PD-ABM-872

Final Evaluation of the El Salvador Family Health Services Project

IQC Contract No. AEP-0085-I-00-3002-00
Delivery Order No. 17

Submitted to:

USAID/El Salvador
Torre "M" Olimpica
Avenida Olimpica, Frent Plaza Peru
San Salvador, El Salvador

Submitted by:

Development Associates, Inc.
1730 North Lynn Street
Arlington, Virginia 22209
(703) 276-0677

Prepared by:

Victoria Wells, PhD
Diane Urban
John Wolff
Maria Gutierrez-Valencia

October 21, 1994

© Copyright 1994 Development Associates, Inc.

BEST AVAILABLE COPY

List of Abbreviations

AIDS	Acquired Inmune Deficiency Response
ANTEL	Administración Nacional de Telecomunicaciones
BCP	Birth Control Pills
CBD	Community-based Distribution
CDC	Centers for Disease Control and Prevention
CPR	Contraceptive Prevalence Rate
CYP	Couple-Years-of-Protection
DAR	Rural Distribution of Contraceptives
ES	El Salvador
ETS	Enfermedad Transmisible Sexualmente
FESAL	Encuesta Nacional de Salud Familiar
FHI	Family Health International
FHSP	Family Health Services Project
FP	Family Planning
GOES	Government of El Salvador
HPN	Health, Population and Nutrition
HSA/ES	Health Sector Assessment/El Salvador
IEC	Information, Education, and Communication
IEP	Research, Evaluation, and Planning
IPPF	International Planned Parenthood federation
ISSS	Instituto Salvadoreño del Seguro Social
IUD	Intra-uterine Device
JHU	Johns Hopkins University
MCH	Maternal-Child Health
MSPAS	Ministry of Health (Ministerio de Salud Pública y Asistencia Social)
NGO	Non-governmental Organization
PACD	Project Activity Completion Date
PAHO	Pan American Health Organization
PROSAMI	Proyecto de Salud Materna y Supervivencia Infantil
PVO	Private Voluntary Organization
PHP or PSP	Rural Health Promoter
PWP	People in Work Places
RHP	Rural Health Program
SDA	Salvadoran Demographic Association (Asociación Demográfica Salvadoreña)
SES	Socioeconomic Status
SMP	Social Marketing Program
SMRD	Social Marketing and Resource Development
STD	Sexually Transmitted Disease
TA	Technical Assistance
USAID	United States Agency for International Development

ElsaAbre.r24

Executive Summary

Scope of Work

USAID/El Salvador, Office of Health, Population, and Nutrition (USAID/ES, HPN), developed the following plan for the interim evaluation of Project No. 519-0363, Family Health Services, authorized in 1990, by the Salvadorean Demographic Association (SDA). The Project has a life of 5 years, with total funding of $35,826,000 (USAID input = $22,000,000 and SDA input = $13,826,000). The Project purpose is to continue and to expand the delivery of birth spacing and Maternal-Child Health (MCH) services to high risk populations in rural and marginal urban areas and to improve the quality and efficiency of these services. Cambridge Consultation Corporation (CCC) was hired to provide technical assistance and monitoring. The goals of the interim evaluation were to:

1. Evaluate the reorganization and expansion of rural health services, including regional, satellite, and marketplace clinics; the physician-referral system with particular emphasis on efficacy (including method mix); and general project logistics, technical assistance (received and required), IEC/training, and sustainability.

2. Evaluate the institutional development of the SDA focusing on social marketing and ultimate sustainability, program evaluation and management capability.

3. Describe the Project's impact on policy development and research.

Methodology

The evaluation team from Development Associates was led by Victoria Wells, MD, DPH, Chief of Party, Population and Family Planning Specialist; Maria Gutierrez-Valencia, Social Marketing and Economics Expert; Diane Urban, Information, Education/Training, and Communications Expert; and John Wolff, Logistics Expert.

The team utilized these methods:

1. Interviews with key persons at SDA, Ministry of Health (MSPAS), CCC, and USAID, and interviews with the private sector (physicians, church leaders, consultants).

2. Observations and questionnaires used in rural and marginal urban areas in each of the four regions (Central, Paracentral, Occident, Orient).

3. Review of official project documentation and correspondence.

4. Analysis of pertinent demographic, financial, and clinical statistics.

5. Site visits to 4 regional clinics, 4 satellite clinics, 4 marketplace clinics (2 fully funded by SDA, 2 provided only contraceptives by SDA), and the warehouse in each region.

6. Site visits to homes of Profamilia Health Promoters (PHPs) and Distributors of Rural Contraceptives (DARs) in three of the 4 regions.

7. Review of short-term consultants' reports, CCC monitors' evaluations, and SDA supervisors' evaluations.

CONCLUSIONS/RECOMMENDATIONS

A. COMPONENT I: Family Health Services Delivery

Reorganization and Expansion of Rural Services

1. The SDA deserves to be recognized for working effectively to reach its rural health program goals.

RECOMMENDATION: USAID should continue to fund the RHP.

2. The rural program has met most of the numerical goals, in terms of number of PHPs, and DARs recruited and trained, and villages covered. However, the quality of services needs improvement.

RECOMMENDATIONS: Strengthen the training and supervision of the PHPs and DARs:

- ***Conduct an assessment of training needs.***
- ***Hire a consultant, who is an expert in training rural illiterate and low-level literate populations, for up to one year to enrich training. The person should be based in the rural area.***
- ***Reorganize and expand the training department.***
- ***Train the promoter supervisors and auxiliary nurses in both substantive and educational areas.***
- ***Develop mastery modules, certificates, and recognition for PHPs.***

3. The Project has been hindered by lack of supplies. The evaluation team observed that the rural project seems to receive less logistical support than the clinical program.

RECOMMENDATIONS: Upper management should draft an explicit policy to make sure that the rural program has adequate supplies and supervise administrative procedures to guarantee that it does.

- ***Decentralize logistics.***

4. IEC materials are generally very good, and materials exist for illiterate people. The video products are excellent. What is lacking is a mass media campaign.

RECOMMENDATIONS: Develop additional materials with client input, particularly for illiterate adults and teens.

- ***The mass media campaign promoting family planning should be begun as soon as possible.***

- ***Encourage SDA staff to learn how to package, and track sales of its video products to assist the SMP in self-sufficiency efforts.***

5. The rural program sometimes duplicates efforts of other MSPAS and NGOs.

RECOMMENDATION: Increase efficiency though integration with MSPAS and other rural health promoters.

Expansion of SDA Clinical Services System

6. During the life of the Project, the number of users has increased in all four types of clinic services (regional, satellite, marketplace, and physician-referral) with increases in family planning services being less than in other specialties. This trend corresponds to SDA's expansion of services and goal of financial sustainability. The SDA deserves praise for developing a full-complement of MCH services.

RECOMMENDATIONS:

- ***Increase emphasis on family planning through USAID reimbursement for the provision of these services.***

7. Hiring physicians to provide health and FP services in marketplace clinics is one of SDA's many laudable schemes. However, the current organization of satellite and marketplace clinics leads to inefficiencies because the clinics revolve around medical services provided only 2-20 hours/week.

RECOMMENDATIONS:

- ***Expand the nurse's role and permit them to insert IUD's and provide MCH services through additional training and administrative support.***

8. The number of sterilizations has not increased over the past 4 years. The trend towards increasing couple-years-of-protection (CYP) through adding other methods should be encouraged. This begins with making sure that all necessary equipment and supplies are available at all times. Since sufficient supplies for Noristeret and IUD insertion are not on hand, SDA should be more aggressive in its approach to use of Norplant and make it available throughout the country.

RECOMMENDATIONS:

- ***Apparatus for inserting IUDs must be available always.***

- ***Physicians, including those in the Referral Network must be trained in the insertion of IUDs and implantation of Norplant.***

- ***Additional types of injectable contraceptives such as Depo-Provera, should be investigated. However, dependence on extra-mural sources of funding should not be increased in this pursuit.***

B. COMPONENT II: Institutional Development

Social Marketing Program

1. The Social Marketing and Resource Department, created in February, 1993, was operated by one person with the first assistant hired 6 months later. Lack of top-level commitment to the social marketing program (SMP) has hindered its success.

RECOMMENDATIONS:

- ***<u>Political support</u> and full cooperation is required from SDAs Board of Directors upper Management and Supervisors to ensure the success of the various resource development activities planned by the SMRD division as well as USAID staff in charge of managing the RHP.***

  Due to the importance attaining a high level of sustainability, not only to comply with the terms of the Cooperative Agreement, but to decrease donor-dependency, SDA must ensure that all its staff are well informed about the goals and plans of this Division qualifications and legitimacy of its staff; as well as their duties and responsibilities.

Sustainability

1. Significant funding has been already allocated to building infrastructure.

RECOMMENDATIONS:

- ***SDA should decentralize its administrative systems so that decision-making can occur at the regional level. A decentralized model of administration has the potential for improving efficiency. Each clinic must have a certain degree of independence or autonomy so that its management is able to solve problems as they arise without having to go through the central level.***

- ***The FHSP is approaching its third year. Significant funding has been already allocated to building infrastructure. Any forthcoming funding from USAID should be re-allocated to areas where funding and support is most needed, e.g, Training, Quality Assurance and Mass Media campaigns as well as ensuring that the program has the necessary supplies to serve the rural population.***

- ***The maintenance of the clinics that compose the expansion of services is a costly proposition of USAID. One way for USAID to make the best use of its funding is to consider establishing an arrangement with SDA to pay for SDA's delivery of clinic-based services on a reimbursement basis.***

- ***The achievement of financial sustainability is an organization-wide responsibility. Both recovering the highest per cent possible of costs and increasing the self-sustaining level of the program is the responsibility of all***

staff at SDA. This means that all persons employed or somewhat connected to SDA, e.g., PHPs, should be trained about how they all can contribute to achieving this institutional goal.

- ***It is recommended that an organization wide Management Review be conducted by a local auditing firm of international standing, e.g., Price Waterhouse or KPMG, Peat, Marwick to determine the cost-effectiveness of the Family Health Services Project as it has been implemented by SDA.***

- ***Investigate local communities' subsidizing the PSP's salary, and factories and other sources of support for satellite and marketplace clinics.***

2. Institutional development has neglected staff development.

RECOMMENDATION:

- ***Focus technical training on PSPs, nurses, and physicians, and management training on directors and clinic managers.***

3. Sustainability requires a variety of techniques.

RECOMMENDATION:

- ***Investigate the establishment of an endowment fund first recommended in February 1993.***

C. Component III: Policy Development and Research

1. Neither USAID nor CCC is viewed as a partner by SDA, although relations have improved over the life of the Project.

RECOMMENDATION:

- ***USAID and CCC should continue to meet with the Executive Director of SDA regularly.***

- ***An independent consultation regarding management, finances, and the efficacy of TA should be performed.***

2. National policy development has not been led by SDA.

RECOMMENDATION:

- ***Future funding should require explicit involvement with MSPAS.***

3. Strengthening of the research division is needed.

RECOMMENDATION:

- ***Medium-term consultation (6-8 months) in research (including, but not limited to, statistics and epidemiology) would enhance the IEP division.***

LESSONS LEARNED

1. Without frequent and careful introspection, the management of any institution can get administratively top-heavy and lose sight of its direction and goals.

2. To increase financial sustainability in recipient organizations, USAID must increase its relationship as a partner rather than a distant donor. Flexibility in allowing tangible as well as personnel resources to be used for non-project activities would enhance this goal.

3. To promote effective working relationships, USAID could stipulate in the cooperative agreement the responsibility of the recipient to maintain a good **and productive** working relationship.

4. "Family planning" is not self-sustainable. USAID has therefore encouraged expansion of services in order to attain financial sustainability. However, this has led to a decrease in emphasis on family planning. Changing reimbursement could balance this trend.

5. Even highly skilled individuals do not follow through and apply what they have learned without supervision and monitoring.

6. Just because pamphlets have pictures and no words does not mean that they will be accepted by illiterate people. Cultural norms and values may make them reject graphic drawings of private body parts.

NicEXSum.r24

I. Background

A. Project Description

1. History

Authorized in July 1990, Project No. 519-0363, Family Health Services began with the signing of a Cooperative Agreement between the United States Agency for International Development (USAID) El Salvador, Office of Health, Population, and Nutrition and a local non-governmental organization (NGO), the Salvadoran Demographic Association (SDA). In December of 1990, Cambridge Consulting Corporation (CCC) was contracted to provide technical assistance to the Project. The Project has a life of five years with an anticipated completion date of July 31, 1995. Total Project funding is $35,826,000 or C120,286,200 as counterpart contribution. The Project follows family planning Projects 519-0210, Population Dynamics, and 519-0275, Operational Program Grant to the SDA.

The SDA is a Salvadoran voluntary organization dedicated to providing family planning and maternal child health (MCH) services. Beginning operations in 1962, it is recognized as the pioneer agency in fostering family planning in El Salvador. It is popularly known as "Pro-Familia."

El Salvador recently emerged from an eleven-year conflict which led to a reported 75,000 deaths. Outmigration of citizens may have been as high as one million. These demographic changes must be remembered as this project is evaluated. Nevertheless, El Salvador has a population density estimated to be 655 inhabitants/square mile, the highest in Latin America.

According to 1994 Population Reference Bureau statistics, El Salvador has a population of approximately 5.6 million people. The birth rate is 33/1,000; the death rate is 7/1,000. The growth rate is high at 2.7%. The population is young — 44% are under 15 years of age, and only 4% are over 65. Approximately 45% of the people live in urban areas.

The Total Fertility Rate (TFR), or probable live number of births per woman during her reproductive years, is 3.9. The number varies from 2.7 per woman living in Metropolitan San Salvador to 5 per rural woman. Although nearly 99% of women know about at least one modern method of contraception, only 48% of married women aged 15-44 are using a modern method of contraception. In rural areas, the percentage falls to 41%. The desired number of children is very close to the actual, indicating a need to improve education programs. Female sterilization is the most frequently used form of contraception — 59% of the El Salvador contraceptive prevalence rate (CPR) is composed of female sterilization, by women who already have 3-4 children.

The infant mortality rate is 45/1,000 live births. The rate is high, particularly among children in the first month of life.

2. Goal and Purpose

The Project goal is twofold: to improve general reproductive health services and to improve the quality of life and health of the population.

The Project purpose as stated in the Project Paper is to continue and to expand the delivery of birth spacing and MCH services to high risk populations in rural and marginal urban areas and improve the quality and efficiency of these services. Although this Project is designed to integrate MCH services with family planning, the main Project focus is on the expansion of family planning services.

This project directly contributes to the Mission's Strategic Objective No. 4 of "Improved Quality with Equity in Health and Education" by increasing contraceptive prevalence and increasing access to health and child survival services.

Goals for the Project include enabling the SDA to increase its service coverage and provide child survival (vaccinations, ORS distribution, growth monitoring, breastfeeding promotion, vitamin A distribution, ARI treatment, etc.) and maternal health care to over 1,550 rural villages and urban areas where SDA clinics operate. By the end of the Project, the numbers of Salvadoran couples using birth spacing methods will have increased from 120,000 (in 1988) to 200,000 and there will be increased rural contraceptive prevalence from 34% to 40%. Maternal and child health will have improved, as indicated by an increase in the usage of ORS packages in selected rural areas by 20% and other service statistics. In addition, the SDA will have improved its operational efficiency and developed new sources of income to partially support the family planning programs offered to the poor.

3. Project Description

The project consists of three components:

- Family Health Services Delivery, for expanding family planning services to rural and marginal areas;
- Institutional development that will enhance the financial viability of the SDA through improvements in its organizational efficiency and the addition of new services to generate income; and
- Policy development and research to develop national policies which place contraceptives and other medicines within the reach of the poorest Salvadorans.

B. Purpose of Evaluation/Methodology

The purpose of the evaluation, as defined in the Cooperative Agreement signed between USAID and SDA, was to assess implementation performance, to identify obstacles to project implementation and, as appropriate, recommend modifications to the Project to enhance achievement of the Project purpose and goals.

We would like to clarify the parameters of the evaluation team's work: it falls into the realm of qualitative, rather than quantitative, research. According to the "Handbook for Excellence in Focus Group Research," (Debus, Mary; Porter/Novelli; 1988; pp.2-5), qualitative research is done to answer the question <u>why</u>, whereas quantitative research answers questions of <u>how many</u> and <u>how often</u>. The qualitative research process is one of discovery, rather than proof.

It is subjective, rather than objective, and allows insight into behavior and trends, rather than measuring levels of action, etc.

Two primary qualitative techniques are used: individual in-depth interviews and focus group discussions (FGDs). FGDs were not conducted during our month in El Salvador because they are time-consuming to organize, implement, and report on. Instead, we drafted questionnaires to focus our observations and interviews, and documented selected field activities on videotape.

Analysis of qualitative data is interpretive rather than descriptive. It involves small numbers of respondents who are not generally sampled on a probability basis. No attempt is made to draw firm conclusions or to generalize results to the population at large.

Ideally, qualitative techniques are used with quantitative techniques in a complementary manner. The evaluation team relied upon documents and information provided by SDA and USAID El Salvador for background information and quantitative data. In almost every instance, such information was generously and abundantly given.

However, occasionally information was requested and not provided (such as salary levels for male and female SDA staff). The final report cannot include information that was not made available to the team when they were in El Salvador.

The basic methodology followed as prescribed in the terms of reference was:

1. Initial interviews in person and follow-up interviews by phone and fax with key persons from ADS, the Ministry of Public Health and Social Welfare (MSPAS), CC and USAID, and interviews with the private sector (physicians, religious leaders, consultants).

2. Observations were conducted and questionnaires were completed in rural and urban-marginal areas in three of the four health regions (Central, Eastern, Western). Promoters were interviewed and observed doing home visits. Eight interviews were videotaped. Clients were interviewed immediately after the home visits to gauge their learning and satisfaction. Distributors (DARs) were also interviewed.

3. Review of official project documents and correspondence.

4. Analyses of demographic statistics; financial documents; clinic data, information, education, and communication (IEC) print materials and videotapes; training manuals and course curricula; evaluation reports.

5. Field trips to 4 regional clinics, 4 satellite clinics and 4 clinics in markets (2 founded by ADS, 2 that receive contraceptives provided by ADS), and warehouses in each region.

6. Observation of 2 training classes for promoters and one training class for DAMAS voluntarias.

7. Review of short term consultant reports, monitoring evaluations by CCC and evaluations by ADS supervisors.

Occasionally, the team found variance between project purposes and outputs stated in the logical framework of the project paper and the actual Cooperative Agreement signed between USAID and SDA. The team adhered to statements written in the Cooperative Agreement.

1. Team Members/Responsibilities

Dr. Victoria Wells, as leader of the evaluation team, was responsible for overall assessment of the management components. She also served as the population and family planning specialist.

Maria E. Gutierrez-Valencia is a financial systems and social marketing consultant and as such had responsibility for the evaluation of these Project components.

Diane Urban, as specialist in information, education, training and communications (IEC), was responsible for the assessment of these Project related components.

John Wolff, logistics specialist, was responsible for the components of logistics and supplies management and management information systems.

elsa-ch1.r24

II. Results: Findings and Conclusions

A. COMPONENT I: Family Health Services Delivery

1. Reorganization and Expansion of Rural Services

a. General Description

Background and Purpose

The Reorganization and Expansion of the Rural Health Services Program, (RHP), serves the purpose of continuing and expanding the delivery of Family Planning (FP) and Maternal Child Health (MCH) services to high risk populations in rural and marginal urban areas of El Salvador. The goal of the project is to improve the quality and efficiency of these services.

Project objectives include: 1) increasing contraceptive use, especially for women between the ages of 15 to 24 years old; 2) providing MCH services in order to treat diarrheal diseases and acute respiratory infections; provide immunizations; and improve nutritional status. In this regard, the RHP began distributing prenatal vitamins and antiparasite medicine. (For a complete listing of goals and accomplishments to date, see p.II-3 and 20).

The RHP fits into the National Population Policy of El Salvador, as it refers to "regionalization"; that is, variations in strategies and actions reflecting social and geographic differences. (Lininger, Executive Summary, p.49)

One of the "Lines of Action" in the National Population Policy is:

> *Increase FP services in rural areas, in marginal urban areas, and for vulnerable groups, according to their needs, living conditions, and socio-cultural norms. (Ibid, p.50)*

Serving the rural population supports the Salvadoran Demographic Association's (SDA) new focus which includes concern for family welfare and desire to be seen as a leader in the solution of national problems.

In order to attain these goals, the SDA hired 10 new staff for each of its four regional RHP offices. Included were a Regional Supervisor and secretary, plus four teams composed of a promoter supervisor and an auxiliary nurse.

The task of the regional teams was to select candidates for the job of Profamilia Health Promoters (PHPs), preferably from the pool of Community Based Distributors (DARs) who already sold contraceptives and referred clients to Profamilia clinics.

New candidates are currently trained for 10 days by the SDA Training Unit, and they are then followed in the field by Training Department Supervisors and regional supervisory teams.

Monitors hired by Cambridge Consulting Company (CCC) also make home visits to check on supplies, etc.

Specific goals and accomplishments to date are listed below. (Table 1)

Table 1: Specific Goals and Accomplishments

Activity	Goals As of	Baseline Number	Number Achieved to Date	Percent
Increase SDA contraceptive users from 120,000 to 200,000	1988	120,000	191,000	96%
Contribute to the increase of rural contraceptive prevalence from 34% to 40%	12/90	34%	43%	108%
Increase rural ORS and home electrolyte treatment for diarrhea by 20%	12/90	11%	43%	139%
Increase distribution outlets in rural areas by 750	12/90	800	1,382	78%
Select and train 1,150 PHPs	12/90	0	5/94 1,096	95%
Select 50 MD's for Referral System	12/90	0	49	98%
Expanded services in SDA clinics	12/90	-	done	100%
6 New Satellite clinics opened	12/90	0	6	100%
12 Marketplace clinics opened	12/90	0	12	100%
Decrease no. of DAR's from 800 to 400	12/90	800	5/94 381	95%
Central Referral Clinic opened	12/90	0*	0*	0*
Social Marketing Program Expanded - more outlets and more products	12/90	0	not done	0
Mass media campaign carried out	12/90	0	0	0
Research Studies Completed to test viability and cost-effectiveness of satellite clinics	12/90	**	4	50%

* The Central Referral Clinic was never begun because of the purchase of the hospital.
** See Annex 54 for a list of the research studies.

Activity	Goals as of	Baseline	Percent	Comments
Development info. materials	12/90	0	100%	1,625,000 pamphlets printed, 1,414,900 distributed.
Develop MCH materials.	12/90	0	100%	Program proposed by SDA rejected by USAID because it appeared to pay incentives. New strategy being developed by SDA.
Train private MD's in rural & marginal urban areas about FP.	12/90	0	0	
	12/90	17 of 25		Training is given each year to MD's in the Referral Network.
	12/90	28 of 30		The focus is on SDA norms as they apply to FP & MCH procedures, and how to fill out forms.
	12/90	28 of 40		

Results of the National Family Health Survey, FESAL 1993 show lower total fertility rates (TFR) in El Salvador than in 1988.

Table 2: Total Fertility Rate (TFR)

Area of Residence	Period	
	1983-1988	1988-1993
Total El Salvador	4.17	3.85
Metro San Salvador	2.59	2.69
Other Urban	3.37	3.52
Rural	5.59	4.96

Source: FESAL 1993

15

From the period 1983-1988 to the period 1988-1993, the TFR fell from 4.17 children to 3.85. The greatest decrease is seen in the rural areas. The increases seen in urban areas may be due to immigration of rural women with higher fertility rates, or other factors.

Contraceptive prevalence increased from 47.1% in 1988 to 53.3% in 1993. The greatest increases were in rural areas (see table 3 below).

Table 3: Prevalence of Contraceptive Use According to Area of Residence and Type of Methods

Area of Residence	Total (by Year)		Type of Method/Year			
			Permanent		Temporary	
	1988	1993	1988	1993	1988	1993
Total (Nation)	47.1	53.3	30.2	31.9	16.9	21.4
Metro San Salvador	64.4	66.4	38.2	36.9	26.2	29.5
Other	56.4	56.7	34.7	32.7	21.7	24.0
Rural	34.2	42.8	24.2	28.2	10.0	14.6

Permanent = sterilization; Temporary = all other forms of contraception

Source: FESAL 1988 and 1993

Survey results also show that SDA is the second most important source of contraceptives in the rural areas, after the Ministry of Health. (Table 4)

Table 4: Source of Contraceptives According to Year and Area of Residence Women, Married/in Union, 15-44 Years Old.

Source	Total		Area of Residence					
			ASS		Urban		Rural	
	1988	1993	1988	1993	1988	1993	1988	1993
MSPAS	56.9	48.9	40.4	36.4	61.0	48.6	67.1	61.6
SDA	12.6	15.3	8.6	12.8	9.3	12.5	18.9	20.0
ISSS	11.5	14.5	23.4	22.4	10.4	15.7	2.7	5.8
Drugstore	8.2	9.3	9.6	13.4	10.4	10.0	5.1	4.7
Doctor	4.3	4.2	9.3	7.2	.4	.1	.7	1.4
Other	6.0	7.5	8.7	.2	6.2	8.6	3.8	6.5
NS/NR	0.3	0.3	0.0	.7	0.2	0.3	0.7	0.0
TOTAL	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Source: FESAL 1988 and 1993

Conclusion

The SDA has the capability to speed the decline in the population growth rate because of their expertise, USAID support, and Network of PHPs. These resources are being under-utilized at present because (primarily) of financial considerations and unavailability of key contraceptives in the rural areas. Although our team cannot quantify the speed at which these interventions would decrease population growth, we strongly believed FP resources were not being maximally used for FP purposes.

RHP Goals for Outreach Workers

As shown in Table I, p. II-2, the goals of the RHP for outreach workers were to:

- Increase distribution outlets in rural villages by 750 outlets, from 800 to 1550.
- Select and train 1,150 Pro-Familia Health Promoters (PHPs) in modern FP methods.
- Decrease the number of rural contraceptive distributors (DARs) from 800 to 400 and continue to provide them with training, supervision, and supplies.

Community outreach workers

Findings:

* According to SDA annual progress reports, as of December, 1993 there were 1,276 active outreach workers: 836 PHPs and 440 DARs. The 440 DARs included: 1) many of the 800 DARs active in 1990 during the former USAID Project who continued as DARs rather than becoming retrained as PHPs or terminating their association with the SDA; and 2) new candidates who were selected and trained between 1991 and 1993.

By May, 1994, 200 more PHPs and 60 more DARs were added, for a total of 1,546, each with one distribution outlet. Given a 10% desertion rate, the number of outreach workers with distribution outlets at the time of the evaluation was approximately 1,382. This represents 78% of the project goal of 1,550 outlets.

According to data provided by the RHP, the PHPs and DARs are evenly distributed throughout the country (Annex 31). While some larger villages are covered by more than one promoter, the size of the villages has decreased over time to incorporate small villages.

Date	June 1992	Nov./92	Jul./93
No. of Villages	234	466	743
No. of Families/Village	237	218	208
No. of Children < 5	237	217	215
No. of Women at Fertile Age	300	275	252
No. of Women on Family Planning	78	70	72
No. of Pregnant Women	24	22	25
No. of Habitants	1,249	1,204	1,151

Source: Rural Health Program Department Data

* As of December, 1993, 835 PHPs had been trained (SDA 1993 Report.) As of May, 1994, 200 additional PHPs were trained and 60 more will be trained in June for a total of 1,096. This represents 95% of the project goal.

* According to Training Department data, as of May, 1994 there were a total of 381 DARs. This exceeds the goal of reducing the number of DARs from 800 to 400 by 105%.

Conclusions:

The SDA has recruited and trained sufficient numbers of PHPs and reduced the number of DARs to meet their programmatic goals for numbers of rural health workers and distribution posts. The team feels that the focus should shift to upgrading the skills of the community outreach workers rather than adding more. This upgrading could occur through advanced training held at central training sites, increased supervision, and improved monthly refresher courses that are routinely held to help outreach workers succeed.

Improved quality should become the goal for home visits and group talks that are the routine tasks of the PHPs.

Quality of services would be reflected by home visits that included: attention to all the FP and MCH problems; interpersonal communication skills including establishing rapport; encouraging two-way communication by asking questions, listening, and answering questions; demonstrating techniques; using audiovisual materials, like pamphlets; and summarizing key points. Referrals would be made as appropriate. Supplies would be sold and/or distributed. Checklists could be developed to record these activities.

Quality group skills would include: preparation of topic, room, supplies; inviting the group, and using "ice breakers" to relax people; using participatory exercises; demonstrating how to mix ORS or prepare nutritious foods, for example; checking to see what people remembered, summarizing key points, and handing out take-home materials.

RECOMMENDATION: Maintain the current number of PHPs and DARs. Concentrate on providing quality of services rather than on expanding geographically. The more dispersed the outreach workers are, the harder it is to supervise and supply them. The RHP might want to consider placing outreach workers in slightly larger towns and asking very isolated persons to come to them.

Other organizations in El Salvador, such as PROSAMI, have a network of rural PHPs which could be used as a resource to provide more FP services.

RECOMMENDATION: Encourage USAID and SDA to include PROSAMI in FP discussions and include staff and appropriate organizations in their umbrella group in project design and implementation.

Organizational Structure

The RHP falls within the realm of the SDA's Medical Department. In May 1994, the former director of the RHP left to become Medical Director of the Pro-Familia Hospital. The Assistant Director was promoted; then the assistant director slot was eliminated. At this time, the Director is therefore doing two jobs.

There are four regional offices (Central, Paracentral, Occidental and Oriental), each of which has a Regional Supervisor and Secretary plus four supervisory teams composed of a promotor supervisor (PS) and an auxiliary nurse.

Since the RHP represents such a large percentage of the SDA's activities, involving 1,400 community workers throughout the country, and an ample SDA staff, the program is important enough to have a director who reports directly to the SDA Executive Director. The program has grown over the past three years, and may expand even further, and needs to be led by an individual who has vast knowledge of the rural areas, simple home medical treatments and family planning technology, and the SDA.

***RECOMMENDATIONS:** The current acting director is fully qualified to be promoted to director of the project. We recommend it. Doing so would support the SDA's and USAID's goals to involve more qualified women in executive positions.*

- ***There is no reason not to re-write the qualifications for the job, which currently specify that the director must be a physician. SDA could send a revised scope of work to USAID and ask them to approve it, according to their established procedures. Hire an assistant director whose management skills will complement the current director's technical skills. This will enable the director to spend more time in the field supervising activities in the regional offices, doing strategic planning, coordinating with other SDA Departments, USAID, CCC, etc.***

- ***Due to the effort required by the promoter supervisors and auxiliary nurses to travel to rural sites to supervise the PHPs and DARs, and the need to provide individualized feedback and modeling of correct techniques to enable PHPs and DARs to internalize what they learned at the initial training course, hire more permanent staff, including more auxiliary nurses who can help the existing regional supervisory teams to extend coverage. In addition, hire a training specialist who works in the region, teaches the supervisory teams how to train PHPs and DARs, and plans monthly refresher training courses. We strongly recommend this to insure quality of care.***

We recognize that this recommendation would involve increasing expenditures and allocating a larger percentage of the RHP budget to training. Many variables are involved when deciding what percentage of the budget should be allocated for training. They include: stage of the project; number of trainees; goals for the training: complexity of the material to be learned, prior preparation of the participants, degree of cognitive and behavioral excellence sought; the way the training is provided--at a central location in San Salvador, at local monthly meetings, one-on-one practicums in the village (which are the most effective for skill development); training materials to be developed, adapted, and distributed; degree of post-training follow-up and supervision to periodically assess knowledge and skills. Besides community level workers, supervisors must be trained and evaluated on the job.

The investment in training needs to be linked to program performance which is routinely monitored.

Do clients know what to do if they get side effects from using contraceptives? What are their continuation rates? Are they referred appropriately to SDA clinics if they develop serious problems? Are they achieving their goals of preventing unwanted pregnancies? Do they have literature which tells them how to take the pill? And what to do if they forget to take one?

The SDA must decide what performance levels are important and then decide how to achieve them.

RECOMMENDATION: SDA should work with an experienced training consultant to decide upon performance objectives and options for achieving them. That exercise would develop a work plan and budget to meet their needs.

Effectiveness of RHP

In order to measure the effectiveness of the RHP,, all four members of the Evaluation Team visited the regional areas. The medical expert visited SDA regional, satellite, and marketplace clinics; the logistical expert visited warehouses and storage facilities. The IEC expert and the financial expert concentrated on interviewing PHPs, DARs, and clients. In total, 14 PHPs, 3 DARs, and 18 clients were interviewed. Eight PHP client interviews were videotaped.

Prior to going out to the field, the IEC expert drafted simple checklists and questionnaires based on the PHP training manual and SDA Planning and Evaluation Department instruments. They included a checklist for PHP Daily Activities, home visits, interpersonal communication skills, and group talks, as well as a questionnaire to indicate client learning and satisfaction. The logistics expert provided a checklist for supplies. (See Annexes 1-6.)

The RHP graciously provided four potential travel itineraries for each of the four RHP regions, and USAID provided parameters for the geographical areas we visited. Between Tuesday, May 24 and Friday, May 27, we visited 3 regions: Occidental, Central and Oriental. Upon arrival we talked with the Regional Supervisory team about their work. They mentioned problems such as:

- Vehicles have to go to San Salvador for repairs and simple maintenance which requires a long turn-around time.

RECOMMENDATION: Incorporate SDA's suggestion to use approved garages in the regions which charge prescribed rates for maintenance and repair. Allow staff to spend up to a specified amount without prior approval from the central level.

- The SDA should be applauded for allocating the majority of injectables to the rural program. Nonetheless, our team observed the several rural areas where the supplies appeared to be less adequate than what were available at the corresponding regional clinic. If a greater quantity of injectables are being provided to the rural program than to the clinical program, it is obviously not enough.

RECOMMENDATIONS: Do anything possible to get injectables delivered to the rural areas, such as allowing the rural program to borrow materials from the clinical program (which the evaluation team found to be stocked), or re-allocating funds so that essential contraceptives are available.

- Missed opportunities are occurring for female sterilization because the SDA van will not take fewer than 3 women at a time; if only 2 women decide to go, they are not transported.

RECOMMENDATION: This policy should be changed because a satisfied client will spread the word-as will a dissatisfied one. This makes recruitment harder. Schedule the use of the sole vehicle per region for patient transportation very carefully. Establish routes which stop in larger villages so that PHPs can direct their clients to places where pick-up is guaranteed at a specified time.

- We asked to see PHP and DAR folders that contained results of initial training course deficiencies, plus results of supervisory visits by training supervisors from the IEC Department, regional supervisory teams composed of a promoter supervisor and an auxiliary nurse, and CCC monitors. None existed.

RECOMMENDATION: Create a file, computerized if possible, for each PHP and DAR, which contains the above mentioned information. If it is not feasible to keep these files current, due to lack of modern and functioning computer hardware and software in the regions. A good option, suggested by SDA, would be to keep all comments in the PHP's and DAR's folder at home.

SITE VISITS

After the discussions with regional supervisory teams, we randomly picked a route, and headed out with the Director of the RHP or the Regional Supervisor, and a regional supervisory team. We used the aforementioned questionnaires and checklists to guide our interviews and observations.

Rural Health Promoters (PHP's)

The 14 PHPs we visited had been in their positions for an average of two years. They were selected according to the following criteria:

- Live in a community of up to 2,000 inhabitants.
- Leadership qualities.
- Known and accepted by the community.
- Good interpersonal relations.
- Talks well.
- At least a 3rd grade education.
- Four hours available per day to work on the RHP.
- Preferably community and/or health project experience.
- Positive attitude towards FP.
- Willing to complete work goals.
- Over 18 years old, but no maximum age limit.
- Willing to attend periodic training activities.
- Willing to make home visits.
- Not strongly identified with a religious group or political party.

The PHPs we met generally fit these criteria, which makes it easy for them to relate to the community. SDA did a survey of the characteristics of 86% of the 836 PHPs in October,

1993. The results were as follows: 87% were female; 53% are less than 30 years old; 60% are married or in union; 51% have 1-3 children; the age of the last child is over 6 years for 37%; and 62% are practicing FP (Annex 8).

DESERTION RATE

The desertion rate is between 8-14%, according the Director of the RHP. Because of this, promoter supervisors have a monthly quota of PHPs and DARs to recruit.

As of September 1993, the biggest cause of desertion, 43%, is recruitment by the MOH. If PHPs move to another town that needs their services, they are kept on. However, 28% were dropped because they moved to the city. Low productivity (9%), disciplinary faults, (such as selling products at a price which differs from SDAs) (2.3%), and other reasons account for the rest (Annex 9).

The desertion rate used to be higher when individuals with a high school education were recruited, although they were easier to train and supervise. The new criteria guarantee that community people will be serving community people. The challenge is to provide sufficient training to the generally less educated PHPs and DARs.

RECOMMENDATION: To prevent desertion, we support the SDA's recommendation to focus on the 9% of PHPs with low productivity and help them to provide quality services by increasing supervisory visits and refresher training.

We also support their recommendation which says that a DAR should be recruited to fill the vacancy when a PHP leaves, and visit the FP clients in order to assure continuity of service.

VISITS WITH RURAL HEALTH PROMOTERS AND CLIENTS

The procedure we followed was:

- Talk with the PHP about what s/he did that day.
- Count supplies.
- Observe 1 or 2 home visits.
- Videotape 8 interviews.
- Interview the client immediately afterwards.

When PHPs were asked what they most like about their work, 8 of the 14 individuals interviewed mentioned working with people in the community. Five mentioned providing FP and/or MCH education, and one wanted to learn and have responsibilities.

DAILY ACTIVITIES

When we asked the 14 PHP's what they had done that day, we discovered that 8 PHPs had planned their daily route; 10 had prioritized their visits, at least mentally if not on paper; 7 had updated the information folder; 7 had written in their field notebook; 5 had counted vitamins and contraceptives; 3 had counted medicines; and 4 had counted pamphlets.

This impressionistic snapshot shows what happened on one day of the month. To routinely perform these daily tasks which are listed in the PHPs manual would make it easier to achieve the PHP's goals which include:

- Have an updated community census
- Have 17 active FP clients
- Provide ORS, antiparasite medicine and vitamin A to children under 5, and multivitamins to pregnant women
- Refer children for vaccinations and ARI treatment
- Fill out forms, reference cards (2 for sterilization per month), field notebook, monthly reports of supplies and activities
- Conduct health education through home visits, interviews in the community, talks, and demonstrations
- Use and distribute educational materials (see Annex 11)

A review of RHP service goals and achievements from 1991-1994 generally shows that the project has been moving steadily forward. (Table 5 below)

Table 5: Rural Program Services and Non-Family Planning Referrals Provided by Year

	1991	1992	1993	1/3 1994
ORS	4,691 prescriptions	59,644	315,906	167,275
Vitamins for Children	138,060 prescriptions	1,694,741	5,585,608	2,663,250
Prenatal Vitamins	29,970 prescriptions	1,058,063	2,761,335	791,210
Medical Referrals	152 persons	8,502	18,477	8,594

However, from the beginning, (See SDA Annual '91 Report for RHP) work has been hampered by lack of prenatal vitamins, vitamin A, ORS, and antiparasite medicine. Some PHPs currently seemed to have an oversupply of condoms.

We observed that some PHPs do not take supplies into the field because they do not anticipate the need, and are then unable to sell pills or condoms if the need arises. To

prevent missed opportunities, we recommend more training in that area, as well as about the use of educational materials.

The PHPs did not usually know what supplies they had on hand, storage was haphazard, and they did not project their needs nor write orders to fill them.

They commented that they liked the materials for illiterates about health (three child survival diseases) nutrition, and cancer. Problems were noted in materials on condom use and prevention of STDs because of the graphic nature of the drawings. The PHPs did have a folder with a sample of each pamphlet which was taken on home visits. It is a useful practice.

RECOMMENDATIONS: Have trainers and supervisors remind PHPs to put supplies into their bags in order to carry and sell them as appropriate.

- ***Do a survey with PHPs and DARs to find out which educational materials they like most and concentrate on supplying those.***
- ***Update the materials folder when new materials are produced.***
- ***Teach PHPs how to use educational material by demonstrating this skill and letting PHPs practice until they get it right at the initial training, monthly meetings, and home visits.***
- ***Ask a consultant to do a train-the-trainer workshop for RHP supervisory personnel just on that topic, and***
- ***Invite a behavior change specialist to do a study and suggest the best approach for using educational materials to reinforce messages delivered on home visits.***
- ***Do a special study to present ideas about condom use for illiterate people, since it is so universally difficult to provide information which is in harmony with cultural preferences with regard to seeing explicit drawings of body parts.***
- ***Take an artist to the field and conduct focus group discussions to see how local residents might present information about condom use and vasectomy. The artist can encourage people to draw and/or suggest ideas which he draws and modifies when they give feedback.***

RELATIONS WITH SUPERVISORS

Referring again to the interview results (see Annex 10), all of the PHPs interviewed could identify their supervisor and said that their supervisors gave them advice, supplies, and educational material. Supervisors helped fill out notebooks and forms, and gave feedback on home visits.

All PHPs were satisfied with their jobs and would recommend to others that they become a PHP. Their reasons included: learning new things, having contact with community people, and helping people. Having more PHPs seemed like a good idea to them because it would ensure that the community is fully covered.

Four PHPs had suggestions about how to improve the RHP program, including: do home visits with the auxiliary nurse more frequently at least once or twice a month; provide more training and include more sessions on MCH care and first aid; and increase the amount of medicine given to PHPs. The suggestions are reasonable. The need for intensive and frequent help during home visits might be indicated in some cases. We observed that the most dramatic changes were made when an auxiliary nurse demonstrated how to explain health topics, use a pamphlet, make a referral, etc. The PHP then imitated this behavior on the subsequent home visit.

RECOMMENDATION: To the extent possible, incorporate PHPs suggestions about how to improve the RHP: doing home visits with an auxiliary nurse at least once/month; provide more training on MCH topics and first aid; and increase the amount of medicine given to PHP's.

VIDEOTAPED INTERVIEWS

We videotaped four PHPs in different towns making two home visits for a total of eight interviews.

Before videotaping, the RHP supervisor always asked permission and the camera man was discreet; however, we know that being videotaped might have inhibited PHPs and/or made them nervous. Nonetheless, we, the Financial and the IEC experts, feel that the videotapes offer useful insights, both positive and negative, which we are providing to the SDA in a separate memo, on the following topics: Medical Content (temporary and permanent methods, ARI, EPI); Interpersonal Communication Skills, use of the manual, pamphlets, vaccination cards, and referral slips; cost-recovery techniques, missed opportunities, and the preventive rather than the curative approach.

Positive findings included: giving correct information; using simple words; giving the client an opportunity to ask questions, answering them, and checking for understanding; dispelling myths; making timely and appropriate referrals; using the PHP manual and pamphlets well; addressing all problems that needed attention, such as colds, fever, diarrhea, and vaccination; keeping cost-recovery in mind when asking for payment for goods and services; taking a preventive, rather than a curative approach, to treating ARI symptoms, etc. Negative findings were the opposite.

RECOMMENDATIONS: That the current and former director of the RHP, the director of IEC Department and the managers of training and communications, review the videotape, confirm our findings, and decide what should be done.

- ***We recommend that every PHP who was videotaped review their taped interview with their auxiliary nurse supervisor. If they are willing, the interviews could be edited and shown at a monthly meeting, stopping the video frequently to discuss strong and weak points. These videos could also be used to train regional supervisory teams and PHPs and DARs at their initial training.***

- ***Since it is imperative to have first hand information about what is going on in the field, periodic and frequent site visits by top level SDA staff (in all relevant departments) to monitor quality of service delivery and supervision are best. An alternative that could be easily implemented would be to send a two-person crew (camera plus sound since audio is tricky in the field) to record interviews that will provide objective feedback for all concerned. Bring a VCR/monitor to provide instant playback opportunities.***

- ***The PHPs could be involved in the creation of training videos which would address some of the issues covered, such as interpersonal communication skills, or how to advise a woman to get ready to go to the clinic for an operation. This will motivate them to thoroughly study and learn the content of the video lesson.***

INTERPERSONAL COMMUNICATION SKILLS

We used a checklist to guide the observation of interpersonal communication skills. It is a mixture of three schema used: Johns Hopkins/Family Planning; WHO/Diarrheal Diseases; John Snow/ARI.

We found that there was a strong pattern of PHPs establishing rapport and giving advice; they were weaker on asking questions and encouraging clients; and weakest on checking for understanding, giving praise, and making referrals (Annex 14). Behavior was not standardized.

RECOMMENDATION: Develop a curriculum for interpersonal communication skills, and a checklist that covers the main skills that a PHP should employ during an interview with a client. Train supervisors to use the checklist and model behaviors that PHPs are found to be weak in when doing home visits.

Rural Distributors of Contraceptives - (DARs)

There are currently 381 DARs working in the rural program. They stay at their homes, and clients come to them. Their job is to promote and sell temporary FP methods, including injectables. They refer community residents to SDA clinics for cytology tests and sterilization. They provide educational materials, and may speak to groups. They store supplies and fill out forms to track client visits and sales. They do not include MCH services in their work (Annex 21).

Training courses for the DARs focus on family planning, with emphasis on the minimum criteria for distributing hormonal methods, as well as side effects. Participants also learn how to inject hormonal contraceptives.

We were able to visit only three DARs during our field trip. Our interviews revealed that: these individuals had been DARs for 6-25 years, starting with SDA before the current Rural Health project began; and they like their work because they can serve the community. On that day, one of the DARs had updated her information folder, and counted supplies, including educational materials. Two had not. All knew who their supervisor was, and said that the person provided advice, supplies, and educational materials.

Their suggestions to improve the program include: supply DARs with injectables, coordinate better with the MSPAs, increase the number of rural distributors so that everyone has easy access, and prepare cards to refer people to SDA clinics. (Annex 22).

RECOMMENDATIONS: Make better use of the DARs in the delivery of MCH services. They should be taught when and how to refer clients for MCH services to PHPs if one lives nearby; they could sell ORS and other supplies.

Summary

The RHP has been effective. The number of users of the rural program has steadily increased during the life of the Project as indicated in the following table 6.

Table 6: Number of Users, including Regional Clinics

Year	1991	1992	1/4 1994	1994
Occidental	416 users	361 users	884 users	2,652 users
Central	234 users	416 users	596 users	1,788 users
Paracentral	331 users	535 users	882 users	2,646 users
Oriental	311 users	462 users	824 users	2,472 users
Year to Date	13,169 users	22,825 users	15,184 users	45,552 users

In terms of overall efficacy, the following table 7 indicates the steady increase in CYP in all four rural health regions.

Table 7: Total Couple-Years of Protection by Region (Rural Program), Including Regional Clinics

Year	1991	1992	1993	1/3 1994
Occidental	166 CYP	279 CYP	444 CYP	476 CYP
Central	92 CYP	229 CYP	300 CYP	325 CYP
Paracentral	174 CYP	313 CYP	643 CYP	658 CYP
Oriental	253 CYP	284 CYP	439 CYP	409 CYP
Year to Date	8,077 CYP	13,447 CYP	22,874 CYP	9,176 CYP

The numbers of users of the RHP and couple years protection show progressive increases and are pegged to the availability of supplies (Annex 24). The numbers are impressive, and the RHP deserves to be congratulated. It is important to ask questions about how the services were delivered.

RECOMMENDATION: Continue to keep up the good work on quantity of services; now it is time to examine weaknesses, which have been suggested by viewing the video, evaluating training results as well as samples of regional supervisors' reports, and FESAL 1993 survey results. Decide upon performance goals and redesign the training with the help of a short term consultant.

Home Gardens

In 1991, the RHP began the bidding process to contract a company to run the Home Garden project. However, the bids were too costly and project implementation was postponed to 1992. In 1992, the Home Garden project began with a pilot project of 55 gardens in 5 communities. The Project terminated in 1993 because participants lost interest in buying seeds, etc. which was necessary to sustain the Project.

RECOMMENDATION: Expanding the RHP in terms of community development projects will dilute efforts to deliver quality health services in the rural area. SDA should concentrate on what it does best and not renew the Project.

b. Logistics

The logical framework contains no indicators of goals or targets for logistics. The overall objective is to improve the logistics capability of SDA. The Project, through the financial and technical assistance provided, has increased the logistics capability of SDA. According to the Medical Director, the selection of all pharmaceuticals and supplies for all programs is handled by a medical committee composed of members of the Board of Directors, the Executive Director, the Hospital Medical Director and the Director of the Medical Division, sometimes aided by the Medical Directors of the Santa Tecla and San Salvador Regional

Clinics. Drug selection for this sub-component has been traditionally a static procedure, i.e., the same contraceptives and pharmaceuticals have been chosen for years. These materials are judged to be the most efficacious for field use, and by not varying the makeup of the PHP/DAR package, training and supervision are facilitated.

Through its annual Action Plan, SDA requests a certain number of oral contraceptives and USAID delivers Lo-Femenal which, owing to its low content of estrogen, is the oral contraceptive most user-tolerated with fewer side effects. All of the other products distributed by the PHPs and DARs (condoms, oral rehydration salts, infant vitamins, prenatal vitamins, vitamin A and mebendazole) are provided by USAID. The exception is the injectable contraceptive Noristerat which is furnished by International Planned Parenthood Foundation (IPPF).

The Manual of Purchases and Supplies Procedures produced by CCC for SDA in 1991 and revised in 1993, provides guidance in proper purchasing (including a section on avoiding conflicts of interest) and reception of commodities. According to the SDA Manager of Procurement and Supplies, this manual, together with the training provided by the long-term consultancies in logistics and purchasing, did much to unify and put in order the purchasing and supply system.

The quantities of pharmaceuticals and contraceptives required are based on consumption statistics and projections with consideration given to existing local and warehouse inventories and commodities in the pipeline. As noted below, the functioning of the system is not without its faults.

For the rural program, USAID provides all pharmaceuticals, with the exception of Nonsterat. SDA should endeavor to absorb an ever-increasing share, reflecting progress towards sustainability.

Computer equipment and software requirements were determined by studies and evaluations conducted by CCC long and short-term MIS technical assistance in consultation with MIS personnel at SDA. Computer equipment and software needs are tempered by availability of finances, consultants and other training. A more equitable distribution of computers and computer equipment is desirable. Of the 61 SDA computers in inventory, only eight are assigned outside central level, and of these eight, four are considered to be old, if not obsolete. The computers not in service might be replaced by those not being used at headquarters, e.g., some of the Division Directors have computers but don't use them.

RECOMMENDATION: Relocate some of the better computers outside the central level.

The newly remodeled central warehouse at Santa Tecla was noted as being clean and orderly. Space is adequate, as is light and ventilation (five air extractors including one electric powered). The warehouse is adequately protected against entry of rain water. Security is adequate. Six wall-mounted fire extinguishers were noted as charged and strategically positioned. It would be helpful if a small power lift truck were provided to facilitate stacking (only a hand cart is now available). This and other equipment were recommended by a CCC

short-term warehousing consultant in March, 1992. In the evaluator's opinion, other than the lift truck, more equipment is not really needed.

RECOMMENDATION: A small power lift truck should be provided to the central warehouse.

Regarding all programs, not every product was identified by bin cards (cards attached to each commodity supply indicated name of product, date of expiration, quantity received, quantity distributed and balance). The cards observed detailed limited information, mainly the product name and expiration date. This anomaly was noted in the regional warehouses as well.

RECOMMENDATION: Bin cards should be appropriately used for all products at the central and regional warehouses to facilitate product identification.

The newly built (USAID-financed) regional warehouses at Santa Ana and San Miguel suffer from some construction problems. In both, although false ceilings were installed to alleviate high temperatures, the height of the buildings is not sufficient. Air circulation is poor. Although air extractors were indicated in the basic design, there are none installed, only fans, despite the recommendation found in the reports of the CCC short-term advisor, Sr. Azocor. The San Miguel warehouse is particularly poorly ventilated with louvered windows on only one side of the building. More louvered windows could be installed on two other sides to provide cross ventilation. The same could be done with at least one wall of the Santa Ana warehouse. This would also improve illumination which was especially poor in San Miguel. These modifications could be accomplished with little expense incurred. These new windows along with ceiling air extractors would do much to reduce interior temperatures. Wall-mounted fire extinguishers were noted at both warehouses but apparently those in Santa Ana were only recently installed because their empty shipping cartons were noted laying on top of a trash heap.

RECOMMENDATION: The warehouses at Santa Ana and San Miguel should be modified to allow more ventilation, i.e., air extractors and more louvered windows.

An MIS system is in place at the central warehouse providing data on commodity purchase orders, arrivals, distribution, transfers, suppliers and inventory. The regions produce this data manually and send it to the central warehouse where it is consolidated and forwarded to Procurement and Supplies at central level. A Kardex system is also in use at the central and regional warehouses. Physical inventories are taken twice a year, in June and December. The central warehouse manager stated that SDA internal audit personnel also perform selective inventories on almost a monthly basis.

There is a quantity of USAID-procured tools for vehicle repair in the central warehouse. These items are awaiting improved security before being transferred to the vehicle workshop. (see maintenance section of this report).

Irregularities were noted in contraceptive supply at the central warehouse and consequently at lower levels. Some 1,000 out-of-date Copper-T units had to be resterilized to prolong their life for four more years. This reflects the low demand -- and oversupply -- for this contraceptive which may be partially the result of insufficient SDA promotion in the clinics and the rural program.

There were 1,000 Norplant sets of six units each received in May, 1992 at the warehouse. Due to expire in December of this year, these units are to be divided among the Ministry of Health (MSPAS), the Salvadoran Institute for Social Security (SISS), ANTEL Hospital and SDA facilities. As of May 31, 1994, the MOH has removed 200 sets and the SDA, 50. Because SDA required extensive clinical trials of this product, its distribution has been delayed.

The use of Norplant was not implemented earlier because:

- The Family Health International/Johns Hopkins University (FHI/JHU) proposal was too expensive.
- SDA delayed response.
- The number of implants to be utilized was overestimated.
- Adequate counseling has not yet been available.
- Norplant is very expensive and methods of cost-recovery have not yet been identified.

According to the Warehouse Manager, the injectable contraceptive Noristerat has been out-of-stock in the central warehouse since February of this year. Lack of this contraceptive was also noted by all PHPs contacted during evaluation team visits. When questioned about this situation, the Manager of Purchases and Supplies attributed the cause of the stockout to increased demand at both clinics and in the rural program. This plus the fact that, according to the former Director of the Rural Program and the Director of the Medical Division, the IPPF did not purchase enough globally and consequently had to reduce the SDA request from a 1 1/2 years' supply to a 1 year's supply. A new quantity of Noristerat is scheduled to arrive in early June. Prudence dictates that future acquisitions of this contraceptive by both SDA and IPPF be planned carefully in advance since this product is indeed growing in popularity.

The central warehouse has had a stockout of prenatal vitamins since December, 1993; vitamin A since March, 1993, and mebendazole since April, 1994. This points to faulty needs assessment and/or procurement difficulties.

RECOMMENDATION: SDA must ensure adequate supplies.

At the regional warehouses, the pharmaceuticals, contraceptives and supplies for the RHP are stored separately from commodities destined for other programs. This allows a more facile control. The commodities for this program are delivered to the PHPs and DARs every 3 months. At the time of the evaluator's visit to the Santa Ana regional warehouse, it was noted that there was a complete lack of condoms, Copper-Ts, injectables and vitamin A for this sub-component. At the San Miguel warehouse there was a stockout of condoms, injectables and vitamin A. It was reported that all stock available of these items had been delivered to the field, leaving no reserve stock in the warehouses. However, some PHPs/DARs have complained of having no injectable contraceptives since February, as well as a lack

prenatal vitamins. Vitamin A and mebendazole antiparasitic are only distributed during semi-annual campaigns; however, intestinal parasites are a continuing problem in rural El Salvador and should be treated when symptoms are exhibited.

