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AN ASSESSMENT OF THE NATIONAL FAMILY PLANNING PROGRAM IN EL SALVADOR

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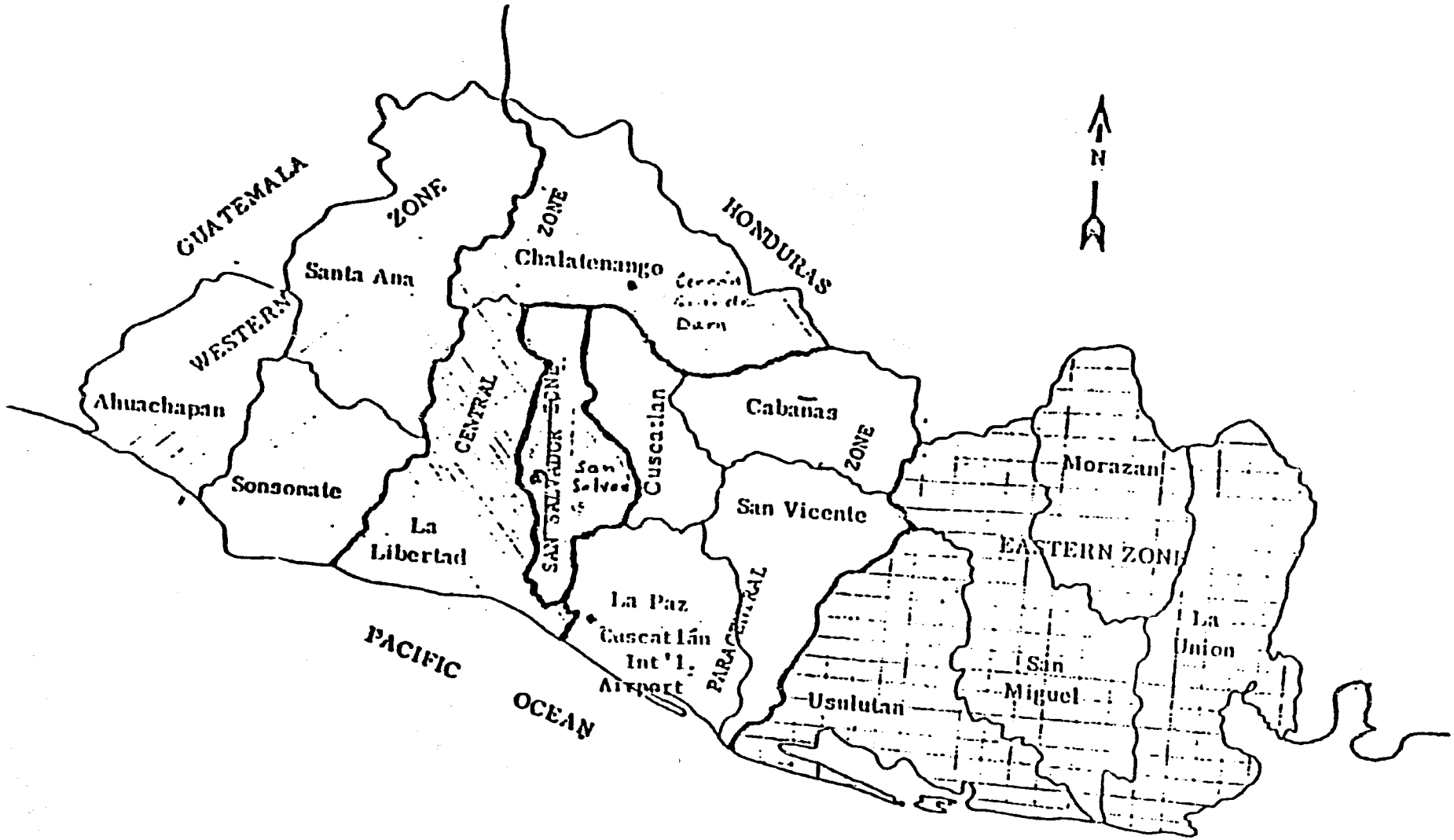
FIVE HEALTH REGIONS OF EL SALVADOR



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ABBREVIATIONS

AID	Agency for International Development
APHA	American Public Health Association
AVS	Association of Voluntary Sterilization
CBD	Community-Based Distribution
CBR	Crude Birth Rate
CDC	Communicable Disease Center
CRS	Commercial Retail Sales
DAI	Development Associates, Inc.
FP	Family Planning
GFR	General Fertility Rate
GOES	Government of El Salvador
IFRP	International Fertility Research Program
IPPF	International Planned Parenthood Federation
ISSS	Salvadorean Institute of Social Security
JHPIEGO	Johns Hopkins Program of International Education in Gynecology and Obstetrics
MCH/FP/N	Maternal Child Health/Family Planning/Nutrition
MOH	Ministry of Health
NPC	National Population Commission
PAHO	Pan American Health Organization
RHA	Rural Health Aide
SDA	Salvadorean Demographic Association
TCP	Technical Committee for Population
TFR	Total Fertility Rate
UNFPA	United Nations Fund for Population

I. EXECUTIVE SUMMARY

I. EXECUTIVE SUMMARY

Scope of Work

USAID/El Salvador requested an assessment of the national family planning program. Accordingly, the American Public Health Association (APHA) was asked to contract a team of consultants to conduct this assessment. The Scope of Work for this team was originally developed by USAID/El Salvador, subsequently discussed with team members and AID/Washington, and finalized during the mission to El Salvador. This Scope of Work was as follows:

- Review and analyze family planning programs.
- Assess the utility and reliability of family planning statistics.
- Assess the voluntary sterilization program.
- Assess the quality of MCH/FP training.
- Assess the Rural Health Aide (RHA) program.
- Assess the Technical Committee for Population (TCP).
- Make recommendations on strategies in MCH/FP.

Methodology and Team Members

The three international consultants contracted by APHA were:

Carolyn Benbow, Health Education and Training

Dario de Leon, Clinical Program and Systems Analysis

Louis Gardella, Jr., Public Health and Family Planning

Current programs were assessed and recommendations formulated on the basis of site visits, interviews, document reviews and analysis, meetings, and observations.

Background

The basic socioeconomic problems of El Salvador include heavy population pressure on the land aggravated by a high population growth rate, a coffee-dependent economy, a high rate of illiteracy, and extremely uneven distribution of land and income.

The nation's population has more than doubled in the past 25 years and is increasing at about 33 percent per annum. El Salvador's population density is the highest in Latin America: 513 persons per square mile. Emigration stimulated by population and political pressures has become an increasingly important demographic factor. The Government of El Salvador (GOES) has instituted an aggressive population policy. Since 1966, USAID has supported GOES efforts to reduce the rate of population growth.

Although data indicate a decrease in the crude birth rate from a high 48.7 in 1960-1964 to 43 in 1979, the rate of natural increase has not declined at the same rate for two reasons: a continuous decline in the death rate and a stable birth rate. In addition, the absolute number of births is increasing because the number of women of reproductive age is increasing.

Current Program Status

From 1963 to 1968, all family planning services were provided by the Salvadorean Demographic Association (SDA). The Ministry of Health (MOH) began to participate actively in the program in 1969. By mid-1980, 265 MOH facilities were providing such services. Since the MOH has primary responsibility for the delivery of health services to rural areas, and since approximately 80 percent of the Salvadorean population is not covered by other health services, the MOH is the major agency for the provision of family planning services.

Although it still maintains three clinics, the SDA now concentrates on training, research, and evaluation activities while providing family planning information through the mass media.

The Salvadorean Institute of Social Security (ISSS), which serves approximately 6 percent of the population, has 36 clinics and hospitals and focuses on groups such as factory workers and school teachers in urban areas and medium-sized regional towns.

A. Voluntary Sterilization

A system of sterilization clinics is dispersed throughout the country. These clinics are equipped and staffed by physicians and paramedical personnel trained with the assistance of international organizations. All three of the above-mentioned institutions offer sterilization services and all have instituted procedures to ensure that informed and voluntary consent for the operation is obtained. In fact, sterilization is the predominant method chosen to limit family size. As of 1979, 97,400 voluntary sterilizations (including 3,600 male

sterilizations) were performed. This constitutes nearly 52 percent of all family planning acceptors.

B. Policy Goal of FP Program

To accomplish the policy goal of a significant reduction in the crude birth rate, the family planning program should reach 65,000 new acceptors per year and should (having 222,000 as active users) reach 38 percent of the women at fertile age in a five-year period. Though the family planning programs of the private family planning association and of the Ministry of Health have succeeded to a large extent, 20,000 additional acceptors per year are needed to meet the government goals. In addition, a large percentage of women seeking sterilization are older, multiparous women. Continuation rates for oral contraceptive users remain low.

C. Data System

The family planning program in El Salvador does not have a unified data system that provides accurate service statistics. The system suffers from a high degree of duplication and over-enumeration. Another deficiency is the inaccuracy of active user statistics.

D. Administration

The MCH/FP/N Division of the MOH has a well trained and motivated staff. However, except for routine administration, staff functions are limited. The majority of field administrators in all three institutions has received no formalized training in administration, and the Health Training School does not receive sustained support for its training program in administration. A serious defect within the MCH/FP/N Division is the lack of an office with sole responsibility for family planning activities.

E. Logistics

The MCH/FP/N Division of the MOH depends on the Central Administration Office to provide transportation and purchase supplies. Because of the inadequacies of the transport systems of the MOH, shipment of MCH/FP/N supplies to the regional and local health facilities is delayed and the travel of supervisors and family planning referral patients is restricted. The system for the purchase of supplies and medicines is cumbersome and delays the delivery of items for six to eight months. Despite these logistical problems, the major health centers and field posts have adequate family planning supplies. Storage of family planning supplies and contraceptives at the central and regional levels is excellent. Warehouse management personnel are self-trained and have no formal training. Nor is there support for such training.

F. Rural Health Aides Program

A program for Rural Health Aides (RHAs) was initiated by the MOH in 1976. RHAs are responsible for preventive care through community health education in the rural areas; they also stimulate improved use of health facilities. RHAs appear to be well trained, enthusiastic, and well supervised. An important part of the RHAs' job is to promote family planning, to make family planning referrals, and to distribute contraceptives. RHAs contacted by the mission know the family planning patterns of their area and are aware of the obstacles preventing certain families from practicing family planning. They are trying to overcome these obstacles by providing continuing education, improving materials, and improving receptivity and transportation at local facilities. When RHAs are able to secure transport to health facilities, sterilization referral rates increase significantly.

G. Training

Performance of MOH personnel in the field has demonstrated the importance of continuous in-service training and supervision. Current staff have received varying amounts and levels of training; supervision in health facilities is insufficient. The Health Training School has been effective in providing well designed courses for various categories of personnel in response to staff and community needs.

H. Technical Committee for Population

The Technical Committee for Population (TCP) is under the aegis of the Ministry of Planning. Members of the Committee are representatives from the public and private agencies concerned with national population issues. TCP, theoretically, is the legal body responsible for coordinating national population activities with the public and private agencies and the international donors, for resolving and minimizing conflicts or problems that may arise between the agencies, and for conducting studies for population formulation. However, the TCP's role as a coordinating agency has not been fully recognized by the family planning institutions. New leadership in the family planning institutions and international donors are attempting to clarify TCP's role and responsibilities as a directorate for the coordination of national population activities.

Recommendations

The team has developed recommendations relevant to strategic planning, coordination, training, and motivation. Each recommendation is accompanied by a brief discussion of its rationale and a guide for implementation. The recommendations are summarized as follows:

- The Ministry of Health, with AID assistance, should take steps to implement priority actions that will strengthen and expand the capabilities of the Ministry's family planning program.

- A national demographic research program should be developed.

- Inter-institutional coordination should be strengthened.

- Increased emphasis should be given to community health education and to sex education, moving beyond the appeal to initial family planning acceptors, clarifying and extending the definition of family planning, and confronting issues on the side effects of contraceptive methods that have cultural and/or scientific validity.

- The MOH should focus on a continuous training program in MCH/FP for various categories of personnel--physician-interns, nurses, nurse-auxiliaries, rural health aides, parteras empericas--and take advantage of the soon-to-be constructed health training centers to implement a sustained training-supervision system.

- Population motivation efforts of various institutions should be coordinated to ensure maximum outreach in rural areas and to promote inter-institutional staff cooperation and cross-referral.

- The family planning component of the Rural Health Aide Program should be strengthened through the provision of materials appropriate for the target population, of vehicles for transport to family planning services, of continual supplies of contraceptives, and through more flexible schedules in health care facilities.

- In addition to other methods, which would be equally offered and emphasized through patient education, the voluntary sterilization programs of the Salvadorean Institute of Social Security should be expanded to all hospitals and zone medical units. The supervisory capacity at the central level should be strengthened.

- International donor support to Salvadorean institutions involved in the implementation of population programs should be continued. Coordination among parallel external international donors is recommended. Specifically recommended is coordination of parallel project proposals, implementation schedules, and budget allocations.

Limitations

The team wishes to go on record as having stated the constraints on an assessment of this type at this time in El Salvador. The political situation in the summer of 1980 was considered to be sufficiently dangerous to severely restrict travel within El Salvador. In addition, all program officials indicated that program implementation, particularly in the rural areas, had suffered in recent months because of the political crisis. The team believes that it was unable to gain the perspective desirable for an adequate assessment and that this document accordingly reflects these limitations.

II. INTRODUCTION AND BACKGROUND

I. INTRODUCTION

Terms of Reference

In July of 1980, terms were drafted for an evaluation of the El Salvador Population Program.

A. Objectives

1. Review and analyze program activities of the public and private family planning programs.
2. Assess the utility and reliability of family planning statistics.
3. Assess the voluntary sterilization program and its relative emphasis to date on voluntary sterilization versus temporary methods.
4. Assess and identify the quality of MCH/FP training programs in terms of content, duration, and retraining.
5. Assess the effectiveness of the Rural Health Aides Program and its relationship to the family planning program.
6. Discuss future strategies in MCH/FP with Salvadorean program officials in the public and private sectors.

B. Team Composition and Plan of Work

The team was made up of three specialists: one physician health planner, one health educator, and one specialist in family planning. Recruitment was based on professional experience in Latin America rather than on academic credentials alone.

The team included three international consultants contracted by the American Public Health Association and financed by AID. The team members were:

Carolyn Benbow, M.P.H.

Consultant in Health Education and Training

Dario de Leon, M.D., M.P.H.

Specialist in Health Planning and
Specialist in Systems Analysis

Louis Gardella, Jr., B.S., R.S.

Public Health and Family Planning Specialist

Based on its observations and findings, the team made recommendations for improvements in the present systems and for the allocation of USAID support. To make recommendations for future improvements in the family planning sector, the team acquainted itself with the structures and role of the various organizations responsible for coordinating national family planning programs with programs of major international donors. It also identified obstacles that impede the progress of the program.

C. Preliminary Activities

Before the team's arrival in El Salvador, Mr. Gardella scheduled meetings with officials at AID's Latin American Office and Office of Population for Latin America. Background material for the team's work was collected and distributed to the other members of the team. Ms. Benbow scheduled meetings with IPPF, AVS, and UNFPA officials in New York and obtained background material for distribution to the team. The team met in Washington for a briefing session with AID/W and APHA officials. USAID/El Salvador requested that the various Salvadorean institutions implementing population programs prepare data on their activities before the team arrived. A standardized form was prepared for each institution.

D. Technical and Administrative Support

Consultants were contracted by the American Public Health Association, which was responsible for travel arrangements, per diem, and honoraria. The USAID mission assumed responsibility for team members in the country. Technical backstopping was provided by the AID Office of Population for Latin America (David Denman).

The team traveled to El Salvador on July 6. Two team members stayed for three weeks; the educator stayed 15 days. A one-way debriefing session was held at AID in Washington on August 29 to discuss the final report and to conclude the mission.

E. Work Performed and Methodology

Each member was assigned responsibilities for observation, analysis, and assessments. The duties were allocated as follows:

Training, Rural Health Aide Program, Salvadorean Demographic Association, Information, Education and Communication Activities, UNFPA and IPPF Inputs	Carolyn Benbow

Voluntary Sterilization, Clinic Systems, Trends in Family Planning Services, Ministry of Health's Family Planning Services, Service Statistics	Dr. de Leon
Management and Supply System at Ministry of Health, Social Security Family Planning Program, Population Technical Committee, Introduction and Background, Country Profile, AID Inputs	Louis Gardella

The team visited, reviewed, and observed the activities of institutions in El Salvador. As Ms. Benbow's assigned responsibilities were principally in training, IEC, and the rural health program, she operated independently much of the time. There was considerable overlap in the responsibilities of Dr. de Leon and Mr. Gardella; they frequently visited the sites together. Site visits were as follows:

Dr. de Leon and Mr. Gardella

Ministry of Health

San Martin Health Unit, Cojutepeque Health Center, San Rafael Cedros Health Post, Regional Health Office Clinic Santa Ana, Regional Hospital Santa Tecla, Central Warehouse San Salvador

Salvadorean Demographic Association

Clinics of Santa Ana, Santa Tecla, and San Salvador

Ms. Benbow

Ministry of Health

Health Training School, Rural Health Aides Program Canton Nazaret, San Jose Villanueva Health Post, Regional Health Offices, Santa Ana and Santa Tecla, Lourdes Health Unit

Site visits, interviews, document reviews and analysis, meetings, and observations formed the basis for the assessments of current programs and the formulation of recommendations. The team met daily to discuss its observations on each content area. Proposed recommendations from each team member were discussed in the context of the Scope of Work. Weekly meetings were held at USAID to discuss the team's progress and observations; tentative recommendations were presented to USAID/El Salvador.

F. Documents Reviewed

The following documents were reviewed by the evaluation team during the course of the mission:

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Socioeconomic and Demographic Indicators

The Republic of El Salvador is located in Central America and is bordered by Guatemala, Honduras, and Nicaragua, from which it is separated by the Gulf of Fonseca. The country faces the Pacific Ocean on the south.

El Salvador is separated by mountain ranges running east to west and forming three distinct regions: a hot, narrow Pacific coastal belt on the south; a subtropical central region of valleys and plateaus, where most of the population lives; and a mountainous northern region. Ninety percent of the land is of volcanic origin. Almost all of the land is under cultivation. Coffee is planted high on the mountains.

The basic economic and social problems of the underdeveloped Salvadorean economy include heavy population pressure on the land aggravated by a very high population growth rate, a coffee-dependent economy, limited unused arable land and mineral resources, a high illiteracy rate, high seasonal unemployment, and very uneven distribution of income. The industrial sector, which is concerned primarily with the processing or production of light consumer goods, did not develop significantly in the 1970s. The economic infrastructure (roads, electric power, and commercial banking facilities) is fairly well developed. The economy still is primarily agricultural, with coffee representing 41 percent of total exports and cotton 13 percent. Corn, beans, and sorghum are the chief subsistence crops.

The population of El Salvador in 1979 was estimated at 4.5 million and was projected to increase to 5.6 million by 1985. The high growth potential is reinforced by the fact that 48 percent of the population is under 15 years of age.

The population has more than doubled in the last 25 years and is growing at about 3.3 percent per annum. The greatest growth is in rural areas among families with low literacy and income and limited knowledge of family planning. Assuming a continuation of the current annual growth rate of more than 3.0 percent and taking into account the annual net emigration of some 50,000, the population is projected to be 10 million by the year 2000. El Salvador, with the greatest population density of any country in Latin America, has over 216 persons per square kilometer. Forty percent of the population is urban and 60 percent is rural. (See Exhibit 1.)

Historical Background on the El Salvador Family Planning Program

El Salvador is in the midst of a demographic transition. It has achieved the low mortality rates characteristic of a modernizing country while maintaining traditionally high natural birth rates. During the second half of this century, the crude death rate declined dramatically, but the crude birth rate changed little. This difference has led to El Salvador's "population explosion."

Whereas in 1950 the population of the country was 1,856,000, by mid-1980 approximately 4.6 million people were occupying the 8,260 square miles of land that are El Salvador, making it one of the most densely populated countries in the Western Hemisphere, with 531 persons per square mile.

It is predicted that at the current rate of natural growth (estimated at 3.3 percent in 1980), the population of El Salvador will double by the year 2000; this means that 8.8 million people will be crowded into this already over-crowded country.

Emigration stimulated by population and political pressures has become an increasingly important factor influencing El Salvador's relations with other nations, particularly Honduras, the United States and, to a lesser degree, other nations in Central America.

Exhibit 1

COUNTRY DATA ON EL SALVADOR [1]

Area	Population		Density
21,041 Km^2 (Equivalent to Massachusetts)	4.5 million (mid 1980)		210 per Km^2 (1979)
	Natural Growth Rate	3.3%	
	Net Outmigration	20,000	
	Net Growth Rate	2.9%	

Population Characteristics

Crude Death Rate (per 1,000)	8
Crude Birth Rate (per 1,000)	43
Urban (per 1,000)	31
Rural (per 1,000)	51
Number of Years to Double	24
Life Expectancy at Birth	61
Economically-active Population (1978)	33%
Effective Unemployment Rate (1979)	52%
GNP per capita Constant (1976$) (1976)	$ 560
(1979)	$ 740
Agricultural Output per Rural Person (1978)	U.S. $ 338
Growth Rate of GDP (1970-1978)	5.0%
Growth Rate Per Capita GDP (1970-1978)	2.1%

Education

Adult Literacy (1979	65.0%
Enrollment Ratio Age 9-15 (1978)	67.0%

Income Distribution (1976)

% Income, Lowest 10%	2.1%
% Income, Lowest 40%	15.8%
% Income, Highest 5%	21.4%

Land Ownership (1971)

% of land in largest 10% of farms	78%
% of land in smallest 50% of farms	5%

Average Daily Caloric Intake	1,890

National Income Accounts

	(1978) (Millions)	% GDP
Gross Domestic Product	U.S. $3,357	100%
Government Expenditures	534	17
Government Revenues	473	15
Gross Capital Investment	731	24
Exports	848	28
Imports	1,029	34

Coffee Sector (current prices)

% of GDP	
1974	11%
1978	15%
% of Exports	
1974	42%
1978	61%

Net Foreign Reserves, Year-end, 1979 (millions)	U.S. $ 135

External Public Debt Service

Debt Service Ratio (1978)	3.4%
External Debt to GDP (1978)	10.6%

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[1] El Salvador, Country Development Strategy Statement FY 82, January 1980.

Realizing that efforts to improve the socioeconomic conditions of the country are hampered by the high population growth rate, the GOES has instituted an aggressive policy of population control. USAID/El Salvador supports GOES efforts to design and implement programs that will result in a rapid decline in the population growth rate. Between 1966 and 1980, USAID/El Salvador contributed $5,600,000 in bilateral funding to the family planning program to assist the GOES and selected private organizations in delivering services and in dramatizing the adverse effects of rapid population growth on social and economic development.

Although data indicate a decrease in the crude birth rate, from a high of 48.7 in the 1960-1964 period to 43 in 1979, which can be attributed in great part to the family planning program, the decline is less significant when two other factors are taken into account. The first of these is the previously mentioned decline in the mortality rate from 15.0 in the earlier period to an officially estimated 8 today. The second is the fact that the number of women in the reproductive age groups has increased--a trend which will continue, because nearly half of the population is under 15 years of age--and this in turn has led to an increase in the absolute number of births each year.

