

PD-MAP-587
12A

PROJECT EVALUATION SUMMARY (PES) - PART I

Report Control
Symbol U-447

1. PROJECT TITLE Family Planning and Population		2. PROJECT NUMBER 519-0149	3. MISSION/AID/W OFFICE USAID/EI Salvador
		4. EVALUATION NUMBER (Enter the number maintained by the reporting unit, e.g., Country or AID/W Administrative Center Fiscal Year Serial No. beginning with No. 1 each FY) 84-01	
		<input checked="" type="checkbox"/> REGULAR EVALUATION <input type="checkbox"/> SPECIAL EVALUATION	

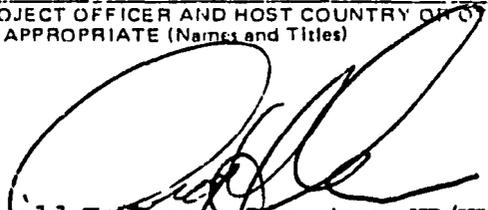
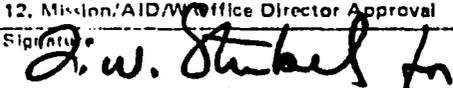
5. KEY PROJECT IMPLEMENTATION DATES			6. ESTIMATED PROJECT FUNDING		7. PERIOD COVERED BY EVALUATION	
A. First PRO-AG or Equivalent FY <u>66</u>	B. Final Obligation Expected FY <u>82</u>	C. Final Input Delivery FY <u>83</u>	A. Total \$ <u>20,280,759</u>	B. U.S. \$ <u>8,642,811</u>	From (month/yr.) <u>January, 1980</u>	To (month/yr.) <u>December, 1983</u>
					Date of Evaluation Review <u>April 13, 1984</u>	

B. ACTION DECISIONS APPROVED BY MISSION OR AID/W OFFICE DIRECTOR

A. List decisions and/or unresolved issues; cite those items needing further study. (NOTE: Mission decisions which anticipate AID/W or regional office action should specify type of document, e.g., airgram, SPAR, PIO, which will present detailed request.)	B. NAME OF OFFICER RESPONSIBLE FOR ACTION	C. DATE ACTION TO BE COMPLETED
1. Implementation Letter requesting actions to be carried out by the Salvadoran Demographic Association (ADS), Project 519-0275.	R. G. Toledo	May 2, 1984
2. Analysis of Action Plan submitted by ADS.	R. G. Toledo	May 15, 1984
3. Approval of the Action Plan by an Implementation Letter (draft)	R. G. Toledo	May 16, 1984
4. Implementation Letter approved	Mission Director	June 11, 1984

The attached three reports constitute the Family Planning and Population Project (No. 519-0149) evaluation which was undertaken as a basis for continued A.I.D. financial support to the Salvadoran Demographic Association's programs.

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS			10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT		
<input type="checkbox"/> Project Paper	<input checked="" type="checkbox"/> Implementation Plan e.g., CPI Network	<input type="checkbox"/> Other (Specify)	A. <input type="checkbox"/> Continue Project Without Change		
<input checked="" type="checkbox"/> Financial Plan	<input type="checkbox"/> PIO/T		B. <input checked="" type="checkbox"/> Change Project Design and/or		
<input type="checkbox"/> Logical Framework	<input type="checkbox"/> PIO/C	<input type="checkbox"/> Other (Specify)	<input checked="" type="checkbox"/> Change Implementation Plan		
<input type="checkbox"/> Project Agreement	<input type="checkbox"/> PIO/P		C. <input type="checkbox"/> Discontinue Project		

11. PROJECT OFFICER AND HOST COUNTRY OF OTHER RANKING PARTICIPANTS AS APPROPRIATE (Name and Title)		12. Mission/AID/W Office Director Approval	
 Donald P. Enos, Director, HR/HA, USAID/ES		Signature: 	
		Typed Name: <u>Martin V. Dagata</u>	
		Director, USAID/ES	
		Date:	

AID 1330-15 (3-78)

JAM
RGT/dp

**INSTRUCTIONS FOR COMPLETING FORM AID 1330-15 & 15A,
PROJECT EVALUATION SUMMARY (PES)—PART I & II**

EVALUATION PROCESS - Officials of the Host Government and AID Mission should collaborate in periodic evaluation of the progress of each project. (For AID/W projects, participation of grantees is appropriate.) Timing of such regular evaluations should be linked to the key decisional requirements of the project, as listed in the Evaluation Plan included in the Project Paper and as confirmed in the Evaluation Schedule of the Annual Budget Submission; otherwise annually. A description of the evaluation process is found in Handbook 3, Part II, Chapter 8.

PURPOSES OF SUMMARY - The Project Evaluation Summary (PES) is prepared after each review to record information which is useful both to the implementors (including the Host Government and contractors) and to concerned AID/W units. It serves four purposes:

(1) Record of decisions reached by responsible officials, so that those who participated in the evaluation process are clear about the conclusions, and so that headquarters is aware of the next steps.

(2) Notice that a scheduled evaluation has been completed, with a brief record of the method and participation for future reference.

(3) Summary of progress and current status for use in answering queries.

(4) Suggestions about lessons learned for use in planning and reviewing other projects of a similar nature. The PES and other project documentation are retained in DS/DIU/DI and are available to project planners.

CONTENTS OF SUMMARY - A PES submittal has two parts, plus relevant attachments if any.

PART I REQUIRED: Form AID 1330-15 contains identifying information about the project and evaluation (Items 1-7), action decisions about the project's future (Items 8-10), and signatures (Items 11-12). Since the PES reports decisions, it is signed by the Director of the Mission or AID/W Office responsible for the project. Space is also provided for signatures of the project officer, host country and other ranking participants in the evaluation, to the extent appropriate.

PART II, OPTION 1: For regular evaluations, use continuation sheets to respond to Items 13-23 as outlined in the attached Form AID 1330-15A.

PART II, OPTION 2: For a special evaluation, the reporting unit may opt for a somewhat varied format, with a different sequence or greater detail in some areas, however, Items 13-23 should all be addressed.

ATTACHMENTS: As appropriate, reports of host governments, contractors, and others, utilized in the preparation of the evaluation summary, should be labeled A, B, C, etc., attached to the PES submittal (Missions are to submit 7 copies and AID/W Offices 7 copies) and listed under Item 23. Where it is necessary to transmit these source documents separately from the PES, Block 23 of the PES should note how this material was transmitted, when, number of copies and to whom.

SUBMITTAL PROCEDURE: Missions will submit the PES Facesheet, continuation sheets, and attachments under cover of an airgram which will be received by the Cable Room. AID/W Offices will submit the PES Facesheet, continuation sheets, and attachments to MO/PAV, Room B-930, NS under cover of a memorandum which cites any distribution instructions beyond the standard distribution. All AID/W Offices and most Missions will use the blank cut PES Facesheet and plain bond for continuation sheets, which can be reproduced on copiers. Those Missions preferring to use hecto, may order the form in hecto sets from AID/W, Distribution Branch. There will be a standard distribution made in AID/W of all field-originated PES's. Copies will be sent to the corresponding bureau's DP, DR, the country desk and Evaluation Office. Other copies will be sent to PPC, SER, PDC and DS (including DI and ARC). For AID/W-generated PES's, copies will be distributed to all bureaus.

PROJECT EVALUATION SUMMARY (PES) – PART II

The following topics are to be covered in a brief narrative statement (averaging about 200 words or half a page per item) and attached to the printed PES facesheet. Each topic should have an underlined heading. If a topic is not pertinent to a particular evaluation, list the topic and state: "Not pertinent at this time". The Summary (Item 13) should always be included, and should not exceed 200 words.

13. SUMMARY - Summarize the current project situation, mentioning progress in relation to design, prospects of achieving the purpose and goal, major problems encountered etc.

14. EVALUATION METHODOLOGY - What was the reason for the evaluation, e.g., clarify project design, measure progress, verify program/project hypotheses, improve implementation, assess a pilot phase, prepare budget, etc? Where appropriate, refer to the Evaluation Plan in the Project Paper. Describe the methods used for this evaluation, including the study design, scope, cost, techniques of data collection, analysis and data sources. Identify agencies and key individuals (host, other donor, public, AID) participating and contributing.

15. EXTERNAL FACTORS - Identify and discuss major changes in project setting, including socio-economic conditions and host government priorities, which have an impact on the project. Examine continuing validity of assumptions.

16. INPUTS - Are there any problems with commodities, technical services, training or other inputs as to quality, quantity, timeliness, etc? Any changes needed in the type or amount of inputs to produce outputs?

17. OUTPUTS - Measure actual progress against projected output targets in current project design or implementation plan. Use tabular format if desired. Comment on significant management experiences. If outputs are not on target, discuss causes (e.g., problems with inputs, implementation assumptions). Are any changes needed in the outputs to achieve purpose?

18. PURPOSE - Quote approved project purpose. Cite progress toward each End of Project Status (EOPS) condition. When can achievement be expected? Is the set of EOPS conditions still considered a good description of what will exist when the purpose is achieved? Discuss the causes of any shortfalls in terms of the causal linkage between outputs and purpose or external factors.

19. GOAL/SUBGOAL - Quote approved goal, and subgoal, where relevant, to which the project contributes. Describe status by citing evidence available to date from specified indicators, and by mentioning the progress of other contributory projects. To what extent can progress toward goal/subgoal be attributed to purpose achievement, to other projects, to other causal factors? If progress is less than satisfactory, explore the reasons, e.g., purpose inadequate for hypothesized impact, new external factors affect purpose-subgoal/goal linkage.

20. BENEFICIARIES - Identify the direct and indirect beneficiaries of this project in terms of criteria in Sec. 102(d) of the FAA (e.g., a. increase small-farm, labor-intensive agricultural productivity; b. reduce infant mortality; c. control population growth; d. promote greater equality in income; e. reduce rates of unemployment and underemployment). Summarize data on the nature of benefits and the identity and number of those benefitting, even if some aspects were reported in preceding questions on output, purpose, or subgoal/goal. For AID/W projects, assess likelihood that results of projects will be used in LDC's.

21. UNPLANNED EFFECTS - Has the project had any unexpected results or impact, such as changes in social structure, environment, health, technical or economic situation? Are these effects advantageous or not? Do they require any change in project design or execution?

22. LESSONS LEARNED - What advice can you give a colleague about development strategy, e.g., how to tackle a similar development problem or to manage a similar project in another country? What can be suggested for follow-on in this country? Similarly, do you have any suggestions about evaluation methodology?

23. SPECIAL COMMENTS OR REMARKS - Include any significant policy or program management implications. Also list titles of attachments and number of pages.

SOCIAL MARKETING PROJECT

EXECUTIVE SUMMARY

The Social Marketing Project (SMP) is part of the ADS national population program. It has developed an efficient system for distributing the CONDOR condom, currently priced at .75 Colones per three-pack, the PERLA oral contraceptive priced at 2.00 Colones per cycle, and the SUAVE tablet, priced at .75 Colones per three-pack.

During 1983 sales fell from levels achieved in 1982. The CONDOR suffered the most significant loss, with a 1983 total distribution to 551,804 pieces, down from the 1,707,302 level of 1982. PERLA also suffered a loss of sales, though not as significant, from 158,023 cycles in 1982 to 129,022 cycles in 1983. Also, of course, total couple-year-protection (CYP) fell from 23,159 in 1982 to 15,889 in 1983.

The substantial loss of CYP is essentially due to the lackluster performance of CONDOR during 1983. Although pharmacies report that in general all sales have declined due to conditions of social and economic uncertainty, the price increase of CONDOR from .30 Colones per three-pack to .75 per three-pack, and the PERLA increase from 1.00 to 2.00 per cycle during the final months of 1982, without support of an aggressive media campaign and sales promotion strategy also must have had a negative influence on sales. Media advertising was actually reduced during 1983. No advertising was done at all during the last six months of 1983.

Although the cost of CYP in 1983 (\$14.56) was less than 1982 (\$16.93) and less than the ADS Community Distribution program, it is still relatively high to costs in other Social Marketing programs. ADS, however, can do much to lower the cost per CYP and increase its sales volume.

The situation of social and economic insecurity notwithstanding, this assessment has not identified any structural constraint in the current ADS SMP that would frustrate the recuperation of sales volumes lost during 1983. Upon considering alternative management structures through which the SMP could function (1) continue as department of ADS, (2) restructuring as separate commercial entity, (3) turn distribution function over to national distribution company, (4) or curtail the SMP operation, this assessment finds that ADS SMP is the most appropriate structure, already having competent staff, information system, and functioning distribution system.

4.

To ensure that the SMP functions effectively and efficiently, it is recommended that ADS hire a permanent manager. Since an executive search will probably consume 2-3 months, ADS should take advantage of its current staff and select an interim product manager, who will assume responsibility for the PANTHER launch, already one month behind schedule. ADS will also, during this time, be able to assess this manager's performance and, if effective, consider this person for the manager's job.

Also, ADS should focus on the following objectives:

1. Launch PANTHER, June 1st.
2. Initiate executive search for long term manager, starting 24 April.
3. Review price structure of ADS contraceptive products, starting May, 1984.
4. Review bonus distribution of contraceptive products to reduce advantage that accrues to large volume buyers. Start immediately.
5. Review .15 Colon rebate on price stickers. Immediate.
6. Prepare advertising strategy and promotional campaign for PANTHER. Immediate.
7. Prepare advertising strategy for remainder of 1984. Immediate.
8. Restack and re-arrange stock in the two subsidiary storage places to facilitate proper warehousing of products

EVALUATION OF SOCIAL MARKETING PROJECT

ASOCIACION DEMOGRAFICA SALVADORENA

14 April, 1984

Introduction

The scope of the evaluation was developed with the cooperation of the AID-Salvador Health Group, Mr. Donald Enos, Mr. John Massey, and Dr. Guillermo Toledo. The two major objectives established were to 1) provide a description and analysis of the Social Marketing Project (SMP) of (ADS) Asociacion Demografica Salvadorena and 2) to assist AID Salvador and ADS in making decisions concerning its future operation. Since Alberto Aragon of Aragon Associates has already developed several excellent market analyses, this evaluation was focused principally on the management and operation of the SMP, organizational issues involved, project impact in terms of outputs produced, and an examination of key economic and financial aspects. The work consisted of interviews and discussions with both AID and ADS staff, Pharmacists, Doctors, Point of Purchase (POP) employees, and consumers; reading and analysis of background documents and reports; and field work (direct observation of marketing and sales operation, physical distribution, analysis of plant and personal structure, review of records, ledgers and reports). The evaluation thus makes assessments, both quantitative and qualitative, of the ADS SMP as it now functions. Recommendations developed from the assessment, included in the last section of this report, have been made available to AID & ADS during the evaluation through discussions, which have been an integral part of the review process.

1. Asociacion Demografica Salvadorena (ADS)

ADS was founded in May, 1962, duly incorporated in El Salvador as a non-profit organization, apolitical, with the objectives of research and service, without restrictions as to creed, race, nationality, sex, or socio-economic position. ADS receives its tax exemption and import privileges through a ministerial decree, approved and signed by the Ministry of Health, on January 9, 1973.

In discussions with MOH officials and the President of the Salvadoran Chemists & Pharmacists Association it was noted that ADS maintains excellent relations with the professional communities involved in the spectrum of its various programs and initiatives. (See organizational Chart of ADS, Annex I).

ADS - Social Marketing Program (SMP)

The SMP was begun in 1976, and has evolved through a number of changes. This history is not within the scope of this assessment, and can be found in several of the documents listed in the Bibliography.

The objective of the SMP, as envisioned by ADS, is to market contraceptives to low income consumers who are unable to secure products regularly at traditional market prices.

Another objective of the SMP is, that through aggressive marketing techniques, and the additions of other, more profitable contraceptive product lines, the program will become self-financing within "a reasonable time". To achieve the above two major objectives ADS has created a Social Marketing Department (See Section VI Management Audit/Analysis). This department is one of several programs currently being implemented, including 1) Community Distribution of Contraceptives (See ADS 1984 Implementation Plan and Edmonds Report), 2) mass media education, 3) family clinic program. The SMP department, as envisioned by Dr. Gustavo Argueta (ADS Executive Director) and Lic. Carlos Maravilla (Administrative Manager), has the complete both responsibility and authority to market the contraceptive products Condor, Perla, Suave, manage an ancillary vending machine program of condoms and Oral Contraceptives (OC's), and develop and launch other contraceptive products, e.g., the Panther condom.

II. Project Impact

The Products

1) Condor

Condor is currently sold in an attractive 3-pack, or in single units to consumer. It is marketed by ADS directly to the point of purchase (POP), a pharmacy or drugstore, by dispenser containing 25 three-packs. Unlike Panther, the Condor individual unit is clear plastic, with the letters "Ackwell, made in U.S.A." Although the Condor is without doubt well known, and it currently according to estimates by the two SMP salesmen, holds a 60% market share, the clear plastic individual unit can be easily replaced by contraband condoms

from a variety of sources and sold as "Condor". In one of the pharmacies visited a 3-pack of Condors purchased actually yielded 2 Tahiti units. The competition from contraband will be significantly reduced, however, with the newly designed 3-pack wrapper which will further distinguish Condor from products available in the community and clinic based distribution programs of the ISSS, MOH, and ADS. The threat of contraband infiltration notwithstanding, Condor does in fact move well in the contraceptive market. It's closest historical competitors are priced 2 to 4 times higher; another possible competitor, the .007, at Cols. 1.90 was found in only one pharmacy visited during this assessment. Although during POP level conversations mention was made continuously about how even "poor" people choose higher priced condoms because they assume something is "wrong" with a low priced item, and there does seem to be a place for another condom in the majority of pharmacies visited at a price between Condor (at .75 per three-pack) and brands starting at Cols. 4.00, the current lag of Condor sales is not due to a perceived difference in quality; rather it is, as most pharmacy personnel indicate, part of a general decline of sales.

The following chart shows annual unit sales and Bonus * distribution since 1978

C O N D O R
ANNUAL SALES

YEAR		TOTALS	BONUS *
1978**	Units	620,663	No Record
	Colones	67,355	
1979**	Units	748,837	30,700
	Colones	37,224	
1980**	Units	546,600	41,250
	Colones	29,055	
1981	Units	773,925	85,875
	Colones	48,665	
1982	Units	789,059	240,506
	Colones	55,988	
1983	Units	386,775	82,425
	Colones	62,141	

* (Bonus product is provided without additional cost to the POP in accordance with the ADS Bonus plan. See annex 4.)

** Monthly sales records not available.

2) Perla

Perla has proven to be a highly saleable product. It is very well packaged. In terms of visual display it is attractive, and all pharmacy personnel contacted were pleased with its presentation.

The SMP salesmen estimate that it currently holds an average 45% market share. In terms of information available at the pharmacy level, there have been few complaints concerning Perla, and these have been related to facial spotting or discoloration, which has not been verified by any systematic research..

In terms of competition, there are incidents of contraband orals appearing at the pharmacy level. During the field work phase of this assessment, one pharmacy in Cojutepeque was found to have Noriday cycles without wrappers in the Perla Dispenser, selling at the Perla price of Cols. 2.00. When asked about this anomaly, the owner stated, simply, that he was able to acquire this small supply at a convenient price. Also, the salesmen report that some competition has its source in the ADS vending machine operation, from which a person can secure a Perla cycle at ¢.20 and then resell to individuals or pharmacies at lower prices than the Perla cycle distributed directly from ADS to the Pharmacies. This kind of "Discounting" has been described by the project staff as a nuisance, and in terms of volume it is certainly not significant, at the pharmacy market level.

The following chart shows annual unit sales and Bonus Distribution since 1979:

<u>P E R L A</u>			
<u>YEAR</u>		<u>TOTALS</u>	<u>BONUS</u>
1979*	Units/cycles	8,352	1,152
	Colones	Note Available	
1980*	Units	50,988	3,231
	Colones	28,123	
1981	Units	93,881	12,192
	Colones	62,558	
1982	Units	94,624	36,130
	Colones	74,825	
1983	Units	78,648	13,910
	Colones	108,805	

* Monthly sales records not available.

3) Suave

Suave, through attractively packaged, has not achieved a significant sales record. Its current market share, as estimated by the SMP salesmen, is 12% of a relatively small market. On the pharmacy level one of the problems of Suave, as reported by a majority of pharmacy personnel, is that it was very "hot", and there had been "many" reports of unpleasant or "burning" sensations by consumers. These reports have not been substantiated through any formal research.

The following chart shows annual sales and bonus distribution since 1981

S U A V E

YEAR		TOTALS	BONUS
1981*	Units	43,041	(not available)
	Colones	5,853	
1982	Units	25,768	1,360
	Colones	3,505	
1983	Units	44,700	
	Colones	7,364	

* Suave was introduced in 1981.

III. SALES

The following chart provides annual unit sales information and revenue for years 1981, 82, and 83 (See Annex 2 for sales records)?

<u>1 9 8 3</u>	<u>1 9 8 1</u>	<u>1 9 8 2</u>	
Units/US\$	Units*/US\$**	Units/US\$	
CONDOR 15,934	773,925/ 13,478	789.059/14,356	386,757/
PERLA 27,899	93,881/ 16,041	94,624/19,186	78,648/
SUAVE 44,700/ 1,888	43,041/ 1,501	23,768 3,899	
TOTALS 45,721	910,847/ 30,020	909.451/ 34,441	510,105/

* Does not include bonus distribution.

** All dollar conversions at 3.9

From the above chart it is seen that although sales in colones indicate a rising trend, actual unit sales of Condor and Perla dropped in 1983 from 1982 levels, especially in the case of Condor, which registered a 46% decrease. Both Condor and Perla underwent price changes in November, 1982: the Condor retail price was raised 150%, from .30 per 3-pack to .75; the Perla retail price was raised 100%, from ₡1.00 to ₡2.00. In discussions with ADS salesmen and pharmacy personnel concerning a decline in sales levels, however, the price increase is not mentioned as a contributory factor in reduced unit sales; rather, the problem is perceived as a universal decline in all sales.

The above decline in unit sales could also very well be associated with the difficulties of doing business in El Salvador. ADS records currently show 718 pharmacies as point of purchase; down considerable from the 850 participating pharmacies in 1982. Also, ADS has not been able to place products successfully in other channels such as supermarkets or small stores, although in the San Salvador area an attempt is now underway to place Condor in motels and cooperatives. It should also be noted that 90% of the 41 pharmacies visited (see annex 3 for list of pharmacies) during this assessment in the San Salvador urban area have installed iron bars and gratings over windows and doors due to the climate of unsecurity. Customers are forced to queue and are thus served through the bars, effectively nullifying any strategy of merchandising products

11

or using the selling floor or space to promote shopping and sales. Also, according to ADS salesmen, since 60% of the pharmacies now have bars and gates, the process of selling to the retailer has been made more difficult. Although ADS salesmen gradually win entry to the pharmacy, significant numbers of sales are made through the bars, looking into the stock shelves and attempting to check contraceptive inventories. Pharmacy owner also keep irregular hours, leaving the work to attendants, who do not usually have authority to order products. However, all pharmacies visited during the assessment had ADS stock on hand. Stock outs have not contributed to the unit sales decline. Promotion through mass media during the 81/83 period was also gradually reduced and in the final six months of 83 there was no paid promotional support, due to contractual problems with the advertising agency.

There are currently a total of 333 vending machines (274 condoms and 59 OC's) operating in the SMP. These machines and contraceptive products are supplied by IPPF. The machines are located in Bus Stations, Hotels, garages, market areas, and gas stations. Annual Unit Sales and Revenues since 1982 are listed below (See Annex 2):

1) 1982

Condoms	47,737 pieces	\$ 2,544.40
OC	28,267.....	\$ 919.10

2) 1983

Condoms	82,659.....	\$ 4,428.00
OC	36,624.....	\$ 1,522.00

3) 1984

Condoms	20,624.....	\$ 1,121.00
OC	6,612.....	\$ 316.00

IV. Project Outputs
Couple Years Protection.

The conversion of contraceptive distribution data into Couple-Years protection (CYP) is currently used as one output indicator of various types of Family Planning Services-delivery Programs. However, the CYP measure should not, of course, be used as a basis for comparing projects with different objectives and structures. The total cost of CYP is also computed differently, depending on information available and accounting systems utilized. In this assessment only direct operational costs taken from ADS monthly accounting statements have been included as total annual

12

costs. The CIF value of the contraceptive product has not been included, nor has an attempt been made to assign a percentage of ADS/ budget for plant and capital equipment as a cost to the SMP. (See Annex 5 for the monthly cost resume for 1981, 82, and 83.) The only change in the cost structure was made in the last three months of 1983, reducing the aggregate costs of those months through a redistribution of relatively significant printing charges for packaging materials scheduled for use in 1984.

a) 1981 CYP* and cost per CYP (contraceptive unit quantities contain bonus distributions and unit sales of vending machines)

CONDOR: 859,800 - 100 = 8,598 CYP
 PERLA: 106,073 - 13 = 8,159 CYP
 SUAVE: 43,041 - 100 = 430 CYP

TOTAL CYP 17,187

* CYP has been calculated on the basis of the standard conversion factor used in social marketing programs: 100 condoms is equivalent to 1 CYP, 13 OC cycles to 1 CYP, and 100 vaginal tablets to 1 CYP.

Revenue 1981 Costs and Revenue includes vending machines (Note: figures include vending machines)

Total Cost = ₡ 754,415
 Total Revenue = 117,076
 Net Cost = 637,335

Cost per CYP = ₡ 37.00 - 3.9 = \$ 9.48

b) 1982 CYP and cost per CYP

CONDOR: 1,073,302 - 100 = 10,733 CYP
 PERLA: 158,023 - 13 = 12,155
 SUAVE: 27,128 - 100 = 271

TOTAL CYP 23,159

1982 Costs and Revenue

Total Cost = ₡ 1,682.278

$$\begin{array}{rcl} \text{Revenue} & = & 152.837 \\ \text{Net Cost} & = & \frac{}{\text{¢ } 1,529,441} \end{array}$$

$$\text{Cost per CYP} = \text{¢ } 66,04 - 3.9 = \$16.93$$

c) 1983 CYP and cost per CYP

CONDOR:	551,804	-	100	=	5,518
PERLA:	129,022	-	13	=	9,924
SUAVE	44,700	-	100	=	<u>447</u>

TOTAL CYP 15,889

1983 Costs and Revenue

Total Cost	=	1,084.332
Total Revenue	=	<u>181,995</u>
Net Cost	=	<u>902,337</u>

$$\text{Cost per CYP} = \text{¢ } 56.79 - 3.9 = \$14.56$$

Although the cost for 1983 CYP is lower than 1982, it is disturbing to note the decrease in CYP of 31% during calendar year 1983. Discussion of this key output will be developed in the final section of this evaluation.

Advertising, Training and Education Outputs

The advertising output through the Rumbo Agency, though found unsatisfactory in terms of both methodology and management, in fact has made an impact. Condor and Perla are becoming market words. Messages have reached urban, semi urban and rural areas. (See Annex 4 for samples messages that have been used during 81, 82, and half of 83).

Training and education is an important function of ADS, and to support the SMP periodic seminars have been held for the medical and pharmaceutical associations membership to promote the project. While the results of these seminars and presentations cannot be quantified, ADS executives correctly perceive the need for Doctor/s and Pharmacist/s cooperation. This necessary cooperation has been achieved and is currently maintained.

ADS has recently selected another advertising firm, Comercial, to handle the complete account (SMP and all other ADS media activities).

Comercial's approach is much more methodological, and it is thought that with the technical assistance of Aragon and Associates an effective campaign can be developed, supervised, and evaluated.

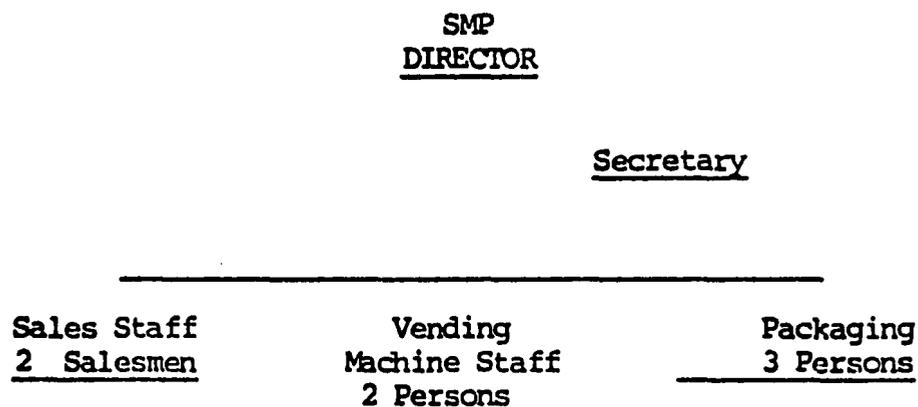
Although at this point unquantifiable, there has been definite change in consumer attitude toward contraceptives. ADS salesmen and executives report that it is now possible at pharmacy level to discuss contraceptives openly, to examine products, and make public purchases.

During this assessment it was possible to examine products (at those pharmacies actually entered) and discuss consumer behavior and attitudes with pharmacy personnel in all pharmacies visited (See Annex 5 for list of pharmacies visited). It's worth mentioning here that customers became involved in these conversations. With more time available these conversations could easily have been utilized to discuss themes presented in focus groups.

V. MANAGEMENT AUDIT/ANALYSIS:

1. Organizational structure and personnel function.

The SMP functions as a Department of ADS and is currently structured as shown in the following chart:



During the last 15 months, the SMP Department has had a director for 2 months (one person in September/October of 1983) and 5 days (one person during March). Part of the Director's job is currently done on an Ad-Hoc basis by Lic. Carlos Maravilla, the Administrative Director of ADS, who has little time available for the SMP, and his participation is generally triggered by a problem which needs immediate attention, a type of Administrative First Aid.

13

The two salesmen, fortunately, have several years experience in the SMP, and the commission structure is such that it keeps them focused on their sales routines without supervision. The salesmen are assigned to the two sales territories and travel the specific routes in accordance with a standard itinerary. They are also responsible for distribution and collection of payments, coordinating these activities with the Accounting Department and Inventory-Warehouse person.

The two person vending machine staff also functions without close supervision, coordinating activities with accounting and inventory/warehousing, and stocking and repairing machines. Currently, there is no permanent secretary assigned to the Department.

The 3 person packaging staff works in response to demand, taking its cues from salesmen, accounting, inventory, and the Director of Administration. At optimal production they are able to package by hand 50 dispensers each per day.

2. Management Information System

The ADS/SMP Management Information System, fortunately, is indeed quite good, as indicated by the comprehensive formats encountered during the evaluation. Sales, inventory, financial information is readily available, current, and dependable. The Reporting System itself is at the moment maintaining the SMP's integrity as a unit. The formats, designed to support the project, now provide the map that enables coordination between the key ADS sub-units, sales, vending machines, accounting, personnel, and inventory. This information system will be computerized during 1984.

3. Plant and Equipment

In May, 1983, ADS purchased a modern, 4 story building in the Government Center of San Salvador. The SMP Department has its office space in this building, where space is also currently provided for packaging and warehousing.

The central warehouse in the ADS building has approximately 50 m² of space, and is utilized for general storage. It is well insulated and relatively cool and open. SMP stock is stored in master cartons until delivered to the packaging unit.

Secondary storage space is available at the ADS automotive repair facility in downtown El Salvador. At the time of this assessment 40 master cartons of Panther and Akwell for Condor were stacked in a rather warm environment, 80° Fahrenheit, in columns well over 8 ft. high, in

an area of 6 m².

