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15

CLASSIFICATION
 PROJECT EVALUATION SUMMARY (PES) - PART I

Report Symbol U-447

1. PROJECT TITLE POPULATION II	2. PROJECT NUMBER 525-0204	3. MISSION/AID/W OFFICE USAID/PANAMA
	4. EVALUATION NUMBER (Enter the number maintained by the reporting unit e.g., Country or AID/W Administrative Code, Fiscal Year, Serial No. beginning with No. 1 each FY) <u>1</u>	
<input checked="" type="checkbox"/> REGULAR EVALUATION <input type="checkbox"/> SPECIAL EVALUATION		

5. KEY PROJECT IMPLEMENTATION DATES	6. ESTIMATED PROJECT FUNDING	7. PERIOD COVERED BY EVALUATION
A. First PRO-AG or Equivalent FY <u>79</u> B. Final Obligation Expected FY <u>85</u> C. Final Input Delivery FY <u>85</u>	A. Total \$ <u>9,540</u> B. U.S. \$ <u>3,250</u>	From (month/yr.) <u>August 1979</u> To (month/yr.) <u>March 1984</u> Date of Evaluation Review <u>March 1984</u>

8. ACTION DECISIONS APPROVED BY MISSION OR AID/W OFFICE DIRECTOR

A. List decisions and/or unresolved issues; cite those items needing further study. (NOTE: Mission decisions which anticipate AID/W or regional office action should specify type of document, e.g., airgram, SPAR, PIO, which will present detailed request.)	B. NAME OF OFFICER RESPONSIBLE FOR ACTION	C. DATE ACTION TO BE COMPLETED
1. In coordination with implementing agencies, develop a plan for completion of project activities.	Project Officer	January 1984
2. Evaluate possible extension of Project Termination Date as required by 1. above.	ODR	March 1984
3. Ministry of Health to complete National Contraceptive Prevalence Survey.	Project Officer/ MOH	June 1984
4. Establish policy dialogue on the Ministry of Health's establishment of a plan for funding contraceptive purchases following project termination.	Director, ERG Chief, Project Officer	May 1984

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS	10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT
<input type="checkbox"/> Project Paper <input type="checkbox"/> Implementation Plan e.g., CPI Network <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Financial Plan <input type="checkbox"/> PIO/T <input type="checkbox"/> Logical Framework <input type="checkbox"/> PIO/C <input type="checkbox"/> Other (Specify) _____ <input checked="" type="checkbox"/> Project Agreement <input type="checkbox"/> PIO/P	A. <input type="checkbox"/> Continue Project Without Change B. <input type="checkbox"/> Change Project Design and/or <input checked="" type="checkbox"/> Change Implementation Plan C. <input type="checkbox"/> Discontinue Project

11. PROJECT OFFICER AND HOST COUNTRY OR OTHER RANKING PARTICIPANTS AS APPROPRIATE (Names and Titles)	12. Mission/AID/W Office Director Approval
<i>M. Cernik</i> Marvin Cernik, USAID Project Manager	Signature <i>Robin Gomez</i> Typed Name Robin Gomez Date <u>3/28/84</u>

13. SUMMARY

The use of contraceptives and voluntary sterilization for family planning continues to be high in Panama. Estimates of the Ministry of Health (MOH) indicate that the crude birth rate (CBR) has decreased from over 40 per thousand population in 1960 to less than 28 per thousand population in 1981. Ministry's figures for 1981 indicate that the CBR was 27.4 per thousand, down from 29 per thousand in 1978. The reason for the decrease is that family planning services are being provided by both the public and the private sector in rural and urban areas. These family planning services and information on contraception have helped support the change toward smaller size families.

Progress in project activities is satisfactory in delivery of services and sex education, but unsatisfactory in development of information, education and communication (IEC) activities. Although an organized IEC program has not been well established by the MOH, the delivery of family planning services to users has been good. It is the users that are delivering the family planning message. The "word of mouth" message among the successful users thus served to fill the gap caused by the absence of an organized IEC program.

With a September 1984 Project Assistance Completion Date, 80 percent of time planned for the project implementation has elapsed and 67 percent (\$2.444 million) of Life of Project Fund (\$3.250 million) has been obligated and 55 percent (\$1.159 million) has been spent. Even though project goal and purpose are being met, initial project start was delayed by several months awaiting workplan approval and funds; therefore, activities such as sex education and IEC will need more time for completion. Further delays were experienced in 1981/82 when the first

2

Project Agreement Amendment took nearly 15 months to sign due to discussions and modifications. Consequently, more time is also needed for the MCH to develop funding requirements and plan for contraceptive purchases and for the private sector agency to develop alternative approaches for expansion of commercial marketing of contraceptives.

14. EVALUATION METHODOLOGY

The purpose of the evaluation was to measure project progress and to stimulate improvement in implementation.

In 1983, four different evaluations on the Population II Project were conducted. Copies of each of these evaluations are attached. These evaluations are as follows:

1. "A report on an Evaluation of the Sex Education Component of Population II, USAID/Panama". This evaluation was performed March 7-18, 1983 by Norine C. Jewell under a centrally funded American Public Health Association Contract.
2. "Family Planning Communication Needs Assessment and Population II IEC Evaluation". This evaluation, carried out in January 1983, by Lyle Saunders and Patrick Coleman was also centrally funded under a contract with Population Communications Services.
3. "Final Report on Mid-Project Evaluation of the Contraceptives Logistics Component of Population II". Funded with Mission program support funds, the evaluation was carried out by Pedro A. Martiz in June-July, 1983.
4. "Project Evaluation - Project Population II No.525-0204". John Coury, USAID Population Officer, prepared the report in July, 1983.

15. EXTERNAL FACTORS

While there has been no major change in the project as originally designed, scarce resources in the three Ministries involved (Health, Education, Labor) often place a limit on the capacity to move the program faster and more efficiently. For example, funds were made available to hire one logistic person, but funds to hire one IEC technician and for vehicle fuel and vehicle maintenance have not been adequately provided for in the GCP budgets. To illustrate, the Maternal and Child Health budget in 1982 and 1983 was \$16.7 million and \$17.3 million, respectively. The small budget increase went into raised salaries, but adjustment for inflation was inadequate. It is unlikely that these conditions of scarce resources will improve, because the Government is in an austerity mode and cutting expenditures wherever it can. Therefore, project assumptions that there will be an increase or improvement in logistics, administration and supervision, cannot be expected to be fully realized.

The delivery of family planning services by the Ministry of Health (MOH) is satisfactory. But family planning does not receive the desired priority in the MOH because its program is integrated in the Maternal and Child Health (MCH) System. Under MCH, the demand for curative care of children preoccupies the health personnel's time and energy.

16. INPUTS

Contraceptive commodities have been arriving on schedule, but often problems are experienced in timely distribution due to the lack of effective vehicle maintenance or shortage of gasoline funds. Rather than relying on a more desirable organized distribution network, the

distribution system for contraceptives and equipment in the MCH has had to utilize various types of resources. While cooperation of commercial companies, other public agencies, community members and utilization of personal vehicles and resources belonging to health officials are positive contributions, the system lacks control and the consistency required to be more fully responsive to the users.

The development and implementation of IEC activities in the MCH have been sporadic and poorly implemented. Consequently, and using other approaches, efforts are underway for the MCH to develop radio broadcast vaccination campaigns for childhood diseases along with a family planning message. As mothers bring in children for vaccination, the mothers will be given further information on family planning, contraception and child spacing health benefits. Furthermore, an alternative IEC approach will be training of pharmacists in promoting contraceptive information and expanding commercial contraceptive sales through pharmacists. In both these approaches, services through availability of contraceptives will serve as a way in providing information, education, communication on family planning to the people.

17. OUTPUTS

For project output targets, see "Project Evaluation - Project Population II No.525-0204", attachment No.4.

The development of an IEC infrastructure and IEC materials in the Ministry of Health is behind schedule due to a GOP hiring freeze, which prohibits employment of an IEC Specialists. Alternative actions are being taken to overcome problems in IEC activities as discussion in No.16, INPUTS, above.

A slow start on sex education activities in the Ministry of Education and a delay in signing of Project Agreement (lasting nearly 15 months) Amendment has placed the program behind schedule. The decision to train only education guidance counselors, rather than all secondary school teachers, has also been a delay factor. Two hundred ten education guidance counselors have been trained, and 90 remain to be trained. As counselors receive training, they initiate training for the 2000 secondary school teachers and offer sex education information to secondary school level children. This has worked well. Furthermore, sex education received favorable attention in late 1983 when the Minister of Education approved a sex education curriculum to be tested in several pilot schools.

18. PURPOSE

The project purpose is "to expand delivery of family planning information and services to a higher proportion of the fertile age group".

Progress toward the End of Project Status (EOPS) is presented as follows:

1. Increased number of fertile age women who are active users: A contraceptive prevalence survey (CPS) is planned to be carried out in early 1984. The 1984 CPS data will be compared with the 1979 CPS data to determine the number of new rural and urban acceptors. Present estimates are that new active users have increased by 30 percent (72,000) in the past four years. The estimated EOPS figure was 91,000. This figure is likely to be exceeded by 1985. MOH figures indicate that 63.4 percent of the women in the fertile age group are using contraceptives, a substantial increase over the 53 percent in 1976.

6

2. Increase in male contraception: No reliable figures are available, but the 1984 CPS will provide an indication of the trend. To date, the project has provided and distributed sufficient condoms for at least 12,000 male users.
3. Increase in adolescent understanding of human sexuality and reproductive process and practical knowledge of options to delay conception: Over 200 school guidance counselors have received training, a booklet on "Adolescents and Sexuality" was produced and distributed, and over 2500 health personnel and educators have received sex education and family planning training. It is estimated that 100,000 of over 300,000 adolescents have been reached under this project with sex education and family planning messages.
4. Increase in contraceptive use continuation rates: Information on continuation rates will be available upon completion of the 1984 CPS.
5. Increased public and private sector support for population family planning activities: Some 70 percent of contraceptive users receive their services from the Ministry of Health or the Institute of Social Security. The balance of the contraceptives are provided by pharmacies (9%), private doctors (10%) and APLAFA (11%) in the private sector. This positive action by the various groups supports the project purpose, but more needs to be done in the private sector (providing only 30 percent as source of contraception) through commercial retail sales of contraceptives.

19. GCAL/SUBGCAL

The sector goal 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". The project goal to contribute to a reduction of the crude birth rate (CBR) to 25 per thousand over the five-year project period is well on schedule. MCH figures for 1981 indicate that the CBR was 27.4 per thousand, down from 29 per thousand in 1978. It appears that Panama should reduce its population growth rate to the two percent per annum target before the year 2000.

20. BENEFICIARIES

The total number of continuing contraceptive users and new acceptors is estimated to represent around 285,000, who have chosen and are now able to limit their family size. In addition, a large number of over 410,000 men, women, adolescents, teachers and parents have expanded their knowledge about family planning and sex education.

21. UNPLANNED EFFECTS

The project has not experienced any unexpected results or impact. However, support from AID/W intermediaries is extremely useful to the project. The intermediaries can respond quickly as demonstrated in the initiation of the Contraceptive Prevalence Survey, resource feasibility study for family planning support in the private sector now in progress, and the attached project evaluation documents.

22. LESSONS LEARNED

Although the project's IEC program in the Ministry of Health has received little attention, contraceptive use continues to be increasing. The provision of family planning services in the public sector and in the private sector demonstrates that the availability of services is a very

effective IEC tool. The word of "mouth to mouth" communication works for family planning. Making family planning services available, and at low cost, is viewed as a positive means for IEC communications in family planning. A satisfied user carries the message well.

The future focus on doing IEC in family planning should continue to be through delivery of services, making such service readily available and cheap in both the private and the public sector.

23. SPECIAL COMMENTS OR REMARKS

Following project termination in 1985 (assuming a one year extension), it is anticipated that the Ministry of Health will purchase its own supply of contraceptives. Because of the Government's austerity program and resource shortages, it is not certain at this time that funds will be made available for contraceptives. Thus far, the MOH has not budgeted for contraceptive purchases, but the Social Security System has been purchasing contraceptives for Panama City. Priority consideration for a phase over dialogue is necessary.

Also the Ministry of Health is very restrictive and maintains that it should delivery contraceptive services, because it wants to retain authority. For example, the Ministry does not permit delivery of oral contraceptives without a prescription through community based distribution (CBS) programs and restricts expansion of contraceptive delivery through APLAFA, a private organization. CBS programs are based on delivery without prescription. Here too, a policy dialogue might be useful. Fortunately, pharmacies in the private sector are authorized to sell contraceptives without prescription, but the contraceptives are expensive and only small amounts are marketed.

Attachments to this Project Evaluation Summary are listed under item 14, Evaluation Methodology.

The data below summarizes the nature of estimated project (POP II) beneficiaries.

BENEFICIARIES
(by Institution)

	I E and C			Contraceptive Services		
	<u>TOTAL</u>	<u>Urban</u>	<u>Rural</u>	<u>TOTAL</u>	<u>Urban</u>	<u>Rural</u>
<u>MINISTRY OF HEALTH</u>						
Men (20+)	100,000	90,000	10,000	15,000	-	-
Male Adolescents (15-19)	10,000	8,000	2,000	2,000	-	-
Women (20-49)	150,000	100,00	50,000	68,000	50,000	18,000
Female Adolescents (15-19)	<u>5,000</u>	-	-	<u>5,000</u>	-	-
Total Males/Females	265,000	-	-	90,000	-	-
<u>MINISTRY OF EDUCATION</u>						
Adolescents (10-19)	75,000	-	-	-	-	-
Men and women ages 20+, who are parents	10,000	-	-	-	-	-
<u>APLAFA</u>						
Adolescents	10,000	10,000	-	(2,000) <u>1/</u>		(2,000)
Men and women, age 20+, who are parents or teachers	1,400	1,400	-	(500) <u>1/</u>		(500)
Men and women, age 20+, who are members of private sector organizations	35,000	30,000	5,000	(4,500) <u>1/</u>		(4,500)
<u>I.P.H.E</u>						
Males/females age 12+, who are parents or other family members	15,000	-	-	-	-	-
GRAND TOTALS	<u><u>411,400</u></u>	<u><u>-</u></u>	<u><u>-</u></u>	<u><u>97,000</u></u>	<u><u>-</u></u>	<u><u>-</u></u>

1/ APLAFA contraceptive services are shown apart since they are not financed directly by the Grant.

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revised

4-12-83

NOT OFFICIAL
DRAFT
FOR EDITORIAL REVIEW ONLY

A REPORT ON AN EVALUATION
OF THE SEX EDUCATION COMPONENT
OF POPULATION II, USAID/PANAMA

A Report Prepared By:
NORINE C. JEWELL, M.P.H.

During The Period:
March 7-18, 1983

Supported By The:
U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

AUTHORIZATION:

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C O N T E N T S

	<u>Page</u>
PREFACE	
ABBREVIATIONS	
I. INTRODUCTION	1
II. BACKGROUND	3
History of the Sex Education Project	3
Purpose of the Consultant's Visit	5
Scope of Evaluation	5
Evaluation Methodology	7
III. OBSERVATIONS AND FINDINGS	10
State of the Art of Sex Education	10
National Commission on Sex Education	11
Program Activity	12
A. Interinstitutional Effort	12
1. Present Status	12
2. Problems and Obstacles	15
B. Ministry of Health	16
1. Present Status	16
2. Problems and Obstacles	17
C. Ministry of Education	19
1. Present Status	19
2. Problems and Obstacles	21
D. National Directorate of the Child and Family	22
1. Present Status	22
2. Problems and Obstacles	24
E. Panamanian Institute for Special Education	25
1. Present Status	25
2. Problems and Obstacles	25
F. AID Participation	26
1. Present Status	26
2. Problems and Obstacles	27
Project Administration	27
A. Contractual Arrangement	27

	<u>Page</u>
B. Role of the Ministry of Planning and Economic Policy	28
C. Coordination with Other Agencies	28
Project Agreement with APLAFA	28
IV. RECOMMENDATIONS	30
State of the Art of Sex Education in the United States and Panama	30
National Commission on Sex Education	30
Program Activity	30
A. Interinstitutional Effort	30
B. Ministry of Health	34
C. Ministry of Education	35
D. National Directorate of the Child and Family	37
E. Panamanian Institute for Special Education	38
F. AID Participation	39
Project Administration	39
A. Contractual Agreement	39
B. Role of the Ministry of Planning and Economic Policy	39
C. Coordination with Other Agencies	40
Project Agreement with APLAFA	40
Future Evaluation of the Project Agreement	41
 APPENDICES	
Appendix A: List of Persons Contacted	
Appendix B: Progress Reports from Grantees (Spanish)	

PREFACE

This evaluation of the USAID/Panama sex education component of POPULATION II is a follow-up of a two-step evaluation visit to Panama in July, August and September of 1981. There has been significant progress in the program since that time. The consultant continues to believe that if the grantee institutions meet their stated goals by the end of the project period, Panama will have a model of a sex education program on a national scale, of great value to other countries wishing to pursue a similar objective.

The consultant wishes to express her appreciation to John Coury, USAID/Panama, for his complete support in conducting the evaluation. His commitment to the success of the program has been consistent throughout, and has ensured a thorough examination of all activities and documents required for a useful evaluation.

It is particularly noteworthy that during the eighteen month period since the previous evaluation, a Presidential Commission (Comision Nacional Para la Familia) coordinated by Monsignor Marcos G. McGrath, C.S.C., head of the Catholic Church in Panama, issued a report which gave priority to the development of sex education in the schools. The impact on unwanted and untimely pregnancies of a widely supported sex education effort such as that found in Panama, is certain to be significant. Continued support from AID/Washington and the Mission in Panama is highly desirable.

ABBREVIATIONS

AID	Agency for International Development
APLAFA	International Planned Parenthood Affiliate of Panama
DINNFA	National Directorate of the Child and Family
IEC	Information, Education and Communications
IPHE	Panamanian Institute for Special Education
MCH	Maternal and Child Health
MOE	Ministry of Education
MOH	Ministry of Health
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development

I. INTRODUCTION

Most AID-assisted family planning efforts include an information, education and communications component (IEC) but a separate sex education effort extending to the non-health sector through multiple institutions is a rather unique undertaking. In Panama the sex education program is part of POPULATION II and assistance is provided to the Ministry of Education (MOE), the Ministry of Labor's National Directorate of the Child and Family (DINNFA), the Panamanian Institute for Special Education (IPHE), the Ministry of Health (MOH), and the International Planned Parenthood Affiliata of Panama (APLAFA).

As part of POPULATION II, the sex education program is the second of two strategies for expanding the delivery of family planning information and services to a larger proportion of the fertile-age group. Through the five grantee institutions mentioned above, sex education and family planning information will reach the mentally and physically handicapped and their families and teachers, day-care and pre-school children and their families and teachers, staff and residents of institutions for child protective services, populations served by community organization efforts, secondary school students and their families and teachers, low-income adolescents and their families in a suburb of Panama City which contains about 10% of the country's total population, and recipients of maternal, child and adolescent health services of the Ministry of Health. In addition, groups such as the national Red Cross youth volunteers, labor unions, factory workers and the National Guard currently receive technical assistance in sex education from the five grantee institutions and will reach their constituency.

It is stated in the Project Agreement that the aim is to introduce and institutionalize sex education in Panama; that funds are to be used to help launch a national program of sex education, specifically the first two phases of

the three-phase program designed by the National Commission on Sex Education. In the initial phases, financial assistance is to be provided to train multidisciplinary "core" teams from the member institutions of the National Commission to be sex education trainers, and to enable these teams to train professional employees of their institutions.

The Project Agreement is three and a half years old. A mid-term evaluation was conducted after two years to assess progress and make recommendations. The Project Agreement with APLAFA is separate from that of the other four institutions but it is included because the goals are essentially the same. The current evaluation will again assess progress and make recommendations for the remaining eighteen-month period, at the end of which AID wishes to phase out family planning and sex education assistance to Panama through the Mission.

II. BACKGROUND

History of the Sex Education Project

The major single event which gave impetus to AID participation in a sex education program in Panama was the formation of a National Commission on Sex Education in 1979. Many ministries and private agencies were represented on the Commission (excluding the International Planned Parenthood Affiliate). The Commission prepared a comprehensive document which reflected an extensive understanding of the need for sex education, acknowledged the problems of definitions, recognized the potential for opposition and expressed the need for broad-based support if the effort were to succeed. Many of the staff involved in writing the document had received training during conferences held in Guatemala and which had a noticeable influence on the approach, philosophy and goals of the Commission.

Subsequently, AID entered into formal agreement with four of the major institutions represented on the Commission, as well as with the International Planned Parenthood Affiliate (APLAFA), to assist the grantees to pursue the goals set forth by the Commission. It should be noted that AID did not contract directly with the Commission, which was and is a voluntary group without independent authority or responsibilities. Its existence is dependent upon the interest and willingness of each representative institution to devote time to its activities.

Initially, the Commission proved to be an excellent vehicle through which the first phase of the national program could be pursued: that of training a core team of professionals within the central offices of each institution who could then conduct the second phase of training staff at regional and local levels. A drawback of the Commission's activity has been the absence of APLAFA which has acquired considerable experience in many aspects of sex education. Nevertheless the various AID grantees worked in a coordinated fashion through

the Commission to develop and implement five seminars in order to train the specified number of staff for each ministry and agency. AID reimbursed expenses to the grantees, each of which took a turn in hosting a seminar.

The second phase of the national program consists of using the core teams trained in the five national seminars, to train staff at regional and local levels, as well as volunteers. Each institution agreed to offer their expertise to the others for training related to their particular service area. When this consultant arrived during the July-September 1981 period the institutions had reached a standstill due to conflicting views of the second phase and a difference of opinion regarding the Commission's role. While some institutions had initiated activities for the second phase, the Commission as an entity had not advanced specific plans, criteria or standards to provide guidance for the programs of the member institutions. Yet some Commission members strongly insisted that no activity should be undertaken without the approval of the Commission.

The root of the problem was that in order to proceed to a staff training phase, each institution had to mobilize its resources to meet needs of its particular target population with strategies appropriate to its services and policies. The Commission was not in a position to direct the efforts of its members nor even to provide guidance, since it is by nature of its representative composition an advocacy body and not an accrediting institution. Furthermore, representatives on the Commission were not a homogeneous group, and some were apparently not even reflecting their institution's official views.

By the end of the Consultant's evaluation visit and shortly thereafter the ministries and agencies initiated steps to pursue their own sex education programs and implemented the second phase of the national project. Just prior to conducting skills training plans were elaborated to describe what was to be done, by whom, what their training needs were and how their institution intended to carry the sex education program to its final stage.

While the implementation of the second phase by the various institutions necessitated a high degree of independent and autonomous activity, the fact that this occurred over the protest of some Commission members implied a sense of failure regarding the Commission's role, and it has not conducted meetings since. Nevertheless, as will be discussed further on, there is certainly a continuing need for coordination and mutual support among the programs which the Commission could fill.

Purpose of the Consultant's Visit

The AID Mission requested that the consultant measure progress in attaining project objectives, identify problems and constraints, suggest remedies, and recommend the type and degree of USAID assistance during the remainder of the project. The Mission specified that it wanted the consultant to measure progress in the following manner:-

- * Assess quality of training activities.
- * Analyze each agency's program goals, objectives and strategies.
- * Analyze utilization of the personnel that have been trained in sex education.

During the consultant's exit interview, the AID Mission staff also expressed particular interest in the likelihood of continued program activity once bilateral funding comes to a close, and possible steps that could be taken during the remaining eighteen months of the project to enhance that likelihood. Therefore the evaluation should make an effort to guide planning through September, 1984 in anticipation of a cessation of AID assistance beyond that date.

Scope of Evaluation

As had been clearly stated in the 1981 visit, the evaluation does not attempt to assess the quality and effectiveness of the sex education programs

of each grantee but rather the institutional development assistance provided by the AID. The AID's participation is confined primarily to training of professionals and volunteers who will ultimately deliver sex education, technical materials, and professional assistance with studies, surveys and evaluations.

The distinction regarding the scope of the evaluation is critical, as was underscored during the 1981 evaluation. When the consultant arrived, the Commission member representing the Ministry of Health urged other members to refuse cooperation in the AID evaluation on the grounds that only the Commission should evaluate Panama's sex education program. It was subsequently made very clear by the consultant and the AID Mission staff that evaluation extended to the terms of the Project Agreement which was agreed to by all parties. The result of this clarification was that all but the Ministry of Health participated in the AID evaluation with enthusiasm. Detailed information about each grantee's program was elaborated in writing and used as a frame of reference for AID to judge its own participation as well as to identify other possible areas of assistance. The same spirit of cooperation was continued during this evaluation visit.

However, a major limitation on both the scope and methodology of this evaluation was that it took place during vacation time. This was complicated by the fact that many institutions required that staff take accumulated vacation time, partly because the government's budget was under debate and there were few funds available for on-going activities. Vacationing staff had to meet with the consultant on their own time. No interviews were held with IPHE staff, who could not even be reached, and the DINNEFA project director was not available for any follow-up interviews. Furthermore, the Ministry of Education project director, who had accepted a post with the university, left the Ministry within a few days after the interview leaving in question specific action plans until a replacement is brought in.

21

Nonetheless, most programs have advanced to a stage where inadequate interview time and personnel turn-over can be partially compensated by the availability of documents and the momentum of activities carried on by other staff. In order to provide consistency with the mid-term evaluation of the sex education program the following factors were again examined and taken into account during the selection of evaluation topics:-

- * Nature of AID assistance:- Assistance is for the development and not the delivery of the sex education programs.
- * Evaluation of the Sex Education Programs:- The Project Agreement provides for a base-line study which will ultimately serve the grantees' need to evaluate their own efforts.
- * Specificity of Grantee Goals and Objectives:- The goals described in the Project Agreement are quite general. Even though there are more detailed expectations contained in the Project Paper, this evaluation adheres to the terms of the Project Agreement.
- * Absence of Sex Education Guidelines:- Neither guidelines nor standards are as widely developed or accepted in the area of sex education as they are for family planning services.
- * Quality of Grantee Program Plans:- It is important to the AID to examine the adviseability of participation in sex education programs. Thus while the focus of evaluation is not directly on the programs, there is a compelling reason for assessing the quality of the plans and strategies in order to make judgements about the AID's participation according to its own goals and needs.

In the previous evaluation a matrix was used to display the possible areas of evaluation and the final selection of topics. A very similar matrix is shown in Exhibit A in order to provide continuity from the 1981 evaluation.

Evaluation Methodology

The methodology used during the evaluation consisted primarily of the following:-

- * Review of the purpose, goals, and objectives of the AID and each grantee institution as envisioned in the Project Agreement which was revised since the last evaluation, and in the Frame of Reference provided in 1981 by each institution.

22

Exhibit A

MATRIX USED TO DETERMINE SCOPE OF EVALUATION

Possible Topics for Evaluation	Type of Evaluation			
	Impact	Efficiency	Effectiveness	Quality
Further reduction in birth rate (Project Paper)				
Expansion of delivery of family planning information and services to higher proportion of fertile-age group (Project Paper)		*	*	
Introduction and institutionalization of sex education in Panama	*	X	X	X
Goal and objectives of National Commission on Sex Education (appendix of Project Paper)				
Sex education program of each grantee (internal grantee documents)				
Implementation of first two phases of national program (Project Agreement)	X	X	X	X
Use of AID funds for training	X	X	X	X
** Use of AID funds for materials	*	X	X	X
** Use of AID funds for other assistance	*	X	X	X
AID project administration	X	X	X	X

** insufficient use for evaluation of impact at this time

Code: X = Focus of evaluation

* = Should be included in final evaluation

Impact = ultimate changes effected through the activity

Efficiency = use of resources to achieve goals

Effectiveness = progress toward stated goals Quality = maintenance of standards

- * Up-date of the purpose, goals, objectives, and strategies of the grantees and the AID through interviews and review of documents.
- * Assessment of the quality and feasibility of the current purpose, goals, and objectives of each grantee institution using the "Analytical Framework" formulated especially for the previous evaluation and based on widely accepted principles of sex education programs in the U.S.
- * Assessment of the quality of training, materials and technical assistance funded by the AID based on progress of each grantee as described during interviews and/or in documents.

The difficulty in evaluating institutional development is that the methodology is limited primarily to interviews at the decision-making level of the institutions and review of documents. Direct observation of delivery of sex education activities, even those carried out on a demonstration basis, would confuse the AID's role. The consultant continued to maintain a low profile with regard to the service staff and volunteers who are just beginning to teach the program. Site visits to training programs would have been appropriate but there were none scheduled.

24

III. OBSERVATIONS AND FINDINGS

State of the Art of Sex Education

It is important to reiterate here the points made in the previous evaluation report regarding sex education in the U.S. and Panama. For a large majority of individuals who experience unplanned, untimely or unwanted pregnancies, effective contraceptive behavior can be achieved only after sexuality education provides them with factual information, knowledge of themselves and their options, and stronger skills in personal decision-making. However, sex education programs are characterized by an absence of widely accepted or recognized standards, definitions and expectations. Moreover, they are frequently surrounded by emotionalism and controversy which precludes their systematic development and evaluation.

Sex education programs tend to be undertaken locally by private organizations (often, family planning agencies) or by a single school or school district, without benefit of information-sharing networks. There have been some successful efforts in recent years to compile and synthesize experiences in delivering sex education, which document curriculum, evaluation methodologies, techniques for building community support, and teacher training programs. Nevertheless, provision of sex education continues to be fragmented, with little institutionalization, little commitment from the top, and with narrow support.

Panama's experience is unique in many ways. Whereas most programs are initiated locally by a few interested individuals, in Panama commitment has come from very high levels including the previous president of the country, the ministries and institutions which formed the National Commission on Sex Education, a presidential commission on the Family, and the head of the Catholic Church. Furthermore, whereas professionals from the education or health field might initiate a general program which is eventually modified for populations with special needs, in Panama the program was initiated by professionals from many disciplines.

The experience in the United States has been that once a program is started, professionals from education, medicine, mental retardation, child care and other fields will seek out and request training and assistance from staff who are already hard-pressed to meet its own obligations. In Panama the special service populations have always been taken into account. Simultaneous efforts have been pursued to meet needs of mentally and physically handicapped individuals and their families, day care center children and their parents, the secondary school system and other segments of the community.

The combination of mutual support among government institutions and private agencies, the top-level commitment, and the broad base of support from different professional fields have placed the Panama national sex education activities in a strong position to be advanced through all stages of institutionalization. This view is reinforced by the February, 1983 draft report of a Needs Assessment for Family Planning Communication prepared by Lyle Saunders and Patrick Coleman. They state that "Panama may be somewhat ahead of most other countries in its efforts to implement sex education widely, and any help that can be given to move matters along successfully should be given a high priority."

National Commission on Sex Education

Despite the Commission's failure to assume continued leadership after the five national training seminars of the first phase of the program, it has potential for meeting needs of a national effort. Unfortunately, around the time of the 1981 evaluation visit some Commission members were attempting to exert authority through what is actually a voluntary, representative body. It is important to note that a resolution came about for two reasons:- the Ministry of Education made it clear that the Commission had no role in the development of the MOE program unless specifically invited to do so, and then the MOE moved quickly into the staff training phase according to a long-range strategy

26

it devised for a school-based sex education program; and the AID Mission began to relate to each institution as a grantee with contract obligations rather than as members of a voluntary Commission, thereby encouraging each to move forward with its own plans and activities to be funded directly by AID.

While the experience in 1981 left many of the institutions wary of the Commission, it could serve some important coordinating functions. It was an excellent mechanism to ensure consistency at the beginning of the program, yet it was inevitable that at some point each Commission member institution would have to re-direct its energies internally in order to pursue strategies tailored to its service populations and resources. Had this been more acceptable to all Commission members it might have continued in a support role until it was needed in a more active fashion once again.

Program Activity

A. Interinstitutional Effort

1. Present Status

The Project Agreement does not have to be assessed as a unified effort, particularly since certain phases of program activity require each grantee to work quite separately. Nevertheless, the overall purpose of the sex education component of POPULATION II is to institutionalize sex education using AID funds to launch the first two phases of a national sex education program, proposed by the National Commission, the last phase of which is the actual delivery of the education. The Project Agreement allocates funds to four institutions through the Ministry of Planning, and a separate Project Agreement is signed with APLAFA which refers to more specific APALFA goals rather than the Commission's national program. A revised Project Agreement was signed in June, 1982 reflecting more current objectives of each of the four institutions involved in the Commission, and they continue to be unified around central goals.

21

Institutions are expected to provide sufficient and appropriate personnel to carry out the project activities, to evaluate their own activities, and to maintain close coordination with the other institutions. In turn, the AID provides grantees with the funds necessary for them to select and train individuals who will teach sex education, to develop and utilize appropriate technical materials and other resources, and to obtain assistance for different components of the programs such as needs assessment studies and curriculum.

The major accomplishment of the first phase of the program through late 1981 was the interinstitutional training of the "core" teams through five seminars. Institutions sent to each seminar a few of their total number of staff designated to be trained, so that there was a multidisciplinary team in each seminar. Since that time, the grantees have largely pursued activities which best suit their particular institutions for the second phase of the national program:-

- * The MOH does relatively little in sex education but has continued training its own personnel through the recently formed Integrated Adolescent Health sub-division of the Maternal and Child Health Division and has provided personnel as resources to sex education training of other groups. It also receives support from the UNFPA for its sex education activities.
- * The MOE has nearly completed the training of guidance counselors in all schools, has drafted a curriculum for three different grade levels and is now preparing a more detailed action plan for the next phase which will involve parents, teachers, and introduction of the curriculum on a pilot basis.
- * DINNFA has trained day care teachers as well as other professionals and has delivered many sex education programs to various of their target groups in order to assess the results and make modifications in their overall approach; they have initiated an extensive collaborative effort with the national Red Cross to train volunteers; they are about to conduct an internal evaluation to revise program content, improve evaluation instruments and up-grade teaching skills; and they introduced an especially effective teaching technique which stimulates greater participation in their seminars and workshops from the recipients.
- * IPHE had progressed rather rapidly by the end of 1981 to staff training and were delivering some sex education programs to parents of their target population on an experimental basis, but they seem to have remained at a similar stage of development since then and have not developed formal curriculum or otherwise systematized their activities.

