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UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY  
AGENCY FOR INTERNATIONAL DEVELOPMENT  
Washington, D. C. 20523

EL SALVADOR

PROJECT PAPER

POPULATION DYNAMICS

AID/LAC/P-257

Project Number: 519-0210

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RECORD COPY

AGENCY FOR INTERNATIONAL DEVELOPMENT <b>PROJECT DATA SHEET</b>		1. TRANSACTION CODE <input checked="" type="checkbox"/> A = Add <input type="checkbox"/> C = Change <input type="checkbox"/> D = Delete	Amendment Number _____	DOCUMENT CODE <b>3</b>
COUNTRY/ENTITY <b>El Salvador</b>		3. PROJECT NUMBER <b>519-0210</b>		
4. BUREAU/OFFICE <b>LAC</b>		5. PROJECT TITLE (maximum 40 characters) <b>Population Dynamics</b>		
6. PROJECT ASSISTANCE COMPLETION DATE (PACD) MM DU YY <b>19 3 88</b>		7. ESTIMATED DATE OF OBLIGATION (Under "B" below, enter 1, 2, 3, or 4) A. Initial FY <b>85</b> B. Quarter <b>4</b> C. Final FY <b>86</b>		

8. COSTS (5000 OR EQUIVALENT \$) = \_\_\_\_\_

A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total			3525	3400	6600	10000
(Grant)			3525	3400	6600	10000
(Loan)						
Other U.S.						
1.						
2.						
Host Country			500		1770	1770
Other Donor(s)			260		760	760
<b>TOTALS</b>						

9. SCHEDULE OF AID FUNDING (\$000)

A. APPRO. PRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH CODE 1. Grant 2. Loan	D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
			1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) POP	440	440	--	--	10,000	--	10,000	
(2)	420							
(3)								
(4)								
<b>TOTALS</b>								

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each) <b>450                      420</b>		11. SECONDARY PURPOSE CODE	
12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)			
A. Code	<b>BWV</b>	<b>PVON</b>	
B. Amount			

13. PROJECT PURPOSE (maximum 480 characters)

To improve and expand the provision of family planning and reproductive health services by strengthening those institutions which presently provide services to Salvadoran couples, particularly those in rural areas.

14. SCHEDULED EVALUATIONS				15. SOURCE/ORIGIN OF GOODS AND SERVICES			
Interim	MM YY	MM YY	Final	MM YY	MM YY	MM YY	MM YY
	<b>01 87</b>			<b>08 88</b>			
				<input type="checkbox"/> 000 <input type="checkbox"/> 941 <input type="checkbox"/> Local <input type="checkbox"/> Other (Specify) _____			

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a \_\_\_\_\_ page PP Amendment)

17. APPROVED BY	Signature	<b>ROBIN L. GOMEZ</b> , Mission Director	18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION
	Title	<b>USAID El Salvador</b>	
	Date Signed	MM DD YY <b>08 27 88</b>	MM DD YY 

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## PROJECT AUTHORIZATION

Name of the Country: El Salvador  
Salvadoran Demographic Association (ADS)  
The Government of El Salvador (GOES)

Name of Project: Population Dynamics

Number of Project: 519-0210

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Population Dynamics Project for El Salvador, encompassing a grant to the Salvadoran Demographic Association (ADS) and a grant to the Government of El Salvador (GOES), involving planned obligations not to exceed Ten Million United States Dollars in grant funds over a three year period ending September 30, 1983, subject to the availability of funds in accordance with the A.I.D. CEB allotment process, to help in financing foreign exchange and local currency costs for the Project. The planned life of the Project is 37 months from the date of initial obligation.

2. The Project consists of technical and financial support to develop the capacity of El Salvador's private and public sectors to improve and expand the provision of family planning and reproductive health services by strengthening those institutions which presently provide services to Salvadoran couples, particularly in rural areas.

3. The Project Agreements, which may be negotiated and executed by the officer to whom such authority is delegated in accordance with A.I.D. regulations and Delegations of Authority, shall be subject to the following terms and conditions, together with such terms and conditions as A.I.D. may deem appropriate.

a. Source of Origin and Commodities, Nationality of Services

Commodities financed by A.I.D. under the Project shall have their source and origin in the United States or in member countries of the Central American Common Market, except as A.I.D. may otherwise agree in writing. Except for ocean shipping, the suppliers of commodities or services shall have the United States or the member countries of the Central American Common Market as their place of nationality, except as A.I.D. may otherwise agree in writing. Ocean shipping financed by A.I.D. under the Project, except as A.I.D. may otherwise agree in writing, shall be financed only on flag vessels of the United States.

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## b. Conditions Precedent to Disbursement

Except as A.I.D. may otherwise agree in writing, for disbursements under the ADS Agreement the following conditions apply:

Prior to disbursement of A.I.D. funds, or issuance by A.I.D. of documentation pursuant to which disbursement will be made, the ADS will nominate a representative to the Special Administrative and Technical Unit (SATU), to serve as a member of the Technical Advisory Group.

Prior to any disbursement of funds or the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the ADS will furnish to A.I.D., except as A.I.D. may otherwise agree in writing, in form and substance satisfactory to A.I.D.: a) A statement by the Board of Directors of ADS in which it names the person empowered in ADS to receive the funds provided under this Agreement and of any additional representative(s), together with a specimen signature of each person so designated; and b) Evidence that ADS has established a colon-denominated bank account, separate from accounts of other ADS programs, to control the receipt and disbursement of the Agreement funds, including the complete account number and name.

Prior to expenditure of funds under this Agreement for additional staff in the IEC Department, the ADS will submit to A.I.D., in form and substance satisfactory to A.I.D., a report outlining the new staffing pattern for this Department.

Except as A.I.D. may otherwise agree in writing for disbursements under the GOES Agreement, the following conditions apply:

Prior to the first disbursement under the Grant, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the Grantee will, except as the parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

(a) Evidence that this Agreement has been duly ratified by, and executed on behalf of, the Grantee and that it constitutes a valid and legally binding obligation of the Grantee in accordance with all of its terms.

(b) A statement of the name(s) of the person(s) holding or acting in the office of the Grantee specified in Section 8.2, and of any additional representative(s), together with the specimen signature of each person specified in such statement.

(c) Evidence, in form and substance satisfactory to A.I.D. that a Special Administrative and Technical Unit (SATU) has been constituted by Ministerial Decree, under the auspices of the Ministry of Health (MOH).

(d) Evidence that the Salvadoran Social Security Institute (ISSS) and the National Telecommunications Administration (ANTEL), have signed individual separate agreements with the Ministry of Health specifying the responsibilities and duties of these GOES agencies as delineated in the Attachment 1, Program Description.

(e) Evidence that the MOH has assigned a representative to the Technical Advisory Group of the SATU.

(f) Evidence that the Ministry of Health has established a National Health Commission, including members from the ISSS, and the ANTEL Hospital, to establish national policies on health.

Prior to the first disbursement of A.I.D. funds under the Grant, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made to the ISSS and ANTEL, they will assign a representative to the Technical Advisory Group of the SATU.

c) Covenants

GOES Agreement

(a) The Grantee shall covenant that unless A.I.D. otherwise agrees in writing, the professional staff of the SATU will have A.I.D.'s concurrence prior to contracting or any contract extensions.

(b) The Grantee covenants that it will use its best efforts to increase the national family planning budget by 25% over the next three years, using A.I.D. local currency counterpart and other resources.

(c) Within 60 days of meeting conditions precedent, the GOES will prepare implementation plans for MOH activities, as well as implementation plans for ISSS, ANTEL, and MIPLEN family planning activities under the Project and for carrying out a physical inventory of contraceptives in all ISSS clinics and hospital warehouses.

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(d) The Grantee covenants that none of the funds made available under this Grant may be used to finance any costs relating to (a) performance of abortion as a method of family planning, (b) motivation or coercion of any person to undergo abortion, (c) biomedical research which relates, in whole or in part, to methods of, or the performance of, abortion as a method of family planning, or (d) active promotion of abortion as a method of family planning.

(e) Within 90 days of signature of the Agreement, the GOES agrees to provide an office, secret staff from the ISSS, A.F.E.L., and M.H., and establish an Infertility Clinic.

## ADS Agreement

Within sixty days of signature of this Cooperative Agreement, the ADS will provide to A.I.D. an implementation plan providing; (1) scopes of work for the new personnel for the ADS Information, Education, and Communication Department and the Department of Administration to be funded under this Agreement, (2) a schedule and description of the baseline survey, and a plan for development of materials and messages for the first Project year for the mass-media campaign, and (3) a training plan which encompasses a list of the organizations to be involved, types and timing of training, and estimated budgets for individual training activities for the first Project year.

All procurement of goods and services over \$25,000 will be approved in writing by the Director of the Office of Human Resources and Humanitarian Assistance.

Project activities and programs developed under this Agreement by the ADS will follow the policy guidelines and objectives of the National Family Planning Program.

The Salvadoran Demographic Association will comply with the A.I.D. restrictions on promotion of abortion as a family planning method, which will be specified in the Cooperative Grant Agreement with the ADS.

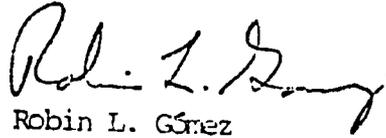
## d. Waivers

U.S. source/origin requirements are hereby waived in order to permit the procurement of training services in other Latin American countries for participant training under the Project, with an estimated value of approximately \$59,000 under A.I.D. Geographic Code No. 935, under the Grant Agreement with the GOES.

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A sole source waiver is hereby authorized to permit the procurement of four American Motors Corporation (AMC) jeeps with an estimated value of \$60,000.



Robin L. Góñez  
Mission Director  
USAID/El Salvador

Date 8/29/85

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PAHO	Pan American Health Organization
PTC	Population Technical Committee
RAPID	Resources for the Awareness of Population Impact on Development
RHA	Rural Health Aide (ARS)
SDA	Salvadoran Demographic Association
SE	Social Educator
SW	Social Worker
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
UCS	Salvadoran Peasants Union
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
USG	United States Government

The Project Development Committee consisted of:

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Development Associates, Inc. (DA) Team

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## LIST OF ACRONYMS USED

ACES	Salvadoran Coffee Growers Association
ANTEL	National Telecommunications Administration
AV	Audio Visual
AVS	Association for Voluntary Sterilization
CA	Cooperating Agency
CBD	Community Based (Contraceptive) Distribution
CBR	Crude Birth Rate
CDC	Centers for Disease Control
CDSS	Country Development Strategy Statement
CENTA	Centro Nacional de Tecnología Agropecuaria
CESAD	Salvadoran Evangelical Committee for Assistance and Development
CLASP	Caribbean and Latin American Scholarship Plan
CONADES	National Commission for Displaced Persons of El Salvador
CPS	Contraceptive Prevalence Survey
CRS	Contraceptive Retail Sales
CSM	Contraceptive Social Marketing
CYP	Couple Year Protection
DIDECO	Community Development Authority
ETV	Educational Television
FESACORA	Salvadoran Federation of Agrarian Reform Cooperatives
FHI	Family Health International
FP	Family Planning
FPA	Family Planning Association
GOES	Government of El Salvador
IEC	Information, Education, Communication
IPAVS	International Program of the Association for Voluntary Sterilization
IPPF	International Planned Parenthood Federation
ISSS	Salvadoran Social Security Institute
ISTA	Salvadoran Institute for Agrarian Transformation
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
LAC	Latin American and Caribbean
MCCT	Ministry of Culture, Communications and Tourism
MCH	Maternal and Child Health
MCH/FP	Maternal Child Health/Family Planning
MOE	Ministry of Education
MOI	Ministry of the Interior
MIPLAN	Ministry of Planning
MOH	Ministry of Health and Social Assistance
NFPP	National Family Planning Program
NPC	National Population Commission
OCOPLAF	Family Planning Coordinating Office
PAC	Paramedical, Auxiliary and Community (Personnel)

**I. PROJECT SUMMARY AND RECOMMENDATIONS**

**A. Recommendation**

USAID/El Salvador recommends the authorization of a \$10 million grant to support the efforts of the Salvadoran National Family Planning Program, including both public and private sectors, to promote broadly based reproductive health care programs.

**B. Summary**

El Salvador is the most densely populated country in the western hemisphere, with a population of 4.8 million persons in a total land area of 8,600 sq. miles. It is estimated that in 1985 the total fertility rate was 5.6 children per rural woman and 3.8 children per urban woman. Despite a substantial increase in contraceptive coverage from 35% of women in union of fertile age in 1978 to 46% in 1985, younger couples of fertile age need to be offered temporary methods through the various Salvadoran institutions presently providing services<sup>1/</sup>. On the average, 45% of Salvadoran women currently in union that do not presently use these methods agree with the principle of family planning.

Therefore, the purpose of this project is to improve and expand on the provision of family planning and reproductive health services by strengthening those institutions which presently provide services to Salvadoran couples, particularly those in rural areas. Individuals in these areas have significantly higher birth rates and, correspondingly, less usage of contraceptives.

The Project will provide the resources necessary to coordinate successfully a multi-sectoral, multi-institutional family planning reproductive health program to improve service delivery and the policy environment for the delivery of services to the Salvadoran population. The Project's objective is to offer an expansion of voluntary family planning services to couples in fertile age, by providing funds to promote training, communications, and the improvement of management, logistics, and equipment maintenance activities of participating agencies. Rural outreach will be the key focus of all Project components, however, urban program maintenance will also be addressed.

The Project has five components:

**1. Administration and Management**

Under the Project, an administrative and technical unit will be created to serve as an implementing unit for Project activities, which will receive

<sup>1/</sup> Contraceptive Prevalence Survey Data, (CPS) 1985.

policy guidance from the National Health Commission (NHC). This special unit is necessary to provide coordination for both public and private agencies' participation in the Project and to avoid the institutional constraints that would be inherent in having any one organization manage the program. This Special Administrative and Technical Unit (SATU) will have access to the highest levels of all of the participating institutions, and will be directly under the authority of the Minister of Health. The professional staff will consist of an Executive Director, administrative staff, and long-term technical assistance in IEC, logistics, maintenance and management. The technical assistance will aid in the development of implementation plans, provide technical expertise to participating institutions, and monitor the implementation of the Project components.

## 2. Information, Education and Communication (IEC)

IEC will be a major focus of the project. Because the Salvadoran Demographic Association (SDA) has the comparative advantage in this specialized area, it will be the lead agency for IEC under the Project. It will collaborate with the MOH and other participating agencies to develop more effective family planning and reproductive health messages, and to involve other organizations, such as cooperatives and worker unions, in the program.

## 3. Training

An improvement in the capability of the GOES and private sector agencies to carry out family planning programs is necessary for the expansion of services. Therefore, family planning service personnel of the MOH, ISSS, SDA, ANTEL, and other participating agencies will be trained to upgrade their skills. Training will be provided in service delivery, IEC skills, logistics and maintenance, and community and patient motivation.

## 4. Logistics/Maintenance

The logistical and materials management capabilities of the major service providers will be strengthened under the Project. Technical advice and assistance for procurement and materials handling will be provided. Increased coordination between the various agencies' logistical systems is a key objective.

## 5. Population Policy and Planning

Population policy dialogue and planning will be promoted and reinforced in this Project through studies, seminars, and an improved ability for coordination and communication among the principal family planning service providers. It is expected that the SATU will study the necessary points of coordination and collaboration among the institutions as a first step in improving and continuing the dialogue between them. In addition, this Project will improve policy commitment of opinion leaders and decision makers to

increasingly favor family planning and reproductive health legislation. The long-term goal of these activities is to attain a larger resource allocation commitment from the Government of El Salvador (GOES) to family planning in El Salvador.

The Mission will sign a Project Agreement with the GOES, under which Project activities will take place with the MOH, ANTEL, and the ISSS. USAID/El Salvador will also sign a new Cooperative Agreement with the Salvadoran Demographic Association (SDA). Overall policy guidance for the Project will be provided by the NHC, which consists of ANTEL, ISSS and the MOH. Operational guidance will be provided by a Technical Advisory Group, which includes the GOES participating organizations and the SDA. For policy and planning, the Ministry of Planning will be the lead organization. The SDA will have primary responsibility for the implementation of the IEC component.

The total cost of the Project is \$12.58 million. A.I.D. will provide \$10 million in Project grant funds. Participating GOES and private sector institutions will provide an additional \$2.58 million in local currency in the form of cash and in-kind contributions. The life of the Project is three years, and the PACD is September 30, 1988.

## II. BACKGROUND AND RATIONALE

### A. Historical Background

The earliest indicators suggest that El Salvador's growth rate was initially low. For example, in 1807 the population growth rate in El Salvador was estimated at 1.7% yearly. Later estimates demonstrated that this rate was maintained until the end of the century.

During the 1930-1950 period, changes became apparent in both birth and death rates in El Salvador. Both rates were high but, El Salvador's birth rate was significantly higher than in other countries. The birth rate was estimated at 50 per 1,000 inhabitants, while the death rate was approximately 30 per 1,000.

During the period 1950 to 1979, the highest population growth in Salvadoran demographic history took place. In 1950, a total population of 2 million was estimated, with a growth rate of 2.7% per annum. By 1971, the National Census counted a population total of 3.5 million persons, which translated into a 3.4% growth rate per annum.

From 1980 to 1983 there were decreases in the demographic indicators due to the civil conflict. The death rate increased from the 10.5 estimated in 1980 to 13.5 in 1983 (SDA Assessment, November, 1984). Similarly, the high fertility rate has also been affected by a permanent or temporary disruption of the family unit, and by migration inside and outside of the country. The

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population growth rate 2/ has decreased while the natural increase 3/ is still high because of high fertility in the rural population. It was estimated that the total fertility rate was 5.6 children per woman for the period of 1980-1983 (MIPLAN estimate).

Migration is the most important demographic indicator affected by the socio-political conflict. For example, the urban population has increased rapidly with the migration of displaced persons from rural areas to urban marginal areas. Similarly, international migration has increased since 1980, such that the net migration rate is negative, an estimated (-) 1.5% 4/. Due to the increase in death and migration, the population growth rate decreased to approximately 1.2% in 1980 and was estimated at 0.6% in 1983. However, data indicate that the Crude Birth Rate continues to be high (37 per 1,000 inhabitants per annum) and if left unchecked, will produce serious long-term problems for the Salvadoran society.

#### B. Project Rationale

Contraceptive Prevalence Surveys (CPS) were carried out in El Salvador during 1973, 1975 and 1978. All the surveys were implemented with technical and financial support from the Centers for Disease Control (CDC) in collaboration with the Salvadoran Demographic Association (SDA). A fourth CPS was planned for 1981, but the socio-political situation at that time prevented its implementation. However, a CPS has recently been completed to evaluate family planning program status as well as collect baseline information for this Project. The present survey was carried out by Westinghouse Health Systems Inc., with SDA collaboration. Final data for the whole country was only available in the last stages of PP preparation.

The most recent prevalence figures in the Country show that 46% of women in fertile age and in union are active contraceptive users. There are an estimated 317,000 active users in the National Family Planning Program, which is the overall term used to describe the programs carried out by the GOES and private sector agencies in furtherance of GOES family planning objectives. The largest provider of services is the MOH with 62.8% of the users; the ISSS share is 15.8%; the SDA provides 11% of services; while private doctors and pharmacies respectively supply 3.2% and 5% of contraceptive needs for couples in union; and various other sources supply the remaining 7.2%.

2/ Growth Rate: The rate at which a population is increasing (or decreasing) in a given year due to natural increase and net migration, expressed as a percentage of the base population.

3/ Natural Increase: The surplus (or deficit) of birth over deaths in a population in a given time period.

4/ Los Programas de Población y Planificación Familiar: Situación Actual y Perspectivas Técnico-Financieros a Corto Plazo, SDA, Diciembre 1984.

The following chart gives an overall view of the contraceptive prevalence in the Salvadoran population and the active family planning users.

Table I  
EL SALVADOR POPULATION PROFILE  
(000)

	<u>1978</u> CPS	<u>1984</u> (Estimated)	<u>1985</u> CPS	<u>1988</u> (Projected)
I Population	4,282	4,640	4,780	5,137
II Women of Fertile Age (estimated of I 24%)	1,028	1,114	1,147	1,233
III Married Women of Fertile Age (60% of II)	617	668	688	740
IV Overall Contraceptive Prevalence	34%	45%	46%	50%
V Active users in the Program	210	301	317	370

As Table I above indicates, despite a substantial increase in contraceptive coverage from 34% in 1978 to 46% in 1985, there are still areas where the Salvadoran family planning programs are not fully effective. Considering urban/rural differences, one finds a progressively higher number of women who use modern contraceptive methods in urban areas. In metropolitan San Salvador usage is 58.9%. The other urban centers registered 48% of women in union using contraceptives, while only 29% of rural women in union use effective methods. Similar differences between rural and urban areas were found in the 1978 CPS.

Non-usage in the rural areas is complicated by an increasing unmet demand of non-users. On the average, 45% of women currently married (in union) that do not presently use FP methods, agree with the principle of family planning. This is an indication of a high degree of unsatisfied demand.

In addition, most current acceptors are those using permanent methods of contraception, and then only after they have satisfied their desire for children. The average number of children per user is 4.3 which means the present program misses the younger couples of fertile age.

Regarding overall prevalence, actual and desired, the 1985 CPS' preliminary results, shown in Table II below, show that the younger couples in fertile age have less coverage. The following chart reflects both the national prevalence rates and the rural prevalence rates, which are far lower (See Annex D for a further breakout of prevalence rates):

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Table II  
Contraceptive Prevalence per Age Group

<u>Age Group</u>	<u>National Prevalence Rates</u>	<u>Rural Prevalence Rates</u>
15-19	21.3%	10.9%
20-24	34.7%	20.7%
25-29	50.6%	35.3%
30-34	62.6%	42.4%
35-39	55.4%	39.2%
40-44	49.8%	30.0%
45-49	35.9%	20.0%

The striking difference between patterns in urban and rural prevalence rates is also repeated in the preliminary data from the 1985 CPS with regard to fertility rates:

Table III  
Total Fertility  
Rates

National	4.3
Metropolitan	3.6
Other Urban Areas	3.9
Rural	5.6

Therefore, it can be seen that an education campaign should be implemented which emphasizes child spacing among women 24 years of age or under, and that a strong focus on rural areas is essential. In fact, it reflects the reality that family planning programs have not really impacted significantly on rural areas.

Two inadequacies must be remedied in the present system to satisfy the continuing demand for family planning services. The first is to promote a mix of contraceptive methods; the second, is to promote the use of reversible methods among the young couples. With both these approaches, a greater emphasis must be placed on rural outreach. Data from a recent PAHO report and the present CPS demonstrate that the average active user of family planning services is of relatively high parity <sup>5/</sup>, and just under thirty years of age. Average age per method according to the estimated data provided by PAHO <sup>6/</sup>:

<sup>5/</sup> Number of live births per woman

<sup>6/</sup> Pan American Health Organization Report 1984

Voluntary surgical contraception	28.2 years
Intrauterine device users	23.4 years
Oral contraceptive users	24.3 years

The average number of children per woman, by method according to the recent PAHO report is:

Voluntary surgical contraception	3.87
Oral contraceptives	2.00
Intrauterine devices	2.04 <u>7/</u>

Since the Salvadoran population is a young population, the number of adolescents entering the fertile age group will have significant consequences on the population growth. Recent data from the CPS show that young women of fertile age are largely unprotected in terms of risk of unwanted pregnancy. Since both in and out-migration as well as increased death rates in El Salvador are unusually high due to the conflict, the usual indicator of population growth does not accurately reflect the demographic situation. The 1.1% population growth rate estimated by the Ministry of Planning (1984) hides the real population problem of high rural fertility.

In addition, the percentage of maternity beds occupied by women recuperating from abortions is approximately 25%. It is unknown how many of these pregnancy complications are attributable to induced as opposed to spontaneous abortions. Recent MOH statistics demonstrate that the hospitalizations because of abortions or hospital abortions has not significantly decreased in the past five years, which indicates that expanded family planning inputs have been ineffective as a means of preventing abortion as a means of terminating unwanted pregnancies.

### C. Constraints to Acceptance of Family Planning

#### 1. Socio-Cultural Constraints

The most important socio-cultural constraint for a successful family planning program in El Salvador is, without a doubt, illiteracy. Estimated to be at 65% nationally, it is assumed to be much higher in the rural areas, and probably still higher among rural women. This makes information, education and communication an extremely important tasks, and indicates that there is a need for using special techniques for reaching rural audiences, which are harder to inform and motivate.

Cultural perception of family planning particularly impacts on the voluntary acceptance of family planning methods. The 1985 CPS study demonstrated that 26% of the respondents did not seek family planning, since they personally did not care for family planning or did not want the side effects which accompany

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7/ Ibid

a temporary method such as the IUD or the Pill. About 15% of the respondents reported non-usage because of the fact that their husbands (partners) were opposed to them seeking family planning. The third reason for rejecting contraception was that the women were nursing and did not believe that they were at risk of becoming pregnant.

Although religion has been mentioned in the socio-cultural literature as a great constraint to family planning in Latin America, the CPS pointed out that for the clients, religion is perceived as a minor problem. In contrast to the position of the Vatican on contraception and family planning, the position the Salvadoran Church hierarchy has taken has been one of benign neglect, which allows most of the population to decide themselves about their reproductive health and family planning needs.

Socio-cultural beliefs at the community level may be an impediment to project implementation in rural areas. Many women in these areas believe that contraceptives are bad for one's health. Other women think that the IUD causes cancer. These cultural perceptions can be overcome by a coordinated communication campaign which will help direct rural women to seek family planning services and to make informed choices concerning contraception.

## 2. Institutional Constraints

The Ministry of Health, the primary service provider in the rural areas and in the nation as a whole, is faced with a highly centralized, multilayered, administrative system. The Salvadoran Social Security Institute is restricted legally by its charter to membership-related programs, and thus is restricted in its expansion capabilities. The SDA is an efficient provider of family planning services, but it has a small administrative staff and limited capability to expand the level of family planning services beyond which they are currently providing. In addition to these internal institutional constraints, one other major obstacle to the effective delivery of family planning information and services is the lack of cooperation among the participating agencies. There have been differences between the SDA and MOH concerning their respective roles and responsibilities, areas of coverage of the two organizations, and standards of practice.

The results of this constraints analysis indicate; (1) that a new structure, linked to the major service providers, must be created to provide policy guidance and coordinate activities, implement this Project, and assist the participating agencies to effectively utilize the resources, which will be made available under this Project, and (2) that participating agencies recognize the need to work together, but require a vehicle for cooperation that will both coordinate work and allocate resources to support program expansion. For these reasons, the SATU was created to manage the Project.

Specific organizational constraints to improvement and extension of family planning services are identified and discussed below:

a. The Ministry of Health (MOH)

The MOH is by far the major provider of FP services in El Salvador. However, it is affected by a variety of administrative, organizational, financial, and management problems, which are discussed in greater detail in the Institutional Analysis Section of this document. The MOH has recently changed its organizational structure, combining normative and operational systems into a unified program. This change is expected to facilitate coordination, but will place strains on program development. The family planning programs in the Ministry are now under the auspices of the Department of Maternal and Child Health and will require guidance and resources to be given the emphasis that they deserve. Further, their systems of logistics and management will require considerable improvement before they will be able to handle their expanded family planning service program.

b. Ministry of Planning (MIPLAN)

The Ministry of Planning (MIPLAN) is formally and legally responsible for guiding and monitoring the Salvadoran National Family Planning Program. MIPLAN convenes and directs the National Population Commission, which is a policy group consisting of nine GOES Ministers. The Population Department at MIPLAN is also responsible for facilitating communication and monitoring population related programs carried out by members of the Population Technical Committee (PTC). The PTC is composed of representatives from both public and private agencies involved in family planning programs and was established to share information and develop national policy. MIPLAN's Population Department is supposed to convene the Population Technical Committee and provide it with support and technical expertise.

This structure, however, has never been fully operational. The National Population Commission has not met, and the PTC has been an irregular, informal gathering without a specific goal. Furthermore, the PTC is without any authority or the resources to implement programs. Each agency functions independently and has an independent relationship with both governmental sources of funds and external donors.

c. Salvadoran Social Security Institute (ISSS)

The ISSS provides health services for only a small percentage of the total population, largely in urban areas. In fact, the ISSS family planning program is very limited, consisting principally of a small family planning unit located within the Department of Preventive Medicine.

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Despite its relatively small size, the ISSS family planning management structure suffers from many of the same administrative constraints as does the Ministry of Health. There is little program authority at the operating level. The official policy guidelines for family planning emphasize complete integration of services within a preventive health framework that affords considerable emphasis to infant care (up to three months) and cancer detection. The ISSS does have a strong family planning focus in spite of its diffused organizational and management structure. This is the result of the personalities involved at the program direction level. The current General Director of the ISSS is a committed advocate and promoter of family planning and, as a consequence, medical personnel are aware of and promote the program.

d. National Telecommunications Administration (ANTEL) Hospital

The ANTEL manages a small, hospital based family planning program, established to provide medical services to company employees.

The ANTEL hospital provides services in response to client requests, but undertakes few initiatives. Its program is small and funds are limited. The General Director of the Administration places little emphasis on family planning. Personnel have received little training in family planning, and facilities and equipment are less than optimum.

e. Salvadoran Demographic Association (SDA)

The SDA is a private voluntary organization totally devoted to providing family planning services. It is the most efficient provider, on a limited scale, of family planning education and services in the country, and particularly in the area of IEC. They provide approximately 11% of clinical family planning services. The organization of SDA is clear and simple. There are no intervening layers between the operating divisions and their access to authority and direction. Departmental responsibilities are clear and distinct and there is little program overlap. However, the SDA's primary constraint is that its organizational structure was developed for a small organization and, hence, is capable of providing services only through a limited number of sites or clinics. In addition, financial and purchasing authority, and program coordination is highly centralized. Therefore, expansion of its operations would require considerable additional staff to handle effectively a major increase in activities.

3. Population Policy and Planning Constraints

The Government of El Salvador first announced a population policy in October 1974, through a Council of Ministers' resolution. This Integral Population Policy, has been the legal framework within which the family planning

activities have been developed over the last eleven years in El Salvador. The policy lists vague general purposes such as "to procure the full development of human beings" and "to provide for greater participation of each and every one in the responsibilities and benefits of progress." One of its more "specific" objectives sets forth the purpose of "modifying the population dynamics." Others refer to improving nutritional levels, seeking the reduction of mortality and morbidity rates, promoting a skilled labor force, raising women's participation in the development process and determining "the impact of the demographic variable on development" and creating "the basic instruments for sustaining the decision-making process."

Not all of the above-mentioned purposes are accompanied by action proposals which are intended to make possible their achievement. It is proposed to instill responsible attitudes in the population "and change reproductive attitudes in family units", as well as complement this with "mass education programs."

The 1974 Integral Population Policy is a general statement of objectives for social development. Its positive contribution to family planning is minimal and the lack of concrete and quantifiable goals prevents it from being translated into effective action. However, it should be taken into account that it was the first government pronouncement on the subject, which explicitly allows for the existence and dissemination of education, information and communication programs and of family planning services. It is within this legal framework that it has been possible to carry out the programs of the last ten years. Although the results might be judged to be insufficient, they have had significant effects in allowing FP programs to operate in El Salvador.

More recent actions indicate a clear GOES intention to move beyond this level of vague commitment. Article 118 of the 1983 GOES Constitution provides that the Government will carry out population programs. Recently, El Salvador was one of 148 world signatories to the recommendations for a World Population Plan of Action for next decade, adopted at the second International Conference on Population. The primary recommendation at the August 1984 Conference was for those countries that consider that their growth rates hinder their national development to adopt appropriate population programs and policies. In addition, a new draft population policy is presently before the GOES and, if adopted, would constitute a major advance, since the new draft policy is much more specific than the prior statements by the GOES.

The emphasis of this policy would be on integral mother-child health care, with family planning as an essential component, and would cover information, formal and informal education, and communication activities.

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The new population policy will also reflect the GOES position on internal and international migration. It is also likely that the need for obtaining new information on the country's demographic development and the systematization of existing information will also be subject of the population policy, to create the basis for socio-demographic research.

The GOES' interest in formulating and implementing an adequate population policy seems clear. The program that A.I.D. and the GOES will implement under this Project is intended to assist them in carrying out the new policy and beyond that to more successfully implement family planning programs and to a greater national awareness of the population problem in El Salvador.

#### 4. Financial Constraints

Financial constraints to the expansion of family planning services by the GOES include the pressure which is exerted on social programs in general, including health programs, by the current civil conflict coupled with an economic depression; the focus of health resources on curative services, particularly those provided in the larger facilities in urban and suburban areas; the lack of adequate equipment and supplies for all health services; and the emphasis which present international financing sources give to maternal and child health programs rather than family planning.

Over the last few years, the national budget has declined slightly (after inflation) and there has been a shift of resources away from development programs. The health budget <sup>8/</sup> has declined sharply (after inflation) but responsibilities have grown. Programs have been expanded primarily with external resources and by shifting funds within the Ministry. The MOH is increasingly dependent on international resources for new programs and even for maintaining the levels of on-going programs.

The financial problems for the MOH will be aggravated if population growth continues at existing high rates. Annex E shows estimated required rates of growth of the expenditures of the MOH considering several assumptions on the growth of per capita income and on the impact of population programs.

In addition, medical and health resources have focused on curative services primarily in the urban and suburban areas. The ISSS and ANTEL are restricted by their charters to serving different categories of industrial workers who are located in population centers. The SDA initially was developed as an urban program to provide FP services and to mobilize popular opinion and support for family planning and has only recently shifted to a nation-wide focus. Its program is still primarily urban. The Ministry of Health allocates over 60% of its program resources to hospitals, which are urban or suburban-based.

