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PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION

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525 TWENTY-THIRD STREET, N.W., WASHINGTON, D.C. 20037, U.S.A. CABLE ADDRESS: OFSANPAN

IN REPLY REFER TO: PD-62/3 AID (c) TELEPHONE 223-4700

27 September 1972

Dr. Jarold A. Kieffer
Assistant Administrator
Bureau for Population and
Humanitarian Assistance
Agency for International Development
Department of State
Washington, D.C. 20523

Dear Dr. Kieffer:

I have the pleasure to transmit, herewith, the report of the Evaluation Mission on the activities of the Department of Health and Population Dynamics of the Pan American Health Organization. This report is furnished in accordance with the requirement of Article X of the Grant from the Agency for International Development to the Pan American Health Organization of 1 July 1971, and with Amendment No. 14 placing responsibility for conduct of the evaluation with this Organization.

The three-month delay in providing this report to you was, of course, a consequence of the decision of AID not to carry out the evaluation in the first trimester of the calendar year as specified in the contract. The Agency, instead, requested that PAHO take the responsibility for the evaluation on 4 May 1972. Our agreement to this request was formalized in Amendment No. 14, mentioned above.

Unde these circumstances, PAHO amended the workscope of the Evaluation Mission to include not only those activities funded by AID, but all activities of PAHO in the health and population field. The report therefore addresses itself to this broader charge.

In the years since the program's inception and the first AID grant, considerable progress has been achieved. From an activity utilizing the services of one professional employee, paid by the Organization, it has grown to 21 professional personnel on the staff funded by

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the Organization. In the early days, the activities were almost wholly funded by AID; now, with funds from the Organization and others, including the United Nations Fund for Population Activities and the World Health Organization, the United States contribution approximates 60%. The number of projects has multiplied, and our 1973 budget contemplates 48 projects with activities in 22 countries of the Hemisphere.

The Evaluation Team's report recognizes this progress in its statement in answer to the first question submitted by PAHO: "There should be no doubt that PAHO has a unique and important role to play in the family planning field, and the Evaluation Team unanimously supports continuation of direct AID support to PAHO and of expanding it in some areas."

The report goes on to review PAHO's activities and makes a number of suggestions and recommendations aimed at improving performance. We shall be submitting detailed comments on these at a later date and following discussions with the Evaluation Team and with your staff.

I would like to note, however, that a number of these suggestions have been or are being acted upon now. A reorganization of the Department is under serious consideration; more adequate space and physical arrangements will be provided shortly; action has been undertaken, through discussions with the Department of Human Resources, to utilize their capabilities and capacities in improving the program of education and training, including fellowships, institutional support and manpower studies. Preliminary plans have been developed for the establishment of an Evaluation Unit; and plans are under way for the expansion and extension of programs of communication and health education.

In regard to the specific recommendations of the Evaluation Team, quoted above, we have reviewed the report with respect to those items which should be expanded. We believe these should be programs aimed at extending services to rural areas, expanding activities in communication and health education, providing institutional support, conducting demonstrations and studies relating to "models", and further development of the maternity-centered approach exemplified by the project in Costa Rica. It is in this light that our 1973 budget submission has been prepared for discussion with the Agency.

We would like to call your attention to the last paragraph on page 15 of the report regarding the advantages of the AID grant. We hope that you will give serious attention to this part of the report.

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Its importance lies not only in the frustrations arising from delays in agreements but more importantly in adverse effects on the provision of services to people, consequently in the achievement of program objectives.

Members of my staff and I would appreciate the opportunity to discuss this report with you and jointly with members of the Evaluation Team. We sincerely appreciate the time and effort of the members of this Team and hope that their report can serve to develop a fruitful association of mutual benefit to both AID and our Organization.

Sincerely yours,

Chas. L. Williams Jr.

for Abraham Horwitz
Director

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EVALUATION REPORT

OF THE

DEPARTMENT OF HEALTH AND POPULATION DYNAMICS

PAN AMERICAN HEALTH ORGANIZATION

1972

Dr. Charles A. Lininger, Coordinator
Dr. L. P. Chow
Dr. José Donayre
Dr. Félix Gruber

SEPTEMBER 1972

NEW YORK

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FOREWORD

An Evaluation Team was formed in May 1972 at the invitation of Dr. Richard A. Prindle, Chief of the Department of Health and Population Dynamics of the Pan American Health Organization, with the concurrence of AID. Four members were appointed and served on the Team:

Dr. L. P. Chow (Johns Hopkins University)

Dr. José Donayre (United Nations Fund for Population Activities)

Dr. Félix Gruber (University of North Carolina)

Dr. Charles A. Lininger (The Population Council)

A fifth person, Mr. Luis Ratinoff, Sociologist (Inter-American Development Bank), was invited to serve but was unable to accept. The Team was convened by PAHO on 22 May 1972 in Washington, D. C. for general orientation, discussion of PAHO policy, and to communicate the charge.

The AID/PAHO agreement for the period 1/VII/71 to 30/VI/72 called for an evaluation of the activities under the agreement during the first quarter of 1972. When this could not be carried out by AID, it was agreed in May 1972 that PAHO should organize the team with AID's concurrence. At this time PAHO broadened the scope of the evaluation "to look at our total departmental activities in the fields of maternal and child health and family planning."

The original charge to the Team asked for "a preliminary review of the program and preliminary recommendations for PAHO and AID" in the hope that these could be used in the consideration of the continuation of AID support to PAHO beyond 30 June 1972. Team members could not accept this schedule due

to the size of the task and the previous commitments that most members had for the weeks ahead. By mutual agreement the original workplan was extended to allow additional time for fact-finding and interpretation, and expanded to call for a more thorough review and evaluation. Even so, the 15 days per team member allotted to the evaluation did not permit examination in detail or field visits to all projects. For example, Chile, the Regional Library, the Three-Nations Program and CLAP were not visited although the Director of CLAP was interviewed extensively in Washington.

Team members conducted their review by means of an extensive study of PAHO files and other documentation on its work and through numerous interviews with PAHO headquarters staff in Washington. Field staff from Haiti and Ecuador-Peru also were interviewed in Washington at the convenience of the team members, and two members of the team made site visits to Colombia and Costa Rica. They discussed the programs and PAHO's activities in considerable detail with the local field staff and with representatives of other interested institutions in the countries visited. All of the requests made to PAHO by team members for information were promptly and courteously filled except as noted in the report that data were not available.

The final report reflects the individual contributions of the various team members who were in contact with each other throughout the study period. A division of labor was agreed upon among the members of the team and a coordinator was selected. With few exceptions due to necessary editing to adapt the material to the format of the report, the various sections are as written by each author. Prior to final typing PAHO was asked to review the manuscript for major errors of fact or interpretation, but no conclusions were changed as a result of the few suggestions that were proposed.

PAHO EVALUATION REPORT

PART I

A. Answer PAHO questions

B. Answer AID questions

PART II

A. HEADQUARTERS

1. Policy setting
2. Advisory committee
3. Program planning (project summary, $, overtime, subject)
4. Administration
5. Staffing and organograma (overtime)
6. Consultants
7. Population-related activities
8. Coordination with other agencies

B. EDUCATION, TRAINING, COMMUNICATIONS

1. Fellowships
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C. RESEARCH AND EVALUATION

1. C.L.A.P.
2. Other investigations
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D. COUNTRY PROJECTS

1. Colombia
2. Costa Rica

PART I

IA.1: ANSWER FIRST PAHO QUESTION

"...provide comment to AID with respect to the desirability of continuing our present contract and, possibly, expanding the support." (Ref. PD/63/2 AID (EV), 12 May 1972).

There should be no doubt that PAHO has a unique and important role to play in the family planning field and the Evaluation Team unanimously supports the continuation of direct AID support to PAHO and of expanding it in some areas.

Continued direct AID financing of PAHO should support PAHO's capacity to promote and oversee population activities, and should provide funds for country activities that are not suitable for UNFPA support. Alternative funding such as from the UNFPA should be sought and used by PAHO where possible for major country projects, but direct AID support appears to be essential to maintain the levels of training, promotion, research assistance, and country program activities that are appropriate for PAHO at this time.

The question at this critical point, after the experience of several significant years, is how and when in the chain of events leading to national family planning programs is PAHO best suited for effective action.

A major conclusion follows from the analysis of PAHO/PD operations to date, that the Department is clearly and unequivocably identified with the MCH/FP approach. Together with PAHO's recognized prestige and connections in the countries of the Region, this defines, we feel, a special role for PAHO, provided that PAHO soon will develop:

i) models for delivery of integrated MCH/FP services for urban and rural areas, and

ii) a comprehensive formal strategy integrating the various components

or inputs needed to establish self-sustaining MCH/FP programs. Both now are lacking to a degree that we consider this a major shortcoming requiring PAHO's immediate and special attention. (Other relatively minor operational problems are pointed out throughout Part II of this Report. The components of PAHO's activities are reviewed there in narrower focus and any problems observed are mentioned as reminders for PAHO's management, although in many cases they were previously known and in some cases steps were being taken to resolve them.)

The completion of i) and ii) will provide the basic reference for the communications program of PAHO to disseminate the health rationale for family planning and the priorities for public and private action. PAHO is uniquely suited to lead and educate regarding the medical grounds for smaller families and reduced population growth. Education, training and technical assistance should be specifically designed to enable and implement the foregoing, and evaluation will consider the appropriateness of the targets and the success in achieving them.

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Before continuing with our suggestions for areas of concentration for PAHO, we wish to establish our understanding of certain terms and concepts and to indicate their meaning in the sections that follow. Specifically, we are concerned with the several possible meanings of integrated MCH/FP services, and of the concept vertical organization of family planning or MCH services.

Vertical organization of family planning presumably means separate organization and administration, possibly but not necessarily with parallel services for MCH. Integrated MCH/FP means FP and MCH being administered jointly by the same agency. The vertical approach permits concentration on FP alone,

with all the immediate advantages inherent therein for fast results, innovation, and visibility; but as a special, adequately financed program often the vertical approach is not readily accomodated by the host governments of the region. Mostly they do not share the special sense of urgency that might justify assigning this favored status to family planning as compared with the other MCH services. (Historically in the Region the vertical approach was successful in the private sector and depended in large part on external funding, although recently this has begun to change a little. The private agencies were able to limit their role to FP, but of course the public health services had a previous commitment to MCH.)

The integrated approach has been promoted by PAHO and seems to be favored by the majority of the governments of the Region. It stands for the joint administration and provision of services for MCH and FP by one organization, presumably the national health services. Theoretically it permits of various forms of administration. The extreme form of integration may be called integration-without-specialization, in which the same staff would deliver curative and preventive (FP) services during the same clinic hours. Another form may be called integration-with-specialization; this would have specialized staff and consulting rooms for family planning and others for MCH, or the same staff and rooms assigned different hours for FP and for MCH, with education for both and referrals between "services" regularly carried out. (The first form of organization is strongly attacked on the assumption that health manpower is scarce and that curative services will absorb available professional time and preventive services will be neglected. Rightly or wrongly, PAHO is perceived by many as supporting only the integration-without-specialization approach, and of opposing the "vertical"

approach and the integrated MCH/FP with specialization.)

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We feel that PAHO now is in a position to adopt more explicitly planned strategies for work in the Region and we offer a number of specific recommendations for consideration. If adopted, these would largely replace the opportunistic approach which has depended heavily on the inspiration of dedicated project advisors.

(a) Under the present conditions, where a large number of agencies are involved in family planning and related actions, PAHO/PD cannot expect to fill all needs in the health area. In order to improve coordination and to take proper advantage of PAHO's prestige and connections in the countries of the Region, it would seem advisable for PAHO to concentrate on those countries where the MCH approach could best result in the change of negative governmental attitudes.

(b) As a second area of concentration, PAHO should consider those countries where acceptance of family planning is made on the basis of an MCH approach, either as a total national policy or as a part of it. We assume that there will be countries where the so-called "vertical" approach will be preferred and PAHO should not forcefully promote the integrated MCH/FP approach there, especially if the implementation apparatus is weak.

(c) Since the integrated MCH/FP model is still an experimental design, PAHO should assist it in a small number of countries, pulling together all the necessary resources in order to work out a series of demonstrations or tests, which would result from alternate organizations of services depending on particular local conditions. For this purpose. the criteria for selection of appropriate countries becomes extremely important. (Note that this decision means the abandonment of the

present untenable goal of covering as many countries as possible.)

(d) Simultaneous to the application of the integrated MCH/FP approach, PAHO should scientifically explore by itself the validity of "vertical" organization of the delivery of family planning services. This would be a drastic departure from the position maintained by PAHO up to now, and should be intended as a test and a way for PAHO to achieve a more diversified experience. Not all countries should be expected to adopt integrated services, and above all both systems probably should coexist in many countries and blend into intermediate schemes. Vertical organization also may provide an opportunity for the infrastructure developed for family planning services to be used subsequently to advance the other MCH services.

(e) Special emphasis should be placed on finding viable approaches for delivering MCH and FP services to the rural populations who, compared with their urban counterparts, receive little or no care. There is widespread belief that fully professional care in rural areas is impossible to achieve over the next decade. PAHO should take the lead in developing MCH and FP services, emphasizing preventive aspects and placing greater reliance on paramedical and auxiliary personnel with well-defined delegated functions.

Finally, we feel that continued or expanded support to PAHO should contemplate further changes soon in the organization and administration of PAHO/PD Department, for it has outgrown its present system and needs prompt attention. MCH has tended to be separated from FP, population dynamics and population policy (Classifications 4100 and 4900, respectively), and the treatment of the three topics in 4900 has been uneven and perhaps confused. It is recommended that MCH and FP be joined and administered by a section

with an organizational focus on the delivery of services. This section should concern itself with all three of the previously mentioned prototypic systems, vertical, and integrated with and without specialization, as well as with blends or modifications that may be appropriate on pragmatic grounds. Another section should have explicit responsibility for population policy and dynamics as well as research and evaluation activities not explicitly delegated to the other section. Policy Guidelines for these two sections should immediately be rewritten and given wide circulation and their implications discussed in special sessions of meetings with the assembled senior field staff (regional and country representative, at least). An interdepartmental Task Force also should be organized from Headquarters staff and charged with the responsibility for planning ways for the other departments to contribute to the rapid institutionalization of FP services.

It is also recommended that the Department expand its formal procedures for the professional review and approval of new projects and activities, and to pay particular attention to each activity's importance in the overall strategy. (PAHO should provide most of its support for projects and activities that form part of its general plan, although it also should have funds for promotional and opportunistic activities that could not be anticipated when PAHO's overall budget is prepared.)

IA.2: ANSWER SECOND PAHO QUESTION

"...preliminary recommendations with respect to the techniques and operation of a continuing function within the Department..."

PAHO's evaluation goals are appropriate and its initial efforts to establish an evaluation procedure are commendable, but much remains to be done to reach these difficult goals. The suggestions which follow for the most part are tentative and PAHO's developing evaluation procedures need and deserve the continuing close attention of a senior professional.

(a) To the extent that projects and activities have measurable goals they should be specified in the proposal and be considered in the professional review prior to approval. Typically the projects also will have goals or purposes that must be judged qualitatively due to the complex and changing setting of many action-oriented population activities which confounds cause-to-effect analysis. Within this framework, we suggest that PAHO's continuing evaluation be considered at two levels: Monitoring and Evaluation.

(b) Monitoring is concerned with collecting and presenting the data so that it can be ready to be evaluated. The data are generated at the level of projects or activities. Evaluation is the critical analysis of the data, and should be carried out at various levels:

(i) The specific components of the PAHO/PD within a country (i.e., education, MCH, FP services, etc.)

(ii) The overall combined effect of those components.

(iii) Comparisons between countries.

(iv) Decision making based on the above steps.

(v) Follow-up of those decisions.

Both monitoring and evaluation must be made in regular, periodic fashion;

(iii), (iv), and (v) above require formal meetings with the participation of the PAHO/PD Director.

(c) For the implementation of such a system the following division of labor is recommended:

(1) Monitoring: assigned to the project (or activity) manager at PAHO/PD headquarters, following the procedures set out by the evaluation unit. Most of the information will originate in the field, but it may be supplemented by resumes or condensations of the information received from the field, or by trip reports, etc.

(2) Evaluation: Steps (i) and (ii): Countries should be divided among members of the staff. One person should be responsible for all the PD programs within a country.

Steps (iii), (iv), and (v): Based on formal presentations with opportunities to raise questions for additional information, clarification, etc. Usually will include the participation of the PAHO/PD Director or his delegate.

(d) Responsibility for the implementation of the decisions made in (v) above should be made explicit in the decision. Whether it be the person responsible for the particular country or another, the specialists of the organization should be ready to help these persons with specific problems.

(e) Monitoring tends to be a continuous operation tied closely to good administration. Evaluation should be scheduled annually or more often

at the discretion of the PD Chief, and should be considered a prerequisite for major new decisions.

A more detailed consideration of the system proposed is found under the EVALUATION section in Part IIC.4 of this Report.

IB.1: ANSWER AID'S QUESTIONS

AID's concerns have been stated several times and many individual questions have been posed. Most of AID's concerns have been treated elsewhere but the first section below briefly treats individual questions that were raised and the second section deals with broader areas.

IB.1a: Economic trade-off costs

Neither PAHO nor the Evaluation Team has engaged in elaborate analytical or simulation exercises that would yield quantitative estimates of costs and benefits of inputs allocated to alternative uses. Nevertheless, we believe that governmental support of family planning is an essential component of national population policies of countries in the Region aimed at reducing population growth and encouraging smaller families.

Governmental support of family planning is important for the direct effects that flow from the services rendered, and equally for the lagged interaction effects that we expect to follow as other agencies adopt reinforcing policies and families set goals for fewer children and wider intervals between their births. PAHO is in a special position (due to its prestige and long contacts with health ministries) to encourage and assist ministries to support family planning, and the possible alternatives to PAHO for these activities seem to be incomplete substitutes.

The question therefore should not be whether to support PAHO, but one of how and at what level to do so.

The economic trade-off costs between family planning outlays and other health activities in the context of rapid population growth are explored in part in Omran's Health Benefits of Family Planning (Geneva, October 1971), but more explicit analysis of trade-offs should be sought by PAHO, either through in-house research or in subsidized out-house analysis.

IB.1b: Promotional activities

PAHO for years has worked for the health and welfare of mothers and children through various departments and only in recent years has added PD where this has been given special emphasis. Promotional efforts for family planning seem to be the exclusive responsibility of PD, and in the context of their concern for mothers and children, with one important exception. The Director of the Organization also is reported to assist in promoting family planning and fertility reduction in private conversations with leaders in the Region. The Director is reported as having pointed out the overwhelming deterrent effect that rapid population growth has on reaching solutions to many of the remaining unmet health goals.

We urge PAHO to make explicit and public its professional opinions with regard to population matters including rapid growth and family planning, to communicate these widely, and to promote and assist the member governments in actions that would be appropriate to each circumstance.

We also encourage PAHO to assist and enable the Directing Committee or CSP (?) to consider new resolutions on population matters or to elaborate on the intent of prior ones at their next meeting. This would seem to be appropriate on the basis of the professional positions on population expressed by the senior staff and administrative officers of PAHO, and the nearness of the officially designated World Population Year.

IB.1c: Purposes of the Foreign Assistance Act

The Committee does not consider itself expert on the purposes of the U.S. Foreign Assistance Act and suggests that A.I.D. staff could better compare the reported activities of PAHO to the purposes of the Act as it is written and interpreted within the U.S. Government.

IB.1d: Duplication

Immediately a distinction should be made between desirable and undesirable duplication. Duplication that results in encroachments and overlapping efforts are to be avoided as undesirable, but two or more organizations undertaking activities with similar objectives but in different countries or even in the same country where the approaches are coordinated and complementary is not only acceptable but probably is to be sought and fostered. This is because the profession still does not have all the answers with regard to the promotion and delivery of services and fertility reduction, and alternative approaches and different personnel likely will prove to be productive in different ways. With careful periodic analysis it should be possible to understand the lessons to be learned, and to feed them back into subsequent planning and administration so that the best approaches can then be adopted.

PAHO is a party to little undesirable duplication, although it operates in many similar fields and countries as AID, Population Council, IPPF, etc. The organizations with the longest experience in the field for the most part have evolved satisfactory arrangements with each other, although PAHO and IPPF should increase their professional contacts with each other. New opportunities for duplication may arise as the many new entrants supported by AID try to work in the Region.

It should be recognized that local institutions often have preferences for the philosophy, style of operation, or personnel of one or another potential donor, and donors therefore are not always good substitutes for one another. This is another reason to support two or more organizations in the same field.

IB.1e: New opportunities

There are needs and opportunities that PAHO has not yet satisfied: for example, models and demonstration projects for delivery of services in rural areas and the effective utilization of obstetrices, matronas, and nurse auxiliaries; broad communication of the health benefits of family planning and implications of rapid population growth for the health sector; and effective integration of family planning with MCH on a national level in several countries. These are described elsewhere in sufficient detail.

