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EVALUATION OF THE
EL SALVADOR POPULATION DYNAMICS
(REPRODUCTIVE HEALTH)
PROJECT (519-0210)

by

William D. Bair
Juan Ricardo Braun
John Massey
Robert J. Murray

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Population Technical Assistance Project
DUAL & Associates, Inc. and International Science
and Technology Institute, Inc.
1601 North Kent Street, Suite 1014
Arlington, Virginia 22209
Phone: (703) 243-8666
Telex: 271837 ISTI UR
FAX: (703) 358-9271

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Glossary

ANTEL	National Telecommunications Agency
AVS	Association for Voluntary Sterilization
CBD	Community based distribution
CCC	Cambridge Consulting Corporation
CDSS	Contraceptive Prevalence Survey
CYP	Couple year of protection
EEC	European Economic Community
FESAL	National Health Survey
GOES	Government of El Salvador
HEU	Health Education Unit (MOH)
HID	Health Information Designs, Inc.
HMO	Health maintenance organization
HTS	Health Training School
IEC	Information, education, and communication
IP	Interpersonal
ITC	Inter-Institutional Technical Committee
IPPF	International Planned Parenthood Federation
ISSS	Salvadoran Social Security Institute
MCH	Maternal and child health
MCH/FP	Maternal and child health/family planning
MIPLAN	Ministry of Planning
MIS	Management information system
MOE	Ministry of Education
MOH	Ministry of Health
PO	Population Office

POPTECH	Population Technical Assistance Project
RHA	Rural Health Aide
SATU	Special Administrative and Technical Unit
SDA	Salvadoran Demographic Association
SETEFE	GOES unit for coordinating foreign assistance
SOW	Scope of work
STD	Sexually transmitted disease
TA	Technical assistance
TBA	Traditional birth attendant
TC	Training Committee
TFR	Total fertility rate
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development (Mission)
VSC	Voluntary surgical contraception

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The evaluation team wishes to express its appreciation for the unlimited collaboration we received from the many persons and institutions contacted in this evaluation.

Both the Minister and the Director General of Health made time in their busy schedules to discuss the project with us. The executive and technical staffs of the institutions which comprise SATU -- the Ministry of Health, the Social Security Institute, ANTEL, the Ministry of Planning and the Salvadoran Demographic Association -- were extremely helpful in providing insights and specific information.

The Executive Director of SATU was especially helpful in supplying needed documents, arranging field visits and providing an important GOES perspective. The Cambridge Consulting Corporation provided administrative assistance, necessary documentation and considerable insights into project operations. Persons contacted in a field visit to the occidental and the central regions were friendly and frank in their description of their work related to this project. USAID's detailed preparation of the scope of work, initial briefing and quick response consultation throughout the evaluation process was much appreciated.

Finally, we were most appreciative of the excellent secretarial support provided throughout preparation of this report.

Executive Summary

Preface

The El Salvador Population Dynamics (Reproductive Health) Project (519-0210) is making solid progress in accomplishing its desired outputs. Given the difficulties inherent in implementing programs in El Salvador, the accomplishments made to date are remarkable. In administration, after a rocky start, the flow of funding for advances and liquidations has been smoothed out, and coordination and program implementation can now become the priority of SATU staff. The training component has exceeded its goals in terms of numbers of trainees, although some important groups have not yet received training. Although there might have been better coordination between mass media and interpersonal promotional efforts, first-rate campaigns were diffused through radio and TV and excellent printed materials were produced. Finally, a very fine beginning was made toward establishing a solid system for contraceptive logistics and equipment maintenance, with an accompanying management information system.

Despite solid progress in accomplishing the desired outputs, family planning service indicators (the bottom line in projects like this) increased only in the private sector program, which is also supported by other A.I.D. projects. Very encouraging, however, was the definite upturn in service numbers noted in 1989 for the major provider, the GOES, perhaps indicating that a favorable trend is developing.

The Context

With a population exceeding 5 million living in a total land area of 8,600 square miles, El Salvador is the most densely populated country of the Western Hemisphere. Following 25 years of family planning programs, contraceptive prevalence had reached as high as 45 percent by 1985 but was disproportionately lower in the rural areas and among younger couples. This produced a continuing high total fertility rate of 5.6 children per woman in the rural areas and 3.8 in the urban areas.

The Project

The project was designed primarily to improve and expand on provision of family planning and reproductive health services by strengthening the institutions, particularly in rural areas, that already provided services to Salvadoran couples. Efforts were directed mainly toward coordinating the efforts of these institutions, both to stimulate demand for family planning services and to improve the quality of the services provided.

The project was divided into two subagreements: one with the Government of El Salvador (GOES) amounting to \$7,105,000 that covered support for public institutions, and the other with Salvadoran Demographic Association (SDA) totaling \$2,895,000, mainly to provide support for the GOES information, education, and communication (IEC) campaign. Both agreements were signed August 29, 1985. Due to delays especially in the initial stages, the original project completion date, Oct. 30, 1988, was extended to June 30, 1990.

The project includes five project components:

- **Administration** -- through a Special Technical and Administration Unit (SATU) to provide coordination, technical assistance and administrative support to four GOES institutions (Ministry of Health [MOH]), Salvadoran Social Security Institute [ISSS] and the National Telecommunications Agency [ANTEL] and the Ministry of Planning [MIPLAN]), together with the private sector SDA.
- **Training** -- to upgrade skills of service providers and of motivators and educators.
- **Information, Education and Communication (IEC)** -- to promote changes in attitudes and behavior to increase the use of family planning services.
- **Management Information System (MIS), Logistics and Maintenance** -- to improve the contraceptive supply system and maintenance of medical equipment and to provide management information.
- **Policy** -- to improve the policy climate for expanded family planning services.

The Evaluation

The Population Technical Assistance (POPTECH) Project provided four international consultants experienced in family planning management, training, IEC and management systems/logistics to carry out an interim evaluation of the project between August 28 and October 10, 1989.

The scope of work for the evaluation consisted of a series of specific questions to be answered regarding the five project components. The evaluation team based its responses to these questions on interviews with project personnel, reviews of project reports and related documents, and field visits, although the latter were limited by security considerations.

Two earlier evaluations were reviewed: the Development Associates evaluation of SATU, dated April 1987, and a subsequent evaluation of SATU, dated September 1988, by a Salvadoran firm, Annichiarico and Gonzalez. Both provided in-depth perspectives on the fiscal and administrative problems facing SATU as it dealt both with A.I.D. and with the GOES bureaucracy.

Progress to Date

Through July 1989, the project had incurred expenditures of 62 percent of its authorized budget. Despite the substantial initial delay and subsequent difficulties in maintaining a smooth financial flow and consistent supply of goods and services, the project has made significant progress in several important respects:

- SATU and a Special Health Commission were formed and have met regularly to provide the coordination, policy and management decisions required for the project.
- 159 person months of technical assistance were provided by Health Information Designs (HID) and its successor contractor, Cambridge Consulting Corporation (CCC).
- Training targets were exceeded, with the GOES and SDA institutions

together training 118 percent of the number planned.

- A mass media IEC campaign was carried out, which reached nearly 4 million persons.
- A management information system (MIS) was developed that is improving contraceptive logistics and producing service statistics in a timely and orderly fashion.
- A National Population Policy was approved September 1988.
- The National Health Survey (FESAL 88) was completed in 1988.
- Over the period 1986 to 1988, there was an overall increase of 10 percent in family planning coverage, but this reflected growth only in private sector (SDA) service provision, an effort supported by other projects in addition to this one. During the last year, from 1988 to 1989, there was a 12 percent increase in couple years of protection (CYP) provided by the public sector, however.

Response to Specific Questions of the Scope of Work

Answers to all the questions of the Scope of Work have been provided, detailing both successes and shortcomings in each of the component areas. These answers are summarized in the conclusions section (7) below.

Relation to Mission Strategy

This project relates directly to mission strategy, which recognizes the need to reduce high rates of population growth largely through expansion of family planning programs. The project meets strategy objectives of strengthening service institutions and prepares the ground for better targeting of service delivery to high risk populations in rural and urban areas.

Conclusions

Summary

Although substantial progress was made in each project component, much remains to be done to consolidate the advances into more effective family planning services. The degree of progress must be judged in the context of the extraordinarily difficult conditions that persisted throughout the project period. Earthquake, civil disturbance, economic decline, exodus of personnel and disruption by municipal and national elections all acted as constraints to the normal conduct of business.

Project Components

- **Administration.** SATU and the Special Health Commission provided effective forums for coordination, planning and monitoring of activities. Annual plans outlined activities and budgets consistent with project objectives. Failure to articulate specific objectives and strategies to achieve them, or to develop plans for monitoring and supervision, may have contributed to some weakness in implementation.

The administrative problems of maintaining an adequate flow of funding and assuring

timely procurement of goods and services had the most severely limiting effect on project progress. All the implementing agencies involved -- A.I.D., the GOES institutions participating in the project, and the government organization that coordinates foreign assistance (SETEFE) -- contributed to the complex administrative situation. The situation, whose roots were inherent in the structure itself and compounded by the various agencies' performances, sorely taxed SATU's administrative capability. Earlier evaluations confirmed that the problems had existed from the start of the project.

Although effective in the technical areas of MIS, training and IEC, the technical assistance provided in management and administration was not as successful in helping SATU solve the myriad problems of dealing with the several layers of GOES and A.I.D. bureaucracy. Physical separation of the TA team from GOES counterparts meant that communication between them was less than adequate and that readily identifiable counterpart relationships could not easily be developed. Careful attention to working relationships and transfer of responsibility is imperative in the remaining months of the project.

- **Training.** Substantial success was achieved in this component: Training of generally acceptable quality was provided to numbers of personnel 20 percent above the planned targets. Although the training emphasized those working in the rural areas, some groups such as Rural Health Aides, doctors in their initial year of service and graduate nurses could have received more attention. Reasonable attention was given to modern pedagogic methods, but course design could have been more closely linked to specific jobs and more emphasis could have been placed on curricula validation.
- **IEC.** An effective mass media campaign, planned and implemented in a technically appropriate fashion in 1988, reached nearly 4 million persons. Some of the impact of this campaign was lost due to a delay in implementing the companion interpersonal communication campaign.
- **MIS, Logistics/Maintenance.** The management information system, planned initially to improve the distribution and warehousing of contraceptives, has been effective in this area. In addition, its capabilities have been expanded to include production of orderly and timely service delivery information that emphasizes CYPs as a measure of progress. Various tasks remain to be completed, including transferring this technology to national counterparts, completing the training and operational manuals, and installing the system in the SDA.

Success has not been achieved in improving maintenance of medical equipment due primarily to procurement problems, possibly compounded by less than adequate commitment to concepts of preventive maintenance.

- **Policy.** Achieving the adoption of the National Population Policy was a noteworthy achievement. MIPLAN efforts to disseminate this policy have lagged, however, as have actions on population research and the creation of a population data bank.

Other accomplishments in the policy area included SDA's completion of FESAL 88 and MOH's development of several important policy documents. Although the present administration's policy on population is not yet clear, it appears to be at least as favorable as that of its predecessors.

Lessons Learned

In summary the lessons learned are as follows:

- **Administration**

1. Projects involving institution building and developing the capability to conduct coordinated planning should anticipate at least a five-year time frame.
2. Complicated bureaucratic structures should be avoided. If they are required, substantial administrative and financial management assistance is essential.
3. Technical assistance should be provided through a close, day-to-day working relationship with identified counterparts.
4. To be effective in integration with multiple health activities, family planning must receive some special attention.
5. Equal attention must be paid to monitoring programmatic functions as that given to fiscal matters.

- **Training**

1. To achieve desired changes in service delivery, equal attention must be given to training for the local policymakers and decision makers who organize services and establish priorities (doctors and nurses) as to lower-level service providers.
2. Both initial training needs assessment and a periodic review of training outcomes on the job are required.

- **IEC**

1. A coordinated blend of all the elements of mass media and interpersonal communication is required for an effective IEC program.
2. More resources, time and energy are required for interpersonal campaigns, which are more difficult to develop.

- **MIS, Logistics/Maintenance**

A computerized logistics management system can be effective in improving contraceptive supply as well as providing a service statistics system that can be operated by service point staff.

Recommendations

The recommendations summarized below are divided into short-term (until the end of the project June 1990) and long-term (for future project development).

Short-term

■ Administration and Planning

1. A local financial analyst should be contracted for three to six months to assist in completing all project fiscal matters and to help to make projections for the future.
2. CCC should immediately initiate a phase down/phase over plan of action to shift responsibility to GOES counterparts.
3. USAID, CCC and the SATU Executive Director should meet weekly to resolve any program or interpersonal problems or misunderstandings.
4. SATU members should develop and adhere to a rigorous schedule of meetings dedicated to setting priorities, monitoring progress and planning future programs.
5. Analysis of pending evaluations should be carried out.

■ Training

1. SATU should reactivate the Inter-Institutional Training Committee to review performance and strategies and to set priorities among pending training actions.
2. The reactivated Training Committee should hold a one- to two-week workshop to analyze content and focus of high volume training programs.
3. The Training Committee should complete design efforts for training community-level workers.

■ IEC

1. SATU and MOH should carry out the planned interpersonal communication campaign.
2. The ITC and the contractor, Johns Hopkins University Population Communication Services project, should carry out the impact evaluation of the mass media campaign.
3. SATU should give priority to acquiring basic low cost audiovisual equipment and expedite its procurement.

■ MIS/Logistics/Maintenance

1. SATU and the technical assistance team should make arrangements for an evaluation of the MIS.

2. The technical assistance team should complete the documentation for the MIS.
3. The technical assistance team should install the MIS in SDA.
4. The technical assistance team should program central- to local-level feedback reports into the MIS.
5. The technical assistance team and the MOH should transfer the central-level MIS to MOH immediately.
6. SATU and the technical assistance team should institute a preventive maintenance program immediately.

■ **Policy**

1. MIPLAN should carry out the planned actions to disseminate the population policy.
2. CCC technical assistance should be utilized to develop the initial phase of the Data Bank.
3. MOH should issue a directive assigning priority attention to reproductive health.
4. MOH should adopt the strategy for extension of family planning services to the rural areas.
5. MOH should approve and disseminate the norms for reproductive health.

Long-Term

■ **Planning and Administration**

1. Support should be continued for positive aspects of this project in coordination, training, reproductive health service delivery and IEC. Higher priority should be given to family planning.
2. Alternatives for future project administration must avoid difficulties encountered in this project. (i) Alternatives should be considered to the present cumbersome system with its layered bureaucracies; (ii) the responsibility of technical assistance personnel in support of GOES institutional capability must be clearly delineated; (iii) administrative personnel trained by the project should be retained within the system; and (iv) USAID should review its accounting, procurement and disbursement procedures, including consideration for a 180-day limit for advances.

■ **Training**

1. Long-term technical assistance for training should be contracted.
2. Two long-term international training scholarships in training methodology should be provided.

3. Discrepancy analysis for high volume course should be included and a supervisory system to maintain skill-level data should be implemented.
4. Refresher training for key field-level physicians, graduate nurses and auxiliary nurses should be included.
5. Awareness building courses for change agents should be supported.

- **IEC**

Mass media and interpersonal communication should be well coordinated in any IEC campaign.

- **MIS, Logistics/Maintenance**

1. Initial MIS design must be closely coordinated with institutional technical personnel at the central level so as to assure consistency among information systems.

2. Biomedical equipment supply efforts should be coordinated among users and donor agencies.

- **Policy**

1. UNFPA should be urged to continue general support to MIPLAN with selected USAID assistance to be provided through centrally funded policy projects.

2. USAID should support SDA in seeking policy change leading to greater access to quality family planning services, especially in the private sector.

1. The Context

El Salvador is the most densely populated country in the western hemisphere, with a population of more than 5 million living in a total land area of 8,600 square miles. A.I.D. assistance to the family planning program in El Salvador began 23 years ago with a grant to the Salvadoran Demographic Association (SDA) (project 519-0149), the private sector family planning association. Shortly thereafter, in 1967, A.I.D. began providing assistance to the Ministry of Health (MOH) under the same project. Assistance to the Salvadoran Social Security Institute (ISSS) began in 1970 and ended in 1980.