20

FINANCIAL STATUS OF SEX EDUCATION PROGRAM

12

MOE

<u>Materials</u>	
Budgeted	\$101,000
(Approved)	99,000
*Reimbursed	20,734
Balance	80,266

<u>Training</u>
115,000
(58,000)
28,282
86,718

<u>Technical Assistance</u>
10,000
(5,000)
-
10,000

<u>Total</u>
226,000
(162,000)
49,016
Balance 176,984 - 78%
(Advance - 47,000)

IPHE

Budgeted	\$ 70,000
(Approved)	28,000
*Reimbursed	22,711
Balance	47,289

43,000
(20,143)
24,657
18,343

15,000
(-)
-
15,000

128,000
(48,143)
47,368
Balance 80,632 - 63%
(Advance - 9,879)

DINNFA

Budgeted	\$ 50,000
(Approved)	50,000
*Reimbursed	24,628
Balance	25,372

110,000
(all)
56,807
53,193

30,000
(all)
-
20,000

190,000
(all)
81,435
Balance 108,565 - 57%
(Advance - 59,474)

14

APLAF A

<u>Adolescents</u>	
Budgeted	\$ 65,000
(Approved)	49,255
*Reimbursed	28,052
Balance	36,948

<u>Parents</u>
12,000
(10,332)
5,915
6,085

<u>Outreach</u>	<u>Other</u>
40,000	29,000
(37,243)	(28,625)
12,945	11,900
27,055	17,100

<u>Total</u>
146,000
(125,455)
58,812
Balance 87,188 - 60%
(Advance - 7,754)

MOH

<u>IEC</u>	
Budgeted	\$330,000
(Approved)	230,000
*Reimbursed	56,122
Balance	273,878

<u>Training</u>
247,000
(93,000)
48,498
198,502

<u>Evaluation/Studies</u>
113,000
(69,000)
15,714
97,286

<u>Total</u>
690,000
(392,000)
120,334
Balance 569,666 - 83%
(Advance - ---)

- * APLAFA has continued their sex education program in the San Miguelito area as before, with continuing restrictions on their activities due to the absence of stronger formal recognition of APLAFA on the part of many public agencies; and they completed an investigative study with the Catholic University of adolescent sexual knowledge, attitude and practice.

Based on the interviews during the evaluation visit it is apparent that all grantees would benefit greatly from coming together more frequently to exchange experiences, identify common needs, and share technical assistance.

2. Problems and Obstacles

There is little formal communications among the grantee institutions and during the past year and a half that each has had to concentrate resources internally there has not been much need to coordinate efforts. The goal of the multidisciplinary "core" teams was that professionals from health, education and various social services would contribute to the training of all staff, but there is less collaboration than planned. To some extent the separate programs have been fairly self-sufficient and have not required as much assistance as originally envisioned, but there has also been some negative reactions from the attempt in 1981 by some Commission members to exert control over the national program. The MOE has frequently called upon DINNFA for assistance but has made consultant arrangements with individual health care and medical professionals rather than going through the Ministry of Health. The MOH has made attempts to prevent individual contracts. IPHE had previously planned to request assistance from APLAFA but has not renewed these efforts since the cancellation of a workshop with APLAFA under pressure from some of the Commission members in 1981.

The AID Mission has encouraged coordination by inviting grantees to participate in meetings to view materials they might wish to purchase, or to discuss any other areas in which they would all be interested. However, the Mission's position has been that collaboration on a national scale is an obligation of the grantees and other Panamanian institutions. The Mission wants to avoid any misunderstanding of its role and a perception that it is imposing a sex educa-

tion program on the country, a strategy that has been markedly successful in strengthening the relationship with the grantees. While more coordination among agencies can sometimes be accomplished through contract requirements, such as more frequent and routine meetings and shared use of technical assistance, this approach would have conflicted with the Mission's overall strategy and such pressure can produce the opposite results.

Another problem with the interinstitutional effort has been the slow start-up as well as periods of administrative hold-ups for various grantees, with the result that with eighteen months left there is still a very large proportion of funds unspent. It is critical that programs have very specific plans through the end of the project period and that implementation meet deadlines in order that the AID assistance not be terminated in mid-stream merely because expenditures failed to keep pace with planned budgets. The further advanced all grantee programs by September 1984 the greater the possibility of a successful national, unified program.

B. Ministry of Health

1. Present Status

Sex education activities within the MOH are reimbursable by both AID and UNFPA, but these activities are minimal and are difficult to distinguish from adolescent health and family planning services. During the interim since the national seminars in 1980-81, the MOH has provided some training in sex education to at least 200 national and regional staff including health and social service personnel, and a minimum of a week on sex education is now included in the training of nurse auxiliaries in their two-year program at the national level. Plans for including such training in other professional institutions were only vaguely mentioned. On the whole, many MOH personnel have made extensive use of their skills in sex education, integrating them into other health services.

21

During 1982 the MOH carried out six training seminars for regional MOH personnel in adolescent health with an emphasis on sex education; three seminars were reimbursed by AID and three by UNFPA. A few posters with adolescent sexuality and health themes have been printed with UNFPA funds, an adolescent sexuality booklet printed with AID funds has just been completed, and materials designs are sitting on some shelves. A few MOH personnel assist in sex education workshops of other institutions at the national and regional level, and some regional personnel have organized local workshops, primarily around the subject of healthy adolescent development.

If any measurable strides are to be made in sex education within the MOH it will be done through the recently organized sub-division of Integrated Adolescent Health which has a heavy emphasis on sexuality, and through integrated family planning activities which are not organized into a categorical program. Furthermore, progress in the area of sex education is highly dependent upon the MOH performance on their family planning contract, since the Project Agreement does not provide an elaborated plan for sex education with a separately earmarked budget within POPULATION II. Only the MOH investigative studies in sex education can be separated and moved ahead more rapidly, since they are tied into the national program, and according to the Project Agreement they are intended to meet needs of all of the grantees.

2. Problems and Obstacles

The MOH performance regarding family planning has not measured up to the Mission's expectations and it is therefore unlikely that there will ever be a strong MOH sex education program. One reflection of the prevailing attitude within MOH toward family planning is the large proportion of the budget which is unspent with only a year and a half remaining in the project. The representative of the Ministry of Planning and Economic Policy was so concerned with the situation that he initiated a meeting with the MOH, the con-

sultant and the Mission to discuss whether there was a possibility of completing the objectives of the Agreement.

The MOH personnel responsible for the AID contract believe both family planning and sex education are best achieved through total integration into all health services. Resources are neither adequate nor organized in a coherent fashion at the different decision-making levels and in the field that would ensure a consistent, quality family planning effort. To obtain a picture of family planning and sex education one must interview several individuals, and even then the information is conflicting. Unplanned, untimely pregnancies are not considered a serious problem except as they affect adolescents, and even then the goal is less that of effective contraceptive behavior than of changes in sexual behavior. Neither the number of abortions nor the proportion of out-of-wedlock births was felt to be a very compelling problem. This attitude is unlike that of the professionals within the other grantee institutions who give high priority to unwanted pregnancies and family instability, and believe that sex education with family planning information and services are critical to resolving the problems.

During the joint meeting referred to above, some practical suggestions were made with regard to the investigative studies. However, the discussions surrounding training and development of materials did not produce any real changes in the MOH approach but rather highlighted the reasons behind current strategies for sex education. The MOH personnel present during the meeting expressed the opinion that unless the purpose and goals of the funds were more flexible it may not be possible to make use of them before the project ends. There may be sufficient interest in the off-set equipment that the MOH central office could be encouraged to produce more materials, which are in demand out in the field and would certainly be used, if their request for the equipment were reconsidered.

32
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C. Ministry of Education

1. Present Status

At the beginning of the Project Agreement the Ministry assigned responsibility to the department which oversees professional development. Just prior to the end of the September, 1981 evaluation visit the Ministry placed responsibility for the second phase of the sex education program with the department which oversees guidance counselors in all schools throughout the country. The change in delegation of responsibility reflected the move from the first phase of the national program in which central office staff of the participating institutions were trained as core teams of trainers, to the second phase in which staff at all levels were to be trained to develop and implement the sex education program. Use of training has been extensive.

The Ministry of Education decided that the development, introduction and supervision of sex education in the schools could best be carried out by guidance counselors, whose role is to provide counseling to students and parents in education and vocational pursuits. Guidance counselors complete the same training as teachers and then must apply and compete for their position. While they have not undergone specialized education, their job responsibilities require good communications with students and parents, and it was felt that they would be most experienced in the in the skill areas needed to deal with the sex education program. It is not intended that they necessarily teach the courses, but rather that they secure parental input and approval, select and orient teachers who would be appropriate as classroom teachers and present a curriculum which was recently developed with the assistance of a consultant with experience in the Guatemala sex education program. The strategy includes training all guidance counselors in the two-week sessions to ensure that at least one in each school successfully relates well to parents and students in so sensitive an area, of the two to four guidance

counselors generally assigned to a school. The Ministry acknowledges that not everyone will be comfortable with the topic of sexuality in a classroom or with a group of parents.

The next phase of the program is not yet planned in detail, partially because the director of the department just took a job with the university and partially because project personnel want more exposure to similar programs in other countries. The staff is very conscious of the difficulties of the next phase: parental reaction to sex education balanced against the need for input and support, teachers' reactions to a new curriculum and changes in their working conditions, administrators' reactions to instituting a new program. While the precise strategy for the next phase will not be developed until a new director has been appointed the project staff are assuming that there will be a pilot project in a defined geographic area to facilitate close supervision by central staff.

Despite the challenges facing the Ministry when the current phase is completed, scheduled for July of this year when over 250 guidance counselors will have been trained, an important element in the school-based sex education program has been the high level commitment to such a goal. The previous president of the country had been vocally supportive while he was Minister of Education and the current Minister and close assistants are equally supportive. Furthermore a presidential commission headed up by the Archbishop of Panama made a strong recommendation in its published report that sex education be taught in the schools, and that the MOE's newly created department for parent communications be active in behalf of this effort. Within the MOE other resources will be available to assist the department which oversees guidance counselors, including the department of curriculum which helped to develop the initial sex education curriculum, and the department which is responsible for administration which will direct school administrators to help implement the program. A difficult problem facing guidance counselors will

be their fellow teachers. The teachers' union, to which guidance counselors also belong, is strong and vocal about their working conditions.

In summary, the next phase of the MOE program will be difficult, but this is a challenge rather than a problem or obstacle as long as the next director of the project pursues the current line of thinking with regard to selecting a pilot project area. The ultimate goal of this phase is to put a 12-hour sex education program into place in three grades of the secondary school system, for which the curriculum has been designed. Support from within the MOE is reinforced by support from other sources: many communities have benefited from the sex education efforts of the other grantee institutions and project staff intends to call upon them once the pilot area has been selected; and members of the Catholic Church have been involved in the training of the guidance counselors, either as trainers or as participants in the opening and closing ceremonies.

MOE project staff are planning to visit other programs and/or attend courses and workshops in other countries in order to expand their resource materials for guidance counselors and seek ideas for introducing the program to parents and schools. A small library has been compiled for each of 79 schools and a more extensive resource center is being developed for each province, but project staff feel they have not yet had opportunities to visit other programs, observe first hand the experiences of other school systems, and review literature available in other countries which could be used or adapted for use in Panama. They are also eager to have technical assistance in the development of their own resource materials once they have reviewed what is currently available.

2. Problems and Obstacles

A problem area for the MOE has been internal administrative hold-ups in expediting billing under the Project Agreement. Delays within the MOE

administrative office contributed significantly to an eight-month standstill in training activities, complicated by the MOH failure to sign the revised Project Agreement under which the other grantees are funded. The director said he was discouraged enough to consider dropping the project. There have been no further delays since then, but neither have there been any policy or procedure changes within the MOE that would reduce the possibility of recurrence.

A possible obstacle to completing project goals and objectives within the POPULATION II time period is the pace at which the MOE program must follow. Progress during the next phase can easily be slowed by the nature of the task: gaining the approval of parents and teachers. Each step in the process can only be initiated when the preceding step has successfully obtained the support of the parents and teachers. MOE project staff expressed this problem when they stated that the next phase is a source of particular anxiety to them because it places control over the success or failure of the program outside of their department.

D. National Directorate of the Child and Family (DINNFA)

1. Present Status

Within the Ministry of Labor, DINNFA is the department responsible for services to low income families, either directly or on a referral basis. DINNFA's social workers provide case management to families and link them up to day care, child protective custody, community education programs and related services, using a network of professionals from other departments of the Ministry as well as other agencies and institutions. The strategy chosen for the sex education program for pre-school children, children in protective custody and low income adolescents and families is the training of professionals and volunteers who will teach the program. Few professionals are directly supervised by DINNFA so the strategy includes orientation and training of supervisors of the professionals selected. Use of training has been extensive.

To date, DINNFA has trained and up-dated the skills of over 200 day care center teachers and provided orientation to their supervisors; they are in the process of preparing seminars for personnel of institutions (both public and private) for homeless children, they are working closely with the national Red Cross and have carried out training for the Red Cross Youth organization so that they will provide sex education to their peers.

DINNFA is particularly pleased with the effectiveness of a training technique for preparing professionals and volunteers to be sex educators, and which has been used in the nutrition program of the Ministry. It was taught to DINNFA personnel at the central level early in 1982 and is referred to as the "participatory technique" or non-formal education method. It places a trainer in the role of facilitator and participants conduct their own research and analysis of problems in their community or within their peer groups. The trainer and participants then select teaching methods and subject areas that address identified needs. While simple and common in principle, it marked a significant move away from didactic teaching of sex education toward a more dynamic method of responding to perceived needs of those being trained as sex educators. It is best used on a limited bases for those who will be teaching sex education, and possibly in sex education programs where participants are enrolled for a long-term course. DINNFA staff feels it should not be used on a wide scale for the school-based sex education program except for training the MOE professionals who in turn need to train guidance counselors and teachers. It is felt that wide-spread use would dilute its effectiveness because it could not be properly supervised by those who are most experienced in using the technique.

DINNFA is planning to teach others in the use of the technique for both sex education and the national breast feeding program because many professionals are involved in both programs. A large seminar is planned to which staff from all grantee institutions would be invited, as well as from other agencies,

and about eight staff who are skilled in the technique will conduct the seminar. DINNFA also collaborates in other ways with the grantee institutions, more so than the staff of the other sex education projects. They have taught in some of the seminars and have continuously expressed a willingness to share their experiences and activities including evaluation methodologies, studies which they hope to conduct, and materials they hope to develop.

2. Problems and Obstacles

Limitations on DINNFA's sex education program progress include overall budget reductions within the Ministry, staff turnover, and some administrative hold-ups including some changes in billing and reimbursement by the Panamanian Government's Accounting Office which has held up some AID funding. Nevertheless it does not appear that there are major limitations on their progress, although it has slowed due to the need for technical assistance in certain areas without which they hesitate to move too quickly. In particular the staff has expressed the need for systematic and long-term assistance of at least one year in the design and production of a variety of materials. Such materials are needed in the classroom and other settings for a diverse audience. Staff has also asked for assistance in the development of a pre-school curriculum and studies or needs assessments to furnish information for modifying and up-grading their sex education program. They also want to visit other programs and gain first-hand experience before institutionalizing their program.

By the end of the Project Agreement period the project director wants to have a very concrete program and set of recommendations for a national sex education program. He specifically stated that this was a goal all members of the National Commission on Sex Education had agreed upon and he wishes to adhere to it.

E. Panamanian Institute for Special Education

1. Present Status

Due to the vacation period no one from IPHE was interviewed. The evaluation was based entirely on a review of documents and interviews with the AID Mission. IPHE had progressed rapidly by the time of the 1981 evaluation, from training of central staff in the national seminars to the training and supervision of IPHE personnel in classroom settings with parents. During the 1981 visit they had initiated classroom activities in Panama City in order to test their strategies and make modifications. In the interim since then they have continued to train and supervise IPHE personnel around the country, providing skills up-grading based on observation and evaluation visits, and feedback from personnel and volunteers. They have not yet finalized the content of the education programs or prepared curriculum guides and a standardized packet of accompanying materials. While program descriptions and many resource materials are available, the sex education as a whole has not been institutionalized. They had planned to obtain technical assistance during 1982 before moving into the final stages of the program, but have not yet done so, nor have they conducted a comprehensive internal evaluation.

It should be noted that IPHE is well known outside of Panama for its capability in meeting needs of the handicapped and have provided training for professionals from other countries. When they have institutionalized their sex education program it is expected that other countries will want technical assistance and training from them. They have used training very well.

2. Problems and Obstacles

The target population of IPHE has highly specialized needs, with every conceivable mental and physical handicap. The major obstacle for IPHE appears to be the pioneering nature of their effort. Sexuality education

for the mentally and physically disabled extends to their families, personnel of institutions and out-patient services, and other professionals who are involved with their education, health and social needs. Unplanned, untimely and unwanted pregnancies can be reduced in this population but effective contraceptive behavior must be accompanied by sexuality education and sensitivity on the part of families and professionals. IPHE staff have not had many opportunities to observe similar efforts elsewhere nor have they benefited from outside technical assistance in Panama. There is an understandable reluctance to finalize a program without a greater exchange of ideas among professionals with similar goals and programs.

F. AID Participation

1. Present Status

The Project Agreement has been revised since the 1981 evaluation visit but the nature of the AID's participation in the sex education program was not changed. AID support is confined to funding for personnel training, the purchase of appropriate materials, and funding of technical assistance for the development of the grantee institutions' programs. The AID does not pay salaries of personnel, support the actual delivery of the sex education program except when it relates to the grantee's need to test and modify aspects of its program, and the AID does not establish the goals, objectives or strategies for the program.

The role which the Mission project staff has played is highly praised by grantees. During interviews grantee staff stated that they are pursuing the programs and strategies most suited to Panama and that the Mission has been fully supportive of them without interfering in any way. The Mission's approach must certainly be credited with the strong relationship with the institutions in a potentially controversial program which threatened to become political during the 1981 evaluation. As described earlier in this report, MOH staff ser-

ving on the National Commission implied that the AID was directing the efforts in sex education. Other members ignored the accusation and renewed activities in collaboration with the Mission when it appeared that the Commission had reached a stalemate. The AID's relationship to grantees and the clear limitations on its participation have contributed to the progress of individual programs since the 1981 evaluation visit.

2. Problems and Obstacles

The only problem with the AID participation is that its termination date of September 1984 corresponds with budget periods and not necessarily with the pace of the evolving sex education program. Ideally the phase-out of AID participation should match a certain level of institutionalization of the sex education program.

Project Administration

A. Contractual Arrangement

The contract is oriented around annual approval of narrative and budget plans, authorization of expenditures by the AID project officer on a quarterly basis and progress reports from grantees. A serious hold-up for all parties was the failure of the Minister of Health to sign the revised Project Agreement during 1982. Grantees were not authorized to encumber expenses for activities during this period, which interfered with progress in the training area which is so heavily dependent upon AID funds. However, current procedures providing for annual approval of funds is an improvement over the 1981 situation requiring quarterly approval.

A potential problem with the current contractual arrangement is that all funds must be encumbered by September 1984. Without a provision for carry-over, the pace of the sex education program may prevent the use of all budget funds.

42-1

B. Role of the Ministry of Planning and Economic Policy

The Ministry's role has not changed; that is, it is primarily one of monitoring incoming assistance and progress toward goals of the grantee institutions. The current staff person assigned to this particular Project Agreement expressed a willingness to facilitate progress in any way he can. As previously mentioned, he called a meeting with the MOH on his own initiative because he was concerned about the failure of the MOH to expend funds earmarked for sex education activities, and was already aware of the similar situation with family planning service funds within the MOH. He also expressed a strong interest in the use of technical assistance consultants for grantees as a means of obtaining a more accurate picture of the quality and effectiveness of their programs.

C. Coordination With Other Agencies

There is little indication of funding possibilities for sex education programs other than the AID, except for limited support to the MOH by the United Nations Fund for Population Activities (UNFPA) and support to APLAFA by the International Planned Parenthood Federation and similar agencies. Communications with UNFPA continue to be sporadic and vague. The UNFPA representative in Panama at the time of the 1981 evaluation made contradictory statements regarding assistance to the MOH and there currently is no representative.

A problem with the lack of communication with the UNFPA is that it might proceed independently to support sex education activities without consulting with the AID and benefiting from evaluation efforts.

Project Agreement with APLAFA

Support to APLAFA is oriented around direct delivery of sex education programs to adolescents living in the San Miguelito area, their parents, and professionals from other fields who require training in human sexuality and

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assistance in the development of their own sex education programs. As an IPPF affiliate, APLAFA's education services are monitored to some extent, and there is therefore some degree of standardization with international guidelines.

Progress toward objectives described in the Project Agreement is quite satisfactory, but APLAFA feels strongly that evaluation has been strictly confined to quantifiable activities. They would very much like to have feedback specific enough to make changes in their program design. While they collaborated with the Catholic University on a study of attitudes and behavior of adolescents (see Appendices) they are waiting for the University to conduct a symposium which will provide better guidance on how to use the information generated by the study. APLAFA also feels that their materials are not very responsive to education and outreach needs, and would like some technical assistance.

Perhaps the biggest question facing the education division of APLAFA is whether they should expand the services they offer to adolescents in the geographic area they currently serve, or expand the geographic area and provide sex education to greater numbers of adolescents and their families. While this question does not directly pertain to AID's participation in the sex education program it is important in the context of the AID's overall assessment of the institutions it supports.

44

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IV. RECOMMENDATIONS

State of the Art of Sex Education in the United States and Panama

Few countries give official recognition to comprehensive sex education programs, and efforts which are currently undertaken in the field of sex education cannot be characterized as adhering to any widely acceptable standards. The emerging sex education program in Panama has high-level commitment and an unusually broad base of support, and is an exception to most.

RECOMMENDATION: Every opportunity should be taken to share Panama's experience with similar efforts in other AID countries, and AID support should be continued and enhanced until each institution has achieved self-sufficiency in the delivery of its sex education program.

National Commission on Sex Education

The Project Agreement established goals and objectives adopted by the National Commission, but individual institutions and agencies are the grantees rather than the Commission itself, a voluntary body. While the Commission can play an important role in the coordination of a national sex education program, individual Commission members have disagreed over this role.

RECOMMENDATION: The AID should continue its policy of relating separately to each grantee, monitoring the progress of each toward its contract obligations, encouraging and facilitating coordination, but leaving to the grantees the decision as to whether they will use the Commission as a coordinating mechanism.

Program Activity

A. Interinstitutional Effort

Grantee institutions have expressed a desire for technical assistance



in several areas and the most urgent recommendations in this report relate to these technical assistance needs. Problems and obstacles to progress identified in the evaluation are due primarily to lack of experience or expertise in certain phases of the programs, and grantees are in the enviable position of readiness to apply any experiences and strategies they determine would be useful and appropriate. The representative of the Ministry of Planning and Economic Policy expressed the desirability for technical assistance consultants also, because he feels they can provide an objective assessment of quality and effectiveness he could not otherwise obtain from the institutions.

With only eighteen months to go and the Mission's project officer about to depart after having worked with the project from its earliest days, it is highly advisable to develop a plan at once, and to implement the technical assistance over the next several months. With a plan in place, the Mission project officer's departure will not disrupt continuity or alter the direction of the program, and implementation over the next several months will stimulate progress which is needed to meet the September 1984 deadline.

Since many grantees described similar technical assistance needs, and others could clearly benefit from expertise they may not have foreseen, the recommendations are designed to meet requests as well as to ensure coordination among the institutions. Technical assistance has been identified in the areas of research, evaluation, materials production, curriculum development and strategies for obtaining community support.

RECOMMENDATIONS: The Project Agreement identified base-line data as an objective, and the MOH as the lead agency for conducting any such studies. The Mission should now obtain technical assistance consultants to meet with all grantees, discuss the first draft of a study to be submitted by the MOH in order to ensure that most research needs of the grantees are met by the study design, and all grantees should be asked to participate

46

in the APLAFA/Catholic University symposium on their study in order to make any needed modifications in the MOH study to ensure a basis for comparison. Final approval after these two steps should be obtained by the Mission from each institution, separately, in keeping with the contractual relationship, i.e. it should not be the role of the MOH to obtain such approval from the other institutions and relay it to the Mission.

- * Limited studies or surveys are valuable to sex education programs as needs assessment tools and for feedback in order to modify methodologies. Each grantee has a different service population but can use similar techniques for assessing needs. The Mission should request of the consultants who assist with the base-line study that they also provide this type of assistance to grantees as part of their institutional development, so that they may conduct limited surveys and studies as part of their on-going program in the future. Furthermore, since some grantees feel they could immediately undertake such limited studies (e.g. DINNEA) after receiving some assistance, the Mission should request specific plans and assurances that other project activities will be completed by September 1984.
- * Evaluation techniques are needed for assessing program content, teacher effectiveness, appropriateness of materials and other aspects of the programs. The Mission should identify with the grantees the best method for meeting this need, preferably through a workshop in which both grantees and outside professionals could exchange experiences.
- * Materials production is required by all grantees and the Mission should immediately implement the recommendations contained in the Family Planning IEC Needs Assessment report of Coleman and Saunders with two additions: that APLAFA share in the assistance, at their request, and that the MOH be informed that the Mission will not reconsider their request for off-set equipment until the consultants in materials production have developed a

4/1

plan for the Ministry's IEC effort; and once approved by the Ministry the consultants assess all needed resources for materials development.

- * Curriculum development needs have been expressed by all grantees. A curriculum specialist already familiar with Panama's program should assist the grantees to outline the desired curriculum for each target population and to identify and secure the services of professionals from various fields who can assist with the development of the content for such special audiences as the mentally retarded and pre-school children.
- * Strategies for securing community support are required by all grantees, the MOE in particular. This need should be met by supporting observation trips and participation in courses related to programs similar to that of each grantee; and by convening at least one workshop in which professionals from within and outside Panama are brought in to exchange ideas. Grantees should be permitted to contract with those individuals from the workshop who can best give them on-site assistance in developing community support.
- * Interinstitutional coordination and support from the Ministry of Planning and Economic Policy should be enhanced by the Mission. It should consider a joint meeting to discuss these recommendations, develop a plan to schedule technical assistance, review the names and backgrounds of possible consultants from outside Panama as well as within the country, and finalize dates.
- * Content, purpose and scope of the study to be undertaken by the MOH must be thoroughly discussed with the Mission project officer before his departure and documented in detail, particularly because he felt that the APLAFA study did not provide all of the data that would be required for a sex education program that addresses effective contraceptive behavior.

48

B. Ministry of Health

The MOH has not performed well under the POPULATION II Project Agreement, primarily because personnel responsible for this effort do not feel family planning or sex education should be a separate program within health services and feel that funding guidelines are therefore too rigid to support a complete integration of the activities. It is far too late in the Project Agreement to expect a sudden reversal of a pattern of many years. Other grantees' sex education programs have very good potential for meeting goals and having the desired effect on unplanned pregnancies as envisioned in POPULATION II, and they require the support and attention of the Mission.

However, the MOH is responsible for conducting studies which are to serve as base-line data for sex education programs of all grantees, and the Ministry does have the in-house capabilities for carrying out such activities. Furthermore, the MOH has requested off-set equipment which it feels would permit them to produce more family planning and sex education materials, even though they have produced very little to date using outside services which AID has always been willing to reimburse.

RECOMMENDATIONS: Any Mission support of the MOH in sex education should concentrate on studies, particularly the comprehensive knowledge, attitude and practice study which would provide a base-line for subsequent evaluation of the sex education programs; and the Mission should request a first draft of that study from the MOH, submit it to joint discussion with all grantees and outside technical assistance consultants, request that all grantees attend the Catholic University/APLAFA symposium on their study, and ensure that the study meets AID-accepted survey methodology, the informational needs of all grantees, and the criteria for comparison with the APLAFA study. Prior to final authorization for expenditures the Mission

119

should make provision for follow-up assistance from the same consultants for the analysis phase, and request a detailed description and schedule for training interviewers, conducting the study, and tabulating results.

With regard to sex education materials, since there is a demand for them by professionals in the field, and since the MOH seems to be so interested in off-set equipment, the Mission should consider implementation of the Coleman-Saunders IEC Needs Assessment recommendations. Since materials development technical assistance will be brought in for the other grantees anyway, further work could be done with the MOH, informing them that if they approve and implement an action plan for IEC and sex education materials as a result of the technical assistance, reconsideration of the request for off-set equipment would be included in the consultants' overall needs assessment and recommendations. However, the Mission should not initiate efforts to increase any other MOH activities in sex education but should give due consideration to any initiatives undertaken by the MOH.

C. Ministry of Education

To date, the MOE has demonstrated both commitment to integrating sex education into the public school system and an understanding of the sensitive nature of the program's content. Their strategy consists of training guidance counselors to develop and coordinate sex education programs in their schools, and to meet with parents prior to implementing classroom activities. The first phase is scheduled to end in June of this year, by which time 250 guidance counselors will have been trained in two-week courses, through eight seminars offered throughout the country. There is no detailed plan for the second phase, although a 12-hour curriculum has been developed for three grades at the high school level.

RECOMMENDATIONS: It is imperative that the July-September Quarterly Plan submitted to AID outline the MOE's strategy for the second phase, and the AID adhere to its role of supporting development as opposed to delivery of programs. It is possible but unlikely that a new director might by-pass a pilot program with a few guidance counselors, and attempt to initiate the program nation-wide using all trained guidance counselors, a strategy that would not be eligible for support within the confines of the Project Agreement and AID's role.

It is advisable to request a meeting prior to July with the new director, or with the Ministry official responsible for hiring a new director if the process has not been completed by June, and to outline the kind of information the Mission would like to have in the Plan:-

- which teachers, within which schools, will be selected to initiate the sex education program in this phase;
- what materials and teaching guides will accompany the curriculum;
- how will individual teachers be selected, how will they be trained and supervised; and their working conditions changed and accommodated;
- how will curriculum, teaching techniques and materials be tested, and how will the courses be structured within the school day, or will they be outside school hours;
- how will school administrators, guidance counselors and teachers approach the parents and what will be the parents' role, e.g. . advisory, participatory, monitoring, permission slips, etc.;
- how will the initial experiences of the pilot phase be shared with the rest of the country's guidance counselors

51

- 51 -

It is also recommended that MOE staff have as much opportunity as possible to travel to other programs outside Panama. There have been at least as many failures as successes in the sex education field and Panama's MOE has an excellent chance at success if the next phase is well thought out. Experiences are generally confined to individual communities so it is difficult to make a single trip to any country and hope to learn from a comprehensive program. The recommendations of the interinstitutional effort will also contribute significantly to the MOE program.

D. National Directorate of the Child and Family (DINNFA)

DINNFA is progressing very well according to their planned program and now welcomes technical assistance and approval of AID to pay for specific activities in studies or surveys, a curriculum guide for pre-schoolers, and design and production of materials. They have made excellent use of the training programs.

RECOMMENDATIONS: It is highly recommended that their technical assistance needs be met as described under the interinstitutional recommendations, and that on a limited basis they proceed with needs assessments surveys, while the more extensive research study is being carried out through the MOH. DINNFA was particularly anxious to build in a great deal of assistance from someone on design and production of materials since they do not have a capability in that area.

It is also recommended that if DINNFA does experience the anticipated hold-ups from the Government Accounting Office regarding AID reimbursement, Carlos Sanchez of the Ministry of Planning and Economic Policy be invited to participate in a joint meeting to resolve it.

Furthermore, it is recommended that the AID provide as much support as possible for the seminar on the participatory technique which



is planned for staff of many agencies working both in breast feeding and sex education. However, the Mission should request in advance a plan for follow-up of the participants who will be doing sex education, including their role and responsibilities and what groups they are expected to train and/or educate using the new technique.

E. Panamanian Institute for Special Education

As described earlier, IPHE had progressed rapidly by the time of the 1981 evaluation effort. Since that time their extensive training activities have not led to a phase in which a sex education program has been integrated into the institution, accompanied by curriculum and teaching guides.

RECOMMENDATIONS: It is essential that IPHE receive good technical assistance and feedback for their program for the handicapped. Their need is for expertise of a highly specialized nature, not found in many areas outside of Colombia, Uruguay or the United States, and they have already expressed the desire for someone to come to Panama. Once technical assistance is identified and brought in, IPHE staff will benefit from travelling to other areas for observation, after which it is expected that they can systematize their program activities.

50

F. AID Participation

The AID Mission has been remarkably successful in supporting the developmental phase of a national sex education program, which has already begun to extend sexuality and family planning education to segments of the population that would not ordinarily be reached by the public health system. The potential for controversy has never surfaced, in large part because the Mission project officer has painstakingly adhered to the limited role of developing institutional capabilities, leaving to the institutions the role of planning and implementing their sex education programs.

RECOMMENDATION: Prior to the departure of the Mission project officer who has been so instrumental in the AID's participation, a detailed plan for technical assistance for the grantees should be finalized, and activities initiated.

Project Administration

A. Contractual Agreement

RECOMMENDATION: Progress toward goals should be carefully monitored over the next eighteen months and provision made for carry-over of funds beyond September 1984 if it appears that the deadline will not be met. It is crucial that activities not be speeded up to meet planned expenditures at the expense of the necessary steps that must occur to successfully institutionalize the programs.

B. Role of the Ministry of Planning and Economic Policy

RECOMMENDATIONS: The representative of the Ministry should be invited to assist in planning and implementing technical assistance for the grantees and his participation should also be sought whenever administrative hold-ups within Panamanian institutions cause delays in activity.

54

C. Coordination with Other Agencies

RECOMMENDATION; The Mission Director should request a formal communication to the AID from the UNFPA regarding its future plans for Panama's sex education program, and a commitment that the UNFPA will not proceed with any plans until it has met with Mission staff to discuss past evaluations and current status of the program.

