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POPULATION STRATEGY PAPER: EL SALVADOR

1978 REVISION

USAID/ El Salvador

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EXECUTIVE SUMMARY

El Salvador continues to experience an excessive rate of population growth estimated at 3.3% yearly with a crude birth rate of approximately 40/1000. Although the GOES, in recognition of the adverse effects on development prospects of such rapid growth, established a National Population Policy in 1974, family planning practice levels by geographic area remain relatively low, averaging 14.2% of women in fertile age in 1975, with coverage particularly deficit in rural areas.

This paper presents a strategy for assisting the GOES in design and implementation of more focused family planning service activities and development policies that can create a greater impact on fertility during 1978 through 1982. Whereas Mission policy has focused nearly exclusively on expanding delivery of fertility control services, the key factor in reducing fertility, the objective of this strategy is to assist the GOES in 1) defining target groups that contribute disproportionately to population growth, and 2) directing intensified motivational campaigns and services to them not only in family planning, but also through population-related activities in other sectors. To this end the Mission will stimulate the GOES to increase its attention to the specific target groups identified in this Strategy -- rural men, rural women, adolescents and marginal urban populations -- and will support actions to develop operational approaches to influence each group. Various programmatic alternatives for each target population, defined by location and age, are proposed.

An analysis of the GOES five year target of contraceptive prevalence coverage of 317,000 women in fertile age leads the Mission to believe that it is unrealistically high on the basis of the proposed GOES long-range program as currently outlined. Our judgement is that a more accurate projection would be 38% of married women in reproductive age, totalling 222,000 by 1982, which would represent a decline in the CBR to at least 33/1000. The Mission's Strategy is designed to assure that the GOES not only reaches this coverage level, but develops the institutional capability to exceed it in future years.

USAID/ES priorities will focus on two general areas. Continued assistance will be provided for operational programs to extend the availability of family planning services by support to the voluntary sterilization program; cost-effective and community-based delivery systems, increasingly integrated with health, nutrition, agriculture and education actions; adolescent fertility initiatives; and clinic improvement approaches.

Second, attention will be given to the broader needs of "population policy" development. For this purpose, the Mission will be increasing its advisory assistance to the National Population Commission to identify fertility determinants in the El Salvadoran context as a basis for the development of programs that increase motivation for smaller families. The Mission will place particular emphasis in generating greater GOES commitment to the stimulation of community participation in population planning and improvement in the status and role of women in the development process.

Within the timeframe of this Strategy, 1978-1982, the Mission estimates its technical assistance commitment to the El Salvador population program at approximately \$3.9 million, which would be complementary to the \$20 million national counterpart and the \$7.9 million estimated from the other international donors.

TABLE 1
RELEVANT DEMOGRAPHIC AND SOCIAL DATA

| | |
|---|-------------------------|
| Population (estimate as of July 1977) | 4,387,000 ^{1/} |
| Crude Birth Rate (per thousand), 1976 | 40.2 ^{2/} |
| Crude Death Rate (per thousand), 1976 | 7.5 ^{2/} |
| Rate of Natural Increase | 3.3% |
| Number of Years to Double | 22 |
| Estimated Net Outmigration Rate (per thousand), 1976 | 3.0 ^{3/} |
| Total Fertility Rate (children) | 6.0 |
| Infant Mortality Rate (per thousand live births)..... | 95-120 ^{4/} |
| Maternal Mortality Rate, 1975 (per 100,000 live births) | 95 |
| Population 14 years and under | 46% |
| Legal Age of Marriage | |
| Male | 16 |
| Female | 14 |
| Life Expectancy at Birth | |
| Male | 58 |
| Female | 63 |

1/ U.S. Bureau of Census: World Population Report, 1977, (in press)

2/ Ministerio de Economía, Dirección General de Estadística y Censos, El Salvador en Cifras, 1977, San Salvador, El Salvador. Junio 1977.

3/ Dirección General de Estadística y Censos (DIGESTIC), 1976. La Población de El Salvador por Sexo y Edad en el Período 1952-2000, Principales Indicadores Demográficos, San Salvador.

4/ Range of variation based on analysis of 1973 National Fertility Study (Potter, 1975, p. 46) and on official estimate based on 1971 census data using the gross mortality technique (Ministerio de Planificación y Coordinación del Desarrollo Económico y Social, 1976; Algunas Diferencias Geográficas de la Mortalidad en El Salvador, San Salvador).

TABLE 1 - Cont.

| | |
|--|-----------------------|
| Per Capita National Income per annum | \$381 ^{5/} |
| Rural Population..... | 60% |
| Population Density per square mile | 531 |
| Unemployment and Underemployment in Rural Areas | 47% |
| Annual Net Increment to Labor Force | 40,000-60,000 |
| Literacy - National | 61% |
| Urban 77% | |
| Rural 47% | |
| Number of Currently Married Women or Women Currently in Consensual Union, 15-44 | 534,000 |
| Women in Fertile Age (WIFA), 1975 | 873,000 ^{6/} |
| Contraceptive Use Prevalence (coverage of WIFA), 1975 | 14.2% ^{6/} |
| Metropolitan 29.2% | |
| Urban 15.8 | |
| Rural 9.1 | |
| Women in Fertile Age, 1977 (estimated) | 906,300 ^{7/} |
| Contraceptive Use Prevalence (of WIFA), 1977 (est.) | 17.4% ^{8/} |

^{5/} Central Reserve Bank, 1977

^{6/} FESAL-75

^{7/} Programa para la Implementación de la Política Integral de Población, MOH/ISSS/SDA, Population Council, 1977.

