

PD-AAA-786-B1

5190149 - (2)

ACTION MEMORANDUM FOR THE ASSISTANT ADMINISTRATOR, PHA

FROM: PHA/POP, R. T. Ravenholt *RTR/RB*

7/11
55/8
10/24/75

SUBJECT: Approval of Project Paper for El Salvador, Family Planning and Population Program 519-15-580-149

PROBLEM: The cost of the third and final phase of this project will be less than \$2 million over a proposed three-year extension. Therefore, your approval is requested.

DISCUSSION: This PP authorizes a final three years of AID funding totalling \$1,978,000 in support of El Salvador's efforts to reduce the crude birth rates. An estimated contribution of \$4,419,000 equivalent is expected from the Ministry of Health, the Salvadorean Social Security Institute, and other national agencies during the period of this extension. Based on the proposed level of Salvadorean and other donor inputs, the crude birth rate should approach 30 per 1,000 by the end of the project. An evaluation on the project, scheduled by the Center for Disease Control in FY 1977 should more precisely fix the ultimate demographic input figure.

AID resources will be provided to assist the National Population Commission in implementing the government's national population policy. The Population Technical Committee, the working arm of the Population Commission, will be responsible for organizing and carrying out all project activities. There will be a total of 10 private and governmental organizations and units involved.

At the end of the project in December, 1978, there will be a total of 174,000 women (approximately 19% of the population) in the fertile age (WIFA) protected with effective contraceptive methods - male and female sterilizations, pills, IUD's, condoms, etc. Over 85% of the adult population will have access to family planning services and information on the advantages of limiting fertility. There will be an institutional mechanism to monitor the activities in each of the organizations and a national evaluation system to measure demographic trends.

AID's grant inputs will include contraceptive supplies, sterilization equipment, training, educational materials, clinic equipment and specialized technical assistance. AID will also concentrate on a number of small innovative sub-activities to reach segments of the population that are not being covered by the present family planning delivery system. For example: malaria workers, agricultural extension agents, volunteer health workers, rural promoters and satisfied users will work in communities in the promotion of family planning,

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ACTION MEMORANDUM FOR THE ASSISTANT ADMINISTRATOR, PHA

referral of patients to clinics and re-supplying contraceptives to users. Also, condom machines and possibly pill dispensing machines will be placed in selected locations to resupply users.

From 1966 thru June, 1975, AID has invested \$2,810,000 in assisting the Government of El Salvador and selected private organizations in the delivery of family planning services and in dramatizing the adverse effects of rapid population growth on social and economic development. In the early years of AID assistance to El Salvador, the government's involvement tended to be passive and cautious. Starting in 1973, the government began to take a stronger interest in population matters. For the first time cabinet members began to make public statements about the demographic situation and its effect on the delivery of social services, agricultural production, nutritional status of the population, educational institutions, migration of Salvadoreans, etc. USAID assistance played a key role in creating this awareness and the favorable climate for an attack on the population problem.

In 1974 with considerable technical assistance from USAID, the government prepared a "National Population Policy", which was announced by the President of the Republic in his annual address to the nation. The Policy establishes the legal and administrative framework for the Government to allocate further resources to reduce its population growth rate. Now that the Government has shown its serious intention to reduce the growth rate by allocating budget support and personnel, it is the judgement of the project designers that AID's input over the next three years will have a significant impact on the demography of the country as well as establishing the provision of family planning services as a regular part of the health and other delivery systems.

For its part AID will concentrate, although not exclusively, on providing contraceptive supplies, modern sterilization equipment and training related to new techniques, areas which are presently beyond the fiscal/technical capability of the Government. The substantial Government budget increase projected will be primarily devoted to the considerable expansion of infrastructure for family planning services and programs. AID assistance is considered necessary to absorb the start-up costs of the many innovations proposed in the project.

The Mission expects to obtain the agreement of the Minister of Public Health prior to disbursements of funds, that nurses will be allowed to provide first visit consultations to family planning clients, particularly in rural areas where physicians are insufficient. General agreement has been reached with the MOH and a training schedule prepared. Initial placement of such trained para-medics in rural areas will encounter the least resistance by the medical community and constitute the break-through for their gradual expansion.

ACTION MEMORANDUM FOR THE ASSISTANT ADMINISTRATOR, PHA

To achieve the expansion of the FP program as planned, much external assistance will be required. There is no overlapping of AID assistance with the other chief donors, such as UNFPA and IPPF, whose support is mostly for personnel costs. Moreover, all foreign donor activities will be coordinated by the GOES Population Technical Committee.

These authorization and funding requirements are within those levels described on page 108 of the Latin America P.D.B. for the FY 1976 Presentation to the Congress.

This program document has been reviewed and cleared by all AID offices concerned. All relevant AID policy determinations on family planning have been incorporated in this program.

RECOMMENDATION: That you give your approval to the attached document to authorize funds through FY 1978.

Approved: James D. Crowley

Disapproved: _____

Date: 1/9/76

Attachment: Project Paper (PP) for El Salvador

PROJECT PAPER FACESHEET

TO BE COMPLETED BY ORIGINATING OFFICE

ORIGINAL CHANGE
 ADD DELETE

DOCUMENT
 LOCAL
 3

2. COUNTRY/REGIONAL ENTITY/GRANTEE
El Salvador

3. DOCUMENT REVISION NUMBER

4. PROJECT NUMBER
519-0149

5. BUREAU
 A. SYMBOL B. CODE
IA & PHA 3 & 5

6. ESTIMATED FY OF PROJECT COMPLETION
 FY **78**

7. PROJECT TITLE - SHORT (STAY WITHIN BRACKETS)
 Family Planning and Population

8. ESTIMATED FY OF AUTHORIZATION/OBLIGATION
 A. INITIAL **12/75** B. FINAL FY **78**

9. SECONDARY TECHNICAL CODES (MAXIMUM SIX CODES OF THREE POSITIONS EACH)

430 460 420 450

10. ESTIMATED TOTAL COST (5000 OR EQUIVALENT, \$1 = 2.5)

A. PROGRAM FINANCING	FIRST YEAR			ALL YEARS		
	B. FX	C. L/C	D. TOTAL	E. FX	F. L/C	G. TOTAL
AID APPROPRIATED TOTAL	581	90	671	1,650	328	1,978
(GRANT)	(581)	(90)	(671)	(1,650)	(328)	(1,978)
(LOAN)	(-)	(-)	(-)	(-)	(-)	(-)
OTHER 1.						
U.S. 2.						
HOST GOVERNMENT		1,249	1,249		4,419	4,419
OTHER DONOR(S)	100	520	620	367	1,447	1,814
TOTALS	681	1,859	2,540	2,017	6,194	8,211

11. ESTIMATED COSTS/AID APPROPRIATED FUNDS (\$000)

A. APPRO-PRIMARY PRIOR. ALPH. CODE	B. PRIMARY TECH. CODE	FY 76		FY 77		FY 78		ALL YEARS		
		D. GRANT	E. LOAN	D. GRANT	E. LOAN	D. GRANT	E. LOAN	D. GRANT	E. LOAN	
PH	441	400		671		614		693		1,978
TOTALS		671		614		693		1,978		

12. ESTIMATED EXPENDITURES **439 729 834**

13. PROJECT PURPOSE(S) (STAY WITHIN BRACKETS) CHECK IF DIFFERENT FROM PID/PRP

To establish the institutional capacity and capability in El Salvador to protect a minimum of 174,000 women in fertile age with effective methods of contraception.

