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

EL SALVADOR

PROJECT PAPER

FAMILY HEALTH SERVICES

AID/LAC/P-552

Project Number: 519-0363

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE: C (A = Add, C = Change, D = Delete)

Amendment Number: N/A

DOCUMENT CODE: 3

COUNTRY/ENTITY: EL SALVADOR

3. PROJECT NUMBER: 519-0363

4. BUREAU/OFFICE: LAC 05

5. PROJECT TITLE (maximum 40 characters): FAMILY HEALTH SERVICES

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 06 DD 30 YY 95

7. ESTIMATED DATE OF OBLIGATION (Under "B" below, enter 1, 2, 3, or 4)

A. Initial FY 90 B. Quarter 3 C. Final FY 93

8. COSTS ($000 OR EQUIVALENT $1 =)

A. FUNDING SOURCE	FIRST FY 90 B. FX	C. L/C	D. Total	LIFE OF PROJECT E. FX	F. L/C	G. Total
AID Appropriated Total						
(Grant)	(5,750)	( )	( )	(22,000)	( )	( )
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S. 1.						
Other U.S. 2.						
Host Country SDA					13,826	
Other Donor(s)						
TOTALS	5,750			22,000	13,826	

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	2. Loan	D. OBLIGATIONS TO DATE 1. Grant	2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	2. Loan	F. LIFE OF PROJECT 1. Grant	2. Loan
(1) 104	444	440		000		5,750		22,000	
(2)									
(3)									
(4)									
TOTALS						5,750		22,000	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): 510

11. SECONDARY PURPOSE CODE: 533

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code	BRW	BUW	PVON	TNG			
B. Amount	12,000	7,000	22,000	6,000			

13. PROJECT PURPOSE (maximum 480 characters)

To continue and to expand the delivery of birth spacing and maternal/child health services to high risk populations in rural and marginal urban areas and improve the quality and efficiency of these services.

14. SCHEDULED EVALUATIONS

Interim MM 02 YY 93 | MM YY | Final MM 04 YY 95

15. SOURCE/ORIGIN OF GOODS AND SERVICES: [X] 000 [X] 941 [X] Local [ ] Other (Specify)

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

Methods of implementation and financing are hereby concurred with.

Frank Breen A/CONT

17. APPROVED BY

Signature: Henry H. Bassford

Title: Mission Director

Date Signed: MM 06 DD 21 YY 93

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION

MM DD YY

PROJECT AUTHORIZATION

Name of the Country: El Salvador

Name of Project: Family Health Services

Number of Project: 519-0363

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Family Health Services Project for El Salvador, encompassing a grant to the Salvadoran Demographic Association and involving planned obligations not to exceed Twenty Two Million United States Dollars (US$22,000,000) in grant funds over a five year period from the date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing foreign exchange and local currency costs for the Project. The planned life of the Project is approximately five years from the date of obligation.

2. The Project consists of technical and financial assistance to the Salvadoran Demographic Association to continue and to expand the delivery of birth spacing and maternal/child health services to high risk populations in rural and marginal urban areas and improve the quality and efficiency of these services.

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

a. Source and Origin of Commodities and Nationality of Services

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

b. Conditions Precedent to Disbursement

Prior to the disbursement of A.I.D. funds, or to the issuance of any documentation pursuant to which disbursement will be made, the Salvadoran Demographic Association shall provide evidence that it has established an adequate system of financial management and controls to account for and manage A.I.D.-provided resources.

c. Covenants

The SDA shall comply with A.I.D. restrictions on promotion of abortion as a family planning method, as stipulated in the Standard Provisions for Grants with Non-U.S. Private Voluntary Organizations.

John L. Lovaas
Director, a.i
USAID/El Salvador

7/24/90
Date

Clearances:
HPN, RThornton (draft) Date 7-17-90
CONT, DFranklin (draft Date 7-19-90
CO, LMcGhee (draft) Date 7-20-90
DPP, TMcKee (draft) Date 7-20-90
AMDO, JHeard (draft) Date 7-20-90

Drafted: PRJ, DKennedy
5304B

b. Conditions Precedent to Disbursement

Prior to the disbursement of A.I.D. funds, or to the issuance of any documentation pursuant to which disbursement will be made, the Salvadoran Demographic Association shall provide evidence that it has established an adequate system of financial management and controls to account for and manage A.I.D.-provided resources.

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Henry H. Bassford
Director
USAID/El Salvador

Date

Clearances:

HPN, RThornton	KA	Date	7/17/90
CONT, DFrankl[illegible]	SF	Date	7/17/90
CO, LMcGhee	LMC	Date	7/20/90
DPP, TMcKee	[illegible]	Date	7/20/90
AMDO, JHeard	H	Date	7/20/90
DDIR, JLovaas		Date	

Drafted: PRJ, DKennedy
5304B

FUNDS AVAILABLE
FUNDS AVAILABLE ✓ RECEIVED
7/18/90
7/18/90

LIST OF ACRONYMS USED IN THE PROJECT PAPER

ADS	Asociación Demografica Salvadoreña (also SDA)
A&E	Architect and Engineering
AID	Agency for International Development
AID/W	Agency for International Development in Washington
ASHONPLAFA	Asociación Hondureña de Planificación Familiar
APROFAM	Asociación Pro-Familia de Guatemala
APSISA	Health Systems Support Project
ARI	Acute Respiratory Infection (also IRA)
AUX	Nurse (term comparable to U.S. Practical Nurse)
AVSC	Association for Voluntary Surgical Contraception
BS	Birth Spacing
CACM	Central American Common Market
CALMA	Centro de Apoyo a la Lactancia Materna
CBD	Community Based (contraceptive) Distributor
CBI	Caribbean Basin Initiative
CDC	Center for Disease Control
CDSS	Country Development Strategy Statement
CENCAP	Centro Nacional de Capacitación Agropecuario
CIF	Cost, Insurance and Freight
COP	Chief of Party
CP	Conditions Precedent to Disbursement
CPA	Certified Public Accountant
CPSD	Commodities and Program Support Division
CPT	Contraceptive procurement Table
CRC	Central Referral Clinic (also Central Referral Center)
CYP	Couple Years of Protection
DHS	Demographic Health Survey
EOP	End of Project
FAR	Federal Acquisition Regulations
FEPADE	Fundación Empresarial para el Desarrollo Educativo
FESAL	Family Demographic and Health Survey
FHI	Family Health Institute
FHP	Family Health provider (also PHP, Pro-Familia Health provider)
FP	Family Planning
FP/MCH	Family Planning/Maternal Child Health
FPSMS	Family Planning Supply Management System
FSN	Foreign Service National
FSN/PSC	Foreign Service National Personal Services Contractor
FWD	Four Wheel Drive
FX	Foreign Exchange
GDP	Gross Domestic Product
GAO	General Accounting Office
GOES	Government of El Salvador
GSA	General Services Administration
H	AID/W Office of Health

HE	Health (AID functional account)
HC	Host Country
HPN	Health Population and Nutrition Office (USAID/El Salvador)
IC	Institutional Contractor
IDB	International Development Bank
IEC	Information, Education, Communications
INCAE	Instituto Centroamericano de Administración de Empresas
IPPF	International Planned Parenthood Federation
IRA	Infermidad Respiratorio Aguda (also ARI, Acute Respiratory Infection)
ISSS	Salvadoran Social Security Institute
IUD	Intra-uterine Device
IV	Intravenous
LAC	AID/Washington Bureau for Latin America and the Caribbean
LC	Local Currency
LDC	Less Developed Country
LOP	Life of Project
MBO	Management by Objectives
MCH	Mother/Child Health
MCH/FP	Maternal Child Health/Family Planning
MIS	Management Information System
MOH	Ministry of Health
ORT	Oral Rehydration Therapy
ORS	Oral Rehydration Salts
PAHO	Pan American Health Organization
PHP	Pro-Familia Health Promoter (also FHP)
PIC	Project Implementation Committee
PIO/T	Project Implementation Order for Technical Assistance
PN	Population/Nutrition (AID Functional Account for)
PP	Project Paper
PSA	Procurement Services Agent
PSC	Personal Services Contract(or)
PVO	Private Voluntary Organization
ROCAP	Regional Office for Central American Programs
RN	Registered Nurse
SDA	Salvadoran Demographic Association (also PROFAMILIA)
SMP	Social Marketing Program
S&T	AID/W Office for Science and Technology
TA	Technical Assistance
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
UNFPA	United Nations Fund for Population Activities
US	United States (also found in PP as U.S.)
UNICEF	United Nations International Children's Education Fund
USAID	United States Agency for International Development
VA	Veterans Administration

Doc. 4756B

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ACTION MEMORANDUM TO THE DIRECTOR

FROM: AMDP, William G. Kaschak *William G. Kaschak*

SUBJ: Authorization of the Family Health Services Project (519-0363)

DATE: May 23, 1990

Problem: Your approval is required to authorize the Family Health Services Project, No. 519-0363, with U.S. $22,000,000 Section 104 DA Life of Project Funding.

Discussion: The Family Health Services Project is a five year effort with estimated life of project funding of $22 million in Section 104 (Health and Population), to be obligated by means of a Handbook 13 agreement with the Salvadoran Demographic Association. The Project is a follow-on to the Mission's two ongoing family planning projects (Population Dynamics, 519-0210 and the Operational Program Grant with the Salvadoran Demographic Association, 519-0275) which will end in late FY 90. The purpose of the new Family Health Services Project is to improve and expand the delivery of family planning and maternal child health services to high risk populations in rural and marginal urban areas. As indicated by the Project purpose, and consistent with the recently approved USAID Country Development Strategy Statement, the Family Health Services Project will integrate selected maternal child health interventions with the promotion of modern family planning methods. The Salvadoran Demographic Association (SDA) will be the implementing agency for Project activities.

The Project contains three components: (1) Family Health Service Delivery, which will provide support to continue and expand the ongoing family planning service program of the SDA and to add select maternal child health services (e.g., immunization, prenatal care, oral rehydration therapy, and nutrition education) to the range of services provided by the SDA; (2) Institutional Development, which will finance the development and implementation of new products and services (e.g., opening a central referral clinic) that will strengthen the SDA's ability to sustain its program in rural and marginal urban areas and concurrently expand the availability of health care; and (3) Policy Development and Research, which will finance studies and information/education programs to increase contraceptive prevalence and improve the policy framework in which the public and private sectors work. Project inputs will include technical assistance in communications, training, and family planning services management; operational support for training and information/education programs; and commodities.

As a direct result of Project activities, the total number of families using modern family planning methods provided by the SDA will increase from 120,000 to 200,000. An additional 1,550 rural communities will have access to SDA provided family planning and maternal child health services. And, by the end

of the Project, the SDA will be more financially self-reliant, although service Programs at the current level will continue to require A.I.D. or other donor support.

The Mission Review, chaired by the AMDP, was held on February 22. The primary issue was that of sustainability: the degree to which SDA would be capable of maintaining Project level service delivery at the end of the Project. It was agreed by the meeting's participants that, although the SDA would not be capable by the PACD to self-finance delivery of services at the Project level, earnings from the planned Central Referral Clinic should provide the SDA with a new funding source which will permit the institution to finance a larger portion of its program than at present. The current fee structure, which is based on common acceptable practice, willingness and ability to pay, and the availability and cost of comparable health care for the beneficiary population will also be studied during Project implementation with a view towards revising the fee structure upwards to cover more of the actual cost of providing services. It was agreed that, although despite these efforts, the SDA will continue to require A.I.D. assistance to carry out its current level of program activities. Nonetheless, it was also agreed that the Project activities were of sufficient importance to merit approval, giving, of course high priority to the issue of financial independence during Project implementation.

Procurement, which is an important and complex element of the Project was also discussed. Of specific concern was the question of USAID staff time and resources that would be required for the various foreign and local procurement actions. Consistent with recent Mission Policy guidance, it was agreed that A.I.D. would only be responsible for procurement of the technical assistance, to be carried out using 8(a) procedures; contraceptives and ORS; a US PSC Procurement Specialist; and contracting Project audits and evaluations. All other Procurement will be done by the SDA or the Technical Assistance Contractor, who will use a procurement expert on its team. The technical assistance contemplated in the Project also includes a procurement specialist who will reside at SDA headquarters. All procurement over $25,000 will be approved by A.I.D. in writing.

The SDA's financial and management capabilities were examined during the field-work phase of a recent Regional Inspector General audit. While no written results have been presented to date, preliminary indications are that some deficiencies were found relating to SDA's financial management and procurement capabilities. The Project's designers took the impending audit findings into consideration during the Project's analyses and design phase. The technical assistance that will be provided by the Project will assist the SDA to modify and improve its current operating systems where needed, whether in financial management, procurement or other areas of administration.

The Project design team also carried out an independent analysis of the SDA's system of financial controls and procurement capabilities and found: 1) that the SDA accounting system complies with generally accepted accounting

principals; 2) the SDA system for issuing checks requires appropriate signatures and approvals and is controlled by the internal audit department; 3) the accounting and treasury functions are well defined, and segregated; 4) internal cash controls and disbursement procedures exist with adequate standards in place to account for disbursements; 5) routine procedure for payments of over 300 colones are made by check and petty cash controls are adequate; and 6) a current list of signatures and initials required for disbursements is maintained. In addition, the analysis determined that adequate controls to safeguard and account for Project resources are in place and that each SDA program has its separate bank account. Also, periodic internal control audits are conducted at all levels to ensure that all safeguards and controls are strictly adhered to by the SDA's Administrative Department. However, to further ensure adequate controls, the Project calls for monthly financial monitoring of the revenues and expenditures of the program (the report format will be jointly designed by SDA and the USAID Project Manager according to U.S. standard disbursement procedures). In addition, and in view of the proposed expansion in SDA's activities as a result of this project, the technical assistance will include a finance and accounting advisor. Moreover, Project funds have been budgeted for annual external audits to be carried out by a U.S. CPA affiliate using GAO standards.

In sum, the above measures related to improvements in SDA's financial management and controls system should prove adequate to address all deficiencies, reported by the RIG in informal debriefings, in SDA's internal financial controls system or procurement procedures.

Recommendation: I recommend that you sign this memorandum and the Project Authorization for the five year Family Health Services Project No. 519-0363 for a total Life of Project funding amount of U.S. $22 million.

Authority: The attached State Cable No. 047722 from the LAC Bureau confirms delegation of authority to you to approve and authorize this Project for a revised total LOP of U.S.$22 million.

APPROVED _____

DISAPPROVED _____

DATE 6/22/90

UNCLASSIFIED STATE 047722

ACTION AIDP INFO AMB DCM ECON

USAID/SAN SALVADOR
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AIDAC

E.O. 12356: N/A
TAGS:
SUBJECT: EL SALVADOR FAMILY HEALTH SERVICES PROJECT
(519-0363)

REF: A) SAN SALVADOR 01381

PER REF. A DESCRIPTION OF SUBJECT PROJECT, LAC BUREAU RECONFIRMS ITS DELEGATION OF AUTHORITY TO THE MISSION DIRECTOR TO APPROVE AND AUTHORIZE THE PROJECT IN THE FIELD WITH THE UNDERSTANDING THAT THE REVISED DOLS 22.0 MILLION LOP FUNDING INCREASES THE APPROVED NPD BUDGET BY DOLS 3 MILLION TO FUND ACTIVITIES THAT WERE PROPOSED IN THE NPD BUT FOR WHICH PRELIMINARY COST ESTIMATES WERE TOO LOW AND THAT NO NEW ACTIVITIES ARE BEING ADDED TO THOSE INCLUDED IN THE APPROVED NPD.
EAGLEBURGER
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ACTION TO: PRJ
ACTION DUE: 2/20

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DPPO	IRD	JAO/PER
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AMDO	IRD/RUD	GSO/S

Subject:

ACTION TAKEN: No action needed
DATE: 2/15
INITIALS: SDK

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USAID/SAN SALVADOR

Rcvd. in HPN
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Date

I. PROJECT SUMMARY AND RECOMMENDATIONS

A. Project Summary

Inadequate birth spacing and poor maternal health continue to result in high infant mortality rates, particularly among rural women in El Salvador. Despite an impressive family planning program, the population growth rate remains high, at about 2.5%. While most Salvadoran women in fertile age know about methods of modern contraception, only a third of these women now use them, and most of the women using modern methods live in urban areas. This disparity in rural and urban use can be seen in fertility rates; while the national average is 4.6 children per women, among rural women the fertility rate (average number of births) is 5.9. The result is not only continuing high birth rates, but poor infant and child health stemming from inadequate maternal health. As a result, El Salvador also has high perinatal mortality rates (deaths in the first month after birth).

The Family Health Services Project (519-0363) directly supports the shared USAID and GOES objective of broadening the benefits of growth through the expansion of employment opportunities and basic services, such as health care. Financial and technical support provided under the Project will enable the Salvadoran Demographic Association (SDA), a private national family planning agency, to increase its service coverage and provide child survival and maternal health care to over 1,550 rural villages and urban areas where SDA clinics operate. By the end of the Project, the numbers of Salvadoran couples using birth spacing methods will have increased from 120,000 (1988) to 200,000 and maternal and child health will have improved, as demonstrated by an increase in the usage of ORS package and service statistics. In addition, the SDA will have improved its operational efficiency and developed new sources of income to partially support the family planning programs offered to the poor.

The Project goal is twofold: to improve general reproductive health services in El Salvador; and to improve the quality of life and health of the Salvadoran population through the reduction of infant and child mortality/morbidity. The Project purpose is to continue and to expand the delivery of birth spacing and maternal child health services (MCH) to high risk populations in rural and marginal urban areas and improve the quality and efficiency of these services. The Project includes three components: (1) Family Health Service Delivery, which will provide support to continue and to expand the ongoing family planning service program of SDA and provide select interventions in maternal/child survival services; (2) Institutional Development, which will research and finance the development and implementation of new products and services that will strengthen the Salvadoran Demographic Association's ability to sustain its programs, and provide select quality, affordable health services to urban and marginal populations; and, (3) Policy Development and Research, which includes support for demographic studies, health

surveys, morbidity and mortality studies and coordination with other donors, providers and institutions. Project inputs will include technical assistance in communications, training, research, financial management and family planning services management (including logistics and management information systems), operational support for training and information/education programs, and commodities.

Three groups are targeted as major beneficiaries. The priority scaling of these groups presented below reflects the rural, high-risk emphasis of the Project:

a) women of fertile age and children under the age of five years living in 1,550 of the country's poorest and smallest rural communities;

b) women of fertile age and children under the age of five years living in some 100 of the country's rural towns; and

c) the general population of those marginal urban areas with populations of more than 5,000.

The total cost of this five year Project (spanning six fiscal years) is $35,826,120. A.I.D. will provide $22,000,000, or 61% of the funds required, with the SDA providing $13,826,120 (39%) through fees and voluntary contributions. A.I.D. funds will be obligated as follows:

	FY 90	FY 91	FY 92	FY 93	FY 94	FY 95	TOTAL
HE	1,500	1,000	1,300	3,200	0	0	7,000
PN	4,250	7,000	3,750	0	0	0	15,000
TOTAL	5,750	8,000	5,050	3,200	0	0	22,000

The SDA's contributions to the Project will be as follows:

1,449	2,590	2,619	2,748	2,875	1,545	13,826

B. Recommendation

The Family Health Services Project will make an important contribution to reducing population growth and improving maternal and child health, as well as reducing pressures on the already overloaded public sector to provide health care and other services for a burgeoning population. As such, the Project is consistent with the Mission's 5 year Country Development Strategy Statement, 1990-94. The Project Development and Review Committees, therefore, recommend authorization of the Family Health Services Project for a $22 Million grant to support the efforts of the Salvadoran Demographic Association pursuant to the authority redelegated to the Mission Director USAID/El Salvador by the AA/LAC (State 258688) and reconfirmed on February 13, 1990 (State 47722).

BEST AVAILABLE

II. PROJECT BACKGROUND, RATIONALE AND PROBLEM DESCRIPTION

A. Country Setting

Over the past decade, civil conflict, global recession, and a devastating earthquake have battered the economic and social fabric of El Salvador. The civil conflict that began in 1979 has caused extensive damage to infrastructure and disrupted production. On the economic front, the prosperous era of the 1970's, with its 5.4% annual average growth in GDP, was quickly brought to an end, and the country entered a prolonged economic slump from which it has yet to fully recover. Real GDP fell by 22% between 1979 and 1983, and per capita GDP fell further, by 29%. Substantial aid flows beginning in 1983 have provided some relief, and the economy has now begun a modest recovery posting annual average real growth rates of about 1.5% from 1983 to 1988. However, population growth, despite emigration, exceeded these rates and per capita GDP fell further. According to an IDB report, per capita GDP was the same in 1988 as in 1964.

Notwithstanding the economic decline resulting from the civil conflict and further exacerbated by the 1986 earthquake and a major offensive in the capital in November and December 1989, El Salvador has made progress. Most notable is the fact that democratic processes have a strong foothold, with Salvadorans turning out in significant numbers to vote four times in the past five years. And, in June 1989, Salvadorans witnessed the first transition in power between two democratically elected Presidents. The newly elected government has expressed its firm commitment to bring an end to the decade of civil conflict and to restore economic and social stability to the country, and as evidence of this commitment, has initiated peace discussions with the insurgent forces and launched a structural reform and adjustment program accompanied by a program of special assistance targeted to the poorest segments of the Salvadoran population.

B. Project Background and Setting

El Salvador, the most densely populated country in continental Latin America, has long been concerned with birth spacing and contraceptive use. Much of the early support in this area came from private voluntary organizations. Birth spacing services were first provided by the Salvadoran Demographic Association, an affiliate of International Planned Parenthood Federation (IPPF). However, the Salvadoran government quickly became involved and both private and public sector providers have been active in this area since the early sixties. In 1967, in response to the interest of the Ministry of Health (MOH), the SDA turned over much of its clinical services to the Ministry, which now has major responsibility for providing such services in the country through a system of hospitals, health centers, units, posts and rural health promoters. Concurrently, the SDA shifted its focus to temporary family planning methods.

This general division of responsibility still holds today. Service statistics collected in the 1988 National Demographic Health Survey indicate that of all users of clinical methods, 69% obtained assistance from the MOH, while only 14% of all users were assisted by the SDA; other providers (including the Social Security Institute, ISSS) accounted for the other 17%. However, the MOH has demonstrated little receptivity to new family planning initiatives. Thus, any real expansion in service coverage will likely be achieved only through the private sector, as demonstrated by the following statistics:

	MOH	SDA	ISSS	Private Clinics	Pharmacies
Oral Contraceptives	51%	23%	8%	6%	12%
Condoms	26%	41%	7%	6%	20%

Currently, there are four sources of birth spacing services available to high risk rural families in El Salvador: 1) traditional birth attendants (TBAs), 2) MOH clinical and outreach services supported by USAID, 3) SDA community-based distributors (CBDs) supported by USAID, and, 4) private voluntary agencies (PVO). Each provides different services to rural families, and each provides only partial geographical coverage.

TBA's are the traditional source of obstetric and gynecological care, providing prenatal and postpartum care and attention during births in rural communities. In recent years, the MOH has recognized the importance of these workers and has trained a large proportion of these rural TBA's in modern medical techniques. However, TBA's do not now provide any information on modern methods of pregnancy prevention.

MOH services to rural areas have been expanded since 1985, currently consisting of nearly 600 rural health promoters. These promoters make household visits in which they provide some preventive and curative care, and refer cases needing advanced clinical care and those interested in modern contraception to the nearest MOH facility. For many, the fact that rural health promoters are not equipped to advise women on the benefits and risks associated with modern family planning methods means that these rural women will not be motivated to seek out birth spacing services from a nearby MOH clinic. Those who do go to a MOH clinic for assistance, however, obtain contraceptives for a small service fee.

The rural outreach program of the Salvadoran Demographic Association consists of 800 Community Based Distributors who sell contraceptives (condoms and pills), provide contraceptive education and refer cases needing clinical care to one of four urban SDA clinics, or to an MOH facility. Like their counterparts in the public sector, these front line health care workers (i.e., the SDA distributors) need to

improve training to better respond to questions concerning benefits and risks of modern family planning. One of the main reasons why young Salvadoran women in union do not use contraceptives is the desire to become pregnant. The tendency to pronatalism has negatively impacted maternal and child health in El Salvador. This, coupled with the fact that fears regarding the negative effects of modern methods of family planning accounts for two important reasons why women are not using modern methods (Demographic Health Survey, 1988), and explains to some extent the disparity in the number of women who know about modern methods and those that use them.

A few other non-governmental organizations also provide health and family planning services in El Salvador. However, the overwhelming focus of these programs is on health care, with only limited resources devoted to birth spacing programs due to religious or other policy reasons of the organizations. Nonetheless, there are several organizations that could expand service coverage (e.g., CALMA, Pro-Life Ministries, Save the Children, International Rescue Committee) if given technical assistance and commodity support.

C. Project Rationale

1. Demographic Trends*: El Salvador is about the size of the state of Massachusetts. It has a population of over 5.1 million and a population density estimated to be 250 inhabitants per square kilometer, the highest in Continental Latin America. The population growth rate decreased slightly in the early 80's, but since 1985 has remained fairly steady at an estimated 2.5 percent per year. Fertility rates and average family size have not changed over the past three years. The Total Fertility Rate (TFR) is 4.6 children per woman (probable number of live births to a woman during her reproductive years), and rates are even higher in rural areas where the TFR is 5.9 per woman as of 1988.

From 1985 to 1988, use of contraceptives for birth spacing and to end childbearing increased only slightly among women in union, at a rate of one percent per year. Urban use increased by about 6.1% while rural use increased by only 4.1%. Although nearly ninety-nine percent of women (and ninety-seven percent of rural women) know about at least one method of modern contraception, in 1988 only forty-seven percent of women in union aged 15-44 were found to be using modern contraception. This compared to an even lower rate of thirty-four percent in rural areas.

The reasons reported for using contraception vary according to residence. Seventy-seven percent of rural women using contraception reported using it to suspend fertility while only twenty-three percent used

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*Data in this section is based on the results of the 1988 Demographic Health Survey carried out by the SDA and the Center for Disease Control, 2/89.

contraception for birth spacing. Although urban women also used contraception primarily to limit childbearing, a higher percentage (30%) used contraception to space births. In general, use was found to be most prevalent among women over 24 years of age with over three children, highest in urban areas and strongly correlated with educational level and female labor force participation. According to the 1988 survey, eighty percent of last births were desired while twenty percent were unplanned. The percent unplanned increased with the age and parity of the woman and was highest among women of low educational status.

In summary, the recent demographic and health survey revealed several areas of concern related to contraceptive use and maternal child health: (a) the low rate of contraceptive use in rural areas; (b) heavy use of surgical contraception for terminating fertility rather than use of methods for birth spacing; and (c) the high rate of fertility and low use of contraceptives among adolescents and young women.

2. Trends in Health and Nutrition: Since the late seventies and the onset of socio-political conflict and the economic crisis, international donors have provided substantial aid to the public sector. As a result of this assistance and in spite of major internal problems, key indicators taken from national surveys show gradual improvement in the health and nutritional status of the Salvadoran population.

It is important to note that although overall improvements were recorded by key indicators over the past ten years, these same indicators also experienced short-term increases during the worst of the economic and political crisis in the early eighties. Crude mortality, infant mortality and life expectancy all worsened in the early eighties before resuming their pattern of gradual improvement between 1983-1985.

Despite the rate of progress, El Salvador continues to have major health problems. Perinatal mortality, or death among children in the first month of life, claims the highest number of lives in the country among all age groups. Diarrheal disease and acute respiratory infections (ARI) continue to be among the principal causes of sickness and death. Also of particular concern is the nutritional status of young children. Weight for age measurements among children under five years have shown only slight improvement since the latter part of the seventies.

Improved maternal health and better child spacing could significantly reduce the number of infant and child deaths, which in 1988 totalled 23,000. Perinatal mortality is most probably related to early and continuous childbearing and lactation, lack of adequate prenatal care, repeated bouts of acute infectious disease, and poverty among women all of which result in low birth weights and lack of resistance to acute infectious diseases.

3. Socio-Political and Economic Trends: From the late seventies until the mid-eighties, the regional economic crisis and socio-political

conflict in the countryside combined to cause a steep economic decline in El Salvador. Although employment increased in the informal sector during this time, the economic decline resulted in a doubling of unemployment in the formal sector. This was accompanied by an increase in agricultural production costs, a drop in real farm prices and a decrease in the production of staples as well as export crops. Total food supplies per capita decreased twenty percent during this period. Conflict in both rural and urban areas caused widespread population displacement, placing great strain on public sector institutions already constrained by widespread destruction of infrastructure when these institutions were forced to take budget cuts in proportion to the total public sector budget reduction (and in real terms due to inflation).

Since 1984 there has been a slight improvement in per capita agricultural production, although farm prices remain low. As a result, the purchasing power of farm families continues to be constricted. Since 1984 the unemployment picture has also improved slightly, although when current wages are adjusted for inflation, real wages can be seen to have fallen since 1978. The purchasing power of the annual wage in 1988 is estimated to be little more than half of its 1978 value. These economic trends have obviously inhibited greater improvements in health status.

In 1989, however, the GOES began to carry out macro-economic adjustment measures designed to stimulate production and improve economic growth in the next decade. While there may be short-term negative impacts on some families' income despite GOES employment generation programs, these reforms are critical to long-term sustainable economic growth. Until the country moves onto this growth path, expanded social service programs particularly in health care, will be needed.

D. Problem Statement

Inadequate birth spacing and poor maternal health continues to result in high infant mortality rates, particularly among the rural poor in El Salvador. Although birth spacing and maternal-child health services are available throughout El Salvador, service delivery has been concentrated in urban areas while rural care is limited both in scope and geographic coverage. The current network of health care providers does not have the technical nor financial means to expand low-cost service and educational programs to areas most in need; and, the public sector programs are further hampered by policies which give inadequate priority to family planning services. Moreover, the economic situation of rural and marginal urban families continues to be difficult, reducing access to adequate medical care and increasing the risk of maternal and child undernutrition. Thus, there is a clear need for support to birth spacing and MCH service programs in El Salvador, particularly in rural areas.

E. Constraints to Improving Family Health and Birth Spacing

1. Financial and Economic Constraints: Financial constraints to the expansion of birth spacing and MCH services exist at two levels:

that of the provider, whether the MOH, the SDA or other public or private agency, and that of the user. From the point of view of the provider, inflation, economic adjustment (e.g., increases in gasoline and electricity rates), and the direct impacts of the war (e.g., burned vehicles, power outages resulting in product spoilage, etc.) have resulted in significantly higher service costs. Between 1980 and 1985, for example, the cumulative effect of inflation resulted in a 50 percent reduction in the MOH's budget in real terms. As a result, the rural service expansion plans of the MOH have been implemented only partially and equipment and medical supplies purchases have fallen; the availability of significant external donor resources, notably those from the U.S., have, therefore, been key to the stability of the system. Public and private sector programs have been equally affected, although the private sector has been able to recoup a minimal share of the service cost through fees for services.

At the user level, as noted in the previous section, family incomes have remained low, while prices for basic foods and medicines have increased. The devaluations of 1986 and 1989, combined with high import taxes on pharmaceuticals, have resulted in a doubling of the price of most medicines in the past two years. Because of these factors, both the public and private sector health agencies have been reluctant to increase user fees.

2. Institutional Constraints:

As noted in the background section of this Project Paper, first line health care workers (i.e., MOH rural promoters and SDA's distributors) do not provide trained advice to rural women and men on the benefits and risks associated with modern family planning/birth spacing methods. The MOH rural health promoters' are not permitted to prescribe clinical contraceptives, while the SDA's 800 distributers could be better trained in explaining the benefits and connection of birth spacing and maternal/child health. Both the SDA and MOH have launched efforts to improve the training and supervision of their rural workers, but further reinforcement and, in the case of the SDA, a revised strategy for rural health services, are needed.

In addition, although the SDA has extensive experience in family planning and a good reputation, leading the way by introducing new family planning methods, such as injectables, it has severe organizational problems. The organization's program has grown rapidly and the management systems and structure need revision to enable SDA to maintain its excellent reputation and still meet the challenges of a large and dynamic program. Specifically, decision making is highly centralized. While this may be convenient for fiscal control and rapid decision making, it means that decisions often do not adjust to the specific conditions of the clinics, and that the SDA at times fails to achieve an optimal use of personnel and may, therefore, incur higher costs.

Physicians in key management positions need to be replaced by full-time administrators (who may happen to be M.D.s), who are willing to devote more time to addressing personnel and infrastructure problems that have developed with the growth of the SDA. Moreover, SDA managers at all levels need better, more reliable sources of information on which to base decisions, such as would be provided through the automation of the accounting and budgeting systems and automation and expansion of the patient record system.

Finally, throughout the health care system, there exists a lack of coordination among providers, resulting in a costly duplication of services or programs. Recognizing this, the MOH established an Inter-Sectoral Health Committee to principally coordinate donor efforts in child survival. However, at the present time, no forum exists for the discussion of family planning policy and programming issues. Therefore, either expansion of the Committee's role, or creation of another forum for the discussion of issues related to family planning, for example, benefits and side-effects of injectables and whether they should be widely offered, the impact of tariffs on pharmaceuticals on health and family planning goals of the GOES, etc., should be promoted.

3. Socio-Political Constraints: Over the last ten years, health service delivery to the rural population has been restricted in the northern and eastern sections of the nation due to the conflict. In the north eastern department of Morazan, for example, the International Committee of the Red Cross provides the only source for reliable medical attention. Transportation stoppages have interrupted the regular delivery of pharmaceuticals to hospitals and health centers in nearly all areas of the country at one time or another, and in the most recent offensive, one of the country's fourteen hospitals was significantly damaged when armed insurgents took over the building and located bombs throughout it. This situation has exacerbated the already low coverage of these rural populations.

4. General Infrastructure: Access to potable water is a constraint to improving health status as diarrheal disease caused by lack of hygiene is a factor in the high rate of morbidity and mortality among children. Rates are particularly high in rural areas where access to potable water has dropped alarmingly, from 30% in 1984 to an estimated 16% in 1989. The internal conflict, high natural growth rates, and lack of maintenance of existing systems caused the precipitous drop in access. The GOES and A.I.D. have, however, recently agreed upon a program to expand potable water and associated health education programs in 2,000 rural villages, which will contribute to reversing the trend and improving family health.

5. Educational Levels: Women's educational status is directly related to the nutritional status of children as well as to the use of modern contraception. The 1988 Demographic and Health Survey (FESAL-88)

found formal education to have a positive impact on use of temporary methods. According to a recent nutrition survey, women with higher levels of education were also found to have fewer children with severe or moderate levels of undernutrition. Fortunately, women in El Salvador are becoming more educated. Most young women between 15-24 years of age have between 4-9 years of formal education compared to 0-3 years for older women.

6. Socio-Cultural Constraints to Use of Modern Contraception: Those constraints identified by the Demographic Health Survey (FESAL) which influence women's attitudes toward modern family planning may be conceptually grouped into seven categories: 1) female pronatalist attitudes, 2) fears, 2) the desire among young adults to have children, 4) religion, 5) access, 6) lack of knowledge about fertility, and 7) male attitudes toward the control of their own fertility.

When those unable to get pregnant or currently sexually inactive were removed from the sample, the category of fears was found to have accounted for seventy-five percent of the reasons why women were not using modern contraception. All were fears about the negative impact of modern methods on the well-being of the woman, future or existing child, or the dynamics of the family. The most important of these was the negative association between modern contraception and the early postpartum period or breastfeeding. According to SDA outreach personnel, women believe that birth control pills are detrimental and therefore will pass through the breast milk and cause diarrhea in the newborn. For this reason they may not be taken after pregnancy or when lactating (which for ninety-six percent of rural woman in El Salvador lasts for over eighteen months).

Women also fear side effects of modern methods. According to SDA rural promoters, women most commonly believe that modern methods will cause cancer, that pills will form a "ball" in the abdomen, that a child will be born deformed or with an IUD stuck in its body, or that they will be left permanently sterile. Men reportedly fear that contraception will change their partner's personality, making her irritable and promiscuous. Fears related to previous experiences with contraception were also a barrier to current use of contraception. Most women cited problems with the pill, IUD and injections. Fifty-six percent of rural women not using contraception believe that pills are harmful, while forty-seven percent believe that IUD's are harmful.

The second most important barrier was the young couple's desire to have children as soon as possible after union. This reason formed eight percent of reasons given for not using modern contraception. Young women in rural El Salvador begin sexual activity and form their first union in late adolescence. Eighteen percent of girls 15-19 years of age admitted having had at least one sexual encounter before forming a union. Average age at union in rural areas is 19. Twenty-seven percent of adolescents

15-19 years of age were in union and pregnant at the time of the survey. A woman's ability to have children is important for the continuance of the union itself. However, there is demand among this age group for contraception; over half of the adolescents 15-19 interviewed in the recent survey did not want to become pregnant.

The third most important barrier was religious beliefs (6.4%). This belief is not restricted to those of the Catholic faith but includes some Evangelical churches as well. Religious beliefs which are shared in the community often restrict a woman's ability to openly seek birth spacing services. This is particularly true if the source of modern contraception is clearly identified as such within the community.

The fourth reason for not using contraception was distance to the source. This was mentioned by less than one percent of women in spite of the fact that it takes over half an hour of travel by foot and on buses for most rural women to get to the nearest source of contraception.

Perhaps the most subtle, but another important barrier to the use of contraception is the Salvadoran woman's lack of understanding of her own fertility cycle. Even among women with over ten years of education, nearly seventy-five percent do not know when they are most likely to become pregnant. This lack of knowledge makes a woman powerless in decisions about her own body. She cannot understand how each method works or make reasonable decisions about the numerous options opened to her. Those women who for religious or other reasons rely on rhythm (which is as common as the use of condoms) or withdrawal cannot possibly do so effectively. It is no wonder that these methods were associated in the survey with a fatalistic outlook on life.

Male attitudes toward their own fertility also constrain use of modern contraception. Men feel that control of fertility is the woman's responsibility; only three percent of contraception in the nation is due to vasectomies or the use of condoms. However, there is some indication that male awareness has increased: from 1985 to 1988 the use of condoms tripled.

7. Policy Constraints: Article 118 of the Constitution adopted in 1983 states that The government will adopt population policies with the objective of insuring the well-being of the inhabitants of the Republic.

The existence of this rather broad and positive statement regarding population policies and family planning programs have enabled organizations such as the SDA to operate their programs generally without any government intervention, unlike other developing nations. However, in the application of this policy, the government has not demonstrated the leadership and support for family planning programs which the continuing high population growth rate merits in terms of El Salvador's economic and social development. As an illustration, continuing high

tariffs on contraceptives place these beyond the reach of more than one quarter of El Salvador's population (e.g., the price of a one-month cycle of birth control pills averages 30-40 colones, which exceeds the minimum wage for a full day of work in the urban area and several days in rural areas). In a similar vein, an aggressive family planning program would be characterized by efforts by the government to broaden the range of modern family planning methods available. Instead, the MOH continues to refuse to introduce injectables into its product line, and devotes a greater percentage of its resources to clinical contraception (i.e., sterilization) which, is used to stop childbearing, rather to other means for birth-spacing.

F. Project Strategy

As noted above, high rates of infant mortality can be directly linked to inadequate birth spacing. Yet, there are a host of constraints, notably socio-cultural and economic, which have impeded women from accessing modern methods of family planning and maternal and child health care services. In reviewing USAID's strategy for promoting voluntary family planning against the findings of the 1988 National Health Survey, particularly those which provide insight as to the large difference between women with knowledge of modern family planning methods (98%) and women who practice modern family planning (47%), the Mission has reached the conclusion that an integration of maternal child health services with family planning promotional efforts would result in increased contraceptive prevalence. The reason for this is a belief that the positive benefits of family planning, particularly as they regard the health of an existing child (e.g., dissuading nursing mothers of the belief that oral contraceptives will somehow result in illnesses in nursing infants, or demonstrating the linkage between birth spacing and higher birth-weights and better newborn health) can be more easily communicated in a non-threatening setting, such as that provided in a program that offers birth spacing counseling as an integral part of a maternal child health program.

Accordingly, the Mission has adjusted its strategy to focus on support for integrated MCH and birth spacing programs, and reduce significantly the levels for vertical programs. Given the success of the SDA's family planning program and geographic coverage, and in view of the public sector's limited commitment for birth spacing programs, USAID will focus this Project's resources on the private sector. Concurrent with the initiation of this Project, the Mission will undertake discussions with leadership in the Ministry of Health to integrate family planning services more fully into the MOH's rural health program. Contingent upon a commitment by the MOH to a more aggressive and balanced family planning program, the Mission will amend the Health Systems Support Project (519-0308) in FY 1991 to provide additional support to implement such a program.

The Family Health Services Project (519-0363) will continue to support current efforts in birth spacing and will expand coverage of birth spacing and maternal-child health preventive services to rural and marginal urban areas. This will be accomplished in the marginal urban areas by: 1) expanding the array of clinical services now offered in the four SDA clinics, and creating at least four additional rural satellite clinics, 2) creating several new urban satellite clinics serving the SDA San Salvador clinic, and 3) developing urban distribution sites (puestos) in commercial areas of San Salvador. Rural expansion will consist of: 1) decentralizing the service delivery of the SDA, 2) integrating MCH preventive services into SDA birth spacing activities, 3) expanding the scope and geographical coverage of the SDA's rural community-based distributor program, 4) developing a physician referral system for reproductive health needs, and, 5) strengthening training of rural providers to insure services reduce socio-cultural constraints such as fears, religious barriers, lack of basic knowledge, etc.

USAID will also support institutional development activities under this Project designed to address institutional constraints and increase the financial sustainability of the SDA and provide a range of complementary MCH and other clinical services. This will include: 1) development of a Central Referral Center and Day-care Surgical Unit, 2) expansion of the social marketing program, and 3) testing of other service expansion schemes to both generate an income and broaden service coverage.

Finally, the strategy of this Project also includes support for policy development and research and coordination efforts. Research activities will address policy constraints and provide new information about specific contraceptive methods, and national-level data on the most important issues in maternal-child health and birth spacing. The results of these studies will enhance Project implementation, identify significant policy issues for further USAID, MOH and SDA attention, and provide data for evaluation of impact.

G. Relationship to Other USAID Projects

Three other USAID Projects will directly complement the Family Health Services Project. First, on the public sector side, and as noted earlier, the Mission plans to amend the Health Systems Support Project, No. 519-0308, to add support for birthspacing/family planning programs to the second Project component, Improving Basic Health Services Delivery, which focuses on the extension of MOH rural outreach programs. Commodity as well as technical support would be provided to the MOH under the amended Health Systems Support Project.

The Mission's Public Services Restoration Project, No. 519-0320, provides support for health education and the construction of rural water systems (typically water points) to expand access in rural areas to

potable water. Under this Project, approximately 2,000 rural villages will gain access to potable water. To the extent appropriate, activities under the Family Health Services Project will be coordinated to enhance the impact of both projects. For example, the SDA Pro-Family Health Promoters will be used to identify possible target communities for the water points to be constructed under Project 519-0320.

Lastly, USAID is now developing a new PVO Maternal Health and Child Survival Program, No. 519-0367, which will strengthen and expand the MCH activities of primarily local PVO's. As now envisioned, this Project would be focussed on areas now unserved by the MOH or by the SDA, and thus broaden overall MCH coverage.