^{8/} GOES program data report 158,200 WIFA as active users, June 1977; compiled by USAID/ES/H&P.

I. INTRODUCTION

The data in Table 1 vividly reflect the seriousness of what many regard as the major detriment to El Salvador's economic development: its past and continuing excessive rate of population growth. The smallest country in Latin America, it is also the most densely populated. Its annual rate of natural increase, estimated at 3.3 percent, results from continuing high birth rates of more than 40 per thousand population coupled with rapidly declining overall mortality rates officially estimated at 7.5 per thousand.

Sixty per cent of the population is considered rural while forty per cent lives in urban areas. Of the three major urban centers, the capital, San Salvador, is by far the largest, reporting in 1976 a population of 564,000 or 16% of the total population. A recent study ^{1/} of rural to urban shift for several Latin American countries for the 1961 to 1980 period estimates that El Salvador will have one of the lowest rates of urban increase. Simultaneously, the study indicates that population growth of the rural population will be the highest among the countries studied, projected to increase by 82% over the next twenty years. The impact of such a growth pattern and means of affecting it are a primary focus of this presentation.

The key element in El Salvador's future population growth rate, the current age structure of the population, is typical of a developing country. The pyramid, as outlined in Figure 1, is supported by a large base representing 46% of the population under 15 years of age. As a result, El Salvador has an excessively high dependency ratio of approximately 95 dependents under ten or over sixty-five years per 100 persons of working age. This compares unfavorably with the average of .76 for developing countries and .52 for the industrialized nations. ^{2/} Low income levels characteristic of such a highly skewed population composition tend to foster premature labor of children, which in the short-term deprives them of educational opportunities, and over the longer range retards their prospects for improved living standards.

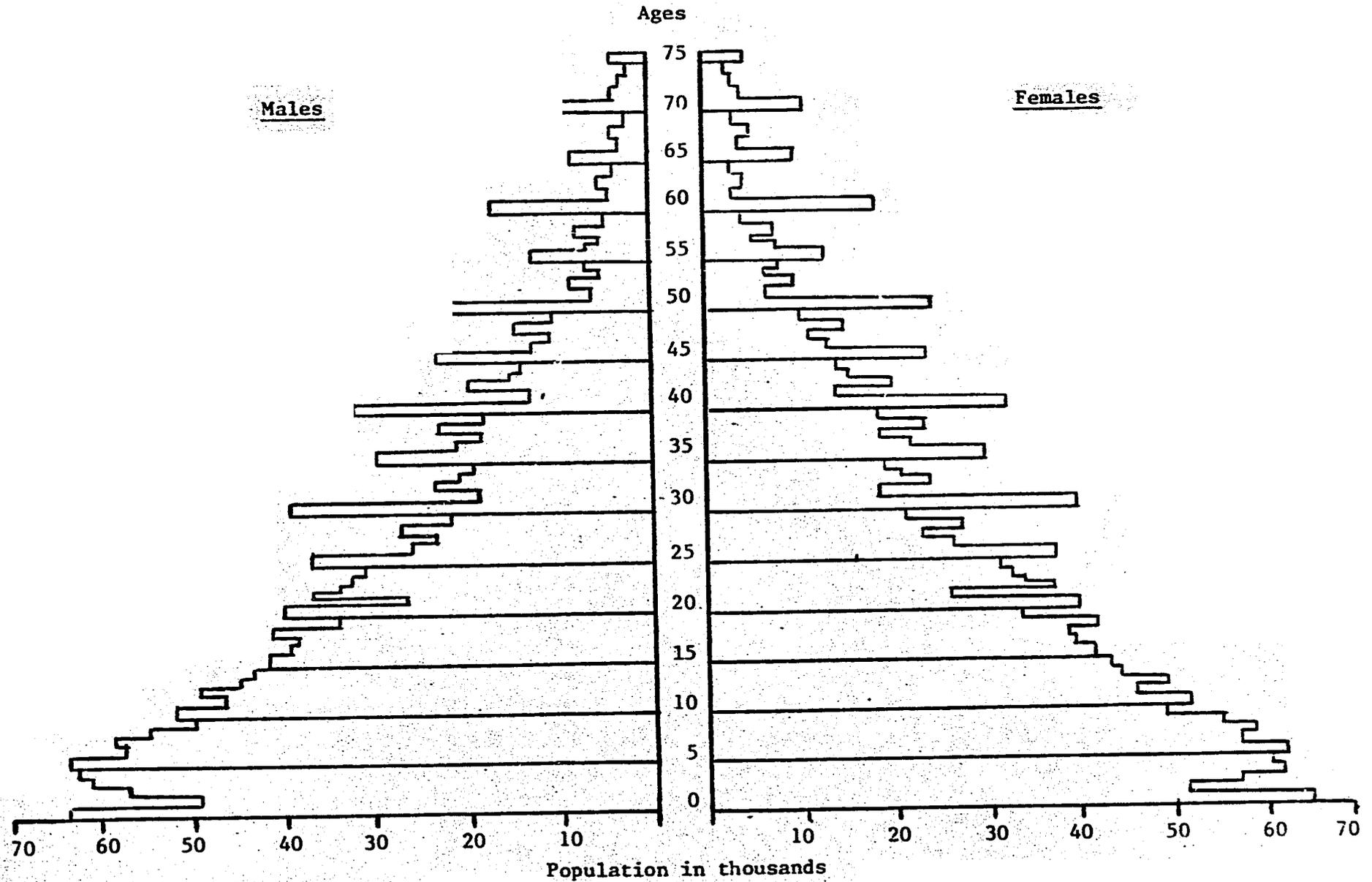
Rapid population growth has also contributed to low wages and increasing unemployment and underemployment throughout the country. USAID estimates unemployment to exceed 17% in 1976. The Salvadorean demographic profile indicates that the labor force will increase at a rate of 3.5% per annum for the next ten years. On this basis the economy must create 50,000 to 60,000 new jobs annually if unemployment is not to increase.

