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UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
AGENCY FOR INTERNATIONAL DEVELOPMENT
Washington, D. C. 20523

COSTA RICA

PROJECT PAPER

FAMILY PLANNING SELF-RELIANCE

000061.

AID/LAC/P-153

Project Number:515-0168

UNCLASSIFIED

AGENCY FOR INTERNATIONAL DEVELOPMENT
PROJECT DATA SHEET

1. TRANSACTION CODE: A = Add, C = Change, D = Delete. Amendment Number: _____

2. COUNTRY/ENTITY: COSTA RICA

3. PROJECT NUMBER: 515-0168

4. BUREAU/OFFICE: LAC [05] Family Planning Self-Reliance

5. PROJECT TITLE (maximum 60 characters): _____

6. PROJECT ASSISTANCE COMPLETION DATE (FY): MM DD YY [09][30][88]

7. ESTIMATED DATE OF OBLIGATION (Under "B." below, enter 1, 2, 3, or 4):
A. Initial FY [83] B. Quarter [3] C. Final FY [87]

8. COSTS (\$000 OR EQUIVALENT \$1 =)

| A. FUNDING SOURCE | FIRST FY 83 | | | LIFE OF PROJECT | | |
|-------------------------|-------------|------------|--------------|-----------------|--------------|--------------|
| | B. FX | C. L/C | D. Total | E. FX | F. L/C | G. Total |
| AID Appropriated Total | | | | | | |
| (Grant) | (500) | (450) | (950) | (900) | (1,600) | (2,500) |
| (Loan) | () | () | () | () | () | () |
| Other | | | | | | |
| 1. Host Country ADC | 100 | 200 | 300 | 500 | 1,500 | 2,000 |
| 2. Other Donor(s) UNFPA | -- | 200 | 200 | -- | 1,000 | 1,000 |
| TOTALS | 600 | 850 | 1,450 | 1,400 | 4,100 | 5,500 |

9. SCHEDULE OF AID FUNDING (\$000)

| A. APPRO. RELATION | B. PRIMARY PURPOSE CODE | C. PRIMARY TECH. CODE | | D. OBLIGATIONS TO DATE | | E. AMOUNT APPROVED THIS ACTION | | F. LIFE OF PROJECT | |
|--------------------|-------------------------|-----------------------|---------|------------------------|---------|--------------------------------|---------|--------------------|---------|
| | | 1. Grant | 2. Loan | 1. Grant | 2. Loan | 1. Grant | 2. Loan | 1. Grant | 2. Loan |
| (1) P | 440 | 440 | | | | 950 | | 2,500 | |
| (2) | | | | | | | | | |
| (3) | | | | | | | | | |
| (4) | | | | | | | | | |
| TOTALS | | | | | | 950 | | 2,500 | |

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): 450, 480

11. SECONDARY PURPOSE CODE: _____

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

| A. Code | B. Amount |
|---------|-----------|
| BRW | 3,125 |
| BVW | 2,375 |

13. PROJECT PURPOSE (maximum 480 characters)

The purpose of this project is to revitalize and expand family planning services through public, private and commercial sector activities and to enhance their self-reliance

14. SCHEDULED EVALUATIONS: Interim [06][85], Final [09][88]

15. SOURCE/ORIGIN OF GOODS AND SERVICES: 000, 941, Local, Other (Specify) CACM

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a _____ page PP Amendment.)

17. APPROVED BY: Bastiaan Schouten, Director a.i. Date Signed: 07/18/83

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MM DD YY

PROJECT AUTHORIZATION

Name of Country/Entity: Costa Rica

Costa Rican Demographic Association &
(ASDECOSTA)

Name of Project: Family Planning Self-Reliance

Number of Project: 515-0168

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Family Planning Self-Reliance Project for Costa Rica, involving planned obligations not to exceed two million five hundred thousand (\$2,500,000.00) in grant funds over a 5 year period from date of authorization subject to the availability of funds in accordance with the A.I.D. OYB/allotment process to help in financing foreign exchange and local currency costs of the project. The planned life of the project is 5 years from the date of initial obligation.

2. The project consists of a program to revitalize the public sector family planning program, expand the service delivery capacity of the commercial and voluntary sectors and enhance the financial self-reliance of all family planning activities.

3. The Project Agreement which may be negotiated and executed by the officers to whom such authority is delegated in accordance with A.I.D. regulations and Delegations of Authority shall be subject to the following essential terms and covenants and major conditions together with such other terms and conditions as A.I.D. may deem appropriate.

a. Source and Origin of Commodities, Nationality of Services

Commodities financed by A.I.D. under the project shall have their source and origin in the Central American Common Market or in the United States, except as A.I.D. may otherwise agree in writing. Except for ocean shipping, the suppliers of commodities or services shall have the Central American Common Market or the United States as their place of nationality, except as A.I.D. may otherwise agree in writing. Ocean shipping financed by A.I.D. under the project shall, except as A.I.D. may otherwise agree in writing, be financed only on flag vessels of the United States.

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b. Other

Prior to any disbursement or the issuance of any commitment to disburse under the CRS component of the project, ADC and ASDECOSTA must submit to USAID/CR a legally binding document stating that: 1) ADC owns 100% of the ASDECOSTA shares; 2) No ASDECOSTA stock will be transferred, sold or encumbered; 3) All profits generated by ASDECOSTA's commercial activities will be reinvested in ADC or ASDECOSTA activities in support of the National Family Planning Program, and 4) ASDECOSTA will not declare dividends or incur, indebtedness, other than short term obligations for normal operating expenses, without A.I.D. approval during the life of the project.

Prior to any issuance of any contract signed by ADC or ASDECOSTA for activities financed under this project, A.I.D. approval must be obtained.

c. Covenants

ADC and ASDECOSTA shall covenant:

Not to modify or change ASDECOSTA's corporate charter during the life of the project without A.I.D. approval;

That ASDECOSTA will carry out detailed bookkeeping to assure that project funds are not used for other commercial ventures;

To obtain prior A.I.D. approval of key ASDECOSTA personnel and their respective salaries;

To make all books and records of ADC and ASDECOSTA available for an annual external audit.

Clearance:

Thomas McKee:GDD (in draft)
William Schrider:CONT (in draft)
IO:Joan Silver (in draft)
PO:Edelbosque
ADDIR:Olastig

Signature:

B. Schouten
Bastiaan Schouten

Director a.i.

Date:

7/18/83

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LIST OF ACRONYMS USED IN THE PP

- 1- ADC Costa Rican Demographic Association
- 2- ASDECOSTA Costa Rican Demographic Association - Contraceptive Sales Affiliate
- 3- CCSS Social Security Institute
- 4- CDC Centers for Disease Control
- 5- CIF Center for Family Integration
- 6- COF Center for Family Orientation
- 7- CLI Limon Information Center
- 8- CONAPO National Population Commission
- 9- CPS Contraceptive Prevalence Survey
- 10- CRS Contraceptive Retail Sales
- 11- DA Development Associates
- 12- IE&C Information, Education and Communication (Program)
- 13- IFRP International Fertility Research Program
- 14- IPPF International Planned Parenthood Federation
- 15- LAC Latin America and the Caribbean
- 16- MIDEPLAN Ministry of Planning and Economic Policy
- 17- MOE Ministry of Education
- 18- PCS Population Communications Service, Johns Hopkins University
- 19- MOH Ministry of Health
- 20- UNFPA United Nations Fund for Population Activities

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I. SUMMARY AND RECOMMENDATIONS

A. Summary

The goal of the Family Planning Self-Reliance project is to promote socioeconomic development and satisfy basic human needs of the Costa Rican poor by increasing access to family planning services and information. Costa Rica is currently facing the most serious socioeconomic crisis in its modern history. Its very high population growth rate (2.8 per cent) is a contributing factor to problems such as high unemployment, excess demand for public services, environmental degradation and decreasing productivity.

The purpose of this project is to expand family planning services through public, private and commercial sector activities. Costa Rica is committed to providing adequate health and education services to all its citizens. However, there is extensive government involvement in the health/population area which has resulted in a heavy degree of dependency on GOCR initiatives and policies. The GOCR administration in power during the period 1978-82, used its influence to minimize family planning initiatives, eliminate training, information and service delivery programs and reduce institutional and even individual commitments to family planning. As a result the national population program has lost momentum. A revitalized public sector family planning program is necessary because public sector institutions, the CCSS and the MOH, currently provide the bulk of the available services. However, in learning from past experience, the private/commercial sectors must be given progressively larger roles in future family planning initiatives to guarantee effective family planning services and adequate commodity supplies.

The project will be implemented by the Costa Rican Demographic Association, (ADC) whose staff will be responsible for: 1) the design, preparation, and implementation of training programs for public sector (MOH & CCSS) personnel, 2) the development of a nationwide information, education and communication program, and 3) the preparation of studies with contract assistance to evaluate ADC's program and identify new revenue producing activities. The AID funded support for these activities including technical assistance, training and supplies amount to \$1,115,000. Additionally, ASDECOSTA, an affiliate of the ADC will organize a contraceptive Retail Sales distribution program which will function through private sector retail outlets throughout the country. This activity will provide good quality contraceptives to retailers at a low cost. The retailers in turn will be required to sell at fixed, affordable prices for those Costa Ricans on the lower rungs of the economic ladder. AID funds in the amount of \$1,385,000 will provide direct support for the purchase of contraceptives, packaging, marketing, advertising, etc. ASDECOSTA will use the returns from sales to defray part of its overhead expenses.

It is expected that the AID funded support for this project will produce the following outputs:

1. Revitalized and increased public sector participation in family planning to expand the availability of services, counseling, and commodities at CCSS and MOH facilities throughout the country.
2. Expanded service delivery capacity of the private and voluntary sectors.
3. Enhanced financial self-reliance of all family planning activities.
4. Revitalized promotion activities through an information, education, and communication program.

The GOCR is aware of this project's objectives and planned activities. Initial project design activities included an official meeting with the Second Vice President of the Republic, the Minister of Health and the Executive President of the CCSS. The project has been reviewed with the Ministry of Planning, and the official request for assistance is from the First Vice President (Annex D).

The ADC's commitment to family planning has been unwavering. Although a private, non-profit organization, ADC's Board of Directors fully supported the creation of ASDECOSTA, a for-profit affiliate of ADC, for the initiation of the commercial retail sales activity. ADC believes that the demand among the poor for low cost contraceptive products will fully justify the creation of ASDECOSTA. The public sector recognizes the importance of the service delivery and training components funded under the project, and that recognition of the demand for family planning assistance will facilitate ADC and ASDECOSTA's efforts to inform, and educate a broad spectrum of the population, and to provide certain contraceptives at lower than market prices.

This set of circumstances is regarded by USAID/CR as providing an opportunity to restore and upgrade a once model population program. Furthermore, the Family Planning Self Reliance project will represent an important element in AID's efforts to help restore economic stability and help bring about economic recovery.

B. Historical Summary:

Concern over rapid population growth and its effects on the economy, health, housing and education began to arise in Costa Rica in the early '60s. The first organized family planning activities began in 1962 when Clinica Biblica, a private institution, started distributing contraceptives at its hospital in San Jose, and Goodwill Caravans, another private non-profit agency sponsored by protestant churches, provided medical care and community education in remote rural areas. During the same period, the Interamerican Institute for Agricultural Sciences (IICA) at Turrialba organized a family planning program that offered contraceptives to the wives of IICA farm workers, and in 1966, the Costa Rican Demographic Association (ADC) was established to develop an awareness of population problems and to encourage public support of family planning programs.

Finally in 1967, the GOCR established a family planning policy by presidential decree and an Office of Population was created within the Ministry of Health (MOH). By 1968, family planning services had been initiated in nine health clinics and USAID began to supply contraceptives, commodities, and funding to the MOH to develop and integrate family planning services into its clinics throughout the country. Also in 1968, the National Family Planning Committee (CONAPO) composed of several interested government and private organizations was organized to provide a forum for the exchange of population/family planning information.

The MOH integrated family planning services with basic health services in its larger centers located in urban and semi-urban areas, and the CCSS started providing family planning services in its larger hospitals and dispensaries in 1970. Also in 1970, the Ministry of Education created the General Supervisory Office for Sex Education and initiated plans for a sex education program designed for secondary schools. The ADC assumed the role of secretariat of CONAPO and the responsibility for more than half of the information, education, and communication activities of the national program. The University of Costa Rica had the primary role of training physicians, graduate nurses and others. The Center of Family Orientation (COF) and the Center of Family Integration (CIF) played major roles in providing courses in sex education and responsible parenthood to pre-marital couples, married couples and teachers.

The Costa Rican program became a model for the region. Population growth rates dropped from 4.7% in 1960 to 2.4% in 1976. Unfortunately however, after reaching its lowest point in 1976, population growth rates reversed. Initially, observers said the increase was temporary and cyclical as a result of a population makeup which included an unusually large number of women of reproductive ages. Currently, the birth rate is estimated to be 32 per 1,000 as compared to 29 per 1,000 with a higher mortality rate in 1976 and the upward shift is considered to be a trend rather than a temporary phenomenon. The policies of the GOCR administration between 1978 and 1982 were not helpful in reversing these trends. This project will attempt to reverse this demographic trend.

C. Findings and Recommendations

The following are the major findings of the analyses contained herein:

- 1) Costa Rica's high population growth rate of approximately 2.8% as compared to the Latin American regional rate of 2.2% seriously undermines the capacity of the country to achieve sustained social and economic growth and development.
- 2) Costa Rica has the institutional capacity to revitalize its national family planning program.
- 3) Without AID assistance, which would represent a major source of external support for population related activities and services, it is highly

unlikely that an urgently needed expansion of family planning activities could be undertaken in Costa Rica.

4) The activities proposed in this project will increase accessibility of commodities and will have a direct and measurable impact on the national family planning program. Further, it is a cost-effective means to achieve this end.

5) AID support to expand and diversify private/commercial sector participation in family planning is a critical project element which will assure program continuity and overall effectiveness.

6) Project monitoring and evaluation criteria and procedures have been established; there are no environmental issues and all statutory criteria have been satisfied.

Recommendation:

It is recommended that USAID/Costa Rica authorize a grant in the amount of \$2,500,000.00 over a five year period beginning in FY 1983 to support the Family Planning Self Reliance Project (515-0168) with the Costa Rican Demographic Association as implementing entity and coordinator of this joint private/public sector activity.

II. BACKGROUND AND RATIONALE

A. Rationale

For over two decades until 1977, Costa Rica sustained an average real GDP growth rate in excess of 6% per year. During this period the Costa Ricans achieved one of the higher levels of per capita income in Latin America. Compared with other countries in the area, the benefits of growth in income were fairly equitably distributed, health services became widely extended, infant mortality declined sharply, and the rates of population growth dropped from 3.7% to 2.4%. In a political setting in which the democratic tradition has survived longer than any other in Central or South America, Costa Rica seemed to be a model developing country well on its way toward the eradication of poverty.

Today the country is in the midst of a serious, and seemingly intractable economic crisis. The declining trend in real growth of the GDP which began after 1979 turned to negative 4.6% in 1981, and minus 9.1% in 1982. Per capita income has declined a total of 20.8% in the last three years (1980-82). Double digit inflation, open unemployment, huge public sector deficits and an enormous external debt characterize the deepening crisis. Add to the foregoing the relatively pronounced increase in the population growth rate from 2.4% in 1977 to an estimated 2.6% in 1982.

Excessive population growth is a significant problem confronting the economic recovery of Costa Rica. Once this country had a stellar family planning program vis-a-vis other LAC countries. Tremendous progress was made

in extending family planning services to an ever-increasing number of women so that by 1976 the acceptor rate had reached 65% of the women in the fertile ages. As a result, the crude birth rate dropped to 29 per 1,000 in 1976 from 45 per 1,000 in 1964. While there has been a lack of interest by the government in sponsoring family planning programs during recent years, the prevalence rate has remained about the same. The crude birth rate on the other hand has increased from 29 per 1,000 in 1976 to 32 per 1,000 in 1982, suggesting an urgent need for expanded services, education and increased accessibility to low cost contraceptive devices.

The current government recognizes the serious short-term economic and medical repercussions of excessive population growth. The GOCR has very limited resources available to provide medical care to pregnant women, post-partum mothers and new-born infants. The financial burden of a growing population is especially onerous during this period of extreme economic crisis in Costa Rica.

The current administration also recognizes that the current net rate of population growth - 2.8 percent per year - constitutes a serious long-term constraint for economic development. With over fifty percent of the population under the age of 20, the economic system will be hard pressed to create a sufficient number of jobs over the next ten to twenty years to even maintain unemployment at a manageable, albeit high level. Facilities to satisfy even basic human needs, such as water, food, electricity, housing, and medical care will also have to be expanded tremendously and at great cost. Already, there are indications that the failure to meet these expectations is leading to serious social turmoil.

The decline in the service capacity of the public sector over the past four years when combined with the underdevelopment of the private sector delivery system has led to an unmet demand for family planning services equal to about 15 to 20 percent of the women of fertile ages. This represents approximately 120,000 women in immediate need of services among the 590,000 women in fertile ages in Costa Rica. Because of high fertility and low mortality in previous years, the number of women of fertile ages will increase by nearly 3.0 percent per year over the next ten years so that the total family planning delivery system must increase by nearly 50 percent just to not lose ground. Current unmet demand for services when combined with unavoidable expansion in the target population, represents a tremendous challenge for a country in economic crisis.