To review briefly the history of the program: From 1963 to 1968, all public family planning services were provided by the SDA. The MOH became an active participant in the program in 1969 and by 1971 was offering family planning services in all five health regions. By mid-1980, 265 facilities were providing such services. Since the MOH has primary responsibility for the delivery of health services to rural areas and since 80 percent of the total population expects health care from this service, the MOH is considered to be the most important agency for the delivery of family planning services.

The emphasis has been on women between the ages of 20 and 30, the optimum time for a woman to bear children. Indeed, a very high proportion of births have been to women up to 30 years of age. However, a large proportion of program resources have been used among low-fertility women, i.e., those 30 years or older. One can attribute this distribution in part to the high proportion of sterilizations of the total case load and to the fact that the sterilization procedure is most attractive to high parity older women.

III. DEMOGRAPHIC TRENDS AND USE OF CONTRACEPTIVES IN EL SALVADOR

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In 1977, the Ministry of Health, the Institute of Social Security of El Salvador, and the Salvadorean Demographic Association presented a proposal of implement the national population policy. According to the authors of that proposal, the rate of natural increase should be lowered to 2.0 percent by 1982. The targets that have to be reached by the national family planning program to accomplish that objective are defined in the proposal. The national population policy had other objectives, such as a 10 percent reduction in unemployment by 1980, an increase in the number of jobs for women, improvement of the nutritional level of the population, and legal actions to stimulate other programs related to population (Ministerio de Salud, 1977).

With the establishment of a national population policy, an adequate measurement of population activities and outcomes became more important. Given that need, the realities of the vital statistics have to be pointed out. As demonstrated in three different reports, there is a high percentage of under-registration in mortality in El Salvadador. Collver (Collver, 1977) estimated 25 percent under-reporting in mortality in 1965. The Inter-American Mortality Study (Puffer and Serrano, 1971) revealed that under-reporting of infant mortality in rural areas was 23.4 percent. A review of responses to questions on mortality included in the 1971 census showed that under-reporting of infant mortality in the rural areas of El Salvador was 39 percent. This under-reporting confuses the real situation, giving a false impression of accomplishments in mortality control. Data systems of registration of contraceptive use are also inadequate. Several studies have shown that the numbers of new acceptors of temporary contraceptive methods and of active users of those methods are over-estimated.

The geographic distribution of contraceptive users is not known in spite of the fact that the information exists in the clinics.

To obtain information about contraceptive use and fertility, two contraceptive prevalence surveys were conducted in 1975 and 1978. These surveys were carried out by the SDA with the cooperation of the MOH and with technical assistance from the Family Planning Evaluation Division of the Center for Disease Control (CDC).

Demographic Trends

On the one hand, the crude birth rate has remained high (see Table 1): 42 to 49 births per thousand population. On the other hand, the mortality rate has consistently declined since the early 1930s.

The difference between birth rates and death rates has resulted in an increase in the rate of natural increase from 1.4 percent in the early 1930s to 3.0 percent in 1970. It is estimated that the rate of natural increase is at least 3 percent even after adjustments are made for immigration and mortality under-registration (Morris, 1979). The effect of demographic trends is plotted in Figure 1.

Annual data for the years 1960-1979 show that the crude birth rate declined only slightly from 1960 through 1970 and that it has remained almost constant ever since (see Table 2). The population estimate for 1975 was 4 million. If the birth

Table 1

AVERAGE ANNUAL BIRTH AND DEATH RATES IN EL SALVADOR, BY FIVE-YEAR PERIODS, 1900-1974

5-Year Period	Crude Birth Rate*	Crude Death Rate*	Rate of Natural Increase (%)
1900-04	43.8	29.7	1.4
1905-09	43.5	31.4	1.2
1910-14	44.7	31.1	1.4
1915-19	42.9	41.2	0.2
1920-24	46.6	32.8	1.4
1925-29	47.1	34.1	1.3
1930-34	46.5	32.7	1.4
1935-39	45.4	29.6	1.6
1940-44	45.2	28.5	1.7
1945-49	44.8	22.8	2.2
1950-54	47.9	20.0	2.8
1955-59	47.9	17.7	3.0
1960-64	48.7	15.0	3.4
1965-69	44.4	9.8	3.5
1970-74	41.5	8.6	3.3

* per 1,000 population

Sources of Data

1900-59: Collver, O.A., Birth Rates in Latin America-New Estimates of Historical Trends and Fluctuations, Research Series No. 7, University of California, Berkeley: Institute of International Studies, 1965.

1960-69: U.N. Demographic Yearbooks, 1966-1971.

1970-74: Ministerio de Economia, Direccion General de Estadistica y Censos, El Salvador en Cifras 1977, El Salvador, C.A., Junio de 1977.

Figure 1

AVERAGE ANNUAL BIRTH AND DEATH RATES BY FIVE-YEAR PERIODS
EL SALVADOR, 1900-1974

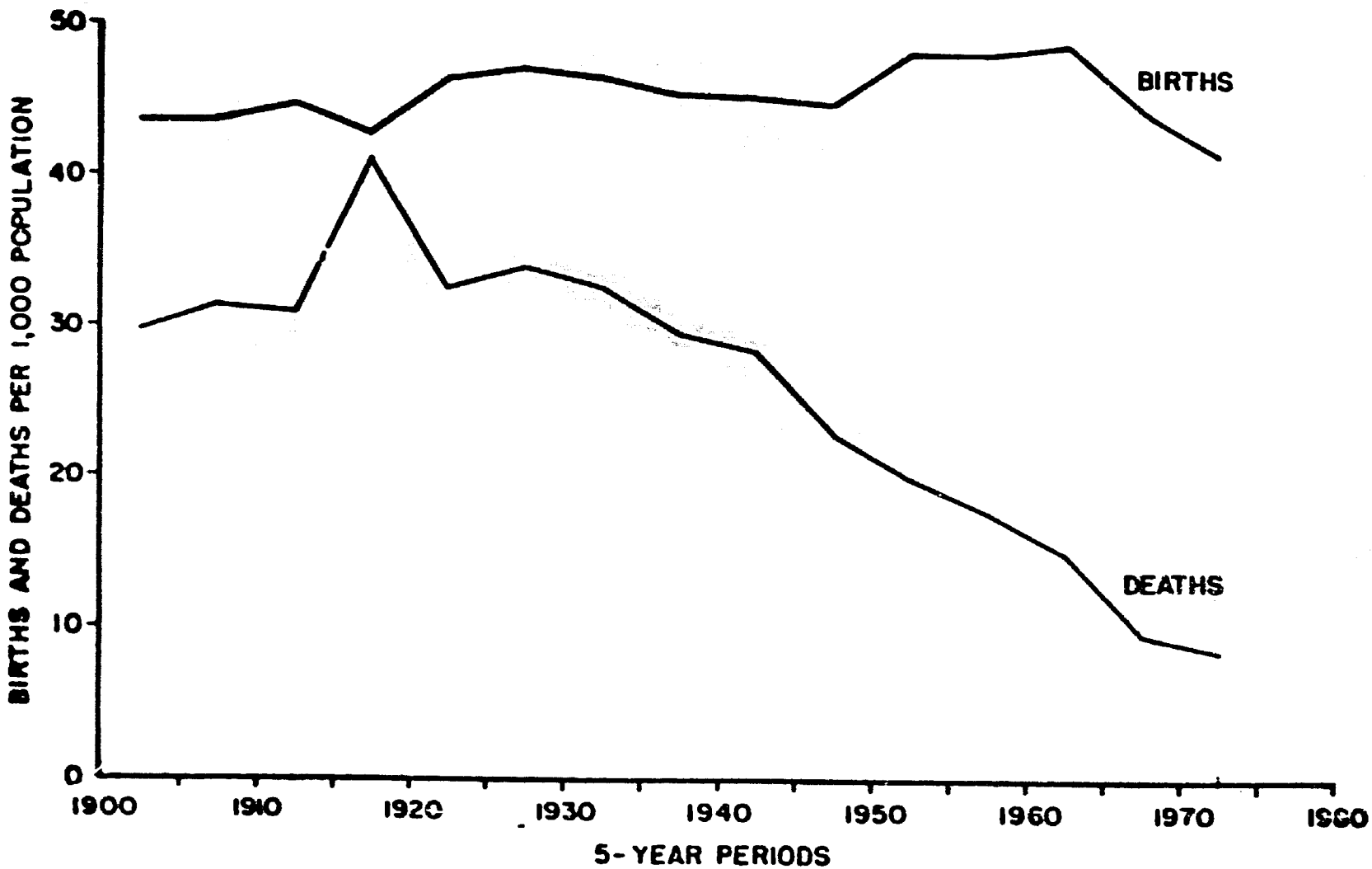


Table 2

SELECTED VITAL AND POPULATION DATA,
EL SALVADOR, 1960-1979

Year	Estimated Population (000s)	No. of Live Births	Crude Birth Rate[2]	Crude Death Rate[2]	Natural Increase (%)	IMR[4]
1960	2,454	121,403	49.5	15.0[3]	3.5	76.3
1961	2,527	124,871	49.4	15.0[3]	3.4	70.0
1962	2,627	127,154	48.4	15.0[3]	3.3	71.4
1963	2,720	133,395	49.0	15.0[3]	3.4	67.7
1964	2,824	133,072	47.1	15.0[3]	3.2	65.0
1965	2,928	137,430	46.9	10.6	3.6	70.6
1966	3,037	137,950	45.4	10.0	3.5	62.0
1967	3,151	139,955	44.4	9.2	3.5	63.1
1968	3,266	140,986	43.2	9.1	3.4	59.2
1969	3,390	142,699	42.1	9.9	3.2	63.3
1970	3,534	141,471	40.0	9.9	3.0	66.6
1971	3,555	154,309	43.4	8.1	3.5	52.5
1972	3,668	153,464	41.8	8.8	3.3	58.3
1973	3,771	155,632	41.3	8.5	3.3	59.1
1974	3,887	158,524	40.8	7.9	3.3	53.4
1975	4,005	159,731	39.9	7.9	3.2	58.1
1976	4,122	165,822	40.2	7.5	3.3	55.2
1977	4,255	177,531	41.7	7.8	3.4	59.3
1978	4,353	172,897	39.7	6.9	3.3	49.5
1979[1]	4,436	173,568	39.1	7.4	3.2	53.1

[1] Preliminary data
[2] Per 1,000 population
[3] Estimate prepared by the U.N. Economic Commission for Latin America; recorded rates were 11.4, 11.3, 11.5, 10.9, and 10.4.
[4] IMR: Infant Mortality Rate per 1,000 live births

Sources of Data

1. U.N. Demographic Yearbooks, 1966-1971.
2. Ministerio de Economia, Direccion General de Estadistica y Censos, Anuario Estadistico, 1971, Volumen II, Demografia y Salud, El Salvador, C.A., Noviembre de 1972.
3. Ministerio de Economia, Direccion General de Estadistica y Censos, Anuario Estadistico, 1972, Volumen II, Demografia y Salud, El Salvador, C.A., Diciembre de 1973.
4. Ministerio de Economia, Direccion General de Estadistica y Censos, Anuario Estadistico, 1974, Volumen II, El Salvador, C.A., Enero de 1977.
5. Ministerio de Economia, Direccion General de Estadistica y Censos, El Salvador en Cifras, 1977, El Salvador, C.A., Junio de 1977.
6. Ministerio de Economia, Direccion General de Estadistica y Censos, Anuario Estadistico, 1978, Columen II, El Salvador, C.A., 1979.

rate remains constant, it is estimated that the population of El Salvador will be 10 million in the year 2000. Considering that during the period 1975 through 1980 there has been a 20 percent increase in the number of women aged 15-44 and a 23 percent increase in the number of women aged 15-29, the population in 20 years could be well over 10 million.

Trends in Family Planning Services

Data on new admissions exist for the three institutions that form the public family planning program in El Salvador. These institutions are the Ministry of Public Health, the Salvadorean Demographic Association, and the Institute of Social Security of El Salvador. The term "new admissions" is used instead of "new acceptors" because a patient could be receiving services in more than one clinic and be counted in each clinic as "new." In addition, if a patient moves to another institution, he or she is counted as a new admission. Another source of duplication is the "re-admission," that is, the patient who has terminated participation in the family planning program but who becomes a user again and is counted as a new admission. It has been estimated that in this system the rate of duplication or over-enumeration is 20 percent (Morris, 1979).

Table 3 presents information on new admissions, by year and method of contraception, since the program began in El Salvador. The total number of new admissions is plotted in Figure 2. It can be seen that the first substantial increase--78 percent--was from 1968 to 1969. That increment continued through 1972, when the MOH implemented the family planning program in clinics throughout the country. The number of new admissions reached a plateau from 1971 through 1973. After 1973, the voluntary sterilization program started and the number of new admissions increased substantially (30 percent from 1973 to 1974). That increase was attributable to acceptance of the voluntary sterilization program in El Salvador. New admissions per year jumped from 43,100 in 1975 to almost 70,000 in 1978, for an increase of 55 percent during that period. There were 10,622 fewer new admissions in 1979 than in 1978, producing a decline of 16 percent.

The analysis of new acceptors by method shows interesting trends (see Figure 3). The voluntary sterilization program has had very good acceptance among women. The annual number of sterilizations has increased every year, except 1979, that showed a decline of 7 percent in the figure reported for the year before. The highest number of female sterilizations, 24,162, was reported in 1978.

The number of new acceptors of oral contraceptives increased until 1971, reached and maintained a plateau after 1973, then declined sharply during 1979.

The IUD has had a plateau throughout the history of the family planning program. Currently, the MCH/FP Division is planning to conduct several workshops on IUDs for the purpose of improving the attitude of clinical personnel toward this method.

Table 3

NEW ADMISSIONS BY YEAR AND METHOD OF CONTRACEPTION
EL SALVADOR, 1966-1979
(000s)

Year	Method of Contraception[1]				Total
	IUD	Orals	Sterilizations[2]	Other	
1966	4.8	1.2	-	0.1	6.1
1967	8.2	2.0	-	0.1	10.3
1968	7.6	6.6	-	0.1	14.4
1969	6.1	19.1	-	0.4	25.7
1970	4.1	24.2	-	0.6	29.0
1971	5.0	29.6	-	1.5	36.1
1972	7.4	26.9	0.4	2.1	36.8
1973	6.8	19.5	4.6	0.9	31.7
1974	7.6	24.3	5.7	3.7	41.3
1975	6.7	22.0	12.3	2.1	43.1
1976	8.2	24.9	15.0	4.1	52.2
1977	8.9	28.6	20.1	6.9	64.5
1978	8.1	28.5	24.2	6.1	66.9
1979[3]	7.2	23.2	22.4	3.5	56.3

1 Numbers for each method do not always add to country total because of rounding.
2 Sterilizations not reported until late 1972.
3 Preliminary data.

Source of Data: FESAL-78-Contraceptive Survey-1978, El Salvador: Salvadorean Demographic Association, August 1979.

Figure 2

ANNUAL NUMBER OF NEW ADMISSIONS, FAMILY PLANNING PROGRAM,
EL SALVADOR, 1966-1979

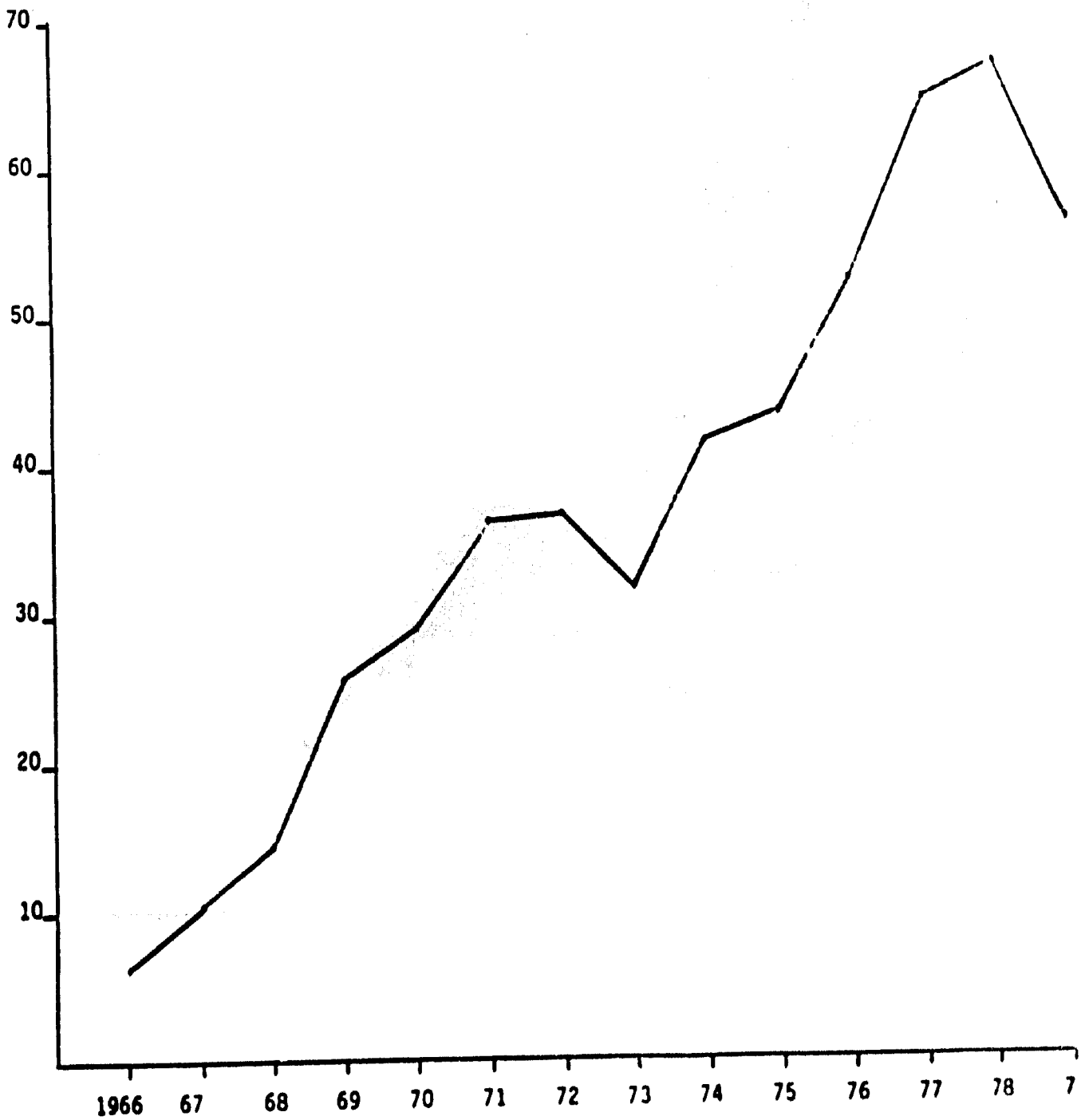
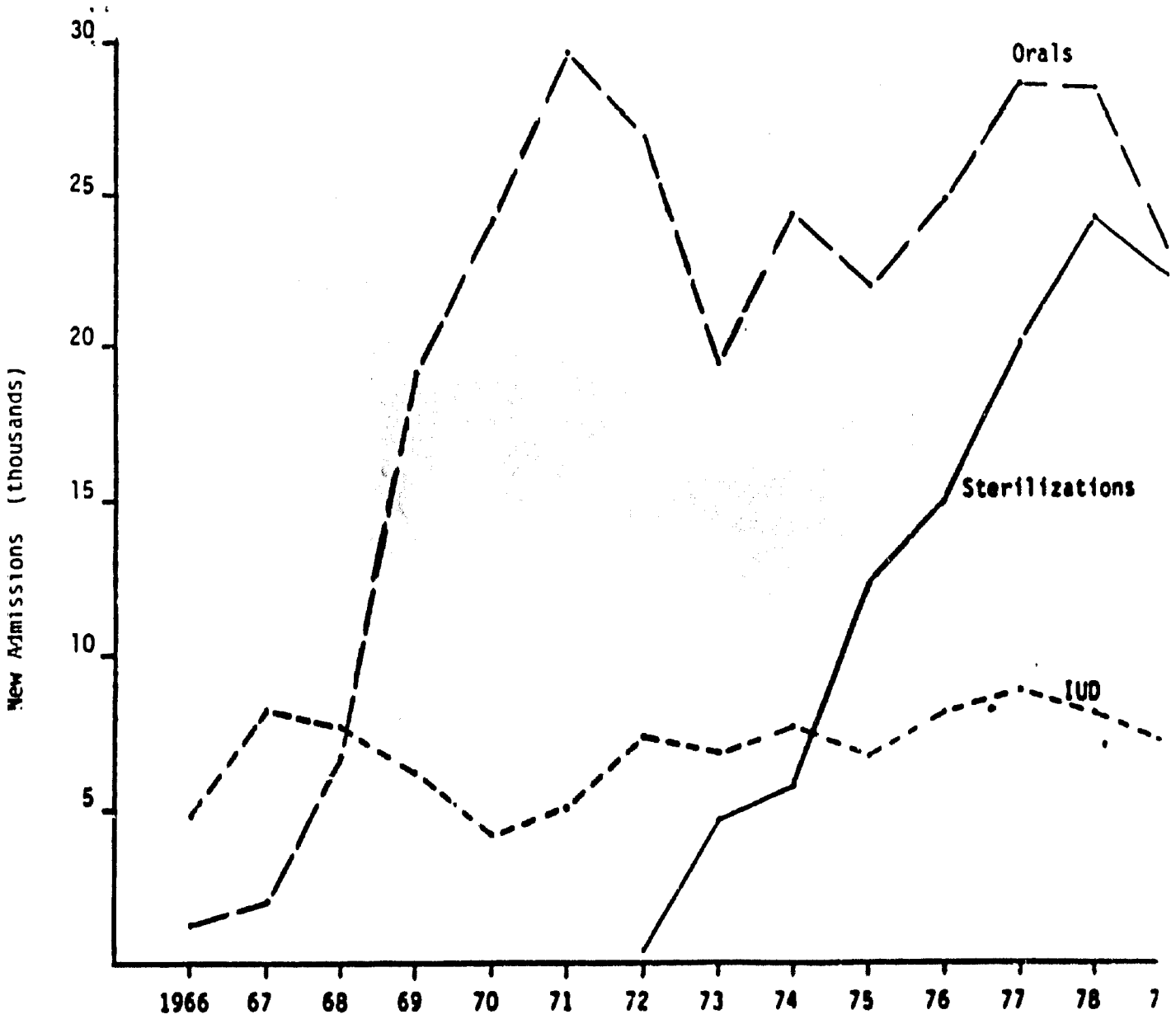


Figure 3

NEW ADMISSIONS, BY YEAR AND METHOD OF CONTRACEPTION,
EL SALVADOR, 1966-1979



Contraceptive Prevalence Surveys

Two contraceptive prevalence surveys were carried out recently, one in 1975 and one in 1978 (FESAL 1975 and FESAL 1978). Those surveys were conducted by the SDA with the cooperation of the MOH and with technical assistance from the CDC. The main objectives of the surveys were to obtain information on the use and source of contraceptives, the incidence of abortion, and fertility levels in rural and urban areas. Some of the findings are described here.

For the purposes of the surveys, the following definition of urban-rural residence was used: "Metropolitan Area: The area comprising San Salvador and the surrounding urban areas of Ayutustepeque, Cuscatancingo, Delgado, Ilopango, Mexicanos, San Marcos, and Soyapango." Urban areas are all other municipal capitals and rural areas are the rest of the country. The sampling frame was in a previous fertility survey conducted in 1973 (Rugamas, 1975).