The SDA will continue receiving financial and technical support from other sources, specifically:

- technical assistance, contraceptive commodities, and administrative support from the International Planned Parenthood Federation, Western Hemisphere Region (IPPF/WHR);

- support for the voluntary surgical contraception program from the Association for Voluntary Surgical Contraception (AVSC); and,

- from Family Health International, FHI, for supporting research activities, such as the ongoing study of NORPLANT (an injectable contraceptive).

The AVSC project is funded by A.I.D., through S&T/POP. The FHI research project is funded by the USAID through project 519-0210, Population Dynamics.

H. Consistency with GOES and A.I.D. Strategies

The recently-approved GOES Population Policy (1988) clearly recognizes the need for achieving outreach in birth spacing and child survival service delivery. As noted above, the MOH has taken the lead in establishing committees to coordinate donor resources provided for child survival and maternal health. The MOH is also committed to the expansion of rural health services, albeit with limited attention to the issue of family planning. It has doubled the number of rural health promoters since 1985 and regional health offices continue to strengthen preventive and curative health services. Moreover, the GOES' draft Five Year Plan discusses the need to coordinate public and private sector efforts to maximize the use of public funds spent on health care programs, focussing on the problems of malnutrition and infant mortality through prevention.

The Mission strategy for the health, population and nutrition sector, as articulated in the CDSS for the 1990-1994 period: 1) shifts resources from curative to preventive services and from urban to rural

populations and, 2) increases the utilization and coordination of private sector health delivery systems.

This Project is fully consistent with both GOES and Mission strategies as it will support new and expanded private sector birth spacing and maternal-child health services to high risk populations in rural and marginal urban areas.

III. DETAILED PROJECT DESCRIPTION

A. Goal and Purpose

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

The Project purpose is to continue and to expand the delivery of birth spacing and maternal child health services (MCH) to high risk populations in rural and marginal urban areas and improve the quality and efficiency of these services.

By expanding the delivery of birth spacing services, and in turn, contraceptive prevalence, the Project will contribute to a direct impact on infant and child mortality. The introduction of select maternal child health care interventions, such as the use of oral rehydration salts, will complement the birthspacing services, by making family planning more accessible. Moreover, the addition of select maternal child health care interventions is valuable in and of itself, given the gaps in the current health care system. While important, the select MCH interventions are secondary, the major focus of the Project will be on expansion of birth spacing services.

B. End of Project Status

By the end of the Project its implementation will have achieved the following:

a) increased the number of Salvadoran couples using birth spacing methods from 120,000 in 1988 to 200,000 in 1995;

b) incorporated child survival modalities (vaccination, ORS distribution, growth monitoring, breast feeding promotion, hygiene education, vitamin A distribution, ARI treatment, etc.) in the routine of birth spacing services offered by SDA rural promoters;

c) increased the number of cases treated for diarrhea (via ORS packets distribution) in selected rural areas from 10% to 50%; and

d) increased rural contraceptive prevalence from 34% to 40%.

C. Project Beneficiaries

The principal beneficiaries of Project activities will be women in fertile age and children under age five in 1,500 of the country's poorest and smallest rural communities, where SDA's pro-family health promoters (PHP) will provide birthspacing and maternal/child health counseling and services. In addition, SDA's program will provide assistance to women and children under age five in approximately 100 additional rural towns and marginal urban areas close to SDA's regional facilities (e.g., San Salvador, Santa Ana, etc.) and to men in fertile age from marginal urban and rural areas. Within this beneficiary population, the Project will devote special attention to the following sub-groups, who were identified as priority audiences for birthspacing programs through the analyses of the 1988 National Health Survey:

a) Youths, living in rural and marginal urban areas, between the ages of 15-24 years of age with low levels of formal education and who are active sexually; and

b) Pregnant women.

c) Children under the age of five years

In the long term, Project activities in birth spacing, may influence maternal, infant and child mortality, employment rates, school attendance, educational levels and economic status. The selected interventions in maternal child health will also contribute to reductions in maternal, infant and child mortality rates and malnutrition, as well as morbidity and mortality rates due to diarrhea, acute respiratory infections and immunizable illnesses among children under five years of age. These benefits are described in more detail in Annex G.

D. Project Components

COMPONENT I: FAMILY HEALTH SERVICES DELIVERY:

The main objective of the Project is to expand family planning services offered to rural areas and extend services to selected marginal urban populations. In addition, in order to stimulate expansion and increase the effectiveness of birth spacing programs of the SDA, maternal/child health care activities will be added to available services. This Component will deal with activities in both rural and marginal urban areas of the country, as well as maintain and, if possible, increase current service delivery in the urban areas of El Salvador. The activities of this Component will help to overcome socio-cultural constraints to the use of modern contraception through information, education and communication programs primarily of an

interpersonal nature, de-emphasizing the use of mass media, and financial and institutional constraints through improvements in the efficiency and effectiveness of clinical and outreach programs of the SDA. The Project includes the following MCH concerns:

i) Diarrheal disease - causes and methods of prevention (e.g., washing vegetables, boiling water, etc.), provision of parasite medicine, preparation and use of oral rehydration salts and home electrolyte solutions;

ii) Immunizable illnesses - which illnesses are preventable, how vaccines work, and where to refer mothers and children;

iii) Respiratory infections - identification of individuals at risk, detection of infection, simple treatment and knowing where and when to go to obtain medical attention; and

iv) Nutrition - prenatal diet, children's diet, distribution of prenatal vitamins and vitamin A supplements, promotion of breastfeeding, starting a home garden, and growth monitoring.

a. Reorganization and Expansion of Rural Services: To expand rural services requires reorganization and extension of the current rural outreach program. The Community Based Distribution (CBD) program will be continued throughout the life of the Project, but on a reduced scale (i.e., the number of contraceptive distributors will be reduced from 800 to 400). This level of CBD workers, coupled with the increased numbers of new health promoters (PHP), will enable SDA to sustain the levels of contraceptive sales realized in 1989. Complementing this program, the SDA will initiate a new Pro-Familia Health Promoter program. To begin, the SDA will select 400 community volunteers to serve as Pro-Family Health Promoters and train these individuals in contraception and birth spacing methods and complications, the importance of integrating birth spacing and extending rural service delivery, and the above mentioned maternal-child health problems and interventions.

Training will also focus on improving information and education skills of the CBDs and PHPs. These promoters will be trained at the beginning of the second year of the Project using selection procedures as described in Annex G. The new name (i.e., Pro-Family Health Promoter) will signal the community that the SDA provider no longer only distributes contraceptives, but also provides basic maternal and child health care assistance; the intent is to provide a non-threatening environment in which women will be more likely to seek out information on birth spacing methods.

Over the life of the Project an additional 750 community volunteers will be added in three phases (of 250 each). By the end of the Project, the SDA's rural outreach network will have been expanded to

include 400 CBD's and 1,150 Pro-Family Health Promoters (PHP). Concurrently, SDA will improve the supervision of these workers by adding additional supervisory teams (consisting of a nurse and a driver). The current ratio of 1 supervisor per 250 CBDs will be reduced to approximately 1 supervisory nurse per every 85 health promoters/CBDs. These supervisory teams will also receive training in the areas described above, as well as supervision and motivation techniques (see Annex H for further details).

b. The Social Marketing Program (SMP): The SDA's social marketing program, which consists of the sale of products donated by A.I.D. to retail outlets (e.g., pharmacies and "mom and pop" stores), will be expanded to include additional outlets, thereby making low cost contraceptives accessible to a wider segment of the population. These outlets currently provide oral contraceptives to 18% of all users of oral contraceptives and to 26% of condom users. In addition, as described in Component II of the Project, the range of products sold in these outlets will be increased, as a means for increasing the availability of ORS and other medical supplies, as well as improving SDA revenues and, in turn, the financial viability of the SDA.

c. Expansion of SDA Clinical Services System: The SDA Clinic system will be significantly expanded during the life of the Project, through: a) the expansion of services offered in existing SDA Clinics; b) opening of twelve marketplace clinics and six new marginal urban satellite clinics, and c) addition of fifty private physicians to the rural referral network of the SDA. Details of these activities follow:

i) SDA Clinics. SDA now has four clinics located in Santa Tecla, Santa Ana, San Miguel, and San Salvador. The four SDA clinics accept referrals from the CBDs for clinical services and provide the full range of contraceptive methods including natural family planning to walk-in patients. These clinics also identify and treat problems related to the use of modern contraception, sexually transmitted diseases, infertility and cancer. These services will be continued under the Project, and others, such as general medicine, pediatrics and wider gynecological services, will be introduced. Evidence collected by the SDA suggests that considerable demand exists for general medical care and pediatric services from private care facilities such as the SDA which charge reasonable fees. Technical assistance financed under the Project will assist the SDA in further analyzing the demand for such services and developing a viable plan for their initiation on a financially sound basis (i.e., with appropriate cost-recovery mechanisms). Upon completion of this feasibility study, the Project will finance equipment and technical assistance related to this service expansion. In addition, if beneficiaries need an increased level of care or services not available in the local SDA clinic, they will be referred to the SDA Central Referral Clinic, which will be financed under the Project (see Component II).

ii) Marketplace Clinics. To extend marginal urban area coverage, SDA will establish new service outlets ("stations") in 12 of the municipal markets in El Salvador. These stations will be in the heavily populated commercial markets and designed to serve high-density, low income areas. A previous SDA effort of this type in the 1970s indicates that the exposure afforded by the marketplace location should generate a significant increase in the demand for birth spacing and maternal-child health services.

These stations will be staffed by a trained health promoter and consist of one room in a store front location provided by the municipality at little or no cost. These market-based health promoters will provide services which are similar to those of their rural counterparts discussed in detail above (i.e., the distribution of contraceptives and MCH commodities and health education activities), and receive the same types of training and supervision. As with the CBDs and PHPs, complex birthspacing or MCH problems will be referred to the SDA clinics or other private providers.

iii) New Satellite Clinics. The Project will create up to six new "satellite" clinics located in areas of the country not now adequately served by the SDA, including marginal urban areas of San Salvador and possibly San Francisco Gotera, La Union, Chalatenango, or Metapan. These will serve as additional entry points for the marginal urban and rural population, and provide basic health promoter services. Staffed by an auxiliary nurse with periodic physician back-up, these satellite clinics will be able to provide a slightly higher level of services than the PHPs or marketplace clinics, particularly related to MCH services. However, complex problems will still be referred to the nearest full-service SDA clinic or other health care provider.

Birth spacing and maternal child health care services will be provided at the lowest possible cost to the recipient. Fees will be based on a sliding scale depending on the nature of the services provided and the recipients' ability to pay; the scale will be reviewed and, if necessary, revised annually to reflect costs and the changing economic situation of the poor.

Prior to initiating all six clinics, the SDA will test the viability and cost-effectiveness of satellite clinics for urban population. This testing will be carried out in San Salvador, which has the highest population density and is most accessible to the SDA Medical Director. A six month lease of suitable sites and the assignment of two auxiliary nurses for 20 hours per month each will test the feasibility of these clinics. The six month period will also allow testing of demand and desirability. The satellite clinics must demonstrate that they can create a higher demand than a CBD who has no fixed operating costs and is performing many of the same services as the satellite clinics. The difference is that the point of entry will be an auxiliary nurse rather

than a CBD, and therefore referrals will be directly to the physician or the SDA clinic. This may also help to increase the demand for birth spacing services.

iv) Physicians Network. The expansion of SDA's rural and marginal urban area outreach programs, through CBDs and rural health promoters, will result in greater demand for more complicated medical services in birth-spacing. While the SDA now operates referral clinics in four major Salvadoran cities to handle some of these cases, it is expected that the demand for services will outstrip SDA's current capacity. Moreover, it will be more cost-effective if patients having complex problems see physicians in sites closer to where the patients live. Accordingly, under this Project, SDA will establish a physicians referral network, consisting of fifty physicians. These doctors will be selected from rural towns or close-by urban areas to serve the highest risk and most underserved areas of El Salvador. They will be trained in the Maternity Hospital and will be supervised by the SDA Medical Department. A standard below-market fee schedule will be developed by SDA which doctors will use for patients referred by SDA. Patients will pay a portion of the fee, with SDA making up the remainder.

d. Improved IEC Support System: Data concerning socio-cultural constraints to the use of modern contraception identified by the 1988 Demographic Health Survey, as summarized in the constraints section of this Project Paper, places information, education and communication (IEC) activities alongside those activities designed to expand service coverage in terms of importance to Project success. Therefore, significant levels of Project resources will be devoted to these supportive activities, as follows:

i) Information. The term applied to those activities which convey printed messages to the client is information. The preparation and distribution of posters and pamphlets comprise most Project activities of this type. These materials convey information to the rural and marginal urban participants, as well as to CBDs and PHPs. SDA currently produces and distributes a wide variety of such materials on birth spacing and family planning. These materials will be modified under the Project to reflect findings of DHS 88, for example, to dispel illogical fears about possible side effects from use of IUDs and oral contraceptives.

New materials for target populations, particularly in maternal-child health and child survival topics will also be developed and distributed. As Child Survival has been a focus in the region over the past five years, it will probably not be necessary to develop entirely new materials for these topic areas. However, modifications will probably be necessary in some cases; this, unfortunately, will require lengthy efforts in design, field testing, re-design and often re-testing before materials are finally available for reproduction and distribution.

ii) Education. Education is interpersonal communication which takes place on an individual level or in groups. PHPs, CBDs, and Referral Physicians are actively involved in educating their clientele. These activities may make use of printed material or other educational aids. Under the Project, technical assistance will help SDA to expand and make more effective its public education program. USAID will fund two educational projects proposed by SDA. One will increase demand for male methods by using male "satisfied users" in rural and marginal urban areas. In rural activities, the educator/drivers who are a part of the supervisory network will coordinate this activity. The second, medical sector training, will provide private practitioners serving rural and marginal urban populations with education in family planning. A recent study found sixty-five percent of private practitioners have had no courses in family planning since attending medical school.

iii) Communication. The communications section of public education consists of the use of mass communications media, specifically radio and television. Although the Project will focus primarily on increasing education via methods of personal interaction, some television and radio messages are essential for reinforcement. The emphasis on such announcements will, however, be significantly reduced from prior years and a greater proportion of the communications budget will be used for radio (i.e., 70% of the budget, versus 30% for television).

SDA will select and contract a new publicity agency to manage television and radio coverage and other mass media promotions (following procedures of Handbook 11, Host Country Contracts). The spots will emphasize the new SDA image (i.e., Family Health, highlighting services such as men's clinic and the wider range of pediatric care available). New media spots will be designed to be culturally sensitive and directed primarily toward the most important market segments.

Radio coverage will follow the strategy of television coverage. Airing of existing spots will continue. Some new spots will be developed in the same topic areas as those selected for television. These media spots will be coordinated not only with TV messages, but also with the inter-personal education which is taking place through the rural outreach activities of this Project.

e. Inputs: A.I.D. Project funds totalling $15,546,900 will be used to finance technical assistance, training, IEC activities, equipment and materials and contraceptives. Counterpart resources equivalent to $3,040,260 will be used to finance SDA counterpart for rural/urban expansion activities, expansion of clinical services and part of the Information, Education and Communications campaign.

COMPONENT II: INSTITUTIONAL DEVELOPMENT:

This component of the Project will enhance the financial viability of the Salvadoran Demographic Association through improvements in the SDA's organizational efficiency (e.g., re-organization of SDA's clinical services and referral mechanism to improve efficiency, and new cost-recovery schemes) and the addition of new services which, in addition to generating income, will provide quality affordable clinical services to a slightly higher income segment of the urban population. This Component directly addresses the existing institutional constraints of SDA, through development of the following activities:

1) expansion of the Social Marketing Program (SMP); 2) establishment of a new Central Referral Clinic (CRC); 3) marketing and feasibility studies related to additional SDA medical services expansion; and 4) improvements to operational efficiency.

a) Expansion of the Social Marketing Program. As discussed earlier, the Social Marketing Program (SMP) involves the sale of modern contraceptives (provided free of charge to the SDA) through local retail outlets. Prices are significantly below prevailing market rates. During the last three years, sales have increased significantly:

Year	Revenues in U.S. $
1987	139,000.
1988	205,000.
1989	233,000.
1990 (projected)	243,000.

In spite of this impressive increase in sales, the program is not able to cover its costs. New products or other ways to increase revenues or to decrease costs must be implemented to improve the cost effectiveness of this program, which constitutes an important contribution to increasing contraceptive prevalence. Therefore, during the Project, technical assistance personnel will help SDA to explore new products to add to SDA's social marketing program's sales. One of the problems in selling new products is that they will need to be "non-registered" i.e., not taxable. This limits the number of potential new products. If further investigation concludes that the range of non-registered products which could be sold is inadequate, the option of creating a subsidiary of the SDA to sell "registered" products will be explored. Expansion of the product line must also proceed cautiously, so as not to diminish the vigor of the contraceptive sales program which must remain a priority.

b) Establishment of a Central Referral Clinic (CRC). This will be one of the key elements for enhancing the self-sufficiency of the SDA program. The primary function of the Central Referral Clinic is to

provide a more complex technical level and array of services to participants, centralizing services in one location for the low income population, and, thereby achieving cost savings. However, in addition to these cost savings, the CRC will include a "private medical center" which will offer general and speciality doctors' services (e.g., pediatrics, outpatient surgery unit, dental services) to a slightly higher income segment of the population who can afford to pay for a private physician. Income will be generated through the rental of office space and/or cost/risk-sharing arrangements with the resident physicians.

Low income patients referred to this Clinic will receive advanced family and maternal child health services. For the other services of the Central Referral Clinic, SDA will establish a fee to charge the patients based on the medical/surgical specialty provided. SDA will share this fee with the provider. The purpose of these offices is to provide SDA with the maximum income possible while providing services within the scope of its mission. For more details about the installation and operation of diverse services of the Central Referral Clinic, see Annex G., section G.5.

If the projected revenue schedule described in the financial section of this paper is achieved, it will generate $718,700 in additional net income for SDA during Project life. This income will then partially subsidize the rural extension and marginal urban services described in Component One. The Central Referral Center is therefore a financial and programmatic link to the other services offered by SDA.

c) Marketing and Feasibility Studies. In addition to the two activities described above, the SDA will carry out studies to determine whether other service expansion options would be viable. Among the options that will be studied are the following:

1) Additional Medical Services in Existing SDA Clinics. In addition to the establishment of a private medical center in the Central Referral Clinic, the SDA will also assess the demand and potential cost-effectiveness of introducing either general or specialty services to other SDA clinics. The addition of more services such as general medicine, pediatrics, and possibly dentistry, may provide SDA with additional revenues, and may enable SDA to offer this care at prices appropriate for families who cannot afford private physicians at regular prices but are willing to pay more than for what they will receive at the MOH clinics.

A market analysis will determine if sufficient demand exists for these additional low-cost medical services and which SDA clinics are most likely to succeed. Improvements in infrastructure for each clinic will offer the public a service viewed as equal in quality to those provided by private

physicians. These renovations will also provide additional consulting offices for the new physicians and separate them physically from the birth spacing activities. The pilot test may require nine months including an active promotional campaign to establish actual existence of demand.

2) Medical Insurance Company. According to a preliminary study recently carried out for USAID/El Salvador, the SDA, in order to diversify its services and attain more financial self-sufficiency could consider starting a medical insurance company. This option has the potential advantage of generating additional income through the expansion of SDA-serviced population to include individuals without insurance (e.g., domestic employees) or employees of firms who want an option to Social Security. Many companies in El Salvador already have arrangements with private physicians which they use in lieu of Social Security for minor medical problems. An employee/employer plan which offers their employees and families a higher level of medical service with reduced loss of work-time may be an attractive option.

Although starting a medical insurance company may be desirable, it will not be considered for the next two years as SDA will need to devote its energies to adding new services required in the rural and marginal urban areas, and improving SDA's efficiency in delivering those services it now offers. Starting a medical insurance or a prepaid program poses more risks than advantages. Further, SDA's management does not now have the time or expertise to start such a sophisticated program, and there are financial risks in starting an insurance company that SDA cannot now afford to assume. After a period of two years, if SDA is in a better operational and financial position and has the financial reserves that would be necessary to start-up this subsidiary company, its feasibility will be studied.

The combination of the Central Referral Clinic and the expansion of the Social Marketing Program, combines with other SDA income (excluding any estimates from activities to be studied), will allow significant increase in SDA contributions to its own sustainability. The current growth rate of the Social Marketing Program will allow it to generate $1,925,600 during the life of the Project. The medical clinics, including the Central Referral Clinic, will generate $1,713,100, while other sources will contribute $714,300 in the same period. As a result, the SDA will become increasingly self reliant during the life of the Project. See Table 1, Projected Revenues for a Four Year Period on page 26, and Tables 2, Cost per Contraceptive User by Year and 3, Sources of Project Financing by Year on page 27.

d. Improvements to Operational Efficiency: The service expansion plans outlined in Component I must be carried out in concert with changes to SDA's organization, staffing, and operating procedures if the programs are to be effective and achieve some degree of financial self-sufficiency. Thus, activities under this Component will include technical assistance and operational support for decentralization and improved supervision of SDA programs; improvements to management information and financial accountability systems; and modification of personnel policies, such as training and payment plans. These activities respond directly to institutional and administrative constraints identified in the Institutional Analysis conducted as part of Project Development.

One major goal of SDA will be to decentralize its administrative systems to place supervision and decision-making as close as possible to operational levels, thereby improving efficiency. For example: a) the SDA Clinics will have greater autonomy; b) a business manager will direct the Central Referral Clinic; and c) each new or expanded SDA program will have sufficient supervision and independence to carry out its objectives.

Technical assistance personnel will cooperate with the Board of Directors, the Executive Director and the Department/Clinic Chiefs to develop and implement a Management by Objectives system following the principles developed by the American Management Association. Training and programs will also be provided to the Board of Directors and the Executive Director to facilitate mastery and use of strategic planning procedures. Broad goal setting, needs assessment, discrepancy analysis and related techniques will be used to help ensure that available resources are focussed on priority goals and objectives. The adoption of MBO and training in strategic planning will help increase efficiency of operation, establishing systematic milestones against which to evaluate processes and progress. Each department will create annual, semester and quarterly objectives for its activities, sales, training, etc. Quarterly meetings will evaluate progress toward established objectives, resources required, progress and problems and other issues related to improving performance.

Refinement and modernization of the existing accounting, remuneration and inventory systems, with help from technical assistance and other means should achieve the best results consistent with the goals and objectives of SDA. These efforts will be closely coordinated with the strategic planning, management by objectives and human resource development activities of this component's training strategy.

An Improved SDA Management Information System (MIS) will be established in the San Salvador Clinic to encode medical records of all SDA clients and to create a medical data bank which will assist the physicians and nurses in providing better diagnostics and services. The MIS will also include a complete inventory and accountability of the

TABLE 1

REVENUES GENERATED BY SDA - PROJECTED REVENUES 1990-94
(000's US$)

Revenue Generating Activities	Appr. 1990	Proj. 1991	1992	1993	1994	1995	Total 5 Years
Social Marketing Program	243.0	300.0	359.1	390.4	410.3	222.8	1,925.60
Satellite Clinics	77.4	162.2	199.8	211.7	224.4	118.9	994.40
Cen. Ref. Clinic (CRC)	0.0	0.0	158.8	195.8	229.7	134.4	718.70
Medical Clinics Subtotal	77.4	162.2	358.6	407.5	454.1	253.3	1,713.10
Education & Training	1.8	3.8	4.5	4.8	5.1	2.7	22.70
Administration	9.8	19.5	19.5	20.7	21.9	11.6	103.00
Public Relations & Research/Development	35.2	107.7	118.0	125.0	132.5	70.2	588.60
TOTAL REVENUES	367.2	593.2	859.7	948.4	1,023.9	560.6	4,353.00

Note: SDA revenue projections for 1995 cover a six month period up to PACD.

TABLE 2
ESTIMATED COST PER CONTRACEPTIVE USER
BY YEAR AND PROGRAM
(IN US$)

PROGRAM	1990	1991	1992	1993	1994	1995
Community-Based Distribution	10.00	12.00	15.00	10.00	8.00	6.00
Social Marketing	8.00	10.00	10.00	8.00	6.00	4.00
Clinic	10.00	20.00	10.00	15.00	12.00	10.00

TABLE 3
SOURCE OF FINANCING
BY YEAR
(IN 000's US$)

INSTITUTION	1990	1991	1992	1993	1994	1995
A.I.D.	5.750	6.250	4.000	3.000	2.000	1.000
I.P.P.F.	.500	.500	.500	.500	.500	.500
Other AID	.050	.050	.050	.050	.050	.050
SDA	.270	.600	.900	.970	1.050	1.140
TOTAL	6.570	7.400	5.450	4.520	3.600	2.690
PERCENT AID	85.91%	85.89%	73.39%	66.37%	55.56%	37.17%
PERCENT SDA	4.64%	7.36%	16.51%	21.46%	29.17%	42.38%

Santa Tecla warehouse. This MIS will improve the procurement system of SDA. It will be established by the technical assistance team utilizing current SDA computer equipment and some additional equipment as needed. The proposed system will contribute to the achievement of goals by: 1) providing a valuable tool for research, monitoring and better accountability of the interaction of SDA with its patients; and 2) allowing immediate access to patient data, preparing statistical tabulations and reports as needed on accounting and health variables gathered daily i.e., reports on the number of patients served, revenues collected from patients, revenues collected by the new expanded rural health clinical services. Overall financial data and specific information on the warehouse operations will also be more easily prepared.

Finally, this Project will also assist SDA in improving its personnel management policies. Careful analysis of skills, knowledge and attitudes required for optimal functioning in each position in SDA will be carried out, leading to development of internal selection, training, retraining and motivation procedures. Systematic implementation and monitoring by the Executive Director and Board of Directors will advance the staff efficiency to the highest possible levels consistent with organizational goals.

As a result of activities contemplated under Component II, average cost per user will decrease over the life of the Project. Over the first three years of the Project, costs per user per program will increase, due to the costs associated with launching all the new programs (e.g., training and purchase of equipment). These additional costs will be largely paid for with grant resources, given that modifications to the fee schedule can only be undertaken gradually. As observed in Table 2 on the previous page, the cost per user increases from $10 per user in 1990 to $15 per user in 1992. However, upon completion of start-up costs for system expansion, outlays begin to decrease until the cost per user by the end of program reaches an estimated $6 per year.

e. Inputs: International and national long and short-term technical assistance, as well as commodities and operational support will be financed with $3,838,100 in AID dollar resources. Counterpart funding for this Component will total $4,239,870 and be used for some local currency costs associated with the expansion of clinical services, the Social Marketing Program and participant training. See Annex J.

COMPONENT III: POLICY DEVELOPMENT AND RESEARCH

a. Research and Policy Dialogue: As noted in the background and Constraints sections of this Project Paper, national policies which place contraceptives and other medicines out of the reach of the poor population, as well as institutional policies which result in inadequate resources being devoted to maternal and child health problems, have inhibited greater strides in birth-spacing and improving child health. Accordingly, research activities and concomitant efforts to disseminate findings and improve targeting of scarce resources (e.g., donor coordination) are an important part of this Project. The findings of research studies will be used to both enhance SDA's project implementation, as well as to strengthen the policy framework of the country by more accurately identifying and targeting vulnerable population groups, increasing the awareness and acceptability of available modern birth spacing techniques, and improving understanding of the role of communication and education in family planning and health care programs.

The Project will finance the following research activities:

Demographic Health Survey (FESAL): The Demographic and Health Survey, the single most important source of information about national demographic and health trends in El Salvador, has been conducted twice in the past. In both instances implementation and analysis was done by the SDA with technical assistance from the Center for Disease Control (CDC). Findings have been instrumental in the design of this project, as well as policy level discussions with the Ministry of Health on the need for a more aggressive family planning program. This Project will fund a third FESAL planned for 1993. Outside technical assistance will be necessary in all stages of study design, implementation and analysis. The results of the FESAL will be available in 1994 and will be disseminated through a national seminar. In addition, the Project will finance additional analysis of data collected in the first two FESALs. on topics such as perinatal mortality.

MCH Morbidity and Mortality Study: Perinatal mortality is the major cause of death in El Salvador. Although the recent FESAL surveys have provided much information about infant mortality, little to nothing is known about the causes of perinatal death. For this reason, USAID will fund a prospective study of perinatal mortality as a part of this Project (AID buy-in). The study, to be done in 1993-95, will utilize the national sampling frame developed by the FESAL. As a prospective epidemiological study, it will require careful design and intensive field work. Outside technical assistance will be necessary in all stages of study design, implementation and analysis. The results of the MCH Survey will be available in 1995, and used to focus health agency attention on this pressing health care issue affecting children.

Studies and Research in Contraception: During the life of this Project several studies may improve understanding of contraceptive

methods or services. A study of the impact of the Norplant 5-year contraceptive is currently underway in a joint effort with Family Health International (FHI) and SDA. This Project will assume responsibility for the remainder of the Norplant Study (AID buy-in). Other studies may include anthropological research on men's attitudes toward the use of modern contraception, and the effectiveness of utilizing "satisfied users" groups for service delivery.

IUD Postpartum Study: This study is also currently underway as a joint project between the Maternity Hospital, the Salvadoran Social Security Institute (ISSS), and SDA. The study will evaluate the acceptance of IUD use by the medical community and users in order to define problems inhibiting broad acceptance and design methods and solve them. The study will be near completion at the beginning of this Project (June, 1990). The Project will fund an additional year - through June, 1991 - to allow for the IUD Postpartum Study to be completed (AID buy-in). Dissemination of the results of the study will be accomplished through a national seminar.

SDA Program Design and Effectiveness: To obtain measures of effectiveness of service (how well services are delivered), SDA will conduct three studies during the life of the Project. These will take place in 1991, 1993 and 1995. Studies on the effectiveness of SDA clinical services will also be conducted. These will take place during the first several years of the Project and will be used to improve service delivery. The results of these studies will be used to evaluate and modify SDA training and education activities, as well as to evaluate Project activities during the midterm and final Project evaluations.

The results of all of the studies listed above will be disseminated and discussed, as appropriate, on a national level. The Project will provide funding to the SDA to facilitate regular meetings of all the health care agencies and donors, to inform them of ongoing research efforts and to facilitate the exchange of information on program plans and successes, thus avoiding perhaps costly duplication or contradiction of efforts. Donor coordination efforts will be carried out at two levels: national and community.

The national level context of the SDA's Family Health Services Project includes all those agencies providing services for birth spacing and maternal-child health in El Salvador. Major donors and providers in these fields include the Ministry of Health (with Projects funded by USAID, UNFPA, and PAHO), and private voluntary organizations participating in the USAID PVO Maternal Health Child Survival Project, 519-0367.

On the local community level, health promoters of the MOH and private voluntary organizations, pharmacies and traditional sources of care, including traditional birth attendants (parteras empiricas) and

traditional practitioners (curanderas), all provide birth spacing and other MCH services.

b. Inputs: This Component includes short-term international technical assistance, training in research methodologies (emphasizing recent developments in data gathering and analysis techniques), operational support and limited commodities totalling $3,260,800, of which $1,793,800 will be financed by AID and $1,881,900 will be financed by SDA.

IV. FINANCIAL PLAN

A. Project Budget

The cost associated with the Family Health Service Delivery Project is $35,826,120, of which A.I.D. will finance $22,000,000 and the Salvadoran Demographic Association will contribute $13,826,120 in counterpart funds and generated revenues. A.I.D. resources will be used to finance technical assistance and training ($5,573,300), logistics and commodities ($4,575,600), program administration ($6,390,200), the I.E.C. campaign and research ($3,395,000), program audits and evaluations ($821,200) and provide for contingencies and inflation ($1,244,700). SDA will contribute $13,826,120 in counterpart funds and generated revenues. Counterpart resources from the Salvadoran Demographic Association will finance local currency costs associated with the rural/urban outreach program ($885,450), expansion of clinical services ($3,845,200), the I.E.C. campaign ($22,670), the Social Marketing Program ($2,513,250), program coordination with other donors ($1,781,920), research and participant training ($113,540) and program administration and overhead ($2,637,840). Other contributions account for $2,026,230.

See Tables 4 through 7 on the following pages for more detail on the Project's financial plan.

B. Recurrent Cost Analysis

Recurrent Costs to SDA created as a result of this Project total approximately $750,000, of which nearly $700,000 represents annual salary costs. These additional annual costs are essential if SDA is to reach its expanded service targets. Moreover, over the long term, the operational efficiencies and service expansion financed by the Project will result in reduced average cost per user (from $10 in 1990 to $6 by EOP). Lower service costs will place family planning within the reach of thousands more Salvadorans than now enjoy access to this service.

However, SDA will not, during the life of this Project, attain financial self-sufficiency. While this is a long-term objective, the rationale of the Project must be based on the greater social and economic good to be derived from making birth-spacing and maternal-child health

TABLE 4
SUMMARY COST ESTIMATE AND FINANCIAL PLAN
(US $ 000)

SOURCE	AID		SDA		TOTAL
	FX	LC	FX	LC	
FAM. HEALTH SERV.	6,680.05	8,866.85		3,040.26	18,587.16
INST. DEVELOPMENT	2,854.65	983.45		4,239.89	8,077.99
POLICY DEVELOPMENT AND RESEARCH	998.50	795.30		1,881.90	3,675.70
AUDIT/EVAL.	821.20				821.20
OTHER CONTRIB. AND OVERHEAD				4,664.07	4,664.07
TOTAL	11,354.40	10,645.60	0.00	13,826.12	35,826.12

	A.I.D.	SDA	PROJECT
GRAND TOTALS	22,000.00	13,826.12	35,826.12

TABLE 5
SUMMARY COST ESTIMATE BY INPUT AND COMPONENT

AID Budget by Component/Item (US$000)	COMPT. I FAM. HEALTH SERVICES	COMPT. II INST. DEV.	COMPT III POLICY DEV. RESEARCH	AUDIT AND EVALUATION	TOTAL
Tech. Asst.	2,519.20	1,805.00	675.00		4,999.20
Training	380.70	193.40	0.00		574.10
Logistics & Commodities	3,883.40	692.20	0.00		4,575.60
Program Adm. & Coordination	5,597.60	732.60	60.00		6,390.20
I. E. C.	2,751.10	0.00	0.00		2,751.10
Research	0.00	0.00	643.90		643.90
Audits & Evaluations				821.20	821.20
Contingencies and Inflation	414.90	414.90	414.90		1,244.70
TOTAL	15,546.90	3,838.10	1,793.80	821.20	22,000.00

TABLE 6

PROJECTION OF EXPENDITURES BY FISCAL YEAR (SUMMARY)

Family Health Serv. Delivery Budget AID & Contraceptives in 000's US$	FY90		FY91		FY92		FY93		FY94		FY95		Total	
	AID	SDA	AID	SDA	AID	SDA	AID	SDA	AID	SDA	AID	SDA	AID	SDA
I-FAMILY HEALTH SERVICES														
A-Rural-Urban Expansion	599.00	65.67	1,359.50	141.18	1,383.50	162.35	1,787.00	105.70	1,858.00	214.71	835.60	114.85	7,563.00	805.45
B-Clinical Services	213.80	158.12	439.10	338.95	462.40	350.83	837.20	449.53	528.20	517.02	300.20	276.54	2,490.20	2,132.14
C-Patient Referral System	18.10		39.40		6.10		6.30		1.60		0.00		65.70	
D-Participant Training	0.00		30.00		50.00		10.00		10.00		0.00		90.00	
E-Information, Comm. & Public Edu.	270.10	1.80	640.30	3.76	545.30	4.63	653.70	4.60	560.10	5.09	281.60	2.70	2,751.10	22.67
F-Technical Assistance	0.00		541.50		526.50		429.00		285.00		150.00		1,932.00	
G-Vehicles	260.00		0.00		0.00		0.00		0.00		0.00		260.00	
H-Contingencies	69.15		69.15		69.15		69.15		69.15		69.15		414.90	
Subtotal I...	1,431.20	225.60	3,010.00	484.90	3,014.00	557.80	3,332.40	641.10	3,114.20	736.80	1,644.60	394.10	15,546.00	3,040.26
II-INSTITUTIONAL DEVELOPMENT														
A Clinical Services	181.40	77.42	166.50	162.23	62.00	358.55	100.10	407.49	48.00	454.11	45.10	253.28	604.70	1,713.08
B Social Mktg Expansion	163.10	186.31	188.80	408.20	37.10	496.82	120.70	636.33	225.40	679.67	128.40	307.03	863.50	2,513.25
C Participant Training	0.00	1.01	30.00	2.16	30.00	2.49	30.00	2.84	30.00	3.28	30.00	1.76	150.00	13.56
D Technical Assistance	0.00		491.50		431.50		403.00		319.00		154.00		1,805.00	
E Contingencies	69.15		69.15		69.15		69.15		69.15		69.15		414.90	
Subtotal II...	413.70	264.70	946.00	670.60	630.60	857.85	720.00	946.66	692.40	1,037.03	426.70	562.97	3,838.10	4,239.89
III- POLICY DEVELOPMENT & RESEARCH														
A Program Coordination-Donors	19.00	126.78	10.00	301.05	10.00	337.40	10.00	375.63	10.00	418.05	10.00	223.20	60.00	1,781.92
B Prog. Coord. Research	63.80	7.42	76.30	15.94	183.00	18.34	202.00	31.09	64.40	24.34	40.80	12.97	643.90	99.98
C Technical Assistance	0.00		45.00		180.00		100.00		100.00		90.00		675.00	
D. Contingencies	69.15		69.15		69.15		69.15		69.15		69.15		414.90	
Subtotal III...	133.00	133.20	202.30	317.03	443.00	355.70	463.00	306.70	343.00	442.10	210.00	235.17	1,793.80	1,881.90
IV- AUDIT / EVALUATIONS														
A Evaluation SDA Clinical Services	4.60		10.30		12.90		7.30		0.60		0.00		35.00	
B Evaluation SDA Trng. & Educ.	2.40		5.50		6.00		8.00		9.00		4.00		36.20	
C Audit / Project Evaluation	75.00		150.00		150.00		150.00		75.00		150.00		750.00	
Subtotal IV...	82.00		165.00		168.00		165.23		83.00		154.00		821.20	
Program Admin. and Overhead		195.62		420.57		483.65		555.21		639.65		342.15		2,637.04
Other Contributions		629.90		795.46		384.38		207.27		18.75		9.33		2,026.23
													0.00	
TOTAL	2,059.90	1,449.11	4,324.30	2,589.55	4,258.20	2,619.38	4,686.60	2,747.95	4,234.00	2,875.36	2,435.90	1,344.76	22,000.00	13,826.12

TABLE 7

PAYMENT VERIFICATION MATRIX
($US 000)

METHOD OF IMPLEMENTATION	METHOD OF FINANCING	APPROX. AMOUNT AID	TOTAL
1. TECHNICAL ASSISTANCE (Components I, II & III)			
Direct AID Proc.	Dir. Payment	4,999.20	4,9. 20
2. TRAINING (Components I & II)			
Local:			
HC Procurement	Dir. Reimb.	354.10	
Participant:			
Dir. AID Placement	Dir. Payment	220.00	
			574.10
3. LOGISTICS & COMMODITIES (Components I & II)			
Direct AID/GSA Proc.	Dir. Payment	1,371.80	
HC/Inst. Contractor	Dir. Reimb.	3,203.80	4,575.60
4. PROG. ADMINISTRATION & COORDINATION (Compts. I, II & III)			
HC/Procurement	Dir. Reimb.	6,043.30	
Dir. AID/GSA Proc.	Dir. Payment	346.90	6,390.20
5. INFORMATION, EDUCATION & COMMUNICATIONS (IEC) (Component I)			
HC Procurement	Dir. Reimb.	2,751.10	2,751.10
6. RESEARCH (Component III)			
AID Dir. (Buy-in)	Dir. Reimb.	323.50	
HC Procurement	Dir. Reimb.	320.40	643.90
7. EVALUATIONS/AUDITS			
Dir. AID Proc.	Dir. Payment	821.20	821.20
8. CONTINGENCIES/INFLATION	To be determined	1,244.70	1,244.70
TOTAL		22,000.00	22,000.00

services more widely available. Given this, the issue at hand is whether the SDA is an efficient provider of such services and whether cost recovery mechanisms are being developed which, over the long-term, will enable the SDA to attain financial self-sufficiency. Both factors are explicit concerns being addressed by the Project.

V. PROJECT IMPLEMENTATION PLAN

Several major activities are involved in the successful implementation of this Project. The relations among the components have to be designed to facilitate rational use of SDA's available manpower while providing it with extensive training and technical assistance to improve its internal capabilities.

The following chart shows the sequence and duration of major activities as well as proposing which entity(ies) should be responsible for each action: SDA, USAID, Institutional Contractor (IC) and/or combinations thereof.

Implementation

Event	Responsible Institution	Date
General Activities:		
PP Authorized	AID	5/90
Agreement Signed	AID-SDA	6/90
PIO/T prepared	AID	6/90
CPs to Disbursement	SDA	7/90
Contract TA	AID/SDA	9/90
Implementation By Component		
I Family Health Service Delivery:		
i. Initiate procurement of vehicles, contraceptives medical equipment, etc.	IC/AID	7/90
ii. CBD Rural outreach implementation schedule for training and public education:		
a) Hire director, supervising nurses, auxiliary nurses, etc. in all 4 clinics;	SDA	8/90-12/90
b) Field Orientation;	SDA	11-12/90

c) Training;	SDA/CENCAP Maternity Hosp.	11-12/90
d) Screening and selection of CBDs and 250 PHP's;	SDA	9/90-7/91
e) PHP Training;	SDA	9/90-6/91
f) PHP public education in all B.S. areas;	SDA/CENCAP	11/91-6/95
g) Selection of additional PHP's (250);	SDA	3/92-4/92
h) Training of new PHP's;	SDA/CENCAP	5/92-8/92
i) Selection of new PHP's(250);	SDA	6/93-8/93
j) Training of New PHP's;	SDA/CENCAP	9/93-11/93
k) Medical Training;	SDA/Maternity	6-7/91
l) Admin/Mgmt Training;	SDA/IC/FEPADE	9/90-6/94
m) Public Education;	SDA	9/90-6/95
n) Information/Communications;	SDA/IC	3/91-6/95
iii. Organize marginal urban service centers and supervision:	SDA	8/90-6/95
a) Pilot test of clinics;	SDA	1/91-9/91
b) Start more satellite centers of other SDA clinics;	SDA	12/91-6/92
c) Pilot test addition of general pediatric & dental services in one SDA clinic;	SDA	8/90-12/90
d) Duplicate process at another SDA clinic if pilot is successful;	SDA	12/92-5/93
e) Start program at 2 remaining SDA clinics;	SDA	1/93-6/95
iv. Plan decentralization of referral providers;	SDA/IC	1/91-3/92

v. Selection and training of referral providers;	SDA/IC	1/91-3/92
vi. Training:		
a) Revise, re-design and continue internal training programs;	SDA/IC	11/90-6/95
b) Participant Training;	SDA/IC	1/91-6/93
II Institutional Development:		
i. Conduct strategic planning sessions for Board;	SDA/IC	8/90
ii. Conduct group dynamics and communications sessions;	IC	9/90
iii. Develop management by objectives (MBO) system and provide training;	IC	9/90
iv. Modify and improve personnel system;	SDA/IC	9/90-12/91
v. Develop human resource management system;	SDA/IC	9/90-12/91
vi. Conduct marketing and feasibility studies;	SDA	9/90-12/91
vii. Develop CRCs.	SDA	8/90-6/95
III Policy Development and Research:		
i. Join and attend Inter-Sectoral Committee on Child Survival;	SDA	8/90-6/95
ii. Sample Frame elaboration of FESAL, 93;	SDA/IC	8/91-6/92
iii. FESAL, 1993;	SDA/IC	6/91-6/93
iv. Maternal/Child Mortality Study;	SDA/IC	1/93-3/95
v. IUD Study;	SDA/IC	9/90-12/90

vi. Evaluation of Clinical Services;	SDA/IC	9/90-12/92
vii. Evaluation of SDA's Education and Training;	SDA/IC	12/90-12/95
viii. Yearly Audit.	External Auditors	11-12/90-95

VI. MONITORING PLAN

A. Aspects of Implementation to be Monitored

SDA and USAID Project managers will monitor two broadly defined aspects of the Project - inputs and outputs. Inputs consist of TA and training (long term, short term, and in-country), logistics (remodeling costs, office supplies, vehicles, contraceptives, medical supplies, pharmaceuticals), public education program costs, research costs and audits. Outputs are defined as services delivered. These include (but are not limited to) number of rural distribution points established, number and type of health workers and mothers recruited and trained, increase in clinical services provided and number of research studies completed.