1/ Robert Fox and Jerrold Hugueta, Population and Urban Trends of Central America and Panama, 1977, IDB: Washington, D.C.

2/ USAID/ES/Economics Office, 1978

FIGURE 1

El Salvador: Population Pyramid by Age and Sex, June 1971



Source: 1971 Population Census

The GOES is acutely aware that efforts to improve the socio-economic conditions of the country, which include poor health conditions, high unemployment/underemployment and low economic growth, are hampered by such rapid population growth. In consequence, the GOES has committed itself to an aggressive population policy. USAID/El Salvador is strongly supporting the GOES efforts to develop and carry out programs under their policy which will result in a rapid decline in the population growth rate.

A. Purpose of the Paper

This paper represents a strategy for assisting the GOES in design and implementation of more focused family planning service activities and development policies that can have a greater impact upon fertility during the period 1978 through 1982 and beyond. The USAID recognizes that the expanded delivery of high quality family planning services is the most effective and efficient method of reducing fertility in the short range and is thus continuing its emphasis in this area. The average annual crude birth rate had decreased from a level of 48-49 per 1000 in the early 1960's to 41-42 per 1000 in the early 1970's. However, since 1974, the CBR has remained at a level of about 40 per 1000 (Table 2), indicating that updated estimates of active users of contraception may be overstated. This plateau is particularly alarming in the face of the ever-increasing number of women coming in the fertile ages due to El Salvador's young age structure.

To counter this trend USAID is emphasizing that services, including information, be focused toward specific target groups of the population where their impact can be greatest. The primary objective of the Strategy thus becomes to assist the Government in defining those target groups and directing intensified motivational campaigns and services toward them not only in family planning, but also through population-related activities in the health, nutrition, education, agricultural and industrial sectors. Recognizing the importance of these other aspects of development in indirectly stimulating fertility reduction, USAID is supporting action in areas which, evidence from the Salvadoran or related context indicates, can favorably affect fertility control. The USAID's activities in these areas will be coordinated with those of the National Population Commission which is responsible for implementation of the National Population Policy. The USAID will be increasing advisory assistance to the Commission in order to improve its overall strategic population planning, coordination of family planning programs, and development of policies and programs in other sectors to reduce the birth rate.

TABLE 2

Selected Vital and Population Data
El Salvador: 1960-76

| <u>Year</u> | <u>Estimated Population (000's)</u> | <u>No. of Live Births</u> | <u>Crude Birth Rate²</u> | <u>Crude Death Rate²</u> | <u>Natural Increase (%)</u> | <u>IMR⁴</u> |
|-------------------|---|-----------------------------------|---|---|-------------------------------------|------------------------|
| 1960 | 2,454 | 121,403 | 49.5 | 15.0 ³ | 3.5 | 76.3 |
| 1961 | 2,527 | 124,871 | 49.4 | 15.0 ³ | 3.4 | 70.0 |
| 1962 | 2,627 | 127,154 | 48.4 | 15.0 ³ | 3.3 | 71.4 |
| 1963 | 2,720 | 133,395 | 49.0 | 15.0 ³ | 3.4 | 67.7 |
| 1964 | 2,824 | 133,072 | 47.1 | 15.0 ³ | 3.2 | 65.0 |
| 1965 | 2,928 | 137,430 | 46.9 | 10.6 | 3.6 | 70.6 |
| 1966 | 3,037 | 137,950 | 45.4 | 10.0 | 3.5 | 62.0 |
| 1967 | 3,151 | 139,955 | 44.4 | 9.2 | 3.5 | 63.1 |
| 1968 | 3,266 | 140,986 | 43.2 | 9.1 | 3.4 | 59.2 |
| 1969 | 3,390 | 142,699 | 42.1 | 9.9 | 3.2 | 63.3 |
| 1970 | 3,534 | 141,471 | 40.0 | 9.9 | 3.0 | 66.6 |
| 1971 | 3,555 | 154,309 | 43.4 | 8.1 | 3.5 | 52.5 |
| 1972 | 3,668 | 153,464 | 41.8 | 8.8 | 3.3 | 58.3 |
| 1973 | 3,771 | 155,632 | 41.3 | 8.5 | 3.3 | 59.1 |
| 1974 | 3,887 | 158,524 | 40.8 | 7.9 | 3.3 | 53.4 |
| 1975 | 4,010 | 160,782 | 40.1 | 8.0 | 3.2 | 58.2 |
| 1976 ¹ | 4,123 | 165,740 | 40.2 | 7.5 | 3.3 | 55.3 |

