-----------|-----------|
|                        | B. FX  | C. L/C  | D. TOTAL | E. FX           | F. L/C    | G. TOTAL  |
| AID APPROPRIATED TOTAL | 450  | 109     | 559      | 1,502           | 1,598     | 3,100     |
| (GRANT) PN             | ( 450 )  | ( 109 ) | ( 559 )  | ( 1,502 )       | ( 1,598 ) | ( 3,100 ) |
| (LOAN)                 | ( )  | ( )     | ( )      | ( )             | ( )       | ( )       |
| OTHER U.S. 1.          |  |         |          |                 |           |           |
| OTHER U.S. 2.          |  |         |          |                 |           |           |
| HOST COUNTRY           |  | 117     | 117      |                 | 4,977     | 4,977     |
| OTHER DONOR(S)         |  |         |          | 50              | 1,263     | 1,313     |
| TOTALS                 | 450  | 226     | 676      | 1,552           | 7,838     | 9,390     |

| A. APPROPRIATION | B. PRIMARY PURPOSE CODE | PRIMARY TECH. CODE |         | E. 1ST FY <u>79</u> |         | H. 2ND FY <u>80</u> |         | K. 3RD FY <u>81</u> |         |
|------------------|-------------------------|--------------------|---------|---------------------|---------|---------------------|---------|---------------------|---------|
|                  |                         | C. GRANT           | D. LOAN | F. GRANT            | G. LOAN | I. GRANT            | J. LOAN | L. GRANT            | M. LOAN |
| (1) PN           | 444                     | 440                |         | 559                 |         | 552                 |         | 565                 |         |
| (2)              |                         |                    |         |                     |         |                     |         |                     |         |
| (3)              |                         |                    |         |                     |         |                     |         |                     |         |
| (4)              |                         |                    |         |                     |         |                     |         |                     |         |
| TOTALS           |                         |                    |         | 559                 |         | 552                 |         | 565                 |         |

| A. APPROPRIATION | N. 4TH FY <u>82</u> |         | O. 5TH FY <u>83</u> |         | LIFE OF PROJECT |         | 12. IN-DEPTH EVAL. SCHEDULED                |
|------------------|---------------------|---------|---------------------|---------|-----------------|---------|---|
|                  | D. GRANT            | P. LOAN | R. GRANT            | S. LOAN | T. GRANT        | U. LOAN |   |
| (1) PN           | 654                 |         | 770                 |         | 3,100           |         | <input type="text" value="MM 1 FY 10 8 0"/> |
| (2)              |                     |         |                     |         |                 |         |   |
| (3)              |                     |         |                     |         |                 |         |   |
| (4)              |                     |         |                     |         |                 |         |   |
| TOTALS           | 654                 |         | 770                 |         | 3,100           |         |   |

13. DATA CHANGE INDICATOR. WERE CHANGES MADE IN THE PID FACESHEET DATA, BLOCKS 12, 13, 14, OR 15 OR IN PRP FACESHEET DATA, BLOCK 12? IF YES, ATTACH CHANGED PID FACESHEET.

1 = NO  
 2 = YES

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|---|--|--|
| 14. ORIGINATING OFFICE CLEARANCE<br>SIGNATURE  |  | 15. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION<br><input type="text" value="MM 07 11 6 7 9"/> |
| TITLE<br>Warren E. Lane<br>Acting Director  | DATE SIGNED<br><input type="text" value="MM 07 11 2 7 9"/> |  |

## POPULATION II

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LAC/DR BULK FILES

UNFPA Project Proposal, "Proyecto de Extension del Programa de Salud Materno Infantil, 1979-1982," Departamento Materno Infantil, Division de Salud Familiar, Ministerio de Salud, Republica de Panama.

Polly F. Harrison, "Female Reproductive Life: Its Characteristics and Attendant Value in Panama - A Basis for Sociocultural Analysis," December 1, 1978, Panama and Port-au-Prince.

Programa Nacional de Educaci3n Sexual, Panam3, 1979.

## I. DESCRIPTION OF THE PROJECT

### A. BACKGROUND AND STATEMENT OF THE PROBLEM

#### 1. The Terminating Project\*

AID has been providing population assistance to Panama for 12 years (FY1968-FY1979). The goal of the original project - to achieve a 2.0% growth rate by the year 2000 - is likely to be a reality before the turn of the century. By 1977, Panama's rate of growth had slowed to 2.4%. The purpose of the terminating project - to increase awareness of family planning, increase the demand for family planning, and to provide family planning services through the Ministry of Health's (MOH) Maternal and Child Health (MCH) program - has been achieved: 98% of Panamanian women are aware of family planning, almost half of fertile age women, married or in a union, are active users of some method, and the MOH/CSS (Caja de Seguro Social) currently offers family planning at 364 health facilities compared with a mere 15 service locations in 1968.

During the past 12 years, AID has provided clinical equipment and contraceptive commodities for the MCH program to improve the capability of the MOH to deliver family planning services. Bilateral funds and intermediary organizations have been used to finance training of personnel at all levels (physicians, nurses, health assistants, women's health care specialists, health administrators) so that they have sufficient conceptual and technical background to deliver effectively family planning information and services. AID has supported a continuous MOH-sponsored MCH/family planning mass media campaign consisting of radio spots, published pamphlets and folders, and posters. In addition, AID has provided a limited amount of support for the Asociación Panameña para la Planificación Familiar (APLAFA). Through 18 project agreements (16 with the MOH and two with APLAFA) over a 12-year period, AID has contributed \$4.6 million to family planning (and MCH) in Panama.

The achievements of the terminating Health and Population Project are impressive. Panama is one of some 30 developing countries to have registered a substantial reduction in its birth rate in recent years. In the decade since the inception of the AID-supported family planning program, the birth rate has decreased dramatically from 38.9 per thousand in 1968 to 28.4 per thousand in 1977, a reduction of 27%. This is the result of education, urbanization and widespread adoption of modern means of contraception. Approximately 47% - or nearly one half - of women in fertile age (ages 15 to 49), in either legal or consensual union, now use contraception in Panama, an impressively high prevalence rate for a developing country. In addition, more than

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\* Project 525-0142, Health and Population, will terminate on August 31, 1979.

twenty per cent of fertile age women in Panama have adopted voluntary surgical contraception, an achievement equalled by few countries in the developing world. Of those who now practice contraception, 70% receive family planning services through the public sector (the combined Ministry of Health/Social Security Agency delivery system).

Despite this marked progress, however, demographic trends and limited GOP capability to provide family planning services to the groups that most need help pose the threat of a reversal of the trend toward a lower population growth rate.

## 2. Demographic Trends

### (a) High Population Growth Rate

Gains from the reduction of the crude birth rate are being offset by continuing high population growth. This is due, for the most part, to an even more dramatic decline in the death rate. Panama's crude death rate has declined steadily over the past 40 years from a high of 12.9 per thousand in the early 1930's to an estimated 4.4 per thousand in 1977.\* The crude birth rate, on the other hand, remained high and nearly constant between 1930 and 1970 (see Table 1, Annex VI). The result was a rapid growth in Panama's population with a steadily rising rate of natural increase to a high of 3.14% per year (average) between 1965-70. Panama was in effect experiencing a "population explosion". It was not until the 1970's that this so-called explosion was checked as the birth rate began to register a gradual but definite decrease. The still falling death rate portends continued rapid population growth as people increasingly live longer. Life expectancy is now an estimated 66.5 years of age (65 for men, 68 for women.\*\* Infant mortality rates have declined significantly and maternal mortality has also declined, from 135.3 deaths to 67.47 per 100,000 live births between 1968 and 1977.\*\*\* Perhaps the most notable change, however, is in the decrease in rural infant mortality.\*\*\*\* This has significance for the rate of population

\* Dirección de Estadística y Censo: Panamá en cifras, 1969-1973, 1970-1974, 1972-1976, 1973-1977. Contraloría General de la República, Panama, November 1974, October 1975, November 1977, and November 1978.

\*\* Two decades ago, according to U.N. estimates for 1960/61, life expectancy was 57.6 years for males and 60.8 years for females (Area Handbook for Panama, 1972, p.61).

\*\*\* Op. cit., Dirección de Estadística y Censo, Panamá en cifras.

\*\*\*\*

| <u>Infant Mortality per 1000 Live Births</u> | <u>1967</u> | <u>1977</u> |
|--|-------------|-------------|
| Total  | 42.7        | 28.1        |
| Urban  | 33.0        | 26.8        |
| Rural  | 49.7        | 29.3        |

Source: "La Salud Panameña en Cifras: 1977", Ministry of Health, 1978.

increase because the fertility rate is substantially higher in rural areas of Panama than in urban areas.

The net result of continued high fertility, coupled with steady reductions of death rates in all groups including infants and mothers, is an absolute increase in population. Panama's current population is estimated to be 1,825,500 (1978). In 1960, the nation's population was 1,075,541. At the present growth rate of 2.4% per year, the country would double its population approximately every 29 years. Medium term projections calculated by Panama's Bureau of Statistics and Census predict a population of 2,800,000 by the year 2000 only 21 years from now.\*

(b) Young Age Structure

Due to the high fertility of the 1960's, Panama's population is today disproportionately young: forty-three percent is under 15 years of age (see Table 5, Annex VI). For every 100 persons aged 15 to 64, there are 89 who are either younger or older than this conventional definition of working age. Panama's young age structure creates a substantial burden of dependency on the country's economically active population and is a heavy drain on already overburdened private and public sector service structures.

This youthful age structure has potentially serious implications for future demographic trends. The number of women 15-49, that is, women at risk of pregnancy, is expected to increase from 321,000 to 517,000 in the period between 1970 and 1985 (see Table 4, Annex VI). Women of child-bearing age will continue to increase as a percentage of the total population during this period as women born during the high fertility period of the 1960's enter the fertile age range. Without continued high adoption of family planning practices, these women can be expected to contribute to an increase in the crude birth rate or, put another way, to a disappointing reversal in its steady decline since 1970.

The implications for rural population growth are even more worrisome. A greater percentage of the rural population than the urban population is under 15.\*\* Fertility is higher among rural women than urban women. These groups have five and three live births per woman, respectively. Moreover, a smaller percentage of rural women than urban women practice contraception. Despite a trend towards migration of rural youth, especially females, to urban areas, it is expected that rural births will increase significantly over the next 15 to 20 years.

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\* Dirección de Estadística y Censo: Estadística Panameña Bol. No.772, "Proyecciones de Población de la República de Panamá, por Sexo y Grupos de Edad: Años 1950-2000", medium projection, Table 9.

\*\* Figures for 1960 show that people 0-14 years of age accounted for 47.1% of the rural population while for the urban population the corresponding percentage was 38.2%. (Source: Robert W. Fox and Jerrold W. Huguet, Population and Urban Trends in Central America and Panama, Inter-American Development Bank, Washington, D.C. 1977).

(c) High Fertility in the 15-19 Age Group

During the decade since 1970, a rising proportion of all births in Panama have been occurring among teenagers 15-19 years of age.\* Women in this age group, representing 22.6% of fertile age women in Panama, now account for over 19% of all births in the country, up from 18% in 1970. While this may be proportionally in line, the effects of teenage fertility have serious consequences for the young mother and her child (or children) and result in high social costs to the state.

What is significant about this group is that while they represent almost a quarter of WIFA, only 7% are married or in a union as compared with 70% for women 20 to 49. The arrival of a child signals for many teenage mothers the termination or, at a minimum, the very strong inhibition of educational and, thus, employment, opportunities. It involves health risks for both the teenage mother and her child and may mean poor health over the longer term for the child. A substantially high proportion of these children are unplanned and unwanted. Abortion is often sought during early pregnancy even though it is illegal in Panama except in cases where the mother's life is certifiably endangered. The below 19 age group now accounts for 20% of all abortion hospitalizations; no data exist on the number of non-hospitalized abortions, but it is thought to be high for this age group. A contraceptive prevalence survey being carried out in Panama during the second half of 1979 will provide data on, inter alia, the proportion of abortions requiring hospitalization and the incidence of abortion stratified by age, residence, and income.

A final and, over the long run, potentially more serious impact of the trend toward an increasing proportion of births to teenagers is its effect on population growth - i.e., decreasing the median age for childbearing: if everything else is equal, women who start bearing children earlier will bear more children during their lifetime, contributing to an increase in the birth rate. The result will be to offset a large share of the fertility decrease at other ages, eventually dissipating the hard-won progress in reducing the birth rate in Panama over the last decade.

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\* Of live births to women 12-19, only 2.5% occurred to women under 15 in 1976, the last year for which data are available. For the purpose of this paper, female teenagers are defined to mean women between 15 and 19 years of age.

### 3. Limited GOP Capability to Provide Family Planning Services

#### (a) Insufficient Coverage

Despite progress during the last decade in introducing family planning to Panama and in extending service coverage to an estimated 47% of fertile-age women in Panama, many more would like to be practicing contraception. The most striking evidence for this conclusion comes from the 1976 National Fertility Survey\* which showed that among women 20-49 years of age, and either married or in a union, 63% did not want any more children, and 33% declared that their last pregnancy had been unplanned. There is also some preliminary and disturbing evidence to suggest that there is a declining rate of new acceptors particularly in formally sponsored family programs. Any decline is indeed cause for alarm since it would be occurring at the same time the number of women in fertile age is increasing dramatically.

While most women in Panama, at least in urban areas and the more accessible rural areas, now know that family planning exists\*\* - they have heard the term "family planning" as well as the names of some contraceptive techniques - they are uncertain about family planning, lack knowledge of what it really means, and have only limited understanding of how a few contraceptive techniques are used and how they actually work.

Use of contraception varies greatly depending on a woman's level of education and place of residence. Predictably, contraceptive use is highest among women who have completed secondary school and among women in urban areas. Highest fertility is found among wives of campesinos and landless agricultural laborers. Women with less than four years of education on the average have six children; women with at least some secondary school, those who can aspire to alternative roles to early marriages and motherhood, average three children.

Despite the fact that a much lower proportion of rural women use family planning than do urban women, there is support for the thesis that rural women, if provided with adequate access to family planning services, would practice contraception far more widely than they do today. For example, a projection of

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\* The National Fertility Survey, part of the World Fertility Survey program, was conducted during the months of December 1975 and March 1976 by the Population Studies Office of the Ministry of Health.

\*\* The National Fertility Survey shows that an extremely high percentage of ever-married or in union women age 20-49 are aware of some methods of contraception (99% in urban areas and 96% in rural areas).

existing demand identified by the National Fertility Survey showed that of women 20-49 years of age who did not want more children, almost half lived in rural areas. Demand is also high among urban women. A third of those surveyed who did not want additional children lived in the metropolitan Panama City area; other evidence supports this high demand among low-income urban women.\*

In 1979, it is estimated that women of fertile age number approximately 437,000.\*\* Given an estimated contraceptive prevalence rate among all women of close to 40%, there are approximately 262,000 who are not covered. Demographic trends assure that the number of unprotected women will continue to increase unless progress is made in extending coverage.

Other population sub-groups who have been almost entirely neglected by family planning programs are men and adolescents. Virtually no organized attempts have been made to extend coverage to the male population with the exception of the National Guard (Panama's combined police and military organization which has an estimated 8,500 members) which sponsors an active vasectomy program. The same is true for adolescents who have no formal access to reliable sex education and family planning information and services. The public school curriculum is devoid of information on sexual development and human reproduction and how to deal with them, and the Government MCH program is designed to attract young women (and only women) to family planning services during the course of or immediately following pregnancy.

(b) Ineffective Coverage

Family planning services in Panama are provided by the Government through the integrated Ministry of Health/Social Security Agency system.\*\*\* They are offered in the context of an

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\* Annex VIII-B for data on demand among young, low-income females in the heavily populated urban district of San Miguelito.

\*\* Op.cit., Fox and Huguet, page 197.

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| <u>Source of Services</u>                 | <u>% of Contracepting Population Served</u> |
|---|---|
| Ministry of Health/Social Security Agency | 70.2  |
| APLAFSA (IPPF Affiliate)                  | 1.1   |
| Private M.D.                              | 11.3  |
| Pharmacy                                  | 15.4  |
| Other                                     | <u>1.6</u>                                  |
| Total:                                    | 99.6 (Discrepancy caused by rounding.)      |

Source: National Fertility Survey, Panama, 1977. (cont. next page...)

integrated Maternal & Child Health Care program which addresses family planning as an element of health care. The MOH has also determined that no other institution (private physicians and pharmacies are exempted) may provide surgical or medical contraceptives, although in practice the prohibition is somewhat relaxed (see footnote on APLAFA, page 11 ). Family planning, furthermore, is presently offered only by health sector institutions, be they public or private. Thus, the current family planning delivery system in Panama is hampered by sectorial limitations in addition to program, policy, and institutional deficiencies.

Analysis of the terminating AID population project, evaluations of the AID loan for Rural Health Delivery Systems, and analytical work undertaken in support of this Project have pointed to some key weaknesses in the MOH/CSS system which restrict effective family planning coverage. Most critically in need of improvement are the three following areas:

(1) Administration: The effectiveness of the MOH/CSS family planning program is seriously impaired by poor intra-institutional communications; by an inefficient logistics system; and by insufficiently trained administrative personnel.

Communications are poor between the national MOH/CSS offices and regional offices - the country is divided into 10 health regions - and between the regional level and health facilities located in the region for which it has supervisory responsibility. One result is that Ministry policy and regulations are not uniformly applied, including in the area of family planning.

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. . . Integration of the MOH and Social Security health systems was begun in 1974 and is complete except for the metropolitan area. This means that outside Panama City, the CSS is implementing the Ministry of Health's MCH program including its family planning component, providing services to both asegurados and those not entitled to CSS benefits. In metropolitan Panama, CSS family planning services have been provided only for therapeutic reasons. In 1980, however, the CSS will offer the MOH family planning program to its urban clientele. Full integration of the public health systems in Panama City is expected to begin during 1979 and 1980. Much remains to be done to achieve full integration country-wide, however. AID is playing a major role in accomplishing this through Loan 525-U-045, Rural Health Delivery Systems, which provides \$400,000 to help effect unified systems for accounting, budgeting, inventory control, personnel administration, data gathering and maintenance at the provincial level. The systems will be designed to permit replication on easy adaptation at the national (Panama City) level once integration is effected. With assistance from PAHO, a systems integration (and upgrading) plan has been developed for implementation over the next 18 months.

Lack of transportation is a major cause of the low level of intra-institutional interaction, and contributes also to the generally inadequate logistics system. Lack of vehicles results in supervisors who can't visit facilities, doctors who can't spend sufficient time at outlying health posts, and family planning commodities and equipment which aren't delivered on time or in the quantities needed. Stories abound of women who have become discouraged about family planning (and even pregnant) because a critical element was missing: medical personnel to insert IUDs or to perform tubal ligations, or an adequate supply of pills or condoms.\* Inadequate storage and record-keeping are other problems which contribute to the substandard logistics system. Another is the existence of duplicate MOH and CSS distribution systems for clinical equipment and supplies. Because family planning up to the present has been a ministry program rather than an integrated MOH/CSS effort, the MOH has borne sole responsibility for distributing contraceptives and information and promotional material on family planning; too often, as a result, these commodities have failed to even reach CSS facilities and, because of inefficiencies in the Ministry's logistics system, they frequently have failed to arrive promptly or in sufficient quantities at its own facilities.

(2) MOH/Client Relationship:

Many personnel charged with family planning functions have been shown to be inadequately trained in human reproduction and the use of family planning; they lack preparation in communicating information to the client and are ill prepared to deal sensitively with potential program acceptors. This includes personnel whose responsibility it is to provide contraception to men and women and yet who often have no understanding of the way that specific methods work, nor of the indications for prescribing a particular method. Use of complex terms may not mask ignorance, but certainly confuse the poorly educated listener. For many, a trip to a health facility to learn about family planning represents a considerable psychological and, sometimes, physical effort. Full of fears and concerns about contraception, the woman is frequently presented with a coldly clinical description of contraceptive devices and how to use them. Over-extended health personnel may have neither the time nor the orientation to discuss general and individualized benefits of child spacing and smaller families or to engage in an encouraging give-and-take discussion with the interested but still uncertain and often ignorant inquirer.

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\* Another problem associated with pill usage is the frequent MOH practice of providing women with only one month's cycle per visit. This means they must return each month, often travelling long and difficult distances. Many can't or don't make the trip regularly; and the result all too often is another unplanned child.

The problem, at base, is really one of inadequate preparation. Although training in family planning has been a part of the MOH's program since its inception, the majority of health personnel are still not provided with sufficient, specific training in family planning and adequate clinical experience in contraceptive use and application. For those with training, refresher courses may be years away.

The reasons for inadequate training are several. First, efforts have been concentrated on nurses and physicians. Medical school curriculum in family planning for physicians has been highly theoretical rather than clinical and practical; the family planning modules in nursing and paramedic curricula are inadequate for the work these individuals are later expected to perform in the field. Another problem is that about half of Panama's physicians are trained abroad in medical schools which do not include family planning instruction in their courses of study. Additionally, some staff who could play an influential role in attracting or maintaining acceptors (e.g., receptionists who often chat with women for hours in health facility waiting rooms) receive no training in family planning whatsoever. Finally, Ministry financial resources have always been too limited to carry out the kind of training needed to prepare all health sector personnel in human reproduction, family planning and contraception, demography and communications techniques.

### (3) The Clinic-only Approach:

As earlier noted, the Ministry's MCH program, through which it provides family planning services, is oriented toward young women who are either pregnant or new mothers. It may also reach those who visit health facilities on other health matters. Extension of family planning services, in other words, is restricted to those who seek out a health clinic in the first place, for whatever reason. The MOH has not yet made strong efforts to extend family planning information directly to people through effective public contact, despite evidence showing that such contact between health personnel and the community can greatly stimulate demand for family planning services.

Without question, the clinic-only approach restricts coverage of adolescents who are unlikely to seek family planning assistance at a health facility. It is they who are most in need of reasoned guidance in family planning, linking it with education, employment, family welfare, emotional stability, nutrition - and not simply with physical health. The clinic-only approach also restricts coverage of men. They are not effectively reached through a health facility unless they are visiting a clinic on some other medical problem and take the initiative to ask for condoms, are prescribed condoms in the event of venereal disease, or they have made a definite appointment to discuss or undergo a vasectomy.

## B. DETAILED PROJECT DESCRIPTION

### 1. Project Goal, Purpose, and Strategy

The goal of the Project is to contribute to a further reduction in Panama's birth rate which will strengthen efforts to improve the quality of life of lower-income Panamanians. Specifically, the Project will contribute to a reduction in the crude birth rate (CBR) to 25 per thousand over a period of five years. Reduction of the birth rate is consistent with both GOP and AID development priorities as discussed in Section D of this chapter. A reduction in the CBR to 25/1000 should assist Panama to reduce its population growth rate to 2% per annum by the year 2000 or sooner.

The purpose of the Project is to expand delivery of family planning information and services to a higher proportion of the fertile age group. The Project will extend outreach to a greater number of fertile age women in rural areas and low-income sections of metropolitan Panama and to two new target groups, adolescents and men, both on a countrywide basis. By the end of the Project, coverage should have been extended from 40% to 71% of fertile age women including the below 20 age group. In addition to attracting new acceptors, the Project will also assist institutions with ongoing family planning programs to maintain current users and re-attract those who have discontinued use of contraception except for the most traditional methods.

The strategy of the Project is two-fold: First, the Project will continue to support the GOP's integrated approach to the delivery of family planning services, building on the successes of the terminating 12-year Health and Population grant project, and join with UNFPA (United Nations Fund for Population Activities) in a complementary program to improve and expand family planning coverage. UNFPA will support the Maternal and Child Health program of the MOH,\* including some family planning. AID, for its part, will concentrate wholly on the improvement and expansion of (a) family planning services, including sterilization, and (b) family planning information, education and communication (I, E and C) activities.

Second, the Project will encourage new avenues of outreach by assisting non-health sector institutions to extend family planning through sex education and family planning information and education

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\* Unless otherwise indicated, "Ministry of Health" is understood to mean the integrated MOH/CSS public health system subject to the limitations described in the footnote on page 7.

activities. Through these new initiatives, the Project will help to raise the awareness and increase the use of family planning services by women (including the below 20 age group) and men heretofore unreached by family planning activities.

Because the Ministry of Health, as stated earlier, reserves to itself the right to distribute contraceptives except for those sold commercially, expansion of services under the Project will be limited to those offered by the MOH/CSS integrated public health system.\*

## 2. Project Activities:

Project activities cluster around three principal objectives -

- (1) extension of contraceptive coverage;
- (2) expansion of I E and C outreach; and
- (3) introduction and institutionalization of sex education.

In the following pages, the paper describes the activities to be undertaken by the Project in support of these objectives.

- (a) Ministry of Health/CSS Program (AID grant contribution: \$2,455,600).

Under this program, AID will join with UNFPA in a complementary program to improve and expand family planning coverage.

Through a \$2.4 million grant over four years (1979-82), UNFPA will support the MOH's Maternal and Child Health Program, including family planning. It will provide funding for improved MCH training and supervision; clinical equipment for obstetrical and gynecological care (including high risk pregnancy and cancer detection programs), and for pediatrics; and improved logistics.

AID, on the other hand, will focus exclusively on the family planning component of the MOH's integrated program. Through the Project, it will provide funds to improve the quality and coverage of family planning services; improve and expand I E and C activities; train medical and para-medical personnel in family planning; and provide limited support for improvements in supervision and

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\* APLAFA will continue to provide contraceptives at its urban San Miguelito clinic throughout the Project period. Contraceptive commodities are furnished to APLAFA by the International Planned Parenthood Foundation. APLAFA furnishes contraceptives with the reluctant acquiescence of the MOH, and technically only for training and demonstration purposes.

logistics. Each of these is discussed below.

- Family Planning Services

The MOH/CSS provides contraceptive coverage to 70% of all active users and is the sole source of contraceptive services in the public sector. Its service delivery capability is key to the success of the Project. Service quality must be improved and volume of contraceptive availability increased to meet both present and future demand for services. The latter is expected to expand greatly as a result of outreach activities of the MOH and APLAFA and the new national sex education program.

UNFPA and AID will both contribute contraceptives and supporting clinical equipment. The AID contraceptive requirements have been determined in the light of UNFPA's planned donation and will increase after 1982 when the UNFPA project terminates.\* (For details, see commodity tables, Annex X.)

Apart from providing centrally procured condoms and oral contraceptives, AID will help introduce through the Project what will be for Panama a series of contraceptive innovations. These include simpler sterilization procedures; methods appropriate for adolescents and the intermittently sexually active (e.g., foams, jellies, neosampoon); and a new and large-scale effort in male contraception which includes condom distribution and vasectomies. Their inclusion in the Project reflects the MOH/CSS desire to make appropriate contraceptive technology available to a greater proportion of the target group.

Simpler sterilization procedures include the laparoscopy and mini-lap techniques which are quicker and less expensive than the more common tubal ligation procedure. A large backlog of voluntary sterilization requests makes these alternatives attractive. At present there are approximately 20 laparoscopes in the country. The MOH will continue to send two physicians per year for training at Johns Hopkins - PIEGO. Each will return with a laparoscope for his/her institution (a total of 10 additional laparoscopes during the life of the Project). Three extra laparoscopes will be purchased as temporary replacements for instruments being serviced at the Laparoscope Repair and Maintenance Center, thereby avoiding prolonged periods during which laparoscopic sterilization is unavailable in certain locations.

The public health sector will also begin to distribute or to make more available, as the case may be, a wider variety of contraceptive methods - IUDs, diaphragms, spermicides, condoms. These may be far more attractive options to many women whose main

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\* In the event of a follow-on UNFPA maternal/child health project which includes a contraceptive component, funds now budgeted for the anticipated post-1982 shortfall in contraceptives will be reprogrammed.

interest lies in postponing pregnancy - or in spacing pregnancies. At present the most familiar and available methods in Panama are oral contraceptives and female sterilization; however, the pill has negative connotations for many women and sterilization is, of course, appropriate only for women who definitely desire no more children.

Alternative methods are especially desirable in the case of adolescents, particularly for those who, though not yet having entered a stable relationship, will nonetheless want protection for infrequent sexual contacts. With the exception of the IUD, moreover, these methods can be readily distributed without medical supervision, making contraception more accessible to this group. Health personnel will be instructed in the use and prescription of these methods as part of the training in family planning they will receive under the Project, and promotion and explanation of these methods directed toward the target group will be effected through the Project's I E and C component.

Utilization of contraception by men has been largely ignored by the Ministry of Health up to this time. The MOH program, designed primarily to serve women in the context of integrated Maternal and Child Health services, acted as a constraint. Now, however, the Ministry is interested in making it easier for men to procure condoms in health facilities without the need to see medical personnel. Condom displays will be installed in all health facilities consisting of a simple cardboard wall arrangement of the type used in the "Condor" campaign; they will be kept fully stocked with condoms available to men (and women) without the need for medical consultation. A trial program of stocking government offices with similar condom displays will be pilot tested. The MOH will be responsible for distributing condoms to all health facilities and government offices. The strategy of making condoms widely available at no cost offers a simple, effective, low-cost means of preventing unwanted pregnancy. (The FY 80 cost to AID for condoms is less than 4¢ apiece.)

Major constraints to increasing reliance on male sterilization are public ignorance and cultural shibboleths about the simple procedure and the lack of sufficient operating facilities and equipment: vasectomies are not assigned high priority in the over-subscribed waiting lists of operating facilities. APLAFA will provide IPPF funds to the MOH during the Project to convert six hospital rooms into operating rooms, and AID grant funds will finance medical equipment needed to perform vasectomies. Vasectomy kits will be provided to public hospitals throughout Panama. The Project will also provide funds to establish a vasectomy center at Santo Tomás hospital in Panama City by furnishing an operating room with the medical equipment needed to perform vasectomies. The center will perform an estimated 12 vasectomies per day and will offer diagnosis and counseling services in male

infertility and may serve as a pilot for the expansion of similar programs in male contraception to other locations. At present, vasectomies are performed exclusively by urologists (there are about 17 practicing in Panama, 11 of whom are located in the metropolitan area), usually in private clinics. Under the Project, urologists who will perform vasectomies in public hospitals will be sent to the U.S. at the rate of two per year for refresher training in vasectomies, male infertility and new developments in urology. The Project will also fund special I E and C activities designed for the male audience to help overcome ignorance and address psychological and other concerns about male sterilization.

In support of all MOH/CSS contraceptive services, the Project will provide a limited amount of clinical equipment, all of which is directly related to family planning. Some of the equipment will be used in the delivery of contraception - e.g., IUD insertion kits, laparoscopy, mini-lap, laparotomy, vasectomy and tubal ligation kits. Limited quantities of equipment needed for PAP smears and gynecological examinations, both important features of the MOH family planning program, will also be provided.\* (See Annex IX for list of clinical equipment to be funded by the Project).

- Information, Education and Communication Activities

As discussed in an earlier section, the evidence seems clear that past family planning information and education activities have had limited success in reaching women, particularly rural women who are most in need of more adequate coverage.\*\* Approaches to adolescents have been limited to a few sex education pamphlets, and

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\* Clinical equipment needs were determined on the basis of a 1978 MOH inventory of clinical equipment requirements at all MOH and MOH/CSS health facilities. UNFPA will provide equipment for the overall MCH program with its emphasis on prenatal care, cancer detection and pediatric care. With the exception of contraceptives, UNFPA will fund only a very small portion of commodities directly related to family planning.

\*\* See Polly F. Harrison, Female Reproductive Life: Its Characteristics and Attendant Values in Panama, Panama, December 1978; and, Ricardo Vernon, Consultant's Report, Chicago, 1978.

no attempt has been made to attract men to contraception either as users or supporters.

In extending outreach, the UNFPA project will also provide materials and equipment for I E and C activities focussed principally, however, on improved maternal and child health. The UN project will assist the MOH in addition in a program to establish five pilot adolescent centers in urban areas - Panama (Boca la Caja), Colón, and one town in the provinces of Chiriqui, Veraguas and Herrera. Placed within existing MOH facilities, these centers will "develop activities aimed at better understanding of the health problems of youth, including reproductive health, and to formulate specific programs for them". UNFPA will also provide funds for a series of regional seminars on adolescent health in 1979 and 1980 and will finance in 1981 a study of the family environment and employment sources for adolescents.

Under the AID Project, MOH/CSS will mount a vigorous, improved information and education campaign with the following features:

- . Materials will be specially developed to attract rural women with little educational background to adopt family planning;
- . In all I E and C activities, emphasis will be placed on the details of specific contraceptive methods;
- . For the first time, materials will be pre-tested to insure that the messages are clear, persuasive, and appropriate for the audience;
- . Greater emphasis will be given simpler, folder formats, as recommended by a University of Chicago consultant;\*
- . The mass media campaign will be a mixed media effort, well coordinated and with periodic changes in emphases to maintain interest and reach different audiences;
- . Mass media materials will be developed for men;

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\* Dr. Donald Bogue of the University's Program in Communication, Research and Education for Population and Social Development found in a 1977 evaluation study that I E and C materials produced to that time in Panama under the Health and Population Project had not been sufficiently effective because they were too costly (thus, distribution was limited), they didn't contain enough specific information, and they lacked the benefit of any pre-testing.

. The MOH/CSS will increase the coverage of communities with promotional material and informational talks on family planning; and

. Community volunteers will be enlisted to promote family planning and provide information in their communities.

I E and C activities will be coordinated by a full-time communications specialist located in the MOH Maternal and Child Health Division. Technical assistance will be provided by the University of Chicago's Program in Communication, Research and Education for Population and Social Development.

The Project will assist the MOH/CSS to accomplish the following in its I E and C program:

(1) Send health teams to visit schools to show films and talk on sex education and distribute written materials.

(2) Provide family planning chazlas at health facilities.

(3) Prepare pamphlets on sex education for approximately 250,000 adolescents.

(4) Design a special series of pamphlets, folders, posters, billboards and radio spots to publicize the benefits of male contraception, including vasectomy. Simple folders will explain the nature of the vasectomy operation and proper use of the condom, and all promotional information will indicate that services are available at local health facilities.

(5) Produce pamphlets and folders explaining family planning; these will include a series of simple folders on each of the following methods: the IUD, oral contraceptives, creams and foams, female sterilization, the condom, and vasectomy. Such publications will be available at all health installations, and will be distributed by health teams when giving family planning talks in health facilities and before community groups.

(6) MOH will continue broadcasting radio spots and commentary on family planning on a daily basis. A selection of radio stations has been made to assure comprehensive geographic coverage; national radio chains as well as regional stations will broadcast information on family planning (including spots on particular methods), indicating that the local health facility provides these services.

(7) Finally, sets of posters and a limited number of well-placed billboards will complement radio outreach and written

materials. Posters will be placed in health facilities as well as other locations (shops, public offices) in the community.

The Ministry of Health currently employs 72 health educators. Among their responsibilities is the presentation of informative and promotional talks on family planning in health facilities and communities. These outreach activities, particularly at the community level, will complement MOH/CSS clinic-based activities in family planning and provide an important forum for face-to-face dialogue on family planning with rural women and men, including adolescents.

Health educator activities will be developed and coordinated on a regional basis. The Project will provide U.S. or third country training in educational and communications techniques for eight health educators. It will also help finance a jeep, portable generator, projector, and set of family planning films for each of the 10 health regions since community outreach by health educators has been severely restricted by a lack of transportation and materials, especially films; the mobile generators are being provided for use in remote communities which have no electricity and which are at some distance from the nearest facility.

To help evaluate and improve the effectiveness of the outreach program, the Project will provide funds to support an annual, national level meeting of all health educators for this purpose.

#### - Training

A third major component of the MOH/CSS family planning program is training, to be carried out in-country except for a limited amount of specialized short-term training abroad.

The recently approved UNFPA - Ministry of Health project also includes support for training in family planning. However, most UNFPA-funded training will not focus exclusively on family planning, but rather treat family planning in the context of a general Maternal-Child Health program that includes nine other components. A review of UNFPA-funded training activities (see bulk files for details of UNFPA project) shows family planning to be a major component of only 10 of the 30 courses and seminars proposed for the UNFPA project's first year. Moreover, UNFPA-funded training will be directed principally to physicians, nurses, and high-level administrative personnel. AID-funded training will focus on paramedical and non-health sector personnel (e.g. nurse auxiliaries, health assistants, malaria and community sanitation outreach workers). The AID Project proposal for training has been carefully reviewed to assure that there is no duplication of effort between the two projects. In some cases, both projects will offer family planning training to the same category of personnel. For example, approximately 670 nurse auxil-

aries will be trained in family planning by the UNFPA project over four years, and 625 by the AID project during five years. However, there are over 2,500 nurse auxiliaries in the Republic of Panama, and the support of both projects is necessary to achieve even minimum coverage.

Under the AID Project, most family planning training will be carried out in-country at the regional level.\* The national MCH office in Panama City will help each regional office to prepare its training agenda and curriculum, and will organize national training courses for regional personnel who will assume training functions in their regions. Meetings between central and regional personnel will be held annually to evaluate prior year training activities and replan for the next year.

By carrying out most of the training at the regional level instead of in Panama City as in past years, more courses will be possible because of the expanded pool of teaching personnel and the savings effected in transportation and per diem. Approximately 4,500 MOH employees are expected to receive training in the field during the life of the Project.

Introductory and refresher training will be provided in the following: family planning (advances in contraception, techniques, indications and counterindications of various methods of contraception); communicating information in family planning; family planning and sex education for nurse auxiliaries; and administration of family planning programs for administrative personnel. New training to be initiated under the Project includes practical training in family planning for all graduate medical students and community nursing students (whose curricula are weak in family planning); family planning training for outreach workers such as malaria campaign employees and community volunteers; and basic training in logistics for MOH/CSS personnel. The Project will continue support for Women's Health Care Specialists who are nurses trained to prescribe and provide most methods of contra-

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\* Each of the 10 health region MCH structures has a physician and a nurse in charge of MCH activities, and a team of obstetricians-gynecologists, nurses, health educators, health assistants, social workers, nurse auxiliaries, etc., assigned to it and located at various health facilities - hospitals, health centers and sub-centers, and health posts - throughout the region.

ception, including IUD insertion.\* Finally, the Project will provide funding for human relations training for all levels of health personnel in order to improve the quality of treatment patients receive at MOH/CSS facilities. The MOH believes - and social soundness research substantiates - that the treatment family planning clients receive at health facilities is an important factor in determining the probability of their dropping out or remaining in the family planning program.

Short-term training abroad for approximately 85 persons will be provided in the United States and third countries, e.g., Mexico, Guatemala, Costa Rica, and Colombia, for training of trainers in family planning and sex education; health professionals working in adolescent family planning and sex education; for specialists in communications and educational techniques; for physicians in technical aspects of family planning including sterilization; and for administrative personnel in logistics. Funds for observation trips in the U.S. or other countries are also included.

- Improvements in Logistics and Supervision

One of the acknowledged weak spots in the Ministry of Health's family planning program has been its supervision and logistics management. Both the UNFPA and AID projects will contribute to improving the administration of the MOH's MCH and family planning programs. UNFPA will provide some technical assistance to improve the logistics system. It will also finance vehicles for most of the health regions and the central office to be used for supervision purposes, as well as salaries for extra hours worked by supervisors. It will also fund the costs of regular meetings of the MCH program supervisors.

The AID Project will finance three jeeps for supervision in the remaining health regions, and a 10-ton truck to provide reliable transportation for distributing family planning equipment and contraceptive supplies throughout the Republic. The Project will also finance a series of courses in logistics management for MOH/CSS personnel responsible for this aspect of the family planning program.

Generalized improvements in the logistic system of both health agencies will also result from the administrative reform efforts being financed under AID's loan 045, Rural Health Delivery Systems. (See footnote page 7 ). Streamlined and unified ordering, inventory control, storage, and distribution systems should do much to improve

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\* Women's Health Care Specialists have been trained under the terminating AID project in intensive, three-month Post Basic Courses given at the Azuero Community Nursing School. The course prepares nurses to provide almost the full range of family planning services in an integrated MCH/FP context in marginal areas with scarce medical personnel. Approximately 40 such Health Care Specialists have been trained to date.

the current logistical nightmare which plagues the national public health system, including its family planning program.

- Evaluation and Studies

Because reliable data will be critical in evaluating Project progress, particularly at the purpose and goal level, the Project will help fund a number of studies. These studies will generate data on contraceptive prevalence, user continuation rates, male attitudes towards family planning and male contraception, and adolescent attitudes towards sex and family planning. In each case, research will be conducted early on in Project implementation (to gather baseline data) and again two to three years later. This will provide AID and the GOP with useful data for measuring changes in attitudes and practices concerning sex and family planning which occur during the life of the Project. Findings from the studies will also provide the Ministry of Health and other institutions with a more reliable and timely data base for use in programming and budgeting future family planning and sex education activities.

AID, through this grant or central funding, will finance technical assistance in the design, preparation, execution and analysis of the studies which are to be coordinated through the Office of Population Studies in the Ministry of Health. Personnel from the Bureau for Statistics and Census in the Controller General's office will also participate. For further details on the four major studies and the evaluations planned under the Project, see Section V., Evaluation Arrangements.

(b) The APLAFA Program (AID Grant Contribution: \$96,000)

The Asociación Panameña para el Planeamiento de la Familia, APLAFA, is the private IPPF affiliate which has been providing family planning information and services in Panama since 1966. Because of the Ministry of Health's proscription against non-MOH delivery of services, APLAFA exercises caution in its service delivery program. According to the terms of its agreement with the MOH, APLAFA should only provide clinical services for training and demonstration purposes. In practice, however, APLAFA provides all methods at its family planning clinic in the low-income urban district of San Miguelito to those who visit the clinic seeking services. Active users served by the clinic currently number about 300.

Despite its limited service coverage at the present time, APLAFA is highly regarded in Panama as a leader in the population and family planning field, and its assistance is sought with frequency by a large and varied number of organizations and informal groups.

Over the next few years, APLAFA will concentrate its efforts in the following activities: (1) establishment of a multi-service center for adolescents in San Miguelito, which will serve as a base of operations for information and education activities for adolescents, their families and educators; (2) promotion and coordination of family planning and sex education activities for other private and public sector organizations, and (3) establishment of a condom vending

machine project. While other donors will finance the major portion of the first activity, i.e. construction, equipping and staffing of the adolescent center, the Project will provide financing for a series of sex education seminars to be conducted by the new center. The Project will directly assist the second activity, with special attention to extending outreach in the private sector; and AID central funds will contribute to the third activity.

- Family Planning and Sex Education for Adolescents

APLAFA's most ambitious undertaking during the next few years will be the creation of a multi-service Adolescent Center adjacent to APLAFA's clinic in San Miguelito. The Center, planned as a pilot project, has been designed in light of experience with other adolescent centers (The Door in New York and CORA in Mexico City)\* and the results of an adolescent survey conducted in San Miguelito by APLAFA in 1978 (Annex VIII-B). A series of meetings with community leaders has enlisted grass roots support for the Center and, in a follow-on to the first seminar sponsored by APLAFA and CRESALC\*\* in December 1978 on "Sex Education and Adolescence", APLAFA formed the Panamanian Committee on Sex Education, COPEs. It is composed of social scientists and other professionals from MOH/CSS, MOE, Ministry of Labor, National Guard, Tribunal Tutelar de Menores, I.P.H.E., and the San Miguelito parish. COPEs collaborates in and supports sex education programs sponsored by APLAFA at the national level.

Facilities for the Adolescent Center will include a portion of APLAFA's current installation as well as a new structure on the same lot; construction and equipment will be financed by other sources, including private Panamanian donations. The Center will offer counselling for social, educational and psychological problems; legal advice; career counselling; recreational and cultural activities; library facilities; and educational programs amongst which will be a comprehensive sex education and family planning program. It is this last activity - sex education and family planning - which AID will help finance under the Project.