Project Agreement with APLAFA

As an affiliate of the International Planned Parenthood Federation, APLAFA is much less dependent upon AID for the development of its sex education program. Nevertheless its function as an agency includes the area of sex education and it has been of great value to overall coordination of efforts that APLAFA is also an AID grantee, particularly since some ministries do not accord APLAFA the recognition it should have. Staff of various agencies have informally worked with APLAFA, in part as a result of the AID-related activities.

RECOMMENDATION: The Mission should obtain a commitment from APLAFA and the Catholic University to offer their symposium on their study prior to the departure of the Mission project officer, and with sufficient time to integrate findings of the symposium into the study to be conducted by the MOH. Furthermore the Mission should inform all grantees that in order for AID to be accountable for the expenditure of funds, participation in the symposium and selection of a methodological basis of comparison between the two studies will be a prerequisite for final approval of the MOH study.

Future Evaluation of the Project Agreement

A review of the 1981 evaluation report and recommendations reveals that most recommendations were either implemented, not necessary due to other actions, or postponed to a more appropriate phase of the program. One recommendation that was not implemented relates to the grantees' obligation to maintain records and document in quarterly progress reports the use and effectiveness of AID assistance.

RECOMMENDATION: The Mission should prepare for the final evaluation of the sex education Project Agreement by informing all grantees that they are required, under terms of the Agreement, to conduct their own evaluations. The Mission should formally request results of evaluations through the period ending June 1984, prior to the end of the September 1984 termination date, including at least the following types of information:-

- total training sessions, type of individuals trained and quantity;
- description of the activities carried out by those who were trained;
- description of the use and impact of materials;
- description of any other technical assistance reimbursed by AID and its impact on the development of the sex education program; and,
- present status (as of June 1984) and future plans of the sex education program.

56

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FAMILY PLANNING COMMUNICATION
NEEDS ASSESSMENT AND POPULATION II IEC
EVALUATION: PANAMA

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Dates of In-country Work:
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51

TABLE OF CONTENTS

Executive Summary	i
Introduction.....	iii
Part I. Needs Assessment	
A. Family Planning Overview.....	1
B. Government Agencies Involved in Family Planning.....	3
C. Private-sector Family Planning Agencies.....	7
D. Sex Education Programs.....	9
E. International Assistance.....	10
F. Conclusions and Recommendations.....	13
Part II. Population II IEC Activities	
A. Introduction.....	16
B. Family Planning in Panama.....	17
C. Channels of Communication.....	19
D. Specific Requirements in the Project Agreement.....	36
E. Conclusions and Recommendations.....	43
Part III. Country Profile	
A. Demographic Information.....	51
B. Social Information.....	52
C. Type of Government.....	52
D. Population Policy.....	52
E. Family Planning Policy.....	53
F. Contraceptive Prevalance.....	53
G. Broadcast Media.....	54
H. Print Media.....	56
I. Other IEC Resources.....	57
Appendices	
A. List of Contacts in Panama.....	60
B. Contraceptive Prevalence Survey Data.....	62
C. List of Radio Stations in Panama.....	65
D. Sample of Market Research by Solarian Corporation.....	78
E. Critique of Leaflets.....	85

92

Executive Summary

Panama is on the borderline of being classified as a developed country. Its high per capita GNP (\$1,730) and high contraceptive usage rate (63%) have caused the Ministry of Health (MOH) and government officials in general to feel that family planning programs do not need lots of attention or promotion. The women of Panama are demanding services that the government is hard-pressed to meet at the present time. As a result, there is a lack of interest and action in IEC on the part of the MOH. The MOH also lacks a qualified communication specialist who could design, produce and implement communication programs.

Despite all the positive aspects of the family planning program in Panama, IEC efforts could be especially effective in the promotion of temporary methods (e.g. pill, IUD) as a means for couples to space their children. Female sterilization is the most popular contraceptive method; and women have four to six children by the time they are 25 years old. A good IEC campaign could explain the benefits and advantages of childspacing to young women.

Panama is a pioneer in the area of sex education. The government has seen the problems of teenage pregnancies and the large percentage (70%) of out-of-wedlock births, and is taking steps to resolve these problems. The Ministry of Education (MOE) is introducing formal curriculum on family life, contraception, human reproduction and other themes in March 1984. The MOE has already trained their guidance counselors in these fields, and they are providing individual and small group counseling. Other government institutions are also participating in the sex education program.

The private sector with APLAFA is also providing some sex education services and training in the San Miquelito area. Their program, based on the Door (New York) and APROFAM (Guatemala) models, is serving as a prototype for the non-formal aspects of the government's sex education program.

The sex education program could use technical assistance in the development and creation of audio-visual aids and promotional materials. Both the public and private sectors lack communication specialists who know how to design

messages and materials for a specific audience in an attractive manner. All the organizations involved with the sex education program need materials for parents and adolescents. A general consensus exists that materials could and should be shared by all the organizations participating in the sex education program.

The broadcast and print media are greatly under-utilized for family planning IEC activities. There exists an awareness of the population problem and a desire to assist the program on the part of the media. Actions should be taken to involve the media more, especially in the areas of childspacing, responsible parenthood, teenage pregnancies, and male participation in the family planning program.

USAID is the principal funding agent for the Panamanian family planning program. AID officials are extremely concerned about how their funds have been used and how they will be spent by the time the grant ends in October 1984. AID is especially troubled by the lack of activity in IEC. It is our opinion that the Ministry of Health cannot and will not mount an effective IEC program in family planning and AID will need to reprogram their funds at the end of the grant.

Introduction

The following report is the result of a two-week assignment by the authors in the Republic of Panama from January 15-28, 1983. The principal objective was to conduct a needs assessment of IEC activities in family planning. Secondary objectives were to: 1) evaluate the IEC materials currently being used and make recommendations for improvements; and 2) make recommendations on future Population Communication Services assistance in Panama.

Since the Ministry of Health is the primary mover in IEC/family planning, most of the time was spent with them. USAID/Panama gave invaluable assistance and insights into the program also. The Ministry of Education, the Ministry of Labor and Social Welfare and the Panamanian Family Planning Association supplied the majority of information on the status and development of the sex education program. All information was gathered in Panama City except a one-day trip to the Colon Health Region.

The report contains a wealth of information. Included are background data, evaluations and assessments. The report is organized into three sections. The first section contains an assessment of the family planning institutions and conclusions and recommendations. The second section is an evaluation of the IEC activities as prescribed by the Population II grant from AID/Panama to various government ministries. This evaluation was submitted to AID/FRD/Panama at their request, as a separate report. It is included here as supplemental data. The third section is a country profile which consists of relevant background information for the reader. The last part of the report contains the appendices of additional information which supplement the report.

PART I. NEEDS ASSESSMENT

A. Family Planning Overview

There is little or no concern about population growth in Panama. The latest reported birth rate was 27 and falling. The death rate at 6 per thousand is comparable to that of a highly developed country. The resulting growth rate of 2.1 percent is considered to be no problem. The Government has endorsed the declaration emanating from the 1974 Bucharest Conference that couples have a right to determine the number and spacing of their children and is permissive about and mildly supportive of family planning activities. The Catholic Church (more than 90 percent of the population are Catholics) has also been highly permissive although, with a visit from the Pope imminent, there is some feeling that for a time attitudes may be a bit more restrictive.

There is no explicit population policy, but with UN support a group has been set up in the Ministry of Planning and Economic Policy to study trends in population changes and make recommendations about how to handle any trends that threaten development aspirations. There is some official concern about the distribution of the population and especially about the rapid movement of people into urban areas, particularly the metropolitan area of Panama City, and a few policies aimed at a better distribution have been adopted.

USAID and UNFPA have been supporting population and family planning activities for nearly 20 years and a few other countries have provided support for individual projects with some implications for family planning. Among the private-sector agencies, the Pathfinder Fund, FPIA, IPAVS and IPPF have supported family planning activities.

Family planning is firmly in the hands of the medical profession in Panama and it is especially dominated by government health agencies. Family planning has no separate identity. It is conceived as being totally integrated with the Maternal and Child Health services of the Ministry of Health. As such it has a low priority in the hierarchy of health services. Since the health professions do not advertise, not much importance is attached to IEC activity, and such activity as is carried on has as a principal objective the orientation of potential health service clients to the availability of services. There is no IEC unit in the Maternal and Child Health Division central office, and IEC activities have been and continue to be the responsibility of a health educator with minimal training in communications and with no staff. The bureaucracy is also extremely sluggish. In the past year there have been three Ministers of Health and two heads of the MCH Division. The most recent of the latter has been in office only three months. Simple contracts for some radio programing have been held in the legal department for four months and are not approved yet, despite the fact that they are identical with earlier contracts that were approved. A request to print a few leaflets remained for more than two years in the Minister's office before being approved. Between field facilities and the central headquarters are regional health offices that serve to block more than facilitate the flow of information from the center to the field.

As of 1981 there were 398 health facilities from which services, including family planning, were available. These included health posts in small villages staffed by a single medical assistant with one year's training; sub-centers, health centers, and hospitals of the Ministry of Health; and the polyclinics and hospitals of the Caja de Seguro Social which provide health services to CSS members in the metropolitan area and, under an arrangement with the Ministry of Health, to the general public in other areas.

Health examinations are required as a prior condition to receiving an IUD or orals and a follow-up examination is required also for both. Pills are available

only on prescription. The first supply is for one-month only. At the end of the month there is a second health examination after which pills are generally provided for a three-month period. Sterilization, for which there is a long waiting period, requires, even for the mini-lap, at least two nights' hospitalization. Women who are affluent and impatient can obtain the operation under a private arrangement, from the same physician who would have performed it at a health facility, for upwards of \$250.

Seventy percent of all contraceptives are obtained at Government facilities; an additional 10 percent are obtained from private physicians, and 9 percent from pharmacies. The Government logistics system does not function well and contraceptives frequently are in short supply. Doctors are not present in health posts and sub-centers every day and those who patronize them in search of family planning materials or services have to wait until one comes.

Depo-Provera is not available through the Government system, which follows the rulings of the FDA in the U.S., but some pharmacies can supply a Mexican injectable that can be given by a private physician. There are no community-based distribution systems and no social marketing of contraceptives. The possibility of setting up some kind of subsidized commercial retail sales system with the help of a private Panamanian organization is being explored by the AID population officer.

IEC activity is minimal. As indicated above, it has no priority and there is not an adequate staff to manage it. A requirement of the Population II Agreement, signed in 1979, called for the MCH Division to provide a full-time qualified communication specialist to coordinate and oversee IEC activities. None has been employed; none is likely to be. In the three years that the Agreement has been in force no informational materials have been printed and most health facilities have not had any during the past year or two. There has been no organized attempt to use newspapers. A few radio spots have been run sporadically and there have been one or two TV talks. The main communication channel is the interpersonal exchange that take place through the informal networks that exist throughout the country and that which goes on between health facility employees or health educators and the public they serve. Health educators do have some audio-visual equipment (10 jeeps with sound and film equipment were provided by AID) but the equipment is probably used more for general health promotion than for family planning. There has been little or no progress towards most of the objectives for family planning IEC specified and agreed to in Population II, and the prospects for the future do not look promising.

Despite the restrictive service and contraceptive availability and the lack of any vigorous IEC effort, contraceptive acceptance and use in Panama is comparable to that of a highly developed country. A 1979 Contraceptive Prevalence Survey showed that 63 percent of married women in the reproductive age group were using contraceptives, up from 53 percent reported in an earlier survey in 1975. Sixty-seven percent of eligible urban women were using contraceptives and 55 percent of those in rural areas. Thirty percent of the married women of reproductive age have been sterilized (the modal method) despite the relative difficulty of getting service and Ministry restrictions that limit sterilization to women who are at least 28 years of age and have four or more living children. (Marriage age is quite low in rural areas and many women are said to have four children by the time they reach age 20.) Orals were the next most popular method, followed by IUD's.

One of the questions asked of the chief of the MCH Division of the Ministry of Health was: "What would be likely to happen if AID no longer supplied contraceptives and other support?" He noted that no funding is provided for family planning by the Ministry now and that, given other priorities and shortages of

funds, none is likely to be. Given their low priority, family planning services, if outside support were withdrawn, would be greatly curtailed and the little IEC activity that now goes on would be terminated, except for the face to face information transmitted by health staff. In that event, if it were felt necessary to keep family planning going, it would have to be done through the private sector. Given the degree of demand that now exists, it is likely that a high rate of contraceptive use could be continued if materials were available from commercial sources.

B. Government Agencies Involved in Family Planning

Ministry of Health (MOH)

USAID has been supporting family planning in the MOH since 1965 and UNFPA for almost as long. The Population II Agreement provided \$330,000 to MOH for IEC activities during the five-year period, 1980-1984. For an account of how this has been handled and what has been done see the Mid-Term Review (Part II) prepared by Patrick Coleman and Lyle Saunders at the request of USAID/Panama.

The Government, through the MOH and its sister agency CSS, has a virtual monopoly on family planning services and contraceptives in Panama. The private association, APLAFA, operated a few clinics in the country from the mid-1960's into the early 1970's, but it is now restricted to one and devotes most of its time to sex education and work with adolescents. Contraceptive services and presumably supplies are available from private physicians and pharmacies. Seventy percent of contraceptives are obtained from Government facilities, according to the 1979 Contraceptive Prevalence Survey; twenty percent come from private physicians and clinics and pharmacies.

Aside from a few radio spots and some outreach activities by health educators, the MOH has done little in IEC during the first two-thirds of the Population II Agreement period. Of the \$330,000 allocated, only around \$60,000 has been spent. Nothing has been printed and the few health centers that were visited during this assessment reported that they had been out of support materials for more than a year. Audio-visual aids are in short supply; jeeps and equipment provided to the MOH for family planning outreach are being used for other purposes.

From the beginning of the Population II Agreement to mid-1982, IEC was the responsibility of a health educator who had attended several short-term communication training courses, and no staff was designated to work with him. He left around August 1982 to become head of the Health Education section and IEC was left in the temporary charge of a nurse. As of January 21, 1983 there is a new full-time person with IEC responsibility—a health educator who has attended four short communications training courses. Her unit is called Community Organization and Education, and she, like her predecessors, has no staff to work with.

One of the requirements of the Population II Agreement was that the Maternal and Child Health Division (MCH), which is responsible in the MOH for family planning IEC activity, employ a full-time communication specialist to coordinate IEC activities. None has been employed, and none is likely to be since the MOH does not have funds for such a person this year and is not likely to have them next year. It is also unlikely that a qualified person with both communication skills and a knowledge of family planning could be found in Panama.

Family planning is regarded by the MCH Division not as a separate identifiable activity but as an integral part of maternal and child health. Since IEC activities are not generally used to promote or inform people about MCH services,

there seems to be little interest in informing them about or urging them to practice family planning.

Services and materials are available free (to members) in the polyclinics and hospitals of the Caja de Seguro Social and in several types of MOH facilities in all parts of the country. Under an arrangement between MOH and CSS, the latter provides services exclusively for its members in the metropolitan area, but may serve the general public for a small fee in other parts of the country. MOH facilities and personnel include health posts serviced by a local resident (in very small villages) who has received a year of training. Sub-centers, located in somewhat larger villages, are staffed by a receptionist/secretary and an auxiliary nurse and receive regular visits at periodic intervals by doctors. Larger health centers are staffed by a medical archives (records) assistant, and for each of four specialized divisions auxiliary nurses, nurses, and physicians. There are health educators in each of the ten health regions who work both with communities and with health facility staffs.

Private physicians and pharmacists provide some family planning information in connection with their service and sales functions, but they receive no materials from MCH, and the pharmacists, at least, have had no family planning training.

Family planning services are not free. In 1979 the Government, in an effort to induce people to value the service they receive, instituted a nominal fee of 50¢ per visit to the health facilities. (The funds remain in the local community where they are used, at the discretion of a committee of local citizens, to maintain and improve the facility and its services.) There is a \$20 fee for female sterilization in the Government facilities (private physicians are said to charge around \$250).

There are no contraceptive retail social marketing programs in operation and no community-based distribution systems.

Ministry of Education (MOE)

The Population II Agreement between USAID and a series of Panamanian government agencies provides \$226,000 to the MOE for commodities, training, and technical assistance. Over a five-year period the Ministry is expected to provide staff for the teaching program organized by the Commission on Sex Education, and to train about 260 secondary school guidance counselors through two-week workshops on counseling and orientation in human development and sex education who will then be expected to provide sex education to secondary students and work at the community level with parents and groups interested in sex education. Baseline studies useful in measuring changes in attitudes or behavior following the introduction of sex education courses in schools were also to be done, but the necessary funds went to the MOH, not the MOE.

For some reason, the Population II Agreement with MOE was not signed until August 1981. Training of counselors began in November of that year. About half of the 260 guidance counselors in the system have been trained up to now. The training has an interdisciplinary focus on the biological, sociological, and psychological aspects of human development. The major themes are human sexuality, human development, family life, audio-visual techniques, abortion, human reproduction, dynamics of interpersonal communication, venereal disease, responsible parenthood, contraceptives, and use of teaching aids. Thirty to 40 counselors are trained in each group.

A second phase for the Project, which is scheduled to end in April 1983, is now in the planning stage. It is hoped that sex education courses can begin in secondary schools in the term that begins March 1984. AID will in March 1983 provide a technical assistance person to evaluate progress made to date and later another to help design and implement a curriculum. It is hoped that parents may be involved in the program, at least to the extent of being informed about the program and having an opportunity to cooperate and give their approval. Teachers who will be working with the students will also need an orientation to the program; details of how to provide it are still in the planning stage.

A need is foreseen for a prior survey of both students and parents to assess their current knowledge and attitudes about sex education. MOE has people who could do the survey with some outside technical help.

A variety of types are involved in the planning: teachers, counselors, doctors, social workers, social scientists, and (one would hope) parents. A small pilot project will be activated to provide feedback for curriculum planning. It is planned that there will be activities for youth outside the formal classroom sessions that will provide opportunities for a freer exchange of views among students and with their teachers and counselors. Parents will be invited to participate in some of these sessions.

The Population II Agreement funds training, materials and equipment, and technical help. The Office of Professional and Educational Counseling, which is active in the Project, has some materials from AID and is now listing what more they may want. They have also received some audio-visual materials from AID. They need many more materials and equipment. They are willing (and able) to adapt material from other countries, but would prefer to have as many as possible originating in Panama. They will require technical assistance in design and production, and have received some from private-sector sources, notably Johnson and Johnson and Kimberley Clark companies. (Patrick Coleman helped to prepare a list of materials and equipment they needed. He also discussed slide/tape shows, videotape as a substitute for films, print materials, use of folk media, and uses of radio, one of which would be for informing and involving parents.) It is possible that materials on two levels may be needed: for students, and for parents and other adults. A bibliography on sex education and human development has been compiled and will be given to all secondary schools; each school with a counselor (most) will receive books worth \$500 as a basic library for counselors and students.

Caja de Seguro Social (CSS)

CCS, through its polyclinics and hospitals located mainly in urban areas, provides a high proportion of the family planning services available in Panama. It has a large membership, some mandatory by virtue of their jobs, others voluntary. Family planning services are free to members; for others there is a small charge, the amount varying with the type of service given. CSS has an agreement with the Ministry of Health under which it serves only its members in the metropolitan area, but shares with the Ministry the provision of family planning services to the general public in other parts of the country. To compensate CSS for this service, some of the salaries of the CSS medical staff are paid by the Ministry.

CSS has no family planning information program except for the information that is provided clients in a face to face situation.

Ministry of Labor and Social Welfare, National Directorate for the Child and the Family (DINNFA)

The Population II Agreement of USAID and Panamanian agencies provided \$190,000 to DINNFA for commodities, training, and studies and evaluation in the area of sex education.

The sex education program of DINNFA has been operative since 1980. The agency works with such population groups as the poorest people, teachers at juvenile halls, community leaders, adolescents, organized women's groups, and some government officials.

During 1982 the agency worked with some 300 individuals in three provinces. The main approach has been through workshops. About 25 have been organized to date. Workshops run 6 to 9 days, 8 hours a day. For government employees they are held Monday through Friday; for the general public on weekends. Two days are generally spent making audio-visual materials that the trainees can use after the workshop ends. Participants are trained to be carriers of information about sex education. The themes of the National Commission on Sex Education are followed; techniques emphasize group dynamics and those of non-formal education. For the first two years, medical staff of the Ministry of Health were used for medical subjects, such as the physiology of reproduction, but this practice has been dropped because the trainees didn't understand the presentations. Now DINNFA does its own teaching with expert help from the Ministry of Education.

DINNFA has, uses, and needs audio-visual aids such as films, slides (they make their own), drawings and posters (also largely homemade) and is in the process of getting a slide/tape show done for them by TV Channel 11. It would like to use video tape in the training and probably will be able to through a relationship with Channel 11 (a public station) which is very cooperative and will provide help to any extent that does not require an expenditure by the station. The station, for example, will transmit 29 second "capsules" for DINNFA or provide such "capsules" to any other agency or station that might want to use them.

DINNFA needs more training and support materials, both for teaching purposes and to distribute to trainees and others. It is willing to share its materials with APLAFA, the MOH, or any other agency that can make good use of them.

The Ministry of Health was supposed to do a study of attitudes towards sex in Panama. It has not done so. DINNFA would like the information a study would provide as a guide to its own approach. It gets little information about the proposed study from MOH. It is known that a questionnaire has been designed, but DINNFA has not seen it. They are afraid that too grandiose a study may be undertaken and would prefer something that could be more quickly done. They are considering undertaking a small-scale study themselves. Social workers in their Ministry have had experience with questionnaires and could do a study if they had a bit of technical help in designing it.

Panamanian Institute for Special Education (IPHE)

The clientele of IPHE is mainly handicapped children and youth and their parents and teachers. It is funded, in part, by several countries including Holland and West Germany, and from USAID in the Population II Agreement is receiving \$128,000 for commodities, training, and technical assistance.

In 1980 some 31 staff members of IPHE participated in a three-week training session in sex education sponsored by the National Commission on Sex Education. (The Commission is no longer functioning, but there are plans to resurrect it.) Staff members of the Ministries of Education and Health and the National Directorate of Child and the Family (DINNFA), as well as some from other government agencies, also attended the sessions. There were five sessions, four funded by USAID and one by UNFPA. These were the first large-scale training opportunities in sex education in Panama. The underlying idea was that those who attended would serve as trainers of other staff members both locally and on the national level.

IPHE has and maintains a large, well-stocked audio-visual facility, donated by the Government of Holland. Before the training sessions, some materials were being supplied by APLAFA for family planning promotion and information. AID has also provided films, books, other print materials, projectors, and expenses for training sessions.

IPHE operates a multi-level program for disseminating information. Recipients are the agency's own staff, less severely handicapped children, and parents of the severely handicapped. Some family planning services, including contraceptives, are supplied in addition to information.

The projection for 1983 is that IPHE will serve some 750 handicapped children and around 2,800 teachers, staff, and parents.

C. Private-sector Family Planning Agencies

Asociación Panameña para el Planamiento de la Familia (APLAFA)

APLAFA was established in 1965, opened its first clinic in 1966, and at its peak was operating five clinics. Since 1969 it has received support from IPPF, and USAID has also provided some funding. A few years ago the Ministry of Health took over responsibility for family planning in the country and APLAFA is now permitted to operate only one clinic. Its principal activities now are sex education and work with adolescents. It is concerned with IEC only in terms of interpersonal communication with its clients, although it has provided some printed materials and some teaching assistance to the Confederation of Workers (CTRP).

APLAFA's immediate area of service is San Miguelito, a rapidly growing satellite community of Panama City, with a population now of around 200,000. Its table of organization lists a department of education and a public relations office. The education unit aspires to serve both adults and youth, but the main emphasis is on adolescents. APLAFA acquired funds that have enabled it to construct a rather large two-story building that is used as an adolescent center. It is well designed and roomy and contains a large classroom, a dark room, a well-arranged and equipped library, and a large multi-purpose ground floor room that can be used for dramas, dances, sports, gymnastics, and large meetings.

Around 70 percent of all births in Panama are out of wedlock, many of them to young girls, and APLAFA gives a high priority to teaching young people how to deal with matters of sex. A variety of activities are sponsored to bring youth into the center, but the main purpose is sex education. Anyone in the age group 12 to 25 is welcomed, and the formal classes that are held average 30 to 40 persons each.

APLAFA has a large stock of print materials on hand, some of it original with them, but we obtained no information about how it is distributed. (The AID population officer says the same materials have been stacked up for years.) Among the materials are large numbers of copies of Population Reports, some of which were recently borrowed by the Ministry of Health. APLAFA also has films and projectors, both well maintained. The staff would like other films, especially on subjects related to adolescent sex and of a type that will stimulate discussion rather than attempt to provide answers. They have a Betamax video cassette player, but no tapes and no suitable TV on which to display them. They make their own transparencies for use with an overhead projector in teaching. They have just printed a first run of 500 posters, designed by one of the young students they serve, to use in advertising the courses and other events they sponsor and have plans for another poster to promote the center itself. They are also planning to print and distribute stick-on decals with the center's logo, to give out to adolescents to decorate their rooms, clothes and possessions.

APLAFA's approach to adolescents is one that would be appropriate for expanding to other parts of the country, but the association has neither the funds nor the dynamic leadership to do much more than it is now doing. The present Executive Director, Dr. Julio Lavergne, an obstetrician, is the patriarch of family planning in Panama and a leading figure in organizing the association. He was president for a number of years but resigned to take over the Director's post when the former Director resigned. The AID mission has questioned his leadership and will probably not be funding many APLAFA activities in the future. It was not possible for the team to evaluate APLAFA's activities directly.

Confederación de Trabajadores de la República de Panama (CTRP)

Established in 1956, CTRP is a syndicate composed of 25 labor unions with a total membership of between 45,000 and 50,000. Most of the members work in the industrial and commercial sectors.

A grant from the Pathfinder Fund in 1981 enabled CTRP to add family planning to the areas in which it was already carrying on extensive programs of education for its members. The grant will end soon, but the Confederation hopes and expects to be able to continue its informational and promotional work in family planning.

There were some problems when the family planning program started because some members viewed it as part of a plot by the CIA to keep Panama's population small. The Confederation handled this problem wisely by instituting talks about problem areas related to population, such as delinquency, health of mothers, urbanization, and teenage pregnancies. The opposition was quickly defused and the Confederation moved on to a more direct treatment of family planning. Their format is to offer evening lectures to union groups throughout the country and to select from the audiences interested people to be multipliers and promoters of family planning. Those selected undergo a one-week, 40-hour, training program. To date, about 25 training programs have been held for some 800 workers, with help from the private family planning association, APLAFA, which has supplied technical information and people to explain it. After training, the workers do informal promotion of family planning at their work place and distribute some information materials supplied by APLAFA. No help is received from the central

offices of the Ministry of Health, but some local or regional MOH employees sometimes help with lectures or other information.

CTRP has asked for a batch of informational materials from Pathfinder, but none has yet been received. It has received a few films from AID.

Each union has distributors who provide condoms at no charge to members.

The Confederation uses a part-time psychologist to counsel children of members about moral problems including those related to sex and problems at home. This is a very new undertaking. Twenty-two young people attended the first session.

CTRP needs formal family planning training for five or six key people, to learn about all aspects of contraception and family planning. It could make good use of slides and simple pamphlets and posters. It would welcome batches of the posters and leaflets that the MOH appears to be about ready to produce, but is not likely to get any.

This is a program with a large receptive clientele and one well worth supporting. The contact person is Lic. Francisco Sanchez, Sub-secretary of Education.

D. Sex Education Programs

There is considerable interest in sex education in Panama. Sex education for adolescents is the major focus of activity of APLAFA, which, under the terms of an agreement with the Ministry of Health, operates only one family planning clinic. (See the section in this report on APLAFA.)

The Population II Project of USAID equally emphasized sex education and family planning and included as project agencies, in addition to the Ministry of Health, the Ministry of Education, Ministry of Labor and Social Welfare, and the Panamanian Institute for Special Education, an organization that pays special attention to the educational needs of the handicapped.

The Project Agreement called for the Ministry of Health to include sex education in its IEC activities, to use its corps of professionals, especially health educators, to give talks on sex education and to provide training in sex education for nurse auxiliaries. Funds were also provided for some out-of-country training for those who might become trainers in the area of sex education, but these have not been used. In March 1983, USAID will bring in a consultant from the U.S. to evaluate what has been done under the Population II Agreement.

Population II funds were to be used to help launch a National Program of Sex Education. The first two phases were to include training by the National Commission of Sex Education of multidisciplinary teams from the agencies collaborating in Population II and to use these teams to train professional employees of the Government's social welfare ministries. It was envisaged that about 90 people would be trained. A third phase, now in the planning stage, will be to train guidance counselors in all secondary schools (a fair amount of this has already been done) and teachers and to begin to offer sex education courses in those schools. (See the section in this report on the Ministry of Education.)

E. International Assistance

Multilateral

United Nations Fund for Population Activities (UNFPA)

UNFPA support for Maternal and Child Health/Family Planning began in 1976. The objectives have been to: reduce maternal, child, and adolescent mortality and morbidity; increase the coverage and effectiveness of sex education and family planning services; and develop a program of training, IEC activity, supplies and equipment, and operational research aimed at providing special health services for youth. Funds have also been made available through a series of grants for studying the impact of population changes on national and rural development, integrating demographic variables into the development planning process, assisting in conducting the 1980 census, studying the dynamics of internal migration and the growth of the metropolitan area, and strengthening the training of nurses for MCH/FP work. Executing agencies for the various projects have included UNFPA itself, UNESCO, WHO/PAHO. As of the end of October 1981, \$3,744.271 had been spent or budgeted for these projects.

World Health Organization/Pan American Health Organization (WHO/PAHO)

WHO/PAHO has supported programs in family health and maternal and child health. Training, consultants, and the operation of a few special purpose units have been the principal inputs.

Bilateral

United States Agency for International Development (USAID)

USAID has supported family planning in Panama since 1965. The most recent agreement, involving a grant of \$3.25 million, was signed in 1979 and is scheduled to run through FY 1984. The focus is on sex education and family planning. For family planning the agreement provides for contraceptives, equipment (e.g., laparoscopes), logistics materials and support equipment, training for medical, paramedical, and other health employees, transport for health educators, and IEC activities.

The AID HPN officer is Mr. John P. Coury. The mailing address is: USAID/Panama, APO Miami 34002. Mr. Coury's office phone is 64-40-11; his home phone is 69-57-32. Mr. Coury will be transferring to Jamaica in the summer or early fall of 1983.

USAID Panama, we were told, is no longer funding health projects and the Mission Director and new head of the Human Resources Section would both like to phase out support for population and family planning.

Private Sector

Association for Voluntary Sterilization, International Project (IPAVS)

The Association is funding an operation for the maintenance and repair of endoscopic equipment and has been doing so since at least 1980. Earlier the Association provided some equipment, along with funds for training in sterilization techniques.

Development Associates, Inc.

Working with APLAFA, the private family planning association, Development Associates has organized, over the past six years, a series of seminars in population and family planning for Panamanian journalists. The latest of the series brought in journalists from other countries of Latin America.

Family Planning International Assistance (FPIA)

FPIA supports the work with adolescents that APLAFA is doing at its San Miguelito Center. In IEC the support will provide courses for 1,600 adolescents and motivational talks for 6,000 young people as well as courses for parents and educators. The funding will permit some 2,000 medical consultations and 14,000 pap smear tests as well as contraceptive services for around 1,200 persons. FPIA has also provided substantial amounts of family planning commodities to institutions in Panama.

International Fertility Research Program (IFRP)

The Program has sponsored two seminars on high-risk pregnancy and family planning, one in response to a request from the Ministry of Health. It has also done research on incomplete abortions coming to hospitals and maternity care monitoring. It is anticipated that IFRP will soon undertake a study of sterilizations in Panama to learn, among other objectives, why there has been such a heavy favorable response to sterilization with almost no promotion having been done and with sterilizations relatively hard to obtain at Ministry of Health facilities.

International Planned Parenthood Federation (IPPF)

APLAFA has been a member of IPPF since 1969. In recent years IPPF has provided support at a level of around \$125,000 a year for APLAFA's sex education and adolescent programs, including a project that provides special services to adolescent mothers. The funds also help support APLAFA's one clinic and some training for rural health workers.

JHPIEGO

The JHPIEGO Training Center in David City provides training in sterilization techniques.

Pathfinder Fund

A Pathfinder grant to the Confederación de Trabajadores de la República de Panama enabled it to offer family planning motivation courses for CTRP members and to train a small group to become advisers and promoters of family planning in their work places, as well as distributors of condoms. CTRP was the first and is the largest labor union in Panama.

Inter-American Training Center for Communications in Population (CIACOP)

In June 1979 the Center conducted a training program for 26 professionals with educational responsibilities in the Ministry of Health.

E. Conclusions and Recommendations

Panama does not present many opportunities for either projects or technical assistance and, with the possible exception of the field of sex education, should not be given a high priority by Population Communication Services. Although the family planning service situation is far from ideal and there is little IEC activity, the contraceptive use rate is high, the birth rate is below 30, there is no official concern about population growth, and there is some possibility that AID support for family planning in the country will not continue beyond the expiration of the current Agreement.

Family Planning. There is no family planning, except that carried on by private physicians and the sale of contraceptives through pharmacies, other than the services offered by the MCH Division of the Ministry of Health and the collaborating facilities of the Caja de Seguro Social. One private-sector project is a prospect. USAID/Panama is holding preliminary talks with a private-sector Panamanian foundation looking toward the possible establishment of a social marketing scheme for contraceptives. It is too early to say what may become of this idea, and some opposition from the Ministry of Health is not improbable. If the idea should be approved, there could be a possible need for outside assistance in designing the project and formulating an information program for it as well as helping with the design and production of informational materials.

