

AGENCY FOR INTERNATIONAL DEVELOPMENT
PROJECT IDENTIFICATION DOCUMENT
FACESHEET (PID)

1. TRANSACTION CODE
A = Add
C = Change
D = Delete

Revision No. _____

DOCUMENT CODE 1

2. COUNTRY/ENTITY
COSTA RICA

3. PROJECT NUMBER
515-0168

4. BUREAU/OFFICE
A. Symbol LAC
B. Code 05

5. PROJECT TITLE (maximum 46 characters)
Family Planning Self-Reliance

6. ESTIMATED FY OF AUTHORIZATION/OBLIGATION/COMPLETION
A. Initial FY 8 | 3
B. Final FY 8 | 7
C. PACD 8 | 8

7. ESTIMATED COSTS (\$000 OR EQUIVALENT, \$1 =)
FUNDING SOURCE LIFE OF PROJECT
A. AID 2,090
B. Other U.S. 1. _____
2. _____
C. Host Country 600
D. Other Donor(s) IPPF 1,750
TOTAL 4,440

8. PROPOSED BUDGET AID FUNDS (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. 1ST FY		E. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) P	440	440		570		2,090	
(2)							
(3)							
(4)							
TOTALS							

9. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)
450 480

10. SECONDARY PURPOSE CODE

11. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)
A. Code BRW BVW
B. Amount 2,665 1,775

12. PROJECT PURPOSE (maximum 480 characters)
The purpose of this project is to revitalize and expand family planning services through public, private and commercial sector activities.

13. RESOURCES REQUIRED FOR PROJECT DEVELOPMENT
Staff: TDY, 3 person months, AID/Washington.

14. ORIGINATING OFFICE CLEARANCE
Signature: [Signature]
Title: Director, USAID/Costa Rica
Date Signed: MM DD YY

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

16. PROJECT DOCUMENT ACTION TAKEN
S = Suspended CA = Conditionally Approved
A = Approved DD = Decision Deferred
D = Disapproved

17. COMMENTS

18. ACTION APPROVED BY
Signature: _____
Title: _____

19. ACTION REFERENCE

20. ACTION DATE
MM DD YY

LIST OF ACRONYMS USED IN THE PID

- 1- ADC Costa Rican Demographic Association
- 2- ASDECOSTA Costa Rican Demographic Association - Contraceptive Sales
Affiliate
- 3- AVS Association for Voluntary Sterilization
- 4- CCSS Social Security Institute
- 5- CDC Centers for Disease Control
- 6- CDSS Country Development Strategy Statement
- 7- CIF Center for Family Integration
- 8- COF Center for Family Orientation
- 9- CLI Limon Information Center
- 10-CONAPO National Population Commission
- 11 CPS Contraceptive Prevalence Survey
- 12- CRS Contraceptive Retail Sales
- 13- DA Development Associates
- 14- FPIA Family Planning International
- 15- IEC Information, Education, Communication (Organization)
- 16- IE&C Information, Education and Communication (Program)
- 17- IFRP International Fertility Research Program
- 18- IPPF International Planned Parenthood Federation
- 19- JHPIEGO/ Johns Hopkins Program for International Education in
PIEGO Gynecology and Obstetrics
- 20- LAC Latin America and the Caribbean
- 21- MOE Ministry of Education
- 22- MOH Ministry of Health
- 23- OFIPLAN National Planning Office
- 23- UNFPA United Nations Family Planning Agency

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FAMILY PLANNING SELF-RELIANCE

I. BACKGROUND AND PROBLEM STATEMENT

The Costa Rican CDSS has identified excessive population growth as a significant problem confronting the economic development of Costa Rica. While Costa Rica once had a stellar family planning program vis-a-vis other LAC countries, the previous administration - which was vigorously anti-family planning- has inflicted damage upon the program. Prior to the previous administration, tremendous progress was made in extending family planning services to an ever-increasing number of women in the fertile ages and in reducing the crude birth rate to 29 in 1976 from 45 in 1964. The current administration wishes to regain program momentum and is willing to commit substantial resources to do so, despite serious budget problems. The Mission intends to support this revitalization in order to place the program on a more stable and self-reliant basis.

The current government recognizes the serious short-term economic and medical repercussions of excessive population growth. Large annual increments to the population immediately burden the limited resources available to provide medical care to pregnant women, post-partum mothers and new-born infants. Then, in a few years, these children must be provided with costly education. During this period of extreme economic crisis in Costa Rica, these financial burdens would be especially onerous. Funds are urgently needed to service the country's tremendous external debt and to invest in job and income producing businesses, not to pay for unwanted pregnancies and births.

The current administration also recognizes that the current rate of population growth - 2.4 percent per year- represents a serious long-term constraint for economic development . With over fifty percent of the population under the age of 20, the economic system will be hard pressed to create a sufficient number of jobs over the next ten to twenty years to even maintain unemployment at a reasonable, albeit high level. Basic human needs such as water, food, electricity, housing, and medical care will also have to be expanded tremendously and at great cost to maintain the quality of life to which the Costa Ricans have become accustomed. A failure to meet these expectations could lead to serious social turmoil.

The decline in the service capacity of the public sector over the past four years when combined with the underdevelopment of the private sector delivery system has led to an unmet demand for family planning services equal to about 15 to 20 percent of the women of fertile ages. This represents approximately 120,000 women in immediate need of services among the 590,000 women in fertile ages in Costa Rica. Because of high fertility and low mortality in previous years, the number of women of fertile ages will increase by nearly 3.0 percent per year over the next

ten years so that the total family planning delivery system must increase by nearly 50 percent just to not lose ground. In summary, current unmet demand for services when combined with unavoidable expansion in the target population, represents a tremendous challenge for a country in economic crisis.