The devaluation of the national currency is responsible for a 300-500% increase in the retail prices of contraceptives. While it has been proven that wealthy citizens will continue to purchase the more costly commodities, poorer people depend exclusively on the public sector, which recently has been unable to satisfy increasing demand levels with reduced budgets. Moreover, the austerity program imposed on government funded programs makes it unlikely that the public sector will be able to maintain ever present levels of support.

This project will help the Costa Ricans to meet their family planning needs by supporting a family planning program which extends beyond the public sector and into the homes of those most affected by the economic crisis. There is program leadership, as well as a trained staff in ADC. There is also evidence of a demand to know more about family planning. By sponsoring efforts to expand the public sector family planning program, to increase the service delivery capacity of the commercial and voluntary sectors and to enhance the financial self-reliance of all family planning activities, the project will address the three major factors currently limiting program effectiveness.

Finally, the project will provide technical assistance and funds for special projects to stimulate overall program self-reliance. The CRS component will attempt to expand coverage, introduce fees for services and generate some income for the ADC. The development of self reliance, meaning the identification and implantation of new income generating activities, will assure the continued viability of the ADC; alternate sources of family planning services and information and most importantly the accessibility of low priced commodities for poorer people.

B. PRIOR INTERNATIONAL ASSISTANCE

1) A.I.D

In 1976, AID approved the Family Planning Services Project (515-0132) for Costa Rica. During the planned three-year life of project, AID made a grant of \$1,160,000 to pursue the following objectives:

- a) Complete availability of contraceptives to 85-90% of the total fertile population by 1979;
- b) Protect 150,000 women in fertile ages as continuing acceptors in the public sector clinical programs of the Ministry of Health (MOH) and the Social Security Institute (CCSS).
- c) Reduce the birthrate from 28.3 per thousand to 20 per thousand by 1979-80;
- d) Establish twelve surgical contraception service centers located in strategic urban centers throughout the country. Establish one major training center and two sub-training centers to teach surgical contraception;
- e) Establish three Women Health Care Specialists training centers graduating 240 by end 1979;
- f) Train 150 auxiliary nurses, 150 "granny midwives", 140 agriculture extension agents, 100 community development and social workers, and 500 malaria voluntary collaborators in family planning and related subjects to provide family planning information, education and motivation and to distribute pills, condoms and other non-clinical contraceptives;

g) Initiate family planning activities in an additional 125 rural clinics, bringing total distribution points through the MOH and CCSS to 395.

h) Country-wide massive IEGC penetration with emphasis on the rural dwellers; and,

i) Train 18,000 rural couples in family planning education and responsible parenthood and 30,000 teenagers and pre-marital adults in family planning and sex education.

The project was to be implemented by three government entities and three private organizations. The MOH, the CCSS and the ADC would deliver services. The OOF, CIE and MOE would work on information, education and communication (IE&C) activities. The ADC was selected as the leader organization and coordinator for the National Program in the Consejo Nacional de Población (CONAPO).

During the last months of 1976, activities to promote voluntary sterilization, which as a means of contraception is illegal in Costa Rica, became a political issue. The National Population Program received abundant negative publicity. AID project activities continued with only minor modifications. Support to the surgical contraception centers was provided by intermediary organizations AVS, IFRP and JHPIEGO. The training of auxiliary nurses was dropped after the local Professional Nurses Association voiced its opposition to the activity.

In May, 1978 a new government administration came to power. The President of Costa Rica, as well as the Director of the National Planning Office (OFIPLAN) supported pronatalist policies.

Already that year, project activities were affected by the new policies. The MOE reduced personnel in its Sex Education Office to one person with no decision making capacity. From that point on, AID resources for the MOE were used exclusively to reprint and distribute previously prepared sex education manuals. The MOE discouraged extensive use of the information and did not follow up to determine the effectiveness of their distribution efforts.

The MOH ordered that all family planning posters be removed from health posts throughout the country. Doctors received orders to discuss family planning only when asked, and to provide services on the same basis. AID resources given to the MOH were used primarily to purchase commodities in support of the Maternal/Child Health Program.

AID resources for the CCSS were earmarked for the purchase of vehicles to support service delivery in rural areas. The CCSS was less affected than the MOH by the official policies. They were also instructed to eliminate promotion and provide requested services only. However, some doctors within the CCSS system continued previously established relationships

with JHPIEGO and IFRP, and independently supported Population Program objectives.

The private sector organizations, CIF, COF and ADC used most of the project resources allocated to them for IE&C activities. The ADC, as leader of CONAPO, expanded its activities to cover sociodemographic research, the organization of widely publicized seminars and conferences, the publication and distribution of research findings and even service delivery through its Centro Limonense de Información (CLI). CIF and COF concentrated their efforts on family planning publications, pre-marital courses and seminars and a daily radio program.

Project S15-0132 was scheduled to terminate in 1979. USAID/CR planned the Family Planning Services II Project for FY 1980. OFIPLAN blocked every effort to design and negotiate this project, so USAID/CR requested an extension of the 1976 project and \$387,000. Since the approval of FY 1980 resources to finance the project extension, AID has not allocated additional resources for family planning programs in Costa Rica. The exchange rate situation, very favorable to the U.S. dollar, allowed the Mission to extend individual project agreements until June 30, 1982, but AID support has been minimal for the last three years.

2) Other Donors

The last major UNFPA program for Costa Rica terminated in 1978. Until that time, UNFPA provided an average of \$1.0 million annually to support service delivery and IE&C activities.

In 1979, OFIPLAN succeeded in blocking CONAPO efforts to negotiate a new four-year project with UNFPA. Instead, UNFPA approved a \$400,000 transition project to support on-going IE&C and service delivery activities.

In 1980, OFIPLAN sent UNFPA a four-year, \$4.8 million project proposal. Approximately 80% of the requested program resources was assigned as budget support for government institutions then only marginally involved with effective family planning activities. UNFPA rejected the proposal.

In 1981 and 1982, UNFPA donated approximately \$100,000 annually to support research projects carried out by OFIPLAN. None of these projects had favorable impact on the National Population Program because they were utilized to promote the prevailing official views. UNFPA is currently involved in negotiations with several GOCR entities. It is expected that UNFPA will accept a 2-3 year project which would provide approximately \$200,000 annually to support family planning training initiatives and some service delivery.

IPPF grants the ADC, its affiliate in Costa Rica, an annual average of \$400,000. This amount covers administrative costs and supports socio-demographic research, IE&C activities and commodity purchases and distribution.

Development Associates, a U.S. consulting firm, provides minimal support for training activities, CDC, PCS, IFRP, and the Futures Group, all centrally funded AID contractors and grantees, occasionally support research and minor program activities. No other donors support the Costa Rican Family Planning Program.

C. CONSTRAINTS ANALYSIS

As outlined in the Background and Rationale section, a number of serious constraints now limit the Costa Rican Family Planning Program. These include: 1) the shortage of financial resources from both domestic and international sources, 2) a weakened organizational capacity in the public sector and underdeveloped commercial and voluntary sectors and 3) the lack of a positive and well defined population policy.

1) Financial Limitations

The major providers of funds for family planning in Costa Rica are the Government and the CCSS. Both are now under stringent financial pressure due to unprecedented levels of inflation and national debt. Cost cutting measures are being implemented under the GOCR's economic stabilization and recovery program. Obviously, funds for family planning are not exempt from such drastic cuts which are expected to be as high as 20% of last year's budget. USAID/CR believes that both the MOH and CCSS will do everything possible to support family planning at the highest funding level possible.

Multilateral population donors such as IPPF and UNFPA have cut back their budgets to Latin America and the Caribbean. UNFPA's reductions in their programs have also been dramatic. Their planned contribution of approximately \$200,000 annually for 1983 and 1984 will be merely 20% of UNFPA's annual contributions during the 1974-78 period. IPPF's reductions to private voluntary institutions in the LAC region, which have been less dramatic than UNFPA's, have, nevertheless, had significant negative impact. It is anticipated that IPPF will provide a fairly constant level of US dollar support to Costa Rica over the life of this project.

AID family planning support to Costa Rica has also declined recently. The previous government's antagonism toward family planning was a contributing factor, but it is also true that AID had chosen to de-emphasize the Costa Rican program because of its relative success up until 1978.

2) Institutional Constraints

Up until 1978, the public sector capacity to deliver family planning services had been improving steadily. Each and every year from 1968 until 1978 the public sector attracted an increasing number of new users, maintained a reasonable rate of user continuation, and expanded the number of active users. Such performance required a motivated and skilled staff, clear guidance from the program's leadership and proper supervision.

Program administrators realized in 1978 that the program could not continue to expand at such an accelerated rate. Women who had not taken advantage of the program would have been more difficult to attract. In a sense, the 'easier' clients had already been enrolled. Special and more costly efforts would be needed to motivate new acceptors into the program. In addition, renewed effort would be needed to retain a greater percentage of acceptors in the program. These modifications would have meant that the program would have grown at a more modest rate than in the past decade. Unfortunately, these challenges could not be met as the program failed to receive support from the government in power.

The GOCR administration opposed family planning and believed that the country needed to increase its population. Family planning agencies were unable to obtain GOCR support for funding from international organizations, such as the UNFPA. Motivation programs to attract patients were stopped, e.g. family planning posters could not be placed in the health centers. The official supply and distribution of educational materials such as pamphlets and flyers, as well as staff training in family planning was discontinued. Several legal cases were brought against the Costa Rican Demographic Association related to voluntary sterilization, and these were won by the Association.

The four years of adversity has had its impact on the internal and external image of the family planning entities and on staff morale and turnover. Many well-trained and motivated personnel have left the program. New personnel have not received the proper training nor experience to deliver family planning services. Basic materials, such as pamphlets, posters and films were missing. Program leadership retreated.

As a direct result of the official policies, the public program has lost momentum. For several years now, the number of active users in the program has remained about the same.

The family planning program in Costa Rica has been overly dependent on the public sector for the delivery of family planning services. The voluntary sector unfortunately no longer provides direct services to clients, and the commercial sector has been low keyed in its efforts to market contraceptives. Because of the underdevelopment of the voluntary and commercial sectors in Costa Rica, potential users have not been converted to acceptors.

Today in Costa Rica, there are no reasonably priced alternatives to the public sector for obtaining contraceptives. Therefore, despite the change in the new government's attitude toward family planning, its financial situation will constrain its ability to serve all the needs. A stronger voluntary and commercial sector could go a long way towards filling this gap. And, the commercial and voluntary sectors ultimately have the ability to deliver contraceptives at lower prices than the public sector. Whether clients pay directly or through their taxes for family planning services, stronger voluntary and commercial programs will reduce the overall financial burden of providing family planning.

3) Policy and Legal Constraints

Costa Rica, over the years, has made progress in family planning without a population policy explicitly approved by the legislature. There have been administrations which have supported these programs, some with greater enthusiasm than others, and there have been administrations which have opposed them. By and large, Costa Rican officialdom seems comfortable with this ambiguity. The population, especially the poorer may be better served with a favorable, explicit policy.

The Mission does not plan to be a major force behind efforts to modify the existing policies of the executive, nor to promote new legislation. Politically, population and family planning are extremely sensitive matters. However, to the degree that we can support useful, analytical efforts which have the potential to influence the overall policy and legal environment, we propose to judiciously support them through this project. Additionally, the Mission, consistent with the foregoing will attempt as appropriate to initiate a low keyed dialogue to encourage:

- Continued financial support for the MOH and CCSS service delivery systems;
- Approval of the pending UNFPA project proposal, and
- Increased GOCR commitment to family planning.

III. PROJECT DESCRIPTION

A. Introduction

This project has three major objectives:

1. Revitalize the public sector family planning program;
2. Expand the service delivery capacity of the commercial and voluntary sectors, and
3. Enhance the financial self-reliance of all family planning activities.

Several strategies will be employed to achieve these objectives. First, to strengthen the public sector program, the project will provide support for staff training, communication and motivation activities, selected commodities and equipment purchases. Further, as indicated in Section II, the project will seek opportunities to improve the policy and legal basis for the effective delivery of family planning services.

Second, to expand the service capacity of the voluntary and commercial sectors, the project will provide funds for the initiation of a commercial retail sales program.

Third, to enhance the financial self-reliance of family planning activities, the project will support the implementation of efficiency measures to cut costs and increase productivity, attempt to introduce cost recovery schemes such as fee-for-service or sale of contraceptives, and fund-raising activities such as membership fees, voluntary contributions and special events.

B. Public Sector Service Delivery (Support for the Existing Program)

During this period of extreme financial difficulty, the public sector must cut back costs wherever possible. Any program that can be delayed, will be delayed. Very few new programs will be initiated. Equipment replacement and renovation will be postponed. Staff training will slacken. Important communication support, such as posters, pamphlets, flyers, will be limited to conserve resources. For a program like family planning which has been neglected over the past four years, these cost-cutting measures will be especially severe. This project will, therefore, assist the public sector during this financial crisis to shore up its family planning program.

This project will support the in-country training of public sector employees directly responsible for carrying out the family planning program. This will include doctors, nurses, paramedics, secretaries and social workers assigned to family planning. For the majority of staff which have already received basic training in family planning, this will mean a short refresher course to bring them up-to-date on the latest developments in family planning techniques as well as to convey to them the impact of a growing population on the government's economic recovery program. Thus the refresher course will be both informational and motivational. It is important that the new administration display such renewed interest in family planning.

For the new employees working in family planning, a slightly longer course will be designed to provide them with basic information and practical training in family planning. This is necessary because nearly all medical and paramedical personnel who have recently graduated from the university have not received specialized training in family planning. It is hoped that in the next few years family planning will be fully integrated into the university curriculum at no cost to this project, but, in the meantime, this temporary measure must be taken.

This project will also support the revitalization of the public sector family planning communication program. It will provide for posters, pamphlets, flyers and radio announcements advertising the program's services. Because the public sector already has a significant delivery capacity in place and can expand its capacity at minimal cost, this program is expected to have a major impact at modest cost. This communication effort assumes a certain latent demand for family planning which will only require informing the client about the availability of the services, not educating and motivating them about family planning.

It will be extremely difficult over the next few years for the administrators of the family planning program to maintain and repair the

equipment needed to expand a neglected family planning program. Costly repairs, scarce and expensive spare parts will have to wait for better days years from now. Purchasing new equipment will be close to impossible. Nevertheless, adequate repair and maintenance as well as purchase of a minimal amount of new equipment will be necessary if the program is to be revitalized. This project will, therefore, provide the public program with a very small amount of equipment over the next three years. Obviously, the equipment purchased will be of highest priority to the program because of the very severe budget crisis. This will allow program administrators to more adequately maintain and repair existing equipment.

Over the next three years, the new government will be trying to develop a national population policy. The Mission does not plan to take a major role in the efforts to modify existing policies of the executive, nor to promote new legislation dealing with population, as it continues to be a politically sensitive matter. However, through this project, we propose to selectively support useful, analytical efforts which have the potential to influence the overall policy and legal environment.

During years four and five of this project, the Mission envisions the need to carry out a modest amount of special data analyses which can help program administrators to design new programs and policies to improve programs and to expand services to the harder-to-reach sub-populations. It is assumed that by that time the government will have additional funds available to launch these new initiatives. Because a planned contraceptive prevalence survey sponsored by the S&T Bureau will provide the basic data, little collection of additional data will be required, thereby reducing project costs to data analysis.

C. Commercial Sales (Support for Innovative Initiatives)

ASDECOSTA, an affiliate of the ADC specially created to implement CRS activities in Costa Rica, will be the implementing entity for the CRS component of this project. ASDECOSTA has direct contacts with IPPF to secure donations of program commodities, and with PROFAMILIA/ IPPF to obtain commodities at the best possible prices. (PROFAMILIA was created by the IPPF to benefit affiliated institutions like ASDECOSTA with economies of scale).

After termination of the proposed project, the above mentioned contacts will guarantee ASDECOSTA a constant supply of program commodities at adequate prices. This, in turn, will maintain the CRS program at all levels as a reliable source of commodities. Thus, the upper income groups will be able to continue purchasing the more expensive traditional brands and the low and middle-low income groups will be able to use the private sector - CRS channels to obtain affordable commodities and information without overloading the public sector system.

The Contraceptive Retail Sales (CRS) Program will expand the availability of contraceptive products, lower the price and allow patients greater freedom of movement back and forth between the commercial and public sectors according to their immediate family planning needs. Because of the

financial and programmatic burden on the debt-ridden public sector and because of the tremendous upward pressure on the commercial price of imports such as contraceptives, a CRS program is especially critical at this point. A successful CRS program will also make the overall national family planning program ultimately more self-reliant.

The Mission believes the CRS program will achieve several key targets:

1. Increase the percentage of the oral contraceptives delivered by the commercial sector to 35 percent by 1987 from a current 23 percent;
2. Increase the percentage of condoms delivered by the commercial sector to 55 percent by 1987 from a current 44 percent; and
3. Increase percentage of vaginal methods delivered by commercial sector to 85 percent from a current 77 percent.

