

**MIDTERM EVALUATION OF THE
ECUADOR HEALTH AND FAMILY
PLANNING PROJECT
(518-0084)**

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TABLE OF CONTENTS

ABBREVIATIONS.....	v
EXECUTIVE SUMMARY.....	vii
1. INTRODUCTION.....	1
1.1 Overview of the Project.....	1
1.2 Population Policy in Ecuador.....	4
1.3 Trends in Fertility and Contraceptive Use.....	5
2. METHODOLOGY OF THE EVALUATION.....	7
3. USAID MANAGEMENT.....	9
4. DONOR COORDINATION.....	11

TABLES AND GRAPHS

Graph 1	Trends in all Method Contraceptive Prevalence Rate, 1979-1994.....	13
Graph 2	Total Fertility Rate Over Time, 1965-1994.....	14
Table 1	Tasas Especificas de Fecundidad por Edad (por 1000 Muderes) y Tasa Global de Fecundidad (TGF) Para el Periodo 1989-1994 (*).por Dominios de Estudio y Caracteristicas Seleccionadas: Mujeres de 15 A 49 Años de Edad.....	15
Table 2	Desired End of Project Status*.....	17
Table 3	Planned Success Indicators for Public Sector Institutions Included in the USAID Grant Agreement with the GOE.....	18
Table 4	Tendencia de la Prevalencia del Uso de Metodos Anticonceptivos en el Ecuador. Segun Caracteristicas Seleccionadas: Mujeres Casadas/Unidas de 15 A 49 Años de Edad.....	19
Table 5	Fuente de Obtencion de Metodos Modernos Segun Region y Lugar de Residencia y Metodo: Mujeres que Usan Anticonceptivos Modernos de 15 A 49 Años de Edad.....	20
Table 6	Razon Para no Usar Anticonceptivos. Por Area y Region: Mujeres Casadas/Unidas que no Usan Anticonceptivos de 15 A 49 Años de Edad.....	22

APPENDICES

- A. Evaluation Scope of Work
- B. List of Contacts
- C. Bibliography
- D. Methodology for the Analysis of Cost Recovery and Sustainability by APROFE and CEMOPLAF
- E. Checklists and questionnaires Used to Assess Quality of Care
 - "Learning Guide for IUD Counseling Skills" (pp. 25-26) and "Learning Guide for IUD Clinical Skills" (pp. 27-30), JHPIEGO IUD Course Handbook, March 1993.
 - "Observation Checklist for Interaction between New Family Planning Client and Service Provider" (pp. 45-51), JHU/PCS and Family Planning Association of Kenya, 1992.
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 - List of questions, p. 20, Seccion 6: Prevencion de Infecciones, version preliminar, AVSC, 1993.
- F. Supervisory Checklist for APROFE's Department of Operations
- G. Supervisory Checklist for Information and Education of CEMOPLAF's Department of Education
- H. CEMOPLAF's Self-Study Continuing Education Course for Counselors, Department of Education
- I. Infection Prevention in Family Planning Service, pp. 31, 38-41, Prevencion de Infecciones, JHPIEGO, 1991.
- J. DNMS/IESS Training Courses Held
- K. DNMS/IESS, List of Planned Training Session for Staff of Health Dispensaries of Private Companies
- L. Elements of a Formal Exoneration System
- M. Technical Assistance of JHU/PCS
- N. Ministerio de Finanzas, Ayuda Memoria, December 1994

ANNEXES

- 1. Evaluation of APROFE Activities under the Evaluation of the Ecuador Health and Family Planning Project

TABLES ANNEX 1

Table 1-1	Total Population and Women of Reproductive Age by Province and the Number of APROFE and CEMOPLAF Clinics Located in the Provinces	1-38
Table 1-2	Overview of APROFE'S Service Delivery Network and Services Provided 1991-1994.....	1-39
Table 1-3	Overall Cost Recovery Benchmarks	1-40

Table 1-4	Estimated Overall Levels of Cost Recovery.....	1-40
Table 1-5	Service Center Cost Recovery Benchmarks.....	1-41
Table 1-6	APROFE Support Service Cost Recovery.....	1-41
Table 1-7	Support Service Revenues as Percentage of all Internal Revenues.....	1-42
Table 1-8	Revenues from Support Services as Percentage of Support Service Costs.....	1-42
Table 1-9	Trends in Key Program Variables.....	1-43
Table 1-10	Utilization of Clinical Services at APROFE.....	1-43
Table 1-11	Overview of APROFE'S IEC Programs.....	1-44
Table 1-12	APROFE: New Users by Method.....	1-45
Table 1-13	Prices for Selected Family Planning Services at APROFE Clinics (SUCRES).....	1-45

2. Evaluation of CEMOPLAF Activities under the Evaluation of the Ecuador Health and Family Planning Project

TABLES ANNEX 2

Table 2-1	Overview of CEMOPLAF's Service Delivery Network and Services Provided 1991-1994.....	2-38
Table 2-2	Overall Cost Recovery Benchmarks.....	2-39
Table 2-3	Estimated Overall Levels of Cost Recovery.....	2-39
Table 2-4	Service Center Cost Recovery Benchmarks.....	2-40
Table 2-5	CEMOPLAF Support Service Cost Recovery.....	2-40
Table 2-6	Support Service Revenues as Percentage of all Internal Revenues.....	2-41
Table 2-7	Revenues from Support Services as Percentage of Support Service Costs.....	2-41
Table 2-8	Trends in Key Program Variables.....	2-42
Table 2-9	Overview of CEMOPLAF'S IEC Programs.....	2-43
Table 2-10	CEMOPLAF: New Users by Method.....	2-44
Table 2-11	Prices for Selected Family Planning Services at CEMOPLAF Clinics (Sucres).....	2-44
Table 2-12	Total Population and Women of Reproductive Age by Province AND the Number of APROFE and CEMOPLAF Clinics Located in the Provinces.....	2-45

3. Evaluation of the Non-project Assistance Component of the Ecuador Health and Family Planning Project

TABLES ANNEX 3

Table 3-1	Budgets and Disbursements for NPA by Institution(in Dollars and 000 Sucres).....	3-28
Table 3-2	Planned Success Indicators for Public Sector Institutions Included in the USAID Grant Agreement with the GOE.....	3-29

Table 3-3	Disbursements, Expenditures, and Amount Remaining by Institution (in 000 Suces) as of June 30, 1994	3-30
Table 3-4	Fuente de Obtencion de Metodos Modernos Segun Region Y Lugar de Residencia Y Metodo: Mujeres Que Usan Anticonceptivos Modernos de 15 A 49 Años de Edad.....	3-31
Table 3-5	Percent of all Users of Contraception who Cite the MSP as their Method Source	3-33
Table 3-6	Percent of all Users of Specific Methods who Cite MSP as their Method Source (1994)	3-33
Table 3-7	MSP Service Coverage for Selected Provinces by Type of Care 1989.....	3-34
Table 3-8	Percent of Married Women, Ages 15-49 Who are Using Contraception in 1994 for Four MSP Target Provinces.....	3-34
Table 3-9	Summary of Contraceptive Commodities Provided to DNMS/IESS by USAID 1992-1994 (US\$)	3-35
Table 3-10	Summary of Contraceptive Commodities Provided to Seguro Social Campesino by USAID 1992-1994 (US\$)	3-36
Table 3-11	Number of Visits for Selected Maternal and Family Planning Services at the SSC Dispensaries 1990-1993.....	3-36

ABBREVIATIONS

APROFE	Asociacion de Pro-Bienestar de la Familia Ecuatoriana
AVSC	Association for Voluntary Surgical Contraception
CBD	community-based distribution/distributor
CDC	Centers for Disease Control and Prevention
CEMEIN	State Center of Medicines and Medical Insumos
CEMOPLAF	Centro Medico de Orientacion y Planificacion Familiar
CEPAR	Centro de Estudios y Paternidad Responsable
CONADE	National Development Council
DNMS	Direccion Nacional Medico Social
EOPS	End of Project Status
ESF	Economic Support Fund
GOE	Government of Ecuador
HMO	health maintenance organization
KAP	knowledge, attitudes, and practice
ICPD	International Conference on Population and Development
IEC	Information, Education, and Communication
IESS	Instituto Ecuatoriano de Seguridad Social (Social Security Institute)
INOPAL	Operations Research in Family Planning and Maternal-Child Health for Latin America and the Caribbean Project
IPC	Interpersonal Communications
IPPF	International Planned Parenthood Federation
IUD	intrauterine device
JHU/PCS	Johns Hopkins University Population Communication Services
MOF	Ministry of Finance
MSP	Ministry of Public Health
NPA	Non-project Assistance
NPC	National Population Council
OB/GYN	doctor of obstetrics and gynecology
PACD	project assistance completion date
PFA	Patient Flow Analysis
PIC	Program Implementing Committee
PID	pelvic inflammatory disease
PP	Project Paper
PVO	Private Voluntary Organization
RTI	reproductive tract infection
S/	sucre (Ecuadorian currency)
SSC	Seguro Social Campesino
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
World Bank	International Bank for Reconstruction and Development

EXECUTIVE SUMMARY

Introduction

The midterm evaluation of The Ecuador Health and Family Planning Program (518-0084) was carried out by a four-person team between October 21 and November 10, 1994. The evaluation assessed the progress of two private voluntary organizations (PVOs) (Asociacion de Pro-Bienestar de la Familia Ecuatoriana [APROFE] and Centro Medico de Orientacion y Planificacion Familiar [CEMOPLAF]) in their efforts to increase cost recovery and achieve sustainability. It also assessed the two organizations' information, education, and communication (IEC) programs and the quality of care provided at their clinics. Finally, the evaluation examined progress in the Non-project Assistance (NPA) component of the bilateral that is being implemented by five Government of Ecuador (GOE) ministries.

The Ecuador Health and Family Planning Program is a six-year program (1991-1997) to increase the use, effectiveness, and sustainability of family planning services in Ecuador. The program was authorized in August 1991 with a budget of US\$10.5 million and was amended in January 1994 to increase the budget to US\$15 million.

