

5150105 (7)

PROJECT EVALUATION SUMMARY

ENTERED
8/30/77

PD-AAA-666-F1

1. Mission or AID/W Office Name USAID/Costa Rica		2. Project Number 515-0132	
3. Project Title Family Planning Services			
4. Key Project Dates (Fiscal Years) a. Project Agreement FY77 Signed b. Final Obligation FY79 c. Final Input FY80 Delivered			5. Total U.S. Funding Life of Project \$ 1,160,000
6. Evaluation Number as Listed in Eval. Schedule I. 1	7. Period Covered by this Evaluation From: 10/76 To: 7/77 Month/year Month/year		8. Date of this Evaluation Review 8/11/77 Month/year
9. Action Decisions Reached at Evaluation Review, including items needing further study (Note--This list does <u>not</u> constitute an action request to AID/W. Use telegrams, airgrams, SPARS, etc., for action) (1) AID participate in multi-donor and GOCR evaluation of entire National Family Planning Program. (2) Amend Project Paper.		10. Officer or Unit responsible for follow-up Population Officer Population Officer	11. Date action to be completed 12/77 2/78

12. Signatures:

Project Officer	Mission or AID/W Office Director
Signature <i>James R. Cumiskey</i>	Signature <i>Joe J. Sconce</i>
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Date August 12, 1977	Date

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13. SUMMARY - Although the population growth rate in Costa Rica has fallen significantly during the past 10-15 years, there has not yet been any kind of major evaluation of the causes of this decrease -- i.e., the extent to which it is a response (1) to unique socio-economic characteristics in Costa Rica and (2) to the National Family Program. Dr. J. Mayone Stykos of Cornell University has begun a study on fertility determinants in Costa Rica, the second stage of which the Mission has recommended be approved. In addition, as stated in this Evaluation Report, the Mission recommends that a multi-donor/GOCR evaluation be done of the entire National Program.

These evaluations are especially important at this time because of recent program reversals -- ban on voluntary sterilizations, ban of IUD, restrictions on use of paramedics, and generally bad publicity. Also, in spite of past success the present population growth rate is relatively high. Many more women must be reached if Costa Rica is going to achieve a replacement growth rate within the next 15 to 20 years. The costs of not doing so -- social, economic, and environmental -- must be illustrated, for the GOCR to make the required commitment to a dynamic family planning program.

14. EVALUATION METHODOLOGY -- This was a regular evaluation although, due to time constraints within the Mission and the need to wait until the new Population Officer had become thoroughly familiar with the Program, the evaluation was delayed from January to July 1977

Information from the recently completed World Fertility Survey was used in the evaluation. Also, in trying to analyze these data and the number of FP acceptors nation-wide, we became more aware of data and reporting deficiencies in the Program.

The evaluation was an in-house one, although findings have been discussed with the appropriate Costa Rican officials. The Mission Population Officer and Assistant Population Officer did the bulk of the work, assisted by the Mission Evaluation Coordinator and other staff. The Final Evaluation Review Meeting was chaired by the AID Affairs Officer and attended by the Population Officer, Assistant Population Officer, Controller, Program Officer, IDI (Controller), Health/Nutrition Officer, and Mission Evaluation Coordinator.

15. Documents to be revised to reflect decisions noted page 1 (other side:)

Project Paper (PP) Logical Framework CPI Network Financial Plan
 PIO/T PIO/C PIO/P Project Agreement Other
 This evaluation brought out ideas for a new project --
a Project Identification Document (PID) will follow.

I. GENERAL OVERVIEW OF COSTA RICA'S FAMILY PLANNING PROGRAM

Demographic transition in Costa Rica has been dramatic, with the population growth rate having decreased from 3.2 percent in 1967 to 2.3 percent in 1977.