Contraceptive Use by Age, Residence, and Method

In 1978, 34 percent of all women 15-44 years of age were using contraception. A definite variation of contraceptive use according to residence was found in both surveys. The percentage of women using contraception who live in the metropolitan area was 56 percent, as compared to 26 percent of women living in rural areas. The contraceptive method most frequently used was sterilization. Eighteen percent of all women were sterilized in 1978. Sterilization was chosen by 28 percent of the women living in the metropolitan area and by 15 percent of those living in the rural areas. Oral contraceptives were the second method of choice. Oral contraceptives were used by 9 percent of all women, 14 percent of women living in the metropolitan area, 12 percent of women from urban areas, and 6 percent of women from rural areas (see Table 4).

Interesting results are found in Table 5, which compares the method of contraception used in 1975 and 1978 by residence, education, and age groups. The number of sterilizations almost doubled between 1975 and 1978. There was an increase in the number of sterilizations in all areas of residence, and that increase was especially significant in rural areas, where the percentage more than doubled from 6 percent to 15 percent. Sterilization showed an increase in all age groups, except women under 20 years of age. Use of oral contraceptives increased only 1.4 percent from 1975 to 1978. Although the percentages are low, use of oral contraception increased most in the rural areas. It declined 4.2 percent in women 15-19 years of age. Use of the IUD increased only slightly from 1975 to 1978.

It is interesting to note that despite the fact that approximately 280,000 women became acceptors of oral contraceptives during a 14-year period (see Table 3), only about 78,000 women were using this method in 1978. This finding is consistent with low continuation of oral contraceptives found in El Salvador (Morris et al, 1979; Rugamas and Mendoza, 1976); the studies showed continuation rates of 63 percent and 50 percent at 12 months and 24 months, respectively.

A group of women who should be a priority for maternal and child health and family planning programs is women 15-19 years of age. Only 8 percent of these women are using some method of contraception, as shown in Table 6.

Table 4 1/

PERCENT OF CURRENTLY MARRIED WOMEN AGED 15-44*
CURRENTLY USING CONTRACEPTION, BY RESIDENCE AND METHOD,
EL SALVADOR, 1978

Method	Total	Metro San Salvador	Other Urban	Rural
Currently Using:	34.4	56.4	41.9	26.2
Sterilization	18.0	28.0	20.1	14.7
Orals	8.7	13.8	12.3	6.2
IUD	3.3	7.5	4.0	2.0
Rhythm	1.7	1.9	2.1	1.6
Condom	1.5	2.5	2.0	1.1
Other**	1.2	2.7	1.6	0.5
Not Currently Using:	65.6	43.6	58.1	73.5
TOTAL	100.0	100.0	100.0	100.0
Number of Cases (Unweighted)	1,476	375	441	660

*In this and subsequent tables, women in consensual unions are included as currently married.

**Other methods include injection, foam, withdrawal, and diaphragm.

NOTE: In this and subsequent tables, the subtotals may not add to totals due to rounding.

1/ **Source of Data:** FESAL-78-Contraceptive Survey-1978, El Salvador: Salvadorean Demographic Association, August 1979.

Table 5 [1/]

PERCENT OF CURRENTLY MARRIED WOMEN AGED 15-44
CURRENTLY USING CONTRACEPTION, BY METHOD,
EL SALVADOR, 1975 and 1978

	Sterilization			Orals			IUD			Condom		
	1975	1978	Difference	1975	1978	Difference	1975	1978	Difference	1975	1978	Difference
Total	9.7	18.0	8.3	7.3	8.7	1.4	2.0	3.3	1.3	0.6	1.5	0.9
Residence:												
Metro San Salvador	17.2	28.0	10.8	14.8	13.8	-1.0	5.2	7.5	2.3	2.4	2.5	0.1
Other Urban	12.6	20.1	7.5	10.5	12.3	1.8	1.2	4.0	2.8	0.2	2.0	1.8
Rural	6.4	14.7	8.3	4.0	6.2	2.2	1.6	2.0	0.8	0.3	1.1	0.8
Education:												
<Primary 3	7.6	15.5	7.9	4.6	6.5	1.9	1.4	2.9	1.5	0.2	0.6	0.4
Primary 4-6	14.2	23.7	9.5	13.6	11.6	-2.0	3.5	3.8	0.3	1.6	2.8	1.2
≥Secondary 7	15.1	20.8	5.7	13.9	14.9	1.0	3.6	4.4	0.8	1.8	4.3	2.5
Age:												
15-19	0.0	0.0	--	9.2	5.0	-4.2	0.0	1.0	1.0	0.8	1.5	0.7
20-24	2.2	11.7	9.5	8.0	14.7	6.7	2.6	2.7	0.1	0.7	2.6	1.9
25-29	12.4	24.2	11.8	9.5	10.7	1.2	2.6	2.4	-0.2	0.0	1.6	1.6
30-34	18.1	22.3	4.2	10.7	9.0	-1.7	2.6	4.0	1.4	1.5	1.0	0.5
35-39	11.5	26.0	14.5	4.7	4.7	0.0	3.0	4.7	1.7	0.4	0.9	0.5
40-44	6.3	16.9	10.6	2.5	2.2	-0.3	0.6	4.6	4.0	0.0	1.2	1.2

1/ Source of Data: FESAL-78-Contraceptive Study-1978, El Salvador: Salvadorean Demographic Association, August 1979.

Table 6 [1/]

PERCENT OF CURRENTLY MARRIED WOMEN AGED 15-49
USING CONTRACEPTION, BY AGE GROUP AND METHOD,
EL SALVADOR, 1978

Method	Age Group 15-19	20-24	25-29	30-34	35-39	40-44	45-49
Currently Using	8.3	33.3	43.7	38.3	40.6	29.0	21.6
Sterilization	0.0	11.7	24.2	22.3	26.0	16.9	12.4
Orals	5.0	14.7	10.7	9.0	4.7	2.2	6.9
IUD	1.0	2.7	2.4	4.0	4.7	4.6	1.7
Rhythm	0.0	0.8	3.8	0.5	3.8	0.9	0.6
Condom	1.5	2.6	1.6	1.0	0.9	1.2	0.0
Other*	0.8	0.8	1.0	1.5	0.5	3.2	0.0
Not Currently Using	91.7	66.7	56.3	61.7	59.4	71.0	78.4
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of Cases (Unweighted)	133	315	338	309	216	165	118

* Other methods include injection, foam, withdrawal, and diaphragm.

[1/] Source of Data: FESAL-78-Contraceptive Survey-1978, El Salvador: Salvadorean Demographic Association, August 1979.

Because of the high acceptance of sterilization in El Salvador, age of women and number of living children are important factors. Table 7 shows that 61 percent of sterilized women are 30 years of age and over and that only 9 percent of sterilized women have less than three living children.

A. Source of Contraceptive Services

The MOH provided 62 percent of all contraceptive methods used in El Salvador in 1978, an increase of 3 percent from 1975. In rural areas the MOH provides 75 percent of all contraceptives. The use of contraceptive methods provided by the ISSS declined 6 percent during the period under consideration. That decline was in the metropolitan and rural areas. Private physicians and pharmacies provide a low percentage of contraceptive methods, especially in rural areas (see Table 8).

B. Potential Use of Contraceptives in Rural Areas

The argument is that people living in rural areas like to have large families and that, consequently, use of contraceptive methods among them is low. This argument does not seem to be valid in El Salvador. Married women, not pregnant women, were asked if they wanted a pregnancy and only 20 percent of them answered positively. According to data presented in Table 10, 65 percent of the women living in rural areas did not want a pregnancy. The proportion was higher (72 percent) in the metroplitan area but lower in other urban areas. In other words, fewer women in rural areas than women in cities, except metropolitan San Salvador, want a pregnancy. Table 10 also shows that 49 percent of women who have had one delivery do not want another pregnancy and that only 18 percent or less of women who have had two or more deliveries want another pregnancy. It is obvious that women would prefer to have small families, regardless of the place of residence. If we consider that only 26 percent of women living in rural areas are using contraceptives (see Table 4), we have to conlude that the lack of family planning services in the rural areas is the main reason for the low proportion of contraceptive use among women living in those areas.

The information presented in Tables 11 through 14 further supports this conclusion. The tables show that the proportion of non-users who desire to use contraceptives methods is the same, regardless of place of residence. The highest proportion (53 percent) of women who live in rural areas and who have used contraceptives before desire to use them; the figure for women living in the metropolitan area is 22 percent and for women in urban areas 35 percent. The knowledge of availability of contraception in rural areas is very high, as is the knowledge of availability of sterilization. Table 14 shows that most of the women living in rural areas who do not want to have more children are interested in surgical contraception and have obtained information on the availability of services from the MOH. The finding for women living in urban areas is similar. All of this information seems to indicate that as soon as family planning services can be made available to women in rural areas, women will benefit from them.

Table 7 [1]

DEMOGRAPHIC PROFILE OF WOMEN USING FEMALE STERILIZATION
EL SALVADOR, 1978

Age Group	Percent Distribution
15-19	0.0
20-24	16.1
25-29	23.3
30-34	25.2
35-39	24.5
40-44	11.0
TOTAL	100.0
Number of Cases (Unweighted)	330

Number of Living Children	
0-1	1.3
2	7.9
3	27.3
4	14.2
5	15.5
6	10.5
7+	23.3
TOTAL	100.0
Number of Cases (Unweighted)	330

[1] Source of Data: FESAL-78-Contraceptive Survey-1978, El Salvador: Salvadorean Demographic Association, August 1979.

Table 8 1/

SOURCE OF CONTRACEPTION FOR CURRENT USERS, BY RESIDENCE, EL SALVADOR, 1975 and 1978

Source of Contraception	Total			Metro San Salvador			Other Urban			Rural		
	1975	1978	Difference	1975	1978	Difference	1975	1978	Difference	1975	1978	Differenc
Public												
Ministry of Health	58.8	61.7	2.9	35.2	38.1	2.9	65.4	59.4	-6.0	73.4	75.7	2.3
Social Security Institute	17.5	11.8	-5.7	31.5	23.0	-8.5	12.7	15.8	3.1	9.7	3.6	-6.1
Demographic Association	5.3	7.7	1.9	6.5	11.5	5.0	5.4	6.3	0.9	5.6	6.5	0.9
Private												
Pharmacy	9.1	7.2	-1.9	13.0	12.9	-0.1	10.0	6.9	-3.1	4.8	4.4	-0.4
Private Physician	4.7	5.1	0.4	7.4	10.4	3.0	3.6	4.4	0.8	3.2	2.7	-0.5
Not Applicable*	2.0	5.7	3.7	3.7	3.7	—	0.9	7.1	6.2	1.6	6.0	4.4
Other	2.0	0.7	-1.3	2.8	0.4	-2.4	1.8	0.2	-1.6	1.6	1.2	-0.4
TOTAL	100.0	100.0		100.0	100.0		100.0	100.0		100.0	100.0	
Public/Private Ratio**	5.9:1	6.6:1		3.6:1	3.1:1		6.1:1	7.2:1		11.1:1	12.1:1	

*Users of rhythm or withdrawal

**Public: Ministry of Health, Social Security Institute, Demographic Association
Private: Pharmacy, Private Physician

1/ Source of Data: FESAL-78-Contraceptive Survey-1978, El Salvador: Salvadorean Demographic Association, August 1979.

Table 9 1/

SOURCE OF CONTRACEPTION FOR CURRENT USERS OF STERILIZATION, ORALS, IUD, CONDOMS
CURRENTLY MARRIED WOMEN AGED 15-44
EL SALVADOR, 1975 and 1978
(Percent Distribution)

Source of Contraception	Total*			Sterilization			Orals			IUD			Condoms		
	1975	1978	Difference	1975	1978	Difference	1975	1978	Difference	1975	1978	% Change	1975	1978	Difference
Ministry of Health	58.8	61.7	2.9	70.2	69.1	-1.1	62.2	69.9	7.7	42.4	78.4	36.0	0.0	5.8	5.8
Social Security Institute	17.5	11.8	-5.7	18.4	15.2	-3.2	19.3	12.9	-6.4	24.2	3.9	-20.3	0.0	4.2	4.2
Demographic Association	5.8	7.7	1.9	5.1	10.6	5.5	3.4	3.8	0.4	21.2	12.8	-8.4	0.0	0.0	--
Pharmacy	9.1	7.2	-1.9	0.0	0.0	--	11.8	8.3	-3.5	0.0	0.0	--	80.0	83.3	3.3
Private Physician	4.7	5.1	0.4	5.1	4.6	-0.5	0.0	5.2	5.2	12.1	3.9	-8.2	0.0	0.0	--
Not Applicable**	2.0	5.7	3.7	0.0	0.0	--	0.8	0.0	-0.8	0.0	0.0	--	0.0	0.0	--
Other	2.0	0.7	-1.3	1.3	0.6	-0.7	2.5	0.0	-2.5	0.0	1.0	1.0	20.0	6.7	-13.3
TOTAL	100.0	100.0		100.0	100.0		100.0	100.0		100.0	100.0		100.0	100.0	
Public/Private Ratio***	5.9:1	6.6:1		18.4:1	20.6:1		7.2:1	6.4:1		7.2:1	24.4:1		0.0:1	0.1:1	

*Total included all methods
**Use of rhythm and withdrawal
***Public: Ministry of Health, Social Security Institute, Demographic Association
Private: Pharmacy, Private Physician

1/ Source of Data: FESAL-78-Contraceptive Survey-1978, El Salvador: Salvadorean Demographic Association, August 1979.

Table 10 [1/]

CURRENT PREGNANCY INTENTION, BY RESIDENCE AND PARITY,
CURRENTLY MARRIED WOMEN AGED 15-44,
EL SALVADOR, 1978
(Percent Distribution)

Pregnancy Intention	Total	Residence: Metro San Salvador	Residence: Other Urban	Residence: Rural	Parity: 0	Parity: 1	Parity: 2	Parity: 3	Parity: 4-5	Parity: 6-
Currently Pregnant	14.7	15.1	16.2	14.1	34.5	18.4	15.9	15.3	9.2	10.
Desire Pregnancy										
Yes	19.7	13.0	21.5	20.8	53.8	31.9	18.4	18.1	14.4	9.
No	65.4	71.5	62.2	65.1	11.7	49.0	65.6	66.6	76.4	80.
Don't Know	9.1	0.4	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.
Number of Women (Unweighted)	1,476	375	441	660	114	208	267	233	319	3:

[1/] Source of Data: FESAL-78-Contraceptive Survey-1978, El Salvador: Salvadorean Demographic Association, August 1979.

Table 11 [1/]

PERCENTAGE OF NON-USERS WHO DESIRE TO USE A CONTRACEPTIVE METHOD, BY PREVIOUS USE AND RESIDENCE, CURRENTLY MARRIED WOMEN AGED 15-44, EL SALVADOR, 1978

	Total	San Salvador	Urban	Rural
Percentage of All Non-Users Who Desire to Use a Contraceptive Method	26.3 (886)	26.0 (151)	21.7 (243)	27.7 (492)
Percentage of Past Users Who Desire to Use a Contraceptive Method	42.2 (208)	22.1 (63)	35.1 (69)	52.7 (76)
Percentage of Those Who Have Never Used Who Desire to Use a Contraceptive Method	22.4 (678)	28.8 (88)	17.6 (174)	23.0 (416)

NOTE: Unweighted number of cases shown in parenthesis.

1/ Source of Data: FESAL-78-Contraceptive Survey-1978, El Salvador: Demographic Association, August 1979.

Table 12 [1]

PERCENTAGE OF NON-USERS WHO HAVE KNOWLEDGE OF AVAILABILITY OF CONTRACEPTION, BY DESIRE TO USE A METHOD AND RESIDENCE, CURRENTLY MARRIED WOMEN AGED 15-44, EL SALVADOR, 1978

	Total	Metro San Salvador	Other Urban	Rural
Percentage of Non-Users Who Know Where to Obtain Contraceptive Method	80.9 (886)	93.7 (151)	85.7 (243)	77.7 (492)
Percentage of Non-Users Who Desire to Use Who Know Where to Obtain Contraceptive Method	87.5 (240)	92.6 (37)	82.2 (70)	87.3 (133)
Percentage of Non-Users Who Do Not Desire to Use Who Know Where to Obtain Contraceptive Method	78.6 (646)	94.1 (114)	86.6 (173)	73.5 (359)

NOTE: Unweighted number of cases shown in parenthesis.

[1] Source of Data: FESAL-78-Contraceptive Survey-1978, El Salvador: Salvadorean Demographic Association, August 1979.

Table 13 [1/]

KNOWLEDGE OF AVAILABILITY OF STERILIZATION SERVICES
OR PLACE WITH INFORMATION ABOUT STERILIZATION, BY RESIDENCE AND EDUCATION,
CURRENTLY MARRIED WOMEN AGED 15-44 WHO DO NOT WANT MORE CHILDREN
AND WHO ARE INTERESTED IN STERILIZATION,
EL SALVADOR, 1978

	Percentage With Knowledge of Availability	Number of Cases (Unweighted)
TOTAL	88.8	325
Residence		
Metro San Salvador	90.1	73
Other Urban	87.3	105
Rural	89.2	147
Education		
≤Primary 3	87.1	200
Primary 4-6	93.1	81
Secondary 7+	93.2	44

NOTE: This table excludes women who already have surgical contraception.

1/ Source of Data: FESAL-78-Contraceptive Survey-1978, El Salvador: Salvadorean Demographic Association, August 1979.

Table 14 1/

PERCENT WOMEN INTERESTED IN SURGICAL CONTRACEPTION
WITH KNOWLEDGE OF WHERE TO OBTAIN INFORMATION FOR PROCEDURE,
BY SOURCE OF INFORMATION, BY RESIDENCE,
CURRENTLY MARRIED WOMEN AGED 15-44 WHO DO NOT WANT MORE CHILDREN,
EL SALVADOR, 1978
(Percentage Distribution)

Source of Information	Total	Metro San Salvador	Other Urban	Rural
Ministry of Health	83.1	44.0	93.1	87.7
Demographic Association	8.6	28.0	3.9	6.3
Social Security Institute	4.6	17.1	2.7	2.6
Private Physician	1.6	11.0	0.3	0.0
Pharmacy	0.0	0.0	0.0	0.0
Hospital, Unspecified	0.8	0.0	0.0	1.3
Other/Unknown	1.3	0.0	0.0	2.0
TOTAL	100.0	100.0	100.0	100.0
Public/Private Ratio*	60.2:1	8.1:1	332.3:1	**
Number of Cases (Unweighted)	278	66	89	123

* Public: Ministry of Health, Demographic Association, Social Security Institute
Private: Private Physician, Pharmacy
** No Private

1/ Source of Data: FESAL-78-Contraceptive Survey-1978, El Salvador: Salvadorean Deomographic Association, August 1979.

Another interesting finding is that about two-thirds of of all women are interested in a community-based distribution program of contraceptives, regardless of place of residence and education (see Table 15). (The SDA Community-Based Distribution Program is discussed elsewhere in this report).

C. Abortion Data

FESAL 78 included several questions on abortion because of MOH interest in complications. The questions were not designed to differentiate between spontaneous and induced abortions because it was possible that the latter might be under-reported if direct questions about induced abortions were asked.

Information about abortion is presented in Tables 16 through 18. Overall, 20 percent of all married women have had at least one abortion. There is no significant difference by residence.

The percentage of women with complications following the most recent abortion who received medical attention was 54 in the country. The percentage was higher in San Salvador (83 percent) than in the rural areas (42 percent). The proportion of women who were hospitalized for complications following most recent abortions was almost the same in all urban areas, but considerably lower (27 percent) in rural areas.

Information about the place of treatment for abortion complications is presented in Table 18. Hospitals were the place of treatment for 72 of those who received medical attention. There were no significant differences by residence.

Almost 20 percent of women with abortion complications were treated by private physicians in urban areas, as compared to only 3 percent in rural areas. Midwives attended 17 percent of women with abortion complications in rural areas. This finding underscores the importance of training midwives.

Data on maternal deaths by cause of death are presented on Table 19. Deaths attributed to abortions represent about 11 percent of all maternal deaths.

D. Fertility

Data on fertility were obtained by asking pregnant women about the date of last delivery. According to FESAL 78, the crude birth rate estimated for 1978 was 43 per thousand for the whole country. The official crude birth rate reported for that year was 39.7 per thousand. Considering the under-registration of live births in the national system, the adjusted crude birth rate would be 43 per thousand. Similar results were found when FESAL 75 and official data were compared (Morris 1979).

Interesting results are found when FESAL 75 and FESAL 78 data (see Table 20) are compared. Although the same country crude birth rate was found in both years, the results by residence differed. The crude birth rate in metropolitan El Salvador declined from 34 per thousand in 1975 to 27 per thousand in 1978--a 20

Table 15 1/

INTEREST IN COMMUNITY-BASED DISTRIBUTION (CBD) PROGRAM,
BY RESIDENCE AND EDUCATION,
CURRENTLY MARRIED WOMEN AGED 15-44,
EL SALVADOR, 1978

	Percent Interest in CBD	Number of Cases (Unweighted)
TOTAL	65.5	1,169
Residence		
Metro San Salvador	69.1	266
Other Urban	62.4	338
Rural	65.8	565
Education		
<Primary 3	64.5	699
Primary 4-6	67.8	273
Secondary 7+	66.8	197

NOTE: This table excludes women who already have surgical contraception.

1/ Source of Data: FESAL-78 Contraceptive Survey-1978, El Salvador: Salvadorean Demographic Association, August 1979.

Table 16 [1]

PERCENT OF WOMEN AGED 15-44 WITH AT LEAST ONE ABORTION, SPONTANEOUS OR INDUCED, BY MARITAL STATUS AND RESIDENCE, EL SALVADOR, 1978

Marital Status	Total	Metro San Salvador	Other Urban	Rural
Married	19.9	18.8	16.2	21.6
Separated/Widow/ Divorced	7.4	16.3	5.4	5.7
Never Married	0.0	0.0	0.0	0.0
TOTAL	13.3	12.6	9.9	14.9
Number of Cases (Unweighted)				
Married	1,476	375	441	660
Separated/Widow/ Divorced	305	91	112	102
Never Married	377	129	129	119
TOTAL	2,158	595	682	881

1/ Source of Data: FESAL-78-Contraceptive Survey-1978, El Salvador: Salvadorean Demographic Association, August 1979.

Table 17 [1]

COMPLICATIONS FOLLOWING MOST RECENT ABORTION
FOR WOMEN AGED 15-44 WITH HISTORY OF ABORTION, BY RESIDENCE,
EL SALVADOR, 1978

Residence	Number of Cases	Percent Receiving Medical Attention	Percent Hospitalized
Total	339	*54.0*	*40.8*
Metro San Salvador	91	*83.2*	*68.1*
Other Urban	88	*70.3*	*64.2*
Rural	160	*41.9*	*27.0*

[1] Source of Data: FESAL-78-Contraceptive Survey-1978, El Salvador: Salvadorean Demographic Association, August 1979.