In 1985, when plans were being made for a new USAID project, it became clear that the focus should be on improving and expanding the provision of family planning and reproductive health services to Salvadoran couples in rural areas and in younger age groups. Significant improvements in contraceptive prevalence had been taking place among women in fertile age in union -- from 35 percent in 1978 (based on the 1978 Contraceptive Prevalence Survey [CPS]) to 46 percent in 1985 (based on the 1985 National Health Survey [FESAL]). Most of these increases, however, seemed to occur primarily in urban areas and among women midway or near the end of their reproductive lives. Indeed, when rural/urban prevalences found in the 1978 CPS were compared with the results of the 1985 FESAL, the disparity between the two had not substantially changed. The data indicated a particularly high unmet demand for services in rural areas. Estimates were that the total fertility rate was still as high as 5.6 for rural women, compared with 3.8 for urban women. These high rates contribute to problems of poor maternal and child health (MCH), family welfare and a population growth rate inconsistent with the country's economic development objectives.

The 1985 FESAL showed that 95 percent of all users received their contraceptives from four sources: the MOH, the ISSS, the SDA and commercial pharmacies. Fully 90 percent of all rural users were reached by either the MOH (71 percent) or SDA (19.3 percent), with only 8 percent served by ISSS or pharmacies.

The strategy that was designed to increase prevalence focused on both the **demand** for services and the **supply** of these services. On the demand side, the focus would be on activities designed to inform and motivate potential users to seek services, especially younger rural women. On the supply side, the emphasis would be on actions to assure the continuous availability of program commodities, equipment and trained personnel to deliver the family planning services. As an important corollary to improving demand, project designers sought to foster a policy climate that would be favorable to family planning programs. Similarly, as an adjunct to improving supply, efforts were included to foster coordination among the major service providers.

2. The Project

2. The Project

2.1 Organization

Against the background of lower use of contraceptives by rural, younger couples and the recognition of shortcomings in coordination of existing efforts, this project, the El Salvador Population Dynamics (Reproductive Health) Project (519-0210), was signed August 29, 1985 between the USAID and the Government of El Salvador (GOES) for \$7,105,000 in grant funds. A companion cooperative agreement was signed on the same date between USAID and the Salvadoran Demographic Association (SDA), for \$2,895,000 in grant funds. Due to implementation delays, the original project completion date, October 30, 1988, was extended on two occasions to June 30, 1990. Thus, what was originally conceived of as a three-year project has been extended to a five-year effort.

Four GOES institutions were involved in the project: the MOH, the ISSS, the National Telecommunications Agency (ANTEL), and the Ministry of Planning (MIPLAN). The MOH was to implement the greater part of the GOES project activities, including service delivery, most training activities, conduct of the interpersonal information, education, and communication (IEC) campaign, and the policy initiatives. ISSS and ANTEL were largely users of the training, equipment, and IEC provided by the project. MIPLAN was to promote adoption and dissemination of a National Population Policy. The role of SDA, which has a broad spectrum of clinical and non-clinical family planning information and service programs, consisted primarily of conducting a mass media IEC campaign and training. These activities were to be directed largely to other ministries involved only peripherally in actual project administration.

To coordinate the activities of these various organizations, the project called for the formation of a Special Health Commission, a high-level coordinating policy planning group to include chief executives of the MOH, the ISSS, ANTEL's health service, MIPLAN, and SDA. Additionally, a project technical and administrative coordinating group (the Special Administrative and Technical Unit -- SATU) was to be organized, composed of a Technical Advisory Group (technical-level representatives of the above mentioned organizations), an Executive Directorate chaired by the Director General of the MOH and staffed with administrative personnel, and a technical assistance team to be contracted by the project.

SATU, together with the inter-institutional technical committees that it organized (primarily for IEC, training, and logistics¹), provide the forum for technical coordination, program planning, and monitoring of progress. SATU also handles all fiscal and administrative aspects of the A.I.D. - GOES grant agreement. This entails dealing through SETEFE, the GOES institution for coordinating foreign assistance, and the "Corte de Cuentas," the GOES agency whose functions are similar to those of the U.S. Office of Management and Budget.

SDA deals directly with A.I.D. on the financial aspects of its cooperative agreement, but has participated in the coordination meetings mentioned above.

Two institutional contractors, Health Information Designs, Inc. (HID) and Cambridge Consulting Corporation (CCC), which took over the contract in the spring of 1988, have provided a total of approximately 159 person months of long- and short-term technical assistance for all project activities.

¹Three committees not included in the original plans were added later: on cancer detection, infertility, and sexually transmitted disease.

2.2 Project Purpose and Objectives

The project purpose, as described in the Project Paper, was "to improve and expand provision of family planning and reproductive health services, by strengthening those institutions, particularly in rural areas, which presently provide services to Salvadoran couples."

To achieve this overall purpose, the project had five components to strengthen those institutions already providing services. These components were as follows:

- **Administration** To provide a mechanism (SATU) to improve the coordination, planning and monitoring of all project activities.
- **Training** To upgrade skills of providers in the MOH, ISSS, SDA, ANTEL and other participating institutions in service delivery, IEC, logistics and maintenance, and community and patient motivation. SDA would provide training for change agents such as teachers and promoters from other ministries, primarily the Ministries of Education, Agriculture and Interior.
- **Information, Education and Communication (IEC)** To promote attitudes and behaviors that increase the use of family planning and reproductive health services. To achieve this objective the project was expected to expand the existing educational services of the participating organizations and develop new campaigns targeted at rural areas.
- **MIS/Logistics/Maintenance** To develop a logistics and maintenance system to track family planning commodities through the supply systems of participating institutions, improve contraceptive warehouse management and develop an improved maintenance program for clinical equipment and medical facilities. In support of the improved logistics and maintenance systems, a management information system (MIS) was to be developed.
- **Policy** To promote adoption and dissemination of a National Population Policy, train policy and decision makers, and develop strategies and policies for provision of services to the rural sector.

3. The Evaluation

3.1 Team Composition and Timing

The evaluation team was composed of specialists in four areas, namely: i) management of family planning programs, ii) management information systems and logistics, iii) information, education and communication, and iv) training. The management consultant also served as team leader. The evaluation was carried out through the Population Technical Assistance (POPTECH) Project between August 28 and October 10, 1989.

3.2 Purpose of the Evaluation and Scope of Work

The purpose of this interim evaluation, as modified in discussions with the USAID project manager, was to assess the overall performance of the project against its targets. Specific recommendations were to be provided aimed at improving project implementation, primarily through elimination or reduction of major problems and bottlenecks.

The Scope of Work (SOW) consisted of a series of specific questions or tasks, arranged by major component of the project. These questions form the basis for the report (see Appendix A). In discussion with the USAID project manager, the SOW was modified slightly with the deletion of questions calling for comparisons with activities that took place before the project period and the clarification of others. The consultants were instructed to closely follow the amended list of questions, both in their research and in the organization of the report. Although the questions were primarily directed toward the project components of administration, IEC, training, MIS/logistics/maintenance, and policy, the evaluation team also gave some attention to the outcomes in service delivery.

3.3 Methodology

Data for this evaluation were collected through a variety of means: individual and group interviews of key personnel, review of training consultant reports, review of prior external and implementing agency evaluations of the project, review of USAID records (expenditure reports, semi-annual reports, etc.), review of actual materials produced under the project (i.e., educational materials, software, training curricula, etc.), conversations with consultants on other USAID projects, and a field trip to selected locations. Anecdotal comments were collected from recipients of training at the various levels. These data are not dealt with separately; rather, they are integrated into the narrative.

Although each consultant was ultimately responsible for the content of his section, all major findings were discussed among the entire team to verify the logic and test usefulness of the material to the evaluation and as content for the overall report. Thus, all conclusions and recommendations represent general consensus of the team. The draft report in its various stages of development was discussed with mission staff, the technical assistance team, and key implementation counterparts.

Interviews with key project personnel were structured according to the questions listed in the SOW, and were conducted in an informal and relaxed manner (see Appendix B for full list of persons interviewed).

A wealth of information was obtained from project records in USAID (semi-annual reports, expenditure documents), minutes of committee meetings in USAID, SDA, SATU, the Special Health Commission and individual GOES implementing agencies, and periodic reporting to USAID by the HID and CCC technical assistance teams. Resource documents such as the FESAL 85 and 88 were also reviewed.

Also extremely helpful were the numerous evaluation documents reviewed. Among these evaluations, two were referred to extensively: "Evaluation of Special Administrative and Technical Unit (SATU)," prepared by Development Associates Inc., April 1987 and "Evaluation of SATU" by Annicchiarico and Gonzales, September 1988. Both of these provided excellent detailed discussions of many elements of project administration and management. Particularly useful were the discussions of fiscal management procedures required by USAID and the GOES, largely eliminating the need to cover this ground again under the current evaluation. Self-evaluations performed by implementing agencies (MOH, ANTEL, and ISSS) were also reviewed. MOH's evaluation had been completed in early 1989, ISSS was finishing its analysis at the time of the evaluation, while ANTEL's was still being prepared. All had been undertaken at the behest of SATU (see Appendix C for a bibliography of documents received).

Field visits were planned to the Paracentral, Central and Occidental Health regions, but because of security considerations, only the Central and Occidental regions were visited. While in these locations, the team visited three health facilities and the surrounding communities where village-level health workers were operating. The purpose of these visits was to verify that the various support systems financed by the project were present and to assess the quality of these systems.

4. Summary of Progress to Date

4.1 Financial Summary

At the end of year four of its operations, the project had expended just over 62 percent of its total budget, but had underspent in the IEC and training line items (45.6 percent and 49.7 percent of budget expended respectively) and was significantly below budget in the policy area (8.4 percent) (see Table 1 below).

Table 1

Project Financial Summary
(\$000s as of 7/31/89)

	Total Budget (A.I.D.) ¹	Actual Expenditures by Year ²				Total	Percent Spent
		1986	1987	1988	1989		
TA	2,655.3	.0	402.9	964.7	833.9	2,206.5	83.1
Administration	602.9	18.1	41.7	317.1	104.8	485.7	80.6
IEC	2,111.6	.0	144.9	484.4	334.4	963.7	45.6
Training	1,544.9	22.1	30.1	381.2	335.4	768.8	49.7
Log./Maint.	2,058.0	.0	463.6	463.6	627.6	294.8	59.4
Policy	137.9	.0				11.6	8.4
Project Eval.	000.0	.0	.0	.0	.0	.0	.0
Contingencies and Inflation	196.5	.0	.0	32.4	.0	32.4	16.5
Research ³	692.9	.0	.0	315.4	238.0	553.4	79.9
Grand Total	10,000.0	40.2	1,103.7	2,958.9	2,317.1	6,244.1	62.4

¹This column reflects the amendments made by implementation letter in the course of the project

²Based on information obtained from the USAID Offices of Health/Population/Nutrition and the Controller. The figures include accrued expenses through July 1, 1989.

³FESAL 88 expenses, Nutrition Survey and NORPLANT® clinical trials.

4.2 Programmatic

4.2.1 Administration

Through the creation of SATU and the Special Health Commission, an active coordinating mechanism was established among public and private family planning service delivery institutions.

4.2.2 Technical Assistance Provided

The two contractors, HID and its successor contractor CCC, provided a total of approximately 159 person months of long- and short-term technical assistance in the following areas: management and administration, IEC, training, management information systems/logistics/maintenance, rural referral systems and private health insurance schemes. The breakdown

in level of effort by specialty of the long-term advisors is as follows: management/administration, 35 months; MIS/logistics/maintenance, 78 months; and IEC, 35 months. A total of 13 months of short-term technical assistance was provided in a variety technical areas.

4.2.3 Training

A total of 8,166 persons, or 97 percent of the levels planned in the Project Paper, have been trained through the GOES component. Training has taken place both at community, and at the central/regional levels, in a variety of topics. Almost double the planned output were achieved in the SDA component, with 5,097 trainees trained versus 2,901 planned. Trainees included both rural and urban participants, and focused both on community based distributors and community change agents who can act as message multipliers.

Together, the GOES and SDA components trained more than 12,700 persons, or 118 percent of the output targets.

4.2.4 IEC

A full mass media campaign was carried out during 1988. Preliminary data suggest that it has reached nearly 4 million people, mainly in the rural areas. A radio soap opera of 100 episodes designed for entertainment and education has been produced and is being broadcast by three radio networks. More than 1.7 million units of 15 different types of printed materials -- posters, pamphlets, etc. -- have been produced and distributed throughout the country. A national song contest was held. An IEC inter-institutional committee has functioned effectively to plan, implement and monitor IEC activities. The Health Training School (HTS) has completed 12 one-week IEC courses for about 350 officers from different government units.

4.2.5 MIS/Logistics/Maintenance

A computerized national family planning logistics and service statistics system was designed and implemented in the public sector and improvements were achieved in the availability of medical equipment and in maintenance of laparoscopes.

4.2.6 Policy

A National Population Policy was adopted, a national health survey (the 1988 FESAL) was completed, and policy improvements are in process in the MOH.

4.2.7 Coverage

Over the project period, there has been an overall increase of 10 percent in couple years of protection (CYP) provided through methods supplied by the GOES and SDA.² CYPs provided through the private sector program, which has also been supported by other projects,

²This analysis of trends in coverage is based on quantities of contraceptives distributed expressed as couple years of protection (CYP) because these are the best available figures. The FESAL 88 cannot be used to assess the impact of the project activities, since FESAL 88 field work began in May of 1988 and project financed activities that might affect the public began only in late 1987. This report states that there was no significant change since 1985 in overall contraceptive prevalence in rural and urban populations or source of supply of contraceptive products (Family Health Survey, 1988, CDC and SDA, pp. 31-35). Likewise, trends in user statistics are difficult to interpret since a change to the new MIS system occurred during the project period. Several ways of maintaining data make comparison questionable and reporting from service delivery points is not yet as complete as desired.

have increased nearly 50 percent, and as of 1989, the SDA was providing approximately 29 percent of the aggregate CYP. Coverage provided by the GOES, however, has declined slightly (-.6 percent).

Both the GOES and SDA efforts have met with some success in increasing the use of temporary methods (orals and condoms), indicating a probable increase of family planning use among the younger couples. Both programs also showed significant increases between 1988 and 1989. It is hoped that the 12.5 percent increase reported for the GOES in 1989 is the beginning of a favorable trend in service delivery (see Table 2 below). It may be significant that project financed activities that affected the public sector began only in late 1987.

Table 2
Couple Years of Protection
1986 - 1989
(000s)

	<u>1986</u>	<u>1987</u>	<u>% Chg 86-87</u>	<u>1988</u>	<u>% Chg 87-88</u>	<u>1989</u>	<u>% Chg 88-89</u>	<u>% Chg 86-89</u>
GOES								
Pills	26.3	24.1	- 8.6	27.3	13.3	31.3	14.9	19.0
Condoms	8.0	7.4	- 7.7	7.2	- 2.7	11.7	64.3	47.6
IUD	.5	.7	25.1	.2	-76.6	.2	42.9	-58.1
VSC	<u>272.7</u>	<u>253.6</u>	- 7.0	<u>237.3</u>	- 6.4	<u>262.4</u>	10.6	- 3.8
Total	<u>307.6</u>	<u>285.7</u>	- 7.1	<u>271.9</u>	- 4.8	<u>305.8</u>	12.5	- .6
SDA								
Pills	15.2	19.4	27.7	21.7	11.8	26.2	20.9	72.5
Condoms	14.7	16.0	9.2	21.8	35.7	22.1	1.4	50.3
IUD	2.9	3.9	32.8	4.3	9.9	5.6	30.8	90.8
VSC	<u>52.5</u>	<u>58.1</u>	10.6	<u>69.0</u>	18.6	<u>72.6</u>	5.3	38.2
Total	<u>85.4</u>	<u>97.5</u>	14.2	<u>116.7</u>	19.7	<u>126.6</u>	8.4	48.2
Grand Total	393.0	383.2	- 2.5	388.6	1.4	432.3	11.3	10.0

Note: This table is based on quantities of contraceptives distributed expressed as couple years of protection (CYP). 1989 figures are annualized, 1988 figures annualized to use new MIS 9-month figures for full year. Numbers in the chart are rounded, but percents are calculated based on the actual numbers. Thus, there may be some apparent internal inconsistencies. Sources: SATU, SDA. Small supplies (foam, tablets, etc.) are not included.

5. Responses to Specific Questions of Scope of Work

5. Responses to Specific Questions of Scope of Work

5.1 Administration

1.i Personnel³

1.i.a) **Are current staffing patterns and project supported personnel sufficient and possess the qualifications necessary to accomplish the project's outputs?**

SATU's core staff, which constitutes its Executive Directorate, is composed of an Executive Director, an Administrator, a chief of purchasing, 2 accountants, 2 secretaries and a messenger. Eleven other positions that serve as support personnel for various project activities also are listed as SATU staff members: 4 physicians (2 in the MCH department of MOH, 1 as part-time director of project 210 activities at ANTEL, and 1 in charge of the voluntary sterilization program at Santiago de Maria, ANTEL's central hospital) and 7 educators (5 in the health regions, 1 in the MOH's MCH department and 1 in the MOH's Health Education Unit [HEU]). Apart from the Executive Director, who is an obstetrician-gynecologist and brings these technical skills to the project, there are no technicians in the SATU core staff.