¹Preliminary data

²Per 1,000 population

³Estimate prepared by the UN Economic Commission for Latin America;

Recorded rates were 11.4, 11.3, 11.5, 10.9, and 10.4

⁴IMR: Infant Mortality Rate per 1,000 live births

Sources of Data:

1. UN Demographic Yearbooks, 1966-1971
2. Ministerio de Economía--Dirección General de Estadística y Censos: Anuario Estadístico, 1971, Volumen II, Demografía y Salud, El Salvador, C.A., Noviembre de 1972
3. Ministerio de Economía--Dirección General de Estadística y Censos: Anuario Estadístico, 1972, Volumen II, Demografía y Salud, El Salvador, C.A., Diciembre de 1973
4. Ministerio de Economía--Dirección General de Estadística y Censos: Anuario Estadístico, 1974, Volumen II, El Salvador, C.A., Enero de 1977
5. Ministerio de Economía--Dirección General de Estadística y Censos: El Salvador en Cifras, 1977, El Salvador, C.A., Junio de 1977

B. Background: GOES Policy and Goals

In recognition of the adverse effects of rapid population growth on economic, political and social development, the President of El Salvador announced the National Population Policy in October 1974. The Policy is broadly stated, calling for modification of the "the Demographic Dynamic," and lists as one of its immediate objectives in this area, the reduction of the accelerated rate of population growth.

Health and medical attention provided to this end are to be based on respect for individual liberties and the dignity of the family and to include the distribution of information, counsel and assistance to couples wanting to space or limit their offspring. The policy mandates supporting actions in education, labor, and in women's development. In addition, the policy supports actions and policies in a number of other fields which encourage further reduction in the growth rate through the development process.

To strengthen implementation of the 1974 Policy, in December 1977 the GOES transferred the Population Commission from the Ministry of Planning to the Ministry of the Presidency under the jurisdiction of the Vice-President. The executive arm of the Commission, the Population Technical Committee, was similarly transferred to the Ministry of the Presidency in February 1978, thereby increasing its authority to coordinate population activities through its technical and budgetary review powers. Both the Commission and the Technical Committee are currently reviewing the demographic goals implied in the National Population Policy as a basis for developing and coordinating activities to achieve them.

The population policy does only in the most vague terms specify a target annual growth rate. For example, a goal is stated "to reduce the population growth rate from 3.5% to 2.0% or 1.0%," with no date given for the achievement of this goal. Rather, the operational goal is set in terms of contraceptive prevalence rates by method and year, set by the three primary family planning and population organizations -- the Ministry of Health (MOH), the Salvadoran Demographic Association (SDA), and the Social Security Institute (ISSS). Based on the 1982 Public Sector contraceptive goal of 29% of all women in fertile ages, endorsed by the Population Commission in 1978 (see Table 3), a target of 317,000 women practicing fertility control is projected, i.e., about 53% of married women in reproductive ages (MWRA), implying that the crude birth rate would be expected to decrease from 40/1000 to about 25/1000.

However, projections by both the Center for Disease Control (CDC) and the Population Council, which take into account the expected age-method

TABLE 3

Five Year Projection of Contraceptive Users (Thousands) and
Per Cent of Women in Fertile Age (WIFA)
Covered in Public Program

| Public Sector | 1978 | 1979 | 1980 | 1981 | 1982 |
|--------------------------------------|--------|--------|--------|--------|--------|
| Ministry of Health | 134.4 | 163.3 | 195.2 | 228.3 | 258.4 |
| Social Security Institute | 16.1 | 19.3 | 23.2 | 28.1 | 32.4 |
| Salvadorean Demographic Association | 15.5 | 18.0 | 20.9 | 23.6 | 26.4 |
| TOTAL | 166.0 | 200.8 | 239.2 | 280.1 | 317.2 |
| ===== | | | | | |
| WIFA Active Users (Public Sector) | 17.72% | 20.58% | 23.21% | 26.76% | 29.24% |

Source: Program for Implementing the Integral Population Policy, page 17,
Ministry of Health, Social Security Institute, Salvadorean Demo-
graphic Association; technical assistance by Population Council.
January 14, 1977, San Salvador. Copy on file: DS/POP/LA, AID/W.

mix of new acceptors and continuation rates in El Salvador, agree that in 1982 there would probably be between 222,000 and 239,000 active users (see Table 4). Although there is considerable variance in the numbers of new acceptors for 1982, the active users estimated by CDC and the Population Council are close due to different assumptions in method mix. In either case, these numbers would represent 38% - 39% of married women and, in turn, be associated with a decline in the crude birth rate to 33/1000 with a crude death rate of 8/1000, resulting in a crude rate of natural population increase of 25/1000 or 2.5% by 1982. 3/

TABLE 4

Annual Number of New Acceptors:
Comparison of GOES Program Goals,
Population Council and CDC Estimates

| <u>Year</u> | <u>Public Sector Goal and Private Sector*</u> | <u>Population Council</u> | <u>CDC</u> |
|-------------------------------|---|---------------------------|------------|
| 1977 | 72,960 | 61,000 | 48,000 |
| 1978 | 88,850 | 74,000 | 50,000 |
| 1979 | 104,061 | 80,000 | 53,000 |
| 1980 | 117,884 | 91,000 | 56,000 |
| 1981 | 129,524 | 107,000 | 64,000 |
| 1982 | 134,544 | 113,000 | 67,000 |
| <u>Active Users</u> (1982) | 317,000 | 239,000 | 222,000 |
| % of Married Women | 53% | 39% | 38% |

* It is expected that most Private Sector users will be absorbed by the SDA through the CRS program merchandising subsidized-priced orals, condoms and foaming tablets, subsequent to 1980. Also it is assumed that sterilizations obtained through the private sector will make up a small percentage of total contraception.