RECOMMENDATION: Mebendazole should be a regular item for PHP/DAR distribution in the rural program.

From data collected from 10 PHPs during the evaluation team's field visits, the following stockouts were determined:

- all 10 had no injectable contraceptives[1];
- four had no infant vitamins; and
- seven had no prenatal vitamins.

From the above mentioned shortages registered in warehouses and in the field it must be concluded that a sufficient quantity of these items had not been ordered. This indicates faulty needs assessment and/or procurement difficulties. SDA supervisors are also aware of stock deficiencies through their regular supervisory work. It is interesting to note that the CCC monitors report stock inventories bi-monthly. It would appear that these reports are not utilized by SDA.

RECOMMENDATION: SDA must utilize CCC monitors' monthly reports and procure supplies appropriately.

Procurement for contraceptives and pharmaceuticals for the RHP is handled by USAID and SDA (for the injectable contraceptive used). Sufficient USAID funding is available for resupply. USAID frequently combines purchases for other health projects with those for this sub-component of the Family Health Services Project. These purchases are normally made through the General Services Administration in the United States.

Through the efforts of CCC technical assistance, the Procurement and Supplies Department of SDA has developed a system of proper purchasing and supply administration that follows the regulations of A.I.D. Handbook 11. However, the aforementioned stock-outs demonstrate that correct procedures are not always followed.

RECOMMENDATION: The short-term Logistics and Warehousing Advisor should determine the steps needed to rectify the supply situation and implement measures to prevent these problems in the future when he returns for a two week period in July. With proper and timely communication, these logistics problems can be resolved.

[1]Injectables are not provided by USAID, but by IPPF.

Maintenance

The Department of Maintenance and General Services is responsible for accomplishing, or having accomplished, all general and vehicle maintenance. There is an SDA maintenance workshop in San Salvador where some general corrective and the majority of vehicle preventive maintenance is performed. All efforts are made to reduce the higher costs of preventive and corrective maintenance charged by private garages or vehicle agencies.

The workshop is small and insecure. According to the Manager of Maintenance and General Services, the workshop area, including the tool room, must be made more secure before a quantity of tools now stored in the central warehouse (since February of this year) can be transferred to the workshop. The Manager stated that security modifications of the vehicle tool room would begin in June. There is no specified time frame for other modifications, e.g., construction of high outside walls to enclose the workshop area, as there exists the possibility that the workshop property will be sold and the workshop moved to a new location.

RECOMMENDATION: If it is decided that the workshop property will not be sold, security modifications should be made as soon as possible in accordance with the SDA plan to remodel.

There are two technicians and one mechanic employed for general maintenance. The mechanic and technicians travel to the various regions at least once a month performing routine preventive maintenance on equipment. In 1992, maintenance training was provided to staff by a private company on Saturdays for a two-month period for servicing electrical equipment and air conditioning units. More training is contemplated for this year. Some technical assistance was provided by USAID under the Family Health Service Project, 519-0275, but more is needed, particularly in the servicing of general medical and biomedical equipment.

According to the Manager of Maintenance and General Services, there are sufficient tools for the general maintenance work but most of the manuals are not in the Spanish language. Maintenance routines have been established but no maintenance manual has been produced.

The Department has responsibility for preventive maintenance and some corrective maintenance of 63 vehicles (30 provided by USAID) and 10 motorcycles. This is being done with three mechanics. There was a fourth but he resigned to accept a better position and there are no immediate plans to replace him. It is estimated that 95% of vehicle maintenance performed is of a preventive nature. Most corrective maintenance is referred to vehicle agencies. There is literally not enough space available at the workshop to perform more than occasional corrective maintenance nor are there specialized equipment and tools available. Also due to lack of space and dubious security, spare parts are not stored at the workshop but at the central warehouse. Parts in warehouse inventory are basic, e.g., air filters and tires.

All preventive vehicle maintenance must be accomplished at the workshop; none is allowed at the regional level. While this system maintains strict control, it is not efficient. For example, when basic preventive maintenance such as an oil change is due for a vehicle

assigned to San Miguel, the vehicle must be brought into the workshop in San Salvador. It would be considerably more practical and less costly overall, if basic preventive maintenance work were permitted to be done in San Miguel at a private garage. It would be even more practical and even less costly if the driver in San Miguel were provided with the tools to do the job himself. If this were allowed, the vehicle records produced manually and forwarded to the Department of Maintenance and General Services could include information on the type of preventive maintenance performed and maintenance control could be maintained.

RECOMMENDATION: A set of basic tools should be assigned and inventoried at each region to facilitate on-site preventive vehicle maintenance. Regional drivers should receive basic preventive maintenance training. Failing this, private local garages should be used.

The mechanics received some training in general maintenance in 1992 and 1993 (3 months on Saturdays) but specialized training is needed, particularly to service automatic transmissions and electronic ignition systems because manuals are lacking.

In an apparent attempt to reduce costs, the 23 Jeep Cherokee vehicles ordered by USAID for the RHP, were two-door, lacked front passenger outside mirrors and were not air conditioned; however, after the vehicles arrived, air conditioning was installed locally. The operational/maintenance manuals provided with the USAID - procured vehicles are in the English language. Spanish language manuals are difficult to obtain from US manufacturers.

RECOMMENDATIONS:

- ***(1) Vehicle operational/maintenance manuals in the Spanish language should be provided to the vehicle workshop and the regions. (A copy of the Cherokee manual in Spanish might be obtained for reproduction, from the Ministry of Public Health vehicle workshop).***

- ***(2) Training in complicated maintenance or corrective maintenance, such as servicing automatic transmissions, should be provided to SDS mechanics.***

Positive results of technical assistance are dramatic in the area of vehicle preventive maintenance. The short-term Transport and Maintenance Advisor, the MIS Advisor and the short-term Computer Programmer collaborated to develop a computer program that provides monthly data by vehicle and by program: vehicle travel (mileage), vehicle efficiency, preventive and corrective maintenance cost analysis, cost analysis by program and utilization analysis.

These data are collected by the chief mechanic at the workshop and brought to the Department of Maintenance and General Services each month. There the data is fed into the MIS (there is no space available for a computer and printer at the workshop). The Transport and Maintenance Advisor is scheduled to return in July to follow up and further refine the maintenance MIS.

c. Computers/MIS

Data for supply management for the sub-component, RHP is provided in the general MIS system for Procurement and Supplies. This system is in place at the central warehouse. Although it was planned to install computers in the regions to accomplish mechanized inventory control in January of this year, they have not yet been installed. USAID is withholding spending approval for MIS hardware and software pending a study and justification from SDA of its MIS past and anticipated purchases. This study is presently in progress.

A MIS program providing statistical data on PHP/DAR activities was developed for this sub-component, again with CCC technical assistance working in coordination with the SDA MIS Department. This system is operative at the central level and was partially operative until recently at the regional level. It allows for better control over the movements (hirings and departures) of the PHPs and DARs. It also provides data on contraceptives available in the rural area and the number of users.

Although it is not known if the monitors refer to MIS information at the central warehouse, it would seem logical for them to do so, particularly when adjusting book balances to physical inventories. Because monitors' reports are not shared with Rural Program personnel, the link between Rural Program MIS and monitors' reports is lacking.

The system was installed for this sub-component in the regions of Santa Ana and San Miguel (not yet installed in Cojutepeque or Santa Tecla as the region farthest from headquarters are a lower priority. Equipment is planned for the Paracentral Region in 1994 and for the Central Region in 1995.), but it is not presently functioning in either of these two regions. In Santa Ana there is a problem with the software and in San Miguel, the hard disk. Both problems are to be rectified shortly. In order to mechanize data, a secretary and a promotor or auxiliary nurse from each of the regions brought their manually prepared records to SDA/San Salvador to use the MIS equipment there.

d. Sustainability in the Rural Program

The Rural Health Program is a large program with a large infrastructure that consumes a significant amount of financial resources. This is justified because of the population the program serves. However, it is the infrastructure (Administration and Coordination of the Project and Logistics and Supplies) that makes the program very expensive.

In projecting, determining and/or calculating financial sustainability in the rural program one has to be aware that this is a program with a cost of C10.3 Million of which approximately C7.3 Million, or 71%, represent remuneration to project staff*; C1.1 Million in Supplies (includes gas, vehicle parts and maintenance of vehicles and other supplies); C1.4

* The breakdown is: salaries 20.6%; Other renumeration 5.0%; Bonuses to PHP's 45.4%.

Million or 14% in maintenance of vehicles, office equipment and others. The recovery rate of C392.7 thousand in 1993, or 4%.

RECOMMENDATION: Other alternatives for delivery of the services provided by the project should be explored in order to reduce its high costs. For example: (1) the use of motorcycles by the PHPs instead of vehicles to reduce costs in vehicle purchase, maintenance and repair which consumes approximately 24.3% of the project's budget. (2) Determine which computerized equipment can be transferred to the regions instead of continuing to purchase equipment.

In some regional clinics there were contraceptives and vitamins available, while the RHP program, which has its administrative office within the clinics, did not. Our reading of SDAs motives for the existence of the contraceptive at the regional clinics and not at the rural program was perhaps due to the difference in price between the two outlets. The sale price of NORISTERAT in the rural clinics is higher as compared to the rural program therefore, income is greater. This alone could be a motivating facet for SDA to keep it in stock at the regional clinics and not at the rural program. The reason for this? might be due to the pressure exercised by the donor for SDA to perform well in the recovery of costs and the attainment of sustainability.

RECOMMENDATION: During the SOMARC Consultant's visit to the SMP program, a detailed analysis should be done to determine the reason for the NORISTERAT stock-out in the RHP while the regional clinics did not suffer this problem. Consider the fact that the product enjoys a higher price in the clinics than in the RFP.

RECOMMENDATION: The Rural Health Program's budget should be re-structured so that financing is allocated more for those activities that enhance the quality of the program such as training and IEC, as well as ensuring that the program has the necessary supplies to serve the rural population.

Judging by the poor skills shown by some of the rural program field staff, and the evaluation team's recognition of the need for training at all levels, it is vital then that the total amount of training funds made available by ADS for this activity be clarified by presenting a break-down for the different training activities planned.

- ***The RHP is an expensive project because of the big infrastructure at the central office. Plans should be made to investigate a way to phase out costs for PHP compensation. Providing them with products to sell, for which they will earn a commission to help defray the costs of their salaries, is one way that this could be done. Start with a pilot project. Ask villages to pay their salaries is another way.***

e. Technical Assistance

The monitoring system mounted by CCC is providing a great deal of quantitative and qualitative information related to the activities of the PHPs and DARs, as well as the adequacy of contraceptive and pharmaceutical supplies. There are four CCC Monitors who travel throughout the four regions reviewing the performance of the PHPs, DARs, Supervisors of the Promoters, and auxiliary nursing personnel involved in promoter training.

In gathering their data, the Monitors are in an ideal position to assist the promoters in improving their record keeping and management of supplies but, since they are not SDA personnel, they are proscribed from taking an educative role. This is stifling both to the efforts of the Monitors and to the programs they support. By not allowing the Monitors to share the benefits of their experience and expertise with the PHPs and DARs, use of a significant resource is being neglected. In a June 9 meeting to discuss a draft of the evaluation report, USAID staff recommended that the CCC monitors be replaced by SDA personnel to perform the monitoring function. The elimination of this objective reporting source, previously thought essential in the Project Paper for keeping USAID apprised of the condition of the RHP, should be carefully considered. Until then the following is recommended.

RECOMMENDATION: SDA should allow the monitors to take a more educative role during their field visits as is done by Clapp and Mayne monitors for the APSISA Project. Periodic joint travel with promoter supervisors is also recommended.

The Monitors' reports are largely quantitative, providing information that reflects the functioning of the RHP, the Medical Program in the SDA clinics, the Social Marketing Program, and the logistics process. The reporting format was developed by CCC in concert with the USAID Health, Population and Nutrition (HPN) Office. Recently the reporting format has received criticism from SDA with suggestions on how to improve it. A meeting between SDA, USAID and CCC is pending for review of the monitoring plan and reporting format.

Until early this year, in accordance to the wishes of the former USAID Project Manager, the Monitors' reports were delivered to USAID then later to SDA after a USAID review. This created the suspicion among SDA personnel that the Monitors were conducting espionage rather than technical assistance, a suspicion that still lingers today even though SDA now receives the Monitors' reports at the same time as they are delivered to USAID.

The Monitors also check central and regional warehouse stock. The data gathered by the Monitors regarding product status and the workings of the logistics system is accurate. Effective and efficient use of the data could be improved, however. For example, the SDA Manager of Procurement and Supplies does not receive a copy of the monthly Monitors' reports nor does he meet with them to discuss supply difficulties. The Monitors and supervisors don't meet regularly to exchange information. This appears to be a waste of a valuable resource with which to correct supply problems and bottlenecks.

RECOMMENDATIONS: The monitors' reports, particularly the bi-monthly inventory reports, should be shared with the Manager of Procurement and Supplies.

- ***Monitors should meet at least monthly with the SDA Medical Director, the SDA Director of the Rural Program, the SDA Manager of Procurement and Supplies and meet separately with SDA PHP/RHP medical supervisors.***

All of the technical assistance provided to this Project (the work of the COP, IEC Advisor, Logistics and Warehouse Advisor, Transport and Maintenance Advisor, etc.) is directly or indirectly related to this sub-component. The work of the CCC Monitors comprises the bulk of the direct technical assistance provided over the life of the Project for the RHP. The long-term assistance of the Procurement Advisor, Logistics Advisor and MIS Advisor contributed greatly to this sub-component. Over the long-term also, the services of the Rural Health Education Advisor continues to be an important contribution. A short-term consultancy in IEC for curricula development in 1992 was also directly related to the RHP sub-component. But according to IEC personnel interviewed, its success was limited. It is felt that CCC did not help the consultant to focus on the scope of work, and here she did not provide useful or timely assistance. The consultant's final report, (which was approved and distributed many months after the consultant's visit) however, was considered valuable by the IEC evaluator.

IEC staff and the CCC long-term consultant mentioned the following areas for short-term technical assistance:

- conducting a training of trainers workshop (on how to train semi-literate adults. APROFAM in Guatemala might be a source);
- design of materials for illiterates;
- production of interactive training materials, consisting of videos and manuals;
- training evaluation;
- mass media campaigns evaluation; and
- evaluation of the methodology used to produce audio-visual and print materials.
- technical and financial managers need training in how to decentralize; supervisors into training skills

Follow-up short term technical assistance in the areas of logistics and warehousing scheduled for two weeks in July can serve to eliminate the readily apparent weaknesses in the supply system as well as the field reporting problems mentioned earlier. Outside of these still-existing needs, the technical assistance related to this sub-component has been adequate, although, with reference to the monitoring effort, not fully utilized.

RECOMMENDATIONS: Training Department staff should become more specialized. This requires short-term technical assistance based on real needs. More short-term technical assistance has been revealed by IE&C/Training Department staff and should be provided.

Aside from the technical assistance activities mentioned above, the CCC presence was particularly visible in improving warehousing and distribution at the SDA central and regional levels. Short-term technical assistance was responsible for the reordering and remodeling of the central warehouse and training SDA personnel from the Procurement and Supplies Department and the central warehouse in the MIS logistics system. A short-term consultant from CCC made the basic design for the construction of warehouses in Santa Ana and San Miguel. The following manuals relating to warehousing were produced: General Manual of Warehousing and Supply, Norms and Procedures of Product Reception and Warehousing, Manual of Procurement and Supplies Procedures, Training Manual of Procurement and Supply and a Guide for Optimization of the Physical Areas of the Central Warehouse (includes regional warehouses as well).

f. Information, Education, and Communication (IEC)

Background

The role of the IEC Department is to support the RHP by producing materials for training courses and client education, as well as managing a mass media campaign to make the rural area more aware of the rural workers and health topics. The IEC Department has supported the training effort by producing a wonderful task-oriented PHP manual that is used as a reference on home visits.

RECOMMENDATION: Since the manual is so often consulted by PHPs during home visits, we suggest adding checklists for:

- ***Complications and danger signs of hormonal methods;***
- ***Counselling a woman who will be sterilized (what to eat, wear, etc.)***

The IEC Department has also produced excellent training videos:

- A Day in the Life of the PHP;
- Ten Golden Rules for the PHP;
- Immunization;
- ARI;
- Nutrition, Growth, and Development;
- Diarrheal Diseases;
- Family Planning;
- Promotion in the Community; and
- Vasectomy.

The long-term advisor has been very helpful in this area. Trainers have also been taught to use video materials effectively in workshops.

RECOMMENDATIONS: To build upon this strong foundation, we recommend producing videos that are interactive and can be used in training sessions to involve trainees in questions, demonstrations, and other training activities.

- ***Use video to record training sessions and provide feedback to trainers. The videos could be the basis for a video training library on FP and MCH topics. They could also be edited and sold as part of the social marketing program.***

- ***Given SDA formal approval, we support the CCC advisor's recommendation to send TV monitors to the rural areas and use them to show a combination of films, TV programs, such as episodes that Televisa in Mexico produced incorporating FP themes, and SDA videos.***

Materials Production

Pamphlets on various FP and MCH themes have been produced to support the rural workers.

- The Pill (literates)
- The Pill (illiterates)
- Injectables (literates)
- Food (literates/illiterates)
- The condom (illiterates)
- To avoid Pregnancy and Sexually Transmitted Diseases, Use the Condom (literates)
- Vasectomy (literates)
- Female Sterilization (literates)
- Cancer of the Uterus and Cervix (literates)
- Post-partum Care (literates)
- Nutrition during Pregnancy (literates)

In addition, the SDA has produced pamphlets which were not financed by the USAID project, but which reinforce the key messages to be delivered:

- The IUD, Myths and Taboos
- Risk of Pregnancy in Adolescents
- What is Adolescence?
- What is Menstruation?

All of the materials were pre-tested during focus group discussions (FGDs) organized and implemented by subcontractors to the SDA. The target audience included both men and women between the ages of 15-45. When discussing the pre-testing process, the evaluator suggested including profiles of the participants in the summary report, and writing a memo saying why suggestions are not followed, in the few instances when this is the case.
During a 6-week training session in Santa Cruz, California in 1993, the IEC Department learned how to conduct interviews as part of formative research prior to scripting or drafting material. This should be routinely incorporated into the materials production process.

41

RECOMMENDATION: Put more emphasis on formative research, as well as on using FESAL 1993 results, to design messages which address specific areas that the target audience needs to understand family planning so that they will overcome their fears and learn what behavior constitutes a healthy choice. Results shows that women and men 15-24 are a prime group to reach.

- ***Use focus group discussions to develop materials. Include an artist as part of the process, whenever possible, so that he can immediately incorporate local residents' ideas and concepts in designing or revising materials.***

Distribution:

At the end of the year, the IEC Department sends samples of materials to the directors of the Training Department, the RHP, the clinics and the documentation centers. Based on their requests, reprints are ordered, and new materials are sent to the Central Warehouse in Santa Tecla. No one seems to be responsible for making sure that the materials get to the regional areas, the PHPs or the clients. Monitoring at the local level is done by CCC and the RHP.

RECOMMENDATION: The IEC Department should design a strategy to make sure that materials get to the end users, PHPs, DARs and clients. They should also monitor the process by making visits to clinics and communities.

Mass Media Campaign

The following statements about the mass media campaign are based upon discussions that the evaluation team had with the Director of the IEC Department, the Director of the Communications Department, the long-term CCC communications advisor, USAID officials assigned to the RHP evaluation, and representatives of the ad agency who sponsored a meeting to discuss the RHP mass media campaign. The evaluation team also read documents that were given to the team; there was no evidence that an RHP contract had been signed with the ad agency. If it was, the document was not made available to the evaluation team at the time of the visit. The biggest problem mentioned by the above mentioned people (with the exception of the USAID representatives) was the lack of a mass media campaign to support RHP communication efforts.

According to information given to the evaluation team, the terms of reference to hire an ad agency were written in May 1991 but were not approved by USAID until May 1993. In the fall of 1993, bidding was canceled due to irregularities and alleged conflicts of interest. The terms of reference were re-written to reflect FESAL 1993 survey results, bidding began, and Publicidad Comercial was selected. The ad agency is awaiting USAID final contract approval before starting work on the project.

In the meantime, SDA staff has been resourceful in obtaining free airtime for educational topics, such as the population explosion, and has produced a series of programs for two local TV shows, "Buenos Dias" and "Nuestra Gente."

The evaluation team was asked if it is worth the effort to hire an ad agency? According to the SDA staff interviewed, it is worth the effort. The FESAL 1993 revealed that there are gaps in the National Family Planning Program. For example, despite the fact that the majority of women in child-bearing ages do not want to be pregnant, they are not using family planning methods. With regard to youth, 59% of 15-24 year olds had sex the month before the survey; less than half used contraception. Only 1.5% of couples used condoms to prevent AIDS.

We reviewed the IEC strategy for support to the Family Health Services project and felt that the plan considered FESAL 1993 research results, that the objectives, target audiences, media mix, and components of the campaign were very adequately handled. With the IEC Department staff and the long-term IEC advisor, we discussed costs, geographical coverage, and the quantity of radio and TV spots to be provided. We were assured that: production costs were moderate; broadcast costs were in line with current practices in El Salvador; geographical coverage will be nation-wide including the Occidental Region which has FP and MCH needs which definitely must be addressed. We agreed to discuss the number of radio and TV spots with the ad agency because there seemed to be too few spots, each with too many messages.

The Ad Agency

We visited Publicidad Comercial, heard a presentation about the agency, saw samples of TV and graphic materials, including TV spots done for the Ministry of Education about youth gangs, toured the facilities and met staff. Publicidad Comercial ranks number 1 in billing in El Salvador, and the staff is certainly professional and technically competent. No RHP materials were available because the ad agency staff said they didn't want to start work on them without a signed contract.

We discussed pre-testing, which is very important for both TV and radio spots. Since there were no funds allocated to this function in the ad agency contract, the SDA IEP Department will undertake this activity, according to the Director of the IEC Department.

They agreed to produce more radio spots, each one with only one key message. SDA had previously mounted a small radio campaign to support the RHP, but found it very difficult and time-consuming to buy media time on local radio stations and monitor results. An ad agency is needed to do this.

RECOMMENDATION: Because a well-designed mass media campaign motivates people to plan their families and use SDA's services, it is important to sign the contract with the ad agency and get started with the mass media campaign.

- ***Increase the number of radio spots to provide variety and focus on one key message at a time. The messages should be based on research and cover methods, as well as Profamilia services, and be creative in how PHPs and DARs are used. The community needs to know who these SDA staff are and what they do.***

- ***Involve the Creative Department of the Ad Agency in going to the field to develop radio and TV spots with input from local people during focus group discussions.***

- ***Since it is expensive for the Ad Agency to produce TV spots, let the SDA TV Center produce at least one additional spot to add variety to the campaign without incurring great additional costs.***

Interpersonal Communications

By default, interpersonal communication became the predominant mode of communication for the RHP. We applied an observation checklist to PHP conversations during home visits (see earlier section) and concluded that PHPs used a wide variety of techniques and styles. These should be standardized so that they include all of the steps which guarantee that an interview will be successful.

RECOMMENDATION: Devise an observation check-list for interpersonal communication skills which meets SDA needs and apply it to a valid sampling of PHPs and DARs as they make home visits. Use the results to design an interactive training module and video.

- **Train-the-trainers in how to model and teach interpersonal communication skills. Have interactive communication skills be one of the units of mastery (discussed below).**

g. Training

While the evaluation team was in El Salvador, only two training activities were held, one for Volunteers and one for PHPs. Because of conflicting responsibilities such as meetings with SDA and USAID staff plus fieldwork, it was only possible to observe part of the Volunteers' training and one afternoon of the PHP training.

We got a flavor of the training provided to PHPs in El Salvador by observing two teams of SDA trainers teaching about diarrheal diseases and filling out forms. The trainers were dynamic, used interactive techniques, such as games, and case studies. Concepts were presented in simple language. A video was shown to reinforce key points. The male trainer effectively stopped the video, repeated key information, asked questions and summarized. A post-test followed the video. The female trainer who taught PHPs how to fill out forms first demonstrated, then asked trainees to fill in the blanks on transparencies used with an overhead projector. She gave simple situations related to using ORS: what to do in case of twins, someone 15 days old, someone 25 years old.

RECOMMENDATIONS: *A weakness was that not everyone could see the material because the overhead project was poorly positioned. Likewise, not everyone could hear; the trainer needed a microphone.*

- ***Pay attention to the logistics of the training so that every participant has equal access to the information provided.***

- ***Because the educational and literacy level of the trainees is at a third grade level, instead of having written exams, evaluate learning by designing an additional training exercise that covers the same territory and seeing if new information can be put into practice. Such exercises must include role plays, games, filling in diagrams, treasure hunts, etc.***

- ***Upon completion of the initial training course, have the Training Department provide the regional supervisory teams with a list of precise areas that each PHP is weak in so that an individual folder, preferably computerized can be created in the regional office. This will guide follow-up visits by the training supervisors, regional supervisory teams, and CCC monitors.***

Recruitment of Trainees

The training process begins with recruitment. RHP supervisory staff go to the community, ask who the leaders are, (such as midwives) and visit with them. If the person meets the requirements, the supervisor gives him a verbal or written invitation to the next training (Annex 18).

We learned by interviewing 4 randomly selected trainees at the May PHP training course in San Salvador that during recruitment interviews they received partial information about the training and what it means to be a PHP (Annex 17). The time that elapsed between the invitation and the training was from 2 months to 4 days.

RECOMMENDATIONS: Ask the IEC Department to design a brochure for the PHP that lists PHP goals, functions, and benefits; use it in recruitment.

- ***Improve the prospects for recruiting good candidates by offering recruits free health care in SDA clinics. This has proven to be successful in a pilot project area. PHPs will be more likely to refer people for services that they themselves have experienced.***

- ***Set a norm for when to invite participants to the training courses, and stick to it.***

PHPs decided to come to the training course because they wanted to serve the community, learn to live a better life, and make money to send their children to school.

None of those interviewed had been a DAR previously. They expect that family members will help them fulfill their tasks by delivering medicines and baby-sitting, etc. They will also be exposed to community residents who come to the home looking for the PHP who spends the majority of his time on home visits.

All of the interviewees liked the training course. They enjoyed learning about FP and Maternal/Child health. They liked the instructors and felt they could ask for help. They

wished the training could be longer. By the end of the course they received written contracts with the terms of their employment. This is a good practice which should be continued (Annex 19).

RECOMMENDATIONS: Given the special characteristics of the students, the complexity of the topics taught, and the importance of "getting it right," more days should be added to the training course so that all of the training topics are covered sufficiently. The Director of Training and the training staff should meet to discuss this recommendation, basing changes in course design on areas that are hardest to master. Technical assistance should be provided to redesign initial and subsequent training courses for both PHPs and DARs, who get periodic refresher courses.

- ***Having read the memos about the refresher training which cited problems that supervisory teams seem to be having with content, training process, and logistics, we recommend that each region hire a training team to plan and implement monthly sessions on refresher topics.***

The evaluation team read several "Guias Pedagogicas" which included the following information for each training activity:

- ***Name of exercise***
- ***Topic***
- ***Objective of Learning***
- ***Time***
- ***Preparation Activities***
- ***Step-by-Step Procedure***
- ***Evaluation***

However, the information was sketchy and repetitive.

The Training Department manual on vasectomy was the best one we observed.

RECOMMENDATIONS: The Training Department should obtain and review training manuals from other IPPF affiliates to get ideas for modifying their "Guias Pedagogicas." A good example is "Capacitando Sin Letras," available from APROFAM in Guatemala.

- ***Stimulate PHPs to learn by providing more learning materials and opportunities.***

After getting a graduation certificate from the initial training, provide simple home study materials on the topics in the PHP manual. Modify the drafts of the modules that eventually became the existing manual. They use a self-instruction format which is appropriate if the modules have simple language and pictures.

The trainers could design a step-by-step plan that would lead to mastery of a topic. A certificate "Master of ARI," for example, could be awarded to PHPs who:

- ***attended a basic training***
- ***completed a home study course***
- ***completed 10 perfect home visits about the topic (under supervision of the auxiliary nurse) including information, supplies, education, interpersonal communication skills***
- ***Demonstrated to their peer group at the monthly meetings***

The award ceremony could include incentives such as a T-shirt, or free care at an SDA clinic for 1 month. The PHP could be interviewed on the radio, or featured in the PHP Bulletin. This would create a "tiered or multi-leveled" system of PHPs, and additional responsibilities and benefits could be designed for them.

h. Client Satisfaction

After each of the home interviews we videotaped, we talked to clients about their relationship with the PHP and whether or not they understood what had happened during the interview.

We found that the PHPs had visited them an average of 5 times in the past 12 months. The interview they had just completed was rated good or very good. PHP profiles have been created for each interview to show whether or not the client understood why the PHP came; understood the messages; received a pamphlet, referral slip, etc; and is planning to do anything to treat the problem (Annex 14). Reviewing these PHP profiles will show what the content of the home visits was.

The PHPs are told to focus on one theme for the home visit, and if there is a pressing problem, to switch topics and return another day. What happens is that there are missed opportunities to help or refer children with ARI, conduct growth monitoring, etc. There are also missed opportunities to sell products because supplies were left at home (or were out of stock) or motivate clients to pay for services in an attempt to recover costs.

The clients generally understood the purpose of the visit and could remember much of what was said. Often the PHP used a folder containing a sampling of pamphlets to explain ideas, but educational materials were left with the client in only 2 cases. Clients said that they would follow the advice (re: taking pills, vitamins, going to the clinic to get children vaccinated, etc.).

We never received the impression that clients were pressured to have sterilization operations; they understood it was permanent.

47

All of the clients say they will continue to receive the PHP in order to get education and supplies, and would recommend the PHP to others in order to get FP education, have someone to talk to about problems, and avoid going to the hospital. The one suggestion made to improve the RHP was to keep a good stock of Noristerat (Annex 15). We observed that the lack of injectables is damaging to the credibility of the PHPs. They found that their case load is declining because women cannot tolerate the pill or their partners won't use condoms. Condom use was encouraged by the PHPs but they didn't have them or didn't think to sell these supplies.

RECOMMENDATIONS: PHPs should be trained to understand that the quality of home visits is more important than the quantity. Feedback from supervisors immediately after the interview would help to impart this information.

- ***We support Dr. Goenz' suggestion made in a March 1994 memo to the Chief of Party of CCC/El Salvador that research be done in rural homes to know the penetration and acceptance of SDA programs and the PHP. We are not sure that CCC monitors are the best ones to do this; the SDA Research Department might be more experienced. However, the parties concerned should decide upon a way to measure community acceptance. The information is important to help design mass media campaigns to support the PHPs as well as design training programs to teach PHPs and DAR's how to satisfy clients and improve their acceptance in the community.***

Another recommendation is to have the PHPs put maps of the community on their wall, and use different colored pins to show who needs follow-up care-ie-blue, monthly pills; red, diarrhea case, etc. This is a visual reminder which supplements the information in the PHP's notebooks about follow-up visits which are required. "Dardo's Story" a video in Spanish about a rural physician, shows this technique. It can be ordered from Esperanza in Phoenix, Arizona.

GROUP TALKS

We observed one group talk about FP and MCH topics and used a checklist made by consulting the PHP manual to evaluate it. On the positive side, we found that the speaker knew the topic, was dynamic and asked the participants questions. On the negative side, the PHP did not speak loudly, summarize ideas, or use AV materials (Annex 16).

Recommendation: If giving effective group talks is an essential skill for PHPs, they must receive more supervised practice. Produce a video devoted solely to this topic. Let PHPs watch regional trainers demonstrate the techniques. Let PHPs prepare a 5-minute talk for the monthly meeting, videotape it, and get individual and group feedback. A certificate of mastery could be created for this topic.

i. Method Mix

The following table 8 shows which type of contraceptive is desired by Salvadoran women nationwide.

48

Table 8: FESAL 1993 - Percent of Women Desiring Contraception by Type

Type of Contraceptive	Percent
Injections	32%
Oral	23%
Female Sterilization	20%
Don't Know	14%
Natural	5%
Other	6%
TOTAL	**100%**

Injections are the preferred method, followed by oral contraceptive, and female sterilization. The method mix at SDA has changed between 1991 and 1994 to reflect similar preferences by clients.

Table 9: Method Mix (by percentage) 1991 and 1994

Period	1991			1994		
TYPES OF CONTRACEPTION	ORAL TABLETS	CONDOMS	INJECTABLES	ORAL TABLETS	CONDOMS	INJECTA-BLES
Occidental	77	11	11	62	8	30
Central	55	13	32	59	13	27
Paracentral	63	10	26	70	06	26
Oriental	69	11	20	57	16	27
Total including regional clinics	77	8	14	48	8	44

* Columns may not add to 100% because of rounding.

The major change that has occurred is the decrease in birth control pills (BCPs) in favor of injections. The use of condoms has not changed markedly during the 3 years of the program.

The following table indicates the steady increase in couple years of protection (CYP) provided by the rural program for condoms, BCPs, and injections from 1991 through 1993. The decline in 1994 of injections is due to the unavailability of Noristerat in the rural program.

Table 10: Method Mix and Couple Years of Protection (CYP)
1991 to 1994

	1991	1992	1993	1994*
Condoms (APP)	674 CYP	1,725 CYP	1,887 CYP	2,250 CYP
Oral Contraceptives	6,232 CYP	7,832 CYP	11,054 CYP	13,182 CYP
Injections	1,171 CYP	3,890 CYP	9,933 CYP	12,096 CYP

* Projected

When the injectables went out of stock in the rural areas in February, 1994, the use of the pill and condom went up (Annex 24). However, a percentage of women have already deserted and will continue to desert because of the side effects of the pill and the reluctance of their partners to use condoms.

RECOMMENDATION: Noristerat, or an alternative, must be available at all times.

MALE VASECTOMY PROGRAM

SDA conducted a pilot project which includes the selection and training of satisfied male users to motivate and refer potential clients to SDA clinics. This strategy was not implemented because the men wanted to be paid for each man they referred for vasectomy, and USAID policy worldwide doesn't permit this.

SDA devised another strategy which involved training the male members of the RHP supervisory teams. In June, this group will be trained in how to promote vasectomy. At the same time, the IEC Department produced a video which the PHP's will be trained to use in their efforts to recruit male vasectomy clients. The video was produced using SDA staff as the cast. It turned out very well.

RECOMMENDATIONS: We recommend that SDA considers quantifying their expectations of PHPs regarding the permanent temporary method clarifying and ratio and a number of clients. The medical director should meet with the PHPs to negotiate a high but realistic number.

- ***Pretest the vasectomy video with rural men to see if they like and accept it, especially the part that shows a real operation.***

j. WID

Each region has a director for the RHP, one out of four of whom are women. Each region has four supervisory teams with a male supervisor promoter and a female auxiliary nurse, with the exception of one female supervisor.

The percentage of pill, injectable, IUD, condom, and sterilization recipients indicates that women are the main recipients of FP services. By definition, the recipients of Maternal Child Health Services are women and children.

It is easier for women to design, manage, implement and supervise programs for women. Here, the Director of the RHP, plus the Directors of the IEC, Training, and Communications functions are women, as are 87% of the PHPs. Project sustainability is enhanced since the programs will be designed with women in mind. SDA has adopted a gender sensitive plan to promote the active role of women in decision-making in the design, implementation and evaluation of their programs.

RECOMMENDATION: SDA should examine the salary scale for the RHP supervisory team members, with an eye toward equalizing the pay for the males and female auxiliary nurses.

k. General Conclusions

Between 1988 and 1993, the average number of children per rural woman decreased more than 11% (from 5.59 to 4.96); whereas the fertility rate increased in urban areas. The proportion of women using SDA has stayed the same (20%), but more rural women are family planning, in that the contraceptive prevalence increased from 34% to 43%. The contribution of SDA to the lowered fertility rate and increased contraceptive prevalence might have been even greater had a properly designed mass media campaign, scheduled for 1992, occurred.

In MCH, other indicators ?? are increased use of health services, a diminished prevalence of diarrheal diseases, greater immunization coverage, and better growth monitoring. This has helped to decrease infant mortality in rural areas from 61/1,000 in 1983-1988 to 44/1,000 in 1988-1993. Mortality of children under 5 decreased from 84 to 52 per 1,000 in the same period. The SDA can share credit for this with the MSPAS and other service providers in the public and private sectors.

From the beginning of the program, evaluations done by the IEP Department have shown that the initial training course has not produced PHPs that the Training Department has deemed 100% prepared to handle all of the fine points of FP and MCH care.

Follow-up evaluations done 2 months after the training in 1991 and 1992 showed that the learning retention rate may be worse, the sa ne, or better after putting the ideas they have learned into practice.

The IEP Department made recommendations to give priority follow-up to those who leave the training below standard, focussing on those with problems such as identifying whether or not to give out oral contraceptives. (Follow-up to Training on Modules 1 and 2 for 4 groups of PHPs, November 1991).

Identifying those contraindicated for the pill is still a problem. The CCC monitors in their recent report mentioned that 27% of the PHPs and 56% of the DARs do not know or properly apply information about contraindications for hormonal contraceptives; 22% of the PHPs and 35% of the DARs have poor knowledge of side effects. They are not remembering and/or applying what they learned at the training course.

Interestingly, the IEP Department provided an evaluation of a follow-up study of a seminar for nurses about counselling skills for potential sterilization clients. Only 40% were correctly using the interview skills and forms on the job afterward. Sixty percent were not, for lack of interest on their part or of their institutions. The graduates needed more follow-up, more useful forms, etc.

The point is that even highly skilled individuals do not follow through and apply what they have learned without much supervision and monitoring.

The RHP is aware of the difficulties and has devised strategies to provide continuous education in the field. An auxiliary nurse, who may or may have vast training as a trainer, accompanies a PHP on home visits to demonstrate what to do. They discuss the PHP's attitudes, good qualities, and weaknesses and make a plan for a revisit. New graduates and PHPs with problems get priority attention.

Monthly meetings and special classes for small groups who have similar learning needs are being implemented, too.

This is a difficult challenge that SDA is trying to handle. It seems better to train fewer numbers very well, than spread resources too thin. Extra staff who are training experts would help to provide sufficient on-site follow-up training and refresher courses to assure quality of care in the rural areas.

2. Expansion of SDA Clinical Services System: Regional Clinics

SDA operates 4 regional clinics, six satellite clinics, and 2 market clinics. The map (Annex 31) lists the location of each. The four regional clinics operate in San Salvador, Santa Tecla, Santa Ana, and San Miguel. The organizational structure is generally the same for all: the clinic manager is a non-physician who is responsible for reports, personnel, and all administrative issues for the clinic itself, plus its satellite and marketplace extensions. There is also a part-time medical director who is responsible for communicating with the central office (San Salvador). The roles of the two "chiefs" are not clearly delineated, but it appears that the medical director has the authority whereas the manager has the responsibility (see Annex 34 for the organizational structure).

RECOMMENDATION: SDA should link authority with responsibility by clearly delineating functions of the clinic managers and medical directors.

Each regional clinic offers:

- Medical consultation in family planning, pediatrics, prenatal-care, gynecology, colposcopy, and cytology. The clinic in San Salvador also offers specialty services in sexually transmitted diseases and ultrasonography.
- Surgical sterilizations (male and female) and diagnostic laparoscopy.
- Social service in FP and sexually transmitted diseases (STDs).
- Contraceptives.
- Medicines.
- Laboratory services (San Salvador clinic).

In 1993, 32% of 29,132 users was for FP. In the first quarter of 1994, 30% of 25,704 was for FP. Thus, 19% fewer users for FP were seen.

RECOMMENDATION: The decline in number of family planning users in 1994 needs to be assessed.

In pediatrics, immunizations are not offered, because the scope of the Project included referrals only for immunizations.

RECOMMENDATION: Offer immunizations at the regional clinics whenever a nurse is present.

The clinic in San Salvador operates a Center for Adolescents, which provides services in gynecology, general medicine, psychiatry, psychology, as well as family planning. In 1994, 10 of 798 consultations (1%) were for family planning.

RECOMMENDATION: Since the Center for Adolescents is a great resource for El Salvador, SDA should make a specific effort towards publicizing the availability of FP services there in hopes that this would increase the demand.

The physicians' hours are distributed according to the table 11 below.

Table 11:

Service Provided	Physician Hours/Week
Family Planning: sterilizations	15-30
Pre-Natal Care/Gynecology	26-38*
Specialized Gynecology (colposcopy)	2-4
Pediatrics	4-6

- Includes temporary family planning methods.

The regional clinics are spacious, clean, and well-equipped. The physical structure was well-maintained, e.g. a machinist was observed doing routine maintenance on the autoclave.

RECOMMENDATION: Keep the current buildings and their maintenance.

Over the life of project, the CYP has not changed significantly in the clinical program. The following four tables indicate the CYP by year.

Table 12: Couple-Years-of-Protection Provided by Clinics Year 1991

Productivity by Clinic									
Clin	**1***	**2***	**3+**	**4+**	**5+**	**6+**	**7+**	**8+**	**9+**
SAN SALV	9,378	3,759	1,778	2,989	457	2,027	18,126	2,088	27,537
STA. TEC.	3,589	1,917	309	337	60	572	19,422	684	21,393
STA. ANA	3,553	1,842	378	136	55	336	21,362	396	22,672
SAN MIG.	3,233	1,822	221	463	61	717	19,368	234	21,079
SAN FCO. GOT.	18	5	-	-	-	-	-	-	-
LA UNI.	33	5	0	0	0	1	0	0	1
ZACA.	1	0	0	-	0	0	-	-	0
USU.	3	-	-	-	-	-	-	-	-
SOYA.	653	159	21	47	4	47	0	0	122
8 CLI. MAR.	10	0	8	0	1	8	0	0	17
Total	20,471	9,509	2,715	3,972	2,638	3,708	78,278	1,530	92,821**

1 = First Visit
2 = First Visit for Family Planning
3 = BCP
4 = IUD
5 = Condoms
6 = Injections
7 = Sterilization Women
8 = Sterilization Men.
9 = Total

* = number of persons
+ = couple-year-protection (CYP)
** = Total of columns 3-8

55

Table 12: Couple-Years-of-Protection Provided by Clinics
Year 1992

Productivity by Clinic 1992									
Clin	**1***	**2***	**3+**	**4+**	**5+**	**6+**	**7+**	**8+**	**9+**
SAN SALV	11,406	3,922	1,806	313	585	2,447	24,066	7,268	34,368
STA. TEC.	5,042	2,256	303	430	58	680	24,498	540	26,518
STA. ANA	5,813	2,525	407	121	53	456	31,194	432	32,663
SAN MIG.	4,512	2,089	209	418	75	836	22,716	216	24,480
SAN FCO. GOT.	949	85	13	105	1	27	-	-	146
ZACA	76	-	-	-	-	-	-	-	-
USU.	22	-	20	-	2	9	-	-	31
SOYA	2,266	841	137	59	40	229	-	-	31
TOTAL	30,086	4,718	2,895	1,446	814	4,684	102,474	8,456	118,683

1 = First Visit
2 = First Visit for Family Planning
3 = BCP
4 = IUD
5 = Condoms
6 = Injections
7 = Sterilization Women
8 = Sterilization Men
9 = Total

* = number of persons
+ = couple-year-protection (CYP)
** = Total of columns 3-8

Table 12: Couple-Years-of-Protection Provided by Clinics
Year 1993

Productivity by Clinic 1993									
Clin	**1***	**2***	**3+**	**4+**	**5+**	**6+**	**7+**	**8+**	**9+**
SAN SALV	11,210	3,735	1,460	4,611	240	2,508	20,916	1,764	31,537
STA. TEC.	5,298	2,251	221	733	42	720	18,788	602	21,115
STA. ANA	6,528	2,349	384	200	42	567	22,680	-	24,231
SAN MIG.	5,073	2,177	188	529	47	88	20,174	154	21,989
SAN FCO. GOT.	1,320	118	25	194	5	61	-	-	287
LA UNI.	1,324	248	57	43	25	118	-	-	249
ZAC.	101	20	32	-	5	80	-	-	130
USU.	102	19	21	-	3	30	-	-	54
SOY.	2,810	918	271	122	64	504	-	-	97
TOTAL	33,766	11,835	2,659	6,432	473	4,676	82,558	2,520	100,569

1 = First Visit
2 = First Visit for Family Planning
3 = BCP
4 = IUD
5 = Condoms
6 = Injections
7 = Sterilization Women
8 = Sterilization Men
9 = Total

* = number of persons
+ = couple-year-protection (CYP)
** = Total of columns 3-8

57

Table 12: Couple-Years-of-Protection Provided by Clinics Year 1994

Productivity by Clinic, 1994									
CLIN	1*	2*	3.	4.	5.	6.	7.	8.	9.
SAN SALV	3,523	981	431	1,505	243	627	4,984	434	8,255 24,765*
STA. TEC.	2,037	889	120	408	14	189	9,198	224	10,155 30,465*
STA.ANA	1,786	684	119	40	14	126	7,630	112	8,041 24,123*
SAN MIG.	1,395	548	63	233	28	194	5,684	56	6,271 18,813*
SAN FCO.GOT.	427	29	9	79	-	21	-	-	109 327*
LA UNION	443	67	22	21	13	35	-	-	93 279*
ZACA	126	21	13	-	1	24	-	-	37 111*
USU.	136	18	4	-	-	7	-	-	11 33*
SOYA	869	270	109	111	35	167	-	-	428 1284*
CHALAT.	659	40	28	45	4	12	-	-	89 267*
AHUACHA.	511	26	4	40	1	6	-	-	51 153*
COJUTE.	330	59	15	6	1	34	-	-	56 *168 **33596
TOTAL	12,242	3,632	937	2,488	354	1,442	27,496	826	100,788**

These figures are through April 1994, and were multiplied by three when compared with previous years.

* Data multiplied by 3.

1 = First Visit
2 = First Visit for Family Planning
3 = BCP
4 = IUD
5 = Condoms
6 = Injections
7 = Sterilization Women
8 = Sterilization Men

9 = Total

* = number of persons
. = couple-year-protection (CYP)
** = Total of columns 3-8

To summarize the tables on pp. 11-41 to 11-44 indicate:

1. Total CYP (including sterilizations) decreased for two regional clinics (San Salvador and San Miguel), increased slightly at one Sta Ana) and increased markedly at one (Santa Tecla)

2. The satellite clinics, begun in 1991, have increased in CYP.

3. For all clinics, the totals of CYP are:

   1991: 92,821
   1992: 118,683
   1993: 100,569
   1994: 100,788

   Since 1991, the CYP has increased in the regional clinic program.

4. Analyzing temporary methods as one of our goals:

   1991: 13,033
   1992: 9,809
   1993: 14,240
   1994: 5,221

5. First visits for family planning were increased overall; although less in 1994 than 1992 and 1993.

   1991: 9,509
   1992: 11,718
   1993: 11,835
   1994: 10,896

The previous tables indicate that overall, from 1991 to 1994, the change has been similar to the chart below, taken for just 2 years at Santa Tecla (1991 - 1992).

Table 13:

	1991	1992	% Change
New Visits	not given	4,512	?
Return Visits	7,381	9,799	+33%
FP Only visits	1,946	2,089	+ 7%
FP Return	2,361	2,309	- 2%
Total FP	4,307	4,398	+ 2%
Orals	696	393	-44%
Condoms	22	4	-82%
Suppositories	13	1	-92%
Injections	4,236	2,994	-29%
Vasectomies	22	?	?
Female Sterilization	1,696	1,780	+ 5%

For the 4 regional clinics which have been operating since the beginning of the Project, the percent change from 1991 to 1994 in total CYP is:

Table 14:

Clinic	% Change (1994* - 1991)
San Salvador	- 22%
Santa Tecla	+ 39%
Santa Ana	+ 11%
San Miguel	- 10%

* Numbers obtained by multiplying January-April 1994 by 3.

RECOMMENDATION: Increase CYP in the regional clinics by active promotion of FP by all clinic staff. TA in health promotion should be offered, and the mass media campaign should begin immediately.

For June 1994, only a list of active users is available. Unfortunately this statistic differs from previous statistics which calculated "Couple-Years of Protection," which is calculated as:

1 CYP (Couple-Years-of-Protection) =
13 cycles of BCPs
6 injections
150 condoms
150 suppositories
1/3.5 IUDs
1/3.5 Norplant
1/14 Sterilization

Visits to some regional or satellite clinics may have decreased in 1993 or 1994 because of the addition of a referral system to rural physicians.

The efficiency of the regional clinics was moderate: nurses are not counseling, DAMAS VOLUNTARIAS are being under-utilized. The majority of family planning counseling is done by a sole social worker.

RECOMMENDATION: A quality assurance program should be implemented at the regional level to improve efficiency and increase time for counselling by the staff. Both nurses and "Damas Voluntarias" should be utilized more.

The clinic directors appear competent and capable of managing within severe constraints caused by the absence of regional authority and dependence upon the central administration for even small decisions. They appear to be more interested in office space than improving services. There seems to be a desire to know size/space/equipment as power rather than the development of human resources, through training.

This is reflected in the percentage of expenses that goes to training throughout SDS (see the table on 11-85), which was approximately 1% in both 1993 and 1994.

RECOMMENDATION: Increase the allocation for staff training at all levels of regional clinics: management, physicians, nurses, DAMAS VOLUNTARIAS, and others.

In 1993, the majority of new users of family planning services of SDA for FP occurred in the rural program:

Table 15:

Setting	Number of Consultations
Clinics (Regional and Satellite)	12,226
Marketplace clinics	364
Rural Program	36,275
Total	**48,865**

61

The 12,226 consultations for family planning represent 12% of the 103,367 visits to all the clinics in 1993 (Annexes 41 and 42).

RECOMMENDATIONS:

- ***A cost/user analysis should be performed to investigate the efficiency of seeing patients through the clinics or the RHP.***
- ***SDA should be viewed as a diversified provider of health care services, and not merely FP. TA should be provided to help SDA meet their fundamental goals of providing FP as well as related MCH services.***

b. Logistics

The contraceptive and pharmaceutical supplies distribution system is adequate for this sub-component. The two regional clinics observed had a sufficient quantity of stock on hand in contrast to the lack of supplies of the PHPs and DARs.

The SDA clinic supervision is provided by two medical doctors who visit the clinics usually two times a month; internal audits are performed quarterly. The CCC Monitors make monthly visits to the regional clinics to check inventories of contraceptives and pharmaceuticals and twice a year take physical inventories of stock. Inventories of USAID-supplied equipment are taken quarterly.

The CCC Monitors are charged with checking stock balances to determine if resupply is adequate; checking the condition of the stock; checking Kardex files and the distribution of printed material and the use of videos and other audiovisual material.

According to the SDA Medical Director, the selection of appropriate pharmaceuticals, medical supplies and equipment is made by the Medical Committee which is composed of the Board of Director, the Executive Directory the Hospital Director, the Medical Director, Santa Tecla and San Salvador Regional Clinics. There is adequate medical equipment provided to regional clinics for limited gynecologic surgery and female and male sterilizations. Computer and software selection is made by SDA MIS in consultation with CCC.

Determination of commodities quantities required is based on the supply requisitions provided by the regions, which in turn are based on consumption and balance on hand. The requisitions are studied at the Procurement and Supplies Department, and after considering stock balances at the Central Warehouse, either approved or modified if not properly justified. For local procurement without need of central level authorization, the regions are limited to a circulating fund of 3,000 colones with a single purchase limit of 300 colones. This seems low for regional operations but it does signify tight central control.

RECOMMENDATIONS: SDA should consider increasing the regional circulating funds to 5,000 colones with a 500 colones single purchase limit.

Information regarding central warehouse storage and procurement is provided in the section dealing with the sub-component, RHP. Contraceptives and pharmaceuticals for the regional clinics are stored in the clinic pharmacies. Storage is secure and adequate, but space is limited in the Santa Ana clinic.

RECOMMENDATION: The storage space at Santa Ana should be increased.

The CCC monitors make regional clinic visits once per month. Their monthly reports go to the Project Manager.HPN/USAID and the Executive Director of SDA.

RECOMMENDATION: The CCC monitors' reports should be utilized by the regional administration.

c. Computers/MIS

Use of the computer in supply management is not yet functioning at the regional level. The SDA MIS Department is currently researching the justification for this expansion for USAID approval. For information regarding computer use in supply management at the central warehouse please see the logistics section relating to the sub-component, RHP.

The four regional clinics are using a computer program (SAC) for the administration of clinics. The program provides data on clinical histories, sales and inventories.

RECOMMENDATION: Increase computer capability at the regional level.

- ***Provide newer equipment to the regions. Of the 61 ADS computers existing at the time of the evaluation, only eight were in the region and four are old according to the Chief of ADS/MIS.***
- ***Install in the regions a supply management program similar to that used at the central warehouse.***
- ***Get computers <u>operating</u> in the region.***

d. Financial Sustainability

Annex 36 lists the prices for SDA services. Efforts to make services self-sustainable led to a change in price structure in October 1993. SDA decided on the basis of research that some users were able to pay more for the services than they had been previously. This may have resulted in fewer users, but more income. Total sustainability is impossible because the patients pay less for services than they cost; even to zero when they are unable to pay.

Another reason sustainability is "impossible" is that the incomes of clients are small relative to costs For example, at the San Miguel clinic:

Table 16:

Year	2 month's income in colones	2 month's in $	Annualized
1991	27,194	3,126	$18,756
1992	29,777	3,423	$20,538
1993	61,214	7,036	$42,216

In the RHP, the highest budget line item is the salaries. The approximate total cost of this activity is C.13 Million. In 1993, salaries represented C.6.6 Million or 51%, followed by materials and supplies C.3.0 Million or 23%, and maintenance C.2.7 Million or 21%. The recovery level in this program is of 18% or C/.2.3 Million.

RECOMMENDATIONS: This is a costly part of the RHP without any doubt. The maintenance of the clinics that compose the expansion of services is a rather costly proposition for USAID. One alternative for USAID to make the best use of its funding and at the same time accomplish the same objective is to establish an arrangement with SDA to pay for SDA's delivery of clinic-based services on a reimbursement basis.

There are various alternatives for sustainability beyond USAID funding, and of course fund raising is one of them.

Fund Raising however, should be a function performed throughout the year by SDA and I believe they are doing so mainly with local businesses. Donations accepted by SDA from private donors however, should not generate additional recurrent costs to the organization. Contracts with external donors should be negotiated based on direct and indirect (overhead) expenditures projected previously by SDA.

The establishment on an Endowment Fund is also another option that USAID should explore. In the establishment of an Endowment, the donor would have to decide:

(1) What is the objective of the Fund?
(2) What type of expenditure is the donor willing to support?, per cent of total budget?; total budget?, etc.
(3) Who will have control of the Fund?. SDA' Board and AID's Representatives(s)?
(4) Should the principal investment amount be used for operations? Should it not be used at all? Can it be used with previous authorization from the entity controlling the fund after certain amount of years?
(5) Who should make contributions (deposits into) to the fund? From where should these contributions come?
(6) After how many accumulated years in the fund can SDA withdraw from it? two years? three years?

The Fund must be established by SDA. SDA for instance could ensure that between 5-10% from the annual increment in its cash resources through cost recovery is set aside for the

establishment of an Endowment Fund. This fund could be the equivalent of 25% of the total yearly expenditure of the Association. It is recommended that SDA external auditors be consulted on the percent level most adequate to SDA' circumstances. AID then matches these funds put aside by SDA for this purpose up to a previously agreed level.

