

PDAAA-787-A1

8

AID 1020-25 (7-84)	SECURITY CLASSIFICATION	001 PROJECT NUMBER
PROJECT APPRAISAL REPORT (PAR) (U-446) See M.O. 1026.1	UNCLASSIFIED	5190149-5 519-15-580-149

002 PAR	MO.	DAY	YR.	003 U.S. OBLIGATION SPAN	004 PROJECT TITLE
AS OF:	0	7	0	FY 66 Thru FY 72	Family Planning
008 COOPERATING COUNTRY - REGION - AID/W OFFICE					
EL SALVADOR					

A.I.D. Project
Center
1055 H.E.

AID DOLLAR FINANCING-OBLIGATIONS (\$000)	TOTAL	CONTRACT (NON-ADD)	PERSONNEL SERVICES		PARTICIPANTS		COMMODITIES		OTHER COSTS		
			AID	PASA	CONTRACT	DIR. PASA	CONTRACT	DIR. PASA	CONTRACT	DIR. PASA	CONTRACT
CUMULATIVE NET THRU ACTUAL YEAR (FY 1969)	863	154 1/2	100	6	154 1/2	45	---	277	---	288	---
PROPOSED OPERATIONAL YEAR (FY 1970)	403	---	35	---	---	15	---	160	---	193	---

CCC VALUE OF P.L. 480 COMMODITIES (\$000)	→	Thru Actual Year :	Operational Year Program :
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007 IMPLEMENTING AGENCY TABLE

If contractors or participating agencies are employed, enter the name and contract or PASA number of each in appropriate spaces below; in the case of voluntary agencies, enter name and registration number from M.O. 1551.1, Attachment A. Enter the appropriate descriptive code in columns b and c, using the coding guide provided below.

TYPE CODE b	TYPE CODE c	a. IMPLEMENTING AGENCY	TYPE CODE		d. CONTRACT PASA/VOLAG NO.	e. LEAVE BLANK FOR AID/W USE
			b.	c.		
1. U.S. CONTRACTOR	0. PARTICIPATING AGENCY					
2. LOCAL CONTRACTOR	1. UNIVERSITY					
3. THIRD COUNTRY CONTRACTOR	2. NON-PROFIT INSTITUTION					
4. PARTICIPATING AGENCY	3. ARCHITECTURAL & ENGINEERING					
5. VOLUNTARY AGENCY	4. CONSTRUCTION					
6. OTHER:	5. OTHER COMMERCIAL					
	6. INDIVIDUAL					
	7. OTHER:					

PART I - PROJECT IMPACT

I-A. GENERAL NARRATIVE STATEMENT ON PROJECT EFFECTIVENESS, SIGNIFICANCE & EFFICIENCY.

This summary narrative should begin with a brief (one or two paragraph) statement of the principal events in the history of the project since the last PAR. Following this should come a concise narrative statement which evaluates the overall efficiency, effectiveness and significance of the project from the standpoint of:

- (1) overall performance and effectiveness of project implementation in achieving stated project targets;
- (2) the contribution to achievement of sector and goal plans;
- (3) anticipated results compared to costs, i.e., efficiency in resource utilization;
- (4) the continued relevance, importance and significance of the project to country development and/or the furtherance of U.S. objectives.

Include in the above outline, as necessary and appropriate, significant remedial actions undertaken or planned. The narrative can best be done after the rest of PART I is completed. It should integrate the partial analyses in I-B and I-C into an overall balanced appraisal of the project's impact. The narrative can refer to other sections of the PAR which are pertinent. If the evaluation in the previous PAR has not significantly changed, or if the project is too new to have achieved significant results, this Part should so state.

008 NARRATIVE FOR PART I-A (Continue on form AID 1020-25 if as necessary):

1/ \$153,000 of this amount was for local payroll and support. Such costs have been obligated under other costs starting in FY1969.

MISSION DIRECTOR APPROVAL →	SIGNATURE	DATE
	<i>Paul Dech...</i>	Sept 24, 1969

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PAR CONTINUATION SHEET

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1. HISTORY OF PROJECT

The Salvadoran Demographic Association (SDA), a private association, was organized in 1963 and commenced an active family planning program in 1965. With the cooperation of the Pathfinder Fund, the SDA established two research clinics to explore the feasibility of the use of contraceptives in El Salvador. Through this research project, it was learned that the acceptability and the demand for a family planning program in El Salvador existed. The SDA at this time requested assistance from AID to permit the expansion of its program for promoting public understanding of population growth in relation to economic and social development and family welfare, and to assist in the provision of advisory and clinical services in family planning techniques to Salvadorans who desired such services.

In March 1966, a Project Agreement for \$30,000 was signed between the USAID and the SDA to support the expansion of the program.

This initial Agreement projected the establishment of 13 family planning clinics with the capacity of providing a total of 3,000 consultations per month when in full operation. In addition, the SDA was to participate in demographic research in collaboration with local and international organizations, provide practical training through its clinical facilities, and take the lead in broadening public knowledge of population problems and solutions.

The International Planned Parenthood Federation, (IPPF) gave financial assistance in the amount of \$15,000 to the SDA in 1966. This was to be used to help pay for clinical operations, including the purchase of supplies.

A second Project Agreement was signed in January 1967, for \$66,000 for the expansion into a second phase leading to the eventual goal of creating an institutional capability to provide family planning services to all Salvadorans who may desire them.

The IPPF contributed \$35,000 in assisting the SDA during 1967.

During 1967, in addition to operating its own facilities, the SDA had been working closely with GOES health officials in the elaboration of an operational plan for the possible initiation in January 1968 of a GOES sponsored family planning program. In fact, during 1967 the SDA had provided family planning services in seven Ministry of Health facilities.

In 1967 the Non-capital Project Paper (PROP) was prepared by the USAID and sent to AID/W under the Project Title "Family Planning and Health Services". The project strategy as set forth in the PROP was that of seeking to develop an institution in the Government of El Salvador that can eventually assume the responsibility of administering an amplified action program that would reduce the birth rate in the country to the point that the GOES can effectively meet the demand for progress in social and economical development." Project targets and a course of action also were established in the PROP.

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In January 1968 a Project Agreement was signed between the USAID and the GOES Ministry of Health providing \$177,000 (subsequently revised to \$192,700) for the initiation of the first phase of a four-phase GOES Family Planning and Maternal-Child Health Care Program. Each of the phases corresponded to a geographic section of the country which was targeted to receive family planning services. The Agreement called for the expansion of the existing program of Maternal-Child Health and the addition of family planning services.

In February 1968 the third Project Agreement was signed with the SDA for the continuance and further expansion of its program. This Agreement was for \$87,000.