This project will help the Costa Ricans to meet these challenges by supporting them to enliven a dormant family planning program which if it had been left unattended for many more years might have lost its ability to recuperate. Today, there are many elements ready to spring to life again: political will, program leadership, trained staff, and a public knowledgeable about family planning. Major financial limitations require more cost efficient initiatives. Now is not the time to be complacent because of the fine program performance in the past. Rather, the program must recognize its weaknesses and overcome them as quickly as possible.

By sponsoring efforts to revitalize the public sector family planning program, to expand the service delivery capacity of the commercial and voluntary sectors and to enhance the financial self-reliance of all family planning activities, the project will address the three major factors currently limiting program effectiveness. Project activities will specifically support the CCSS's service delivery initiatives to reconquer pre-1978 service levels. A CRS program will be initiated to expand family planning services, to promote a more active private sector participation in the program and to reduce pressure (as demand for services, information and commodities) on the CCSS during critical years for the Costa Rican socioeconomic and political system (1983-87).

Because Costa Rica has achieved a 65% contraceptive prevalence level, the CRS program is justified by drastic changes in the national economy during the last two years. The national currency has suffered a 700% devaluation during this period while incomes on the average have increased only 80%. Unemployment is currently three times higher than in normal periods, and inflation is expected to reach 120% in 1982. The disposable income of lower class families has been drastically reduced. The Mission fears that unless immediate actions are taken, prevalence could drop significantly and demand for services and commodities from the CCSS could increase dramatically when that institution is least able to respond effectively.

The devaluation of the national currency is responsible for a 500-800% increase in the retail price of commodities. While it has been proven that wealthy citizens will continue to purchase the more costly commodities, members of the less fortunate classes will depend exclusively on the public sector, which will be unable to satisfy increasing demand levels with reduced budgets unless a CRS program supplies commodities at affordable prices.

Finally, the project will provide technical assistance and funds for special projects to stimulate overall program self-reliance. This project component will attempt to insulate the National Family Planning

Program from politics and to reduce its dependency on public sector initiatives. The Mission believes that a more self reliant program will perform more effectively and successfully in times of adversity like the 1978-1982 period.

II. PRIOR INTERNATIONAL ASSISTANCE

A. AID

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

a) Complete availability of contraceptives to 85-90% of the total fertile population by 1979;

b) Protect 150,000 women in fertile ages as continuing acceptors in the public sector clinical programs of the Ministry of Health (MOH) and the Social Security Institute (CCSS).

c) Reduce the birthrate from 28.3 per thousand to 20 per thousand by 1979-80;

d) Establish twelve surgical contraception service centers located in strategic urban centers throughout the country. Establish one major training center and two sub-training centers to teach surgical contraception;

e) Establish three Women Health Care Specialists training centers graduating 240 by end 1979;

f) Train 150 auxiliary nurses, 150 "granny midwives", 140 agriculture extension agents, 100 community development and social workers, and 500 malaria voluntary collaborators in family planning and related subjects to provide family planning information, education and motivation and to distribute orals, condoms and other non-clinical contraceptives;

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

(h) Country-wide massive IE&C penetration with emphasis on the rural dwellers; and,

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

The project was to be implemented by three government entities and three private organizations. The MOH, the CCSS and the ADC would deliver services. The COF, CIF and MOE would work on information, education and communication (IE&C) activities. The ADC was selected as

the leader organization and coordinator for the National Program in the Consejo Nacional de Población (CONAPO).

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

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

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

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

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

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

Project 515-0132 was scheduled to terminate in 1979. USAID/CR planned the Family Planning Services II Project for FY 1980. OFIPLAN blocked every effort to design and negotiate this project, so USAID/CR

requested an extension of the 1976 project and \$387,000. Since the approval of FY 1980 resources to finance the project extension, AID has not allocated additional resources for family planning programs in Costa Rica. The exchange rate situation, very favorable to the U.S. dollar, has allowed the Mission to extend individual project agreements until June 30, 1982, but AID support has been minimal for the last two years.

B. Other Donors

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

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

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

During the last two years, UNFPA has provided less than \$100,000 annually to support research projects carried out by OFIPLAN. None of these projects has had favorable impact on the National Population Program because they were utilized to promote the official, pronatalist views.

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

DA provides minimal support for training activities, and other donors like PIEGO and IFRP occasionally support research activities. No other donors support the Costa Rican Family Planning Program.

III. CONSTRAINTS ANALYSIS

As outlined in the Background and Problem Statement section, a number of serious constraints now limit the revitalization of the Costa Rican Family Planning Program. These include: 1.) the shortage of financial resources from both domestic and international sources, 2.) a weakened organizational capacity in the public sector and underdeveloped commercial and voluntary sectors and 3.) an inadequate legal and policy foundation for a comprehensive family planning program.

A. Financial Limitations

The major providers of funds for family planning in Costa Rica have for many years been the Government and the CCSS. Both are now under stringent financial pressure due to unprecedented levels of inflation and national debt. Cost cutting measures must be implemented if disaster is to be avoided. Obviously, funds for family planning will not be exempt from such drastic cuts. But USAID/CR thinks that both the MOH and CCSS will do everything possible to support family planning at the highest funding level possible.