The funds are used to open an investment account that generates revenue for SDA. There are restrictions imposed in these kind of funds. Number one is that the principal amount can not be used by SDA. The organization can only use the interest gained from this investment after a certain amount of years, as stipulated by the donor.

Cost Based Reimbursement System (CBRS). A cost based reimbursement system is a more complex method for reimbursing SDA for services provided to AID's designated patient-user group. This system could be much more effective in encouraging SDA to: (1) contain costs in the delivery of its services; (2) establish the necessary cost accounting module in order for it to be able to determine on a regular basis the costs incurred in delivering services.

Under this system USAID/ES would reimburse SDA for services provided by SDA' facilities to USAID's patient-user group. This group could be classified by USAID as those in level 2/relative poverty and level three/median income of the Ministry of Health's socio-economic scale (please see MOH's classification in the table below). Both the classification and fees to be used by SDA must be agreed prior to the initiation of a contractual arrangement between SDA and USAID/ES.

MOH SOCIO-ECONOMIC SCALE

Level 1:	**Extreme Poverty**	**-**	**No Charge**	**MOH**
Level 2:	**Relative Poverty**	**-**	**45% up to c. 250**	**SDA**
Level 3:	**Median Income**	**-**	**75% up to c. 500**	**SDA**
Level 4:	**High Income**	**-**	**100% Fee**	**OTHER**

The following steps are suggested to be followed by both USAID and SDA in establishing a cost based reimbursement arrangement:

1) Develop Procedure Costs: Cost per patient per procedure or service delivered. This level is determined by costing out each individual procedure provided by SDA in its clinics, including administrative or overhead costs typically generated by these services.

The amount of time spent by SDA' staff delivering services is a vital data information for the calculation of the fee. SDA would require technical assistance in determining these costs because its accounting system does not presently collect this detailed information on service costs, it is obtained by SDA at present only on a global basis (per program).

2) Cost Accounting Module: SDA has already developed terms of Reference for this process. This system would have to be implemented as soon as possible, and staff both at the Central Office and the regional offices trained in its use. Under a cost-based recovery system SDA could no longer rely on gross numbers — as are generated now by its present

Fund Accounting system, to provide an accurate performance perspective under a CBRS constraints. The type of budget forecasts and system to back-up that budget advocated here requires evaluation at the product-line (per patient, per procedure) level.

In other words, the establishment of a CBRS contract between USAID/ES and SDA requires that SDA develops and establishes administrative and data collection systems and procedures capable of examining the costs incurred by patients (users) at the procedure level, that it analyses the cost behavior of individual departments or Divisions within the clinics, and that it implements sound strategies to contain costs in order to be able to project costs at the service line level, obtain accurate information and prevent budget short-falls. CBRS can be a very effective vehicle USAID can use to encourage cost containment.

2. Payment Arrangements: USAID/ES's Financial Management Division could determine the terms of payment to be used in this case. It is suggested though, that SDA be provided with an advance, say, the equivalent of the total cost of one month of provision of the service as calculated according to the above rule.

The restrictions attached to this "advance" is that it can only be used when "reimbursements" from USAID are delayed. The funds in-bank at present from the sale of contraceptives or AID-IL funds could be those USAID designates for this purpose, regulations permitting.

A cost-based reimbursement agreement can be combined with the establishment of an Endowment Fund. The endowment fund would determine the life of the agreement and the endowment itself.

USAID can choose for instance to reimburse SDA for services provided to its selected patient group up until the Endowment fund has generated sufficient capital for SDA to continue provision of services without depending totally on outside donors. This calculation should take into account SDA' locally to generate within three years an equivalent of 60% of SDA' annual expenditure.

The amount of time for this agreement would depend on the amount of capital determined to be used in the initiation of an endowment fund.

USAID can explore within its regulations what would be the possibility to use the funds presently inactive in SDA' USAID-il account to establish the endowment (as an initial amount or capital funds) since those funds were generated by sale of contraceptives. The question is: can these funds be considered part of SDA's locally raised income?

Contributions to the fund would have to be made by SDA and this should be stipulated within the USAID/SDA agreement. Funds to replenish the fund should come from SDA's sale of services.

3) USAID would have to develop a set of procedures to handle the vouchers and payments of the new patient-reimbursement arrangement.

e. Technical Assistance

Through the financial and technical assistance provided, the Project has increased the logistics capability of SDA. According to the Manager of the Procurement and Supplies Department, the technical assistance provided helped greatly to unify and put the purchasing and supply system in order. USAID financing has increased the variety and quantity of contraceptives, pharmaceuticals, audio-visual materials and medical equipment available to the organization. The manuals covering procurement and supplies developed by CCC technical assistance have been instrumental in improving supply management, according to the Manager of the Procurement and Supplies Department.

The regional clinic directors at Santa Tecla and San Miguel reported that they had never received TA from CCC. The TA focused on logistics, procurement, and computer systems at the central level and rural monitoring.

RECOMMENDATION: In light of the decrease in users, absence of supplies, and minimal computerization, technical assistance needs to address enriching management, logistics, computers, and clinical issues.

f. Information, Education, Communication (IEC)

The pamphlets available in the regional clinics were reviewed, and specific comments regarding them were made directly to the IEC department. Pamphlets targeted at young women were not found in any of the four regional, four satellite, nor two marketplace clinics. Pamphlets targeted at young men were not found either.

When the evaluation team visited, a video program was being shown to women waiting at a regional clinic. Unfortunately, the program (a scientific explanation of vasectomy) was not selected with Salvadoran women in mind.

The IEC Department supported the regional clinics by creating 4 pamphlets on medical themes for patients' use:

- cervical-uterine cancer
- female sterilization
- post-partum care
- nutrition for pregnant women.

These pamphlets, as well as the ones produced for the general public on FP and MCH themes, are printed and reprinted upon demand. Women who are waiting to see the medical staff can read them, and the staff can use them to explain procedures, etc.

The IEC Department also supplies calendars and wall charts on medical topics, and sends videos on various themes so that waiting patients can watch them. Each regional clinic also has a documentation center with books, journals, reports, and audio-visual materials supplied by the IEC Department. SDA reports thousands of students and others using these libraries every year.

RECOMMENDATION: Distribute pamphlets and flipcharts to the regional clinics.

- ***Include the regional clinics in the mass media campaign.***

g. Training

The Medical Sector has been offered training in the following:

- Hormonal Methods, pills and injections
- Contraceptive Methods
- Counseling for Voluntary Surgical Contraception (1992)
- Congresses and courses on AIDS and sexually transmitted diseases (1992)

No training has been provided especially for medical and paramedical staff at regional clinics. In 1993, two courses were planned, one on Norplant and another on supervisory skills, but neither was held.

RECOMMENDATION: Clinical staff in the regions should have in-service training on advances in the contraceptive field, counselling, and promotion of FP.

h. Client Satisfaction

A study was performed on clients, and the clients are generally satisfied. (More improvements could be made with additional client input.)

RECOMMENDATION: Enhance the IEP Division through medium-term technical assistance in the area of study design, analysis, and interpretation, in order to fully investigate client satisfaction. Focus on the decrease in users in 1994.

i. Method Mix

Sterilizations remain the most commonly chosen method of contraception. (Refer to Tables of pp. II41-44.) Of temporary methods, injections are the most popular. At the regional clinics of San Salvador, Santa Tecla, and San Miguel, the IUD is the second choice; whereas at Santa Ana, pills are the consistent second choice.

RECOMMENDATION: Investigate why Santa Ana differs from the other three regions in method mix.

Sterilizations are popular because:

- The all-or-nothing concept is attractive to both promoters and clients.
- Physicians perform them, thus increasing their prestige.
- 100% efficacy.

- Promotion materials do not mention contraindications or side-effects.
- The PHPs do a lot of good work - both in temporary methods and sterilizations. The quota of 2 sterilizations per month, however, represents the historic emphasis on permanent methods that USAID has been wondering about.
- False impressions and myths of alternative methods.
- Ignorance about alternative methods.
- Cheapest method (only 10 colones) until 1994, when the price was raised to 50 colones (which is the equivalent of two injections (4 months' coverage) or 17 cycles of pills (17 months' coverage).
- No apparatus to deal with.
- The pamphlet, "Female Sterilization," states "It's the surest FP method" right on the cover. Likewise, inside, no contraindications are mentioned. Rather, it states, "Sterilization is simple, sure, and rapid." This is very different from a list of six things in the Vasectomy pamphlet that could scare men away from the operation.

The role of sterilization in FP may change drastically as injections have become more available and popular. In 1993, 32% of women preferred injections, contrasted to 20% for sterilization (Annex 32). See table on p. II-34.

The IUD is not popular in this country. Reasons are not clear, but include:

- No apparatus in some satellite clinics.
- Cost is MORE than sterilization.
- There is a perception that it causes cancer, increased libido.
- The fact that some experts believe that it is an abortifacient causes some physicians to be reluctant to recommend or insert this device.

* Norplant is a very new method which SDA is appropriately adding to its method mix. At this time, there appears to be no demand for Norplant, even by clinic staff.

Six Norplants have been inserted in San Salvador since the inception of this project in March 1994. The procedure is done only in San Salvador.

Vasectomies are rare -- approximately each regional clinic performs one per month.

A study performed by SDA investigated sterilization between 1973-1991. Over these 19 years, the number of women sterilized increased, whereas the number of men decreased. Over this period of time, the average age of sterilization decreased from 29 to 27 years, reflecting changes in SDA's institutional norms and procedures yet the number of living children has not changed. If the average age of women being sterilized is LESS by 2 years,

AND the mean number of children is the same, then the women MUST be having those children PRIOR to 27 rather than 29. But that's not the more important point. The more important point is that the mean number of children prior to sterilization is not decreasing. And decreasing this is one of the only 2 ways sterilization will ultimately reduce the population growth rate [the second way is simply through the increase in the number of sterilizations.]

Fifty percent of women being sterilized never used contraceptives before sterilization.

The profile of men being sterilized is different from that of women: men have had an average of 8 years of education, whereas women have had an average of 3.5 years.

RECOMMENDATIONS:

- ***Target FP programs at men as well as women.***

j. WID

When comparing the percentage of pill, injectable, IUD, and female sterilization recipients to the percentage of condom and vasectomy clients, it is easy to see that women are the main benefactors of FP services. By definition, the recipients of MCH services are women and children.

Women do not fill as many management and executive positions in the medical programs as in the rural health program. The medical department is dominated by men. The medical director, his two supervisors, and the four regional medical directors are all men. Nurses and social workers are usually women.

Comparing results in regional areas outside of San Salvador to results in the rural area (FESAL 1993) outcomes were more sustained when women staff predominated: in urban areas, the fertility rate increased from 3.37 in 1983-1988 to 3.52 in 1988-1993, as opposed to rural areas, where the fertility rate decreased. This shows that a need exists to promote and support work in the regional and satellite clinics.

RECOMMENDATIONS: More women should be involved in planning and implementing FP and MCH services in the urban areas, especially outside San Salvador.

- ***Attention needs to be given to training needs of regional clinical staff.***
- ***Training in Norplant insertion, counseling, indications and contraindications should begin as soon as possible.***
- ***Empower nurses to provide more direct family planning services, such as the insertion of IUDs.***
- ***Increase the use of temporary methods by creating a special mass media campaign, empowering nurses, and improving IEC materials in the clinics.***

70

3. Expansion of SDA Clinical Services System: Satellite Clinics

a. General Description

There are 6 satellite clinics: two associated with San Miguel (La Union and Gotera), one with Santa Tecla (Chalatenango), one with Santa Ana (Ahuachapan), and two with San Salvador (Soyapango and Cojutepeque). The number of visits may have been affected by the establishment of satellite and marketplace clinics, but according to the medical director, the number of consultations continued to increase.

The satellite clinics are called "Pro-familia" and are general clinics, offering family planning services. An increasing client base provides a source of patients for FP. Satellite clinics have a full-time nurse and custodian. A general physician attends 1-2 hours each day and provides services in gynecology (PAPs), pre-natal care, pediatrics, and family planning. Women who seek sterilizations are referred to the regional clinic, and are transported by an SDA vehicle.

RECOMMENDATION: In order to promote FP among patients who are seeking other services, a protocol for offering FP services should be created and used on every patient. This protocol would educate every patient about the value of FP.

Physicians earn 800 colones/month (approximately ¢22/hour). This contrasts to the ISSS which pays approximately ¢17/hour, the MSPAS which pays ¢13-14/hour, and private practice, which pays ¢27/hour (gross). Physicians in the satellite clinic are expected to see 6 patients/hour (144 patients/24 hours). If they see extra, they are paid 6 colones/patient (¢0.69). During the hours of physician coverage, 14-20 patients are seen in the satellite clinics. During the other 6 hours, 4-6 patients are seen.

RECOMMENDATIONS:

- ***Recruitment of physicians is not a problem. Maintain the current salary structure.***
- ***To make satellite clinics more efficient, analyze and improve the use of the nurses' time. The satellite clinics would be more efficient if programs such as health promotion lectures were offered during the hours when no physician is present. Increase the role of the nurse through training. Increase physicians' hours.***

The cost for an injection in the clinic is 28 colones ($3.22), compared to 12 colones ($1.38) in the field.

In pediatrics, immunizations are not offered except during special campaigns. Referrals are made for immunizations to MSPAS clinics and other sites.

RECOMMENDATION: Immunizations, at least for tetanus, should be always available at satellite clinics. Where refrigeration is not available, weekly sessions should be held providing immunizations. When these services are active, the IEC Department should make the public aware of them and motivate people to use them.

Satellite clinics have increased in visits as indicated by the following table 17, taken for just 2 months during the first 3 years of the clinics.

Table 17: Number of Clinic Visits

Year (in 2-month period)	La Union	Gotera
1991	1	0
1992	33	8
1993	53	28

The SDA creates annual objectives, and for satellite clinics these included CYP and consultations in specific areas. The satellite clinics succeeded in meeting 1994 objectives in the areas of CYP (temporary methods), gynecologic consultations, general medical consultations, reproductive health consultations, and cytologies. They did not succeed in the areas of FP or MCH consultations. SDA planned that 6,535 of 31,380 (21%) consultations in the satellite clinics would be for FP. Thus far in 1994, 1,447 of 10,348 consultations have been for FP (14%).

In 1993, 4,000 of 13,800 (29%) consultations were planned to be for FP; by April, 1,163 of 4,313 (27%) had been for FP.

Both the proportion of consultations planned for FP, and the proportion of consultations realized for FP have decreased this year, as was true for the regional clinics (Annex 29).

The physicians' hours are well-utilized, although family planning is the least common reason for consultation (following pediatrics, general gynecology, pre-natal visits, and general medical visits).

RECOMMENDATION: Although expanding services is good, the priority of FP should not diminish. Keeping FP the focus of the satellite clinics should be done through altering the cost reimbursement system, the mass media campaign, and training satellite clinic staff in FP.

The evaluation team believes that subsidizing FP services more fully than other medical services would ensure that FP remains the focus of the satellite clinics.

Regarding the placement of the clinics, SDA conducted a study on at least 8 different sites. (Table 18) The criteria were not clear from the studies, nor did they appear to be the most important characteristics.

Table 18:

Feasibility Studies of 8 Sites for the Satellite Clinics								
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**
Suchitoto	.01	5.4	**.29**	**204**	.53	.72	.81	**.23**
La Libertad	**.05**	**5.5**	.26	**250**	.52	.84	**.87**	.49
Ciudad Barrios	.04	5.4	**.34**	259	.48	**.93**	.76	.51
Sensuntepeque	**.06**	5.3	.23	268	.50	**.88**	.77	.47
Ilobasco	.04	**5.5**	.12	275	.52	.80	**.83**	**.45**
* Chalatenango	.04	**5.6**	.28	283	**.54**	.76	.80	.50
* Ahuachapan	.02	5.0	.19	331	**.55**	.61	.82	.55
Atiquizaya	.03	4.7	.26	351	.52	.70	.82	.57

• = Sites of eventual clinics.

The **emphasized** numbers indicate the clinics that, on the basis of these data, might have been selected as sites.

1 = % of population that desires family planning services.
2 = Average number of persons/house.
3 = % unemployed.
4 = Average monthly income (in colones).
5 = % women aged 15-49.
6 = % of population "dependent"
7 = % positive reaction to "pro-familia" name.
8 = % that pay > 20.00 Colones to see doctor.

From this determination, La Libertad, Suchitoto, and Ilobasco would be the first sites. However, Chalatenango and Ahuachapan were selected.

The studies reviewed by our team were excellent beginnings in the field of program evaluation. The research would benefit from TA in respondent bias, sample size, control groups, etc. which were frequently omitted.

RECOMMENDATION: As stated earlier, the IEP Division requires TA in epidemiology to improve study design, analysis, and interpretation. With every evaluation, what will be done with the results should be explicitly written prior to study implementation.

b. Logistics

Supplies for the satellite clinics are provided by the regional clinics every 3 months. From field observation the supply system appears adequate with sufficient stock levels of USAID provided contraceptives and medicines; IPPF injectable contraceptives were not uniformly available, as noted below.

The Ahuachapan Clinic had no ORS, vitamin A, nor immunizations available (however, none of these are considered the customary stock items). Soyapango had multivitamins, antibiotics, birth control pills, condoms, but no Noristerat. The Kardex was up to date and clear.

As with the regional clinics, two medical supervisors visit the satellite clinics twice a month to verify sufficient stock resupply. The CCC monitors visit the satellite clinics monthly, and check stock inventories every 2 months. This supervision is adequate.

Selection of appropriate pharmaceuticals, medical supplies and medical equipment is based on clinic function and is selected by the Medical Directors at SDA headquarters. Commodities quantities needed are fed to the regions where the requests are examined and satellite clinic requisitions are prepared and forwarded to the central level. Requisitions are examined by the Department of Procurement and Supplies and the Medical Directors as to their appropriateness.

Storage of pharmaceuticals and contraceptives at satellite clinics is provided by storage cabinets. Generally the clinics are well supplied with contraceptives and pharmaceuticals. Typical USAID equipment supplied is: an instrument sterilizer, gynecological table, two fans, goose neck floor lamp, adult and pediatric scale, typewriter and water cooler.

The procurement system for satellite clinics follows the same procedure outlined under the sub-component, RHP.

c. Computers/MIS

Neither supplies, management, nor statistics are computerized at the level of satellite clinics.

d. Sustainability

Table 19:

Year	2 months' income in colones	2 months' in $	Gotera colones	Gotera $
1991	1,265	145.	982	113
1992	5,199	598	3,472	393
1993	17,011	1,955	14,699	1,689

The overhead of maintaining an office 8 hours/day when very few patients are seen except during the physicians' hours, makes alternative locations sensible. The SDA medical director is piloting a project to use private physicians' offices as SDA satellites in Sonsonate. There should be significant cost savings for SDA. There would be no need for an SDA rented clinic nor an SDA nurse and part-time doctor. The private doctor, in partnership with SDA, would supply medical services to patients referred to him by SDA. These patients would be charged a reduced rate for the referral visit but the doctor would be seeing more patients daily and would be building up a new clientele. This should be most attractive to a young doctor trying to increase his practice.

RECOMMENDATIONS:

- ***Support the pilot project of using physicians' offices as SDA satellites. Evaluate aggressively the physicians' commitment to FP.***
- ***Empowering the nurses would support sustainability through increased efficiency.***

e. Technical Assistance

On November 15, 1991, CCC evaluated the first satellite clinic which was located in Terminal prior to its moving to Soyapango. Their suggestions were too vague, and therefore not used. A huge study was repeated (12/15/92) by SDA, and the recommendations were repeated.

RECOMMENDATION: TA directed towards increasing satellite clinic efficiency should begin.

f. IEC

FP is not promoted through IEC materials at satellite clinics.

RECOMMENDATION: Distribute IEC materials and design a FP protocol for patients visiting the satellite clinics.

75

g. Training

In 1991, a training course was planned for 14 paramedics who work in the satellite clinics and marketplace clinic. Eleven persons attended. No training has been planned or implemented in 1992, 1993, or 1994.

RECOMMENDATION: Satellite clinic nurses should be trained in insertion of IUDs, and be empowered to serve as physician extenders to provide all temporary methods of FP.

h. Client Satisfaction

The variety of consultations in primary care provided at the satellite clinics may indicate client satisfaction. However, we did not assess client satisfaction systematically.

i. Method Mix

The most preferred methods are injections and oral pills. Clients are referred to regional clinics for sterilizations. Condoms and IUDs are unpopular.

j. WID

The vast majority of patients are women, as are the nurses on staff. As in the other clinical programs, men may be overlooked.

RECOMMENDATION: A campaign targeting men should begin.

k. Additional Recommendations

- ***Training needs of satellite and marketplace clinics need to be surveyed and addressed.***
- ***Consider having the nearby factories support the satellite clinics.***
- ***Avoid overhead through renting private physicians' offices.***
- ***Consider outreach efforts targeting teens and men.***
- ***Expand nurses' role.***
- ***Provide IUD insertion apparatus.***

4. Expansion of SDA Clinical Services System: Marketplace Clinics

a. General Description

The SDA has 12 marketplace clinics, two are SDA project dependent, eight are clinics supported by the municipality of San Salvador and two are not really clinics, but distributors who are located in markets. There are many municipally supported marketplace clinics in and around San Salvador in which it would be possible to expand SDA contraceptive supply services in the future. A great advantage for SDA in this partnership is financial: SDA is

relieved of establishing and staffing its own physical clinics, whose cost effectiveness is in doubt. The municipally supported marketplace clinics have their own physical structure and medical staff. The municipal marketplace clinics could be a key method to the expansion of SDA family planning coverage while reducing costs. Immediate future plans, however, do not envision an expansion of agreements with city hall for these clinics. The objective now, according to the Director of the Medical Division, is to stabilize their work with the existing eight.

RECOMMENDATION: SDA should work directly with the municipalities in order to assess cost/user and the benefit of increasing marketplace clinics.

SDA operates two marketplace clinics: (Zacatecoluca/Santa Tecla region and Usulutan/San Miguel region). Each has a full-time nurse and a physician 2 hours/week. The nurse provides family planning counseling and methods; the physician provides general medical, gynecologic, obstetric, and pediatric services. The range of services is similar to that in satellite clinics, but on a much-reduced schedule.

In pediatrics, immunizations are not offered because only referrals to MSPAS and other clinics are made to receive immunizations. Once a week, an SDA driver comes to transport women to the regional clinic where sterilizations will be performed. Once a month, the regional medical director and clinic manager each visit the market clinic. Likewise, the nurses' level of independence seems appropriate -- she can prescribe pills/injections if the client fulfills criteria.

In 1994, 84 of 509 (17%) of consultations were for family planning. Of nine objectives for 1994, five were met or exceeded (reproductive health visits, OB-GYN visits, MCH visits, general medical visits, and establishment of new marketplace clinics) and five were not met (CYP temporary methods; referrals to physicians; consultations for FP, and cytologies) (Annex 30).

As in the regional and satellite clinics, FP is not the focus of the marketplace clinics.

In short, the evaluation team recommends changing reimbursement to cost basis with greater subsidies for FP than for other medical services. This would increase SDA's priority for FP.

RECOMMENDATION: Reinforce the primacy of FP through use of the FP "protocol" mentioned earlier which each patient would fill out in order to educate them regarding FP.

The marketplace clinics are disdained by the regional clinic staff. Similarly, the SDA Medical Director believes the marketplace clinics are less effective because their location is in a place where people are shopping and in a hurry. The nearby sellers are not customers because they are interested in selling. The market smells offend potential patients. However, the nurses report similar numbers of patient/doctor-hour in the marketplace clinics as in the satellite clinics. Most of the patients referred to the market clinics are referred by the rural program, the PHPs.

b. Logistics

Distribution of contraceptive and pharmaceutical supplies is provided by regional clinics every 3 months to the Project dependent clinics of Usulutan (eastern region) and Zacatecoluca (paracentral region). For the eight marketplace clinics supported by the municipality and supplied contraceptives by SDA, the SDA delivers the supplies. For the market distributor in Santa Rosa de Lima, a promoter supervisor from the eastern region makes monthly deliveries. The same is done by a promoter supervisor from the western region when servicing the market distributor in Metapan.

Field observation by the evaluation team members indicated that the Usulutan marketplace clinic had adequate contraceptives and medicines but the marketplace clinic in Zacatecoluca was without injectable contraceptives. As there was insufficient time in which to make other marketplace clinic visits, no comments can be made about the adequacy of supplies in those.

The supervisory system by SDA -- visits by a Promoter Supervisor -- and monthly visits by the CCC monitors is adequate to signal commodity resupply difficulties.

Selection of appropriate pharmaceuticals, medical supplies and other equipment for the marketplace clinics is made by the SDA Medical Committee. The commodities selected are adequate for the consultations and care administered at the SDA dependent marketplace clinics. The municipally supported marketplace clinics receive the same contraceptives as those provided to the SDA clinics.

Commodities quantities needed for the SDA supported clinics in Usulutan and Zacatecoluca are requested from the regional clinics. Requests are examined at the regional level and, if approved, are passed on to central level along with regional and satellite clinic requests. Supplies for the eight municipally supported clinics are determined by monthly consumption records and supplies are provided monthly from the central warehouse. For the two market distributors the same is done but supplied from regional stocks by regional promoter supervisors at the time of their monthly visits.

At the clinics in Usulutan and Zacatecoluca commodities are stored in a steel cabinet which is entirely adequate for clinic needs. As there was not sufficient time to visit other marketplace clinics, no comment can be made as to their storage conditions.

c. Computers/MIS

Computer use is not indicated for the marketplace clinics.

d. Sustainability

SDA calculated the total cost of a medical consultation for FP at the regional and satellite clinics. Although San Francisco Gotera was the most costly of the eight studied, it is not slated for closure. Both it and La Union were more costly in terms of human resources, functional costs, and overall costs than the two market clinics (Annex 39).

Price list

¢10 Consultation
¢20/40 IUD
¢25/40 Injection
¢50/300 Vasectomy
¢50/300 Female sterilization

RECOMMENDATION: Encourage municipal involvement to share costs.

e. Technical Assistance

Despite extensive technical assistance in logistics, severe problems threaten the success of the Project. TA has been inadequate.

RECOMMENDATION: TA regarding enhancing nurses' functions, management, placement of clinics should occur.

f. IEC

Materials promoting FP were scarce in the marketplace clinics.

RECOMMENDATION: Provide the same materials that the other programs have for the clients.

g. Training

The nurses appeared competent -- both administratively and technically. They knew the rules, how to complete the forms, and their inventory. Technically, they answered questions completely and accurately. Also, their checklist to use as "standing order/s" seemed appropriate. SDA provides training for the nurses of the municipal marketplace clinics in contraceptive methods.

RECOMMENDATION: Empowering nurses to provide direct FP services would increase marketplace clinic efficiency.

h. Client Satisfaction

The patients we interviewed at the market clinics were content with services, but would like to have more physician coverage.

i. Method Mix

Injections are the most common method, followed by the BCP. No sterilizations are offered, but women may be transported to the regional clinic on certain days of the week. IUDs are not requested because women think they don't work. They also believe they cause cancer.

j. WID

Marketplace clinics serve predominantly women. The nurses are women. However, men are not sufficiently addressed.

RECOMMENDATION: Create a market program geared towards men.

k. Additional Recommendations

- **Add running water to each clinic.**
- **Expand physicians' hours.**
- **Advertise locations.**

5. Expansion of SDA Clinical Services System: Physician Referral System

a. General Description

Forty-nine physicians have agreed to be referral physicians for the SDA. They are paid 5 colones by the patient and 15 by the SDA (a total of $2.30) to see a patient referred by a PHP or other SDA worker. ($2.30 contrasts to the usual $3.45-6.90 a physician receives in his/her private clinic.) Patients who visit these physicians must pay an additional amount for medicine and treatment. In 1993, the cost was 420,000 colones ($48,276). 18,477 referrals were made by PHPs to these physicians. Approximately one-third kept their appointments.

Services include family planning, gynecologic examinations, pre-natal visits, and pediatrics for children less than 5 years of age. The impact of these physicians on FP users has not been assessed. The total number of FP users (see Tables ____) has not markedly increased, although the program is very new and results may occur in the future.

Communication between the regional clinics and the physicians of reference is minimal. The referring physicians receive supervision directly from San Salvador, even if they are in another region. Likewise, the medical director at the region does not know either who or where the referring physicians are. All referring physicians have relationships with PHPs, but they are only informal relationships. The evaluation team thought that decentralizing authority would increase clinic-physician communication.

RECOMMENDATION: Formal meetings should occur among the regional medical director, the referring physicians in that region, and the rural PHPs.

SDA recruits physicians who are competent in one or more of the areas of services offered. They are screened and accepted by the central office. Neither interviews nor examinations are required. Only 3 applicants have been rejected, one because of problems with alcohol, and the other two because they had not completed their medical training.

The criteria for joining the program are not adequate. Although it is good that physicians are required to live in the community where they will be working, they are not screened for competence and/or interest in FP.

RECOMMENDATION: Ensure commitment to PF through mandatory regular training, e.g. annual sessions on "New Development in FP," etc.

Supervision is minimal. Supervising physicians attempt to visit the referring physicians monthly to check on administrative issues, not clinical expertise, competence, or productivity. However, one referring physician had not yet see the supervisor (after 5 months of being in the program). When supervision occurs, it includes both administrative and technical issues. Administrative issues are: 1) visit actually occurred; 2) forms correctly filled out; 3) receipt submitted on time; 4) schedule up to date; 5) records clear: 6) supplies adequate; and 7) signature. The single technical issue: did the diagnosis and the treatment coincide. The supervising physician randomly selects a patient chart and monitors it. If mistakes were made, he corrects them through educating the physician.

RECOMMENDATION: Monthly visits, if followed, would be adequate to provide guidance to the physicians and to recover data for the central level.

The referring physicians' program is an inexpensive and useful network for expanding SDA's reputation but is not increasing family planning users.

b. Logistics

Logistics is not required because at this time the referring physicians do not use materials or contraceptives provided by SDA.

c. Computers/MIS

Not used.

d. Sustainability

At this time, no attempts are being made to gradually increase the patients' portions of fees. Therefore, the visits are almost totally subsidized by SDA.

RECOMMENDATION: SDA should conduct a pilot project to increase the proportion of the fee paid by the patient and investigate compliance.

e. Technical Assistance

Technical assistance in the field is not received. It would be helpful, however, for the monitors to make occasional visits to the physicians in the referral network to check on the outcome of PHP referrals.

RECOMMENDATION: The CCC monitors should make occasional visits to the physicians in the referral network.

f. IEC

IEC needs are addressed by supplying pamphlets, calendars, and wall charts.

RECOMMENDATION: SDA should provide the referral physicians with the IEC materials available to the other programs.

g. Training

Training has been given each year for physicians in the referral network. Training consists of a 1-day "required" training course in San Salvador, which is not always attended. This course covers the SDA history and structure, administrative issues such as forms and billing, and the management of PF methods. A manual of standards is given, and physicians are expected to follow it. It is complete, detailed, and accurate. In 1991, 17 of 25 physicians were trained. In 1992, 28, or 8 more than planned, were trained. In 1993, 28 of 40 were trained.

RECOMMENDATIONS: Training must increase to make the physicians in the referral network promote FP.

RECOMMENDATION: Each referral physician should be able to insert an IUD. Implantation of Norplant should be taught and encouraged.

h. Client Satisfaction

The patients interviewed at the physician's office we visited were content with services. However, we did not formally assess client satisfaction.

i. Method Mix

Information on the method mix was not available.

j. WID

Many of the referral physicians are women.

k. Additional Recommendations

- **Physicians should be allowed, during their residency, to see SDA patients.**
- **Physicians should meet and work with PHPs.**

II-COMPA.R24

B. Component II: Institutional Development

Table 20: Summary of Specific Goals and Accomplishments

OBJECTIVE	PROGRESS TO DATE	% REACHED	COMMENT
Expand SMP	not done	%	Delays due to AID's contracts regulations; high fees bid by bidders on distribution of contraceptives contract
Create Central Referral Clinic	not done	%	
Add medical services to SDA Clinics	done	100%	
Pre-paid medical insurance plan	not done	0%	
Decentralization	not done	0%	Programmatic decentralization; partial administrative decentralization (select and supervise staff at regional level; pay is centralized)
Improved MIS system	done	100%	
Personnel study and enrichment	done	100%	Short term TA in 1993 analyzed personnel structure
Decrease cost per user from $15 to $6	not available	not available	Cost/user is not currently calculated by SDA

1. Expansion of the Social Marketing Program

a. General Description

Establishment of New Division

The "Social Marketing and Resource Development Division" (SMRD) is a newly created department within SDA. Social Marketing at SDA was in the past a component of the IEC Department. Prior to the establishment of the new Division of SMRD, there was a Marketing Division at SDA headed by a Marketing Manager, a Secretary, four salesmen and an accountant assistant.

The scope of work, duties and responsibilities of the new SMRD Division dramatically increased in scope with the creation of this new Division. At present, the Division's scope of work includes both the Social Marketing of Contraceptives program, and other major income

generating activities which are of significant importance to SDA in the achievement of its sustainability goals.

The establishment of the new SMRD Division suffered some set-backs in its initial stages. A month after the recruitment of the Division's Director from the private sector, SDA decided to transfer its Manager to the FESAL project which was in progress rather than have him help develop a plan of action for the new Division.

This showed lack of political commitment on SDA part by:

1. knowing that the present Director of the Division came from the private commercial sector and did not have experience in the not-for-profit sector.

2. allowing the new Director, despite his lack of knowledge of the not for profit sector, to work on his own for six months before he could hire an assistant.

3. instead of providing the necessary support to the newly appointed Director by maintaining the SMP manager in the Division, SDA instead incurred an expense by sending the Director to the Dominican Republic to learn how to work with SDA and to learn how the IPPF affiliate there did social marketing so it could be replicated in El Salvador. As it turned out, the modus operandi in the Dominican Republic was totally counter to that in El Salvador because of the bonus system used in El Salvador.

In addition, SDA has only in the last years made an effort to strengthen the Social Marketing and Resource Development Division due to SDA final realization that funding from USAID might not be forthcoming at the level it has been up until now, if at all.

Instead, SDA has concentrated all its efforts and capital in purchasing equipping, and setting up management for the hospital. Please keep in mind that the project has been in operation since the end of 1989. Therefore, SDA's political commitment to both Social Marketing and Resource (Financial) Development — with exception of the hospital — is not evident.

Technical Assistance in Financial Resource Development

Technical assistance (TA) in Resource Development (Fund Raising) was provided during visits in February and September, 1993. The technical assistance helped SDA identify two major areas of "financial resource development:" cost recovery and income generation.

The SMRD Division's fund raising activities have been identified as follows:

MARKETING PLAN	
COST RECOVERY	**INCOME GENERATION**
Short Term: Sales of Medicines Contraceptives in Clinics Medical Consultations	**Short Term:** Distributor New Products and Services Laboratory Donations Family Planning Services to Industry Education Activities: Library Audiovisual Production Rental of Audio Visual Equipment **Medium Term** Pro-Familia Studies and Research **Long Term** Network of Pharmacies

Approximately 98% of the recommendations made during those TA visits have been implemented by SDA, and the Resource Development part of SDA' sustainability program is on its way. There is still one recommendation pending implementation or further investigation by SDA. That is the establishment of an Endowment Fund.

Findings:

During the Evaluation Team's field trips to the four regions, we learned that some Regional staff did not understand why the SMRD was created or how it was staffed.

This could be due to lack of information regarding this Division's role in helping SDA achieve sustainability of the SMP's Director. It appears as if the regional staff does not understand the duties and responsibilities or SMRD Division's goals.

The role the SMRD Division will play within SDA in achieving its sustainability goals must be clearly explained to the regional staff to avoid further misunderstandings and possible lack of interest in cooperating in the implementation of the marketing/resource development plan.

RECOMMENDATIONS:

<u>Political Support</u> and full cooperation is required from SDA'S upper management including supervisory and managerial levels, to guarantee the success of the various Resource Development activities planned by this division. Although some support has been forthcoming, the SMRL division feels that much more will be needed in the future from both the Board of Directors and the management at SDA, as well as from USAID staff in charge of the management and monitoring of the RHP.

Due to the importance to the SDA of attaining a high level of sustainability, not only to comply with the terms of the Cooperative Agreement but to decrease donor-dependency, the SDA must ensure that all of its staff are well informed about the

SMRD Division's goals. It is also important to clarify what the duties and responsibilities of the Division's members are, and explain their plans.

Further more, the regional staff sees Social Marketing and Resource development as just one more Division to enhance SDA Headquarters. The regional staff, as was described to us, feels that SDA Headquarters are a big bureaucracy where decisions are made without really consulting with the regions. Instead, according to the regional staff, decisions are communicated to them making then non-participatory that autocratic.

As the evaluation team perceived the problem, this is the net effect of the partial administrative decentralization SDA claims too have effected to date.

Expansion and Modification of SMP and Generation of Revenues

Until December, 1993, SDA's social marketing program (SMP) was implemented with the assistance of four salesmen which SDA had on staff. SDA remunerated these salesmen with a salary, fringe benefits and a 10% commission. Market research conducted by SDA on commissions paid by other organizations to salesmen of high volume items revealed that commissions in El Salvador ranged between 2-3% as opposed to 10%. This represented a difference of 7-8%.

At the time, the organization was aware that the SMP's cost-effectiveness was hampered not only by the high commissions paid to its salesmen, but also by the high salary levels, and the "bonuses" given to pharmacies (which includes a number of free contraceptives for the sale of a certain number of items). These bonuses are in addition to the 25% the pharmacy makes on the sale of the contraceptive.

SMP Technical Assistance

Cambridge Consulting Corporation hired a consultant (Mr. Milo Schaub) to assess SDA's needs for TA in the area of social marketing. The main purpose of the TA was to find ways to streamline the SMP.

Mr. Schaub visited in 1992, and recommended that the SDA change the SMP practice of using on-staff salesmen to recruiting the services of a co-distributor that would take charge of sales, packaging, storage, invoicing, etc., of the whole SMP. The co-distributor then would assist SDA in expanding the SMP and enhancing SDA's financial viability.

After calculating the potential savings that could be achieved by eliminating the additional 7-8% being paid to its salesmen, SDA decided to further investigate the possibility of engaging the services of a co-distributor. The newly appointed Director of the SMRD Development Division was sent on an observation trip to the Dominican Republic, where the IPPF affiliate, PROFAMILIA-Dominicana, is implementing the same type of SMP distribution system. Upon return from the Dominican Republic, the Director proceeded to develop the "Terms of Reference" for the co-distributors' bid. Several companies responded to this bid.

In the meantime, the sales forces learned about SDA's plan to change its contraceptive sales/distribution scheme. During the months of September through December, sales dropped. The four salesmen dedicated most of their time to collecting receivables from a credit portfolio of approximately C.600,000. By December 31, the credit portfolio was significantly reduced to C.150,00. The salesmen's interest in collecting was due mainly to the fact that SDA pays its commissions based on sales plus collections, not on sales alone.

New SMP Strategy: On-staff Salesmen/Private Distributors

After examining several proposals, SDA concluded that due to the high commissions requested by the co-distributors (the lowest commission was 25%), they would not contract with any co-distributor.

Once this decision was made, SDA; SMP staff developed a new implementation plan and budget which included significant cost savings. This plan reverts to the old scheme of using on-staff salesmen. It is important to note though, that the 1994 action plan was presented to USAID based on the co-distributor scheme.

Staffing Gaps and Other Problems

SDA laid-off its salesmen based on researching commissions paid in El Salvador to salesmen of high volume products. This created another major gap in sales. During the months of January through March, 1994, the Marketing Division had no salesmen. The Marketing Division's Director and his Assistant attempted to fill this gap until SDA decided to request approval from USAID to recruit two salesmen to be paid from locally generated funds (AID-IL). USAID approved hiring two salesmen for two months.

The following table was given to the evaluation team to support the significant savings to be achieved by SDA by eliminating the Sales force commissions and other expenses:

OVERALL PROJECTIONS OF COST AND SAVINGS BY USING SALESMEN SCHEME COMPARISON OF 1993 EXPENDITURES AND PROJECTIONS FOR EXPENDITURES AND 1994 IN US DOLLARS @ 8.70 colones

ITEM	ACTUAL 1993	%	STRATEGY 1994	%	TOTAL REDUCTION	%
Salary/Fringe Benef. to Salesmen	10,805	7%	8,678	10%	2,127	20%
Commissions	45,299	28%	11,325	13%	33,974	75.5 %
Packaging Material	16,092	10%	9,655	11%	6,437	40%
Per Diem	2,299	1%	2,299	3%	0	0%
Gas & Lube	5,747	4%	5,747	7%	0	0%
Bonuses to Pharmacies for "Vinetas"	25,747	16%	25,747	31%	0	0%
Salaries/Packers	11,207	7%	0	0%	11,207	100%
Bonuses to Pharmacies in Products	42,264	27%	21,126	25%	21,138	50%
TOTALS	159,460	100 %	84,577	100 %	74,883	47%

Source: *SDA Social Marketing of Contraceptives and Resource Development Division.*

According to M. Schaub's recommendations the switch from in-house sales force to a co-distributor scheme could be less expensive and more efficient in marketing SDA products.

If the plan of action was only approved by USAID in February 1994, then SDA shouldn't have eliminated the sales force it had in-house until the new scheme, that of the co-distributor, was in place and ready to operate. This was a poor managerial decision.

The salary arrangement with these new salesmen includes fringe benefits at the level mandated by GOES plus a commission of 3%. The salary levels for the salesmen do not differ from those paid to salesmen by other companies. SDA decided to pay its "new" sales force at the levels mandated by GOES because this budget line item alone would represent a savings to SDA of 7% from previous levels.

Expenditures to the cover the costs of selling SDA's products according to the new implementation scheme and the SMRD Division's plan have dropped considerably. Expenditures between March and May totalled C. 60,192.53, or US$ 6,918.68, as opposed to an expenditure in 1993 of $179,282.40, or US$ 20,607.

SDA's comments that the periods 1993 vis-a-vis 1994 cannot be compared because in 1993 there were five (*) sales men as opposed to two in 1994 is very valid. The fact remains

however, that the estimated savings for 1994 is 47%, and that among the major items where savings can be achieved in 1994 are salaries (20%) and commissions, and (75%) respectively of the total projected expenditure for 1994.

Expenditure projections for the June-September period estimate that expenditures for those months will amount to C.167,200 or US$19,218, and an estimated income of C.525,000 per month or US$60,345. This is due to the 47% in savings that would be realized by SDA by implementing the "new 1994 strategy."

These reductions are due mainly to cost savings expected by SDA in the following items:

- Salary/Fringe Benefits 20%
- Commissions 75%
- Packaging Material 40%
- Salaries/Packers 100%
- Bonuses to Pharmacies 50%

Condoms

The condoms donated by USAID to the Association have a high degree of acceptability, and low cost; therefore, SDA has been able to corner a good share of the market. SDA's purchased condoms, on the other hand, have stiff competition in the market, but SDA's prices are competitive despite this. The bonuses given to the pharmacies are definitely a motivating sales factor for the pharmacists.

Please see the following table for a complete proposed adjusted bonuses to pharmacies developed for the purpose of increasing SDA's sales of contraceptives:

Proposed Bonuses to Pharmacies (*)
Revised

	For Credit Sales			For Cash Sales		
CONDOR dispes.	(6+1)	(12+2)	(18+3)	(6+1)	(10+2)	(20+4)
PERLA dispens	(26+5)	(52+10)	(100+20)	(25+5)	(50+10)	
PANTHER dispens	(10+1) (56+6)	(20+2) (100+12)	(30+3) (200+25)	(10+1) (50+6)	(20+2) (100+15)	(28+3)
PRIME dispens	(10+1)	(20+2)	(30+3)	(10+1)	(20+2)	(28+3)
PRIME SPERMI-CIDE dispens	(56+6)	(100+12)	(200+25)	(56+6)	(100+12)	
ROUGH RIDER dispens	(10+1) (58+6)	(20+2) (100+12)	(30+3) (200+25)	(10+1) (56+6)	(20+2) (100+1)	(28+3)
MINIGYON cycles	(100+5) (250+12)	(150+7) (300+15)	(200+10) (300+35)	(100+10)	(150+12)	(200+25)

Source: *SDA Social Marketing of Contraceptives and Resource Development Division, May 30th, 1994.*

(*) Bonuses to pharmacies represent a certain number of items given to the pharmacy for the sale of a box of the same item. For example, Condor condoms in the first line of this table: for the sale of 6 dispensers of Condor, SDA gives the pharmacy a free dispenser.

SDA is proposing a New Scheme

SDA's Marketing Division is proposing a less complex and less costly scheme, although, **this new scheme also uses salesmen on staff**. SDA perceives this scheme as one that could have the same effect in terms of expansion as the co-distributor scheme, and a high degree of desirability in terms of both cost recovery and sustainability.

This scheme utilizes the infrastructure of three or four large pharmacies-distributors in the country to assist SDA in the sales and distribution in the country's interior. In the meantime, SDA with its on-staff salesmen would be able to cover sales in San Salvador/Metropolitan area.

The following table presents the proposed "cost reduction" as calculated for the SMP by the SMRD. The table presents a comparison between expenditures incurred in 1993 vis-a-vis the projected savings for 1994:

Overall Projections of Cost and Savings by Using On-Staff Salesmen: Comparison of 1993 Expenditures and Projections for 1994 Expenditures

	In U.S. Dollars @ 8.70					
	Actual 1993	%	Strategy 1994	%	Total Reduction	%
Salary/Fringe Benefits to Salesmen	10,805	7%	8,678	10%	2,127	20%
Commissions	45,299	28%	11,325	13%	33,974	75.5%
Packaging Material	16,092	10%	9,655	11%	6,437	40%
Per Diem	2,299	1%	2,299	3%	0	0%
Gas and Lube	5,747	4%	5,747	7%	0	0%
Bonuses to Pharmacies for "Vinetas"	25,747	16%	25,747	31%	0	0%
Salaries/Packers	11,207	7%	0	0%	11,207	100%
Bonuses to Pharmacies in Products	42,264	27%	21,126	25%	21,138	50%
Totals	159,460	100%	84,577	100%	74,883	47%

Source: *SDA Social Marketing of Contraceptives and Resource Development Division.*

Conclusions:

Although, SDA staff at the central offices in San Salvador are somewhat aware of the importance of the SMRD Division, the Evaluation Team did not perceive the same awareness at the regional levels. There appears to be some resistance to accepting the need for the creation of this Division, and some misunderstanding regarding the importance of having a separate Division exclusively charged with raising net capital for the achievement of SDA's sustainability goals.

SDA's SMP has been plagued by serious gaps in sales and several other administrative problems as described above. Although TA was forthcoming, the recommendations made were not feasible for SDA to implement mainly due to the high commissions required by co-distributors in El Salvador. Although similar programs are successful in other countries, such as the Dominican Republic, the conditions prevailing in El Salvador are significantly different regarding arrangements, bonuses and commissions with co-distributors.

A year was lost by the Social Marketing and Resource Development Division mainly due to the pending approval from USAID for the commercial use of the IEC Department audio-visual equipment, which had restrictions imposed by the donor for these purposes. This coupled

with the period of time (December 1993 until March 1994) when the Division had no sales force and both the Division's Director and his assistant had to perform the duties of salesmen.

In addition, between September and December 1993 when the on-staff sales force learned of SDA new plans to engage the services of a co-distributor, sales dropped because the sales force dedicated its time to collecting receivables outstanding for approximately C. 600,000. These receivables were reduced to C. 150,000 during that period. The fact that SDA pays its commissions based on monies collected and not on sales played an important role in the sales force's interest in collecting these receivables.

This indicates that the SMP program will accomplish levels of financial sustainability closer to those required by the agreement between the time elapsed and PACD. The optimistic view is due to the implementation of the new SMP plan (on-staff salesmen + significant savings) which has a potential to recover significant costs, as well as assist SDA in its sustainability goals.

RECOMMENDATIONS:

- ***In view of the unsuccessful attempt by SDA to contract with an outside organization for its SMP, and based on analysis of cost-effectiveness made by SDA, it is recommended that a thorough analysis of the two SMP schemes be made by the Consultant with the assistance of the SOMARC Consultant who began begun work in June 1994, and will return in 1-2 months.***

- ***The co-distributor scheme, though it appears to be an expensive proposition, should be thoroughly re-analyzed. A distributor brings in a major marketing force, advanced warehousing techniques, transportation of the product within the capital as well as the interior, and vast experience in management of substantial credit portfolios.***

- ***Judging by the significant cut in costs (47% annually), the on-staff salesmen/pharmacy distributor scheme appears to be the most appealing. There remains however, the nagging question of whether SDA should extend credit to these pharmacy-distributors for large sums of money prior to the sale of contraceptives. SDA first of all would have to ensure payment for all contraceptives sold through the pharmacy-distributors.***

- ***Since the SMP is purely a commercial scheme, the Marketing Plan should include a "Profit and Loss" statement.***

b. Logistics

Selection of contraceptives for this component is the responsibility of the SDA Medical Committee in coordination with Social Marketing Program (SMP) personnel. Three kinds of oral contraceptives (one now procured by USAID), six brands of condoms (three from USAID) and the USAID supplied IUD Copper-T are provided. Personnel at the central warehouse repackage one brand of condoms (Blue Gold) to present a more attractive product at point of sale. Other condoms received (Condor and Panther) are packaged at the central warehouse as well. Designs and artwork for the packaging is provided in-house by the Information, Education and Communications (IE&C) Department; the printing is done by private companies.

Eight varieties of decals advertising different brands of condoms are produced and sold at commercial distribution points for 1.25 colones each.

A Somarc (Social Marketing) representative will arrive from Mexico in June to evaluate planning now underway to diversify the products available to SDA for commercial sale. CCC is working with SDA to develop new ideas and new products for sale in order to help close the sustainability gap.

At the present writing there are two salespersons; one more is expected to be hired shortly. These, along with 28 sales representatives of seven commercial wholesalers (four sales representatives from each of the seven wholesalers), account for the sales efforts. All receive their supplies from SDA salesmen.

According to the CCC Chief of Party, CCC is presently assisting the MIS and SMP Program in the creation of a simple computerized inventory control program for commodities which are stored at the central warehouse. This is to be the beginning of a more complex system to be developed later. According to SDA Social Marketing Program staff, presently data is provided for sales, salespersons' liquidations, late payments and age of balances, but not inventory.

Determination of the quantity of contraceptives is regulated by product inventory in the central warehouse and the volume of sales, or the quantity distributed to points of sale. Procurement of these commodities is performed by the Procurement and Supplies Department in coordination with the Manager of the SMRD Division. USAID procures commodities for this program through the General Services Administration (GSA) or the Veterans Administration.

c. Studies conducted

Socio-Economic Studies to Establish New Prices

SDA conducted socio-economic studies both in Metropolitan San Salvador and the regions. The socio-economic study consisted of a form entitled "Socio-economic Registry" which contained the following questions:

Questions for Service User	Questions on Husband/Companion
Name, address, place of work, telephone number, position, monthly salary, code (for SDA use).	Name, working? Yes/No, telephone number, place of work, position, monthly salary
Name of Interviewer, Post, observations, assigned category, signature	

One hundred socio-economic interviews were conducted at the San Salvador Clinic, and 221 at other SDA Clinics. These interviews resulted in a three tier clinic services user income classification for the San Salvador Clinic as follows:

San Salvador Clinic

Category	%	Socio-Economic Level
A	24%	C. 3,000 and Up
B	47%	C. 1,000 to 3,000
C	29%	C. 0 to 1,000

The same three tier clinic services user income classification was used for the Santa Tecla Clinic, which is located in Metropolitan Clinic San Salvador.

Santa Tecla Clinic

Category	%	Socio-Economic Level
A	13%	C. 3,000 and Up
B	50%	C. 1,000 to 3,000
C	37%	C. 0 to 1,000

The results show that the clientele in Santa Tecla Clinic has more people in the lowest income category, C, and fewer people in the highest income category, A. These interviews were important because they revealed the level of income of SDA services users, particularly those who are employed. The evaluation suggests that in order for SDA to be able to determine its clients' socio-economic level, a more involved and detailed socio-economic study should be done.

The categories determined in the "socio-economic classification" or salary level system conducted by SDA should be re-examined for the following reasons:

To classify literally thousands of people under three categories based on three questions asked the user in a short interview does not serve any purpose to SDA or the user.

Although we all recognize the advances SDA has made in providing family planning services in El Salvador, we must also recognize that there are areas were SDA has no experience and this is one of them. SDA could take advantage of the experience gained by the Ministry of Health in conducting these kind of studies, and request assistance from MOH in the design and implementation of such a study.

- an important factor to be considered in the implementation of the system, is that both the Metropolitan and Western regions have generated in the past higher income through fees-for-services than the Central, Para-central, and Eastern regions. These three regions have been classified by various studies as lower economic output regions.

- the possibility exists that under the new socio-economic classification system, patients that require fewer resources in their treatment end up unfairly financing those whose treatment requires much resource input. This could be attributed to the fee system's structure having been oriented towards the socio-economic profile of the health system's users, as opposed to being hospital/center resource based.

Poverty Distribution by Region

Region	Extreme Poverty %	Relative Poverty %	Total
Whole Country	35.0	32.70	67.70
Metropolitan	15.19	30.93	46.12
Western Region	34.45	32.88	67.33
Eastern Region	40.60	30.13	70.73
Central 2	50.98	26.36	77.34
Central 1	41.51	36.65	78.16

Source: *APSISA Evaluation Report, January 21, 1994*

Other Studies Conducted

Diagnosis Phase: The following studies serve as the basis for developing the tools and instruments necessary to establish a Cost Recovery system for SDA's facilities. The cost studies and research conducted as a basis for the development of a fee-for-service system; the cost of provision of services to SDA conducted by the Association such as the "Analysis of Cost Effectiveness" by Consultancies and Research in Health Services, February 20th, 1992; and the "Market Study to Increase Services in SDA Clinics," by Central American Marketing Consultants, December 15th, 1992.

RECOMMENDATIONS:

In order not to run the risk of either over/under charging service users, and because there might exist differences among various groups in the capacity to defray a portion of their health and family planning bills, it is recommended that SDA conduct a second patient socio-economic study by region.

The forms to be utilized for the socio-economic study should be able to reflect the real socio-economic status of the users of SDA's services, not just their income.

The following are suggestions for questions to be included in the "socio-economic classification forms:"

- basic data: name, address, etc.
- economic dependency: self? others?
- home characteristics: type (one family/multi-family), own, rent.
- basic services, additional information to locate dwelling.
- schooling.
- employment: have you worked during the last 15 days, part-time/full time?
- if not what did you do: study, incapacitated, invalid, etc.

- job title
- how often do you get paid?
- do you have additional income?
- what is your salary? Do you receive cash payments? other?
- other members of the family that contribute to your sustenance

This socio-economic system should be able to classify patients at least in four different categories, assigning a certain percentage charge from the "real" costs of provision of services to the different levels, for example:

Level 1:	Extreme Poverty	-	determine contribution
Level 2:	Relative Poverty		
	Urban	-	45% up to C.....
	Rural	-	35% up to C.....
Level 3:	Median Income	-	75% up to C.....
Level 4:	High Income	-	100% fee

This is the same system developed and used by APSISA.

