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INTERIM EVALUATION OF THE FAMILY
PLANNING SELF-RELIANCE PROJECT
COSTA RICAN DEMOGRAPHIC ASSOCIATION

by

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GLOSSARY

ADC	Asociación Demográfica Costarricense (Costa Rican Demographic Association)
AERMC	Alternativa Educativa Radifónica para la Mujer Costarricense (Alternative Radio Education Project for Costa Rican Women)
CA	Cooperative Agreement
CCSS	Caja Costarricense de Seguro Social (Costa Rican Social Security Agency)
CDC	Centers for Disease Control
CEMEC	Centro para el Mejoramiento de Educación en Ciencias (Center for the Advancement of Science Education)
CIF	Centro de Integración Familiar (Center for Family Integration)
COF	Centro de Orientación Familiar (Center for Family Orientation)
CONAPO	Consejo Nacional de Población (National Population Council)
CRS	Commercial retail sales
CSM	Contraceptive social marketing
CPS	Contraceptive Prevalence Survey
CYP	Couple years of protection
DHS	Demographic and Health Survey
DIS	Departamento de Investigaciones Sociodemográficas (Socio-Demographic Research Department)
FPSRP	Family Planning Self-Reliance Project
GOCR	Government of Costa Rica
IE&C	Information, education and communication
IPPF	International Planned Parenthood Federation

IPPF/WHR	International Planned Parenthood Federation/Western Hemisphere Region
MIS	Management information system
MOE	Ministry of Education
MOH	Ministry of Health
OC	Oral contraceptive
PVO	Private voluntary organization
SOMARC	Social Marketing for Change
SOW	Scope of work
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
UNESCO	United Nations Educational, Scientific and Cultural Organization
TIPPS	Technical Information on Population for the Private Sector

EXECUTIVE SUMMARY

1. Background

This mid-term evaluation covers the first three years of a five-year Family Planning Self-Reliance Project (FPSRP) for Costa Rica, funded in part by the United States Agency for International Development. Due to lack of data, it was difficult for the evaluators to assess whether the Project was achieving either its demographic goals or its objectives to improve family planning services and increase contraceptive supplies. The only available figures showed that family planning was being provided in 311 government facilities, short of the goal of 400, and that the effort to make a private sector contraceptive supplier (PROFAMILIA) cover 35 percent of its costs through contraceptive and other sales was still at an embryonic stage. Nonetheless, some progress was being made in all areas, and it was expected that by the Project's termination, the overall picture might be brighter.

The Project was initiated at the instigation of the Costa Rican government in 1983, at a time of worsening economic conditions and fast-increasing birthrates. It represented a return to the early 1970s, when Costa Rica's family planning program was viewed as a model throughout Central America. The Project goal was both to revitalize the public sector effort (which had been deemphasized for nearly a decade) and to develop a new private sector capability to provide family planning. This latter aspect was considered particularly important to prepare for the moment when financing would be reduced or withdrawn and family service delivery would need to have become financially self-sufficient, at least to some degree.

A private sector organization, the Costa Rican Demographic Association (ADC), was selected to administer the Project. Funding was set at \$5.5 million, with \$2.5 million from USAID, \$2 million from the ADC and the International Planned Parenthood Federation with which it is affiliated, and \$1 million from the United Nations Fund for Population Activities (UNFPA).

2. Constraints

Despite the improved climate for family planning in Costa Rica, several barriers on the national scene were identified as continuing to impede progress. The government contraceptive delivery system was found to be inefficient, with supplies often not available. This problem has been exacerbated by the integration of health-family planning facilities run by the Ministry of Health (MOH) with those run by the Costa Rican Social

Security Agency (CCSS). The CCSS, while stronger financially, is perceived as less concerned with providing family planning services than is the MOH; some problems in the delivery chain can be traced directly to CCSS. In the private sector, strict government rules concerning registration of oral contraceptives are seen as having kept PROFAMILIA from selling any contraceptives except condoms, thus limiting considerably its revenues. Government strictures regarding mass media advertising of contraceptives were also perceived as a constraint to efforts to generate income from contraceptive sales. MOH's failure to collect comprehensive family planning service statistics, while not directly affecting the success of any project component, was found to be a major constraint to any effort to judge Project effectiveness. To date, USAID has relied on the ADC to deal with the various problems that are hampering both the national program and Project activities.

3. General Performance/Future Prospects

Despite the various problems, however, ADC was judged to have done a commendable job in providing training to government health personnel, in researching various issues of importance to family planning, and in having generally helped increase public awareness of the need for family planning. The evaluation is pessimistic about the prospects for the continuation of Project activities, once funding ends, however. Due in part to financial problems, the government has made no plans to take over procurement of contraceptive supplies after 1988. Training, research, and information, education and communication (IE&C) efforts may also falter at the end of the Project.

4. Recommendations

4.1 General Strategy

Assessment of Project Components

(1) Better assessment is needed of performance of three project aspects: training, IE&C, and the role of women. To evaluate training, data are needed both on trainee profiles and on post-training performance. Analysis of whether the IE&C component is meeting its goals will require an inventory of all IE&C materials that have been distributed to clinics during the project. Analysis of the cost effectiveness of the IE&C component should be based on listener profiles, the needs, and identification of messages that are considered most acceptable and relevant. Analysis should be made of the effect of the project on women's access to production inputs and markets, division of labor, income and role in household and community.

Enhanced Self-Reliance

(2) ADC should review the potential for cost-recovery of its training, research, and IE&C activities, both within the country and throughout Central America. ADC staff have technical skills in these areas that might be contracted by outside organizations. There may also be a market for its various IE&C publications. PROFAMILIA might also offer technical and consulting services to Latin American countries interested in starting a contraceptive social marketing program.

4.2 Project Activities

4.2.1 Contraceptive Supplies

Logistic Management

(3) The efficiency of the system of contraceptive logistic management should be improved, with particular stress on forecasting of contraceptive needs. ADC should consider switching from its manual inventory system to a bar coding and computerized system. PROFAMILIA should be involved in all discussions in regard to contraceptive logistics.

Procurement

(4) The reliance on ADC in the contraceptive procurement process should be gradually diminished. USAID should sponsor a meeting to discuss ADC's role in the process after 1988. Participants should include representatives from the government (CCSS and the MOH), ADC, PROFAMILIA, Centers for Disease Control and the new AID centrally funded Contraceptive Logistics Management project.

4.2.2 Training

(5) Training staff should be given rotating course assignments and should participate in external family planning training programs. The Project should also embark on a vigorous "training of trainers" program to help institutionalize family planning skills within the CCSS, MOH, or Ministry of Education.

(6) The curricula and content of the training programs should be reviewed on a periodic basis.

4.2.3 Research

(7) USAID should promote efforts to improve the collection of reliable family planning service statistics, preferably on a quarterly or a semi-annual basis.

(8) Additional permanent staff positions in research should be created.

(9) There should be closer collaboration between the Research Department and the Training Department in the identification of research topics and the dissemination of research findings.

4.2.4 Commercial Sector

(10) Efforts should be made to identify and develop other "new" non-contraceptive products that PROFAMILIA might distribute and market. The administrative and financial ramifications of such a move should be taken into account.

(11) A pilot effort should be made to involve employers in offering family planning services. Existing AID-funded programs concerned with expanding the role of the private sector in family planning, (the TIPPS and Enterprise Projects), could assist the government and ADC in initiating such an activity.

(12) Consideration should be given to supplying CCSS and MOH clinic waiting areas with video cassettes on family planning and other health-related issues. A number of AID-funded activities could be drawn upon to implement this recommendation.

4.3 ADC Administration

(13) An overall Project implementation schedule for each FPSRP task should be developed, indicating the responsible individual(s) and a time completion schedule for each task.

(14) ADC should automate its office procedures, including through the use of word processing equipment and an automated accounting system.

4.4 Women's Role

(15) The Project might assemble a women's issue task force which could discuss research opportunities in the area of women and development.

4.5 USAID's Role

(16) USAID should encourage the government to commit more of its own resources towards institutionalizing family planning. The government should build up its own training, research and IE&C capabilities, especially as they relate to population and family planning.

(17) USAID should also urge the GOGR to create a National Coordinator for Family Planning and to reactivate the National Population Council.

(18) USAID should consider approaching the GOGR with the idea of encouraging an evaluation of the CCSS and MOH health centers and clinic operations as they pertain to family planning services and offering its assistance to help improve operations.

(19) USAID should encourage greater involvement by the private sector in family planning activities. In this regard, it should urge lifting or modifying the ban on mass media advertising of contraceptives.

I. INTRODUCTION

I.1 Project Background

In July 1983, the United States Agency for International Development/Costa Rica (USAID) signed a five-year Cooperative Agreement (CA) with the Costa Rican Demographic Association (Asociación Demográfica Costarricense or ADC) for a Family Planning Self-Reliance Project (FPSRP). The focus of the FPSRP is to promote socioeconomic development and satisfy the basic needs of the Costa Rican poor by increasing access to family planning services and information. Through a variety of activities, the project seeks to revitalize and expand family planning services in the public, private, and commercial sectors and to enhance the self-reliance of these sectors. USAID expects the project to have four main outputs:

- Revitalized and increased public sector participation in family planning to expand the availability of services, counseling and commodities at the Costa Rican Social Security System (Caja Costarricense de Seguro Social or CCSS) and Ministry of Health (MOH) facilities throughout the country.
- Expanded service delivery capacity of the private and voluntary sectors.
- Enhanced financial self-reliance of all family planning activities.
- Revitalized promotion activities through an information, education and communication (IE&C) program.

The total FPSRP budget for the five years was \$5.5 million, of which \$2.5 million represented USAID funds, \$2.0 million were to come from ADC and the International Planned Parenthood Federation (IPPF) with which it is affiliated, and the remaining \$1.0 million from the United Nations Fund for Population Activities (UNFPA).

