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Report to the
Association for Voluntary Sterilization

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

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February, 1984

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51

ELS EVALUATION REPORT

INDEX

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

52

ABBREVIATIONS

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

53

ACKNOWLEDGEMENT

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

PROGRAM OBJECTIVE

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

Specific Objectives

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

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

55

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

NATIONAL OVERVIEW

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

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

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

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

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

51

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

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

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

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

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

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

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

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

58

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

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

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

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

MOH:	Orals	44%
	IUD	20%
	VSC	36%

SDA:	temporary methods	36%
	VSC	64%

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

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

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

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

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

EL SALVADOR. CRUDE BIRTH RATES

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

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

VOLUNTARY SURGICAL STERILIZATION PROGRAMS

MINISTRY OF PUBLIC HEALTH (MOH)

Site visits:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

42

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

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

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

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

SALVADOREAN DEMOGRAPHIC ASSOCIATION (SDA)

Site Visits:

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

103

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

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

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

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

Urban Users

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

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

Rural Users

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

104

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

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

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

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

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

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

Funding for VSC programs carried out in 1983.

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

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

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

SALVADOREAN SOCIAL SECURITY INSTITUTE

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

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

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

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

6/8

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

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

MOH - Low income population (1.5 million)

SSSI- Middle-class

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

(Dr. Bustamante)

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

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

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

OTHER VSC PROGRAMS

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

TRAINING OF PERSONNEL

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

67

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

SUPPLIES - MAINTENANCE

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

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

STATISTICAL DATA

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

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

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

63

As can be seen:

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

CONCLUSIONS AND RECOMMENDATIONS

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

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

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

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

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

69

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

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

Recommendation

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

SERVICE AVAILABILITY AND ACCESSIBILITY

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

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

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

*(See Document No.1)

The results of this situation are:

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

Recommendation

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

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

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

POST-PARTUM PROJECT

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

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

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

Recommendation

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

SUPPLY OF AND DEMAND FOR VSC SERVICES

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

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

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

INTEGRATION OF VSC WITHIN HEALTH SERVICES AND TEMPORARY CONTRACEPTIVE METHODS

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

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

*(See Document No. 1, attached)

12

INFORMATION AND EDUCATION

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

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

MEDICAL ASPECTS

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

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

11

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

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

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

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

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

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

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

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

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

Recommendations

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

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

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

STATISTICS, RECORDS, COMPLICATIONS

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

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

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

* (See Document No. 7)

** (See Document No. 8)

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

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

Recommendation

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

IMPACT OF CIVIL CONFLICT ON VSC PROGRAMS

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

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

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

Recommendation

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

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VSC IMPACT ON SOCIAL, DEMOGRAPHIC AND HEALTH ASPECTS

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

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

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

FINAL COMMENTS

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

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

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

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

11

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

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

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

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

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

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

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

13

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

19

SCHEDULE - WORK PROGRAM

FEBRUARY, 1984

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

MARCH, 1984

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

21

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12

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