On the administrative side, SATU's role involves the very time-consuming job of handling all GOES project financial matters, including preparing requests for advance payments by USAID and processing liquidations, as well as carrying on all project correspondence. In addition to these routine functions, it must cope with more complex tasks, such as developing annual action and budget plans and undertaking major budget reprogramming exercises, which often have a higher priority than the routine jobs. It may also be called on to solve logistics or procurement problems. The unit's staff is quite capable of accomplishing all its routine tasks. Work on these is often interrupted, however, when the more complex problems arise. A major obstacle appears to be the necessity for involving the Administrator in all administrative activities of the unit, with the result that some tasks must wait until others are accomplished.

1.i.b) **To what extent has the SATU implemented the recommendations made by the Management Evaluation completed in early 1987? Explain why SATU did not accomplish the recommendations.**

The observations below refer to whether the recommendation was accomplished, irrespective of whether SATU or another agency took the action.

Recommendations

2.a: **"Adding personnel: an accountant, a logistics manager, a training coordinator and technical assistance coordinator."**

There was partial compliance with the addition of an accountant. The logistics function was added to the duties of the technical assistance person for logistics, and training function was covered by a staff member of the MCH department. Coordination of technical assistance was variously covered by international technical assistance team leaders and the president of CCC. A personal services contractor to help USAID in the management of the project was not hired.

³ The paragraph numbering system in this chapter follows the numbers of the questions as presented in the SOW.

2.b: "Providing long promised technical assistance in management." This point is discussed below, in the sections on Finance (1.ii) and Programmatic Management (1.iii) in this section on Administration.

2.c: "Updating and reviewing SATU management guidance documents including the A.I.D. administrative guide (to be prepared) and the SATU operations manual."

Completed. The A.I.D. administrative guide was issued as Implementation Letter No. 17; the SATU operations manual was prepared.

2.d: "Providing a Project Executive Director to manage day-to-day operations and to supervise the SATU administrative office."

The position of Executive Director was created and filled, with positive results (see question 1.i.c immediately below).

2.e: "Providing adequate office space for SATU and International Technical Assistance team."

Original plans had SATU sharing space with the technical assistance team. The 1986 earthquake disrupted this plan, with SATU locating itself in a hallway off the Directorate of Human Services offices while the technical assistance team had to be relocated, first in the Maternity Hospital, then in the Terraza Hotel, and finally in its present location in Colonia Escalon.

1.i.c) How has the establishment of an Executive Director position improved project implementation and interinstitutional coordination?

From its inception, SATU suffered from lack of identity regarding its role of providing coordination and technical and administrative support to GOES institutions and SDA. If SATU was to succeed in coordinating and assisting implementation, it needed some degree of authority over the participating institutions (including the MOH), above and beyond providing control over the flow of funds. By virtue of her title, the individual in the position of Executive Director now has significant authority over the project elements within the MOH, permitting some internal direction over agency activities, not just coordination of project implementation.

1.i.d) Is the project Executive Director position given sufficient authority to expedite project implementation?

Yes, with qualifications. The Executive Director has to deal with competing priorities within the MOH in maintaining interest and support of the authorities in carrying out the 210 project. For example, the MOH Child Survival Project (UNICEF/EEC funded) was headed by the Vice Minister of Health, and many of the staff in the MCH department are assigned to work on both projects. Thus, the Executive Director has only partial control over many of SATU's key personnel. Further, the change in the Presidency and MOH leadership as a result of the March elections has meant a hiatus in strong political direction from the Director General of MOH, with the result that normally routine administrative actions within the MOH take a considerable amount of time or stop completely. On occasion also, the Executive Director has not received vital financial data, or the information itself has been so uncertain, that decisions on implementation and procurement have been difficult. The result is a lessening of efficiency and to some extent, authority to act in the interest of the project.

1.1c) Is the current project personnel structure too hierarchical for agile project implementation?

SATU has good access to the MOH's Director General, other departments in the MOH, the authorities in the participating institutions, and the health regions. This is primarily the result of SATU's having been made an independent entity within the MOH; now the Director General serves as the chairman of SATU's Executive Directorate, with the authority to make policy decisions and to provide overall supervision of the Directorate's operations. When the SATU functions were within the MCH department, communication was much more difficult.

1.ii Finance

1.ii.a) How well is SATU administrative personnel implementing financial responsibilities to disburse funds, report expenses and obtain advances?

SATU administrative personnel have improved in their ability to carry out their financial responsibilities. At the start of the project, SATU's administrative staff was unqualified, inexperienced with both USAID and GOES financial procedures, and unaware of the financial needs of the project.

Following the naming of an Executive Director in September 1987 and a change of Administrators in March 1988, the situation improved, although staff still does not have the appropriate blend of background and experience necessary to manage the finances of such a complex project in a fully efficient and professional manner. Even today, neither the project staff nor the technical committees has a clear idea of available project resources.

Despite the improvements, the legacy of poor initial financial management, compounded by inadequate orientation by USAID, has not been entirely overcome. Likewise, the financial task itself remains exceedingly complex, involving multiple layers of decision-making (A.I.D., SETEFE, the Corte de Cuentas, MOH, and SATU) and inflexible financial procedures on the part of both USAID and SETEFE. As a result of these various constraints, project administration has constantly had to struggle to obtain adequate resources in a timely manner and to understand the financial situation of the project at any one time.

1.ii.b) Is this management unit an administrative mechanism that is recommended for replication in new projects?

SATU has proven to be a useful administrative mechanism for this project. It cannot, however, be recommended for replication in new projects in its present form. If a similar unit is to be replicated, several steps must be taken to avoid the problems that have been experienced in this project. The unit must have more independence from the GOES bureaucracy, with autonomy to manage funds, set and revise objectives and work plans, procure supplies and equipment, as well as to disburse directly to public and private institutions. Such a unit should also be independent of any one organization; rather, control should be shared by technical staff of all participating institutions. SATU's relationship with technical assistance must be much clearer and closer, physically as well as organizationally. Finally, it must have adequate financial management strength (both in staff as well as in control systems) and support from donors to guarantee a smooth flow of financial and material resources to the institutions participating in the project.

1.ii.c) How has the local procurement accelerated the accomplishment of project activities?

If anything, the local procurement procedures of the project have slowed the accomplishment of project activities. With the exception of the procurement of microcomputers (done relatively quickly by the technical assistance team), delays in all procurements have produced

corresponding delays in project implementation. At the start of the project, SATU was charged with local purchasing. Lengthy GOES purchasing procedures, often incompatible with USAID financial requirements, doomed this arrangement. Early this year, local procurement responsibility was transferred to USAID, in order to facilitate purchasing. Although some commodities have been purchased, lack of agreement between SATU, the technical assistance team and the participating institutions on the specifications for the commodities has caused delays in the remaining local procurements. A lengthy reprogramming effort is under way, which may resolve these outstanding procurement issues.

1.ii.d) In what way has the computerized financial system helped the SATU?

Although the computerized financial system has introduced some organization into SATU's finances, it has not helped SATU as much as it might have. Essentially, it resembles an electronic checkbook, keeping only a monthly record of checks and subtotals by budget category. It does not keep cumulative data, cannot report against budget, cannot give breakdowns by organization, and does nothing to track advances, past liquidations, or other financial data.

A more extensive computerized accounting system might have reduced delays in the financial disbursement process resulting from inaccuracies in SATU financial reports. It probably would not have been cost effective, however, to invest in a computerized system for an institution created only for the implementation of this project. On the other hand, the technical assistance team could have provided SATU with simple, spreadsheet-based financial control systems and this would probably have been much more helpful to SATU than the system provided.

From the perspective of the project counterpart personnel, what role has the technical assistance played in accomplishing financial and management objectives?

The technical assistance component has done little to facilitate accomplishment of financial and management objectives. Repeated turnover in team leaders (the person responsible for financial and management technical assistance) at the start of the project, the lack of emphasis on financial skills in the selection of individuals to fill this position, and the physical separation between SATU and the technical assistance team, have resulted in minimal technical assistance having been provided in these key areas. The team is sensitive to these deficiencies and has recommended hiring a financial specialist for the duration of the project.

1.ii.f) Do the participating agencies agree that the administrator is responding to their financial needs?

The current Administrator has shown considerable initiative and a strong desire to learn, responding well to the needs of the agencies within her professional limitations. Without a solid background in USAID and GOES financial systems, however, the Administrator has found it difficult to meet all the professional demands of her job. This was recognized and examined in detail by a financial analysis of the project conducted in 1988.

1.ii.g) Is the Executive Director providing sufficient time and interest to project implementation?

Although interest and dedication on the Executive Director's part are very evident, she estimates that the demands of financial administration occupy about 80 percent of her time. Since lower-level staff are unable to handle these tasks, operational aspects of the project have undoubtedly suffered.

1.ii.h) What has been SATU's working relationship with SETEFE? Is SETEFE responding adequately and on a timely basis to SATU's requests and priorities?

SATU currently has a good working relationship with SETEFE. It appears that, within the existing bureaucratic limitations, SETEFE is responsive to the needs of SATU and the project. The SETEFE staff member who works directly with SATU demonstrated a thorough knowledge of the project and an interest in helping to resolve problems. It is questionable, however, whether good relationships and desire are sufficient to overcome the many bureaucratic steps that exist in the planning, approval, disbursement and financial accounting process.

1.iii Programmatic Management

1.iii.a) Are yearly action plans prepared with sufficient [technical] criteria provided by all SATU's members? Or do they tend to be guided by a specific institution and/or technician?

Annual action plans listing activities and budgets were prepared by all of SATU's members. Although there were some limitations in the way these plans expressed objectives, strategies and priorities, the activities listed and budgets attached were consistent with project objectives. Plans improved over time.

SDA prepared annual plans within the framework of its plans for IPPF. These plans included objectives, goals and strategies for achieving them, as well as lists of activities and budgets. The plans were approved by USAID, SATU review not being required.

Annual Plans of GOES institutions are expected to follow the general planning guidelines of SETEFE. The 1988 guidelines provided an excellent conceptual framework; they were, however, only partially followed by the institutions involved. SATU provided technical and programmatic guidelines, both through general meetings and through the work of the Executive Director and the technical assistance team. Minutes of the regularly held meetings of SATU and the Special Health Commission demonstrated that strategic planning and establishment of priorities were included in the process, though this was not clearly demonstrated in the Annual Plans. Had the same consideration been given to analyzing programmatic developments that was accorded financial progress, more systematic monitoring and analysis of supervision and institutional reports would have been required, resulting in a correspondingly firmer basis for subsequent planning.

The plans prepared by the individual institutions were consolidated by SATU into a comprehensive plan to be approved by SETEFE and USAID. Obviously, both because of its major role in the project and because SATU's chairman is also Director General of Health, the MOH weighed heavily in the planning process. The other institutions interviewed confirmed their participation in the process to a satisfactory degree, however.

Included in the plans in association with family planning were several complex actions of detection of cancer, control of sexually transmitted diseases (STD) and treatment of infertility. These programs were all viewed as part of the overall goal of achieving reproductive health. A more practical approach might have been to have placed more initial emphasis on preventing high risk pregnancy. These other programs could have been phased in when it was clear there was the capability of implementing them within a heavily burdened system.

1.iii.b) Is there an efficient supervision scheme implemented by the SATU to assure smooth project implementation? Is there any feedback from supervisors to the higher levels when problems occur to correct the errors detected?

The supervision scheme for family planning supervision has published guidelines and is appropriate. Since implementation and its supervision is the responsibility of the collaborating institutions, the SATU Directorate must utilize reports from these institutions as the basis for monitoring program activities. A supervision module has been designed as part of the MIS, which, when operational, will be able to assist in this area.

In the MOH, implementation responsibility is delegated to the Health Regions where supervision, feedback and problem solving occur. A reproductive health supervision team is assigned to each MOH region, headed by a doctor and supported by nurses, and a health educator. These teams, however, review all elements of the health system, not just the reproductive health aspects, with the result that attention to reproductive health can become diluted. They reported, for example, that they were often taken away from supervision responsibilities to carry out other activities such as the local programming exercise sponsored by the Pan American Health Organization and vaccination campaigns. These competing priorities, plus the absence of completed MOH supervisory report forms at the few units visited, suggest the supervision may be less intense in practice than in plan.

The supervisors themselves appeared articulate and well informed. Solution of the problem is primarily a matter of protecting supervisors' time and assigning priorities. The MOH 1989 internal evaluation recognizes the need to strengthen the supervision of the program. The evaluation recommends more training for supervisory personnel to improve skills as well as to promote the reproductive health programs among other supervisors and service providers. These steps would all be helpful, but it will also be necessary for the MOH to direct attention to how priorities are allocated.

The ISSS's supervisory system is general, rather than being specifically directed toward the reproductive health activity. SDA supervision follows IPPF guidelines and provides management with a good sense of program trends, problems and successes.

1.iii.c) Do action plans developed by each of the participating institutions under this project respond directly to the programmatic priorities of that institution?

All the respondents from the several institutions (MOH, ISSS, ANTEL, and SDA) stated that this program does respond to important programmatic needs of their institutions. Where these institutions, and the various respondents in them, placed it in their priorities depended a good deal on their other responsibilities in the health field. A regional director of health service, for example, did not give as high a priority to reproductive health as did those involved in MCH. Nevertheless, there was a consistent response of satisfaction with the way this project brought a better coordination not only in family planning but also in other aspects of institutional activities in the health sector. Enthusiasm was evident for the concept of reproductive health. Early detection of cancer was high on a list of concerns. Family planning is recognized as making a substantial contribution to maternal and child health and nutrition. Those in leadership positions, however, were careful to disassociate themselves from being labeled as "controlistas" (birth control advocates).

Probably the best fit of priorities, however, was with the SDA, whose overall policy and strategy are closest to those of this project.

1.iii.d) Are the project goals and objectives well understood by each of the participating institutions?

Participating institutions tended to agree on the broad purpose of the project, but were less in accord as the interpretation became more specific. Most, if not all, agency officials expressed their support, if the overall project goal was stated in its broadest terms -- increasing coordination and extending family planning coverage. Agency plans also tended to reflect the objectives stated in these terms. If the goal was refined to include a focus on the rural population or the younger couples in need of reversible methods of family planning, there was less consistent association with the goal. If improved reproductive health was described as the goal, most of the institutions preferred to interpret this more broadly than did the Project Paper, incorporating, for example, STDs, infertility, and cancer detection as part of reproductive health. The differences in

articulation of the goals seemed related more to the overall agenda of each of the institutions than to any actual misunderstanding. For each agency, the tendency was to express the goals in a way that would meet the broadest possible set of its own priorities, responsibilities or interests.

1.iii.c) Is the technical assistance team providing adequate inputs to program development?

The technical assistance team has, to some degree, provided the level of inputs anticipated in the project design. It is probably fair to say that, from the beginning, the MOH and USAID have had different appreciations of the need for technical assistance. The critical breaks in the continuity of team leadership have made it more difficult to create confidence in the technical assistance provided. The earthquake destruction that disrupted plans for housing the technical assistance team together with SATU has added to the problem. The physical separation between the two groups has hampered development of close working relationships between them, a problem that is now showing itself in some misunderstandings among team members and counterparts. Some of the institutions indicated they are just now learning the value of the team: what it can be expected to provide and how to avail themselves of this resource. The initial discrepancy on viewpoints has made it more difficult for the technical assistance team to fit into the program development process.

The technical assistance team leader reported he was requested to assist in the early stages of action plan development and in the critiquing of the comprehensive action plans, but was less actively involved in the actual development of plans. The technical assistance team leader has, however, regularly attended SATU meetings as part of the planning, management and monitoring process. A short-term financial management consultant was provided to supplement the Development Associates administrative evaluation of SATU. The complexities of the USAID/SETEFE/MOH bureaucracies are ultimately the problem that must be addressed, and despite its efforts, the team has had limited success in dealing with these.

The technical assistance group has been closely involved in the IEC, MIS/logistics and training activities -- discrete areas with specific technical tasks to be performed and for which the consultants were well qualified. The IEC, training, and MIS/logistics sections of this evaluation provide more detailed assessment of this participation. The discussions of training and logistics will include the consensus viewpoint that more long-term assistance was needed in training and procurement.

5.2 IEC

2.i Quality of work of each participating institution.

2.i.a) On what criteria was material developed by each participating institution to generate more public demand for public health services? Were there guidelines from the project manager?