Another secondary storage area is located in Santa Tecla, a town about 20 minutes via vehicle from the ADS San Salvador. An old shed of some 150 m² has been pressed into service within the ADS clinic compound. ADS has not been able to make improvements necessary because title to the property had not, until 1983, been available. Plans are now being developed to construct warehouse space within the compound. Currently, the storage space is utilized for bulk products and equipment, mixed together, much of it antiquated and unserviceable. The building has an ancient tin roof, is open at the side facing the clinic compound, closed by wire, and thus inside there is general covering of dust and grit on the inventory, some of which is stacked to the roof beams. There is no insulation, and the daily temperature probably exceeds 80° F in the afternoons.

4. Analysis of Costs and Efficiency

The SMP, operating without a manager, in conditions that are economically and socially uncertain, is evidence of the high quality of work that was put into the original design, the quality of ADS personnel, and the support of concerned Technical Assistance consultants. That it continues to function at all during these times is probably proof enough of its relative efficiency as an organization. (However, whether funds are utilized in the most efficient manner, and whether or not the SMP should operate at the input or investment level maintained during 1982 and 1983 is a judgement that informed project management should make on the basis information and evaluations now available).

Obviously, the project does not operate at its most efficient level. For example, the new Panther product, currently in the design stage, does not have a product manager. There is no CPM or formal sequence of event control, and thus any step missed must be repeated, at additional cost. The new Condor 3-pack and dispenser, as another example, was received from the supplier, and has been in inventory since Sept, 1983: on Friday, 6 April 1984, the Packaging Department discovered that the dispenser was in fact too small to house the 25 three-packs. This of course, should have been resolved earlier, by a Manager working with check-list or CPM, to ensure timely delivery of appropriate product components.

As shown in the SMP cost breakdown - (Annex 3), annual operating costs have risen from £682,278 (1982) to £1,084.331 (1983). Without an operational plan and manager, however, it is not possible to determine how effectively and efficiently funds, time, and personnel were utilized to produce a problematic sales record.

VI. MARKETING & SALES ADMINISTRATION

1. Objectives and Strategies

Contraceptive sales goals for 1984, as established in the ADS 1984 implementation plan are:

Condor	500,000 units -	5,000 CYP
Perla	120,000 cycle -	9,321 CYP
Suave	48,000 units -	480 CYP
Pantera	500,000 units -	5,000 CYP
TOTAL CYP		11,411

To attain the above annual sales levels, the SMP must produce a monthly average of:

Condor	41,700
Perla	10,000
Suave	48,000
Pantera	50,000 (start-up March '84)

1984 sales figures from January and February, show a slight decline from the same period in 1983.

1983	Cash sales Jan & Feb.	£ 25,083
	Credit sales	£ 35,825
	Total Sales	£ 60,908
1984	Cash sales Jan & Feb	£ 17,210
	Credit sales	£ 41,312
	Total Sales	£ 58,522

It is also, of course, worth pointing out that credit sales in the first two months of 1984 are already 15% higher January and February of 1983, which is indicative of the ADS salesman's effort to place products at points of purchase through a rather easy credit policy of a 60 day grace period.

The Panther is already at this writing a month behind, or down 50,000 units. Unit sales of ADS products (including credit sales) during January & February of 1984 are:

	<u>1984 (Jan-Feb.)</u>	<u>1983 Jan-Feb</u>
Condor	109,200	118,200
Perla	24,555	28,320
Suave	25,350	9,000

Sales of both Condor and Perla have fallen off somewhat. Suave has, surprisingly, gained in sales.

18

The projected cost for 1984, drawn from the ADS implementation plan, can be estimated from the following budget projections.

Personnel	370,110
Promotion	244,530
Packages & Printing	76,050
Equipment & Plant	27,300
Maintenance Plant & Equip.	11,700
Gas & Oil	23,400
Uniforms	11,700
Supplies	7,800
Payment Sales Commissions to Retail Personnel	70,200
Commissions to ADS Salesmen	23,400
Miscellaneous	<u>19,500</u>

TOTAL PROJECT EXPENDITURE ₡ 885,690

Assuming that Condor, Perla, and Suave will sell in small lots (to expedite this exercise), the following revenue projections, based on 100% sales, can be developed:

1. Condor - 500,000 units.....	6,667 dispensers	
	ea. 13.15	87,671
2. Perla - 12,000 cycles.....	5,000 dispensers	
	ea. 18.00.....	90,000
3. Suave - 48,000 units	640 dispensers	
	ea. 13.15	8,416
4. Panther - 500,000 units	6,667 dispensers	
	ea. 52.60*.....	350,684

(This assumes a retail price of C 3.00 for a Panther 3-pack, and this four fold increase over the Condor is maintained in Panther dispenser to FOP)

Total Projected Revenue	536,771
Total Projected Cost	885,690
Net Projected Cost	
(11,411 CYP)	348,919
Projected cost/Per CYP C	30.50
at 3.9	US\$ 7,84

5. Vending Machine Sales:

Assuming that vending machine sales of OC's and condoms hold at 1983 sales levels, a fairly safe assumption at this point (according to information available, condom sales are higher than the first two months of 83.), the SMP will sell 82,000 condoms and 37,000 OC's, a total revenue of ₡ 27,000, which will add 3,666 CYP and lower the projected cost per CYP to ₡ 17.23, or US \$4.42.

The above cost per CYP, as currently projected, is probably the lowest possible. Pantera is still not in the market (a 50,000 units loss) and unit sales show a downward trend.

The above numbers are of secondary importance in terms of 1984 implementation. The implementation plan lacks a description of quantitative feedback mechanisms to facilitate decision making by project management. Evaluation should be constant, not relegated to a June or July '84 evaluation of performance as noted in the implementation plan.

The implementation plan also fails to outline a strategy or set of tactics through which the SMP will attain projected unit sales and, concomitantly, achieve a cost per CYP lower than 82 and 83.

2. Review of Marketing Plan

Aragon & Associates have already made an important contribution to the ADS Marketing Plan. Although marketing is not the primary focus of this evaluation, a few comments are in order.

a. The SMP currently has no manager or marketing manager, and will thus not derive full benefit from the marketing plan developed with the assistance of Aragon & Associates. Also, the development of Panther is falling behind, essentially due to lack of a product manager or project manager who would normally shepherd the product through design and test stages to product launch. The product was yet to be priced, packaged, and registered--nor has a launch target date been rescheduled.

b. Pricing Policy

There is no information available within ADS that would indicate how prices were originally established. Also, there is no information available concerning the strategy behind bonus dispensers to POP's (See Annex 4 for current price list and bonus distribution).

The redemption of each 3-pack or cycle sales sticker by ADS for ₡.15, though an excellent sales tool, seems to have been instituted without much analysis. (there is no record or information available).

Why not C .10, or C .20?

A C .10 per sales sticker commission to a pharmacy sales clerk, paid directly by the ADS Salesman during his call and reimbursed to him by ADS accounting, would be easier to calculate, and could mean a savings of 33% of the projected budget line stem of ₡ 70,200, or ₡ 23,166. Even if unit sales for 1984 were to plunge by 50%, the ₡ .10 rebate would mean a savings of ₡ 11,583, almost sufficient to cover the projected cost of maintenance of plant and equipment.

It should be noted here that ADS is utilizing a more methodological approach to develop a price for the Panther.

3. Advertising and Promotion

Aragon and Associates has made a major contribution to upgrade ADS advertising and promotion. Both advertising and promotional activities have declined during the past two years. Only ₡ 64,186 in 1982, and ₡ 47,922 in 1983, were paid out for radio spots (see Annex 5), a substantial decrease, at a time when a substantial price increase of Perla, 100%, and Condor, 150%, needed the support of an aggressive promotional campaign.

4. Sales Development and Management

Currently the ADS two man sales force is a rather effective unit, considering lack of manager, little if any promotion, hiatus of advertising, and the uncertain social setting. Aside from selling and distributing product, the salesmen are also an important source of market information that has not been utilized systematically. A manager, of course, would be able to exploit this information while developing a strategy and setting objective. In actuality, what now occurs is that on Monday morning of each work week the salesmen process documentation from the previous week, meet on an ad hoc basis with any ADS administrative personnel, pick up products at the warehouse, and leave for a week of sales work. Since they follow standard routes it would be possible to locate them if necessary. Direct supervision of actual sales work at this point, fortunately, is unnecessary, due to satisfactory commission levels, which may not be sufficient incentive, if sales continue to weaken. Prospecting and missionary work to develop new pops, seen as basically unproductive by the salesmen at this point, will need close supervision by ADS management.

VII. ORGANIZATIONAL ISSUES

1. Institutional Capability

ADS is a strong organization with an active board of directors. The current director, Dr. Gustavo Argueta, has excellent contacts at the MOH,

Pharmacist and Chemist Association, and Medical Association. He is also committed to the development of the SMP on the "basis of commercial criteria." ADS's top administrative manager, degree in administration with major work in finance, also sees the SMP developing along commercial lines. ADS, institutionally, through an efficient and cooperative staff offers the SMP administrative support; e.g., accounting, management information system, warehouse, and office space.

The major institutional constraint is continuity of management. Without continuous management the SMP cannot be expected to produce the kind of products and sales to 1) increase revenue, 2) reach more consumers, and 3) reduce costs per CYP.

2. Relation of ADS to SMP

ADS executive directors and members of the Board of Directors have obviously done effective work in establishing the SMP as an operational department within ADS, and also quite important, in securing the necessary support of both public and private sectors to facilitate its development as a marketing organization. This assessment has not identified any ADS institutional constraint formal or informal, that would limit the development of the SMP in accordance with its objectives.

3. Options regarding the future of the SMP

In discussions with ADS personnel and consultants concerning a possible restructuring of the SMP, the following four options were identified:

- 1) The SMP continue as a department of ADS.
- 2) The SMP, removed as Department of ADS, operates as a marketing organization with its own plant and personnel, receiving support from ADS through its Board of Directors.
- 3) The distribution of product turned over to a national distributor, with ADS maintaining responsibility for promotion and advertising.
- 4) Discontinue the SMP.

In assessing option 4 above, a discontinuance of the SMP and maintenance of MOH-ISSS-ADS community distributions would simply not make sense in either demographic or economic terms. The SMP does in fact take family planning products out of clinic based programs and community distribution

programs, using a variety of channels of distribution to reach much broader segments of low income groups. Through the SMP the cost per CYP can be reduced significantly in relation to institutional programs, thus making this form of distribution economically attractive.

Assuming that the "now uncertain" economic and social conditions of El Salvador do not worsen, a well structured and managed SMP could in fact perform at levels that would provide products to significant numbers of consumers at an acceptable cost per CYP. Aragon in his marketing plan indicates a potential market of 390,000 consumers (p.28). A 10% share of this market would mean 39,000 consumers, and their conversion into users would trigger an increase of 3 fold over CYP goals set for 1984.

Also, the urban and semi urban structure of the market does facilitate distribution, allowing customers relatively easy access to sales outlets. With the development of an aggressive promotional and advertising program, supervised and coordinated by competent management, the possibility of distribution at low relative cost favors maintaining the SMP.

Option 3 above, turning the distribution over to a national distributor would be rather difficult at this point.

The experience of ADS with national distributors indicates that this option must be carefully examined. Conversations with professionals familiar with distribution firms have yielded the following points:

- 1) There is not a single national distributor with access to the number of pharmacies now included in the ADS distribution system.
- 2) The ADS product would be one of an assortment of products handed by a distributor and would not receive the same kind of sales promotion as provided by the ADS sales force.
- 3) The total cost of the SMP would probably increase: the distributor would not provide the same rate of return in relation to expenditure now received by ADS.
- 4) There is a good possibility that sales volume would decrease, due to lack of interest on part of distributor, with less attention given to ADS product. Also a distributor would not provide the same credit system currently made available by ADS to pharmacies (60 days without interest), and thus the possibility of stock-outs at the POP level, triggering additional reduction in overall sales, would be increased. Unless ADS has sufficient control over the distributor, and is able to ensure that its current credit policy is maintained and that its products are managed in a way to augment sales, then this option should not be considered as viable.

Option 2 would initially have higher relative costs than the other 3 options. The SMP developed as commercial entity would need plant, equipment and personnel; and it would also have to rely on the close support of ADS to maintain tax exemptions and public and private sector contacts. Since ADS would have to assume a role as "Padrino" and consultant, there would also be much duplication of effort. Since ADS currently intends to operate an SMP on the basis of market criteria, a new "company" or distinct SMP project at this point is not an attractive option.

The first option is at this point in time the most viable of the above four. ADS already has an effective distribution system, experienced salesmen, an efficient administrative support staff, and a fully operational management information system that facilitates control, supervision, and evaluation on all levels. The key element lacking, of course, is a project manager/marketing manager, who would assume responsibility for planning, implementation, and evaluation, and would have the authority to make all operational decisions, reporting directly to the ADS Executive Director. Budget is available this key position, and thus there should be no financial constraint that would adversely affect the selection of a qualified manager.

VII. OBSERVATIONS AND RECOMMENDATIONS

1. Project Outputs

As indicated by the cost per CYP analysis, sales during 1983 fell off dramatically while costs rose, and thus the cost per CYP increased virtually two fold over the 1981 cost per CYP. Also, of course, the CYP levels developed in 1981 and 1982 dropped significantly.

Several factors that, without doubt, probably influenced the 1983 decline are listed below:

- 1) The Condor and Perla price changes (Condor 150% - Perla 100%) at the end of 1982, without support of an aggressive media, promotional, and sales campaign.
- 2) General decline in sales noted by all pharmacy personnel.
- 3) Gradual modification of pharmacies through the placement of bars and iron gates to increase security (reducing to zero possibilities for in-store merchandising of products).
- 4) Pharmacy owners spending less time in pharmacies (thus lack of aggressive management).

The above factors have been drawn out of the experience of this assessment. An ADS evaluation of the 1983 SMP performance has not been done, and thus there currently is no strategy or set of tactics, informed by analysis of the prior year, to guide project implementation to the sales goals set in the 1984 implementation plan.

New project management should ensure, 1) that any retail price change of product be part of an overall strategy, and 2) that all initial survey work provides the basic information upon which marketing decisions are made.

The pervasive climate of uncertainty notwithstanding, there is without doubt an accessible market in Salvador (see Aragon, Marketing Plan) that can be defined in both quantitative and qualitative terms. This definition should be one of the first tasks assigned to the project manager.

2. Management

As indicated throughout this assessment the primary constraint to effective and efficient SMP operation is the lack of a project manager. It is urgent that ADS embark immediately on a search for the appropriate manager. In the short term there is also much to be done, and it is recommended here that ADS appoint a product manager/coordinator for the Further product, already behind schedule. This coordinator can also serve as interim project manager until a long term manager is selected through a search process.

While the objective of marketing low priced contraceptive to low income groups is the primary concern of a social marketing venture, ADS staff has consumed much valuable time attempting to develop a strategy through which a "self-financing" SMP can be achieved. This time should be dedicated, instead, to the continuous review and implementation by a project manager of tactical measures that tend to increase sales, reduce marginal costs, and thus systematically produce lower cost per CYP ratios.

Also, both interim manager and long term manager, and the SMP, would benefit from additional technical assistance through international sources that have both management and marketing experience derived from the implementation of other Social Marketing projects.

3. Pricing

The pricing of the ADS product line and the "Bonus" system has been discussed by Aragon (Marketing Plan). This assessment has not examined the history of ADS price strategy, since the necessary information does

25

not exist. As noted earlier in this assessment ADS is, however, developing a marketing strategy for the new Panther product, and price of course will be considered an integral part. The bonus product delivered to POP's, however, must be rigorously examined by project management. Although it is obviously an excellent device to maximize sales at the retail level and thus increase over all CYP, ADS could forego on large volume sales (10 dispensers or more) a significant source of revenue. Actually, sales of 49 dispensers or over of Perla and Condor are infrequent (as salesmen report), an average of 2 per month. Yet the bonus structure exists and should the number of high volume sales increase, ADS would be committed to provide the bonus products, which would, for example, if left unchecked, add 15 bonus dispensers for each 50 sold to large volume purchasers, thus increasing the mark-up to 117% (see Aragon, Marketing Plan), and this does not include the C .15 rebate on retail price stickers. Although it would be difficult to reduce at this point the bonus product given to the small volume buyer (1 bonus dispenser for each 5 purchased), ADS should take immediate action and amend the bonus structure for large buyers, starting at 10 dispensers, and computing the bonus on the basis of a percentage system that would function inversely along a scale rather than maintain a rigid proportion. Large volume buyers should not be encouraged to discount products to smaller pharmacies through the same channels that ADS now controls.

In terms of the overall structure of ADS product distribution and pricing, this assessment has not found any significant "internal competition" between sub-projects. Community distributions of condoms are quite limited; distribution of OC's could very well overlap a certain portion of the lower income classification, but not to the detriment of the SMP. Also, upon scrutiny, the vending machine sales of limited quantities of product are not seen as having a negative influence on the SMP sales to pharmacies. This assessment visited a total of 41 pharmacies and found only the two relatively minor instances of "contraband" mentioned earlier in this report.

It is considered that the vending machine, community distribution, and SMP markets at this point are quite well "segmented", and that discussion or study of distribution procedures or relative prices should be considered low priority. ADS should focus clearly on the launching of the Panther product during the months of April/May, 1984. Pricing of Condor, Perla, and Suave should be also reviewed during 1984.

4. ADS Products

Except for random, unsubstantiated complaints regarding the Suave product concerning irritation, all product lines in terms of quality have an excellent reputation. The new package design for Condor should effectively curtail any contraband Tahiti that enters the market in the old Condor 3-packs. Closer identification of the Akwell product with the Condor 3-pack symbol would be highly advantageous, however. This assessment discovered, in qualitative terms, a type of consumer cynicism regarding the Condor and "what it really is". The clear "Akwell, made in USA" trade mark on the clear individual plastic unit leaves doubt about the condor product. A Condor logo on the plastic unit, like the Panther, would definitely improve consumer confidence in the Condor product.

5. Cost of Couple Years Protection

Cost of CYP is a dependent variable of sales quantity and cost. CYP can be utilized as a measure by project management to relate continuously the quantity and cost variables. One annual objective of the SMP should be the reduction of CYP cost along with the attainment of projected sales goals. Reducing the cost of CYP, however, although an important undertaking, is not the primary objective, nor is self-sufficiency an realistic goal in the short term. Unexamined effects to cut costs of advertising, promotion, market research can be counterproductive and actually impede market development and reduce revenue.

6. Advertising and Promotion

Although the advertising account has been changed from Rumbo to Commercial, a much more technical organization (see Aragon), project management should coordinate all advertising and promotional activities to ensure that they are integrated into the SMP's marketing strategy. At the moment of this assessment no clear statement can be found of what is to be expected of the advertising activities listed on in implementation plan.

7. Physical Distribution

ADS operates an efficient physical distribution, effectively monitored through an information system (see annex for collection of key documents). Inventory, distribution, and sales records are kept up to date. Salesmen draw products from inventory and effect the distribution; balances in their possession are recorded as "transit" until placed in POP or returned to inventory. In terms of its physical operation, the salesman delivery system has not been tested at a sustained high volume of operation, and might very well need modification as sales increase,

perhaps turning physical distribution over to a delivery team.

8. Warehouse

Although the central warehouse in the ADS building is quite satisfactory, both the Santa Tecla storage space and automotive shop storage space need immediate attention. Contraceptive products should be clearly separated by type and date of entry and stored in a climate that enhances shelf life. In particular, the Santa Tecla warehouse should be inventoried and materials and equipment deemed unserviceable should be retired from inventory.

BIBLIOGRAPHY

- 1) Informe sobre comercializacion de anticonceptivos de la ADS. Recomendaciones. Lic. Danilo Salcedo, Lic. David Araya, Sr. Roberto Caceros. Abril 1982.
- 2.) Plan de Implementacion programas a ser financiados con fondos de la AID. Asociacion Demografica Salvadorena.
- 3) Report of the Distributional Study (in P.O.P) of the International Contraceptive Social Marketing Research Project, conducted in El Salvador. Aragon & Associates. November 1982.
- 4) Plan de Mercadeo de International Contraceptive Social Marketing Project para Asociacion Demografica Salvadorena. Aragon and Associates.
- 5) Final Report Evaluation of the Management and the Effectiveness of the Family Planning and Population. Scott Edmond (Team Leader), Eugenia Monterroso, Diane Urban, Darwin Bell. March 1984.
- 6) International Contraceptive Social Marketing Project Advertising Agency Assessment. Aragon & Associates. January 1983.
- 7) Report of the Basic Marketing Study of the International Contraceptive Marketing Project. Conducted in El Salvador. Aragon & Associates. El Salvador-Guatemala, December 1982-February 1983.
- 8) Estatutos. Asociacion Demografica Salvadorena. Marzo 1982.

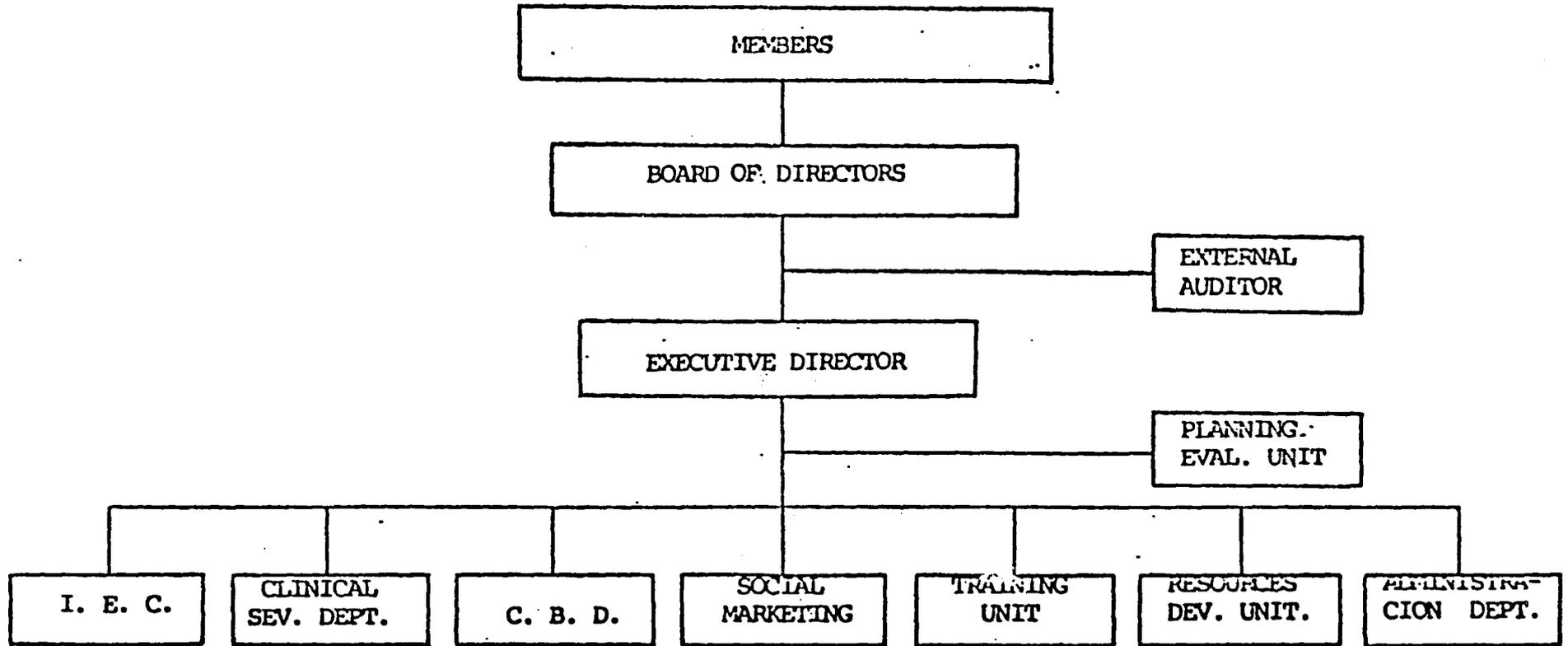
- 9) Plan de Estrategias para 1981. Programa Mercadeo Social. Lic. Jorge Castaneda. Noviembre 1980.
- 10) Estudio de Mercado. Evaluacion de Campana Publicitaria Pro-Familia. Consultores en Mercadeo de Centroamerica. Octubre 1980.
- 11) Report of the Qualitative Part of the International Contraceptive Social Marketing Research Project, Conduced in El Salvador. Aragon & Associates. November-December 1982.

PERSONS CONTACTED DURING EVALUATION

- 1) Dr. Rafael Amuz Rodriguez
Presidente Colegio de Quimicos y Farmaceuticos
- 2) Alberto Aragon - Aragon Assoc.
- 3) Dr. Gustavo Argueta - President ADS
- 4) Lic. Carlos Maravilla - ADS Administrative Director
- 5) Sr. Carlos Portillo -salesman ADS
- 6) Sr. Roberto Henriquez - Salesman ADS
- 7) Martin Caballero - Div. ADS Communications
- 8) Carlos Argueta - Warehouseman ADS
- 9) Roberto Cacero - Account Dept. ADS
- 10) Oscar Antonio Funes - SMP Committee of the Board of Director.
- 11) Orlando Melendez - SMP Committee of the Board of Director.

ASOCIACION DEMOGRAFICA SALVADOREÑA

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CUADRO COMPARATIVO DE VENTAS 1981

CONDOR

Mes	<u>Vendedores A. D. S.</u>			<u>Vendedores Ancalmo</u>		
	<u>Cant. Vendida</u>	<u>Bonif.</u>	<u>Valor</u>	<u>Cant. Vendida</u>	<u>Bonif.</u>	<u>Valor</u>
Enero	55.125		£ 3.449.20	29.325		£ 1.368.50
Febrero	105.975		6.504.30	22.125		1.032.50
Marzo	67.650		4.341.30	21.600		798.00
Abril	34.650		2.339.99	12.000		560.00
Mayo	31.950		2.197.28	7.725		360.50
Junio	53.325		3.719.48	-.-		-.-
Julio	86.325		5.576.00	37.500		2.240.00
Agosto	44.850		3.108.90	-.-		-.-
Sept.	43.200		2.973.60	-.-		-.-
Octubre	22.350		1.560.80	-.-		-.-
Nov.	60.675		3.978.40	-.-		-.-
Dic.	<u>37.575</u>		<u>2.556.00</u>	<u>-.-</u>		<u>-.-</u>
TOTAL	643.650 ✓		£ 42.305.25 ✓	130.275 ✓		£ 6.359.50

PERLA

Mes	<u>Vendedores</u>			<u>Vendedores</u>		
	<u>Cant. Vendida</u>	<u>Bonif.</u>	<u>Valor</u>	<u>Cant. Vendida</u>	<u>Bonif.</u>	<u>Valor</u>
Enero	8.280		£ 5.376.00	-.-		-.-
Febrero	7.752		5.212.20	-.-		-.-
Marzo	7.512		4.970.95	-.-		-.-
Abril	5.232		3.553.90	2.160		£ 1.035.00
Mayo	3.280		3.691.15	2.616		1.253.50
Junio	4.729		3.310.55	-.-		-.-
Julio	6.312		4.935.35	-.-		-.-
Agosto	8.928		6.181.75	-.-		-.-
Sept.	4.872		3.554.00	-.-		-.-
Octubre	8.976		5.064.00	-.-		-.-
Nov.	7.368		5.426.00	-.-		-.-
Dic.	<u>5.880</u>		<u>4.210.00</u>	<u>-.-</u>		<u>-.-</u>
TOTAL	79.121 ✓		£ 55.485.85 ✓	4.776 ✓		£ 2.288.5

SUAVE

<u>Mes</u>	<u>Vendedores A. D. S.</u>			<u>Vendedores Ancalmo</u>		
	<u>Cant. Vendi da</u>	<u>Bonif.</u>	<u>Valor</u>	<u>Cant. Vendi da</u>	<u>Bonif.</u>	<u>Valor</u>
Enero	20.775		£ 2.811.20	-.-	-.-	-.-
Febrero	10.500		1.411.60	-.-	-.-	-.-
Marzo	3.375		388.70	-.-	-.-	-.-
Abril	1.425		220.70	-.-	-.-	-.-
Mayo	1.050		153.50	-.-	-.-	-.-
Junio	441		65.55	-.-	-.-	-.-
Julio	450		53.25	-.-	-.-	-.-
Agosto	1.275		188.75	-.-	-.-	-.-
Sept.	675		134.40	-.-	-.-	-.-
Octubre	750		112.00	-.-	-.-	-.-
Nov.	2.250		302.40	-.-	-.-	-.-
Dic.	75		11.20	-.-	-.-	-.-
	<u>43.041</u> ✓		<u>£ 5.853.25</u> ✓			

CUADRO COMPARATIVO DE VENTAS 1982

CONDOR

<u>Mes</u>	<u>Cantidad Vendida</u>	<u>Bonificaciones</u>	<u>Valor</u>
Enero	59.850	13.275	£ 4.252.80
Febrero	90.300	20.790	5.782.40
Marzo	50.025	11.125	3.483.20
Abril	25.200	5.400	1.773.60
Mayo	40.500	10.650	2.844.00
Junio	36.375	9.375	2.536.00
Julio	95.925	32.250	6.519.20
Agosto	34.125	-.-	1.980.80
Septiembre	79.725	-.-	4.207.20
Octubre	160.500	-.-	8.149.60
Noviembre	69.575	-.-	8.335.95
Diciembre	66.225	18.375	6.007.90
TOTALES	808.325	121.240	£ 55.872.65

PERLA

<u>Mes</u>	<u>Cantidad Vendida</u>	<u>Bonificaciones</u>	<u>Valor</u>
Enero	7.224	2.064	£ 5.318.00
Febrero	7.758	2.280	5.608.00
Marzo	6.090	1.194	4.410.00
Abril	4.248	672	3.186.00
Mayo	7.056	918	5.192.00
Junio	10.536	3.192	7.302.00
Julio	8.016	1.488	5.912.00
Agosto	7.248		4.454.00
Septiembre	15.480		8.910.00
Octubre	26.250		14.172.00
Noviembre	9.768		5.229.00
Diciembre	6.072	1.392	5.422.40
TATALES	115.746	13.200	£ 75.115.40

93)

SUAVE

<u>Mes</u>	<u>Cantidad Vendida</u>	<u>Bonificaciones</u>	<u>Valor</u>
Enero	900	75	134.40
Febrero	1.350	75	190.40
Marzo	1.500	75	224.00
Abril	1.725	75	246.40
Mayo	1.800	75	268.80
Junio	1.800	150	268.80
Julio	3.000	300	112.00
Agosto	1.875		257.60
Septiembre	3.600		504.00
Octubre	3.675		492.80
Noviembre	1.875		260.05
Diciembre	<u>1.725</u>	<u>225</u>	<u>300.50</u>
TOTALES	24.825	1.050	£3.259.75

34

CUADRO COMPARATIVO DE VENTAS 1983

CONDOR

<u>Mes</u>	<u>Cantidad Vendida</u>	<u>Bonificaciones</u>	<u>Valor</u>
Enero	88.950	23.775	£ 12.175.90
Febrero	29.250	5.100	5.005.25
Marzo	19.275	3.375	3.379.55
Abril	24.825	4.725	4.295.15
Mayo	21.450	3.750	3.760.90
Junio	25.500	5.550	4.225.50
Julio	36.000	7.425	5.969.50
Agosto	18.000	3.150	3.090.25
Septiembre	35.475	7.425	5.910.75
Octubre	23.250	4.275	4.004.70
Noviembre	53.475	11.775	8.816.20
Diciembre	11.250	2.100	1.972.50
	<u>386.700</u>	<u>82.425</u>	<u>£ 62.606.15</u>