Source: Anderson, CDC, Trip Report, April 1977; national data and TABRAP model estimates.

3/ John E. Anderson, CDC, Resource Support Services Report, April 15, 1977.

C. USAID/El Salvador Focus

The Mission, as well as the GOES, will focus its Strategy on changes in the birth rate as the ultimate goal of its activities, including in its Strategy approaches to affect various preconditions of contraceptive use, including education, urbanization, and income distribution. The other two determinants of population growth, migration and mortality, are only briefly treated herein, given that program activities are aimed at measures to affect the crude and age-specific birth rates.

Thus taking into account this single and most important dimension of population growth, i.e., the birth rate, and the most direct means of affecting it, the use of effective contraception, the Mission judges that the GOES target of 29% coverage of WIFA in 1982, totalling 317,000 women, is overly optimistic. As mentioned above, based upon CDC and Population Council advice, it estimates that a more accurate projection would be 38% of married women, totalling 222,000, when adjustments for overcounting are made. The National Population Commission, with technical assistance from AID and CDC, is currently reviewing its demographic goals, prevalence targets and the institutional performance objectives of the three public agencies that deliver family planning services. The 1978 Contraceptive Prevalence Survey to be conducted by the SDA with CDC technical assistance will be useful in providing a firmer basis for establishment of these goals.

To the performance objectives of these institutions needs to be added the activities of the private sector, as well as the information/promotion actions of the community distribution programs. To date, the role of the private sector has been modest, but it is expected to increase as intensified mass media and other communications efforts stimulate demand for more services from both the public and private sectors. Such an effect is, in fact, a major objective of the Commercial Retail Sales (CRS) program now underway, as well as one of the aims of community development workers, agricultural extension agents and home economists, military personnel, and Rural Health Aides working in outreach programs.

As a part of its Strategy, USAID is encouraging the Commission to refine further its Population Policy by developing specific contraceptive prevalence objectives by target groups. In the meantime, taking into account available demographic data and its knowledge of the country situation, USAID has developed its own listing of priority target groups, to which this Strategy is largely addressed. (See Section III.A.).

II. OVERVIEW OF THE COUNTRY SITUATION

A. Demographic Structure (Urban/Rural Differences)

To date the Salvadoran population program has generally benefitted the urban populace. Data for the metropolitan region from the 1961 census estimates the general fertility rate (GFR) at 149.8; official data from the 1971 census for the same area reflected a decline of the GFR to 116.0, a drop of 22.6% (see Table 5). Estimates from the contraceptive prevalence survey conducted in 1975, FESAL-75, ^{4/} place the crude birth rate in metropolitan San Salvador at 31-33 compared to rural rates exceeding 45 per 1,000 (see Table 6). Thus it seems safe to conclude that average fertility, particularly in the metropolitan area, is lower than it was a decade ago. In rural areas, however, neither development nor family planning programs seem to have had the desired effect to date.

These differences in fertility are reflected as well in the age-specific composition of the population in urban and rural areas. Whereas in the urban areas, children in the 0-4 group (in which risks of morbidity and mortality are highest) represent 14% of the total population, in the rural areas, this group comprises 20% of all residents. Moreover, as might be expected, the rural areas exhibit significantly poor health status than do the urban areas. Although a key indicator of health status, infant mortality rate (IMR), for the population as a whole seems to have declined from nearly 80/1000 in 1960 to 58/1000 in 1975, recent studies show that the IMR for the countryside is at a level of 95 to 120/1000 when under-reporting is corrected. ^{5/} The maternal mortality rate in rural areas is even higher than the 95/100,000 women for the country as a whole, reflecting the fact that pregnancy is a dangerous event in the lives of rural women, particularly since nearly three-fourths are delivered by untrained rural midwives.

Despite heavy investment in the educational system of the Government over the past decade, levels of educational attainment and opportunities for education remain low, particularly for the rural poor. Nationwide, approximately 50% of those over 10 years of age are functionally illiterate; in rural areas the figure approaches 70% (1975). The gap between children eligible for education in rural areas and those actually enrolled is substantial. For example, at the primary level, enrollment in 1970 represented barely half of the primary school children eligible. Whereas overall 44% have graduated from the 6th grade, less than 12% of rural resi-

^{4/} FESAL-75, National Survey on Fertility and Family Planning in El Salvador, 1975; Salvadoran Demographic Association with Center for Disease Control (CDC) assistance.

^{5/} It is assumed that under-reporting for the urban areas exists but at a much lower rate than that for rural areas.