It probably is not appropriate for PAHO to pioneer in new fields remote from its historical concerns, at least until its traditional fields are well served; for example, PAHO probably should leave the private sector or commercial marketing to other agencies. PAHO, however, should counsel governments to assist activities in these other fields to operate more effectively, and should promote collaboration or even partnership in projects if such an arrangement would more easily accomplish desired goals.

IB.1f: Future funding potential

It is not yet within the competence of the Evaluation Team to make strong recommendations as to the precise level of PAHO's need for funds, except that we advocate that PAHO be supported for those activities favored or commended in the various sections of the Report. Country projects can be costly and we have not surveyed carefully the prospects for PAHO to initiate important new ones in the next 12-18 months or their probable costs, but good projects of this type should not be delayed long due to lack of funds.

IB.1g: Attributable reduction in birth rates

We doubt that birth rate reductions can be demonstrated as having resulted from PAHO's efforts to date, nor do we feel that this is an appropriate test to apply to PAHO's activities at this stage in the Region. Birth rate changes are the consequence of many interacting factors, and it is difficult to quantify the responsibility of one factor in a complex and changing environment.

IB.1h: Leadership change-in-attitudes

PAHO's activities have contributed to a greater acceptance of family planning among leaders in the Region. Unfortunately it also is believed that PAHO has influenced against effective private, vertical family planning systems in a few instances, although not everywhere. Even if these beliefs are unfounded, it is unfortunate that they could seem plausible to many responsible individuals.

IB.1i: New developments in technology, services

We do not believe that PAHO has contributed new developments in technology related to population, and that it is too early to assess their possible contribution with regard to the delivery of services. Certainly PAHO can be credited with the integrated MCH/FP approach, but its utility has not been adequately assessed.

IB.1j: Coordination or strategy with others

PAHO speaks in favor of coordination and joint strategy more convincingly than its experience demonstrates, although there is evidence that the difficulties in putting the principles into practice stem from the lack of experience in trying to do it well, and the backgrounds of certain staff

members. This is one of the important reasons for urging PAHO to issue more explicit official policy statements and guidelines. PAHO's promotional and other activities on population matters in a country now seems to depend too heavily on the attitudes of the staff assigned there.

IB.1k: Management effectiveness

PAHO still lacks the efficiency it desires for the PD Department, including its field staff, but there is evidence that it slowly has been improving its effectiveness through the generally high caliber of key personnel hired and in the expansion of its staff to cope directly with opportunities open to PAHO. As indicated elsewhere, more needs to be done to establish or improve models and strategies, review of proposals, formal adoption of projects, monitoring of progress, evaluation of projects, and the sharing of PAHO's policy positions and experiences within PAHO and with other donors and operating agencies.

The PD Department and its activities require substantial inputs presumably not available through regular PAHO funding channels, and this reliance on special funding makes the PD Department vulnerable to any uncertainties that may be associated with it. There may be no fully satisfactory solution to the difficulties of funding long-term programs, including staff build-up, with short-term funding, but AID should attempt to minimize the problems associated with this situation to allow better use of PAHO's comparative advantages. AID must realize that the time and energy of PAHO's top staff that is required to deal with avoidable "crises" associated with AID funding is taken away from its application to real problems of planning and administration of the program. The AID grant, as opposed to a contract, is a major step in resolving this, but it too should be carefully reviewed periodically for possible new improvements.

IB.2: SUBSTANTIVE AREAS OF AID CONCERN

Other questions raised by AID concern delivery systems, including postpartum, and six questions are discussed separately under a through f below. A seventh and final question, g, follows; this concerns research activities.

a. Are PAHO's current expanded community maternal and child health activities effective in promoting family planning practice?

b. How much weight is being given to the family planning component by the integrated MCH-FP program?

c. Is PAHO's current policy--which is to act only through maternal and child health programs for its population projects--an effective and efficient one?

d. Would some other health program provide a more acceptable delivery system?

e. Can other agencies within the U.N. family be expected to cover other approaches in Latin America?

f. What are the prospects for the postpartum program with PAHO?

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a. Effectiveness of PAHO's expanded MCH-FP program

This question cannot be answered directly at this stage, because most PAHO population programs in Latin America are less than two years old. The question may therefore be examined only from a theoretical standpoint.

It has been agreed that women during the postpartum period are most receptive to a family planning message. In institutionalized deliveries, postpartum women are captured clients, some of whom may never be reached by any other approach. Enough evidence has been gathered as to the

effectiveness and efficiency of postpartum family planning programs; there seems to be little argument about the desirability of expanding postpartum family planning educational activities to cover the prenatal period as well as to reach women at the well-baby clinics. Prenatal family planning education may not be too effective if measured only by the subsequent acceptance rate. Its impact will have to be measured on a long-term basis, and this is why the question cannot be answered precisely at this time.

Strengthening family planning educational efforts on women who bring their children to the well-baby clinics is an important approach of PAHO. The argument for this approach is that immediately after delivery, women may not be ready emotionally to listen to family planning messages. She has just gone through the pains of labor and may still be worried about her household and her children at home. Moreover, most maternity cases are permitted to leave the hospital a few days after delivery; women are discharged before they are ready emotionally to think about planning for the next conception.

Women in the well-baby clinics, on the contrary, are settled and are in a better mood to listen to a family planning message. When approaching these women, timing is a critical factor. If approached too late, she may very well have conceived already again.

It is still too early to say how effective and efficient this approach will be, but it certainly deserves continued support. Its effectiveness, and that of the prenatal and postnatal approach of PAHO, should be systematically monitored and thoroughly evaluated at some later time, not only for PAHO's own guidance but also for the reference of other programs.

The maternity centered family planning program of PAHO and of WHO nevertheless does have a rather serious weakness. This weakness is particularly

serious when a woman's initial entry into a family planning program is made at a prenatal or well-baby clinic or at an institution where delivery takes place. With some exceptions, the proportion of pregnant women who attend prenatal clinics or whose delivery takes place in an institution is low in Latin America. A large proportion of women in need of family planning counseling is missed by such an approach. Often the proportion missed is the most important because they are less educated, live in rural areas, and will have many pregnancies, constituting the high-risk group. The program should try to reach and convey the family planning message to these women, but unfortunately the PAHO expanded MCH-FP program is still unable to completely solve this dilemma.

In order to overcome the above problem, PAHO's MCH-FP program should take the initiative to locate and approach prenatal or postnatal women. Enrollment in this program should take place at the women's homes, rather than at clinics or hospitals. Special efforts should be made in rural areas rather than in the urban centers. Rather than approaching those who are wealthy and educated, women of lower socioeconomic status with less education should be the primary target. This is an ironic statement, but well-to-do women can essentially be ignored by public family planning programs because they will probably take care of themselves and they contribute a smaller proportion to the annual births in a country.

b. Weight of family planning component in the PAHO MCH-FP program

This is a classic question related to an issue on integrated MCH-family planning programs. Those who are in favor of MCH complain that family planning detracts from efforts and resources which are due the regular MCH program; however, the family planners are often impatient about the indirect approach of family planning through MCH.

It seems to have been agreed that family planning is an essential and integral component of a comprehensive maternal and child health care program, and without this component, the MCH program is incomplete. If that is so, then the above question may not be so important, at least from a theoretical viewpoint, because promoting the conventional MCH is equivalent to promoting family planning and vice versa.

Suppose that we are seriously concerned with the health and welfare of a mother (which is the MCH program objective), we will inevitably find out that too many births which occur successively with short intervals are not to the health advantage of the mother nor of the child. We would automatically advise her to delay the next pregnancy or to avoid having too many pregnancies, without identifying it as a family planning program.

There is evidence, although not proof, which indicates that frequent contact or exposure to community workers--home economists, social workers, or malaria control workers--will favorably affect and modernize the thinking and behavior of people. By the same token, frequent visits by family planning workers for the family planning cause alone will make people more health conscious, resulting in more utilization of health facilities and health services, hence lead to better health. It is therefore not wise to be overly concerned about the percentage of effort that is spent for family planning as opposed to the regular MCH. The main concern should rather be whether the program--be it MCH or family planning, or a combination of both --is a good one. Most regular MCH programs do not help the family planning goals, not because they are MCH, but because they are poor programs even for MCH. The reverse may also be said; some family planning programs do not help MCH because they are poor programs for family planning. Since it is a firmly established policy for WHO and PAHO to promote family planning as an integral

part of an MCH program, the future concern should be how to really improve these expanded MCH programs rather than quarreling over the weight of either component. It is a conviction of the members that a really good health program usually performs multiple functions.

c. Delivery systems for family planning

According to Freyman, these are the major functions of a family planning program: generating social support, motivating people and providing services for the motivated. An adequate delivery system, therefore, is an important consideration.

Family planning services may be delivered through clinical and nonclinical channels. The following are types of delivery systems through clinical facilties:

i. Use of private clinics - This has been extensively used in Taiwan and Korea with considerable success. In developed countries, private doctors are major providers of family planning services. PAHO should explore the use of private doctors in Latin America before concluding that "it does not work" without really trying. Use of nurses or midwives in private practice for family planning is another area of high hope.

ii. Special family planning clinics - Most planned parenthood clinics are established solely or mainly for family planning, and there are many such types of service facilities in Latin America. Since most of these clinics are operated by voluntary organizations which have somewhat different objectives and approaches, PAHO should invest its efforts in exploring other types of service delivery systems. Experience in some countries in Asia indicates

that setting up unipurpose FP clinics in the official program is not too rewarding. Programs should not always be conceived with a rigid MCH orientation so that activities directed to males--the distribution of condoms and later, sterilization--be completely disregarded. Also attitudes and experiences with female sterilization and abortion services should be studied and discussed.

iii. Hospitals - The importance of modern hospitals as the centers of health prevention and promotion has been discussed previously. The expanded postpartum program of PAHO, which is largely hospital-centered, is aiming in this direction.

PAHO has thus far been able to include in its scheme a limited number of public hospitals (e.g., governmental and Social Security) in a few countries, e.g., Costa Rica, Nicaragua, Guatemala, and Haiti; also, several other countries may be included in the near future. PAHO, however, has not been able to expand the program to cover other types of hospitals, such as community hospitals, military hospitals, missionary hospitals, and private hospitals. All of these hospitals are important educational and recruitment points for family planning. Efforts to include more promptly more of these hospitals should be intensified.

iv. Health centers and other public health clinics - These public health clinical facilities have been the main providers of family planning services, and will continue to be a main source for such. PAHO family planning program services are delivered largely through these public health facilities. These, however, should not be the only channel for provision of family planning services. PAHO

should explore the use of other delivery systems which would include exploring the feasibility of various nonclinical service delivery systems--which will be discussed below.

The problems associated with excess fertility are particularly serious in the developing world where adequate health care facilities are usually grossly inadequate. If family planning services are to be delivered only through hospitals or clinics, there is no hope that the ultimate program goal can be achieved. The irony is that in a country where the need for family planning is most urgent, the clinical facilities are usually the poorest. The nature of the problem is similar in Latin America where clinical facilities and trained manpower are inadequate in rural areas. Nonclinical family planning delivery systems to be explored by PAHO may include the following:

i. Use of auxiliary personnel - With reasonable training, various types and levels of auxiliary personnel should be able to provide a limited scope of family planning services such as the distribution of oral contraceptives and other contraceptive supplies, or the insertion of IUDs. The importance of more extensive use of paramedical personnel in Latin America and improvement of their training methods and career structures have been discussed in the previous sections.

ii. Commercial channel - Use of commercial channels for distributing contraceptive supplies has been attempted by a few countries. Examples are the distribution of pills by drug stores in Costa Rica, and the Nirodh program in India.

An important subject for PAHO to explore is how to better utilize these private channels for contraceptive services in the region.

These private channels should also be useful for the dissemination of family planning information and messages--and PAHO should design a program which will facilitate such a process.

iii. Use of other community establishments and mailing systems - Aside from commercial channels, various community facilities may be utilized for family planning program purposes. The mailing technique has been used extensively for the promotion of family planning and less extensively for the distribution of contraceptive supplies in Taiwan, both with considerable success. This technique may be explored by PAHO for countries where postal services are good.

d. Other health programs for delivery of family planning

PAHO has a variety of health projects in various Latin American countries. These projects may not be able to provide family planning services but should be able to better promote family planning program concepts. Examples are malaria eradication programs, programs for the improvement of teaching in medical and nursing schools, sanitation improvement, hospital administration, health education, improvement of vital statistics systems, school health, and various communicable diseases control programs. Auxiliary personnel employed for some of these specific projects may be utilized also to distribute contraceptive supplies in remote areas. Some discussion along this line has already been made particularly with regard to the use of the malaria eradication project staff for family planning; however, relatively little has actually been accomplished.

Better coordination and closer cooperation with other technical divisions in the PAHO Headquarters is extremely important. Divisions or units with which the Population Dynamics Department should seek a closer working

relationship include the nutrition, health education, health statistics, malaria control, cancer control, and nursing units. The planning and evaluation unit of PAHO is well known for its expertise in health planning--these talents and resources should be used more extensively to help the program goals of the Population Dynamics Department.

e. Approaches by other UN organizations

Inasmuch as population problems are multidisciplinary, United Nations specialized agencies other than health, should do more to help family planning - this is not only possible but also highly desirable. Exploration of such a possibility, however, should not minimize the important role that PAHO has been playing in the Region. Family planning is still to be approached mainly for health reasons and its services are still to be provided through the basic health infrastructure. This is true particularly in Latin America. Examples of possible approaches by other agencies may include the following:

- Population education in the regular school system and family planning communication programs by UNESCO
- Nutrition education and family planning by FAO and the World Food Program
- Adult education and family planning by UNESCO
- Various youth programs supported by UNICEF to incorporate family planning education
- Community development programs to include family planning activities by FAO
- Family planning programs for the workers by ILO

All of the above are important and item, "Community development programs to include family planning activities..." deserves special mention. It is

said that for people to be able to conceive the basic concept of family planning, a minimum level of "modernization" is necessary. Some degree of development should proceed in a community before the need for family planning can be really appreciated and accepted by the people. This argument is analogous to that of "need for basic health structure for family planning to be successful..."

Community development programs in rural areas or in the urban slums offer unusual opportunities to promote family planning as an integral part of various developmental programs among the right audiences--the people who are in need of the services most. Despite this opportunity, relatively little has been done except a few pilot programs which have incorporated family planning. More systematic efforts to plan a workable community development program along this principle are urgently required. Such a program should be designed in such a way that it has quantifiable objectives and targets; and its progress and achievement can be evaluated and documented in scientific terms for future guidance.

f. Postpartum program

There has been discussion on the desirability and possible effectiveness of the redesigned postpartum program of PAHO to expand its educational component to include the prenatal period and to cover mothers at the well-baby clinics. Although at this stage it is still premature to evaluate its effectiveness, the impression is that the program has been well thought out and should produce a reasonable output if implemented according to the plan. In fact, in Costa Rica, new acceptors from this source accounted for about 17 per cent of the total new acceptors from all sources in 1971.

It is difficult to discuss the relative efficacy of the new PAHO postpartum program with the earlier program implemented by the Population Council.

The difficulty will be greater if the program effectiveness is to be evaluated only by a number of direct or indirect acceptors, because the real effect of educational programs may not be quantified within a limited length of time. The only comment the evaluation group may make in this connection is that the redesigned postpartum program of PAHO is what a comprehensive MCH-FP program should be and on that account deserves continued support.

The Population Council, which has supported the postpartum program in Colombia for the past several years, has already expressed the desire for PAHO to take it over. PAHO has in principle indicated its willingness to assume the responsibility but the Ministry of Health seemed to be considerably reluctant to include this program in the existing MCH-FP program. The reasons for this reluctance may be complicated, and it might take a while before such a transfer of responsibility can really take place.

The prospects for other countries in the Region to start similar postpartum MCH-FP programs seem to be bright. With the redesigned expanded program of PAHO, there should be no serious objection to the inclusion of such activities in the regular hospital systems. The problem is rather an administrative one: funding, manpower, logistics, and organization structure of administering such programs.

* * * * *

g. Do research activities supported by PAHO stimulate family planning activities?

Some of the research activities supported by PD are more closely related to stimulating family planning actions than others. For example, the ones being carried out in the sociodemographic field in Brazil, Chile, Peru, and Mexico are of more direct relevance than those carried out in the basic-clinic field in Uruguay, Argentina, and Chile. These latter research activities have

no short-term stimulating effect on FP activities, but their long-term efficacy can be argued.

The overall impression that was obtained regarding research is that PAHO/PD may be moving away from typical public health research into more basic-clinic type of research. If this happens, public family planning programs will suffer from a lack of relevant research on the actual day-to-day FP issues and problems.

IIA - HEADQUARTERS

IIA.1: THE POLICY SETTING

The Organization is an international health agency* and in the tradition of international agencies, resolutions, directives, and policy guides have considerable significance. Official actions are commented upon and reviewed below, followed by a review of the written expressions of professional goals and standards for relevant health activities made by its senior staff and advisors. The presentation is organized by type of activity.

(a) Official Actions

Traditional MCH: The concept of an integrated approach to MCH was demonstrated long ago in a context far removed from current population concerns. In October 1948 the Organization declined to adopt the Declaration on the Health of the Child as it was developed and presented to the Organization by the Ninth Pan American Child Congress, for although it found nothing objectionable, it "(did not believe) it advisable to create a complete separation between the child and the rest of the family nucleus..." (CE5.R11, October 1948). The Organization's Directing Council, through Resolution CD2.4, October 1948, confirmed the importance then of integration in the MCH setting and it added a supplementary article to that effect as a condition for its approval of the Declaration.

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*The Organization is the oldest international health agency in existence, having been established in 1902 as the International Sanitary Bureau in Washington, D.C. Following various intermediate changes in name and organization, the Organization officially became the regional office of the World Health Organization on 1 July 1949 while also retaining its former separate status as the international health agency of the Governments of the Americas.

The Organization serves a dual role, as promoter and interpreter of health goals and standards for the profession and WHO to the Governments, and as executing agency for the Governments within prescribed areas of health activity.

The Organization also manifested its early and continuing interest in MCH when it recommended in 1949 that WHO establish an MCH section (CD3.3), and that special attention be given to MCH in planning for, and in future programs and budgets (CSP15.4, CSP15.5, 1958).

Family Planning: Family planning seems not to have been dealt with specifically in the official actions of PAHO's Directing Council or its quadrennial conferences. WHO in 1968 indicated that technical assistance in family planning should be provided to Governments on request (WHA21.43, 1968) but the PAHO language has not been that direct.

Population Dynamics: Concern with this topic dates from 1964 when PAHO's Directing Council recommended that studies in population dynamics be undertaken (CD15.31, 1964). No progress was reported on population topics at the 1965 meeting, although progress was reported in other areas. However, in 1965 new work was under way including major studies in the formulation of a biomedical research policy for the Region, population dynamics and medical demography; PAHO and WHO also were reported to be collaborating in developing a coordinated regional program in research and training in population dynamics (CD16.21, 1965).

In another action that year, "in line with WHA18.49," the Directing Council resolved to request the Director, "to provide technical advice, as requested, on the health aspects of population dynamics," and "the establishment within the structure of the Pan American Sanitary Bureau of an office of health and population dynamics, including a Population Information Center (PIC)." (CSP17.22, September-October 1966).

Official actions shifted to population policy in subsequent years, except that in 1968 and 1970 it was officially recommended to the UNDP that funds be allocated for population dynamics (CD18.16, 1968; CSP18.26, 1970).

Population Policy: The Directing Council in 1967 selected the topic "Participation of the Health Sector in Population Policy" for the Technical Discussions to be held in 1968 as part of the 18th Meeting of the Directing Council, 20th Meeting of the Regional Committee of WHO (CD17.33, 1967). An extensive discussion paper of the same title (CD18/DT/1; Eng.) was prepared, presented and discussed, and a five-point resolution was approved by the Directing Council (CD18.29, 1968). The first three points took note of the Final Report of the Technical Discussions and expressed satisfaction with the "deliberations," expressed thanks to those who participated, and recommended that the report be given the widest possible distribution. (It subsequently was published in the English edition of the Boletín de la Oficina Sanitaria Panamericana, but not in the Spanish edition.) The final points, 4 and 5, recommended that the Director study the possibility (author's italics) that the Organization:

- "Provide the countries with the assistance necessary for the development of programs of information to the community on aspects related to the subject;
- "Promote and coordinate research and the training of personnel in this field; and
- "Promote technical assistance as requested by the Governments. (and)
- "Appoint a Working Group of multidisciplinary nature... to analyze the interrelationships of health and population policies... (consider) different points of view presented ...(with investigation) to obtain adequate knowledge..."

DISCUSSION

Initially, the norms of WHO and PAHO are distinguished, although formally the norms of WHO also serve for PAHO (CD65. and CSP66.).