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<sup>8/</sup> The Ministry of Health's budget in 1980 was £178.4 million colones, 11% of the government budget which was £1,645 million. In 1985 the health budget is £197.5 million, 8% of the government's budget of £2,404.5 million and a loss of purchasing power of 37% due to a 12% inflation rate. The Ministry is now faced with a 10% reduction in budget for the remainder of CY '85, which further impedes their operating capability.

Financial limitations prevent a major shift of resources away from health facilities. Effectively, then, equipment and supplies are scarce in all Salvadoran health programs throughout the country and, as noted above, program coverage is expanding while budgets decline. The lack of general health resources combined with the priority given to curative services effectively prevents new preventive health and family planning programs except when specifically supported by foreign donors. The UNFPA is the major donor to the Ministries of Health, Planning, and Education in population-related programs and their emphasis is not on family planning. Specific, focused family planning programming is needed in order to produce family planning results.

The various organizations which have rural outreach programs and represent groups not yet participating in the family planning program have very limited financial resources which are almost exclusively devoted to organizational maintenance. Expansion of their work into family planning information and services requires making available additional financial and material resources to these organizations.

#### D. Relationship of Project to A.I.D. Strategy

The overall A.I.D. strategy <sup>9/</sup> with respect to population cites as its basic principles "freedom of choice" and "informed consent." The U.S. assistance programs are to support, among other things, dissemination of family planning information and education, training for services providers, and demographic and social science research and analysis designed both to improve voluntary family planning programs and to assist LDCs develop and improve their development policies and programs. This Project coincides with these objectives. The overall purpose of the Project is to improve the quality and expand the availability of services throughout the country. A major thrust of the Project is information, education, and communication to enable family planning acceptors to have available to them a greater degree of information on the various services and methods.

#### Conformance with LAC Strategy

The LAC Bureau strategy <sup>10/</sup> on family planning in the region during the remainder of the 1980s is to concentrate on policy reform, technology transfer, institutional development, and support for private and commercial initiatives. An additional, specific objective, is to increase contraceptive prevalence by 50% in the Latin American and Caribbean region. The strategy for "stage two" countries like El Salvador, (i.e. where a basic service delivery infrastructure is in place) is to strengthen policy commitment and to improve and build upon existing programs.

9/ A.I.D. Policy Paper, Population Assistance, September, 1982, Bureau for Program and Policy Coordination

10/ LAC Bureau Strategy, May 1985

The Population Dynamics Project will provide an effective channel for A.I.D. resources to existing institutions and programs to further the above mentioned objectives for El Salvador. Better coordination of services, administrative efficiency, and increased delivery of services and contraceptives are the priorities under this Project. Policy dialogue and reform will be enhanced through leadership training and other measures. A.I.D. will continue to stress the need for family planning to become less dependent on external resources in the long-term by encouraging improved management techniques and programs which at least cover their own costs for participating private and public sector institutions.

E. Relationship to A.I.D. and Other Donor Assistance

A.I.D. Assistance

U.S. Government assistance to El Salvador for family planning commenced in 1966. In that year, A.I.D. initiated support to the Salvadoran Demographic Association, the FP pioneer in the country, with donations of clinical equipment and provision of training opportunities to SDA staff members, under the Family Planning and Population Project (No. 519-0149). By 1969, the SDA operated 40 clinics. These clinics were gradually phased out as the MOH assumed the responsibility for providing family planning clinic services as a public health intervention. However, the SDA still offers a full range of family planning services in four facilities, and conducts a contraceptive social marketing program throughout the country.

Beginning in 1967, A.I.D. also provided financial assistance to the Maternal Child Health and Family Planning Program (MCH) of the MOH. This assistance included the financing of personnel, transportation, medical and surgical equipment, clinical equipment and materials, contraceptives, in-country and overseas training of personnel, technical advisory services, a mass media communications campaign, and printing of information and motivational materials for the family planning program.

Assistance to the Salvadoran Social Security Institute (ISSS) began in 1970. A.I.D. provided support for training of personnel and promotional activities. In addition, procurement of office equipment, spare parts, vehicles and audio-visual equipment was financed. Support to the ISSS ended in 1980.

The 519-0149 Project component supporting the SDA continued until December 1983. A.I.D. began a new project, Salvadoran Demographic Association Grant (519-0275) with the SDA in January 1984, essentially to continue support for the expansion of the same activities developed under the old project. Funding for the current project with the SDA totals \$5.4 million, and the Project will terminate in December, 1986.

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Public sector support has continued, however, with the donation of contraceptives (condoms, pills, IUD's). In addition, PL-480 generated funds have been provided for mass media campaigns on family welfare including family planning, and for salary support of 80 Rural Health Aides (RHAs). The latter provide primary health care services including delivery of contraceptives.

In addition, A.I.D. presently has an on-going \$25 million Project with the Ministry of Health entitled Health Systems Vitalization, No. 519-0291, which is providing activities, complementary to this Project, in logistics management improvement, medical equipment maintenance, and the establishment of a HIS system.

## 2. Other Donor Assistance

Projected international donor assistance to El Salvador is illustrated in Table III below for the period of the Project (1985 - 1988)

### Other Donor Assistance to El Salvador Family Planning Programs (\$000)

<u>DONOR</u>	<u>CY 1985</u>	<u>CY 1986</u>	<u>CY 1987</u>	<u>CY 1988</u>
UNFPA	530	1,355	1,270	1,420
IPPF	490	550	615	690
AVS	280	310	300	300
FHI	<u>6</u>	<u>10</u>	<u>11</u>	<u>12</u>
TOTALS	1,306	2,225	2,196	2,422

GRAND TOTAL = \$8,149

At present, there does not appear to be any duplication of effort, since each donor is supporting different and specific activities, described below.

a. UNFPA: The UNFPA supports mainly the maternal/child care and nutrition aspects of overall primary health care within the MOH. They also support a population education project with the Ministry of Education. Although some UNFPA activities are marginally useful to family planning, in total, they have a negligible impact on family planning, and it is basically a maternal-child health program.

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b. IPPF/WHR: The Western Hemisphere's Regional Office of IPPF, which is an A.I.D. approved private voluntary organization (PVO), has supported the SDA's operating budget for approximately 20 years. During this period this group has provided contraceptives, medical equipment and technical assistance. IPPF/WHR has also sponsored short-term FP training in the US, and in other countries, in areas such as administration and management.

c. IPAVS: This agency has a Cooperative Agreement with the Bureau for Science and Technology, Office of Population (S&T/POP) to support voluntary surgical contraception programs carried out by the SDA and the MOH.

d. FHI: This PVO also has a Cooperative Agreement with S&T/POP to fund research and surveys in new contraceptive techniques throughout the world. It has been working in El Salvador for approximately 10 years.

The funding levels for the 1985 programs carried out by the donors listed above in MCH and other family planning activities and their recipient agencies are summarized as follows:

Ministry of Health:	\$ 332,000 - UNFPA
	<u>110,000 - IFAVS</u>
	\$ 442,000 - Totals
Salvadoran Demographic Association	\$1,733,000 - A.I.D.
	490,000 - IPPF
	<u>166,000 - IPAVS</u>
	\$2,389,000 - Total
ISSS	nil
ANTEL	nil

It should be noted that UNFPA's current projects are terminating in 1985 and new projects are now being developed. These may include: 1) a project with the MOH for extension of the coverage of the maternal-child health/nutrition/family planning programs to give attention to primary health care (approximately \$5 million); 2) a project with the Ministry of Education in the areas of Population Education, as an add-on to the on-going Special Training in Population Education Project (\$300,000); and 3) a project with the Ministry of Planning for Population Policy(\$510,000). This final program consists mainly of providing experts for the establishment of a population policy with regard to migration issues, and the provision of local experts to work on demographic matters for the MIPLAN. UNFPA's activities with the MIPLAN will not overlap with this Project's components.

### III. DETAILED PROJECT DESCRIPTION

#### A. Goal and Purpose

The goal of this Project is to improve the quality of life and health of the Salvadoran population, and reduce the population growth rate.

The purpose is to improve and expand on provision of family planning and reproductive health services by strengthening those institutions which presently provide services to Salvadoran couples, particularly to those in rural areas.

#### B. Project Strategy

This Project will establish new and strengthen existing programs over a three-year period to improve reproductive health and family planning conditions in El Salvador. The Project is designed to strengthen the programs of participating organizations. These institutions require additional resources and training to more effectively carry out FP service delivery and information, education and communication activities.

The population sector has been characterized by fragmentation and a lack of cooperation and coordination. Recent analyses have revealed duplication of service areas and showed that there are maldistribution problems with regard to the material resources for family planning among the entities involved in provision of FP services. In addition, there is an insufficient amount of material and financial resources throughout the family planning system. This Project will attempt to remedy the situation through the unification of criteria on population policy and coordination of activities carried out by the NHC. The SATU will serve as a forum for inter-institutional communication, as well as have executive responsibility and resources, to act as a funding and resource conduit to facilitate the adequate and incremental growth of each institution by expediting each institution's program. In addition, should the coordination of FP institutions envisioned under this Project not be feasible, the strengthening of each agency's individual program can stand alone as a separate activity and will serve to achieve Project objectives.

The current formal GOES family planning policy was established in 1974. However, the policy has been reviewed to develop more specific goals and objectives for population and family planning. The revised Population Policy is in draft and has been submitted to the Minister of Planning for final approval. The new draft policy calls for a higher level of coordination between the government and communities, as well as for greater coordination among the implementing institutions. It also recommends the incorporation of population subjects into the education system of El Salvador in order to expand the family planning coverage among the rural population. These recommendations are clearly consistent with the primary objectives of the Population Dynamics Project.

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## 1. Institutional Development Strategy

This Project will improve the institutional capability of each participating agency. A contract with a U.S. PVO or private firm with experience in family planning will be a major source of technical assistance, training, materials, and equipment to improve the organizations with which it works.

Under the Project, the SATU will attempt to assist in the establishment of standards for program and financial management that will be transferred to other agency programs and improve sector-wide performance. Agencies will be assisted in improving productivity and cost effectiveness of operations. The training to be carried out under the Project has as its primary task improving the capability of all participating agencies. By organizing, coordinating, and assisting in training contracted through the participating agencies, quality of existing training programs will improve as well as access to training by other agencies. This will improve the level of effort and institutional capability in all participating agencies. More specific end-of-project objectives for each institution are described in the Institutional Analysis section of this paper.

### a. The Ministry of Health

Because the MOH provides most of the FP-related services in El Salvador and because it stands to gain most by this Project's institution-building activities, the administrative unit and A.I.D. contracted technical assistance will coordinate closely to improve the Ministry's FP service delivery system. In addition to the training provided in administration and management, the MOH personnel seconded to the SATU will acquire improved technical and program management skills. Training programs also will be conducted for MOH personnel in combined management and technical fields.

The most important institution building activities with the MOH will attempt to resolve some of the Ministry's logistics system problems. The procurement and property management systems established, with the aid of the technical assistance, will be an effective tool to ensure an adequate stock of family planning commodities in the participating agencies.

### b. Ministry of Planning

The Ministry of Planning will be strengthened through the demographic and program data collection system that will be established under this Project. Through the family planning focus of Population Dynamics and the technical assistance being provided, it is hoped that a more family planning results-orientation emphasis will be added to the national population policy. The focus will be towards programmatic rather than theoretical solutions. MIPLAN population planning efforts will be oriented towards practical approaches to national population issues.

c. Salvadoran Social Security Institute

The ISSS will benefit from the training given under the Project and the return of personnel who are assigned to work with the SATU. Social Security has indicated that it is particularly interested in programs for supervisory and client contact personnel. In addition, commodities will be provided, and improvements made to the logistics and equipment maintenance systems through the technical assistance provided under the Project. The participation of ISSS staff in the development of IEC materials will also assist in the expansion of client recruitment.

d. Salvadoran Demographic Association

The SDA will be the lead agency for IEC under the Project. It will also assume the role as trainer-coordinator of grass-roots organizations wishing to become active in family planning. The SDA will acquire a new constituency, giving it a truly national program and strength in the rural areas and in rural outreach and contraceptive distribution-referral and follow-up programs. A particular effort will be made to develop programs with groups reaching younger couples of fertile age, especially in the rural areas. The SDA will consult with the SATU staff in the development of criteria and standards of these new programs. The SDA will identify prospective program participants and the SATU and SDA will help them to develop an adequate program description. The SATU will provide the agencies with appropriate financial and material assistance. Training and IEC support will be provided by the SDA through its IEC and Training Divisions.

C. Project Beneficiaries

The direct beneficiaries of the Project will be approximately 370,000 couples of fertile age, who at the end of the Project are expected to be using contraceptive methods. This figure represents an estimated 50% rate of contraceptive prevalence among women in union which will be reached by the Project's termination. Although these individuals will be dispersed geographically, it is expected that because rural outreach is a prime focus of this Project, the majority of new users will be in rural areas. In addition, the Project will seek to maintain the current levels of usage and contraceptive availability in the urban areas.

The Project will also specifically target as beneficiaries the displaced population, and will attempt to expand family planning services to this group through CONADES, SDA, Project Hope, and the Salvadoran Evangelical Committee for Assistance and Development (CESAD). CONADES will carry out a program which is promotional in nature, while Project Hope, CESAD, and the SDA will continue providing services and education to people located in displaced person settlements throughout El Salvador.

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Indirect project beneficiaries will include the entire Salvadoran population, as a reduction in the high growth rate will enable them to have a higher standard of living.

The primary institutions to be involved in, and to benefit from the Project are, the MOH, SDA, ISSS and ANTEL Hospital. The SDA will in turn provide services, training and IEC to the Salvadoran Campesino Organization (UCS), Salvadoran Federation of Agrarian Reform Cooperatives (FESACORA), Community Development Authority (DIDECO), and National Center for Agrobusiness Technology (CENTA).

#### D. PROJECT COMPONENTS

Project activities will be in the areas of IEC, training, logistics management/maintenance, promotion of policy and planning dialogue. For the successful and timely implementation of this project, a centralized administrative structure will also be established.

##### 1. ADMINISTRATION AND MANAGEMENT COMPONENT

The MOH, ISSS, ANTEL and A.I.D. have agreed on the need to establish a Special Administrative and Technical Unit (SATU), responsible for the management and coordination of Project activities. The SATU will have direct access to the senior management of each of the participating institutions, as well as having a direct line of authority from the Minister of Health to carry out Project activities for the Ministry. The SATU will function as the administrative mechanism for the Project, under the general policy guidance of the NHC. The Unit will also manage A.I.D. funds flowing to the GOES participating agencies under the Project. The SATU will essentially consist of three parts: (1) a Technical Advisory Group, which will be the decision-making body for the Unit, and will include the SDA and GOES participating organizations; (2) an administrative staff who will be responsible for overall Project management; and (3) a technical assistance team which will provide technical expertise to the participating organizations on Project activities. An organizational chart of the SATU and overall Project management is included in Annex N. Finally the SATU will be created only on a temporary basis, and will be disbanded after completion of the Project. While it is expected that as one of the Project outputs some type of inter-institutional coordinating mechanism for family planning programs will be established, a Unit with the scope of responsibility of the SATU will not be required.

The Technical Advisory Group will meet periodically to review and approve implementation plans, training plans, and Project activities. The members of the Technical Advisory Group will be representatives from each of the participating organizations and they will oversee the execution of functions and responsibilities pertaining to their respective institutions.

The administrative staff will consist of an Executive Director, with ultimate responsibility for Project implementation, and a professional staff. The Executive Director will function as the head of the Unit, directly under the

Minister of Health and will have overall responsibility for administration and implementation of the Project. Selection of all of the professional administrative staff will be a joint A.I.D./GOES process. All administrative personnel will be hired through host country contracts; A.I.D. will concur in the selection of professional staff, and will approve any subsequent contract extensions for these individuals.

The technical assistance staff will be contracted by A.I.D., and will form an integral part of the Unit. It is expected that this contract will be awarded to a qualified small business firm, and will thus fulfill the mandates of the Gray Amendment. The firm will also have the capability, through their contract, to respond to short-term technical assistance and equipment needs.

Overall policy guidance for the SATU will be provided by the National Health Commission. The National Health Commission will be established by the GOES to formulate health and FP policies, and consists of the MOH, ISSS and ANTEL, headed by the Minister of Health. This Commission will oversee the activities of the National Family Planning Program (NFPP), coordinating efforts of international donors as well as of the GOES agencies: MOH, ISSS, HIPLAN, and ANTEL.

The Commission will have representatives from the GOES entities which will meet periodically to assess program performance as well as to coordinate normative and operative functions of the program nationwide. The Commission will: a) develop health norms and policies which will help to assure coordination and collaboration of all agencies; b) carry out inter- and intrasectorial coordination in the population sector; and c) provide orientation in policy aspects to the SATU.

a) The Special Administrative and Technical Unit (SATU)

(1) Technical Advisory Group

Functions of the Technical Advisory Group will be to :

- 1) assess the national inventory of human and material resources, per institution and per department of El Salvador;
- 2) review and approve, in coordination with A.I.D., implementation plans for each institution involved in this Project;
- 3) determine allocation of Project commodities/equipment based on the diagnosis briefly described in (1) and in coordination with A.I.D.; and
- 4) determine needs for periodic evaluations aside from those planned for this Project.

b) Administrative Staff

The Executive Director will be a highly qualified and well-experienced administrator of family planning programs. He/she will be a physician, preferably an obstetrician/gynecologist, with a knowledge of demographic statistics and several years of management experience. The functions of this individual will be: (a) to ensure overall Project performance, and issue bi-monthly Project implementation and status reports; (b) to analyze the statistical data to be generated by the Project and HIPLAN to forecast FP program requirements and those for the participating institutions; and (c) to have direct responsibility for monitoring MOH project activities and resolving critical problems within the Ministry.

Other members of the administrative staff will include a controller, a health educator, a training specialist, a logistics/maintenance expert, in addition to secretaries and other support staff. The controller will be directly under the Executive Director and will be responsible for financial management and control of all Project funds flowing through the SATU. He/she will provide to the Executive Director a biweekly financial status report of the entire Project broken down by component, by institution, and individual activity. He/she will also prepare the reimbursement requests and other financial reports for A.I.D., and will have overall responsibility for accounting for A.I.D. funds expended by the GOES agencies. The technical experts on the administrative staff will work with institutional counterparts to determine the needs of the family planning programs and monitor program performance, in their respective areas of expertise.

c) Technical Assistance Team

Because of the extent of the different programs to be implemented under this Project with the SATU, and the need to relate to all entities under this Project, the technical assistance will be contracted directly by A.I.D., through authority to be contained in the Project Agreement. Short term technical assistance will be provided under this contract, as well. This will include technical assistance to assist the MOH in establishing an infertility clinic, which will permit the Ministry to offer a full range of reproductive health services. A complete description of the Infertility Clinic is included in Annex F. A plan for technical assistance is included in the following page as Table V.

This technical assistance will include:

a) IEC Specialist (3 year LOP): He/she will work directly with the Health Education Division and the Health Training School within the MOH as well as with the IEC Department of the SDA, and will receive technical support from the Production Unit of the MCH Department of the Ministry of Health. Short-term technical assistance will be contracted to assist the IEC specialist. An IEC unit within the MCH Department will produce pamphlets,

TABLE V

TECHNICAL ASSISTANCE PLAN

<u>Field of Expertise</u>	<u>Timing</u>	<u>Duties</u>
(A) <u>Long Term</u>		
Management, Administration advisor	36 person months 9/85-9/88	Chief of Party for the Technical Assistance team, and the management advisor for the Project. He/She will determine short-term T.A. needs, design the management information system, and assist in designing system for data gathering program. He/She will be the Chief liason between the implementing institutions and AID.
Information/ Education/ Communication Specialist	36 person-months 9/85-9/88	IEC Specialist. He/She will work directly with the Health Education Division and the Health Training School within the MOH as well as with the IEC Department of the SDA, and will receive technical support from the Production Unit of the MOH Department of the Ministry of Health. Short-term Technical assistance will be contracted to assist the IEC Specialist in specific cases of communication such as psychology of communications, sociology, etc. The Production Unit within the MOH's MCH Department will produce pamphlets, brochures, posters and other materials and promote interpersonal communication as well as educational diagnostic techniques at the community level.
Logistics, Maintenance Specialist	36 person-months 11/85-11/88	Logistics and Maintenance Specialist. He/She will coordinate the operations of the participating institutions in logistics and possess a wide experience in maintenance of bio-medical equipment, with emphasis on laparoscopes. He/She will coordinate maintenance activities nationwide for the ISSS, the MOH and the ANTEL Hospital and with the SDA maintenance department.

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**(B) Short Term**

<b>Training Specialist</b>	<b>10 person-months</b> 1/86-6/86 1/87-1/87 6/87-6/87 1/88-6/88 1/88-1/88 6/87-6/88	<b>Provide the governmental and the private sectors of El Salvador Technical expertise in curricula development for training of personnel to deal with rural population of El Salvador. Also, this individual will design and implement in collaboration with SDA, training modules for field personnel of non-traditional agencies working in rural areas.</b>
<b>Bio-Medical, Maintenance Specialist</b>	<b>6 person-months</b> 4/86-6/86 4/86-8/86 4/87-6/87 4/87-4/87 6/87-6/87 6/88-6/88 6/88-6/88	<b>Technical Assistance, equipment and training in the area of management information systems to develop a computerized management system to allow the MOH to monitor and assess status of biomedical equipment, supplies, medical instruments, and spare parts for all equipment.</b>
<b>IEC Design Specialist</b>	<b>6 Person-months</b> 11/86-4/87 3/88-4/88	<b>MassMedia Design Specialist. He/She will advise SDA and the SATU in the design and pre-test of new materials. He/She will also collaborate with the IEC long term advisor in designing a person to-person communication campaign.</b>
<b>Medical Technical, Specialist</b>	<b>2 person-months</b> 11/86-2/86	<b>Assists in the design and in the implementation of specialized medical equipment for the infertility clinic.</b>

brochures, posters and other materials and promote interpersonal communication as well as educational diagnostic techniques at the community level.

b) Logistics and Maintenance Specialist (3 years LOP): He/she will be located in the SATU and will coordinate the operations of the participating institutions in logistics and maintenance. This individual will possess wide experience in maintenance of bio-medical equipment, with emphasis on laparoscopes. He/she will coordinate technical assistance and will oversee maintenance activities nationwide for the ISSS, the MOH and the ANTEL Hospital and with the SDA maintenance department.

c) Management/Administration Expert (3 years LOP): This individual will be Chief of Party for the technical assistance team, and serve as the management advisor for the Project. He/she will determine short-term t.a. needs, design the management information system, and assist in designing system for data gathering.

## 2. INFORMATION, EDUCATION AND COMMUNICATION (IEC) COMPONENT

Investment in IEC programs, personnel and equipment is critical to family planning outreach, client motivation and improved contraceptive coverage. Research has shown that a decrease in the number of educational activities was accompanied by a decrease in the number of users of FP services <sup>11/</sup>. Hence, this Component will expand the existing educational services of the participating organizations and will develop new campaigns, which will be targeted at rural areas.

### a. GOES IEC Activities

Through the SATU, funds will be channeled to the MOH's Health Education Department, which will produce coordinated educational campaigns. These campaigns will emphasize non-formal education and will produce special materials to support the efforts of outreach workers, such as RHAs, Traditional Birth Attendants (TBAs), malaria workers, and community health workers.

As part of a joint effort with the SDA, the MOH will conduct a multi-media campaign aimed at increasing contraceptive usage by 20% in three years among young rural couples in fertile age group. Special educational materials will be produced for community health workers, as well as for supervisory personnel. Rural volunteers for this campaign will be drawn from the ranks of RHAs, TBAs, satisfied users, health establishment personnel and rural health supervisors. Rural and urban leaders will be reached with announcements in the press. Posters will support the campaign, as well as pamphlets for new readers. Billboards will be created to be used along the highways as well as flipcharts and self-instructional manuals produced as teaching and learning aids for promoters and their supervisors. A complete description of the multi-media campaign activities and the timing of the various events is included as Annex G.

<sup>11/</sup>(Evaluación del Proyecto de FNUAP: ELS74/POI: Programa de Salud Materno Infantil y PF en El Salvador 1974-84 Vol.1, Pg 61).

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b. SDA IEC Activities

The SDA will have the majority of the responsibility for the various IEC Programs and will play the leadership role with regard to the mass-media campaigns. The IEC Unit within the SDA, in coordination with the SATU, will do all of the program planning prior to production of any materials for the mass-media campaign, as well as contracting with advertising agencies, printers, and Educational Television (ETV) for production activities. Because of its extensive experience in this area the SDA will be responsible for production of radio and TV messages. Special characters will be created by SDA for radio to facilitate audience identification with the source of information. Radio and TV spots will be created to give specific information about the location of services.

The media mix will be determined by the baseline study of the target population. Audience habits, preferred stations and listening times, as well as the cost of the media will be considered in selecting each medium and the number of times to broadcast messages per month or year. All materials will be pre-tested before being distributed or broadcasted. A list of equipment and supplies is included in Annex H.

This Component will be managed by the Health Education Specialist in the SATU, with guidance and expertise being provided by the long and short-term technical advisors.

Prior to development of any materials under this Component, a baseline survey will be undertaken. Under the technical assistance contract, a private firm will interview a subset of the CPS '85 respondents to assess attitudes and behavior relevant to FP media such as:

- Family planning behavior and attitudes that can be changed by educational activities;
- Specific or probable causes of behavior;
- New behavior that can be adopted by the target group;
- Social, cultural, and economic barriers to contraceptive usage and determination of family planning size;
- Communication channels that can be used; and
- Promotion mechanisms that should be used.

The results of this survey will be used to produce guidelines to determine content of IEC materials, and selected themes for all organizations. In the end of the second year of the Project, a special evaluation of the messages carried by the media will be held. Finally, an overall impact evaluation of IEC will take place in the last year of the Project.

The materials and campaigns to be undertaken by this Component will also be in close conformity with existing GOES policies and strategies. The official policy is to include FP as one of the components in its integrated maternal and child health programs and to offer information and services, primarily to the population at high epidemiological risk: women of child-bearing age and children under five. Specific preventive measures to be addressed include: immunizations, control of diarrhea, oral rehydration, control of acute respiratory infections, and prevention of common diseases. The messages in materials will always include a reference to responsible parenthood. Those specifically tailored to family planning will give support for having taken the decision to plan family size, explain the role of contraceptives, and inform where, how, and when one can receive services.

### 3. TRAINING COMPONENT

Complementing the information, education, and communication programs, will be a comprehensive training program for medical, paramedical, and administrative personnel who are working in the family planning delivery system. The SATU will coordinate training efforts with the SDA, since both GOES participating institutions and the SDA will be involved in their training activities. The institutions to be involved in this Training Component are: (a) MOH, (b) ISSS, (c) SDA, (d) Ministry of Interior through DIDECO's promoters, (e) Ministry of Planning (Department of Population), (f) institutions providing services to displaced families, (g) agrarian reform cooperatives through FESACORA, (h) Ministry of Education, and (i) the Ministry of Agriculture through CENTA. The SATU will coordinate training with the SDA, which will be responsible for providing training to governmental institutions not traditionally involved in FP, such as FESACORA, DIDECO and CENTA.

The SATU staff will provide short term technical assistance to design and develop a curriculum of courses for the training. The SATU will assist with monitoring and evaluating of training events. In close cooperation with USAID, the SATU will plan and expedite the selection and placement of trainees in third country and U.S. training programs.

Training will be arranged in the areas of FP service delivery, IEC skills, as well as in logistics/maintenance needs. Additionally, family planning personnel at all levels will receive training in community and patient motivation. Special seminars to be carried out by MIPLAN will assemble policy makers and opinion leaders with the ultimate objective of creating a more favorable climate for the formulation and implementation of a positive population policy. A list of all courses to be offered, the number and types of trainees, and the timing of all training currently planned to be held during the life of the project for the SDA and the MOH is included in the following page as Table VI.

MOH TRAINING PLAN

TRAINING ACTIVITY	DURATION	TOTAL NUMBER OF TRAINEES	TRAINEES BY PROGRAM YEAR			COST
			1	2	3	
Refresher Training for 1,050 RHAs	2 days	1,050	250	350	450	35,580
Training TB Program Promoters as FP Promoters	2 days	1,500	500	500	500	50,140
Refresher Training for TBAs	2 days	1,200	400	500	300	40,000
Training of Medical, Paramedical, Auxiliary and Community Personnel in Puppet Theater	3 days	1,800	600	600	600	30,000
Refresher Training in Puppet Theater Use and Maintenance	1 day	1,200	-	600	600	10,200
Teaching Methodology Courses for RHAs	10 days	300	100	100	100	25,500
Management Training for Professionals in the Health Education Center (I, E & C Training)	5 days	9	9	-	-	2,550
Training in Evaluation Skills and Focus Group Techniques (I, E & C Training)	3 days educators & supervisors	22	22	-	22	3,300
Patient Education Skills, General and for Young Couples (I, E & C Training)	3 days & superv. 1 x for 2 months	34	34	-	34	8,500
I, E and C Production Skills Course for Health Education Center Staff	40 days + 2 days a month for 10 mos.	9	9	-	9	27,000
I, E and C Production Skills Course for Regional Health Educators	40 days + 2 days a month for 10 mos.	30	30	30	30	45,900
Contraceptive Technology Update for Health Educators and Nurses (I, E & C Training)	1 day	50 incl. ISSS & ANTEL	50	50	50	7,500
Seminar on Self-Instructional Material (I, E and C Training)	3 days	2	2	-	-	300

Table VI

MOH TRAINING PLAN

TRAINING ACTIVITY	DURATION	TOTAL NUMBER OF TRAINEES	TRAINEES BY PROGRAM YEAR			COST
			1	2	3	
Seminar on Budgeting (I, E & C Training)	3 days	10	10	-	-	1,500
Seminar on Manual Development (I, E & C Training)	5 days	3	3	-	-	750
Seminar on relating to Ad Agencies (I, E & C Training)	3 days	9	9	-	-	1,350
Continuing Education in once-a-month Seminars (I, E & C Training)	12 days	34	34	34	34	12,240
PPBS Seminar	3 days	40	20	10	10	2,400
Project Management and Evaluation Seminar	2 days	40	20	10	10	1,600
Management Information Systems Seminar	3 days	40	20	10	10	2,400
Effective Supervision Seminar	3 days	40	20	10	10	2,400
Supervisors' Training (Central and Regional)	5 days	25	25	-	-	2,500
Equipment Maintenance and Logistics Seminar - Phase I	5 days	8	8	-	-	5,500*
Equipment Maintenance and Logistics Seminar - Phase II	5 days	42	14	14	14	19,500*
Annual Seminar on Reproductive Health Update	3 days	200	200	200	200	81,000*

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MOH TRAINING PLAN

TRAINING ACTIVITY	DURATION	TOTAL NUMBER OF TRAINEES	TRAINEES BY PROGRAM YEAR			COST
			1	2	3	
Project Administrators Course	3 days	25	25	25	25	4,500
Project Development Seminar for Rural Agencies	3 days	20	20	-	-	2,400
Decision-Makers/Opinion Molders Seminars (2 each year)	1 day	120	40	40	40	12,000*

\* Includes cost for 2 U.S. Expert Consultants

\*\* Includes cost for 6 U.S. Expert Consultants

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SDA TRAINING PLAN

TRAINING ACTIVITY	DURATION	TOTAL OF TRAINEES	TRAINEES BY PROGRAM YEAR			COST
			1	2	3	
15 Workshop-Seminars for Rural and Urban Promoters	5 days	450	150	150	150	25,000
6 Courses for Pre-Service Medical Students	10 days	450	150	150	150	7,600
4 Workshop-Seminars for Damas Voluntarias	20 hrs.	320	80	80	160	7,200
15 Seminars for Vasectomized Promoters	1 day	180	60	60	60	31,000
6 Seminars for "Socios" of ADS	1 day	120	40	40	40	12,500
9 Courses for Physicians and Paramedical Personnel	3 days	200	65	65	70	55,750
12 Workshops for Damas Voluntarias	1 day	220	75	75	70	6,600
6 Courses for Medical, Paramedical Personnel Working in D.P. Camps	3 and 4 days	226	-	113	113	26,500
12 Courses for Urban and Rural School Teachers in Family Planning and Sex Education	5 days	360	120	120	120	34,000
3 Seminars for Key Government Functionaries	2 days	25	-	-	25	7,800
6 Seminars for Religious Leaders	3 days	150	-	75	75	9,500
4 Seminars in Family Planning and Sex Education for Student Teachers	5 days	100	-	-	100	7,500
4 Courses for Social Workers	5 days	100	-	-	100	7,500
						<u>238,450</u>

S 238,450

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Training will be arranged and funded in a variety of ways (see Methods of Implementation and Financing, Annex I), depending on the type of training and the institution through which the training is being offered. In the case of the GOES agencies, the following model will be adopted: An overall operational plan for training activities will be developed by the institution, in coordination with the SATU. These plans will specify course content and objectives; methodology; evaluation plan and follow-up; dates, numbers and types of trainees; and a line item budget and payment schedule. The plans will then be forwarded to the Technical Advisory Group for review and approval. The training, in many cases, will be carried out by the SATU using short-term technical assistance and will be financed by the funds managed by the Special Unit.

To carry out a specific training event in accordance with the approved plan the relevant institution will therefore simply forward a request for funding for the course, and any changes from the original description contained in the plan. The Unit will provide an advance for the proposed training costs to the requesting agency, and will then request a follow-up financial report.