Table 18 [1]

PLACE OF TREATMENT FOR WOMEN AGED 15-44 WITH COMPLICATIONS FOLLOWING MOST RECENT ABORTION, BY RESIDENCE, EL SALVADOR 1978

Place of Treatment	Total	Metro San Salvador	Other Urban	Rural
Hospital	72.2	72.4	74.7	70.9
Health Center/Post	3.5	2.1	0.6	5.6
Private Physician	10.7	18.1	19.4	2.7
Midwife	10.2	2.1	5.3	16.6
Family	2.1	0.0	0.0	4.2
Other	1.4	5.3	0.0	0.0
TOTAL	100.0	100.0	100.0	100.0
Number of Cases (Unweighted)	209	76	61	72

[1] Source of Data: FESAL-78-Contraception Survey-1978, El Salvador: Salvadorean Demographic Association, August 1979.

Table 19

MATERNAL DEATHS BY CAUSE OF DEATH,
EL SALVADOR, 1972-1978

Cause of Death	1972	1973	1974	1975	1976	1977	1978
Toxic Pregnancy and Postpartum	15	13	15	15	18	13	11
Hemorrhaging during Pregnancy and Delivery	10	8	18	16	14	18	14
Other Abortions and Those not Specified	19	15	12	26	14	12	16
Septic Deliveries and Postpartum Infections	9	8	9	6	11	10	6
Other Pregnancies, Deliveries, and Postpartum Complications	127	98	97	85	74	100	85
TOTAL	180	142	151	148	131	153	132
Abortion Deaths / Maternal Deaths =	10.6%	10.6%	7.9%	17.6%	10.7%	7.8%	12.1%

Sources of Data:

1. Ministerio de Economia, Direccion General de Estadistica y Censos, Anuario Estadistico, 1973 y 1974, Columen II, Demografia y Salud, El Salvador, C.A., Diciembre de 1974 y Enero de 1977.
2. Ministerio de Salud Publica y Asistencia Social, Salud Publica en Cifras, 1975, El Salvador, C.A., 1977.
3. Ministerio de Economia, Direccion General de Estadistica y Censos, Anuario Estadistico 1975-1978, Volumen II, Demografia y Salud, El Salvador, C.A., 1975-1978.

Table 20

EL SALVADOR: RECENT CRUDE BIRTH RATES, VITAL REGISTRATION (FESAL 75 and FESAL 78)

Vital Registration

1972	41.8
1973	41.3
1974	40.8
1975	39.9
1976	40.2
1977	41.7
1978	39.7

FESAL Data

	Total	Metro	Other Urban	Rural
FESAL 75	43	34	36	49
FESAL 78	43	27	31	51

Sources: Vital Statistics: Direccion General de Estadisticas y Censos, Anuario Estadistica, 1976, Volume II, Table 221-01, p. 17.

FESAL 75, L. Morris et al., "Contraceptive Use and Demographic Trends in El Salvador," Studies in Family Planning, 10 February 1979, pp. 49-50.

FESAL 78.

percent decrease. In other urban areas, the decrease was 14 percent. The crude birth rate increased slightly in rural areas. The team questions whether the slight increase in rural areas (which account for 60 percent of the population) could offset the significant decrease in the metropolitan and rural areas (which account for 40 percent of the population).

E. Contraception Needed to Decrease Crude Birth Rate

An estimate of contraceptive users is needed to determine how many users should be protected to accomplish the national government goal of reducing the rate of natural increase to 2 percent. Anderson (1977) estimated the number of new acceptors needed to decrease the crude birth rate from 41 per thousand in 1975 to 30 per thousand in 1985. The variables that he considers in his estimations are new acceptors by method and age and continuation rates in El Salvador. According the Anderson, the number of active users of contraceptives should be 222,000 women 15-44 years of age, or approximately 38 percent of married women.

To cover the number of active users established by the Anderson model, the family planning program should reach 65,000 new acceptors each year. For the year 1979, there were a total of 56,000 "new admissions." However, given a 20 percent figure for over-counting and the high number of sterilizations (of users of permanent methods, and not of new admissions), the real number of new acceptors would be less than 46,000. Consequently, the family planning program has an annual deficit of about 20,000 new acceptors to reach the government goals.

In summary, the proportion of active users (34 percent) is well under the percentage needed to decrease the crude birth rate and the rate of natural increase of the population, and the proportion of new acceptors has to be increased substantially to reach that goal. There is a potential demand for family planning services in all residential areas, especially in the rural areas. (See Table 21.)

The team found that several studies on the El Salvador family planning program were recently conducted. Among the studies were an analysis of the family planning data system, contraceptive prevalence surveys, a patient-flow analysis, and a study of logistics. These studies are important in that they recommend ways and means to improve the services and management of the present family planning program, particularly the MOH program. With a few exceptions, the recommendations have not been acted upon by the agencies involved. Nor have the studies been compiled for easy access by persons interested in the results. The more recent studies should be compiled and analyzed so that the recommendations can be implemented.

Table 21 1/

EL SALVADOR: ESTIMATES OF GENERAL FERTILITY RATE, TOTAL FERTILITY RATE, AND CRUDE BIRTH RATE, BY RESIDENCE (FESAL 78)

	Total	Metro	Other Urban	Rural
GFR	208	106	142	272
TFR	6.3	2.6	4.1	8.4
CBR	43	27	31	51
95% Confidence Limits, CBR*	40-45	22-31	26-35	46-55

* Assumes simple random sampling.

1/ Source of Data: FESAL-78-Contraceptive Survey-1978, El Salvador: Salvadorean Demographic Association, August 1979.

IV. REVIEW OF FAMILY PLANNING ACTIVITIES IN EL SALVADOR

IV. REVIEW OF FAMILY PLANNING ACTIVITIES IN EL SALVADOR

Maternal and Child Health, Family Planning and Nutrition, Division of the Ministry of Public Health

The Maternal and Child Health Family Planning and Nutrition Division (MCH/FP/N) of the Ministry of Public Health is in charge of the government family planning program. MCH/FP/N began giving family planning services in 1968 in the Central Region and gradually covered the country through 1971. During that period, the Salvadorean Demographic Association transferred 33 family planning clinics to the MOH. Currently, the MCH/FP/N is responsible for the organization, planning, implementation, supervision, and evaluation of the MOH family planning program.

A. Organization

The MCH/FP/N Division is part of the Bureau of Technical Normative Services of the MOH. It has five sections (see organization chart, Appendix E).

The MCH/FP/N Division has a staff of 24: eight physicians, three nutritionists, three health educators, one social worker, one draftsman, one warehouseman, one accountant, and six secretaries. There are three obstetricians, two pediatricians, two public health physicians, and the director.

The MCH/FP/N Division has to coordinate its activities with the Bureau of Operative Services, which is essentially responsible for supervising the country's five health regions. Each of the regions has a central office and part of the staff of each central office comprises a multidisciplinary team of supervisors. The team supervises the health facilities where health services are provided. Four different types of health facilities exist: hospitals, which provide comprehensive health services; health centers, which are small hospitals that provide not only outpatient services, but also hospitalization, including surgery; health units; and health posts. The latter provide essentially outpatient services. One of the differences between health units and health posts is that the health units have medical personnel all week and the health posts have physician-services only some days of the week.

Currently, family planning services are provided at 10 hospitals, 9 health centers, 92 health units and 142 health posts, and 7 mobile units. There are 260 health facilities (see Table 22).

Sterilization services are provided at hospitals and health centers. Health units and health posts offer only temporary contraceptive methods.

Table 22

MINISTRY OF HEALTH FACILITIES OFFERING FAMILY PLANNING SERVICES
BY HEALTH REGION, 1979

Health Regions	Mobil Units	Hospitals	Health Centers	Health Units	Health Posts	TOTAL
Western	---	3	2	17	21	43
Central	---	2	-	15	38	55
Paracentral	---	2	3	12	29	46
Eastern	---	2	3	27	50	82
Metropolitan	7	1	1	21	4	34
TOTAL	7	10	9	92	142	260

Source: Ministry of Public Health and Social Assistance, Department of Health Statistics.

B. Norms and Procedures

The family planning program and procedures are described in a manual that was reviewed and updated in 1979. The most important aspects are summarized below.

Any person who requires family planning services will receive attention during working hours.

It is recommended that all IUD insertions be handled by physicians, new users be instructed, and follow-up provided. New users of orals can be initiated by physicians or nurses. It is recommended that auxiliary nurses be responsible for follow-up.

After the first visit, IUD patients are to be asked to return in six weeks for control and every year thereafter. Orals patients are to be followed up by the auxiliary nurse six weeks after the first visit and every six months thereafter. It is recommended that condoms be provided by any member of the health team upon request. The four criteria for termination of a patient from the family planning program are pregnancy, menopause, patient request, and two months after missing the last appointment.

According to the norms, the Rural Health Aide should work in his/her communities to promote and distribute oral contraceptives to continuing users and to distribute condoms upon request.

There are no norms and procedures for promotional activities for the family planning program.

C. Operational Problems

During the past few months, there have been several changes in the professional staff at MCH/FP/N. The director of the division has been in that position for about six months. The other two physicians have been working in the family planning program for five months and three weeks. The staffing changes have affected the management of the family planning program at the central level, and specifically the coordination and supervision of the clinics.

The low number of family planning patients in the clinics is attributable mainly to three factors: lack of community promotion, negative attitude of some physicians toward family planning, and clinic organization of patient services.

In August and September 1979, the MOH conducted a patient-flow analysis in 24 of its clinics. This study was conducted with technical assistance from CDC personnel. Preliminary data of that study show that patients must wait a long time for services. The average time for initial family planning patients ranged from 1 hour and 47 minutes in one clinic to 6 hours and 36 minutes in another. The average time for resupply ranged from 21 minutes to 4 hours and 23 minutes. The percentage of that time spent by all patients in contact with staff ranged from 9 percent to 29 percent.

As indicated in the patient-flow analysis, six problems led to long waiting periods:

"1. Patients were not served on a "first come-first served" basis.

2. Patients were served in a numerous short-duration contact.

3. Patients were scheduled, and arrived in large unmanageable numbers.

4. Patients were served in large groups.

5. Patients were scheduled to arrive earlier than the staff to serve them.

6. There appear to be no clear-cut protocols for serving patients with various service needs."

These problems, plus the fact that a patient attending a MOH clinic loses a day's pay, make attendance at a clinic unattractive. Thus, the best referral mechanism for patients (satisfied users) seems to be lacking in the MOH family planning program.

Some physicians working in the MOH family planning program have negative attitudes toward family planning. Negative attitudes are more prevalent among interns (physicians who have completed their school training and are working the obligatory year prior to graduation). These young physicians lack adequate training in family planning and have to be trained in it.

Another factor affecting the low coverage of the MOH family planning program is lack of promotion at the community level. Nurses in the clinics conduct promotion activities among the attending patients. Even this activity has low coverage if we consider the fact that only 6,983 and 6,167 women in the postpartum period were registered in the family planning program in 1977 and 1978, respectively.

The RHA could increase substantially the promotion of the family planning program. In the Western Health Region, there are 54 RHAs. Among their numerous activities is family planning promotion. During the first six months of 1980, RHAs referred 360 females for sterilizations and 40 men for vasectomies. The number of vasectomies is important if we consider that all MOH clinics performed only 277 vasectomies in 1978. One-third of the RHA-referred female sterilizations were done during a special Saturday clinic, when the regional office provided an ambulance for patient transportation. This is an example of what can be accomplished by enthusiastic personnel with adequate logistical support.

D. Health Education at Ministry of Health

The Health Sector Assessment completed in 1977 notes that Ministry of Health efforts in health education "are rendered ineffective by inadequately trained and motivated staff, shortages of materials and equipment, a lack of scheduling and coordination between health education and other health activities and the absence of institutionalized programs to involve the community in efforts to improve its general health status."[1] Though there are some indications that certain aspects of this situation began to change in 1980, this statement still accurately describes what is a global problem. The university initiated a specialty in health education in the medical school, but because of the lack of positions in this field, few students have elected to major in the subject. Thus, the majority of people working as health educators lack specialized training.

The Health Education Division of the MOH is responsible for the design, preparation, and dissemination of health education materials, instruction of personnel in techniques of health education, and supervision of regional health educators. The Division has drawn up a list of objectives and activities and has identified the principal obstacles to improvement of the health education program. Most of these obstacles are mentioned above, but emphasis should be given to the lack of clarity about health education within the MOH and to the lack of coordination with related organizations such as the Ministry of Education.

The division staff is small. There is a director, two education supervisors, two graphics technicians, and one audiovisual specialist. Though the staff appear to be enthusiastic and eager to use health education as an effective means of increasing use of MOH services and of improving health levels through preventive health care, they cannot begin to organize or implement an effective program to this end. Nor can they provide any significant assistance to regional health education supervisors. There are, at present, two or three such supervisors in each region; most have been trained in social work. Again, these individuals appear to be interested in integrating health education concepts into MOH activities, but they lack the training and the organizational support to do so. One regional health education supervisor observed that there is never enough time for preventive health education in the health facilities, and that insuficient time is allotted for training the local health team in health education at other than a perfunctory traditional level.

The family planning program takes a limited approach and allots limited time for staff training in health education. Human reproduction, population, basic motivational techniques (e.g., presenting talks to groups of women patients in health facilities), and contraceptive methods are covered, but the staff are not trained in substantive techniques for dealing with some of the major barriers

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[1] AID, Health Sector Assessment El Salvador, 1978.

to family planning usage and continuation (e.g., concern about side effects and male resistance). One health educator noted that MOH staff do not have a complete understanding of the meaning of family planning but rather are instructed in the "small family" ideal and the "demographic problem." Inadequate attention is given to the relationship of family planning to maternal-child health and nutrition, to the concept of child-spacing, and to the varying capacities and desires of individual families.

Though the Health Education Division views MCH/FP education as a priority, it has no direct relationship with MCH/FP Division health education staff. There are three health educators and one draftsman on the staff. As does the Health Education Division, this group develops projects and submits them to the Operative Division for approval. Once the projects are approved, the MCH/FP/N Division health educators provide technical assistance in project implementation. Because of the high levels of international support given to this division, these health educators are relatively well supplied with materials and equipment. Coordination between these two health education groups is not formalized, and mechanisms for internal MOH coordination in health education should be improved.

The MCH/FP health educators conduct annual workshops--at central, regional and local levels--on a family planning-related subject and they distribute a variety of FP materials to health facilities. There has been positive feedback on the materials from the field, and requests for MCH and nutrition materials have been submitted as well. The need for such materials is slowly being met through UNFPA funds.

One project recently designed by this group of health educators is an extension of previous motivational work with MOH clerical and logistical staff at the central office. These staff are encouraged to pick up condoms at a central location in the MOH building and to promote usage of the contraceptive among family and friends. The new project proposes that health facilities place cabinets with a supply of condoms in waiting rooms and in men's rooms to eliminate the need for special family planning consultation.

Another recently designed project is a two-week course for traditional midwives which includes a week of practical training in rural health facilities. An excellent manual has been designed for use in this course. Similar courses have been conducted in at least one region with assistance from the MCH/FP/N health educator.

Salvadorean Social Security Institute

The Salvadorean Social Security Institute (ISSS) is an autonomous agency responsible for the planning, management, and administration of the Salvadorean social insurance system. ISSS is supervised by a board of 12 directors, which includes the Minister of Labor, representatives of management and labor, and other professional groups.

The ISSS system provides workers and their families with insurance against illness, maternity, family planning, disability, old age, death, and involuntary termination of employment.

The impact of health services on the health status of the Salvadorean people is limited. Approximately 6 percent of the total population is covered by the social security system; over the next few years, coverage may increase 20 percent. Health services are provided through a network of hospitals and urban clinics.

ISSS provides full family planning services, including male and female sterilization. However, these services are limited because the Division of Family Planning is staffed by one physician. There is no other staff member or support staff. The physician in charge is responsible for the planning, implementation, and supervision of all ISSS family planning activities. The division is presently under the Department of Preventive Medicine and will soon be transferred to the Department of Ob/Gyn. The recently appointed chief of the Department of Ob/Gyn is also the president of the SDA. Plans are being formulated to strengthen the division with additional supervisory personnel and to expand family planning services to all ISSS hospitals and medical units. More emphasis will be put on motivation at the postpartum level and on sterilization services.

Family planning data are computerized, but because computer programmers and operators are under-trained, the data being retrieved are inaccurate and unusable by management.

With the advent of responsible leadership, the ISSS family planning program promises to be more responsive to the need for a viable family planning program. However, to be responsive the program requires technical assistance and small amounts of material support. Management plans to solicit international donor assistance to strengthen this activity.

Salvadorean Demographic Association

The Salvadorean Demographic Association, a private family planning association and an affiliate of the IPPF, continues to participate in a variety of population activities in El Salvador. The Board of Directors is "very active and, despite the difficult socio-political environment of the country, meets frequently to discuss policy issues."[2] Furthermore, since the current executive director took office in July 1979, an extremely high level of administration and staff communication has been maintained.

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[2] Asociacion Demografica Salvadorena, "Work-Program Budget 1981," Report to IPPF, New York.

The 1974 national population policy outlined the following role for the SDA:

--provide information, particularly via mass media;

--offer model clinical contraceptive and sterilization services;

--conduct evaluations; and

--carry out some training.

Subsequently, when the Population Technical Committee assigned responsibilities to various organizations, the SDA was requested to collaborate in population education and communication activities and to initiate a mass media campaign. These activities are discussed in the sections on individual projects which follow.

A. Clinic Services

Prior to 1967, only the SDA provided clinical family planning services in El Salvador. During the five-year period 1968-1973, the SDA transferred 33 family planning clinics to the Ministry of Health. Presently, the Association operates three urban clinics in San Salvador, Santa Tecla, and Santa Ana. Since 1977, three small rural clinics have operated in the cotton-raising eastern zone as part of the COASAL project. The 1979 family planning statistics of the three urban clinics are:

New Users	3,318
Continuing Users	49,172
Physician Consultations	18,562
Female Sterilizations	2,810
Vasectomies	305 3/

Among the contraceptive methods provided are orals, IUDs, condoms, spermicides, and vaginal tablets. Cancer detection screening is a routine part of the examination. The clinics appear to have an effective service statistics system which provides accurate statistical data and which uses an administrative feedback mechanism. However, unlike ISSS family planning data, figures for active users are not collected periodically or put on the computer. Tabulation is done by hand, but on a timely basis. Patients are still over-counted.

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3 Asociacion Demografica Salvadorena, 1979 Informed Anual de Labores.

An additional clinic is planned for San Miguel in the Eastern Region. This clinic, to be constructed in 1980, will be the referral point for the recently funded community-based distribution program discussed below. (Medical aspects of the sterilization project are covered in the section on sterilization activities.) The clinics that were observed were clean, well equipped, and efficiently run by a well trained staff of professionals and volunteers. Post-sterilization care is provided in a waiting area where beds are located.

Education/motivation is an integral part of SDA clinic and extension services; nurses provide most of the education in the benefits of family planning reproduction and contraceptive methods and receive backup support from the social workers. Each clinic also has staff members trained in sex education who can respond to patients' questions about family planning. (The SDA mass communications campaign encourages the public to ask questions.) Clinic staff appear to be well trained in family planning education, though there is no centralized coordination of this training through the Information and Education Department.

B. Mass Media

As mentioned previously, the SDA has been assigned the responsibility for all mass media communication activities in El Salvador. Working with a local advertising agency, the SDA has designed, tested, produced, and monitored a major IEC campaign through the media. AID began to support this project in 1976. Funding for the project ran out in mid-1980, but a new AID-SDA agreement for $134,150 over one year will permit the campaign to resume on July 16, 1980. Since mid-1979, a new concept has underlined the messages; today, the benefits of a small family ("Pro Familia") rather than the accessibility of SDA services are stressed.

The "Pro Familia" symbol is repeated in all components of this campaign and is displayed outside SDA facilities. "Pro Familia" calendars are displayed everywhere, even in home offices of rural health aides working in isolated areas. The strategy developed by the SDA in collaboration with the advertising agency under contract, Rumbo Publicity Agency, includes two stages: introduction of the "Pro-Familia" concept and education. Stage 2, now under implementation, focuses on the combination of a general education message (e.g., responsible parenthood, a good teacher, etc.) with more specific information on desirable actions to be taken (e.g., sex education with children). It includes messages on integrated population policy in an effort to motivate and inform the population of El Salvador's demographic situation. Twenty percent of the campaign budget is allocated to such population policy messages; the remaining 80 percent is for the "Pro Familia" campaign.

By attaching communications questions to the 1978 contraceptive prevalence survey, data were collected for an analysis of the ways in which Salvadoreans obtain information on family planning. This study showed that radio was the most effective medium. It identified some target groups

which had not yet been effectively reached by the campaign at that time. Particular importance was given to young women aged 15-19. Reasons for not using contraception were identified; male attitude and fear of side effects were identified as the most important. Subsequent SDA mass communications efforts have attempted to incorporate this information into the campaign design.

Some media time, as well as some press and bus space, are provided free to the SDA for this campaign; the 1977 campaign reached the population through the following media:4/

Media	Paid	Free	Total
Radio	31,560	31,560	63,120
TV Spots	41	41	82
Press Announcements	79	79	158
Bus Advertisements	768	30	798
Posters	36,488		36,488
Brochures	169,710		169,710
Flip Charts	813		813
Bulletins	515		515
Calendars	150,000		150,000
Miscellaneous Publications	927		927

C. Training of Young Facilitators

This project trains young volunteers, aged 15-20, to give talks and stimulate discussions in schools and community groups that request assistance. Two groups of facilitators have received 80 hours of theoretical training and approximately the same amount of practical preparation. Though 1,000 presentations were given in 1979, only 30 to 40 a month have been requested in recent months because of the political situation. The facilitators usually spend about one and one-half hours with the classes or groups and frequently use audiovisual aids. The themes which are frequently requested are population in El Salvador, origin and legal aspects of the family, human reproduction, family planning, contraceptive methods, psychosocial development, venereal disease, alcoholism, and drugs. Since most Salvadoreans have had minimum access to sex education in school (though recent adaptations in curricula by the Ministry of Education indicate that this is changing), this project provides a needed service to schools and organizations. Current decreases in activities should not be considered to be a reflection on project quality or utility. The financial support which this project has received from OXFAM will terminate in 1980.

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4 Ibid.

D. Community-Based Distribution (CBD)

Project COASAL, which began in September 1977, was designed to provide family planning information and services to the rural population in the cotton-raising coastal zone. First-year costs were paid by the Cotton Growers' Association. The project operates in three of the country's 14 departments with 47 distribution sites. Three full-time promoters distribute contraceptives and escort groups to the urban clinics for sterilization.

According to a recently signed (June 1980) agreement between the SDA and USAID/El Salvador, with a budget of $450,850, this project will be expanded to include coverage of all four departments in the Eastern Region and beyond the cotton-growing area. The four departments contain 30 percent of the country's population. Four state-level coordinators, 12 district-level promoters, and 12 nurse-auxiliaries will be trained to work in this project. Quantitative goals have been established to define the number of distribution sites, number of people to receive services, and number of patients to be referred for sterilization. In addition to referral and distribution, community meetings to promote family planning will be organized. A clinic providing voluntary sterilization services will be established in San Miguel with AVS funds, thus reducing greatly the transportation time that family planning users in this zone require to reach services.

The SDA, again with the collaboration of Rumbo Publicity Agency, has initiated the design of a communications campaign which will accompany the CBD project in the Eastern Region. In designing message content and presentation, a list of barriers to family planning acceptance in Latin America was developed using the field research being studied. Messages which attempt to deal with these barriers will be particularly appropriate for community-level health education.