The Organization's mandate to work in population-related activities differs by type of activity. As regards the promotion of and assistance for family planning delivery systems, at best the mandate from the

Organization is obscure; the mandates originating in the World Health Assemblies over the period 1965-1968 (WHA18.49, WHA19.43, WHA20.41, WHA21.43) are progressively more permissive and open as regards family planning, as compared with those of the regional Organization. On the other hand, PAHO probably has greater authority than WHO to promote and assist in the formulation of population policy, although the phrase in author's italics above could be interpreted narrowly.

There are unambiguous PAHO mandates for work in research, training, and public information as regards population dynamics, medical demography, PAHO's program activities, and population policy.

(b) Other Documentation

The 1970 Annual Report of the Director is more explicit with regard to family planning than the PAHO resolutions. Several sections of the Report dealing with population matters are subtitled "Maternal and Child Health and Family Planning." Population policy seems to have been omitted entirely from the 1970 Report, and health and population dynamics is subsumed under MCH and FP, except in classifying project activities. Nevertheless, in expressing the goal of the Organization in its health and population dynamics program, family planning is not mentioned. It subsequently is mentioned explicitly in 5 of the 15 following paragraphs of this section in which activities are reported.

There are a few other sources of PAHO expression of norms. One is the looseleaf set, Policy Guides for the Planning of PAHO/WHO Programs, divided into almost 40 categories following the standard PAHO index of activities. About one-fourth of the categories remains "to be prepared," and all but one of the others are dated from November 1965 to May 1966, including "Maternal and Child Health." One exception is "Health and Population Dymanics," dated

April 1971; unlike the others, it is double-spaced and looks suspiciously like a draft, although it was said to be in final form. The Guide for MCH (Rev. March 1966) has not been revised again to incorporate family planning as an integral part of that unit. Some interesting sections from it are excerpted below:

"Policy Guides II B 4100 (MCH) Rev. March 1966"

"...efforts to improve health must reach mothers and children through all government programs (specifically in health, education and welfare) and not merely through conventional maternal and child health service." p.2

"Latin America has insufficient health resources to cope with the magnitude and extent of the health problems of mothers and children. These resources will produce their greatest return if the total personal health care of mothers and children is fully integrated into a single system which fuses preventive and curative care." p.2

"...norms of service...should aim to: deliver a minimum coverage continuously to 100 per cent of the population within the sphere of influence; to screen out those families and individuals in need of more intensive service (educational and curative); and to provide such service to them." p.3

Reproduced below also are some interesting excerpts from the Guide for Health and Population Dynamics:

"Policy Guides II B 4900 (Health and Population Dynamics) April 1971"

(POPULATION DYNAMICS AND FAMILY PLANNING)

"I. General Policies and Objectives..." (circuitously and at the end of the second page) "In view of these considerations and the factors enumerated above, PAHO's policy becomes one of:

"Promotion of any activities designed to preserve and promote health and well-being for the people of this Hemisphere, and to the extent that the following contribute to that goal:

"1. Promotion, assistance, and support of the development of family planning programs as part of the total health services, and

"2. Encouragement, assistance, and support of governments (sic) in the development of population policies consonant with their needs and national circumstances." pp. 1-3

"II. Plan of Action

"Every country must have an awareness of the dimensions and dynamics of its population. Encouragement should be given to the development of a policy, recognizing that this policy may establish no goal nor formulate a defined plan . . .

"Irrespective of its population policy, every country should be encouraged to establish a policy with respect to family planning...stress should be placed on the role of family planning as a public health measure and as a normal part of health services, especially maternal and child health services. Thus, the government (sic) should be encouraged to see its responsibility to assure the provision of family planning programs in health services... pp.3-4

"...Whether it (the Government) chooses to carry out the program or to support and encourage private and voluntary groups to do so is an internal matter...but...this latter approach may seriously inhibit the orderly integration of such programs with other health services... p. 4

"...A number of approaches may be used, such as combining the family planning activities with programs of maternal and child health, relating the program to activities within general health services, or conducting them as part of postpartum or maternity centered activities... p. 5

"III. Assistance from the Organization"

(There follow 6 points enumerating the gamut of assistance including consultation, equipment, and supplies (within limitations), support for fellowships, seminars, short courses, and curriculum development, research and research training, evaluation, and probably for family planning. The latter verbatim is:)

"4. Assistance in coordination with various other sectors, especially relating to other agencies and institutions concerned with populations (sic) and family planning." (and a seventh point states:)

"7. With the approval of the Ministry of Health, assistance can also be provided to other agencies, such as Social Security, the military health services, private agencies, etc."

Two other documents, one each from PAHO and WHO, are specifically oriented to provide MCH/FP guidelines. The PAHO document, undated and unsigned, was

prepared by Drs. Jorge Rosselot and Eliana Camacho in the latter part of 1970: Normas Generales para Planificación de Programas de la OPS/OMS Salud Materno-infantil (Dpto. de Salud y Dinámica de la Población). The WHO document is Maternity-Centered Family Planning Programme, Guidelines (Geneva, May 1971, WHO). The latter one from WHO appears not to be available in Spanish.

The PAHO document mentions Regulación de la Fecundidad (fertility regulation) as the fifth objective: overall protection of the family, prenatal control, attended birth, postpartum control, and fertility regulation. Later, Annex 5 of the document sets a technical target for contraceptive acceptors at 15 per cent of the women in child-bearing ages (15-44 years). The WHO document offers no target for the proportion of acceptors, but expects that contraceptive services will be made available to all women who deliver in large maternity institutions, and family planning services are included among the necessary minimum acceptable MCH care activities for rural populations.

Discussion

Family planning is more explicitly treated in these "other" documents than in the formal resolutions of the governing bodies of PAHO. WHO presents a family planning program guideline. PAHO offers a guideline for planning an MCH program in which family planning is included.

PAHO shares the widespread understanding that there is inadequate health care in the rural areas of many countries of the Region, and that health manpower is scarce and unevenly distributed, but seems to have no interim plan to deliver minimum care for pregnant women and infants and family planning services in these areas.

Norms or guidelines for activities under the heading of population dynamics and regarding population policy were not encountered.

IIA.2: ADVISORY COMMITTEE

Two meetings of the PD Advisory Committee were held two years apart, in 1970 and 1972. The composition of the Committee changed substantially from the first to the second meeting, with one member at both meetings. Of the 11 persons invited to the recent Committee, six were rather closely associated with PAHO (consultants, contractors, or prospective recipients of substantial PAHO support), and five were not associated in this way. Seven of the 11 appointees attended the meetings, including four of those associated with PAHO.

Some materials had been made available to the Committee earlier, but a large book of background materials was presented to each member on the first morning of the week-long Committee meetings. Following opening remarks by PAHO's Director, the Chief of PD proposed an agenda for the sessions that scheduled a briefing session on a different major activity of the Division each morning and discussions and recommendations each afternoon. This was adopted but modified somewhat during the week. The Committee recommendations were released several weeks after the sessions ended and following a review of the tape of the sessions and editing by PAHO staff.

The next meeting of the Advisory Committee is tentatively scheduled for 1973 when annual meetings will continue.

DISCUSSION

The concept of the advisory committee is excellent. The deliberations and recommendations of the recent Committee appear to have been limited by a lack of prior information about PAHO's activities on the part of some Committee members, and the closeness to PAHO of others. The first might be rectified by changing or rotating no more than 1/3 of the Committee members each meeting, by recruiting from other organizations working in the field,

and by preparing and circulating in advance of the meeting background and position papers on the major topics to be covered. Key persons associated with major PAHO projects should be available to provide information to the Advisory Committee but they should not participate in the Committee's final deliberations.

IIA.3: PROGRAM PLANNING AND EXECUTION

Program planning is difficult to assess at a point in time. Nevertheless we have looked at the guidelines prepared at headquarters which might help to orient Ministries and PAHO staff in planning their activities and possible requests for assistance to PAHO (See IIA.1). The written record appears to be deficient in this area, and considerable reliance seems to have been placed on verbal orientation of staff and on their individual predispositions and initiatives. This in part is due to the sensitivities regarding population and the consequent unwillingness of official entities to be explicit and definitive in print. Some of the deficiencies are no doubt a consequence of the moment in time at which the evaluation team is studying the PD, for it takes time to evolve norms and procedures. Progress has been unfortunately slow; this may also have been hampered by the shortage of personnel and in some measure, by the composition of the staff and their individual backgrounds.

Program planning is revealed in the pattern of activities which PAHO has promoted, responded to, or been involved in. One effort to assess this is through a list of significant activities of PAHO in this field over the recent years.

SIGNIFICANT EFFORTS OF PAHO IN THE POPULATION FIELD

Year	Activity	Result
1965	PAHO/WHO Conference on Population Dynamics	Limited licence for action
1966 fwd.	Courses in health dynamics, Santiago and later, Sao Paulo	Innovative, important
1968 fwd.	Trinidad & Tobago National program	Unable to develop national program
1968 fwd.	Colombia National program	Reasonably successful
1969 fwd.	Increased PAHO staff and creation of PD department	Necessary and moderately successful

Year	Activity	Result
1970 fwd.	Advisory Committee of PD	Limited value to date
1970 fwd.	Haitian National program	
1971 fwd.	Chile program	Moderately successful but unfortunate delays
1971 fwd.	Costa Rican program	Reasonably successful but limited in scope

These data reveal an increasing involvement of PAHO and a pattern of moderate but not outstanding success. Neither the 1967 Caracas Meeting nor the 1968 Bogotá Conference on the Teaching of Demography in Medical Schools are entered in the table as the OAS and PAFAMS, respectively, are judged to deserve the main credit, although in both instances PAHO was officially associated.

DISCUSSION

The courses in health dynamics in São Paulo and Santiago are recognized as the first and the most widely known courses of this type to which candidates from countries in the Region could be directed for professional orientation to the population field. The quality and orientation of the courses are well known. These courses were an important contribution to the development of population activities, and no doubt it was significant that they were in important Latin American university settings and with international agency support. (The Asociación Demográfica Salvadoreña also entered the field early with shorter courses for persons in the Central American Region, but these were not substitutes for the São Paulo and Santiago series.)

There is a discernable movement toward involvement with country programs which also is commendable, even though some of PAHO's opportunities

of a few years ago did not end favorably (overtures from the Dominican Republic were not followed up; the pre- and post-revolution efforts in Peru came to naught; Trinidad and Tobago has not developed as a national program). PAHO's recent experience in this regard is better, although partial evidence suggests that activities with regard to Chile, Peru, and Ecuador might have benefited from an earlier or more complete exchange of information with other interested institutions.

Finally, the need for a more formal and integrated program strategy has been discussed elsewhere in this Report, expecially in setting priorities for training, courses, and fellowships and relating them more closely to program activities.

IIA.4: ADMINISTRATIVE PRACTICES

PAHO's long experience as an international agency has evolved administrative procedures which appear to meet professional standards of administration and accountability, and there probably is little flexibility or opportunity for change within the procedures. Nevertheless, there may be some small modifications that would enhance the performance of the Department of Health and Population Dynamics and be compatible with the overall system, and one area deserving of negotiation with AID (see Item h).

a. A distinction can be made between the general agreement between PAHO and the Ministry for activities in the country, and the specific project to be implemented. We accept the first as a necessary and given part of PAHO's procedures which will continue, and only comment on the project description.

b. Whether the individual project be described within the general agreement, or be separately negotiated, we feel that the individual project should be given more explicit treatment. For every period for which funding or approval is provided, an explicit statement of the purposes and conditions of PAHO assistance should be prepared. It also should have sections on its antecedents, and record an approved budget by major line items. This statement should be transmitted to and accepted by the institution receiving and administering the funds. In the case of consulting missions which are administered by PAHO, a report should be promptly transmitted to the requesting and authorizing institution(s).

c. A project budget should not be rigid and unyielding, and depending upon the policies of PAHO and its donors, flexibility up to 10 or 20 per cent without changing the overall amount should be permitted to the recipient institution.

d. Evaluators also may want to set targets in the project document. This may be possible, but the uncertainties inherent in many situations and the professional, developmental nature of many work plans may not lend themselves to precise targets. We do, however, urge that purposes of the grant be described with as much specificity and detail as the situation permits.

e. PAHO should obtain periodic reporting on the activities that they support, and establish a more explicit and objective monitoring of the grants. The reports should briefly describe progress toward the purposes of the grant, and expenditures by broad budget category.

f. We suggest that the documentation on each project be maintained in a single master file, or cross-referenced from such a file to some central repository such as the library for substantive reports, or the computer for the financial records (with appropriate back-up documents to be retained according to the judgement of the Organization). Of course, if the substantive reports are stored centrally, they should also be carefully catalogued and cross-indexed to the project to which it is related.

g. Evaluation is discussed in the section on research and evaluation, for evaluation is different from the monitoring of individual projects.

h. Until the Organization has experienced an extended period of satisfactory stable arrangements for obtaining supplies for country programs, especially contraceptives, PAHO should have authority to spend grant funds to prevent or ameliorate emergency situations that threaten to delay the progress of the programs.

IIA.5: STAFFING

PAHO has been slow to fill all the staff positions authorized and this has slowed somewhat the work of the department. On the other hand, there are limited numbers of capable, experienced persons available, which explains in large part PAHO's inability to promptly fill the positions.

We found the quality and dedication of the staff with whom we came in contact with few exceptions to be competent, concerned, and knowledgeable and the recently hired staff appeared to maintain or increase the overall quality of staff. Perhaps the level of responsibility of the work assigned to a few headquarters positions exceeds the grade-level, experience, and maturity of the persons carrying out the tasks. The individuals that we have in mind compensated with great energy and dedication, but consideration should be given to a review of this and possible upgrading of one or a few positions.

Following are organogramas of the department.

DEPARTMENT OF HEALTH AND POPULATION DYNAMICS ORGANIZATIONAL CHART

ADMINISTRATION
Administrative Officer (P.7)
Mr. Alfonso S. Guerra
Administrative Clerk (G.5)
Mr. David A. Feffer
Secretary (G.4)
Mrs. Virginia Somoza (Temp.)

Chief (P.6) Dr. Richard A. Prindle*
Administrative Assistant (G.6)
Vacant
Secretary (G.5)
Mrs. Lucy Betancourt
Clerk (G.5)
Vacant
Clerk-Typist (G.4)
Miss Anadina Martinez (Temp.)

INFORMATION
Technical Officer (P.2)
Miss Sylvia Cambiaso
Information Clerk (G.5)
Mrs. Laura Wilson
Secretary (G.4)
Mrs. Nancy Barrero (Temp.)

FAMILY PLANNING
Medical Officer (P.4)
Dr. Dean Tirador
Nurse/Public Health (P.4)
Vacant
Demographer (P.2)
Mr. Carlos Gómez
Secretary (G.4)
Miss Kay Ford

EDUCATION AND TRAINING
Medical Officer (P.5)*
Dr. Silvio Gómez
Educational Aides (P.3)
Dr. Maria T. Cano
Technical Officer (P.2)
Miss Vicki Hammer
Secretary (G.4)*
Miss Nelly Ruiz

MATERNAL AND CHILD HEALTH
Medical Officer (P.5)*
Dr. Jorge Rosselot
Medical Officer (P.4)
Dr. Jorge Osuna
Medical Officer (P.4)*
Vacant
Secretary (G.4)*
Miss Genoveva Nordenflycht

RESEARCH - CLAP
Director (P.5)*
Dr. Roberto Caldeyro-Barcia
Perinatologist (P.4)*
Dr. R. L. Schwarcz
Perinatologist (P.4)*
Dr. O. H. Althabe
Perinatologist (P.4)*
Vacant
Geneticist (P.4)*
Elect. Technician (P.3)*
Vacant
Neurologist (P.4)*
Vacant
Statistician (P.4)*
Vacant

HEADQUARTERS STAFF NOT DIRECTLY IN PD
Medical Officer (P.4)
Fellowships (Recruiting)
Technical Officer (P.2)
Budget and Finance
Mr. Abul Hassan

Clerk (G.6)
Fellowships
Mrs. Isabel Wallis
Clerk (G.5)
Finance (Vacant)

Clerk (G.5)
Personnel
Mrs. S. Scioville

FIELD STAFF

ZONE I
Medical Officer (P.4)*
Zone Advisor (Jamaica)
Dr. Mario Felszer
Medical Officer (P.4)
Zone Advisor (Trinidad)
Dr. Pierre Severyns
Family Educator (P.4)
Zone Advisor (Trinidad)
Mrs. Kanta Khipple
Nurse/Midwife (P.3)
Zone Advisor (Barbados)
Miss G. Allman

ZONE II
Medical Officer (P.4)*
Haiti, Dr. Gerard Rolland
Mass Commun.Expert(P.4)
Haiti (Vacant)*
Health Educator (P.3)*
Haiti (Vacant)
Statistician (P.2)*
Haiti (Vacant)
Secretary (G.4)
Haiti
Mrs. Emile Amedée

ZONE III
Medical Officer (P.4)*
Zone Advisor (C.R.)
Dr. Jesus López
Medical Officer (P.4)
Zone Advisor (C.R.)
Dr Germán Mora
Nurse (P.4)
Reg. Advisor ST/NUR
Miss Mabel Zapenas
Secretary-Nursing (G.5)*
Guatemala (Recruiting)
Secretary (G.4)
Vacant

ZONE IV
Medical Officer (P.4)
Colombia
Dr. Nora Bertoni
Medical Officer (P.4)
Colombia (Vacant)
Medical Officer (P.4)*
Ecuador
Dr. Duncan Pedersen
Social worker (P.4)
Reg. Advisor (Bogotá)
Miss Gloria Abate
Nurse (P.4)*
Reg. Advisor ST/NUR
Miss Agnes Lima

ZONE V
Medical Officer (P.4)*
Brazil - Vacant

ZONE VI
Medical Officer (P.5)*
Zone Advisor (Argentina)
Dr. Francisco Mardones
Medical Officer (P.4)*
Chile
Dr. Néstor Suárez Ojeda
Secretary (G.4)
Mrs. Nélida Suárez

* Paid by funds other than AID

IIA.6: CONSULTANTS

(a) Terms of Contract, Objectives, and Programming

The text of the AID Project Agreement with PAHO does not describe in any detail the objectives of the consultant program of the rationale for the use of consultants vis-a-vis the substantive areas covered by PAHO/PD operations, the areas assigned to the existing permanent staff and the long-term design of staffing patterns. The only element of programming in the Project Agreement is a quantitative one, the provision of 94 man months of consultants for 1971. In the absence of any justification or evaluation of past experience, this number seems arbitrary.

However, in two documents entitled "Summary of the Working Document Education and Training in Health and Population Dynamics in Latin America" referring to a paper prepared for a meeting at Headquarters held in March-April 1968, and "Activities of the Department of Health and Population Dynamics," some elements of programming can be found:

1. To provide 25 man months of consultants per year to seven national MCH/FP programs in the methodology and execution of in-service training.
2. To provide technical assistance in the preparation of educational materials for in-service training.
3. To assist in the development of evaluation methodology and in the implementation of government training programs and university education and training courses.

(b) Analysis of Information

The Team was provided with information on short-term consultantships in 1970 and 1971 and the analysis therefore is limited to these years. There was not sufficient time to obtain information for 1969, although during that year a total of 50 man/months were used, a larger program than in 1970.

1. Distribution by Category

In general terms, and due to the lack of appropriate definition of the term "Consultant," both in the contractual documents and in the operational sense, a variety of activities are covered under this item:

a. Experts for project-related activities in the field.

b. Experts for organizational or preparatory work for seminars, courses, and meetings.

c. Lecturers in courses and seminars.

d. Participants in regular Committee meetings and field personnel meetings.

e. Experts for development of headquarters activities.

f. Preliminary contracts with personnel later joining as regular staff members or retained on contract.

g. Other.

During 1970, of a total of 38.5 man/months used, nearly 74.0 per cent were connected with field operations. However, 41.6 per cent of the total were for category f. that is, staff under consultant contract pending regular appointments.

During 1971, field activities either at country or at regional level accounted for 69.4 per cent of the total 86 consultant man/months, a similar proportion to the level in 1970. Zone I (Venezuela, Surinam, Guyana, and the Caribbean Islands with the exception of the Dominican Republic, Haiti, and Cuba) had the largest share of consultant-months, followed by the regional programs and by Zones VI (Argentina, Chile, Paraguay, and Uruguay) and III (Central America and Panama), while Zone II (Cuba, the Dominican Republic, Haiti, and Mexico) received only 1/4 month of consultant time.

Lecturers for courses (18.3 per cent) and attendance of meetings at Headquarters (4.5 per cent) accounted for nearly 23 per cent of all consultant months. In 1971, with the appointment of former "consultants" as staff members, the use of the consulting budget for support of staff is reduced to 7.8 per cent of the total use of the item.

2. Distribution by Subject

Although a number of subjects are covered by consultants, the most significant differentiation which can be made is between Family Planning or FP-containing subjects, and MCH or health-related ones without family planning. The percentages that follow are approximations that were worked out from expanding the information provided and reviewing a number of consultant reports.