Multilateral population donors such as IPPF and UNFPA have been cutting back their budgets to Latin America and the Caribbean in order to be more responsive to the tremendous needs in Africa and parts of Asia. UNFPA's reductions to LAC government programs have been dramatic, and it is unlikely that they will substantially assist the new administration's efforts to strengthen the public program, if indeed they provide any support. IPPF's reductions to private voluntary institutions in the LAC region which have been less dramatic than UNFPA's, have, nevertheless, had significant negative impact. It is anticipated that IPPF will provide a fairly constant level of US dollar support to Costa Rica over the life of this project which will, however, mean less purchasing power each year due to inflation.

AID family planning support to Costa Rica has also declined recently. In addition to this general reduction of AID support for family planning activities in Latin America and the Caribbean, AID bilateral and intermediary funds have been seriously limited by the previous government's antagonism toward family planning. In trimming its LAC budget, AID has also chosen to de-emphasize the Costa Rican program because of its relative success up until 1978. But without the help of AID during the next few years, it is unlikely that a weakened Costa Rican program could be revitalized. And several years from now Costa Rica would most likely be presented with an even bleaker demographic and financial forecast.

B. Institutional Constraints

1. Public Sector

Up until 1978, the public sector capacity to deliver family planning services had been improving steadily. Each and every year from 1968 until 1978 the public sector attracted an increasing number of new users, maintained a reasonable rate of user continuation, and expanded the number of active users (See Table 1 in Annex A). Such performance required a motivated and skilled staff, clear guidance from the program's leadership and proper supervision.

Program administrators realized in 1978 that the program could not continue to expand at such an accelerated rate. Women who had not taken advantage of the program to date would be more difficult

to attract. In a sense, the 'easier' clients had already been enrolled. Special and more costly efforts would be needed to motivate new acceptors into the program. In addition, renewed effort would be needed to retain a greater percentage of acceptors in the program. If successful, these modifications would have meant that the program would have grown but at a more modest rate than in the past decade. Unfortunately, these challenges could not be met as the program began to suffer serious attacks from the government in power from February 1978 until May, 1982.

Between 1978 and 1982 the public sector family planning program was deprived of official support. The ruling party following pronatalist policies, opposed family planning and believed that the country needed to increase its population. They made it difficult for family planning agencies to obtain funding from international organizations, such as the UNFPA. They forced the public sector to stop overt motivation programs to attract patients, e.g. no family planning posters could be placed in the health centers. They discontinued the official supply and distribution of educational materials such as pamphlets and flyers, as well as staff training in family planning. They tried to close down the private family planning association and make a political issue of family planning. Several legal cases were brought against the Family Planning Association of Costa Rica related to voluntary sterilization. However, these have since been won by the Association.

The four years of adversity has had its impact on the internal and external image of the family planning entities and on staff morale and turnover. Many well-trained and motivated personnel have left the program. The remaining staff was frustrated. New personnel did not receive the proper training and experience to deliver family planning. Basic materials, such as pamphlets, poster and films were missing. Program leadership retreated.

As a direct result of the official policies, the public program has abruptly stagnated. For several years now, the number of active users in the program has remained at approximately 125,000.

2. Private Sector

The family planning program in Costa Rica has been overly dependent on the public sector for the delivery of family planning services. The voluntary sector has unfortunately abdicated its traditional role of directly providing services. And the commercial sector has been quite passive in its efforts to market contraceptives. Because of the underdevelopment of the voluntary and commercial sectors in Costa Rica, potential users have been left quite vulnerable to capricious changes in the public sector program.

Today in Costa Rica, there are no reasonably priced alternatives to the public sector for obtaining contraceptives. Therefore, despite the change in the new government's attitude toward

family planning, its financial situation will constrain its ability to serve all the needs. A stronger voluntary and commercial sector could go a long way towards filling this gap. And, the commercial and voluntary sectors ultimately have the ability to deliver contraceptives at lower prices than the public sector. Whether clients pay directly or through their taxes for family planning services, stronger voluntary and commercial programs will reduce the overall financial burden of providing family planning.

C. Policy and Legal Constraints

Although Costa Rica made tremendous progress without an explicit population policy, the Mission believes that a population policy would have protected the family planning program from adverse official policies. ADC officials suggest that a national population policy approved by Congress would have had the legal footing to better withstand opposition. In any case, it is always better for the program to have explicit policy support from both the executive and legislative branches of government. And to date, an explicit population policy has never been issued by either branch of government.

Several existing laws limit the effectiveness of the family planning program and the ability of women to exercise their right to regulate their fertility. For one, voluntary sterilization for contraceptive purposes is illegal in Costa Rica. It is allowed only for specific medical reasons. Legal discrimination against women is another example of outdated laws which impact negatively on the family planning efforts. And, there are numerous other less dramatic, but important examples.

The Mission does not plan to be a major force behind efforts to modify existing policies and legislation; politically, it continues to be an extremely sensitive area. However, to the degree that we can support useful analytical efforts which have the potential to influence the overall policy and legal environment, we propose to judiciously support them through this project..

IV. PROJECT DESCRIPTION

This project has three major objectives:

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

Several strategies will be employed to achieve these objectives. First, to revitalize the public sector program, the project will provide support for staff training, communication and motivation activities, selected commodities and equipment, and developing an adequate

policy and legal basis for the effective delivery of family planning services.

Second, to expand the service capacity of the voluntary and commercial sectors, the project will provide funds for the initiation of a commercial retail sales program which may operate on a self-financing or profit-making basis by the end of the project.

Third, to enhance the financial self-reliance of family planning activities, the project will support the implementation of efficiency measures to cut costs and increase productivity, 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.