E. Commercial Retail Sales (CRS)

Currently supported and managed by Development Associates, Inc. (DAI), this project will be absorbed by the SDA in December 1980. The project provides low-cost contraceptives in drugstores and small shops. Marketing techniques have been used to promote condoms (the "Condor" trademark) and oral contraceptives (the "Perla" trademark). Intensive radio campaigns (50,000 radio ads for Condor in 1979) have been conducted for each product. The products are distributed by three project promoters and a pharmaceutical distributor. Ninety-four percent of the country's 842 pharmacies and over 1,000 small shops carry the products. Similar marketing campaigns are planned for other contraceptive products, such as Neo-Sampoon and jellies. The objective of the campaigns is financial self-sufficiency through contraceptive sales. The SDA provided training to a group of pharmacists in support of this program; additional training is planned.

Another commercial project organized and implemented by the SDA involves installing and supplying vending machines for condoms and orals.

Condom machines were first installed in 1974 and are dispensing over 3,000 condoms a month. Machines for pills were first installed in 1977 and are now dispensing an average of 400 pill cycles a month. These efforts will continue and will complement the sales to pharmacies.

A Department of Social Marketing will be established within the SDA, which will manage both programs. A marketing expert who will head the department is already working with DAI on the transition of the project.

F. Training

The Association has taken advantage of training opportunities both in-country and abroad and, as a result, has an extremely well trained staff in all departments. (Staff training will be discussed in further detail in another section of this report.)

The Association has organized various courses for personnel from government agencies and private organizations and for community leaders. Ministry of Agriculture extension agents (both agronomists and home educators), malaria workers, nurse-auxiliaries, nurses, and social promoters have received such training. In 1979, 73 agronomists, 57 home educators, 5 club agents, and 6 rural supervisors were trained as one component of a project with the Agricultural Training Center. The project, however, was suspended because the current government has instructed agricultural field workers to concentrate on other issues, mainly agrarian reform, during the political crisis. Training was also provided in 1979 through workshops and seminars for teachers in the Ministry of Education's training program for laborers.

Groups of SDA volunteers have been trained as motivators of family planning services. At the end of 1979, such volunteer groups were working in four cities. The first training course for male volunteers and men who had had vasectomies was conducted in 1979.

G. Research and Evaluation

The Planning, Research and Evaluation Unit appears to be fully integrated into the Association's activities and to be responding to the needs of the various departments in designing the research to be conducted. The staff of this section is limited in size and should be expanded to meet increased program requirements. For example, in collaboration with the CDC, the unit is preparing for the evaluation of the CBD program in the eastern zone.

H. Funding

The Association has been successful in obtaining financial support from a variety of sources, both domestic and international. Of the 1979

budget of $741,000, 57 percent was supplied by the IPPF. In 1980, however, non-IPPF support is projected to decrease to 47 percent and in 1981 to 27 percent largely because of increasing support from AID.

Program Administration, Supply, and Logistical Systems

A. Maternal Child Health/Family Planning Division

The evaluation team analyzed and observed at the central, regional, and local levels the interrelationships of the administrative functions and how they affect the provision of materials and supplies needed to dispense family planning services to the people. It must be noted that field observations were restricted for security reasons and remote rural health facilities were not visited. However, the team was able to observe the central office, one regional office, and several semi-rural health facilities. The analysis of the administration, supply, and logistical systems and of their support of field activities was as complete as it could be, given circumstances beyond the control of the team and the Ministry. An analysis by functions follows.

1. Administrative Services

The director of the MCH/FP Division is Dr. Raul Moran Tejada. Dr. Tejada, recently appointed to this position, is responsible for planning, coordinating, and supervising the work of the MCH/FP Division at the central level. In addition, he is responsible for coordinating with the regional offices the division's field activities. He does not have direct responsibility for the supervision of field personnel. Supervisory responsibilities are directed from regional offices and hospitals.

The MCH/FP/N Division has a well trained and motivated central staff. However, the staff is small and its effectiveness, particularly in family planning, is limited.

There is no responsible entity in the MOH for family planning activities. The Minister and other high officials of the MOH are proposing to establish a Division of Population that would assume sole responsibility for population activities and which would report directly to the Minister. Another proposal is to establish a family planning section under the MCH/FP Division. Given the serious demographic problems of the country and the significant contributions from international donors to support population activities, one would think that the MOH would have a family planning office staffed with personnel who would have responsibilities for implementing family planning activities.

2. Supply and Logistical System

The MCH/FP Division stores and distributes the equipment, drugs, and contraceptives independent of the Ministry's system. However, the Ministry's central purchasing office is responsible for purchasing supplies not provided by international donors.

The team observed that at the regional and local levels, there was an adequate supply of contraceptives, equipment, and materials to carry out family planning activities. The physicians and nurses interviewed in the field indicated that there were sufficient family planning supplies. The team visited the central warehouse, which was well stocked; items were stored in an orderly fashion and inventoried in an efficient card system. The chief warehouseman had a thorough understanding of the system of receiving and disbursement. His chief complaint was obtaining transport to move supplies to the field. The team visited the regional warehouse at Santa Ana and found the same orderly situation as existed in the central warehouse. Storage space at local health facilities was, in most cases, small and overcrowded. Even so, family planning supplies were separated from other supplies and easily available to the staff. In all facilities it was noted that the inventory card system was up to date and standardized throughout the system.

Requisition of MCH/FP supplies has been standardized. Health facilities forward their requisitions to the MCH/FP central warehouse every three months. The requisition for MCH/FP supplies is first approved by the regional director and then by the director of the MCH/FP Division, and then forwarded to the warehouse for processing and delivery. Delivery to field facilities usually takes from 6 to 10 days, depending on the availability of transportation. It must be noted that the facilities visited were in close proximity to San Salvador.

The director of MCH/FP is concerned about delays in the purchase of supplies and transport. The present system takes advantage of lower prices for quantity purchasing. An average of 6 to 9 months is required to fill a request made at the institutional level. Delay occurs because it is required that the Ministry's Purchasing Committee require the approval of the Finance Ministry if the purchase price exceeds U.S. $1,000. The lack of transport to distribute supplies to the field is a major problem.

There was a large supply of condoms and oral contraceptives at the central warehouse. If the acceptor demand increases over the next few years, there will be no shortage of orals or condoms in El Salvador. (See Appendix B.)

Management of family planning activities at the central level should be strengthened, if coordination between the central, regional, and local health levels is to be improved. An office at the central level should have sole responsibility for family planning activities and should be staffed by professionals who would devote their full time to MOH family planning activities. Their responsibilities would be to supervise and coordinate voluntary sterilization, make evaluations, collect and analyze

family planning statistics, and coordinate activities with international agencies.

Because of the inadequacies of the transport systems of the MOH, the shipment of MCH/FP/N supplies to the regional and local health facilities is delayed and travel by supervisors and family planning referral patients is restricted. The cumbersome system for purchasing supplies and medicines delays delivery of such items for 6 to 8 months. Despite these logistical problems, the major health centers and field posts have adequate family planning supplies.

3. Finances

The 1979 budget of the MOH was $57 million, of which approximately $150,000 were allocated to the MCH/FP Division. The $150,000 figure is a summary budget which supports the division's activities. A breakdown of funds used specifically for MOH family planning activities was not available. It is assumed that the majority of MOH family planning activities was not available. It is assumed that the majority of MOH family planning activities is principally supported by UNFPA and AID. The MCH/FP Division has a full-time accountant whose responsibility is to keep account of MCH/FP and international donor funds.

With the assistance of the PAHO, the MOH has taken steps to adopt a programming budget system. The Ministry's initiative in this area is constrained by the national budgeting process, which is based on line-item forecasting.

4. Administrative Training

The majority of the field administrators and managers has no formalized training. No educational system exists in the country to satisfy this need.

B. Salvadorean Demographic Association

The team observed SDA administrative and management functions at the central office and in three clinics. The team visited the three SDA family planning clinics in San Salvador, Santa Tecla, and Santa Ana and observed clinic operations.

The management staff at the SDA is well trained and highly motivated, a reflection of the work of an active Board of Directors and the executive secretary. No defects that in any way hinder the field operations were observed by the evaluation team.

The organizational structure is illustrated in the chart in Appendix F.

1. SDA Administrative Services

The activities of the administrative department are the responsibility of the executive director. The functions of the department are to plan, direct, supervise, coordinate, and control the budget, accounts, and purchases and to support the field stations. It was observed that these services function smoothly. One problem that the team observed was the large staff that is presently on the SDA's payroll. The policy of the previous Board of Directors and executive secretaries was to hire more personnel than were needed. The labor laws of El Salvador make it difficult and expensive to lay off personnel without cause. The Board of Directors is hesitant to reduce the number of staff because there are insufficient funds for severance pay, which is required by law. Some of the extra personnel will be used in the expanding SDA Eastern Province Project.

2. SDA Supply and Logistical System

The three SDA clinics have adequate supplies and materials to support the routine services and the sterilization program. There is an adequate supply of materials, contraceptives, and surgical equipment at the central warehouse to support the three clinics. The clinics are close to the capital and facilities are available to transport supplies on short notice. The SDA transportation system is adequate to transport patients to clinics and to move supplies from the central warehouse, but when the program expands in the Eastern Province, there may be need for additional transport.

In sum, the administrative and logistical systems of the SDA are adequate and capable of supporting the SDA's present activities. Expansion will probably require additional transportation. The excellence of leadership and the supervisory structure allow for effective control over SDA activities.

Voluntary Sterilization Program

Sterilization services were formally introduced in the Salvadorean family planning program in July 1974 with the assistance of the Association of Voluntary Sterilization. Before 1974, women who wanted to be sterilized had to fulfill the following requirements: be 30 years of age or older, have five or more living children, obtain written authorization from the husband, and provide a blood or cash donation. Patients had to document their age and number of living children. The result of the requirements was sterilization of a low number of women, even though many women desired that procedure as a contraceptive method.

With the introduction of surgical procedures as part of the contraceptive method offered by the family planning program, the requirements for the sterilization of women changed to the following: be 30 years of age

and have one living child, or be 25 years of age and have two living children, or be any age and have three living children. The documentations on age and number of living children were eliminated, as were the requirements for the husband's authorization and any donations. These changes resulted in a substantial increase in the number of women being sterilized.

Another important factor that contributed in the sterilization program was the establishment of the national population policy in October 1974. That year, the MOH offered surgical procedures in 18 of its health facilities. By 1980, 35 clinics and hospitals were offering sterilization services throughout the country (see Table 23). The requirements for female sterilization changed again in 1979, when it was established that a woman needed only to have two living children to be sterilized.

All of these factors have resulted in the significant acceptance of sterilization as a means for not having more children (see Table 2 and Figure 1). The number of female sterilizations performed yearly doubled from 1975 to 1978, when 24,162 sterilizations were reported. The number of sterilizations declined 7 percent from 1978 to 1979.

As is shown in Table 24 and Figure 4, the number of vasectomies has remained small and constant.

Between July 1975 and June 1977, 24,267 women (approximately 3 percent of all ever-married women) in El Salvador obtained a tubal sterilization at Ministry of Health hospitals and clinics. In December 1976, a nationwide sample survey showed that 11 percent of all ever-married women aged 15-44 had undergone surgical contraception. However, through 1977, the expected decline in the crude birth rate, which has ranged between 39.9 and 41.8 per 1,000 population since 1972, did not occur.

Three retrospective studies were made by the MOH to determine the demographic characteristics of the women who obtained tubal sterilizations; the most successful methods of attracting women into the FP program; the reason the birth rate has failed to decline; and the psychosexual outcome of tubal ligation on women. In the first study, data were abstracted from the hospital consent forms of 24,267 women. In the second study, hospital charts of a 10 percent sample of this population were reviewed. Differing sample fractions based on the number of procedures performed by the hospital were used. The sampling fractions ranged from 1/2 to 1/20 of the patients in a given hospital. In the third study, a 50 percent random sample of the 2,580 women in the second study was selected for personal interviews. However, only a 50 percent completion rate was accomplished, leaving only 604 women available for more detailed analysis. These studies were made between October 1977 and March 1978. An analysis of the data obtained from the three studies was published in April 1978 by the Ministerio de Salud Publica y Assistencia Social de El Salvador in a report titled Evaluacion de Intervencion Quirurgica de Planificacion Familiar.

In May 1978, the MOH requested technical assistance from the CDC to further analyze the study data. The most important findings of that analysis are presented here. They were described by Paris and Conn in their December 1978 trip report (Paris and Conn, 1979).

Table 23

NUMBER OF CLINICS OFFERING FAMILY PLANNING SERVICES
EL SALVADOR, 1980

	Clinics Offering All Methods, Including Sterilizations	Clinics Offering All Methods, Except Sterilizations	Total
MOH	26	234	260
ISSS	6	29	35
AVS	3	0	3
TOTAL	35	263	298

Source: USAID/El Salvador.

Table 24

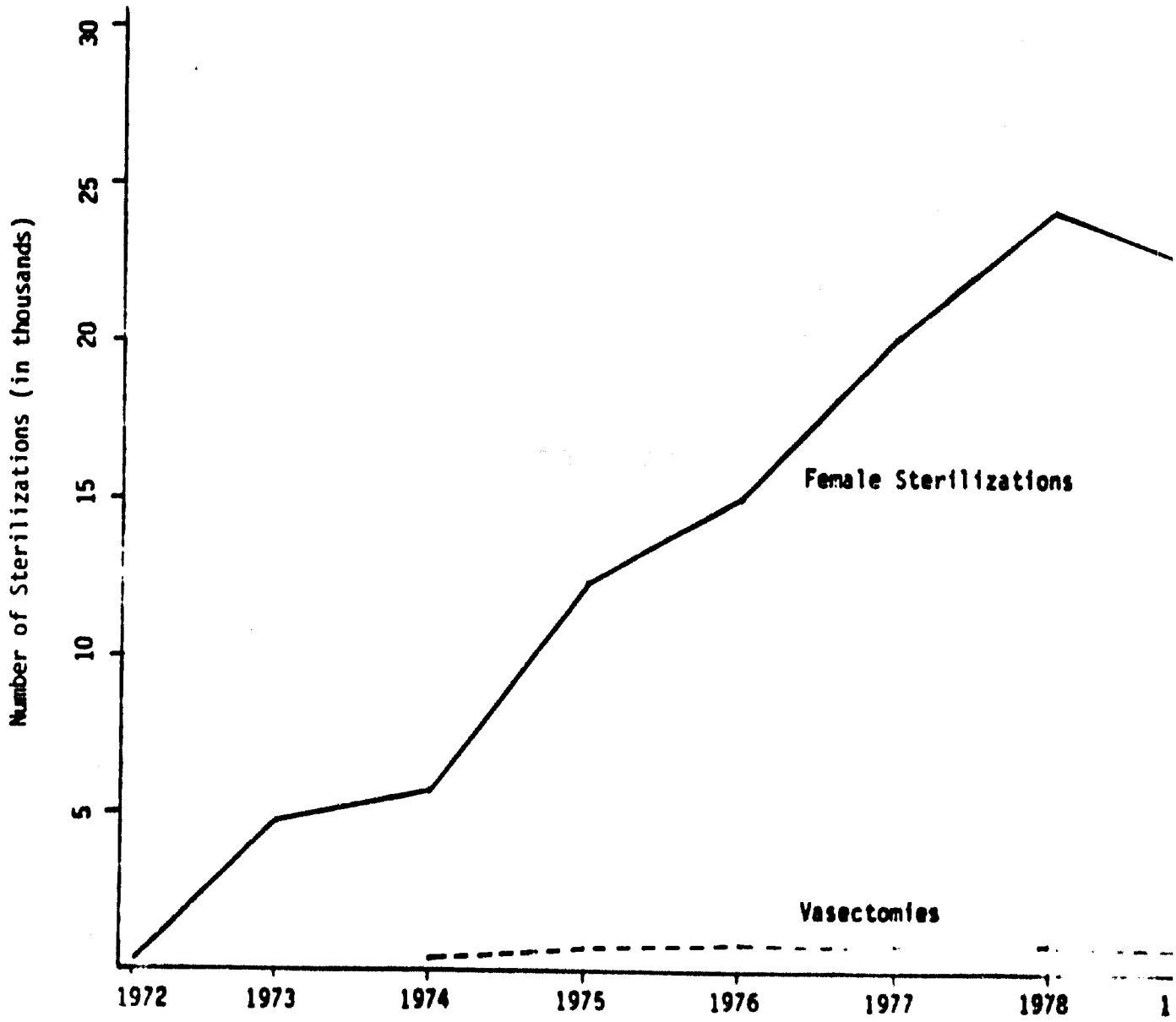
NUMBER OF STERILIZATIONS, BY INSTITUTION
EL SALVADOR, 1975-1979

Institution		1975	1976	1977	1978	1979
MOH	Female	9,195	12,047	15,792	18,585	17,307
	Male	127	260	267	277	197
ADS	Female	965	1,077	1,718	2,665	2,810
	Male	375	399	392	346	305
ISSS	Female	2,047	1,859	2,551	2,912	2,297
	Male	.68	92	113	254	149
TOTAL	Female	12,207	14,983	20,061	24,162	22,414
	Male	570	751	772	877	651

Source: USAID/El Salvador.

Figure 4

VOLUNTARY STERILIZATIONS, FAMILY PLANNING PROGRAM
EL SALVADOR, 1972-1979



A. Demographic and Socioeconomic Characteristics Of Patient Sample

The following is a summary of the most important characteristics of the women interviewed.

1. Urban - Rural Distribution

Forty-one percent of the women in the sample lived in urban areas and 59 percent lived in rural areas.

2. Previous Use of Contraceptive Methods

The form of contraception that each woman said was the primary contraceptive she had previously used was coded under previous use. The majority (55 percent) had never used any form of contraception; another 35 percent had used oral contraceptives; and the remaining 10 percent were distributed among the other methods. However, the percentage of women previously using contraception changed over time during the two-year period under discussion.

3. Duration of Use of Contraceptives

The 45 percent who had used some form of contraception were asked how long they had used that method. Fifty-one percent had used the stated method for more than 12 months and 35 percent for more than 24 months.

4. Age

The median age of the women was 30.8 years.

5. Gravidity and Number of Living Children

The median number of pregnancies in this sample was 5.7 and the median number of living children was 4.9.

6. Marital Status

The majority of the women in the sample either entered into a consensual union (54 percent) or a legal union (34 percent); only 12 percent were not currently in a permanent union.

7. Education

The majority of the women in the sample (67 percent) had completed between one and six years of school (39 percent had completed one to three years and 28 percent four to six years), while 26 percent had no formal education and seven percent had over six years.

8. Occupation

The majority of the women in the sample (55 percent) was not employed. The remainder was equally distributed among vendors (9.0 percent), domestic servants (6.0 percent), agricultural workers (8.3 percent), laborers (6.5 percent), and other low-paying workers (13.5 percent). Only 1.5 percent were employed as professional-administrative workers.

9. Economic Status

An index to evaluate the patient's economic status was derived from various questions on income, type of residence, and number of people living in the same room as the patient, and patients were classified as having either an adequate or inadequate economic status. The majority (93 percent) of the sample had an inadequate economic status.

B. Results of Selected Variables

1. Changes Over Time

The results of an analysis of many of the patients' characteristics over the two-year period (examined in six-month intervals) were as follows: The total number of procedures performed, the percentage of interval procedures performed, the percentage of younger women with potential higher gravidity who were brought into the program (low age at first pregnancy and women who were previously non-contraceptors) all increased over time. No change was found to occur over time in the following categories: education, marital status, number of living children, urban-rural residence, percentage of home deliveries, or outcome of last delivery. The percentage of tubal ligations performed as interval procedures increased from 27 percent between July and December 1975 to 45 percent from July 1976 to June 1977.

The median age of women in the sample decreased from 32.2 for the period July-December 1975 to 29.1 for the period January-July 1977, as can be seen in the following table.

Median Age for Each Time Period

	July-Dec 1975	Jan-June 1976	July-Dec 1976	Jan-June 1977	Total
Median Age	32.2	31.1	29.5	29.1	100.0
	n=114	n=132	n=161	n=180	n=587

The percentage of previous non-contraceptors who were being sterilized increased from 54 percent in the period July-December 1976 to 62 percent in the period January-June 1977.

The percentage of women with early first pregnancies (less than 20 years old) increased during the four time periods of the program from 57 percent during June-December 1975 to approximately 64 percent in the period January-June 1977. However, the median family size did not change during that period. Another important finding was that even though the program was designed to attract more rural women, no change was found to occur in urban-rural distribution during the four time periods.

2. Type of Procedure

Since the performance of interval (i.e., non-postpartum) tubal ligations may be expected to have a greater effect on the birth rate than postpartum tubal ligations, various variables were evaluated for their association with interval procedures. The following demographic factors were associated with a greater chance of receiving or seeking an interval procedure: being more educated, urban residence, having less than three children, having had the last delivery at home, and having been a previous contraceptor. The following factors did not influence the patient's chances of receiving or seeking an interval procedure: marital status, age, and outcome of last pregnancy.

3. Age

To have the greatest effect on efforts to reduce a country's birth rate, a sterilization program should attempt to attract women who have not yet reached a high gravidity. Since a woman's gravidity is highly associated with her age, it is also important to attract younger women into the program. To determine what variables were associated with the younger women who were receiving tubal ligations, age was cross-classified with region, marital status, and education. Younger women were found to more likely

receive tubal ligations if they were educated, unmarried, and living in Regions IV and V. (Some of these variables are discussed below.)

A higher percentage of the younger women (30 years old or younger) were married; 63 percent of the unmarried women were less than 31 years old, as compared with 50 percent of the married women for the same age group.

4. Previous Use of Contraception

For a sterilization program to have a lowering effect on a country's birth rate, it must attract women who are at risk of having additional pregnancies. Since women who are currently not contracepting are at a greater risk of having additional pregnancies, multiple cross-classifications were performed to determine which demographic characteristics were associated with the history of previous use of contraception. A history of previous use was found to be associated with: a higher education, a higher economic status, marriage, urban living, lower gravidity, work in the labor, administrative-professional-technical professions, work in the vendor fields, an increased chance of getting an interval procedure, and a shorter hospital stay. Previous use was not found to be associated with: place of last delivery, outcome of last pregnancy, or age. The only demographic factors associated with longer duration of use were: being older, having more than seven years of education, and living in urban areas.

5. Number of Living Children

To beneficially affect the birth rate, a sterilization procedure program should seek to attract women before they produce a large family. Therefore, various variables were evaluated to determine what demographic factors might be associated with a woman seeking a tubal ligation before she had obtained large family size. The women who sought a tubal ligation before obtaining a large family were more likely to have a higher education, to work in a professional, technical, or service field, to be urban, and to be younger. Non-associated factors were: marital status, economic status, bad outcome of last pregnancy, and duration of contraceptive use.

6. Urban-Rural Distribution

The rural women who received a tubal ligation had more pregnancies, had larger families, were slightly younger at first pregnancy, were more likely to have had their last delivery at home, and were less likely than urban women to live in Region V. Rural women were similar to urban women in the outcome of the last pregnancy, age, and marital status.