Extrapolations from preliminary World Fertility Survey data on Costa Rica show that 45 percent of all women of reproductive age (WRA, 20 to 49 yrs.), are using some form of family planning and that 60 to 65 percent of married women of reproductive age (MWRA) practicing family planning are receiving services from the public sector. ^{1/} Population experts estimate that a replacement level of fertility (an average of slightly more than two children per couple) can be reached only if at least 65 percent of all married women of reproductive age (MWRA) are correctly practicing fertility control methods. These data show that while Costa Rica has experienced a dramatic reduction in fertility rates, it still has a relatively high population growth rate. It is probable that continued reductions in Costa Rica's population growth rate will be increasingly difficult to achieve unless the Government of Costa Rica develops a commitment to reaching or coming close to zero population growth (ZPG). ZPG would be reached 60 to 70 years after the replacement level of fertility has been achieved. Such a commitment would require an analysis of the relation of population growth to socio-economic development in Costa Rica and formulation of a firm population policy; and the provision of a broader range of contraceptive services, possibly including legalized voluntary sterilization.

Because Costa Rica's population growth rate is still not low and in fact is high in many rural areas (more than 3 percent), the Mission has taken a relatively critical view of the Costa Rican Family Planning Program in this evaluation -- although this is not meant to overshadow the country's past success in reducing fertility. The most difficult tasks do, however, remain in front of the Family Planning Program. It is more difficult and expensive to extend services to the more remote areas and to educate and motivate the more traditionally minded segment of society concerning the benefits of fewer children. This leads to the question of whether fertility rates can continue to decline without a more aggressive Family Planning Program.

^{1/} These numbers are the best estimates currently available in Costa Rica, but due to problems in the collection of service statistics, they are subject to error.

AID is in its tenth year of assistance to the family planning program. As of September 30, 1976 (end of the transition quarter) approximately \$2.5 million has been obligated (see Table 1). Most of these funds have been expended for administrative costs, followed by commodities, training, Information, Education and Communication (IE&C) activities, and research (see Table 2). The present three year project (Family Planning Services) was approved on July 29, 1976 for implementation during FY77-79. This project financed activities similar to those covered by previous AID-GOCR projects.

II. EVALUATION FINDINGS

A. External Factors

In recent months, the Family Planning Program has suffered a series of program reversals which call into question one of the basic assumptions upon which the new Family Planning Services Project had been based: i.e., "that the GOCR will continue its positive position regarding national family planning policy." The first reversal was the banning of sterilization, even though preliminary data from the World Fertility Survey (WFS) show it to have been second only to oral contraceptives as a method of choice by Costa Rican women and even though the Hospital Mexico had a backlog of 750 cases when forced to stop performing voluntary sterilizations several months ago. Perhaps even more importantly, adverse publicity went beyond the sterilization issue to the entire Family Planning Program. This in turn resulted in a temporary ban on the Intrauterine Device (IUD), a method of contraception used by nearly 8 percent of the users interviewed through the WFS. The third setback has been abandonment of the Women's Health Care Specialist Program which was to upgrade the skills of auxiliary nurses, allowing them to perform some activities that only physicians and more highly trained nurses are authorized to perform. The Professional Nurses Association has refused, however, to endorse the program.

The above setbacks also illustrate that other project assumptions were too optimistic: i.e., that opposition to family planning would remain minimal and that conservative physicians and nurses would be unable to hold back the greater use of para-medics.

These problems seem to point up the need for greater publicity on the inter-relationships between population growth and socio-economic development. Until the need for further reductions in population growth is demonstrated, it is unlikely that the GOCR will adopt a "positive national population policy" or commit itself to a dynamic Family Planning Program. This might mean greater attention to basic policy and research questions in future Project Agreements.

B. Goal Level

As stated in the Project Paper, the Sector Goal is "to reduce the national fertility rate (CBR from 29/1,000 in 1976 to 20/1,000 in 1980), which will enhance and support the possibilities for success of other development strategies and programs aimed at the lower income earners."

Current data show the CBR as 28/1,000, with regional CBR's varying considerably -- from a low near 25/1,000 in the Meseta Central to 36/1,000 in the rural periphery.