During the first project year, participant training of MOH educators, nursing school instructors, nurse trainers and IEC staff will be given priority, so that they will be available as trainers for subsequent in-country training. This type of participant training will be undertaken by short-term U.S. based contractors through the overall technical assistance contract. For in-country training design and development, the Unit staff will provide appropriate technical assistance or arrange for such expertise to be provided by outside experts. In-country training will include, among others, Rural Health Aides (RHAs), malaria workers, auxiliary nurses, and social year physicians who are located in the rural areas and will serve to expand services to that population.

Through training of key administrators/managers, IEC and service delivery personnel, and by working with the institutions implementing the training in the design, and later evaluating the training, the beneficiary institutions' training capability will be improved.

#### 4. LOGISTICS/MAINTENANCE COMPONENT

##### a. Logistics

The goal of the Logistics Sub-component of the Project is to strengthen the inventory control, distribution, and forecasting capabilities of the MOH, ISSS, and SDA. The specific objective for these institutions is to strengthen their logistics networks from the central to the regional and local levels. In order to achieve these goals, a management information system will be established that will enable program planners/supervisors and supply personnel to track contraceptives, by method and brand. Planners/supervisors will track commodities throughout the respective supply systems of the institutions, to

determine quantities to be issued to the regional and local warehouses, to assess the supply status of the programs, to detect possible expiration dates, and to forecast supply requirements.

Contraceptive warehousing is urgently needed, as most of the present central level facility is completely inadequate. Remodelling and some new construction of warehousing will be financed by the Project for the MOH.

Under the SATU, short term technical assistance will be contracted to design management information systems for contraceptives for the participating organizations. For the MOH, a system will be designed that will be compatible to the new MOH MIS, to be provided under the ongoing Health Systems Vitalization Project (519-0291). The MIS will collect and report key data that are essential to carrying out the functions mentioned above; 1) quantities of contraceptives dispersed to users and 2) balances on hand, by method and brand. Key personnel will be trained in the use of these data as a management/supervisory tool. A microcomputer-based system will produce reports on the supply status of the programs, to identify facilities that are out of compliance with pre-established supply levels.

Data generated by the supply MIS will also be used to assess program performance, including coverage of the respective programs in terms of prevalence of use of contraceptives. This will allow program managers to identify clinics and/or geographical areas of their programs that require additional program support.

#### b. Maintenance

Because the MOH, ISSS and SDA are looking for an improvement in the quality of services offered to the population in clinical methods, most of the equipment currently in use will be updated and old or defective parts will be replaced. Further, in order to maintain the existing and new equipment, a strong training component for use and maintenance of equipment is necessary. The SATU logistics staff will coordinate with the Repair and Maintenance Center (RAM) of the SDA and the Maintenance Division of the MOH to ensure that all institutions are provided with adequate equipment and spare parts. USAID will also supply the basic equipment for the Infertility Clinic to be established by the Ministry at the Gynecology Clinic of the MOH's Maternity Hospital. New equipment and spare parts for the SDA will be stocked in the SDA warehouse, to be constructed under Project No. 519-0275. The MOH will keep its own separate stock of spare parts for which a program will be developed to assure continued availability. A preventive maintenance schedule will be developed by the MOH's Maintenance Department and supervised by the logistics/maintenance specialist in the SATU who will be responsible for both logistics and bio-medical equipment maintenance.

A list of equipment and materials provided under this Component is included in Annex H.

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## 5. POLICY AND PLANNING

As of this writing, the new proposed population policy of the Government of El Salvador has not been published. The current policy of 1974, although a landmark for El Salvador, has failed to produce the kind of commitment from past governments needed for the open support and funding of a family planning program. However, it has provided the legal framework to carry out the family planning programs during the last ten years. Adoption of the new policy, however, will give the GOES a clearer framework for carrying out FP programs.

Secondly, information contained in the recent CPS (1985) on family planning coverage in El Salvador shows a substantial difference between urban and rural areas. An estimated 59% of urban women of fertile age regularly use contraceptive methods compared with only 29% in the countryside. Further, because marital unions in the rural areas tend to take place earlier, and because family planning has had lower coverage among younger women of reproductive age, it becomes necessary to promote family planning in the rural areas through service delivery, training and FEC programs. Therefore, this Project will assist in the development of more vigorous strategies and policies for the rural sector.

### b). Project Activities

#### - Motivational workshops and seminars

Educational activities will be designed by the SATU in collaboration with MIPLAN to increase population awareness among political and community leaders in the country, both public and private. These seminars will be focused on demographic problems, such as the economic costs of a high population growth rate, and related problems such as unemployment, health problems, nutritional status, and effect on migration.

#### - Establishment of a demographic data base

The central data bank to be established in MIPLAN will allow the GOES agencies to make periodic evaluations of program performance. The data base will permit MIPLAN to assess user statistics and demographic data that will be now be available for planning purposes.

#### - Survey and evaluative research

The need for ad-hoc and special operations research activities may need to be coordinated through MIPLAN. Studies, that would provide to the government basic social and economic indicators, are vital to the understanding of the Salvadoran population problem. Operations research will be carried out by MIPLAN to evaluate and/or determine better program management methodologies. One example might be research on whether implementation non-governmental organizations or a government agency would be the best way to reach rural populations.

The CPS '88 will be coordinated by MIPLAN along with the SDA which was instrumental in generating the present (CPS 85) data. It is expected that by 1987 the MIPLAN will be prepared to take a leadership role in the coordination of this survey.

#### IV. COST ESTIMATES AND FINANCIAL PLAN

The total cost of activities financed under the Project is estimated at \$12.58 million, of which A.I.D. will grant \$10 million, the GOES will provide \$1.81 million as counterpart, and the SDA will provide \$.77 million as counterpart to their Agreement.

A.I.D. Grant funds will be used for technical assistance, administrative costs, production and dissemination of IEC materials, family planning related equipment and commodities, warehousing space, training, and evaluation of the Project. The GOES contribution will support the Project by funding the administrative personnel attached to the SATU, certain operating expenses, and facilities. The SDA contribution will fund some of the technical personnel and some administrative IEC costs, and operational costs for the RAM Center, and warehouse infrastructure.

The disbursement period of the Project will be approximately three years or until the PACD of September 30, 1988. The following pages contain the project financial table, in which Table A. Summary Budget and Table B. Projection of Expenditures by Fiscal Year are combined for the agreements for both the SDA and the GOES. An additional financial table and projections by Project input is included in Annex I.

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SUMMARY BUDGET  
PROJECT 519-0210: POPULATION DYNAMICS  
GOES COMPONENT

	FY 85			FY 86			FY 87			TOTALS		TOTAL PROJECT
	AID		GOES	AID		GOES	AID		GOES	AID	GOES	
	FX	LC		FX	LC		FX	LC				
(A) <u>Technical Assistance (AID)</u>	360	--	--	520	--	--	520	--	--	1,400	--	1,400.0
(B) <u>Administration (Unit)</u>												
- Staff Salaries	--	50	--	--	50	--	--	55	--	155	--	155.0
- Support Pers.	--	15	5	--	17.2	5	--	19.8	7	52	17	69.0
- Operating Costs/ Office Equipment	20	50	5	--	53.1	5	--	58.7	--	181.8	10	191.8
- Vehicles	60	--	--	--	--	--	--	--	--	60.0	--	60.0
- Sub-Total	80	115	10	--	120.3	10	--	133.5	7	448.8	27	475.8
(C) <u>IEC (MOH)</u>												
- Personnel	--	--	50	--	--	60	--	--	70	--	180	180.0
- Eq. & Supplies	60	10	15	6	--	15	7	--	15	83	45	128.0
- Productions	--	217	15	--	250	15	--	272	15	739	45	784.0
-Sub-Total	60	227	80	6	250	90	7	272	100	822	270	1,092.0
(D) <u>Training (MOH, ISSS, ANTEL)</u>												
- Field Workers	--	80	128	--	70	128	--	50	100	200	356	556.0
- Medical/Para-med.	--	100	150	--	55	80	--	55	100	210	330	540.0
-Administrators	--	17	20	--	16.1	20	--	23.9	20	57	60	117.0
-Educators	--	12	20	--	12.3	20	--	12.1	20	36.4	60	96.4
-Logistics/Maint.	--	6	30	--	12.0	30	--	12	30	30	90	120.0
-Participants	60	--	--	20	--	--	25	--	--	105	--	105.0
-Sub-Total	60	215	348	20	165.4	278	25	153.0	270	638.4	896	1,534.4
(E) <u>Logistics/ Maintenance</u>												
- Personnel	--	--	90	--	--	105	--	--	110	--	305	305.0
- Warehouse	--	120	--	--	--	--	--	--	--	120	--	120.0
- Contraceptives (W)	300	--	--	370	--	--	460.6	--	--	1130.6	--	1,130.6
- Micro-Computers	60	--	--	--	--	--	--	--	--	60.	--	60.0
- Med. Eq., Maint. Hardware, Vehicle Spare Parts	440	--	40	273.4	--	40	273.4	--	40	986.8	120	1,106.8
- Sub-Totals	800	120	130.0	643.4	--	145	734.0	--	150	2297.4	425	2,722.4

F) <u>Policy Planning</u>												
(MIPLAN)												
- Personnel	--	--	30	--	--	30	--	--	30.0	--	90	90.0
- CPS (88)	--	--	--	--	--	--	30	150	23.5	180	23.5	203.5
- Eval./Research	<u>60</u>	<u>30</u>	<u>11</u>	<u>--</u>	<u>60</u>	<u>11</u>	<u>--</u>	<u>20</u>	<u>11.0</u>	<u>170</u>	<u>33.0</u>	<u>203.0</u>
- Sub-Total	<u>60</u>	<u>30</u>	<u>41</u>	<u>--</u>	<u>60</u>	<u>41</u>	<u>30</u>	<u>170</u>	<u>64.5</u>	<u>350</u>	<u>146.5</u>	<u>496.5</u>
G) <u>Project Evaluation</u>	--	--	--	100	29	25	120	30	25.0	279	50.0	329.0
H) <u>Conting./Inflation</u>	<u>238</u>	<u>100</u>	<u>--</u>	<u>22.9</u>	<u>142</u>	<u>--</u>	<u>100</u>	<u>266.5</u>	<u>--</u>	<u>869.4</u>	<u>--</u>	<u>869.4</u>
Grand Total	1658	807	609	1312.3	766.7	589	1536	1025	616.5	7105.0	1814.5	8,919.5

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PROJECT NO. 519-0210  
POPULATION DYNAMICS  
(\$000)  
SDA COMPONENT

	<u>FY85</u>			<u>FY86</u>			<u>FY87</u>			<u>TOTAL AID</u>	<u>TOTAL SDA</u>	<u>TOTAL PROJECT</u>
	<u>FX</u>	<u>LC</u>	<u>SDA</u>	<u>FX</u>	<u>LC</u>	<u>SDA</u>	<u>FX</u>	<u>LC</u>	<u>SDA</u>			
(A) <u>TECHNICAL ASSISTANCE</u>	200	--	--	200	--	--	200	--	--	600	--	600
(B) <u>ADMINISTRATION</u>												
- Infrastructure	--	--	228	--	--	228	--	--	228	--	684	684
- Support Personnel	--	10	5	--	10	5	--	10	5	30	15	45
- Office Equipment	--	5	--	--	--	--	--	--	--	5	--	5
Sub Total (A)	--	15	233	--	10	233	--	10	233	35	699	734
(C) <u>IEC</u>												
- Audiovisual Equipment	60	10	5	6	--	5	--	--	--	76	10	86
- Base Line Study	--	50	10	--	20	10	--	--	--	70	20	90
- Production/Communication of Materials	--	571	--	--	607	--	--	449	--	1627	--	1627
Sub Total (B)	60	631	15	6	627	15	--	449	--	1773	30	1803
(D) <u>TRAINING</u>												
- Rural Agencies	-	35	10	-	33	5	-	10	5	78	20	98
- Teachers and Promoters	-	20	5	-	12	5	-	10	5	42	15	57
- Leaders (MIPLAN)	-	10	2	-	10	2	-	10	2	30	6	36
Sub Total (C)	-	65	17	-	55	12	-	30	12	150	41	191
(E) <u>CONTINGENCIES AND INFLATION</u>	10	79	-	30	168	-	-	50	-	337	-	337
(F) GRAND TOTAL	270	790	265	236	860	260	200	539	245	2895	770	3665

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A table showing the Methods of Implementation and Financing of this project as currently envisioned by the Mission is included in Annex J. The Mission proposes to include a 90 day operating advance to the SDA, and the SATU, based upon appropriate justification from these entities. Since the Project's activities have not been included in the MOH, ISSS, or ANTEL budget, the advance will be necessary to start Project implementation. The GOES agencies and SDA will utilize a 30 day liquidation and reimbursement schedule in order to ensure a constant and timely flow of funds.

In the case of the GOES, the funds will be held in a special account and managed by the SATU, which will be responsible for funds allocation among the GOES institutions for each activity.

Procurement of commodities requiring foreign exchange will be made through the U.S. technical assistance contract. This is necessary since the GOES has difficulties in obtaining the foreign exchange required to pay for the goods proposed under the Project. Certain commodities, which can be obtained more easily and directly through existing Cooperative Agreements, that such organizations as the Association for Voluntary Sterilization, Family Planning International Assistance, and the Johns Hopkins Program for International Education in Obstetrics and Gynecology have with ST/POP to provide equipment and services will be purchased through these agreements. These Cooperative Agreements have direct use mechanisms for A.I.D. Missions for procurement. Under these arrangements, the Mission will directly purchase such items as medical kits, endoscopes, and basic equipment for the Repair and Maintenance Centers (RAMs) at the SDA and the MOH.

The technical assistance to be contracted under Component I, which will provide expertise to the SATU, will be an A.I.D. direct contract. Since this technical assistance team is intended to provide assistance and coordination for all organizations involved, it should not be solely responsive to one organization through a contract. In this way, through a contract with A.I.D., the technical assistance will have greater autonomy, and will be responsible for the overall management of project activities from A.I.D.'s perspective. The contract will be on a cost plus fixed fee basis. In addition to some procurement, the contract will include funds for short-term technical assistance as needs are identified. These short-term needs will be financed through sub-contracts with individuals or other firms.

Recurring costs as a result of the Population Dynamics Project are minimal, since this Project does not depend on adding a new cadre of health personnel. It reinforces the existing participating institutions and their personnel, in a systematic way, to improve the overall outputs of the NFPP. However, the procurement system, which will be developed under the Project, will probably engender recurring costs. Vehicles donated to the Project will need continuing maintenance, fuel, insurance and storage facilities.

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Maintenance and depreciation costs to medical equipment will also be a recurrent expense. Maintenance of laparoscopic equipment has proven to be a recurrent, but necessary expense to provide high volume voluntary surgical contraception in the country. Likewise, depreciation and replacement expenses for necessary medical equipment is required for any health care system.

Normal wear and tear and depreciation of the family planning commodity warehouse will continue as a yearly recurrent cost. Further, additional pharmaceuticals such as meperidine and valium, which are required for surgical interventions in reproductive health and family planning will be needed, on a continuing basis.

## V. SUMMARY OF PROJECT ANALYSES

### A. INSTITUTIONAL ANALYSIS

#### 1. Coordination and Organizational Problems of the Participating Institutions

In order to improve and expand the contraceptive services available to the people of El Salvador, and particularly to younger couples of fertile age and the rural poor, this Project must augment services and assist the major service providers in the country, i.e. the Ministry of Health, the Salvadoran Social Security Institute, and the Salvadoran Demographic Association. It also must assist the new, smaller family planning service providers and agencies to participate more fully in the national program.

One of the major constraints to the effective delivery of family planning information and services is a lack of cooperation among the participating agencies. There have been disputes between the SDA and the MOH as to their respective roles and responsibilities, areas of coverage, standards of practice, etc. This is, at least in part, a result of the differences in program purpose among the different family planning agencies. The MOH is committed to health and FP program integration and reflects an integrated approach to population and development, standards of practice, etc. The ISSS is more vertical in its family planning focus, and insists on applying its own standards and approaches. The SDA is more supportive of private initiatives and oriented towards flexible, innovative solutions. All of the institutions have a commitment to voluntarism in family planning.

##### a. The Ministry of Health (MOH)

The Ministry of Health provides approximately 63% of all family planning services in El Salvador through some 280 hospitals, centers, units, and posts, 37% of which are located in urban and 63% in rural areas. All health facilities offer temporary family planning methods. Permanent methods are provided at 10 hospitals, 12 health centers and the health unit at the Port of Acajutla. An organizational chart is contained in Annex K which illustrates the overall administrative structure of these health facilities. The overall

policy guidance for provision of FP services has been entrusted to the Maternal and Child Health and Family Planning Department (MCH/FP) of the Ministry. As the organizational chart shows, in the five health regions the MOH provides services through a system of hospitals, health centers, units, and posts as well as mobile teams. Family planning services that are provided by physicians, nurses, and auxiliary nurses throughout this system are supplemented at the community level by some 260 RHAs and 1,050 TBAs.

Overall administrative obstacles which affect the MOH include a centralized bureaucratic system for program and budget development and for expenditure and project execution; a lack of program authority at the operating levels; burdensome and ineffective reporting and control systems; and ineffective project supervision. Logistical problems include an already over-burdened system of procurement and distribution of pharmaceuticals and equipment, a lack of preventive maintenance and equipment repair capability, inadequate projections and lack of inventory control.

The MOH has been affected by conflicting advice from its multiple donors, some of whom advocate vertical family planning programs and others who advocate various types of integrated programs involving general health, maternal and child health, and population and development. This has resulted in confusion among administrative and program staff. However, a policy decision has recently been made by the MOH to incorporate family planning into the maternal and child health program. Different financial and program development and reporting systems are used in different projects funded by different donors. A project may be with MIPLAN, or directly with MOH, but the individual line and staff managers must develop their own program and budget requests to meet the requirements of the MOH Directors and the planning unit in the Ministry of Planning. The managers are responsible for translating their program concepts into budgetary formats acceptable to all the relevant levels of authority. They have little training in preparation of appropriate budget documents, and since formats are changed with some regularity, there is confusion about budgetary requirements. For this reason, the SATU will be responsible for handling all Project funds that are to flow through the Ministry of Health, and will undertake training for MOH personnel in management and budgeting procedures.

Purchasing procedures are further obstacles to project implementation. Spending authority is centralized even for minor program expenditures and the approval and authority protocol creates problems and delays for line managers. Purchases over £25,000 (\$6,250) must be advertised and bids solicited by the Purchasing Department. This results in a process of negotiation between purchasing and the line departments' requirements and further delays. The final bids are evaluated by the purchasing department only and the responsible line agency is informed of the results. There is no separation of technical and financial proposals, no prequalification of bidders (except for financial qualifications/bonding capabilities) and no consideration of quality in the bidding process. In order to avoid these

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problems, which is expected to be dealt with in an institutional improvement project for the MOH early next year, the technical assistance will undertake purchasing for the Project.

Further factors that affect the Ministry's ability to provide services include unclear channels of communication concerning decisions made on programs at higher levels, and lack of trained administrators. With regard to the rural outreach program, the RHAs, which this Project will utilize to further extend services to rural areas, are subjected to an inordinate amount of bureaucratic requirements.

Because of these problems, A.I.D. is not attempting, under this project, to consolidate the management of family planning programs under the Ministry of Health. The SATU will have technical personnel that can relate to all levels of the Ministry, will be established through a ministerial decree, and will be under the direct authority of the Minister.

Furthermore, although the private sector agencies share in the overall objectives of the NFPP, their independence and the effectiveness of the private and voluntary sector could be compromised by establishing the MOH as the overall manager of this Project.

However, there are several specific objectives that this Project will accomplish with regard to improvement in the institutional problems. Through the SATU, and more specifically, the technical assistance to be provided by the Project, the MOH will receive training in management, evaluation, supervision of personnel, and use of management information systems. Furthermore, with regard to the logistics system, the Ministry has already shown a commitment to resolution of the problems of warehousing space, procurement, and distribution. They have recently reviewed their procedures in this regard and, with assistance from the Project, will identify and resolve deficiencies in the logistical chain, repair regional warehouse facilities, and retain personnel, when indicated. The SATU will also work to assure that, by the end of the Project, family planning and rural outreach programs will have more streamlined administrative structures. In summary, one of the objectives of this Program will be to assist the MOH to resolve those administrative and institutional problems which are impediments to the delivery of FP services.

#### **b. Ministry of Planning (MIPLAN)**

The Ministry of Planning is formally and legally responsible for the overall supervision of the Salvadoran national population program. The MIPLAN convenes and directs the National Population Commission (composed of nine Ministers) in matters relating to the Integral Population Policy and related programs. The Population Department of MIPLAN's Bureau for Planning is responsible for facilitating communication among population programs through the Population Technical Committee. The Population Technical Committee has representatives from all agencies involved in family planning programs and was

established to share information about family planning programs, and to develop national population policy. MIPLAN's Population Department is responsible for convening the Population Technical Committee and providing it with supporting services. An organization chart of this Department is included in Annex K. The Population Department reports directly to the Vice-Minister of Planning. Just recently, it was upgraded from an office to a Department, although the staff is fairly small, consisting of four professionals and a secretary. This office is essentially funded by UNFPA, and is responsible for performing demographic analyses and projections with regard to statistics and census data.

MIPLAN has as its objective in this area the balancing of population growth with national resources. This search for a population policy has directed its attention to demographic, economic, and sociological research, and away from the specific implementation problems of concern to the family planning service agencies. MIPLAN has been the recipient of UNFPA assistance in Population Policy and the Population Department has undertaken a limited number of research studies and prepared reports on population related issues.

The MIPLAN structure established for guiding and coordinating the family planning program has never been fully operational. The coordinating system is without executive authority or resources to implement cooperative programs. Each agency functions independently and has an independent relationship with both governmental sources of funds and external donors. The implementation agencies have a different focus of work from that of MIPLAN and find MIPLAN removed from their specific program needs.

As a result of the Project, several major objectives will be achieved with regard to the MIPLAN and its involvement in family planning. Through the Project, the Ministry of Planning should improve its relevance to the family planning program implementation problems faced by the participating institutions. The Population Department will focus more on programs and less on policy considerations. Research activities should be designed to test and evaluate information and service delivery systems. Data collection and reporting systems will be developed, field tested and instituted throughout the country. A national demographic data base will be developed and regular surveys conducted of FP user statistics and motivational research. Based on these activities, information should be provided to national leaders and decision makers to lead them towards a national population policy based on the realities of program work in El Salvador.

Population department personnel will also receive training in operational research, and evaluation methodology. In addition, training in data collection and processing systems, population projections and correlations between population and socio-economic data will also be given. Specific evaluation and research project proposals should be developed by the unit and supported on the basis of their contribution to the problems faced by the country. Support should be given to projects relevant to the implementation of the national family planning program.

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c. Salvadoran Social Security Institute (ISSS)

The ISSS provides health services for about 16% of the total population, largely in urban areas. Monetary contributions made by the workers and their employers are paying for medical and retirement benefits.

The family planning program of the ISSS is limited. The program is under the supervision of one officer, three organizational levels removed from executive or budgetary authority, and only indirectly linked with the service-providers. The ISSS has a small family planning unit within the Department of Preventive Medicine. A single part-time physician, assisted by one social worker and two educators, supervises the entire family planning program at the ISSS. An organizational chart of the ISSS is provided in Annex K.

The family planning program is part of the Maternal and Child Health and Family Planning Division under the Medical Department. Services are provided at 36 facilities (four hospitals and 32 clinics) nationwide. Each clinic is staffed by a medical director, an administrator, a chief nurse, and depending on workload, by additional staff. There are no MCH/FP-specific staff at either the central, regional, or hospital/clinic level, but social workers and social educators who have family planning among their responsibilities are employed at the regional and local levels.

The ISSS family planning management structure displays many of the same constraints as those of the Ministry of Health. It has a centralized system for programs and budget development and for expenditure and project execution, and there is little program authority at the operating level.

It should be noted that the ISSS has a strong, almost vertical family planning focus in spite of a diffused organizational and management structure. This is the result of the personalities currently involved at the program direction level. The current General Director of the ISSS is a committed advocate and promoter of family planning and, as a consequence, medical personnel are aware of and promote the program. Social educators/workers discuss its benefits in factories and group meetings and clients requesting services receive them. The ISSS family planning program is self-supporting; it purchases most of its own contraceptives but also occasionally receives contraceptive and equipment supplies from MOH and SDA. The ISSS receives educational materials from SDA and reproduces them. Its personnel receive family planning training on an ad-hoc basis.

The Social Security medical system is regarded generally as well administered. The ISSS charter restricts program activities to those directed to the welfare of covered workers and their families. The ISSS is prepared to expand coverage to new groups of workers and thereby expand its medical service responsibilities, but cannot take on nationally focussed responsibilities. However, Social Security's focus on workers and worker

benefits has permitted it to develop a clear program purpose and effective programs, in spite of organizational constraints. Additional responsibilities supporting other organizations would severely overload its present structure.

This Project, through the SATU, will assist the ISSS to work towards a series of institutional improvements. Among them would be an organizational upgrading of the family planning activities. Personnel will be trained under the Project, who will then be responsible for continuing in-service training in the hospitals and the clinics. It is also expected that this department will assume responsibility for developing family planning information and educational materials. In addition, once the Project is terminated, they will be responsible for training hospital and clinic staff in family planning and arranging medical/technical training for the doctors. The family planning department would eventually be responsible for insuring an adequate supply of contraceptives and family planning equipment and supplies and would evaluate and report on family planning program effectiveness to the Director General.

e. National Telecommunications Administration (ANTEL)

The National Telecommunications Administration (ANTEL) manages a small, hospital-based family planning program. The ANTEL hospital was established to provide medical services to company employees (currently 5,300) who are primarily women (90%) as part of the company's benefit package. The ANTEL Hospital is responsible for personnel in the Metro-San Salvador area and those referred from other locations.

ANTEL provides services in response to client requests, but undertakes few initiatives. Its program is small and funds are limited. The general director places little emphasis on health, and the hospital authorities place minor emphasis on family planning. Personnel have received limited training in family planning as well as facilities and equipment up-date and improvement. Nevertheless, within these limitations, the people responsible for providing family planning services are capable and willing to expand their work, given opportunity and direction.

Therefore, to improve the institutional capability of the ANTEL, appropriate staff need to be trained, facilities need to be upgraded, and material support, which will be provided under this Project, made available to permit them to deliver effective family planning information and services. The family planning staff at the ANTEL Hospital is willing to expand the program, but this is impossible without a greater organizational commitment, which the Project will assist in furthering.

f. Salvadoran Demographic Association (SDA)

The SDA, an IPPF affiliate, is the largest private provider of family planning services in the country. Part of SDA's overall family planning program is a vigorous education and training effort in urban as well as rural areas, directed primarily at community leaders, adolescents, couples of fertile age,

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and illiterates. Medical services are provided in four clinics in the country's four largest cities where all methods are offered. In addition, one clinic is located in a displaced persons camp, where all methods, surgical and temporary, are offered.

SDA's Commercial Retail Sales (CRS) program, started in 1978 provides an estimated 16,000 couple/years of protection through the sale of condoms, pills and vaginal tablets. Its Community Based Distribution (CBD) program in the Eastern region employed 107 persons. The CBD program was terminated in 1985, due to unsatisfactory cost-effectiveness.

The SDA is the current recipient of an AID grant; its financial and administrative systems have been evaluated. In general, the SDA has been found to be staffed by competent, dedicated people who are contributing significantly to family planning efforts in El Salvador. The organization of the SDA is clear and simple, with a limited number of departments relating directly to the Executive Director. There are no intervening layers between the operating divisions and their access to authority and program guidance. Departmental responsibilities are clear and distinct.

The SDA has the clear focus and purpose to provide family planning information and services. Program managers understand their role and their relationship to overall organizational purpose. Financial and purchasing authority is centralized and coordination of departmental requirements is provided by the executive. At present, the system depends on having a competent, strong Executive Director. A large expansion of services would require considerable extra staff.

The SDA currently has major responsibilities in the national FP program for mass media communications, and social marketing. An effort to reach out to "grass-roots" organizations, to identify, mobilize, train, assist and monitor many organizations newly involved in family planning outreach would require a concentration of program resources and a considerable application of staff skills.

The SDA executive board is in agreement, however, on a strategy for expansion of the organization's IEC capabilities and strengthening of collaboration with grass-roots organizations, and the need to provide training to upgrade the quality of personnel and provide them with the specific skills they require to work more effectively.

The SDA has an appropriate organizational structure for the level of activity at which it is currently working. An organizational chart is included in Annex K. It has started to reach the limits of capacity of that structure and should now consider how it can reorganize to increase efficiency and program accountability.

Staffing additions, required for more effective work by the SDA, which will be accomplished by the end of the Project, include the executive department noted above plus some augmentation of specific operational staff in specific programs. The IEC staff will be increased to more fully meet this department's national mass media responsibilities. The Training Department is understaffed and additional personnel will be hired there. Throughout the SDA, program managers and supervisors will receive training in management and supervisory skills. Most of them have learned on the job and could work more efficiently with some specific training in program design and development, budgeting, scheduling, and in the use of management information systems.

## B. SOCIAL SOUNDNESS ANALYSIS

The social soundness of this Project is considered in each of three separate but distinct aspects: 1) socio-cultural feasibility; 2) diffusion effect and 3) social impact. All three of these points provide a social context within which the Project will operate.

### 1. Socio Cultural Feasability.

Socio-cultural feasibility of Project activities is an important consideration because the ultimate success of the program depends on the local beliefs, social structure and the organizational milieu in which the Project has to operate.

Through a Ministry of Health study and the recently completed Contraceptive Prevalence Survey, jointly carried out by the SDA and Westinghouse Health Systems, the Mission has attempted to identify and analyze attitudes and beliefs regarding FP. It was found that contraceptive knowledge in the country was quite high; although attitudinal problems affect their use. Although an average of 45% of women in fertile age agree with family planning, they are not using contraceptive methods. In addition, the difference in contraceptive use between the urban and rural areas of the country reflects attitude and belief differences regarding usage of contraceptives. The present usage in the rural areas is approximately 29%, whereas all urban areas have an average of approximately 50% usage rates. The recent studies have identified attitudinal problems concerning use of contraception that are the result of lack of knowledge concerning side effects of the temporal methods. Communication failure between partners on method choice (i.e. uncertainty or rejection of methods by one of the partners) is also a major factor in the lack of use of contraceptives. A pronatalist attitude has been reported in some of the Salvadoran rural areas and may be attested to by the higher total fertility rate of rural women as opposed to urban women.

This Project is intended to impact beneficially on the lives of the urban and rural poor. It is important that at all levels of Salvadoran society the Project is perceived as such. At the political level, some church related organizations will most likely not support the program since they often see population programs as short sighted and an attempt to remedy symptoms rather

than the "root causes." However, the church and/or religious attitudes are not expected to hinder or impede the Project's progress. Attitudes of paternalism may affect the implementation of the Project at the higher political levels. A pervasive attitude to "protect" people from certain information or programs must be understood and overcome. However, it is also not expected that this will impede the effective implementation of the Project.

The range of individuals that are to be reached by this Project will be from varied locations and circumstances, from urban slums to rural subsistence farms, to displaced person settlements. The importance of reaching the population through a target-group specific and well coordinated IEC campaign is the key to increasing motivation. Recognizing the socio-cultural differences between rural and urban areas, the rural population will have a separate type of campaign from the urban strategies to be developed for the IEC Component. The ultimate objective will be to motivate those who are seeking information and services to the nearest government or private installation.

## 2. Spread Effects - The Diffusion

The ultimate success of this Project lies in the promotion of family planning commitment at various levels. The National Health Commission will provide the policy coordination, while the SATU will provide the operational coordination at the technical level of the various participating agencies. The responsibility of each of these will be to increase their capacity to commit more governmental and private resources to reproductive health in their respective arenas of influence. Through policy seminars and studies, with the specific intent to strengthen population policy, the Project is expected to impact on other ministries and other related programs. One of these other programs is a new rural health plan that is being developed by the MOH, which will be given a family planning orientation through training.

Through this Project, the objectives of the existing national family planning program regarding increased contraceptive coverage will be furthered. However, a precondition for achieving the goals of the national program is improved coordination among the FP service providers. The expansion of services is most needed in the rural areas especially with regard to temporarily methods such as oral contraceptives and IUDs. The medical and administrative personnel charged with promotion and implementation of the Project will need to be reinforced to strengthen the country's operational commitment to family planning. The future of the national program will depend on coordination and increased government commitment to this activity. One of the obstacles to diffusion of family planning is related to education; there is a direct correlation between little education and low contraceptive usage. Since the emphasis of this Project is rural areas where the educational levels are the lowest, communication strategies to effectively inform and motivate the population concerning voluntary family planning will be required. It is expected that the increase in active users in the program will be from 317,000 in 1985 to 370,000 in 1988. Plans to motivate the Ministry of Health

personnel to improve interpersonal communication to assist in the diffusion, acceptance and eventual practice of voluntary family planning in El Salvador will contribute to this objective. As demonstrated in the CPS'85, over 50% of the respondents claimed that an interpersonal source of communication was how they first heard of family planning. This indicates the importance of new, coordinated interpersonal communication strategies.

The eastern half of the country, which is economically less developed, has slightly different customs and beliefs than the western half. In general, the Western half is more privileged in terms of education, economic indicators, and therefore higher utilizers of contraceptive methods. In contrast, the Eastern portion of the country will require a focused and concentrated effort to increase the amount of goods and services flowing into that area. In part, the achievement of this project will depend on how well the logistics system will be able to respond to those in need. Emphasis in this project will be given to Eastern rural population.