7. Place of Last Delivery

Since one index of an effective government-sponsored tubal ligation program may be how well it attracts women who had their last delivery at home (women who previously had possibly not been involved in the medical system), the place of last delivery was stratified against various demographic factors. The following women were more likely to have had a tubal ligation after a home delivery: those with a lower occupational level, lower economic levels, rural women, younger women, women with fewer living children, and women with lower gravidities (age may be a factor for the last two groups). The percentage of post-home deliveries did not change with marital status, previous contraceptive use, or time (even though the percentage of interval procedures changed with time).

As of 1977, the effect of the program on crude birth rates was as follows: Three recent studies suggest that the decrease in the birth rate--a result of this program--would be small at that point in time. The studies are discussed below.

The following is an excerpt from a paper on contraceptive prevalence surveys and their use in evaluations of FP programs.

> During the 18-month period between July 1975 and December 1976, the Ministry of Health in El Salvador provided surgical contraception services to approximately 18,000 women, or almost 4 percent of the married women of childbearing age, but no decline in the crude birth rate in 1977 was observed compared with either 1975 or 1976. Although prevalence surveys are scheduled at three-year intervals in El Salvador to provide data for program evaluation, a supplement was added to the December 1976 National Labor Force Survey to obtain current data on contraceptive use. There was an absolute increase of only 1.5 percent in use of contraception in the 18-month period between the two surveys (from 19.3 percent to 20.9 percent). The small overall net increase was due to a decrease in reliance on non-permanent methods of contraception while sterilization had increased. The usage of sterilization had increased by 4 percentage points, which was offset by a decrease in users of non-permanent methods of contraception of 2.5 percentage points. Thus, evidence was available to show that the increase in use of sterilization was not a net additive increase to total contraceptive use. The 1978 Contraceptive Prevalence Survey is currently under analysis and will provide updated information to measure program achievement or document the lack of program achievement.[1]

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[1] L. Morris et al., "The Use of Contraceptive Prevalence Surveys to Evaluate the Family Planning Program in El Salvador and Other Countries in Latin America," A Paper Presented at the Annual Conference of the Epidemiologic Intelligence Service, 1979.

According to one regression analysis, an increase of 2 to 6 percentage points in the proportion of couples using contraception reduces by one point the crude birth rate (Northman, D.L. and E. Hofstatter, Population and Family Planning Program (9th Edition), New York, Population Council, 1978). Since the 25,000 women sterilized in El Salvador represent only 5 percent to 6 percent of the married women of reproductive age in El Salvador, the crude birth rate would only be expected to drop one point at most. However, in light of the data discussed above, an absolute increase of only 1.5 percent in the use of contraception would be expected to result in a decline of less than one point in the birth rate.

In a recent evaluation of data on the 1971-1975 sterilization program in Panama (marriage duration-specific birth rates and birth rates specific for duration since the birth of the last-wanted child were used), it was found that the number of births averted by sterilization ranged from 0.8 births per woman to 1.1 births per woman. If these data were applied to the El Salvador program, the total number of births averted would be 25,000. Since these births would not have all occurred in one year--they would have been spread over the remaining 10 to 15 years of reproductive life--one could expect to see very little change in the crude birth rate in one to two years (Westoff, C., J. McCarthy, N. Goldman, and F. Mascarin, "Contraceptive Sterilization and Births Averted in Panama"; unpublished data).

According to Paris and Conn, results of the present survey also indicate that a decline in the 1977 birth rate should not have been expected. The results indicated that women who received a tubal sterilization in the first year of the program were older, of a higher gravidity, and better contraceptors and that they therefore had a lower fertility potential than women who had the operation in the second year of the program. It would be expected that women sterilized in the first year of the program would not have had as many potential births averted by sterilization as women sterilized in the second year. A decline in the birth rate in 1978 should be indicative of the averted births of the second group. However, according to data presented in this report in the section on "Demographic Trends and Use of Contraceptives," the expected effect did not occur. Unfortunately, no data are available on continuation rates for women who used temporary methods in 1978 and 1979 or on the characteristics of patients who were sterilized during those years. It would be useful to know the ages and parity characteristics of these groups.

As the data presented in this section show, there is need to focus family planning resources on families with high fertility potential. If the objective of the government program is to rapidly reduce the birth rate, priority should be given to outreach and promotion activities to provide family planning services to younger women with low parity and, specifically, to women 15 to 24 years of age.

Program Statistics

The family planning program in El Salvador does not have a unified data system that provides periodically accurate program statistics.

National data of the family planning program must be viewed with caution because of the large number of duplications and over-enumeration. It is estimated that the figures for new admissiona have been over-counted by 20 percent (Morris, 1979). Duplication occurs for the following reasons: When a patient is seen in a clinic for the first time, she is classified as a "new admission." That means that, if the patient receives services in more than one clinic, she is counted as a new admission in each clinic. Duplication also occurs when a patient changes institutions; for example, a patient receiving services in a MOH clinic might move to a SDA clinic. Patients who have discontinued contraceptive methods for any reason and who begin receiving family planning services again are also counted as new admissions, and not as readmissions to the program. There is no mechanism to determine the actual number of new acceptors (patients who have never used contraceptives before) and readmissions.

Another deficiency of the family planning program data system is the inaccuracy of active-users statistics. According to the MOH norms, a patient should be considered to have been terminated in the program if she missed her last appointment for more than two months. This norm is not always enforced and many patients who should be considered inactive are counted as active users.

Several studies made before 1976 show that the number of active users reported by the program was over-counted by 40 percent to 50 percent (Morris, 1979).

The two contraceptive surveys conducted in 1975 and 1978 (FESAL 75 and FESAL 78) provided useful information to measure program achievement, or the lack of it. The results of those surveys, as well as the findings of a study on sterilization services, are discussed elsewhere in this report. The studies provided useful information on the effect the program had in the past. However, they did not provide a mechanism to monitor periodically the program to determine whether the tasks planned to reach the government population goals are being achieved.

Taking into consideration the considerable duplication of patients, the family planning program as of 1979 had a deficit of about 20,000 new acceptors per year. (See section on "Trends" in this report.) This fact, the fact that the sterilization program is reaching older women who have three or more living children, and the low continuation rates for oral contraceptives explain why the family planning program in El Salvador has not affected the crude birth rate.

Ministry of Health Rural Health Aide Program

The MOH initiated its Rural Health Aide Program in 1976. This new category of health personnel was established to provide outreach and some primary health care services in rural areas. RHAs are responsible for preventive care through the education of rural families in general health. Maternal-child health and nutrition are emphasized. In addition, RHAs promote improved use of health facilities through education and referral.

The activities of the RHAs include:

--collection of data on all families in the area, including information on age of family members, family planning practice, infant mortality, and water and waste disposal systems;

--selection of 100 families (on the basis of sanitary and economic conditions, presence of women of fertile age, and number of children under 5) on which to focus activities;

--health education through home visits and group meetings;

--referral to health facilities, especially for pre- and postnatal care and well-baby care, with emphasis on vaccination, malnutrition, and family planning;

--delivery of contraceptives (condoms and subsequent cycles of orals); anti-parasitic medication; symptomatic treatment for muscle aches, mild diarrhea, and eye infections; and intramuscular injections as prescribed by medical officer; and

--first aid.

The RHAs are selected from the community where they will work and participate in a 10-week training course designed and implemented by the Public Health Training School. Graduates become salaried MOH employees. As of July 1980, 340 positions for RHAs existed. Only 260 of these positions have been filled. Thre has been a spate of resignations in rural areas because of the political situation. Plans are to expand this program to include over 1,000 rural health aides by 1982.

The responsibility for supervising the RHAs has been transferred recently from the malaria workers to a team of supervisors who, in turn, are supervised by the staff of the regional health office. At present, each supervisor covers approximately 10 RHAs and visits each community twice a month. Supervisors also receive training at the Health Training School. The supervisory system appears to function quite effectively, though the degree to which it has been integrated into the system of health posts centers, and units varies from region to region.

Although the program is well designed, with practical objectives in areas essential for improved health levels in rural areas, opinion varies as to how successful it has been, particularly in family planning. Critics claim that RHAs have made few [illegible]rrals for family planning to MOH health facilities and have distribut[illegible] few condoms and pills. Although a comprehensive evaluation of th[illegible]ram[1] indicates that few referral cards

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[1] Ministerio de Salud Publica y Asistencia Social, Division MCH/FP/N, Informe Final de la II Evaluacion del Programa de Ayudantes Rurales de Salud, 1980.

from RHAs are received in health posts in all four rural health regions, the main source of family planning information in the community is reported to be the RHA. Furthermore, the RHAs indicate that they spend the greatest percentage (29 percent) of their time on family planning, that family planning is the activity most needed by the community (22 percent), but that it is also the area in which it is most difficult to work (33 percent).

In reviewing the findings of a team that visited the field, the authors conclude that implementation of this program, particularly in collaboration with MOH facilities, varies among the regions. For example, in the Central Region, where the program is strongly supported, there is close and continual coordination between the RHAs and the health posts, with RHAs working one day a week at the posts and, at the same time, receiving on-the-job training and supervision. In some other districts it appears that health post workers have relatively little contact with RHAs.

It would not be judicious to evaluate RHA performance only on the basis of the number of referral cards received at health posts because many communities have access, by bus, to several health care facilities. For example, the people of Canton Nazaret in Department La Libertad are referred to the nearest health post, which takes about an hour to reach on foot. The hospital in Santa Tecla, however, can be reached by bus in less than an hour and a person can take care of other business while in the city. Thus, referral to the hospital becomes the most attractive alternative. Since hospitals are administered separately from the rural health infrastructure, they do not process the RHAs' referral cards. There are numerous examples of lost referral cards and other problems in each region, despite patient follow-up.

RHAs have a problem with health facility schedules and finding available physicians. When a woman is referred by a RHA for family planning and travels for several hours to a health post only to be told that the doctor's schedule is full or that she will have to wait six hours, she is likely to take her referral card home and to take the RHA's advice less seriously in the future.

RHAs in general appear to be well trained and well supervised. Salary levels are high enough and rural employment opportunities scarce enough that before the increase in political activity in rural areas, there was virtually no turnover. Part of the RHA's job is to know who is practicing family planning in the districts. The RHAs who were contacted not only knew this information, but they had identified what they thought were the obstacles that were preventing certain families from practicing and were trying to overcome these obstacles through continuing education and through the provision of additional materials appropriate for the target population. One obstacle cited by RHAs is lack of transportation to escort men and women to sterilization facilities. When vehicles were provided on Fridays and Saturdays in some parts of the Western Region, sterilization rates increased significantly.

Staff Training

A. Ministry of Health

The MOH Training Department, part of the Department of Human Resources, is made up of three units:

- Nurse Training Unit (responsible for the three nursing schools and the three nurse auxiliary courses)
- Continuing Education and In-Service Training Unit
- Health Training School.

The Health Training School designs and implements training in primary health care, administration, and integrated health care. The school has placed strong emphasis on family planning information and motivation. The Office of Primary Health Care conducts training programs for RHAs, RHA supervisors, and traditional midwives. The courses appear to be well designed and responsive to the needs of the various MOH units and of field staff. However, the school can only respond to requests from offices within the Ministry and it cannot initiate courses for which it identifies a need through its training experiences. The director and his staff work hard and have experience in the design and implementation of training programs. It would seem that they are in an excellent position to play a larger role in the determination of training needs, and particularly follow-up and continuing education.

Nurse-auxiliaries receive a year of training and then spend a year in a MOH health facility before they are licensed. Nurse-auxiliaries began to be integrated into the system in the 1950s and they appear to be functioning as effective members of rural health teams and as caretakers of health posts on days when the physician is rotated to another health post. During their years of theoretical training, they receive some training in family planning promotion and service delivery to provide backup to the physicians. The MCH/FP Division has identified the need for additional auxiliaries trained in family planning. Several courses have been provided for the auxiliaries by the Health Training School.

The Health Training School, again in response to a request from the MCH/FP/N Division, initiated a training program for maternal child health/family planning nurses in 1976. Between 1976 and 1978, five 12-week courses were given to 63 practicing nurses. This new category of specialized nurses has helped to meet the demand for qualified non-physician personnel within the MOH and the community's demand for MCH/FP services. However, the MOH has decided that instead of creating specialized nurse categories it prefers to integrate the curriculum for these nurses into the MCH courses at the nursing schools. To this end, nursing instructors are now working with staff of the Health Training School. In three years, all graduating nurses

will have received a significantly increased number of hours of MCH family planning training. Another reason that may underly the MOH's decision to terminate the specialized nursing courses is the severe shortage of nurses throughout the country. It is anticipated that 200 rural health nursing posts will remain unfilled in 1981. It would be difficult for the MOH to release working nurses for the 12 weeks of training.

Training of RHAs and RHA supervisors appears to be comprehensive and effective. Though the supervisory system provides for some in-service training, refresher courses for both categories of personnel should be encouraged, and particular emphasis should be placed on program coordination/backup support and on continuing motivation in family planning. Refresher courses could provide a forum at which to address such pressing issues as lack of program coordination, rumors about side effects, male resistance, and religious/cultural resistance. Other members of health teams working with rural populations should be included in this training.

The course of study for physicians includes a one-year rotating internship and a year of social service, usually in a rural health unit or as a member of a mobile team serving several health posts. During the rotating internship, 10 weeks are set aside for public health training, and two of these weeks are devoted to training at the Health Training School. Two days are set aside for family planning training.

The MOH recognizes that the training described above is inadequate and does not prepare young physicians for the reality of work in rural areas. Certainly, insufficient attention is given to the provision of family planning advice and service. Some physicians receive in-service training in IUD insertion and sterilization during the rotating internship and some have been provided with short-term specialized training. The MOH intends to systematize training for these graduating physicians. Such training is planned as part of the UNFPA-supported MCH/FP project.

The MOH has made several efforts to integrate traditional midwives into the formal health systems. RHAs are instructed to contact the local midwives, to work with them in prenatal care and delivery, and to educate the midwives in family planning. Nurses and auxiliary nurses also are encouraged to collaborate with the midwives. In 1979 the Health Training School held a course in community distribution of contraceptives for midwives. Some of the trainees have been functioning effectively as distributors of contraceptives. Additional courses are planned as part of the UNFPA-sponsored MCH/FP project.

Also planned for the UNFPA project are the above-mentioned courses in family planning for medical students, sterilization training for physicians, and additional training for nurses, auxiliaries, and rural health volunteers.

B. SDA

There has been little staff turnover, and the SDA has taken advantage of training opportunities abroad. In addition, the SDA has developed

its own model sterilization training program and has reached a level of sophisticated service delivery and outreach programming that enables it to provide much of its own staff training. Courses are regularly given for physicians, nurses, auxiliaries, and social workers, with additional trainees coming from family planning programs in other Central American countries. In the early 1970s, as SDA clinics were transferred to the MCH, the SDA also provided refresher training to MOH personnel.

In recent years, many SDA staff members have attended "Pro Familia" training workshops in Colombia. All three supervising nurses in the urban clinics have attended more than one course abroad and have worked with SDA for over eight years. Thus, other than the training of CBD staff for the Eastern Region project, no large-scale efforts are needed or foreseen for staff training within the SDA. However, SDA staff should be encouraged to maintain these high training levels through participation in courses abroad and through the organization of seminars and workshops in El Salvador. Family planning personnel from GOES should be included in these activities.

National Population Commission

The National Population Commission (NPC) was established by Decree 20 (see Appendix G) in 1974. This was the first national commitment to population planning. The NPC was placed under the Office of the President and was transferred in 1977 to the Ministry of Planning and Coordination of Economic and Social Planning by Decree 29 (see Appendix H). The NPC is technically the highest level government organization that deals with demographic matters.

The NPC is served by a Technical Committee for Population (TCP) which is composed of the heads of all public and private institutions concerned with population issues. The TCP undertakes the necessary studies for population formulation, proposes alternative measures, and executes the decisions of the NPC. Decrees 20 and 29 are wide ranging in their assignment of responsibilities and activities; the NPC is instructed to find ways to improve nutrition, reduce the rates of mortality and morbidity, and improve employment opportunities and the general socioeconomic condition of women. The 1978-1982 Development Plan explicitly incorporates the goal of fertility reduction for the first time.

The TCP is headed by a full-time chairman and convenes weekly. The four content areas covered are family planning, nutrition, international migration, and mass communication. The TCP is empowered to coordinate the activities of the public and private agencies working in these four areas and to provide a stimulus for future activities. It also oversees the specific programs on population/family planning that are identified in the National Development Plan.

The scope of work for the TCP covers the following areas:

--integrated education;

--integrated health services;

--employment and development of human resources;

--institutional structure for population activities;

--population legislation;

--migration;

--population research and evaluation;

--regional development;

--development and conservation of natural resources; and

--social communication.

The present staff of the TCP is one director, one economist, one social worker, two demographers, and one communications technician. These professionals' primary responsibilities are to coordinate with the public and private agencies the planning stages of the diversified programs proposed for funding by international donors. The staff recently updated a 1974 policy paper to better define and clarify the role, function, and responsibility of the TCP. There is a definite need for a prestigious professional assistant at the director level who can provide technical and administrative support to the director and staff and who can be a driving force in the effort to build collaborative relationships with other organizations.

The demographic situation in El Salvador requires that all public and private sectors coordinate their efforts to plan and implement population programs that are directed at reducing the fertility rate. The TCP has a legal mandate to assume the role to support relationships that would contribute to improved communications and increased coordination between the TCP, the public and private sectors, and the international donors and to resolve and minimize conflicts or problems among these organizations.

Reinforcing the leadership role and augmenting the professional staff of the TCP could be crucial to the establishment of a viable organization that would assume the principal role of ensuring that national population activities are implemented in accordance with the population policies established by the National Population Commission.

AID recently approved a proposal of the Population Technical Committee of the Ministry of Planning to conduct a one-year, $200,000 umbrella project in population education. The overall project will move beyond an educational approach to family planning to institutionalization of a broad-based population education concept to be adopted by a variety of institutions. Among the predicted results of this program are heightened awareness

among agency staff and the rural population of the national demographic/ecological problem and elimination of some barriers to family planning acceptance.

This ambitious project requires coordination at all stages with the Ministries of Education, Agriculture, and Health and Interior, and with the ISSS and SDA. Specific training plans are to be developed by an inter-institutional technical team. A three-stage multiplier effect will result in 200 trained technicians/supervisors and 800 trained promoters. Training will be provided in workshops, seminars, conferences, etc., in family life and family planning, sex education and family planning, demography, ecology, and materials development and use.

If successfully implemented, the project will fill an important gap identified by the team: the lack of substantive inter-institutional cooperation at central and local levels. This project could provide the pivotal vehicle for moving beyond a limited approach to population education and for instituting the coordinated extension of the mass communication campaign. However, past experiences with inter-institutional efforts spearheaded by the Population Technical Committee cast doubt on the feasibility of implementing the project. The formation and functioning of the technical team will be determining factors in the implementation of the project. Thus, it is suggested that every effort be made to provide this group with the necessary training and technical assistance.

External Donors

A. AID

Among the bilateral and multilateral donors, AID has played an important role in support of national population programs. AID bilateral population assistance, from the initial Population Project in 1966 through fiscal year 1980, has totaled $5.6 million (see Table 25). The objective of AID's assistance has been to strengthen the institutional capacity of the public and private agencies to enable them to make available family planning information and services. Specifically, AID bilateral assistance has been concentrated in five areas: technical assistance, provision of contraceptive supplies, primary support for voluntary sterilization programs, support for the development of the family planning infrastructure, and support for training of personnel to provide family planning services, including administrators, physicians, nurses, and rural health aides. AID's development assistance to population activities in El Salvador is basically compatible with the major socioeconomic development programs of the GOES.

In conjunction with the UNFPA, IPPF, and other donors and grantees, AID has contributed substantial assistance to the Ministry of Health MCH/FP/N Division to achieve its objectives. AID was responsible for the MOH's assumption of an increasing proportion of the program budget.

Table 25

CUMULATIVE USAID/ES POPULATION AND FAMILY PLANNING PROJECT FUNDING 1/

Institution	Year	USAID Grant Money	TOTAL
Salvadorean Demographic Association	1966	$ 30,000	
	1967	89,000	
	1968	87,000	
	1969	99,000	
	1970	93,000	
	1971	90,000	
	1972	119,177	
	1973	125,713	
	1974	113,000	
	1975	--	
	1976	23,407	
	1977	284,010	
	1978	117,461	
	1979	271,486	
	1980	650,000	
		SUB-TOTAL	$2,191,254
Ministry of Health	1968	192,700	
	1969	215,000	
	1970	302,795	
	1971	200,000	
	1972	199,170	
	1973	103,800	
	1974	136,200	
	1975	193,469	
	1976	196,000	
	1977	244,667	
	1978	447,000	
	1979	266,221	
		SUB-TOTAL	$2,697,022
Salvadorean Social Security Institute	1970	70,000	
	1971	101,285	
	1972	39,488	
	1973	95,800	
	1974	39,100	
	1975	33,000	
	1976	8,735	
	1977	31,323	
		SUB-TOTAL	$ 418,731

Table 25, cont.

Institution	Year	USAID Grant Money	TOTAL
Union Comunal	1971	$ 3,000	
	1972	9,650	
	1973	--	
	1974	--	
	1975	--	
	1976	27,590	
		SUB-TOTAL	$ 45,240
Ministry of Planning	1979	58,564	
	1980	200,000	
		SUB-TOTAL	$ 258,564
		GRAND TOTAL	$ 5,610,811

1/ Lic. Roberto Chavez B., USAID/El Salvador.

In addition to direct support to the MOH, AID also has provided direct support to other GOES agencies, such as the ISSS, the SDA, and the Ministry of Planning. AID has contributed directly and indirectly to the support of non-governmental and private sector organizations that have played a significant role in the national effort; for example, the SDA receives support from the IPPF, DAI, and AVS which, in turn, receive support from AID.

B. UNFPA

Support has been provided by the UNFPA to the Ministry of Health's MCH/FP Program since 1975. The MCH/FP project, which previously had been executed by the Population Council, was expanded considerably in the new four-year proposal approved in August 1979. The Ministry of Health is directly responsible for the implementation of project activities; occasionally it receives from PAHO technical assistance in administration, health education, and research and evaluation. Three million dollars have been allocated for this project; approximately $1 million will be used to provide salary support for national personnel and $1.4 million will be used for equipment.

Project activities are organized under seven mutually reinforcing subprograms: clinical activities, primary health care in rural areas, provision of technical assistance in family planning to other government institutions, clinical and primary health care training, information/education, research and evaluation, and administration. Nearly all the national positions financed by the UNFPA are to be absorbed by the government during the following year. An additional $355,000 of rephased funds from the previous MCH/FP project will be used to construct or modernize and equip four regional health training centers; construction is scheduled to begin in late 1980.

The UNFPA is also supporting the population census, scheduled to be conducted in late 1980. While the census project appears to be proceeding according to schedule, the MCH/FP project was experiencing a low implementation rate in June 1980, largely because of the political situation in the country. The assumption by the MOH of direct execution has undoubtedly contributed to delays in implementation as the MCH/FP/N Division begins to organize its staff to absorb the administrative aspects of the project.

C. IPPF

The IPPF continues to support various program activities of the SDA, its local affiliate. However, the percentage of the SDA budget contributed by the IPPF was reduced from 57 percent in 1979 to 47 percent in 1980, and it is projected to be reduced to 27 percent in 1981. The SDA projects supported by the IPPF in 1980 include the operation of clinics, special projects (private physicians and contraceptive vending machines), training, project evaluation, administration, and volunteer activities. The IPPF's total contribution to the SDA in 1980 was $428,291.