TABLE 5

Estimated General Fertility Rates by Area
(Number of Children 0-1 per 1,000 Women, Ages 14-44)
1961-1971

| A R E A | 1961 | 1971 | % Changes |
|---------------------------|-------|-------|-----------|
| Metropolitan San Salvador | 149.8 | 116.0 | -22.6 |
| Urban | 148.8 | 124.3 | -16.5 |
| Rural | 204.7 | 206.7 | + 1.0 |
| Total, El Salvador | 180.9 | 170.0 | - 6.0 |

Source: Census Data

TABLE 6

Crude Birth Rates and Contraceptive Usage
by Geographic Zone, 1975

| A R E A | Crude Birth Rate (per thous. population) | Women in Fertile Age Using Contraceptives |
|--------------|---|---|
| Metropolitan | 31-33 | 29.2% |
| Urban | 34-35 | 15.8% |
| Rural | 46-47 | 9.1% |

Source: FESAL-75

dents have successfully completed four to six grades.^{6/} Although it should be assumed that many rural children are included in "urban" school statistics, the magnitude of the difference is significant. Barriers to school attendance are in some cases economic, both because of the cost of clothing and supplies and the felt cost to the poorer families of loss of an economic asset. Serious shortages of trained teachers and facilities hamper attendance as well as does the fact that the majority of rural schools provide only the first three grades of school.

Finally, health attitudes and practices of the rural population stand in sharp contrast to modern economic values. Success in terms of economic and material gain is far more important than other rewards or prestige. The typical agriculturalist is both aware of and amenable to adopting new technologies, and economic rather than social barriers to their use are the major constraint to modernizing the sector. In contrast, however, traditional fatalist religious and spiritual values pervade in rural life. This sense of fatalism is evident not only among the rural but the urban marginal poor as well. A socio-economic survey ^{7/} highlighted the fact that the vast majority of such families felt that they had no control over their own destinies. Such attitudes are obvious key factors affecting the behavior of these groups in relation to reproduction and contraceptive uses.

B. Attitudes Toward Family Planning: Effect on GOES Goals

A recent anthropological study by Harrison ^{8/} indicated that the attitude of the target population toward family planning is to limit family size largely for economic reasons. The sample considered family planning a "final action" rather than a means of spacing children, and took a rough cost-benefit analysis into consideration regarding desired family size. Until children become economically active (field work, day labor, or help around the house), they are considered a burden. Girls are considered a burden for a longer time since there are more job opportunities for boys (3-10) than for girls, especially in agricul-

^{6/} USAID/ES: Education Sector Analysis; Basic and Occupational Skills Training Program, March 1978.

^{7/} Housing Foundation, (FSDVM), Estudio Socioeconómico de Santa Ana, 1977.

^{8/} Polly F. Harrison, The Social and Cultural Context of Health Delivery In Rural El Salvador: Implications for Programming, March-May, 1976, Contract AID-519-127.

ture, although girls 4-5 years old assume responsibility for taking care of younger siblings. Harrison states that rural respondents thought that 3 or 4 children constituted the ideal family size although 30% of the sample had already surpassed their ideal. Murray's study ^{9/} of health attitudes of the rural population indicated that although there is not yet an explicit demand in rural areas for modern contraceptives, there is most definitely a desire for moderate sized families.

Whereas this lack of demand could reflect a lack of service availability or of information, at this critical point in El Salvador's demographic situation it is necessary to look as well at other factors that seem to be affecting demand for modern contraceptives. Since these are described in more detail in the discussion of the specific target groups, they are summarized here only in support of the Mission's assessment as to the likelihood GOES prevalence targets will be achieved.

Key among the factors affecting adoption of modern family planning methods in Salvadorean rural areas (as well as other countries) seems to be the attitude of the rural male. Although the two most recent anthropological studies of Salvadoran rural attitudes (Harrison and Murray) have shown the Salvadoran rural male is very aware of the health of his spouse and children and does not consider them to be healthy, he is often simultaneously opposed to contraception. These studies indicate his opposition is linked (1) explicitly to an alleged fear of side effects of the Pill, IUD, etc., on her health, (2) implicitly to a fear that contraception will lead to her infidelity, or (3) to mere traditionalism. For these reasons, we consider the rural male as the most critical element to increased acceptance of family planning and, consequently, have designated him the prime target of this Strategy. (See Section III. B.1).

The importance of the health issue in El Salvador was illuminated in a recent study of indigenous midwives (Harrison ^{10/}) which indicated substantial opposition on their part to encouraging women to use oral contraceptives due to (1) fears of side effects, and (2) their view that this form of contraception is "against nature." Nonetheless, many of these same parteras advocated sterilization ("when you've had all your children") and, in fact, were themselves sterilized.

Sterilization, at least for women, surprisingly faces much less opposition from either a physical or religious point of view. The GOES prediction (see Table 7) that family planning services from the public sector will increase from 136,000 in 1977 to 317,000 in 1982 (an increase of

9/ Gerald F. Murray, Traditional and Modern Strategies of Health Care Delivery Among Peasants in El Salvador, March 1977, Contract AID/LA-C-1186.

10/ Polly F. Harrison, Women in El Salvador: Some Basic Facts for Development Planning, October 1976 - April 1977, AID Contract 519-143

TABLE 7

GOES FAMILY PLANNING ACCEPTOR GOALS FOR THE PUBLIC SECTOR
1977 and 1982

| | <u>1977</u> | <u>1982 (estimated)</u> |
|---|--------------|-------------------------|
| <u>Active Users (thousands) All Methods</u> | | |
| Ministry of Health | 109.9 | 258.5 |
| ISSS | 13.3 | 32.4 |
| SDA | 13.1 | 26.4 |
| TOTAL | <u>136.3</u> | <u>317.3</u> |
| Female Population, 15-44 | 906.3 | 1,085. |
| Active Contraceptive Coverage | 15% | 29.2% |
| <u>Users (thousands) by Method and Percentage</u> | | |
| Sterilization - Female | 34.5 (25.3%) | 90.9 (28.6%) |
| Sterilization - Male | 4.6 (3.4%) | 7.6 (2.4%) |
| Orals | 66.5 (48.8%) | 131.4 (41.4%) |
| IUD's | 21.3 (15.6%) | 61.2 (19.3%) |
| Condoms, others | 9.4 (6.9%) | 26.2 (8.3%) |

SOURCE: Programa para la Implementación de la Política Integral de Población. January 1977, Page 33.