The reproductive health needs of the displaced population in El Salvador are being addressed by this Project. According to a recent census of the displaced population as of May 1985 <sup>12/</sup>, the number of displaced is estimated at 412,000 registered by CONADES. However, the Mission estimates a total of 525,000 displaced, which represents approximately 12% of the total Salvadoran population. This Project will address the needs of this population through the direct supply of commodities and training of the medical and paramedical staff providing services to this needy population.

### 3. Social Consequences

#### a. Access to resources and opportunities

This Project will provide access to training opportunities for medical, paramedical and administrative personnel to transfer technologies, which will improve the management ability of the program on a business as well as techno-scientific level. Secondly, the Project will provide clients with new information, service opportunities, and new contraceptive technologies to meet their reproductive health needs. Thirdly, the introduction of material resources to update and expand clinical services will strengthen the existing infrastructure to provide services to meet increasing demands in family planning.

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12/ Baseline Survey of Displaced Families

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b. Changes in Participation

This Project has the implication of shifts in policy and institutional capacity of the various health institutions in the country. This Project attempts to unify the public sector at a political and operational level. This renewed effort for coordination will undoubtedly bring with it new approaches to the problems of logistics, and communication and program management.

The need to face these challenges in a coordinated fashion for the public sector is obvious from the potential demand for services in El Salvador. However, it is equally important that private and private not-for-profit organizations will also need to coordinate and lend their expertise to improve the overall performance of the program.

At the end of this Project it is expected that through new coordination and closer collaboration the Project will approach a unified way to articulate national family planning needs through a multi-disciplinary and multisectoral implementation unit.

C. TECHNICAL ANALYSES

The technical requirements pertaining to the areas of IEC, Training, and Logistics/Maintenance, being addressed by the Project, are analyzed below:

1. IEC Component

a. Information Requirements

The current CPS '85 survey provides data which is useful for IEC program planning: educational, geographic, morbidity, mortality and parity indicators. The results provide data about key target audiences that need family planning information. However, further investigations will be needed to identify consumer and population segment profiles for target audience behavior that can be changed by education and information.

b. Coordination Requirements

Among the higher levels in each of the major service institutions that might be involved in providing IEC services for FP and population education, there has been no definition of, or agreement upon, IEC policies and norms. Nor have there been long-term nationwide coordinated programs for FP. Institutions have not tended to share results of research findings on a regular basis nor design joint programs to meet common ends in this area. With few exceptions (UNFPA sponsored a 2-year multi-media maternal/infant health, nutrition, family planning campaign in the MOH) institutional IEC departments have generally tended to react to ad-hoc demands for print media (i.e. posters and pamphlets), rather than plan coordinated campaigns with a

fixed budget to achieve certain common objectives. The recent vaccination campaign was a notable exception. Staff from several institutions cooperated to produce a very effective multi-media campaign.

c. Human Resource Needs

With regard to human resources, there have been no standard technical criteria for hiring health educators, or long-range continuing educational plans to assure that all educators share a common base of knowledge. The current two-year course on population education sponsored by the UN provides a good opportunity to upgrade knowledge and educational materials production skills. However, there is no coordinated plan to recruit students from various ministries, and educators who work far from San Salvador do not have the opportunity to attend.

Results of the CPS '85 study reveal that there is a need for FP education and motivation. Over 90% of women in fertile age know about FP, and, although 74% of them are in favor of it, approximately 45% of those in favor, do not practice FP. Hence, a large percentage of women in urban and rural areas who are in need, have to be motivated to utilize services.

The study showed that knowledge of FP technique directly correlates with higher levels of education. According to the CPS '85, the individuals who were interviewed under the Survey first heard about FP from the following sources:

CATEGORY	PERCENT
Relative/friend	20.5
Radio	19.6
Health care provider	18.6
School	15.3
TV	9.1
Newspaper	1.4
Other	5.6
Do not know	9.3

The results indicate that it is important to FP to provide quality services, as well as to improve the interpersonal skills of health care providers and community change agents, since they account over 50% of the sources of information. Health care providers and teachers are important sources for this motivation as is radio and TV (in urban areas). It is important to improve communication campaigns, especially to the rural areas where contraceptive prevalence levels are low.

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The reasons that women in union do not use temporary FP methods include:

REASON	PERCENT
Husband opposed	16
Do not like	14
Provokes side-effects	12
Breast feeding	12
Already sterilized	10
Wants a child	8
Not permanent	8
Religion	4
Cost	1
Other	14

To overcome the predominant reasons for non-use, one must create messages to reach couples who can be convinced to change their minds about the usefulness of FP methods and their side-effects. Men must be included in the campaign because they influence their partners' decision-making process.

The following table shows the relationship between knowledge of methods, preference and use.

KNOWLEDGE, USE, AND PREFERENCE FOR  
VARIOUS CONTRACEPTIVE METHODS

METHODS	KNOWLEDGE	PREFERENCE	USE
	%	%	%
Female Sterilization	91	65	31
Male Sterilization	72	1	1
Injections	71	2	1
IUD	83	9	5
Pill	92	20	10
Condom	82	2	1
Vaginals	59	1	-
Rhythm	51	-	-
Withdrawal	32	-	-
Other	5	-	-

The results show that the methods for which there is more preference than use are female sterilization, the pill, and the IUD. Finally, the CPS'85 showed that the national immunization campaign was able to motivate 42% of the population to vaccinate their children under five on at least one of the three Sundays scheduled. Radio, promoters, TV, and the press, in that order, combined to yield the impressive outcome. Both interpersonal and mass media components are important for attaining results in educational campaigns.

Interviews with health education personnel uncovered training needs, which will be addressed by the project, which include the following areas:

- 1) Theory of adult education;
- 2) Group dynamics;
- 3) Use of audio-visual materials;
- 4) Working with youth; and
- 5) Update on contraceptive technology.

## 2. Training Component

Because of a chronic shortage of funds for training, attrition and turnover of trained personnel, there is a continuing need for further improvement of the overall training system and specific family planning training programs. The following types of personnel require training in the areas indicated.

### a. Paramedical, Auxiliary and Community (PAC) Personnel

In general, training curricula in nurses and auxiliary nursing schools tend to focus on clinical, hospital-based health care and not enough on a community setting. Social aspects of health care get insufficient attention, as does the teaching of the requirements for team work and supervision and the care for and preventive maintenance of medical equipment, as well as promotion techniques and the use of audio-visual materials.

Some of these shortcomings have begun to be remedied through special in-country courses at the MOH'S Escuela de Capacitación Sanitaria and in its programs in the regions, in remedial, continuing, and pre-service training programs. Primarily due to financial constraints, there has been a dearth of this type of training until recently. Another shortcoming affecting pre-service education and training of nurses and auxiliary is the lack of accurate, up-to-date job descriptions of the positions for which the future family planning service provider is being trained. Specific components of pre-service education and training programs should be tailored to the student's future job functions.

The situation concerning the training and preparation of the MOH's traditional birth attendants (TBAs) is somewhat better. The basic pre-service training of ten days' theory and five days' practice, which includes a section (two modules) of family planning-related subject matter, is quite community and primary health care oriented. There is likewise a well-designed system of continuing training through short courses and workshops. After having trained 150 TBAs in 1981, the MOH intended to train 300 in the following years in 20 courses per year. Due to financial constraints, however, only 10 courses were implemented in 1984. Some 750 of the total estimated 2,000 TBAs in the country have received basic training. The planned number of one-week refresher courses (10 per year with 20 to 25 participants per course) could not be offered because of lack of funds.

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The RHAs pre-service training is likewise community and primary health care oriented and has been offered in four regions. Starting in 1976, it had graduated 340 RHAs through 1978. Since then, only 50 graduated in 1981, 30 in 1982, and 28 in 1984. Currently, only a total of 260 RHAs are still in active service. Many resigned after the MOH failed to pay their salaries for several months. Those still in active service are in dire need of refresher training, for which the MOH lacks funds. During the next three years an additional 525 RHAs are scheduled to be trained

Another category of community workers, the usuarias satisfechas, have been very effective promoters of family planning in their communities. So far, these "satisfied users" have been mainly promoting the methods they were satisfied with. They should receive basic training in and information about all family planning methods which should be included in their promotional activities.

The MOH's Health Educators supervise and train the RHAs and TBAs. Most Health Educators have received training in media production but require additional instruction in program management and assistance. Most declined to attend the UNFPA's course in population education, because it would have taken too much of their time, since it is a two year course with regular afternoon sessions.

#### b. Physicians

Medical students receive some, but inadequate training in family planning during their seven years at the country's medical schools and additional training at the MOH and/or SDA prior to their year of social service. The basic knowledge thus acquired will be periodically updated and deepened in seminars, workshops and on-the-job training on specific family planning topics and issues. Physicians specializing in Ob/Gyn could receive better training in surgical contraceptive techniques which should be offered in periodic contraceptive update programs in MOH, ISSS and SDA facilities. The estimated 150 physicians needed for the expanded program should receive intensive training in clinical and administrative aspects of family planning. All physicians in the MOH, ISSS and SDA programs need periodic refresher training.

#### c. Trainers

The quality of the FP trainers, their own training as trainers, and their enthusiasm and dedication are key factors in the effectiveness of any training program. Each of the Salvadoran institutions involved in the training of paramedical, auxiliary, and community personnel working in family planning service and IEC activities, has some staff who had attended Training of Trainers (TOT) courses in the USA and in third countries (exact figures are unavailable). For the most part, the personnel thus trained have been utilized as trainers and instructors, while several have actually functioned as TOTs upon their return from training. Others have been given responsibilities as training program planners and managers. Nevertheless, there still is an urgent need to:

- Train additional TOTs for all institutions and entities involved in the training of trainers, instructors and educators, and
- Give refresher training either abroad or in-country courses and workshops to staff who attended TOT training in the past.

d. Policy and Opinion Makers

Influencing policy and opinion makers may or may not be properly placed in the "training" category, since much of the methods and techniques employed in doing so overlap with IEC activities under the Policy and Planning Component.

El Salvador's top political leaders and lawmakers currently are only lukewarm about or tolerant toward family planning. It has a low priority among them. To change the climate in the country towards a more positive public and official attitude regarding family planning, key political leaders, legislators, and such opinion molders as press, radio and TV journalists, influential society and community leaders, as well as religious leaders, should be sponsored to visit countries with declared population policies and effective programs. They should also be invited to seminars at which the findings of the latest contraceptive prevalence survey are presented, interpreted and their implications discussed. Likewise, a RAPID for Central America presentation with follow-up discussion can be arranged for the same categories of participants.

The following types of training to be provided are:

a. Supervision and Evaluation

Recurring findings in evaluations and program descriptions demonstrate a lack of adequate supervision of personnel at basic and mid-levels. This lack exists at the central as well as the regional levels. A recent evaluation of the UNFPA's project with the MOH's MCH-FP Division noted that, for instance, supervision of health educators in the regions is spotty due to the shortage of appropriately trained supervisory personnel. Training in principles and various aspects of supervision, as well as in evaluation is needed for all personnel supervising others, but especially for the Regional Supervisors and personnel in charge of health posts, health centers, hospitals, and within the MOH itself.

b. Administration/Management

Training needs in this area cover quite a broad spectrum at all levels, ranging from field supervisors to hospital administrators, from accountants to controllers, from section heads to department chiefs and the division director. It likewise includes the corresponding personnel in the five health regions.

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All of the basic and mid-level training, ranging from community needs assessment, project planning, record-keeping, evaluation and fiscal control, supervisory techniques for administrators and managers, program information systems application, delegation of functions, rationalization of the personnel management system, data gathering and analysis, cost benefit/effectiveness analysis, preparation and control of budgets and logistics plans, etc., should be developed and implemented in-country, since there is already a qualified cadre of trainers who, however, need refresher training. The training of top level administrators could best be accomplished, in seminars and courses, including international expertise/instructors. Top administrators should also be sponsored to attend international seminars, workshops and observational visits on appropriate topics.

On the intermediary and advanced levels, principles of statistics, use of population statistics and census findings for forecasting service needs, should to be covered by training. Such staff should also become familiar with new technology, for example microcomputers and software applicable to such aspects of management as planning, logistics, inventory control, financial management and evaluation.

#### c. Maintenance, Logistics, and Warehousing Training Needs

These areas, vitally important to the availability and proper and timely delivery of all family planning services, often tend to be the weakest component of a national (and regional) family planning program. It is especially weak with regard for the implementation of a responsive contraceptive supply system to the rural areas of the country. Frequently equipment breakdowns can be avoided by appropriate preventive maintenance. Each nurse and auxiliary nurse working in aspects of the program in which medical and audio-visual equipment is used, should be trained in preventive maintenance principles and techniques. The six technicians in charge of equipment maintenance at the MOH, ISSS and SDA, urgently require re-training in the maintenance of endoscopic equipment, due to the fact, that they were last trained in 1975.

Efficient logistics and warehousing assures the proper and timely distribution of drug supplies and consumables. Central and regional warehouse supervisors and a central monitor must therefore be trained regarding such practices and actions as minimum stock levels, the use of feedback on consumption for ordering, the importance of sequence of supply delivery, a uniform inventorying and reporting system with techniques for making need projections, distribution systems, etc. The area of logistics and warehousing lends itself especially well to the use of minicomputers and the proper software. Should the MOH and/or ISSS and the SDA decide to computerize their inventory and logistics records, it will have to be paralleled by the training of personnel.

In summary, there is considerable need for pre-service and in-service training for all categories and levels of personnel engaged in family planning activities. Motivational training for policy and opinion makers is also critical.

### 3. Logistics/Maintenance Component

#### a. Background

There are requirements for improvements in the SDA and ISSS medical logistic systems with respect to equipment, medications and commodities, affecting the safety, efficacy and quality of their services. There are even greater requirements for improvement in the MOH logistics system. The following major needs exist in the MOH logistics/supply management system, in particular:

- Improvements in consumption projections to allow better management of supply stock levels.
- Improvements in operating procedures for the control of distribution and prevention of stock expiration.
- Better procedures to manage expired, unacceptable or deteriorated items in the supply chain, and to regulate the appropriate, safe use of critical items.
- Procedures for personnel recruitment, preparation, motivation and professional supervision.
- Better coordinated procurement cycles, including inventory control systems linking supplies to service and preventing stock shrinkage.
- Provision of better warehousing facilities for FP commodities.

#### b. Methodology

Because of the constraints in the logistics systems of the three major organizations in charge of FP programs for providing adequate amounts and types of contraceptives to rural outlets of the health system, a new approach to logistics management is required.

At present, the MOH, ISSS and SDA are supplying outlets with contraceptives based on quantities of contraceptive units issued from central warehouses to rural and urban outlets, without taking into consideration units dispensed to users or beneficiaries of the program. Supplies are delivered based on inventory status in the case of the MOH and the SDA, and only on an actual needs basis by the ISSS. A system is required which will mitigate the occurrence of excessively high or low inventory. This system should be based on two different levels of implementation: a) the field level, where clinics are located and b) the regional and central levels where stocks will be kept. In order to make the system work, the following measures should be taken:

- 1) Technical Assistance is needed to thoroughly analyze the current logistics systems used by the three major providers, to develop new written procedures for inventory control, to design training for personnel at all levels of the

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logistics systems, and to assess warehouse expansion requirements for the MOH and provide specifications to build a new central warehouse.

## 2) MOH Management Information System (MIS)

FP inventory control requirements should as much as possible be met through interface with the MIS to be put in place under the Health System Vitalization Project (519-0291). Even a micro-computer based MIS could improve control of delivery of contraceptives to the field, and the inventory control of the three major service providers. The Centers for Disease Control in Atlanta, GA. has developed computer software to implement a rapid delivery/inventory control system based on experience in other countries, such as Thailand and Brazil, where computerized systems have been in place for some time.

## 3) Training

Basically, two different types of training are required to implement the logistics section:

- a) Development of skills for use of basic data collection reporting forms; and
- b) Use of the data by key supply personnel in determining issue quantities, in assessing the supply status and for forecasting supply requirements.

## 4) Contraceptive Supply

At present, various donors are providing contraceptives to the MOH, SDA and ISSS based on status reports measuring quantities issued from warehouses to regional and local levels, and based on rough projections of the new users to be covered by the program. No rationale is currently used by these institutions to forecast use of contraceptives. A new system is required to allow provision of contraceptives on a more rational basis and to allow better forecasting of needs. Annex I reflects projections of contraceptive needs for the country during the next three years, based on actual consumption and program coverage data from the 1985 CPS (preliminary results). (Because no other source of information is available at present, these projections will be utilized by A.I.D. in providing enough contraceptives initially for a two year period under the Project).

Based on demand for contraceptives, frequency of resupply, and the lead time required, a new program should establish maximum and minimum stock levels. These stock levels, in conjunction with data on drawdowns and balances on hand, should be used to assess the supply status and include measures to detect deficiencies in the supply system.

Two concepts should be developed:

- a) Quantities of contraceptives (in units) dispensed to users, and
- b) Balance of contraceptives (in units) on hand.

The system should be strengthened at the following levels:

Clinic Levels: Using data collected at the clinic level, present and future stock levels should be calculated at the end of a quarter, and this information provided to MOH regional offices, and the main offices of the ISSS and SDA.

The following calculation could be used:

$$\frac{\text{Balance on hand at the end of quarter}}{\text{Monthly average dispensed during the quarter}} = \text{Months of Supply on Hand}$$

As a result of this calculation, both field level and regional level staff can determine supply inventory requirements.

A supply schedule for the facilities in the field will thus be established. For example, if a quarterly supply system has been implemented, and during Quarter "X" the "Z" facility has dispensed 100 cycles of oral contraceptives, and at the same time they have 800 cycles on hand (balance remaining in the facility), the "Z" clinic still has an eight month supply. This implies that they are overstocked and therefore no new stock is required during that quarter.

To assess quantities to be issued from the region or central level to field levels, and continuing with the same example of quarterly basis deliveries, the quantity is determined as follows:

Issue Qty. = (Number of months to be stocked (a) x Monthly average dispensed during quarter (b) - Balance that should be on hand (c)

Example: under a quarter based system, if (a) = 4, (b) = 100 and (c) = 50 cycles of oral contraceptives, then:

(a x b) - c = 350 cycles to be provided from the regional warehouse to facility "Z." The "Z" clinic will then receive 4 boxes of (100 cycles each) tablets.

## 2) Regional/Central Level:

It is necessary to assess the status of warehouses at these levels. The assessment will be obtained through the following formula:

Balance on hand at the end of quarter = Months of supply on hand  
Sum of quantities dispensed by clinics  
divided by 3 (gives monthly average)

Assuming that it is established that a region requires a nine month supply in its warehouses, a reserved stock of three months will be established. This "reserve" will then be the "reorder point" level, assuming a six months operating stock.

To maintain a six month stock at regional levels, the central level in San Salvador should have a six month "reserve" in addition to a regular six month supply. Therefore, a twelve month stock should be maintained at central warehouses. The entire system, from rural posts to central San Salvador warehouses, should have sufficient stocks of contraceptives to satisfy client demand. If additional demand for temporary contraceptives is generated, the reserve is further justified to provide a buffer for possible field level shortages. Because the implementation and full operation of this system will take at least two years to generate adequate accrued data on use and coverage, A.I.D. will provide a two year initial supply of contraceptives and supply requirements will be adjusted once the new logistics system is operational.

In summary, the technical analyses confirms the need for the type of assistance proposed under this Project, for training, IEC, and particularly logistics/maintenance requirements. The technical soundness is predicated on an approach which fosters greater cooperation between the public and private sectors, includes appropriate technical assistance and training and, most importantly, obtains an organizational commitment to change early in the LOP.

#### D. ECONOMIC ANALYSIS

The Population Dynamics Project aims at increasing contraceptive prevalence in El Salvador through strengthening the coordination among, and the planning and operating efficiency of, public and private family planning programs. The Project also aims at improving promotional efforts among young females at risk of pregnancy, who are currently not utilizing any contraceptive methods. The ultimate goal of the Project is to improve the quality of health and life among Salvadorans, especially in rural areas, and to reduce the population growth rate.

In economic terms, the Project aims at reducing the population in future years and consequently the economic costs, such as consumption, which are associated with a larger population in the future. A reduction in consumption costs in the case of El Salvador should result in a short run increase in per capita income since current population levels and population growth rate are high in relation to the country's productive capacity and current production trends.

In order to estimate the economic feasibility of the Project, a cost benefit analysis, which estimated an internal rate of return, was performed. Project economic benefits estimated are the consumption saved during 15 years by the births averted by the Project. Project economic costs include: a) the production foregone for 15 years attributable to the births averted by the project; b) project financial costs converted into colones at the parallel rate of exchange; and c) indirect costs associated with the Project.

The internal rate of return was estimated under two scenarios: 1) utilizing the assumption that the target group has a potential fertility rate of 50%; and 2) utilizing the assumption that the target group has an effective fertility rate of 18.4 %. Under the first assumption, the IRR is 64.6% and the benefit/cost ratio 2.4 utilizing a 12% discount rate. Under the second assumption, the IRR is 28.5% and the benefit/cost ratio 1.64. While the analysis suggests a highly positive rate of return in either case of this broad range of options, it must be recognized that such estimates may be upwardly biased. This would result from the fact that consumption saved was estimated for only 15 years, which excludes a subsequent period during which the births averted by the project may produce more than they consume. Similarly, the "joy" of having babies was not quantified as a Project cost. The inclusion of these two elements was judged to be outside the scope of reliability of the analysis. Details of the methodology utilized and calculations are in Annex M.

## VI. IMPLEMENTATION PLAN

### A. Implementation Responsibilities and Administrative Arrangements

The \$10 million grant will be obligated through 1) A Grant Agreement with the GOES and 2) a new Cooperative Agreement with the Salvadoran Demographic Association, the major implementor of the IEC component. The Agreement with the GOES will be signed by the Minister of Planning (MIPLAN), the Ministry of Health (MOH), the Salvadoran Social Security Institute (ISSS) and the Administración Nacional de Telecomunicaciones (ANTEL), the participating GOES agencies. This GOES Agreement will specify clearly the roles, responsibilities, and the authorities of the various organizations, and will also outline how the funds are to flow to the SATU, and ultimately to the participating agencies for the Project activities. In addition, the ISSS and ANTEL will sign agreements with the MOH that indicate that they will submit yearly operational plans to the SATU, which will be under the overall authority of the MOH.

As a precondition to expenditure of funds by the GOES for all Project activities, establishment of the SATU will be required. Detailed budget and implementation plan for each institution will be developed within 60 days of meeting Conditions Precedent. These plans will be prepared by the management unit, and will be presented to the Technical Advisory Group, which will approve these documents. Once these plans and budgets are also approved by A.I.D., individual activities under the Project will commence.

Further approval by A.I.D. for activities required by the Project Agreement will be made through Implementation Letter, or PIO/T's, PIO/C's, and PIO/Ps. Approximately \$2 million for a contract with a private firm or PVO to serve as the technical assistance part of the SATU, will be implemented through a direct contract with A.I.D., under authority to be included in the Project Agreement. In those cases where A.I.D. concurrence is required under the technical assistance contract, a formal request for the goods and services will not be required from the GOES.

Implementation of the Project will be monitored by USAID at monthly and quarterly reviews by a USAID Project Review Committee. This Committee shall consist of the Associate Mission Director, and representatives from the Office of Projects, Controller's Office, Management Office, Office of Human Resources and Humanitarian Assistance, and the Office of Development Programs.

The USAID Project Review Committee will (a) periodically review existing and proposed resource allocations under the Project; (b) review obligating documents and project status reports, and (d) make recommendations to the Mission Director as required.

#### B. Schedule of Major Events

The attached PERT chart (Table VI-1 on the following pages) provides the overall picture of Project implementation, with essential activities and timing carefully laid out. This will serve as the Project's general implementation plan and will assist Project management to follow and track progress in the various components.

#### C. Disbursement Procedures

Standard A.I.D. disbursement procedures will be employed, appropriate to the complexity and requirements of each of the Project activities. A.I.D. direct disbursement mechanisms will be handled at the Mission level. In addition, direct Letters of Commitment will be used for procurement of commodities requiring foreign exchange. Project funds to be provided as local currency for the GOES institutions will be channelled through the SATU to the implementing institutions. All GOES funds will be handled through the GOES's extraordinary budget process.

#### D. Waivers

Included in the Project authorization will be a request for waiver of competition for the purchase of AMC jeeps under the Project. The Ministry of Health has decided that it will standardize its vehicle fleet on AMC and Ford. For the purposes of the Project, a four-wheel vehicle will be needed to reach certain rural areas and AMC jeeps are excellent for this purpose. Additional study is underway to determine if a sole source waiver is needed for purchase of the computer, which will possibly be an IBM.

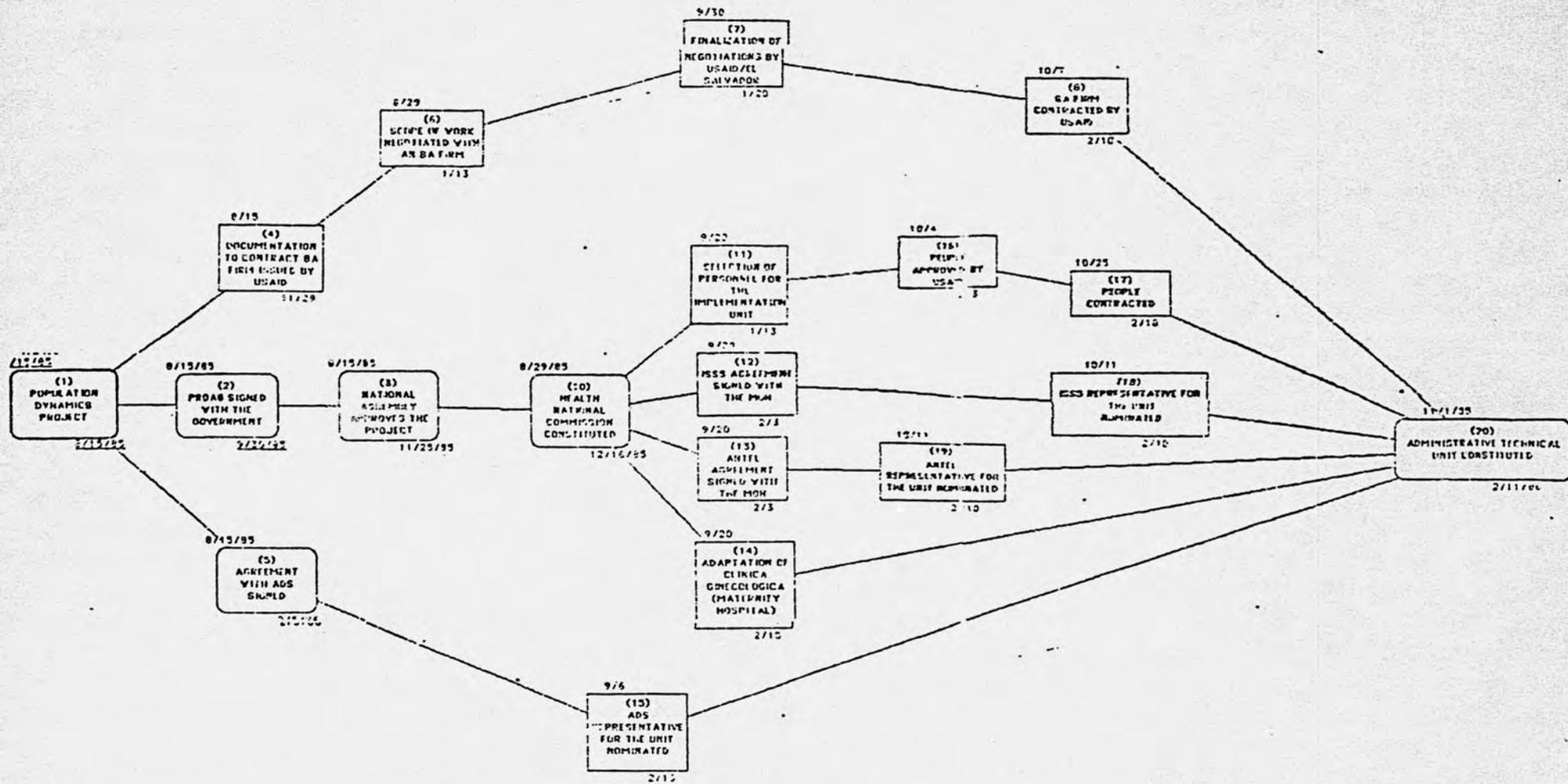
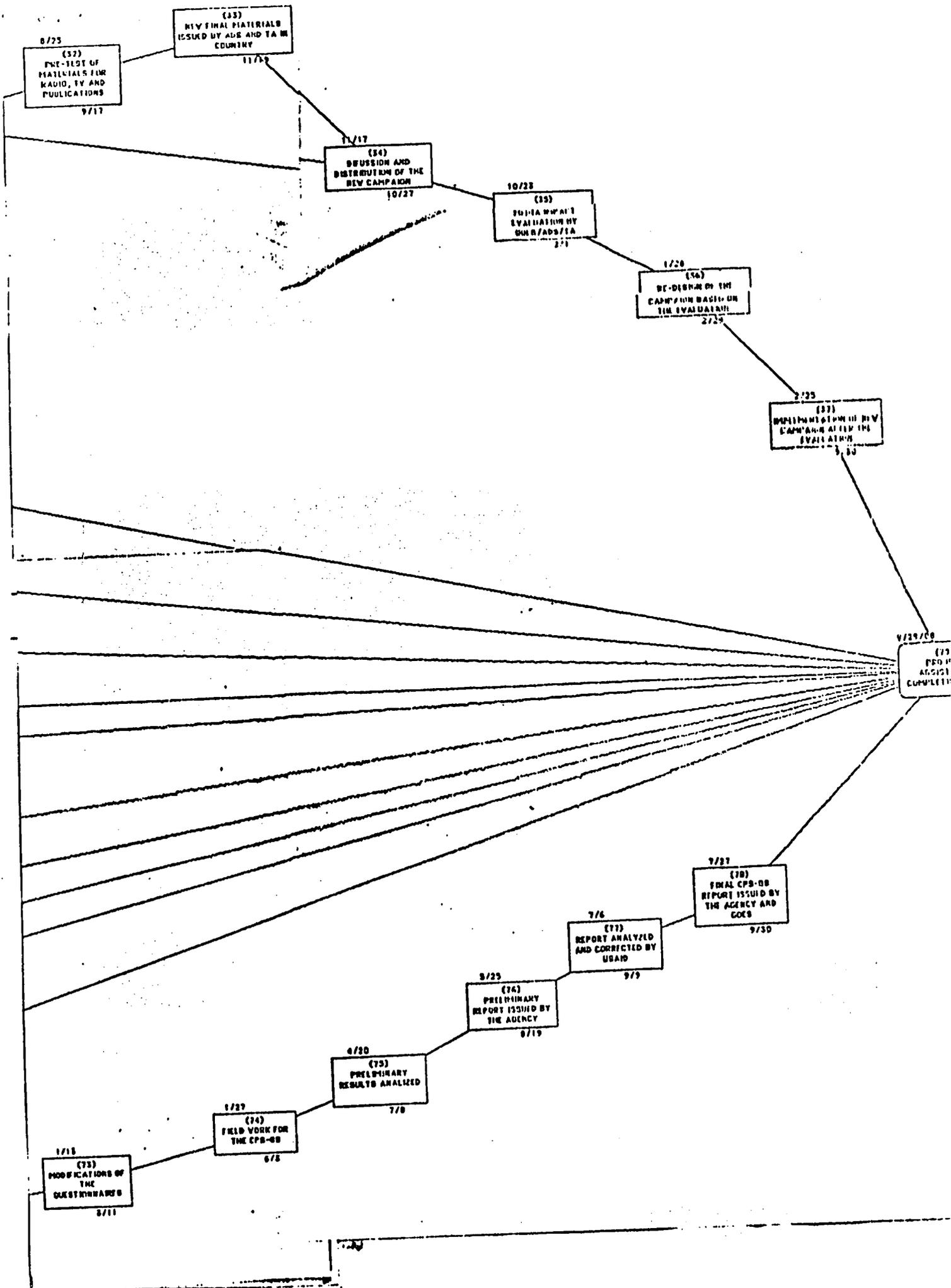


TABLE VII

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**VII. PROJECT MONITORING**

Primary USAID monitoring responsibility for the Project will rest with a direct hire Project Manager, located in the Office of Human Resources and Humanitarian Affairs (HR/HIA). He will be assisted by a direct hire FSN Health/Family Planning Officer, who will have some specific management responsibilities. The Project Manager may be assisted by a PSC Procurement Specialist, who will advise on logistics and commodity procurement requirements and procedures for the Project, depending on the need once the Project is underway. To help ensure the smooth implementation of Project activities, the Mission Project Review Committee, mentioned previously, will periodically review Project status.

**VIII. CONDITIONS AND COVENANTS**

Additional Conditions and Covenants beyond those normally contained in the standard A.I.D. agreement, for the GOES Agreement and the Cooperative Grant Agreement with the SDA will be as follows:

**A. Conditions Precedent:**

**I) GOES Agreement:**

- a) Prior to disbursement of A.I.D. funds to the Project, the GOES will establish the National Health Commission.
- b) Prior to the disbursement of A.I.D. funds, the MOH will formally and legally constitute the Special Administrative and Technical Unit, by ministerial decree.
- c) Prior to disbursement of funds, the ISSS and ANTEL will have signed an agreement with the MOH specifying Project roles, responsibilities, and authorities for these organizations
- d) Prior to the disbursement of A.I.D. funds for ISSS activities, the ISSS will nominate a representative to the SATU.
- e) Prior to disbursement of A.I.D. funds for ANTEL activities under ANTEL, the ANTEL will Nominate a representative for the SATU.
- f) Prior to disbursement of A.I.D. funds for Project activities with the MOH, the MOH will nominate a representative to the SATU.
- g) Prior to disbursement of A.I.D. funds, evidence that the GOES has constituted a National Health Commission.