14. WERE CHANGES MADE IN THE PID/PRP FACESHEET DATA NOT INCLUDED ABOVE? IF YES, ATTACH CHANGED PID AND/OR PRP FACESHEET.

YES NO

15. ORIGINATING OFFICE CLEARANCE

SIGNATURE _____

TITLE _____

DATE SIGNED
 MO. DAY YR.
10 24 78

16. DATE RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION
 MO. DAY YR.

2. Page 2 of PP is revised, due to an upward adjustment in AID/W- provided contraceptives as documented in paragraph 3 below, as follows:

"Recommendations:

	<u>76</u>	<u>77</u>	<u>78</u>	<u>Total</u>
Grant (Mission)	\$263	\$300	\$349	\$912,000
(AID/W)	<u>408</u>	<u>314</u>	<u>344</u>	<u>1066,000</u>
	\$671	\$614	\$693	\$1978,000"

3. Estimated contraceptives and other FP supplies requirements for project.

CY 1976 - 1978

<u>Type</u>	<u>1976</u>	<u>1977</u>	<u>1978</u>	<u>Sources</u>	<u>Estimated Cost (\$000)</u>
Condoms (gross)	30,000	40,000	40,000	AID/W	550
Orals (m/c)	1,500,000	650,000	847,000	AID/W	516
	100,000	150,000	200,000	COES	90
	120,000	120,000	120,000	IPFF	72
IUD	10,000	15,000	10,000	USAID/ES	17.5
Vasectomy Kits	5	5	5	USAID/ES	1.5
Mini Lap Kits	16	16	10	USAID/ES	5.4
Laparoscopes	6	8	6	PIEGO/AID/W	80
Optics (only)	10	8	6	PIEGO/AID/W	24
Foams & Jellies	5,000*	8,000*	9,000*	USAID/ES	26
Injections	1,000	5,000	5,000	UNICEF	11

* Users

4. In the past, the Mission has had difficulty in keeping track of the numerous centrally-funded contracts that are available to support field activities. The Mission has received copies of the airgrams and cables announcing the particular specialty and interest of these different organizations, but in many cases, these contracts have been modified and one organization may have a better performance record in, say, Latin America than in other areas of the world. The Mission intent in requesting that AID/W prepare a DASP was to have a single document that lists all the resources available to support field activities. We suggest PHA/POP could at least attach a list of all centrally-funded contracts, type of support available, and the date that the information was transmitted to the USAIDs. Our experience has been that these contracts are most valuable and are very useful in providing rapid responses to host country needs for assistance.

Areas in which we intend to use the contracts are:

- a. Training of local personnel in sterilization techniques - Association for Voluntary Sterilizations, PIEGO, Pathfinder.
- b. Research - International Fertility Research Program (IFRP) of U. of North Carolina, AVS, Pathfinder, Pop Council, International Planned Parenthood Federation (IPPF), Smithsonian Institute.
- c. Policy and Law - American Public Health Association (APHA), Smithsonian, Tufts University.
- d. Demographic Trends and Mini-KAP - Center for Disease Control (CDC) and Smithsonian.

e. Training outside of country - Development Associates, Inc.

f. Education, information and communications (EI&C) - World Education, Inc.

g. Family Planning Services Statistics - U.S. Bureau of Census.

h. Rural Delivery System with Agricultural Extension Agents - USDA.

The role of the other major donors has been well coordinated with USAID inputs. IPPF channels its support through the local Demographic Association and tends to concentrate on areas not covered by the government programs. Most of the Demographic Association's support comes from IPPF and the Association is represented on the Population Technical Committee, as detailed in the PP.

The UNFPA recently signed a one-year project agreement with the Ministry of Health and this is expected to be extended to a three-year project. The UNFPA project purports to increase the coverage of MCH patients with family planning services. The bulk of the fund is for salaries, clinic equipment and technical assistance from the Population Council, the executing agency for the grant. At present, the project is limited to the MOH delivery system (and there is no question of the need), whereas, the AID inputs cover 10 organizations and will focus on more innovative ways to expand delivery services outside the traditional health structure.

Reference cable notes that according to U.S. Bureau of Census, the crude birth rate (CBR) of El Salvador is 41 per thousand population. Mission has used the local Demographic Association's estimates of 42/1000, as of 1974, which is also the Population Reference Bureau's figure.

The Mission is reluctant to commit itself to figures without a better data base. Taking the most optimistic figures and assuming that the commercial sales of contraceptives continue to do as well as they have in the past, the CBR could, indeed, drop to the low 30's by 1978. As a result of the evaluation system (Mini-KAP in particular) of the project, we will be able to determine the real demographic impact of the activities. Mission also intends to use the services of Mr. Leo Morris, Family Planning Evaluation Division, Center for Disease Control (CDC), Atlanta, Ga., to analyze the demographic trends and this will be documented in the yearly evaluation of the project.

5. The term "viability" of the Population Technical Committee may not be the most accurate to describe the issue, perhaps influence or effectiveness would be more appropriate. The real issue is whether a committee of technicians can substantially influence the budgets, policies and procedures of the various ministries toward a common goal as outlined in GOES Population Policy. USAID/ES is providing technical assistance of management consultants to the committee and we believe that the results will be positive. Also we have discussed this with the other donors and they are pushing in same direction.

6. Commercial coverage of both urban and rural poor groups is considered important to the project. We have observed (Continuation Study 1974) that many acceptors will go to government clinics for an initial visit, but will subsequently purchase supplies from the local pharmacy for convenience. In some cases, the services may be subsidized, but we believe that once

an individual begins to contracept, it tends to be an irreversible behavior that he or she will be willing to pay for. The question of whether a program can become fully independent within the time frame of the project is irrelevant, since our inputs are not expected to take care of all problems. Our funds are seed monies and are expected to help build the local capability to take care of their own problems.

Condom and pill machines will be used in selected locations such as factory dressing rooms, military barracks, and rural cooperative centers, where security is not a problem. At the International Fair in November 1974, the local Demographic Association displayed a condom machine and sold over \$350 worth of condoms at 4 cents each. Plans are underway to have demographic displays with pill and condom machines at numerous small town fairs throughout the country.

7. At this point, Mission is not sure whether further bilateral assistance will be required after FY 1978. We do feel that by 1978 there will be a definite downward movement in the CBR and a local institutional capability to deliver services. If further assistance is required after 1978 (MOH presently receives approximately 15% of national budget), the Mission's present thinking is that such assistance should be in the form of a loan, but not necessarily from AID. We believe that the evaluation of the project in FY 77 should address this matter.

8. Projected coverage of 174,000 women in organized family planning programs by the end of project is a realistic estimate based on the available supplies, personnel, and proposed delivery systems. As pointed out

in the PP (page 25), a larger investment is politically unwise and probably beyond the host country's managerial capability. For more detailed demographic data, Mission will work with CONAPLAN, CDC, and the Demographic Association to develop a profile of the target population. We already have population projections but question their reliability and would prefer to transmit the information when the first Mini-KAP is tabulated. For example, the MOH on its official publication (1975) reports 716, 159 women in fertile age, while the Demographic Association estimates 910,000 and CDC projects 927,785.

9. The point in reference cable that the CBR decline will accelerate as service coverage increases is well taken and we would welcome the services of a demographer for one month TDY in early 1976 to help us analyze the situation.

10. The backlog of patients waiting for sterilizations is a problem that should be solved within the next year. PIEGO is training four M.D.s to operate laparoscopes in November 1975. In September 1975, 10 physicians were trained in Mini-Lap procedures by AVS consultant and the training of 10 M.D.s in vasectomy procedures is scheduled for November-December 1975. Additional doctors will be trained as soon as the equipment can be purchased, trainees identified, and facilities prepared. We have moved continuously to make sure that all personnel performing surgical procedures are well trained, thus avoiding adverse publicity. Success to date in sterilizations has been attributed to word of mouth communication by patients who were pleased with services received. The use of para-

medical personnel in rural areas where there are few physicians should not present an insurmountable problem. Mission has been coordinating with other donors and is pushing for use of para-medics. We already have agreement from the Minister of Health to put medical kits with an abundant supply of contraceptives in the homes of 1,500 malaria workers. To demonstrate the value of trained Women's Health Care Specialists (WHCS), we have an agreement to place these nurses in selected rural sites. We feel certain that these nurses will demonstrate their ability to deliver services and convince the physicians they are not a threat to their jobs.

11. The discrepancy in PP and CP was the result of an upward revision (for CP) by PHA/POP in the cost of central funds for contraceptives. We have recalculated, using new estimates of contraceptive needs, the revised yearly and total costs of the project as shown in the face sheet and paragraphs 2 and 3 of this annex. Also, these new figures should be reflected in the Log Frame (Annex E), Inputs Section, as "b. AID/W contraceptives (\$ thous) (1,120) - FY 76 ⁴⁰⁸~~293~~., FY 77 ³¹⁴~~384~~, FY 78 ³⁴⁴~~443~~."

PART I Project Summary and Recommendation

B. Recommendations:

	<u>76</u>	<u>77</u>	<u>78</u>	<u>Total</u>
Grant (Mission)	\$263	\$300	\$349	\$912,000
(AID/W)	408	314	344	<u>1,066,000</u>
Total New AID Obligations				\$1,978,000

C. Description of the Project.

The project will build the institutional capacity and capability in El Salvador to alleviate its population problem. Under the project, which includes a number of sub-projects, resources will be provided to assist the National Population Commission in implementing the National Population Policy. The Population Technical Committee, the working arm of the Population Commission, will be responsible for organizing and carrying out all project activities, but this does not preclude AID working directly with selected individual organizations. There will be a total of 10 private and governmental organizations and units involved.