SUAVE PERLA

<u>Mes</u>	<u>Cantidad Vendida</u>	<u>Bonificaciones</u>	<u>Valor</u>
Enero	20.400	4.104	£ 27.819.60
Febrero	7.920	1.464	10.680.00
Marzo	7.008	1.272	9.631.20
Abril	5.592	912	2.768.80
Mayo	4.680	744	6.432.00
Junio	3.096	432	4.334.40
Julio	4.704	672	6.585.60
Agosto	3.768	552	5.275.20
Septiembre	6.936	1.248	9.588.00
Octubre	4.896	768	6.732.00
Noviembre	6.840	1.248	9.331.20
Diciembre	2.808	504	4.627.67
TOTALES	<u>78.648</u>	<u>13.920</u>	<u>£108.805.67</u>

35

SUAVE

<u>Mes</u>	<u>Cantidad Vendida</u>	<u>Bonificaciones</u>	<u>Valor</u>
Enero	5.325	225	£ 933.65
Febrero	3.675	300	644.35
Marzo	1.350		236.70
Abril	3.075	225	539.15
Mayo	3.150	375	552.30
Junio	2.250	150	394.50
Julio	2.700	225	473.40
Agosto	3.825	375	670.65
Septiembre	3.150	150	552.30
Octubre	4.800	150	841.60
Noviembre	7.350	450	1.288.70
Diciembre	<u>1.350</u>	<u>75</u>	<u>236.70</u>
TOTALES	42.000	2.700	£ 7.364.00

jo

INFORME DE VENTAS MES DE FEBRERO

Y

RESUMEN DE DISTRIBUCION DE ANTICONCEPTIVOS

POR MEDIO DE MAQUINAS

1983

<u>Producto</u>	<u>Cuota Mensual</u>		<u>Cuota Anual</u>	
<u>Mercado Social</u>				
Condor		41.700		500.000
Perla		10.000		120.000
Suave		4.000		48.000
Pantera		41.700		500.000
<u>Máquinas</u>				
Condomes		7.200		86.400
Píldoras		3.125		37.500
<u>Producto</u>	<u>Actividad Mensual</u>		<u>Actividad Anual</u>	
	<u>Unidades</u>	<u>Valor</u>	<u>Unidades</u>	<u>Valor</u>
Condor	44.025	6.411.15	109.200	15.331.50
% Cumplimiento	105.6%		21.8%	
Perla	10.227	11.618.40	24.555	27.840,00
% Cumplimiento	102.3%		20.5%	
Suave	7.425	1.183.50	25.350	3.899.50
% Cumplimiento	185.6%		52.8%	
Pantera				
% Cumplimiento		NO ESTA EN	EL MERCADO	
Condomes	11.683	2.490.65	20.624	4.371.35
% Cumplimiento	162.3%		23.9%	
Píldoras	3.835	731.60	6.612	1.234.70
% Cumplimiento	122.7%		17.6%	
		22.432.30		52.677.05

CUADRO COMPARATIVO DE VENTAS

AÑO: 1982, 1983, 1984

Año	Mes	Máquina	Contado	Crédito	D.C.A.
1982	Marzo	£ 1.588.40	£ 8.006.80	£ 3.854.20	£ 853.60
	Abril	1.194.15	7.128.40		289.35
	Mayo	1.502.65	8.304.80		713.70
	Junio	1.502.45	10.106.80		-.-
	Julio	1.018.05	12.879.20		576.95
	Agosto	1.283.95	6.692.40		-.-
	Septiembre	1.760.50	11.356.00		0.10
	Octubre	1.433.45	8.627.00		2.216.05
	Noviembre	1.300.55	50.583.30		2.252.40
	Diciembre	1.089.15	11.792.30		202.10
			<u>£ 13.673.30</u>	<u>£ 135.477.00</u>	<u>£ 3.854.20</u>
1983	Enero	£ 2.161.15	£ 15.123.50	£ 12.753.35	£ 1.572.55
	Febrero	1.699.95	3.545.80	12.361.55	1.354.90
	Marzo	1.034.05	3.211.15	10.710.00	116.05
	Abril	1.981.95	5.444.70	3.776.60	-.-
	Mayo	2.198.20	5.532.80	11.039.70	3.408.90
	Junio	1.484.30	705.65	4.973.20	246.00
	Julio	2.617.55	2.296.65	9.154.77	1.039.00
	Agosto	1.984.60	1.583.75	8.460.00	3.504.45
	Septiembre	1.689.25	3.620.25	4.556.75	-.-
	Octubre	2.440.90	2.942.35	10.463.00	-.-
	Noviembre	2.307.40	5.829.40	10.613.55	3.602.95
	Diciembre	1.610.00	1.814.55	8.176.60	-.-
		<u>£ 23.209.30</u>	<u>£ 51.650.55</u>	<u>£ 107.039.07</u>	<u>£ 14.844.80</u>
1984	Enero	£ 2.383.80	£ 4.900.15	£ 8.925.20	-.-
	Febrero	3.222.25	3.379.25	17.195.55	-.-
	Marzo	1.807.85	3.325.25	15.312.35	-.-

296

Anexo 2

CUADRO COMPARATIVO DE DISTRIBUCION DE ANTICONCEPTIVOS
E INGRESOS POR MEDIO DE MAQUINAS 1982, 1983 y 1984

1982

<u>Mes</u>	<u>Condomes</u>		<u>Pildoras</u>	
	<u>Cantidad</u>	<u>Valor</u>	<u>Cantidad</u>	<u>Valor</u>
Marzo	6.113	£ 1.318.00	3.275	£ 490.25
Abril	3.472	726.90	1.633	247.40
Mayo	5.683	1.200.15	2.456	302.50
Junio	4.963	1.016.00	3.146	486.45
Julio	3.887	786.30	1.788	231.75
Agosto	4.214	874.50	2.912	409.45
Septiembre	7.348	1.558.00	4.388	494.60
Octubre	4.167	829.30	3.054	312.05
Noviembre	4.619	945.55	2.721	355.00
Diciembre	3.271	667.55	1.896	254.70
Totales	47.737	£ 9.922.25	27,269	£ 3.584.15

1983

<u>Mes</u>	<u>Condomes</u>		<u>Pildoras</u>	
	<u>Cantidad</u>	<u>Valor</u>	<u>Cantidad</u>	<u>Valor</u>
Enero	7.802	£ 1.711.60	3.587	£ 449.55
Febrero	6.176	1.341.70	2.667	368.25
Marzo	3.560	755.15	1.977	278.30
Abril	6.888	1.444.75	3.964	591.45
Mayo	7.307	1.567.05	3.569	576.90
Junio	5.467	1.123.60	2.370	360.70
Julio	9.951	2.053.55	3.565	522.20
Agosto	7.142	1.449.60	3.305	535.00
Septiembre	5.549	1.172.80	2.612	516.45
Octubre	8.991	1.854.80	3.667	691.50
Noviembre	8.164	1.706.80	2.995	600.60
Diciembre	5.682	1.089.90	2.346	446.50
Totales	82,679	£ 17.271.30	36.624	£ 5.937.40

1984

<u>Mes</u>	<u>Condomes</u>		<u>Pildoras</u>	
	<u>Cantidad</u>	<u>Valor</u>	<u>Cantidad</u>	<u>Valor</u>
Enero	8.941	£ 1.880.70	2.777	£ 503.10
Febrero	11.683	2.490.65	3.835	731.60
Totales	20.624	£ 4.371.35	6.612	£ 1.234.70

an 43
A-3

PHARMACIES VISITED, week of APRIL 2, 1954

SAN SALVADOR

- | | |
|--------------------|-------------------|
| 1. Fontana | 16. Universitaria |
| 2. Osma | 17. Garcia Maria |
| 3. Rex | 18. Seoane |
| 4. San Ernesto | 19. Limena |
| 5. Las Gardenias | 20. Principal |
| 6. Monte Verde | 21. Santa Elisa |
| 7. Don Emilio | 22. Lisboa |
| 8. El Progreso | 23. San Patricio |
| 9. San Antonio | 24. Leymar |
| 10. Maria | 25. Munoz |
| 11. Brasilia | |
| 12. Zacamil | |
| 13. El Sol | |
| 14. Libertad | |
| 15. Centro America | |

PROVINCIAL PHARMACIES VISITED week of APRIL 2, 1954

CONUTEPEQUE

1. La Salud
2. Novoa

3. Santa Marta
4. Sagrado Corazon
5. San Jose
6. San Antonio
7. San Rafael
8. Nueva
9. El Carmen
10. Moderna
11. San Judas

SAN MARTIN

1. Josue
2. San Martin
3. La Botica
4. Americana
5. Nueva

SOCIAL MARKETING PROJECT COSTSFOR CALENDAR YEARS 81, 82, 83

	<u>1981</u>	<u>1982</u>	<u>1983</u>
January	5,133.21	8,707.85	11,763.22
February	13,173.47	24,526.58	27,584.84
March	23,627.67	58,941.46	41,519.90
April	35,957.77	76,883.05	61,794.91
May	43,892.60	96,322.78	70,776.95
June	55,378.84	116,432.24	100,944.79
July	65,324.87	145,243.08	116,491.20
August	75,268.80	161,392.69	132,834.90
September	90,898.57	182,894.43	187,659.01
October	102,025.92	197,176.25	208,047.97
November	112,261.20	214,688.91	221,562.81
December	131,472.20	399,068.94	235,888.20
	754,415.12	1,682,278.30	1,416,868.70
			- 341,133.62 [*]
			1,075,735.18
			+ <u>8,596.60</u> ^{**}
			1,084,331.78

* PURCHASES OF DISPENSERS

and 3 orders for 1984 utilization.

** PURCHASES OF PREMIUMS - Tablets, Pencils,
Pens, etc. for utilization 1982.

42

PRICE LIST

1 - CONDOR (3-Pack)

Quantity	Bonus	Price to Distributor	Retail Price
From 1 to 49 disp.	+ 1 bonus for each 5 disp.	¢ 13.15	¢0.75 3-pack
From 50 to 100 disp.	+12 disp. for each 50 disp.	¢ 12.00	¢0.75 3-pack
From 100 to 300 disp.	+15 disp. for each 50 disp.	¢ 11.25	¢0.75 3-pack

2 - PERLA

Quantity	Bonus	Price to Distributor	Retail Price
From 1 to 49 disp.	+ 1 disp. for each 5 disp.	¢ 33.60	¢2.00 cycle
From 50 disp. on	+ 12 disp. for each 50 disp.	¢ 31.20	¢2.00 cycle

3 - SUAVE

Quantity	Bonus	Price to Distributor	Retail Price
From 1 to 47 disp.	+ 1 bonus for each 5 disp.	¢ 13.15	¢0.75 3-pack
From 50 to 100 disp.	+ 12 disp. for each 50 disp.	¢ 12.00	¢0.75 3-pack

NOTE: The price tag of each retail unit sold by a pharmacy employee is

~~reduced~~ by UGS for ¢0.15 each.

(4)

PRESUPUESTO DE RADIO DEL PROGRAMA DE
 COMERCIALIZACION.-

<u>MES</u>	<u>1982</u>	<u>1983</u>
ENERO	₡ 7.459.65	₡ 12.604.80
FEBRERO	8.290.80	11.635.20
MARZO	7.698.60	13.089.60
ABRIL	7.698.60	9.752.40
MAYO	7.698.60	9.752.40
JUNIO	7.698.60	9.752.40
JULIO	5.000.--	9.752.40
AGOSTO	4.400.--	9.752.40
SEPTIEMBRE	2.400.--	9.752.40
OCTUBRE	2.250.--	9.752.40
NOVIEMBRE	1.850.--	
DICIEMBRE	1.742.--	

TOTAL: ₡ 64.186.85

₡ 95.844.--*

* 50% para el Programa de Comercialización

₡ 47.922.--

NOTA: Apartir del 1º de Octubre de 1983 a la fecha la Campaña de
 Comunicaciones Musivas ha sido suspendida.

MCR/Midem.

JINGLE CONDOR

PARA CONDOR LO IMPORTANTE

PARA CONDOR LO IMPORTANTE ES TU PROPIO MUNDO
TU FAMILIA, POR ESO FUE CREADO PARA BRINDARTE
SEGURIDAD, LA SEGURIDAD DE PODER DECIDIR CUANDO
TRAER UN NUEVO HIJO DE LOS DOS.

PRESERVATIVO CONDOR, USALO, RECOMIENDALO, SON
A TRES POR TREINTA CENTAVOS.

CONDOR SIEMPRE CONTIGO HACIENDO TU MUNDO A LA MEDIDA

PRESERVATIVOS CONDOR, SIEMPRE CONTIGO.

SUAVE - PIENSA QUE TU SIENDO UNA MUJER DEBES BUSCAR...

PIENSA QUE TU SIENDO UNA MUJER DEBES
BUSCAR REALIZAR IDEALES PROYECTANDO TUS
TRIUNFOS PARA UN FUTURO MEJOR.

PARA TI MUJER ES SUAVE LA NUEVA TABLETA
ANTICONCEPTIVA INTIMA QUE TE BRINDA
TRANQUILIDAD Y SEGURIDAD EN ESA OCASION
ESPECIAL .

PIENSA QUE TU SIENDO UNA MUJER DEBES TRIUNFAR
CON SUAVE...

TU GRATA TRANQUILIDAD.
DE VENTA EN TIENDAS Y FARMACIAS.

INVENTORY OF CONTRACEPTIVES, 31 MARCH 1984

Noriday 1 + 50 (oral) Perla

Date	8/82
Lot No.	92730
Date of receipt	20/1/83
Quantity received	150,000 cycles
On hand	142,571 cycles

Preservative Made in USA. Condor

Shipment # 1	Date	2/83
	Lot No.	6324045
	Date of receipt	6/4/84
	Quantity received	335,700
	On hand	137,700

Shipment # 2	Date prod.	9/83
	Lot No.	6093080
	Date of receipt	2/12/83
	Quantity received	497,900
	On hand	497,900

Shipment # 3

In this shipment the boxes present three different lots as follows:

Date prod. 9/83 Lot No. 6093081

Date prod. 12/83 Lot No. 6123113

Date prod. 12/83 Lot No. 6123114

Date of receipt 16/3/84

Quantity received 100,200 units

On hand 100,200 units

Preservativo para maquina Sweether Super Skin

Date of receipt 5/10/82

Quantity received 1.300 dozen

On hand 450 dozen

Ovulos New Sampoo

Date prod. 12/78

Lot No. 0009

Lot No. 0011

Date of receipt 16/8/79

Quantity received 4.000 dozen

On hand 2.014 dozen

INVENTORY OF PACKING MATERIAL FOR CONTRACEPTIVES

Perla

	<u>Quantity</u>
Envelope one cycle	26.000
Dispenser Perla (24 envelopes)	3.600
Instructions	417.600
Pack for 3 cycles Perla	31.900

Condor

Condor 3-pack	160,000
Dispenser Condor (25 envelopes)	19,500

Suave

Suave 3-pack	69,600
Dispensers Suave (for 3 packs)	2.250

PROMOTIONAL MATERIAL

Posters Perla	8.100 units
Postesr Condor	24,000 units

BIBLIOGRAPHY

- 1) Informe sobre comercialización de anticonceptivos de la ADS. Recomendaciones. Lic. Danilo Salcedo, Lic. David Araya, Sr. Roberto Caceros. Abril 1982.
- 2) Plan de Implementación Programas a ser Financiados con fondos de la AID. Asociación Demográfica Salvadoreña.
- 3) Report of the Distributional Study (in P.O.P.) of the International Contraceptive Social Marketing Research Project, conducted in El Salvador. Aragon & Associates. November 1982.
- 4) Plan de Mercadeo de International Contraceptive Social Marketing Project para Asociación Demográfica Salvadoreña. Aragon and Associates.
- 5) Final Report Evaluation of the Management and the Effectiveness of the family Planning and Population. Scott Edmonds (Team Leader), Eugenia Monterroso, Diane Urban, Darwin Bell. March 1984.
- 6) International Contraceptive Social Marketing Project. Advertising Agency Assessment. Aragon & Associates. January 1983.
- 7) Report of the Basic Marketing Study of the International Contraceptive Marketing Project. Conducted in El Salvador. Aragon & Associates. El Salvador-Guatemala, December 1982-February 1983.
- 8) Estatutos. Asociación Demográfica Salvadoreña. Marzo 1983.
- 9) Plan de Estrategias para 1981. Programa Mercadeo Social. Lic. Jorge Castaneda. Noviembre 1980.
- 10) Estudio de Mercado. Evaluación de Campaña Publicitaria Pro-Familia. Consultores en Mercadeo de Centroamérica. Octubre 1980.
- 11) Report of the Qualitative Part of the International Contraceptive Social Marketing Research Project, Conducted in El Salvador. Aragon & Associates. November-December 1982.

XD-ANP-589-A

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Report to the
Association for Voluntary Sterilization

000281

EVALUATION OF THE VOLUNTARY STERILIZATION PROGRAMS IN THE
REPUBLIC OF EL SALVADOR
(February 17 to March 3, 1984)

Submitted by:

Gonzalo Echeverry, M.D.
Bogotá, Colombia
AVS Consultant

February, 1984

6410-615
w.p.s.

51

ELS EVALUATION REPORT

INDEX

	<u>Page</u>
ABBREVIATIONS.	i
ACKNOWLEDGEMENT.	ii
PROGRAM OBJECTIVE.	1
Specific Objectives	1
NATIONAL OVERVIEW.	3
El Salvador, Crude Birth Rates (table).	6
VOLUNTARY SURGICAL STERILIZATION PROGRAMS.	7
MINISTRY OF PUBLIC HEALTH (MOH)	7
SALVADOREAN DEMOGRAPHIC ASSOCIATION (SDA)	9
Urban Users.	10
Rural Users	10
SALVADOREAN SOCIAL SECURITY INSTITUTE (SSSI).	12
OTHER VSC PROGRAMS.	13
TRAINING OF PERSONNEL	13
SUPPLIES - MAINTENANCE	14
STATISTICAL DATA.	14
CONCLUSIONS AND RECOMMENDATIONS.	15
SERVICE AVAILABILITY AND ACCESSIBILITY	16
POST-PARTUM PROJECT	17
SUPPLY OF AND DEMAND FOR VSC SERVICES	18
INTEGRATION OF VSC WITHIN HEALTH SERVICES AND TEMPORARY CONTRA- CEPTIVE METHODS.	18
INFORMATION AND EDUCATION.	19
MEDICAL ASPECTS.	19
STATISTICS, RECORDS, COMPLICATIONS	21
IMPACT OF CIVIL CONFLICT ON VSC PROGRAMS	22
VSC IMPACT ON SOCIAL, DEMOGRAPHIC AND HEALTH ASPECTS	23
FINAL COMMENTS.	23
SCHEDULE - WORK PROGRAM	26
CONTACTS.	28
LIST OF DOCUMENTS.....	30

52

ABBREVIATIONS

ANTEL	National Administration of Telecommunications
AVS	Association for Voluntary Sterilization
CBD	Community Based Distribution of Contraceptives
ELS	El Salvador
FP	Family Planning
HR	Human Resources
IEC	Information, Education, Communication
IPPF	International Planned Parenthood Federation
IUD	Intra Uterine Device
MCH	Maternal and Child Health
MOH	Ministry of Health
OB/GYN	Obstetrics and Gynaecology
OR	Operating Room
SDA	Salvadorean Demographic Association
SSSI	Salvadorean Social Security Institute
USAID	Agency for International Development, U.S.
VSC	Voluntary Surgical Contraception

53

ACKNOWLEDGEMENT

The constant and efficient assistance received from the US/AID Mission in San Salvador, through John Massey and Guillermo Toledo, and from the Asociación Demográfica Salvadoreña, through Gustavo Argueta, his Department Directors and secretarial personnel, in respect of coordination of interviews, transportation and other logistic requirements, made this task not only possible but pleasing. To all of them my sincere gratitude.

PROGRAM OBJECTIVE

Evaluate the quality and output of VSC programs carried out in El Salvador under the auspices of AVS, as a prerequisite to a new bilateral agreement between local US/AID and the Salvadorean Ministry of Public Health. In view of the fact that the AVS-assisted VSC programs carried out by the Salvadorean Demographic Association (SDA) and the Ministry of Health are part of the National Family Planning Program, the US/AID Mission has requested AVS to make a comprehensive evaluation of them, in order to complement the findings of a bilateral family planning program evaluation team. Special attention should be given to the overall conduct of the program under the currently prevailing conditions of civil strife.

Specific Objectives

1. Review and assess the policies, organization, implementation and effects of the program in respect of:
 - a. service availability and accessibility, organization and distribution;
 - b. integration of VSC services within health and family planning programs;
 - c. organization and scope of the IEC and counselling activities with special emphasis on patient recruitment, including information and counselling procedures, as well as informed consent.

2. Evaluate the medical quality of services including aspects such as:
 - a. distribution of service sites;
 - b. up-grading of physical installations;
 - c. improvement of operating rooms and surgical equipment;
 - d. Provision and maintenance of equipment;
 - e. surgical procedures: techniques, anaesthesia, pre-, intra- and post-surgical monitoring; duration of patients at clinic.

55

- f. emergency provisions;
 - g. quality of client treatment;
 - h. complication and death statistics
3. Inter-relations between programs.
 4. Impact of the prevailing civil conflict on the implementation and output of the VSC program.
 5. Impact of the VSC program in social, demographic and health terms.
 6. Unmet needs and recommendations to improve future programs and/or their expansion in the areas of medical quality, programmatic organization, output, attention to clients and user satisfaction.

NATIONAL OVERVIEW

El Salvador is located in the middle of Central America and borders on Guatemala, Honduras and the Pacific Ocean. The country occupies an area of 21.000 square kilometres (8.220² miles) and has 4.600.000 inhabitants. This gives a population density of 224 per square kilometer, the highest in the Western Hemisphere. The above mentioned population estimate is the one most commonly accepted; the last population census was carried out in 1971 and there are no official indices on mortality caused by the armed conflict of the past years, nor information on the national migration to foreign countries.

The demographic indices utilized by the Government for 1983 are as follows:

Population	4.600.000
Population density	224 inhabitants/ Km ²
Crude birth rate	37.9
Crude death rate	9
Growth rate	2.9%
Total fertility rate	5.4
Urban population	41.1%

Since the initiation of family planning activities in Latin America in 1965, the Republic of El Salvador has occupied an important position in respect of population policies and family planning activities started on a private basis through IPPF-affiliated organizations. However, the Government soon adopted this movement and promoted population policies and established family planning programs in the Mother and Child Health Department of the Ministry of Health.

Consequently, a National Population Council was established in which seven government ministries participated, and a technical population committee was created in which Government, SDA, SSSI and other semi-official entities were involved. Finally, the new Political Constitution of the Republic of El Salvador, in force since 1983, in its article No. 118 reads: "The Government will adopt a population policy aimed at improving the family welfare of the Salvadorean population". However, what actually reflects the Salvadorean Government's attitude towards family planning activities is the extension and volume of its programs carried out by the Ministry of Health, as will be seen below, and the assistance given to programs carried out by semi-official institutions, such as the ISSS, or private, as the SDA. The Government and the whole country are aware of the benefits of family planning. This attitude is maintained in spite of the armed conflict and the influence of the Church in a country as Catholic as El Salvador.

51

The family planning programs in El Salvador are carried out by the MOH, the SDA, the SSSI, the Telecommunications Administration (ANTEL) and the Military Hospital. These five institutions provide information on and services for contraceptive methods, including VSC.

The MOH family planning program is an integral part of the health services and is provided through the Ministry's network. It covers all Central and Regional Hospitals, as well as the health centres and health units. The Maternal and Child Care Division has a general family planning coordination unit, which is responsible for the provision of services. Only Regional Hospitals have specialized family planning personnel.

IEC activities are carried out in Central Hospitals by family planning educators and by Rural Health Auxiliaries in peripheral and rural areas. All temporary contraceptive methods are available. VSC services are provided at ten hospitals and 12 health centres.

The Salvadorean Demographic Association (SDA) provides all contraceptive methods at its four clinics located in San Salvador, Santa Tecla, Santa Rosa and San Miguel. IEC activities are carried out by family planning educators in the cities, and by rural working teams dependant on the CBD program in peripheral and rural areas. The CBD Program has approximately 2,000 community distribution posts, covering all the municipalities and cantons of the country.

The SSSI also offers all contraceptive methods at its Central Hospital in El Salvador and at three regional hospitals located in Santa Rosa, Sonsonate and San Miguel. IEC activities include the distribution of brochures and posters among all the Institute's health care centres.

The Telecommunication Administration (ANTEL) owns a hospital in San Salvador where temporary and permanent contraceptive methods are provided to its affiliates. The same is the case with the Central Military Hospital in San Salvador.

The 1978 National Fertility Survey findings published by the SDA in 1980 (see attachment) indicates that 34.4% of women in fertile age utilize contraceptives, with the following prevalence by method:

Sterilization	52%	Natural	5%
Oral	25%	Condom	4%
IUD	10%	Others	4%

The same survey shows that contraceptive methods are obtained from the following sources:

Ministry of Health	61.7%
Social Security Institute	11.8%
Demographic Association	7.7%
Drugstores	7.2%
Private physicians	5.1%
Rythm or coitus interruptus	5.7%
Other	.8%

The above tables show the relative importance of the different programs in respect of distribution of users by methods and the higher prevalence of sterilization over each temporary method and over the total of these in 1978.

The acceptance of methods by the new users registered in 1983, is different in the MOH and in the SDA:

MOH:	Orals	44%
	IUD	20%
	VSC	36%

SDA:	temporary methods	36%
	VSC	64%

The difference might be due to the IEC work carried out by the rural teams of the CBD Dept. of the SDA, and to the transportation facilities offered.

At the time of writing, preliminary and credit studies are being implemented for a contraceptive prevalence survey, which should take place in 1984, the difficult political situation permitting.

As can be seen, in the Republic of El Salvador there is a national awareness of family planning, both at the institutional and popular levels. There is a preference for permanent methods and the network necessary to provide services throughout the country exists. With regard to the impact of the civil conflict on the family planning programs, the general opinion is that the increased insecurity has seriously affected transportation and communication necessary for the education activities and for the provision of services, and that the poverty generated by the conflict in displaced or disjointed families has brought a stronger motivation towards family planning.

Finally, I would like to make a comment which is not part of the objectives of this study: In spite of the awareness created at

a national level towards family planning and the large number of institutions able to provide services, "the official birth rate has remained between 40 to 43/1000 since 1968 and there has not been a consistent decrease during the past years", as can be seen in table 33 of the National Fertility Survey (1978), transcribed below. The 1983 MOH figure has been added:

EL SALVADOR. CRUDE BIRTH RATES

1972	41.8
1973	41.3
1974	40.8
1975	39.9
1976	40.2
1977	41.4 (preliminary)
1983	37.9 (MOH)

Although people are aware of this contradictory situation, I was not able to obtain a satisfactory explanation of this demographic paradox.

VOLUNTARY SURGICAL STERILIZATION PROGRAMS

MINISTRY OF PUBLIC HEALTH (MOH)

Site visits:

Maternity Hospital, San Salvador
Gynaecological Clinic, San Salvador
San Rafael Hospital, Santa Tecla
Health Centre, San Bartolo
Health Centre, San Francisco de Gotera

In 1962 the family planning programs in El Salvador were initiated by the Salvadorean Demographic Association, with the participation of approximately 60 clinics of the Ministry of Health. In 1968, the Government took responsibility for these programs and increased their numbers progressively. At present, temporary contraceptive methods are offered in 250 family planning clinics located at Health Units, Health Centres and Hospitals. 22 of these offer surgical contraception (10 hospitals and 12 Health Centres). It is worth mentioning that the Health Centres in El Salvador are actually rural hospitals with 40 to 60 beds, which offer maternity and general surgery services. Hereinafter they will be referred to as "hospitals".

The VSC program of the MOH is basically a hospital program where female post-partum and interval sterilization or vasectomy is provided, according to demand.

The IEC Family Planning Campaign includes VSC information and education which is part of the Health Education Campaign. The communication media are utilized. They include radio, posters, pamphlets, puppets and discussions carried out by health education personnel and satisfied users.

An intra-hospital IEC program for information on family planning is also available, especially directed to post-partum patients. Whenever a temporary method is adopted, a follow-up examination is scheduled four weeks after delivery, at which time the selected contraceptive method is made available. All necessary information on surgical contraception is provided by a social worker or nurse during a session for those who decide to proceed with VSC, and an informed consent form is signed before surgery. Surgery is generally scheduled for the day after delivery, in the operating room of the respective hospital, and never in the delivery rooms.

Interval cases are referred to a hospital by health education personnel or by rural health auxiliaries. Once the patient is

101

in the hospital, a medical evaluation is carried out and detailed information is provided by a physician, nurse or social worker in order to obtain informed consent before surgery.

Since all these hospitals provide general surgery services, the operating rooms, surgical equipment, sterilization facilities for medical elements and equipment, and the provision of emergency or accident care requirements are adequate and sufficient.

Periumbilical minilaparotomy is utilized in post-partum cases and laparoscopy with Yoon rings for interval cases. Conventional minilaparotomy is only performed when, for some reason, the laparoscopy cannot be utilized. Vasectomy is performed using normal technique with one or two incisions. It was observed that high quality surgical techniques are performed by skilled and confident surgeons.

The mentioned techniques utilized for female sterilization are carried out under sedation/analgesia with intravenous diazepam-petidine and local infiltration of xylocaine 1% without epinephrine. The sedation/analgesia is given by the operating-room auxiliary and the local infiltration by the surgeon. Only in cases of respiratory or cardiovascular depression an anaesthesiologist is involved. In some hospitals sedation/analgesia is complemented with talamonal.

Adequate pre- and post-operative monitoring was not observed. Blood pressure was not controlled or registered during or after surgery. We were also informed that no pre-operative hemoglobin or hematocrit determinations were performed.

As all other services offered by the Ministry of Health, temporary contraception and VSC are provided free of charge.

Special reference is made in respect of the unit composed by the Maternity Hospital of San Salvador and the Gynaecological Clinic. The hospital has in its obstetrical wards a good IEC activity in family planning, which includes information on VSC. These activities are carried out by special educators, social workers or satisfied users. Immediate post-partum minilaparotomy is offered as well as interval laparoscopy. In 1983 the Maternity Hospital carried out 2.600 post-partum minilaparotomies (12% of live births), and 2.147 interval laparoscopies.

The gynaecological clinic is located in a modern building annexed to the Maternity Hospital, and was constructed and equipped with AVS assistance. The purpose for the establishment of this clinic was to serve as a model institution for family planning and voluntary surgical contraception activities, and regional centre for demonstration and training (Central America and Caribbean).

62

It has 16 examining rooms and five operating rooms which include all necessary annexes. It was constructed with ultra-modern concepts both from the point of view of architecture and equipment. At the moment, only the gynaecological and the family planning consulting services are in operation. The initial objective was to dedicate all of the surgery area to VSC, but it has now been decided to transfer some gynaecological surgery presently carried out at the Maternity Hospital.