The program contains both Project and Non-project Assistance. The budget for the Project Assistance is US\$12.5 million, and it includes funding for PVO family planning service delivery and institutional support as well as technical assistance and purchase of contraceptive commodities. The budget for the Non-project Assistance is US\$2.5 million. There is also an Economic Support Fund (ESF) component that funds activities of Centro de Estudios y Paternidad Responsable (CEPAR) and the Vicariate of Esmeraldas and the Archbishopric of Cuenca, however, these activities were not included in the Scope of Work for this evaluation.

USAID Program Strategies and Support

USAID has been providing assistance to develop family planning services in Ecuador over the past 30 years. This assistance has supported efforts of the private sector and the GOE to expand access to family planning with impressive results. Family planning in Ecuador is widely considered to have advanced to the level of a moderately strong program. The family planning program effort coupled with Ecuador's upper-middle socioeconomic setting are associated with a substantial decline of about 30% in fertility between 1975 and 1990.¹

Given the relatively mature nature of the family planning programs in Ecuador, USAID embarked on the current program not only to continue the progress that had been made, but pursue a number of challenging objectives. As part of a global USAID emphasis on sustainability, the USAID Mission in Ecuador determined that the two major PVO providers, APROFE and CEMOPLAF, were poised to "graduate" from being donor-sustained organizations and to become financially independent. They were both important providers of family planning services, had a solid user based, and had

¹W. Parker Mauldin and John A. Ross, "Family Planning Programs: Efforts and Results, 1982-1989," Studies in Family Planning, Vol 22, No. 6, Nov/Dec 1991.

sufficiently well-developed organizational capabilities. In addition, both organizations were already recovering about a quarter of their operating costs. The project assistance component of the current USAID program was then developed, in large measure, to provide transitional support to APROFE and CEMOLAF in order to increase their cost recovery levels while maintaining good quality services and existing clients and attracting new clients.

The objectives set out in the current Ecuador Health and Family Planning Program all underscore the confidence that USAID had in the abilities of the two principal PVOs and the GOE. Table 1 demonstrates clearly that progress continues. Between 1989 and 1994, the fertility rate declined further from 3.8 to 3.6. In the same period, the use of modern contraceptive methods increased from 53% to 57% nearly reaching the end of project target three years early. Cost recovery for the PVOs is on target with the original end of project targets. Only in the area of expanded delivery of services through the public sector is progress not what was anticipated.

The Ecuador Health and Family Planning Program has three strategies for achieving its purposes. Under each is a description of what has been supported by USAID and/or what was anticipated.

1. Ensuring PVO sustainability at APROFE and CEMOPLAF through a) cost-recovery strategies to enable cross subsidies; b) a capital fund for each institution; and c) institutional, strategic, and financial planning to develop a more entrepreneurial approach to family planning service delivery.

The objective of cross subsidies is to improve the income generating capability of APROFE and CEMOPLAF. The USAID program has supported both organizations' expansion of non-family planning service activities such as laboratory services, pharmacies, and maternal and child health services (immunizations, pediatric care, etc.). The program has funded the purchase of medical equipment for the labs, the initial stocking of essential drugs, as well as specialized surgical equipment and materials. The second element of sustainability, a capital fund for each PVO, was just being established at the time of the evaluation and could not be evaluated. The third element of institutional, strategic, and financial planning has been pursued as part of the cost recovery efforts.

2. Improving service delivery by increasing access to services for key target populations (rural areas primarily through public sector institutions [MSP and IESS] [see No. 3 below]); in urban areas through the PVOs and commercial entities to reach young couples with temporary methods; and to contraceptives used by men.

The program has supported the operations of the two PVOs' existing field staff and expansion of services. A key element of this strategy has been the development of communications programs to generate demand among young couples and men and also for temporary and modern methods of contraception. Further, it was expected that APROFE and CEMOPLAF would continue to assure high-quality services through their service delivery networks. With the emphasis on sustainability, it was anticipated that the support for operations would gradually diminish and be fully covered by own-income revenues by the end of the project.

In order to expand PVO services, the USAID program has supported a) an increased variety of contraceptives including the initial introduction of Depo-Provera and NORPLANT®; b) technical assistance in IEC; and c) contraceptive procurement.

3. Improving public sector policies by providing Non-project Assistance (NPA) to five public institutions to bring about policy changes and more active support for family planning. These institutions are the National Development Council (CONADE), the Ministry of Public Health (MSP), the two parts of the Social Security Institute (IESS)—the Dirección Nacional Médico Social (DNMS) and the Seguro Social Campesino (SSC)—and the Ministry of Finance (MOF).

The NPA was designed to condition specific policy changes by the GOE in exchange for financial support to five public institutions. It was assumed that these policy changes would result in stronger government commitment and financial support for family planning and also in improved service delivery programs. As part of the Grant Agreement with USAID, each public sector institution proposed a program of activities to a) improve maternal health and family planning service delivery programs (MSP, DNMS, and SSC); b) help implement the national population policy (CONADE); and c) manage local currency agreements of MSP, DNMS, SSC, and CONADE and improve financial management and administration (MOF).

HIGHLIGHTS OF THE PROGRAM'S PERFORMANCE

Project Assistance Component

APROFE and CEMOPLAF are the two principal PVOs providing family planning service delivery and receiving USAID support. Both PVOs are national in scope and coverage and have played an ever increasing role in the provision of family planning services. As of 1994, together they provided family planning services to nearly 28% of all those using contraception in Ecuador. Provision of modern methods, particularly the intrauterine device (IUD), by these two PVOs is even more notable since together they supplied nearly 50% of all users of IUDs in the country. These two family planning organizations appear to have responded fully to the objectives set in the USAID program, although this evaluation had identified signs that the accelerated cost recovery targets (adopted in the PP amendment of 1994) may be met only at the expense of family planning service delivery.

APROFE

Founded in 1965, APROFE is the national affiliate of the International Planned Parenthood Federation (IPPF). APROFE's diverse objectives include not only family planning and health but also activities such as income generation programs for women and community activities for young people. The organization maintains its programmatic focus on women but has expanded its target groups to include men within the context of the family, and it has placed a particular focus on young people. APROFE facilities are concentrated in primary and secondary urban areas in the coastal region of Ecuador, although clinics are also maintained in the cities of Quito, Ambato, Cuenca, and Loja in the highlands.

APROFE maintains a network of clinics, sterilization centers, laboratories (of which several are specialized Papanicolaou analysis centers), and pharmacies. APROFE also has a community-

based distribution (CBD) program and a mobile clinic and a boat clinic, both of which serve Guayas Province. A network of associated doctors and midwives is also supported by APROFE.

Since the beginning of the current USAID program in 1991, APROFE has grown from 18 to 20 clinics, and 12 of 16 planned laboratories are functioning. Eleven of 19 planned pharmacies are functioning, and two clinics are equipped with sonograms. Program outputs also include targets of 50% of new users under age 25 and a 100% increase in male use of contraception. In 1993, 49% of new users were under 25. If the trend of the first six months continues, 57% of new users in 1994 will be under 25. Between 1991 and 1993, there was a 45% increase in vasectomies.

Though a specific increase in the number of new users was not specified, an increase in the delivery of family planning services was anticipated. However, there has been an 8% decline between 1991 and 1993. In addition, the number of control visits for family planning has also declined. At the same time, the delivery of non-family planning services has increased.² As will be discussed below, the decline in family planning services appears to be a consequence of the cost-recovery efforts.

CEMOPLAF

CEMOPLAF was created in 1974 to offer family planning and reproductive health services to low-income couples. Currently, CEMOPLAF operates a network of clinics, most of which have laboratories and pharmacies. The clinics are located in nine provinces, principally in the highlands. In addition, CEMOPLAF has Associated Professionals and a network of doctors that provide surgical sterilization. The service delivery network also includes community health posts (mini-clinics that are open on market days in particular areas) and community-based distributors.

Since 1991, CEMOPLAF has set up 19 of 20 projected laboratories and 15 pharmacies, one more than planned. Thirteen of CEMOPLAF's 20 clinics have achieved 100% capacity (as measured by maximum caseloads). Only one of a projected 12 clinics is equipped to perform sonograms.

While no specific outputs were set for new acceptors under the USAID program of assistance, an increase was anticipated. However, the number of new acceptors declined by 12% between 1991 and 1993, and the number of control visits for family planning also declined. As was the case with APROFE, the delivery of non-family planning services has increased. It was projected that 50% of new users would be under age 25 by 1993. This level was reached and surpassed in 1994. The projected output for rural users was 45%, and nearly 30% of new users have been from rural areas. Male use was to increase by 100% over the life of the project, and vasectomies increased from 52 in 1991 to 269 in 1993.

² Non-family planning services include Papsmear, colposcopy, sonogram, gynecology, prenatal, pediatric, and general health care.

Cost Recovery and Sustainability

A major strategy pursued by APROFE and CEMOPLAF under the USAID program is cost recovery and sustainability. With the exception of the capital funds that could not be evaluated, the program called for the following:

- Increase PVO cost recovery to (65) 80% of all costs, including contraceptives.³
- Increase revenues attributable to laboratories, pharmacies, and ultrasound from the current 15% of all operating costs to (45) 60%.
- Develop cross-subsidization capabilities and non-family planning services as profit centers.
- Develop strategic financial planning capabilities including marketing, health maintenance organizations (HMOs), pricing, and other activities such as fund-raising and grantsmanship.
- Incorporate market-oriented pricing strategies and procedures and an HMO approach to accounting and financial management (established and operational by year three, i.e. 1994).

Overall, APROFE and CEMOPLAF are on track in terms of financial sustainability and cost recovery targets. Both have passed the break-even point for direct laboratory, pharmacy, and ultrasound costs, and both are expected to recover between 42% and 45% of direct and indirect clinical service costs in 1994. These non-family planning support services already seem to be subsidizing the clinical services and CBD.

Both organizations have sound basic financial accounting systems. Other major outputs of the project, strategic planning, cross subsidization, and a means testing and exoneration system, are basically in place. The exact level of subsidy of non-family planning services is unclear. Both PVOs can or already have achieved the program's original targets. However, the increased levels for cost recovery set forth in the PP Amendment, while perhaps attainable, are desirable only if they can be carried out while maintaining planned levels of family planning service delivery.