At the end of the project in December 1978, there will be a total of 174,000 women (approximately 19% of the population) in the fertile age (WIFA) protected with effective contraceptive methods - male and female sterilizations, pills, IUD's, condoms, etc. The protection of the 174,000 women will be reached through the mobilization of national resources supplemented by AID and other donors (UNFPA, IPPF, Pathfinder, Population Council, IFRP, Inter-American Foundation, PAHO, etc.). Each host country organization (Part III, Section A) will have a clearly defined area of concentration in the implementation of the National Population Policy. Over 85% of the population will have access to family planning services and information on the advantages of limiting fertility.

There will be an institutional mechanism to monitor the activities in each of the organizations and a national evaluation system to measure demographic trends.

AID's grant inputs will include contraceptive supplies, sterilization equipment, training, educational materials, clinic equipment and specialized technical assistance. AID will also concentrate on a number of small innovative sub-activities to reach segments of the population that are not being covered by the present FP delivery system. For example: malaria workers, agricultural extension agents, volunteer health workers, rural promoters and satisfied users will work in communities in the promotion of family planning, referral of patients to clinics and re-supplying contraceptives to users. Also, condom machines and possibly pill dispensing machines will be placed in selected locations to resupply users. All of the activities proposed in the project are based on documented evidence in El Salvador or other similar situations (see bibliography) which has convinced the project designers (in collaborative style) that the collective inputs will produce the outputs forecast which in turn achieve the project purpose.

The fact that there will already be a reduction in the birth rate by the end of the project will substantiate that the institutional capacity and capability exists in-country to further reduce the population growth rate.

D. Summary Findings

From 1966 thru June 1975, AID has invested \$2,810,000 in assisting the Government of El Salvador and selected private organizations in the delivery of family planning services and in dramatizing the adverse effects of rapid population growth on social and economic development. In the early years of

AID assistance, activities were often conducted in an indirect fashion and the GOES involvement tended to be passive and cautious. Starting in 1973, the Government began to take a stronger interest in population matters. For the first time, Cabinet Members began to make public statements about the demographic situation and its effect on the delivery of social services, agricultural production, nutritional status of the population, educational institutions, migration of Salvadorans, etc. USAID assistance played a key role in creating this awareness and the favorable climate for an attack on the population problem.

In 1974 with considerable technical assistance from USAID, the Government of El Salvador prepared a "National Population Policy", which was announced by the President of the Republic in his annual address to the nation. The Policy establishes the legal and administrative framework for the Government to allocate further resources to reduce its population growth rate. Now that the Government has shown its serious intention to reduce the growth rate by allocating budget support and personnel, it is the judgement of the project designers that AID's input over the next three years will have a significant impact on the demography of the country as well as establishing the provision of family planning services as a regular part of the health delivery systems.

We believe that the project meets all applicable statutory criteria.

E. Project Issues.

The Mission Implementation and Evaluation Committee (MIE) in its review of the Project Paper raised the following issues: (1) viability of the Population Technical Committee as a working arm of the Population Commission (composed of six Ministers representing: Health, Labor, Education, Agriculture, Interior

and Planning Board), (2) need for continued AID assistance, (3) feasibility of using nurses as primary providers of family planning services in light of professional sensitivities of local physicians, and (4) relationship of AID to other donor inputs.

The Committee concluded that the issues are satisfied addressed in the following manner:

(1) The Mission is to provide technical assistance of management consultant to help the Technical Committee in developing a concrete work plan involving all relevant governmental agencies. CONAPLAN has assigned counterpart personnel to follow-through on recommendations.

(2) AID will concentrate, although not exclusively, on providing contraceptive supplies, modern sterilization equipment and training related to new techniques, areas which are presently beyond the fiscal/technical capability of the GOES. The substantial GOES budget increase projected will be primarily devoted to the considerable expansion of infrastructure for FP services and programs. AID assistance is considered necessary to absorb the start-up costs of the many innovations proposed in the project.

(3) The Mission expects to obtain the Public Health Minister's agreement, prior to disbursements of funds, that nurses will be allowed to provide first visit consultations to family planning clients, particularly in rural areas where physicians are insufficient. General agreement has been reached with the MOH and a training schedule prepared. Initial placement of such trained paramedics in rural areas will encounter the least resistance by the medical community and constitute the break-through for their gradual expansion.

(4) To achieve the vast expansion of the FP program as planned, much external

assistance will be required. There is no overlapping of AID assistance with the other chief donors, such as UNFPA and IPPF, whose support is mostly for personnel costs. (See Annex B for component breakdowns.) Moreover, all foreign donor activities will be coordinated by the GOES Population Technical Committee.

PART II: Project Background

A. Background

El Salvador's last census, 1971, demonstrated a dramatic population growth rate of 3.5% over the previous ten years. The 3,549,260 inhabitants registered in the 1971 National Census numbered two and a half times the population of 1930, and represented a doubling of the population in the 20 years from 1950 to 1971. In terms of land-area, this population and growth rate means that El Salvador has a gross density of 490 persons per square mile and a net factor of over 600 per square mile (per geodetic survey and 1974 tabulation of the 1971 Census), i.e., discounting the waterways, swamps, and some extremely mountainous areas.

This was sufficient to cause concern among certain government officials and private sector leaders, who realized that efforts to raise per capita income levels for the poor were being swallowed up by the increase in the population and that it would become increasingly impossible to provide adequate social services to the increasing population. However, as early as 1962, this awareness had precipitated the formation of the non-government Salvadorean Demographic Association (SDA). The SDA's initial purpose was to disseminate information on the country's demographic situation and to provide family planning clinical services on a private, but low-cost basis to the general public. The SDA went through several evolutions, affected largely by the increasing governmental interest in pursuing a health-connected family planning service. However, the thrust of the SDA remains essentially the same, and SDA today is the leading private organization supporting family planning information and clinic services expansion, research and evaluation.

In 1968, upon request of the Ministry of Health (MOH), the USAID Mission in San Salvador began giving support to the first government-supported and operated family planning and health services program. This program was designed to create a governmental capacity to respond to the public's need for family planning material assistance, while attempting to raise the level of public and private awareness by the GOES. AID financing in FY 1969 supported the joining of public and private sector efforts. For the first time, FP services were included as an integral part of the MOH Division of Maternal-Child Health. The SDA received budget support and commodities, which allowed the SDA to carry out educational, motivational, training, and research activities. (See PROP Family Planning and Health Services, Project #519-15-530-149, submitted Sept. 1, 1967. Also, see Vernon R. Scott, End of Tour Report, April 20, 1970, TOAID A-74).

There are three major benchmarks in this continuing program:

1. The first phase, successfully completed in 1971, ended Mission funding of clinical personnel when these doctors and nurses were included in GOES payrolls.
2. The second phase began development of a national population policy and expansion of the national FP program. AID supported expansion of the clinic infrastructure, increased training of personnel, and provision of technical advisors. Two studies in 1974-75 measured progress: Leo Morris and Tegualda Monreal, Center for Disease Control (CDC), Field Trip Report, Oct. 13-19, 1974, dated Dec. 30, 1974; and PAR No. 75-4, submitted May, 1975, covering the period of July 1973 to December 1974. The latter includes reference to the official GOES population policy of October 1974.*

* Copy of CONAPLAN's policy on file in PHA/POP/LA.

3. The present (third) phase consists of a concerted and coordinated effort to use all means available to deliver these health/population services throughout the marginal urban and rural areas. Currently, with the impetus created by the National Population Policy declaration, the USAID and public/private sector programs reflect consensus that adequate conditions prevail to permit a concerted effort for impact on the general demographic situation. For example, agreement has been reached that the rural population must be the primary target of future programs. Further, there is growing support for resolution of one of the key bottlenecks to implementation of a rural-oriented strategy, that is, the traditional public health sector attitude that physicians per se should be the principal agents in providing services, including those services of preventive medicine and thus, family planning. Resolution of this bottleneck, which has impeded impact upon marginal urban population as well, will go a long way toward development of personnel to provide basic health services of somewhat less sophisticated delivery, but critical to general health improvement, including access to family planning services for the poorest majority in El Salvador

In summary, the GOES has taken appropriate steps to alleviate the demographic situation while simultaneously striving for improved health delivery services for the general population at reduced cost. Family planning is basically institutionalized within the public and private sectors, although the impact (significant growth rate reduction overall) will require concerted effort and support of AID through 1978. At that juncture, evaluation should demonstrate both full institutional capability and definite impact trend reflected in a declining birth rate.