The Adolescent Center will form a separate department within APLAFA. Each of its three main sections will be headed by a coordinator who will be assisted by a cadre of adolescent "promoters" whose participation in turn will be directed by two promoter coordinators. A technical advisory group and interdisciplinary team of social and medical science professionals will provide technical assistance to the Center. Fund raising will be the responsibility of an Adolescent Center Foundation. Because the new Center will attempt to be as responsive as possible in meeting adolescent needs, many of the

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\* APLAFA's director and the recently designated chief of the Adolescent Center visited the two centers in 1978 courtesy of IPPF.

\*\* The Regional Committee on Sex Education for Latin America and the Caribbean is based in Costa Rica and provides technical and financial support for sex education activities in Latin America.

details of its operations will be developed with the participation of its young clients.

Through the Project, AID will assist in financing a continuing series of courses and seminars in family planning and sex education to be conducted by the Adolescent Center for adolescents and their parents and teachers. Courses will be tagged beginner through advanced in order to tailor content to the student. Over the life of the Project, an estimated 225 seminars will be held, with approximately 45 adolescents in each. Some 22 seminars for parents and 24 for school teachers will complement the adolescent educational program. AID will help fund course instructors and didactic materials, including printed information to be distributed to course participants.

- Private Sector Outreach

APLAFA currently provides speakers or arranges programs on family planning at the request of public and private organizations. Through the Project, it will be assisted to take a more active role in promoting and assisting family planning activities for private organizations. Some groups which have already indicated a strong interest in a family planning-sex education program include the Confederation of Workers of the Republic of Panama, or CTRP (the AIFLD supported labor union confederation which has an estimated 30,000 members), and the Federation of Savings and Loan Cooperatives of Panama, FEDFA, with approximately 22,000 members.

The Project will contribute (a) seed money for establishing a seminar format for private businesses which will pay APLAFA a fee for its services, thereby helping make this activity revenue-generating rather than a constant draw down on APLAFA resources; and (b) funds for APLAFA to use in developing sex education and family planning presentations for private groups and service organizations. APLAFA will be responsible for promoting, arranging, and partially funding programs for these groups.

APLAFA will continue to assist public sector organizations as needed; recently, for instance, it participated in a two-week sex education seminar organized by the Ministry of Labor and Social Welfare for adolescent residents of a Panama City suburb, and it is now working on similar training for approximately 800 Panama City municipal employees at the request of the mayor's office. However, the increasing participation of State agencies in family planning will lift some of the burden from APLAFA in the public sector and enable it to take the initiative in extending family planning information (and possibly services) to members of private professional, business, and service organizations.

- Condom Vending Pilot Program

Although not included under the grant, APLAFA's condom vending machine program bears mentioning because it is indicative of the kinds of activities APLAFA is interested in supporting and because financial assistance for the program is being provided through an AID/W centrally funded and administered commercial/retail sales project. Beginning in 1978, APLAFA has provided a limited number of condom vending machines on a pilot basis (e.g., to the Panama City fire department) and expects to expand the program later this year in cooperation with the National Guard. Further expansion, if supported by experience with the first series of machines, will be programmed early in 1980.

(c) National Program of Sex Education

- The Program

A National Commission on Sex Education was established informally in Panama in March 1979 and is comprised of the Ministries of Education, Health/CSS,\* Labor and Welfare, the Tribunal Tutelar de Menores, and the Panamanian Institute for Special Education, I.P.H.E. The Commission's principal objective is to establish a National Program of Sex Education with financing from AID, UNFPA and, if needed, other sources such as the Norwegians and Canadians. The Commission has established a series of working objectives (see bulk files) and has requested the short-time assistance of a PAHO consultant to complete the design of an inter-ministerial, national sex education program to be institutionalized over the next five years.

In preparation for its introduction, the National Commission sponsored a two-day seminar May 23-24, 1979, to which AID and CRESALC were invited to discuss, inter alia, objectives of sex education, sex education in Latin America and Panama, appropriate types of educational methodology, and the National Program.

The Commission plans to undertake a three-phase program to (1) train multidisciplinary teams from the five member institutions to be effective sex education trainers;\*\* (2) employ these teams to train over 3,300 professional employees of the social welfare ministries mentioned above; and (3) use the 3,300 as sex education multipliers within their home institutions. In the case

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\* The Social Security Agency is considered a separate member for purposes of the Metropolitan Corridor only.

\*\* Thirty-six from MOE will be trained; 23 from MOH (plus seven from CSS/Panama City); 12 from I.P.H.E.; nine from the Ministry of Labor; and three from the Tutelar de Menores, or a total of 90 sex education trainers.

of the Ministry of Education, some of the corps of newly trained teachers will be engaged to train an additional 2,790 teachers. AID, through the Project, will help finance the first two stages and UNFPA the last phase.

Sex education is known to have the strong support of Panama's current President. As Minister of Education, he stated:

"Sex (in Panama) is still considered a type of taboo, and the word 'sexual' seems to create a distance between people and needed information. The word sex is still very much associated with sin, and I believe the problem has to be attacked in a very scientific and also psychological manner ... We consider that Family Sex Education should be a course of study just as mathematics, geometry, science, grammar ...." He added that while "there is great ignorance on the part of students, there is also great ignorance on the part of their parents. Therefore, if we are to instruct the children, we will also have to provide courses for their parents."\*

To launch the National Program of Sex Education, approximately 90 people will be trained in late 1979 in intensive, one-month courses (30 in each course) covering all aspects of human sexuality and recommended teaching methodology. Once trained, these interdisciplinary teams will then commence with the task of training 3,300 professionals selected by the participating ministries who will serve as sex education multipliers. Among these will be some 2,000 school teachers whose training and function are discussed below.

- Ministry of Education (AID grant contribution: \$455,000)

The MOE will contribute 36 persons to the core sex education group. It will then select approximately 2,000 of its public school teachers for phase two training and another 2,000 teachers for phase three training which will start in 1981. By 1984, 4,000 or 15% of the estimated 27,000 teachers in the country will have received formal classroom and practical training in sex education.

The first group of 2,000 will be trained in month-long courses each with an average of 20 students. Courses will be held over the period 1980-84 per the schedule shown on page 61 and will

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\* Informal translation of an interview reprinted in Conciencia, the newsletter published monthly by APLAFA (Issue No. 83, August 1978).

normally be arranged to coincide with the January-March vacation period. Courses will provide training in biology (anatomy, physiology, human reproduction, venereal diseases); psychology (psychosexual development, sexual orientation, abortion); social development (family life, family planning, responsible parenthood, contraceptive methods); pedagogy (methodology and techniques in sex education for groups), use of teaching materials and human resources in human development and sex education); and, sex education in the context of the child, adolescent, couple, adult, and parent.

For the first two years 1980-81, training will take place in Panama City where the 90-member teaching corps is located; this will allow the training to be well organized and wrinkle-free by 1982 when provincial teaching teams will begin regional sex education training in the interior of Panama except for the more remote areas such as Bocas del Toro, San Blas, and the Darien for which training will continue to be carried out in Panama City.

Once trained, the teachers will have responsibility for providing sex education information to student groups, incorporating sex education materials into the school curriculum,\* and working at the community level with parents and other members of the community in sex education.

AID will provide funds for MOE and all other members of the core teaching teams, and will finance transportation and per diem costs for the 2,000 teachers to be trained in sex education. It will also help finance audiovisual and other material to be used in sex education courses.

- Panamanian Institute for Special Education (I.P.H.E.)  
(AID grant contribution: \$93,400)

Through the Project, sex education, including training in family planning and family life, will be provided to 227 I.P.H.E. teachers and counselors for incorporation into I.P.H.E. programs.

I.P.H.E. is a semi-governmental welfare agency which operates centers for handicapped children up to the age of 17 and schools for their parents, and a network of community based day care/pre-school centers which also offer non-formal education for

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\* Although a formal decision is still to be made, the Commission is considering the introduction of sex education during the last year or two of primary school and offering it in the ciclo básico, Panama's recently established, vocationally oriented schools which run through the ninth grade, and in traditional secondary schools.

parents and other family members. These centers are known as Child and Family Orientation Centers, or COIFs. Currently there are 12 schools throughout the country for the handicapped and 135 COIFs, 99 of which are located in rural areas, 31 in marginal urban communities, and four in impoverished Indian communities, all areas with high birth rates.

The sex education training course will be developed by the National Commission on Sex Education which will also provide the teaching teams to train I.P.H.E. personnel and design and produce teaching materials for the month-long course. Courses will be phased over the life of the Project and will commence with personnel from the metropolitan Panama City area. Course material will cover biology and sexual development, nutrition, community outreach (including a week of field work), and family planning. Participants will be evaluated on each of the modules and there will also be a final course evaluation.

In addition to funding transportation and per diem for I.P.H.E. teachers and counselors who will receive training in sex education and family planning, the Project will finance audio-visual equipment and printed materials to be used by I.P.H.E. personnel for educating parents and other family members, including adolescents, reached through their programs for handicapped children and pre-school children. The Project will also finance technical assistance during the last year of the Project to help evaluate the effectiveness of family planning/sex education outreach through IPHE.

To summarize Project activities, they include a continued large-scale program with the Ministry of Health/CSS focussed on family planning services; I E & C activities; improved training of health sector personnel; strengthened logistics and supervision; and more timely and reliable family planning data. They include assistance to APLAFA in sex education and family planning for adolescents and, on a smaller scale, their parents and teachers; and in extending family planning and sex education to private sector groups, including businesses, cooperatives, labor unions, and community and service institutions. And finally, they include assistance to the Ministry of Education and the Panamanian Institute for Special Education in a major new national program of sex education.

In the aggregate, these activities will accomplish the following objectives, first listed on page 11 : (1) extension of contraceptive coverage; (2) expansion of I E and C outreach; and (3) introduction and institutionalization of sex education. They will reach the groups - rural women, low-income urban women, adolescents and men - which are most in need of additional coverage if the Project goal of a lowered birth rate is to be achieved.

### 3. End-of-Project Status, Major Outputs

The Project purpose - expansion of family planning information and services to a higher proportion of the fertile age group - will have been achieved if by the end of five years (a) there is an increase in the number of fertile age women, rural and urban, who are active users; (b) male adoption of contraception - through condom use or vasectomies - has risen; (c) increased numbers of adolescents have an understanding of human sexuality and the reproductive process, and know what options are available to delay conception and how to exercise those options; (d) user continuation rates have improved because of a decline in drop-out rates; and (e) there is an increase in public and private sector support for population/family planning activities.

#### Major Project outputs will be:

- (1) Family planning services provided in a dependable, humane and understanding manner at all MOH/CSS health facilities.
- (2) Sex education introduced in the public schools.
- (3) Family planning information and services are systematically available to adolescents.
- (4) Active public and private sector programs to attract males to family planning established and operating.
- (5) Increase in community-based family planning outreach.
- (6) Increased number of health and non-health sector personnel receiving training in sex education, family planning and demography.
- (7) Improved data base for population/family planning, including capability to update information.

### 4. Inputs

The total Project cost is estimated at \$8,077,000 of which AID will provide \$3,100,000 (38%) through a development Grant; of this amount, 27% will be used to finance centrally procured commodities. The GOP contribution, largely in salaries, is estimated at \$4,951,600. An additional counterpart contribution estimated at \$25,000 will be provided by APLAFA.

The major portion - 79% - of the AID Grant is programmed for the Ministry of Health. The Ministry of Education will receive 15% of Grants funds and IPHE and APLAFA each 3%. Very clearly, the focus of the AID family planning program in Panama

remains with the Ministry of Health/CSS.

Major Project inputs include contraceptives, equipment (sterilization, family planning clinical, audio visual, and mobile generators), vehicles, and family planning personnel; and information, education and communication inputs such as printed materials or radio contracts. Other inputs include training, most of it in-country, for MOH, MOE and I.P.H.E. personnel; a limited amount of technical assistance for MOE and I.P.H.E.; and funds for evaluation, four special studies, and other supportive research. A summary input financial plan appears on the following page.

(U. S. \$000)

| <u>PROJECT INPUTS</u>                        | <u>AID</u>   | <u>GOP</u>   | <u>TOTAL</u> |
|--|--------------|--------------|--------------|
| <u>(a) Ministry of Health</u>                |              |              |              |
| Contraceptives                               | 917*         | -            | 917          |
| Equipment**                                  | 335          | -            | 335          |
| Vehicles                                     | 103          | 10           | 113          |
| Information/Education                        |              |              |              |
| Materials                                    | 586          | -            | 586          |
| Training                                     | 248          | -            | 248          |
| Family Planning Specialists                  |              |              |              |
| and Administrators                           | -            | 3,399        | 3,399        |
| Evaluations and Studies                      | 266          | 150          | 416          |
|  | <u>2,455</u> | <u>3,559</u> | <u>6,014</u> |
| <u>(b) APLAFA</u>                            |              |              |              |
| Information/Education                        |              |              |              |
| Materials                                    | 96           | 25***        | 121          |
| <u>(c) National Program of Sex Education</u> |              |              |              |
| <u>Ministry of Education</u>                 |              |              |              |
| Training****                                 | 403          | 1,336        | 1,739        |
| Equipment and Materials                      | 42           | -            | 42           |
| Technical Assistance                         | 10           | -            | 10           |
|  | <u>455</u>   | <u>1,336</u> | <u>1,791</u> |
| <u>IPHE</u>                                  |              |              |              |
| Training                                     | 41           | 57           | 98           |
| Equipment                                    | 39           | -            | 39           |
| Technical Assistance                         | 6            | -            | 6            |
| Evaluation                                   | 8            | -            | 8            |
|  | <u>94</u>    | <u>57</u>    | <u>151</u>   |
| TOTALS                                       | 3,100        | 4,977        | 8,077        |
|  | =====        | =====        | =====        |

\* Of this amount, \$820,000 is for centrally procured contraceptives.

\*\* Includes sterilization, family planning clinical, and audio visual equipment and mobile generators.

\*\*\* A contribution of \$25,000 is estimated from APLAFA which is privately funded.

\*\*\*\* Includes training of trainers in sex education from the Ministries of Education (36) and Labor and Social Welfare (9), IPHE (12), and the Tutelar de Menores (3). Similar training for 30 MOH/CSS employees is included in the training line item for the Ministry of Health.

## C. PROJECT BENEFICIARIES

### 1. Identification of the Target Group

The target group for the Project can be divided into four population subgroups: (1) rural women, especially those who live in small isolated communities; (2) low-income urban women, concentrated for the most part in the Panama City-Colon Metropolitan Corridor; (3) adolescents; and, (4) men.

These subgroups were selected by the Project's executing agencies - MOH, APLAFA, MOE and IPHE - for one or more of the following reasons: (1) statistics show them to have high fertility rates; (2) their use of contraception is low; (3) little or no attempt has been made to reach them with family planning before now; and (4) some evidence exists to show positive attitudes towards contraception.

Rural women, the most important target subgroup, were selected because they, more than any other group, contribute to a higher birth rate. On the average, they bear almost two more children per woman than urban women. According to the 1976 National Fertility Survey, contraceptive prevalence is also lower among rural women; of women 20 to 49, either married or in a union, at risk of pregnancy, 50% in rural areas were using some method of contraception as compared with 70% of women in urban areas. However, the prevalence of contraceptive use among rural women is probably overestimated since neither Indian subgroups nor remote areas were included in the sample. In short, a much lower proportion of rural women than urban women practice family planning; at the same time, they account for a far higher proportion of babies born in Panama each year.\*

Low-income urban women were selected as a target subgroup because (a) a large proportion of them are rural migrants - still rural women in knowledge and attitudes, lacking accurate information about their bodies, the reproductive process and family planning; (b) they are more likely than women in rural areas to be heads of household and, needing to earn a steady income, cannot afford to have and support large numbers of children; and (c) population

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\* This is based on a higher crude birth rate in rural areas than in urban areas together with a higher gross reproduction rate which is perhaps a more accurate reflection of rural-urban fertility differentials since it controls for age distribution (the urban population comprising a greater proportion of women of childbearing age than the rural population). (Op. cit., Fox and Hugué, pp. 180-182.)

pressure is already severe in the metropolitan area and is projected to increase at a rapid rate until the end of the century when an estimated 57% (or 1.6 million) of Panama's population will be living in the Panama City - Colon metropolitan areas. Swelling urban ranks are already diminishing the country's carrying capacity - not enough jobs for the economically active population and insufficient educational, health and housing facilities to serve the population in general.

Adolescents, those in the 15 to 19 age range\*, were included because of evidence showing that they have accounted in recent years for an increasing percentage of all births in Panama (females 19 and under, accounted for 18.21% of total births in 1970, gradually increasing to 19.14% in 1976) and for at least 20% of all abortions; the percentage refers to reported abortions - those ending in hospitalization - and is thought to be considerably underestimated.\*\* It also tends to be the rural young, and particularly the female rural young, ages 15 to 30, who migrate to urban areas; knowing little about reproduction and even less how to prevent it, swept into the more colorful and faster paced tempo of urban life, often without family and friends, they succumb to temptation and, unwillingly, add yet another child to the swollen ranks of the urban poor.

The fourth and final subgroup, men, was selected because relying on both sexes for contraception will clearly assure greater coverage. Up to now, very little has been done to interest men in either condom use or vasectomies - or to encourage their increased support for contraception amongst their wives, girlfriends and daughters. Contraception among men in Panama is low. The 1977 World Fertility Survey showed only 1.9% of women 20 to 49 relying on the condom or male sterilization for contraception. Investment costs in a condom distribution program are low, much lower than for many contraceptive delivery systems for women; and while the cost of a vasectomy performed by a private physician has been beyond the reach

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\* The 15 to 19 age span is used by the Ministry of Health in Panama for family planning purposes although it otherwise defines adolescence as ages 10-24. The MOH reasons that women 20 to 24 are already covered by current family planning programs and that providing clinical services to girls 12 to 14 years of age is neither socially nor politically feasible at this time.

\*\* Given that abortion is illegal in Panama and findings such as those in Dr. J. Moreno, Estudio del Aborto en el Hospital Santo Tomas de Panama, 1979.

of most Panamanian males, the MOH/CSS health system with Project assistance will offer low-cost vasectomies throughout the country.\*

## 2. Beneficiaries

It is expected that the Project will provide an estimated 128,000 beneficiaries (new acceptors) with contraceptive services over the life of the Project and reach another 822,000 through informational and educational activities including sex education. When new acceptors of contraceptive services to be provided by APLAFA and UNFPA are included, the number of beneficiaries for the period 1979-1984 rises to 203,900. (See Table 1 for breakout of data by subgroups and institution.)

## 3. Project Benefits

Anticipated benefits from a successful family planning program which results in progressive reductions in family size as well as in the overall population growth rate are numerous. Major benefits expected to result from the Project are described below, beginning with health. Almost all Project benefits, even those primarily social in nature, have economic consequences - for the individual, the family, and the State-although precise economic measurement may be extremely difficult.

Five principal health benefits to the target group should occur as a result of the Project: (a) Fewer pregnancies, accompanied by increased spacing between births, should result in improved health for mothers and children, fewer maternal deaths, and fewer retarded and handicapped children. (b) With increased spacing between pregnancies, low-income mothers will be able to devote a longer span of time to breast feeding each infant which should have a nutritional impact on the child leading to less sickness. (c) As knowledge and adoption of contraception spreads, there should be a reduction in the number of illegal and unsafe abortions. (d) An increase in condom usage should result in a lower incidence of venereal disease for both men and women.\*\* (e) A key general health benefit to target families

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\* Present cost of a private sector vasectomy is around \$150. At Santo Tomas and other public hospitals, the cost under the Project will be only \$10, the contribution any patient operated on in a public hospital must make.

\*\* Rates for venereal disease are high in both urban and rural Panama. To combat the disease, the Ministry of Health is undertaking an anti-VD campaign through its epidemiology unit. AID has assisted under the terminating Health and Population Project by publishing a series of pamphlets covering the causes, prevention and cure of venereal disease.

| BENEFICIARIES (by Institution)  |  | I E and C      |                |                       | Contraceptive Services         |        |        |  |
|---|--|----------------|----------------|-----------------------|--------------------------------|--------|--------|--|
|   |  | TOTAL          | Urban          | Rural                 | TOTAL                          | Urban  | Rural  |  |
| <u>MINISTRY OF HEALTH</u>   |  |                |                |                       |                                |        |        |  |
| Sex Edu-<br>cation  | Men (20+)                                  | 300,000        | 150,000        | 150,000               | 27,000                         | -      | -      |  |
|   | Male Adolescents (15-19)                   | 75,000         | 50,000         | 25,000                | 10,000                         | -      | -      |  |
|   | Total                                      | <u>375,000</u> | <u>200,000</u> | <u>175,000</u>        | <u>37,000</u>                  | -      | -      |  |
|   | Women (20-49)                              | 250,000        | 150,000        | 100,000               | 83,300                         | 43,300 | 40,000 |  |
|   | Female Adolescents (15-19)                 | 75,000         | -              | -                     | 7,700                          | -      | -      |  |
|   | Total                                      | <u>325,000</u> | -              | -                     | <u>91,000</u>                  | -      | -      |  |
|   |  |                |                |                       | <u>(68,400)</u> <sup>1/</sup>  |        |        |  |
|   | <u>MINISTRY OF EDUCATION</u>               |                |                |                       |                                |        |        |  |
|   | Adolescents (10-19)                        | 150,000        | -              | -                     | -                              | -      | -      |  |
|   | Men and women ages 20+, who<br>are parents | 15,000         | -              | -                     | -                              | -      | -      |  |
| <u>APLAFA</u>   |  |                |                |                       |                                |        |        |  |
| Adolescents   | 10,000                                     | 10,000         | -              | (2,500) <sup>2/</sup> | (2,500)                        | -      |        |  |
| Men and women, age 20+, who<br>are parents or teachers                        | 1,400                                      | 1,400          | -              | (500)                 | (500)                          | -      |        |  |
| Men and women, age 20+, who are<br>members of private sector<br>organizations | 52,000                                     | 42,000         | 10,000         | (4,500)               | (4,500)                        | -      |        |  |
| <u>I.P.H.E.</u>   |  |                |                |                       |                                |        |        |  |
| Males/females age 12+, who are<br>parents or other family members             | 31,000                                     | -              | -              | -                     | -                              | -      |        |  |
| GRAND TOTALS  |  | <u>950,000</u> | -              | -                     | <u>128,000</u>                 | -      | -      |  |
|   |  |                |                |                       | <u>(203,900)</u> <sup>3/</sup> |        |        |  |

<sup>1/</sup> This represents anticipated new acceptors under the UNFPA Maternal/Child Health Project, 1979-1982.

<sup>2/</sup> APLAFA contraceptive services are shown apart since they are not financed directly by the Grant - See footnote on page 11 for clarification.

<sup>3/</sup> This represents anticipated new acceptors under the combined contraceptive services provided by AID, UNFPA, and APLAFA.

in general should be better family nutrition; malnutrition should decline among members of the target population, especially among those located in isolated rural areas.

Other significant socio-economic benefits expected from the Project include the following: (a) Rural and urban low-income families, as a result of having fewer children, will have an opportunity to enjoy a higher standard of living. (b) By the year 2000, fewer workers than currently estimated should be entering the work force which will have positive effects on wage levels, unemployment rates, and the distribution of income. (c) Savings to the GOP will be significant in social welfare programs, e.g., health and education services and subsidized employment programs. The Economic Analysis quantifies savings in the education sector due to births averted or postponed through greater use of contraception.

Project benefits for target women are particularly high: (a) As indicated above, with fewer pregnancies, adverse effects on maternal health, especially among women living in isolated rural areas, can be significantly reduced. (b) Freedom from childbearing coupled with the power to space and plan the number of births will enable target group women to assume roles other than those of exclusively wife and mother. It will increase their ability to take advantage of educational and work opportunities available to them; the resulting enhancement of woman's economic and social status will eventually be reflected in further reductions in fertility in addition to the improvement in national output which will occur. As a result of Project activities, a higher proportion of women living in low-income urban areas should be able to assume salaried employment, of special importance since they are more likely than rural women to be heads of household. And rural women will be in a better position to take advantage of new opportunities being created in commerce and industry outside the metropolitan corridor. (c) As wives and mothers, women with fewer children should also have the time to be more effective in these roles; just as improved nutrition is a benefit of smaller family size so is the quality of family care, in general, and of child care, on the part of both parents. (d) Teenage girls and younger women, especially those migrating into Panama City from rural areas in search of increased educational and employment opportunities, will be able to pursue these opportunities that would otherwise be shut off to them or strongly inhibited by an early and undesired pregnancy.

Project benefits to children, as indicated above, are significant. With fewer siblings, children will have greater opportunities for a better diet and better health, for more or better quality academic and vocational training, for more parental care and attention. Children - indeed all family members - should benefit, too, from a decrease in crowding, particularly in low-income urban areas where existing housing is more adequate for smaller families.

#### 4. Indirect Beneficiaries

Indirect beneficiaries of the Project are many and varied. They include new entrants into the labor market 15 to 20 years from now who will not have to compete for increasingly scarce jobs. They include clients of the public educational and health systems who will find higher quality services offered as a result of a reduction in the number of births per year. In the final analysis, they include the target groups for all programs, public or private, national or other donor funded, who will find opportunities - for better health care, education, training, employment, credit, etc. - enhanced with fewer people to compete for scarce resources.

Others who will indirectly benefit from the Project are individuals, who may or may not be target group members, who will benefit from I E and C activities or clinical services after the Project has terminated. Thus, adults who receive family planning information, including sex education, under the Project are expected to transmit accurate information to their children as well as to peers beyond the life of Population II. Similarly, adolescents should continue to transmit useful information to their parents as well as to their friends, and school teachers, community leaders, and health sector employees should also continue transmitting information on the reproductive process and on family planning.

Additionally, individuals who may not be defined as target group members but who receive information on family planning through the Project (e.g., by hearing radio messages, reading pamphlets, etc.) or are otherwise motivated by the Project toward greater reliance on modern contraceptive means may be considered indirect beneficiaries of the Project. Its heavy emphasis on providing information on contraception and the reproductive process in a clear and understandable manner and on making family planning services more widely available and in a more dependable, humane, and understanding manner should have payoffs in the large numbers of Panamanians who, whether or not part of the target population, benefit directly or indirectly from the Project.

## D. PROJECT PRIORITY AND RELATION TO OTHER PROGRAMS

### 1. Government of Panama Priorities

The Project goal - reducing the population growth rate - complements two major objectives of current GOP development strategy: achievement of a higher rate of economic growth and a wider, more egalitarian distribution of the benefits of this growth, including the extension of social services to a larger share of the population. Soaring unemployment, an overwhelmingly youthful age structure, an already costly social services budget and a negative growth rate in recent years caused by zero economic growth coupled with an annual 2.5% population growth rate all act, however, as constraints to these objectives and lend urgency to the need for a reduction in population growth.

While the GOP does not have an explicit population policy with demographic goals, it is supportive of family planning and increasingly aware of demographic implications for development. Family planning in Panama is considered by the Government as part of its national health policy: to provide services means to improve health. Programmatically the policy has resulted in the integration of family planning activities into the national Maternal and Child Health Care Program of the Ministry of Health.

Since 1969 when a population program was first introduced in Panama under A.I.D. auspices, Government support has grown both for family planning per se and for the inclusion of demographic considerations at the national policy level. The Ministry of Planning, with assistance from UNFPA, has established a population unit, and an interministerial national demographic commission exists to consider the effects of demographic variables on its development policies and prospects. The ambitious new National Program of Sex Education is further testimony to GOP concern. The Mission expects additional evidence over the life of the Project of increased political and budgetary support for activities which support a reduction in population growth in Panama.

### 2. AID Priorities

The Project supports U.S. Government population policy, AID policy and USAID/Panama's development strategy and long range goals for the next two decades.

The Third Annual Report on U.S. International Population Policy issued by the NSC Ad Hoc Group on Population Policy in January 1979 lists 10 elements which have been shown to be key to successful population programs:

1. Leadership commitment.

2. Rooting family planning in community life.
3. Advancing the legal, social, and economic status of women.
4. Provision of family planning services.
5. Expanded provision of personalized family planning advice and support at the village level; expanded use of paramedics.
6. Broader population education and awareness.
7. Emphasis on population goals in economic development.
8. Biomedical research and the development of better means of contraception.
9. Raising the age of marriage, especially for women, and,
10. Improved organization, management, and administration of population programs.

AID projects in Panama, funded centrally or through the Mission, support all ten of these key elements. This Project directly supports elements 2, 4, 5, 6, and 10. Panama's expected participation in the RAPID Project\* and continued exposure of key public and private sector individuals to population related seminars and conferences will help to ensure the first element (leadership commitment) and element 7 (emphasis on population goals in economic development). Implementation of section 104(d) of the FAA through AID projects and continuous USG-GOP contact will also support elements 1 and 7.\*\*AID efforts in Panama to assist the Government in providing better education to a greater proportion of the population and forthcoming initiatives in employment creation, job

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\* The RAPID Project (Resources of the Awareness of Population Impact on Development) is a centrally funded AID effort to demonstrate to government and private sector leaders in developing countries the effects of population growth on socio-economic development. The contractors under the Project prepare a country-specific analysis of the effect of population factors on the achievement of the country's social and economic goals and present the analysis in dialogue format to national leaders for consideration along with comparable research done by host country analysts. Papers are short and concise; they examine fertility, population growth, internal migration, urbanization and if relevant, external migration as these factors relate to each of the country's principal development goals and programs. The Ministry of Planning has recently expressed interest in the RAPID Project in a number of discussions with Mission personnel; a formal request from the GOP to participate is expected once specific details of the project have been clarified.

\*\* In early 1979, the Ambassador circulated a paper to all Mission personnel - Embassy, AID, ICA, GAO - outlining Panama's demographic growth problem and urging that it be addressed in a "consciousness raising" effort during regular contacts with Panamanian counterparts. See Annex VII for text of the Ambassador's message.

skills training\* and national provision of quality day care/pre-school centers will help to advance the status of women (element 3) and contribute indirectly to raising the age of marriage (element 9). Finally, assistance in support of biomedical research provided to Panama by the International Fertility Research Project directly contributes to element 8.

The Project will receive a major boost from AID's \$9.5 million rural health delivery loan which is helping to expand public health coverage particularly in remote rural areas and improve administration of Panama's public health system. Approximately 23% of the loan is being used to expand MOH/CSS facilities by constructing and equipping four health centers, 14 sub-centers, and 225 posts; prior to commitment of the loan in October 1976, there were 238 facilities, including hospitals. The health loan will increase the total number of public health facilities to 481 by early 1981, or double the 1976 total.

The health loan is also helping to finance training for (a) nurse auxiliaries (counterpart financing to train 400 auxiliaries) to provide assistance in preventive and curative care, environmental health and nutrition at health sub-centers, centers and hospitals, and (b) health assistants (loan financing to train 300) who offer primary health care through health posts located in small rural communities of less than 500 people. This corps of paramedics undergoes a year-long provincial training program which includes family planning information and education; on the job they will provide information and partial services (condoms, foam and resupply of oral contraceptives). The health assistants, once all are trained, should serve as one of the most effective means of

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\* The following is extracted from USAID/Panama's 1981-85 Country Development Strategy Statement, page 46: "No strategy for employment creation would be complete without addressing the need to slow the creation of employment seekers. As indicated in part I.A., workforce of the Metropolitan Corridor is expected to double by the year 2000. Any action which can hold down this growth enhances the chances of success of the program. Panama has had notable success in reducing the population growth and birth rates. To reinforce the downward trend, USAID will continue a family planning program. A key focus of this program will be on adolescents who have become the prime contributors to Panama's population growth. By collaborating in a vigorous campaign to help young women delay pregnancy, while providing them with opportunities to upgrade their skills, USAID will be helping to reduce both population growth and unemployment". Mention is also made of potential AID- private sector collaboration in the areas of, inter alia, health facilities in poor communities, assistance to small enterprises, day care facilities and other services to facilitate greater participation of women in the labor market.

family planning outreach in remote rural areas. (See also footnote on page 7 for contribution of loan 045 to an improved logistics system for the integrated MOH/CSS health network. Administration of the latter is also being improved under the loan through Masters of Public Health training for 15 health care administrators.)

### 3. Relation to Other Activities

The activities described below are financed in varying degrees by AID through centrally funded contracts or, as in the case of UNICEF and UNFPA, an annual contribution; AID's 1979 contribution to UNFPA amounted to approximately 30% (\$30 million) of the Fund's budget.

(a) United Nations Fund for Population Activities (UNFPA):  
In the spring of 1979, UNFPA gave preliminary approval and an advance of funds for a \$2.375 million, four-year extension 1979-1982 of the MOH's Maternal and Child Health Care Program previously supported by AID.

Of the total UNFPA donation, \$236,000 is for full and part-time advisors from the Pan American Health Organization (PAHO is the executing agency for the UNFPA project); \$422,000 for per diem and transportation costs for program supervision by MOH central and provincial personnel; \$221,000 for short-term technical training of MOH personnel abroad; \$404,000 for in-country training; \$241,000 for educational equipment, films, printing costs, data processing, and laboratory equipment related to the Maternal and Child Health program; \$630,000 for medical equipment for 21 hospitals and health centers and 172 health posts, audio visual equipment, jeeps and boats, office and laboratory equipment; \$349,000 for contraceptives; and \$108,000 for research.

Through these inputs the UNFPA project will continue to upgrade the MOH's MCH program, including some support for family planning activities. As stated earlier in the Project Description, great care has been exercised to assure that the UNFPA and AID projects in no way duplicate one another but at every phase, line item by line item, are complementary and mutually supportive. Without the AID project, the MOH would be unable to meet its family planning objectives and enhance its capability to deliver information and services on an ever-expanding scale, particularly to the four population groups most in need of coverage.

AID and UNFPA have agreed to maintain close coordination during implementation of the two projects, a process which will be facilitated by the assignment to Panama of a full-time UNFPA - financed project officer. Regular meetings will be held between the USAID and UNFPA project officers and, as appropriate, MOH and

representatives from other institutions.

The Mission and UNFPA have also agreed informally to joint support of the new GOP National Program of Sex Education. While the general scope of the program is known, detailed implementation and financial plans need to be prepared; UNFPA will finance the services of a Peruvian PAHO consultant to assist with the task. AID, through the Project, will finance the initial training of 90 sex education trainers from five Government agencies and the training of over 3,300 public sector employees, over half of them school teachers in sex education. UNFPA and possibly other donors will help fund sex education activities to be carried out by the MOH and other institutions.

Other related Fund activities include a recently terminated UNFPA project with the MOE to evaluate the impact of vocational schools on rural-urban migration and assistance to the Ministry of Planning and Economic Policy (MPPE) to establish a population unit and carry out a series of migration studies.

(b) UNESCO: The Tribunal Tutelar de Menores, a juvenile agency within the Ministry of Government and Justice with responsibility for delinquents and runaways, has requested assistance from UNESCO with a sex education project to benefit the adolescents it serves. A Chilean consultant is expected to assist in designing the project before September 1979; probable magnitude of the UNESCO effort is \$65,000 over a two-year period. The Mission plans to monitor the project closely since it may provide data on a potentially successful approach to adolescents which could prove useful in other programs directed to the below 20 age group.

(c) International Planned Parenthood Federation (IPPF) in 1979 will provide \$117,200 to its local affiliate, the Asociación Panameña para el Planeamiento de la Familia (APLAFA). Those funds include \$51,000 for personnel; \$12,000 for contraceptives and a vehicle; \$20,000 to be provided the MOH for remodeling six hospital rooms and other support of the Ministry's sterilization services;\* and \$34,000 for APLAFA's family planning clinic, condom distribution program, and new Adolescent Center. For the period 1980-1985 IPPF's estimated contribution to APLAFA is about \$476,000 or 62% of the Association's budget.

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\* IPPF funds have been used previously to convert hospital rooms into operating rooms, which eases pressure on overcrowded facilities and reduces the delay in responding to voluntary sterilization requests.

(d) International Project-Association for Voluntary Sterilization (IPAVS) is supporting in 1979 the cost of a repair and maintenance center for laparoscopes in the MOH at a cost of \$40,000 dollars. It also helps fund GOP participation in seminars and conferences such as the May 1979 conference on sterilization held in Korea to which Panama sent four delegates.

(e) Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO) will train two urologists per year in advanced fertility control techniques. Upon certification that the urologists have successfully completed their practical training, PIEGO will place a laparoscope or laprocator in their home medical institution.

(f) Family Planning International Assistance (FPIA) will continue providing support to APLAFA during the Project period. APLAFA has requested salary support for new sex education employees who will work out of its Adolescent Center. Funding requirement for 1980-84 is \$186,000.

(g) Pathfinder Fund: In its first involvement in Panama, Pathfinder is expected during the Project to assist the Confederation of Panamanian Workers (CTRP) in a program of sex education and family planning information for its members and to provide similar assistance upon request to small private voluntary organizations, in coordination with APLAFA.

(h) Center for Disease Control (CDC): Over the 1979-80 period, the Atlanta-based organization will assist the MOH Office of Data to carry out a contraceptive prevalence survey and to assist it with a follow-on survey in 1983. The CDC will also provide a limited amount of technical assistance to the MOH in program management and logistics.

(i) Development Associates Incorporated (DAI) has financed training courses in family planning and sex education for the Ministry of Health and APLAFA. Under DAI auspices, MOH personnel have either received general in-country training in family planning or specialized training in the U.S. or third countries. Annually, DAI has sponsored at least one seminar given by APLAFA in family planning, demographic growth, and environmental and ecological concerns. One of DAI's most successful recent activities was its sponsorship of attendance by employees of non-health entities in Panama in the sex education course at the Universidad del Valle in Guatemala in 1978. As a direct result of the seminar, USAID/Panama received a request from the Ministry of Education for AID support of a national sex education program. DAI will continue to assist with training for medical and paramedical personnel through June 1979, when its centrally funded contract with AID/W expires. Assistance will be continued under a successor contractor.

(j) American Home Economics Association (AHEA) assists the school of economics of the University of Panama in providing training in family planning to home economics teachers, and for incorporating family planning into home economics-related seminars. A Panamanian was named in April 1979 to serve as Regional Director of the AHEA International Family Planning Project for Latin America and the Caribbean.

(k) International Fertility Research Project (IFRP) provides assistance related to biomedical research in family planning, abortion and operational research. During 1978, it helped to fund a study of abortion in Panama's Santo Tomás Hospital and sponsored a large, highly successful family planning and high risk pregnancy seminar in Panama which drew medical personnel from all sections of the country and brought leading specialists to Panama from the U.S. to deliver papers and serve as discussants.

(l) University of Chicago Program in Communication, Research and Education for Population and Social Development will continue to provide the MOH with training and technical assistance in the design, preparation and evaluation of mass media materials. An evaluation conducted by two members of the Program's staff in 1978 yielded useful information on current MOH I E & C activities; these findings are being taken into consideration in planning the I E & C component for this Project. The University will assist in pre-testing new materials developed during the Project.

## II. PROJECT ANALYSES

### A. ECONOMIC ANALYSIS

#### 1. Benefits

The Project will have two basic impacts: averting some unknown number of births forever, and increasing the spacing of pregnancies for some unknown number of women. The benefits of births averted forever, to name a few, will be less demand on government agencies such as education and health, less political pressure from the work force as unemployment becomes less of a problem, and increased family nutritional status as family size is reduced, thereby reducing demands on the health sector. Less frequent pregnancies will enhance maternal health and increase the probabilities that stronger and healthier babies will be born. Women should also be able to devote a longer time to breast feeding per child which should have a nutritional impact on the child leading to less sickness and thus less demand upon the health sector. To a somewhat lesser extent than with births averted, there will be other benefits from the Project, also, such as increased opportunities for women for more education and better jobs and a reduction in venereal disease resulting from increased condom usage. Although the enumeration of expected benefits is relatively easy, quantification is not. As discussed below, while it is recognized that there will be several types of benefits occurring, only one, education costs avoided, is quantified.

#### 2. Application and Conclusions of Benefit/Cost Analysis

It was determined that least cost analysis would not be appropriate for this Project because there were no substantive alternative comparisons to be made (see Annex VII-A for a discussion of the reasons leading to this conclusion). Instead, what might be determined "partial" benefit/cost analysis has been employed to analyze the impact of the Project. It is partial in the sense that only one type of benefit is considered - education costs avoided due to averted or postponed birth resulting from contraceptive practices. The benefits from this one source alone justify the Project. It was felt unnecessary to carry the analysis further, given the difficulty of quantifying other benefits (see general benefit discussion above), and especially in light of worldwide studies showing the value of such programs for developing countries.

The general fertility rate (GFR) is used as a proxy for estimating births averted under the Project. The fertility rate of the contraceptive population is quite likely to be higher than that of the WIFA population because the latter will contain more sexually inactive and subfecund members than, it can be inferred, will the former. To the extent that is true, the use of the GFR understates the number of births averted. On the other hand, some of those who decide to use contraceptive devices probably would practice some other form of contraception in the absence of a formal program, and thus, to the extent that that is true, the GFR overstates the births averted as a result of the Project. Hence, though it is recognized that various adjustments are normally made to the GFR in order to arrive at an estimate of births averted as a result of a family planning project, such a procedure is not conducted for this B/C analysis based on the assumption that the various adjustments would be at least partially offsetting and that the grossness of the other data used in the analysis would not warrant such refinements.

If we assume a 1979 population of 1.8 million and a crude birth rate of 28 per 1,000, live births for 1979 would be approximately 50,400. Fox and Huguot estimate that in 1979 there is a WIFA population of 437,000 (somewhat higher than would be estimated using MOH figures). Based on the above figures the GFR is 115 per 1,000 (equivalent to:  $50,000 \div 437,000$ ). The estimated total number of births averted as a result of the Project is shown in Table 1. Dividing the total Project costs of \$8.077 million by the 44,160 figure gives an average cost figure in nominal dollars of \$183 per birth averted. Adjusting the Project cost items to include only those that pertain to birth control gives a cost per beneficiary figure of \$48; see Annex VIII-A for basis of calculation.

TABLE 1

ESTIMATED BIRTHS AVERTED DUE TO PROJECT\*

| <u>Year</u> | <u>Number<br/>Contracepting</u> | <u>GFR**</u> | <u>Births Averted</u> |
|-------------|---------------------------------|--------------|-----------------------|
| 1980        | 25,600                          | 115          | 2,944                 |
| 1981        | 51,200                          | 115          | 5,888                 |
| 1982        | 76,800                          | 115          | 8,832                 |
| 1983        | 102,400                         | 115          | 11,776                |
| 1984        | 128,000                         | 115          | <u>14,720</u>         |
|             |                                 | TOTAL        | 44,160                |

\* See Annex 4 for details

\*\* General Fertility Rate: births per 1,000 WIFA.

To conduct the "partial" benefit/cost analysis, the education costs averted, i.e., benefits, are apportioned according to the year in which they would occur had the cohort attended school. The average cost per student per year for grades 1-9 is \$160.\* The calculation of annual costs averted was simplified by assuming that all members of the cohort would have attended school through grade nine without repeating any year. While it would have been possible to use 1968-1973 data from the 1975 USAID/Panama Education Sector Assessment to adjust the yearly enrollment figures for drop outs and grade repeaters, such refinements were not included since they would not appreciably affect the results. Had the refinements been included, the cost averted figures would have been somewhat higher given the higher rate of grade repeaters than drop-outs (Chart A IX-4, USAID/Panama Educational Sector Assessment, April 1975). (See Annex 1 for estimate of total education costs avoided per year as a result of the Project). All Project costs are included in the analysis, not just the actual costs of the contraceptive devices, because the other cost elements are considered necessary to attract and keep people contracepting.