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

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

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

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

To fully inform the public about the renewed interest of the public sector to provide family planning will require an adequate communication program. Such a program will include posters, pamphlets,

flyers and radio announcements advertising the program's services. Because the public sector already has a significant delivery capacity in place and can expand its capacity at minimal cost, a successful communication program could immediately have major impact at modest cost. This communication effort assumes a certain latent demand for family planning which will only require informing the client about the availability of the services, not educating and motivating them about family planning. Special efforts outside the scope of this project to educate and motivate potential new users of family planning may be necessary although this target group is relatively small in Costa Rica. This more difficult task of educating and motivating new users will probably be delayed to conserve limited resources.

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

Over the next three years, the new government will be trying very enthusiastically to develop a national population policy. It is felt that such a policy, if approved by the legislature, will protect the program in the future from capricious political attacks. The Mission feels that it is particularly important to depoliticize family planning and that a technically sound population policy will help to do so. It has, therefore, decided to invest a small amount of 'insurance' money during the first three years of this project in developing a new population policy. Since Costa Rica has the technical staff and adequate data, development costs can be kept to a minimum.

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

B. Commercial Sales (Support for Innovative Initiatives)

Contraceptive Retail Sales (CRS) programs are already operating in Guatemala, El Salvador and Ecuador, just to mention a few countries in the region. Experiences to date show that CRS programs

can be an effective and efficient tool to increase contraceptive prevalence levels while reducing net costs of family planning programs. CRS programs bring the commercial and voluntary sectors of the host society to assist in implementation of family planning activities. The increased level of participation is expected to reduce or eliminate many obstacles affecting traditional programs. By increasing the number of outlets for program commodities, and by reducing the cost of those commodities, CRS programs increase availability and use of effective contraception. For all of these reasons, Costa Rica has taken the initial steps to establish a CRS program.

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

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

The Contraceptive Retail Sales (CRS) Program will expand the availability of contraceptive products, lower the price and allow patients greater freedom of movement back and forth between the commercial and public sectors according to their immediate family planning needs. Because of the financial and programmatic burden on the debt-ridden public sector and because of the tremendous upward pressure on the commercial price of imports such as contraceptives, a CRS program is especially critical at this point. A successful CRS program will also make the overall national family planning program ultimately more self reliant.

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

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

3. Increase percentage of vaginal methods delivered by commercial sector to 85 percent from a current 77 percent.

Contraceptive sales over the life of project are estimated at:

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

These sales projections will equal approximately 55 thousand person years of protection over the life of project. And, by the end of the project, the recurring cost per couple year of protection is estimated at US \$9.00. This cost compares favorably with the standard cost per couple year of protection in Latin America for an efficient urban clinical FP program which is US \$50.00. The project will also be recovering 53 percent of its total cost by the end of the project.

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

The CRS program will use existing commercial distribution channels and methods. Since the retailers, wholesalers and distributors will earn a fair margin by commercial standards, a continuous flow of contraceptives will be assured. The CRS program will be promoted by the local media and point-of-service displays, posters and pamphlets.

While ultimate goal of this CRS component is to become completely self-sustaining at some point, a specific time table will be developed during PP preparation. If satisfactory sales targets can be attained and the price of contraceptives remains approximately the same to the local executing organization in 1987 as they will be to AID in bulk purchase (a fairly reasonable assumption), the Costa Rican CRS initiative has the potential to achieve this goal.

To launch the CRS program will require both quantitative and qualitative market research leading to a full marketing plan. Such a plan will set target markets, product concepts, and marketing strategies for each product. A local advertising firm will then be contracted to

implement a publicity campaign which will include radio and television spots (which are quite inexpensive in Costa Rica at this time) and point-of-purchase posters, stickers and displays. After the initial launch of the publicity campaign, maintenance advertising will continue over the life of project, based on continuous monitoring of customer behavior.

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

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

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

The implementing agency (ASDECOSTA) will provide warehousing, office space, accounting services, and clerical support at a reasonable overhead rate. Legal counsel will help throughout the project to ensure the proper procedures are followed with regard to registration, importation, advertising and sales.

C. Self-Reliance

Program self-reliance will be an important determinant of how and when AID family planning assistance to Costa Rica is terminated. While the majority of program costs have already been assumed by local organizations with local funds, one must ask at what price? Yes, local funds are covering nearly all the costs of the CCSS and MOH programs which provide 75 percent of all family planning services in the nation. But again, at what price? Are there not significant cost-cutting and efficiency measures which could be implemented to reduce the public's tax burden to obtain such services? Are there not commercial distribution systems which can deliver family planning to the public at much lower cost than the public sector's clinical program? Are there not many means for family planning programs to recover much, if not all, of the cost to deliver the services without relying so heavily on the costly public sector program? The presumed answers to these questions have led the Mission to propose several extremely important and innovative activities under this project.

First, the Mission will provide the public sector with expert tech-

nical assistance to implement efficiency measures which will increase productivity and reduce costs. At the beginning of the project a basic needs assessment will be carried out by a team of management experts who will concentrate exclusively on the family planning program. Within this limited scope, they will, for example, recommend ways to improve worker productivity, contraceptive procurement and management information systems.

Second, the project will work with the private Family Planning Association of Costa Rica (ADC) affiliated with the International Family Planning Federation to introduce fee-for-services and the sale of contraceptives into all appropriate activities. In addition, the ADC will be helped to improve its local fund raising capacity by encouraging the expansion of activities such as membership fees, voluntary contributions and special events.