**II) Salvadoran Demographic Association Agreement:**

Prior to disbursement of A.I.D. funds under the amended Cooperative Agreement, the SDA will:

- a) Nominate a representative for the SATU.

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**B. Covenants (GOES Agreement)**

- 1) The GOES agrees that, unless A.I.D. otherwise agrees in writing, that professional personnel to be contracted for the SATU, and all contract extensions, will have A.I.D.'s concurrence.
- 2) The GOES will use its best efforts to increase its national family planning budget by 25% percent over the next three years, using A.I.D. controlled local currency and other resources.
- 3) Within 60 days of meeting Conditions Precedent, the GOES will prepare implementation plans for MOH activities, as well as implementation plans for ISSS and ANTEL family planning activities under the Project, and for carrying out a physical inventory of contraceptives in all ISSS clinics and hospital warehouses.
- 4) Within 90 days of signature of the Agreement, the GOES agrees to provide office, second staff from the ISSS, ANTEL, and MOH, and establish an Infertility Clinic.

**IX. EVALUATION AND FINANCIAL REVIEWS**

**A. Evaluation**

A.I.D. and the GOES/SDA will conduct two project reviews, utilizing in-house and external resources to be financed under the Project in both the second and the third years of the project. A mid-term evaluation is scheduled for one and one-half years after signature of the Project Agreement. This evaluation will measure progress of the delivery of contraceptives, compare efficiency of the logistics system before and during project implementation at all levels of the system, review status of maintenance of bio-medical equipment before and after Project implementation, and follow-up on patient's records for voluntary sterilization procedures compared with the current monitoring system implemented of the MOH and ISSS.

A final evaluation is expected at the end of the Project in 1988, in combination with a Contraceptive Prevalence Survey (CPS). This evaluation will measure, besides the aspects considered in the mid-term evaluation, program coverage and rural population attitudes toward family planning. The final evaluation and the '88 CPS will also measure the impact of the JEC campaigns to be implemented under the Project as well as that implemented under the SDA'S project No. 519-0275. It will also review the problems encountered during implementation of the Project.

The evaluation will be carried out by a team of specialists, including external consultants. This team will be contracted by the Mission utilizing Project funds. In its report, the team will identify and discuss major changes in the Project's setting, including socio-economic conditions and the status of the Project at the end.

In this final evaluation, the long-term impact of the Project will be assessed in terms of: (a) number of women in the fertile age group contracepting at that time, (b) percentage of rural women of those contracepting, and (c) age-groups of the women contracepting, as well as method of choice per each age-group. Logistics improvement and interinstitutional coordination will also be assessed. Both the GOES and ADS will participate fully in the evaluations and in the CPS.

B. Financial Reviews

Besides programmatic evaluations of the Population Dynamics Project, periodic financial reviews will be carried out by local firms with technical advice from external sources as well as from the Mission Controller's Office. The Controller's office will prepare the norms and guidelines to be followed in the reviews. The financial reviews will be implemented annually and the results will also be used as accounting tools by the participating entities to improve their accounting performance. Therefore, these reviews will constitute a kind of technical assistance for the beneficiary institutions.

LOGICAL FRAMEWORK PROJECT  
POPULATION DYNAMICS, PROJECT NO. 519-0210

ANNEX A

Life of Project: 3 years  
From FY 1985 to FY 1988  
Total U.S. Funding: \$10.0 Million  
Date Prepared: August, 1985

<u>NARRATIVE</u>	<u>OBJECTIVELY VERIFIABLE INDICATOR</u>	<u>MEANS OF VERIFICATION</u>	<u>ASSUMPTIONS</u>
<u>Project Goal</u>			
To improve the quality of life and health of the Salvadoran population and reduce the population growth rate.	Decrease in crude birth rate from 38/1,000 to 35/1000.	CPS Data	The GOES will perceive family planning as a vital national priority.
<u>Project Purpose</u>			
To improve and expand on provision of family planning and reproductive health services, by strengthening those institutions, particularly in rural areas, which presently provide services to Salvadoran couples.	Active number of contraceptive users increased from 317,000 to 370,000.	MIPLAN Databank CPS Data SDA data and records.	GOES resources and support of family planning activities will be expanded over the life of the Project.
	A comprehensive, on-going effective education, information and communication of program, aimed at target audiences will have been established.	Participating institutions records and reports.	
<u>Outputs</u>			
(1) Special Administration and Technical Assistance Unit (SATU).	An Administrative Unit functioning, and three long-term technical consultants on board.	Reports from the SATU and participating institutions.	That participating agencies will give the SATU necessary authorities and support to effectively coordinate Project activities.

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NARRATIVE	OBJECTIVELY VERIFIABLE INDICATOR	MEANS OF VERIFICATION	ASSUMPTIONS
<b>(2) Information, Education, Communication Program (IEC).</b>	<p>All major newspapers and radio stations will be carrying appropriate family planning messages and programs.</p> <p>Radio campaigns and pamphlets and other distribution literature will be developed for rural areas.</p> <p>SDA providing IEC services to the GOES and other organizations involved in providing family planning services.</p>	<p>Participating institutions records and reports.</p>	<p>That improved media techniques will be effective in reaching the target population and will be able to motivate them to use family planning techniques.</p>
<b>(3) <u>Training</u></b>	<p>Community leaders will receive promotional training in family planning and population matters.</p> <p>Approximately 1,350 RHAs, 1,700 TBAs, and malaria promoters working in the field will be trained.</p> <p>Program administrators of the MOH, ISS, MIPLAN and SDA will be trained in management, budgeting, project management, evaluation, and IEC.</p>	<p>Training reports from the SATU.</p>	<p>Community leaders will be interested and desire training in FP and population matters.</p> <p>Participating agencies release individuals from routine work requirements.</p>
<b>(4) Logistics/Maintenance</b>	<p>A Management Information System to track contraceptives through the supply systems of the participating institutions will be in place and functioning.</p> <p>A maintenance program for clinical equipment and medical facilities will be operational</p>	<p>Project quarterly reports.</p>	
<b>(5) Policy Planning</b>	<p>At least 40 seminars at decision-making levels held for GOES and private sector officials.</p> <p>Establishment of a demographic data base.</p>	<p>Project quarterly reports.</p>	

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NARRATIVE	OBJECTIVELY VERIFIABLE INDICATOR	MEANS OF VERIFICATION	ASSUMPTIONS
<u>Inputs</u>	<u>Budget</u> (000's)		
(1) <u>Technical Assistance</u>	2,000.0	USAID/El Salvador Controller's financial reports, implementation plans, and GOES and SDA reimbursement requests.	
(2) <u>Administration</u>	483.8		
(3) <u>IEC</u>	2,595.0		
(4) <u>Training</u>	788.4		
(5) <u>Logistics/Maintenance</u>	2,297.4		
(6) <u>Policy Planning</u>	350.0		
(7) <u>Project Evaluation</u>	279.0		
(8) <u>Conting./Inflation</u>	1,206.4		

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## 5C(2) PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A. includes criteria applicable to all projects. Part B: applies to projects funded from specific sources only: B.1. applies to all projects funded with Development Assistance Funds, B.2. applies to projects funded with Development Assistance loans, and B.3. applies to projects funded from ESP.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?

### A. GENERAL CRITERIA FOR PROJECT

1. FY 1982 Appropriation Act Sec. 523; FAA Sec. 634A; Sec. 633(D).

A Congressional Notification was submitted to the Hill on this Project July 17, 1985

(a) Describe how authorizing and appropriations committees of Senate and House have been or will be notified concerning the project;

(b) is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than \$1 million over that amount)?

YES

2. FAA Sec. 611(a)(1). Prior to obligation in excess of \$100,00, will there be

YES

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(a) engineering, financial or other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

YES

3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?

Approval by the GOES Legislative Assembly is required for the public sector part of the Project Approval is expected within 2-3 weeks and no problems are anticipated

4. FAA Sec. 611(b); FY 1982 Appropriation Act Sec. 501. If for water or water-related land resource construction, has project met the standards and criteria as set forth in the Principles and Standards for Planning Water and Related Land Resources, dated October 25, 1973? (See AID Handbook 3 for new guidelines.)

N/A

5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project?

N/A

6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.

No. This Project is intended to meet the specific needs of the various agencies providing family planning services in El Salvador

7. FAA Sec. 601(a). Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; and (c) encourage development and use of cooperatives, and credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

NO

8. FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

NO

9. FAA Sec. 612(b), 636(h);  
FY 1982 Appropriation  
Act Sec. 507. Describe  
steps taken to assure  
that, to the maximum  
extent possible, the  
country is contributing  
local currencies to meet  
the cost of contractual  
and other services, and  
foreign currencies owned  
by the U.S. are utilized  
in lieu of dollars.
10. FAA Sec. 612(d). Does  
the U.S. own excess  
foreign currency of the  
country and, if so, what  
arrangements have been  
made for its release? NO
11. FAA Sec. 601(e). Will  
the project utilize  
competitive selection  
procedures for the  
awarding of contracts,  
except where applicable  
procurement rules allow  
otherwise? YES
12. FY 1982 Appropriation Act  
Sec. 521. If assistance  
is for the production of  
any commodity for export,  
is the commodity likely  
to be in surplus on world  
markets at the time the  
resulting productive  
capacity becomes  
operative, and is such  
assistance likely to  
cause substantial injury  
to U.S. producers of the  
same, similar or  
competing commodity? N/A
13. FAA 118(c) and (d).  
Does the project comply  
with the environmental  
procedures set forth in  
AID Regulation 16? Does YES

the project or program take into consideration the problem of the destruction of tropical forests?

14. FAA 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (dollars or local currency generated therefrom)?

N/A

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FAA Sec. 102(b), 111, 113, 281(a). Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and

This Project will assist in the improvement of the quality of life of the rural poor, through the reduction in the rate of population growth. It will assist the GOES to meet its targets concerning reduction of the population rate.

otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries?

b. FAA Sec. 103, 103A, 104, 105, 106. Does the project fit the criteria for the type of funds (functional account) being used?

YES

c. FAA Sec. 107. Is emphasis on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?

YES

d. FAA Sec. 110(a). Will the recipient country provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?

YES

---

e. FAA Sec. 110(b).  
Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to Congress been made, and efforts for other financing, or is the recipient country "relatively least developed"? (M.O. 1232.1 defined a capital project as "the construction, expansion, equipping or alteration of a physical facility or facilities financed by AID dollar assistance of not less than \$100,000, including related advisory, managerial and training services, and not undertaken as part of a project of a predominantly technical assistance character.

NO

f. FAA Sec. 122(b). Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?

NO

g. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage

The Project responds directly to the needs of the population for family planning services and to institutions which provide them

institutional development;  
and supports civil  
education and training in  
skills required for  
effective participation in  
governmental processes  
essential to self-government.

2. Development Assistance Project  
Criteria (Loans Only)

N/A

- a. FAA Sec. 122(b).  
Information and conclusion  
on capacity of the country  
to repay the loan, at a  
reasonable rate of interest.
- b. FAA Sec. 620(d). If  
assistance is for any  
productive enterprise which  
will compete with U.S.  
enterprises, is there an  
agreement by the recipient  
country to prevent export  
to the U.S. of more than  
20% of the enterprise's  
annual production during  
the life of the loan?
- c. ISDCA of 1981, Sec. 724  
(c) and (d). If for  
Nicaragua, does the loan  
agreement require that the  
funds be used to the  
maximum extent possible for  
the private sector? Does  
the project provide for  
monitoring under FAA Sec.  
624(g)?

3. Economic Support Fund  
Project Criteria

N/A

- a. FAA Sec. 531(a). Will  
this assistance promote  
economic or political
-

stability? To the extent possible, does it reflect the policy directions of FAA Section 102?

- b. FAA Sec. 531(c). Will assistance under this chapter be used for military, or paramilitary activities?
- c. FAA Sec. 534. Will ESP funds be used to finance the construction of the operation or maintenance of, or the supplying of fuel for, a nuclear facility? If so, has the President certified that such use of funds is indispensable to nonproliferation objectives?
- d. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made?

## 5C(3) - STANDARD ITEM CHECKLIST

Listed below are the statutory items which normally will be covered routinely in those provisions of an assistance agreement dealing with its implementation, or covered in the agreement by imposing limits on certain uses of funds.

These items are arranged under the general headings of (A) Procurement, (B) Construction, and (C) Other Restrictions.

### A. Procurement

1. FAA Sec. 602. Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed? YES
  
  2. FAA Sec. 604(a). Will all procurement be from the U.S. except as otherwise determined by the President or under delegation from him? YES
  
  3. FAA Sec. 604(d). If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company? YES
  
  4. FAA Sec. 604(e); ISDCA of 1950 Sec. 755(a). Is offshore procurement of agricultural commodity or product is to be N/A
-

financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.)

5. FAA Sec. 604(c). Will construction or engineering services be procured from firms of countries otherwise eligible under Code 941, but which have attained a competitive capability in international markets in one or these areas?
6. FAA Sec. 603. Is the shipping excluded from compliance with requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 per centum of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent that such vessels are available at fair and reasonable rates?
7. FAA Sec. 621. If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? If the facilities of other

N/A

NO

YES

Federal agencies will be utilized, are they particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?

8. International Air Transport. Fair Competitive Practices Act, 1974. If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available?

YES

9. FY 1982 Appropriation Act Sec. 504. If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States?

YES

B. Construction

N/A

1. FAA Sec. 601(d). If capital (e.g., construction) project, will U.S. engineering and professional services to be used?
2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable?

3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million (except for productive enterprises in Egypt that were described in the CP)? N/A

C. Other Restrictions

1. FAA Sec. 122(b). If development loan, is interest rate at least 2% per annum during grace period and at least 3% per annum thereafter? N/A
2. FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights? N/A
3. FAA Sec. 620(h). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries? YES
4. Will arrangements preclude use of financing: YES
- a. FAA Sec. 104(f); FY 1982 Appropriation Act Sec. 525: (1) To pay for performance of abortions as a method of family

planning or to motivate or coerce persons to practice abortions; (2) to pay for performance of involuntary sterilization as method of family planning, or to coerce or provide financial incentive to any person to undergo sterilization; (3) to pay for any biomedical research which relates, in whole or part, to methods or the performance of abortions or involuntary sterilizations as a means of family planning; (4) to lobby for abortion?

b. FAA Sec. 620(c). To compensate owners for expropriated nationalized property?

N/A

c. FAA Sec. 660. To provide training or advice or provide any financial support for police, prisons, or other law enforcement forces, except for narcotics programs?

N/A

d. FAA Sec. 662. For CIA activities?

N/A

e. FAA Sec. 636(i). For purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained?

N/A

f. FY 1982 Appropriation Act, Sec. 503. To pay pensions, annuities, retirement pay, or

N/A

adjusted service  
compensation for military  
personnel?

g. FY 1982 Appropriation  
Act, Sec. 505. To pay  
U.N. assessments,  
arrearages or dues?

N/A

h. FY 1982 Appropriation  
Act, Sec. 505. To carry  
out provisions of FAA  
section 209(d) (Transfer  
of FAA funds to  
multilateral  
organizations for  
lending)?

N/A

i. FY 1982 Appropriation  
Act, Sec. 510. To  
finance the export of  
nuclear equipment, fuel,  
or technology or to train  
foreign nationals in  
nuclear fields?

N/A

j. FY 1982 Appropriation  
Act, Sec. 511. Will  
assistance be provided  
for the purpose of aiding  
the efforts of the  
government of such  
country to repress the  
legitimate rights of the  
population of such  
country contrary to the  
Universal Declaration of  
Human Rights?

N/A

k. FY 1982 Appropriation  
Act, Sec. 515. To be  
used for publicity or  
propaganda purposes  
within U.S. not  
authorized by Congress?

N/A



*San Salvador* 23 de julio de 1985.

*Sección* CORRESPONDENCIA

*Asunto:* Ref/solicitud de financiamiento p/el Proyecto GOES/AID "Salud Reproductiva".

MINISTERIO DE SALUD PÚBLICA  
Y ASISTENCIA SOCIAL  
REPÚBLICA DE EL SALVADOR, C. A.  
TELEX 20704 MSPAS-SAL

Sr. Robin Gómez  
Director USAID/El Salvador,  
Embajada Americana,  
Ciudad.

Por la presente me permito enviar a usted para los fines consiguientes, el original y dos copias de un Proyecto para actividades de población (1985-1988).

Este documento fue preparado por personal técnico de las Instituciones participantes: Ministerio de Salud Pública y Asistencia Social, Instituto Salvadoreño del Seguro Social y Hospital de ANTEL, para desarrollar un Plan de Acción en Actividades de "Salud Reproductiva", a ser presentado posteriormente.

Este proyecto cuenta con la aprobación de este Ministerio y constituye un apoyo fundamental a las políticas contempladas en el Plan Nacional de Salud, dentro de cuyos programas básicos están la Atención Médica Integral a la Persona y el Desarrollo de los Recursos. Dentro del Programa de Atención Médica Integral a la Persona está incluido el Subprograma de Atención Integral a la Madre. Las actividades de este subprograma han sido concebidas con un enfoque de atención al riesgo para la salud de la madre, por lo cual este proyecto se enmarca dentro del concepto de Salud Reproductiva.

Sin otro particular, pláceme saludarle con afecto y alta estima.

DIOS, UNION, LIBERTAD,



*[Signature]*  
Dr. Benjamín Valdez h.  
MINISTRO

AL CONTESTAR ESTE OFICIO, CITENSE LOS DATOS CONTENIDOS EN EL CUADRO DEL ANGULO SUPERIOR DERECHO.

CON ANEXO

49

DR. OSCAR ANTONIO RODRÍGUEZ

San Salvador, 24 de Julio de 1985.

163/2.1.1

Sr. Robin Gómez,  
Director  
USAID/El Salvador  
Embajada Americana  
San Salvador.

Estimado Sr. Gómez:

Es de nuestro conocimiento que el Ministerio de Salud Pública de El Salvador ha presentado para consideración de A.I.D., un proyecto para financiamiento de actividades de Planificación Familiar en nuestro país para un período de tres años. El objetivo básico de ese proyecto es aumentar la cobertura de los servicios de Planificación Familiar en las áreas rurales de El Salvador en donde, en la actualidad, la cobertura del programa es sumamente baja. El proyecto en mención comprende básicamente actividades promocionales y de adiestramiento tanto a personal de instituciones tradicionales en la prestación de servicios de Planificación Familiar como a aquellas que poseen personal de campo pero cuyas funciones no incluyen servicios de salud reproductiva.

Dado la gran importancia del proyecto mencionado, en una reunión sostenida con el Ministro de Salud Pública y Asistencia Social el pasado 19 de Julio, la Asociación Demográfica Salvadoreña acordó trabajar en coordinación con el Gobierno de El Salvador a fin de complementar las actividades mencionadas en el proyecto gubernamental.

Básicamente, ADS colaborará en dos aspectos del mismo: a) promoción a través de medios masivos de comunicación con mensajes dirigidos primariamente a la población rural del país, y b) adiestramiento del personal de aquellas instituciones que como el ISTA, DIDECO, CENTA, no han

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DR. OSCAR ANTONIO RODRIGUEZ

....2

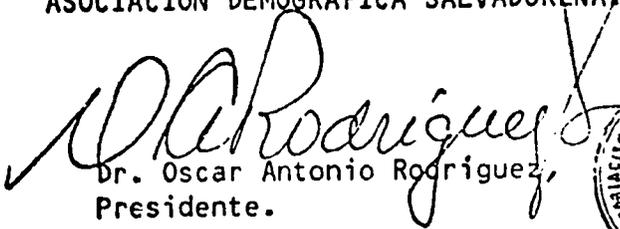
estado hasta la fecha involucradas en estos programas pero cuya participación es absolutamente indispensable a fin de llegar a través de sus agentes de cambio, a las regiones rurales de El Salvador.

Considerando que el actual proyecto 519-0275 suscrito con la USAID/El Salvador, si bien tiene y se desarrollan actividades similares a las arriba descritas, no es suficiente para desarrollar el programa nacional en la forma solicitada por el Gobierno de El Salvador, solicitamos a Ud. por este medio, que ADS y AID suscriban un nuevo convenio específicamente en las actividades que desarrollará el nuevo proyecto de actividades de población (Dinámica de Población) a firmarse con el GOES, el cual complementará al proyecto que AID y el GOES suscribirán próximamente.

No omito manifestar a Ud. que en lo que al nuevo proyecto concierne, las actividades específicas que desarrollará ADS seguirán los lineamientos de promoción y adiestramiento que se determinen a través del Programa Nacional de Planificación Familiar, según la Política Integral de Población.

Atentamente.

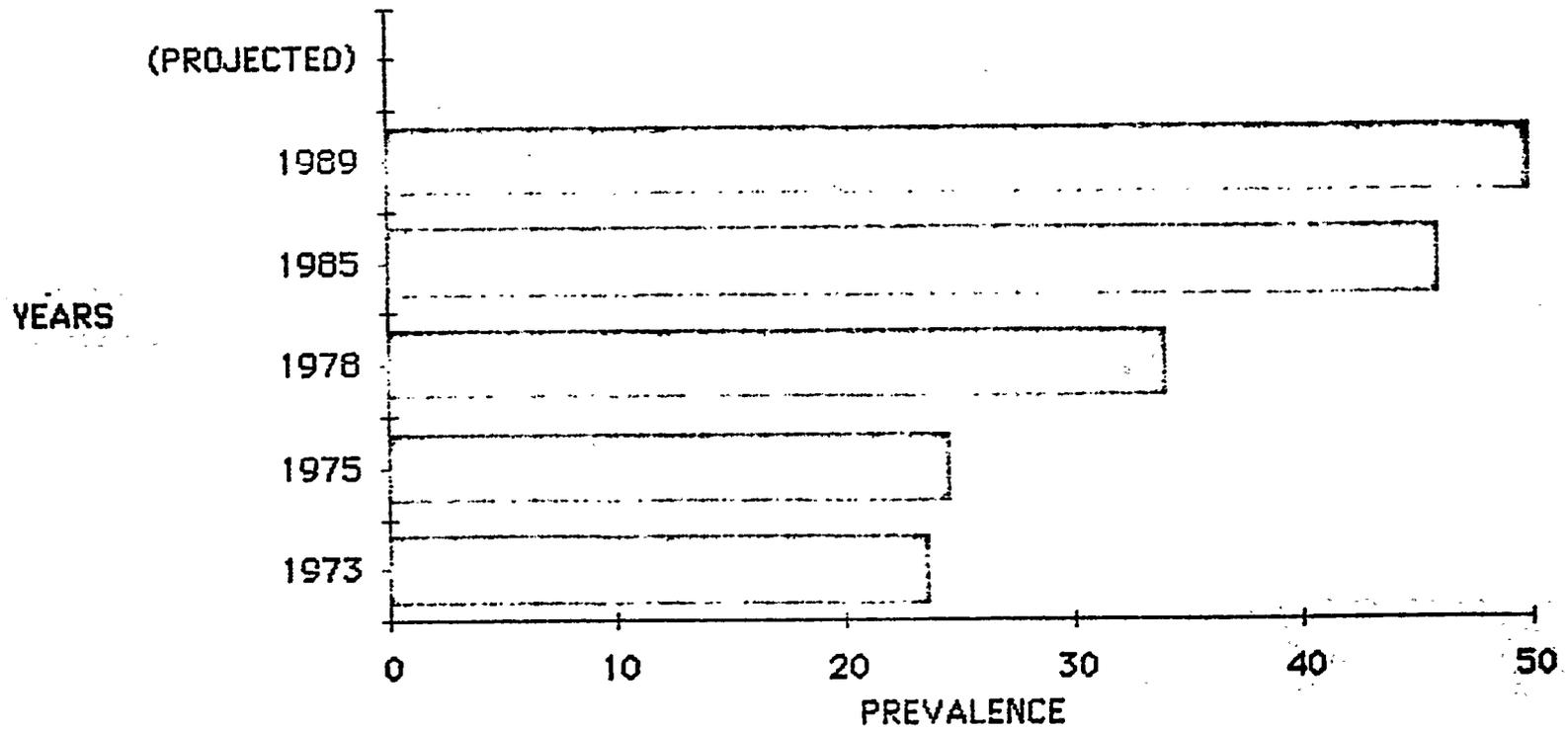
ASOCIACION DEMOGRAFICA SALVADOREÑA

  
Dr. Oscar Antonio Rodríguez,  
Presidente.



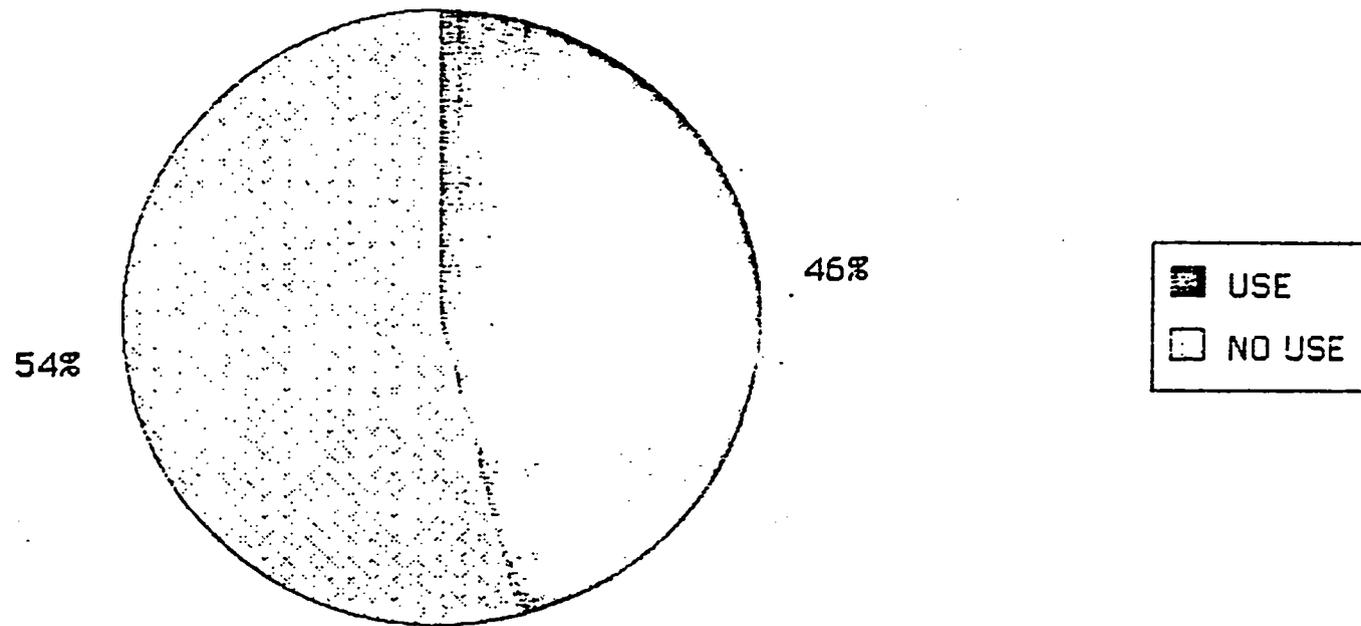
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EL SALVADOR  
OVERALL CONTRACEPTIVE PREVALENCE  
(1973 - 1989)



1617

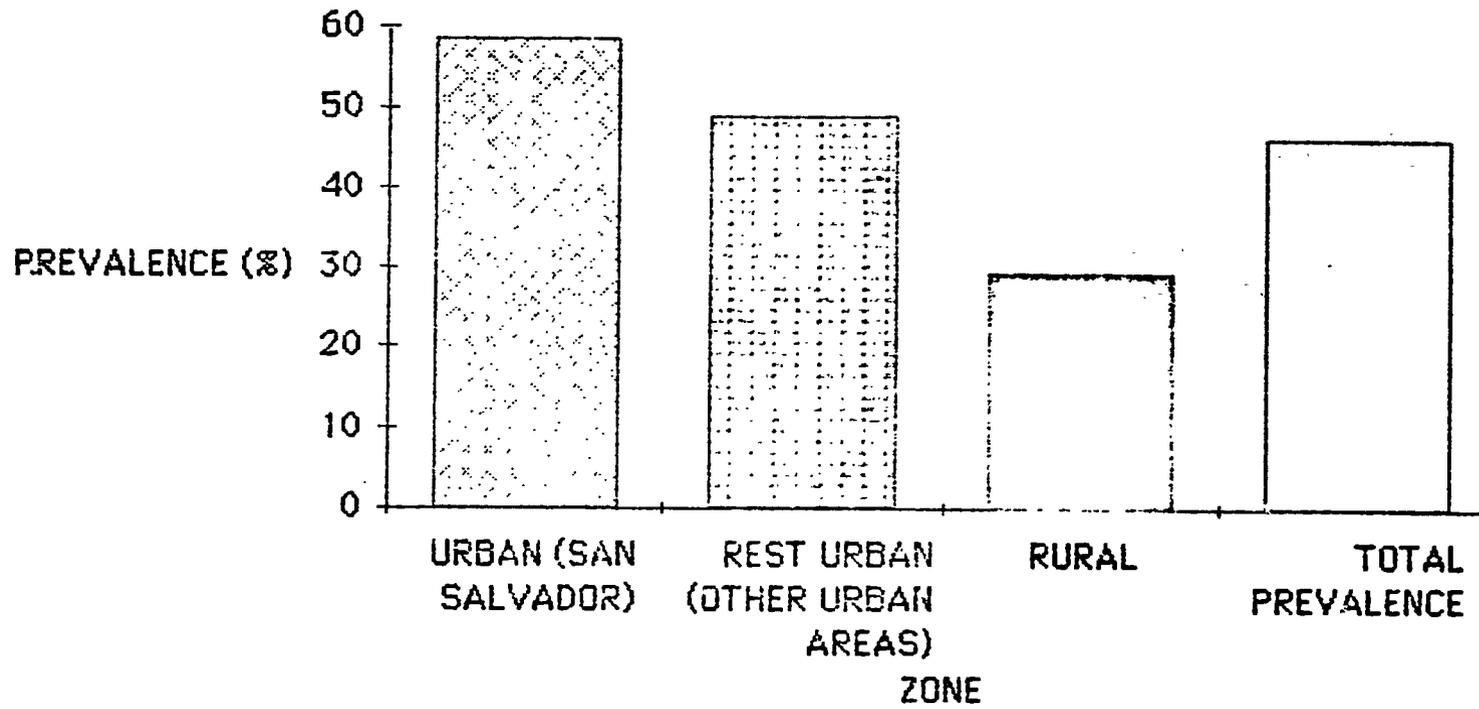
CONTRACEPTIVE PREVALENCE IN EL SALVADOR - 1985  
(WOMEN IN UNION)



10/22

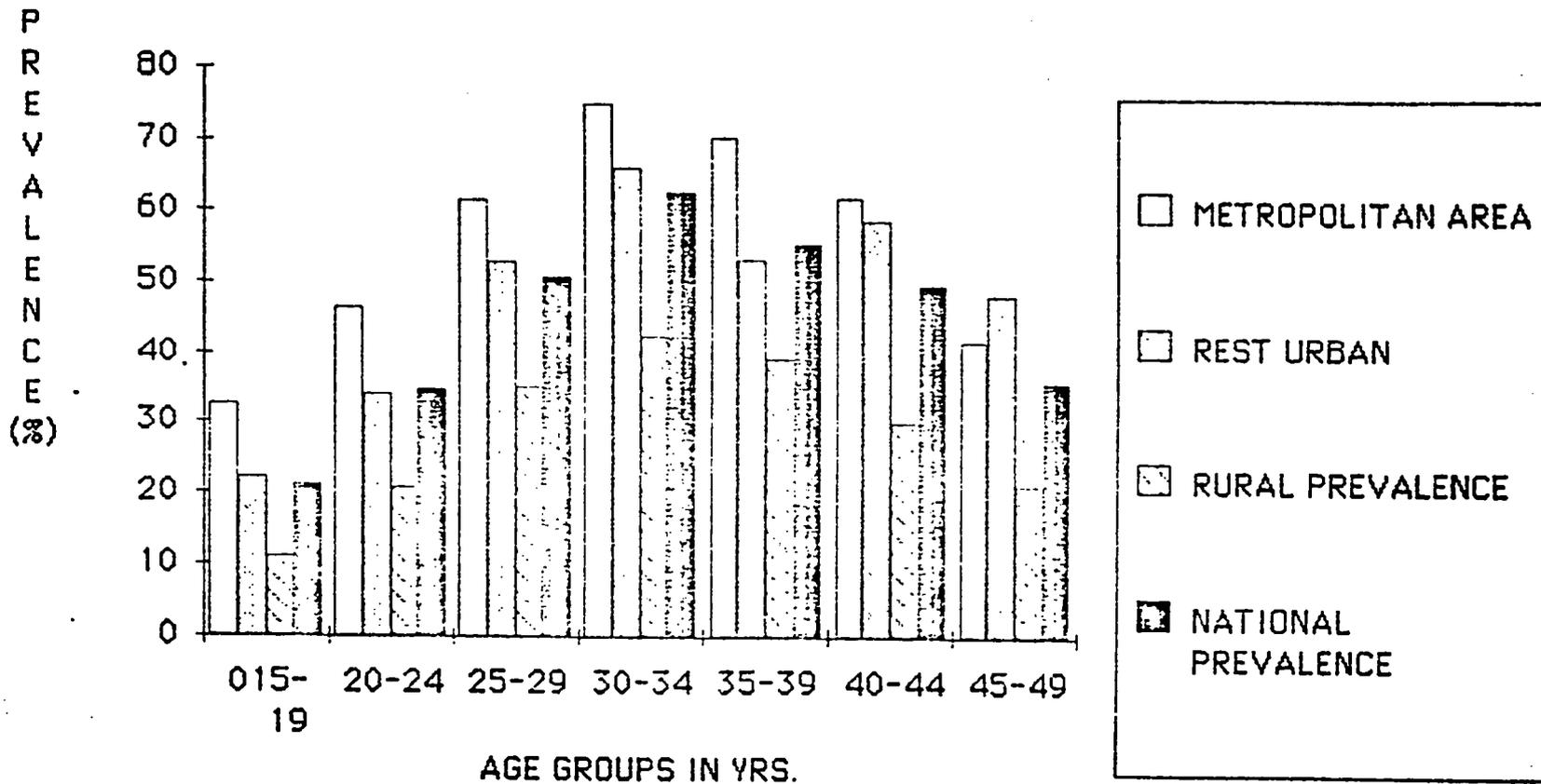
GRAPHIC

GLOBAL CONTRACEPTIVE PREVALENCE PER ZONE - 1985  
(WOMEN IN UNION)

