

PD-ABD-302

73998

Prepared for

Office of Population
Bureau for Science and Technology
Agency for International Development
Washington, D.C.
under Contract No. DPE-3024-Z-00-8078-00
and USAID/San Jose
under PIO/T No. 515-000-3-10026
Project No. 936-3024

**MIDTERM EVALUATION OF
FAMILY PLANNING
SELF-RELIANCE PROJECTS,
COSTA RICA**

by

Robert Wickham

Fieldwork

June 2 - July 21, 1991

Edited and Produced by

Population Technical Assistance Project
DUAL & Associates, Inc. and International Science
and Technology Institute, Inc.
1601 North Kent Street, Suite 1014
Arlington, Virginia 22209
Phone: (703) 243-8666
Telex: 271837 ISTI UR
FAX: (703) 358-9271

Report No. 90-106-122
Published October 10, 1991

Table of Contents

Glossary	v
Acknowledgments	vii
Project Identification Data	ix
Executive Summary	xi
1. Introduction	1
1.1 Purpose and Focus of Evaluation	1
1.2 Project Objectives	1
1.2.1 General Objectives	1
1.2.2 Specific Objectives	1
1.2.3 Economic, Social and Political Context of the Project	2
2. Public Sector Program	5
2.1 Major Findings and Conclusions	5
2.2 Major Recommendations	6
2.2.1 Current Project	6
2.2.2 Possible Future Project	6
2.3 Communications	7
2.3.1 Findings and Conclusions	7
2.3.2 Recommendations	8
2.4 Training	8
2.4.1 Curriculum Review and Revision	8
2.4.1.1 Findings and Conclusions	8
2.4.1.2 Recommendations	9
2.4.2 In-Service Training	9
2.4.2.1 Findings and Conclusions	9
2.4.2.2 Recommendations	9
2.4.3 Training of Trainers	10
2.4.3.1 Findings and Conclusions	10
2.4.3.2 Recommendation	10
2.4.4 Teaching Materials	10

2.4.4.1	Findings and Conclusions	10
2.4.4.2	Recommendations	10
2.5	Research	11
2.5.1	Findings and Conclusions	11
2.5.2	Recommendations	12
2.6	Procurement	12
2.6.1	Findings and Conclusions	12
2.6.2	Recommendation	12
2.7	Information System	13
2.7.1	Findings and Conclusions	13
2.7.2	Recommendations	14
2.8	Supervision	14
2.8.1	Findings and Conclusions	14
2.8.2	Recommendations	15
2.9	Institutional Counterpart	16
2.9.1	Findings and Conclusions	16
2.9.2	Recommendations	16
2.10	Subagreements with Private Entities	17
2.10.1	Findings and Conclusions	17
2.10.2	Recommendation	17
2.11	Sex Education	17
2.11.1	Findings and Conclusions	17
2.11.2	Recommendations	17
2.12	Contraceptive Procurement and Distribution	18
2.12.1	Findings and Conclusions	18
2.12.2	Recommendations	18
2.13	Gender Issues	18
2.14	Possible Future Project	18
3.	Contraceptive Social Marketing	21
3.1	Findings and Conclusions	21

3.2	Recommendations	22
4.	Increased Service Delivery Alternatives	23
4.1	Findings and Conclusions	23
4.2	Recommendation	23

List of Appendices

Appendix A	Terms of Reference
Appendix B	Persons Interviewed
Appendix C	Health Facilities Visited
Appendix D	Documents Reviewed
Appendix E	Borrador
Appendix F	Recommended Tentative Allocation for 1993-95

Glossary

ADC	Costa Rican Demographic Association
A.I.D.	Agency for International Development
CCSS	Costa Rican Institute for Social Security
CDC	Centers for Disease Control
CENDEISSS	National Center for Teaching and Research in Health and Social Security
CPR	contraceptive prevalence rate
DHS	Demographic and Health Survey
IEC	information, education and communication
IMR	infant mortality rate
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
JHU/PCS	Johns Hopkins University/Population Communication Services
KAP	knowledge, attitudes and practice
MIS	management information system
MOH	Ministry of Health
PFA	patient-flow analysis
SR	Reproductive Health (unit)
UCR	University of Costa Rica
USAID	United States Agency for International Development (overseas mission)

Acknowledgments

The consultant would like to thank the many staff members of the CCSS and MOH and the general manager of PROFAMILIA, all of whom gave substantial amounts of time for interviews. Thanks are due particularly to the staff of the Reproductive Health Unit of CCSS, who were helpful in many additional ways. Their support, together with the support of USAID staff in San Jose, helped to make this assignment an interesting and enjoyable one.

Project Identification Data

PROJECT TITLE: Family Planning Self-Reliance/Human Reproduction

PROJECT NUMBER: 515-0168.02

CRITICAL PROJECT DATES: May 27, 1988 - July 18, 1993

PROJECT FUNDING: \$1.8M program costs
\$2M contraceptives

MODE OF IMPLEMENTATION: Caja Costarricense de Seguro Social

PROJECT TITLE: Family Planning Self-Reliance/Contraceptive Social Marketing

PROJECT NUMBER: 515-0168.03

CRITICAL PROJECT DATES: August 4, 1988 - July 18, 1993

PROJECT FUNDING: \$2.2M (including \$700,000 in contraceptives within the total amount)

MODE OF IMPLEMENTATION: PROFAMILIA/Asdecosta S.A.

Executive Summary

Introduction

This midterm evaluation was carried out from June 3-29, 1991. At the request of the USAID Project Officer, attention was focused principally on the public sector family planning program. Thus, the report includes detailed findings, conclusions and recommendations relating to family planning services provided by the Costa Rican Institute for Social Security (CCSS) and the Ministry of Health (MOH). The report also has sections on (1) the contraceptive social marketing program, which is managed by PROFAMILIA, and (2) alternative service delivery mechanisms that might lighten the burden on the public sector. The format of the report is in accordance with the terms of reference.

Purpose and Focus of Evaluation

One purpose of this evaluation is to review the operating strengths and weaknesses of each program in order to identify areas that can be improved immediately and to document the limitations inherent in each of the programs. Because USAID seeks to phase out population assistance in the medium term in Costa Rica, it is important to view the administrative aspects of the project as it stands at mid-point, and the feasibility of sustaining each of the program components with domestic financing. USAID wants to avoid a post-project deterioration of the program, and will attempt to ensure that adequate systems and financial, physical and human resources are in place to maintain the programs at the required levels of service delivery.

In accordance with the terms of reference, this is not an impact evaluation because data from the ongoing Health and Demographic Survey (DHS) will not be available until 1992. The evaluation focuses therefore on achievement of only the second and third specific project objectives (see below).

A second purpose of this evaluation is to look at the near future — 1993-95 — and (1) discuss options for increasing the public/private mix of service delivery alternatives to reduce, or at least not dramatically increase, the budgetary burden on the public sector; and (2) recommend elements of a follow-on project for the period. With respect to (1), this might include factory-based programs or programs in marginal urban communities in which there is a fee-for-service or cost-sharing arrangement.

The general objectives of the project are as follows:

- (1) Improve the Costa Rican public sector family planning services;
- (2) Expand the roles of the commercial and voluntary sectors; and
- (3) Foster improved integration of family planning services within the preventive health care program and maximize resources to reduce dependence on outside financing.

The following specific objectives provide a system of measuring project achievement. The instruments used to measure these targets will be the 1991 DHS, periodic patient-flow analyses, and program records that will monitor the dissemination of the informational materials.

The specific objectives have been or continue to be as follows:

- (1) Improve contraceptive use by increasing the contraceptive prevalence rate and the percentage of modern contraceptive use; and by reducing unwanted or mistimed pregnancies and the crude birth rate.
- (2) Improve service delivery by reducing waiting time in all clinics; increasing professional/patient contact; ensuring an adequate contraceptive supply; providing contraceptives to patients according to established norms; and making available low-cost, quality contraceptives in all establishments as allowed by law.
- (3) Improve education by regularly including family planning in medical and nursing school curricula and in CENDEISS's continuing education programs; including postpartum family planning counseling in all hospitals; distributing informational materials on family planning countrywide; teaching sex education in schools; and disseminating sex education materials to the non-enrolled school-age population.

Major Findings, Conclusions and Recommendations

Public Sector Program

Major Findings and Conclusions

In part as a result of project support, a Reproductive Health (SR) unit has been established in the Preventive Medicine Department of the CCSS, and family planning services are available in virtually all CCSS and MOH service facilities. Contraceptive supplies generally are adequate. Informational materials regarding family planning have been distributed to all facilities. The three supervisors in the SR unit make periodic visits to all facilities to assess and facilitate family planning supplies and services. Family planning is now recognized by both the CCSS and the MOH as an essential service, and the CCSS leadership has given its assurance that the CCSS will assume full financial responsibility for family planning when USAID support terminates.