B. Detailed Description

Sector Goal - To reduce the national fertility rate, which will enhance and support the possibilities for success of other development strategies and programs aimed at the lower-income earners.

Project Purpose

- To establish the institutional capacity and capability to protect 174,000 women in fertile age (WIFA) with effective methods of contraception. The conditions that will indicate the purpose has been achieved will be (1) 174,000 ^{Continued} acceptors (excludes drop-outs) enrolled in the organized family planning programs and (2) an increase in the financial and budgetary resources to population/family planning activities.

Planned Outputs of the Project

- 1. Expanded national sterilization program.
- 2. A women's health care specialist training center established.
- 3. Community health aide system established in rural areas.
- 4. Comprehensive GOES work plan issued, revised and implemented.
- 5. Medical/paramedical personnel trained in more effective family planning techniques and/or administrative procedures.
- 6. Establishment of annual mini-KAP surveys and counterpart family planning data system computerized.
- 7. Establishment of family planning information system by non-medical referral agents in rural areas.

Planned Inputs of the project.

(See Log Frame attached for detailed budget breakdowns by agency, component and year)

- 1. AID-appropriated funds of \$1,978,000 for the life-of-project. Bilateral funds of \$912,000 are to be used for contract services, commodities, participant training and support of other costs, including research, while AID/W centrally-funded contraceptives (orals and condoms) valued at \$1,066,000 are requested.
2. A Host Country contribution from the Ministry of Health, the Salvadorean Social Security Institute, and other national agencies of \$4,419,000 for the three years. These funds support personnel (in-kind medical and administrative services) and commodity purchases, including contraceptives.
3. Other Donors to provide \$1,814,000 to the project. UNFPA, IPPF, Pathfinder, Population Council, Inter-American Foundation, PAHO and others can be expected to fund substantial personnel and equipment costs as well as international training and other supportive activities.

The sector goal to which this project will contribute is the establishment of a downward trend in national fertility rates in all population sectors and age groups, but particularly among the rural poor and urban marginated ^{1/} populations. This decline is expected to approximate one point per thousand during

^{1/} In this PP the terms "marginated" or "marginal" when applied to urban populations are used to identify dwellers who although geographically located in city/town environments possess the values, attitudes, and mores of rural inhabitants, and who for lack of functional literacy, skills, and means of self-improvement are unable to participate fully in the economy and thereby improve living conditions.

each of the three years of the AID supported project (CY 1976-1978). With a 1975 crude birth rate (CBR) estimate of 42/1000, the rate will eventually drop to 38/1000 in 1979.^{2/} The project purpose is to establish the institutional capacity and capability to protect 174,000 women in fertile age with effective methods of contraception by means of a greater mobilization of national resources. Accordingly, the target number of women in fertile age, protected by the public program, deemed necessary to indicate end-of-project status is estimated at 174,000 by December 31, 1978.

^{2/} The results of contraception due to the project in 1978 will become evident only in 1979 as births averted during that year.

PART III - PROJECT ANALYSIS

A. Technical Analysis Including Environment Assessment

The project will utilize the most advanced methods in family planning technology including modern male and female sterilization procedures, which are strongly supported by the GOES. Presently, there are 15 hospital clinics providing female sterilizations to post-partum patients. Of these clinics, five use laparoscopes, two use mini-laparotomy kits and one uses the culdoscope. The clinics alone have three-month waiting lists for the procedure. Also, five vasectomy clinics are operational, but there is a waiting time of over two months. The acceptability of sterilization as a form of "parental responsibility" is phenomenally high in El Salvador. According to the Population Reference Bureau, in 1973 the country performed 22% of all female sterilizations reported in organized family planning programs in Latin America; El Salvador's population represents 2% of the LA total.

A pilot study (1974)^{1/} among campesinos (rural workers) has shown that men will accept and use condoms. In addition, orals, IUDs, foam, jellies, diaphragms, and injections for females are available in both private and public clinics, with some extension of these services through cooperative groups.

Organized programs as of March 1975, show 87,000 acceptors among women, or almost 10% of the total female population in the fertile age group. There is an indication that private sector programs are reaching an equivalent number. Condom sales in 1973 totalled 58,900 gross; female sales of pills covered 289,200 cycles.^{2/}

1/ "Pilot Condom Distribution Program" by John Manning, Peace Corps Volunteer

2/ See FP Annual Report dated January 1975.

To ensure that the rural population and the poorer groups in the "zonas marginales" have maximum access to family planning services, a number of innovative delivery systems are a part of the project. Emphasis will be placed on using the Women's Health Care Specialist (non-physician) as the primary provider of family planning services. Volunteer malaria workers, agricultural extension agents, rural promoters, satisfied users, military personnel, and auxiliary nurses are and will be used to re-supply oral users. These workers are being provided training kits and printed materials in order to be able to explain better the various methods and sources of clinical services. Most of the workers are to have an ample supply of condoms for all their clients in their area of control.

The reliance on non-physicians is necessary because over 70% of the practicing doctors are located in the capital city and there is no other effective way to reach the rural populace with family planning services. At the same time, an analysis of hospital records in the capital city and the 14 MOH regional hospitals shows that these facilities are reaching a significant number of the rural population (approx. 30% of patient load). Expansion of services, as proposed, will reach a much larger number of people with both interim (contraceptives) and the more permanent methods (sterilizations) of family planning. Extending the outreach of the hospitals is possible because of the small size of the country and the relatively well-developed road system.

The Ministry of Health and the Social Security Institute network of health services (See Part IV, A, 1) will continue to be the backbone of the delivery system with a proposed expansion of strong back-up from the para-medical and non-medical workers. Also, there will be an expansion of the commercial sector to include such innovative approaches as condom and

pill dispensing machines. The basis for the latter is a pilot study (1974) testing use of ten condom machines. The study indicated this impersonal method of supplying family planning commodities was culturally acceptable and that when placed in the proper locations, security was not a problem. Another study (Comercialización de Anticonceptivos, 1975) of contraceptive sales in 63 pharmacies with promotional efforts indicated that this was an effective way to reach a sizeable segment of the population. Plans are under-way to duplicate the promotional program in the country store setting.

The entire project will provide employment for about 1,082 persons: at least 300 low-level community workers, 216 physicians (some part-time), 268 graduate and auxiliary nurses, 14 social workers, 84 user-promoters, 200 agricultural extension agents (part-time), and 19 administrative personnel. In the public sector almost all of the personnel will be involved in the provision of family planning services. Its impact on the private sector can not be estimated at this time.

From previous pilot project activities, the host country has already shown its capability to maintain and operate all the equipment to be purchased for the project.

There does not appear to be any part of this project which will lead to the further degradation of the environment. Hopefully, this project will help reduce further strain on the environment due to population density and scarcity of utilizable land.

Analyses and conclusions reached in this paper are based on AID guidelines and are in compliance with Section 611 of the Foreign Assistance Act.

In conclusion, the grant funds to be expended in this project are for goods and services which in the professional judgement of the technicians developing the project are essential for completion of the program. We also believe that it meets the requirement of Section 611 (a) and (b) of the FAA.

B. Financial Analysis and Plan

1. The financial rate of return/viability for the project are based on the G.E. Tempo Models "Offering Bonuses for Reduced Fertility" (1973) and "Economic Incentives: a Strategy for Family Planning Programs" (1972). According to the G.E. Tempo study, the capital value of an infant at birth, in present value (discounted) terms, is negative in all LDC's. Using the model, the value of preventing a birth in El Salvador is \$835. (See detailed explanation, Part III, Section D). During the life of the project (CY 76-CY 78) approximately 83,360 births will be prevented for a savings of \$71,275,600 ($\$835 \times 85,360$) against a cost of \$7,781,000 for implementing the Program.

2. Recurrent Budget Analysis of Implementing Agencies.

Upon examination of the budgets of our principal counterparts, the Ministry of Health and the Salvadorean Social Security Institute, the Mission believes that the local resource allotment to guarantee the project's continuity after AID's financial withdrawal will be sustained. At the same time, the Legislature of El Salvador must approve budgets annually; thus the estimates shown in the document cannot be considered final and binding.

These budgets, projected through 1978, have been jointly analyzed by AID and counterparts with agreement that they constitute the best estimates at this time. As detailed below, the MOH fiscal commitment will progressively increase to encompass the program expansion from \$652,872 in 1976, to \$784,791 in 1977 and \$838,115 in 1978. There is no reason to believe that this budgetary level of support to the project will not be maintained or increased after 1978. As for ISSS, projections of support total \$210,532 in 1976, \$311,300 in 1977, and \$467,300 in 1978. The same assumption stated above for the MOH applies to the ISSS situation and these are planning figures.