I.2 The Evaluation

The CA's scope of work (SOW) states that over the life of the CA there will be three external evaluations. The first evaluation, scheduled for November 1984, did not take place. The second evaluation, an interim evaluation, was scheduled in January 1986. The date was changed to August 1986 and is the basis for the report presented here. A third and final evaluation is scheduled for September 1988.

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The evaluation was conducted during the period August 18 to September 11, 1986 and involved four approaches:

- A review of official project documents in the ADC and USAID such as activity reports and supporting data; the Cooperative Agreement and appendices; bulletins, publications, pamphlets and specialized reports, and statistical and financial reports.
- Interviews with officials whose programs are linked to ADC (see Appendix B).
- Field visits to 11 MOH and CCSS clinics and health centers in Limon, Alajuela, San Ramon, Esparza and Puntarenas. Visits were also made to several pharmacies in all of these locations.
- Collection of primary survey data from a systematic quota sample (N=800) of clinic users (N=400) and female respondents ages 15-49 years residing in households in selected locations in the Central Valley (N=400), to assess their knowledge of family planning communications produced through the project.

The main difficulty in the evaluation process was that of finding solid information that would show whether project goals were being met. Neither demographic data nor family planning service statistics were available at the time of evaluation. Likewise, some of the project's goals have no quantitative indicators, and thus there were few objective yardsticks by which to measure project outputs (see Section III.2). These constraints aside, the evaluation team encountered no obstacles during the evaluation. There was complete and open cooperation from USAID, ADC and from the other organizations that were contacted.

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II. DEVELOPMENT OF THE PROJECT

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II.1 Development of Family Planning Activities in Costa Rica

In 1962, Costa Rica became aware of the effects of rapid population growth on its economy and health, housing and education sectors. In response, various private institutions organized family planning and health educational activities which were available to limited segments of Costa Rica's urban and rural populations. In 1966, the ADC was established to foster a greater national awareness of population programs and encourage public support for family planning programs.

In 1967, the Government of Costa Rica (GOCR) established a family planning policy and created an Office of Population in the Ministry of Health (MOH). A modest nine-clinic family planning program began a year later with USAID funding and contraceptive commodity assistance. A National Population Council (CONAPO), comprised of interested GOCR and private organizations, was also established in 1968 to coordinate the country's population and family planning activities and provide a forum for information exchange.

The two major organizations that provide health care in Costa Rica, the MOH and the Costa Rican Social Security System (CCSS), began to include family planning services in their larger hospitals and health centers in 1970. During this same year, sex education and family life education programs were developed by the Ministry of Education (MOE), the University of Costa Rica, and by two private organizations, the Center for Family Orientation (Centro de Orientación Familiar or COF) and the Center for Family Integration (Centro de Integración Familiar or CIF). The ADC assumed the secretariat role for CONAPO and took the responsibility for over half of the country's family planning IE&C program. As a result of these combined activities, the Costa Rican population and family planning program became a model for the Central American region.

II.2 Demographic Developments

During the first half of the 1970s, the country's family planning program was considered highly successful. Population growth rates dropped from 3.8 percent in 1960 to 2.5 percent in 1976, and the country boasted a 65 percent acceptor rate among women in fertile ages (15-44 years). After 1976, however, population growth rates began to increase, reaching 2.8 percent in 1982. One reason for the rapid growth was that the fertile age group (15-49 years) was increasing at the rapid rate

of three percent a year. Another factor was a high rate of immigration. So little is known about the fertility patterns of the new arrivals, however, that it is difficult to judge the part being played by this second factor.

II.3 Political and Economic Developments

The GOCR has long been committed to providing adequate health and educational services to all its citizens, and because of its extensive involvement in health and population, the population has become heavily dependent on government initiatives and policies. Thus, when the Government moved between 1978 and 1982 to deemphasize population and family planning activities, the effect was dramatic. The administration eliminated training and information programs, CONAPO was dismantled, and the CCSS and MOH were discouraged from promoting family planning services in their clinics. The decline in public service capacity, combined with an underdeveloped private sector delivery system, led to a 20 percent unmet demand for family planning services (or 120,000 of the 590,000 Costa Rican women of reproductive age). It was estimated that family planning services would need to increase by 50 percent in order to keep pace with population growth.

The period 1979-1982 was also a time of economic difficulty. Up until 1977, Costa Rica had a real Gross Domestic Product in excess of 6 percent per year. In 1979, however, GDP began to decline. By 1981, it had dropped to a negative 4.6 percent, and by 1982, it had slipped further to a minus 9.1 percent. Per capita incomes declined by 20.8 percent during the three-year period 1980-82, and the concomitant effects of double digit inflation, increased unemployment, growing public sector deficits and external debt exacerbated Costa Rica's economic crisis. The attempt to make adjustments through currency devaluation resulted in an increase in the price of contraceptives by 300-500 percent.

II.4 Initiation of Project

In 1982, a new administration, recognizing that excessive population growth was having serious short-term economic and health repercussions, modified the stance towards family planning. It adopted a laissez-faire attitude towards existing efforts and sought assistance from external sources. As a major donor agency supporting world-wide efforts to improve population and family planning programs, USAID responded to Costa Rica's need. For a variety of political and financial reasons, it was decided to channel the funds through a private sector organization, rather than through the MOH. Because of its longstanding involvement and prominence in population and family

planning activities in Costa Rica, the ADC was selected.

II.5 Current Political Constraints

Despite its good intentions, however, the new administration has had to contend with a backlog of inertia towards family planning in the government departments primarily concerned with delivery of services. The lack of interest is rooted in part in the move begun in 1962 to integrate all CCSS and MOH health-family planning facilities. The hope was that integration would eliminate duplication of services and thereby reduce government expenditures. While a good move from an economic point-of-view, integration has not progressed smoothly.

A central problem is that CCSS workers may be less inclined to promote family planning than are health personnel: CCSS emphasizes a curative approach to health care while MOH emphasizes a preventive one. Since family planning is primarily concerned with prevention, CCSS staff may not be as philosophically in tune with this activity as are MOH personnel.

In this dispute, CCSS wields the greater power. Even though the President of CCSS is not a Cabinet member, he controls more resources--facilities, staff and budgets--than does the Minister of Health. Moreover, 85 percent of Costa Ricans are covered directly by CCSS programs whose funding emanates from payroll deductions, employer assessments and individual contributions.

From a Project point of view, it is significant that the CCSS has control at a number of critical points in the chain of family planning service delivery. All contraceptives supplied through the Project are delivered to the Central Pharmaceutical Warehouse, which is run by the CCSS. In integrated clinics, it is CCSS personnel who manage the pharmacies and fill prescriptions for oral contraceptives. The problems that have arisen in these areas have been a cause of contention at the clinic level between CCSS and MOH personnel (see Section IV.1.1) and have resulted in a deterioration of services.

III. ACHIEVEMENT OF OBJECTIVES

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III.1 Overall Goal and Strategy

Although an appreciable portion of Project funds were to go into activities that would strengthen the public sector, USAID's primary strategy in the FPSRP was to build a private sector capability to provide family planning services. Not only was there a need to supplement the services that could be provided by the government. More important, Project planners were looking to the future, when external support might be reduced or even cease to be available, and family planning services, if they were to continue, would need to be self-sustaining, at least to some degree. The Project, therefore, placed considerable emphasis on assisting the private sector to generate income which would, in the long run, increase its self-reliance.

III.2 Specific Objectives and Strategy

Six main project goals, the indicators of success set forth in the Project's Logical Framework, and the strategy that would be employed to achieve the goals are described below.

1. Revitalization of the public sector

The overall goal was to increase to 400 the number of MOH and CCSS facilities providing family services, counseling, and commodities. The strategy was to enable this expansion to occur through provision of

- refresher and new family planning training to public sector health personnel and family planning workers (physicians, nurses, paramedics, secretaries and social workers);
- contraceptive supplies; and
- communication and motivation activities.

2. Expansion of the service delivery capacity of the commercial and voluntary sectors

The overall goal was to increase the supply of contraceptives that were available at low prices in commercial pharmacies and retail sales outlets and through voluntary agencies. The strategy was to develop the capability of ADC's private sector arm (now known as PROFAMILIA) to make low-cost contraceptives available to these suppliers. The strategy included heavy

reliance on local commercial resources for publicity, promotion, packaging and distribution, and market research.

The anticipated commercial retail sales (CRS) targets included increasing the percentage oral contraceptive (OC) pills delivered by the commercial sector from 23 percent to 35 percent, of condoms from 44 percent to 55 percent, and of vaginal methods from 77 percent to 85 percent.

PROPOSED SALES PER YEAR (in 1,000s)

Method	1983	1984	1985	1986	1987	Total
OC Pills (cycles)	50	75	100	100	100	425
Condoms (unit)	150	225	300	300	300	1,375
Vaginals (boxes)	100	150	200	200	200	850

3. Enhancement of self-reliance of all family planning activities

Although the Project called for increased self-reliance of all project activities, the only measurable objective was that PROFAMILIA should expand to the point where it could cover at least 35 percent of total program costs with income from sales of family planning/health commodities. Specific strategies were developed for ADC and the government program.

ADC strategy involved

- efficiency measures to cut costs and increase productivity,
- introduction of cost recovery schemes such as fee for service or sale of contraceptives, and
- fund raising activities such as membership fees, voluntary contributions and special events.

The design for the GOOCR called for it to

- use managerial expertise to improve worker productivity,

- improve contraceptive procurement practices, and
- implement an effective management information system (MIS).

Additional technical assistance for the MIS activity was to be provided from AID's Policy Planning and Administrative Improvement Grant.

4. Revitalized IE&C Promotion Activities

This effort, which could be encompassed within the objective of revitalizing the public sector, specifically called for the display or availability of family planning posters and literature in the 400 targeted MOH and CCSS facilities.

Together these four objectives were designed to contribute to two more general goals:

5. To promote the socio-economic development and satisfy human needs of Costa Rican poor by increasing access to family planning, and
6. To revitalize and expand family planning services through private, public and commercial sector activities.

The indicator of success of the first goal was to decrease the birth rate from 32 to 28 per 1,000 by the Project's end and of the second, to increase the total number of users of family planning activities from 150,000 to 200,000.