The principal areas of weakness are (1) Serious delays have occurred in reforming medical and nursing school curricula to incorporate family planning as a subject and in providing family planning in-service training for service providers. This situation has resulted in many service providers' lacking knowledge and skills about family planning; (2) The SR unit operates quite independently of the Department of Preventive Medicine, and its staff positions are temporary; (3) The SR unit supervisors do not have technical or administrative authority over service providers, resulting in norms' (e.g., the supply of contraceptives to clients) not always being followed; (4) The areas of research and management information systems (MIS) are weak; (5) SR unit staff lack skills in program planning and management; (6) There has been no progress in sex education for the in-school population; (7) There is little organized postpartum family planning counseling in hospitals.

Major Recommendations

Current Project

- (1) Prepare a plan and budget with measurable goals for information, education and communication (IEC) activity for the balance of the current project period; develop

a plan for control and distribution of print materials; establish a system for monitoring and evaluating the impact of the IEC effort.

- (2) Plan and implement in-service training on the basis of an updated assessment of training needs; plan for an evaluation of the impact of training.
- (3) Accelerate reform of the curricula of the medical, nursing and social work schools to include family planning; include family planning in the internships of all medical students.
- (4) Develop a research strategy taking into account the needs of related units of Preventive Medicine, e.g., Maternal Care; provide technical assistance to SR to plan and carry out patient-flow analyses and simple operations research; explore opportunities to contract research with other institutions.
- (5) Provide technical assistance to SR for better use of the MIS; encourage the research component of SR to make more use of the MIS.
- (6) Continue supervisory visits with greater focus on problem clinics; improve data-collection instruments used by the supervisors and prepare analytical reports for management that indicate how family planning services can be improved.
- (7) Require a substantially improved program plan and budget with measurable goals for the fiscal year beginning November 1, 1991; provide short-term training in planning and management to selected staff of the SR unit; encourage the leadership of the CCSS Technical Division to integrate SR more effectively into Preventive Medicine.
- (8) Organize postpartum family planning counseling in all hospitals that have maternity services.

Possible Future Project

- (1) Encourage the Technical Division of CCSS to define the functions of the SR unit within Preventive Medicine; define SR relationships with central, regional and local levels; determine SR staffing requirements; have official positions established and budgeted for prior to the end of calendar year 1992 (given that USAID support for staff salaries is scheduled to terminate in July 1993).
- (2) Press CCSS to prepare now to ensure its ability to buy quality contraceptives at low prices beginning in 1993.
- (3) Provide declining support for contraceptive purchases during 1993-95; CCSS should begin to buy some portion of all contraceptives beginning in 1993 or as soon as possible thereafter.
- (4) Have family planning designated as a priority area for CCSS and MOH in order that contraceptive supplies will not be subject to future budget cuts.

- (5) Develop tentative plans for IEC, research and training activities for the 1993-95 period with a provision for declining-scale support from USAID.

Contraceptive Social Marketing

Findings and Conclusions

The Contraceptive Social Marketing program has been in operation since January 1984. The implementing entity is PROFAMILIA, a profit-making firm owned by the Costa Rican Demographic Association (ADC).

Condoms are currently the only contraceptive product line sold by PROFAMILIA. These are provided free by USAID and are distributed throughout most of the country, including many rural areas, via commercial channels. PROFAMILIA's share of the condom market is currently about 30 percent. Its sales of condoms have increased from 500,000 in the first year to 2,600,000 in the fifth.

Because of product registration requirements in Costa Rica and lack of interest in the relatively small Costa Rican market on the part of several potential suppliers, PROFAMILIA has not yet been successful in offering oral contraceptives. PROFAMILIA is currently negotiating with a potential supplier and expects to begin sale of orals through pharmacies in the near future.

PROFAMILIA has made remarkable progress toward achieving financial self-sufficiency. The PROFAMILIA general manager estimates that the organization will have net assets of \$1 million by the end of the current project period (July 1993). If USAID can provide approximately \$150,000 per year from 1993-95, PROFAMILIA believes it can be 100 percent self-sufficient by the end of that time.

Recommendations

- (1) USAID should provide support to PROFAMILIA of approximately \$150,000 per year for the two-year period 1993-95.
- (2) Whenever feasible, USAID should assist PROFAMILIA in the latter's efforts to secure oral contraceptives from international sources at the lowest possible price.
- (3) In order to institutionalize PROFAMILIA's success, USAID might recommend the appointment of a strong deputy at such time as can be managed without impairing the organization's financial self-sufficiency.

Increased Service Delivery Alternatives

Findings and Conclusions

Few service delivery alternatives exist, outside of CCSS, the MOH, PROFAMILIA and private practitioners (most of whom also work for the CCSS). The CCSS does give financial support to several doctors' cooperatives in urban areas based on the size of population that the

cooperatives cover. Clients receive care free of charge, but all those employed pay a substantial compulsory fee to CCSS for, among other things, medical care.

Recommendation

The CCSS should be encouraged to enunciate a positive position regarding cooperatives as a model for delivering health care.

1. Introduction

1.1 Purpose and Focus of Evaluation

One purpose of this midterm evaluation is to review the operating strengths and weaknesses of each program in order to identify areas that can be improved immediately and to document the limitations inherent in each of the programs. Because USAID seeks to phase out population assistance in the medium term in Costa Rica, it is important to view the administrative aspects of the project as it stands at mid-point, and the feasibility of sustaining each of the program components with domestic financing. USAID wants to avoid a post-project deterioration of the program, and will attempt to ensure that adequate systems and financial, physical and human resources are in place to maintain the programs at the required levels of service delivery.

In accordance with the terms of reference, this is not an impact evaluation because data from the ongoing Health and Demographic Survey (DHS) will not be available until 1992. The evaluation focuses therefore on achievement of the second and third specific objectives set forth below.

A second purpose of this evaluation is to look at the near future — 1993-95 — and to (1) discuss options for increasing the public/private mix of service delivery alternatives so as to reduce, or at least not dramatically increase, the budgetary burden on the public sector; and (2) recommend elements of a follow-on project for the period.

1.2 Project Objectives

1.2.1 General Objectives

The general objectives of the project are as follows:

- (1) Improve the quality and quantity of services provided by the Costa Rican public sector family planning program;
- (2) Expand the service delivery capacity of the commercial and voluntary sectors; and
- (3) Foster improved integration of family planning services within the preventive health care program and maximize resources to eventually reduce the dependence on external financing.

1.2.2 Specific Objectives

The following specific objectives provide a system of measuring project achievement. The instruments used to measure these targets will be the 1991 DHS, periodical patient-flow analyses and program records that will monitor the dissemination of the informational materials.

The specific objectives of the project have been, or continue to be, as follows:

- (1) **Improve contraceptive use by**
 - a. Increasing the contraceptive prevalence rate to 70 percent by 1992;
 - b. Increasing the contraceptive prevalence rate (modern methods) to 50 percent by 1992;
 - c. Reducing unwanted or mistimed pregnancies from 40 percent to 25 percent; and
 - d. Reducing the crude birth rate from 32.6/1,000 to 28/1,000.

- (2) **Improve service delivery by**
 - a. Reducing waiting time (to an average of 60 minutes) in all clinics;
 - b. Increasing professional/patient contact for counseling and education in all clinics;
 - c. Ensuring an adequate contraceptive supply at central and field units;
 - d. Providing contraceptives to patients according to established norms, i.e., six cycles of orals, IUDs for four years if no problems are encountered; and
 - e. Making available low-cost, quality contraceptives in all establishments as allowed by law.

- (3) **Improve education by**
 - a. Including family planning in medical and nursing school curricula, to be taught regularly by 1990;
 - b. Including family planning in the National Center for Teaching and Research in Health and Social Security's (CENDEISS) continuing education programs, to be supported by the general budget by 1992;
 - c. Including postpartum family planning counseling in all hospitals by 1989;
 - d. Distributing informational materials on family planning countrywide and establishing a regular distribution system by 1989;
 - e. Teaching sex education in school by 1992; and
 - f. Disseminating sex-education materials to the non-enrolled school-age population by 1990.

1.2.3 Economic, Social and Political Context of the Project

The economic burden on Costa Rica of a rapidly growing population has been well documented. In 1985 the rate of natural increase nationwide was 2.8 percent; when refugees and immigrants are added, the population growth rate is estimated to be close to 4 percent that year. Some 50 percent of the population is under 20 years of age. This situation creates a demand for employment, infrastructure, education, and so on, which the country would be hard-pressed to satisfy under almost any circumstances. It is especially difficult now, given the government's economic readjustment program, which entails substantial reductions in public sector budgets, the scope of public sector activities, and the number of public sector employees. The health sector is not immune to these reductions. The Ministry of Health (MOH) budget, for example, has been cut substantially in recent years (no doubt in part because the MOH and the Costa Rican Institute for Social Security [CCSS] increasingly have overlapping activities).

Although the CCSS is faring much better than the MOH because a substantial part of its funding comes from contributions of employers and employees, it conceivably could face problems in securing approval of new, permanent positions to staff the Reproductive Health (SR) unit. (USAID currently funds the SR unit professional positions through this project.) Typically, MOH and CCSS salary levels are such that most employees, both professional and nonprofessional, hold additional jobs after hours in order to make ends meet. Low salary levels, together with very inadequate budgets for equipment, supplies and effective supervision, tend to create a work environment that results in less than satisfactory health care from the client's perspective. Limited provider/patient contact time and long waiting times (which can have economic costs for the client) are indicative of this situation.