In order for monitoring to occur, current reporting forms and flow of information must be reviewed by the technical assistance staff and modified where necessary. Monitoring will be facilitated by the development of the management information system (MIS) under this Project. Supervisory personnel will visit the community-level providers frequently, once every month (or a total of twelve times per year) at the beginning, dropping back to once every six weeks (or eight times a year) once the program is underway.

B. Tier Design of the Monitoring Plan and Relationship to the Evaluation Plan

A project's monitoring system must be designed from the outset not only to provide current information about project activities, but also information that is needed to conduct the midterm and final project evaluations. The two evaluations planned for this Project are based on a tiered monitoring and evaluation design developed over the past several years by USAID/LAC/S&T/H for the Child Survival program. In this design, Tier I corresponds to evaluation of the inputs and outputs discussed above. Tier II evaluates the effectiveness level, while Tier III corresponds to measurements of overall impact. More details regarding the Tier design are presented in the Evaluation Arrangements Section IX of this paper. The Project monitoring system will serve as the principal source of information during evaluations of Tier I. At a minimum it will provide data on the inputs, outputs and objectively verifiable indicators listed in the log frame of this paper.

C. Financial Monitoring, Accountability and Audit

Financial monitoring of the revenues and expenditures of the program shall be done on a monthly basis through a series of reports which shall be developed jointly by SDA and the project officer in charge at USAID following US standard disbursement procedures.

On a yearly basis, a complete financial audit will be conducted by external auditors. The audit will be contracted at the beginning or prior to the start of the fiscal year being audited, thereby allowing the auditors to perform such specified procedures as petty cash counts, observe physical inventory counts, monitor payroll distributions, assess internal controls and accounting procedures, review accounting ledgers and documents for adequacy, or perform other interum tests which they deem necessary. USAID will approve the statement of work before SDA contracts the external auditors and USAID, at its discretion, may supervise the audit and review the draft reports. The external auditors will be be affiliated with US CPA firms using GAO standards.

In addition, USAID/El Salvador, at its discretion will contract for financial management services to include financial monitoring of transactions carried out by SDA or concurrent audits.

During the third year of the project, a complete evaluation of the financial status and goals shall be conducted by external project evaluators and concurrently with the external auditors. At the end of the project a complete financial audit shall be conducted of the results of the program. All audits shall be conducted with US CPA and GAO standards.

D. Assessment of A.I.D. Monitoring Capability

Primary USAID monitoring responsibility for the Project rests with a personal service contract (PSC/FSN) to be contracted under this project who will be the Project Manager. This person will work on a day-to-day basis reporting directly to the Population Officer and/or his Assistant, located in the USAID/EL Salvador Office of Health, Population and Nutrition (HPN). These three persons will be supervised by a U.S. direct hire, who is the Deputy Director of the HPN Office. The Project Manager will be assisted by a US/PSC Procurement Specialist, who will provide advice on logistics and commodity procurement requirements and procedures for the Project, depending on the need once the Project is underway. Considering that most of the procurement effort under this project will be during the first two years of implementation and from then on only monitoring of shipments and/or minor procurement actions will be taken, the procurement specialist will not be fully contracted by the Family Health Services Project but be split funded with other health projects monitored by the HPN office. To help ensure the smooth implementation of Project activities, the Mission Project Implementation Committee (PIC), mentioned previously, will periodically review Project status.

VII. SUMMARIES OF ANALYSES

A. Technical Analysis Summary

The major technical interventions this project promotes relate to: (1)

birth spacing/family planning; (2) selected diseases control (diarrhea and acute respiratory diseases, parasites control immunopreventable diseases); (3) nutrition interventions (growth monitoring, breastfeeding and Vitamin A and other nutritional interventions).

These problem areas are chosen because they are the most critical ones in the country. The methodologies are chosen because they offer optimal chances for effective results. For example, birth spacing appears to have the single greatest effect on child survival as well as in maternal morbidity and mortality. Sex Education for younger women is a clear priority. Pregnancy is especially dangerous to women in their teen years because of malnourishment. Also the general structure of their pelvic growth is not complete. Recent statistics demonstrate that 15% of all El Salvador's Maternity Hospital entrants are from abortion related causes. Also, hemorrhage and toxemia are other important causes for maternal deaths in El Salvador. Hemorrhage is more likely to occur among women with a high parity. When family planning programs are widely available, the need for abortion decreases sharply.

Diarrhea is a common childhood disease. In El Salvador, deaths due to intestinal infections are the second cause of death in all ages forming 6.4 % of all deaths. The reliable supply of oral rehydration salts (ORS) of good quality to mothers and health workers is a cornerstone of programs to Control of Diarrheal Disease.

Acute respiratory infections (ARI) affect approximately the 67.3% of all children under five in El Salvador. In rural areas of the country the percentage is an even higher -- 73.6%. ARI, if not treated, leads to more serious illnesses, contributing to higher rates of child mortality in this country. Thus, interventions under this Project targeted at prevention and early detection and treatment will contribute to averting deaths due to acute respiratory infections.

Poor nutrition underlies more than half of early childhood mortality, accounts for most of the immunological deficiency in the world, reduces learning potential and performance, limits work capacity and increases reproductive wastage. The 1988 nutrition survey showed that 30% of the children in El Salvador suffer from a certain degree of malnutrition. Growth monitoring is one technique for alerting parents to the problem and it can be easily taught and monitored by rural health workers of the level planned under this Project. It is a key tool to measure nutritional improvements among children under the age of two. Measuring growth through anthropometric measures is a useful practice and a good health status indicator. The Project will reach mothers through growth promotion campaigns to prevent nutritional deterioration during pregnancy, increase birth-weight, and provide treatment for health risks. Breastfeeding will continue to be actively promoted under the Project.

Emphasis will also be given in the health education activities of the health promoters to parasitic infestations and vitamin A deficiencies. Lack

of adequate hygienic conditions in the community make parasitic infestations common among rural children. This Project will attack parasites in selected communities nationwide through education as well as through distribution of antiparasitics via the Social Marketing Program of the SDA. Tapeworm medicine made available to rural mothers will also be distributed under the Project. Lack of vitamin A causes loss of vision, growth retardation and increments respiratory illness. The Project will continue implementing vitamin A treatments in selected areas of the country.

The success of the SDA's CBD program demonstrates the technical and cultural feasibility of privately supported efforts using rural health promoters. Thus, the Project's emphasis on expansion of SDA's rural outreach, including related clinical services, is appropriate and technically feasible.

The Project will use three major methods for achieving its goals:

Local Community Volunteers, usually village women, can be effective service and product distributers. This requires education and supervision. To meet the goals of the rural outreach program and expand marginal urban coverage this technical approach is appropriate and necessary.

SDA's social marketing of contraceptives will continue to receive support because it has shown effectiveness. It has 900 participating pharmacies and 1,000 small stores throughout the country; and has more than doubled the number of contraceptive users in the last five years.

Clinic based services, while requiring travel to them, have the advantage of offering broader ranges of more complex birth spacing and maternal child health services.

B. Economic Analysis Summary

1. General Considerations: Measuring project benefits in monetary terms with any reliable degree of accuracy requires an expensive and time consuming research effort, a demand and cost effectiveness analysis has been used to justify the project from an economic perspective.

The project will correct two basic weaknesses in the health system of El Salvador which have major economic impacts. First, it shifts resources from curative to preventive services. There is ample evidence that emphasizing preventive rather than curative medicine as a more cost effective method for improving health status.

Second, the project concentrates resources on rural and marginal urban areas. This modifies the current emphasis of providing scarce resources to urban hospitals (tertiary care) rather than to dispersed primary care facilities in areas of rural population. Health problems, including the highest rates of fertility, morbidity and mortality and the lowest use of modern contraception, are most acute in rural areas. The earlier problems are

detected, the less costly the treatment. Thus, expanding efforts in rural areas will help to avert higher treatment costs.

In addition, through the various project interventions several economic benefits will result over the life of project (LOP):

a) For female adolescents, who account for some 40 percent of all Salvadoran fertility, a delay in childbearing gives her more time to mature including enhanced opportunities for school attendance and productive employment to augment family income;

b) For young women in union, birth spacing gives the body a chance to recover between births allowing time to spend on the existing family or seek outside employment. Moreover , longer time periods between pregnancies greatly reduces the likelihood of complications requiring more costly medical attention;

c) For older women it allows benefits similar to those described for young women if she chooses birth spacing or allows her to terminate childbearing once she has obtained her preferred number of children;

d) Hospital costs should decline due to reduced treatment for abortion related causes (Recent statistics show that 15% of maternity hospital entrants are from abortion related causes).

The principal focus of the Project will be on birth spacing, especially for younger women (between ages 15 to 24). The number of couples using birth spacing methods will increase from 120,000 in 1988 up to 200,000 in 1995, an increase of 80,000 couples. Project activities in birth spacing will positively influence maternal, infant and child mortality as well as employment rates, school attendance, educational status and hospital costs. Project actions will also result in reduced consumption costs when a reduction in population growth rate occurs in future years. This will result in a short run increase in per capita income as current population levels and growth rates are high in relation to the country's production capacity and current production trends.

Project activities in MCH will also influence maternal, infant and child mortality rates and nutritional status. These actions will reduce morbidity and mortality rates due to diarrhea, acute respiratory infections and immunizable illness among children under five years of age.

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An A.I.D. project with similar characteristics approved by ROCAP in 1984 provides indicators which are useful in judging the MCH activities, especially

ORS, under this Project. It points out that interventions have fairly well defined costs but benefits arise indirectly from averting cases of illness and death. The non quantifiable benefits of the program include the pure utility gain from averting deaths from, and lessening the severity of, diarrhea, malnutrition and the conditions aggravated by them. There are possible productivity gains from the postponing of young children's deaths and from the future school and work performances of well-nourished children.

C. Cost Effectiveness Analysis Summary

The purpose of the cost effectiveness analysis is to provide a rational basis for the selection of specific interventions and strategies which will serve the purpose of the Project. The analysis discusses the costs and effectiveness of each intervention used to address the problems discussed above: high rates of fertility, diarrheal disease and undernutrition among the high risk population in rural and marginal urban areas.

The method used in the analysis follows the description of cost/effectiveness analysis described in Delp. P. (1977) "Cost Effectiveness Analysis," System Tools for Project Planning, Indiana University. Effectiveness is the product of the reliability of the intervention (in preventing births or dehydration during diarrheal episodes, for example) and its rate of acceptance among the population. Specific sources used for the calculation of effectiveness of each intervention are cited below the tables in Annex F. Estimates of acceptance are based on national survey data where possible. Cost estimates are based on the life of project (LOP) costs and estimates from the Bloom Children's Hospital for each intervention.

1. Contraception: The most cost/effective temporary contraceptive method is the pill. Its cost per year of protection is higher than that of the IUD, however it is popular and highly reliable. Therefore, the Project should make this contraceptive available and promote its use among young couples interested in temporary methods.

The most cost/effective method of all is female sterilization. The cost of this method is highly reliable and it is the most popular form of contraception in El Salvador. This method should therefore also continue to be provided to high risk women through this Project.

The IUD is the second most cost effective temporary method, due primarily to its low level of acceptance rather than cost. The cost per year of protection for an IUD is lower than that of oral contraceptives. This is also true for condoms. The cost/effectiveness ratios for both condoms and the IUD would be improved if acceptance levels were increased. The Project should, therefore, make these alternatives available and promote increased levels of acceptance among the highest risk.

Condoms are the least most cost/effective temporary method of modern contraception. As a result of previous SDA efforts, the use of condoms has increased dramatically in El Salvador over the past three years. The Project should therefore also make condoms available to the highest risk population.

Vasectomy cost/effectiveness rates are the lowest of all methods of modern contraception due to their low levels of acceptance and use. However, since vasectomies are less costly to perform than female sterilizations, are as reliable, and their CYP is nearly as long, increasing their acceptance would improve the cost/effectiveness ratio accordingly. Indeed, if vasectomies were to be as acceptable as female sterilization, they would become the most cost/effective permanent method. The Project should increase both the availability of vasectomies and their acceptance as a method.

2. Diarrheal Disease: Diarrheal disease is the principal direct cause of illness and death among children under five in El Salvador. Most diarrhea related death results from the dehydration which accompanies it. Therefore, interventions which prevent or cure dehydration during episodes of diarrhea are effective in preventing diarrhea related deaths. Analyses, indicate that the most effective method is oral rehydration salts (ORS). In recent years, the emphasis on child survival has raised the use of ORS to ten percent of diarrheal episodes among children under five. The second most effective method is the home remedy, an electrolyte solution made with common household ingredients (lemon, sugar, salt). Although this method is as reliable as ORS when used properly, its use during diarrhea episodes is low. Inpatient hospital rehydration is the most reliable alternative for rehydration where children are attended and monitored by trained medical personnel. However, acceptance of internship of children is low among the highest risk population.

The home electrolyte solution is slightly more cost/effective than oral rehydration salts. Therefore, this Project will offer both of these methods to risk populations in El Salvador, financing public education to promote their increased acceptance and use. Given its low cost, an increase in the correct use of home solution during childhood diarrhea would be a particularly cost/effective intervention.

3. Malnutrition: There are four interventions designed to improve the nutritional status of pregnant women or children under five; prenatal vitamins, multivitamins, vitamin A, and home gardens. All four methods are viewed favorably by the high risk population. The reliability of these interventions in the prevention or treatment of the most important vitamin deficiencies, however, vary widely.

The most cost/effective intervention by far is that of vitamin A capsules. Their effectiveness is high and their cost is low. Although multivitamins also contain vitamin A, the dosage is not sufficient for treatment of severe vitamin A deficiency. Home gardens also provide vitamins and iron to the family. However, the dosages will again be small and benefits divided among family members.

The second most cost/effective intervention is prenatal vitamins. The most important nutritional deficiency among pregnant women is that of iron; prenatal vitamins are formulated to remedy this deficiency. Although their cost of delivery is high, effectiveness is also high. These will, therefore be provided to high risk pregnant women through the Project.

The two interventions which are least cost/effective are home gardens and multivitamins. Although their cost per year of protection is relatively low, their acceptability is high. These interventions will receive minimal attention under the project.

4. Conclusion: Five major contraceptive measures all show positive cost/effectiveness ratios. The contraceptive pill, female sterilization, the condom and the IUD merit continued promotion through this Project. Furthermore, male vasectomy should receives education and promotion because it is a highly effective approach, but is not widely accepted.

The distribution of oral rehydration salts and education and promotion of the preparation of home solutions for rehydration are cost/effective interventions which should receive heavy support under this Project. The analysis shows that vitamin A for children and prenatal vitamins for mothers are cost effective measures to improve maternal and child health and therefore important inclusions in the Project. Multivitamins for children and seeds for family gardens do not demonstrate high levels of cost/effectiveness and will receive minimal support.

Annex F.2.1. and F.2.2. provide greater detail about the cost effectiveness and sensitivity analyses.

D. Social Soundness Analysis Summary

The Project Social Soundness report discusses the feasibility of the Project in rural areas. Obviously, the national context (i.e., the continuing conflict, economic adjustment and varying degrees of service availability and continuity of service) will affect the success of the Project. More importantly, however, are issues related to the rural context in which the project will be implemented.

General issues which effect the Project in the rural context include the economic and employment status of the rural family, sources of division within communities including economic status, politics and religion, the fear and mistrust caused by living in an atmosphere of violence, and the poor health and nutritional status of rural women and children. More specifically, however, the social soundness analysis identifies attitudinal and other socio-cultural constraints that will have an effect on the acceptance and use of birth-spacing and MCH services. Chief among these are beliefs and behavior of women and men related to control of their own fertility. For example, sexual encounters begin and unions form during adolescence, and men take little responsibility for controlling pregnancy. Women's lack of knowledge

about their own fertility cycle is also an important factor underlying the lack of use or ineffective use of modern contraception. Results of a recent survey show that only sixteen percent of women in El Salvador understand when they are most likely to become pregnant.

There are also several important variables which are important determinants of fertility behavior, but are exogenous to the Project. These include the educational level, employment and economic status of the woman, and socio-political conflict in rural areas.

The Project design was based on, and is, therefore, thoroughly consistent with the findings of the Social Soundness Analysis. For example, the major socio-cultural barriers to use of modern contraception have not been a prior focus of SDA training, education or mass media. These will now become a major coherent focus of intervention in order to increase use rates. While all barriers identified were being addressed, albeit some more thoroughly than others, the areas of male and adolescent fertility need to be strengthened.

The Social Soundness Analysis also addresses the issue of community involvement. According to this analysis, by the end of the Project, there will be a total of 75,312 participants in the rural outreach project during the last year alone. This is a conservative estimate based on 35-75 participants per outreach worker per year. Possibilities of diffusion of Project concepts and behaviors beyond Project participants vary according to the subject matter, and a series of factors involving the community and outreach worker. Education messages and strategies will be designed to take into account these factors.

E. Administrative Analysis Summary

1. Organization: The Salvadoran Demographic Association is a nonprofit organization formed in 1962. It is an affiliate of the IPPF. Sources of financing include donations from individuals, firms, sponsors and diverse international organizations including IPPF, FHI, USAID and others. Over the last six years SDA has received major grants from USAID; in 1988-89 alone , A.I.D. support totalled $3,800,000.

The organization is governed by a Board of Directors, selected by a General Assembly, which designates primary operational responsibility to an Executive Director who oversees six departments. As noted in the background section of this Paper, the organization is highly centralized. In addition, there is a tendency for Board Members to become directly involved in technical issues and operating affairs which inhibits or disturbs the normal functioning of the departments. To address this constraint, the Project will finance training programs for Board Members to improve Board/Management interaction and thus facilitate Project implementation. Global or strategic planning concepts will be introduced to the Board of Directors and the Executive Director and principles of Management by Objectives (MBO) to the Department Managers.

2. Management: Because of the nature of its evolution, the SDA program is highly centralized. This may be convenient for fiscal control and rapid decision making, however, the drawback to this system is that decisions do not always respond to local conditions in the clinics and rural programs. Given emphasis on rural service delivery and community participation, decentralization will be introduced to facilitate expansion of activities, one of the major SDA objectives for the next five years. The specific nature of the departments currently included in the SDA management system is now being re-organized to strengthen coordination and clarity of responsibility. In addition, the general experience of the department managers and the staff has been operation on a program basis. Short-term perspectives dominate in scheduling and completing activities. Therefore, workshops in strategic planning and MBO will be offered under the Project.

3. Staffing: As noted throughout the Paper, staff training is required to upgrade skills in technical areas, as well as management skills. While the staff, in general, has the skills required to implement the Project, formal academic training of the key SDA managers and technicians will be required to sustain Project activities once TA personnel leave.

A thorough and systematic human resource management system will be developed. Technical assistance will begin with an analysis of existing procedures. Strategic planning seminars, revision of present training programs, personnel selection systems, development of supervision systems, just and reasonable pay scales, and related issues will also be required

4. SDA Procurement Capability: Existing capabilities are adequate for local procurement and contracting of local consultants. However, the Project will finance a resident Procurement Specialist working at SDA headquarters to carry out all procurements for the SDA. All transactions over $25,000 will require A.I.D. approval. AID will continue to purchase contraceptives and equipment as well as contract international technical assistance.

5. Accounting and Financial Control Systems: The first draft of an audit of the Mission's family planning program, carried out by the Office of the Regional Inspector General in October 1989, has not as yet been presented to the Mission. However, indications are that the findings will show some deficiencies in SDA's financial controls system. Adequate provision has, therefore, been made in the Technical Assistance and Training Plans of this Project for correcting any weaknesses identified by the audit. Project resources will also be used to improve accounting and financial control systems and to make financial information more accessible to SDA management and USAID/El Salvador.

VIII. CONDITIONS PRECEDENT AND COVENANTS

In addition to the standard conditions precedent to disbursement regarding designation of authorized representatives, opening a separate bank account and submission of annual action plans, the following Conditions Precedent and Special Covenants will be included in the Grant Agreement.

1. Prior to initial disbursement, the USAID Controller will review the SDA's financial management system to ensure that any previously identified deficiencies have been corrected and certify that the SDA has adequate financial controls in place to account for Project funds.

2. All procurement of goods and services over $ 25,000 will be approved in writing by AID.

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

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

5. Participant training elements of this Project will be accomplished in accordance with the polices, allowances, guidance and reporting requirements of AID Handbook 10-Participant Training.

IX. EVALUATION ARRANGEMENTS

The Family Health Services Project will begin on June 30, 1990 and end on June 30, 1995. Two evaluations are scheduled for this Project. The first will be a midterm evaluation which will take place in the spring of 1993. The midterm evaluation should follow the completion of the Demographic and Health Survey (FESAL) to be carried out in 1993. The final results of this survey may then be used during the midterm evaluation to determine impact to date. The second and final evaluation should take place from April to May of 1995, as the Project is scheduled to end on June 30, of that year.

Both must consider three levels of program evaluation. The monitoring/supervision plan for the Project also follows the Tier model. Although these levels have been given various names, for purposes of discussion in this project paper the levels are:

TIER I		TIER II		TIER III
Input	—— Output	———— Effectiveness	————	Project Impact

A. Tier I: Input-Output Level Measures:

1. Input Level Measures: The input level of evaluation includes consideration of the adequacy and movement of all inputs to the project. Major input categories are logistics (equipment and supplies), technical assistance, training and education. Information for the input level will be available from SDA and USAID Project management.

2. Output Level Measures: The output level of evaluation involves measurement of the services and activities of the project. Key outputs for this Project include: 1) expansion and strengthening of the family planning

distribution network, 2) integration of birth spacing and MCH services, 3) expansion and improvement of the public education program and 4) enhancement of the SDA management capacity. Information for the output level will also be available from SDA and USAID Project management and reports. Objectively verifiable indicators are listed in the Log Frame of this project paper.

B. Tier II: Effectiveness Level Measures

The effectiveness level of evaluation is less easily measured since it involves the results of service delivery. For instance, this level measures how well the community health workers understand their training and are able to teach community members about birth spacing or the mixing of ORS. Information for this level of evaluation normally is not available from project management reports. Rather, data is taken from special provider surveys implemented at the beginning, middle and end of projects. An effectiveness-level study on social marketing is being conducted by Johns Hopkins. This will provide the Project with baseline information on the extent to which mass media is reaching the target population. This project will also fund a study of the effectiveness of the community-level outreach workers which will take place at the end of the project and be available for the final project evaluation.

C. Tier III: Impact Level Measures

The impact of the Project in its broadest sense is measured on this level of evaluation. What was the impact of the Project on the use of contraception? What changes occurred in child spacing, maternal and infant mortality over the period of the Project? Data for the impact level will be available for the midterm evaluation from the Demographic and Health Survey (FESAL) to be conducted in 1992. Impact level data for the final evaluation will be available from projections of earlier trends based on service-level output and effectiveness information.

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Chp 2, HB 3
(TM 3:43)

AGENCY FOR INTERNATIONAL DEVELOPMENT
PROJECT IDENTIFICATION DOCUMENT FACESHEET (PID)

1. TRANSACTION CODE: A (A = Add, C = Change, D = Delete) — Revision No. ____ — DOCUMENT CODE 1

2. COUNTRY/ENTITY: EL SALVADOR

3. PROJECT NUMBER: 519-0363

4. BUREAU/OFFICE: LAC — A. Symbol — B. Code 05

5. PROJECT TITLE (maximum 40 characters): FAMILY HEALTH SERVICES

6. ESTIMATED FY OF AUTHORIZATION/OBLIGATION/COMPLETION
- A. Initial FY 90
- B. Final FY 93
- C. PACD 95

7. ESTIMATED COSTS ($000 OR EQUIVALENT, $1 =)

FUNDING SOURCE	LIFE OF PROJECT
A. AID	$19,000
B. Other U.S. 1.	
B. Other U.S. 2.	
C. Host Country	6,333
D. Other Donor(s)	
TOTAL	$25,333

8. PROPOSED BUDGET AID FUNDS ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	C. PRIMARY TECH. CODE 2. Loan	D. 1ST FY 90 1. Grant	D. 1ST FY 90 2. Loan	E. LIFE OF PROJECT 1. Grant	E. LIFE OF PROJECT 2. Loan
(1) 104	444	440		5,200		19,000	
(2)							
(3)							
(4)							
TOTALS				5,200		19,000	

9. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): 510

10. SECONDARY PURPOSE CODE: 533

11. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code	BRW	BUW	PVON	TNG			
B. Amount	10,000	5,000	19,000	4,000			

12. PROJECT PURPOSE (maximum 480 characters)

To improve and expand the delivery of family planning and maternal child health services to high risk populations in rural and marginal urban areas.

13. RESOURCES REQUIRED FOR PROJECT DEVELOPMENT

Staff:
- Family Planning Management Specialist - 7 weeks
- Health Services Specialist - 5 weeks
- Financial Analyst/Economist - 3 weeks
- Communications Specialist - 4 weeks

Funds
- PD&S - $140,000

14. ORIGINATING OFFICE CLEARANCE
Signature: William H. Kaschak
Title: Associate Mission Director for Program and Project Development
Date Signed: MM 11 DD 07 YY 89

15. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MM DD YY

16. PROJECT DOCUMENT ACTION TAKEN
- S = Suspended
- A = Approved
- D = Disapproved
- CA = Conditionally Approved
- DD = Decision Deferred

17. COMMENTS

18. ACTION APPROVED BY
Signature: Henry H. Bassford
Title: Mission Director, El Salvador

19. ACTION REFERENCE

20. ACTION DATE: MM 11 DD 07 YY 89

AID 1330-2 (8-79)

ANNEX A

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LOGICAL FRAMEWORK

NARRATIVE	OBJECTIVELY VERIFYABLE INDICATOR	MEANS OF VERIFICATION	ASSUMPTION
Project Goal: To improve general reproductive health services in El Salvador; and to improve the quality of life and health of the Salvadoran population through the reduction of infant and child mortality/morbidity.	-Increase the use of child spacing practices by 30%. -Decrease the rate of infant mortality from 48 in 1,000 live births to 40 in 1,000.	SDA data research and FESAL Survey.	Internal conflict subsides to permit promotion of the availability/accessibility of Family Health Services.
Project Purpose: To improve and expand delivery of birth spacing and MCH/FP Services to high risk populations in rural/ marginal urban areas and to improve their quality & efficiency.	-Active number of SDA contraceptive users increased from 120,000 in 1988 to 200,000 in 1994. -Rural contraceptive prevalence increased from 34% to 40%. -ORS and home electrolyte treatment for diarrhea increased by 50%.	FESAL Survey and SDA data.	Current Level of delivery of public health services is maintained.
Outputs: 1) Family Health Services Delivery;	Establishment/Availability of: -Distribution Outlets in rural villages increased by 750. -1,150 PHPs selected and trained in modern FP methods. -Physician referral system of 50 M.D.s established. -Expanded services in SDA clinics. -6 New satellite clinics opened.	T.A. reports, SDA evaluations, site visits and Quarterly Reports.	Appropriate Sites can be identified. Internal conflict will not affect rural expansion.

LOGFRAME MATRIX
ANNEX B

NARRATIVE	OBJECTIVELY VERIFYABLE INDICATOR	MEANS OF VERIFICATION	ASSUMPTION
	-1,600 outreach personnel trained/ carrying out education/Communication programs on modern FP methods and offering MCH services. and -Education in MCH/FP reaches 1,550 rural villages.		
2) Institutional Development/SDA Management capacity Enhanced.	-Central Referral Clinic opened. -Social Marketing Program expanded. -Mass media campaign carried out.	Site visits, Quarterly Reports, Airing of TV, Radio announcements and distribution of printed materials.	Sufficient demand for services exists.
3) Policy Development & Research.	-7 Research studies completed with extensive national dissemination of of data and policy recommendations.	Copies of studies, Reports produced on seminars/meetings.	Research teams are able to travel to all of the Project areas.

<u>Inputs (US$ 000):</u>

A.I.D.	
Technical Assistance	$4,999.20
Training	574.10
Logistics/Commodities	4,575.60
Prog. Admn. & Coord.	6,390.20
I. E. C.	2,751.10
Research	643.90
Audit & Evaluation	821.20
Contingencies/Inflation	1,244.70
Total A.I.D.	22,000.00
SDA & Other Contributions	13,826.12
PROJECT TOTAL	35,826.12

<u>Conditions Precedent to Project Implementation:</u>

-Procurement Plan from SDA.
-Inventory Control System outlined.
-Project Manager hired.
-T.A. contracted.
-Referral Physicians and Sup. nurses contracted.
-750 new PHPs screened, selected and deployed.
-800 CBDs screened, selected and trained as PHPs.
-Satellite Clinic sites selected.
-Central Referral Clinic (CRC) remodeled.

ANNEX C - A.I.D. PROJECT STATUTORY CHECKLIST

Introduction

The statutory checklist is divided into three parts: 5C(1) - Country Checklist; 5C(2) - Project Checklist; and 5C(3) - Standard Item Checklist.

The Country Checklist, composed of items affecting the eligibility for foreign assistance of the country as a whole, is to be reviewed and completed by AID/W at the beginning of each fiscal year. In most cases responsibility for preparation of responses to the country checklist is assigned to the desk officers, who would work with the Assistant General Counsel for their region. The responsible officer should ensure that this part of the checklist is updated periodically. The checklist should be attached to the first PP of the fiscal year and then referenced in subsequent PPs.

The Project Checklist focuses on statutory items that directly concern the project. Although the project checklist should be reviewed and completed in the field, information should be requested from Washington whenever necessary. A completed project checklist should be included with each PP; however, the list should also be reviewed at the time a PID is prepared so that legal issues that may bear on project design are identified early.

The Standard Item Checklist is intended as a working tool, rather than for inclusion in a project paper. It provides condensed coverage, in checklist form, of statutory matters routinely covered in the project agreement (e.g., 50/50 shipping). Items from this list should be noted in the PP or added to the project checklist when they warrant special treatment or concern.

The country and project checklists are organized according to categories of items relating to Development Assistance, the Economic Support Fund, or both.

These Checklists include the applicable statutory criteria from the Foreign Assistance Act of 1961, as amended ("FAA"); the International Security and Development Cooperation Act of 1981 ("ISDCA of 1981"); the International Security and Development Cooperation Act of 1985 ("ISDCA of 1985"); the Anti-Drug Abuse Act of 1986 ("1986 Drug Act"); the FY 1990 Foreign Assistance Appropriations Act ("FY 1990 Appropriations Act"); the Omnibus Trade and Competitiveness Act of 1988 ("Trade Act"); the Foreign Relations Authorization Act, Fiscal Years 1988 and 1989 ("State Authorization"); and miscellaneous provisions from various other Acts.

These Checklists do not list every statutory provision that might be relevant. For example, the Checklists do not include country-specific limitations that are enacted, usually for a single year, in foreign assistance appropriations legislation. Instead, the Checklists are intended to provide a convenient reference for provisions of relatively great importance and general applicability.

Prior to an actual obligation of funds, Missions are encouraged to review any Checklist completed at an earlier phase in a project or program cycle to determine whether more recently enacted provisions of law included on the most recent Checklist may now apply.

Space has been provided at the right of the Checklist questions for responses and notes.

5C(1) - COUNTRY CHECKLIST

Listed below are statutory criteria applicable to: (A) FAA funds generally; (B)(1) Development Assistance funds only; or (B)(2) the Economic Support Fund only.

A. GENERAL CRITERIA FOR COUNTRY ELIGIBILITY

1. FY 1990 Appropriations Act Sec. 569(b). Has the President certified to the Congress that the government of the recipient country is failing to take adequate measures to prevent narcotic drugs or other controlled substances which are cultivated, produced or processed illicitly, in whole or in part, in such country or transported through such country, from being sold illegally within the jurisdiction of such country to United States Government personnel or their dependents or from entering the United States unlawfully? — No.

2. FAA Sec. 481(h); FY 1990 Appropriations Act Sec. 569(b). (These provisions apply to assistance of any kind provided by grant, sale, loan, lease, credit, guaranty, or insurance, except assistance from the Child Survival Fund or relating to international narcotics control, disaster and refugee relief, narcotics education and awareness, or the provision of food or medicine.) If the recipient is a "major illicit drug producing country" (defined as a country producing during a fiscal year at least five metric tons of opium or 500 metric tons of coca or marijuana) or a "major drug-transit country" (defined as a country that is a significant direct source of illicit drugs significantly affecting the United States, through which such drugs — N/A

are transported, or through which significant sums of drug-related profits are laundered with the knowledge or complicity of the government): (a) Does the country have in place a bilateral narcotics agreement with the United States, or a multilateral narcotics agreement? and (b) Has the President in the March 1 International Narcotics Control Strategy Report (INSCR) determined and certified to the Congress (without Congressional enactment, within 45 days of continuous session, of a resolution disapproving such a certification), or has the President determined and certified to the Congress on any other date (with enactment by Congress of a resolution approving such certification), that (1) during the previous year the country has cooperated fully with the United States or taken adequate steps on its own to satisfy the goals agreed to in a bilateral narcotics agreement with the United States or in a multilateral agreement, to prevent illicit drugs produced or processed in or transported through such country from being transported into the United States, to prevent and punish drug profit laundering in the country, and to prevent and punish bribery and other forms of public corruption which facilitate production or shipment of illicit drugs or discourage prosecution of such acts, or that (2) the vital national interests of the United States require the provision of such assistance?

3. 1986 Drug Act Sec. 2013. (This section applies to the same categories of assistance subject to the restrictions in FAA Sec. 481(h), above.) If recipient country is a "major illicit drug producing country" or "major drug-transit country" (as defined for the purpose of FAA Sec 481(h)), has the President submitted a report to N/A

Congress listing such country as one: (a) which, as a matter of government policy, encourages or facilitates the production or distribution of illicit drugs; (b) in which any senior official of the government engages in, encourages, or facilitates the production or distribution of illegal drugs; (c) in which any member of a U.S. Government agency has suffered or been threatened with violence inflicted by or with the complicity of any government officer; or (d) which fails to provide reasonable cooperation to lawful activities of U.S. drug enforcement agents, unless the President has provided the required certification to Congress pertaining to U.S. national interests and the drug control and criminal prosecution efforts of that country?

4. FAA Sec. 620(c). If assistance is to a government, is the government indebted to any U.S. citizen for goods or services furnished or ordered where: (a) such citizen has exhausted available legal remedies, (b) the debt is not denied or contested by such government, or (c) the indebtedness arises under an unconditional guaranty of payment given by such government or controlled entity?

No.

5. FAA Sec. 620(e)(1). If assistance is to a government, has it (including any government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities?

No. (The GOES has made demonstrable progress toward compensation in the CAESS case.)

6. FAA Secs. 620(a), 620(f), 620D; FY 1990 Appropriations Act Secs. 512, 548. Is recipient country a Communist country? If so, has the President: (a) determined that assistance to the country is vital to the security of the United States, that the recipient country is not controlled by the international Communist conspiracy, and that such assistance will further promote the independence of the recipient country from international communism, or (b) removed a country from applicable restrictions on assistance to communist countries upon a determination and report to Congress that such action is important to the national interest of the United States? Will assistance be provided either directly or indirectly to Angola, Cambodia, Cuba, Iraq, Libya, Vietnam, South Yemen, Iran or Syria? Will assistance be provided to Afghanistan without a certification, or will assistance be provided inside Afghanistan through the Soviet-controlled government of Afghanistan? No.

7. FAA Sec. 620(j). Has the country permitted, or failed to take adequate measures to prevent, damage or destruction by mob action of U.S. property? No.

8. FAA Sec. 620(l). Has the country failed to enter into an investment guaranty agreement with OPIC? No.

9. FAA Sec. 620(o); Fishermen's Protective Act of 1967 (as amended) Sec. 5. (a) Has the country seized, or imposed any penalty or sanction against, any U.S. fishing vessel because of fishing activities in international waters? (b) If so, has any deduction required by the Fishermen's Protective Act been made? No.

10. FAA Sec. 620(q); FY 1990 Appropriations Act Sec. 518 (Brooke Amendment). (a) Has the government of the recipient country been in default for more than six months on interest or principal of any loan to the country under the FAA? (b) Has the country been in default for more than one year on interest or principal on any U.S. loan under a program for which the FY 1990 Appropriations Act appropriates funds?

From time to time, the GOES has been in default under both provisions, which has resulted in prohibition of obligation of new funds; however, such periods have been of very short duration. Currently (as of April 2), the GOES is not in default under either provision.

11. FAA Sec. 620(s). If contemplated assistance is development loan or to come from Economic Support Fund, has the Administrator taken into account the percentage of the country's budget and amount of the country's foreign exchange or other resources spent on military equipment? (Reference may be made to the annual "Taking Into Consideration" memo: "Yes, taken into account by the Administrator at time of approval of Agency OYB." This approval by the Administrator of the Operational Year Budget can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.)

Yes, taken into account by Administrator at the time of approval of Agency OYB.

12. FAA Sec. 620(t). Has the country severed diplomatic relations with the United States? If so, have relations been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?

No.

13. FAA Sec. 620(u). What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the A.I.D. Administrator in determining the current A.I.D. Operational Year Budget? (Reference may be made to the "Taking into Consideration" memo.)

This issue was addressed in regard to the FY 1990 program in the "Taking into Consideration" memo dated December 20, 1989.

14. FAA Sec. 620A. Has the President determined that the recipient country grants sanctuary from prosecution to any individual or group which has committed an act of international terrorism or otherwise supports international terrorism? No.

15. FY 1990 Appropriations Act Sec. 564. Has the country been determined by the President to: (a) grant sanctuary from prosecution to any individual or group which has committed an act of international terrorism, or (b) otherwise support international terrorism, unless the President has waived this restriction on grounds of national security or for humanitarian reasons? No.

16. ISDCA of 1985 Sec. 552(b). Has the Secretary of State determined that the country is a high terrorist threat country after the Secretary of Transportation has determined, pursuant to section 1115(e)(2) of the Federal Aviation Act of 1958, that an airport in the country does not maintain and administer effective security measures? No.

17. FAA Sec. 666(b). Does the country object, on the basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. who is present in such country to carry out economic development programs under the FAA? No.

18. FAA Secs. 669, 670. Has the country, after August 3, 1977, delivered to any other country or received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or safeguards, and without special certification by the President? Has it transferred a nuclear explosive device to a non-nuclear weapon state, or if such a state, either received or No.

detonated a nuclear explosive device? (FAA Sec. 620E permits a special waiver of Sec. 669 for Pakistan.)	
19. FAA Sec. 670. If the country is a non-nuclear weapon state, has it, on or after August 8, 1985, exported (or attempted to export) illegally from the United States any material, equipment, or technology which would contribute significantly to the ability of a country to manufacture a nuclear explosive device?	No.
20. ISDCA of 1981 Sec. 720. Was the country represented at the Meeting of Ministers of Foreign Affairs and Heads of Delegations of the Non-Aligned Countries to the 36th General Assembly of the U.N. on Sept. 25 and 28, 1981, and did it fail to disassociate itself from the communique issued? If so, has the President taken it into account? (Reference may be made to the "Taking into Consideration" memo.)	No, it was not represented; EL Salvador is not a member of the Non-Aligned Movement.
21. FY 1990 Appropriations Act Sec. 513. Has the duly elected Head of Government of the country been deposed by military coup or decree? If assistance has been terminated, has the President notified Congress that a democratically elected government has taken office prior to the resumption of assistance?	No.
22. FY 1990 Appropriations Act Sec. 539. Does the recipient country fully cooperate with the international refugee assistance organizations, the United States, and other governments in facilitating lasting solutions to refugee situations, including resettlement without respect to race, sex, religion, or national origin?	Yes.

B. FUNDING SOURCE CRITERIA FOR COUNTRY ELIGIBILITY

1. Development Assistance Country Criteria

a. FAA Sec. 116. Has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, can it be demonstrated that contemplated assistance will directly benefit the needy?	No.
b. FY 1990 Appropriations Act Sec. 535. Has the President certified that use of DA funds by this country would violate any of the prohibitions against use of funds to pay for the performance of abortions as a method of family planning, to motivate or coerce any person to practice abortions, to pay for the performance of involuntary sterilization as a method of family planning, to coerce or provide any financial incentive to any person to undergo sterilizations, to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?	No.

2. Economic Support Fund Country Criteria

a. FAA Sec. 502B. Has it been determined that the country has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, has the President found that the country made such significant improvement in its human rights record that furnishing such assistance is in the U.S. national interest?	Yes. The President has certified that El Salvador continues to make significant progress toward improving its human rights record.

b. FY 1990 Appropriations Act Sec. 569(d). Has this country met its drug eradication targets or otherwise taken significant steps to halt illicit drug production or trafficking?

While the country does not have drug eradication targets, it has taken steps to halt illicit drug trafficking and fully cooperates with relevant international authorities.

c. FY 1990 Appropriations Act Title II. Has the President reported to the Congress on the extent to which the Government of El Salvador has made demonstrable progress in settling outstanding expropriation claims of American citizens in compliance with the judgement of the Salvadoran Supreme Court.

Yes.

"Country Checklist for FY 1990"

Clearances:
LAC/CEN: L. Simard
LAC/SA: S. Olds (Draft)
LAC/DR: L. Odle (Draft)
ARA/CEN: P. Butenis (Draft)
RLA/USAID/El Salvador: I. Smyer (Draft)
State/IOSB: T. Hobgood (Draft)
LAC/GC: K. Hansen (Draft)

5C(2) - PROJECT CHECKLIST

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

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?	YES. SUBMITTED AND APPROVED WITH PROJECT 519-0356.