III.3 Achievements

Goal 1: Expansion of Public Sector Activities.

At the time of the evaluation, it was extremely difficult to assess the degree of success made to date in achieving Project goals. The only goal for which data were available was numbers of MOH and CCSS clinics where family planning was available. Here, the ADC data indicate that contraceptives supplied by the Project were available at 311 centers, considerably short of the goal of 400.

Goal 2: Expansion of service capacity of commercial and voluntary sectors.

Because the Project logframe provided no quantitative indicators (i.e. number of outlets, amounts of contraceptives, price levels), it was impossible to assess achievements in this area. Figures exist showing favorable prices and sales trends for condoms--the main contraceptive being sold. Because PROFAMILIA is unable to sell OC pills, however, it is fair to surmise that the levels of achievement expected for this Project activity are not being realized.

Goal 3: Financial self-reliance enhanced.

Because PROFAMILIA is only selling condoms, it has barely begun operating at an expenditure level where the level of self-sufficiency can be judged. During the first two years (1983-84), neither expenses nor revenues were incurred, and during the second, only 25 percent of the budget was spent. While over 70 percent of the third year budget had been spent during the first 11 months (\$228,000 out of a budgeted \$317,000), total net revenues for condom sales of \$30,000 represent only a small percentage (13 percent) of expenditures, far below the 35 percent goal set forth in the Project logframe.

Goal 4: Revitalized IE&C promotion activities.

While family planning posters of good quality have been produced, it is not known what percentage of the projected 400 MOH and CCSS facilities either are displaying posters or are providing literature. It had been anticipated in the logframe that the clinics might keep such records, but this has not been the case.

Goals 5 and 6: Decrease of birth rate and increase in total number of family planning users.

Figures on the birth rate and a count of family planning acceptors were expected from a Contraceptive Prevalence Survey (CPS) scheduled for 1984. Because the CPS did not take place until 1986, neither indicator was available in time for this evaluation. On the other hand, while analysis is not complete, preliminary findings of the data from the 1986 Demographic and Health Survey (DHS) of 3,527 women ages 15-49 years indicate that the use of contraception in Costa Rica is on the

increase.¹ The percentage of women (15-49) reporting current contraceptive use increased from 64.6 percent in 1981 to 68.5 percent in 1986. Among the contraceptive methods used, OC pill use (19.3 percent) declined slightly and condom use increased by over 50 percent or from 8.1 percent in 1981 to 12.4 percent in 1986. There was little change in the use of male or female sterilization but there was an increase in the use of natural methods (rhythm and withdrawal).

The number of users (currently married) of the national family planning program increased from 92,904 in 1981 to 117,475 in 1986. While this is nowhere near the project goal, at least the trend is upward.

1 The basis of comparison included 1976 Costa Rica Fertility Survey and the 1978 and 1981 CPS.

IV. PROJECT PERFORMANCE

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IV.1 Revitalization of the Public Sector

IV.1.1 Contraceptive Supplies

IV.1.1.1 Distribution System. ADC has been the dominant force in contraceptive logistics in Costa Rica since 1966. Through its Supply Department, it maintains a large inventory of contraceptive and clinical support items. These are provided primarily by the International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR), Family Planning International Assistance (FPIA), and UNFPA. Supplies of contraceptive commodities are transferred to the GOCCR Central Pharmaceutical Warehouse of the CCSS, which distributes them to CCSS and MOH clinics, which in turn make them available to users. The contraceptives include seven brands of OC pills (Noriday, Femenal, Microgynon, Nordette, Lo-femenol and Microval); condoms, creams and jellies; two injectables (Depoprovera and Noristerat); and two types of IUDs (Copper "T" and Lippes Loop).

USAID is not involved in supplying contraceptives to the public sector. It does, however, supply contraceptives to PROFAMILIA, which contracts warehouse space and services from ADC (see Section IV.2.1).

IV.1.1.2 Problems. This commodity supply system has a number of weaknesses, partly because the internal logistics control system is weak and partly because supplies tend to be disrupted or misused as a result of the recent integration of the MOH-CCSS health delivery system. Moreover, the government has become over-dependent on donors as suppliers of contraceptives.

o Internal Controls

The warehouse operates on a first-in-first-out basis, which ensures that contraceptives are distributed in the order in which they are received. Inventories are manually controlled and appear to be adequately maintained. The overall system of receipt, inventory control and shipments are satisfactory. The physical storage facility is well maintained and secure. At the time of the evaluation, however, a large quantity of OC pills were outdated, awaiting a disposition decision from the MOH.

Commodities and logistical reports are descriptive and statistical and are prepared and distributed regularly. No trend data are collected indicating consumption levels or changes nor are there data on the frequency of stockouts or emergency order activity. Inventory data do not indicate "months on hand" or

other projections such as couple years of protection (CYP), commonly used in contraceptive commodity programs. The lack of available service statistics from the MOH affects ADC's ability to equate contraceptive distribution with active acceptor usage.

o Problems in Integrated Clinics

About 80 percent of the facilities receiving FPSRP commodities are integrated. Problems have arisen in these clinics, particularly in regard to OC pills. MOH staff have reported that the CCSS-operated pharmacies have either been out of stock or that the pharmacists have changed prescription quantities (i.e. reduced the number of cycles from six to three) or in some instances, given patients different formulations or brands from the ones prescribed for them by MOH physicians.

Among clinics that are not integrated, MOH clinics appear to have been losing clientele. While there was an increase in the use of CCSS clinics from 61.7 percent in 1981 to 74.7 percent in 1986, the use of MOH clinics decreased in this same period, from 38.3 percent to 25.3 percent. This decrease may reflect in part a perception that services are less acceptable in MOH clinics. ADC has received calls from MOH clinics that have reported oral contraceptive stockouts and requested interim supplies. ADC has complied with these requests promptly and has notified CCSS and the MOH when they do so. This has, however, made ADC function as a "back-up" central pharmacy supply system for the GOCCR contraceptives. This does not appear to be an efficient logistical arrangement even on an ad hoc basis.

o Procurement

The GOCCR has become over-dependent on ADC as the source of contraceptives for its clinic programs. Although USAID can no longer continue to supply contraceptives to Costa Rica after 1988, no thought appears to have been given to how the government will take over this responsibility. CCSS includes contraceptives in its own formulary purchases, but actual purchases have been exceedingly low due to the lack of funds and the abundance of readily available contraceptives supplied at no cost through the FPSRP. The GOCCR has not begun to explore sources of contraceptive supplies through its Pharmaceutical Procurement Division.

IV.1.1.3 Initiatives for Improving Contraceptive Supply System. During late spring of 1986, a commodities expert from the Centers for Disease Control (CDC) reviewed the contraceptive logistics system. The main recommendation was that CCSS take over formal responsibility for the system, eliminating ADC as a middleman. Previously ADC had submitted a separate proposal to the MOH and CCSS which called for it to formalize its manage-

ment responsibilities for the distribution system; CCSS would remain as part of the system, but ADC would have increased authority to make sure that it functioned efficiently. Neither proposal addresses the problem of who will pay for contraceptive commodities if ADC ceases to receive them from donor sources.

IV.1.1.4 Recommendations.

- o The reliance on ADC must be gradually diminished over the remaining two years of the FPSRP. ADC should not continue to play the role of back-up central pharmacy to the GOCR. This is not only inefficient, but it perpetuates dependency.

- o ADC's proposed logistics plan deserves careful consideration.

- o A meeting to discuss ADC's role in the contraceptive procurement process after 1988 should be scheduled as soon as possible. USAID could suggest and sponsor the meeting and assist in facilitating some of the discussions between the GOCR (CCSS and the MOH) and ADC. Additionally, USAID could involve consultants from CDC and the new AID centrally funded Contraceptive Logistics Management project. Any plan should involve a complete assessment of the current system, future needs, and an explicit decision regarding who will be responsible for doing what in the most efficient way possible.

- o All outdated contraceptives should be removed from ADC's warehouse facility, both to avoid shipping these to clinics and to make better use of the warehouse space.

- o Consideration should be given to generating data on contraceptive forecasting and projections of use for all locations receiving FPSRP commodities. While this procedure depends upon the CCSS Central Pharmacy Warehouse, ADC could suggest its use to CCSS and employ it itself. The forecasting system could provide data that would improve commodities management and stockage anticipation and reduce the need to fill "emergency" orders and stockouts. In addition, the Commodities Monthly Activity Report could be improved by including information on trends and projections of contraceptive commodities.

ADC should consider switching from its manual inventory system to a bar coding and computerized system. This change would improve controls and permit field verification of commodity flow. In addition, it would assist in logistics management and future program evaluations.

IV.1.2 Training

While there were no specific training goals in the logframe, the cooperative agreement called for concentration on family planning training for physicians and obstetrical nurses in light of the lack thereof in Costa Rican medical school and nursing education training.

Over the past three years, ADC's Training Department has played a significant role in providing family planning training to hundreds of professional and support personnel in the MOH and CCSS. The training has usually focused on medical and technical themes concerned with contraceptive methods as well as the ways to motivate new family planning acceptors and administrative matters concerned with service delivery.

The Training Department's technical staff have the requisite credentials and expertise for conducting well-organized and -presented family planning courses, and all materials are first-rate. Training materials are continually being updated and where necessary, adjusted to meet the particular needs of the group(s) being trained.

On the other hand, there has been little or no follow-up on trainees, and therefore, it is difficult to evaluate whether participants have put their training into practice, or indeed, even to develop a complete profile on those trained.

Training has been carried out at CENDEISSS and in the regions, as appropriate. There is talk about ADC's having its own training facilities that might also serve as a regional (Central American) training center. Although plans to expand the present facility are being prepared, ADC has not estimated the potential market throughout the region.