Project Agreements were signed in FY 1969 with both the GOES (\$215,000) and the SDA (\$93,000) for further expansion of the family planning program.

2. OVERALL EFFICIENCY, EFFECTIVENESS, AND SIGNIFICANCE OF THE PROJECT

a. Overall Performance and Effectiveness of the Project Implementation in Achieving Stated Project Targets

In general progress towards targets has been very good. As is discussed in Part 1-B, both the SDA and the GOES have encountered some difficulties in the past in reaching their coverage targets, but either these growing pains have been eliminated or project targets have been adjusted to account for them. Three unexpected developments -- the Papal Encyclical, a problem with a University of El Salvador medical student, and the Salvadoran-Honduran conflict -- have had negative effects to date on progress (See Part 1-C #13). Within the direct scope of the program, however, the majority of the problems which have been encountered and have slowed progress toward targets have been internal GOES problems: poor supervision and inadequate motivation. A lack of interest by physicians has affected the programs of both the GOES and ^{the} SDA. Additionally, in many cases targets were overly optimistic either because the difficulties in areas of low population concentrations had not been considered fully or because the USAID technician deliberately established an exaggerated level of performance in order to elicit the maximum effort from the local institution. Slow AID procurement also delayed progress in some cases by causing clinical and transportation equipment to arrive behind schedule.

Training and promotion goals have always been met. The training program has virtually eliminated the bottleneck caused by a scarcity of physicians knowledgeable in the techniques of birth control. A successful promotional program has contributed to the gradual acceptance of family planning despite the predominance of the Catholic religion and the Papal Encyclical.

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b. The Contribution to Achievement of Sector and Goal Plans

Prior to the difficulties between El Salvador and Honduras in July 1969, the Program appeared to be proceeding satisfactorily toward sector and program goals; approximately 43,000 women had been inscribed in the program and the monthly enrollment rate was increasing. ^{1/} The SDA had developed into a viable institution and was assisting the Ministry of Health in the development of the GOES program.

However, when the difficulties with Honduras, discussed in Part 1-C, began the GOES suspended all but emergency health activities in 80% of its facilities. Family planning patients returning for control visits were given consultations (an exception to the emergency ruling), but first consultations were not permitted. Since 85% of the SDA clinics are in GOES facilities, its program was affected also. As a result of the above, the number of first consultations dropped to its lowest level since April 1968.

The entire effect of the conflict on the project goals cannot be measured accurately for some time, although owing to the realization that the war was at least in part a result of population pressures, the GOES has expressed its determination to expand family planning services at an even faster pace than previously planned.

c. Anticipated Results Compared to Costs, i.e. Efficiency in Resource Utilization

To date, the major funding components of this program have been budgetary support to the Salvadoran Demographic Association, and more recently to the GOES Ministry of Health, and commodities. Funding, up to now has been basically an investment, and no measurable return has resulted as yet. In the future, as the birth rate begins to fall, the returns to the economy will be quantifiable in terms of reduced demands on the country's very scarce food, land, housing, health, and educational resources.

In working to develop the SDA, the USAID utilized its resources efficiently. The SDA has matured, transferred its knowledge to the Ministry of Health, and actually may be ready to be gradually eliminated, having served its purpose. At the time the project began, political conditions made it

^{1/} See Part 1-C for a discussion of the "drop out" rate.

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impossible to work effectively with the GOES. Those conditions have changed, in no small way a result of the promotional work of the SDA.

d. The Continued Relevance, Importance, and Significance of the Project to Country Development and/or Furtherance of U.S. Objectives

It is almost universally agreed that the most serious problem which El Salvador faces at the present time is its high man/land ratio, of almost 400 persons per square mile. The seriousness of this problem is accentuated by the extremely high (3.7%) rate of population growth, and the high dependency ratio (approximately 50% of the population under 15 years old). In view of this situation, the need to reduce the population growth rate is of the highest priority, and the project therefore is relevant, important, and significant to USAID and GOES objectives for the economic and social development of the country.

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PART I-B - PROJECT EFFECTIVENESS

I-B-1 - OUTPUT REPORT AND FORECAST - (See detailed instructions)

CODE NO. ID/W USE ONLY	2. This section is designed to record progress toward the achievement of each project output target which was scheduled in the PIP, Part II. Where progress toward a target is significantly greater or less than scheduled, describe reason(s) beneath the target.	3. ACTUAL AND PLANNED OUTPUTS (ALL DATA CUMULATIVE)				6. PROJECTED TOTAL FOR PROJECT LIFE
		3. ACTUAL CUM. TO DATE	4. AS OF PRIOR JUNE 30		5. PLANNED BY NEXT JUNE 30	
			a. PLANNED	b. ACTUAL		
	<p>The first PIP for this project was drafted in July 1969. Project output targets for 1966 and 1967 have been obtained from the Project Agreements. The 1968 targets have come from the Non-Capital Project Paper (PROP).</p> <p><u>1966</u></p> <p>1. To establish thirteen SDA clinics in eight departments of El Salvador, providing more than 3,000 consultations per month. Each clinic to operate at least ten hours per week and to be staffed by a physician and a graduate nurse trained in family planning methods.</p> <p>Thirteen clinics were established, were operating at least ten hours weekly, and were staffed by a physician and a graduate nurse trained in family planning. Three additional clinics were operating in the offices of private practitioners contracted by the SDA, thereby making a total of 16 clinics in operation. Almost all clinics were situated in urban areas throughout the country. At the end of the year the clinics were providing about 2,400 consultations monthly. However, the monthly average for the year was 1,270 consultations. The attached table contains data on consultations for this and all subsequent years of operation.</p>					

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2. SDA to participate in demographic research, in collaboration with local and international entities, provide practical training in family planning through its clinical facilities, and take the lead in broadening public knowledge of population problems and solutions.

Research was begun or carried out on a variety of topics: (a) In August 1966 the SDA began a survey of 1,800 of its clients to form a tentative model of the age-specific fertility rate by socio-economic condition, and to explore client motivation and attitudes in order to form an idea of the potential receptivity to an expanded program; (b) Assistance was given by the SDA to a Salvadoran physician for the completion of a study entitled "The IUD and Family Planning", (c) studies were initiated for the planning of a training course in family planning to be given in cooperation with the University of El Salvador Medical School. The SDA received a \$15,000 budget support grant from the International Planned Parenthood Federation to expand family planning services in the clinics.

As a result of the study on the IUD, it was decided that the IUD was acceptable in rural areas and the fear of using this device was reduced. Partially as a result of the studies on a training course, a Central American Training Center was established in El Salvador. This Center now conducts family planning training courses on a regular basis several times a year.