Since it is not known how many of the births will just be postponed and not averted forever as a result of the Project, two extreme cases were analyzed: (1) births averted forever; and (2) births just postponed for the five-year Project period. See Annexes 2 and 3 for B/C ratio derivation. In this first case, to consider the education costs avoided as benefits, it is necessary to assume that, had the births not been averted, the birth-averted cohort would not be able to find employment during its economically active life to even partially offset the cost of its rearing and education. Such an assumption does not appear to be overly strong, particularly from an incremental point of view, given Panama's existing high unemployment rate of 10-15% and, though diminishing, still high population growth rate relative to the current and expect future GDP growth rate.

The savings in educational costs for this 44,160-births-averted-forever case leads to a B/C ratio of 1.86. In present value terms, the cost per birth averted is \$108 rather than the \$183 nominal figure discussed earlier. In the second case, the benefits are the cost savings accruing to the economy as a result of the five-year postponement. It is assumed that the 44,160 births would occur without the Project and that, as a consequence, education costs would begin in 1986. With the Project, it is assumed the births are

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\* 1978 data, Department of Statistics, National Directorate for Planning and Educational Reform of the Ministry of Education. The figure of \$160 is based on salary, a portion of materials cost and central and provincial administrative costs but excludes equipment and construction. The exclusion of equipment, construction and maintenance costs leads to an understatement of the cost per student and hence, an understatement of the B/C ratio.

postponed five years so that education costs do not begin to occur until 1991. The benefits of the Project under this postponement assumption are obtained by subtracting the present value costs of educating the cohort beginning in 1991 from the present value costs of educating the cohort beginning in 1986. This procedure produces a B/C ratio of 0.94.

With minimum and maximum B/C ratios ranging between 0.94 and 1.86, and with only one of the several expected benefits used in the calculations, the Mission concludes that the Project will realize a substantial rate of return.

## B. SOCIAL SOUNDNESS SUMMARY

The Social Soundness Analysis (Annex VIII-B) describes the Project's four target subgroups in socio-economic terms and, where known, provides information about their fertility, attitudes towards family planning, and knowledge and use of contraceptives.\* It assesses the Project's sociocultural feasibility and discusses anticipated Project benefits and the several spread effects which can reasonably be expected from the Project.

The Analysis is based on data from five principal sources. Main sources of general information on the target groups were the 1970 Population Census; a series of studies of low-income neighborhoods in Panama City and Colon carried out by the Ministry of Housing in 1974 and 1975; and 1977 civil registry data obtained through the Ministry of Health. The two primary data sources on fertility, knowledge and use of contraceptive services, as well as need for services, were the World Fertility Survey (WFS), carried out by the Ministry of Health in late 1975 and 1976; and a case study of women living in the District of Cañazas, Province of Veraguas, carried out in mid-1978 by a U.S. anthropologist under an AID contract.

The Analysis concludes that the Project is soundly conceived from a sociocultural perspective. It bases this judgment on several factors, perhaps the most important being that family planning is already widely known about and accepted in Panama. Usage rates are high

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\* While a great deal is known about rural Panamanian women and, to a somewhat lesser extent, about low-income urban women, few data are available on adolescents and men, particularly insofar as attitudes towards family planning, sexual behavior, and knowledge and practice of contraception. This information will be gathered with Project assistance through a series of studies described in Section V of the Paper.

and large segments of the Panamanian population have heard the term "family planning" and have at least some knowledge of what it means. There is a clear demand for services, and service delivery efforts to date of the Ministry of Health and support organizations such as APLAFA have met with a relatively high level of acceptance.

The Analysis foresees no major sociocultural obstacles to the family planning services to be provided under the Project. However, it does identify special characteristics of the target population (e.g., ignorance of sexual development and the reproductive process, reliance on certain authority figures for information) as well as constraints to current service delivery (e.g., overly clinical approach of health staff, irregular and infrequent hours of service) that should be taken into account in designing the I E and C and clinical services to be provided under the Project. All recommendations for addressing these special population characteristics and potential constraints to successful service delivery have been incorporated into the Project design. Additional data to be gathered under the Project on attitudes towards family planning, contraceptive prevalence and continuation rates, and sexual behavior will be used to improve the design of information and education materials and improve the way in which clinical services are provided, a key factor in attracting and maintaining family planning acceptors.

In its final section, the Analysis indicates that several elements of the Project design virtually assure (a) the spread of benefits to both target group and non-target group members during and after the life of the Project, and (b) the future replicability of key Project components. This conclusion is based on the Project's strong emphasis on providing information on contraception and the reproductive process in a clear, understandable manner and on training the staffs of participating institutions to provide both information and contraceptive services with sensitivity and understanding, and with as much knowledge and accuracy as possible.

Although not specifically mentioned in the Analysis, to the degree the Project is successful in reducing the number of births per year in Panama and in permitting more women to choose when they wish to bear children and how many children to have, the efforts of AID and other development programs to improve the quality of life for the rural and urban poor will be enhanced.

### C. TECHNICAL FEASIBILITY

#### 1. Adequacy of Outreach/Delivery System

The first question to be addressed is the conceptual soundness of the overall strategy - that is, to continue support to the integrated Ministry of Health/CSS family planning program and, in a departure from previous practice, begin to provide assistance for sex education and family planning activities to entities outside the MOH. As discussed elsewhere in the

Paper, the MOH dominates family planning in Panama, representing the source of services for 70% of all women acceptors in the country. It alone has the geographical coverage, trained personnel, and infrastructure to carry out an active family planning program. Its resources are being greatly expanded and upgraded through this and other projects resulting in many more people providing family planning information and services at many more locations in rural and urban Panama. The emphasis in the Project on paramedic delivery and community level outreach by professionals and volunteers will enhance this capability. Both the provision of health care services (especially in preventive health) by paramedics and the involvement of community members in promoting "Equal Health for All" are concepts that have been developed and tested through previous AID-financed projects in the health sector.

The initiation of activities in other public sector agencies outside the health sector is a clear departure from the previous AID-supported family planning program. However, interest and commitment of the implementing agencies are strong, including from the Ministry of Health which will also participate in and provide technical backstopping for the new program of sex education. Interest in the latter is not new. Several years ago the Ministry of Education requested technical assistance through the U.N. to design a sex education program, an initiative which never advanced beyond the planning stage as a result of a change in administration. However, this year the MOE and other ministries have declared their commitment to establishing a national sex education program, and on their own formed a National Sex Education Commission. This Commission will be responsible for coordinating all public sector sex education activities. Comprised of representatives of the MOH/CSS, MOE, Ministry of Labor and Social Welfare, Tutelar de Menores and IPHE, the Commission will define the scope of the national sex education program, develop curriculum, coordinate technical assistance and training and oversee materials development. Although currently an effective but informal working group, the Commission is expected to be given formal status during the latter part of 1979.

A second point is the feasibility of working specifically through certain institutions - MOE, I.P.H.E. and APLAFA - to accomplish the Project purpose. Although neither the MOE or I.P.H.E. has experience in family planning and sex education, both have demonstrated commitment to the program over the past half year, and both are in an excellent position to reach the target population, the MOE through its broad access to Panamanian youth (and their families) and I.P.H.E. through its access to the very low-income rural and urban poor. Both are established, respected public sector institutions with the personnel and infrastructure required for extensive geographical coverage. Each also has a long history of successfully enlisting community support for their activities; this experience of working with community leaders

and padres de familia groups will be especially useful in paving the way for public support of adolescent sex education, especially in rural areas.

APLAFA currently represents the only organized family planning/sex education program alternative to the public sector. Although the Ministry of Health has not always been encouraging of APLAFA efforts, the Association has played an extremely useful, innovative role in family planning in Panama, providing a model which the public sector has frequently emulated. Its recent promotion of sex education for adolescents and their families is an excellent case in point. APLAFA's Adolescent Center offers an alternative service delivery model to clinic-based services for adolescents, and its program of providing family planning-sex education talks in an informal setting or at employees' place of work is an effective alternative strategy for delivering I E and C. A large number of private sector organizations have approached AID and APLAFA in recent months for assistance in providing sex education/family planning programs to their members. This is outreach work at which APLAFA excels, and it is enthusiastic about meeting these private sector needs and in encouraging other groups to sponsor similar programs. APLAFA in all cases refers its audiences to MOH facilities (or private physicians) for clinical services.

A final strategy issue is the feasibility of supporting the delivery of contraceptive services solely through the public sector, given the Project purpose of expanding service delivery to a higher proportion of the fertile age group. By virtue of its authority over health policy, which in Panama includes family planning, the Ministry of Health has determined that contraceptives may be provided only by the MOH-CSS health care system and by private physicians and pharmacists. While this decision may be disputed on technical grounds, it nevertheless represents GOP policy at the present time, and contraceptive services will continue to be provided only through MOH-CSS clinics for the foreseeable future. As indicated in the Paper, the family planning program can draw on an extensive and still expanding network of public health facilities, all of which are staffed and equipped to provide some family planning services at almost no cost to the client. The Project has been designed to ensure as nearly as possible that these services will, in fact, attract new acceptors and maintain both present and new users at acceptable levels.

Project activities to be carried out by the four executing agencies should mutually reinforce the probability of achieving the Project purpose. All low-income groups, including those located in small, widely dispersed rural settlements many of which have not a single physician and only a rudimentary pharmacy, and including for the first time adolescents and men, should be provided with increasingly easy access to high quality family planning services as a result of the Project.

## 2. Proposed Contraceptive Technologies

Under the Project, there will be a shift in emphasis in contraceptive methods - to simpler sterilization procedures, towards methods appropriate for adolescents, and towards greater reliance on male contraception. These new directions reflect the desire of MOH/CSS family planning administrators to make appropriate contraceptive technology available to a greater proportion of the target group.

### (a) Female sterilization.

The Project will seek to make simpler techniques of voluntary sterilization more widely available to meet the existing backlog of requests and the increased demand expected to be generated by the Project. The World Fertility Survey revealed that voluntary female sterilization is the most popular means of contraception among ever-married (or in union) women age 20-49. Almost 26% of these women had been sterilized, compared with the 20.6% of women who were active users of the pill. If the proportion of women who stated in the World Fertility Survey that they did not want any more children (see Section I.A.2 Demographic Trends) is taken as an index of the demand for sterilization, then it is clear that there is a significant unsatisfied demand for this method of contraception.

Voluntary sterilization will continue to be available exclusively at hospitals. The MOH/CSS hospitals currently have adequate numbers of OB/GYN personnel. The Project will provide the sterilization equipment required and training for some personnel so that laparoscopy and mini-laparotomy can be performed on a widespread basis, replacing the more common (more costly and more time consuming) tubal ligation procedure. Simplification of the female sterilization procedure will make it possible to perform a greater number of sterilizations by reducing the demand on operating facilities and personnel.

### (b) Wider variety of reversible methods.

A second shift in contraceptive technology is towards greater variety of effective, reversible contraceptive methods. Currently, the most widely known and available methods in Panama are oral contraceptives and female sterilization. However, with negative characteristics assigned by many women to the pill, and sterilization appropriate only for those women who definitely desire no additional pregnancies, the availability of methods such as the IUD, the diaphragm, spermicides, and condoms offer additional options to women whose concern is postponing or spacing pregnancies. These alternatives are especially desirable in the case of adolescents, particularly those who, not yet having entered a stable relationship, will nonetheless want protection for their infrequent sexual contacts. With the exception of the IUD, moreover, these methods can be readily distributed without medical supervision, making contraception more accessible to this group. Health personnel will be instructed in the use and prescription of these methods as part of the training in

family planning they will receive under the Project, and promotion and explanation of these methods directed towards the target population will be effected through the Project's I E and C component.

(c) Male contraception.

The final shift in contraceptive technology through the Project will be a new emphasis on male contraception. Unfortunately, there are few reliable data on male contraception in Panama.\* The World Fertility Survey, which sampled only women 20-49, revealed that just 1.5% of these women (2.3% of all female users) relied on the condom for contraception. Another 0.4% of women (0.6% of all women using contraception) relied on male sterilization. Despite the lack of prevalence data on men, informal queries of physicians and nurses indicate that there is interest on the part of men in using contraception, and private pharmacies, essentially the only source of condom supplies independent of the MOH, sell a large volume of condoms - but at high prices: \$.40 to \$3.75 per box of three (\$.25 - \$.30 if sold individually). The strategy of making condoms widely available at no cost offers a simple, effective low-cost means of preventing unwanted pregnancy. This strategy will be supported by the I E and C efforts discussed under Project Activities.

The more significant technical issue in male contraception involves (a) increasing the availability of the vasectomy which is now limited by a lack of adequate operating facilities, equipment and trained personnel, and (b) increasing its adoption which is inhibited by ignorance and psychological and other concerns about male sterilization. These constraints will be addressed during the Project through AID and other donor assistance: adequately equipped operating facilities will be increased, staffed by better trained personnel; vasectomy kits will be provided to all public hospitals in Panama; a special pilot vasectomy center will be established in Panama City to perform vasectomies (estimated 12 per day) and offer diagnosis and counseling services in male infertility; and I E and C activities will be designed especially to address those knowledge and other constraints which affect acceptor rates.

In conclusion, while there are a number of technical feasibility issues involved in the Project, Project activities have

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\* The MOH does not maintain accurate records of condom distribution through Ministry facilities on which to base estimates of current users. This is largely because the MOH family planning program, designed primarily to serve women in the context of an integrated Maternal and Child Health program, has never prior to the development of this Project focussed on making family planning services accessible to men.

been designed to take these issues into account, and funds are provided for a wide variety of supporting inputs which should help to guarantee the technical feasibility of the Project.

#### D. INSTITUTIONAL FEASIBILITY SUMMARY

Information for this section was drawn from two principal sources: one the report of a technician from the American Public Health Association who was contracted in early 1979 to analyze the capabilities of organizations expected to participate in the Project, and the other a considerable body of data on and experience with these organizations which exists within the Mission.

As indicated earlier in the Paper, two GOP ministries, a semi-autonomous welfare institution, and the local IPPF affiliate will implement the Project. They are the Ministry of Health, Ministry of Education, Panamanian Institute for Special Education (I.P.H.E.), and the Panamanian Family Planning Association, APLAFA. The Institutional Feasibility section (Annex VIII-C ) describes in general terms the role and organizational structure of each entity, evaluates the quality of institutional performance, assesses staff capabilities and adequacy of other resources available to carry out the Project, and attempts a reasonable calculation of expected institutional counterpart.

The analysis concludes that all four institutions possess the commitment, capability and a good portion of the resources needed to undertake the activities proposed in the Project. It indicates, however, that because family planning is a new area for two of the institutions (MOE and I.P.H.E.) and sex education is new to all of them, some training of staff will be required. Proposed fields and magnitudes of training for each institution are identified and discussed in the Project Paper as are other resource requirements - e.g., for vehicles, audiovisual equipment, family planning materials - needed to carry out the Project.

Since the Ministry of Health, more than any other agency, is crucial to the success of the Project, its ability to implement the Project effectively and efficiently calls for special scrutiny. The institutional analysis notes that the MOH is in the process of significantly expanding its staff as it opens new health facilities across Panama, particularly in remote rural areas. During the first 18 months of the Project, with AID loan funds, 132 additional facilities will be established most of which are to be staffed with new hire personnel. The latter include health assistants and nurse auxiliaries who will staff health posts and sub-centers, respectively; year-long training programs for both are designed to provide a reasonably thorough background in family planning information and services.

The Ministry's outreach capability will be further extended by additional Women's Health Care Specialists who are prepared to

offer the entire range of contraceptive services, short of sterilization, and by increasing use of its corps of 72 field level health educators; eight educators will receive special training under the Project in effective family planning extension techniques, and educators in each health region will be provided a jeep and audio-visual equipment and materials for use in community extension work. Efforts of the health educators and aforementioned paramedical personnel will be augmented further by training community malaria workers in family planning and by enlisting community volunteers to promote family planning and provide information in their communities. Finally, regular medical personnel should be more effective in extending family planning and retaining acceptors through improved technical and human relations skills to be provided under the Project.

Central Ministry staff (MCH Division/Panama City) will be strengthened by the planned addition of four new positions and the presence of long-and short-term PAHO personnel funded under the UNFPA project. In addition, the analysis highlights the need for additional assistance to the MCH office in I E and C and this is expected to occur during the first year of Project implementation. Other problems identified in the analysis include inadequate logistics and supervisory systems and an insufficient information base, all of which bear directly on the Project outcome; improvements in each of these three areas are programmed either under this Project, the UNFPA project or AID's Rural Health Delivery System loan or, in some instances, under all three.

Because of the existing pattern of institutional relationships, no overall coordinating mechanism has been established to carry out Project activities. However, it is the judgment of the Mission that this will not necessarily prejudice Project implementation for a number of reasons. First, most I E and C activities and all contraceptive services under the Project are located within a single institution, the Ministry of Health; thus, the Project carries with it no overwhelming requirement for interagency coordination. What will be important, however, is to maintain effective coordination between the two principal donors to the MOH family planning program - AID and UNFPA; this has been discussed with Mission, UNDP and UNFPA personnel, and close coordination is anticipated, including with PAHO which is the implementing agency for the UNFPA Maternal-Child Health Program.

Second, the activities of the Ministry of Education and IPHE fall under the rubric of the National Program of Sex Education, being directed by a five-agency National Commission on Sex Education which includes the MOH, MOE and I.P.H.E. Thus, a coordinating mechanism for the sex education component of the Project exists, and the Mission will be able to maintain Project oversight both through the Commission as well as through three of its member institutions.

Third, while coordination between the MOH and APLAFA is highly desirable, it is not practicable at this time because of the Ministry's unwillingness to cooperate with the IPPF affiliate. As indicated in Section IV of the Project Paper, however, an effort will be made during the life of the Project to encourage these two agencies toward a more conciliatory, if not collaborative, relationship. In the meantime, the USAID population officer will attempt insofar as possible to assure that no wasteful duplication of effort occurs and that possible sources of friction are minimized.

E. ENVIRONMENTAL CONCERNS

The Mission conducted an Initial Environmental Examination (IEE) (Annex VIII-E ) to determine whether the proposed Project activities would have any significant adverse effects on the environment. The Mission concluded that the Project would have no significant effect on the human or natural environment. The Assistant Administrator for Latin America and the Caribbean approved a negative determination on December 15, 1978.

No substantive changes have occurred in the Project design since the PID was submitted. Therefore, no additional examination is needed.

### III. FINANCIAL PLAN

The following tables present the financial plan for this Project. Table 1, Overall Financial Plan, shows the costs of AID, GOP, and other donor inputs; Table 2 shows a projection of expenditures by fiscal year and funding source over the life of the Project. Table 3 presents the overall Training Plan for the Project.

AID's contribution of \$3,100,000 will be used to provide contraceptive commodities, family planning and audio visual equipment, mobile generators, vehicles, funding of printed materials and mass media coverage of the family planning program, private sector information and education costs in family planning and sex education, training of personnel as sex education instructors, training in family planning abroad and in-country, technical assistance and evaluations and studies. AID's contribution to the Ministry of Health is \$2,455,600; to the Ministry of Education, \$455,000; to APLAFA, \$96,000 and to the Panamanian Institute for Special Education (IPHE), \$93,400.

The GOP counterpart of \$4,951,600 is in salaries of Ministry of Health personnel directly related to the implementation of family planning programs and vehicle and equipment maintenance and repair costs; salaries of Ministry of Education personnel who are instructors or teachers who attend sex education seminars; and IPHE salaries of personnel who attend sex education seminars. APLAFA, a privately funded agency, is contributing administrative support in developing, coordinating and implementing courses, seminars and talks on family planning and related activities. This support is estimated at \$25,000.

Total planned funding for the UNFPA project, entitled "Extension of the Maternal-Child Health Program," is \$2,375,000. The main thrust of this project, as its name indicates, is pre-and post natal and child health care. However, the UNFPA contraceptive component is directly in support of family planning; for this reason, \$349,000 of contraceptives is included in the overall financial plan and shown on the PP facesheet. While other components may be related to family planning activities, they are not an integral part of the AID Project and have not been included in the financial plan.

The Overall Financial Plan shows \$200,000 under sterilization equipment. This amount represents the cost of repair and maintenance for laparoscopes provided by IPAVS as well as the cost of training GOP personnel. The estimated cost is \$40,000 per year for the five-year life of this Project.

The \$714,000 is APLAFA's funding from 1980-1984 provided by International Planned Parenthood Foundation (\$476,000), Comité Regional de Educación Sexual para América Latina y el Caribe, or CRESALC (\$27,000), Development Associates (\$25,000) and Family

Planning International Association (\$186,000). This contribution enables APLAFA to continue its outreach programs in the public and private sectors.

The \$50,000 under the training component for the Ministry of Health represents \$25,000 contributed by the Johns Hopkins Program for International Education in Gynecology and Obstetrics for Training ten urologists in using laparoscopes over the five-year Project, and \$25,000 for Development Associates, Inc. assistance to the MOH in third country training.

See Annex VIII-D, Financial Analysis, for a description of the basis on which cost estimates were made for AID-financed inputs, a brief analysis of the MOH budget, and a description of the basis on which counterpart contributions were calculated.

OVERALL FINANCIAL PLAN  
POPULATION II  
(\$000)

| <u>Component</u>  | <u>A.I.D.</u> | <u>GOP</u> | <u>Other Donor</u> | <u>TOTAL</u>      |
|---|---------------|------------|--------------------|-------------------|
| Centrally Procured Commodities in AID/W<br>UNFPA Contraceptives (Condoms and Pills) | \$ 820.0      |            | \$ 271.0           | \$ 820.0<br>271.0 |
| Sub-Total   | \$ 820.00     |            | \$ 271.0           | \$1,091.0         |
| <u>Commodities</u>  |               |            |                    |                   |
| Mission Procured Contraceptives<br>UNFPA Contraceptives (Foams, Jellies, IUD's)     | \$ 97.6       |            | \$ 78.0            | \$ 97.6<br>78.0   |
| <u>Equipment</u>  |               |            |                    |                   |
| Sterilization   | 160.0         |            | 200.0              | 360.0             |
| Family Planning Related   | 118.0         |            |                    | 118.0             |
| Audio Visual  |               |            |                    |                   |
| MOH   | 51.0          |            |                    | 51.0              |
| MOE   | 42.0          |            |                    | 42.0              |
| IPHE  | 38.7          |            |                    | 38.7              |
| Mobile Generators   | 6.0           |            |                    | 6.0               |
| Vehicles  | 103.0         | \$ 10.0    |                    | 113.0             |
| Sub-Total   | \$ 616.3      | \$ 10.0    | \$ 278.0           | \$ 904.3          |
| Salaries of Family Planning Specialists<br>and Administrative Personnel             |               | \$3,399.0  |                    | \$3,399.0         |
| <u>Information, Education &amp; Communication Activities</u>                        |               |            |                    |                   |
| MOH Printed Materials & Mass Media  | \$ 586.0      |            |                    | \$ 586.0          |
| APLAF & Private Sector  | 96.0          | 25.0       | \$ 714.0           | 835.0             |
| Sub-Total   | \$ 682.0      | \$ 25.0    | \$ 714.0           | \$1,421.0         |
| <u>Training</u>   |               |            |                    |                   |
| MOH   | \$ 248.0      |            | \$ 50.0            | 298.0             |
| MOE   | 403.0         | \$1,335.6  |                    | \$1,738.6         |
| IPHE  | 40.7          | 57.0       |                    | 97.7              |
| Sub-Total   | \$ 691.7      | \$1,392.6  | \$ 50.0            | \$2,134.3         |
| <u>Technical Assistance</u>   |               |            |                    |                   |
| IPHE  | \$ 6.0        |            |                    | \$ 6.0            |
| MOE   | 10.0          |            |                    | 10.0              |
| Sub-Total   | \$ 16.0       |            |                    | \$ 16.0           |
| <u>Evaluation and Studies</u>   | \$ 274.0      | \$ 150.0   |                    | \$ 424.0          |
| Total   | \$3,100.0     | \$4,976.6  | \$1,313.0          | \$9,389.6         |

Note: The Other Donor column represents UNFPA contraceptives, \$349.0; IPAYS family planning related equipment, \$200.0; APLAF funding by IPPF, CRESALC, O.A. and FPIA, \$714.0 and JHPIEGO, \$25.0 and Development Associates \$25.0 for training.

**POPULATION II**  
**Projection of Expenditures by Fiscal Year**  
**(US \$000)**

| COMPONENT   | FY 79 |       | FY 80 |       | FY 81 |       | FY 82 |       | FY 83  |       | FY 84  |       | TOTAL |        | Grand Total |        |
|---|-------|-------|-------|-------|-------|-------|-------|-------|--------|-------|--------|-------|-------|--------|-------------|--------|
|   | AID   | GOP   | AID   | GOP   | AID   | GOP   | AID   | GOP   | AID    | GOP   | AID    | GOP   | AID   | GOP    |             |        |
| Centrally Procured Commodities AID/A  | \$    |       | 40.3  |       | 25.9  |       | 4.0   |       | 320.8  |       | 219.0  |       | 820.0 |        | 820.0       |        |
| <u>Commodities</u>  |       |       |       |       |       |       |       |       |        |       |        |       |       |        |             |        |
| Mission Procured Contraceptives   | \$    |       | 22.5  |       | 16.5  |       | 31.7  |       | 26.9   |       |        |       | 97.6  |        | 97.6        |        |
| <u>Equipment</u>  |       |       |       |       |       |       |       |       |        |       |        |       |       |        |             |        |
| Sterilization   | \$    |       | 53.3  |       | 53.3  |       | 53.4  |       |        |       |        |       | 160.0 |        | 160.0       |        |
| Family Planning Related   |       |       | 50.0  |       | 60.0  |       | 8.0   |       |        |       |        |       | 113.0 |        | 113.0       |        |
| Audio Visual  |       |       |       |       |       |       |       |       |        |       |        |       |       |        |             |        |
| MOM   |       |       | 51.0  |       |       |       |       |       |        |       |        |       | 51.0  |        | 51.0        |        |
| MOE   |       |       | 35.0  |       | 7.0   |       |       |       |        |       |        |       | 42.0  |        | 42.0        |        |
| IPME  |       |       | 33.7  |       | 5.0   |       |       |       |        |       |        |       | 33.7  |        | 33.7        |        |
| Mobile Generators   |       |       | 6.0   |       |       |       |       |       |        |       |        |       | 6.0   |        | 6.0         |        |
| Vehicles  |       |       |       |       |       |       |       |       |        |       |        |       |       |        |             |        |
| Sub-Total   | \$    |       | 103.0 | 2.0   | 141.8 | 2.0   | 93.1  | 2.0   | 26.9   | 2.0   | 2.0    | 2.0   | 103.0 | 10.0   | 113.0       |        |
|   | \$    |       | 354.5 | 2.0   | 141.8 | 2.0   | 93.1  | 2.0   | 26.9   | 2.0   | 2.0    | 2.0   | 616.3 | 10.0   | 626.3       |        |
| <u>Salaries of Family Planning Specialists and Administrative Personnel</u> | \$    | 100.0 |       | 630.0 |       | 662.0 |       | 695.0 |        | 729.0 |        | 583.0 |       | 3399.0 | 3399.0      |        |
| <u>Information, Education and Communication Activities</u>                  |       |       |       |       |       |       |       |       |        |       |        |       |       |        |             |        |
| MOM Printed Materials and Mass Media  | \$    | 20.0  |       | 120.0 |       | 154.0 |       | 109.0 |        | 99.0  |        | 84.0  |       | 526.0  |             | 586.0  |
| APLATA and Private Sector   |       |       |       | 16.0  | 5.0*  | 22.0  | 5.0*  | 22.0  | 5.0*   | 20.0  | 5.0*   | 16.0  | 5.0*  | 26.0   | 25.0*       | 121.0  |
| Sub-Total   | \$    | 20.0  |       | 136.0 | 5.0   | 176.0 | 5.0   | 131.0 | 5.0    | 119.0 | 5.0    | 100.0 | 5.0   | 682.0  | 25.0        | 707.0  |
| <u>Training</u>   |       |       |       |       |       |       |       |       |        |       |        |       |       |        |             |        |
| MOM   | \$    | 9.0   |       | 45.0  |       | 65.0  |       | 53.0  |        | 45.0  |        | 31.0  |       | 248.0  |             | 248.0  |
| MOE   |       | 2.0   | 17.0  | 42.7  | 207.7 | 79.3  | 269.4 | 93.0  | 280.5  | 93.0  | 280.5  | 93.0  | 280.5 | 403.0  | 1335.6      | 1738.6 |
| IPME  |       |       |       | 11.7  | 15.0  | 11.3  | 15.0  | 7.0   | 10.0   | 5.7   | 9.0    | 5.0   | 8.0   | 40.7   | 57.0        | 97.7   |
| Sub-Total   | \$    | 11.0  | 17.0  | 99.4  | 222.7 | 155.6 | 284.4 | 153.0 | 290.5  | 143.7 | 289.5  | 129.0 | 288.5 | 491.7  | 1392.6      | 2084.3 |
| <u>Technical Assistance</u>   |       |       |       |       |       |       |       |       |        |       |        |       |       |        |             |        |
| IPME  | \$    |       |       | 6.0   |       |       |       |       |        |       |        |       |       | 6.0    |             | 6.0    |
| MOE   |       |       |       | 10.0  |       |       |       |       |        |       |        |       |       | 10.0   |             | 10.0   |
| Sub-Total   | \$    |       |       | 16.0  |       |       |       |       |        |       |        |       |       | 16.0   |             | 16.0   |
| <u>Evaluation and Studies</u>   | \$    |       |       | 76.0  | 28.1  | 21.0  | 20.0  | 56.0  | 31.4   | 58.0  | 25.5   | 53.0  | 25.0  | 274.0  | 150.0       | 424.0  |
| Sub-Total   | \$    | 31.0  | 117.0 | 681.9 | 897.8 | 504.4 | 983.4 | 433.1 | 1023.9 | 347.6 | 1051.0 | 282.0 | 903.5 | 2280.0 | 4976.6      | 7256.6 |
| GRAND TOTAL   | \$    | 31.0  | 117.0 | 722.2 | 897.8 | 600.3 | 983.4 | 577.1 | 1023.9 | 668.4 | 1051.0 | 501.0 | 903.5 | 3100.0 | 4976.6      | 8076.6 |

\*APLATA is privately funded.

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Table 2

POPULATION II  
TRAINING PLAN  
NUMBER OF INDIVIDUALS TO BE TRAINED

INSTITUTION, SUBJECT  
DURATION OF TRAINING AND TYPE  
OF PERSONNEL  
MINISTRY OF HEALTH

|   | <u>YR. 1</u> | <u>YR. 2</u> | <u>YR. 3</u> | <u>YR. 4</u> | <u>YR. 5</u> | <u>TOTAL</u> |
|---|--------------|--------------|--------------|--------------|--------------|--------------|
| <b>A. <u>In-Country</u></b>   |              |              |              |              |              |              |
| Training of trainers in Sex Edu.(4 weeks)   | 30           | --           | --           | --           | --           | 30           |
| Seminars on Family Planning for medical & nursing students, interns, sanitation inspectors, community volunteers (1-5 days)             | 1065         | 810          | 995          | 995          | 995          | 4860         |
| Evaluation Training for health educators (3 days)   | 65           | --           | --           | --           | --           | 65           |
| Seminar on sex education/family planning for nurse auxiliaries, admin. personnel, pharmacists, OB/GYN, & general practitioners (3 days) | 125          | 310          | 125          | 125          | 125          | 810          |
| Training logistics-supply pers. (3 days)  | 15           | --           | --           | --           | --           | 15           |
| Training in human relations for various staff (3 days)  | 90           | 90           | 90           | 90           | 90           | 450          |
| Post basic course - Women's Health Care Specialists for nurses (4 months)   | --           | 30           | 30           | 30           | 30           | 120          |
| Sub-Total   | 1390         | 1240         | 1240         | 1240         | 1240         | 6350         |

INSTITUTION, SUBJECT  
DURATION OF TRAINING AND TYPE  
OF PERSONNEL

|  | <u>YR. 1</u> | <u>YR. 2</u> | <u>YR. 3</u> | <u>YR. 4</u> | <u>YR. 5</u> | <u>TOTAL</u> |
|--|--------------|--------------|--------------|--------------|--------------|--------------|
| <b>B. External</b>   |              |              |              |              |              |              |
| Trainers in family planning for administrators (6-8 weeks)                         | 4            | 4            | 4            | 3            | --           | 15           |
| Family Planning, sex education - for adolescents (various staff) (4 weeks)         | 3            | 2            | 2            | --           | --           | 7            |
| Sex educators - selected staff (6 weeks)   | 3            | 4            | 2            | --           | --           | 9            |
| Communications in family planning for health educators (4 weeks)                   | 1            | --           | 1            | --           | --           | 2            |
| Production and evaluation of audio-visual materials for health educators (4 weeks) | 2            | 2            | 1            | 2            | --           | 7            |
| Family planning methodology for various professionals (8 weeks)                    | 4            | 6            | --           | --           | --           | 10           |
| Laparoscopy and Mini-Lap techniques for OB/GYN (4 weeks)                           | 2            | 2            | 2            | 2            | 2            | 10           |
| Vasectomy and Infertility for urologists (4 weeks)                                 | 4            | 4            | 2            | 2            | 2            | 14           |
| Observation trips (1 week)   | 5            | --           | --           | --           | --           | 5            |
| Education Techniques in Social Communications for health educators (2 weeks)       | --           | 6            | --           | --           | --           | 6            |
| Sub-Total  | <u>28</u>    | <u>30</u>    | <u>14</u>    | <u>9</u>     | <u>4</u>     | <u>85</u>    |
| TOTAL MOH  | <u>1418</u>  | <u>1270</u>  | <u>1254</u>  | <u>1249</u>  | <u>1244</u>  | <u>6435</u>  |

| INSTITUTION, SUBJECT<br>DURATION OF TRAINING AND TYPE<br>OF PERSONNEL | YR. 1       | YR. 2       | YR. 3       | YR. 4       | YR. 5       | TOTAL        |
|---|-------------|-------------|-------------|-------------|-------------|--------------|
| <u>MINISTRY OF EDUCATION</u>  |             |             |             |             |             |              |
| Training of trainers in sex education<br>(4 weeks)                    | 36          | --          | --          | --          | --          | 36           |
| Sex Education for public school<br>teachers (4 weeks)                 | 240         | 407         | 440         | 440         | 440         | 1967         |
| TOTAL MOE   | <u>276</u>  | <u>407</u>  | <u>440</u>  | <u>440</u>  | <u>440</u>  | <u>2003</u>  |
| <u>IPHE</u>   |             |             |             |             |             |              |
| Training of trainers in sex education (4weeks)                        | 12          | --          | --          | --          | --          | 12           |
| Sex education/family planning (4 weeks)                               | 50          | 58          | 39          | 36          | 32          | 215          |
| TOTAL IPHE  | <u>62</u>   | <u>58</u>   | <u>39</u>   | <u>36</u>   | <u>32</u>   | <u>227</u>   |
| <u>MINISTRY OF LABOR</u>  |             |             |             |             |             |              |
| Training of trainers in sex education<br>(4 weeks)                    | 9           | --          | --          | --          | --          | 9            |
| <u>TUTELAR DE MENORES</u>   |             |             |             |             |             |              |
| Training of trainers in sex education<br>(4 weeks)                    | 3           | --          | --          | --          | --          | 3            |
| GRAND TOTAL   | <u>1768</u> | <u>1735</u> | <u>1733</u> | <u>1725</u> | <u>1716</u> | <u>8,677</u> |

#### IV. IMPLEMENTATION PLAN

##### A. Administrative Arrangements for Project Implementation

The Grantee will be the Government of Panama,\* and the executing agencies will be the Ministry of Health, the Ministry of Education, the Institute for Special Education (I.P.H.E.), and APLAFA, the private Panamanian Family Planning Association. Within the Ministry of Health which will receive the major portion (79%) of grant funds, the Department of Maternal and Child Health will have responsibility for implementing the Project. The Ministry of Education and I.P.H.E., which will execute a sex education program, will participate through the Office of Teacher Training and the Offices of Pre-School Education and Social Assistance Services, respectively. All three GOP institutions are members of the National Commission on Sex Education, and Mission liaison will be maintained with that organization particularly during the early stage of Project implementation when the Project will help fund the training of interdisciplinary teams of sex educators from five public sector agencies. APLAFA will be responsible for executing its part of the Project through the Association's Executive Director and three operating divisions: information and education, adolescent center, and resources development.

The executing agencies will be responsible for providing sufficient personnel at the appropriate technical level to carry out Project activities; selecting individuals for training within Panama and abroad, as described in the section on Project Activities; developing and carrying out, where appropriate, courses and seminars; developing appropriate didactic and media materials and arranging for their publication and dissemination; procuring equipment, materials, and the limited amount of technical assistance programmed under the Project according to procedures agreed to by AID, maintaining all equipment and materials in good operational condition and providing counterparts for technical assistance personnel; gathering and maintaining data needed to evaluate the progress and impact of the Project; and participating in annual and special evaluations. The Ministry of Health, which will be the only institution under the Project to provide grant-funded clinical services, will be responsible for: maintaining careful inventory control of contraceptive supplies, timely delivery of contraceptive commodities to its 480 health facilities throughout Panama, and adequate stocking of condom displays in public institutions.

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\* See Section VI for discussion of possibility of a separate grant agreement with APLAFA.

B. USAID Monitoring Responsibility and Administrative Procedures

1. Project Monitoring. Within the Mission, the Population II Project Team will have overall responsibility for monitoring the progress of the Project; members include representatives from the following offices: human resources development, development resources, development planning, and controller. The Mission's Population Officer will serve as Project Manager, responsible for overseeing day-to-day implementation and field monitoring of Project activities.

In the absence of a central host country coordinating mechanism for the Project due to present institutional attitudes (particularly of the MOH towards APLAFA), the USAID Population Officer will be called upon to play a special role to assure that each portion of the Project is proceeding according to schedule, that there is no wasteful duplication of effort, and that effective coordination is maintained between AID and the other principal family planning donor, UNFPA. The importance of the latter has already been the subject of some discussion among Mission, UNDP and UNFPA personnel and the prognosis for an effectual working relationship is good. The Mission Population Officer will also coordinate closely with other family planning agencies such as IPPF, FPIA, and IPAUS. This role - of coordinating closely with and among executing agencies and other donors - is not new to the USAID since its Population Officer was required to perform a similar function for much the same reason under the terminating Health and Population Project. An effort will be made, however, over the course of the Project to move the Panamanian agencies toward a more conciliatory and unified working relationship in their mutual attack on the problems associated with a high population growth rate.

2. Disbursement Procedures will be fully outlined in Project Implementation Letter No. 1. Funds will be disbursed by AID to each of the four executing agencies by means of an initial advance to be adjusted quarterly based on anticipated disbursement schedules and actual expenditures for preceding quarters. Reimbursement for the training of 12 sex education trainers from the Ministry of Labor and Tutelar de Menores will be done through the Ministry of Education and for seven similar trainers from CSS/Panama City through the Ministry of Health. All requests for reimbursements will be accompanied by satisfactory evidence of claimed expenditures. Regular financial reports and certified copies of payment orders for goods and services are required. Grant funds will be disbursed over a five-year period. (See Table 2, Financial Plan, for projected disbursements by fiscal year and the proposed implementation schedule shown in this section.)

3. Procurement Procedures. The selection of consultants and contractors, procurement of equipment and materials, shipping and insuring will be carried out in accordance with the standard procedures called for in the Grant Agreement. It is anticipated that all goods

and services procured under the Grant, with the exception of certain contraceptive commodities, will be contracted directly by the executing agencies, with AID's prior concurrence. Oral contraceptives and condoms for distribution through the Ministry of Health will be procured through AID/Washington's central procurement system.

Reports will be obtained, where necessary, concerning procurement requirements, including source/origin. These reports and requirements will be monitored by the Office of Development Resources and the Controller's Office through review of vouchers and supporting documentation submitted in substantiation of reimbursement requests.

C. Proposed Implementation Schedule for Selected Key Events

1979

- August 15 - Project Agreement Signed
- August - Presentation of RAPID Project to Planning Ministry
- August - October - Seminars conducted to train sex education trainers (5 institutions)
- August 31 - I E & C media contracts signed (MOH)
- November 15 - Conditions precedent met
- November 30 - MOH training plan approved by Mission
- December 15 - IFB issued for vehicles (MOH)
- December - Procurement initiated for I E & C materials, audiovisual equipment, generators, sterilization and other family planning equipment and contraceptives

1980

- January - March - Teachers trained in sex education (MOE)
- March - Technical assistance to MOE and IPHE in sex education in process
- April - Final report issued on Contraceptive Prevalence Survey
- June - Male Contraception Study begins  
Adolescent Survey begins
- November 30 - Evaluation of first year implementation completed

1981

- January - March - Teachers trained in sex education (MOE)
- February - Contraceptive Use Continuation Survey begins
- December 31 - Evaluation of second year implementation completed

1982

- January - March - Teachers trained in sex education (MOE)
- April - First purpose-level evaluation completed
- December - UNFPA Project terminates

1983

- January - March - Teachers trained in sex education (MOE)
- March - Second Contraceptive Prevalence Survey initiated
- June - Second Contraceptive Use Continuation Survey begins
- September - Second Male Contraception Study initiated  
Second Adolescent Study initiated

1984

- January - TDY evaluation assistance to IPHE in process
- January - March - Teachers trained in sex education (MOE)
- February - Evaluation of fourth year implementation completed
- July - Final purpose-level evaluation completed
- September 30 - Project activities completed;  
Project terminates.

## V. EVALUATION ARRANGEMENTS

Evaluation is an important element of the Project. Two types will be carried out during the course of the Project: annual evaluations which measure progress towards achieving planned outputs, and two in-depth evaluations which will measure progress towards achieving the Project's purpose and assess the effect this is having on the Project goal of reducing Panama's birth rate to 25 per thousand by 1985.

### 1. Annual Evaluations

A standard evaluation of the Project will be conducted annually, with the first scheduled for October 1980. These evaluations will be carried out by the GOP, APLAFA and AID and will be conducted according to procedures to be established in Annex 1 of the Project Grant Agreement or in Project Implementation Letter No. 1. The USAID evaluation officer will serve as a member of the joint GOP-AID and APLAFA-AID teams and will, inter alia, coordinate evaluation activities and preparation of the evaluation report, and follow up on all actions recommended by the evaluations.

Annual evaluations will measure progress towards outputs, effectiveness of inputs, validate the causal relationship between inputs and outputs, and suggest steps to improve Project Implementation. Among points to be covered are the following:

- utilization of the grant;
- timeliness and adequacy of counterpart contributions, including the quality, sufficiency and effectiveness of GOP personnel assigned to family planning or sex education activities under the Project;
- timeliness, adequacy and effective use of contraceptives, equipment, materials and vehicles funded under the Project; and
- extent to which the four target groups are being reached in an effective and efficient manner by the Project.

Data will be gathered through evaluations built into courses, seminars and other training; implementation reviews; audits; and other means according to the institution involved. IPHE has requested special assistance in the Project's last year in conducting a wrap-up evaluation, and \$8,000 has been budgeted for this purpose.

### 2. Purpose - level Evaluation

The Project involves profound social changes. It will only be successful if it motivates people to adopt on a permanent basis attitudes and practices which may be fundamentally different from those traditionally held. It is by evaluating the rate, effects and

permanence of the desired social change that AID and the participating institutions will be able to judge the degree to which the Project is successful in accomplishing its purpose and goal.