Recommendations

o While training activities to date have been highly satisfactory, there should be an on-going review of curricula and content. This continual reassessment is particularly important in the absence of an explicit statement in project documentation that links training objectives to overall project goals.

o Staff should be given rotating course assignments in order to expand their training capabilities and sustain their interest as course facilitators. FPRSP trainers should be given the opportunity to participate in external family planning training programs particularly those using audio-video materials, films and closed circuit television.

o The Training Department should collect statistical data on each training participant and should conduct follow-up on each health professional and auxiliary trained. Data such as the profiles of training participants, especially physicians, nurses and auxiliary staff, could be collected, in order to ensure that the training courses are meeting needs.

o The Project should embark on a vigorous "training of trainers" program to help institutionalize family planning skills within the CCSS, MOH, or MOE.

o ADC should make a systematic examination of the future (beyond 1988) needs for training in Costa Rica and explore the market for its training services elsewhere in Central and South America prior to making a commitment of funds for the construction of a training facility. Cost estimates and revenue projections will also be required in order to determine the potential for cost recovery and self-sufficiency.

IV.1.3 Research

ADC's reputation for high quality research predated the FPSRP and has been enhanced thanks to Project inputs. Since 1983, the Socio-Demographic Research Department (Departamento de Investigaciones Sociodemográficas or DIS) has produced six major research reports. The most recent DIS publication, a preliminary report for the 1986 DHS, was presented in August 1986. DIS received technical assistance from the CDC for both this report and for an earlier 1985 Women's Health Survey (a cancer-focused study). The FPSRP has also provided support to researchers at the University of Costa Rica for three historical demographic studies and for seven theses in demography. A listing of these research titles appears in Appendix C.

While the DIS has the capability of designing and conducting a wide range of research endeavors, it does not have a permanent staff and must recruit and hire personnel on an as-needed basis. It has access to several high-quality research consultants in the areas of sampling, research design, demography, data processing and statistics. Nonetheless, lack of permanent staff has resulted in delays and problems in continuity. Furthermore, DIS has been operating with an Acting Director for some time.

ADC has made a commendable effort in the dissemination of demographic research findings, having arranged for timely distribution throughout the country and the Latin American research community. ADC has sponsored several demographic seminars which have been well received and have contributed to the training objectives of the logframe and CA. In May, 1986,

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ADC published the Proceedings for the Eighth National Demographic Seminar held in San Jose on September 7-9, 1983.

One area that has been neglected by the DIS has been the collection and analysis of family planning service statistics. The reason is lack of raw data from the government. For the last four years, the MOH has had neither funds nor personnel to provide the kind of detailed data that are needed to provide a basis for analysis of Project activities. The only information comes from the Ministry's Biostatistical Section, which issues an annual report called the Memoria. This, however, contains primarily generalized totals of maternal health-related visits, with little or no details on family planning services. In addition, no budgetary and expenditure data are available on MOH family planning service activities. CCSS relies on the MOH to publish any service statistics it collects on family planning activities, and thus the data here are also scanty.

Another area that has received too little attention has been the exchange of information between the Research and Training Divisions. The training courses are an appropriate forum to bring research findings about family planning to the attention of professionals who will be in the front ranks of those delivering services.

ADC has given some consideration to marketing its demographic research capabilities within and outside the country. As with training, however, it has not looked into either the demand or the costs involved.

Recommendations

o Efforts must be made to start collecting reliable service statistics. Funding exists in the FPSRP budget to assist in this activity. USAID could help facilitate the meetings among the various parties involved--ADC, CCSS, and MOH.

Consideration should be given to producing family planning service statistics on a quarterly or semiannual basis.

o The position of DIS director should be filled as soon as possible. It would also be desirable to hire additional permanent staff to provide continuity and reduce the need for continual training and orientation of temporary staff. A cadre of permanent research staff would add to ADC's credibility as a research consultant organization.

o Prior to marketing its research services, ADC should investigate the potential Latin American market and prepare a detailed operational plan along with cost projections and revenue estimates.

o Efforts should be made to publish and distribute preliminary results for the 1985 Women's Health Survey, and results should be disseminated in a readable format to MCH clinic staff and other interested individuals. In addition, selected topics from this survey as well as the DHS and other studies could be included in editions of the publication Salud para Todos.

o There should be closer collaboration between the Training Department and the Research Department. Research themes and data could be integrated into training courses for health professionals, educators, administrators and other decision makers. Workshops for the training of trainers could be designed from data collected from DHS and other surveys. Conversely, new research opportunities could be identified through these workshops.

IV.2 Expanded Private and Voluntary Sector

IV.2.1 Performance

There is little evidence to date that the Project has succeeded in expanding distribution of family planning services through the private and voluntary sectors. As a result of the creation of PROFAMILIA, however, it may have laid the groundwork for such growth in the future. PROFAMILIA, established in 1981² by ADC to handle its contraceptive social marketing (CSM) activities, has developed during the project life into a promising for-profit company with plans that could make it self-sufficient within the next five years.

A wholly owned subsidiary of ADC, PROFAMILIA has its own autonomous directorate, management and staff and plans soon to move from ADC's building, where it now rents office space, to a location in another part of town.

Currently PROFAMILIA markets "BARON" condoms supplied through the Project. These are marketed in private pharmacies and supermarkets throughout the country, with distribution and promotional activities handled through local subcontracts with

2 At that time called ASDECOSTA S.A.; the name change in 1983 was to make the operation seem more separate from its parent organization ADC.

leading Costa Rican firms.³ Technical assistance has been provided through the Project.

Condom sales have far exceeded initial expectations. The leading supermarket chain increased its order from an initial 50 dispensers (3,600 units) to 250 dispensers (18,000 units) during the first three weeks of sales and sales were 120,000 units during the first three months.

Nonetheless, until plans to expand the product line can be carried out, PROFAMILIA cannot realistically expect to begin to achieve the 35 percent self-sufficiency level called for in the logframe. These plans include providing both a full line of contraceptives (OC pills, foams and jellies as well as condoms and IUDs), other health-related products, and several other products such as baby shampoo, soap, an infant drinking cup and a unique disposable razor. Because these items can be bought cheaply wholesale, and because preliminary research suggests that they can be retailed in volume (100,000 razors and 50,000 infant cups annually), there is a prospect of a solid revenue return.

PROFAMILIA has also already explored potential supply sources for its contraceptive products. The information indicates that with direct purchases of commodities, prices to the consumer can be reduced, a move that should in turn increase the volume of sales and eventually revenues. Even if the product line expands dramatically over the coming two years, however, it will be impossible to make up for this activity's slow start (see Section III.2), and it is unlikely that all monies will have been spent by 1988.

IV.2.2 Constraints

The major problem to date is that sales of OC pills have not been possible because of delays in the registration process of the brands in question (Noriday, Norminest and Norquest). At the time of the evaluation, two years had elapsed since attempts began to get the necessary documentation from the manufacturer (a process that usually takes 30 days), and official approval was not expected for another six months or until March 1987. Pill sales should begin within two months of approval (in May 1987). Another problem may have been the legal prohibition against the advertising on any mass media of ethical pharmaceutical products and sanctions of fines and 30 days in jail for any mass media advertising of abortion-related articles and products

³ The advertising agency is Alberto H. Garnier and the distributor is CEFA Corporation S.A.

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that would inhibit procreation. The only permissible television publicity is the use of PROFAMILIA's slogan⁴ in voice-over scripts with a picture of a condom package. There is no way to assess the effect of this prohibition; it is true, however, that vigorous, explicit TV advertising campaigns usually have a positive effect on product sales. Since television is well developed and available in Costa Rica, it is highly likely that commercial advertising of brand names would enhance recognition, reinforce motivation, and result in increased contraceptive sales.

IV.2.3 Recommendations

- o PROFAMILIA should revise its budget so that expenditures and contraceptive sales come into alignment. No additional funding should be needed for this component for the remainder of the Project life.

- o Efforts should be made to identify and develop other "new" non-contraceptive products that can be commercially marketed and distributed for retail sale. Revenue projections will need to be recalculated commensurate with the numbers of new products introduced and sold. An expanded sales force and administrative support will be necessary as product lines are increased and business expands. Any personnel additions and expenses should be in accordance with business conditions and be weighed carefully against actual revenues.

- o PROFAMILIA should be involved in all discussions pertaining to contraceptive procurement and logistics (see Section IV.1.1.4). Contraceptive acquisition for the commercial program may have to proceed separately from that for the public sector. Contraceptives purchased directly from the manufacturer in sufficient quantities could be packaged in custom-printed and embossed packets to reflect PROFAMILIA's logo and/or brand name. This might reduce some of the local packaging costs and enhance consumer appeal.

- o PROFAMILIA should make itself available to provide technical and consulting services to Latin American countries interested in starting or improving on-going CSM programs. Undertaken on a fee-for-service basis, these activities could generate additional revenues for the company.

⁴ "Have Only the Children Who You Can Make Happy"

o PROFAMILIA's expected relocation to separate offices should proceed as rapidly as practical.

o The GOCR's ban on the commercial advertising of contraceptives on television should be removed.

o A pilot effort should be made to involve employers in offering family planning services. In Costa Rica, since a pregnant working woman is entitled to four months of paid maternity benefits prior to and following the birth of her child, fewer births would result in reduced costs to employers and to the GOCR health system. An effective, work-site family planning program, which is promoted and endorsed by employers and management and which offers family planning information or even low-cost contraceptives, could augment existing CCSS and MOH clinic initiatives. Existing AID-funded programs concerned with expanding the role of the private sector in family planning, (the TIPPS and ENTERPRISE Projects), could assist the GOCR and ADC in initiating such an activity.

IV.3 Enhanced Financial Self-Reliance

Although the Project's SOW called for increased self-reliance for all family planning activities, the only concrete step in this direction has been the creation of PROFAMILIA. The prospects of PROFAMILIA's becoming self-reliant are discussed in Section IV.2.1. Theoretically, ADC might be able to generate other revenue by selling services to GOCR: for example, government, CCSS and MOH might pay ADC to conduct demographic and health research; the government might purchase IE&C services for its health centers and clinics; or it might hire ADC to conduct family planning training courses for health professionals. There might also be a private sector organization market for training and IE&C. Since very little research has been undertaken on any efforts in this direction, however, (see Sections IV.1.2 and IV.1.3), it is evident that they will not be generating the level of income that would make ADC self-reliant any time in the near future.