Twelve persons (six doctors and six nurses) were sent to Mexico for training in family planning at the Centro de Estudios de Demografía, Reproducción y Planificación de Familia (Dr. Rice Wray Clinic). On their return they were given practical training in family planning at SDA clinics. Additionally, four members of the Board of Directors of the SDA attended the Central American Conference on Population and Family Planning.

Promotional activities took place in two ways: (a) a social worker for promotion of family planning was hired; and (b) public meetings were held in the communities where family planning was being started.

1967

1. Twenty-six SDA clinics to be functioning by 1968, providing an estimated 5,800 consultations monthly.

Twenty-three clinics were operating by the end of the year and four additional clinics were ready to begin operations in January, 1968. Three thousand five hundred (3,500) consultations were being provided monthly, some 2,300 short of the goal. The projection of 5,800 consultations per month was based partly on the figure of 26 clinics in operation, but in addition, it relied on the experience in the capital city, San Salvador,

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and other relatively large metropolitan areas where demand for services is more centralized and where such factors as better transportation and communications tend to minimize the barriers to obtaining the services. The second ten clinics were established in areas of lower population concentrations and hence the original consultation estimate was somewhat overly optimistic. In addition, Project Agreement targets often are set at higher than expected levels in order to obtain the maximum effort from the SDA.

2. Two clinics in San Salvador which were operating on a two-hour per day basis to be consolidated into one full-time clinic, operating 44 hours daily.

This target was not achieved because of the difficulty in finding a physician who would work full time, as required. \$1200 (\$480) per month was offered, which was all SDA could afford given the other demands on its budget. No physician responded to this offer.

3. SDA, through the use of a USAID provided mobile clinic, to make family planning services available to areas in which the establishment of permanent clinics not yet feasible and/or economical. The mobile clinic to be equipped for the purpose and staffed by trained medical personnel.

This target was not realized due to the unavailability of a physician and other personnel who were willing to work with the mobile clinic in rural areas. The vehicle was never ordered.

4. The Administrative capability of the SDA to be strengthened by the appointment of a full-time administrator and an additional supervising nurse.

The Executive Secretary position was established in the SDA. The incumbent was supervising the work of the office, personnel, and social workers. He is considered to be an exceptionally effective leader and largely responsible for the progress made by the SDA. The additional supervising nurse also was appointed.

5. SDA to participate in demographic research in collaboration with local and international entities and take the lead in broadening public knowledge of population problems and solutions.

The SDA continued to work closely with the IPPF and received \$40,000 for budgetary support. The Population Council of the United States approved the donation of \$18,000 for assistance in financing the operations of the Regional Training Center (See #9). The Center began operations in July 1967 and is presently funded by the Population Council (\$21,000 per year) and ROCAP (\$25,000 per year beginning in FY 1969). See also #6 below.

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6. SDA to continue and intensify its promotional work in order to gain increased financial support from public and private sources by (a) preparing and implementing a systematic program of public information to broaden knowledge of population problems and programs among leadership groups, and (b) applying modern techniques and materials in the promotion of family planning at the community level.

The SDA hired an additional social worker to work in the promotion of the general program to solicit new members and gain financial support from public and private sources. 100 NEW SDA members were obtained as a result.

A total of 442 talks were given to approximately 11,000 government and private industry employees, and patients of the SDA clinics. Round table discussions and promotional programs were held in eight communities of the country. Educational movies pertaining to family planning were shown on one of the local television stations.

7. SDA to conduct a survey, consisting of 2,000 clients, to determine the effectiveness and acceptability of the family planning methods in use. The results to be used in determining the relative emphasis to be given different methods and in estimating the effects of the SDA program on population growth.

This survey was postponed as no qualified persons could be found to carry it out. It was begun in 1968.

8. SDA to undertake a program to enable it to offer "packaged" services to institutional clients, private or public. The "package" may include such items as surveys, preparation of clinic plans, specification of procurement needs, training of personnel, conduct of information programs, supervision of operations, provision of technical services, and financial advice. This to be done on an experimental basis.

The program to offer "packaged" services to institutional entities was carried out on an experimental basis with the ADOC shoe company and the De Sola Enterprises. Each organization opened a clinic and although operations in both were successful in terms of effectively reaching the target groups, it was found that the per patient costs were high in comparison to the SDA clinics (which have lower administrative costs per patient). When SDA or GOES clinics were opened nearby, these experimental clinics were closed down and the patients transferred to the new clinics. Further experiments were not attempted due to the lack of interest on the part of other companies.

9. SDA to provide theoretical and practical training in family planning to physicians, nurses, and social workers to assure that all facilities operating under the USAID agreement are staffed with well-trained personnel.

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With the cooperation of the Population Council, the Regional Training Course on Population Dynamics, Physiology of Reproduction, and Family Planning was initiated (See also #5). A total of 176 physicians, nurses, and Social workers from the Central American countries, of which 100 were Salvadoran, participated. Special courses also were held in El Salvador's two nursing schools. As a result of these courses nurses now maintain more accurate patient files, and doctors have learned new techniques for communicating effectively with their patients. Doctors are now better able to decide which family planning method to use and they are more skilled at inserting IUDs.

10. Two courses of one week each to be conducted in which 24 physicians, nurses and social workers are to be prepared for immediate or future employment by the SDA.

These two courses were conducted successfully in March and April of 1967. They were considered pilot courses for the Regional Training Course.

11. SDA to train up to twenty additional doctors, nurses, and social workers in the existing family planning training course.

This was done at the Regional Training Center. These special courses continue to be conducted in addition to the regular regional training courses.

1968 (SDA)

1. A total of 30 SDA clinics to be functioning by the end of FY 1968.

The SDA opened twelve additional clinics during 1968. Two clinics were turned over to the GOES and two were phased out. The total number of clinics was thus raised to 31, one above the target.

2. 12,000 new patients to be placed under contraceptive control by the end of FY 1968. An additional 24,000 medical consultations to be required.

12,012 new patients were inscribed in the program. 45,000 additional medical consultations were given. The excess over 24,000 consultations was largely a result of the shift from IUDs to pills. Women using pills require more frequent medical consultations than do women using IUDs. This shift can be seen in the increasing number of "Non-Medical Control" visits shown in the attached consultation table.