Reliable baseline data are critical to this evaluation process. Present information about attitudes and practices is insufficient, particularly for the two target groups - adolescents and men - who were not included under the prior AID project in Health and Population. Data are also weak on the prevalence of contraception and contraceptive "drop-out" rates. Four kinds of investigations have thus been programmed under the Project. In each case, there will be an initial study carried out early in the Project (1979 - 1981) followed by a second one two or three years later. These will provide AID and the GOP with useful data for measuring changes in attitudes and practices concerning sex and family planning which occur during the life of the Project; in AID parlance, the data will help verify achievement of the expected End-of-Project Status for Population II. Findings from these studies will also provide the Ministry of Health and other institutions with a more reliable and timely data base for use in programming and budgeting future family planning and sex education activities.

The four types of investigations to be conducted under the Project are summarized below. AID, through this grant or central funding, will finance technical assistance in the design, preparation, execution and analysis of the studies which are to be coordinated through the Office of Population Studies in the Ministry of Health. Liaison will also be maintained with the Bureau for Statistics and Census in the Controller General's Office.

(a) Contraceptive Prevalence Survey

Beginning in June 1979 with funding provided under the terminating AID family planning project, the Ministry of Health will conduct a national contraceptive prevalence survey which will sample women 15 to 49 years of age in 3,000 households distributed almost evenly between rural and urban areas. The survey will generate data on knowledge and use of contraception, sources of information and services, incidence of abortion, and fertility patterns. In order to be able to make correlations between income and family planning data, an income question is being included in the questionnaire. The survey will provide baseline information against which to measure the impact of Project activities. A second contraceptive prevalence survey will be carried out toward the latter part of the Project to measure changes in the prevalence of contraceptive use, fertility patterns, and, in particular, changes in awareness of family planning resulting from the Project's I E & C activities.

Technical assistance in structuring the sample, modifying the survey instrument to Panamanian conditions, training interviewers,

administering the questionnaire, and analyzing the results is being provided to the MOH by the Center for Disease Control under a central AID contract (RSSA). Field work is expected to be complete by September, a preliminary report issued in January 1980, and a final report published in April or May of that year.

(b) Contraceptive Use Continuation Survey

A major objective of the Project is to improve contraceptive continuation rates in the MOH-CSS family planning program through improvements in the quality of clinical services and in the expansion and upgrading of I E & C activities. Two surveys on user continuation will help AID and the MOH to determine if Project activities are having the desired effect. The surveys will generate useful information on sources of discontent with existing services, e.g., the methods themselves, the quality of attention clients receive at service outlets, and the accessibility or availability of services. The first survey is planned for 1981, with a follow-on survey scheduled two years later.

(c) Study of Male Contraception and Male Attitudes towards Family Planning

Because male participation in family planning programs is new in Panama and little information is available on male contraception and attitudes towards family planning, two studies will be conducted during the Project, the first planned for 1980 and the second in 1983 or 84. Although the most appropriate research methodology has not yet been selected, the objectives of the research will be to gather data on: male attitudes towards male contraception (including vasectomy); male attitudes towards female contraception; patterns and levels of current male contraception; and successful delivery strategies for attracting male participation in or support for contraception. The first study will provide baseline data while the second will be useful in determining changes in attitudes and practices that have resulted from Project activities.

(d) Adolescent Attitudes towards Sex and Family Planning

Despite overwhelming agreement among health and education professionals of the pressing need to reach adolescents with sex education and family planning information and services, data on this group are scarce. The Project will therefore help fund two national surveys of adolescents; the first will gather baseline information in 1980 on: adolescent awareness of human sexuality and family planning, sources of information on these subjects, patterns of sexual conduct, sources of services for contraception, abortion, and successful program approaches to adolescents. The repeat survey in late 1983 will indicate the degree to which activities for adolescents have been successful in providing sex education and family planning orientation and services to this target group.

Using the data from the studies, it is planned to carry out two purpose-level evaluations, the first sometime in 1982 and the second in 1984, the final year of Project implementation. The final evaluation will be the most extensive and important. It will help AID and the GOP determine what progress has been made toward achieving a 2% annual population growth rate, and effects of the reduction in the population growth rate on the target groups and on GOP efforts to improve the quality of life of lower-income Panamanians. It will also provide guidance on the nature and magnitude of any subsequent program in population and family planning should the need for one be indicated by the findings of the end-of-Project evaluation.

## VI. NEGOTIATING STATUS, CONDITIONS AND COVENANTS

### A. Negotiating Status

Over a period of almost 18 months, the Mission has worked closely with public and private sector institutions in developing the Project. It accurately reflects the agreements and understandings arrived at during this process, and there are no major program issues remaining to be solved. The one outstanding policy issue is whether to have one project agreement to which all four executing agencies would be signatory or to have two agreements, one with the Ministries of Health and Education and I.P.H.E., and the other with APLAFA. The latter solution, while not ideal, would help to ensure APLAFA's autonomy to carry out its portion of the Project. This issue is under discussion with the Government and is expected to be resolved shortly. A draft grant agreement is being prepared, and negotiation and signature should take no longer than a month from the date of authorization.

### B. Conditions Precedent to Disbursement

#### 1. Conditions Precedent to First Disbursement

Prior to the first disbursement under the Grant, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the Grantee will, except as otherwise agreed in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

(a) An opinion of counsel acceptable to A.I.D. that the Agreement has been duly authorized and/or ratified by, and executed on behalf of, the Grantee, and that it constitutes a valid and legally binding obligation of the Grantee in accordance with all of its terms;

(b) A statement of the name of the person holding or acting in the office of the Grantee for purposes of the Grant, and of any additional representatives, together with a specimen signature of each person specified in such statement.

#### 2. Additional Disbursements by Each Implementing Institution

Prior to disbursement under the Grant, or to the issuance by A.I.D. of documentation by which disbursement will be made by each implementing institution, for any purpose other than to finance (i) training of trainers in sex education or (ii) extension of media contracts, the Grantee will, except as the Parties may otherwise agree in writing, furnish to A.I.D. or cause to be furnished to A.I.D., in form and substance satisfactory to A.I.D., evidence that a Project Coordinator mutually acceptable to A.I.D. and the Grantee has been named by that implementing agency.

3. Condition Precedent to Disbursement for Training  
by Each Implementing Institution

Prior to any disbursement under the Grant, or to the issuance by A.I.D. of any documentation by which disbursement will be made by each implementing institution which will carry out, under the Grant, training activities other than training of trainers in sex education, Grantee will, except as otherwise agreed in writing by A.I.D., furnish to A.I.D., or cause to be furnished to A.I.D., in form and substance satisfactory to A.I.D., a training plan for that institution.

C. Covenants

The Grantee shall covenant that, except as A.I.D. and the Grantee may otherwise agree in writing, Grantee shall provide adequate budget for continuation of the program of family planning and sex education for five years beyond final disbursement of the Grant.

## ANNEXES

- I. Statutory Project Checklist
- II. GOP Request for Assistance
- III. Draft Project Authorization
- IV. DAEC PID Cable
- V. Logical Framework
- VI. Demographic Charts/Tables
  - Table 1 - Reported Crude Birth Rate, Crude Death Rate, and Rate of Natural Increase for Panama, 1930 to 1970.
  - Table 2 - Annual Number of Live Births, Crude Birth Rates, Death Rates and Rate of Natural Increase, 1960, 1965, 1970-1977.
  - Table 3 - Estimated Total Population 1950-1975 and Projected Population 1980-2000.
  - Table 4 - Female Population 15-49, Estimated for 1970 and 1975, and Projected for 1980 and 1985.
  - Table 5 - Structure by Sex and Age of the Population of Panama: 1970 census.
- VII. Ambassador's Memorandum: U.S. Mission Personnel Support for Population Activities in Panama, and Letter to Secretary Vance.
- VIII. Project Analyses
  - A. Annexes to Economic Analysis
  - B. Social Soundness Analysis
  - C. Institutional Feasibility
  - D. Financial Analysis
  - E. Initial Environmental Examination
- IX. Equipment/Materials Lists
  - A. Ministry of Health
  - B. Ministry of Education
  - C. I.P.H.E.
- X. Contraceptive Commodity Tables

## Part I

|              |           |                         |                                  |                     |
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5C(2) - PROJECT CHECKLIST

Listed below are, first, statutory criteria applicable generally to projects with FAA funds, and then project criteria applicable to individual fund sources: Development Assistance (with a sub-category for criteria applicable only to loans); and Security Supporting Assistance funds.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? IDENTIFY. HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?

Country checklist is up to date. See Guaymi Area Development PP. The Standard item check-list has been reviewed.

A. GENERAL CRITERIA FOR PROJECT.

1. App. Unnumbered; FAA Sec. 653(b); Sec. 671
  - (a) Describe how Committees on Appropriations of Senate and House have been or will be notified concerning the project;
  - (b) is assistance within (Operation Year Budget) country or international organization allocation reported to Congress (or not more than \$1 million over that figure)

(a) The Project was included in the AID FY 80 Congressional Presentation, p.218; a revised notification will be forwarded to the Congress.
2. FAA Sec. 611(a)(1). Prior to obligation in excess of \$100,000, will there be (a) engineering, financial, and other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

Yes.
3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?

No further legislation action is required to accomplish the Project purpose.
4. FAA Sec. 611(b); App. Sec. 107. If for water or water-related land resource construction, has project met the standards and criteria as per *the Principles and Standards for Planning Water and Related Land Resources dated October 25, 1973*?

Not applicable.
5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed \$1 million, has Mission Director certified the country's capability effectively to maintain and utilize the project?

Not applicable.
6. FAA Sec. 209, 619. Is project susceptible of execution as part of regional or multi-lateral project? If so why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. If assistance is for newly independent country, is it furnished through multi-lateral organizations or plans to the maximum extent appropriate?

No. A family planning program to be successful must be designed with extreme sensitivity to national cultural and social characteristics. Project will be carried out in close coordination with a companion UNFPA project. Project experience with adolescent outreach and introduction of a national sex education program for school-age children may be of use to other countries in the area.

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A

7. FAA Sec. 601(a); (and Sec. 201(f) for development loans). Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

The Project should assist Panama's efforts in relation to items (b), (d), and (f).

8. FAA Sec. 601(b). Information and conclusion on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

All procurement will be U.S. source and origin except for a limited amount of procurement which will be host country source and origin. A number of private U.S. organizations will provide technical assistance and training under the project.

9. FAA Sec. 612(b); Sec. 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized to meet the cost of contractual and other services.

Not applicable. (The currency used in Panama is the U.S. dollar, although it is denominated a "Balboa". There is no U.S. owned "local currency".)

10. FAA Sec. 612(d). Does the U.S. own excess foreign currency and, if so, what arrangements have been made for its release?

Not applicable.

11. ISA 14. Are any FAA funds for FY 78 being used in this Project to construct, operate, maintain, or supply fuel for, any nuclear powerplant under an agreement for cooperation between the United States and any other country?

No.

## B. FUNDING CRITERIA FOR PROJECT

### 1. Development Assistance Project Criteria

a. FAA Sec. 102(c); Sec. 111; Sec. 281a. Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production, spreading investment out from cities to small towns and rural areas; and (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions?

The Project is designed to further decrease Panama's birthrate by expanding delivery of family planning services especially in rural areas. With the option of limiting and/or delaying childbirths, rural women and low-income urban women will be in a better position to upgrade their skills, obtain productive employment, and contribute to increased personal and national income.

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b. FAA Sec. 103, 103A, 104, 105, 106, 107. Is assistance being made available: [Include only applicable paragraph -- e.g., a, b, etc. -- which corresponds to source of funds used. If more than one fund source is used for project, include relevant paragraph for each fund source.]

- (1) [103] for agriculture, rural development or nutrition; if so, extent to which activity is specifically designed to increase productivity and income of rural poor; [103A] if for agricultural research, is full account taken of needs of small farmers;
- (2) [104] for population planning or health; if so, extent to which activity extends low-cost, integrated delivery systems to provide health and family planning services, especially to rural areas and poor;
- (3) [105] for education, public administration, or human resources development; if so, extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, or strengthens management capability of institutions enabling the poor to participate in development;
- (4) [106] for technical assistance, energy, research, reconstruction, and selected development problems; if so, extent activity is:
  - (a) technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;
  - (b) to help alleviate energy problem;
  - (c) research into, and evaluation of, economic development processes and techniques;
  - (d) reconstruction after natural or manmade disaster;
  - (e) for special development problem, and to enable proper utilization of earlier U.S. infrastructure, etc., assistance;
  - (f) for programs of urban development, especially small labor-intensive enterprises, marketing systems, and financial or other institutions to help urban poor participate in economic and social development.

The Project is designed to extend family planning services to (a) isolated rural areas which to date have had only minimal access to these services and (b) low-income urban areas. The Project will utilize the expanding network of rural health facilities being financed under AID loan 525-U-045, Rural Health Delivery System, and the corps of paramedics being trained under the loan. By reaching rural and urban poor at an early age through new initiatives in adolescent out-reach and a national sex education program, the Project will contribute to a reduction in the number of early, often unwanted, and repeated pregnancies among the socio-economic strata which can least afford large families.

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(5) [107] by grants for coordinated private effort to develop and disseminate intermediate technologies appropriate for developing countries.

c. FAA Sec. 110(a); Sec. 208(e). Is the recipient country willing to contribute funds to the project, and in what manner has or will it provide assurances that it will provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or has the latter cost-sharing requirement been waived for a "relatively least-developed" country)?

d. FAA Sec. 110(b). Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to Congress been made, and efforts for other financing, or is the recipient country "relatively least developed"?

e. FAA Sec. 207; Sec. 113. Extent to which assistance reflects appropriate emphasis on; (1) encouraging development of democratic, economic, political, and social institutions; (2) self-help in meeting the country's food needs; (3) improving availability of trained worker-power in the country; (4) programs designed to meet the country's health needs; (5) other important areas of economic, political, and social development, including industry; free labor unions, cooperatives, and Voluntary Agencies; transportation and communication; planning and public administration; urban development, and modernization of existing laws; or (6) integrating women into the recipient country's national economy.

f. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.

The Government has agreed to provide a counterpart contribution in excess of 25% of total Project cost and has so stated in the letter of application.

Not applicable.

This Project will contribute towards the achievement of objectives (1), (3), (4), (5), and (6).

The Project builds on the needs, desires and capacities of the population and the implementing agencies. It will strengthen the institutional effectiveness of the Ministry of Health in the areas of program management, logistics, personnel and service quality, and introduce new areas of competence in three other implementing agencies. The Project will also stimulate local level participation by enlisting community support in extending family planning information and education and in shaping an effective sex education program.

g. FAA Sec. 201(b)(2)-(4) and -(8); Sec. 201(e); Sec. 211(a)(1)-(3) and -(8). Does the activity give reasonable promise of contributing to the development: of economic resources, or to the increase of productive capacities and self-sustaining economic growth; or of educational or other institutions directed toward social progress? Is it related to and consistent with other development activities, and will it contribute to realizable long-range objectives? And does project paper provide information and conclusion on an activity's economic and technical soundness?

h. FAA Sec. 201(b)(6); Sec. 211(a)(5), (6). Information and conclusion on possible effects of the assistance on U.S. economy, with special reference to areas of substantial labor surplus, and extent to which U.S. commodities and assistance are furnished in a manner consistent with improving or safeguarding the U.S. balance-of-payments position.

2. Development Assistance Project Criteria (Loans only)

a. FAA Sec. 201(b)(1). Information and conclusion on availability of financing from other free-world sources, including private sources within U.S.

b. FAA Sec. 201(b)(2); 201(d). Information and conclusion on (1) capacity of the country to repay the loan, including reasonableness of repayment prospects, and (2) reasonableness and legality (under laws of country and U.S.) of lending and relending terms of the loan.

c. FAA Sec. 201(e). If loan is not made pursuant to a multilateral plan, and the amount of the loan exceeds \$100,000, has country submitted to AID an application for such funds together with assurances to indicate that funds will be used in an economically and technically sound manner?

d. FAA Sec. 201(f). Does project paper describe how project will promote the country's economic development taking into account the country's human and material resources requirements and relationship between ultimate objectives of the project and overall economic development?

A reduction in the number of births will (a) help free women to make productive contributions to the national economy and (b) hold down GOP expenditures in the areas of education, health and housing. The Project will also contribute to strengthening the effectiveness of education, health and family planning institutions in Panama and complement other donor and GOP development programs. Feasibility of the Project is demonstrated in Section II of the PP.

The Project will have no foreseeable adverse effects on the U.S. economy; procurement in the U.S. of equipment, supplies, technical assistance and training planned under the Project will, on the contrary, serve to enhance the U.S. balance-of-payments position.

This section is not applicable. Project is a Grant.

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e. FAA Sec. 202(a). Total amount of money under loan which is going directly to private enterprise, is going to intermediate credit institutions or other borrowers for use by private enterprise, is being used to finance imports from private sources, or is otherwise being used to finance procurements from private sources?

f. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete in the U.S. with U.S. enterprise, is there an agreement by the recipient country to prevent export to the U.S. of more than 20% of the enterprise's annual production during the life of the loan?

3. Project Criteria Solely for Security Supporting Assistance

a. FAA Sec. 531. How will this assistance support promote economic or political stability?

b. FAA Sec. 533(c)(1). *Will assistance under the Southern African Special Requirements Fund be used for military, guerrilla, or paramilitary activities?*

4. Additional Criteria for Alliance for Progress

[Note: Alliance for Progress projects should add the following two items to a project checklist.]

a. FAA Sec. 251(b)(1), -(8). Does assistance take into account principles of the Act of Bogota and the Charter of Punta del Este; and to what extent will the activity contribute to the economic or political integration of Latin America?

b. FAA Sec. 251(b)(8); 251(h). For loans, has there been taken into account the effort made by recipient nation to repatriate capital invested in other countries by their own citizens? Is loan consistent with the findings and recommendations of the Inter-American Committee for the Alliance for Progress (now "CEPCIES," the Permanent Executive Committee of the OAS) in its annual review of national development activities?

This section is not applicable. Project is funded from Development Assistance.

Yes; however, given the nature of the Project, it can make no real contribution to the economic or political integration of Latin America.

Not applicable.

DRAFT PROJECT AUTHORIZATION

Name of Country: Panama  
Name of Project: Population II  
Number of Project: 525-0204

Pursuant to Part I, Chapter I, Section 104 of the Foreign Assistance Act, as amended, I hereby authorize a Grant to the Republic of Panama, the "Cooperating Country," of not to exceed three million, one hundred thousand United States Dollars (\$3,100,000), the "Authorized Amount," to help in financing certain foreign exchange and local currency costs of goods and services required for a project to expand delivery of family planning information and services to a higher proportion of Panama's fertile age group. Of the authorized amount, five hundred fifty-nine thousand United States Dollars (\$559,000) will be obligated when the Project Agreement is executed. I approve further increments during the period FY 1980 through FY 1983 of up to two million, five hundred forty-one thousand United States Dollars (\$2,541,000), subject to the availability of funds in accordance with A.I.D. allotment procedures.

I hereby authorize the initiation of negotiation and execution of the Project Agreement by the officer to whom such authority has been delegated in accordance with A.I.D. regulations and Delegations of Authority subject to such allotment and congressional notification procedures as are required and to the following essential terms, covenants and conditions together with such other terms and conditions as A.I.D. may deem appropriate:

a. Source and Origin of Goods and Services

Goods and services financed by A.I.D. under the Project shall have their source and origin in the Cooperating Country or in the United States except as A.I.D. may otherwise agree in writing.

b. Conditions Precedent to First Disbursement

Prior to the first disbursement under the Grant, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the Grantee will, except as otherwise

agreed in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

(i) An opinion of counsel acceptable to A.I.D. that the Agreement has been duly authorized and/or ratified by, and executed on behalf of, the Grantee, and that it constitutes a valid and legally binding obligation of the Grantee in accordance with all of its terms;

(ii) A statement of the name of the person holding or acting in the office of the Grantee for purposes of the Grant, and of any additional representatives, together with a specimen signature of each person specified in such statement.

c. Additional Disbursements by Each Implementing Institution

Prior to disbursement under the Grant, or to the issuance by A.I.D. of documentation by which disbursement will be made by each implementing institution, for any purpose other than to finance (i) training of trainers in sex education or (ii) extension of media contracts, the Grantee will, except as the Parties may otherwise agree in writing, furnish to A.I.D. or cause to be furnished to A.I.D., in form and substance satisfactory to A.I.D. evidence that a Project Coordinator mutually acceptable to A.I.D. and the Grantee has been named by that implementing agency.

d. Condition Precedent to Disbursement for Training by Each Implementing Institution

Prior to any disbursement under the Grant, or to the issuance by A.I.D. of any documentation by which disbursement will be made by each implementing institution which will carry out, under the Grant, training activities other than training of trainers in sex education, Grantee will, except as otherwise agreed in writing by A.I.D., furnish to A.I.D., or cause to be furnished to A.I.D., in form and substance satisfactory to A.I.D., a training plan for that institution.

e. Covenants

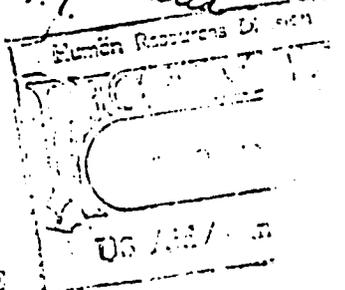
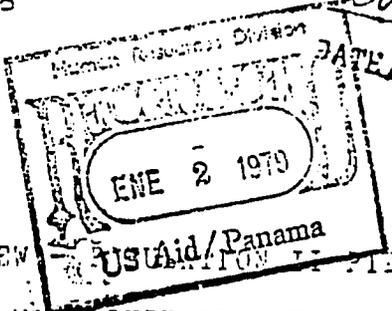
The Grantee shall covenant that, except as A.I.D. and the Grantee may otherwise agree in writing, Grantee shall provide adequate budget for continuation of the program of family planning and sex education for five years beyond final disbursement of the Grant.

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 DUE: 1/10/79



AIDAC

E.O. 12065: N/A

TAGS:

SUBJECT: DAEC REVIEW

1. THE SUBJECT PID WAS REVIEWED AND APPROVED BY THE DAEC ON DECEMBER 14, 1978. THE FOLLOWING COMMENTS AND GUIDANCE ARE PROVIDED TO ASSIST THE MISSION IN PREPARING THE PP.

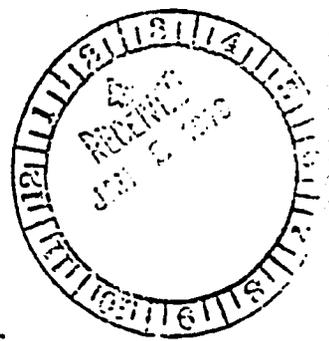
2. PROJECT STRATEGY: THE EXPANSION OF FAMILY PLANNING COVERAGE THROUGH THE USE OF PRIVATE SECTOR INSTITUTIONS AND NON-MOH/CSS GOVERNMENT AGENCIES IS AN INNOVATIVE APPROACH AND IS TO BE ENCOURAGED. HOWEVER, IN ADOPTING THIS STRATEGY, THE MISSION WILL NEED TO CAREFULLY CONSIDER A NUMBER OF ISSUES, ALL OF WHICH SHOULD BE ADDRESSED IN THE PP:

-- A. MOH SUPPORT: THE PID INDICATES THAT THE MOH HAS EXERCISED PREDOMINANT CONTROL OF NATIONAL FAMILY PLANNING ACTIVITIES AND THAT SERVICES PROVIDED BY OTHER ENTITIES, SUCH AS APLAFA, HAVE BEEN LIMITED. GIVEN THE PREVAILING ROLE OF THE MOH IN THE PRESENT FAMILY PLANNING DELIVERY SYSTEM AND THE PLANS FOR INTEGRATION OF THE MOH AND CSS, CONCERN WAS EXPRESSED THAT THE PID DID NOT DEMONSTRATE MOH/CSS ACCEPTANCE OF THE PROPOSED PROJECT STRATEGY, WHICH WOULD APPEAR TO BE ESSENTIAL IF THE PROJECT IS TO BE SUCCESSFUL.

WHILE EXPANDED USE OF THE PRIVATE SECTOR SHOULD BE SOUGHT, THE PP WILL NEED TO EVALUATE THE ADVANTAGES AND DISADVANTAGES OF SHIFTING THE FOCUS OF MISSION SUPPORT TO DELIVERY MECHANISMS OUTSIDE THE AUSPICES OF THE MOH/CSS. IN DESCRIBING THE PROJECT STRATEGY, THE PP SHOULD FULLY DISCUSS THE EXTENT TO WHICH MOH/CSS PARTICIPATION IS NECESSARY IN ORDER TO ACHIEVE PROJECT OBJECTIVES, THE POSITION WHICH THE MOH/CSS WILL OCCUPY IN THE ULTIMATE MIX OF INTERMEDIARIES SELECTED, AND THE DEGREE TO WHICH MOH/CSS SUPPORT CAN BE ANTICIPATED FOR INCREASED PRIVATE SECTOR PARTICIPATION IN FAMILY PLANNING ACTIVITIES. THE PP SHOULD ALSO DISCUSS THE ROLE OF CENTRALLY FUNDED POPULATION CONTRACTS AND GRANTS AND ACTIVITIES OF OTHER DONORS IN EXPANDING PRIVATE SECTOR FAMILY PLANNING SERVICES AND HOW THESE RELATE TO THE MOH AND THE PROPOSED PROGRAM

-- B. INSTITUTIONAL CAPACITY: ALTHOUGH THE PID IDENTIFIES APLAFA AND OTHER PRIVATE ORGANIZATIONS AS POSSIBLE INTER-

| OFF   | ACT | INF |
|-------|-----|-----|
| DIR   |     | ✓   |
| D/DIR |     |     |
| CCNT  |     |     |
| ECON  |     |     |
| EX-O  |     |     |
| DP    |     |     |
| DR    |     |     |
| ARD   |     |     |
| HRD   | ✓   |     |
| CES   |     |     |
| RCC   |     |     |
| LMD   |     |     |
| AAS   |     |     |
| IIS   |     |     |
| RHUCO |     |     |
| EMS   |     |     |
| C&R   |     |     |



MEDIARIES, THERE IS NO EVIDENCE TO INDICATE THAT ANY ANALYSIS HAS BEEN UNDERTAKEN TO DETERMINE WHETHER, IN FACT, THESE ORGANIZATIONS HAVE THE COMMITMENT AND INSTITUTIONAL CAPACITY NECESSARY TO CARRY OUT AN EXPANDED FAMILY PLANNING ROLE. IN ORDER TO MORE CLEARLY ASSESS THE FEASIBILITY OF THIS STRATEGY, THE PP SHOULD INCLUDE A SUMMARY ANALYSIS OF PROPOSED PARTICIPANT ORGANIZATIONS WHICH ADDRESSES BOTH INDIVIDUAL INSTITUTIONAL CAPABILITIES AND COMMITMENT AS WELL AS ANY TECHNICAL ASSISTANCE AND TRAINING THAT WOULD BE REQUIRED TO ENSURE THEIR EFFECTIVE PARTICIPATION IN THE PROJECT. THE PP SHOULD ALSO IDENTIFY ANY OTHER CONSTRAINTS, SUCH AS LEGAL OR POLITICAL RESTRICTIONS, WHICH MIGHT INHIBIT EXPANSION OF FAMILY PLANNING COVERAGE ON THE PART OF PRIVATE INSTITUTIONS.

-- C. COORDINATION: THE PII INDICATES THAT THE MISSION PLANS TO UTILIZE SEPARATE PROJECT AGREEMENTS WITH EACH OF THE PARTICIPATING INSTITUTIONS. BECAUSE OF THE NUMBER OF PRIVATE SECTOR ORGANIZATIONS INVOLVED AND THE DIVERSITY OF SERVICES PROVIDED, THE PP SHOULD DISCUSS THE MECHANISM AND AGENT TO BE USED TO COORDINATE PROJECT ACTIVITIES, ARRANGEMENTS FOR MONITORING AND EVALUATING PROJECT ACTIVITIES, AND THE MOH/CSS ROLE, IF ANY, IN THESE TASKS.

2. TARGET GROUP: BASED ON THE FINDINGS OF THE NATIONAL FERTILITY SURVEY, THE PID HAS IDENTIFIED TWO PRIMARY TARGET GROUPS: WOMEN IN RURAL AREAS AND WOMEN 15-19 YEARS OF AGE. THE PP SHOULD DISCUSS HOW FAMILY PLANNING COVERAGE WILL BE EXPANDED TO RURAL AREAS, THE TYPES OF FAMILY PLANNING SERVICES THAT WILL BE MADE AVAILABLE TO THE TWO PRIORITY TARGET GROUPS, PERSONNEL NEEDED TO EFFECT OUTREACH SERVICES

AND IEC ACTIVITIES APPROPRIATE AND RESPONSIVE TO THE PARTICULAR NEEDS OF THE TARGET POPULATION. THE PP SHOULD ALSO INDICATE ACCEPTANCE BY THE MOH, AND OTHER PARTICIPATING INSTITUTIONS, OF THE TARGET SUBGROUPS AND THE DATA BASE AND ANALYSES UPON WHICH THEY WERE IDENTIFIED.

3. GOP COMMITMENT: BECAUSE OF THE DIFFICULT ECONOMIC SITUATION WHICH PANAMA NOW FACES, THE PP SHOULD DISCUSS THE EXTENT OF GOP COMMITMENT TO PROVIDE COUNTERPART FUNDING, PERHAPS SPELLED OUT IN A COVENANT; THE DISCRETE PROJECT ACTIVITIES THAT GOP COUNTERPART WILL SUPPORT; AND THE GOVERNMENT'S ABILITY TO PROVIDE INCREASED FUNDING WHEN THE PROJECT IS TERMINATED. THE 25 PERCENT REQUIREMENT WILL APPLY ONLY TO THOSE AID FUNDS WHICH GO DIRECTLY TO THE GOP. THEREFORE, IF THE PROJECT INCLUDES DIRECT AID FINANCIAL SUPPORT TO PRIVATE INSTITUTIONS, AND IF THESE INSTITUTIONS ARE PVO'S WHICH ARE NOT REQUIRED TO PROVIDE COUNTERPART FUNDS, THE MISSION MAY NEED TO REVISE THE PROPOSED LEVEL OF AID FUNDING ACCORDINGLY.

4. ROLE OF PHARMACISTS. BECAUSE PHARMACIES SERVE AT LEAST  
UNCLASSIFIED STATE 326348

15 PERCENT OF THE CONTRACEPTING POPULATION, THE PP SHOULD DISCUSS THE ROLE OF PHARMACISTS IN EXTENDING FAMILY PLANNING SERVICES, AND CONSIDER THE POSSIBLE ADVANTAGES OF INCLUDING THIS GROUP IN THE TRAINING PROGRAM OR OF FINANCING A COMMERCIAL RETAIL SALES PROGRAM.

5. ECONOMIC ANALYSIS: THE ECONOMIC ANALYSIS OF THE PP SHOULD PROVIDE AVERAGE COST PER BIRTH AVERTED AND AVERAGE COST PER ACCEPTOR FIGURES FOR EACH OF THE DIFFERENT TYPES OF CONTRACEPTIVE PROGRAMS CARRIED OUT BY EACH INSTITUTION LIKELY TO PARTICIPATE IN THE PROJECT. FINAL SELECTION OF PARTICIPATING INSTITUTIONS SHOULD BE BASED ON THE ABOVE COST FIGURES, WITH PARTICULAR ATTENTION GIVEN TO THE EFFECT RURAL INACCESSIBILITY MAY HAVE ON THESE AND OTHER COSTS. THE PP SHOULD ALSO INCLUDE A DISCUSSION AND ANALYSIS OF THE ANTICIPATED CLIENT FEE SCHEDULES FOR EACH OF THE DELIVERY SYSTEMS.

6. SOCIAL ANALYSIS:

--A. TARGET GROUP ATTITUDES: WHILE THE PID HAS IDENTIFIED RURAL WOMEN AND TEENAGE FEMALES AS THOSE MOST IN NEED OF FAMILY PLANNING COVERAGE, THE ATTITUDES OF THESE GROUPS TOWARD FAMILY PLANNING IS DISCUSSED ONLY INSOFAR AS THE NATIONAL FERTILITY SURVEY IDENTIFIED THE PERCENTAGE OF WOMEN WHO DID NOT WANT ANOTHER CHILD. THE SOCIAL ANALYSIS OF THE PP SHOULD ADDRESS THE ATTITUDES AND BEHAVIOR PATTERNS OF THE VARIOUS REGIONAL/ETHNIC GROUPS TOWARDS FAMILY

PLANNING, THE FAMILY DECISION-MAKING PROCESS WITH REGARD TO FAMILY SIZE, IMPLICATIONS OF THE TARGET GROUP'S PERCEPTION OF HOUSEHOLD LABOR NEEDS ON FAMILY SIZE, AND THE ACCEPTABILITY OF THE PROPOSED CONTRACEPTIVE METHODS TO THE INTENDED BENEFICIARIES.

-- B. ROLE OF MEN: THE PID IDENTIFIES BOTH RURAL WOMEN AND TEENAGE FEMALES AS INTENDED BENEFICIARIES, BUT DOES NOT INCLUDE MEN IN THE TARGET GROUP. THE PP SHOULD DISCUSS THE ATTITUDE OF MEN TOWARD CONTROLLING FAMILY SIZE, WHAT ROLE MEN WILL PLAY IN THE EXPANSION OF FAMILY PLANNING COVERAGE, AND PROJECT ACTIVITIES WHICH WILL BE UNDERTAKEN TO ENCOURAGE THEIR PARTICIPATION. NEWSOM

PT  
#6848

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UNCLASSIFIED

STATE 326942

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 1979 to FY 1983  
Total U.S. Funding \$3,100,000  
Date Prepared: May 1979

Project Title & Number: Population II, Project No. 525-0204

| NARRATIVE SUMMARY  | OBJECTIVELY VERIFIABLE INDICATORS   | MEANS OF VERIFICATION   | IMPORTANT ASSUMPTIONS   |
|--|---|---|---|
| <p>Program or Sector Goal: The broader objective to which this project contributes:</p> <p>To contribute to a further reduction in Panama's birth rate which will strengthen efforts to improve the quality of life of lower income Panamanians.</p> | <p>Measures of Goal Achievement:</p> <p>Crude birth rate reduced from 28/1000 in 1979 to 25/1000 in 1984.</p> | <p>Civil registry data published by the Office of Statistics and Census. Ministry of Health data.</p> | <p>Assumptions for achieving goal targets:</p> <p>Increased participation in family planning programs will result in sufficiently fewer births to offset demographic trends which threaten to reverse the declining CBR.</p> <p>Contraceptive commodities financed by AID are available in the volumes and on the dates required.</p> <p>GOP policies do not discourage the expansion of family planning services.</p> <p>Effective opposition to family planning does not develop.</p> |

PAGE 1

PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK

Life of Project:  
From FY 1979 to FY 1983  
Total U.S. Funding \$3,100,000  
Date Prepared: May 1979

Project Title & Number: Population II, Project No. 525-0204

PAGE 2

| NARRATIVE SUMMARY   | OBJECTIVELY VERIFIABLE INDICATORS  | MEANS OF VERIFICATION  | IMPORTANT ASSUMPTIONS  |
|---|--|--|--|
| <p><b>Project Purpose:</b></p> <p>To expand delivery of family planning information and services to a higher proportion of the fertile age group.</p> | <p>Conditions that will indicate purpose has been achieved: End of project status.</p> <ol style="list-style-type: none"> <li>Increased number of fertile age women who are active users:               <ul style="list-style-type: none"> <li>- 44,700 new rural acceptors</li> <li>- 46,300 new urban acceptors.</li> </ul> </li> <li>Increase in male contraception:               <ul style="list-style-type: none"> <li>- 35,266 using condoms</li> <li>- 1,156 sterilized.</li> </ul> </li> <li>Increase in adolescent understanding of human sexuality and the reproductive process and practical knowledge of options to delay conception:               <ul style="list-style-type: none"> <li>- 150,000 adolescents ages 10-19 receiving sex education in the public schools.</li> <li>- 160,000+adolescents ages 15-19 provided with family planning I E and C.</li> </ul> </li> <li>Increase in contraceptive use continuation rates:               <ul style="list-style-type: none"> <li>- reduction in user dropout rates from ___/1000 in 1979 to ___/1000 in 1984.1/</li> </ul> </li> <li>Increased public and private sector support for population/family planning activities.</li> </ol> <p>-----</p> <p>1/ Data to be provided by contraceptive use continuation surveys.</p> | <p>Contraceptive prevalence surveys - 1979, 1983.1/</p> <p>Male contraception studies - 1980, 1983.</p> <p>Ministry of Education records. Adolescent surveys - 1980, 1983.</p> <p>Contraceptive use continuation surveys - 1981, 1983.</p> <p>Ministry budgets.<br/>Record of requests to APLAFA.</p> <p>-----</p> <p>1/ Achievement of each EOPS indicator may also be verified by MOH, MOE, IPHE and APLAFA records.</p> | <p>Assumptions for achieving purpose:</p> <p>GOP continues to support provision of family planning services.</p> <p>National Program for Sex Education continues to receive high level support, and no significant grass roots opposition developa.</p> <p>New contraceptive technologies promoted by the Project meet with acceptance.</p> <p>Qualitative improvements in service delivery occur as planned.</p> <p>MOH/CSS facilities increase and administrative improvements, including in logistics and supervision, occur - as planned under AID loan 525-U-045 and this Project.</p> <p>Family planning component of UNFPA project is also effective.</p> |

PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK

Life of Project:  
From FY 1979 to FY 1983  
Total U.S. Funding \$3,100,000  
Date Prepared: May 1979

Project Title & Number: Population II, Project No. 525-0204

| NARRATIVE SUMMARY   | OBJECTIVELY VERIFIABLE INDICATORS   | MEANS OF VERIFICATION   | IMPORTANT ASSUMPTIONS  |
|---|---|---|--|
| <p>Outputs:</p> <p>1. Family planning services provided in a dependable, humane and understanding manner at all MOH/CSS health facilities.</p> <p>2. Sex education introduced in the public schools.</p> <p>3. Family planning information and services are systematically available to adolescents.</p> <p>4. Active public and private sector programs to attract males to family planning established and operating.</p> <p>5. Increase in community-based family planning outreach.</p> | <p>Magnitude of Outputs:</p> <ul style="list-style-type: none"> <li>- 480 health facilities providing family planning.</li> <li>- % of health facility visitors who become acceptors increases.</li> </ul><br><ul style="list-style-type: none"> <li>- 4,000 teachers providing sex education to students and their parents through the public schools.</li> <li>- effective I E &amp; C for adolescents occurring.</li> <li>- APLAFA Adolescent Center conducts 225 adolescent seminars.</li> <li>- Five MOH adolescent centers in operation.</li> <li>- Condom displays installed and kept fully stocked in all health facilities and government offices.</li> <li>- 10 urologists trained in vasectomies</li> <li>- pilot vasectomy center and 6 new operating rooms established and operating</li> <li>- effective I E &amp; C occurring</li> </ul><br><ul style="list-style-type: none"> <li>- 72 health educators, 125 community malaria workers, 75 pharmacists, and 2,500 community volunteers-trained and offering family planning at the community level, mostly in rural areas.</li> </ul> | <ul style="list-style-type: none"> <li>USAID records and project documents, (Population II and Loan 045).</li> <li>GOP reports, records and accounts.</li> <li>APLAFAs reports, records and accounts.</li> <li>Project evaluations.</li> <li>Field monitoring reports.</li> </ul> | <p>Assumptions for achieving outputs:</p> <p>Continued GOP support for project initiatives through provision of agreed-upon inputs.</p><br><p>Other donor inputs provided as planned and in a timely manner.</p><br><p>Community members are available to serve as family planning promoters in rural areas.</p><br><p>APLAFAs is provided with sufficient autonomy and donor support to carry out planned Project activities.</p> |

PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK

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Total U. S. Funding \$3,100,000  
Date Prepared: May 1979

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| NARRATIVE SUMMARY  | OBJECTIVELY VERIFIABLE INDICATORS   | MEANS OF VERIFICATION | IMPORTANT ASSUMPTIONS                     |
|--|---|-----------------------|---|
| <p>Outputs:</p> <p>6. Increased number of health and non-health sector personnel receiving training in sex education, family planning and demography.</p> <p>7. Improved data base for population/family planning, including capability to update information.</p> | <p>Magnitude of Outputs:</p> <ul style="list-style-type: none"> <li>- minimum 25 seminars on family planning provided by APLAFA to private sector groups.</li> <li>- 210 IPHE personnel - trained, providing family planning and sex education to COIF parents and School for Parents members.</li> <li>90 GOP personnel trained as sex education trainers</li> <li>3,300 employees of Social Welfare Ministries trained in sex education.</li> <li>210 IPHE employees trained in sex education and family planning.</li> <li>75 pharmacists trained in family planning.</li> <li>MOH/CSS</li> <li>800 trained in administration of family planning programs.</li> <li>15 trained in logistics management.</li> <li>10 physicians trained in sterilization.</li> <li>450 medical &amp; para-medical personnel trained in human relations.</li> <li>2850 trained in family planning services.</li> <li>8 trained in communications and family planning; social communications methodology; production and evaluation of mass media materials.</li> <li>Two contraceptive prevalence surveys completed.</li> <li>Two contraceptive use continuation surveys completed.</li> <li>Two adolescent surveys completed.</li> <li>Two studies of male contraception and attitudes toward family planning completed.</li> </ul> |                       | <p>Assumptions for achieving outputs:</p> |

PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK

Life of Project:  
From FY 1979 to FY 1983  
Total U.S. Funding \$3,100,000  
Date Prepared: May 1979

Project Title & Number: POPULATION II, PROJECT 525-0204

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| NARRATIVE SUMMARY   | OBJECTIVELY VERIFIABLE INDICATORS   |   |  | MEANS OF VERIFICATION  | IMPORTANT ASSUMPTIONS  |
|---|---|---|--|--|--|
| Inputs:   | Implementation Targets (U.S. \$000)   |   |  |  | Assumptions for providing inputs:  |
|   | AID   | GOP   | TOTAL  |  |  |
| 1. <u>Ministry of Health</u><br>Contraceptives<br>Equipment 1/<br>Vehicles<br>Information/Education Materials<br>Training<br>Family Planning Specialists<br>and Administrators<br>Evaluations and Studies | 917 1/<br>335<br>103<br>586<br>248<br>-<br>266<br>2,455   | -<br>-<br>10<br>-<br>-<br>3,399<br>150<br>3,559 | 917<br>335<br>113<br>586<br>248<br>3,399<br>416<br>6,014 | USAID records and project documents. 1/<br>GOP accounts, records, reports. 1/<br>Field monitoring reports.<br>APLAFA records. 1/ | AID funds and contraceptive commodities available as planned.<br>GOP economic situation permits provision of counterpart personnel and funds as required.<br>Qualified GOP personnel available for training. |
| 2. <u>APLAPA</u><br>Information/Education Materials   | 96  | 25 2/   | 121  |  |  |
| 3. <u>National Program of Sex Education</u>   |   |   |  |  |  |
| <u>Ministry of Education</u><br>Training 2/<br>Equipment and Materials<br>Technical Assistance  | 403<br>42<br>10<br>455  | 1,336<br>-<br>-<br>1,336                        | 1,739<br>42<br>10<br>1,791                               |  |  |
| <u>IPHE</u><br>Training<br>Equipment<br>Technical Assistance<br>Evaluation  | 41<br>39<br>6<br>8<br>94  | 57<br>-<br>-<br>-<br>57                         | 98<br>39<br>6<br>8<br>151                                |  |  |
|   | <u>3,100</u>  | <u>4,977</u>                                    | <u>8,077</u>   |  |  |
| 1/ Includes sterilization, family planning clinical, and audiovisual equipment and mobile generators.<br>2/ Includes training of trainers in sex education from other GOP agencies.                       | 1/ Of this amount, \$820,000 is for centrally procured contraceptives.<br>2/ A contribution of \$25,000 is estimated from APLAPA which is privately funded. |   |  | 1/ Signed contracts, purchase orders, training records, voucher reports, etc.  |  |

REPORTED CRUDE BIRTH RATE, CRUDE DEATH RATE, AND RATE OF NATURAL INCREASE FOR PANAMA, 1930 to 1970.\*

| Period  | Crude birth rate | Crude death rate | Rate of natural increase (%) |
|---------|------------------|------------------|------------------------------|
| 1930-34 | 36.5             | 12.9             | 2.36                         |
| 1935-39 | 36.4             | 12.9             | 2.35                         |
| 1940-44 | 37.5             | 8.8              | 2.87                         |
| 1945-49 | 36.1             | 10.9             | 2.52                         |
| 1950-54 | 37.5             | 8.8              | 2.87                         |
| 1955-59 | 39.8             | 9.1              | 3.07                         |
| 1960-64 | 40.2             | 7.8              | 3.24                         |
| 1965-70 | 38.5             | 7.1              | 3.14                         |

Note: The rates for 1930 through 1959 are from U.S. Bureau of the Census, Population of Panama, Estimated and Projections: 1961 to 2001. Demographic Reports for Foreign Countries, Series P-96, No. 2, U.S. Government Printing Office, Washington, D.C. The rates for 1960 through 1970 are from Panamá, Dirección de Estadística y Censo, La Población de Panamá, 1973, pp.16,31.