Estimated Operational Budgets,
Principal Counterparts,
Earmarked for Family Planning Activities.

<u>1976</u>	<u>MOH</u>	<u>ISSS</u>
Personnel (in-kind medical and adm. services)	\$554,994	\$158,074
Commodities (includes contraceptives)	<u>97,878</u>	<u>52,458</u>
Total	\$652,872	\$210,532
 <u>1977</u>		
Personnel (in-kind medical and adm. services)	\$618,413	\$235,800
Commodities (includes contraceptives)	<u>166,378</u>	<u>75,500</u>
Total	\$784,791	\$311,300
 <u>1978</u>		
Personnel (in-kind medical and adm. services)	\$638,115	\$354,050
Commodities (includes contraceptives)	<u>200,000</u>	<u>113,250</u>
Total	\$838,115	\$467,300
GRAND TOTAL FOR BOTH AGENCIES		\$3,265,000

Listed below are other governmental and private organizations which will participate in the project. Their contribution is not broken down annually since a substantial increase in their budgets is not anticipated and their inputs are usually in-kind:

Salvadoran Demographic Association	\$ 60,000 annually
CONAPLAN	75,000 "
Unión Comunal Salvadoreña	70,000 "
Clicina Mejoramiento de Comunidades Marginales	14,000 "
FOCCO (Programa de Fomento y Cooperación Comunal por Esfuerzo Propio y Ayuda Mutua).	11,000 "
Ministry of Education	50,000 "

Ministry of Agriculture	\$ 46,000 annually
Ministry of Defense	<u>60,000</u> "
T O T A L	\$ 386,000
TOTAL FOR THREE-YEAR LIFE OF THE PROJECT	\$1,158,000
GRAND TOTAL OF ALL LOCAL AGENCIES FOR LIFE OF PROJECT	\$4,419,000

C. Social Analysis

The conclusions presented in this section are based on a wide range of studies and reports (see bibliography), observations of Salvadoran professionals with a social science background, and the first-hand knowledge of the technicians preparing the reports.

1. The intended beneficiaries of this project are the rural and urban poor who cannot afford family planning services from a private physician. The program will not only make available family planning services, but also provide the recipients with the information to make a choice as to the number of children desired. From a series of well-designed surveys and knowledge, attitudes and practices (KAP) studies by the private Demographic Association (SDA) and the Ministry of Health, we know that middle and upper class Salvadoran families are regulating their fertility. Since innovations diffuse from urban to rural (not vice-versa), we propose to saturate the urban areas with services as well as further extend services to the countryside. We have found that if a campesino's city cousin is not an acceptor, there is less chance of convincing the campesino. Furthermore, due to the small size of the country and its cities, the urbanites (often poor) return frequently to the countryside and are excellent conveyors of new technology. (See Rogers, Diffusion of Innovations).

There are approximately 900,000 Salvadoran women in the fertile age group. Each year approximately 170,000 children are born and there are an estimated 70,000 illegally induced abortions, e.i., those performed without acceptable medical supervision. Approximately one out of nine such abortions results in the hospitalization of the woman for an average of three days. This is a drain on the health budget that the country cannot afford, not to mention the human suffering involved. In addition, studies by the Demographic Association (1972), indicated that 72% of children born are the result of consensual partners and unregistered marriages and are legally considered "illegitimate". KAP studies indicate that over 30% of the children would not have been born if reliable family planning services were available.

In the total population (1972), 73.6% of all children under five years of age are suffering from first, second, or third degree malnutrition and the relationship between family size and the prevalence of nutritional problems is evident. (See Contribution of Family Planning to Health and Nutrition).

The philosophical basis for providing family planning services by the Government and private associations is to improve the health and well-being of the recipients. Besides receiving clinical contraceptive services, female patients are given a complete physical examination and any maladies are treated as part of the family planning services. For example: in 1974, 62% of all females receiving services (MOH, SDA, and ISSS) had gynecological infections and were provided treatment. Also, cancer screening and treatment of positive patients is a regular part of the services of the project. Since patients benefit immediately from the services provided, the spread effect of the project is assured because satisfied users are the best conveyors of the

message on the benefits of family planning. In fact, the project will provide training to rural acceptors to work in hospital wards and clinics to explain to prospective patients the "what, when, where, and how" of family planning services.

To ensure that the project is responsive to the expressed wants and needs of the community, in formulation of the project, the designers have drawn heavily on the observations of the Juarez Associates Report (1975). This contractor convened panels in villages and summarized the reactions in regard to the provision of family planning services. As an example, we found objection to the emphasis in the information program on the role of women in fertility control to the exclusion of men. As a result, the information program was redesigned and there has been an increasing demand for male sterilizations, and a pilot condom distribution project was initiated. Also, many female acceptors have told us they do not have to practice family planning secretly now that their partners understand it and accept mutual responsibility for determining the number of children.

2. In the design, careful consideration has been given to social impediments which might adversely affect the success of the project. It is often suggested that the Latin males' "machismo" attitude gives little hope for a rapid decline in fertility. However, recent field experience in El Salvador (see "Pilot Rural Condom Distribution Program by Manning", 1974) indicates that the rural males are enthusiastic condom users. Recognizing the imperfection and inconvenience of condoms, many campesino males are now requesting vasectomies. In the first month of opening the initial vasectomy

clinic, the seven-man Board of Directors and 40 regular members of a rural cooperative were vasectomized. The single drawback is the current two-month waiting list for the service. This evidence indicates that Salvadorean males will indeed assume responsibility for limitation of their family size when a program is designed with a strong educational component which clearly explains in campesino terminology the advantages of family planning and the methods to be used.*

Since El Salvador is a predominantly Catholic country, it has also been argued that wide acceptance of modern contraceptive technology is unlikely. This has not been the case in El Salvador. First, a number of priests have been very active in promoting natural methods of family planning. Admittedly these methods have a high failure rate, but any method is better than none, and more important, many couples who fail to prevent a birth by using the natural method are likely to resort to more modern methods of family size limitation. Moreover, there has been no strong or effective effort by the Church to deter progress in the promotions of more modern methods.

The project designers have had frequent dialogues with church leaders and emphasis is placed on the campesinos "right" to the information on methods to limit their family size and the necessity of the individual to decide how to use the information. This approach, while a policy of the government, also appears compatible with modern church dogma (see Bishops' statement from Mexico, 1973, and Bishops Conference at Medellín, 1968). In 1974, the Salvadoran Catholic Church sponsored a three-day public meeting on population

* See Allen LeBaron and Associates Draft Report #1 of "Investigation of the Social & Economic Aspects of the Proposed Tenure and Production Program" (June 1975) for a description of Salvadorean peasantry as highly independent in character with advanced modern orientation and high value placed on education.

problems. The meeting, which was broadcast over radio, featured a number of prominent clergy who expounded on the adverse social and economic effects of runaway population growth rates. Except for a few isolated cases, there appears to be no reason to believe that this project will fail because of opposition from any religious group.*

3. Impact on Women: While it is obvious the general program has a high ratio of female participation, e.i., the target group, project designers feel strongly that the FAA Section 113 and resulting Policy Determination No. 60 of 1974 have broader implications. In brief, we see a direct relationship between family planning, women's status, female employment and opportunity for female self-realization, as equivalent and mutually reinforcing objectives of this project.

For example, in the employment sector, women in El Salvador tend to follow the traditional transference from non-paid family household chores to domestic service jobs, which do not always provide opportunities for advancement, nor do they comply with the minimum wages and working conditions provided by labor laws. Women seeking business/industrial employment may have to take lesser jobs and/or find employers reluctant to hire them because of laws providing for three-months paid maternity leave per pregnancy. Seen from a family planning point of view, their situation tends to enhance fertility rates unless steps are taken to circumvent the problem. The project designers have attempted to develop an approach that would address this problem and would receive the support of the cooperating ministries and private sector organizations. As a result, although it cannot yet

*Again, see the LeBaron Study for the view that religion is of minor significance in the culture of the Salvadorean campesino, page 25 of the draft report.

be tested for progress against the P.D. 60 objectives, this particular project has moved beyond consideration of the women's participation solely as a target group for family planning.