A. GENERAL CRITERIA FOR PROJECT

1. FY 1990 Appropriations Act Sec. 523; FAA Sec. 634A. If money is to be obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified?	YES. IN MAY 1990 THE CN FOR THE FAMILY HEALTH SERVICES PROJECT WAS PRESENTED TO CONGRESS.
2. FAA Sec. 611(a). Prior to an obligation in excess of $500,000, will there be: (a) engineering, financial or other plans necessary to carry out the assistance; and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?	N/A
3. FAA Sec. 611(a)(2). If legislative action is required within recipient country with respect to an obligation in excess of $500,000, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance?	N/A

4.	FAA Sec. 611(b); FY 1990 Appropriations Act Sec. 501. If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.)	N/A
5.	FAA Sec. 611(e). If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed $1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively?	N/A
6.	FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.	N/A
7.	FAA Sec. 601(a). Information and conclusions on whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.	N/A
8.	FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).	N/A

9. FAA Secs. 612(b), 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.

THIS PROJECT WILL BE IMPLEMENTED BY A PRIVATE NON-PROFIT INSTITUTION, WHICH WILL CONTRIBUTE THE EQUIVALENT OF US $13,826,000. IN LOCAL CURRENCY.

10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

NO.

11. FY 1990 Appropriations Act Sec. 521. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?

NO

12. FY 1990 Appropriations Act Sec. 547. Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel?

NO

13. FAA Sec. 119(g)(4)-(6) & (10). Will the assistance: (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other

NO

wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?

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

15. FY 1990 Appropriations Act, Title II, under heading "Agency for International Development." If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government? N/A

16. FY 1990 Appropriations Act Sec. 537. If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.? YES. YES.

17. FY 1990 Appropriations Act Sec. 514. If funds are being obligated under an appropriation account to which they were not appropriated, has the President consulted with and provided a written justification to the House and Senate Appropriations Committees and has such obligation been subject to regular notification procedures? N/A

18. State Authorization Sec. 139 (as interpreted by conference report). Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision).	N/A
19. Trade Act Sec. 5164 (as interpreted by conference report), amending Metric Conversion Act of 1975 Sec. 2. Does the project use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate?	N/A
20. FY 1990 Appropriations Act, Title II, under heading "Women in Development." Will assistance be designed so that the percentage of women participants will be demonstrably increased?	THE PRIMARY PARTICIPANTS/ BENEFICIARIES OF THE PROJECT ARE WOMEN AND CHILDREN UNDER 5 YEARS.
21. FY 1990 Appropriations Act Sec. 592(a). If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies, has A.I.D. (a) required that local currencies be deposited in a separate account established by the recipient government, (b) entered into an agreement with that government providing the amount of local currencies to be generated and the terms and conditions under which the currencies so deposited may be utilized, and (c) established by agreement the responsibilities of A.I.D. and that government to monitor and account for deposits into and disbursements from the separate account?	N/A

Will such local currencies, or an equivalent amount of local currencies, be used only to carry out the purposes of the DA or ESF chapters of the FAA (depending on which chapter is the source of the assistance) or for the administrative requirements of the United States Government?	N/A
Has A.I.D. taken all appropriate steps to ensure that the equivalent of local currencies disbursed from the separate account are used for the agreed purposes?	N/A
If assistance is terminated to a country, will any unencumbered balances of funds remaining in a separate account be disposed of for purposes agreed to by the recipient government and the United States Government?	N/A

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FY 1990 Appropriations Act Sec. 546 (as interpreted by conference report for original enactment). If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities: (1) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (2) in support of research that is intended primarily to benefit U.S. producers?	N/A
b. FAA Sec. 107. Is special emphasis placed on use of appropriate technology (defined as relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?	N/A
c. FAA Sec. 281(b). Describe extent to which the activity recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.	THE PROJECT WILL BE IMPLEMENTED BY A NATIONAL PVO. INSTITUTIONAL DEVELOPMEN OF THE IMPLEMENTING ORGANIZATION IS AN IMPORTANT PROJECT GOAL.

d. FAA Sec. 101(a). Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?

N/A

e. FAA Secs. 102(b), 111, 113, 281(a). Describe extent to which activity will: (1) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (2) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life, and otherwise encourage democratic private and local governmental institutions; (3) support the self-help efforts of developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries.

THE FAMILY HEALTH SERVICES PROJECT WILL SPREAD THE BENEFITS OF HEALTH DELIVERY SERVICES TO RURAL AND MARGINAL POOR. WOMEN ESPECIALLY ARE TARGETED AS PRINCIPAL PARTICIPAN

f. FAA Secs. 103, 103A, 104, 105, 106, 120-21; FY 1990 Appropriations Act, Title II, under heading "Sub-Saharan Africa, DA." Does the project fit the criteria for the source of funds (functional account) being used?

YES

g. FY 1990 Appropriations Act, Title II, under heading "Sub-Saharan Africa, DA." Have local currencies generated by the sale of imports or foreign exchange by the government of a country in Sub-Saharan Africa from funds appropriated under Sub-Saharan Africa, DA been deposited in a special account established by that government, and are these local currencies available only for

N/A

5C(1) - COUNTRY CHECKLIST

Listed below are statutory criteria applicable to: (A) FAA funds generally; (B)(1) Development Assistance funds only; or (B)(2) the Economic Support Fund only.

A. GENERAL CRITERIA FOR COUNTRY ELIGIBILITY

1. FY 1990 Appropriations Act Sec. 569(b). Has the President certified to the Congress that the government of the recipient country is failing to take adequate measures to prevent narcotic drugs or other controlled substances which are cultivated, produced or processed illicitly, in whole or in part, in such country or transported through such country, from being sold illegally within the jurisdiction of such country to United States Government personnel or their dependents or from entering the United States unlawfully? — No.

2. FAA Sec. 481(h); FY 1990 Appropriations Act Sec. 569(b). (These provisions apply to assistance of any kind provided by grant, sale, loan, lease, credit, guaranty, or insurance, except assistance from the Child Survival Fund or relating to international narcotics control, disaster and refugee relief, narcotics education and awareness, or the provision of food or medicine.) If the recipient is a "major illicit drug producing country" (defined as a country producing during a fiscal year at least five metric tons of opium or 500 metric tons of coca or marijuana) or a "major drug-transit country" (defined as a country that is a significant direct source of illicit drugs significantly affecting the United States, through which such drugs — N/A

are transported, or through which significant sums of drug-related profits are laundered with the knowledge or complicity of the government): (a) Does the country have in place a bilateral narcotics agreement with the United States, or a multilateral narcotics agreement? and (b) Has the President in the March 1 International Narcotics Control Strategy Report (INSCR) determined and certified to the Congress (without Congressional enactment, within 45 days of continuous session, of a resolution disapproving such a certification), or has the President determined and certified to the Congress on any other date (with enactment by Congress of a resolution approving such certification), that (1) during the previous year the country has cooperated fully with the United States or taken adequate steps on its own to satisfy the goals agreed to in a bilateral narcotics agreement with the United States or in a multilateral agreement, to prevent illicit drugs produced or processed in or transported through such country from being transported into the United States, to prevent and punish drug profit laundering in the country, and to prevent and punish bribery and other forms of public corruption which facilitate production or shipment of illicit drugs or discourage prosecution of such acts, or that (2) the vital national interests of the United States require the provision of such assistance?

3. 1986 Drug Act Sec. 2013. (This section applies to the same categories of assistance subject to the restrictions in FAA Sec. 481(h), above.) If recipient country is a "major illicit drug producing country" or "major drug-transit country" (as defined for the purpose of FAA Sec 481(h)), has the President submitted a report to N/A

Congress listing such country as one: (a) which, as a matter of government policy, encourages or facilitates the production or distribution of illicit drugs; (b) in which any senior official of the government engages in, encourages, or facilitates the production or distribution of illegal drugs; (c) in which any member of a U.S. Government agency has suffered or been threatened with violence inflicted by or with the complicity of any government officer; or (d) which fails to provide reasonable cooperation to lawful activities of U.S. drug enforcement agents, unless the President has provided the required certification to Congress pertaining to U.S. national interests and the drug control and criminal prosecution efforts of that country?

4. FAA Sec. 620(c). If assistance is to a government, is the government indebted to any U.S. citizen for goods or services furnished or ordered where: (a) such citizen has exhausted available legal remedies, (b) the debt is not denied or contested by such government, or (c) the indebtedness arises under an unconditional guaranty of payment given by such government or controlled entity?

No.

5. FAA Sec. 620(e)(1). If assistance is to a government, has it (including any government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities?

No. (The GOES has made demonstrable progress toward compensation in the CAESS case.)

6. FAA Secs. 620(a), 620(f), 620D; FY 1990 Appropriations Act Secs. 512, 548. Is recipient country a Communist country? If so, has the President: (a) determined that assistance to the country is vital to the security of the United States, that the recipient country is not controlled by the international Communist conspiracy, and that such assistance will further promote the independence of the recipient country from international communism, or (b) removed a country from applicable restrictions on assistance to communist countries upon a determination and report to Congress that such action is important to the national interest of the United States? Will assistance be provided either directly or indirectly to Angola, Cambodia, Cuba, Iraq, Libya, Vietnam, South Yemen, Iran or Syria? Will assistance be provided to Afghanistan without a certification, or will assistance be provided inside Afghanistan through the Soviet-controlled government of Afghanistan? No.

7. FAA Sec. 620(j). Has the country permitted, or failed to take adequate measures to prevent, damage or destruction by mob action of U.S. property? No.

8. FAA Sec. 620(l). Has the country failed to enter into an investment guaranty agreement with OPIC? No.

9. FAA Sec. 620(o); Fishermen's Protective Act of 1967 (as amended) Sec. 5. (a) Has the country seized, or imposed any penalty or sanction against, any U.S. fishing vessel because of fishing activities in international waters? (b) If so, has any deduction required by the Fishermen's Protective Act been made? No.

10. FAA Sec. 620(q); FY 1990 Appropriations Act Sec. 518 (Brooke Amendment). (a) Has the government of the recipient country been in default for more than six months on interest or principal of any loan to the country under the FAA? (b) Has the country been in default for more than one year on interest or principal on any U.S. loan under a program for which the FY 1990 Appropriations Act appropriates funds?

From time to time, the GOZS has been in default under both provisions, which has resulted in prohibition of obligation of new funds; however, such periods have been of very short duration. Currently (as of April 2), the GOZS is not in default under either provision.

11. FAA Sec. 620(s). If contemplated assistance is development loan or to come from Economic Support Fund, has the Administrator taken into account the percentage of the country's budget and amount of the country's foreign exchange or other resources spent on military equipment? (Reference may be made to the annual "Taking Into Consideration" memo: "Yes, taken into account by the Administrator at time of approval of Agency OYB." This approval by the Administrator of the Operational Year Budget can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.)

Yes, taken into account by Administrator at the time of approval of Agency OYB.

12. FAA Sec. 620(t). Has the country severed diplomatic relations with the United States? If so, have relations been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?

No.

13. FAA Sec. 620(u). What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the A.I.D. Administrator in determining the current A.I.D. Operational Year Budget? (Reference may be made to the "Taking into Consideration" memo.)

This issue was addressed in regard to the FY 1990 program in the "Taking into Consideration" memo dated December 20, 1989.

14. FAA Sec. 620A. Has the President determined that the recipient country grants sanctuary from prosecution to any individual or group which has committed an act of international terrorism or otherwise supports international terrorism? — No.

15. FY 1990 Appropriations Act Sec. 564. Has the country been determined by the President to: (a) grant sanctuary from prosecution to any individual or group which has committed an act of international terrorism, or (b) otherwise support international terrorism, unless the President has waived this restriction on grounds of national security or for humanitarian reasons? — No.

16. ISDCA of 1985 Sec. 552(b). Has the Secretary of State determined that the country is a high terrorist threat country after the Secretary of Transportation has determined, pursuant to section 1115(e)(2) of the Federal Aviation Act of 1958, that an airport in the country does not maintain and administer effective security measures? — No.

17. FAA Sec. 666(b). Does the country object, on the basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. who is present in such country to carry out economic development programs under the FAA? — No.

18. FAA Secs. 669, 670. Has the country, after August 3, 1977, delivered to any other country or received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or safeguards, and without special certification by the President? Has it transferred a nuclear explosive device to a non-nuclear weapon state, or if such a state, either received or — No.

detonated a nuclear explosive device? (FAA Sec. 620E permits a special waiver of Sec. 669 for Pakistan.)	
19. FAA Sec. 670. If the country is a non-nuclear weapon state, has it, on or after August 8, 1985, exported (or attempted to export) illegally from the United States any material, equipment, or technology which would contribute significantly to the ability of a country to manufacture a nuclear explosive device?	No.
20. ISDCA of 1981 Sec. 720. Was the country represented at the Meeting of Ministers of Foreign Affairs and Heads of Delegations of the Non-Aligned Countries to the 36th General Assembly of the U.N. on Sept. 25 and 28, 1981, and did it fail to disassociate itself from the communique issued? If so, has the President taken it into account? (Reference may be made to the "Taking into Consideration" memo.)	No, it was not represented; EL Salvador is not a member of the Non-Aligned Movement.
21. FY 1990 Appropriations Act Sec. 513. Has the duly elected Head of Government of the country been deposed by military coup or decree? If assistance has been terminated, has the President notified Congress that a democratically elected government has taken office prior to the resumption of assistance?	No.
22. FY 1990 Appropriations Act Sec. 539. Does the recipient country fully cooperate with the international refugee assistance organizations, the United States, and other governments in facilitating lasting solutions to refugee situations, including resettlement without respect to race, sex, religion, or national origin?	Yes.

B. FUNDING SOURCE CRITERIA FOR COUNTRY ELIGIBILITY

1. Development Assistance Country Criteria

a. FAA Sec. 116. Has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, can it be demonstrated that contemplated assistance will directly benefit the needy?	No.
b. FY 1990 Appropriations Act Sec. 535. Has the President certified that use of DA funds by this country would violate any of the prohibitions against use of funds to pay for the performance of abortions as a method of family planning, to motivate or coerce any person to practice abortions, to pay for the performance of involuntary sterilization as a method of family planning, to coerce or provide any financial incentive to any person to undergo sterilizations, to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?	No.

2. Economic Support Fund Country Criteria

a. FAA Sec. 502B. Has it been determined that the country has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, has the President found that the country made such significant improvement in its human rights record that furnishing such assistance is in the U.S. national interest?	Yes. The President has certified that El Salvador continues to make significant progress toward improving its human rights record.

b. FY 1990 Appropriations Act Sec. 569(d). Has this country met its drug eradication targets or otherwise taken significant steps to halt illicit drug production or trafficking?

While the country does not have drug eradication targets, it has taken steps to halt illicit drug trafficking and fully cooperates with relevant international authorities.

c. FY 1990 Appropriations Act Title II. Has the President reported to the Congress on the extent to which the Government of El Salvador has made demonstrable progress in settling outstanding expropriation claims of American citizens in compliance with the judgement of the Salvadoran Supreme Court.

Yes.

"Country Checklist for FY 1990"

Clearances:
LAC/CEN: L. Simard
LAC/SA: S. Olds (Draft)
LAC/DR: L. Odle (Draft)
ARA/CEN: P. Butenis (Draft)
RLA/USAID/El Salvador: I. Smyer (Draft)
State/IOSB: T. Hobgood (Draft)
LAC/GC: K. Hansen (Draft)

5C(2) - PROJECT CHECKLIST

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

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?	YES. SUBMITTED AND APPROVED WITH PROJECT 519-0356.

A. GENERAL CRITERIA FOR PROJECT

1. FY 1990 Appropriations Act Sec. 523; FAA Sec. 634A. If money is to be obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified?	YES. IN MAY 1990 THE CN FOR THE FAMILY HEALTH SERVICES PROJECT WAS PRESENTED TO CONGRESS.
2. FAA Sec. 611(a). Prior to an obligation in excess of $500,000, will there be: (a) engineering, financial or other plans necessary to carry out the assistance; and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?	N/A
3. FAA Sec. 611(a)(2). If legislative action is required within recipient country with respect to an obligation in excess of $500,000, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance?	N/A

4. FAA Sec. 611(b); FY 1990 Appropriations Act Sec. 501. If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.) N/A

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

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

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

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

9. FAA Secs. 612(b), 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.	THIS PROJECT WILL BE IMPLEMENTED BY A PRIVATE NON-PROFIT INSTITUTION, WHICH WILL CONTRIBUTE THE EQUIVALENT OF US $13,826,000. IN LOCAL CURRENCY.
10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?	NO.
11. FY 1990 Appropriations Act Sec. 521. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?	NO
12. FY 1990 Appropriations Act Sec. 547. Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel?	NO
13. FAA Sec. 119(g)(4)-(6) & (10). Will the assistance: (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other	NO

wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?

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

15. FY 1990 Appropriations Act, Title II, under heading "Agency for International Development." If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government? N/A

16. FY 1990 Appropriations Act Sec. 537. If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.? YES. YES.

17. FY 1990 Appropriations Act Sec. 514. If funds are being obligated under an appropriation account to which they were not appropriated, has the President consulted with and provided a written justification to the House and Senate Appropriations Committees and has such obligation been subject to regular notification procedures? N/A

18. State Authorization Sec. 139 (as interpreted by conference report). Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision).	N/A
19. Trade Act Sec. 5164 (as interpreted by conference report), amending Metric Conversion Act of 1975 Sec. 2. Does the project use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate?	N/A
20. FY 1990 Appropriations Act, Title II, under heading "Women in Development." Will assistance be designed so that the percentage of women participants will be demonstrably increased?	THE PRIMARY PARTICIPANTS/ BENEFICIARIES OF THE PROJECT ARE WOMEN AND CHILDREN UNDER 5 YEARS.
21. FY 1990 Appropriations Act Sec. 592(a). If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies, has A.I.D. (a) required that local currencies be deposited in a separate account established by the recipient government, (b) entered into an agreement with that government providing the amount of local currencies to be generated and the terms and conditions under which the currencies so deposited may be utilized, and (c) established by agreement the responsibilities of A.I.D. and that government to monitor and account for deposits in, and disbursements from the separate account?	N/A

Will such local currencies, or an equivalent amount of local currencies, be used only to carry out the purposes of the DA or ESF chapters of the FAA (depending on which chapter is the source of the assistance) or for the administrative requirements of the United States Government?	N/A
Has A.I.D. taken all appropriate steps to ensure that the equivalent of local currencies disbursed from the separate account are used for the agreed purposes?	N/A
If assistance is terminated to a country, will any unencumbered balances of funds remaining in a separate account be disposed of for purposes agreed to by the recipient government and the United States Government?	N/A

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FY 1990 Appropriations Act Sec. 546 (as interpreted by conference report for original enactment). If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities: (1) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (2) in support of research that is intended primarily to benefit U.S. producers?	N/A
b. FAA Sec. 107. Is special emphasis placed on use of appropriate technology (defined as relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?	N/A
c. FAA Sec. 281(b). Describe extent to which the activity recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.	THE PROJECT WILL BE IMPLEMENTED BY A NATIONAL PVO. INSTITUTIONAL DEVELOPME OF THE IMPLEMENTING ORGANIZATION IS AN IMPORTANT PROJECT GOAL.

d. FAA Sec. 101(a). Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?	N/A
e. FAA Secs. 102(b), 111, 113, 281(a). Describe extent to which activity will: (1) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (2) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life, and otherwise encourage democratic private and local governmental institutions; (3) support the self-help efforts of developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries.	THE FAMILY HEALTH SERVICES PROJECT WILL SPREAD THE BENEFITS OF HEALTH DELIVERY SERVICES TO RURAL AND MARGINAL POOR. WOMEN ESPECIALLY ARE TARGETED AS PRINCIPAL PARTICIPAN
f. FAA Secs. 103, 103A, 104, 105, 106, 120-21; FY 1990 Appropriations Act, Title II, under heading "Sub-Saharan Africa, DA." Does the project fit the criteria for the source of funds (functional account) being used?	YES
g. FY 1990 Appropriations Act, Title II, under heading "Sub-Saharan Africa, DA." Have local currencies generated by the sale of imports or foreign exchange by the government of a country in Sub-Saharan Africa from funds appropriated under Sub-Saharan Africa, DA been deposited in a special account established by that government, and are these local currencies available only for	N/A

(5) [120-21] for the Sahelian region; if so, (a) extent to which there is international coordination in planning and implementation; participation and support by African countries and organizations in determining development priorities; and a long-term, multidonor development plan which calls for equitable burden-sharing with other donors; (b) has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of projects funds (dollars or local currency generated therefrom)?

DRAFTER:GC/LP:EHonnold:3/20/90:2169J

PRO-FAMILIA

ASOCIACION DEMOGRAFICA SALVADOREÑA

APARTADO POSTAL 1338 CABLE: DEMOSAL - SAN SALVADOR, EL SALVADOR, C. A.

21 de febrero de 1990

Sr. Henry H. Bassford
Director
USAID/El Salvador,
San Salvador.

Estimado Sr. Bassford:

Por este medio me place saludarlo y hacer referencia a la continua asistencia que la Agencia para el Desarrollo Internacional del Gobierno de los Estados Unidos de América ha venido brindando a nuestra Asociación desde 1964.

Es el objetivo de la Asociación Demográfica Salvadoreña seguir contribuyendo a que la familia salvadoreña alcance el bienestar tan necesario para ella, máxime en estos momentos de tanta gravedad por los que atraviesa nuestro país. Para alcanzar este objetivo, el Gobierno de los Estados Unidos de América a través de la Misión de la A.I.D. para El Salvador suscribió dos convenios, el Proyecto Dinámica de Población y Salud Reproductiva No. 519-0210 y el Proyecto Mejoramiento de los Servicios de Planificación Familiar No. 519-0275.

Como es de su conocimiento, ambos proyectos están próximos a expirar. Sin embargo, creemos que nuestra misión no ha concluido. Recientes encuestas como la FESAL-88 y la ESANES-88, comprueban claramente que aún queda mucho por hacer tanto en planificación familiar como en atención materna e infantil en el menor de cinco años. Es así que la A.D.S. ha planificado expandir sus servicios más allá de las tradicionales actividades de planificación familiar, incorporando atenciones en supervivencia infantil y control d la madre embarazada, con el mayor énfasis hacia las poblaciones rurales de nuestro país. Sentimos que un enfoque integral de salud, tal como lo necesita nuestro país, debe ser implementado por la A.D.S., sin buscar corregir todos los problemas de nuestro pueblo, pero sí contribuir dentro de nuestras posibilidades, a mitigar sus precarias condiciones de salud, contribuyendo a los esfuerzos que en este sentido verifican tanto el Ministerio de Salud Pública como otras organizaciones privadas a nivel nacional.

PRO-FAMILIA

ASOCIACION DEMOGRAFICA SALVADOREÑA

APARTADO POSTAL 1338 CABLE: DEMOSAL · SAN SALVADOR, EL SALVADOR, C. A.

Por lo tanto, solicitamos a usted que se continúe la asistencia a la A.D.S., suscribiendo un nuevo Convenio de Donación hasta por un monto de veintidós millones de dólares y por una duración mínima de cinco años, en el cual se incorporen todas aquellas actividades de supervivencia infantil y atención a la madre, que complementen nuestras tradicionales actividades de planificación familiar, en una forma totalmente integrada. Por nuestra parte, la A.D.S. aportaría aproximadamente catorce millones de dólares tanto en efectivo como en servicios y especies, como fondos de contrapartida, para implementar las actividades mencionadas anteriormente.

Sabemos nosotros que la expansión de nuestras actividades en una forma tan ambiciosa requerirá el que la A.D.S. mejore su actual situación financiera de tal manera que pueda disminuirse paulatinamente la contribución que nos dé A.I.D. y que esos costos puedan ser absorbidos a la larga tanto por asistencia generada localmente como por otras fuentes internacionales diferentes a la A.I.D. Es por eso que solicitamos que sea incluido un componente en este proyecto que enfoque directamente esta situación y nos permita desarrollar nuestra capacidad de generar recursos en busca de acercarnos a una autosuficiencia.

Sírvase aceptar, Sr. Bassford, las más altas muestras de consideración y estima.

Dr. Oscar Antonio Rodríguez
Presidente.

ASOCIACION DEMOGRAFICA SALVADOREÑA PRESIDENTE

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ANNEX E

CERTIFICATION PURSUANT TO SECTION 611 (e) OF THE FOREIGN ASSISTANCE ACT, AS AMENDED

Background

El Salvador, the most densely populated country in the continental Latin America, has long been concerned with birth spacing and contraceptive use. Much of the early support in this area came from private voluntary organizations. The Salvadoran Demographic Association (SDA), an affiliate of IPPF, was the first of these organizations to provide birth spacing services. The Family Health Services Project will provide assistance to the SDA to improve and expand its delivery of family planning and maternal child health services to high risk populations in rural and marginal urban areas. The Project will integrate selected maternal child health interventions with the promotion of modern family planning methods through three components: (1) Family Health Service Delivery, which will provide support to continue and expand the ongoing family planning service program of the SDA and to add select maternal child health services (e.g., immunization, prenatal care, oral rehydration therapy, and nutrition education) to the range of services provided by the SDA; (2) Institutional Development, which will finance the development and implementation of new products and services (e.g., opening a central referral clinic) that will strengthen the SDA's ability to sustain its program in rural and marginal urban areas and concurrently expand the availability of health care; and (3) Policy Development and Research, which will finance studies and information/education programs to increase contraceptive prevalence and improve the policy framework in which the public and private sectors work.

Certification

I, Henry H. Bassford, Principal Officer of the Agency for International Development in El Salvador, having taken into account, among other things, the maintenance and utilization of projects in El Salvador previously financed or assisted by the United States, do hereby certify pursuant to Section 611 (e) of the Foreign Assistance Act of 1961, as amended, that in my judgment the Salvadoran Demographic Association has both the financial capability and the human resources capability to effectively implement, utilize and maintain the Family Health Services Project 519-0363.

This judgment is based upon the Project analysis as detailed in the Family Health Services Project Paper and is subject to the conditions imposed therein.

Henry H. Bassford
Mission Director

Date 6/22/90

ANNEX F

F.1. TECHNICAL ANALYSIS

The technical analysis for this Project assesses the appropriateness of technologies that will be employed, and demonstrates that methods selected are the most suitable and cost-effective. The reader is urged to read this peace in conjunction with the economic analysis which addresses the issue of cost.

The major technical interventions which this project promotes relate to (1) birth spacing/family planning, (2) selected diseases control, a) diarrhea and acute respiratory diseases, b) parasite control and immuno-preventable diseases; (3) nutrition interventions: a) growth monitoring, b) breast-feeding, and c) vitamin A and other nutrient interventions. The selection of these interventions and the design of the delivery system for them is based on experience gained in similar projects throughout the world which have demonstrated their effectiveness.

A. Analysis of Technical Interventions

A.1. BIRTH SPACING/FAMILY PLANNING

Birth spacing appears to have the single greatest effect on child survival as well as in maternal morbidity and mortality. Many children die each year because of the hazards associated with rapid child bearing. We should keep in mind that a child triples his birth-weight in his first year, and this could be jeopardized when the mother becomes pregnant too soon after giving birth.

Pregnancies are most dangerous for women who:

a) are less than 18 years of age;
b) have had too many births (more than four);
c) have had an inappropriate inter pregnancy interval;
d) have medical histories that place them at risk; and
e) do not wish another child and resort to unsafe means to terminate their pregnancies.

The Project will address each of these high-risk factors, as follows:

Education for younger women will be given a priority. The 1988 El Salvador Demographic Health Survey clearly shows that 90% of respondents agreed with the statement that sex education should be taught in secondary schools and 66.4% stated that it should be thought in primary schools. Most of the women in this age group can not correctly identify the time during their menstrual cycle when they are most likely to become pregnant. This is not surprising when one analyzes the birth statistics for El Salvador and finds that adolescents account for approximately 40% of all Salvadoran fertility. These young mothers are also at higher risk of complications such as eclampsia, congenital malformations and

hemorrhagic complications associated with pregnancy. In addition to this, younger women generally suffer from poor prenatal and postnatal care which results in higher morbidity and mortality among this age group. Pregnancy is especially dangerous to women in their teen years because they are more malnourished as a group and the general structure of their pelvic growth is not complete. Therefore, educational efforts, under the Project should be directed, as proposed, to this age group.

Higher parity also increases a woman's risk in pregnancy. Women who have more than four births are more likely to require delivery by Caesarean Section or forceps because the higher the parity the higher incidence of anomalous fetal positions such as breech presentations, etc. High parity women are at higher risk of antepartum and post partum complications such as uterine prolapse, cervical erosion, placenta previa, abrupto placentae and the appearance of other diseases such as diabetes.

Women who already suffer poor health and become pregnant too soon, are particularly prone to spontaneous abortions, stillbirths or low birth-weight babies who are much less likely to survive. Babies born less than 2 years after their next oldest sibling are twice as likely to die as babies born after a 2 year interval.

Preexisting medical problems and a history of complications during pregnancy can place a women at high risk for obstetrical problems. Such women need to space their pregnancies by using family planning services to avoid the severe consequences which may ensue from pregnancy. Moreover, adequate prenatal and postnatal control is vital for both the mother and the baby. Currently, prenatal care is used on a limited basis in El Salvador; the 1988 Health Survey showed that only 67.5% of respondents had experienced the benefit of prenatal care; however, only 56.9% had experienced "adequate" (between 5 and 8 visits) prenatal care.

Finally, pregnancies sometimes end in abortion. When women do not have access to family planning services, and they do not want the pregnancy, they may opt for illegal abortions. However, as other Latin American studies have shown, when family planning programs are widely available, the need for abortion decreases sharply. The worldwide estimate is 20-30% of all pregnancies end in induced abortion. Recent statistics demonstrate that 15% of all Maternity Hospital entrants are from abortion related causes. The tragic reality of these statistics testify to the fact that Salvadoran women continue to obtain abortions which are costly to their health and the hospital system which must pay for their cure, rest and recuperation. Also, abortion is responsible for a high incidence of maternal mortality rates in El Salvador, as shown in a Maternal Mortality Survey (January 1989), which analyzed maternal deaths occurring from 1983 to 1987. This study clearly shows abortion related deaths to be the fourth leading cause of maternal deaths in El Salvador. The study also showed that hemorrhage and toxemia are other important causes of maternal deaths in El Salvador; and as explained above, hemorrhage is more likely to occur among women with a high parity.

However, as other Latin American studies have shown, when family planning programs are available, abortion rates decrease sharply.

Community Based Approach: In addition to existing urban programs and the success of the social marketing program, community participation is the next logical step to increase family planning coverage and reduce problems associated with access and availability of contraceptives especially to those women in high risk. Operations research for the Ministry of Health has shown the effectiveness of delivering community based services and reaching clients their own homes. The cost of performing such activity has been reasonable by development cost standards. Data obtained from private sector assessments have shown that community based efforts in El Salvador have been costing $6.00 per user. Therefore, the Community Based Distribution (CBD) approach is appropriate for the Project to cover this hard to reach audience.

Benefits accrued from use of birth spacing methods are four-fold:

a) Children's lives are saved through proper spacing, as existing children are allowed time to develop before another arrives.

b) Mother's lives are saved through proper use of their reproductive availability by avoiding pregnancy too soon after giving birth, thereby allowing the mother to regain her strength and a better nutrition status between pregnancies.

c) Higher nutrition status for the entire family is achieved due to the availability of more calories for existing family members.

d) Young couples are provided more time to plan their future, by completing their education, fulfilling their children's basic needs, being able to spend their savings on a permanent shelter, etc.

Therefore, investments in family planning strategies are worthy considering all the factors that jeopardize mothers and children's lives.

Couple years of protection (CYP), is a widely accepted indicator by AID, as well as by other international donors and by providers of family planning in El Salvador. This concept is the basis for the current Family Planning Supplies Management System, which has been established by the major FP providers on the Salvadoran scene. The CYP, which converts distribution data to user data, applies factors to contraceptive usage data (i.e. units of oral contraceptives, condoms and IUDs) needed to cover one couple for one year. Voluntary surgical contraception also provides a standard number of couple years of protection which is another calculation in estimating the number of users in one year.

Efforts in delivering contraceptives to new potential users are worthwhile. Therefore, this Project will provide them with integrated family planning/MCH services.

BEST AVAILABLE

A.2. SELECTED DISEASE CONTROL

a. Diarrhea:

This is a common childhood disease which mothers and other family caretakers have been treating since the beginning of the human race. The home treatment is generally successful, as evidenced by the fact that only 1-2% of children treated with this remedy die from any acute diarrheal disease episode. However, therapy for diarrhea must begin promptly with appropriate feeding and fluids at home.

In El Salvador, deaths due to intestinal infections are the second cause of death in all ages forming 6.4 % of all deaths. Diarrheal disease (including intestinal helminths, amoebiasis and dysentery) is the first cause of infection in El Salvador, comprising 57.6% of all infectious disease. The 1988 Demographic Health Survey data shows that 29.1% of children under five were reported to have had diarrhea during the two weeks prior to the interview; this percentage increased to 33.2% for rural children. However, only 10.8% of children with diarrhea received ORS packets as treatment.

Malnutrition and diarrhea interact in several ways detrimental to children's health. First, diarrhea produces serious nutritional deficits. Second, malnourished children suffer diarrheal episodes of longer duration and of increased severity. Diarrhea can be defined as acute or chronic depending on the duration of the sickness. Chronic diarrheas are more likely to be present in malnourished children, who in turn are more severely malnourished by the diarrhea and so on. Acute diarrheal episodes can be attacked by oral rehydration which has proven to be an effective deterrent to extended morbidity and even mortality from those acute episodes.

A reliable supply of oral rehydration salts (ORS) of good quality made available to mothers and health workers is a cornerstone for Control of Diarrheal Disease Programs. The approach to supply management and distribution in ORT programs must be pragmatic and creative, identifying, stimulating, and making effective all those supply channels which can put knowledge of ORT, and packets of ORS, in the hands of mothers and health workers.

In order to assure provision of a reliable supply of ORS to the beneficiaries and ensure correct use of ORS, some conditions should be fulfilled: 1) Mothers must modify their behavior and health practices; 2) Providers of health services must prescribe ORS when needed, and actively promote the prevention of disease; and 3) The private sector must contribute to the supply and demand for ORS.

b. Respiratory Diseases:

The decline in death rates from ARI in industrialized countries at the beginning of this century occurred for a variety of reasons, probably

due as much to better living conditions and improvements in nutrition as to improved medical care. The main respiratory infections that kill children are acute lower respiratory infections: pneumonia, bronchiolitis, and croup.

In El Salvador, acute respiratory infections (ARI) affect approximately 67 [illegible] of children under five nationwide and 73.6% of children living [illegible] rural areas of the country. These data show that ARI is one of the l[illegible]g causes of child mortality in El Salvador. Thus, a strategy shall be followed by this Project to avert deaths due to acute respiratory infections. In this sense, prevention continues to be the most practical approach, including chemoprophylaxis, vaccines, measles vaccines, pertussis vaccines, BCG, etc. The Project will deal with educational interventions in trying to reduce the high incidence of these diseases and examination of patients against a specifically developed ARI checklist for possible referral.

c. Parasite control:

Lack of adequate hygienic conditions in the community lead to parasites, and if contracted by an already malnourished child will worsen his nutritional status. In addition, parasitic infections could produce an increment of ARI among persons with nematode or trematode infections. It has been suggested that the associated local inflammation and damage to lung parenchyma may predispose an individual to bacterial super-infection. This Project will attack these problems in selected communities nationwide through education, as well as through distribution of antiparasitics via the Social Marketing Program in the Community Based Distribution Program implemented by the SDA. Educational messages are simple and can easily be conveyed through Project activities; the distribution of antiparasitics can also be done effectively and safely through this level of health care worker.

d. Immuno-preventable diseases:

As an integration of all of the aforementioned diseases prevention strategies, specific interventions to increase the immunization program will become an integral part of this Project. However, specific interventions will include health education and referral to the private and public sector health clinics. Vaccination coverage in El Salvador is not low; the 1988 DHS shows that 68.8% of women in fertile age were vaccinated against tetanus during their last pregnancy. In the case of children under five, the following coverage was reported in the 1988 DHS:

BCG	77.3%
Polio	61.5%
DPT	61.4%
Measles	81.0%

We should keep in mind that 80% coverage of children is generally considered sufficient to protect a population from epidemic outbreaks.

BEST AVAILABLE

Nonetheless, educational support is needed in El Salvador to increase current vaccination coverage. Families worldwide fail to use immunization services for a variety of reasons. Clinics are often far away and open on a sporadic basis or at inconvenient times; clinic workers rarely go out to the surrounding communities, often for lack of transportation or per diem costs. This project will bring intensive education to the communities to generate a demand to be satisfied by the public and private health sectors networks.

A.3. NUTRITION INTERVENTIONS

Economic growth and increased food production are not sufficient to reduce malnutrition in developing countries. Economic development itself is retarded by undernutrition. Poor nutrition underlies more than half of early childhood mortality, accounts for most of the acquired immune deficiency in the world, reduces learning potential and performance, limits work capacity, and increases reproductive wastage. For the very young people, malnutrition is lethal. It is a major contributor to the alarmingly high infant and child mortality rates in developing countries. This Project will, therefore, support three primary nutrition interventions; growth monitoring, breast feeding, and the reduction of vitamin A deficiency.

In El Salvador, a 1988 nutritional survey showed that approximately 50% of children in this country suffer from a certain degree of malnutrition, and that 15% are moderate to severely malnourished. As a consequence of malnutrition, growth development is seriously affected in approximately 60% of malnourished children of El Salvador.

Growth retardation starts being identified during the first year of life, but it will worsen during the second year and will change only slightly thereafter. Growth monitoring, therefore constitutes a key tool to measure improvements in nutritional status among children under the age of two when compared against pre-established patterns. By measuring growth we measure health. Two of the most important measurement indicators of a healthy child are that he should be growing and that he should be about the right weight for his age; also, a child should show adequate development for his age.

The community plays an important role in establishing nutrition interventions. Nothing can be achieved if the problem is not attacked at community levels. "Community nutrition" is therefore the whole of the nutritional sciences applied to the consumer as groups or as individuals. It is the interface between food and people and probably some 90% of all nutrition takes place in the home.

Growth monitoring, then, becomes an important element in community nutrition interventions as delineated in this Project, and will be achieved only if both health workers and families receive the adequate

training and nutrition education to measure child development. This project will also reach women of childbearing age through growth promotion programs in order to prevent their nutritional deterioration during pregnancy, increase their child's birth-weight, and provide screening and treatment for health risks.

The advantages of breast-feeding for the welfare of mothers and children are well known. This is the best form of nutrition for the young infant and an important means of spacing births. Breast milk and breast-feeding benefits include:

a) Breast milk provides some immunological protection for the infant;
b) Breast milk best satisfies the infant's nutritional needs;
c) Breast-feeding costs less than feeding with substitutes;
d) Because of the immunological and nutritional advantages of breast milk and because preparing substitutes properly is difficult in much of the developing world, breast-fed infants are less likely to develop infections or malnutrition; and
e) Breast-feeding protects against pregnancy, although the length of this contraceptive effect is not predictable. For instance, by six months about 20 to 50 percent of breast-feeding women are menstruating and need contraception just as much as if they were not breast-feeding.

The 1988 Demographic Health Survey shows that 17 months is the mean duration for breast-feeding in El Salvador and that, in 1988, 95.3% of mothers breast-fed their most recently born child. There was a slight increase in this average when the rate was compared to the 16-month-mean duration period of 1985. There are statistical differences when this average is compared in rural versus urban populations (17.9 vs. 14.7) showing that breast-feeding is more likely to be accepted by rural women than by urban women in El Salvador. When we compare these statistics to other Latin American countries, El Salvador is within the high range of breast-feeding; e.g.: in Venezuela, 3 months is the mean for breast-feeding; similarly, Costa Rica has an average of 1.8, Dominican Republic of 7.2 and Mexico of 6.7. Thus, in achieving all of the advantages breast-feeding can provide to children, mothers and health workers shall be educated in the benefits the breast milk provides. Besides, it is largely proven that a woman who breast-feeds frequently day and night, providing the baby with little supplementation and is not menstruating might reasonably wait 12 or 18 months to start combined contraceptive pills or might start progestogen only methods earlier. While breast-feeding is common in EL Salvador, educational efforts nonetheless need to continue to ensure that use doesn't decline due to changing economic and social factors. This project has a twofold goal in this respect:

a) To preserve breast-feeding for its value in terms of infant nutrition and health, both where it is now common and to encourage and facilitate breast-feeding in those regions of the country where the practice is declining, as well as;

b) To provide a safe and effective means of contraception to breast-feeding women at the appropriate time to prevent unwanted pregnancies.

Vitamin A: It has long been known that lack of vitamin A causes loss of vision in small children. Xerophtalmia, the medical term for this condition, begins with an inability to see in low light. Also, vitamin A deficiency has proven to produce growth retardation in young children and to increase respiratory illnesses because of damage to respiratory tissues. Vitamin A deficiency is a public health problem in an estimated 73 countries and territories around the world.

Project interventions to address prevention/reduction in the incidence of vitamin A deficiencies will include continued distribution of vitamin A capsules, nutrition education, and promotion of home gardens in selected communities. It is accepted that malnutrition is not the lack of a single nutrient but of a combination of them. Raising home gardens through community education will provide the basis and the opportunity for residents of the community to get an adequate nutrient ration. Home gardens, thus, will become an integral part of this Project in order to provide participants with other nutrients such as iron. Iron requirements during pregnancy become elevated and home gardens could, to some degree, provide the additional iron requirements of pregnant women.

B. METHODOLOGICAL APPROACH/DELIVERY SYSTEMS

The Salvadoran Demographic Association will use three technical approaches to deliver family health services. These approaches include: a) Community Based Distribution; b) Social Marketing; and c) delivery of Clinical Based Services.

a. Community Based Distribution:

Local volunteers, usually village women, are recruited to educate their neighbors in family planning, prenatal, inter-gestational, postnatal care and maternal child health modalities. The CBD worker is also responsible for distributing maternal-child health and family planning methods (MCH/FP) to his/her neighbors. Therefore, the CBD worker must know the indications and contraindications of each of the methods. CBD workers are supervised by trained nurses who assure the quality of service delivery and screen patients for referrals.

There are specific advantages to using CBD workers. First, rural and marginal urban users can obtain contraceptive methods from their neighbors which increase access and availability of the contraceptive and MCH methods. Second, most of the CBD workers are from the communities in

which they offer distribution services. In the majority of cases this means that the CBD distributer instills more confidence in the user. Third, CBD workers through this Project, will be able to identify, treat and/or refer high reproductive risk cases to the nearest SDA private physician or clinic. Finally, the CBD worker will be a resource person for the community motivating and educating his/her neighbors and sharing educational materials which will be helpful in improving FP/MCH practices in the community.

Some disadvantages to using CBD workers are: the cost per user may be high; many CBD workers have been specialized in family planning services (as opposed to combined FP/MCH); and, finally, some potential users may lack confidence in the CBD worker since, to some users, a local person may not be perceived as reliable or as trustworthy as the doctor or nurse in the neighboring village.

In order to meet the goals of rural outreach and expanded urban marginal coverage, the Project will use CBD workers as a major means to expand and increase contraceptive coverage to the rural areas.

b. Social Marketing:

The Salvadoran Demographic Association has been actively involved in the commercial retail sale of contraceptives through approximately 900 participating pharmacies and 1000 small stores located in urban centers throughout El Salvador. The Social Marketing Program takes advantage of the existing network of pharmacies and stores to increase the sale of contraceptives by selling them at lower prices while maintaining sufficient profit margin to generate income for the SDA. Through this approach, the SDA has more than doubled the number of contraceptive users in the last 5 years.