MCH Division, MOH. Technical help with IEC is badly needed by this Division, which is responsible for IEC activities in the MOH. The Division was to have provided a communication specialist at the beginning of the current Agreement with AID. It did not and it cannot. There is thus need for technical help from a highly competent specialist who could develop and sell to the Division a plan for a comprehensive IEC program and take the lead in planning and designing suitable materials and seeing that they get produced and distributed. Such a person would need to be either full-time in Panama for a minimum of six months or be prepared to make periodic visits of at least a month's duration at three-month intervals for at least a year. Activities will need to be developed for both the general public and the MOH employees providing family planning services or information.

There are several drawbacks to providing such a specialist: 1) the Division has no IEC staff, so there would be only one person to work with; 2) family planning IEC has a very low priority in the Division; and 3) the bureaucracy of the Ministry is very sluggish. It might be possible, if funds were available, to work through one or another of the commercial agencies with professional expertise, but this would need approval of the Division. AID is not yet certain how it will proceed. Several alternatives were presented in the attached mid-term review of the Population II Agreement, and these will be under consideration. Consultants will be coming soon to evaluate what MOH has been and is doing in sex education and in logistics. When these have been done, it is the intention of AID to convene a meeting of the Ministry of Planning and Economic Policy, which oversees all external assistance, the Ministry of Health, the Ministry of Education, and the DINNFA unit of the Ministry of Labor and Social Welfare to discuss performance under the Population II Agreement and decide what can be done to improve it, especially that of the MCH Division. At that time some decision may be taken on whether or not technical assistance in IEC will be required for the MCH Division.

Ministry of Planning and Economic Policy. UNFPA is funding, within this Ministry, a unit that is supposed to be studying the relationship among population variables and development planning. There is, however, no systematic arrangement

for transmitting the findings to the high-level officials who make decisions about such matters. Some help in designing such a system and getting it into operation would normally be desirable, but in Panama where there is no explicit population policy, no serious development problems, and little interest in population dynamics, such a system would probably be premature.

Sex Education. There is considerable interest in sex education in Panama and there is an official regulation promulgated a few years ago, that all schools should offer instruction in the the area of sex education. Several agencies are active in this field and it is anticipated that sex education courses will be available in all secondary schools in the term that starts in March 1984.

Ministry of Education. The Ministry could use and would welcome technical help in the design and production of teaching aids and print materials for parents, other community members, and adolescents. They could also use help in the development of a proposed bibliography on sex education materials that could be used in setting up a basic library in each of the secondary schools. Arrangements have been made for the Ministry to be evaluated soon with regard to its performance in advancing sex education as provided in the Population II Agreement, and another consultant will be coming to assist with curriculum development. So far there are no plans for an IEC consultant, but one could make an important contribution.

Panama may be somewhat ahead of most other countries in its efforts to implement sex education widely, and any help that can be given to move matters along successfully should be given a high priority. Provision should also be made for an early evaluation of the secondary school program to generate information useful in modifying the program should that be necessary.

DINNFA, Ministry of Labor and Social Welfare. DINNFA, whose concern is with the child and the family, is participating in the sex education program. It could benefit from and would welcome technical assistance in the preparation of materials for people of low education or illiterates--materials of the type that PIACT is experienced in developing. DINNFA's needs are not extensive and a single communication specialist could serve both DINNFA and the Ministry of Education.

PART II. POPULATION II IEC ACTIVITIES

POPULATION IN TEC. ACTIVITIES

A MID-TERM REVIEW

BY

PATRICK COLEMAN

LYLE SAUNDERS

PANAMA CITY
JANUARY 28, 1983

INTRODUCTION

Population II is a Grant Agreement between USAID/Panama and the Ministries of Health and Planning and Economic Policy of the Government of Panama for a Project to expand family planning information, education, and communications outreach activities, to extend family planning services, and to promote the introduction and institutionalization of sex education. The Panamanian agencies active with the Ministry of Health (MOH) in the Project are the Ministry of Education (MOE), the Ministry of Labor and Social Welfare, and the Panamanian Institute for Special Education. A separate agreement was signed with the private family planning association, APLAFA, primarily to promote sex education, operate an adolescent center, and carry on outreach activities in the community of San Miguelito.

Population II continues for an additional five years a relationship under which USAID has been providing assistance for family planning to Panama since 1965. The current Agreement was signed on August 31, 1979, but there was no significant activity of the Project until early in 1980. The Agreement will terminate at the end of FY 1984.

With more than half of the Project's time span now past, AID/Panama has concluded that it is necessary to assess how some of its components are progressing. A mid-Project evaluation is also a requirement set forth in the Project Agreement. This first report, prepared by a two-person team from the Population Communication Services Unit of Johns Hopkins University's Population Information Program, a centrally funded AID/Washington contractor, is focused on the information, education, and communications (IEC) activities called for in the Project Agreement.

Later assessments will be concerned with sex education activities and the logistics support system of the Ministry of Health's family planning services.

This report is based on a rapid overview and assessment of the IEC activities of the Maternal and Child (MCH) Division of MOH that have been undertaken in fulfillment of the terms of the Agreement. Information was gathered and the report written in the period January 17 through January 28, 1983. A list of persons from whom information was obtained is appended.

This report is organized around a series of activities that are to be carried on as components of what the Agreement envisioned would be "a vigorous and improved family planning information and education campaign". Each type of activity is dealt with separately, along with appropriate comments, judgments, and suggestions for improvement. In many of the activities specified in the Agreement family planning IEC and sex education are lumped together, but this report will not concern itself with the latter.

FAMILY PLANNING IN PANAMA

Family planning has a low priority in Panama. There is no official concern about the population growth rate and no official policy to do anything about it. The Government has endorsed a declaration of the 1974 Bucharest Conference which states that couples have a right to determine for themselves the number and spacing of their children and that governments have an obligation to assure that they have access to the means to exercise that right. The implicit policy of the Government is

thus permissive and low key, and the rationale for offering family planning services is the enhancement of health and welfare, not a reduction in the birth rate.

Family planning is almost exclusively in the hands of the health professions and the approach is highly conservative. Contraceptives can be obtained only from a health facility, a private physician, or a pharmacy. Prescriptions are required for oral contraceptives and a health examination is required prior to issuing a prescription and after the pills have been used for a period of time. Sterilization is the preferred contraceptive method; especially in the rural areas where it holds a two to one advantage over the next preferred method. Even though the MOH has made sterilization less accessible by imposing restrictive requirements, currently 28 years of age and four living children, there is a two months wait to be sterilized. Part of the reason for the delay is that sterilizations are done only in hospitals and usually require two nights stay. Some MOH staff view the conservative approach to sterilization as overly restrictive in the rural areas and as forcing women either to risk having more children or to use a contraceptive method that is not what they want. Vasectomies can be performed only by a urologist. There is no program of subsidized commercial retail sales and no community based distribution programs. Seventy per cent of contraceptive users obtained their supplies from health centers, hospitals, or the facilities of the Caja de Seguro Social (CSS), according to the findings of the 1979 Contraceptive Prevalence Survey; 10 per cent obtain supplies from private physicians or clinics, 9 per cent from pharmacies.

The IEC program for family planning is also approached conservatively. The emphasis is not on motivation but on the promotion of services. Family planning is a responsibility of the MCH Division, but there is no separate unit concerned with it. The IEC approach is through health messages. Family planning is conceived as being totally integrated with health services and has no separate identity. IEC too is conceived as being an integral part of the provision of health information and there is no staff identified exclusively with it. Throughout the span of Population II there has been only one person in the MCH central office with a designated responsibility for family planning IEC. The result has been a very light use of available channels of communications and a heavy reliance on interpersonal communications.

CHANNELS OF COMMUNICATION

Radio

Radio is the best medium for reaching the kinds of audience the MCH is interested in, but relatively little use has been made of it. In the last half of 1981 approximately a dozen radio spots were transmitted on about the same number of stations for a period of six months. (Available records are sketchy and different people remember differently, so it is difficult to be precise about the numbers.) Themes emphasized included anti-abortion messages, population growth in Panama, responsible parenthood, family planning, and the responsibility of men in family planning. A second group of eight spots was transmitted over a six months period in the latter part of 1982. In these the dominant messages intended were that family planning is important and that to obtain service one should go to a MOH facility. Spots in this series were very

short, running only from about 10 to 25 seconds each. These spots are being reprogrammed for transmission this year, but the contracts with the stations have been held up in the upper echolons of the MCH for the last four months. No one in the MCH Division knows why there has been a delay in approving the contracts when they are identical to the one's used previously.

Stations were selected on the basis of their coverages of intended audiences, and the times of transmission were varied so as to reach different categories of listeners, e.g., men, housewives, adolescents, at times convenient for them. Basic information for determining program schedules was obtained from audience research findings provided by an advertising agency. The judgment of the Public Relations officer of the MCH was also sought and followed. Stations used in both the 1981 and 1982 series included some affiliated with national chains and some that were independent.

The spots were written by the one person responsible in the MCH Division for family planning IEC, a health educator with some background training in communications, with review and modifications by other members of the MCH staff and the Public Relations Officer.

The 1982 radio spots were pretested in both urban and rural areas. The testing was done under contract by a private agency, the Instituto de Educación para el Desarrollo. Among those interviewed in the testing process there was considerable confusion about whether the primary message of the spots related to advantages of family planning or were simply urging listeners to go to a health facility.

An attempt was made, with the cooperation of the Institute for Special Education (IPHE), to monitor the broadcasts using blind listeners. Because of the sporadic nature of the monitoring the results were inconclusive, but they seemed to indicate that some of the stations were not adhering to the terms of their contract in relation to the frequency or timing of transmission of the spots.

A number of criticisms of the use of radio for family planning IEC can be made:

- Total radio use was minimal and cannot be considered as qualifying as an adequate contribution toward "a vigorous and improved family planning information and education campaign," as called for in the Population II Agreement.
- The target audiences were not sharply defined.
- The messages, as revealed by the pretests, were confusing and should have been rewritten with a sharper focus before being broadcast.
- The spots were not long enough to permit a desirable repetition of elements of the message within a single spot.
- There was no attempt to appeal to special audiences of interest to the family planning service program, such as women who had discontinued contraceptive use.
- There was no attempt to create or reinforce an image of MOH facilities as welcoming family planning users or potential users.
- The medium was not used to counteract rumors about the assumed dangers or disadvantages of contraceptives that are present in any population using family planning methods.

- A more precise monitoring system should have been used, and contracts with stations should have carried clauses providing penalties for the failure of a station to adhere to timing or frequency requirements.
- A much wider mix of radio formats should be used--e.g., discussions, musical jingles, interviews, micro programs, dramas--to better inform various segments of the population about family planning, contraceptive methods, and the programs and services of the MCH.

Television

In the first half of 1982, on the television talk show "Nosotros", two programs about MCH Division activities were aired on Channel 2 on Sundays between three and four-thirty P.M. A short ten to fifteen minute talk on MCH/FP by a doctor of the Ministry was programmed for each. Presentations were made under a six months contract at a cost of \$300 per month. The Ministry, however, was not able at times to prepare its program in time to be broadcast as scheduled. In those instances the Ministry was charged for the program under the terms of their contract, even though their program was not broadcast.

Also on Channel 2 at eleven P.M. brief commentaries related to family planning were contracted to be transmitted during a period in 1982 at a cost of \$500 per month. It is our understanding that some of the commentaries were not made as scheduled, but the MCH was charged by the program's producer. As of the date of this report, this dispute has not been resolved.

There has been very little use of television during the period of the Population II Agreement, possibly because there is no one in the MCH Division who has either the time or the expertise to devise suitable programming. The new Division head, however, is considering a wider use of television in the future, rationalizing the decision on the grounds that there is a segment of the rural population that has access to television broadcasts and can be reached by them. But without the necessary expertise to develop sound programs, it is doubtful that much can be done.

Criticisms of the television offerings under Population II include the following:

- The output has been so minimal that it could not have an effective impact.
- Films on family planning topics could have been used but were not. Properly selected films could have been more effective than the "talking heads" presentations.
- Because television is 10 to 15 times as expensive to produce and transmit as radio, it may be questioned whether a greater use of television is a cost effective way to reach the MCH Division's intended audiences.
- The possibility that some aspects of health and family planning service activities might be the basis for televised news events has not been explored. Several of these could be effective and inexpensive ways of attracting public interest in MCH activities.

The press

As a result of a series of six annual seminars for journalists conducted in Panama by Development Associates under the sponsorship of

APLAFAs, local journalists have been sensitized to population problems and issues and have tended to give some priority to population or family planning news from the wire services or other sources when they have space to fill. A few editorials have also appeared in the press dealing with one or another aspects of population or family planning.

The Ministry, through its Public Relations office, has in the past tried to feed information about family planning to newspapers, but without much success. To assure a better receptivity to such efforts, the MOH is considering paying working journalists to produce such materials in the expectation that the journalists will work to get their own writing published. The head of the Ministry's Public Relations office is himself a journalist and sub-editor of a local newspaper and presumably has the contacts necessary to assure some acceptance of Ministry materials by the press.

The new head of the MCH Division has expressed an interest in using the press to run advertisements listing and describing the various services offered by the Division, with the dual purpose of better informing the public about what is available to them and enhancing the public image of the Division and its facilities and services.

With relation to the use of the press for family planning IEC it can be said that:

- As with other media, the press has not been systematically or effectively used and its potential for informing the public about family planning has not been fully exploited.
- It will not be economical or especially effective to run multiple message ads in the newspapers. A more effective and cheaper way of informing the public would be a handbill type of announcement

that could be produced locally, distributed widely, and that could give for each locality the address, types of service, and times of service for each MCH facility.

-- A more systematic use of newspapers for what they can do best would be a desirable component of a comprehensive media campaign for both health and family planning promotion.

-- A good use for newspapers might be to prepare, either for daily editions or Sunday supplements, informative articles on responsible parenthood, or the large problem of out of wedlock births, or the needs of adolescents for sex education.

Journalists could be found who could write these for a fee with a prior understanding with an editor that the materials would be used.

-- Newspapers are not a good way to reach rural audiences. But they can be very effective in building supportive public opinion among the middle and upper classes.

Films and Other Audio-visual Materials

Films appear to be extensively used, when available, both in health centers and as part of the outreach programs of health educators. In some of the larger health centers, it is reported that films are sometimes shown to clients waiting for service and that the films used are always preceded or followed by a talk or discussion led by a member of the staff. It is doubtful that women waiting for services see films, because very few health centers have their own projectors or personnel with time to be changing reels of films. Also the content of a film is

not discussed by the MOH staff to the extent that the film is connected in the audience's mind with the rest of the "charla". The film is too often an isolated activity which must stand on it's own.

Some of the films in use were provided by AID as part of the Population II Agreement. Where these films are or how they are being used is not known. AID should ask for an accounting of these films before consideration is given to the purchase of the new films.

There is an expressed need for more films, and ideally the MOH would like to have a film depository or library in each of the health regions. A more effective arrangement might be to have a central library that could periodically, say at monthly intervals, send batches of films to regions that request them. Under an arrangement such as this, films could be better cared for and a given amount of funds would provide a wider variety of titles since it would not be necessary to have many prints of the same film.

Some interest in making its own films has been expressed in the MOH, but it is realized that this is not likely soon to be possible.

A number of the films now available are regarded as not being entirely satisfactory. An interest was expressed in having some assistance in identifying films that would better suit the needs of those using them. More suitable films might be assured in the future if, when new purchases are considered, a copy could be rented and tested before a purchase is made.

Films alone have limited utility, and it is essential that when they are used for transmitting information there is an opportunity for discussion, clarification, and reinforcement either before or after

presentation of the film. One way to strengthen the usefulness of films would be to prepare and distribute a study guide for each, much as the guide developed for and available with the film "Dos Caminos".

A need has also been expressed for portable flip charts that can be used by health assistants and health center workers. It would be useful to have identical information on flip charts used in talks and training sessions and on leaflets that could be given out to the public or to trainees to reinforce what has been presented to them. A major topic for which flip charts are thought to be needed is methods of contraception. There could also be a use for others on such topics as reproductive physiology or responsible parenthood. Flip charts would be useful both in health centers and for the extension work of those in the field. They should ideally be small, light, and easy to carry. The production or purchase and distribution of flip charts for members of the MCH staff in contact with clients could provide an informational tool of considerable value, and steps should be taken to obtain them.

Slides and slide/tape presentations can be very useful for transmitting information to captive audiences at relatively low cost and with greater flexibility than films offer. Under Population II AID has provided 10 slide projectors for the MOH, but to date no slides have been developed for the family planning component. However a few slides for sex education have been prepared and distributed.

After reviewing the slides on concepción (conception) and nacimiento (birth) it is our opinion that they could be greatly improved. The colors are very pale and will not show up unless a room is completely dark. The slides were also taken from books and the reproduced copies

are not sharp and the text is hard to read. We suggest redoing the important slides as drawings using contrasting colors. The drawings should be in the proper camera aspect ratio so they fill the whole viewing area. The texts on the slides should be done with a press-type for easy reading from a distance.

The MCH Division relies heavily on outside sources for its audio-visual aids and seems not to have considered the possibility of producing slides of its own and using them to illustrate talks or, in conjunction with cassette recordings, as an equivalent to a film, but at much less cost than a film would require.

The Division has shown no interest in experimenting with the use of folk media, such as puppet shows or local drama presentations, that have been successfully used in other Latin American and Asian countries.

Billboards

Use of billboards was begun to a limited extent in 1979 and two of them are still standing with the original messages. About 10 billboards were located on highways throughout the country and at strategic sites such as near health centers where family planning services are offered. One billboard that had been placed in a favorable location across from a drive-in theater pictured all the contraceptive methods, including prominent representations of the condom and diaphragm. These were found to be objectionable to some people and the billboard was removed.

No new billboards have been erected to call attention to family planning, and none are planned for 1983. Billboards could again serve a useful purpose for the display of well chosen themes such as responsible parenthood or messages for adolescents.

Print Materials

As of this date there have been no family planning informational materials printed during the period of the Population II Agreement.

Materials ready for printing are said to have been developed and were ready for printing at the start of the Agreement in 1980. The MCH Division explains that the delay in obtaining authorization for printing has been due to failure of the Office of the Minister to act. Drafts of the materials remained for more than two years in the Office of the Minister without authorization to print being given. These materials have now been resurrected, and there are plans to have them printed soon.

Leaflets. Leaflets used in the Population I period, which were largely adaptations from those used in El Salvador, have been redesigned for use in rural areas in the current agreement period. There are five leaflets now at the printers. They deal with oral contraceptives; vasectomy; general contraceptive methods; cremes, foams, and spermicides; and the condom. Each of the leaflets was designed for the rural audience. All five have been pretested in the field by the same organization that pretested the radio spots. It is not known whether or not changes in the leaflets were made as a result of pretest information

A press run of 25,000 copies is proposed for each of the leaflets, with the understanding that any of them may need to be revised after a trial in the field. When revisions have been made, or it becomes clear that no changes are needed, a second larger press run will be contracted to provide sufficient copies to last through the remainder of the Population II Agreement.

After a review of the text and layout of each of the proposed leaflets, we conclude that:

- The texts are generally too long and include details that can better be transmitted in a face to face situation in a health facility.
- The language is sometimes unclear, especially for a rural audience, either because of poor wording or the inclusion of technical terms.
- It would be desirable to have the last page relatively uncluttered (it is cluttered on the prototypes of some of the leaflets), including only the logo of the MOH and some space in which local staffs could add the address and hours of service at their facility.
- In general, the leaflets are of acceptable quality, but their impact and utility might be improved with some minor changes.
- The distribution of leaflets was not entirely satisfactory in Population I and there have been no materials to distribute since the start of Population II. Materials sent through regional health offices undergo prolonged delays before reaching the health centers, sub-centers, and posts. The distribution process needs to be improved to facilitate delivery to local facilities.

Pamphlets A series of six pamphlets was initially proposed in 1981. Proposed topics were: Where We Come From; A New Life; Human Reproduction; Contraceptive Methods; Feeding The Child; and A Guide For Talking About Sex Education, the latter an aid for parents to use in talking about sex with their children.

As of now the Contraceptive Methods pamphlet is at the printers. A press run of 10,000 is proposed. Nothing has been done with the others.

The MCH Division has some sex education pamphlets from Mexico that are under review to see how they might be adapted for use here.

Pamphlets are considered to be useful both as a support for the service staff of the MCH Division and for the information of the general public.

The present lack of pamphlet material is probably hindering for the service staff of health posts and centers, since they need it to augment and reinforce their own knowledge and understanding when working with clients.

Posters To date there have been no posters available during the period of Population II. In 1981 the MCH Division designed and pretested five posters. One illustration was considered objectionable and a change was recommended. Pretest results showed the posters were acceptable and would be understood. After analysing the pretest data MCH decided to print three. Their titles are Aborto? No! (Abortion? No!), Planificación Familiar (Family Planning), and Un Niño Necesita.... (A Child Needs).

The MCH Division has asked for price quotes for 5,000 copies of each poster. They also plan on making each poster into a volante (flyer) of much smaller size. The volantes are also out for bids, with 25,000 of each one to be printed.

None of the proposed posters is especially designed for the attention of males or adolescents. The MCH Division may be well advised to

consider adding two more, one calling attention to the need for responsible fatherhood and one designed to appeal to adolescents.

Interpersonal

The most widely used and perhaps the most effective channel of communication about family planning in Panama is the spontaneous informal interchange of information that goes on among members of the public or between satisfied users of one or another method of contraception and their friends, as well as the communication that takes place between the health staff members and their clients. Evidence of this generalization can be found in the acceptance of sterilization. There is no activity in the MCH Division or any other organized source to promote or provide information about sterilization, and sterilization services are perhaps among the hardest to obtain at the facilities of the MCH Division or CSS. Yet female sterilization is the most widely used method in this country. People learn about it from one another, as they perhaps also learn about the advantages of planning families and the merits or disadvantages of other contraceptive methods.

There is a perception of the importance of interpersonal communication within the MCH Division and a concern about the quality of such communication in the interchange among staff members and between staff and the public they serve. The need for improvement is felt to be especially important at the lower staff levels, and especially for the asistentes de salud who man health posts in small villages and who need periodic refresher training. To meet the need the MCH, with AID support, has undertaken a program (temporarily suspended) to provide at least

minimal training in human relations and interpersonal communications as an effort to improve the quality of relationships between its staff and the public they serve. One day courses taught by the present head of Health Education have been offered. Some 20 to 25 sessions have been held with about 40 persons attending each.

It may be thought that in Panama the amount and quality of information sharing about family planning among members of the public is sufficient to sustain the relatively high level of contraceptive acceptance and use that exists here, and that, in terms of governmental policy, is considered to be satisfactory. To the extent that is believed to be true, it might be argued that there is no great need for a family planning information program. It should be remembered, however, that the interpersonal networks need to be stimulated and primed with information if they are to continue to function in relation to a given area of information, such as family planning; and the provision of that stimulation and that priming is the function of information programs. Such programs are also useful in contributing toward the development of a sense of unity, purpose, competence, and importance among service staff, and thus in helping to build morale and improve the quality of services offered.

In the area of interpersonal communications, two continuing needs that should be met by the MCH Division are:

- A continuation of the human relations training that has been going on; and
- the provision of refresher training for health assistants (as well as for other types of staff).

Vehicles and Equipment

Under one of the provisions of the Population II Agreement, USAID/Panama provided ten mobile units (Jeeps) each equipped with film and slide projectors, generators, screens, microphones, amplifiers, and speakers. One unit was assigned to each of the health regions for use mainly by health educators in the family planning information program. The vehicles are large enough to permit several MCH staff and health educators to travel together to rural areas, so that a variety of services may be provided during a single trip. Past experience in Panama, for example in the tuberculosis program carried on some years ago, have shown mobile units to be an effective means of supplying information and services in rural areas.

The sound equipment in the unit is used to announce the arrival of the team in a community and to inform the inhabitants of what services are to be offered and where. Films are shown both to attract an audience and to provide information on a particular health or family planning topic. Films have proven to be very attractive and everyone attends from small children to the very old. Despite the variety of persons in the audiences, there have been no reports of negative reactions to the family planning materials presented.

In the interpersonal exchanges that take place following a film, print materials and other audio-visuals aids, such as flip charts, can be highly useful. These are and have been in short supply, and it may be hoped that one of the actions taken soon with Population II funds will be the purchase or production of these teaching aids and their distribution.

Another important and needed addition to the equipment would be a cassette deck for each unit. These could serve two functions: they would permit the use of pre-recorded messages and other information to assure correctness and uniformity in what is transmitted; and they could serve as an essential component in slide/tape presentations that can have for small audiences many of the advantages of films with less expense and more flexibility.

The mobile units were provided mainly for family planning information use. However, it is recognized that, inasmuch as the program in Panama integrates family planning with all other MCH services, the vehicles are not likely to be used exclusively for family planning. They are under the control of regional health directors who determine how the vehicles will be used and by whom. Since these represent a sizeable investment for AID, it would seem appropriate for the Agency to devise some system for determining how the jeeps are used, perhaps in the form of a periodic report from the offices of the regional health directors and periodic supervisory visits by the central level MCH Division staff.

Field trips by AID personnel, MCH staff, and one member of the evaluation team reveal that the mobile units are being misused. Some vehicles are used for transportation only, with the audio-visual equipment having been dismantled and spread throughout a region. Such usage defeats the purpose for which the vehicles were intended and suggests a complete disregard of the intent of AID/MCH under the Population II agreement concerning mobile units. The utility of the mobile units for MCH/family planning needs to be re-evaluated.

Specific Requirements in the Project Agreement

The Project Agreement is quite specific about certain activities that are to be undertaken and certain accomplishments that are to be achieved by the MOH during the term of Population II. Among them are the following:

1. "Project funds will provide United States or third country training in educational and communications techniques for approximately eight health educators..."

Although USAID/Panama has consistently informed the MOH of available training opportunities in the United States, there has been no response. To date no health educators have gone anywhere for training abroad.

Under Population I, one person, Carlos Harris, was sent to a training course at the University of Chicago. He is no longer working in the MCH Division. Population II funds were used to send the present head of Health Education (he was then the only person in MCH responsible for or working in the IEC program) to Puerto Rico to observe programs there, but no training.

If it is not going to be possible at any time during the remainder of Population II to send any health education personnel abroad for training, perhaps some exploration of possibilities for in-country training in communications using local and/or expatriate trainers to organize and conduct one or more courses should be undertaken.

2. "The Project will help finance an annual, national level meeting of health educators to evaluate and improve the effectiveness of the community outreach program."

Annual health educators' meetings are held, but not with Project funds, nor do they deal exclusively with family planning matters. We have not been able to learn of any formal evaluations that may have been undertaken and have not heard of or been shown any set of suggestions for improving the community outreach program. It is doubtful that any exist.

3. "...groups of voluntary active users will be organized within the communities to promote and provide information on family planning and sex education within their respective communities..."

This has not been done. But we understand that plans are underway to restructure community health committees organized some time ago with a view of selecting certain members to be used as voluntary promoters of family planning. At this time there are no plans to use volunteers for promoting or providing information about sex education.

The volunteer promoters of family planning, if and when they are organized and activated, represent another group that will need support materials that are not presently available.

4. "...a mass media campaign using several different media will be mounted."

This has not been done. The various media have been used only sparsely and in no coordinated way.

5. "...the coverage in communities will be increased by promotional material and informational talks on family planning and sex education."

No promotional materials have been available for distribution. Some presentations on family planning have undoubtedly been made by health educators and other MCH staff members, but not as part of a deliberately organized program.

6. "...family planning and sex education materials will be developed for the rural population."

Up to now, MOH has developed no sex education materials for the public. They have received one leaflet, one pamphlet, and two comic books on sex education from Mexico which the MCH Division may try to adapt for use in Panama. These are single copies only and would have to be redesigned and produced in quantity to be useful here. No time schedule for producing them has been decided.

The person formerly responsible for IEC activity stated that he personally had designed or adapted print materials for the rural audience, specifically the five posters and five leaflets mentioned above. In our judgment they are not particularly suited for rural people. These are the only print materials now projected and they, when available, will be used in the metropolitan and other urban areas as well as in rural places.

MOH has developed no sex education materials for the public.

7. "...sex education activities and the usage of specific contraceptive methods will be stressed in all information, education, and communications activities."

As previously noted there is no ongoing sex education program by the MCH Division and no materials are available other than the films used by health educators in rural areas, few or any of which are concerned with sex education. However, an interest in sex education has been stimulated, especially among adolescents and young adults, by the work of APLAFA, and some doctors and other staff members of the MOH, on their own initiative and in a relatively unorganized way, are conducting some sex education activities.

There is a perceived need within MOH to provide information and training on sex education to its staff to equip them to work with the public in this area.

8. "Information, Education, and Communications activities will be coordinated by a full-time communications specialist located in the Ministry of Health's Maternal and Child Health Division. Under the Project, the Ministry of Health/CSS will mount a vigorous and improved family planning information and education campaign."

In the opinion of the chief of the MCH Division there is no one in the Ministry capable of filling the position of communications specialist, and there are no funds--and are not likely to be any this year or next--to pay an additional person even if one could be found outside the Ministry and could be induced to take the job. This critical position thus remains unfilled and is likely to continue unfilled through the remaining lifetime of the Population II Agreement.

The MCH Division chief would ideally like to have the help of a broadly trained specialist who understands pretesting and evaluation techniques and is skilled in the design and production of all types of

relevant IEC materials and programs for both public information and training purposes. Whether such a person could be found in Panama is problematic, but perhaps an agency could be found that could, by combining the skills of staff members, provide the requisite range of skills. Such an arrangement, even if possible, would be far from ideal since what is needed is a single individual who would assume a large share of responsibility for stimulating, initiating, and guiding projects from conception through completion and evaluation. Such an individual would also require a staff to work with, and there is no IEC staff in the MCH Division. What there is is a single person who on January 21 became head of a unit called Organización y Educación a la Comunidad and will be the person responsible for IEC. The new incumbent was trained in biology and chemistry for teaching at the University level and has a diploma in health education. She has had communications training in four short term courses: one in Puerto Rico, two in Panama conducted by UNESCO and CIACOP, and a recent one in Brazil on health marketing. Without outside help and with no designated staff to work with, it is unlikely that the pace of IEC will increase significantly in the remaining months of the Population II Agreement, especially since the new appointee (new to the job, not to the MOH where she has worked for fourteen years) appears to be more oriented toward studies and research as an immediate need rather than toward getting materials produced and the media used.

Given the past record of IEC in Population II and the prospects for the future as they now appear, it is highly probable that time will run out on Population II with a considerable portion of the allocation for IEC activities still unspent. Should that happen, the alternatives for

USAID/Panama would seem to be two: extend the time of the Agreement or de-allocate what may be a sizeable sum of money. (With about 66 per cent of the time now past, the IEC program has spent around \$60,000 of its allocation of \$330,000.)

If neither of those alternatives is attractive ways will have to be found to speed up the output of the MCH Division. This will not be easy, and perhaps not possible, even with the help of a communications specialist. But there are several options that might be considered to salvage what can be saved. Among these are the following:

1. Seek additional funds to contract with an individual or agency for either full or part time technical assistance to the MCH Division.
2. Amend the Agreement to release to AID/Panama funds from the IEC allocations in Population II that AID could use to:
 - a. identify and contract with a Panamanian individual or agency capable or providing the necessary expertise on a full- or part-time basis;
 - b. identify and contract with an expatriate individual to come for a year or at periodic intervals to work with the MCH Division.
 - c. work out a shared cost arrangement that would enable a U.S. institution to provide a qualified specialist to work with the MCH Division either as a full-time resident or as a periodic visitor.
3. Obtain part-time technical assistance from a centrally funded U.S. based institution. If this option were followed it would be necessary that the specialist come several times during the coming year and stay for relatively long periods of time.

Whatever option is followed it will be necessary that the MCH Division provide an IEC staff of reasonably qualified people for the specialist to work with or equivalent funds to engage the services of personnel in professional agencies.

105

Conclusions and Recommendations

On the basis of our rapid review of IEC activities carried out under the terms of the Population II Agreement, we have reached the following conclusions:

1. There is no urgency about family planning in top levels of the Government or in the Ministry of Health. There are no targets for birth or growth rates. Family planning is undertaken for health and welfare reasons, not to meet demographic objectives. Contraceptive acceptance and use rates are high in comparison to those of most other Latin American countries. There is little dissatisfaction with the way things are going.

2. Family planning is not a high priority activity of the MOH. The relatively low status of family planning communications is indicated by the fact that there is not an IEC unit in the Ministry and that despite the existence of a substantial grant from Population II there is no cadre of staff designated to work on family planning communications. Responsibility now appears to lie with a single person in a unit concerned with community organization and education.

3. Progress to date in meeting the requirements of Population II have been minimal. If the present rate of implementation continues (as it is likely to do), it will be necessary to extend the Agreement beyond its present termination date or de-allocate a large portion of the funds allocated for IEC.

4. There is no one in the MOH capable of meeting the qualifications needed to be considered as a communications specialist. And there is not

likely to be since the MCH Division has no funds for additional personnel this year and is unlikely to have any next year.

5. In the past year there have been three Ministers of Health, two MCH chiefs, and a temporary person with nursing training designated to be in charge of IEC activity for the past six or seven months.

Responsibility for IEC has now passed to a new head of a Community Organization and Education unit, but the unit has no staff and a significant acceleration in the pace of IEC activity appears unlikely.

6. Media are not being fully exploited. Radio should be a preferred medium for reaching rural people who are a main target of the family planning IEC effort. But its use has been sporadic and limited in terms of possible formats.

7. There is an over-reliance on films in comparison to less expensive and more flexible channels such as slides, flip charts, cassettes, and traditional folk media.

8. There has been little differentiation of audiences and little attempt to develop channels and messages most appropriate for each segment of the total audience. The various segments--men, youth, dissatisfied users of contraception, rural dwellers, women of different age and parity--each require somewhat different messages and each is best reached by a particular combination of channels. It would be desirable in an improved program to attempt to develop a specific package of messages and means for reaching each identifiable segment.

9. Local staff members who have received few or no materials from headquarters are beginning to develop their own. This trend should be encouraged and supported.