The overriding criterion for communication material development has been that it should support the activities of the participating institutions. Most of the materials that have been produced are designed to help generate family planning demand among the rural and urban marginal populations.

Each participating institution (MOH, ISSS, and SDA) produced a set of norms so that unified technical criteria for materials production could be used. The decisions as to which norms could be accommodated within the overall strategy were taken in SATU as well as in the Inter-Institutional Technical Committee (ITC) IEC meetings.

MOH personnel in the Health Education Unit (HEU) were trained through a UNESCO training component in basic methodology for prototype materials production. They then participated in a workshop, along with health educators and other health officials, to produce prototype materials for the project. The printed materials that resulted (e.g., posters) were validated in rural communities.

The project manager provided verbal guidelines to help define the overall goals but essentially delegated responsibility for implementation and monitoring to the ITC.

2.i.b) Do the participating institutions have well-trained and sufficient personnel to respond to IEC needs?

In general, the participating institutions have very few well-trained IEC personnel in upper echelon management. On the other hand, there has been substantial improvement in the quality of these personnel through the project's far-reaching efforts to train all levels in basic IEC concepts and practices.

With its separate HEU, the MOH has the best trained IEC officers of the various institutions participating in the project. The Unit's IEC team is particularly strong in the area of print materials production. In addition the Unit's Director has benefited from the interaction with the individual providing IEC technical assistance, having acted as his unofficial counterpart. MIPLAN has one well-trained communication officer. There is no comparable skill within ISSS and ANTEL. SDA relies primarily on the private commercial sector for IEC; it has been providing adequate basic IEC training to its field staff.

2.i.c) Has the technical assistance provided adequate support and technical guidance in this crucial component?

The IEC communication consultant has provided adequate support to the participating institutions. He has been a key factor in helping to establish the Inter-Institutional Technical Committee (ITC) for IEC, in the planning and execution of a mass media campaign, in the production of a radio soap opera for education and entertainment, in the training of a substantial number of officers throughout the country in IEC theory and practice, as well as with other activities. His performance has been good in spite of the project complexity and its administrative and financial problems.

On the other hand, the mass media campaign had some shortcomings. Most important, the mass media campaign should have been better coordinated with the development of plans for the interpersonal (IP) and group communication components. In addition, more attention should have been paid to coordinating the mass media campaign with a parallel SDA promotional advertising campaign supported by A.I.D. project 0275. The simultaneous airing of two similar campaigns may have led to message saturation of the audience.

One of the principal reasons for the poor coordination with the IP component was a major delay in hiring the interpersonal advisors. The first officer was not in place until February 1989, but by then, the bulk of the mass media campaign was over. The delay had serious consequences, since interpersonal communication is at the heart of any communication campaign (see question 2.i.i below). The awareness-motivation -- i.e., the generation of demand produced by the mass media -- may have been substantially reduced because of the lack of a strong and organized IP component. What was needed was a field-level infrastructure that was specifically oriented and motivated to help convince, on a face-to-face basis, the potential users to plan their families and adopt a method. Additionally, service delivery personnel need motivation to ensure that clients are well received and family planning services are readily available in a culturally acceptable fashion.

2.i.d) Is the advertising agency responding to ITC needs as requested?

In general, the advertising agency, which is the leader in this field in El Salvador, has responded to the terms of reference provided by the different participating institutions for the implementation of the mass media campaign. SDA has undertaken administrative coordination and the ITC and the expatriate technical advisor have handled the technical aspects.

Although some IFEU staff and MIPLAN officers have commented that the project mass media campaign was presented in too glossy a fashion, with too little educational content, these remarks may reflect confusion over which messages belonged to the 0210 campaign and which were part of the 0275 campaign. The SDA campaign was intentionally somewhat more glossy than the ITC campaign, since it was designed to promote purchases of contraceptives through a social marketing project and to promote SDA as an institution providing family planning.

2.i.c) Is the mass media campaign adequately designed and implemented to generate demand for family planning services?

The mass media communication campaign was designed according to the terms of reference developed by the participating agencies and provided to the contracted advertising agency. Preliminary data based on audience ratings seem to indicate that nearly 3.8 million people were reached by the messages, many of whom reside in rural areas. As a possible measure of program effectiveness, SDA data also indicated that substantially more women attended its clinics in 1988 than in 1987.

With respect to implementation, the campaign seems to have had some shortcomings. Not only was it not launched in coordination with the interpersonal and group communication components (see 2.i.c above); it was also not coordinated with the distribution of printed material, although this was beyond the control of the project (see 2.i.g below). Another implementation problem was the oversaturation in the diffusion of radio and TV spots, already mentioned in c) above. As can be seen in Table 3, with both the 0210 and the 0275 projects under way simultaneously, there was a resulting heavy message load in the two media. Oversaturation has been known to result in an audience backlash that negatively affects message retention, and which, in turn, results in reduced cost effectiveness.

In addition to the overabundance of messages, an excessive number of concepts may have been diffused.

Table 3
Number of Prototype Radio and TV Spots
Aired During Simultaneous P210
and P275 Mass Media Campaigns

Project	Spots	Radio	Television
P210	Interinstitutional	8	4
P275	Fundraising SDA	-	4
P275	SDA rural contracep. distribution	5	-
P275	SDA clinics	12	6
P275	Social marketing condoms	-	2
Total		<u>25</u>	<u>16</u>

2.i.f) Is mass media an alternative that should continue or would person-to-person techniques be more effective?

Both techniques -- mass media and interpersonal communication -- have a role to play. Interpersonal communication is more effective for attitude and behavior change, whereas mass media's strength lies in changing knowledge and producing awareness. Thus, an integrated IEC family planning campaign using both channels of communication is required. This means that mass media campaigns should always be executed in coordination with interpersonal and group communication, supported by printed materials and audiovisual equipment. As the target audience's attention is being caught by a TV and radio campaign, an interpersonal campaign can serve to maintain interest and refine understanding. Mass media, however, should never be considered a replacement for interpersonal communications, as the latter is the heart of any IEC family planning campaign.

2.i.g) Do printed materials reinforce mass media messages in a simple and direct manner so that the public understands?

Printed materials such as posters, pamphlets and flip charts contain messages similar to those being diffused via radio, TV, movie theaters and billboards, thereby providing the desired reinforcement.

The messages are simple and clear and are easily understood by the public they were intended to affect. Their production was based on an adequate methodology, including validation of the messages (see Section 2.i.a above). The slogan "Tranquilos y encantados de la vida" ("contented and happy with life") has been particularly successful.

The print shop that was awarded the contract in public bidding was closed down by judicial order unrelated to this project. This resulted in a substantial delay in the delivery of materials (posters, pamphlets, etc.).

2.i.h) What is the proportional distribution of media time for the mass media campaign, e.g.: is there more of an emphasis on rural rather than urban areas or vice versa?

A review of the media diffusion plans and the reports provided by the advertising agency indicates that the emphasis of the campaign has been on the rural population. The radio spots, too, demonstrate in their language and style that they have been designed to reach the rural population.

In the 1988 mass media campaign, carried from March through December, 33,800 radio spots (8 different spots) and 1,129 TV spots (4 different ones) were broadcast over 58 radio stations and 6 television channels. Considerably greater air time is dedicated to radio, the preferred medium to reach rural areas. As listenership and viewership data are incomplete, it is impossible to be precise on the proportional distribution of the mass media.

2.i.i) Do interpersonal message campaigns reinforce the mass media campaign agreed to by the ITC?

Because of long delays in hiring interpersonal campaign staff (see Section 2.i.c above), an interpersonal communication campaign has not been properly executed. Therefore, this component has not been able to reinforce the 1988 mass media campaign. The hiring process has taken nearly two years. The first request to hire two interpersonal communication officers was made in November 1987. Due to a combination of contractual constraints and delays in identifying candidates, three vacancy announcements had to be made. Problems were not solved until February 1989, and the new staff finally were in place in July 1989, as the mass media campaign was winding down.

2.ii Inter-Institutional Technical Committee (ITC)

2.ii.a) Is this committee an effective administrative mechanism to coordinate interinstitutional activities?

The Inter-Institutional Technical Committee for IEC is an effective coordinating mechanism. It includes representatives from the project participating institutions -- MOH, ISSS, MIPLAN, SDA, ANTEL, CCC -- as well as from other ministries such as Agriculture, Education, and Interior. One of its main achievements has been to produce a frank dialogue about IEC matters among the implementing agencies. It has thus made possible for the first time in El Salvador a thorough awareness among all institutions of the work being done by the others. Its members have been meeting regularly to establish, among other things, IEC global strategy and to plan and discuss activities, progress and problems.

2.ii.b) Is there an equal participation in the ITC by all the project institutions or is there just a tendency to be oriented by a specific institution?

The ITC has been an open forum in which IEC issues can be presented and discussed by all members without any type of restriction or bias. Its members have worked diligently in their efforts to achieve consensus, even on the most controversial of issues. In the opinion of some of the members, however, the MOH representative or the IEC consultant have tended to exert undue influence over decisions on certain issues.

2.ii.c) Is the ITC coordinating adequately with the advertising agency?

The advertising agency has followed the criteria and guidelines provided by the ITC. With respect to the mass media campaign, these related primarily to overall message design and the validation process, not the subsequent production and post-production process. Most of the guidelines were established by a subcommittee of the ITC, made up of the Chief of the HEU, the SDA representative, and the IEC consultant. This subcommittee kept ITC members informed periodically about progress and problems encountered.

2.ii.d) Is the ITC providing the necessary criteria to permit the ad agency to produce effective TV and radio spots and printed materials?

The ITC provided the guidelines needed to enable the ad agency to produce TV and radio spots and printed materials. Guidelines covered such issues as the message emphasis and diffusion frequencies. The ad agency either accepted them or changed them, according to its professional judgment. In some instances, messages were changed two or three times by the ITC until both groups (ITC and the advertising agency) agreed upon the final version.

2.iii Publicity materials/campaigns

2.iii.a) Are radio messages designed according to target groups idiosyncrasies and needs?

The radio messages (including the spots and the soap opera) are designed according to the cultural patterns of the target population. The design is based on a baseline study that provided qualitative as well as quantitative data. Additional information was obtained in the initial stages of the project and the accumulated experience of the advertising agency, producers and the participating project members was brought to bear on the design.

Despite all this effort, however, several officers from the various institutions expressed concern that the language style used was too stereotyped. It was their perspective that the campesino (small farmer) had evolved over the last 10 years and no longer uses the language

of the project radio programs. Furthermore, some expressed the point of view that the campesino does not like to be stereotyped in the media messages and that he/she reacts negatively when he/she hears the rural stereotyped language. The planned impact evaluation should clarify these issues.

2.iii.b) Are printed materials designed in accordance with modern teaching techniques utilized for illiterate people?

The printed materials are designed to be appropriate for illiterate rural and marginal urban populations. Prototype materials were developed at the "Communication en Salud Reproductiva" workshop using a sound methodology. All printed materials were validated afterwards.

Although most of the material is intended to be useful for illiterates, those sections designed for persons with some literacy skills may be too complex. The instructions included in some pamphlets require fairly advanced literacy skills, if they are to be read and understood well enough to be followed.

The flipchart content is appropriate. The users (educators, promoters, nurses) suggested, however, that the charts themselves are thick, heavy and cumbersome to use and that they easily fall apart. During field visits, a number of respondents indicated that because of these difficulties, the flipcharts remain in the storeroom unused.

Too little is known about the use and availability of all printed materials -- how they are used or whether the educators and other officers have enough for distribution or only enough for showing to the potential clientele.

2.iii.c) Is the publicity material pre-tested before distribution a/o diffusion?

In general, the printed materials (posters, leaflets, flipcharts, etc.) have been validated by the HEU and the radio and TV spots and programs by a specialized agency contracted for that purpose by the advertising agency.

The radio soap opera was evaluated by an expert before diffusion, although only for the technical component (sound effects, splitting, etc.), not for its content and language. All scripts were reviewed before production, however, by an HEU officer by recommendation of the ITC-IEC committee. Her main task was to look for potential inconsistencies in the family planning medical aspects included in each script.

2.iii.d) Is the monitoring scheme used by GOES and the SDA designed to reflect adequate and quick results?

The project has a limited monitoring system for IEC, consisting solely of checking diffusion frequency of the mass media campaign. The monitoring is carried out by a monitoring company contracted by SDA in conjunction with the advertising agency. Its role is limited to checking what media has broadcast what radio and TV spot at what time. This information is sent periodically to SDA, where it is compared with the planned diffusion schedule. If an omission is detected, a claim is made to the particular media, which then makes corrections accordingly. The MOH, ISSS, ANTEL and MIPLAN do not have a campaign monitoring system.

2.iii.e) Are the results used for a continuous "fine tuning" of the campaign?

The results of the limited effort described in section 2.iii.d) above are not applicable to refining a campaign strategy. No systematic evaluation component was accomplished for the

1988 mass media campaign. Such a component could have helped identify either positive or negative impact in the target population and provided data to assist planners make corrections accordingly. A research effort had been planned to measure the impact of the 1988 mass media campaign, but due to several constraints, could not be carried out. Consequently, an excellent opportunity to measure the impact of an extensive mass media family planning campaign was probably lost. An evaluation is scheduled to take place during the last quarter of 1989, however. For this evaluation, a scaled down version of the 1988 campaign is being programmed. During this second phase, no effort has been made to refine the campaign by revalidating the messages currently on the air.

2.iii.f) Is the IEC technical assistance responsive to GOES/SDA needs?

In the opinion of SDA officers, the IEC advisor has provided appropriate advice in communication and advertising, and his personal experience has been of great value for the development and achievement of SDA objectives. Similar opinions were expressed in interviews with personnel of GOES institutions (see section 2.i.c for further information).

The interpersonal consultants have been hired only recently, and thus it is not possible to evaluate their degree of responsiveness to GOES/SDA.

5.3 Training

3.i. Training Committee

3.i.a) Is the Committee an effective administrative mechanism to coordinate interinstitutional activities?

The Training Committee (TC) is potentially a useful forum for technical and administrative coordination of project training activities. In practice, however, the group has met only occasionally, and each time at the call of the short-term training consultant. Its membership largely overlaps that of the ITC, which met regularly. The ability of the ITC to function suggests that the TC could also be an effective organization, if more initiative were taken to organize meetings.

Issues addressed during the limited number of meetings held in 1986 and 1987 included (i) definition of the Committee's role and responsibilities; (ii) review the results of visits of the short-term consultant; (iii) planning Committee activities and additional short-term consultancies; and (iv) selecting candidates and planning for short-term overseas training financed under the Project.

Theoretically, the MOH's Health Training School (HTS) could have served as an alternative to the TC. It is staffed with competent training program design personnel and has considerable experience in administering large programs. The HTS, however, is viewed as merely an "administrator" of training programs, not as a technical resource to other organizational elements in the GOES.

3.i.b) Is there equal participation in the committee by all the project institutions or is there a tendency to be "oriented" by a specific institution?

Review of minutes of meetings and interviews with a number of members indicate that there seemed to be a egalitarian atmosphere in the conduct of these meetings and that no single agency dominated the proceedings.

3.i.c) Is the committee coordinating adequately with the international technical assistance?

When the TC functioned, coordination was good, but because meetings were not held regularly, coordination was limited in frequency and time. Since the signing of the CCC contract and non-renewal of technical assistance for the training component, there have been no meetings of the TC, as such.

3.ii Training Curricula of Each Institution

3.ii.a) Does each participating institution have training curricula?

Each institution that is providing training under the project (MOH, ISSS, and SDA) has prepared curricula for all its major, high volume training programs.

Courses provided through the GOES covered a wide spectrum of subjects, ranging from "How to give a motivational talk to potential family planning acceptors" for satisfied users to "IUD Insertion Techniques" for physicians and nurses, to "Maintenance of Laparoscopic Equipment" for maintenance personnel. The SDA offered such courses as "Refresher Course on Reproductive Health for Community Based Distributors."

3.ii.b) Are they adequate and in accordance with each institution's priorities?

In general, the curricular materials reviewed are adequate and in accordance with institutional priorities. They contain reasonably clear educational objectives and specification of contents (whether the focus was on skills, knowledge, or attitudes) and address issues of teaching methodology and evaluation of learning.

As for institutional priorities, the traditional approach to curriculum design was used, which bases course content on the designers' perspective as to what the worker should know. Few institutions used the standard competency-based technique of specifying occupational/educational profiles to ensure consistency with its perspective of the job for which training was being provided. Two exceptions were needs assessment of the traditional midwife carried out by MOH's MCH Department and the use of focus groups to verify the content of the course for IEC facilitators (Ministry of Interior). Both represent a step in the right direction.