Health care costs are obviously higher for that segment of the population that uses private practitioners (most of the latter, as noted elsewhere, also work for the CCSS) and buys medicines from private pharmacies. Offsetting these higher costs are reduced waiting times and the privilege of choosing one's physician.

In a social context, Costa Rica has a relatively low infant mortality rate (IMR), a high literacy level and a high contraceptive prevalence rate (CPR) estimated at about 69 percent in 1986, indicating that family planning is well accepted. There is, however, is a substantial use of traditional, less reliable methods (use of modern temporary methods stood at only 42 percent in 1986) and considerable unmet need: The 1985 DHS survey showed that 40 percent of last pregnancies were unwanted. In part because of the current economic difficulties facing the country, roughly one-third of the country's women, many of whom are unmarried, are working outside their homes, and an estimated 20 percent of Costa Rican families are headed by women. The social situation suggests that there is an important need to provide a range of safe, effective, readily accessible, affordable contraceptives, particularly to the female population. (Research indicates that women are the principal purchasers of contraceptives, including condoms, in Costa Rica.)

Notwithstanding Costa Rica's relatively high CPR, family planning is still a somewhat sensitive issue politically. This in part explains the absence of sex education in schools, the existing restrictions on advertising or promoting particular contraceptives, and the relatively limited choice of modern contraceptive methods. Voluntary sterilization, for example, is permitted only when a panel of physicians indicates that it is medically necessary.

Health authorities have been able to make family planning a less sensitive issue by emphasizing its importance as a health intervention rather than as a demographic goal and by increasingly integrating it into other facets of preventive medicine.

Another way politics indirectly affects public sector family planning services in Costa Rica is through the spoils system. Each time there is a change in the political party that governs at the national level, there is usually a fairly widespread change not only in staffing but also in policies relating to organization, structure, and so on, of programs. The result, unfortunately, is a lack of continuity of effort and a failure to reward good performance. This has created a work environment in which staff morale frequently is poor.

2. Public Sector Program

2. Public Sector Program

2.1 Major Findings and Conclusions

In part as a result of project support, a Reproductive Health (SR) unit has been established in the Preventive Medicine Department of the CCSS, and family planning services are available in virtually all CCSS and MOH service facilities. Contraceptive supplies generally are adequate. Informational materials regarding family planning have been distributed to all facilities. The three supervisors in the SR unit make periodic visits to all facilities to assess and facilitate family planning supplies and services. Family planning is now recognized by both the CCSS and the MOH as an essential service, and the CCSS leadership has given its assurance that the CCSS will assume full financial responsibility for family planning when USAID support terminates.

The principal areas of weakness are that (1) Serious delays have occurred in reforming medical and nursing school curricula to incorporate family planning and in offering family planning in-service training for service providers. This has caused a number of service providers to be deficient in knowledge and skills about family planning; (2) The SR unit operates quite independently of the Department of Preventive Medicine, and its staff positions are temporary; (3) The SR unit supervisors do not have technical or administrative authority over service providers, resulting in norms' (e.g., the supply of contraceptives to clients) not always being followed; (4) The areas of research and management information systems (MIS) are weak; (5) SR unit staff lack skills in program planning and management; (6) There has been no progress in sex education for the in-school population; (7) There is little organized postpartum family planning counseling in hospitals.

With regard to the specific objective of reducing waiting time in all clinics, it is not possible to determine whether there has been a reduction because the patient-flow analyses have not yet been undertaken. Regarding increasing professional/patient contact, one can reasonably assume that there has been some increase in professional/patient contact for counseling and education because the supervisors have ensured the availability of family planning-related supplies and equipment as well as information, education and communication (IEC) materials — but this has not been studied or documented. (One must recognize also that family planning is only one activity among many that clinics and health centers offer, and it may be unrealistic to expect very significant improvement in family planning services in the absence of improvements in health services generally.)

Regarding educational aspects, identifiable progress has been made only in the distribution of informational materials on family planning and sex education. Family planning information is being distributed countrywide, and a portion of the non-enrolled school-age population is being reached through collaborative efforts between SR and the UNFPA-funded Program for Adolescents, which is also in CCSS's Department of Preventive Medicine. There is little organized postpartum family planning counseling in hospitals, although the SR unit has placed IEC equipment and materials in all facilities with postpartum rooms.

2.2 Major Recommendations

2.2.1 Current Project

- (1) Prepare a plan and budget with measurable goals for IEC activity for the balance of the current project period; develop a plan for control and distribution of print materials; establish a system for monitoring and evaluating the impact of the IEC effort; initiate collaborative work in IEC materials development with the Public Relations unit of the CCSS.
- (2) Plan and implement in-service training on the basis of an updated assessment of training needs; plan for an evaluation of the impact of training.
- (3) Accelerate reform of the curricula of the medical, nursing and social work schools to include family planning; include family planning in the internships of all medical students.
- (4) Develop a research strategy taking into account the needs of related units of Preventive Medicine, e.g., Maternal Care; provide technical assistance to SR to plan and carry out patient-flow analyses and simple operations research; explore opportunities to contract research with other institutions.
- (5) Provide technical assistance to SR for better use of the MIS; encourage the research component of SR to make more use of the MIS.
- (6) Continue supervisory visits with greater focus on problem clinics; improve data-collection instruments used by the supervisors and prepare analytical reports for management that indicate how family planning services can be improved.
- (7) Require a substantially improved program plan and budget with measurable targets or goals for the fiscal year beginning November 1, 1991; provide short-term training in planning and management to selected staff of the SR unit; encourage the CCSS Technical Division and the Preventive Medicine Department of this division to integrate SR more effectively into Preventive Medicine.
- (8) Organize postpartum family planning counseling in all hospitals that have maternity services.

2.2.2 Possible Future Project

- (1) Encourage the Technical Division of CCSS to define the functions of the SR unit within Preventive Medicine; define relationships with central, regional and local levels; determine staffing requirements; have official positions established and budgeted for prior to the end of calendar year 1992 (given that USAID support for staff salaries is scheduled to terminate in July 1993).
- (2) Press CCSS to take necessary steps now to ensure the possibility of buying quality contraceptives at low prices beginning in 1993.

- (3) Provide declining support for contraceptive purchases during 1993-95 in such a way that CCSS is buying some portion of all contraceptives beginning in 1993 or as soon as possible thereafter.
- (4) Have family planning designated as a priority area for CCSS and MOH in order that contraceptive supplies will not be subject to budget cuts.
- (5) Develop tentative plans for IEC, research and training activities for the 1993-95 period with a provision for declining-scale support from A.I.D.

2.3 Communications

2.3.1 Findings and Conclusions

The elements of communications to be addressed include technical assistance from Johns Hopkins University/Population Communication Services (JHU/PCS) to assist SR to develop IEC strategy, including for mass media, print materials development, mass media production, evaluation techniques and data analysis of impact. The strategy must be multi-institutional and include public, private and commercial sector activities.

A good strategic plan was developed at the initiation of the project with technical assistance from JHU/PCS. The staff person who received training in IEC at Hopkins left the SR unit shortly after returning to Costa Rica. Subsequent planning and monitoring of IEC activity have suffered as a result of the staff member's departure. Nevertheless, there has been substantial production of quality materials of various types to date. In addition to production and airing of materials on TV and radio, the production of print materials has been considerable and of good quality. With respect to distribution of print materials, the focus has been on family planning service providers in clinics, health centers, adolescent centers and health clinics of factories and other business enterprises. Distribution has normally been made in the course of supervisory visits to ensure that materials reach the actual service providers.

Early in the life of the project, the SR unit reportedly attempted to develop collaborative activities with the Public Relations unit of the CCSS, which bears general responsibility for CCSS IEC activities. This effort was unsuccessful and the SR unit therefore proceeded on its own.

Major areas of need in this component are an updated plan and budget for November 1, 1991 to July 1993; creation of a plan to control distribution of print material (so that SR knows where various materials have been distributed, what stocks remain, and so on); development of a system for monitoring use of materials; and evaluation of the effectiveness of materials. The SR unit would like technical assistance from PCS to carry out the last activity.

This project component is functioning effectively. It could undoubtedly be improved, however, if a staff member were to receive short-term training similar to that provided earlier. The SR unit ultimately will need to become better integrated into the CCSS, presumably including integration of IEC work into the PR unit. Therefore, it would be beneficial to try to develop collaborative efforts now.

2.3.2 Recommendations

- (1) Prepare a plan and budget with measurable goals for IEC activity for the balance of the project period.
- (2) Prepare a written plan for control and distribution of print materials.
- (3) Develop a plan for periodic assessment of the use of IEC materials that are given to service providers and others.
- (4) Arrange for an evaluation of the effectiveness of IEC materials with technical assistance from JHU/PCS.
- (5) Arrange for short-term training in IEC for an SR staff member.
- (6) Initiate collaborative work with the CCSS Public Relations unit.

2.4 Training

The elements of training that need to be addressed are as follows: curriculum review and revision to incorporate family planning in medical schools and nursing schools; in-service training in family planning for doctors, nurses and other family planning service providers; training of trainers in family planning; and development of family planning teaching materials for universities and CENDEISSS. Technical assistance for curriculum review and revision is to be provided by the Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO).