I would also like to refer to the vasectomy project being carried out in the hospitals of Sonsonate, Ahuachapán, Santa Ana, San Miguel and Zacatecoluca, the health centres at San Bartolo, La Unión and Cojutepeque and the health units of San Jacinto and Acajutla. The objective of this AVS-funded project is to perform an estimated of 120 vasectomies per year in each of the 10 sites mentioned above but, to this date, the project has not started activities due to bureaucratic complications which have prevented the nationalization of funds transferred by AVS. It seems that at the last moment these inconveniences have been overcome and that it will be possible to initiate project operation soon.

Financing. The funding of VSC programs carried out by the MOH in 1983 was as follows:

USAID/ELS	- Medical Supervision, support personnel salaries, IEC, disposable materials, vehicle maintenance, international observation travel	400,000
UNFPA	- Temporary contraceptive methods, salaries, training	700,000
IPAVS	- Vasectomy project	89,250
MOH	- A difficult to identify part of the MOH Regular Budget for Family Planning	4,000,000

SALVADOREAN DEMOGRAPHIC ASSOCIATION (SDA)

Site Visits:

SDA Central Offices, San Salvador
 FP Clinic, San Salvador
 FP Clinic, Santa Tecla
 FP Clinic, Santa Rosa
 FP Clinic "El Refugio", Santa Tecla

103

The "San Miguel" Clinic was not visited because the trip was not considered safe.

The SDA in El Salvador has two types of family planning projects: One called "Clinical Program" which is carried out in the above mentioned clinics, and one implemented by the Community Based Distribution Department (CBD) which covers almost all the cantons of El Salvador. It has approximately 2,000 distribution posts. The Clinical program provides information on FP and offers all contraceptive methods, including interval laparoscopy and vasectomy.

The VSC/SDA users can be classified in two groups, according to their origin:

1. Urban users, informed by the general family planning program through the IEC Department.
2. Rural users, informed by the work teams of the Community Based Distribution Department (CBD).

Urban Users

The IEC department has three family planning educators (two in San Salvador and one in Santa Ana) who have the responsibility to inform people on family planning activities in their respective cities. VSC is offered along with other available methods. People interested in VSC receive more detailed information through group or individual meetings and special pamphlets, and are referred to the nearest SDA Clinic. Radio spots are broadcasted to inform on all contraceptive methods, including VSC, and the resulting users come to the clinics in search of the procedure.

Once in the clinic, the applicant is interviewed by a nurse who provides detailed information, and the client who adopts a VSC procedure goes through a medical evaluation and a personal interview with a social worker to sign the informed consent form. When the requestor is illiterate his/her fingerprints, together with the social worker's signature, are required. The date and time of the surgery is then scheduled.

Rural Users

The people who live in cities or rural areas where no IEC educators are available, receive information through the CBD program. The clients interested in VSC communicate with the CBD distribution posts who in turn communicate with the CBD mobile units. The mobile unit visits the client and provides

104

all necessary information on VSC and temporary methods. If the person decides to adopt the permanent method, he/she is referred to the nearest clinic where a medical evaluation is carried out, along with the procedures described above. CBD rural personnel provide patient transport to and from the nearest ADS clinic.

SDA sterilizations are not performed in fully-equipped surgical theaters as in the MOH hospitals. ADS clinics generally operate in old houses where space has been adapted for waiting rooms, secretarial facilities, consulting rooms, operating and recovery rooms and general services areas. The facilities adapted for surgery are satisfactory, although the operating rooms in the visited clinics could be substantially up-graded in terms of performance and appearance, at a low cost. Obviously, ADS does not perform post-partum minilaparotomy. It only carries out interval laparoscopy (rarely minilap) and vasectomies.

Our views expressed for the MOH are also valid for the SDA program in respect of surgical techniques, skill and high efficiency of surgeons and auxiliary operating room (OR) personnel and analgesia/anaesthesia procedures. The opinion on the lack of monitoring and control of vital signs during operation and recovery, as well as the lack of haematic assessment before surgery, also applies in this case. Emphasis is made on these negative aspects, because both are included in the AVS Medical Standards for VSC.

Equipment and working elements are satisfactory in terms of quality and quantity. Some clinics have only one laparoscopy available. If, for some reason, it were to break down the program would have to be interrupted, with the subsequent inconveniences for patients and program.

In the three clinics visited, it was observed that adequate provision for emergency cases is available: vehicle, arrangement with a nearby hospital, emergency drugs for respiratory or cardio-vascular complications, oxygen, etc.

The SDA charges a voluntary fee for sterilization, but no requestor is refused service because he/she cannot pay.

Funding for VSC programs carried out in 1983.

IPAVS: Subgrant ELS-13-CO-2-A covers procedures carried out in San Miguel, and Santa Tecla and Vasectomies in Santa Ana, personnel in San Miguel and Santa Tecla, institutional reimbursement of \$7 per case, rent for two clinics and utilities for the three...

274.693

USAID/ELS.	All Santa Ana Clinic expenses except for vasectomy	69,000
IPPF.	From the total US\$ 250,000, \$38,500 are allocated for VSC	38,500
USAID/ELS.	Contributes with US\$ 1.040,000 to the CBD program, half of which is estimated to be directed to VSC activities as one of CBD's principal objectives is the recruitment and transportation of VSC acceptors	500,000
		<hr/> \$ 883,193

(The above information was provided by the Financial and Administrative Department of SDA).

SALVADOREAN SOCIAL SECURITY INSTITUTE

Site Visits. Unfortunately on Monday, February 20, the day on which this assignment was initiated, the ISSS personnel went on a general strike and all hospitals, clinics, wards and offices were closed, making any site visits impossible.

However, Dr. Jorge Bustamante, Chief of the Ob/Gyn Department, and Dr. Melvin Hernández, Family Planning Coordinator, kindly accepted an appointment at the USAID offices. The information transcribed below was obtained. On Saturday, March 3, the day on which this mission terminated, the strike was still in force and all SSSI offices continued to be closed.

In 1979 the SSSI included Family Planning as part of its public health preventive medicine programs. However, the lack of a clear definition of the lines of responsibility prevented this program to develop. In 1980 family planning was included within the Ob/Gyn Department. This Department gave family planning a new orientation with the establishment of an MCH and family planning program, complemented by post-graduate training in Ob/Gyn, which included contraceptive techniques such as laparoscopy, interval and post-partum minilaparotomy, and vasectomy.

Its policy is to provide temporary as well as surgical contraceptive methods to all requestors, provided that all necessary information is made available and that acceptance is completely voluntary without undue inducement or pressure, but also with no limitations. "As far as I know, nobody has been sterilized without his/her full consent" (Dr. Bustamante).

6/8

VSC services are provided in the Central Hospital of San Salvador and the Ilopango medical unit where laparoscopy and vasectomy are available, and in the regional hospitals of Santa Ana, Sonsonate and San Miguel which provide post-partum minilap with an average of one case per 10 births.

According to the SSSI Directors, family planning in El Salvador is distributed as follows:

MOH - Low income population (1.5 million)

SSSI- Middle-class

SDA - Low-income population from the Eastern part of the Country and high-income population that choose SDA services "for their excellent reputation"

(Dr. Bustamante)

He considers that there is enough room for the three institutions and that they have good working inter-relationship. However, there is some overlapping in the activities of the field workers.

The SSSI would be interested in introducing interval VSC at its three regional hospitals which only deliver post-partum VSC, but this has not been accomplished for lack of laparoscopes. Interval minilap is not taken into consideration because it is an "unpopular procedure. . . Minilap has been unlucky in El Salvador".

The VSC services are delivered at no cost to the SSSI affiliates and are financed by the Institute's regular budget.

OTHER VSC PROGRAMS

The National Telecommunication Administration provides VSC (laparoscopy) in its Central Hospital in San Salvador. The Central Military Hospital delivers vasectomy and interval laparoscopy for the spouses of its affiliates. The scope of VSC services provided by private physicians could not be measured, but it is estimated that they only serve a small portion of the population due to high cost and the number of public institutions offering the same services.

TRAINING OF PERSONNEL

At the time of this study, we immediately observed the outstandingly high technical quality of surgeons and auxiliary personnel working in the VSC programs of the MOH and SDA.

67

There is no reason to believe that the inspected sample is not representative for the country. We must therefore conclude that El Salvador has sufficient personnel, both from a quantitative and qualitative point of view, to maintain present and future programs in a very satisfactory manner. Furthermore, El Salvador has the technical capacity and facilities to train all required personnel with quality standards as high as can be provided in other countries. Besides, post-graduates in gynaecology receive a complete training in VSC techniques.

SUPPLIES - MAINTENANCE

JH/PIEGO has provided all laparoscopes available in the country and has distributed them among the different institutions through the MOH. The Yoon Rings are provided by AVS. The Ministry of Health established a Maintenance and Repair Unit with the responsibility of repairing equipment throughout the country. However, SDA will organize its own Unit in order to facilitate preventive maintenance of laparoscopes and their eventual repair.

Occasionally some programs have experienced a shortage of rings, which has been solved in collaboration between the MOH and SDA. These institutions lend each other various elements when necessary.

STATISTICAL DATA

The evolution, scope and magnitude of VSC programs in El Salvador can be seen in the following table:

Female Sterilization and vasectomies carried out in El Salvador
MODIFICATION OF TABLE No. 15 OF THE MOH REPORT TO THE V INTER-
NATIONAL CONFERENCE, SANTO DOMINGO, December 1983.

Year	MOH	SSSI	SDA	OTHER	TOTAL	VASECTOMIES
1975	9,195	2,047	1,015		12,257	575
1976	12,047	1,859	1,139		15,045	754
1977	15,792	2,868	1,718		20,378	772
1978	18,585	6,349	2,665		27,599	836
1979	17,307	5,583	2,810	23	25,723	668
1980	15,887	5,678	2,936	53	24,554	581
1981	13,799	4,361	3,083	42	21,285	420
1982	14,379	3,781	4,811	50	23,021	460
1983	14,622	1,993	6,043		22,658	
	131,613	34,519	26,220	168	192,520	5,566
	68%	18%	14%		100%	

63

As can be seen:

- a. The VSC programs constantly increased, up to 1978 (year of the beginning of armed disruption) when a decrease is observed with the exception of those carried out by SDA.
- b. If the SSSI is considered a governmental institution, the Government VSC programs represent 86% of the total VSC procedures, against 14% of the private SDA program.
- c. Vasectomy only represents 2.5% of total VSC.
- d. Between 1975 and 1983, there were 197,586 sterilizations, some of which may have ceased to be active because of death or menopause. However, the sterilizations performed before 1975 are not included in this table and might replace the drop-outs. Therefore, it can be assumed that nearly 200,000 couples practice family planning by VSC. This represents a coverage of 20% of women in fertile age.

CONCLUSIONS AND RECOMMENDATIONS

There is a clear Government policy to promote family planning and provide the necessary services. This can be seen not only in the text of its new Constitution, where an article reads: "The Government will adopt a population policy aimed at improving the family welfare of the Salvadorean population", but also through the implementation of 86% of the total sterilizations carried out in El Salvador through the MOH and the SSSI.

It is an action policy rather than a legal one and it is complemented by the awareness of the population of the usefulness of VSC. VSC is the most accepted contraceptive method: In 1978 more than half of the women utilizing a contraceptive method had adopted VSC (National Fertility Survey).

Curiously enough, during El Salvador's presidential election campaign we observed that one of the political parties had included family planning in its pre-electoral program.

On the other hand, the existing regulations for VSC in the different institutions are very liberal:

- a. The MOH accepts sterilization of women older than 26 with one living child; older than 25 with two living children and at any age with three living children (Regulation 1983, attached). (See Document No. 4.)

69

- b. SDA's regulation stipulates that the client be older than 18 years of age. (Users Reference Manual, 1983, attached.) (See Document No. 5.)
- c. The SSSI regulations require only the woman's request for a VSC procedure. (Draft document under preparation "Family Planning Sub-program", attached.) (See Document No. 6.)

NOTE: The above regulations cover only female voluntary sterilization for family planning purposes and do not interfere with medical sterilization. There are no regulations in respect to vasectomy.

Recommendation

There should be no interference with these regulations. Although in some cases they appear to be extremely liberal, it seems advisable that these same institutions determine the regulations and control one another.

SERVICE AVAILABILITY AND ACCESSIBILITY

Presently (1984) there are 31 clinics delivering VSC in El Salvador: 23 of the MOH, 4 of the SDA and 4 of the SSSI, which cover, respectively, 68, 14 and 18 percent of the total sterilizations carried out in the country.

The services are distributed among 22 cities and, due to the small size of El Salvador's territory, this is an adequate coverage (see attached map)*. San Salvador, Santa Ana and San Miguel are served by one MOH, one SDA and one SSSI clinic; Santa Tecla by one MOH and one SDA clinic and Sonsonate by one MOH and one SSSI clinic. The rest of the cities are covered by the MOH hospitals or health centres.

In the section which describes VSC programs, it is explained how the large network of clinics (23) only has a few urban PP educators and rural health auxiliaries for the recruitment of clients, while the four clinics of the SDA are served by 29 rural teams composed of three persons and one vehicle each. These teams have the capacity to cover the whole country. In other words, there is a large national structure (23 clinics) with little logistic support for the IEC activities and transport of clients, along with a small structure (4 clinics) with plenty of resources to cover IEC activities and transportation.

*(See Document No.1)

The results of this situation are:

- a. Rural clients prefer to utilize the services offered by SDA because transport to and from the clinic is included, although long distances are to be covered, instead of utilizing the services of hospitals or health centres nearer to their homes where transportation is not offered.
- b. The hospitals and health centres complain that rural clients prefer to utilize SDA services because of the efficiency of the information and education activities implemented by the rural teams of the Association.
- c. The cost of sterilization is exceptionally high in the SDA programs: if the SDA budget for 1983 is divided by the procedures carried out during the same year, we get $\$882,193 \div 6,043 = \$146/\text{case}$.

Recommendation

Assistance to these institutions should be maintained and reinforced. It would be convenient to study ways to strengthen the three institutions by integrating their efforts on the national level, to increase efficiency and take full advantage of the MOH excellent service network and SDA's capacity for IEC coverage and transportation.

This is the real problem of VSC in El Salvador, the rest are minor problems related to communications, statistics, supplies, etc., and there is no need to extend services, as the existing facilities are sufficient to cover the country's needs.

If the programs carried out by the MOH and SDA could be integrated to achieve a better distribution of resources, El Salvador would be in a position to offer the best voluntary surgical contraception program in Latin America.

POST-PARTUM PROJECT

One cannot go ahead without mentioning, although very shortly, the VSC post-partum program delivered by 10 hospitals and 12 health centres of the MOH. Of the total procedures carried out by the MOH, 60% are immediate post-partum minilaparotomies. The MOH has always held that post-partum is the best time for family planning and VSC, and has implemented this idea with excellent results. However, the lack of IEC personnel in combination with the lack of resources for service activities to cover the extra demand that IEC activities could

generate, prevents this program from becoming a more significant one.

Elements such as awareness, technique, surgical facilities and qualified personnel combine in El Salvador to implement a post-partum program with a greater coverage than the present one.

Recommendation

Carry out an in-depth study of the post-partum program needs and give ample support to cover the existing potential demand.

SUPPLY OF AND DEMAND FOR VSC SERVICES

There is no way to quantify the demand for VSC services, but statistical data available consistently show that close to 50% of potential clients choose VSC as a family planning method, thus indicating that it is widely accepted. The installed capacity for providing VSC is, to this date, sufficient to cover existing demand. No indication of waiting lists or patient backlog was found.

As mentioned before and as can be seen on the attached map*, the distribution of VSC service facilities is adequate but, we repeat, the number of VSC service sites available will be sufficient only to the extent that the integration of IEC and logistic resources is realized.

No need to open new clinics is envisaged. The SSSI is interested in extending its services to one or two more sites, but this is due to the fact that its services are exclusively for social security-affiliates.

INTEGRATION OF VSC WITHIN HEALTH SERVICES AND TEMPORARY CONTRACEPTIVE METHODS

VSC services are integrated in and form an integral part of the health programs implemented by the MOH and the SSSI. The clinics run by SDA are single-purpose, dedicated exclusively to family planning activities.

All temporary family planning methods are available in all SDA, MOH and SSSI clinics.

*(See Document No. 1, attached)

12

INFORMATION AND EDUCATION

The IEC process for VSC programs carried out by the MOH and the SDA has been described in detail in the corresponding section of this report. However, by recommendation of AVS and the USAID/ELS Office of Human Resources, special attention was given to the counselling and informed consent aspects of the program. It was concluded that:

- a. There was no evidence of pressure or coercive practices on clients to adopt VSC as a method of family planning.
- b. There are no material incentives neither for VSC users nor for the personnel involved in IEC activities.
- c. No quotas have been established for IEC personnel for the recruitment of VSC acceptors. (The programmatic objectives adopted for a determined working period for budgetary and administrative purposes have erroneously been interpreted as quotas). Consequently, there are no disciplinary measures for unmet objectives.
- d. In both programs there is a time gap between the request for sterilization and the procedure. Also, more than one person is involved in the counselling sessions and informed consent procedures.
- e. Clients receive a respectful and human treatment in all programs.
- f. All VSC clinics offer temporary contraceptive methods.

MEDICAL ASPECTS

1. Physical and surgical facilities are appropriate in the MOH programs. They are part of the respective surgical departments of hospitals and health centres. It is obvious that in some hospitals (San Salvador Maternity, for example), the facilities are not modern, but they comply with required standards for abdominal surgery.

Although the hospitals of the SSSI were not visited for the reasons stated above, we were informed that VSC is performed within the surgical facilities of the hospitals and benefit from all their services.

11

The VSC program of SDA performs in houses which have been adapted, and which therefore do not have all the advantages of the surgical department of a General Hospital. However, they are considered adequate and comply with AVS Medical Standards. With some effort and low-cost investment some details could be modernized and up-graded, especially in respect of the maintenance and handling of endoscopic equipment. Presently its maintenance is carried out in inadequate plastic basins, in the very operating room.

All services have appropriate sterilization elements (autoclave), which are correctly utilized.

2. As mentioned before, all equipment and supplies were found to be appropriate. However, emphasis is made on the need to supply at least two endoscopes to those services which carry out more than four procedures a day, in order to correctly prepare the equipment between two operations and to prevent unnecessary inconveniences by the loss of one.

With regard to expendable material and drugs, occasionally the hospital and health centres suffer from shortages. This, however, is a constant phenomenon in Latin America Governmental Hospitals.

Permanent equipment such as operating tables, auxiliary tables, stretchers, etc. are in some cases modest, but serve their purposes appropriately.

The provision of endoscopes, surgical instruments and Yoon Rings is complicated because of the various agencies involved: JHPIEGO provides endoscopes to the three institutions, but they have to be delivered through the MOH with its consequent bureaucratic problems. AVS supplies rings, surgical instruments, operating room equipment and some expendable items; AID supplies vehicles and other elements. A better coordination between the international agencies and the Salvadorean Institutions would be very desirable in order to accelerate the delivery mechanisms.

3. Six laparoscopies, two post-partum minilaparotomies and one vasectomy were observed. No comments are made on interval laparotomy as it is rarely practiced in the country.

The high technical quality of both surgeons and operating room auxiliary personnel was outstanding.

4. The MOH programs do not require special provisions for emergency cases, as they operate in hospitals with all surgical facilities. The SDA clinics do need them and they comply with AVS Medical Standards, in terms of vehicles for transportation of patients, agreements for emergency surgery with nearby hospitals, and emergency drugs in the ORs.

Recommendations

Take the necessary steps to provide each operating room that carries out more than four procedures a day with a minimum of two endoscopes.

Promote the standardization of criteria among the international agencies that support VSC programs and establish an efficient mechanism for the delivery of necessary equipment to the projects.

Pre- and post-operative medical evaluation requirements should be carried out and registered in order to comply with AVS Medical Standards.

STATISTICS, RECORDS, COMPLICATIONS

In the MOH, the VSC patients have the same medical history as other surgical patients, and these are kept in the General Files* of the MOH. However, VSC clients fill out a form (see annex) containing information on the procedure requested, personal data, fertility and informed consent. This form contains an additional statement in respect of relieving the hospital of the responsibility for any consequence that may be derived from surgery. Follow-up information is entered in the clinical history.

The SDA/VSC Register is the same used for all family planning methods, but with additional information. Post-operative follow-up information is registered on the back of this form. A separate form containing the data of the register and the informed consent form is filed by alphabetical order.**

When revising the files of both institutions no information other than the number and type of procedure carried out was found. When enquiring on data regarding morbidity and mortality, the SDA replied that there was no exact information available, but that they had reported to AVS the following cases:

* (See Document No. 7)

** (See Document No. 8)

One death because of peritonitis following a burn of the large bowel in a laparoscopy with electrocoagulation; one patient with heavy bleeding from a vessel in the abdominal wall; one case of retroperitoneal hematoma observed through the laparoscope that was put under observation and was spontaneously reabsorbed.

There are few cases of reported pregnancies since women usually do not report to the hospitals or clinics. An average of 3% of infection in the abdominal wall is estimated.

Recommendation

The establishment of an efficient statistical system common to the three institutions to enable a permanent monitoring of the program and to serve the program administrators for decision-making purposes when necessary.

IMPACT OF CIVIL CONFLICT ON VSC PROGRAMS

We have already referred to the impact of the civil conflict on VSC programs, in terms of a decrease of the program since 1973 and the difficulties encountered for the transportation of IEC personnel and patients in rural areas, and also the increased motivation originated by the poverty of abandoned families.

However, the VSC programs being carried out in urban areas are very active and cover both urban demand and the rural population that has come to the cities in search of safety and protection.

It is worth mentioning that in the camps for displaced persons, IEC programs are carried out and contraceptive methods are made available, including VSC. Also, there is a small SDA clinic in a camp located in Santa Tecla (El refugio). The people are members of families disrupted by death, or with members active in the conflict, with the "Guerrilla" or with the regular armed forces. In many cases they are young women that have abandoned their rural homes. In this abnormal situation, women who request VSC cannot always be expected to be clearly aware of the significance of their decision.

Recommendation

Reinforce the IEC campaigns implemented in the camps for displaced persons to ensure that each person availing himself of permanent voluntary surgical contraception is in a state of emotional fitness adequate enough to make a sound decision.

jk

VSC IMPACT ON SOCIAL, DEMOGRAPHIC AND HEALTH ASPECTS

Generally, it is said that VSC has little influence on demography due to the fact that people requesting this method have already completed their families. In other words, that VSC does not limit the family size and consequently does not have a substantial effect on fertility rates.

The situation in El Salvador is a good illustration of this statement, as can be seen in the Table on page 6 regarding the evolution of fertility rates in which, in spite of intensive family planning campaigns, the decrease in fertility rates is not significant.

We believe, however, that VSC has a beneficial effect on health as this method guarantees a permanent and efficient contraceptive with no side effects to young people who consider their families to be complete and who, otherwise, would use conventional contraceptives for 15 or more years with the risk of side effects and of unwanted pregnancies that could end in dangerous, illegal abortions.

FINAL COMMENTS

The Republic of El Salvador has a voluntary sterilization program that can be considered the most advanced in Latin America. This is due to Government policy and to the active programs carried out by the Ministry of Health, the Social Security Institute of El Salvador and the Demographic Association of El Salvador, as well as to the people's consciousness of the need to have recourse to a permanent method when the family is complete and the spouses still have a long period of fertile life.

As long as the ideal contraceptive has not been invented (and it still seems to be remote), voluntary sterilization will continue to be increasingly acceptable and the demand for this method is not likely to become saturated, since there will always be new couples who require it and demand it.

Even though the voluntary sterilization programs in El Salvador have been successful, we think that they must continue to be developed with enthusiasm and with renewed efforts to remedy their deficiencies and improve their services.

The number of clinics that offer voluntary sterilization services is enough and is well distributed throughout the country. It appears that this number should not be increased. However, one or two more VSC services should be created in the SSSI.

11

The post-partum program of the Ministry of Health should be carefully studied in order to expand it to all health centres where maternity services are available, and to provide the necessary support to engage sufficient personnel for information and follow-up patients.

The Ministry of Health requires a larger IEC program for family planning, because the number of health educators and or rural auxiliaries do not seem to be sufficient.

The 20 rural teams of the SDA are capable to completely cover the country with its IEC campaign. It is not clear why this work should be carried out by groups of three persons when the geographic and population coverage could be triplicated if they worked separately in individual territories. Also it is not logical that VSC requestors recruited by the rural personnel of the SDA have to be delivered to distant clinics, when the same good services can be found in the nearest hospital or health centre, thus avoiding unnecessary waste of time and transportation. It is important that a solution acceptable to both entities be identified, to allow them to begin collaborating, to mutual benefit, and improve utilization of the existing valuable resources.

Another weak point of the programs are the statistics. The records are good enough when they are filled in properly. However, there is no system to facilitate the codification of data on sterilizations and follow-up for monthly monitoring, that could serve as a guide to administrators in making decisions on program management.

It looks like there were no coordination among the funding agencies which support voluntary sterilization in El Salvador. There seems to be duplication of efforts and a not to clear definition of fields of action to permit institutions to address their requests to the right source of support.

Also, it would be desirable to clearly define the request and delivery mechanisms of endoscopy and surgical equipment, operating room supplies, expendables, medicines, etc. which are being provided by so many different agencies.

In summary, the primary need of the voluntary sterilization programs in El Salvador is unity. This does not mean that there should be only one institution, eliminating the others, but that the three most important institutions working today could come to an agreement to permit an efficient utilization of resources to the benefit of the users who, in the long run, are the main objective of the programs.

13

It will not be easy to achieve such an agreement among the institutions which provide VSC services in El Salvador, and neither would it be easy to achieve it among the international agencies. A progressive approach with mutual good-will can lead, nevertheless, to a unification of criteria which will keep the Salvadorean VSC program as the best in Latin America.

19

SCHEDULE - WORK PROGRAM

FEBRUARY, 1984

16	Bogotá - New York	
17	New York, AVS	
18	New York - Miami	
19	Miami - San Salvador	
20	08:00 - 9:15	USAID
	09:30 -16:30	Asociación Demográfica Salvadoreña Salvadorean Demographic Association (SDA)
21	08:00 -09:00	US/AID
	09:30 -11:00	Ministry of Health, MCH Direction
	11:30 -13:00	USAID.
	15:00 -16:30	SDA, Demographic Association, IEC
22	08:00 -10:00	SDA Clinic, San Salvador
	10:30 -11:30	Director of Ob/Gyn and Chief of FP, Social Security Salvadorean Institute (SSSI)
	12:00 -13:30	SDA, CBD Department
	14:00 -17:00	Medical Department, DSA.
23	08:00 -10:00	San Rafael Hospital, Santa Tecla
	10:30 -13:00	SDA Clinic, Santa Tecla
	13:00 -18:00	Field Visit to CBD program of SDA Distribution posts of Curazao and Scacoyo. Visit to rural sterilized patients.
24	AM	SDA Clinic in Santa Ana
	13:30 -15:00	Financial and Administrative Dept., SDA
	15:30 -17:00	USAID
25/26		Report work
27	AM	Maternity Hospital and Gynaecological Clinic, MOH
	PM	Health Centre of San Bartolo, MOH
28	08:00 -10:00	SDA Clinic, San Salvador
	10:30 -13:00	El Refugio Clinic, SDA Santa Tecla
	PM	Report work
29	08:00 -10:00	Discussion on Evaluation with SDA
	10:30 -12:00	Meeting with Development Associates/AID Evaluation Group.
	PM	Meeting with Terrence Jezowski, AVS

MARCH, 1984

01	08:00 - 10:00	Meeting with USAID/HR and Development Associates Evaluation Group
	10:30 - 12:00	Meeting with USAID Mission Director
	PM	Meeting with SDA personnel and T. Jezowski.
02	08:00 - 11:00	Meeting with the Directors of the OB/Gyn and Family Planning Department of the Social Security Institute and Development Associates Evaluation Group.
	15:00 - 16:00	USAID Mission Director
03	08:00 - 14:00	Trip to San Francisco de Gotera (Morazán); visit to Health Centre and return to San Salvador.
	17:00	San Salvador - Panama
04		Panama - Bogotá

21

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12

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(12)

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XD-AAP-589-B

FINAL PROJECT EVALUATION
OF THE
MANAGEMENT AND THE EFFECTIVENESS
OF THE FAMILY PLANNING AND POPULATION
PROJECT NUMBER 519-0149

Under Contract No. PDC-0000-I-11-3077-00

Submitted To:

U.S. Agency for International Development
El Salvador

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March 1984

DEVELOPMENT ASSOCIATES, INC.

ACKNOWLEDGEMENTS

The team wishes to express its gratitude to the Salvadoran Demographic Association for all its informational help, and for providing offices, equipment and transportation; to the Maternal Child Health Family Planning Division of the Ministry of Health; to the Directorate of Family Planning of the Social Security Institute; and to the staff of USAID/EL Salvador for the time and attention they gave to help the team complete their mission successfully.