133%) is based in great part on the continuing and increasing popularity of sterilization. The procedure has been performed in El Salvador since 1954, primarily with post-partum patients, until 1971 when it became an outpatient procedure to satisfy the increasing demand for it from both rural and urban women. Recent improvements in technology, mainly laparoscopy, have increased demand for this procedure. In fact, with the expansion currently underway of sterilization facilities into the interior of the country (see Figure 2), the Mission has little doubt that the projections of increased use of this method of fertility control are far underestimated in absolute numbers.

It is precisely based on this point that the Mission differs in the first instance with GOES five year targets, in that the 28.6% prevalence of female sterilization projected for 1982 appears understated since it represents only 90,900 women, whereas already current reporting (December 1977) indicates accumulated totals of over 80,000 female sterilizations.

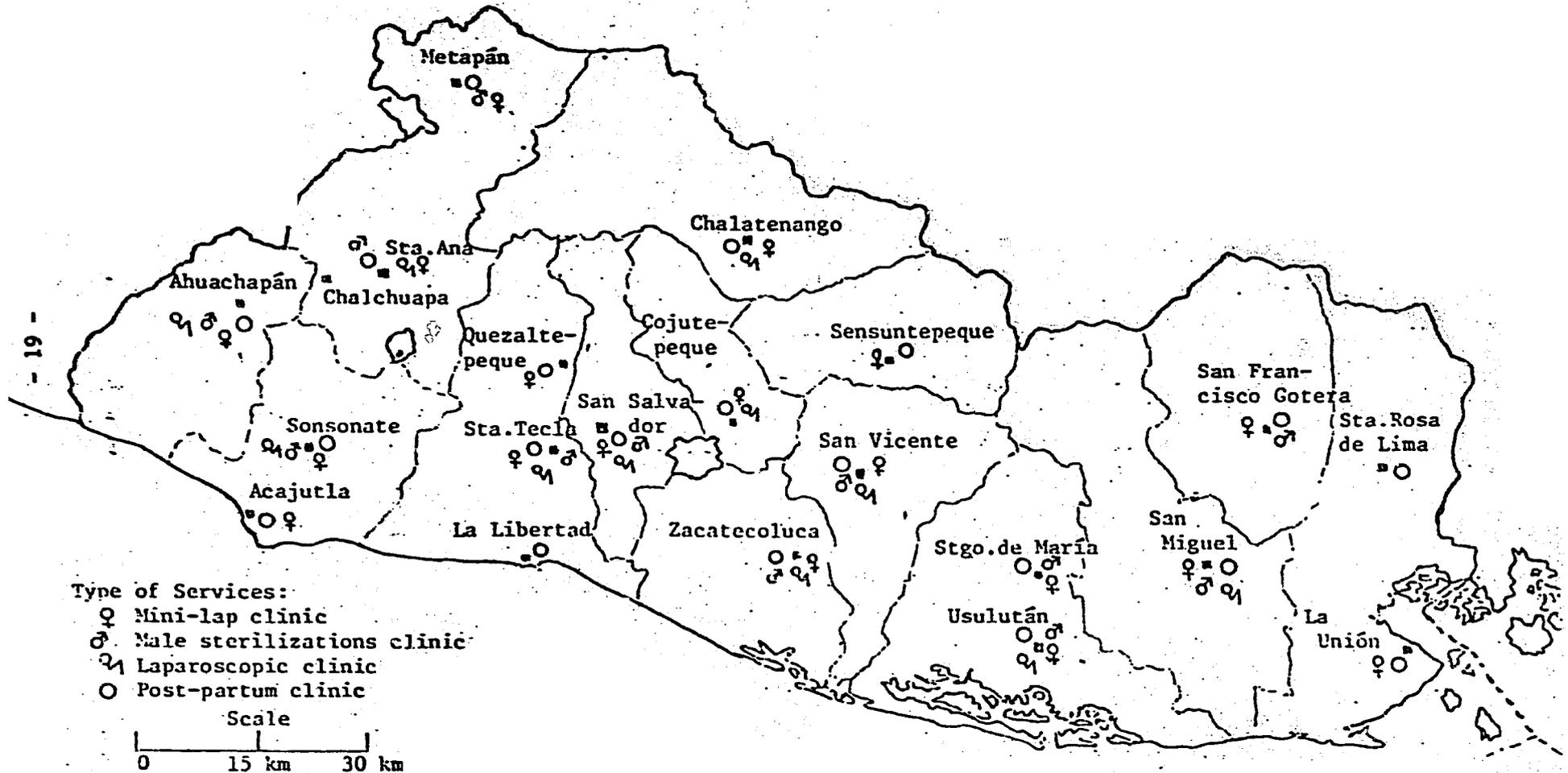
Second, preliminary results of the 1976 Labor Force Survey, which includes fertility/contraceptive use data now being analyzed by CDC/SDA, suggest that recent prevalence increases are mainly due to sterilizations of women who had previously employed temporary methods, principally orals. Such a transfer phenomenon is not surprising and leads the Mission to believe further that, because pill use will become more and more restricted to progressively younger cohorts of acceptors, the absolute number of Pill users may stabilize at a lower level than that projected by the GOES for 1982.