3. Health education oriented toward family planning and mass communications to be intensified.

Promotional work including health education was carried out in a variety of ways: (a) 48,700 people received talks regarding family planning; (b) 12 round table discussions were held throughout the country, attended by 1,600 persons; (c) arrangements were made and carried out with one of the local television stations to continue to telecast movies pertaining to the

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population problem and family planning; (d) slides were projected on screens in 30 theaters in the country; (e) 125,000 pamphlets on family planning were distributed; (f) sex education classes at the Plan Básico (junior high school) level were begun and four courses were held; and (g) 25 volunteers (Gray Ladies) were enlisted to promote the program in the San Salvador Maternity Hospital.

4. The Regional Training Center in Family Planning to continue to assist in the training of Salvadoran as well as other Central American personnel.

A total of 532 persons were given training at the Regional Training Center; 250 of these were physicians, nurses, and other personnel of the GOES, the SDA, and the Social Security hospital; 282 were medical personnel from the other Central American countries. This exceeded the ProAg goal of 500.

5. Close relations with the Ministry of Health (MOH) to be established and maintained, and the SDA to offer assistance in planning and supervision to the MOH.

This was done. The Medical Director of the SDA worked closely with GOES officials on the implementation of the plan to put family planning into the GOES health clinics. The SDA provided the GOES with oral contraceptives, lent them equipment and trained their personnel.

6. IPPF to contribute \$40,000 and the SDA to contribute \$11,000 to the furtherance of the program.

The IPPF contributed \$45,000. The SDA contribution slightly exceeded \$11,000.

1968(GOES)

1. Family planning activities to be initiated in FY 1968 at the San Salvador Maternity Hospital and 30 health centers and units in the San Salvador health district.

This target was changed slightly. Instead of the San Salvador health district the Para Central Region was selected. The reasons for this change were the following: (a) All health activities in the Para Central region are under the control of a GOES Regional Health Director; those in the San Salvador region are not; (b) the Para Central region is rural and it was decided that the GOES Pilot Program would be more indicative of needs and problems if carried out in a rural area since the SDA was working in the urban areas; (c) the Para Central region is a more difficult area, both because it is rural, and because it has problems (e.g. transportation) which do not exist in other rural areas; it was decided that the GOES

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should learn about as many problems as possible during the early stages of the program; and (d) the Para Central region is located close to the capital city, which was considered important for a pilot program.

At the end of CY 1968, the GOES offered family planning in 28 of its health centers, units and posts in the Para Central Health Region. This was two short of the target. However, by January 1969 a total of 35 health centers offered family planning. The family planning program at the Maternity Hospital was begun under the direction of the SDA.

2. 10,000 women to be placed under contraceptive control by the end of FY 1968. 20,000 consultations to be given.

1,800 family planning patients were enrolled in the program. An additional 4,300 consultations were given. The reasons for not reaching the targeted levels are the following:

a..The program was late in starting. AID/W did not give the USAID the authority to obligate funds, which delayed the signing of the Project Agreement. The resulting late arrival of clinical and transportation equipment created a delay in initiating services.

b. Poor supervision. The GOES regional director lacked interest in the program, and the USAID advisors did not have sufficient time to adequately supervise the entire area.

c. Lack of enthusiasm on the part of the physicians and other staff in the program. This is partially a result of (b) above, but also due to the belief by most physicians that they should be paid extra for working in the family planning program.

d. Poor promotion. The Minister of Health restricted the mass dissemination of promotional materials, and personnel were not adequately trained in education and promotion. The Papal Encyclical not only had negative effects on the promotion of the program, but in addition, gave program personnel a reason for failure.

e. Program targets were established when it was thought that the program would be operating in urban areas. With the shift to the more difficult rural areas (see #1 above) the targets should have been reduced.

f. Lost time. A great deal of time is lost (approximately one month per year) due to vacations and holidays of the GOES. In addition GOES laws allow for a great deal of sick leave, which employees take advantage of. The SDA, being private, did not have these problems, and the increase in lost time resulting from the shift to a government program was not fully anticipated.

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3. Family planning services to be offered on a once a week basis at each clinic and to include contraceptive control, cancer detection, instruction in family responsibility, and family planning and health education.

Family Planning Services were offered on a daily basis as an integral part of the overall public health program. All other targeted services also were offered.

4. 55 physicians, nurses, and health educators to be trained in family planning during FY 1968. Two physicians to be trained in cytological laboratory procedures.

Of the 250 persons trained, approximately 190 were from the GOES, thus the target was greatly exceeded. One physician was trained in cytological laboratory procedures, and one with training was hired. This was considered sufficient to meet the existing demand. Present plans are to train one more as demand for cytological services has now increased.

5. A cancer detection program to be an integral part of the project. A total of 10,000 laboratory smears (pap smears) to be performed during the first year of operation. The purchase of special laboratory equipment for this service to be made.

1,800 pap smear examinations were performed during the year. It was targeted that 10,000 new women would enter the GOES program, but only 1,800 women actually were inscribed (see #2 above). The laboratory equipment arrived in February 1969, and the laboratory commenced operations when the technician trained in cytological laboratory procedures returned from his training. The laboratory has a capacity of 25,000 cytological exams per year.

6. Fifteen rural communities to be covered on a once a week basis by mobile units equipped with health teams consisting of a physician, a graduate nurse, and a driver.

Three mobile units were purchased and three health teams were formed. The fifteen communities were covered on a twice a week basis, thus exceeding expectations. By January 1969 twenty-two communities were receiving family planning services from the mobile units.

1968 (Target totals)

1. A total of 60 family planning centers (30 SDA and 30 GOES) to be in operation by the end of FY 1968.

A total of 60 family planning centers (31 SDA, 28 GOES, and 1 Social Security) were in operation by the end of CY 1968. The total as of the end

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of FY 1968 was about 46.

2. A total of 22,000 women to be enrolled in the program.

Approximately 13,800 women (12,000 SDA and 1,800 GOES) were enrolled in the program. This was some 8,000 short of the target. The reasons for not reaching targeted levels have been discussed above, under the "1968 (GOES)" heading.

3. A total of 44,000 additional consultations to be given during 1968.

Almost 50,000 additional consultations were given. This was a result of the larger than anticipated number of consultations given by the SDA during the year.