RECOMMENDATION: Develop a final standardized socio-economic data collection instrument to develop with the assistance of the technical assistance contractor. This instrument could be fine-tuned so that it can be easily and rapidly filled out by the Social Worker. During field tests on a selected month the Social Work Units at SDA' clinics should conduct the pilot tests and collect the necessary data to determine the socio-economic status of the group of clinical patients under study.

d. Social Marketing: IEC

We reviewed the marketing plan for commercializing the services of the audiovisual production center, and think that the plan is very well thought-out. Our one concern is that if the AV Production Center gets popular, it will be hard to resist the temptation to give priority to work that pays well, rather than producing SDA training videos.

RECOMMENDATIONS: It is important to develop a bank of freelance video production personnel to ensure that adequate staffing is maintained to handle both SDA's work and that which comes into the AV Production Center.

Additional ideas for marketing include:

- ***Create a library of videotapes on FP and MCH topics that can be rented or sold to schools and universities. Do research to see what the needs are, and fill them with videos that the SDA has already produced, to begin with. The income generated from sales can be used to produce videos on other topics that are in demand.***

- ***Package and sell the drawings that have been prepared to teach about contraindications of hormonal methods. IPPF affiliates, medical and nursing schools, nursing and midwives' associations might be clients.***

e. Training

The IEC Department hasn't designed attractive labels, or boxes, for its video materials. They don't have brochures or price lists to mail out to advertise their products, nor are they set up with computer software to track the sale of IEC materials and videos.

RECOMMENDATION: Train IEC or Social Marketing Department staff to package, advertise, and distribute materials, learning computer programs to track inventory, purchase orders, etc.

f. Additional Recommendation

The SMP director should meet monthly with the CCC COP, and USAID project officer.

2. Establishment of a Central Referral Clinic (CRC)

The CRC was never established. It was not implemented because ADS decided to purchase a hospital which could provide the services (which had been planned to occur at the CRC) as well as increase revenues through diversification and broadening of services. SDA requested permission from USAID not to establish a CRC and USAID approved their request.

3. Marketing and Feasibility Studies

Family Health Services Project, SDA
Summary of Actions Taken to Improve Social Marketing/Sustainability*

Action	Recommendations/Status to Date	Recommended by This Evaluation	Comments
TA/FEBB. 1992	"Analysis of cost Effectiveness" by Consultancies and Research in Health Services.	No further recommendation.	Study appears to be complete and useful. SDA used data in its plans for subsequent years.
TA/DEC. 1992	"Market Study to Increase Services in SDA Clinics," by Central American Marketing Consultants.	No further recommendation.	Same as above.
Study 1992	"Feasibility Study for the Opening of New Satellite Clinics"		
Study 1992	"Retrospective Study of the Feasibility of Establishing Satellite Clinic #1"		
TA MILO SCHAUB 1992	Recommendations made; further explored by SDA in 1993. **STATUS:** SDA determined that commission to co-distrib. too high.	SOMARC: assist SDA to further analyze: co-distributor versus on-staff salesmen in Metro area versus distributor - pharmacies outside Metro San Salvador	SDA recommends on-staff salesmen for Metro San Salvador and Distributor-pharmacies for outside San Salvador Metro area.
TA TONIA PAPKE FEB. 1993	A) Two complimentary policy areas identified: 1) Cost Recovery; 2) Income Generation B) Evaluation & Analysis of income generated; Identif/ Eval. of non-FP services; Study & Eval. of Public Relations Dept. activities; Plan & Supervision of market research strategy. **STATUS:** Marketing plan developed & presently in process being of implemented.	**Additional Recommendation:** Further explore establishment of an Endowment Fund as recommended by TA.	1) Agreement with TA recommendations. Continue implementation of Marketing Plan as developed by SDA's SMRD Division.

Action	Recommendations/Status to Date	Recommended by This Evaluation	Comments
MAY 1993	Social Marketing & Resource Development Division develops "Marketing Plan," presents to SDA's Board of Directors. **STATUS:** Plan approved and in process of implementation.	Socio-economic study determined three socio-economic levels including urban, rural, and geographic location. SDA should look into socio-economic conditions of population at the regional level. **STATUS:** implemented.	Socio-economic conditions vary between urban-rural and between regions.
TA/1993	"Study of Cost-effectiveness of Satellite and Market Clinics"		
TA/1993	"Market Study to Increase Services in SDA Clinics, by SDA in San Miguel, Sta. Tecla y Sta. Ana"		
TA/1993	"Cost Effectiveness Study for SDA Clinics"		
SDA' SMRP Divi. May 1993	"Marketing Plan" short, medium, long term.	(1) Incorporate establishment of "Endowment Fund" into Resource Development Plan. (2) Incorporate "Profit & Loss" statement into Marketing Plan.	Plan has been well thought-out. All aspects of TA recommendations were considered & incorporated.

4. Institutional Development - MIS

The Project has allowed MIS to contribute to the development of SDA by providing computer technology and equipment. According to the Manager of the MIS Department, the Project has allowed SDA/MIS to provide more applied systems and has trained more personnel in computers than any other Salvadoran NGO. A brief history of Project accomplishments follows:

In 1991, the Project's first full year, SDA was able to bring up to date and improve its existing computer equipment capacity by extending capacities of memory and hard disks to prepare for new contemplated programs. Computer software was standardized as well. Word Perfect and Lotus were adopted as standard packages as were MS-Dos and Netware as operative systems.

In 1992 a local area network (LAN system) for microcomputers was installed and 17 computers were acquired. This network was initiated to satisfy the needs of word processing and other administrative tasks in the majority of SDA headquarter's Divisions and Departments.

In 1992 and 1993 computer use training was provided to secretarial and operational personnel and in 1993. Specialized computer programs were acquired, such as a statistical program and a specialized program for the processing of data for FESAL 1993. Thirteen new computers were installed and other programs such as Page Maker and Harvard Graphics, were obtained for various SDA Divisions and Departments.

5. Sustainability

Annex 37 demonstrates the network necessary for institutional sustainability.

If we take the definition of sustainability as the ability of an organization to: (1) expand the delivery of uninterrupted and high quality service; (2) adapt to the environment; and (3) increase its control over resources, we can say that SDA's Family Health Service project at this point does not meet the sustainability criteria.

SDA continues to be beset by problems arising in part at least from centralization of operations. If we take the first condition from the sustainability definition: expand the delivery of uninterrupted and high quality service: SDA's service delivered through the rural program was interrupted for over a month because SDA rural program had run out of the contraceptive Noristerat. If SDA has to provide another type of contraceptive to a user or convince the user to use another method, then SDA is not providing high quality service (This was the major complaint from the users interviewed during the field interviews). If the evaluation team concluded that SDA should not expand its services but instead re-train the field personnel (PHPs), then SDA is not ready to expand the delivery of uninterrupted and high quality services.

Adapt to the environment. There are two area where the organization does not seem to have the capability for strategic adjustment due to changing internal and external conditions.

Internal conditions, caused by the rapid growth of the organization, such as an accounting system capable of responding to SDA growth needs, and needs for cost information and accurately forecasting contraceptive needs. SDA seemed to have underestimated the demand for NORISTERAT; when demand surpassed supply, SDA was unable to respond rapidly to solve this problem.

Instead, SDA is dependent upon its IPPF to re-supply of this contraceptive, putting the user in the difficult task of deciding to choose another method until NORISTERAT is available. These are two examples of not being able to adapt to the environment. Systems do not match needs.

External conditions, such as lack of coordination with the public sector. There are also tremendous needs for information and education of the Salvadorean population in family planning methods and the clarification and elimination of myths about family planning, particularly about sterilization and the IUD. SDA at this stage has not implemented an adequate educational campaign, which would include the use of mass media as well as interpersonal communication techniques to meet this need.

The improved quality of the services which managerial improvements will lead to, will result in more people continuing to use contraceptives rather than dropping out of contraceptive practice because they feel dissatisfied with the available family planning services.

Expand the Delivery of Uninterrupted and High Quality Service and Adapt to the Environment

The RHP project as it is structured at present, generates considerable recurrent costs for manpower, facilities and vehicle maintenance, supplies, logistics, and transportation which cannot be met by SDA if USAID decides to reduce or withdraw funding. The Project has an expensive infrastructure which is consuming most of the Project financial resources, while areas like Training and Information, Education and Communication are being allocated meager budgets when one tries to match need vis-a-vis financial resource allocation.

The Project structure hampers the ability to sustain project activities. The Project is suffering from the typical disadvantages of a centralized structure and from serious recurrent costs problems. During field visits, for example, it was observed that vehicles have to be brought to San Salvador for repairs. Regional clinics cannot have their own vehicles repaired even if the repair required is just a "tire change." There was a consensus among the Regional staff that SDA's regional facilities are not a priority for the central office in San Salvador. The following table presents the percent allocated by major SDA budget line item category:

Budget Line Item	1993	Projected for 1994
Adm./Coordination	35%	52.5%
Logistics and Supplies	39%	34%
Adm./Coordination Logistics and Supplies Combined	74%	86%
Training	1.2%	.6%
IEC	15.8%	12.0%

The detailed budget for 1993 and 1994 as presented in the plan of action for both years were reviewed in detail. Training as a major line item within the budget is still very low at 0.6%. Even if the budget for training of field staff is included within the IEC budget line item, this only represents 12% of the total budget, when compared with 85% projected for 1994 for Administration/Coordination, Logistics and Supplies.

DECENTRALIZATION has not taken place at SDA. The regional staff is still quite dependent on the center for most decisions. Another second example is the low level of funds in the region's petty cash fund which are not even sufficient to cover a tire purchase, change and/or repair in a vehicle. Problems like this could easily and quickly be solved at the regional level.

The following comments were also made by the regional staff to the evaluation team:

Lack of computerized equipment in good working condition at the regional level. (This is another example of the criticism expressed by the regional staff about the Central Office in San Salvador). Over and over we were told that all good equipment is in San Salvador. Old equipment was transferred to the regions.

Regarding programmatic decentralization, the regional staff feels that every aspect of the program at SDA is conceived, managed and controlled by the Medical Department in San Salvador.

In the Financial Management area there is no decentralization at SDA. All accounts are managed and controlled at the headquarters. There are no accounting systems in operation at the regions. The regions simply send their vouchers and summary reports to SDA

headquarters in San Salvador and the headquarters staff inputs the information into the system, generate monthly status reports and sends these back to the regions. Budgetary control is not in the hands of the regional staff per se.

The regions do not have decision-making authority for purchasing. Every item is purchased in San Salvador. Even if the budgets are prepared at the regional level, those are in most instances significantly cut when they arrive at the center.

One of the goals of this project is for SDA to decentralize its administrative systems to entrust both the supervision and decision-making to the operational levels (the regions). Another goal is for SDA to receive technical assistance and implement a Management by Objectives (MBO) system. All of the above indicates that SDA is far from implementing these requirements which are clearly stipulated in the project agreement.

RECOMMENDATION:

- ***SDA should continue to decentralize its administrative systems so that supervision and decision-making occur at the regional level. A decentralized model of administration has the potential for improving efficiency. Each clinic must have a certain degree of independence or autonomy so that its management is able to solve problems as they arise without having to go through the central level. The example of the vehicles having to go to the Central Garage for repairs is an excellent one.***

- ***The clinics would determine the level of supervision needed and would work more efficiently by having the independence to carry put their own objectives. It is understood that regional objectives should be in line with those of the Project and of the organization as a whole.***

- ***SDA should consider decentralizing the accounting function completely. This could be accomplished on a gradual basis starting with the Oriental Region which seems to be prepared to take on this responsibility. Once this pilot project is completed, ADs should continue with another region until the four regions have completely taken on this responsibility.***

Additional Sources of Funding

SDA's funding through sources other than USAID has been significantly reduced. SDA' is not receiving any funding from FHI and the Hewlett Foundation in 1994. IPPF, the Federation to which SDA is affiliated, has significantly reduced its funding. If USAID were to pull out of this project at this particular time, the Project would suffer.

The following table presents an example of the significant way in which IPPF, have been reducing funding as USAID's increases.

	1991	1992	1993
IPPF	3.324.6 16%	2,220.1 9%	2,572.9 7%
USAID	11,866.4 56%	19,346.6 64%	24,420.7 63%

SDA' contribution to defray budgetary costs is being absorbed by the hospital, and SDA has no working capital because it was used to purchase the hospital.

According to SDA, ..."we consider that in the event of AID's withdrawal of funding, our activities would be reduced .....". But the aim of the project is for it to be sustainable upon withdrawal of funding by the donor. The conclusion here is that the project is not sustainable by SDA's own acknowledgment.

Increase its control over resources. SDA is highly dependent on USAID for financial support. USAID is financing the majority of an organization's expenditures, while other donor's funding consistently reduce. SDA is now implementing an "austerity program" to liberate its own funds (e.g. non-AID funds raised locally by the Association) plus good portion of IPPF's funding, to cover other expenditures, e.g., the newly acquired Hospital Profamilia.

There is no particular problem with this system, except that the austerity program in the long run will affect the operation of both the clinical and rural health programs which are AID financed. According to Regional staff, and some members of SDA's Central Office staff, important areas like Training and IEC as well as the **Regional Clinics are feeling the pinch of the severe "austerity plan"** in the reduction of their budgets."

SDA could cover the salaries of additional staff e.g. an accountant and an auxiliary, from the IPPF's grant. IPPF has traditionally provided funding to their affiliates to cover operational costs under the line item entitled "Project Support" (Apoyo a Proyectos).

However, the major financial problem SDA has at present is the problem of lack of liquidity. IPPF's grant to cover operational expenses other than contraceptives has diminished substantially.

RECOMMENDATIONS: The RHP is approaching its third year. Significant funding has been already allocated to building infrastructure. Any forthcoming funding from USAID should be re-allocated to areas were funding and support is most needed, e.g., Training, Quality Assurance and Mass Media campaigns.

- ***To offer a quality service, additional space, re-modeling, and hiring new staff is not necessary. Perhaps the improvement of services through re-training or additional training of field staff might be sufficient to be able to offer a quality service.***

- ***SDA should be concentrating its future efforts on continuing to improve the quality of its services; empowering its staff to work together to prevent or solve problems. Staff who carry the day-to-day activities of a clinic, for instance, know which aspects of their work function well and which don't.***

  They are in an excellent position to use this knowledge to propose practical changes that they themselves ultimately carry out: They should concentrate on looking for sustainability initiatives that will continue after donor support has ended. Building additional infra-structure should be considered when SDA' liquidity issue, and the issues described above are resolved. If the RHP is to become a self-sustaining project in the future it will not be by building additional infrastructure.

- ***An organization-wide management review should be conducted by a local auditing firm of international standing, e.g., Price Waterhouse, KPMG, Peat, Marwick and Mitchel or any other auditing firm in this category, to determine the cost-effectiveness of the Family Health Services Project as it has been implemented by SDA.***

- ***USAID should hire a local consultant to develop the "Terms of Reference" (Guidelines) for this management review. The management review should include, but should not be limited to, determining the cost-effectiveness of the RHP; availability of funding from SDA-locally raised funds to carry the RHP in case of a significant withdrawal of funding by USAID; examine salary scales and actual salary levels at SDA; and sources of funding for SDA' activities other than the RHP. The Terms of Reference should be reviewed and approved by USAID/ES.***

Sustainability in the Rural Program

The Rural Health Program is a large program with a large infrastructure that consumes a significant amount of financial resources. This is justified because of the population the program serves. However, it is the infrastructure (Administration and Coordination of the Project and Logistics and Supplies) that makes the program extremely expensive. In projecting, determining and/or calculating financial sustainability in the rural program, one has to be aware that this is a program with a cost of C.10.3 Million of which approximately C.7.3 Million or 71% go into salaries; C.1.1 Million in Supplies (includes gas, vehicle parts, and other supplies); C.1.4 Million or 14% in Maintenance of vehicles, office equipment and others. The recovery rate of C/392.7 thousand in 1993 represents 4% of the costs.

RECOMMENDATION: The Rural Health Program should be re-structured so that more financing is allocated for those activities that enhance the quality of the program, such as training and IEC, as well as into ensuring that the program has the necessary supplies to serve the rural population.

It was observed that in some rural clinics there were contraceptives and vitamins available, while the rural program, which has its administrative office within the clinics, did not. It is recommended that during the SOMARC consultant's visit to the SMP a detailed analysis be done to determine exactly why there is a NORISTERAT stock-out in the RHP while the rural clinics did not suffer this problem. During this analysis, the fact that the product enjoys a higher price in the clinics than in the RHP must be taken into consideration.

"Note that table #37 indicates a significant increase in the medical division's expenditure in 1992 surpassing income by a 181%. In 1993, expenses for this division again surpassed income by 125%. This is due to the clinic expansion program (see recommendation to USAID to consider a reimbursement payment plan with SDA as opposed to the present support of clinic-based service delivery).

Comparison Expenditure As Per Cent of USAID Income Raised by Programs 1991-1993

Department	1991	%	1992	%	1993	%
Social Marketing						
- Income	1,020,722		1,337,968		1,266,743	
- Expenses	N/A		100,520	7.5	179,282	14
Medical Division						
- Income	324,350		534,958		768,784	
- Expenses	N/A		970,140	+181	965,232	+125
Other						
- Income	0		0		0	
- Expenses	0		669,103	100	821,686	100

Table #38 indicates that expenditures for administration were 714% in 1991: 2711% in 1992 and a sudden drop to 55% in 1993 due to a significant increase in income that year. Unfortunately, this information is not included in the Family Health Services project's audit. This information would be in the IPPF audit which SDA did not make available to us.

Comparison Expenditure As Per Cent of SDA Income Raised by Programs 1991-1993

Department	1991	%	1992	%	1993	%
Marketing						
- Income	1,160,482		1,612,236		2,004,869	
- Expenses	88,718	7.6	6,939	.4	1,724	.08
Medical						
- Income	1,025,481		1,407,519		2,058,898	
- Expenses	748,739	73	707,295	50	1,003,861	49
Administration						
- Income	368,736		77,880		4,702,221	
- Expenses	2,632,093	714	2,111,938	2,711	2,587,995	55
IEC						
- Income	273,265		412,658		319,092	
- Expenses	0	N/A	135,801	33	269,825	85
PED Division						
- Income	0		0		0	
- Expenses	0		0		361	

105

Sustainability of the Medical Expansion Program

In the RHP, the highest budget line item is the salaries. The approximate total cost of this activity is C.13 Million. In 1993 these represented C.6.6 Million or 51%, followed by materials and supplies C.3.0 Million or 23%, and maintenance C.2.7 Million or 21%. The recovery level in this program is 18% or C.2.3 Million.

RECOMMENDATION: The maintenance of the clinics that compose the expansion of services is a costly proposition for USAID. One way for USAID to make the best use of its funding is by establishing an arrangement with SDA to pay for SDA's delivery of clinic-based services on a reimbursement basis.

Financial Sustainability as an Organization Wide-Responsibility

Both recovering the highest per cent possible of costs and increasing the self-sustaining level of the program is the responsibility of all staff at SDA. This means that all persons employed or somewhat connected to SDA e.g., PHPs, should be trained and made aware of how they all can contribute to achieving the institutional goal of sustainability.

PHPs or Auxiliary Nurses, for instance, should not suggest to the client that a specific low fee can be paid for the Association's services. Instead, when concluding an interview or counseling session with a client, the person responsible should inform them of the cost of the service and suggest that s/he get as close as possible to this amount when paying the fee for the service.

Counterpart Funding

While this evaluation exercise was taking place, an analysis of counterpart funding was performed by the USAID's RHP Financial Analyst in which the Analyst concludes that the counterpart contribution is not likely be met by SDA due to the proximity of PACD which is July 30th, 1995. Please find annexed both the Financial Analyst Memorandum to Mr. Michael Deal, PRJ and the analysis of "Counterpart Contribution" (Annex 40).

Macro-Economic Indicators

During the war years private investment, economic growth, and all government sectors suffered severe funding reductions with the exception of the Ministry of Defense. Between the 1950's and 1970's, the annual GNP oscillated between 4.8% and 4.7%, it suffered a sharp decline in the 1980's to -1.2%.

The economy in El Salvador should be watched carefully, and projections should be made conservatively and conscientiously. Inflation declined from 23% in 1989, to 19.3% in 1990, and to 9.8% in 1991, but increased to 20% in 1992. The Consumer Price Index grew at an annual rate of 11%, substantially below the 17% rate registered during the same period in 1991. In the world market prices suffered a sharp fall.

Devaluation of the Colon has not kept pace with the inflationary spiral, therefore purchasing power has been significantly corroded by this factor. A case in point is the MOH's physicians' salaries which have declined due to a sharp decline in purchasing power.

Projections for economic growth for the years 1993-1995 are estimated to be between 5-7% by the more conservative, and 10% by the more optimistic. There appears to be significant interest in the part of some business people to invest in El Salvador. Much emphasis has been given to the remittances sent by Salvadorans living abroad, which have been estimated to be US$850M. However, the employment crisis in the US (where most Salvadorans live) has to be considered, as well as the fact that the Salvadoran society is a consumer society. Market exchange, which used to be fixed, has been freed to be driven by demand.

It is expected that GOES expenditures in the health sector will continue to increase — these increased by 21% for fiscal year 1993, because of the decline in the defense budget. Foreign debt decreased because some debts were forgiven. However, total outstanding public sector debt increased by $267M or 13%. The State has taken strict measures to modernize itself, reduce spending, and revitalize the economy.

The economic capacity of the health system's users has been severely limited by the impoverishment of the MOH's service users mainly caused by the war. At present it is estimated that at least 60% of the population can be classified as living in extreme poverty. Those living in absolute poverty represent 23.5% of all urban households.

6. Women in Development (WID) Issues

Women represent 51% or one hundred and twenty six (126) women-staff out of two hundred and forty eight (248) total project staff. When these figures are analyzed further, they revealed that only 20% or a total of seven (7) women are employed by the RHP in supervisory/managerial positions as opposed to twenty eight (28) men or 80% of the total number of persons in supervisory/managerial positions. All four (4) medical supervisors in the Project are male. Registered and Auxiliary Nurse posts always filled by females in the RHP. The rest of the female staff are in secretarial posts.

Following is a table exhibiting the different posts in the Project and its women-men ratio:

Staffing Ratio/Professional Posts
Family Health Services Project
Asociacion Demografica Salvadorena

Staff Post/Title	No. Women	%	No. Men	%	Total
Total No. Staff	126	51%	122	49%	278
In Management/Supervisory Posts (Supervisor, Jefe, Director, Gerente)	7	20%	28	80%	35
Physicians	16	37%	27	63%	43
Medical Supervisors	0	0%	4	100%	4
Registered Nurses	2	100%	0	0%	2
Auxiliary Nurses	50	100%	0	0%	50
Social Workers	5	84%	1	16%	6
Promoters of All Types	1,392	87%	208	13%	1,500
Regional Supervisors (Rural)	3	75%	1	25%	4
Promoter Supervisors (Rural)	1	6%	15	94%	16
Auxiliary Nurses	16	100%	0	0%	16

Source: *SDA' Finance Department.*

The SDA did not provide a list of salaries after several requests. We therefore could not assess the salary equity by gender.

Although the major recipients of care by SDA are women, the organization remains administratively male-dominated. This is particularly true in the medical division.

RECOMMENDATIONS:

- ***SDA should provide the salary list to USAID for evaluation.***
- ***If women are paid unfairly, this should be corrected.***

II-COMPB.R24

C. Component III: Policy Development and Research

Summary of Specific Goals and Accomplishments

OBJECTIVE	PROGRESS TO DATE	% REACHED	COMMENT
Conduct FESAL	done	100%	
MCH Morbidity and Mortality Study	proposal written	--	USAID did not approve this study because its estimated cost exceeded one million dollars. Instead, pertinent questions were added to FESAL-93.
Norplant Study	in process	--	FHI is monitoring this study.
IUD post-partum study	done	100%	
1991 effectiveness of service	done	100%	
1993 effectiveness of service	in process	--	Repeated biannually
1995 effectiveness of service	not done	0%	Repeated biannually
Personnel study and enrichment	done	100%	Short term TA in 1993 analyzed personnel structure

1. External Policy

SDA has been involved in policy development by attending two committees, neither of which has ultimate policy control in El Salvador. The COTEPO (Committee on Population) has met many times over the past 2 years.* Its members include SDA, MSPAS, MIPLAN, and many other GOES institutions. Dra. Veronica Siman Betancourt and Lic. Roberto Aguilar are the co-coordinators from the Ministry of Planning. Sr. Juan Carlos Salguero has been representing SDA. COTEPO met weekly through April, 1994, to develop a regional presentation about population policy for the International Conference on Population and Development which will occured in Egypt in September, 1994. However, COTEPO has not met since then.

RECOMMENDATION: This committee would benefit from increased support from both USAID and SDA.

*COTEPO's Mission is extensive; the committee is responsible for coordinating the implementation of the GOES Population Policy.

The "Reproductive Health Committee" includes representatives from MSPAS, ISSS, SDA, MIPLAN, ANTEL, and the OB-GYN Society. The committee was formed following a conference in Ecuador sponsored by the Pan-American Health Organization in October, 1993; which focused on post-partum health and family planning. The committee has met five times and has determined its objectives to be: national standards, the structure of inter-institutional collaboration, the coordination of publicity, and unified reporting systems.

RECOMMENDATION: The International Reproductive Health Committee must be supported by both USAID and SDA.

The MSPAS supports family planning services, and houses the large APSISA project, also funded by USAID. Unfortunately, the number of women being seen by the MSPAS for family planning has decreased from 1991 to 1993 (see Annex 15).

SDA worked with the Ministry of Education to produce teaching guidelines for population education and train teachers nationwide in their use. Activities with the Ministry of-Education should be reactivated and expanded because education through the public schools would increase awareness among youth throughout El Salvador. For example, FESAL-93 reported that 12% of women 15-49 years of age correctly identified the time of the month when pregnancy is most likely to occur (only 8% of rural women correctly identified this) (Annex 38). The need for increased education is paramount.

RECOMMENDATION: SDA should work with the MSPAS to stimulate and coordinate their efforts in FP. SDA must work with the Ministry of Education to make family planning a part of public school curricula.

SDA views IPPF as its most important affiliate, although USAID provides the majority of its funding.

RECOMMENDATION: IPPF regulations and involvement must be coordinated with USAID's involvement.

2. Internal Policy

a. Organizational Structure

Internally, the executive director meets with the "Executive Committee" every Friday for two hours to discuss norms, policies, procedures and plans. He maintains a standard that if three members of the committee share a problem, they must bring it to the entire group. The management style of the executive director is vertical: he communicates through explicit lines of authority to frontline workers. Of the five division directors (Planning, Finances, SMP, IEC/Training, Medical) only one is a woman. (see Annex 35 for the organizational structure)

The Board of Directors is extremely involved in day-to-day decisions at SDA. However, representatives from AID and CCC do not regularly meet with the Board.

The medical division is directed by Dr. Castro who has two assistants (Drs. Sandoval y Lara), and four regional directors (Drs. Duenas (S.A.), Barillas (S.T.), Enriquez (S.S.), and Molina (S.M.). The assistants supervise the regional directors, and serve as the physicians in the marketplace clinics.

b. Strategies

The 1993 annual report includes the following areas among others:

- reproductive heath services;
- family planning among adolescents;
- studies; and
- public relations.

The first area has six specific objectives, and only one of these relates to family planning. The other five are: 1) increase the number of PHP's; 2) increase ORS usage; 3) increase pre-natal care; 4) increase pediatric care; and 5) increase vitamin A.

The second area has four components, three of which refer to increasing volunteers' involvement and the fourth to educate.

The area of studies refers to the Norplant study, FESAL, and the "integration of FP" with clinical services.

The fourth area refers to the increase of donations; increase in personnel; and program evaluation including: a) the study of 3 satellite and 2 marketplace clinics; b) the increase of clinics mentioned in the third area above; and c) client satisfaction.

c. Program Planning and Management

The percent success of income generated in each of the three major types of clinics (regional, satellite, and marketplace) based on annual projections decreased from 1993 to 1994. This could mean that the goals were too high, or that expected changes did not occur. This is significant in that sustainability appears to be decreasing rather than increasing (Annex 27).

Of six goals for 1994 for the adolescent clinic, only one (number of psychologic consultations) was met by May 1. Consultations in family planning, gynecology, psychiatry, medicine, and cytology were not met. This indicates either poor planning, that is, an exaggeration of successful activities; or poor management, that is, not realizing attainable objectives (Annex 28).

Technical assistance has not occurred in the area of management.

Several incidents indicate sub-optimal management of the project:

- No formal feasibility study was conducted prior to the purchase of the hospital.
- Senior staff was not consulted regarding the purchase of the hospital.
- The availability of supplies, including an essential contraceptive (Noristerat) has not warranted adequate resources to ensure success.
- The clinic managers expressed concerns about the central administration focusing too much on central (San Salvador) issues and not enough on service delivery and the regional programs.
- The technical assistance that has been agreed upon is not optimally used.

- The conflict of interest in accepting bids for a publicity campaign seems naive. Subsequent handling of the problem seems guarded. For example, in the 1993 annual report (p. 60), SDA describes the cause of the delay as "the complexity of the donor's (USAID's) regulations."

- The feasibility study of placement of the first satellite clinic occurred after it was in existence, near a brothel, drunks, and needed to be moved to Soyapango. Perhaps it could have been located more appropriately had the feasibility study preceded its structure.

- Procurement: Vans were bought without air conditioning, ventilation, mirrors all of which had to be retro-fitted.

- Judgment: Administrators, including the medical director, consider logistics to be good, despite the unavailability of Noristerat for several months.

- Clinic and central administrators stress physical space and materials as priorities rather than services and productivity.

- The proportion of spending which goes for administration is much too high.

It is understood that within the administrative expenses incurred by ADS there are several budget lines items necessary for the operation of the program such as salaries, fringe benefits, over-time, travel and per diem, transport and meals, bonuses to PHPs. However, because these are all recurrent costs SDA should make an effort to contain them and reduce its administrative expenditures particularly in the areas of transport and maintenance of vehicles.

- Some SDA administrators were sent to Guatemala City to study "How to Run Clinics" but no clinic managers were included.

RECOMMENDATION: An entire management review should be performed. Although management was included in the contractors scope of work but it was not provided. The management requires fortification.

d. Financial Management

SDA has established a sound system of accounting which is computerized. The system is a Fund Accounting system which discriminates between income and expenditure by "funding source." That is, that the accounting system is able to maintain separate accounts for each one of the donors that provide funding to SDA.

The computer program used with the manual version of the Fund Accounting System was developed for SDA by Price Waterhouse. The computerized version was developed by Tecnologia Apropiada (TECAPRO), a Costa Rican computer programming company which has assisted the IPPF New York Regional Office in computerizing all of the family planning affiliates in the Western Hemisphere Region. IPPF's idea in terms of computerization has been to standardize all systems throughout the region.

Health Care Cost Accounting

Although SDA has an excellent Fund Accounting system, the system lacks a cost component, which is required for SDA's family planning facilities to keep track of their costs by

procedure. The Cost component would also provide SDA with cost information required for SDA to be able to update prices by both Cost of Living (COL) and inflation.

Following are a series of recommendations about a Cost Accounting system appropriate for Cost Recovery facilities:

Cost Accounting

Explanation: Cost Accounting is a sub-field of accounting that records, measures, and reports information about costs. A cost is a sacrifice of resources. Cost Accounting is Management Accounting (Internal Accounting) plus some external reporting. Many disciplines and processes can benefit from a quality cost accounting data base, and cost accounting is the ideal system for those organizations that provide clinic and hospital based services. These include:

- budgeting;
- new program and capital project evaluation;
- inventory management;
- pricing and price adjustment;
- addition or divestiture of a service;
- profitability determination by group of purchasers (payers);
- cost control; and
- overhead and corporate expense allocation.

Costing Methodologies: Job Costing vis-a-vis Process Costing vis-a-vis Relative Value Units (RVUs)

The process of costing can be described as either job costing, process costing, or a combination of the two. On job costing each job is the unit of activity to be costed. The activity is easily identified and costs are easily traceable. Examples of industries using job costing are ship builders, aircraft firms, and printing plants. In each of these fields, a job card or equivalent computer record can be used to document materials consumed and labor applied. In contrast to job costing, process costing divides the costs for a stream of like products by the total units to determine, essentially, an average component cost per unit. Process costing is commonly used in the chemical, food processing, paper, and textile industries.

In the health care industry, time and materials are not tracked by the job. However, repetitive services such as sterilizations, and insertions of IUDs are performed. The amount of resources consumed for each similar service can vary dramatically, depending upon a variety of clinical considerations.

A third costing tool methodology, known as Relative Value Units (RVUs) is commonly used in the health care industry. RVUs are units of measure, an indexing technique for relating work effort to output. RVUs recognize the relative differences in the consumption of resources between various procedures or services. As a measure of output, relative value units are particularly helpful in determining work load, measuring productivity, or calculating procedure costs in service areas such as the laboratory or radiology departments.

Indirect or Overhead Expenses

These include support services, such as administration, the medical staff office and public relations, which are not directly traceable to a particular service or procedure. The expenses apply to more than one direct service.

The Matrix for collection of basic data at clinics and/or hospitals, for the development of the service pricing structure, as well as the cost studies conducted, indicate that a "process costing" methodology was utilized, as opposed to Relative Value Units (RVUs) which is the methodology commonly used in the health care industry. The studies did consider the Indirect (overhead) expenses on a more global basis.

Nevertheless, because the cost studies were performed to determine the cost of providing services by SDA, on a global basis, as opposed to the cost for a single unit of service which would be required at a health facility, the methodology used is acceptable, as long as it is kept in mind that the same methodology should not be used when training staff at the regional level. In this case RVU calculations should be performed, as well as the step down method of allocation utilized in calculating Indirect (overhead) expenses.

Allocation of Overhead

In the case of overhead (indirect costs), the Step Down Method of allocation of overhead to direct patient care departments is recommended for both clinics and the hospital, in order to be able to determine the full cost of providing services. The allocation process requires two inputs: the set of costs to be allocated; and the selection of a statistical base on which to allocate those costs.

For example: A Clinic/hospital has five departments. Three of the departments are revenue-producing (Clinic, Routine Care, and ICU) and two are overhead (Medical Records and Housekeeping). To allocate costs to Medical Records and Housekeeping, its necessary to use a reasonable measure of each department's utilization of the overhead services. This measure is provided by the Step Down Method of allocation.

Cost Behavior Characteristics

Although the concepts of costs may appear trivial, they are fundamental to cost accounting and are often misunderstood in practice. Cost behavior is a function of time, resource management style, corporate goals and objectives as well as the organization's cost accounting objectives.

Explanation: To determine standard and expected actual costs, we must know how costs react under various circumstances. There are two basic cost behavior patterns, fixed and variable. Fixed costs do not change as the level of measured activity or workload fluctuates. Variable costs will change in more or less direct proportion to the volume of activity.

Recommendation on Training Regional Staff

Both the Finance Department, and the SDA Regional Facility Staff should be fully trained in the above processes, and once trained, these staff should be able to update the cost accounting system's (or module) information on an ongoing basis.

Factors and Conditions Necessary to Sustain the Cost Recovery System

In light of the urgent need SDA has to establish management systems appropriate for the identification of costs by procedure, the following factors and conditions have been identified as necessary to sustain the (CR) system SDA has planned for:

- Improving staff efficiency, service delivery, eliminating over/under-utilization of resources, and creating a formal Quality Assurance program are part of what is required to sustain the CR system.

- A very important part of clinic resource management that contributes significantly to the control of health facilities resources is the development of **clinical practice profiles.** A clinical practice profile is a model of patient care that delineates the appropriate range in number and mix of services necessary for providing high-quality care to a very specifically defined (homogeneous) type of patient. Clinicians, for instance, do not control the cost of a laboratory procedure, but they do control how often and on which occasions that procedure is ordered for all patients or any one patient.

Because costs can be associated with each service, a clinical practice profile can be used to determine the expected costs of implementing the prescribed plan and the cost impact of under-utilization or over-utilization of services. Clinical practice profile variance reports (by department, physician, or patient) can document service cost variances from the expected treatment. Linking clinical profiles with cost data is a critical step in developing budgets and new program requests.

Explanation: Clinical profiles provide mechanisms to determine the department's needs on the basis of the projected number of cases, the number of procedures or tests per case, and the cost per procedure or test. Improving the quality of clinical services through the use of clinical practice profiles will establish the SDA as a leader in quality management, and will assist the institution in a more efficient use of its resources.

- Cost Recovery systems must also be accompanied by a Quality Assurance program. The resource management data can also be incorporated into the hospital or Center's existing quality assurance programs. To enhance use of clinical profiles for quality management, each clinical practice profile could be expanded to include expected clinical outcomes. The critical indication of quality would be collected during the patient-tracking process and used for evaluating the actual outcome as compared to the expected outcome. The patient level resource management tool, including expected outcomes, can be used to address a variety of quality-of-care activities.

Monitoring the progress of the CR System:

SDA should be vigilant to shifts in the economy and needs for price increases. These should be done on an incremental basis. Exercises to "measure the elasticity of the market" either through focus groups or through clinic surveys, should also be considered by the SDA.

This exercise will not only yield valuable information relating to the price structure, but will provide SDA with the opportunity to be in direct contact with representative groups of the communities where SDA operates, to hear first hand: the community's perception of the SDA services and to make the communities aware that their contributions serve as the basis for

improvement in the services SDA provides. The studies already done by the SDA should serve as the "base line data" to compare the results.

Indirect (overhead) expenses should be calculated as soon as possible by each health facility's staff to determine the level of expenditure in this important budget item. This is particularly important in assessing the sufficiency with which the cost recovery system is covering costs (level of recovery) of services.

It would also be very important for SDA to determine exactly when and where SDA's services are coinciding with services provided by other health care organizations like NGOs. This will enhance coordination and cooperation, and detect whether service users prefer other NGO's to SDA's facilities/services and why.

3. Technical Assistance

TA has been provided by CCC in many areas, as listed throughout this report. However, the efficacy of this TA has not been optimal.

RECOMMENDATIONS:

- ***Locate all of CCC's offices within the SDA building.***
- ***CCC should share information with USAID and SDA simultaneously.***
- ***CCC's monitors should be encouraged to share findings and suggestions directly with SDA workers. They should meet at least monthly with regional supervisors and directors.***
- ***All TA contracts should be discussed with SDA during the design phase.***

4. Research

a. General Description

Ongoing assessment of services and income occurs throughout SDA: RHP, clinics, and social marketing SMRD Division. Annex 54 lists the studies performed by SDA.

However, the scale of this research is often insufficient, and problems arise in three major areas:

- Inadequate study design;
  No routine use of control groups in epidemiologic studies;
  No mention of how many refused to be interviewed;
  Fancy statistics cannot compensate for selection bias (e.g., 105 of 200 women affirmatively answered questions regarding Noristerat; but what about the other 95?).

- Erroneous conclusions from data analyses/interpretations.
  In the retrospective study of sterilization, women were sterilized with fewer children if they have more education. This is an ecologic analysis which does not indicate whether we should be educating women or otherwise influencing

them. In the absence of controlling for other independent variables (including, but not limited to, socio-economic status), concluding that an association is causal is naive.

- Inadequate implementation of recommendations.
  Some studies have made recommendations which could be more strongly enacted. The SDA is to be commended for its start in realizing these changes. For example, the study of cervical cytologies indicated a need in El Salvador to target PAP smears among younger women, because although the 7.2% abnormality rate corresponds to worldwide figures, the age at which women demonstrate pathology is younger in ES than worldwide. (Among women < 35, the rate of carcinoma in situ is three times what it is in the US; for invasive cancer, the rate here is twice that in US.) Yet when the nurse in Gotera asked to do cytology exams in the field, she was not allowed to do so. Another example from the same study is the recommendation to improve (p. 13) inter-institutional collaboration which has been weak. Another study, regarding adolescents, states there is a dearth of data and it suggests "increasing legal support" for adolescents to use contraception (p. 185), but action implementing this has not occurred. The report also states that parents are pragmatic regarding adolescent sex (p. 93) yet PHP's are not addressing young people. In the study of 3 satellite clinics and 2 marketplace clinics: (Remember 1792): providing vaccinations in satellite clinics was recommended. This continues to be rare.

- Assumptions are made without supporting data.
  For example, in the study of sterilization, the authors conclude that because women are not seeking reversals, that they were well-informed prior to making a decision to be sterilized.

- The study purpose does not seem to be congruent with methods.
  For example, there is detailed study of cervical cytologies. Although it is an interesting study, it is not clear what SDA was intending to discover through it.

- The prioritization of research is not systematic.
  For example, although 8 studies exist for the feasibility of opening satellite and marketplace clinics, no feasibility study for the purchase of a hospital was performed. In the study of morbidity and mortality (MCH), the consultant's specifications are more clear than the specifications for the study itself. **

CCC has not provided TA to the IEP Division in the area of research. CDC in Atlanta has provided the only TA to this group-no one has provided TA to the rest of the SDA staff in how to implement research results.

The strengths of research and evaluation at SDA includes:

- Research extends beyond SDA, for example, FESAL is nationwide.
- Many areas are studied.

**(This study was directed by the TA contractor, CCC, and therefore our team's recommendations are directed to CCC.)

- The Director and staff are motivated.
- Attempts to monitor services exist.

RECOMMENDATIONS:

- ***Technical assistance in research has been inadequate. Training is required in the areas of study design, analysis, interpretation, and implementation of results for IEP Department Staff, but also for SDA staff.***

- ***All studies should have explicit goals stated at their commencement.***

- ***Hire an epidemiologist for 6-12 months to tutor and train on-the-job.***

II-COMPC.R24

III. Recommendations

A. Component I: Family Health Services Delivery

1. Reorganization and Expansion of Rural Services

a. General Description

- Maintain the current number of PHPs and DARs. Concentrate on providing quality of services rather than on expanding geographically. The more disperse the outreach workers are, the harder it is to supervise and supply them. The RHP might want to consider placing outreach workers in slightly larger towns and asking very isolated persons to come to them.

- Encourage USAID and SDA to include PROSAMI in FP discussions and include staff and appropriate organizations in their umbrella group in project design and implementation.

- The current acting director is fully qualified to be promoted to director of the project. We recommend it. Doing so would support the SDA's and USAID's goals to involve more qualified women in executive positions.

- There is no reason not to re-write the qualifications for the job, which currently specify that the director must be a physician. SDA could send a revised scope of work to USAID and ask them to approve it, according to their established procedures. Hire an assistant director whose management skills will complement the current director's technical skills. This will enable the director to spend more time in the field supervising activities in the regional offices, doing strategic planning, coordinating with other SDA Departments, USAID, CCC, etc.

- Due to the effort required by the promoter supervisors and auxiliary nurses to travel to rural sites to supervise the PHPs and DARs, and the need to provide individualized feedback and modeling of correct techniques to enable PHPs and DARs to internalize what they learned at the initial training course, hire more permanent staff, including more auxiliary nurses who can help the existing regional supervisory teams to extend coverage. In addition, hire a training specialist who works in the region, teaches the supervisory teams how to train PHPs and DARs, and plans monthly refresher training courses. We strongly recommend this to insure quality of care.

- SDA should work with an experienced training consultant to decide upon performance objectives and options for achieving them. That exercise would develop a work plan and budget to meet their needs.

- Incorporate SDA's suggestion to use approved garages in the regions which charge prescribed rates for maintenance and repair. Allow staff to spend up to a specified amount without prior approval from the central level.

- Do anything possible to get injectables delivered to the rural areas, such as allowing the rural program to borrow materials from the clinical program which the evaluation team found to be stocked, or re-allocating funds so that essential contraceptives are available.

- Missed opportunities are occurring for female sterilization because the SDA van will not take fewer than 3 women at a time; if only 2 women decide to go, they are not transported.

- This policy should be changed because a satisfied client will spread the word-and so will a dissatisfied one. It makes recruitment harder. Schedule the use of the sole vehicle per region for patient transportation very carefully. Establish routes which stop in larger villages so that PHP's can direct their clients to places where pick-up is guaranteed at a specified time.

- We asked to see PHP and DAR folders that contained results of initial training course deficiencies, plus results of supervisory visits by training supervisors from the IEC Department, regional supervisory teams composed of a promoter supervisor and an auxiliary nurse, and CCC monitors. None existed.

- Create a file, computerized if possible, for each PHP and DAR, which contains the above mentioned information. If it is not feasible to keep these files current, due to lack of modern and functioning computer hardware and software in the regions, a good option, suggested by SDA, would be to keep all comments in the PHP's and DAR's folder at home.

- To prevent desertion, we support the SDA's recommendation to focus on the 9% of PHPs with low productivity and help them to provide quality services by increasing supervisory visits and refresher training.

- We also support their recommendation which says that a DAR should be recruited to fill the vacancy when a PHP leaves, and visit the FP clients in order to assure continuity of service.

- Have trainers and supervisors remind PHPs to put supplies into their bags in order to carry and sell them as appropriate.

- Do a survey with PHPs and DARs to find out which educational materials they like most and concentrate on supplying those.

- Update the materials folder when new materials are produced.

- Teach PHP's how to use educational material by demonstrating this skill and letting PHP's practice until they get it right at the initial training, monthly meetings, and home visits.

- Ask a consultant to do a train-the-trainer workshop for RHP supervisory personnel just on that topic, and

- Invite a behavior change specialist to do a study and suggest the best approach for using educational materials to reinforce messages delivered on home visits.

- Do a special study to present ideas about condom use for illiterate people, since it is so universally difficult to provide information which is in harmony with cultural preferences with regard to seeing explicit drawings of body parts.

- Take an artist to the field and conduct focus group discussions to see how local residents might present information about condom use and vasectomy. The artist can encourage people to draw and/or suggest ideas which he draws and modifies when they give feedback.

- To the extent possible, incorporate PHP's suggestions about how to improve the RHP: doing home visits with an auxiliary nurse at least once a month; provide more training on MCH topics and first aid; and increase the amount of medicine given to PHPs.

- The current and former director of the RHP, the director of IEC Department and the managers of training and communications, should review the videotape, confirm our findings, and decide what should be done.

- We recommend that every PHP who was videotaped review their taped interview with their auxiliary nurse supervisor. If they are willing, the interviews could be edited and shown at a monthly meeting, stopping the video frequently to discuss strong and weak points. These videos could also be used to train regional supervisory teams and PHPs and DARs at their initial training.

- Since it is imperative to have first hand information about what is going on in the field, periodic and frequent site visits by top level SDA staff (in <u>all</u> relevant departments) to monitor quality of service delivery and supervision are best. An alternative that could be easily implemented would be to send a two-person crew (camera plus sound since audio is tricky in the field) to record interviews that will provide objective feedback for all concerned. Bring a VCR/monitor to provide instant playback opportunities.

- The PHPs could be involved in the creation of training videos which would address some of the issues covered, such as interpersonal communication skills, or how to advise a woman to get ready to go to the clinic for an operation. This will motivate them to thoroughly study and learn the content of the video lesson.

- Develop a curriculum for interpersonal communication skills, and a checklist that covers the main skills that a PHP should employ during an interview with a client. Train supervisors to use the checklist and model behaviors that PHP's are found to be weak in when doing home visits.

- Make better use of the DARs in the delivery of MCH services. They should be taught when and how to refer clients for MCH services to PHPs if one lives nearby; they could sell ORS and other supplies.

- Continue to keep up the good work on quantity of services. Now it is time to examine weaknesses, which have been suggested by viewing the video, evaluating training results as well as samples of regional supervisors' reports, and FESAL 1993 survey results. Decide upon performance goals and redesign the training with the help of a short term consultant.

- Expanding the RHP in terms of community development projects will dilute efforts to deliver quality health services in the rural area. SDA should concentrate on what it does best and not renew the Project.

b. Logistics

- Relocate some of the better computers outside the central level.
- A small power lift truck should be provided to the central warehouse.
- Bin cards should be appropriately used for all products at the central and regional warehouses to facilitate product identification.
- The warehouses at Santa Ana and San Miguel should be modified to allow more ventilation, i.e., air extractors and more louvered windows.
- SDA must ensure adequate supplies.
- Mebendazole should be a regular item for PHP/DAR distribution in the rural program.
- SDA must utilize CCC monitors' monthly reports and procure supplies appropriately.
- The short-term Logistics and Warehousing Advisor should determine the steps needed to rectify the supply situation and implement measures to prevent these problems in the future when he returns for a two week period in July. With proper and timely communication, these logistics problems can be resolved.
- If it is decided that the workshop property will not be sold, security modifications should be made as soon as possible in accordance with the SDA plan to remodel.
- A set of basic tools should be assigned and inventoried at each region to facilitate on-site preventive vehicle maintenance. Regional drivers should receive basic preventive maintenance training. Failing this, private local garages should be used.
- Vehicle operational/maintenance manuals in the Spanish language should be provided to the vehicle workshop and the regions. (A copy of the Cherokee manual in Spanish might be obtained for reproduction, from the Ministry of Public Health vehicle workshop).
- Training in complicated maintenance or corrective maintenance, such as servicing automatic transmissions, should be provided to SDS mechanics.

c. Computers/MIS

NO RECOMMENDATIONS

d. Sustainability in the Rural Program

- Other alternatives for delivery of the services provided by the project should be explored in order to reduce its high costs. For example: (1) the use of motorcycles by the PHPs instead of vehicles to reduce costs in vehicle purchase, maintenance and repair which consumes approximately 24.3% of the project's budget. (2) Determine which computerized equipment can be transferred to the regions instead of continuing

to purchase equipment, which inflates the part of the budget that covers infrastructure.

- During the SOMARC Consultant's visit to the SMP program, a detailed analysis should be done to determine the reason for the NORISTERAT stock-out in the RHP since the regional clinics did not suffer this problem. Consider the fact that the product enjoys a higher price in the clinics than in the RFP.

- The Rural Health Program's budget should be re-structured so that financing is allocated more for those activities that enhance the quality of the program such as training and IEC, as well as ensuring that the program has the necessary supplies to serve the rural population.

- The RHP is an expensive project because of the big infrastructure at the central office. Plans should be made to investigate a way to phase out costs for PHP compensation. Providing them with products to sell, for which they will earn a commission to help defray the costs of their salaries, is one way that this could be done. Start with a pilot project. Ask villages to pay their salaries is another way.

e. Technical Assistance

- SDA should allow the monitors to take a more educative role during their field visits as is done by Clapp and Mayne monitors for the APSISA Project. Periodic joint travel with promoter supervisors is also recommended.

- The monitors' reports, particularly the bi-monthly inventory reports, should be shared with the Manager of Procurement and Supplies.

- Monitors should meet at least monthly with the SDA Medical Director, the DA Director of the Rural Program, the SDA Manager of Procurement and Supplies and meet separately with SDA PHP/RHP medical supervisors.

- Training Department staff should become more specialized. This requires short-term technical assistance based on real needs. More short-term technical assistance has been revealed by IE&C/Training Department staff and should be provided.

f. Information, Education, and Communication (IEC)

- Since the manual is so often consulted by PHP's during home visits, we suggest adding checklists for:

- Complications and danger signs of hormonal methods;

- Counselling a woman who will be sterilized (what to eat, wear, etc.)

- To build upon this strong foundation, we recommend producing videos that are interactive and can be used in training sessions to involve trainees in questions, demonstrations, and other training activities.

- Use video to record training sessions and provide feedback to trainers. The videos could be the basis for a video training library on FP and MCH topics. They could also be edited and sold as part of the social marketing program.

- Given SDA formal approval, we support the CCC advisor's recommendation to send TV monitors to the rural areas and use them to show a combination of films, TV programs, such as episodes that Televisa in Mexico produced incorporating FP themes, and SDA videos.

- Put more emphasis on formative research, as well as on using FESAL 1993 results, to design messages which address specific areas that the target audience needs to understand in family planning so that they will overcome their fears and learn what behavior constitutes a healthy choice. Results shows that women and men 15-24 are a prime group to reach.

- Use focus group discussions to develop materials. Include an artist as part of the process, whenever possible, so that he can immediately incorporate local residents' ideas and concepts in designing or revising materials.

- The IEC Department should design a strategy to make sure that materials get to the end users, PHPs, DARs and clients. They should also monitor the process by making visits to clinics and communities.

- Because a well-designed mass media campaign motivates people to plan their families and use SDA's services, it is important to sign the contract with the ad agency and get started with the mass media campaign.

- Increase the number of radio spots to provide variety and focus on one key message at a time. The messages should be based on research and cover methods, as well as Profamilia services, and be creative in how PHPs and DARs are used. The community needs to know who these SDA staff are and what they do.

- Involve the Creative Department of the Ad Agency in going to the field to develop radio and TV spots with input from local people during focus group discussions.

- Since it is expensive for the Ad Agency to produce TV spots, let the SDA TV Center produce at least one additional spot to add variety to the campaign without incurring great additional costs.

- Devise an observation check-list for interpersonal communication skills which meets SDA needs and apply it to a valid sampling of PHPs and DARs as they make home visits. Use the results to design an interactive training module and video.

- Train-the-trainers in how to model and teach interpersonal communication skills. Have interactive communication skills be one of the units of mastery. (Discussed below).

- A weakness was that not everyone could see the material because the overhead project was poorly positioned. Likewise, not everyone could hear; the trainer needed a microphone.

- Pay attention to the logistics of the training so that every participant has equal access to the information provided.

- Because the educational and literacy level of the trainees is at a third grade level, instead of having written exams, evaluate learning by designing an additional training exercise that covers the same territory and seeing if new information can be put into

practice. Such exercises must include role plays, games, filling in diagrams, treasure hunts, etc.

- Upon completion of the initial training course, have the Training Department provide the regional supervisory teams with a list of precise areas that each PHP is weak in so that an individual folder, preferably computerized can be created in the regional office. This will guide follow-up visits by the training supervisors, regional supervisory teams, and CCC monitors.

- Ask the IEC Department to design a brochure for the PHP that lists PHP goals, functions, and benefits; use it in recruitment.

- Improve the prospects for recruiting good candidates by offering recruits free health care in SDA clinics. This has proven to be successful in a pilot project area. PHPs will be more likely to refer people for services that they themselves have experienced.

- Set a norm for when to invite participants to the training courses, and stick to it.

- Given the special characteristics of the students, the complexity of the topics taught, and the importance of "getting it right," more days should be added to the training course so that all of the training topics are covered sufficiently. The Director of Training and the training staff should meet to discuss this recommendation, basing changes in course design on areas that are hardest to master. Technical assistance should be provided to redesign initial and subsequent training courses for both PHPs and DARs, who get periodic refresher courses.

- Having read the memos about the refresher training which cited problems that supervisory teams seem to be having with content, training process, and logistics, we recommend that each region hire a training team to plan and implement monthly sessions on refresher topics.

- The Training Department should obtain and review training manuals from other IPPF affiliates to get ideas for modifying their "Guias Pedagogicas." A good example is "Capacitando Sin Letras," available from APROFAM in Guatemala.

- Stimulate PHPs to learn by providing more learning materials and opportunities.

h. Client Satisfaction

- PHPs should be trained to understand that the quality of home visits is more important than the quantity. Feedback from supervisors immediately after the interview would help to impart this information.

- We support Dr. Goenz' suggestion made in a March 1994 memo to the Chief of Party of CCC/El Salvador that research be done in rural homes to know the penetration and acceptance of SDA programs and the PHP. We are not sure that CCC monitors are the best ones to do this; the SDA Research Department might be more experienced. However, the parties concerned should decide upon a way to measure community acceptance. The information is important to help design mass media campaigns to support the PHPs as well as design training programs to teach PHPs and DAR's how to satisfy clients and improve their acceptance in the community.

- If giving effective group talks is an essential skill for PHPs, they must receive more supervised practice. Produce a video devoted solely to this topic. Let PHPs watch regional trainers demonstrate the techniques. Let PHPs prepare a 5-minute talk for the monthly meeting, videotape it, and get individual and group feedback. A certificate of mastery could be created for this topic.

i. Method Mix

- Noristerat, or an alternative, must be available at all times.