Recommendations

1. **Financial Management.** Financial management systems at both organizations should be upgraded to improve the ability to identify income and losses by cost center and by services and to track trends.
2. **Strategic Planning.** Both organizations need to strengthen their capabilities in strategic planning. For example, links between pricing levels, exoneration, provision of non-family

³ The figures in parenthesis are from the original Project Paper (PP), and these numbers are followed by the levels set in the amendment to the PP.

planning services, and provision of family planning services need to be identified. Special studies are needed which may lead to reduced cost-recovery targets, a loosening of exonerations, and a revision of family planning services targets.

Based on improved information, financing strategies should be articulated that specify the services or geographic areas to be emphasized, marketing strategies, cost and pricing tactics, and cross subsidization (by location and by service) strategies and targets.

Non-financial aspects of sustainability should be emphasized and developed. This includes the ability to carry out higher level analyses with more rigorous analyses of costs, strategic analyses and planning, and so forth. Technical assistance to strengthen strategic planning with a combination of in-country and off-shore training for appropriate staff will be needed.

3. Exonerations. A more complete plan for strengthening means testing and exoneration systems should be developed. One outcome of this could be the establishment of a dedicated fund for the indigent so that there would be complete accounting for services and income while giving access to lower income strata.
4. HMO and Other Management Approaches. The PP output on HMO-type accounting and management approaches should be modified to cover the exploration of alternative financing and management approaches that might include prepayment or third party payments.
5. Capital Endowments. The endowment projections should be reviewed based on current levels, and endowment plans and overall projections should be adjusted accordingly.

Information, Education, and Communication

APROFE

APROFE has a well-diversified IEC program. The target groups for its communications programs are women, men and the family, and young people. These groups are reached through traditional mass media (radio, television, and newspapers) and Interpersonal Communications (IPC) programs (with support materials such as brochures, slides, and films) as well as through special projects for women and youth. APROFE's IEC strategy also promotes the organization and its activities through radio, television spots, press articles, and ads ("Sostenimiento" program) and thus contributes to its goal of sustainability by attracting new clients. APROFE also has an active public relations effort that has resulted in good press coverage.

One of the strengths of the IEC program has been formative and evaluate research. A number of research studies, particularly pretesting and post-testing of IEC campaigns and source of information about services, have been carried out. The previously noted decline in family planning services delivery (at the same time that non-family planning services increased) appears to be due largely to non-IEC factors such as the cost-recovery policy. This policy has had a direct impact on IEC programming since there is little interest in promoting family planning through IEC efforts once clinics have reached full operating capacity or full cost recovery or both.

Recommendations

6. **Strategy Planning in IEC.** APROFE should develop a strategic plan in IEC. It should conduct operations research to determine the role of social and educational factors relative to policy and economic factors in influencing the rate of new users and continuing users. APROFE should organize and run a seminar for clinic directors on advantages and practical uses of IEC.
7. **Organization and Management.** The IEC Department should have responsibility for strategic and campaign planning. There should be clear, written terms of reference for IPC technical support and supervision. A more formalized functional relationship between the IEC and Evaluation Departments should be established to assure rational, appropriate research planning.
8. **Subcontract Management.** APROFE should involve de Maruri, the advertizing agency, more fully in strategic planning and negotiate a more satisfactory monitoring system with de Maruri. APROFE should also get a second opinion on radio station selection and once the current subcontract is over, entertain competitive bids. APROFE should consider the many qualified Ecuadorian production firms in a competitive bidding process.
9. **Campaign Planning.** Once a strategic plan has been developed, APROFE should prepare detailed campaign plans. It also needs to reconsider the current levels of investment in the Youth Project and decrease or eliminate funding. Further, campaign plans should be based on a more rational distribution of resources between institutional advertizing and promotional campaigns and involve improved media planning as well as more detailed, elaborate messages for segmented audiences.

CEMOPLAF

CEMOPLAF currently manages a well-organized and ambitious IEC program including mass media, print materials, and interpersonal education. The IEC program is designed to promote the institution and its expanding range of family planning and medical services, generate new family planning users, and assure the continuation of current users. The priority audience of the IEC program is married women, women under age 25, and women in rural areas. Secondary audiences are the spouses and families of contracepting women, especially men. The audience of CEMOPLAF is largely rural with a significant indigenous population. This audience and the audience in urban areas are poor with relatively less education and social mobility than the population at large.

As with APROFE, there are various factors, such as the policy of cost recovery, that have led to a decline in family planning clients. In addition, in the 13 of CEMOPLAF's 20 clinics that have achieved 100% capacity, there is little interest in generating more demand. Since each clinic must pay for all IEC activities, the clinic directors have been reluctant to invest in IEC.

Recommendations

10. Strategic Planning in IEC. Since IEC is comprised of IPC, mass media, and print materials, a comprehensive strategy should be developed that encompasses all three. In this strategy, CEMOPLAF should focus on the seven centers out of 20 that are below 100% capacity. Operations research should be used to determine role of social and educational factors in the decline of new and current users by region and segmented target group. If the results show that IEC can have a significant role, CEMOPLAF should conduct a seminar for clinic directors on the role of IEC. CEMOPLAF should prepare a strategic plan for mass media, IPC, and print materials.

11. Organization and Management. CEMOPLAF should designate the Department of Public Relations and Resource Generation as the department responsible for strategic planning. The management links between the Department of Education, the Department of Community Distribution, and clinic directors should be clarified and strengthened. Clear terms of reference should be written for all departments, and authority should continue to devolve from the executive director to each department head for execution of the terms of reference.

Once a new, organization-wide IEC strategy is developed by the Public Relations Department (in collaboration with other central CEMOPLAF departments and local clinics), clear terms of reference have been written for each department or clinic, and funds have been allocated according to this strategy, then each head of department/director of clinic can take full and complete charge of his/her activities.

12. Research. CEMOPLAF should carry out more structured research activities to determine the relative importance of social and educational factors relative to policy and economic factors. It should redesign the Fuentes de Referencia questionnaire and also redesign the formative, pretest, and evaluation methodologies.

13. Campaign Planning. Based on the strategic plan recommended above, CEMOPLAF should prepare detailed campaign plans including messages for more segmented audiences; media plans that more rationally distribute resources among IPC, mass media, and print materials; and more cost-effective selection of radio stations.

IEC Technical Assistance

The Johns Hopkins University Population Communication Services Project (JHU/PCS) has provided technical assistance to the USAID-supported Ecuadorian family planning IEC programs since 1990. JHU/PCS has primarily assisted in creating and supporting the National Family Planning IEC Technical Committee and providing technical support to APROFE and CEMOPLAF.

The primary effort of the Committee has been the production of the *Entre Nosotras* radio series financed by JHU/PCS. Individual radio stations are being approached by clinic directors and asked to donate time. CEMOPLAF has contracted only seven stations so far, and APROFE has yet to enlist the help of de Maruri in negotiating with stations. Since no money is to be spent on broadcast

purchase, it is not clear how this program will be sustained when JHU/PCS funds have been exhausted.

The technical assistance provided by JHU/PCS to both APROFE and CEMOPLAF has been very positive. First, both agencies give ample credit to JHU/PCS for training them in classic and proven communications methodologies. Second, it is clear that staff at both PVOs understands the communications process and is well on the way to implementing it.

As recognized by the JHU/PCS resident representative, several elements of the communications process need improvement. Most of the following recommendations mirror those cited for IEC for each PVO and will necessarily involve more technical assistance from JHU/PCS.

Recommendations

14. Strategic Planning in IEC. JHU/PCS should work closely with both agencies to help them develop the overall strategic plans that can give direction to their IEC programs.
15. Program Planning. More technical support from JHU/PCS should be provided both agencies in the following areas: production quality, audience segmentation, IEC programming continuity, and supervision of their IPC.
16. Research. Although both APROFE and CEMOPLAF have received training and technical support in research techniques, they—and particularly CEMOPLAF—need more experience and training in both formative and evaluative research that can be used for strategic planning.
17. Subcontracts. Although both agencies have been trained in dealing with advertizing agencies, JHU/PCS should help them either better manage their existing subcontracts or consider ways to use private agencies.
18. National IEC Coordinating Committee. The National Family Planning IEC Technical Committee should engage individual participating agencies more fully and invite MSP's Division of Communications and Education to be member. New terms of reference should be written to include explicitly a coordination function. JHU/PCS and the Committee need to develop a financial strategy that will ensure that the participating agencies are responsible for the majority of the production costs by the end of the Cooperative Agreements with USAID.
19. Air Time for Entre Nosotras. Working with advertizing agencies, JHU/PCS and the PVOs need to develop a new strategy for securing free air time. Since longer programs may be undesirable for radio stations offering free air time, more attention should be given to working with agencies and stations to edit programs where feasible.

Quality of Care

Seven elements of quality of care were assessed for this evaluation: 1) method choice; 2) information and counseling; 3) technical competence; 4) interpersonal relationships; 5) continuity of care; 6) appropriateness and acceptability of services; and 7) accessibility. Both APROFE and CEMOPLAF have worked to improve the quality of service delivery during the 1990s. They both have service delivery programs with a high standard of care. The staffs of both organizations have increased technical knowledge and improved interpersonal communication skills. Clinic staff are now familiar with the concept of counseling. Clients can choose from a growing number of methods at centers that are conveniently located.

Both PVOs are providing a broader range of reproductive health services (family planning and obstetrical and gynecological care including prenatal care, ultrasound, colposcopy, reproductive tract infection [RTI] diagnosis and treatment) and general health services than before. Given the broader range of reproductive health services are now being provided and the endemic nature of RTIs, the prevention, diagnosis, and treatment of RTIs needs to be given greater attention. This finding is especially important for programs in other countries that are beginning to add more health services.

The following recommendations pertain to both APROFE and CEMOPLAF and are given to help them "fine tune" and maintain services that are already of high quality.