The following examples are some of the project features demonstrating this:

- a. The MOH Director of the Division of Maternal-Child Health and Family Planning is a woman physician, whose own sensitivity regarding the relationship of policies to women's rights and status is particularly acute and is reflected in both public employment of family planning personnel and in public policy. For instance, the National Population Policy has as one of its objectives that of increasing women's participation in the labor market and has been influenced by the evidence that fertility is reduced when females have a saleable skill outside the household.
- b. The project will expand family planning services at the factory site. Local experience (the Population Dynamics Quarterly, Winter 1974) has shown 80% reduction in pregnancies when good FP services are provided at the factory site.
- c. Extended promotion of FP information and services to the rural areas, principally through extension agents and cooperative groups, helps reinforce the changing role of both women and men toward responsible parenthood. Women participants in one of the largest campesino organizations in the country are now being encouraged by the male members to form a women's organization to obtain new skills, including literacy, along with education in family planning, nutrition, and more traditional occupations of the household. The campesino group is sponsoring this movement and

simultaneously seeking means of reducing the time-consuming chores of women in the home. Family planning, which is just beginning to impact on the rural areas, is seen as a key factor influencing this changing role of women and increased awareness among men that happier, healthier women can mean generally improved social and economic conditions.

- d. Concentration on production of informational materials, which are principally visual-aids to education, has tended to enhance the already high level of interest in education (per the LeBaron study) and provided a certain filling of the gap in materials to reinforce functional literacy. This is particularly important in El Salvador where rural education is generally only through the third grade, and women's access to literacy stimulation is particularly limited due to lack of exposure outside the home.
- e. Provision of male orientation in family planning, as is GOES policy, has helped shift responsibility from the women and afforded her greater security and protection.

In summary, by attention to employment of women in the family planning program, by recognizing and directing attention to women in the employment sector, by encouraging extension of family planning informational and other services through family type organizations and directing services toward men, and by specific attention to policies relating family planning to other economic and social conditions, we believe we are beginning to realize a changing role and status of women, particularly in the rural areas. Follow-up evaluation of this should be considered at some future date, in connection with the final evaluation of this project.

D. Economic Analysis

With an annual population growth rate of 3.1% (July 1975), El Salvador doubles its population every 22 years. When the population growth rate is subtracted from an annual GNP growth rate of 5.7% and an inflation factor is taken into account, the prospects for rapid per capita economic growth are dismal.

The nation's supply of potential land and natural resources is strained by the gross population density of 490 persons per square mile. The labor force for the next 20 years has already been born and presently 46% of the population is under 15 years of age. According to the Government's planning estimates, unemployment is approximately 22% and underemployment is considerably higher.

The project is an investment in human capital with the emphasis on quality of life for the individual family. Incomes for most campesino families are relatively fixed. Therefore, a family of four tends to have the same resources to divide as a family of eight. While incomes may go up and employment opportunities may increase, there is already a critical situation regarding present and future employment opportunities. The incidence of malnutrition (73% for those under five years of age), impaired learning capacity, and high infant mortality are some of the human costs of the preceding and current rapid population growth rates.

The designers of this project have calculated (using the TEMPO Model) that the value of preventing a birth in El Salvador is \$835. As of March 1975, there were 87,000 women contracepting in organized family planning programs. Based on the national fertility rate of 194 births per 1000 women in the

fertile age group, we calculate that 16,870 births* were prevented for a saving of \$14,086,450 (\$835 x 16,870). During the life of the project (1976 to 1978) the target is a twenty per cent increase (based on estimates of clinics' performance) in the number of births prevented annually, but more importantly, the project will build the institutional capability for the GOES to continue this program without substantial foreign assistance. Using the most conservative figures (re number of births prevented), the table below shows the projected economic rate of return from the public program.

Year	Number Acceptors Annually (in 000)	Number of births prevented Annually	Dollar Value	Dollar Cost of Program	Rate of Return
CY 76	121	23,474	\$19,600,790	\$2,454,000	699%
CY 77	145	28,130	23,488,550	2,652,091	786%
CY 78	<u>174</u>	<u>33,756</u>	<u>28,186,260</u>	<u>2,674,909</u>	<u>954%</u>
TOTAL		85,360	\$71,275,600	\$7,781,000	816%

Obviously the model makes a number of assumptions which the designers are not qualified to defend (although we intend to examine these concepts more closely as staff time permits), but even if we assume that the model is 70% incorrect, the economic rate of return is still well over the acceptable minimum of 15%.

For a more detailed general economic analysis of El Salvador, see the DAP and the Mission's Strategy Paper dated September 1973 and June 1974 respectively.

In an attempt to analyze the benefits of a larger investment, the project designers concluded that a substantially bigger investment from AID is presently beyond the managerial capability of the host country institutions.

*This estimate is probably low since over 17% of acceptors have chosen sterilization which is permanent.

PART IV - Implementation Arrangements

A. Analysis of the Recipients and AID's Administrative Arrangements

1. Recipients

This project will be administered through the National Population Commission that is composed of six Ministers whose functions were established with the declaration of the Government's National Population Policy. To carry out the policies of the National Population Commission, a Technical Committee of representatives of the implementing agencies (described below) has been established.

CONAPLAN, the Planning Office of the GOES, will assume a role of Coordination and Planning. The Technical Committee is in the process of drawing up a plan of action which is subject to review and approval by the Commission.

Organizations involved in the delivery of services and affecting changes at the community level are as follows:

- (a) Ministry of Health (MOH) - operates 14 hospitals - eight health centers - 69 health units - 114 health posts - all of which will deliver family planning services. The MOH has primary responsibility for delivery of services to rural areas and has coverage of approximately 80% of the population. It also serves as a trainer and technical advisor to other agencies working in the project.
- (b) Salvadorean Social Security Institute (ISSS) - maintains 38 clinics and covers 5% of the population with services, but this is expected to increase to 15-20% of the population by 1980. ISSS tends to focus on factory workers in urban areas and medium size regional towns.

- (c) Ministry of Agriculture (MAG) Extension Service - responsible for working with farm families and training rural leaders. Also refers patients to MOH clinics, distributes condoms, and resupplies pill patients who have enrolled in MOH clinics.
- (d) Salvadoran Demographic Association - responsible for operational research, training, evaluation and mass media campaigns. Also expected to work with private industry on commercial distribution of contraceptives and inclusion of population content in training institutions.
- (e) Ministry of Defense - will deliver services to own personnel through their separate health services. It is also contemplated that the military will distribute contraceptives to rural communities and provide referral cards to villagers for services at MOH clinics.
- (f) Unión Comunal Salvadoreña (UCS) - a rural cooperative (40,000 members) that has a staff of nine promoters (exclusively for family planning) who conduct educational programs, distribute condoms and take patients to MOH clinics. Considered primary recruiter for vasectomy patients.
- (f) Bureau of Census - responsible for data base from which demographic changes can be measured and processing of national surveys co-directed by CONAPLAN.
- (h) Ministry of Education (MOE) - responsible for sex education. Plans are underway which will utilize MOE's educational television station to disseminate the population message. This is now considered an underutilized resource with considerable potential.

2. A.I.D.

No additional direct-hire staff commitment is contemplated in this project. We do, however, intend to continue utilizing short-term specialists who can be provided under AID/W Central Contracts with PHA/POP. As an attachment to this document, AID/W is requested to prepare a Development Assistance Support Paper (DASP) that details the types of centrally funded support available to carry out this project. The DASP should include services and goods available from PVO's, universities, private companies, foundations and other government agencies (PASA's), as well as the central procurement of contraceptives and family planning-specific supplies.

USAID/ES will procure goods and services to support the project through established AID channels. ProAg's will be signed with the Ministry of Health and the Social Security Institute and be subject to the review of the Population Technical Committee. Other institutions, such as the Demographic Association and Ministry of Agriculture, will also receive AID assistance and that support will be included in the ProAg's of the MOH to assure compatibility with the National Population Program.

B. Implementation Plan

Each of the organizations and agencies carrying out population activities will be represented in the Population Technical Committee. Each of the participating members has a relatively well-defined plan, but there are some gaps in specific areas and the linkages between the organizations are not always clear. For example, in the past, the mass media campaign by the SDA may not have been very responsive to the clientele of the ISSS or MOH. To circumvent this problem, all assistance (not only from AID, but UN, PVOs, etc.) will be

channeled through the Technical Committee. To further refine the plans of organizations and deal with specific problems that arise, the project will draw upon the expertise provided by AID/W Central Contracts as described above in Part IV, 2.

The life of the project is from CY-76 through CY-78. (See Project Performance Tracking Network Chart, attached as Annex A)

Milestones, against which success, planned implementation, and completion can be measured, are contained in the specific plans of the participating agencies and organizations, and are only considered to be indicators of the institutions' performance. The real measure of success is the institutional capability within the country to handle its population problem without external assistance. The true test of whether the institutional capacity/capability is sufficient and effective will be reflected in a definite trend of declining fertility by the end of this project. (For further details see Evaluation Arrangements, Section C below.)