IV.4 Information, Education and Communication

IV.4.1 Performance

ADC has been Costa Rica's prime producer of IE&C materials on family planning since the Project's start and thus can be credited for any improvement in the national receptivity to family planning that can be traced to promotional activities. Its efforts have included the motivation and orientation of

leaders, the training of teachers of sex education, youth work, and the establishment of adolescent centers.

In addition, ADC has funded the design and publication of various informational and educational materials including provision of family planning messages for the daily radio program "Las Platicas de Don Rafael," the preparation and publication of an annual health-related paperback entitled Salud para Todos, and support for the "Dialogo" radio program produced by the Center for Family Orientation (Centro de Orientación Familiar or COF).

Slightly more than 20 percent of the "Las Platicas de Don Rafael" broadcasts have been concerned with family planning themes, including methods of contraception, child spacing, maternal health, and human sexuality. Although the program is well known throughout the country and "Don Rafael" is considered something of a folk hero, there has not been a significant increase in percentage of listeners since 1978. Salud para Todos is considered to be a very valuable health reference source among its primary readers--rural women, ages 15-49 years. Overall, the IE&C Department's materials are reputed throughout the country for their accuracy and clarity of presentation. Pamphlets and booklets on family planning themes contain up-to-date content and illustrations are perceived as artistically attractive.

IV.4.2 Problems

While the quality of the IE&C output has been good, execution of this component has fallen short on a number of scores. ADC has not been successful in persuading the GOCR to develop a specific national IE&C campaign for adolescents. Nor has sufficient allowance in the FPSRP been made for inputs from the Center for the Advancement of Science Education (Centro para el Mejoramiento de Educación en Ciencias or CEMEC) or from the newly created United Nations Educational, Scientific and Cultural Organization (UNESCO) Population Education Program. A more effective use of these programs and resources could assist ADC in structuring IE&C activities for adolescents and in developing a program that would be attractive to the GOCR.

ADC also has not been fully successful in providing information to field workers. It has received requests from the MOE for technical assistance in providing materials for several CCSS and MOH clinics, but health personnel providing family planning clinical services at the clinic level expressed the feeling that they were cut off from central sources of information.

Another problem concerned air time for the radio program "Las Plasticas de Don Rafael." Since it is considered a public service program, broadcast air time is not regular, a factor which may adversely affect listenership.

Finally, there is a conspicuous absence of understanding of the typical audience of FPSRP-supported publications and other IE&C activities. Little is known about whether attitudes and behaviors have been influenced by ADC-designed and -supported family planning messages. This kind of information is considered an integral part of any effective IE&C campaign.

IV.4.3 Recommendations

o A regular review of the IE&C component should be instituted, focusing particularly on whether it is cost effective. Since radio and television are effective means of communication in Costa Rica, research should solicit listener profiles, assess needs, and identify the messages that are considered most acceptable and relevant in contemporary Costa Rica. The results should be examined with an eye to whether IE&C activities are contributing to family planning revitalization in a cost-effective manner. ADC's Research Department could assist in the design of these empirically focused IE&C studies.

o CCSS and MOH should undertake an inventory of all IE&C materials that have been distributed to clinics during the Project.

o ADC should review the potential for cost-recovery and partial self-financing of its IE&C activities. The potential market for its technical skills and publications should be examined both within the country and throughout Central America. ADC has been considering the sale of some of its publications (training manuals, pamphlets, reports and Salud para Todos), but has not estimated potential demand or possible revenues. The high degree of professional skills, capabilities and experiences that are found among ADC's staff form a bank of talent that may be highly marketable.

o Salud para Todos and the "Plasticas de Don Rafael" should be linked to the broader aspects of the Project. For example, specific data and graphic materials such as those utilized in the presentation of the 1986 DHS results to journalists could be included in both the publication and in radio broadcasts. These data and information could be of general use to current and potential contraceptive users and to family planning clinic staff.

o The use of video cassettes on family planning and other health-related issues in CCSS and MOH clinics waiting areas should be considered. A number of AID-funded activities could be drawn upon to implement this recommendation.

V. WOMEN AND DEVELOPMENT

V. WOMEN AND DEVELOPMENT

Women have been a central focus in many FPSRP family planning and population activities. Although, with one exception, all ADC's operating departments are headed by men, ADC has hired a number of experienced female professional staff who hold responsible positions in IE&C and training. Women also serve on ADC's Board of Directors and thus have the opportunity to participate in the organization's policy development and strategic and operational planning activities. The Executive Director is particularly sensitive to women's issues and has been a strong advocate of greater participation for women in family planning and health activities.

Many of ADC's IE&C and training programs have been directed towards women. Women have been involved in researching and writing "Plasticas de Don Rafael," "Dialogo," and Salud para Todos, all of which contain messages designed especially for women.

The COF, which received funds through the Project for "Dialogo," has played a particularly strong role in Costa Rican feminist issues and concerns. ADC also provided funding for a year (mid-1985 to mid-1986) to the Alternate Radio Education Project for Costa Rican Women (Alternativa Educativa Radiofonica para la Mujer Costaricense [AERMC]). This two-year activity, sponsored originally by Johns Hopkins University, developed 2,536 radio broadcasts on four networks especially for women, as well as numerous messages and pamphlets also designed specifically for women.

The FPSRP has undertaken several studies that have focused on women's issues including the prevalence of female cancers, maternal health, and contraceptive behavior. The 1986 DHS involved a national sample of women (ages 15 to 49 years) and focused on broader morbidity and health behavioral issues including the use of clinic services. Data on contraceptive behavior similar to the 1978 and 1981 CPS were also collected and, when analyzed, will provide Costa Rica with a corpus of data that will reflect changes in contraceptive use, child spacing and other areas directly affecting women.

On the other hand, while the Project has done a good job in focusing on health and family planning issues as they relate women, it has not addressed the broader question of women's role in society, her access to income and jobs, or the effect of the use of family planning on the economic status of women.

Recommendations

o An assessment should be made of any effect the FPSRP may have had on women's access to production inputs and markets, division of labor, income and role in household and community.

o The Project might also assemble a women's issue task force which could discuss research opportunities in the area of women and development.

o If additional program funds are obtained from ADC or other sources, a portion should be used to review the relevance to Costa Rican women of materials developed under the Project. Any information that is outdated or inappropriate should be eliminated. Attention should also be directed to the development of new materials that would help women achieve full participation in the country's economic development.

o Strong efforts should be made to ensure that the findings from the 1986 DHS as well as those from the 1985 cancer study are presented to all levels of the population in an understandable way. Private voluntary organizations (PVOs) such as COF and women's organizations could be of assistance in providing a forum for the dissemination of these research results to the lay public, including adolescents, to health professionals, paraprofessionals and to policy makers.

VI. PROJECT ADMINISTRATION

VI. PROJECT ADMINISTRATION

VI.1 Administration, Management and Human Resources

ADC has a well-developed management system and administrative structure. As a result of a recent reorganization, all functional department chiefs report directly to the Executive Director. Weekly staff meetings and monthly Board of Directors meetings provide regular opportunities for ADC's senior managerial and operational staff to meet and discuss common concerns and to report on progress. Communication between key Project staff appears to be adequate. The FPSRP Director is easily accessible and available for consultations. A newly created Senior Administrator position was filled in mid-1986.

ADC's Executive Director has excellent links to virtually all ministries and levels of the GOCR. ADC's technical staff salaries are higher than those in the government sector, an important factor in attracting and retaining quality staff. There has, however, been a recent turnover in two senior level positions: the Deputy Director position, a position which will be abolished, and the Chief of the Research Division.

While communication with USAID has been open and frequent, submission of FPSRP progress reports to USAID has, on occasion, been late. Although the office is well equipped and maintained, secretarial staff do not routinely use word processing although the software is available on the microcomputers in the Research Department.

VI.2 Finance and Contracts

ADC has well-established financial procedures and controls which easily accommodated the FPSRP and are a benefit to the FPSRP's operations. A manual financial processing and control system is used currently, but an automated system will be put into use by the end of 1986. ADC has its own internal auditor who also serves as ADC's chief financial officer and who reports directly to the Executive Director. Regular internal financial reports are made to ADC's Board of Directors. These reports appear to be of high quality.

The Accounting Department keeps accurate control of disbursements and is prompt in submission of vouchers. ADC uses a three-month expenditure forecast system, which ensures availability of funds. All reports associated with Project expenditures and cost projections were found to be without errors and in accordance with generally accepted accounting principles.

External audits are regularly conducted by Price-Waterhouse and these have been found to be satisfactory, as have those audits conducted for IPPF.

Contractual matters pertaining to the Project have been handled internally. The recently hired Administrator is a lawyer and will assume responsibility for all contractual matters. Additional legal and contract resources are readily available through local law firms.

VI.3 Recommendations

o Progress reports to USAID must be delivered on schedule. The process could be expedited if these reports were prepared on a word processing system.

o An overall Project implementation schedule for each FPSRP task should be developed, indicating the responsible individual(s) and a time completion schedule for each task. This could be kept on the word processor.

The planned introduction of an automated accounting system should proceed as quickly as possible and should handle all Project and departmental operating budgets, vouchers and disbursements, payroll, purchasing and accounts payable, as well as inventories, vehicle maintenance schedules and shipments, and cost and financial projections.

VII. THE FUTURE

VII. THE FUTURE

VII.1 Indicators of Overall Project Success

In the past three years, according to training participants, Costa Rica has experienced a family planning renaissance characterized by a growing public interest in population concerns. Although much of this change has come about because of the government's renewed interest in family planning, it is certain that the FPSRP has also played a catalytic role. Moreover, there is every reason to believe that the FPSRP will continue to stimulate further positive changes.

VII.2 Institutionalization

The ultimate test of Project success will depend upon the degree to which Project activities become institutionalized. Here the record is only partially reassuring.