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CONSULTATIONS GIVEN BY THE SALVADORAN DEMOGRAPHIC ASSOCIATION (SDA), THE GOES
MINISTRY OF HEALTH (GOES) AND THE SALVADORAN INSTITUTE OF SOCIAL SECURITY (ISSS)
1966-1969

	1st Consultations			Medical Control			Non-Medical Control			Total		
	SDA	GOES	ISSS	SDA	GOES	ISSS	SDA	GOES	ISSS	SDA	GOES	ISSS
1966												
Jan												
Feb	800											800
Mar	170			106								276
Apr	190			202								392
May	383			329								712
Jun	520			479								999
Jul	657			834								1,541
Aug	700			956								1,656
Sep	884			1,117								2,001
Oct	932			1,380								2,312
Nov	890			1,552								2,442
Dec	749			1,364								2,113
Total	6,875			8,369								15,244
Mo. Ave.	573			697								1,270
1967												
Jan	1,011			1,883								2,894
Feb	916			1,517			278					2,711
Mar	830			2,019			346					3,195
Apr	881			1,523			370					2,774
May	892			1,992			431					3,315
Jun	804			2,040			507					3,351
Jul	963			2,103			608					3,674
Aug	746			2,119			729					3,594
Sep	812			2,085			613					3,510
Oct	933			3,208			901					5,042
Nov	933			2,334			852					4,119
Dec	710			1,870			1,162					3,742
Total	10,431			24,693			6,797					41,921
Mo. Ave.	869			2,058			566					3,493
1968												
Jan	1,021			2,023			1,324					4,868
Feb	1,016			2,204			1,209					4,429
Mar	1,043			2,428			1,405					4,876
Apr	870	59		2,167	152		1,311	73				4,348
May	950	210		2,310	190		1,640	151				4,900
Jun	841	223		2,208	242		1,628	168				4,677
Jul	1,288	347		2,403	263		2,162	268				5,853
Aug	980	302		2,125	223		2,319	381				5,434

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CONSULTATIONS GIVEN BY THE SALVADORAN DEMOGRAPHIC ASSOCIATION (SDA), THE GOES
MINISTRY OF HEALTH (GOES) AND THE SALVADORAN INSTITUTE OF SOCIAL SECURITY (ISSS)
1966-1969

	1st Consultations			Medical Control			Non Medical Control			Total		
	SDA	GOES	ISSS	SDA	GOES	ISSS	SDA	GOES	ISSS	SDA	GOES	ISSS
1968 (Cont.)												
Sep	1,110	283		2,036	225		2,511	473		5,657	981	
Oct	1,184	298		1,992	218		3,117	588		6,293	1,104	
Nov	976	276	181	2,030	175	4	3,270	720	1	6,276	1,171	186
Dec	733	150	205	1,384	132	56	2,776	769	0	4,893	1,051	261
Total	12,012	2,148	386	25,820	1,820	60	24,672	3,591	1	62,504	7,559	447
Mo. Ave.	1,001	239	193	2,152	202	30	2,056	399	-	5,209	840	223
1969												
Jan	1,110	369		2,080	267		3,574	961		6,764	1,597	
Feb	1,139	555	293 ^{2/}	1,810	211	87 ^{2/}	3,476	1,136	370 ^{2/}	6,425	1,922	750 ^{2/}
Mar	1,104	659	256	2,093	459	63	4,058	1,393	446	7,255	2,711	765
Apr	805	673	226	1,908	709	53	3,035	1,674	534	5,748	3,038	813
May	883	637	260	2,148	836	71	4,145	1,948	962	7,176	3,421	1,293
Jun	727	540	546	2,298	1,022	101	4,084	2,230	806	7,109	3,792	1,453
Jul	422	274	298	1,245	823	156	4,775	3,441	1,342	6,442	3,538	1,796
Total	6,190	3,907	1,879	13,582	4,327	531	27,147	11,803	4,460	46,919	20,037	6,870
Mo. Ave.	884	558	313	1,940	618	89	3,878	1,686	743	6,702	2,862	1,145

	1st Consultations All Institutions	Medical Control All Institutions	Non-Medical Control All Institutions	Total All Institutions
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TOTALS^{3/}

	1st Consultations All Institutions	Medical Control All Institutions	Non-Medical Control All Institutions	Total All Institutions
1968				
Jan	1,021	2,523	1,324	4,868
Feb	1,016	2,204	1,209	4,429
Mar	1,043	2,428	1,405	4,876
Apr	929	2,319	1,384	4,632
May	1,160	2,500	1,791	5,451
Jun	1,064	2,450	1,796	5,310
Jul	1,635	2,666	2,430	6,731
Aug	1,282	2,358	2,700	6,340
Sep	1,393	2,261	2,984	6,638
Oct	1,482	2,210	3,705	7,397
Nov	1,433	2,209	3,991	7,633
Dec	1,088	1,572	3,545	6,205
Total	14,546 ^{4/}	27,700	28,264	70,510
Mo. Ave.	1,433 ^{4/}	2,384 ^{4/}	2,455 ^{4/}	6,272 ^{4/}

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**CONSULTATIONS GIVEN BY THE SALVADORAN DEMOGRAPHIC ASSOCIATION (SDA), THE GOES
MINISTRY OF HEALTH (GOES) AND THE SALVADORAN INSTITUTE OF SOCIAL SECURITY (ISS)
1966-1969**

<u>TOTALS</u> <u>1969</u>	<u>1st Consultation</u>	<u>Medical Control</u>	<u>Non-Medical Control</u>	<u>Total</u>
Jan	1,479	2,347	4,535	8,361
Feb	1,987	2,108	5,002	9,097
Mar	2,219	2,615	5,897	10,731
Apr	1,704	2,670	5,243	9,617
May	1,780	3,055	7,055	11,890
Jun	1,813	3,421	7,120	12,354
Jul	994	2,224	8,558	11,776
TOTAL	11,576	18,440	43,410	73,826
Mo. Ave.	1,711	2,634	6,201	10,546

1/Number of consultations between October, 1965 and February, 1966 when demand for a family planning program was being explored.

2/Figures for this month are actually cumulative for January and February.

3/Prior to 1968 the SDA was the only organization operating. Its totals will therefore be the totals for the program.

4/ Weighted by the number of months each agency actually operated during the year.

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which focused on reductions in the number of women not under control would appear more appropriate. Women not under control can be expected to continue the reproductive process in much the same way as they always have, and unless the size of this group is reduced, a fall in the number of births each year, or even quite likely a fall in the birth rate, cannot be expected.

We estimate that there are presently some 587,000 women in the fertile age group -- 15 to 45 years old. We also estimate that 50% of the population is under 16 years old. Assuming that 52% of the population is female, the following table may be constructed:

	Age	
	Under 16	16 to 65
Total Population	1,633,000	1,633,000
Female Population	850,000	850,000
Average Population at each Age	56,700	17,300

Using these data, the number of women in the 15-45 age group totals 575,000 ($30 \times 17,300 / 56,700$), quite close to the above estimate of 587,000. Thus the data in the table seem reasonable.

Assuming that in each of the next four years 56,700 women enter the fertile age group, while only 17,300 women leave, the net addition per year would be 39,400. During the next four years this group should increase by about 158,000 to a level of 745,000 in 1972.