There are a number of minor details which must be negotiated with the separate organizations, but there is general agreement on the thrust of the project. For example, agreement has been reached on the need to improve the MOH family planning services statistics, but it has not been decided whether the MOH will use a self-contained mini-computer or attempt to use Bureau of Census facilities. In both cases the cost is about the same and the options are being studied.

Each agency will monitor its own program and provide quarterly activity and statistical reports to the Population Technical Committee as well as AID and UNFPA. The statistical reports will be incorporated in the world wide

AID/W-PHA/POP report. The AID/ES Health and Population Staff (2 DH, one local professional) will make frequent field trips with local counterparts, and the two Population Council Advisors (monitors for the UNFPA inputs into the program) are also expected to do the same. To ensure that local supervisory personnel and senior officials of the participating organizations are in touch with field activities, at least once a week, a short video tape (15-30 minutes) will be made on particular projects and shown to the Technical Committee and appropriate agency officials. These tapes will include the reactions and problems of field workers as well as the impressions of patients who have been receiving services. This is seen as a very effective device for detecting problems and mobilizing resources to take corrective actions and also provides the beneficiaries with a mechanism for feedback on the system.

The evaluative methodologies and techniques to be used in the implementation plan are described in Section C.

Logistical support in the form of contraceptives will be centrally procured with the Mission issuing Type 5 nonfunded PIO/Cs for orals and condoms. ISSS will continue to provide its own pills by issuing (free) prescriptions to its own or local pharmacies. To augment AID supplied orals, the MOH will purchase pills in order to give patients with side effects another alternative. Responsibility for movement of supplies within the country will be handled by the operating agencies. This capability is considered completely adequate.

As explained in the Social Analysis, careful consideration was given to the views of the beneficiaries in designing the project. The beneficiaries

views are well-documented in the Juarez Associates Report, the SDA's KAP Studies, the MOH Continuation Rate Study, the LeBaron Study, and many other individual studies by the International Fertility Research Program (IFRP) with local institutions (see bibliography). With respect to the program's impact on the changing role and status of women, it has been suggested that the program will produce positive change and that this should be subject to a special evaluation, possibly in conjunction with the final project evaluation.

Family planning programs tend to have a built-in information feedback system in that patients who are dissatisfied stop using services. All participating agencies will maintain records from which dropout rates can be determined, giving an indication of patient satisfaction.

As mentioned above, video tapes of patient reaction to services will be made. In addition, regular in-service management meetings will be held with community family planning promoters, such as Malaria workers and satisfied users. It is felt that this category of worker is an excellent information feedback source from the community.

C. Evaluation Arrangements for the Project

The overall evaluation of the project will rest with CONAPLAN and the Research and Evaluation Division of the Salvadorean Demographic Association. The SDA has already conducted a National Fertility Study (1973) that provides initial baseline data against which to measure demographic trends. Annually, CONAPLAN and SDA will conduct an abbreviated nationwide household sample survey to detect changes in family size, percentage of population contracepting by method, source of family planning services, age of FP acceptors, de-

sired family size, etc., which will be used to verify modifications in the birth rate.

In each of the participating organizations, there is a data collection system that will serve to quantify progress toward planned outputs such as personnel trained, number of FP acceptors by method, talks given, messages aired, movement of contraceptives in the commercial sector, etc. These reports will also point out institutional problems that may develop. External evaluation of selected sub-projects are also planned. For example, the USDA will evaluate the impact of ^{the} family planning training program for 700 campesinos leaders by Agricultural Extension Agents. We want to know if, after a short period of training, these leaders can be used as effective promoters of family planning. We are interested in whether their activities do, in fact, lead to more acceptors at family planning clinics. The SDA will perform a similar function in evaluating the rural promotion efforts of the Union Comunal Salvadoreña. We also propose that AID perform an independent evaluation of the impact of the program including women's role in development.

With the computerized data collection system now nearly complete at the Social Security Institute, it will be possible to determine (1) number of clients and method of FP used; (2) performance of each clinic; (3) age of clients, method of contraception and number living children; (4) changes in Methods; (5) amounts of supplies dispensed. A similar system will be instituted in the Ministry of Health which will include reporting of all other clinics and units delivering family planning services. A quarterly report will be prepared and clinics that appear to be having problems will be visited by a regional supervisor for corrective action.

D. Conditions, Covenants and Negotiating Status.

The host country has taken all necessary actions and we can execute ProAg's as soon as this project is approved by AID/W. As part of the next MOH ProAg, we expect to document the Minister's agreement that trained para-medical personnel will be allowed to provide first visit consultations to family planning patients in rural areas where physicians are not available. We have general agreement with MOH and a training schedule for nurses has been prepared. The only details lacking are the selection of precise areas where the newly trained Women's Health Care Specialists will work and the supervision arrangements.

There is a certain amount of sensitivity in this area since some physicians see this new category of worker as a threat to the doctor's domain. To ensure that local physicians understand that these para-medics represent an expansion of the M.D.'s ability to give better service to more patients, we are providing studies of other countries' experiences in this area as well as on-site visits to operational programs. Given the apparent support of senior officials in the MOH and the demand for family planning services in the rural areas which cannot be met by the physicians, we believe that agreement can be reached to use more para-medical personnel. Furthermore, their placement during the first year in the most remote rural areas will minimize their being perceived as threats to physicians, whose practices are concentrated in the cities.

The UNFPA has approved (August 1975) a one-year project with the Ministry of Health. The bulk of the funds under this project will be used for hiring personnel to provide family planning services. Subject to the demonstration

of substantial progress, UNFPA is expected to approve a three-year project and the MOH will have assumed the cost of all salaries by the end of this period. AID/ES worked very closely with the UN in the development of the project and will continue to do so in the implementation. There is complete agreement between UNFPA and AID on the direction of the project.

ATTACHMENTS:

No PRP was prepared for this project (See State 150225) since it is an on-going project, but the present project has a very definite new orientation. Past efforts have gone into sensitizing the Government to the adverse effects of rapid population growth on social and economic development and carrying out a number of relatively small scale projects in the provision of FP services. All of these activities have led to a commitment by the government (see Population Policy) to reduce its population growth rate. This commitment was fostered to some extent by a big demand from the public for FP services, generated by previous efforts. Now that the government has declared its intentions and allocated budget and human resources to attack the population problem, AID assistance will be directed toward providing the technical assistance and commodity resources necessary to make a more substantial demographic impact.

Details that will be of particular interest to technical reviewers include:

1. An annual nationwide sample survey (mini-KAP) which can detect demographic changes.

2. The emphasis of the project on permanent methods of family planning (male and female sterilizations). By the end of AID's input into this project in 1978, the public program will be performing approximately 22,000 sterilizations annually and these services will become a regular part of the integrated health services.
3. The use of para-medical personnel as the primary providers of family planning services in remote rural clinics.
4. The use of malaria workers, agricultural extension agents, military personnel, rural promoters and satisfied users, as distributors of family planning information and non-prescription contraceptives.
5. The delivery of FP services at factory sites, i.e., taking the services to the workers rather than vice versa.
6. The provision of contraceptives through commercial channels, including the use of condom and pill-dispensing machines.
7. The use of the educational television network to air messages on population matters.

Any other required attachment will be prepared by AID/W, PHA/POP/LA as part of the DASP.

country: El Salvador	project no: 519-0149	project title: FAMILY PLANNING AND POPULATION	date: 9/75	/ X / original / / revision #	approved:
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CPI NARRATIVE

	<u>DATE</u>	<u>ACTION</u>	<u>PRIMARY AGENT</u>		<u>DATE</u>	<u>ACTION</u>	<u>PRIMARY AGENT</u>
1.	12/75	Two ProAg's signed with MOH and ISSS.	USAID	7.	11/76	Analysis by CDC (Atlanta) of Mini-KAP survey completed and results received by Mission.	AID/W
2.	2/76	ISSS Sterilization Center equipped, staffed and operating.	H.C.	8.	12/76	40 MOH and ISSS physicians trained in sterilization techniques and operating in at least 14 hospitals.	H.C.
3.	3/76	Women's Health Care Specialist Training Center established to upgrade FP skills of nurses.	H.C.	9.	12/76	24 Women's Health Care Specialist Nurses trained and reassigned to MOH health units.	H.C.
4.	8/76	80 Community Health Aides selected, trained, distributing contraceptives, and referring clients to clinics in rural areas.	H.C.	10.	12/76	Two ProAg's signed.	USAID
5.	8/76	GOES Population Work Plan issued by Population Technical Committee delineating tasks of governmental agencies.	H.C.	11.	4/77	200 Agricultural Extensionists Trained in FP information/referral work on-site and promoting in rural areas.	H.C.
6.	10/76	120 Auxiliary Nurses of MOH trained in new FP procedures and reassigned to health units.	H.C.	12.	4/77	Delivery of prior year contraceptive order for orals and condoms completed.	AID/W
				13.	8/77	70 additional (for total of 150) community health aides selected, trained and on-site in rural communities.	H.C.