2.4.1 Curriculum Review and Revision

2.4.1.1 Findings and Conclusions

This project component has made little progress to date. Delays in obtaining technical assistance from JHPIEGO have meant that only now are the medical schools and nursing schools beginning to address the issue of curriculum revision. Proposed observational visits to the United States and other Latin American universities have not yet been firmed up. The situation is further complicated because a larger curriculum revision effort is currently under way in the universities, which must be completed by August 1991, and there is no assurance that the family planning component can also be finished on time.

An equally important need is to incorporate time for family planning in the internships of medical students. This has not yet been done in a systematic fashion. When these two steps have been taken, there will be less need for in-service training in family planning for doctors who are beginning their careers with obligatory social service in CCSS and MOH facilities in various areas of the country.

This element of the training component requires priority attention, given that health care personnel will otherwise continue to enter service without training in family planning.

2.4.1.2 Recommendations

- (1) USAID, SR and CENDEISSS should encourage and assist the universities to move ahead with curriculum revision. USAID should ensure that JHPIEGO provides the necessary technical support in a timely manner.
- (2) SR, CENDEISSS and the university medical schools should ensure that time is provided for family planning training in the internship phase of medical education.
- (3) The School of Social Work should be encouraged and assisted to revise its curriculum to include family planning.

2.4.2 In-Service Training

2.4.2.1 Findings and Conclusions

An in-service training program was planned and initiated by CENDEISSS early in the project. Seventy doctors (all but three from CCSS) from five regions received three days of training in two facilities in San Jose. Participants evaluated the course favorably, although the structure of the training program (i.e., sites chosen for practical training) did not permit sufficient acquisition of skills (for example, insertion of IUDs). There was also a consensus that future training should be decentralized, which would reduce costs; include nurses and other family planning service providers; and be so organized as to permit participation of MOH doctors (who cannot be granted more than three days leave for such training).

The training program was halted after the initial phase because of a governmental determination that CCSS staff could not be compensated for serving as trainers. It has taken almost a year and a half to find a solution to this problem, during which time no training has been given. An agreement is now being drawn up between CCSS and the University of Costa Rica (UCR) whereby the latter will appoint and compensate the trainers. If this agreement is approved by the CCSS legal advisor, the SR, CENDEISSS and UCR will need to agree on how the in-service training program will be developed, implemented and evaluated. Thus far, little progress has been made in this direction. It will also be necessary to develop a training program that is short enough to permit participation by MOH doctors who are doing their Social Service.

The interruption in this training program for a year and a half has undoubtedly affected the quantity and quality of family planning services available in Costa Rica. One can only speculate as to whether a solution could have been found more promptly had there been more effective leadership or a higher-level commitment within CCSS regarding this problem.

2.4.2.2 Recommendations

- (1) Establish a steering committee composed of representatives of SR, CENDEISSS and the UCR and reach agreement on development of an effective in-service training program. Because CENDEISSS is the institution with *de facto* responsibility for in-service training, the major burden of planning and managing the training program will undoubtedly fall on its shoulders.

- (2) Have SR promptly carry out an assessment of training needs throughout the health service delivery network. This can be done in the course of scheduled supervisory visits to the field. Team members should be given guidance regarding the kinds of information they should seek.
- (3) Ensure that training is made available for all types of staff working in family planning.
- (4) Develop plans for follow-up assessment of the impact of training. Assessments can be made in the course of supervisors' field visits.

2.4.3 Training of Trainers

2.4.3.1 Findings and Conclusions

It is difficult to assess this element of the project component independent of the elements of curriculum review/revision and in-service training. Some training is implicit in whatever visits university staff may make to universities in the U.S. and other Latin American universities. The same is probably true of the technical assistance being provided by JHPIEGO. SR and CENDEISSS staff are aware of the need to ensure that trainers for in-service training have the necessary orientation, curricular materials, and so on, so that training complies with established norms.

2.4.3.2 Recommendation

Project leadership should ensure that adequate training is provided for trainers/professors as part of the planning for curriculum revision and in-service training.

2.4.4 Teaching Materials

2.4.4.1 Findings and Conclusions

An undetermined quantity of teaching materials has been obtained from JHPIEGO through the project, including anatomical models and books. These have been distributed to CENDEISSS and to the medical and nursing schools.

Given that training has been suspended for a year and a half and that curriculum review and revision are just beginning, one cannot judge the adequacy and usefulness of the teaching materials.

2.4.4.2 Recommendations

SR should have more organized information available regarding training materials received under the project. As planning for in-service training proceeds, an early identification of additional training material needs, if any, should be made.

2.5 Research

2.5.1 Findings and Conclusions

A research coordinator was to be contracted under the project and a life-of-project research plan designed and carried out. The plan was to include two Young Adult Surveys, a DHS, patient-flow analyses, and operations research. The expectation was that some research would be contracted out to other institutions and that some would be done in-house.

Research activity appears to be isolated, rather than being linked to other project components. It is not coordinated with other units of Preventive Medicine nor is it linked with the Research unit of the Technical Division of the CCSS. Lack of coordination with other units of Preventive Medicine could present obstacles, given that it is probably difficult to improve family planning services alone in a clinic in which family planning is one of many services provided.

A research coordinator is in place and preliminary analyses have recently been completed for the first Young Adult Survey. The survey had technical assistance from the Centers for Disease Control (CDC). Fieldwork was carried out by the Costa Rican Demographic Association (ADC) under a contract with CCSS. The survey was delayed for almost a year pending CCSS approval of the contract.

There has also been a substantial delay in initiating the first patient-flow analysis (PFA). The principal reason reportedly was a delay of almost a year in obtaining technical assistance from CDC. This is now scheduled for July 1991. Preliminary plans for the PFA, including its scope, methodology and linkage with other relevant units of Preventive Medicine (of which SR is a part) appear to be vague.

Rather than a demographic and health survey, a knowledge, attitudes and practice (KAP) study will be carried out with technical assistance from CDC. Planning will take place sometime before the end of this fiscal year (October 31, 1991) and fieldwork is scheduled to be undertaken in February 1992. A decision has not yet been made as to whether fieldwork will be contracted to ADC.

Apart from the PFA, there has been no operations research nor has any thought been given to this area. A Population Council staff member associated with the A.I.D.-funded Operations Research Project for Latin America will be in Costa Rica in the near future and possibly could be of help in this area.

In conclusion,

- (1) Relatively little research has been accomplished under the project to date.
- (2) There appears to be no research strategy.
- (3) Research activity appears to be isolated, rather than being linked to other project components.

2.5.2 Recommendations

- (1) Develop a research strategy, with technical assistance as required.
- (2) Accelerate research planning and implementation, with technical assistance as required.
- (3) Explore opportunities for simple operations research in close coordination with SR staff and other units of Preventive Medicine. Seek additional technical assistance as needed.
- (4) Explore additional possibilities to contract research with other Costa Rican research entities.

2.6 Procurement

2.6.1 Findings and Conclusions

The elements of procurement that must be addressed include the following: equipment and materials for family planning services and related uterine cancer detection in clinics and health centers; equipment and materials for IEC for clinics and other family planning service outlets; TV and radio spots; and print materials (posters, leaflets, and so on; computer, printer and related software; forms for reporting family planning activity).

Materials and equipment have been purchased as required, and distribution has occurred as planned. Most records are adequate. Monitoring of use of equipment for family planning services and IEC is planned for the near future.

There is one major problem area: purchases exceeding one million colones (approximately \$8,000) must be put out for public bid by CCSS, a process that can take as long as two years and can result in unsatisfactory products or materials. This has forced SR to limit its purchases to orders of a maximum of one million colones at a time. The result frequently is an inadequate quantity of the product in question in relation to program needs.

Procurement is functioning well under constraints that appear to be unavoidable.

2.6.2 Recommendation

Continue current procurement practices, unless some appropriate way can be found to avoid the one-million-colon limit without reducing procurement quality or delaying program implementation.

2.7 Information System

2.7.1 Findings and Conclusions

This component called for technical and other assistance to MOH and CCSS in the area of service statistics to improve accuracy in projecting contraceptive needs and assistance to MOH to improve contraceptive distribution and inventory control.

CDC has provided technical assistance to CCSS for estimating contraceptive needs (although CDC estimates on at least one occasion were below actual requirements, necessitating an emergency shipment). CCSS supplies both its own and all MOH facilities with contraceptives (and medicines). This represents an expansion of its responsibilities; until recently, the CCSS had supplied only those MOH health centers whose operations were integrated with CCSS health clinics, but not those that were operating independently. At an early stage of the project, technical assistance and equipment for contraceptive distribution and inventory control had been given to the MOH, with generally unsatisfactory results. Since CCSS now handles all contraceptive distribution, this is no longer a problem.

CDC also gave CCSS help with design of forms to record family planning service activity in CCSS clinics. This shows the total number of new acceptors and continuing users by method and age group. Given that the MOH already collects relatively detailed family planning service data, the MOH information system was not changed.