Contraceptive sales over the life of project are estimated at:

| <u>PRODUCT</u> | <u>1983</u> | <u>1984</u> | <u>1985</u> | <u>1986</u> | <u>1987</u> | <u>TOTAL</u> |
|---------------------|-------------|-------------|-------------|-------------|-------------|--------------|
| | | | (000s) | | | |
| Orals (cycles) | 50 | 75 | 100 | 100 | 100 | 425 |
| Condoms (units) | 150 | 225 | 300 | 300 | 300 | 1375 |
| Vaginals (unit bxs) | 100 | 150 | 200 | 200 | 200 | 850 |

These sales projections will equal approximately 55 thousand person years of protection over the life of project. And, by the end of the project, the recurring cost per couple year of protection is estimated at US \$9.00. This cost compares favorably with the standard cost per couple year of protection in Latin America for an efficient urban clinical FP program which is US \$50.00.

The CRS program will advertise through the mass media and distribute through existing commercial drug distribution channels. Initial funding for marketing research, promotion, packaging, staff and technical assistance will be provided by AID. Revenues generated from sales will be placed in a separate bank account until reprogrammed by AID and the executing agency on an annual basis, or as agreed by both parties. During project implementation, the CRS component will be closely monitored by a Mission contractor under a PSC, assisted as necessary by the Futures Group. At the end of the project, management and financial responsibility will be turned over to the host country executing agency at no additional cost to AID.

The CRS program will use existing commercial distribution channels and methods. Since the retailers, wholesalers and distributors will earn a fair margin by commercial standards, a continuous flow of

contraceptives will be assured. The CRS program will be promoted by the local media and point-of-service displays, posters and pamphlets. Advertising and marketing efforts will emphasize the priorities and preferences of the low income groups to assure their participation as clients of the program.

One eventual goal of this CRS component is to become self-sustaining. If satisfactory sales targets can be attained and the price of contraceptives remains approximately the same to the local executing organization in 1987 as they will be to AID in bulk purchase (a fairly reasonable assumption), the Costa Rican CRS initiative has the potential to achieve this goal. Ultimately, however, the basic goal is to create a system which continuously attracts new acceptors. The extent to which the system may require subsidies should decline substantially during the life of the project.

To launch the CRS program will require both quantitative and qualitative market research leading to a full marketing plan. Such a plan will set target markets, product concepts, and marketing strategies for each product. A local advertising firm will then be contracted to implement a publicity campaign which will include radio and television spots (which are quite inexpensive in Costa Rica at this time) and point-of-purchase posters, stickers and displays. After the initial launch of the publicity campaign, maintenance advertising will continue over the life of project, based on continuous monitoring of customer behavior. ADC and ASDECOSTA have been active during the last few months identifying, contacting and negotiating with advertising and marketing agencies and direct distributors to assure that implementation of these activities can be initiated soon after the signing of the Agreement. Quantitative and qualitative market research activities are already in progress. A centrally funded \$25,000 Futures Group Grant contract will finance all costs.

The packaging of the product will be carried out in Costa Rica according to the specifications of the marketing plan. Many raw materials such as wrapping, ink, and lamination will probably need to be imported in addition to the contraceptive products. Packaging in Costa Rica will, nevertheless, be significantly cheaper than bringing in wrapped and finished goods, according to estimates in the Futures Group preliminary studies.

The products will be distributed through existing commercial channels. The Mission prefers the use of existing commercial systems rather than the creation of a new one for several reasons: existing profitable firms have a proven track record in a competitive environment and their efficiency will reduce costs. Commercial distributors will, therefore, be asked to bid for a contract let by the executing agency.

Two promoters (salespersons) will be hired to supervise and stimulate sales. They will visit sales points on a continuous basis to monitor sales, inspect product presentation (i.e. displays, posters, etc.) and ensure price. They will be paid on a salary plus commission basis.

Legal counsel will help throughout the project to ensure the proper procedures are followed with regard to registration, importation, advertising and sales.

D. Self-Reliance

Expenditures for the Costa Rican family planning program by the public sector add to this country's burdensome public sector costs. In an effort to cut back on these costs, this project will fund the following activities:

First, the Mission will make available to the public sector technical assistance to implement efficiency measures which will increase productivity and reduce costs. Management experts will, for example, recommend ways to improve worker productivity, contraceptive procurement and management information systems. This will be closely coordinated with the technical assistance provided under the CCSS component of AID's Policy, Planning and Administrative Improvement (PPAI) Grant.

Second, the project will work with the private Family Planning Association of Costa Rica (ADC) to introduce fee-for-services and the sale of contraceptives where possible. In addition, the ADC will be helped to improve its local fund raising capacity by encouraging the expansion of activities such as membership fees, voluntary contributions and special events. Possibilities for ADC participation in new, income generating activities will also be explored.

Third, the previously described commercial sales program will place a significant portion of service delivery on an increasingly self-reliant basis.

In summary, the Mission believes that by supporting the public program, the substantial expansion of commercial sales, and the means toward program self-reliance, AID can contribute to the development of a strong and stable program which can service the vast majority of the need.

E. Complementary Intermediary Support

The Mission bilateral strategy will require complementary support from AID intermediaries. The intermediary programs have recognized special expertise which can more efficiently carry out elements of the program necessary for Costa Rica. The Mission will rely on Pathfinder and FPIA to develop innovative service projects with CIF, COF, CLI, ADC and other private groups. Their special talents and careful attention will ensure success of experimental efforts. The Mission will require the technical and management assistance of Development Associates to monitor implementation of the training element of this bilateral project. CDC, Johns Hopkins PCS and Futures Group intermediary contracts will be relied on to provide needed technical assistance in logistics, commercial sales and communications. IFRP and RAPID II (if this project can be implemented to meet Costa Rican needs) will be encouraged to provide small amounts of assistance for specialized research studies and the application of micro-computers to program implementation. CPS will be required to carry out contraceptive prevalence surveys in 1984 and 1988 to assess and design service programs. The complementary UNFPA project,

if approved by MIDEPLAN, will supply assistance for training and research activities and some commodities for the program. And, last but not least, IPPF must provide a continual and adequate level of basic core support and contraceptives as well as project funds for strategic activities. The following Table provides the Mission estimates of the level of support planned from the various international family planning organizations over the next three years. It is not possible at this time to provide estimates beyond three years. Each year the Mission plans to provide a rolling estimate for the following three years to ensure the participation of these organizations, or their centrally funded successors.

ESTIMATED INTERMEDIARY REQUIREMENTS
FOR COSTA RICA, 1983 THROUGH 1985
(US \$000s)

| <u>PROGRAM</u> | <u>1983</u> | <u>1984</u> | <u>1985</u> |
|----------------|-------------|-------------|-------------|
| IFRP | 20 | 20 | 20 |
| DA | 16 | 13 | 20 |
| CPS | - | 75 | - |
| RAPID II | 10 | 10 | 10 |
| CDC | 10 | 10 | 10 |
| Futures | 15 | 15 | 15 |
| PCS | 10 | 10 | 10 |
| <hr/> | | | |
| TOTAL | 810 | 153 | 85 |

7. Beneficiaries

As explained in the Programmatic Concerns Section V of this document, USAID sees the great majority of beneficiaries belonging to the lower-middle and lower income levels of the population. Public sector programs of the MOH and CCSS concentrate on serving the poorer groups in both rural and urban areas. Project financed information and promotional efforts will be tailored to effectively reach and attract those groups. The CRS component may be attractive to some middle-income level citizens. However, the CRS program will focus advertising and marketing efforts on the needs and priorities of the lower income groups. These aspects of the project will be closely monitored by USAID/CR and ADC with the assistance of the MOH and CCSS. Adjustments will be made as required to maintain project focus on the needs of these target beneficiaries.

IV. PROJECT ANALYSES

A. FINANCIAL PLAN AND ANALYSIS

1. Summary

The total cost of this project will come to U.S. \$5.5 million. The USAID contribution consists of U.S. \$2.5 million in grant funds. The IPPF through its affiliate in Costa Rica (ADC) will contribute approximately U.S. \$2.0 million during life of project, and UNFPA is expected to contribute U.S. \$1.0 million during the same period. The GOCR's health services networks are expected to contribute approximately U.S. \$10.0 million through family planning consultas and other medical services associated with family planning. This in-kind contribution however, is not factored into the other project costs because ADC will be the only implementing entity for this project.

ADC will concentrate on supporting the extensive and on-going service delivery efforts of GOCR institutions with approximately one third of the project's resources. The other two thirds will be earmarked for an aggressive drive to increase private sector participation in family planning and for specific activities that will seek to expand and diversify the ADC's financial base.

The ADC delivers only a small amount of family planning services through its Centro Limonense (CLI). The bulk of all family planning services offered in Costa Rica are provided and financed by GOCR institutions (CCSS and MOH). These GOCR institutions are expected to continue providing family planning consultas nationwide while receiving this project's support to improve quality of services and upgrade personnel capabilities. Because the ADC will step up its information and motivation activities, demand for consultas is expected to increase during life of project. It is estimated that the CCSS and the MOH will provide and finance one million consultas during life of project, each costing those institutions an average US \$8.73. Thus, the GOCR in-kind contribution to the national program is in fact many times greater than the estimated ADC/IPPF/UNFPA counterpart for the Family Planning Self Reliance Project.

Summary of Expenditures by Institution
(U.S. \$000)

| <u>Institution</u> | <u>Years</u> | | | | | |
|--|--------------|-----------|-----------|-----------|-----------|--------------|
| <u>A. Support to Project</u> | | | | | | |
| | <u>83-84</u> | <u>85</u> | <u>86</u> | <u>87</u> | <u>88</u> | <u>Total</u> |
| ADC/IPPF | 400 | 400 | 400 | 400 | 400 | 2,000 |
| UNFPA | 200 | 200 | 200 | 200 | 200 | 1,000 |
| Totals | 600 | 600 | 600 | 600 | 600 | 3,000 |
| <u>B. Cost of Consultas (estimates of in-kind support external to project)</u> | | | | | | |
| MOH | 500 | 525 | 600 | 650 | 725 | 3,000 |
| CCSS | 1,000 | 1,200 | 1,400 | 1,500 | 1,900 | 7,000 |
| Totals | 1,500 | 1,725 | 2,000 | 2,150 | 2,625 | 10,000 |

Summary of Expenditures by Input Category
(Direct Support to Project Only in U.S. \$000)

| | <u>A.I.D.</u> | <u>ADC/IPPF</u> | <u>UNFPA</u> |
|----------------------|---------------|-----------------|--------------|
| Technical Assistance | 390 | 100 | 100 |
| Training | 195 | 100 | 500 |
| Commodities | 485 | 1,100 | 300 |
| Administration | 160 | 500 | 100 |
| Self Reliance | 320 | -- | -- |
| IE&C | 175 | 200 | -- |
| Other* | 620 | 100 | -- |
| Contingency | 155 | -- | -- |
| Total | 2,500 | 2,000 | 1,000 |

* Other includes: Logistics, equipment, policy analysis and support activities for the CRS program.

SUMMARY OF PROJECT INPUTS
(U.S. \$000s)

| <u>Public Sector</u> | <u>1983</u> | <u>1984</u> | <u>1985</u> | <u>1986</u> | <u>1987</u> | <u>Total</u> |
|--------------------------------------|-------------|-------------|-------------|-------------|-------------|--------------|
| Training | 35 | 80 | 80 | -- | -- | 195 |
| Communication | 50 | 40 | 30 | 20 | -- | 140 |
| Logistics | 40 | 40 | 40 | 25 | 20 | 165 |
| Equipment | 10 | 10 | 10 | 10 | 10 | 50 |
| Policy Analysis | 10 | 10 | 10 | 10 | 10 | 50 |
| Administration | 10 | 20 | 25 | 20 | 15 | 90 |
| Sub-total | 155 | 200 | 195 | 85 | 55 | 690 |
| <u>Commercial Sales</u> | | | | | | |
| Personnel | 9 | 28 | 28 | 30 | 31 | 126 |
| Advertising Campaigns | 10 | 90 | 65 | 75 | 75 | 315 |
| Market Research | 5 | 5 | 15 | 5 | 15 | 45 |
| Legal and Auditing Services | 5 | 5 | 5 | 5 | 5 | 25 |
| Products | 50 | 75 | 135 | 125 | 100 | 485 |
| Packaging | 15 | 30 | 60 | 50 | 35 | 190 |
| Short-Term T.A. | 30 | 40 | 40 | 20 | -- | 130 |
| Project Consultant | 12 | 25 | 25 | 25 | 13 | 100 |
| Administration | 35 | 30 | 30 | 25 | 25 | 145 |
| Expenses | 171 | 328 | 403 | 360 | 299 | 1,646 |
| (Income) | -- | (30) | (75) | (100) | (125) | (330) |
| Sub-total | 171 | 298 | 328 | 260 | 174 | 1,231 |
| <u>Self Reliance</u> | | | | | | |
| Technical Assistance (long-term) | -- | 100 | 80 | 65 | 50 | 295 |
| Technical Assistance (short-term) | 10 | 20 | 20 | 20 | 10 | 80 |
| Special Projects | -- | 10 | 10 | 15 | 15 | 50 |
| Sub-total | 10 | 130 | 110 | 100 | 75 | 425 |
| SUB-TOTAL | 336 | 628 | 633 | 445 | 304 | 2,346 |
| <u>Contingencies</u> | -- | 35 | 35 | 40 | 44 | 154 |
| GRAND-TOTAL | 336 | 663 | 668 | 485 | 348 | 2,500 |

2. Recurrent Cost Analysis

Project recurrent costs are considered to be those incremental costs generated for the implementing organizations after the Project Assistance Completion Date (PACD) as a result of the project. Since the major objectives of this project include increasing private sector participation in family planning and enhancing the financial self reliance of the ADC, project designers have paid close attention to minimizing such costs. The additional private sector participation in the family planning program is motivated by the CRS project component. The sale of contraceptive commodities will allow large (distributors) and small (retailers) entrepreneurs to expand their sales and increase profits. Additional personnel and operating costs will thus respond to market conditions and will only require the standard management decisions in each enterprise.

ASDECOSTA, now a legally constituted for-profit organization owned by ADC, is the only project entity which will have to hire new personnel to implement proposed activities. Since in the past ASDECOSTA had limited its activities to periodic sales of small quantities of condoms, a one person staff was adequate. The proposed expansion of activities requires an increase in personnel. However, the planned increase is minimal. The manager and two sales persons will be assisted by a secretary from the ADC secretarial pool and an assistant manager may be hired if volume of business requires it.

By end of project (in 1988) ASDECOSTA is expected to be receiving revenues of no less than U.S. \$150,000 and will be paying personnel costs no greater than U.S. \$40,000. Since the proposed staff level is really a core group, USAID/CF believes that no additions would have been necessary if ASDECOSTA had already been operating a full time commercial program. Thus, the personnel increase is a cost effective response to transform ASDECOSTA from an experimental, limited involvement activity to a full and profitable commercial operation. After termination of AID assistance, ASDECOSTA will continue operating in close collaboration with ADC. By that time also, ASDECOSTA is expected to have close business ties with PROFAMILIA International (IFPF's regional CRS entity). This relationship will guarantee adequate supplies of technical assistance and commodities at affordable prices.

ADC will maintain its present staff level to implement the Family Planning Self Reliance project, and will contract for technical assistance or supplemental administrative services when and if project demands require it.* Thus, the project will involve no recurrent costs for ADC.

The public sector program, like ADC, will not require additional personnel. A possible recurrent cost to the MOH and the CCSS may be the increased demand for family planning services resulting from the project's promotional and IEAC activities. USAID thinks that any demand related cost increase will be minimized or offset by the CRS program and long-term savings produced by the averted births.

*Once the public sector program is revitalized and self reliance (income generating/cost saving) activities are identified during life of project, ADC will scale down its activities in those areas and do only "maintenance work" with its traditional staff level and programs.

B. ECONOMIC ANALYSIS

1. Introduction

The literature in economic growth strongly emphasizes the fact that rapid demographic growth, which is a characteristic of LDCs, constitutes a serious barrier to economic growth and development. In recent decades, therefore, family planning programs have received increasing attention in development programs. The problem of underdevelopment in the poor countries is that per capita income is so low that the rate of savings is per force small. Since savings rates are low, capital formation is low, while population on the other hand grows at an accelerated rate. The possibility of increasing savings is limited because of poverty; under these circumstances the main adjustment to break out of this vicious circle must come through a reduction in the population's rate of growth.

In the absence of technological change, in the long run, if the growth rate of population (labor) is higher than the rate of growth of capital, the economy's capital intensity decreases, marginal productivity of labor falls, per capita income declines and the possibilities of increasing the rates of savings and investment are further reduced; the circle closes, condemning LDC's to rates of per capita consumption at poverty levels.

Accordingly, the implementation of family planning programs that contribute in the long term to reduce the demographic growth rate, is one of the most important instruments that can be used to help developing countries to escape from the barriers of underdevelopment and to start a path toward self sustained growth.

2. The Effects on Costa Rica's Economy

a. Growth Trends in the Seventies

Between 1973 and 1979, Costa Rica's gross domestic product reflected an annual average growth rate of 5.5%. During this time period per capita GDP which is a better measure of living standard grew at an annual average rate of 2.9%, the difference, 2.6%, is explained by the growth in population; at the same time, per capita consumption increased at an average rate of 3.6% annually and unemployment was reduced to the low level of 4.6% in 1978.