ACRONYMS

ADS	-	Salvadoran Demographic Association
AID	-	Agency for International Development
APHA	-	American Public Health Association
ARS	-	Rural Health Aide
AVS	-	Association for Voluntary Sterilization
CBR	-	Crude Birth Rate
CBF	-	Community-Based Distribution
CDC	-	Center for Disease Control
CRS	-	Commercial Retail Sales
CYP	-	Couple Years Protection
FP	-	Family Planning
GSE	-	Government of El Salvador
IEC	-	Information, Education and Communication
IIRP	-	International Fertility Research Program
IPPF	-	International Planned Parenthood Federation
ISSS	-	Instituto Salvadoreño del Seguro Social (Salvadoran Social Security Institute)
ISLA	-	Instituto Salvadoreño de Transformación Agraria
JHPIEGO	-	Johns Hopkins Program for International Education in Gynecology and Obstetrics
MCH	-	Maternal and Child Health
MINPLAN	-	Ministry of Planning

MOH	-	Ministry of Health
NPC	-	National Population Commission
OCOFIAF	-	Oficina Coordinadora de Planificación Familiar
PAHO	-	Pan American Health Organization
TCP	-	Technical Committee on Population
TFR	-	Total Fertility Rate
UNFPA	-	United Nations Fund for Population Activities
KAP	-	Knowledge, Attitude and Practice

TABLE OF CONTENTS

	<u>Page</u>
ACKNOWLEDGEMENTS	ii
ACRONYMS	iii
I. EXECUTIVE SUMMARY	1
A. Scope of Work	1
B. Methodology	1
C. Demographic and Socio-Economic Situation in El Salvador	3
D. Family Planning Programs	3
E. General Recommendations	3
II. INTRODUCTION	4
A. Demographic Situation in El Salvador	4
B. Population/Family Planning Activities in El Salvador (1980-1983)	5
C. Family Planning Acceptor Characteristics	7
D. Family Planning Service Coverage in 1983	8
E. Family Planning Level of Acceptance for Years 1980-1983 by Agency	8
F. Number of Facilities in El Salvador Where Family Planning Services are Available (1983) by Provider and Type of Service	10
G. The National Contraceptive Prevalence Study (FESAL-1978)	10
H. Family Planning Services for Displaced Persons	11
I. AID Inputs to Population/Family Planning Activities in El Salvador, FY 1978-1984	12
J. UNFPA Assistance to the Ministry of Health (ELC/74/FC I)	13
III. ASOCIACION DEMOGRAFICA SALVADORENA	13
A. Background and Description	13
B. Salvadoran Demographic Association Recommendations	14
1. Community-Based Distribution Department	14
2. Clinical Services Department	15
3. Administration and Finance Department	15

89

	<u>Page</u>
4. Training Unit	16
5. Planning, Evaluation and Research Unit.	16
6. Information, Education and Communications Department.	16
7. Resource Development and Public Relations Unit.	16
C. Community-Based Distribution Department	16
1. Program Description	18
2. Staffing.	19
3. Vehicle Maintenance	19
4. Logistics	20
5. Cost Benefit Analysis of the CBD Program.	21
6. Training.	23
7. Achievements.	23
D. Clinical Services Department	25
E. Administration and Finance Department	27
1. Program Description	27
2. Logistics	27
3. Vehicle Maintenance	30
F. Training Unit	30
1. Program Description	30
2. Activities	31
3. Training Programs	32
a. CBD Staff Training	32
b. Sex Education Promoters Training	33
c. Volunteer Training	33
G. Planning, Evaluation and Research Unit	34
1. Program Description	34
2. List of Studies by Year Carried out by the Evaluation Unit	38
H. Information, Education and Communications Department	35
1. Program Description	35
2. Implementation of Mass Media Campaign Information	36
3. Budget for Mass Media Campaign	36
4. Staffing	37
5. Activities	37
6. Other Education Department Programs	38
7. Use of Advertising Agencies	38
a. History	38
b. Current Situation	39

98

	<u>Page</u>
c. Monitoring	41
d. Mass Media Plan	41
e. Materials	42
8. Interagency Cooperation	43
I. Resource Development and Public Relations Unit	43
IV. MINISTRY OF HEALTH ACTIVITIES	44
A. Background	44
B. Recommendations.	44
1. Oficina Coordinadora de Planificación Familiar (OCOPLAF)	44
2. Rural Health Aides Program (ARS).	45
C. Oficina Coordinadora de Planificación Familiar (OCOPLAF)	45
D. Rural Health Aides and their Impact on Family Planning in El Salvador	45
E. Health Education	46
F. Logistics	49
G. Vehicle Maintenance.	50
H. Training	51
V. SALVADORAN INSTITUTE OF SOCIAL SECURITY (ISSS)	52
A. Background	52
B. Recommendations.	52
C. Program Description.	53
VI. ANNEXES	
Annex 1 Organizational Chart of ADS	
Annex 2 Organizational Chart of MOH	
Annex 3 CBD Program Staff as of December 1983	
Annex 4 Geograpnic Location of CBD Distribution Posts, 1983.	
Annex 5 Organization Chart of I.E.C. Dept. ADS	
Annex 6 Planned and Actual Objectives for Mass Media Campaign 1981-4 (ADS)	

- Annex 7 Creation of New Media Materials by Year 1981-1984
- Annex 8 Graph Showing No. Registrations in the MOH Family Planning Program by Method, 1969-1983
- Annex 9 Graph Showing Age Structure of Women Registered in the MOH Family Planning Program 1983
- Annex 10 Graph Showing Average No. Living Children from Women Registered in the MOH Family Planning Program by Method (1983)

VII. LIST OF REFERENCES

LIST OF TABLES

		<u>Page</u>
Table 1	Average Age of Acceptor by Method (1983),	7
Table 2	Average Number of Living Children of Acceptors by Method (1983).	7
Table 3	New Acceptors by Year by Provider	8
Table 4	MOH-ISSS New Acceptors by Method of Acceptance (1980-83).	9
Table 5	ADS New Acceptors by Method of Acceptance (1980-83).	9
Table 6	Number of Facilities in El Salvador When Family Planning Services are Available by Provider and Type of Service.	10
Table 7	Estimated MOH-ISSS Active Users by Method Compared to Active Users in FESAL-78	11
Table 8	ADS Estimated Active Users by Method Compared to Active Users in FESAL-78	11
Table 9	Other Donor Contributions to ADS in CY 1983 in US Dollars	12
Table 10	Distribution of Management and Technical Staff.	19
Table 11	CBD Couple Years Protection	22
Table 12	Brief Analysis of Total Eligible Couples Served by CBD Distributors and CBD Support Staff by Region.	24
Table 13	CBD Program Planned and Accomplished Activities for 1980-83	26
Table 14a	Current Contraceptive Inventory Stock of Contraceptives as of February 29, 1984.	29
Table 14b	Lot Numbers, Dates and Quantities of Orals as of February 17, 1984	29
Table 15	Ministry of Health Oral Contraceptive Use, 1980-1984.	41

93

I. EXECUTIVE SUMMARY

A. Scope of Work

The team, under the guidance of the USAID/El Salvador Office of Human and Humanitarian Affairs, developed the following scope of work, which was discussed with the Mission Director and other USAID staff shortly after arrival.

1. Review and analyze program activities of public and private family planning (FP) programs.
2. Review the MOH data collection system on the basis of the PAHO report (team has a copy).
3. Assess the demand and rationale for supplying pills, IUDs, and other temporary methods.
4. Assess FP training programs in terms of objectives, content, methodology, duration and impact.
5. After completion of the above, propose alternative strategies for AID's future FP activities.

At the meeting it was agreed that a cost-benefit analysis should be done in the ADS community-based distribution program.

The team did not deal with the Voluntary Sterilization or Commercial Retail Sales components as these were to be evaluated by other organizations. However, most other elements of family planning activities were assessed.

B. Methodology

The evaluation methodology used by the team was as follows:

- Review of official project documentation and correspondence;
- Critical review of periodic reports prepared by the MOH, SDA and ISSS;
- In-depth interviews of central, regional and local project implementation staff;
- Sufficient site visits to gather adequate information for assessing project implementation;
- Review of project audits available in HR/HA and CONT files; and
- Review of the Evaluation Report prepared by the APHA team in 1980.

11

Development Associates' evaluation team members were:

- Scott Edmonds - Chief of Party, Population and Family Planning Specialist
- Darwin Bell, Logistics Specialist
- Eugenia Monterroso, Training Specialist
- Diane Urban, Mass Media Specialist

Members of the evaluation team traveled to four regions of the country to observe family planning activities and to interview not only those providing services but also the clients. It was not possible to travel extensively due to the political situation (just before elections), but a cross-sectional view will be included in the evaluation report. The following places and institutions were visited:

- San Salvador:** Ministry of Health
Minister's and Vice-Minister's Offices
Operating Services Office
Maternal and Child Health Care Division
OCOPLAF Unit
Health Education Department
Metropolitan Maintenance Center and Motor Pool
National Training School (Human Resources Dept.)
San Jacinto Clinic
Metropolitan Warehouse at Candelaria (separate warehouse)
Salvadoran Demographic Association
Publicidad Comercial
- Santa Tecla:** Ministry of Health Regional Clinic
Cooperative Health Aid Station at Lourdes
ADS Clinic and Warehouse
Government-operated Farm "Pasatiempo"
- La Libertad:** Cantón Melara
Cantón Cangrejera
- San Miguel:** MOH Regional Hospitals
ADS CBD Program's Regional Headquarters
- Santa Ana:** MOH Regional Warehouse and Motor Pool
ADS Clinic
ADS Regional Office
Cantón Palo de Campana
Cantón Ayuta
Cantón La Magdalena
Chalchuapa
Finca Malacara

92

C. Demographic and Socio-Economic Situation in El Salvador

The Government of El Salvador is aware of the problems created by population pressures and encourages family planning and out-migration. Its new constitution (Section 118) contains a statement on population.

According to estimates, the past ten years have shown a crude birth rate decrease from 41.4 per 1000 of population in 1971 to an estimated 37.9 in 1983. The number of children per woman (total fertility rate) has decreased by about one child per woman in the past twelve years.

Socio-economic conditions in the country have worsened, in part due to the internal unrest. Thus, this has adversely affected the life of its people.

D. Family Planning Programs

Family planning activities were started in 1962 by the Salvadoran Demographic Association (ADS). Since 1968, the GOES-MOH-ISSS has taken major responsibility in providing services, while in later years the ADS has concentrated on IEC and CBD programs. The number of persons using a modern method of contraception has increased by 55% since 1978. The average age of contraceptors has decreased significantly over the same period.

E. General Recommendations

The evaluation team recommends continued AID support to family planning service and IEC providers in both the public and private sectors, based on their accomplishments as noted in this report.

AID strategies for FP activities should be a balanced approach the amount of support to the government and non-government institutions involved in family planning activities. This support should take into consideration the strengths of the institutions involved and their defined role in the total effort. For example, ADS has been assigned the major responsibility in IEC activities and has the experience and contacts to do this.

AID project staff should take the initiative in establishing routine implementation meetings (weekly if possible) with implementing agencies in order to monitor the activities AID is supporting. In the interest of inter-project coordination and time-saving, it might be possible to meet with the various project directors at the same time.

Although the private (ADS) and public (MOH-ISSS) institutions are using two different statistical systems to assess family planning impact (active users versus couple year protection), and it would be easier to measure impact using one system, it is not

96

recommended that AID press for a single system at this time. Each of the systems has been put in place recently and meets the specific needs of the separate organizations using them.

II. INTRODUCTION

In order to assess the family planning activities in El Salvador, it is necessary to include some information which can provide a clear picture of the various aspects of the program. The following brief analysis should be helpful in this respect.

A. Demographic Situation in El Salvador

El Salvador is the smallest country in Central America and has the highest population density in the region (249 inhabitants/Km²). From 1971-1981, the population growth rate has been estimated to be approximately 3.2% per annum. If the increase were to continue unchecked, the population would double in 22 years. The following table provides estimated demographic data:*

Total Population (1983) (61% rural and 39% urban)	1,716,774
Crude Birth Rate (1983)	37.9
Crude Death Rate	8.1
Rate of Natural Increase	29.8
Total Fertility Rate	5.4
Estimated Life Expectancy at Birth for Males	62.6 years
Estimated Life Expectancy at Birth for Females	67.1

The number of Salvadoran women in the fertile age group (15-44) in 1983 is estimated to be 1,037,346 by the Department of Population in the Ministry of Planning.

On the positive side, the government of El Salvador instituted the following article in its recently-adopted Constitution, (Article 118): "The State will adopt population policies for the purpose of ensuring the welfare of the inhabitants of the country." On the negative side, the Salvadoran economy has been badly hurt by a number of internal and external political and

economic factors which have affected the daily life of the people. The public sector has received reduced revenues which limits its capability to provide services.

Private sector investment has decreased, which has resulted in lay-offs and fewer new jobs. The Per Capita Income for the country in 1981 was \$636, but has probably declined since then.

Due to the internal conflict, people are involuntarily and voluntarily migrating to safer areas. Data on out-migration were not available to the team.

What effect these factors have on family planning acceptance is still to be determined; however, it indicates a need for smaller families.

Shrinking resources points to a need to maximize the efficiency of family planning programs by the institutions involved by combining efforts and cooperating as much as possible.

B. Population/Family Planning Activities in El Salvador (1980-83)

This evaluation will not cover in depth those population/family planning activities which transpired prior to the previous 1980 evaluation done by the American Public Health Association Team but will include a brief historical description.

The government established a National Population Commission located in the Ministry of Planning, Coordination and Economic and Social Development. This Commission deals with policy and has delegated technical and operational decisions to a Technical Committee on Population, comprised of representatives of various Ministries, such as Education, Agriculture, Health, etc. These two groups only meet on an "ad hoc" basis.

The three main providers of family planning education and services are: the Ministry of Health (MOH), which provides services to approximately 20% of the eligible couples; ADS, which services 6% of the eligible couples; and the Social Security Institute, which services 2%. The activities of each of these organizations will be addressed separately in this report.

Family Planning Statistics in El Salvador

Unfortunately, the three FP services providers do not use a single method of reporting family planning statistics. The Ministry of Health and ISSS are developing a reporting system recommended by a Pan-American Health Organization Advisor. This system uses "active users" as a measure of coverage.

The ADS, at the recommendation of an IPPF technical advisor, has adopted the "couple years protection" system.

12

The two systems make it difficult to incorporate the data into one statement measuring the impact of the services on a national basis. A brief description of the various methodologies follows.

The technique of active users as a means of measuring the results of FP method use went into effect in October 1983. The PAHO Advisor also applied this method retrospectively to statistics dating from 1979. The results will be shown in several tables in this report.

A brief description of this method, which covers three contraceptives (sterilization, orals and IUDs), follows.

Each of the contraceptive methods has a different formula to calculate use/effectiveness.

IUDs - The use/effectiveness (.60 for previous year and .8567 for current year) is applied to the number of IUDs inserted during a two-year time period. After expulsions and other types of discontinuation are taken into account, one rate is applied to those acceptors from the last year and another rate is applied to those who accepted IUDs during the current year. The two categories are combined into a total "active user" rate.

Orals - The use/effectiveness formula varies from that of the IUD. In this case .564 is used for acceptors who began last year and .7037 is applied for those who began during the current year. The figures are then added together to obtain an annual rate.

Sterilization - This method yields higher use-effectiveness, as it is a permanent method. The formula here is .995 for those accepting during the past year and .99 for the current year.

The age of the acceptor is also considered in calculating active users of this method. (See November 1983 OPS Report of Horacio F. Gutierrez, PAHO Advisor, for further details). The "Couple Years Protection" (CYP) method of measuring impact of family planning services used by ADS assigns a period of time during which a couple is protected by a certain method.

For example, one voluntary surgical contraception provides 12.5 years CYP, and 13 cycles of orals provide one CYP, as do 100 condoms. CYP may be a less precise way of measuring impact than the previous method, but it is easier to use in programs which emphasize distribution of contraceptives by machines or by distributors who have minimal education.

It would be more efficient to use a single statistical system to measure results, as recommended by the APHA Evaluation in 1980. However, IPPF has requested all its affiliates in Central America to use the couple years protection system as a mean of measuring

the impact of family planning programs and ADS has complied with this request.

The ISSS feeds its service statistics into the MOH system.

C. Family Planning Acceptor Characteristics

The following data describe MOH acceptors by age and parity.

Table 1

Average Age of Acceptor by Method (1983)*

Voluntary Sterilizations	28.2
IUD Acceptors	23.4
Oral Acceptors	24.3

*This average age of family planning acceptors by method has not shown a significant change since 1980.

Source: PAHO Advisors Report, 1983.

Table 2

Average Number of Living Children of Acceptors by Method (1983) (MOH)

Voluntary Sterilizations	3.87
Orals	2.00
IUDs	2.04

Source: PAHO Advisors Report, 1983.

The data reveal that the average acceptor is comparatively young, which corresponds to the young age at which Salvadoran women enter into marriage or consensual unions. A look at the age structure of the female population at risk shows that 66% of the women in the fertile age groups are in the ages 15-29, and these

100

age groups are already contracepting. There were no data available on the acceptor profile of ADS and ISSS, and inasmuch as the Ministry of Health is the main provider, it can be inferred that the acceptors served by the other providers do not vary significantly from the above figures.

D. Family Planning Service Coverage in 1983

The Ministry of Health estimates that its active users (168,250 in 1983) represents 19.1% of the target population (85% of women age 15-44 yrs.). The ADS estimates that it is serving 52,904, representing 6%, and the ISSS is serving 17,635, or 2%. Private physicians and druggists outside of the above-mentioned system are providing some services and while no exact data exist, a conservative estimate of the number of people being served might be 44,000 or 5% of the eligible population. Thus, the estimated coverage is 32.1% of the target population.

It should be noted that permanent method coverage is computed on the basis of persons accepting the method in previous years, which protects them from unwanted pregnancy for a number of years.

E. Family Planning Level of Acceptance (all methods) for the Years 1980-1983 by Agency

The following data show new acceptors for the MOH-ISSS and ADS from 1980-1983:*

Table 3*

New Acceptors by Year by Provider

<u>Year</u>	<u>MOH-ISSS</u>	<u>ADS</u>	<u>TOTAL</u>
1980	42,066	5,365	47,431
1981	35,383	6,382	41,765
1982	38,199	11,106	49,305
1983	40,950	25,267	66,217

(These figures do not include those using the Commercial Retail Sales Outlets.)

Source PAHO Advisors Report, 1983:
ADS Annual Reports.

* The MOH only includes voluntary sterilization, orals, and IUDs in its service statistics.

101

These figures reflect a crude measurement of momentum of family planning services during these years. They indicate that the demand for services expressed as new acceptors has not plateaued except in the case of the MOH. However, the decrease in new acceptors in the MOH may be attributed to the civil unrest in the period 1980-82.

Table 4

MOH-ISSS New Acceptors by Method of Acceptance (In percent)
(1980-83)

	<u>1980</u>	<u>1981</u>	<u>1982</u>	<u>1983</u>
Orals	43.1%	48.6%	44.7%	44.4%
IUDs	13.3%	17.1%	17.5%	19.9%
Vol. Sterilization	38.0%	39.3%	37.8%	35.7%
Other Methods	5%	Not Reported	Not Reported	Not Reported

Table 5

ADS New Acceptors by Method of Acceptance (In percent)
(1980 - 83)

Method:	<u>1980</u>	<u>1981</u>	<u>1982</u>	<u>1983</u>
Permanent Method	29.6%	48.7%	43.7%	24.0%
Temporary Methods	70.4%	51.3%	56.3%	76.0%

Source: ADS Annual Reports 1980-83.

102

F. Number of Facilities in El Salvador where Family Planning Services are Available (1983) by Provider and Type of Service*

Table 6

Surgical Contraception, IUDs, Orals and Other Methods		IUD, Orals and Other Methods Only	Orals and Other Non-Clinical Methods Only
MOH	23	234	260
ISSS	6	35	35
ADS	4	4	2,004
	<u>33</u>	<u>272</u>	<u>2,299</u>

Source: USAID/El Salvador.

*This does not include those 765 pharmacies and 341 vending machines in ADS's Social Marketing Project, nor private physicians and pharmacies.

These figures indicate that the country in both rural and urban areas is covered by locations where family planning services can be obtained.

G. The National Contraceptive Prevalence Study (FESAL-78)

The National Contraceptive Prevalence Study carried out in El Salvador (FESAL-78) estimated active users to be 183,000 persons. Current 1983 estimates indicate 282,789 persons are active users, an absolute increase of 99,789 or a 55% increase over the six-year period. The percentage figure of active users in the FESAL-78 study indicated 34.4% of married women or those in consensual unions were contracepting; however, they excluded 39% of women in the fertile age group (15-44) as being single or pregnant. If the same base for target population were used, the 1983 percent of active users would now be 44.6%.

This study (FESAL-78) also provided data on persons contracepting by method (Table 11, pg. 32, FESAL). The method mix in 1978 for the three main methods was sterilization 52%, Orals 25%, IUDs 9%, and other methods 14%.

The active users estimated by the MOH for 1983 compared to the national usage figures of FESAL are depicted in the following tables.

* In the case of voluntary sterilization, the term "active user" represents cumulative prevalence from prior years.

103

Table 7

Estimated MOH-ISSS Active Users by Method, 1983
Compared to Active Users in FESAL 78* by Percent**

	1983	1978	Difference
Voluntary Sterilization	72.2%	52.0%	+ 20.2%
Orals	17.4%	25.0%	- 7.6%
IUDs	10.4%	9.0%	+ 1.4%

*Other methods not included.

**Source: PAHO Advisors Report.

Table 8

ADS Estimated Active Users by Method, 1983
Compared to Active Users in FESAL 78 - by Percent*

Method	1983	1978	Difference
Voluntary Sterilization	74.4%	52.0%	+ 22.4%
Orals & Other Methods	17.5%	25.0%	- 5.4%
IUDs	8.1%	9.0%	- 0.7%

*Source: ADS Annual Report, 1980.

H. Family Planning Services for Displaced Persons

As of December 31, 1983, there were 263,391 registered displaced persons. The government has appointed a Commission to supervise and care for displaced persons (CONADES). This organization does not have sufficient funds and depends on private and voluntary agencies, both national and international, to assist in providing food, clothing, health and other social services. At least nine private organizations are providing these services in the various displaced person settlements. ADS currently has AID funding to support a nurse and a part-time doctor at the displaced persons settlement at Santa Tecla.

104

If acceptance rates in settlements prove to be of sufficient magnitude, expansion of IEC and clinic activities should be considered; however, they should be combined with health services, if possible.

I. AID Inputs to Population/Family Planning Activities in El Salvador FY 1978-84 (AID Projects No. 519-0149, No. 519-0275)

AID's bilateral funds have been provided to the MOH, ADS and ISSS under a single project. The breakdown of these inputs in U.S. dollars is as follows:

	<u>Inputs</u>	<u>% of Total</u>
ADS (1978-84)	\$5,412,205	(88%)
MOH (1978-82)	697,382	(11%)
ISSS (1977-80)	22,350	(1%)
TOTAL	<u>\$6,131,937</u>	<u>100%</u>

Source: USAID/El Salvador Controller's Office.

These funds have provided contraceptives; vehicles; medical equipment and supplies; training -- both in El Salvador and overseas -- information and educational materials and programs; and research studies.

AID support in CY 1983 to ADS by project in U.S. Dollars (conversion rate £2.5=\$1.00) is as follows:

Displaced Persons Project	\$ 29,175
Voluntary Sterilizations*	74,923
CBD	1,050,200
TOTAL	<u>\$1,154,298</u>

*IP-AVS also provided support amounting to \$255,682 in CY 83.

Source: ADS Reports.

Table 9

Other Donor Contributions to ADS in CY 1983 in U.S. Dollars

IPPF (Conversion rate £3.6=\$1.00)	\$463,298
Development Associates	8,288
IP-AVS	255,682
TOTAL	<u>\$727,268</u>

Source: ADS Report to IPPF dated 1984.

105

J. UNFPA Assistance to the Ministry of Health (ELS/74/PO-1)

The UNFPA had budgeted a total support figure of \$2,890,562 to support MCH/FP activities in the MOH, \$974,713 of which is unutilized. This project started in 1974 and is ongoing.

The UNFPA resources were little used during 1974-1980 (\$291,835), but starting in 1981 the drawdown on resources increased.

The UNFPA has supported MOH/FP local salary costs, technical assistance, operational research, local and international training, equipment and contraceptives. The type of contraceptive supplied by UNFPA were orals and IUDs (Lippes Loops). The total amount of contraceptives budgeted under this project 1981-1983 was \$188,771.

An illustrative UNFPA budget for 1983 is as follows:

1. Contraceptives	\$ 45,606
2. AV and Office Equipment	39,576
3. Maintenance of Equipment	22,232
4. Seminars	10,000
Miscellaneous	<u>41,318</u>
TOTAL	\$158,732

Source: UNFPA Reprogramming Report 1981.

It should be noted that the MOH has absorbed salaries of local personnel, and 1982 was the last year that UNFPA budgeted for local salary support.

UNFPA assistance was channeled through OCOPLAF in the MOH Division and helped strengthen that unit.

III. ASOCIACION DEMOGRAFICA SALVADORENA

A. Background and Description

The Salvadoran Demographic Association (ADS) was established in 1962. It is an affiliate of the International Planned Parenthood Federation (IPPF) which provides most of the institutional support. It is one of three family planning service providers in El Salvador, the others being the Ministry of Health and the Social Security Institute. The Agency for International Development (AID) support began in 1966 and has continued to the present time.

Currently, ADS, which operates under the direction of a Board of Directors, has an Executive Director, a Unit of Planning, Evaluation and Investigation, a Unit of Public Relations, and seven departments as follows: Department of Medical Services; Information, Education and Communication (IEC); Training;

106

Community-Based Distribution of Contraceptives; Social Marketing; and Administration and Finance (See Annex 1). Each of these functional areas will be reviewed in this report.

The organization has a total budget in 1983 of the equivalent of \$1,842,904 (Colones 2.5/\$1). It employs 254 people and operates a fleet of 61 vehicles. In 1984, ADS moved into a newly-purchased, four-story building.

The Association has not significantly curtailed its activities during the current unrest and operates in all parts of the country.

P. Salvadoran Demographic Association Recommendations

In general, ADS was found to be staffed by competent, dedicated people and the Association is contributing significantly to family planning efforts in El Salvador. The following recommendations are directed towards improving certain programs operated by the Association.

1. Community-Based Distribution Department

This program needs to restructure its staffing to increase worker productivity and decrease staff costs. An advisor with experience in managing successful CBD programs should be recruited to assist ADS.

Efforts should be made to increase the number of persons using temporary methods served by the distributors, not by creating more posts, but by insuring that distributors are well selected, motivated, trained and provided with a range of contraceptives.

Consideration should be given to allowing community-based distributors to keep all money from sales (rather than present 50%). Non-monetary incentives should also be considered.

Because of slow sales, many of the post contraceptives in stock are old and unusable. They should be removed and fresh supplies provided.

Attention should be paid to pooling clients which are brought to clinics. The closest facility to the home of the client should be utilized, whether it is MOH, ISSS or ADS, to reduce transportation costs. In certain instances the purchase and use of motorcycles would reduce costs (for example, they could be used by the promoter).

A pilot study should be made using minibuses to pick up the clients on fixed schedules and stops. These clients would be assembled by the promoters.

107

There is a need to streamline the logistics system. This could be done by combining the storage facilities at the regional office into one room. One set of inventory records could be used, indicating shelf-life dates on each card. All stock of expired-date contraceptives and those which are unusable should be recalled, surveyed, and destroyed.

Shelf cards should be established, indicating shelf life dates on each contraceptive product.

All CBD training activities could be assigned to the program instead of the training unit. CBD staff have a high training competency based on practical program skills. A short course on training techniques could fully prepare them to conduct the training.

Reporting requirements of AID on providing contraceptive protection to married women of fertile age should be stated in terms of CYP instead of active users. This would allow more possibility to assess program projected versus achieved activities.

Examine possibility of conducting community talks when requested instead of promoting them as a regular program activity. Staff efforts could then be concentrated in home visits, which seem to be more effective.

2. Clinical Services Department

Examine the workload of social workers to see if they have sufficient time to counsel clients; if not, consider using volunteers or other personnel to assist them.

Each clinic orders and maintains records and a small supply of contraceptives for issue upon request of clients. The supply is inadequate at present and should be increased to at least a three-month usage level.

3. Administration and Finance Department

A cost analysis should be made on vehicle repairs. This should include salaries, transportation, and per diem of all mechanics going to regional offices to perform all service and maintenance. The costs should be compared to having the service done in local garages as some other fleet operations do. This would mean that some repairs would warrant bringing vehicles to San Salvador to the authorized dealer. Therefore, ADS mechanics would primarily diagnose trouble, place vehicles in local shops and approve repairs when complete. No repair facility would need to be constructed; thus, no special building permits need be obtained. A parking facility could be fenced in on the lot owned by ADS near the new office building.

108

Rebuild the Santa Tecla warehouse to provide safe and adequate storage facilities.

Review job descriptions of the Chief of Purchasing and Supplies Section and that of the person in charge of warehousing and inventories. Good management principles would indicate that authority over purchasing should not reside in the same position that has ultimate authority and responsibility over inventories in the warehouse of goods he has purchased. Warehousing and inventories should report through other channels to the Director of Administration and Financial Services.

4. Training Unit

With the small staff and limited resources the training unit has, consideration should be given to the strengthening of the volunteer program and to cooperation with IEC Department activities:

Attendance at a training-of-trainers' course should be considered for the training unit staff, as well as two or three of their key instructors.

5. Planning, Evaluation and Research Unit

No major national level study such as FESAL-78 is recommended in 1984 because of unsettled conditions in the country.

This unit needs to improve its capability to conduct valid studies and evaluations, and it is recommended that technical assistance be provided through short-term advisors in family planning statistical analysis, design and implementation of studies, and evaluation techniques.

The procurement of a microcomputer with appropriate attachments and software along with training of staff in its use would be very helpful to ADS by shortening the time for processing data as well as other administrative functions, and it is recommended that this be considered.

6. Information, Education and Communications Department

ADS should refer to the Education Department plan, which carefully analyzes audiences to be reached. It lists the rationale for the messages to be delivered and the media to use. To this plan would be added a system of continuous evaluation and utilization of the feedback generated to improve the understanding of the messages by the target audience.

109

They should continue to pretest materials and conduct an impact evaluation by: (1) including appropriate questions as proposed in the 1984 FESAL, (2) training rural teachers or government workers to conduct local surveys, and (3) conducting phone surveys after TV or radio spots have been broadcast.

Feedback about the audience would be obtained if they were asked to telephone or write for information or a small gift.

ADS should conduct an evaluation of the expectations and fears of potential FP users, including adolescents in urban areas and the hardest to reach in rural areas. This information will help to define target populations and develop communications strategies and messages. They should analyze annual cost increases before finalizing the budget to ensure that it is accurate and comprehensive, then follow it. They should continue to separate advertising costs for the social marketing program from those for the mass media program.

A contract should be signed with the advertising agency which includes an annual budget. This will facilitate the development of annual work plans, clarify mutual expectations and set parameters for broadcast activities.

The department should be reorganized to decrease the number of workers the assistant department director supervises.

They should continue to use findings from the information needs study of FP users to write materials. Also, they should ask physicians to check drafts of mass media materials for medical content. Space should be left on the back of pamphlets for information about the location of the nearest clinic or distribution post.

ADS should experiment with production techniques, including involvement of the target audience, rural clinic staff, etc., to write drafts of scripts and supply drawings or photographs for graphics. Interviews might also be recorded and edited for local flavor. Greater use should be made of photographers in developing audiovisual materials. An informal reassessment should be made of the church's and the army's attitudes towards FP messages after the visit of the Pope and the March elections. Talks should be held with opinion leaders in the mass media, government and rural areas to assess their needs and gain their support.

ADS should ensure that decision makers as well as managers are aware of results of interagency planning meetings, so that appropriate policy-level decisions are made.

They should participate in the new multimedia educational projects that the Ministry of Education and Agriculture are planning for school children, adults via formal and non-formal education, agrarian reform recipients, and displaced persons.

Technical assistance should be obtained in order to analyze how the various departments in the Ministry of Health responsible for health education can cooperate viably to plan and implement FP mass media activities. Damaged audiovisual materials should be replaced and current film and TV materials added to the holdings. Obsolete written material should be replaced with new publications. A learning center should be created for adolescents with independent study and group learning spaces. This center should be located in the auditorium on the first floor, should serve as a multi-purpose room, and be equipped with a video-cassette player and monitor which could be used for educational programs.

7. Resource Development and Public Relations Unit

Additional fund raising activities should be developed as this unit gains experience. Such activities as selling of clothing (T-shirts) and dishes with family planning logos, establishing food shops in various locations, collecting used clothing for sale in a shop or other small businesses could be considered.

C. Community-Based Distribution Department

1. Program Description

As a result of the experience and effectiveness ADS obtained from the two-year project implemented in the eastern cotton zone from 1977 to 1979 to provide information and deliver family planning services to the rural population through community workers, ADS planned a major expansion of their community-based approach. In addition, the data obtained by the FESAL-78 study,* in which 65.6% of the women interviewed in the country -- users and non-users -- expressed interest in community-based distribution methods, indicated a need to support those services in the rural areas.

In 1980 ADS received funding from USAID to cover the entire eastern region of the country, developing the capacity to continue expansion toward a national community-based family planning effort. By 1983 ADS had covered all four regions of El Salvador: oriental, central, para-central, and occidental. (See Annex 4.) The specific goals were to obtain a nationwide coverage of contraceptive distribution facilities through 2,000 distribution posts; to protect married women of

*See Chart 23, page 44, FESAL-78

reproductive age with temporary methods (8,760 women in 1981; 14,240 in 1982; and 22,540 in 1983); to refer interested persons to ADS clinics for permanent family planning methods (3,392 women in 1981, 5,613 in 1982, and 5,867 in 1983); and to provide information through community meetings (330 meetings in 1981, 1,900 in 1982, and 3,960 in 1983).