The SR unit currently receives three sets of information: (1) each month, it receives a diskette from CCSS Medical Records that shows the consumption of contraceptives by clinic as reported by each clinic pharmacy; (2) it receives a monthly report from the CCSS central warehouse on what it has sent to each clinic; (3) it receives (on a quarterly basis) monthly reports from Medical Records on clinic family planning service activity using the form that was designed with technical assistance from CDC.

The current system has a number of problems. First, the diskette report shows a number of clinics with no output of contraceptives for several months and then an output of as many as several thousand. SR staff did not seem to be aware of this situation until it was pointed out to them. Their speculation was that, on an irregular basis, the pharmacy may give supplies to the staff in the clinic who provide family planning services. Another possibility is that the clinic provides supplies to nearby MOH facilities on a periodic basis.

The central warehouse reports come to the SR unit as a result of the initiative of a staff member who left the program long ago. This information is not used at all (for example, it is not compared with the CCSS diskettes that contain the clinic reports).

The report on family planning service activity comes quarterly rather than monthly from Medical Records, even though the information is available to Medical Records on a monthly basis. (Each clinic sends a monthly report on all its health services activities to Medical Records.) There was no explanation for this delay, other than that this is the frequency of distribution Medical Records chose. Apart from timing, it is not clear how accurate the information is, why it is collected, or how it is or could be used. To the SR unit's credit, it has organized training in filling out the form for medical records staff at the regional level. In addition, when supervisors visit health facilities, they ask whether the form is being filled out.

The MOH data on family planning services are roughly two years out of date, and there is little likelihood that this situation will improve in the foreseeable future. Consequently, the SR unit does not get reports from the organization that provides perhaps one-third of all public sector family planning services.

There is also the possibility of some double counting at integrated CCSS-MOH clinics (which represent the large majority of clinics in the country). This is very understandable, given the complexities of the public health care system in Costa Rica. For example, if the MOH doctor is not present on a given day or week (which is frequently the case), the CCSS staff may provide the family planning service and the family planning activity is reported as a CCSS service. In other instances, there may be a mix of staff, e.g., a CCSS doctor and MOH nurse, or vice versa, raising a question of how the service should be attributed. Suffice it to say, the reliability, completeness and timeliness of the family planning service activity data appear to be major problems.

Another interesting finding from available data is that most clinics report roughly a three-to-one use of low-dose orals versus high-dose. Some clinics, however, report the reverse. SR staff had no explanation for this situation. Indeed, SR staff carry out virtually no analysis of data collected nor do they appear to use any of the information. The principal reason appears to be a lack of orientation and training in this regard. It is also quite certain that SR's Research unit does not use the data either.

The information system area warrants priority attention. The principal need is for technical assistance and short-term training with an operational and practical orientation. With manpower scarce and the delivery system complex, the aim should be to use available information more effectively and to improve its quality without making demands on staff for additional information at various levels of the health care system.

2.7.2 Recommendations

- (1) Provide technical assistance and short-term training to the SR unit in use of information collected.
- (2) Require that next year's program plan and budget show how information will be used to improve program performance. This should include a description of the kinds of analyses and reports the unit will prepare.
- (3) Explore how the Research unit can become involved in MIS activity.

2.8 Supervision

2.8.1 Findings and Conclusions

Support is provided under the project for a team of three professionals who make regularly scheduled visits to all CCSS and MOH integrated facilities to supervise family planning activities.

The team has represented a useful link with the field in an institutional setting in which headquarters professional staff typically have little contact with the field. Its members have been able and willing to spend roughly half-time in field visits because they are paid substantially more than their colleagues in other sections of the Department of Preventive Medicine (many of whom hold second jobs to supplement their salaries and do not have the time to be away from San Jose for field trips). The corollary is that, unless SR staff continue to be paid at higher levels than is the norm for Preventive Medicine, there may be no incentive for continuing the current supervision activity and it may therefore disappear, with negative consequences for availability of family planning services throughout Costa Rica.

The supervisors' link with the field has also meant that family planning service providers have received equipment and supplies for family planning, IEC materials, materials for uterine cancer detection and an assured supply of contraceptives. The team has also given assistance regarding the information system for family planning. The team knows the extent to which family planning services are offered in accordance with CCSS and MOH norms in virtually all public health services facilities in the country. When a clinic director is receptive, team members have been able to recommend actions to improve the provision of family planning services. In several instances in which the local level has not been receptive to findings or recommendations regarding compliance with norms, the SR unit has gone to higher levels of the CCSS, which have required compliance. Finally, team members have collected useful information on family planning service activity, equipment and supplies in each facility and use of forms designed for this purpose. They have also identified service delivery staff who need in-service training in family planning.

The supervisors, however, do not have technical or administrative authority over the family planning activities they visit. The team cannot insist on compliance with established norms, even where norms clearly are not being followed — for example, in range of methods offered or quantity of contraceptive supplies given to a client. Plans to decentralize authority within the CCSS and to strengthen supervision, especially at regional levels, suggest that their authority will not increase in the future. The team's potential usefulness has not been realized in other areas, as well: Team members have not collected uniform information during field visits, and there has been little analysis of information collected or formulation of proposed actions to overcome deficiencies, apart from actions to supply equipment, materials and contraceptives and to improve data collection.

Although the supervisors do not have technical or administrative authority, their regular visits to nearly all clinics and health centers have probably been the second most important factor in ensuring that family planning services are available in virtually all public sector health organizations in Costa Rica. (The most important factor is the A.I.D.-provided supply of contraceptives.)

2.8.2 Recommendations

- (1) Continue the current supervisory activity the three team members perform.
- (2) Revise the data-collection instruments the team uses, to identify areas in which family planning services should be improved.
- (3) Prepare analytical reports for higher levels of CCSS management indicating where norms are not being followed, where family planning services are offered on only a limited basis and so on.

- (4) Revise job descriptions to reflect activities team members can feasibly perform.
- (5) Plan field visits to focus particularly on problem clinics.
- (6) Use field visits to carry out simple operations research activities, such as exit interviews with clients and focus group interviews (where clinic leadership agrees).

2.9 Institutional Counterpart

2.9.1 Findings and Conclusions

CCSS has fulfilled most of the responsibilities it accepted under its agreement with USAID. These include establishing an implementing entity with adequate personnel; preparing an annual plan and budget; administering and accounting for project funds; providing office space, transport and per diems; designing and implementing strategies and activities in communications, research, training and curriculum revision; executing agreements with the MOH; supplying contraceptives to nonprofit entities that provide services to the poor; and reporting to A.I.D. on a semi-annual basis.

Areas in which CCSS performance has clearly been less than adequate have been identified earlier in this report and include developing and implementing an annual planning, budgeting, monitoring and evaluation cycle (and reporting on performance on the basis thereof); in-service training; research; curriculum revision; and the information system.

Another concern is that the CCSS has treated the SR unit as a somewhat independent entity, rather than one that is integrated into Preventive Medicine, of which it is formally a part. While this has had its advantages and disadvantages, the unit cannot continue to maintain an independent existence and at the same time move toward increased integration with the Preventive Medicine Department — a step that will be essential if the CCSS is to assume full financial responsibility for its operations by 1995.

The CCSS has generally fulfilled its responsibilities under its agreement with USAID.

2.9.2 Recommendations

- (1) CCSS should give attention to planning, budgeting, monitoring and evaluation; training; curriculum reform; research; and the information system.
- (2) CCSS Technical Division and its Preventive Medicine Department should work toward increased integration of SR activities with other Preventive Medicine activities.
- (3) CCSS should continue to ensure that transportation is made available to the SR unit as required under the agreement with USAID in order to continue the important work of supervision.

2.10 Subagreements with Private Entities

2.10.1 Findings and Conclusions

CCSS was to (1) execute agreements with nonprofit entities that provide social services in family planning to the poor and supply contraceptives to these entities; and (2) contract with other entities, public or private, to provide necessary services or commodities.

CCSS has entered into a limited number of agreements and contracts. These include with the ADC for research assistance, the Clinica Biblia for family planning services for the poor, and commercial firms for IEC goods and services, including TV, radio and print materials. Agreements are likely to be signed soon with the UCR for sponsorship of in-service training.

CCSS has performed appropriately in this area.

2.10.2 Recommendation

CCSS should attempt to broaden the number of institutions with which it has agreements or contracts, particularly for provision of family planning services to the poor and in the area of research.

2.11 Sex Education

2.11.1 Findings and Conclusions

The expectation was that sex education would be included in the school curriculum by 1992 and that sex education materials would be distributed to the non-enrolled school-aged population by 1990.

Because of opposition from the Catholic Church, no progress has been made in introducing sex education materials in schools. Those not enrolled in schools have been reached to some extent by the UNFPA-funded Program for Adolescents in a collaborative effort with the SR unit. The program, like the SR unit, is in the Preventive Medicine Department.

The school-based component has not been successful for reasons that lie beyond the control of project authorities. There has been moderate progress in the out-of-school area.

2.11.2 Recommendations

- (1) Do not attempt to force the issue regarding sex education in the schools.
- (2) Make a greater effort to collaborate on relevant activities with the Program for Adolescents.