Our recommendations are as follows:

1. In order to be more effective, the MCH Division will require at least periodic technical assistance in the operation of an IEC program and the design, creation, and production of audio-visual materials. If it is important to USAID/Panama that the Population II Agreement be fulfilled on schedule, consideration should be given to making such assistance available.

2. If such assistance is provided, and if it is to be useful, MCH should be prepared to provide a full-time counterpart during the period of the assistance.

3. Radio use should be expanded in terms of time and the use of a wider range of formats and specific messages for sharply defined audience segments.

4. Consideration should be given by the MCH Division to mounting the comprehensive mass media campaign called for in Population II.

5. Old billboards should be replaced and new ones set up to provide information about health and family planning services and promote the idea of responsible parenthood.

6. All print materials should be redesigned to make them more suitable for rural audiences.

7. IEC materials emphasizing the following themes should be developed: a) counteracting rumors about bad effects of contraceptives; 2) male participation in family planning and responsible paternity; 3) the return to contraceptive use of those who have discontinued; and 4) responsible parenthood for adults of both sexes.

8. The program of training in human relations and interpersonal communication should be revived and continued and all MOH service personnel should receive such training periodically.

9. Low cost audio-visual materials can and should be produced in-country.

10. The use of television should be discontinued except for coverage of newsworthy events. The medium is not cost effective and is not ideally suited for reaching rural audiences.

11. After examining the pretest questionnaire, data, and analysis we found them to be adequate. However, there are other organizations in Panama that may provide more indepth information. AID/MCH should investigate who does market research for the three largest advertising agencies and consider using one of these organizations for future pretests.

APPENDIX 1

Persons Seen

USAID/Panama

Mr. John P. Coury, HPN Officer
Sra. Angela de Mata, Assistant to Mr. Coury
Mr. Steve Ryner, Chief Human Resources Division

Maternal and Child Health Division, Ministry of Health

Dr. Egberto Stanziola, Chief
Lic. Ezequiel Urrutia, Head of Health Education
Sra. Flor de Vasquez, Acting Head of IEC activities
Srita. Ermila Muñoz, Head, Community Organization and Education unit
Lic. Orlando Kievers, Head, Public Relations Department, MOH

Caja de Seguro Social

Dra. Lucia de Moreno, Head, Maternal and Child Health

APLAFA

Dr. Julio Lavergne, Executive Director
Lic. Francisco Beens, Education Director

Confederation of Workers of the Republic of Panama

Mr. Francisco Sanchez, Sub-secretary of Education

Ministry of Education Office of Professional and Education
Counselling

Lic. Gerardo Valderrama, Director,
Lic. Fabio Bethancourt, Technical Sub-Director
Lic. Rebecca de Delgado, Administrative Sub Director
Prof. Elvia Jayes, Program Coordinator, Sex Education
Prof. Egberto Blanco, Program Coordinator, Sex Education

Colon Health Region

Dr. Ricardo Guzman, Sub-Director

Centro de Salud Patricia Duncan

Dr. A. Guzman, Medical Director
Sra. Elsa de Quintero, Head Nurse
Sra. Eugenia de Ordoñez, Nurse

Centro de Salud Nuevo San Juan

Dra. Mabel Bernal de Gonzales, Medical Director
Sra. Isabel de Cadet, Head Nurse
Sra. Sandra de Cumberbatch, Obstetrical Nurse
Sra. M. de R. de Hernandez, Nurse

National Directorate of the Child and the Family (DINFA)

Sra. Rina de Barba, Sub-Director, Family Orientation Unit.

Ministry of Planning and Economic Policy

Lic. Carlos Sanchez, International Technical Cooperation Planner

APPENDIX 2

General criticisms of the forthcoming leaflets are included in the body of this report and need not be repeated. This appendix will attempt to suggest means by which each of the five leaflets may be improved so that they will be better understood in rural areas.

El Condom o Preserativo

On the cover of this leaflet it says, "la pareja, que usan..." This phrase should be omitted for two reasons. First the MCH Division should be promoting male participation in family planning. Every contraceptive method is used by the couple so why single out the condom to include this phrase? The second reason is simplicity. Leaflets should be straightforward using simple words. The added text will only confuse the general public.

Inside the leaflet there should be several illustrations demonstrating how the condom is put on the penis. Words like ejaculation, semen, climax and procedure should be changed for simpler words.

La Vasectomia

This leaflet contains way too much information. Several points could be combined or omitted. For example, when talking about damage to the male sex organs you also could add that all parts of the sex act remain the same except there is no possibility of an unwanted pregnancy (Points No. 4, 7, 13). Also questions about returning to an active sex life and risk of pregnancy are repetitious (Points No. 10, 12). We would omit the

castration/vasectomy comparison or change it to a plainly worded statement that vasectomy is not castration (Point 14). The language needs to be simplified. For example: diminutive, spermatozoids, pleasurable, ejaculation, virility, and organism, should be presented in words used by the rural people.

Metodos para: Planificar la Familia

The first two inside pages of this leaflet don't belong. They deal with what is family planning and human reproduction and not general contraceptive methods. When explaining the barrier methods avoid the word "eliminate" and use the word "barrier". I'm not sure a rural person understands words like: spermatozoid, vasdeferens, fallopian tubes, and sexual capacity. We recommend that simpler words be used.

Cremas, Espumas, Supositorios y Ovulos

This leaflet also needs several words to be changed for easier understanding by the rural people: fecundity, impede, immobilizing, and chemical compounds. In the "how to use" section of the leaflet it should be made clear that not all spermicides come with applicators. If applicators are supplied they should be used to insert the spermicide. If no applicator comes with the package, such as the case of the foaming tablets, none is needed. It should be made clear that every new sexual relation requires a new dose of spermicide.

PART III. COUNTRY PROFILE

PANAMA

A. Demographic Information

		<u>Source</u>
Total population--mid-1982 (in millions)	1.9	(13)
Projected population in year 2000(in millions)	2.7	(13)
Crude birth rate--mid-1982 (per 1,000 population)	27	(13)
Crude death rate--mid-1982 (per 1,000 population)	6	(13)
Rate of natural increase (percent)	2.1	(13)
Median age (1980)	19.7	(10)
Life expectancy at birth (1980)	70	(13)
Total fertility rate--mid-1982	4.1	(13)
Women 15-44 in marital or consensual unions (1981) (in thousands)	241	(12)
Desired family size	Not available	
Average age at marriage, females (1981)	20	(12)
Population under age 15 (percent)	43	(13)
Population over age 65 (percent)	4	(13)
Dependency ratio (1980)	78.5	(10)
Urban population (1980) (percent)	54	(10)

Migration, internal

The spatial distribution of the population is considered by the Government to be hampering the attainment of development objectives. Problems include: high concentration of population and economic activities in the metropolis, dispersion of rural population, and difficulties in contact and communication between urban and rural areas. Four planning regions have been established with a specific policy for each: controlling growth of population and economic activity in the metropolitan region; colonization of eastern area; and strengthening rural development in central and western areas.

Migration, international

International migration is small and is not considered a problem.

Note: The above figures have been taken from different sources, represent different time periods, and in some instances are estimates, not precise measurements. They should all be regarded as approximations.

B. Social Information

		<u>Source</u>
Literacy--male/female adults, percent literate	86/84	(12)
Official language	Spanish	(3)
Proportion for whom English is their native language (percent)	14	(3)
Religions: Roman Catholic (percent)	93	(3)
Protestant (percent)	6	(3)
Education: Years compulsory	9	(3)
Proportion in primary schools, males/females (percent)	94/96	(9)
Proportion in secondary schools, males/females (percent)	46/53	(9)
Economically active males/females (percent)	85/32	(12)
Labor force engaged in agriculture (percent)	51	(13)
Per capita GNP (1980)	\$1730	(13)

C. Type of Government (3)

Centralized Republic. Date of Independence, November 3, 1903

Constitution, October 11, 1972

Branches: Executive----President (Chief of State)

Legislative--National Legislative Council

National Assembly of Community Representatives

Judicial----Supreme Court

Ministries--Presidency

Foreign Relations

Commerce and Industry

Interior and Treasury

Planning and Economic Policy

Health

Education

Public Works

Agricultural Development

Labor and Social Welfare

Government and Justice

Police and Military are combined in a unique Guardia Nacional.

D. Population Policy

There is no explicit population policy. The rate of growth is considered to be satisfactory and not requiring intervention. External migration is not a problem, but there are programs, presumably based on an implicit policy, to effect some controls on internal migration and bring about some changes in the distribution of population within the country. Health activities, especially

those that contribute toward increased life expectancy and lower infant and child mortality, affect demographic variables, as do those directed toward reducing infertility or enabling more pregnancies to be carried to term. But any effects on demographic variables are by-products and not the intended consequences of any stated population policy. Health, not birth control, is the name of the family planning game in Panama.

E. Family Planning Policy

The Government attitude towards family planning is permissive for reasons of health and welfare. Official support is provided through the Ministry of Health which includes family planning as an integral part of its Maternal and Child Health program. Virtually all family planning materials and services that are not obtained from private physicians or pharmacies are dispensed through the facilities of the Ministry of Health.

F. Contraceptive Prevalence

Contraceptive prevalence surveys were done in 1975 and 1979. The appended tables are from a summary of the findings of those surveys that appeared in Studies in Family Planning (12:(10), October 1981.) They indicate that in 1979 68 percent of the urban and 55 percent of the rural women, age 15-44 and currently married, were using a contraceptive method. Sterilization was the modal method; 29 percent of the urban and 30 percent of the rural women interviewed had been sterilized. Orals were the method of choice of 19 percent of those reporting; the proportion using other methods was small.

The rate of female sterilization is surprisingly high, especially in view of the fact that sterilizations can be obtained only from government hospitals (or at high prices from private physicians) with a fairly long waiting period and that there has been no IEC promotion of sterilization in the country. Information about the operation apparently has been transmitted mainly by satisfied users. USAID/Panama is planning to bring in an IFRP consultant to try to learn why sterilization has been so acceptable in Panama and how women have learned about it.

Vasectomy services are not offered by the Ministry of Health.

Most contraceptives are, like sterilization, obtained from government facilities. More than 70 percent are received from Ministry of Health (MOH) hospitals, MOH health centers or health posts, or the polyclinics and hospitals of the Caja de Seguro Social which collaborate with the MOH in offering family planning services. Around 10 percent come from private physicians or clinics, and 9 percent from pharmacies.

There are no programs for the social marketing of contraceptives or community-based distribution in Panama.

An indication of the trend in contraceptive usage in Panama may be seen in a comparison of the proportion using contraception in the 1975 and the 1979 surveys. During this period the proportion of married women ages 20-44 using contraception increased from 53 to 63 percent.

Details of the major findings of the 1979 Contraceptive Prevalence Survey will be found in Appendix B.

G. Broadcast Media

Panama has a sophisticated network of broadcast media. Some radio and all television stations (except Channel 13) use repeaters for diffusion of their signals throughout the country. This enables people in the least accessible parts of the country to have access to at least radio programming as a source of information and entertainment. The Government of Panama also claims that more than 80 percent of the population has access to electricity, which means that watching television is as least possible, if one can afford to purchase a television set.

Television. At present there are four television channels. They are: 1) Televisora Nacional, S.A.-Channel 2; 2) Corporación Panameña de Radiodifusión, RPC-Channel 4; 3) Televisión Educativa-Channel 11; and 4) Medios Panameños, S.A.-Telemetro Channel 13.

All the TV stations are privately owned except Televisión Educativa (TVE) which is part of the National University of the Republic of Panama. TVE is financed through the budget of the Ministry of Education. The Japanese government has supplied the funds for building the physical plant for TVE and has trained most of the technical staff in Japan. The Japanese are still financially and technically supporting this project. It should be noted that the U.S. Armed Forces Radio and Television Services (AFRTS) has two television channels (Channel 8 in the Panama City area and Channel 10 in the Colon area) which service the military bases along the Canal. Transmissions can be received within a radius of approximately fifty miles from their points of origin.

Each of the three commercial stations has studios for producing programs in-house. Most of the locally produced programs are talk-shows, children's programs, and news and commentaries. TVE has both a studio and mobile facilities for remote recordings. TVE produces both educational and cultural programs. AFRTS has both studios and remote facilities also. It produces only news and informational programs of interest to U.S. Military personnel.

As previously noted, commercial television has been used by the Ministry of Health to promote family planning. All of the commercial stations are quite receptive to the idea of transmitting family planning programs, as long as they are paid for. The stations charge the government less than the going rate for their time. There has been no attempt to transmit a family planning drama but the consensus is that it could be done. In 1982, Channel 4 broadcast a "soap opera" produced in Mexico which carried a very strong pro-family planning message. However, the Ministry of Health had nothing to do with the transmission of this multi-episode program and did nothing to take advantage of its broadcasts. The public reaction appeared to be positive because its ratings were the same as those received by other "soap operas" in Panama.

TVE has not been used to transmit any family planning information. However, the station is assisting the Ministry of Education and DINNFA in programming sex education programs and ads on videotape. AFRTS has shown feature films with family planning or sex education themes, but not on a regular basis. It is very doubtful if their channels could be used for transmitting Panamanian family planning programs.

In 1978 there were 206,000 television sets in the country. It is now estimated that there are more than 220,000. While the number is large, it is also misleading.

The vast majority of the sets are in the metropolitan and Colon areas. A TV set is still a scarce commodity outside the large cities.

Radio. Appendix C lists all the AM, FM, and short wave radio stations in Panama. The total number is 101. Some stations are AM and FM and others are retransmission stations. The actual total is around 70 stations.

Stations range in power from 10 to 700,000 watts. Most of the stations have between 1,000 and 10,000 watts of power. With the large number of stations, it is safe to say that radio covers the entire country, as well as parts of neighboring countries such as Costa Rica, Colombia, and the Caribbean Islands.

All of the radio stations are privately owned except one, Radio Libertad. In times of emergency, or some very important event, the stronger stations in the provinces will pick up signals from Radio Libertad and form a national chain to cover the entire country.

Every station in the country has facilities for recording programs. Some facilities are quite elaborate and sophisticated, and others are quite basic. The best recording studios are in the metropolitan area stations.

Radio programs in Panama are usually live. Programming varies from station to station, but generally consists of music, news, dramas, interviews, debates, discussions, and commentaries. No station necessarily uses all of those formats. Some specialize in dramas and news, others in music, and still others program only news and commentaries. The large number of stations and the variety in programming offer the Panamanian public a wide selection to fit individual tastes.

The Ministry of Health has been using radio for dissemination of family planning information since 1970. The only formats used have been spots and interviews. No effort has been made to use this valuable medium of communication to its maximum. The Ministry has used a total of 20 stations, both local and national in coverage, to broadcast family planning information. At present contracts with 12 stations covering a six-month period are being drawn up. In Appendix C stations marked with an asterisk are those used or about to be used for family planning information.

Stations are quite willing to transmit family planning information. They collaborate with the government by charging it a reduced rate. However, an informal monitoring of radio transmissions has shown that about half the stations do not fulfill their contract requirements in regard to either frequency or timing of broadcasts.

There are no accurate figures on the number of radio receivers in Panama. The Ministry of Health's Public Relations Officer estimates that there are over 400,000. Radio is definitely the medium of access to information for most Panamanians. People listen to radios on their way to work, at work, and at home, and with most stations broadcasting at least 18 hours a day this medium offers an excellent opportunity for informing and motivating the public.

H. Print Media

Official figures list the literacy rate in Panama at almost 80 percent. While this implies that a large majority of the population can read, it does not imply that access to and comprehension of newspapers, magazines, books, and journals is a fact. On the contrary, a sizeable portion of the rural population cannot read above the third grade level, and, furthermore, access to print materials is limited to the large cities and people who live along the major highways. Torrential downpours during the eight-month rainy season make transportation and the distribution of print materials problematic in the rural areas.

Information provided by government officials points out that there are no Panamanian magazines to speak of. Magazines are printed for one or two issues and then cease to exist. A large number of magazines in several languages are imported and are readily available in all the large cities.

There are a number of publishers that print both journals and books; Editorial McGraw-Hill Latino-Americana, S.A. is the largest. Their output is minimal in both categories. The sophisticated Panamanian reader appears to prefer imported literature and technical materials to locally produced print materials. The government has its own publishing house, La Nacion, under the Instituto Nacional del Cultura (National Cultural Institute.) It is responsible for printing all government reports and educational materials, However, its equipment frequently breaks down and there are often extended delays. This has resulted in part of the government's business going to the private sector where punctual delivery and high quality are assured.

There are approximately 100 printers throughout the country. They specialize in posters, pamphlets, small reports, and advertising materials. Some print shops are very professional and produce top quality materials; others are small and use equipment manufactured in the early part of the century.

There are seven daily newspapers and two bi-monthly papers. The dailies are: Critica, La Estrella de Panama, La Republica, El Matutine, La Prensa, Star and Herald, and Financial Times. The latter two are published in English, the others in Spanish. The bi-monthly papers are Unidad and Bayano, both published in Spanish. In Panama City one also finds the Miami Herald, New York Times, and Wall Street Journal every day. All the newspapers are privately owned and freedom of the press is rarely restricted.

The Spanish language papers are widely read in the metropolitan area by middle and upper class people, but their total circulation is estimated to be less than 150,000 readers. Our empirical observation gives us the impression that this number may be low because in many offices a single copy is read by several people. The English language papers appeal to the large American community and the international business community.

Thanks to a series of seminars for journalists sponsored by APLAFA and Development Associates, the newspapers are highly sensitized to population and family planning. This has led to their picking up wire service stories about population matters and using them as fillers. Several newspapers have also published pro-family planning editorials applauding the government's actions in family planning and urging them to do even more. The Ministry of Health has been quite lax in promoting coverage of population and family planning events through newspapers. They seem content with promoting their own Minister instead of the Ministry's activities.

I. Other IEC Resources

Advertising Agencies. There are more than 40 advertising agencies in Panama. They run the gamut from small one-person companies to agencies with a staff of more than 30 people. Some agencies specialize in one type of publicity, for example billboards, while others are capable of creating materials for intensive multi-media advertising campaigns.

The three largest agencies are: Compania Latinamericana de Publicidad, S.A., Campagnoni, Aleman Publicidad, S.A. (representing Leo Burnett International), and McCann Erickson de Panama, S.A. These last two are part of international firms that ranked in the top five in worldwide sales last year. The Ministry of Health contracted with Latinoamericana de Publicidad, S.A. in the mid-1970's to create, produce, and program family planning promotional materials. The contract was cancelled when the agency raised the price of its services.

A large part of the commercial advertising that is produced for use in Central America is done by the agencies in Panama. The agencies here are much more sophisticated and creative than those in other Central American countries. Panama serves as a regional center for advertising for Central America and the Spanish-speaking islands of the Caribbean.

Market Research Agencies. There is one large market research firm in Panama, Solarian Corporation, S.A. The Instituto de Educacion para el Desarrollo is a much smaller market research firm that has done some pretests of radio spots and posters for the Ministry of Health. The general consensus is that Solarian does better quality work and is used extensively by advertising agencies and the media to conduct audience research for them. A small sample of the type of work Solarian does may be found in Appendix D.

Solarian was recently contracted by USAID/Panama to do a feasibility study on a possible contraceptive retail sales program. The USAID population officer was quite pleased with their work.

Communication Training Programs. There are no communication training programs operating on a regular basis on Panama. USAID has sponsored several seminars on communications for family planning activities for the Ministry of Health, but these have been discontinued. The UNFPA has also sponsored communication training programs in the past, but none are currently scheduled for 1983. The National University of Panama offers classes in communication to its journalism students, but not for non-students.

Other Resource Organizations with Potential for IEC Work in Family Planning. The city of Panama has four professional-quality sound recording studios equipped to record professional musicians or large-scale dramatic presentations.

There are several film and video production companies that have complete production facilities. The use of videotape is growing rapidly in Panama because of the presence of all the Japanese video corporations and the low cost of video hardware.

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122

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APPENDICES

List of Contacts in Panama

USAID/Panama

Mr. John Coury, HPN Officer
Sra. Angela de Mata, Assistant to Mr. Coury
Mr. Steve Ryner, Head, Human Services
Mr. Elias Padilla, Assistant Head, Human Resources
Mr. Tom Cox, Office of Development Planning

Ministry of Health

Dr. Egberto Stanziola, Chief, MCH Division
Lic. Ezequiel Urrutia, Head of Health Education
Sra. Flor de Vasquez, Acting head of IEC Activities, MCH Division
Sta. Ermila Muñoz, Head, Community Organization and Education Unit, MCH Divis:
Lic. Orlando Kievers, Head, Public Relations Department

Caja de Seguro Social

Dra. Lucia de Moreno, Head, Maternal and Child Health

APLAFA

Dr. Julio Lavergne, Executive Director
Lic. Francisco Beens, Education Director

Confederation of Workers of the Republic of Panama

Mr. Francisco Sanchez, Sub-secretary of Education

Ministry of Education

Lic. Gerardo Valderama, Director, Office of Professional & Education Counsellor
Lic. Fabio Bethancourt, Technical Sub-Director " " "
Lic. Rebecca de Delgado, Administrative Sub-Director " " "
Prof. Elvia Jayes, Prog. Coordinator, Sex Education " " "
Prof. Egberto Blanco, Prog. Coord. Sex Education " " "

Colon Health Region

Dr. Ricardo Guzman, Sub-Director

Centra de Salud Patricia Duncan

Dr. A. Guzman, Medical Director
Sra. Elsa de Quintero, Head Nurse
Sra. Eugenia de Ordonez, Nurse

Centro de Salud Nuevo San Juan

Dra. Mabel Bernal de Gonzales, Medical Director
Srta. Isabel Cadet, Head Nurse
Sra. Sandra de Cumberbatch, Obstetrical Nurse
Sra. M.de R.de Hernandez, Nurse

National Directorate of the Child and the Family (DINNFA)

Sra. Rina de Barba, Sub-Director, Family Orientation Unit

Ministry of Planning and Economic Policy

Lic. Carlos Sanchez, International Technical Cooperation Planner

Contraceptive Prevalence Survey Data

The following tables were taken from Richard S. Monteith et al., "Contraceptive Use and Fertility in the Republic of Panama," Studies in Family Planning, Vol. 12, No. 10, October 1981, p. 334-340.

TABLE 5 Panama: percent of currently married women age 15-44 currently using contraception, by residence, age group, and method, 1979 Contraceptive Prevalence Survey

Current use and method	Total	Residence		Age group					
		Urban	Rural	15-19	20-24	25-29	30-34	35-39	40-44
Currently using	60.6	67.1	55.0	28.9	46.0	60.1	69.1	73.4	67.6
Sterilization	29.7	29.0	30.3	0.0	3.3	15.7	40.3	53.1	56.5
Orals	19.0	23.7	14.9	19.4	32.6	27.8	16.3	9.4	4.6
IUD	3.7	5.5	2.2	2.7	3.4	5.3	5.2	2.6	1.9
Rhythm	2.9	3.1	2.7	2.1	2.7	3.4	1.3	5.6	1.3
Condom	1.7	1.9	1.5	0.8	2.1	1.5	1.9	1.7	1.7
Withdrawal	1.4	0.3	2.4	1.6	1.8	1.7	2.1	0.4	1.1
Other methods ^a	2.2	3.7	1.0	2.1	2.2	4.8	2.0	0.7	0.6
Not currently using ^b	39.4	32.9	45.0	71.1	52.0	39.9	30.9	26.6	32.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of cases (unweighted)	(1,528)	(831)	(697)	(117)	(283)	(371)	(311)	(267)	(179)

NOTE: In this and subsequent tables, subtotals may not add to totals due to rounding. ^aOther methods include injections, diaphragm, foam, jelly, and tablets. ^bCategory includes current use of douche and other ineffective methods.

TABLE 9 Panama: source of contraception by residence and method for current users of contraception, currently married women age 15-44, 1979 Contraceptive Prevalence Survey (percent distribution)

Source of contraception	Total	Residence		Method			
		Urban	Rural	Sterilization	Orals	IUD	Condoms
MOH hospital	38.0	29.4	47.0	67.5	11.8	13.0	6.6
MOH health center/post	23.3	17.3	29.6	8.7	47.4	46.4	19.5
CSS	9.3	14.6	3.8	11.0	9.5	11.4	3.9
Private physician/clinic	10.5	16.2	4.4	9.9	10.6	23.9	0.0
Pharmacy	9.0	13.9	3.8	0.0	17.4	0.0	64.7
Other source	1.0	2.0	0.2	0.1	1.4	3.6	5.3
Not applicable ^a	2.1	1.6	2.6	0.0	0.0	0.0	0.0
Unknown	6.7	4.9	8.6	2.4	1.9	1.8	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of cases (unweighted)	(936)	(562)	(374)	(419)	(315)	(67)	(27)

^aIncludes those using rhythm and withdrawal.

TABLE 11 Panama: percent distribution of currently married women age 15-44 currently using contraception, by place of last live birth and source of contraception by place of last live birth, 1979 Contraceptive Prevalence Survey

	Place of last live birth (since 1975)				
	MOH hospital	MOH health center	CSS	Private M.D. or hospital	Midwife
Percent using contraception	62.4	48.8	59.1	76.9	28.1
Source of contraception					
MOH hospital	33.6	18.2	10.4	11.5	30.9
MOH health center/post	32.3	62.6	18.2	4.4	42.7
CSS	6.7	1.8	42.5	3.5	6.7
Private M.D.	6.6	6.4	9.2	57.6	0.0
Pharmacy	11.0	6.4	8.5	19.5	3.3
Other	0.6	0.0	5.8	1.8	0.0
Not applicable	3.0	0.0	0.0	0.0	0.0
Unknown	6.3	4.6	5.3	1.8	16.4
Total	100.0	100.0	100.0	100.0	100.0
Number of cases (unweighted)	(372)	(35)	(60)	(41)	(26)

TABLE 13 Panama: percent of women age 15-44 in need of family planning services,^a by residence and selected characteristics, 1979 Contraceptive Prevalence Survey

Characteristic	Total	Residence	
		Urban	Rural
Total	12.3 (2,347)	7.7 (1,394)	17.7 (953)
Age			
15-19	5.5 (520)	4.4 (337)	7.2 (183)
20-24	12.1 (459)	7.7 (276)	17.7 (183)
25-29	17.1 (457)	11.2 (283)	25.1 (174)
30-34	15.0 (379)	11.8 (225)	18.3 (154)
35-39	14.3 (309)	9.5 (170)	18.3 (139)
40-44	17.7 (223)	3.7 (103)	26.6 (120)
Marital status			
Currently married	19.3 (1,528)	13.6 (831)	24.3 (697)
Separated/divorced/widowed	8.6 (246)	5.7 (158)	12.8 (88)
Never married	1.0 (573)	0.9 (405)	1.3 (168)
Number of living children			
0	1.6 (700)	1.3 (481)	2.2 (219)
1	18.3 (376)	14.2 (249)	24.7 (127)
2	15.1 (355)	10.6 (216)	20.0 (139)
3	16.7 (287)	13.9 (176)	20.2 (111)
4	21.3 (209)	14.6 (113)	27.0 (96)
5	17.1 (150)	11.3 (67)	21.0 (83)
6+	23.4 (270)	10.0 (92)	28.6 (178)
Education			
<Primary complete	24.3 (488)	13.2 (121)	27.0 (367)
Primary complete	13.5 (399)	9.8 (260)	15.7 (339)
>Primary complete	7.1 (1,260)	6.6 (1,013)	8.5 (247)
Work status ^b			
Working	7.3 (659)	6.2 (527)	10.7 (132)
Not working	14.2 (1,676)	8.7 (864)	18.8 (812)
Monthly household income ^c			
First quartile	18.8 (427)	8.2 (92)	21.2 (335)
Second quartile	11.1 (505)	9.8 (278)	12.3 (227)
Third quartile	9.4 (421)	9.2 (327)	10.1 (94)
Fourth quartile	6.7 (349)	6.0 (498)	11.4 (51)

NOTE: Figures in parentheses are unweighted number of cases. ^aIn need of family planning services (at risk of unplanned pregnancy) is defined in text. ^b12 cases with unknown work status were excluded. ^c445 cases with unknown income were excluded.

128

TABLE 14 Panama: percent distribution of women age 15-44 in need of family planning services,* by residence and selected characteristics, 1979 Contraceptive Prevalence Survey

Characteristic	Total	Residence	
		Urban	Rural
Total (313 cases) ^b	100.0	33.5	66.5
Age			
15-19	12.5	5.8	6.7
20-24	19.5	7.0	12.4
25-29	23.0	8.7	14.3
30-34	15.8	6.4	9.4
35-39	14.1	4.3	9.7
40-44	15.2	1.2	14.0
Marital status			
Currently married	89.9	29.2	60.7
Separated/divorced/widowed	7.5	2.9	4.6
Never married	2.7	1.4	1.2
Number of living children			
0	4.9	2.5	2.4
1	21.4	10.1	11.2
2	15.8	5.8	10.0
3	13.3	6.0	7.3
4	13.2	4.1	9.1
5	8.7	2.3	6.4
6+	→ 22.7	2.7	20.0 ←
Education			
<Primary complete	40.8	4.3	36.4
Primary complete	28.6	7.7	20.9
>Primary complete	30.6	21.5	9.1
Work status			
Working	15.6	10.1	5.5
Not working	83.8	23.4	60.4
Unknown	0.6	0.0	0.6
Monthly household income			
First quartile	28.7	2.3	26.4
Second quartile	20.1	8.3	11.8
Third quartile	11.9	8.3	3.6
Fourth quartile	12.9	10.1	2.7
Unknown	26.4	4.6	21.9

*For definition, see text. ^bUnweighted number of women in sample who are in need of family planning services.

REPUBLICA DE PANAMA

MINISTERIO DE GOBIERNO Y JUSTICIA

ESTACIONES DE RADIODIFUSION QUE FUNCIONAN EN LA REPUBLICA

13 de Enero de 1983

NOMBRE DE LA EMISORA CONCESIONARIO Y DIRECCION	INDICATIVO	FRECUENCIA KHz	POTENCIA
<u>PROVINCIA DE PANAMA:</u>			
* 1) <u>RADIO UNO</u> <u>ALONSO PINZON</u> Urbanización Obarrio, calle 5-B No. 13, Edificio Kerina Tel. 64-3494	HORS	570	1
* 2) <u>CIRCUITO RPC</u> <u>JAIIME DE LA GUARDIA</u> Edificio Chesterfield Avenida Nacional Tel. 25-0160 - 25-1015	HOM	610	10
* 3) <u>RADIO MIA</u> <u>RANON PEREIRA D.</u> Avenida Perú, No. 28-48 Tel. 25-6700	HOS-22	650	10
* 4) <u>RADIO HOGAR</u> <u>RVDO. ROSENDO TORRES</u> Vía Porras No. 82 Tel. 23-1132	HOLY	670	1

Cont...

NOMBRE DE LA EMISORA CONCESIONARIO Y DIRECCION	INDICATIVO	FRECUENCIA KHz	POTENCIA
* 5) <u>RADIO CONTINENTE</u> CIA. PAVAMENA DE PROMOCIONES PROFESIONALES - RODRIGO CORREA Vía España-Edificio Plaza Regency, Primer Piso. Tel. 69-3370 - 69-6162.	HOQ-51	700	5
* 6) <u>RADIO EXITOSA</u> <u>ARISTIDES DE ICAZA</u> Calle 46 y Avenida Colombia Tel. 25-1141 - 25-1288	HOR-44	730	5
* 7) <u>LA VOZ DEL ISTMO</u> <u>ALCIBIADES LOPEZ</u> Ave. de Los Mártires y Calle Rochet Tel. 62-0368	HOXO	760	5
8) <u>SNV (Southern Command Network)</u> Fuerza de los Estados Unidos Fuerte Clayton Corregimiento de Ancón Tel. 97-5567	HOP-61	790	10
9) <u>RADIO MUNDIAL</u> <u>CARLOS IVAN ZUÑIGA</u> Vía Argentina No. 32 El Cangrejo (Frente al Almacén Linmar) Tel. 69-4043	HOG	810	1
* 10) <u>RADIO LIBERTAD</u> <u>DAVILO CABALLERO</u> Edificio de la Contraloría 7o. Piso Tel. 69-3033	HOL-80	840	10
* 11) <u>RADIO MUSICAL</u> <u>NESTOR DE ICAZA</u> Edificio Dorchester, Vía España 4o. Piso Tel. 64-5239 - 64-8339	HOHO	870	5

Cont...

NOBRE DE LA EMISORA CONCESIONARIO Y DIRECCION	INDICATIVO	FRECUENCIA	POTENCIA
12) <u>LA VOZ DEL PUEBLO</u> MODESTO LOMBARDO VEGA Calle 17 Oeste No. 78 Tel. 62-2434	HOHA	900	1
* 13) <u>RADIO TV-2</u> JUAN CARLOS MARCOS Avenida Bolívar Tel. 60-0571	HOK	940	1
14) <u>RADIO CENTRO CADENA NACIONAL</u> RAUL MONTENEGRO	HOK-71	960	1
* 15) <u>ABC DE PANAMA</u> LUIS CASTILLA BRAVO San Miguelito (ENTRADA DE PARAISO) Tel. 67-6559 - 67-6846	HOO-44	990	3
* 16) <u>LA VOZ DE PANAMA</u> JOSE GABRIEL DIAZ Calle 85 No. 42, San Francisco de la Caleta - Tel. 26-4084	HRJ-60	1,060	1
17) <u>RADIO TIC TAC</u> RIGOBERTO PAREDES Avenida Central, Edificio Remi Tel. 27-0069	HQJ-24	1,080	1
18) <u>K W CONTENENTE</u> RODRIGO CORREA Vía España, Edificio Regency Tel. 69-6162	HOM-21	1,120	1

Cont...