- We recommend that SDA considers quantifying their expectations of PHPs regarding the permanent temporary method clarifying and ratio and a number of clients. The medical director should meet with the PHPs to negotiate a high but realistic number.

- Pretest the vasectomy video with rural men to see if they like and accept it, especially the part that shows a real operation.

j. WID

- SDA should examine the salary scale for the RHP supervisory team members, with an eye toward equalizing the pay for the males and female auxiliary nurses.

k. General Conclusions

NO RECOMMENDATIONS

2. Expansion of SDA Clinical Services System

- SDA should link authority with responsibility by clearly delineating functions of the clinic managers and medical directors.

- The decline in number of family planning users in 1994 needs to be assessed.

- Offer immunizations at the regional clinics whenever a nurse is present.

- Since the Center for Adolescents is a great resource for El Salvador, SDA should make a specific effort towards publicizing the availability of FP services there in order to increase the demand.

- Keep the current buildings and their maintenance.

- Increase CYP in the regional clinics by active promotion of FP by all clinic staff. TA in health promotion should be offered, and the mass media campaign should begin immediately.

- A quality assurance program should be implemented at the regional level to improve efficiency and increase time for counselling by the staff. Both nurses and Damas Voluntarias should be utilized more.

- Increase the allocation for staff training at all levels of regional clinics: management, physicians, nurses, Damas Voluntarias, and others.

- A cost/user analysis should be performed to investigate the efficiency of seeing patients through the clinics or the RHP.
- SDA should be viewed as a diversified provider of health care services, and not merely FP. TA should be provided to help SDA meet their fundamental goals of providing FP as well as related MCH services.
- SDA should consider increasing the regional circulating funds to 5,000 colones with a 500 colones single purchase limit.
- The storage space at Santa Ana should be increased.
- The CCC monitors' reports should be utilized by the regional administration.
- Increase computer capability at the regional level.
- Provide newer equipment to the regions. Of the 61 ADS computers existing at the time of the evaluation, only eight were in the region and four are old according to the Chief of ADS/MIS.
- Install in the regions a supply management program similar to that used at the central warehouse.
- Get computers operating in the region.
- This is a costly part of the RHP without any doubt. The maintenance of the clinics that compose the expansion of services is a rather costly proposition for USAID. One alternative for USAID to make the best use of its funding and at the same time accomplish the same objective is to establish an arrangement with SDA to pay for SDA's delivery of clinic-based services on a reimbursement basis.
- In light of the decrease in users, absence of supplies, and minimal computerization, technical assistance needs to address enriching management, logistics, computers, and clinical issues.
- Distribute pamphlets and flipcharts to the regional clinics.
- Include the regional clinics in the mass media campaign.
- Clinical staff in the regions should have in-service training on advances in the contraceptive field, counselling, and promotion of FP.
- Enhance the IEP Division through medium-term technical assistance in the area of study design, analysis, and interpretation, in order to fully investigate client satisfaction. Focus on the decrease in users in 1994.
- Investigate why Santa Ana differs from the other three regions in method mix.
- Target FP programs at men as well as women.
- More women should be involved in planning and implementing FP and MCH services in the urban areas, especially outside San Salvador.

- Attention needs to be given to training needs of regional clinical staff.
- Training in Norplant insertion, counseling, indications and contraindications should begin as soon as possible.
- Empower nurses to provide more direct family planning services, such as the insertion of IUDs.
- Increase the use of temporary methods by creating a special mass media campaign, empowering nurses, and improving IEC materials in the clinics.

3. Expansion of SDA Clinical Services System: Satellite Clinics

a. General Description

- In order to promote FP among patients who are seeking other services, a protocol for offering FP services should be created and used on every patient. This protocol would educate every patient about the value of FP.
- Recruitment of physicians is not a problem. Maintain the current salary structure.
- To make satellite clinics more efficient, analyze and improve the use of the nurses' time. The satellite clinics would be more efficient if programs such as health promotion lectures were offered during the hours when no physician is present. Increase the role of the nurse through training. Increase physicians' hours.
- Immunizations, at least for tetanus, should be always available at satellite clinics. Where refrigeration is not available, weekly sessions should be held providing immunizations. When these services are active, the IEC Department should make the public aware of them and motivate people to use them.
- Although expanding services is good, the priority of FP should not diminish. Keeping FP the focus of the satellite clinics should be done through altering the cost reimbursement system, the mass media campaign, and training satellite clinic staff in FP.
- As stated earlier, the IEP Division requires TA in epidemiology to improve study design, analysis, and interpretation. With every evaluation, <u>what will be done with the results</u> should be explicitly written prior to study implementation.

b. Logistics

NO RECOMMENDATIONS

c. Computers/MIS

NO RECOMMENDATIONS

d. Sustainability

- Support the pilot project of using physicians' offices as SDA satellites. Evaluate aggressively the physicians' commitment to FP.

- Empowering the nurses would support sustainability through increased efficiency.

e. Technical Assistance

- TA directed towards increasing satellite clinic efficiency should begin.

f. IEC

- Distribute IEC materials and design a FP protocol for patients visiting the satellite clinics.

g. Training

- Satellite clinic nurses should be trained in insertion of IUDs, and be empowered to serve as physician extenders to provide all temporary methods of FP.

h. Client Satisfaction

NO RECOMMENDATIONS

i. Method Mix

NO RECOMMENDATIONS

j. WID

- A campaign targeting men should begin.

k. Additional Recommendations

- Training needs of satellite and marketplace clinics need to be surveyed and addressed.
- Consider having the nearby factories support the satellite clinics.
- Avoid overhead through renting private physicians' offices.
- Consider outreach efforts targeting teens and men.
- Expand nurses' role.
- Provide IUD insertion apparatus.

4. Expansion of SDA Clinical Services System: Marketplace Clinics

a. General Description

- SDA should work directly with the municipalities in order to assess cost/user and the benefit of increasing marketplace clinics.
- Reinforce the primacy of FP through use of the FP "protocol" mentioned earlier which each patient would fill out in order to educate them regarding FP.

b. Logistics

NO RECOMMENDATIONS

c. Computers/MIS

NO RECOMMENDATIONS

d. Sustainability

- Encourage municipal involvement to share costs.

e. Technical Assistance

- TA regarding enhancing nurses' functions, management, placement of clinics should occur.

f. IEC

- Provide the same materials that the other programs have for the clients.

g. Training

- Empowering nurses to provide direct FP services would increase marketplace clinic efficiency.

h. Client Satisfaction

NO RECOMMENDATIONS

i. Method Mix

NO RECOMMENDATIONS

j. WID

- Create a market program geared towards men.

k. Additional Recommendations

- Add running water to each clinic.
- Expand physicians' hours.
- Advertise locations.

5. Expansion of SDA Clinical Services System: Physician Referral System

a. General Description

- Formal meetings should occur among the regional medical director, the referring physicians in that region, and the rural PHPs.

- Ensure commitment to PF through mandatory regular training, e.g. annual sessions on "New Development in FP," etc.

- Monthly visits, if followed, would be adequate to provide guidance to the physicians and to recover data for the central level.

b. Logistics

NO RECOMMENDATIONS

c. Computers/MIS

NO RECOMMDNDATIONS

d. Sustainability

- SDA should conduct a pilot project to increase the proportion of the fee paid by the patient and investigate compliance.

e. Technical Assistance

- The CCC monitors should make occasional visits to the physicians in the referral network.

f. IEC

- SDA should provide the referral physicians with the IEC materials available to the other programs.

g. Training

- Training must increase to make the physicians in the referral network promote FP.

- Each referral physician should be able to insert an IUD. Implantation of Norplant should be taught and encouraged.

h. Client Satisfaction

NO RECOMMENDATIONS

i. Method Mix

NO RECOMMENDATIONS

j. WID

NO RECOMMENDATIONS

k. Additional Recommendations

- Physicians should be allowed, during their residency, to see SDA patients.

- Physicians should meet and work with PHPs.

B. Component II: Institutional Development

1. The Social Marketing Program

a. General Description

- Political Support and full cooperation is required from SDA's upper management including supervisory and managerial levels, to guarantee the success of the various Resource Development activities planned by this division. Although some support has been forthcoming, the SMRD division feels that much more will be needed in the future from both the Board of Directors and the management at SDA, as well as from USAID staff in charge of the management and monitoring of the RHP.

- Due to the importance to the SDA of attaining a high level of sustainability, not only to comply with the terms of the Cooperative Agreement but to decrease donor-dependency, the SDA must ensure that all of its staff are well-informed about the SMRD Division's goals. It is also important to clarify what the duties and responsibilities of the Division's members are, and explain their plans.

- In view of the unsuccessful attempt by SDA to contract with an outside organization for its SMP, and based on analysis of cost-effectiveness made by SDA, it is recommended that a thorough analysis of the two SMP schemes be made by the Consultant with the assistance of the SOMARC Consultant who began begun work in June 1994, and will return in 1-2 months.

- The co-distributor scheme, though it appears to be an expensive proposition, should be thoroughly re-analyzed. A distributor brings in a major marketing force with it, advanced warehousing techniques, transportation of the product within the capital as well as the interior, and vast experience in management of substantial credit portfolios.

- Judging by the significant cut in costs (47% annually), the on-staff salesmen/pharmacy distributor scheme appears to be the most appealing. There remains however, the nagging question of whether SDA should extend credit to these pharmacy-distributors for large sums of money prior to the sale of contraceptives. SDA first of all would have to ensure payment for all contraceptives sold through the pharmacy-distributors.

- Since the SMP is purely a commercial scheme, the Marketing Plan should include a "Profit and Loss" statement.

b. Logistics

NO RECOMMENDATIONS

c. Studies conducted

- In order not to run the risk of either over/under charging service users, and because there might exist differences among various groups in the capacity to defray a portion

of their health and family planning bills, it is recommended that SDA conduct a second patient socio-economic study by region.

- The forms to be utilized for the socio-economic study should be able to reflect the real socio-economic status of the users of SDA's services, not just their income.

- Develop a final standardized socio-economic data collection instrument to develop with the assistance of the technical assistance contractor. This instrument could be fine-tuned so that it can be easily and rapidly filled out by the Social Worker. During field tests on a selected month the Social Work Units at SDA' clinics should conduct the pilot tests and collect the necessary data to determine the socio-economic status of the group of clinical patients under study.

d. Social Marketing: IEC

- It is important to develop a bank of freelance video production personnel to ensure that adequate staffing is maintained to handle both SDA's work and that which comes into the AV Production Center.

Additional ideas for marketing include:

- Create a library of videotapes on FP and MCH topics that can be rented or sold to schools and universities. Do research to see what the needs are, and fill them with videos that the SDA has already produced, to begin with. The income generated from sales can be used to produce videos on other topics that are in demand.

- Package and sell the drawings that have been prepared to teach about contraindications of hormonal methods. IPPF affiliates, medical and nursing schools, nursing and midwives' associations might be clients.

e. Training

- Train IEC or social Marketing Department staff to package, advertise, and distribute materials, learning computer programs to track inventory, purchase orders, etc.

f. Additional Recommendation

- The SMP director should meet monthly with the CCC COP, and USAID project officer.

2. Establishment of a Central Referral Clinic (CRC)

NO RECOMMENDATIONS

3. Marketing and Feasibility Studies

NO RECOMMENDATIONS

4. Institutional Development - MIS

NO RECOMMENDATIONS

5. Sustainability

- Annex 37 demonstrates the network necessary for institutional sustainability.

- Expand the Delivery of Uninterrupted and High Quality Service and Adapt to the Environment

- SDA should continue to decentralize its administrative systems so that supervision and decision-making occur at the regional level. A decentralized model of administration has the potential for improving efficiency. Each clinic must have a certain degree of independence or autonomy so that its management is able to solve problems as they arise without having to go through the central level. The example of the vehicles having to go to the Central Garage for repairs is an excellent one.

- The clinics would determine the level of supervision needed and would work more efficiently by having the independence to carry put their own objectives. It is understood that regional objectives should be in line with those of the Project and of the organization as a whole.

- SDA should consider decentralizing the accounting function completely. This could be accomplished on a gradual basis starting with the Oriental Region which seems to be prepared to take on this responsibility. Once this pilot project is completed, ADs should continue with another region until the four regions have completely taken on this responsibility.

- The RHP is approaching its third year. Significant funding has been already allocated to building infrastructure. Any forthcoming funding from USAID should be re-allocated to areas were funding and support is most needed, e.g., Training, Quality Assurance and Mass Media campaigns.

- To offer a quality service, additional space, re-modeling, and hiring new staff is not necessary. Perhaps the improvement of services through re-training or additional training of field staff might be sufficient to be able to offer a quality service.

- SDA should be concentrating its future efforts on continuing to improve the quality of its services; empowering its staff to work together to prevent or solve problems. Staff who carry the day-to-day activities of a clinic, for instance, know which aspects of their work function well and which do not.

- They are in an excellent position to use this knowledge to propose practical changes that they themselves ultimately carry out. They should concentrate on looking for sustainability initiatives that will continue after donor support has ended. Building additional infra-structure should be considered when SDA liquidity issue, and the issues described above are resolved. If the RHP is to become a self-sustaining project in the future it will not be by building additional infrastructure.

- An organization-wide management review should be conducted by a local auditing firm of international standing, e.g., Price Waterhouse or any other auditing firm in this

category, to determine the cost-effectiveness of the Family Health Services Project as it has been implemented by SDA.

- USAID should hire a local consultant to develop the "Terms of Reference" (Guidelines) for this management review. The management review should include, but should not be limited to, determining the cost-effectiveness of the RHP; availability of funding from SDA-locally raised funds to carry the RHP in case of a significant withdrawal of funding by USAID; examine salary scales and actual salary levels at SDA; and sources of funding for SDA' activities other than the RHP. The Terms of Reference should be reviewed and approved by USAID/ES.

- The Rural Health Program should be re-structured so that more financing is allocated for those activities that enhance the quality of the program, such as training and IEC, as well as into ensuring that the program has the necessary supplies to serve the rural population.

- The maintenance of the clinics that compose the expansion of services is a costly proposition for USAID. One way for USAID to make the best use of its funding would be to establish an arrangement with SDA to **pay for SDA's delivery of clinic-based services on a reimbursement basis.**

6. Women in Development (WID) Issues

- SDA should provide the salary list to USAID for evaluation.

- If women are paid unfairly, this should be corrected.

C. Component III: Policy Development And Research

1. External Policy

- This committee would benefit from increased support from both USAID and SDA.

- The International Reproductive Health Committee must be supported by both USAID and SDA.

- SDA should work with the MSPAS to stimulate and coordinate their efforts in FP. SDA must work with the Ministry of Education to make family planning a part of public school curricula.

- IPPF regulations and involvement must be coordinated with USAID's involvement.

2. Internal Policy

a. Organizational Structure

NO RECOMMENDATIONS

b. Strategies

NO RECOMMENDATIONS

c. Program Planning and Management

- An entire management review should be performed. Although management was included in the contractors scope of work but it was not provided. The management requires fortification.

d. Financial Management

NO RECOMMENDATIONS

3. Technical Assistance

- Locate all of CCC's offices within the SDA building.
- CCC should share information with USAID and SDA simultaneously.
- CCC's monitors should be encouraged to share findings and suggestions directly with SDA workers. They should meet at least monthly with regional supervisors and directors.
- All TA contracts should be discussed with SDA during the design phase.

4. Research

a. General Description

NO RECOMMENDATIONS

b. Recommendations

- Technical assistance in research has been inadequate. Training is required in the areas of study design, analysis, interpretation, and implementation of results for IEP Department Staff, but also for SDA staff.
- All studies should have explicit goals stated at their commencement.
- Hire an epidemiologist for 6-12 months to tutor and train on-the-job.

IIIRecom.r24

IV. Lessons Learned

1. The world of USAID and its consultants is small. Personalities will inevitably clash from time to time. However, these clashes can be kept to a minimum by:

   - Project Design Implications - Stipulating in the cooperative agreement the responsibility of the recipient of USAID funding to maintain a good **and productive** working relationship.

   - Broad Action Implications - Separating the function of monitoring from that of technical assistance. Request for technical assistance, to be effective, must come from within the organization. Contrariwise, monitoring, to be effective, must come from an external organization.

2. Without frequent and careful introspection, the management of any institution can get administratively top-heavy and lose sight of its direction and goals.

3. Technical assistance is not synonymous with evaluation.

4. Even highly skilled individuals do not follow through and apply what they have learned without supervision and monitoring.

5. Just because pamphlets have pictures and no words does not mean that they will be accepted by illiterate people. Cultural norms and values may make them reject graphic drawings of private body parts.

6. To increase financial sustainability in recipient organizations, USAID must increase its relationship as a partner rather than a distant donor. Flexibility in allowing SDA to use tangible as well as personnel resources for non-project activities would enhance this goal.

7. Expanding rural programs in family planning and increasing self-sufficiency may be mutually exclusive.

8. Focus Groups

   The steps in doing focus groups are enumerated below.

   - Obtain clearance from government/MSPAS/leader of village to "do" one.

   - Recruit women. The number of variables being studied will determine the number of women/focus groups needed.

   - Select a place to meet that is confidential.

- Devise questions, then translate them, making sure to include vernacular.
- Find culturally acceptable investigators.
- Train them.
- Tape, transcribe.
- Analyze.

These steps are difficult and time-consuming, and may be impossible for short-term consultants to implement. Alternatives include in-depth interviews with clients and on-site observations.

9. Secrets erode morale.

10. Objectives with numbers attached are perceived as more important than others.

11. "Family planning" is not self-sustainable. USAID has therefore encouraged expansion of services in order to attain financial sustainability. However, this has led to a decrease in emphasis on family planning. Changing reimbursement could balance this trend.

1. Report of the Completion of Goals, 1993-1994, Incomes
2. Report of the Completion of Goals, 1993-1994, Adolescent Center
3. Report of the Completion of Goals, 1993-1994, Satellite Clinics
4. Report of the Completion of Goals, 1993-1994, Clinics in the Market Area
5. Notes on Cotepo
6. Contraceptive Method Women prefer to use
7. Report of the Completion of Goals, 1993-1994, Regional Clinics
8. Flow Chart of Clinics
9. Organizational Structure
10. New Prices
11. Test Bone Chart
12. Family Planning National Sourvey
13. Cost/Benefit Research for Satelite and Market Clinics
14. Counterpart Contribution Report for ADA Project 519-0363

ATTACHMENT I

I. BACKGROUND

The subject of this interim evaluation is Project No. 519-0363 Family Health Services being implemented under a Cooperative Agreement exclusively with the Salvadoran Demographic Association (SDA), a local NGO, affiliated with International Planned Parenthood Federation (IPPF). This is a $35,826,000 project with a life of project (LOP) of five years. USAID's contribution is $22 million and the SDA's contribution is $ 13,826,000. The Cooperative Agreement was signed on July 31, 1990 and current Project Assistance Completion Date (PACD) is July 30, 1995. A total of $16,420,900 has been obligated and as of March 31, 1993 $3,204,461 had been disbursed by the SDA as counterpart contribution. This project is a follow-on to the USAID's two family planning projects which ended in FY90 (519-0210 and 519-0275).

The Salvadoran Demographic Association is a Salvadoran private voluntary organization that was constituted in 1962 and started receiving USAID support in 1963. Since then, the SDA has continuously received financing from the USAID for developing its family planning programs.

The **purpose of the Project No.519-0363 project** is to improve and expand the delivery of family planning and maternal child health (MCH) services to high risk populations in rural and marginal urban areas of El Salvador. The big difference between this project and the previous ones is the integration of family planning with other MCH activities, rather provide than solely family planning as was the practice through FY90. This Project as designed, is consistent with the USAID Strategy framework as detailed in the 1992-97 Program Objective Document. Specifically, it responds to Strategic Objective #4 "Healthier, Better Educated Salvadorans", and Program Outcome 2, "Increased contraceptive prevalence", and Program Outcome 3, Although SDA is the exclusive implementing agency, contraceptives are also provided to Salvadoran Social Security Institute (ISSS) under the Project.

Project <u>inputs</u> as described in the Cooperative Agreement are: technical assistance (contracted directly by USAID using Small Business Act, Section 8(a) procedures), training (long term, short term and in country), logistics (remodelling costs, office supplies, vehicles, contraceptives, medical supplies, pharmaceuticals), public education program costs, research costs and audits. <u>Outputs</u> are defined by the Cooperative Agreement as services delivered, including but not limited to, number of rural distribution points established, number and type of health workers and mothers recruited and trained, increase in clinical services provided, number of research studies completed, and increase in the number of family planning acceptors.The project contains three components: (1) <u>Family Health Delivery</u>: this component provides support to continue and expand the family planning services of the SDA and adds select MCH interventions (e.g., immunization, prenatal care, oral rehydration therapy, and nutrition education) to the range of services provided by the SDA; (2) <u>Institutional Development</u>: this component will enhance the financial viability of the SDA through improvements in its organizational efficier cy and the addition of new services to generate income; and, (3) <u>Policy Development and Research</u>: to promote national policies which place contraceptives and other medicines within the reach of the poorest population.

Under each project component, a series of activities were programmed:

(1) **FAMILY HEALTH SERVICES DELIVERY COMPONENT:**

(a) **Reorganization and Expansion of Rural Services:** The SDA Community Based Distribution program for contraceptives continues its operations but is being reduced during the life of the project from 800 family planning posts to 400. To complement this program, the SDA initiated a new Pro-Familia Health Promoter program (PSP) providing not only contraceptives but also basic MCH assistance. The basic objective of the PSP is "to provide a non-threatening environment in which women will be more likely to seek out information on birth spacing methods."

(b) **The Social Marketing Program:** It consists of the sale of contraceptives donated by USAID to retail outlets (pharmacies and small stores). Plans are to expand it include additional outlets and to increase the range of products sold. The importance of this program is not only the fact that contraceptives are made available to the general population at a low cost but also that it is designed recover a portion of its costs thus assisting SDA reach its sustainability goal.

(c) **Expansion of SDA Clinical Services System:** Three basic activities are planned: i. expansion of services traditionally offered in SDA clinics, ii. opening of 12 marketplace clinics and 6 marginal urban satellite clinics, and iii. addition of up to 50 private physicians to a referral network.

(d) **Improved IEC Support System:** the constraints identified by the 1988 Demographic Health Survey indicated that a significant support to IEC activities was required to assure project success. The Information Pamphlets on family planning and MCH were prepared and distributed to rural and urban marginal participants. In Education, interpersonal communication became the focus as a means of educating SDA's clientele, complemented with printed materials and other educational aids. Also, the Project includes two educational projects: one to increase demand for male methods using satisfied male users, and other to provide family planning training to private practitioners serving rural and marginal urban populations. In Communications, the projects considers the use of mass media, specifically radio and TV, to broadcast messages to reinforce public education. SDA will select and contract a publicity agency to manage the production and diffusion of a mass media campaign emphasizing the new SDA image and promoting a wider range of services.

(2) **INSTITUTIONAL DEVELOPMENT COMPONENT:** This component directly addresses the institutional constraints of SDA that were present at the moment of the design of the project. Macro activities considered include:

(a) **Expansion of the Social Marketing Program, (See 1(a) above)),**

(b) **Establishment of a Central Referral Clinic (CRC):** This is considered a key element for enhancing the self-sufficiency of the SDA program. Its primary function is to provide a more complex and technical array of services to participants, centralizing services in one location for the low income population.

(c) **Marketing and Feasibility Studies:** The studies were designed to determine whether other service expansion options would be viable (e.g., additional medical services, medical insurance, improvements to operational efficiency).

ANNEXES

	Page
Annex 1: PSP - Activities	A1 -1
Annex 2: PSP - Supplies	A2 -1
Annex 3: PSP - Home Visits	A3 -1
Annex 4: Interpersonal Communication	A4 -1
Annex 5: PSP - Satisfaction	A5 -1
Annex 6: Group Talks	A6 -1
Annex 7: PSP Characteristics - Profile	A7 -1
Annex 8: PSP's Characteristics - Statistics	A8 -1
Annex 9: Desertion Causes - PSP	A9 -1
Annex 10: PSP - Daily Activities - Statistics	A10-1
Annex 11: PSP Goals	A11-1
Annex 12: RHP Activities 1991, 1992, 1993	A12-1
Annex 13: Interpersonal Communication - Statistics	A13-1
Annex 14: PSP Profiles	A14-1
Annex 15: Satisfied Client	A15-1
Annex 16: Group Talks - Statistics	A16-1
Annex 17: Training Course	A17-1
Annex 18: Invitation	A18-1
Annex 19: Volunteer	A19-1
Annex 20: Exercise	A20-1
Annex 21: DAR's Jobs	A21-1
Annex 22: Results - DAR	A22-1
Annex 23: Job Descriptions	A23-1
Annex 24: Users of INJ, T.O., and Condoms 1991, 1992, 1993, 1994	A24-1
Annex 25: Activities RHP: Graphs	A25-1
Annex 26: RHP - Organizational Chart	A26-1
Annex 27: Report of the Completion of Goals, 1993-1994, Incomes	A27-1
Annex 28: Report of the Completion of Goals, 1993-1994, Adolescent Center	A28-1
Annex 29: Report of the Completion of Goals, 1993-1994, Satellite Clinics	A29-1
Annex 30: Report of the Completion of Goals, 1993-1994, Clinics in the Market Area	A30-1
Annex 31: Map	A31-1
Annex 32: Contraceptive Method Women Prefer to Use	A32-1
Annex 33: Report of the Completion of Goals, 1993-1994, Regional Clinics	A33-1
Annex 34: Organizational Statement - SDA Clinics	A34-1
Annex 35: Organizational Structure - SDA	A35-1
Annex 36: New Prices	A36-1
Annex 37: Sustainability Tree	A37-1
Annex 38: Family Planning National Survey	A38-1
Annex 39: Cost/Benefit Research for Satellite and Market Clinics	A39-1

Annex 40: Counterpart Contribution Report for ADA Project 519-0363 . . . . . A40-1
Annex 41: Type of Services 1993 . . . . . A41-1
Annex 42: Contraceptive Method 1993 . . . . . A42-1
Annex 43: Map A43-1
Annex 44: Persons Interviewed A44-1
Annex 45: Logical Framework A45-1
Annex 46: Comparative Chart of the Clinic in La Union 1991, 1992, 1993 . . . . . A46-1
Annex 47: Comparative Chart of the Clinic in Gotera A47-1
Annex 48: Comparative Chart of the Clinic in San Miguel A48-1
Annex 49: Comparative Chart of Visits in Santa Tecla Clinic A49-1
Annex 50: Preference Physician Profile A50-1
Annex 51: National Coverage of Family Planning A51-1
Annex 52: Scope of Work (Attachment I) A52-1
Annex 53: Bibliography A53-1
Annex 54: Research Studies Performed by SDA A54-1
Annex 55: Executive Summary in Spanish (Resumen Ejecutivo) A55-1

142

ANNEX 1

NAME: _____ **OBSERVER:** _____

CHECKLIST: PSP DAILY ACTIVITIES

1. ¿POR CUANTO TIEMPO HA SIDO USTED UN PSP?

_____

2. ¿QUE LE GUSTA MAS ACERCA DE SU TRABAJO?

_____

_____

3. ¿QUE HIZO USTED HOY?
   - a. planeó la ruta YES_____NO_____
   - b. prioritizó las visitas YES_____NO_____
   - c. revisó su folder de informacion YES_____NO_____
   - d. escribió en su cuaderno de campo YES_____NO_____
   - e. revisó sus formularios YES_____NO_____
   - f. contó la cantidad de
     - 1. vitaminas YES_____NO_____
     - 2. anticonceptivos YES_____NO_____
     - 3. medicamentos YES_____NO_____
     - 4. folletos YES_____NO_____

4. ¿QUIEN ES SU SUPERVISOR? _____

5. ¿QUE HACE DURANTE SUS VISITAS DE SUPERVISION?

_____

_____

   - A. da consejos YES_____NO_____
   - B. da suministros YES_____NO_____
   - C. da materiales/folletos YES_____NO_____

6. ¿RECOMENDARIA A OTRAS PERSONAS QUE SE HACE UN PSP? YES_____NO_____

7. ¿POR QUE NO LO RECOMENDARIA?

_____

_____

8. ¿TIENE USTED ALGUNA SUGERENCIA PARA MEJORAR LA SUPERVISION? YES_____NO_____

9. ¿CUAL SERIA SU SUGERENCIA?

_____

_____

_____

10. ¿TIENE USTED ALGUNA SUGERENCIA PARA MEJORAR LA CAPACITACION? YES_____NO_____

11. ¿CUAL SERIA SU SUGERENCIA?

143

ANNEX 2

SUMINISTROS DE PROMOTORES

ANTICONCEPTIVOS

ORALES LOFEMINAL (CICLOS) _____

INYECTABLES (UNIDADES) _____

PRESERVATIVOS (UNIDADES) _____

OTROS PRODUCTOS

SALES DE REHIDRACION (SOBRES) _____

VITAMINAS INFANTIL (FRASCOS) _____

VITAMINAS PRENATAL (FRASCOS) _____

VITAMINAS A (FRASCOS) _____

ANTIPARASITARIO (FRASCOS) _____

MATERIAL EDUCATIVO _____

TIPO _____

HAY FALTANTES DE ALGUN PRODUCTO? _____

CUAL? _____

HAY ESCACEZ DE ALGUN PRODUCTO? _____

CUAL? _____

HAY PRODUCTO VENCIDO? _____

CUAL? _____

COMENTARIOS _____

_____

_____

_____

_____

ANNEX 3

NAME: _____ OBSERVER: _____
JOB: _____ DATE: _____
PLACE: _____

OBSERVATION CHECKLIST: HOME VISIT

1. FAMILY PLANNING
   - A. APPLICABLE YES_____NO_____
   - B. PILLS YES_____NO_____
     - 1. Explained contraindications YES_____NO_____
     - 2. Explained how to use YES_____NO_____
     - 3. Explained possible side effects YES_____NO_____
   - C. NORPLANT
     - 1. Explained contraindications YES_____NO_____
     - 2. Explained how to use YES_____NO_____
     - 3. Explained possible side effects YES_____NO_____
   - D. CONDOM YES_____NO_____
   - E. FEMALE STERILIZATION
     - 1. Explained what it is YES_____NO_____
     - 2. Explained when its ok to have it YES_____NO_____
   - F. VASECTOMY
     - 1. Explained what it is YES_____NO_____

2. EPI
   - A. Applicable
     - 1. children under 5 YES_____NO_____
     - 2. Pregnant woman YES_____NO_____
   - B. Identified children with no vaccinations YES_____NO_____
   - C. Identified children with incomplete vac. YES_____NO_____
     - a. BCG YES_____NO_____
     - b. Polio YES_____NO_____
     - c. DPT YES_____NO_____
     - D. Measles YES_____NO_____
     - E. TB YES_____NO_____
   - D. Identified pregnant woman/tet. tox. YES_____NO_____

3. ARI
   - A. Applicable YES_____NO_____
   - B. Diagnosed case YES_____NO_____
   - C. Referred to hospital YES_____NO_____
   - D. Referred to health unit YES_____NO_____
   - E. Treated at home YES_____NO_____

4. Diarrhea
   - A. Applicable YES_____NO_____
   - B. Diagnosed case YES_____NO_____
   - C. Referred to health unit YES_____NO_____
   - D. Treated at home/ORS YES_____NO_____

5. Nutrition and Growth Monitoring
   - A. Applicable
     - 1. children under 5 YES_____NO_____
     - 2. Pregnant woman YES_____NO_____
   - B. Child under 5

145

1. weighed YES_____NO____
2. measured YES_____NO____
3. gave vitamins YES_____NO____
4. gave advice YES_____NO____

C. Pregnant Woman
1. refer to health unit/prenatal care YES_____NO____
2. gave vitamins YES_____NO____
3. gave advice YES_____NO____

D. Mother with baby
1. Observed breastfeeding YES_____NO____
2. Gave advice YES_____NO____

6. Supplies
A. Pills YES_____NO____
B. Vitamins
1. A YES_____NO____
2. Multi YES_____NO____
C. Anti Parasite medicine YES_____NO____

7. Materials
A. Checklists
1. pill
a. contraindications YES_____NO____
b. side effects YES_____NO____
2. Norplant
a. contraindications YES_____NO____
b. side effects YES_____NO____
B. Control lists
1. pills YES_____NO____
2. vitamins YES_____NO____
C. promoter's manual YES_____NO____
D. Pamphlets YES_____NO____
E. Health card YES_____NO____
F. Flipcharts YES_____NO____
G. Laminated pages YES_____NO____
H. Other

8. Techniques used
A. Home visit YES_____NO____
B. Interview YES_____NO____
C. Demonstration YES_____NO____
D. Group Talk YES_____NO____

9. Comments:

146

RESULTS OF PSP HOME VISIT SURVEY
MAY 1994

EDUCATIONAL MATERIAL

PSP #	TYPE OF EDUCATIONAL MATERIAL
1	Venereal diseases, post-partum care, reproduction risks, sterilization
2	Pills, nutrition, post-partum care, reproduction risks, sterilization
3	N/A
4	N/A
5	N/A
6	N/A
7	Not specified
8	Not specified
9	N/A
10	Nutrition
11	Pregnant woman, Pro-Family calendars, family planning, vasectomy, child nutrition, cholera, post-partum care
12	Cancer, nutrition, post-partum care, IUD
13	None
14	N/A

147

ANNEX 4

OBSERVATION CHECKLIST
INTERPERSONAL COMMUNICATION

1.	ESTABLISH RAPPORT	a) YES 9	NO 5
		b) YES 8	NO 6
2.	ASK QUESTIONS	a) YES 8	NO 6
		b) YES 7	NO 7
3.	PRAISE	a) YES 3	NO 11
		b) YES 6	NO 8
4.	ENCOURAGE	a) YES 6	NO 8
		b) YES 6	NO 10
5.	ADVISE	a) YES 9	NO 5
		b) YES 7	NO 7
6.	CHECK UNDERSTANDING	a) YES 5	NO 9
		b) YES 4	NO 10
7.	REFER	a) YES 4	NO 10
		b) YES 1	NO 13

ANNEX 5

SATISFIED CLIENT

Buenos dias/buenas tardes. Me llamo --------. Estamos haciendo un estudio sobre la satisfaccion de los clientes de los PROMOTORES DE SALUD PRO-FAMILIA. Nos gustaria hacerle unas preguntas sobre su visita hace _____ dias.

La informacion que usted nos da sera de beneficio para el programa de salud comunitaria y tiene caracter confidencial.

Nombre entrevistador(a):_____

NOMBRE DEL PSP: _____
LUGAR:_____
FECHA:_____

1. EN LOS ULTIMOS 12 MESES, ¿CUANTAS VECES HA VISITADO EL PSP A SU HOGAR? @ 5
_____2. EN GENERAL, ¿COMO LE HA PARECIDO LA ATENCION DE (mention day)?

Very Good	Good	Bad	N/A
8	8	0	1

3. ¿CUAL FUE EL MOTIVO PRINCIPAL DE LA VISITA DEL PSP AQUELLA DIA?
_____
_____
4. ¿QUE DIJO
_____
_____
_____

5. ¿LE DIO ALGO?
_____
_____
_____

6. ¿QUE HIZO USTED PARA TRATAR (EL PROBLEMA)?
_____
_____
_____

6A. ¿ESTA MEJORANDO EL/LA PACIENTE?_____

6B. ¿POR QUE NO ESTA MEJORANDO?
_____
_____
6C. ¿QUE PIENSA HACER ACERCA DE ESTO?
_____

7. ¿VA A SEGUIR RECIBIENDO EL PSP?

YES	NO	N/A
16	0	1

8. ¿POR QUE PIENSA SEGUIR RECIBIENDOLE?

- Receive information on diferent health care topics.
- Get medicine and vitamins from the PSP.

9. ¿RECOMENDARIA A OTRAS PERSONAS HACER USO DE LOS SERVICIOS DEL PSP?

YES	NO	N/A
16	0	1

10. ¿POR QUE LO RECOMENDARIA?

- Avoid going to the hospital.
- It is a big help.
- Receive good health advice.
- It is very important.
- Receive family planning education.
- Have someone to talk to about problems.

11. ¿TIENE USTED ALGUNA SUGERENCIA PARA MEJORAR ESTOS SERVICIOS?

YES	NO	DON'T KNOW	N/A
3	12	1	1

12. ¿CUAL SERIA SU SUGERENCIA?

- Keep a good stock of medicine (e.g. Noristerat).
- Receive training frecquently.

GRACIAS SEÑORA, MUY AMABLE POR SU TIEMPO Y ATENCION.

150

ANNEX 6

NAME: _____ OBSERVER: _____
JOB: _____ DATE: _____
PLACE: _____

OBSERVATION CHECKLIST: GROUP TALKS

1. Knows topic YES_____NO____
2. Speaks clearly YES_____NO____
3. Speaks loudly YES_____NO____
4. Looks at people YES_____NO____
5. Is neatly dressed YES_____NO____
6. Is dynamic YES_____NO____
7. Respects ideas of others YES_____NO____
8. Asks questions YES_____NO____
9. Summarizes ideas YES_____NO____
10. Uses AV materials YES_____NO____

151

ANNEX 7

DEFINICION DE COMUNIDAD PARA LA CREACION DE PSP Y PERFIL DEL PSP

COMUNIDAD:

LOCALIDAD BASE, CUYA POBLACIÓN SEA HASTA DE 2000 HABITANTES, UBICADA EN EL ÁREA RURAL, Y QUE EN ESTE LUGAR NO EXISTAN OTRAS ONG O GUBERNAMENTALES QUE CUBRA LAS DEMANDAS DE SALUD CONTEMPLADAS EN EL PROYECTO, O QUE SE CONSIDERE QUE LAS LOCALIDADES EN MENCIÓN NO SE LES DÁ LA SUFICIENTE COBERTURA DE SALUD.

CARACTERISTICAS DE UN PSP:

-CONDICIONES DE LÍDER EN LA COMUNIDAD
-RECONOCIDO, ACEPTADO EN LA COMUNIDAD
-BUENAS RELACIONES INTERPERSONALES
-FACILIDAD DE EXPRESIÓN
-NIVEL ACADÉMICO MÍNIMO DE 3º GRADO
-CON DISPONIBILIDAD DE TIEMPO AL PROGRAMA (MÍNIMO CUATRO HORAS)
-PREFERENTEMENTE CON EXPERIENCIA EN ACTIVIDADES COMUNITARIAS Y/O PROGRAMAS DE SALUD
-ACTITUD POSITIVA EN PLANIFICACIÓN FAMILIAR
-DISPOSICIÓN PARA CUMPLIR METAS DE TRABAJO
-MAYOR DE 21 AÑOS
-QUE RESIDA EN LA COMUNIDAD BASE
-DISPOSICIÓN PARA RECIBIR PERIÓDICAMENTE ACTIVIDADES DE CAPACITACIÓN
-DISPOSICIÓN PARA REALIZAR VISITAS DOMICILIARIAS EN SU COMUNIDAD.

ANNEX 8

A.D.S.
Expansión Servicios Rurales

RESULTADOS DE ENCUESTA SOBRE CARACTERISTICAS DE LOS PROMOTORES DE SALUD PRO–FAMILIA

	Casos	Activos	Porcentaje
NUMERO DE PSP ENCUESTADOS	715	836	86

SEXO	Casos	% de la muestra
MASCULINO	93	13
FEMENINO	622	87

EDAD		
GRUPO DE 19 A 20 AÑOS	7	0.9
GRUPO DE 21 A 25 AÑOS	196	27.4
GRUPO DE 26 A 30 AÑOS	174	24.3
GRUPO DE 31 A 35 AÑOS	108	15.1
GRUPO DE 36 A 40 AÑOS	111	15.5
GRUPO DE 41 A 45 AÑOS	57	7.9
GRUPO DE 46 A 50 AÑOS	30	4.1
GRUPO DE 51 AÑOS O MAS	25	3.4
NO CONTESTARON	6	0.8

ESTADO CIVIL		
CASADOS	223	31.1
SOLTEROS	263	36.7
ACOMPAÑADOS	205	28.6
VIUDOS	20	2.7
DIVORCIADOS	3	0.4

153

NUMERO DE HIJOS

UNO	102	14.2
DOS	145	20.2
TRES	119	16.6
CUATRO	88	12.3
CINCO	53	7.4
MAS DE CINCO	87	12.1
SIN HIJOS	120	16.7

EDAD DEL ULTIMO HIJO

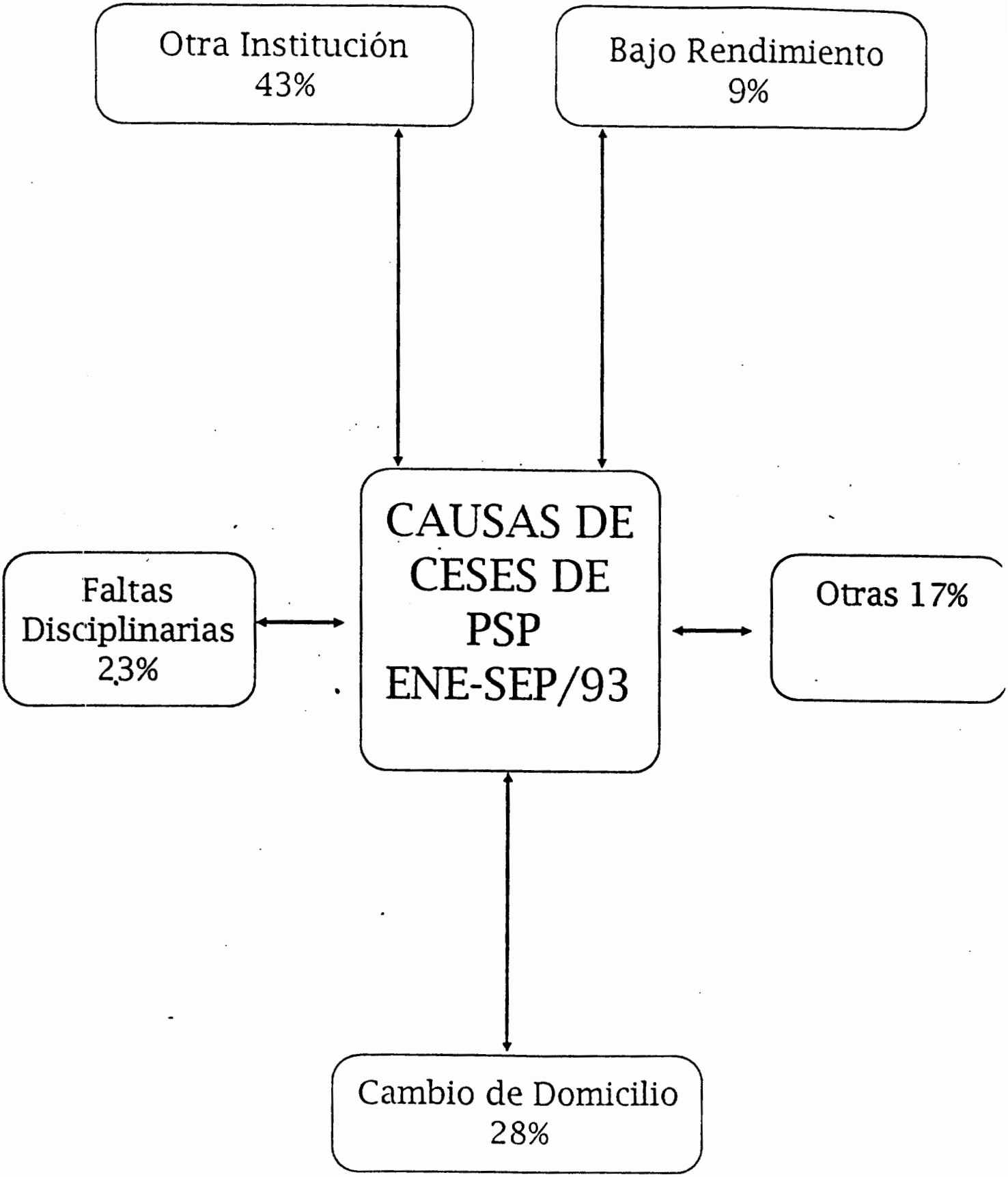
1 ANO	89	12.4
2 ANOS	79	11
3 ANOS	68	9.5
4 ANOS	57	7.9
5 ANOS	36	5
6 Ó MÁS AÑOS	264	36.9

METODO DE PLANIFICACION FAMILIAR QUE ACTUALMENTE USA

ESTERILIZACION FEMENINA	247	34.5
ESTERILIZACION MASCULINA	11	1.5
DIU	16	2.2
INYECTABLE	77	10.7
ORALES	23	3.2
CONDON	37	5.1
OTRO	30	4.1
NINGUNO	273	38

MEA/malh
11/11/93

154



Fuente: Informes Estadísticos del Programa Rural

155

ANNEX 10

NAME: _____ OBSERVER: _____
PLACE: _____ DATE: _____

CHECKLIST: PSP DAILY ACTIVITIES

1. ¿POR CUANTO TIEMPO HA SIDO USTED UN PSP?

2. ¿QUE LE GUSTA MAS ACERCA DE SU TRABAJO?

PSP NAME	QUESTION # 1	QUESTION # 2
1. Carina	3 yrs.	Meet and help people
2. Catalina	4 yrs.	Have big responsibilities and get some knowledge
3. Dolores	2 yrs.	Promote health services to the community
4. Leonor	2 yrs.	Have contact with the community
5. Izabel	2 yrs.	Have contact with people
6. Maria	3½ yrs.	Have contact with the community
7. Elma	10 mths.	Give orientation to people on health topics
8. Otilia	1½ yrs.	Provide Family Planning Education
9. Daysi	13 yrs.	Working with the community
10. Jose	2 yrs.	Provide Family Planning Education
11. Paula	6 mths.	Provide Family Planning Education and Mother/Child Care
12. Miriam	10 mths.	Meet people and provide Family Planning Education
13. Iris	4 yrs.	help and communicate with people
14. Rosa	1 yrs.	Help people

3. ¿QUE HIZO USTED HOY?

a. planeó la ruta YES 8 NO 6
b. prioritizó las visitas YES 10 NO 4
c. revisó su folder de informacion YES 7 NO 7
d. escribió en su cuaderno de campo YES 9 NO 5
e. revisó sus formularios YES 7 NO 7
f. contó la cantidad de

3. medicamentos YES 3 NO 11
4. folletos YES 4 NO 10

4. ¿QUIEN ES SU SUPERVISOR? everybody could name their supervisor

5. ¿QUE HACE DURANTE SUS VISITAS DE SUPERVISION?
A. da consejos YES 13 NO 1
B. da suministros YES 11 NO 3
C. da materiales/folletos YES 11 NO 3

Comments:
- Check if the contraceptive method used is working fine.
- Fill out the notebook and folder for each visit and keep medicines neat.
- Answer questions and give support to the community.
- Talk about problems during the home visits.

6. ¿RECOMENDARIA A OTRAS PERSONAS QUE SE HACE UN PSF? YES 14 NO 0

7. ¿POR QUE LO RECOMENDARIA?
- Learn new things.
- Help the community.
- Have good contact with people.
- Fully cover the community during home visits.

8 ¿TIENE USTED ALGUNA SUGERENCIA PARA MEJORAR LA SUPERVISION? YES 4 NO 10

9. ¿CUAL SERIA SU SUGERENCIA?
- There are a lot of benefits to the community, so it is program should continue.
- Do home visits with a nurse at least once a month.
- Increase the amount of medicine per person.
- Get lunch expenses.
- Visit twice a month instead of once.

10. ¿TIENE USTED ALGUNA SUGERENCIA PARA MEJORAR LA CAPACITACION? YES 11 NO 3

11. ¿CUAL SERIA SU SUGERENCIA?
- Give speeches concerning health topics at the schools.
- Involve the community in the vaccination and nutrition campaigns.
- Visit twice a month instead of once.
- Keep good stock of contraceptives.
- Need pamphlets for illiterate people.
- Women over 35 years old must be sterilized.
- Machismo and protestant churches are barriers to birth control methods.
- Need more training on Maternal/Child Care.
- Learn first aid.

PSP CONTRACEPTIVE SUPPLIES

PSP #	ORALES LOFEMINAL (ciclos)	INYECTABLES (unidades)	PRESERVATIVOS (unidades)
1	9	0	100
2	20	0	43
3	N/A	N/A	N/A
4	30	0	101
5	N/A	N/A	N/A
6	N/A	N/A	N/A
7	54	0	78
8	4	0	36
9	36	0	192
10	16	0	76
11	9	0	129
12	7	0	87
13	12	0	34
14	N/A	N/A	N/A
TOTAL	**197**	**0**	**876**

158

OTHER SUPPLIES

A. SALES DE HIDRATACION (sobres)
B. VITAMINAS INFANTIL
C. VITAMINAS PRENATAL
D. VITAMINAS A
E. ANTIPARASITARIO

PSP #	A	B	C	D	E
1	177	0	340	0	0
2	150	0	0	0	0
3	N/A	N/A	N/A	N/A	N/A
4	80	2	0	0	0
5	N/A	N/A	N/A	N/A	N/A
6	N/A	N/A	N/A	N/A	N/A
7	106	330	0	0	0
8	125	0	0	0	0
9	84	20	0	0	0
10	68	260	0	0	0
11	97	0	20	0	0
12	68	85	153	8	0
13	28	3	0	0	0
14	N/A	N/A	N/A	N/A	N/A
TOTAL	983	700	513	8	0

ANNEX 11

METAS PARA CADA P.S.P.

1. MANTENER UN CENSO ACTUALIZADO DE LA COMUNIDAD QUE ATIENDE.

2. MANTENER A MÁS DE 17 HOMBRES Y/O MUJERES DE SU COMUNIDAD UTILIZANDO UN MÉTODO TEMPORAL DE PLANIFICACIÓN FAMILIAR.

3. ATENDER CON SUERO ORAL, DE FORMA INMEDIATA, TODOS LOS CASOS DE DIARREA QUE SE PRESENTEN EN LA COMUNIDAD Y DE LOS CUALES SE ENTERA O SE LE COMUNICA.

4. ENTREGAR MULTIVITAMINAS PRENATALES A SEÑORAS EMBARAZADAS DE SU COMUNIDAD DE ACUERDO A LAS POLÍTICAS QUE LA INSTITUCIÓN ESTABLEZCA.

5. CONTROLAR QUE LOS NIÑOS MENORES DE 5 AÑOS DE SU COMUNIDAD TENGAN SU ESQUEMA DE VACUNACIÓN COMPLETA.

6. DAR UN MÍNIMO DE 2 CHARLAS MENSUAL EN SALUD E HIGIENE A LAS PERSONAS DE SU COMUNIDAD.

7. ENTREGAR TRATAMIENTOS ANTIPARASITARIOS A NIÑOS MENORES DE 5 AÑOS DE SU COMUNIDAD DE ACUERDO A POLÍTICAS QUE LA INSTITUCIÓN ESTABLEZCA.

8. ENTREGAR TRATAMIENTOS CON VITAMINA "A" A NIÑOS MENORES DE 5 AÑOS DE SU COMUNIDAD DE ACUERDO A POLÍTICAS QUE LA INSTITUCIÓN ESTABLEZCA.

9. ENTREGAR TRATAMIENTO CON MULTIVITAMINAS INFANTILES A NIÑOS MENORES DE 5 AÑOS DE SU COMUNIDAD DE ACUERDO A POLÍTICAS QUE LA INSTITUCIÓN ESTABLEZCA.

10. REALIZAR UN PROMEDIO DE 7 VISITAS DOMICILIARIAS, POR DÍA.

FUNCIONES DEL PROMOTOR DE SALUD PRO-FAMILIA (PSP)

TRABAJO ADMINISTRATIVO:

-ELABORAR CON LA COLABORACIÓN DEL PROMOTOR SUPERVISOR, CENSO Y CROQUIS DE LA COMUNIDAD Y ACTUALIZARLO CADA AÑO.

-LLEVAR HOJAS DE CONTROL DE PLANIFICACIÓN FAMILIAR Y SERVICIOS MATERNO INFANTIL (INVENTARIOS, ETC.).

-ELABORAR TARJETAS DE REFERENCIA A CLÍNICAS Y ESTABLECIMIENTOS DE SALUD.

-MANTENER LAS NORMAS DE ALMACENAMIENTO Y BODEGAJE DE LOS INSUMOS DEL PROGRAMA.

-ELABORAR HOJA DE CONTROL DE ACTIVIDADES REALIZADAS.

-ELABORAR REPORTE MENSUAL DE ACTIVIDADES.

ACTIVIDADES COMUNITARIAS

-PROPORCIONAR INFORMACIÓN DE LOS SERVICIOS DISPONIBLES DE PLANIFICACIÓN FAMILIAR Y SERVICIOS MATERNO INFANTIL A LA COMUNIDAD.

-INFORMAR SOBRE USO, VENTAJAS Y EFECTOS DE LOS MÉTODOS DE PLANIFICACIÓN FAMILIAR.

-PROMOVER LA PARTICIPACIÓN COMUNITARIA EN EVENTOS DE APOYO A LOS SERVICIOS DE PLANIFICACIÓN FAMILIAR Y SERVICIO MATERNO INFANTIL.

-PROMOVER EL CAMBIO DE ACTITUDES DE LA COMUNIDAD PARA LA ACEPTACIÓN DE SERVICIOS DE PLANIFICACIÓN FAMILIAR Y SERVICIOS MATERNO INFANTIL.

-PROMOVER Y MOTIVAR LA CREACIÓN DE HUERTOS CASEROS EN SU COMUNIDAD.

-IMPARTIR CHARLAS SOBRE ASPECTOS DE PLANIFICACIÓN FAMILIAR Y SALUD MATERNO INFANTIL.

-DISTRIBUCIÓN DE MATERIAL EDUCATIVO SOBRE PLANIFICACIÓN FAMILIAR Y DIFERENTES ASPECTOS DE SALUD.

ENTREGA DE SERVICIOS:

-PROPORCIONAR MÉTODOS DE PLANIFICACIÓN FAMILIAR A USUARIAS QUE VOLUNTARIAMENTE LO DEMANDEN DE ACUERDO A LAS NORMAS Y PROCEDIMIENTOS ESTABLECIDOS POR ADS.

-EFECTUAR SEGUIMIENTO A USUARIAS QUE RECIBIERON SERVICIOS DE MÉTODOS DE PLANIFICACIÓN FAMILIAR EN CLÍNICAS PRO-FAMILIA. EN CASO DE SER REQUERIDO EL MÉTODO INYECTABLE PODRÁ SER APLICADO POR EL PSP, SI LA USUARIA LO SOLICITA.

-IDENTIFICACIÓN Y REFERENCIA A LA CLÍNICAS DE USUARIAS DE PLANIFICACIÓN FAMILIAR.

-IDENTIFICAR Y REFERIR A ESTABLECIMIENTOS DE SALUD MÁS CERCANO, MÉDICOS DE REFERENCIA Y SERVICIOS DE ADS DE USUARIAS QUE REQUIERAN ATENCIÓN MATERNO INFANTIL A OTRO NIVEL.

-COLABORAR CON EL PROMOTOR Y AUXILIAR DE ENFERMERÍA LAS DIFERENTES ACTIVIDADES RELACIONADAS CON EL PROGRAMA (CAMPAÑAS DE VACUNACIÓN, DESPARASITACIÓN, S.R.O. Y OTROS).

REALIZAR VISITAS DOMICILIARIAS PARA CAPTAR A NUEVAS USUARIAS Y MANTENER ACTIVAS A LAS SUBSECUENTES EN LOS SERVICIOS DE PLANIFICACIÓN FAMILIAR Y SALUD MATERNO INFANTIL.