Population growth during those years was more than compensated by public and private investment. Costa Rica's government invested heavily in infrastructure projects and in human capital through extensive educational and health programs. Gross investment increased 9.3% between 1972 and 1980 and together with a more qualified labor force permitted the achievement of higher standards of living.

b. The Reversal of the Growth Trends

Since 1980 Costa Rica has been facing the most severe economic crisis in many decades. Structural problems, that had been accumulating for several years, together with more recent conjunctural factors emerged simultaneously dragging the country into economic chaos. GDP decreased 4.6% in 1981, 9.1% in 1982 and a further decrease of about 2-3% is estimated for 1983; exports dropped sharply, unemployment reached 9.4% and inflation climbed to the highest levels in recent history (90% in 1982).

The population's standard of living suffered drastic deterioration. Per capital GDP decreased steadily in the last three years, 1.6% in 1980, 7.4% in 1981 and 11.8% in 1982; per capita private consumption decreased 32.9% during the same period and gross investment fell more than 77% between 1980 and 1982. External public debt amounted to \$3.061 million as of December 1982, and the debt service ratio for 1983 is estimated at 78%.

Even with the very optimistic assumption that Costa Rica's economy will completely stabilize in 1983 and will start a recovery path in 1984 at an annual average growth rate of 4.6%, the per capital GDP level attained by 1979 would not be achieved again until 1994.

c. The Family Planning Program Economic Rationale

More than 45% of the high levels of investment attained by the economy between 1973 and 1980 were externally financed. It is obvious that Costa Rica is unable to continue importing savings to finance new investment projects. As a result, the growing labor force will have a lower endowment of capital to work with, productivity will decrease, and the people's standard of living will continue to deteriorate. Rapid population growth exacerbates the problem of generating savings from domestic sources, and in Costa Rica since each member of the labor force must support two other persons, little income is left for savings or investment after basic consumption expenses have been met.

One of the main causes of the economic crisis has been the excessive growth of government's expenditures, which will have to be drastically reduced to bring about stability and economic recovery. For the next several years, therefore, public educational and health programs will have to be reduced accordingly. Furthermore the public sector simply cannot continue to absorb a growing labor force, as was the case in the second half of the seventies, when about two out of every five new jobs in the economy were created by the public sector. Today, about 20% of the labor force is employed in the public sector.

d. Economic Benefits

Even though no quantitative evaluation has been made, the economic benefits to be derived from this project are numerous and directly follow from the economic growth theory that justifies family planning programs in LDC's and from Costa Rica's economic background, current situation and the economic growth prospects discussed above.

In view of the investment and savings constraint a lower rate of increase in population and in the labor force will imply a lower decline in productivity. Over the long run Costa Rica might then be able to reach a higher growth path.

As savings are a function of per capita income, the lesser the population and the greater the productivity of the labor force, the larger the savings and therefore the possibilities to attain a better standard of living for Costa Ricans.

As a result of the activities planned through the project, the national economy will achieve significant savings as a factor of reduced demand for services largely provided by the GOCR, such as education, health, housing, etc. These savings in turn will remain free to be invested in other areas and should more effectively improve the quality of life for all Costa Ricans.

3. Cost Effectiveness

In designing the Family Planning Self Reliance project, the Mission has considered the following factors:

- a) ADC is an experienced organization with very capable management and staff.
- b) ASDECOSTA was formed and legally established by ADC under the guidance of IPPF's Profamilia International.
- c) The MOH and the CCSS health service delivery networks already reach over 85% of the population. Physical facilities and personnel levels as they are today can meet the objective of universal coverage.

The Mission has carefully analyzed these factors and reached the conclusion that they guarantee the project's cost effectiveness. Specifically, as coordinator of the National Commission for Population (CONAPO), the ADC successfully managed the national family planning program for many years. Through this project AID utilizes the expertise now available in ADC's management, staff and institutional structure. Because of ADC's extensive capabilities, recurrent costs to the ADC as a result of the project are minimal. By the same token the project will not have to cover expensive institution building activities.

In addition, ADC will add to the project its extensive network of international contacts which offer technical assistance, commodities and general know-how at minimal or no cost to the project.

Secondly, even though ASDECOSTA is a newly formed organization, it is the product of IPPF's extensive experience in Latin America. Furthermore, ASDECOSTA will utilize the services and systems of successful national distributors and advertising agencies that will contribute to the project with the experience and procedures developed through many years of productive operations.

Costa Rica's health services network is a model for most of Latin America and the developing world. The public sector institutions, CCSS and MOH already have a significant delivery capacity in place that can be expanded to achieve a major impact at a minimal marginal cost. The Family Planning Self Reliance project will invest a very modest amount of resources for IE&C and training activities which are expected to increase the effectiveness of the existing health services system and benefit thousands of Costa Ricans seeking family planning information and services.

In conclusion, project designers have carefully assessed the needs and capabilities of the national family planning program and targeted project assistance to efficiently address weaknesses while systematically capitalizing on program strengths. The result, we expect, will be maximum cost effectiveness through optimum utilization of host country and other donor resources.

C. SOCIAL SOUNDNESS ANALYSIS

1. Introduction

In reviewing the sociological information available on family planning programs in Costa Rica, the Mission judges this project to be socially sound based on the criteria required by AID. First, family planning as a concept and a practice is compatible with the socio-cultural environment in Costa Rica. The Contraceptive Prevalence Surveys of 1978 and 1981 carried out by Westinghouse Health Systems and the Asociación Demográfica Costarricense detail and reinforce this conclusion. Second, the practice of family planning has already successfully diffused from the urban to the rural areas of Costa Rica, due in great part to the network of rural health posts. Third, the broad distribution of project benefits is assured by the variety of activities planned under the project.

This project is designed to assist in the delivery of family planning services, especially to the lower income levels, where the need is most urgent at a critical moment for Costa Rica in economic terms, while also providing the opportunity for the private family planning organization to develop self-reliance.

2. Socio-Cultural Acceptability

Despite the fact that the Legislative Assembly has not written into law a Family Planning Policy, family planning services have been offered since 1968, within a program which includes activities in education, research and information dissemination, with the collaboration of various public and private organizations. The objectives of the general program have been presented with an orientation towards improvements in maternal child health, and the couples' right to choose when and how many children to have.

Up until 1976, the public sector capacity to deliver family planning services had been improving steadily. Each year there was an increase in the number of new users, a reasonable rate of user continuation, and expansion in the number of active users. However, by 1978, it became obvious that the program could not continue to expand at the same rate, as women who had not taken advantage of the services thus far would be more difficult to attract. Further, the government which entered in 1978, was opposed to the program and unwilling to fund expansion of the program.

Although the Contraceptive Prevalence Survey of 1981 indicated a 65% prevalence, the information was recorded in the first months of 1981, before the full impact of the monetary devaluation/inflation crisis was felt. The most drastic changes in the economy have occurred since then, tremendously affecting disposable family income and public health family planning delivery services.

There is now an unmet demand for family planning services of approximately 21% of women of fertile ages. This includes unsatisfied users, and non-users aware of their needs for family planning, and those ambivalent due to fears and misconceptions. About 120,000 women of the 590,000 women in fertile ages in Costa Rica are thus affected by this situation. Because of high fertility and low mortality in previous years, the number of women in fertile ages will increase by nearly 3.0% per year over the next ten years.

The direct beneficiaries of this project will be the estimated 200,000 women of fertile ages who will actively be using contraceptives in Costa Rica by the year 1987. By the end of the project, USAID expects to regain lost ground and reach a 70% prevalence level.

With the decline in prices of contraceptives in the commercial sector, as a result of the Contraceptive Retail Sales program, poorer middle class users will be more able to purchase their supplies from this sector. Shifting a significant number of users to commercial purchases and also improving the efficiency in the public program will mean that more public resources can be dedicated to serving the poorest segments of the population.

The Contraceptive Prevalence Survey of 1981 demonstrated the following:

a) Fertility

Socioeconomic variables that affect fertility are not so marked in Costa Rica as in other Latin American countries. This is believed to be due to the rapid socioeconomic development and educational achievements of Costa Rica as a whole, the universalized health system, and effects of mass media as an information source and equalizer. Better educated, wealthier Costa Rican women have an average of 3 children, while poorer, rural, and lower class women have an average of five children.

b) Reproductive Preferences

Eighty-one percent of fertile women in union want to stop having children; or space their pregnancies, fifty two percent stated that they do not want more children than they already have, while thirty-nine percent stated that their last child was unwanted, either for having been conceived too soon after the last pregnancy, or for not having wanted any more children at all.

The nearly universal preference for family size is at least two children, though the Costa Rican inclination is towards three as the ideal number.

c) Contraceptive Awareness, Acceptability and Supply

All women surveyed had heard of at least one method of birth control and nearly all (98%) knew where to acquire commodities, (public health pharmacies and rural health posts, commercial pharmacies). There is an acknowledged discrepancy between awareness and practice, which is due to a variety of factors such as fear, male attitudes, negative experience with contraceptives or with service delivery personnel.

The public sector primarily serves the least privileged women, those least educated, rural dwellers, and of the lowest social classes, ninety per cent of those surveyed, as compared to fifty percent of the better educated and wealthier women.

3. General Conclusions

This project will enable the ADC and public entities to respond to those needs identified in the Prevalence Survey of 1981.

The program will not only make family planning services more widely available, but will also provide the recipients with the information necessary to make the appropriate decisions concerning the number of children desired.

In addition to indirect benefits which accrue over time as fertility declines, direct improvements in the health and well-being of Costa Rican families will be realized from reductions in childbearing. Being able to space pregnancies and to reduce the number of unwanted births will benefit the health and nutrition of the mother and her offspring.

Family planning is one of the most important steps which can be taken to reduce neonatal, infant, child and maternal mortality. Presuming a relationship between smaller families and improved nutrition (through higher per capita caloric consumption), the relationship between smaller family size and improved family health can be seen to be critical, especially in the rural areas where a high percentage of the children under 5 years of age suffer from some degree of malnutrition.

Through the continued and improved public sector family planning program, and the CRS program the availability of services and benefits will be widely received. Since all programs are completely voluntary, only those truly desiring Family Planning Services receive them.

D. TECHNICAL ANALYSIS

1. Demand for Family Planning Services

The Contraceptive Prevalence Survey of 1981 demonstrates a significant level of unmet demand that still exists for family planning services, and a considerable user drop out rate despite the efforts of the family planning programs since 1968. While negative former governmental policies are a factor contributing to this unmet need, another is the discrepancy between awareness and practice.

There are also constraints not previously measured. Though the health center may be close by, the accessibility of the actual service, the schedule and quality of attention should be taken into consideration. A recent (1983) advance published by the ADC "Availability of Services and Contraception in the Rural Areas of Costa Rica", reflects information collected in the latter part of 1982 which documents that: of the 173 communities visited, 50% have some public health service, 25% have the private services of a doctor, and 20% have a pharmacy or "botiquín", which serves a rural population with a limited supply of mostly non-prescription types of remedies. A very limited number of drug stores and "botiquines" in rural areas sporadically provide a few contraceptive methods and the public sector, especially MOH, presently suffers from insufficient supply of contraceptives, inadequate distribution system, poor equipment maintenance procedures, and a lack of informational materials, all of which lead to poor quality services.

Therefore, the demand for family planning services continues to exist among women who lack access to adequate services, who become pregnant due to ignorance or misuse of contraceptives, or who are

ambivalent about the subject, but reachable through motivational campaigns to overcome their fears and misconceptions. However, the quality of services must improve to attract and retain these new users.

2. Contraceptives Technology and Delivery

This project will rely on the standard variety of non-permanent contraceptives including natural family planning methods for the public sector delivery system. The CRS program will market AID supplied orals, condoms and vaginal tablets. These contraceptive methods are beyond the experimental stage, and their effectiveness under a variety of conditions is well known.

While the theoretical effectiveness of contraceptive methods is known, failure resulting from the way a method is used is very difficult to ascertain. Careful education and counseling is necessary, to ensure correct usage. Hands-on training is essential for many doctors and nurses currently practicing both in CCSS and MOH, as there has been a noted lack of any real training, follow up or supervision in this area for the last five years, which has caused a negative impact on the program.

The training and supervision of public health doctors, nurses and support personnel in the theory and practice of contraceptive methods are critical areas which are to be dealt with through this project, to assure quality service delivery in a humane setting. ADC will also continued efforts to improve the curriculum of the University medical schools to assure that family planning is adequately covered.

Besides updating the medical personnel in contraceptive technology, plans include policy and information seminars for the Directors of various health institutions, a specific training program for nurse auxiliaries who work at rural health posts, and another program dealing with methods, taboos and the psychology of family planning for support personnel such as social workers, secretaries who handle statistics and office visits, and health promoters working in the field.

The means of channelling information and integrating family planning into the educational process remains controversial. IESC activities will be directed towards varied target groups, ranging from adolescents to rural and low-income urban radio audiences, opinion leaders and industrial workers and women in all categories. As the formal education system is not yet receptive to sex education at the level of curriculum programming, the most effective ways of disseminating information to the public of all ages are through informal education, popular publications and mass media approaches. The media reaches most areas of Costa Rica, though the messages must be subtly addressed to be accepted by the censors.

The Costa Rican family planning program has not had a demographic thrust, but rather an orientation towards personal rights. That type of family planning message can be effectively disseminated

through points of service information, motivation, counseling and education. Motivated personnel in hospitals, clinics and pharmacies, using IE&C materials, can relay that information to interested parties. Person to person communication by informed and satisfied users, also serves as an effective grassroots information network.

As for the CRS program, according to the feasibility study, the necessary conditions for implementation exist in Costa Rica. There are capable advertising agencies for an appropriate promotional campaign, suitable market research firms for social marketing information needs, and a variety of distributors to choose from to provide nationwide coverage in a relatively short period of time. Consumer information will be provided at the point of purchase, and within the contraceptive packaging. ASDECOSTA will implement the CRS component, as detailed in Annex I.

E. INSTITUTIONAL ANALYSIS

1. Asociación Demográfica Costarricense (ADC)

a. General Description

ADC is a private voluntary family planning organization, an affiliate of IPPF, and uses a traditional hierarchical organizational system consisting of an executive director, deputy director and various departments, each with a support staff and department head who reports to the deputy director. The deputy director coordinates the activities of the departments and serves as administrative liaison between ADC and donor agencies.

ADC presently employs a staff of 35. Financial assistance has been received from international organizations, mainly IPPF, and UNFPA (See Background, AID and Other Donors) both for administrative costs and in-kind donations of contraceptives and equipment. The association was founded in 1966 and has expanded greatly since then, although setbacks were suffered during the 1978-82 period. Major activities implemented include the establishment and maintenance of a clinic in Limón, an effective distribution system for the commodities received from international donors to the CCSS and MOH networks, publications, media programs, the Contraceptive Prevalence Survey with Westinghouse Health Systems and the creation of ASDECOSTA for commercial purposes.

ADC was coordinator for the National Commission on Population (CONAPO) between 1968 and 1978, and managed a successful multi-million dollar family planning program during this period.

b. Management Systems

As an affiliate of IPPF, ADC has a full range of management systems which conform to program requirements and IPPF

international standards. IPPF performs regular audits to assure that guidelines are followed, and has made structural changes when deemed necessary. External audits performed indicate that funds have been used properly.

c. ADC as Project Coordinator

ADC has been chosen as the coordinator for this project because of its management capabilities, experience in the field, and efficient administrative and financial procedures. As a private entity, ADC has the flexibility to make immediate decisions and necessary changes. Public sector entities are bound by the laws of Public Administration and Finances and cannot make changes in an established plan or budget without referring the issue to other institutions.

ADC as a private social welfare organization is free to contract with companies and individuals, for technical assistance, commodities, services, publications, or whatever is needed, by choosing the best available, while not being bound by the lengthy public bidding process.

Coordination of the training courses to be provided for family planning service and support personnel in the CCSS and MOH is an important task requiring an outside facilitator, as the Health Sector has suffered from duplication and a lack of real coordination. Also, by ADC control over the organization and financing of the courses, a regular schedule can be followed without waiting for funding (the public sector is funded by twelfths of the annual budget). Close coordination with CCSS and MOH will be important as the personnel to be trained must have the hierarchical approval to attend courses.

ADC coordinates commodity distribution through the CCSS and MOH networks. Each has its own system and type of distribution points, requiring separate procedures and careful control. ADC maintains computerized inventories, and close contact with donor agencies and commercial representatives to avoid major commodity stock outs.

Based on past experiences, and proven capability, USAID/CR believes that the ADC is the most appropriate entity for the coordination and implementation of this project. The commercialization and self reliance (fund-raising) components could only be considered for implementation by a private organization.

2. Ministry of Health

The MOH budget has been constricted in real terms, for although the GOGR emphasizes health services, the CCSS has received an increasing portion of the health sector financing since it has taken on nearly all hospitals and curative care services.

MOH remains as the leader in health policy and preventive medicine, and with its network of health centers and rural health posts that reach the most remote areas of Costa Rica, deserves attention as an important provider of family planning services, both in terms of medical consultations (consultas) and commodities distribution through a system of redeemable coupons. MOH will actively participate in this project through service delivery, and information dissemination while key personnel in rural outreach programs will receive vital training from ADC coordinated activities to provide more effective services.