Because Costa Rica's declining fertility has been a complex response to over-all economic development and relatively unique socio-economic characteristics, as well as to the country's Family Planning Program, it is difficult to determine how far fertility might decrease in the near future. However, assuming a 1980 gross mortality rate of 4.5 to 5.0 per 1,000, the targeted CBR of 20 would imply a population growth rate of 1.5 to 1.6 percent. As stated earlier, this would probably require a broader range and a greater accessibility to family planning services than currently exists in Costa Rica, possibly including the legalization of voluntary sterilization. Therefore, considering the present political environment in which the Program is operating, we feel that achievement of a CBR of 20/1,000 by 1980 is doubtful unless efforts are made to demonstrate the economic and environmental effects of a 2.0 to 2.3 percent population growth rate in Costa Rica and to encourage the GOCP to adopt a population policy as part of its future development plans.

C. Purpose Level

The Project Purpose is "to consolidate the institutional capacity to protect 150,000 women of fertile age with effective methods of contraception by the end of CY1979." This would mean (1) increased program (public sector) coverage from approximately 22 percent of Women of Reproductive Age (WRA) in 1976 to 35 percent at the end of CY79; (2) increased rural coverage from 20 percent of WRA in 1976 to 50 percent in 1980; and (3) increased financial and logistic support for FP activities by the GOCP and involved agencies.

A revised projection of the number of WRA in 1979 (553,000 instead of 430,000) requires that the first target indicator be changed. If the original objective of reaching 35 percent of the WRA were retained, this would mean coverage reaching 194,000 women instead of 150,000. Also, in comparing data from the WFS and service statistics from the public sector family planning program, we found some basic inconsistencies. Because of these difficulties, and because we feel that the program target should

be a GOOCR one; we recommend that this first purpose-level indicator be re-assessed and revised in the amended Project Paper to be submitted following a large-scale multi-donor evaluation of the program. Most recent data from the Costa Rica Demographic Association (CRDA) show approximately 77,500 women being covered by the program.

Service statistics for the Family Planning Program are weak, especially concerning continuous users. Each SIDESCO monthly report lists new acceptors by method; but instead of reporting continuous acceptors and drop-outs by method, only the number of visits by continuous users is given. Since this includes return visits, we have no real way of knowing how many continuous users are being serviced by the public sector. This points out a significant weakness in the National Family Planning Program -- and one which must be addressed before a true evaluation of Program effectiveness can be done. 2/

The same problem holds for the second purpose-level indicator, expansion of rural coverage. As of May 31, 1977 there were 213 established rural health posts. These represent almost 65 percent of all distribution points, but inadequate monthly reporting from the rural health posts makes it impossible to quantify coverage in rural areas. We can, however, hypothesize that family planning services have increased as the rural health program has expanded.

The GOOCR agencies participating in the National Family Planning Program have increased the number of service delivery points, especially in rural areas. However, even though commending this increased financial commitment, to health services in general, the Mission is concerned that the Ministry of Health is not yet buying (or planning to buy) its own contraceptive supplies. All now being used in the MOH program are supplied by non-government sources. By the end of the project, we expect the GOOCR to have initiated some procurement.

D. Output/Input Level

Looking at individual outputs specified in the Project Paper:

- (1) Two New Women Health Care Specialist (WHCS) training centers established by CCSS - would result in total of 3 centers capable of training 180 nurses as WHCS between 1977-79:

2/ This service statistics/information problem will also be addressed as part of USAID's proposed FY79 Basic Needs Information System Project.

The Social Security Institute (CCSS) has taken over the operation of all hospitals and urban clinics in Costa Rica. All medical services are provided free of charge to those who are covered by social security insurance. Those who are not covered by social security are covered by the GOCR's Family Assistance and Social Development Program. At present, the CCSS looks after the medical needs of the urban population and the MOH provides health care services to the rural population. Social Security hospitals and clinics account for approximately 60% of all new acceptors and 52 percent of all family planning services.

According to the Project Paper, the CCSS was to have the primary responsibility for training nurses as Women's Health Care Specialists (WHCS). These specialists were to deliver family planning services to areas not served by a physician on a full-time basis. The PP envisioned 60 graduate nurses and 18 auxiliary nurses trained as WHCS by December 1976 and a total of 180 auxiliaries trained and assigned to MOH rural health posts and semi-rural dispensaries of the CCSS during the life of the project.