ANNEX 12

1991

	PTP	REAL	%
. Años Protección Pareja	7,200	8,100	113
. Referencias para vacunación	1,500	4,079	272
. Actividades de información en salud e higiene	300	2,480	826
. Referencias para métodos permanentes	4,500	2,640	59
. Casos de diarrea tratados con SRO	10,000	2,311	23
. Referencias casos de IRA	8,000	1,873	23
. Tratamientos con multivitaminas infantiles	22,000	4,602	21
. Distribución de multivimínas prenatales	500,000	29,970	6
. Tratamientos antiparasitarios	10,000	0	0
. Distribución de perlas de vitamina "A"	10,000	0	0
. Organizar el desarrollo de huertos caseros en 30 comunidades	750	0	0

1992

	PTP	REAL	%
- Total APP (*)	7,796	11,918	153
- Distribución de T.O. (ciclos)	93,600	101,840	109
- Distribución de condones (unidades)	81,000	172,631	213
- Distribución de inyectables (Unids.)	5,940	23,340	393
- Tratar casos diarrea	100,000	30,032	30
- Entregar sobres de SRO	200,000	59,644	30
- Tratamientos antiparasitarios	135,000	87,183	65
- Perlas Vit. "A"	135,000	87,117	65
- Vitaminas infantiles	2,430,000	1,694,741	70
- Vitaminas prenatales	1,944,000	1,058,063	54
- Referencias IRA	24,000	24,741	103
- Referencias Vacunación	44,000	42,893	97
- Casos referidos a médico	6,500	8,508	131
- Entrevistas	590,000	692,440	117
- Charlas	10,800	12,065	112
- Huertos Caseros	300	0	0
- Comunidades con Huertos Caseros	20	0	0
- Médicos de Referencia funcionando	20	39	125
- PSP funcionando	600	592	99
- DAR funcionando	400	375	94

1993

	PTP	REAL	LOGROS %
- APP	22,464	23,073	103
- Ciclos de T. O.	165,000	143,700	87
- Condones	255,000	283,093	111
- Inyectables	47,480	59,601	126
- Niños c/Diarrea Trat. p/la vez	47,000	57,747	123
- Dist. de Tab. Antip.	1.284,000	1.387,903	108
- No. Niños trat. c/perla "A"	264,000	114,938	44
- No.Niños trat. c/Multv. Inf.	39,000	45,239	116
- Dist. Tab. Multiv. Inf.	5,000,000	5.585,608	112
- Núm. de Muj.trat. c/vit. Prenatal	19,500	21,351	109
- Dist. Tab. Vit.PrenataL	2,690,800	2,761,335	103
- Act. de Inf. en Salud e Higiene	14,600	15,534	106
- Casos de IRA	66,000	42,165	64
- Niños p/Vacunación	60,000	71,722	120
- Casos p/consulta a Méd.	18,200	18,477	102
- Médicos de Refer.Financ.	50	49	98
- PSP Funcionando	960	892	93
- DAR funcionando	400	484	121

ANNEX 13

NAME: _____

JOB: _____

PLACE: _____

OBSERVATION CHECKLIST
INTERPERSONAL COMMUNICATION

1. ESTABLISH RAPPORT YES_____NO_____

2. ASK QUESTIONS YES_____NO_____

3. PRAISE YES_____NO_____

4. ENCOURAGE YES_____NO_____

5. ADVISE YES_____NO_____

6. CHECK UNDERSTANDING YES_____NO_____

7. REFER YES_____NO_____

OBSERVER: _____

DATE: _____

PSP PROFILES

1. During the first home visit, the PSP provided family planning education. She explained female sterilization, when it is good to have it and its advantages. She also talked about cancer of the reproductive organs. EPI was applicable for children under 5 but there was no pregnant woman. There were identified children with no vaccinations and incomplete vaccination (e.g. BCG). Also, ARI as well as Diarrhea were applicable. The Nutrition and Growth Monitoring was applicable for children under 5 who were advised.
   Comments: The nurse used pamphlets and showed the woman what a sterilization is with a demonstration.
   Satisfied Client Comments: The client said the purpose of the PSP visit was to give information of female sterilization. She advised her not to eat anything before the surgery and to forget obout getting pregnant again. She also gave her pamphlets of how the matrix looks 40 days after giving birth, cancer, and special care after sterilization takes place. The client has already decided to be sterilized.

   During the second home visit, the PSP provided family planning education. She explained the use of pills, their contraindications and possible side effects. The person said she used injectables in the past but it was too strong for her. EPI was applicable for children under 5 but there was no pregnant woman. ARI and Diarrhea were not applicable in this case nor The Nutrition and Growth Monitoring.
   Comments: she encouraged her to have a cancer control test.
   Satisfied Client Comments: The client said the purpose of the PSP visit was to give her family planning education. In the past, she used injectable but now she uses pills and will continue using them.

2. During the first home visit, the PSP did not provide family planning education. The Nutrition and Growth Monitoring was applicable for children under 5 who were advised. she gave information on parasites and how to prevent them (e.g. children must wear clothes).
   Satisfied Client Comments: The client did not know the purpose of the PSP visit, but she talked about house hygiene and family planning education. She said the PSP usually gives her contraceptive pills. she will continue taking pills and will try to bury the garbage.

165

During the third home visit, the PSP provided family planning education. She explained the use of pills, their contraindications and possible side effects. She provided information on the use of condoms. She explained female sterilization and vasectomy and when it is good to have one. She identified children with no vaccinations. ARI and Diarrhea were not applicable in this case. The Nutrition and Growth Monitoring was applicable for children under 5 who were weighed and measured. Vitamins and advice were provided. Also, a mother with a weaning child was observed who received information on child care.
Satisfied Client Comments: The client said the purpose of the PSP's visit to provide family planning education and vaccination. She will follow her advice.

10. During the first home visit, the PSP provided family planning education. The person was already using pills and has no problems. EPI,ARI and the Nutrition and Growth Monitoring were not applicable in this case. She provided information on preventive Diarrhea which was applicable in this case.
Comments: The PSP explained how flies contaminate food. Also, she advised her to put chloro in water. She mentioned the signs of dehydratation.
Satisfied Client Comments: The client said the purpose of the PSP's visit was to provide family planning education and environmental hygiene. She was advised to clean everything to avoid diseases.

11. During the first home visit, the PSP provided family planning education. The person said she will take contraceptive pills until she gets sterilized. The PSP explained when it is good to have it and gave her some advice. She was well supplied with pamphlets. EPI, ARI, Diarrhea and the Nutrition and Growth Monitoring were not applicable in this case.
Satisfied Client Comments: The client said the purpose of the PSP visit was to provide family planning eduction. She gave her a referral card in case she decides to be sterilized.

During the second home visit, the PSP provided family planning education and explained the use of condoms and gave her some samples. She explained female sterilization and when it is good to have it and she showed her a pamphlet. She explained that after 35 years old it is recommended to quit using pills and change to another method (condoms were recommended). EPI, ARI, Diarrhea were not applicable in this case nor the Nutrition and Growth Monitoring.

Comments: The PSP used her catalog and pamphlets to show the place where sterilization takes place. Since the person had a problem with her stomach or uterus, the PSP recommended not to have sex for 15 days so as not to get an infection. The person said she got a cytology test.
Satisfied Client Comments: the client said the purpose of the PSP's visit to provide information on sterilization. She advised her to be checked by a doctor and should not have sex until she got her next period.
NOTE: The PSP forgot to tell the woman to fast before the sterilization, wash, etc. The auxiliary nurse, her supervisor gave this information.

12. She did not do home visits because she was sick.

13. N/A

14. N/A

ANNEX 15

Buenos dias/buenas tardes. Me llamo --------. Estamos haciendo un estudio sobre la satisfaccion de los clientes de los PROMOTORES DE SALUD PRO-FAMILIA. Nos gustaria hacerle unas preguntas sobre su visita el dia de hoy.

La informacion que usted nos da sera de beneficio para el programa de salud comunitaria y tiene caracter confidencial.

Nombre entrevistador(a):_____

NOMBRE DEL PSP: _____
LUGAR:_____
FECHA:_____

1. EN LOS ULTIMOS 12 MESES, ¿CUANTAS VECES HA VISITADO EL PSP A SU HOGAR?
_____2. EN GENERAL, ¿COMO LE HA PARECIDO LA ATENCION DE ESTA DIA?
_____

3. ¿CUAL FUE EL MOTIVO PRINCIPAL DE LA VISITA DEL PSP HOY?
_____
_____

4. ¿QUE DIJO
_____
_____
_____

5. ¿LE DIO ALGO?
_____
_____
_____

6. ¿QUE HARA EN EL PROXIMO FUTURO PARA TRATAR (EL PROBLEMA)?
_____
_____
_____

7. ¿VA A SEGUIR RECIBIENDO EL PSP?
_____

8. ¿POR QUE NO PIENSA SEGUIR RECIBIENDOLE?
_____
_____

9. ¿RECOMENDARIA A OTRAS PERSONAS HACER USO DE LOS SERVICIOS DEL PSP?
_____

10. ¿POR QUE NO LO RECOMENDARIA?
_____
_____

11. ¿TIENE USTED ALGUNA SUGERENCIA PARA MEJORAR ESTOS SERVICIOS?
_____

12. ¿CUAL SERIA SU SUGERENCIA?
_____ _____
_____
_____

168

During the third home visit, the PSP provided family planning education. She explained the use of pills, their contraindications and possible side effects. She provided information on the use of condoms. She explained female sterilization and vasectomy and when it is good to have one. She identified children with no vaccinations. ARI and Diarrhea were not applicable in this case. The Nutrition and Growth Monitoring was applicable for children under 5 who were weighed and measured. Vitamins and advice were provided. Also, a mother with a weaning child was observed who received information on child care.
Satisfied Client Comments: The client said the purpose of the PSP's visit to provide family planning education and vaccination. She will follow her advice.

10. During the first home visit, the PSP provided family planning education. The person was already using pills and has no problems. EPI,ARI and the Nutrition and Growth Monitoring were not applicable in this case. She provided information on preventive Diarrhea which was applicable in this case.
Comments: The PSP explained how flies contaminate food. Also, she advised her to put chloro in water. She mentioned the signs of dehydratation.
Satisfied Client Comments: The client said the purpose of the PSP's visit was to provide family planning education and environmental hygiene. She was advised to clean everything to avoid diseases.

11. During the first home visit, the PSP provided family planning education. The person said she will take contraceptive pills until she gets sterilized. The PSP explained when it is good to have it and gave her some advice. She was well supplied with pamphlets. EPI, ARI, Diarrhea and the Nutrition and Growth Monitoring were not applicable in this case.
Satisfied Client Comments: The client said the purpose of the PSP visit was to provide family planning eduction. She gave her a referral card in case she decides to be sterilized.

During the second home visit, the PSP provided family planning education and explained the use of condoms and gave her some samples. She explained female sterilization and when it is good to have it and she showed her a pamphlet. She explained that after 35 years old it is recommended to quit using pills and change to another method (condoms were recommended). EPI, ARI, Diarrhea were not applicable in this case nor the Nutrition and Growth Monitoring.

Comments: The PSP used her catalog and pamphlets to show the place where sterilization takes place. Since the person had a problem with her stomach or uterus, the PSP recommended not to have sex for 15 days so as not to get an infection. The person said she got a cytology test.
Satisfied Client Comments: the client said the purpose of the PSP's visit to provide information on sterilization. She advised her to be checked by a doctor and should not have sex until she got her next period.
NOTE: The PSP forgot to tell the woman to fast before the sterilization, wash, etc. The auxiliary nurse, her supervisor gave this information.

12. She did not do home visits because she was sick.

13. N/A

14. N/A

ANNEX 15

Buenos dias/buenas tardes. Me llamo --------. Estamos haciendo un estudio sobre la satisfaccion de los clientes de los PROMOTORES DE SALUD PRO-FAMILIA. Nos gustaria hacerle unas preguntas sobre su visita el dia de hoy.

La informacion que usted nos da sera de beneficio para el programa de salud comunitaria y tiene caracter confidencial.

Nombre entrevistador(a):_____

NOMBRE DEL PSP: _____
LUGAR:_____
FECHA:_____

1. EN LOS ULTIMOS 12 MESES, ¿CUANTAS VECES HA VISITADO EL PSP A SU HOGAR?
_____2. EN GENERAL, ¿COMO LE HA PARECIDO LA ATENCION DE ESTA DIA?
_____

3. ¿CUAL FUE EL MOTIVO PRINCIPAL DE LA VISITA DEL PSP HOY?
_____
_____

4. ¿QUE DIJO
_____
_____
_____

5. ¿LE DIO ALGO?
_____
_____
_____

6. ¿QUE HARA EN EL PROXIMO FUTURO PARA TRATAR (EL PROBLEMA)?
_____
_____
_____

7. ¿VA A SEGUIR RECIBIENDO EL PSP?
_____

8. ¿POR QUE NO PIENSA SEGUIR RECIBIENDOLE?
_____
_____

9. ¿RECOMENDARIA A OTRAS PERSONAS HACER USO DE LOS SERVICIOS DEL PSP?
_____

10. ¿POR QUE NO LO RECOMENDARIA?
_____
_____

11. ¿TIENE USTED ALGUNA SUGERENCIA PARA MEJORAR ESTOS SERVICIOS?
_____

12. ¿CUAL SERIA SU SUGERENCIA?
_____
_____
_____

ANNEX 16

NAME: Lic Dolores Reyes OBSERVER: M. Gutierrez
JOB: PJP DATE: Mayo 24/94
PLACE: San Fan Buenos Aires

OBSERVATION CHECKLIST: GROUP TALKS

1. Knows topic YES X NO ____
2. Speaks clearly YES X NO ____
3. Speaks loudly YES ____ NO X
4. Looks at people YES X NO ____
5. Is neatly dressed YES X NO ____
6. Is dynamic YES X NO ____
7. Respects ideas of others YES ____ NO ____ ?
8. Asks questions YES X NO ____
9. Summarizes ideas YES ____ NO X
10. Uses AV materials YES ____ NO X

ANNEX 17

TRAINING COURSE

1. How were you invited to attend the course?

2. When you were invited to go to the course, do you think the information given was sufficient and clear or you need more explanation?

RESPONDENT #	QUESTION # 1	QUESTION # 2
1	-A MSP visited. -An ADS supervisory team visited.	-Told me there would be many subjects to learn. -Ask if I were free to come. -Said I would learn all about PF methods; how to give injections and prescribe pills. -On return, I would be responsible to visit community and explain things like how to take medicines.
2	-Regional Director (Sr. Murillo) came to my house.	-He said I would get housing and food. Explained what it was to be a PSP, have ORS and go to visit houses. I would get paid.
3	-A PSP supervisor came to my house. He knew that my brother-in-law was a PSP. -A nurse came to tell me that the course would be in San Salvador and/or San Miguel.	-Talked of work. We would take a census, have 17 users, etc. Didn't mention benefits of being a PSP.

4	-The PSP in my canton will move. I will replace him.	-Good orientation to the training course. Resp. of the PSP: 1)census 2)give talks on FP and other topics 3)responsibilities: work 4hrs/day, get 460c/mo. Don't give benefits. -My contract is for 1 yr. After I may be a promoter for the MSP.

3. How many days before the course started were you invited?

4. What did motivate you to attend the PSP course?

5. Before you became a PSP, were you a DAR?

RESP. #	QUESTION # 3	QUESTION # 4	QUESTION # 5
1	2 months	-Serve the community. -Although the local priest said PF is bad, I wanted to come.	NO
2	2 weeks	-Serve the community. -With the money, I can send my kids to school.	NO
3	1 month	-Learn how to live better. -Begin a new life. -Learn to help community.	NO
4	4 days before (hard to get baby-sitter)	-FP is very important and wanted to bring it to my community.	NO

6. What else do you do besides the job you do as a PSP? (specify whether it is inside or outside of the house)

7. Does anyone from your family help you to ~~get~~ meet the program's goals?

8. Who helps you?

RESP. #	QUESTION # 6	QUESTION # 7	QUESTION # 8
1	I sew	-Yes. -Father, he took the course, but doesn't like the work. -Brother.	Will deliver medicine and pills.
2	No, I have 4 kids and the money helps	No	
3	Sew	-Yes -Mother	She'll baby-sit
4	Sew in a factory. Make and sell cheese	No	

COMMENTS ON TRAINING:

1. I like the training
   -How to give medicine to children
   -How to avoid pregnancies
   -Many teachers
   -Good food

2. It's lovely -I'm learning things I didn't know about FP. There are many ways to avoid pregnancy. I can ask for explanations.

3. Taught us how to satisfy the needs of the community with regard to FP/MI prevention. We will form a committee to do a community census. Need more time. Another week.

4. I like the course, especially the topics FP, diarrhea, ARI. Everything is good.

PRO-FAMILIA

ANNEX 18

ASOCIACION DEMOGRAFICA SALVADOREÑA
Expansión de Servicios Rurales

I N V I T A C I O N

Señor (a):

_____

_____

Presente

En nombre de la Asociación Demográfica Salvadoreña, le estamos invitando a participar a la Jornada de Capacitación, con el objeto de actualizar y ampliar sus conocimientos sobre Planificación Familiar y Salud Materno infantil; para que usted desarrolle sus actividades como _____.

Dicho evento se llevará a cabo los días:
_____ al _____ de_____ de 199___ en el local de _____
Se han hecho arreglos para su alojamiento en:

_____

por lo que solicitamos su confirmación con el Promotor Supervisor respectivo.

La asistencia a esta capacitación es necesaria para que usted adquiera los conocimientos básicos del Programa y oriente adecuadamente a sus usuarios.

Rogamos su puntual asistencia

Atentamente,

_____ _____
Promotor Supervisor Supervisor Regional

29/09/93

176

ANNEX 19

CARTA CONVENIO DE COLABORACION VOLUNTARIA ENTRE ASOCIACION DEMOGRAFICA SALVADOREÑA Y PROMOTORES DE SALUD PRO-FAMILIA

I. _____

_____

_____, *con el fin de mejorar la salud de los habitantes de su comunidad, se compromete a realizar las siguientes actividades:*

1. *Actividades comunitarias y/o de salud*

2. *Visitas domiciliarias con mensajes de Planificación Familiar y Salud Materno Infantil*

3. *Capacitación, asistirá a todo evento educativo que el Programa indique y también planificará charlas dentro de su comunidad.*

4. *Entregará informes a los Promotores Supervisores de acuerdo a la programación que cada uno de ellos designe. Para poder realizar, el PSP dedicará cuatro horas diarias al Programa, estas actividades serán supervisadas por la Asociación Demográfica Salvadoreña.*

II. La Asociación Demográfica Salvadoreña, a través de su Programa de Servicios Rurales, se compromete a capacitarlo para que pueda cumplir con sus actividades, así como apoyarlo por medio de visitas que le hará cada cierto tiempo su personal, en las cuales se verificará su labor y se le proveerá de medicamentos, papelería y otros insumos propios del Programa.

III. La Asociación Demográfica Salvadoreña, como un reconocimiento a las actividades que efectúa en bien de su comunidad, otorgará una bonificación mensual de CUATROCIENTOS SESENTA COLONES EXACTOS (¢460.oo), que le será entregada mensualmente hasta que finalice este convenio.

IV. Este convenio podrá darse por terminado, cuando una de las partes lo considere conveniente; para lo cual se requerirá una comunicación escrita con quince días de anticipación.

V. Este convenio se iniciará a partir del _____ de mil novecientos noventa y cuatro y durará hasta el 31 de diciembre de mil novecientos noventa y cuatro. Pero podrá continuarse año con año a partir de esa fecha, siempre que ninguna de las dos partes comunique lo contrario por escrito, antes del 15 de diciembre de cada año.

VI. Este convenio se prorrogará anualmente y tendrá una duración máxima hasta el 30 de julio de mil novecientos noventa y cinco.

Para dejar constancia de la aceptación de este convenio, lo firmamos en _____, el _____ de mil novecientos noventa y cuatro.

f: _____
Gerente del Programa

f: _____
Supervisor Regional

f: _____
Promotor Supervisor

f: _____
Promotor Salud Pro-Familia

EJERCICIO "SILUETA"

TEMA: CONTRAINDICACIONES PARA EL USO DE LA PÍLDORA ANTICONCEPTIVA

PROPOSITO:

Enseñar a los participantes cuales son las contraindicaciones para el uso de la Píldora.

OBJETIVO DE APRENDIZAJE:

Los participantes serán capaces de:

- Reconocer todas las contraindicaciones para el uso de la píldora según normas programáticas.

TIEMPO: 45'

PREPARACION PREVIA:

Recorte un pedazo de cartulina o cartón de 80 x 35 cms. y allí dibuje el cuerpo de una mujer. (Como el que aparece en el ejemplo).

Elabore círculos de dos cms. de diámetro, de color azul.

PROCEDIMIENTO:

1. Inicie explicando lo que es una contraindicación y por qué se deben tomar en cuenta antes de darle la píldora a una señora.

2. Coloque el dibujo al frente, en un lugar visible para todos.

3. Explique una por una las contraindicaciones y conforme las explique coloque un círculo en el lugar del cuerpo de la mujer (dibujo). Empiece explicando las de la cabeza , el pecho y así sucesivamente.

4. Cuide de que cada contraindicación quede suficientemente clara para los participantes.

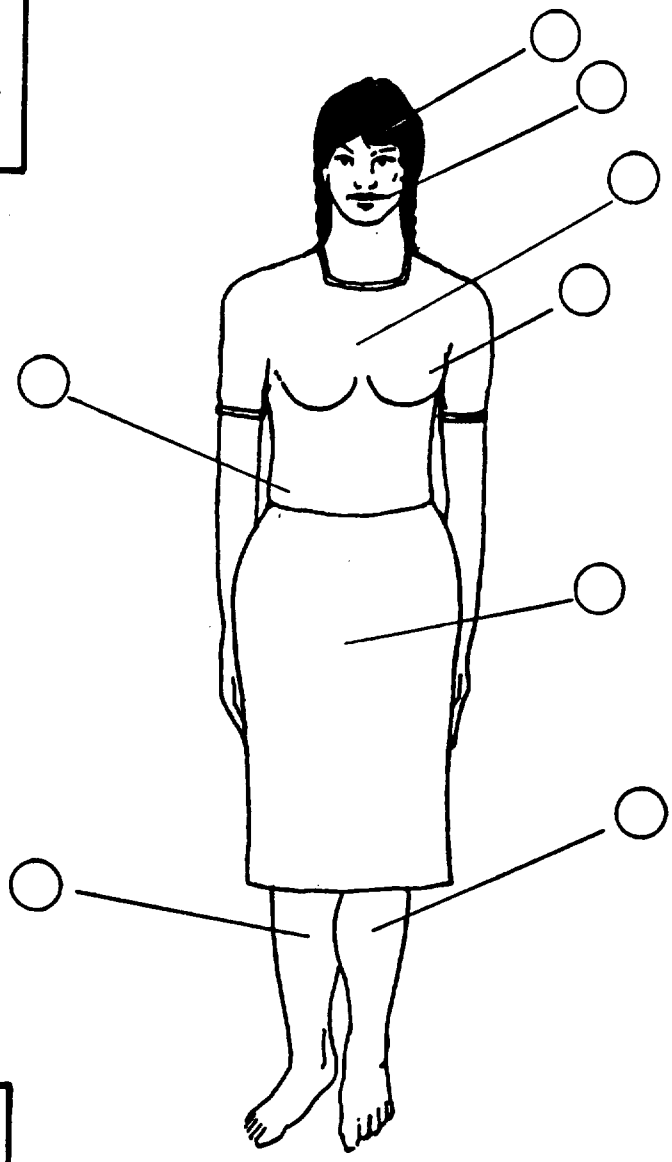
EVALUE EL APRENDIZAJE:

5. Dejando los círculos pegados en la silueta, pida a los participantes que cada uno piense en algún problema médico que haya tenido o que tiene algún amigo o familiar. No deben comentar el problema con otros. Puede ser una contraindicación o cualquier otro problema de salud. Luego, solicite a un voluntario que informe al grupo de su problema. Pida otro voluntario para decir si el problema es una contraindicación del uso de la píldora o no. Si es, debería pasar al frente y señalar al grupo, el círculo azul en la silueta que representa este problema.

6. Continúe el ejercicio pidiendo que el voluntario que acaba de dar respuesta, informe sobre el problema médico que él ha escogido.

7. Pida otro voluntario para dar respuesta y así sucesivamente hasta que todos hayan tenido la oportunidad de presentar un problema y dar respuesta al problema presentado por otro.

8. Si el grupo es grande, se puede hacer el ejercicio por subgrupos de 8 a 10 personas.



ANNEX 21

FUNCIONES DEL DISTRIBUIDOR DE ANTICONCEPTIVOS RURAL (DAR)

1. Proporcionar información de los servicios disponibles de Planificación Familiar a la Comunidad
2. Informar sobre uso,ventajas y efectos de los Métodos de Planificación Familiar.
3. Proporcionar Métodos de Planificación Familiar a usuarias que voluntariamente lo demanden de acuerdo a las normas y procedimientos establecidos por ADS.
4. Llevar hojas de control de Planificación Familiar (inventarios y entrega de productos a usuarias)
5. Mantener las normas de almacenamiento y bodegaje de los insumos del Programa.
6. Efectuar seguimiento a usuarias que recibieron Métodos de Planificación Familiar en las Clínicas Pro-Familia, en caso de ser requerido el Método Inyectable, podrá ser aplicado por el DAR, si la usuaria lo solicita
7. Promover el cambio de actitudes de la comunidad para la aceptación de los servicios de Planificación Familiar.
8. Identificación y referencias de usuarias de Planificación Familiar a las Clínicas Pro-Familia.
9. Distribuir material educativo sobre Planificación Familiar
10. Elaborar tarjetas de referencia a clínicas y establecimientos de salud.
11. Promover la participación comunitaria en eventos de apoyo a los servicios de Planificación Familiar
12. Colaborar con el personal de promoción de ADS en las diferentes actividades relacionadas con el progama (charlas, etc.)

182

ANNEX 22

NAME: _____ OBSERVER: _____
PLACE: _____ DATE: _____

CHECKLIST: DAR DAILY ACTIVITIES

1. ¿POR CUANTO TIEMPO HA SIDO USTED UN DAR?

2. ¿QUE LE GUSTA MAS ACERCA DE SU TRABAJO?

DAR NAME	QUESTION # 1	QUESTION # 2
1. Sonia	6 yrs.	Being in contact with the neighbors.
2. Cayetana	25 yrs.	Talking to people.
3. Rosa	14 yrs.	Cooperating with the community.

3. ¿QUE HIZO USTED HOY?
   a. planeó la ruta YES 0 NO 3
   b. prioritizó las visitas YES 0 NO 3
   c. revisó su folder de informacion YES 1 NO 2
   d. escribió en su cuaderno de campo YES 0 NO 3
   e. revisó sus formularios YES 0 NO 3
   f. contó la cantidad de
      1. vitaminas YES 1 NO 2
      2. anticonceptivos YES 1 NO 2
      3. medicamentos YES 1 NO 2
      4. folletos YES 1 NO 2

4. ¿QUIEN ES SU SUPERVISOR? all knew who their supervisor was

5. ¿QUE HACE DURANTE SUS VISITAS DE SUPERVISION?

   A. da consejos YES 3 NO 0
   B. da suministros YES 3 NO 0
   C. da materiales/folletos YES 2 NO 1

6. ¿RECOMENDARIA A OTRAS PERSONAS QUE SE HACE UN DAR? YES 2 NO 1

7. ¿POR QUE NO LO RECOMENDARIA?

   - Not everyone is sincere.
   - Some people like to waste time.

8. ¿TIENE USTED ALGUNA SUGERENCIA PARA MEJORAR LA SUPERVISION? YES 0 NO 3

9. ¿CUAL SERIA SU SUGERENCIA?

   - Improve the lack of "Noristerat"

10. ¿TIENE USTED ALGUNA SUGERENCIA PARA MEJORAR LA CAPACITACION? YES 0 NO 3

11. ¿CUAL SERIA SU SUGERENCIA?

- Get references from the health centers of the MSP.
- Increase the number of DAR's and PSP's to fully cover the community.
- Make reference cards for ADS.

USTED ES MUY AMABLE. GRACIAS POR SU TIEMPO Y ATENCION.

ANNEX 23

MECANISMOS DE ENLACE CON A.D.S.

CANALES DE COMUNICACIÓN:

1. PROMOTOR SUPERVISOR: ES LA PERSONA QUE PERIÓDICAMENTE ESTARÁ EN CONTACTO CON EL PSP Y A QUIÉN EL PSP BUSCARÁ EN SU REGIÓN CUANDO NECESITE UNA ATENCIÓN RELACIONADA CON SU TRABAJO.

2. AUXILIAR DE ENFERMERÍA: ES LA PERSONA QUE SIRVE DE APOYO EN LO RELATIVO A NORMAS Y PROCEDIMIENTOS EN LA ATENCIÓN DE USUARIAS.

3. SUPERVISOR REGIONAL: ES LA PERSONA QUE EN FORMA PERIÓDICA VISITA AL PSP PARA VALORAR SU TRABAJO, TAMBIÉN SIRVE DE APOYO A LA ACTIVIDADES DEL PROMOTOR SUPERVISOR Y AUXILIAR DE ENFERMERÍA.

4. GERENTE Y/O ASISTENTE DE GERENCIA: PERIÓDICAMENTE VISITARÁ AL PSP PARA VALORAR SUS ACTIVIDADES, LIMITACIONES Y ALCANCES REALIZADOS.

5. ASISTENCIA TÉCNICA: PERIÓDICAMENTE UNA PERSONA DE LA ASISTENCIA TÉCNICA, QUE TAMBIÉN SE IDENTIFICARÁ COMO MONITOR, VISITARÁ A LOS PSP PARA VALORAR CÓMO SE ESTAN DESARROLLANDO EN SUS ACTIVIDADES LOS PSP.

6. MÉDICOS DE REFERENCIA: EN CIUDADES IMPORTANTES DEL PAÍS, ESTARÁN DANDO SUS SERVICIOS, MÉDICOS QUE ATENDERÁN A PERSONAS QUE LOS PSP REFIERAN POR CONSULTAS DE GINECOLOGÍA, PEDIATRÍA, PLANIFICACIÓN FAMILIAR Y PRENATAL.
CADA MÉDICO DE REFERENCIA, ATENDERÁ LAS REFRENCIAS DE VARIOS PSP QUE SE ENCUENTRAN EN ZONAS ALEDAÑAS.

7. SUPERVISOR CAPACITADOR — ESTA PERSONA VISITARÁ A LOS PSP PARA DARLES AYUDA SOBRE ASPECTOS EDUCATIVOS

8. ENFERMERA CLÍNICA: — ES LA PERSONA QUE SIRVE DE APOYO EN LO RELATIVO A LA ATENCION DE USUARIAS DE MÉTODOS TEMPORALES Y QUIRÚRGICOS Y QUE AMERITAN ATENCIÓN EN CLÍNICA.

9. SECRETARIA: — EN LA PERSONA QUE SIRVE DE APOYO EN ACTIVIDADES SECRETARIALES DEL PROGRAMA, Y A TRAVÉS DE QUIÉN, EL PSP PUEDE SOLICITAR UNA ATENCIÓN O VISITA DEL PROMOTOR -SUPERVISOR, AUXILIAR DE ENFERMERÍA O SUPERVISOR REGIONAL.

CUANDO UN PSP SOLICITE UNA ATENCIÓN EN CLÍNICA COMO CONSULTA GINECOLÓGICA, DE PLANIFICACIÓN FAMILIAR O PRENATAL PARA ÉL, DEBERÁ IDENTIFICARSE COMO PSP CON LA ENFERMERA DE CLÍNICA PARA PROPORCIONARLE UNA ATENCIÓN MÁS RÁPIDA.

"MOTIVOS POR EL CUAL SE PUEDE SUSPENDER A UN P.S.P."

*CUANDO A PESAR DE HABER RECIBIDO LOS MÓDULOS DE CAPACITACIÓN RESPECTIVOS, EL PSP NO CUMPLA CON LAS NORMAS Y PROCEDIMIENTOS DE LA ADS.

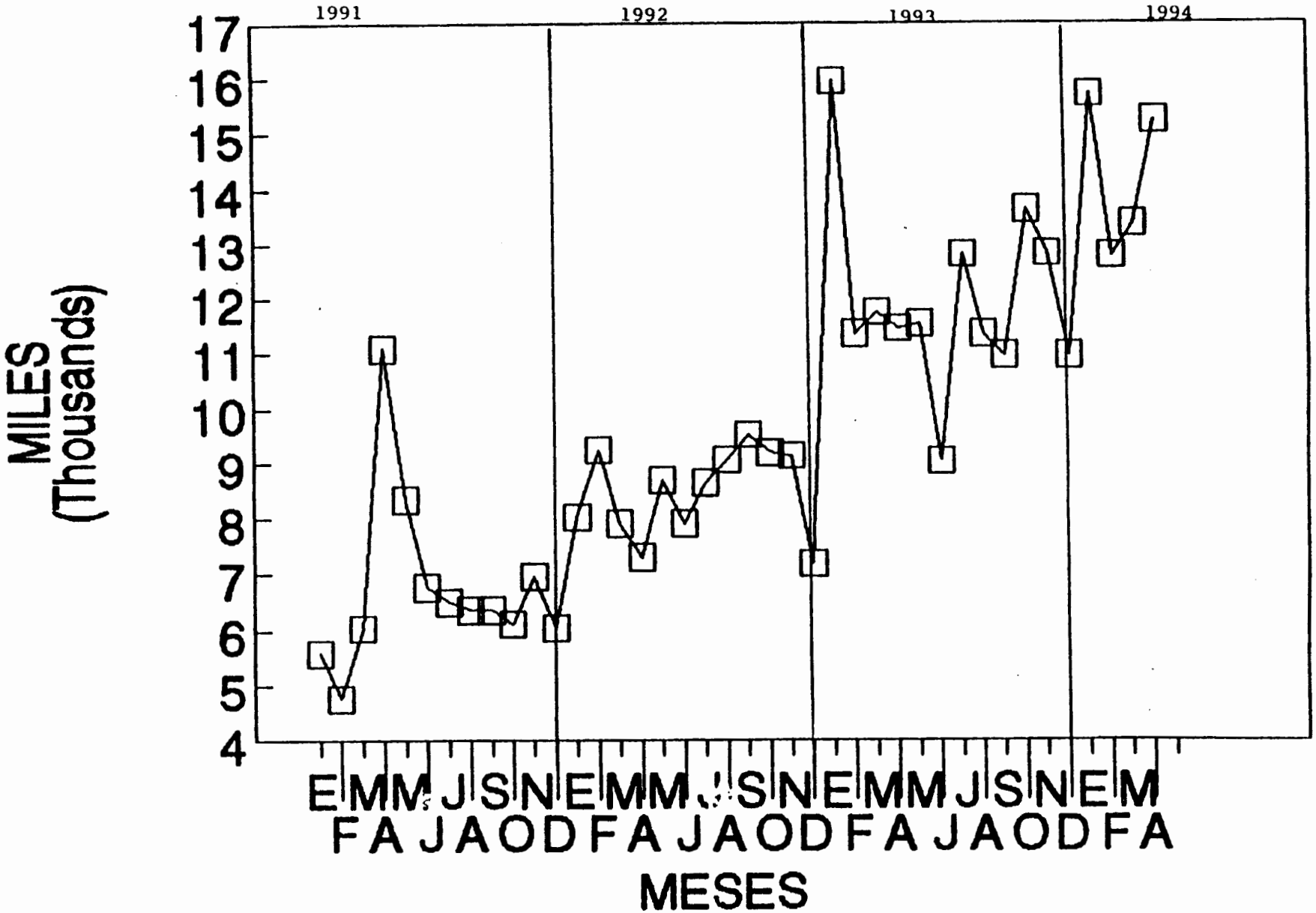
*CUANDO UN PSP CAMBIE DE DOCIMICILIO.

*CUANDO UN PSP NO CUMPLA CON LAS METAS ESPERADAS DE ÉL.

*CUANDO EL PSP NO ESTÉ ACORDE CON EL PERFIL DE DESEMPEÑO REQUERIDO.

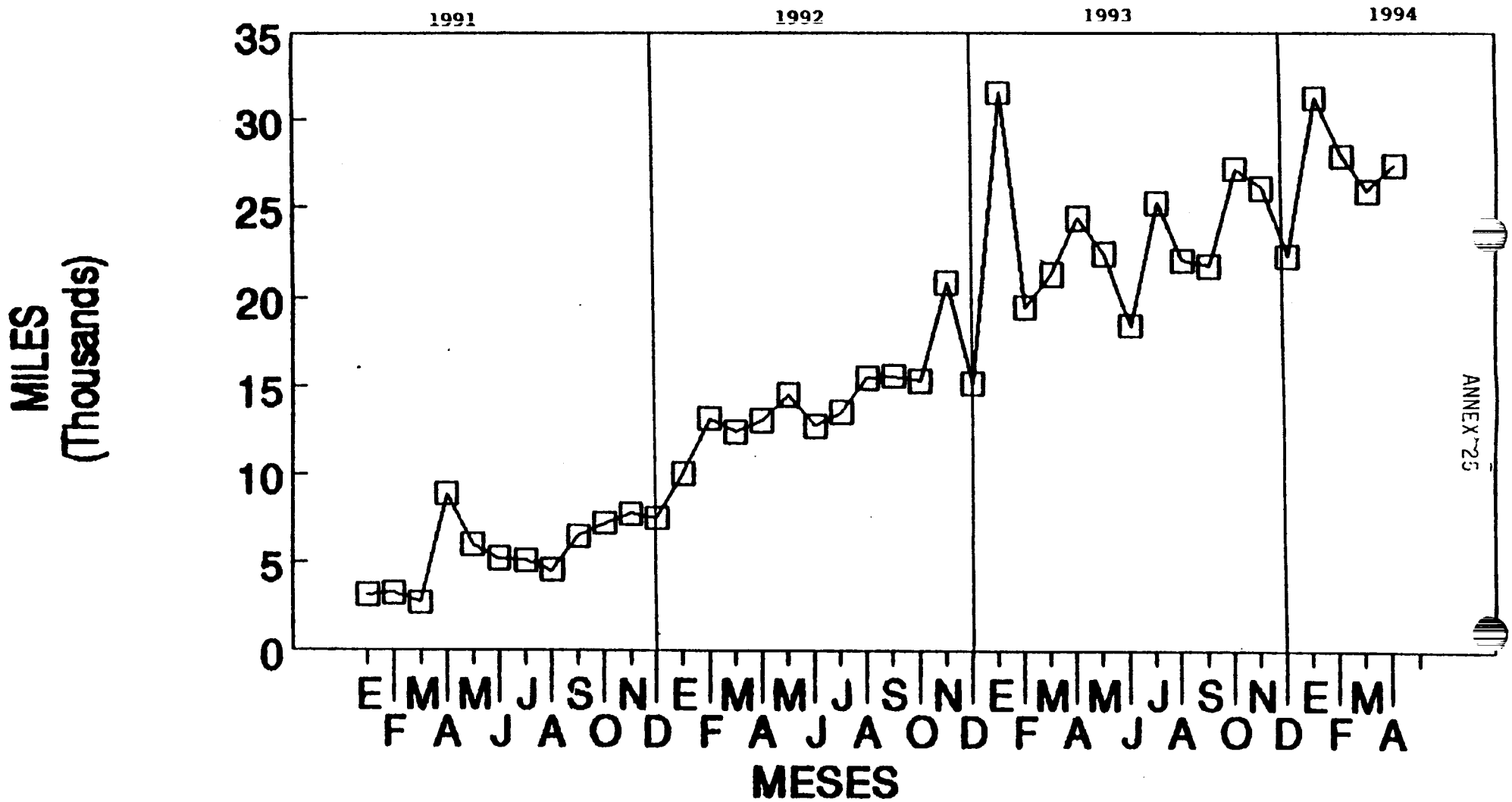
*CUANDO UN PSP ALTERE LOS PRECIOS DE VENTA DE LOS PRODUCTOS ANTI-CONCEPTIVOS ESTABLECIDOS POR LA INSTITUCIÓN.

DISTRIBUCION DE LOFEMENAL A USUARIOS PROGRAMA DE SALUR RURAL 1991 ABRIL 1994



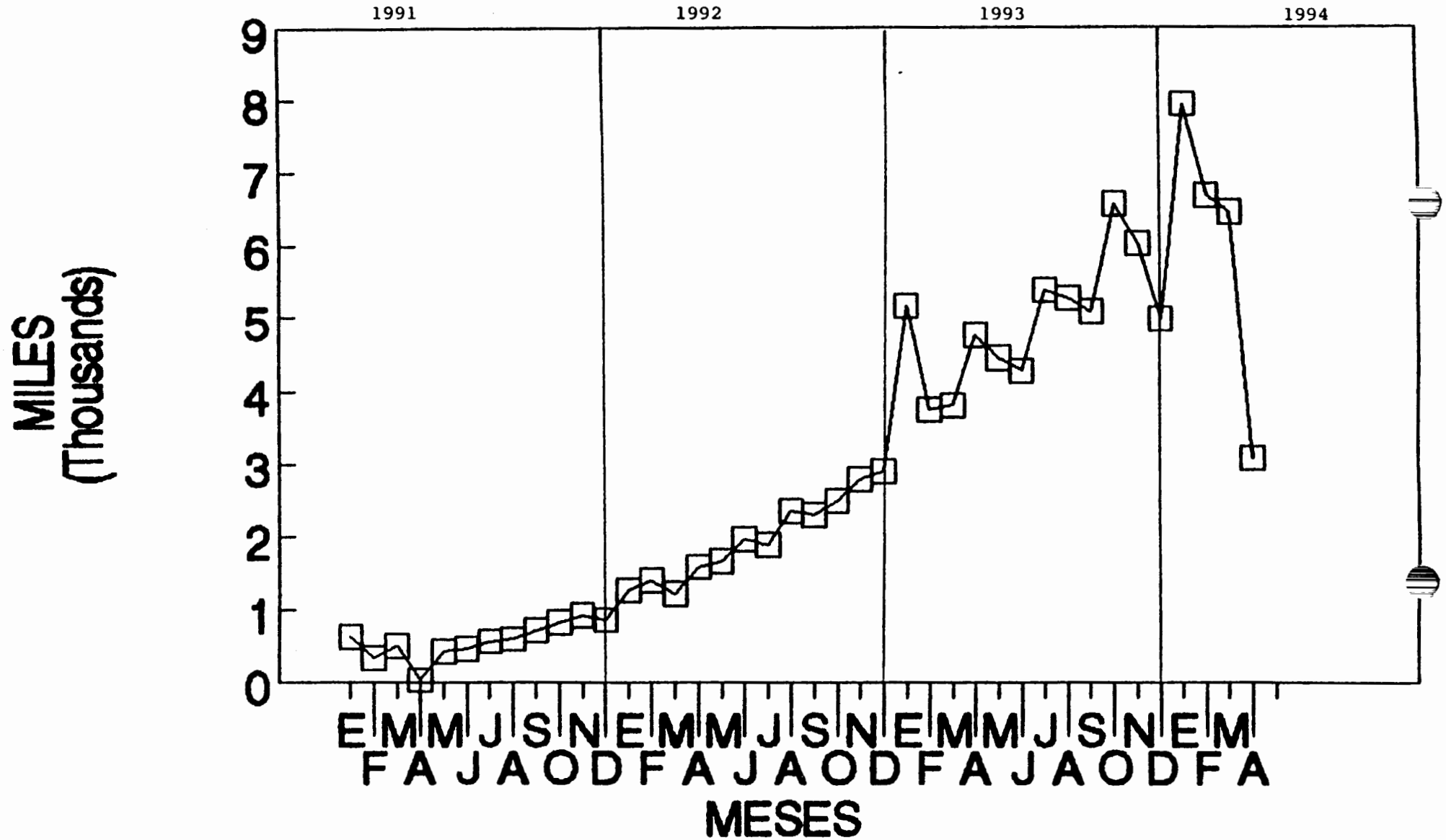
ANNEX 24

DISTRIBUCION DE CONDONES A USUARIOS
PROGRAMA DE SALUD RURAL 1991 ABRIL 1994



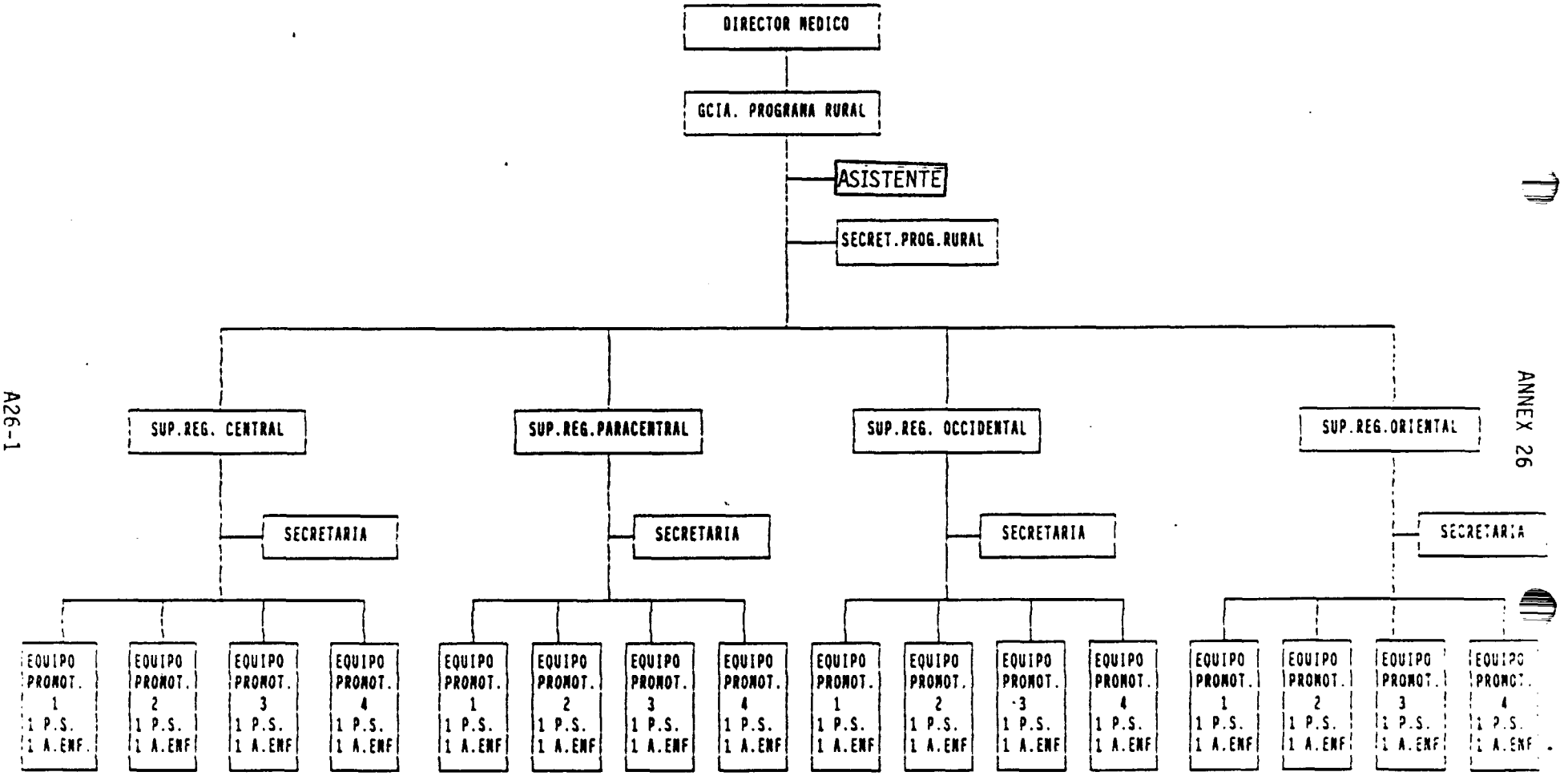
ANNEX 25

DISTRIBUCION DE INYECTABLES A USUARIOS
PROGRAMA DE SALUD RURAL 1991 ABRIL 1994



A25-2

ORGANIGRAMA PROGRAMA DE SALUD RURAL



INFORME COMPARATIVO DE CUMPLIMIENTO DE METAS

›. DEL PROYECTO: MED/04-90-AID-A

›MBRE DEL PROYECTO: EXPANSION DEL SISTEMA DE SERVICIOS CLINICOS DE ADS

UNIDAD EJECUTORA: DIVISION MEDICA

DESCRIPCION DE METAS	1993			1994		
	PROGRAMAC. ANUAL	REALIZADO A ABRIL	% DE LOGRO ABRIL	PROGRAMAC. ANUAL	REALIZADO A ABRIL	% DE LOGRO ABRIL
INGRESOS						
-CLINICAS REGIONALES	2,033,250	573,019	28	4,129,625	865,419	21
-CLINICAS EN AREAS DE MERCADO	18,400	6,915	38	100,100	22,899	23
-CLINICAS SATELITES	213,300	83,528	39	805,500	264,955	33
-CLINICA DE E.T.S.		48,853			24,312	
TOTAL INGRESOS CLINICAS	2,264,950	712,315	31	5,035,225	1,197,585	24
-REORGANIZACION Y EXPANSION DE SERVICIOS RURALES	389,750	169,725	44	940,700	185,013	20
-CENTRO DE ATENCION INTEGRAL DEL ADOLESCENTE		2,684		27,600	6,164	22
TOTAL INGRESOS DIVISION MEDICA	2,654,700	884,724	33	6,003,525	1,388,762	23

ANNEX 27

INFORME COMPARATIVO DE CUMPLIMIENTO DE METAS

O. DEL PROYECTO: MED/04-90-AID-A

OMBRE DEL PROYECTO: EXPANSION DEL SISTEMA DE SERVICIOS CLINICOS DE ADS

UNIDAD EJECUTORA: DIVISION MEDICA

DESCRIPCION DE METAS	1993			1994		
	PROGRAMAC. ANUAL	REALIZADO A ABRIL	% DE LOGRO ABRIL	PROGRAMAC. ANUAL	REALIZADO A ABRIL	% DE LOGRO ABRIL
CENTRO DEL ADOLESCENTE						
-CONSULTAS PLANIFICACION FAMILIAR	24	10	42	100	10	10
-CONSULTAS GINECOLOGICAS	500	47	9	500	30	6
-CONSULTAS GENERAL	1,000	150	15	2,800	164	6
-CONSULTAS PSICOLOGIAS	700	290	41	1,200	414	35
-CONSULTAS PSIQUIATRICAS	180	73	41	850	164	19
-CITOLOGIAS				100	11	11
-APP					1	
-CHARLAS EDUCATIVAS		7	0		4	

ANNEX 28

193

ASOCIACION DEMOGRAFICA SALVADOREÑA

INFORME COMPARATIVO DE CUMPLIMIENTO DE METAS

No. DEL PROYECTO: MED/04-90-AID-A

NOMBRE DEL PROYECTO: EXPANSION DEL SISTEMA DE SERVICIOS CLINICOS DE ADS

UNIDAD EJECUTORA: DIVISION MEDICA

DESCRIPCION DE METAS	1993			1994		
	PROGRAMAC. ANUAL	REALIZADO A ABRIL	% DE LOGRO ABRIL	PROGRAMAC. ANUAL	REALIZADO A ABRIL	% DE LOGRO ABRIL
CLINICAS SATELITES						
-APP METODOS TEMPORALES	1,890	494	26	2,600	825	32
-CONSULTAS PLANIFICACION FAMILIAR	4,000	1,163	29	6,535	1,447	22
-CONSULTAS MATERNO INFANTIL	4,300	1,449	34	7,900	1,676	21
-CONSULTAS GINECOLOGICAS	4,200	1,598	38	8,650	3,481	40
-CONSULTAS GENERALES	1,300	265	20	2,345	963	41
-ATENCIONES EN SALUD REPRODUCTIVA		38		300	648	216
-NUEVAS CLINICAS SATELITES	4	3	75	2	0	0
-CITOLOGIAS				5,650	2,133	38
-REFERENCIAS USUARIOS METODOS PERMANENTES					28	0

ANNEX 29

124

INFORME COMPARATIVO DE CUMPLIMIENTO DE METAS

DEL PROYECTO: MED/04-90-AID-A

MBRE DEL PROYECTO: EXPANSION DEL SISTEMA DE SERVICIOS CLINICOS DE ADS

UNIDAD EJECUTORA: DIVISION MEDICA

DESCRIPCION DE METAS	1993			1994		
	PROGRAMAC. ANUAL	REALIZADO A ABRIL	% DE LOGRO ABRIL	PROGRAMAC. ANUAL	REALIZADO A ABRIL	% DE LOGRO ABRIL
CLINICAS EN AREAS DE MERCADO						
APP METODOS TEMPORALES	300	98	33	430	119	28
REFERENCIAS A MEDICOS DE REFERENCIA	1000	188	19	780	87	11
ATENCIONES EN SALUD REPRODUCTIVA	600	847	141	1,000	425	43
CONSULTAS PLANIFICACION FAMILIAR				360	84	23
CONSULTAS GINECOLOGICAS				240	303	126
CONSULTAS MATERNO INFANTIL				160	69	43
CONSULTAS GENERALES				40	53	133
CITOLOGIAS				700	165	24
NUEVAS CLINICAS DE MERCADO	2	0	0	2	2	100
REFERENCIAS USUARIOS A METODOS PERMANENTES		62	0		19	

EL SALVADOR

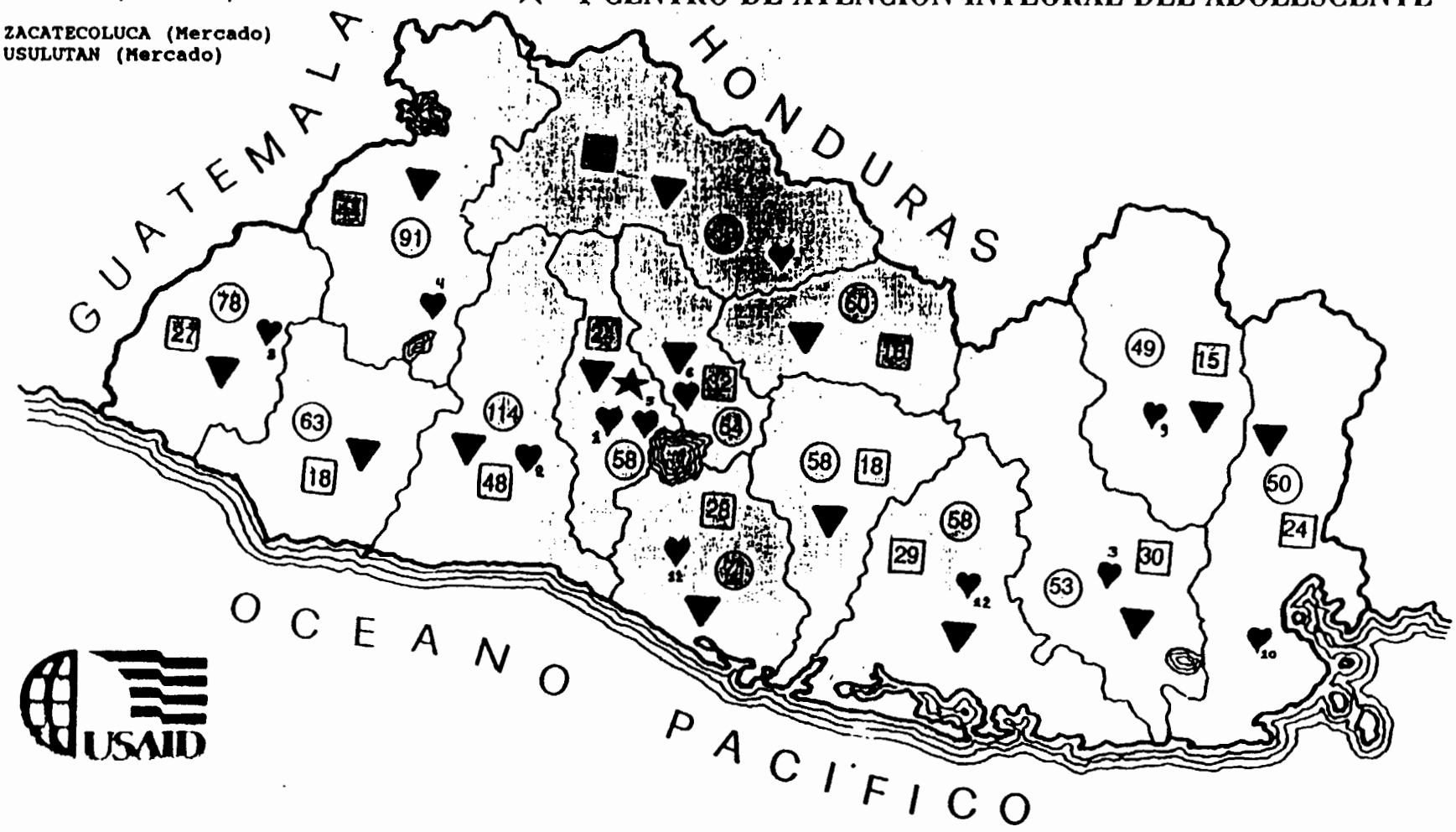
1. SAN SALVADOR (Regional)
2. SANTA TECLA (Regional)
3. SAN MIGUEL (Regional)
4. SANTA ANA (Regional)