In 1970 approximately 5.0 per cent of consultant months were used for direct MCH activities while in the rest, FP and MCH were appropriately blended when FP was not the principal or only subject. During this period, no PAHO funds were used. A considerable change occurred in 1971 when 34.8 per cent of consultant months appear to have been used for direct MCH activities, of which 15.0 per cent were financed by other PAHO resources, and 19.8 from AID funds.

USE OF CONSULTING FUNDS BY SUBJECT AND SOURCE OF FUNDS, 1970 AND 1971

	1970	1971
MCH only	5.0	34.8
AID	5.0	19.8
PAHO	-	15.0
MCH/FP	95.0	65.2
AID	95.0	65.2
PAHO	-	-
Total(%)	100.0	100.0

3. Utilization of Consultant Reports

A thorough study could not be made of this important element of evaluation due to time limitations, and additional study, perhaps by Headquarters staff, would be advisable. Based on the limited number of reports that were made available and reviewed, it would seem that some adjustments would yield improved results. Written terms of reference were not apparent for each consultant mission and, judging from the less than positive comments elicited by a number of reports it is possible that a clearer definition of purposes or a detailed description of what was intended could have prevented recommendations either too general or too unrealistic to be implemented. A further area to be explored relates to the frequency of follow-up of consultant recommendations. The degree of their implementation could well disclose whether or not the program is utilized for appropriate objectives and if it responds to major needs. At least one valuable report seems to have been dropped or ignored by PAHO's local and Headquarters staff.

4. Limitations of the Consultant Approach

The preceding analysis suggests that the largest difficulties arise when consultants are hired to help in the design of policies. The complexities of the internal PAHO structure and of the mandates and existing policies in fields closely related to Population Dynamics, considerably limit the ability of an external individual on a short-term assignment. For example, we observed two occasions in which consultants were hired to develop policies related to the interface between Health/MCH and Population/Family Planning. The results have been extremely limited even though in one case eleven months were allowed. There may be additional explanations for the use of consultants, but we feel that the PAHO staff itself should be prepared to undertake this task and cope with the intricacies of policy making.

5. Traveling by Staff Personnel

As an adjunct to the analysis of the consultant program and as a basis for decision between its continuation at projected increased rates, and the enlargement of present staff personnel, a computation was made of traveling days by the latter during 1971 and up to the present moment in 1972. The following observations may be useful.

- In spite of the considerable increase in total consultant months in 1972, the permanent staff continued to travel at frequencies and lengths similar to those in 1971. Is this because consultants are not used for work in substantive areas covered by staff? Or that the increase in country projects or openings demand staff travel? (It seems that travel by staff is about equally divided between promotion and implementation purposes.)
- The sections more strained by traveling schedules are Education and Training (three members) which completed 29 weeks of mission in 1971 and 14.5 weeks in 1972 up to June, and Family Planning where only one staff member had 15 weeks of mission in 1971 and six weeks in the period covered in 1972.

(c) Discussion

There is an evident discrepancy in the consultant program between its stated purposes and the structure and achievements of the operation. This is undoubtedly related to the absence of detailed programming which has left PAHO/PD with a free hand to operate this particular component of its activities.

The analysis of the performance of PAHO/PD in this area points to the need now for carefully planning the role of consultants and the objectives of particular missions. The setting of a quantitative goal for the use of consultants' services would be extremely inadvisable at this point, because

it would submit PAHO/PD to undue pressures to spend their allocation and encourage erratic, unorganized efforts.

The following items should be taken into account when programming further investments in consultant services for PAHO/PD:

1. As country programs grow in importance within the overall PAHO/PD operations, central budgeting for field consultants should decrease, since in most cases consultants can be included in country programs. At the present time central budgeting for blocks of unspecified consulting time should decrease significantly although the total amount of consulting time may or may not decrease, depending on the needs and budgeting for country projects.

2. Consultant services should be better organized to improve productivity. In this regard, detailed and specific terms of reference should be produced for each mission, with indications for the structure of the report and with emphasis on the precise objectives of the task. Copies of the reports should promptly be delivered to the requesting agencies. Similarly, PAHO/PD should be prepared to implement the consultant's recommendations, or go on record as to why the report was not useful. The underlying assumption is that services of consultants should be used with precise objectives in mind, usually ones that have to do with evident program needs.

3. A definition of "Consultant Services" should be attempted with the purpose of streamlining this component, eliminating from this category those services which are not in the realm of technical assistance.

4. It would seem appropriate at this point to consider an enlargement of the present permanent staff, both to ease their travel pressure but most significantly, to decrease the use of consultants. However, before thinking on a further expansion of staff, attention should be paid to the completion of staffing plans as presented in the 1971 chart where a number of posts are still vacant.

IIA.7: POPULATION RELATED ACTIVITIES

PD has established contacts with other departments of PAHO but there is little evidence that the other units have incorporated significant activities in support of family planning in their plans or projects. Opportunities could be identified in various fields: health planning, administration, nursing and midwifery, statistics, research, and so forth.

Population activities remain concentrated in HPD although efforts should be continued with increased vigor to promote support and assistance for family planning services in the other regularly funded activities of the Organization. In addition special activities of assistance to population goals should be sought from other departments through agreements including "seed money" from PD to finance them at the start, if necessary.

The Director of the Organization should consider highlighting within the Organization and to the member Governments the serious impact that demographic factors have on health and welfare, in order to raise the effective level of concern throughout both audiences, which incidentally will interact favorably with the U.N.'s official and worldwide efforts for the Population Year.

IIA.8: COORDINATION WITH OTHER AGENCIES

It is the Evaluation Team's impression that the Organization has shifted significantly in recent years toward increased communication and coordination on population matters with other public and private organizations that also support or conduct activities in population. This reputation, and the salutary effects derived from the actions that earned it, requires continued conscious efforts to continue and increase it. Coordination and communication must be reciprocal and should recognize the fact that as yet no organization operating in the region has sufficient manpower, funding, or expertise to dominate the field, or is likely soon to do so, and that divisions of labor and specialization are essential for the greatest benefit of the people and the countries of the region.

Division of labor and specialization should not imply exclusivity--for example, that no more than one organization should operate in the same substantive area (research and evaluation, demonstration and testing of rural delivery systems, etc.) or geographical area (e.g., the experience in Colombia). This form of operation does call on PAHO and the other organizations to be sensitive to and make special efforts to avoid "encroachments" on programs underway, and to discuss promptly and candidly areas of possible overlap or conflict. Some of the less obvious overlaps or encroachments include the overloading of local capacity and the hiring away of key staff. The first may occur when funding agencies depend on the same organization or staff to supervise and administer projects funded independently and without coordination. Communication and the early discussion to determine whether there are potential conflicts is recommended. We do not recommend on principle an exclusive relationship between a local institution and a single donor, although for practical reasons it may be desirable at a particular point in time and be arrived at by mutual consent.

IIB - EDUCATION, TRAINING AND COMMUNICATIONS

IIB.1 and 2: Fellowships; Seminars and Courses

Apart from specific components of education and training included in most of the country projects, the line items managed from Headquarters include Fellowships and Seminars/Courses. The information and its analysis are therefore arranged following such pattern.

TERMS OF CONTRACT, OBJECTIVES AND PROGRAMMING

As it has been expressed before, apart from establishing quantitative goals for certain activities, the text of the AID Project Agreement with PAHO does not offer any detailed description of the type or characteristics of the activities allowed within its framework, nor does it provide any guidelines or limitations for the use of the funds in the performance of these activities.

Only some general objectives are included in the document and programming is limited to the setting of numerical targets. In the case of the Education and Training component, the targets for 1971 are to award 182 fellowships and to sponsor 20 seminars and conferences.

In the two documents mentioned in IA.6, which were not declarations of policy or formal programmes for some of the components included, a number of more specific albeit scattered presentations of purposes and targets can be found. The following list is extracted from these documents in what pertains to education and training. It should be mentioned, however, that the reasons were not given for the targets thus proposed.

1. FELLOWSHIPS:

   a. To promote the teaching of specific skills required in the provision of FP/MCH services to personnel engaged in service delivery.

b. To provide 50 long-term and 120 short-term fellowships for post-graduate training in fields related to health and population dynamics.

c. To train faculty members of Medical, Nursing and other related schools, in population dynamics. For this purpose, 30 long-term fellowships per year increasing to 70 per cent were envisaged, as well as returning fellowship grants of undefined size.

d. To survey FP educational and training facilities in Latin America every three years.

2. SEMINARS AND COURSES:

a. To develop and improve the capacity of University Departments to teach FP as part of MCH, demography and human reproductive physiology. To this end, five institutional grants per year were to be provided to Schools of Medicine, Nursing, Midwifery, Social Work and Public Health. In addition, one seminar per year in reproductive physiology was to be organized.

b. To promote motivation and orientation of FP/MCH personnel, through the realization of three seminars per year for personnel of Health Ministries in three countries. Directive personnel were to be approached by informal meetings to inform them of current developments in the field. Medical and paramedical personnel were to receive information on actual FP/MCH programs and their relevance to national social and economic situation, administrative techniques, and demographic effects. Finally, local level personnel were to be instructed by seminars on technical aspects of FP/MCH programs in separate groups of medical and paramedical.

c. To organize approximately two meetings per year on results and progress of research programs.

d. To organize two seminars per year in skills related to educational methodology.

e. To conduct orientation meetings within PAHO.

ANALYSIS OF INFORMATION

1. FELLOWSHIPS:

Two main kinds of fellowships are combined in the information provided, those awarded to participants in PAHO-supported courses and seminars (irrespective of origin of funds), and those awarded to individuals for training in specific institutions. A third but minor group correspond to the so-called "observation tours".

A sharp increase in the number of fellowships occurred in 1971 when over 200 were awarded, a three-fold increase from the 77 in 1970. For 1972 a further moderate increase is expected. We have been able to analyze figures pertaining to the 1971 program and further to review twenty-five files of non-course fellowships during that year. The following information has been gathered:

a. PAHO Course vs. non-PAHO Course Fellowships:

Out of a total of 204 fellowships, 113 (55 per cent) correspond to courses financed by PAHO from various sources and 91 fellowships for non-PAHO supported courses. In the first category 108 were covered by AID funds and only five by PAHO funds. In the second category 39 fellowships are financed by AID funds, 52 are under PAHO financing.

b. Subject:

A number of subjects are included in the fellowship program

and again the most significant differentiation that can be made is between family planning and non-family planning oriented fellowships. Since in some cases the differentiation becomes rather arbitrary, a sensible measure of other elements has been considered when qualifying a family planning orientation.

Insofar as course fellowships are concerned, we find that 38 of them (35 per cent) financed by AID, do not have an explicit family planning content; for example, the courses in Clinical and Social Pediatrics (23 fellowships awarded) and the CLAP and Three-Nation Courses (10 fellowships awarded).

On the other hand, out of 39 non-PAHO course fellowships financed with AID funds, 16 of them (41 per cent) have not been explicitly related to family planning. Support was given, for instance, to training in Pediatrics, neo-natology and genetics. In addition, undefined "observation tours" account for 10 of the remaining 23 fellowships. This indicates that only 13 direct fellowships were awarded for specific courses with a substantial family planning content.

c. Duration:

The large majority of awards are for short-term training, a consequence of including here fellowships for participants in PAHO-supported courses which are mostly of the short-term type. A similar effect is additionally produced by including observation tours of one to three months. Thus, 156 out of 204 fellowships are below four months duration. Only 44 had a duration of more than eight months and of these, five were for more than 12 months, indicating a limited effort in the sustained and more complete training of professionals in Latin America.

d. Financing of fellowships:

AID funds are used for financing most family planning trainees, and PAHO regular funds for most non-family planning trainees, but to a lesser extent AID funds are used in a considerable number of cases for financing non-family planning trainees, both in PAHO course and non-PAHO programs, and regular PAHO fellowship funds are used not only for health or MCH training but also for family planning. This is indicative of the fact that the use of AID funds in non-family planning training is not due to lack of other resources but rather to the procedure for assigning available funds. One aspect of this is the inflexibility in switching PAHO's regular fellowship funds once they have been programmed to countries and purposes. Since this occurs well in advance of their use, PAHO only has the AID funds to use for adjustments to new opportunities or changed conditions. (Also see the Note on page 61 for an additional point.)

e. Program orientation:

Although the data collected are insufficient to support the point in factual terms, we have the strong impression that the fellowship program lacks a project related purpose. In other words, while specific country projects managed by PAHO are on the increase, the fellowship program continues to be built on the existing and unorganized demand. The ready explanation for this could be that courses and fellowships with specific objectives are also included in country projects and do not form a part of the data made available for analysis. However, if this were the case, we would expect the fellowship program to be dropping in importance rather than increasing as it has in the last two years and in the projections for the future. In addition, as the program becomes superseded by components in country projects, it would be logical to expect a narrowing in its scope, size, and content, and a greater delineation of areas to be covered within an explicit strategy.

f. Survey of ex-fellows:

A survey was attempted early in 1972 to obtain information on the post-training activities of former fellows of PAHO/PD.

Adequate questionnaires were sent to 121 fellows, probably more than one-third of all fellowships since the program started. Sixty-seven returns were accounted for.

A more complete response will have to be obtained in order to confirm the validity of some interesting but tentative results, such as the following:

- 42 per cent of fellowships were provided to individuals working in FP programs.
- 72 per cent of those receiving fellowships were later engaged in FP activities.
- 78 per cent of recipients were from government agencies (MOH or related); 54 per cent were involved in teaching and 31 per cent in administrative levels.
- 88 per cent of awards were for training in Latin America, which reflects the PAHO-supported courses in the total.
- 96 per cent were for short-term training, equally related to the above observations.

2. SEMINARS AND COURSES:

Three categories of meetings are included under this heading, covering various periods from 1965 to 1972:

a. International meetings.

b. International courses and seminars.

c. National Courses.

In general, activities of this nature have increased with the years, reflecting together with the increases in the number of fellowship awards, a continued reliance on information and training for motivation as well as for professional development. It should be pointed out that, as in the case of fellowships, the increase in seminars is mainly in short-term activities. From 1965 to date nearly one hundred courses, seminars and meetings have been held under the auspices of PAHO, with approximately half of them in 1971 and 1972. It is expected that the number in 1972 will be larger.

a. International meetings:

Out of 13 such meetings held between 1968 and 1972, seven took place at PAHO Headquarters, three of them corresponded to regular meetings of Advisory Committees, which should probably form a special category. The remaining four were technical meetings convened at Headquarters to explore subjects ranging from components of FPP (nutrition, cervical cancer) to health education and educational technology.

In all cases, family planning elements are reasonably well incorporated with the exception of the meeting on Research on Maternal Risk at CLAP (Uruguay) which is rather directed to MCH. It has not been possible to analyze the origin of funds used for each of these meetings but based on their content noted above, this would not appear to warrant any further exploration.

b. International courses and seminars:

A total of 45 are reported by PAHO to have taken place between 1965 and 1972. The majority of them are serial (annual or biannual) courses which have been conducted from the late sixties to date.

A useful exercise was carried out and reported in the document,

"Evaluation of selected international courses in Health and Population Dynamics". This reviewed the content of most of the courses, according to the list of subjects covered in them. However, two of the three classifications used are not well defined, one being "Population Dynamics" and the other "Health and Population Dynamics".

According to the data provided, two out of eight courses analyzed contain 20 per cent or less family planning and "direct" population dynamics subjects. These are the CLAP Courses on the Scientific Basis for the Care of the Mother, Fetus and Newborn, better defined as a course on Perinatology-cum-Reproductive Physiology; and the Courses on Clinical and Social Pediatrics respectively. In both cases AID funds have been used for partial support, mainly in the way of fellowship awards.

Out of the remaining six courses, three of the most important international courses have similar orientations and, therefore, areas of overlap and duplication. These are the Latin American Course in Maternal and Child Health and Family Welfare, the Course on Health and Population Dynamics and the Latin American Course on Integrated Care of the Woman. The first two were initiated between 1967 and 1968 with an approximately annual schedule, while the latter is a 1971 addition. All three courses were held in Chile, using PAHO funds, and one of them also was held in Argentina and another in Brazil. These three courses should be reviewed with the objective of eliminating duplications and of integrating them into a more comprehensive training scheme which also would provide more balanced support to institutions and countries.

c. National courses:

A total of 42 courses are listed to have taken place between 1968 and 1972, the bulk of them between 1970 and 1972. One of the listed activities was not a course, but rather support extended for a donor agency meeting promoted by the Population Council and convened by the Government of the Dominican Republic to advise in the reformulation and possible expansion of their family planning program.

Only five of the courses have limited contents of family planning, although Peru cancelled two others of this category which had been proposed for 1972. Those with limited family planning content are the course on Perinatology, the Seminars on Social Pediatrics, and the Pediatric Seminars, the latter two based on the Chile program of Clinical and Social Pediatrics mentioned in item b.

DISCUSSION

Although Education and Training appears to have a high priority among PAHO/PD activities, little has been done to design a formal strategy based on a thorough analysis of the situation in the field, the needs of countries and the region, and the real possibilities of implementation by the PAHO/PD apparatus. As a result, most of the activities developed in the field of Education and Training are disconnected and seem mainly to continue the familiar ones to which are channelled the spontaneous, disorganized demand of institutions and countries.

This is especially the case of the Fellowship program which does not present a defined pattern to the observer. In comparing achievements with the few stated goals, failures are more noticeable in the case of long-term fellowships which were planned in large numbers for post-graduate training and, more specifically, for faculty members of medical and paramedical schools.

In view of these facts, we endorse the survey of the needs and infrastructure for training in the field of health and population in the region being arranged jointly with the School of Public Health of the University of Antioquia, Medellín, Colombia. Although this exercise might be time-consuming and complex, it should be an important tool to redirect the program. While the survey is being planned and carried out, PAHO/PD should examine its past performance and consider several adjustments in the AID-financed fellowship component:

a. To reduce the significance of the program while building training components into country projects, and to concentrate on a smaller scholarship program with major emphasis on long-term training.

b. To narrow down the scope of the program to those subjects more directly related to health and population, leaving demographic and statistical training largely to other agencies already active in the field, and to whom PAHO/PD would make referrals.

c. To develop a more program-oriented design, in accordance with the needs detected in the past years and in preparation for possible country projects.

d. To build a system for the regular follow-up of fellows after completion of award.

NOTE: Inasmuch as PAHO finances some population fellowships and training for important non-AID countries using other funds, it is prudent to accept PAHO's use of some AID funds in marginal uses which might otherwise have absorbed regular funds.

Seminars and Conferences show a higher level of achievement in numerical as well as in substantive terms. As a matter of fact, PAHO/PD has been able to gradually organize a number of course series in a region where only limited training opportunities existed before. The support of university groups might

be the most important contribution of PAHO/PD. Out of a target of "five grants per year" to university medical and paramedical schools, PAHO/PD has been able to work in up to nine departments comprising three Schools of Public Health, one Department of Pediatrics, two Schools of Nursing, and three Special Departments linked to Medical Schools. Although, as we have indicated before, the need exists for a more even geographic distribution of efforts and for a higher stress in FP, this seems to be an area where PAHO/PD can continue to be effective.

In the case of International Courses and most of the National Courses, PAHO/PD provides basic support for the institutions concerned. The training offered is therefore part of a larger effort of institution building in which a large component of research is also considered.

The additional activities programmed for Education and Training have received less attention. Although supplementary information might exist in specific country programs, the objective of holding three seminars per year for personnel of Health Ministries in three countries, seems not to have been completed. The same can be said for meetings planned on results of research programs. In the case of orientation meetings proposed for personnel of PAHO, appropriate measures have been begun to link PD Headquarters and field personnel. However, little has been done in a formal way to gain the acceptance of other PAHO Divisions, to strengthen coordination with them, and to use their skills and experience in the pursuit of PD goals. This particular subject is discussed elsewhere.

The following lines of action can be suggested for the more effective development of Seminars and Conferences:

a. To improve the geographical distribution in the support of training and research institutions.

b. To reexamine the content of certain international courses where overlapping occurs, in order to either make them complementary or integrating them into a more comprehensive scheme.

c. To continue improving the population content of courses and seminars, especially those related to reproductive physiology and pediatrics.

IIB.3: COMMUNICATION AND HEALTH EDUCATION OF THE PUBLIC

A WHO Study Group on "Health Education in Health Aspects of Family Planning" in 1971 defined the objectives of family planning communication and education as follows:

1. To develop within the community a social environment and attitude wherein family planning is an accepted and advocated practice;
2. To help people comprehend the health and other values of family planning;
3. To make people understand the need for continued observance of family planning practices;
4. To provide psychological support for those who accept family planning practices; and
5. To ensure that all family health services and contacts with the staff are satisfying to the individuals.

Based on the above, it is obvious that activities which facilitate communication related to MCH/FP should form an essential component of the overall program activities of the Division of Health and Population Dynamics (PD) of PAHO.

The PAHO communication program consists of two parts, depending upon the audience to whom the information is being addressed: (1) professional and technical communication, or (2) communication for the general public.