Supervision of MOH activities at the health center and health post levels is the responsibility of the Department of Medical Assistance. The country is divided into five health regions each with its area chief, and sub-divided into districts, where health centers operate, usually with a full complement of personnel: a doctor, nurses, sanitary inspectors, social workers, auxiliary nurses and auxiliary nutritionists.

The rural health post is generally staffed with auxiliary personnel - auxiliary nurses, nutritionists, health promoters. A doctor from the health center visits on a monthly or bi-monthly basis. Family planning programs at the MOH will be best served by providing training and refresher courses for all levels of personnel. Supervision and evaluation units are being strengthened for the health services delivery system in general, and the family planning program will benefit by these activities.

MOH was not chosen to coordinate the project activities because its financial and administrative procedures are cumbersome, and also, the experiences of the former program financed by AID indicate that the public sector is inclined toward politicizing family planning, which hampers the effectiveness of the program.

4. The Costa Rican Social Security Institute (CCSS)

The Costa Rican Social Security Institute provides health care services to 85% of the Costa Rican population, and is financed through payroll quotas paid into the system by employers, employees and the GOCR.

The CCSS will most likely provide more than half of the public sector family planning services, as the Contraceptive Prevalence Survey shows that the CCSS is preferred over the MOH (62% - 38%) for service delivery.

Since the CCSS is a major provider of clinical family planning services, a substantial portion of the project is geared toward up-dating the contraceptive technologies utilized and disseminated by clinicians and support personnel. An ambitious series of in-depth courses has been developed by the CCSS and MOH in conjunction with the ADC, which will be offered at the CCSS "Centro de Docencia."

As in the case with the MOH, the ADC will coordinate the training aspects of the project, assure financing and effective management. Supervision of service delivery will be increased as the CCSS is improving its supervision system, and family planning programs will benefit as a result.

The CCSS maintains a stock of contraceptives, both commercially purchased, and ADC supplied, which are distributed to the clinic pharmacies on a regular basis. This project will seek to improve the logistics management system with technical assistance from the CDC, which is already underway.

I&C activities will be programmed in coordination with the ADC, as information dissemination is a vital part of the family planning visit.

5. ASDECOSTA

ASDECOSTA, is a legally constituted corporation (Sociedad Anonima) which is owned by ADC and controlled by the ADC Board of Directors. It has become the vehicle for the implementation of the CRS program which will package, promote and distribute low-cost contraceptives to a commercial market.

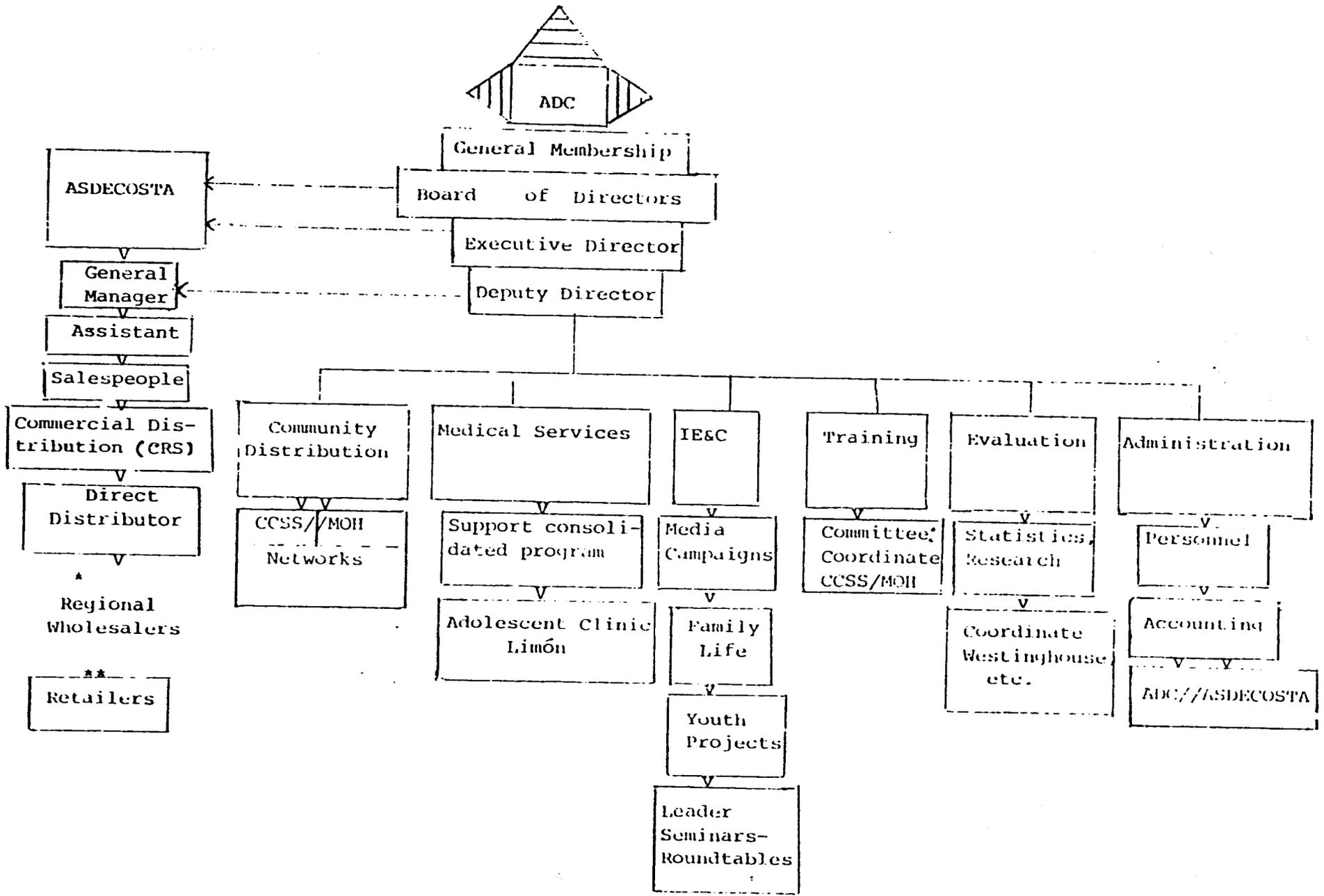
The staffing pattern will consist of a General Manager, two sales people, Assistant Manager if merited by volume of work, and possibly a secretary from the ADC pool. The accounting will be managed by ADC, as their system is computerized. Internal and external audits will be performed at regularly scheduled intervals. ASDECOSTA overhead will be primarily absorbed by ADC.

Contraceptives will be donated by AID; ADC will retrieve the commodities from customs as the agent of ASDECOSTA paying tariff as required. This procedure was approved by General Counsel/LAC in AID/W to avoid both charges of unfair competition, and also of the sale of goods donated to a non-profit organization.

ASDECOSTA will sub-contract all the necessary services: marketing studies, advertising, warehousing, packaging. Use of the private sector wholesaler/distributor system already in place has been determined to be the most appropriate distribution system.

Technical assistance for the CRS program will be provided primarily by short-term interventions in quarterly visits by project funded CRS experts, rather than a resident expert in charge of project management. Approval of all contracts must be received from USAID/CR.

For further details, see Annex H, reports by CRS experts from the Futures Group.



V. PROGRAMMATIC CONCERNS SUMMARY

A. GOCR Commitment level, counterpart funding and personnel

The ADC has supplied the following data and estimates:

Between 1974-77, the CCSS and the MOH offered 840,330 units of medical consultation for family planning (consultas). Data for period 1978-1982 was not collected, however, ADC estimates that at least 820,000 consultas were offered by those entities. For the period 1983-88, ADC estimates that the CCSS and the MOH will promote family planning services and will provide at least 1,155,000 consultas. ADC also estimates that the average cost of a consulta is U.S. \$8.73, thus, the GOCR's in kind contribution just for family planning service delivery during life of project is estimated to be no less than U.S. \$10.08 million. In addition, the CCSS will provide warehouse space for commodities, some CCSS procured commodities still in stock, and the support of its distribution network.

The Mission has no reason to doubt the GOCR commitment albeit in low profile, to family planning. President Monge himself addressed the last annual IPPF Conference and expressed his support for family planning. The Second Vice President, the Minister of Health, and top management of the CCSS have publicly and/or privately expressed an equally positive attitude toward family planning initiatives. The First Lady hosted a family planning conference in San Jose which was sponsored by the UNFPA.

Along the same lines, the Mission knows the CCSS and the MOH are committed to providing adequate personnel levels to work in family planning. Both the MOH and the CCSS are currently strengthening evaluation and supervision units that will support the family planning program. Together with the ADC, both the MOH and the CCSS have designed an ambitious training program to be financed with project resources. In planning sessions, CCSS and MOH officials stressed the fact that personnel are already assigned and working in family planning activities. AID's contribution is only expected to assist educate, inform and motivate these health workers to guarantee high quality, efficient performance.

B. Participation of Other Donors and Intermediaries

USAID/CR, LAC/DR/POP and ST/POP have worked together in negotiations with other donors such as IPPF and UNFPA and intermediaries such as IFRP, DA, CDC and the Futures Group to assure adequate funding levels, commodity flows and technical assistance as required by the planned activities. Each organization has been presented with a clear explanation of the Costa Rican program needs and has agreed to assist if permitted. IPPF will provide ADC's core support and will supply a significant amount of commodities for the public sector program. UNFPA will concentrate on training and research, and will complement IPPF's commodity transfers if this is necessary. IFRP will continue working with the CCSS' Hospital Mexico in research activities. DA will help the Mission monitor and evaluate training and IE&C activities. CDC will also continue collaborating with ADC and the CCSS to minimize problems related to storage and distribution of commodities.

C. Plans for AID Phase-Out

AID has been seriously considering phasing out its population activities in Costa Rica since the early 1970s. The 1976 Family Planning Services project was supposed to be the last bilateral AID project in this sector. Rapidly changing technical, economic and sociopolitical circumstances in Costa Rica justify the Family Planning Self Reliance project, and similar conditions may justify a project extension or even a new project in 1988. Unlike the 1976 project, the Family Planning Self Reliance project earmarks almost two thirds of its resources to commercial/self reliance activities. These activities are expected to have both a financial and an attitudinal impact on the ADC, the CCSS and the MOH. Financially, they aim to expand and diversify the ADC's income base to reduce dependence on the public sector. From an attitudinal perspective, project activities are expected to reverse current trends and support the position of Costa Ricans who believe that government should be reduced in size and influence and that the private and commercial sectors should take a more significant role in development. The Mission believes that this is the most promising approach toward the development, in a reasonable time frame, of a truly independent family planning program for Costa Rica.

D. Commodity Requirements and Suppliers

Centers for Disease Control (CDC) expert, Dr. Mark Oberle, has visited Costa Rica three times during the last year to evaluate the storage capacity and distribution infrastructure of the Costa Rican family planning organizations. With the information gathered by CDC, ST/POP (AID/W) has determined current commodity stock levels and projected future needs. Also as a result of CDC's assistance, ADC and the CCSS have discarded outdated commodities and plan to send surpluses of certain low demand products (e.g. Noriday brand orals) to Guatemala.

ST/POP has discussed this information with IPPF and received assurances that all needs will be adequately covered. Specifically, IPPF has agreed to supply during FY 83-84 750,000 cycles of Ovral and Feminal brand orals to fully cover 1983 and 1984 needs. IPPF has also agreed to give ADC an adequate monetary allowance to permit local purchases of commodities as required by program needs. These measures will allow ADC to respond effectively to all public sector programs that include commodity distribution.

LAC/DR/POP and ST/POP have also negotiated with UNFPA and received assurance from that organization to the effect that UNFPA will cover any additional commodity needs the public sector program may identify during life of project. Thus, IPPF and UNFPA will be the only donors required to supply commodities for the non-commercial component program. USAID does not anticipate the participation of any other organization in this area.

The Family Planning Self Reliance project will provide \$485,000 to fully fund all commodity needs of the CRS program during life of project. Based on the Futures Group analysis (see Annex H third report) this funding

level for commodity purchases will guarantee substantial income for ASDECOSTA by end of project.

E. Implementing Agencies

All project activities will be implemented by ADC. ADC will support the public sector program through new and existing agreements with the CCSS and the MOH, and will subcontract with ASDECOSTA for the implementation of the CRS program. The CCSS and the MOH as is now traditional, will cover all service delivery, and with ADC's assistance, will work on intensive training and IE&C activities aimed at revitalizing the public sector program. ASDECOSTA's management and sales staff, supported by ADC's administrative structure, will decide on all sales, marketing and distribution aspects of the commercial initiatives. ASDECOSTA will purchase services from advertising and market research agencies and will later decide on the most appropriate distribution mechanism, be it through a wholesaler/distributor or a self-contained system.

F. MOH vs. CRS

The MOH commodity distribution program is a public service which focuses on the needs of the rural population served by MOH health posts. Unlike the CCSS, the MOH program is more advanced and has incorporated fee-for-service concepts. Imperfect as it is, since a doctor must assess the client's capacity to pay for commodities, the MOH system makes it clear to clients that they must share the burden of the cost of comprehensive medical services provided by the government.

However, as is the case with the CCSS, the MOH system is plagued with bureaucratic requirements and limitations. Clients faced with the option of purchasing reasonably priced commodities in a nearby pharmacy or commercial outlet will seriously consider paying an additional amount to avoid delays and trips to the nearest health post. Again, the Mission justifies the CRS program in terms of its capacity to (1) expand coverage by reaching those who need commodities and cannot go to a health post at any given time; (2) reduce the pressure of the demands on public services, and (3) directly involving the private sector in family planning services.

The MOH system will continue to operate in basically the same way as it has for several years. MOH as well as CCSS clients who cannot afford commercially priced (imported) commodities, but who can afford CRS products will now have a choice. Eventually, as the CRS program becomes established and well known, the public services will concentrate on the poorest of the poor, and the CRS system will serve those with a little more financial flexibility. Different services for different clientele.

G. Management of the CRS Program

The CRS program will be managed by ASDECOSTA under a contract with ADC. AID will supply all commodity needs during life of project to guarantee the generation of substantial income by end of project. ASDECOSTA

will have up to five employees including a general manager, an assistant, two sales persons and perhaps a secretary. ADC's administrative and accounting structures will support ASDECOSTA. In addition, ASDECOSTA will purchase services from advertising and market research agencies and may use the distribution network of a nationwide direct distributor if such an option offers greater coverage and/or significantly larger sales. For several months now, ASDECOSTA officials have been in contact and negotiating with advertising and market research agencies, legal advisors and even with a few direct distributors and wholesalers. With the assistance of CRS experts, ASDECOSTA has developed selection criteria which will be included in their proposal to USAID/CR for a CRS program, and will determine final selection decisions.

The Family Planning Self Reliance Project will finance quarterly evaluation/monitoring/technical assistance interventions by a CRS expert for at least the first three years of operations. An adequate amount is also earmarked for short term expert assistance to deal with implementation problems as they arise.

Although this model is somewhat different from management structures selected by other CRS programs in the region, it satisfies ST/PCP, LAC/DR, and USAID/CR requirements for adequate management of activities and control of project resources.

H. Legal Analysis

See Annex A and Annex I. Legal adviser to ASDECOSTA, Attorney Alfredo Bolaños has determined in his legal analysis (Annex I) that ASDECOSTA S. A. complies with all legal requirements and can implement the CRS program as described in Section III. C. of this document. The Project Agreement to be signed by USAID/CR and ADC will include all conditions requested by AID/W approval cables, Annex A, and Section VI. E. of this document.

I. Beneficiaries

The following table indicates ADC estimates in terms of continuous acceptors per program and year.

| Year | Public Sector Program (000) | CRS Program (000) | Total |
|------|--------------------------------|----------------------|-------|
| 1983 | 95.0 | -- | 95.00 |
| 1984 | 95.5 | 17.5 | 113.0 |
| 1985 | 100.0 | 31.5 | 131.5 |
| 1986 | 100.0 | 41.0 | 141.0 |
| 1987 | 100.0 | 50.0 | 150.0 |
| 1988 | 100.0 | 55.0 | 155.0 |

In addition to the number of continuous acceptors, between 60,000 and 75,000 women in fertile ages will benefit each year from program services such as family planning information and education, surgical contraception for health reasons (as authorized by the appropriate medical and legal codes), family planning consultas with impact on maternal and/or child health and program commodities. Thus, during life of project an annual average of approximately 200,000 women will benefit from the planned activities.

Between 70 and 80 percent of the beneficiaries belong to the poorest economic classes, and will receive services through CCSS and MOH programs. Because the CRS program will also focus on beneficiaries in the lower economic classes, most of the remaining 20-30 percent of the beneficiaries will belong to these categories. However, it is expected that a small number of middle-high class citizens will take advantage of the CRS program. None of the wealthier citizens are expected as beneficiaries.

J. The Public Sector Program

The public sector program will be implemented by the CCSS and the MOH. These two organizations already have well established family planning service delivery networks which have been operating since the late 1960s. Both institutional programs are managed by capable professionals unquestionably committed to family planning/responsible parenthood objectives.

The Family Planning Self Reliance project will use the CCSS training center (Centro de Docencia) to sponsor intensive family planning training and motivation courses to reach medical and administrative personnel of the CCSS and MOH involved in service delivery. Those who have never received adequate family planning training as a result of the 1978-82 GOCR policies will receive comprehensive training. Those in need of refresher courses will receive them and all trainees will be motivated to provide effective and efficient family planning services consistent with the policies of the current GOCR administration.