\* Robert W. Fox and Jerrold W. Huguet, Population and Urban Trends in Central America and Panama, Inter-American Development Bank, Washington, D.C., 1977, page 177.

PANAMA: ANNUAL NUMBER OF LIVE BIRTHS, CRUDE BIRTH RATES,  
DEATH RATES AND RATE OF NATURAL INCREASE, 1960, 1965, 1970-1977.

|      | <u>No. of Live Births</u> | <u>Crude Birth Rate</u> | <u>Crude Death Rate</u> | <u>Natural Increase (%)</u> |
|------|---------------------------|-------------------------|-------------------------|-----------------------------|
| 1960 | 42,359                    | 39.1                    | 8.2                     | 3.1                         |
| 1965 | 48,377                    | 38.4                    | 7.2                     | 3.1                         |
| 1970 | 53,287                    | 37.1                    | 7.1                     | 3.0                         |
| 1971 | 54,948                    | 37.2                    | 6.7                     | 3.0                         |
| 1972 | 54,910                    | 36.0                    | 6.0                     | 3.0                         |
| 1973 | 52,091                    | 33.2                    | 5.8                     | 2.7                         |
| 1974 | 52,772                    | 32.6                    | 5.6                     | 2.7                         |
| 1975 | 53,790                    | 32.3                    | 5.2                     | 2.7                         |
| 1976 | 53,001                    | 30.8                    | 4.8                     | 2.6                         |
| 1977 | 50,389                    | 28.5                    | 4.4                     | 2.4                         |

Sources of Data:

1960-1967: Dirección de Estadística y Censo: Estadística Panameña, Bol. No. 562. Contraloría General de la República, Panamá, July 1973.

1968-1977: Dirección de Estadística y Censo: Panamá en Cifras, 1968-1972, 1969-1973, 1970-1974, 1972-1976 y 1973-1977. Contraloría General de la República, Panamá, Noviembre de 1974, Octubre de 1975, Noviembre de 1977. y Noviembre de 1978.

PANAMA: ESTIMATED TOTAL POPULATION 1950-1975 AND  
PROJECTED POPULATION 1980-2000

| <u>Year</u> | <u>Total Population</u><br><u>(1000's)</u> |
|-------------|--|
| 1950        | 825  |
| 1955        | 947  |
| 1960        | 1095                                       |
| 1965        | 1269                                       |
| 1970        | 1464                                       |
| 1975        | 1678                                       |
| 1980        | 1896                                       |
| 1985        | 2117                                       |
| 1990        | 2346                                       |
| 1995        | 2583                                       |
| 2000        | 2823                                       |

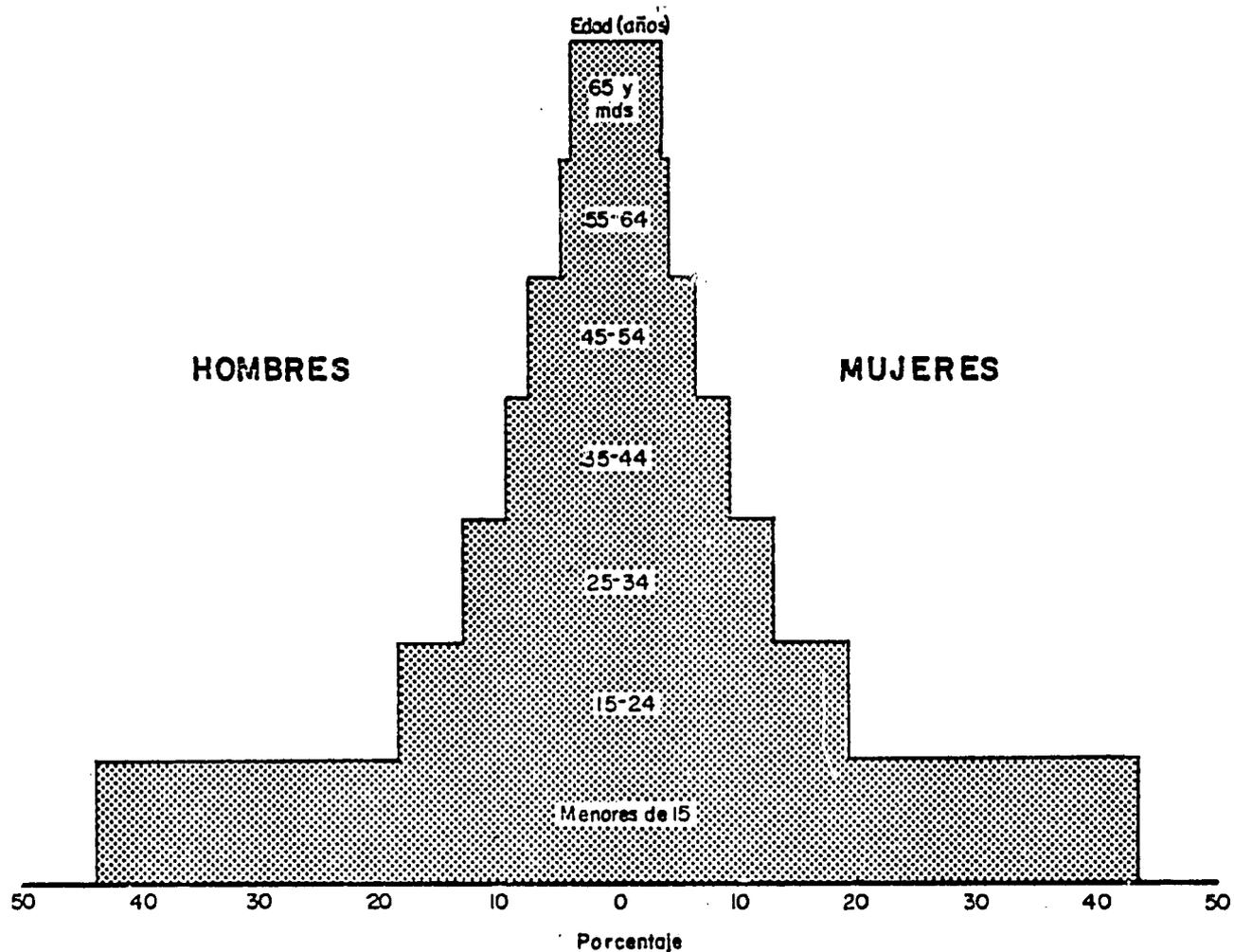
Source: Dirección de Estadística y Censo: Estadística Panameña Bol. No. 772, "Proyecciones de Población de la República de Panamá, por Sexo y Grupos de Edad: Años 1950-2000", medium projection, Table 9.

PANAMA: FEMALE POPULATION 15-49, ESTIMATED FOR 1970 AND 1975,  
AND PROJECTED FOR 1980 AND 1985.

|  | <u>Y E A R</u> |             |             |             |
|--|----------------|-------------|-------------|-------------|
|  | <u>1970</u>    | <u>1975</u> | <u>1980</u> | <u>1985</u> |
| Number of Women<br>15-49 (1000's)            | 321            | 377         | 444         | 517         |
| Women 15-49 as a percent<br>total population | 21.9           | 22.5        | 23.4        | 24.4        |

Source: Dirección de Estadística y Censo: Estadística Panameña Bol. No. 772,  
"Proyecciones de Población de la República de Panamá, por Sexo y  
Grupos de Ead: Años 1950-2000", medium projection, Table 9.

STRUCTURE BY SEX AND AGE OF THE POPULATION OF PANAMA: 1970 CENSUS



Source: Estadística Panameña (Suplemento) Panorama Estadístico sobre la Mujer, Contraloría General de la República, Dirección de Estadística y Censo, January 1975.

# memorandum

DATE: January 18, 1979

REPLY TO  
ATTN OF:

Ambler H. Moss, Jr. *AMH*  
Ambassador

SUBJECT:

U.S. Mission Personnel Support for Population Activities in Panama.

TO:

All U.S. Mission Personnel

Attached is a briefing paper prepared by USAID on recent demographic growth trends in Panama and on the successful U.S.-supported family planning program. Officers should play an active role in encouraging Panamanian officials at all levels - in all sectors of government as well as in private industry - to promote policies and activities that will result in less rapid population growth. I strongly urge all officers to read the paper and to use it as background in your conversations with host government officials and representatives of the private sector.

Att. a/s

HRD:ABloom:my:1/18/79

Distribution:

Embassy (Economic, Political, Consular, Administration,  
-- Treaty Implementation Offices)

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FHWA  
MILGP  
AGRI  
GAO  
AID



Buy U.S. Savings Bonds Regularly on the Payroll Savings Plan

BRIEFING PAPER

DEMOGRAPHIC GROWTH AND POPULATION ACTIVITIES IN PANAMA

Summary:

Panama has been experiencing a gradual but marked decline in its birth rate during the past decade, largely due to the widespread adoption of modern means of contraception. In 1968, the Crude Birth Rate was 38.9 per thousand; by 1977 it had dropped to 29.5 per thousand. Seventy per cent of women using contraception receive family planning services through the public sector (the Ministry of Health or the Social Security Institute). Of women aged 15-44, married or in a consensual union, almost one-half are currently using contraception, an impressively high prevalence rate for a developing country.

Despite the substantial achievements of the Government-sponsored family planning program, there is an unsatisfied demand for contraceptive services in Panama. In order to extend the coverage of family planning services, especially to adolescents and rural women, population activities should be promoted by all sectors - health, education, agriculture, housing, labor, and private business and industry.

The Problem:

Panama's population is currently estimated at 1,771,300 (1977). In 1960, the nation's population was 1,075,541. Currently growing at a rate of 2.5% annually, the country has the capacity to double its population approximately every 26 years. Forty-three percent of Panama's population is under 15 years of age, creating a substantial burden of dependency on

that portion of the population that is economically active. Demographic growth is compounded in urban centers by a great influx of migrants from rural areas. During the 1960-1970 decade, San Miquelito, the marginal district of Panama City, registered a staggering annual rate of increase of 19%. By 1980, almost one-third of the country's population will be located in Panama City and the adjacent district of San Miguelito. The combination of absolute growth and internal migrations will strain the capacity of public services and create a formidable demand for employment.

"World Population: The Silent Explosion" refers to a trend observed among LDC's in which an "...unprecedentedly rapid drop in death rates ..." is accompanied by a "...much more slowly falling birth rate." Panama's Crude Death Rate had already fallen as low as 7 per thousand by the early 1960's, lower than the current death rate of developed countries such as the United States. However, Panama's birth rate hovered at about 40 per thousand. As a result, the rate of natural increase for the decade was greater than 3% per year. Panama was clearly among those countries experiencing a "population explosion". The birth rate began a gradual but marked decline in the decade of 1970's. By 1977, the birth rate had reached 29.5 per thousand, the Crude Growth Rate, 2.5% per year. This represents a 25% decrease in the birth rate over a period of only ten years. This rapid transition is due principally to the widespread use of modern means of contraception.

Although the birth rate has been falling, an alarming trend has been the increasing proportion of births among adolescents in Panama. Adolescent

mothers account for 19% of all births in the country. The National Fertility Survey conducted in 1976 determined that among women aged 20-49 and currently in a marriage or consensual union, 63% did not want any more children. Thirty-three percent declared that their last pregnancy was "unplanned"

While almost all women in Panama know that family planning exists, actual use of contraception varies greatly depending on a woman's level of education and place of residence. Predictably, contraceptive use is highest among women who have completed secondary school and among women in urban areas. For example, women raised in rural areas have an average of 4.7 children, in contrast to women raised in the city, who average 3.1 children. Highest fertility is found among wives of campesinos and landless agricultural laborers. Women with less than four years of education on the average have 6 children; women with at least some secondary school, those who can aspire to alternative roles to early marriage and motherhood, average three children.

What is Being Done:

In the late 1960's the Government of Panama began a concerted effort to increase the availability of health services by constructing health facilities throughout the country and training large numbers of paraprofessional and auxiliary health personnel. One of the areas which the Ministry of Health has given special emphasis is the Maternal and Child Health program. While contraception had previously been available through private physicians and pharmacies, and family planning services

were offered through the local International Planned Parenthood Federation affiliate (APLAF) beginning in 1968, the family planning activities of the Maternal and Child Health program marked the initiation of the nationwide government-supported population program. Funding assistance of more than \$4 million was extended by AID in the form of a number of grants for Maternal and Child Health activities, including family planning education and services. Over a period of 11 years, AID has provided the MOH program with clinical and office equipment and contraceptives, vehicles, and instructional materials for family planning. Health personnel and national and community leaders were trained in such areas as demography, women's health care, sex education, communication skills, and modern sterilization techniques. Some existing health facilities were remodeled so that a full range of MCH and family planning services could be provided.

Today family planning services are available at 374 hospitals, health centers and subcenters and health posts throughout Panama. Approximately 47% of women aged 15-44, currently married or in a consensual union, are using contraception. This compares with 24% of women 15-44 years old in Paraguay and El Salvador who are currently using contraception. In Panama the most prevalent method, surgical contraception, has been adopted by 40% of those women currently contracepting.

A Future Strategy:

To date family planning services and information have been provided exclusively by the Ministry of Health and APLAF. The Social Security Institute, probably the major provider of health care in Panama, does not

have a formal family planning program, although contraception, including sterilization, are provided on a therapeutic basis. Yet concern over the effects of continued growth and interest in engaging family planning education activities have been expressed by other sectors such as education, labor and planning. AID believes that social workers, educators, labor leaders, psychologists, and home economists should be encouraged to promote family planning by incorporating population information in their regular community outreach programs. These activities can be especially effective in approaching those groups who do not usually avail themselves of the formal Maternal and Child Health Family Planning Program. While some spontaneous requests for AID assistance have been received in recent months, the institutionalization of population activities in sectors apart from health depends very much upon upper echelon support of this endeavor.

Embassy staff can take advantage of their regular contacts at all levels of Panamanian government and society to instill a consciousness of the compelling need to address the demographic growth problem with concrete policies and programs. In conclusion, then, it is the responsibility of all Embassy personnel to focus attention on the significance of "The Silent Explosion" for the accomplishment of national development and foreign policy goals alike.

Panama, Republic of Panama

January 16, 1979

Honorable Cyrus R. Vance  
Secretary of State  
Washington, D. C. 20520

Dear Mr. Secretary:

I have read with great interest "World Population: The Silent Explosion" and share your concern for the ramifications of rapid demographic growth, particularly in the development world. It is indeed incumbent upon all members of the Embassy community to stress in their contacts with leaders of government and the private sphere the effect of population growth on all aspects of national development.

"World Population: The Silent Explosion" identifies Panama as one of the 30 LDC's that have achieved a substantial reduction in the birthrate in recent years. The reduction of fertility in Panama is due in large part to the effectiveness of the Government-supported family planning program, which provides contraceptive services to 70% of women using contraception. The program, in which family planning is provided under the aegis of Maternal and Child Health, has received over \$4 million in grant funds from the Agency for International Development since 1968. On the basis of the impressive past success of the family planning program, I strongly support AID's current efforts and future strategy to provide family planning services to men and women throughout Panama.

Among the activities supported by AID bilateral assistance, or planned in the new grant program now being designed, are numerous actions in the priority areas identified in "World Population: The Silent Explosion": discussions about the significance of population matters with leaders at all levels; the use of paramedics to extend the delivery of health services, including family planning, to isolated rural communities; academic and vocational education programs for girls as well as boys; encouragement for the formulation of population goals in the context of social and economic development; and assistance to the Ministry of Health to improve management and

- 2 -

administration in the health and family planning programs. The AID-funded family planning program is closely coordinated with other local bilateral assistance programs, notably that of the United Nations Fund for Population Activities. Coordination has also been maintained with the local International Planned Parenthood Federation affiliate, APLAFA. The AID Mission has increasingly promoted the involvement of other non-governmental organizations, such as the Pathfinder Fund and the Association for Voluntary Sterilization, in population activities. Technical assistance in research has been arranged through the Center for Disease Control and private organizations such as the International Fertility Research Project.

In the decade since the inception of the AID-supported government family planning program, the birth rate in Panama has decreased dramatically from 38.9 per thousand to 29.5 per thousand, a reduction of 24%. An indication of the impressive success of the program is the increase in the prevalence of use of contraception: by 1976, 47% of all Panamanian women between the ages of 15 and 44 and in a marriage or consensual union were using some method of family planning. More than twenty per cent of fertile age women in Panama have adopted voluntary surgical contraception, an achievement equalled by few countries in the developing world.

One of the factors that is likely to perpetuate a pattern of relatively rapid population growth is the entry into fertile age of a large number of adolescents, products of the peak fertility period of the early 1960's. Despite the general decline in fertility in Panama, each year teenagers give birth to an increasingly larger proportion of all children. Adolescents accounted for 19% of all births in Panama in 1975. Thus there is reason to focus our programs on adolescents for whom an early often unwanted pregnancy, may force a premature end to education and circumscribe future employment opportunities. Another group which will be the object of continued program efforts are rural women, whose fertility is considerably higher than that of their urban counterparts.

Evidence indicates that an unsatisfied demand for family planning services persists in Panama. The 1976 National Fertility Survey demonstrated that 63% of all women aged 20-49, married or in a consensual union, did not want any more children. Thirty-three per cent of women declared that their last pregnancy was "unplanned". In short, despite the encouraging strides that have been made, United States support to family planning activities in Panama must be maintained.

- 3 -

"World Population: The Silent Explosion" is a cogent elucidation of the problem that countries such as Panama will continue to face, one that threatens to mitigate the gains of national development efforts. My staff and I will be attentive to opportunities to impress upon public and private figures the magnitude of the problem and the importance of diminishing growth for the future of Panamanian development.

Sincerely

Ambler H. Moss Jr.  
Ambassador

HRD:ABloom:mg

THE SECRETARY OF STATE  
WASHINGTON

Dear Mr. Ambassador:

I urge you to examine and use the enclosed timely and comprehensive study of the world population problem prepared by Ambassador Marshall Green, the Department's Coordinator of Population Affairs.

It is difficult to overemphasize the importance of this problem, which increasingly affects a broad range of foreign policy issues, including economic development, world hunger, energy and natural resources, basic human rights, public health, unemployment and social unrest, political instability, emigration, and local conflicts. Even though there is evidence that effective national family planning programs can lower birth rates, world population will continue to grow in the next few decades in historically unprecedented numbers, largely due to the unusually large proportion of young people about to enter their reproductive years; the current world population of over four billion, already overburdening many of the planet's ecosystems, will probably double within 35 years.

Preoccupied with other pressing problems, and aware of the sensitivities and complexities of population issues, political leaders often fail to give this problem the continuing attention and priority it deserves. Yet, experience has

The Honorable  
Ambler Holmes Moss, Jr.,  
American Ambassador,  
Panama, Panama.

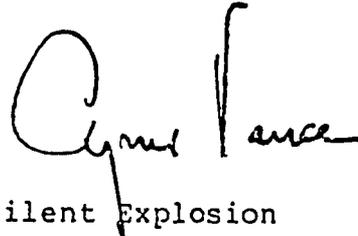
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shown that an essential precondition to reduction of population growth rates is the unequivocal commitment by national leadership to population/family planning programs. Even though the effects of today's programs can only be seen gradually in years to come, the failure to act can have incalculable, perhaps tragic, consequences for future generations.

I hope that you and your staff will not only read the study but will also consider ways of using it in your contacts with public and private figures; to this end, additional copies are being forwarded to you.

I welcome any thoughts you may have on how the United States and the international community might more effectively address this transcendent global problem.

Sincerely,



Enclosure:

World Population: Silent Explosion

INAPPROPRIATENESS OF LEAST-COST ANALYSIS

Least-cost analysis was not conducted because, for reasons discussed below, there were no substantive alternative comparisons to be made:

(1) GOP policy has established specific roles for the several public and private institutions providing various family planning services. Currently the MOH has the best developed total delivery or outreach system providing I E and C, contraceptive services, and personnel training. APLAFA has a small outreach capacity only in the Metropolitan Corridor and provides basically only I E and C. To consider it as an alternative to the MOH would require estimating the cost of developing a delivery system comparable to that of the MOH. IPHE is a semi-government institution with a very specific role as discussed earlier. Finally, the MOE provides expertise in the area of sex education and effective teaching.

(2) Implicit in the GOP program is the subsidization of family planning programs through the MOH for the very-low-income groups who are the primary focus of this Project. Although such a subsidization program will attract some clients who could afford to pay more for the services than required, the extra cost resulting from the system is assumed to be offset by the extra benefits obtained by attracting members of low-income groups who otherwise would not participate in family planning programs. Furthermore, experience indicates that higher-income groups will tend to prefer the private sector. The inefficiency of the system is thus considered minimal and justifiable. While it would be possible to develop subsidization programs which would allow the private sector (doctors, private clinics, and pharmacies) to provide at least some of the family planning services to the lower-income groups, the GOP apparently considers such programs administratively impractical and probably more costly than its own, especially given the experience in developed countries such as the U.S. The Mission thus considered it unrealistic to attempt to develop cost estimates for the delivery of comparable services by the private sector. Furthermore, the private sector currently does not, on any significant scale, and most likely will not in the near future, provide services to low-income areas, particularly in rural Panama. The difficulty of attracting adequate private medical personnel to poor areas is well documented worldwide.

(3) Due to the high retail prices of contraceptive devices and medical consultations, it is doubtful that the principal target groups can afford to purchase these services from the private

sector. Retail price ranges for the various contraceptive devices are: (1) \$1.95 to \$3.90/month for oral contraceptives; (2) condoms - \$0.40 to \$3.75 per box of three (\$0.25 to \$0.30 if sold individually); and (3) \$2.25 to \$2.75 per month for foams and jellies. These costs added to the \$15 to \$40 cost per doctor's visit in the private sector clearly place retail contraceptives beyond the reach of the target group.

(4) The MOH's expanding health delivery system into the urban and rural poor areas provides one unified system for assuring that the most needy groups will be reached by a comprehensive family planning program that goes beyond the mere distribution of contraceptive devices.

PROCEDURE USED TO OBTAIN \$48 COST/BENEFICIARY FIGURE

## A. 100% of the following costs

|                                 |    |           |
|---------------------------------|----|-----------|
| Contraceptives                  | \$ | 917,000   |
| Sterilization equipment         |    | 160,000   |
| Salaries                        |    | 3,399,000 |
| Information/Education Materials |    | 707,000   |

## B. 33% of the following costs

|                        |    |                |                |
|------------------------|----|----------------|----------------|
| Equipment              | \$ | 256,000        |                |
| Vehicles               |    | 113,000        |                |
| Training               |    | 2,085,000      |                |
| Technical Assistance   |    | 16,000         |                |
| Evaluation and Studies |    | <u>424,000</u> |                |
| Sub-total              | \$ | 2,894,000      | X .33          |
|                        |    |                | <u>955,020</u> |
|                        |    |                | TOTAL          |
|                        |    |                | \$6,138,020    |

$$\frac{\$6,138,020}{\$128,000} = \$47.95$$

EDUCATIONAL COST FLOW OF BIRTH AVERTED COHORT (1)

| <u>Year</u> | 1980                     | 1981         | 1982         | 1983          | 1984         | <u>Total Cost<br/>Avoided<br/>per Year</u> |
|-------------|--------------------------|--------------|--------------|---------------|--------------|--|
| 1979        |                          |              |              |               |              |  |
| 1980        |                          |              |              |               |              |  |
| 1981        |                          |              |              |               |              |  |
| 1982        |                          |              |              |               |              |  |
| 1983        |                          |              |              |               |              |  |
| 1984        |                          |              |              |               |              |  |
| 1985        |                          |              |              |               |              |  |
| 1986        | 2,944x\$160= (2) (1) (3) |              |              |               |              |  |
| 1987        | ↓                        | 5,888x\$160= |              |               |              | \$ 471,040                                 |
| 1988        |                          | ↓            | 8,832x\$160= |               |              | 1,413,120                                  |
| 1989        |                          |              | ↓            | 11,776x\$160= |              | 2,826,240                                  |
| 1990        |                          |              |              | ↓             | 14,720x\$160 | 4,710,400                                  |
| 1991        |                          |              |              |               | ↓            | 7,065,600                                  |
| 1992        |                          |              |              |               |              | 7,065,600                                  |
| 1993        |                          |              |              |               |              | 7,065,600                                  |
| 1994        |                          |              |              |               |              | 7,065,600                                  |
| 1995        |                          |              |              |               |              | 7,065,600                                  |
| 1996        |                          |              |              |               |              | 6,594,560                                  |
| 1997        |                          |              |              |               |              | 5,652,480                                  |
| 1998        |                          |              |              |               |              | 4,239,360                                  |
|             |                          |              |              |               |              | 2,355,200                                  |
|             |                          |              |              |               |              | <hr/>                                      |
|             |                          |              |              |               |              | \$63,590,400                               |

(1) Those children born in 1980 are assumed to begin first grade in 1986; those born in 1981 begin school in 1987; etc.

(2) The figure for each year refers to births averted as a result of the Project.

(3) \$160 = the estimated average cost per student per year for grades 1 to 9.

BENEFIT COST ANALYSIS  
(Births Averted Case)

| Yr | Project Costs | Project Benefits<br>(Ed. Costs Avoided) | Discount Factor<br>(15%) | P.V. Costs         | P.V. Benefits      |
|----|---------------|---|--------------------------|--------------------|--------------------|
| 79 | \$ 148,000    |   | .870                     | \$ 128,760         |                    |
| 80 | 1,620,000     |   | .756                     | 1,224,720          |                    |
| 81 | 1,583,700     |   | .658                     | 1,042,075          |                    |
| 82 | 1,601,000     |   | .572                     | 915,772            |                    |
| 83 | 1,719,400     |   | .497                     | 854,542            |                    |
| 84 | 1,404,500     |   | .432                     | 606,744            |                    |
| 85 |               |   | .376                     |                    |                    |
| 86 |               | \$ 471,040                              | .327                     |                    | \$ 154,030         |
| 87 |               | 1,413,120                               | .284                     |                    | 401,326            |
| 88 |               | 2,826,240                               | .247                     |                    | 698,081            |
| 89 |               | 4,710,400                               | .215                     |                    | 1,012,736          |
| 90 |               | 7,065,600                               | .187                     |                    | 1,321,267          |
| 91 |               | 7,065,600                               | .163                     |                    | 1,151,693          |
| 92 |               | 7,065,600                               | .141                     |                    | 996,250            |
| 93 |               | 7,065,600                               | .123                     |                    | 869,069            |
| 94 |               | 7,065,600                               | .107                     |                    | 756,019            |
| 95 |               | 6,594,560                               | .093                     |                    | 613,294            |
| 96 |               | 5,652,480                               | .081                     |                    | 457,851            |
| 97 |               | 4,239,360                               | .070                     |                    | 296,755            |
| 98 |               | 2,355,200                               | .061                     |                    | 143,667            |
|    |               |   |                          | <u>\$4,772,613</u> | <u>\$8,872,038</u> |
|    |               |   | TOTALS                   | <u>-----</u>       | <u>-----</u>       |

$$B/C = \frac{\$8,872,038}{\$4,772,613} = 1.86$$

$$\frac{\$4,772,613}{\$44,160} = \$108 \text{ Present value cost per birth averted}$$

BENEFIT COST ANALYSIS

(Births Postponed Case)

If the effect of the Project were to just postpone the births by five years, the following would be the present value costs to the Government for educating the cohort. (1)

|      | <u>Total Cost to Educate Cohort</u> | <u>Discount Factor (15%)</u> | <u>Present Value</u> |
|------|-------------------------------------|------------------------------|----------------------|
| 1991 | \$ 471,040                          | .163                         | \$ 76,780            |
| 1992 | 1,413,120                           | .141                         | 199,250              |
| 1993 | 2,826,240                           | .123                         | 347,628              |
| 1994 | 4,710,400                           | .107                         | 504,013              |
| 1995 | 7,065,600                           | .093                         | 657,101              |
| 1996 | 7,065,600                           | .081                         | 572,314              |
| 1997 | 7,065,600                           | .070                         | 494,592              |
| 1998 | 7,065,600                           | .061                         | 431,002              |
| 1999 | 7,065,600                           | .053                         | 374,477              |
| 2000 | 6,594,560                           | .046                         | 303,350              |
| 2001 | 5,652,480                           | .040                         | 226,099              |
| 2002 | 4,239,360                           | .035                         | 148,378              |
| 2003 | <u>2,355,200</u>                    | .030                         | <u>70,656</u>        |
|      | (\$88,894,080)                      | TOTAL Present Value Cost     | \$4,405,640          |

(1) See Annex 1 for further details.

Present value of costs to educate cohort  
assuming the births occurred. See Annex. 2 \$8,872,038

Present value of costs to educate cohort  
assuming births delayed five years 4,405,640

Savings to Government \$4,466,398

$$B/C = \frac{\$4,466,398}{\$4,772,613} = 0.94$$

Interpretation: The total cost in nominal dollars of educating the cohort for 12 years is the same \$88.9 million regardless of the starting date. However, if the effect of the family planning were to delay the births by five years, and if we assume the government could obtain a 15% rate of return on these funds, it would only need to have \$4,405,640 available in 1979 (present value dollars) to pay for educating the cohort which begins its education in 1991, whereas if the births were not postponed, the government would need to have \$8,872,038 in 1979 to pay for the cohort which begins its education in 1986.

CALCULATING BIRTHS AVERTED

1. 1979 Population = 1.8 million
2. Crude Birth Rate = 28 per 1000
3. Live Births:  $\frac{x}{1,800,000} = \frac{28}{1000}$  ;  $x = 50,400$
4. WIFA = 437,000 Source: Fox and Huguet  

$$\text{GFR} = \frac{50,400}{437,000} = \frac{115}{1000}$$
5. If we then assume that the GFR figure is constant over the 5 year Project period (an assumption which leads to a slight overstatement of births averted assuming the program reduces fertility as a result of the increased contraception) the births averted would be for the 5 year period (we assume no change in 1979):

| <u>Year</u> | <u>Number</u><br><u>Contracepting</u> | <u>GFR</u> | <u>Births Averted</u> |
|-------------|---------------------------------------|------------|-----------------------|
| 1980        | 25,600                                | 115        | 2,944                 |
| 1981        | 51,200                                | 115        | 5,888                 |
| 1982        | 76,800                                | 115        | 8,832                 |
| 1983        | 102,400                               | 115        | 11,776                |
| 1984        | 128,000                               | 115        | 14,720                |
|             |                                       | TOTAL      | 44,160                |

- Cost per Birth averted:
6.  $\frac{\text{Total Project Cost}}{\text{Births averted}} = \frac{\$ 8,076,600}{44,160} = \$183$

\$183 equals cost per birth averted in nominal terms, i.e., without taking into account the timing of the costs.

## SOCIAL SOUNDNESS ANALYSIS

### I. Introduction and Methodology

Of key importance in trying to understand the proposed Project from a socio-cultural standpoint is that family planning is a known and proven quantity in Panama. Usage rates are high and large segments of the Panamanian population have at least heard the term "family planning" and have some knowledge of what it means. There is a clear demand for services, and service delivery efforts to date of the MOH and support organizations such as APLAFA have met with a relatively high level of acceptance.

This Project has a dual focus: (a) Strengthening and upgrading the quality of existing clinical services to improve delivery to current users as well as new users who are expected to seek services at health facilities over the life of the Project; (b) Extending outreach, both of clinical and IE&C services, to groups among whom coverage still remains relatively low. In the case of the former, from a socio-cultural viewpoint the task becomes one of identifying existing constraints to effective clinical service delivery that are currently serving as disincentives to both new users and current users. In the case of the latter, the task becomes one of also identifying special characteristics of these groups and designing service delivery programs that build on these special characteristics.

Several data sources were consulted in undertaking the analysis summarized in the following pages. Primary sources of general information on the target groups include the 1970 Population Census; a series of studies of low-income neighborhoods in Panama City and Colon carried out by the Ministry of Housing in 1974 and 1975; and 1977 civil registry data obtained through the Ministry of Health. The two primary data sources on fertility, knowledge and use of contraceptive services, as well as need for services were the World Fertility Survey (WFS) carried out by the Ministry of Health in late 1975 and early 1976 and published in 1977; and an anthropological case study of women living in the District of Cañazas, Province of Veraguas, carried out by Polly Harrison specifically as part of Project preparation activities. The fertility survey is a national study based on a stratified random sample of 3,700 women in Panama. All women interviewed were between the ages of 20 and 49. Particularly useful from this survey, for purposes of carrying out the social soundness analysis, were the detailed data available on fertility characteristics and contraceptive use broken out for urban and rural areas. Harrison's study complements the WFS by providing additional information on knowledge and attitudes toward family planning. The Harrison study also provides data on contraceptive use and need for services in isolated areas not sampled in the WFS.

## II. Target Group Description

### A. Rural Women

#### 1. General Profile of Rural Life in Panama<sup>1</sup>

Rural women account for the largest group expected to benefit from this Project. At present most of these women (a) lack sufficient knowledge of what family planning is and the range of services available, and (b) even if they are aware of what family planning is and are interested in contracepting, have limited access to family planning services.

The majority of these women live in relatively isolated areas. The population density in these areas tends to be low, and inhabitants are for the most part highly dispersed. Getting to the nearest town where a health center is located can be a difficult and time-consuming proposition. There are few roads and those that exist are often not usable during the rainy season. In many rural areas mountainous terrain or thick jungle undergrowth make travel difficult even by foot or animal.

As is indicated in the description of poverty contained in the CDSS, some 512,000 individuals, or approximately 57% of Panama's rural population, are currently living in poverty. The majority of these individuals live in isolated areas and eke out a living from subsistence agriculture. Land holdings tend to be low (average of 10 hectares per family) and the majority of these small land holdings are on soils that are inappropriate for cultivation. Land is cleared for cultivation using slash and burn techniques, and seeds are sown by hand without tilling; no chemical products or mechanical power are utilized. While some families change the location of their homestead every few years as they slash and burn into the frontier area, most stay in the same vicinity and alternate production on various dispersed plots.

Living conditions in many rural areas of Panama are still substandard. Especially in areas that are isolated and off the road, houses tend to consist of only one room with an adjoining lean-to kitchen. Most houses have dirt floors, and the majority still lack electricity, potable

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<sup>1/</sup> This section summarizes the description of the rural poor contained in the 1981 Country Development Strategy Statement (CDSS) for Panama.

water and sanitary facilities.<sup>1/</sup> Access to health services is minimal <sup>2/</sup>, and most births are still unattended by either a physician or a nurse.<sup>3/</sup>

Results of a malnutrition survey recently carried out in Veraguas, a province that like other primarily rural provinces has a population that is highly dispersed and for the most part isolated, indicated that a large proportion of the province's inhabitants were malnourished and with malnutrition being particularly severe among the population aged 1-4. Twenty-nine per cent of the latter group were found to be in second degree malnutrition and 5% in third degree. Province level data suggest that enteritis and diarrhea remain principal causes of death in Chiriqui and the Darien, provinces where, like Veraguas, significant segments of the population remain isolated.

Illiteracy remains high especially among the population 40 years and over. In some rural areas illiteracy is also quite high even among adults between the ages of 15-39, reaching in some districts as high as 70%. Few of the remaining inhabitants of these areas have had over two or three years of schooling.

The family unit itself is still dominated by the male, who plays the role of chief bread winner as well as decision maker.<sup>4/</sup> In those communities where houses are clustered together and near a school, the school director tends to assume the role of community authority figure, and in many areas of rural Panama, clergy continue to play key roles as advisor and confessor. Since the reform in the political structure in 1972, the elected representatives to the National Assembly from each ward are increasingly assuming the role of community spokesman/authority figure.

## 2. Characteristics of Rural Women

Data on rural women are available from a variety of sources including the 1970 Census and WFS carried out in 1976. Like their male counterparts, the majority of young women 15 and under in rural areas either have attended school or are attending school and can read and write. Many women, 40 and over, however, are illiterate, and in isolated rural

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- <sup>1/</sup> The average figures for the CDSS target districts were 78%, 93%, 91%, and 84%, respectively, for dirt floors, absence of electricity, non-approved water source, and non-approved sanitary facilities.
  - <sup>2/</sup> In 1976 the average physician/population ratio for the CDSS target districts was .2/10,000.
  - <sup>3/</sup> Only 32% of all births in the CDSS target districts in 1976 were attended by either a physician or a nurse.
  - <sup>4/</sup> While women play key roles in the decision making process, this role is usually restricted to decisions related to family health and child care.

areas illiteracy rates for females between the ages of 15-39 are also high. Only 48,5% of the women interviewed by Harrison felt that they could realistically call themselves literate.

While schooling opportunities have increased significantly in recent years, there are still areas in rural Panama where schools do not go beyond three or four grades. Young people desiring to pursue their studies find themselves forced to leave home and go to a nearby town that offers a more complete school program. Major beneficiaries of this temporary "outmigration" tend to be boys. Girls more often than not remain at home to assist with household chores and prepare themselves for their future marital responsibilities.

Off-farm employment opportunities for women living in rural areas remain extremely limited. A recent household survey shows women as making up less than 17% of the economically active population in rural areas. Most report assisting on the farm or selling farm products. Harrison in her study reports that while some women acknowledge having performed work for cash,<sup>1/</sup> the amount received is very little. Women by and large do not see themselves as primary wage earners, nor do they see their environment as offering much in the way of employment opportunities.

Given existing limitations, both in education and employment opportunities, many young women see as their salvation migrating into the cities to find employment as domestics. Migration usually occurs during the adolescent years, and the migrant daughter is viewed by her family as a distinct asset. In areas where average monthly family income is \$35, a salary for a domestic worker of \$40-70 a month is seen as a large amount of money, especially when the daughter sends back up to \$50 a month to supplement her family's income.

### 3. Fertility

While data from the population census and other sources indicate that marriage age or age of union is increasing in Panama, data from WFS and the Harrison study indicate that, for women living in rural areas, this event still takes place quite early. The average marriage age or age of union for rural women in 1976 was 17.4 years, and there are indications from Harrison's 1978 study that in isolated areas marriage or union may be taking place even earlier (16.1 years).

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<sup>1/</sup> For example, field work, petty trade, spinning cotton thread and selling it, washing clothes, cooking for the school teacher.

Pregnancy comes close on the heels of union, with an average lapse of 1.1 years between actual union and birth of the first child.

Family size, while decreasing somewhat, is still very large with the average number of live births for women living in rural areas registered at 4.9. Harrison in her study detected even higher averages. Among women she interviewed, the average number of pregnancies per woman was 5.75; live births averaged 5.36. The average number of live children per woman was 4.3.

Accompanying these high birth figures are an apparent minimal knowledge and understanding of the reproductive process. Sixty-seven per cent of Harrison's sample reported being totally unprepared for and consequently frightened, some quite severely, by their first menstruation. Those who had been prepared had received counsel primarily on dietary and other precautions that should be followed beginning with the onset of menstruation. Those who were in no way prepared for their first menstruation received counseling after the fact, usually by a traditional authority figure (grandmother, aunt, curandera), the counseling consisting primarily of consolation. Missing from most counseling, either before or after the first menstruation, was any anatomical sexual or reproductive data, primarily because the transmitters of information did not have this information to give. The net result for many of these girls is a lesson learned the hard way, the link between pregnancy and fertility only beginning to come clear at the onset of the first pregnancy.

Attitudes toward provision of information, however, appear to be changing, especially as the rural population becomes better informed. Eighty-three per cent of the younger women interviewed by Harrison felt adolescent girls should definitely be counseled and given factual information before menarche.

#### 4. Knowledge, Attitudes toward, and Use of Contraceptives.

While most rural women have heard the term "family planning" as well as the names of some contraceptive techniques, the general picture is one of ambivalence about family planning in general, uncertainty and lack of knowledge of what it really means. When asked by Harrison what the term "family planning" meant, over half of her sample 35 years and older replied that family planning was synonymous with "el no tener más hijos" (not having any more children). Only the younger women saw family planning as a method for spacing children. Beyond this their knowledge was also limited.

Harrison also found that knowledge of specific contraceptive techniques was rudimentary and that the little knowledge that was possessed was not well internalized. Sixty-one per cent of the women interviewed knew of the pill; 46% had some knowledge of the IUD; and 36% had heard of female sterilization. Other contraceptive techniques (condom, male sterilization, creams, jellies, injections) were virtually unknown. Understanding of how these contraceptive techniques were used and how they worked was even more limited. Thirty-three per cent of the women knew that female sterilization was an operation, that it took place in the hospital, and that it terminated childbearing altogether. Only 27% had some knowledge of the pill and most of this knowledge centered around how you take it. Eighteen per cent knew something about the IUD, primarily how it is placed.

The only contraceptive technique that had negative bits of information associated with it was the pill. Twenty-four per cent of the sample reported fear of using the pill. The fears were, however, specifically of the technique itself (brought on in larger part by warnings given by health center personnel out of context - "don't take the pill while you are pregnant," "don't take it if you have varicose veins") and not of contraception per se.

The primary source of information and discussion on contraceptives was the health sector. Information on sterilization tended to come from doctors; while nurses, and to a lesser extent health aides, provided information on reversible methods. After health center personnel, the second most sought after source for discussion of family planning was spouses. While they neither were the initiators of the discussions nor served as real sources of information, spouses were perceived in general as being supportive.

The proportion of rural women currently using modern contraceptive techniques is low and varies significantly depending on the sample interviewed. The WFS, which reached primarily women living in accessible rural areas (e.g., in small towns, houses near usable roads) reported only half of women between 20 and 45, married or in union, as contracepting. Harrison, whose sample was composed of women living in a relatively isolated community, two hours' walk from the nearest town, reported even lower figures. Only 18% of her sample acknowledged ever using a modern method of contraception, and only 12% were currently contracepting using these methods. This is not to say, however, that other, more traditional methods are not used by these women. Forty-two per cent of Harrison's sample reported practicing post-partum abstinence (anywhere from six to 24 months), and 27% reported using their own version of the rhythm technique.