An advantage of the SDA Social Marketing Program is to make use of existing infrastructure to increases user access. Many users who do not wish to pay for a medical consultation and/or who want to refill their prescription can go to the nearest SDA participating pharmacy to obtain temporary contraceptives at lower prices. Many times women or men who want to use family planning are prevented from doing so because they feel required go to a clinic where they must wait for hours to see public service practitioners who the user may perceive do not ensure confidentiality. Receiving contraceptives from a pharmacy is far more convenient for these people. The cost to maintain government subsidized FP programs is enormous; social marketing is a cost effective way of reaching a portion of the target audience since the distribution network and sales network are already in place.

The disadvantages of the Social Marketing approach is that patients who may have complications may or may not be instructed to go to a clinic for follow-up. Because of the nature of the pharmacies, they do not provide the full range of contraceptive options that a clinic can. Some pharmacies realize that the government cannot enforce regulations

and sometimes provide the general public with expired medicines. Also, under skilled pharmacy personnel can decrease the effectiveness of the pharmacies as a service delivery mechanism. Educational programs in communities can, however, help to prevent these problems.

This project will continue to support the SDA in contraceptive social marketing and will expand the product line to include simple MCH products that can be sold at low cost to improve the health of Salvadoran mothers and children.

c. Clinic Based Services:

The clinic based health delivery system provides a broader range of services and a higher degree of expertise for recipients of family planning services. Trained nurses and physicians are much more qualified at providing care to clients than midwives or CBD workers. Due to the level of expertise of the clinic personnel it is always a preferred approach to the delivery of any health service when it can be made readily affordable and available.

The disadvantages of the clinic system are: a) it caters to those, mostly urban participants, who are close by and have greater access; and b) client follow up under the clinical system depends on user motivation (health professionals rarely make home visits). These disadvantages are nonetheless for outweighed by the sound medical reasons for ensuring clinical family planning services are available.

F.2 ECONOMIC ANALYSIS

F.2.1. COST EFFECTIVENESS ANALYSIS:

I. INTRODUCTION

The purpose of this cost-effectiveness analysis is to provide a rational basis for the selection of specific interventions and strategies which will serve the purpose of the Project. The purpose of the Project is to improve the health well being of the Salvadoran population. In order to achieve this purpose, the Project will address the most important health problems in El Salvador. These are problems related to maternal-child health. They are birth spacing, diarrheal disease, poor nutritional status, immunizable illnesses and respiratory infections. As this Project is to be implemented by the Salvadoran Demographic Association, the principal focus of the Project will be birth spacing, although MCH preventive services will also be provided. All services will be targeted towards the portion of the population which has the highest rates of fertility, morbidity and mortality and the lowest use of modern contraception. This analysis discusses the costs and effectiveness of each intervention used to address the problems of high rates of fertility, diarrheal disease and undernutrition among the high risk population.

II. METHODOLOGY

The method used is based on the description of cost/effectiveness analysis described in Delp, P. (1977) "Cost Effectiveness Analysis", Systems Tools for Project Planning, Indiana University. Effectiveness is defined as the product of the reliability of the intervention (in preventing births or dehydration during diarrheal episodes, for example) and its rate of acceptance among the population. Specific sources used for the calculation of effectiveness of each intervention are cited below each table. Estimates of acceptance are based on national survey data where possible. Cost estimates are based on the life of Project (LOP) costs and estimates from El Salvador's Bloom Children's Hospital which are associated with each intervention. The cost of each intervention includes the cost of service delivery for each.

III. COST EFFECTIVENESS OF PROJECT INTERVENTIONS

A. FERTILITY: COST EFFECTIVENESS OF MODERN METHODS OF CONTRACEPTION:

Table 1, next page, shows effectiveness of modern methods of contraception in El Salvador to be highest for female sterilization, followed by contraceptive pills, condoms and the IUD. Vasectomy has the lowest effectiveness due to its low acceptance. Female sterilization is fully reliable and has a high rate of acceptance among women.

TABLE 1
EFFECTIVENESS ESTIMATES FOR MODERN METHODS OF CONTRACEPTION
EL SALVADOR

METHOD	Reliability	Acceptance	Effectiveness (%)
Vasectomy	98	0.01	0.60
Condom	90	0.02	1.80
Pill	95	0.08	7.60
IUD	90	0.02	1.80
Sterilization	98	0.30	29.40

Note: Reliability is based on the ability of the method to prevent contraception. Acceptance is based on actual usage of the method (FESAL 1988)

TABLE 2
COST ANALYSIS OF MODERN METHODS OF CONTRACEPTION
EL SALVADOR
(in US$)

METHOD	CYP	Cost/Unit	Cost/Year
Vasectomy	14.00	68.061	4.86
Condom (unit)	0.01	0.059	5.90
Pill (cycle)	0.08	0.289	3.76
IUD (unit)	2.50	2.500	1.00
Female Sterilization	14.00	70.718	5.05

Sources: CYP from SDA and USAID (personal communications), Sterilization CYP based on the FESAL, 1988 (Table 6.1); Cost is based on the medical/clinical budget and 60% of the rural health delivery budget (totaling 19.6 million US$) allocated according to SDA use-rates for 1988 from the FESAL, 1988, plus the LOP cost of each type of contraception, divided by the number of units of each type.

According to the analysis of cost in Table 2 above, surgical methods are the most costly for the Project. However, because surgical

According to the analysis of cost in Table 2 on the previous page, surgical methods are the most costly for the Project. However, because surgical methods provide the longest protection and, in the case of female sterilization, has a high degree of acceptance, its cost per year of protection is lower than condoms. A detailed breakdown of attribution of costs by method is provided in the tables of this analysis. Among the three temporary methods, the cost per year of protection is lowest for the IUD. The next lowest cost for a temporary method is the pill.

TABLE 3
COST-EFFECTIVENESS RATIOS FOR MODERN METHODS OF CONTRACEPTION
IN EL SALVADOR
(in US$)

METHOD	Cost/Year Protection	Effectiveness (%)	Ratio
Vasectomy	4.86	0.60	0.12
Condom	5.90	1.80	0.31
Pill	3.76	7.60	2.02
IUD	1.00	1.80	1.80
Female Sterilization	5.05	29.40	5.82

Table 3 above, shows the cost-effectiveness ratios per method. A high cost-effectiveness ratio indicates that the method has a higher cost effectiveness. Thus female sterilization is the most cost effective method, followed by the pill, IUD and condoms. Vasectomies are the least cost-effective method. This is important as the Project purpose will also be served most by increasing the use of temporary methods and promoting birth spacing among younger couples. Female sterilization is currently the most popular form of modern contraception in El Salvador. Therefore, its high acceptance provides a high cost-effectiveness ratio. However, sterilizations alone are unable to significantly reduce the dependency ratio or fertility rate in El Salvador because couples seek sterilization at older ages when they have already completed their families, and this does not affect fertility rates for younger aged couples. Sterilization is not an appropriate method for younger couples who are still interested in producing children, nor does it provide the spacing of births necessary to improve maternal health, family well being and viability of future offspring.

The factors mentioned above underscore the importance of temporary methods, as the most appropriate and effective methods for this Project. The pill has the highest cost/effectiveness ratio of temporary methods, therefore, the Project should make this contraceptive available and promote its use among young couples interested in temporary methods.

The second most cost-effective temporary method is the IUD. Reliability is excellent, however, with better acceptance it could become the most cost-effective temporary method. Therefore, this method should continue to be promoted and distributed.

Condoms are the least most cost-effective temporary method of modern contraception. As a result of previous SDA efforts, the use of condoms has increased dramatically in El Salvador over the past three years. The Project should, therefore, also make condoms available to the high risk population.

Vasectomy cost-effectiveness rates are the lowest of all methods of modern contraception due to their low levels of acceptance and use. Since vasectomies are similar in cost to female sterilizations, are as reliable and their CYP is nearly as long, increasing their acceptance would improve the cost-effectiveness ratio accordingly. Indeed, if vasectomies were to be as acceptable as female sterilization, they would become the most cost/effective permanent method. The Project should therefore also increase both the availability of vasectomies and their acceptance as a method.

B. Diarrheal Disease

Diarrheal disease is the principal direct cause of illness and death among children under five in El Salvador. Most of the death related to diarrhea is actually caused by the dehydration which accompanies it. Therefore, interventions which prevent or cure dehydration during episodes of diarrhea are effective in preventing diarrhea-related deaths.

Table 4 next page, compares the effectiveness of the three most important interventions for dehydration during diarrheal episodes. According to this analysis, the most effective method is oral rehydration salts (ORS). In recent years, the emphasis on Child Survival in El Salvador has raised the use of ORS to ten percent of diarrheal episodes among children under five. The second most effective method is the home solution, an electrolyte solution made with common household ingredients (lemon, sugar, salt). Although this method is as reliable as ORS when used properly, its use during childhood diarrhea episodes is low. Inpatient hospital rehydration is the most reliable alternative for rehydration as children are monitored and attended by trained medical personnel; however, acceptance of internship of children is low among the highest risk population. Only when a child is severely undernourished or dehydrated will a family bring him in to the hospital and leave him there.

TABLE 4
EFFECTIVENESS ESTIMATES FOR DIARRHEAL DISEASE INTERVENTIONS
EL SALVADOR

METHOD	Reliability	Acceptance	Effectiveness
ORS	65	.1	6.5
Home Electr. Solution	65	.02	1.3
Hospital Rehydration	95	.003	0.3

Note: Reliability is the ability of the intervention to prevent diarrhea mortality among children under five by curing or preventing dehydration during diarrhea episodes.

Sources: Reliability based on estimates from Bloom Children's Hospital; Acceptance for ORS and home solution based on the FESAL, 1988 (table 12.4); Acceptance for hospital rehydration based on the percent of children under five years with severe weight for height deficiency.

TABLE 5
COST ESTIMATES FOR DIARRHEAL DISEASE INTERVENTIONS
EL SALVADOR
(in US$)

METHOD	Protection per Episode	Cost/ Unit	Cost per Treatment
ORS	.33/packet	.27	0.82
Home solution	.33/liter	.05	0.15
Hospital Rehydration	1.00/treatment	46.88	46.88

Table 5 above, presents the cost of each of these interventions per protected diarrheal episode. There are three episodes of diarrhea among children under five in El Salvador each year.

According to this analysis, the most expensive method is inpatient hospital rehydration. Both alternative methods are much less expensive by episode. Since ORS packets must be purchased, they are more costly than the home electrolyte solution.

Note: Cost per unit for nutrition, diarrheal and ascaris interventions was calculated by dividing 40% of the rural outreach project budget LOP by the eight MCH interventions (pre-natal vitamins., multivitamins, vitamin A, gardens, vaccination, growth monitoring, ORS and anti-parasite medications), adding the total unit cost of the intervention itself and dividing that by the number of units LOP; cost estimates therefore include educational and other service delivery costs related to each intervention.

TABLE 6
COST-EFFECTIVENESS RATIOS FOR DIARRHEAL DISEASE INTERVENTIONS
EL SALVADOR
(in US$)

METHOD	Cost/ Treatment	Effectiveness % Protection	Ratio
ORS	.82	6.5	7.9
Home Solution	.15	1.3	8.7
Hospital Rehydr.	46.88	0.3	0.006

Table 6 presents the cost/effectiveness ratios for each of these interventions. The home electrolyte solution is shown to be slightly more cost/effective than oral rehydration salts. Both of these methods should be made available through this Project to risk populations in El Salvador. The Project should also include public education to promote their increased acceptance and use. Given its low cost, an increase in the correct use of the home solution during childhood diarrhea would be a particularly cost/effective intervention.

Inpatient hospital rehydration is by far the least cost/effective intervention for diarrheal diseases. This is due to a combination of its high cost and low acceptance. It is presented here for comparison and is not as a priority Project activity.

C. Roundworm (Ascaries) Infestations

Table 7 next page, presents effectiveness estimates for alternative methods of treating ascaris infestations in children under five years of age. Although more reliable, hospital treatment of ascaris (like that of dehydration) is considered to be the least effective when community acceptance and access are taken into account.

TABLE 7
EFFECTIVENESS ESTIMATES FOR ASCARIS INTERVENTIONS
EL SALVADOR

METHOD	Reliability	Acceptance	Effectiveness
Ascaris Medication	80	.80	64
Hospital Treatment	95	.15	14

Note: Reliability is based on the ability of the intervention to cure ascaris infection Sources: Reliability and Acceptance estimates from Bloom Children's Hospital (personal communication).

Table 8 below, compares the cost per protected episode of each intervention used in the treatment of ascaris. According to this analysis, ascaris medicine delivered through the rural outreach component of the Project costs less than hospital treatment.

TABLE 8
COST ESTIMATES FOR ASCARIS INTERVENTIONS
EL SALVADOR
(in US$)

METHOD	Protection per Episode	Cost per Unit	Cost/ Treatment
Ascaris Medication	0.16/pill	1.01	6.30
Hospital Treatment	1.00	20.00	20.00

TABLE 9
COST-EFFECTIVENESS RATIOS FOR ASCARIS TREATMENT INTERVENTIONS
EL SALVADOR
(in US$)

METHOD	Cost per Treatment	Effectiveness (%)	Ratio
Ascaris Medication	6.3	64	10.2
Hospital Treatment	20.0	14	.7

Table 9 compares the cost/effectiveness ratios of each of these interventions. As expected from the above discussion, the most cost/effective method of treating ascaris infections in children under five is with medicine delivered through the rural outreach component of the Project. Outpatient clinical treatment is much less cost/effective and is not recommended for the Project. It is presented here primarily for comparison.

D. Malnutrition

Table 10 next page, presents the effectiveness of four interventions designed to improve the nutritional status of pregnant women or children under five. All four methods are looked upon favorably by the high risk population; vitamins are popular and garden seeds are expected to be in demand. The reliability of these interventions in the prevention or treatment of the most important vitamin deficiencies in El Salvador, however, varies widely. The most important nutritional deficiency among pregnant women is that of iron, while vitamin A is the most serious vitamin deficiency among children under five. Therefore, prenatal vitamins and vitamin A capsules have the highest effectiveness levels. They directly impact upon the most serious deficiencies. Although multivitamins also contain vitamin A, the dosage is not sufficient for treatment of severe vitamin A deficiency. Home gardens also provide vitamins and iron to the family; however, the dosages will again be small and benefits will be divided among family members.

TABLE 10
EFFECTIVENESS ESTIMATES FOR NUTRITION INTERVENTIONS
EL SALVADOR

METHOD	Reliability	Acceptance	Effectiveness
Prenatal Vitamins	95	.80	76
Multivitamins	25	.80	20
Vitamin A	95	.80	76
Gardens	15	.80	12

Note: Reliability is based on the ability of the intervention to improve the most significant nutritional problems of the individual (pregnant woman or child under five). Sources: Reliability and Acceptance based on technical assistance estimates.

Table 11 next page, compares the cost per year of protection for each of these same interventions. The most expensive interventions are prenatal vitamins, home gardens and multivitamins. Although the cost per unit for prenatal and multivitamins is low, they must be given in large quantities in order to achieve full coverage. Seeds are more expensive per unit, but they must also be given in large quantities if full coverage is to be achieved. In contrast, the estimated cost per year of protection for vitamin A capsules is low. This is because the cost per unit for delivery of vitamin A is high, but only two capsules are given each year for full coverage.

TABLE 11
COST ESTIMATES FOR NUTRITION INTERVENTIONS
EL SALVADOR
(in US$)

METHOD	Protection /year	Cost /unit	Cost/ Year
Prenatal Vitamins	.004/pill	.06	15.0
Multivitamins	.003/pill	.02	6.7
Vitamin A	.5/capsule	.67	1.3
Gardens	.05/seed pkt.	.36	7.2

TABLE 12
COST-EFFECTIVENESS RATIOS FOR NUTRITION INTERVENTIONS
EL SALVADOR
(in US$)

METHOD	Cost/ Episode	Effectiveness. (%)	Ratio
Prenatal vits.	15.0	76	5.1
Multivitamins	6.7	20	3.0
Vitamin A	1.3	76	58.5
Gardens	7.2	12	1.7

Table 12 presents a comparison of the cost/effectiveness ratio of these nutrition interventions. The most cost/effective intervention by far is that of vitamin A capsules. Their effectiveness is high and their cost is low. These should, therefore, be provided to the high risk through the Project. The second most cost/effective intervention is prenatal vitamins. Although their cost of delivery is high, effectiveness is also high. These should also be provided to high risk pregnant women through the Project.

The two interventions which were least cost/effective were multivitamins and home gardens. Although, their cost per year of protection was relatively low and their acceptability high, neither impact directly upon the most serious vitamin deficiencies in El Salvador. However, since home gardens and multivitamins are both interventions which are popular among the high risk population, promotion of them might serve as important incentives to Project participation.

IV. CONCLUSION

Five major contraceptive measures all show positive cost-effectiveness ratios. The contraceptive pill, female sterilization, the condom and the IUD merit continued promotion through this Project. Further, education and promotion should be given to male vasectomy because it is a highly effective approach, but is not widely accepted.

The distribution of oral rehydration salts, and education and promotion of the preparation of home solutions for rehydration are cost-effective interventions which should receive support from this project. Tapeworm medicine made available to rural mothers will also be cost-effective and should be supported by the project.

This analysis shows that vitamin A for children and prenatal vitamins for mothers will be cost-effective measures to improve maternal and child health. They should be included in this Project.

Multivitamins for children and seeds for family gardens do not demonstrate high levels of cost-effectiveness, however, as stated above, both interventions have a good degree of acceptance among the high risk population and, therefore, should be included in the Project.

F.2.2. SENSITIVITY ANALYSIS

The Sensitivity Analysis is based on the knowledge that sufficient uncertainties exist on most, if not all, projections or estimates of project cost and benefits to warrant an examination of the effects of changes in the most important estimates and assumptions on the profitability and financial stability of the Project, (AID Handbook 3, App. 3D, Page 3D-20, Sensitivity Test). In the case of this Project, the sensitivity analysis is based on the effect of such changes on the Project's "cost effectiveness," as the benefits are not measured in monetary or "profitability" terms.

The first point is that the Project should not have as many uncertainties in its projections of costs and benefits as projects in such fields as agribusiness, industry and infrastructure and those that are export oriented. For example, in an agribusiness project weather changes or disease can serve to change project outputs dramatically from year to year. Likewise foreign competition or exchange rate swings and anomalies can have major impacts on project revenues and costs; and introduction of new technology packages can have high degree of uncertainty regarding rates of acceptance.

That is not to say that the Family Health Services Project is not subject to uncertainties which could alter its cost effectiveness. However, the uncertainties endogenous to the Project appear to be fewer, and less subject to unforeseen events which could prove dramatic with a consequent substantial loss in Project benefits or a substantial rise in Project costs. The same cannot be said for exogenous factors.

The most likely risk to achieving Project benefits is the current insurrection in the country which, while impacting on urban areas and especially its marginal zones, is most severe in the countryside. As the project focuses on rural areas and marginal urban zones, an escalation in fighting could have very negative impacts on achieving Project outputs and purposes. In a worse case scenario Project activities would need to be substantially cut back in rural areas and refocused on marginal urban areas and clinical services. This would entail a down scaling of yearly budgetary allocations with a likely transference of funds to other USAID projects and toward general economic stabilization goals.

On the other hand, if the insurgency gradually diminishes and terminates, the achievement of project outputs and purposes would be more easily met and likely exceeded. Because highly contested zones are excluded from the current project, a reduction and gradual elimination of the insurgency would allow expanded outreach and necessitate additional funds for goods and services to be provided in villages and hamlets in addition to those currently planned.

The other possible events which must be taken into account are economic growth, whether positive or negative, and its impact on unemployment rates; in other words the relative economic health of the country. This is also related to the insurgency although cause and effect can be argued. If the economy improves many of the Project interventions will become more affordable and there will be less of a need for subsides. This would make the Project more self sustaining with a consequent reduced donor role in the future. Furthermore, it is likely that a greater demand for project goods and services would result.

Alternatively, if there is a further economic deterioration and unemployment rises, the subsidy portion of the Project would need to increase and the least costly methods, such as home solutions for diarrhea, would need to be emphasized. The greater the economic decline, the less likely it is that the Project will meet its anticipated outputs and purpose.

The above factors are exogenous to the Project but could have a major impact on its results. With regard to endogenous factors, a determination of sensitivity should focus on the parameters which, when combined, make up the internal dynamics of the Project and from the cost effective analysis. The parameters are: 1) the reliability of the intervention; 2) the rate of acceptance of the intervention among the population; and 3) the cost of each intervention including the cost of service delivery for each.

Uncertainty regarding each of the parameters is minimal in view of extension survey and analysis work already undertaken in El Salvador. The 1988 Family Health Survey (FESAL'88) is the fourth national survey since 1975, and the second survey since 1985 to examine the use of maternal and child health services and immunization levels for children less than five years of age. Random samples were taken of 3,579 women between 15 and 44 years of age who were interviewed during the FESAL'88, with the participation of the United States Government's Center for Disease Control, and results are highly reliable from a statistical point of view. The survey was especially useful in judging the rate of acceptance of the intervention among the population.

The other parameters making up the cost effectiveness, i.e. the reliability of the intervention among the population and the cost of the intervention, are further verified by studies in the United States and other LDCs in which AID has long experience.

It is likely that the highest of uncertainty lies in the rate of acceptance of the intervention among the population. It would appear far more likely that the rate of acceptance will increase, rather than decline, and the Project impact will be greater than projected, all other factors being equal, i.e. the insurgency and economic situation.

To increase the chances for greater acceptance the Project should maximize, consistent with the absorptive capacity of the SDA, educational

and outreach programs. The analysis shows that among contraception techniques, the strongest impacts could be made in the use of temporary methods (IUDs and pills).

Condoms, although not among the most cost effective, constitute an important method of temporary birth spacing since they are effective with few perceived side effects and studies show that their use has increased dramatically over the past three years. Intensification of educational programs and an increase of distribution channels would further accelerate condom use, and thereby the cost effectiveness of this method.

There also appears to be substantial potential for improving the cost effectiveness of vasectomies. The analysis shows that if vasectomies were to be as acceptable as female sterilization, they would become the most cost effective permanent method. The key problem, is their low level of acceptance and use. Although results would be highly uncertain and risky in terms of achieving acceptable output levels in comparison to cost, it may be worthwhile to consider an expanded education, media, and incentive program because of the potential for achieving much improved cost effectiveness.

Finally, it is pointed out that the pill is also highly popular and one of the most cost effective temporary methods, but there are certain persisting fears related to side effects. Education and availability should be maximized to decrease these fears and encourage this family planning option.

Acceptance rates are based on a multitude of individual perceptions and that the composite is moving toward greater acceptance. It is difficult to imagine circumstances that could lead in the direction of less acceptance. Perceptions, of course, are changed by education and promotion and uncertainties can be removed by intensifying those efforts as they relate to programs of contraception.

The Project activities, relating to maternal and child health, will also require an element of persuasion. Families will accept the MCH interventions if convinced that they are reliable and affordable.

Regarding diarrheal disease, the principal cause of illness and death among children under five in El Salvador, oral dehydration salts (ORS) and a home solution using common household ingredients (lemon, sugar, and salt) are highly reliable and the later is extremely low cost. However, ORS is currently used in only ten percent of diarrheal episodes among children under five and the home solution is used even less.

It is difficult, if not impossible, to imagine a situation in which acceptance of these remedies would decline from current levels. Therefore, a sensitivity analysis should view factors which are likely to increase utilization. It would appear that an intensification of educational, promotional and outreach programs would have a measurable

impact on participant usage of the recommended remedies. The greatest uncertainty limiting application would appear to be the level of the rural insurrection. The principal limiting factor on the expansion side is the absorptive capacity of the SDA rather than funding.

One can make similar judgments for the recommended interventions for malnutrition and treatment of ascaris infestations.

In conclusion, the highest risk to the Project achieving its goals is a possible escalation of the country-wide insurrection. A second level of risk can be attributed to negative economic growth rates and increased unemployment and underemployment, in other words the country's relative economic health. The third level of risk pertains to whether or not acceptance levels will rise or fall and the cost of the intervention. Finally, the least risk pertains to the reliability of the intervention in view of the fact that all of them have been tested and applied in a variety of settings.

A number of calculations have been made to compare cost effectiveness of the various family planning and mother child health interventions by changing the parameters, specifically the cost per unit and acceptance levels. Cost per unit has been changed by a factor of plus and minus twenty percent. Acceptance levels have been increased by twenty percent for contraceptive methods and for diarrheal interventions in view of the increasing effectiveness of educational and promotion programs. It is inconceivable that acceptance levels would decline.

TABLE 1
EFFECTIVENESS TO COST RATIOS FOR MODERN METHODS OF CONTRACEPTION
(- 20% cost per year)
(in US$)

METHOD	Cost/Year Protection	Effectiveness (%)	Ratio
Vasectomy	3.88	0.7	0.180
Condom	4.72	2.1	0.444
Pill	3.010	9.1	3.023
IUD	0.80	2.1	2.625
Steriliz.	4.04	35.3	8.737

Tables 1 and 2 show the effectiveness cost ratios for the five contraceptive methods. In both tables the effectiveness assumptions have been increased by twenty percent to take into account the probable

effects of educational and outreach programs. Finally, the cost per year has been decreased by twenty percent in table 1 and increased by twenty percent in table 2.

The results of the sensitivity analysis show that whether cost per unit is increased or decreased by twenty percent, the comparative cost effectiveness does not change. The male interventions remain the least cost effective. Although female sterilization is by far the most effective method of contraception, it is necessary to reiterate the caveat that it is not a birth spacing solution and it is almost always chosen by women who already have the desired number of children.

TABLE 2
EFFECTIVENESS TO COST RATIOS FOR MODERN METHODS OF CONTRACEPTION
(+ 20% cost per year)
(in US$)

METHOD	Cost/Year Protection	Effectiveness (%)	Ratio
Vasectomy	5.83	0.7	0.12
Condom	7.08	2.1	0.29
Pill	4.51	9.1	2.02
IUD	1.20	2.1	1.75
Sterilize.	6.06	35.3	5.83

With regard to maternal child health, tables have been prepared varying the cost per unit by plus and minus twenty percent for interventions relating to nutrition and to diarrheal disease. No table was prepared for ascaris intervention because the difference in cost effectiveness between the two treatments is so vast.

Table 3 shows the cost effectiveness ratios with an increase of twenty percent in the cost per unit, while table 4 shows it with a reduction of twenty percent.

Whether the cost per unit is increased or decreased by twenty percent, the cost effectiveness comparisons do not change. The vitamin A intervention is by far the most cost effective method.

TABLE 3
EFFECTIVENESS TO COST RATIO FOR NUTRITION INTERVENTIONS
(+ 20% cost per unit)
(in US$)

METHOD	Cost per Treatment	Effectiveness	Ratio
Prenatal vitamins	18.0	76	4.2
Multivitamins	8.0	20	2.5
Vitamin A	1.6	76	47.5
Gardens	8.6	12	1.4

TABLE 4
EFFECTIVENESS TO COST RATIO FOR NUTRITION INTERVENTIONS
(- 20% cost per unit)
(in US$)

METHOD	Cost per Treatment	Effectiveness	Ratio
Prenatal vitamins	12.0	76	6.3
Multivitamins	5.3	20	3.8
Vitamin A	1.1	76	69.1
Gardens	5.8	12	2.1

Finally, cost effectiveness comparisons were recalculated for diarrheal disease interventions. In addition, acceptance levels were increased by twenty percent to take into account the likely effects of educational and outreach programs. Table 5 shows the cost effectiveness ratios with an increased cost per unit of twenty percent while table 6 shows it with a reduction of twenty percent.

TABLE 5
EFFECTIVENESS TO COST RATIO FOR DIARRHEAL DISEASE INTERVENTIONS
(+ 20% cost per unit)
(in US$)

METHOD	Cost per Treatment	Effectiveness	Ratio
ORS	0.98	7.8	7.96
Home Electrolyte Solution	.18	1.5	8.33
Hospital Rehydration	56.25	0.34	0.006

TABLE 6
EFFECTIVENESS TO COST RATIO FOR DIARRHEAL DISEASE INTERVENTIONS
(- 20% cost per unit)
(in US$)

METHOD	Cost per Treatment	Effectiveness	Ratio
ORS	0.65	7.8	12.00
Home Electrolyte Solution	0.12	1.5	12.5
Hospital Rehydration	38.51	0.34	0.009

The tables indicate that regardless of adjustments made in acceptance levels or costs, the cost effectiveness ratios do not alter the ranking of the preferred solutions. Clearly, the ORS and Home Electrolyte Solution remedies, which rank very closely, far outweigh the Hospital Rehydration Treatment in cost effectiveness.

F.2.3. SHADOW PRICING

Project results would not change significantly if adjusted by "shadow pricing" or "opportunity costs." Furthermore, shadow pricing does not allow this Project to be compared to others as benefits cannot be quantified in terms of monetary values thus negating internal rate of return or cost/benefit analysis. For this reason the economic analysis uses the alternative of cost effectiveness analysis.

As stated in A.I.D. Handbook 3, it is "an approach to project appraisal in which project benefits or costs are identified, but only the costs are monetizied. Unlike the procedures used in the traditional cost-benefit analysis, no attempt is made to place a monetary estimate on project benefits because project benefits are difficult or impossible to quantify... or difficult to express in monetary terms (e.g. health effects from a primary health care project...)."

Considering the Project parameters, the most significant factor to shadow price is foreign exchange, as the A.I.D. grant 22.0 million dollars will either be used to import goods and services or to purchase local currency for the local currency costs of the project.

Currently, El Salvador over-values the colon when compared to its true economic relationship to foreign exchange. Although the current inter-bank rate (March 1990) is ₡6.9 to US$1, the true market or shadow rate, is calculated at approximately ₡9.0 to $1. Because of current policy dialogue between international donors, especially the U.S., and the relatively new Cristiani administration which is much prone to allow the free play of market forces than the previous administration, it is expected that the divergence between the two rates will narrow over the five year life of project.

Thus, instead of a current spread of some 23.3% between the inter-bank and shadow rate, it may reasonably be expected that the spread will nearly halve to approximately 14%, if not lower.

If the figure of 14% is utilized, it would mean that all local costs for the Project funded by A.I.D. dollar grants should be reduced by 14% to obtain their true economic costs. (23.3% if the current disparity is utilized).

As a portion of the 22.0 million dollar A.I.D. grant will be converted to local currency, we can conclude that the same locally produced goods and services should cost 14%, or currently 23.3%, less than they do in financial terms. In other words the A.I.D. grant would be reduced by between 2.4 million (in round numbers using the 14% figure) or 4.5 million dollars (using the current 23.3%) to purchase the same amount of goods and services.

It is important to note that the Salvadoran economy is subsidizing the imported goods and services by similar amounts. As A.I.D. is paying for all Project imports, the amount of the A.I.D. dollars grant used for foreign imports would not change regardless of the differential between the exchange rates.

Thus in economic terms, during the life of the Project El Salvador and the U.S. will pay between 14% (projected) and 23.3% (current) more for local currency costs than if such cost were valued at their true economic price.

The conclusion is that the same level of outputs could be reached with a lower level of inputs. Thus, the use of shadow pricing only improves the real economic return from the project when foreign exchange rate affects are taken into account.

The second factor usually taken into account in such an analysis is the adjustment for unskilled labor. As El Salvador suffers from significant under-utilization of its unskilled labor, its society does not really give up any goods or services by using otherwise unemployed labor in the productive activities the project makes possible. The opportunity cost of unskilled labor is generally taken as 85 percent of the wages paid to such workers.

The use of unskilled labor in the current project will not be significant statistically. The lowest level project inputs, other than warehouse laborers and movers of goods, are the village level PHPs and CBDs. However, the training provided them to carry out their functions and their own entrepreneurial skill in selling products related to the Project, excludes them from being defined, as unskilled wage labor.

The best conclusion appears to be that project results would not change significantly if costs are adjusted by the economic costs of unskilled labor and foreign exchange.

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ANNEX F

F.3 SOCIAL SOUNDNESS ANALYSIS

I. INTRODUCTION

The purpose of a project social soundness analysis is to provide the donor and implementing institution with a discussion of the sociocultural feasibility of the project, the probable extent of diffusion of the knowledge and practices it will introduce, and the probable extent of its social impact among different groups.

II. CONTEXT OF THE PROJECT AND IDENTIFICATION OF CONSTRAINTS

A. Sociocultural Context the Project

An analysis of the sociocultural feasibility of the project must begin with an understanding of the broad national-level context.

1. National-level context

a) Demographic Trends: El Salvador is about the size of the state of Massachusetts. It has a population of over 5.1 million and a population density estimated to be 250 inhabitants per square kilometer. The population growth rate has remained relatively steady at an estimated 2.5 percent per year. According to the most recent national survey, fertility rates and average family size have decreased over the past twenty years. However, rates continue to be high. The Total Fertility Rate (TFR) had remained at 4.6 during the last three year period in which data was collected (1985-1988).

From 1985 to 1988, use of contraceptives for birth spacing and termination of childbearing increased among women in union at a rate of one percent per year. In 1988, forty seven percent of women not wanting to get pregnant were found to be using some form of modern contraception. Since 1975, female sterilization has tripled; however, the use of pills and the IUD has remained constant, while condom use has quadrupled and other methods have nearly tripled. Overall use of contraceptives has more than doubled since 1975.

The recent demographic and health survey revealed several areas of concern about contraceptive use: the low rate of contraceptive use in rural areas, use of contraceptives for termination of childbearing rather than for birth spacing, and the high rate of fertility and low use of contraceptives among adolescents and young women. The recent survey found the average age at union to be 20 years. However, twenty-four percent of women 15-19 years of age were found to be in union, and twenty-seven percent were pregnant at the time of the survey. This group is at high risk of maternal undernutrition. Their children are at risk of fetal undernutrition, low birth weight and early death.

b) Trends in Health and Nutrition: Since the late seventies and the onset of socio political conflict and the economic crisis, international donors have flooded the public sector with assistance. As a result of this assistance, key indicators taken from national surveys show gradual improvement in the health and nutritional status of the Salvadoran population.

Although overall improvements were recorded by key indicators over the past ten years, some deterioration occurred during the worst of the economic and political crisis in the early eighties. Crude mortality, infant mortality and life expectancy all worsened in the early eighties before resuming their pattern of gradual improvement in 1983-1985.

A recent national nutrition survey showed the nutritional status of young children to be of particular concern. Weight for age measurements among children under five have shown only slight improvement to date since the latter part of the seventies.

Perinatal mortality, or death among children in the first month of life, is also a major concern, claiming the highest number of lives every year in in El Salvador. Diarrheal disease and acute respiratory infections continue to be the principal causes of sickness and death among all ages. The high rates of perinatal mortality are related to early and continuous childbearing and lactation, lack of adequate prenatal care, repeated bouts of acute infectious disease, and poverty among women. A large proportion of children born to high-risk women die within the first month of life as they are undernourished at birth and lack resistance to acute infectious diseases.

c) Sociopolitical and Economic Trends: From the late seventies until the mid eighties, the regional economic crisis and and sociopolitical conflict in the countryside combined to cause a steep economic decline in El Salvador. This resulted in a doubling of unemployment, an increase in agricultural production costs, a drop in real farm prices and a decrease in the production of staples as well as export crops. Total food supplies per capita decreased twenty percent during this period. Conflict in both rural and urban areas caused widespread population displacement, placing considerable pressure on public sector institutions already constrained by widespread destruction of infrastructure, and public sub-sector budget reductions proportionate to across the board public sector budget cuts, and in real terms due to inflation.

Since 1984 there has been a slight improvement in per capita agricultural; production, however farm prices remain low. As a result, the purchasing power of farm families continues to be constricted, agricultural production and the demand for farm labor are depressed, lack of foreign exchange and inflation continue to make production expensive, and food prices remain high.

Since 1984 the unemployment picture has also improved slightly; however, when current wages are adjusted for inflation, real wages can be seen to have fallen since 1978. The purchasing power of the annual wage in 1988 was estimated to be little more than half of its 1978 value.

The GOES is implementing macroeconomic adjustment measures designed to stimulate production and improve economic growth. However, this will entail a short run increase in the vulnerability of some population groups due to removal of food subsidies, increased unemployment among low income unskilled or semi-skilled workers, and an increase in the prices of basic commodities. The impact of these measures is already being felt in urban areas.

d) Institutions and providers: El Salvador, the most densely populated country in continental Latin America, has long been concerned with birth spacing and contraceptive use. Much of the early support in this area came from private voluntary organizations. Birth spacing services were first provided by the Salvadoran Demographic Association (SDA). However, the Salvadoran government quickly became involved and both private and public sector providers have been active in this area since the early sixties. In 1967, the SDA turned over much of its clinical services to the Ministry of Health (MOH), which currently has major responsibility for providing such services in the country through a system of hospitals, health centers, units, posts and rural health promoters. However, as mentioned earlier, the severe budget restrictions facing the public sector limit the MOH's ability to respond to all of the health care needs of the total population.

B. Beneficiary context: rural areas

The second step in a sociocultural analysis involves a description of the beneficiary context. The Family Health Services Project is designed to serve all men and women in fertile age in El Salvador. However, it is specifically targeted towards the rural population.

1. General issues

a) Rural/urban distribution of the population: In the late seventies El Salvador's population was seventy-five percent rural. Since that time, sociopolitical conflict has caused widespread displacement, particularly in the northern and eastern sections of the country. According to a national study of the displaced conducted in 1985, most moved from their rural communities to the nearest urban area. A large percentage also moved to San Salvador. Unlike previous urban migrants fueled by economic and other concerns, the displaced were not single

individuals or young adults with small families. The average family displaced by conflict was found to be made up older adults with four children, two of whom were under five years of age. Most owned land in the village they had left. By 1985, ten percent of the population had been displaced by the conflict. As a result of this massive internal shift in population distribution, half of the Salvadoran population now lives in urban areas.

b) Sizes and types of rural communities: Rural communities in El Salvador are divided politically into types based on population size. The largest are "municipios" of up to 2,000 population. Next in size are the "cantones" with 500-2000 inhabitants, followed by "caserios" the smallest community unit. This Project is aimed primarily at individuals and couples who live in the two smallest community types.

c) Economic divisions: Rural communities in El Salvador have traditionally consisted of a small number of extended families whose members have known each other for generations, have intermarried and maintain a shared social and cultural conception of the world. Although some families own a store, are carpenters or do sewing, the principal occupation of all has traditionally been agriculture.

However, these rural communities were never economically homogeneous. Most agricultural activity is on a subsistence or less than subsistence level and most families cannot afford to purchase or support large animals such as cows or horses. Some families in rural communities have more land and, therefore, may also grow cash crops and support large animals. The differences in economic status may seem small to outsiders, but are important within the village. The wealthier farmers, for instance, harvest their corn along with their neighbors but, later in the season when many families have run out of supplies, they sell their surplus to their neighbors in the village for a profit.

d) Employment and migration: Over the past fifty years, macro-level socioeconomic forces have accentuated this division of wealth in rural villages. Population growth combined with uneven land distribution and centuries of use have caused many rural families to exceed the agricultural capacity of their land. The wealthier families have become employers, hiring their neighbors on a sharecropping basis. Even before the conflict began, these same economic and demographic forces intensified the relationship between rural and urban areas, thus changing the nature of rural villages forever. As an increasing number of individuals from rural communities had to seek sources of income outside of their community, the supply of seasonal migratory labor in export crops (cotton, coffee) increased, sometimes (as now) outstripping demand. Those who could not support themselves in the village

either moved permanently to nearby urban areas or sent a member (older child or husband) to work in the urban area during the week or for longer periods. This urbanization was further intensified by the conflict, which at its highest resulted in an estimated 500,000 person internal migration, and an equal number of emigrants to the U.S. and to other neighboring countries.

e) Fear and mistrust: For those rural families in conflictive areas who stayed behind, the violence and political polarization have caused increased wariness. Where individuals were relatively secure about their relationships with their neighbors before the war they are now less secure, unsure of their neighbors political involvement and afraid of being unjustly pointed out. As a result, many are reluctant to involve themselves in community activities for fear they will be suspected of wrongdoing by representatives of one side or the other. This has had a significant impact on all interpersonal education, particularly that which is designed to take place in groups.

f) Economic status: The economic status of the rural agricultural family has also deteriorated since the early eighties. From 1980-1985 an increase in agricultural production costs and a drop in real farm prices caused a decrease in the production of corn and beans. Total food supplies per capita fell twenty percent during this period. Since 1984 there has been a slight improvement in per capita agricultural production; however, farm prices remain low. As a result, the purchasing power of farm families continues to be constricted, and agricultural production is depressed. Food prices remain high. This situation is particularly difficult for the increasing number of farm families whose size is greater than their land's ability to provide a subsistence living. These families do not produce enough food for the entire year much less a surplus for sale, and are, therefore, affected by food prices primarily as rural consumers. The wage labor situation is also difficult. From the late seventies until the mid eighties, there was a steep economic decline in El Salvador. This resulted in a doubling of unemployment, and the demand for farm labor was depressed. The unemployment picture has improved slightly since 1984, however real wages have fallen since 1978. The purchasing power of the annual wage in 1988 is estimated to be little more than half of its 1978 value.

C. Health and nutrition

1. Nutrition: The nutritional status of children under five years of age improved from 1965 to 1978, however since that time little improvement has been made. Rates are highest in rural areas and among children 12-24 months of age. One out of every two rural children under five years of age is malnourished to some degree. Seven out of every hundred are moderately or severely undernourished (weight for age).

Undernutrition in children has been found to be associated with low economic and educational status and recent displacement. There is no direct measure of the nutritional status of women in rural areas. However, a 1978 study found fourteen percent of pregnant women to have moderate or severe anemia, and a recent study on maternal mortality found anemia to be the most important associated factor. Iron deficiency is particularly high among pregnant rural women where nearly half receive no prenatal care and over half deliver at home with a midwife. Maternal nutritional status is also associated with low birth weight and increased risk of perinatal mortality.

Vitamin A deficiencies among young children also continue to be of concern. Recent studies of schoolchildren have shown twenty-five percent to have moderate or severe serum deficiencies, making A deficiency the most important cause of bilateral blindness among young children. Even mild deficiencies of vitamin A have been found to increase vulnerability to infectious disease (diarrhea and respiratory infections).

2. Diarrheal disease and acute respiratory infections (ARI): Childhood undernutrition is related to diarrheal disease, as foods are not properly absorbed and food intake is commonly restricted by parents during a diarrheal episode. Childhood undernutrition is also associated with ARI, particularly pneumonia, pertussis and bronchitis. Diarrhea and ARI are the leading causes of illness and death among young rural children. Rural women fear these illnesses and go to great lengths to prevent and cure them. Indeed, the first reason women give for not using contraception is that they are breast-feeding and the "hot" quality of the pill will cause harm to their child. This feared harm is most probably diarrheal disease.