1. Professional and technical communication:

   a. Documentation Center at the Headquarters

      The plan is to collect and distribute relevant information and materials to the staff members of PAHO (including field staff) and to the collaborating institutions in the Region. Newsletters about the related activities of the Department have recently been

prepared and distributed to keep related individuals informed of the current program status and activities of PAHO.

b. The Regional Library of Medicine

PAHO has been assisting the Regional Library of Medicine, located in São Paulo, Brazil since 1967, with the objective of facilitating regional communications on biomedical sciences, including MCH/FP.

c. The Library of the Latin American Center of Perinatology and Human Development (CLAP)

PAHO assisted CLAP in the collection of scientific publications related to MCH and Family Planning and supported some of its publications to further the dissemination of related scientific information within the Region.

2. Communication for and education of the general public:

A communication and educational program to enhance the awareness of political leaders and the general public of the problems related to the rapid population growth and health and welfare of mothers and children, and to create a social and political environment to "legitimize" MCH/FP is particularly important in Latin America. Activities of limited scope in this regard which have been undertaken by PAHO include the following:

a. Technical assistance to countries

Advisory services have been given by PAHO--through its regular staff members and its short-term consultants--to a number of its member countries for the planning of communication programs, including the design, production and evaluation of the communication materials developed.

Several workshops or seminars on communication methodologies have been organized by PAHO with the participation of the key staff of the member countries in order to enhance their professional competence.

b. Sex education and family life education

PAHO has been involved in the family life education programs in Trinidad and Tobago, Jamaica, St. Vincent and El Salvador and has expressed its interest in assisting in a sex education program in Costa Rica.

c. The educational component of MCH-Family Planning

Communication and the health education of the public on maternal and child health care and services is an essential component of the MCH-Family Planning program. PAHO, in order to promote the related services, has been encouraging the promotion of related educational activities to facilitate the attainment of the program goals. Assistance for this phase of activities is usually in the form of advisory and consultative services including some financial support for the preparation and production of materials.

d. Pilot project in educational technology and material production

PAHO contracted with the International Institute for Educational Technology to study and recommend methods for the improvement of patient information and education methodology for the postpartum program in Costa Rica. Also, PAHO assisted the country in establishing a Center for Materials Production to facilitate public education on MCH-Family Planning as well as on general population education and sex education.

As an essential part of the comprehensive postpartum program, the plan is to develop self-instructional materials which can be used at the clinics for patient education and which interfere little with routine clinic procedures.

PAHO's communication program has hitherto been concentrated on two major aspects as indicated above; namely, communication to enhance the technical competence of related professionals and PAHO's own technical staff, and education of the public to enhance their acceptance of related activities and programs. These are correct approaches for which there is no objection. The question is whether the individual projects implemented are the best approach to reach these goals, and whether there are alternative methods which will better meet the goals more promptly and at less cost. In other words, given a fixed amount of resource to meet the stated objectives, are these projects the best approaches, and if not, what should or should not be done or how should or should not they be done? Following are some critical observations on groups of PAHO communication projects.

1. Documentation Center at the Headquarters

The project has just been started and it would be difficult at this stage to assess its merits. A general impression is that the attempt to bring the headquarter and field staffs closer by periodically preparing and distributing newsletters to inform of all the related activities is superb, if the quality of work can be consistently maintained without undue demand on the time of the professional staff at headquarters. We commend PAHO's stated approach to operate where possible as an "expeditor" rather than as a "depository" of materials. That is, PAHO will help to identify and locate desired materials and arrange for the requestor to obtain them directly from the source.

Most international organizations interested in population programs are publishing technical materials periodically and it should be possible for PAHO to better utilize these available resources

to meet their purposes. Examples of such publications include those prepared by the IPPF, Population Council, United Nations, World Health Organizations, Ford Foundation and others. The documentary services of the Population Council are particularly systematic and comprehensive including such periodicals as Studies in Family Planning, Country Profiles, Reports on Population/Family Planning, Population Chronicle, and Current Publications in Population/Family Planning. The latter publication, which appears bi-monthly, reviews most of the current technical papers on related subjects and gives a concise summary of their major findings--this should be useful in up-dating the knowledge of the related professional staff. In addition, the Population Council reproduces selected scientific articles of special relevance to organizations or individuals in the related field. (Interested persons can have their names included in the regular mailing list in order to receive all of these publications at no cost.)

As a way of expanding the activities of the Documentation Center, PAHO might wish to examine the following questions:

a. Are all the related professional staff receiving regularly most of the technical materials cited above, and if not, can steps be undertaken promptly to ensure that they receive them regularly?

b. Suppose that most of these publications are received by the staff, what other technical materials are needed by the staff? Will the planned Documentation Center fill the needs at a reasonable cost? Are the Staff aware of what the Center can do for them?

c. Some mechanism of evaluating the actual utilization of the materials received should be established. Will it be possible

to undertake a simple survey for this evaluative purpose?

It is advisable that major scientific publications related to population matters, including the technical reports of WHO related to MCH-Family Planning, should be translated into Spanish and distributed to related institutions and individuals, if this is not already a routine practice of PAHO. The Population Council has arranged for the regular translation of Studies in Family Planning and a limited number of related publications and articles; similar arrangements should be made by PAHO for facilitating the dissemination of scientific knowledge about MCH-Family Planning.

2. Regional Library of Medicine and Library of CLAP

No one can argue against the utility of a good library, which is indispensable for scientific advancement and for improvement of the quality of work. The real question is--given a fixed amount of resource, whatever amount it may be, would an investment by PAHO in these libraries be the best way to achieve the [illegible]ted program objective of PAHO? PAHO should evaluate the actual utilization rates of these libraries not only by their own organizations or within the country, but also by organizations in other countries within the region to see if the projects merit the investment.

A good retrieval system of scientific information and references is a dream of students, scholars, and administrators and this is why many organizations around the world are so anxious to set up clearing houses of related information. In the population field, more than a dozen international organizations have attempted to provide such a function to serve others. There are commercial or private non-profit organizations providing such services, and the recent development

and use of Microfiche for the retrieval of documents and information has greatly facilitated such mechanism.

A large number of staff with high technical competence in all related subjects is required to provide such services of high quality. The Regional library and the CLAP library cannot be expected to provide such services unless their organizations are expanded substantially and a huge number of technical staff is added. In this case, they would be capable of offering their services not only to the institutions within the Region, but also to those in the whole world. PAHO, in this regard, is faced with three alternatives in its decision making:

a. Increase its involvement substantially to enable these libraries to really meet the regional or global needs as described above.

b. Invest a modest amount of money and effort to upgrade the library facilities in a few selected organizations in countries throughout the region.

c. Direct the current investment to meet other more urgent program needs, but develop technical competency at the headquarters to make better use of related facilities or services which are already available and which are capable of providing more comprehensive services. For example, the East West Population Center, with AID assistance, is developing such a capability. A staff member of PAHO should keep close contact with all the related organizations and developments and see to it that these facilities are best used to be most advantageous to the PAHO programs.

3. Communication programs for the general public

A remarkable change of attitude in favor of population programs has occurred in many countries in the Region during the past several years. The general attitude toward family planning as a means of achieving the country's demographic goals, however, is still in need of modification. The need to "develop within the community a social environment and attitude wherein family planning is an accepted and advocated practice", as stated by a WHO Study Group on Health Education in Health Aspects of Family Planning is particularly relevant and urgent in Latin America. A fundamental problem that is facing PAHO is how such a need be most effectively, promptly and efficiently met.

It is understandable that because of the controversial nature of the problem in a large part of the Region, the communication and educational effort for population programs has hitherto been rather limited and tended to be defensive rather than active. Although it probably is a safe strategy for PAHO not to touch any sensitive issue in order to avoid possible backlash, it should also be possible to more tactfully approach the problem and actively create such a favorable climate for family planning. PAHO is now in a position to review the basic communication strategy, for which experience gained in other countries in modifying the general climate for family planning should be studied, and wherever possible, applied. Lessons may be learned from the experiences in the Republic of China (Taiwan), Korea, Thailand, the Philippines, and other Asian countries which have adopted positive population policies in spite of their traditional beliefs in favor of large families.

a. The Population Dynamics Department should work more closely with the Health Education Unit of PAHO to examine and determine its

overall communication and health educational strategies. Such strategy review should include extensive discussion and study of the feasibilities of utilizing other related resources to meet the program objectives of PAHO. Examples are the use of nutritional educational programs or malaria control programs to facilitate population and family planning education.

Inasmuch as population program activities are multidisciplinary in nature--calling for resources and efforts of all sources--a communication program to help attain the program goals should be a coordinated effort of all the related organizations. It is inadequate for PAHO to simply assign a limited number of consultants or field staffs to help related program activities of its member countries on a piecemeal basis. PAHO should take the initiative and assume the major responsibility to study: (i) what are the communication needs to facilitate the attainment of PAHO's ultimate program goals; (ii) how may these needs be most effectively and efficiently met; (iii) what resources are available to meet such needs; (iv) which organization is most suitable to assume a particular responsibility; (v) how may the related activities be coordinated; (vi) what and where do gaps exist; (vii) how may these gaps be filled.

With a limited number of professional staff members at PAHO, it is unwise for it to attempt to undertake all the necessary activities by itself, but neither is it advisable for PAHO to simply expect other organizations to do what it wishes to be done. The best strategy is to encourage other organizations to help PAHO in achieving its program goals.

b. PAHO should endeavor to undertake a limited number of well thought

out pilot communication programs to disclose and determine what are the most effective approaches in reaching the program objectives. Research projects of limited scope had been undertaken in Taiwan to better design communication programs and to modify community attitudes for family planning with a remarkable success--there is no reason why similar approaches cannot be adopted in Latin America for similar purposes.

Communication and educational programs and materials are often designed by experts without much consideration for the needs, acceptance, comprehension of local people. In this respect, the pilot project which studies the best methods to motivate women for family planning practices, and which designs effective communication materials to meet the program need in Costa Rica is an important approach, which should be continuously and wholeheartedly supported.

c. Communication programs should be designed in such a way that their impact can be properly measured and evaluated. Evaluation of communication programs is particularly important in the Region because of the controversial nature of the program.

4. Population education in the medical and allied professional school

Education in population dynamics and family planning in the context of maternal and child health in the medical, nursing, and other allied professional schools is a legitimate activity of PAHO. Such effort should include studying the current status of related activities, examination of the adequacy of existing curriculum, the qualifications of the teaching faculty, adequacy of teaching methods and media, and evaluating the impact of such teaching efforts. The detail has been discussed under the section on Education.

5. Population education in the regular school system

This is another important aspect for the promotion of MCH-Family Planning Program for attainment of the long-term goal of the program, and PAHO cannot afford to not be concerned with its development and progress. It has now become apparent that world population problems will be with us for a few more decades, and that the educational approach to modify basic concepts about family size and fertility behavior probably is the most important method to achieve the long-term program goal. PAHO should take the initiative to study the current status and activities in this area of various organizations such as IPPF, UNESCO, and others, and see to it that the related program activities are adequately carried out. Should any gap in program activities exist, PAHO should see to it that such a gap is filled by encouraging other organizations to start relevant programs, or by implementing appropriate programs by itself.

By the same token, family life education and sex education in the school system should be promoted; also, PAHO should pay adequate attention to see to it that activities are being undertaken by the related organizations well enough to meet the overall objectives of PAHO's population programs.

In summary, the overall objectives of the Department of Population Dynamics cannot be met unless an effective communication program is designed and implemented to promote the program activities and to facilitate the acceptance of MCH-Family Planning. The need for an effective communication program is particularly serious in Latin America in order to create awareness of the problems and of the need and demand for related services in political leaders and in the general public. It therefore is essential that PAHO strengthen and improve the communication aspect of the MCH-Family Planning program.

IIC - RESEARCH AND EVALUATION

IIC.1: C.L.A.P. (Latin American Center of Perinatology and Human Development)

This is a research center for basic and clinical research. It has been functioning since 1947 in the Service of Obstetric Physiology and the Obstetric Clinic of the Medical School of the University of the Republic, Montevideo, Uruguay. It was included in the PAHO program in 1970 in order to prevent its collapse due to lack of funds, acquiring the status of a PAHO-associated institution and its head, Dr. R. Caldeyro, becoming a PAHO officer. In addition to the basic and clinical research orientation, there is training and some efforts toward the practical applications of their investigations at the clinician's level. CLAP collaborates with the Latin American Institute of the Physiology of Human Reproduction (ILAFIR) in Argentina and the Center for the Biology of Human Reproduction (CEBRE) at the University of Chile in the teaching of the two-year Latin American Course in the Biology of Human Reproduction and the six-week seminar on the Teaching of Human Reproduction. In addition, CLAP research and personnel are widely used as training resources in the region. (Plans to expand and formalize this collaboration into a new institution, a Research and Training Center (RTC) as a part of the WHO expanded program in human reproduction, are discussed in the next section).

The research output seems to be of good scientific quality as measured by publications in international journals. The training aspects of the center are well planned and there is a follow-up of the alumni for the purpose of evaluation and helping to promote the alumni's own research and teaching activities at their level sites. CLAP personnel have adequate qualifications and experience.

DISCUSSION

The quality and importance of the research and training conducted by CLAP is not questioned. What should be discussed is the appropriateness of linking this type of research to population oriented programs.

CLAP's projects are directly related to maternal health and specifically to the mechanisms of labor and parturition, and they seem to belong more naturally to reproductive physiology than to MCH/FP. The relation of CLAP activities to family planning or fertility control is quite minimal. It would seem advisable, therefore, to direct this otherwise valuable project and its derivatives, such as special seminars and courses, to sources of support outside the MCH/FP field. The opportunity could be at hand, due to the presence of the "WHO programme of Expanded Research and Training in Reproductive Physiology", of which CLAP could be a natural component. It would also be useful to explore the possibilities of transferring CLAP from the Health and Population Dynamics to other sections of PAHO dealing with health research activities. It is suggested elsewhere in the report that PAHO/PD should establish appropriate coordination with such sections.

Alternatively, PAHO might wish to support CLAP or other Latin American institutions for work on the major prevalent clinical problems in MCH, FP, and fertility control as they appear in the region. Multidisciplinary, problem-oriented research involving scientists from the biological sciences, epidemiology, biostatistics, and the behavioral sciences could seek breakthroughs on problems of regional significance. The involvement of other sections of PAHO appears to be beneficial for such widening in the research approach of CLAP whose present staff would continue pursuing their present research interests.

IIC.2: Research and Training Centers (RTC)

This is discussed primarily in terms of the role of PAHO/PD in programs of Physiology of Reproduction research, and secondarily to the analysis underlying the proposal for the region.

As to the role of PAHO/PD in this type of activity, the Department is not staffed to undertake such a large and complex task, that of promoting, screening, and financing reproductive physiology research projects in the region. The proposal for hiring two more outstanding scientists from Latin American institutions to form a team on the basis of a part-time dedication to a regional scheme is not convincing and appears to be based on an incomplete analysis of the situation. Furthermore, while PAHO/PD is still far from accomplishing all of its objectives in the MCH/FP field, an additional burden of these dimensions might further weaken the basic program. While it is recognized that an intervention of PAHO/PD in reproductive physiology research could be advantageous in the process of legitimizing family planning, the main question raised here is the degree of involvement that PAHO/PD may afford without affecting their present and future level of operations in MCH/FP.

There also is a serious additional problem in the proposed scheme, the limited participation of scientists from countries other than those involved in the Three-Nation Programme. The plan does not assure broad, effective participation of all interested institutions in the process of setting policies, priorities, and guidelines for research, and possibly in the decision-making process for approving particular projects for funding.

There seems to be an excessive concentration on the "Three-Nation Programme" as a first step of a larger design which is not well specified in time and content. If the plan is the one introduced for the WHO program,

its training component will require considerable time from the Three-Nation Programme staff and neither reflects a realistic assessment of needs nor contemplates institutional support for the trainees' countries of origin. Similarly, the expansion of the areas of research accorded to the various groups within the Three-Nation Programme is hardly advisable in view of the existence of other research groups in the region and the need to strengthen their operations rather than relegating them to a tertiary role.

DISCUSSION

If PAHO/PD considers it of overwhelming importance to acquire a role in the fostering of reproductive physiology research in the region, a role in fact brought by the WHO scheme for which PAHO would expectedly have regional responsibilities, it should do so under two conditions:

1. That the effective administration of the program does not become a burden, distracting efforts from MCH/FP, their main field of responsibility.
2. That it provides a framework for the operation of all viable centers in the region.

According to these principles, PAHO/PD should not become directly involved in the operation of reproductive physiology research, but rather join forces with other agencies already active in the field, in order to devise a proper strategy and insure the proper balance in support for the region. As expressed in the case of CLAP, PAHO should study the possibilities of involving sections other than PD in the management of those programmes. An arrangement of this sort may permit a more comprehensive scheme where the now lacking epidemiological, biostatistical, and demographic aspects would receive appropriate attention so that the family and community

research components also could be developed.

PAHO/PD should organize as its first activity a full feasibility study of institutions and human resources in the field, and become the driving force to bring together into a more concerted action the now often disparate efforts. In this connection, the influence of PAHO/PD might be exerted to transform ALIRH or build into it a more operational organization representing all institutions in the region rather than individual scientists. This body so decentralized might then undertake the promotion and screening of research projects which in fact constitute the largest and most controversial aspects of the actual work, leaving PAHO as an administrative, financing, and coordinating resource.

IIC.3: Other Investigations

Earlier the Department of Statistics of PAHO supported research activities related to population dynamics. Support of this type of activity now is provided through PAHO/PD. These activities are justified by (1) the need for increased knowledge of the inter-relationships between health, population dynamics, economic development and social change; (2) its contribution to the general improvement of statistical information in Latin America; and (3) to obtain socio-demographic data over an extended period to determine patterns of population change in Latin America.

In order to accomplish those purposes PAHO supports research activities in qualified, existing institutions for work in Mexico, Brazil, Chile and Peru. The range of activities assisted is quite broad; it includes agreement with other consulting institutions, grant for library facilities and equipment, training and fellowships, and salaries. Eight specific research projects have been completed, but due to the lack of information at PAHO headquarters, we have no comments on the scientific quality of those projects.

At the moment there are no written plans for the future course of this program other than to continue support to the currently supported institutions for about the next three years. The amount and the flexibility of the support provided to the institutions indicates that it is granted with the idea of institutional development in mind, but fellowships for staff development have not appeared to have been regularly built in. Some of the resources are also utilized in teaching activities, and we find nothing objectionable in principle to this.

There has been no major effort from PAHO headquarters to closely supervise and evaluate these projects. It seems that much of the support is granted on the basis of the prestige of the recipient institution, and evaluation has largely been left to the institutions themselves. According to the

1972-1974 budget projections, there are no plans for PAHO's future withdrawal from these projects.

RECOMMENDATIONS

1. Continue support to the existing institutions but with a more closely supervised evaluation as part of an overall research investment strategy for family planning and fertility reduction. The stretegy should combine both research per se and the dissemination of research findings.

2. Formulate a 5-year plan for research investment in Latin America including the continuation and expansion of present PAHO policy with the addition of a closer evaluation. It should seek to utilize research activities as a means of raising the level of research, providing relevant information for teaching, and providing solutions or insights for administrators and policy makers. More favorable attitudes toward family planning and fertility control among health professionals and students throughout Latin America can be expected to result. This is a strategy that may pay off handsomely in the near future.

   It should be borne in mind that in Latin America especially, today's technology depends on the health sector to provide FP and FC services, the supply side in the equations that determine fertility levels. The potential of the health sector to influence the demand--the timing in the life cycle, the intervals between births, and the number of children--is likely to be enormous. We foresee three major Latin American echelons in this regard:

   a. Schools of Public Health.

   b. Medical, Nursing and Midwives schools at the professors level.

   c. Medical, Nursing and Midwives schools at the students level.

PAHO may provide small grants for relevant pieces of research directly to selected Schools of Public Health and Medical Schools; these schools, in turn, may sponsor students' theses on relevant topics. Each year PAHO could encourage national, local, or Latin American conferences where the best works would be presented, and they also should be considered for publication, including PAHO's own publications. Of course, PAHO need not and should not act alone and unilaterally in this field.

PAHO will need competent staff to be responsible for the scientific quality of the work supported, and it may be necessary to make arrangements with qualified institutions to assist with these aspects.

3. PAHO should acquire staff capabilities at headquarters level which eventually will take over the responsibility of managing these programs. PAHO must be able to respond quickly and effectively to field needs, and, at the same time, produce original research of their own and evaluation plans so as to give PAHO appropriate capability and status in this area. If FP and FC activities are to be institutionalized in Latin America as part of the health professions, PAHO and many national groups will have to attract or develop professionals with scientific status to their programs.

IIC.4: EVALUATION

Under this heading three distinct topics are considered: the Evaluation Unit at PD Headquarters, the consideration of family planning in health, and the monitoring of projects.