2.12 Contraceptive Procurement and Distribution

2.12.1 Findings and Conclusions

A.I.D. supplies low-dose oral contraceptives, IUDs and condoms, and CCSS buys its high-dose orals. CCSS is now responsible for all warehousing and distribution of contraceptives to CCSS and MOH family planning service delivery points; the procedures for providing contraceptives to the MOH clinics that are not integrated with the CCSS are still being worked out and supplies do not always flow smoothly to these facilities.

Contraceptive procurement and distribution have on the whole been handled effectively. In the 12 clinics and health centers visited in several regions of the country, supplies of contraceptives were adequate (due in part, as pointed out above, to the work of the team of supervisors). No expired materials were found in clinic pharmacies. Similarly, contraceptive supplies at the central warehouse seem to be well managed, and a well-organized distribution system is in place. Several reports were heard about temporary shortages of some supplies in some facilities. This has occurred apparently in part because of errors in ordering supplies from the central warehouse, in part because the responsibility for supplying non-integrated MOH facilities has not been formalized completely, in part because in a few isolated instances the person responsible for subdistribution has arbitrarily sent lower quantities than were requested, and in part because there have been underestimations of requirements in planning for contraceptive procurement.

2.12.2 Recommendations

- (1) Formalize the arrangement between the CCSS and MOH regarding distribution of contraceptives to non-integrated facilities.
- (2) Ensure that CCSS clinics supply contraceptives to other facilities in accordance with established norms.
- (3) Continue to have the team of supervisors check on adequacy of contraceptive supplies in clinic and health center pharmacies.

2.13 Gender Issues

Women are overwhelmingly the clients — and beneficiaries — of family planning in CCSS and MOH service facilities. The training organized at the beginning of the project was for doctors only, however. SR and CENDEISSS agree that future training will include nurses (who typically are females and are more involved in family planning than are the doctors, in part because a substantial portion of the doctors are recent graduates doing their Social Service and have little experience, including in family planning).

2.14 Possible Future Project

The situation currently can be summarized as follows: (1) a high proportion (about 70 percent) of women in Costa Rica practice family planning; (2) the public perceives family planning

as a service that the public sector is obligated to supply; (3) family planning services and contraceptive supplies are generally widely available through CCSS and MOH facilities, although the range of family planning methods is limited; (4) the CCSS leadership is unequivocal regarding its commitment to assume responsibility for contraceptive purchase when A.I.D. support terminates; (5) the SR unit is and is perceived to be relatively independent of the Preventive Medicine Department; (6) SR has accomplished important project objectives, yet it has serious weaknesses; (7) the Preventive Medicine Department reportedly is relatively weak and has a very limited budget; (8) CCSS leaders are currently studying the existing CCSS structure to determine how the system can be decentralized, how supervision can be strengthened, and how quality of services can be improved.

The above situation analysis suggests the following strategy for 1993-95:

Design a project that provides declining USAID support and that is realistic in the sense that it can be supported totally and effectively by CCSS by the end of 1995. In developing the design, take the following steps:

- (1) Press CCSS to prepare now to ensure its ability to buy contraceptives cheaply beginning in 1993.
- (2) Provide declining support for contraceptive purchases during 1993-95; CCSS should begin to buy some portion of all contraceptives beginning in 1993, or as soon as possible thereafter.
- (3) Press the CCSS Technical Department to define specific and realistic functions, required staffing, and qualifications for the reproductive health area in an integrated setting. Include specific relationships with regional and local-level units, including those of the MOH. Prepare realistic job descriptions.
- (4) Establish and budget for official CCSS SR positions prior to the end of calendar year 1992, given that USAID support for SR staff salaries is scheduled to terminate in July 1993.
- (5) Designate family planning as a priority area for CCSS and MOH to ensure that contraceptive supplies are not subject to budget cuts.
- (6) Develop tentative plans and budgets for IEC, in-service training, and research activities for the 1993-95 period with provision for declining-scale support from USAID. These plans should assume that SR will be integrated into Preventive Medicine.

An issue in which USAID should have an interest is the organization for SR within Preventive Medicine. Although one could argue logically that SR activities (and staff) could be placed within the Women's Health Section, the Adolescent Program and the Adult Section of the Department, there is a strong possibility that, under such an arrangement, family planning would not get the focused attention that may be required to ensure its continued availability throughout the country. USAID should press for an SR section in Preventive Medicine, even if the section were staffed with as few as two professionals.

3. Contraceptive Social Marketing

3. Contraceptive Social Marketing

3.1 Findings and Conclusions

The Contraceptive Social Marketing program has been in operation since January 1984. The implementing entity is PROFAMILIA, a profit-making firm owned by the Costa Rican Demographic Association (ADC).

The only contraceptive currently sold by PROFAMILIA currently is condoms. These are provided free by A.I.D. and are distributed throughout most of the country, including many rural areas, via commercial channels. PROFAMILIA's share of the condom market is currently about 30 percent. Its sale of condoms has increased from 500,000 in the first year to 2,600,000 in the fifth.

Because of product registration requirements in Costa Rica and lack of interest in the relatively small Costa Rican market on the part of some potential major suppliers, PROFAMILIA has not yet been successful in offering oral contraceptives. PROFAMILIA is now holding discussions with the pharmaceutical manufacturer Schering that would involve purchasing the low-dose oral Microgynin for about 55¢ a cycle and retailing it for about \$2.50 through pharmacies. The current retail price for the equivalent product is about \$6.

PROFAMILIA has completed a marketing survey at Schering's request and estimates that it could sell roughly 200,000 cycles per annum. The average client for the product, according to the survey, would be a middle-class woman under 30 years of age. This would relieve to some extent the contraceptive supply burden that falls on the public sector, fulfilling one of the project's objectives. It is obvious that if the price to PROFAMILIA were lower (closer to the price A.I.D. now pays for orals), the retail price could be reduced further, which would likely result in an increased market.

PROFAMILIA plans to undertake the purchase and sale of orals with no support from A.I.D.

In addition to contraceptives, PROFAMILIA has pioneered in selling several somewhat related products because they can contribute to attaining financial self-sufficiency. These include an infant's drinking cup, materials for cervical/uterine cancer detection and rubber gloves. The CCSS is a major purchaser of the latter two products.

PROFAMILIA has made remarkable progress toward achieving self-sufficiency. It has done so through a combination of entrepreneurial management, a lean staffing structure, excellent marketing, use of existing private sector mechanisms, and expansion of product lines. USAID's decision to permit PROFAMILIA to use income from the sale of donated products to buy other products for sale has been an important contributing factor. PROFAMILIA is already ahead of the targets that were set for self-sufficiency. The PROFAMILIA director estimates that the organization will have net assets of \$1 million by the end of the current project period (July 1993). If A.I.D. can provide approximately \$150,000 per year (in products or funds) during the period 1993-95, PROFAMILIA believes it can be 100 percent self-sufficient by 1995.

One area of concern regarding PROFAMILIA is its dependence on one person, the general manager, for its current success. Given the importance of keeping a lean staffing structure (a total of two and three-quarter persons currently) in order to reach financial self-sufficiency by 1995, it is difficult to suggest actions that could be taken now to address this concern. If PROFAMILIA continues to flourish, it might be useful to recommend appointment of a strong deputy general manager when such a position can be supported without adversely affecting the organization's self-sufficiency.

3.2 Recommendations

- (1) A.I.D. should provide support to PROFAMILIA of approximately \$150,000 per year for the two-year period 1993-95.
- (2) Whenever feasible, A.I.D. should assist PROFAMILIA in the latter's efforts to secure oral contraceptives from international sources at the lowest possible price.
- (3) In order to institutionalize PROFAMILIA's success, USAID might recommend the appointment of a strong deputy at such time as can be managed without impairing the organization's financial self-sufficiency.

4. Increased Service Delivery Alternatives

4.1 Findings and Conclusions

With free health care available to virtually all those who seek it (and who are willing to spend substantial time in the process), there has been little development of alternative family planning service delivery models in Costa Rica, apart from that of private practice. Practically all services are delivered through CCSS, the MOH, PROFAMILIA, and private practice by doctors, most of whom also work for the CCSS. A couple of other models do exist, but they do not represent significant alternatives in their present forms.

For example, CCSS services include assignment of part-time medical staff to basic health clinics located in private enterprises (e.g., factories that do assembly work), a benefit that these companies receive in return for compulsory contributions to CCSS. These enterprises represent a potentially important target population for family planning services because a very large proportion of their employees are young women. The services now provided by CCSS are typically minimal, however — a doctor may have to cover as many as 20 clinics — and they have a curative rather than preventive focus. Finding the CCSS medical services insufficient, a number of enterprises have either hired medical and nursing staff or have contracted with one of several private organizations that have been established to provide such services. (The SR unit staff have visited a large proportion of these enterprises and have provided contraceptive supplies and IEC materials to their clinics.)

Another model is the doctors' cooperative. There are only a few of these and they are in urban areas. In this model, the CCSS gives financial support to the cooperative based on the size of the population it covers. Clients receive services free of charge. (Those clients who are regularly employed will normally have paid a substantial compulsory fee to the CCSS for medical care.) The three cooperatives visited seemed to be working effectively and were serving substantial population groups. The area of coverage of one of the cooperatives in San Jose includes a large lower-income population. A major concern of some of the cooperatives is the position of the CCSS vis-a-vis this model of health care. It is not clear, for example, whether the CCSS views the cooperatives favorably or whether it favors establishment of more cooperatives and/or expansion of existing ones.