3. Fertility beliefs and behavior:

a) Early sexual encounters: Young women in rural El Salvador begin sexual activity in late adolescence. Eighteen percent of girls 15-19 years of age and twenty-eight percent of young women 20-24 years of age in the rural areas have at least one sexual encounter before marrying or forming a permanent union. These first experiences occur most often between the ages of 15 and 17 and are not influenced by the educational status of the woman. Only 2% of these encounters included the use of contraception. By the age of 15-19, twenty four percent of girls are married or in union. The average age at marriage or union in rural areas is 20.

b) Control of fertility: Although a variety of traditional methods are used for these purposes including a tree bark said to prevent pregnancy, herbal teas and behaviors (carrying heavy loads, washing clothes with vigor, jumping from a chair, etc.) thought to cause miscarriage, and herbal as well as witchcraft remedies thought to promote pregnancy, women in the target group are not controlling their fertility effectively. FESAL 88 demonstrated that a large percentage of young women do not know what time in their menstrual cycle that they are most likely to

become pregnant. Women seek advice about methods of fertility control from relatives, friends, traditional practitioners, midwives, witches, pharmacists and modern medical personnel. They also seek help from illegal and poorly trained rural abortionists. Much of this activity takes place without the consent or knowledge of their partner or husband.

c) Knowledge and use of modern methods: Precisely because women are so involved in their own fertility, knowledge of modern methods of contraception among rural women is high. Over ninety percent know of sterilization and pills, over eighty percent know of condoms and IUDs, over seventy percent know about injections and vasectomies, and over sixty percent know about vaginal methods. Less known are the rhythm method, withdrawal, and other such natural methods.

Rural women know about modern methods of contraception but only thirty-four percent use them. This rate is lower than the overall contraceptive use rate for El Salvador which was estimated at forty-seven percent. In spite of programming efforts, rural use only increased by 4.1% in the last three year period for which data was collected; the rural Total Fertility Rate (TFR) has remained 5.9 since 1985. Fertility is highest in rural areas where an average woman has had 7.4 live births by the time she reaches the end of her childbearing period (44 years of age).

Seventy-seven percent of all rural women using contraception to terminate childbearing, while only twenty-three percent use contraception for birth spacing. Use of temporary methods (mainly pills) is most prevalent among young rural women 15-24 with 0-2 children, while women 24 years or older with three or more children favor sterilization and termination of fertility. Except for the IUD, the use of temporary methods has increased slightly over the past three years. However, in rural areas the main reason for using modern methods overall is still to terminate fertility rather than to space births. There is a dramatic jump in sterilization from 3% to 28% once a woman has 2 living children. The average age at which rural women first use contraception is 32, when they already have had at least four living children. One of the principal reasons women decide to terminate childbearing is that they have the desired number of children. Another is the health of the mother and her advanced age. The woman's health is a concern especially among women with over four living children. Most sterilizations are done during the month following delivery, mainly during the delivery itself. Ninety percent of rural women who have been sterilized say they are satisfied with their decision.

In 1987, during the most recent national survey, seventy-three percent of rural women of fertile age in union did not want to get pregnant. Most of these were older women with three or more

living children. However, most women in all age groups did not want to get pregnant, including fifty-six percent of women 15-19 years of age. Forty-three percent of the total were using modern methods of contraception: thirty percent were sterilized, while thirteen percent were using temporary methods (primarily pills). Fifty-seven percent of all rural women not wanting to get pregnant were not using modern contraception of any kind. According to another estimate, twenty-eight percent of rural women are considered to be in need for family planning services, however only eighteen percent of these have ever used modern contraception and only forty percent of these say they want to do so in the future.

d) Barriers to the use of modern methods: When those rrently pregnant, in menopause, sub-fecund or operated, and those not sexually active were omitted from the sample, the reasons given by women for not using modern contraception were the following: being postpartum or breast-feeding (49%), fear of side effects (14%), because their spouse was against it (9%), because they wanted to get pregnant (8.6%), religious reasons (6.4%), because they had side effects the last time they used a modern method (3.6%), because of their advanced age (3.6%), or because the source was too far away (-1%). Other barriers to use of contraception or participation in the program were not listed by women, but were associated with the use of contraception by the survey itself. Some of these may be potentially influenced by the Project, while others may impact upon the Project but are exogenous to the Project itself. These may be grouped into larger categories as follows:

4. Constraints/Barriers which May be Lowered by the Project:

a) Fears: Fears form seventy-seven percent of the reasons why women are not using modern contraception. The first reason for not using modern methods of birth spacing is because the woman is either recently postpartum or breast-feeding (49%). During the postpartum period and throughout lactation, which in El Salvador's rural areas lasts an average of eighteen months and is practiced by ninety-six percent of women, many rural women observe dietary restrictions which are believed to strengthen the mother and prevent the child from getting sick. These restrictions are part of a binary cognitive system in which foods and illnesses (among other things) are categorized along a continuum between "hot" and "cold." Their categorization has little to do with their actual temperature, but rather with their origin and perceived effect. In this case, it is the pill, the most commonly used temporary method, which is restricted. According to rural belief, the pill is "hot" (as is much medicine) and, therefore, too strong to take during lactation. If it is consumed, its "hot" qualities will be transferred to the child through the mother's milk and cause diarrhea in the child.

The second reason for not using modern methods of contraception is fear of side effects (14%). Many rural women believe that modern methods will cause cancer or that it is bad to take too many pills because they will gradually form a ball in the abdomen. Some also fear that the pill will make them thin or cause skin discolorations on their face, or that a child might be born in spite of the contraceptive with an IUD stuck in its head or body. Some fear that use of a temporary method might cause them to become permanently infertile. Condoms, also, are not popular among women as they are said to be "hot" and to irritate the vaginal walls. According to the recent survey, fifty-six percent of rural women not using contraception believe that pills are harmful, while forty-seven percent believe that IUDs are harmful.

These fears are related to the third reason why women do not use modern contraception which is that their spouse or partner is opposed (9%). Men frequently express the same fears as women concerning the well-being of their wife or future child. Another fear which is specific to men is that modern contraceptive methods will cause a change in the personality of their wife. They fear that she will become angry and difficult to live with or, even more commonly, that she will become promiscuous. This concern has increased as more and more men must leave the village for periods to seek outside employment.

Previous negative experiences with modern contraception were also barriers to current use. Problems were particularly associated with previous use of the pill, IUD and injection. Women also stopped using modern contraceptives because they were not effective. This was especially true for vaginal methods, withdrawal, natural methods and the IUD. Some women also found condoms and the injection difficult to use. Interestingly, belief in the negative effect of the pill and IUD increases with the educational level of the woman.

b) Young couples desire to have children: The fourth reason given for not using modern contraception was the women's desire to become pregnant (8.6%). The desire for pregnancy is particularly prevalent among young women and those with less than two children. Most rural women enter union at an early age and begin childbearing as soon as possible. A woman's ability to have children is important for the continuance of the union itself; a woman who is unable to provide a child may be abandoned or her partner may begin another concurrent family which will. Among male reasons for opposing contraception are also concepts of ownership and "maleness" associated with having many children. Women who are childless are to be pitied as children are a source not only of labor or support during old age but also of joy. Although young couples do want children, there is demand in this age group for contraception. Over half of the young women in union interviewed in the recent survey did not yet want to become pregnant.

c) Religious beliefs: The next most important reasons for not using modern methods of contraception were religious concerns (6.4%). To appreciate this constraint, one must understand that the religious structure of rural El Salvador (and the rest of Central America) has changed dramatically over the past decade. Up until a few years age, nearly all of the rural population belonged to the Catholic church. In recent years, a variety of Evangelical Protestant groups have made tremendous inroads in rural areas. This increase in religious pluralism has caused sometimes bitter divisions within small rural communities. We do not know how much change has occurred in rural attitudes toward contraception as a result of the Protestantism of rural communities. According to the recent survey, many rural women feel that it is up to God to decide how many children they will have. Fatalism was especially associated with withdrawal, vaginal and natural methods. Fatalism is not restricted to those of the Catholic faith but includes some Evangelical churches as well and in many cases, Evangelical fatalism is stronger than Catholic fatalism. Both churches are opposed to any modern method but abstinence, withdrawal, rhythm or other "natural" means. On the other hand, the social disapproval of contraception which is common in other parts of Central America and is related to religious belief is less of a barrier in rural El Salvador. Most rural women in all age groups, including the very young, said they would prefer to get modern contraception in a clinic where they are known than go to one where they are not known.

d) Access The last few reasons were given by only a few respondents. One of these was the distance to a source (under 1%). According to the recent national survey, it takes over half an hour of travel (by foot and on buses) for most rural women to get to the nearest source of contraceptives. The average time to temporary methods is 42 minutes, while the average time to permanent methods is 86 minutes. Public sector facilities are the main source of contraception; however, SDA is second, followed by pharmacies. Urban access, in contrast, was much better. It is a positive comment on their desire to use contraception that only a small percentage of rural women cited access as a constraint.

e) Lack of knowledge about her own fertility: Perhaps the most subtle but greatest underlying barrier to use of modern contraception was not specifically listed by women as a constraint. That is the Salvadoran women's lack of knowledge about her own fertility cycle. Only sixteen percent of Salvadoran women (twelve percent of rural women) understand their fertility cycle and can correctly identify the week in which they are most likely to become pregnant. Even among women with over ten years of education, nearly seventy-five percent do not understand their own fertility cycle. This lack of information makes a woman powerless in decisions about her body. If women do not know there is a fertility cycle, much less its timing, they may know about the existence of modern contraceptive methods but they cannot

understand how each works or decide about the numerous options available to them. Those women who for religious or other reasons rely on rhythm (which is as common as the use of condoms) or withdrawal (the fifth most common method) cannot possibly do so effectively. It is no wonder that women have no confidence in these methods and that they are associated with a fatalistic outlook on life.

f) Male attitudes toward the control of their own fertility: Men feel that control of fertility is the woman's responsibility. For this reason as well as others discussed above, male use of contraception is low; only four percent of contraception is provided by vasectomies. However, there is some indication that male awareness of contraception has increased in recent years. From 1985 to 1988, the use of withdrawal increased, and the use of condoms tripled. Women also share the idea that contraception is the woman's responsibility. Only a small percentage of rural women in union who would like to use modern contraception in the future would urge their partner to seek male sterilization. Condoms are still unpopular among women as well as men.

5. Those which are exogenous to the Project

a) Women's educational status: Women's educational status is also directly related to the use of modern contraception. The recent survey showed formal education to have a positive impact on the use of temporary methods and a negative impact on the use of sterilization. Although this variable is outside the scope of this Project, studies have shown that women (including rural women) are becoming more educated. Young women in El Salvador between 15-24 years of age have had on the average between 4-9 years of formal education, compared with older women who have had 0-3 years. According to the recent survey, most of the women not using modern contraception who want to do so in the future are young women, 15-29 years of age. Desire for contraception increases with the educational level of the young woman.

b) Economic and employment status of women: The economic and employment status of a woman also affects her reproductive behavior. One of the reasons given by rural women for not using modern contraception was the cost of the method, while the principal reason given for ending childbearing was economic difficulty (64%). Interestingly, this reason was not associated with greater numbers of children. Those citing economic difficulty most frequently were younger women with two or three. Modern contraception is also used most often by women with employment outside of the home (64%). Employed women used all methods more frequently than unemployed women, but the greatest increase was in the rate of sterilization. although these variables are also outside of the scope of this Project, a positive note is the awareness young women have of economic pressures and the need for contraception.

c) Conflict and mistrust in rural areas: The amount of sociopolitical conflict in El Salvador will affect the rate of participation in the Project, not only of community members who are potential beneficiaries but also of SDA health promoters. Violence in a community will cause both promoters and community members to resist interaction, particularly in groups. This is an important variable which is also exogenous to the Project.

d) Providers of birth spacing and health care: There are four sources of birth spacing services currently available to high risk rural families in El Salvador: 1) traditional birth attendants (TBA's), 2) MOH clinical and outreach services supported by UNICEF, USAID, and PAHO, 3) SDA community-based distributors (CBDs) supported by USAID and IPPF, and 4) some private voluntary organizations (Save the Children and others). Each provides different services to rural families, and each provides only partial geographical coverage.

TBAs are the traditional source of obstetric and gynecological care in rural communities. They have long provided women with herbal methods for controlling fertility, prenatal and postpartum care and attention during births. In recent years, the MOH has trained a large proportion of these rural TBA's in modern medical techniques. MOH services to rural areas also consist of nearly 600 rural health promoters. These promoters make household visits in which they provide some preventive and curative care. They also refer cases needing advanced clinical care and those interested in modern contraception to the nearest MOH facility. Contraceptives provided by the MOH are currently distributed in the clinics free of charge. The rural outreach program of the Salvadoran Demographic Association consists of 800 Community Based Distributors who sell contraceptives (condoms and pills), provide contraceptive education and refer cases needing clinical care to one of four urban SDA clinics, or to an MOH facility.

III. ANALYSIS OF PROJECT DESCRIPTION AND ELEMENTS

A. Brief Project Description

The Family Health Services Project (519-0363) of the Salvadoran Demographic Association (SDA) will continue to support current efforts in birth spacing and will expand coverage of family planning and maternal-child health preventive services to rural and marginal urban areas areas through the private sector. This will be accomplished in the marginal urban areas by: 1) expanding the array of clinical services currently offered in the four outlying clinics, 2) creating four new urban satellite clinics serving the San Salvador clinic, and 3) creating urban distribution sites (puestos) in commercial areas of San Salvador. Rural expansion will consist of 1) decentralizing the service delivery of the Salvadoran Demographic Association, 2) integrating preventive services in MCH into SDA birth spacing activities, 3) expanding the scope and geographical coverage of the SDA's rural community-based distributor program, and 3) developing a physician referral system.

The strategy of this Project also includes support to research activities which will provide new information about specific contraceptive methods, and national-level data on the most important issues in maternal-child health and birth spacing. The results of these studies will inform the development of the project, identify significant policy issues, and provide data for evaluation of impact.

USAID will also support institutional development activities under this Project which are designed to increase the financial sustainability of SDA. This will include: 1) development of a Central Referral Center and Day-care Surgical Unit, 2) expansion of the social marketing program, and 3) testing of a variety of pricing strategies and SDA employee and physician payment mechanisms.

The communications strategy of this Project is divided conceptually by SDA into four parts: information, communications, training and education. Information consists of printed materials which are distributed throughout the SDA system. The rural health promoters will have these available to use as teaching aides.

Communication consists of mass media spots using television and radio. The strategy in communication will involve the development of six new spots for both media, and increased controls over when the spots are aired. Training will take place with SDA staff and with other institutions and providers.

The training strategy is to improve SDA functioning, staff knowledge about the new rural emphasis and the integration of birth spacing with other MCH interventions, and proficiency in the implementation of new teaching and clinical techniques. It will also strengthen SDA's commitment to rural expansion of services by providing rural promoters from other institutions with training in birth spacing education, and by training men to form "satisfied users" groups in rural and urban areas.

The strategy in public education is to strengthen and reorganize SDA rural outreach staff, train them in educational techniques, and increase the numbers of rural promoters (now called CBDs). This increase will be coordinated with other private and public institutions providing rural outreach services, and will be designed not only to improve access in rural areas but also to diversify services by integrating birth spacing into MCH.

B. Beneficiaries

1. Determination of need

The new emphasis on extending rural coverage was determined by the results of the recent national demographic and health survey (FESAL, 1988), which showed knowledge of modern contraception to be nearly universal in rural areas, but use to be low. The decreased emphasis

placed on female sterilization was also the result of this survey which found the use of temporary methods to be very low and the fertility of young rural women to be high. The decision to re-conceptualize family planning by focusing on birth spacing and integrating it into broader MCH services was one which was taken by SDA and USAID personnel, based on a desire to place modern contraception in a more realistic context for women.

2. Minimum participator profiles

The new project is designed to serve all women in fertile age and all men in El Salvador. Special emphasis is placed on rural and marginal urban populations.

In rural areas, the female participator is expected to seek the rural promoter or be sought out by the rural health promoter for either birth spacing or MCH services. If seeking birth spacing, she will be a woman in union or active sexually between the age of 15-44. She will at first be a woman over 24 years of age, with two children, who wants information or referral about female sterilization or the pill. However, it is hoped that this Project will increase the number of young rural women (15-24 years) who will demand information and referral for temporary methods.

The male participator in rural areas is also expected to be sought out or seek the rural health promoter for either birth spacing or MCH services. As the project has not focused on men until now, most will probably have to at first be sought out. The male participator will be of any age, in union or active sexually. As with the female participator, it is hoped that an increasing number of young men will seek temporary methods. It is also hoped that an increasing number of men will seek vasectomies.

Female and male participators are also expected to seek SDA rural promoters for preventive services in nutrition, diarrheal disease, respiratory infections, and immunization. These will be families with young children under five years of age. Most will be provided with education, while some will be given oral rehydration salts or vitamins, and some will be referred to SDA clinics or other providers.

3. Participation and Coordination

SDA personnel on all levels were integrally involved in the design of the Family Health Services Project. Rural families were not directly involved, however the information they provided to interviewers during a series of national demographic and health surveys formed the basis for the project strategy. The information they continue to provide in subsequent studies and as Project participants or beneficiaries will continue to be the baseline for Project evaluation and future direction.

4. Motivation and incentives

Rural women and men are expected to continue to want birth spacing and MCH services because the majority in all geographical areas and among all ages do not want to get pregnant, and because their children continue to have high rates of infectious disease and undernutrition. Contraceptive methods provided by SDA rural promoters are less expensive than those of the Ministry of Health when the cost of an MOH consultation is taken into account. SDA services are also more accessible since the SDA rural promoters are members of and live in the rural area, rather than coming in for a visit periodically. SDA also provides private transportation for rural patients going to and from its clinics for sterilization. The addition of other MCH services and decreased emphasis on sterilization is also expected to increase the contact SDA promoters make with rural families, thus increasing the opportunity for discussions about birth spacing. Families are expected to like nutrition services such as growth monitoring, free vitamins for children and pregnant women. They are also expected to like education on respiratory infections and diarrheal disease, and the provision of free oral rehydration salts.

IV. SOCIOCULTURAL FEASIBILITY

A. Relationship of Sociocultural Constraints to the Project

1. Adolescent and Young Adult Fertility

The area of adolescent and young adult fertility has been weaker than it should be given the tremendous need in this area. During the design of this Project, SDA education and training staff suggested several programs aimed at adolescents and young adults; however, these were token efforts (TV's in public places, lectures) directed at the low risk population (employed urban adults, adolescents over 14 years of age still in school) whose impact would be negligible. Under this Project, materials and spots will be developed specifically for these groups. However, the delivery mechanism of the Project deals with adolescents and young adults only as members of the male and female population in general, rather than as a priority group. Focusing efforts on this group would improve the impact of Project activities on reducing fertility. This will be addressed by the technical assistance team.

2. Men

The subgroup addressed most thoroughly by the Project is that of men. The Project will offer not only materials and spots developed especially for men, but also clinical services for men and a rural outreach program implemented by men which will reach men through groups of "satisfied users."

3. Fears

Fears about contraception and ignorance about fertility are among the most serious barriers to the use of modern contraception among all age groups and among men and women alike. Activities designed to lower these barriers will be provided to an increasing number of rural men and women in fertile age throughout the life of the project. One cannot stress the importance of strong programming dealing with these barriers. Lowering them will require intensive efforts in interpersonal education reinforced by printed and broadcast material. A few pamphlets and a simple negation of fears will not do the trick. Thus, this area too must be continuously monitored by the Project implementers.

B. Identification and Discussion of Project assumptions related to Sociocultural Feasibility

The following discussion is based on three assumptions which underlie the Project description in the final Project Implementation Document:

1. Impact of the Pronatalist Constraint

This barrier can be decreased by increasing understanding of the economic and health benefits of family planning. Although this is true, it clearly is not sufficient. Salvadoran women increasingly understand the relationship between fertility and economics. Most of the women who decided to terminate their fertility did so for economic reasons, and outside employment was found to be strongly correlated with use of modern contraception. Nevertheless, this understanding does not in itself override other pronatalist concerns involving religious beliefs and individual value within the community. Thus, the reason for a major Project focus on a combination of integrated family planning, MCH and IEC activities.

2. Integration of MCH Services with Birth Spacing

It is true in a sense that the integration of these services will make family planning more attractive to potential users; however, the incorporation of other-than-contraceptive services into SDA rural outreach should improve the accessibility of SDA contraceptive services in several more important ways. First, in rural areas, SDA is perceived by some as only interested in pushing sterilization. Incorporation of more MCH services will presenting a more acceptable, humanistic image of SDA to the community. Second, it will also allow women (and men) to visit the SDA representative for a range of MCH activities rather than for contraception alone. The woman who does not want her neighbors to know she is seeking contraception can say she went to the SDA representative for other services, while the woman who goes to the SDA representative for MCH services will also be exposed to information and education about modern contraception.

V. ESTIMATES OF RURAL IMPACT: ACHIEVEMENT OF BROAD SECTORAL GOALS

A. Rural Community Involvement

1. Determinants of Involvement

The degree of rural community involvement affected by the Project will vary according to several factors in its implementation and location:

a) Characteristics of the SDA outreach worker: One of the most important potential determinants to community involvement is the individual selected as the SDA community promoter. This individual's religious affiliation, economic status, time availability, marital status, educational level, willingness to work, basic aptitude as an educator and leadership standing in the community will all affect the level of community participation in the Project. Thus, it is of the utmost importance that the SDA choose these outreach personnel carefully. Maximum participation will occur where the SDA promoter:

i) is female;
ii) is of no particular (or socially marked) religious persuasion, (particularly in those communities where religious division among Catholic/Evangelical lines is a source of tension);
iii) is from the mid-level economic strata in the community;
iv) is ideally between 30 to 50 years of age with grown children;
v) is excited about the Project activities (and receives sufficient supervision and training);
vi) has at least three years of formal education;
vii) has a previous reputation as an upstanding member of the community and some aptitude for teaching; and
viii) has no fear, or shame common among rural women, about speaking to individuals or groups.

b. The degree of violence in the area: Over the life of this Project, SDA plans on extending rural coverage to 750 new villages in areas which are under-served and at high risk. These villages are usually located in semi-conflictive or formerly conflictive areas. If the violence does not decrease over this five year period, or indeed increases, Project expansion will be seriously constrained. Not only might SDA personnel not be allowed into these area; even if they are admitted, few villagers in these areas will want to act as SDA community organizers or even group participants for fear of being labeled subversive by one side or the other.

c. Community characteristics: Several characteristics of the rural communities themselves will also affect participation. If the community is divided strongly along religious, economic or other lines, the chance that participation will be negatively affected increases. If the SDA community outreach person is

allied with one faction or the other, the Project will also be associated with that faction, limiting participation in the Project by members of the other group(s). Unfortunately, divisions such as these are very common in rural areas. They often follow kinship lines and are long-standing feuds over many generations. They are also not readily apparent to un-trained outside observers, and may be unrecognized during community and outreach worker selection.

2. Probable Degree of Community Involvement

Those communities experiencing little political violence who have few internal divisions and a good (and well trained) SDA outreach worker, may be expected to have maximum community involvement. Of the total 1,550 SDA communities projected by the end of the Project, 400 will only have a CBD (contraceptive distributor), as many as 400 will be retrained existing CBDs and 750 will be new. Therefore, at its best the Project will have 1,150 rural communities with maximum involvement. As internal divisions are common, perfect SDA outreach workers hard to find, and most new villages will be in semi-conflictive areas, a more realistic estimate is that a third of these, or a total of 384, will be such that maximum involvement is possible.

To estimate the probable number of community participants, let us assume then that the number of Project villages is divided by level of involvement into thirds (384 on each level). According to SDA outreach personnel, the average number of participants for an existing CBD (community distributor providing no MCH services) is 35. The addition of MCH services should increase participation by at least a third. This is a conservative estimate. Therefore, the minimum participant level for the new outreach worker would be roughly 40. At a maximum, participation would double to 75. Let us say that 55 is the medium participation level. This would yield a total of 13,400 participants from minimum level villages, 21,112 from medium level villages, and 28,800 from maximum level village. This is a total of 63,312 rural participants from the birth spacing/MCH workers of the rural outreach program. To these we then must add the 30 participants of each of the 400 rural promoters which remain only CBDs. This adds 12,000 participants, bringing the conservative total to 75,312 by the end of the five years. The Project goal is an additional 80,000, which is entirely feasible.

We should keep in mind that not all of these participants will be using SDA services for contraception. Most of the initial increase in participants will be due to the additional array of services in MCH, especially those which are immediately most attractive such as seeds for gardens, ORS packets, and vitamins. In those communities where group educational sessions are possible, these should also increase the number of participants.

3. Possibilities for Diffusion

Understanding new concepts delivered by the Project takes time. Just because someone participates in the Project does not mean that she grasps the concepts, much less incorporates them into her behavior. Those women seeking birth spacing from the outset can be expected to listen to conceptual information and incorporate this into their behavior rapidly. Those seeking MCH services can be expected to listen to the information related to what they seek and (if it is presented correctly and in line with what they believe) incorporate these changes into their behavior. Incorporation of birth spacing information by the new participants to the rural outreach project who are seeking MCH services is more problematical. In contrast to those seeking birth spacing, this new group may be against modern contraception or undecided. They will need time to be approached about this subject and persuaded (if they ever are).

Diffusion of these new concepts and behaviors into the rest of the community and from community to community also proceeds slowly. Divisions within and between communities impede this process as those not associating with participants will not be exposed to the new ideas. Even in communities where few serious divisions exist, diffusion generally proceeds along extended kinship lines and these individuals see most of each other, seek each other's advice and speak most frankly with each other about intimate subjects such as health and fertility.

Acceptance of ideas and diffusion also varies by subject matter. Easily understood concepts which fit within local conceptual structures spread rapidly. One might expect rapid diffusion of information about gardens and vitamins, for example. On the other hand, those which require major behavior change and/or do not fit within local concepts will be much slower. These will include changing attitudes toward using pills during lactation and male demand for sterilization.

For this reason, the way in which new ideas are introduced has a huge impact on the rapidity of acceptance and diffusion. For example, if women are convinced that the pill is too "hot" to use during lactation, one should not try to convince them that it is not; tackling the whole "hot"/"cold" humoral theory of disease is a losing battle. It would be better to emphasize the other methods of contraception are available and are not too "hot" for the baby.

4. Probable Impact on the High Risk Population and Major Indicators

a) Impact of birth spacing activities: Use of modern contraception has a direct positive impact on the woman. If she is an adolescent, she delays childbearing and is given more time to mature (including attend school if possible). If she is a young woman in union, it allows her to space births, giving her

body a chance to recover between births, and giving her time to spend on her existing family or seek outside employment. If she is an older women, it allows her the benefits of use by a younger woman if she chooses birth spacing, or it allows her to terminate childbearing once her ideal number of children has been obtained.

Use of modern contraception has an indirect positive impact on her partner, her children and others. If she is an adolescent, her partner is given more time to mature (including attend school), one possibly low birth weight birth has been avoided, and her parents are spared the burden (as well as the joy) of caring for an infant. If she is a young woman in union, the couple is given more time to spend with existing children and less economic stress is placed on the family unit. If she is an older woman, the benefits to the couple are similar to those of the younger couple.

Project activities in birth spacing, then, may be expected to influence maternal, infant and child mortality, as well as employment rates, school attendance and educational levels, and economic status.

b) Impact of maternal-child health activities: The MCH services in diarrheal disease, acute respiratory infections, nutrition and immunization which will be added to birth spacing services in rural areas will have a direct impact on the participating family. The average rural participant family will probably be made up of two adults and two to three children, two of whom are under five years of age. All members will benefit from an understanding of oral rehydration salt (ORS) use, and education about hygiene and diet during diarrheal disease. All will also benefit from education which teaches them to recognize the danger signs associated with acute respiratory infections (pneumonia and bronchitis). Activities promoting immunization should benefit children under five. Those associated with nutrition (home gardens, prenatal nutrition and promotion of lactation, child nutrition, growth monitoring, vitamins) will primarily benefit pregnant and lactating women and children under five, though the whole family will benefit from home gardens. Project activities in MCH, then, will also influence maternal, infant and child mortality rates and nutritional status, as well as morbidity and mortality rates due to diarrhea, IRA and immunizable illnesses among children under five years of age.

F.4 ADMINISTRATIVE ANALYSIS

The purpose of this analysis is to assess the administrative capabilities of the Salvadoran Demographic Association (SDA) as implementor of the Project and to determine whether the specific implementation plan, Section V of this Paper is likely to be workable.

Strong administration requires capable human resources and efficient systems. The review of these includes SDA's legal status, organization pattern, management and staffing, financial status, administrative and financial systems, planning, monitoring and evaluating systems and human resource management.

SDA has been providing a broad range of family planning services for many years. It has successfully developed volunteer groups to help promote and provide family planning services. It is well known and respected in the country through the name "Pro-Familia." It has organized rural outreach programs and its success rates (e.g., CYP) are among the best in this region.

A. Legal Status

The Salvadoran Demographic Association is a non-profit organization formed in 1962. It is an affiliate of the IPPF.

B. Financial Status

SDA receives donations from individuals, firms, sponsors and diverse international organizations including IPPF, FHI, USAID and others. Over the last six years SDA has received major grants from USAID, specifically through Projects 0210 and 0275. In 1982 and 1983 the organization received about $1,200,000. From 1984 to 1987 the average amount was approximately $1,800,000 per year. Between 1988-89 the amount was $3,800,000. SDA's past ability to manage these funds has been acceptable, although the increase in 1988, and that currently proposed in this Project will require technical assistance in order for the SDA to improve its absorptive capacity.

C. Pattern of Organization

The General Assembly elects a Board of Directors which designates primary operational responsibility to an Executive Director who oversees four departments. These are:

a) Planning, Evaluation and Research;
b) Administration and Finance;

c) I.E.C (Training, IEC, Research and SMP); and
d) Medical Clinics.

The Board Members change frequently (i.e., every two years); all the current members were elected in the last election. This suggests that the specific knowledges and skills which these leaders bring to their new responsibilities may be heterogeneous. Systematic orientation and training programs do not exist for new Board Members.

The Board of Directors delegates operating responsibility to the Executive Director who supervises Department Managers. The Board's role is active and participatory; it pays close attention to the operation of the organization. Board members establish policy and presumably leave implementation to the Executive Director and Staff. However, in SDA a chronic problem is the tendency of the Board Members to become directly involved in technical issues and operating affairs and thereby inhibit or disturb the normal functioning of the departments. They also become involved in procurement and hiring, attempting to influence choice of sources of supplies and services.

Because of the nature of its evolution, the SDA organization is clear and simple although highly centralized. Most important decisions occur in the main office in San Salvador where all information is stored (except patient records). For example, the Director of the Rural Distribution Program does not have control over that department's budget. This may be convenient for fiscal control and rapid decision making, but it means that many decisions often do not respond to the specific conditions of the clinics and other dependencies, particularly in rural areas. Centralization is not conducive to expansion of activities, one of the major SDA objectives for the next five years. This restricts delegation of authority limiting opportunities to increase productivity and improve staff morale.

The specific nature of the departments currently included in the SDA management system may be improved through a recent suggestion to reorganize them. For example, the differences between the financial, administrative and accounting functions should be more clearly specified because management by objectives currently is not feasible and the budgeting approach being used is antiquated and establishing fixed and recurrent costs difficult. The functions assigned to the information and communication departments are not adequately differentiated from those which should logically pertain to education and training. Much of what is community information involves training, and many training activities involve simple dissemination of information.

The nature of the general experience of the managers and the staff contributes to operation on a program basis rather than by strategic planning with a clear understanding of the specified goals and objectives and the methodologies for achieving them. Short-term perspectives

predominate in scheduling and completing activities; programs are not evaluated against the yardstick of strategic plans. Moreover, the lack of clear procedures, job descriptions, monitoring systems and administrative guidelines impedes the cost effective expansion of services. Thus, The Project includes technical assistance to enable SDA to make needed organizational changes.

In summary, the existing organizational structure inhibits coordination of activities between the four departments, four clinics and the rural distribution office. Therefore, this project will include support for changes to this structure.

D. Administrative and Financial Systems

Financial Controls: SDA has adequate financial and management capabilities to plan and budget for the proposed activities of the Project, particularly if provided the technical assistance proposed to modify current operating systems to meet the demands of the expanded program. Adequate controls to safeguard and account for Project resources are also in place. A cash control system exists with standard operating procedures to account for disbursements (i.e., required signatures and initials). Each program has its separate bank account. Issuing checks requires approvals and signatures from appropriate SDA personnel, whose signatures are controlled by the Internal Auditing department. The cashiers office issues checks only if documentation is correctly certified and includes the correct initials and signatures. Internal accounting operating procedures are strictly enforced by the Internal Auditing Department. Periodic internal control audits are conducted at all levels to ensure that all safeguards and controls are strictly adhered to by the employees of SDA's Administration Department.

The following key controls were evaluated to determine compliance with sound management practices:

a) An organization chart is documented and up to date;

b) The SDA accounting system complies with generally accepted accounting principles and with the local government's legal requirements;

c) The accounting manual conforms with the chart of accounts, and adequately explains all accounting applications. The manual has been legalized by the appropriate government of El Salvador Offices;

d) Internal cash controls and disbursement procedures exist with adequate standards in place to account for disbursements;

e) A current list of signatures and initials required for disbursements is maintained;

f) The SDA system for issuing checks requires appropriate signatures and approvals and is controlled by the Internal Auditing Department;

g) The accounting and treasury functions are well defined, and segregated;

h) The routine procedure for disbursements of over ¢300 is by check;

i) Petty cash controls are adequate with a limit of ¢299.99 with the account reconciled on a regular basis; and

j) Personnel attendance is well documented; however, not segregated from payroll preparations.

SDA has improved its capacity for accounting control by installing a data processing package provided by TECAPRO which contains the modules required to keep records and provide reports on program costs. The Project provides a long term national logistic and international financial advisor to ensure SDA systems are appropriate for expanded program initiatives.

The existing accounting system complies with generally accepted accounting principles and standards of the accrual method. The following key applications were reviewed in detail:

a) cash payment journal;
b) liabilities, i.e., accounts payable journal;
c) general ledger reconciliations to sub accounts;
d) bank reconciliations; and
e) journal entries.

Financial statements are produced on a regular monthly basis

Procurement and Inventory Control: USAID or an institutional contractor will procure services and commodities including technical assistance, vehicles, contraceptives, vitamins and other commodities. Limited local procurement will be conducted by SDA. Procurement is done by the purchasing department at central headquarters. Department directors make requests for products or services. If the products are not available at the warehouse, three bids are solicited and a purchase order is issued and sent to the lowest bidder. When the merchandise and invoice are received, the goods are checked against the purchase order. If the material is accepted the accompanying invoice is sent to the accounting department for coding and payment. The cashier's office issues payments directly to the supplier. SDA auditors manage internal purchasing controls in cooperation with external auditors. For local procurements the necessary canvassing of potential bidders can be done by SDA since they have the mechanism to advertise, select and monitor contractor performance.

Inventory controls are adequate. Periodic physical inventories are performed by the Internal Audit Department and the resulting data reconciled with the accounting records.

Audit: Audit is well structured in three levels: 1) internal, 2) external and 3) USAID. Adequate audit coverage exists within SDA. The organization employees a full time time internal auditor whose function is to ensure that the internal controls are observed and strictly adhered to. An internal auditing team exists whose function is to conduct impromptu audits of different sections within the Department of Administration. These internal checks ensure that the standard operating procedures are being followed.

Coopers and Lybrand are SDA's external auditors and carry out an audit once a year.

At present, a non-federal audit is in progress. Preliminary findings included in management letters on internal controls have been thoroughly analyzed, and specific Project TA designed to correct the weaknesses pointed out. A chart showing key actions and timing will be prepared for the arrival of the TA team to assure that all weaknesses are addressed in a timely fashion.

E. Planning, Monitoring and Evaluation

Global or strategic planning is the primary responsibility of the Board and Directors. The Board must redefine its functions, rights and responsibilities, and the scope of its actions. It must specify more clearly, and respect the role of the Executive Director, who must define the roles of the Department managers and their employees.

Technical assistance will facilitate these efforts. The Board and Executive Director will receive training in Needs Assessment and Strategic Planning. The development of SDA's goals and objectives will be done by the Board of Directors. The Executive Director and his Department Managers will receive extensive training in Management by Objectives (MBO). Implementation, monitoring and supervision will be the responsibility of the Executive Director.

With the help of technical assistance, SDA can install Management by Objectives (MBO) planning, monitoring and supervision procedures and systems to improve operations. Development of such procedures will focus efforts and solve several of the problems of administration and human resource management.

F. Human Resource Management

A systematic human resource management function includes all the major processes and controls required for efficient management of the personnel of an organization. Typically, procedures are established for

definition of the required function (job descriptions), which includes the precise specification of the nature of the skills, knowledges and attitudes the employee should have to carry out his responsibilities successfully. The combination of functions and requirements, correlated with local labor availability, establishes a basis for remuneration of each employee in a given job. Expectations and standards of performance are: 1) the basis for evaluation of employee compliance and fulfillment of the requirements, 2) considerations for promotion, demotion, training, and, 3) as elements in a systematic monitoring and supervision function. Changes in the goals and objectives of the organization or the specific characteristics of the job, fluctuations in the availability of required human resources, and other factors contribute to the specification of training and development needs which the organization must provide either from within or through relations with other organizations (i.e., hospitals, universities, training centers, schools, etc).

SDA does not now have a comprehensive human resource management system as described in the preceding paragraph. This is because it has grown rapidly in recent years and has devoted most of its efforts to project operations and has not had adequate time or resources to improve internal mechanisms. Some initial elements exist which may be transformed into a system, given commitment from the Board of Directors and provision of technical assistance.

SDA has four departments. About 190 people work at SDA, including 20 part-time doctors. Among large categories of people are 16 secretaries, 26 cleaning people (ordenanzas), 20 auxiliary nurses, 8 sales persons and 7 drivers. Some 124 person work directly in projects, twenty in project support, and 45 in administration, maintenance and general services. SDA is the third largest IPPF affiliate in the world, but its staff per CYP ratio is high.

The spirit and dedication of the department managers are laudable. They are hard working professionals who devote large amounts of time to their work. The majority of them have learned their primarily jobs through direct experience. They do not have extensive specific training nor the theoretical background normally associated with their responsibilities. The managers show dedication and positive attitudes toward their work. Several of them have various years of experience with SDA, but their direct qualifications merit scrutiny. For example, the Administrative Manager is an accountant, not a financial analyst. The person in charge of Social Marketing has had no major training in the subject. The person in charge of education and training is a social worker with no specific training in issues such as instructional design and development or educational technology for health. Similar situations exist for other major managers within SDA, including the Medical/Clinical manager who has no training in Public Health Administration.

These deficiencies need to be identified to the extent that they impede SDA's mission, and a strategy for reducing skill shortages developed and implemented. Some of the department heads have excessive

work loads, partially because of SDA's organization and partially because of the lack of adequate training. These people show signs of stress and overwork. The key position in SDA's outreach program, the Community-Based Distributer (CBD) does not have clearly specified functions, nor an adequate definition of his/her role. Historically, her function has been simple and uncomplicated. It may not be possible for him/her to take on the role of facilitator, community developer, and leader implicit in the Family Health Services Project; this will need to be evaluated as the Project is implemented.

Although there is an internal program for personnel training, (85/18, Strengthening SDA Personnel) it falls short of the expectations of a systematic training program for all levels of personnel in the organization. The purpose of the existing program is to provide basic knowledge, skills, and attitudes to the various participants in the SDA programs. It is too general, its curriculum highly repetitive and its scope limited. As an example of the latter, within SDA there is little evidence of awareness and use of newer approaches to education and training such as needs assessment, instructional design and development, systematic formative evaluation and follow-up, and many other subjects.

In addition to the above, the long-term viability of SDA requires that the issues of pay scale and job definitions be addressed. There is no personnel department; only one person is in charge of payroll. No personnel manual, code or guide for personnel responsibilities and related issues exists. Job descriptions are available for only a few positions. Systematic interrelation of functions and responsibilities is not always clear. Furthermore, individual knowledge of responsibilities, goals and objectives are difficult to establish. It is unclear how staff members are evaluated and held responsible for complying with their functions (particularly difficult without job descriptions). Providing pay increases or promotions may not be systematically based on performance standards.

The existing pay scale has been developed on an ad hoc basis. There is no evidence that a careful labor market survey was conducted to establish the basis for existing salaries. Since few job descriptions exist it would not be possible to conduct a systematic analysis of requirements and local labor supply.

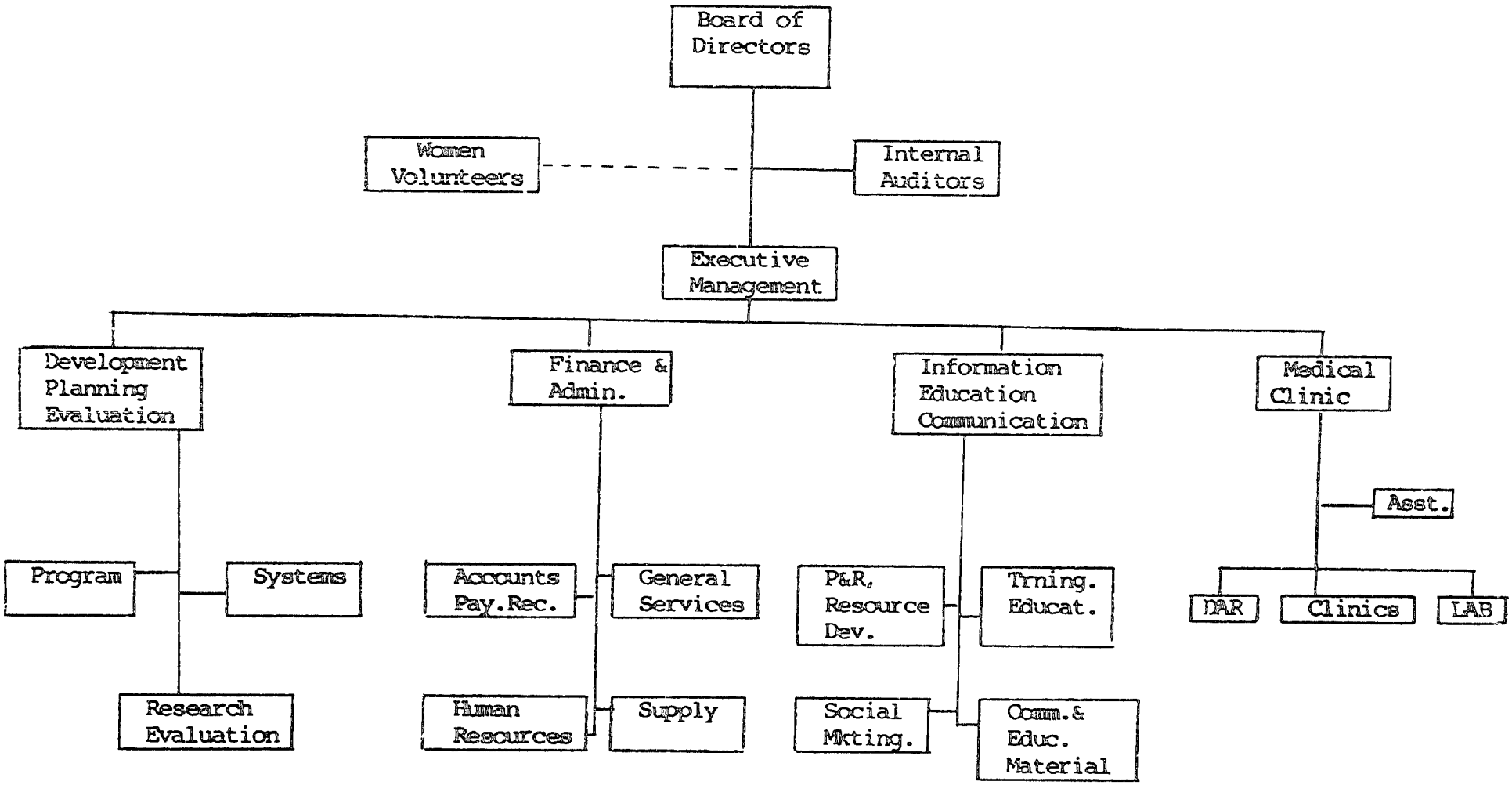
In sum, SDA should have a thorough and systematic human resource management system. Its development will require use of technical assistance which could begin with an analysis of existing procedures, a systematic work study, strategic planning seminars, an MBO system, revision of training, personnel selection, development of supervision systems, just and reasonable pay scales, and related issues.