In 1968 there were 141,000 births, 29,800 deaths, and 4,200 (net) immigrants. The population rose from 3,151,100 to 3,266,500, a growth rate of 3.66%. Using the crude birth rate of 43.2 births per 1,000 persons ($141,000 / 3,266,500$) and the crude death rate of 9.1 deaths per 1,000 persons ($29,800 / 3,266,500$), the rate of natural increase is 34.1 per 1,000 persons ($43.2 - 9.1$), or 3.4%, slightly below the actual growth rate shown above.

Assuming that 62,000 women (32,000 in the Family Planning Program and 30,000 privately) of the 587,000 in the reproductive ages were under control at the end of 1968 the following table may be constructed:

	1968
1) Population	3,266,500
2) Number of women in reproductive ages	587,000
3) Number of women under control	62,000
4) Number of women not under control (2-3)	525,000
5) Number of births	141,000
6) Crude birth rate (5:1)	43.2
7) Crude death rate	9.1
8) Rate of natural increase (6-7)	34.1
9) Birth rate for women <u>not</u> under control (5:4)	269.0

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In 1972, assuming (a) that there are 190,000 women under control out of a total of 745,000 women in the reproductive ages; (b) that the death rate remains the same as in 1968; and (c) that the population growth rate falls according to present projections 1/ to a level of 2.8%, (implying a rate of natural increase of no higher than 28.0 per 1,000 persons), the following table may be constructed:

	<u>1972</u>
1) Population	3,720,000
2) Number of women in reproductive ages	745,000
3) Number of women under control	<u>190,000</u>
4) Number of women <u>not</u> under control (2-3)	555,000
5) Number of births (6x1)	138,000
6) Crude birth rate(7/8)	37.1
7) Crude death rate	<u>9.1</u>
8) Rate of natural increase	28.0
9) Birth rate for women <u>not</u> under control (5:4)	249.0

As can be seen, a reduction of this sort in the population growth rate implies a reduction in the birth rate for women not under family planning control, an implication which does not seem justified. 2/ If it is assumed that this birth rate remains the same as in 1968 (269.0) then the revised table for 1972 would be as follows:

	<u>1972</u>
1) Population	3,720,000
2) Number of women in reproductive ages	745,000
3) Number of women under control (2-4)	<u>232,000</u>
4) Number of women <u>not</u> under control (5:9x1000)	513,000
5) Number of births (6x1)	138,000
6) Crude birth rate (7/8)	37.1
7) Crude death rate	<u>9.1</u>
8) Rate of natural increase	28.0
9) Birth rate for women <u>not</u> under control	269.0

Thus, this rough estimate, which does not consider family planning activities in the years 1969-1971, indicates that our target of 190,000 women under control by 1972 is at least 40,000 below what is actually needed if our goal of 2.8% rate of population growth in 1972 is to be reached. With 190,000 women under control, the natural rate of increase would fall not lower than 31.0 per 1,000 persons in 1972, and the population growth rate would probably be slightly higher than 3.1% per year.

1/ 1969 (3.7%), 1970 (3.5%), 1971 (3.2%), 1972 (2.8%).

2/ It is assumed that women under family planning control do not have children. The relaxing of this assumption would serve to strengthen the conclusions of the analysis.

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- ** (1) It is difficult at present to determine exactly how many women are under family planning control as neither the "drop out" rate nor the total number of "drop outs" has been determined. The assumption is made by USAID officials that the total number of women recorded under "first consultation" is the number of women actually in the program. This undoubtedly overstates the actual figure. A continuous evaluation system which is expected to be built into the program under a contract with Columbia University should reveal the impact and significance of the "drop out" factor on program goals.

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PART I-C - Continued

C.2 - GENERAL QUESTIONS

These questions concern developments since the prior PAR. For each question place "Y" for Yes, "N" for No, or "NA" for Not Applicable in the right hand column. For each question where "Y" is entered, explain briefly in the space below the table.	MARK IN THIS COL.
013 Have there been any significant, unusual or unanticipated results not covered so far in this PAR?	Y
014 Have means, conditions or activities other than project measures had a substantial effect on project output or accomplishments?	Y
015 Have any problems arisen as the result of advice or action or major contributions to the project by another donor?	N
016 If the answer to 014 or 015 is yes, or for any other reason, is the project now less necessary, unnecessary or subject to modification or earlier termination?	Y
017 Have any important lessons, positive or negative, emerged which might have broad applicability?	Y
018 Has this project revealed any requirement for research or new technical aids on which AID/W should take the initiative?	Y
019 Do any aspects of the project lend themselves to publicity in newspapers, magazines, television or films in the United States?	N
020 Has there been a lack of effective cooperating country media coverage? (Make sure AID/W has copies of existing coverage.)	N
021 <u>NARRATIVE FOR PART I-C.2</u> Identify each explanatory note by the number of the entry to which it pertains. (Continue on form AID 1020-25 I as necessary):	

013 (a) The Papal Encyclical had both positive and negative effects. It provided publicity on a larger scale than was possible with only SIA and GOES promotional funds; some persons now enrolled in the program learned of the availability of family planning through this medium. On the other hand, the Encyclical had its negative effects in frightening away potential or existing patients. The balance between the two effects is difficult to assess, although it is most likely that the overall impact was a negative one.

(b) Around the beginning of 1969 a medical student from the University of El Salvador serving his one-year internship at one of the GOES rural health facilities refused to engage in family planning activities and was transferred to a clinic which did not offer family planning services. As a result of his transfer, he and the Medical Students Association of the University began an anti-family planning campaign which resulted in a temporary suspension of promotional activities by the GOES and a limitation of field visits by the USAID technician.

The Salvadoran Legislature conducted hearings with the Minister of Health, the SIA, the Public Health Physicians Association, the Salvadoran Medical Association, the Salvadoran Association of Gynecologists and Pediatricians, the Board of Directors of the Medical School, the President of the Medical Students Association, and the student involved. The Legislature has not yet completed its study of the problem, but if it should rule against GOES activities in family planning, the SDA would have to remove its facilities from the GOES clinics (28 of the 32 SDA centers are in GOES clinics) and operate on its own. This extreme action seems unlikely, however, and the Legislature is expected either to pronounce itself in favor of family planning (on a voluntary basis) or to take a neutral stand.