NOMBRE DE LA EMISORA CONCESIONARIO Y DIRECCION	INDICATIVO	FRECUENCIA	POTENCIA
19) <u>RADIO MIL</u> LILIA DE GARCIA DE PAREDES Ave. de Los Mártires No. 21-A-42 Tel. 62-0001 - 62-0427	HOR-58	1,100	1
* 20) <u>RADIO JUVENIL (FM-99)</u> ROOSEVELT DE ICAZA Vía España y Avenida Justo Arosemena D4-53. Tel. 25-1115 - 25-1155	HOT-49	1,140	1
* 21) <u>RADIO DIEZ</u> CARLOS IVÁN ZUÑIGA Vía Argentina. Tel. 23-7603	HOF-91	1,210	4
* 22) <u>RADIO B B</u> ANDRES VEGA CEDEÑO Calle 46 y Ave. Colombia Tel. 25-1250 - 25-9957	HOR-44	1,240	1
* 23) <u>RADIO FEMENINA</u> CLELIA DE ARAUZ Calle 45 y Ave. Colombia Tel. 27-2626 - 27-2803	HOT-22	1,270	0.5
24) <u>RADIO GUADALUPE</u> MANUEL GONZALEZ NATERA Ave. Perú calle 29 Este Tel: 25-1934 - 25-2929	HOS-23	1,290	1
25) <u>RADIO CADENA MILLONARIA</u> BALBINO MACIAS VASQUEZ y LEROY KITSON HUBBARD JOSEPH Tel. 21-9623	HOZ-38	1,350	1
26) <u>LA VOZ UNIVERSAL</u> JESUS CORTON VALIÑO		1,360	

Cont...

NOMBRE DE LA EMISORA CONCESIONARIO Y DIRECCION	INDICATIVO	FRECUENCIA	POTENCIA
27) <u>RADIO TITANIA</u> JOSE GABRIEL DIAZ Calle 85 No. 42, San Francisco de la Caleta. Tel. 21-8516	HRJ-60	1,380	1
28) <u>SUPER RADIO</u> RAMON FERNANDEZ DOMINECH	HORS	1,410	10
29) <u>RADIO EXITO</u> ARISTIDES DE ICAZA Ave. de Las Américas La Chorrera. Tel. 53-3300	HOR-43	1,490	1
30) <u>RADIO OESTE</u> LUIS ANTONIO DELGADO MORALES. La Chorrera		217.250 MHz	
31) <u>RADIO X LA PAVAMEÑA</u> LUIS OLMEDO RUSSELL Vía Santa Elena, calle 15, Esquina No. 70-1, Parque Lefevre Tel. 24-1298	HOA-95	1,510	3
32) <u>RADIO SONORA</u> RODRIGO CORREA Vía España, Edificio Regency		1,120	1
33) <u>STEREO SELECTA</u> ALONSO PINZON	HOT-96	96.900 MHz	1

Cont...

NOBRE DE LA EMISORA
CONCESIONARIO Y DIRECCION

INDICATIVO

FRECUENCIA (MHz)

POTENCIA

EMISORAS EN FRECUENCIA MODULADA (FM)

1) <u>ESTEREO 89</u> RICARDO BUSTAMANTE R. Calle 66, Bethania No. 641 Tel. 61-0123	HOX-48	89.9	1
* 2) <u>ESTEREO AZUL</u> ANTONIO ARADJO RODRIGUEZ Edificio Carrillón, Vía Argentina Tel. 69-3682	HOO-60	101.5	1
* 3) <u>STEREO REY</u> VICTOR MARTINEZ BLANCO Calle Elvira Méndez y Vía España Tel. 64-9897	HOB-98	102.	1
4) <u>STEREO PANAMA</u> MODESTO LOMBARDO VEGA Calle 17 Oeste No. 79 Tel. 62-2435 - 64-5106	HON-94	106.7	1
* 5) <u>OMEGA FM STEREO</u> GUILLERMO ANTONIO ADAMES Calle 16, El Cangrejo, Edificio Don Isaac (Planta Baja) Tel. 64-9145	HOC-40	107.3	
* 6) <u>RPC RADIO</u> JAIME DE LA GUARDIA <i>Sólo es RPC-AM</i>	HOH-88 HOH-86	98.3 90.0	0.25 1
7) <u>SCN (Southern Command Network)</u> Fuerza de los Estados Unidos	HOP-61	91.5	1

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NOMBRE DE LA EMISORA
CONCESIONARIO Y DIRECCION

INDICATIVO

FRECUENCIA

POTENCIA

* 8)	<u>ABC DE PANAMA</u> LUIS CASTILLA BRAVO	HOH-44	92	0.10
9)	<u>RADIO B B</u> ANDRES VEGA CEDAÑO	HOR-44	92.5	0.050
10)	<u>RADIO EXITO</u> ARISTIDES DE ICAZA	HOR-43	95.3	0.01
11)	<u>K W CONTINENTE</u> Cía. Panameña de Promociones Profesionales RODRIGO CORREA	HOQ-51	95.9	0.40
12)	<u>RPC RADIO</u> JAIME DE LA GUARDIA	HOHM	97.3	0.40
* 13)	<u>STEREO BAHIA</u> ERVESTO ISAAC FERNANDEZ	HOS-34	98.5	1
* 14)	<u>RADIO JUVENIL FM-99</u> ROOSEVELT DE ICAZA	HIB-39	99.3	1
15)	<u>RADIO DIEZ</u> CARLOS IVAN ZUÑIGA	HOE-91	101.1	0.5
16)	<u>RADIO TIC TAC</u> RIGORIO PAREDES	HOJ-22	102.5	1
17)	<u>COMPANIA PANAMEÑA DE PROMOCIONES PROFESIONALES</u> RODRIGO CORREA	HOQ-51	103.1	0.30
18)	<u>RADIO MIL</u> LILIA DE GARCIA DE PAREDES	HOE-2	103.9	1
19)	<u>RADIO VIDA</u> RICARDO LAY	HOX-44	105.1	1
20)	<u>RADIO X LA PANAMEÑA</u>	HOB-99	105.70	

158

NOMBRE DE LA EMISORA
CONCESIONARIO Y DIRECCION

INDICATIVO

FRECUENCIA

POTENCIA

PROVINCIA DE COLON:

* 1) <u>CIRCUITO RPC</u> JAIME DE LA GUARDIA	HON-2	560	1
2) <u>CPR</u> MODESTO DE LEON A. Calle 6a., Ave. Balboa y El Frente. Tel. 47-1300	HOK-22	640	1
3) <u>RADIO HIT</u> ALONSO FERNANDEZ Avenida Meléndez No. 15.119 Tel. 45-0880	HOB-51	880	1
* 4) <u>RADIO CONTINENTE</u> RODRIGO CORREA		1,030	1
* 5) <u>RADIO MIA</u> RAMON PEREIRA D.	HOS-25	1,150	0.25
6) <u>CORPORACION NACIONAL DE</u> <u>RADIODIFUSION</u>		1,260	
7) <u>CIA. PAVAMEÑA DE PROMOCIONES</u> <u>PROFESIONALES</u> RODRIGO CORREA	HOC-54	1,330	
* 8) <u>RADIO SUPERSOL</u> ESTEBAN LAY Calle 10a. Santa Isabel y Roosevelt. Tel. 47-1042 y 47-1044	HOL	1,390	1
9) <u>SCV</u> Fuerza de los Estados Unidos Fuerte Davis, Cristóbal	HOA-61	1,420	1
10) <u>RADIO 11</u> <u>CORPORACION NACIONAL DE</u>	HOK-2	1,570	0.1

Cont...

NOBRE DE LA EMISORA
CONCESIONARIO Y DIRECCION

INDICATIVO

FRECUENCIA

POTENCIA

* 11) <u>ESTEREO BAHIA</u> ERNESTO ISAAC FERNANDEZ Avenida Bolívar, No. 9136 Tel. 47-9763	HOE-29	104.3	1
* 12) <u>RADIO LIBERTAD</u> DAVILO CABALLERO	HOL-84	910 680	5
13) <u>SGN</u> (FM) Fuerza de los Estados Unidos Fuerte Davis, Cristóbal	HOA-61	98.3	
<u>PROVINCIA DE CHIRIQUI:</u>			
1) <u>RADIO RUMBOS</u> CAMILO GOZAINÉ Edificio Gozaine, David Tel. 75-5151	HOF-32	680	0.5
2) <u>RADIO CHIRIQUI</u> RAMON GUERRA Calle M.J. Sosa, Edificio Don Enrique Tel. 75-3472	HOB-55	780	10
3) <u>RADIO GUAYMI (Radio Libertad)</u> Ave. 5a. David Tel. 75-3708	HOL-81	890	5
4) <u>LA VOZ DEL BARU</u> OLMEDO MORALES Ave. Bolívar y calle 2a. Norte Tel. 75-3739 - 75-3326	HOU	1025	1
* 5) <u>ONDAS CHIRICAVAS</u> ABIGAIL VDA. DE CALVO Calle M Norte, David	HOC-20	1,160	5

NOMBRE DE LA EMISORA
CONCESIONARIO Y DIRECCIÓN

INDICATIVO

FRECUENCIA

POTENCIA

6)	<u>RADIO CRISTAL</u> DANIEL MORHAIM Ave. 5a. Este y Calle C Norte Tel. 75-4489	HON-26	740	5
7)	<u>RADIO RUMBOS</u> CAMILO GOZAINÉ	HOB-47	1,320	3
8)	<u>RADIO COLOSAL</u> DANIEL MORHAIM Ave. 5a. Este Tel. 75-2555	HOC-38	1,370	1
9)	<u>RADIO MI PREFERIDA</u> JOSE ANTONIO MORA ROMERO Puerto Armuelles Tel. 70-7408	HOK-85	1,420	3
* 10)	<u>RADIO MIA</u> RAMÓN PEREIRA D. Los Algarrobos, Dolega Tel. 75-3277	HOR-57	980 540	1 2.5
* 11)	<u>RPC</u> FERNANDO ELETA ALMARAN	HOH-4	580	0.25/

EMISORAS EN FRECUENCIA MODULADA EN LA PROVINCIA DE CHIRIQUI:

1)	<u>RADIO COLOSAL</u> DANIEL MORHAIM		94.3	700
2)	<u>RADIO CRISTAL</u> DANIEL MORHAIM		98.1	40
3)	<u>FM-81 (PROMEDIARIOS)</u> OLMEDO GONZALEZ BEYTIA		99.1 217.000 (enlace)	1
4)	<u>RADIO RUMBOS</u> CAMILO GOZAINÉ	HOB-47	1,320	3

Cont...

NOMBRE DE LA EMISORA CONCESIONARIO Y DIRECCION	INDICATIVO	FRECUENCIA	POTENCIA	RET
5) <u>RADIO GUAYMI</u> Radio Libertad		102.7	100	
6) <u>RADIO MI PREFERIDA</u> JOSE ANTONIO MORA ROMERO		105.3	10	
* 7) <u>RADIO MIA</u> RAMON PEREIRA D.		106.7	30	
8) <u>RADIO CHIRIQUI</u>		107.1	1	
<u>PROVINCIA DE HERRERA:</u>				
1) <u>RADIO PROVINCIAS</u> GASPAR ALONSO REYES ULLOA Urbanización Las Mercedes Tel. 96-2668/	HQJ-35	630	1	
2) <u>RADIO REPUBLICA</u> SIGN E. COHEN C. Paseo Geenzier - Chitré Tel. 96-4627	HCB-50	720	10	
* 3) <u>EXITOSA DE LAS PROVINCIAS CENTRALES</u> JULIO SUCRE Calle Julio Arjona, Chitré Tel. 96-2597 - 96-2686	HOL-60	800	5	
4) <u>RADIO REFORMA</u> PEDRO SOLIS VILLALAZ Paseo Enrique Geenzier - Chitré Tel. 96-4171	HOL-55	860	1	
5) <u>RADIO RITMO (SECMA, S.A.)</u> SIGN E. COHEN C.	HQQ-62	1,070	5	
6) <u>ONDA TROPICAL</u> MANOLIN JIMENEZ	HCR-31	1.200	1	

Conc...

NOMBRE DE LA EMISORA CONCESIONARIO Y DIRECCION	INDICATIVO	FRECUENCIA	POTENCIA	R
7) <u>RADIO AZUERO</u> (RADIO LIBERTAD) FABIO RODRIGUEZ Edificio Intel, 3o. Piso Tel. 96-2868	HOL-83	770	10	
* 8) <u>CIRCUITO RPC</u> FERNANDO ELETA ALMARAN	HOH-3	590	1	
<u>PROVINCIA DE LOS SANTOS:</u>				
1) <u>DIMENSION 55</u> EMILIO BENJAMIN ESPINO Paseo Carlos L. López y Ave. Porrás. Tel. 94-6323	HOY-28	550	5	
* 2) <u>RADIO PENINSULA</u> RODRIGO CORREA Macaracas, Prov. de Los Santos Tel.	HOR-56	830	1	
* 3) <u>ONDAS DEL CAVAJAGUA</u> SILVERIO VILLARREAL Tel. 94-6200	HQJ-2	1,050	1	
4) <u>LA VOZ DE TONOSI</u> EDI ESTHER HERNANDEZ Tonosí Tel.	HOT-40	1,400	1	
5) <u>RADIO CRISOL</u> EDI ESTHER HERNANDEZ (La Villa de Los Santos)	HQJ-97	1,430	1	
6) <u>ESTEREO CRISOL (FM)</u> EDI ESTHER HERNANDEZ Prov. de Los Santos	HQJ-98	91.100 MHz	1	

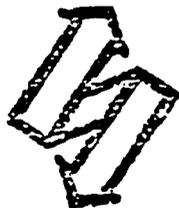
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NOBRE DE LA EMISORA CONCESIONARIO Y DIRECCION	INDICATIVO	FRECUENCIA	POTENCIA
2) <u>RADIO URRACA</u> (RADIO LIBERTAD) Tel. 98-4662 - 96-4331	HOL-82	840	10
3) <u>ONDAS CENTRALES</u> HECTOR A. SANTACOLOMA REYES Avenida Central, Santiago Tel. 98-4428	HOS-97 HOS-97 (FM)	970 99.5 MHz	1 0.1
* 4) <u>RADIO LIBERTAD</u>		1,090	1
5) <u>RADIO DOS MARES</u> ISAAC ACHER MELAMED Los Remedios, Corregimiento de La Peña, Santiago, Prov. de Veraguas	HOU-84	1,180	1

APPENDIX D

Sample of Market Research by Solarian Corporation



Solarian Corporation S.A.

Panamá

145

ESTUDIO DE AUDIENCIA EN MACARACAS - SABANA GRANDE Y TONOSI

I.- INTRODUCCION

La Asociación Nacional de Anunciantes (ANDA) patrocinó recientemente un estudio de audiencia en las Provincias Centrales. Como parte de este estudio se encuestó las regiones de Macaracas, Sábana Grande y Tonosí con el objeto de tener información sobre la situación de radio en las áreas rurales de la Provincia de Los Santos y específicamente sobre la audiencia de Radio Península.

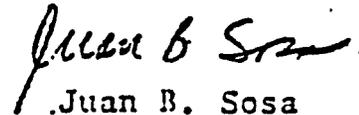
La información que se obtuvo fué la siguiente:

1. Participación de Audiencia de las Radioemisoras: En total se llevaron a cabo 111 entrevistas de tipo coincidental en un período que abarcó desde las 6:00 AM hasta las 5:00 PM. Las 111 entrevistas fueron divididas entre las tres regiones descritas anteriormente.
2. Preferencia de Radioemisoras: Esta es una información de tipo preferencial ya que se les preguntó a las personas entrevistadas que mencionaran las tres radioemisoras de mayor preferencia.
3. Se preguntó específicamente si había escuchado Radio Península durante las últimas 48 horas; en caso de que no la hubiera escuchado se le preguntó si la había escuchado durante la última semana.

4. Se le preguntó al entrevistado que mencionara los programas que había escuchado en Radio Península. Esta fue una respuesta totalmente espontánea.
5. Se le preguntó al entrevistado que mencionara los tres programas de mayor preferencia en Radio Península.
6. Se le preguntó al entrevistado que mencionara los tres programas de menor preferencia en Radio Península.

La encuesta de radio se llevó a cabo durante el día 29 de Octubre de 1980.

SOLARIAN CORPORATION, S.A.



Juan B. Sosa
Presidente

JBS/vdcg.



Solarian Corporation S.A.



asociación nacional de anunciantes

ESTUDIO DE AUDIENCIA EN
MACARACAS - SABANA GRANDE - TONOSI

Prov. Los Santos

Noviembre 1980

148

II.- RESULTADOS DEL ESTUDIO

1. PARTICIPACION DE AUDIENCIA MACARACAS - SABANA GRANDE - TONOSI

41%	Radio Península
18	Radio Reforma
10	Radio Exitosa
8	Radio República
5	Radio Mía
5	Radio R.P.C.
<u>13</u>	Otras Emisoras
100%	

2. EMISORAS PREFERIDAS

(Se podía mencionar tres emisoras por persona)
(Pregunta de Preferencia)

75%	Radio Península
55	Radio Exitosa
50	Radio Reforma
25	Radio República
23	Radio Mía
18	Radio R.P.C.
14	Ondas del Canajagua
8	Radio Provincias
6	Radio Tonosí

3. INCIDENCIA DE HABER ESCUCHADO RADIO PENINSULA EN LA ULTIMA SEMANA

(Base: Total de entrevistas III)

	<u>ULTIMAS 48 Horas</u>	<u>ULTIMA SEMANA</u>	<u>TOTAL</u>
Ha escuchado	66%	19%	85%
No ha escuchado			<u>15%</u>
			100%

4. INCIDENCIA DE HABER ESCUCHADO PROGRAMAS DE RADIO PENINSULA Y PREFERENCIA DE PROGRAMAS

<u>AM</u>	<u>HAN ESCUCHADO</u>	<u>MAS PREFERIDO</u>	<u>MENOS PREFERIDO</u>
5:00- 6:00	25%	29%	5%
6:00- 6:30	9	17	1
6:30- 6:45	9	12	8
6:45- 7:00	11	3	6
7:00- 8:00	13	14	3
8:00- 8:30	4	9	8
8:30- 8:45	9	6	9
8:45-11:00	12	9	8
11:00-11:30	17	16	4
11:30-12:00	14	23	9

150

<u>PM</u>	<u>HAN ESCUCHADO</u>	<u>MAS PREFERIDO</u>	<u>MENOS PREFERIDO</u>
12:00- 1:00	14	16	1
1:00- 1:30	2	7	20
1:30- 3:00	7	3	3
3:00- 3:50	9	13	1
3:30- 5:00	7	5	4
5:00- 6:00	17	11	1
6:00 6:30	5	18	8
6:30- 7:00	14	17	7
7:30-11:00	14	7	6
BASE:	(111)	(94)	(94)

BASE 111: Total de Entrevistas *

BASE 94: Total de entrevistas de personas que han escuchado Radio Peñínsula durante la última semana.

Critique of Leaflets

General criticisms of the forthcoming leaflets are included in the body of this report and need not be repeated. This appendix will attempt to suggest means by which each of the five leaflets may be improved so that they will be better understood in rural areas.

El Condón o Preserativo

On the cover of this leaflet it says, "la pareja, que usan..." This phrase should be omitted for two reasons. First the MCH Division should be promoting male participation in family planning. Every contraceptive method is used by the couple so why single out the condom to include this phrase? The second reason is simplicity. Leaflets should be straightforward using simple words. The added text will only confuse the general public.

Inside the leaflet there should be several illustrations demonstrating how the condom is put on the penis. Words like ejaculation, semen, climax and procedure should be changed for simpler words.

La Vasectomia

This leaflet contains way too much information. Several points could be combined or omitted. For example, when talking about damage to the male sex organs you also could add that all parts of the sex act remain the same except there is no possibility of an unwanted pregnancy (Points No. 4, 7, 13). Also questions about returning to an active sex life and risk of pregnancy are repetitious (Points No. 10, 12). We would omit the

castration/vasectomy comparison or change it to a plainly worded statement that vasectomy is not castration (Point 14). The language needs to be simplified. For example: diminutive, spermatozoids, pleasurable, ejaculation, virility, and organism, should be presented in words used by the rural people.

Metodos para: Planificar la Familia

The first two inside pages of this leaflet don't belong. They deal with what is family planning and human reproduction and not general contraceptive methods. When explaining the barrier methods avoid the word "eliminate" and use the word "barrier". I'm not sure a rural person understands words like: spermatozoid, vasdeferens, fallopian tubes, and sexual capacity. We recommend that simpler words be used.

Cremas, Espumas, Supositorios y Ovulos

This leaflet also needs several words to be changed for easier understanding by the rural people: fecundity, impede, immobilizing, and chemical compounds. In the "how to use" section of the leaflet it should be made clear that not all spermicides come with applicators. If applicators are supplied they should be used to insert the spermicide. If no applicator comes with the package, such as the case of the foaming tablets, none is needed. It should be made clear that every new sexual relation requires a new dose of spermicide.

Las Pastillas Anticonceptivas

The title page does not need the word anticonceptivas. The contraceptive pill is widely known and called simply the pill. There is no reason to call it anything else. This leaflet contains way too much information using language and terms too technical for a rural audience. Each point needs to be cut in half, in terms of quantity of verbage. The MCH Division should decide what is the minimum of information needed and provide it and not include in one leaflet everything anyone may want to know about the pill.

17
XO-APP-497-B
15N-35417

FINAL REPORT ON MID PROJECT EVALUATION
OF THE CONTRACEPTIVES LOGISTICS COMPONENT
OF POPULATION II

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155.

C O N T E N T S

INTRODUCTION

Methodology

Page	
5	I. On the logistics personnel financed under the project.
6	II. Up-to-date information on contraceptives
8	III. Regarding the utilization of the vehicle financed under the project.
9	IV. In relation to the distribution of contraceptives.
13	V. In relation to storage of contraceptives.
15	VI. Other aspects and related recommendations
22	VII. Final Recommendation
24	Annex I
	Annex II
	Map with visited regions
	Maps showing visited places in each region

156

INTRODUCTION

The United States of America's Agency for International Development (USAID/PANAMA) has been funding since 1979 activities related to the improvement of the logistics system for contraceptive supplies and other commodities of the Family Planning sub-program, under the Grant Agreement, Project No. 525-0204 (Population II) between the Republic of Panama, represented by the Ministry of Health, and the United States of America, represented by USAID/Panama.

The Project's second objective, outlined in the Section "Project Definition" of Amendment No. 1 of June 18, 1982, states: "Extension of family planning services."

Likewise, in the Project Description, page 5 of the Agreement of August 1979, under the activities aimed at improvements in logistics and supervision, the following is mentioned:

"Timely and efficient delivery of medical services and contraceptives are critical to the success of any family planning program. In order to strengthen the logistics capability of the Ministry of Health/CSS, the Project will provide funds to permit an increase in staff charged with the management of family planning logistics, including ordering, inventory control, storage, and distribution functions.

The Project will also finance a series of courses in logistics management for those Ministry of Health/CSS personnel responsible for logistics in family planning.

157

In addition, the Project will finance the purchase of a 10-ton truck to be used for distributing family planning equipment and contraceptive supplies."

In Attachment 1 of the Agreement, Overall Financial Plan, appear, among others the following budgetary line items (in thousands of dollars), granted to the Ministry of Health:

Vehicles (van and jeeps)	103	4	107
Salaries of Family Planning Specialists and Administrative Personnel	60 ¹ / ₁	1,392	1,452

In Attachment 1 of the 1982 Amendment, aforementioned, the amount of US\$60,000 is allowed to cover salaries of the family planning logistics system's support staff.

¹ Salaries of family planning logistics management support staff.

158

The present evaluation of the logistics component is part of the General Mid-Project Evaluation required by the Agreement, as stipulated on page 12 of Amendment No. 1:

"The Project will finance an in-depth evaluation at the approximate mid-point in the national sex education program to determine the effects of the program."

The other components of the General Mid-Project Evaluation are "sex education" and "family planning information, education, and communication systems."

METHODOLOGY

The methodology employed in this evaluation includes the aspects detailed below:

- (1) Interview with the following staff that are responsible at national level for the logistics component of Family Planning sub-program:
 - a) Dr. Egberto Stanziola, Chief of Maternal and Child Health Program of the Ministry of Health;
 - b) Mr. Franklin Vega, Logistics Supervisor of MOH/MCH;
 - c) Mrs. Anabella Morales, Logistics Secretary of MOH/MCH;
 - d) Mrs. Marisol Cedeño, Assistant Administrator of MOH/MCH.
- (2) Review of the logistics system files.
- (3) Visits to the facilities, at the national level.
- (4) Design of a form to gather data in the interviews and visits to the health facilities.
- (5) Visits to health facilities, at different levels, in almost all provinces of the Republic.

(6) Interviews with the health personnel in the visited health facilities.

(7) Preparation of charts and maps.

Before initiating the visits to the health facilities, a meeting was held with Dr. Stanziola to discuss the methodology to be followed, as well as to coordinate the schedule of visits. The Ministry of Health agreed to inform the responsible individuals in each region to be visited, and assigned Mr. Vega to join us in the visits.

Instead of five (5) Regional Health Systems, as required in the evaluation contract, we visited seven (7), namely West Panama; East Panama; Colon; Azuero (Herrera-Los Santos); Veraguas; Bocas del Toro; and Chiriqui. We also visited Panama City's Metropolitan Health Region, which is not integrated with the Social Security System.

A total of 42 facilities were visited -- see detailed list in Annex I. However, for data collection purposes, only 36 forms were completed, since the form included aspects on both distribution and storage which, in some instances, concerned two facilities visited in the same place. In most of the visits, we were accompanied by Mr. Franklin Vega, present logistics supervisor of the Program.

The collection of data was completed between May 25 and June 17, 1983. The form prepared to collect the information in the visits to regions and health facilities appears in Annex 2.

Both the places and the facilities were intentionally selected and only in a few cases was an advance notice given of our visit. Therefore, this report is not intended to be considered a scientific document, but rather a means of feedback on some matters that could be corrected or improved.

160

I would like to mention that at all times I received complete cooperation from the health personnel, especially those members of the Maternal and Child Health Program. I am very appreciative of their assistance.

I. ON THE LOGISTICS PERSONNEL FINANCED UNDER THE PROJECT POPULATION II

1. Findings and Comments

From the interviews mentioned in the introduction, the following data were gathered:

<u>Name and title of position</u>	<u>Dr. E. Stanziola Chief of MOH/MCH</u>	<u>Respective Official</u>
Franklin Vega*		
MOH/MCH Logistics Supervisor	80%	50%
Anabella de Morales		
MOH/MCH Logistics Secretary	80%	90%

From observations during the several visits to the MOH/MCH offices, I estimate that Mr. Vega devotes 60% of his working time to the contraceptives logistics duties while Mrs. Morales devotes 50% of her time.

Beginning in June of this year, both officials have been incorporated into the Ministry of Health regular budget. This follows the original plans that the financing of their salaries and other expenses under the Population II Project was on a temporary basis.

*Mario Sánchez filled that position for a short time previously.

161

The main problem Mr. Vega has confronted in the fulfillment of his duties is the limited time he is able to devote to the supervision and distribution of contraceptives, due to:

- a) Non approval of many of his planned trips;
- b) Lack of regular availability of a vehicle.

This was confirmed during the Evaluation, when Mr. Vega could not join us in three of the field visits.

2. Conclusions

a) Mr. Vega has been unable to carry out a better supervision and distribution of the contraceptives due to the aforementioned reasons.

- b) We consider the appointment of these officials by the Ministry of Health to be a very positive decision.

3. Recommendations

- a) The MOH/MCH administration should expedite procedures to allow Mr. Vega the optimum fulfillment of his duties.
- b) USAID/Panama should send a congratulatory note to the Ministry of health for the appointments of Mr. Vega and Mrs. Morales.

II. UP TO DATE INFORMATION ON CONTRACEPTIVES

1. Findings and Comments

During visits to different health regions, the following result was obtained when we inquired if the health personnel considered that they were sufficiently informed with regard to the use of the various contraceptives:

162

<u>Personnel</u>	<u>Yes</u>	<u>No.</u>	<u>Do not know or no answer obtained</u>
Physicians	17	10	9
Nurses	25	5	6
Auxiliary nurses	23	10	3
Health assistants	<u>7</u>	<u>5</u>	<u>24</u>
Totals	72	30	42

As can be observed, the number of positive opinions equals exactly the sum of negative answers plus those of "Do not know or no answer obtained" -- (72 vs. 72).

We detected, also, the following matters which we think require attention:

- a) Information was lacking regarding low dose oral contraceptives. Necessary orientation from the national level was not provided. In several cases we confirmed that patients had been given, indiscriminately, high and low dose orals, which coincides with the high number of mentioned side effects.
- b) There was a considerable number of statements regarding insufficient orientation on contraceptives and some indications of low emphasis being given to family planning in the Maternal and Child seminars.
- c) One of the most frequent suggestions we were given was the need for more training activities, both for orientation purposes and for updating the personnel, on contraceptive methods.

2. Conclusions

It is evident that the health personnel possess and receive insufficient information on contraceptive methods.

3. Recommendations

- a) Carry out more supervisory, educational, and updating activities on contraceptives at regional and area levels.
- b) Reinforce emphasis on contraceptives and family planning aspects in the training activities of the MOH/MCH.

III. REGARDING THE UTILIZATION OF THE VEHICLE (VAN) FINANCED UNDER THE PROJECT POPULATION II

1. Finding and Comments

We observed from the trips made and in the visits conducted to the MOH/MCH offices, that the van financed under the Project was not being utilized.

Dr. Stanziola, Chief of MOH/MCH, told us that the van was seldom utilized because of high fuel consumption and the existing limitations in this respect in the Ministry of Health. That is why, he added, they prefer to use other available vehicles, which consume less fuel. Yet, the van is used for special purposes, such as picking up large quantities of contraceptives at the shipping terminals, or when it is lent to the Epidemiology Division to pick up large vaccine shipments from the airport.

Mr. Vega indicated that he barely uses the van and it is more often utilized by the Epidemiology Division and the General Directorate of Health.

2. Conclusions

- a) Apparently, it was a poor decision to acquire this type of vehicle, considering its high fuel consumption.
- b) The other MOH/MCH vehicles substitute for the van and attempt to meet program needs.

3. Recommendations

- a) Provide increased supply of fuel for the van so that it can be utilized more frequently in the distribution of contraceptives.
- b) Transfer the van to the General Directorate of Health, in exchange of a similar vehicle, but more fuel economic.

IV. IN RELATION TO THE DISTRIBUTION OF CONTRACEPTIVES

1. Findings and Comments

All facilities visited reported that they receive contraceptives. We could also confirm that all visited facilities had contraceptives, although they differed greatly as to types and quantities available.

Logically, in the three health sub-centers, visited, we found less assortment of contraceptives, while the majority of the other facilities visited (hospitals, health centers, warehouses), we found a relatively high variety of contraceptives.

Following is a detail of the availability of varieties of contraceptives in the health facilities at the moment of the visits:

165

<u>Variety</u>	<u>Yes</u>	<u>No.</u>
Oral contraceptives, regular dose	31 (86%)	5 (14%)
Oral contraceptives, low dose	4 (11%)	32 (89%)
Condoms	34 (94%)	2 (6%)
Jelly and applicators	21 (53%)	15 (42%)
Lippes "B"	10 (28%)	26 (72%)
Lippes "C"	26 (72%)	10 (28%)
Lippes "D"	27 (75%)	9 (25%)
Cooper "T"	12 (33%)	24 (67%)
Vaginal tablets	6 (17%)	30 (83%)
Diaphragm No. 65	17 (47%)	19 (53%)
Diaphragm No. 70	13 (36%)	23 (64%)
Diaphragm No. 75	13 (36%)	23 (64%)

A large number of the individuals interviewed complained of the delays in receiving the contraceptives (56%) and that they were not provided with all the varieties they requested (67%). A smaller percentage replied that they did not receive sufficient quantities (45%).

The usual period of time between the request and the receipt of the contraceptives varies greatly: from a couple of days to several months, as can be seen in the following table:

<u>Period of time</u>	<u>Frequency</u>
Less than 2 days	16
From 2 to 3 days	8
From 10 to 14 days	3
From 1 to 2 months	3
Four months	1
So variable that no precise data could be given	5

The great majority of facilities visited (81%) receive the contraceptives from the regional office or from the respective area office and only 19% from the MOH/MCH Office. These latter cases were almost all of the regional offices, as should be expected.

166

In almost all cases, within the regions, the oral contraceptives are received through the pharmacies or medical warehouses, under the responsibility of the Social Security personnel.

On the other hand, and almost always, the rest of the contraceptives are received from the MCH regional coordinating office, or from the area or health center's chief nurse.

With regard to the efficiency of the distribution system, the majority replied affirmatively (61%), taking into consideration, we believe, the shortage of vehicles and fuel in the health system, and the communication difficulties in several areas.

We found an acute shortage of vehicles in the facilities visited, and when they are available, other priorities appear. In several instances, the interested official himself uses his own car to pick up and transport the contraceptives.

Also at the national level, at the MCH Warehouse, there is a lack of the following contraceptives (as of 6-20-83): Lippes Loops and vaginal tablets. In addition, there is a short supply of low dose oral contraceptives and spermicide jellies.

2. Conclusions

- a) Distribution is not effective, considering that only four (4) contraceptives, out of the list of 12, were found in stock in more than 70% of the facilities at the moment of the visits. They were, in order of availability: Condoms (94%), high dose oral (86%), Lippes "D" (75%), and Lippes "C" (72%).

- b) On the other hand, the lack of availability of various contraceptives was notorious, such as: low dose oral contraceptive (83%), vaginal tablets (83%), Lippes "B" (72%), Copper "T" (67%), and No. 70 and 75 Diaphragms (64%).
- c) Taking into account the vehicle and fuel limitations of the health system in general, we believe that the distribution is quite efficient at regional, area, and local levels. It is at the national level where an increased rationalization of resources (staff and vehicles) are needed in order to improve distribution and supervision of the contraceptives.

3. Recommendations

- a) If possible, an individual should be appointed -- specialized physician or nurse -- as chief or responsible for the Family Planning sub-program, in that the MCH program is too complex for the few existing units at national executive level.