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

In summary, the Mission judges that by supporting the revitalization of the public program, the substantial expansion of the commercial sales, and the means toward program self-reliance, AID can phase out its bilateral family planning assistance to Costa Rica, confident in a strong and stable program which can service the vast majority of the need.

D. Complementary Intermediary Support

The Mission bilateral strategy will require complementary support from AID intermediaries. The intermediary programs have recognized special expertise which can more efficiently carry out elements of the program necessary for Costa Rica.

With regard to service delivery, the Mission expects AVS and PIEGO to support both public and private sector health personnel to carry out the ongoing activities in their field of expertise. USAID believes that direct involvement with these programs is not desirable. The Mission will rely on Pathfinder and FPIA to develop innovative service projects with CIF, COF, CLI, ADC and other private groups. Their special talents and careful attention will ensure success of experimental efforts. The Mission will require the technical and management assistance of DA to design and implement the training element of this bilateral project. CDC, CRS, and IEC intermediary contracts will be relied on to provide needed technical assistance in logistics, commercial sales and communications, respectively. IFRP and RAPID II (if this project can be implemented to meet Costa Rican needs) will be encouraged to provide small amounts of assistance for specialized research studies and the application of micro-computers to program implementation. CPS will be required to carry out contraceptive prevalence surveys in 1984 and 1988 to assess and design service programs. UNFPA contraceptives are urgently needed to complement AID's capabilities in this area. And, last but not least, IPPF must provide a continual and adequate level of basic core support and contraceptives as well as project funds for strategic activities.

Table I provides the Mission estimates of the level of support required from the various international family planning organizations over the next three years. It is not possible at this time to provide estimates beyond three years. Each year the Mission plans to provide a rolling estimate for the following three years to ensure the strategic participation of these important organizations.

Table I
ESTIMATED INTERMEDIARY REQUIREMENTS
FOR COSTA RICA, 1982 THROUGH 1984
(\$US 000s)

<u>PROGRAM</u>	<u>1982</u>	<u>1983</u>	<u>1984</u>
AVS	-	50	50
PATHFINDER	25	25	25
FPIA	22	22	22
IFRP	20	20	20
DA	18	16	13
CPS	-	-	75
IEC	20	20	20
CRS	20	20	20
PIEGO	15	15	15
PIP	23	23	23
RAPID II	10	10	10
CDC	10	10	10
IPPF	368	400	425
UNFPA	75	75	75
<hr/>			
TOTAL	625	706	803

V. Beneficiaries

The direct beneficiaries of this project will be the estimated 250,000 married women of fertile ages who will actively be using contraceptives in Costa Rica by the year 1987. This represents a 25 percent increase over five years (five percent per annum) in overall service capacity from the current 200,000 active users today. By the end of the project, prevalence will increase from 65 percent of the married women in Costa Rica to 70 percent. It is anticipated that separated, divorced, widowed and single women wishing to use contraceptives will also benefit from increased availability and lower prices although exact data are not and will not be available to estimate the number of beneficiaries.

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

Many clients are now unnecessarily forced to use the clinic-based services in the CCSS, for example, for condom re-supply. Such clients will no longer need to wait long hours or be turned away because of stock-outs in the public program. The expansion of the commercial sector and the lowering of prices will help tremendously to reduce this problem.

VI. IMPLEMENTATION PLAN AND INSTITUTIONAL ANALYSIS

Several key institutions in Costa Rica have demonstrated their abilities to implement successfully a wide variety of family planning activities and to serve a remarkable percentage of the clients in need. Prior to 1978, the FP program in Costa Rica was an exemplary model worldwide.

A. Public Sector Delivery System

Three key institutions participate directly in the public service delivery system : the MOH, Social Security and the ADC. And, until 1978, they were able to expand deliberately and consistently without sacrificing service quality. Unfortunately, during the past four years, the political environment vis-a-vis family planning deteriorated and program expansion stopped. Despite this serious impediment, these three institutions maintained their service capacity at approximately 200,000 active users. It is fully expected that with an improved political environment, they will regain their leadership status both regionally and worldwide. The Mission plans to continue to work with these three experienced and tested institutions.

Obviously, each of these institutions is today faced with financial and management problems. Some of these problems will have to be addressed before PP approval. For example, how seriously will the financial constraints of the MOH and CCSS limit their abilities to deliver family planning? Will there be any serious staff cutbacks? If not, it is expected that the implementation of this project will move along relatively smoothly.

The CCSS system will be asked to utilize its proven training capacity to instruct and motivate both MOH and CCSS personnel. The CCSS staff in some 50 service centers and MOH's 780 health promoters will participate in this project's training program. A consulting firm, will help the Mission to design and execute the training program. At the same time, the ADC will provide several kinds of services to MOH and CCSS service points: communication support, data analysis, and logistical support with AID funding and contraceptives with IPPF funding. ADC has experience and proven abilities in these areas. For example ADC can design and manufacture new posters, pamphlets and radio spots announcing in a sensitive manner the revitalization of the national program. It can monitor the national program by analyzing various data sources and can provide detail men and transport to supply the MOH and CCSS with contraceptives. No major organizational changes will be needed for the ADC to carry out these activities.

B. Commercial Sales

The major institutional weakness in the family planning program has been the deficient delivery capacity of the commercial sector. Indeed, it was left relatively dormant while the program's leadership concentrated on the public sector. Now the leadership has recognized the problem and is very interested in developing the potential of the commercial sector. To this end, the ADC has established a sister organization to sell contraceptives through commercial channels. The new organization, ASDECOSTA, will have the ability to enter into a variety of commercial ventures including the ones proposed in this project. ASDECOSTA can potentially combine family planning experience with commercial expertise.