The Evaluation Unit

This is a fairly new unit according to the organizational charts of the Department of Health and Population Dynamics. Its activities started in 1970 with a part-time specialist in data management. In mid-1972 a demographer joined the unit. These individuals see their role as a combination of assistance and research.

They consider that their first purpose is to assist countries in the improvement of data management, following a strategy to mechanize the system of data collection. They favor using sorting machines first and eventually, computers when the country develops the capability to handle them.

A representative of this unit visited the Colombia program in 1970 and proposed a new system after concluding that there was a poor system of data collection and low reliability of the data being collected. It has not been implemented. The part-time specialist in data management, more recently has been working with the Costa Rica program in the development of forms which could be managed with a sorting system. She thinks that this form may be used by other Central American countries.

In terms of their research input, the Evaluation Unit is concerned with the health aspects of family planning and operational research, working through existing Latin American institutions in large part. This is discussed in the next section.

Family Planning and Health

The Evaluation Unit and the PD staff member in Costa Rica have developed a conceptual framework for the organization of MCH services, including family planning, and the referral and treatment of patients for an urban and near-urban population. It is based on a screening of patients by risk status and their differential handling within the system. Included in the conceptualization are evaluation targets, primarily in accounting for the appearance of women at successive contacts in the system, and of study to those that fail to appear to use the services.

Currently they are seeking to apply this to the existing program in Costa Rica, and to develop an adequate reporting system and a protocol for a hospital-based clinical study of maternal risk. They do their work primarily through consultations, seminars for motivation and information, and on-the-job training of local personnel.

DISCUSSION

This unit seems to lack orientation from their superiors, which is accentuated by their physical location at headquarters. The staff are far from their director (Dr. Tirador) who is located in another building and who travels a great deal. Until this problem is resolved, special efforts should be made for them to meet regularly with him.

If this unit is to operate effectively to provide technical assistance, it soon will need more data management specialists. Programs in the field will not be willing to stay in the "sorting" phase for long. For example, the Costa Rica program has already developed three forms or cards per client, and will outgrow the sorting mechanisms before long. Whether PAHO or this unit should staff to provide intensive technical assistance in this area is dubious in the light of other organizations already in this

field and the multitude of approaches recommended by them. Special efforts should be made to utilize other organizations in countries where historically such collaboration is indicated, perhaps with mutually redefined goals for each country. PAHO should have professional competence to assist in setting standards and in defining goals, even if it is not heavily engaged in training and assistance for the actual data management itself. If the latter course is adopted PAHO should encourage countries to seek assistance from qualified organizations, and cooperate closely with them.

The participation of the unit in research efforts will be very difficult if much assistance is needed for data management operations. On the other hand, if PAHO develops a strong team for research and evaluation, they may do special studies or evaluations utilizing the computer facilities of the Washington office, but this will require more than part-time dedication which is the most that the present staff could do. Neither should PAHO consider using its evaluation unit for the day-to-day evaluation of Latin American programs, for this should be delegated to the various project managers and the normal review procedure upward through the line of command.

Monitoring and Evaluation of Projects

Another aspect of evaluation is the continuous process of obtaining information on project activities; this can be called monitoring. Apart from its usefulness in on-going administration, this information also may be organized in periodic reviews to evaluate progress. One of several possible ways to conceptualize and organize this process is presented below.

a) Standardized forms for the reporting of information from the country level to PAHO/PD Headquarters

PAHO/PD should encourage and assist the responsible project staff to prepare standardized project data in the country, and to interpret it for local purposes. These data should include selected standard tables according to PAHO/PD Headquarters specifications if the previously planned data will not suffice. (The standard forms or tables referred to should not be confused with the day-to-day forms used in family planning programs in countries.)

The same approach should be utilized for the other PAHO/PD activities managed from headquarters (education, research, fellowships, etc.). Financial information should also come through a set of standardized forms or presentations.

A complete set of these forms, with additional comment or interpretation as may be necessary to understand special circumstances, should constitute the regular project report from the PAHO country mission to headquarters.

b) Checking the completeness of reports sent to headquarters

Reports should be checked routinely for completeness and understanding by project managers, and the report should be sent back if omissions are present or important questions unanswered.

c) Preparation of summary of tables, charts, etc. needed for evaluation

From time to time it will be desirable to combine or justapose new and previous information in order to better visualize trends, changes in the achievement of objectives, or changes in cost-effectiveness. The project manager probably will be the person most familiar with the data and able to organize the information in order to obtain a coherent view of developments, and he should carry out or oversee this task.

d) Critical review of the data by area

The country, or in special cases a project which extends over two or more countries, should be the next level of analysis, according to the type of activity. PD Headquarters staff should be assigned to a given country (or project) for rather long periods so that they may develop an intimate knowledge and understanding of the activities, and that person should look into all aspects of the work there. The responsible person may, of course, seek the advice of the specialists within the organization for specific areas or problems. In this step the responsible staff member should try to estimate the quality of the different components of the project: for example, technical assistance, training, logistics, administration, etc., and brief notes on the conclusions should be included. The critical review should end with general conclusions on the combined effect of the country activities (project) and perhaps even a simple rating from very good to very bad.

e) Comparison of programs between countries

After d) is completed for similar activities in several countries, a formal meeting should follow. In this meeting the director and the staff responsible for the various projects (activities) should be present. New summarization graphs, tables, etc., may need to be prepared for this meeting in order to present clear between-country comparisons. (If the activity in question is not repeated so that comparisons will not be possible, the formal review at the higher level can take place directly.)

f) Measure of the degree of implementation of decisions and of their effectiveness

The responsibility for this falls at the top levels of administration, and may be based on the accumulated information from the meetings referred to in e) above.

IID.1: COLOMBIA

PROGRAMA DE EXTENSION DE SERVICIOS DE PROTECCION MATERNA E INFANTIL (PESMI)

1. Promotion

Before PAHO/PD began to assist PESMI in 1968, other agencies had been doing the promotional work for FP activities in Colombia. Since that time PAHO/PD has had a special opportunity to be influential, and this was enhanced by PAHO's history of collaboration with the Colombian MOH in other health areas. All the agencies interviewed agreed on this point, and that to the present time PAHO/PD continues to concentrate on providing assistance and support to MOH requests. PAHO/PD does not appear to promote many new initiatives for the MOH, but the immediate future provides a good opportunity for PAHO/PD to work with them and ASCOFAME and the Population Council to determine the best way to continue the postpartum program after December 1972. PAHO/PD also could consider promotion with the MOH for greater use of auxiliary personnel, especially in rural areas.

PAHO/PD promotion activities today tend to be inhibited by several factors: a) Colombian authorities are undecided about implementing more aggressive FP activities. They apparently feel that there are other less politically problematic priorities in the health field. b) PAHO is faced with the problem of trying to implement a politically difficult program. c) PAHO has not produced a comprehensive strategy with the MOH. d) Within the MOH, PAHO/PD has favored the inclusion of the FP program under MCH departments. This limits the potential of the program to relate to other departments within the MOH structure and prevents the FP directors from occupying higher positions within the MOH hierarchy. e) FP is treated with so much caution by the PAHO/PD personnel in the country that the program is

practically isolated from other PAHO personnel in Colombia and there is little contact with other interested agencies in the country.

However, there is a positive picture too. Consider the trends of national investments in the program, an index to measure the country's interest in the program. The MOH has increased its participation steadily, from approximately 20 million Colombian pesos in 1971 to approximately 30 in 1972 and 40 in 1973. PAHO/PD's contribution during those years has been around 5 million Colombian pesos; therefore, the Colombian Government provides a substantial amount of the program support. These figures have to be adjusted though, with two facts: a) the gradual and modest decline through inflation of the Colombian peso, and b) the small per cent of the program activities devoted to FP.

2. Assistance/support

Since April 1969 PAHO/PD is helping the program for expanding MCH services of the MOH in Colombia through its *Programa de Extensión de Servicios de Protección Materna e Infantil* (PESMI). This aid was given according to an agreement between the Government of Colombia and PAHO signed in August 1968. The strategy has been to integrate FP as part of MCH activities, especially in the rural areas. There is no office for population or FP *per se* in the MOH. In order to realistically assess PAHO/PD impact in this country it is important to take into account the relative lack of resources for health and rural health infrastructure, and the under-utilization of the available resources. This is not unusual in Latin America, but it is complicated in Colombia due to the federal structure of government and the absence of a unified health service.

The MOH did not start its present FP program from zero. ASCOFAME had already initiated FP in 370 clinics with MOH awareness, utilizing the

resources of the university medical schools of the country and seven regional coordinators for family planning. The MOH took over administration of this program and has been expanding it.

There is general agreement among directors of the MOH and other interested agencies in the country that the PAHO/PD assistance has been of high quality. One of these directors said that the program now is better organized under the MOH, as compared to when it was managed by ASCOFAME.

PAHO/PD helped the MOH to draw a plan following accepted health administration criteria. This plan has provided guidance and baseline reference to the program all these years.

Headquarter personnel

The Colombian team seems to be well qualified, sufficient in quantity, and able to work together and with the PAHO/PD officer in the area. There is no lack of leadership from the Colombian/PAHO/PD team in the traditional areas of activity. The program (PESMI) is located under the Division of Medical Care of the MOH. There is intentionally no formal coordination with other FP programs in Colombia (postpartum program, Pro-familia program) but there is an informal understanding of each others areas of action, i.e., the PESMI program is mainly oriented to rural areas and the lower socio-economic groups who use the public clinics there, while the others cover urban areas and higher socio-economic groups. PESMI activities are classified in terms of training, family planning, MCH, activities of the auxiliary nurse and the rural health promotor, and supervision and evaluation. PESMI carries out these activities using the existing health resources of the MOH and with adequate supplementary budget from the MOH and PAHO/PD. The program has never been able to spend all the money budgeted in a given year, but its performance in this regard is continually improving as seen in Graph #1 and Table #1. The ultimate goal of this program is the institutionalization of

all its activities within the MOH structure. So far, the country has responded to budget increases as seen in Table #2.

The main difficulties faced by the MOH/PESMI are a) those imposed by working through the MOH and integrating FP with MCH activities; and b) by the area to be served, i.e., the rural area. The MCH coverage is very low (approximately 15-20% of target population ?) and the Division of Medical Care follows a policy of integration of services which does not favor emphasis on services to specific groups. The administrative process of the MOH is too slow, and is complicated by the political implications of technical decisions. The program only offers services when a physician is permanently available at the local level, and this policy presents a great limitation due to the scarcity of Colombian physicians, especially in the rural areas. The rural areas are staffed with recently graduated physicians who are assigned to their posts in fulfillment of one year of obligatory public service. Seventy-five per cent of physicians practice in the capital cities where only 30% of the population live. The situation regarding registered nurses is even worse.

The PAHO/PD country officer estimates that the program devotes 20% of its time to FP when all the different activities of the program are taken into account (training, supervision, evaluation, and services.) If actual provision of FP services is considered, the percentage may be reduced to 15%. Direct provision of FP services is surely no lower than 10%.

The Colombian program does not emphasize demographic effects. The PAHO/PD country officer stressed many times that it was not a FP program but an MCH program with FP components.

An idea of the place of the FP component in relation to the other components of the program is given by the coverage projections of PESMI for 1972 and 1974 as presented below:

PESMI Coverage Target Projections

Activity	Years 1972	1974
Services to Children	60%	86%
Services to Pregnants	45%	66%
Services to Family Planners	15%	23%

The management difficulties previously encountered in the MOH resulted in a change in the administration of the program funds from INPES (Instituto Nacional de Programas Especiales de Salud) to SEM (Servicio de Erradicación de Malaria). It is agreed that SEM is performing a much better job, but PAHO found that the administrative control was not adequate. On this basis, new guidelines were supplied by PAHO that are different from the standard MOH ones. They are followed but they create some duplication of work and resentment among SEM personnel. The PAHO/PD country officer reported that in order to get the program going it had to be operated in a semi-vertical way within the MOH, and remains so, but this is opposed by the rest of MOH structures. An example of this opposition is supplied by the fact that regular coordinating meetings with the state program coordinators had to be suspended because MOH authorities felt that this type of activity did not follow the norms of the Ministry regarding coordination and supervision of other programs.

The federalist rather than centralist governmental structure means that PESMI headquarters personnel have to work through each of the state health departments. Before they can start activities in a health department, a contract of agreement must be signed in each case. Close supervision has been a constant need. PESMI headquarters feel that there is a long way to go towards the acceptance of MCH and FP activities as routine health services at the state health department level. They feel that some jealousy and

resentment has aroused among other MOH departments due to the aggressiveness of PESMI personnel and to the special treatment that the program receives in terms of budget support and management.

Despite all these difficulties the program has been expanding gradually to the extent that today all the 25 state health departments and the three municipal health departments have signed contracts of agreement with PESMI. In 1969 none of the municipal health departments and only ten of the state health departments had signed MOH contracts of agreement. In December 1971, 518 health centers (80% of those with permanent physicians) were included in the program. A typical distribution of time of the health center physician is:

50% to children

15% to pregnant mothers

35% to adults (FP is included here).

Most of the adults seen in the health centers are women. Males are practically unreachable because they do not care to go to a health center and because the MOH policy forbids the utilization of mass communication methods. Promotion activities are restricted to meetings within the health centers and house-to-house visits. In order to improve this situation PESMI utilizes trained voluntary personnel called promotora rural de salud. These promotoras are supposed to do house-to-house promotion of the program and provision of first aid services. This aspect of the program has not received a complete evaluation yet. One of the problems reported has been that in many areas the promotora spent most of the time in direct provision of services. Also, there has been about 40% drop outs among promotoras in the last three years. This drop out problem has been also seen at the state coordinators level.

The contribution of physicians in the rural areas are limited by their frequent turn over. They spend only a year in the area according to the national law of medical practice which makes one year of rural service compulsory for new graduates. Also, a tendency against the FP activities of the program has been observed among recent medical graduates. PESMI feels that the main source of support for the program activities and especially for the FP activities comes from the auxiliary nurses at the health centers.

PESMI headquarters feel that PAHO/PD has done a remarkable job with them. They have great appreciation and close relations with the PAHO/PD country officer. The only difficulty mentioned was the concern about PAHO's lack of increase of its budgetary support for the program.

3. Evaluation

This is the weakest point in the Colombian program. The PAHO/PD country officer is of the opinion that the program reporting system is inadequate. In the first place, she thinks that the MOH standard reporting system for other programs (PESMI was supposed to follow it) is insufficient in quantity, quality, and timing. They tried to improve reporting for PESMI by using a modified system using some modified forms and design of new ones. This resulted in some duplication of effort and low reliability of the information, and timing has not been improved. PESMI's statistician feels that this is due to failures in the supervision at the state coordinators level. Notwithstanding, they try to evaluate three aspects: quality of effort, coverage, and target accomplishment. Specifically for FP, data for new acceptors is sent to ASCOFAME and is processed monthly. Breakdowns by state and municipal entities, and by contraceptive method chosen are calculated. Cumulative totals for various months of a given year are also made and a yearly target accomplishment calculation per center is produced. This is done at ASCOFAME

by contract, and the resulting information is confidential. It is sent to PESMI and they feed it back to the state coordinators. The PAHO/PD country officer feels that a weakness of this system is that does not provide information on the total number of contraceptors per center (only the new ones), and it does not show discontinuation rates. She feels that the FP component of the program is not being evaluated in terms of changes of attitudes and practices toward family planning nor in terms of possible changes in the health sector in general or in fertility levels in particular.

PESMI staff recognizes these failures and there are plans for improvement. Among these plans they have a follow-up study of new acceptors. They plan to get comparative information from the three FP programs operating in the country. (A pilot study previously was conducted by ASCOFAME for the postpartum program, and ASCOFAME is funded in 1972 to begin the larger study.)

The highlights of the Colombian program evaluation are now presented by activities:

Training: Table #3 presents targets accomplished. There were few physicians trained in 1971 due to political problems in the universities; there have been no courses in 1972 due to a mass media attack against the program. PESMI is worried about this lack of training received by the current medical students. However, the students themselves oppose this training, but once they graduate they are more receptive to it. As they stay a short time in the rural areas, it seems that the special training of physicians is going to be a continuous operation until the university political situation changes.

The most impressive discordance between target and accomplishment is seen at the auxiliary nurses level. This unusual overaccomplishment is a demonstration of the importance they have in the program. The auxiliary

nurses were trained for delegation of medical tasks. Considering that there are 518 health centers in operation, it is obvious that there has been some drop-outs from the program. However, it appears that without auxiliary nurses there would be no program in Colombia.

PESMI thinks today that the original target for promotoras rurales was set too high. Their main concern is the high drop-out rate. They have done a study of this problem and the reasons given for dropping out were migration, need to work in a gainful occupation, and continuation of studies. Perhaps the PESMI age requirements for selection of promotoras should be raised. Regarding health education assistants, the MOH has not accepted the training of these professionals yet.

PESMI has made efforts at the evaluation of the content of the courses, the teaching methods used and the degree of satisfaction of the graduates. They have also measured acquired knowledge in the courses for auxiliary nurses and promotoras. PESMI seems to be satisfied with these aspects.

Family Planning: Tables #4 and #5 show FP activities for PESMI specifically (1969-1971) and for PESMI and the other programs in Colombia. As mentioned before the data refers to new acceptors only. Table #5 presents targets accomplished; in this case the information is for all consultations. Subtracting the new acceptors in 1971 (54,972) from the total consultations performed for the same year (182,838) we may have an estimation of the number of controls seen during that time; this comes out to be 127,866. A ratio controls/new acceptors would be a rough approximation to the retention capacity of the program. This figure is 2.3/1. New acceptors by method is represented in Table #6, and quarterly trends for PESMI in Graph #2.

Regarding cost, we made a gross estimation of this at Mr. Bair's office. Figures for new acceptors in U.S. dollars are of the order of 8, 10 and 15 for

the postpartum, the MOH and the Pro-Familia programs respectively.

In order to evaluate this information one has to take into account the restrictions faced by this program already mentioned before (PAHO and MOH policies and strategies plus government lack of definition plus expansion to rural areas.) Another point to be taken into account is the duration of the program. If one looks for demographic effects, it is not clear that the program is having any effect yet. Nor is it clear that the program should be evaluated now through that approach. The Colombians themselves say that they are not doing a FP program. Their goal is more oriented to the long-term institutionalization of these activities through an MCH strategy. If one takes this point of view, there is a feeling of accomplishment in the sense that the program has been able to expand to most of the health centers run by the MOH. However, we should be concerned with the capacity of the program of holding those gains. Signs of increased resistance from the universities, medical students, and newly-graduated physicians are there; and the program depends heavily, perhaps too much, on them. Local supervision is having troubles. The government's lack of decision is producing a situation of stagnation which has already had concrete negative effects on the program (no training for physicians this year and a slight drop in new acceptors for the first trimester of 1972--only 4,000 according to ASCOFAME confidential figures.) The politicians' assessment of the FP activities political implications creates a bottleneck for important technical decisions and activities. At this point there is no clear way out of this difficult situation.

In terms of FP activities <u>per se</u>, (I would like to have seen a higher rate of new acceptors), there is a small but definite trend upwards in the number of new acceptors from 1970 to 1971 as seen in Gra #2. There should now be greater concern with discontinuation rates, and the program director

should pay more attention to this aspect at this point. Maybe the promotoras can be reoriented toward this area of activity rather than to get new acceptors. It may be possible that once a woman is on the program, she will not be unreceptive to the young age of these workers. Another bothersome problem is the trend towards preference of oral contraceptives. This trend is confirmed by the 1972 first trimester new acceptors figures (orals: 2,575; IUD: 1,252; Rhythm: 23; others: 129). Our concern with this trend is that orals are not free while IUDs are. This may mean that high discontinuation rates are to be expected during this year.

It may be wise at this point to concentrate effort on consolidation of the centers with programs rather than expansion of new health centers (the program already covers 80% of the eligible ones). This consolidation effort should concentrate on the reporting system and supervision; and to a careful assessment of the program strategy and methods at the local level. The study and improvement of discontinuation rates should be the focus of the consolidation activities. Is it impossible to try to reach the men through male promotores? Condoms have less political implications than other methods and are not dependent on the availability of medical skills. Is it not possible to develop an auxiliary nurse/midwife? The program is in need of personnel of this type. The potential community leadership of this health worker would be an invaluable asset not only to FP but to all the other aspects of the program.

MCH Activities: An important aspect of interest to us relates to postpartum consultations. This is the weakest area of the MCH activities. The ratio "consultations with pregnant women/postpartum consultations" is 8/1. This is related to the low proportion of deliveries attended by the personnel of the health center. Typically a woman is seen in the prenatal clinic,

and later she is delivered by a traditional midwife who has little contact with the health center. This is an important disruption in the continuity of care which points out again to the need for an auxiliary nurse with midwifery training and the incorporation or replacement of the traditional midwife. One should realize that unless that gap is filled, the pre-natal care will have little connection with the delivery care or with the post-partum care. It also was interesting to learn that doctors participate more in the pre-natal care than in the well-baby clinic activities which are performed mostly by the auxiliary nurse.