country:	project no:	project title:
El Salvador	519-0149	Family Planning and Population

date:
9/75

/x/ original
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approved:

CPI NARRATIVE

<u>DATE</u>	<u>ACTION</u>	<u>PRIMARY AGENT</u>
14. 11/77	Results of annual mini-KAP survey received by Mission.	AID/W
15. 12/77	Two ProAgs signed.	USAID
16. 4/78	Delivery of prior year contraceptive order for orals and condoms completed.	AID/W
17. 11/78	Results of annual mini-KAP survey received by Mission.	AID/W
18. 12/78	End-of-Project Report written.	USAID

ANNEX B

SUMMARY COST ESTIMATE AND FINANCIAL PLAN

(US \$000)

Family Planning and Population/El Salvador

Source	AID/ES		AID/W FX only	Host Country LC only	Other Donors		Total
	FX	LC			FX	LC	
1. Contraceptives (Condoms and pills)			1,066	232	50		1,348
2. Personnel				3,436		978	4,414
3. Training and Participants	191					90	281
4. Data System	70			40	10		120
5. Travel				6	7		13
6. Commodities	129	90		705	300	379	1,603
7. Contracts	114	6					120
8. Other Costs, Mater- ials Production, Mass Media, Training, Seminars, Community Aides.		200					200
Inflation Factor	80						80
Contingency		32					32
T O T A L	584	328	1,066	4,419	367	1,447	8,211

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NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Sector Goal: To reduce the national fertility rate which will enhance the possibilities for success of other development strategies and programs aimed at the lower income groups.	Measures of Goal Achievement: Crude birth rate (CBR) reduction from approximately 47/1000 in 1975 to approximately 38/1000 in 1979.* * Effect of 1978 program on birth rates will not be felt until 1979.	a) National and international surveys and studies. c) Census information, Vital Statistics registers. c) Extrapolation from contraceptive use data.	1. GOES will not reverse its positive position regarding the national population policy with demographic as well as health and other rationale. 2. Private sector usage continues to increase at the present rate for next 3 years.
Project Purpose: To establish the institutional capacity and capability to protect a minimum of 174,000 women in fertile age (WFA) with effective methods of contraception.	Conditions that will indicate purpose has been achieved: End of project status. a) MOH providing protection to 113,100 WFA, 1558 to 34,800 and 504 to 26,100; organized programs' coverage of WFA to increase from approximately 10% to 19% nationally and rural coverage to rise from 6% to 13%. (Provisional figures subject to revision). b) Increase in financial and budgetary resources devoted to population/family planning activities as quantified in Financial Analysis, Part III, Section B.	To verify purpose achievements: a) Analysis of clinic records; annual fertility survey (Mini-KAP); public service program (MOH, ISSS, SOA) statistics quarterly, annual and other reports; estimates of acceptors within non-clinical distribution programs. b) Analysis of program and budgets of agencies.	Assumptions for achieving purpose: 1. Rural women will continue to receive 10% of all MCH services provided by urban centers. (See Technical Analysis, Part III, Section A.) 2. Innovations diffuse from urban to rural areas. 3. Opposition to FP from the Catholic Church, press and political groups will remain minimal. 4. The Salvadoran rural population is considered an "advanced peasantry", values education, and accepts innovations.
Outputs: 1. Expanded national sterilization program. 2. A Women's Health Care Specialist training Center established and expanded. 3. Community Health Aide system established in rural areas. 4. Comprehensive GOES Population Work Plan issued, revised and implemented. 5. Medical/paramedical personnel trained in more effective FP techniques and administrative procedures. 6. Establishment of annual Mini-KAP surveys; counterpart FP data systems computerized. 7. The establishment of FP Information System by non-medical referral agents in rural areas.	Magnitude of Outputs: 1) Capacity to handle 15,000 cases in 1st yr., 18,000 in 2nd yr. and 22,000 in 3rd yr. 2) Capacity to train 24 nurses in 1st yr. and 48 nurses in 2nd and 3rd yrs. 3) 80 Aides operative by 8/76, 150 by 8/77 and 225 by 8/78. 4) Issuance by Population Technical Committee by 8/76; active involvement of relevant GOES ministries/agencies in Plan execution by 10/77. 5) MO's in sterilization - 40 by 12/75, 70 by 12/77. Nurses as WHCS - 24 by 12/76, 72 by 12/77 and 120 by 12/78. Auxiliaries as pill distributors w/o physician's ex 120 by 12/76, 500 by 12/77. Health administrators - 5 Regional Management Seminar annually. 6) Three annual reports, available by November of each year; ISSS system fully operational by 6/76 and MOH system by 6/78. 7) Ministry Agriculture Extension Agents and Home economists - 50 operative by 6/76 and 200 by 4/77. Women organizers of rural coops promoting FP - 14 by 6/76, 21 by 12/77. Community workers of marginal zone agencies - 50 by 1/77 100 by 1/78.	To verify outputs: On site field visits by resident advisors; routine administrative reports and contacts; Commodity Receiving Reports; review of training plans and reimbursement vouchers and observation at courses; consultants' reports. To verify inputs: Fiscal data of participating agencies.	Assumptions for achieving outputs: 1. Public health infrastructure will continue to expand. 2. Demand for male and female sterilization will remain high. 3. Conservative physicians will not be able to hold back the greater utilization of paramedics. Assumptions for providing inputs: 1. USAID assistance will continue through the second and third years of the project. 2. Centrally-funded contraceptives will be available. 3. The Host Country contribution will be provided at the level stated.

Inputs	Implementation Targets (in 5000's and person months (Pm) as appropriate)			
	FY 76 and 5th Q	FY 77	FY 78	
1. AID APPROPRIATED 1,778				
a. USAID Bilateral (912) Tec. Services 120	a. 253 Contract personnel (5/15 pm) for commercial contraceptive study, sociodemographic dev. and communications advice (56).	a. 300 Contracts (3/6 pm) for health admin and FP program evaluations (24)	a. 359 FP program evaluations (3/6 pm) - (30)	
Commodities 215	Clinical S A-V equip, condom vending machines & research contraceptives (69)	Medical kits, surgical equipment and A-V materials (60)	Pilot contraceptives, surgical & clinical equipment (30)	
Participants 191	Demography (2/24 pm), FP management and new techniques (8/40 pm), mass media (3/6 pm), Nurse Training (18/54 pm) - (75)	FP program administration and evaluation (5/3 pm) demography (2/24 pm) sampling (1/12 pm) - (55)	Demography (2/24 pm), FP program management (3/18 pm), advanced fertility control techniques and other academic (5/29 pm) - (60).	
Other Costs, inc. research 270	Rural health aides - Phase I, collection/analysis of FP data, materials production, invitational travel (99)	Rural aides - Phase II and other info/referral agents, training, materials, data system (113)	Rural promotion/services support, training, surveys, invitational travel (58).	
b. AID/W contraceptives 1066	b. 409	b. 317	b. 244	
2. HOST COUNTRY 4,419	1,249	1,482	1,688	
a. MOH (2,276) Administrators, supervisors, medical and paramedical personnel assigned full or part time to project - 1812 Contraceptives, medical instruments & equip. 464	a. 653 Personnel 555 Commodities 58	a. 785 Personnel 619 Commodities 166	a. 838 Personnel 638 Commodities 200	
b. ISSS (Soc. Sec. Inst.) (989) Personnel assigned to project (F/T & P/T) 748 Contraceptives and equip. 241	b. 210 Personnel 158 Commodities 52	b. 311 Personnel 236 Commodities 75	b. 467 Personnel 354 Commodities 113	
c. Other agencies (1,158) Counterpart funds, principally in manpower resources, devoted to project.	c. 386 (estimated)	c. 386 (estimated)	c. 386 (estimated)	
3. OTHER DONORS 1,814	620	710	884	
Personnel costs 978	318	352	308	
Contraceptives 50	12	16	22	
Other commodities 679	253	302	124	
International Trg. 90	30	30	30	
Data sys., travel, misc. 17	7	10	0	
TOTAL PROJECT 7,781	2,454	2,652	2,675	