3.ii.c) How well do the trained personnel implement new knowledge in their daily work?

Personnel who have received training appeared to have extensive knowledge of the program, both of its philosophy and of some of the detail. Those interviewed included traditional midwives, regional health educators, satisfied users (a cadre of community-level personnel used as family planning promoters in clinical settings), and nursing staff. All seemed just recently to have taken one course or another financed by the project. It was impossible to assess how well these recent graduates performed their tasks, however.

As in many countries, little use is made of the techniques of discrepancy analysis and/or systematic data collection by supervisory systems to detect needs for continuing or in-service education to maintain skill levels or to assess how well the training is serving a particular group of workers.

3.ii.d) How many persons have been trained during the life of the project (LOP) and by each participating institution?

A wide variety of project financed training curricula were designed for community-level and institutional health staff by the participating institutions. A total of 84 different training

events for these two categories of personnel were observed in Action Plans of the GOES and SDA components. Many of these training events were repeated several times, encompassing large numbers of trainees.

The Project Paper indicates that the project would finance the training of 7,862 participants by the GOES and 2,901 by the SDA subgrantee. The grant agreements, however, include no numerical outputs for the training component.

On the basis of SATU records of participants' per diem as a source of numbers of persons trained, a cumulative total of 7,616 trainees from all GOES institutions were recorded, from the inception of the project through August of 1989. This number of trainees is 97 percent of that originally planned for the GOES in the Project Paper (pp. 28-30). SDA trained 5,097 persons, or 176 percent of the number planned (see Table 4 below).

Table 4
Cumulative Numbers of Trainees
by Institution,
Percent of Planned
1985-1989

<u>Partic. Institution</u>	<u>No.Partic. Trained</u>	<u>% of Planned*</u>	<u>Planned</u>
MOH	5,581	6,525	86
ISSS	2,035	1,337	152
SDA	<u>5,097</u>	<u>2,901</u>	176
Total	12,713	10,763	118

**As contained in the Project Paper (pp. 28-31).*

Despite these accomplishments, some categories of trainees were omitted. Neither the rural health aide (Ayudantes Rurale de Salud) nor the community health assistant (Asistente Comunitario de Salud) received any training on family planning subjects under the project. These worker categories have significant possibilities of effectively reaching rural populations with family planning messages. Another group, planned under the project but not included, was the malaria volunteer. Finally, general physicians (those in their required year of social service following graduation from medical school and those in regular service), graduate nurses and auxiliaries were underrepresented in the training program, although these groups are the mainstay of rural health facilities. Recently, work has begun on focusing curricular design efforts on the community-level workers (i.e., rural health aides, community health assistants, promoters and volunteers).

As of October 1989, actual expenditures for the GOES and SDA training component totaled \$433,983, which is 55 percent of the \$788,400 budgeted in the Project Paper. Expenditures reflected a variable pattern, with only \$22,000 spent in 1986, \$30,000 in 1987, \$381,000 in 1988 (fully 87 percent of all expenditures), and only \$500 in 1989.

3.ii.e) Are the curricula designed to achieve a larger service coverage among the rural population?

Of the more than 12,000 workers who received training under the project to date, almost 60 percent (7,496) were identified in the available records as rural outreach workers of one category or another. Categories of rural workers receiving training included traditional midwives, satisfied users, rural teachers, promoters from different ministries, and rural leaders. Central- and regional-level health staff included physicians, nurses, supervisors of various categories of workers, as well as opinion leaders reached by MIPLAN courses. Training activities for the MOH are carried out by the MCH department, the regional health offices, and the HTS. The HTS carried out a large number of the courses on reproductive health provided to community-level workers (e.g., traditional midwives, satisfied users etc.). This unit was also involved in planning, design and implementation of specialized courses in areas of maintenance, management information systems and IEC.

For the GOES component, the traditional midwife, with a total of 1,306 training enrollments (there may be more than one course for a given midwife), appeared to represent the largest single group of trainees that was of rural origin. Next largest was the satisfied user group. Thus, although the GOES component of the project did not address the training of significant numbers of certain other categories of rural workers (see Question 3.iii.d above), the overall focus of training seems to have been on rural workers who could have an impact on coverage.

The rural focus of SDA was even more marked, with about 72 percent of its trainees coming from these areas. Large numbers of promoters working for other ministries, rural teachers, medical personnel from private voluntary organizations (PVO), members of farm cooperatives, students, community leaders and others were included in its training programs. A program with great promise, just now getting under way, is a collaborative effort between SDA (with funds from this project), UNFPA, MIPLAN and the Ministry of Education to train 22,000 rural teachers in population education subjects.

3.ii.f) How well are the institutions following modern teaching techniques?

The curricula reviewed generally showed good adherence to teaching techniques that are appropriate to the skills needed (i.e., practice is included to enhance psychomotor skill learning, participatory techniques are used to increase knowledge and modify attitudes and beliefs about family planning, etc.).

3.ii.g) How well is the technical assistance supporting the participating institutions?

Four two-week short-term consultancies were carried out between 1986 and 1988. The objectives included (i) performing an assessment of the training capacities of the participating institutions, (ii) strengthening their training capabilities, and (iii) designing an evaluation and follow-up strategy for the component.

The first and last objectives were successfully accomplished. An excellent analysis was prepared of the capabilities of the participating institutions and, in late 1987, a one-day workshop was held to develop a simplified evaluation and follow-up strategy for training. In addition, two efforts have been made to evaluate and improve training activities: A needs assessment was performed by the MCH department to determine the relevance and completeness of the midwife training course and, using focus groups, the training requirements were established for IEC facilitators in the Ministry of Interior.

Too little time, however, was available through the consultancies to make measurable progress in furthering the objective of strengthening training capabilities. In June 1988, a two-week workshop was held for trainers from the participating institutions to learn and practice modern teaching skills. Assistance was also provided in reviewing or designing instructional materials and a number of curricula such as minilaparotomy, IUD insertion, midwife training, laparoscopy repair and MIS training.

The TC might have played a role in improving the capabilities of the participating institutions to carry out training programs, but the infrequency of its meetings precluded this. With the change in technical assistance contractors, all technical assistance to training was terminated, indicating that priorities for the time remaining in the project were in areas other than training.

5.4 MIS/Logistics/Maintenance

The Management Information System (MIS) developed by the project has been implemented at the MOH, ISSS and ANTEL (ANTEL, due to its small size, functions as part of the MOH system). The MIS has not yet been adapted for or installed at SDA, although SDA is scheduled to be included in the system before the end of the project. Since this evaluation focuses upon the accomplishments of the project, the following responses refer to the MIS developed and installed with its assistance. The SDA logistics system has already been reviewed in depth by previous consultancies (see list of documents).

4.i Contraceptives

4.i.a) Has each institution the technical capability to perform an inventory of contraceptives at any time?

Each institution has demonstrated the technical capability to perform regular inventories. All GOES institutions must, by law, conduct a physical inventory of all consumable items each six months. Many do so more frequently. These control procedures, including the use of standard requisition forms, have been in place for some time. In addition to periodic inventories, most health facilities have a stock control system with a separate store room for drugs and medical supplies, a pharmacy for maintaining smaller stocks for distribution to patients, and stock cards.

4.i.b) Are the personnel adequately trained for accomplishing their work?

Personnel involved in logistics management had a good understanding of the procedures and forms needed to control the flow of family planning commodities. Most had received training in the use of the MIS.

4.i.c) Do the institutions record adequate data for assessing contraceptive needs at each outlet?

For the purpose of the MIS, each outlet records contraceptives distributed to each client. These data are summarized into daily and monthly consumption of each type of contraceptive. The outlets also provide beginning stock and ending stock and make adjustments for losses or transfers of commodities to other locations. On a monthly basis, these two totals (amount distributed and consumption according to inventory records) are reconciled and this information is forwarded to the regional or central level, depending on the institution. Once the data are entered into the computer, the MIS then automatically calculates minimum and maximum stocks for each location, using the average consumption of each commodity over the past several (ordinarily three) months. This is then multiplied by the number of months minimum and maximum stock desired (usually two and four months, respectively).

4.i.d) Are contraceptives distributed on time?

An analysis of the performance of the MIS over the past 18 months revealed that there have been no stockouts at any health facility participating in the MIS since April 1988, when the MIS was put into place. No problems of inadequate stocks were observed, and MIS reports confirmed that distributions are made on time. Even in regions where each facility must actively request additional stocks (i.e., a "pull" system), the MIS is regularly used by regional supervisory personnel to check requests, thus minimizing problems in distribution.

4.i.c) What are the criteria or priorities each institution uses to assign/deliver contraceptives to its clinics?

The maximum and minimum values established by the MIS system are the basic criteria used to assign contraceptives to clinics. As explained in 4.i.c above, those values reflect average consumption over the past three months, recalculated monthly by the computerized system. Once the stock level at or a health facility falls below the minimum level, the MIS monthly distribution report identifies such centers and suggests replenishment to adequate levels. This report is used as the basis for preparing distribution lists for the warehouse (where a "push" system is used, i.e., the managing entity sends commodities based on projections of needs rather than on requests) or for evaluating requisitions from the health units (where a pull system exists). Those clinics with stocks at or below the minimum level can then be assigned priority for resupply.

4.i.f) What kind of logistics data are used by the institutions for delivering contraceptives to its clinics?

Information on recommended shipments to each clinic, derived from the data described above (see section 4.i.c above), results either in a shipment list (push), or a revised requisition (pull). This information is compared to the existing stocks prior to delivery, and adjusted as necessary.

4.i.g) What system do they use for sending contraceptives to the clinics? A pull or push system?

In several regions (those in which the MIS has been fully implemented), a push system is used. In other regions, a pull system is used, although a change to a push system is eventually planned for all institutions. At the MOH, the central level uses a push system to the regions, although the central and regional warehouses have not yet been integrated into the system.

4.i.h) Are clinics' requests and plans taken into account for determining contraceptives assignments?

Throughout the system, a clinic can request additional contraceptives if it anticipates an abnormal increase in demand. The MIS, since it continually adjusts for increasing consumption by averaging the past three months use, can accommodate normal increases in consumption. Annual service delivery objectives, an integral part of the new local programming effort, can be included in the MIS reporting system.

4.i.i) Do the institutions keep a minimum and a maximum stock? Based on what criteria?

The MIS automatically establishes a minimum stock of two months supply and a maximum stock of four months supply. Experience has shown that adequate stock levels are not always maintained at service delivery facilities, but that large stocks are kept at either the central warehouse or the regional warehouses. These stocks should be variable, depending on the regional or institutional delivery schedule. The technical assistance group is currently making adjustments

in the MIS to accommodate user-selectable variations in these stock levels. One useful modification in the system would be to include a global calculation of the number of months stocks of each commodity available on a national basis, to facilitate reordering from donors or commercial sources. This module, including regional warehouses and the central level, is being developed.

4.ii. Medical and Laparoscopic Supplies

4.ii.a) Has the medical equipment procured under the project been adequately distributed? Based on what criteria?

There have been three major procurements for medical equipment, all conducted by USAID. The first request, for basic family planning equipment, has been delivered to the MOH warehouse, and a great deal of the equipment has been distributed. Some buffer stocks remain. The basic criteria for distribution was current activity and number of health facilities providing family planning services. The second major procurement, for minilaparotomy and IUD insertion equipment, has been partially distributed. Most of the IUD equipment was distributed to health facilities. Only two locations (of a planned total of 40), however, have received minilap equipment, since distribution takes place only following training. Training is now under way and a new distribution plan has been developed. The third major procurement, for infertility and general surgical equipment, is under way. The completion of this procurement is being delayed pending the reprogramming exercise that was undertaken following the shift of responsibility for local procurement from SATU to USAID (see 1.ii.c above).

4.ii.b) Are the supplies responding to each institution's needs?

In general, the supplies requested correspond to each institution's needs. The amount delivered, however, has varied considerably from the amount requested, particularly in the case of minilap kits, IUD kits and the third and final procurement. Delays in delivery have also caused problems, since needs often change over time.

4.ii.c) Is the laparoscopic equipment being fully used?

Using an evaluation criteria of 5 procedures per month per facility with a laparoscope, a study of the average number of procedures for the past six months was done. The results are presented in Table 5:

**Table 5
Utilization of Laparoscopes**

Institution	Total Lap. Centers	Number Doing More than 5/Mo.
MOH	21	16
ISSS	5	3
<u>SDA</u>	<u>6</u>	<u>6</u>
Total	32	25

Overall, the large majority of laparoscopes appear to be efficiently used. During the evaluation, some reservations were expressed regarding reliance on laparoscopes for voluntary surgical contraception. An effort is now under way to expand the use of minilaparotomy procedures, using more cost effective and more easily maintained surgical instruments. As planned, laparoscopes should be concentrated at major medical facilities where they can be intensively used and appropriately maintained.

4.ii.d) Does the GOES have an appropriate maintenance system for both laparoscopes and medical equipment in general?

The GOES maintenance system for laparoscopes and medical equipment has been decentralized to the regional level in order to ease transportation problems. While this decentralization may be an appropriate manner of providing maintenance, it has created additional needs for infrastructure, staff, training and stocks of spare parts. The project has helped to develop effective maintenance procedures, manuals and training modules, particularly for laparoscopes. Delays in the procurement of spare parts have limited the ability of the project to institutionalize changes in the maintenance system. For example, at one center, the only laparoscope had been out of use for a year, effectively paralyzing the VSC program. Finally, a current lack of the most basic infrastructure at the central level (the laparoscopic maintenance facility has no electricity and therefore is not operating) calls into question the degree of commitment to this maintenance program by the MOH as well as the wisdom of using the MOH as the central clearinghouse for parts and maintenance.

4.ii.e) Do the institutions provide preventive maintenance for medical equipment?

Efforts by the project to establish a regular preventive maintenance program have not produced the desired results. At the MOH, preventive maintenance does not take place. There, the maintenance system is primarily reactive, repairing equipment once it fails. SDA and ISSS do provide preventive maintenance to all its laparoscopes at least once a month.

4.ii.f) Does the maintenance unit of the MOH have adequate and sufficient resources to promptly react to technical needs?

As explained in section 4.ii.d above, decentralization of maintenance facilities has created the need for additional personnel, equipment, and facilities. These needs have been only partially met. The cost effectiveness of the decentralized maintenance program, particularly in a small country such as El Salvador, is also in question. It is hard to justify six or seven different maintenance facilities, each with trained staff, a supply of repair equipment and spare parts, when there are less than 100 laparoscopes in the entire country. Also, if the MOH is unable to keep one central laparoscopic facility operating, how can it be expected to do so for six facilities?

4.ii.g) How well does the technical assistance respond to current institutional needs for contraceptive logistics and management?

The technical assistance provided to develop a contraceptive logistics system has been excellent, as has the quality of the assistance in equipment maintenance. The quantity and quality of assistance in management of these programs has been less adequate. Now that the basic systems have been developed and are in place, the technical assistance team needs to concentrate more on transferring management skills. Finally, in the case of the maintenance program, it appears that a much stronger commitment from the MOH is required to justify additional inputs.

4.iii Management Information System

4.iii.a) Is the technical assistance providing adequate timely inputs to institutional needs?

Assistance provided in MIS has been both timely and appropriate. The technical assistance team has been able to develop and, largely, to implement an MIS that adequately covers the logistics needs indicated in the original project proposal, as well as to incorporate statistics on family planning acceptors and couple months of protection (the measure used in the project, rather than the more common couple years of protection or CYP). The design, programming and implementation of this system is without a doubt one of the major accomplishments of the project as a whole and, particularly, of the technical assistance team.

Until now, however, SDA has not been incorporated into the MIS. SDA provides a significant percentage of the total family planning services provided in El Salvador. Unless it is eventually included, the system itself cannot be considered a complete success on a national basis. The MOH/ISSS system needs to be redesigned and significantly rewritten for use at SDA. To this end, an implementation plan to adapt the MIS to SDA's needs has been prepared and revised, but a great deal of work is still necessary to carry out the implementation process. The technical assistance team must assign a high priority to incorporation of SDA into the MIS.

One worrisome aspect of the development of the MIS has been the apparent lack of involvement of MOH and ISSS MIS technical and statistical personnel in system design and development. The MIS department of the MOH and the ISSS have not participated in this process and are unaware of the technical structure of the system. Because the technical assistance group has developed the system in isolation from its technical counterparts, serious problems could arise once the expert advisors depart.

At the regional level, concern was also expressed by statistical personnel regarding the lack of input into the system design process, particularly in the design of reports. Although these staff were consulted prior to system design, they were apparently presented with a fait accompli once the program itself had been finished, rather than having had regular meetings throughout the system development process. Final evaluations are under way, but changes in the system at this late date (18 months after it was put in use) will require much more effort than the same changes would have required earlier in the development process.