2. Staffing

In order to achieve the services targeted, the program at the end of the study period had 102 management and technical staff, distributed by region as follows:

<u>Category</u>	<u>Regions</u>				<u>Total</u>
	Oriental	Para - Central	Occidental	Central	
Program Director					1
Secretary					1
Driver					1
Regional Coordinator	1	1	1	1	4
Department Coordinator	2	2	2	2	8
Promoter/Driver	9	6	7	7	29
Auxiliary Nurses	9	6	7	7	29
Rural Guides	9	6	7	7	29
Technical/Aux. Nurse					1
TOTAL	30	21	24	24	102

3. Vehicle Maintenance

Field visits to the eastern and western regions indicated that the vehicles are the backbone of the community-based distribution system, yet are a source of problems. For example, in Santa Ana, of the eleven cars assigned, only six are in operation. Of those out of service, one has been in the central garage (San Salvador) for a year for motor repair; one out for thirty days for body work (central); one in the central garage for six months for Volkswagen parts; and a 1978 Landrover in a local (Santa Ana) shop for body, lights,

112

radiator and transmission repair (although it has been in the local shop twenty-six days, it seems to be moving along nicely).

During the visit to the eastern region it was possible to see two mechanics from the ADS maintenance garage at work. In two weeks, they had repaired one vehicle that had been out of service for eight months, and done a complete overhaul of a gasoline motor from a second. This one cannot be reassembled until the part is located and purchased. It appears that a major amount of vehicle downtime occurs while waiting for central shop mechanics to make a visit or waiting for spare parts. Local repair shops could get the cars on the road faster and make for a more efficient operation. Major overhauls that cannot be done in the major regional town could be brought to San Salvador to the local dealer.

4. Logistics

Eleven types of contraceptives are donated to ADS by AID and IPPF. The Administrative Office of ADS prepares all customs clearance documents and obtains the necessary import tax waivers. When the shipment arrives, the administrative office clears it and takes it to its storage facility in its headquarters building.

Each regional office has a separate storage room controlled by each of two departmental coordinators. This seems a waste of space, as the supplies in each are small and in consistent disorder. One person who is already employed in the CBD project could be given the responsibility of maintaining the control cards and preparation of regular replacement requisitions.

The Departmental Coordinator in turn issues contraceptives to the promoters that he coordinates. Each promoter is responsible for carrying these supplies in the vehicle and issuing replacement supplies to the distributor in her home. Since the distributor sells whatever contraceptives she can, she is authorized to keep half of what she collects -- for orals fifty centavos, condoms ten centavos, neo-sampoon twenty centavos, jelly and foams three colones. When she gets new supplies, she turns the money over to the promoter.

These small amounts of money are sent up the management line until the chief of the regional office deposits them in the branch of the bank ADS uses. The volume is small and seems more of an administrative bother than it is worth. Perhaps if all was left with the distributor, it could be an incentive for more sales.

113

5. Cost Benefit Analysis of the Community-Based Distribution (CBD) Program

The higher costs of CYP in 1981 and 1982, shown in Table 11, reflect somewhat the "start-up" costs of the project. Table 11 also shows the heavy demand for voluntary sterilizations. For example, in 1983, 91.9% of the CYP was provided by this method. It should be noted that the CBD program not only refers clients, but also provides transportation for the voluntary sterilization acceptors to and from the ADS clinics and provides follow-up services. This makes this program somewhat different from the majority of other CBD programs which provide mostly temporary methods to those they serve. In terms of cost-benefits, the costs of the CBD program are relatively high in comparison with the standard \$10-12 per CYP, which is a figure often used.

There are only two ways that the cost-benefit ratio can be improved. The first is to reduce costs and the other is to increase productivity -- or, alternatively, a combination of the two, which probably makes more sense.

In looking at project costs, it would seem that some costs are relatively fixed, i.e., rent, utilities, etc. Others can be adjusted. Looking at the CBD program's 1983 budget, it appears that personnel cost (58.3%) and maintenance or operation of vehicles (23.5%) constitute the largest variable costs. The productivity of the workers should be carefully examined to see if there are duplication of duties, excessive layering of personnel and if, in fact, they are supported in the field by efficient back-up services. (See Table 11.) The unitized costs of operating the vehicles indicate a cost of Colones 0.50 per kilometer, which translates into \$0.34 per mile (Sources: CBD 1983 Budget and Jan. 1984 mileages report). This would seem to be a relatively high figure considering it does not include depreciation of the vehicle and insurance nor salaries of mechanics. The relative effectiveness of utilizing local repair facilities versus the present centralized maintenance system could be examined. Currently there are a total of eight personnel, including six mechanics and a chief mechanic, maintaining a fleet of approximately 61 vehicles. In replacing transportation units, attention might be given to the use of motorcycles for certain types of personnel, promoters for example, which could reduce costs as well as the danger of theft of a more expensive vehicle, such as jeeps.

Looking at the Project's outputs in terms of what the voluntary distributors contribute to family planning, the level is very low as regards temporary methods. In comparison with Colombia, which is known to have a successful CBD program, El Salvador's distribution is relatively low. For example, voluntary distributors in Colombia, on the average, distribute 40 cycles of orals a month, 17 condoms and 24 units

114

of cream jellies, etc. (Source: PROFAMILIA'S 1982 Annual Report.) In El Salvador, the distributors average 2.8 cycles of orals a month, 2 condoms a month, and less than 1 per month of other temporary methods. (Source: ADS's 1983 Annual Report.) Of course, El Salvador's CBD program has a larger proportion of referrals for voluntary sterilization than Colombia, but how many of these are referred by the distributors or other CBD personnel is not known.

In any event, attention should be given to increasing the number of temporary method acceptors recruited by distributors. This does not mean increasing the number of distributors and support staff (1 per every 400 eligible people should be sufficient) but, rather, more careful selection, better training, interesting incentives and, as a last resort, giving less attention to the non-producers and more support to active distributors. It should be noted that the normal progression of family planning acceptors should start with spacing of children by a temporary method, then proceed to a permanent method when the desired family size is reached. Thus, the demand for temporary methods can be expected to increase as family planning usage becomes more widespread in the population.

Table 11
CBD Couple Years Protection

Method	1981		1982		1983	
	Amount	CYP	Amount	CYP	Amount	CYP
Sterilization	1,469	18,363	3,889	48,613	4,789	59,863
Pills	7,577	585	26,061	2,005	61,643	4,742
Condoms	4,988	50	15,136	151	40,961	410
Foams/Jellies	159	2	327	3	404	4
Neosampon	103	1	256	3	384	4
IUDs	6	15	21	53	50	125
TOTAL CYP		<u>19,014</u>		<u>50,828</u>		<u>65,148</u>
COST PER CYP IN \$'s		\$37/CYP		\$19/CYP		\$16.78/ CYP

NOTES:

- (1) Standard use for sterilization to determine CYP is 12.5 years.
- (2) Standard use for Pills to determine CYP is 13 cycles per year.
- (3) Standard use for Condoms to determine CYP is 100 units per year.
- (4) Standard use for Foams/Jellies/Neos to determine CYP is 100 units/year.
- (5) Standard use for IUDs to determine CYP is 2.5 years.

112

6. Training

All CBD staff have been hired after successfully completing a basic training course. Several refresher courses and seminars have also been provided to staff in the areas identified by both the program director and the regional coordinators as needed. Since 1982 this training has been provided in coordination with the ADS training department. Further details on this training will be discussed under the training department section. The (CBD) staff in turn are responsible for the distributors training, which is mainly carried out on an individual basis. In addition, periodically each region provides formal group training to their distributors. Each region has at least one coordinator trained outside El Salvador. The training department staff in ADS participates actively in the designing and implementing of the training for CBD personnel; however, distributors training is completely designed and developed by the CBD program officials.

7. Achievements

Of the 2,000 contraceptive distribution posts ADS planned to establish during the three-year period, 1814 are currently functioning in the four regions. The map in Annex 4 shows that they are evenly distributed throughout the country in terms of geographic location. It was found, however, that approximately 10% of the posts are not functioning at the village level as intended. The posts are located in urban areas close to the Ministry of Health facilities or at the Ministry of Health's rural health aides homes. According to the CBD's program director, they continue to support them because users find it more convenient and faster to obtain supplies directly from such CBD posts rather than going through the bureaucratic procedures at public health services facilities.

Based upon distributor performance, the program is currently closing down and/or relocating the least productive posts to better utilize the program resources. From the analysis done in Table 12, it can be observed that distribution posts which have potential clients to reach are receiving more than four supervision visits per year and there is an average ratio of 17 posts to one staff member. Relating these facts with the average number of contraceptives the posts distribute monthly, there seems to be no significant differences between programmatic efforts and distribution posts outcomes. In other words, increased supervision does not lead to greater output.

Table 12

Brief Analysis of Total Eligible Couples (85% of Women are 15-44)
Served by CBD Distributors and CBD Support Staff by Region

WESTERN REGION

No. target population (1)	179,936
No. CBD posts	455
Ratio of target population to post	400:1
No. CBD support staff	23
Ratio of posts to CBD staff	17:1
No. visits to post/mo/staff (4 visits per year)	6

CENTRAL REGION (Excluding San Salvador)

No. target population	150,666
No. CBD posts	485
Ratio target population to posts	327.1
No. CBD support staff	27
Ratio CBD posts to CBD staff	18:1
No. visits to posts/mo/staff (4 visits per year)	6

PARA-CENTRAL REGION

No. target population	171,145
No. CBD posts	370
Ratio target population to posts	462:1
No. CBD support staff	23
Ratio CBD posts to staff	16:1
No. visits to post/mo/staff (4 visits per year)	5.3

EASTERN ZONE

No. target population	152,649
No. CBD posts	514
Ratio target population to CBD post	297
No. CBD support staff	31
Ratio CBD posts to staff	16.6:1
No. visits to posts/mo/staff	5.5

(1) Source: PAHO Advisors, Report MOH, April 1983.

107

According to Table 13, in 1981 the CBD program accomplished 26.1% of the goal of providing temporary family planning methods to married women of reproductive age, and 16.3% of the goal to providing a permanent method of contraception. For 1982 and 1983, it is not possible to assess the outcomes in terms of the programmatic goals that were established, because since July 1982 ADS introduced a new system to simplify these statistics and since then, temporary family planning services results are presented in couple years protection instead of active users.

D. Clinical Services Department

This department operates four clinics -- one each in San Salvador, Santa Tecla, Santa Ana, and San Miguel. In addition, a small clinic which offers temporary methods is stationed at the displaced person settlement in Santa Tecla.

The clinical service staff consist of the following:

- 1 Medical Director (full time)
- 15 Doctors (part-time)
- 19 Nurses
- 3 Technicians
- 4 Social Workers
- 32 Other Support Staff

In 1983 this department's budget was \$375,415. The clinics do accept voluntary donations for their services which amounted to Colones 43,427 in 1983.

According to ADS statistics in 1983, clinic staff performed 6,043 male and female sterilizations, inserted 865 IUDs, provided 6,000 cycles of orals and 1,600 units of other types of temporary contraception.

Sterilization referrals from ADS's CBD program (4,789 in 1983) account for a considerable proportion of the services provided by the clinics. The department also sells IUDs and other contraceptives to private physicians and medical clinics.

In absolute terms, worker productivity in these clinics is high; for example, in 1983, approximately 18,000 techniques, including sterilizations, delivery of temporary methods and cytology were done.

The clinics do a considerable amount of client follow-up and serve as training sites for ADS and MCH clinical staff.

The only comment the team might have is that four social workers seem inadequate to counsel over 18,000 clients. Based on 220 working days a year, this would mean 20 consultations a day per social worker, a considerable workload.

118

TABLE 13
CBD PROGRAM PLANNED AND ACCOMPLISHED ACTIVITIES FOR 1980-1983

PLANNED 1981	ACCOMPLISHED 1981	PLANNED 1982	ACCOMPLISHED 1982	PLANNED 1983	ACCOMPLISHED 1983
1. At least 584 distribution sites functioning at the village level.	1. 151 functioning (25.9% of goal).	1. At least 949 distribution sites functioning at the village level.	1. 1,351 functioning (142% of goal).	1. At least 1,979 distribution sites functioning at the village level.	1. 1,814 functioning (91.6% of goal).
2. At least 8,760 married women of reproductive age receive supplies from distribution sites.	2. 2,286 married women of reproductive age receiving supplies from distribution sites (26.1% of goal).	2. At least 14,226 married women of reproductive age receiving supplies from distribution sites.	2. 4,857 newly married women of reproductive age receiving supplies from distribution sites (34% of goal). (1).	2. At least 22,000 married women of reproductive age receiving supplies from distribution sites.	2. (2)
3. At least 3,392 married women of reproductive age receive a permanent method of contraception.	3. 552 married women received a permanent method (16.3% of goal).	3. At least 5,613 married women of reproductive age receive a permanent method of contraception.	3. 3,889 married women of reproductive age received a permanent method (69% of goal).	3. --	3. (2)
4. At least 1,168 community meetings held for an estimated 11,630 participants.	4. 339 meetings held for an estimated 9,454 participants (80.9% of goal).	4. At least 1,900 community meetings held for an estimated 18,990 participants.	4. 1,951 meetings held for an estimated 45,509 participants (102% of goal).	4. At least 3,960 community meetings held for an estimated 40,000 participants.	4. 1,466 meetings held for an estimated 32,579 participants (81.4% of goal).

NOTES: (1) Only new users were considered. The statistical system was changed from active users to couple year protection (CYP).
(2) Only CYP figures are available and no conversion to active users was possible.

E. Administration and Finance Department

1. Program Description

This ADS department has major responsibility for the general operation of the agency and program support. This includes finance (purchasing, accounting, budget preparation, payment of bills) building and motor vehicle maintenance, payroll and personnel administration. This department has a director and 48 employees, both professional and non professional. The budget for administration in 1983 was Colones 1,069,214, approximately 15.7% of the Association's total budget. Funds are also provided for processing payroll on an outside computer.

The team studied ADS's administrative procedures in depth. There was currently an IPPF financial audit in process and this can be made available to AID/EL Salvador. The team understood there has been a change of purchasing procedures at ADS. In previous major expenditures, a sealed bid method was utilized. It is not clear what method is currently in use.

The maintenance of vehicles is carried out in a central shop in San Salvador. Mechanics visit the regional offices periodically but, according to some of the regional directors of ADS, this system is not working as well as the system previously used where local garages provided service. There was one case reported where a vehicle has been out of service since November 1983.

2. Logistics

The storage room in the new building on the second floor is about 35 x 40 feet with steel shelving. The program supplies (contraceptives) are mixed with administrative, office and automotive replacement parts. While there is general neatness and order, it would probably facilitate speed and accuracy to arrange clearly identified sections for Automotive Parts, Office Supplies, Cleaning/Toilet Supplies and Contraceptive or Program Supplies.

The ADS clinic in Santa Tecla is located in a large old colonial style house in this small suburban community located 15 miles west of San Salvador. After several years of paying a nominal rent for the property, the wealthy owner donated it to ADS. Behind the 10 bed clinic, operating room, and classrooms are storage units in what used to be servants' quarters, animal sheds and workshops. These are now used as the main warehouse for bulk supplies arriving from abroad. These are transported to the central office storeroom where supplies are stored to issue directly to local promoters, and sent by road or air to eastern and western regional offices.

The warehouse has a slanted tin roof about seven to ten feet high. It is old and has many holes. Two sides and the back are cinder block while the front is coarse chicken wire. The two plywood doors each have a padlock for the only security.

The contraceptives are stacked on a cement floor, as high as six to ten feet (depending on the slope of the roof). They are all in their original cardboard containers. There are no shelves, dividers, pallets or coverings. Damaged boxes are not set apart, merely stacked as they come off the truck. The boxes are covered with dust and subject to water leaking through the roof and rain blown through the chicken wire. There is no protection from the heat of the sun on the tin roof -- not even sufficient distance if the ventilation was ideal. Moreover, there is insufficient space to stack properly by commodity to allow quality control by the first-in-first-out method of issuing stock.

There are plans to build a new extension in the courtyard in front of the present storage sheds. However, it would be more effective to take the roof off the present sheds and, using the same rear and side walls, build a proper warehouse. It should have enough height to give proper ventilation to stored goods and an insulated roof to cut down the heat. Shelves should be built to correctly store supplies and equipment for first-in-first-out quality control and ease of inventory taking.

Each office in San Salvador and the regions has a schedule that indicates the day on which their supplies are issued. The request forms are in duplicate. The copy is held in the storeroom when supplies are issued until the original is returned signed by the receiving promoter or section chief. The central region staff pick up supplies directly and transport them to the use site. Supplies for the western region are sent by road (unless terrorists are active), while those to the eastern region go by air (since the bridges have been destroyed).

Below are the oral and general contraceptive inventories as of February 7 and 29, 1984, respectively. Such inventories are done every three months and sent to the Department of Planning, Evaluation and Statistics which in turn finalizes it to meet the reporting requirements to AID.

121

Table 14 (a)

Current Contraceptive Inventory
Stock of Contraceptives as of February 29, 1984

Depo Provera	0 Bottles
Noristerat	0 Bottles
Koromex	0 Tubes
Neosampoom	2035 Gross
Lippes Loops	282 Units
Copper T	3999 Units
Diaphragms	380 Units
Condoms (made in USA)	6596 Hundreds
Pantera Condoms	6584 Hundreds
Tahiti Condoms	3349 Hundreds
Condoms for machine sales	1000 Half/gross

Table 14 (b)

Lot Numbers, Dates and Quantities of Orals as of February 17, 1984

NORIDAY 1 + 50

Lot No. 24529	Cycles	73,200	Date 7/76
Lot No. 24658	Cycles	264,000	Date 8/76
Lot No. 64768	Cycles	162,000	Date 9/76
Lot No. 75670	Cycles	1,200	Date 11/77
Lot No. 66228	Cycles	110,400	Date 4/78
Lot No. 06257	Cycles	65,400	Date 6/78
Lot No. 16256	Cycles	178,200	Date 6/78
Lot No. 26563	Cycles	18,000	Date 3/78
Lot No. 86566	Cycles	165,600	Date 10/78
Lot No. 92730	Cycles	62,400	Date 8/82
Lot No. 92730	Cycles	<u>87,700</u>	Date 8/82

Total Noriday 1,188,000

LO-FEMENAL

Lot No. 1836003 Cycles 100,701 Date 1/83

NORLESTRIN 28 Cycles 687

NORLESTRIN 21 Cycles 244

NORMINEST Cycles 1,541

OVRAL Cycles 17,097

The standard inventory record cards are in use and current in the offices visited. The requisition forms are used consistently and reconcile with supplies and product record cards. The system does not seem cumbersome and can easily handle greater volume.

122

During inspections of supplies, all levels of staff are aware of the meaning of the expiration dates on products. However, there is no apparent system to store and issue products only by the first-in-first-out method. Too many storerooms are in a jumble of open cases of products with some on shelves but obviously being issued from cases rather than shelves. Some products are expiration dated only on boxes, yet these are not noted on shelf stock. As can be seen from the inventory above, there are nearly half a million cycles of Noriday 1 + 50 dated 1976. These have been tested and found ineffective. An order should be sent formally notifying the staff of this and start the procedure to destroy them. It is well known by word of mouth and has a very negative effect on use of this brand. If other stock years are ineffective, they should likewise be destroyed.

3. Vehicle Maintenance

The central repair facility located at 1218 1a. Calle Poniente was visited. It is quite small in size, lacking in some tools and equipment (for example, no hoist), was filled with vehicles of various sizes and ages either awaiting repair or being stripped for parts. The shop foreman explained that usually spare parts were not a problem, that his mechanics went to the field when needed to make routine vehicle repairs, and when they needed major repairs, they were brought to the central shop. There are no special vehicles or tools for field repair use.

There are 61 vehicles in ADS of which 30 are gasoline and 31 are diesel. During 1983, the average operating cost per year per vehicle was \$4,562. Comparing this with other users, the MOH was \$3,731 (including labor), and Red Cross was \$5,328. While these figures are interesting, it must be remembered that the type of vehicles, ages and terrain vary in each case.

F. Training Unit

1. Program Description

The training unit in ADS was created in 1982, primarily to respond to the training needs imposed on the Association by the increasing number of CBD staff and volunteer workers. Additionally, it has taken the responsibilities of (1) promoting positive attitudes toward family planning and sex education among adolescents and community leaders; and (2) cooperating with other similar agencies in El Salvador.

The unit is staffed by a director, an assistant, a social worker, and a secretary.

123

The duties of the unit are primarily to arrange for sites and schedule training courses, obtain instructors, and develop curricula in cooperation with ADS supervisory personnel. In addition, the unit is responsible for all the technical and administrative management of the ADS volunteer program.

Formal programming objectives as well as job descriptions are in the process of being finalized and approved by the executive director. At the operational level, however, an implementation plan of training activities is prepared annually. The technical staff is functioning with one of the director's assistants primarily charged with coordinating the volunteer program, and the other coordinating the remaining training actions. The unit director is responsible for the overall planning, implementing, supervising, and evaluating of the department.

The funds spent by the department during the last two years were:*

1982	£115,219 \$ 40,088
1983	£214,400 \$ 85,760

*\$1.00 = £2.50

Ninety-six percent of the money allotted to the department came from other individual and agency donors, supplementing USAID's inputs and cooperating with the implementation of their projected activities.

2. Activities

In 1982, the training unit, with the cooperation of other program professionals and outside trainers when needed, offered 13 courses for 282 CBD staff and community leaders. Also 14 informative activities were organized for 345 participants.

In 1983, 26 courses were given to 622 persons and 145 informative activities were offered to more than 10,000 persons.

In 1981, 59% of the training efforts were addressed to ADS staff and 41% to community supporters. In 1983, 55% of training activities were dedicated to community volunteers vs. 45% directed toward the Association personnel.

104

A tendency to provide more training to volunteers than to ADS staff can be noticed in 1983. However, it is difficult to assess the unit's effectiveness in responding to the Association training needs, because it was only at the beginning of operations that the unit conducted a formal assessment. Such an evaluation has not been repeated on a yearly basis to detect newly created needs for training.

3. Training Programs

There are three main components to the training efforts of the unit:

- a. The preparation and updating of CBD staff teams, each consisting of a promoter, an auxiliary nurse, and a rural guide;
- b. The preparation of sex education promoters, which the program can use such as normal school students, mature adolescents, or community leaders;
- c. The preparation of volunteers for promoting family planning services, helping with clerical work, reception of clients at the association clinics, and providing information on sexuality to adolescents.

a. CBD Staff Training

The CBD staff training is designed with the close cooperation of the CBD program director. Also, regional coordinators provide theoretical background and practical work application to the training. However, in its actual implementation, CBD staff do not participate actively as trainers, even though they have the skills and experience needed.

One member of the team visited a training course where auxiliary nurses from the CBD program were being trained. The purpose of the course was to better prepare participants to understand other community actions, such as environmental sanitation, community development, and maternal and child health care, and to promote the cause of family planning in a more integrated fashion.

The training curriculum, such as the one recently prepared for CBD staff, consisted of lectures by highly trained professors, followed by active group participation by the trainees reacting to and role-playing with the information just presented. The curriculum did not specify time allotted for lecture and group discussions.

The trainees were very enthusiastic and receptive. The trainer was a university professor who seemed to be well prepared on the topic presented and had the ability to

12

establish good relationships with trainees. Of special concern was the fact that the information presented was very theoretical with little applicability to the trainees' practical work. Both the training facilities and the number of auxiliary nurses being trained were optimum to create a good learning environment.

b. Sex Education Promoters Training

With regard to the training program for sex education promoters, the department has designed, in cooperation with IEC staff, a curriculum with appropriate objectives, content, methodologies, and evaluation. They have also prepared suitable training materials. It was learned that both the training unit and IEC staff, as well as some of the key trainers, have for the last two years attended various workshops to improve their skills and knowledge in this area.

The multiplier effect of this program is readily seen by the number of people who have been informed by the participants after completion of training; 135 graduates have informed more than 10,300 persons on sexuality and family planning, including adolescents, teachers, and parents.

c. Volunteer Training

The group of volunteers (Damas Voluntarias) has been cooperating with the Association since 1968. As of December 1983, there were 91 active volunteers.

When they first come into the program, a basic course is offered to prepare them on family planning services promotion as well as to counsel them on possible placement alternatives they have after training. Refresher workshops and sessions are conducted frequently to maintain volunteers' motivation and provide them with updated information.

The impact of the training unit's administrative, technical, and training effort on improvement in ADS promotional services by volunteers was noted in 1982 when volunteers contributed 7,318 working hours. In 1983, they contributed 10,834 hours. They also worked in initiating family planning services promotion in two hospitals in the interior of the country, raising funds for ADS and enrolling new associates.

In reviewing the training programs already described, it is apparent that considerable progress has been made. However, as the training unit has been profitably involved in informational and volunteer services activities, the possibility of amplifying these actions could be examined to benefit the overall efforts of the ADS program.

12

The training operation in ADS has developed to the extent that each program is acquiring higher training competency based on practical departmental skills and training abroad. The training unit should continue to support this trend. Effective training techniques are best developed when taught to a person with in-depth knowledge of the departmental subject matter.

5. Planning, Evaluation and Research Unit

1. Program Description

This unit works directly under the Executive Director and functions to serve the departments in ADS. Its staffing consists of a chief and two professionals with a background in sociology and economics. Other staff members include a supervisor, ten "coders-tabulators-interviewers" and a secretary. The unit has conducted a total of seventeen evaluations and studies since 1980. (See list attached.) These evaluations-studies are relevant to the organization's work and, while a review of the studies indicates that the quality of the data could be improved, the unit's findings have been helpful to ADS. The unit also prepares statistical reports on ADS' activities for presentation to appropriate agencies inside and outside the government.

Conclusion: This unit could benefit from technical assistance to design and analyze studies. Currently, the organization buys computer time for certain internal functions such as payroll. These funds could be used to buy a mini-computer, which the staff could be trained to use.

2. List of Studies by Year Carried Out by the Evaluation Unit

- | | |
|------|------------------------------------------------------------------------------------------|
| 1983 | 1. Evaluation of the mass media campaign (ADS). |
| | 2. Evaluation of the community-based distribution activities. |
| | 3. Evaluation of the medical services program. |
| 1982 | 1. Pretest of radio spot announcements concerning vaginal contraceptives. |
| | 2. Study of the functions of community-based distribution personnel. |
| | 3. Study and development, of a new statistical system for ADS (couple years protection). |
| | 4. Cost analysis of the Medical Services Program. |

127

5. Study of client characteristics of those attending medical clinics.
 6. Study of sexual activity of medical clinic clients.
- 1981
1. Study on frequency of sexual relations of CBD clients.
 2. KAP study of health personnel
 3. Study to determine if FP users would pay for services.
 4. Study on ADS employees' attitude on working hours.
 5. Patient flow study in ADS clinics.
 6. Study of the organization of the medical services department of ADS.
- 1980
1. Study on brand names for vaginal tablets.
 2. Study of family life in the El Salvador community.
 3. Evaluation of the community-based distribution program.

H. Information, Education and Communications Department

1. Program Description

El Salvador's Three Year Government Plan, 1981-3, gives priority to population and human development and asks the Salvadoran Demographic Association (ADS) to continue to assume responsibility for all mass media communication activities related to population and family planning (FP) Programs. (Triennial Plan of ADS, p. 3.)

The government first asked ADS to assume national responsibility for coordinating and implementing these activities in 1974 because ADS already had six years of successful experience in this area.

The general objective of the mass media campaign has been to reduce the population growth rate by giving individuals sufficient information to decide to begin or continue using FP services.

Specific themes have included: (1) reinforcing the need for FP, (2) promoting the use of contraceptives, (3) giving information about the location of services, (4) promoting sex

128

education, (5) encouraging responsible parenthood and greater participation of the male in FP activities. (Communication Strategies in Population and Family Planning in El Salvador: 1970-1983, pp. 8-9.)

In 1981, ADS' activities were assessed by an independent study which found that almost 100% of the women in the capital and over 90% of rural women had seen or heard FP messages via at least one mass or interpersonal channel. (Evaluation of Family Planning Communications in El Salvador, Bertrand et al, p. 193.)

Ninety-four percent of respondents had exposure via at least one of the mass media. (Op cit, p. 186.)

The following report shows how ADS implemented its national mass media responsibilities from 1981-4. The information is based upon conducting interviews with key staff and reading relevant documents.

2. Implementation of Mass Media Campaign Information

The information, education and communications (IEC) department at ADS is responsible for formulating the plan, project and activities, such as choosing the media to use to develop specific campaigns. The department has worked in conjunction with four advertising agencies since 1976 to realize these plans.

The current campaign has planning input from three other sources: (1) the Evaluation Unit's 1983 survey of information needs of FP program users, (2) the Executive Director of ADS and a three-member sub-committee of the Executive Board and (3) ADS staff members. Thus, the scope of the messages and the content serve the needs of the target population, ADS staff and the Executive Board.

3. Budget for Mass Media Campaign*

<u>Year</u>	<u>Budget</u>	<u>Spent</u>
1981-2	₡585,375 \$234,150	₡536,773 \$214,709
1983	₡495,442 \$198,177	₡472,368 \$188,947
1984	₡326,442 \$ 82,700	

*Exchange Rate = ₡2.5/\$1.00 from 1981-3 and ₡3.95/\$1.00 for 1984.

129

It was difficult to arrive at budget figures from 1981-82 because the donor agency funding periods were June 80 - May 81 and July 81 - December 82.

The funds in the 1981-2 line represent funds donated from June 1980 - December 1982, the expenses represent totals from January 81 December 82. In 1983, the budget included expenses for the social marketing campaign; in 1964, these are removed.

Much more money was spent on mass media activities than on the department's other three projects combined. These were: (1) Urban Community Education programs for workers and residents of marginal areas; (2) Sex Education programs in learning centers; and (3) the Documentation Center.

The mass media campaign uses most of the department's resources because it is expensive to create and broadcast spots. However, when one calculates the number of times a spot can be broadcast and the number of people who can be reached by radio, TV and the press, the cost per exposure decreases substantially.

4. Staffing

The IEC Department has nine employees. Professional staff include the director, his assistant, three educators, one librarian, one artist/photographer, and one monitor for radio and TV spots. There is also one secretary. (See Annex 4 for an organization chart.) The number of staff has remained constant since 1981; only one employee left and was replaced.

The staff is trained to handle multiple functions in response to changing needs. For example, when campaigns are not being broadcast, the media monitor does community work; the artist also runs the audiovisual equipment. This flexibility might make supervision difficult. In addition, the assistant director supervises nine people. A general standard for supervision is that six employees are considered manageable. There is no one on the staff who has previously worked for an advertising agency or written and produced programs for commercial radio and TV. The department director writes scripts and guides productions in addition to his managerial functions.

The department occupies all of the ground floor of the new ADS building, so it is readily available to visitors. The library is used by adults and students on a daily basis.

5. Activities

In the period under study, mass media campaign activities have included creating and broadcasting radio and TV spots, and producing and distributing posters, pamphlets, press releases, calendars and metal signs. (See Annex 7.)

130

ADS did not consistently realize its plans, although much work was accomplished. In 1981, the executive director died and until a new director was installed, ADS was governed by a committee of the Executive Board. Work priorities changed, and the donor agency consented verbally to project changes which were made according to the Director of the Education Department.

