

PROJECT ASSISTANCE COMPLETION REPORT  
Family Planning Self Reliance/Human Reproduction

Grant 515-0168.02 with the Caja Costarricense de Seguro Social  
May 27, 1988- July 18, 1993

\$1,800,000 plus \$2,000,000 in-kind contraceptives

I. BACKGROUND:

USAID/Costa Rica signed a grant agreement directly with the GOCR as represented by the Ministry of Health, and the autonomous Caja Costarricense de Seguro Social for the purpose of managing the financial and in-kind resources for the family planning program. The previous agreement, (1983-88) had been with the Costa Rican Demographic Association, which had coordinated activities with the public sector entities. The MOH and CCSS have provided family planning services since 1971, and over time have augmented the number of clinics that provide these services nationwide to include virtually the entire public health care network. Technical assistance under another project in the area of administrative reforms (515-0190) from 1983-87 improved the materials management and logistics system of the CCSS, which enhanced the family planning project success.

II. Project Status vs. Planned Outputs

-Planned EOPS

1. Current family planning users and program beneficiaries of activities funded by the project increased from 127,000 to 180,000.

-- Public sector clientele increased to 183,100. This is an increase from 16% to 22% of women of fertile ages (15-49)

2. Increase contraceptive prevalence to 70% among women in union.

-- Prevalence increased to 74.8% among women in union.

3. Increase prevalence of modern contraceptive methods to 50%

-- Prevalence remains at 44.6 % for temporary methods, sterilization rose from 17% in 1986 to 24% in 1992.

4. --Crude birth rate dropped from 28.5 in 1988 to 25 in 1992, thereby reducing the natural growth rate to 2.1%

### III. Project Status at PACD

A. Procurement. All project funded procurements were completed. The CCSS is now procuring all of the contraceptive requirements for oral contraceptives, condoms and IUDs. In October 1993, the CCSS increased the method mix to include the injectable contraceptive, Depo-Provera. Over ninety percent of the voluntary sterilizations take place in the CCSS facilities. Sterilizations are still tightly controlled, and must be justified before a medical board for the health of the woman.

B. Training. Emphasis was placed on courses for training of trainers, In-service clinical training, and the inclusion of practical clinical and counselling aspects in the medical and nursing school academic and internship programs. A core group of medical doctors and nurses received technical training from the Johns Hopkins Program in Obstetrics and Gynecology, utilizing anatomical models and participatory techniques. They have subsequently prepared curricula for their respective universities and teaching centers, which will be instated for the 1994 academic year.

C. Research. Nationwide contraceptive prevalence surveys were carried out for the 15 - 24 year old population, and the 15-49 year old population. Preliminary results were published, and continued analysis will be financed under the new project 515-0261. Patient flow analyses in major clinics pointed out administrative and managerial strengths and weaknesses in the outpatient services, which were presented to the clinic directors and the CCSS management with recommendations to be addressed.

D. Information, Education and Communications. Mass media messages introduced the subject of reproductive risk, focusing on age groups, spacing, medical and socioeconomic contraindications. Print materials were produced for the industrial workplace, for clinic support and patient education, and for adolescents and pre-adolescents. Distribution of materials was nationwide. Videos were produced for the 24 largest maternity wards and pre-natal clinics, to attract the post-partum audience for immediate contraception.

E. Administration and Supervision. As a free-standing unit within the Department of Preventive Medicine, the Reproductive Health Program was strong while project financing supported the personnel. However, with the termination of project financing for administration, the project management unit dissolved. The management of the new project has been subdivided into different functional areas of the CCSS with oversight by committee. A position was approved for CY1994 for monitoring reproductive health concerns within the women's Health Program. This is an important step, as even without external project financing, there are a variety of technical and administrative actions that require a manager. Training, logistics and procurement, and information programs all continue. With the decentralization of the Social Security Institute, and its "takeover" of all clinical service delivery from the Ministry of Health, there is an attempt to involve local and regional level committees in decision making and supervisory roles to assure quality

of care. The central level remains important in providing service delivery standards, bulk procurement, information, and technical back support.

#### IV. Progress Towards Purpose

The EOPS section above indicates that the project surpassed its targets in most cases.

#### V. Monitoring Responsibilities

The Mission will continue to monitor the Reproductive Health Program through the transition program, Reproductive Health Consolidation. Resources for project monitoring have been included in the project, and a project officer will be in charge until PACD.

#### VI. Data collection and Evaluation

An evaluation of the evolution of the family planning program over 25 years is planned for 1995. Data from the 1976, 1981, 1986 and 1992 prevalence surveys will provide most of the necessary information. Additional analysis will be carried out under the transition project, and included in the evaluation.

#### VII. Lessons Learned

Costa Rica may be unique in its strong public health programs, with wide ranging nationwide coverage. It may not be easily replicable, due to its special circumstances. The National Prevalence Survey statistics indicate a growth of public sector family planning services, indicating that the demand is greater in the public, pre-paid social security institution and Ministry of Health, rather than in the significantly higher cost private sector market. There is minimal private subsidized services, essentially limited to a private non-profit hospital that cross-subsidizes services. No major NGO is involved in clinical services, which is a different scenario from most Latin American countries. This environment of state-supported services was strengthened through the project, yet also during the project period, different administrative models were successfully implemented by the Social Security Institute for outpatient services, including family planning, that can improve access to and quality of services.

Female education levels, rural residence and socioeconomic status are still major indicators of differences in fertility, with educational levels leading the variables in importance.

In a country with a strong health services network, and a mature family planning program, transition to full domestic financing is highly desirable. Over the period of the project there has been an "institutionalization" of the program, as part of the preventive health scheme, and provision of regular outpatient services. The stigma of implied imposition of external entities setting policies has been overcome. Analyses of opinions of leaders from all walks of life indicate an acceptance of the philosophy and activities of

the reproductive health program, including sex education at early ages.

In management terms, even if services are horizontalized, there needs to be a person monitoring procurement logistics, technical standards, new product introduction, training and information, to assure high quality services.