The Project covers a significant part of ADC's technical payroll, including logistics, communications, training and research, and special projects for a total of 17 full-time and 21 part-time positions, as of the end of 1986. At the Project's end, without additional funding from one or several external sources and/or significant revenues from PROFAMILIA's commercial activities, it will have to function at a reduced level.

VII.3 The Transition from ADC to the Government

VII.3.1 The Prospects

The most jarring effect of the end of Project financing will be with respect to contraceptive supplies, an issue that has been inadequately addressed to date. ADC hopes to continue to play a significant role in the contraceptive procurement process in the coming years, and it is highly likely that its continued participation could help generate funds for organizational support.

Given that Costa Rica's family planning services are primarily located in the public sector, however, this may not be a suitable course of action. Certainly, in the short term, ADC could assist the GOCR in efforts to improve its contraceptive commodities, procurement and inventory system. Over the long haul, ADC could legitimately continue to store and supply contraceptives to PROFAMILIA and to supply them to government clinics with other such items as slides for PAP smears. On the other hand, it is more appropriate that the procurement process

should be assumed by the Government. If the CCSS Central Pharmacy improved its procedures, it theoretically might solve most, if not all, of the contraceptive logistical problems. At present, however, since none of these issues has been investigated, the prospect is that there will be a sharp decline in the supply of contraceptives when the Project ends. The prospect is no brighter in regard to IE&C, research and training. The GOCR, never strong in these areas, has essentially abdicated these functions to ADC and other PVOs, and unless another source of funding is developed, it is likely that these activities will cease at the Project's end.

VII.3.2 External Factors Affecting the Transition

Although the immediate picture is discouraging, there are a number of factors external to the Project that suggest the government will not allow the situation to deteriorate totally.

VII.3.2.1 Positive.

o Pro-Family Planning Orientation

The pro-family planning climate which paved the way for the project is still very much in evidence. The President has pledged his support for family planning activities. There is talk of reestablishing CONAPO and presumably, thereby refocusing the attention of both the GOCR and the private sector on the need for long-term institutionalization of family planning activities. Furthermore, CONAPO could provide the impetus for development of a national population policy that would formalize the GOCR's endorsement of these efforts.

o Demand

Before the FPSRP, there were high levels of contraceptive prevalence, knowledge of contraceptive methods, and contraceptives freely available from public and private sources. Recent survey research continues to substantiate high degrees of interest in fertility control and child spacing among women at risk of pregnancy. Furthermore, as the number of women at risk continues to grow, so too will the demand for contraceptive services.

o Technical and Structural Capabilities

The GOCR has the capability and the technical resources for family planning service delivery. For example, the GOCR could absorb the commodity and logistics activities through the CCSS Central Pharmacy Procurement System. IE&C and training activities could be carried out through the MOH, CCSS, the

Ministry of Communication, the MOE and the University of Costa Rica. Research could be taken over by the Directorate General of Statistics and Census, the University of Costa Rica and the MOH's Division of Biostatistics. PROFAMILIA and the commercial sector program could function on their own if sales goals were achieved.

VII.3.2.2 Negative Factors. Against the positive factors described above, there stands one major and several minor constraints. The prime constraint is lack of funds. The country's economic situation remains perilous. Productivity is continuing to decline and the external debt continues to grow. It is not at all apparent that the GOCR has the fiscal resources to subsidize training, IE&C, contraceptive commodities procurement and applied and evaluational research. For example, if the Government were to take over Project functions as described above, it would have to hire additional staff with the kind of skills that are now available through ADC and other PVOs such as COF or from the large universities in San Jose or Heredia. A less costly alternative might be to contract some of the services to ADC and other PVOs that are already in place. This alternative would also have the advantage of shifting public attention to an established organization that has a positive image and is highly credible. Since family planning remain a sensitive Issue, it might be wise for the Government itself to remain in the background. Whichever route is taken, however, the costs would be substantial.

In addition to costs, three other obstacles also need to be addressed. These are interrelated and include

- political friction between CCSS and the MOH,
- disruption of services at the clinic level caused by integration, and
- failure of the Government to collect and distribute family planning statistics.

Their combined effect on project implementation has been deleterious (see Section IV.1.1.2), and if steps are not taken, the prospects for long-term institutionalization of Project activities within the Government are not promising.

VII.4 Possible USAID Role

In general, USAID has distanced itself from GOCR family planning operations. It designed the Project with a view to strengthening the private sector and has looked to the evolution of this sector to help assure the future of family planning

activities in Costa Rica. USAID has not interfered with ADC's implementation of the Project. In particular, it has depended on ADC to take the initiative to reconcile the differences between CCSS and the MOH. ADC has made a number of attempts in this direction, with little success. While the situation has improved at the sub-directorate and division levels, an impasse remains at the top level.

Without political pressure applied from the highest levels of the GPCR, it may be unrealistic to expect CCSS and MOH to improve the integration of their clinics and health centers. Without the intervention of USAID, however, ADC may be powerless to stimulate the needed action from top GOCR officials. Thus the time may have come for USAID to communicate its concern to the GOCR that scarce health resources should be used more efficiently.

USAID might consider encouraging changes in two areas: allocation of resources and management of the integrated delivery system.

o Resources

-- From the Government

USAID should encourage the GOCR to commit more of its own resources towards institutionalizing family planning. Specifically, it should urge the GOCR to create a National Coordinator for Family Planning and to reactivate CONAPO. The National Coordinator would report directly to the GOCR Executive Office. The Coordinator position would provide the liaison between CCSS and the MOH and other agencies in the GOCR (e.g., the MOE, the Directorate General of Statistics and Census), with ADC and other PVOs, and with other integrated groups in the private sector. The Coordinator would also be the Chairman of CONAPO and be responsible for providing significant leadership in developing a national population and family planning policy. In addition, this office should be responsible for collecting family planning service statistics from CCSS and the MOH and be an additional clearinghouse for official GOCR population related reports. ADC and the FPRSP could provide significant assistance to support the development of this position.

In respect to CONAPO, USAID could coordinate existing resources available through many centrally funded AID projects which could assist the GOCR in structuring CONAPO to be an effective organization.

The GOCR should also be encouraged to build up its own training, research and IE&C capabilities especially as they relate to population and family planning (see Recommendation regarding "training of trainers" in Section IV.1.2) and the use of video cassettes in family planning CCSS and MOH clinics in Section IV.4.3).

-- From the Private Sector

USAID should encourage greater involvement by the private sector in family planning activities. A vigorous contraceptive social marketing program would contribute to revitalizing the national concern for family planning. Specifically, USAID should assist PROFAMILIA in its efforts to ensure that additional contraceptives and other health products are available for distribution and sale as soon as possible. Priority should go to expediting registration of oral contraceptives. Furthermore, USAID should reiterate its concern that PROFAMILIA retain its physical and organizational separateness from ADC.

o Integration

..... If possible, USAID should consider approaching the GOCR with the idea of encouraging an evaluation of the CCSS and MOH health centers and clinic operations as they pertain to family planning services. USAID could offer to assist the GOCR in identifying and considering options that would enable it to operate its family planning clinics more efficiently. It could also offer to provide the GOCR with external technical resources.

The evaluation should include an analysis of the staffing and commodities distribution systems. It should also examine communication between health personnel providing family planning clinical services. A newsletter or some periodic update on activities, therapies, resources, etc. would be of benefit to many of the staff who have expressed feeling "cut off" from central sources of information and data. It would also be of interest to conduct a user evaluation survey and a survey of integrated health clinic staff in order to identify problem areas and develop the appropriate remedies.

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VIII. SUMMARY OF MAJOR RECOMMENDATIONS

VIII. SUMMARY OF MAJOR RECOMMENDATIONS

VIII.1 Project Components

VIII.1.1 Revitalization of the Public Sector

Contraceptive Supplies.

o Logistics Management

(1) The efficiency of the system of contraceptive logistics management should be improved. The CCSS Central Pharmacy Warehouse and the ADC should improve their forecasting of contraceptive needs. The Commodities Monthly Activity Report could be revised to include information on trends and projections of contraceptive commodities. ADC should consider switching from its manual inventory system to a bar coding and computerized system. PROFAMILIA should be involved in all discussions in regard to contraceptive logistics.

o Procurement

(2) The reliance on ADC should be gradually diminished. ADC should not continue to play the role of back-up central pharmacy to the GOCR.

(3) USAID should sponsor a meeting to discuss ADC's role in the contraceptive procurement process after 1988. Participants should include representatives from the GOCR (CCSS and the MOH), ADC, PROFAMILIA, CDC and the new AID centrally funded Contraceptive Logistics Management project. Any plan should involve a complete assessment of the current system, future needs, and an explicit decision regarding who will be responsible for doing what in the most efficient way possible.

Training.

(4) Training staff should be given rotating course assignments and should participate in external family planning training programs, particularly to enhance their skills in audio-video materials, films and closed circuit television. The Project should also embark on a vigorous "training of trainers" program to help institutionalize family planning skills within the CCSS, MOH, or MOE.

(5) The curricula and content of the training programs should be reviewed on a periodic basis.

(6) To facilitate efforts at evaluation, the Training Department should collect statistical data on each training participant and should conduct follow-up on each health professional and auxiliary trained.

Research.

(7) USAID should promote efforts to improve the collection of reliable family planning service statistics, preferably on a quarterly or a semi-annual basis.

(8) Additional permanent staff positions in research should be created.

(9) There should be closer collaboration between the Research Department and the Training Department in the dissemination of research findings and identification of research topics.

VIII.1.2 Expansion of Service Delivery by Commercial/Voluntary Sectors

(10) Efforts should be made to identify and develop other "new" non-contraceptive products which PROFAMILIA might distribute and market. The administrative and financial ramifications of such a move should be taken into account.

(11) A pilot effort should be made to involve employers in offering family planning services. Existing AID-funded programs concerned with expanding the role of the private sector in family planning, (the TIPPS and Enterprise Projects), could assist the GOCR and ADC in initiating such an activity.