In 1982, an independent consultant recommended using TV in addition to radio, so funds were shifted from one line item to another. Therefore, radio output was below target, and an unplanned program was implemented.

In 1983, pamphlets were a priority and funds were transferred from the poster line. The calendar output was below target because production costs rose substantially during the year and the budget was not sufficient to cover the planned number of units.

6. Other Education Department Programs

Besides the mass media campaign, the IEC Department has implemented three other major activities to inform various segments of the population about FP. One program is targeted at workers, organized groups, and slum dwellers in San Salvador. In 1984, the department hopes that 10% of those who attend talks will subsequently visit FP clinics. Another program provides sex education to students of both sexes in educational centers in San Salvador. Some of these adolescents are trained to do peer counseling to achieve a multiplier effect. In addition, the Documentation Center houses the library where readers do research, and the librarian sends materials to other educational centers. There is also a photography studio.

ADS plans to equip an auditorium and build space for group and self-learning activities.

7. Use of Advertising Agencies

a. History

From 1978-1983, ADS used the Rumbo Ad Agency to handle its account. Because ADS was not totally satisfied with the process by which the agency produced materials, or the materials themselves, a consultant was asked to evaluate the agency. The quality of advertising plans, familiarity with contraceptive marketing, use of pre-testing messages, adequacy of media use, and appropriateness of media mix were assessed. (International Contraceptive Social Marketing Project, Advertising Agency Assessment. Aragon and Associates, 1983, p.1.)

121

The assessment found that Rumbo prepared ADS ads and made media decisions based on client approval and an assumption about the media the consumer is most likely to be exposed to, based on geographical area. (Op. cit., p. 6.)

There was no attempt to determine target audience, consumer needs and dislikes, or conduct pretest for spots of copy, although Rumbo has in-house research facilities (Op cit., pp. 6-8), and the donor agency contract specified that the ad agency would design, test, monitor and place information.

Rumbo's ads were often rejected by ADS and its committee composed of Executive Board Members and Director of the IEC Department. As a result, the agency invested many hours in the handling of the ADS account. For its part, ADS felt pushed to accept materials. Thus, tensions resulted and ADS used many of the criteria suggested by the Executive Board.

The process involved having two Executive Board members (one of whom is a publicist), the Business Manager, and Executive Director visit three leading ad agencies to hear presentations and see materials. The agency's attitude towards family planning was also discussed.

b. Current Situation

Publicidad Comercial was chosen and has begun to produce radio spots and posters to support the community-based distribution (CBD) program by increasing awareness of the location of distribution posts. So far, there is no contract and the ad agency has not billed ADS for production time. They will charge a percent of the distribution costs per program.

Three campaigns are planned:

- To reinforce the CBD program: 1 radio spot, poster and pamphlet;
- To motivate clinic attendance: 1 TV spot and pamphlet; and
- To orient and inform the public: 1 TV and radio spot.

Two suggestions made in the above-mentioned assessment of the Rumbo Agency. Besides having one ADS staff member designated as liaison, attention is being given to pre-testing. The creative director spent time in the rural

132

areas talking with villagers to understand their needs and vocabulary. He also read the report on information needs for FP users and used this information to create drawings and scripts for the director of the Education Department and the media sub-committee of the Executive Board. The materials were revised and given to ADS' Evaluation Unit for a target audience pretest. The agency has demonstrated willingness to spend time on this essential activity.

The media selected for the CBD program will be radio, 80%, and pamphlets and posters, 20%. The selection is in accordance with the findings of the 1983 research about information needs of FP users that 84, 59 and 51% respectively of women in rural areas listen to radio, watch TV, and read newspapers respectively (p.9). Radio was the most frequently mentioned mass media means of hearing about FP (p.7). These findings are similar to those cited in the National 1978 Contraceptive Prevalence Study (FESAL-1978).

While the penetration of radio is greatest, television is also available in rural areas with electricity. The medium might be more important if more specialized spots were produced to address researched information on the target population.

The ad agency will use radio and TV rating information to reach the greatest number of individuals for the lowest possible costs. The information was commissioned in February 1983 by a group of Salvadoran ad agencies, and they might decide to update this information this year. For radio, there are rating sheets which show the rating for each station in the capital, and the eastern and western regions of the country for two-hour time periods from Monday-Saturday, and on Sunday. In place of an audience analysis, the agency relies upon its knowledge of the type of audience that listens to soap operas, music and sports programs, etc., to decide when to broadcast spots.

For television, there is a rating of the best TV programs broadcast on three commercial channels. Program information includes: day, channel, time, rating; socioeconomic level of viewer, sex, age, and zone of the country. According to the data, not much TV is watched in rural areas. The agency multiplies the rating by the population base in a region to determine the reach of a specific TV program or radio station to calculate the cost per 1,000.

Decisions about when to schedule spots will be based on audience characteristics and cost. Daily TV and analysis is currently done by calling homes with telephones, and a weekly report is mailed to the agency. The method could be adapted to evaluate if ADS spots are seen. A telephone survey conducted by the Evaluation Unit might be done after the spots are broadcast to test for penetration and recall.

133

c. Monitoring

ADS Education Department staff monitor the airing of radio and TV spots by comparing the ad agency's monthly schedule to an independent company's listing of spots actually broadcast. Staff also listen to radio and TV programs to conduct spot checks.

However, there is no information about the number of listeners nor the effect of the information upon them, although to assess mass media campaigns and organizations one must know if the target audience has been exposed to campaign elements.

In order for a mass media campaign to be effective, the target audience must be exposed to campaign elements; they must understand, remember, and accept information, and they must adopt new behavior to effect changes in their health behavior. If any of the steps are missed, no further impact would be expected. Therefore, it is important in the beginning to know who hears the messages.

d. Mass Media Plan

The mass media plan for 1984 specifies three campaigns and lists targets for the production of TV spots, pamphlets, etc. However, there are no specific objectives, such as increasing couple year protection "x percent" in region "y," nor evidence of an integrated campaign designed to accomplish the goal.

A plan might divide the population between those who accept FP and those who do not, and the program should focus on the latter. To design a plan, research would be used together with socio-economic data and information about why individuals have not begun using FP, in general, and various methods, in particular.

The multi-media campaign would be issue oriented, and would attempt to increase FP practice by "X" percent in a given area. For example, to reach the skeptical population, specific messages would be created to neutralize or clarify misconceptions. For permanent methods, issues might involve fear of the operation, its side-effects, or after-effects on health and sex life, etc.

The ideas to be transmitted would be delivered to the target audience through group meetings, pamphlets, posters, the mass media, etc., in the appropriate sequence. Messages would reinforce each other to achieve the objective.

134

The education department would specify what staff would do, which aspects of the campaign, when, where and how. The Director would decide what percent of the budget to use for each activity, would make sure messages were consistent, and would implement an impact evaluation plan.

e. Materials

The assessment occurred during the time when few FP radio or TV spots were broadcast due to the fact that upcoming elections meant that political campaign messages monopolized the airwaves.

However, TV spots were viewed and radio scripts and brochures were read. The TV spots dealt with family planning and social marketing; spots for the latter were more innovative. Production was adequate; impact is unknown.

Unusual for Latin America, the majority of radio scripts produced by ADS have dealt with specific methods of family planning. Of the sample of 18 scripts read, from a total production of 61, 14 dealt with sterilization, 2 with pills and IUDs, and 1 with motivation to attend the health clinics. The scripts varied in length and interest. All of the scripts read made reference to receiving services in clinics of either the Ministry of Health, the Social Security or ADS. Occasionally, the information was slightly misleading -- i.e., the ease of female sterilization. Compared to other female surgery, female sterilization is relatively simple. However, compared to vasectomy, it is more complicated.

Pamphlets were targeted for rural inhabitants, but were also used for urbanites, adolescents, etc., because there were not sufficient funds to produce specific materials for special groups. Although colors were bright and the paper was fine, the vocabulary was often overwhelming for illiterate or barely literate populations -- neisseria gonorrhoeae was used in the VD pamphlet -- and occasionally drawings of people in rags were questionable. Health messages on the back added useful information.

In addition to ADS materials, radio scripts prepared by training rural workers in the Ministry of Health to write scripts which are then polished by professionals in headquarters at the Department of Health Education at the Ministry of Health were read. The language was in the vernacular and messages were innovative. Also, "The Family," an educational TV talk show produced by the Ministry of Education, was broadcast during the assessment period. The scripting lacked imagination; however, it might be useful for ADS to collaborate with this program to produce FP programming.

135

8. Interagency Cooperation

Although the National Population Commission created the Population Technical Committee to coordinate FP activities, this mechanism was not viable for collaboration on mass media materials, according to the Director of the IEC Department at ADS.

Recently, a commission created by the Population Department of the Ministry of Planning, composed of representatives at the management level from the Ministries of Health, Education, Planning and ADS began meeting to coordinate the implementation of the national population education plan.

Coordination also seems imperative because various agencies are involved in producing FP messages via the mass media for rural areas. For example, in the Ministry of Health, there are two units that make pamphlets and training materials. One specifically attached to the Maternal Child Health Division, and the another which serves the entire Ministry of Health. Each department has its strengths, and coordination between them and among the other agencies above would capitalize on specialized talents.

In addition, since the Ministries of Education and Agriculture have recently received a large grant to prepare multimedia educational projects for school children, adults, agrarian reform recipients, and displaced persons, it is important to synchronize health education activities at the outset.

I. Resource Development and Public Relations Unit

This four-person unit has the responsibility of local fund-raising for ADS. The Director solicits donations, recruits members, and collects membership fees.

In 1983 the Unit collected Colones 194,209 by various fund-raising activities, including raffling of two vehicles. Additional fund-raising activities could be carried out, such as sales of clothing with family planning logos, dishes, establishing food shops in various locations, collecting used clothing for sale in a shop and other small enterprises.

136

IV. MINISTRY OF HEALTH (MOH) ACTIVITIES
UNDER PROJECT 519-0149/MOH

July 1981 - December 1982

A. Background

This project started in 1978 to support family planning activities in the MOH. The original agreement listed twelve work activities. These included: supporting the Rural Health Aides; conducting several family planning studies; training medical and auxiliary staff, and providing vehicle, medical equipment and supplies.

The original agreement identified AID's contribution as \$443,145. In March 1979, an amendment increased this amount by \$172,951; another amendment lengthened the Project Assistance Completion Date (PACD) of the project to June 1981. In March 1981, the remaining funds were reprogrammed to finance a sub-project which created a coordinating office for family planning (OCOPLAF) in the MOH. This was a result of a recommendation made by the 1980 APHA Evaluation Team. AID support continued until December 1982 when the MOH assumed expenses for maintaining the unit. The total project input for 1981-82 by AID was \$357,784.

B. Recommendations

1. Oficina Coordinadora de Planificación Familiar (OCOPLAF)

OCOPLAF is functioning well and its present organizational structure and mandate are adequate. Support should be provided, if necessary, to allow them to continue to conduct training and retraining activities, coordinate or conduct special studies, monitor the MOH's Family Planning information system, and promote family planning within the MOH.

Contraceptives are to be provided under another AID-supported project (519-0291), and it is recommended that the supply system should be integrated into the MOH's medical supply system when developed under the above mentioned project. Until that time, OCOPLAF should insure adequate supplies of contraceptives.

In order to insure no stock-outs in MOH facilities prior to the arrival of the new contraceptive order, the MOH could borrow from the ADS, which has an oversupply of certain types of contraceptives.

On the basis of discussions with various levels of personnel at the MOH, emphasis should be on sending MOH staff involved in FP abroad for short courses and observations. USAID should include funds for this purpose in its budget.

151

2. Rural Health Aides Program (ARS)

This is a program that seemed to spring from the community. Currently, the ARS is working well and it might be possible to restructure the program in such a way that they could obtain training and initial medicines from the MOH supplied by AID under a contractual agreement with a private sector agency, such as ADS or Project Hope. The subsequent medical and contraceptive supplies and the supervision they need could be obtained from that same private organization.

Another suggestion is to incorporate the ARS into the private sector health system. They could serve in areas where there are no health facilities or pharmacies. An initial supply of simple medicines and contraceptives could be issued to them and they could purchase, at cost, resupply items. They could also render simple services and charge for them. They should be trained well and work under norms which are clearly defined.

Consideration should be given to the use of ARSs in the displaced persons camps either employed by a PVO or on a commercial basis.

C. Oficina Coordinadora de Planificación Familiar (OCOPLAF)

Under the agreement the following objectives for OCOPLAF were stated:

- Improve family planning supervision and evaluation at the regional and central levels;
- Increase family planning acceptance in the MOH program;
- Establish regional offices and staff them;
- Provide vehicles to the regions to be used in supervision;
- Train personnel at central and regional levels to efficiently administer MOH and FP programs;
- Establish lines of authority and delegate responsibility to the regions for MOH and FP activities;
- Carry out family planning education and promotion;
- Conduct the following studies: a patient flow study; a comparative study of use/effectiveness of the Copper T and Lippes Loop IUDs; and a study on the effectiveness of using "satisfied users" as promoters in MOH facilities; and
- Establish a traveling puppet show promoting family planning;

The following achievements were completed under the agreement:

- Family Planning acceptance rates in the MOH were higher in 1983 than in 1982;
- Regional offices were established;
- Three-day training courses were provided on how to administer MOH and FP to 181 regional personnel, as were ten-day courses on family planning clerical and surgical techniques for 82 MOH staff;
- Ten eight-week practical courses were given to 165 MOH staff in hospitals in all regions;
- Two thousand pamphlets on six FP methods were purchased and these were delivered;
- A series of 11 brochures on different family planning subjects were developed and 78,168 were distributed;
- Several mailings were developed and 2,000 were distributed;
- A puppet show on family planning was organized and used in the para-central region;
- The data for the studies were collected and are being analyzed; and
- The Pilot Project using satisfied users was implemented in 11 hospitals throughout the country and resulted in 2,771 patient referrals and 635 acceptors of clinical methods.

Comments: On the basis of document reviews, discussions with members of the OCOPLAF team and field visits to the regions, this project has more than fulfilled its stated objectives.

Comments on the promotion of family planning in the MOH will be included in the education section of this report.

D. Rural Health Aides (ARS) and their Impact on Family Planning in El Salvador

This program started in 1976-77 in the MOH and AID started supporting it in 1978. Basically, it consisted of the hiring and retraining of Malaria Program Personnel who were no longer required to work because of the decrease in malaria incidence at that time.

129

They receive a small salary (343 Colones per month) and a uniform from the MOH, and work in remote rural areas of more than 100 houses where there is no health center and where access is limited. ARS are evenly distributed throughout the country.

AID supports those working in areas of agrarian reform (ISTA) and cooperatives.

The pattern of supervision follows closely that of the Malaria Program in which each ten ARS staff have a supervisor. They have a map of their area and know the occupants of each house which they visit periodically.

Their duties consist of: carrying out health and family planning education; primary health care including first aid; work with indigenous midwives; and referral of those needing additional health care to the nearest health facility. They also have a supply of medicines and contraceptives and give injections.

The team visited four ARSs in two regions and interviewed three supervisors. Regional family planning statistics were obtained from two regions and the national level. At the national level, the family planning output was not separated into those supported by AID and those supported by GOES. However, on the regional level there was separation.

The National Level Statistics for 1983 will be presented first; currently employed are 232 ARS and 39 supervisors, of which 70 ARS and 10 supervisors are paid by AID.

In family planning activities, the ARS contacted 27,021 persons of which 2,403 were referred to clinics. They distributed 4,275 cycles of orals and 3,841 dozen condoms. On a cost benefit analysis comparing the output of the ARS with that of the CBD program, it is the team's consensus that support of ARS is a good investment.

Activities of Rural Health Aides in Family Planning by Region

Eastern Region

There are fourteen AID-supported Rural Health Aides (ARS) and two supervisors out of a total of 54 ARS employees in the Eastern Region, according to the MOH Regional Director's Report.

During 1983, the report states that the ARS contacted 8,151 people to discuss family planning and referred 546 of them to clinics. They distributed 885 cycles of orals, and 1,038 dozen condoms. The AID-supported ARS contributed to 1,566 contacts, 222 of whom were referred to clinics. They also distributed 448 cycles of orals and 281 dozen condoms.

1/11

Western Region

There are currently 52 ARS working in the Western Region, and of this number, 11 are supported by AID. The family planning output for the ARS in the region in 1983 was 4,452 persons contacted, of which 552 were referred for services (12.4% of those contacted accepted family planning). Of the total, AID-supported ARS contributed 1,463 contacts and referred 151 persons for family planning services.

There is no breakdown on how many of the contraceptives distributed in the program by ARS come from the AID-supported ARS, but in total, the ARS distributed 1,315 cycles of orals and 1,690 dozen condoms.

Conclusions: The team found that the ARS are well trained and supervised. The main obstacles they confront are related to lack of support. They lack daily control forms and stationery; uniforms have not been renewed since they joined the program; the ice boxes used for vaccination activities are lacking or in bad condition; salaries have not been paid regularly, creating for them additional economic problems and job uncertainty; the majority of motorcycles given to the regional supervisors are out of use because they need mechanical repairs, and even though they are supplied regularly with contraceptives, they are seldom provided other medicines they distribute.

E. Health Education

The ADS has been given the major responsibility for national IEC activities; however, the MOH and ISSS also play a role in this activity.

IEC activities relating to family planning emanate from two sources within the MOH. The Health Education Division is responsible for developing radio programs on those aspects of family planning which positively affect the health of mothers and children.

The other educational unit is located in the MCH Division (OCOPLAF) and deals more specifically with Family Planning/MCH materials. The evaluation team member concerned with IEC met with both heads of these units briefly and reviewed the media produced and distributed.

The person responsible for health education at the MCH unit is one of four persons on the Commission created by the Population Department of the Ministry of Planning to implement the national population education plan. This group will develop a national level strategy on creating media on family planning.

144

This committee meets periodically to insure the best use of media with the resources available. MOH workers, such as the ARS, also do word-of-mouth education and counseling.

The ISSS also promotes family planning by distributing educational materials obtained from the MOH and ADS. ISSS social workers visit factories and other establishments where individuals covered under the social security system work to educate them about these matters.

F. Logistics

Currently, temporary contraceptive supplies are made available to the MOH by UNFPA. The Health Systems Vitalization project will provide funds for more supplies in 1984 from AID and UNFPA. The supplies are stored in one central and five regional warehouses. Distribution is by vehicle from the San Salvador warehouse. There is a partially developed supply management system that is applied in an inconsistent manner. Earlier studies by MOH and an outside consultant resulted in a law being passed establishing a procurement unit within the MOH. This in turn has positively affected storage, distribution and the records to facilitate purchase and control of warehousing.

In order to indicate the overall movement of contraceptive supplies, the Ministry provided the information in Table 15 below.

Table 15

MINISTRY OF PUBLIC HEALTH
Oral Contraceptive Use
1980-1984

<u>Type</u>	<u>Amount</u>		<u>Distributed</u>	<u>Balance</u>	<u>Date</u>
	<u>Received</u>	<u>& Rate</u>			
Microgynon 28	198,300	3/83	85,525	112,775	12/84
Morinyl-1+50	1,681,860	7/80			
	5,000	12/82	1,494,666	192,194	12/82
	25,000	2/83	1,371,272	123,394	12/83
Neogynon 28	190,000	2/81	76,450	113,450	12/81
	125,000	2/83	114,865	15,900	3/84
Ovral	125,000	3/83		141,411*	3/84

Source: Operational Services, Ministry of Health, memo dated March 15, 1984.

*Assume balance, 1982, was 16,411 cycles.

142

There are substantial warehouse facilities available in the central area of El Salvador and in the five regions. Of course, they are principally for MOH medical supplies and equipment, but they are also handling family planning contraceptive supplies.

The central warehouse at Candelaria is the principal family planning warehouse. It is large, well lighted and has good ventilation. The stock is on clearly-marked shelves that can be quickly inventoried. The record cards are current and backed by proper order forms from regions. The place was clean and the tone of management was good and clearly reflected in the knowledge of and the morale shown by those workers interviewed. But there is a breakdown of efficiency evident when regional warehouses, hospitals, health center units and health posts were visited. As an example, in Santa Ana there were no condoms, but plenty in the central warehouse. The same thing applies to IUDs. There may have been requests on the way, but there was no evidence of it. The regional storage facilities in the old hospital in San Miguel were bad (the building is 160 years old). Perhaps when the new regional hospital is in operation, there will be proper facilities. However, the warehouse in Santa Ana is much better. It is a brick structure with good shelves, fair light and ventilation -- but all family planning supplies are stocked on the floor in the rear. The records are current, but there is no system to indicate the minimum supply on hand necessitating reordering. A health center visited had adequate space and shelving, but lacked supplies and was in very bad order with supplies on the floor and no expiration date controls.

Contraceptive supplies are sent from the central warehouse in Candelaria on a regular basis in response to request forms sent in. They go by truck, or vehicle, if needed, whenever an official is traveling to the point of need.

The worse part of the system seems to be a lack of establishing reorder levels. The clerk that keeps up the stock cards has no system to alert his chief (who must do reordering) that items are either exhausted or down to a few days' supply level. Supply management training is badly needed.

The stock record cards always seem to be current and an inventory can be typed up in very short order. The annual ordering cycle of the Ministry may affect the contraceptive supplies, but it seems to be a by-product of this exercise. When the planned new supply management system is installed, both quantities and qualitative elements must be included as regards contraceptives.

As mentioned above, the shelf life of contraceptives is given minimal attention and nothing is being done to destroy the out-of-date Noriday manufactured in 1976. The results of testing the 1977 and 1978 batches should be given to the Ministry with instructions on how to carry out the destruction of expired items.

140

G. Vehicle Maintenance

The maintenance facilities at Matazano Center on the outskirts of San Salvador and the supply warehouse and vehicle maintenance compound in Santa Ana are basically spacious and sound. However, it is immediately apparent that they have suffered from long-standing budgetary deprivation.

At present (1984), the MOH has 392 cars countrywide. At the same time, there are 68 slated for 1984 disposal and 28 were disposed of in 1983. The 1983 cost of operation of 250 vehicles is as follows:

	<u>Cars & Trucks</u> Colones	<u>Motorcycles</u> Colones
Materials & Parts	95,431.54	2,991.98
Grease & Oil	14,874.88	148.59
Tires & Tubes	82,606.93	1,554.72
Labor	40,262.76	1,293.48
	<u>233,176.11</u>	<u>5,988.27</u>
	\$ 93,270.44*	\$2,395.31

*(Colones 2.5 = \$1)

This amounted to \$3,731 last year (1983) for operation per vehicle (including labor). None of these vehicles is used exclusively for family planning, but with the fleet suffering from inadequate supervision and spare parts, it has a secondary negative effect on delivery of contraceptive supplies from the central warehouse.

H. Training

All central and regional training activities coordinated by OCOPLAF for 1981 and 1982 were programmed by the central level staff in cooperation with the regional supervisors (regional OCOPLAF directors). After completion of the initial phase in 1983, each regional OCOPLAF director has become responsible for developing training in his region, submitting programs and budgets to the central level office for approval purposes only. All training is currently designed and implemented at the regional level.

Approximately 95% of the funds the MOH has required to prepare their personnel in medical and non-medical aspects to successfully implement their MCH/FP program have come from other donors. AID's input for training provided for a family planning implementation program course attended by 22 medical and

144

paramedical staff at central regional levels at the beginning of 1981.

Comprehensive efforts have been directed toward different levels of personnel in developing their medical, management, planning, supervising, and evaluating skills. All the courses and workshops have been conducted at different training sites in El Salvador. Some regional supervisors and key personnel have received training abroad, allowing them to obtain an overall view of similar program operations, interchange experiences, and learn more about innovative program strategies.

The team found that the training support the MOH has received has produced satisfactory results in terms of the multiple activities the trainees have implemented after their training. There is a need for short courses and observation visits in other Latin American countries, especially for administrative personnel involved in planning, supervising, and evaluating the program.

This type of training would have a three-fold impact: (1) provide an additional incentive to the staff attending it; (2) develop a more balanced program for delivering permanent and temporary methods, and (3) elevate morale of implementing staff.

V. SALVADORAN INSTITUTE OF SOCIAL SECURITY (ISSS)

A. Background

This organization serves the work force of El Salvador. It covers approximately 285,000 workers, their wives, and their children up to three months of age, with complete medical services, including family planning. Costs of this service are paid into a medical insurance fund by the employees, employers, and the GOES. Permanent family planning methods are offered by the OB/GYN department and temporary methods are available in its 35 facilities located throughout the country. The ISSS has been a provider of these services for many years. In the FESAL-78 study, 11.8% of contracepting women received family planning services from ISSS. The team was unable to visit the hospital in San Salvador because of an on-going strike, but was able to discuss the program with the chief of the OB/GYN department and the doctor responsible for administering the family planning activities. The service statistics at the central and regional level are incorporated into those of the MOH and use of the MOH system of reporting.

B. Recommendations

The ISSS should be provided with voluntary sterilization equipment and materials to supplement their permanent methods service delivery at three hospitals.

105

There is also a need to reactivate training and re-training activities for medical and paramedical personnel because this activity has been operating at a low level during the past two years. Vehicle and operation costs should be provided to permit the Family Planning Coordinator to make regular supervisory visits to ISSS facilities.

Five sets of audiovisual equipment should be provided to support IEC activities at the central and regional levels. These should include sound-slide projectors, overhead projectors and movie projectors, films and audiovisual supplies.

C. Program Description

All methods, both temporary and permanent, are offered, the latter in the hospitals. Contraceptives are provided to ISSS by the MOH through its supply channels, and the two organizations work closely together at the regional level.

In addition to trained doctors, the ISSS has nurses and social workers who provide information and education. The social workers visit factories and workplaces to counsel both men and women about family planning, in addition to safety practices and hygiene.

According to the chief of the OB/GYN department, almost half of the new acceptors choose permanent methods, but no statistics were available to support this. It was also stated that almost twenty percent of the women who deliver in the ISSS hospitals opt for a permanent method.

ISSS maintains stringent controls on actual procedures and norms for its staff, along with continuing training. Certainly, the clients demand service as they are paying at least a portion of the costs.

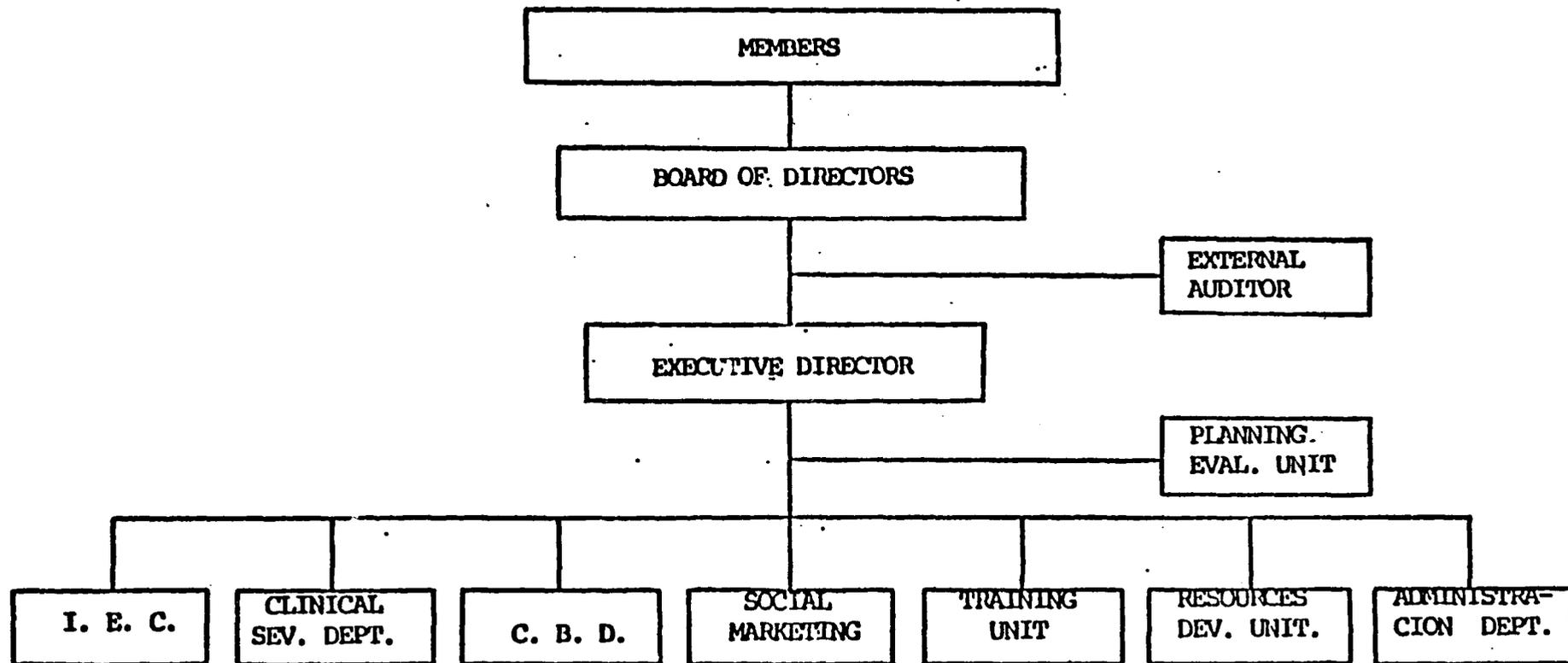
This concludes the narrative report. In the following section are Annexes 1 through 10 and a list of references.