5. SOYAPANGO (Satélite)
6. COJUTEPEQUE (Satélite)
7. CHALATENANGO (Satélite)
8. AHUACHAPAN (Satélite)
9. GOTERA (Satélite)
10. LA UNION (Satélite)

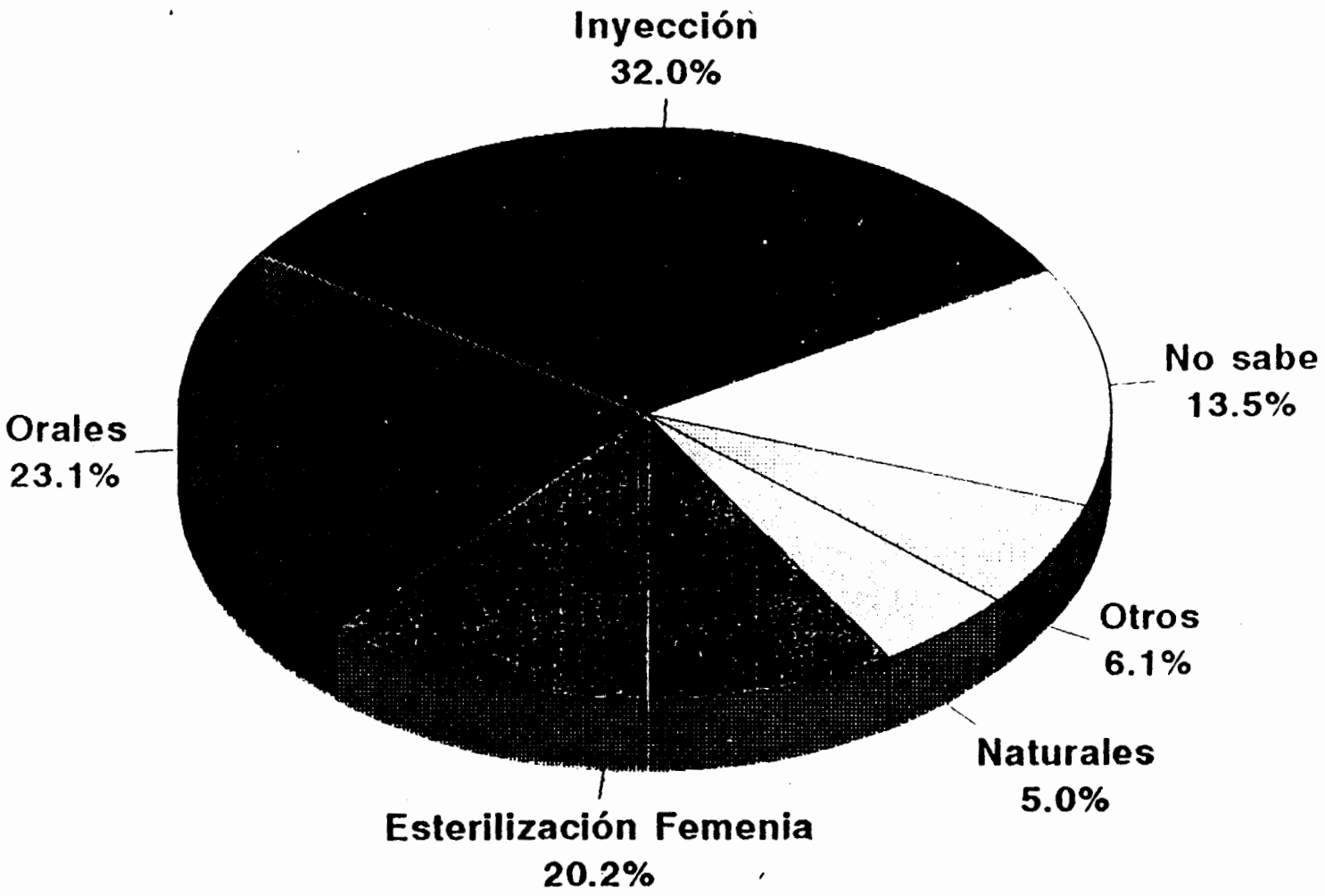
11. ZACATECOLUCA (Mercado)
12. USULUTAN (Mercado)

UBICACION GEOGRAFICA

- ♥ 12 CLINICAS PRO-FAMILIA
- ▼ 49 MEDICOS DE REFERENCIAS
- 907 PROMOTORES DE SALUD PRO-FAMILIA (PSP)
- 377 DISTRIBUIDORES DE ANTICONCEPTIVOS RURALES (DAR)
- ★ 1 CENTRO DE ATENCION INTEGRAL DEL ADOLESCENTE



Método Preferido por las Mujeres que Desean Usar



INFORME COMPARATIVO DE CUMPLIMIENTO DE METAS

No. DEL PROYECTO: MED/04-90-AID-A

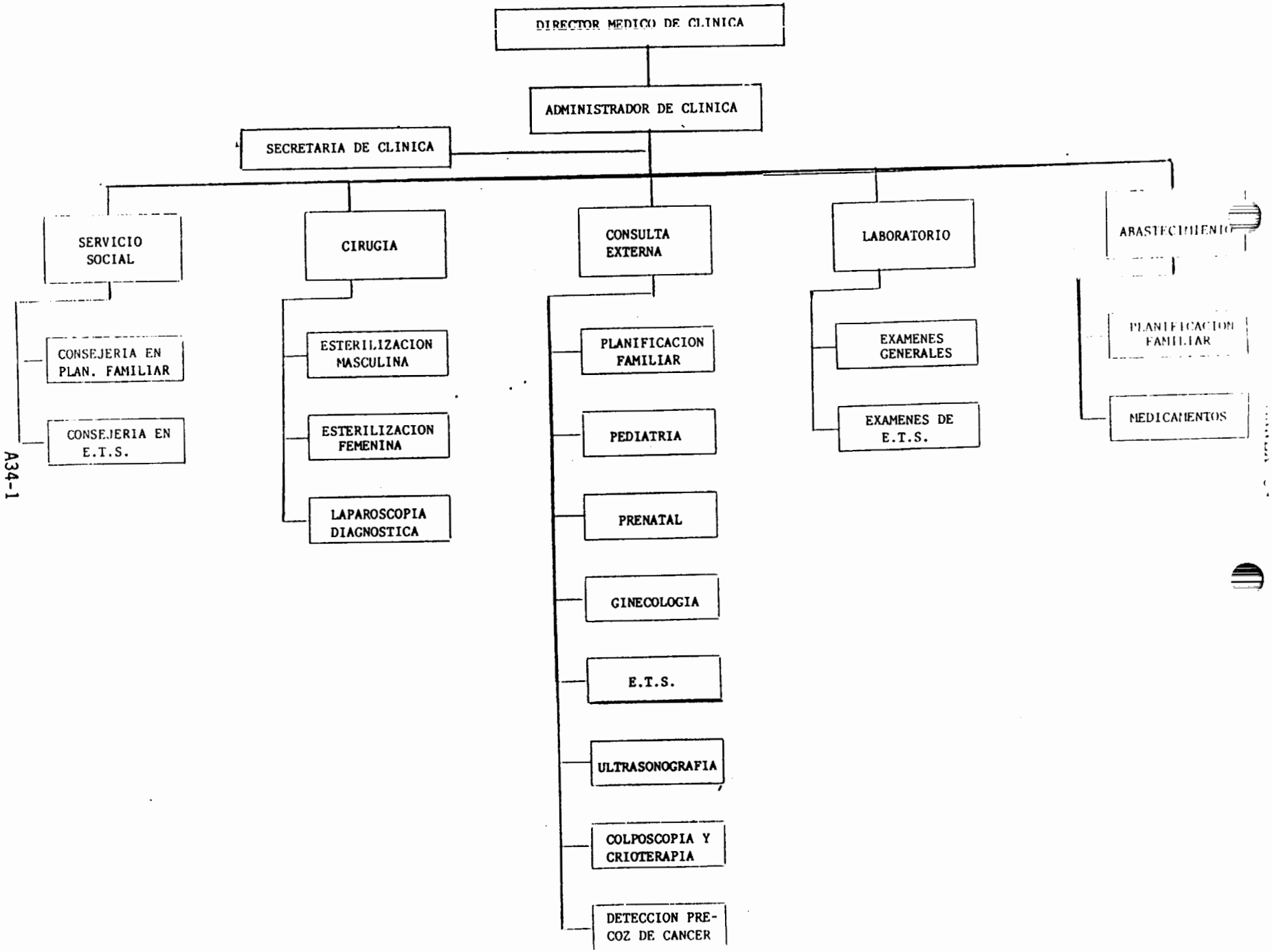
NOMBRE DEL PROYECTO: EXPANSION DEL SISTEMA DE SERVICIOS CLINICOS DE ADS

UNIDAD EJECUTORA: DIVISION MEDICA

DESCRIPCION DE METAS	1993			1994		
	PROGRAMAC. ANUAL	REALIZADO A ABRIL	% DE LOGRO ABRIL	PROGRAMAC. ANUAL	REALIZADO A ABRIL	% DE LOGRO ABRIL
CLINICAS REGIONALES						
-APP METODOS TEMPORALES	20,150	4,707	23	17,000	4,397	26
-CONSULTAS DE PLANIFICACION FAMILIAR	27,500	9,346	34	30,750	7,821	25
-PROCEDIMIENTOS DE AQV	6,840	2,020	30	6,600	2,023	31
-CONSULTAS MATENO INFANTIL	10,600	3,224	30	11,300	2,840	25
-CONSULTAS GINECOLOGICAS	39,100	13,369	34	42,800	12,300	29
-CONSULTAS DE E.S.T.	5,500	1,173	21	4,800	630	13
-CONSULTAS GENERALES				400	290	73
-CITOLOGIAS	26,300	9,105	35	29,600	7,651	26
-EXAMENES DE LABORATORIO	20,000	6,435	32	27,500	4,823	18
-CREACION DE LABORATORIO CLINICA DE ADS	1	0				
-PROCEDIMIENTOS DE COLPOSCOPIA	720	251	35	800	270	34
-PROCEDIMIENTOS DE CRIOTERAPIA	360	159	44	525	180	34
-PROCEDIMIENTOS DE BIOPSIAS				685	239	35
-PROCEDIMIENTOS DE ULTRASONOGRAFIA	1,400	379	27	1,500	304	20
-DOSIS DE VACUNACION	3,550	1,279	36	4,450	1,049	24
-LAPAROSCOPIAS DIAGNOSTICAS				25	7	28

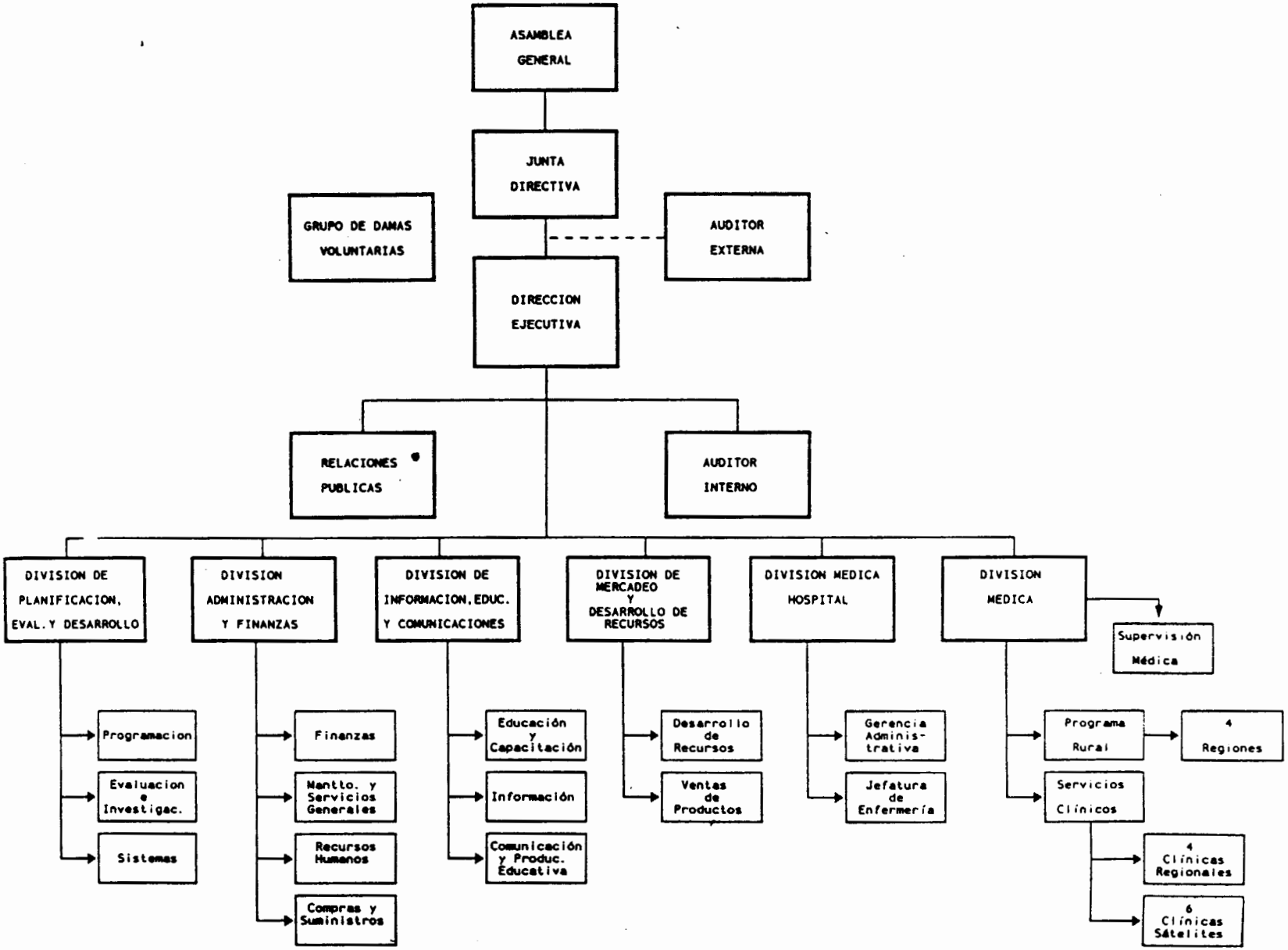
ANNEX 33

ORGANIGRAMA FUNCIONAL DE CLINICAS DE ADS



ASOCIACION DEMOGRAFICA SALVADOREÑA

ESTRUCTURA ORGANIZATIVA



200

ASOCIACION DEMOGRAFICA SALVADOREÑA
Dirección Médica

NUEVOS PRECIOS

SERVICIOS Y PRODUCTOS	PRECIOS	
	USUARIAS	PARTICULARES
– CONSULTA DE PLANIFICACION FAMILIAR	10.00	
–CONSULTA DE PEDIATRIA	10.00	
–CONSULTA PRENATAL	10.00	
–CONSULTA GINECOLOGICA	10.00	
–CONSULTA GENERAL	10.00	
–CITOLOGIA	10.00	15.00
–CICLOS DE ANOVULATORIOS ORALES	5.00	25.00
–DISPOSITIVOS INTRAUTERINOS	20.00	40.00
–INYECTABLES	25.00	40.00
–OVULOS VAGINALES (10 UNIDADES)	1.50	1.50
–CONDON (UNIDAD)	0.30	0.30
–LAPAROSCOPIA DIAGNOSTICA (Entrevista por T.S.)		300.00
–CONSULTA E.T.S.	25.00	
–VASECTOMIA DEMANDA ESPONTANEA	50.00	
–VASECTOMIA REFERIDA POR MEDICO (entrevista por T.S.)		300.00
–ESTERILIZACION FEMENINA DEMANDA ESPONTANEA	50.00	
–ESTERILIZACION FEMENINA REFERIDA POR MEDICO (entrevista por T.S.)	300.00	
–COLPOSCOPIA	50.00	100.00
–BIOPSIA	100.00	100.00
–CRIOTERAPIA	100.00	100.00
–ULTRASONOGRAFIA	100.00	100.00
–APLICACION DE INYECCIONES	2.00	5.00
–JERINGA	1.00	1.00

24 de septiembre de 1993
SCG/tmo.–

NUEVOPRE.WK1

ANNEX 36

101

Sustainability

Contributing Factors

Programmatic

- [illegible]
- Adequate Contraceptive Mix
- Incentives vs. performance
- Support from the Community (Beneficiaries)
- * Adequate Logistics System
- ~~Referral~~ System Working adequately
- Physicians Network Working

Managerial

- Board Support
- Technical/Adm. Levels Support
- Activities being Conducted in Cost-effective manner
- Adequate Supervision of PSPs DARs.
- * Adequate Logistics System

Financial

- Adequate Financial Mgt. Syst.
  - Acctg. System
  - Cost System
- Adequate WC Levels
- Adequate Fin. Support from IPPF
- Other donor funding
- Adequate Mgt. of Income.
  - Revert to programs
  - [illegible]

* Ensured @ both levels

ANNEX 38

TABLA 21

Distribución Porcentual de las Mujeres 15-49 Años de Edad,
según Semana en el Ciclo Menstrual que Piensan es Más Probable
que Una Mujer Pueda Quedar Embarazada, por Area de Residencia y Edad
Encuesta Nacional de Salud Familiar: El Salvador, 1993
(FESAL-93)

		Residencia			Edad (años)		
	Total	AMSS	Resto Urbano	Rural	15-19	20-24	25-49
Una Semana Antes de que la Regla Comience	9.0	9.6	10.7	7.3	11.9	9.0	7.8
Durante la Regla	2.6	2.7	2.5	2.7	4.2	[illegible]	1.8
Una Semana Después de que la Regla Comience	37.2	37.0	37.6	37.0	[illegible]	36.4	42.2
Dos Semanas Después de que la Regla Comience*	**12.3**	**17.5**	**13.0**	**7.9**	**9.2**	[illegible]	**14.0**
Tres Semanas Después de que la Regla Comience	3.6	5.3	2.6	3.0	3.4	4.3	3.4
No Hay Diferencia, Cualquier Tiempo es Igual	6.2	5.9	6.4	6.3	6.9	6.1	6.0
Otro	1.2	1.6	1.3	0.9	1.3	1.2	1.2
No Sabe o No Responde	27.8	20.4	25.9	34.9	36.9	28.6	23.6
Total	100.0	100.0	100.0	100.0	100.	[illegible]	100.0
No. de Casos (No Ponderados)	(6207)	(1782)	(1834)	(2591)	(1157)	(1161)	(3889)

*/ Respuesta esperada.

ANNEX 39

COESS S.A. DE C.V. ESTUDIO COSTO/RENDIMIENTO CLINICAS SATELITES Y DE MERCADO

ADS_0405

CUADRO Nro. 26 COSTOS DE ACTIVIDADES DE PLANIFICACION FAMILI

CLINICAS REGIONALES, SATELITES Y DE MERCADO

CLINICA / PROCEDIMIENTO	Consulta Médica P.F. Costo Total *	Consulta Médica P.F. Costo Propio **	Abastecimiento Oral Costo Total *	Abastecimiento Oral Costo Propio **	Abastecimiento Inyectable Costo Total *	Abastecimiento Inyectable Costo Propio **
1. San Salvador	77.57	48.26	11.39	8.46	11.7	8.77
2. Santa Tecla	66.77	40.18	10.16	7.47	10.44	7.
3. Santa Ana	79.68	55.92	6.96	4.5[illegible]		36
4. San Miguel						
5. Satélite Terminal (Feb.91 - Feb.92)						
6. Satélite Soyapango (Marzo - Junio 92)	69.90	44.36	12.99	10.44	18.69	16.14
7. Gotera	95.35	62.50	19.19	13.03	32.01	21.74
8 La Unión	7[illegible].00	52.06	15.61	10.56	28.55	
9. Zacatecoluca	0.00	0.00	19.14	12.79		
10. Usulutan	0.00	0.00	21.40			18.34

Costo de Clínicas Regionales corresponden al period [illegible] 1991 (Estudio C[illegible]
y los de las Satélites y de Mercado al periodo ener[illegible] 92

* Costo Total= Costo Propio + Costo Apoyo de las Divisiones (en colones)
** Costo Propio= Remuneraciones + Costo de Funcionamiento (no incluye Costo de D[illegible]siones)

CUADRO Nro. 29

MATRIZ DE COSTO (**) PARA LOS SERVICIOS DE ABASTECIMIENTO INYECTABLE POR CLINICA

ENERO - JUNIO 1992 *

PROCEDIMIENTO / CATEGORIA DE GASTO	Terminal Feb.91-92	Soyapango Ene.-Jun.92	Gotera	La Unión	Usulután	Zacatecoluca	PROMEDIO
A. Recursos Humanos							
1. Directos	3.05	2.30	2.81	2.76	2.25	2.25	2.47
2. Complementarios	6.00	1.10	5.94	4.69	12.00	13.60	7.47
3. SUB-TOTAL (1+2)	9.05	3.40	8.75	7.45	14.25	15.85	9.94
4. Indirectos	6.50	2.00	7.56	6.22	0.00	0.00	3.16
5. SUB-TOTAL (3+4)	15.55	5.40	16.31	13.67	14.25	15.85	13.10
B. COSTOS FUNC.-OPERACION							
6. Servicios	1.07	10.20	2.96	3.72	0.06	0.15	3.42
7. Mat. y Sum. Generales	0.24	0.49	2.03	1.50	2.38	2.15	1.71
8. Mat. y Sum. Especifico	0.24	0.00	0.00	0.00	0.00	0.00	0.00
9. Deprec. Mobil. y Equipo	0.05	0.05	0.44	0.40	0.37	0.19	0.29
10. SUB-TOTAL (6+7+8+9)	1.60	10.74	5.43	5.62	2.81	2.49	5.42
11. TOTAL CLINICAS (5+10)	17.15	16.14	21.74	19.29	17.06	18.34	18.51
C. APOYO DIVISIONAL							
12. Costo Directo Apoyo Divisiones	3.34	2.55	10.27	9.26	8.47	10.20	8.15
13. T O T A L	20.49	18.69	32.01	28.55	25.53	28.54	26.66

Fuente: Investigación de campo y datos de diversas fuentes de ADS.

* Periodo de datos enero - junio 1992, excepto en C. Satélite Terminal (Feb.91 - Feb.92).
** Costo en colones

MATRIZ DE COSTO PARA LOS SERVICIOS DE ATENCION POR ENFERMERIA *
POR CLINICA

ENERO - JUNIO 1992

CUADRO Nro. 29

CATEGORIA DE GASTO / PROCEDIMIENTO	Gotera	La Unión	Usulután	Zacatecoluca*	PROMEDIO
A. Recursos Humanos					
1. Directos	2.81	2.50	1.96	2.25 *	[illegible]
2. Complementarios	5.94	4.27	11.00	13.60 *	[illegible]
3. SUB-TOTAL (1+2)	8.75	6.77	12.96		11.08
4. Indirectos	7.56	5.66	[illegible]	[illegible] *	3.31
5. SUB-TOTAL (3+4)	16.31	12.43	12.96	15.85 *	
B. COSTOS FUNC.-OPERACION					
6. Servicios	2.96	3.43	0.04	0.16 *	1.65
7. Mat. y Sum. Generales	2.04	1.37	2.09	[illegible] *	1.92
8. Mat. y Sum. Especifico	0.00	0.00	0.00	*	[illegible]
9. Deprec. Mobil. y Equipo	0.44	0.36	[illegible]		[illegible]
10. SUB-TOTAL (6+7+8+9)	5.44	5.16		2.52 *	3.90
11. TOTAL CLINICAS (5+10)	21.75	17.59	15.42	18.37 *	18.28
C. APOYO DIVISIONAL					
12. Costo Directo Apoyo Divisiones	10.27	8.42	7.40	10.19 *	9.07
13. T O T A L	32.02	26.01	22.82	28.56 *	27.35

Fuente: Investigación de campo y datos de diversas fuentes de ADS.

* Actividad que no se realiza en la clínica Satélite de Soyapango.

ANNEX 40

UNITED STATES GOVERNMENT

memorandum

DATE: JUNE 7, 1994

REPLY TO ATTN OF: MARTIN SCHULZ, FA/CONT

SUBJECT: COUNTERPART CONTRIBUTION REPORT FOR PROJECT 519-0363 SALVADOREAN DEMOGRAPHIC ASSOCIATION (SDA)

TO: MICHAEL DEAL, PRJ

Attached you will find the accumulated counterpart contribution by element as of December 31, 1993, which amounts to Colones 44,837,475 = $5,704,513 at $1.00 = C7.86. This represents 41% of the total Colones counterpart at the time of the signing of the agreement in July 1990. In addition, a comparison of the amount budgeted to be contributed by USAID shows expenditures of $10,994,323 which represents about 50% of total USAID contribution as of December 31, 1993. SDA contribution to the project was projected to be about 39% of the total project cost. As of December 31, 1993 they have achieved 16% of the total while USAID has contributed 31%.

In March of this year, USAID communicated to the SDA the changes in counterpart contribution reporting requirements. The SDA is reviewing the procedures it is currently using and will submit NLT June 30 of this year the new procedures as well as a request to revise the counterpart contribution agreed upon in the original agreement. The current PACD is July 30, 1995 and at the historical rate the counterpart contribution is not likely to be met completely.

Regarding the documentation submitted by the SDA, I have reviewed it and find it to be responsive to the requirements as specified in the Mission Operations Manual chapter 780 "Counterpart contribution monitoring and reporting requirements".

Clearance: PShahidinejad, SFA/CONT

cc: MTdeValdes, FA/CONT

OPTIONAL FORM NO. 10
(REV. 1-80)
GSA FPMR (41 CFR) 101-11.6
5010-114

*U.S. GPO: 1992-312-071/50046

207

SALVADOREAN DEMOGRAPHIC ASSOCIATION
COUNTERPART CONTRIBUTION SUMMARY

COMPONENT	COUNTERPART BUDGETED $ JULY 90	COUNTERPART BUDGETED $1 = C7.86 JULY 90	COUNTERPART AS OF DIC 31, 1993 $	COUNTERPART AS OF DIC 31, 1993 $1 = C7.86
TECHNICAL ASSISTANCE	0	0	0	0
TRAINING	14,000	110,040	5,776	45,399
LOGISTICS & COMMODITIES	2,738,000	21,520,680	1,129,680	8,879,285
PROJECT ADMINISTRATION & COORDINATION	10,952,000	86,082,720	4,518,721	35,517,147
INFORMATION, EDUCATION, COMMUNICATIONS	22,000	172,920	9,077	71,345
RESEARCH	100,000	786,000	41,259	324,296
AUDITS & EVALUATIONS	0	0	0	0
CONTINGENCIES & INFLATION	0	0	0	0
TOTAL	13,826,000	108,672,360	5,704,513	44,837,472
PERCENTAGE COUNTERPART @ C7.86 = $1.00 AS OF DECEMBER 31, 1993			41.26%	41.26%

SALVADOREAN DEMOGRAPHIC ASSOCIATION
USAID CONTRIBUTION

COMPONENT	USAID BUDGETED $ JULY 90		USAID EXPENDE AS OF DIC 31, 1993 $	
TECHNICAL ASSISTANCE	4,999,200		3,252,527	
TRAINING	574,100		118,982	
LOGISTICS & COMMODITIES	4,575,600		3,140,787	
PROJECT ADMINISTRATION & COORDINATION	6,390,200		3,221,327	
INFORMATION, EDUCATION, COMMUNICATIONS	2,751,100		936,456	
RESEARCH	643,900		214,502	
AUDITS & EVALUATIONS	821,200		107,821	
CONTINGENCIES & INFLATION	1,244,700		1,921	
TOTAL	22,000,000		10,994,323	
PERCENTAGE USAID AS OF DECEMBER 31, 1993			49.97%	

SALVADOREAN DEMOGRAPHIC ASSOCIATION
USAID CONTRIBUTION VS COUNTERPART (BUDGETED & EXPENDED)

COMPONENT	COUNTERPART BUDGETED $ JULY 90	COUNTERPART EXPENDED $ DIC 31, 1993	USAID BUDGETED $ JULY 90	USAID EXPENDED $ DIC 31, 1993
TECHNICAL ASSISTANCE	0	0	4,999,200	3,252,527
TRAINING	14,000	5,776	574,100	118,982
LOGISTICS & COMMODITIES	2,738,000	1,129,680	4,575,600	3,140,787
PROJECT ADMINISTRATION & COORDINATION	10,952,000	4,518,721	6,390,200	3,221,327
INFORMATION, EDUCATION, COMMUNICATIONS	22,000	9,077	2,751,100	936,456
RESEARCH	100,000	41,259	643,900	214,502
AUDITS & EVALUATIONS	0	0	821,200	107,821
CONTINGENCIES & INFLATION	0	0	1,244,700	1,921
TOTAL	13,826,000	5,704,513	22,000,000	10,994,323
PERCENTAGE COUNTERPART @ C7.86 = $1.00 AS OF DECEMBER 31, 1993		41.26%		49.97%

208

SALVADOREAN DEMOGRAPHIC ASSOCIATION

TOTAL PROJECT USAID CONTRIBUTION VS COUNTERPART (BUDGETED & EXPENDED)

COMPONENT	COUNTERPART BUDGETED $ JULY 90	USAID BUDGETED $ JULY 90	COUNTERPART EXPENDED $ JULY 90	USAID EXPENDED $ DIC 31, 1993
TECHNICAL ASSISTANCE	0	4,999,200	0	3,252,527
TRAINING	14,000	574,100	5,776	118,982
LOGISTICS & COMMODITIES	2,738,000	4,575,600	1,129,680	3,140,787
PROJECT ADMINISTRATION & COORDINATION	10,952,000	6,390,200	4,518,721	3,221,327
INFORMATION, EDUCATION, COMMUNICATIONS	22,000	2,751,100	9,077	936,456
RESEARCH	100,000	643,900	41,259	214,502
AUDITS & EVALUATIONS	0	821,200	0	107,821
CONTINGENCIES & INFLATION	0	1,244,700	0	1,921
TOTAL	13,826,000	22,000,000	5,704,513	10,994,323
PERCENTAGE COUNTERPART @ C7.00 = $1.00 AS OF DECEMBER 31, 1993		38.59%		
PERCENTAGE COUNTERPART OF TOTAL AS OF DEC 31, 1993			0.16	
PERCENTAGE USAID OF TOTAL AS OF DEC 31, 1993				0.31

INFORME ANUAL 1993
IPPF–ADS

TABLA S2
Otros Servicios prestados por la APF a través de lugares clínicos

CLASE DE SERVICIO	NUMERO VISITAS
CONSULTAS	
♦ Ginecologica	48,689
♦ Pediatrica	14,408
♦ Prenatal	6,850
♦ De E.S.T.	2,954
♦ Masculina	281
♦ General	3,185
DOSIS DE VACUNACION	
EXAMEN DE LABORATORIO	
♦ Citologías	30,067
♦ Ecuse	108
♦ Pruebas de embarazo	2,032
♦ Examenes de EST	1,951
OTROS SERVICIOS	
♦ Otros Examenes	12,903
♦ Ultrasonografía	1,103
♦ Laporoscopía Diagnóstica	37
♦ Colposcopía	731
ACTIVIDADES PROMOCIONALES	
♦ Toma de Biopsias	608
♦ Criocauterio	459
♦ Charlas (Asistentes)	16,439
♦ Consejería (Personas Atendidas)	14,210

210

ANNEX 42

TABLA S1
Servicios Anticonceptivos a través de las Clínicas de la APF

METODO ANTICONCEPTIVO	EN LAS CLINICAS	
	Número de Aceptante Nuevos de P.F.	Número de Visitas Anticonceptivas de todos los Aceptantes
Esterilización Masculina	205	279
Esterilización Femenina	5,900	7,920
Implante	0	44
D I U	681	3,150
Abstinencia Periódica	0	0
Diafragma	0	0
Inyectable dosis 2 meses	3,204	12,260
Oral	1,607	5,870
Espuma	0	0
Crema Jalea	0	0
Condón	560	1,137
Tableta Vaginal	69	152
Método Natural	0	0
TOTAL DE METODOS	* **48,865**	** **70,287**

* Los 70,287 de total de visitas de anticonceptiva incluye:
364 visitas de Planificación Familiar de Clínicas de Mercado
725 visitas de Planificación Familiar de Médicos de Referencia
38,386 visitas de Planificación Familiar del Programa Rural

* * Los 48,865 Aceptantes nuevos de Planificación Familiar incluye:
36,275 Usuarios nuevos del Programa Rural
364 Usuarios nuevos de Clínicas de Mercado

EL SALVADOR

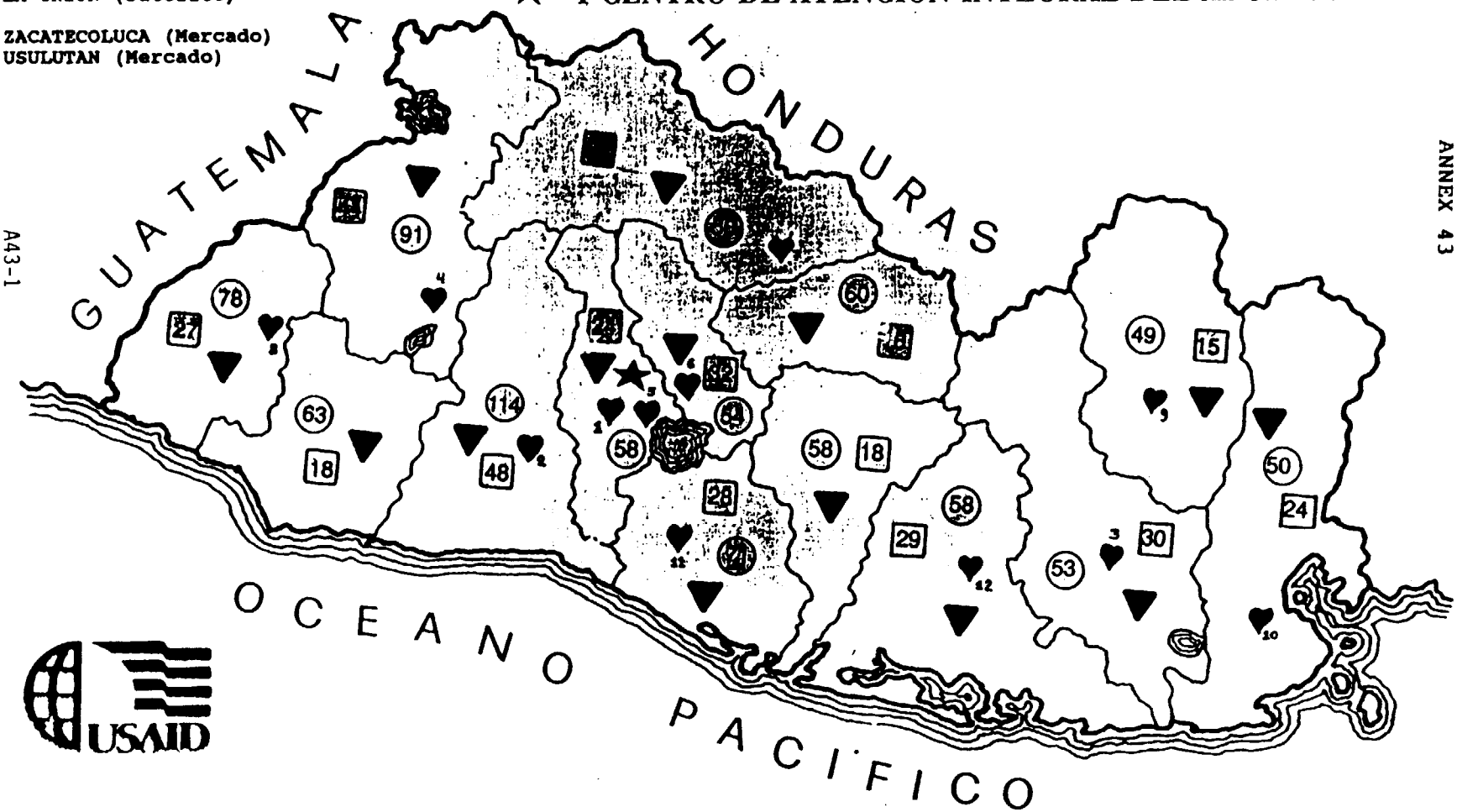
1. SAN SALVADOR (Regional)
2. SANTA TECLA (Regional)
3. SAN MIGUEL (Regional)
4. SANTA ANA (Regional)

5. SOYAPANGO (Satélite)
6. COJUTEPEQUE (Satélite)
7. CHALATENANGO (Satélite)
8. AHUACHAPAN (Satélite)
9. GOTERA (Satélite)
0. LA UNION (Satélite)

1. ZACATECOLUCA (Mercado)
2. USULUTAN (Mercado)

UBICACION GEOGRAFICA

♥ 12 CLINICAS PRO-FAMILIA
▼ 49 MEDICOS DE REFERENCIAS
907 PROMOTORES DE SALUD PRO-FAMILIA (PSP)
377 DISTRIBUIDORES DE ANTICONCEPTIVOS RURALES (DAR)
★ 1 CENTRO DE ATENCION INTEGRAL DEL ADOLESCENTE



ANNEX 44

PERSONS INTERVIEWED

ADS Headquarters - San Salvaldor

Jorge Hernandez Isussi, Executive Director
Dora Elena Castillo, IE&C Director
Dr. Samuel Castro Gonzalez, Medical Director
Jose Mario Caceres Henriquez, Planning Director
Juan Antonio Rivas, Social Marketing Director
Jose Hernan Arteaga Huezo, Finance and Administration Director
Dr.Francisco Andres Goenz P., Pro-Familia Hospital Director
Cossette de Padilla Ramirez, Communication and Production Manager
Luis Roberto Orellana, Transport and General Maintenance Manager
Gustavo Escalante, Procurement and Supplies Manager
Mary Argueta, Rural Program Assistant
Ana Maria de Espinoza, MIS Manager
Geraldina de Arevalo, Social Marketing Assistant
Jorge Garay, Salesman, Southern Zone
Guillermo Arvelar, Rural Education Supervisor
Concha Marina de Morazan, President, Damas Voluntarias
Arily de Kruzusem, Dama Voluntaria
Esperanza de Villeda, Dama Voluntaria
Violeta Schultz, Dama Voluntaria
Maria Mercedes de Cruz, Director, San Miguel, Damas Voluntarias
Marta Eugenia Avila, Dama Voluntaria
Maria Reyes Alvarenga, Canton Buenos Aires, PSP
Maria Leonor Vasquez, Canton Lance Verde, PSP

ADS Soyapango

Susana de Sonoreia, Clinic Nurse
Maria Elvira Moterroza de Felidon, Chief Nurse
Dra. Patricia Guerra de Hadiz
Sonia Elizabeth Corcenia, Secretary

ADS Santa Tecla

Carlos Argueta, Central Warehouse Manager
Mayra Sosa Castaneda, Secretary
Joaquin Jovel, Regional Manager
Flora Cancura, Chief Nurse
Dr. Carlos Enrique Perez Arce
4 Patients

ADS Santa Ana

Francisco Flores, Regional Manager
Sandra de Cuellar, Pharmacy Chief
Sandra de Moreno, Secretary
Walter Antonio Cotto, Promoter Supervisor, Santa Ana Norte

Consuelo del Carmen Ramirez, Auxiliary Nurse, Santa Ana Norte
Jose Omar Fagoaga, Promoter Supervisor, Santa Ana Sur
Maria Eugenia Vanegas de Mejia, Auxiliary Nurse, Santa Ana Sur
Miguel Gonzalez, Promoter Supervisor, Sonsonate
Celia Rosa Flores de Flores, Auxiliary Nurse, Sonsonate
Mauricio Castro, Promoter Supervisor, Ahuachapan
Juana Rosa Mendoza, Auxiliary Nurse, Ahuachapan
Jose Luis Castillo Jaime, Promoter Supervisor, San Vicente
Elizalbleth Menjivar Perez, Auxiliary Nurse, San Vicente
Teresa Salinas, Canton Santa Cruz, PSP
Otilia Giron, Canton La Ceiba, PSP
Daysi Romero, Canton Tierra Blanca, PSP

ADS Ahuachapan

Maria de Transito Reyes Linares, Clinic Nurse
Fermin Alfredo Landaverde, Clinic Orderly

ADS San Miguel

Dr. Julio Cesar Martinez, Regional Medical Director
Silvia Moreno, Regional Manager
Sarina Melani Gerelo, Chief of Nurses
Maria Martinez, Social Worker
Jose Gilberto Villatoro Velis, Regional Supervisor
Mateo Armando Giron, Promoter Supervison, Usulatan
Elsa Marina de la Cruz Portillo, Nurse, Usulatan
Gabriel Francisco Berrios Flores, Promotor Supervisor, San Miguel
Carlota Elizabeth Ochoa de Romero, Nurse, San Miguel
Juan Pablo Pineda Santos, Promoter, La Union
Reina Dinora Canas Canas, Nurse, La Union
Luis Humberto Chavez Barberena, Promoter Supervisor, Morazan
Silvia Haydee Aguilar de Quijano, Nurse, Morazan
Sonia del Carmen Mata de Zelaya, Secretary
Olivia Josefina Romero Lazo, PSP
Jose Carmen Marquez, Canton Chulanquera, PSP
Iris Ofelia Bolaños, PSP

ADS San Francisco Gotera

Emerita Azucena, Clinic Nurse
Luis Tomas Carcamo, Clinic Orderly

ADS Usulutan

Maria Julia Cabezas, Marketplace Clinic Nurse
Paula Andrea Garcia, Canton Obrajuelo, PSP
Miriam Rivas, Canton San Francisco, PSP

ADS Zacatetoluca

Marina Ramos Alverenga, Marketplace Clinic Nurse

ADS San Vicente

Ana Corina Tenorio, Lotificacion Miraflores, PSP
Catalina Velasquez, Canton El Sauce, PSP
Maria Elena Escobar, Canton Agua Zarca, PSP
Escobar Aparicio, San Vicente, PSP

USAID

Paul Hartenberger, HPN Director
Brenda Doe, HPN Deputy Director
Karen Freeman, Evaluation Officer
Dr. Raul Guillermo Toledo, Project Manager
Carrie Thompson, WID Officer
Mark Gallagher, Economist
Martin Schultz, Fiancial Analyst
Ana Cristina Mejia, Projects Office

CCC

Dr. Lawrence Smith, Jr., Chief of Party
Manuel Rodriguez Casado, IE&C Advisor
Mario Moran, Field Monitor
Maria Mercedes de Molina, Field Monitor
Rosario de Castro-Olmedo. Administrator

ANSAL (Health Sector Analysis)

Dr. Jaime Ayalde, Epidemiologist
Dr. Cynthia Prieto, Health Planning and Administration Specialist

Ministry of Public Health

Dr. Gustavo Argueta, Acting Minister of Health
Mercedes Irogoyen, Director, APSISA Project
Dr. Cruz Gonzalez, Director, MCH

Advertising Agency - San Salvador

Manuel Rene Villacorta, Director of Client Service

SOMARC

Carmen Lopez, Consultant

OTHER

Steven C. Mobley, Private Sector Officer, PSI
Dr. Ricardo Campos Martinez, Nutritional Commission, COQUIN

245

LOGICAL FRAMEWORK

NARRATIVE	OBJECTIVELY VERIFYABLE INDICATOR	MEANS OF VERIFICATION	ASSUMPTION
Project Goal: To improve general reproductive health services in El Salvador; and to improve the quality of life and health of the Salvadoran population through the reduction of infant and child mortality/morbidity.	-Increase the use of child spacing practices by 30%. -Decrease the rate of infant mortality from 48 in 1,000 live births to 40 in 1,000.	SDA data research and FESAL Survey.	Internal conflict subsides to permit promotion of the availability/accessibility of Family Health Services.
Project Purpose: To improve and expand delivery of birth spacing and MCH/FP Services to high risk populations in rural/marginal urban areas and to improve their quality & efficiency.	-Active number of SDA contraceptive users increased from 120,000 in 1988 to 200,000 in 1994. -Rural contraceptive prevalence increased from 34% to 40%. -ORS and home electrolyte treatment for diarrhea increased by 50%.	FESAL Survey and SDA data.	Current Level of delivery of public health services is maintained.
Outputs: 1) Family Health Services Delivery;	Establishment/Availability of: -Distribution Outlets in rural villages increased by 750. -1,150 PHPs selected and trained in modern FP methods. -Physician referral system of 50 M.D.s established. -Expanded services in SDA clinics. -6 New satellite clinics opened.	T.A. reports, SDA evaluations, site visits and Quarterly Reports.	Appropriate Sites can be identified. Internal conflict will not affect rural expansion.

NARRATIVE	OBJECTIVELY VERIFYABLE INDICATOR	MEANS OF VERIFICATION	ASSUMPTION
	-1,600 outreach personnel trained/ carrying out education/Communication programs on modern FP methods and offering MCH services. and -Education in MCH/FP reaches 1,550 rural villages.		
2) Institutional Development/SDA Management capacity Enhanced.	-Central Referral Clinic opened. -Social Marketing Program expanded. -Mass media campaign carried out.	Site visits, Quarterly Reports, Airing of TV, Radio announcements and distribution of printed materials.	Sufficient demand for services exists.
3) Policy Development & Research.	-7 Research studies completed with extensive national dissemination of of data and policy recommendations.	Copies of studies, Reports produced on seminars/meetings.	Research teams are able to travel to all of the Project areas.

Inputs (US$ 000):

A.I.D.	
Technical Assistance	$4,999.20
Training	574.10
Logistics/Commodities	4,575.60
Prog. Admn. & Coord.	6,390.20
I. E. C.	2,751.10
Research	643.90
Audit & Evaluation	821.20
Contingencies/Inflation	1,244.70
Total A.I.D.	22,000.00
SDA & Other Contributions	13,826.12
PROJECT TOTAL	35,826.12

Conditions Precedent to Project Implementation:

-Procurement Plan from SDA.
-Inventory Control System outlined.
-Project Manager hired.
-T.A. contracted.
-Referral Physicians and Sup. nurses contracted.
-750 new PHPs screened, selected and deployed.
-800 CBDs screened, selected and trained as PHPs.
-Satellite Clinic sites selected.
-Central Referral Clinic (CRC) remodeled.

217

NARRATIVE	OBJECTIVELY VERIFYABLE INDICATOR	MEANS OF VERIFICATION	ASSUMPTION
	-1,600 outreach personnel trained/ carrying out education/Communication programs on modern FP methods and offering MCH services. and -Education in MCH/FP reaches 1,550 rural villages.		
2) Institutional Development/SDA Management capacity Enhanced.	-Central Referral Clinic opened. -Social Marketing Program expanded. -Mass media campaign carried out.	Site visits, Quarterly Reports, Airing of TV, Radio announcements and distribution of printed materials.	Sufficient demand for services exists.
3) Policy Development & Research.	-7 Research studies completed with extensive national dissemination of of data and policy recommendations.	Copies of studies, Reports produced on seminars/meetings.	Research teams are able to travel to all of the Project areas.

Inputs (US$ 000):

A.I.D.	
Technical Assistance	$4,999.20
Training	574.10
Logistics/Commodities	4,575.60
Prog. Admn. & Coord.	6,390.20
I. E. C.	2,751.10
Research	643.90
Audit & Evaluation	821.20
Contingencies/Inflation	1,244.70
Total A.I.D.	22,000.00
SDA & Other Contributions	13,826.12
PROJECT TOTAL	35,826.12

Conditions Precedent to Project Implementation:

-Procurement Plan from SDA.
-Inventory Control System outlined.
-Project Manager hired.
-T.A. contracted.
-Referral Physicians and Sup. nurses contracted.
-750 new PHPs screened, selected and deployed.
-800 CBDs screened, selected and trained as PHPs.
-Satellite Clinic sites selected.
-Central Referral Clinic (CRC) remodeled.

ANNEX 46

CUADRO COMPARATIVO DEL RENDIMIENTO DE LA CLINICA LA UNION
DURANTE LOS MESES DE NOVIEMBRE Y DICIEMBRE DE LOS AÑOS 1991, 1992 Y 1993

ACTIVIDADES		AÑO 1991		AÑO 1992		AÑO 1993	
		NOVIEMB.	DICIEMB.	NOVIEMB.	DICIEM.	NOVIEMB.	DICIEMB.
Consulta	1°	15	14	11	16	12	11
Planificación Familiar	2°	0	1	12	21	35	18
Consulta	1°	15	12	28	33	69	49
Ginecológica	2°	0	0	29	29	104	76
Consulta	1°	4	4	13	13	28	10
Pediátrica	2°	2	2	13	7	28	13
Consulta	1°	1	1	2	1	9	3
Prenatal	2°	1	1	9	6	9	9
Consulta	1°	1	1	1	0	8	5
General	2°	0	0	3	1	10	4
Toma de Citologias		18	18	33	38	98	73
Ingresos		632.95	632.95	2,523.20	2,675.50	10,106.20	6,904.50

RENCLILU

ANNEX 47

CUADRO COMPARATIVO DEL RENDIMIENTO DE LA CLINICA GOTERA
DURANTE LOS MESES DE NOVIEMBRE Y DICIEMBRE DE LOS AÑOS 1991, 1992 Y 1993

		AÑO 1991		AÑO 1992		AÑO 1993	
ACTIVIDADES		NOVIEMB.	DICIEMB.	NOVIEMB.	DICIEM.	NOVIEMB.	DICIEMB.
Consulta	1°	5	8	4	7	7	9
Planificación Familiar	2°	0	0	7	1	15	13
Consulta	1°	8	12	25	22	20	22
Ginecológica	2°	0	2	23	32	62	88
Consulta	1°	2	3	22	21	22	19
Pediátrica	2°	1	0	10	19	24	20
Consulta	1°	3	1	1	3	0	4
Prenatal	2°	0	3	2	2	7	5
Consulta	1°	0	2	7	6	21	29
General	2°	0	0	4	6	20	31
Toma de Citologias		8	16	27	31	47	59
Ingresos		305.80	675.85	1,658.05	1,764.30	7,102.80	7,595.80

RENCLIGO

220

ANNEX 48

CUADRO COMPARATIVO DEL RENDIMIENTO DE LA CLINICA SAN MIGUEL
DURANTE LOS MESES DE NOVIEMBRE Y DICIEMBRE DE LOS AÑOS 1991, 1992 Y 1993

ACTIVIDADES		AÑO 1991		AÑO 1992		AÑO 1993	
		NOVIEMB.	DICIEMB.	NOVIEMB.	DICIEM.	NOVIEMB.	DICIEMB.
Consulta	1°	161	124	114	121	184	101
Planificación Familiar	2°	200	115	114	183	229	221
Consulta	1°	154	112	119	139	204	133
Ginecológica	2°	417	273	344	417	399	393
Consulta	1°	27	30	33	29	20	28
Pediátrica	2°	54	42	62	62	69	73
Consulta	1°	8	4	9	4	10	7
Prenatal	2°	11	6	22	20	25	26
Consulta	1°	0	0	1	0	2	1
General	2°	8	2	8	5	17	2
Toma de Citologias		258	204	212	300	283	293
A.Q.V	FEM.	112	80	64	67	139	65
	MAS.	0	1	1	0	0	1
Colposcopias		0	0	2	8	4	8
Toma de Biopsias		0	0	2	8	4	8
Crioterapia		0	0	0	1	1	1
Ingresos		15,010.55	12,183.10	14,133.20	15,643.70	31,604.35	29,610.10

221

CUADRO COMPARATIVO DE CONSULTAS E INGRESOS. CLINICA STA.TECLA
DEL AÑO 1982 AL AÑO 1993

	82	83	84	85	86	87	88	89	90	91	92	93
PLANIFICACION FAMILIAR	3852	3390	3539	3324	4460	5934	6083	6020	5864	3002	3674	5732
ESTERILIZACION FEMENINA	1250	2190	1391	618	671	824	817	829	1036	1143	1360	1342
ESTERILIZACION MASCULINA	213	286	233	79	36	32	34	44	30	39	30	45
CONSULTA PEDIATRICA	-	-	-	-	-	-	376	290	861	753	1054	1107
PRENATALES	-	-	-	-	-	-	143	118	247	287	495	759
OCASIONALES	286	194	149	200	208	497	464	465	-	-	-	-
GINECOLOGICAS	-	-	-	-	-	-	-	-	398	2210	4925	5777
CITOLOGIA / PAP	-	-	680	1029	1215	1932	2226	2175	3302	2768	3724	4606
COLPOSCOPIA	-	-	-	-	-	-	-	-	-	-	116	146
TOMA BIOPSIA	-	-	-	-	-	-	-	-	-	-	79	101
CRIO-CAUTERIO	-	-	-	-	-	-	-	-	-	-	33	92
INGRESOS			2265.30	7,597.60	11,452.25	26,903.65	66920.05	91050.05	107.301.30	134.580	191.046.40	275.887.95

ANNEX 49

A49-1

22

PERFIL DEL MEDICO DE REFERENCIA

- GRADUADO POR UNA UNIVERSIDAD NACIONAL, RECONOCIDA POR MINISTERIO DE SALUD, DE EDUCACION O INCORPORADO A ALGUNA DE ELLAS.
- ESPECIALIDAD: MEDICINA GENERAL. DEPENDIENDO DE LA LOCALIDAD Y DISPONIBILIDAD, PODRA TENER OTRA ESPECIALIDAD, EN CUYO CASO SE PREFIERE DE GINECOLOGIA Y OBSTETRICIA
- QUE RESIDA TODO EL TIEMPO O LA MAYOR PARTE DE EL, EN LA CIUDAD SELECCIONADA
- QUE COMULGUE CON LOS PROGRAMAS DE PLANIFICACION FAMILIAR
- DISPUESTO A TRABAJAR BAJO EL SISTEMA DE PAGO DE HONORARIOS SUBSIDIADOS
- DISPUESTO A ATENDER A LOS USUARIOS REFERIDOS O EMERGENCIAS AUN LOS DIAS DE FIN DE SEMANA
- DISPUESTO A TRABAJAR DE ACUERDO A NORMAS DE ATENCION DE LA ADS
- DISPUESTO A RECIBIR CAPACITACION

ANNEX 51

COBERTURA NACIONAL DE PLANIFICACION FAMILIAR
AÑOS 1991 - 1992 - 1993

	1 9 9 1	1 9 9 2	1 9 9 3
- RESPONSABILIDAD MSPAS	4,568,787	4,640,224	4,290 736
- EMBARAZADAS ESPERADAS	228,439	232,011	252,396
- POBLACION EDAD FERTIL	913,753	974,447	1,060,064
- POBLACION PARA PLANIFICACION FAMILIAR	715,994	733,011	746,420
- MUJERES PROTEGIDAS	68,209	56,658	48,871
- COBERTURA DE PLANIFICACION FAMILIAR	9.5	7.7	6.5

ATTACHMENT I

I. BACKGROUND:

The subject of this interim evaluation is Project No. 519-0363 Family Health Services being implemented under a Cooperative Agreement exclusively with the Salvadoran Demographic Association (SDA), a local NGO, affiliated with International Planned Parenthood Federation (IPPF). This is a $35,826,000 project with a life of project (LOP) of five years. USAID's contribution is $22 million and the SDA's contribution is $ 13,826,000. The Cooperative Agreement was signed on July 31, 1990 and current Project Assistance Completion Date (PACD) is July 30, 1995. As of , a total of $16,420,900 has been obligated and as of March 31, 1993 $3,204,461 had been disbursed by the SDA as counterpart contribution. This project is a follow-on to the USAID's two family planning projects which ended in FY90 (519-0210 and 519-0275).