Adequate documentation (a technical manual for programmers, a users manual for those who will use the program on a daily basis, and an MIS manual for those MOH managers who will use the information) could provide continuity once the project ends and reduce the potential problems outlined above to a minimum. No documentation of any type has yet been finished, although it was reported that some documentation was being prepared. Adequate documentation for programmers, program users and information users must be produced, reviewed and revised prior to the end of the project.

Finally, problems were observed in data collection for the MIS. A review of the percentage of health units reporting over the past six months (see Table 6, next page) shows that approximately 20 percent of all units do not furnish monthly data to the system. At ISSS, over 50 percent do not report. The MOH has recently shown some improvement, whereas ISSS needs closer monitoring. Closer follow up needs to be conducted, probably in conjunction with periodic supervision in both institutions.

Considering the number and magnitude of the tasks to be accomplished prior to the end of the project, the MIS technical assistance staff must rigorously schedule its remaining time if it expects to conclude successfully an effort that has gotten off to such a promising start.

4.iii.b) Are the institutional personnel receiving an adequate computer training?

Many health staff have received basic training in software applications such as Word Perfect and LOTUS 1-2-3. Orientation in basic hardware operation and maintenance seems to have been somewhat limited in scope and depth, lacking exposure to basic skills in analyzing and correcting problems that occur. Training in the MIS program itself has been limited to staff directly responsible for operating the system on a day-to-day basis. In general, the training seems to have been slanted more toward the theoretical and less on the practical use of the programs for management and problem solving.

Table 6

**Health Units Not Reporting Data Through
MIS For 6-Month Period - 1989**

		<u>Number Not Reporting</u>	<u>Total Centers</u>	<u>Percent Not Reporting</u>
January	MOH	55	315	17.5
	ISSS	<u>5</u>	<u>9</u>	55.6
	Total	60	324	18.5
February	MOH	77	345	24.4
	ISSS	<u>44</u>	<u>73</u>	60.3
	Total	121	388	31.2
March	MOH	82	315	26.0
	ISSS	<u>45</u>	<u>73</u>	61.6
	Total	127	388	32.7
April	MOH	90	315	28.6
	ISSS	<u>44</u>	<u>73</u>	60.3
	Total	134	388	34.5
May	MOH	52	315	16.5
	ISSS	<u>42</u>	<u>73</u>	57.5
	Total	94	388	24.2
June	MOH	52	424	12.3
	ISSS	<u>42</u>	<u>73</u>	57.5
	Total	94	497	18.9

4.iii.c) **Is the training design based on institutional needs assessed by both the institutions and the technical assistance MIS expert?**

As in other training programs, little use was made of needs assessment to determine course contents and teaching methodologies. As a result, courses may not be optimally efficient and effective in teaching the desired knowledge and skills related to practical program management.

4.iii.d) **Is this component helping each participating institution and the SATU in expediting financial aspects of the project?**

The MIS component provided little if any direct help to participating institutions in improving the financial aspects of the project. Although basic training in the use of spreadsheets and word processing software was provided, there is little evidence that the institutions actually make use of those newly acquired skills to help solve project-related financial problems. The computerized checkbook system developed for SATU as part of the MIS component was inadequate to meet the financial needs of the project (see Section 1.ii.d).

4.iii.e) Was the computer distribution made on basis of needs and potential usage by each institution?

The distribution of the 21 computers was made as shown in Table 7 below:

Table 7
Distribution of Computers

<u>Agency</u>	<u>Number</u>
Cambridge Consulting Corporation	7
SDA	4
MOH Regional Headquarters (1 yet to be delivered)	5
SATU	1
MIPLAN	1
SETEFE	1
ISSS	1
MOH Statistics Department	1

CCC makes good use of its computers, but it is difficult to justify their being the largest recipient of hardware. Perhaps if CCC had to depend more on SATU and the participating institutions for its computers, its isolation would have been reduced. In any case, this equipment will be turned over to the implementing agencies at the end of the project.

SDA is not yet using its hardware for the project MIS (still under development), but instead uses the equipment for its accounting department. MOH regional headquarters need and use the full number of machines allocated and would benefit from having an additional spare machine to use as a temporary replacement in case of breakdown. SATU could have probably made good use of an additional machine if more financial and administrative applications had been developed for its use. The MIPLAN computer is underutilized, since the population data base that justified its acquisition was never developed. It is hoped that SETEFE's use of the donated microcomputer is contributing to improvements in the project's financial situation, although SETEFE does not yet have a central MIS (those applications in use were developed on an ad hoc basis by employees). ISSS is making good use of its microcomputer. The MOH Statistics Department is using its machine for the preparation of the GOES Five Year Plan.

5.5 Policy and Planning

5.i) Is the MIPLAN's Population Office (PO) adequately responding to El Salvador's policy needs in population? If not, what are the impediments the PO is currently facing and what will the recommendations be to achieve its proper role?

The Office's success in securing approval of the National Population Policy was noteworthy. Due to a number of obstacles, however, most of the other actions called for in the Project Paper were not accomplished.

The PO's role consisted mainly of organizing the seminars and providing the information that led up to the final approval of the National Population Policy in September 1988.

Although this document is appropriate for the El Salvador setting, it does not specifically advocate family planning, as such. The term is used only once, in the glossary where the term "reproductive health" is defined. The population policy places reproductive health in the context of improving the quality of family life as the foundation for socio-economic development and effectively calls attention to the impact of rapid population growth on employment, education and environment. It also contains the essential features of most population programs: It recommends expansion of reproductive health services, population education in formal and non-formal settings, and intensive IEC programs in population aimed at balancing the work force supply with demand, promoting responsible parenthood and improving the status of women. Thus, it provides a policy background that should permit the development of the most essential features of a population program.

On the other hand, a number of planned activities were not carried out: The planned leadership education and dissemination of the population policy has not begun, the Data Bank has not been developed, and the planned research not been accomplished.

Among obstacles encountered, the total destruction by the earthquake of the building in which the Population Office was located must be ranked high. The inadequate temporary facilities to which it moved undoubtedly had an impact on its performance. Only recently has the Office moved into better quarters. Changes in executive leadership of the Office also presented problems, as did the issue as to whether MIPLAN communication activities should be reviewed by the ITC.

Not all project activities are feasible at this late date, but some progress could be made in most areas. Too little time remains to complete the Data Bank, for example, but the computer is installed and there are staff capable of using it. Some technical assistance could be provided by the CCC team leader to develop the conceptual framework (data to be gathered, sources, degree of disaggregation, needs to be served, etc.). CCC consultants could assist with the computer programming and initial instructions in its use. Future actions would require a more comprehensive approach including promotion, setting up data collection procedures, connections to other data banks, training in use of the system and in use of the data produced, etc. This MIPLAN Data Bank, however, should not be counted on now or in the future as a primary source of information for monitoring family planning programs for management purposes.

It is also too late to carry out any research, but in the future, efforts should be directed to identifying information needs and contracting specific research to be carried out by universities or private sector institutions.

Much could be done over the remaining months to provide leadership training and dissemination of the population policy. Some initial steps have already been taken, including some planning and preparation of prototype material. The impediments to further progress are perceived funding shortages and inadequate basic supplies. These are primarily administrative problems, however, that could be resolved if the decision were made to go forward.

Other institutions made significant contributions in the area of policy. For example, policy funds were used to complete the 1988 FESAL, with SDA the lead Salvadoran institution. Likewise, the MOH prepared key planning and policy documents. For example, an excellent strategy paper was prepared for the extension of reproductive health service to the rural areas. This paper could provide the basis for policy decisions, intra-ministerial cooperation, and strengthening of the training and supervisory components essential for its implementation. The norms for reproductive health programs are well conceptualized and provide, among other things, a basis for para-professional and community leadership participation in the delivery of family planning services. An MOH concept paper on high risk pregnancy is in its formative stages, but this shows promise of becoming a key policy document, demonstrating the impact of family planning in reducing the risks of infant and maternal mortality associated with pregnancy.

5.ii) Is the MIPLAN's PO staff adequately trained to respond to El Salvador's needs in obtaining an adequate Population Policy?

The PO is staffed by a well-trained group of professionals. All have university degrees, with specialties ranging from demography, economics, public health, and biology to philosophy, sociology and social communication. Most have done graduate study in Costa Rica or in Chile with CELADE. Some have done graduate work in the United States. Their training and understanding of the population area should enable them to play a more dynamic role than they do at present, if they choose to do so, and bureaucratic constraints permit.

An area in which additional training would be helpful might be in analyzing how different socio-economic factors are affecting population and vice versa. CELADE provides graduate courses in this subject. These could be complemented by technical assistance or tutorials at the Research Triangle Institute or the Population Council to assure a full understanding of how family planning and contraceptive prevalence fit into these equations.

Additionally, staff might benefit from cooperative training with the National Bureau of Statistics to explore with the U.S. Bureau of Census ways for securing better demographic data without actually taking a full census. A national census has not been taken since 1971, and tremendous change including massive migration has occurred. Though the need is obvious, undertaking a full census at this time would be problematic.

5.iii) What is the GOES attitude re population programs?

Although the government has not expressed itself publicly in this area, it appears likely to remain at least as permissive as the previous administration and will possibly be somewhat more supportive of population programs. It appears, however, that the national government is not prepared at this time to take a public stand openly favoring family planning. If it were, it would have at least included reproductive health in one of the recently published "Siete Programas Iniciales de Rescate Social" ("Seven Programs of Social Rescue"). This conclusion that the government is not ready to take a strong position was borne out through interviews with leadership in MIPLAN and the health and family planning field and reviews of news files.

SDA is optimistic about the prospects of increasing support from the highest levels, in part because this year President Cristiani became 1 of 35 supporting members of SDA, as did 7 other top leaders. President Cristiani also participated in the inauguration of the first Congress on Reproductive Health and is expected to participate similarly in the planned seminars to disseminate the results of FESAL 88. SDA was able to secure a national postage stamp issuance in July 1989 honoring the association.

On the whole, MOH personnel appear disposed to support family planning. Comments of the newly appointed Director General of Health indicated full recognition of the importance of preventing high risk pregnancy as part of reproductive health and improved nutrition. The Minister of Health stated that support of national population policy was one of the key policies of the health sector. MIPLAN personnel cite the Minister of Planning's clear recognition of the importance of demographic factors in socio-economic development and family welfare. On the other hand, a health planner who had reviewed preliminary national planning documents for the social sector stated there is little recognition in those plans of the impact of demographic factors.

In sum, although it is too early to tell, it appears the present government will at least continue the policy of the previous administration, allowing programs to function freely, although not with strongly publicized support. Moreover, there is reasonable expectation this support will increase.

6. Relation to Mission Strategy

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In the chapter on Spreading the Benefits of Growth, the present Country Development Strategy Statement notes the continuing high population growth rate and the need to achieve further reductions, largely through expanded family planning programs. Additionally, it calls attention to the inequities of service availability and inequities of health indicators among the rural and urban marginal population in comparison with other segments of the population.

The past strategy was to strengthen service delivery systems, which this project was designed to accomplish with some emphasis on the rural and urban marginal populations. Through the coordination, training, IEC, and MIS and logistic systems, the project has contributed significantly to strengthening the public and private sector health and family planning institutions. These institutions are thus in a better position to utilize further assistance in the targeted fashion contemplated in the CDSS to meet the needs of high risk populations in rural and urban marginal populations.

7. Conclusions

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7.1 Constraints

This project has functioned under extraordinarily difficult conditions of earthquake, critical economic decline, civil disturbance, exodus of personnel and disruption by municipal and national elections. To have continued to operate and make as much progress as it has is a tribute to project personnel at all levels.

7.2 General Progress

Substantial progress was made in improving coordination and strengthening institutional capacity through training, MIS/logistics, IEC and policy activities, despite critical constraints both external and internal to the project. Much remains to be done to consolidate these gains into more effective family planning service delivery, with emphasis on the younger couples of the rural population.

Despite significant improvements in 1989, the GOES institutions supported by this project were not successful in increasing contraceptive coverage in the project period. Performance in the private sector, supported by other projects in addition to project 0210, was substantially better, but on a smaller scale. Nonetheless, by 1989, SDA was providing approximately 29 percent of the aggregate CYP. Overall increases in CYP during the period 1986 to 1989 were 10 percent, made up of a 48.2 percent increase in SDA service, and offset to some degree by a 0.6 percent decrease in the service provided by the GOES institutions. It is hoped that the 12 percent increase in the 1989 GOES service delivery is the beginning a more favorable trend.

7.3 Program Components

7.3.1 Administration

1. SATU and the Special Health Commission were established, met regularly, and dealt seriously with policy, technical and administrative issues. These meetings increased communication and coordination among public sector institutions and, to a somewhat lesser degree, with the private sector. SATU's close affiliation with the Director General of Health ensured that SATU received guidance, supervision and support. Ministry capabilities were severely strained by external circumstances. SATU could have been more effective had the Ministry been able to provide more support in personnel and working conditions. Vigorous actions made possible by the appointment of an Executive Director with stronger administrative staff brought considerable improvement. Nevertheless, SATU's performance was severely taxed by the multiple bureaucracies through which it had to work.
2. Annual plans improved over time, providing lists of activities and budgets consistent with project objectives albeit overly optimistic in light of the circumstances (e.g., among other things inclusion of STDs and cancer detection as reproductive health interventions). These plans could have been further improved by more clearly specifying objectives, articulating strategies and priorities, demonstrating the analysis of past performance, placing greater emphasis on supervision and monitoring and making more explicit the attention to family planning service delivery. Important planning/policy documents regarding service norms and extension of services were drafted by the MOH with SATU assistance. SDA Annual Plans were developed within the IPPF planning framework which provides for more clarification of objectives and strategies.

3. Project administration suffered from initial delays in project start-up and critical problems of procurement and continuity of financing. These problems, which are being resolved, arose from bureaucratic complexities and problems in performance found among all institutions involved -- USAID, SETEFE, SATU and the GOES implementing agencies. Had more financial management and procurement guidance been provided initially, had SATU personnel possessed sharper financial administrative skills, and had more technical assistance been provided in these areas, problems might have been ameliorated, but still not solved. At this point, these problems are seen to be the most important impediment to project performance. Because they are basically structural problems, the question arises as to the viability of the project administrative structure itself, which required SATU to handle the financial management and significant portions of procurement. To be fully effective, SATU would have required more autonomy and independence from the MOH bureaucratic structures.

In summary, although SATU has served effectively as a coordinating mechanism, its problems with financial, administrative and logistics have impeded project actions and also limited SATU's own ability to make as strong a technical contribution to the project as it might have.

With a simpler grant agreement with USAID and less complex implementation responsibilities, SDA has escaped most of these problems.

4. Technical assistance provided in IEC, training and MIS/logistics was actively and effectively utilized as long as consultant roles were clearly identified and the need for services was recognized. On the other hand, technical assistance in administration and planning was not fully utilized, although the situation appears to be improving. The overall effectiveness of the technical assistance has been limited by many of the constraints mentioned above (see Section 7.1). Additionally, there was a lack of continuity in team leadership, and space availability after the earthquake made it impossible to house the technical assistance team together with SATU. Thus, establishing good lines of communication and developing cooperation have been difficult.

The effectiveness of the excellent training assistance was limited by its intermittent nature. Inadequate provision was made in project planning for longer term training assistance and for assistance with procurement. At the time of evaluation, the communication and relationship between USAID, SATU and CCC appeared to be less smooth than it was reported to have been in the past. It is imperative that all parties communicate on a regular basis to clarify problems and misunderstandings in order to ensure maximum project outputs over the remaining nine months.

7.3.2 Training

1. Despite the delays experienced by the project as a whole and irregularities in the flow of funding, considerable training of generally acceptable quality was carried out. The areas of training conform to the signed agreements: namely, family planning service delivery, IEC, logistics and maintenance. Appropriate attention was given to community and patient motivation skills at the various levels of health service providers by both the GOES and SDA implementing agencies. There were shortfalls in the provision of training: MOH failed to train rural health aides (Ayudantes Rurales de Salud) and community health assistants (Asistente Comunitario de Salud) or to arrange in-service training for physicians, graduate and auxiliary nurses on general family planning topics, although these categories of workers are the mainstay of rural health facilities. Likewise, MIPLAN did not carry out the leadership training that had been planned.

In summary, although the training component has met 118 percent of the planned outputs for the various levels of workers, greater attention needs to be given by the MOH to peripheral health facility staff and the community-level worker.