Note: We received a similar suggestion from a MCH regional coordinator.

- b) Place international orders of contraceptives with plenty of lead time, taking into consideration the trends of the demands for the different regions.
- c) While recommendation (a) is being considered, the following could be done to improve the handling of orders:
 1. Provide the secretary of the MOH/MCH Director with a separate in-basket to receive all contraceptive orders.
 2. The logistics supervisor must be closely monitoring the contents of this basket in order to expedite approvals of orders with the Director.

160

- d) The logistics supervisor should periodically telephone the responsible individuals for the contraceptives in each region to determine their needs and provide necessary solutions. This will be much more important, especially when supervision trips are limited due to lack of fuel and/or vehicle.
- e) Orders of the different contraceptives should be carefully planned at the national level, in order to avoid running out of stock and, consequently, being unable to supply the regions.

V. IN RELATION TO STORAGE OF CONTRACEPTIVES

1. Findings and Comments

Regarding the storage conditions and the inventory controls, the following replies were obtained:

<u>Conditions</u>	<u>Yes</u>	<u>No.</u>
Adequate space	32 (97%)	1 (3%)
Security	31 (94%)	2 (6%)
Adequate ventilation	29 (88%)	4 (12%)
Inventory control	11 (33%)	22 (67%)
Boxes are marked and kept according to receiving date	1 (3%)	32 (97%)

As can be seen, in the majority of cases, the space limitations, security, and storage ventilation conditions are satisfactory. In only a few cases, the contraceptive jellies were stored under conditions of higher temperatures than advisable.

169

On the contrary, in the majority of cases there are no adequate inventory systems* and the boxes with contraceptives are almost never marketed nor stored according to date of receipt.

In most cases, at the nurse's office, a daily record is kept of the contraceptives provided to the family planning patients.

2. Conclusions

- a) Generally, storage conditions are good.
- b) There is a need to utilize a simple first-in-first-out system to mark and store the boxes of contraceptives according to date of receipt.

3. Recommendations

- a) Develop and implement, in all medicine stores and warehouses at regional level, a simple inventory control system, consisting of adequately marking and storing, according to date of receipt, all boxes of contraceptives.
- b) Condition an area in the Ministry of Health's new national level warehouse, for all commodities related to family planning, and especially, for the contraceptive supplies. The MCH Program Director is very aware of this need. It would also be advisable to install a large ventilator fan on the wall, which would be more economical than an air conditioning unit.

* There is an existing attitude that, because the contraceptives are donated commodities, there is no need to keep a strict control of them.

170

- c) The logistics supervisor should devote some time to the implementation of a simple inventory control system in the regions lacking such systems, (similar to the system employed in the warehouse at the national level).
- d) The boxes of oral contraceptives should be labeled in an adequately visible way so as to indicate contents of each box (low or high dose).

VI. OTHER ASPECTS AND RELATED RECOMMENDATIONS

1. Delivery of Contraceptives in Areas of Difficult Transportation and the Logistics System at Different Levels

All regional headquarters, even those facing difficult transportation problems, can be reached from Panama City by surface, air, or by sea.

Also, the responsible health officials in each one of the regions know the best and most efficient ways to distribute the contraceptives and other commodities to the various facilities under their supervision.

The problem really lies in the following limitations:

- a) Scarcity of vehicles in good conditions;
- b) Insufficient funds for maintenance and repair of vehicles;
- c) Limited budgetary allowances for fuel and lubricants;
- d) Reduced funds for travelling allowances for the staff;
- e) Slow bureaucratic procedures for travel authorizations and allowances;
- f) Excessive regulations on expense control due to the present fiscal crisis.

171

All these limitations are worsened at the lower bureaucratic levels. That is, they are more acute at the regional rather than at the national level, and much worse at the area or local level than at the regional level.

All in all, we were informed on several occasions, (and we have had the opportunity to confirm this in many other situations during previous field work in all the provinces), that, at regional levels, and even more, at area and local levels, all types of resources are being utilized to distribute the contraceptives and other commodities for the health programs, including those for family planning. For instance, joint collaboration of commercial companies and community members, vehicles and resources belonging to the health officials themselves, and coordination with other Ministries and public agencies.

The other problem affecting the contraceptive logistics at all levels is the fact that there are many other matters of greater priority in the health sector.

2. Towards a Standard Logistics System

At this moment, there is not a standard logistics system for the whole country. In a large part, this seems to be due to the existence of two organizational realities within the health sector: the Ministry of Health and the Social Security. In addition, there is an integrated sub-sector (covering almost all the country), and another sub-sector which is not integrated (the Metropolitan Region, which includes the districts of Panama and San Miguelito).

172

Oral contraceptives are periodically sent from the Social Security Medical Warehouse at the national level, to the regional medical warehouses.

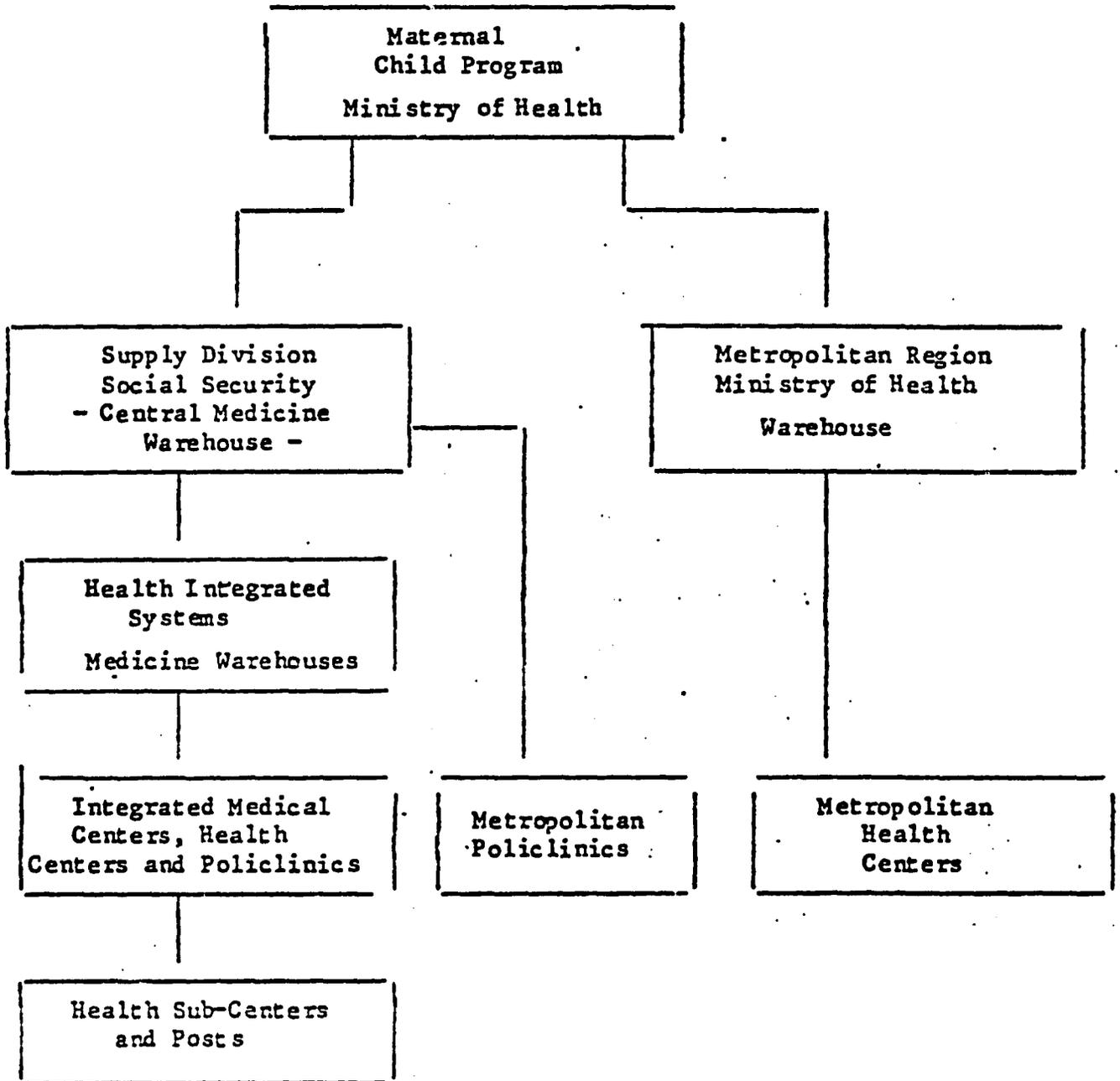
The MOH/MCH receives requests for contraceptives from both sub-sectors. In the integrated sub-sector we found that the trend is for oral contraceptives to be kept at the medical warehouses or pharmacies, and the rest of the contraceptives are maintained at the respective regional warehouses or at the family planning offices (with emphasis on nurse's offices). Within each integrated system or region, the responsible units must request oral contraceptives from one place (medicine warehouses or pharmacies), and the rest of the supplies from another place, (generally, the family planning coordinating nurse). In some cases, there is confusion as to where to submit the request for the contraceptives.

This matter should be discussed and analyzed to arrive at a better decision.

One option we suggest is the following:

That MCH receive the requests and delivers contraceptives only to the following two entities: the Supply Division of the Social Security and the Metropolitan Region of the Ministry of Health. They, in turn, would receive and deliver orders, respectively, to the Medical Warehouse or regional pharmacies of the Integrated Health Systems and to the Metropolitan Health Centers.

FLOWCHART OF CONTRACEPTIVES DISTRIBUTION



174
2

Among the advantages of a unified system such as this, should be mentioned:

- a) The bulk of the orders and deliveries would be in charge of the Supply Division of the Social Security, which has more resources than the Ministry of Health (more personnel for logistics, more ample warehouses, less limitations in terms of vehicles, fuel, etc.)
- b) Distribution would be much more efficient, as advantage can be taken of the same trips for delivery of Social Security medicines to the Intergrated Health Systems and to distribute the contraceptive orders, resulting in a cost economy for the Ministry of Health. For example: during this evaluation, on a trip to Santiago, the station wagon assigned to Maternal and Child consumed a total of twenty (20) gallons of gasoline round-trip (at \$2.28 per gallon, the total cost in gas was \$45.60). Six trips in a year would cost \$273.60. If we compute all fuel expenses in each one of the regions where the vehicle must go, we have a clear idea of the extent of the savings under consideration.
- c) The health facilities would place their orders to only one place, saving double work and possible confusions (more efficiency and effectiveness).
- d) The limited resources--staff, vehicles, fuel, and travel allowances of the MOH/MCH could be better employed in supervision and advisory activities for the various levels.

17/5

3. Other Interesting Matters Observed

a. Regarding the Copper "T"

In general terms, we evidenced interest and demand for the Copper "T". On various occasions we were told by the health staff that they were notified that the Copper "T" had been discontinued due to its high cost. In other places, its application was restricted to gynecologists. In one occasion, they had been so heavily controlled that the chief gynecologist did not know of its availability at his own facility for a period of almost two months. On two occasions we were told that there is a certain trend among physicians, especially gynecologists, to prescribe the Copper "T" for patients who were not channeled toward the family planning program.

b. Public Condom Dispenser

A condom dispenser was observed at the treatment room of the Health Center in San Mateo. The chief nurse told us that results have been very positive and that the public is already used to this mechanism and takes advantage of it frequently.

This same idea should be adopted and adapted in other health facilities.

c) Surgical Kits

We found in several regional warehouses surgical kits financed by the Project, some of which were incomplete. We were told that some instruments had been taken out, at the

176

request of the chief physician, in order to meet urgent needs in the surgery rooms and in the equipment stores. On the other hand, requests for these kits and instruments have been received from area and local level facilities. We believe that an inventory of these kits should be taken in each Region, plus investigating the needs of the health facilities and then proceed to rationally distribute the kits. If necessary, a new order should be placed, financed by the Project, to supply all the kits and instruments that are required.

d) Regarding Diaphragms

Aside from the shortage of diaphragms previously mentioned, in some facilities they also lack the diaphragm measuring devices or rings.

In the majority of cases, we were told that this method is very seldom used, or not used at all, especially because it requires a special type of patient with a higher educational level.

e) Extension of the Family Planning Activities to Lower Levels

In two occasions we were told of the need to expand the activities of the family planning sub-program to the health post level and to increase other activities at the health sub-centers.

f) Lack of Equipment and Materials for Public and Patient Education

Many of those interviewed indicated great interest in being supplied or better provided with equipment and materials

17/11

for the education of patients and public. There are no movie nor slide projectors, educational films, flipcharts, models, etc.

In practically all installations we observed posters and/or health education bulletin boards allusive to family planning.

We believe that the possibility of acquiring additional audio-visual equipment and preparing more educational materials should be considered.

g) Interest of the Personnel

In most of the visited places, we could appraise great interest of the health personnel for the family planning activities, specially by nursing staff.

h) Dependency on Oral Contraceptives

Even though it is not the purpose of this evaluation, we consider it important to mention that we observed a great reliance or dependency on oral contraceptives, at the same time that we were told about side effects in a number of patients.

It would be advisable to investigate this matter, and take the necessary measures.

VII. FINAL RECOMMENDATION

We recommend that this report be read and discussed in a meeting with the regional coordinators and other representatives of the Maternal and Child Program throughout the country.

178

In such a meeting, the data obtained could be discussed and reviewed, as well as the conclusions and the various specific recommendations, in order to arrive at decisions that will improve the whole contraceptive logistics system of the family planning sub-program.

SUMMARY OF ACTIVITIES
ACCOMPLISHED

	<u>Name</u>	<u>Date</u>	<u>Subject</u>
1. With USAID/Panama Panama City	John P. Coury	9-11-83 and 5-20-83	Interviews
	Gerald Gold/ Elida de Zambrano	5-25-83	Signing of Contract
2. With Maternal and Child Health Program, Ministry of Health Panama City	Dr. Alfredo Moltó Director in Charge of Public Health	5-26-83	Initial Interview
	Dr. Egberto Stam- ziola, MCH Director	5-26-83 6-17-83	Initial interview Final interview
	Marisol Cedeño MCH Assistant Administrator	5-26-83	Interview
	Franklin Vega MCH Logistics Officer	5-26-83	Interview
	Anabella de Morales, MCH Logistics Secretary	6-8-83	Interview

3. Visits to regional offices and health installations.

<u>Region</u>	<u>Location</u>	<u>Date</u>	<u>Health Installation</u>
West Panama	La Chorrera	5-27-83	Regional Office
	" "	5-27-83	Nicolas Solano Hospital
	" "	5-27-83	M. Ruiz Health Center
East Panama	Capira	5-27-83	Health Center
	Chepo	5-30-83	Regional Office
	"	5-30-83	Regional Hospital
	Pacora	5-30-83	Health Center

120

<u>Region</u>	<u>Location</u>	<u>Date</u>	<u>Health Installation</u>
Colon	Colon	5-31-83	Regional Office
	"	5-31-83	M.A. Guerrero Hospital
	"	5-31-83	9th Street Health Center
	Sabanitas	6-10-83	Integrated Medical Center
	Portobelo	6-10-83	Health Center
Azucar	Nuevo San Juan	6-10-83	Integrated Medical Center
	Chitre	6-1-83	Regional Office
	"	6-1-83	Maternal and Child Hospital
	Macaracas	6-1-83	Integrated Medical Center
	Ponuga	6-3-83	Health Sub Center
Veraguas	Soná	6-2-83	Integrated Medical Center
	Río de Jesús	6-2-83	Health Center
	Santiago	6-3-83	Regional Office
	"	6-3-83	Specialized Polyclinic
	Cañazas	6-3-83	Integrated Medical Center
Bocas del Toro	Bocas del Toro	6-6-83	Integrated Medical Center
	Almirante	6-7-83	Integrated Medical Center
	Chanquinola	6-7-83	Integrated Medical Center and Regional Office
Metropolitan	Panama City	6-9-83	Rómulo Roux Health Center
	"	6-9-83	Pueblo Nuevo
	"	6-20-83	New warehouse, at national level of MOC/MCH
Chiriquí	"	6-13-83	San Felipe Health Center
	David	6-14-83	Regional Office
	David	6-14-83	J.D. Obladía Maternal and Child Hospital
	Alanje	6-14-83	Health Center
	Boquerón	6-14-83	Health Center
	Aserrio	6-14-83	Health Sub Center
	Paso Canoá	6-14-83	Health Center
Chiriquí	David	6-15-83	Barrio Bolívar Health Center
	Volcán	6-15-83	Health Center
	Cerro Punta	6-15-83	Health Sub Center
	Dolega	6-15-83	Health Center
	Concepción	6-15-83	Integrated Medical Center
	San Lorenzo	6-16-83	Health Center
	David	6-16-83	San Mateo Health Center

EVALUACION INTERMEDIA DEL COMPONENTE LOGISTICO DE LOS ANTICONCEPTIVOS
EN EL PROYECTO POBLACION II ENTRE USAID/PANAMA Y EL MINISTERIO DE SALUD
DE LA REPUBLICA DE PANAMA

- FORMULARIO DE RECOLECCION DE DATOS -

Fecha: _____

Lugar: _____

I. Distribución

Información obtenida mediante entrevista a persona(s) encargada(s):

1. Se reciben los anticonceptivos?

Observaciones:

a. Sí _____ No _____

b. A tiempo? Sí _____ No _____

c. Aproximadamente, cuánto tiempo de los anticonceptivos?

d. En cantidades suficientes? Sí _____ No _____

e. En variedades solicitadas? Sí _____ No _____

f. En variedades disponibles?

	Sí	No	Observaciones
Orales, dosis normal	_____	_____	_____
Orales, dosis baja	_____	_____	_____
Condomes	_____	_____	_____
Espuma (Jalea)	_____	_____	_____
Aplicador	_____	_____	_____
Lippes "B"	_____	_____	_____
Lippes "C"	_____	_____	_____
Lippes "D"	_____	_____	_____
"T" de Cobre	_____	_____	_____
Pastillas Vaginales	_____	_____	_____
Diafragma No. 65	_____	_____	_____
Diafragma No. 70	_____	_____	_____
Diafragma No 75	_____	_____	_____

2. Considera usted que la forma como se transportan y distribuyen los anticonceptivos es la más eficiente (más económica con resultados satisfactorios)? Sí _____ No _____ Por qué? _____

3. De qué oficina o funcionario reciben los anticonceptivos?

a. Mediante solicitud o requisición? .SÍ ___ No ___

b. A veces sin requisición? SÍ ___ No ___

4. Considera usted que todo el personal de Salud está suficientemente informado acerca del uso de los distintos tipos de anticonceptivos?

	SÍ	No	Observaciones
Médicos	___	___	___
Enfermeras	___	___	___
Auxiliares	___	___	___
Asistentes de Salud	___	___	___
Otros (especifique)	___	___	___

5. Cuáles son los problemas o dificultades más comunes en relación con los anticonceptivos? (especialmente en cuanto a logística) _____

II. Almacenamiento

Informaciones obtenidas mediante observación y entrevista(s) a persona(s) encargada(s): _____

1. Lugar

	SÍ	No	Observaciones
a. Espacio apropiado	___	___	___
b. Condiciones de seguridad	___	___	___
c. Ventilación adecuada	___	___	___
d. Otras condiciones (Protección de lluvia, etc.)	___	___	___

2. Control de inventario

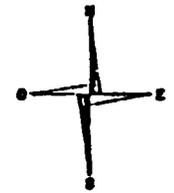
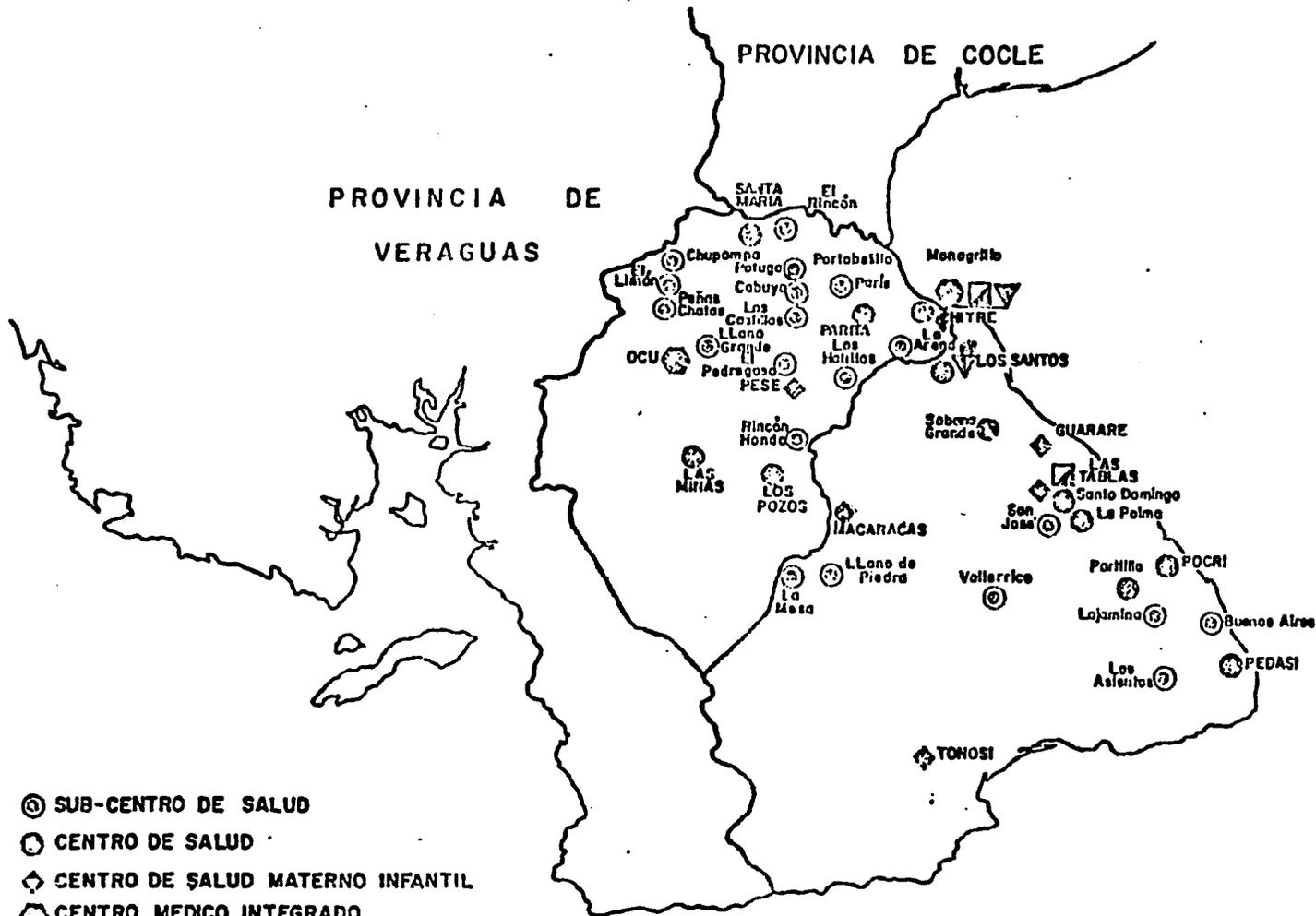
	SÍ	No	Observaciones
a. Se utiliza?	___	___	___
b. Se ordenan y marcan las cajas según fecha de recibo y se distribuyen consecuentemente?	___	___	___

102

III. Otros asuntos de importancia detectados: _____

IV. Recomendaciones

SISTEMA INTEGRADO DE SALUD AZUERO



- ⊙ SUB-CENTRO DE SALUD
- CENTRO DE SALUD
- ◇ CENTRO DE SALUD MATERNO INFANTIL
- ⊕ CENTRO MEDICO INTEGRADO
- ▣ POLICLINICA
- ▽ HOSPITAL

ESCALA 1:1,000,000
0 20 Km

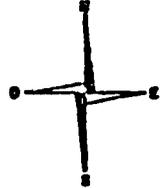
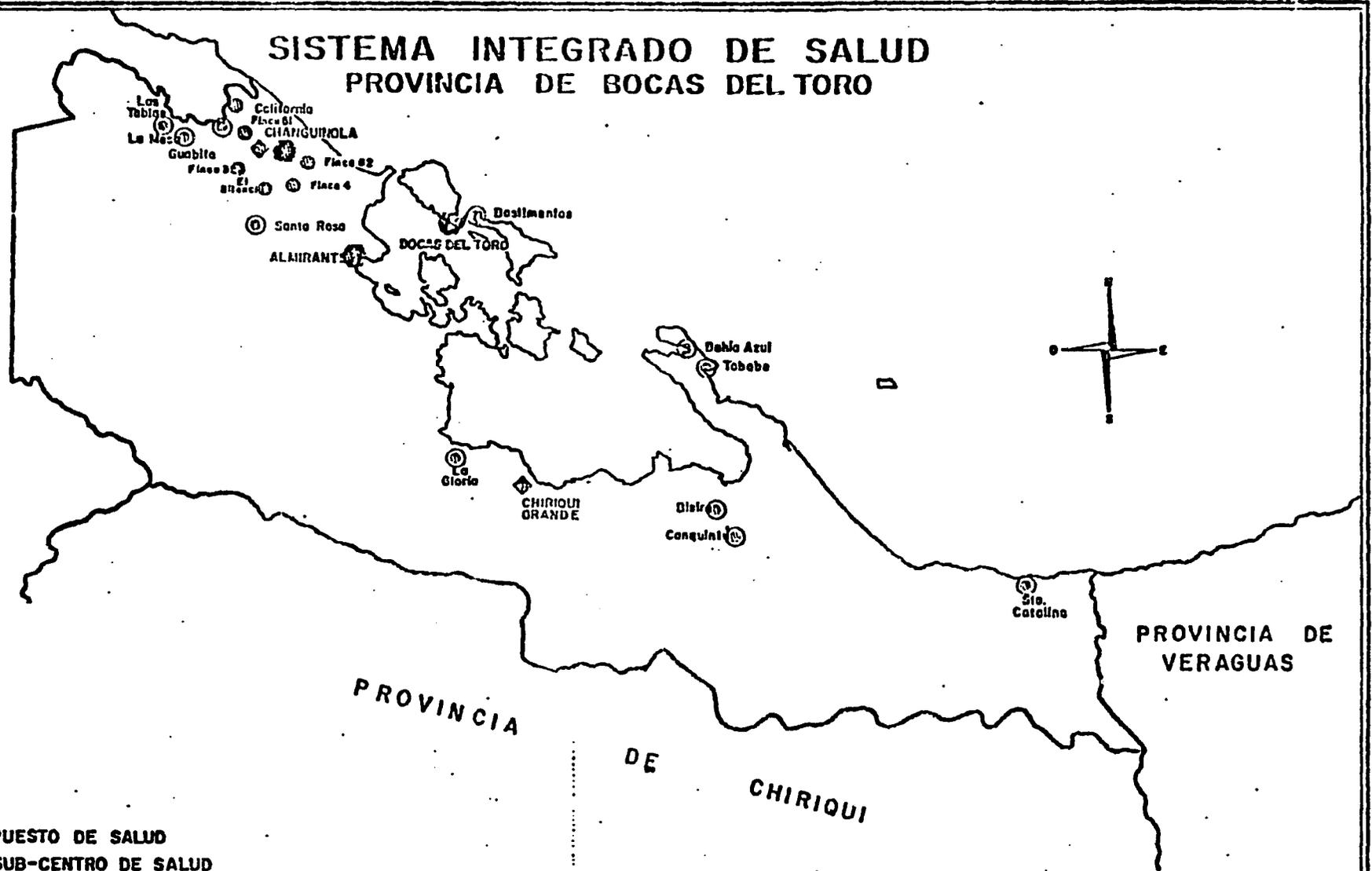