Despite this general picture of low knowledge and use of contraceptives, women overall tend to be receptive to the idea of contracepting. About 79% of the rural women interviewed by Harrison had positive attitudes toward contraception, and 15% were either neutral or ambivalent. Only 6% were openly hostile. As mentioned previously, at least in the area where Harrison conducted her study, male attitudes were generally favorable also.

5. Need for Contraceptive Services and Desire to Limit Family Size

Despite generally low levels of awareness and understanding of contraception, there are clear indications of a definite desire on the part of rural women to limit their family size. Nearly two thirds (65.8%) of the rural women interviewed in the WFS indicated a desire to have no more children. Harrison's data support this finding (58% indicated that they either wanted no more children or wished they had fewer children). Unplanned pregnancies were high with 31% of multiparous women in Harrison's sample indicating they were upset at discovering they were pregnant, 22% were resigned and 16% indicated they were worried (only 19% reported that they were happy when they discovered they were pregnant). Some 19% of the rural women interviewed in the WFS indicated that they both wanted no more children and yet were not using contraceptives.

B. Low-income Urban Woman

1. General Profile of Life in Urban Marginal Areas

Low-income urban women, predominantly those living in Metropolitan Panama, make up approximately 22% of expected Project beneficiaries. A significant portion of these women live with their families in crowded conditions in communities clustered in and around Panama City and Colon. While access to basic health and education services for these individuals is in general higher than for their rural counterparts, significant portions of this population live in shacks or tenements with a ratio of three or more inhabitants per room. Water and sanitary facilities, if they are available, are shared<sup>1/</sup>; and in many communities sewage conditions are very poor with garbage and feces mingling with mud in the dirt passageways during seasonal rains.

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<sup>1/</sup> According to the 1970 Census, 53% and 64% of the residents of Panama City and Colon, respectively, had either a non-approved or communal water source. The comparable figures for non-approved or communal sanitary facilities were 39% and 65%, respectively.

Particularly alarming for the inhabitants of these communities is the general lack of employment opportunities. Surveys of several low-income neighborhoods of Panama and Colon carried out by the Ministry of Housing in 1974 and 1975 place full-time employment among household heads at between 52% and 77%. Even in cases of earned income, the amount was limited, barely sufficient to cover basic needs.<sup>1/</sup> While the majority of the adult population living in these areas are literate, education levels are low (the majority have only a 6th grade education or less), and job opportunities are for the most part in service sector activities where low skills requirements go hand in hand with low salaries.

Given the large size of these urban communities and their heterogeneous composition (large segments of the inhabitants are recent rural migrants), opportunities for community cohesiveness and the emergence of a central leader or authority figure, as is found in many rural areas, are limited. Identity lies within the family structure itself - with the migrant parents and their grown daughters and sons and their families living either in close proximity in the same community or in nearby communities.

## 2. Characteristics of Low-income Urban Women

Women living in the areas described above share with their male counterparts generally low educational and skill levels as well as a tendency, where they are employed, to work in service sector activities where wages are extremely low. A large proportion of the target group work as domestics earning a salary between \$40 and \$70 a month. While employment data for low-income women are not available, general figures for the Metropolitan area indicate that a much higher percentage of the female economically active population in this area, as compared to rural areas, are either employed or looking for work. In 1977, female employment as a proportion of the economically active workforce in the Metropolitan area registered at 35%; 14% of the Metropolitan female labor force were unemployed; and 44% were underemployed.<sup>2/</sup>

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<sup>1/</sup> Most surveys found that 60% or more of the families were living below the CDSS poverty line, making \$200 or less a month.

<sup>2/</sup> 1977 Household Survey, Bureau of Statistics and Census, Panama.

Particularly disturbing is the high percentage of women in the Metropolitan area who are heads of household and who are at the same time unemployed. The 1977 Household Survey revealed that females represented 18% of all household heads; 32% of these women were unemployed. The GOP, aware of the unemployment problem in general and the problem among unemployed household heads in particular, launched a temporary Emergency Employment Program in 1977 wherein participants had to prove economic need and that there was no other adult employed in the household. Of the 25,000 people hired under this program, two thirds (16,700) were women.

Particularly significant, from the point of view of the proposed population project, is that a large portion of women living in low-income areas of Metropolitan Panama City and Colon are relatively recent migrants. As indicated in Section A, these women are the product of a rural milieu where opportunities for women, both in terms of education and employment, are low. They come into Panama City, primarily as adolescents, with limited or no knowledge of either contraception or the reproductive process and learn about female reproduction the hard way. The result, an unplanned child, either becomes a hostage to fortune, limiting both the girls opportunities for education and skills upgrading as well as employment, or is sent back to mama who, with resignation and little pleasure, cares for this new added responsibility.

### 3. Fertility, Knowledge and Use of Family Planning, Need for Contraceptive Services

Specific data regarding fertility, knowledge, and use of family planning services, and need for contraceptive services are not available for women living in urban marginal areas. Most of the data which are available focus on urban women in general, collapsing socio-economic strata and for the most part educational levels. Aside from the data on levels of contraceptive use, these data share many similarities with the data available for women living in rural areas. Women tend to marry or enter into a union relatively young (average of 19.1 years); live births, especially among women with six years of education or less are high (average of 4.2 per woman); and patterns of contraceptive use are similar, with the pill and sterilization being the two most widely used methods of contraception.

While available data suggest a higher level of contraceptive use for the urban population as a whole (60% as com-

pared to 45% for rural areas), there is a definite existing need among this population for contraceptive services: (a) 40% of the urban Metropolitan population, or approximately 77,000 women are not using contraceptives; (b) 23% of this group, or 17,000 women not currently using contraceptive services, do not want to have any more children. It is possible to assume, given other data showing a clear relationship between contraceptive usage rate and educational level, that the majority of women in need of contraceptive services are indeed low-income.

### C. Adolescents

Approximately 250,000 adolescents are expected to benefit from this project; approximately one half reside in the Metropolitan area, the remainder live in isolated rural areas or small rural towns. While general information is available on adolescents as members of the overall family unit (see Sections A (1) and B (1) - General Profile of Life in Rural and Urban Marginal areas), specific data on fertility among women of this age group, knowledge and use of family planning, and need for contraceptive services are limited.

Indirect indications of a generally positive attitude toward and need for family planning services among low-income adolescents are available through APLAFA's family planning clinic located in San Miguelito. Almost 30% of all women who sought family planning services at APLAFA's clinic in 1978 were under 20 years of age. Of these, 86% had been pregnant at least once, and 80% had at least one child. The 12% who admitted to having had an abortion probably represent underreporting, since abortion is illegal and other indicators<sup>1/</sup> have pointed to a higher rate of abortion among adolescents.

That there is indeed interest among adolescents in receiving more information on sex education is evidenced by the results of a survey of 400 young people between the ages of 12 and 19 carried out by APLAFA in an attempt to detect existing demand for their proposed multi-service center for adolescents. In addition to overwhelming support for such a center, those interviewed expressed an interest in receiving more information on sex education. They not only wanted to participate in the organization and administration of the center but expressed a desire to contribute economically to its operation,

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<sup>1/</sup> Moreno, Dr. J., Estudio del Aborto en el Hospital Santo Tomás de Panamá, 1979.

D. Men

Approximately 375,000 urban and rural males are expected to be provided with information about family planning over the life of the Project; of these, an estimated 37,000 will elect to practice contraception, either using the condom or undergoing a vasectomy. While the World Fertility Survey revealed that very few women (1.9% of the female population ages 20-49) relied either on the condom or male sterilization for contraception, informal queries of both private and public sector physicians and nurses indicate that there is a definite interest on the part of men in using contraception. Private pharmacies, essentially the only source of condom supplies other than the MOH, sell a large volume of condoms. Physicians report an existing demand for vasectomies, and the National Guard maintains an active vasectomy program.

### III. Socio-cultural Feasibility

No major socio-cultural obstacles to the provision of family planning information and services per se are anticipated. The target group description contained in the previous section demonstrates that women living in isolated rural areas and low-income urban women hold positive attitudes towards family planning and have a definite need for the expanded family planning services to be delivered under the Project. Data available for adolescents and men, although more limited, also point to positive attitudes and a general need for such services among members of these target groups.

That the need exists and that attitudes are in general positive do not necessarily mean, however, that service delivery modes chosen will automatically be successful. In order to maximize the probability for success of a project of this nature it is especially important to take into account the special characteristics of the target populations and their experience to date with contraceptive service delivery.

Salient characteristics of rural women suggested by Harrison's study and WFS which provide clear guidelines for information and service delivery under the proposed Project include the following:

- A general ambivalence and uncertainty about family planning coupled with a general lack of understanding of what family planning means;
- A basic lack of understanding of sexuality, the reproductive process, and the physiological changes that accompany puberty;
- Generally low education levels, coupled with high illiteracy rates among older women, in particular;
- Some indications of negative information about the pill;
- Outside of sterilization and the pill, little or no knowledge of other contraceptive techniques;
- The apparently important role of authority figures, both older women (aunts, "curanderas", grandmothers) and males (primarily spouses) in shaping attitudes about human sexuality and family planning.

Recent information on clinical and IE&C activities in rural communities point to weaknesses which, unless modified, could pose obstacles to Project success:

With regard to IE&C services:

- Family planning courses, per se, are not available; information which is transmitted is usually given by health sector personnel on the run and with little attempt to adapt the contents to women's interests and needs;
- Doctors and nurses exhibit a tendency to use complex terms that are virtually unknown by potential and current users (e.g. "Papanicolau," "hemoglobin," "fallopian tubes") when discussing contraceptive devices and female reproduction with their patients;
- That information which is transmitted is almost completely factual and tends to focus on instructions regarding use of a specific contraceptive device. Little attempt is made to place family planning within the context of the woman's health and life and those of her family;
- Rather than encouraging women to participate in discussions of family planning by asking questions and interjecting examples from their own experience, most health clinic personnel tend to use an authoritarian, one-way style of information transmittal.

With regard to clinical services:

- Most clinical services suffer from a "postponement" syndrome. It is, for example, not unusual for a woman who has come to a health clinic seeking clinical services or information about family planning to be told that she must return a day or two later when the clinic is open for these services. For women living a long distance from a health facility, this presents a definite deterrent and a disincentive to pursue family planning any further. Another postponement mechanism that discourages continued use of clinical services is the current practice of providing women with only a month's supply of pills at a time. Faced with the prospect of returning repeatedly to the health clinic, especially when the distances between the woman's house and the health facility are far and when roads and trails are either intransitable or dangerous, it is easy for women to give

up contraception altogether or else fall back on traditional and less effective methods.

- It is not unusual for rural health clinic staff to exhibit a general lack of understanding with regard to women's concerns and fears about contraceptive devices. Rather than taking the time to soothe a nervous patient and explain to her what he/she is doing or providing, the tendency of the doctor or nurse is often to maintain a psychological distance, performing only the necessary physical action.

Given below are some recommended strategies for delivery of IE&C and clinical services under the Project which both address these potential deterrents to successful information outreach and service delivery as well as take into account the special characteristics of the target groups.

A. Proposed Project Strategies for IE&C Outreach

1. All IE&C activities - family planning courses, pamphlets, posters, mass media presentations - should be tailored to the interests and needs of the particular audience. Staff providing family planning courses and preparing pamphlets and mass media materials should receive training that specifically prepares them to transmit messages that are readily understandable by illiterate and semi-literate populations and that address family planning in the context of the mother's health and that of her family. Materials developed and courses prepared should also take into account the idiosyncracies and beliefs of the target populations, using these as stepping stones for presenting the desired factual information.
2. All materials developed should be pretested and revised as needed before exposure to the target population. Constant revision of family planning course content should be carried out through end of course evaluations and individual course follow-up. To the extent possible, local participation should also be solicited in the development of family planning materials.
3. Rather than creating new institutions or programs, an attempt should be made to channel IE&C activities through organizations and programs that are known and that already have accepted outreach channels. Organizations in rural areas that already have these outreach capabilities include the MOH, through its rural health

program; the MOE, through its local "padres de familia" groups; and the IPHE Child and Family Orientation Centers through their local "Comites de Apoyo". Organizations with existing outreach facilities that can be tapped in the Metropolitan area include: APLAFA, which already has an established capability to provide IE&C services and backlog of requests to provide additional services; labor unions, and credit as well as consumer cooperatives.

4. Recognizing the important role of community leaders, especially in rural areas, in molding community attitudes towards proposed interventions from the outside specific efforts should be made to work with these leaders. They should be provided with a basic orientation to family planning and sex education course content before these courses in fact take place in their communities. APLAFA already has experience in offering courses for clergy, school directors and other community members in Panama City. The MOE can introduce sex education activities at the community level through their "padres de familia" groups. These parent groups could determine what types of information/activities they want their children to be exposed to and in turn contribute to the preparation of didactic materials.

B. Strategies for Delivery of Clinical Services

1. In order to get at the postponement syndrome, pills (after the first prescription) could be distributed at the community level by rural health assistants (paramedics) trained in family planning and contraceptive service delivery. They could also distribute other contraceptives - condoms, spermicides - which don't require a prior examination at a health center or sub-center.

2. All doctors, nurses, nurse auxiliaries and health assistants in health clinics should receive training in human relations and in public relation skills. This training should emphasize sensitivity to the patient's background and concerns. In addition, health center personnel, including health auxiliaries and receptionists, should participate in courses on family planning and be prepared to answer questions and provide information on family planning as the interest surfaces, even when the purpose of the health center visit is to obtain other types of medical services.

3. Given the detected reluctance on the part of some rural women to use oral contraceptives, great care should be taken to train health personnel to provide accurate, balanced and complete information on the pill.
4. While outside of the above, no major problems are anticipated in promoting either sterilization or pills, close tabs should be kept on acceptance, especially on the part of adolescents, of other methods - e.g., foams, neosampoons, condoms, diaphragms - and on male attitudes towards condoms and vasectomies. Case studies should be carried out early in the Project to obtain baseline information on existing attitudes and knowledge which can be used in designing programs geared toward promoting these techniques.
5. A potential obstacle to delivery of clinical services to adolescents are attitudes of health clinic personnel themselves, who due to personal feelings about distributing contraceptive devices to unmarried adolescents, might either refuse to provide these services altogether or do so in a begrudging manner. Therefore, the following suggestions are made: (a) through a series of courses programmed for health staff, attempts should be made to surface any negative attitudes and either neutralize them or recommend that these personnel work in other areas; (b) interim evaluations of the MOH's experimental adolescent clinical services delivery program should explore attitudes and experiences of adolescents with health sector personnel, again with an eye toward either reassuring and convincing these personnel or recommending that they be shifted to another program.
6. Attempts should also be made to detect objections of a similar nature among other adults - e.g., parents, clergy and community leaders. In the event such objections are detected, special efforts should be made to provide a broader perspective of the benefits - to themselves, their children, and society - of preventing early and unwanted children.

#### IV. Benefit Incidence

No adverse impacts are anticipated, either on the Project beneficiaries themselves, or on those individuals not directly benefitting from the Project. Potential benefits, however, of a successful population program which results in progressive reductions in family size as well as in the overall population growth rate are numerous.

A. Health Benefits

Three major health benefits for target group members should ensue as a result of Project activities: (1) Fewer pregnancies, accompanied by increased spacing between births, should reduce the chances of complications during pregnancy that often result in adverse health effects for both the mother and the fetus; (b) With increased spacing between pregnancies, low-income mothers will have a longer time period in which to breastfeed their infants, a distinct advantage especially in target areas included under the Project where parents, due to severe income constraints, cannot afford to purchase food supplements of the same nutritional value as maternal milk; (c) A key general health benefit to target families in general should be better family nutrition. Incidence of second and third degree malnutrition should decline among members of the target population, especially among those located in isolated rural areas.

B. Economic and Social Benefits

A variety of economic and social benefits are expected as a result of Project activities: (1) Low-income families, as a result of having fewer children, will have an opportunity to enjoy a higher standard of living; (2) By the year 2000, fewer workers than currently estimated should be entering the workforce; (3) Savings to the GOP in social and welfare programs (e.g. health and education services, subsidies) should be significant on a per year basis; (4) Crowding should be significantly lower, especially in low-income urban areas where existing housing is more adequate for smaller families; (5) Many children, who might otherwise not have had an opportunity to complete their academic/vocational training due to family financial constraints, should be able to continue with their schooling.

C. Benefits to Women

Potential Project benefits for target women are particularly high: (1) As indicated above, with fewer pregnancies, coupled with increased spacing between pregnancies, adverse effects on maternal health, especially among women living in isolated rural areas, can be significantly

reduced; (2) Freedom from childbearing coupled with the power to space and plan numbers of births will free target group women to assume roles other than those of exclusively wife and mother. In particular, a significant number of women living in low-income urban areas, many of whom are heads of household, should be able to assume salaried employment; (3) As wives and mothers, women with fewer children should also have the time to be more effective in these roles as well; and (4) Teenage girls and younger women, especially those migrating into Panama City from rural areas in search of increased educational and employment opportunities, will be able to pursue these opportunities that would otherwise be shut off to them or strongly inhibited by an early and undesired pregnancy.

#### V. Spread Effects

Several elements of the Project design virtually assure the spread of benefits to target group individuals who will not directly benefit from either IE&C activities or the clinical services during the life of the Project. These elements will also facilitate future replicability of key Project components:

- A. A heavy emphasis is to be placed on providing information on contraception and the reproduction process in a clear and understandable manner to Project beneficiaries. Via the natural flow of communication that is expected to result: (1) Adults who have received family planning information, including sex education, are expected to transmit accurate information to their children as well as to peers; (2) Adolescents should transmit useful information to their parents as well as to their friends; and (3) School teachers, community leaders, and health sector employers should also continue transmitting information on the reproductive process and on family planning.
- B. All IE&C materials, including courses, pamphlets and mass media messages, will be designed in such a way that they can be used by other institutions not directly receiving Project support, both during and after the life of the Project.
- C. A key emphasis of the Project will be on building the institutional capability within the MOH, MOE, APLAFA and IPHE to provide family planning IE&C and in the case of MOH, contraception services. Once the Project terminates, these institutions are expected to be able to continue providing outreach and clinical services to progressively larger segments of the population.

- D. In the case of the MOH and APLAFA's experimental adolescent centers,<sup>1/</sup> careful monitoring of Project experiences through a before and after evaluation will provide the data base necessary to disseminate successful results which should attract more adolescents to the centers and possibly interest APLAFA and the MOH as well as other institutions in establishing additional centers and/or expanding the program of existing centers.
- E. Seminars on family planning and demography conducted for Government officials and private sector leaders<sup>2/</sup> should result in greater consideration of demographic variables in policy making and stronger support among high-level Panamanians for a national family planning program. This could result in both a formal population policy and expanded family planning efforts at the program level.

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<sup>1/</sup> The five planned MOH adolescent centers will be established with funds from UNFPA, IPPF and other donor funds will finance the APLAFA center. This Project will assist in developing materials to be used in the centers and in financing for the APLAFA center a series of courses and seminars in family planning and sex education to be conducted for adolescents, their parents and teachers.

<sup>2/</sup> Such as those to be presented under the AID centrally funded RAPID Project (See footnote page 37 of the Project Paper).

### INSTITUTIONAL FEASIBILITY \*

Two GOP ministries, a semi-autonomous welfare institution, and the local IPPF affiliate will implement the Project. They are the Ministry of Health/Social Security Agency, Ministry of Education, Panamanian Institute for Special Education (I.P.H.E.), and the Panamanian Family Planning Association, APLAFA.

These institutions have clearly demonstrated their interest in and commitment to the Project. They also have been presented with ample evidence during the Project preparation period of the demand for family planning information and services, often expressed by the potential beneficiaries themselves.

All four organizations possess the institutional capability to carry out the activities proposed in the Project. Because, however, family planning is a new field for two of the institutions and sex education is new to all of them, some staff training will be required. Proposed areas and magnitudes of training by institution for local and third country training have been identified and are discussed in Part B. 2, Project Activities.

There follows a discussion of the institutional setting, capabilities, and resources of each of the implementing agencies.

#### 1. The Ministry of Health (MOH)

##### Role, Organization and Performance

The present Ministry of Health, created by Cabinet Decree No. 1 on January 15, 1969, is the official government institution responsible for determining and executing national health policy. Firmly committed to raising the health standards of individuals, families, and communities throughout the Republic on an equitable basis, the Ministry since the early 1970's has launched or expanded programs which have had a direct and significant impact on the country's health standards. Significant declines in morbidity-mortality rates have resulted from the continuing efforts of the MOH to shift personnel, budget and other medical resources from a hospital - based focus to a more decentralized system of community health committees, health posts, sub-centers, centers, rural and provincial hospitals. The net result has been to greatly extend health coverage

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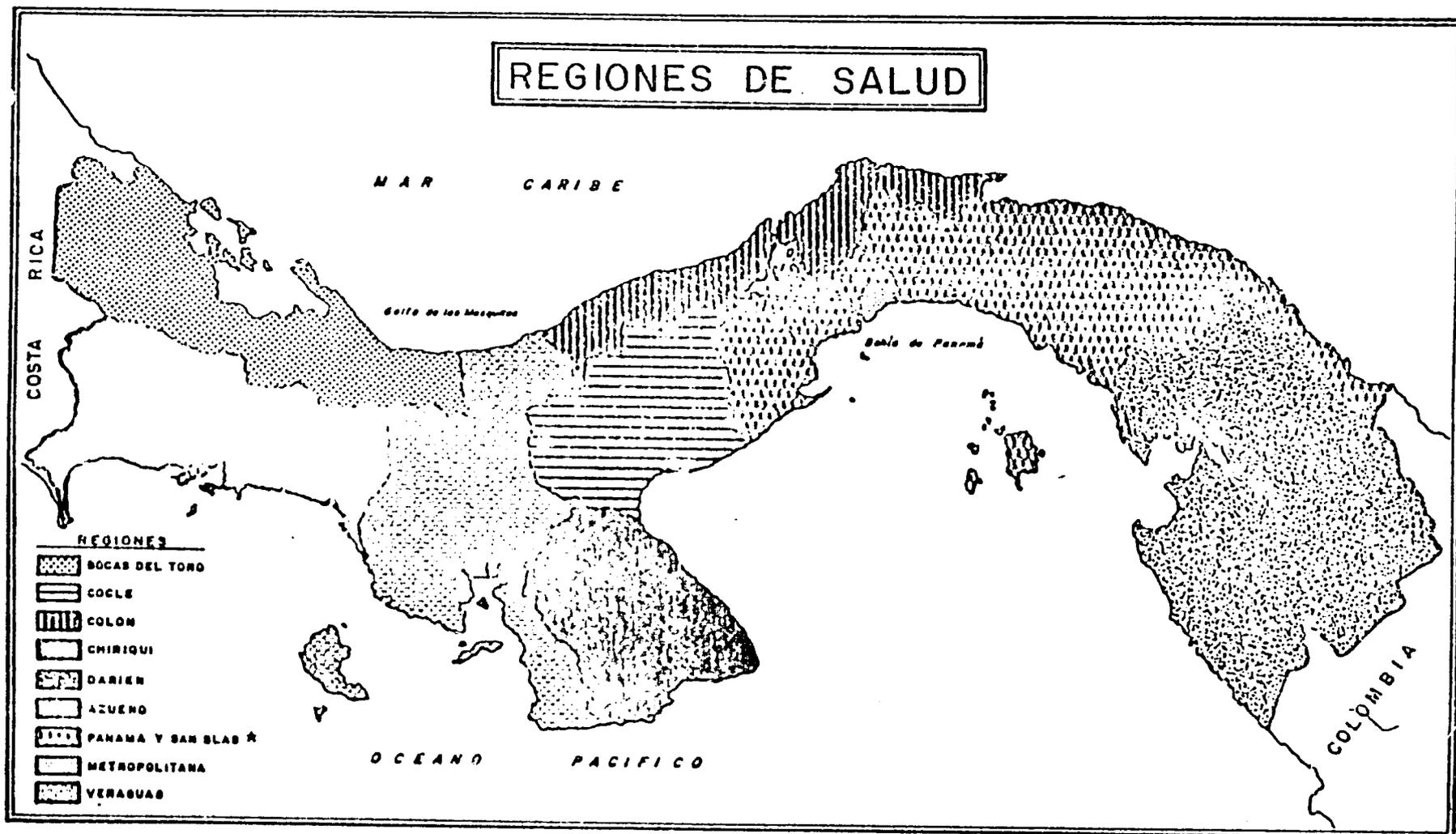
\* This section was prepared with the assistance of John P. Coury of the American Public Health Association who spent two months in Panama in early 1979 gathering and analyzing data on the institutions expected to participate in the Population II Project.

and to make public health resources more accessible to marginal populations in greatest need of such resources.

Family planning is considered by the Panamanian government to be an aspect of national health and, in that context, is treated as an integral part of the MOH's Maternal and Child Health (MCH) program. In this approach, fertility regulation is directed to protecting the mother and her offspring through the spacing of children and for purposes of controlling or limiting the number of children per family. A distinct population or demographic policy as such does not exist in Panama. Nevertheless, with the exception of abortion which is illegal except when medically indicated, the Ministry of Health is committed to the full range of family planning activities including contraceptive services, information, education, and training of personnel. At the same time, the Ministry is careful to guard its pre-eminent role in family planning and has not always welcomed the participation of other organizations in the area. It has taken an active role in controlling the use of contraceptive methods in the public sector - regulating the use of oral contraceptives and IUD's, prohibiting the use of injectables, and establishing norms which restrict male and female sterilization according to the age and number of live children of the individual seeking the operation.

Organizationally, the Ministry of Health consists of a national headquarters located in Panama City, nine Health Regions (these correspond to the country's nine provinces), and four specialized National Hospitals also located in the capital city. The regional subdivisions carry out health programs and policies established at the national level and have been granted increasing autonomy to do so since the mid-1970's as the move to decentralize the Ministry's structure and operations has gained impetus. The MOH has also systematically cultivated the direct participation of community residents through the establishment of over 1,000 Community Health Committees (Comités de Salud) which have strengthened the capacity of rural and low-income urban localities to address common health and other development needs.

In line with its policies of decentralized health care and "Salud Igual para Todos", the Ministry has vastly extended its network of public health facilities throughout the country over the past ten years and particularly since 1976 with the help of AID loan 525-U-045, Rural Health Delivery System. Current public health facilities include four special hospitals (in Panama City), 26 general hospitals (Panama City and rest of the country), 73 health centers, 164 health sub-centers, and 82 health posts. Over the next 20 months, an additional 132 facilities, the majority of them health posts, are to be constructed, greatly expanding public



\* San Blas constitutes a 10th health region but is sometimes considered part of the Panama health region for administrative purposes.



health care coverage including family planning.

Health/family planning coverage is also being expanded through the creation of a single, unified National Health System, the result of integrating the Social Security Agency (CSS)\* with the Ministry of Health. This has been accomplished gradually with all CSS facilities in the provinces, including rural sections of the metropolitan corridor and Colon, now integrated; facilities of the MOH and CSS in the metropolitan Panama City area (where the bulk of CSS facilities are located) will be integrated during the life of the Project. Integration has greatly expanded the facilities available to clients who are the responsibility of MOH, i.e., they may now receive services at facilities previously restricted to those who qualified for Social Security benefits. The integrated system operates at the provincial level under the direction of the Regional Health Offices which has authority over all integrated MOH/CSS facilities from warehouses to hospitals. It is at this level, in fact, that integration and coordination have taken place since the Health Ministry at the national level operates in a highly vertical manner.

As indicated earlier, it is the Ministry's Maternal and Child Health (MCH) Department which has primary responsibility for executing the Ministry's programs and policies related to family planning. This Department is one of five special health components of the National Office for Family Health (Dirección de Salud Familiar). The others include: dental health, mental health, adult health and nursing, (see Organizational Chart). Family Health is itself one of five National Offices which comprise the General Health Office (Dirección General de Salud).

The MCH Department is divided into various service and technical components: maternal health (which has responsibility for family planning services, as well as all other maternal services, such as prenatal and postnatal care); infant health; nursing; information and education; and social service. At the national level, these are each staffed by only one technical person. In spite of each component's small size, however, its responsibility is great: i.e., to design and supervise programs in its respective area of concern, and play an instrumental role in policy formulation although final policy authority rests with the Minister.

Family planning activities follow the structural lines of the maternal health component of the MCH Department. This allows for the provision of family planning services at all levels and in all facilities where maternal services are provided. Although this does allow the family planning program access to all expectant mothers (prenatal) and also, through the well-baby clinics, to mothers

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\* Footnote on Page 7 of the Project Paper.

**MINISTRO**  
**VICE-MINISTRO**

**MINISTRY OF HEALTH**

UNIVERSIDAD  
I.D.A.A.N.  
C.B.B.

ASESORES INTERNACIONALES  
COMISION NACIONAL DE POLITICA DEMOGRAFICA

ASESORIA LEGAL

ESTUDIOS DE POBLACION

RELACIONES PUBLICAS

DOCENCIA E INVESTIGACION

ASUNTOS INTERNACIONALES

ORGANIZACION Y EDUCACION DE LA COMUNITAT

DIRECCION GENERAL DE SALUD

DIRECCION ADMINISTRATIVA

COMITE TECNICO

ESTADISTICA Y COMPUTERS ELECTRONICOS

AUDITORIA

ORGANIZACION Y METODOS

DIRECCION DE SALUD FAMILIAR

DIRECCION DE NUTRICION

DIRECCION DE PLANIFICACION

DIRECCION DE SALUD AMBIENTAL

DIRECCION DE EPIDEMIOLOGIA

INFORMACION Y ESTADISTICA

PERSONAL Y PLANTAS

FINANZAS

PROCESOS

IMPRESION Y PUBLICACIONES

SERVICIOS GENERALES

MANTENIMIENTO Y REPARACION EQUIPO ROBOTICO

ALMACEN CENTRAL

SALUD MENTAL

SALUD MENTAL

SALUD ADULTOS

SALUD MATER INF

SALUD INFAN

PROGRAMA COMUNITARIO DE SALUD

PROGRAMA COMUNITARIO DE SALUD

DEPARTAMENTO DE SALUD

LABORATORIO Y DIAGNOSTICO

LABORATORIO VETERINARIO

LABORATORIO DE INVESTIGACION

REGION DE BOCAS DEL TORO

REGION DE CHIRIQUI

REGION DE VERAGUAS

REGION DE AZUARO

REGION DE COCLE

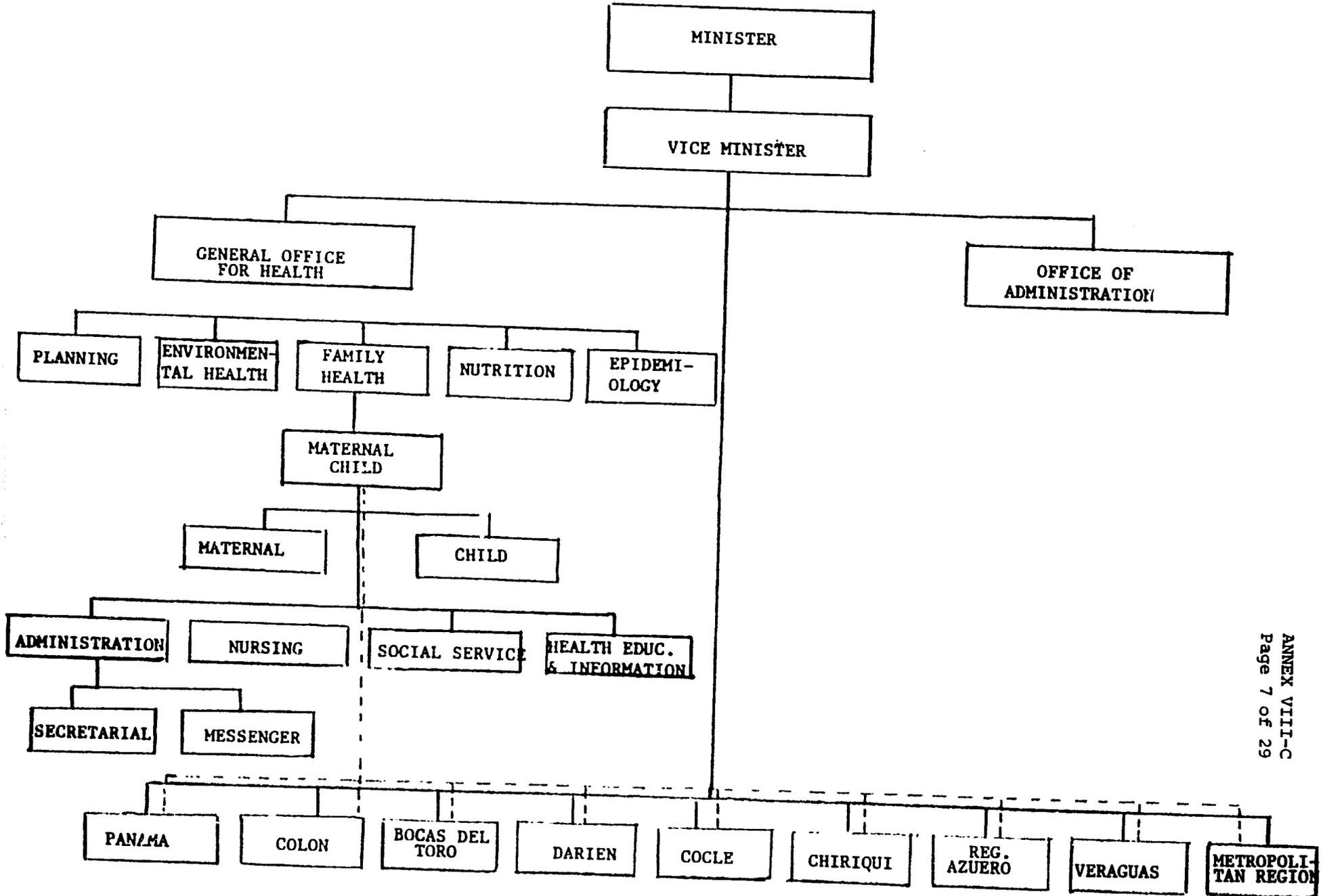
REGION DE PARANA

REGION DE EDLOR

REGION DE BARRER

HOSPITALES RACIONALES

REGION METROPOLITANA



with young children (since maternal services are integrated with infant services), the present structure does not allow for easy access to young, nulliparous women who may wish to delay their first pregnancies, nor does it allow for services to reach the male population. In order to delivery family planning information and services effectively to all the proposed target groups, the MCH division will need to broaden its operational mandate beyond the "maternal" and "child" of its title and coordinate with other MOH divisions, e.g., with the epidemiology and environmental sanitation units in order to effectively reach Panamanian men.

Other aspects of Ministry operations which could affect implementation of the Project include logistics and supervision. A poor logistics system plagues the National Health System and could adversely affect the Project since timely delivery of medical services and contraceptives, which requires a smoothly functioning logistics system, is critical to the success of the Population II Project. Warehouse and other storage facilities, inventory control, transportation and other logistics elements at the national and all subsidiary levels are entirely inadequate; by taking over, however, in some places the facilities presently operated by the CSS, generally considered to be superior to MOH facilities, improvements are already occurring. This Project, the current AID health loan, and the UNFPA MCH/FP project all address the problem, and a modernized, integrated logistics system should be in place and operating sometime in 1981.

A major problem which could be resolved by more adequate supervision is the lack of uniform application at the field level of MOH policies and procedures. Although a great deal of effort is expended at the central (Panama City) level to establish health, including family planning, policies and procedures, there is considerable evidence to show that at the service level - from health post to hospital - they are either not followed or are reinterpreted according to the personal predilections of local administrators and medical personnel. In most cases, this proves to be detrimental to the family planning program. It has been discovered, for instance, that many dispensary personnel are not aware that all contraceptives are to be provided free of charge. Regulations governing sterilization are not applied uniformly: e.g., the MOH requires that a patient have four children while in at least one provincial health region, the requirement has been reduced, at the discretion of the regional health director, to a minimum of two children per patient. Although the MOH at the central level views condoms as a disease preventative in addition to a contraceptive, condoms are not being distributed by health facilities to those suffering from venereal disease and their contacts. In fact, doctors and nurses appear to prescribe this method

infrequently, even as a stop-gap measure, either prior to commencing with oral contraceptives or IUD insertion, or when a method has been temporarily interrupted. Local inventories of condoms are as much as three or four years old.

In another departure from MOH policy, many health facilities only allot certain days or hours to family planning services. It is the intention of the Ministry of Health, however, that family planning services be made available during all regular clinic session and that this be so stated in the "weekly calendar of services" published in the field.

Apparently extensive failure, whether by design or ignorance, to apply Health Ministry policies and procedures is damaging efforts to make family planning widely available at the service level. What is needed is to inform all health staff, including auxiliary and administrative personnel, about family planning policies and procedures and through regular supervision visits, workshops and conferences, ensure that they are being carried out effectively by everyone from health region directors to dispensary staff and clinic receptionists. At the same time, supervisors should be open to suggestions at the field level and serve as a feedback channel to the central ministry. Knowledge that some provincial facilities, for instance, are requiring that a sterilization client have two children rather than the four currently stipulated by MOH headquarters, might eventually lead the latter to a salutary re-examination and modification of its position on this subject.

To facilitate more regular and effective contact between the Ministry in Panama City and its vast field network, the Population II Project will provide vehicles for supervisory visits and fund periodic evaluation meetings of representatives from all units of the MOH/CSS System. The UNFPA project, in addition, includes funds for field visits and national meetings of health system personnel.

#### Staffing and Other Resources

Having had responsibility for implementation of the terminating 12-year AID Health and Population project, the staff of the Maternal and Child Health Division possesses the experience necessary for satisfactory implementation of the new Project. The full-time UNFPA project manager, who will be located in the MCH Division, will strengthen division capabilities as will the planned addition of four positions for a pediatrician, two administrators, and a nurse and a steady flow of short-term advisors - approximately 42 person months - programmed under the UNFPA project. Additional assistance is also recommended for the health educator in the MCH division who is responsible for I E & C activities. A considerably strengthened I E and C effort is a major objective of the Project,

calling for preparation of many new materials with new subject matter directed at new audiences, and the testing and evaluation of these materials for the first time; this must be accomplished in addition to regular participation in charlas, seminars, and workshops and supervision of local radio and printing contracts. In all, too great a workload for a single individual.

Although the MCH unit itself has neither the staff nor facilities for evaluation, the Ministry's Office of Population Studies and Training and Research Office will assist in annual evaluations of the Project and a series of special investigations in areas of new initiative for the MOH: adolescent activities and male family planning. The Population Studies Office, with the help of external consultants, demonstrated its capability in developing and carrying out the National Fertility Survey in 1976 as part of the World Fertility Survey, and the Office is currently undertaking a Contraceptive Prevalence Survey with assistance from the Center for Disease Control and AID.

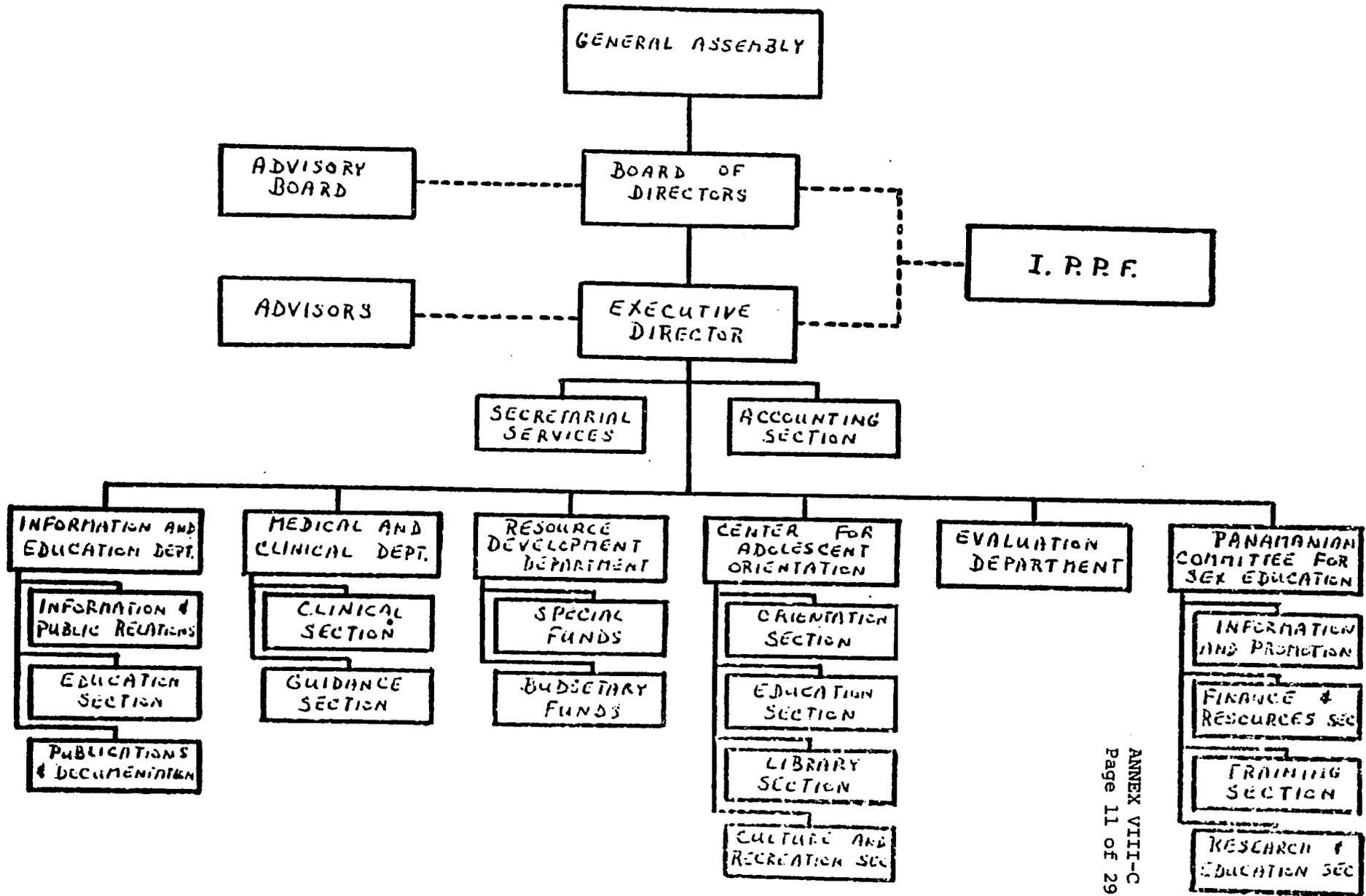
Physical facilities of the Ministry of Health are limited at both the national and local level. The central office of the MCH program in Panama City is extremely cramped, consisting of nothing more than one large room approximately 30 feet by 60 feet which has been subdivided into a large central area for secretaries and a waiting area, and various cubicles which provide for three smaller offices and one small conference room. All MCH personnel - professionals, secretaries, and messengers - are crowded into this area, often along with cartons of diaphragms, printers ink, etc. Air conditioning, ample furniture, and office equipment and a generous library of professional literature help offset the disadvantages of such cramped quarters. With assignment of a permanent PAHO advisor to the unit, however, and a steady flow of short-term advisors, some increase in office space will be required. Because present facilities do not allow for expansion, and budgetary restrictions, at least for the immediate future, will permit no new construction, the MOH is considering renting additional working space.

At the regional level, the regional MCH coordinator usually operates out of his/her regular office, such as the director's office in a maternity hospital; no office is specifically assigned to MCH at this level, even though the MCH program is supposed to operate, at least theoretically, through the Regional Health Director.