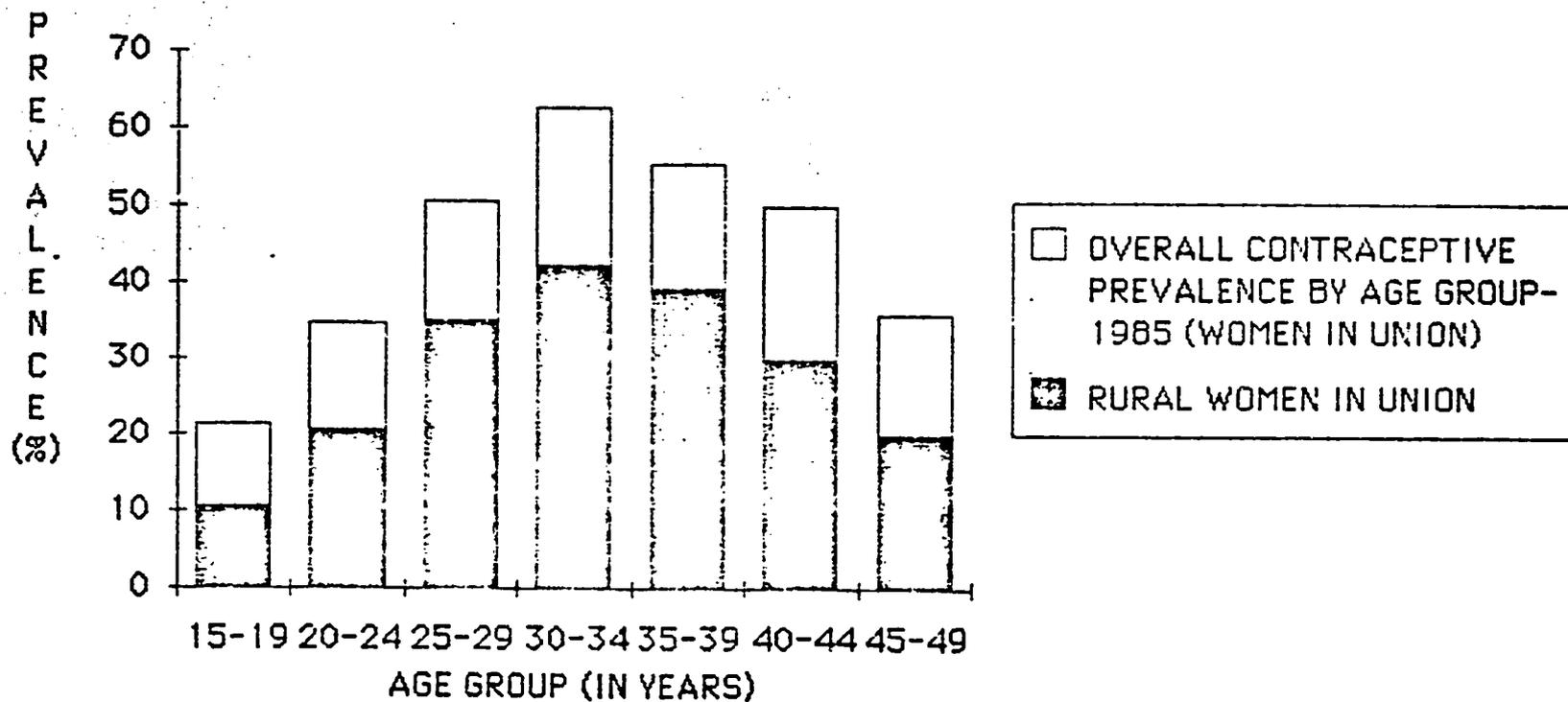


103x

EL SALVADOR-1985  
 CONTRACEPTIVE PREVALENCE  
 (WOMEN IN UNION)



EL SALVADOR - 1985  
CONTRACEPTIVE PREVALENCE BY AGE GROUP  
(WOMEN IN UNION)



THE IMPACT OF POPULATION PROGRAMS  
on  
THE EXPENDITURES OF THE MOH IN EL SALVADOR

Hector Correa  
University Research Corporation  
University of Pittsburgh

Margarita Rovira  
U.S. AID/MO  
El Salvador

The object of this note is to present estimates of the impact that population programs are likely to have on the expenditures of the MOH of El Salvador.

As a starting point, the basic assumptions used to obtain the estimates mentioned above will be described.

The estimates are based on the relationship<sup>^</sup> that statistical information shows that exists between per capita income and demand for the services of Md's, Nurses and Nurse Auxiliaries in Latin American Countries. With this result, and forecasts of the rate of growth of per capita income in El Salvador, it is possible to estimate the demand for the services of health personnel mentioned before.

The results presented in Table 1 below are obtained with two assumptions with respect to the rate of growth of per capita income in El Salvador from 1985 to 2000. These assumptions are that the rate of growth will be 2.5% and 3.0% per year. They are somewhat larger than the observed rates of growth in the last few years, but correspond to the expectations of the current government.

Table 1  
 Estimates of the required rates of growth of the  
 Expenditures of the MCH  
 obtained with several assumptions on the  
 growth of per capita income and on the  
 impact of population programs

	Expend. in MD's		Expend. in NR's.		Expend. in NA's.		Total Expend.	
	2.5%	3.0%	2.5%	3.0%	2.5%	3.0%	2.5%	3.0%
Income								
Popult. growth								
2.0%	5.10	5.72	3.44	4.30	5.60	6.24	4.88	5.56
2.5%	6.66	7.29	5.48	6.33	7.20	7.85	6.57	7.26
3.0%	6.99	7.62	5.80	6.66	7.53	8.17	6.89	7.58

Once estimates of the number of Md's, Nurses and Nurse Auxiliaries whose services are likely to be demanded in El Salvador are available, it is possible to estimate the number that should be hired by the MCH in order to maintain the proportion that it currently has with respect to the total health services offered in El Salvador.

The estimates of the expenditures of the MCH are obtained multiplying the number of persons that should be in the payroll of the MCH by the salaries that they are likely to receive. These salaries are estimated assuming that they will grow at a rate equal to that of the income per capita in the country. This means that it is assumed that the economic conditions of the health personnel in the MCH will maintain the same relation that it currently has with respect to the income of other segments of the population.

In summary it can be said that the estimates obtained reflect the demand for health services in El Salvador, the contribution that the MCH should make to satisfy that demand, and the growth of that the salaries of the personnel in the MCH is likely to have.

The results in Table 1 show that if the population of El Salvador keeps growing at its current rate of approximately 3% per year, and income per capita grows at 2.5% per year, the expenditures of the MCH in Md's should grow at 6.99% per year. These expenses should grow at 7.62% per year if the rate of growth of per capita income reaches 3.0% per year. Total expenditures in health personnel should grow at 6.89% and 7.58% per year.

The substantial reduction that the expenditures of the MCH should have in case that the population programs succeed in reducing the rate of population growth from 3.0% to 2.0% can also be observed in Table 1. For instance, total expenditures of the MCH in health personnel reduce from a rate of growth of 6.89% per year to one of 4.88% per year under the assumption that income per capita grows at 2.5% per year. This means that a reduction of 1% points in the rate of growth of the population brings about a reduction in about 2% points per year in the rate of growth of the expenditures of the MCH through the year 2000.

A clearer idea of the meaning of the results just commented is obtained with the information presented in Table 2. This Table shows indices of the expenditures of the MCH in year 2000, computed assuming that those in year 1985 were equal to 100, and that they grow at the rates presented in Table 1. The Table shows, for instance, that the expenditures of the MCH in year 2000 in Md's will be equal to 211 if the rate of population growth is 2.0% per year, and that of per capita income is 2.5% per year. On the other hand, retaining the assumption with respect to the rate of growth of per capita income, but assuming that the rate of population growth will be 3.0% per year, the expenditures of the MCH will be 276.

1087

The numbers in parenthesis in Table 2 show that for the results just commented, the MOH could reduce its expenditures in 24% if the rate of population growth is reduced from 3.0% to 2.0% per year. When total expenditures are considered, the reduction of the expenditures of the MOH with a reduction of the rate of population growth from 3.0% to 2.0% per year is of 25%.

Table 2  
 Estimates of the required expenditures of the MOH  
 in year 2000 assuming that those in year 1985  
 were equal to 100, and that they grow at  
 the rates presented in Table 1

	Expend. in MD's		Expend. in NR's.		Expend. in NA's.		Total Expend.	
	2.5%	3.0%	2.5%	3.0%	2.5%	3.0%	2.5%	3.0%
Income	211	230	166	188	226	248	204	225
	(76)	(76)	(71)	(72)	(76)	(76)	(75)	(75)
Popult. growth	261	287	223	251	284	311	260	286
	(95)	(95)	(96)	(96)	(96)	(96)	(96)	(96)
	276	301	233	261	297	325	272	299
	(100)	(100)	(100)	(100)	(100)	(100)	(100)	(100)

### Infertility clinic

Infertility is a major reproductive health problem worldwide. It occurs in 10-15% of couples in the developed countries and in an even higher percentage in many developing countries.\* It occurs most often as the sequella of genital tract infections. Due to the fact that much of the sexually transmitted disease in El Salvador goes untreated, it is estimated that infertility rates well exceed the developed country rates. The Salvadoran National Family Planning Program which provides voluntary surgical contraceptive techniques through the major service institutions in the country, has a responsibility to assist in the resumption of fertility via reanasthmosis of the fallopian tubes for those women who after close examination wish to do so.

The Ministry of Health, concerned with family and reproductive Health, wants to treat fertility of the Salvadoran couple in all its aspects by offering methods for the suspension of fertility, as well as the treatment of infertility. Because an infertility clinic is non-existent in El Salvador and the potential demand for one is great (approximately 60,000 women in reproductive age), a basic infertility clinic with the minimum requirements is proposed at the Clinica Gynecologica to act as the major referral center for the ADS, ISSS and the MOH. The infertility clinic would have the option to treat private patients to gain self sufficiency after the life of the project and to help the Clinica Gynecologica through the Patronato of the Maternity Hospital (a not-for-profit group organized to help the Maternity hospital and the Clinica Gynecologica).

The Clinic will occupy floor space in the Clinica Gynecologica a MOH clinic and will offer an array of tests for both female and male factors with emphasis on the female factors since they contribute 60% to the total rate of infertility.\*\*

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\* Reproductive Health Care Manual, Connell E. and Tatum H., Creative Informatics, Inc., 1985.

\*\* DeCherney A. "Intertility: General Principles of Evaluation In Kase N, Weingold A, eds. Principles and Practice of Clinical Gynecology, New York: John Wiley and Sons, 1983

Tests in the infertility clinic will include the following factors: 1. Anovulation, 2. Tubal Disease, 3. Pelvic Pathology, 4. Cervical factors, 5. Endocrine factors, 6. Andrological factors.

Follow-up treatment will consist of medical-surgical treatment which will require a minimum amount of equipment such as an operating microscope for microsurgery (reanastomosis of the fallopian tubes) and microsurgery equipment designed for this purpose.

El Salvador presently has 10 trained Ob-Gyn practitioners who represent all of the major institutions, and are willing and able to function in this referral clinic for the National Family Planning and Reproductive Health Program. With appropriate technical assistance, the equipment can be imported, local installation made and the usage facilitated by on-site demonstrations.

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MASS MEDIA CAMPAIGN.....

	1	2	3	4	1	2	3	4	1	2	3	4
		<u>1986</u>				<u>1987</u>				<u>1988</u>		
5) Booklets/ Pamphlets 2 per year 250,000 copies each.		<u>Drafts</u>	<u>Pretest</u>	<u>Final Art</u>	<u>Drafts</u>	<u>Pretest</u>	<u>Final Art</u>	<u>Drafts</u>	<u>Pretest</u>	<u>Final Art</u>		
				<u>Printing</u>			<u>DISTRIBUTION</u> -----					
6) Slides for movies one series of 3 slides for 35 theatres/yr.		<u>Drafts</u>	<u>Focus groups</u>	<u>Production</u>	<u>Drafts</u>	<u>Focus groups</u>	<u>Production</u>	<u>Drafts</u>	<u>Focus groups</u>	<u>Production</u>		
				<u>Distribution</u>			<u>Distribution</u>			<u>Distribution</u>		
				<u>Showings</u> -----			<u>Showings</u> -----			<u>Showings</u> -----		
7) 1 calendar/yr. 300,000 copies		<u>Drafts</u>	<u>Pretest</u>	<u>Final Art</u>		<u>Drafts</u>	<u>Pretest</u>	<u>Final Art</u>		<u>Drafts</u>	<u>Pretest</u>	<u>Final Art</u>
				<u>Printing</u>				<u>Printing</u>				<u>Printing</u>
				<u>Distribution</u>				<u>Distribution</u>				<u>Distr</u>
8) Fotonovela one item of 10 pages/yr. 360,000 copies		<u>Drafts</u>	<u>Pretest</u>	<u>Revision</u>	<u>Drafts</u>	<u>Pretest</u>	<u>Revision</u>	<u>Drafts</u>	<u>Pretest</u>	<u>Revision</u>		
				<u>Printing</u>			<u>Printing</u>			<u>Printing</u>		
				<u>DISTRIBUTION</u> -----			<u>DISTRIBUTION</u> -----			<u>DISTRIBUTION</u> -----		

MASS MEDIA CAMPAIGN.....

	<u>1986</u>				<u>1987</u>				<u>1988</u>			
	1	2	3	4	1	2	3	4	1	2	3	4
9) 10 billboards	<u>Elaboration</u>	---	<u>Location</u>		<u>Elaboration</u>		<u>Location</u>		<u>Elaboration</u>		<u>Location</u>	
				<u>Showing</u> -----				<u>Showing</u> -----				<u>Showing</u> -----
10) Flipcharts-one of 30 pages/yr. 1000 copies	<u>Drafts</u>		<u>Pretest</u>		---	<u>Drafts</u> ----				<u>Draft</u>		<u>Pretest</u>
				<u>Revision</u>				<u>Revision</u> -----				<u>Revis</u>
				---	<u>Printing</u> -----							<u>Print</u>
					<u>Distribution</u>					<u>Distribution</u>		
11) Self-instruction manuals for promoters and supervisors 1000 copies of one/yr. for promoters 500 copies of one/yr. for supervisors	<u>Drafts</u>				---	<u>Drafts</u> -----				---	<u>Drafts</u> -----	
				<u>Pretesting</u> ---				<u>Pretesting</u>				<u>Pretesting</u>
				<u>Revision</u>				<u>Revision</u>				<u>Revision</u>
				---	<u>Printing</u> -----							---
						<u>Distribution</u> -----				<u>Distribution</u> --		<u>Distr</u>

4/2/11

Time Table

ADS MAINTENANCE CAMPAIGN  
1987

	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
Medium												
1. <u>TV</u>												
A. 4 spots				<u>2 scripts</u>	<u>Pretests</u>	<u>Filming</u>	<u>Editing</u>	<u>2 scripts</u>	<u>Pretests</u>	<u>Filming</u>	<u>Edit.</u>	
B. Rapid Presentations		<u>Draft</u>	<u>Pretest</u>	<u>Revision</u>					<u>Broadcast</u>	-----		
C. Interviews					<u>Planning</u>	<u>Interviews</u>	<u>Editing</u>					
						<u>Seminars</u>	-----					
									<u>Broadcast</u>	-----		
2. Publications												
A. Newsletter		<u>1st Letter</u>				<u>2nd. letter</u>					<u>3rd. letter</u>	
B. Press Releases (4 per month)												-----

## ANNEX H

ILLUSTRATIVE LIST OF EQUIPMENT NEEDS  
FOR THE PROJECT

A. IEC Equipment

IBM Composer		5,000
Special Desks and Chairs		1,400
6 Slide projectors		3,000
6 Movie projectors		3,000
6 Screens		2,100
6 Projection tables		1,200
4 Reel to reel tape recorders		4,000
10 Cassette tape recorders		2,000
1 Betamax portable video system (portable camera, tripod, etc)		20,000
1 B & W T.V. closed circuit camera and monitor with teaching attachment for Laparoscope		10,000
4 Blackboards		1,400
4 Flip Chart Stands		800
4 Screens		10,600
1 Mimcography machine		500
2 Automatic Cameras		200
3 Professional camera plus tripod, lenses and filters		6,000
2 Overhead projector		600
1 Screen review slide		1,000
Dissolver		1,000
Calculators		1,000
Dark Room Equipment		<u>8,200</u>
Sub Total		83,000

B. MEDICAL EQUIPMENT

Basic Stock, Maintenance for RAM center, hardware, optics, tools, supplies		50,000
12 Laparoscope Systems A or B to restock system \$6,000		72,000
200 IUD insertion kits No. 6 \$60		12,000
200 IUD insertion kits No. 3 \$200		40,000
200 Gyn Emergency kits No. 2 \$160		32,000
50 Tensor 200 W automatic AC/DC battery emergency power \$50		2,500

200 Medical lights for IUD insertion \$50 ea.	10,000
Laboratory items, slides, cover slips, microscopes for teaching. Colposcopes stains, etc.	50,000
Microsurgical equipment, Microsurgical Microscope Special Operating loops	50,000
50 Operating tables, operating equipment and sterilization solutions \$15,000 per center	250,000
200 Ob/Gyn sets (speculums sounds, elevators) \$1,000 per set	200,000
60,000 100 ml ampollas meperidine \$70 ea.	42,000
60,000 10 ml ampollas diazepam \$ 2.00 ea.	120,000
15,000 50 ml frasco xylocaine \$3.00 ea.	45,000
Miscellaneous Equipment Needs	<u>10,500</u>
Sub-Total Medical Equipment	986,000
<u>C. Vehicles</u>	
4 Jeeps	60,000
<u>D. Office Equipment</u>	
4 Microcomputers IBM-XT with Modems	40,000
5 Typewriters with memory	5,000
Miscellaneous Office Equipment	5,000
4 Modems	<u>4,000</u>
Sub-Total Office Equipment	54,000
<u>E. Summary of Equipment Needs</u>	
IEC Equipment	83,000
Medical Equipment	986,000
Office Equipment	<u>110,000</u>
Total Estimated Equipment	\$1,179,000

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G O E SA I D

<u>Inputs/Elements</u>	<u>Outputs</u>	<u>FX</u>	<u>LC</u>	<u>Total</u>	<u>Host Country</u>	<u>Project Total</u>
<b>(A) <u>TECHNICAL ASSISTANCE</u></b>	Improvements of Administration (36 p/m) and Management	540	-	540	-	540
	Improvement of Logistics (36 p/m)	540	-	540	-	540
	Maintenance of Medical Equipment (6 p/m)	90	-	90	-	90
	Improvement of IEC (6 p/m)	90	-	90	-	90
	Training update of the Personnel (10 p/m)	140	-	140	-	140
<b>SUB-TOTAL (A)</b>		<u>1,400</u>	<u>-</u>	<u>1,400</u>	<u>-</u>	<u>1,400</u>
<b>(B) <u>ADMINISTRATION</u></b>						
<b>1) <u>Personnel</u></b>	1 Ex. Director	-	55	55	-	55
	1 Logistics Specialist	-	25	25	-	25
	1 IEC Specialists	-	25	25	-	25
	1 Training specialist	-	25	25	-	25
	1 Controller	-	25	25	-	25
<b>Sub-Total 1)</b>		<u>-</u>	<u>155</u>	<u>155</u>	<u>-</u>	<u>155</u>
<b>2) <u>Support</u></b>	2 Secretaries	-	33	33	-	33
	1 Driver	-	-	-	9	9
	1 Janitor messenger	-	-	-	8	8
	1 Customs expeditor	-	19	19	-	19
<b>Sub-Total 2)</b>		<u>-</u>	<u>52</u>	<u>52</u>	<u>17</u>	<u>69</u>
<b>3) <u>Operating Costs</u></b>	Office supplies & Equip.					
	Office paint/repair					
	Telephone and utilities					
	In-country travel					
	Misc. office costs	20	161.8	181.8	10	191.8
<b>Sub-Total 3)</b>		<u>20</u>	<u>161.8</u>	<u>181.8</u>	<u>10</u>	<u>191.8</u>

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4) Vehicles	4 Jeeps	50	-	60	-	60
Sub-Total 4)		<u>60</u>	<u>-</u>	<u>60</u>	<u>-</u>	<u>60</u>
SUB-TOTAL (B)		80	368.8	448.8	27	475.8
 (C) <u>I E C</u>						
1) <u>Personnel</u>	4 Professionals	-	-	-	147	147
	2 Secretaries	-	-	-	33	33
Sub-Total 1)		<u>-</u>	<u>-</u>	<u>-</u>	<u>180</u>	<u>180</u>
2) <u>Equip. &amp; Supplies</u>	Paints, paper, misc. office supplies, drawing outfits/ audiovisuals	73	10	83	45	128
Sub-Total 2)		<u>73</u>	<u>10</u>	<u>83</u>	<u>45</u>	<u>128</u>
3) <u>Productions</u>	Pamphlets (600,000)	-	325	325	-	325
	Posters (50,000)	-	25	25	-	25
	Brochures (300,000)	-	307	307	-	307
	Flip charts (800)	-	32	32	-	32
	Other ed. materials	-	50	50	45	95
Sub-Total 3)		<u>-</u>	<u>739</u>	<u>739</u>	<u>45</u>	<u>784</u>
SUB-TOTAL (C)		73	749	822	270	1,092
 (D) <u>Training</u>						
1) <u>Participant Trng.</u>	9 persons to USA (MCH, ISSS & SDA) in logistics/warehousing	15.5	-	15.5	-	15.5
	2 Educators/trainers from the MOH's Health Education Dept.	15.0	-	15.0	-	15.0
	4 Persons from MCH Dept. (MOH)	15.5	-	15.5	-	15.5
	6 Nurse trainers to Colombia	12.4	-	12.4	-	12.4
	12 Nursing School Instructors to Chile	34.8	-	34.8	-	34.8
	4 Policy Makers/Op. Leaders to Mexico	11.8	-	11.8	-	11.8
Sub-Total 1)		<u>105.0</u>	<u>-</u>	<u>105.0</u>	<u>-</u>	<u>105.0</u>

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2) Paramedical Training in Contraceptive Technology and Program Administrat.	TBA's, Rural Health Aides, Satisfied users, auxiliary nurses	200	-	200	356	556
Sub-Total 2)		200	-	200	356	556
3) Medical Training in Management and Contraceptive Technology	a) Medical personnel b) Administrators	210	-	210	330	540
Sub-Total 3)		210	-	210	330	540
4) Administrator's Training in Mgmt. and Financing	MOH, ISSS and SDA middle Management & Administrators	57	-	57	60	117
Sub-Total 4)		57	-	57	60	117
5) Logistics and Maintenance	a) Medical and Paramedical personnel b) Maintenance technicians c) Administrators	30	-	30	90	120
Sub-Total 5)		30	-	30	90	120
6) IEC Skills	Educators of MOH, ISSS and SDA	36.4	-	36.4	60	96.4
Sub-Total 6)		36.4	-	36.4	60	96.4
SUB-TOTAL (D)		638.4	-	638.4	896	1,534.4
<u>(E) LOGISTICS/MAINTENANCE</u>						
1) Personnel	Maintenance Technicians (Salaries)	-	-	-	305	305
Sub-Total 1)		-	-	-	305	305
2) Contraceptives	Pills	630	-	630	-	630
	IUD's	300	-	300	-	300
	Condoms	100.6	-	100.6	-	100.6
	Foams	100	-	100	-	100
Sub-Total 2)		1,130.6	-	1,130.6	-	1,130.6

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3) Micro-Computers	10 MC for MOH, ISSS, ADS, and MIPLAN for data and Administration of the Program	60	-	60	-	60
Sub-Total 3)		<u>60</u>	<u>-</u>	<u>60</u>	<u>-</u>	<u>60</u>
4) Medical Equip.	Personnel	-	-	-	120	120
	Basic Stock RAM Center	50	-	50	-	50
	200 IUD Kits No. 6	12	-	12	-	12
	200 IUD Kits No. 3	40	-	40	-	40
	200 Mini-Lap. Kits	11.3	-	11.3	-	11.3
	50 Tensor battery operated large	2.5	-	2.5	-	2.5
	12 Laparoscopes	72	-	72	-	72
	200 Lamps	10	-	10	-	10
	200 Gm. Kits No. 2	32	-	32	-	32
	Laboratory Items	50	-	50	-	50
	Infertility Equipments	50	-	50	-	50
	50 Operating Tables and Surgical Equipment	250	-	250	-	250
	200 Sets Ob/Gm.	200	-	200	-	200
	Pharraceuticals	207	-	207	-	207
Sub-Total 4)		<u>986.8</u>	<u>-</u>	<u>986.8</u>	<u>120</u>	<u>1,106.8</u>
5) <u>Warehouse</u>	One dedicated space for the entire system and personnel	-	120	120	-	120
Sub-Total 5)		<u>-</u>	<u>120</u>	<u>120</u>	<u>-</u>	<u>120</u>
SUB-TOTAL (E)		2,177.4	120	2,297.4	425	2,722.4
(F) <u>POLICY PLANNING</u>						
1) <u>Personnel</u>	MIPLAN's Population Department Staff (Salaries)	-	-	-	90	90
Sub-Total 1)		<u>-</u>	<u>-</u>	<u>-</u>	<u>90</u>	<u>90</u>
2) <u>CPS-88</u>	Field Work	-	150	150	-	150
	Data Analysis	20	-	20	-	20
	Write up	10	-	10	-	10
	Dissemination	-	-	-	23.5	23.5
Sub-Total 2)		<u>30</u>	<u>150</u>	<u>180</u>	<u>23.5</u>	<u>203.5</u>

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3) Evaluation/Research	Mid-project Evaluation	80	-	80	11	91
	Operation/research proj.	60	-	60	11	71
	Demographic data base	30	-	30	11	41
Sub-Total 3)		<u>170</u>	<u>-</u>	<u>170</u>	<u>33</u>	<u>203</u>
SUB-TOTAL (F)		200	150	350	146.5	496.5
(G) <u>PROJECT EVALUATION</u>	Impact Eval. Report on the various project components					
	1) (10 p/m)	220	-	220	-	220
	2) Support personnel (sal.)	-	-	-	50	50
	3) Misc. expenses	<u>-</u>	<u>59</u>	<u>59</u>	<u>-</u>	<u>59</u>
SUB-TOTAL (G)		220	59	279	50	329
(H) <u>CONTINGENCIES AND INFLATION</u>		360.9	508.5	869.4	-	869.4
GRAND TOTAL		5,044.7	1955.3	7,007	1,814.5	8,814.5

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Inputs/Elements	Outputs	A.I.D. FX.	LC.	A.I.D. Total	SDA	Project Total
<u>A. Technical Assistance</u>						
	Improvement of IEC and Multimedia IEC campaigns (36 p/m)	540	-0-	540	-	540
	Short Term specialist in Ad-designs, communications and message design specialists (4 p/m)	<u>60</u> 600	<u>-0-</u>	<u>60</u> 600	-	<u>60</u> 600
<u>B. Administration</u>						
1. Infrastructure		-0-	-0-	-0-	684	684
2. Support Personnel	Two IEC personnel and One Secretary	-0-	30	30	15	45
3. Office Equipment	Miscellaneous Office Equipment Chairs desks, tables, fungible	<u>-0-</u>	<u>5</u> 35	<u>5</u> 35	<u>-0-</u> 699	<u>5</u> 734
	SUB-TOTAL ADMIN.					
<u>C. IEC</u>						
1. Audiovisual IEC IEC Equipment						
	Audio Visual Material	50	-0-	50	-0-	60
	Teaching Material	10	10	20	10	20
	Miscellaneous	<u>6</u> 66	<u>-0-</u> 10	<u>6</u> 76	<u>-0-</u> 10	<u>6</u> 86

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2. Baseline Study	Design	—○	10	10	—○	10
	Field Work	—○	40	40	—○	40
	Analysis	—○	10	10	20	30
	Printing	—○	5	5	—○	5
	Dissemination	—○	5	5	—○	5
		—○	<u>70</u>	<u>70</u>	<u>20</u>	<u>90</u>

3. Production/Communication of Material

Radio Campaign	12 radio spots for 30 months over 29 stations	—○	500	500	—○	500
TV Campaign	6 TV spots over 4 stations at 2 spots per day over 30 months	—○	500	500	—○	500
Other Media	10 slides for movie houses	—○	2	2	—○	2
Print Media Campaign	10,000 posters	—○	10	10	—○	10
	250,000 booklets	—○	100	100	—○	100
	500 billboards	—○	75	75	—○	75
	3,000 fotonovelas	—○	240	240	—○	240
Illiteracy Materials for Rural Areas	100,000 self-instruction manuals	—○	200	200	—○	200
		—○	<u>1627</u>	<u>1627</u>	—○	<u>1627</u>
	Sub-Total IEC	66	1707	1773	30	1803

D. Training

Rural Agencies	CENTA volunteers	—○	10	10	—○	10
	FESACORA volunteers	—○	20	20	5	25
	UCS volunteers	—○	10	10	5	15
	Rural Cooperatives	—○	18	18	5	23
	Displaced Persons settlements	—○	20	20	5	25
		—○	<u>78</u>	<u>78</u>	<u>20</u>	<u>98</u>

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Teachers	MOE teachers	-o-	10	10	-o-	10
	Charity school teachers	-o-	5	5	-o-	5
	Other teachers	-o-	10	10	-o-	10
Promoters	Malaria or MAG field workers	-o-	10	10	5	15
	Community Action leaders	-o-	2	2	5	7
	Community Volunteers	-o-	2	2	5	7
	PVO Volunteers	-o-	3	3	-o-	3
		-o-	<u>42</u>	<u>42</u>	<u>15</u>	<u>57</u>
Leaders and Opinion Makers	Parliamentarians	-o-	10	10	3	13
	Leading Business leaders	-o-	5	5	-o-	5
	Leaders in Rural Areas and Cooperatives	-o-	<u>15</u>	<u>15</u>	<u>3</u>	<u>18</u>
		-o-	30	30	6	36
	Sub-Total Training	-o-	<u>150</u>	<u>150</u>	<u>41</u>	<u>191</u>
E) Contingencies & Inflation		40	297	337	-o-	337
F) GRAND TOTAL		706	2189	2895	779	3665

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## METHODS OF FINANCING AND IMPLEMENTATION

ANNEX J

PROJECT ELEMENT	INPUT	IMPLEMENTATION MECHANISM	FINANCING METHOD	APPROXIMATE AMOUNT		
				(A.I.D. and GOES)	(A.I.D./SIDA)	TOTAL
<u>COMPONENT I</u>						
<u>I. ADMINISTRATION AND MANAGEMENT</u>						
Technical Assistance Team						
<u>A. Long-Term</u>						
1. IEC Specialist (3 yrs.)		Contract with 8(a) firm	Direct Pay		600	600
2. Logistics/Maintenance Specialist (3 yrs.)		Contract with 8(a) firm	Direct Pay	540		540
3. Management/Administration Specialist (3 yrs.)		Contract with 8(a) firm	Direct Pay	540		540
<u>B. Short-Term</u>						
1. Maintenance Expert for bio-medical equipment (6 months)		Sub-contract through 8(a) firm	Direct Pay	90		90
2. IEC Design Specialist (6 months)		Sub-contract through 8(a) firm	Direct Pay	90		90
3. Human Resources Specialist (10 months)		Sub-contract through 8(a) firm	Direct Pay	140		140
<u>C. Administrative Costs</u>						
1. Professional Personnel (Executive Director, Logistic Specialist, IEC Specialist, Training Specialist Controller)		Host country contract	Direct Pay	155		155
2. Support Staff (Secretaries, Driver customs expeditor)		Host country contract	Direct Pay	69	45	114
3. Operating Expenses Office repair/renovation Office supplies/equipment Telephone/electricity		Host country procurement/ contract	Host country purchase orders, reimbursement	191.8	5	196.8

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PROJECT ELEMENT	INPUT	IMPLEMENTATION MECHANISM	METHOD		TOTAL
			FINANCING METHOD	APPROXIMATE AMOUNT (A.I.D. and GOES) (A.I.D./SDA)	
4. Vehicles Jeeps (4) Shipping & Transportation Costs		A.I.D. Direct Letter of Commitment	Direct Payment	60	60
5. Infrastructure (SDA. See budget for further details)				684	684
<b>II. <u>COMPONENT II</u></b>					
<b><u>INFORMATION,</u></b>					
<b><u>EDUCATION AND COMMUNICATION</u></b>					
A. Personnel Secretaries		H.C. Direct Contract	Direct Pay	180	180
B. Materials/Supplies for Educational Campaigns (paints, paper, drafting materials)		Sub-contracts through technical assistance firm	Advance	128	86
C. Production Costs (Pamphlets, brochures posters, others)		Host country contract and S&T/POP Cooperative Agreement	Direct Reimbursement Direct Pay	1092	1627
D. Base-line Survey		H.C. Direct Contract	Direct Pay		90
<b>III. <u>COMPONENT III</u></b>					
<b><u>TRAINING</u></b>					
A. Participant Training					
3 MOH/ISSS administrator to the U.S.		Technical assistance firm sub-contract	Direct Reimbursement	105	105
2 Educators/Trainers from the MOH's Health Education Department					
2 Individuals from the Maternal/Child Health Department					