Internal and external evaluations of the MOH and CCSS service delivery programs have indicated that more and better trained supervisors will be required to improve effectiveness of services, efficiency of procedures and to minimize beneficiary dissatisfaction. USAID/CR has already earmarked PD&S resources to train trainer/supervisors. As indicated in Annex D, project resources will also be used to sponsor in-country service delivery supervision courses. Elements of effective supervision will be included in other courses to be offered at the CCSS training center.

VI. PROJECT IMPLEMENTATION

A. Administrative Arrangements

1. Responsibilities

Project implementation will be the responsibility of the Costa Rican Demographic Association (ADC). For activities carried out by

other agencies or ministries under this project, ADC will have responsibility for providing administrative assistance as required, guidance for effective planning and management, approval of specific activities and/or plans (jointly with USAID) and for periodic internal evaluations. A joint ADC/USAID Project Implementation Committee will meet at least on a quarterly basis to review progress and problems based upon information contained in comprehensive quarterly reports, which will be prepared by the ADC staff on a reporting format to be provided by USAID. After the signing of the AID/ADC Project Agreement, ADC will be responsible for preparing and obtaining USAID's approval of all sub-agreements and contracts required for project implementation.

2. Financial Management

Standard AID disbursement procedures will apply.

3. Procurement

AID funded commodities will be procured in accordance with AID and host country contracting procedures and requirements. This project will finance all commodity needs of the CRS program up to a total of \$485,000. All purchases of contraceptive commodities will be coordinated with the Office of Population (AID/W - ST/POP) in order to obtain best quality, price and terms of delivery. The project may also finance a few purchases of small equipment if this is required by CCSS and MOH service delivery units. USAID/CR will be responsible for preparing purchase orders and/or contracts to finance short-term technical assistance services.

4. Training

As a significant step toward the revitalization of the national population program, and specifically, the family planning service delivery networks, training is a key component of the programs supported by the project between 1983 and 1988.

The planned training initiatives, described in detail in ADC's proposal (Annex D) aim to reach at least 1,300 CCSS and MOH officials involved in every phase of family planning service delivery. Thus, thorough emphasis will be placed on the professionals who deliver the service, support staff such as auxiliary nurses, clerks and secretaries will also be receiving some training to improve their skills in the handling of family planning clients.

The ADC's staff will be responsible for design, preparation and organization of these courses. Close collaboration with the CCSS and the MOH will be required to guarantee the participation of key officials and institutional support for the programmatic adjustments that should follow once the officials return to their positions.

5. Contraceptive Retail Sales Program

As described in detail in the Futures Group's three reports (Annex I), this project component will be implemented by ASDECOSTA under contract with ADC. A marketing research agency and an advertising agency sub contracted by ASDECOSTA with project resources will advise ASDECOSTA on all marketing concerns. A legal advisor, also financed with project resources, will be responsible for addressing all legal matters affecting registration, marketing and sales of contraceptives. USAID/CR will contract the services of a CRS expert familiar with the national program to visit Costa Rica on a quarterly basis. In each visit the consultant will analyze and evaluate progress, and formulate plans and recommendations for future implementation tasks.

6. Self Reliance

This project component will require a significant amount of short-term technical assistance support. First of all, consultants collaborating with ADC and USAID/CR will analyze the Costa Rican institutional environment and define a universe of possibilities to diversify and expand the ADC's financial base. ADC and USAID/CR will establish priorities from the total number of options and request the assistance of AID/W and intermediaries such as DA, Futures Group and John Hopkins University to identify experts in each area.

The experts will be contracted, and during short-term interventions will be expected to draft action plans for ADC to implement. Experts can also design pilot projects to be financed under this component and to initiate productive activities in the most promising areas.

Even though consultants will work directly and more closely with ADC than with USAID/CR, the Mission will require briefings and debriefings covering each visit and will approve each initiative in this area requiring project funds prior to its inception. All activities to be financed will be evaluated primarily in terms of their potential to generate income, serve the objectives of the national population program and increase private and commercial sector participation in family planning.

B. Monitoring Plan

USAID/Costa Rica's General Development Division (GDD) will monitor this Project and will have the following responsibilities:

1. Project Management and Monitoring

The Project Manager will be the Assistant General Development Officer responsible for all Human Resources activities. He/she will act as Population Officer. The Population Officer will work closely with ADC management and staff, and can work directly with CCSS, MOH and ASDECOSTA personnel if and when implementation decisions require it. The

Population Officer will represent Mission views in negotiations with other donors, AID intermediaries and AID/W support offices. The Population Officer can be assisted by the Program Assistant(s) working in GDD to perform any of the above mentioned tasks. One person under a personnel services contract will also assist the Population Officer in all implementation and monitoring activities.

The Mission's Loan/Projects Office will backstop project implementation and ensure that adequate control and management methods are being used. It will participate in the preparation and negotiation of the Project Agreement, implementation letters, and will review materials and correspondence related to project design and implementation.

2. Joint Reviews

Joint reviews, undertaken by AID and ADC (MOH, CCSS and/or ASDECOSTA, as needed) representatives, will be held at least quarterly and will be an essential feature of project implementation.

3. Evaluation

The Mission's Population Officer working with the Mission's Evaluation Office will coordinate periodic evaluations as planned in Section C, which follows.

C. Evaluation Arrangements

Periodic evaluations will be an important tool for USAID/CR to measure project progress and to determine what modifications might be made in the project components. The evaluations will measure (1) progress toward the three major project purposes and (2) the performance of ADC as the implementing entity and of the MOH and the CCSS as sub-implementing entities.

Specifically, evaluations will: (1) use service statistics produced by the CCSS and the MOH to determine level of availability of services, counseling and commodities at CCSS and MOH facilities throughout the country; (2) use ASDECOSTA reports to determine volume of commercial activity, and discuss performance of factors such as pricing, packaging, marketing schemes and distribution networks in terms of sales and coverage objectives; (3) use ADC records to review self-reliance projects and activities carried out during a given period and their impact on ADC plans to expand and diversify its financial base; (4) use ADC, CCSS and MOH records as well as independent surveys to determine quantity, quality and effectiveness of I&C activities seeking to influence public opinion on family planning issues, motivate FP programs workers and inform FP program clients.

A tentative evaluation schedule follows:

First evaluation: November, 1984
Second evaluation: January, 1986
Final Evaluation: September, 1988.

Based on project performance and needs, USAID/CR and the ADC will review this tentative schedule and carry out or reprogram evaluation activities accordingly.

D. Conditions and Covenants

In addition to the standard conditions and covenants, the project agreement will contain the following:

- a) AID must approve all contracts signed by ADC or ASDECOSTA for activities financed under this project.
- b) Prior to disbursement of funds under the CRS component of the project, ADC and ASDECOSTA must submit to USAID/CR a legally binding document stating that: 1) ADC owns 100% of the ASDECOSTA shares; 2) No ASDECOSTA stock will be transferred, sold, or encumbered; 3) All profits generated by ASDECOSTA's commercial activities will be reinvested in ADC or ASDECOSTA activities in support of the National Family Planning Program, and 4) ASDECOSTA will not declare dividends or incur, indebtedness, other than short term obligations for normal operating expenses, without AID approval during the life of the project.
- c) AID must approve any modification or change to ASDECOSTA's corporate charter during the life of the project.
- d) ASDECOSTA will carry out detailed bookkeeping to assure that project funds are not used for other commercial ventures.
- e) Key ASDECOSTA personnel and their respective salaries must be approved by AID.
- f) ADC and ASDECOSTA will be subject to an annual external audit.

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TELEGRAM

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P 022305Z NOV 82
FM SECSTATE WASHDC
TO AEMBASSY SAN JOSE PRIORITY 1336-37
BT
UNCLAS STATE 308241

Rec'd 11/14/82

TO: *G.D.S./HR*

ACTION TAKEN:

INITIALS:

AIDAC

E.O. 12356: N/A
TAGS:
SUBJECT:FAMILY PLANNING SELF RELIANCE PID (515-0618)

1. THE DAEC REVIEWED AND APPROVED THE SUBJECT PID ON OCTOBER 15, 1982. THE FOLLOWING COMMENTS AND GUIDANCE ARE PROVIDED TO ASSIST THE MISSION IN PROJECT DEVELOPMENT AND PREPARATION OF THE PROJECT PAPER.

2. ECONOMIC ANALYSIS AND FINANCIAL CONSIDERATIONS.

-- A. THE PID STATED THAT ALTHOUGH FAMILY PLANNING IS ONCE AGAIN A PRIORITY IN COSTA RICA, THE GOCR WILL HAVE TO CUT BACK ON BUDGETARY SUPPORT FOR PUBLIC SECTOR INSTITUTIONS, INCLUDING FUNDING FOR FAMILY PLANNING PROGRAMS, DUE TO THE CURRENT ECONOMIC SITUATION. GOCR'S COMMITMENT TO FAMILY PLANNING PROGRAMS AND ITS WILLINGNESS AND ABILITY TO PROVIDE ADEQUATE COUNTERPART FUNDING AND PERSONNEL SHOULD BE CLEARLY STATED IN THE PP. THE FINANCIAL PLAN IN THE PP SHOULD INCLUDE A BREAKDOWN OF PROJECTED COSTS TO THE GOCR UNDER THE PROJECT, AS WELL AS HOW THE GOCR PLANS TO COVER THOSE COSTS.

-- B. IT WAS STATED IN THE PP THAT INTERMEDIARY SUPPORT OF AND PARTICIPATION IN THE PROJECT WOULD BE REQUIRED OVER THE NEXT THREE YEARS. THE MISSION PLAN TO ENSURE THE PARTICIPATION OF THESE ORGANIZATIONS, SUCH AS IPPF AND UNFPA, SHOULD PLACE SPECIAL EMPHASIS ON THEIR ABILITY TO PROVIDE THE REQUIRED LEVEL OF SUPPORT SPECIFIED IN THE PID DURING A PERIOD OF GENERAL CUTBACKS OF FUNDS FOR FAMILY PLANNING ACTIVITIES IN THE REGION.

-- C. WE EXPECT THIS TO BE THE LAST BILATERAL POPULATION PROJECT FOR COSTA RICA. THE PP SHOULD REFLECT THIS, AND SHOULD DETAIL SPECIFIC ACTIONS OR ACTIVITIES WHICH WILL LEAD TO COSTA RICA'S SELF RELIANCE IN FAMILY PLANNING, AS WELL AS A DETAILED PLAN FOR A.I.D. PHASE-OUT IN THIS SECTOR, TERMINATING AT THE CONCLUSION OF THIS PROJECT.

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3. SOURCE AND FUNDING FOR COMMODITIES. AS STATED IN THE PID, THE SUPPLY AND AVAILABILITY OF COMMODITIES WILL BE CRUCIAL TO THE SUCCESSFUL IMPLEMENTATION OF THE FAMILY PLANNING PROGRAM, ESPECIALLY THE CRS COMPONENT. THE CURRENT PROJECT BUDGET PROVIDES APPROXIMATELY 30 PER CENT OF TOTAL PROJECT FUNDING (DOLS. 1.36 MILLION OF THE TOTAL DOLS. 4.4 MILLION) FOR THE PURCHASE OF COMMODITIES, YET THE SOURCE AND FUNDING OF THE COMMODITIES ARE UNCLEAR. THE PP SHOULD ADDRESS THE FOLLOWING ISSUES CONCERNING COMMODITIES: A COMPLETE ANALYSIS OF TOTAL COMMODITY REQUIREMENTS, THE DATA ON WHICH THESE REQUIREMENTS ARE BASED, AND THE SOURCE OF SUPPLY AND PROJECTED COST OF THE COMMODITIES. IN RELATION TO THE IPPF'S SOURCE OF SUPPLY FOR COMMODITIES, THE PP SHOULD INCLUDE A DETAILED ANALYSIS OF AID COMMODITY FLOWS THROUGH INTERMEDIARIES TO COSTA RICA.

4. IMPLEMENTING AGENCIES. THE RELATIONSHIP BETWEEN IMPLEMENTING AGENCIES AS WELL AS EACH ENTITY'S ROLE AND RESPONSIBILITY IN THE DELIVERY OF FAMILY PLANNING SERVICES SHOULD BE EXPLICITLY STATED IN THE PP. THERE SHOULD ALSO BE A DISCUSSION OF HOW THE ACTIVITIES OF THE VARIOUS INSTITUTIONS WILL BE COORDINATED TO ENSURE THAT THE PUBLIC AND COMMERCIAL COMPONENTS WILL NOT DUPLICATE ACTIVITIES.

5. COMMERCIAL RETAIL SALES (CRS) COMPONENT.

-- A. DURING DEVELOPMENT OF THE PP, THE RATIONALE FOR THE ESTABLISHMENT OF A CRS PROGRAM SHOULD BE BETTER ARTICULATED. MORE DETAIL IS NEEDED IN THE FOLLOWING AREAS: THE EFFECTIVENESS AND COVERAGE OF THE CURRENT COMMERCIAL SALES SYSTEM; HOW THE PROPOSED CRS PROGRAM

WILL DIFFER FROM/IMPROVE UPON THE CURRENT COMMERCIAL SALES SYSTEM; MARKET SEGMENTATION AS IT RELATES TO THE CRS COMPONENT TARGET POPULATION; THE EFFECTIVE DEMAND FOR THE COMMODITIES TO BE SUPPLIED THROUGH THE CRS COMPONENT; THE EXTENT TO WHICH THE CRS COMPONENT WILL EXPAND THE USAGE OF FAMILY PLANNING SERVICES; PRICING STRATEGIES AND EVIDENCE THAT THE TARGET POPULATION IS WILLING AND ABLE TO PAY THE PRICES FOR CONTRACEPTIVES UNDER THE CRS PROGRAM.

-- O. A DETAILED EXPLANATION OF HOW THE CRS COMPONENT OF THE PROJECT WILL BE MANAGED AND BY WHOM IS NEEDED. PROJECT MANAGEMENT FOR THE CRS PROGRAMS IN OTHER COUNTRIES HAS FOLLOWED TWO MODELS. THE MOST FREQUENT PRACTICE HAS BEEN FOR THE MISSION OR AID/W TO CONTRACT WITH A U.S. CONSULTING FIRM, USUALLY FOR A 3-YEAR PERIOD, TO PROVIDE TECHNICAL ASSISTANCE AND TO SERVE AS THE CONDUIT FOR THE FLOW OF FUNDS TO THE CRS COMPONENT ACTIVITIES. AN ALTERNATIVE PROCEDURE BEING TRIED IS FOR

THE MISSION TO CONTRACT WITH A LOCAL FIRM WHICH MANAGES THE IMPLEMENTATION OF THE CRS PROGRAM. MISSION SHOULD CONSIDER BOTH MODELS IN THE SELECTION PROCESS AND JUSTIFY ITS DECISION IN THE PP.

-- C. DURING THE DAEC REVIEW CONCERNS WERE RAISED IN REFERENCE TO THE ESTABLISHMENT BY ADC OF A NEW ENTITY, ASDECOSTA, TO PERFORM THE CRS FUNCTION. IN ORDER TO ENSURE THAT ASDECOSTA HAS THE ABILITY AND SUPPORT TO CARRY OUT THIS FUNCTION, AN INSTITUTIONAL/LEGAL ANALYSIS OF BOTH ADC AND ASDECOSTA SHOULD BE PREPARED FOR INCLUSION IN THE PP. THIS ANALYSIS SHOULD INCLUDE INFORMATION ON: THE RATIONALE FOR ESTABLISHMENT OF ASDECOSTA AS A PROFIT MAKING ENTITY; ASDECOSTA'S LEGAL BASIS AND ORGANIZATIONAL STRUCTURE, INCLUDING A REVIEW OF THEIR CHARTER, INFORMATION ON SHAREHOLDERS, BOARD OF DIRECTORS AND PRINCIPAL EXECUTIVE OFFICERS; AID OVERSIGHT OR CONTROL OVER ISSUANCE OR TRANSFER OF STOCK, MODIFICATION OF OR CHANGES IN ITS CORPORATE CHARTER, ENTERING INTO ANY CONTRACTS FINANCED BY AID, DECLARING ANY DIVIDENDS OR INCREASING INDEBTEDNESS (OTHER THAN SHORT-TERM OBLIGATIONS FOR NORMAL OPERATING EXPENSES), AND COMMERCIAL ACTIVITIES OTHER THAN THOSE DIRECTLY RELATED TO THE CRS PROGRAM. THIS INSTITUTIONAL/LEGAL ANALYSIS SHOULD BE SUBMITTED IN THE FORM OF AN INTERIM REPORT TO AID/W FOR REVIEW AND APPROVAL PRIOR TO MISSION APPROVAL OF THE PROJECT.

6. BENEFICIARIES. DURING PP DEVELOPMENT THE MISSION SHOULD EXPAND UPON AND CLARIFY THE SECTION DEALING WITH PROJECT BENEFICIARIES. THIS SHOULD INCLUDE A MORE DETAILED BREAKDOWN OF BENEFICIARIES BY PROJECT COMPONENT OVER LIFE OF PROJECT AND AS WELL AS BY INCOME GROUP.