VIII.1.3 Enhanced Self-Reliance

(12) ADC should review the potential for cost-recovery of its training, research, and IE&C activities, both within the country and throughout Central America. ADC staff have technical skills in these areas which might be contracted by outside organizations. There may also be a market for its various IE&C publications. PROFAMILIA might also offer technical and consulting services to Latin American countries interested in starting a CSM program.

VIII.1.4 IE&C

(13) A regular review of the IE&C component should be instituted, focusing particularly on whether it is cost effective.

tive. To allow analysis of cost effectiveness, research should be undertaken that solicits listener profiles, assesses needs, and identifies the messages that are considered most acceptable and relevant.

(14) CCSS and MOH should undertake an inventory of all IE&C materials that have been distributed to clinics during the Project.

(15) The use of video cassettes on family planning and other health-related issues in CCSS and MOH clinic waiting areas should be considered. A number of AID-funded activities could be drawn upon to implement this recommendation.

VIII.2 ADC Administration

(16) An overall Project implementation schedule for each FPSRP task should be developed indicating the responsible individual(s) and a time completion schedule for each task.

(17) ADC should automate its office procedures (i.e., by using its word processing equipment and an automated accounting system).

VIII.3 Women's Role

(18) An assessment should be made of any effect the FPSRP may have had on women's access to production inputs and markets, division of labor, income and role in household and community.

(19) The Project might also assemble a women's issue task force which could discuss research opportunities in the area of women and development.

VIII.4 USAID Role

(20) USAID should encourage the GOCR to commit more of its own resources towards institutionalizing family planning. The GOCR should build up its own training, research and IE&C capabilities especially as they relate to population and family planning.

(21) USAID should also urge the GOCR to create a National Coordinator for Family Planning and to reactivate CONAPO. The Coordinator position would provide the liaison between CCSS and the MOH and other agencies in the GOCR, e.g. the MOE, the Directorate General of Statistics and Census, with ADC and other PVOs, and other integrated groups in the private sector. The

Coordinator would also be the Chairman of CONAPO and be responsible for providing significant leadership in developing a national population and family planning policy. In addition, this office should be responsible for collecting family planning service statistics from CCSS and the MOH and be an additional clearinghouse for official GOOCR population related reports. ADC and the FPRSP could provide significant assistance to support the development of this position. In respect to CONAPO, USAID could coordinate existing resources available through many centrally funded AID projects which could assist the GOOCR in making CONAPO to be a more effective organization.

(22) If possible, USAID should consider approaching the GOOCR with the idea of encouraging an evaluation of the CCSS and MOH health centers and clinic operations as they pertain to family planning services and offering its assistance to help improve operations.

(23) USAID should encourage the private sector to become more involved in family planning activities. In this regard, it should urge lifting or modifying the ban on mass media advertising of contraceptives.

APPENDICES

APPENDIX A
SCOPE OF WORK

Appendix A
SCOPE OF WORK

I. Scope of Work

The evaluation's SOW involved four areas:

1. Project Performance and General Considerations
2. Institutional Development
3. Women and Development
4. Outlook on the Future

I.1 Project Performance and General Considerations

- I.1.1 Determine the extent to which ADC has complied with the terms of the Cooperative Agreement and describe any problems encountered with compliance.
- I.1.2 Describe the extent to which the Project has made progress towards achievement of its specifically stated objectives as defined in the Project Paper and Cooperative Agreement. Reference should be made to the Project Logical Framework.
- I.1.3 Determine the appropriateness of present project orientation, taking into account the socio-political atmosphere, pressure groups and the dilemma of demand creation/service availability within the public sector and the utilization of the private sector services at full cost.
- I.1.4 Review the Project in the context of the overall national family planning programs. Examine the focus and direction of family planning activities of the Ministry of Planning, the CCSS, the MOH and the Centro Para el Mejoramiento de la Educacion en Ciencias (CEMEC), etc.

I.1.5 Review the results of the Demographic Information Usage Analysis and its relation to present and future research. Examine the opportunities for effective, small scale research and analysis in the area of demographics/development linkages.

I.1.6 Supply separate sections on:

- the development impact of the project to date.
- the lessons learned including a description of the factors which have proven critical to Project success and a discussion of the techniques or approaches which have proven most effective or had to be changed and why.
- observations and specific recommendations regarding project design, implementation, and project management, including: 1) the elimination of constraints to successful project implementation; 2) actions which could be taken by the Mission or cooperating entities which would contribute to more efficient Project management; and 3) improvements in the Mission management approach.

I.2 Institutional Development

I.2.1 Discuss the local institutional capacities (management, technical, financial) which are being developed to sustain project benefits. Will they be in place when USAID financing ends? What policies are required to facilitate continued long-term impact?

I.2.2 Determine what phases of service delivery have been effectively institutionalized without the need for outside assistance. How will the commodity flow be affected in the near future, with the planned integration of CCSS and MOH services? Can or will the CCSS take over distribution and potentially the purchase of contraceptives under the plan for integrated health services?

I.3 Women and Development

- I.3.1 How were the interests and role of women taken into account at the design and appraisal stages? In what way did women participate in this process? How did their participation or non-participation affect project achievements?
- I.3.2 Was gender-specific data available or has it been developed since? How has such data been used in goal setting and resource allocation?
- I.3.3 What are the effects (impacts if available), positive or negative, of the project concerning women's access to production inputs and markets, division of workloads, income, education and training, role in household and community, and health conditions?

I.4 Outlook on the Future

- I.4.1 Analyze the long term projections for the National Planning Program and the effects of reduced AID and IPPF funding in addition to uncertain IPPF support. A discussion of the role seen as most important to be played by private family planning agencies shall be included.
- I.4.2 Discuss the project benefits which are likely to be sustained after donor funding ends.

APPENDIX B
LIST OF INDIVIDUALS CONTACTED

Appendix B

LIST OF INDIVIDUALS CONTACTED

ASOCIACION DEMOGRAFICA COSTARRICENSE

Dr. Raimondo Riggioni, President
Sr. Victor Morgan, Executive Director
Lic. Jorge Amador, Administrator
Lic. Jose Carvajal, Chief, Training and Evaluation Division
Sr. Jose de Carrillo, Chief, Services and Supplies Division
Lic. Simon Benjamin, Chief, Information and Education Division
Lic. Doris Sosa, Acting Chief, Research Division
Lic. Jorge Lopez, Director, PROFAMILIA
Dr. Marcos Bogan, Member, Evaluation Committee
Sr. Victor Hugo Jimenez, Chief, Accounting Division
Sr. Stanley Bolandi, Director, "Las Platicas de Don Rafael"
Sra. Marlene Retana, Director, "Salud para Todos"

MINISTERIO DE SALUD (Ministry of Health)

Dr. Rafael Salazar Portuguez, Chief, Maternal and Child Health
Lic. Vilma de Solano, Chief, Health Education Division
Dr. Luis Meneses, Regional Director, Huetar Atlantico
Dr. Lenin Sanz, Director, Sectoral Planning Unit

CAJA COSTARRICENSE DE SEGURO SOCIAL (CCSS) (Social Security)

Dr. Jaime Jenkins Zamora, Director, Technical and Health Services
Lic. Mario Loaiza, Executive Assistant to the President

CENTRO DE ORIENTACION FAMILIAR (COF)

Sra. Marina de Solano, Director
Lic. Rebeca Quiros Bonilla, Chief, Programs Division

CENTRO DE MEJORAMIENTO DE LAS CIENCIAS (CEMEC)

Dr. Rolando Berty, Coordinator of Population Education
Prof. Grace Castro Kwong, Consultant

PUBLICIDAD ALBERTO H. GARNIER S.A.

Sr. Miguel Vasquez A., Assistant to the President
Sr. Minor Montenegro A. Account Executive
Lic. Yolanda Huete, Research Executive

ESTUDIOS ECONOMICOS Y ENCUESTAS, S.A.

Lic. Fabio Calvo, President

ALAJUELA

CCSS Clinic

Sra. Maria Elena Rodriguez Solano, Head Obstetrical Nurse, Family Planning Services

Sr. Jose Duran, Pharmacy Supervisor

Centro de Salud (Ministry of Health)

Sra. Julieta Solera Campos, Coordinator, MCH and Family Planning

SAN RAMON

Centro de Salud (Ministry of Health)

Sra. Gladys Araya, Obstetrical Nurse, Family Planning Services

Rural Health Program (Ministry of Health)

Dr. Olger Barbosa, Director

PUNTARENAS

Centro de Salud

Sra. Maria Eugenia Ortiz, Obstetrical Nurse, Family Planning Services

Dr. Sandra Varela, Chief of Pharmacy Services

ESPARZA

Centro de Salud (Ministry of Health)

Sra. Hilda Arana Campos, Obstetrical Nurse, Family Planning Services

il

PUERTO LIMON

Hospital "Dr. Tony Facio"

Dr. Manuel Marengo Corrales, Director

Centro de Salud (CCSS)

Dr. Felipe Pierre Mars, Coordinator, CCSS and MOH Family Planning Services

Centro de Formacion y Recreacion Juvenil

Sr. Jose Luis Castillo, Director
Sr. Larry Wein Calvin, ADC Coordinator and Delegate
Srta. Beneida Hamilton, Technical Staff
Lic. Ricardo Wing Arguello, Sociologist

Direccion Regional de Ensenanza (Regional Education Center)

Sra Marlene Dell, Orientation Consultant

U.S. AID MISSION, SAN JOSE

Mr. Richard K. Archi, Deputy Mission Director
Mr. Kevil Kelley, Assistant Director
Ms. Ann Fariar, Evaluation Office
Mr. John W. Jones, General Development Officer
Mr. David Kitson, Deputy Development Officer
Ms. Betsy K. Murray, Project Officer

MISCELLANEOUS

Mr. Steven Joshua Samuels, USAID Consultant in Social Marketing

APPENDIX C
RESEARCH DEPARTMENT SUPPORTED STUDIES

Appendix C

RESEARCH DEPARTMENT SUPPORTED STUDIES

Researchers Supported and Study Topics

Hector Perez Brignoli

"Fecundidad Y Familia en San Pedro de Mojon (1860-1940)"