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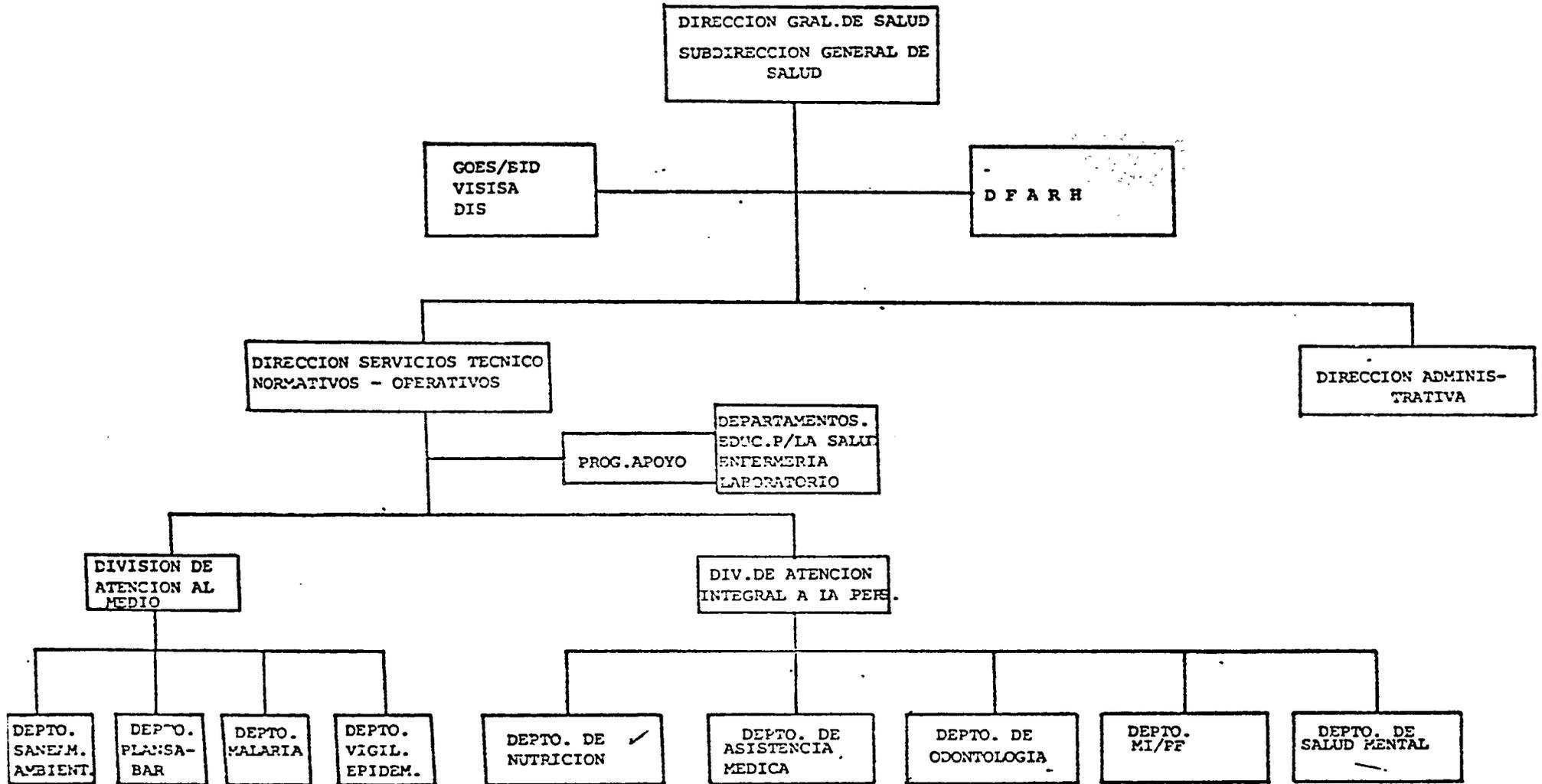
PROJECT ELEMENT	INPUT	IMPLEMENTATION MECHANISM	METHOD		TOTAL
			FINANCING METHOD	APPROXIMATE AMOUNT	
			(A.I.D. and GOES)	(A.I.D./SDA)	
3 Nurse trainers to Columbia					
6 Nursing School Instructor to Chile					
2 MOH/MIPLAN senior level officials to Mexico					
3. Paramedical Training in contraceptive technology and educational and motivational techniques for TBAs, RHAs, auxiliary nurses and satisfied users	SATU		Direct reimbursement for participant training costs	556	556
2. Medical training in contraceptive technology for doctors and medical students	SATU		Direct Reimbursement	540	540
0. Administration/Management/and Financial Management training	SATU or sub-contract through technical assistance firm		Direct Reimbursement	117	117
2. Logistics and Maintenance training	SATU or technical assistance firm		Direct Reimbursement	120	120
2. IEC Skills training for educat.	SATU or technical assistance firm		Direct Reimbursement	96.4	96.4
3. Rural agencies personnel	SDA		Direct Reimbursement		98
1. Teachers/promoters	SDA		Direct Reimbursement		57
2. Leaders	SDV/MIPLAN		Direct Reimbursement		36
<u>IV. COMPONENT IV</u>					
<u>LOGISTICS AND MAINTENANCE</u>					
1. Personnel		Host country contract	Direct Pay	305	305

1.01

PROJECT ELEMENT	INPUT	IMPLEMENTATION MECHANISM	METHOD		TOTAL
			FINANCING METHOD	APPROXIMATE AMOUNT	
			(A.I.D. and GOES)	(A.I.D./SDA)	
B. Contraceptives		A.I.D. Direct Contract	Direct Letter of Commitment	1,130.6	1,130.6
C. Management/Information System (10 microcomputers for MOH, ISSS, SDA, and MIPLAN)		Sub-contract through technical assistance contract	Direct Reimbursement	60	60
D. Medical Equipment and Spare Parts		ST/POP Cooperative Agreements	Direct Pay	899.8	899.8
E. Pharmaceuticals		GSA	Direct Pay	207	207
F. Warehouse (Construction/Renovation)		Host Country contract	Advance	120	120
V. <u>COMPONENT V</u> <u>POLICY PLANNING</u>					
A. Personnel		Host country contract	Direct Pay	90	90
CPS in 1988		Host country contract	Direct Pay	203.5	203.5
3 Evaluations/Research		Host country contract	Direct Pay	203	203
VI. <u>PROJECT EVALUATION</u>		A.I.D. Direct		329	329
VII. <u>CONTINGENCIES/INFLATION</u>				869.4	337
					1206.4

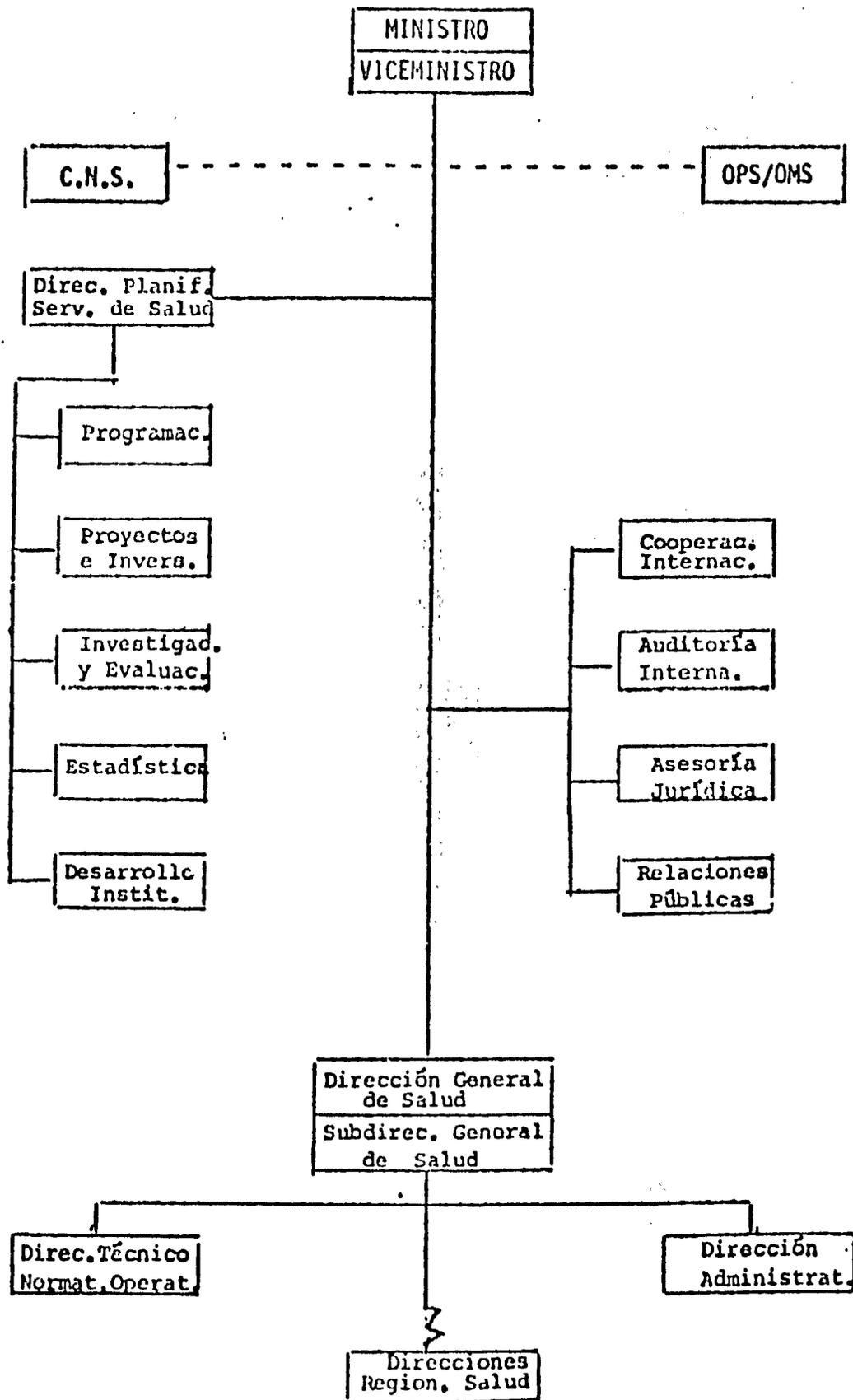
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MINISTERIO DE SALUD

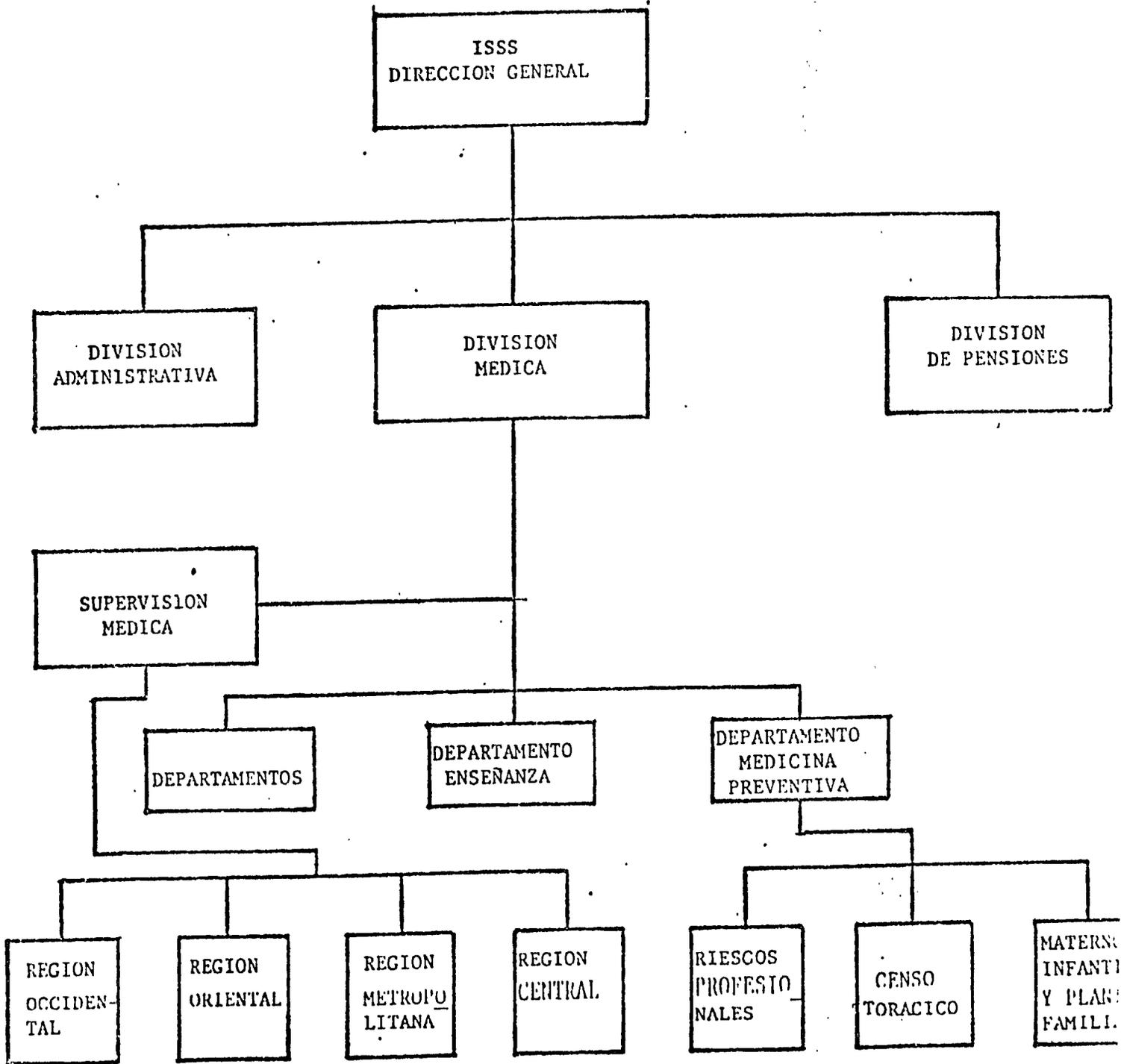


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ORGANIGRAMA DE NIVEL CENTRAL DEL  
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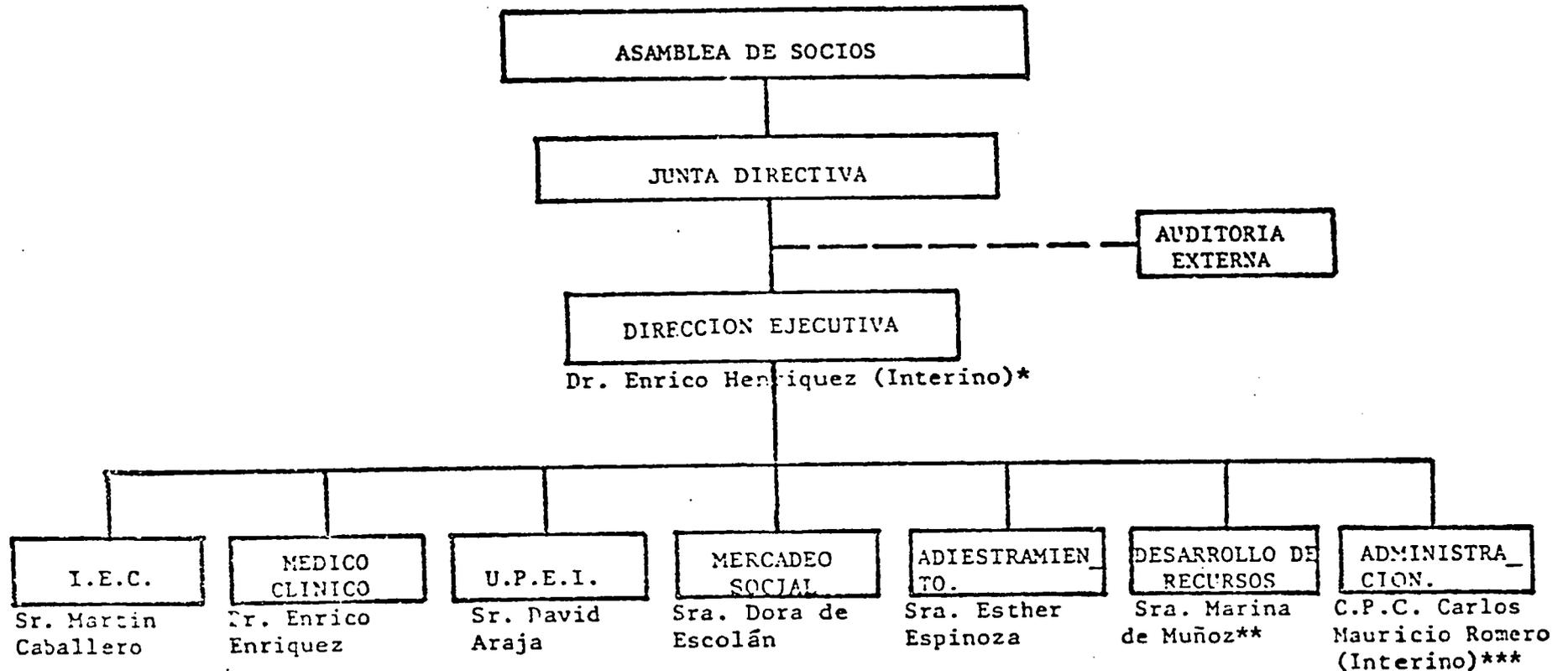


SALVADORAN SOCIAL SECURITY INSTITUTE



## ORGANIGRAMA DE LA ASOCIACION

## DEMOGRAFICA SALVADOREÑA



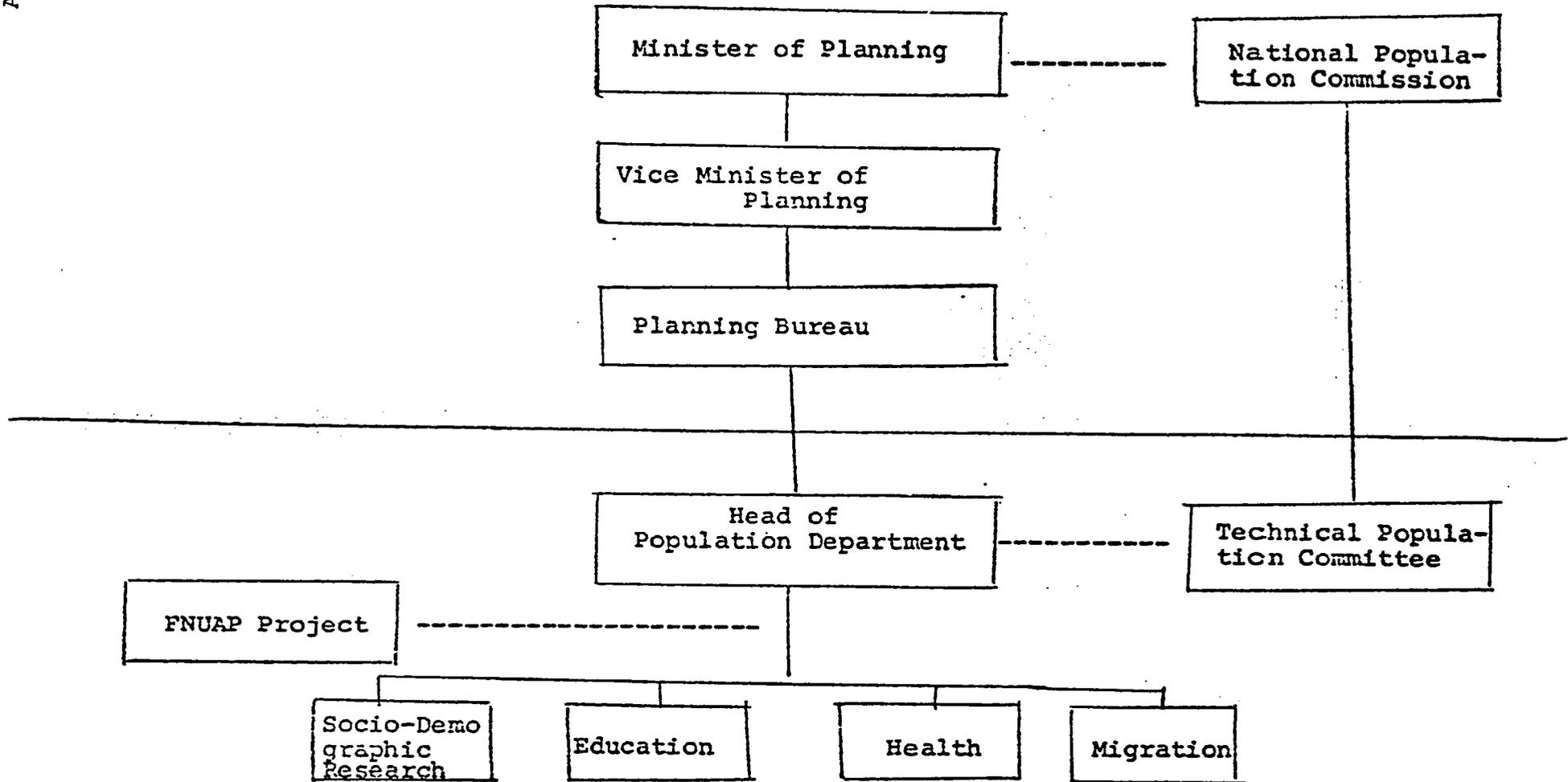
\* El Dr. Enrico Henríquez, tiene nombramiento de Director Ejecutivo Alterno, para atender cuando el titular esté ausente; en dichos casos, la Dirección Médica es atendida por el Dr. Joaquín Ramos Ramírez.

\*\* La Dirección de Desarrollo de Recursos está vacante, la Sra. de Muñoz, Secretaria, atiende los asuntos del Departamento.

\*\*\* El Sr. Romero, por nombramiento de la Junta Directiva, atiende interinament la Dirección Administrativa.

MIPLAN POPULATION DEPARTMENT  
1985 Organization Chart

ANNEX K



### Contraceptive Needs (1985-1988)

Estimated Institutional Target in Thousands of Acceptors  
of Salvadoran Population Dynamics Project FY85-87

Estimated Institutional Consumption of Contraceptives  
in Thousands of Units for F.P. Services FY85-87

Estimated Contraceptive Expenditures in Thousands USA  
for the Salvadoran Family Planning Program FY85-87

	FY85						FY86						
	MOB	ISS	ACS	Phis	Phases	Total	UNITS	MOB	ISS	ACS	Phis	Phases	Total
ORALS	38.00	7.00	8.40	1.80	19.40	75.00	13.00	454.00	58.80	139.20	20.50	212.20	975.00
INJECT	1.00	0.00	2.80	0.70	1.80	6.30							
IUD'S	23.90	4.00	2.00	3.70	0.00	33.60	1.30	31.07	5.20	2.60	4.81	0.00	43.68
CONDOM	0.30	0.40	0.50	0.00	5.00	6.40	100.00	50.00	40.00	50.00	0.00	200.00	640.00
OTHER	0.40	0.00	0.50	0.00	2.00	2.90	100.00	40.00	0.00	50.00	0.00	200.00	290.00
TOTAL	63.40	12.00	13.70	6.00	26.20	121.30							

	FY85						FY86							
	UNITS	MOB	ISS	ACS	Phis	Phases	Total	UNITS	MOB	ISS	ACS	Phis	Phases	Total
ORALS	0.18	68.92	17.76	19.66	3.74	45.40	172.59	0.18	111.15	22.23	24.57	4.08	50.75	218.75
IUD'S	1	31.07	5.20	2.60	4.81	0.00	43.68	1	31.07	5.20	2.60	4.81	0.00	43.68
CONDOM	0.1	5.00	4.00	5.00	0.00	50.00	64.00	0.1	5.00	4.00	5.00	0.00	50.00	64.00
OTHER	0.05	2.00	0.00	2.50	0.00	10.00	14.50	0.05	2.00	0.00	2.50	0.00	10.00	14.50
TOTAL		126.99	26.96	29.76	8.55	105.40	257.68		158.48	33.73	36.87	10.89	130.45	377.23

	FY86						FY87						
	MOB	ISS	ACS	Phis	Phases	Total	UNITS	MOB	ISS	ACS	Phis	Phases	Total
ORALS	47.50	9.50	10.50	2.00	24.25	93.75	13.00	417.50	123.50	135.50	26.50	315.25	1,218.75
INJECT	1.12	0.00	3.14	0.78	2.02	7.06							
IUD'S	29.68	5.00	2.50	4.63	0.00	42.00	1.30	38.84	6.50	3.25	6.31	0.00	54.60
CONDOM	0.50	0.50	0.63	0.00	6.25	8.00	100.00	52.50	50.00	62.50	0.00	225.00	800.00
OTHER	0.45	0.00	0.56	0.00	2.24	3.25	100.00	44.80	0.00	50.00	0.00	224.00	324.80
TOTAL	79.12	15.00	16.75	7.41	32.52	150.81							

	FY86						FY87							
	UNITS	MOB	ISS	ACS	Phis	Phases	Total	UNITS	MOB	ISS	ACS	Phis	Phases	Total
ORALS	0.18	111.15	22.23	24.57	4.08	50.75	218.75	0.18	128.94	27.79	30.71	5.55	70.95	374.22
IUD'S	38.84	6.50	3.25	6.01	0.00	54.60	54.60	1	48.53	8.13	4.06	7.52	0.00	68.25
CONDOMS	0.01	6.25	5.00	6.25	0.00	62.50	81.00	0.2	7.91	6.25	7.81	0.00	78.13	101.00
OTHER	0.05	2.24	0.00	2.80	0.00	11.20	14.24	0.05	2.51	0.00	3.14	0.00	12.54	15.19
TOTAL		158.48	33.73	36.87	10.89	130.45	377.23		197.81	42.16	45.72	13.57	161.60	485.68

	FY87						FY88						
	MOB	ISS	ACS	Phis	Phases	Total	UNITS	MOB	ISS	ACS	Phis	Phases	Total
ORALS	54.72	11.83	13.13	2.50	29.31	117.19	13.00	771.25	154.38	170.63	32.20	394.06	1,523.44
INJECT	1.23	0.00	3.51	0.88	2.26	7.90							
IUD'S	37.54	6.25	3.13	5.73	0.00	52.50	1.30	48.55	8.13	4.06	7.52	0.00	68.25
CONDOM	0.73	0.63	0.78	0.00	7.81	10.00	100.00	78.13	62.50	78.13	0.00	781.25	1,000.00
OTHER	0.56	0.00	0.63	0.00	2.51	3.64	100.00	50.18	0.00	62.72	0.00	250.88	363.78
TOTAL	98.75	18.75	20.54	9.16	40.58	187.59							

	FY87						FY88							
	UNITS	MOB	ISS	ACS	Phis	Phases	Total	UNITS	MOB	ISS	ACS	Phis	Phases	Total
ORALS	0.18	128.94	27.79	30.71	5.55	70.95	374.22	0.18	158.94	32.79	36.71	6.55	80.95	485.68
IUD'S	1	48.53	8.13	4.06	7.52	0.00	68.25	1	58.53	9.13	4.06	7.52	0.00	80.25
CONDOMS	0.2	7.91	6.25	7.81	0.00	78.13	101.00	0.2	7.91	6.25	7.81	0.00	78.13	101.00
OTHER	0.05	2.51	0.00	3.14	0.00	12.54	15.19	0.05	2.51	0.00	3.14	0.00	12.54	15.19
TOTAL		197.81	42.16	45.72	13.57	161.60	485.68		245.81	51.16	53.72	13.57	171.60	607.68

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## ECONOMIC ANALYSIS

### A. Introduction

The Population Dynamics Project aims at increasing contraceptive prevalence in El Salvador through strengthening the coordination among, and the planning and operating efficiency of, public and private family planning programs. The Project also aims at improving promotional efforts among young females at risk of pregnancy, who are currently not utilizing any contraceptive methods. The ultimate goal of the Project is to improve the quality of health and life among Salvadorans, especially in rural areas and to reduce the population growth rate.

In economic terms, the Project aims at reducing the population in future years and consequently the economic costs, such as consumption, which are associated with a larger population in the future. A reduction in consumption costs in the case of El Salvador should result in a short run increase in per capita income since current population levels and population growth rate are high in relation to the country's productive capacity and current production trends.

For the purpose of assessing the economic impact of the Project, it is necessary to estimate the magnitude of the economic benefits and costs associated with the Project, and to estimate the rate at which the present value of the yearly net benefits is equal to zero. The following sections will present a description of the methodology and data base utilized to estimate the Internal Rate of Return and Benefit/Cost Ratio associated with the Project.

### B. Project Economic Benefits

The principal benefit associated with the Project is the fact that the population is going to be smaller in the future and that as a result, economic production in the future is going to be distributed among a smaller number of people, this in turn should increase the amount of resources available for consumption on a per capita basis. This could have two positive results from an economic perspective: a) If the additional resources are not consumed and are saved instead, there will be more resources available for investment; and/or, b) if the additional resources are fully consumed, there is a likelihood that labor productivity will increase. For the purposes of estimating the benefits of the Project, the consumption saved over a fifteen year period will be estimated. However, no attempt will be made to estimate what happens to the consumption saved, although we suspect that it will be fully consumed since the target group is in the rural areas.

The estimation of Project benefits involves several steps: a) The estimation of births which would have taken place in the absence of the Project; b) the estimation of the age profile of those births averted estimated in (a) over a

fifteen year period; and, c) the estimation of consumption associated with the age profile developed in (b). The combination of these three elements will provide us with an estimate of consumption saved by the economy, i.e. the economic benefits which are associated with the Project.

1. Births Averted by the Project

According to estimates made by DAI, the implementation of the Project will result in a net increase in contraceptive prevalence equivalent to protecting an additional 88,800 couples over the three year life of the Project. In other words, the Project will result in 88,800 Gross Couple Years of Protection (GCYP). This estimate is based on projections of additional services which will be delivered by type of contraceptive method. Table 1 presents the estimated additional services, which are expressed in method units (orals, condoms, IUDs, and others) and equivalent GCYP, where:

1 oral unit	= 13 cycles	= 1 GCYP
1 condom unit	= 100 applications	= 1 GCYP
1 IUD unit	= 1.2 insertions	= 1 GCYP
1 Others (foam, etc)=		= 1 GCYP

The GCYPs need to be adjusted to account for: a) the technical effectiveness of the method to be delivered; and, b) the effectiveness with which the contraceptive method will be utilized. For El Salvador the coefficients utilized are as follows:

<u>Method</u>	<u>Technical Application</u>	
	<u>Effectiveness</u>	<u>Effectiveness</u>
Orals	99.5%	92.0%
Condoms	98.5%	85.0%
IUDs	98.0%	95.0%
Others	96.0%	75.0%

The resulting adjustment yields Couple Years of Effective Protection (CYEP), which are estimated on the basis of the following formula:

$$CYEP_T = (GCYP_{jt}) (t_{jT}) (a_{jT})$$

Where:  $CYEP_T$  = CYEP in year T

$GCYP_{jT}$  = GCYP for contraceptive method "j" in year T.

$t_{jT}$  = technical effectiveness of contraceptive "j" in year T,

$a_{jT}$  = application effectiveness of contraceptive "j" in year T.

The resulting CYEP for every year are transformed into Gross Potential Births Averted (GPBA) by multiplying the CYEP each year by an estimated Fertility Rate associated with the women who will participate directly or indirectly in the Project. In the case of el Salvador, two fertility rates are utilized, an estimated fertility rate of 50% which represents the potential fertility of the target group, which are women between the ages of 14 and 25 years of age, and a General Fertility Rate of 13.4% which represents the average of the General Fertility Rate estimated by the following methods:

$$GFR_1 = CBR \times (1/POPWRA) = 18.18\%$$

$$GFR_2 = 1/(TFR/ARY) = 18.69\%$$

Where:

CBR	=	Crude Birth Rate (1984) = 40/1000
POPWRA	=	Percentage of Population accounted for by women at reproductive age (15 - 45) which is estimated at 22%
TFR	=	Total Fertility Rate or the number of live births over the life span of a woman, which was estimated at 5.6 children
AYR	=	Average number of reproductive years (ages 15 to 45), which was estimated at 30

The calculations associated with the estimation of births averted by the project are presented in Table 1.

## 2. Age Profile of Births Averted by the Project

There is an age profile associated with the births averted during the three year life of the project. This profile is estimated in several steps as follows:

- a) The births averted are lagged to account for the nine month human gestation period;
- b) An age profile is developed for a 15 year period beginning with the project. The profile is developed for three different age groups: 0 - 4, 5 - 9, and 10 - 14 years of age. The resulting estimate yields Gross Population Reductions (GPR) for each of the 15 years; and,

- c) The resulting GPRs are subsequently adjusted with natural population reductions associated with death rates for each cohort (See Table 3). The resulting calculation is the Net Population Reduction associated with the Project for a fifteen year period.

The calculations for each of these steps are presented in Table 2. The estimated Net Population Reductions are utilized to estimate the consumption savings for each age group during a fifteen year period.

### 3. Consumption Savings associated with Project

In order to calculate the consumption savings associated with the Project, it is necessary to calculate: a) the average adult per capita consumption; b) the per capita consumption by age group; and, c) health and education per capita costs associated with each age group. In the case of El Salvador, the last income and expenditure survey took place in 1976, while per capita health and education costs are not readily available. Thus, a proxy for each of these two elements had to be found in order to estimate consumption savings associated with the Project.