There are also a limited number of private clinics in urban areas of Costa Rica. These include the Clinica Biblia, which serves a relatively well-to-do population but which also provides free care, including family planning, to those who cannot pay.

Other models might, for example, include permitting an individual or organization to use the current required contributions to the CCSS to purchase health services from private or other sources. The absence of clear government policy regarding establishment of any alternatives, however, suggests that there does not seem to be much potential in this area.

4.2 Recommendation

The CCSS should be encouraged to enunciate a positive position regarding cooperatives as a model for delivering health care.

Appendix A
Terms of Reference

Appendix A

Terms of Reference

EVALUATION: FAMILY PLANNING SELF RELIANCE

I. ACTIVITY TO BE EVALUATED:

Project 515-0168.02, Family Planning Self Reliance/Human Reproduction, May 27, 1988 -July 18, 1993, \$1.8 million in program costs, \$2 million in contraceptives. Implementing entity: Caja Costarricense de Seguro Social.

Project 515-0168.03, Family Planning Self Reliance/Contraceptive Social Marketing, August 4, 1988 - July 18, 1993, \$2.2 million, including \$700,000 in contraceptives within the total amount. Project implementing entity: PROFAMILIA/Asdecosta S.A.

II. PURPOSE

The purpose of this mid-term evaluation is to carry out an analysis of the process under way, to review the operating strengths and weaknesses in each of the programs, with a view toward immediate improvements in those aspects that can be positively modified, and a documentation of the limitations inherent in each of the programs. As A.I.D. is looking toward a phase-out of population assistance in the medium term in Costa Rica, it is important to view the administrative aspects of the project as it stands at mid-point, and the possibility of sustainability of each of the program components with domestic financing. A.I.D. is seeking to avoid a post-project deterioration of the program, and will attempt to ensure that adequate systems, financial, physical and human resources are in place to maintain the programs at the required levels of service delivery. It is also desirable to avoid the substitution of one donor for another in terms of contraceptive budget support, as this prolongs the dependence on external support. The evaluator should bear in mind that the Costa Rican program has reached a degree of stability that is unique in the LAC region. The institutions are in a position to take on full responsibility for their programs. A.I.D. has cut financing to programs in other countries in the past, but has not truly "graduated" any family planning programs in this region.

This is not expected to be an impact evaluation, as survey data from the ongoing Demographic and Health Survey will not be available until 1992. As in all A.I.D. evaluations, the evaluators should address the issues of the relevance of the project activities to the problems being addressed, the effectiveness of the project in attaining its stated objectives, the efficiency of the implementing agencies in their approaches to the activities being carried out, a quick view as to whether or not there is a positive or negative impact resulting from the project activities relative to the objectives of the project, and most of all, sustainability of the eventual development created by the project.

The second purpose of the evaluation, beyond the stock-taking measure, is to take a look at the near future (1993-95) and discuss options for increasing the public/private mix of service delivery alternatives to reduce, or at least not dramatically increase, the budgetary burden on the public sector, without reliance on donated contraceptives on the part of the implementor. This might include factory-based programs, or marginal urban communities, but where there is a fee-for-service or cost-sharing option. Options and limitations should be discussed, with a view toward reducing the restrictions in the short to medium term. There will be no donated contraceptives in the foreseeable future, and that must be factored into any new project idea.

III. BACKGROUND

In 1988, USAID/Costa Rica amended the existing project, entitled "Family Planning Self Reliance" to extend the period an additional five years and to add \$6 million. This amendment also changed the implementing entity from the IPPF affiliate, the Asociacion Demografica Costarricense (ADC), which served as an intermediary for both public and private sector components, to a direct relationship with the public sector health entities, the Ministry of Health and Caja Costarricense de Seguro Social (CCSS), and the private sector Contraceptive Social Marketing firm PROFAMILIA/Asdecosta, which is owned by the ADC.

Reasons for the change in implementing entities were an increased sense of responsibility for family planning within the preventive medicine approach of the Ministry of Health and CCSS; a need for a valid institutional counterpart in terms of actual clinical services being carried out; political and technical will; to improve logistical systems due to A.I.D.-financed technical assistance; and a realization that this program had to be integrated into the maternal child health program offerings in order to improve coverage, and keep up with the demand. The Mission determined that a PVO was not needed to coordinate the contraceptive flow and project-specific information systems for public sector programs. Also, PROFAMILIA had developed sufficient managerial capability to handle a grant independently for the Social Marketing Program, which decreased the bureaucratic aspects of the project management.

Components of the project for the \$3.8-million public sector program are

1. Administration
2. Communications
3. Education and Training
4. Research
5. Commodities

The \$2.2-million private sector program is limited to commercial sales of contraceptives and expansion of the family planning information network through innovative marketing mechanisms:

1. Contraceptives (condoms)
2. Promotional, logistical and administrative costs

IV. SCOPE OF WORK

A. SPECIFIC TASKS

1. PUBLIC SECTOR PROGRAM

Tasks are to review project documentation, i.e., project paper, agreements, work plans and reports against those work plans. The following project components and special interest areas must be evaluated with respect to the effectiveness of their implementation and progress toward the stated objectives.

a. Communications: review strategy for communications, how it was created, utilization of external technical assistance, how the plan is being carried out, the monitoring plan, evaluation plan, possibilities for continuation and new areas to explore.

b. Training: review strategy, activities to date, plans for integration of training activities into regular training programs, problems encountered and solutions required. Long-term viability of training programs as proposed should also be examined.

26

c. **Research:** review plans, structure within project framework, collaboration with other entities such as ADC or universities and the Census Bureau, utilization of resources to their best advantage and development of internal capabilities versus contracting out.

d. **Procurements:** review project procurements of goods and services and discuss compliance with objectives of the program in terms of effective and efficient project and program management, information needs, communications support, clinic upgrading support and the possibility of incorporating replacement requirements in the general institutional budget. Review placement of equipment in central offices and field units.

e. **Information requirements and sources:** examine the use of existing information collected from various data sources and the analytical possibilities for program management.

f. **Supervision:** examine methodologies, instruments, support provided to the field, use of information collected and note improvements made and those still needed.

g. **Institutional counterpart:** report on CCSS and MOH, compliance with the terms of the project agreement, institutional support in terms of logistics, administrative backup, progress toward integration of services and accessibility of family planning (FP) services to the population. Also look at the hours of services scheduled and FP-specific general medical services that include FP. Finally, examine rural/urban differences and contraceptive supplies and availability to users on a regular basis.

h. **Subagreements with private entities:** report on their effectiveness and progress.

i. **Sex education:** examine the progress toward inclusion of topics in health education programs or regular curricula in schools.

j. **Sex education for the nonenrolled school-age population:** report on plans, programs and progress.

k. **Institutional requirements for contraceptive procurement and distribution to CCSS and MOH units:** report on these according to projected needs.

l. **Gender issues:** review data-collection systems for contraceptive use, training opportunities and any other quantitative mechanism for measuring the benefits to women.

2. CONTRACEPTIVE SOCIAL MARKETING

a. **Review project proposal and agreement, progress reports and marketing studies.**

b. **Review product registration and marketing issues.** Discuss possibilities for product-line augmentation. Review limitations and where the Mission might have influence over simplification of procedures or obstacles.

c. **Review progress in attaining self-sufficiency and options to expand the scope to include private sector service delivery alternatives that would not depend on donated contraceptives, as mentioned above.**

d. **Review possible A.I.D. and GOCR impediments to attaining self-sufficiency, such as policies related to source and origin of commodities, A.I.D.-specific brands, central procurement, use of program income, and so on.**

e. **Gender issues:** review data-collection instruments to determine any possible means of measuring benefits to women.

C. METHODS AND PROCEDURES

The evaluator will need to review documentation, carry out interviews with key individuals involved in the project, and visit some clinic sites in the countryside in order to have a well-rounded view of the project. It is expected that a consultant from the Family Planning Logistics Management Project will be providing a technical assessment of the institutional capacity in terms of the transition of the contraceptive procurement, and the integrated distribution of commodities to the CCSS and MOH facilities by the CCSS supply system. This piece can complement the evaluator's more general overview of the logistics and information systems.

Preferred timing for the evaluation is May 1991, with three weeks of fieldwork in Costa Rica, and one week of report preparation, also in country. Finalization of the report will be coordinated with the evaluator's home office.

D. EVALUATOR'S REQUIREMENTS

1. Spanish language capability at least S/3-R/3, as most documents and all interviews will be in Spanish
2. Knowledge of, or experience with public sector family planning programs in Latin America, ideally with experience in Costa Rica
3. Knowledge of or experience with Contraceptive Social Marketing programs
4. Experience in program evaluations
5. Good writing skills, and creative thinking ability

E. REPORTS

This evaluation report is to provide empirical findings based on the areas of interest listed above, conclusions based on the findings and recommendations based on an assessment of the results of the evaluation exercise. The report should include the lessons learned that emerge from the review, and a discussion of how those lessons can be incorporated into ongoing and follow-on project activities.