G. Physical Resource Management

SDA should develop a systematic inventory procedure to identify, label, value and categorize all of its physical assets. It should also choose those which should be depreciated and include the depreciation in the overall planning of the institution.

ORGANIZATIONAL STRUCTURE

SALVADORAN DEMOGRAPHIC ASSOCIATION



ANNEX G.

SUPPORTING INFORMATION FOR PROJECT DESCRIPTION

The sections of this Annex provide additional information to define the specific programs and activities envisioned in the project, but which the main body of the Project description did not present in detail. This Annex provides more detailed information concerning:

G.1 Selection and supervision of the Pro-Familia Health Providers (PHP);
G.2 Possible payment mechanisms for the various Health Providers;
G.3 The Physician Referral System;
G.4 Equipment and organization of SDA's Management Information System (MIS);
G.5 Operating details concerning the Central Referral Clinic (CRC);
G.6 Details about Project Beneficiaries, Community Involvement, Diffusion, and Impact on Major Indicators; and
G.7 The Patient flow System of the Project.

G.1 Selection and supervision of the PHPs:

The selection of the new PHPs will be done in a manner that requires minimal disruption to the existing CBD network. The existing CBDs who wish to may apply for this new position. Those who meet the selection criteria will receive training to work as a Pro-Familia Health Promoter (PHP). Those who do not meet these criteria or do not wish to become an PHP, may continue as CBDs working in their current capacity.

At the moment, each of the SDA clinics has one CDB supervisory team. Each consists of a driver and an auxiliary nurse, serving its respective group of CBDs (between 150 and 250). The primary objective of the supervisory nurse is to visit each CBD distribution point, supply the CBD with the necessary contraceptives, collect information about activities the CBD has undertaken during the past three months, and hold group meetings with community members on birth spacing education. The driver's primary function is to provide the nurse with transportation and to maintain the vehicle.

The Patient Recruiting Team also serves the rural area and consists of a driver and an auxiliary nurse. The team's function is to introduce rural area residents to temporary contraceptive methods and to make referrals to the SDA clinics where those who choose may receive permanent contraceptive methods. They do this by making house visits. This team is under Clinical Services and is not part of the CBD network.

This existing field service infrastructure requires changes to increase recruiting in the rural areas and to establish better training and supervision procedures to increase CBD productivity. The current

ratio of one supervisor per 150-250 CBDs results in too infrequent contact to ensure quality of service. Under the Project, there will be four teams for each SDA clinic. Three will have one auxiliary nurse and one driver each. One will simply be a car with driver. The drivers will provide education and information and distribute contraceptives as well as provide transportation. The eight drivers now working at the SDA clinics, if selected, will receive a higher salary once they successfully complete the training required for this job.

The proposed number of teams will result in one auxiliary nurse for every 85 PHP and CBD (current ratio is approximately 1 to 250). The nurses will be responsible for the continuing training and supervision of the PHPs and CBDs to ensure higher productivity levels.

Two graduate nurses and the Program Director Supervisory Nurse will report to the SDA Director. Each will be responsible for overall supervision of two clinics and will devote 60 to 70 percent of their time to continuing education of the PHPs. The rural outreach program will have 12 nurses (instead of the current 8) available to offer group education classes to the communities. They will also make home visits and insure that the PHPs and CBDs have educational materials and contraceptives. The driver/educator of the fourth team at each clinic will provide supplies to the PHPs and transportation for patients who need to see a physician at the SDA clinics for either permanent contraceptive methods, or insertion of an IUD.

G.2 Payment Mechanisms for Health Providers:

Attention will be given in the Project to improving SDA's financial viability, given that salaries constitute a large percentage of the SDA's recurrent costs, and the quality of service is critical to higher service statistics. The Project will support SDA in testing different payment mechanisms to improve quality and increase cost sharing by patients.

Payments for Pro-Familia Health Providers (PHPs)

Establishing the method of payment for these new providers (PHP) requires pilot studies. SDA does not wish to establish any salary that could only be sustained while AID funding support is provided and then disappear when the AID funding is cut off. SDA prefers paying the PHPs through an incentive system. While nonpecuniary incentives such as shirts, hats, continuing education programs, etc., have a positive effect on motivating PHPs, studies have demonstrated that even a small basic salary provides strong motivation for both productivity and longevity with the program. It may be most effective to offer an attractive program of bonuses or prizes that would establish tangible six month goals for the PHPs to accomplish. This would act as an incentive, but not have the carry-over effect of a salary. For example, offering a PHP a new kitchen stove may be at least as impelling as a straight salary. SDA will test various incentive payments to find the most effective.

Selection and incentive payment mechanisms for PHPs could include:

a) a screening process in which the individual must apply for the PHP job, and pass a test to enter the training program;

b) a training program that explains the health education information PHPs will need, how the patient referral process works and what are their basic job responsibilities. Ideally, this training program would be outside of the community from which the PHP is recruited to provide her/him an initial incentive. They would also receive a certificate or diploma upon graduation; and

c) a commission for selling contraceptives, since this is one of the primary goals of the program. However, initially certain groups will have to purchase the contraceptives as they are currently doing, while others will receive them for free to test for any difference in PHP productivity.

Two payment types of incentive programs that will be tested are:

1. Different types of bonuses for services delivered and costs (such as travel) associated with delivering, will be tested. For example, a group of individuals might receive a set of goals which include an expected number of house visits, contraceptives sold, health education programs, and referrals to auxiliary nurses and SDA clinics. They would have to attend a certain number of training sessions within a six month period, have a predetermined number of meetings with their nurse supervisor, and produce reports. Meeting established goals would make the PHP eligible for a bonus. It may be cash or a nonpecuniary payment such as a scholarship for them or a member of their family to attend a university or a trip for them to attend a seminar in another country.

2. PHPs would receive a minimum monthly stipend to cover traveling expenses to encourage them to reach patients who live further out in the rural areas. In addition, they would have the same incentive system as Type 1, with annual instead of semiannual goals established.

Payment to Physicians and Other Professionals

Payment to all new physicians and surgeons at SDA clinics will be either on a risk-sharing or incentive basis. In the risk sharing plan SDA and the physician or surgeon divide the fee charged to the patient. In an incentive system the provider receives a base salary (60% of his or her total salary), and receives a bonus for the number of patients seen beyond those necessary to cover the base salary.

Specialists who will work at the SDA clinics (pediatricians, obstetricians, gynecologists) also will participate on a risk-sharing basis. They will have well equipped offices, and will accept only paying patients. However, the fees charged will be less than charged by private

physicians in the area. This will provide more access to medical services to the middle class patients who can afford a modest fee. The pediatricians will work a minimum of a 20 hour week, thereby assuring achievement of a higher quality of service than when, as sometimes occurs at SDA, a pediatrician is only available at the clinic for four hours a week.

The obstetricians/gynecologists will receive a risk-sharing payment for office consultations. They also will comprise groups of 3 to 4 colleagues to provide 24-hour coverage for attending low-risk pregnancies. Payment will be per delivery.

Payment to Non-Professional Employees

Non-professional employees will benefit from an incentive system that guarantees a minimum base salary. This minimum risk is often desirable when recruiting to fill certain positions, as when hiring employees at the lower end of the pay scale, who can not afford or are not willing to work on a strictly risk sharing basis. The justification for this is:

a) All employees can affect the number of patients who come to use the SDA clinics;
b) An employee paid a base salary as well as a bonus or incentive is often more productive than an individual who receives an automatic pay raise or a guaranteed base salary; and.
c) SDA will incur less risk and expense than with a system that pays everyone an automatic raise. In addition, SDA will not pay benefits on the portion of the salary that is a bonus. Also an automatic raise carries forward while a bonus does not (important when demand declines). In this incentive system employees will continue to receive their current base salaries, but will receive a bonus every three months if their health center exceeds a previously agreed upon threshold of revenues generated from new patient visits. This threshold will be determined by calculating the level at which the clinic will be financially better than it currently is, while providing employees with the possibility of earning as much as they would through a 10 percent annual raise.

Only revenues generated from new patient visits will be used to fund payment of bonuses; cash bonuses will not draw from gross revenues. This discourages inappropriate demand for services such as laboratory fees, pharmaceuticals, or unnecessary follow-up visits. The employees will receive their current regular salaries. However, any future salary increments will be on the basis of either a quarterly or annual bonus. SDA will study whether to include an annual inflation adjustment. The employees will be informed of the minimum level of revenue required to be eligible for a quarterly bonus. There is a variety of possible combinations. One example would be of a clinic exceeds its established goal level; at the end of the quarter employees would receive 40% of

excess revenues in proportion to their individual salaries. In this manner, everyone will receive the same percentage increase, and the result for each will be the same, even though some receive more than others in absolute amounts. Unlike a risk-sharing plan, if the revenues for the particular quarter do not reach the minimum threshold, the employees' salaries are not reduced. However, this has the potential of freezing employee salaries if the average patient volume of the clinic decreases over time.

Payments in Relation to Patient Costs

A fee will be established for all services provided by SDA clinics, although often at only nominal levels, so that rural and urban marginal poor can take full advantage of the clinics. Because SDA's services are subsidized, their costs are less than almost any other private service delivery organization. Since the prices are low, there is no difference between the urban clinics and the rural clinics. Each patient must pay two colones to enter the clinic. While they pay additional charges depending on the service received, every effort is made to insure that the costs are accessible to the poorest patients.

Even with these low prices, the real cost to many rural patients is still more than they can afford. The main reason is that many live far from the SDA clinic and cannot afford the cost of the transportation or lost time. The SDA physician referral system combined with the increased transportation through the new driver/educators will help solve this problem. The patient will have the option of going to the SDA clinic or to the private physician if she/he is closer than the clinic. Both services will charge the same price. The private physician will contract a fee for service directly with the SDA. The fee will be less than normal charges for private patients because SDA will provide the necessary contraceptives. When the patients see the private physicians, they will pay the basic SDA charge for the service. SDA will cover the difference between this charge and the physicians negotiated fee for services. The physician will receive the full negotiated fee for service rendered, and the patient will pay only what he/she would pay at the SDA clinic. Those patients who are unwilling or unable to pay the basic SDA charge may go to the MOH. This policy demonstrates to the patients that SDA will not offer free services.

G.3 Physician Referral System:

Low-income family planning needs which require a physician will be referred to the SDA clinic if it is within a reasonable distance for the patient. If the patient does not live within a reasonable distance of the SDA clinic, then she/he will have two options. The first option will be access to transportation provided by an SDA car and driver. Three drivers from each of the marginal urban SDA clinics will make routine trips to rural areas. The drivers will notify the CBDs of these scheduled visits so any referred patients can get a ride to the SDA clinic.

It will not be feasible for SDA to provide transportation to all patients needing to see a physician for family planning attention and many of the patients live too far from the SDA clinic to be able to reach them. Therefore, a second option will be explored for patients who need to see a physician. A pilot study will determine the desirability of establishing a network of physicians to whom the patients can be referred. The advantage of a referral system will be that the client who wants family planning services which require a doctor will have much better access, and there will be almost no maintenance cost for having these since physicians will be using their own offices. Also, SDA will be able to maintain high quality services by insisting that patients go to an SDA-approved physician if they wish to receive the service at the minimum SDA subsidized fee. This network of referral physicians will be available for the rural patient who wants access to the full range of reproductive health care services.

The reimbursement mechanism for this referral service is discussed in the Patient Fee for Service Mechanisms section. The CBD will prepare a referral slip in the same manner as when referring the patient to the SDA clinic. Once the patient receives this service from the authorized physician, she/he signs a receipt that the physician will submit to SDA for reimbursement at a previously agreed upon rate. This rate will be uniform and negotiated between the physicians and SDA, and will be less than the doctor would charge for private patients. It is safe to assume there are several qualified physicians who will accept this arrangement since the physician supply is greater than the demand.

G.4. Equipment and Organization of the Management Information System:

The development of the management information system in the San Salvador Clinic will require that the following existing equipment be transferred from the SDA Office of Research and Evaluation to the clinic:

1-PC AT(386) with its display monitor, hard and floppy disks and a printer.

All of the equipment will include its corresponding stabilizer and power converter. In addition, the following supplies or services and accessories will need to be procured locally:

- Installation of a polarized electrical line.	4,000
- 80 M-byte hard disk internal or external cartridge as backup unit.	10,000
- Supplies for one year.	
- 6 boxes of 9-1/2"x11" continuous paper.	1,200
- 6 Ribbons for the chosen printer.	780
- 6 boxes 5 1/2" diskettes DD/DS.	600
- 1 Wall type Air Conditioning unit.	4,500
Total Cost	21,080

SDA is now developing and testing software provided by TICAPRO in San Jose Costa Rica under IPPF sponsorship. A software packaged developed by Cambridge Consulting Corporation for the Ministry of Health's Family Planning Supply Management System (FMSMS) also could be implemented if necessary and feasible.

The chosen MIS option will not be able to transmit the records via telephone link. Therefore, diskettes with the required information can be transferred to SDA's central office. Eventually this MIS option could be equipped to perform data transfer via telephone lines if desired.

System Location, Operation and Function

The central data bank will be located and operated from the SDA's San Salvador clinic. The operation will consist of encoding and loading existing and new medical records and inventory control records, as well as maintaining the data up to date on a daily basis. The inventory control system will function pari-passu with the medical records operation. While these two activities will occur in the same computer, they will be internally separated in sub-directories. Two internal RAM partitions will be made to improve retrieval time.

As stated above, medical records will be updated daily at the clinic. Each clinic (San Salvador, Santa Ana, San Miguel, Santa Tecla and the new clinics) will send written records via messenger once a week for direct encoding into the data bank. Inventory records will be updated on a weekly basis or as needed. Records will be available to the entire SDA clinic network and to the central SDA office. Records will be transferred from the medical data bank and the inventory control system to the SDA Office of Administration, Research and/or any other user by existing messenger service using diskettes.

The number of reports, frequency and formats shall be decided by the Medical, Administration and Planning and Research Directors of SDA with the officer in charge of MIS. The inventory control system reports also will be designed by the Director of the Office of Administration and the officer in charge of MIS.

The staff member currently maintaining the records at the San Salvador clinic will continue performing this task except that he/she will be trained by SDA to enter all records collected from different locations into the central data bank. SDA may also provide training to women volunteers to assist in data entry. Written records will continue to be gathered from the patient as is being done now.

G.5 Central Referral Clinic (CRC):

Each new clinical procedure or service offered by SDA will be directed towards making a profit. The accounting system will assess the financial status of each activity offered at the CRC to ensure that it is generating a surplus, or at least breaking even. SDA will specify

evaluation periods. If an activity is generating a profit, it will move into the second growth step to allow it to expand to meet the demand. If the activity does not meet its projected target after an established period, staff reductions or other adjustments will take place. Each new CRC activity will start with defined financial expectations, periodic evaluations, employees on fixed contracts, and providers on either a risk sharing or incentive payment basis. The following is a proposed list of clinical procedures and laboratory services with suggestions for staffing.

Day Care Surgery Unit

The Day Care Surgery Unit will be an expansion of the existing service in the San Salvador Clinic, which now provides only sterilizations and vasectomies. This surgical unit will move to the Central Referral Clinic, and add one more operating room to accommodate Day Care Surgeries requiring local anesthesia and no hospitalization, such as:

a) extirpation of a mammary cyst;
b) extirpation of lipomas;
c) conesectomy;
d) drainage of abscesses;
e) suturing of minor injuries; and
f) skin biopsies.

The following staff will be required to open this unit eight hours a day:

EMPLOYEE	FTE	NEW	HOURS
Nurse (RN)	1.0	1/2	4
Nurse (Aux)	1.5	1/2	4
Recovery Nurse (aux)	1.0	no	0
Central Supply	1.0	no	0
Laundry Worker	1.0	no	0
Housekeeper	2.0	1 new	8
Guard/Housekeeper	1.0	yes	8
Social Worker	1.0	no	0

This represents the staff necessary to run the Day Care Surgery with the assumption of using one operating room in the mornings for sterilizations, and the other for elective surgery. Hopefully, the demand will increase to enable the staff to operate in the afternoons and possibly on Saturdays.

Surgeons will be paid by procedure. Technical assistance will insure that fee-sharing is equitable and that SDA earns a surplus from this department.

Pharmacy

The pharmacy will be on the first floor of the Central Referral Clinic, and available only to patients of SDA as opening to the general public would require a license. However, offering service to the general public is desirable since it provides access to a wider market. The disadvantage is that it requires for-profit tax status, and the pharmaceutical association could perceive it as direct competition. This option will be explored further during implementation of the Project as the advantages probably outweigh the disadvantages.

Initially, the pharmacy will be open 12 hours a day, from 8 A.M. to 8 P.M. Monday through Friday, and four hours on Saturday mornings on order to provide service to all patients receiving care at the Center. The staff will consist of:

EMPLOYEE	FTE	NEW	HOURS
Pharmacist	1.5	yes	64/week

The above staffing would represent new additions since the pharmacy now operating at the San Salvador Clinic will remain open.

Laboratory

The primary laboratory now located in the San Salvador clinic will be moved to the Central Referral Clinic as the majority of complicated cases will be referred there. However, since a high percentage of the current users of the San Salvador laboratory use this laboratory because of its geographical proximity, it will be necessary to maintain a phlebotomist there who can take the necessary samples and forward them to the Central Referral Clinic for analysis.

The primary laboratory will continue to provide all of the services it now offers, plus other analyses such as bacteriology, which will be added when new laboratory equipment is installed. Staffing for the Central Referral and San Salvador laboratories will be:

EMPLOYEE	FTE	NEW	HOURS
Phlebotomist	1.0	yes	8
Lic. Lab Tech	2.0	1 New	8
Secretary	1.0	no	0

Clinic for Men

Currently, men and women are both treated surgically in the same areas in the San Salvador Clinic. This creates tension for both sexes when they are receiving sterilization. Since the surgical department will move to the CRC, separating the two operating areas will cost little. In addition, there is no clinic for men in San Salvador, so there will be significant demand for one.

A clinic for men will offer private consultations to offer family planning advice, and access to medical consultations for sexually transmitted diseases, fertility, impotence, etc.

This service will be open eight hours a day, Monday through Friday. It will consist of a basic operating room, dressing rooms, a waiting room, an office for the social worker, and an area for the receptionist and nurse. The medical records for these patients will be stored with the other medical records in the central record room. The staff will consist of:

EMPLOYEE	FTE	NEW	HOURS
Nurse (aux)	1.0	yes	8
Social Worker	0.5	no	0
Physician (urologist or general M.D.)	0.25	yes	2

A urologist (if recruited) or a general physician also will be available for consultations 2 hours a day. As demand for this service increases the hours will also increase.

Diagnostic Services

To be a high quality referral center, other diagnostic services will be made available. The following diagnostic services, which could be placed in two rooms, will be added to the CRC:

a) Ultrasound
b) Cryosurgery
c) Colposcopy

Initially, these services will be made available about two hours a day each, and will be staffed by:

EMPLOYEE	FTE	NEW	HOURS
Nurse (aux)	1.0	yes	8

Support Staff

The support staff required for the new Central Referral Clinic will include:

EMPLOYEE	FTE	NEW	HOURS
Med Records Spec.	1.0	no	8
Night Guard/housekeep	1.0	yes	8
Receptionists	1.0	yes	8
Housekeeping	2.0	yes	16
Driver	1.0	no	8

Expenditures Estimation Methodology:

Costs estimates associated with each component category of the Project, which represent expenditures for goods or services presently used by SDA, were based on financial reports provided by SDA's Department of Administration and Accounting. The percentages by each Project category were applied to the projected 1990 expenditures associated with each of the Project Components.

Project costs were estimated as follows for each individual category:

a) Wages, salaries and other personnel related expenditures were provided by SDA's Department of Administration using its personnel salary chart;

b) Vehicle costs were estimated utilizing the standard value of a Ford Bronco FWD;

c) Office Supplies, utilities, uniforms rental and office equipment values were provided by SDA's Department of Administration;

d) Warehouse equipment prices were provided by SDA's Department of Administration using three quotes previously obtained;

e) Building renovation costs were provided by SDA's Administration Department based on three bids from Salvadoran A&E firms;

f) Medical supplies and equipment prices were estimated jointly by the Medical and Administration Departments; and

g) Training, seminars, audits, vitamins, contraceptives and other research and monitoring activities were provided by USAID/HPN.

Revenues Methodology:

Revenues associated with the Project for the next five years were estimated by the SDA's Department of Administration through actual revenues for the 1988 and 1989 until September 30, 1989, and projected revenues for year 1990. A six percent rate increase was applied to each revenue category to obtain revenue estimates for the subsequent year.

G.6 Details about Project Beneficiaries, Community Involvement, Diffusion, and Impact on Major Indicators:

Beneficiary Groups

The primary beneficiary group (women in fertile age and children under the age of five years living in 1500 of the country's poorest and smallest rural communities) lives in areas with weak or nonexistent services. They will receive selected interventions in birth spacing and

maternal child health. In general terms, the interventions will include maternal health and child survival (MCH) education, basic preventive services and referral to clinical care when necessary.

The second beneficiary group (women of fertile ages and children under the age of five years living in some 100 of the country's rural towns) lives in areas which are rural but have more services. They will receive some additional assistance to compliment these services. SDA services will include clinical care in family planning, and MCH education, prevention and referral in birth spacing and maternal-child health.

The third beneficiary group (the general population of those urban and marginal areas with populations of more than 5,000) lives in marginal urban areas and so has some access to public and private sector health care services. These include MOH services supported through AID's Health Systems Support Project, and services provided by a variety of private voluntary organizations. This Project will provide the selected marginal urban populations with clinical care in family planning and pediatrics. To a lesser extent the Project will also provide MCH education, prevention and referral in maternal-child health.

Special Population Subgroups Targeted by the Project

As a result of the recent demographic and health survey, discussed in detail in a previous section of this paper, the following subgroups among the high risk rural and marginal populations are also targeted by the Project:

a) rural or marginal urban adolescents from 15-24 years of age with low levels of formal education who are active sexually or in union will receive special emphasis due to information from demographic and health surveys (presented in the social constraints and background section);

b) pregnant women from marginal urban and rural areas;

c) children between 0-5 years of age living in rural or marginal urban areas (about 35,000 directly targeted by the project); and

d) men in fertile age from marginal urban and rural areas.

Rural and Semi-rural Beneficiaries

The principal focus of this Project is the rural and semi-rural area. The following section describes the rural beneficiaries of this Project in detail. In rural areas, a woman beneficiary of the Project will contact the SDA rural promoter (PHP) for either birth spacing or MCH services. If seeking birth spacing, she will most likely be a woman in union or active sexually between the age of 15-44 years. Most participators will at first be women over 24 years of age, with two or more children, who want information or referral for female sterilization

or the pill. However, this Project will increase the number of younger rural women 15-24 years of age who will demand information and referral for temporary methods. As the image of the SDA program changes in the community, an increasing number of families are expected to also seek SDA services for issues related to maternal-child health.

Men in rural areas are expected to use SDA rural health promoters for family planning services. Men participating in the Project will be of any age who are active sexually. It is hoped that, as a result of the Project, an increasing number of young men will seek temporary methods.

Couples seeking MCH services will be those with young children under five years of age. They will receive education related to diarrheal disease, immunization, nutrition and acute respiratory infections. They will also receive seeds for home gardens, oral rehydration salts, prenatal vitamins, and vitamin A.

Couples requiring more complex birth spacing services will be referred to SDA clinics or SDA-trained referral physicians. If they require more complex services in diarrheal disease, respiratory infections, immunization, or malnutrition, referrals will be made to pediatric services of SDA clinics, or to other sources of care including private providers or the MOH.

Determinants of Community Involvement

The degree of rural community involvement in the Project will vary according to several variables in its implementation and location. Characteristics of the rural communities themselves will affect participation. If the community is divided strongly along religious, economic or other lines, the chance that participation will be negatively affected increases. If the SDA community outreach person allies with one faction or the other, the Project will also be associated with that faction, limiting participation in the Project by members of the other group(s). Therefore, the individuals selected as SDA promoters, PHPs and CBDs alike, are an important variable. The religious affiliation, economic status, time availability, marital status, educational level, willingness to work, basic aptitude as an educator and leadership standing in the community of these individuals will all affect the level of community participation in the Project.

Another determinant will be the degree of violence in the area. Over the life of this Project, SDA will extend rural coverage to 750 new high risk villages that are currently without adequate service. Those which most fit this category are located in semi-conflictive or conflictive areas. If the violence increases in rural areas of El Salvador during this period, Project expansion will be constrained. Even if SDA supervisory personnel may enter these areas, few villagers will want to act as SDA community organizers or even group participants for fear of being labeled subversive by one side or the other.

SDA Promoter Involvement and Supervisory Rates

Of the total 1,550 SDA communities projected by the end of the Project, 400 will only have a CBD (contraceptive distributor), 400 will be retrained promoters (PHP) chosen from among existing CBDs and 750 will be new promoters. Therefore, by the end of the five year period the Project will have 1150 rural communities with SDA health promoters (PHP) providing birth spacing and other MCH preventive services, and 400 rural communities with distributors (CBD). This is a total of 96 PHPs and 33 CBDs for each of the 12 supervisory teams from the four SDA clinics. If each supervisory outreach team can visit three rural promoters a day, the rate of supervisory visits per rural promoter will be once every eight and a half weeks. However, high rates of attrition are common in rural promoter projects. If we calculate a twenty percent attrition rate, this will leave 920 MCH health promoters in rural areas by the end of the Project and 320 CBDs or community distributors. This will increase the frequency of supervisory visits per promoter to once every seven weeks. It will also lower the total number of SDA communities involved in the Project to 1,240.

Estimates of Community Participation

Those communities experiencing little political violence who have few internal divisions and a good (and well trained) SDA outreach worker may be expected to have maximum community involvement. As internal divisions in rural communities are common, perfect SDA outreach workers hard to find, and new villages may be in the highest risk and, therefore, semi-conflictive areas, a more realistic estimate is that a third of the 1150 communities to be served by health promoters, or a total of 384, will be such that maximum involvement is possible.

To estimate the probable number of community participants, let us assume then that the number of Project villages is divided by level of involvement into thirds (384 on each level of high, medium and low involvement). According to SDA outreach personnel, the average number of participants for an existing CBD (community distributor providing no MCH services) is 35. The addition of MCH services should increase participation by at least a third. This is a conservative estimate. Therefore, the minimum participant level for the new outreach worker would be roughly 40. At a maximum, participation would double to 75. Let us say then that 55 is the medium participation level. This would yield a total of 15,400 participants from minimum level villages; 21,112 from medium level villages; and 28,800 from maximum level villages. This is a total of 65,312 rural participants from the birth spacing/MCH workers of the rural outreach program.

To those, we then must add the 30 participants of each of the 400 rural promoters which remain only CBDs . This adds 12,000 participants. Participation will gradually increase during the life of the project to reach a total of 75,300 by the fifth year of the Project.

Behavior Change and Possibilities for Diffusion

We should keep in mind that not all of these participants will be using SDA services for contraception. Most of the initial increase in participants will be due to the additional array of services in MCH, especially those which are most attractive such as seeds for gardens, ORS packets, and vitamins. Understanding new concepts delivered by the Project takes time. Just because someone participates in the Project does not mean that she grasps the concepts, much less incorporates them into her behavior. Those women actively seeking birth spacing from the outset probably will listen to conceptual information and incorporate this into their behavior rapidly. Similarly, those seeking MCH services will listen to the information related to what they seek and (if it is presented correctly and in line with what they believe) incorporate these changes into their behavior. Utilization of birth spacing information by the new participants of the rural outreach program who are not seeking birth spacing services is more problematical. In contrast to those seeking birth spacing, this new group may be against modern contraception or undecided. They will need time to be approached and persuaded about this subject.

Diffusion of these new concepts and behaviors into the rest of the community and from community to community also proceeds slowly. Divisions within and between communities impede this process as those not associating with participants will not be exposed to the new ideas. Even in communities where few serious divisions exist, diffusion generally proceeds along extended kinship lines, as these individuals see most of each other, seek each other's advice and speak most frankly with each other about intimate subjects such as health and fertility. Acceptance of ideas and diffusion also varies by subject matter. Easily understood concepts which fit within local conceptual structures spread rapidly. We expect rapid diffusion of information about gardens and vitamins, for example. On the other hand, those which require major behavior change and do not fit within local concepts will be much slower. These will include changing attitudes toward using pills during lactation and male demand for sterilization.

For this reason, the way of introducing new ideas has a great impact on the rapidity of acceptance and diffusion. For example, if women believe that the pill is too detrimental to use during lactation, one should not try to convince them that it is not. It would be better to emphasize other temporary methods of contraception that are available and are not considered to have a negative impact upon the baby.

G.7 Patient Flow System:

Rural Participants

Most rural participants will first come in contact with this Project either by seeking or being sought out by the SDA (Pro-Familia Health Promoter-PHP) or the Community Based Distributor (CBD) in their

community (See the Patient Flow Chart, next page). A person from each of four hundred small rural communities will serve as a CBD in his/her community, while one from each of 1150 small rural communities will receive training in birth spacing and MCH interventions and serve the community as a PHP for SDA. The Project will expand this network by adding 1150 PHPs and retraining 400 CBDs to provide a broader array of services.

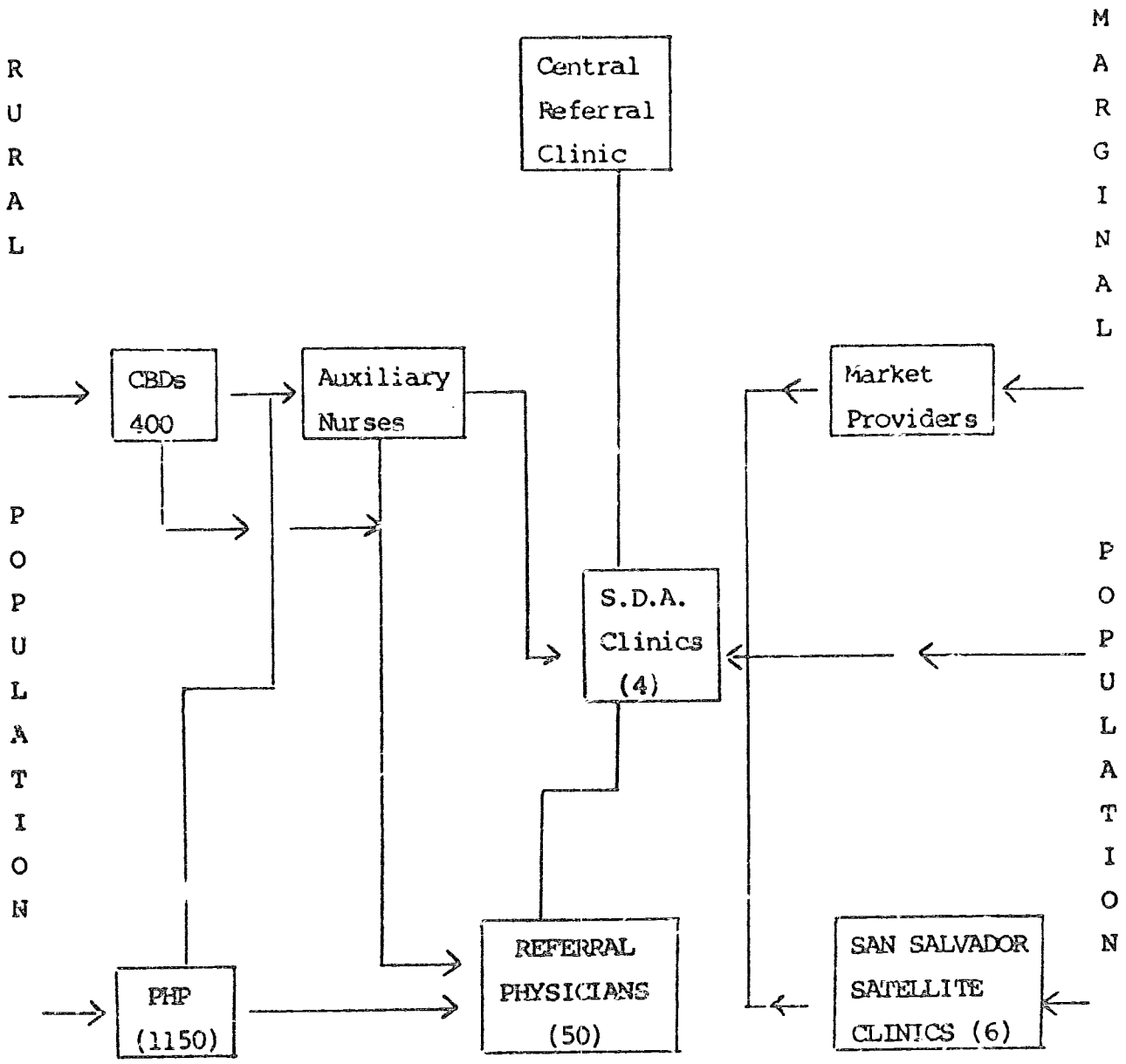
All entry persons provide primary health care and/or birth spacing services in their communities and make referrals. Referrals in family planning will be made to SDA clinics or private providers, while referrals in maternal-child health will be made to private voluntary organizations and others. The Central Referral Clinic will be the end point providing the widest variety of most complex levels of services (see Component II). Those participants coming into contact with CBDs will receive information and education on birth spacing and termination of fertility and will be able to purchase oral contraceptives or condoms at low cost. They will also be referred to SDA clinical services for insertion of an IUD, for female or male sterilization, or for complications related to use of modern contraception.

Those rural participants coming into contact with a Pro-Familia health promoter (PHP) will receive education not only related to birth spacing, but also about those topics most important in improving maternal/child health. In the area of diarrheal disease, health promoters will educate individuals and groups about transmission of disease and the importance of hygiene, children's diet during diarrhea episodes, preparation and use of oral rehydration salts and home electrolyte solution. In acute respiratory infections, promoters will teach women to recognize acute signs and symptoms. In nutrition, promoters will teach about prenatal diet, children's diet, intra-familial food distribution, role of vitamin A, and the use of weight-for-age growth charts. SDA PHPs will also advocate immunization of children under five years of age.

Medical or other supplies will accompany many of these educational interventions. Promoters will provide oral rehydration salts (ORS), prenatal vitamins, vitamin A capsules, ascaris (tapeworm) treatments, and garden seeds to rural participants at low cost. They also will periodically weigh children under five years and use the record of their growth as a teaching tool.

Some participants, attended by either a CBD or a health promoter, will need more than oral contraception, condoms or basic preventive services in MCH. If their problem is minor, the patient may wait for the periodic visit of an SDA auxiliary nurse. The frequency of these visits will vary over the life of the Project.

PATIENT FLOW CHART



If the problem concerns birth spacing or termination of childbearing, those requiring more immediate or technical attention will be referred to the nearest SDA clinic. These participants will receive transportation from an SDA driver and car. SDA will subsidize specific services related to family planning to keep the cost to the rural patient as low as possible, but will recover at least some portion of the cost of the service. If an SDA clinic is too far away, the rural participant needing complex care in family planning will be referred to the nearest SDA Referral Physician. The Project will choose fifty Referral Physicians and train them in sterilization and IUD insertion. Referral Physicians will use their own offices in rural towns in the highest risk areas of the country. Participants seen by Referral Physicians will be referred in turn to SDA clinics if they require even more complex services. If the problem concerns maternal/child health and requires more complex and immediate medical attention than the supervisory nurse may provide, those participants will be referred to the nearest MCH provider. In addition to the SDA network of PHP and satellite clinics, the range of providers in MCH includes the Ministry of Health, private voluntary organizations, and private nurses or physicians.

Under a new PVO Maternal Health/Child Survival Project, USAID will fund an expansion of private voluntary organization activities in maternal/child health over the next five years. This new Project will complement the birth spacing services of the SDA in rural areas by providing the MCH clinical backup which will be so essential to improving the health status of high risk Salvadoran families. Coordination of the SDA health promoter, distribution system with this new initiative will be of utmost importance and is discussed in Component III of this paper. In time then, through the PVO initiative, it will be possible for those recipients requiring complex MCH care to move into the flow of services offered through the PVO network; while those needing complex services in family planning will have the option of going either to an SDA clinic or a Referral Physician provided through this Project.

Marginal-Urban Participant

The participant from the marginal urban community will first enter this Project through: a) contact with market-based health promoters, b) one of the six satellite clinics of the San Salvador clinic, or c) attending one of the four SDA clinics.

ANNEX H

TRAINING PLAN

I. INTRODUCTION

This annex provides details about training to be provided through the Project. Two major areas of training must be covered. The first is that provided to the service personnel in SDA in order for them to successfully fulfill their functions. The second is training for the SDA managers and directors in order that they may fully discharge those functions directly related to planning and managing SDA's structures to achieve the organization's goals and objectives.

A. Training Required on Each Service Level of SDA:

The wide-ranging changes which will be made in SDA's service delivery over the next five years will require training efforts on all provider levels of the organization. Often refresher training will also be required. For instance, the community distributors received their initial training during a three day period in 1983, and since then have only recently received a one day refresher course. This is not enough training for Project purposes.

Service levels in the SDA are broken down into the following groups:

a) Medical/clinical personnel, including nurses, physicians and technicians at all facilities;

b) Middle-level managers, including fiscal management, clinical management and the director of the rural outreach program;

c) Supervisors, including all supervisors of outlying clinic activities and rural outreach nurse supervisors;

d) Community-level providers, who are the new PHP community workers and the existing CBDS ; and

e) Private referral providers, physicians doing referral for SDA in areas not covered by SDA clinics (pilot project).

Training will also be provided for Board Members and Department Directors. In 1991, the Board Members and Executive Director will receive intensive short-term training in Needs Assessment and Strategic Planning. Shortly after that training the Executive Director and Department Managers will receive intensive training in Management by Objectives (MBO) procedures for use in SDA.

The following is a list of the minimum training requirements for each service level for the successful implementation of the Family Health Service Delivery component of this project:

The Medical/clinical personnel, including nurses and physicians and technicians will receive training in:

- contraception and birth spacing methods and complications including the importance of temporary methods, particularly among young women;
- the importance of integrating birth spacing and extending rural service delivery;
- MCH preventive medicine, use of ORS for diarrheal disease, treatment for acute respiratory infections, nutrition interventions and vitamin supplementation;
- administration and management in resource allocation and the use of the MIS, project evaluation and the reporting systems for the new integrated services and their relationship to the MIS, and the use of the referral system; and
- community education issues including: materials selection, modification development and testing and inter-personal communication techniques.

This training will be designed to respond to the background and future functions of these highly qualified people and will use the forms and media most appropriate for them.

The Middle-level managers, including fiscal management, clinical management and the director of the rural outreach program will receive training in:

- contraception and birth spacing methods and complications including the importance of temporary methods, particularly among young women;
- the importance of integrating birth spacing and MCH and extending rural service delivery;
- MCH preventive medicine, use of ORS for diarrheal disease, treatment for acute respiratory infections, nutrition interventions and vitamin supplementation;
- administration and management in planning and the use of the MIS, national survey data and the results of other studies, resource allocation, project evaluation and the importance and role of the MIS, reporting systems for the new integrated services and their relationship to the MIS, and the use of the referral system; and
- community education issues including: materials selection, modification development and testing, and inter-personal communication techniques.

The Supervisors, including all supervisors of outlying clinic activities and rural outreach nurse supervisors will receive training in:

- contraception and birth spacing methods and complications including the importance of temporary methods, particularly among young women;

- the importance of integrating birth spacing and extending rural service delivery;
- MCH preventive medicine, use of ORS for diarrheal disease, treatment for acute respiratory infections, nutrition interventions and vitamin supplementation;
- administration and management in planning and the use of the MIS, national survey data and the results of other studies, resource allocation project evaluation reporting systems for the new integrated services and their relationship to the MIS, and the use of the referral system; and
- community education issues including materials selection, modification development and testing, inter-personal communication, group dynamics and education techniques.

The Community-level providers, who are the new PHP community workers and the existing CBDS will receive training in:

- contraception and birth spacing methods and complications including the importance of temporary methods, particularly among young women;
- the importance of integrating birth spacing and extending rural service delivery;
- MCH preventive medicine, use of ORS for diarrheal disease treatment for acute respiratory infections, nutrition interventions and vitamin supplementation;
- administration and management in reporting systems for the new integrated services and their relationship to the MIS, and the use of the referral system; and
- community education issues including materials selection, modification development and testing, inter-personal communication, group dynamics and education techniques.

The Private referral providers, physicians doing referral for SDA in areas not covered by SDA clinics (pilot project) will receive training in:

- contraception and birth spacing methods and complications including the importance of temporary methods, particularly among young women;
- the importance of integrating birth spacing and extending rural service delivery;
- MCH preventive medicine, use of ORS for diarrheal disease, treatment for acute respiratory infections, nutrition interventions and vitamin supplementation;
- administration and management in reporting systems for the new integrated services, their relationship to the MIS, and the use of the referral system; and
- community education issues including inter-personal communications techniques.

This Training Plan is summarized in the following chart:

Training	Levels				
	Med.	Man.	Sup.	CP	RP
1. Contraception and birth spacing methods and complications.	X	X	X	X	X
2. Issues in contraception and birth spacing including the importance of temporary methods, particularly among young women.	X	X	X	X	X
3. Importance of integrating birth spacing and MCH and extending rural service delivery.	X	X	X	X	X
4. MCH preventive medicine, use of ORS for diarrheal disease, treatment for acute respiratory infections, nutrition interventions and vitamin supplementation.	X	X	X	X	X
5. Administration and management:					
a. Planning and use of the MIS, national survey data and the results of other studies;		X	X		
b. Resource allocation and the use of the MIS;	X	X	X		
c. Project evaluation and the importance and use of the MIS;	X	X	X		
d. Reporting systems for the new integrated services and their relationship to the MIS; and	X	X	X	X	X
e. use of the referral system.	X	X	X	X	X
6. Community education issues including:					
a. Materials review, modification and testing;		X	X	X	
b. Materials development and testing;		X	X	X	
c. Inter-personal communication techniques; and	X	X	X	X	X
d. Group dynamics and education techniques.			X	X	

Training Revision: Training for each of these groups of service personnel in each topic area will be planned, designed and supervised by the SDA education and training division. Training delivery will be done by the SDA staff, technical assistance specialists, use of new curricular materials and assistance from outside institutions. The institutions which may provide training include the Maternity Hospital in San Salvador (particularly for training doctors), a university teaching hospital with the capacity to train referral physicians in contraceptive techniques; FEPADE, a private organization which may offer training in management subjects; CENCAP, a Ministry of Agriculture organization which has training capacity in rural education and outreach. CENCAP trainers are currently receiving instruction in family planning from Johns Hopkins University in a pilot project funded by USAID/El Salvador.