At the service level, family planning activities are administered either from a small office or examining cubicle assigned to MCH in a health center or sub-center or from the small, multi-purpose facilities known as rural health posts. While primitive,

PANAMANIAN FAMILY PLANNING ASSOCIATION

ORGANIZATION CHART



these posts are increasing dramatically and are helping to extend health and family planning coverage far beyond what it was even a few years ago. The health assistants who manage the posts are provided with family planning training and are permitted to distribute condoms, foam and resupplies of oral contraceptives.

Warehouse facilities now used by the MCH program at the central level are entirely inadequate; they are in ill-repair, constitute a fire hazard, and are poorly maintained. Family planning supplies are sometimes improperly stored and instead of being located in a central area are stored in different locations and on different floors. Inadequate warehouse facilities affect all Ministry programs and are part of the logistics problem discussed earlier in this section.

Contribution to the Project

Overall, the MOH contribution to the Project will include the following personnel:

|  | <u>NO.</u> |
|--|------------|
| Obstetrician/Gynecologist  | 70         |
| Registered nurses  | 775        |
| Nurse auxiliaries  | 1,084      |
| Health educators   | 72         |
| Health assistants  | 100        |
| Director of MCH office   | 1          |
| Other administrative personnel<br>(secretaries, messengers, clerks,<br>drivers, accountants, etc.) |            |

It is estimated that these employees will spend from five to 10% of their time on family planning activities. Based on this estimate, their average salaries through the life of the Project equal:

|   |                    |
|---|--------------------|
|   | \$3,399,000        |
| Salaries of personnel to participate in evaluation and studies: | 150,000            |
| Other support costs (gasoline, maintenance)                     | 10,000             |
|   | <u>\$3,559,000</u> |

## 2. Panamanian Family Planning Association (APLAFA)

### Organization and Role

In December 1965, the Panamanian Family Planning Association (Asociación Panameña para el Planeamiento de la Familia), APLAFA, was founded as a non-profit private organization. Fourteen of the sixteen founding members were physicians, an indication of APLAFA's early and enduring orientation towards the medical aspects of family planning. Soon after, on January 14, 1966, APLAFA was granted its "personería jurídica" or legal recognition by the national government.

Policy decisions are made by the nine-member Board of Directors, four of whom are physicians. \* The Board is strongly controlled by its president, who until his recent retirement was a noted obstetrician-gynecologist at the University of Panama's School of Medicine. He was APLAFA's principal founder and has been its only president in 14 years of operation.

The Board of Directors including a president, first and second vice-presidents, secretary and sub-secretary, treasurer, fiscal officer and two other voting members, are all volunteers and meet regularly, at least once a month. During the Board's regular meetings, the Association's Executive Director, a salaried official, is allowed to attend, with voice but without vote. However, he is not allowed to attend special executive meetings held by the Board.

The Executive Director is responsible for the successful execution of APLAFA programs. Within the last year, as the APLAFA president has gradually retired from managing the Association's daily affairs, the new Executive Director, hired in March 1978, has been allowed sample latitude in managing APLAFA. He maintains the necessary contact between APLAFA and other institutions, whether national or international; makes all personnel decisions; and, together with the Board's president and treasurer, signs all checks.

As stated in the Organizational Statutes of APLAFA, the Association's primary activities are to: (1) investigate and recommend solutions to problems caused by population growth; (2) promote the concept of the family and responsible parenthood and (3) study birth regulation. Until the Ministry of Health began to offer family planning clinical services in the early 1970's, APLAFA took the lead in providing contraceptives to the public,

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\* Two other bodies - a General Assembly composed of all members and a five-member Advisory Board drawn from previous directors and founding members - have not functioned for some years. Although one of the Assembly's functions is to elect the APLAFA Board of Directors, in practice the latter names new officers to fill any vacancies.

especially in the urban areas of Panama City and Colon. However, a subsequent agreement, signed between APLAFA and the Ministry of Health in June 1973, restricted the role of APLAFA in the clinical area. APLAFA is now allowed to maintain only two family planning clinics, both within Panama City, for use as research, training and demonstration clinics.\* As a result, APLAFA has directed its efforts into other areas, such as sex education and informational and motivational activities related to acceptance of family planning.

### Institutional Performance

Over the years, APLAFA has earned respect within Panama as a reliable, helpful source of information and training in the areas of sex education, family planning and responsible parenthood. In discussions with many institutions, official as well as private, it was learned that they receive more assistance from APLAFA in these areas than from the information/education unit set up within the Ministry of Health's MCH Division.\*\* APLAFA, through its paid workers and groups of volunteers, has been active in numerous family planning promotional activities, including group presentations, publication of materials, and annual gatherings of members of the Panamanian press organized in an effort to win their support for family planning.

Although increasing demand has been placed upon APLAFA to provide these services, limited resources and institutional weaknesses have prevented APLAFA from responding as adequately as it might. Recent organizational changes, however, and forthcoming personnel additions make it likely that APLAFA will be able to provide increasing assistance in family planning information in both the public and private sector as well as introduce an important new program for adolescents and their parents and teachers.

Since its creation, APLAFA has been recognized by the International Planned Parenthood Federation (IPPF) as its Panamanian affiliate. Funds from IPPF have been available to APLAFA, both for its operational budget as well as for special projects.

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\* APLAFA closed its Marañon clinic in 1978, converting the clinic into its administrative headquarters and operates one clinic now in the rapidly growing peri-urban district of San Miguelito.

\*\* A survey conducted in 1973, for example, among 160 home economics teachers attending a family planning seminar showed that 40% had previously attended an APLAFA family planning course or education activity.

USAID/Panama has also recognized the important role played by APLAFA in the area of family planning and provided financial assistance to it to promote family planning activities under the terminating Health and Population Project.\*

Other institutions working in family planning and related areas also contribute to and collaborate with APLAFA. Among these are the FPIA which helps fund APLAFA salaries and Development Associates which has provided funding for local seminars and to send two APLAFA employees for special training in Guatemala; the Latin American and Caribbean Regional Sex Education Organization (CRESALC) has helped APLAFA to sponsor sex education seminars in Panama. \*\*

APLAFA is steering a statesmanlike course in its relationship with other Panamanian agencies - principally the Ministry of Health - involved in family planning. APLAFA has shown a willingness to collaborate with government ministries and to avoid areas of conflict. It recognizes that it cannot compete with public institutions in providing all services, but seeks instead to serve as an example, or model, which can be adapted by the government for future expansion. That has been APLAFA's past role in opening the way for national acceptance of family planning clinical services, and its new role in areas of sex education and adolescent outreach will have a similar focus.

Illustrative of APLAFA's ability to accommodate is its recognition that leadership in the provision of family planning clinical and contraceptive services now rests with the Ministry of Health. APLAFA has therefore consolidated its clinical activities into one clinic in San Miguelito, which is being used as a pilot center for teaching and research purposes.

APLAFA has made considerable progress in overcoming several institutional weaknesses (poor management at the top, inability to raise funds locally, lack of an adequate accounting system) which caused it to be less than effective in implementing

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\* APLAFA was a signatory to project agreements under 525-0142 with AID and the Ministry of Health in 1968 and 1970 and with the Ministry of Planning and Economic Policy in 1974.

\*\* APLAFA's anticipated donor income (\$810,000) for the five year period 1980-84 will be provided from the following sources: IPPF - 59%, FPIA - 23%, AID - 12%, CRESALC - 3%, and Development Associates - 3%.

its portion of the terminating population project. With the assistance of a U.S. management consultant firm in 1978, APLAFA's organizational structure and operational procedures have been completely overhauled. A completely revised accounting system is now in the hands of a newly hired, experienced accountant, and new fund raising and evaluation departments are in operation. Organizational changes are also facilitating the incorporation of new activities, most prominent among them the new youth center and expanded programs in family planning and sex education for private and public entities.

### Staffing and Other Resources

Staffing has been considerably strengthened over the past two years. APLAFA now has 13 full-time employees on its payroll and enjoys in addition the voluntary services of youth workers and members of the APLAFA sponsored Panamanian Committee for Sex Education, COPEs.\* The present executive director brings a background of management training and experience and leadership skills to the job.

The San Miguelito clinic staff includes a nurse and nursing auxiliary, both trained in IUD-insertion, who work full-time five days a week, and one part-time physician who is in attendance two mornings per week. The nurse and nursing auxiliary are paid personnel, whereas the physician volunteers his services. Clinical activities are practically self-financing.

Administrative staff include secretaries, a janitor and one vehicle driver, who also assists as projectionist for film shows. In addition to the permanent staff, advisors are contracted by APLAFA as required for specific tasks - e.g., a team of advisors was recently contracted to prepare the initial design for a research study on teenage pregnancies. Legal counsel is hired as needed, and APLAFA annually contracts an outside, internationally recognized auditing firm, in accordance with IPPE regulations.

APLAFA is fortunate in having little staff turnover. Most of its employees are extremely dedicated to their jobs and often put in long hours of overtime without complaint, not always the case in public sector agencies. APLAFA will provide training to its staff through a centrally funded AID Contract (successor to Development Associates) and the Regional Committee for Sex Education in Latin

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\* COPEs, formed in December 1978, is comprised of some 25 sociologists, social workers, psychologists, educators, etc., and has its own executive board.

America and the Caribbean (CRESALC). It will also utilize the recently created Panamanian Committee for Sex Education (COPES), a committee composed of local professionals oriented to the field of sex education, to provide training to adolescents and requesting institutions.

APLafa currently operates out of two locations, both within Panama City. Its administrative offices are located in the Marañon District, in the heart of downtown Panama, while the clinic, I and E, and youth center offices are situated in the San Miguelito District, a low-income area which has grown meteorically over the past decade. The Association rents the Marañon offices but owns the San Miguelito facilities. Plans call for construction of the youth center and expansion of other offices on land adjacent to the San Miguelito building which should relieve current crowding. APLafa owns the land, and construction will be done through a loan with the Caja de Seguro Social (National Social Security System).

The San Miguelito facility has an excellent library with a good collection of materials related to family planning. These books will be distributed between two libraries, one to be used as a reference section for scholars working in the area of family planning, sex education and related topics, and the second to be used by the newly established youth center.

APLafa has two vehicles, both in good working condition, and plans to purchase a third - a bus model Volkswagon van - with IPPF funds for use by the adolescent center.

Present clinical equipment is adequate to meet APLafa's needs, and any additional equipment will be provided through IPPF. In the area of Information/Education activities, APLafa has some good equipment, including movie projectors, slide projectors, video-cassette players and tape recorders. It also has two mimeograph machines and one photo-copier, all in good working condition. When large quantities of printed materials are required, APLafa usually contracts with a professional printer; its monthly newsletter, Conciencia, which contains photos, is printed at a very reasonable price.

With expansion in the areas of sex education, I and E, and the adolescent center, APLafa will require additional equipment and educational materials, such as films. Funds have been included in the Project budget for this purpose, particularly in support of sex education activities to be sponsored by the new adolescent center. New storage facilities will accommodate any increase in supplies and equipment. Maintenance of equipment is not a problem in Panama, as it is in many other Latin American countries.

### Contribution to the Project

APLAFAs contribution to this Project consists mainly in time utilized in planning and coordinating its program courses. This is valid also for the design of seminars and courses that respond to requests from other private institutions. These efforts are estimated at \$25,000.

### 3. Ministry of Education

#### Role, Structure and Performance

The Ministry of Education is responsible for establishing a uniform educational system throughout Panama. To do this, the MOE controls the curriculum for teacher training, as well as the curricula used in Panama's secondary and primary schools. Since the public school system is financed through the MOE, that institution has a key role in educational development. Under the Population II Project, the MOE will direct the development and execution of a national sex education into the public schools.

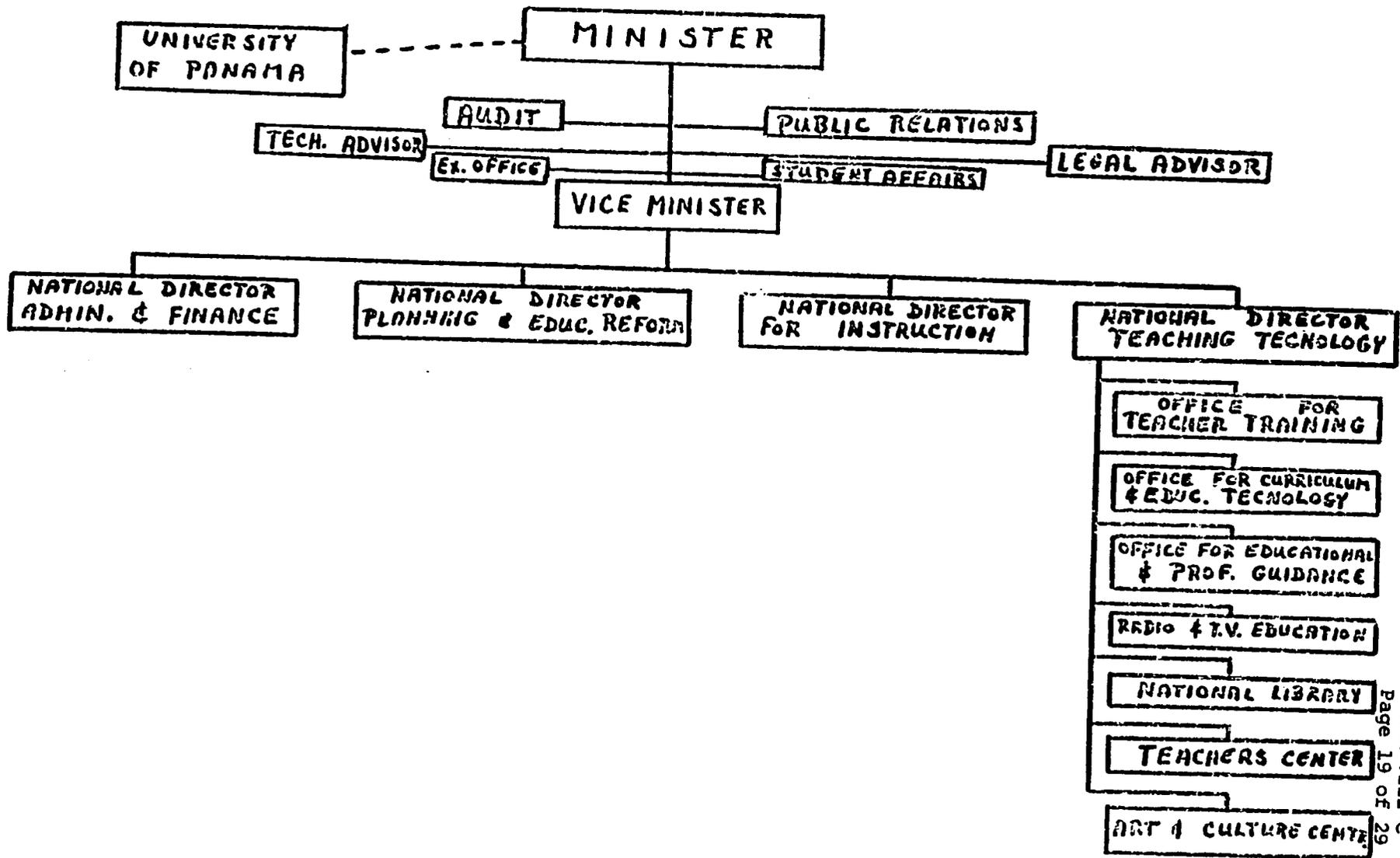
The Ministry of Education (MOE) is organized into four National Directorates: Planning and Educational Reform, Instruction, Teaching Technology, and Administration and Finance, (see Organizational Chart). The Directorate of Teaching Technology is itself divided into seven different offices and centers, one of these being the Office for Teacher Training, which will work with USAID/Panama in executing the proposed sex education/family planning component of the Population II Project.

A Provincial Education Office (Dirección Provincial de Educación) operates in each of Panama's nine provinces and is divided into two basic sections, one handling administrative and financial matters, and the other responsible for the technical and implementation aspects of teaching. Personnel at the provincial level may vary from 50 to over 100, including administrators, supervisors, clerks and support staff. Since 1972, the MOE has been attempting to decentralize its administrative component, placing more responsibility at the provincial levels. To date, this has met with limited success because many of the secondary schools still prefer to communicate directly with the MOE at the national level, bypassing the provincial level.

For other reasons, the MOE structure remains centralized. Because Panama is attempting to institute an educational system with norms and curriculum uniformly established and functioning throughout the country, there is the tendency for educators at all levels to look to the national headquarters for guidance and clarification. Therefore, at the time sex education is introduced into the teaching

ORGANIZATIONAL CHART

The Office for Teacher Training  
Within the Structure of the Ministry of Education



curriculum, it should theoretically be done in a uniform manner. Certain administrative factors also influence the resistance to decentralize the MOE structure. One of these is the procedure for paying salaries of all MOE employees, from the central level planners down to the level of the primary school teachers. All salaries are paid from the National Controllers Office in Panama City, utilizing its computer and other facilities in order to expedite payments. This influences all MOE employees to look to the national level in order to resolve administrative problems, since that is where the money comes from. (In the United States, for example, the situation is different, since basic financing of primary and secondary education is provided for at the local community level).

In many ways, the centralized structure of the MOE may be beneficial to the introduction and implementation of the sex education activities to be funded by the Project. What will be required, however, is a strengthening of the supervisory components at the provincial levels to assure that Project activities, once initiated, are being adequately carried out, to detect and deal with any teacher resistance and provide needed backstopping.

The Mission has long experience in working with the MOE. Its personnel capabilities at the central level and including the nationwide teacher corps are very good, although training will be required in the new specialized area of sex education. MOE's capabilities in the areas of administration, such as provision of supplies and equipment, or its ability to assume more responsibility in these areas, are quite adequate.

At present, the Ministry is the executing agency for a \$13.5 million AID loan which is assisting the GOP to expand its educational system and redirect it to offer practical, vocationally oriented, general, scientific and technical education which will be more responsive to Panama's development needs than the more traditional liberal arts curriculum. While direct Mission experience with the Office of Teacher Training has been limited, MOE personnel who have worked previously with USAID/Panama have been assigned to develop the proposed sex education component of the Project and may be assigned during its execution.

#### Staffing and Other Resources

The Office of Teacher Training includes a director and 17-member professional staff trained in general education, psychology, economics and special teaching (e.g., science and Spanish). The staff usually works in teams in four general areas: basic education, mid-level education, university and special education, and special projects (mostly involving socio-economic or education studies). A newly established special working group within the Office will develop and introduce sex education in the national

school system. Among its members is the director of MOE's Office of Curriculum and Education Technology who recently attended a family planning training seminar in Costa Rica, one of the few MOE staff to have had any training in the field.

The sex education program at the local level will be implemented by individuals drawn from among more than 26,000 primary and secondary school teachers at work throughout the country. Teachers are divided into two types: the "maestro" who teaches at the primary level and has received 12 years of schooling, including three years of teacher training; and the "profesor" who teaches at the secondary level and has from five to six years of university training. The "profesores" have usually specialized in certain subject areas, such as biology, mathematics, or Spanish. Upon being hired by the MOE, teachers work on a two-year trial basis. If found to be acceptable during that period, the teacher is given tenure, and salary increases are based upon years of continued service and merit.

In undertaking the new sex education initiative, the MOE will need to mount a large-scale teacher training program since the great majority of Panamanian teachers at all grade levels lack any preparation in sex education and family planning. It is expected that the MOE will name a special multi-disciplinary team, probably in cooperation with the National Commission on Sex Education, to develop and carry out a teacher training program either in Panama City or at its teacher training school in Santiago.\* In this new sex education initiative, the Ministry has strong backing at the highest level: The President of the Republic, Dr. Aristides Royo, who until last year was Minister of Education, has repeatedly stated that the introduction of sex education into the national educational system is a priority task to be carried out by the MOE. He has expressed his commitment to this effort and has instructed MOE leaders to implement the government's policy.

Facilities and equipment (vehicles, audio-visual and printing equipment) of the Ministry and, in particular, the Teacher Training Office, appear adequate for the moment. The Office of Teacher Training has two 13-passenger buses for use in the interior (private vehicles or public transport are used within the metropolitan Panama City area), and owns a movie projector and two tape recorders. The amount of audio-visual equipment per school varies throughout the country. Movie projectors are not a standard item at all schools. Through the AID Education Loan II, a training center at the Teacher Training School with all the necessary equipment for instructing

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\* Until a few years ago, there were five teachers training schools in Panama. However, because of the excess of unemployed teachers throughout the country, the MOE now has only one teacher training school in operation, in the city of Santiago, which annually graduates approximately 200 new teachers "maestros".



4. Panamanian Institute for Special Education (I.P.H.E.)

Role, Structure and Performance

IPHE is a semi-autonomous public entity\* established by law in November 1951 to provide special education, training and counseling to physically or emotionally handicapped children. In recent years, it has developed two additional programs: "School for Parents of Handicapped Children" and "Centers for Child and Family Orientation" (COIFs). Benefitting from these programs are the parents of handicapped children and pre-school children, other family members, and other adult members of communities which have sponsored COIFs. Through this Project, IPHE will add sex education and family planning to its program of non-formal education for Parents' School branches and COIF families.

IPHE policy is made by the Board of Trustees which meets monthly. Government Decree No. 46 of November 1968 specifically requires that the president of the Board be a professional educator with graduate training in special education. Other members include representatives from the Ministries of Labor and Social Welfare, Health, and Education, as well as the General Controller's Office, the National Lottery, the Lions Club and the National Medical Association. Day-to-day operations are managed by a General Director; the current director who assumed duties in 1978 was previously director of the "Escuela Normal" in Santiago, now the country's only teacher training school. IPHE operations are financed by the Government of Panama and other local institutions, and about 15% of its budget is provided from the earnings of IPHE workshops.\*\*

\* Over 70% of the funding for the 1979 IPHE budget comes directly from the central government's annual budget; financial reports must be presented monthly by IPHE to the Panamanian General Controller's Office; the membership on the Board of Trustees includes representation from various governmental ministries as well as from the General Controller's Office; and all instructors and administrative personnel at IPHE must be approved by the Ministry of Education. IPHE, just as the University of Panama and other public educational institutions, comes under the scrutiny of the Ministry of Education.

\*\* IPHE's 1979 budget, 11.3% larger than its 1978 budget, is derived from the following sources:

| <u>SOURCE</u>                    | <u>AMOUNT</u>      | <u>PERCENT</u> |
|----------------------------------|--------------------|----------------|
| Direct GOP Subsidy               | \$1,967,978        | 71.0           |
| IPHE Workshop Production         | 424,942            | 15.4           |
| National Casinos                 | 271,000            | 9.8            |
| President Remon Racetrack        | 72,000             | 2.6            |
| Panama City Municipal Government | 20,880             | 0.8            |
|                                  | <u>\$2,756,800</u> | <u>99.6%</u>   |

(discrepancy caused by rounding)

The organizational framework of IPHE (see Organization Chart) includes the Administration Office and five functional offices: Special Education, Pre-School Education, Higher Education, Social Assistance Services and Basic Services. All the offices are responsible to the General Director. The services offices have many and varied programs related to special education, such as vocational workshops. There are also health-related programs, such as hearing and visual testing done in the schools throughout Panama, in order to detect problems and refer them for treatment. Through public health clinics, IPHE attempts an early detection of physical and mental problems in infants and pre-school children.

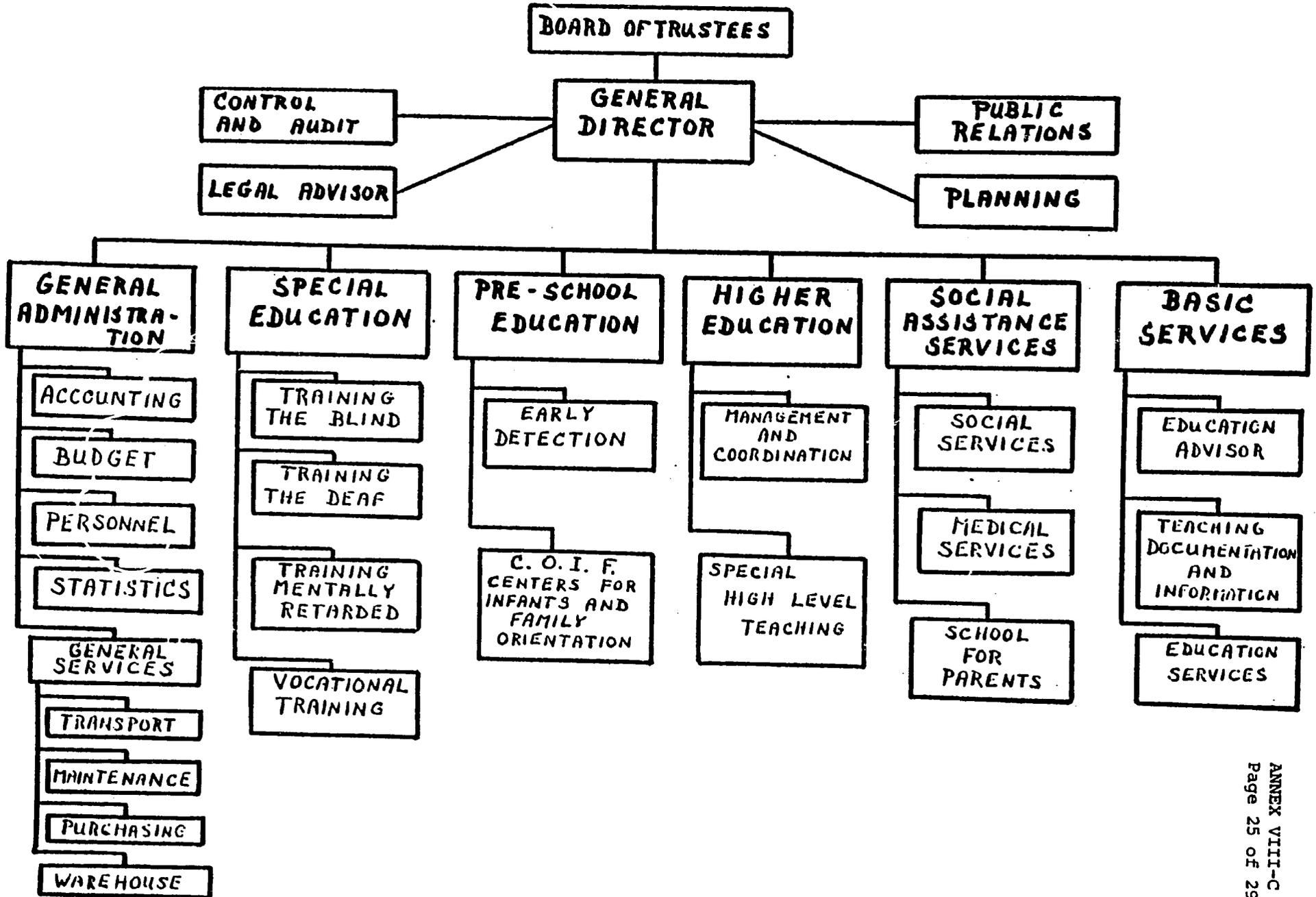
IPHE has also started to provide rehabilitation services. One interesting program is a radio monitoring service, available to advertisers in order that they might be able to verify the broadcast of commercials or messages they had purchased. Blind students are employed to listen to tapes of radio broadcasts and keep records on the frequency and quality of each commercial or message that has been broadcast. Other IPHE workshops employ the handicapped in activities such as carpentry, bookbinding and sewing.

Through its Instituto Superior de Especialización, which is a Central American regional training center for teachers working with the handicapped, IPHE has become recognized both nationally and throughout Central America as a leader in the field of special education for the handicapped. Between 1969 and 1978, 487 students were graduated from the Instituto, 70 of whom were from other countries; in March 1979, some 158 teachers were in training. The curriculum includes specialized courses for the blind, deaf and retarded and an intensive course which combines all three areas. The Instituto receives financial support from the Organization of American States.

In recent years, IPHE has developed programs for two special groups: (1) the parents of handicapped children enrolled at IPHE, and (2) pre-school children. Both programs are effective and well managed although somewhat handicapped by limited funds and personnel.

In 1974, the "School for Parents of Handicapped Children" was formed as part of the IPHE program of Support Services in recognition of the importance of working not only with handicapped children but also with their parents. The primary goal of this school is to help parents better understand and deal with their handicapped children, with other members of the family, and with society in general. The school offers parents individual consultations with specialized technical personnel such as psychiatrists, psychologists, medical physicians and social workers available through the IPHE or other institutions. Literacy training is also offered, and under the

PANAMANIAN INSTITUTE FOR SPECIAL EDUCATION  
ORGANIZATION CHART



Population II Project, the School for Parents will provide a regular program of family planning information and sex education to families of the handicapped. The School for Parents currently operates 12 branches through the country, reaching an estimated 6,850 parents and other family members.

The COIF (Child and Family Orientation Center) program was initiated by IPHE in 1975 as an International Women's Year activity. There are now 135 COIFs in Panama, 99 of which are located in rural areas, 31 in marginal urban communities and four in impoverished Guaymi Indian communities. COIFs currently serve an estimated 6,000 pre-school children, their parents and other family members. They are established and maintained by each community with overall guidance and technical assistance provided by IPHE.\* COIFs provide a day-care/pre-school program for children between 2 and 5 years of age which provides them with basic education health and nutrition services (including in many centers meals utilizing PL 480 Title II foodstuffs). Participation of parents is a critical element; they help build and maintain facilities, make teaching materials and toys, raise funds, prepare meals and serve as classroom aids and teachers. Despite only three and a half years of operation, some COIFs are already producing first graders with a markedly superior level of preparation to their non-COIF classmates, a fact which could have eventual implications for primary school drop-out and repetition rates among low-income children in Panama. COIFs also reach parents and adolescents through seminars on, inter alia, health, nutrition, and child development. Some COIFs, with IPHE assistance, have secured help from GOP ministries in launching community self-help projects and family income-generating projects. Principal beneficiaries in these cases have been women for whom finding employment, particularly in rural areas, is extremely difficult. Many COIFs, located in communities still lacking basic services, have served as catalysts, again with IPHE assistance, for obtaining needed services from public sector institutions. As benefits of the COIF program gain widespread recognition, requests to IPHE to help establish new COIFs have accelerated far beyond its capabilities to adequately respond.

Although the COIF program technically provides services to children between the ages of two and five, in practice many COIFs take children as young as nine months, particularly in urban areas where many mothers work. As its major contribution to the International Year of the Child, USAID/Panama is developing a small \$500,000 OPG through CARE which will provide funds to IPHE to

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\* COIFs are usually organized by a "Comité de Apoyo" (Sponsoring Committee), consisting of community leaders and parents of the pre-school children who will be enrolled in the Center.

up-grade the skills of COIF teachers, including parent-teachers, and improve qualitatively and quantitatively COIF teaching materials; assist in strengthening IPHE's capability to make necessary arrangements to deliver non-formal education in health, nutrition, literacy, agriculture, and vocational arts; and upgrade the physical facilities of approximately 75 COIFs.\* The majority of COIFs currently operate out of substandard, ill equipped one-or two-room buildings, many plagued with structural defects and lacking adequate sanitary facilities and rudimentary kitchen facilities. Additional assistance is being provided to the COIF program on a modest scale by UNICEF, UNESCO and the OAS.

IPHE is viewed by the Panamanian government, and by the Ministry of Education in particular, as a responsible agency for conducting special education programs. The adult education component is considered a valuable contribution to the national education effort, and a growing number of individual communities look to IPHE for guidance in developing COIF day-care/pre-school centers. The success of the COIF program is such, in fact, that the GOP is considering incorporation of COIF activities within the National Office for the Child and Family established in 1979 in the Ministry of Labor and Social Welfare. On all fronts, international, national and down to the local level, IPHE has gained recognition in the field of special education.

#### Staffing and Other Resources

At the end of 1978, IPHE had a total of 891 employees working in Panama City and throughout the country. Of this total, 355 (39.8%) were teachers working directly in classrooms,\*\* 24 were directors and supervisors, 44 were technical staff (such as psychologists, physiotherapists and social workers), eight were medical specialists, 115 administrative personnel and 341 support staff.

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\* Prior USAID assistance to IPHE included an SDA/PL 480 project in 1978 which enabled IPHE to establish a cafeteria for its students and teachers. The cafeteria provides well-balanced meals at no cost to the handicapped children enrolled in IPHE programs and at low cost to IPHE staff and parents of the children. Proceeds from the cafeteria were subsequently used to finance a family life seminar for 35 parents and IPHE employees. (APLAFAs provided resource personnel for the sessions dealing with family planning and contraceptive methods.)

\*\* Many of the teaching staff at IPHE are on loan from the Ministry of Education which continues to pay their salaries; all IPHE teachers must meet the requirements established by the Ministry for all teachers in Panama.

The School for Parents' full-time staff is composed of a director who is a professional high-school level teacher and an instructor with graduate training in adult education. His salary is paid by the Ministry of Education. There are also 10 part-time teachers and two part-time secretaries provided by the national emergency employment program. (In order to curb the rising level of unemployment, the government has instituted a "Plan de Urgencia", providing minimum-wage jobs, paying \$100 per month, to the unemployed and offering their services to official and non-profit private institutions. Although this provides a cheap source of manpower, the quality of service is extremely uneven.) Instructors normally assigned to other IPHE programs are loaned to the School as needed. Since this often involves evening work and extra work without extra pay, the situation is not ideal, but IPHE will have to continue to rely on this method of staffing the School until the permanent staff can be expanded as IPHE's new director is now attempting to do.\*

The better staffed COIF program is directed by a National COIF Coordinator with the assistance of eight provincial supervisors. All nine are full-time employees paid by IPHE. Teachers, especially in the metropolitan Panama City area, are usually provided by the Ministry of Education. When not available through this mechanism, as is usually the case in the areas outside of Panama City, teachers are sought through the "Plan de Urgencia", or volunteers are invited from among mothers in the community.

Instructors at IPHE, including those in the School for Parents and the COIF program, have had little or no training in the areas of sex education, family life education or family planning. Some have participated in APLAFA-sponsored activities and have a general awareness of these topics, but none have been trained in the techniques required in order to present and teach the subject matter. Under the Population II Project, training in the substance and methodology of sex education will be provided by the National Commission for Sex Education. Technical assistance will be provided, as needed, by APLAFA.

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\* Indicative of the School's strong interest in incorporating family planning and sex education into its curriculum is the School Director's recent efforts, assisted by a family planning education specialist, to develop plans for a series of courses covering both topics. On previous occasions she has sought assistance from APLAFA to collaborate in these areas, but with increasing requests from other public and private institutions, and because of its limited resources, APLAFA has not been able to commit itself to any long-term program with the School for Parents.

The Project will also provide IPHE with audio-visual equipment and other teaching aids such as family planning films and reference books on sex education and family planning. IPHE's physical plant - offices and classrooms - is limited but adequate, and it has sufficient vehicles - over 20 panel and pick-up trucks, sedans and a few motorcycles - all in good running condition. IPHE has its own mimeograph facilities and contracts other printing as needed.

In view of the limited scope and simplicity of the proposed sex education/family planning activity and the demonstrated institutional capabilities of IPHE and the two units which will participate in the Project, the Mission is confident that IPHE is well able to implement its portion of the Project without additional assistance except for the aforementioned training of teaching staff in sex education and family planning and provision of a limited amount of equipment and materials. Technical assistance will also be provided toward the end of the Project to help evaluate the effectiveness of family planning outreach through IPHE.

#### Contribution to the Project

The IPHE contribution to the Project will be in salaries of professionals attending sex education and family planning courses (special teachers, doctors, psychologists, psychiatrists, social workers, etc.) calculated at:

|                       |          |
|-----------------------|----------|
| \$250 x 227 x 1 month | \$56,750 |
|-----------------------|----------|

\*  

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The Panamanian Social Security Agency was created in 1941 as an autonomous public sector entity to provide retirement benefits and insure workers and their dependents for illnesses, maternity, funerals, and work-related accidents and illnesses. The well-managed, financially sound agency has five hospitals, 22 policlinics and sex clinics and assists the MOH with the operation and maintenance of integrated health centers and other facilities in provinces where integration is either complete or well advanced.

## FINANCIAL ANALYSIS

Part III, Financial Plan, presents the Overall Financial Plan for the Project and Projected Expenditures by Fiscal Year.

The following section is a description of the basis for AID-financed Project inputs by agency and the amounts required by year over the life of the Project.

### I. COSTING AND TIMING OF PROJECT INPUTS BY IMPLEMENTING AGENCY

#### A. Ministry of Health

The Ministry of Health will receive \$2,455,600 of the \$3,100,000 AID-financed Project. The current Project (525-0142) with the MOH expires in late FY 79. It is planned that some of the commodities identified below as "first year" requirements will be ordered late in FY 79 with expenditures beginning in FY 80. Funds are provided in FY 79 for a limited amount of I E & C printed materials and training to permit implementation of these components. Continued funding of one-year MOH contracts for mass media coverage begins September 1, 1979. Funds have been budgeted to continue this activity through the third quarter of FY 84.

The five-year Project begins with funding in FY 79 and terminates with funding in FY 83. Implementation, however, begins in late FY 79 and continues through the third quarter of FY 84. Funding in FY 83 provides for activities taking place in FY 83 and FY 84.

#### 1. Commodities

(a) Centrally Procured Commodities - AIDTO Circular A-126 dated May 11, 1979 provided guidance for completing FY 81 contraceptive procurement tables and STATE 116038 provided additional information on funding years, delivery years, and cost information. The quantities of pills and condoms derived by completing the information for the ABS and quantities of Lippes Loops needed for the program are shown in Annex X. Costs were increased by approximately 10% per year. The total funding for centrally procured commodities is \$820,000. FY 80 funds are \$114,800 which also include an identified shortfall of pills on hand at the end of FY 79. The FY 81 requirement is \$132,200; FY 82, \$284,200; and FY 83, \$288,800. The FY 82 and 83 increases assume AID will meet most of the contraceptive requirements for the public sector after the UNFPA project ends.

(b) Other Family Planning Commodities, which include diaphragms, foams, jellies and inserters, account for \$5,500, \$9,500, \$16,500, \$22,600 and \$26,900 for each of the five years. See Annex X for user rates. Current prices plus 10% inflation per year were used to cost this component. Diaphragm replacements every two years were also included.

(c) Copper T's which were ordered under the terminating Health and Population Project but were not deliverable until 1980, and were therefore cancelled, will be reordered under this Project. Additional Copper T's will be purchased to cover new requirements in year four. The budget is \$16,600.

(d) Family Planning Sterilization Equipment - This equipment is described in Annex IX. Current prices were used for costing, plus inflation and transportation costs. The total is estimated at \$160,000. This equipment will be ordered in the first year of the Project with staggered deliveries of approximately one third of the equipment arriving in each of the first three years.

(e) Family Planning Related Clinical Equipment is described in Annex IX. Under the terminating Health and Population Project, this type of equipment was ordered through a U.S. military installation in the Canal Zone. Its prices, understood to be more or less comparable to U.S. supplier prices, were used in calculating the cost of this component. Unit prices are based on current prices of equipment plus an inflation factor of 20% per year. An additional 14% is included for accessorial charges or, if the equipment is purchased through private U.S. suppliers, for transportation charges. Approximately 60% of the equipment will be ordered in the first year and 40% in the third year of the Project.

(f) The remaining equipment is in support of the I E & C component of this Project and includes audio visual equipment (\$35,000), films (\$16,000), mobile generators (\$6,000), and 14 vehicles budgeted at \$103,000. This equipment will be ordered in the first year of the Project.

(g) The MOH has requested desks, filing cabinets, typewriters and typing tables, chairs, adding machines and air conditioners. This office furniture and equipment will be ordered through the Excess Property Program at no cost; therefore no budget is presented.

## 2. Information, Education and Communication Activities

(a) Printing of 534,000 pamphlets, 2,764,500 folders, 44,100 posters and construction of seven new billboards for informing the public about family planning and contraceptive methods are budgeted at \$346,000, based on current I E & C contracts in Panama under Project 525-0142. Funding levels are \$15,000 for the first year; \$108,000 for

year two; \$102,000 for year three; \$69,000 for year four and \$52,000 for year five.

(b) Mass Media - Radio Contracts - The previous population project funded this same type of family planning/maternal-child health information campaign. The present Project will fund family planning information only and has been reduced from the previous levels and also reduced over the life of the Project. Funding is \$240,000, of which \$60,000 is available for each of the first two years; \$50,000 for year three; \$40,000 for year four and \$30,000 for year five.

### 3. Training

(a) Short-term<sup>training</sup>/abroad is budgeted at \$90,000 to provide for training of trainers in family planning and sex education; health professionals working in adolescent family planning and sex education; for specialists in communications and educational techniques; for physicians in technical aspects of family planning including sterilization; and for administrative personnel in logistics. Funds for observation trips in the U.S. or other countries are also included. The budget includes costs of per diem and airfare, although training may be provided by various agencies at a flat rate per person. The first year funding is \$10,000; \$35,000 for the second year; \$30,000 for the third year; \$10,000 for the fourth year; and \$5,000 for the fifth year.

(b) In-Country Training - Courses and seminars in family planning, sex education, program administration and human relations. This Project will fund participants' per diem or lunches in the case of local training, transportation, materials and renting a site for the courses. The budget is for \$10,000 in the first year of which \$7,000 is budgeted for training of MOH personnel in sex education; \$25,000 in the second year; and \$41,000 each year for the remaining three years of the Project for a total of \$158,000.

### 4. Studies and Evaluations

Two studies and evaluations on adolescents, two contraceptive prevalence studies, two continuing users surveys, ten "pre tests" in materials testing (two each year) and two case studies on men are contemplated under the Project. A total of \$266,000 is budgeted of which \$76,000 is for year two; \$31,000 for year three; \$56,000 for year four; and \$103,000 for year five.

### B. APLafa

The APLafa program is in Information, Education and Communication. It consists, first, of 225 courses of orientation and training in sex education and family planning for adolescents, 46 courses for parents and educators, and, second, resource development talks and 15 in-

stitutional level symposia on family planning for private businesses. AID will finance the cost of the speakers and educational materials. The total budget for this program is \$56,000 of which \$10,000 is budgeted for each of the first two years and \$12,000 for each of the remaining three years of the Project.

Third, the Project includes funding for APLAFA to coordinate and present courses in family planning and sex education to other organizations in the private sector such as, but not limited to, Confederación de Trabajadores de la República de Panamá (CTRP), and Federación de Cooperativas de Ahorro y Crédito de Panamá, R.L. (FEDPA). These organizations have requested that family planning and sex education courses be presented to their members. The budget provides \$40,000 for outreach to other organizations: \$12,000 in the second and third year; \$10,000 in year four and \$6,000 in year five.

Specific courses will be developed by APLAFA as requests are received.

#### C. Ministry of Education

The AID input to the Ministry of Education is in training of MOE personnel in sex education.

##### 1. Training

Total funding of \$455,000 for the life of the Project is for costs of training which include instructors' per diem, transportation, cost of participants transportation, food for participants and course materials. It is expected that 105 seminars in sex education will be held over the life of the Project to train 2,003 teachers. Funding for the training to start in FY 79 is \$4,000; FY 80, \$45,000; FY 81, \$74,300; FY 82, \$93,000; FY 83, \$186,200 which will fund the remaining seminars to be held in early CY 1984.

##### 2. Commodities

Audio visual equipment, films and books are funded at \$42,000. This equipment will be ordered in FY 79 and FY 80 in the amount of \$25,000 and \$17,000, respectively.

##### 3. Technical Assistance

Ten thousand dollars are budgeted for technical assistance in FY 80 for the sex education program.

#### D. IPHE

The program funded under this Project with IPHE will provide

\$93,400 for training sex educators. Costs are for training IPHE instructors, audio visual equipment to be used in the provinces for sex education/family planning courses, and evaluation.