To date no auxiliary nurses have been trained as WHCS through this project. Furthermore, the CCSS decided to drop the planned training course. This decision was based on the Costa Rican Nursing College's refusal to endorse the training program. The Nursing College stated that: (1) the auxiliary nurses do not have the required educational background to handle the training and (2) those topics covered in the WHCS training not previously covered in the graduate nurses program would be incorporated into the curriculum and there would subsequently be enough graduate nurses to fulfill the original purpose of the WHCS program. Without the endorsement of the Nursing College, the auxiliary nurses would be forbidden by law from practicing those skills they were to learn in the WHCS course. For this reason, the CCSS had to drop the planned training program.

The reasoning behind the Nursing College's refusal is, however, fallacious: (1) the auxiliary nurses do have adequate educational backgrounds to absorb the training; (2) the more highly educated nurses who receive three years of training as opposed to one year for auxiliary nurses do not work in rural health posts, but rather in hospitals and large urban clinics and dispensaries; and (3) the utilization of paramedics to perform certain tasks normally done by physicians or more highly trained paramedics has been successfully demonstrated in other countries. Nonetheless, it appears that the poor rural population which was to be helped through the WHCS program will be denied regular quality service because of professional jealousy.

This component of the project was to have used \$228,000 in 1978 and 1979, or 40 percent of the total bi-lateral local currency costs of the Program for these two years. USAID will have to determine whether other activities aimed at increasing FP services in rural areas should be supported -- and, if so, whether an amended Project Paper should be prepared.

- (2) Established FP information and distribution system by non-medical referral agents in rural areas -- would involve training of 150 empirical midwives, 140 Ag Extension Agents, 50 community development advisors, and 50 rural social workers. They would be trained in FP motivation, referrals, and condom distribution.

The 1977 Project Agreement with the CRDA (Pro/Ag No. AID-CR-251) obligated \$1,700 for three Social Promoters training courses for approximately 60 persons. Thus far, one course has been held for 30 persons. At the request of the MOH, the same Pro/Ag also obligated \$7,025 for ten courses for 150 empirical midwives. To date, one course attended by 18 midwives has been held. The balance of the empirical midwives, as well as the other personnel mentioned above, will be trained over the next two years of the project.

- (3) Expanded program in rural areas by MOH -- resulting in initiation of FP services in 125 rural health posts and 150 women trained as auxiliary nurses to staff rural health posts.

The MOH has extended basic health care to approximately 75 percent of the rural population through the establishment of 231 rural health posts, with family planning services accompanying this extension. Rural health posts (RHP) are headed by an auxiliary nurse and/or health assistant, most of whom are indigenous to the area which they serve. Because the rural health program includes family planning services USAID/Costa Rica has agreed to pay the support costs for these employee while they are receiving their training in San José. The current Project Paper calls for the training of 150 auxiliary nurses over the life of the project at a total cost of \$95,000. This first year of the project, the MOH requested funds from AID for the training of 75 auxiliary nurses, although only 56 are now being trained. Upon completion of training these personnel return to the rural areas to staff new health posts, some of which are still temporarily housed in school or other public buildings.

Physicians from the closest Health Center or hospital visit these RHP's periodically. Because orals are a prescription drug, one of the visiting physician's tasks is to give a physical examination

to each woman desiring to use oral contraceptives. Auxiliary nurses are permitted to resupply continuous pill users, but only in the rural health post and not during home visitations, even though these tri-monthly visits are an integral part of the rural health program. Because health records for each member of each household are maintained in the RHP, the auxiliary nurse should know how many women in her area are practicing family planning and which methods of contraception they are using. It therefore would be a simple matter to have the auxiliary nurse resupply these women in their homes. She would not be prescribing; she would simply be making it more convenient for the acceptor to continue using family planning services by not requiring a return visit to the RHP each time a new supply of orals is needed.

The possibility of allowing paramedics to resupply non-clinical contraceptives was discussed with the Minister of Health in conjunction with his request to USAID/Costa Rica for assistance in the training of health assistants to work in the semi-urban areas around San José. Because of access to health records and personal familiarity with family members, it should be a simple matter to train these paramedics to resupply continuous users rather than referring them to the nearest health facility. However, because of likely criticism from the Medical Association and possible accounting difficulties, ^{3/} the GOCR is unwilling to provide paramedics with the necessary authority.