Recommendations

20. High-quality Norms. A medical/technical committee should be formed with representatives of the various professions involved in client care (e.g., OB/GYN, family planning specialist, pediatrician, midwife, general practitioner, and laboratory technologist). The medical committee should be responsible for approving norms of care and providing technical support to medical personnel and quality assurance in family planning and other health services. Medical norms should be developed and updated periodically to reflect the breadth of services delivered. In addition, family planning norms should also be updated to reflect current international standards.
21. Reproductive Tract Infections. Given that RTIs are endemic, a program should be developed that fully addresses their prevention, diagnosis, and treatment. Medical norms for the diagnosis and treatment of RTIs should be formulated based on internationally accepted standards.
22. Infection Prevention. Training on up-to-date infection prevention methodologies should be provided to doctors, midwives, and nurse auxiliaries.
23. Research. Several studies should be conducted on a) the incidence of pelvic inflammatory disease (PID) in IUD users since the IUD is the major contraceptive provided and PID is a serious potential complication; b) the quality of care from the perspective of the client (a "mystery client" approach would provide systematic in-depth information); c) discontinuation of APROFE and CEMOPLAF users to determine reasons for discontinuation, current use of contraceptives, source of supply, and economic status (similar to what was mentioned in the

IEC section); and d) the economic status of the PVOs' clients and/or whether and where the lower socioeconomic groups are receiving family planning services.

24. Accessibility. Expand service delivery in rural areas through alliances with public, private, and commercial sector agencies; private doctors and midwives; and CBD programs.
25. Organization and Management. Closer collaboration between the various departments (e.g., IEC, public relations, evaluation, operations, medical/technical, and administrative) is needed to maintain high-quality services. Both PVOs should re-emphasize use of Patient Flow Analysis to help monitor quality of care on a regular basis. This assessment methodology should be carried out collaboratively with each clinic. Finally, both PVOs should develop tailored self-evaluation models using the indicators presented in the Handbook of Indicators for Family Planning Program Evaluation (Bertrand et al, 1993).

Future Objectives and USAID Assistance to PVOs

Both APROFE and CEMOPLAF have more than succeeded the projected benchmarks in cost recovery through selling various health services along side their work in family planning service delivery. While both organizations are on track in terms of financial sustainability, the efforts in cost recovery have not been achieved without a price. The decline in the number of new and continuing users of family planning at both organizations has occurred as greater emphasis was placed on non-family planning services. This consequence may also be affecting the delivery of family planning to clients from lower socioeconomic levels, although there is no information to determine the client profiles at either PVO.

This evaluation is particularly well timed given the above finding. Both APROFE and CEMOPLAF along with USAID need to determine future directions and priorities given that USAID's Project Assistance has two important, but apparently conflicting, objectives: 1) cost recovery toward sustainability and 2) extending the availability of family planning services to the harder-to-reach areas and to other under-served segments of the population.

If it is determined that both organizations should embark on difficult program expansion (in rural areas for example), then both PVOs will require further USAID assistance, particularly in terms of extending support for several additional years, perhaps to 1999 or 2000. Efforts to expand service delivery will be costly, and these PVOs will probably be reluctant to pursue risky and cost expansion strategies without somewhat longer-term USAID support than is planned under the current project. Both organizations will need to explore different approaches to service expansion. This may not require building or renting facilities, but perhaps APROFE and CEMOPLAF can utilize public facilities through their links with the SSC and MSP or other strategies, such as part-time or mini-clinics with CBD.

Along with the service delivery programs of APROFE and CEMOPLAF, both organizations (and particularly CEMOPLAF) have been engaged in training health professionals (doctors, nurses, and auxiliary nurses) in reproductive health and family planning from the public sector (MSP and SSC) and also from other countries (e.g., Bolivia). Given the very high quality of services provided by both groups, it is assumed that the quality of training is also high. The training efforts to date are not major activities for these organizations, but they have been filling a critical need in reproductive

health and family planning in Ecuador. Both organizations could expand their work in the training area.

Although the evaluation did not assess the relationship between USAID provision of contraceptive commodities and the objective of self-sufficiency, it is clearly an area that needs to be explored. It is desirable for both APROFE and CEMOPLAF to move toward paying for their contraceptive supplies, and there are examples from other countries where organizations are beginning to purchase their own goods. APROFE and CEMOPLAF already have an arrangement with IPPF to buy commodities at discounted prices.

Recommendations

26. **Cost Recovery.** USAID should not encourage either CEMOPLAF or APROFE to attain higher levels of cost recovery than they are now achieving. The next several months should be a time for assessing the dual objectives of cost recovery and service expansion and developing strategic plans to address the future goals. Assuming the organizations opt to expand their services to harder-to-reach areas, USAID should be prepared to extend the life of the project's assistance for several years to give them time to carry out and consolidate the new efforts.
27. **Capital Funds.** In keeping with longer-term goals of self-sufficiency in relation to USAID resources, the plans to create and build capital funds should be pursued vigorously. USAID should explore expanding the levels intended for these funds, especially if they are needed to support more costly and risky service delivery.
28. **Training Centers.** Because of the critical need for good training in reproductive health and family planning (for example, medical schools do not provide pre-service training in these topics for doctors) in Ecuador and because of the potential to generate further income, both organizations should explore the possibility of operating world-class training centers for the Spanish-speaking countries of South America.
29. **Contraceptive Commodity Costs.** If USAID extends the Life of Project to 1999 or 2000 to give these institutions time to expand and consolidate their expansion, efforts should begin to gradually shift the costs of contraceptive commodities to the PVOs. By the year 2000 both should have become self-sufficient in their commodity needs.

Non-project Assistance

Progress in Public Sector Policies

The NPA was conceived as an innovative way of getting the GOE to move ahead in specific areas of population policy and service delivery. Given the relatively positive climate for family planning in Ecuador at the time the project was developed and the relatively high level of contraceptive prevalence, it was assumed that a new approach to project assistance with the GOE was both feasible and desirable. In addition, there was supportive leadership at the ministerial levels,

implying the will to carry out policy changes. Finally, it was assumed that the US\$2.5 million to be provided through NPA was of sufficient magnitude to serve as leverage for policy change.

USAID designed the NPA with five recipient institutions in the public sector: CONADE, MSP, IESS/DNMS, IESS/SSC, and MOF. The NPA specifies eight indicators of success or benchmarks that entail changes in public sector policies and service delivery. Each of these is listed below with a brief note on progress.

1. CONADE will establish a specific policy implementation plan, including the recreation of the National Population Council by year two.

CONADE officially published the National Plan of Action in Population in October 1994 about one year behind the planned schedule.

2. MSP and IESS will establish regular budget items for maternal health and family planning services by year two.

The MSP increased key line items related to maternal health and family planning in its budget for 1993. In addition, the Ministry made a specific contribution of S/ 70 million (US\$33,000) to a separate account for these activities. Also in 1993, the IESS increased several general line items claiming that the required policy change was fulfilled, however, there was no way to be sure these monies were allocated to the appropriate activities.

3. MOF will support additional budgetary requests from the MSP for maternal health and family planning activities, especially in the areas of supervision and training, by year two.

The MOF supported the increased budgetary requests for the MSP.

4. CEMEIN will purchase 100% of contraceptive commodities required by MSP by year four.

No progress has been made in getting CEMEIN to begin purchasing contraceptive commodities.

5. IESS will purchase with its own budget 100% of contraceptive commodities required by DNMS and SSC by year four.

No progress has been made on having the IESS procure its contraceptive commodities (for either DNMS or SSC).

6. Public sector entities will increase reliance on the private sector, especially in the areas of logistics and training, by year three.

There has been minimal progress on the part of public sector entities (specifically the SSC) in working with the PVOs (particularly CEMOPLAF) for training of staff in reproductive health and family planning.

7. Firms and companies with health centers under IESS regulations will provide on-site family planning by year three.

There has been no progress in getting firms and companies with health centers under the IESS to provide on-site family planning, although a series of training sessions was planned for the end of 1994.

8. Rural clinics of MSP and SSC will provide all contraceptive methods with the full range of stocks and effective logistics systems by 1997.

There appears to have been little or no progress in ensuring that rural clinics of the MSP and SSC were providing effectively a full range of contraceptive methods.

As this accounting shows, the NPA has resulted in some policy changes, but these have been slow in coming and generally addressed in a minimal way compared with what was anticipated at the time of the project design. A series of problems led to the lack of progress including 1) the change to a more conservative government in 1992; 2) a lack of high-level support and consistent leadership; 3) the loss of leverage for USAID funds (because of a US\$70 million health sector loan that was approved one year after the NPA was signed); 4) a lack of understanding of how the NPA was to be implemented; 5) bureaucratic inertia; 6) the inability of the MOF to facilitate the NPA's implementation; and 7) the passive role of USAID management (once the political climate had changed and problems were encountered). These various problems show that the NPA, as it was carried out, has not been an effective or efficient mechanism for bringing about policy changes or for working with public sector institutions in Ecuador. Had just one of the underlying assumptions for the NPA held (e.g., consistent and supportive leadership that was in place at the time the NPA was designed), it is very likely that the NPA could have been successfully implemented as planned.

Following are several options that are possible for the future of the NPA. Each has political, financial, and management implications that will need to be assessed by USAID and the GOE.

- Keep the existing mechanism since the participating institutions are on the verge of completing most of the conditions for the second of three disbursements.
- Modify the NPA so each institution's progress is not tied to the others. Also, review the likelihood that the conditions for the third disbursement can be met and modify conditions accordingly or adopt more aggressive measures (including technical assistance from outside agencies, e.g., the Cooperating Agencies in population) to facilitate the satisfactory fulfillment of the conditions. Review and reprogram a proportion of funds planned for both CONADE and the MOF.
- Amend the PP and Grant Agreement substantially and carry out one or more of the following:
 - * Provide direct project funding to selected or all public sector institutions based on the various program proposals that were attached to the Project Implementation Letters.

- * Provide selected technical assistance inputs (e.g., the Association for Voluntary Surgical Contraception [AVSC] on improving sterilization procedures in the MSP).
- * Establish specific private sector links to improve service delivery in particular areas (selected rural provinces or health areas).
- * Terminate the NPA component of the PP entirely and invest the remaining US\$2 million in the Project Assistance component with private sector institutions.