Again, it appears that the auxiliary nurse is a key person in this program. She should receive strong support from PESMI. If this example is successful, it may be a pattern to follow in many Latin American countries. The promotora rural has not been so successful if she is evaluated following the original plan. It seems clear that they are not successful in promoting the health center activities. However, their work often was similar to "an extension to the home of the auxiliary nurse" and they have been quite successful in this sense. They may be responding to a community demand for home services which is important to satisfy, or they have not developed sufficient credibility and leadership among the people in order to be efficient in their promotion activities. (81% of the promotoras are less than 25 years old and 91% are single). Their high turn-over rate may also be responsible for the low promoting output. A comprehensive evaluation is needed of the promotoras role. She is unquestionably helping the auxiliary nurse and this is very important. If the selection requirements are modified and their service activities start giving them more leadership status, their home visits which now are producing mostly services, may also start producing visits to the health center. Another aspect to be considered as part of their activities is the registration of vital statistics in their areas of

coverage.

Supervision Activities: PESMI realized the need for more active supervision in 1971. The number of visits from headquarters to the state level have increased from 26 in 1969 to 77 in 1970 to 71 in 1971; the mean number of visiting days per visit has gone from 3.9 in 1969 to 3.1 in 1970 to 5.6 in 1971. Supervisory visits from state to local levels have not gone as well, and they think that this is one of the problematic areas of the program. PESMI headquarters do not have enough information on these activities. The high turn-over rate of state coordination is partly responsible for this. The small number of qualified public health registered nurses in the country is another problem. Obviously they should try to fill the state coordinator positions with stable personnel with enough qualifications to be able to supervise and support the work of the auxiliary nurse at the local level. This person probably does not have to be a physician.

4. Projections

Projections of coverage for 1972 and 1974 were presented before (see 2. Assistance/support). It is clear that their targets are increasing regarding family planning, but it is below one-fourth of women in child-bearing ages. PESMI recognizes two major future restrictions. First, the availability of physicians willing to stay in the local health centers; according to the program policy this is a requirement for program implementation. There is little evidence that this problem will be resolved in the near future. As mentioned earlier, it may become worse if resistance to FP activities continues from medical students.

Second, the federalist policy of the government. Parliament approved a new law which will allocate revenues collected by the national government to the states (the situado fiscal law). This law allows the state level to manage those allotments quite independently. The national level sets norms

and provides technical assistance. PESMI feels that if they lose control over the way the money is to be spent, the state level will divert much of it to other purposes. MOH technical directors are very much aware of this problem and they are working to try to include some form of control in the "reglamentation" of the law, but there is no assurance that this will be accepted. If they fail to retain some control, PESMI's problems will multiply to the number of states participating in the program. Even if they find excellent state coordinators, the problem will remain because the technical decisions are made at a higher level in the state hierarchy, and decisions regarding investment of funds will respond to political realities.

RECOMMENDATIONS

1. PAHO/PD should help the Colombian authorities to diagnose more precisely the real political implication of implementing or not implementing FP programs. In order to do this some additional surveys could be promoted in the country; for example, attitudes of elites and of the public on the appropriateness of support for these activities including family planning services in public clinics may come from the director of PESMI, who is in the best situation within the MOH structure to justify those actions on the basis of promotion for his program. A private institution may be needed to carry on these tasks. Thys may provide a more realistic basis to MOH authorities and politicians about what can and cannot be implemented.

2. The PAHO country representative should plan a coordinated effort to assist or reinforce FP activities. He should call for the rest of the PAHO officers in the country to consider how they might help the PAHO/PD officer, who cannot do this because her work is more directed within the PESMI program. Other PAHO officers have more access to other Colombian authorities who may be receptive to these activities. Dr. Gruber had the impression of a feeling of over-cautiousness among all PAHO personnel, but

this feeling is not shared by the Colombian AID representative for population programs, who felt that there is little more that could be done under the present circumstances.

3. PAHO/PD should explore the possibilities for the Colombian program to gain higher positions within the MOH structure. Openings for these possibilities should be promoted. With the present position within the MOH, the program director does not have much weight and does not have official contact with other influential health authorities. This may become of crucial importance if the situado fiscal law is implemented (see 4. Projections).

4. PAHO/PD should help in avoiding a postpartum program crisis. The ideal situation would be that the MOH took over the program; if this is not possible for the time being, a second best alternative should promptly be sought jointly with the MOH, ASCOFAME, and the Population Council.

5. The reporting system should be evaluated in order to consider a better way to manage it. A new consultation by the data processing specialist from PAHO headquarters may be a good start, provided they also visit ASCOFAME where the acceptor data are processed.

6. The program for promotoras rurales should be evaluated. We expect that older, married girls will have greater permanence in the program and be more effective in the promotion activities.

7. The strategy at the local level should be revised. The program should try to reduce its dependence on physicians for provision of services to new acceptors. (Doctors are traditionally trained to take care of patients when something is wrong with them rather than to help them to maintain their health. They become quickly bored with routine preventive activities.) It is quite clear that the auxiliary nurse is the real force behind the provision of services, and the program should adapt to this reality rather than to try to change it. Under these arrangements a doctor will be the resource for

problem cases, but they contemplate expanding the range of activities of the auxiliary nurse in order to include provision of FP services to new acceptors and provision of MCH services to first-unit patients. It would be useful to transform the present auxiliary nurse into an auxiliary nurse/midwife. Further training would be required, but the advantages for the program would be tremendous. In the first place, the auxiliary nurse/ midwife would be able to provide service to patients throughout their whole reproductive life, including deliveries done by her. Her status as health leader would increase and so would the postpartum visits. The output per working session would go up and the cost down. Her close connection with the promotora rural would tend to increase the promotora's leadership also, and this should increase the contact between the clinic and the community.

The main obstacle towards this goal may come from the physicians who may feel threatened in their authority. This is a very delicate problem in which a great deal of diplomacy should be used. The doctors' authority over all the aspects of the program must not be questioned. It may be argued with them that just because of that their skills may be better used for problematic, difficult cases instead of for the day-to-day routine labor.

8. Until the promotoras have greater leadership in the community, redirect their "promoting" actions and try to improve continuation rates of all the program activities but with emphasis on the FP and postpartum ones. In the meantime, they should keep and expand their service activities which also will help them to gain leadership status and at the same time this is a great assistance to the auxiliary nurse. The promoting effect will grow up from the service activities.

9. PESMI should dedicate a great portion of the coming year to consolida-

tion actions directed mainly to improve the reporting system, to supervision activities, and to a careful review of the program projections with the local strategies as one of the main problems to be put into perspective.

10. Prepare contingency plans in case the situado fiscal law goes into effect without regulatory measures giving some control of the use of the funds to PESMI.

11. There should be a substantial improvement in the communication between PAHO/PD and AID and other funding agencies. AID is not receiving reports from PAHO regarding PESMI activities. This is largely due to the fact that the MOH is reluctant to give information to PAHO officially. PAHO should make clear to the MOH that they need periodic official information in order to help evaluate and justify the support. This is a standard way to operate which the Colombian MOH should be able to understand.

CUADRO . 1

EJECUCION PRESUPUESTAL DEL PESMI EN 1970 Y 1971

(Gastos efectuados con cargo al Presupuesto que se maneja en el País)

RUBROS	AÑO FISCAL DE 1970		AÑO FISCAL DE 1971	
	Presupuesto	Ejecución	Presupuesto	Ejecución
I. Sueldos Personal Técnico Administrativo	7,198,356	2,308,756.60	7,452,135.34	4,344,859.08
II. Adiestramiento de personal	3,677,400	2,586,042.11	2,731,805.45	851,358.31
III. Elementos y suministros	2,204,612	952,221.23	3,233,314.71	847,923.96
IV. Viáticos y gastos de viaje	877,578	549,821.85	1,686,630.00	957,124.84
V. Para incremento de acciones Materno Infantiles en organismos locales de Salud (salarios de médicos y auxiliares de enf., citologías).	16,201,269	3,971,862.43	16,284,171.59	12,593,896.58
VI. Evaluación - Investigación	1,800,000	198,454,30	1,540,375.00	o - o
VII. Varios	4,283,331	2,980,874.67	3,837,859.18	1,579,265.50
VIII. Dineros en poder de Servicios Seccionales a 31 de dic.*	o - o	10,274,881.84*	o - o	2,032,809.01*
TOTAL	36,242,546	23,822,915.03	36,766,291.27	23,207,237.28
Porcentaje ejecutado	o - o	66%	o - o	68%

*Esta suma indica el dinero que existía a 31 de diciembre sin que pudiera discriminarse si estaba comprometida como tampoco el gasto que iba a financiar.

CUADRO No. 2

PROGRAMA DE EXTENSION DE SERVICIOS DE PROTECCION MATERNO INFANTIL

PRESUPUESTO DE INGRESOS PARA GASTOS LOCALES SEGUN FUENTES DE FINANCIACION

AÑOS 1969-1972

(Pesos Col.)

FUENTE DE FINANCIACION	AÑO 1969	AÑO 1970	AÑO 1971	AÑO 1972	ACUMULADO 4 AÑOS	%
DINERO APORTADO GOBIERNO NACIONAL	10,000,000	15,000,000	15,000,000	25,000,000	65,000,000	67
APORTES DE OPS	9,068,366	9,068,366	5,086,175	5,086,175*	28,309,082*	33
RECURSOS DE BALANCE DE GOB. NAL. Y OPS/OMS		12,137,036	16,680,117	10,103,715		
TOTAL PRESUPUESTO	19,068,366	36,205,401	36,766,291	40,189,890	93,309,082	100

*No incluye solicitado para 2º Semestre 1972

CUADRO No. 3

ADIESTRAMIENTO DE PERSONAL POR CATEGORIAS PESMI 1969-1971

Categoría de Personal	Metas del Convenio	Personal Adiestrado a Diciembre 1971
Médicos de Organismos Locales	800	484
Auxiliares de Enfermería	90	629
Promotoras Rurales de Salud	4,000	2,589
Médicos Coordinadores y Enfermeras Materno Infantiles	-	66
Asistentes de Educación Sanitaria	30	0

CUADRO No. 4

PESMI

ACTIVIDADES DE PLANIFICACION FAMILIAR

1969-1970-1971

CONFIDENTIAL

	1969	1970	1971
MUNICIPIOS CON PROGRAMA	269	453	495
% X DE MUNICIPIOS INFORMANDO MENSUALMENTE (EN FORMA OPORTUNA)	—	45%	55%
NUEVAS SOLICITANTES	53,255*	44,663	54,972

FUENTE: ASCOFAME - DIVISION ESTUDIOS DE POBLACION
BOLETIN DE SERVICIOS 1969-1970-1971

*Año 1969 y Anteriores

CUADRO No. 5

PESMI

INDICADORES DE LAS ACTIVIDADES DE PLANIFICACION FAMILIAR

QUE SE DESARROLLAN EN EL PAIS

1969-1970-1971

CONFIDENTIAL

CATEGORIA \ ENTIDAD	MINSALUD	PROFAMILIA	POS-PARTUM	TOTAL
NUMERO DE CLINICAS O ESTABLECIMIENTOS FUNCIONANDO 1971	518	32	26	576
NUEVAS SOLICITANTES 1971 (Historia Clínica Básica)	54,972	54,034	34,311	143,331
ACUMULADO DESDE INICIACION DEL PROGRAMA	152,896	129,855	83,955	366,706
PROMEDIO MENSUAL DE NUEVAS SOLICITANTES 1971	4,631	4,460	2,887	11,978
MEF. EN UNION	1,600,639*	123,427*	-	2,439,984
TASA DE NUEVAS SOLICITANTES X 10,000 MEF	343.44*	480.56*	-	587.18

FUENTE: ASCOFAME - DIVISION DE ESTUDIOS DE POBLACION - Boletín de Estadísticas de Servicios, 1970 y 1971

*La Estimación de MEF en unión en cada programa es un dato aproximado; una parte no cuantificada de un grupo está involucrado en el otro debido a que en algunas ciudades ambos programas se realizan.

CUADRO No. 6

NUEVAS SOLICITANTES SEGUN METODO PESMI 1970 y 1971

CONFIDENTIAL

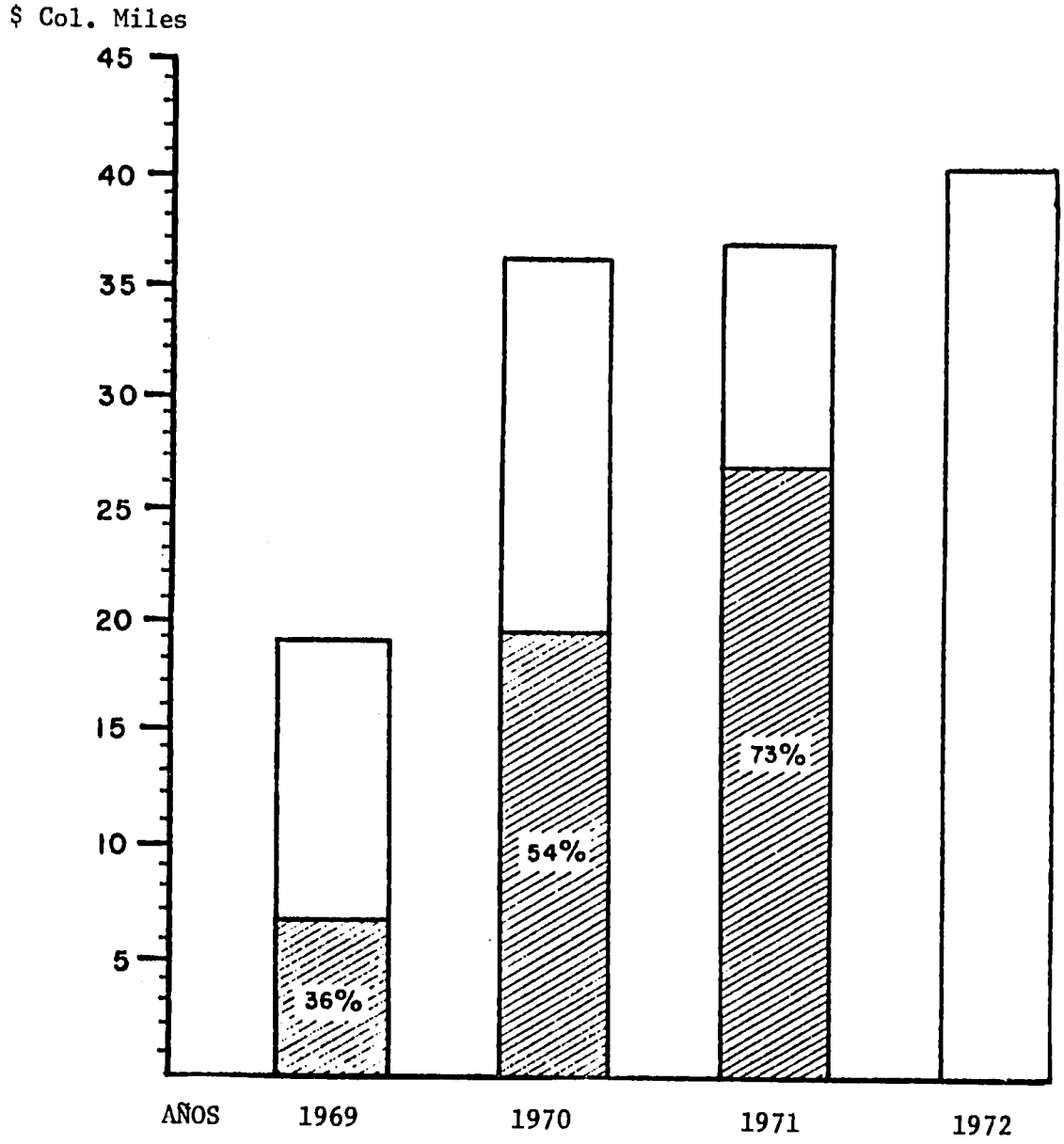
METODOS	AÑO 1970	1971	Diferencia
Anovulatorios	51.8%	58.5%	+6.7%
DIU	43.2%	37.1%	-6.1%
Otros	5.0%	4.4%	-0.6%

Fuente: ASCOFAME - Unidad de Valoración, Boletines Estadísticos de Servicio

GRAFICO No. 1

PRESUPUESTO Y GASTOS DEL PESMI

EN LOS AÑOS QUE SE INDICAN



CONVENCIONES: Presupuesto
Gasto

FUENTE: Presupuesto e Informes Financieros PESMI

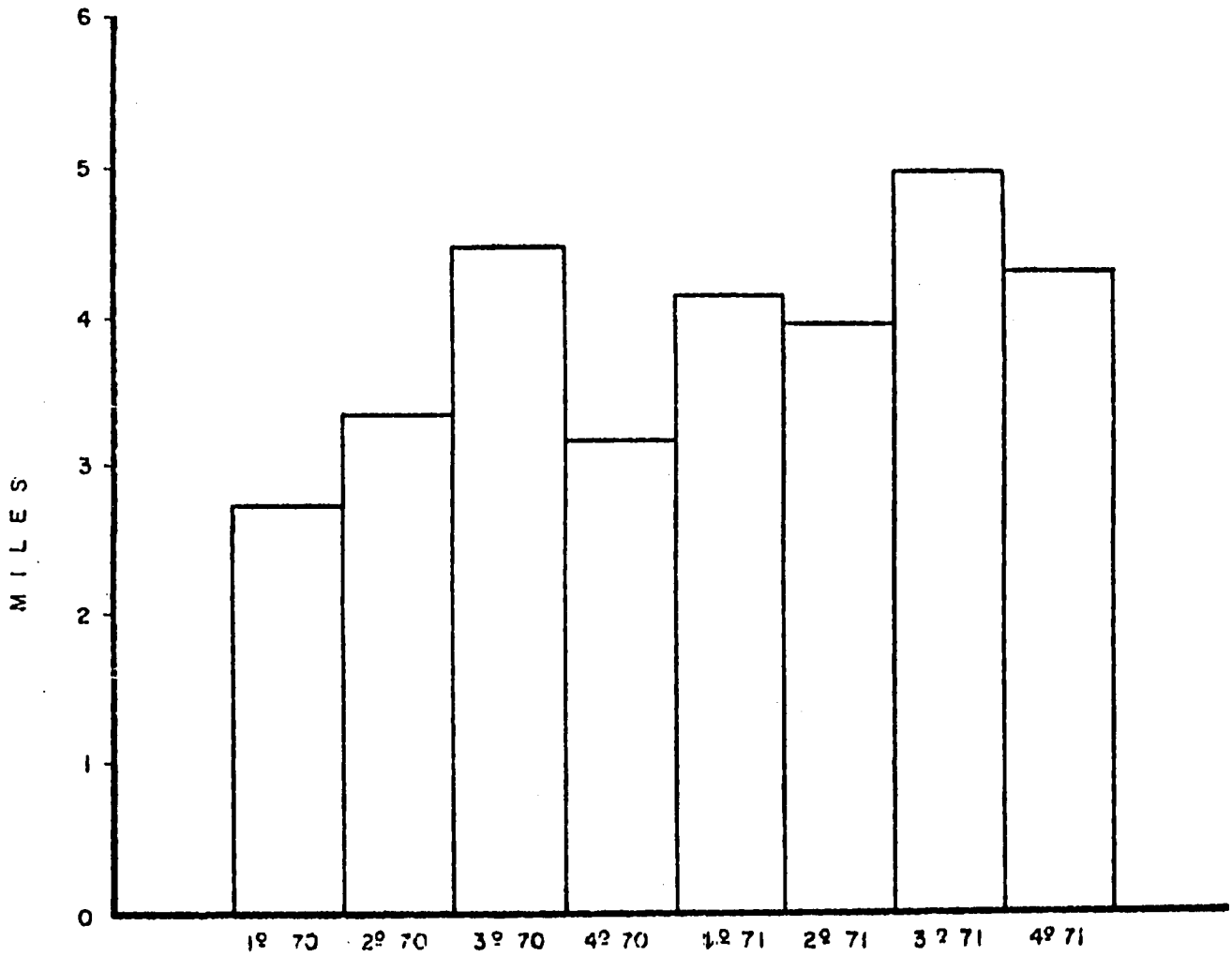
GRAFICO No. 2

PESMI

PROMEDIO TRIMESTRAL DE HISTORIAS CLINICAS RECIBIDAS

1971

CONFIDENTIAL



FUENTE: ASCOFAME - UNIDAD DE VALORACION BOLETINES ESTADISTICOS DE SERVICIO 1971

IID.2: COSTA RICA

1. The Country and Its Health Care System

Costa Rica had a population of 1.73 million on its total area of 50,900 square kilometers of land in 1970, with a density of 34 persons per km^2. Its crude birth rate was 34.4, the crude death rate 6.9, maternal mortality rate 1.4 per 1,000 live births, and the infant mortality rate was 68 per 1,000 live births. The general fertility rate was 161 and the total fertility rate 5,182.