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(c) The inflow of refugees from Honduras in June and July of 1969, the subsequent need for medical and other assistance at Red Cross Centers, and the outbreak of fighting with Honduras resulted in the suspension of all but emergency activities in the GOES health clinics. This resulted in a temporary setback for the family planning program: enrollment for the month of July was down by about 50%. Both the birth rate and the death rate can be expected to increase as a consequence of this suspension and the conflict with Honduras, but the overall effect on the natural rate of population increase is impossible to measure at the time of this writing. In addition, population pressures will be increased owing to the large influx of Salvadorans who were living in Honduras. An estimated 25,000 persons have returned to El Salvador and more can be expected to arrive before the end of the year.

014. See 013 above. All have had a negative effect on the project.

016. The project is now subject to modifications, although it is not known at this time exactly what they will be. As a result of the immigration from Honduras the project is now more necessary than before, a fact which is recognized by the GOES. It may be necessary to change the termination date, although the new date will be dependent on actual GOES performance.

017. Family planning methods are acceptable in a Catholic country if the program is properly planned and conducted.

A good contraceptive is essential if family planning programs are to avoid attacks related to the physical dangers of birth control. At the present time an organization which wishes to attack birth control, and prepares its information adequately, can expose the dangers of any sort of contraceptive (IUD, pill, etc.) and frighten potential and actual users.

018. There is need for a safe contraceptive which requires infrequent medical consultations.

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PART II - IMPLEMENTATION REPORT

II-A - STATUS OF SCHEDULE

022 A-1 - INDIVIDUAL ACTIONS (See detailed instructions M.O. 1026.1). This is a listing of major actions or steps which were scheduled for physical start or continuing implementation in the reporting period as reflected in the Project Implementation Plan, Part I.

(a)		(b) STATUS - PLACE AN "X" IN, ONE COLUMN		
PIP ITEM NO.	MAJOR ACTIONS OR STEPS; CAUSES AND RESULTS OF DELAYS; REMEDIAL STEPS	(1) BEHIND SCHEDULE	(2) ON SCHEDULE	(3) AHEAD OF SCHEDULE
	<p>No PIP prepared for this project prior to 1969.</p> <p>No implementing action sequence.</p>			

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PART II - Continued

023

II-A.2 - OVERALL TIMELINESS

In general, project implementation is (place an "X" in one block):

(a) On schedule	X
(b) Ahead of schedule	
(c) Behind schedule	
(1) AID/W Program Approval	
(2) Implementing Agency (Contractor/Participating Agency/Voluntary Agency)	
(3) Technicians	
(4) Participants	
(5) Commodities (non-FFF)	
(6) Cooperating Country	
(7) Commodities (FFF)	
(8) Other (specify):	

BLOCK (c): If marked, place an "X" in any of the blocks one thru eight that apply. This is limited to key aspects of implementation, e.g., timely delivery of commodities, return of participants to assume their project responsibilities, cooperating country funding, arrival of technicians.

II-B - RESOURCE INPUTS

This section appraises the effectiveness of U.S. resource inputs. There follow illustrative lists of factors, grouped under Implementing Agency, Participant Training and Commodities, that might influence the effectiveness of each of these types of project resources. In the blocks after only those factors which significantly affect project accomplishments, write the letter **P** if effect is positive or satisfactory, or the letter **N** if effect is negative or less than satisfactory.

1. FACTORS-IMPLEMENTING AGENCY (Contract/Participating Agency/Voluntary Agency)

024	IF NO IMPLEMENTING AGENCY IN THIS PROJECT. PLACE AN "X" IN THIS BLOCK:	X	032 Quality, comprehensiveness and candor of required reports	
025	Adequacy of technical knowledge		033 Promptness of required reports	
026	Understanding of project purposes		034 Adherence to work schedule	
027	Project planning and management		035 Working relations with Americans	
028	Ability to adapt technical knowledge to local situation		036 Working relations with cooperating country nationals	
029	Effective use of participant training element		037 Adaptation to local working and living environment	
030	Ability to train and utilize local staff		038 Home office backstopping and substantive interest	
031	Adherence to AID administrative and other requirements		039 Timely recruiting of qualified technicians	
			040 Other (describe):	

2. FACTORS-PARTICIPANT TRAINING

041	IF NO PARTICIPANT ELEMENT IN PROJECT. PLACE AN "X" IN THIS BLOCK:		TRAINING UTILIZATION AND FOLLOW UP	
	PREDEPARTURE		052 Appropriateness of original selection	P
042	English language ability		053 Relevance of training for present project purposes	P
043	Availability of host country funding		054 Appropriateness of post-training placement	P
044	Host country operational considerations (e.g., selection procedures)	P	055 Utility of training regardless of changes in project	P
045	Technical/professional qualifications	P	056 Ability to get meritorious ideas accepted by supervisors	P
046	Quality of technical orientation	P	057 Adequacy of performance	P
047	Quality of general orientation	P	058 Continuance on project	P
048	Participants' collaboration in planning content of program	P	059 Availability of necessary facilities and equipment	P
049	Collaboration by participants' supervisors in planning training	P	060 Mission or contractor follow-up activity	P
050	Participants' availability for training	P	061 Other (describe):	
051	Other (describe):			

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PART II-B - Continued

3. FACTORS-COMMODITIES

PLACE AN "X" IN APPROPRIATE BLOCK:	062 FFF	063 NON-FFF	X	064 NO COMMODITY ELEMENT		072 Control measures against damage and deterioration in shipment.	P
065 Timeliness of AID/W program approval (i.e., PIO/C, Transfer Authorization).					N	073 Control measures against deterioration in storage.	P
066 Quality of commodities, adherence to specifications, marking.					P	074 Readiness and availability of facilities.	P
067 Timeliness in procurement or reconditioning.					N	075 Appropriateness of use of commodities.	P
068 Timeliness of shipment to port of entry.					N	076 Maintenance and spares support.	P
069 Adequacy of port and inland storage facilities.					P	077 Adequacy of property records, accounting and controls.	P
070 Timeliness of shipment from port to site.					P	078 Other (Describe):	
071 Control measures against loss and theft.					P		

Indicate in a concise narrative statement (under the heading a. Overall Implementation Performance, below) your summary appraisal of the status of project implementation, covering both significant achievements and problem areas. This should include any comments about the adequacy of provision of direct hire technicians as well as an overall appraisal of the comments provided under the three headings (b, c & d) which follow. For projects which include a dollar input for generation of local currency to meet local cost requirements, indicate the status of that input (see Detailed Instructions).

Discuss separately (under separate headings b, c & d) the status of Implementing Agency Actions, Participants and Commodities. Where above listed factors are causing significant problems (marked N), describe briefly in the appropriate narrative section: (1) the cause and source of the problem, (2) the consequences of not correcting it, and (3) what corrective action has been taken, called for, or planned by the Mission. Identify each factor discussed by its number.