Recommendations

Given the many problems in implementing the NPA, the following recommendations are made in order to facilitate future progress both in terms of policy changes and program improvements.

30. USAID should maintain the existing NPA mechanism through the end of January 1995 in order for the second disbursement to go forward.
31. USAID should meet immediately with the Program Implementing Committee (PIC) to review the available options, reprogram funds (reduce levels planned for both CONADE and MOF and pull these funds out of the NPA), and review the conditions for the third disbursement. In reviewing the conditions for the third disbursement, the PIC should consider what types of outside technical assistance might be called on to facilitate the required policy changes. Even with some external impetus, if it is unlikely that the conditions will be met, then the NPA for the third disbursement will need to be modified if USAID wants to continue to fund the public sector.
32. USAID should use reprogrammed funds to acquire additional assistance in managing public sector activities (e.g., have CEPAR or an independent organization that is close to USAID hire a project management assistant and to also draw on the expertise of selected Cooperating Agencies).
33. USAID should use reprogrammed funds to acquire selected technical assistance inputs for two of the service delivery institutions (MSP and SSC) that have the potential to reach rural, under-served segments of the population.
34. USAID should explore further public-private sector ties and provide additional resources, if needed, to the private sector to do this.

Progress in Public Sector Service Delivery

Three public sector institutions (MSP, DNMS, and SSC) that are part of the NPA provide health services. While there is little available data to assess, it appears that there has been virtually no impact or improvement in the delivery of services by the public sector. Given a very limited and slow flow of funds through the NPA, this is not surprising. Nevertheless, there have been

improvements in some inputs, such as training, although there is no way to assess the impact of the training. Despite numerous problems with staff turnover, ongoing institutional reforms and reorganizations, and bureaucratic bottlenecks, activities in reproductive health and family planning have occurred in each of the three public sector institutions. These various difficulties are likely to continue in some measure, and the potential for substantial improvements in the delivery of reproductive health and family planning is probably low, but not necessarily unimportant.

Recommendations

Because the MSP and SSC have the potential to reach the rural, under-served segments of the population, USAID should continue to provide financial support to these institutions. Once the DNMS knowledge, attitudes, and practice (KAP) survey data are analyzed, USAID and DNMS staffs can decide together the future needs of the affiliate population and whether continued USAID support is needed. Both the MSP and SSC service delivery programs would benefit from selected technical assistance from particular USAID Cooperating Agencies. Further, these institutions have and can continue to benefit by stronger links with the PVOs. USAID should work with all parties to facilitate strengthening of these links.

1. INTRODUCTION

1.1 Overview of the Project

The Ecuador Health and Family Planning Program (518-0084) is a six-year program (1991–97) with an initial budget of US\$10.5 million. The program was authorized in August 1991 and has been amended once in January 1994 at which time the budget was increased to US\$15 million. The purpose of the program is to increase the use, effectiveness, and sustainability of family planning services in Ecuador.

The program contains both Project and Non-project Assistance. The budget for the Project Assistance is US\$12.5 million (increased from the original level of US\$8 million), and it includes funding for private voluntary organization (PVO) family planning service delivery and institutional support as well as technical assistance and the purchase of contraceptive commodities. The budget for the Non-project Assistance (NPA) is US\$2.5 million and has not changed over the life of the program. There is also an Economic Support Fund (ESF) component that funds activities of CEPAR and the Vicariate of Esmeraldas and the Archbishopric of Cuenca, however, these activities were not included in the Scope of Work for this evaluation.

The Program has three strategies for achieving its purposes:

1. Ensuring PVO sustainability at Asociacion de Pro-Bienestar de la Familia Ecuatoriana (APROFE) and Centro Medico de Orientacion y Planificacion Familiar (CEMOPLAF) through cost-recovery strategies to enable cross subsidies; a capital fund for each institution; and institutional, strategic, and financial planning to develop a more entrepreneurial approach to family planning service delivery.
2. Improving service delivery by increasing access to services for key target populations (rural areas) primarily through public sector institutions (Ministry of Public Health [MSP] and the Social Security Institute [IESS]) and in urban areas through the PVOs and commercial entities to reach young couples with temporary methods and to increase contraceptive use by men.
3. Improving public sector policies by providing NPA to five public institutions (National Development Council [CONADE], MSP, Direccion Nacional Medico Social [DNMS], Seguro Social Campesino [SSC], and the Ministry of Finance [MOF]) to bring about policy changes and more active support for family planning.

The End of Project Status (EOPS) describes four conditions:

- Contraceptive prevalence will increase from 53% to 58%.
- Use of modern contraceptive methods will increase from 40% to 50%.

- Cost recovery and revenue generation by the PVOs will increase from 30% to (65%) 80%.⁴
- Family planning service will be available at all public sector locations.

The PP describes numerous quantitative outputs in each of the major components of the program: PVO sustainability, PVO service delivery, and public sector policies and service delivery. These outputs are described in subsequent sections of this evaluation report. As will be confirmed in the following discussion and in the annexes on the performance of APROFE, CEMOPLAF, and the public sector institutions, excellent progress has been made on the first three of these four conditions. (See Table 2.)

The Program components are the following:

1. PVO Sustainability. USAID has a Cooperative Agreement with each of the two service delivery PVOs: Asociacion de Pro-Bienestar de la Familia Ecuatoriana (APROFE) and the Centro Medico de Orientacion y Planificacion Familiar (CEMOPLAF). By promoting cost recovery, this component of the program is to improve the income generation capability of both PVOs. With USAID funding, both organizations have expanded their non-family planning service activities such as laboratory services, pharmacies, and maternal and child health services (immunizations, pediatric care, etc.). The program has funded the purchase of medical equipment for the labs, the initial stocking of essential drugs, as well as specialized surgical equipment and materials. The second element of sustainability, a capital fund for each PVO, was just being established at the time of the evaluation and could not be evaluated. The third element of institutional, strategic, and financial planning has been pursued as part of the cost recovery efforts.
2. PVO Service Delivery. This component of the Program has supported the operations of the two PVOs' existing field staff and expansion of services. A key element of this strategy has been the development of communications programs to generate demand among young couples and men and also for temporary and modern methods of contraception. Further, it was expected that APROFE and CEMOPLAF would continue to assure high-quality services through their service delivery networks. With the emphasis on sustainability, it was anticipated that the support for operations would gradually diminish and be fully covered by own-income revenues by the end of the project.

In order to expand PVO services, the USAID program has supported: a) an increased variety of contraceptives including the initial introduction of Depo-Provera and NORPLANT[®], b) technical assistance in information, education, and communication (IEC); and c) contraceptive procurement.

3. Public Sector Policies and Service Delivery. The NPA was designed to condition specific policy changes by the Government of Ecuador (GOE) in exchange for financial support to five public institutions (MSP, DNMS, SSC, CONADE, and MOF). It was

⁴The figure in parentheses is from the original Project Paper (PP), and these numbers are followed by the levels set in the amendment to the PP.

assumed that these policy changes would result in stronger government commitment and financial support for family planning and also in improved service delivery programs. The policy changes (also referred to as indicators of success, conditions, and benchmarks) are listed in Table 3.

In terms of the anticipated improvements in public sector service delivery, the following was to be based on proposals submitted by each public sector institution for review by MOF and USAID.

- a) MSP was to improve delivery of maternal health and family planning in selected provinces by improving supervisory capabilities at the provincial level and staff training on new methods and delivery techniques. By project assistance completion date (PACD), there was to be an increase in women getting prenatal care from 47% to 70%, an increase of non-clinical family planning use from 2% to 15%, and an increase in postpartum care from 14% to 26%.
- b) IESS was to reduce maternal morbidity and mortality rates from pregnancy complications and reduce high-risk pregnancies. Activities to be carried out at all IESS service sites (hospitals, centers, subcenters, dispensaries of companies, and private firms) were to include training in service delivery techniques, supervision, IEC, and operations research. By the PACD, the number of dispensaries providing family planning were to increase from 521 to 778. Further, there was to be an increase in prevalence among social security affiliates from 18% to 60% and a change in the method mix, with an increase in intrauterine device (IUD) use from 10% to 50%.
- c) CONADE was expected to make major advances in the implementation of the population policy in Ecuador. Among the specific activities anticipated were 1) a review and update of the existing policy, the establishment of institutional frameworks, and the renewal of the National Population Council (NPC); 2) the integration of population/development factors into the social development process and increased leadership commitment to the long-term social development plan based on demographic levels and trends; 3) the establishment and implementation of a monitoring and evaluation plan for the National Population Policy; and 4) institutional strengthening involving training, technical assistance, and the transfer of computer and other equipment. By the PACD, CONADE was to have issued publications and public declarations on the updated policy and also sector-specific social development plans (health, education, employment, urbanization, etc.); and reviewed, reformulated, and disseminated the national policy.
- d) MOF was to manage local currency agreements of MSP, IESS, and CONADE and improve its capabilities in management and administration and receive training in financial management.

1.2 Population Policy in Ecuador

The basis for the National Population Policy of Ecuador lies in two articles of the National Constitution from 1978. Under a section on individual rights, Article 19 confirms that the State guarantees the right to a standard of living that assures health, nutrition, housing, and social services needed to achieve this standard. Article 24, in a section on the family, holds that responsible parenthood is promoted, along with appropriate education for the family and the right of parents to have the number of children they can maintain and educate.

In 1987, CONADE (the government agency charged with designing the government's economic and social policies) adopted a National Population Policy including two objectives (among others) that were central to provision of maternal health and family planning services. These objectives are 1) to reduce mortality and morbidity to the lowest possible levels, especially for those under five years of age, and 2) to rationalize the growth of population, in relation to the resource and development potential of the country, respectful of the free, informed, and responsible decision of persons and couples on the number and spacing of births they desire. Official approval of the national policy was considered an important step in policy development, however, since it did not include concrete goals, it was seen only a first step toward policy implementation.