Several successful drug distributors, market research companies and advertising firms exist in Costa Rica. Their expertise could greatly assist in the marketing of contraceptive products. It is anticipated that the executing agency will be able to contract these professional services at a reasonable cost. As mentioned earlier, during project implementation, the Mission will rely on experienced S&T/POP contractors to monitor and guide efforts in this area.

C. Self-reliance

To provide the technical assistance required to improve self-reliance, i.e. increased productivity and income-generating abilities, the Mission will be able to select from a number of experienced institutions and/or individuals. With the magnitude of work rather small, perhaps the Mission will employ personal-service contracts with the best management consultants available, including INCAE faculty.

VII. PRELIMINARY FINANCIAL PLAN

The financial plan estimates the following levels of AID funding by objective and by year:

ESTIMATED AID SUPPORT BY OBJECTIVE AND YEAR*
(US \$000s)

	<u>1983</u>	<u>1984</u>	<u>1985</u>	<u>1986</u>	<u>1987</u>	<u>Total</u>
<u>Public Sector</u>						
Training	65	65	65	-	-	195
Communication	65	50	40	20	-	175
Logistics	75	70	70	60	60	335
Equipment	10	5	5	-	-	20
Policy Analysis	20	20	20	20	20	100
<u>Administration</u>	<u>45</u>	<u>40</u>	<u>40</u>	<u>20</u>	<u>15</u>	<u>160</u>
Subtotal	280	250	240	120	95	985
<u>Commercial Sales**</u>						
Market Research	10	5	5	5	5	30
Advertising	80	80	60	50	40	310
Products	50	50	50	50	50	250
Packaging	25	25	25	25	25	125
Legal Counsel	2	2	1	1	1	7
Personnel	15	15	15	15	15	75
<u>Administration</u>	<u>33</u>	<u>32</u>	<u>30</u>	<u>25</u>	<u>25</u>	<u>145</u>
Expenses	215	209	186	171	161	941
<u>(Income)</u>	<u>-</u>	<u>(72)</u>	<u>(75)</u>	<u>(80)</u>	<u>(85)</u>	<u>(312)</u>
Subtotal	215	137	111	91	76	630
<u>Self Reliance</u>						
Technical Asst.	50	50	45	40	30	215
<u>Special Projects</u>	<u>25</u>	<u>25</u>	<u>25</u>	<u>20</u>	<u>10</u>	<u>105</u>
Subtotal	75	75	70	60	40	320
SUBTOTAL	570	462	421	271	211	1935
<u>Inflation and Contingency (10%)</u>						
	<u>-</u>	<u>45</u>	<u>45</u>	<u>35</u>	<u>30</u>	<u>155</u>
GRAND TOTAL	570	507	466	306	241	2090

* Projection is preliminary and will be refined when initial market research is complete.

**During PP preparation, special attention will be given to budgeting TA, training and other resources to contribute to project self sufficiency as soon as possible.

ESTIMATED GOCR SUPPORT BY OBJECTIVE AND YEAR

(U. S. \$000s)

<u>CCSS</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>	<u>1986</u>	<u>1987</u>	<u>Total</u>
Service Delivery	80	80	90	95	100	445
Commodities	--	--	10	10	15	35
<u>MOH</u>						
Service Delivery	<u>15</u>	<u>15</u>	<u>25</u>	<u>30</u>	<u>35</u>	<u>120</u>
Total	95	95	125	135	150	600

ESTIMATED IPPF SUPPORT TO ADC BY OBJECTIVE AND YEAR

(U. S. \$000s)

	<u>1983</u>	<u>1984</u>	<u>1985</u>	<u>1986</u>	<u>1987</u>	<u>Total</u>
Administration/ Operation	150	150	125	125	125	675
Commodities	300	250	225	175	125	1075

The preliminary financial plan calls for the following levels of support to recipient institutions each year:

ESTIMATED AID SUPPORT BY RECIPIENT INSTITUTION AND YEAR

(US \$000s)

<u>Institution</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>	<u>1986</u>	<u>1987</u>	<u>Total</u>
Social Security	210	188	180	90	70	738
MOH	70	62	60	30	25	247
Commercial Firm	215	137	111	91	76	630
Mgmt Consultants	75	75	70	60	40	320
Inflation/Conting.	-	45	45	35	30	155
TOTAL	570	507	466	306	241	2090

It is important to clarify that the ADC will be receiving AID funds under this project to provide several of the above agencies with various services. Nevertheless, the above table attributes the value of these services to the organization which will receive them. Depending on decisions yet to be made on how to contract this work, the support to ADC for these services will vary. At one extreme, ADC could manage the entire project. In other words, ADC would provide or contract for:

(1) all training, communication logistics, policy

analysis, and equipment for the public sector MOH and CCSS components; (2) all professional services of the commercial firm(s) for the CRS program including a subcontract with ASDECOSTA, if appropriate; and (3) all management assistance related to improving self-reliance. ADC would probably require approximately a 20 percent overhead to do so. This overhead rate has been included in the budget. At the least, the Mission will probably decide to contract with the ADC for communications, logistics, and policy analysis in support of the public sector delivery program.

VIII. ISSUES

1. Does ASDECOSTA have the institutional capacity to keep up with rapidly changing market conditions, consumer preferences and the effects of three-digit inflation? Is the CRS program viable?

2. Given the national economic crisis, and other priority concerns, is the GOCR willing to risk the support of some sectors of society to defend the National Family Planning Program?