7. PUBLIC SECTOR PROGRAMS. THE PP SHOULD EXPAND UPON THE ANALYSIS OF THE CAPABILITIES, PROBLEMS, AND REQUIREMENTS OF PUBLIC SECTOR INSTITUTIONS (MOH, CCSS, ETC.) INVOLVED IN THE DELIVERY OF FAMILY PLANNING SERVICES. THIS SHOULD INCLUDE A SECTION ON CURRENT ACTIVITIES, HOW THESE ACTIVITIES RELATE TO OR WILL BE AFFECTED BY THE PROPOSED PROJECT, AND THE ABILITY OF THESE INSTITUTIONS TO DELIVER AND ADMINISTER EXPANDED FAMILY PLANNING SERVICES.

8. PROJECT DEVELOPMENT AND APPROVAL. MISSION SHOULD PROCEED WITH PP DEVELOPMENT. MISSION LEVEL APPROVAL OF THE PP WAS APPROVED BY THE DAEC BUT SHOULD NOT OCCUR UNTIL AFTER AID/W REVIEW AND APPROVAL OF THE INTERIM REPORT REQUESTED ABOVE. THE INTERIM REPORT SHOULD ADDRESS ALL POINTS IN PARAGRAPH 5, SECTIONS B AND C.

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CLASS: UNCLASSIFIED
CHRG: AID 23/21/83
APPRV: AMDIR:BSCHOUTEN
DRFID: GDD:CPOZA:VRV
CLEAR: 1.GDO:TMCKEE
2.PO:OLUSTIG
DISTR: AMB DCM MDIR
DDIR GDD RF

AIDAC

FOR: ROBERT CORNO, LAC/IR/POF
- TONY BONI, ST/POF

E.O. 12356: N/A
SUBJECT: FAMILY PLANNING SELF RELIANCE PROJECT
- (515-2168) INTERIM REPORT

REF: STATE 32241

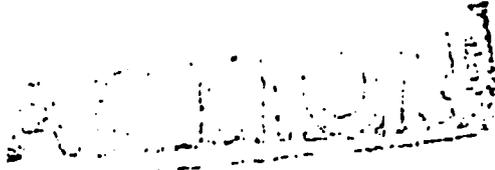
1. IN RESPONSE TO REEDEL, MISSION POUCHED ON 3/21/83 THE INSTITUTIONAL/LEGAL ANALYSIS PERFORMED BY A LOCAL LEGAL FIRM AND BY CSM EXPERT, STEVE SAMUEL, TO CLARIFY POSSIBLE IMPLEMENTATION PROCEDURES AND CONFIRM AIC AND ASDECOSTA'S CAPACITY TO IMPLEMENT THE CRS COMPONENT OF SUBJECT PROJECT.
2. AID/W ALREADY HAS SAMUEL'S FIRST REPORT WHICH CONCLUDES THAT A CSM PROJECT IS NECESSARY AND FEASIBLE IN COSTA RICA.
3. DURING THE LAST TWO WEEKS OF APRIL, WITH THE ASSISTANCE OF BOB CORNO AND POSSIBLY STEVE SAMUEL AND A ST/POF REPRESENTATIVE, USAID/CR WILL MAKE A FINAL DETERMINATION ON THE MOST APPROPRIATE MEANS TO MANAGE SUBJECT PROJECT AND SPECIFICALLY, ITS CRS COMPONENT. AT THIS TIME THE MISSION FAVORS A SYSTEM TO CHANNEL PROJECT RESOURCES THROUGH ADC TO ASDECOSTA. ADC, ONCE THE MANAGER COORDINATOR FOR THE WHOLE NATIONAL POPULATION PROGRAM, HAS THE INSTITUTIONAL CAPACITY TO CONTROL THESE FUNDS AND MONITOR ASDECOSTA'S OPERATIONS.
4. USAID/CR WILL REQUIRE ADC ACCEPTANCE OF THE FOLLOWING CONTROLS PRIOR TO APPROVAL OF THE ABOVE MENTIONED SYSTEM:
 - A) INDEPENDENT AUDITING BY OUTSIDE LOCAL ACCOUNTING FIRM OF INTERNATIONAL STANDARD.
 - B) RESIDENT TECHNICAL ASSISTANCE ADVISOR REPORTING TO THE AID MISSION.
 - C) PERIODIC EVALUATIONS BY EXPERIENCED CSM CONSULTANTS.
 - D) PREPARATION BY ADC OF A PROGRAM PLAN EACH QUARTER, APPROVED BY SPECIAL COMMITTEE.
 - E) SUBSTANTIAL DAY-TO-DAY OVERSIGHT BY AID/SAN JOSE STAFF, PARTICULARLY DURING INITIAL IMPLEMENTATION STAGES.

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SAN JOSE 1986

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21-MAY-83
TOR: 18:10
CN: 15567
CHRG: AID
DIST: AID

ADD AID

NO. 12356: N/A

TAGS:

SUBJECT: POPULATION: INTERIM REPORT ON INSTITUTIONAL AND
LEGAL ANALYSIS: FAMILY PLANNING SELF RELIANCE (515-0615)

REF: STATE 309241 DATED 11/2/82

1. MISSION'S JUDGEMENT TO CONTRACT WITH LOCAL FIRM TO
MANAGE CRS PROGRAM AS OPPOSED TO US CONSULTING FIRM
APPEARS REASONABLE GIVEN ADC ACCEPTANCE OF CONDITIONS
DESCRIBED IN SAMUEL'S REPORT.

2. MANAGERIAL AND POLITICAL RATIONALE FOR ESTABLISHING
ASDECOSTA IS CLEAR. ASDECOSTA'S LEGAL BASIS IS SOUND,
LAW REGISTERED FOR-PROFIT ORGANIZATION WITH CHARTER
ADEQUATE TO PURPOSES OF THIS PROJECT AND IN COMPLIANCE
WITH COSTA RICAN LAW. ISSUES RELATED TO SHAREHOLDERS,
BOARD OF DIRECTORS, AND EXECUTIVE OFFICERS APPEAR
RESOLVED.

3. AID OVERSIGHT APPEARS ASSURED BY PLANNED CONTRACTUAL
PROVISIONS WHICH STIPULATE THAT (1) ADC WILL OWN 100% OF
ASDECOSTA STOCK (THEREFORE, WILL AUTOMATICALLY RECEIVE
ALL DIVIDENDS), (2) NO ASDECOSTA STOCK WILL BE
TRANSFERRED, SOLD OR ENCUMBERED WITHOUT AID APPROVAL,

(3) NO CHANGES IN ASDECOSTA CHARTER CAN BE MADE WITHOUT
PRIOR NOTIFICATION TO AND CONCURRENCE BY AID, (4) ALL
CONTRACTS WITH ASDECOSTA MUST BE APPROVED BY AID,
(5) ASDECOSTA WILL CARRY OUT DETAILED BOOKKEEPING TO
ASSURE THAT NO PROJECT FUNDS ARE SPENT ON OTHER
COMMERCIAL VENTURES, (6) KEY ASDECOSTA PERSONNEL AND
THEIR RESPECTIVE SALARIES MUST BE APPROVED BY AID AND
(7) ASDECOSTA CANNOT DECLARE DIVIDENDS OR INCUR
DEBT (OTHER THAN SHORT TERM OBLIGATIONS FOR
NORMAL OPERATING EXPENSES) WITHOUT AID APPROVAL. THESE
PROVISIONS SHOULD BE CAREFULLY STATED IN AID MISSION
GRANT AGREEMENT WITH ADC WHICH MUST BE CLARIFIED WITH SOME
AID LAWYER.

4. SAMUEL HAS BEEN ADVISED BY COSTA RICAN LAWYER BOLANO
THAT AN ARCHAIC LAW RESTRICTING CONTRACEPTIVE ADVERTISING
WILL MOST LIKELY NOT BE ENFORCED. CAUTION IS THEREFORE
ADVISED IN MISSION APPROVING ADVERTISING CAMPAIGN.

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5. AID/W FINDS INTERIM REPORT ACCEPTABLE AND RECOMMENDS
THAT MISSION MOVE AHEAD WITH PROJECT DEVELOPMENT AND
APPROVAL. SEULTZ

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|-------------------|--------------------------------------|-------------------------|---------------------------|
| PAGE NO. 3M-10 | EFFECTIVE DATE September 30, 1982 | TRANS. MEMO NO. 3:43 | AID HANDBOOK 3, App 3M |
|-------------------|--------------------------------------|-------------------------|---------------------------|

5C(?) PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A. includes criteria applicable to all projects. Part B. applies to projects funded from specific sources only: B.1. applies to all projects funded with Development Assistance Funds, B.2. applies to projects funded with Development Assistance loans, and B.3. applies to projects funded from ESP.

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

Except as noted below , country checklist in AID/LAC/P-123 is up to date**
Yes.

A. GENERAL CRITERIA FOR PROJECT

1. FY 1982 Appropriation Act Sec. 523; FAA Sec. 634A; Sec. 653(D).

Included in Congressional Presentation, FY83

(a) Describe how authorizing and appropriations committees of Senate and House have been or will be notified concerning the project;
(b) is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than \$1 million over that amount)?

2. FAA Sec. 611(a)(1). Prior to obligation in excess of \$100,00, will there be

Yes.

**As of Mar. 18, 1983, Costa Rica was in violation of 620Q of the FAA; the Secretary of State made an exception, for FY 1983

(a) engineering, financial or other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

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

N/A

4. FAA Sec. 611(b); PY 1982 Appropriation Act Sec. 501. If for water or water-related land resource construction, has project met the standards and criteria as set forth in the Principles and Standards for Planning Water and Related Land Resources, dated October 25, 1973? (See AID Handbook 3 for new guidelines.)

N/A

5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project?

N/A

6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.

No. Project is Costa Rica specific in terms of private and public organizations involved, and target groups addressed.

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

- a) No, except to encourage the use of US contraceptives
- b) Yes, by helping the Family Planning activities of ADC a private voluntary organization and by creating a private commercial retail sales (CRS) program
- c) No.
- d) Yes, by creating a CRS program which will provide price competition in the local contraceptive market.
- e) N/A
- f) N/A

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

Project will make use of US produced contraceptives, and will draw in part on US based Technical advisors.

9. FAA Sec. 612(b), 636(b);
FY 1982 Appropriation
Act Sec. 507. Describe
 steps taken to assure
 that, to the maximum
 extent possible, the
 country is contributing
 local currencies to meet
 the cost of contractual
 and other services, and
 foreign currencies owned
 by the U.S. are utilized
 in lieu of dollars.
- Costa Rica is providing
 a substantial contribution
 to the project in local
 currency. The US owns no
 Costa Rican currency.
10. FAA Sec. 612(d). Does
 the U.S. own excess
 foreign currency of the
 country and, if so, what
 arrangements have been
 made for its release?
- N/A
11. FAA Sec. 601(e). Will
 the project utilize
 competitive selection
 procedures for the
 awarding of contracts,
 except where applicable
 procurement rules allow
 otherwise?
- Yes.
12. FY 1982 Appropriation Act
Sec. 521. If assistance
 is for the production of
 any commodity for export,
 is the commodity likely
 to be in surplus on world
 markets at the time the
 resulting productive
 capacity becomes
 operative, and is such
 assistance likely to
 cause substantial injury
 to U.S. producers of the
 same, similar or
 competing commodity?
- N/A
13. FAA 118(c) and (d).
 Does the project comply
 with the environmental
 procedures set forth in
 AID Regulation 16? Does
- Yes

the project or program take into consideration the problem of the destruction of tropical forests?

14. FAA 121(d). If a Sabel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (dollars or local currency generated therefrom)?

N/A

.. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FAA Sec. 102(b), 111, 113, 281(a). Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and

a) The project will insure wide participation of the poor in the benefits of development by extending access to affordable family planning services at the local level.

b) N/A

c) The project will rely on the local resources and self help or a variety of local public and private agencies in implementation.

d) Women and women's organizations will be direct project beneficiaries.

e) N/A

otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries?

b. FAA Sec. 103, 103A, 104, 105, 106. Does the project fit the criteria for the type of funds (functional account) being used?

Yes.

c. FAA Sec. 107. Is emphasis on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?

N/A

d. FAA Sec. 110(a). Will the recipient country provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?

Yes

e. FAA Sec. 110(b).

Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to Congress been made, and efforts for other financing, or is the recipient country "relatively least developed"? (M.O. 1232.1 defined a capital project as "the construction, expansion, equipping or alteration of a physical facility or facilities financed by AID dollar assistance of not less than \$100,000, including related advisory, managerial and training services, and not undertaken as part of a project of a predominantly technical assistance character.

N/A

f. FAA Sec. 122(b). Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?

The activity gives reasonable promise of contributing to self-sustaining economic growth by lowering the population growth rate.

g. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage

The project recognizes the economic necessity and the desire of the people to limit their family size, and will provide information and education to enable people to make rational decisions about family planning.

institutional development;
and supports civil
education and training in
skills required for
effective participation in
governmental processes
essential to self-government.



Alberto Fait L.
PRIMER VICEPRESIDENTE
DE LA REPUBLICA

ANNEX D

PVP-238/83
22 de junio de 1983

Señor
Bastiaan Schouten
Director a. i.
A. I. D.

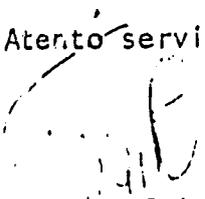
Estimado señor:

Me permito informarle que este Despacho ve con agrado las oportunidades de financiamiento que esa Agencia viene dispensando al País a través de organismos pertenecientes a la iniciativa privada y activos en distintos campos de acción, por medio de los cuales se complementa o se apoya la acción gubernamental.

Dentro de ese marco de referencia se sitúa la Asociación Demográfica Costarricense, la que ha dado una contribución importante al País a través de 17 años de existencia, habiendo sido reconocida "de utilidad pública para los intereses del Estado", mediante Decreto Ejecutivo N° 422-J del 7 de abril de 1983.

Al hacer lo anterior de su conocimiento me es grato suscribirme de usted,

Atento servidor,


Alberto Fait L.

AFL/je



ANNEX E

SCHEDULE OF MAJOR EVENTS

1983

- June 15 Mission PP review.
June 20 Authorization.
June 30 a) Obligation of funds.
b) ADC presents to USAID final plan for implementation of CRS program.
July 15 Contract with CRS consultant signed.
July 31 Agreement between ADC and the CCSS for training activities signed.
August 15 a) Agreement between ADC and ASDECOSTA for implementation of CRS program signed.
b) First visit of CRS consultant.
August 31 a) Initiate contacts with ST/POP to prepare PIO/C for first shipment of commodities. Finalize arrangements for local registration of commodities.
b) Initial CRS marketing analysis completed.
September 15 a) ASDECOSTA negotiates contracts with advertising and marketing firms for CRS activities.
b) Training program coordinator is hired by ADC and meets with CCSS personnel to finalize plans and schedules for training center activities to revitalize the public sector program.
September 30 a) First formal coordination meeting between USAID and ADC.
b) ADC presents plan for self reliance activities during last quarter of 1983 and 1984.
October 15 Initiate formal preparation of training courses and motivational seminars.
October 31 ADC presents IEXC plan for remainder of 1983 and 1984.
November 15 First formal feedback/problem solving meeting; USAID, ADC, MOH and CCSS.
November 30 Distribution of new educational/motivational materials begin.
December 15 Second formal coordination meeting. Plans for 1984 reviewed.

1984

1st Quarter:

- 1- First training course for doctors and nurses.
- 2- First training course for secretaries and medical auxiliaries.
- 3- Coordination meeting.
- 4- Feedback/problem solving meeting.
- 5- Visit by CRS project consultant. Monitoring, programmatic recommendations.
- 6- First motivational seminar for unit directors.

2nd Quarter:

- 1- Initiate sales of CRS products supplied by AID and registered in Costa Rica by ADC.
- 2- First training course for multiplier personnel.
- 3- T.A. assistance for self reliance activities.
- 4- Visit by CRS project consultant. Monitoring.
- 5- Coordination and feedback/problem solving meetings with implementing and sub-implementing entities.

3rd Quarter

- 1- Initial CPS activities for 1985 survey.
- 2- Advertising campaign for CRS products.
- 3- Marketing analysis support continues.
- 4- IE&C activities are intensified. More motivational radio spots, new printed materials.
- 5- Visit by CRS program consultant. Monitoring.
- 6- Coordination and feedback/problem solving meetings with implementing and sub implementing entities.

4th Quarter

- 1- Training course for doctors and nurses.
- 2- Training course for multiplier personnel.
- 3- Visit by DA expert to review training activities.
- 4- Coordinator and feedback/problem solving meetings to review progress during 1984 and plan for 1985.
- 5- Plan with IPPF and UNFPA (through ST/POP) 1985 collaboration.
- 6- Visit by CRS program consultant. Annual assessment.

1985

1st Quarter

- 1- Training course for secretaries and nurse auxiliaries.
- 2- T.A. assistance for self reliance activities.
- 3- Visit CRS program consultant. Monitoring.
- 4- Visit by DA expert. Review supervision system for service delivery. Plan remedial activities DA, AID/W and USAID financed.
- 5- Coordination and problem solving sessions.