079 NARRATIVE FOR PART II-B: (After narrative section a. Overall Implementation Performance, below, follow, on form AID 1020-251 as needed, with the following narrative section headings: b. Implementing Agency, c. Participants, d. Commodities. List all narrative section headings in order. For any headings which are not applicable, mark them as such and follow immediately below with the next narrative section heading.)

- a. Overall Implementation Performance. With the exception of commodity procurement problems, the implementation performance of this project has been good. Training has been conducted either in El Salvador or in Mexico, well qualified persons have been sent and they have used their newly acquired knowledge adequately.
- b. Implementing Agency. N.A.
- c. Participants. All factors positive.
- d. Commodities.

065. All commodities ordered by PIO/C have arrived extremely late, especially pharmaceutical supplies and vehicles.

067. All procurement has been very slow, starting with the USAID/El Salvador procurement office and ending with the supplier. This has had a detrimental effect on the project: centers have been unable to open on schedule, and supervision has been inadequate due to a lack of vehicles.

068. Shipments via surface are very slow. The major factor in 1968 was the New York dock strike.

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PART III - ROLE OF THE COOPERATING COUNTRY

The following list of illustrative items are to be considered by the evaluator. In the block after only those items which significantly affect project effectiveness, write the letter P if the effect of the item is positive or satisfactory, or the letter N if the effect of the item is negative or less than satisfactory.

SPECIFIC OPERATIONAL FACTORS:

080 Coordination and cooperation within and between ministries.	
081 Coordination and cooperation of LDC gov't. with public and private institutions and private enterprise.	P
082 Availability of reliable data for project planning, control and evaluation.	P
083 Competence and/or continuity in executive leadership of project.	P
084 Host country project funding.	P
085 Legislative changes relevant to project purposes.	
086 Existence and adequacy of a project-related LDC organization.	
087 Resolution of procedural and bureaucratic problems.	P
088 Availability of LDC physical resource inputs and/or supporting services and facilities.	P
089 Maintenance of facilities and equipment.	P
090 Resolution of tribal, class or caste problems.	
091 Receptivity to change and innovation.	
092 Political conditions specific to project.	P
093 Capacity to transform ideas into actions, i.e., ability to implement project plans.	N
094 Intent and/or capacity to sustain and expand the impact of the project after U.S. inputs are terminated.	P
095 Extent of LDC efforts to widen the dissemination of project benefits and services.	P
096 Utilization of trained manpower (e.g., participants, counterpart technicians) in project operations.	P
097 Enforcement of relevant procedures (e.g., newly established tax collection and audit system).	P
098 Other:	
HOST COUNTRY COUNTERPART TECHNICIAN FACTORS:	
099 Level of technical education and/or technical experience.	
100 Planning and management skills.	P
101 Amount of technician man years available.	P
102 Continuity of staff.	N
103 Willingness to work in rural areas.	N
104 Pay and allowances.	N
105 Other:	N

In the space below for narrative provide a succinct discussion and overall appraisal of the quality of country performance related to this project, particularly over the past year. Consider important trends and prospects. See Detailed Instructions for an illustrative list of considerations to be covered.

For only those items marked N include brief statements covering the nature of the problem, its impact on the achievement of project targets (i.e., its importance) and the nature and cost of corrective action taken or planned. Identify each explanatory note.

106 NARRATIVE FOR PART III (Continue on form AID 1020-25 I):

092. See Part 1-C, #13. Both the Papal Encyclical and the problem with the Salvadoran medical student have had negative effects on project progress.

101. There is still a large deficit of physicians in El Salvador.

102. About 35% of the physicians at the health services are medical students of the University serving their one year internship. Although some students choose to stay for more than one year, the majority leave upon completion of the required amount of time. Therefore about one-third of the health service staff turns over every year.

103. See Part 1-B, 1967 #3. The lack of interest of Salvadoran physicians to work in rural areas has slowed progress in the past and can be expected to greatly hamper the effectiveness of the project in the future, as the

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need to expand to the rural sector increases.

104. Poor pay and lack of fringe benefits make it extremely difficult to employ good physicians and nurses in the GOES public health programs, and cause a high rate of attrition. The SDA usually does not have this problem, as its physicians use the SDA salaries to supplement their regular sources of income. The SDA also encountered difficulties, however, when it attempted to hire a full-time physician (See Part 1-B, 1967 #2).

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PART IV - PROGRAMMING IMPLICATIONS

IV-A - EFFECT ON PURPOSE AND DESIGN

Indicate in a brief narrative whether the Mission experience to date with this project and/or changing country circumstances call for some adjustment in project purposes or design, and why, and the approximate cost implications. Cover any of the following considerations or others that may be relevant. (See Detailed Instructions for additional illustrative considerations.) Relevant experience or country situations that were described earlier can simply be referenced. The spelling out of specific changes should be left to the appropriate programming documents, but a brief indication of the type of change contemplated should be given here to clarify the need for change.

For example, changes might be indicated if they would:

1. better achieve program/project purposes;
2. address more critical or higher priority purposes within a goal plan;
3. produce desired results at less cost;
4. give more assurance of lasting institutional development upon U.S. withdrawal.

107 NARRATIVE FOR PART IV-A (Continue on form AID 1020-25 I):

The need to have approximately 40,000 more women under control than currently planned if the population growth rate is to fall to desired levels, coupled with the desire by the GOES to move at a faster pace, should result in some changes in the project. What these changes will be and their cost implications depend upon a number of factors which are as yet either unknown or undecided: the ability and willingness of the GOES to absorb the increased recurring costs; the need for either revised country targets or revised population growth rate goals in light of the inconsistency between the two; and the level of the "drop out" rate.

IV-B - PROPOSED ACTION

108 This project should be (Place an "X" in appropriate block(s)):

1. Continued as presently scheduled in PIP.	
2. Continued with minor changes in the PIP, made at Mission level (not requiring submission of an amended PIP to AID/W).	
3. Continued with significant changes in the PIP (but not sufficient to require a revised PROP). A formally revised PIP will follow.	
4. Extended beyond its present schedule to (Date): Mo. ___ Day ___ Yr. ___. Explain in narrative, PROP will follow.	
5. Substantively revised. PROP will follow.	
6. Evaluated in depth to determine its effectiveness, future scope, and duration.	
7. Discontinued earlier than presently scheduled. Date recommended for termination: Mo. ___ Day ___ Yr. ___	
8. Other. Explain in narrative.	X

109 NARRATIVE FOR PART IV-B:

The PIP is presently in draft form and will be modified in accordance with those changes considered necessary as a result of the conflict with Honduras.
(See Part 1-C, 013c).