3. Will intermediaries in fact be able to supply the support envisioned in this project?

IX. PROJECT PAPER PREPARATION PLAN

The following persons comprise the Project Development Committee:

Carlos Poza	Title: USAID/CR Project Officer, General Development Division
Thomas Mckee	General Development Officer
Owen Lustig	Program Officer
G. Franklin Latham	Controller

Reviewing officers will be:

Daniel A. Chaij	Mission Director
Bastiaan Schouten	Assistant Mission Director

TDY assistance from AID/W will be provided by Robert B. Corno to finalize the PP.

A Mission or Rocap economist will do the PP's Economic Analysis.

ADC and CCSS will present detailed draft work plans resulting from on-going negotiations following review of PID by AID/W.

The Mission requires the following technical assistance for PP development:

TECHNICAL ASSISTANCE PLAN FOR
PP PREPARATION

<u>Activities</u>	<u>Organization/ individual</u>	<u>When</u>	<u>Funding Source</u>	<u>Duration (wks)</u>	<u>\$</u>
Training Need Assessment (CCSS)	DA	Completed	S&T	1	2000
Design Communication Act. (CRS)	PSC/IPPF/AIDW	Aug/Sept.	PDS	2	3500
Commodity Handling (CCSS-ADC)	CDC	Aug/Sept.	S&T	1	2000
Policy Analysis Plan (ADC)	ADC	Aug/Sept.	ADC	2	500
Market Research (CRS)	Futures	September	S&T	8	10000
Legal Issues (CRS)	Futures	September	S&T	4 (4 days)	1000
CRS Design	Futures	Aug/Sept.	S&T/PDS	2	3500
Self-reliance Proposal (ADC)	PSC/IPPF	September	PDS	2	2000
PP Finalization (USAID/CR)	AID/W	O/Nov.	OE	2	3500

The project paper (PP) completion date is now scheduled for Oct/Nov. 1982.
Mission level approval of PP is planned.

AID 1020-28 (1-73)
SUPPLEMENT 1

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

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

Life of Project:
From FY 83 to FY 87
Total U.S. Funding \$2,090,000
Date Prepared: July 1, 1982

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

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Program or Sector Goal: The broader objective to which this project contributes: (A-1)</p> <p>Promote socioeconomic development and satisfy basic human needs of the Costa Rican poor by increasing access to family planning services and information.</p>	<p>Measures of Goal Achievement: (A-2)</p> <p>Decrease of birth rate from 29 to 25 per 1,000 by end of project.</p>	<p>(A-3)</p> <p>Contraceptive Prevalence Surveys to be carried out in 1984 and 1988.</p>	<p>Assumptions for achieving goal targets: (A-4)</p> <p>Costa Ricans continue perceiving the importance of family planning as a basic human need.</p>

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY 83 to FY 87
Total U.S. Funding \$2,090,000
Date Prepared: July 1, 1982

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

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Project Purpose: (B-1)</p> <p>The purpose of this project is to revitalize and expand family planning services through public, private and commercial sector activities.</p>	<p>Conditions that will indicate purpose has been achieved: End-of-Project status (B-2)</p> <p>1) Current family planning users in activities funded by the project increase from 200,000 to 250,000.</p>	<p>(B-3)</p> <p>1) Contraceptive Prevalence Surveys, 1984 and 1988.</p> <p>2) Service statistics by private and public sector participating institutions</p>	<p>Assumptions for achieving purpose: (B-4)</p> <p>1) The new GOCR administration continues to support family planning programs and activities.</p> <p>2) Other donor participation minimize impact of GOCR's financial constraints on family planning activities.</p> <p>3) Effective coordination established between the MOH, CCSS, the private and commercial sectors on family planning activities.</p> <p>4) Spread between rural and urban acceptance levels (currently 90-95%) will be maintained or reduced.</p>

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY 83 to FY 87
Total U.S. Funding \$2,090,000
Date Prepared: July 1, 1982

AID 1020-28 (11-73)
SUPPLEMENT 1

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

PAGE 3

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

AID 1020-28 (1-73)
SUPPLEMENT 1

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY 83 to FY 87
Total U.S. Funding \$2,090,000
Date Prepared: July 1, 1982

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

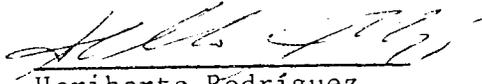
PAGE 4

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Inputs: (D-1)	Implementation Target (Type and Quantity) (D-2) (\$ US 000s)	(D-3)	Assumptions for providing inputs: (D-4)
AID contribution	AID - to:	Review of project's financial records. AID project agreements and other donor project agreements.	Inputs are made in a timely fashion. Continued or increased other donor capacity and willingness to meet commitments.
GOCR contribution	Public Sector 985		
<u>Other Donors</u>	Commercial Sales 630		
IPPF	Self Reliance 320		
	Contingency 155		
	Total: 2,090		
	GOCR -		
	Service Delivery 565		
	Commodities 35		
	IPPF -		
	Administrative		
	Support 675		
	Commodities 1,075		

INITIAL ENVIRONMENTAL EXAMINATION

PROJECT LOCATION: Costa Rica
PROJECT TITLE: Family Planning Self-Reliance
FUNDING: FY 1983 to 1987 Grant \$2,210,000
LIFE OF PROJECT: Four (5) years

IEE PREPARED BY:

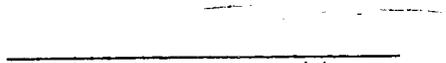

Heriberto Rodríguez
USAID/General Engineer

DATE: July , 1982

ENVIRONMENTAL ACTION

RECOMMENDED: That the project will not have a significant effect on the environment and therefore a negative determination is appropriate.