The Mission decided to utilize personal and government consumption levels as they appear in the national accounts since these statistics are a reasonable proxy of the concepts in question. The sum of personal and government consumption figures were further adjusted as follows:

$$\text{Gross Consumption per capita} = (C_p + C_g) / \text{Population}$$

$$\text{Adjusted Consumption per capita} = \text{GC/capita} \times \text{APC}$$

Where:  $C_p$  = Private Consumption

$C_g$  = Government Consumption

APC = Average Propensity to Consume

The calculation of consumption by age group are in 1984 Colones and projected to grow at a 3% real growth rate according to the Missions macroeconomic projections. The results are presented in Table 4.

In order to calculate the consumption savings by age group as a percentage of average adult per capita consumption, it is assumed to be 12% for age group 0 - 4, 40% for age group 5 - 9, and 70% for age group 10 - 15 years old. The age distribution of consumption savings are then multiplied by net population reductions in order to estimate the economic benefits associated with the Project. The results are presented in Table 5.

## B. Project Economic Costs

There are four types of costs associated with the project: a) Direct project costs transformed into Colones at the parallel market exchange rate of C4.50 = \$1.00; b) Indirect project costs associated with the increase in family planning services; c) Production foregone associated with the productivity of births averted during their lifespan; and, d) the "psychological reward" of having a child which is foregone as a result of the Project.

For the purposes of the project, an attempt was made to estimate the first three types of costs with the full knowledge that the fourth type is an important element but practically impossible to quantify.

The indirect costs are those which need to be incurred by the family planning institutions in order to achieve project objectives but are not covered by the project. These are mostly the costs of commodities delivered as well as other variable costs (labor, transportation, overhead, etc.), which were estimated on the basis of the budgets of participating institutions, and commodity use projections made by the DAI team. These are valued in Colones at the parallel rate of exchange.

Production foregone was estimated by multiplying the average consumption of each age group by an adjustment factor. For the 0 - 4 age group the adjustment factor is zero, for the 5 - 9 group the adjustment factor is .20, for the 10 - 15 age group, the adjustment factor is .70. The analysis was carried only to the fifteenth year with the full knowledge that the full productivity level of the births averted will not have been reached, and that until that point the project analysis will have a tendency to be biased in favor an excess of benefits over costs because the births averted will have consumed more than produced. The calculations are presented in Table 4. The sum of all project related economic costs are presented in Table 6.

## C. Economic Cost Benefit Analysis

The net stream of benefits and costs were utilized to estimate an Internal Rate of Return (IRR) and a Benefit/Cost Ratio. The IRR which makes the Net Present Value of the net stream of benefits equal to zero is 64.6%, while the Benefit/Cost Ratio is 2.4 utilizing a 12% discount rate when the potential fertility rate of 50% is utilized. The IRR is 28.5% and the Benefit/Cost Ratio is 1.64 when the effective General Fertility Rate is utilized. In either case, the Project appears economically justifiable.

TABLE 2: CALCULATION OF NET CUMMULATIVE POPULATION REDUCTIONS (NCORs)

Assumption: 50% Gross Fertility Rate

YEAR	BIRTHS AVERTED BY THE PROJECT (THOUSANDS)	GROSS CUMULATIVE POPULATION REDUCTIONS (GCFRS IN THOUSANDS)				NET CUMULATIVE BIRTHS REDUCTIONS ADJUSTED FOR DEATH RATES (NCORs IN THOUSANDS)			
		0-4	5-9	10-15	TOTAL	0-4	5-9	10-15	TOTAL
1	2.7	2.7	0.0	0.0	2.7	2.6	0.0	0.0	2.6
2	14.0	16.7	0.0	0.0	16.7	15.9	0.0	0.0	15.9
3	28.1	44.8	0.0	0.0	44.8	42.3	0.0	0.0	42.3
4	30.3	75.1	0.0	0.0	75.1	69.7	0.0	0.0	69.7
5	0.0	75.1	0.0	0.0	75.1	66.9	0.0	0.0	66.9
6	0.0	72.4	2.7	0.0	75.1	62.1	2.1	0.0	64.2
7	0.0	58.4	16.7	0.0	75.1	48.6	13.0	0.0	61.6
8	0.0	30.3	44.8	0.0	75.1	24.7	34.5	0.0	59.2
9	0.0	0.0	75.1	0.0	75.1	0.0	56.8	0.0	56.8
10	0.0	0.0	75.1	0.0	75.1	0.0	54.5	0.0	54.5
11	0.0	0.0	72.4	2.7	75.1	0.0	50.6	1.7	52.3
12	0.0	0.0	58.4	16.7	75.1	0.0	39.7	10.7	50.4
13	0.0	0.0	30.3	44.8	75.1	0.0	20.1	28.5	48.6
14	0.0	0.0	0.0	75.1	75.1	0.0	0.0	47.2	47.2
15	0.0	0.0	0.0	75.1	75.1	0.0	0.0	45.8	45.8

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TABLE 1: BIRTHS AVERTED FROM PROJECT IMPLEMENTATION

YEAR	GROSS CONTRACEPTIVE YEARS OF PROTECTION (TCYDAYS) (GCYF)					ADJUSTMENT FOR METHOD FAILURE EFFECTIVENESS COEFFICIENT					ADJUSTMENT FOR APPLICATION FAILURE APPLICATION EFFECTIVENESS COEFFICIENT					BIRTHS AVERTED UTILIZING A 50% GENERAL FERTILITY RATE		BIRTHS AVERTED UTILIZING A 18.4% GENERAL FERTILITY RATE	
	ORALS	CONDOMS	IUDS	OTHERS	TOTAL	ORALS	CONDOMS	IUDS	OTHERS	TOTAL ADJTD GCYFS	ORALS	CONDOMS	IUDS	OTHERS	TOTAL ADJTD CYPFS	TOTAL BIRTHS AVERTED	TOTAL BIRTHS AVERTED (9 M/LAB)	TOTAL BIRTHS AVERTED	TOTAL BIRTHS AVERTED (9 M/LAB)
	99.5%	98.5%	93.0%	95.0%		92.0%	85.0%	95.0%	75.0%										
1	15.0	1.3	6.8	0.3	23.4	14.9	1.3	6.7	0.3	23.2	13.7	1.1	6.3	0.2	21.4	10.7	2.7	3.9	1.0
2	33.8	2.9	15.2	0.7	52.6	33.6	2.9	14.9	0.7	52.1	30.9	2.4	14.2	0.5	48.0	24.0	14.0	8.9	5.2
3	57.2	4.9	25.7	1.0	88.8	56.9	4.8	25.2	1.0	87.9	52.4	4.1	23.9	0.7	81.1	40.6	29.1	14.9	10.4
4					0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	30.4	0.0	11.2
5					0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
6					0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
7					0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
8					0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
9					0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
10					0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
11					0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
12					0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
13					0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
14					0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
15					0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
																75.3	75.3	27.7	27.7

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Table 2: (Continued)

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Assumption: 18.4% Gross Fertility Rate

YEAR	BIRTHS AVERTED BY THE PROJECT (THOUSANDS)	GROSS CUMULATIVE POPULATION REDUCTIONS (GCFRS IN THOUSANDS)				NET CUMULATIVE BIRTHS REDUCTIONS ADJUSTED FOR DEATH RATES (NCORs IN THOUSANDS)			
		0-4	5-9	10-15	TOTAL	0-4	5-9	10-15	TOTAL
1	1.0	1.0	0.0	0.0	1.0	1.0	0.0	0.0	1.0
2	5.2	6.2	0.0	0.0	6.2	5.9	0.0	0.0	5.9
3	10.4	16.6	0.0	0.0	16.6	15.7	0.0	0.0	15.7
4	11.2	27.8	0.0	0.0	27.8	25.8	0.0	0.0	25.8
5	0.0	27.8	0.0	0.0	27.8	24.8	0.0	0.0	24.8
6	0.0	26.8	1.0	0.0	27.8	23.0	0.8	0.0	23.8
7	0.0	21.6	6.2	0.0	27.8	18.0	4.8	0.0	22.8
8	0.0	11.2	16.6	0.0	27.8	9.1	12.8	0.0	21.9
9	0.0	0.0	27.8	0.0	27.8	0.0	21.0	0.0	21.0
10	0.0	0.0	27.8	0.0	27.8	0.0	20.2	0.0	20.2
11	0.0	0.0	26.8	1.0	27.8	0.0	18.7	0.6	19.3
12	0.0	0.0	21.6	6.2	27.8	0.0	14.7	4.0	18.7
13	0.0	0.0	11.2	16.6	27.8	0.0	7.4	10.6	18.0
14	0.0	0.0	0.0	27.8	27.8	0.0	0.0	17.5	17.5
15	0.0	0.0	0.0	26.8	26.8	0.0	0.0	16.9	16.9

TABLE 3: CALCULATIONS -- GROSS OFFSPRING REDUCTIONS ADJUSTED FOR DEATH RATES

Assumptions: 50% Gross Fertility Rate

YEAR	GROSS BIRTHS AVERTED (THOUSANDS)	AVERAGE DEATH RATE BY AGE														
		0	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1	2.7	4.0%														
2	14.0	13.4	4.0%													
3	28.1	27.0	12.9	4.0%												
4	39.3	29.1	25.9	12.4	4.0%											
5	0.0	0.0	27.9	24.9	11.9	4.0%										
6	0.0	0.0	0.0	26.8	23.9	11.4	4.0%									
7	0.0	0.0	0.0	0.0	25.7	22.9	11.0	4.0%								
8	0.0	0.0	0.0	0.0	24.7	22.0	10.5	4.0%								
9	0.0	0.0	0.0	0.0	0.0	23.7	21.1	10.1	4.0%							
10	0.0	0.0	0.0	0.0	0.0	0.0	22.3	20.3	9.7	4.0%						
11	0.0	0.0	0.0	0.0	0.0	0.0	0.0	21.9	19.5	9.3	4.0%					
12	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	21.0	18.7	9.0	4.0%				
13	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	20.1	18.1	8.8	4.0%			
14	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	19.5	17.6	8.5	4.0%		
15	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	19.0	17.1	8.2	4.0%	1.5

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Table 3: (Continued)

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Assumption: 18.4% Gross Fertility Rate

YEAR	GROSS BIRTHS AVERTED (THOUSANDS)	AVERAGE DEATH RATE BY AGE														
		0	1	2	3	4	5	6	7	8	9	10	11	12	13	14
		4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	3.0%	3.0%	3.0%	3.0%	3.0%
1	1.0	1.0														
2	5.2	5.0	0.9													
3	16.4	10.0	4.8	0.9												
4	11.2	10.8	9.6	4.6	0.8											
5	0.0	0.0	10.3	9.2	4.4	0.8										
6	0.0	0.0	0.0	9.9	8.8	4.2	0.8									
7	0.0	0.0	0.0	0.0	9.5	8.5	4.1	0.8								
8	0.0	0.0	0.0	0.0	0.0	9.1	8.1	3.9	0.7							
9	0.0	0.0	0.0	0.0	0.0	0.0	8.8	7.8	3.8	0.7						
10	0.0	0.0	0.0	0.0	0.0	0.0	0.0	8.4	7.5	3.6	0.7					
11	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	8.1	7.2	3.5	0.6				
12	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	7.8	6.9	3.4	0.6			
13	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	7.4	6.7	3.3	0.6		
14	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	7.2	6.5	3.2	0.6	
15	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	7.0	6.3	3.1	0.6

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TABLE 4: CALCULATION OF AVERAGE PER CAPITA CONSUMPTION COSTS PER AGE GROUP

YEAR	AVERAGE PER CAPITA CONSUMPTION	WEIGHED AVERAGE PER CAPITA CONSUMPTION BY AGE GROUP				AVERAGE PER CAPITA INCOME CONSUMPTION PER AGE GROUP		
		0-4	5-9	10-14	15 AND OVER	0-4	5-9	10-14
1	2159	376	1252	2192	3131	0	250	1534
2	2224	387	1250	2257	3225	0	258	1580
3	2290	399	1329	2325	3322	0	266	1628
4	2359	411	1369	2395	3421	0	274	1676
5	2430	423	1410	2467	3524	0	282	1727
6	2503	436	1452	2541	3630	0	290	1778
7	2578	449	1495	2617	3738	0	299	1832
8	2655	462	1540	2695	3851	0	308	1887
9	2735	476	1586	2776	3966	0	317	1943
10	2817	490	1634	2860	4085	0	327	2002
11	2902	505	1683	2945	4208	0	337	2062
12	2989	520	1734	3034	4334	0	347	2124
13	3078	536	1786	3125	4464	0	357	2187
14	3171	552	1839	3218	4598	0	368	2253
15	3266	568	1894	3315	4736	0	379	2320

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Table 5: Calculation of Annual Consumption Savings and Production Foregone

Assumptions: 50% Gross Fertility Rate

YEAR	CALCULATION OF ANNUAL SAVINGS IN POPULATION CONSUMPTION COSTS (THOUSANDS OF COLONES)				CALCULATION OF ANNUAL PRODUCTION LOSSES DUE TO REDUCED POPULATION LEVELS (THOUSANDS OF COLONES)			
	0-4	5-9	10-15	TOTAL	0-4	5-9	10-15	TOTAL
1	977.6	0.0	0.0	977.6	0.0	0.0	0.0	0.0
2	6153.3	0.0	0.0	6153.3	0.0	0.0	0.0	0.0
3	16877.7	0.0	0.0	16877.7	0.0	0.0	0.0	0.0
4	28646.7	0.0	0.0	28646.7	0.0	0.0	0.0	0.0
5	28298.7	0.0	0.0	28298.7	0.0	0.0	0.0	0.0
6	27075.6	3047.2	0.0	30124.8	0.0	609.0	0.0	609.0
7	21821.4	19435.0	0.0	41256.4	0.0	3887.0	0.0	3887.0
8	11411.4	53136.0	0.0	64541.4	0.0	10626.0	0.0	10626.0
9	0.0	90084.8	0.0	90084.8	0.0	18005.6	0.0	18005.6
10	0.0	89053.0	0.0	89053.0	0.0	17821.5	0.0	17821.5
11	0.0	85156.8	4241.5	89401.3	0.0	17052.2	3505.4	20557.6
12	0.0	68839.6	32463.8	101303.6	0.0	13775.9	22726.8	36502.7
13	0.0	35698.6	89062.5	124761.1	0.0	7175.7	62329.5	69505.2
14	0.0	0.0	151889.6	151889.6	0.0	0.0	106341.6	106341.6
15	0.0	0.0	151827.0	151827.0	0.0	0.0	106256.0	106256.0

Table 5: (Continued)

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Assumption: 18.4% Gross Fertility Rate

YEAR	CALCULATION OF ANNUAL SAVINGS IN POPULATION CONSUMPTION COSTS (THOUSANDS OF COLOMBES)				CALCULATION OF ANNUAL PRODUCTION LOSSES DUE TO REDUCED POPULATION LEVELS (THOUSANDS OF COLOMBES)			
	0-4	5-9	10-15	TOTAL	0-4	5-9	10-15	TOTAL
1	376.0	0.0	0.0	376.0	0.0	0.0	0.0	0.0
2	2283.3	0.0	0.0	2283.3	0.0	0.0	0.0	0.0
3	6264.3	0.0	0.0	6264.3	0.0	0.0	0.0	0.0
4	10603.0	0.0	0.0	10603.0	0.0	0.0	0.0	0.0
5	10490.4	0.0	0.0	10490.4	0.0	0.0	0.0	0.0
6	10028.0	1161.6	0.0	11189.6	0.0	232.0	0.0	232.0
7	8082.0	7176.0	0.0	15258.0	0.0	1435.2	0.0	1435.2
8	4204.2	19712.0	0.0	23916.2	0.0	3942.4	0.0	3942.4
9	0.0	33306.0	0.0	33306.0	0.0	6657.0	0.0	6657.0
10	0.0	33006.8	0.0	33006.8	0.0	6605.4	0.0	6605.4
11	0.0	31472.1	1497.0	32969.1	0.0	6301.9	1237.2	7539.1
12	0.0	25489.8	12136.0	37625.8	0.0	5100.9	5476.0	10576.9
13	0.0	13216.4	33125.0	46341.4	0.0	2641.8	23192.2	25834.0
14	0.0	0.0	56315.0	56315.0	0.0	0.0	39427.5	39427.5
15	0.0	0.0	56023.5	56023.5	0.0	0.0	39208.0	39208.0

TABLE 6: CALCULATION OF PROJECT ECONOMIC COSTS

Assumption: 50% General Fertility Rate

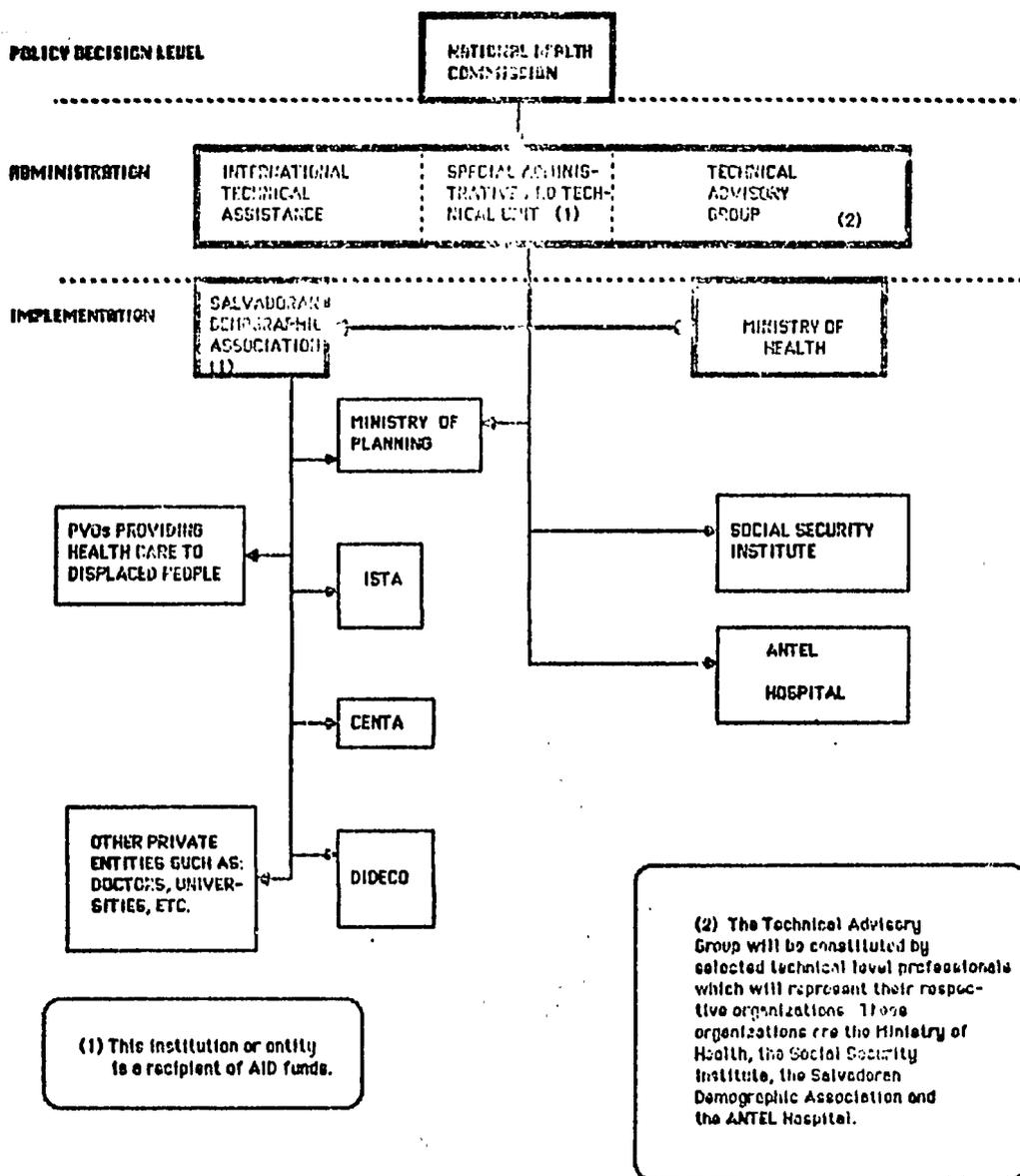
YEAR	PROJECT COSTS	VARIABLE INDIRECT PROJECT COSTS	INCOME CONTRIBUTION FOREGONE
1	14915.0	440.0	0.0
2	15011.6	504.0	0.0
3	14414.6	584.0	0.0
4	0.0		0.0
5	0.0		0.0
6	0.0		609.0
7	0.0		3887.0
8	0.0		10626.0
9	0.0		18005.6
10	0.0		17621.0
11	0.0		20557.6
12	0.0		36502.7
13	0.0		69505.2
14	0.0		106341.6
15	0.0		106256.6

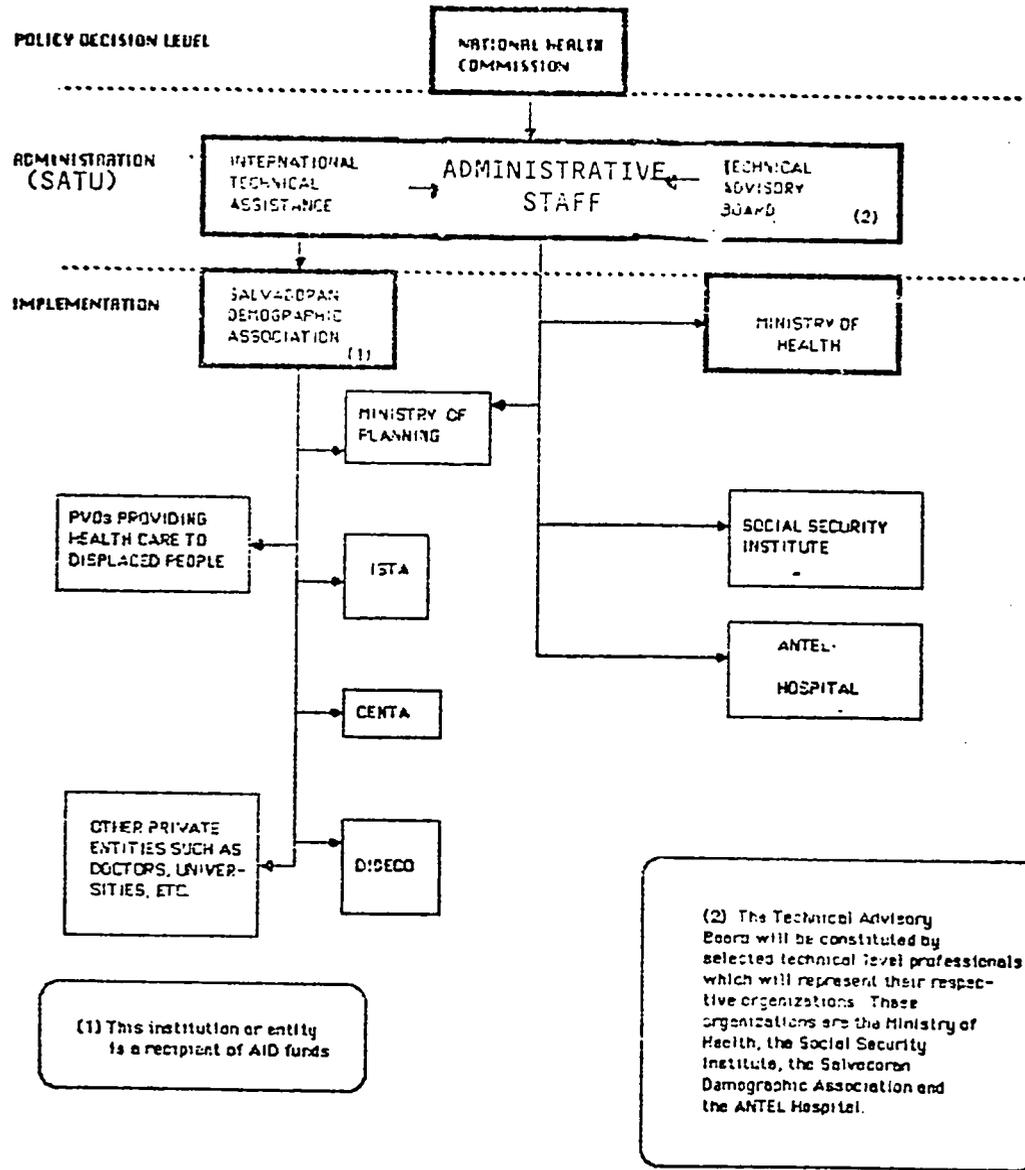
Assumption: 18.4% General Fertility Rate

YEAR	PROJECT COSTS	VARIABLE INDIRECT PROJECT COSTS	INCOME CONTRIBUTION FOREGONE
1	14915.0	440.0	0.0
2	15011.6	504.0	0.0
3	14414.6	584.0	0.0
4	0.0	0.0	0.0
5	0.0	0.0	0.0
6	0.0	0.0	232.0
7	0.0	0.0	1435.2
8	0.0	0.0	3942.4
9	0.0	0.0	6657.0
10	0.0	0.0	6605.4
11	0.0	0.0	7539.1
12	0.0	0.0	13596.9
13	0.0	0.0	25824.0
14	0.0	0.0	39427.5
15	0.0	0.0	39208.0

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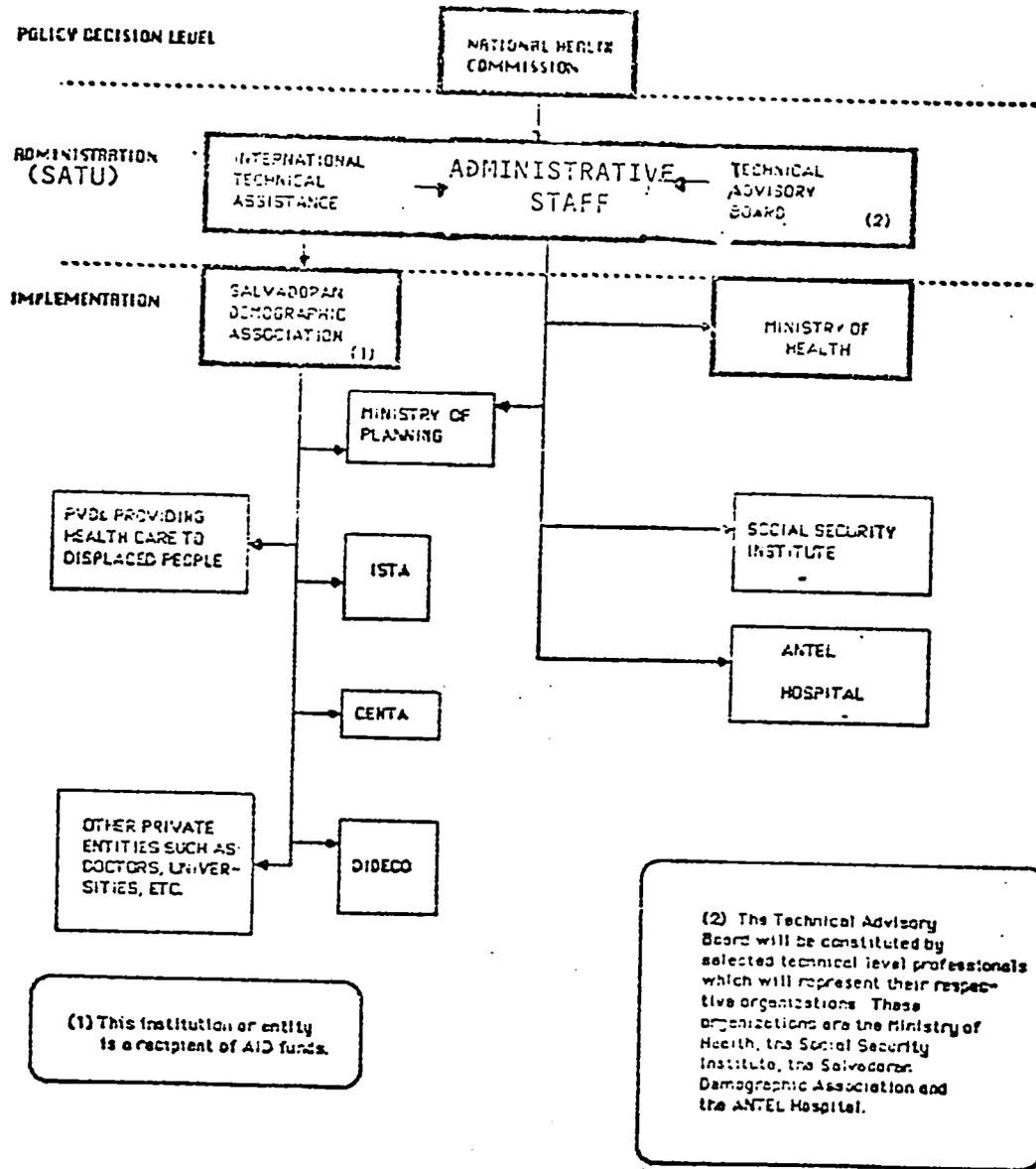
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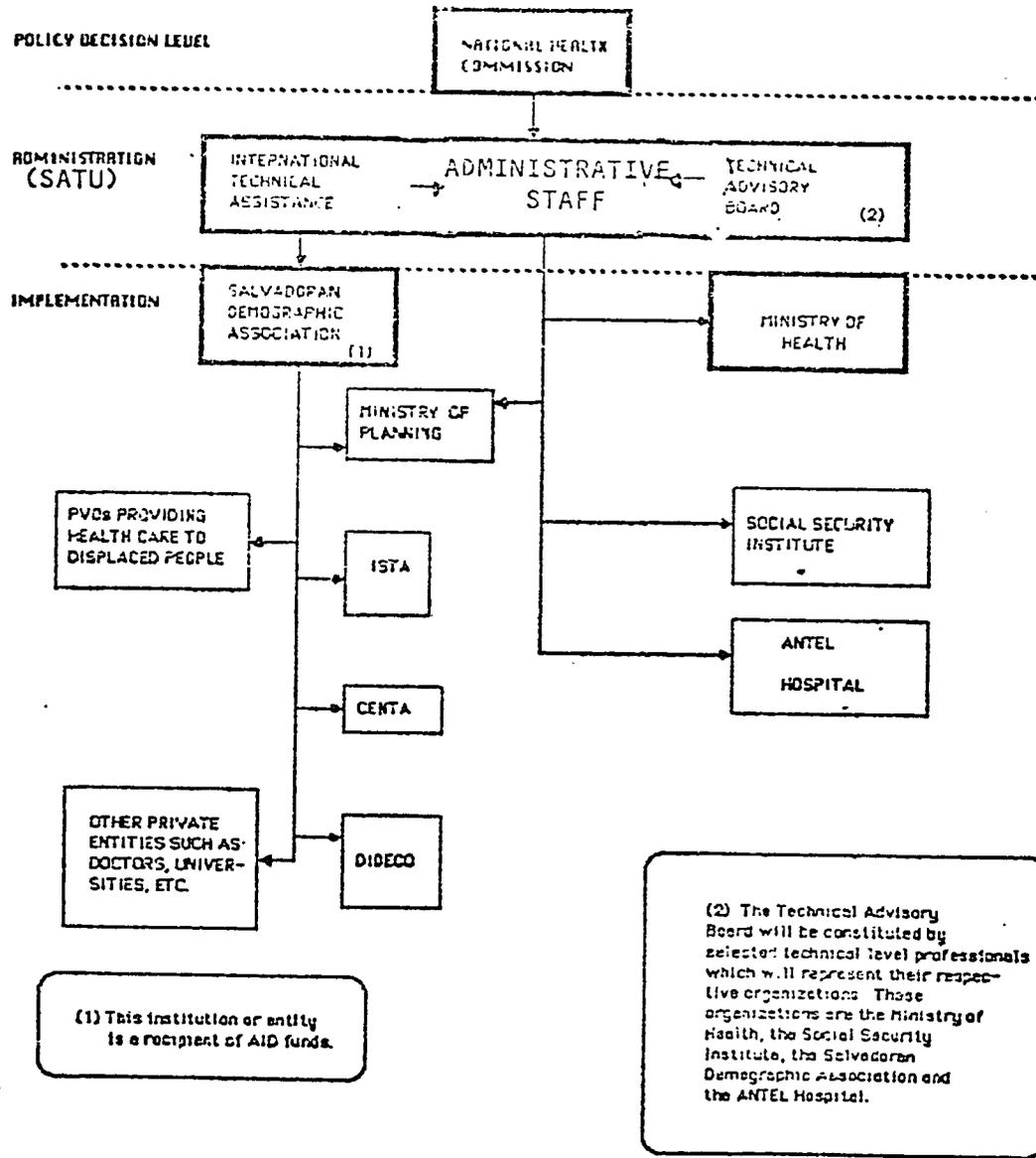




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NARRATIVE	OBJECTIVELY VERIFIABLE INDICATOR	MEANS OF VERIFICATION	ASSUMPTIONS
<u>Inputs</u>	<u>Budget</u> (000's)		
(1) <u>Technical Assistance</u>	2,000.0	USAID/El Salvador Controller's financial reports, implementation plans, and GOES and SDA reimbursement requests.	
(2) <u>Administration</u>	483.8		
(3) <u>IEC</u>	2,595.0		
(4) <u>Training</u>	788.4		
(5) <u>Logistics/Maintenance</u>	2,297.4		
(6) <u>Policy Planning</u>	350.0		
(7) <u>Project Evaluation</u>	279.0		
(8) <u>Conting./Inflation</u>	1,206.4		

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