A draft report in English must be presented to the Mission within 30 days after the commencement of the fieldwork. The final report shall be presented to USAID/Costa Rica no later than 30 days after the termination of the in-country work.

Report format should be as follows:

1. Table of contents.
2. Executive summary: State the objectives of the project, purpose of the evaluation, findings, conclusions and recommendations, and lessons learned about the design and implementation of this type of activity. The executive summary should be prepared in English and Spanish.
3. Body of the report: Discuss the purpose and focus of the evaluation, the economic, political and social context of the project, findings of the evaluation, conclusions drawn from the findings and recommendations based on the findings and conclusions. State the recommendations as actions to improve current project performance, and indicate how they might be incorporated into an eventual follow-on project.

The body of the report should include separate sections for the public sector and contraceptive social marketing programs.

4. Appendices: Include the scope of work, documents consulted and individuals and agencies contacted.

Appendix B
Persons Interviewed

Appendix B

Persons Interviewed

CCSS

Dr. Elias Jimenez F., Executive President
Dr. Guido Miranda G., former Executive President

Dr. Enrique Falcon L.I., Director (farmacoterapia)
Dr. Jorge Fonseca R., Chief, Department of Health Systems Development
Licda. Ligia Moya, Chief, Biomedic Information
Lic. Alvaro Munoz, Chief, Department of Material Resources
Dr. Mario Pacheco M., Director, CENDEISSS
Licda. Zaday Pastor, Chief, Social Health, CENDEISSS
Ing. Carlos Quesada, Director of Operations
Dra. Julieta Rodriguez Rojas, Chief, Adolescent Program
Lic. Salomon Rodriguez, Director of Administration
Dr. Alvaro Salas Ch., Director, Technical Division
Lic. Eduardo Sanchez J., Medical Director
Lic. Manuel Ugarte Brenes, Chief, Department of Programming and Budget Analysis

SALUD REPRODUCTIVA

Dr. Johnny Lopez M., Director
Dr. Gerardo Arias, Supervisor
Dr. Norman Hines Jackson, Supervisor
Dr. Eric Rodriguez, Supervisor
Sr. Juan Chinchilla, Administrator
Dr. Victor Gomez, Demographer

MINISTRY OF HEALTH

Dr. Carlos Castro Charpentier, Minister
Dra. Emilia Leon de Coto, Director General
Dr. Rafael Salazar P., Chief, Maternal Section

PROFAMILIA

Lic. Jorge Lopez M., General Manager

Appendix C
Health Facilities Visited

Appendix C

Health Facilities Visited

Health Center, Ciudad Quesada
Health Clinic, La Fortuna
Health Center, Guapiles
Health Clinic, Guacimo
Health Center, Alajuela
Integrated Health Clinic, Barrio San Jose
Health Clinic, Alfredo Volio
Integrated Health Center, Orosi
Health Clinic, Tibas
Health Clinic, San Rafael de Heredia

Appendix D
Documents Reviewed

Appendix D
Documents Reviewed

CCSS

Action Program and Budget for the Third Year of the Agreement: Self-Sufficiency in Family Planning/Human Reproduction, December 1990 (Spanish)

Action Program and Budget for the Second Year of the Agreement: Self-Sufficiency in Family Planning/Human Reproduction (Spanish)

Action Program in Information, Education and Communication for Reproductive Health, September 1989 (Spanish)

Budget Report on Program in Reproductive Health April 30, 1991, to May 22, 1991 (Spanish)

CENDEISSS Files on In-Service Training in FP

Institutional Policy on Reproductive Health, 1989 (Spanish)

Local Health Systems and Health Cooperatives, the Case of Costa Rica, February 1991 (Spanish)

National Survey on Reasons for Medical Consultations in CCSS, 1987, March 1991 (Spanish)

Profile of the Medical Supervisor (undated) (Spanish)

Programs, Sub-programs and Activities of the Medical Division Management (Spanish)

Project for Creation of the Directorate of Preventive and Social Medicine, May, 1990

Report on Activities for 1990 - Program in Reproductive Health (Spanish)

Reproductive Health, Reality and Perspectives, November 1989 (Spanish)

Technical Norms for Maternal Care, March 1990 (Spanish)

MINISTRY OF HEALTH

Family Planning Consultations by Method and Establishment in 1989, March 1991 (Spanish)

PROFAMILIA

Financial Reports (various) (Spanish)

Marketing Plan for Social Marketing Program, 1990-1991 (undated) (Spanish)

Price Waterhouse, Financial Conditions of PROFAMILIA, 31 March, 1991 and 30 September, 1990 (Spanish)

Study on Principal Characteristics of the Contraceptive Pill Market in Costa Rica, March 1991 (Spanish)

USAID

Family Planning Self Reliance/Human Reproduction: Agreement Among A.I.D., CCSS and MOH, May 27, 1988 (English and Spanish)

Project Paper: Family Planning Self-Reliance (undated)

Appendix E

Borrador

Appendix E

Borrador

Junio 16, 1991

OBSERVACIONES

1. Servicios de planificación se ofrecen en todos los lugares visitados.
2. El suministro de anticonceptivos funciona bien, con la excepción de algunos centros de salud no integrados.
3. Equipos para planificación han sido proveído a clínicas y centros con fondos del proyecto.
4. Materiales de información y educación han sido producidos y distribuidos.
5. Capacitación de personal en planificación (Salud Reproductiva) ha sufrido una demora importante.
6. Revisión del currículum de las Escuelas de Medicina y Enfermería (y Trabajo Social) ha tenido una demora importante.
7. El personal de CCSS no tiene una perspectiva uniforme en relación con el papel de CCSS en planificación y medicina preventiva.
8. Hay defectos y problemas con el sistema de información que se está desarrollando en relación con servicios de planificación.
9. La unidad de Salud Reproductiva se ve como algo independiente, más bien que una unidad que esté bien integrada en Medicina Preventiva. Los puestos que ocupan el equipo humano no forman parte de los puestos oficiales de la CCSS. Además, las responsabilidades del personal (por ejemplo de "supervisión") no coinciden con la estructura actual de la CCSS.
10. La CCSS está en el momento cumpliendo un trabajo importante de: (1) definir prioridades en el sector de servicios de salud; (2) planear la integración de medicina preventiva y atención a las personas; (3) diseñar una estructura organizacional desconcentrada para el mejor manejo de servicios de salud a niveles regional y local.

RECOMMENDACIONES

Por los motivos de que (1) el convenio requiere una evaluación después de dos años; (2) la CCSS está en este momento tomando decisiones relacionadas a la organización de los servicios de salud; (3) hay la posibilidad de apoyo financiero adicional por parte de A.I.D. para el período 1992-1995, parece oportuno en este momento determinar cómo la planificación (o Salud Reproductiva) puede ser integrada efectivamente en la estructura y los sistemas de la CCSS. Hay varios elementos que uno tiene que tomar en cuenta en hacer esta determinación:

1. ¿Qué diseño o modelo de equipo humano se requiere para asegurar que la planificación se ofrece efectivamente dentro de los programas de la CCSS? ¿Cuáles funciones y capacidades están implícitas en este respeto? ¿Cuáles acciones se necesitan para establecer los puestos dentro de la CCSS?

2. Cuales cambios se requieren para asegurar que la planificacion (o Salud Reproductiva) esta integrada en Medicina Preventiva y que tiene relaciones efectivas, incluyendo supervision tecnica y administrativa apropiada, con todos los niveles de la CCSS, incluyendo central, regional y local?
3. Que proceso de planificacion y programacion, incluyendo presupuestario, se requiere ahora para asegurar que: (a) la CCSS asumira la responsabilidad total para la compra de anticonceptivos a partir de 1995 o 1996; (b) la capacitacion, la investigacion y las actividades de informacion y educacion relacionadas con planificacion (o Salud Reproductiva) tendran un apoyo adecuado por parte de la CCSS, incluyendo por medida de mejor integracion con actividades similares de la CCSS?
4. Que tip de convenio se requiere entre la CCSS y el Ministerio de Salud para asegurar no solamente el suministro de anticonceptivos sino otras ayudas necesarias para el buen manejo de servicios de planificacion?
5. Que tipo de sistema de informacion se requiere en relacion con planificacion familiar para el buen manejo del programa que se encaja en el sistema de informacion que la CCSS desarrollara para servir una estructura desconcentrada?
6. Cuales son las necesidades actuales de capacitacion y de asistencia tecnica de la unidad de Salud Reproductiva?

Appendix F

Recommended Tentative Allocation for 1993-95

Appendix F

Recommended Tentative Allocation for 1993-95

CCSS		
Contraceptives:		
Condoms for two years at roughly \$200,000 per annum		\$450,000
Orals for two years with CCSS supplying 50%		120,000
IUDs		<u>30,000</u>
	Subtotal	600,000
IEC		100,000
Research		50,000
In-service training		25,000
TA		<u>50,000</u>
	CCSS Total	825,000
PROFAMILIA		<u>400,000</u>
	Grand Total	\$1,225,000

41