2. Curriculum documents reveal reasonable attention by the participating institutions to modern pedagogical methods (teaching and audio-visual aids) in their specification of behavioral objectives, effective selection of curricular contents that are aligned with the educational objective desired, and selection of training methodologies that are appropriate to the learning desired. The strategy of training of trainers was successfully used in a number of participating institutions. Techniques of discrepancy analysis (periodic evaluation of skill needs of trainees and/or follow-up of training in the workplace to determine impact and/or the need to revise training programs) were not utilized. This led to repeated use of training curricula that have not been validated as effective.
3. The TC functioned only when the short-term training consultant was in-country. Although a potentially useful forum for coordination and resource allocation in training, the TC for this support component of the project is considered to have been non-functional.

7.3.3 IEC

1. An important accomplishment of the project was the successful 1988 mass media campaign, planned to reach nearly four million people. Preliminary data provided by SDA suggest that its clinic visits for family planning services increased significantly between 1987 and 1988. Sound guidelines were provided for implementation, and these were carried out in awarding the contract to the top advertising agency in El Salvador through a competitive bidding process. All messages were validated using a proper methodology before diffusion. The campaign utilized a multi-media approach. The main targets were the rural population between 18 and 35 years old and, to a lesser degree, those living in urban marginal areas. In addition, a highly innovative 100-chapter radio soap opera was produced.

The mass media campaign did not coordinate its activities either with the interpersonal and group communication components (the heart of any IEC campaign), or with the distribution of printed materials and audio visual equipment as recommended by modern communication theories and practices. In addition, it seems that there has been oversaturation in the diffusion of messages and concepts through radio and TV spots. The pending impact evaluation will help clarify these and other matters.

2. Another project success story was the establishment of the ITC, made up of representatives from the project participating institutions -- MOH, ISSS, MIPLAN, SDA, ANTEL, CCC -- plus other Ministries such as Agriculture, Education, and Interior. The committee made possible for the first time in El Salvador a thorough awareness among all institutions of the work being done by the others. Its members have been meeting regularly to establish, among other things, IEC global strategy and to plan and discuss activities, progress and problems.

7.3.4 MIS, Logistics and Maintenance

1. The MIS developed by the project fully meets the requirements laid out in the Project Paper, and has additional features not originally envisioned. It has helped to assure an adequate supply of contraceptives in most health facilities and is

providing potentially useful program management information on CYPs and new users by method. The MIS cannot yet, however, be considered a success: Managers and decision makers have not been trained in its use; essential technical and users manuals have not been prepared; local counterparts at the central level are not currently operating the system; and, most important, the major private sector service provider (SDA) has not been incorporated into the system.

2. The family planning supply logistics system, although not fully adopted as a "push" type system, seems to have improved throughout the country. Most centers have adequate supplies, and large concentrations of stocks are no longer a problem. In the future, it will be necessary to coordinate this subsystem with the MOH's overall medical inventory control and distribution system (now under development), in order to avoid duplication.
3. Hoped-for improvements in laparoscope and biomedical equipment maintenance have not been realized. Long delays in the acquisition of parts (now in-country but not distributed) and poor infrastructure have resulted in inadequate preventive maintenance and have delayed repairs. While there appears to be better coordination between institutions in this area as a result of the project, closer coordination among donors and among public sector projects will be necessary if improvements are to continue.
4. Procurement problems that plagued the maintenance program also had a negative impact on the IEC component. Compounding these problems were indecision and poor communication among USAID, implementing institutions and the technical assistance group regarding the type, quantity and distribution of equipment. These problems are yet to be fully resolved.

7.3.5 Policy

The primary accomplishment in this area was the development and approval in September 1988 of a revised National Population Policy. The training seminars and publication of informational materials intended to disseminate the population policy are only in their initial stages, however, and the planned research was not carried out. Much could still be done over the remaining months to provide leadership education and dissemination of the population policy, as well as to assist various ministries develop population action plans.

The planned Data Bank was not established. With limited additional technical assistance, an initial phase could be accomplished within the time frame of the project.

SDA has played an active and effective role in policy development. The completion of FESAL 88 established an important basis for policy development. Likewise, useful internal policy documents have been prepared in the MOH. Reports of a favorable governmental attitude toward population issues, as well as the MOH's interest in strengthening reproductive health services, provide a climate for continuing improvement in population policies of an operational nature.

8. Lessons Learned

8.1 Planning and Administration

1. Plans for a project with the level of institution-building and joint planning required in this project should anticipate a time frame of at least five years.
2. Projects should avoid multiple bureaucratic steps in the planning, approval, disbursement, and financial accounting process. To the degree these steps are deemed necessary, special care must be given to provide clear procedural guidance and to strengthen substantially the management capabilities of the implementing units.
3. Technical assistance must be closely engaged in a day-to-day working relationship with identified counterparts if full benefit is to be achieved.
4. When family planning is to be integrated with other aspects of health care delivery, priority attention must be assured to the family planning aspects, if levels of coverage consistent with public health concerns or demographic objectives are to be achieved.
5. Equal attention must be given to monitoring programmatic elements (objectives as well as process) of project implementation as is given to tracking the financial aspects.

8.2 Training

1. In projects that seek to improve service utilization, the doctors, nurses and auxiliaries who staff the field-level clinics should be included in the training programs, along with community-level providers and motivators. Training for the medical personnel should not only include the technical aspects of service delivery, but also essential communication skills to inform and motivate the potential client.
2. In large-scale training programs, an investment in an initial, thorough training needs assessment, both of various job categories and of the system itself, are worthwhile. Funding should also be provided for periodic review of training outcomes, at least for the high volume training courses.

8.3 IEC

1. Successful execution of a family planning campaign requires strong emphasis on the timely coordination of all its components. The media selected must include a blend of modern mass media, social marketing methods and traditional interpersonal techniques. No single channel of communication is fully effective in achieving the goals of a complex social program such as family planning.
2. More resources, time and energy should be spent in the planning and execution of the interpersonal and group communication components. These activities are much more difficult to implement than is mass media.

8.4 MIS/Logistics/Maintenance

1. A computerized logistics management system can help assure a dependable, continuous supply of family planning supplies at all service delivery points throughout the country very soon after system implementation, given a reasonable distribution infrastructure.
2. A family planning statistics system can be successfully integrated with a logistics system and the integrated system can be operated by service point staff.
3. Training may need to be provided for personnel handling project financial control and procurement.
4. If a project requires a host country institution to coordinate a considerable number of administrative and financial activities, it is important that technical assistance with adequate administrative and financial expertise be provided.
5. USAID's financial and procurement procedures may need to be made clearer and more reasonable.

9. Recommendations

9.1 Short-Term (until the end of the project)

Highest priority should be given in the remaining nine months of the project to completing the pending actions described below and to planning future program activities. The following short-term actions are recommended:

9.1.1 Administration and Planning

Problems Addressed

A substantial body of unfinished business, both of a programmatic and a financial nature, remains to be accomplished in a short time. Some institutional and personal relationships also need to be addressed, if maximum progress is to be achieved.

1. A local specialist with strong administrative and financial analysis skills should be contracted for a period of three to six months to assist SATU and the implementing agencies resolve any ongoing financial or administrative problems, make a final accounting to USAID, and help to prepare projections of financial requirements for future activities.
2. CCC should immediately implement a phase down/phase over plan of action, transferring equipment and responsibilities to within GOES institutions and SDA as appropriate and ensuring that counterparts are adequately prepared to carry on with the activities supported by this project.
3. The USAID project manager, the technical assistance team and the SATU Executive Director should schedule regular weekly meetings to deal with implementation matters and any outstanding interpersonal problems or misunderstandings that are hindering project progress.
4. The SATU members (including GOES, SDA and CCC) together with USAID should commit themselves to a rigorous schedule of coordinating and planning meetings through the end of this project. These meetings must give balanced attention to resolving outstanding administrative matters, analyzing programmatic progress, establishing short-term priorities for budget allocations, and laying the proper planning groundwork for future activities. Progress in these areas should be reported regularly to the Special Health Commission, identifying needed policy decisions or Commission actions required.
5. The analysis of the internal evaluations of the MOH, ISSS and ANTEL family planning programs should be completed (see Section 3.3).

9.1.2 Training

Problems Addressed

The TC, though inactive for some time, needs to review the progress and problems of the component and make decisions about activities that are feasible in the time remaining. Work has begun to focus curricular design efforts on the community-level worker; this work should be completed and a trial run of these courses implemented.

1. SATU should reactivate the TC to perform a thorough review of training accomplishments under the project, review major strategies used in the project such as training of trainers and set priorities for the remaining months of the project.
2. The TC should hold a one- to two-week workshop with multi-institutional and multidisciplinary participation to perform a thorough analysis of content and focus of training programs for the high volume courses (i.e., traditional midwives, satisfied users, rural teachers, promoters, etc.). This would serve as a reasonable substitute for full-scale, systematic discrepancy analysis with workers on the worksite as objects of the study.
3. The TC and participating institutions should complete curriculum design efforts for the community-level workers (i.e., rural health aides, community health assistants, promoters and volunteers) and carry out a test of the design.

9.1.3 IEC

Problems Addressed

The potential impact of the mass media campaign was probably not achieved due to the lag in implementation of the interpersonal promotion campaign.

1. The MOH should carry out the planned interpersonal and group communication campaign, focusing adequate attention on training and mobilizing field workers at appropriate levels. This effort should be coordinated with a scaled down mass media campaign and proper distribution of printed materials and audio visual equipment. The IEC advisor should devote the substantial majority of his time to the interpersonal component in direct support of the Chief of the HEU, who should be identified as the officer responsible for this activity.
2. SATU and the contractor Johns Hopkins University Population Communication Services project should carry out the planned impact evaluation of the mass media campaign, and its results should be complemented with a final review of trends in family planning service statistics.
3. SATU and USAID should expedite procurement of basic, low cost audiovisual equipment; lesser priority should be given to audiovisual production equipment.

9.1.4 MIS, Logistics, and Maintenance

Problems Addressed

Although a potentially excellent management tool, the MIS has not been completely documented nor has the technology been transferred to national counterparts. In addition, the system has not yet been installed in the SDA. The maintenance program for laparoscopes and medical equipment has not yet been implemented.

1. SATU, with the institutions participating in the project led by the technical assistance team, should conduct an evaluation of the existing MIS, involving statistics and program staff from the central and regional levels, and make modifications in the program resulting from the evaluation.

2. The technical assistance team should write, edit, test and revise documentation for the MIS prior to the end of the project. Three types of documentation should be produced: technical documentation for computer programmers, a users manual for those who will use the program on a day-to-day basis, and an information users manual explaining the use of program outputs (reports, tables, graphs, etc.) for program management and supervision at the central, regional and local levels.
3. The technical assistance staff should develop, install and test an MIS/inventory control system for SDA prior to the end of the project.
4. The technical assistance team should design and program feedback reports for the MIS that would flow from the central to the regional, and from the regional to local levels, rather than just from local levels upwards.
5. The technical assistance team and the MOH should transfer central level MIS operations to the MOH immediately. Technical assistance staff concerned with training in system use, and perhaps other technical assistance staff, should establish participating institutions as their base of operations for the duration of the project.
6. Due to the potential for disruption in the supply system, consideration should be given to increasing the minimum supply of contraceptive stock to be maintained from four to six months and the maximum from four to eight months.
7. SATU and the team should immediately institute a preventive maintenance program for laparoscopes and other medical equipment. They should also evaluate compliance with the program prior to the end of the project and select the most technically competent institution as the coordinator of future maintenance and as the central recipient and distributor of laparoscopic parts.

9.1.5 Policy

Problems Addressed

Although the national policy has been approved, programs to disseminate this information have been delayed. The Data Bank has not yet been developed. Important policy documents within the MOH have not been completed, approved and disseminated.

1. MIPLAN should complete the publishing of informational materials and hold planned policy seminars.
2. CCC should provide technical assistance to develop an initial phase of the Data Bank (conceptual framework and computer programming).
3. The MOH should prepare and issue a directive, assigning appropriate priority to the reproductive health program at all levels of the health services delivery and supervisory system.
4. MOH should adopt its newly drafted strategy for extension of family planning services to the rural areas and continue collaboration with the Department of Community Health and other agencies involved in rural extension to plan the training, promotion and supervisory actions required.
5. MOH should approve the norms for reproductive health contained in the strategy paper. These should be disseminated by MOH, ISSS and ANTEL.

9.2 Long-Term Recommendations

9.2.1 **Planning and Administration**

Problems Addressed

Further support is required to consolidate progress of this project into gains in family planning coverage. Administrative, financial, and procurement problems have unduly hindered implementation of this project.

1. Planning for any future project should include selected positive aspects of this project, such as improved inter-institutional coordination, training, the delivery of reproductive health services, and mass media IEC activities combined with a network of interpersonal communicators. Higher priority must be accorded to family planning service delivery in the context of planning, supervision, and monitoring of health service delivery if desired increases in coverage are to be achieved.
2. Alternatives for future project administration must avoid some of the difficulties encountered by this project. It is recommended that
 - a. To assure government agencies of adequate, timely financial support, alternatives should be considered to the present cumbersome system with its layered bureaucracies. Possible alternatives might be a newly created independent or semi-independent foundation, existing private non-profit organizations or contractors.
 - b. The responsibility of the technical assistance group to work very closely in administrative/fiscal management areas in support of GOES institutional capability must be clearly delineated. Care should be taken that technical assistance is in close physical proximity to the host country organizations that it serves. In particular, the technical assistance contract should include procurement responsibility if that is a major portion of the project.
 - c. Administrative personnel who developed bureaucratic skills under the project should be reincorporated at the end of the project into their respective institutions or, at the least, their participation in the future project should be assured.
 - d. USAID should review its accounting, procurement and disbursement record with the project to identify any problems and to seek ways to respond to requirements of projects such as this in the future. Consideration should be given to allowing a 180-day limit on advances, especially when local procurement is involved.

9.2.2 **Training**

Problems Addressed

Training, as an important input into projects of this type, must be upgraded through technical assistance and improvements in the human resources available to implement these programs. Apart from the quality of the training is the need to target categories of workers who can effectively carry the messages to potential clients and deliver services to acceptors.

1. Long-term international technical assistance needs to be provided for the training component. The MOH Health Training School should be strengthened as a technical resource in health worker training.
2. One to two long-term international, masters degree training scholarships should be provided in areas of competency-based curriculum design, educational technology and evaluation of training.
3. Funding should be provided for full discrepancy analysis of performance of graduates of the major, high volume training courses and implementation of a supervisory system to maintain continuous flow of skill-level data.
4. Systematic refresher training in reproductive risk management needs to be provided for physicians, graduate nurses and auxiliary nurses in the field. Training should include advances in contraceptive technology, myths and beliefs about family planning, and one-on-one communication skills. The MOH should consider revising, in cooperation with the Ministry of Education, medical and nursing school curricula to include modern knowledge and clinical skills in family planning.
5. More "awareness building" courses should be provided for change agents in other ministries, such as teachers, agricultural extensionists and others.

9.2.3 IEC

Problems Addressed

Inadequate attention was given to a balance between the mass media and interpersonal inputs in the promotional campaign for this project.

1. Future projects should strongly emphasize that an IEC family planning campaign requires several components that reinforce and complement one another, in order to produce changes in knowledge, attitudes and behavior as planned. The mass media campaign should not stand on its own but should be executed in coordination with interpersonal and group communication supported by printed materials and audio visual equipment.

9.2.4 Logistics and Maintenance

Problems Addressed

Insufficient attention was given to full and continuous participation of national and regional staff in design, documentation and utilization of the MIS.

1. Initial MIS design and program development should be closely coordinated with institutional technical personnel (statistics and data processing) at the central level. Particular care should be taken to assure consistency and integration with other existing and planned MIS components at all participating institutions. Regional staff should be consulted regularly during the development process. System documentation and training (for programmers, computer users and information users) should be an integral part of the system development process.
2. Biomedical equipment maintenance requirements must be coordinated, not only among institutions, but also among projects and donors.

9.2.5 Policy

Problems Addressed

MIPLAN has not proven to be an aggressive implementor of the kinds of actions planned under the present project. In future, changes in policy need to address operational issues.

1. USAID should encourage UNFPA to support the general policy development efforts of MIPLAN, including expansion of population education programs. USAID should assist MIPLAN in socio-economic development policy analysis through A.I.D. centrally funded policy programs.
2. USAID should support SDA in seeking further policy change leading to improved quality of, and access to, family planning services, particularly in the private sector. Possibilities for such programs include i) encouraging the inclusion of family planning in health insurance plans or HMOs, ii) more active support by industry for family planning services to workers, iii) modification of any restrictive norms, taxes or communication constraints to provision of services, and iv) improving curricula for pre-service or in-service training to include, for example, more up-to-date approaches to family planning service delivery.