The USAID NPA, as part of a well-coordinated effort with UNFPA in policy development, appears to have been an important impetus for advancing the National Population Policy. Through the NPA, CONADE was charged with recreating a National Population Council and developing a national implementation plan for the population policy. Within a year of the NPA's being signed by the GOE, a new government was elected with much less support for population policy. Nevertheless, with the help of CEPAR, CONADE did begin drafting the National Plan of Action in Population. This effort was undertaken within the context of the GOE's preparing for the International Conference on Population and Development (ICPD) (Cairo, September 1994). Although the draft plan was approved in May 1993 by the NPC, conservative groups in Ecuador had strong reservations about the plan's discussion of reproductive rights. As a result, Ecuador was one of the few nations that sided with the Vatican at the ICPD. Despite this stance, Ecuadorian representatives confirmed in their conference speech the right of couples to choose freely the timing and number of their children and the need to guarantee access to information and integrated health and family planning services.

In October 1994, CONADE officially issued the Plan of Action (with an August 1994 date.) The official document includes the secretary-general's speech at the ICPD. In theory, the next steps for CONADE are dissemination of the Plan and working with individual social sector ministries to help them carry out the strategies and basic lines of action that are described in the Plan. Unfortunately, the technical staff assigned to develop the population policy has been reduced to one individual as part of the GOE modernization efforts. UNFPA supports a technical secretariat within CONADE that can work on the implementation of the Plan. Even if the Plan is not implemented, some feel that simply designating it as official is an important achievement.

The current political climate for population policy and family planning is cautious. The GOE is not a strong advocate of family planning, and many of those implementing maternal, reproductive health, and family planning programs are wary of drawing attention to population policy issues in the wake of the ICPD. Most of these individuals believe that as time passes the political climate will become more benign—it may already have done so given CONADE's recent issuance of the Plan of Action. At the same time and despite the commotion surrounding the ICPD, many pointed out that

changes have occurred in official and public opinion about family planning. A generation ago there was either disinterest or outright opposition to family planning. Today there is relatively broad-based support (even if not ardent) and official approval by the GOE of family planning programs.

Finally, the issue of reproductive health as a context for family planning was reviewed with key population actors in Ecuador, both in and out of government. The general consensus is that reproductive health remains an appropriate context for family planning. Surrounding the ICPD preparations, there was some confusion over the meaning of the terms reproductive rights and reproductive health. At the present time, there continues to be greater sensitivity about these terms. Most people feel that, in time, the term reproductive health will again be as acceptable as family planning and that USAID should stay the course with the emphasis on maternal and reproductive health and family planning.

1.3 Trends in Fertility and Contraceptive Use

Since the mid-1960s, levels of fertility in Ecuador have been declining from a total fertility rate (TFR) of 7 to 3.8 in 1989. According to data from the recent ENDEMAIN, fertility has continued this downward trend reaching a TFR of 3.6 in 1994. (See Graph 1 on Trends in TFR, 1965-1994.) There are differences in fertility levels across regions in the country. For example, the TFR in the rural sierra region is 4.8 compared to 3 in Quito. Similarly, the TFR is 4.1 in the rural costa region compared to 2.7 in Guayaquil. Other differences are striking: a TFR of 2.4 for the upper class and 5.7 for the lower class segment of the population. Ecuadorian women with higher education have a TFR of only 2.1 compared to 5.4 and 6.2 for those with incomplete primary education and no schooling, respectively. While dramatic changes have occurred in the lowering of fertility, clearly there are important groups in the population that have not experienced these changes. (See Table 1.)

Trends in contraceptive prevalence have also undergone significant changes. In 1979, prevalence was 34% compared to 53% in 1989. By 1994, prevalence had edged up to 57%. While the rate of increase has slowed, the overall trend toward increasing use of contraception has continued. (See Graph 2 on Trends in Contraceptive Prevalence, 1979-1994.) There are important differences in patterns of use. In the rural sierra region, 42% of women of reproductive age use contraception compared to 70% in Quito. Similarly, 47% of women from the rural costa region as compared to 66% from Guayaquil use contraception. More younger, married women are also using contraception. There has been a striking increase from 39 to 49% of married women ages 20-24 using contraception between 1989 and 1994. The percentage of married women in the youngest age group (15-19) increased slightly, but is only 27%. There are also large differences by level of education: 26% of women with no education use contraception compared to 68% for women with secondary or higher education. (See Table 4.)

Among women using contraception, the changes in use between 1989 and 1994 are accounted for by a higher percentage of women using modern methods (46% modern use compared to 42% at the earlier date) while use of traditional methods has remained at 11%. Of women using modern methods, the three most popular are sterilization, IUD, and pill. (See Table 4.) Most users of modern methods of family planning (62%) rely on private sources of services (private clinics and doctors/midwives, pharmacies, APROFE, and CEMOPLAF) while 38% obtain their methods from the public sector (principally the Ministerio de Salud Publico and the Junta de Beneficiencia around

Guayaquil). In terms of the provision of the IUD in particular, both APROFE and CEMOPLAF are important sources. (See Table 5.)

The 1994 ENDEMAIN contains important information that helps identify future needs in family planning in addition to those under-served segments of the population discussed above: younger women, those living in rural areas, and those who are less educated. Of married women not using contraception, 67% cite reasons such as wanting to become pregnant or actually being pregnant. Nearly 33% give reasons that show concerns or problems with contraception such as they do not like contraception, they are afraid of side effects, they lack knowledge of methods, or their husbands are opposed to their using contraception. Less than 0.5% cite religious reasons. Most of these concerns can be addressed through good information, education, and counseling about family planning. (See Table 6.)

2. METHODOLOGY OF THE EVALUATION

A four-person team spent three weeks (October 21-November 10, 1994) carrying out the midterm evaluation of the Ecuador Health and Family Planning Program. (See Appendix A for the Scope of Work and a list of supplementary questions prepared by the USAID Mission in Ecuador.) The team spent one day at POPTECH offices planning for the fieldwork and three weeks in Ecuador. Data were collected through interviews with officials of key PVOs and GOE ministries. (Appendix B contains the list of persons contacted.) The team also reviewed program documents and other pertinent material made available by the USAID Mission, UNFPA, and so forth. (See Appendix C.)

As requested in the Scope of Work, the team included individuals with expertise in quality of care, IEC, population policy, and financial and sustainability analysis. The USAID health finance advisor in Ecuador conducted the latter analysis. The team was fortunate to have an expert in quality of care who had last visited the relevant PVO institutions in the late 1980s, prior to the beginning of the current bilateral program.

The Scope of Work divided the evaluation into four key areas: 1) sustainability and cost-recovery efforts of APROFE and CEMOPLAF, 2) quality of the health and family planning services of these two PVOs, 3) the progress and impact IEC endeavors of the two institutions and the effectiveness of the technical assistance in this area, and 4) progress in the Non-project Assistance component with five public sector institutions. The team looked at progress in the performance of these four areas and considered the directions for future USAID assistance, both in the remaining years of the current project and in the future.

3. USAID MANAGEMENT

The USAID management team for the bilateral health and family planning program has been fairly consistent over the life of the project. The staff that designed the project in 1990 is still at the USAID Mission. A new project manager was hired in January 1994 replacing the previous project manager who was hired by UNFPA. The new manager has considerable experience in health and family planning and with the key implementing institutions. The transition to a new project manager appears to have been smooth. The relations between USAID staff and the PVOs under the Project Assistance component (APROFE, CEMOPLAF, and CEPAR) are characterized by mutual respect and open communication. There are no management issues for this part of the bilateral.

In managing the NPA, USAID staff has stayed fully informed about the progress (or lack of progress) in implementing this component of the bilateral. The USAID Mission's position on managing an NPA has been essentially to allow the GOE to determine the course of events.⁵ From the beginning, the MOF was clearly assigned the role of manager and facilitator. USAID staff attended planning meetings, provided information, but did not take an active role in resolving implementation problems, of which there were many. Given the passive role of USAID and the ineffectiveness of the MOF in managing the NPA, progress has been very slow. As discussed elsewhere, numerous constraints exist that call into question the validity of the assumptions underlying the NPA. Despite these problems, USAID staff and officials at the various ministries have cordial and candid relations. Further, there are several recent examples of a more proactive role by USAID that is intended to improve service delivery. (Limited technical assistance has been provided by The Centers for Disease Control and Prevention (CDC) and the Association for Voluntary Surgical Contraception (AVSC) in looking at several logistical and procedural problems.) Depending on the USAID Mission's decision about the future of the NPA, more of this kind of assistance may be called for. Despite the past rather passive role, USAID staff is well prepared (both in terms of expertise and understanding of the issues and constraints in the public sector) to take a more active role in implementing the NPA if necessary.

⁵Apparently, there were considerable debates among USAID staff persons about the proper role for USAID in managing an NPA. The views that won out were those favoring minimal involvement.

4. DONOR COORDINATION

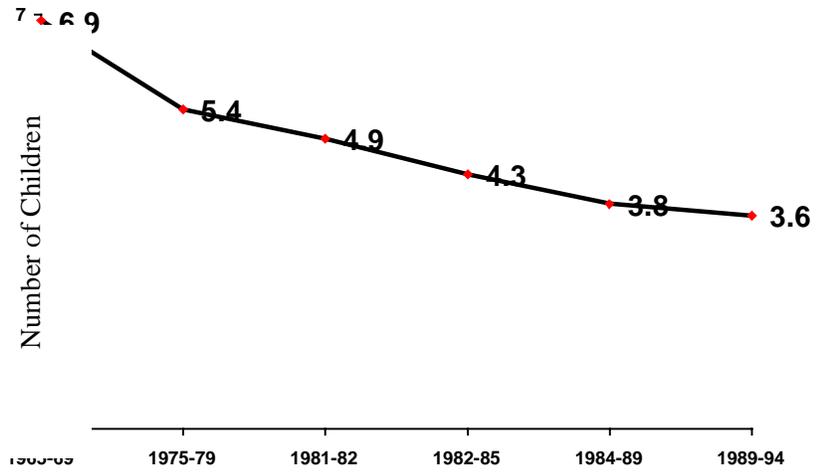
In addition to USAID, the UNFPA and the World Bank have been the principal donors in the health and family planning area. Apparently the Inter-American Bank is currently negotiating a health sector loan with the GOE. For years, USAID has been the primary donor to private organizations such as APROFE, CEMOPLAF, and CEPAR. The UNFPA has concentrated its focus on the public sector, specifically the MSP and CONADE. The World Bank negotiated a large health sector loan for 1992-1997 (The FASBASE Project) to be carried out by the MSP.