- (4) Expanded information systems in FP and sex education focussed in rural areas -- resulting in educational courses, radio broadcasts, TV announcements, and pamphlets.

The Project Paper specified numbers of courses, broadcasts, flipcharts, etc.; however, in this evaluations we looked primarily at the broader roles of COF and CIF, the implementors of these activities.

The Center for Family Orientation (COF) is a non-profit organization which receives funding support from AID (Pro/Ag AID-CR-247),

^{3/} The accounting difficulties would arise because pills are currently sold to those who can afford them (¢3 or \$.36 per cycle) and given free to those who cannot afford them. One alternative to eliminate this difficulty would be for the GOCR to purchase all necessary contraceptives, instead of relying upon supplies from the Demographic Association, and provide free all contraceptives as a part of the Government health service.

UNFPA, and FPIA. Its primary focus is on adult sex education, responsible parenthood, individual and family counselling, a radio program and correspondence courses.

The impact of COF's activities has never been evaluated. While COF has been able to conduct its activities in a satisfactory manner and complete them on schedule, the impact of activities on fertility behavior has never been measured. While trying to measure this impact would be difficult and perhaps expensive, it should be attempted. Only after evaluating the fertility behavior of those attending COF lectures, courses, etc. can AID's investment of Title X funds in this organization be justified. On the other hand, if COF's efforts have not had the desired effect, AID funds might be better spent in other activities. Neither the Project Paper nor any of the Pro/Ags mention what results are expected from COF. Without an agreed upon purpose and objectively verifiable progress indicators, it is difficult, if not impossible, to determine if the results are worth the cost. At present, COF can only tell AID how much money was spent, what activities were conducted, how many people attended, etc.; they cannot tell us how COF's activities have affected the attendees' attitudes and behavior about family size.

The Center for Family Integration (CIF) is also a private non-profit organization engaged in activities very similar to those conducted by COF. In FY77 it is receiving assistance from AID under the terms of Pro/Ag AID-CR-248. The major difference between these two organizations is that CIF is affiliated with the Christian Family Movement of the Catholic Church, while COF is affiliated with the Episcopal Church.

CIF's educational activities instruct course attendees in the Catholic Church's views on responsible parenthood and family planning methodology. Young couples planning to marry in the Catholic Church are required to attend the pre-matrimonial courses given by CIF. In addition to pre-matrimonial courses, which constitute the bulk of CIF's activities, courses for married couples, single people and workers are also given.

As with COF, we know almost nothing about the impact of CIF programs on fertility behavior and/or the cost effectiveness of its educational activities.

Since 75 percent of CIF's activities are mandatory pre-matrimonial courses, the Population Officer has suggested to the Executive Director of CIF that a fee be charged for attendance at these courses. CIF would then become self-supporting within about a year. If AID's assistance to the family planning program does end after FY1979 as currently envisioned, and the other two major donors (UNFPA and FPIA) also ter-

minate their assistance before the end of FY1979 as also is currently contemplated, self-support will be vital to CIF's survival. This is especially true since it is unlikely that the GOCR will provide funds from the national budget to support the work of CIF. It is equally unlikely that the Catholic Church will provide any financial support. In fact, the Archbishop recently ordered CIF to close and it is still not known if the Church will withdraw its approval of CIF's activities. Should this happen, CIF would either have to dissociate itself from the Christian Family Movement or close. If the Church withdraws its support, critics of the National Family Planning Program will probably accelerate their attacks, especially during the upcoming Presidential election in which family planning activities could become an issue.

- (5) Established promotional mechanism to encourage the use of FP services in rural areas -- resulting in 4 promotional teams trained and working ahead of service implementation in rural health posts.

Under the Project Agreement with the CRDA two promoters are working in rural areas where rural health posts are to be established. We anticipate continuing this assistance over the two remaining years of the project.

E. Unplanned Effects

There were no unplanned effects relating to social structure, environmental, technical, or economic situations.