D. Non-Governmental Agencies

Non-governmental agencies have over the past years provided funds to public and private agencies in El Salvador for the development and implementation of the various population activities that the bilateral donors did not directly fund. Programs supported by these agencies were designed to fit their specific technical capabilities and to fill program gaps not suitable for bilateral support for one reason or another. In some cases, these agencies supported short-term activities to meet current needs. Others are continually providing technical backup requested from the government or private agencies.

Responsibility for monitoring and managing non-governmental agencies' inputs is shared by the host country recipient agencies and AID. Many of the agencies that provide assistance are centrally-funded AID grantees and contractors whose activities in El Salvador are monitored by USAID/ES. The National Population Committee was directed to coordinate the activities of the non-governmental agencies with those of the host country recipients. The committee has not effectively assumed this role and at times it has been counterproductive.

The evaluation team did not have time to evaluate the performance of all the agencies now actively implementing programs. (The IPPF, a major donor, is discussed separately.) The team's opinion is that IPPF support and programs have been technically sound and their implementation as good as can be expected given the difficult socio-political situation that has existed in the past few years.

The Program of International Education in Gynecology and Obstetrics at Johns Hopkins (JHPIEGO) and the Association for Voluntary Sterilization have provided adequate support in training, equipment and technical assistance to those Salvadorean agencies concerned with the national voluntary sterilization program.

The International Fertility Research Program (IFRP) has conducted evaluation studies of family planning services and has initiated several clinical studies of contraceptive techniques.

The Center for Disease Control (CDC) has produced over the past few years some excellent technical studies requested by USAID and the GOES. The team's concerns are that these studies have been underutilized and that many of the recommendations have not been implemented.

Over the past years, numerous non-governmental agencies have contributed to the development of El Salvador's population effort. A majority of these agencies was responsive to the needs of the times when their technical capability was most helpful. A few of these agencies failed in their tasks for reasons the team did not investigate. Overall, the team feels that the non-governmental agencies have provided invaluable program and technical resources; they have focused on specific program categories and thus

enabled the recipients to experiment with, develop, and implement activities that otherwise would not have been initiated under bilateral and multilateral grants.

Grant funds contributed by USAID to support family planning projects in El Salvador are listed in Table 25 by institution and year (see pages 80-81).

V. RECOMMENDATIONS

V. RECOMMENDATIONS

Recommendation 1

With AID assistance, the Ministry of Health should take steps to implement priority actions to strengthen and expand the capabilities of the Ministry's family planning program.

A. Rationale

The team found that there was no entity or staff member within the MCH/FP/N Division with sole responsibility for the MOH family planning program, with the exception of the director of the division. The director has many responsibilities other than family planning and cannot devote sufficient time or effort to the FP program. This is also true of the MCH/FP/N supervisory staff. International donors and the Ministry of Health allocate a large amount of financial and material resources to family planning and consider this program to be of the utmost importance. This should justify these agencies' contacting a responsible institution or person with knowledge of the program to plan and implement activities. The team observed that, with the exception of the director of the MCH/FP/N Division, no other staff member has complete knowledge of program activities.

The present data collection system is not adequate at either the field or central level. The system is providing inaccurate data on the acceptors, and the data are not being analyzed to provide an administrative or evaluation tool to correct problems in the program. To maintain a viable ongoing program, continued in-service evaluation is required. This, in turn, requires accurate data on patient statistics.

The team observed that the present services at the family planning clinic need to be improved so that better services can be provided to family planning acceptors. Professional technical supervision of these services is spotty. The family planning acceptors are not receiving the type of services that are conducive for their return to the clinic; hence, there is a large dropout rate. Periodic supervision and the establishment of more accessible schedules would help to alleviate many of the existing problems.

B. Implementation

The evaluation team identified areas where immediate action would strengthen and improve the Ministry of Health's family planning program. These actions are as follows:

1. Recommended Ministry of Health Action

- A separate entity should be established within the Ministry and given sole responsibility for implementing, managing, and coordinating the family planning program.

- The MOH should assign to the above office a technically qualified staff of professionals and the necessary support staff, whose sole responsibilities would be to direct, manage, supervise, and evaluate the implementation of MOH family planning activities.

- Internal evaluation criteria for continual reviews of the program's progress in accomplishing program objectives should be established.

- The present family planning data system should be reviewed to correct the over-counting of new and active users and to use other information, such as contraceptive prevalence studies, patient-flow analysis, and contraceptive inventory and flow, to provide information which management can use as an administrative tool to evaluate and to improve the clinics' family planning services.

- The objective should be the improvement of the quality of services at existing family planning clinics before the expansion of the present service system is considered. The following actions, some of which are discussed in detail in other recommendations, should be taken:

  a. Establish a mechanism for periodic family planning supervision from the central office to regional and local levels.

  b. Develop simplified criteria for clinic procedures to improve the attention and care given to family planning patients. An effort to resolve the problem identified in this report in the discussion of patient-flow analysis should be especially emphasized. (See Chapter IV, pages 48-49.)

  c. Delegate to the trained nurses and auxiliary health personnel more responsibility for family planning clinic operation and patient care, in accordance with the criteria established at the central level for

the possible provision of the initial cycle of oral contraceptives and insertion of IUDs.

d. Develop new educational materials for the Rural Health Aide Program so that RHAs can become more efficient in motivating individuals (person-to-person) in the remote, rural areas of the country.

e. Develop motivation/education activities that would be focused principally at the health facility level and the postpartum period at hospitals and health centers.

f. Establish a system of transportation that would provide MCH/FP referrals from selected remote, rural areas with access to the services available at MOH health facilities.

g. Direct program outreach and promotion activities to provide family planning services to younger women with low parity, specifically, women 15 to 24 years of age.

h. Train administrative staff.

i. Develop administrative-operational procedures that define the duties and responsibilities of the administrative staff.

j. Coordinate regional supervision with central office management and technical staff.

2. Recommended AID Action

- Salary support for personnel of the central level office should be provided, taking into account the salary support provided by UNFPA (i.e., supervisors and top management).
- Provide technical assistance in administration and data collection and analysis to support the family planning office as required and requested by the MOH.
- Provide in-country personnel training at the central, regional, and local levels to improve the collection and analysis of family planning data.

Using the members' overall analysis and observations, the team identified areas in this recommendation that require urgent action by the MOH.

Action on these recommendations should be the criterion with which AID determines future assistance to the MOH family planning program. The team recommends that the MOH take immediate steps to initiate these recommendations and that AID support this effort financially and technically (support is subject to availability of funds).

Recommendation 2

A national demographic research program that would provide demographic, population, and socioeconomic information to support future strategy and a planning and evaluation capacity for the national population institutions should be developed. Inter-institutional coordination should be promoted to ensure a coordinated effort in developing and implementing the national population programs.

A. Rationale

The team came across recent studies and reports that covered many aspects of the demographic situation and program activities. The principal studies were funded by AID, UNFPA, UNDP, and The World Bank. Neither international nor national institutions have made a concerted attempt to assimilate, analyze, or use most of this wealth of information. The information in these reports could be of great value to planners, international and national, in developing future directions for El Salvador's population programs. The team identified priority research areas that the national population planners suggested would supply substantive information useful in the formulation of new strategies in population development. These are as follows:

- Evaluation of the performance of the national population program.
- Studies on the demographic effects of migration and emigration.
- Determination of barriers to the adoption and practice of family planning.
- Studies on adolescent fertility.
- Analyses of past studies or determinants of fertility behavior.
- Analyses of the impact of the recently introduced CBD program.

Coordination between the various national institutions implementing family planning programs is seriously lacking and has been a recognized problem for some time. The lack of coordination between these institutions was still evident when this evaluation was made.

B. Implementation

The Technical Committee for Population should be used to coordinate the research efforts suggested here. The participation of those institutions represented on the TCP and of other institutions that have a research capability and past experience should be encouraged. Research personnel from the various institutions could collaborate on research design, collection and analysis of data, and dissemination of research findings. The TCP should provide the necessary research and specific additional personnel as required and obtain access to computer personnel and facilities.

UNFPA is supporting the creation of a unit in the Directorate of Statistics and Census which will analyze population data from the 1980 census. Once census data are collected and analyzed, the human resources from this unit could apply their technical skills and experience to these research efforts.

UNFPA is considering a project intended to support studies at the Population and Human Resources Unit of the Ministry of Planning. The project would support research activities through a research unit for population policy. AID should investigate the feasibility of funding research projects not included in the UNFPA project. AID should explore the possibility of subcontracting research activities through centrally-funded intermediary mechanisms.

The family planning programs of the various national institutions require a coordinated effort to minimize the overlapping of program activities and inconsistencies in educational messages. The recently approved AID and UNFPA support to the Technical Committee for Population is a promising vehicle for achieving this coordination, if the number of inter-institutional conflicts can be resolved.

The result of coordinated, carefully planned, joint efforts would be the development of an approach for a long-range program based on the country's demographic, economic, and social priorities.

Recommendation 3

Increased emphasis should be given to community health education and to sex education. Efforts should be made to move beyond the appeal to initial family planning acceptors, to clarify and extend the definition of family planning, and to confront issues on the side effects of contraceptive methods that have cultural and/or scientific validity. These efforts will increase the effectiveness of the mass communications campaign of the SDA, which merits continuing support.

A. Rationale

The effectiveness of the mass communications campaign in terms of message recognition has been demonstrated. In addition, the team found that MOH staff have corroborated the findings that the message reaches the rural population, providing an "opening" for community-level family planning education activities.

Given the fairly high acceptance levels of family planning among much of the El Salvadorean population, it would seem that the country has, in large part, moved beyond the "initial acceptance" stage and that increased emphasis should be placed on continuation patterns and on the groups (e.g., adolescents, males, and, in some areas, rural women) identified as being more resistant to family planning practice. To date, health education has tended to instruct and inform rather than to involve the community in national health and population-related decisions.

B. Implementation

Specialized training programs in community health education, focused on population-related themes, should be designed and given to MOH staff (in the MCH/FP/N Division, the Health Education Division, at the Health Training School, and to regional supervisors). This training should be coordinated with the population education project of the Population Technical Committee.

The SDA's young facilitator program is a model for increasing the access of young people to sex education. The SDA's staff training and experience in a variety of health education efforts can be valuable in implementing this recommendation.

The SDA should continue to be supported during the second stage (Stage II: Education) of the mass communications campaign, as should its efforts to implement a communications campaign to accompany the CBD project in the Eastern Region. The SDA should work with community-level personnel of public sector organizations to provide mechanisms for extending the campaign message through face-to-face education efforts. This coordination could be achieved through the organization of one-day workshops at the regional level. An initial step could be the organization of such workshops with rural health aides.

Recommendation 4

The MOH should focus on a continuous training program in MCH/FP for various categories of personnel--physician-interns, nurses, nurse-auxiliaries, rural health aides, parteras empericas--and it should take advantage of the soon-to-be constructed health training centers to implement a sustained

training-supervision system. The Health Training School should be given an increased role in merit decision making, and some of its staff members should receive training-for-trainers.

A. Rationale

The performance of MOH personnel in the field has demonstrated the importance of continuous in-service training and supervision. Current MOH staff have received varying amounts and levels of training. Supervision in the health facilities is insufficient.

The Health Training School has been effective in providing well designed courses for various categories of personnel in response to staff and community needs. As the administrator of the four regional health training centers, the school will have increased access to the community and to the regional offices.

B. Implementation

The MCH/FP/N Division, in coordination with offices of the Operative Bureau and with the Health Training School, should design and implement a program to equalize the training backgrounds of nurses and auxiliaries, to provide more family planning preparation to physician-interns and to parteras empericas, to foster a primary care team concept through training and supervision, and to expand training in administration for staff at the central, regional, and health unit levels. A training module on the collection and use of daily service statistics for management decision making would be particularly useful.

The director and staff of the Health Training School will design specific courses for this program. Two or three staff members should be provided with a course in training-for-trainers abroad that emphasizes family planning information and education and administration.

International donor support to these training efforts should be closely coordinated with the training component of the UNFPA MCH/FP project.

Recommendation 5

Population motivation efforts of various institutions should be coordinated to ensure maximum outreach in rural areas and to promote interinstitutional staff cooperation and cross-referral.

A. Rationale

In general, the team found that public sector staff at all levels were convinced of the immediate need for expanded family planning services throughout El Salvador. Sporadic efforts have been made to involve extension agents and teachers in these efforts, but coordination and follow-up have been subject to the whims of various administrations. Since these institutions share common objectives, the coordination of promotional efforts should, theoretically, be a simple process of program design, implementation, and follow-up.

B. Implementation

The recently approved AID support to the Population Technical Committee of the Ministry of Planning for a population education program is a promising vehicle for achieving this coordination, provided the leadership of the Population Technical Committee is professionally competent and acceptable to all the institutions involved. The first stage of the project calls for the organization of a technical team composed of professionals from the public and private agencies working in family planning. The composition, scope of work, and latitude given to this team will be important determinants of project success. Efforts to promote a positive outcome here could include provision of high quality technical assistance, short-term training, and/or observation trips of the technical team abroad.

Recommendation 6

The family planning component of the Rural Health Aide Program should be strengthened through the provision of materials appropriate for the target population, of vehicles for transport to family planning service clinics, of continual supplies of contraceptives, and of more flexible schedules in health care facilities.

A. Rationale

This program has been effective in linking the health care system with the isolated rural populations. The rural health aides contacted by the team displayed an impressive knowledge of the community and were articulate in identifying the problems experienced in family planning promotion. Support to this resource is lacking when women who are referred to services find that the physician will not see them or when the supply of a given brand of orals is exhausted and a RHA has to suggest that the person change brands. When RHAs have been able to secure transport to health facilities, sterilization referral rates have increased significantly.

RHAs and RHA supervisors believe that the graphic family planning educational material now available is insufficient for the largely illiterate population served. Models of the human body, either purchased or designed and made by the RHAs, would greatly facilitate the RHAs' ability to illustrate human reproduction and contraceptive methods.

B. Implementation

Support should be targeted to the provision of new materials, or to a materials production workshop, and to the training of all RHAs and supervisors in the use of these materials. A vehicle exclusively for the RHA program in each region should be provided and used primarily to transport patients to family planning service facilities. Its supervision should be of secondary importance.

The system for distributing medical and contraceptive supplies to RHAs should be improved, with the Operative Services offices assuming responsibility for rationalizing this distribution system, for assuming a continual flow of each brand of oral contraceptives, and for involving the regions in the administration of the system, perhaps providing long-term supplies for deposit in regional warehouses. The issue of health facility hours must be addressed if the MOH intends to significantly expand its services in rural areas. Leadership should be assumed by physicians at the central Operative Services offices.

Recommendation 7

In addition to other methods, which would be equally offered and emphasized through patient education, the voluntary sterilization programs of the Salvadorean Institute of Social Security should be expanded to include all hospitals and zone medical units. The supervisory capacity at the central level should be strengthened.

A. Rationale

The ISSS has four hospitals and three medical units at the central and zone levels that, if equipped and properly supervised, could provide sterilization services to the men and women covered under the social security system. At this time, only the general hospital in San Salvador provides routine family planning and sterilization services. Over 80 percent of the family planning acceptors come from the metropolitan area. There is an increasing demand for services, particularly sterilization, outside the metropolitan area. Sterilization is the most frequently requested method of contraception.

B. Implementation

Expansion of the voluntary sterilization program would be most effectively accomplished by initiating the following steps:

- Provide sterilization and surgical equipment.
- Employ additional family planning supervisory staff and assign them full time to the Department of Family Planning.
- Provide motivation and education materials.
- Provide administrative training in family planning and sterilization programs.
- Improve the data collection system.

Recommendation 8

International donor support to Salvadorean institutions to implement population programs should be continued. Coordinating among external international donors is recommended specifically for parallel project proposals, implementation schedules, and budget allocations.

A. Rationale

Support from external donors has over a long period been a significant factor in the provision of assistance for the related population activities of the public and private sectors. Current economic and social circumstances and the population balance in El Salvador offer a particularly challenging opportunity for continual bilateral and multilateral assistance. In the preparation of long- and short-range approaches, UNFPA/PAHO coordination with other donors should be strengthened so that a unified approach can be taken to increase the impact of the assistance.

B. Implementation

The international donors, in close coordination with the recipient public and private national institutions, should define overall priorities and identify priority activities; identify potential sources of assistance; and provide direct assistance based on the requirements and capabilities of the national institutions. Where implementation is concerned, the donors should give priority to project management, and not budget management.

APPENDICES

Appendix A

LIST OF OFFICIALS CONTACTED

Appendix A

LIST OF OFFICIALS CONTACTED

Carolyn Benbow

New York

Alvaro Monroy, Program Officer, IPPF
Jewel Kross, Project Officer, AVS
Dr. Marjorie Nicol, Program Officer, UNFPA

El Salvador/Ministry of Health

Dr. Roberto M. Merlos, Director, Health Training School
Jose Antonio Rodriguez, Chief, Primary Health Training Unit, Health Training School
Elizabeth Lopez, Nursing Instructor, Health Training School
Dr. W. Martinez, Rural Health Aides Program, Operative Division
Dr. Raul Toledo, MCH/FP/N Division
Dr. Juan Jose Contreras, Assistant Director, Central Region
Antonio Rodolfo Veras Lemos, Superintendent, RHAs, Central Region
Olga de Alguilar, Nursing Supervisor, Central Region
Marta Lilian Perez, Rural Health Aide, Canton Nazaret, Departamento La Libertad
Victoria Martinez, Nurse-Auxiliary, San Jose Villanueva Health Post
Blanca Lilian Ramirez Castillo, Nurse-Auxiliary, San Jose Villanueva Health Post
Dr. Juan Antonio Perez, Medical Supervisor, Western Region
Gladys Margarita Quinteros, Nurse, Lourdes Health Unit
Dr. Carlos Federico Reyes, Medical Supervisor, Western Region
Ana Lidia de Mendez, Health Education Supervisor, Western Region
Juan Antonio de Leon, Superintendent, RHAs, Western Region
Ana Maria de Zetino, Health Education Supervisor, Western Region
Dr. Jose Mario Diaz Nuila, Chief, Health Education Division
Julio Enrique Salguero, Medical Supervisor, Health Education Division
Ana Vilma C. de Cabrera, Supervisor, Health Education Division

Salvadorean Demographic Association

Rosa Judith Cisneros, Executive Director
David Araya, Director, Research and Evaluation Department
Martin Caballero, Director, Information and Education Department
Beatriz Galan de Alonzo, Social Worker, Information and Education Department

Others

Jorge Claro, Deputy Resident Representative, UNDP
Pedro Antonio Leiva, Communicator, Office of Coordination, Research and Programs, Population Technical Committee, Planning Ministry
Manuel de Luca, Commercial Distribution Program, Development Associates, Inc.
Ricardo Gonzales, Director, Rumbo Publicity Agency
Manuel Garzona, Account Executive, Rumbo Publicity Agency

Dario de Leon and Louis Gardella

AID/Washington

Maura Brackett
David Denman
Robert Corno
Robert Halliday
John James

El Salvador/Ministry of Health

Dr. Raul Toledo, MCH/FP Division
Maria Elena Claros, MCH/FP Division
Dr. W. Martinez, Rural Health Aides Program, Operative Division
Dr. Raul Moran Tejada, MCH/FP Division
Dr. Jose Adam Montes, MCH/FP Division
Dr. Antonio Fernandez, Medical Unit Circuit 7
Sra. Argelin de Herrera, Supervisor, Nurses, MOH
Jarafina de Nunoz, Administrator, C.S. Coyutepeque
Dr. Carlo Alberto, Director, C.S. Coyutepeque

Dr. Luis Alvaro Cunfegas, Regional Office, Santa Ana
Dr. Jose Antonio Chanta, Regional Office, Santa Ana
Sra. Consuelo de Guendia, Administrator, Regional Office, Santa Ana

Social Security

Dr. Jorge Bustamonte, Chief, Department of Ob/Gyn
Dr. Melvin Hernandez, Chief, Division of Family Planning
Dr. Jorge Zavaleta, Family Planning

Salvadorean Demographic Association

Rosa Judith Cisneros, Executive Director
Dr. Jorge Bustamonte, President
Dr. Julio R. Menjuar, Medical Director

Technical Committee for Population

Lic. Mauricio Magana, Director
Margarita Iris de Duron, Social Worker
Ana Bessy Espinoza, Economist
Lydia Hortensia Lemus, Demographer
Raymundo Alvarado, Economic Demographer
Pedro Antonio Leiva, Communication Technician

USAID/El Salvador

Dan Chaiz, Acting Director
Jesse Synder, Chief, Health and Population
Kris Loken, Health Population Section
Lic. Roberto Chavez, Health Population Section

Bureau of Census and Statistics

Hector Aguila, Director, Census and Statistics
Manuel Ayala, Chief, Vital Statistics

Note: This list does not include the names of the many health workers in all institutions or the names of others interviewed during the team's visit.

Appendix B

CONTRACEPTIVES ON HAND IN THE ADS AND MOH CENTRAL WAREHOUSES

Appendix B

CONTRACEPTIVES ON HAND IN THE ADS AND MOH CENTRAL WAREHOUSES [1]

Method	ADS (as of 2/29/80)	MOH (as of 3/14/80)
Oral Contraceptives (Cycles)		
Norminest	29,358	-
Norinyl 1+50	554,960	897,772
Norinyl 1+80	16,773	-
Oral 28	23,414	40,355
Neogynon 28CD	73	-
IUDs (Pieces)		
Lippies A	450	894
Lippies B	700	52
Lippies C	2,202	-
Lippies D	100	151
Saf-T-Coil Small	114	-
Saf-T-Coil Medium	340	-
Saf-T-Coil Large	400	-
Copper T	-	420
Condoms (Pieces)		
Tahiti	1,418,508*	3,484,080
Vaginal Methods		
Neo Sampoon (Tablets)	554,688	
Neo Sampoon (Tubes)	3,000	1,876
Foam	3,524	-
Jelly (Tubes)	7,196	-
Diaphragms	415	-
Other		
Depo-Provera (10 cc vials)	113	-

* 65,808 pieces are packaged for use in vending machines.