2nd Quarter

- 1- First Project evaluation.
- 2- Training course for doctors and nurses.
- 3- Visit by Johns Hopkins expert to review IE&C activities.
- 4- Visit by CRS program consultant. Monitoring.
- 5- Visit by LAC/DR/POP and ST/POP officers. Coordination, assessment, programmatic recommendations.
- 6- Policy analysis activities

3rd Quarter

- 1- T.A. assistance for self-reliance activities.
- 2- Visit by CRS program consultant. Monitoring, programmatic recommendations.
- 3- Evaluation follow-up meeting and activities.
- 4- Coordination and problem solving activities
- 5- Policy analysis activities.
- 6- Assessment of ADC performance with IPPf.
- 7- CPS completed (1985).

4th Quarter

- 1- Training course for doctors and nurses.
- 2 Visit by DA expert to assess impact of training activities and to identify any remaining training needs.
- 3- Coordination and feedback/problem solving meetings to review progress during 1985 and plan for 1986.
- 4- Other donor and intermediary coordination and planning.
- 5- Visit by CRS program consultant. Annual assessment.
- 6- Policy analysis assessment. Plan for final efforts in 1986.

1986

1st Quarter

- 1- T.A. assistance for self reliance activities.
- 2- Visit CRS program consultant. Monitoring.
- 3- Follow up on identified training needs.
- 4- Final policy analysis activities.

2nd Quarter

- 1- First self reliance project agreement signed.
- 2- Assessment of IE&C activities (with Johns Hopkins).
- 3- Visit by CRS program consultant.
- 4- Visit by LAC/DR/POP and ST/POP officers. Coordination, assessment, programmatic recommendations.
- 5- Assessment of ADC performance with IPPF.

3rd Quarter

- 1- Second project evaluation.
- 2- T.A. assistance for self reliance.
- 3- Visit by DA training expert. Follow up, monitoring, assessment.
- 4- Visit by CRS program consultant.
- 5- Review of project activities and objectives with new GOCR administration.

4th Quarter

- 1- Second self reliance project agreement signed.
- 2- Evaluation follow-up.
- 3- Other donor and intermediary coordination and planning.
- 4- Coordination and problem solving meetings to review progress during 1986 and plan for 1987.
- 5- Visit by CRS program consultant. Annual assessment.
- 6- Follow up activities with new GOCR officials and ADC.

1987

1st Quarter

- 1- Self reliance project agreement signed (3rd).
- 2- T.A. for self reliance.
- 3- Review and assessment of policy issues.
- 4- CPS activities.

2nd Quarter

- 1- Self reliance project agreement signed (4th).
- 2- T.A. for self reliance.
- 3- Assessment for IE&C activities (with Johns Hopkins).
- 4- Visit by LAC/DR/POP and ST/POP officers. Coordination, assessment, programmatic recommendations.
- 5- CPS activities.

3rd Quarter

- 1- T. A. for self reliance
- 2- Visit by D.A. training expert. Assessment of service delivery supervision system.
- 3- CPS completed (1987).
- 4- Assessment of ADC performance with IPPF.

4th Quarter

- 1- T.A. for self reliance.
- 2- Other donor and intermediary coordination and planning.
- 3- Coordination and problem solving meetings to review progress during 1987 and plan project termination and AID phase-out in 1988.
- 4- Visit by CRS program consultant. Annual assessment.

1988

1st Quarter

- 1- Visit by LAC/DR/POP officers to assess programmatic conditions and plan phase-out of bilateral program.
- 2- T. A. assistance for self reliance activities. Assessment of self reliance projects.
- 3- Assessment of IE&C activities with Johns Hopkins and ST/POP assistance.

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2nd Quarter

- 1- Preparation and coordination for final evaluation.
- 2- Assessment of all self reliance activities, selection and adoption by ADC of proven productive or most promising options.
- 5- Assessment of ADC performance with IPPF.

3rd Quarter

- 1- Final project evaluation.
- 2- Coordination with other donors and intermediaries for orderly AD phase-out.
- 3- Final visit of CRS program consultant. Final assessment and programmatic recommendations.

ANNEX F

CONTRACEPTIVE REQUIREMENTS

The Centers for Disease Control (CDC) have evaluated the national population program's storage capabilities and distribution infrastructure. CDC officials have also collected data on commodity stock levels to determine contraceptive requirements of the public sector program during life of project. The Futures Group has done a similar evaluation/analysis to determine adequate commodity levels for the CRS project component.

With the information gathered by CDC and the Futures Group, the Office of Population (AID/W) has determined current commodity stock levels and projected future needs.

The Office of Population has discussed this information with IPPF and received assurances that all needs will be adequately covered. IPPF has already agreed to supply during the FY 83-84 period a total of 750,000 cycles of Ovral and Feminalin tablets to fully cover calendar 1983 and 1984 needs. IPPF has also agreed to give the AID an adequate monetary allowance to permit local purchases of commodities as required by program needs.

The Office of Population and the LAC Bureau have also negotiated with UNFPA and received assurances from that office to the effect that they will cover any additional contraceptive needs identified by the public sector program during life of project. Therefore, IPPF and UNFPA will be the only AID intermediaries required to supply commodities for the program. USAID/CR does not anticipate participation of any other organization in this area.

The Family Planning Self Reliance Project will provide \$485,000 to fully fund all commodity needs of the CRS project during life of project. Based on the Futures Group analysis (See third Samuels Report, Annex J) this funding level for commodity purchases will guarantee substantial profits for ASDECOSTA by end of project.

The following three tables reflect findings resulting from CDC's interventions. Detailed commodity requirement tables will be prepared annually with assistance from SI/POP and CDC experts.

TABLE 1
COMMODITIES 1983

| | Inventory (Stock level) (A) 1/1/83 | | | New Shipments (B) 1983 | | | Consumption 2, 3 (C) | | | (A+B-C) (D) | d/c |
|----------------|--|-----------|-----------|------------------------------|-----------|------------------------|-------------------------|----------------------------|-----------|------------------|-----|
| | CCSS | A.D.C. | TOTAL | TOTAL | CCSS | A.D.C. MOH OTHER | TOTAL | CONSUMPTION (ASDECOSTA) | TOTAL | TOTAL (YEARS) | |
| Monday | 470,334 | 343,604 | 813,938 | - | 77,475 | 39,598 | 117,073 | | 696,865 | (6.0) | |
| Oval. | 63,855 | 207,002 | 270,857 | - | 273,245 | 126,396 | 399,641 | | 132,824 | (2/12) | |
| Primovlar | 393,816 | 149,695 | 543,511 | - | 138,334 | 143,569 | 281,903 | | | | |
| Nordette | - | - | - | 150,000 | 26,378 | 16,697 | 43,075 | | 106,925 | (2.5) | |
| Microgynon | 51,831 | - | 51,831 | 290,000 | 26,378 | 16,697 | 43,075 | | 298,756 | (6.7) | |
| SUB-TOTAL | 979,836 | 700,301 | 1,680,137 | 440,000 | 541,810 | 342,957 | 884,767 | | 1,235,370 | (1.4) | |
| Condoms | 877,500 | 2,841,900 | 3,719,400 | 5,770,000 | 1,794,569 | 898,753 | 2,693,322 | (2,160,000) | 4,636,078 | (1.7) | |
| | | | | | | | | | 6,796,078 | (2.5) | |
| cremes/Jellies | 5,004 | 12,526 | 17,530 | 10,000 | 7,670 | 5,459 | 13,129 | | 14,401 | (1.1) | |
| Applicators | 1 | 6,246 | 6,247 | 5,000 | 0 | 4,222 | 4,222 | | 7,025 | (1.7) | |
| <u>PIIDS</u> | | | | | | | | | | | |
| Lippes A | 580 | 319 | 899 | 1,500 | 788 | 1,697 | 2,485 | | - 86 | (0) | |
| B | 967 | 2,860 | 3,827 | 4,000 | 869 | 1,894 | 2,763 | | 5,064 | (1.8) | |
| C | 990 | 3,160 | 4,150 | 0 | 571 | 1,588 | 2,159 | | 1,991 | (11/1) | |
| D | 746 | 511 | 1,257 | 1,500 | 31 | 745 | 776 | | 1,981 | (2.6) | |
| Appl. Lippes: | 663 | 3,445 | 4,108 | 0 | 288 | 626 | 914 | | 3,194 | (3.5) | |

TABLE 2

Oral Contraceptive Coupons Collected by ADC Distribution Agents

Costa Rica, 1982

| Type of Post | Blue Coupons* | Green Coupons | Red Coupons | Total |
|---|---------------|---------------|-------------|---------|
| Private pharmacies, "botiquines," and private individuals | 237,017 | 116 | 1,200 | 241,333 |
| Health centers and posts | 43,964 | 925 | 13 | 44,902 |
| TOTAL | 280,981 | 4,041 | 1,213 | 286,235 |

*MOH clinics distribute blue coupons to most of their oral contraceptive users, but they also issue green coupons to those clients too poor to afford the purchase. Private physicians issue red coupons to private patients, but the coupons are redeemed at the same ADC distribution posts.

TABLE 3

Oral Contraceptives Provided by ADC to the CCSS Warehouse
and to MOH Clinics, by Brand, 1977-1982

| | Noriday/Norinyl | | | Ovral | | |
|-------|-----------------|---------|---------|---------|---------|---------|
| | CCSS | MOH | Total | CCSS | MOH | Total |
| 1977 | --- | 34,771 | 34,771 | 250,000 | 69,032 | 319,032 |
| 1978 | --- | 36,805 | 36,805 | -- | 63,126 | 63,125 |
| 1979 | 72,191 | 36,072 | 108,263 | 11,265 | 69,319 | 80,584 |
| 1980 | 300,000 | 23,510 | 323,510 | -- | 71,727 | 71,727 |
| 1981 | 250,200 | 46,188 | 296,388 | -- | 152,217 | 152,217 |
| 1982 | 150,000 | 42,373 | 192,373 | 50,000 | 135,755 | 185,755 |
| TOTAL | 772,391 | 219,719 | 992,110 | 311,265 | 561,176 | 872,441 |

| | Primovlar | | | Other | | |
|-------|-----------|-----------|-----------|---------|-----|---------|
| | CCSS | MOH | Total | CCSS | MOH | Total |
| 1977 | 250,000 | 228,369 | 478,369 | 100,000 | -- | 100,000 |
| 1978 | -- | 198,504 | 198,504 | -- | -- | -- |
| 1979 | 1,051 | 188,591 | 189,642 | 99,480 | -- | 99,480 |
| 1980 | -- | 177,537 | 177,537 | -- | -- | -- |
| 1981 | -- | 114,153 | 114,153 | -- | -- | -- |
| 1982 | -- | 154,403 | 154,403 | -- | -- | -- |
| TOTAL | 251,051 | 1,061,557 | 1,312,608 | 199,480 | -- | 199,480 |

All Brands--Total

| | CCSS | MOH | Total |
|-------|-----------|-----------|-----------|
| 1977 | 600,000 | 332,172 | 932,172 |
| 1978 | -- | 298,435 | 298,435 |
| 1979 | 183,987 | 293,982 | 477,969 |
| 1980 | 300,000 | 272,774 | 572,774 |
| 1981 | 250,000 | 312,558 | 562,758 |
| 1982 | 200,000 | 332,531 | 532,531 |
| TOTAL | 1,534,187 | 1,842,452 | 3,376,639 |

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LAC/DR-IEE-83-7

ENVIRONMENTAL THRESHOLD DECISION

Project Location : Costa Rica

Project Title and Number : Family Planning Self-reliance
515-0108

Funding : \$2,210,000 - Grant

Life of Project : Five years - FY 1983 - FY 1987

IEE Prepared by : Heriberto Rodriquez
General Engineer

Recommended Threshold Decision : Neg. Determination

Bureau Threshold Decision : Concurrence with recommendation

Action : Copy to Daniel A. Chaij
Director, USAID/Costa Rica

U; Copy to Heriberto Rodriquez

: Copy to Susan Schaeffer,

: Copy to IEE file

James S. Hester Date 18 November 1982

James S. Hester
Environmental Officer
Bureau for Latin America
and the Caribbean

ANNEX B

AID 1020-28 (11-73)
SUPPLEMENT 1

**PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK**

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

Life of Project:
From FY 83 to FY 87
Total U.S. Funding \$2,500,000
Date Prepared: July 1, 1982

Project Title & Number: Family Planning Self Reliance (515-0168)

PAGE 1

| NARRATIVE SUMMARY | OBJECTIVELY VERIFIABLE INDICATORS | MEANS OF VERIFICATION | IMPORTANT ASSUMPTIONS |
|---|--|---|--|
| <p>Program or Sector Goal: The broader objective to which this project contributes: (A-1)</p> <p>Promote socioeconomic development and satisfy basic human needs of the Costa Rican poor by increasing access to family planning services and information</p> | <p>Measures of Goal Achievement: (A-2)</p> <p>Decrease of birth rate from 32 to 28 per 1,000 by end of project</p> | <p>(A-3)</p> <p>Contraceptive Prevalence Surveys to be carried out in 1984 and 1988</p> | <p>Assumptions for achieving goal targets: (A-4)</p> <p>Costa Ricans continue perceiving the importance of family planning as a basic human need</p> |

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project: _____
From FY 83 to FY 87
Total U.S. Funding \$2,500,000
Date Prepared: July 1, 1982

Project Title & Number: Family Planning Self Reliance (515-0168)

| NARRATIVE SUMMARY | OBJECTIVELY VERIFIABLE INDICATORS | MEANS OF VERIFICATION | IMPORTANT ASSUMPTIONS |
|---|---|---|---|
| <p>Project Purpose: (B-1)</p> <p>The purpose of this project is to revitalize and expand family planning services through public, private and commercial sector activities</p> | <p>Conditions that will indicate purpose has been achieved: End-of-Project status. (B-2)</p> <p>1) Current family planning users and program beneficiaries of activities funded by the project increase from 150,000 to 200,000</p> | <p>(B-3)</p> <p>1) Contraceptive Prevalence Surveys, 1984 and 1988</p> <p>2) Service statistics by private and public sector participating institutions</p> | <p>Assumptions for achieving purpose: (B-4)</p> <p>1) The new GOCR administration continues to support family planning programs and activities</p> <p>2) Other donor participation minimize impact of GOCR's financial constraints on family planning activities</p> <p>3) Effective coordination established between the MOH, CCSS, the private and commercial sectors on family planning activities</p> <p>4) Spread between rural and urban acceptance levels (currently 90-95%) will be maintained or reduced</p> |

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY 83 to FY 87
Total U.S. Funding \$2,500,000
Date Prepared: July 1, 1982

Project Title & Number: Family Planning Self Reliance (515-0168)

| NARRATIVE SUMMARY | OBJECTIVELY VERIFIABLE INDICATORS | MEANS OF VERIFICATION | IMPORTANT ASSUMPTIONS |
|--|---|---------------------------------|---|
| Project Outputs: (C-1) | Magnitude of Outputs: (C-2) | (C-3) | Assumptions for achieving outputs: (C-4) |
| 1. Public sector participation in the family planning program revitalized and increased to guarantee availability of services, counseling and commodities at CCSS and MOH facilities throughout the country. | 1. 400 MOH and CCSS facilities providing family planning services nationwide. | 1. MOH, CCSS statistics. | 1. CCSS management continues to support national F.P. Program objectives, thus agreeing to train and support its own as well as MOH and private sector personnel. |
| 2. Service delivery capacity of the commercial and voluntary sectors expanded. | 2. Contraceptives available at reduced prices in commercial pharmacies and retail sales outlets. | 2. CRS/ASDECOSTA sales records. | 2. ADC and ASDECOSTA continue receiving GOCR, IPPF and private sector support. |
| 3. Financial self-reliance of all family planning activities enhanced. | 3. ASDECOSTA fully established and covering at least 35% of total program costs with income from sales of family planning/health commodities. | 3. ADC/ASDECOSTA records. | 3. ASDECOSTA, with assistance from Profamilia International and other donors, maintains control of an adequate share of the commercial market for family planning/health commodities. |
| 4. Revitalized IE&C/promotion activities. | 4. Family Planning posters and literature on display and/or available in 400 MOH and CCSS facilities. | 4. MOH, CCSS and ADC reports | 4. Neither the GOCR nor the private groups openly oppose moderate promotion efforts. |

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project: From FY 83 to FY 87
Total U.S. Funding: \$2,500,000
Date Prepared: July 1, 1982

Project Title & Number: Family Planning Self Reliance (515-0168)

| NARRATIVE SUMMARY | OBJECTIVELY VERIFIABLE INDICATORS | MEANS OF VERIFICATION | IMPORTANT ASSUMPTIONS |
|-----------------------------------|--|---|--|
| Project Inputs: (D-1) | Implementation Target (Type and Quantity) (D-2) | (D-3) | Assumptions for providing inputs: (D-4) |
| AID contribution | (\$ US 000s) AID - to: Public Sector 690 Commercial Sales 1,231 Self Reliance 425 Contingency 154 Total: 2,500 | Review of project's financial records. AID project agreements and other donor project agreements. | Inputs are made in a timely fashion. Continued or increased other donor capacity and willingness to meet commitments. |
| ADC/IPPF counterpart contribution | ADC/IPPF Administrative 500 Support Commodities 1,100 IE&C 200 Training 100 T. A. 100 | | |
| Other Donors | UNFPA Administrative 400 Support Training 500 Commodities 100 | | |