Appendices

Appendix A

Scope of Work

Appendix A
Scope of Work

EVALUATION
POPULATION DYNAMICS (REPRODUCTIVE HEALTH) PROJECT
(519-0210)

- I. Activity to be evaluated: This will be a mid term evaluation of the 519-0210 Population Dynamics Project. The project has been operating for approximately 30 months. The Mission is funding this evaluation out of PD & S since project funds allocated for this activity have been reprogrammed to cover a shortfall in contraceptives procurement for the Government of El Salvador. Lack of essential commodities could seriously jeopardize project implementation, hence the reprogramming was mandatory. Therefore, this mid-project evaluation activity qualifies for the use of PD & S funds under Category IV-Evaluations and Financial Management Audits as described in State 250808 (Policy Guidance for the Utilization and Management of PD & S Funds).
- II. Purpose of Evaluation: The purpose of this evaluation is to provide the USAID/El Salvador, the Government of El Salvador (GOES) and the Salvadoran Demographic Association (SDA) with a written mid-project evaluation report for the Population Dynamics Project. This evaluation, as planned, shall measure progress of the delivery of contraceptives, compare efficiency of the logistics system before and during project implementation at all levels of the system, review status of maintenance of bio-medical equipment before and during project implementation, and follow-up on patient's records for voluntary sterilization procedures compared with the previous monitoring system implemented by the MOH and SSI.
- III. Background: Project purpose, as stated in the Project Paper, is "to improve and expand on provision of family planning and reproductive health services, by strengthening those institutions, particularly in rural areas, which presently provide services to Salvadoran couples."

The specific planned End of Project (EOP) outputs of the project as established in the Logical Framework of the Project Paper, are the following:

1. Special Administrative and Technical Unit (SATU): An Administrative Unit functioning, and three long term technical consultants on board.

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2. Information, Education, Communication Program (IEC): (a) All major newspapers and radio stations will be carrying appropriate family planning messages and programs; (b) radio campaigns and pamphlets and other distribution literature will be developed for rural areas; (c) the SDA providing IEC services to the GOES and other organizations involved in providing family planning services.
3. Training: (a) Community leaders will receive promotional training in family planning and population matters; (b) approximately 1,350 Rural Health Aides (RIA), 1,700 Traditional Birth Attendants (TBA) and malaria promoters working in the field will be trained; (c) program administrators of the Ministry of Health (MOH), Salvadoran Social Security Institute (SSSI), Ministry of Planning (MIPLAN) and SDA will be trained in management, budgeting, project management, evaluation and IEC.
4. Logistics/Maintenance: (a) A Management Information System (MIS) to track contraceptives through the supply systems of the participating institutions will be in place and functioning; (b) a maintenance program for clinical equipment and medical facilities will be operational.
5. Policy and Planning: (a) At least 40 seminars at decision-making levels held for GOES and private sector officials; (b) establishment of a demographic data base.

The project was divided into two subagreements and both were signed on August 30, 1985. The larger agreement (Project Agreement No. 519-0210) was countersigned with the Government of El Salvador for US\$ 7,105,000 to support activities of the MOH, SSSI, MIPLAN and the ANTEL Hospital (The Salvadoran Telephone Company hospital); the smaller component (Cooperative Agreement No. 519-0210-G-00-5496-00) was countersigned with the Salvadoran Demographic Association for US\$ 2,095,000 to provide specific support to the GOES' IEC campaigns.

The major problem faced during project implementation has been the financial administration system between AID, the governmental's Technical Secretariat for External Financing (SETEFE) and the SATU in providing funds to the GOES on a timely manner for project activities. No important problems have been detected in the direct SDA-USAID relationship for financial mechanisms.

The original Project Assistance Completion Date (PACD) was extended from September 30, 1988 to March 31, 1990 for both subagreements.

Previous Project Evaluations: The project has funded one ad-hoc evaluation of its special management unit (Special Administrative and Technical Unit) performed by Development Associates, Inc. in 1987. SATU had been slow in conforming to the appropriate procedures to obtain funds from SETEFE and in maintaining controls with the participating institutions. Hence, SATU needed an analysis of its management to provide specific recommendations for improved SATU management. The evaluation, carried out in February, 1987 provided recommendations to improve SATU performance. Some of those recommendations have been accepted by both the GOES and the USAID and were already implemented.

IV. Statement of work:

A. Objectives:

- (a) Assess the overall project performance by project component and institution in both agreements: GOES project agreement (519-0210) and SDA cooperative agreement (519-0210-G-00-5496-00).
- (b) Provide specific recommendations by problem and by institution for improving project implementation; establishing the major problems/bottlenecks if detected, and suggested ways of solving/avoiding those problems/bottlenecks.
- (c) Write an evaluation report that conforms to the needs of this scope of work as outlined below.
- (d) Analyze the steps each institution follows to fund or disburse funds for project activities including USAID's Controller's office, and make recommendations to improve the system if so required.

B. Specific tasks by Project Component:

(1) Component I: Administration

Background: The facilitation and coordination of this multi-institutional project constitutes an experiment by the USAID and the GOES to utilize a special project unit called Special Administrative and Technical Unit (SATU). The SATU is composed of representatives from each of the participating institutions. There are three sub-committees supporting SATU for coordination and supervision of the three largest project components: (1) Information, Education and Communication, (2) Management Information Systems and Logistics, and (3) Training.

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Evaluation questions pertinent to the Administrative component are as follows:

i. Personnel:

- a. Are the current staffing patterns and project supported personnel sufficient and possessing the qualifications necessary to accomplish the project's outputs?
- b. To what extent has the SATU implemented the recommendations made by the Management Evaluation completed in early 1987? Explain why the SATU did not accomplish the recommendations.
- c. How has the establishment of an Executive Director position improved project implementation and interinstitutional coordination?
- d. Is the project Executive Director position given sufficient authority to expedite project implementation?
- e. Is the current project personnel structure too hierarchical for agile project implementation?

ii. Financial Management:

- a. How well is SATU administrative personnel implementing financial responsibilities to disburse funds, report expenses and obtain advances?
- b. Is this management unit an administrative mechanism that is recommended for replication in new projects?
- c. How has the local procurement accelerated the accomplishment of project activities?
- d. In what way has the computerized financial system helped the SATU?
- e. From the perspective of the project counterpart personnel, what role has the technical assistance played in accomplishing financial and management objectives?
- f. Do the participating agencies agree that the administrator is responding to their financial needs?

- g. Is the Project Coordinator providing sufficient time and interest to project implementation?
- h. What has been SATU's working relationship with SETEFE? Is SETEFE responding adequately and on a timely basis to SATU's requests and priorities?

iii. Programatic Management:

- a. Are yearly action plans prepared with sufficient and technical criteria provided by all the SATU's members? Or, do they tend to be guided by a specific institution and/or technician?
- b. Is there an efficient supervision scheme implemented by the SATU to assure smooth project implementation? Is there any feedback from supervisors to the higher levels when problems occur to correct the errors detected?
- c. Do action plans developed by each of the participating institutions under this project respond directly to the programatic priorities of that institution?
- d. Are the project goals and objectives well understood by each of the participating institutions?
- e. Is the technical assistance team providing adequate inputs to program development?

(2) Component II: Information, Education and Communication

Background. The implementation of this project component is directed by an Interinstitutional Technical Committee (ITC). Delineating IEC programatic aspects and relating directly to the advertising agencies, the ITC manages this project component.

i. Quality of work of each participating institution

- a. On what criteria was material developed by each participating institution to generate more public demand for public health services? Were there guidelines from the project manager?
- b. Do the participating institutions have well trained and sufficient personnel to respond to the IEC needs?

- c. Has the technical assistance provided adequate support and technical guidance in this crucial project component?
- d. Is the advertising agency responding to ITC needs as requested?
- e. Is the mass media campaign adequately designed and implemented to generate demand for family planning services?
- f. Is mass media an alternative that should continue or would person-to-person techniques be more effective?
- g. Do printed materials reinforce mass media messages in a simple and direct manner so that the public understands?
- h. What is the proportioned distribution of media time for the mass media campaign, e g.: is there more of an emphasis on rural rather than urban areas or vice versa?
- i. Do interpersonal message campaigns reinforce the mass media campaigns agreed to by the ITC?
 - ii. Interinstitutional Committee (ITC)
 - a. Is this Committee an effective administrative mechanism to coordinate interinstitutional activities?
 - b. Is there an equal participation in the ITC by all the project institutions or is there just a tendency to be "oriented" by an specific institution?
 - c. Is the EC coordinating adequately with the ad agency?
 - d. Is the ITC providing the necessary criteria to permit the ad. agency to produce effective TV and radio spots and printed materials?
 - iii. Publicity materials/campaigns:
 - a. Are radio messages designed accordingly to target groups idiosyncracies and needs?
 - b. Are printed materials designed in accordance with modern teaching techniques utilized for illiterate people?

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- c. Is the publicity material pre-tested before distribution a/o diffusion?
- d. Is the monitoring scheme used by the GOES and the SDA designed to reflect adequate and quick results?
- e. Are the results used for a continuous "fine tuning" of the campaigns?
- f. Is the JEC technical assistance responsive to GOES/SDA needs?

(3) Component III: Training

Background: Upon the suggestion of the specific technical assistance for this component, the GOES requested an interinstitutional committee coordinating training activities, as in the JEC component. The committee manages this project component.

i. Training committee

- a. Is this Committee an effective administrative mechanism to coordinate interinstitutional activities?
- b. Is there an equal participation in the committee by all the project institutions or is there just a tendency to be "oriented" by a specific institution?
- c. Is the committee coordinating adequately with the international technical assistance?

ii. Training curricula of each institution

- a. Does each participating institution have training curricula?
- b. Are they adequate and in accordance with each institution's priorities?
- c. How well does the trained personnel implement new knowledge on daily work?
- d. How many persons have been trained during the life of the project (LOP) and by each participating institution?

- e. Is there any increase in the number of people trained during the LOP in comparison with the last two years previous to project initiation?
- f. Are the curricula designed to achieve a larger services coverage among the rural population?
- g. How well are the institutions following modern teaching techniques?
- h. Is selection of training activities part of a long term strategy or done on an ad-hoc basis?
- i. How well is the technical assistance supporting the participating institutions?

(4) Component IV: Logistics and Maintenance

Background: A managerial group was formed with representatives from all the participating institutions. This group supervises the Management Information Systems (MIS) aspects of the project as well as supervise and provide guidelines to develop an adequate logistics system for contraceptive distribution and medical equipment maintenance.

- i. Contraceptives:
 1. Has each institution the technical capability to perform an inventory of contraceptives at any time?
 2. Are the personnel adequately trained for accomplishing its work?
 3. Do the institutions record adequate data for assessing contraceptive needs at each outlet?
 4. Are contraceptives distributed on time?
 5. What are the criteria or priorities each institution uses to assign/deliver contraceptives to its facilities?
 6. What kind of logistics data are used by the institutions for delivering contraceptives to its clinics?

7. What system do they use for sending contraceptives to the clinics? A pull or push system?
8. Are clinics' requests and plans taken into account for determining contraceptives assignments?
9. Do the institutions keep a minimum and a maximum stock? Based on what criteria?

ii. Medical and Laparoscopic supplies

1. Has the medical equipment procured under the project been adequately distributed? Based on what criteria?
2. Are the supplies responding to each institutions needs?
3. Is the laparoscopic equipment being fully used?
4. Does the GOES have an appropriate maintenance system for both laparoscopes and medical equipment in general?
5. Do the institutions provide preventive maintenance for medical equipment?
6. Does the maintenance unit of the MOI have adequate and sufficient resources to promptly react to technical needs?
7. How well does the technical assistance respond to current institutional needs for (a) management, (b) contraceptive logistics?

iii. Management Information System:

1. Is the technical assistance providing adequate timely inputs to institutional needs?
2. Are the institutional personnel receiving an adequate computer training?
3. Is the training design based on institutional needs assessed by both the institutions and the technical assistance MIS expert?
4. Is this component helping each participating institution and the SATU in expediting financial aspects of the project?
5. Was the computer distribution made on basis of needs and potential usage by each institution?

Appendix B

List of Persons Contacted

Appendix B

List of Persons Contacted

A. Ministry of Health - Central Office

Dr. Lisandro Vasquez Sosa	Minister of Health
Dr. Jose Maria Ticas	Director General
Dra. Guadalupe de Razeghi	Executive Director SATU
Lic. Belarmina de Henriquez	Administrator SATU
Dra. Juana de Santamaria	Chief of Maternal and Child Health
Dr. Carlos Humberto Bollia	Chief of Family Planning MCH
Dra. Delmy de Hernandez	Chief of Health Education
Dr. Fenando Minervini	Chief of Statistics
Sra. Graciela Torres de Rodas	Health Educator
Ing. Mauricio Consuegra	Deputy Chief Maintenance
Sta. Gloria E. Arcas Fuentes	MCH/FP Department

B. Ministry of Health - Regional Officers

Dr. Roberto Arnoldo Rivera	Director of Central Region
Dr. Narciso Alvarez Caceres	Chief Family Planning Area
Dr. Rodolfo Ventura	Chief Family Planning Area
Sra. Nora de Minervini	Regional Chief Nurse Supervisor
Sr. Luis Antonio Villafuerte	Supply Chief
Sta. Ana E. Buatista Flores	Rep. Health Educator/Promotor
Sta. Patricia Rodas Molina	Rep. Health Educator/Promotor

-Nurses, supervisors, satisfied users, health aides in community health facilities.

C. Health Training School

Dr. Rolando Marroquin	Acting Director
Sra. Estela de Arevalo	Area Coordinator
Sra. Fidelina de Canales	Area Coordinator
Sra. Dolores de Melendez	Area Coordinator

D. Social Security Institute

Dra. Vilma de Aparicio	Deputy Director Medical Service
Dr. Jose Antonio Pereira	Special Advisor Health Planning (previous Director General MOH)
Dr. Rarael Olivares	Chief of Maternal and Child Health Program
Dr. Melvin Hernandez	Chief Family Planning Program
Dra. Mercedes Salazar	Family Planning
Ing. Juan Antonio Cruz V.	Chief of Maintenance
Ing. Cesar Abarca	Procurement Officer

E. ANTEL

Dr. Marco Antonio Salazer	Chief of Family Planning
Sta. Celina Villalta	Health Educator

- F. MIPLAN**
- | | |
|-------------------------------|---|
| Lic. Hugo Mariona | Director of Population Office |
| Dra. Concepcion de Herrera R. | Health Sector Advisor Population Office |
| Lic. Rolando Perez Castillo | IEC Advisor |
- G. SETEFE**
- | | |
|-----------------------------|----------------------|
| Dr. Juan Antonio Altamirano | Chief of Health Area |
|-----------------------------|----------------------|
- H. SDA**
- | | |
|----------------------------|--|
| Dr. Samuel Castro | Interim Executive Director |
| Dr. Jose David Araya | Director of Planning |
| Dr. Carlos Mauricio Romero | Director of Administration and Finance |
| Sra. Dora Castillo | Director of Social Marketing |
| Lic. Leonel Marquer | Training Director |
| Sra. Annette Calvo | Director of Resource Development |
| Sta. Esther Espinoza | Trainer |
| Sr. Victor Rosa | Maintenance |
| Sra. Ana Maria de Quinonez | System Analyst |
- L Advertising Agencies**
- | | |
|---------------------|----------------------------------|
| Sr. Juan Ferreiro | Account Executive APEX |
| Sra. Silvia Salazar | Media Director "Pub. Commercial" |
- J. USAID**
- | | |
|-------------------------|--------------------------------|
| Mr. Richard Thornton | Director HPN |
| Mr. Kevin Armstrong | Deputy Director HPN |
| Dr. Guillermo Toledo | Population Officer |
| Sr. Roberto Brito | Chief Accountant |
| Sta. Rosa Maria Molina | Voucher Examiner |
| Mr. Parvis Shahinidejad | Supervisor Voucher Examination |
| Ms. Debbie Kennedy | Director, Project Development |
| Mr. William Kaschik | Director, Program Development |
| Mr. Donald Harrington | Agriculture |
- K. CCC**
- | | |
|-----------------------------|-----------------------------------|
| Mr. Bjorn Holmgren | Chief of Technical Assistance |
| Mr. Steven Orr | MIS and Logistics Advisor |
| Sr. Manuel Rodriguez Casado | IEC Advisor |
| Ing. Luis Oliva | Logistics and Maintenance Advisor |
| Ing. Mauricio Campos | MIS Advisor |

Appendix C

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Appendix C

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