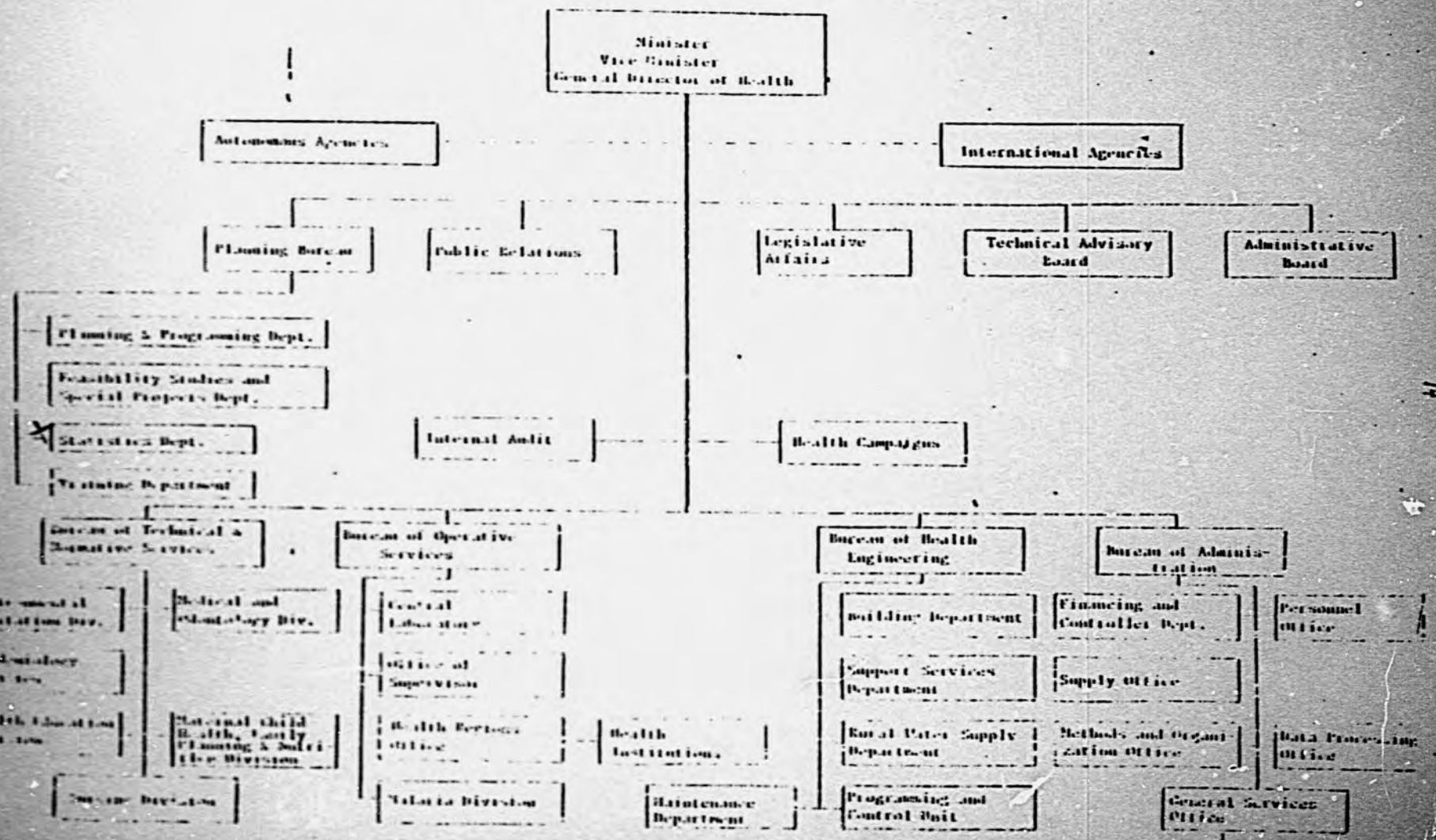
[1] Planning for the Implementation and Evaluation of Community-Based Distribution Program of Contraceptives, CDC.

Appendix C

ORGANIZATION CHART OF THE MINISTRY OF PUBLIC HEALTH AND SOCIAL ASSISTANCE

Appendix C

ORGANIZATIONAL CHART OF THE MINISTRY OF PUBLIC HEALTH AND SOCIAL ASSISTANCE



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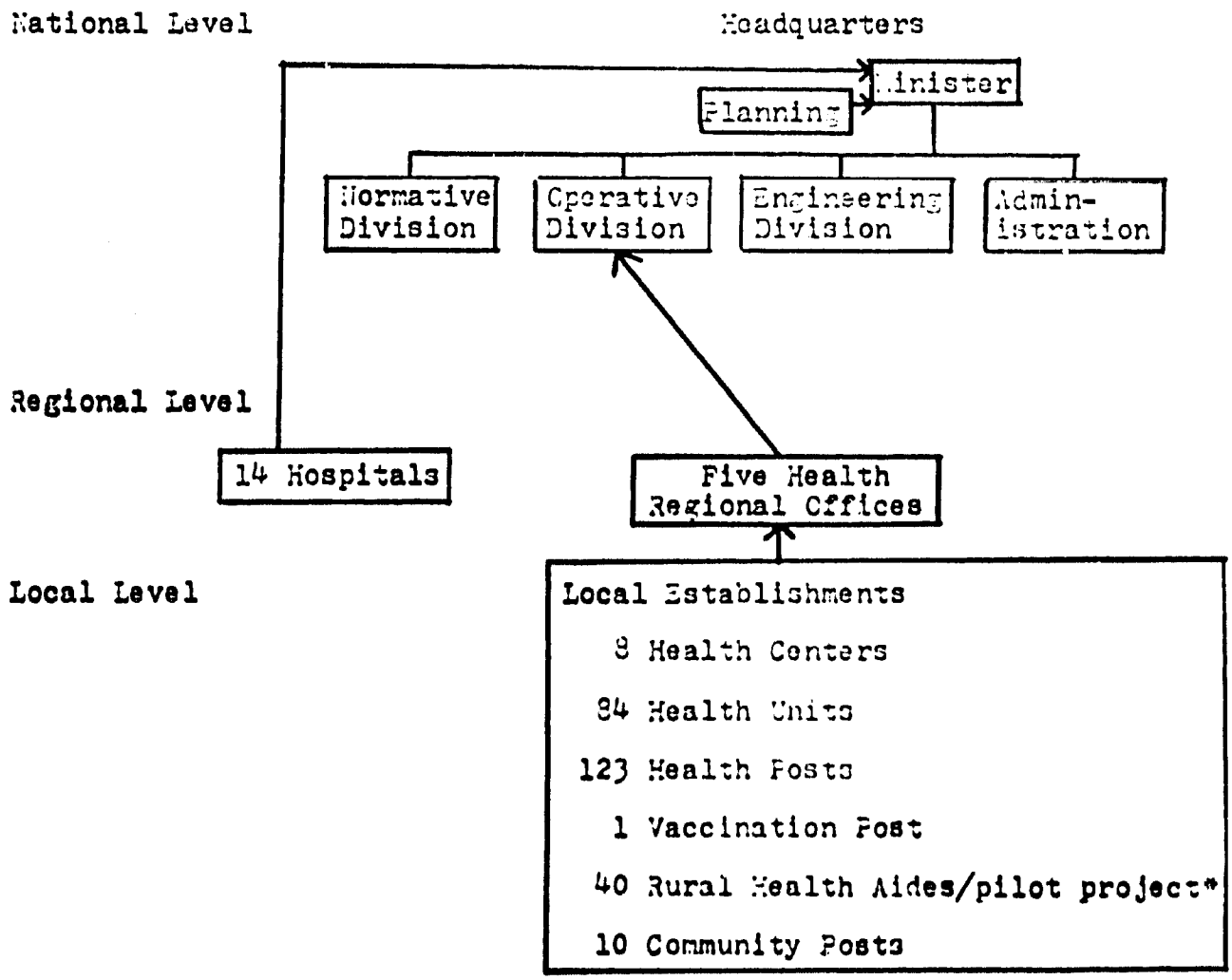
Appendix D

ORGANIZATION STRUCTURE OF THE MINISTRY OF HEALTH

Appendix D

Organization Structure of the
Ministry of Health

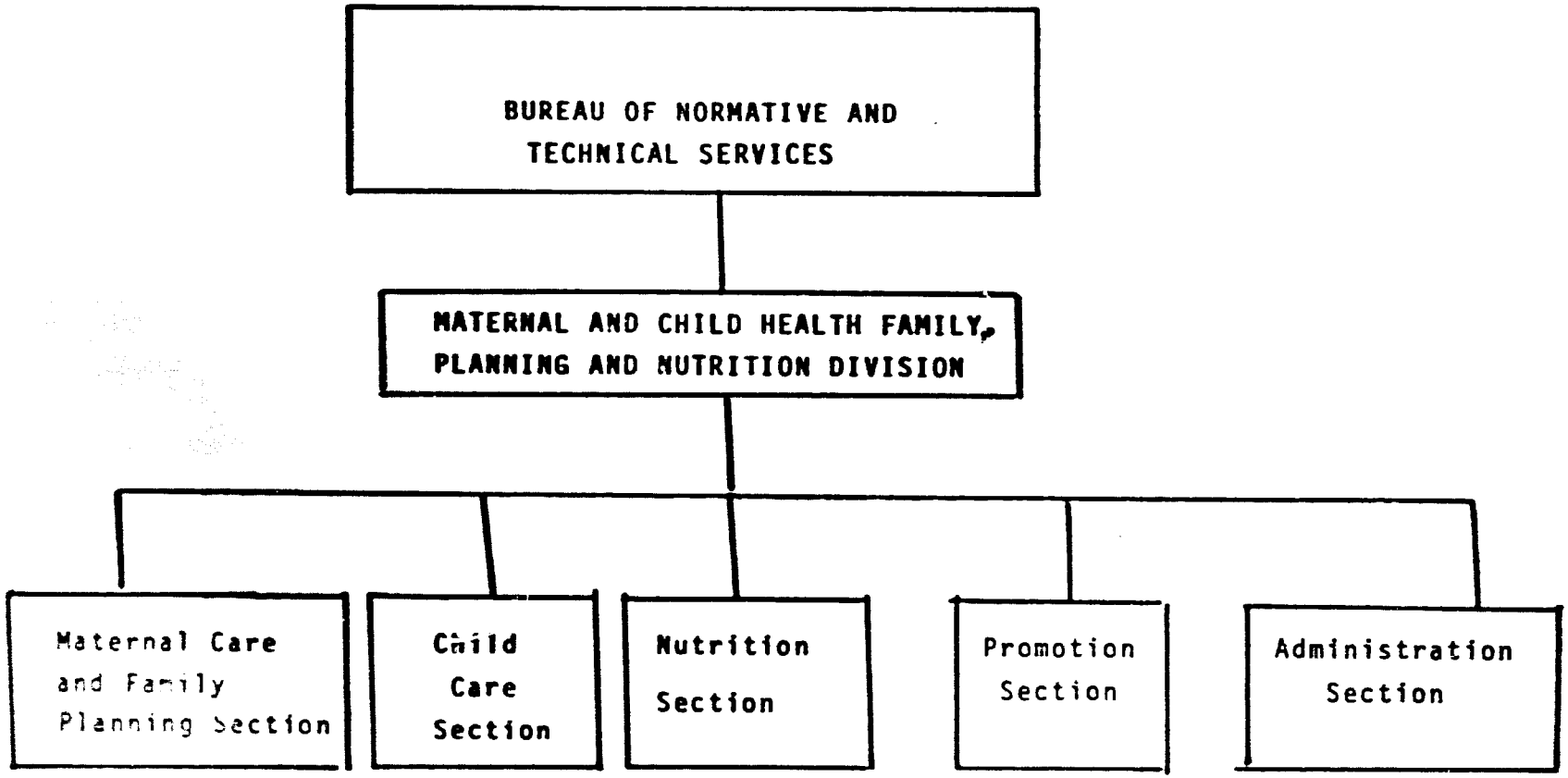


Appendix E

ORGANIZATION OF MCH/FP DIVISION

Appendix E

ORGANIZATION OF MCH/FP DIVISION

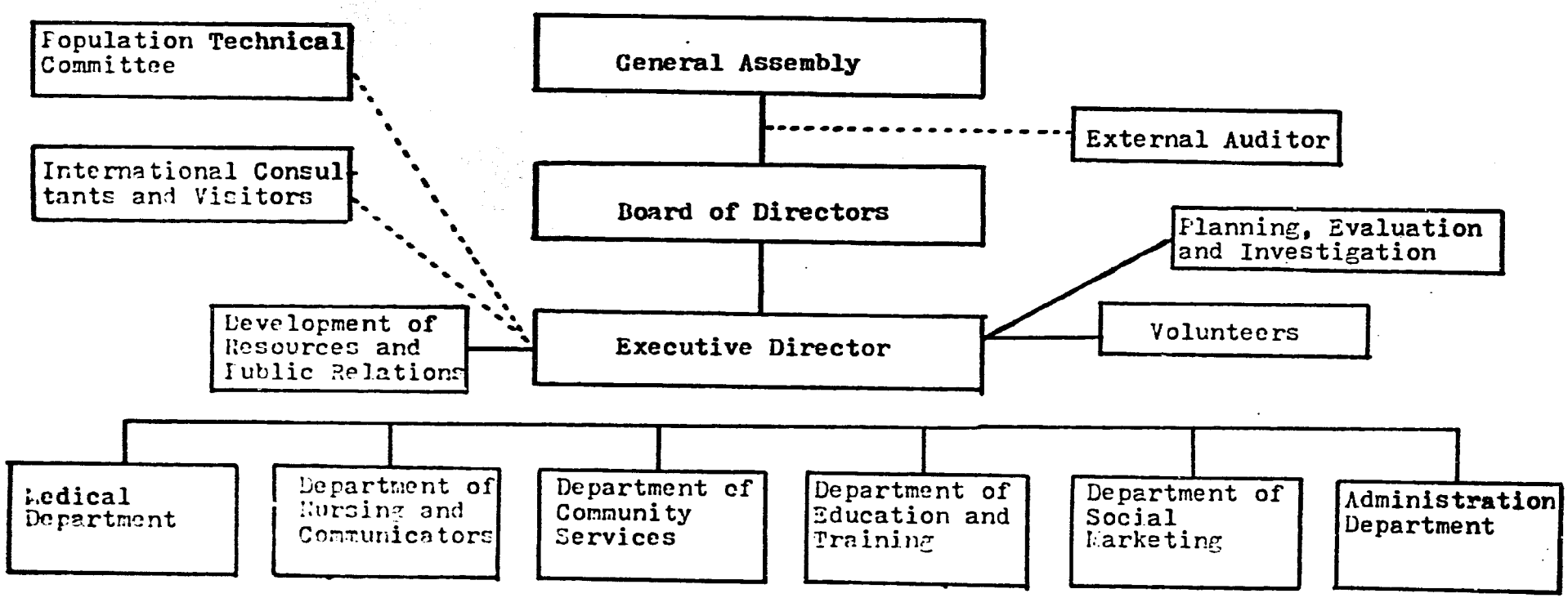


Appendix F

ORGANIZATION CHART OF THE SALVADOREAN DEMOGRAPHIC ASSOCIATION

Appendix F

ORGANIZATION CHART
OF
THE SALVADOREAN DEMOGRAPHIC ASSOCIATION



Appendix G

DECREE 20

DECREE NO. 20

THE EXECUTIVE POWER OF THE REPUBLIC OF EL SALVADOR

CONSIDERING:

I In accomplishing with the constitutional precepts of the Economic Regime and Social Rights that rule the family protection, and in agreement with the demographic situation and in order to improve the health, living, education, nutritional and employment conditions;

II That to obtain the whole development of the human being, it is necessary that the Salvadoreans be brought into a higher participation in the responsibilities and benefits of progress with an adequate harmony of population quality, distribution and magnitude according to the country's resources by the determination of an Integral Population Policy;

III That on October 30, 1974, The Ministers' Council approved the Integral Population Policy and recommended the creation of an administrative structure of that policy;

IV That the State, to accomplish that objective, considered it necessary to coordinate the actions of its different organizations which have similar objectives;

THEREFORE,

Using its legal faculties,

DECREES:

Art. 1 The National Commission on Population is created to realize the goals and objectives of the Integral Population Policy, which will be a

dependency of the Ministry of the Presidency and will have the assistance of a Technical Committee.

Art. 2 The National Commission on Population will be integrated with officials of the following Ministries of State:

- Ministry of the Presidency;
- Ministry of Planning and Coordination of Economic and Social Development;
- Ministry of Interior;
- Ministry of Public Health and Social Assistance;
- Ministry of Education;
- Ministry of Labor and Social Provisions; and
- Ministry of Agriculture.

Art. 3 The Technical Committee will be integrated with representatives from:

a) Population and Human Resources Division of the Ministry of Planning and Coordination of Economic and Social Development, which will be in charge of its coordination;

b) Division of Maternal and Child Care of the Ministry of Public Health and Social Assistance;

c) Direction of Adult and Permanent Education from the Ministry of Education;

d) National Department of Labor from the Ministry of Labor and Social Provision;

e) Planning and Assessment Unit from the Ministry of the Interior;

f) General Direction of Statistics and Census from the Ministry of Economy.

g) Direction of Agriculture Planning from the Ministry of Agriculture;

h) General Direction of Foreign Affairs from the Ministry of Foreign Relations;

i) Salvadorean Institute of Social Security;

j) Salvadorean Minors' Council;

k) Salvadorean Demographic Association; and

l) Other institutions which by law or disposition the National Commission on Population considers convenient.

Art. 4 The duties of the National Commission on Population are:

a) To plan the activities in accordance with the objectives of the Integral Population Policy;

b) To select the alternatives and goals of population programs proposed by the Population Technical Committee; and

c) To select the most adequate instruments to implement the short-, medium-, and long-term policies proposed and developed by the Population Technical Committee.

Art. 5 The National Commission on Population, in order to accomplish its duties, will take into account the objectives of the Integral Population Policy, which are:

a) To improve the status and use of natural resources;

b) To improve the nutritional level;

c) To reduce mortality and morbidity rates;

d) To increase employment opportunities;

e) To better distribute population by strengthening other development areas;

f) To modify the population's dynamics;

g) To raise women's participation in the process of development, increase their social and cultural conditions, and strengthen the family group; and

h) To determine the impact of demographic variables on the development process and create the basic instrument to support the decision process.

Art. 6 The Tecnnical Committee will have the following assignments and duties:

a) To execute the resolutions and policies dictated by the National Commission on Population;

b) To propose to the National Commission on Population the instruments to implement the Integral Population Policy through the plans and programs of medium and short terms;

c) To plan and examine the objectives of the Integral Population Policy;

d) To integrate the departments, sections, and sub-commissions which will be needed for the development of its activities; and

e) Other functions which could be recommended by the National Commission on Population.

Art. 7 The programs of the Integral Population Policy will be financed with national funds and by international donors who could offer financial and technical assistance. To accomplish this, the Government will make the necessary budgetary assignations.

Art. 8 The executive power in the branch of the presidency will formulate the instructions in order to reach the objectives of this decree.

Art. 9 The present decree will be effective eight days after its publication in the Official Newspaper.

GIVEN IN THE PRESIDENCY HOUSE, San Salvador, on the ninth day of November of the year nineteen seventy-seven.

Carlos Humberto Romero
President

Julio Ernesto Astacio
Minister of the Presidency

Roberto Chico Duarte
Minister of Planning and Coordination
Of Economic and Social Development

Armando Leonidas Rojas
Minister of Interior

Cesar Augusto Escalante
Minister of Public Health and Social
Assistance

Carlos Antonia Herrera Rebollo
Minister of Education

Roberto Escobar Garcia
Minister of Labor

Jose Rutilio Aguilera Carreras
Minister of Agriculture

Appendix H

DECREE 29

DECREE NO. 29

THE EXECUTIVE POWER OF THE REPUBLIC OF EL SALVADOR

CONSIDERING:

I That according to the organization structure of the Executive Power, the Ministry of Planning and Coordination of Economic and Social Development is responsible for coordinating the policies and programs of the State;

II That the execution and development of the Integral Population Policy approved by the Ministers' Council on October 30, 1974, requires a more dynamic and integrated process;

III That in order to make viable the points mentioned above, it is necessary to incorporate pertinent reforms to the Executive Decree No. 20, dated November 9, 1977, and published in the Official Newspaper, No. 209, Vol. 257, in the same month and year, by which was created the National Commission on Population;

THEREFORE:

Using legal faculties conferred by Decree No. 1, dated October 15, 1979, and published in the Official Newspaper, No. 191, Vol. 265, in the same month and year,

DECREE:

Art. 1. Articles 1, 2, 3, 5, and 8 are reformed. They correspond to the Executive Decree No. 20, dated November 9, 1977, and published in the

Official Newspaper, No. 209, Vol. 257, on the 11th day of the same month and year, in the following manner:

"Art. 1. The National Commission on Population that will implement the goals and objectives of the Integral Population Policy will be coordinated by the Ministry of Planning and Coordination of Economic and Social Development, which will have an office of Programming, Coordination and Research on Population as part of the Executive Direction of the Coordinating Section and under the advice and assistance of the Technical Committee.

Art. 2. The National Commission on Population will be integrated by officers of the following Ministries of State:

a) Ministry of the Presidency;

b) Ministry of Planning and Coordination of Economic and Social Development;

c) Ministry of Foreign Relations;

d) Ministry of Interior;

e) Ministry of Economy;

f) Ministry of Education;

g) Ministry of Labor;

h) Ministry of Agriculture; and

i) Ministry of Public Health and Social Assistance.

Art. 3. The Population Technical Committee will be integrated by representatives of the Ministries that constitute

the National Commission on Population and by representatives of the following institutions:

a) General Direction of Statistics and Census;

b) Salvadorean Institute of Social Security;

c) Salvadorean Minors' Council;

d) Salvadorean Demographic Association; and

e) Other institutions that by law or disposition of the National Commission on Population would be considered convenient.

This Committee will be directed by the Chief of the Coordination, Programming and Research Unit of the Population Office from the Ministry of Planning and Coordination of Economic and Social Development, who will represent the Ministry mentioned above.

Art. 5. In order to accomplish all of its responsibilities, the National Commission on Population will have to consider the general and specific objectives of the Integral Population Policy, which are:

General Objectives

a) To procure the development of the human resources, and

b) To render a higher participation of each and every member of the society into the responsibilities and benefits of progress.

Specific Objectives

a) To improve the use and proper development of natural resources;

b) To improve nutrition status;

c) To decrease mortality and morbidity;

d) To increase employment opportunities;

e) To distribute population by means of strengthening other development areas;

f) To modify the population's dynamics;

g) To raise women's participation in the process of development, increasing her social and cultural condition and trying to strengthen the family group;

h) To determine the impact of demographic variables in the development process and create the basic mechanisms in order to support the decision process; and

i) Those others that the National Commission on Population would determine.

Art. 8. The Executive Power in its branch of Planning and Coordination of Economic and Social Development will formulate, through the Coordination Unit of the Integral Population Policy, the mechanisms in order to reach the objectives of the present decree."

Art. 2. The present decree will be effective eight days after its publication in the Official Newspaper.

GIVEN AT THE PRESIDENCY HOUSE, San Salvador, on the twenty-sixth day of May in the year nineteen eighty.

Cnel. Dem. ADOLFO ARNOLDO MAJANO RAMOS

CNEL. ING JAIME ABDUL GUTIERREZ

DR. JOSE ANTONIO MORALES ERLICH

DR. JOSE RAMON AVALOS NAVARRETE

ING. JOSE NAPOLEON DUARTE

Dr. Pablo Mauricio Alvergue
Minister of the Presidency

Lic. Atilio Vieytez
Minister of Planning and Coordination
Of Economic and Social Development

Dr. Fidel Chavez Mena
Minister of Exterior Relations

Ing. Jose Ovidio Hernandez Delgado
Minister of Interior

Lic. Guillermo Diaz Salazar
Minister of Economy

Ing. Carlos Aquilino Duarte Funes
Minister of Education

Dr. Julio Alfredo Samayoa h.
Minister of Labor

Ing. Agr. Octavio Orellano Solis
Minister of Agriculture

Dr. Rene Constantino Meza Sandoval
Subsecretary of the Ministry of
Public Health and Social
Assistance, In Charge of the Office