The training and education department of SDA, with technical assistance provided through the Project, will take responsibility for development of training materials, special courses (for example, in MCH subjects). They will also prepare materials to be distributed to the end-users (for example, photo comic books and pamphlets on BS and MCH subjects: see below).

B. Participant Training:

This training will take place in the United States or a third country in Latin America. Training will be provided in those subjects in which technical assistance is being provided, with the objective of preparing a Salvadoran national to fulfill the functions covered by TA.

Training directly related to the first component is:

a) One person will receive post-graduate training in Rural Population and Health Development; and
b) One person will receive post-graduate training in Quality Assurance procedures for Clinic Monitoring.

In the area of institutional development (Component II), certain SDA personnel will receive medium and long-term training in those areas in which SDA will receive foreign technical assistance. The objective will be to provide high quality training to national personnel in the specialities in which TA is being provided in order to be able to replace foreign assistance by national personnel by the end of the Project.

Advanced training is planned in the following areas:

a) One person will receive post-graduate training in Health Systems Management (12 to 18 months in 1992);
b) Two persons will receive Master's level training in Instructional Design and Development for Health, probably at the Catholic University of Chile, Santiago (18 months in 1991);
c) Two persons will receive post-graduate training in Social Marketing Theory and Practice (12 to 18 months in 1993);

d) Two persons will receive post-graduate training in administration and financial analysis and planning, probably at INCAE, in San Jose, Costa Rica (12 to 21 months in 1992);
e) One person will receive long-term training in Rural Population and Health Development during 1992;
f) One person will receive training in Quality Assurance for clinic monitoring during 1991;
g) Four persons will receive short-term training between 1991 and 1992 in administration of educational efforts in similar programs in other countries in the region (APROFAM, ASHONPLAFA, etc.)(one month);
h) Three persons will receive short-term and orientation in Social Marketing efforts in similar programs in other countries in the region (APROFAM, ASHONPLAFA, etc., during a one month period between 1991 and 1992; and
i) A number (approximately 10) of SDA personnel will participate in observational travel, conferences and seminars. Approximately $ 220,000 has been budgeted for these activities over LOP.

Training Design and Development:

The organization of both service and participant training efforts will require a series of design and development steps, all of which will be within the existing skills of the SDA personnel and technical assistance provide by the institutional contractors. These will include:

1. Problem analysis and specification (including bibliographic review). This step requires basic analysis of the difference between the existing situation, target groups required knowledges and attitudes (current abilities) and the desired "end state" (better health indices) and the specification of the discrepancies between the two states;

2. Establishment of specific objectives, done on the basis of the examination of the discrepancy list (#1), developing one or more objectives for each of the discrepancies;

3. Learner Entry Behavior analysis is required in order to have a clear idea of what are the probable existing levels of education, literacy, motivation, etc., which will establish the beginning points for the educative efforts;

4. Behavior by Content analysis, the study of what knowledges and skills are required to lead the user to those final behaviors which will improve her ability to direct and manage her own and her family's health situation. Specification of required behaviors of TBAs , nurses, doctors and other facilitators, is a critical step, because it is important to be able to provide them with the training which they will need to be able to successfully stimulate participation, insure adequate attention and effort to

learn, facilitate comprehension through provision of extra examples from the real-world life of the user, evaluate mastery by the users, etc.;

5. Establishment of evaluative criteria for training success, i.e. how do we know that the target groups learned and applied the knowledge, and that the application had some positive effect on someone's health?;

6. Media selection is the step in which the designers decide which specific medium or group of media will have the best possibility of effectively communicating the information and changing the knowledge and skills of the user within the existing cost, environmental and social constraints. Media selection is influenced by its availability within a specific target area (rural or urban) and by the trainee's experience with the media as forms of information delivery;

7. Media development requires material from first drafts and contents of the intervention under consideration, and its translation to the chosen media. The amount of work involved is related to the sophistication of the media;

8. Field testing of media drafts is critical in order to insure that they have the planned effect. These tests gather information from users about what they understand and do not understand, about their affective reactions to the information which they are learning and their probable disposition to use the knowledge and skills which they are acquiring. This step may be repeated more than once, as required and useful;

9. Revision and improvement of materials following the field tests is the logical activity of incorporating feedback;

10. Final production follows the last revision, once the required level of tested effectiveness is achieved;

11. Distribution of the materials takes place, according to the training plan;

12. Field implementation is the point at which the materials are distributed to a broad array of potential clients (users), through those mechanisms which have been previously designed; and

13. Follow-up and effectiveness evaluation utilize the same criteria (16) previously established to measure the effect of the materials in mass use.

	APR. 90	OCT. 90	APR. 91	OCT. 91	APR. 92	OCT. 92	APR. 93	OCT. 93	APR. 94	OCT. 94	APR. 95
SERVICE TRAINING											
1. Doctors, Medical Personnel	X	X	X	X	X	X	X	X	X	X	X
2. Middle-Manaaers	X	X	X	X	X	X	X	X	X	X	X
3. Supervisors	X	X	X	X	X	X	X	X	X	X	X
4. CBD/PP	X	X	X	X	X	X	X	X	X	X	X
5. Referral Doctors	X	X	X	X	X	X	X	X	X	X	X
6. Strategic Planning		X	X	X	X	X	X	X	X	X	X
7. MBO		X	X	X	X	X	X	X	X	X	X
PARTICIPANT TRAINING											
1. Rural Pop. & Health		X	X	X	X	X	X	X	X		
2. Quality Assurance			X	X	X	X	X	X	X		
3. Health Systems Mgt.		X	X	X	X	X	X	X	X		
4. Instructional Dev.			X	X	X	X	X	X	X	X	
5. Social Marketing		X	X	X	X	X	X	X			
6. Admin. & Managemen			X	X	X	X	X	X			
7. Admin. of IEC	X	X	X	X							
8. Soc. Mkt. Orien.	X	X	X	X							

ANNEX I

DETAILED PROCUREMENT PLAN

I. ASSESSMENT OF HOST COUNTRY CONTRACTING CAPABILITIES

Throughout the implementation of the on-going Improved Delivery of Family Planning Services (519-0275) and the Population Dynamics (519-0210) projects, host country procurement activities have been undertaken by the Salvadoran Demographic Association using host country contracting following USAID Handbook 11 procedures and SDA procedures accepted by USAID. Most of these activities were limited to the procurement of services for evaluation and research purposes and office/medical supplies and equipment. Purchases over $25,000 were approved by USAID through Project Implementation Letters.

SDA's own procurement process is done by the purchasing department at central headquarters. Department directors make requests for products or services and if the products are not available at the warehouse, three bids are requested to decide which supplier will provide the product. A purchase order is issued and sent to the lowest bidder. Upon receipt of the merchandise and invoice the goods received are verified against the purchase order. If the goods are accepted the accompanying invoice is sent to the accounting department for coding and payment. The cashier's office issues payments directly to the supplier. SDA auditors manage internal purchasing controls in cooperation with external auditors. For local purchases, the necessary canvassing of potential bidders can be done by SDA, since they have the mechanism to advertise, select and monitor contractor performance.

Under the Family Health Services project, the SDA will continue with local procurement for supplies and services. The procurement mechanisms will be supervised/monitored by the PSC procurement specialist at USAID's HPN office.

II. PROCUREMENT

This project will include both foreign and local procurement of supplies and services. Host Country procurement will be carried out by SDA following its own procurement mechanisms, which conform to AID procurement regulations. A.I.D. direct procurement will either be carried out by an Institutional Contractor/Procurement Services Agent (PSA) under the guidance of the PSC procurement Specialist in USAID/El Salvador, or by ST/POP/CPSD through the General Services Administration (GSA) and Veterans Administration.

U.S. Procurement: This type will include USAID/El Salvador's procurement of services, the procurement of foreign supplies and services through an Institutional Contractor Purchasing Services Agent, and procurement carried out by AID/W.

USAID Procurements: USAID direct procurements will be limited to services and certain commodities covered by GSA or other governmental agencies. An institutional contractor will act as procurement specialist for the Project. In conformance with recent policy standards, an 8(a) firm will be selected as the IC/Purchasing Services Agent. In addition, the USAID will initiate buy-ins against AID/W centrally funded contracts to carry out selected surveys and research activities as well as project audits and evaluations during the life of the project, and the final project evaluation.

General Services Administration (GSA) Procurements: Contemplated procurements carried out by the GSA under this Project and GSA contract venders will include contraceptives, following the current centrally managed procurement system implemented and monitored by ST/POP/CPSD. Contraceptive requirements will be determined by ST/POP/CPSD and CDC in conformance with the Standard Contraceptive Procurement Tables (CPTs) developed by AID/W. These tables will be updated yearly with corresponding projections for the following four years. Contraceptives purchased under this project will cover both SDA needs and those of the Salvadoran Social Security Institute.

Purchasing Services Agent (PSA) Procurements: As stated above, USAID will contract an Institutional Contractor (IC), that will provide purchasing services besides the technical assistance services described in Annex J. These services will be defined in the PIO/T to be issued by USAID/El Salvador. Specific Federal and USAID Procurement Regulations shall be followed by the IC/PSA in charge of these services. The IC/PSA will undertake procurement of Commodities and of Services:

1. COMMODITIES

a. Pharmaceuticals: The type of pharmaceuticals required under the Project are basic drugs which do not have restricted acquisition regulations, i.e., antiparasitics, vitamins, Oral Rehydration Salts (ORS). Their procurement will be coordinated through the US/PSC Procurement Specialist in the HPN Office of USAID/El Salvador. M/OP/OCMS and the VA will provide necessary procurement support for procurement of pharmaceuticals and related items, i.e. ORS (to be acquired through a buy-in using ST/H).

b. Medical, office and warehouse equipment and supplies: Additional medical equipment required in the SDA clinics and the Central Referral Clinic will be listed by the Association and the specifications reviewed by the technical assistance team. This equipment will be obtained through the IC/PSA in conformance with AID/Federal Acquisition

Regulations. The IC/PSA mechanism will also be used to procure large office equipment required under the Project to implement an efficient management information system.

c. Vehicles: The present SDA fleet will be modernized and standardized to avoid maintenance problems faced due to the array of makes and models currently owned by the implementing agency. The new vehicles will be of U.S. origin, procured via the IC/PSA mechanism.

Delivery of all equipment and materials purchased under the Project will specify CIF, San Salvador or a U.S. Dispatch Agent in Miami for surface freight (via Santo Tomas), and CIF Comalapa for air freight and the 70% U.S. Flag Carrier requirement will be observed. Receipt, distribution and use of goods will be handled by the SDA. Funding from this Project may finance the contracting of one additional port reception person to clear customs and initiate receiving reports.

The foreign procurement mechanism will also utilize the Fedstrip system which will expedite the acquisition and reception of goods to avoid delays in project implementation, as well as the GSA pre-contracting system.

2. SERVICES:

The IC/PSA will manage Project participant training according to Handbook 10, Participant Training regulations. In addition, the IC/PSA will contract short-term technical assistance as needed under the Project. Likewise, the IC/PSA and SDA will coordinate the procurement of necessary publicity services, which are not already included in the advertising agency services to be contracted by SDA following the AID Host Country Contracting procedures (See below). This procurement may include services offered by US based firms with experience in IEC/Mass Media campaigns.

a. Host Country Procurement: The SDA will implement these activities under the guidance of HPN's PSC Procurement Specialist following AID regulations and established SDA procedures described earlier in the Procurement Plan. Project implementation may require small quantities of supplies available locally, most of them limited to office supplies. The SDA will provide USAID with an action plan and detailed budget to cover these anticipated procurements. Upon written approval by USAID of the action plan, SDA will receive a local currency advance to cover the proposed purchases. USAID approval of tender documents and contracts will be required only for contracts exceeding the equivalent of $25,000. Any transaction not meeting AID requirements will be disallowed.

b. Local contracting will include: (a) training sessions, (b) contracting of personnel, (c) some IEC service contracts, (d) restoration of clinics and for renovation of the SDA building for the Central Referral Clinic.

The IEC service contract may be the largest Host Country contract. SDA has experience in this type of procurement having successfully contracted two qualified local agencies during implementation of Project 519-0210. The SDA will utilize similar public bidding and selection mechanisms for the Family Health Services Project. Prior written approval from USAID/El Salvador will be required for any procurement of goods and/or services over the $25,000 limit established. In addition, in compliance with AID regulations, the SDA will also adhere to the requirement to announce procurements exceeding $25,000 in the Commerce Business Daily.

Restoration and remodeling of clinics and of the SDA building will follow the guidelines provided in standard AID regulations for contracting these types of specific services.

A second large host country procurement will be the contract for services to carry out the Family Health Services Survey planned for 1993 (FESAL-93). This survey will be carried out with the technical advise of the CDC, similar to FESAL-88. There will be no charges incurred under this Project for the CDC services.

The SDA will contract local firms to carry out other research as well as internal and programmatic evaluations during the life of the project.

III. SOURCE AND ORIGIN:

The source and origin for procurement of vehicles, contraceptives, medical, office and warehouse equipment, most pharmaceuticals and some medical instruments and supplies will be limited to AID Geographic Code 000. Other equipment, materials, participant training, and services purchased with foreign exchange will include source and origin in the United States, CBI designated Central American Common Market countries and Geographic Code 935.

IV. WAIVERS to be required:

1. A Source and Origin Waiver may be required for Vehicles.

2. For specific training by non-US or CACM sources.

SCHEDULE FOR PROCUREMENTS
(First year of the project)

Type	Action	Estimated Date
IC/PSA Contract	PIO/T issued by USAID/ES (8a firm)	June 1990
	Negotiations	August 1990
	Contracting	September 1990
	TA team arrives	October 1990
Contraceptives (First shipment)	PIO/C issued by USAID/ES	July 1990
	AID/W gets the request	August 1990
	AID/W procures contraceptives	October 1990
	Shipments begin to arrive	January 1991
Oral Rehydration Salts (Buy-in)	PIO/C issued by USAID/ES	January 1991
	AID/W receives the request	January 1991
	AID/W procures the ORS	March 1991
	ORS shipments begin arriving	May 1991
Pharmaceuticals	PIO/C issued by USAID/ES	December 1990
	AID/W receives, reviews	January 1991
	V.A. receives requests Issues tenders Receives/evaluates/awards	January 1991 February 1991 May 1991
	Shipments begin arriving	July 1991
Supplies, Equipment and Vehicles	PIO/Cs issued by USAID/ES	December 1990/ January 1991
	IC/PSA issues tenders	January/ February 1991
	IC/PSA receives bids evaluates and awards	March 1991
	Shipments begin arriving	May 1991

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ANNEX J
TECHNICAL ASSISTANCE PLAN

Technical assistance will be provided to the SDA under each component of the Project. In view of the extent of technical assistance required, it will be contracted directly by AID through authority to be contained in the Cooperative Agreement. Given the qualifications and experience required for the long term advisors, it is believed that third country nationals, as well as U.S. personnel will be likely candidates, with the exception of one long-term Logistics Coordinator, and one short-term Promotion Specialist local hire positions.

The SDA will be involved in finalizing the scopes of work for the technical assistance team to ensure that they feel their needs have been adequately reflected. Long-term technical assistance advisors will be provided for the duration of the project, as specified below.

A. Technical Assistance Requirements:

International Long-Term Technical Assistance	Person Months-Yr.						Total
Title	90	91	92	93	94	95	
Health Management Advisor/COP	3	12	12	12	12	3	54
Finance and Accounting Advisor	3	12	12	12	12	3	54
Rural Health Education Advisor	3	12	12	12	12	3	54
Educational Materials Advisor	3	12	12	12	12	0	51
Procurement Assistant	0	12	12	12	6	0	42
Sub-Total	12	60	60	60	54	9	255

International Short-Term Technical Assistance							
Specialty	90	91	92	93	94	95	
Social Marketing and Advertising	3	3	3	3			12
Personnel Specialist		4	4	3	2		13
Medical Quality Assurance		6	4	4	2	2	18
Logistics		3	3	2			8
Research		3	12	12	12	6	45
Sub-Total	3	19	26	24	16	8	96

National Long-term Assistance							
Title	90	91	92	93	94	95	
Logistics Coordinator	3	12	12	12	12	6	57
MIS Specialist	3	12	12	12	12	6	57
Monitors (4 persons)	16	48	48	48	48	24	232
Sub-Total	22	72	72	72	72	36	346

National Short-Term Assistance							
Title	90	91	92	93	94	95	
Advertising and Promotion	0	2	2	2	2	2	10
Sub-Total							10

SDA Counterpart Personnel for Technical Assistance:

Technical Assistance	SDA Counterpart
Health Management Advisor/COP	Executive Director
Finance and Accounting Advisor	Chief, Dept. of Admin.
Rural Health Education Advisor	Medical Director
Educational Materials Advisor	IEC Director
Procurement Assistant	Department of Admin.
Social Marketing and Advertising	IEC Director
Personnel/Reimbursements	Chief, Dept. of Admin.
Medical Quality Assurance Specialist	Medical Director
Logistics	Chief, Dept. of Admin.
Research	Chief, Research Dept.
Logistics Coordinator (local hire)	Chief, Dept. of Admin.
MIS Specialist	Research Department
Monitors (4 local hires)	
Advertising and Promotion (local hire)	IEC Director

B. General Scopes of Work for Technical Assistance Personnel:

1. The Health Management Advisor/Chief of Party (COP) who will be contracted for the duration of the Project, i.e. fifty-four man months will dedicate approximately one-half of his/her time to efforts in Family Health Service Delivery and one-half to efforts in Institutional Development.

The Chief of Party (COP) will be a health planner who will work with the Executive Director of SDA as his principal counterpart. The COP will coordinate and supervise the activities of the other members of the technical assistance team. He/she will be the principal contact between the team (and the contracting company), SDA and AID. He/she will review their scopes of work and periodic work plans with them and SDA colleagues to assure relevance, appropriateness, and feasibility, especially with regard to SDA policies, plans, programs, and activities. As necessary and appropriate, he/she will assist SDA and the other consultants to revise the scopes of work and work plans in keeping with those criteria. He/she, with SDA counterparts, will also coordinate the overall efforts of the team and of the individual consultants with those of short-term technical assistance personnel.

The COP/Health Planning Advisor will assist his/her technical counterpart in all areas of family planning, birth spacing and maternal/child care with emphasis on those areas and tasks specifically noted in the Project Paper and on those SDA activities directly related to the Project's purpose, outputs, and activities.

The COP will also help organize sessions in strategic planning for Board Members and the Executive Director, and will assist Board Members and the Executive Director to reevaluate existing goals and objectives on a continuing basis.

He/she will organize training in and installation of a Management by Objectives (MBO) program for the Executive Director and the Division and Department Chiefs of SDA. Development of such procedures will focus efforts to orient all activities toward stated objectives with assigned resources and within established time limits. The Health Management Advisor will provide sufficient support to this program to insure achievement of the optimal level of success.

The COP/Health Management Advisor will assist SDA in arranging procedures for defining the role of the Pro-Familia Health Providers, and the criteria for their selection. He/she will assist SDA in the organization of the new satellite Clinics, the Central Referral Clinic, and the market place distribution posts, including their planning, preparation, implementation and the evaluation of their effectiveness.

2. The Finance and Accounting Advisor will be contracted for the duration of the Project (fifty four months). This person will dedicate one hundred percent of his/her time to Institutional Development, particularly developing the procedures needed to administer and manage the SDA programs at an optimal level. He/she will work under the direction of the Chief of Party. As the Financial and Accounting Advisor, he/she will work closely with the Director of the SDA Administration Department for development of the Unit.

The Advisor's work will involve a systematic analysis and description of SDA's financial and accounting systems and of their objectives, strengths, weaknesses, and problems; determination of priority problems and issues; definition of specific problems requiring solutions; definition of criteria for useful solutions to problems; development and an initial feasibility assessment of alternative approaches to solving problems and improving financial systems; and further development, assessment, specification and testing of promising solutions and approaches to improve the SDA's financial and audit mechanisms.

He/she will assist the SDA to improve financial and management capabilities to plan and budget for the Project activities. He/she will assist SDA to improve controls to safeguard and account for Project funds, establish standard operating procedures to account for and properly liquidate A.I.D. disbursements and to carry out periodic internal control audits. Further, he/she will assist in insuring the SDA accounting system complies with generally accepted accounting principals and with the Salvadoran government's legal requirements, and will assist the SDA to modify and refine its present accounting manual to conform with accrual accounting procedures acceptable to A.I.D. and in compliance with Salvadoran accounting/auditing authorities.

The Finance and Accounting Advisor will assist the SDA to develop a financial data processing system which conforms to the accounting standards mentioned above. SDA's systems for the following key functions

will be studied in detail:

- Cash payment journal;
- Liabilities i.e. accounts payable journal;
- General ledger reconciliations to sub-accounts;
- Bank reconciliations; and.
- Approval of journal entries by appropriately relevant officials.

The Finance and Accounting Advisor will help SDA to more clearly define the differences between the financial, administrative and accounting functions, so that management by objectives will be a feasible goal and the accounting system will facilitate establishment of fixed and recurrent costs.

3. The Rural Health Education Advisor, will be contracted for the entire length of Project (fifty four months). One hundred percent of his/her time will be dedicated to Family Health Service Delivery, particularly developing rural service expansion, as well as assisting in improvement of information, education and communications.

The Project's Rural Health Education Advisor will be a health or training professional with adequate and appropriate experience in task analysis and in design, development and implementation of competency-based training programs for volunteer health distributers. He or she will work closely with the Director of the SDA's IEC Department, with other members of the unit, with persons who have training responsibilities at central and regional levels, and with SDA and TA personnel who are developing norms and standards for job performance within the basic health care services and support systems.

The Advisor will help SDA colleagues (and other T.A. personnel) to define specific knowledge and skill requirements and to develop and implement appropriate competency-based training and training evaluation programs and materials for the CBDs, PHPs, referral physicians, auxiliaries, graduate nurses, regional supervisory personnel and with other selected jobs in basic health services delivery and support.

4. The Educational Materials Advisor will be contracted for thirty person months and dedicate one hundred per cent of his/her time to developing all forms of instructional materials such as pamphlets, manuals, guidebooks, audio and video cassettes, posters etc., as well as participate in development of effective small group education techniques.

He/she will have at least five years of experience in the latest principals and procedures for the design, development and use of instructional materials, with at least three years experience in lesser developed countries, preferably in Central America. She/he will be knowledgeable about specification of learning goals and objectives, media selection, methods of presentation and evaluation procedures including field testing and resource techniques.

She/he should be conversant with human learning theory as it applies to rural and marginal urban population and to development of educational materials. She/he should also be knowledgeable about latest techniques for insuring learning through the use of instructional materials such as pamphlets, manuals, posters, photo-novels and other media/forms in order to identify and develop models which will be most useful in this Project taking into account the socio cultural context.

She/he will, with the IEC Director and members of the staff, evaluate existing materials, collect materials from similar projects in other countries and from the MOH. Existing materials will be modified and revised and new materials produced. The Advisor will assist the SDA to evaluate and validate the effectiveness of all instructional methods on a constant basis.

The Advisor will train appropriate SDA personnel in procedures for the development of educational materials through structured sessions and by means of practical, on the job training. She/he will ensure that a sufficient number of SDA personnel acquire optimal levels of skills and knowledge in this area by the end of his/her contract period.

5 The Social Marketing and Advertising Advisor will be contracted on a short-term basis for twelve person months. The Advisor will train SDA staff in social marketing principles and procedures and assist in developing advertising campaigns.

6. The Personnel Specialist will assist SDA to develop an efficient Personnel Department and Personnel Manual. The manual will establish a clear personnel code and comprehensive job descriptions to define SDA personnel positions/responsibilities and deal with related personnel issues. The job descriptions for all positions will reflect a systematic interrelation of functions and responsibilities. The Advisor will develop techniques to ensure that employees have a clear understanding of their individual responsibilities and develop techniques to assure that SDA's employees are evaluated and held responsible for complying with their specific job functions. The advisor will assist SDA to develop, and put into practice, procedures which will ensure that promotions and salary increases are systematically based on performance standards.

She/he will develop a labor market survey to established the basis for salaries, and will develop clear personnel evaluation, monitoring and supervision mechanisms.

7. The Medical Quality Assurance Specialist will be contracted for a total of eighteen months on short-term assignments spaced over LOP to develop and implement quality assurance procedures. The term quality assurance can be defined as "assuring an acceptable and constant level of high quality in the delivery of medical services offered by the SDA clinic network." The Medical Quality Assurance Specialist will dedicate at least 50% of his/her time to Family Health Service Delivery and 50% to the Institutional Development Component. She/he will work with the

Medical Director to develop and install quality assurance standards for all SDA Clinics, Satellite Clinics and the Referral Clinic.

8. The International Logistics Specialist will be contracted for eight months in the first, second and third years of the Project to assist the SDA in logistics related tasks and issues such as determination of priorities; drafting procurement specifications; understanding local and international procurement procedures, including advertising, tenders, qualifications, and evaluation of offers and offerors. The Specialist will assist the SDA in such tasks as: procurement contracting; receipt and evaluation of goods; follow-up procedures for deficiencies; record keeping and inventory control; warehousing and storage; transportation; ordering and processing and distribution of goods and commodities within the SDA system; supply program monitoring and evaluation etc..

9. Research Specialists, will be contracted for forty-five person months of short-term technical assistance. The specific requirements of each research project will determine the specific qualifications for the individual short-term specialist to be contracted.

Short-term Health Services Research Advisors will be called upon as necessary by the SDA to assist in designing and implementing health services research projects. One individual could be selected to provide assistance on an as-needed basis throughout the project, or several individuals selected for particular areas of emphasis. The specific experience and training and scopes of work will be determined by the SDA based on particular needs throughout the course of the project. The Research Advisors will work with the chief of the SDA Research Department, and with other offices (including regional offices) as appropriate. The Specialists will have appropriate experience in design and implementation of health services research projects at the national, regional and local level, with related experience in developing countries and have experience in training health personnel at all levels of the system in design and implementation of health services research projects.

10. A National Logistics Specialist will be contracted for thirty-six months during years one through four of the project to facilitate inventory and distribution of the Family Health Service Delivery. She/he will work in such areas as: receipt and evaluation of goods received; follow-up procedures for deficiencies; record keeping and inventory control; warehousing and storage; transportation; ordering and processing and distribution of orders within the MOH system; supervising stock level systems, criteria and controls; financial, stock control, and performance monitoring systems; and supply program monitoring and evaluation. This person will be assisted by four monitors.

11. A National Specialist in Advertising and Promotion will be contracted for two months per year during LOP to assist in the planning, design, organization and development of Social Marketing Programs, particularly in relation to media campaigns.

ANNEX K

K.1 *PROJECTION OF EXPENDITURE BY FISCAL YEAR*

Family Health Serv. Delivery
Proposed Budget AID

in 000's US$	FY'90	FY'91	FY'92	FY'93	FY'94	FY'95	Total
I-FAMILY HEALTH SERVICES							
A-Rural-Urban Expansion							
Salaries	219.9	500.3	611.5	814.3	714.2	431.3	3,291.5
Office Supplies	13.1	26.1	26.1	26.1	26.1	13.1	130.6
Medical Supplies	10.9	23.4	26.9	31.0	35.6	19.0	146.8
Utilities	6.5	13.1	13.1	13.1	13.1	6.6	65.5
Uniforms	0.6	1.2	1.2	1.2	1.2	0.6	6.0
Equipment(incl.Veh)Maintenance	10.9	23.4	26.9	31.0	35.6	19.0	146.8
Miscellaneous	6.5	13.1	13.1	13.1	13.1	6.6	65.5
Office Equipment	104.5	209.0	209.0	209.0	209.0	104.5	1,045.0
Contraceptives	147.5	202.5	120.3	145.7	179.2	98.9	894.1
Consulting	43.5	93.6	107.7	123.8	142.4	76.2	587.2
Antiparasite	7.2	15.1	28.4	47.2	53.4	26.7	178.0
Seeds	0.0	19.5	27.0	34.5	34.5	0.0	115.5
Vitamins	0.0	18.7	44.6	59.0	66.2	33.1	221.6
ORS Kits	27.0	40.5	67.5	108.0	135.0	0.0	378.0
Staff Training	0.9	10.0	0.0	10.0	0.0	0.0	20.9
PHP Training	0.0	150.0	60.0	60.0	0.0	0.0	270.0
Total I-A	599.0	1,359.5	1,383.3	1,727.0	1,658.6	835.6	7,563.0
B-Clinical Services							
Salaries	123.5	261.1	305.0	392.9	353.5	206.7	1,642.7
Rent	6.4	9.7	6.9	7.6	30.0	26.0	86.6
Office Supplies	14.7	31.1	34.6	38.6	43.3	22.9	185.2
Utilities	4.4	8.8	8.8	8.8	8.8	4.4	44.0
Miscellaneous	1.7	3.4	3.4	3.4	3.4	1.7	17.0
Uniforms	2.4	2.8	0.9	0.9	0.9	0.4	8.3
Medical Equipment	8.1	8.1	0.0	0.0	0.0	0.0	16.2
Office Equipment	44.8	84.4	80.9	85.0	89.6	46.1	430.8
Renovation 4-clinics	0.0	21.9	21.9	0.0	0.0	0.0	43.8
Warehouse equipment	7.8	7.8	0.0	0.0	0.0	0.0	15.6
Total I-B	213.8	439.1	462.4	537.2	529.5	308.2	2,490.2
C-Patient Referral System							
Salaries	1.6	3.1	0.1	2.3	0.8	0.0	10.9
Medical Supplies	17.5	17.5	0.0	0.0	0.0	0.0	35.0
Training	0.0	9.8	5.0	4.0	1.0	0.0	19.8
Total I-C	19.1	30.4	8.1	6.3	1.8	0.0	65.7
D Participants Training	0.0	30.0	20.0	10.0	10.0	0.0	70.0
E Infor., Comm. & Public Edc.	270.1	540.3	545.3	553.7	560.1	281.6	2,751.1
F Technical Assistance	0.0	541.5	526.5	429.0	285.0	150.0	1,932.0
G Vehicles	260.0	0.0	0.0	0.0	0.0	0.0	260.0
H Contingencies	69.15	69.15	69.15	69.15	69.15	69.15	414.9
TOTAL I	1,431.2	3,010.0	3,014.8	3,332.4	3,114.2	1,644.6	15,546.9

(Cont.) *PROJECTION OF EXPENDITURE BY FISCAL YEA R*

Family Health Serv. Delivery
Proposed Budget AID

in 000's US$	FY'90	FY'91	FY'92	FY'93	FY'94	FY'95	Total
II-INSTITUTIONAL DEVELOPMENT							
A-Clinical Services							
Salaries	36.5	44.6	23.1	44.1	19.0	15.1	182.4
Office Maintenance	0.2	0.3	0.1	0.1	0.1	0.3	1.1
Office Supplies	6.5	7.8	4.0	3.2	2.5	7.1	31.1
Utilities	3.6	4.3	2.2	1.7	1.4	3.9	17.1
Uniforms	0.2	0.3	0.1	0.1	0.1	0.2	1.0
Office Equipment	40.1	48.4	24.6	43.5	19.6	15.2	191.4
Miscellaneous	3.1	3.7	1.9	1.5	1.1	3.3	14.6
Med Equip. for Referral Clinic	6.6	4.0	0.0	0.0	0.0	0.0	10 6
Medical Suppl.-2-Oper.Rms.	7.8	4.7	0.0	0 0	0.0	0.0	12.5
SDA Building Renovation	62.0	37.5	0.0	0.0	0 0	0.0	39 5
Personnel Training	14.8	10.9	6.8	5.9	5.0	0.0	43.4
Total II-A	181.4	166.5	62 8	100.1	48.8	45.1	604.7
B-Social Mktng Expansion							
Salaries	34.8	52.9	14.1	42.1	72.7	40.7	257.3
Contraceptives	110.9	109.5	16.0	57.6	116.4	67.3	477.7
Comissions	17.4	26.4	7.0	21.0	36.3	20.4	128.5
Total II-B	163.1	188.8	37.1	120.7	225.4	128.4	863.5
C-Participant Training	0.0	30.0	30.0	30.0	30.0	30.0	150.0
D-Technical Assistance	0.0	491.5	431.5	409.0	319.0	154.0	1,805.0
E-Contingencies	69.15	69.15	69.15	69.15	69.15	69.15	414.9
TOTAL II	413.7	946.0	630.6	729.0	692.4	426.7	3,838.1

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(Cont.) *PROJECTION OF EXPENDITURE BY FISCAL YEA R*

Family Health Serv. Delivery
Proposed Budget AID

in 000's US$	FY'90	FY'91	FY'92	FY'93	FY'94	FY'95	Total
III- POLICY DEVELOPMENT & RESEARCH							
A-Program Coordination-Donors	10.0	10.0	10.0	10.0	10.0	10.0	60.0
Total III-A	10.0	10.0	10.0	10.0	10.0	10.0	60.0
B-Prog. Coord. Research							
FESAL 93	0.0	11.2	132.6	134.0	12.6	0.0	290.4
MCH	20.6	20.6	24.0	39.7	39.7	24.0	168.6
IUD STUDY	5.1	5.1	0.0	0.0	0.0	0.0	10.2
Studies & Resrch in Contracep.	13.1	26.4	27.2	29.1	32.1	16.8	144.7
Further Anal. of Prev. FESAL's	15.0	15.0	0.0	0.0	0.0	0.0	30.0
Total III-B	53.8	78.3	183.8	202.8	84.4	40.8	643.9
C-Technical Assistance	0.0	45.0	180.0	180.0	180.0	90.0	675.0
D-Contingencies	69.15	69.15	69.15	69.15	69.15	69.15	414.9
TOTAL III	133.0	202.5	443.0	462.0	343.6	210.0	1,793.8
IV- EVALUATIONS							
A-Evaluation SDA Clinical Services	4.6	10.3	12.9	7.2	0.0	0.0	35.0
B-Evaluation SDA Training & Edc.	2.4	5.5	6.9	8.0	8.8	4.6	36.2
C-Audits / Project Evaluation	75.0	150.0	150.0	150.0	75.0	150.0	750.0
TOTAL IV	82.0	165.8	169.8	165.2	83.8	154.6	821.2
TOTAL A I D	2,059.8	4,324.2	4,258.1	4,688.5	4,233.9	2,435.8	22,000.0

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Budget by Component Type A.I.D. in 000's US$	COMPONENT I Family Health Services	COMPONENT II Institutional Development	COMPONENT III Policy Development and Research	AUDIT EVALUATION	TOTAL
1.0 TECHNICAL ASSISTANCE					
1.1 Long Term/International	1,665.00	1,215.00			2,880.00
1.2 Short Term/International	195.00	570.00	675.00		1,440.00
1.3 Local Long Term	72.00				72.00
1.4 Local Short Term		20.00			20.00
1.5 Consulting	587.20				587.20
Subtotal	2,519.20	1,805.00	675.00		4,999.20
					0.00
2.0 TRAINING					0.00
2.1 Participant Training	70.00	150.00			220.00
2.2 Short In Country	310.70	43.40			354.10
Subtotal	380.70	193.40			574.10
					0.00
3.0 LOGISTIC					0.00
3.1 Rent	86.60				86.60
3.2 Office Supplies	315.80	31.10			346.90
3.3 Utilities	109.50	17.00			126.50
3.4 Miscellaneous	82.50	14.60			97.10
3.5 Uniforms	14.30	1.00			15.30
3.6 Medical Equipment	16.20				16.20
3.7 Office Equipment	1,475.90	191.40			1,667.30
3.8 Renovation of Clinics	43.80	99.50			143.30
3.9 Warehouse Equipment	15.60				15.60
3.10 Medical Supplies	191.90				191.90
3.11 Equipment Maintenance	146.80				146.80
3.12 Office Maintenance		1.10			1.10
3.13 Contraceptives	894.10	477.70			1,371.80
3.14 Antiparasite	178.00				178.00
3.15 Seeds	115.50				115.50
3.16 Vitamins	221.60				221.60
3.17 ORS Kit	378.00				378.00
3.18 Med. Equip. for Referral Clinics		19.60			19.60
3.19 Med. Supplies for Operat. rooms		12.50			12.50
3.20 Vehicles	260.00				260.00
Subtotal	4,535.90	856.50			5,392.40
					0.00
4.0 PROGRAM ADMINISTRATION & COORDINATION					0.00
4.1 Salaries	4,945.10	439.80			5,384.90
4.2 Program Coordination			60.00		60.00
4.3 Commissions		128.50			128.50
Subtotal	4,945.10	568.30	60.00		5,573.40
					0.00
5.0 INFORMATION, EDUCATION & COMMUNICATION					0.00
5.1 Information, Coop.& Publicity	2,751.10				2,751.10
Subtotal	2,751.10				2,751.10
					0.00
6.0 RESEARCH					0.00
6.1 Research FESOL			320.40		320.40
6.2 Research MCH			168.60		168.60
6.3 IUD Study			10.20		10.20
6.4 Contraceptives			144.70		144.70
Subtotal			643.90		643.90
					0.00
7.0 AUDIT AND EVALUATIONS					0.00
7.1 Audit				750.00	750.00
7.2 Evaluation of SDA Clinics Serv.				35.00	35.00
7.3 Evaluation of Training&Educ.				36.20	36.20
Subtotal				821.20	821.20
					0.00
8.0 CONTINGENCIES AND INFLATION					0.00
8.1 Contingencies and Inflation	414.90	414.90	414.90		1,244.70
Subtotal	414.90	414.90	414.90		1,244.70
					0.00
GRAND TOTAL	15,546.90	3,838.10	1,793.80	821.20	22,000.00
					0.00

BEST AVAILABLE

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ANNEX K

ROJECT 519-0363 FAMILY HEALTH SERVICES	AMOUNT	METHOD OF IMPLEMENTATION	METHOD OF FINANCING
COMMODITIES			
COMPONENT I			
Medical Supplies	181.80	H./C/INST. CONT.	DIRECT REIMB
Office Equipment	1,475.80	H./C/INST. CONT.	DIRECT REIMB
Contraceptives	894.10	AID/GSA	DIRECT PAYMENT
Antiparasite	178.00	INST. CONT.	DIRECT PAYMENT
Seeds	115.50	INST. CONT.	DIRECT PAYMENT
Vitamins	221.60	INST. CONT.	DIRECT PAYMENT
ORS Kits	378.00	INST. CONT.	DIRECT PAYMENT
Medical Equipment	16.20	INST. CONT.	DIRECT REIMB
Warehouse Equipment	15.60	INST. CONT.	DIRECT REIMB
Vehicles	260.00	INST. CONT.	DIRECT REIMB
COMPONENT II			
Office Equipment	191.40	H.C./INST.CONT.	DIRECT REIMB
Med. Equip. for Ref. Clinic	10.60	INST. CONT.	DIRECT REIMB
Medical Supplies Oper. Rms	12.50	INST. CONT.	DIRECT REIMB
Contraceptives	477.70	AID/GSA	DIRECT PAYMENT
TOTAL COMMODITIES	4,428.80		
LOGISTICS			
COMPONENT I			
Salaries	4,945.10	HOST COUNTRY	DIRECT REIMB
Office Supplies	315.80	HOST COUNTRY	DIRECT REIMB
Utilities	109.50	HOST COUNTRY	DIRECT REIMB
Uniforms	14.30	HOST COUNTRY	DIRECT REIMB
Equipment Maintenance	146.80	HOST COUNTRY	DIRECT REIMB
Miscellaneous	82.50	HOST COUNTRY	DIRECT REIMB
Rent	86.60	HOST COUNTRY	DIRECT REIMB
COMPONENT II			
Salaries	439.80	HOST COUNTRY	DIRECT PAYMENT
Office Maintenance	1.10	HOST COUNTRY	DIRECT PAYMENT
Office Supplies	31.10	HOST COUNTRY	DIRECT PAYMENT
Utilities	17.00	HOST COUNTRY	DIRECT PAYMENT
Uniforms	1.00	HOST COUNTRY	DIRECT PAYMENT
Commissions	128.50	HOST COUNTRY	DIRECT PAYMENT
Miscellaneous	14.60	HOST COUNTRY	DIRECT PAYMENT
TOTAL LOGISTICS	6,333.70		

TECHNICAL ASSISTANCE			
COMPONENT I			
Technical Assistance	1,932.00	DIR. AID PROCRMNT	DIRECT PAYMENT
Consulting	587.20	DIR. AID PROCRMNT	DIRECT PAYMENT
COMPONENT II			
Technical Assistance	1,805.00	DIR. AID PROCRMNT	DIRECT PAYMENT
COMPONENT III			
Technical Assistance	675.00	DIR. AID PROCRMNT	DIRECT PAYMENT
TOTAL TECH. ASSISTANCE	4,999.20		
TRAINING (LOCAL)			
COMPONENT I			
Staff Training	20.90	HOST COUNTRY	DIRECT REIMB
PHP Training	270.00	HOST COUNTRY	DIRECT REIMB
Training	19.80	HOST COUNTRY	DIRECT REIMB
COMPONENT II			
Personnel Training	43.40	HOST COUNTRY	DIRECT REIMB
TOTAL LOCAL TRAINING	354.10		
PARTICIPANT TRAINING			
COMPONENT I			
Participant Training	70.00	AID/IC	DIRECT REIMB
COMPONENT II			
Participant Training	150.00	AID/IC	DIRECT REIMB
TOTAL PARTICIPANT TRNING	220.00		
CLINIC RENOVATION			
COMPONENT I			
Renovation 4-clinics	43.80	HOST COUNTRY	DIRECT REIMB
COMPONENT II			
SDA Building Renovation	99.50	HOST COUNTRY	DIRECT REIMB
TOTAL CLINIC RENOVATION	143.30		

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PROGRAM COORDINATION DONORS			
COMPONENT III	60.00	HOST COUNTRY	DIRECT REIMB
TOTAL PROG. COORD. DONORS	60.00		
RESEARCH			
COMPONENT III			
FESAL 93	290.40	HOST COUNTRY	DIRECT REIMB
MCH	168.60	AID DIRECT	BUY-IN
IUD Study	10.20	AID DIRECT	BUY-IN
Studies and Research			
Contracept.	144.70	AID DIRECT	BUY-IN
Anal. of Prev. FESAL's	30.00	HOST COUNTRY	DIRECT REIMB
TOTAL RESEARCH	643.90		
INFO./COM./PUB./& ED.			
COMPONENT I	2,751.10	H.C./I.C.	DIRECT REIMB
TOTAL-INFO.COM./PUB./ED.	2,751.10		
EVALUATIONS/AUDITS			
Eval. SDA Clinical Srvcs	108.39	HOST COUNTRY	DIRECT REIMB
Eval. SDA Trng & Educ.	112.81	HOST COUNTRY	DIRECT REIMB
Audits/Prj. Evaluation	600.00	AID DIRECT	DIRECT PAYMENT
TOTAL EVALUATIONS/AUDITS	8[illegible].20		
CONTINGENCIES & INFLATION			
TOTAL CONT & INFLATION	1,244.70		To be Determined
ROJECT TOTAL	22,000.00		

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