F. Miscellaneous Other Findings

During the course of this evaluation, the Mission also looked at (1) prior year evaluation recommendations relating to the MOH; (2) CONAPO; (3) CRDA; (4) the Limón Information Center; and (5) voluntary sterilization.

(1) Ministry of Health: The 1975 project evaluation stated that "The Mission should insist that a full-time professional be named as Director of the Department of Population of the Ministry of Health and that proper technical supervision be provided for all FP activities of the Ministry." However, instead of being strengthened, the MOH's Dept. of Population has been dissolved and its family planning activities relegated to the Maternal and Child Health Division. This action indicates a lessening rather than a strengthening of commitment to family planning on the part of the MOH.

(2) CONAPO: The National Population Committee is an informal "coordination" organization without legal status and without either head-

quarters or staff. It is composed of the various private and governmental organizations working in the family planning field. Periodic "coordination meetings" are held but each organization continues with its activities as originally planned, and CONAPO's power to approve or disapprove activities is informal. There is no coordinated national plan of action or statement of targets, nor do any of the member organizations have long range plans of more than one year. CONAPO has no members from other government ministries, and offices, such as the Planning Office (OFIPLAN). This has resulted in little attention to the broader issue of population policy and the roles of the several CONAPO agencies in implementing programs to reduce fertility.

CONAPO could become an effective organization if the GOCR should choose to make it one and invest it with the proper authority. However, the GOCR would first need to commit itself to an aggressive family planning program -- an unlikely commitment unless the GOCR is able to differentiate between the rapid decline in fertility it has already achieved and the ramifications of continued growth at 2.3%. This commitment however, is essential if CONAPO is going to truly coordinate and plan long-range directions for family planning/population programs in Costa Rica. Once decisions are made about what needs to be done and how it is to be accomplished, direction can be given and true coordination of effort achieved.

(3) CRDA: The Costa Rican Demographic Association is the local affiliate of the International Planned Parenthood Federation (IPPF). Its primary function is the distribution of contraceptive supplies donated by IPPF and AID, as well as those it purchases with money raised through the sale of contraceptives. It is responsible for the collection, analysis and distribution of the monthly family planning service statistics. CRDA is also involved in the production of some IE&C materials used in training courses conducted by MOH, MOE and various other organizations. These materials are intended for the use of the general public and special groups such as high school teachers, parent organizations, etc.

The CRDA, as the secretariat of CONAPO, is probably its most influential member. Because it administers the UNFPA grant to the national family planning program, CRDA has considerable influence on program direction. Also the Executive Director of CRDA is Chairman of CONAPO. As such, he controls UNFPA grant funds which go to all CONAPO members, as well as those which go to CRDA. This appears to be a questionable procedure, as it puts too much power in the hands of one person.

In its role as the local IPPF affiliate, CRDA should be making use of the mass media to inform people about services offered and especially to counter rumor and false information. USAID has made funds available to the CRDA through project agreements for press releases.

During FY1976, CRDA used only about 30 percent of the funds provided for this purpose. (\$1,450 expended; \$4,800 obligated.) To date, none of the \$5,000 provided for this purpose under the FY77 Pro/Ag (No. AID-CR-251) has been expended.

(4) Limón Information Center: CRDA supplies all MOH and CCSS facilities with contraceptives. In the past, it also supplied contraceptives to the Clínica Bíblica in San José and the Limón Information Center. It stopped providing service to these institutions once the CCSS developed the capability to provide contraceptives. The Clínica Bíblica had a substantial number of continuous users of family planning at the time services were terminated. The Limón Information Center was providing services several nights a week, including required physical examinations by doctors. However, since the CRDA stopped providing contraceptives to the Limón Center, the activities there consist of IE&C only.

AID is providing funds for the administrative cost of running the Limón Center. While this arrangement might have been acceptable when the Center was providing services, it is felt that without services AID funds could be more advantageously applied to activities dealing more directly with the delivery of family planning services.

The Project Agreement between AID and the CRDA for the running of the Limón Center signed during the Transition Quarter (AID-CR-246) provides funds through December, 1977. Unless family planning services are reinstated, AID funding will not be renewed.