USAID and UNFPA staffs have worked closely over the years coordinating their efforts in policy development and service delivery. The UNFPA project with the MSP has concentrated on a select number of provinces, and USAID's assistance was planned for a number of different provinces so the two programs would not overlap. The results of a midterm UNFPA evaluation of service delivery in the MSP led to USAID funding a technical assistance visit by one of its Cooperating Agencies. Similarly, another technical assistance visit for commodity logistics (funded by UNFPA) was extended by USAID to carry out complementary assistance activities.

Relations with the World Bank staff have not been as simple largely because of the nature of the health sector loan. As the loan was being developed with the GOE, there were serious differences between USAID and World Bank staff over the focus of the assistance program and specifically the role of family planning. The Bank loan apparently gave only lip service to family planning, and this despite the increased attention being given to population and family planning issues at Bank headquarters. As a result, the U.S. representative on the World Bank Board abstained from voting to approve the health sector loan. Consequently, the relations with the local World Bank staff in Ecuador have been cool. Nevertheless, the evaluation team met with one local World Bank official who expressed interest in working with the private organizations such as APROFE and CEMOPLAF to improve family planning service in specific health areas under the World Bank's FASBASE project.

GRAPH 1

**TOTAL FERTILITY RATE OVER TIME,
1965 - 1994**

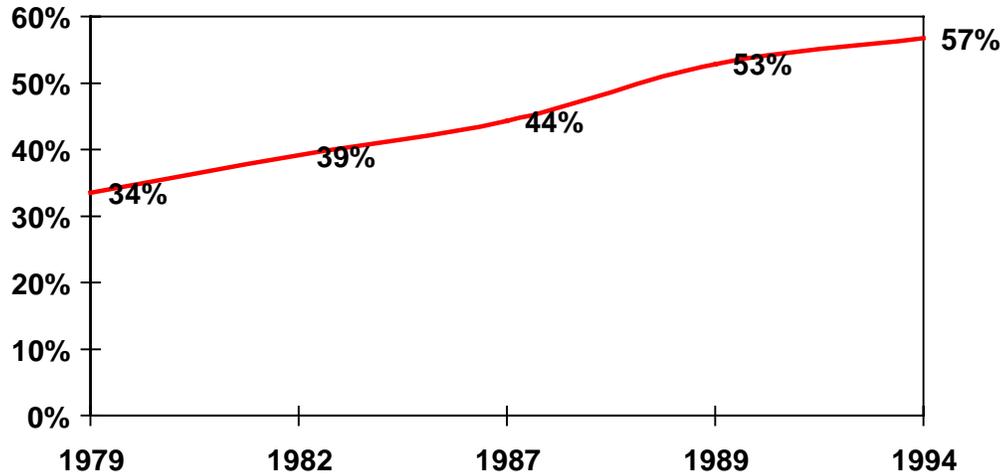


POPTECH, 10/94

Source: World Population Reports, UN, 1992

GRAPH 2

**TRENDS IN ALL METHOD
CONTRACEPTIVE PREVALENCE RATE,
1979 - 1994**



POPTECH, 10/94

Source: Ecuador Contraceptive Prevalence Survey, CDC, 1994

TABLE 1

**Tasas Especificas de Fecundidad por Edad (por 1000 Muderes) y Tasa Global de Fecundidad (TGF) Para el
Periodo 1989-1994 (*).
por Dominios de Estudio y Caracteristicas Seleccionadas:
Mujeres de 15 A 49 Años de Edad**

TASAS ESPECIFICAS Y TGF	PAIS			REGION SIERRA				REGION COSTA			
	Total	Ureara	Rural	Total	Quito	Resto Urbano	Rural	Total	Guayaquil	Resto Ureano	Rural
TASAS ESPECIFICAS:											
15.19	91	76	112	97	77	58	105	95	81	83	121
20.24	184	154	218	186	151	150	227	182	150	184	204
25.29	174	160	199	184	156	163	212	165	149	171	178
30.34	132	109	170	144	111	116	175	121	99	115	162
35.39	89	61	128	114	79	79	145	65	34	62	100
40.44	46	27	72	54	28	19	81	37	12	41	57
45.49	7	1	14	12	-	5	21	1	-	1	2
TGF	3.51	2.99	4.57	3.91	3.01	2.95	4.84	3.33	2.67	3.29	4.12

TASAS ESPECIFICAS Y TGF	PROVINCIAS DE LA SIERRA										PROVINCIA DE LAS COSTA				
	Careni	Imbabra	Picnin-cha	Cocapaxi	Tungu-rahua	Bolivar	Chimp-orazo	Cañar	Azuay	Loca	Esmera Idas	Manaoi	Los Rios	Guayas	El Oro
TASA ESPECIFICAS:															
15.19	114	76	82	107	103	109	105	94	75	65	120	93	114	91	78
20.24	217	173	173	244	180	254	211	223	173	162	214	180	224	169	188
25.29	138	213	164	188	154	211	212	187	199	226	208	152	149	165	180
30.34	119	165	114	226	140	179	160	154	156	177	189	140	132	106	132
35.39	58	158	89	132	85	153	184	106	115	133	134	64	81	54	75
40.44	32	59	37	87	38	92	101	60	56	47	63	56	32	28	38
45.49	18	45	-	3	26	26	21	-	15	20	5	-	5	-	-
TGF	3.78	4.44	3.29	4.95	3.68	5.12	4.97	4.12	3.95	4.15	4.66	3.43	3.68	3.06	3.46

TASAS ESPECIFICAS Y TGF	NIVEL DE INSTRUCCION						ACTIVIDAD ECONOMICA		INDICE SOCIOECONOMICO		
	Ninguno	Primaria incop.	Primaria completa	Secund. incop.	Secund. completa	Superior	No trabaja	Trabaja	Bajo	Medio	Alto

TASAS ESPECIFICAS:

15.19	199	204	119	74	53	19	90	94	163	103	48
20.24	298	260	225	204	142	96	198	165	261	210	128
25.29	265	231	187	165	149	131	186	161	242	187	137
30.34	220	186	127	97	115	109	141	123	206	134	98
35.39	176	122	83	54	51	48	91	87	163	91	52
40.44	79	70	44	20	6	25	42	49	97	52	19
45.49	10	11	6	-	5	-	4	10	14	8	3
TGF	6.24	5.42	3.96	3.07	2.61	2.14	3.76	3.44	5.74	3.94	2.42

Junio de 1989 a Mayo de 1994

Source: Contraceptive Prevalence Survey, CDC

TABLE 2

Desired End of Project Status*			
Indicators	1989	1994	Target
Total Fertility Rate*	3.8	3.6	-
Contraceptive Prevalence Rate	53%	57%	58%
Use of Modern Methods	42%	46%	50%
Use among Specific Subgroups:			
Rural Users			-
Sierra	32%	42%	
Costa	40%	47%	
Young Women (under 25)			
15-19	25%	27%	
20-24	39%	49%	
Increased Cost Recovery**			
APROFE	-	64%	(65%)
CEMOPLAF	-	63%	80%

Source: 1989 and 1994 ENDEMAIN

* No specific change in the TFR was specified in the PP.

** Percent of total costs do not include the value of donated contraceptives.

TABLE 3

Planned Success Indicators for Public Sector Institutions Included in the USAID Grant Agreement with the GOE					
Indicators of Success	CONAD	MSP	DNMSN	SSC	MOF
National Population Council and National Action Plan	X				
Regular Budget for Maternal Health and FP		X	X	X	
Support for Increased Budget Requests for Maternal Health and Family Planning					X
CEMEIN Purchasing 100% of MSP Contraceptive Requirements		X			
Purchasing 100% of Contraceptive Requirements			X	X	
Increased Reliance on Private Sector Groups, especially in Training and Logistics		X	X	X	
Firms and Companies Provide on-site Family Planning			X		
Rural Clinics Provide All Contraceptive Methods with Full Stocks and Effective Logistics		X		X	

Source: USAID Grant Agreement with the GOE

TABLE 4

**Tendencia de la Prevalencia del Uso de Metodos Anticonceptivos en el Ecuador. Segun Caracteristicas Seleccionadas:
Mujeres Casadas/Unidas de 15 A 49 Años de Edad**

CARACTERISTICAS	ENCUESTAS				
	ENF 1979	ESMINVD 1982	ENDESA 1987	ENDEMAIN I 1989	ENDEMAIN II 1994
AREA Y REGION:					
-Urbana	47.7	52.9	53.3	62.2	65.8
-Rural	22.3	26.7	32.7	40.2	44.0
-Sierra	33.4	35.2	38.4	47.9	55.1
-Quito	56.0	58.4	52.7	63.0	70.1
-Resto Urbano	49.0	48.2	50.0	57.0	68.0
-Rural	20.0	20.6	25.0	34.7	42.0
-Costa	34.6	44.6	49.6	57.7	58.2
-Guayaquil	46.0	54.9	57.5	63.4	65.6
-Resto Urbano	40.0	50.3	51.4	63.9	62.3
-Rural	24.0	34.2	41.6	47.3	46.7
INSTRUCCION:					
-Ninguna	12.6	16.6	18.5	25.5	26.0
-Primaria	30.6	36.7	41.0	48.1	50.6
-Secundaria y superior	52.3	60.2	56.6	63.3	68.0
EDAD					
15 - 19	14.0	20.1	15.3	25.0	27.1
20 - 34	35.2	42.2	45.2	53.2	59.0
35 - 49	32.9	40.1	47.9	56.6	59.9
No. DE HIJOS VIVOS:					
0	12.4	16.2	15.4	16.8	16.2
1 3	36.1	43.5	46.8	56.2	62.6
4 y más	31.9	37.0	44.0	51.9	56.3
TOTAL	33.6	39.2	44.3	52.9	56.8

FUENTE:

INEC. ENF 1979. Informe general

ININMS. ESMIVD 1982. Informe demográfico

CEPAR. ENDEMAIN 1989. Informe general

CEPAR. ENDEMAIN 1994. Informe preliminar

Source: Contraceptive Prevalence Survey, CDC

TABLE 5

**Fuente de Obtencion de Metodos Modernos Segun Region y Lugar de Residencia y Metodo:
Mujeres que Usan Anticonceptivos Modernos de 15 A 49 Años de Edad**

LUGAR DE RESIDENCIA Y METODO	SECTOR PUBLICO					SECTOR PRIVADO							TOTAL	No. DE CASOS
	TOTAL	M.S.P.	IESS	Junta de Benef.	Otros	TOTAL	Clin./me d. privado	Farmacia	APROFE	CEMOPLAF	OSF	Otros		
TOTAL PAIS:	37.8	23.4	4.5	8.1	1.3	62.2	26.3	16.4	13.2	14.4	0.2	1.6	100.0	4249
-Esteril. femenina	63.1	34.8	8.0	17.7	2.6	36.9	32.0	0.0	3.2	0.4	0.2	1.1	100.0	1731
-DIU	20.2	15.5	1.4	1.2	2.0	79.8	29.4	0.1	35.7	12.4	0.5	1.6	100.0	1173
-Pildora	19.3	16.3	2.6	0.0	0.4	80.7	15.9	51.2	8.2	3.5	0.0	1.9	100.0	944
-Condón	9.7	8.3	1.4	0.0	0.0	80.3	7.1	72.1	5.5	1.9	0.0	3.8	100.0	278
-Otros (a)	8.9	5.7	0.9	0.9	1.4	91.1	27.2	39.0	16.1	6.9	0.0	1.9	100.0	123
QUITO:	33.0	20.4	7.0	0.0	5.6	67.0	29.7	16.5	7.9	8.6	1.3	3.1	100.0	500
-Esteril. femenina	53.3	28.4	15.2	0.0	9.7	46.7	37.4	0.0	4.7	2.0	1.2	1.6	100.0	191
-DIU	27.4	21.0	1.5	0.0	4.9	72.6	31.7	0.0	14.6	19.5	2.4	4.4	100.0	181
-Pildora	8.9	7.4	1.5	0.0	0.0	91.1	20.6	58.8	2.9	5.9	0.0	2.9	100.0	52
-Condón	7.4	7.4	0.0	0.0	0.0	92.6	2.9	80.9	2.9	0.0	0.0	5.9	100.0	59
-Otros (a)	*	*	*	*	*	*	*	*	*	*	*	*	100.0	17
RESTO URBANO SIERRA:	37.4	24.8	10.5	0.2	1.9	62.6	26.5	12.2	11.8	10.4	0.2	1.5	100.0	765
-Esteril. femenina	63.4	42.1	19.5	0.5	1.3	36.6	31.8	0.0	3.7	0.0	0.4	0.7	100.0	310
-DIU	21.3	12.7	4.6	0.0	4.0	78.7	26.2	0.0	26.8	25.8	0.0	0.0	100.0	285
-Pildora	16.9	14.4	2.5	0.0	0.0	83.1	20.8	39.8	7.7	10.7	0.0	4.0	100.0	113
-Condón	12.8	8.4	4.4	0.0	0.0	87.2	7.4	61.1	5.1	7.0	0.0	6.6	100.0	77
-Otros (a)	21.2	12.9	4.6	0.0	3.7	78.8	37.1	29.3	7.3	2.8	0.0	2.2	100.0	30
RURAL SIERRA:	45.1	37.6	5.3	0.2	2.0	54.9	27.0	11.8	8.3	6.6	0.1	1.2	100.0	874
-Esteril. femenina	71.9	57.8	9.2	0.4	4.5	28.1	24.9	0.0	1.3	0.3	0.3	1.4	100.0	360
-DIU	23.1	21.7	1.4	0.0	0.0	76.9	33.0	0.0	22.7	19.6	0.0	1.5	100.0	270
-Pildora	24.8	21.4	3.4	0.0	0.0	75.2	26.7	41.0	4.8	2.2	0.0	0.5	100.0	151
-Condón	25.1	22.3	2.8	0.0	0.0	74.9	15.4	55.6	2.1	1.7	0.0	0.0	100.0	71
-Otros (a)	*	*	*	*	*	*	*	*	*	*	*	*	100.0	22

LUGAR DE RESIDENCIA Y METODO	SECTOR PUBLICO					SECTOR PRIVADO							TOTAL	No. DE CASOS
	TOTAL	M.S.P.	IESS	Junta de Benef.	Otros	TOTAL	Clin./med. privado	Farmacia	APROFE	CEMOPLAF	OSF	Otros		
GUAYAQUIL:	39.4	10.5	1.5	26.9	0.5	60.6	24.2	15.2	19.6	0.8	0.0	0.9	100.0	575
-Esteril. femenina	67.4	11.5	2.2	53.4	0.3	32.6	28.4	0.0	4.2	0.0	0.0	0.0	100.0	261
-DIU	14.1	9.1	0.0	5.0	0.0	85.9	28.2	0.0	53.6	2.3	0.0	1.8	100.0	173
-Pildora	18.5	14.5	2.4	0.0	1.6	81.5	14.5	60.5	3.2	0.8	0.0	2.4	100.0	102
-Condón	*	*	*	*	*	*	*	*	*	*	*	*	100.0	24
-Otros (a)	*	*	*	*	*	*	*	*	*	*	*	*	100.0	15
RESTO URBANO	37.7	25.2	3.8	7.2	1.5	62.3	25.5	18.3	14.7	2.5	0.1	1.2	100.0	895
COSTA:														
-Esteril. femenina	60.4	36.6	6.5	15.6	1.7	39.6	34.9	0.0	3.6	0.3	0.0	1.0	100.0	371
-DIU	21.0	16.1	0.7	0.7	3.5	79.0	27.0	0.0	46.3	4.6	0.2	0.9	100.0	198
-Pildora	21.7	18.9	2.4	0.0	0.4	78.3	10.1	49.7	12.9	4.0	0.0	1.7	100.0	268
-Condón	1.8	1.8	0.0	0.0	0.0	98.2	11.7	72.8	8.6	1.8	0.0	3.5	100.0	37
-Otros (a)	*	*	*	*	*	*	*	*	*	*	*	*	100.0	21
RURAL COSTA:	33.6	25.0	2.2	6.4	0.0	66.4	26.1	28.1	13.2	1.8	0.0	2.2	100.0	640
-Esteril. femenina	60.4	41.8	2.4	16.2	0.0	39.6	35.7	0.0	1.0	0.2	0.0	2.8	100.0	238
-DIU	14.5	13.5	1.0	0.0	0.0	85.5	30.4	1.0	49.7	4.4	0.0	0.5	100.0	116
-Pildora	18.0	15.2	2.8	0.0	0.0	82.0	16.2	53.3	8.6	2.3	0.0	1.7	100.0	258
-Condón	*	*	*	*	*	*	*	*	*	*	*	*	100.0	10
-Otros (a)	*	*	*	*	*	*	*	*	*	*	*	*	100.0	18

(*) Menos de 25 casos

(a) Otros = includes rhythm and withdrawal, etc.

Source: Contraceptive Prevalence Survey, CDC, 1994

TABLE 6

**Razon Para no Usar Anticonceptivos. Por Area y Region:
Mujeres Casadas/Unidas que no Usan Anticonceptivos de 15 A 49 Años de Edad**

RAZON PARA NO USAR	PAIS			REGION SIERRA				REGION COSTA			
	Total	Urbana	Rural	Total	Quito	Resto Urbano	Rural	Total	Guayaquil	Resto Urbano	Rural
RELACIONADAS CON EMBARAZO											
FERTILIDAD Y ACTIVIDAD SEXUAL:	67.2	72.4	62.6	59.9	67.3	71.1	55.2	73.9	71.2	76.4	73.4
-Embarazada actualmente	22.5	26.2	19.3	18.8	24.8	20.0	17.0	26.0	27.9	28.6	22.8
-Menopausia/subfecunda/operada	16.2	16.0	16.3	13.9	14.8	16.8	13.0	28.2	10.7	20.3	21.1
-Postparto y lactancia	15.8	14.3	17.0	14.7	12.0	13.0	15.8	16.9	13.7	16.6	18.8
-Sin vida sexual	6.4	8.8	4.3	7.7	9.4	14.4	5.5	5.2	9.8	5.1	2.6
-Deseo de embarazo	6.3	7.0	5.7	4.8	6.3	6.9	4.0	7.7	8.9	6.0	8.2
OTRAS RAZONES:	32.8	27.6	37.4	40.1	32.7	28.9	44.8	26.2	28.8	23.6	26.6
-No le gusta	7.5	5.6	9.1	9.6	6.6	7.0	11.1	5.4	6.4	3.8	6.2
-Niedo a efectos colaterales	5.1	4.4	5.6	6.4	4.4	6.5	6.8	3.9	3.4	4.2	3.9
-No conoce métodos	4.9	1.5	7.9	7.6	2.5	2.1	10.3	2.5	0.2	1.3	4.4
-Ocosión del esposo	2.3	2.9	2.8	3.3	4.4	2.3	3.3	2.4	3.2	2.2	2.1
-Se siente vieja	2.0	1.6	2.3	2.4	3.5	1.0	2.4	1.5	1.1	1.4	2.2
-Razones economicas	1.3	1.1	1.5	1.4	1.3	1.8	1.3	1.3	0.7	1.0	1.9
-Tuvo efectos colaterales	1.1	1.2	1.1	0.8	0.3	0.9	0.9	1.4	1.6	1.5	1.3
-Razones religiosas	0.4	0.0	0.6	0.7	0.0	0.2	1.0	0.0	0.0	0.0	0.0
-Otras	7.0	8.3	5.5	6.8	9.8	6.5	6.2	7.2	11.7	7.2	4.5
-No responde	0.7	0.4	1.0	1.1	0.0	0.6	1.5	0.3	0.5	0.4	0.2
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No. de casos	4045	1632	2413	2411	253	493	1665	1634	296	590	748

Source: Contraceptive Prevalence Survey, CDC, 1994