"Estimacion del Numero de Hijos por Matrimonio y de la Edad al Matrimonio en Varios Parroquias del Valle Central de Costa Rica (1850-1910)"

"Estimaciones de la Mortalidad a Partir de la Estructura por Edad de las Muertes en Varios Parroquias del Valle Central de Costa Rica (1950-1910)"

Carlos Oses

"La Poblacion Rural Costarricense de 60 Anos y Mas de de Edad: Su Situacion y Caracteristicas" Heredia, 1985

Luis Montoya

"El Tratamiento Periodistico de las Informaciones sobre Poblacion en la Prensa Costarricense 1950-1984"

Luis Hurtado de Mendoza

"Algunos Aspectos Poblacionales de los Cabecar de Costa Rica"

Luis Alfonso Perez Gomez

"Emigracion Rural y Estructura Socio-Productiva en el Canton de Turrubares, Costa Rica 1950-1983" 1984

Daniel Leon Nunez

"Implicaciones de la Inmigracion Internacional en el Sistema Politico Costarricense" 1985

Carmen Grimaldo e Irma Sandoval

"Embarazo Juvenil en Costa Rica" 1985

Krysia Munoz Jimenez

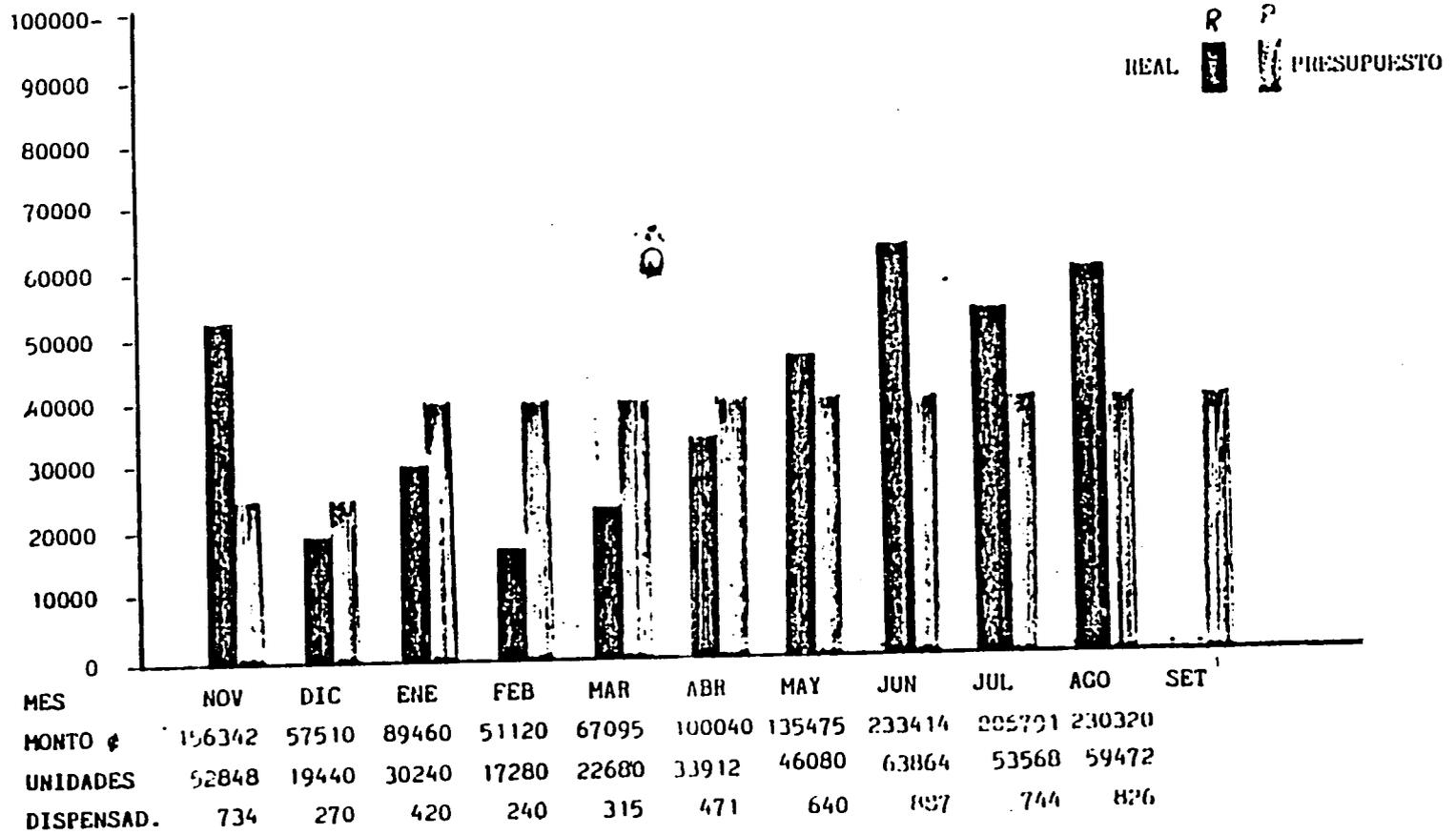
"Los Refugiados en Costa Rica, Producto de la Coyuntura Politica Centroamericana 1979-1984"

APPENDIX D
PROFAMILIA SALES DATA

Appendix D
 PROFAMILIA SALES DATA

PROFAMILIA-ASDECOSTA, S.A.
 COSTA RICA

VENTA DE PRESERVATIVOS BALON (EN PUNTO DE VENTA)
 >VENTAS DEL DISTRIBUIDOR<



APPENDIX E

SELECTED TABLES FROM 1986 DEMOGRAPHIC AND HEALTH SURVEY
COSTA RICA, AUGUST, 1986

Appendix E

SELECTED TABLES FROM 1986 DEMOGRAPHIC AND HEALTH SURVEY
COSTA RICA, AUGUST, 1986

Table 15

Percentage of Women Using Contraceptives
According to Method Used, 1976, 1981, 1986 Survey Comparisons

Método	Mujeres de 20 a 49 años			15 - 49	
	1976	1981	1986	1981	1986
<u>Total</u>	<u>100.0</u>	<u>100.0</u>	<u>100.0</u>	<u>100.0</u>	<u>100.0</u>
Porcentaje que no están usando	32.0	34.0	30.3	35.0	31.5
Porcentaje que están usando	68.0	66.0	69.7	64.6	68.5
<u>Método</u>					
Píldora	22.5	20.5	18.7	20.7	19.3
DIU	5.2	6.0	7.6	5.9	7.3
Condón	8.8	8.0	12.6	8.1	12.4
Inyección	2.0	2.2	1.3	2.2	1.2
Vaginales	1.7	1.2	0.5	1.2	0.6
Ester. Fem	15.9	18.4	17.6	17.2	16.5
Vasectomía	1.0	0.4	0.6	0.4	0.6
Ritmo	5.1	6.3	7.6	6.0	7.3
Retiro	4.6	2.7	3.1	2.8	3.0
Otro	1.2	0.3	0.1	0.3	0.1

Table 17

Percentage Using Contraceptives by Age (Women in Union)

Edad	1976	1981	1986
<u>Total</u> (15 - 49)	-	64.6	68.5
15 - 19	-	45.6	50.4
<u>Total</u> (20 - 49)	68.0	66.0	69.7
20 - 24	63.6	58.2	58.6
25 - 29	69.6	64.8	63.9
30 - 34	72.5	71.6	73.2
35 - 39	75.4	74.9	82.9
40 - 44	70.3	69.9	77.4
45 - 49	51.1	56.2	67.6

Table 18

Percentage of Women Who Obtained or Who Currently Obtain
Their Contraceptives from the Public Sector, According to Method
and Compared to the 1981 CPS

Método	1981	1986
<u>Total</u>	<u>69.2%</u>	<u>76.3%</u>
Píldora	76.2	81.0
DIU	73.0	56.5
Condón	51.2	66.3
Inyección	79.7	(53.8)
Vaginales	(21.9)	(33.3)
Esterilización	87.4	90.6
Vasectomía	(40.0)	(36.4)

Las cifras entre paréntesis indican que el porcentaje fue calculado sobre menos de 40 casos.

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Table 19

Estimate of the Number of Users of the National Family Planning Program According to Contraceptive Method, 1981, 1986

Método e Institución	1981	1986
Número de Usuarías		
<u>Total</u>	<u>92 904</u>	<u>117 475</u>
<u>Método</u>		
Píldora	56 406	63 718
DIU	15 314	16 811
Condón	14 293	33 508
Inyección	5 998	2 631
Vaginales	893	807
<u>Institución</u>		
C.C.S.S	57 367	87 754
M.S.	35 537	29 721
Distribución porcentual		
<u>Total</u>	<u>100.0</u>	<u>100.0</u>
<u>Método</u>		
Píldora	60.7	54.3
DIU	16.5	14.3
Condón	15.4	28.5
Inyección	6.4	2.2
Vaginales	1.0	0.7
<u>Institución</u>		
C.C.S.S	61.7	74.7
M.S.	38.3	25.3

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Table 20

Percentage of Women that Do Not Want Any More Children
According to the Number of Live Births
1976, 1981 and 1986 Survey Comparisons

Hijos vivos	1976 ^{a/}	1981	1986
	Porcentaje que no desea		
<u>Total</u>	<u>52.0</u>	<u>51.5</u>	<u>51.5</u>
0	5.3	6.1	2.7
1	13.0	12.7	21.8
2	35.2	44.7	54.1
3	58.9	64.8	68.6
4	68.4	75.1	78.3
5	74.7	81.9	89.6
6 y más	81.9	86.5	89.7

^{a/} Se refiere a mujeres de 20 a 49 años.

Forma de la pregunta:

ENF 1976: Desea Ud. tener otro hijo alguna vez?

EPA 1981: Desea Ud. tener más hijos algún día?

EFES 1986: Ya tiene Ud. todos los hijos que desea?