196

LUGARES VISITADOS - PLACES VISITED

SISTEMA INTEGRADO DE SALUD
PROVINCIA DE BOCAS DEL TORO

REPUBLICA DE COSTA RICA

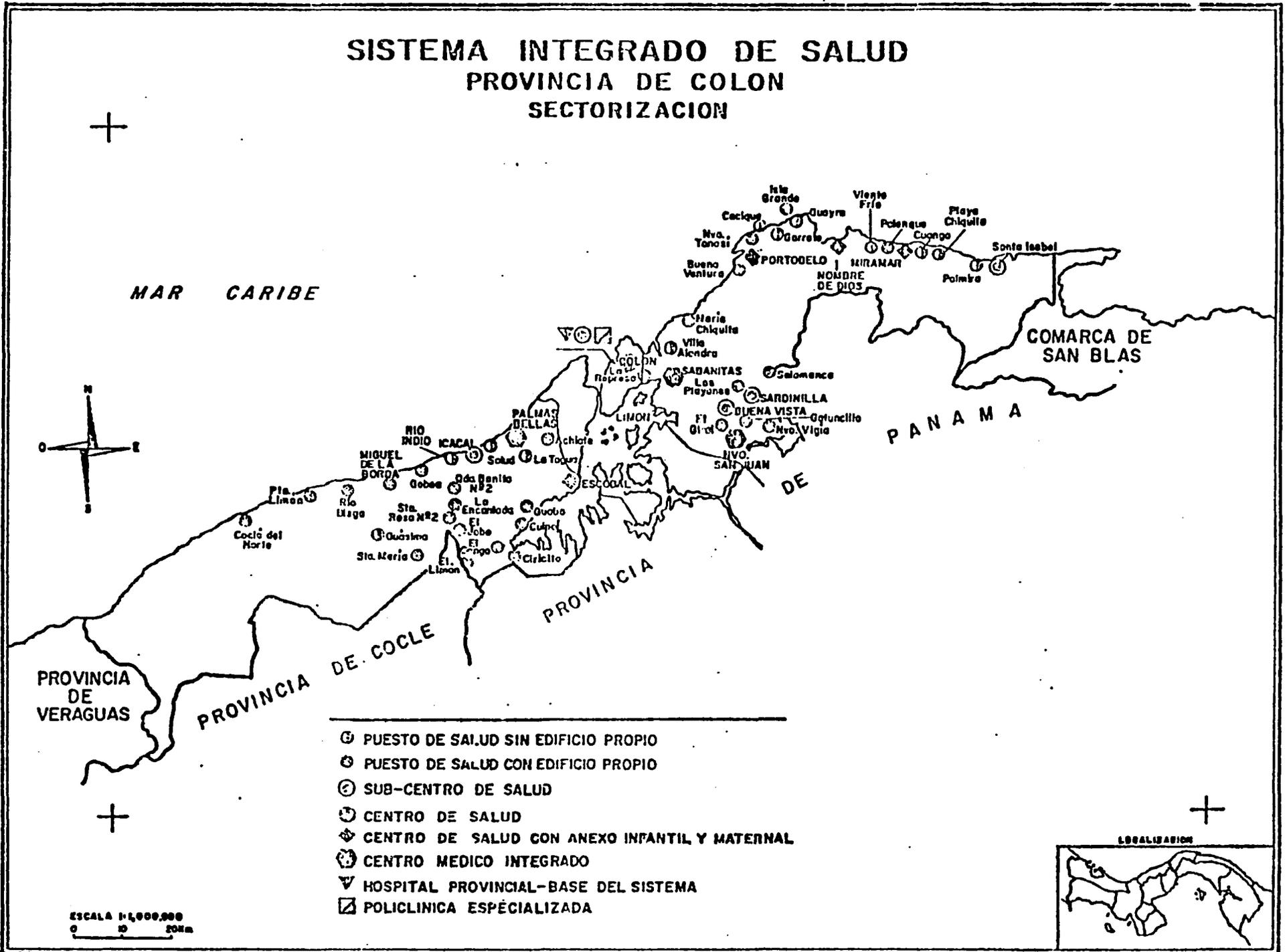


- PUESTO DE SALUD
- ⊕ SUB-CENTRO DE SALUD
- ◆ CENTRO DE SALUD MATERNO INFANTIL
- ⊗ CENTRO MEDICO INTEGRADO

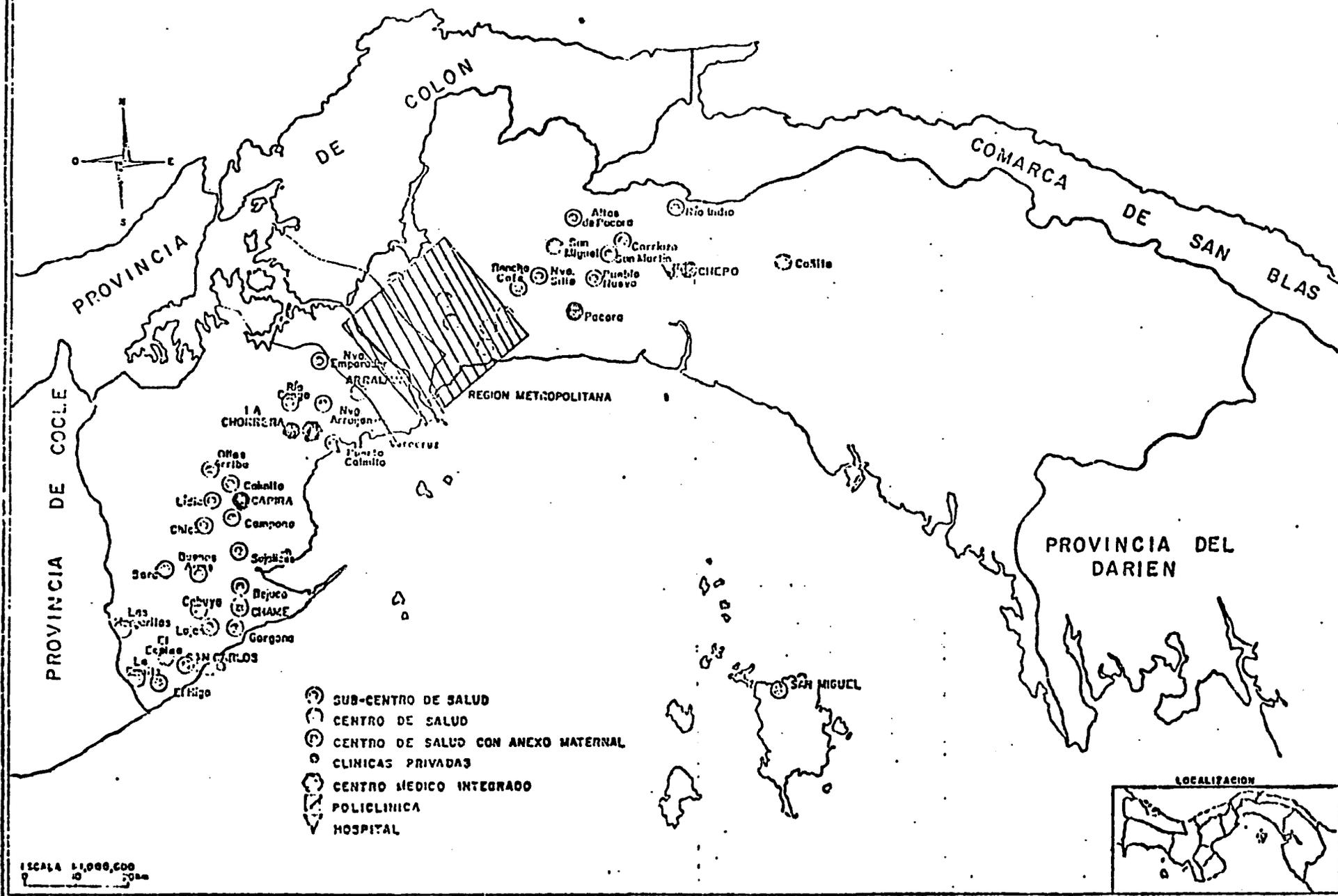
ESCALA 1:100,000
0 10 20 KM



SISTEMA INTEGRADO DE SALUD
 PROVINCIA DE COLON
 SECTORIZACION



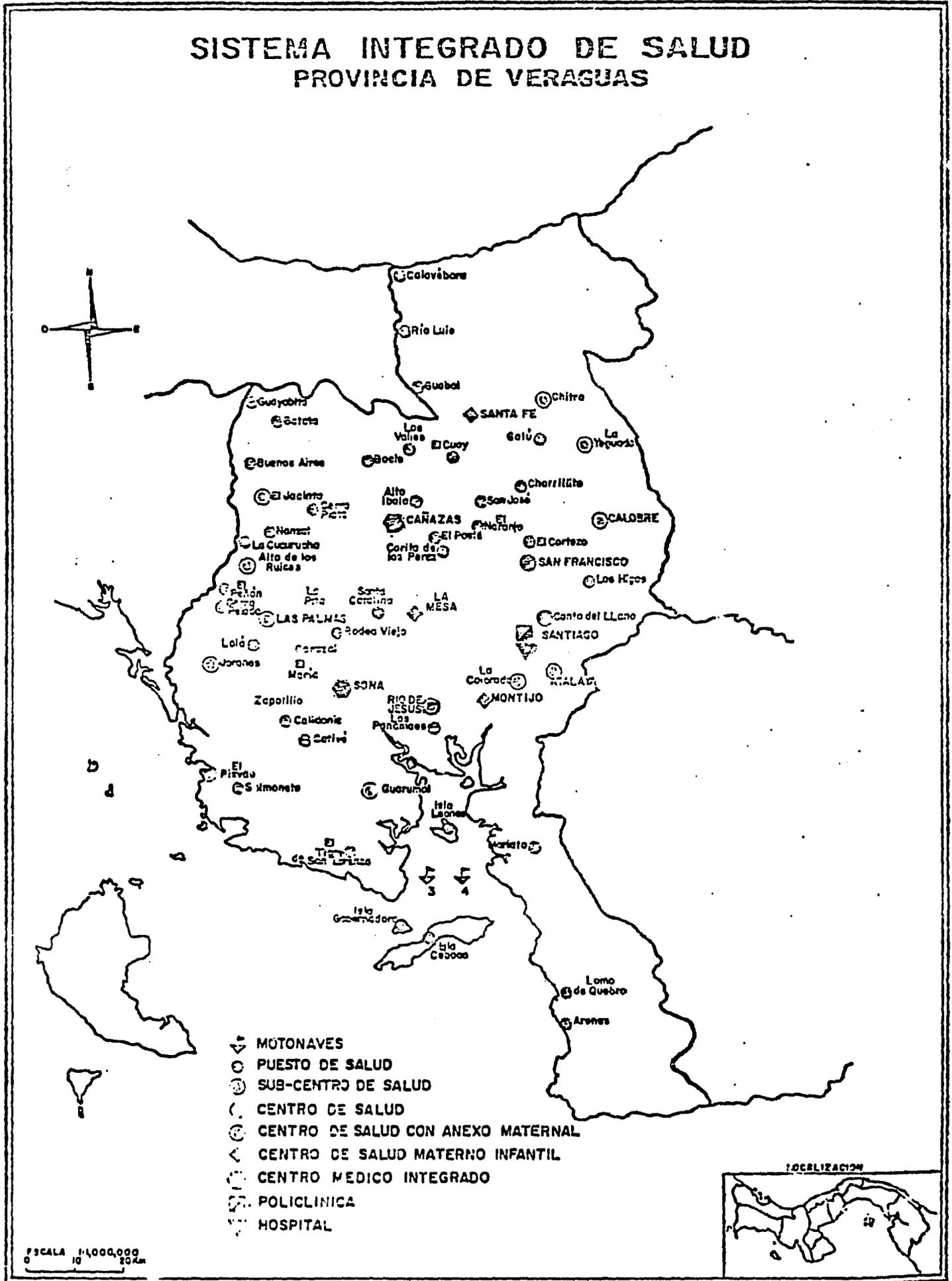
REGION DE SALUD DE LA PROVINCIA DE PANAMA



ESCALA 1:1,000,000

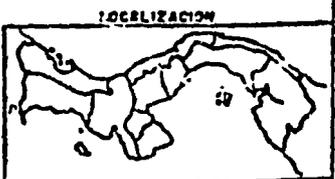


SISTEMA INTEGRADO DE SALUD PROVINCIA DE VERAGUAS



- ▼ MOTONAVES
- PUESTO DE SALUD
- ⊙ SUB-CENTRO DE SALUD
- CENTRO DE SALUD
- ⊙ CENTRO DE SALUD CON ANEXO MATERNAL
- ◁ CENTRO DE SALUD MATERNO INFANTIL
- ⊙ CENTRO MEDICO INTEGRADO
- ⊙ POLICLINICA
- ⊙ HOSPITAL

ESCALA 1:100,000
0 10 20 Km



Prepared by
XO AAP 497 (John Curry
8/83
75N = 35418
17

PROJECT EVALUATION

PROJECT POPULATION II No.525-0204

PROJECT DESCRIPTION AND BACKGROUND:

The Population II Grant Project Agreement, USAID/Panama 525-0204, signed on August 31, 1979 and amended on June 18, 1982, provides funds for five years in the amount of \$3,250,000 to four (4) Government of Panama (GOP) Agencies and the private family planning association, for the purpose of: (1) expanding family planning information, education and communications outreach activities; (2) extending family planning services; and (3) introducing and institutionalizing sex education in Panama.

During the twelve years prior to Population II, AID had contributed \$4.6 million to integrated maternal/child health/family planning activities through 16 project agreements with the Ministry of Health (MOH) and two agreements with the private family planning group, Asociacion Panameña para el Planeamiento de la Familia (APLAFA).

The goal of the Population II Project, to contribute to a reduction of the crude birth rate (CBR) to 25 per thousand over the five-year period, is well on schedule, and it appears that Panama should reduce its population growth rate to the two per cent per annum target sooner than the year 2000, as originally planned. Figures for 1981 indicate that the CBR was 27.4 per thousand, down from 29 per thousand in 1978.

The Project strategy is two-fold: (1) to continue to support the GOP's integrated approach to the delivery of family planning services by providing contraceptives, clinical equipment for sterilization procedures, training for medical/paramedical personnel, improved information/education/communication

AUG - 1 1983
193

activities (e.g., radio spots, mobile IEC units, posters), and logistics support personnel and vehicles to improve the distribution of contraceptive supplies; and (2) to initiate a national level sex education program through provision of technical assistance, training (both local and abroad), and the purchase of audio visual materials and equipment.

The GOP institutions involved in Population II are the Ministry of Health (Maternal/Child Health Division); the Ministry of Education (MOE); the Ministry of Labor and Social Welfare (National Directorate for the Child and Family - DINNEFA); and the Institute for Special Education (IPHE). (See Table 1: Population II Financial Plan for GOP Institutions). A separate agreement was signed with APLAFA and two subsequent amendments have increased the AID grant funding to that institution. (See Table 2: Population II Financial Plan for APLAFA).

EARLY PROJECT IMPLEMENTATION:

The previous USAID/Panama Population Officer, Ms. Abby Bloom, was the principal AID official responsible for the design of the Project Identification Document (PID) and the final Project Paper. Unfortunately, she departed Panama just as the Project Agreement was being signed, and it became the responsibility of the new Population Officer, John Coury, to oversee the implementation phase. Some continuity was maintained, however, thanks to the continued and able participation of the Assistant Population Officer, Ms. Angela Mata, and the support received from both the Chief of the Human Resources Division and the backstop from the Office of Development Resources, (ODR).

194

Sex Education Component

The Project Agreement was signed at the end of August 1979, but it was not until nearly nine months later that all of the five implementing institutions which were to be involved in the sex education component had met the conditions precedent of the ProAg. Each institution encountered difficulties in preparing its annual training plan. Sex education in Panama was a completely new activity and since no previous attempt had been made to incorporate it into the training programs of the implementing institutions, they were hard pressed to deal with the development of a sex education training strategy.

The USAID Population Officer and his assistant worked individually with each institution; and the training plans, as well as the lists of required audiovisual equipment and materials, were prepared. Subsequently, the necessary Project Implementation Letters authorizing the expenditures of Project funds were issued and the Project activities of the sex education component got under way.

One of the major obstacles to the early implementation of the Project was caused by the changes in the designation of the GOP Project Coordinators and, in one case (Ministry of Labor and Social Welfare - MINTRAB), the complete change in the responsible implementing institution. During the Project Design stage, the Social Welfare Office within MINTRAB and its director, Norberta Tejada, and her team had responsibility for the Population II Project. However, as the ProAg was being signed, the newly-created National Directorate for the Child and Family (DINFA) with its new staff was entrusted with the

195

Project implementation. Fortunately, the enthusiasm for Population II as continuously expressed by the DINNEFA Director, Prof. Bertilda de Rivera, and manifested by the dedication of the DINNEFA Project Coordinator, Dr. Edgar Altafulla, helped to overcome their initial limited knowledge and lack of participation in the original Project design. In addition, DINNEFA had just been given the responsibility for the nationwide system of daycare centers (Centros de Orientación Infantil - COIF) and looked upon this as an excellent vehicle for delivering sex education to both the very young and to their parents.

A major early setback to IPHE was their loss of responsibility for the COIF programs. Most of the IPHE activities as envisioned in the original Population II Project design had been centered around the COIF's. When the COIF's were transferred to DINNEFA, IPHE had to redesign its sex education activities around their smaller School for Parents Program. Fortunately, however, the same IPHE staff, Prof. Argentina Garisto and Lic. Samuel Martinez, who had been involved in the Project design phase were named as Project coordinators.

It was the Ministry of Education that suffered the greatest delay in the early Project implementation, primarily due to the changes in staff assigned to the Project. The MOE personnel that participated in the original design of the Project (Profs. Silvia Calvit, Petra Bendiburg and Rosa Harari De Leon), never got to participate in the Project implementation. Furthermore, in late 1982, the responsibility for the Project was transferred from the Dirección de Formación y Perfeccionamiento (Office of Teacher Training and Upgrading) to the Dirección de Orientación Educativa y Profesional (Office of Educational

1976

and Professional Guidance). The basic strategy for Project implementation was therefore changed: from a strategy aimed at attempting to train thousands of MOE teachers, to a more rational approach of training some 230 secondary school guidance counselors, with a uniform and tested curriculum in sex education and human development.

At present, over 80% of the secondary school guidance counselors have received the training in sex education. In addition, a sex education curriculum for three (3) of the secondary levels (first year; fourth year; sixth year) is being tested in five schools. The curriculum had been developed with technical assistance from Lic. Eugenia Monterroso, who had previously worked with the MOE sex educators and is considered by them to be very technically capable.

The Ministry of Health took an active role in promoting the sex education activities under Population II. The head of the Maternal Section of the Maternal Child Health Department, Dr. Maria Luisa Aybar, was instrumental in bringing together all of the implementing institutions into a National Commission on Sex Education. This Commission had been contemplated under the Project Agreement, although it was not to receive Project funding. The Sex Education Commission has remained an informal group of individuals who represent institutions working in the area of sex education. The success of the Commission may be due to its informal nature, thereby taking it out of the political arena. In the two evaluations of the Population II Sex Education Component, conducted by consultant Norine Jewell, reference is made to the value of this inter-institutional commission. However, the consultant continues to advise USAID to maintain its relations with each participating

1971

institution on a one-to-one basis.

The earliest of the Population II sex education activities were a series of Inter-institutional Courses on Sex Education, coordinated by the National Commission. The objective of the courses, financed with Project funds that had been allotted to each of the participating institutions, was to prepare a core group of sex educators, who in turn would train others within their respective institutions. Subsequent to these courses, each institution developed its own program strategies and training activities. DINNEFA began training the COLF instructors and other personnel involved in DINNEFA programs. IPHE began training the teachers in each of the different IPHE programs, (i.e., the School for the Blind; the School for the Deaf; the School for the Mentally Retarded). The Ministry of Education began training its administrative as well as technical personnel; and when it became evident that this strategy was too broad in scope, the responsibility for the Population II sex education activities was transferred to another office, (as previously mentioned), and a more rational strategy of training the high school guidance counselors was adopted.

The MCH also trained its regional health personnel in sex education, not necessarily for them to organize sex education activities, but rather so that they could provide the required technical assistance to the other institutions as they in turn implemented their programs. For example, nurses were updated in such areas as venereal disease and family planning in order to assist in the presentations of these subjects at courses or seminars organized by the other members of the National Commission on Sex Education.

100

Each institution developed a list of audiovisual equipment and materials needed for the sex education activities. All required movie projectors, slide projectors, movie screens, films and portable display easels. USAID assisted in the initial purchases of these items. At present, however, each institution is responsible for making its own purchases. This is in keeping with AID policy to encourage the national institutions to administer their development projects as much as possible. Needless to say, the great delays in moving Project funds has been caused by the incompetence of the administrative offices within each participating institution. For example, an advance of \$30,000 was made to the MOE to purchase much needed audiovisual equipment. Teachers had been trained and they needed the equipment in order to initiate sex education activities in their schools. However, it took the MOE purchasing office more than seven months to purchase these items, which were readily available in the local market.

Each institution also had requests for special equipment and supplies. For example, DINNFA was having difficulty in transporting its sex educators into the provinces. Their one station wagon was not sufficient, as various teams of educators were attempting to conduct activities in different parts of the country at the same time. The Population II Project assisted with the purchase of a suitable vehicle, and the increase in the number of educational activities carried out by the DINNFA personnel has been remarkable.

The MOE requested special sex education encyclopedias for use in all the schools. After careful selection, a series of bibliographic materials was identified and these books are now being purchased and delivered to those schools where the sex education project has been introduced. The MOE also

199:

determined the need for mimeograph equipment in order to produce the large volumes of educational materials required by the schools. This equipment is being purchased for the Project and is to be distributed as each geographic area is incorporated into the sex education program.

Family Planning Component

The Ministry of Health has primary responsibility for the family planning services, IEC, clinical training and investigation activities envisioned under the Population II Project. The MCH Department has attempted to carry out these many activities with a very limited staff. And at the same time, this MCH staff has been responsible for implementing a maternal child health and family planning project financed by the United Nations Fund for Population Activities (UNFPA). This UNFPA project was recognized in the AID Project Agreement and it was hoped that close coordination among the MCH Chief, the Pan American Health Organization advisor responsible for the UNFPA project, and the USAID Population Office, would avoid any duplication of activities. The UNFPA project was to support maternal and child health activities that had not been contemplated in the Population II Project. However, as a result of the UNFPA gradual interest in sex education, the MCH began to use UNFPA funds for activities that initially had been programmed for funding under the AID grant.

The evaluation of the Contraceptives Logistics System, conducted by the consultant Pedro Martiz, (report attached), gives a good picture of the

200

contraceptive supply situation in the GOP health facilities. It was found that some types of contraceptives were lacking in the remote areas. However, the consultant considered that supplies were being made available as needed. Mr. Martiz' important recommendation, that the MXH distribution system be integrated into the system maintained by the Social Security Agency, had been identified in the early years of the Project by consultants from the Atlanta-based Center for Disease Control. This integration would eliminate the unnecessary duplication of expenditures for gasoline, vehicle maintenance and personnel. The Martiz study also identifies a need for more supervision and technical assistance in family planning methods to be provided by the Ministry's central-level personnel to the health field staff.

RECOMMENDATIONS FOR USAID/PANAMA POPULATION STRATEGY

The FY 1984 Panama Country Development Strategy Statement states that the USAID/Panama population sector strategy should "support the purchase of family planning commodities on a continuing basis," and that the continued "support to the sex education and adolescent fertility programs will depend upon their evaluated success here, and the importance to the region of the model programs." This strategy still holds true.

The evaluations of the three central areas of the Population II Project all reaffirm the need for continued, although specific and limited, AID bilateral assistance in the population sector. These areas are: (1) family

201

planning information/education/communication; (2) improved contraceptive logistics systems; and (3) sex education.

The evaluation of the family planning information/education/communication (IEC) activities, prepared by the consultants Lyle Saunders and Patrick Coleman (report attached) stresses the importance of IEC for the success of the Panamanian program. The evaluators, although critical of the limited capability of the MOH personnel responsible for the IEC activities, were nonetheless emphatic of the need for AID to continue support in the provision of the necessary IEC technical assistance, training, supplies, equipment and local production of materials and broadcast of radio messages. These activities should, however, be directed more at the specific target groups (males, rural population, adolescents) as identified in the Population II Project Description and not be as general in nature as has been the case over the past years.

USAID/Panama should carefully consider the recommendations contained in the Saunders/Coleman Report. Although the MOH has not been able to provide the necessary IEC expertise required for the family planning activities, (and there is little indication that such expertise is readily available within the MOH), nevertheless the MOH should be encouraged to contract out for these services. The MOH should be discouraged from any future intent to produce its own printed materials (posters, pamphlets). Past experience has proven the Ministry's limitations in these areas. AID should therefore not finance the purchase of costly printing presses and other similar equipment requested by the MOH.

202

But this is not to say that AID support to family planning IEC should be curtailed. On the contrary, AID should seek alternatives, especially by contracting out to the local private sector (such as marketing and publicity firms) in order to assure the quality of future IEC activities. Furthermore, the private group APLAFA should be encouraged to work increasingly in this area. Under the Project, APLAFA has carried out IEC activities, such as the production of plastic rulers with messages on responsible parenthood. These have met with great success. With the forthcoming purchase of the printing equipment to be financed under the Project it is expected that APLAFA will be able to develop an expertise in the production of family planning promotional and educational materials.

There is also a need for AID to provide IEC technical assistance. This assistance was not contemplated in the Project Agreement and funding was not set aside. But the past years of experience in this area and the conclusions of the evaluators lead to the recommendation that this technical assistance is vital, if any improvement in the quality of the family planning IEC activities is to be expected. It should be mentioned that under another AID/MOH project (the proposed breastfeeding promotion project) the visiting IEC expert, Dr. Richard Burke, also identified the need for technical assistance to the MOH in this area.

The Project should continue to promote incountry training in family planning and avoid sending physicians to expensive training programs abroad. The MOH should be encouraged to conduct the training programs for nurses, as had been done by the Azuero Post-Basic Nursing Course in Maternal/Child Health and Family Planning. The evaluation of the Azuero Program, conducted in the

agreed

203

field among the sixty course graduates, testifies to its success.

USAID should continue to work with the MOH and the technical consultants from Westinghouse Health Systems in the design and implementation of the second Contraceptive Prevalence Survey. The results of that survey, if conducted in 1984, should give a good indication of the degree of success (or failure) of the family planning activities carried out under Population II. The success or failure of the sex education component may have to be measured at a much later date, as the young generations of Panamanians begin to enter their reproductive years and the lessons of responsible parenthood, sex education and family planning are put into practice.

In October 1982, LAC/DR/POP official Maura Brackett visited Panama in order to assist the Mission in the identification of certain areas in the population sector that should be considered for inclusion in future USAID population strategies. Most of her recommendations have been carried out. For example, the Mission has attempted to provide more support to the private sector. In recent months, the USAID Population Office has been responsible for bringing together the private family planning association (APLAFA) and the Patronato Nacional de la Juventud Panameña (PANAJURU), in the hopes that they might develop a project to bring family planning and sex education to the rural youth, one of the priority groups identified under Population II. USAID has provided the necessary funds to APLAFA to assist PANAJURU in training its field extension workers and in providing them with the necessary educational

204

and motivational materials, including audiovisual aids and printed materials.

Under the amendment to increase funds to APLAFA, special emphasis was made the area of resource development. APLAFA has now placed resource development (local fund raising) as its immediate priority, and a special fund raising committee has been established in order to work closely with Robert Temple and Associates, a U.S.-based consulting firm that has specialized in providing technical assistance to private sector family planning associations. The Population II Project will fund this technical assistance, which will provide APLAFA with a resource development feasibility study and fund raising strategy.

APLAFA has also been encouraged to work closely with the Panamanian legislators interested in developing a population policy for the country. The USAID Population Office has given support to APLAFA so that they might educate the legislators regarding population policies that have been developed in other countries, such as Mexico. USAID might explore the possibility of working through other private sector institutions in this same endeavor. It should be noted that in the new Panama Constitution, a special article clearly states that the Government is to develop a national population policy. Although this might be too delicate an area for USAID to provide direct assistance to the Government of Panama or to the Legislature, nevertheless efforts should be explored in the private sector, such as APLAFA.

205

TABLE 1

POPULATION II FINANCIAL PLAN FOR GOP INSTITUTIONS

(In U.S.\$000)

June 18, 1982

	<u>AID</u>	<u>GOP</u>	<u>TOTAL</u>
A. <u>MINISTRY OF HEALTH</u>			
1. Centrally Procured Contraceptives by AID/Washington (1)	(424)	-	(424)
2. Commodities	602	94	696
3. Salaries of Family Planning Specialists & Adm. Personnel (2)	60	1,392	1,452
4. Information, Education & Communication	330	10	340
5. Training	247	100	347
6. Evaluation and Studies	<u>113</u>	<u>70</u>	<u>183</u>
MCH Sub-Total:	1,352	1,666	3,018
B. <u>MINISTRY OF EDUCATION</u>			
1. Commodities	101	40	141
2. Training	115	209	324
3. Technical Assistance	<u>10</u>	<u>-</u>	<u>10</u>
MOE Sub-Total:	226	249	475
C. <u>MITRAB (DINNFA)</u>			
1. Commodities	50	5	55
2. Training	110	50	160
3. Studies and Evaluation	<u>30</u>	<u>10</u>	<u>40</u>
MITRAB Sub-Total:	190	65	255
D. <u>IPHE</u>			
1. Commodities	70	5	75
2. Training	43	50	93
3. Technical Assistance	<u>15</u>	<u>2</u>	<u>17</u>
IPHE Sub-Total:	128	57	185
E. <u>PROJECT EVALUATION</u> (3)			
	<u>-</u>	<u>-</u>	<u>-</u>
TOTAL:	1,896	2,037	3,933

(1) Funded by the Project, not included in the Grant Agreement.

(2) Salaries of family planning logistics management support staff.

(3) The Project evaluation is programmed for the final year of the Project and thus is not included in the three-year budget shown above.

206

TABLE 2

POPULATION II FINANCIAL PLAN FOR APLAFA
 (Asociación Panameña Para el Planeamiento de la Familia)

May 26, 1983

<u>Line Item</u>	<u>AID Grant</u>
Adolescent Information and Education Activities	\$ 75,000
Parents and Educators Information/Education Activities	\$ 12,000
Resource Development Activities	\$ 83,000
Outreach Program	\$ 50,000
Vehicle	<u>\$ 10,000</u>
TOTAL	\$230,000

207

POPULATION II
PROJECT TARGETS AND ACCOMPLISHMENTS

A. MINISTRY OF HEALTH

1. Provide AID centrally-procured condoms and orals -- 1,192,000 condoms and 550,000 cycles of orals were provided to MOH.
2. Provide other contraceptive supplies -- 37,000 Lippes Loops;
-- 15,000 Copper "I's";
-- 5,976 tubes of vaginal contraceptive jelly were provided to MOH.
3. Provide medical equipment and supplies related to family planning -- 415 medical kits (valued at \$55,200) were provided.

-- \$ 50,000 of laparoscopic equipment delivered.

-- \$223,439 of medical equipment/supplies ordered from MEDDAC.
4. Provide vehicle and audiovisual supplies and equipment to establish ten regional mobile units for health educators -- Ten IEC Mobile Units (Jeeps, movie projectors, portable generators, slide projectors, movie screens, portable display easels, public address systems, and packages of family planning films) were provided to MOH.
5. Provide radio spots and contracts with radio stations -- Eight different family planning radio spots were prepared and broadcast over 19 radio stations.
- New contracts with 12 radio stations are in process.
6. Produce information/motivation materials in family planning and sex education. -- Booklet on "Adolescents and Sexuality" was produced and distributed.

-- Posters with five different family planning messages were produced and distributed.

-- Hand-out leaflets with messages identical to the five posters were produced and are being distributed.

AUG - 1 1983

208

7. Provide salaries for contraceptive logistics system supervisor and secretary
 8. Provide a van to transport contraceptive supplies
 9. Provide a vehicle for supervision of Project activities
 10. Provide in-country training in family planning, sex education and administration of family planning programs for 4,500 MOH employees
 11. Prepare 23 MOH personnel and 7 CSS/ Panama City personnel as core trainers for the sex education program
 12. Provide training/observation visits abroad in family planning and sex education
- Contraceptive logistics system supervisor and secretary have been financed by Project, and as of July 1, 1983 their salaries were absorbed by GOP.
 - Van provided to Maternal/Child Health Division for contraceptive distribution.
 - Station wagon was provided to MCH Division for use in supervision of Project activities.
 - 32 nurses were trained in four-month MCH/FP Course at Azuero Training Center.
 - 358 nurses working in hospital surgery received orientation on female sterilization and family planning.
 - 75 health educators trained in preparation of posters for family planning messages.
 - 500 MOH outreach personnel trained in sex education.
 - 1,000 MOH personnel trained in improved human relations.
 - 450 physicians and nurses received refresher training in family planning.
 - 30 MOH and 10 CSS personnel received 3-week Inter-institutional Courses on Sex Education.
 - One member of MOH/CSS sex education training team participated in family planning/sex education workshop at CORA in Mexico.

209

13. Conduct studies on contraceptive prevalence, user continuation rates, male attitudes towards family planning and adolescent attitudes towards sex and family planning

- Epidemiologist responsible for venereal disease component of sex education program participated in V.D. Conference in Puerto Rico.
- MCH Health Educator participated in health/family planning education seminar in Puerto Rico.
- MCH Administrator responsible for administration of Population II Project attended course for family planning administrators at CEDPA in Washington, D.C.
- Two urologists observed vasectomy programs in Houston, Texas.
- First Contraceptive Prevalence Survey was conducted in 1979 and results published.
- The Adolescent Sexuality Study is being designed, with technical assistance from Center for Disease Control (Atlanta) and participation of all other GOP implementing institutions.
- Second Contraceptive Prevalence Survey is planned for early 1984 and preliminary discussions have been held with technicians from Westinghouse.
- A special evaluation of the quality of training given by the Azuero Post-Basic Nursing Course in Maternal/Child Health and Family Planning was conducted in the field among course graduates.
- Two special evaluations of the Sex Education Component of the Project, (both conducted by consultant Norine Jewell) did not require Project funding and involved all Population II implementing institutions.

210

-- A special evaluation of the Information, Education and Communication components of the Project was conducted by AID centrally-funded consultants Lyle Saunders and Patrick Coleman.

-- A special evaluation of the Contraceptives Logistics System of the Project was conducted by local consultant Pedro Martiz.

B. MINISTRY OF EDUCATION (MOE)

1. Prepare 36 core trainers for the sex education program

-- 32 core trainers participated in the Inter-institutional Sex Education Courses.

-- 30 core trainers received additional training.

2. Train 230 secondary school guidance counselors in human development/sex education

-- Over 200 guidance counselors have received 2-week training courses in human development/sex education.

3. Provide audiovisual equipment and supplies for use in the sex education program

-- Ten movie projectors; 3 slide projectors; five slide/sound synchronizers; 10 portable display easels; two overhead projectors and 24 copies of films were distributed to the MOE.

4. Provide sex education didactic/bibliographic materials

-- 12 mimeograph machines to produce didactic materials were delivered.

-- 10 sets of sex education encyclopedias were delivered.

5. With technical assistance, prepare the sex education curriculum for secondary-level schools

-- Technical assistance was provided by Eugenia Monterroso, and sex education was developed for three (3) grades within the secondary school level.

6. Incorporate the sex education program into 65 secondary schools

-- Activity has begun in five secondary schools where the sex education curriculum is being tested.

116

7. Provide training abroad in family planning/sex education

-- One member of MOE central-level training team participated in family planning/sex education workshop at CORA in Mexico.

-- Principal MOE trainer is participating in an eight-week family planning/sex education course at University of California.

8. Initiate sex education into primary schools

-- Activity will not begin until education program is more fully established in the secondary schools.

C. NATIONAL DIRECTORATE OF CHILD & FAMILY (DINNFA)

1. Prepare nine (9) core trainers for sex education program

-- 18 core trainers received 3-week courses on sex education.

2. Train central and field level staff in sex education

-- 12 core trainers received additional training.

-- 19 COIF teachers received training in sex education.

-- 19 Directors of DINNFA institutions received training in sex education.

-- 64 DINNFA central level staff received training in sex education.

3. Provide family planning/sex education talks to parents, adolescents and general public

-- Vehicle was provided to DINNFA, to facilitate sex education and training activities in the interior.

4. Provide audiovisual equipment and supplies for use in sex education program

-- Three movie projectors; one slide projector; one overhead projector; 16 films; 3 tape recorders; three movie screens; and ten portable display easels were provided.

2/2

5. Provide sex education didactic/
bibliographic materials

-- Series of slides with family life/family planning messages are in preparation (scripts have been written and artist is drafting visuals).

6. Provide training abroad in family
planning and sex education

-- Two DINNEFA sex educators participated in eight-week family planning/sex education courses at University of California.

-- One DINNEFA regional staff member participated in family planning/sex education workshop at COORA in Mexico.

-- DINNEFA Project Coordinator participated in seminar on adolescent programs held in Costa Rica.

-- Two central-level sex educators received training at CEDPA in Washington, D.C.

7. Conduct a study on attitudes related
to human sexuality

-- Study is presently postponed, awaiting outcome of plans for MOH adolescent sexuality survey.

8. Design a sex education curriculum for
pre-schoolers

-- Materials being collected and initial discussions among DINNEFA sex educators are in progress. Technical assistance to be required from Project.

D. INSTITUTE FOR SPECIAL EDUCATION (IPHE)

1. Prepare 12 core trainers for sex
education program.

-- 12 core trainers participated in the 3-week Inter-Institutional Sex Education Courses.

-- Five core trainers received additional training in sex education.

2. Train 215 IPHE teachers and
counselors in sex education

-- 400 IPHE teachers and counselors have received training in sex education.

2/3

3. Provide family planning/sex education talks to parents, IPHE students and the general public. --- 60 talks have been given to an estimated 3,000 participants.
4. Provide audiovisual equipment and supplies for use in the sex education program --- 11 movie projectors; 4 slide projectors; one cassette recorder; 5 movie screens; and 4 portable display easels were provided.
5. Provide sex education didactic/bibliographic materials --- Two sets of sex education encyclopedias and 21 copies of films were delivered.
6. Provide training abroad in family planning and sex education --- Head of IPHE Parents Association attended the second part of the sex education course held at the University of California.
7. Provide technical assistance at the close of Project in order to evaluate the effectiveness of IPHE activities --- Activity to begin during final year of Project activities.

E. THE PANAMANIAN PLANNED PARENTHOOD ASSOCIATION (APLAPA)

1. Conduct a minimum of 255 sex education and family planning courses for adolescents --- 171 sex education and family planning courses for adolescents have been held to date.
2. Develop educational materials in sex education and responsible parenthood for use by the adolescents --- 10,000 plastic/rulers with messages related to responsible parenthood were printed and distributed among school children.
--- One overhead projector; 3 portable display easels; and two copies of sex education films provided.
3. Conduct a minimum of 46 courses in sex education/responsible parenthood/and family planning for parents and educators --- 60 courses for parents and educators have been held to date with approximately 1,800 participants.

254

4. Conduct a feasibility study on resource development (fund raising) and design a resource development strategy
 - Contract for provision of technical assistance for feasibility study is in process, and U.S. firm of Robert Semple and Associates has been identified. The strategy preparation will follow the results of the feasibility study.
 - Local consultant will be hired on an honorarium basis, with Project funds, in order to prepare data required for feasibility study.
 - Previous attempts at selling services (such as talks to labor groups) met with limited success.

5. Conduct a minimum of 25 seminars for public and private sector groups, such as labor unions, the National, Guard members and firemen
 - 25 seminars have been held for CTRP labor leaders, with approximately 528 participants.
 - 139 talks have been given to approximately 5,000 individuals to date.

6. Provide assistance to private sector groups working with adolescents and rural area population, to promote family planning information
 - Negotiations are underway with PANAJURU to conduct sex education/family planning training-of-trainers activities aimed at the rural population.

7. Conduct a minimum of two symposia each year on family planning and related population topics
 - Symposium on population and unemployment was held for economists.

2/15