(5) Voluntary Sterilization: The recently completed national fertility survey, which was conducted as part of the World Fertility Survey, indicates that female sterilization was the second most used method of contraception among those women interviewed even though it has never been offered as a contraceptive method by the family planning program. Recent controversy about the legality of sterilization has resulted in virtual unavailability in the public sector, even when justified for medical reasons such as multiparity.

All indications are that both male and female voluntary sterilization are popular with the general public. We feel that there would be a large demand for this service if it were legal and easily obtainable. The National Family Planning Program is quietly working to legalize voluntary sterilization, but the political environment does not look favorable unless top GOCR leadership takes an strong affirmative stand on the need for reduced fertility.

III. REQUIRED PROJECT CHANGES IN DESIGN OR EXECUTION

The current Project Paper should be amended to incorporate some of the findings brought out in this evaluation:

(1) The importance of WHCS training to the overall project will have to be assessed, and a determination about the use of funds will have to be made.

(2) An upgrading of service statistics should be built into the revised project, so that the Mission and GOCR will be better able to evaluate the success and cost effectiveness of the National Planning Program.

(3) Because of recent program reversals and generally poor political environment for the FP Program, the revised project should include some policy level activities -- perhaps including research on the economic ramifications of a 2.0 - 2.3 percent population growth rate, seminars, and/or invitational travel to other countries with strong population policies.

(4) The amended Project Paper should also address the issue and timing of GOCR procurement of contraceptives.

IV. LESSONS LEARNED

Two major lessons were learned:

1. Costa Rica has experienced a dramatic reduction in its fertility and population growth rates. International agencies working with Costa Rica's Family Planning Program and Government officials have been quick to attribute reductions in fertility almost exclusively to the FP Program rather than to the effects of such phenomena as education, urbanization, expanded coverage of the social security system, declining infant mortality, and incorporation of more women in the labor force. The extent to which these other factors have been instrumental in changing preferences on family size is an important area for research and we hope that the current study on determinants of fertility decline being done by J. Mayone Stykos will help to answer the question, "why are couples having fewer children?"

Moreover, the desire of donors and GOCR officials to see success in their programs and a possible oversensitivity to the difficult political issues relating to family planning have caused people to overlook basic problems with the FP Program. These problems include lack of a formalized population policy, poor service statistics, poor coordination between FP agencies and insufficient family planning information via mass media.

This points out the need to look more critically at how programs are implemented and the factors which contribute to the ultimate achievement of program objectives. In the case of the Family Planning Program, to what extent has the Program been responsible for reduced population growth rates in Costa Rica? Would a more efficient and/or aggressive Program have led to a greater reduction? Should donors be more critical of the Program?

2. Although an empirical ad hoc program can have substantial success (as it has in Costa Rica) it can encounter serious and unexpected obstacles if not protected by a formalized legal commitment to it. Without such protection, small but highly vocal and willful groups are able to attack it at vulnerable points. In Costa Rica this has resulted in the ban on voluntary sterilization, the dropping of the WHCS program, and a reluctance of family planning advocates to counterattack with vigorous defense of the FP Program. To avoid these problems, AID and other donors should seek more explicit Government commitment as a requisite of support to the FP Program.

V. SPECIAL COMMENTS

AID and IPPF are now in the tenth year of assistance to the National Family Planning Program. The UNFPA is in its last year of a four-year, \$2.1 million grant to CONAPO. FPIA is in its fourth and possibly last year of assistance to some of the member organization of CONAPO.

The UN resident representative has said it is unlikely that CONAPO will receive another UNFPA grant because Costa Rica is no longer considered one of the countries most in need.

Past evaluations of the Program as well as this one, have been more subjective than objective. There seems to be a general consensus among the donor agencies (AID, UN and FPIA) that an in-depth evaluation of all organizations and facets of the program should be conducted in order to determine how much, if any, foreign assistance will be needed beyond 1979.

Ideally this evaluation should include some GOCR ministries and offices that are not primarily concerned with the Program and should be lead by the GOCR. Representatives from OFIPLAN, Ministry of Finance, and perhaps the Ministry of the Presidency should be included in the initial discussions about the evaluation as well as in the drafting and approving of the scope of work, the actual evaluation and the final report.