This country is one of the most developed in Central America with a per capita income of about $542 American dollars per year, and a literacy rate of 96 per cent.

Health and medical care services are provided by two major systems: the Ministry of Health and Social Security. The latter system covers 53 per cent of the total population.

Health and medical care facilities are relatively well developed, as shown in the Table below:

Health and Medical Care Facilities in Costa Rica, 1970

Type	Number
Hospitals, general	25
Hospitals, special	9
Rural health centers	17
Mobile health units	15
Dispensaries	19
Health posts	7
Rural health units	75

There are a total of 8,057 hospital beds (including both the Ministry of Health and Social Security), of which about 10 per cent are OB-GYN beds. The ratios were 4.7 hospital beds, 0.5 doctors, and 2.3 nurses per 1,000 persons in 1970.

In 1969, there were a total of 57,984 live births in Costa Rica--38,254 or 66 per cent of which occurred in the national hospital system. It, however, was said that nearly 75 per cent of the total deliveries in Costa Rica were institutional deliveries occurring either at hospitals or in health centers.

Nearly half (49.9 per cent) of the total live births in 1969 were of parity 4 or above, and 47.3 per cent of them were from mothers who were either less than 20 or more than 30 years of age. The proportion of the "high risk" births (birth of para 4 and above, or if a woman is less than 20 or more than 30 years old) accounted for 69.8 per cent of the total annual live births, indicating the need to approach this specific group of women for family planning practices.

There was a total of about 384,000 women of childbearing age (15 to 49 years old), which corresponds to 22 per cent of the total population in the country. The overall working target of the family planning program is to recruit 15 per cent of this target group of women to practice family planning.

2. Family Planning Program

Costa Rica is one of the few countries in Latin America which have announced clear demographic goals for their family planning programs.

The family planning movement in Costa Rica dates back about ten years. The first attempt to provide family planning information and service was made by the Clínica Bíblica Hospital in San José and the Instituto Interamericano de Ciencias Agrícolas in Turrialba in 1963. The Asociación Demográfica Costarricense was founded and began activities in 1966.

The Population Office was created within the Ministry of Health in April 1967, for the planning, supervision, and coordination of family planning activities within and under the ministry.

The School of Medicine of the Costa Rican University has established the Centro de Estudios Sociales y Población (CESPO) in 1967, which to some extent is serving as an evaluation center for the overall program activities in Costa Rica.

The Ministry of Education is active particularly in sex education in the schools and in the area of communication and motivation for family planning. Interest in family planning includes some religious groups such as the Centro de Orientación Familiar (COF), and voluntary organizations having major interest in family welfare such as the Centro de Información Familiar (CIF).

To coordinate the related activities of various organizations, the Comité Nacional de Población (CONAPO) was set up in 1970.

The United Nations assigned a group of experts to review the program activities and to make recommendations in 1970. A similar follow-up mission is being organized by PAHO at the request of the United Nations Fund for Population Activities (UNFPA), and will be assigned to Costa Rica soon.

Family planning services are currently provided mainly through three major resources: the health centers and hospitals under the Ministry of Health, the hospitals under the Social Security Administration and the Demographic Association of Costa Rica.

During 1971, a total of 25,625 new acceptors of family planning were recruited of whom the Ministry of Health (including PAHO postpartum project) contributed 17,932 or 70 per cent, and the Social Security system 6,192 or 24.2 per cent. The remaining 1,501 cases, or 5.8 per cent of the total, were recruited by the Demographic Association.

More than two-thirds (71.4 per cent) of the new acceptors accepted oral contraceptives, with 12.4 per cent of these electing to use IUDs. The remaining 16.2 per cent chose other methods.

Distribution of oral contraceptives is the responsibility of the Demographic Association, which has made arrangements with local drug stores for such a purpose. Coupons for pills are issued at various service facilities for family planning. A total of 344,242 cycles of pills were distributed in 1971, corresponding to 28,687 couple-years of protection afforded, or protecting about 7.5 per cent of the women of childbearing age. Including those who accepted IUDs and conventional methods, the proportion of women protected by accepting the methods offered by the family planning program (excluding sterilization and abortion) in 1971 probably was about 10 per cent.

3. PAHO Activities in Population and Family Planning-Interhospital MCH-FP Program

PAHO participation in MCH-Family Planning in Costa Rica dates back to September 1970, but more active involvement in its service activities did not begin until February 1971, when a project entitled "Programa Maternoinfantil y Orientación Integral de la Familia" (Project 4900) was started. This project originated from a previous plan of the Population Council to develop a postpartum family planning program in Costa Rica. Since the Population Council at that time was turning over the international postpartum program to the WHO, it was thought that PAHO was in the best position to take over the program.

PAHO indeed took it over, and expanded the educational phase of the program to cover the prenatal and postnatal period to ensure further integration of postpartum family planning program activities with MCH services. The core of the program includes health education, family planning advice and services, follow-up of patients, detection and treatment of VD, early detection of

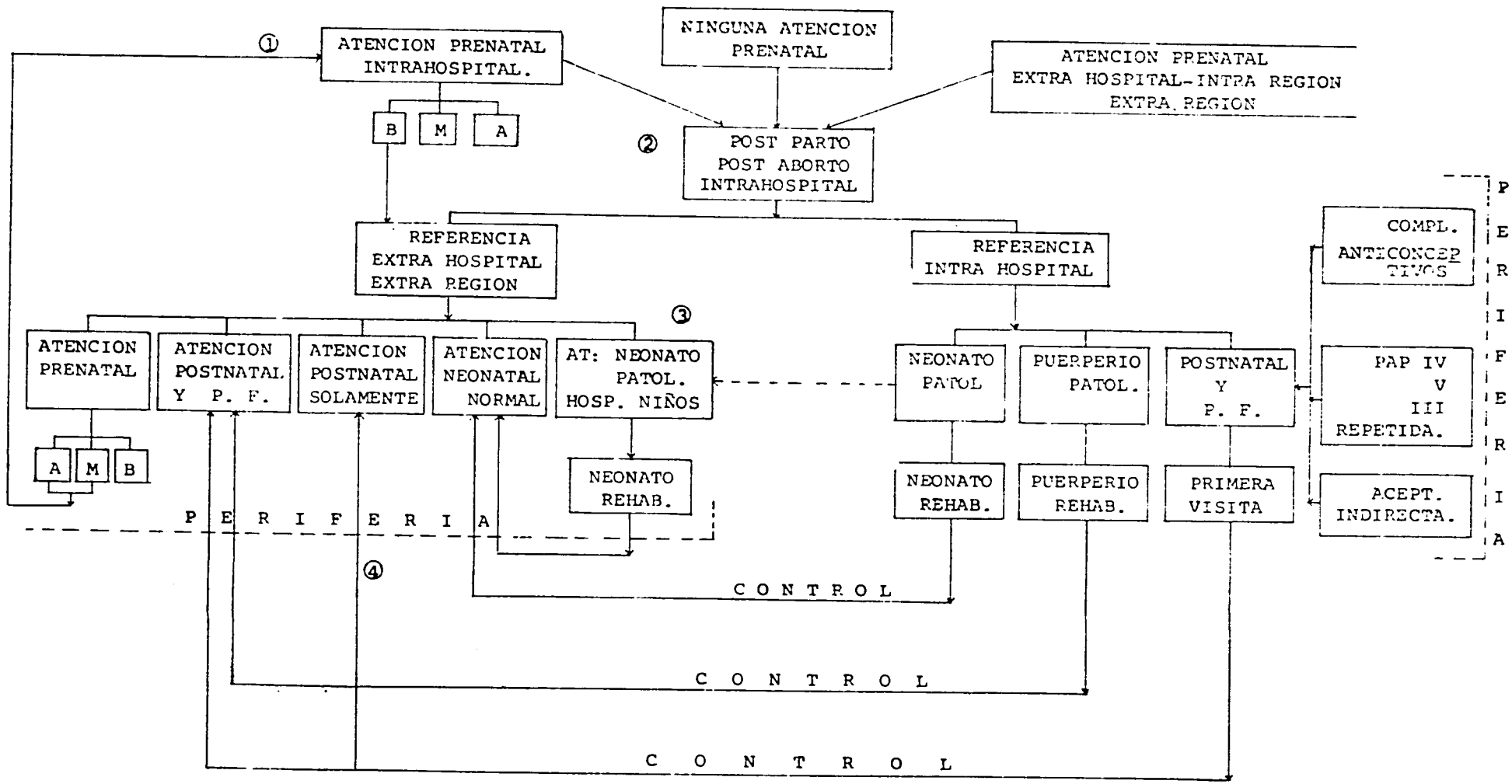
cervical cancer, neonatal health care services, and other maternal and child health care activities.

The program has undergone some modifications and improvements, and the one currently in operation contains the following major features:

1. The "universe" of the program consists of women of childbearing age, who enter the program when they come to hospitals, health centers, and other health organizations for prenatal care, delivery, or post-abortion recoveries. They are assigned to "high," "low," and "medium" risk status based on seven criteria: age, parity, education, marital status, interval between this and the last pregnancy, family income, medical history, and clinical conditions. Arbitrary weights for each of the subcriteria of these criteria are assigned and the total weight for each case is obtained to determine her "risk" status. The chart on page 119 illustrates the recruitment and referral system of the interhospital postpartum program.
2. The program has been paying particular attention to the development of educational technology for effective motivation of women during the prenatal and postnatal periods. The method should interfere as little as possible with the routine clinical and hospital activities. A suggestion is to design some types of self-instructional materials for the purpose of patient education at the outpatient department or the hospital ward.
3. Other concerns of the program are the fertility control methods to be offered and their use-effectiveness.
4. The orientation and training of various levels of personnel and hospital staff is an essential phase of the program.

5. Another important feature is the design and development of a set of recording and reporting forms, and setting up a data center for monitoring and evaluating the program.
6. A complete referral system enabling each of the women to receive appropriate care has been developed (see chart on page 119.) Depending on the degree of risk, a woman may be cared for at the hospitals or referred to the health units for health supervision.
7. The interest is not only to observe those who accepted or who are cared for by a health or medical institution, but also those who have failed to make use of the services for one reason or another. The program intends to study what it calls the "negative factors" that is, why some of the women were not referred for proper care, why some of those who were referred did not accept care, or why some of those who accepted did not continue to practice the methods, etc.
8. The timing of approaching postpartum women is considered an important factor for the success of the program. For example, women may not be ready emotionally to listen to a family planning message immediately after delivery; also, the immediate postpartum insertion of the IUD, aside from its high perforation and expulsion rates, may not be entirely practicable.
9. More extensive utilization of well-baby clinics for the education and motivation of mothers for MCH-Family Planning is being considered. A plan is being developed as an integral part of the comprehensive postpartum program.

The program has been implemented in six hospitals, three of which belong to the Ministry of Health and three others to the Social Security System; and during 1971, a total of 4,438 new acceptors were recruited, corresponding to



PROGRAMA INSTRAHOSPITALARIO DE SALUD MATERNO INFANTIL Y PLANIFICACION FAMILIAR.

a quarter (24.7 per cent) of the total new cases recruited by the Ministry of Health, or 17.3 per cent of the total annual acceptors (25,625) in Costa Rica. Of these, 21.4 per cent accepted IUDs, 67.0 per cent the oral contraceptives, and the remaining 11.6 per cent other methods. The plan is to extend the program to cover five more hospitals in 1972 and to eventually include all the hospitals in Costa Rica by 1973-1974.

PAHO had been involved in a few other activities such as an earlier assistance to CESPO for its evaluation activities. It has expressed its interest in helping a sex education program of CESPO.

4. Comments on PAHO Programs in Costa Rica

1. Postpartum Program

The postpartum family planning program, or, to be more precise, the maternal child health and family planning program in Costa Rica, is justifiable particularly from the following viewpoints:

a. Prior to the implementation of this PAHO program, the Ministry of Health had started family planning program activities and provided services through its health centers and health units. The hospital systems in Costa Rica had not been active in family planning before, and the PAHO program therefore was pertinent and timely in filling the gap of program needs.

b. As analyzed in a previous section, nearly 70 per cent of the total annual live births in Costa Rica were "high risk" births, indicating strongly the need to promptly approach these high risk women for family planning in order to protect and promote the health of mothers and children.

c. It is generally agreed that women during their postpartum period will be most receptive to the message of preventing or deferring the next

pregnancy, and the program approach of PAHO to contact this group of women, therefore, should be most rewarding.

d. The proportion of institutional deliveries in Costa Rica is unusually high (75 per cent) for a developing country. The PAHO postpartum program, therefore, should be able to reach a large proportion of the target population at the stage when they are the most susceptible to the family planning program.

The program is very well thought out and carefully planned but the following questions remain to be answered:

1. Women enter the program only when they come to clinics or hospitals for antenatal or other maternal care, and the program is still unable to pick up those who do not come for such services. This segment constitutes the hard to reach, which is the most important segment of the population in terms of their need for family planning care.
2. In actual practice, the referral system may not function as planned.
3. No systematic follow-up scheme has been implemented, so there is still no way to estimate the use-effectiveness of continuation rate of the methods accepted.
4. The contemplated study of the "negative factors" is extremely important, but a feasible plan for such a study is yet to be developed.
5. Approximately 12 per cent of the total acceptors of this program were acceptors of other methods (that is, methods other than the IUD and pills), the use-effectiveness of which may be lower.
6. The program thus far has included six out of 34 hospitals of various types in the country. Whether the program can be expanded to cover all of the hospitals by 1974 as planned, and whether after the initial assistance of PAHO, the government will be in a position to take

it over without outside financial assistance is a practical question which remains to be answered.

7. The program under the Social Security system, which provide medical care services for half of the total population, has been operating independently using different recording and reporting forms. Although an initial effort has begun, real integration of both programs may take more time.
8. The general impression was that the postpartum family planning program unit in a hospital is still a separate one attached to the hospital; further effort is needed for the program activities and personnel to be thoroughly integrated into the routine function of the hospital.

A modern hospital should not only be a place for the treatment of illnesses, but should also be a center for comprehensive health care including the dissemination of health information and knowledge in order to actively prevent diseases and to promote positive health. In this regard, the postpartum program designed and developed by PAHO is essentially what a comprehensive maternity care program in a modern hospital should be, the implication of which extends beyond family planning services. Upon successful operation, the whole package of this program should be presented to other countries, particularly to those where family planning is still a political controversy, for acceptance. It is a very significant approach to the problem and deserves the continued support needed to ensure its success.

The programs in Costa Rica and a few other Central American countries are pilot in nature. Their accomplishments, therefore, should be carefully monitored and evaluated, so that the factors related to the success or failure could be analyzed and documented in scientific terms. Specific attention

and assistance should be given to the Data Center to enable it to function as planned. Methods of monitoring and evaluating the effectiveness and efficiency of the program operation should be developed and adopted, including the design and implementation of systematic follow-up schemes to determine the use-effectiveness of methods accepted and to study the "negative factors" of the program. The cooperation and assistance of a qualified outside research organization such as a university population center should be desirable and should be actively explored.

2. General Family Planning Program

The Costa Rican family planning program is known as one of the best such programs in Latin America. There are several points in this program which may be of interest to related family planning administrators. These points are discussed briefly below only to the extent of relevance to the PAHO activities in the Region.

a. Location of the National Family Planning Unit

With the health ministry, whether a family planning unit should be included in the MCH Division (or Department), or be an independent division having equal status with other major program divisions within the Ministry, is a classic administrative issue of considerable controversy. The experience in this regard in Costa Rica may deserve some attention.

The Office of Population under the Ministry of Health in Costa Rica is now a unit entirely independent of maternal and child health. In fact, the office enjoys an even higher status than the MCH unit because it is headed by the Vice-Minister.

The program in Costa Rica had once belonged to the MCH Division, but according to the Vice-Minister, the performance had been inadequate, partly due to inadequacy in leadership. After the creation of an independent Office

of Population, the program became able to move more actively. Coordination with other related organizations has also become more satisfactory. The program nevertheless has been thoroughly integrated "functionally" with the maternal and child health programs, as can be seen from the approach of the PAHO assisted postpartum program.

Some argue that for a real integration, the family planning program must be administered by the MCH Unit. This physical integration of family planning and MCH in some instances created problems and weakened the program operation--the Costa Rican experience is an interesting example.

The dilemma of a real integration of family planning and MCH concerns also the organization structure of the population dynamics department at PAHO Headquarters--this will be discussed separately. PAHO's postpartum program, however, is designed in such a way that it can be adopted by and will fit in with any existing organizational structure in a country, regardless of whether a program is horizontally or vertically integrated with MCH.

b. Program Planning and Development Strategy of PAHO

The Costa Rican family planning program had been in operation for some time before PAHO actually started to take part in it. PAHO was requested by the Population Council and other funding agencies to take over the postpartum program planned by the Population Council. Late participation of PAHO in Costa Rica was largely due to a delay in the World Health Organization's policy decision with regard to family planning.

As in other United Nations Organizations, PAHO depends on the formal request of the government in a host country for rendering assistance. This is a sound principle because unless the country is aware of the problems and feels the need for a program and is willing to take the initiative and make a commitment, PAHO cannot and should not go around selling its assistance.

Nevertheless, it should be possible for PAHO to undertake some deliberate efforts to create the need for and demand of such assistance. Such strategy for an active program development is particularly important in this Region where family planning often becomes a political issue.

c. Coordination of Efforts

With a number of international agencies and outside universities participating in the program in Costa Rica--a country with a relatively small population--the need for coordination among related agencies in the country, plus international agencies, will be of particular importance. The question is how the PAHO projects fit in with the overall efforts of the national family planning program, and how they fit in with the efforts of other international agencies.

PAHO is a relative newcomer to the international agencies which are interested in family planning in Costa Rica. Any conflict or duplication of effort should be avoided, but on the other hand, the gaps in efforts should be identified and filled in. This leads to the need for PAHO to adopt new planning technology for the future program development and planning.

"Planning has moved from being an intuitive, spontaneous and subjective projection of activity based on past experience to a much more deliberate, systematic and objective process of mobilizing information and organizing resources" (Carl E. Taylor, "Stage of the Planning Process," unpublished article, November 1970). It is now inadequate for an international organization to simply provide assistance on a piecemeal basis. Based on the experience in Costa Rica and a few other countries in the Region, it should be timely for PAHO at this stage to review the overall program planning and developmental strategies to best achieve its ultimate goals.

d. Other Areas of Possible Interest to PAHO

The desirability for PAHO to study the current status of population education at professional schools and the regular school system has been stressed in an earlier section of this Report. What are other areas for which PAHO may or should invest its resources?

1. Provision of adequate services in rural areas

This always presents a problem which is difficult to solve, and such is true also in Costa Rica. PAHO should seriously explore how the problems may be solved by innovative ideas and methods--not only for Costa Rica but also for other countries in the Region. This automatically leads to the following questions.

2. Utilization of paramedical personnel

Recruitment, training, and utilizing paramedical personnel is probably a feasible method to help solve problems in rural areas and PAHO should implement a program to study related problems to find feasible solutions. The type of personnel to be recruited, recruitment methods, training methodology, career systems and incentive schemes to retain these personnel, roles and responsibilities, a system of refresher training, and supervision and evaluation of performance are among the factors to be studied. Costa Rica seems to be ready for such a study.

3. Delivery scheme of service

Delivery of family planning services, particularly insertion of IUDS and distribution of pills, can and should be improved to serve a larger segment of the Costa Rican population. It was noted that the current system of distributing oral contraceptives through drug stores, although serving the purpose reasonably well, can be further improved to facilitate acceptance.

4. Evaluation of program

CESPO is supposed to assume a major role in monitoring and evaluating related organizations' program input and output; however, this role has not been fully achieved due to several reasons. A number of external organizations are also interested in evaluating the program and these efforts need coordination. For example, a complete health statistical system including family planning statistics has been developed by CELADE. A similar statistical system has been developed by PAHO. Such conflict and duplication of efforts should be avoided and PAHO should take the initiative to ensure coordination.

When a program has been successful for a number of years and has earned a reputation for such, there is a danger of "aging." The program staff, the general public, and the aid agencies all tend to gradually lose their imagination and drive. Although there is no such sign at the present time, PAHO should see to it that whatever input it will make for the program in Costa Rica will stimulate further the interest and enthusiasm of all concerned to keep the program "young."

In conclusion, the PAHO approach to MCH-Family Planning in Costa Rica through the comprehensive postpartum program is unique, deserving all the support needed to ensure its success. Such support should include assistance to ensure the collection of useful data for continued monitoring, the design and implementation of a feasible method of evaluating the use-effectiveness of acceptors, and a study of the "negative factors." Upon successful completion, the program should provide PAHO or other international organizations interested in promoting family planning in the developing areas with a feasible entry point, particularly in countries where family planning is still politically sensitive.

There must be other areas for which PAHO is in a position to render much needed assistance. In order to assume an intellectual leadership in the field, PAHO should actively develop innovative and imaginative thinking to best attain the ultimate goals of the program. Costa Rica appears to be an ideal place for testing the feasibility of various ideas for such purposes.