CONCURRENCE:


Daniel A. Chaij
Mission Director
USAID/Costa Rica

DATE: July , 1982

PROJECT DESCRIPTION

The goal of the project is to promote socioeconomic development and satisfy basic human needs of the Costa Rican poor by increasing access to family planning services and information.

The purpose is to revitalize and expand family planning services, through public, private and commercial sector activities.

This project has three major objectives:

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

Several strategies will be employed to achieve these objectives. First, to revitalize the public sector program, the project will provide support for staff training, communication and motivation activities, selected commodities and equipment, and developing an adequate policy and legal basis for the effective delivery of family planning services.

Second, to expand the service capacity of the voluntary and commercial sectors, the project will provide funds for the initiation of a commercial retail sales program which may operate on a self-financing or profit-making basis by the end of the project.

Third, to enhance the financial self-reliance of family planning activities, the project will support the implementation of: efficiency measures to cut costs and increase productivity, 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.

IMPACT IDENTIFICATION AND EVALUATION FORM

Impact
Identification
and Evaluation^{2/}

Impact Areas and Sub-Areas^{1/}

A. LAND USE

- 1. Changing the character of the land through:
 - a. Increasing the population ----- M
 - b. Extracting natural resources ----- N
 - c. Land clearing ----- N
 - d. Changing soil character ----- N
- 2. Altering natural defenses ----- N
- 3. Foreclosing important uses ----- N
- 4. Jeopardizing man or his works ----- N
- 5. Other factors
- _____
- _____

B. WATER QUALITY

- 1. Physical state of water ----- N
- 2. Chemical and biological states ----- N
- 3. Ecological balance ----- N
- 4. Other factors
- _____
- _____

1/ See Explanatory Notes for this form.

2/ Use the following symbols: N - No environmental impact
L - Little environmental impact
M - Moderate environmental impact
H - High environmental impact
U - Unknown environmental impact

IMPACT IDENTIFICATION AND EVALUATION FORM

C. ATMOSPHERIC

- 1. Air additives ----- N
- 2. Air pollution ----- N
- 3. Noise pollution ----- N
- 4. Other factors
- _____
- _____

D. NATURAL RESOURCES

- 1. Diversion, altered use of water ----- N
- 2. Irreversible, inefficient commitments ----- N
- 3. Other factors
- _____
- _____

E. CULTURAL

- 1. Altering physical symbols ----- L
- 2. Dilution of cultural traditions ----- M
- 3. Other factors
- _____
- _____

F. SOCIOECONOMIC

- 1. Changes in economic/employment patterns ----- L
- 2. Changes in population ----- M
- 3. Changes in cultural patterns -----
- 4. Other factors
- _____
- _____

IMPACT IDENTIFICATION AND EVALUATION FORM

G. HEALTH

- | | |
|---|------------------|
| 1. Changing a natural environment ----- | <u> N </u> |
| 2. Eliminating an ecosystem element ----- | <u> N </u> |
| 3. Other factors | |
| _____ | _____ |
| _____ | _____ |

H. GENERAL

- | | |
|---------------------------------|------------------|
| 1. International impacts ----- | <u> N </u> |
| 2. Controversial impacts ----- | <u> N </u> |
| 3. Larger program impacts ----- | <u> N </u> |
| 4. Other factors | |
| _____ | _____ |
| _____ | _____ |

I. OTHER POSSIBLE IMPACTS (not listed above)

_____	_____
_____	_____
_____	_____

ANNEX A

TABLE I

	Exposed to risk of pregnancy	New Users		Eligible Women that have not joined the program	New Users as a per- centage of amount eligible
		Annual Number	Accumulated Total		
1968	223.324	9.678	9.581	223.324	4.3
1969	231.247	11.931	21.201	221.666	5.4
1970	239.451	19.246	39.831	218.250	8.8
1971	248.908	25.720	64.497	209.077	12.3
1972	258.739	26.718	89.658	194.242	3.9
1973	268.959	29.976	116.650	179.301	16.2
1974	279.582	25.834	139.893	162.932	15.8
1075	290.624	31.010	167.795	150.731	20.6
1976	302.476	28.798	192.949	134.681	21.4
1977	314.812	22.641	211.504	121.863	18.6
1978	327.651	22.365	229.416	116,147	19.2

TABLE II

NUMBER OF COSTA RICAN WOMEN 15-49 CURRENTLY IN UNION WHO ARE USING FOUR MAJOR METHODS OF CONTRACEPTION, BY METHOD AND PLACE OBTAINED (000s)

Method	Total	PUBLIC SOURCE				PRIVATE SOURCE				
		Total Public	SS	MOH	Drugstore w/coupon	Total Priv.	Drugstore w/o coupon	Priv. Clinic	Priv. M.D.	Other
Pill	65	50	30	14	6	15	13	-	2	-
IUD	18	13	8	5	-	5	--	3	2	-
Condom	26	14	9	5	-	12	11	-	-	1
Sterilization	56	51	50	1	-	5	--	5	-	-
Total	165	128	97	25	6	37	24	8	4	1

SS - Social Security
 MOH- Ministry of Health
 Drug. w/ coupon - Drugstore with coupon
 Drug. w/o coupon - Drugstore without coupon
 Priv. Clin. - Private Clinic
 Priv. M.D. - Private Doctor