The evaluation should provide the information needed to make recommendations about the future needs of the program, including the relation of fertility decline to economic development and the distribution of income, most specifically.

In light of AID's previous decision to "graduate" the Family Planning Program from future AID assistance after FY1979 and in light of program setbacks, unforeseen at the time that decision was taken, an in-depth evaluation should prove useful in either confirming the decision or showing that AID's assistance will be needed for a few more years. We therefore recommend that AID participate with the other program donors, implementing organizations and the GOCR in an in-depth evaluation of the entire National Family Planning Program. This evaluation will also identify certain conditions which would need to be met before AID could continue its bi-lateral assistance to the FP program -- e.g., adequate staff in rural health posts to provide FP services.

Table 1

Obligations and Expenditures by year and by Organization
for Family Planning Activities 1965-1976

FY	MOH		CRDA		UCR		CELADE		SSI		CIF		COF		TOTAL	
	Oblig.	Expdt.	Oblig.	Expdt.	Oblig.	Expdt.	Oblig.	Expdt.	Oblig.	Expdt.	Oblig.	Expdt.	Oblig.	Expdt.	Oblig.	Expdt.
1965	47,000	41,510	--	--	--	--	--	--	--	--	--	--	--	--	47,000	41,510
1966	20,750	20,750	--	--	--	--	--	--	--	--	--	--	--	--	20,750	20,750
1967	--	--	57,912	50,008	--	--	--	--	--	--	--	--	--	--	57,912	50,008
1968	141,391	124,676	109,775	107,987	--	--	11,600	8,650	--	--	--	--	--	--	262,776	241,294
1969	153,420	138,691	81,720	80,541	10,615	10,615	6,200	5,654	--	--	--	--	--	--	251,955	235,601
1970	--	--	152,252	148,051	38,812	15,509	--	--	--	--	--	--	--	--	191,064	163,560
1971	113,080	113,080	120,000	119,692	100,249	88,947	--	--	--	--	--	--	--	--	333,329	321,719
1972	51,866	38,730	125,000	121,618	69,455	46,583	--	--	6,830	5,474	--	--	--	--	253,151	212,405
1973	110,000	99,066	64,848	64,712	49,802	47,637	--	--	45,550	18,772	41,177	37,798	--	--	311,377	267,985
1974	119,250	115,593	222,786	209,503	--	--	--	--	15,000	14,734	40,500	40,470	--	--	397,536	380,600
1975	82,094	73,906	112,600	111,621	--	--	--	--	50,300	50,300	32,400	30,992	15,000	14,547	292,394	281,366
1976	36,000	36,000	127,261	127,261	--	--	--	--	51,000	51,000	30,000	30,000	20,000	20,000	264,261	264,261
T.O.	--	--	16,000	16,000	--	--	--	--	5,776	5,776	25,000	25,000	11,253	11,253	58,029	58,029
TOTAL	874,856	802,292	1,190,154	1,157,085	268,933	209,291	17,800	14,304	174,465	146,056	169,077	164,260	46,253	45,800	2,741,534	2,539,088

Table 2

Obligations by year and item

Obligation	1965	1966	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976	T.O.	TOTAL
Investigation	40.000	20.750	--	2.000	7.789	31.254	41.044	26.000	12.360	--	--	--	--	181.197
Commodities	5.000	--	9.695	82.472	90.121	4.230	119.563	40.450	82.447	102.961	38.830	7.230	1.587	584.536
Administration	2.000	--	34.917	107.411	111.772	64.672	134.690	175.998	203.013	224.625	191.519	149.012	39.473	1,438.802
Training	---	--	7.000	34.553	---	38.812	5.438	2.000	7.500	65.950	49.488	79.770	5.776	296.287
IEEC	---	--	6.600	36.330	42.273	52.096	32.594	8.703	6.057	4.000	12.557	28.249	11.253	240.712
TOTAL	47.000	20.750	57.912	262.776	251.955	191.064	333.329	253.151	311.377	397.536	292.394	264.261	58.029	2,741.534