1. Commodities

(a) Audio visual equipment as described in Annex IX totaling \$28,200 of which \$17,000 will be ordered in the first year and \$11,200 in the second year of the Project.

(b) Films on family planning are budgeted at \$8,000 and will be ordered in the first year of the Project.

(c) Reference books in family planning and sex education are budgeted at \$2,500 and will be ordered in the first year.

(d) Filing cabinets have been requested and will be provided through excess property.

2. Training

This component funds training of IPHE personnel in family planning and sex education in Panama City and in the interior. Costs are for per diem and transportation of the participants, course materials and technical assistance. The budget for the five years of the Project is as follows: Courses and TA costing \$17,700 in year two; \$11,300 in year three; \$7,000 in year four; and \$10,700 in year five.

3. Other

An evaluation of the program is expected in year five at a cost of \$8,000 for approximately one person month of a U.S. evaluation specialist.

II. BUDGET ANALYSIS AND COUNTERPART CALCULATION

This section presents a brief analysis of the MOH budget and the basis on which counterpart contributions from MOH, MOE and IPHE were developed. The contribution of APLAFA, a privately funded agency, is also discussed.

A. MOH Budget Analysis

The Ministry of Health's Maternal Child Health/Family Planning budgets for CY 1977, 1978 and 1979 are \$9.12 million, \$9.55 million and \$11.82 million, respectively. Salaries, overtime and temporary personnel account for 78%, 79% and 81% of the total budgets for CYs 1977, 1978 and 1979, respectively. The \$2.3 million increase between 1978 and 1979 was for salary increases to doctors, nurses

and laboratory technicians. Rent, basic services, printing, and general maintenance and repair account for 1% of the budget in each of the three years with general maintenance and repair being the single largest item. General expenses which include food, clothing, per diem and transport, gas and oil, materials and machines and equipment account for the remaining 21%, 20% and 18% of the budgets for CY 1977, 1978 and 1979, respectively. The MOH Maternal Child Health/Family Planning headquarters office plans to hire four additional persons: two in administration, one pediatrician and one nurse. The source of funding has not been disclosed by the MOH, and no counterpart contribution is shown.

## B. Host Country Counterpart

### 1. Ministry of Health

The MOH counterpart is in the form of salaries of personnel who are directly related to the Family Planning Project. These personnel include obstetricians/gynecologists, registered nurses, nurse auxiliaries, health educators, health assistants, personnel in the Office of the Director of Maternal Child Health/Family Planning Programs, and other administrative and clerical personnel such as secretaries and maintenance personnel.

Average salary ranges for these personnel multiplied by an estimated percentage of time spent in family planning activities multiplied by the number of personnel in a category results in approximately \$600,000 of direct salaries. This amount has been increased by 5% over the life of the Project and takes into account that the Project will begin in late FY 79 resulting in a counterpart contribution of \$3,399,000 in Family Planning Activities. The yearly breakout of this counterpart is FY 79, \$100,000; FY 80, \$630,000; FY 81, \$662,000; FY 82, \$695,000; FY 83, \$792,000 and FY 84, \$583,000. Additionally, personnel in the evaluation section of the MOH's Maternal Child Health/Family Planning department have been included at \$150,000 over the life of the Project for their work in evaluations and studies to be conducted as part of the Project.

AID will fund the costs of all Project-related training, travel, per diem, etc.; for this reason, no counterpart contribution is shown. Other counterpart costs are shown in the financial plan which include maintenance and repair of equipment, transportation costs of putting equipment in service centers and gas, oil and maintenance of vehicles.

A small amount of recurring costs are foreseen under the Project. It is assumed here that maintenance of equipment provided under the Project involves some replacement parts after the fifth year, as well as salaries of maintenance personnel. Using AID's six year, sixty thousand mile rule on vehicles, some costs will be incurred on maintaining the vehicles provided under the Project. With an \$11.8

MOH budget, these costs should be easily absorbed.\*

2. APLAFA

APLAFA's contribution is in administrative salaries for development, coordination and implementation of seminars and talks on family planning and related activities. APLAFA will also handle requests for family planning training from private sector organizations. APLAFA is funded by International Parenthood Foundation, Development Associates, CRESALC and FPIA; therefore no GOP counterpart is shown on the financial plan. It is estimated that APLAFA's contribution is at least \$25,000.

3. Ministry of Education

The Ministry of Education counterpart of \$1,335,600 to the Project will be in the form of salaries paid to the professional instructors presenting the sex education seminars and the salaries of teachers who attend the seminars. The seminars will be twenty workdays (one month of salary). The average salary of \$450 per month multiplied by the 1,967 teachers to be trained results in \$885,150 over the five years of the Project. Salaries for instructors average \$750 per month. There will be five instructors for each of the 105 seminars to be held and 36 instructors in one-month training before the seminars start. The total for five years is \$420,450. Salaries of personnel who develop material to be presented as well as secretarial, administrative assistant and clerical personnel salaries are also directly related to this Project. An additional \$30,000 over the life of the Project is estimated for these services.

No recurring or additional budget costs are foreseen as a result of this Project to the Ministry of Education as the instructors and teachers are already on the payroll of the Ministry of Education.

4. IPHE

The IPHE counterpart is calculated at \$57,000 for the life of the Project and is based on 227 people trained for 20 work days at an average salary of \$250 per month.

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\* It is assumed that external sources, including AID, will continue to provide contraceptive commodities beyond termination of the Project. The Mission in its 1981 ABS programmed \$200,000 per year for FYs 1984 and 85 for this purpose.

DEPARTMENT OF STATE  
AGENCY FOR INTERNATIONAL DEVELOPMENT  
WASHINGTON, D. C. 20523

LAC/DR-IEE-79-7

ASSISTANT  
ADMINISTRATOR

ENVIRONMENTAL THRESHOLD DECISION

Location : Panama, R.P.  
Project Title : Population II, 525-0204  
Funding : All years: \$2,500,000; First year (FY '79): \$345,000  
Life of Project: Five years

Mission Recommendation:

Based on the Initial Environmental Examination, the Mission has concluded that the project will not have a significant effect on the human environment and therefore recommends a Negative Determination.

The Latin America and the Caribbean Bureau's Development Assistance Executive Committee has reviewed the Initial Environmental Examination for this project and concurs in the Mission's recommendation for a Negative Determination.

AA/LAC Decision:

Pursuant to the authority vested in the Assistant Administrator for Latin America and the Caribbean under Title 22, Part 216.4a, Environmental Procedures, and based upon the above recommendation, I hereby determine that the proposed project is not an action which will have a significant effect on the human environment, and therefore, is not an action for which an Environmental Impact Statement or an Environmental Assessment will be required.

*Edward W. Lee*  
Assistant Administrator for  
Latin America and the Caribbean

Nov 15 1978  
Date

Clearances:

DAEC Chairman: MBrown MB  
LAC Environmental Advisor: RCOtto OTTO

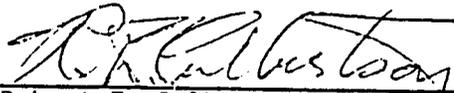
Initial Environmental Examination

Project Location: Panama, R. P.  
Project Title: Population II  
Funding: All years: \$2,500,000  
First year (FY79): \$345,000  
Life of Project: Five years

IEE Prepared by: Gene E. Stanley Date: Nov 20 1978

Environmental Action Recommended

Based on the findings of the following environmental examination, I recommend that the Population II Grant be given a Negative Determination requiring no further environmental review.

Concurrence:  Date: 11/30/78  
Robert E. Culbertson  
Mission Director

Assistant Administrator's Decision:

Signature: \_\_\_\_\_ Date : \_\_\_\_\_

## INITIAL ENVIRONMENTAL EXAMINATION

### PANAMA POPULATION II

#### I. Background

Although Panama's population growth rate has declined from 3.3% to 2.7% per annum over the past decade, current demographic shifts indicate that, without an effective family planning program, this decline in the growth rate will gradually cease.

Almost all organized family planning activities within the country are performed by two institutions: the Ministry of Health, which provides family planning services through a network of hospitals, health centers and subcenters and health posts; APLAFA, the IPPF affiliate, which provides services through two urban clinics in the Panama metropolitan area. The programs of these institutions are actively utilized by over 40% of the country's women in fertile age (70,000 active users) and appear to have made a significant contribution to the decline in the country's birth rate.

Now, however, with the median age of Panama's population at 18 and unusually large numbers of females continuing to enter the 15-19 age group,\* the rate of decline in the birth rate may begin to slow appreciably and hard-won gains of recent years begin to dissipate. Unfortunately, this rapid increase in the fecund young is occurring at the same time the country is apparently experiencing a declining rate of new acceptors in formally sponsored family planning programs -- despite indications disclosed in a recently published National Fertility Survey that Panama has an unsatisfied demand for family planning services.

In view of the country's zero economic growth rate since 1974 and limited physical resource base, failure to reduce the current population growth rate will hinder efforts to achieve better socio-economic conditions. Government attempts to supply jobs, housing and social services to a larger share of the population will be thwarted and the country's physical resource base, upon which a large share of the poorer population is economically dependent, will be increasingly overburdened.

#### II. Project Description

The purpose of the Project is to expand the delivery of family planning information and services to a higher proportion of the fertile age group in Panama. To achieve this objective, the Project will (a) continue Mission support of the successful family planning activities

\*Beginning in 1972, as a result of a period of high fertility in the early 1960's in Panama, a disproportionately large number of young women have entered into the fertile age group annually, now accounting for 20% of all births and 17% of all abortion hospitalizations. Teenagers, as a percentage of the fertile population, are expected to increase until at least 1980.

- 2 -

of the Ministry of Health and (b) begin supporting institutions outside the health sector whose activities will expand family planning coverage beyond that provided by the Ministry of Health. The Project will focus on making family planning services accessible to those poorer segments of the population -- in particular, women 15-19 years of age and rural women and men -- who cannot afford to purchase services in the private sector. The Project should enable recruitment of an additional 100,000 new family planning acceptors by 1983 and a corresponding decline in the population growth rate of approximately 0.1% per year (reaching 2.2% in 1983).

The Project will assist the Ministry of Health to continue and expand family planning information and services to the public by financing contraceptives, training, family planning-related medical equipment, technical assistance, and informational and educational activities. In order to extend family planning coverage beyond the MOH system, the Project will continue support to APLAFA (for continuation of its clinical services and establishment of an adolescent center for low-income urban youth, condom vending machines, and research on adolescent fertility) and initiate assistance to such entities as: the Ministry of Education (for establishment of a program of secondary school sex education); the Ministry of Planning (for assistance to its recently established demographic unit); professional medical associations (for special family planning seminars); and rural cooperatives, labor unions, and agricultural and home economics groups (for informational programs on family planning). The Project will also provide for a secondary analysis of the National Fertility Survey and a nationwide survey of the prevalence of illegally induced abortion, and will encourage greater sensitivity among Panamanian policy makers to the development implications of rapid population growth.

### III. Impact Identification and Evaluation

The Project should have no direct impacts on Panama's physical environment (land, soils, water, air). However, over the long term, the Project's activities will indirectly help to preserve the country's limited physical resource base by reducing the population growth rate and thereby reducing possibilities of future adverse stress, due to overpopulation, on land, water, wild-life and other natural resources.

In terms of cultural and socio-economic factors, the Project will have many direct beneficial impacts. The population's demand for family planning services will be better satisfied as more people will have access to such services. The health status of women should improve because hyperfertility and illegally induced abortions, significant causes of poor physical and mental health and even loss of life, should be reduced as women are provided with greater access to family planning information and services. In addition, women's educational and economic status may be

improved through the reduction of early, often unwanted, pregnancies which tend to circumscribe women's options early on.

Finally, further reduction in the birth rate, the Project's goal, will indirectly have a beneficial impact on the socio-economic status of Panama's population: a smaller population will exert less demand on scarce national resources, better enabling the Government to provide adequate public services to its people, while at the same time permitting increased investment in non-social welfare aspects of development. The attached Impact Identification and Evaluation form provides a summary of these impacts.

IV. Summary and Recommendations

The Project should produce no foreseeable negative impacts on the natural and human environment and, in fact, should cause some long term beneficial impacts in terms of social well-being and economic growth. Thus, this initial environmental examination recommends that the Project be given a Negative Determination.

IMPACT IDENTIFICATION AND EVALUATION FORM

Impact Identification  
and Evaluation

Impact Areas and Sub-Areas

A. LAND USE

1. Changing the character of the land through:
  - a. Increasing the population ----- L+
  - b. Extracting Natural Resources ----- L+
  - c. Land clearing ----- L+
  - d. Changing soil character ----- L+
2. Altering natural defenses ----- L+
3. Foreclosing important uses ----- L+
4. Jeopardizing man or his works ----- N
5. Other factors  
-----  
-----

B. WATER QUALITY

1. Physical state of water ----- L+
2. Chemical and biological states ----- L+
3. Ecological balance ----- L+
4. Other factors  
-----  
-----

C. ATMOSPHERIC

|                          |           |
|--------------------------|-----------|
| 1. Air Additives -----   | <u>L+</u> |
| 2. Air Pollution -----   | <u>L+</u> |
| 3. Noise Pollution ----- | <u>L+</u> |
| 4. Other Factors         |           |
| _____                    | _____     |
| _____                    | _____     |

D. NATURAL RESOURCES

|  |           |
|--|-----------|
| 1. Diversion, altered use of water -----       | <u>L+</u> |
| 2. Irreversible, inefficient commitments ----- | <u>L+</u> |
| 3. Other factors                               |           |
| _____  | _____     |
| _____  | _____     |

E. CULTURAL

|  |          |
|--|----------|
| 1. Altering physical symbols -----       | <u>N</u> |
| 2. Dilution of cultural traditions ----- | <u>N</u> |
| 3. Other factors                         |          |
| _____                                    | _____    |
| _____                                    | _____    |

F. SOCIOECONOMIC

|  |           |
|--|-----------|
| 1. Changes in economic/employment patterns ----- | <u>L+</u> |
| 2. Changes in population -----                   | <u>L+</u> |
| 3. Changes in cultural patterns -----            | <u>N</u>  |
| 4. Other factors                                 |           |
| _____  | _____     |
| _____  | _____     |

G. HEALTH

|   |                               |
|---|-------------------------------|
| 1. Changing a natural environment -----               | <u>          N          </u>  |
| 2. Eliminating an ecosystem element -----             | <u>          N          </u>  |
| 3. Other factors                                      |                               |
| <u>Reducing hyperfertility and illegally induced</u>  |                               |
| <u>abortions, significant causes of poor physical</u> | <u>          M+          </u> |
| <u>and mental health in women.</u>                    |                               |

H. GENERAL

|                                 |                              |
|---------------------------------|------------------------------|
| 1. International impacts -----  | <u>          N          </u> |
| 2. Controversial impacts -----  | <u>          N          </u> |
| 3. Larger program impacts ----- | <u>          N          </u> |
| 4. Other factors                |                              |
| _____                           | _____                        |
| _____                           | _____                        |

I. OTHER POSSIBLE IMPACTS (not listed above)

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |

Explanation of codes:

- N- No environmental impact
- L- Little environmental impact
- M- Moderate environmental impact
- H- High environmental impact
- U- Unknown environmental impact
- ± Positive impact on the environment
- Negative impact on the environment

FAMILY PLANNING STERILIZATION EQUIPMENT (Min.of Health)

| <u>Description</u>  | <u>Quantity</u> | <u>Cost<br/>Per Unit</u> | <u>Total Price</u> |
|---|-----------------|--------------------------|--------------------|
| 1. Medical Kit #1 - DIU insertion   | 500             | 75.00                    | 37,500             |
| 2. Medical Kit #3 - Dysfunctional<br>Uterine Bleeding                       | 50              | 125.00                   | 6,250              |
| 3. Medical Kit #5 - Vasectomy   | 100             | 100.00                   | 10,000             |
| 4. Medical Kit #6 - Vaginal Tubal Ligation                                  | 52              | 120.00                   | 6,240              |
| 5. Medical Kit #8-A Tubal Ligation/Minilap                                  | 150             | 150.00                   | 22,500             |
| 6. Medical Kit #8-B Hookand Elevator (packed)                               | 100             | 25.00                    | 2,500              |
| 7. Minilaparatomy System-Short-grip<br>aplicator with fiber optics (001097) | 15              | 420.00                   | 6,300              |
| 8. Minilap System Complete (000979)   | 50              | 600.00                   | 30,000             |
| 9. Short grip aplicator with out fiber<br>optics (001114)                   | 10              | 370.00                   | 3,700              |
| 10. Falope ring band guide Kit (000879-501)                                 | 100             | 21.00                    | 2,100              |
| 11. Laproscator TM W/O Anesthesia   | 5               | 3,300.00                 | 16,500             |
| 12. Laparascopios   | 3               | 5,000.00                 | 15,000             |
| Total   |                 |                          | <u>158,590</u>     |

FAMILY PLANNING RELATED CLINICAL EQUIPMENT\*

| <u>Description</u>                       | <u>Quantity</u> | <u>Cost<br/>Per Unit</u> | <u>Total Price</u>      |
|--|-----------------|--------------------------|-------------------------|
| 1. Wash basins                           | 50              | 9.00                     | 450.00                  |
| 2. Surgical dressing jar                 | 50              | 8.00                     | 240.00                  |
| 3. Floor light                           | 25              | 28.00                    | 700.00                  |
| 4. Surgical stand light                  | 5               | 1,150.00                 | 5,750.00                |
| 5. Wash basin stands                     | 50              | 71.00                    | 3,550.00                |
| 6. Table, surgical instrument            | 50              | 135.00                   | 6,750.00                |
| 7. Stool, revolving                      | 50              | 66.00                    | 3,300.00                |
| 8. Table, examining                      | 14              | 430.00                   | 6,020.00                |
| 9. Tray, instrument w/cover              | 75              | 7.00                     | 525.00                  |
| 10. Curette, uterine, Rome #4            | 50              | 8.00                     | 400.00                  |
| 11. Curette, uterine, Maleable #4        | 50              | 8.00                     | 400.00                  |
| 12. Forceps, gauze, 10", str.            | 100             | 10.00                    | 1,000.00                |
| 13. Forceps, Hemostatic, curve 5-1/2"    | 400             | 2.00                     | 800.00                  |
| 14. Forceps, Hemostatic, curve, Kelly 7" | 400             | 9.00                     | 3,600.00                |
| 15. Jar, surgical needles 7"             | 100             | 4.00                     | 400.00                  |
| 16. Jar, surgical, needles 5-1/2"        | 100             | 4.00                     | 400.00                  |
| 17. Retractors, rigid - sets of 2        | 100             | 5.00                     | 500.00                  |
| 18. Speculum, vaginal, large             | 400             | 6.00                     | 2,400.00                |
| 19. Pad, operating table                 | 15              | 8.30                     | 124.50                  |
| 20. Speculum, vaginal, small             | 600             | 5.00                     | 3,000.00                |
| 21. Gloves, medium #7-1/2 - set of 2     | 500             | 3.00                     | 1,500.00                |
| 22. Gloves, large #8 - set of 2          | 500             | 3.00                     | 1,500.00                |
| 23. Gloves, small #7 - set of 2          | 500             | 3.00                     | 1,500.00                |
| 24. Electro cauterizer                   | 40              | 3.00                     | 1,200.00                |
| 25. Forceps, Biopsy, cervical            | 50              | 37.00                    | 1,850.00                |
| 26. Curette, Endom. biopsy               | 50              | 6.00                     | 3,300.00                |
| 27. PAP Smear Slides (boxes)             | 500             | 4.00                     | 2,000.00                |
| 28. Scrapers, Ayre (boxes)               | 500             | 5.00                     | 2,500.00                |
| 29. Cito-spray (bottles)                 | 1,000           | 3.00                     | 3,000.00                |
| 30. Portable Slide Tray                  | 500             | 2.00                     | 1,000.00                |
| 31. Stethoscope, adult, binocular        | -               | -                        | -                       |
| <b>Total</b>                             |                 |                          | <b><u>79,785.00</u></b> |

\*For the Ministry of Health

FAMILY PLANNING RELATED CLINICAL EQUIPMENT (VASECTOMY)

| <u>A. FURNITURE</u>    | <u>DESCRIPTION</u>                               | <u>QUANT.</u> | <u>ESTIM/COST<br/>PER UNIT</u> | <u>TOTAL<br/>COST</u> |
|------------------------|--|---------------|--------------------------------|-----------------------|
| 1.                     | Table operating                                  | 1             | \$ 489.-                       | \$ 489.-              |
| 2.                     | Stretchers                                       | 1             | 850.-                          | 850.-                 |
| 3.                     | Lamps, goose neck                                | 1             | 28.                            | 28.                   |
| 4.                     | Electro cauterizing apparatus (complete)         | 1             | 50.-                           | 50.                   |
| 5.                     | Cords, for e/cauterizing apparatus               | 2             | 15.-                           | 30.                   |
| 6.                     | Tables, examining                                | 2             | 450.                           | 900.                  |
| 7.                     | tables, with wheels (or carts)                   | 2             | 300.-                          | 600.                  |
| 8.                     | Cabinets for equipment, instruments              | 2             | 400.-                          | 800.00                |
| 9.                     | Pail, stand                                      | 2             | 75.00                          | 150.00                |
| 10.                    | Stand with basins                                | 2             | 60.00                          | 120.00                |
| 11.                    | Table, for instruments                           | 1             | 250.00                         | 250.00                |
| 12.                    | Stands,  | 2             | 20.00                          | 40.00                 |
| 13.                    | Microscope, binocular                            | 1             | 900.00                         | 900.00                |
| 14.                    | Sphignomanometer, desk                           | 1             | 33.00                          | 33.00                 |
| 15.                    | Basins, for soiled clothes                       | 2             | 10.00                          | 20.00                 |
| 16.                    | Cart, with wheels                                | 1             | 200.00                         | 200.00                |
| 17.                    | Cart, for soiled clothes                         | 1             | 50.00                          | 50.00                 |
| 18.                    | stools, revolving, chrome                        | 3             | 66.00                          | 198.00                |
| 19.                    | Refrigerator                                     | 1             | 350.00                         | <u>350.00</u>         |
| SUB TOTAL              |  |               |                                | 6,058.00              |
| <u>B° INSTRUMENTS:</u> |  |               |                                |                       |
| 20.                    | Forceps, hemostatic, mosquito, curv. 5"          | 60            | 5.00                           | 300.00                |
| 21.                    | Forceps, hemostatic, curv. 5-1/2"                | 36            | 3.00                           | 98.00                 |
| 22.                    | Forceps, hemostatic, straight, 5-1/2"            | 12            | 4.00                           | 60.00                 |
| 23.                    | Forceps, Rochester-Pean Crv. 6-1/4"              | 24            | 10.00                          | 240.00                |
| 24.                    | Forceps, Rochester-Ochsner, crv. 6-1/4"          | 12            | 10.00                          | 120.00                |
| 25.                    | Forceps, Rochester-Oschner, curv. 7-1/4"         | 18            | 10.00                          | 180.00                |
| 26.                    | Forceps, Allix 4 x 5 6-1/4"                      | 36            | 3.00                           | 98.00                 |
| 27.                    | Forceps, hold. straight 7"                       | 18            | 9.00                           | 162.00                |
| 28.                    | Forceps, Bachaus 3 1/4"                          | 36            | 5.00                           | 280.00                |
| 29.                    | Forceps, hold, needles 5 1/2"                    | 12            | 3.00                           | 36.00                 |
| 30.                    | Scissors, surgery, curv. 5-1/2"                  | 12            | 3.00                           | 36.00                 |
| 31.                    | Scissors, surgery, straight, 5-1/2"              | 6             | 7.00                           | 42.00                 |
| 32.                    | Forceps, dissecting, addison w teeth 4-1/2"      | 6             | 3.00                           | 18.00                 |
| 33.                    | Forceps, dissecting, Addison, w/out teeth 4 1/2" | 6             | 3.00                           | 18.00                 |
| 34.                    | Forceps, dissecting 1 x 2 5"                     | 12            | 5.00                           | 60.00                 |
| 35.                    | Forceps, dissecting w/out teeth 5"               | 6             | 3.00                           | 18.00                 |
| 36.                    | Scissors, guze, L, ster 5-1/2"                   | 6             | 5.00                           | 30.00                 |
| 37.                    | Holder, #4                                       | 6             | 4.00                           | 24.00                 |
| 38.                    | Holder, #3                                       | 6             | 4.00                           | 24.00                 |
| 39.                    | Test tubes, 7"                                   | 6             | 1.00                           | 6.00                  |
| 40.                    | Sounds, 6"                                       | 6             | 1.00                           | 6.00                  |
| 41.                    | glasses, 2 oz. chrome                            | 12            | 3.00                           | 36.00                 |
| 42.                    | Basins, emesis, small                            | 12            | 4.00                           | 48.00                 |

B. INSTRUMENTS (Contd.)

|     | <u>DESCRIPTION</u>                  | <u>QUANT.</u> | <u>ESTIM/COST</u><br><u>°PER UNIT</u> | <u>TOTAL</u><br><u>COST</u> |
|-----|-------------------------------------|---------------|---------------------------------------|-----------------------------|
|     |                                     |               | b/forward.....                        | 8,108.00                    |
| 43. | Trays, with cover 12-3/4"x6-3/4"x4" | 1             | 10.00                                 | \$ 10.00                    |
| 44. | Minor surgery, set                  | 1             | 100.00                                | 100.00                      |
| 45. | Retractors, Mayo 8-1/2" x 5/8"      | 12            | 10.00                                 | 120.00                      |
| 46. | Separators, Weithaner               | 6             | 10.00                                 | 60.00                       |
| 47. | Jars, s/steel 6 oz.                 | 18            | 10.00                                 | 180.00                      |
| 48. | Flasks, 500 cc                      | 6             | 1.00                                  | 6.00                        |
| 49. | Flasks, 1,500 cc.                   | 6             | 1.00                                  | 6.00                        |
|     |                                     |               |                                       | <hr/>                       |
|     |                                     | TOTAL:        |                                       | \$8,590.00                  |
|     |                                     |               |                                       | =====                       |

TRANSPORTATION EQUIPMENT\*

| <u>Descriptions</u>  | <u>Quantity</u> | <u>Cost<br/>Per Unit</u> | <u>Total Price</u>    |
|--|-----------------|--------------------------|-----------------------|
| 1. Jeep, 4 Wheel Drive, 6 cylinder                             | 3               | 7,520.00                 | 22,560.00             |
| 2. Jeep, 4 Wheel Drive, 4 cylinder<br>(audio-visual equipment) | 10              | 6,000.00                 | 60,000.00             |
| 3. Truck, stake body 10 ton (Dist. mat.)                       | 1               | 20,000.00                | <u>20,000.00</u>      |
|  |                 |                          | B/. <u>102,560.00</u> |

ELECTRICAL EQUIPMENT \*

|                          |    |        |                     |
|--------------------------|----|--------|---------------------|
| 1. Generator, 1000 watts | 10 | 600.00 | <u>6,000.00</u>     |
| Total                    |    |        | B/. <u>6,000.00</u> |

AUDIO-VISUAL EQUIPMENT \*

|  |    |        |                      |
|--|----|--------|----------------------|
| 1. Movie Projector Bell & Howell, 16mm,<br>Model 545   | 25 | 590.00 | 14,750.00            |
| 2. Slide Projector Kodak Ektagraphic-<br>Carrousel, Model 600  | 15 | 130.00 | 1,950.00             |
| 3. Slide Projector Kodak Ektagraphic-<br>Carrousel, Model 850-H, Automatic   | 2  | 260.00 | 520.00               |
| 4. Sound Equipment TOA, Mod-MA-220-<br>Columnar Type 15 w. - 2 micro-shure<br>Mod-515-S Mod.-520 SL Micro-stand<br>Model MS 10-C-S 53B | 9  | 775.00 | 6,975.00             |
| 5. Sound Equipment: Amplifier, speakers,<br>microf.  | 10 | 634.00 | 6,340.00             |
| 6. Retroprojectors   | 3  | 225.00 | 675.00               |
| 7. Spare Parts   | -  | --     | 2,310.00             |
| 8. Screens   | 20 | 74.00  | <u>1,480.00</u>      |
| Total  |    |        | B/. <u>35,000.00</u> |

\*For the Ministry of Health

MINISTERIO DE EDUCACION - EQUIPO AUDIOVISUAL

| DESCRIPCION   | UNI-<br>DAD | COSTO<br>UNITARIO | COSTO<br>TOTAL |
|---|-------------|-------------------|----------------|
| Proyector de Cine 16m.m. Sonoro (Optico)<br>110-120 voltios 50/60 H2            | 10          | 590.00            | 5,900.00       |
| Pantalla de Cine Portátil<br>1.78 x 1.78  | 10          | 75.00             | 750.00         |
| Proyector de diapositiva<br>(Carrusei) 35 m.m. 110/120 v.                       | 10          | 260.00            | 2,600.00       |
| Bandejas para proyector de diapositivas   | 10          | 65.00             | 650.00         |
| Retroproyector 110-120 v.   | 10          | 450.00            | 4,500.00       |
| Proyectores de diapositivas de batería  | 10          | 27.00             | 270.00         |
| Amplificadores Portátiles de<br>Baterías y Eléctricos                           | 10          | 650.00            | 6,500.00       |
| Equipo de sonido de mesa: Amplificador<br>100 watts de salida por canal 8 ohms. | 10          | 510.00            | 5,100.00       |
| Bocinas para el amplificador (4 para c/u)<br>300 watts - 4 vías woofer Tweeter  | 10          | 450.00            | 4,500.00       |
| Micrófonos Unidireccional 50-14000 H <sub>2</sub><br>200 ohms.                  | 10          | 78.00             | 780.00         |
| Radio Cassettes 21 bandas Am-Fm   | 20          | 125.00            | 2,500.00       |
| Cassettes de 60 y 90  | 1000        | 1.50              | 1,500.00       |

| DESCRIPCION                        | UNI-<br>DAD | COSTO<br>UNITARIO | COSTO<br>TOTAL |
|------------------------------------|-------------|-------------------|----------------|
| Accesorios y Repuestos e Inflación |             |                   | 2,000.00       |
| Libros y Films                     |             |                   | 4,450.00       |
| TOTAL                              |             |                   | 42,000.00      |

Audio Visual Equipment for IPHE

| <u>Description</u>  | <u>Quantity</u>          | <u>Unit Price</u> | <u>Total Cost</u> |
|---|--------------------------|-------------------|-------------------|
| Cinema Projector (16 mm.)   | 12                       | \$ 590.00         | \$7,080.00        |
| Slide Projectos, Kodak 600  | 12                       | 130.00            | 1,560.00          |
| Retroprojector  | 1                        | 260.00            | 260.00            |
| Sound Equipment toa-MA-220<br>2 microphones 15W, microphone stand | 12                       | 775.00            | 9,300.00          |
| Cinema Projector  | 12                       | 708.00            | 8,500.00          |
| Radio Casette   | 12                       | 125.00            | <u>1,500.00</u>   |
|   | Total                    |                   | \$28,200.00       |
| Other IPHE Material:  |                          |                   |                   |
| Books   |                          |                   | 2,500.00          |
| Films   |                          |                   | <u>8,000.00</u>   |
|   | Grand Total of Equipment |                   | \$38,700.00       |

FY-1981 AIS  
COUNTRY: PANAMA

Table I'

EXHIBIT I

Program Analysis of Oral and Condom Supplies

|   | CALENDAR YEAR |         |         |           |           |           |           |
|---|---------------|---------|---------|-----------|-----------|-----------|-----------|
|   | 1978          | 1979    | 1980    | 1981      | 1982      | 1983      | 1984      |
| <b>A. Annual Stock Requirements</b>   |               |         |         |           |           |           |           |
| 1. Married Women of Reproductive Age - MWRA (See Annex A)                                   | 416,760       | 430,255 | 443,786 | 458,035   | 472,314   | 486,281   | 501,247   |
| 2. Desired annual country contraceptive availability/use level as a percent of MWRA         |               |         |         |           |           |           |           |
| a. Orals (not less than 10 percent)   | 12.3          | 14.0    | 15.7    | 17.4      | 16.1      | 20.8      | 22.5      |
| b. Condoms (not less than 10 percent)   | 0.5           | 1.5     | 1.7     | 2.0       | 2.4       | 2.9       | 3.5       |
| 3. Annual country stock requirement to satisfy desired contraceptive availability/use level |               |         |         |           |           |           |           |
| a. Orals - line A2a x line A1 x 12 monthly cycles   | 666,400       | 783,100 | 905,800 | 1,036,100 | 1,172,800 | 1,314,900 | 1,466,100 |
| b. Condoms - line A2b x line A1 x 100 pieces  | 208,400       | 645,400 | 754,400 | 916,100   | 1,133,600 | 1,410,200 | 1,754,400 |
| <b>II. Annual New Supply From Non-AID Bilateral Sources</b>                                 |               |         |         |           |           |           |           |
| 1. Private Commercial Sector  |               |         |         |           |           |           |           |
| a. Orals  | 353,000       | 365,700 | 377,200 | 389,300   | 401,500   | 413,300   | 426,100   |
| b. Condoms  | 140,000       | 146,300 | 150,900 | 155,700   | 160,500   | 165,300   | 170,400   |
| 2. Other Donors   |               |         |         |           |           |           |           |
| a. Orals  | -0-           | 144,700 | 331,400 | 312,600   | 288,600   | -0-       | -0-       |
| b. Condoms  | -0-           | -0-     | -0-     | 365,900   | 388,500   | -0-       | -0-       |
| 3. Host Country Government Procurement  |               |         |         |           |           |           |           |
| a. Orals  | -0-           | -0-     | -0-     | -0-       | -0-       | -0-       | -0-       |
| b. Condoms  | -0-           | -0-     | -0-     | -0-       | -0-       | -0-       | -0-       |
| 4. Total New Supply   |               |         |         |           |           |           |           |
| a. Orals (B1a + B2a + B3a)  |               | 510,400 | 708,600 | 701,900   | 690,100   | 413,300   | 426,100   |
| b. Condoms (B1b + B2b + B3b)  |               | 146,310 | 150,900 | 521,600   | 549,000   | 165,300   | 170,400   |

Table 2

EXHIBIT II

Logistic Analysis of Orals and Condoms

| A. <u>Inventory Analysis - ORALS (thousand H/C)</u>                   | <u>Calendar Year</u> |                  |                    |                    |                    |
|---|----------------------|------------------|--------------------|--------------------|--------------------|
|   | <u>1979</u>          | <u>1980</u>      | <u>1981</u>        | <u>1982</u>        | <u>1983</u>        |
| 1. Beginning of Year Stock  |                      |                  |                    |                    |                    |
| a. AID Bilateral Supply   | <u>489,500</u>       | <u>632,800</u>   |                    |                    |                    |
| b. Other Sources of Supply  | <u>353,000</u>       |                  | <u>518,050</u>     | <u>586,350</u>     | <u>657,450</u>     |
| 2. Add: New Supply  |                      |                  |                    |                    |                    |
| a. AID Bilateral Supply Requirement*                                  | <u>+ 63,000</u>      | <u>+182,450</u>  | <u>+402,500</u>    | <u>+553,800</u>    | <u>+977,200</u>    |
| b. Other Sources of Supply<br>(See H4a of Table 1)                    | <u>+510,400</u>      | <u>+708,600</u>  | <u>+701,900</u>    | <u>+690,100</u>    | <u>+413,300</u>    |
| 3. Less: Contraceptive Availability/Use<br>Level (See A3a of Table 1) | <u>-783,100</u>      | <u>-905,800</u>  | <u>- 1,036,100</u> | <u>- 1,172,800</u> | <u>- 1,314,900</u> |
| 4. End of Year Stock  | <u>632,800</u>       | <u>518,050</u>   | <u>586,350</u>     | <u>657,450</u>     | <u>733,050</u>     |
| <br>  |                      |                  |                    |                    |                    |
| B. <u>Inventory Analysis - CONDOMS (thousand pieces)</u>              | <u>Calendar Year</u> |                  |                    |                    |                    |
|   | <u>1979</u>          | <u>1980</u>      | <u>1981</u>        | <u>1982</u>        | <u>1983</u>        |
| 1. Beginning of Year Stock  |                      |                  |                    |                    |                    |
| a. AID Bilateral Supply   | <u>354,774</u>       |                  |                    |                    |                    |
| b. Other Sources of Supply  | <u>140,000</u>       | <u>432,784</u>   | <u>458,050</u>     | <u>566,800</u>     | <u>705,100</u>     |
| 2. Add: New Supply  |                      |                  |                    |                    |                    |
| a. AID Bilateral Supply Requirement*                                  | <u>+ -0-</u>         | <u>+ 628,766</u> | <u>+ 503,250</u>   | <u>+ 722,900</u>   | <u>+1,417,000</u>  |
| b. Other Sources of Supply<br>(See H4b of Table 1)                    | <u>+146,310</u>      | <u>+ 150,900</u> | <u>+ 521,600</u>   | <u>+549,000</u>    | <u>+ 165,300</u>   |
| 3. Less: Contraceptive Availability/Use<br>Level (See A3b of Table 1) | <u>- 208,300</u>     | <u>- 754,400</u> | <u>- 916,100</u>   | <u>- 1,133,600</u> | <u>- 1,410,200</u> |
| 4. End of Year Stock  | <u>432,784</u>       | <u>458,050</u>   | <u>566,800</u>     | <u>705,100</u>     | <u>877,200</u>     |

\* See Annex B for AID bilateral shipments for 1979. The quantities confirmed for shipment for part of 1980 should be supplemented to ensure a total end of year stock which approximates the expected contraceptive availability/use level for 1981.

FY 1981 AHS  
COUNTRY: PANAMA

WORKSHEET FOR CALCULATION OF ORAL REQUIREMENTS 1980-1983

EXHIBIT III

| <u>1980</u>  |                  | <u>1982</u>  |                    |
|--|------------------|--|--------------------|
| 1. Beginning of year stock (carried forward from end of year stock of previous year - 1979 - and includes both AID and non-AID commodities; see line A4 of Table 2). | 432,784          | 1. Beginning of year stock (carried forward from end of year stock of previous year - 1981 - and includes both AID and non-AID commodities; see line A4 of Table 2). | 566,800            |
| plus   |                  | plus   |                    |
| 2. Non-AID new supply for the year (see B4a of Table 1).   | + 150,900        | 2. Non-AID new supply for the year (see B4a of Table 1).   | + 549,000          |
| minus  |                  | minus  |                    |
| 3. Total expected use - both bilateral and other programs (see contraceptive availability/use level, line A3a of Table 1).   | - 754,400        | 3. Total expected use - both bilateral and other programs (see contraceptive availability/use level, line A3a of Table 1).   | - 1,133,600        |
| minus  |                  | minus  |                    |
| 4. Desired end of year stock (equivalent to <u>50%</u> contraceptive availability/use level for subsequent year, line A3a of 1981 column of Table 1).                | - 458,050        | 4. Desired end of year stock (equivalent to <u>50%</u> contraceptive availability/use level for subsequent year, line A3a of 1983 column of Table 1).                | - 705,100          |
| equals   |                  | equals   |                    |
| 5. Total AID bilateral requirement for 1980  | <u>= 628,766</u> | 5. Total AID bilateral requirement for 1982  | <u>= 722,900</u>   |
| <u>1981</u>  |                  | <u>1983</u>  |                    |
| 1. Beginning of year stock (carried forward from end of year stock of previous year - 1980 - and includes both AID and non-AID commodities; see line A4 of Table 2). | 458,050          | 1. Beginning of year stock (carried forward from end of year stock of previous year - 1982 - and includes both AID and non-AID commodities; see line A4 of Table 2). | 705,100            |
| plus   |                  | plus   |                    |
| 2. Non-AID new supply for the year (see B4a of Table 1).   | + 521,600        | 2. Non-AID new supply for the year (see B4a of Table 1).   | + 165,300          |
| minus  |                  | minus  |                    |
| 3. Total expected use - both bilateral and other programs (see contraceptive availability/use level, line A3a of Table 1).   | - 916,100        | 3. Total expected use - both bilateral and other programs (see contraceptive availability/use level, line A3a of Table 1).   | - 1,410,200        |
| minus  |                  | minus  |                    |
| 4. Desired end of year stock (equivalent to <u>50%</u> contraceptive availability/use level for subsequent year, line A3a of 1982 column of Table 1).                | - 566,800        | 4. Desired end of year stock (equivalent to <u>50%</u> contraceptive availability/use level for subsequent year, line A3a of 1984 column of Table 1).                | - 877,200          |
| equals   |                  | equals   |                    |
| 5. Total AID bilateral requirement for 1981  | <u>= 503,250</u> | 5. Total AID bilateral requirement for 1983  | <u>= 1,417,000</u> |

FY 1981 AID  
COUNTRY: PANAMA

WORKSHEET FOR CALCULATION OF COMMOD REQUIREMENTS 1980-1983

EXHIBIT IV

| <u>1980</u>  |             | <u>1982</u>  |             |
|--|-------------|--|-------------|
| 1. Beginning of year stock (carried forward from end of year stock of previous year - 1979 - and includes both AID and non-AID commodities: see line B4 of Table 2). | 632,800     | 1. Beginning of year stock (carried forward from end of year stock of previous year - 1981 - and includes both AID and non-AID commodities: see line B4 of Table 2). | 586,350     |
| plus   |             | plus   |             |
| 2. Non-AID new supply for the year (see B4b of Table 1).   | + 708,600   | 2. Non-AID new supply for the year (see B4b of Table 1).   | + 690,100   |
| minus  |             | minus  |             |
| 3. Total expected use - both bilateral and other programs (see contraceptive availability/use level, line A3b of Table 1).   | - 905,800   | 3. Total expected use - both bilateral and other programs (see contraceptive availability/use level, line A3b of Table 1).   | - 1,172,800 |
| minus  |             | minus  |             |
| 4. Desired end of year stock (equivalent to <u>50%</u> contraceptive availability/use level for subsequent year, line A3b of 1981 column of Table 1).                | - 518,050   | 4. Desired end of year stock (equivalent to <u>50%</u> contraceptive availability/use level for subsequent year, line A3b of 1983 column of Table 1).                | - 657,450   |
| equals   |             | equals   |             |
| 5. Total AID bilateral requirement for 1980  | = 82,450    | 5. Total AID bilateral requirement for 1982  | = 553,800   |
| <u>1981</u>  |             | <u>1983</u>  |             |
| 1. Beginning of year stock (carried forward from end of year stock of previous year - 1980 - and includes both AID and non-AID commodities: see line B4 of Table 2). | 518,050     | 1. Beginning of year stock (carried forward from end of year stock of previous year - 1982 - and includes both AID and non-AID commodities: see line B4 of Table 2). | 657,450     |
| plus   |             | plus   |             |
| 2. Non-AID new supply for the year (see B4b of Table 1).   | + 701,900   | 2. Non-AID new supply for the year (see B4b of Table 1).   | + 413,300   |
| minus  |             | minus  |             |
| 3. Total expected use - both bilateral and other programs (see contraceptive availability/use level, line A3b of Table 1).   | - 1,036,100 | 3. Total expected use - both bilateral and other programs (see contraceptive availability/use level, line A3b of Table 1).   | - 1,314,900 |
| minus  |             | minus  |             |
| 4. Desired end of year stock (equivalent to <u>50%</u> contraceptive availability/use level for subsequent year, line A3b of 1982 column of Table 1).                | - 586,350   | 4. Desired end of year stock (equivalent to <u>50%</u> contraceptive availability/use level for subsequent year, line A3b of 1984 column of Table 1).                | - 733,050   |
| equals   |             | equals   |             |
| 5. Total AID bilateral requirement for 1981  | = -402,500  | 5. Total AID bilateral requirement for 1983  | = 977,200   |