The Salvadoran Demographic Association is a Salvadoran private voluntary organization that was constituted in 1962 and started receiving USAID support in 1963. Since then, the SDA has continuously received financing from the USAID for developing its family planning programs.

The purpose of the Project No.519-0363 project is to improve and expand the delivery of family planning and maternal child health (MCH) services to high risk populations in rural and marginal urban areas of El Salvador. The big difference between this project and the previous ones is the integration of family planning with other MCH activities, rather provide than solely family planning as was the practice through FY90. This Project as designed, is consistent with the USAID Strategy framework as detailed in the 1992-97 Program Objective Document. Specifically, it responds to Strategic Objective #4 "Healthier, Better Educated Salvadorans", and Program Outcame 2, "Increased contraceptive prevalence", and Program Outcome 3, Although SDA is the exclusive implementing agency, contraceptives are also provided to Salvadoran Social Security Institute (ISSS) under the Project.

Project inputs as described in the Cooperative Agreement are: technical assistance (contracted directly by USAID using Small Business Act, Section 8(a) procedures), training (long term, short term and in country), logistics (remodelling costs, office supplies, vehicles, contraceptives, medical supplies, pharmaceuticals), public education program costs, research costs and audits. Outputs are defined by the Cooperative Agreement as services delivered, including but not limited to, number of rural distribution points established, number and type of health workers and mothers recruited and trained, increase in clinical services provided, number of research studies completed, and increase in the number of family planning acceptors.The project contains three components: (1) Family Health Delivery: this component provides support to continue and expand the family planning services of the SDA and adds select MCH interventions (e.g., immunization, prenatal care, oral rehydration therapy, and nutrition education) to the range of services provided by the SDA; (2) Institutional Development: this component will enhance the financial viability of the SDA through improvements in its organizational efficiency and the addition of new services to generate income; and, (3) Policy Development and Research: to promote national policies which place contraceptives and other medicines within the reach of the poorest population.

Under each project component, a series of activities were programmed:

225

(1) FAMILY HEALTH SERVICES DELIVERY COMPONENT:

(a) Reorganization and Expansion of Rural Services: The SDA Community Based Distribution program for contraceptives continues its operations but is being reduced during the life of the project from 800 family planning posts to 400. To complement this program, the SDA initiated a new Pro-Familia Health Promoter program (PSP) providing not only contraceptives but also basic MCH assistance. The basic objective of the PSP is "to provide a non-threatening environment in which women will be more likely to seek out information on birth spacing methods."

(b) The Social Marketing Program: It consists of the sale of contraceptives donated by USAID to retail outlets (pharmacies and small stores). Plans are to expand it include additional outlets and to increase the range of products sold. The importance of this program is not only the fact that contraceptives are made available to the general population at a low cost but also that it is designed recover a portion of its costs thus assisting SDA reach its sustainability goal.

(c) Expansion of SDA Clinical Services System: Three basic activities are planned: i. expansion of services traditionally offered in SDA clinics, ii. opening of 12 marketplace clinics and 6 marginal urban satellite clinics, and iii. addition of up to 50 private physicians to a referral network.

(d) Improved IEC Support System: the constraints identified by the 1988 Demographic Health Survey indicated that a significant support to IEC activities was required to assure project success. The Information Pamphlets on family planning and MCH were prepared and distributed to rural and urban marginal participants. In Education, interpersonal communication became the focus as a means of educating SDA's clientele, complemented with printed materials and other educational aids. Also, the Project includes two educational projects: one to increase demand for male methods using satisfied male users, and other to provide family planning training to private practitioners serving rural and marginal urban populations. In Communications, the projects considers the use of mass media, specifically radio and TV, to broadcast messages to reinforce public education. SDA will select and contract a publicity agency to manage the production and diffusion of a mass media campaign emphasizing the new SDA image and promoting a wider range of services.

(2) **INSTITUTIONAL DEVELOPMENT COMPONENT:** This component directly addresses the institutional constraints of SDA that were present at the moment of the design of the project. Macro activities considered include:

(a) Expansion of the Social Marketing Program, (See 1(a) above)), (b) Establishment of a Central Referral Clinic (CRC): This is considered a key element for enhancing the self-sufficiency of the SDA program. Its primary function is to provide a more complex and technical array of services to participants, centralizing services in one location for the low income population .

(c) Marketing and Feasibility Studies: The studies were designed to determine whether other service expansion options would be viable (e.g., additional medical services, medical insurance, improvements to operational efficiency).

(3) **POLICY DEVELOPMENT AND RESEARCH COMPONENT:** Findings of research studies will be used to enhance SDA's project implementation and strengthen the natural policy framework regarding contraceptives and its availability to the general population. Research activities include: Demographic Health Survey (FESAL-93), presently underway and with preliminary data expected o/a September 1993. Norplant research study as a prior step before its incorporation into the El Salvador's family planning program, in collaboration and coordination with the Ministry of Health, ANTEL hospital, and the Social Security Institute. IUD Postpartum study which was a study in process when the project was designed and now completed. MCH Morbidity and Mortality Study which was canceled after analyzing costs and benefits. SDA Program design and effectiveness: Three studies were planned to measure service effectiveness.
Also in this component, SDA was charged with playing a mayor role in coordination conducting regular meetings of all the health care agencies and donors.

II. TITLE (ACTIVITY TO BE EVALUATED): Family Health Services Project, Number 519-0363-A-00-0408-00. All of the activities implemented by the Salvadoran Demographic Association (SDA) and the technical assistance contractor (Cambridge Consulting Corporation - CCC) under the aforementioned project description, based on yearly action plans prepared by each, will be evaluated.

III. OBJECTIVE: To provide a team which shall evaluate the above project. A four person (4) evaluation team will review and assess the following:

1) Project accomplishments, problems/constraints, recommendations and lessons learned in a general sense; and specifically in regards to
2) All of the project supported SDA service systems (e.g. social marketing, rural program, clinical delivery of contraceptives and other pharmaceuticals, Management Information System, mass information dissemination, interinstitutional coordination) vis-a-vis project output indicators;
3) Systems improvements scheduled for implementation and institutionalization in the SDA;
4) Improving MCH/FP services delivery;
5) Strengthening policy and program planning and management;
6) The design of an effective cost recovery system toward for the future project sustainability.

III. PURPOSE OF THE EVALUATION:

A. This is a mid-term evaluation, originally scheduled for the spring of 1993, following the completion of the Demographic and Health Survey (FESAL) which is scheduled to end its field work by June of 1993. Evaluation results will be utilized to (a) amend/modify the project if needed to facilitate the SDA the accomplishment of project objectives, (b) conduct long-term planning in regards to sustainability of the family planning

programs in El Salvador via the private sector and the SDA, and (c) assess sustainability issues/strategies that will help enable the SDA to continue operating its program once the US support is diminished or terminated.
B. This evaluation will emphasize two aspects of the project: (1) Rural expansion of family planning and MCH services, and (b) sustainability efforts made by the SDA. However, all aspects of the project should be considered and evaluated.

C. Although this is a project evaluation, and only refers to the largest private provider, the SDA, its results will complement findings and reports to be issued under the Health Sector Assessment effort to be carried out simultaneously by USAID/El Salvador.

Type of Evaluation: As stated in the Cooperative Agreement, Attachment II, DETAILED PROJECT DESCRIPTION, C. Implementation and Monitoring Plan, 1. Monitoring Plan, "The two evaluations planned for this Project are based on a tiered monitoring and evaluation design developed over the past several years by USAID/LAC/S&T/H for the Old CS Survival Program." The three levels of measurement for this evaluation as described in the Cooperative Agreement, are: (1) Tier I: corresponds to evaluation of the inputs and outputs mentioned above, (2) Tier II: evaluates the effectiveness level, (3) Tier III: corresponds to measurements of overall impact (to be measured during the final project evaluation in 1995).

Quoting Section c. Evaluation of Attachment II of the Cooperative Agreement, the three levels are:

1. "i) Input/Output Level: the input level of the evaluations will assess the adequacy and movement of all inputs to the Project. Major input categories include logistics, technical assistance, training and education. The Output Level will involve measurement of the services and activities provided by the Project such as: 1) expansion and strengthening of the family planning distribution network; 2) integration of birth spacing and MCH services; 3) expansion and improvement of the MCH/FP education program; and 4) enhancement of the SDA management capacity, increase financial controls, increased revenues, number of new products and services offered, number of clinics, etc.

2. ii) Effectiveness Level: This level of the evaluations will consider less easily measured indicators such as how well the community health workers (PHP) understand their training and are able to impart their knowledge of MCH/FP to community members, how well educational materials and mass media campaigns reach and are absorbed and adopted by the Project beneficiaries, etc. Data for this level of evaluation will be obtained from special surveys, which the Project will fund at the beginning, middle and end of the Project, as well as collected first hand by the evaluators on field visits and in interviews with Project participants and beneficiaries.

3. iii) Impact Level: The impact level of the evaluations will measure the changes that occurred as a result of the Project in child spacing and in maternal and child morbidity and mortality. Impact level data for the mid-term evaluation (current evaluation) will be obtained from the FESAL (currently underway). Impact level data for the final evaluation will be based on service-level output information".

Agencies involved: Data obtained from this evaluation will be for the programmatic utilization of the SDA and the USAID exclusively.

IV. STATEMENT OF WORK:

The evaluation will assess project impact on the capability and performance of the Salvadoran Demographic Association (SDA) in providing family planning and maternal and child health care (MCH/FP) services to high risk rural and marginal urban populations, to reach the goals established in the Cooperative Agreement, by measuring degree of accomplishment of project objectives. Assess the overall project performance by project component; provide specific recommendations by problem to improve project implementation; identify the major problems/bottlenecks detected; suggest ways of solving/avoiding those problems/bottlenecks; and, analyze the effectiveness of the technical assistance provided to each project component as required in the Cooperative Agreement.

The questions outlined below should be answered as they relate to the overall project performance and to each project output in particular, as described in the Evaluation section of the Cooperative Agreement. (See the PURPOSE OF THE EVALUATION section in this PIO/T).

COMPONENT I: FAMILY HEALTH SERVICES DELIVERY:

(a) Reorganization and Expansion of Rural Services:

General Question:

(b) The Social Marketing Program (SMP):

General Question: Has the SMP help to expand the SDA market share and has it help to generate adequate sustainable funding for the Association?

Consider the following: (Questions to be answered in this section also cover those aspects that ought to be evaluated in Component II, Institutional Development, Expansion of the Social Marketing Program)

1 Has the SMP produced the outputs as planned and expected by the Project and the SDA?
2 Has the technical assistance provided to the SDA had any impact and/or change of strategy for the SMP?
3 Why the SMP has not been expanded/modified yet?
4 Has the SMP generated the expected revenues?
5 Is the new strategy developed by the SDA (private distributors vs. salesmen) adequate for the purposes of the SDA's fund-raising goals?

(c) Expansion of SDA Clinical Services System:

General Question: Has the SDA implemented and developed all of the activities considered in the project to increase its family planning share?

Consider the following:

1. Has the SDA established an adequate contraceptive and pharmaceutical supplies distribution system?
2. Is the supervisory system mounted by the SDA and the monitoring system of the technical assistance appropriate to assure an adequate supply of commodities to the entire system?

3. Medical network and its impact on the increase of the number of FP users as programmed.
4. Establishment and functioning of satellite and marketplace clinics in urban areas where the SDA has not traditionally been a service provider.
5. Capacity of the SDA to support health services.
6. Have the expansion of services in the SDA clinics been effectively accomplished?
7. When it is compared to previous years, has the expansion motivated an increment in the number of FP users as expected?
8. Has the SDA received adequate technical assistance for further analyzing the demand for such services and developing a viable plan for their initiation on a financially sound basis?
9. Are the marketplace clinics efficient when considering number of people attended and type of attention vs. the resources invested for their operation?
10. Did the SDA followed an adequate strategy to establish the "satellite" clinics as required by the Cooperative Agreement?
11. Is the satellite clinics system more efficient that marketplace clinics when results are compared?
12. Has the SDA made any effort to transform these totally project depend clinics to community maintained clinics?
13. Is the referral system working adequately between PHP's, physician network and satellite/main clinics of the SDA?
14. How well has the new physician network been accepted by the overall SDA system and by the communities?
15. Has the SDA developed an adequate monitoring/supervisory system for the private physicians?
16. Have these physicians received an adequate training and a consistent follow-up?
17. Is the beneficiary community comfortable with the services provided?

(d) Improved IEC Support System:

General Question: (I) Has the SDA actually expanded and improved the public education program as scheduled to inform and educate the population of rural and marginal urban areas of the country? (II) Is the SDA technical personnel assigned to this task adequately qualified to manage the magnitude of effort required by the project? Consider the following:

Information:

1 Has the SDA developed adequate brochures and pamphlets as required by the expansion of its project activities scope (e.g.: MCH and family planning)?

2 -Has the SDA designed an appropriate scope of the publicity agency planned to be contracted under the project?

3 Is it really worthwhile the effort considered for the contracting of an advertising agency? Consider level of family planning knowledge by the overall population as recorded by FESAL and other mass media studies.

Education:

1 Has the SDA trained its personnel as needed on the basis of the demand that the integration and expansion of the program required?

2 Has the technical assistance provided in this vital area been effective enough to help the SDA in designing and developing an adequate strategy for public education?

3 Has the SDA and the project given enough emphasis to the training and qualifications of the personnel involved?

4 Has there been any effort to initiate the two educational projects as planned (male "satisfied" users and medical sector training)?

Communication:

1 Has the interpersonal communication been prioritized as required in the Cooperative Agreement?

2 Has the SDA developed and implemented an interpersonal communication system with the health promoters, the family planning distributors and the clinics personnel to assure an adequate education and orientation of its clientele?

3 Did the SDA develop and distribute new materials for target populations particularly in MCH topics?

4 Is the SDA technical personnel assigned to this task adequately qualified to manage the magnitude of effort required by the project?

COMPONENT II: INSTITUTIONAL DEVELOPMENT:
Evaluation of this component is complemented and completed with the Sustainability Section of this PIO/T. See below.

(a) Expansion of the Social Marketing Program

1 What have been the efforts that SDA and the technical assistance have developed/designed to start expansion/modification of the SMP to reach the objective of this project component (enhance the financial viability of the SDA)?

2 Are these efforts being developed on a timely manner considering the project time elapsed at the moment of the evaluation and current PACD?

3 Why the SMP has not been expanded/modified yet?

4 Has the SMP generated the expected revenues?

5 Is the new strategy developed by the SDA (private distributors vs. salesmen) adequate for the purposes of the SDA's fund-raising goals?

6 What studies have the SDA carried out to establish its price policy for determining the best reasonable price for services?

(b) Establishment of a Central Referral Clinic (CRC):
Quoted from the Cooperative Agreement, "this will be one of the key elements of enhancing the self-sufficiency of the SDA program." Keeping this objective in mind:

1 What have been the efforts that the SDA has made to establish and run this clinic?

2 How well has been the participation of the technical assistance in this, if any?

3 Bottlenecks identified for the implementation of this component.

4 What are the strategies and plans the SDA has developed for this component, if any?

(c) Marketing and feasibility studies:

1 Has the SDA carried out the demand and potential cost-effectiveness study for introducing general or specialty services to its clinics, as mentioned in the Cooperative Agreement?

2 Has any market analysis been made to determine demand for these additional costs?

3 What, if any, are the improvements made by the SDA to its operational efficiency?

COMPONENT III: POLICY DEVELOPMENT AND RESEARCH: How has the project strengthened policy and program planning and management? Consider the following:

1 Relationship with other population/family planning providers
2 Technical assistance received in this area
3 Inputs provided by the SDA to the new Population Policy
4 Have the studies performed by the SDA contributed to both enhance SDA's project implementation, as well as to strengthen the policy framework of El Salvador? In what extent?

GENERAL QUESTIONS THAT RELATE TO THE ENTIRE PROJECT (CROSS-CUTTING ISSUES):

1) To what extent has the project increased the ability of the SDA to select, procure, distribute and monitor use of pharmaceuticals, medical supplies and other project related equipment? Consider the following:

a Selection of appropriate pharmaceuticals, medical supplies and other equipment (e.g.: computers, software, medical equipment).
b Determination of pharmaceutical and other commodities quantities required.
c Warehousing and distribution systems.
d Procurement system.
e Technical assistance received

2) How has the project improved the SDA's computer capability for management, supply management, statistics, research; training in computer use; and installation of computer hardware?

a Degree of performance of technical assistance received
b Level of training and knowledge acquired by SDA personnel for managing the new expanded computer capability.

3) How has the project strengthened and expanded SDA support systems, particularly, biomedical equipment and facilities maintenance; warehouses, vehicle maintenance?

a Technical assistance
b SDA's personnel capability

4) To what extent have the project contributed that the SDA improves efficiency while increasing service delivery? Consider the following:

a Technical assistance in the management area
b SDA's top level management personnel's capability in dealing with the level of effort required by the project.
c Role and involvement of the Board of Directors in project related activities and project management

5) Are current indicators being tracked under the project adequate to cases beneficiary impact? What impact level of effort under the project? Evaluators should specifically relate this to the project paper logframe and to the indicators being monitored under the Program Objectives Document as revised in the 93-95 Action Plan.

232

6) Women in Development (WID) issues should be taken into account throughout the evaluation and specifically addressed as follows:

a In what ways did women (compared to men) participate in the process of project implementation?

b Are women obtaining the expected benefits scheduled to be provided by this project?

c Are women receiving the same level of training than the men either contracted or served by this project?

d Are women contracted under the project receiving an equitable salary when compared to men?

e Considering that the SDA has a large body of volunteer women, are they treated equitable and obtaining the same degree of attention and benefits than me do?

f Is the staffing ratio of this project equitable when compared women vs. men?

g How is the performance of women in their interest to the job and their willingness to family planning programs when compared to the men working in similar tasks?

h How did women's integration in AID activities affect the sustainability of project outcomes? Were outcomes more sustained (or less sustained) when women were taken into account in AID activities?

7) **Sustainability**: Despite that the project does not have specific Sustainability section or goals, Component II activities are designed for developing strategies, skills and activities for generating income which should in turn assure project continuity after the PACD. Thus, this crucial issue includes the following questions that shall be answered under each project macro activity (Clinical and rural services, social marketing, IEC, and policy research)

- What activities need to be continued to ensure benefit sustainability?
- Is there enough political support at the SDA's Board and technical/administrative levels for benefits to continue?
- What macroeconomic policies can affect the chances for benefit sustainability?
- What revenues will be needed to sustain these activities?
- Is there a capacity for recurrent cost identification, management, and collection?
- Are there management systems in place that are appropriate for the mix and level of resources likely to be available over the long term?
- Are project activities being conducted in a cost-effective manner? The following additional questions should be also considered:
  - Does the institution know what their services or products cost to produce?
  - What is the cost per unit or cost per beneficiary of the current technology, product or delivery system?
  - How does the project costs compare with the costs elsewhere such as in the private sector?

- What sources of funding have been identified and what are other potential sources?
- Does the institutional implementation arrangement continue after donor support has been withdrawn, or is the SDA likely to continue after project completion?
- Has the institutional arrangement for project implementation strengthened or hampered the possibilities of sustained project activities?
- Does the SDA or its people that will be involved in sustaining the benefits have the capacity to do so?
- Does the project have the necessary support from the beneficiaries, e.g. in the form of active participation in operation of facilities and use of services?
- How do incentives and other factors influence project performance?

METHODS AND PROCEDURES:

The evaluation methodology should include, but not be limited to:

A. Interviews with SDA and USAID (HPN) personnel as well as with the technical assistance (international and local) personnel from the 8(a) contractor, Cambridge Consulting Corporation (CCC) involved in the project.

B. Site visits to SDA facilities and project sites.

C. Review of all pertinent documentation including but not limited to Amendments, PILs, Action Plans for both SDA and technical assistance, SAR reports, liquidation/advance vouchers, field trip reports, audit reports, and project correspondence placed at the USAID official and working project files.

D. Review of all project related documentation and correspondence sited at SDA.

IV - REPORTS:

The contractor shall provide the HPN Office at USAID with the following reports:

1. During the first week of arrival, the team will submit for USAID approval a working outline of the evaluation and a work plan to include a list of proposed site visits. These will be reviewed with contractor participation at an entry interview with the Mission Evaluation Committee.

Draft Report: At least 7 working days before leaving El Salvador, the Chief of Party will provide the USAID with a copy of the draft report in English and Spanish following the outline proposed at the beginning of the consultancy.

The contractor will participate in reviews of this draft with designated USAID officers and in a senior staff review to be held three days after the date of submission of the draft. Contractor will be responsible for incorporating written and oral comments received in this meeting in the final draft. Immediately before departure, the consultants will prepare and deliver 5 copies in English and in Spanish of a final draft report, incorporating drafting or substantive changes, if any. USAID will have 10 working days to review this final draft before returning it to the Contractor.

Final Report: No later than 4 weeks after receipt of the final draft from USAID, the Contractor will submit a final evaluation report, 5 English copies and 5 in Spanish, to USAID/HPN, incorporating clarifications and/or additions requested by the Mission.

The evaluation report will include the following sections:

(A) an Executive Summary, including purpose of the evaluation, methodology used, findings, conclusions and recommendations. It will also include comments on impact and lessons learned. It should be complete enough so that the reader can understand the evaluation without having to read the entire document, i.e. a self-contained document. (B) A copy of the scope of work under which the evaluation was carried out. The methodology used will be explicitly outlined. Any deviation from the scope will be explained. (C) A listing of the evaluation team, their field of expertise and the role they played on the team. (D) A clear presentation of the evaluation recommendations, in a separate section of the report if convenient, so that the reader can easily locate them. (E) The project's lessons learned should be clearly presented with emphasis given to those relating to replicability and sustainability. These should describe the causal relationship factors that proved critical to project success or failure, including necessary political, policy, economic, social and bureaucratic preconditions within the host country and AID. These should also include a discussion of the techniques or approaches which proved most effective or had to be changed and why. (F) A paginated Table of Contents. (G) Annotated bibliography of all project related documents. In addition, the Contractor is responsible for the preparation of the summary and abstract sections of the AID Evaluation Summary (form to be provided) which will be delivered with the final report.

ANNEX 53

BIBLIOGRAFIA

1. INFORME DE SEGUIMIENTO Y CAPACITACION sobre los módulos 1 y 2 dirigida a los primeros 4 grupos de PSP.
Asociación Demográfica Salvadoreña; División de Planificación, Evaluación y Desarrollo.
San Salvador, Noviembre de 1991.

2. INFORME DEL SEGUNDO SEGUIMIENTO A LA CAPACITACION sobre los módulos 1 y 2 dirigidas a los grupos 5,6,7 y 8 de PSP.
Depto. de Evaluación e Investigaciones, Asociación Demográfica Salvadoreña.
San Salvador, Enero de 1992.

3. ENCUESTA NACIONAL DE SALUD FAMILIAR, FESAL-93.
Asociación Demográfica Salvadoreña, División de Información, Educación y Comunicación.
San Salvador, Abril de 1994.

4. INFORME DE CONSULTORIA A CORTO PLAZO EN EL AREA DE EDUCACION EN SALUD, Proyecto Servicios de Salud Familiar.
Cambridge Consulting Corporation.
San Salvador, Mayo 12 de 1993.

5. CONSULTORIA A CORTO PLAZO EN EL ANALISIS DEL AREA DE EDUCACION EN SALUD del Proyecto Servicios de Salud Familiar.
Cambridge Consulting Corporation.
San Salvador, 23 de Noviembre de 1992.

6. INFORME DE AVANCE DEL PROYECTO 519-0363 SERVICIOS DE SALUD FAMILIAR.
Asociación Demográfica Salvadoreña, Depto. de Programación.

7. NUTRICION, CRECIMIENTO Y DESARROLLO.
Asociación Demográfica Salvadoreña; División de información, educación y comunicación, Depto.de Educación y adiestramiento.

8. INFECCIONES RESPIRATORIAS AGUDAS.

9. ENFERMEDADES INMUNOPREVENIBLES.
Asociación Demográfica Salvadoreña; División de información, Educación y Comunicación. Depto. de Educación adiestramiento.

10. MANUAL DE PROMOCION COMUNITARIA.
Asociación Demográfica Salvadoreña.
San Salvador, Marzo de 1992.

11. MANUAL DEL PROMOTOR DE SALUD PRO-FAMILIA.
Asociación Demográfica Salvadoreña. División de Información , Educación y Comunicación.
Departamento de Educación y Adiestramiento.
San Salvador, Mayo de 1992.

236

12. PROYECTO SERVICIOS DE SALUD FAMILIAR, 3er. REPORTE TRIMESTRAL.
Cambridge Consulting Corporation.
Período del 17 de Junio de 1991 al 17 de Septiembre de 1991.

13. INFORME GENERAL DE MONITOREO DEL PROYECTO DE SERVICIOS DE SALUD FAMILIAR, Período Enero 1991-Diciembre 1993.
Cambridge Consulting Corporation.
San Salvador, 24 de Enero de 1994.

14. FAMILY HEALTH SERVICES PROJECT, 4th. QUATERLY PROGRESS REPORT.
Cambridge Consulting Corporation.
San Salvador, for the period December 17, 90-March 17, 91.

15. FAMILY HEALTH SERVICES PROJECT, QUATERLY PROGRESS REPORT.
Cambriddge Consulting Corporation.
San Salvador, for the period December 17, 1991-March 16, 1992.

16. FAMILY HEALTH SERVICES PROJECT, 1st. QUATERLY PROGRESS REPORT.
Cambridge Consulting Corporation.
San Salvador, for the period March 17, 92-June 16, 92.

17. FAMILY HEALTH SERVICES PROJECT, 2nd. QUATERLY PROGRESS REPORT.
Cambridge Consulting Corporation.
For the period March 17, 1992 - June 16, 1992.

18. FAMILY HEALTH SERVICES PROJECT.THIRD QUATERLY PROGRESS REPORT.
Cambridge Consulting Corporation.
For the period June 17, 1992 - September 17, 1992.

19. FAMILY HEALTH SERVICE PROJECT, FOURTH QUATERLY REPORT 1992.
Cambridge Consulting Corporation.
For the period September 17, 1992 - December 17, 1992.

20. INFORME GENERAL DE MONITOREO, Período Enero 1991 - Diciembre 1993.
Cambridge Consulting Corporation.
San Salvador, 24 de Enero de 1994.

21. PLAN DE IMPLEMENTACION CONVENIO AID-ADS (519-0363).
Asociación Demográfica Salvadoreña.
San Salvador, Octubre de 1990.

22. PLAN DE ACCION 1992, Período Enero 1 - Diciembre 31, 1992.
Asociación Demográfica Salvadoreña.
San Salvador, Diciembre de 1991.

23. INFORME DE RESULTADOS. ESTUDIO SOBRE SATISFACCION DE USUARIAS Y CAUSAS DE ABANDONO DEL PROGRAMA DE PLANIFICACION FAMILIAR DE ADS.
Asociación Demográfica Salvadoreña.
San Salvador, Febrero de 1993.

237

24. REVISTA FORO Vol. IX No. 2.
Federación Internacional de Planificación de la familia, región del hemisferio Occidental, Inc.
Diciembre de 1993.

25. GUIA DE METODOS ANTICONCEPTIVOS MODERNOS.
Asociación Demográfica Salvadoreña.
El Salvador, 1990.

26. FOLLETO SISTEMA NORPLANT.
E.E.U.U. August, 1991.

27. INFORME ANUAL ADS 1993.
Asociación Demográfica Salvadoreña.
San Salvador, año de 1993.

28. ENCUESTA NACIONAL DE SALUD FAMILIAR.
El Salvador, Abril de 1994.

29. ESTUDIO DE FACTIBILIDAD PARA LA APERTURA DE CLINICA SATELITE EN LA CIUDAD DE CHALATENANGO.
Investigaciones de Población y Mercado (IPM, S.A.).
El Salvador, 27 de Noviembre de 1992.

30. ESTUDIO DE FACTIBILIDAD PARA LA APERTURA DE CLINICA SATELITE EN LA CIUDAD DE COJUTEPEQUE.
Investigaciones de Población y Mercado, (IPM, S.A.de C.V.).

31. ESTUDIO DE FACTIBILIDAD PARA LA APERTURA DE CLINICA SATELITE EN LA CIUDAD DE SENSUNTEPEQUE.
Investigaciones de Población y Mercado (IPM, S.A. de C.V.).
San Salvador, 27 de Noviembre de 1992.

32. ESTUDIO DE FACTIBILIDAD PARA LA APERTURA DE CLINICA SATELITE EN CIUDAD BARRIOS.
Investigaciones de Población y Mercado (IPM, S.A. de C.V.).
San Salvador, 27 de Noviembre de 1992.

33. ESTUDIO DE FACTIBILIDAD PARA LA APERTURA DE CLINICA SATELITE EN LA CIUDAD DE ILOBASCO.
Investigaciones de Población y Mercado (IPM, S.A. de C.V.).
San Salvador, 27 de Noviembre de 1992.

34. ESTUDIO DE FACTIBILIDAD PARA LA APERTURA DE CLINICA SATELITE EN LA CIUDAD DE AHUACHAPAN.
Investigaciones de Población y Mercado (IPM, S.A. de C.V.).
San Salvador, 27 de Noviembre de 1992.

35. ESTUDIO DE FACTIBILIDAD PARA LA APERTURA DE CLINICA SATELITE EN LA CIUDAD DE SUCHITOTO.
Investigaciones de Población y Mercado (IPM, S.A. de C.V.).

36. ESTUDIO RETROSPECTIVO DE LAS CITOLOGIAS CON ANORMALIDADES ONCOLOGICAS EN LAS CLINICAS REGIONALES DE ADS, período de 1988-1991.
Samuel Castro González, Médico ginecólogo director de la división médica; Jose Mario Cáceres Henríquez, Sociologo Director de la División de Planificación, evaluación y Desarrollo.
San Salvador, Enero de 1994.

37. NORMAS Y PROCEDIMIENTOS PARA LA ENTREGA DE SERVICIOS DE LA DIVISION MEDICA DE ADS.
Asociación Demográfica Salvadoreña, División Médica.
San Salvador, Septiembre de 1991.

38. INFORME ANUAL 1991.
Asociación Demográfica Salvadoreña.
San Salvador, Febrero de 1992.

39. INFORME ANUAL 1992.
Asociación Demográfica Salvadoreña.
El Salvador, Febrero de 1993.

40. MANUAL DE PROCEDIMIENTOS DE COMPRAS Y SUMINISTROS.
Asociación Demográfica Salvadoreña, Proyecto de Servicios de Salud Familiar.
Abril de 1991.

41. PLAN DE ACCION ASISTENCIA TECNICA.
Cambridge Consulting Corporation.
Año de 1994.

42. PLANES DE ACCION, 1991-3.
Deptos: IEC
Asociación demográfica Salvadoreña.
San Salvador, Octubre de 1992.

43. PLAN DE ACCION 1994, PERIODO ENERO 1 - DICIEMBRE 31, 1994.
Asociación Demográfica Salvadoreña.
San Salvador, Octubre de 1993.

44. FINAL REPORT OF THE APSISA, SECOND EVALUATION.
Cambridge Consulting Corporation.
January 21, 1994.

45. REPORTE DE MONITOREO, MARZO DE 1994.
Cambridge Consulting Corporation.
San Salvador, 28 de Abril de 1994.

45. REPORTE DE MONITOREO, SEPTIEMBRE DE 1993.
Cambridge Consulting Corporation.
San Salvador, 13 de Octubre de 1993.

46. REPORTE FINAL DE CONSULTORIA DE CORTO PLAZO EN AREA DE TRANSPORTE Y MANTENIMIENTO.
Cambridge Consulting Corporation.
San Salvador, Septiembre de 1992.

47. REPORTE FINAL DE CONSULTORIA DE CORTO PLAZO EN AREA DE TRANSPORTE Y MANTENIMIENTO.
Cambridge Consulting Corporation.
San Salvador, Febrero de 1992.

48. FINAL REPORT OF THE LOGISTICS ADVISOR, for period December 17, 1990 - December 16, 1992.
Family Health Services Project.

49. MANUAL DE PROCEDIMIENTOS DE COMPRAS Y SUMINISTROS.
Asociación Demográfica Salvadoreña.
San Salvador,Agosto de 1993.

50. DOCUMENTACION TECNICA DEL SISTEMA : TRANSPORTE Y MANTENIMIENTO
Asociación demográfica Salvadoreña, Cambridge Consulting Corp.
San Salvador, Junio de 1993.

51. REPORTE FINAL DE CONSULTORIA A CORTO PLAZO EN EL AREA DE ALMACENAMIENTO.
Cambridge Consulting Corporation.
San Salvador, Abril 7 de 1993.

52. REPORTE FINAL DE CONSULTORIA DE CORTO PLAZO EN EL AREA DE ALMACENAMIENTO.
Cambridge Consulting Corporation.
San Salvador, Marzo de 1992.

53. MANUAL GENERAL DE ALMACENAMIENTO Y SUMINISTROS.
Cambridge Consulting Corporation.
San Salvador, julio de 1992.

54. NORMAS Y PROCEDIMIENTOS DE RECEPCION Y ALMACENAJE DE PRODUCTOS
Cambridge Consulting Corporation.
San Salvador, Mayo de 1992.

55. MANUAL DE ENTRENAMIENTO SOBRE SISTEMAS DE COMPRAS Y SUMINISTROS, GUIA DEL INSTRUCTOR.
Asociación Demográfica Salvadoreña.
Junio de 1992.

56. TECHNICAL PROPOSAL.
Cambridge consulting Corporation.
October 15, 1990.

57. INFORME DE AUDITORIA EXTERNA SOBRE LOS ESTADOS FINANCIEROS AL 31 DE DICIEMBRE DE 1993 Y 1992.
Asociación Demográfica Salvadoreña.
Campos Castellanos y Cia. Auditores y Consultores.

58. GUIAS DE MONITOREO.
Asociación demográfica Salvadoreña, López Salgado y Co.

59. MANUAL DE PROCEDIMIENTOS CONTABLES.
Asociación Demográfica Salvadoreña.
San Salvador, Julio de 1993.

60. SISTEMA FINANCIERO-CONTABLE.
Asociación Demográfica Salvadoreña, López Salgado y Co.
San Salvador, Julio de 1993.

61. COMERCIALIZACION DE LOS SERVICIOS DEL HOSPITAL PRO-FAMILIA.
Asociación Demográfica Salvadoreña, División de Mercadeo Social.
San Salvador, 1993.

62. COMERCIALIZACION DE DONACIONES "CAMPANA CORREO DIRECTO".
Asociación Demográfica Salvadoreña. División de Mercadeo Social.
San Salvador, 1993.

63. LA REFORMA DEL SECTOR SALUD: HACIA SU EQUIDAD Y EFICIENCIA
Análisis del sector Salud de El Salvador.ANSAL.
Mayo de 1994.

64. EVALUATION OF THE ANTI-DRUG FOUNDATION OF EL SALVADOR. (FUNDASALVA).
NAE. Narcotics Awareness and Education Project.
November, 1993.

65. DISENO DEL PLAN DE MERCADO SOCIAL PARA LA ASOCIACION DEMOGRAFICA SALVADORENA.
Cambridge Consulting Corporation.
San Salvador, Junio de 1992.

66. REPORTE FINAL DE CONSULTORIA DE CORTO PLAZO EN AREA DE MERCADO SOCIAL DE ANTICONCEPTIVOS.
Cambridge Consulting Corporation.
San Salvador, Julio de 1992.

67. FINAL REPORT SHORT TERM CONSULTANCY IN INCOME GENERATION ACTIVITIES FOR THE SALVADOREAN DEMOGRAPHIC ASOCIATION.
Cambridge Consulting Corporation.
San Salvador, September 1993.

68. INFORME ANUAL 1993.
Asociación Demográfica Salavadoreña.
San Salvador, Febrero de 1994.

69. PROGRAMA DE TRABAJO PRESUPUESTO 1993.
Asociación Demográfica Salvadoreña.

San Salvador, Octubre de 1992.

70. PRIVATE SECTOR EVALUATION: THE DOMINICAN REPUBLIC.
Robert Culbertson, Earl Jones, Roberto Corpeño, Development Associates, Inc.
June 1983.

71. PROGRAMA DE TRABAJO PRESUPUESTO 1991.
Asociación Demográfica Salvadoreña.
San Saalvador, Octubre de 1990.

72. PROGRAMA DE TRABAJO PRESUPUESTO 1992.
Asociación Demográfica Salvadoreña.
San Salvador, octubre de 1991.

73. INTEGRACION DE GENERO EN PROYECTOS Y PROGRAMAS.
Mayo de 1994.

74. ANALISIS DEL COSTO-EFECTIVIDAD DE LOS SERVICIOS MEDICOS CLINICOS DE LA ADS.
Consultorías e Investigaciones en Servicios de Salud, S.A.
San Salvador, 20 de Febrero de 1992.

75. MODELO DE UN PROYECTO DE MERCADEO SOCIAL DE ANTICONCEPTIVOS PRESENTADO A JUNTA DIRECTIVA DE ADS.
Cambridge Consulting Corporation.
San Salvador, 25 de Junio de 1992.

76. ESTUDIO DE MERCADO PARA LA AMPLIACION DE LOS SERVICIOS DE SALUD EN LAS CLINICAS ADS, TOMO I Y II.
Consultores en Mercadeo de Centro América.
San Salvador, 15 de Diciembre de 1992.

77. THE ROLE OF MINISTRY OF HEALTH HOSPITALS IN EL SALVADOR : CURRENT SITUATION, ALTERNATIVE OPTIONS AND FINANCIAL IMPLICATIONS, PHASE I.
Inter-american Development Bank Education and Health division (SDV/EDN).
March, 1993.

78. EL MUNDO DE MERCADEO DE ADS EN EL SALVADOR, por Lic. Juan Antonio Rivas.
Asociación Demográfica Salvadoreña.
Mayo de 1993.

79. FINAL REPORT OF SHORT-TERM, CONSULTANCY GENERATION RESOURCES.
Cambridge Consulting Corp. Family Health Services Project.
February 1993.

80. REPORTE FINAL DE CONSULTORIA A CORTO PLAZO EN GENERACION DE FONDOS.

242

Cambridge Consulting Corporation.
San Salvador, 31 de Marzo de 1993.

81. DEVELOPMENT ASSISTANCE AND HEALTH PROGRAMS : ISSUES OF SUSTAINABILITY.
A.I.D. Program Evaluation Discussion Paper No. 23.
October, 1987.

82. FINANCIAL MANAGEMENT GUIDELINES ACCOUNTING POLICIES AND PROCEDURES.
Arab Republic of Egipt, Ministry of health.
August, 1993.

83. ACTION PLAN.
USAID/El Salvador.
Years 1995-1996.

84. ESTUDIO DE RELACIONES HUMANAS DE LA ASOCIACION DEMOGRAFICA SALVADORENA, REPORTE PRELIMINAR.
René Varela Santamaría, Consultor.

85. ESTUDIO DE RELACIONES HUMANAS DE LA ASOCIACION DEMOGRAFICA SALVADORENA, REPORTE FINAL.
René Varela Santamaría, Consultor.

86. INFORME DE SITUACION FINANCIERA AL 31 DE DICIEMBRE DE 1993.
Asociación Demográfica Salvadoreña.
San Salvador, Enero de 1994.

87. INFORME DE SITUACION FINANCIERA AL 31 DE DICIEMBRE DE 1992.
Asociación Demográfica Salvadoreña.
San Salvador, 1 de Febrero de 1993.

88. INFORME DE SITUACION FINANCIERA AL 30 DE ABRIL DE 1994.
Asociación Demográfica Salvadoreña.
San Salvador, 19 de Mayo de 1994.

89. CUADRO GLOBAL DE ESTIMACIONES 1994.
Asociación Demográfica Salvadoreña. División Médica.

90. ESTUDIO DE MERCADO PARA LA AMPLIACION DE LOS SERVICIOS DE SALUD EN LAS CLINICAS DE ADS.
Asociación Demográfica Salvadoreña.

91. ANALISIS DE COSTO-EFECTIVIDAD DE LOS SERVICIOS MEDICOS.
Asociación Demográfica Salvadoreña.

92. COSTO-RENDIMIENTO DE 3 CLINICAS SATELITE Y 2 DE MERCADO.
Asociación Demográfica Salvadoreña.

93. COSTO-BENEFICIO DE LOS SERVICIOS A EMPRESAS PATROCINADORAS.
Asociación Demográfica Salvadoreña.

94. EL SALVADOR, PROJECT PAPER. FAMILY HEALTH SERVICES.
United States INternational Development Cooperation Agency.
Agency for International Development.

95. ESPECIFICACIONES PARA LA TRANSMISION DE CUNAS RADIALES SOBRE PLANIFICACION FAMILIAR ADS.
Asociación Demográfica Salvadoreña . División IEC Comunicación y Producción Educativa.
Noviembre 21, 1991.

96. REVISTAS DE ANIVERSARIOS DE ADS No. 30, 31 y 32.
Asociación Demográfica Salvadoreña.

97. CARTAS INFORMATIVAS DESDE 1991 A LA FECHA.
Asociación Demográfica Salvadoreña.

98. INFORMACION Y COMUNICACION SOCIAL.
Asociación Demográfica Salvadoreña.
Año de 1994.

99. COMERCIALIZACION DE LOS SERVICIOS DEL CENTRO DE PRODUCCION AUDIOVISUAL.
Asociación Demográfica Salvadoreña. División de Mercadeo Social.
San Salvador, 1993.

100. ESTRATEGIAS DE IEC EN APOYO AL PROYECTO "SERVICIOS DE SALUD FAMILIAR".
Asociación Demográfica Salvadoreña.

101. PLANES DE ACCION DE 1990 A 1994.
Asociación Demográfica Salvadoreña.

102. REORGANIZACION Y EXPANSION DE SERVICIOS RURALES.
Asociación Demográfica Salvadoreña.
Años de 1991 a 1993.

103. PLAN ESTRATEGICO PERIODO DE 1995-1997
Asociación Demográfica Salvadoreña.
Años de 1995 hasta 1997.

104. MANUAL DEL PROMOTOR DE SALUD PRO-FAMILIA.
Asociación Demográfica Salvadoreña.
San Salvador, año de 1993.

105. GUIAS PEDAGOGICAS CURSOS A PSP
Asociación Demográfica Salvadoreña.
San Salvador, año de 1994.

106. PROYECTO PILOTO PARA LA PROMOCION Y CAPTACION DE USUARIOS A LOS SERVICIOS DE VASECTOMIA.
Asociación Demográfica Salvadoreña.
San Salvador,2 de Julio de 1992.

107. COMPARACION DE OBJETIVOS Y LOGROS EN BASE A ANALISIS DOCUMENTAL : PTP CRONOGRAMA MENSUAL DE ACTIVIDADES Y ESTADOS DE AVANCE.
Asociación Demográfica Salvadoreña.

108. REPORTE DE MAYOR GENERAL 1991.
Agencia Internacionl para el Desarrollo.
Año de 1991.

109. REPORTE DE MAYOR GENERAL 1992.
Agencia Internacional para el Desarrollo.
Año de 1992.

110. REPORTE DE MAYOR GENERAL 1993.
Agencia Internacional para el Desarrollo.
Año de 1993.

111. INFORMES DE PRETESTING DE MATERIALES, 1991-93

112. BIBLIOGRAPHY OF REPORTS AND PUBLICATIONS FAMILY HEALTH SERVICES PROJECT FROM DECEMBER 1990 TO MAY 1994
Cambridge Consulting Corporation.

113. ESTUDIO PILOTO PARA EVALUAR LA EFICIENCIA, EFICACIA Y EFECTIVIDAD DE LA ESTRATEGIA DEL EFECTO MULTIPLICADOR UTILIZADO POR EL DEPARTAMENTO DE EDUCACION Y ADIESTRAMIENTO.
San Salvador 1990.

114. EVALUACION DE IMPACTO DE LOS SEMINARIOS TALLER SOBRE CONSEJERIA PARA LA ANTICONCEPCION QUIRURGICA VOLUNTARIA.
San Salvador 1990.

115. ESTUDIO SOBRE EL USO DEL ENANTATO DE NORETISTERONA COMO METODO ANTICONCEPTIVO.
San Salvador 1990.

116. ESTUDIO DE COSTO BENEFICIO DE LOS SERVICIOS A EMPRESAS PATROCINADORAS.
San Salvador 1991.

117. EVALUACION DE LAS ACTIVIDADES DE EDUCACION Y ADIESTRAMIENTO DIRIGIDAS AL PERSONAL TECNICO Y OPERATIVO DEL PRESR (8 Informes específicos fueron presentados).
San Salvador 1991.

118. SATISFACCION DE USUARIAS Y CAUSAS DE ABANDONO DEL PROGRAMA DE PLANIFICACION FAMILIAR DE ADS.
San Salvador 1991.

119. ANALISIS DE FLUJO DE PACIENTES EN LAS CLINICAS PRO-FAMILIA.
San Salvador 1991.

120. ESTUDIO COSTO-RENDIMIENTO DE SERVICIOS DE ANTICONCEPCION QUIRURGICA VOLUNTARIA PRESTADOS A TRAVES DE CECLISA.
San Salvador 1991.

121. ESTUDIO RETROSPECTIVO DE FACTIBILIDAD DEL ESTABLECIMIENTO DE LA CLINICA SATELITE # 1.
San Salvador 1991.

122. ESTUDIO SOBRE NECESIDADES, INTERESES, Y PROBLEMAS DEL ADOLESCENTE.
San Salvador 1992.

123. ESTUDIO DE FACTIBILIDAD PARA LA APERTURA DE NUEVAS CLINICAS SATELITES.
San Salvador 1992.

124. ESTUDIO RETROSPECTIVO SOBRE LA ANTICONCEPCION QUIRURGICA VOLUNTARIA EN EL PROGRAMA MEDICO DE ADS; PERIODO 1973-1991.
San Salvador 1992.

125. ESTUDIO DE ORGANIZACION Y FUNCIONAMIENTO DEL DEPARTAMENTO DE RELACIONES PUBLICAS Y DESARROLLO DE RECURSOS.
San Salvador 1992.

126. ESTUDIO DE COSTO RENDIMIENTO DE CLINICAS SATELITES Y DE MERCADOS.
San Salvador 1993.

127. ESTUDIO DE MERCADO PARA LA AMPLIACION DE LOS SERVICIOS DE SALUD EN LAS CLINICAS DE ADS EN SAN MIGUEL, SANTA TECLA Y SANTA ANA.
San Salvador 1993.

128. ENCUESTA NACIONAL DE SALUD FAMILIAR.
San Salvador 1993.

129. ESTUDIO DE COSTO EFECTIVIDAD EN LAS CLINICAS DE ADS.
San Salvador 1993.

130. ESTUDIO RETROSPECTIVO DE LAS CITOLOGIAS CON ANORMALIDADES ONCOLOGICAS EN CLINICAS REGIONALES DE ADS.
San Salvador 1993.

131. ESTUDIO DE IMPLANTACION DE NORPLANT (no se ha terminado)
San Salvador 1994.

246

ANNEX 54

ESTUDIOS REALIZADOS CON FONDOS PROVENIENTES DE USAID

1990

- Estudio Piloto para Evaluar la Eficiencia, Eficacia y Efectividad de la Estrategia del Efecto Multiplicador utilizado por el Departamento de Educación y Adiestramiento.
- Monitoreo del Proyecto Desarrollo Curricular para la Educación en Población.
- Evaluación de Impacto de los Seminarios Taller Sobre Consejería para la Anticoncepción Quirúrgica Voluntaria.
- Estudio Sobre el Uso del Enantato de Noretisterona como Método Anticonceptivo.

1991

- Estudio de Costo Beneficio de los Servicios a Empresas Patrocinadoras.
- Evaluación de las Actividades de Educación y Adiestramiento dirigidas al Personal Técnico y Operativo del PRESR (8 Informes específicos fueron presentados).
- Análisis de Flujo de Pacientes en las Clínicas Pro-Familia.
- Satisfacción de Usuarias y Causas de Abandono del Programa de Planificación Familiar de ADS.
- Estudio Costo Rendimiento de Servicios de Anticoncepción Quirúrgica Voluntaria prestados a través de CECLISA.
- Estudio Retrospectivo de Factibilidad del Establecimiento de la Clínica Satélite # 1.

1992

- Estudio Sobre Necesidades, Intereses y Problemas del Adolescente.
- Estudio de Factibilidad para la Apertura de Nuevas Clínicas Satélites.
- Estudio Retrospectivo Sobre la Anticoncepción Quirúrgica Voluntaria en el Programa Médico de ADS; período 1973 - 1991.
- Estudio de Organización y Funcionamiento del Departamento de Relaciones Públicas y Desarrollo de Recursos.

1993

- Estudio de Costo Rendimiento de Clínicas Satélites y de Mercados.
- Estudio de Mercado para la Ampliación de los Servicios de Salud en las Clínicas de ADS en San Miguel, Santa Tecla y Santa Ana.
- Encuesta Nacional de Salud Familiar.
- Estudio de Costo Efectividad Clínicas de ADS.
- Estudio Retrospectivo de las Citologías con Anormalidades Oncológicas en Clínicas Regionales de ADS.

1994
- Estudio de implantes de Norplant (no ha terminado)

248

ANNEX 55

RESUMEN EJECUTIVO

A. INTRODUCCIÓN

USAID/ES, HPN, desarrollo el siguiente plan para la evaluación preliminar del proyecto No. 519-0306, Servicios de Salud Familiar iniciada en Julio de 1991 por la Asociación Demográfica Salvadoreña (ADS). El proyecto tiene una duración de 5 años, con un fondo total de $ 35,826,000 (aporte USAID = $ 22,000,000 y aporte ADS = $13,826,000). El propósito del proyecto es de continuar y expandir el tiempo de dar a luz y mejorar la calidad y eficiencia de los servicios de Salud Materno-Infantil (SMI) para poblaciones rurales de alto riesgo y áreas urbano-marginales. Cambridge Consultions Corporation (CCC) fue contratado para brindar asistencia técnica y monitoreo.

1. Evaluación de la reorganización y expansión de los servicios rurales, clínicas regionales, clínicas satélites, clínicas de mercado, y el sistema de prescripción médica con un énfasis particular en la eficacia (incluyendo el método mixto), logística, asistencia técnica (recibida y requerida), IEC/entrenamiento y continuidad.

2. Evaluación del desarrollo institucional, enfocandose en el mercadeo social y la continuidad avanzada, evaluación de programa y capacidad de administración.

3. Descripción del impacto del proyecto sobre la política de desarrollo y su estudio.

B. METODOLOGIA

El equipo de evaluación de Development Associates estuvo bajo la dirección de Victoria Wells, MD, DPH, Jefe de Grupo, especialista en educación familiar y poblacional; María Gutiérrez-Valencia, especialista en economía y mercadeo social; Diane Urban, especialista en educación; y John Wolff, especialista en logística.

El equipo utilizó los siguientes métodos:

1. Entrevistas con personas claves de ADS, MSPAS, CCC y USAID, y entrevistas con el sector privado (médicos, líderes religiosos, consultores).

2. Observaciones y cuestionarios fueron desarrollados en áreas rurales y urbano-marginales en cada una de las cuatro regiones (Central, Paracentral, Occidental, Oriental).

3. Revisión de documentación y correspondencia de proyectos oficiales.

4. Análisis de la demografía oportuna, finanzas y estadísticas clínicas.

5. Visitas de campo a 4 clínicas regionales, 4 clínicas satélite, 4 clínicas de mercado (2 fundadas totalmente por la ADS, 2 que reciben anticonceptivos de la ADS), y bodegas en cada región.

6. Revisión de reportes de consultores a corto plazo, evaluaciones de monitoreo de CCC, y evaluaciones de supervisores de la ADS.

C. CONCLUSIONES/RECOMENDACIONES

COMPONENTE I: SERVICIOS A DOMICILIO DE PLANIFICACION FAMILIAR

A. Reorganización y Expansión de Servicios Rurales

1) La provisión de servicios, suministros, y la educación en salud en áreas rurales puede resultar en porcentaje bajos de natalidad.
Rec: La campaña promocional de medios publicitarios para la planificación familiar debe comenzar lo más pronto posible.

2) El programa rural ha alcanzado la mayoría de las metas, en términos numéricos de PSPs, DARs, y cantones cubiertos. Sin embargo la calidad de servicios necesitan mejorar.
Rec: Fortalecer la capacitación y supervisión de los PSPs:
a) Reorganizar y expandir el departamento de capacitación.
b) Capacitar a los supervisores de los promotores y enfermeras auxiliares en ambas áreas substancial y educacional.
c) Desarrollar módulos superiores, certificados, y reconocimientos para los PSPs.

3) La asistencia técnica no se ha ajustado al mejoramiento de la capacitación.
Rec: Llevar a cabo un estudio de necesidades de capacitación.
Rec: Contratar un consultor que sea especialista en la capacitación de poblaciones rurales analfabetas y de bajo nivel académico por un período de un año, para enriquecer la capacitación.

4) El proyecto se ha dificultado por la escasez de suministros. El proyecto rural parece que recibe menor apoyo logístico que el programa clínico.
Rec: Asegurar apoyo administrativo a través de una política explícita de apoyo de una administración de alto nivel.

5) Los materiales de IEC son generalmente buenos y existen materiales para personas analfabetas. Los videos de los productos son excelentes.
Rec: Desarrollar material adicional con el aporte del cliente, particularmente para jóvenes y adultos analfabetas.

6) El método mixto es imposibilitado por la dependencia de otras agencias.
Rec: Investigar la provisión de Depo-Provera para el método mixto.

7) El programa rural algunas veces duplica esfuerzos de otras agencias de MSPAS y NGO.
Rec: Incrementar la eficiencia a través de la integración de los promotores rurales de salud con los del MSPAS.

B. Programa de Mercadeo Social

1) El Departamento de Recursos y Mercadeo Social creado el 2/93, empezó a funcionar con una persona y su primer asistente fue contratado 6 meses después. La deficiencia

250