14/6

VI. ANNEXES

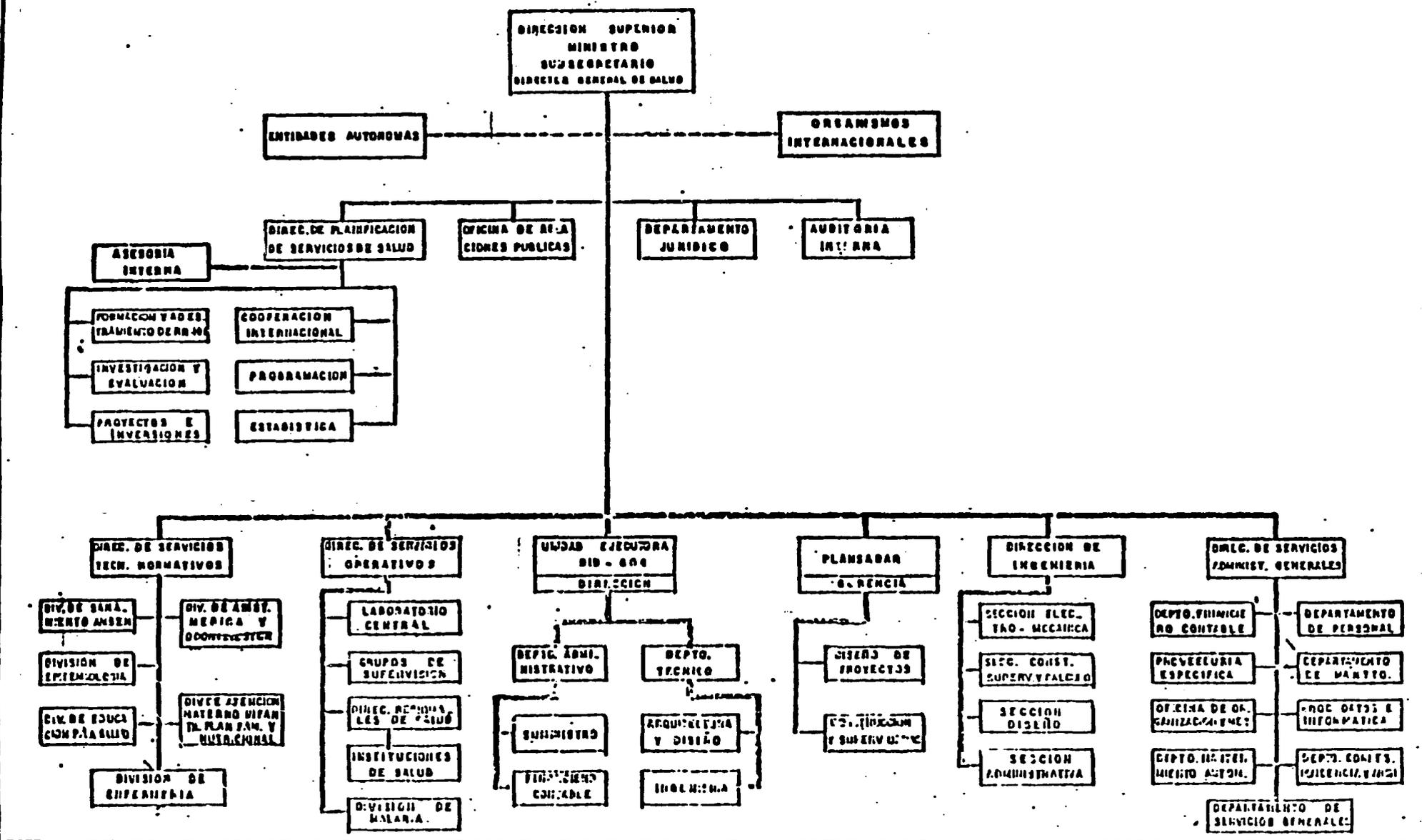
- Annex 1 Organizational Chart of ADS
- Annex 2 Organizational Chart of MOH
- Annex 3 CBD Program Staff as of December 1983
- Annex 4 Geographic Location of CBD Distribution Posts, 1983.
- Annex 5 Organization Chart of I.E.C. Dept. ADS
- Annex 6 Planned and Actual Objectives for Mass Media Campaign 1981-4 (ADS)
- Annex 7 Creation of New Media Materials by year 1981-1984
- Annex 8 Graph Showing No. Registrations in the MOH Family Planning Program by Method, 1969-1983
- Annex 9 Graph Showing Age Structure of Women Registered in the MOH Family Planning Program 1983
- Annex 10 Graph Showing Average No. Living Children from Women Registered in the MOH Family Planning Program by Method (1983)

ASOCIACION DEMOGRAFICA SALVADOREÑA



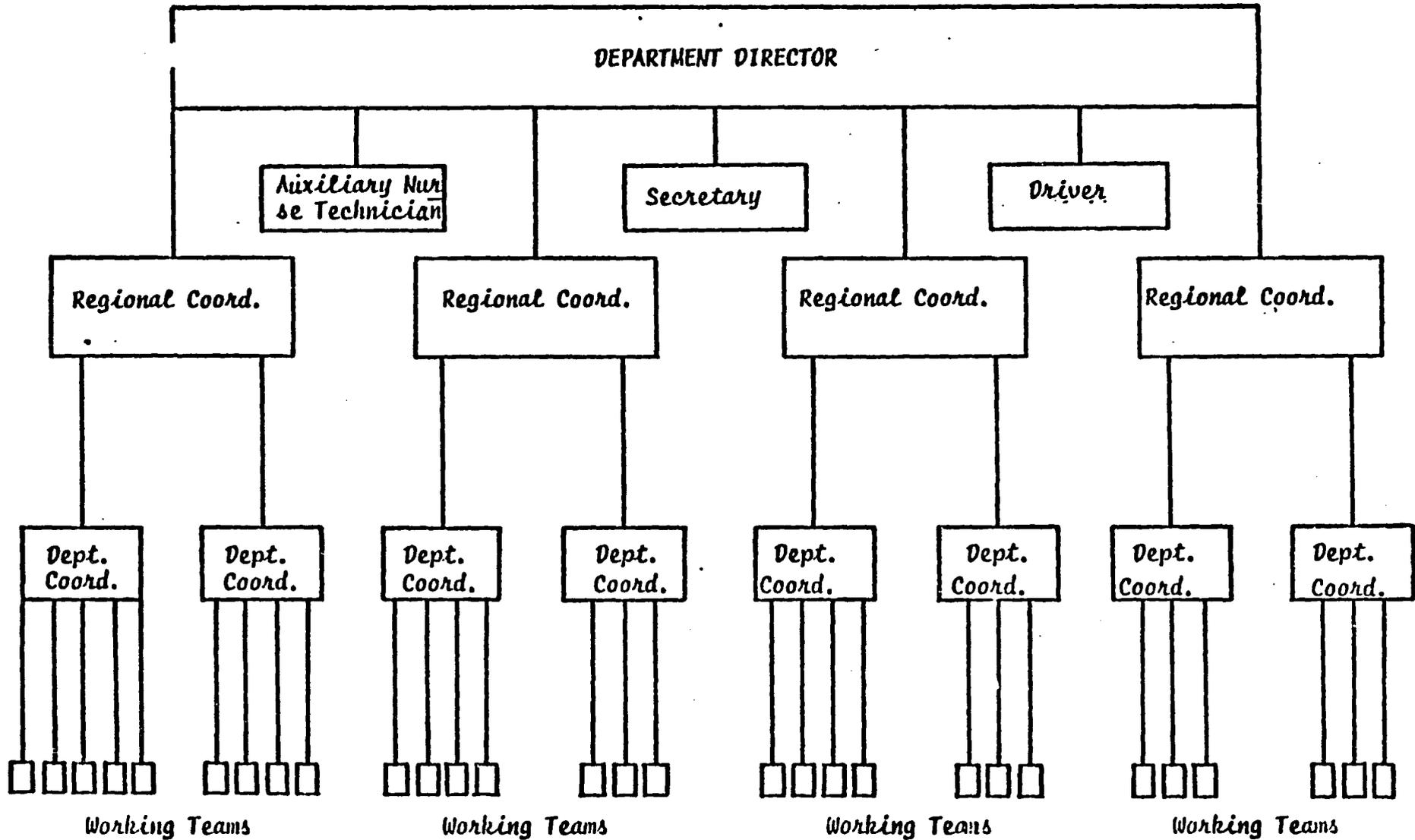
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ORGANIGRAMA DEL MINISTERIO DE SALUD PUBLICA Y ASISTENCIA SOCIAL Annex - 2



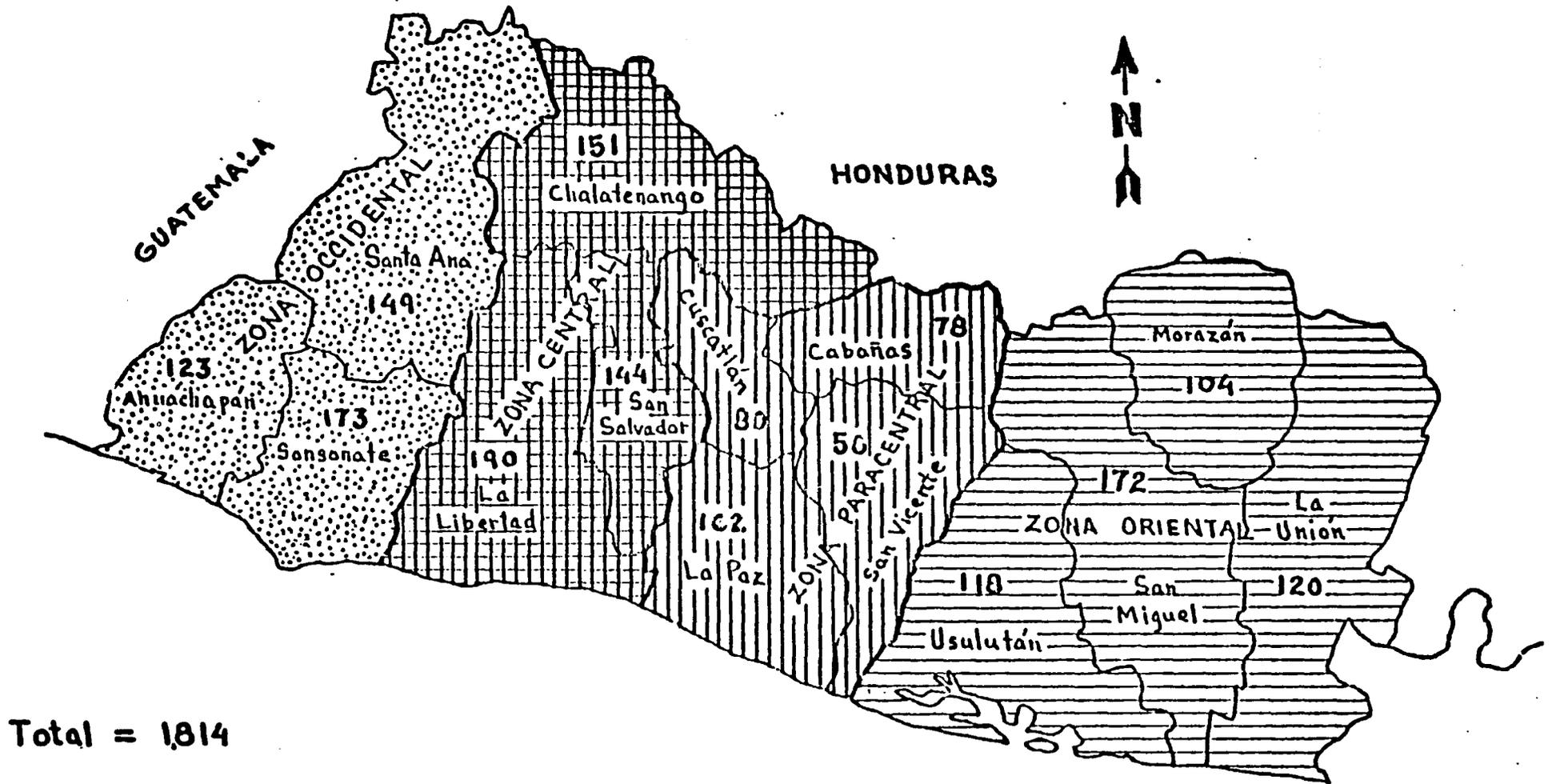
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CBD PROGRAM STAFF AS DECEMBER 1983



150

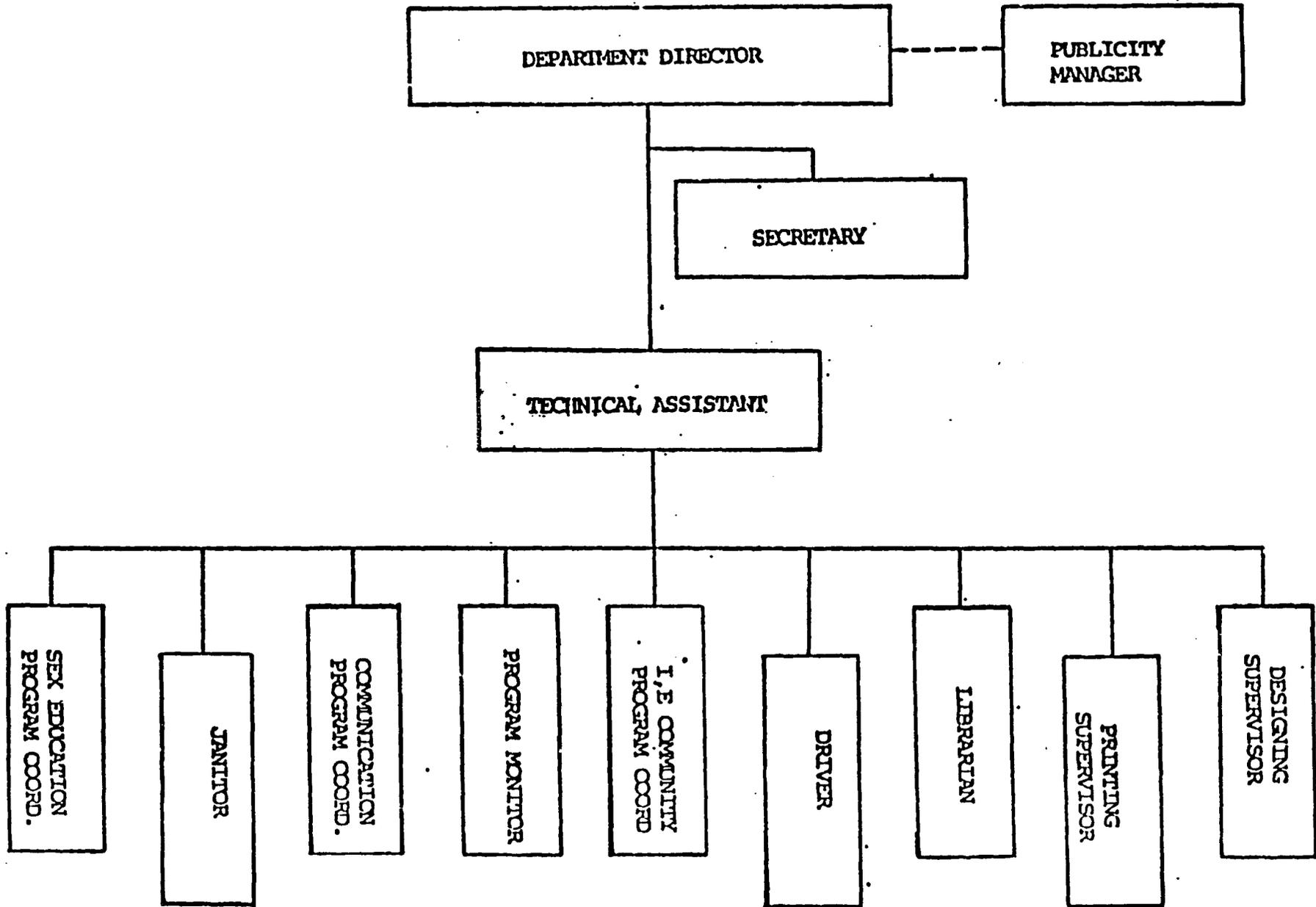
GEOGRAPHIC LOCATION OF DISTRIBUTION POSTS AS OF DECEMBER '83



151

ORGANIZATION CHART OF I. E. C.

DEPT.



152

PLANNED AND ACTUAL OBJECTIVES FOR MASS MEDIA CAMPAIGN, 1981-4

Medium	January 1981 - December 1982			January - December 1983			January Dec./E4
	Planned No. of Messages/Units	Actual No. of Messages/Units	% of Goal Achieved	Planned No. of Messages/Units	Actual No. of Messages Units	% of Goal Achieved	Planned No. of Messages Units
Radio	139,320	83,020*	60%	20,000	20,153*	100.8%	150,000
TV	-	1,522*	-	-	1,310*	-	1,000
Press	-	24	-	-	16	-	?
Pamphlets	210,000	150,000	71%	100,000	117,995	118%	300,000
Posters	110,000	-	0%	60,000	5,545	9.2%	100,000
Calendars	40,000	90,000	225%	40,000	30,000	75%	25,000
Metal Signs	1,400	805	58%	-	390	-	700
Pencils							28,800
Publications							24,000
Message Pre-Tests							37

*50% of all radio and TV spots are donated by broadcasting companies.

157

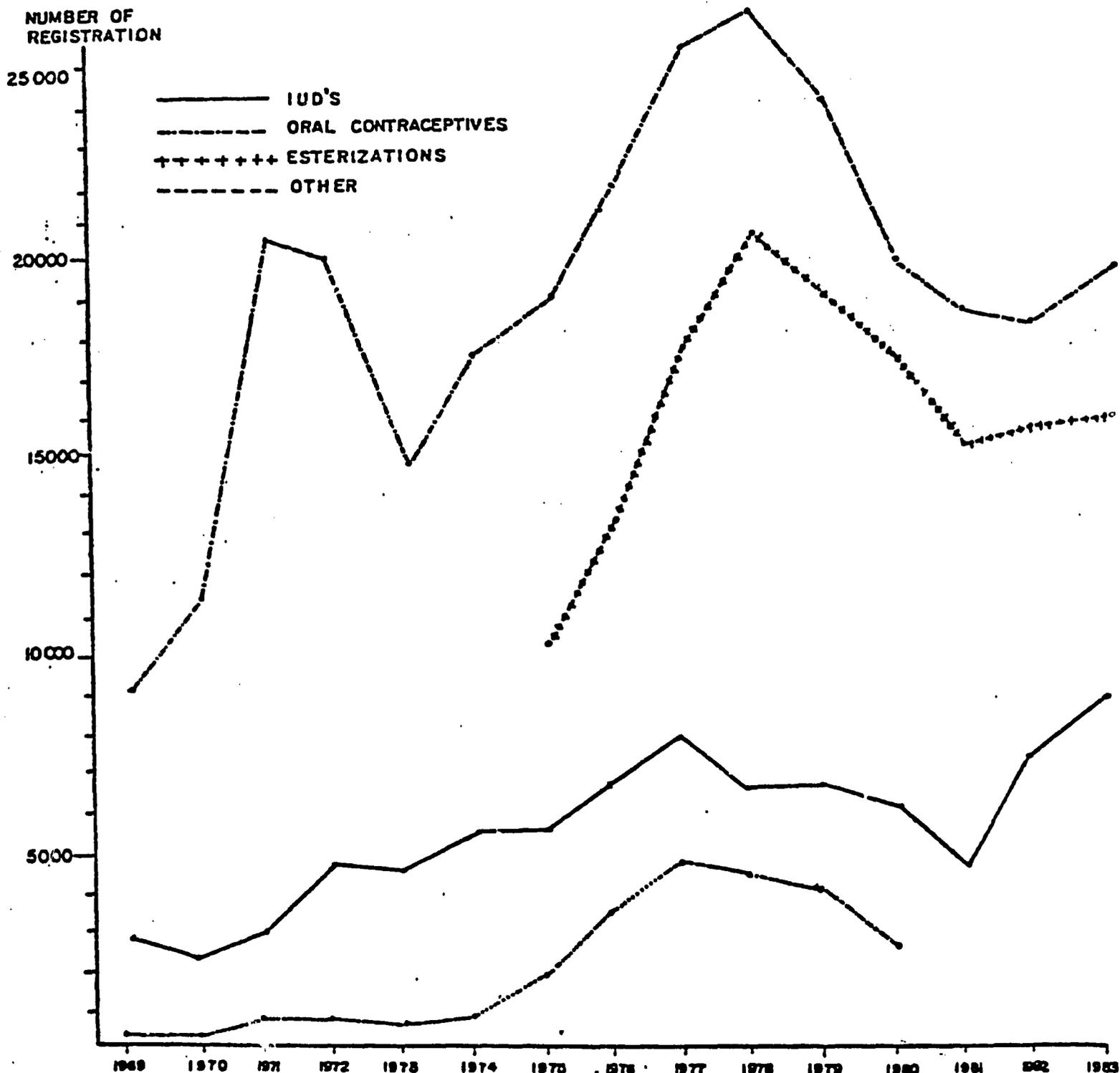
Creation of New Media Materials by Year

Material	1981-2	1983	1984 (Planned)
Radio Spots	13	-	6
Soap Operas	5	-	-
Mini Programs	5	-	-
TV Spots	2	2	2
Press Releases	-	16	2
Pamphlets	-	10	6
Posters	-	-	3
Metal Signs	-	-	1
Calendar	1	1	1
Publications	-	-	2
Pencils	-	-	3

154

FIGURE 1

NUMBER OF REGISTRATION ON VISITS IN THE FP PROGRAMME
M P H / S A (1969-1983)



SOURCE : BULLETINS OF ESTADISTICS 1969-1982, DEPARTAMENT OF ESTADISTICS, MINISTRY OF PUBLIC HEALTH AND SOCIAL WELLGRING

: ESTIMATIONS BASED ON STATISTICAL DATA JAN-JUN 1983

15

FIGURE 2
AGE STRUCTURE FROM WOMEN REGISTERED IN THE
FAMILY PLANNING PROGRAMME
MPH/SA 1983

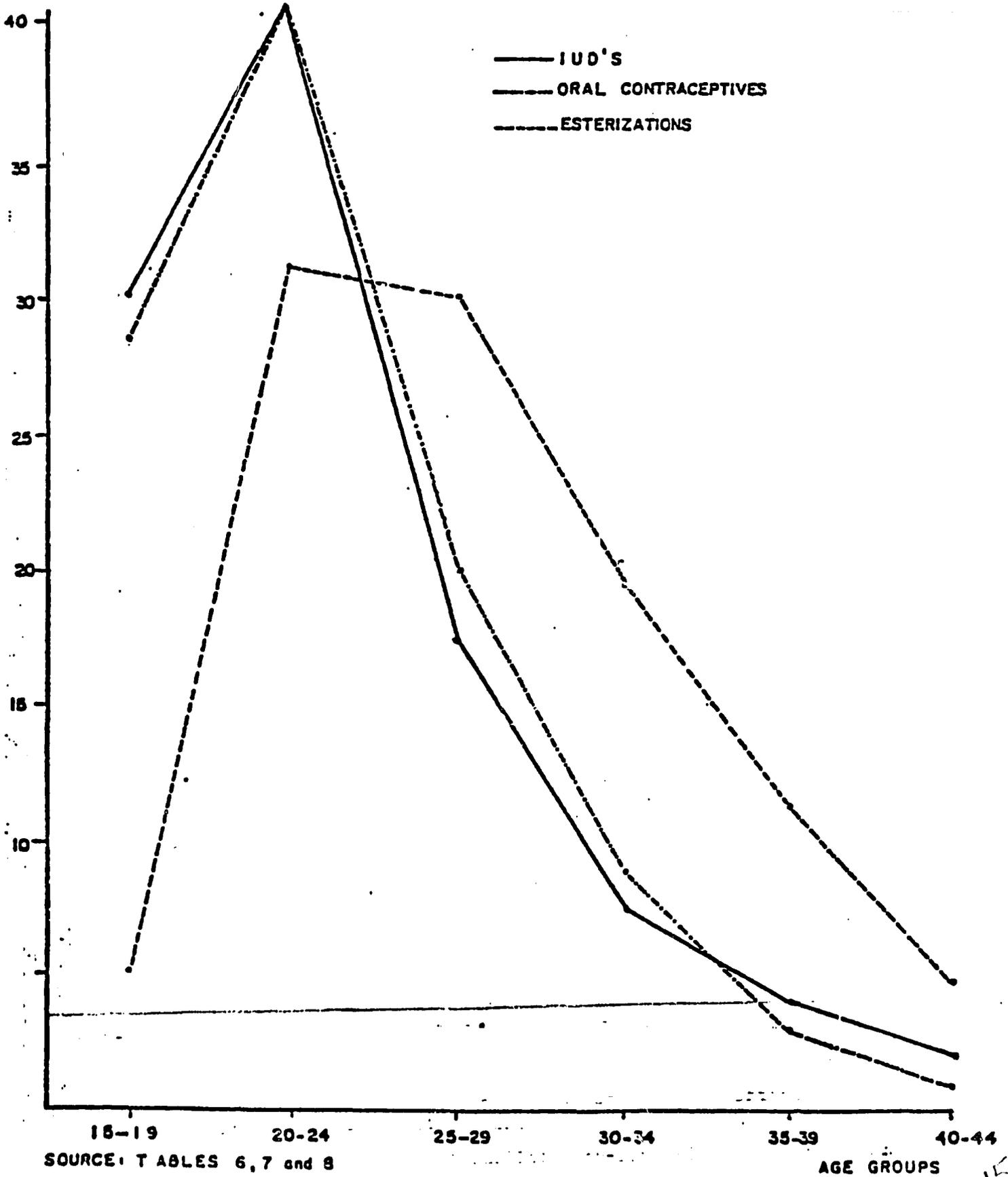
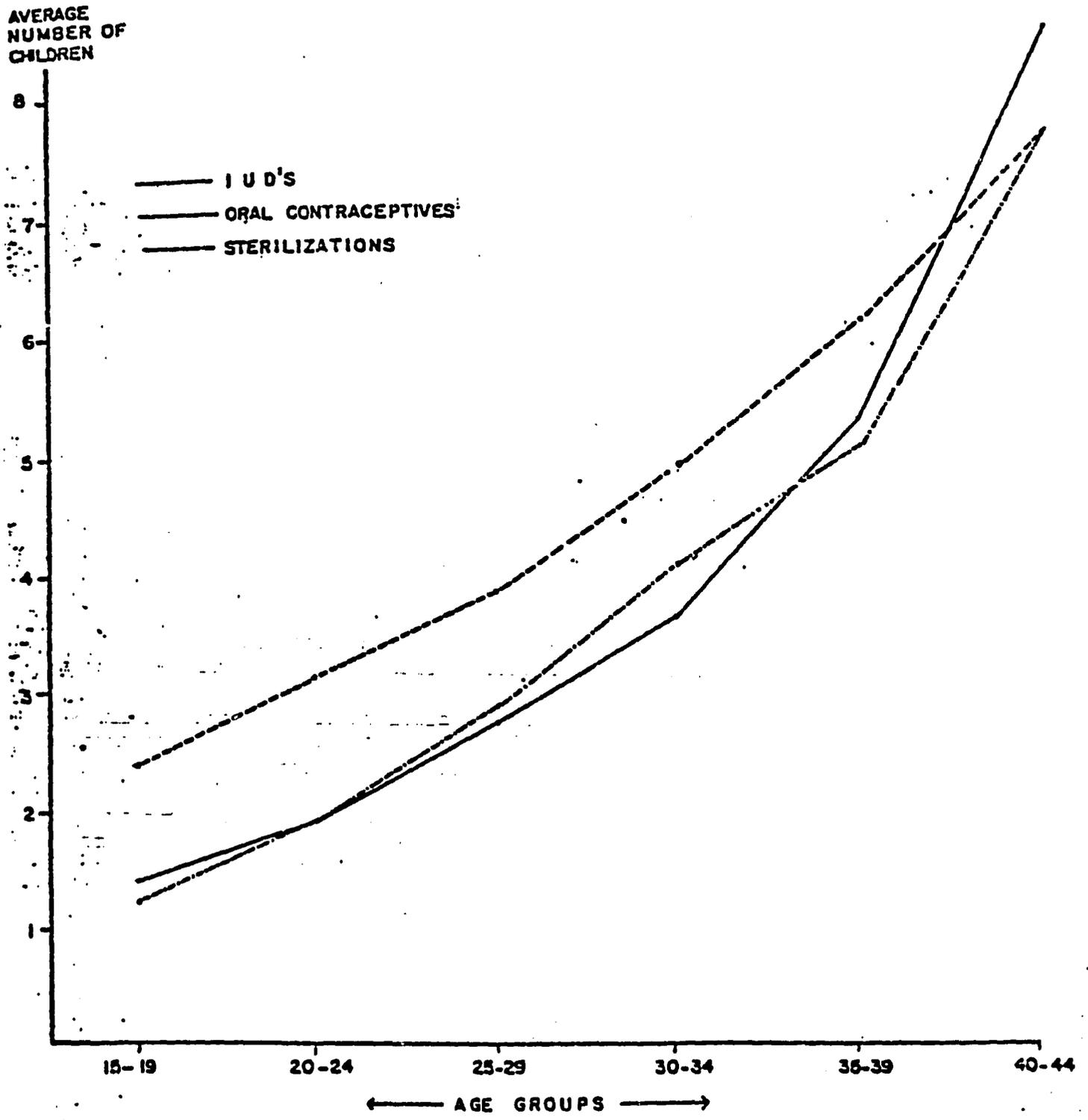


FIGURE 3
 AVERAGE NUMBER OF LIVING NEWBORNS FROM WOMEN
 REGISTERED IN THE FAMILY PLANNING PROGRAMME
 (BY METHOD)
 MPH / SA (1983)



SOURCE: Bulletins of Estadistics 1969-1982, Departament of Estadistics, Ministry of Public Health and Social Wellgring.
 Estimations Based on StatisticalData Jan-Jun 1983.

151

VII. LIST OF REFERENCES

- Una Evaluacion del Programa Nacional de Planificacion Familiar de El Salvador - APHA Team Report - July, 1980.
- Estadisticas de Servicio en el Programa de Planificacion Familiar del Ministerio de Salud Publica y Asistencia Social - Horacio F. Gutierrez, PAHO Consultant to MOH - November, 1983.
- Informe Anual de Labores - 1980 -1981-1982-1983 - Asociacion Demografica Salvadorena.
- Informe del Estudio sobre Caracteristicas de Aceptantes del Programa de Planificacion Familiar inscritos en el Programa Medico Clinico de ADS en 1980, 1981 y 1982 - Evaluation Unit, ADS, February, 1984.
- Estudio sobre Necesidades de Informacion y Beneficios recibidos por el Uso de Anticonceptivos en Usuaris del Programa de Planificacion Familiar - Final Report - Evaluation Unit, ADS.
- Informe de los Resultados del Estudio Numero de Relaciones Sexuales por Semana, de las Usuaris de Anticonceptivos del Proyecto de DCA, Region Oriental - Evaluation Unit, ADS, 1981.
- Proyecto Piloto para la Implementacion de Recomendaciones del Estudio del Itinerario de Usuaris de Planificacion Familiar en los Establecimientos de Salud de la Region Occidental del pais. Maternal and Child Health Division, MOH - February, 1982.
- Informe del Proyecto MOH/AID No. 519-0149 - Period July/81 - Dec/31/1982 - Direccion de Servicios Operativos de Salud, y Division Materno-Infantil y Planificacion Familiar, MOH - April, 1983.
- Cuadro Resumen de la Poblacion Desplazada a Nivel Nacional, por Departamento al 31 de Diciembre de 1983 - Comision Nacional de Asistencia a la Poblacion Desplazada "CONADES" - Undated.-
- Proyecto Piloto de Usuaris Satisfechas de Planificacion Familiar. Division Materno-Infantil, Nutricion y Planificacion Familiar - MOH - April , 1982.
- Quarterly Reports sent to AID from ADS - 1981 - 1983.
- Family Planning Program Report - OCOPLAF, 1969 - 1983.

- El Salvador Project Paper Health Systems Vitalization (AID/LAC/P-150 - Sept. 1983.
- Documentacion del Programa de Ayudantes Rurales: Lineamientos de la Direccion Superior, Programa de Adiestramiento, Instrumentos de Evaluacion, Manual del Ayudante, Jornadas de Educacion Continua en 1983.
- Strategy Document for year 1984 - ADS.
- ADS Proposal for USAID funding in 1984.
- Strategy of Communication in Population and Family Planning in El Salvador: 1979-83.
- Evaluation of Family Planning Communications in El Salvador (Bertrand, et al).
- International Contraceptive Social Marketing Project Advertising Agency Assessment, Aragon & Associates, 1983.
- Film Catalog, ADS.
- Organizational Manual for the IEC Department.
- AID Project Documents, 1978 - 1983.
- Monthly ADS Monitoring Control Reports, 1980 - 1983.
- Radio & TV Rating Data.
- TV Programming Data.
- Mass Media Campaign Plans '84.
- Contract with Rumbo Agency
- Recommendations for Selecting a new agency, ADS 1983.
- Study of the Information Needs and Benefits Perceived for FP Users.
- Scripts and pamphlets from Ministry of Health and ASG.
- Marketing Study, Consultores en Mercadeo de Centroamerica.
- Organization Manual, Department of Administration and Finance, ADS.

159