Male sterilization, while growing in popularity, is much less prevalent except in those cases in which there has been a strong "man-to-man" campaign on the benefits of the procedure and its lack of negative effects. Such a campaign has been most successful in the context of the Unión Comunal Salvadoreña, the largest campesino organization in the country. In some chapters of the organization, as a result of peer influence, more than one-third of the men have had vasectomies. Despite the fact that of 24,516 sterilizations performed in-country by the MOH from July 1975 to June 1977, only 254 or 1% of these were vasectomies, 11/ the Mission believes the projection of vasectomy prevalence (2%) is overly modest, and reflects the conservatism of GOES health officials regarding cultural acceptability of the method (see Table 7).

11/ Ministry of Health, Evaluation of Surgical Methods of Family Planning, 1975 - 1977, unpublished draft, 1978.

Figure 2

LOCATION OF SERVICE POINTS* FOR
VOLUNTARY STERILIZATION - 1977



*Some points include several clinics staffed by the different agencies.

EL SALVADOR, CENTRAL AMERICA

With opposition to orals strong both in rural areas and in the Salvadoran medical community, and for the reasons stated above, the Mission believes GOES assumptions of the 98% increase in use of oral contraception between 1977 and 1982 may be overestimated. However, to counter resistance, a majority of the promotional programs now underway or in the planning stages are designed to stimulate increased use of orals by addressing existing obstacles to their use. Among these barriers is the current restriction to their initial distribution without a pelvic examination and pap smear, a requirement that is often blamed for the association made by many people, including campesinos, between oral contraceptives and cancer, a word formerly foreign to campesino idiom. The GOES strategy for lifting these restrictions, while cautious, is a step forward which will probably be effective; and in the meantime the restriction seems, in practice, to have only a limited effect.

Finally, USAID considers the GOES estimate for increase in use of IUD and "other methods" overly optimistic in the absence of specific campaigns directed toward these methods and increased use of personnel trained in their use.

C. Economic/Political Factors of Population Growth

The country's most significant economic and social problems, hampering fertility control as well as all development efforts, stem from the low levels of income for the bottom 60% of the population, due in great part to a harshly skewed income distribution pattern. Although the lower 60% of the residents in the metropolitan zone received 17% of family income, the top 10% gained 51% of income (1974); 91% of the land-owning population holds 22% of farm land, while 2% owns 60% of the available farm land.^{12/} Consequently, El Salvador's "population problem" which results in poor living conditions for a great majority of the country, appears to that majority to be less a question of too many children than of maldistribution of resources, especially land. Murray writes that as long as great expanses of land are owned by a few wealthy families, rural Salvadorans tend to feel the solution to their plight is not within their control but in the fault of others.

Moreover, low income levels in El Salvador are associated with large families. Given expenses of schooling and the need for child labor for mere survival of these families, school attendance as described above is abysmally low in rural areas. This makes it unlikely that the known positive correlation between education and lowered fertility will be effected in the near future. Thus, prospects are dim for resolution in the short-run of

^{12/} PREALC, "Situación y Perspectivas del Empleo en El Salvador" USAID/ES Economic Office, 1977.

El Salvador's demographic problems through education in the absence of activities more directly related to fertility control.

On the more positive side, however, the Government has, over the last few years increasingly moved to strengthen its political support for a national population program. Fundamental is the existence of the national population policy, now in its fourth year, and the annual implementation plans which have become progressively more specific. The plan for 1978 assigns operational responsibilities for carrying out the population policy to three agencies-- MOH, ISSS and SDA-- whose service strength is in family planning. The plan also requires the more active involvement of other pertinent Ministries -- Education, Labor, Agriculture, and Foreign Affairs -- in developing the secondary emphases in skills training, education, employment-generation and migration policies. Research is to be pursued by the Ministries of Planning, Interior, the Census Office, and the SDA.

Related to positive political development is the reorganization of the Population Technical Committee in position within the government structure as well as membership, undertaken in January 1978. Previously under the Planning Ministry, the Committee has been placed within the jurisdiction of the Ministry of the Presidency, which is headed by the Vice-President. With budget review powers, this Office acts as a super-Ministry if an activist Vice-President is incumbent. Such is the case at present, with Dr. Julio E. Astasio, a former Health Minister whose commitment to family planning is well known.

Finally, the Mission notes a growing sense of urgency in the business community as well as in government circles over the population problem. Whereas increasingly members in the public sector view demographic pressure as a threat to the administration's development projects, businessmen are more apt to be concerned about the political and economic instability resulting from an exacerbation of already-difficult living conditions of the poor.

III. USAID/EL SALVADOR POPULATION STRATEGY

A. Objectives

AID's population program in El Salvador within the framework of this multi-year strategy is designed ultimately to assist the GOES in its efforts to reduce the crude birth rate to at least 33/1000. This is to be accomplished through a combination of family planning programs (short-run) to increase contraceptive prevalence and development programs (long-run) expected to encourage reduced desired family size leading to adoption of effective means of contraception. These programs will be directed toward groups with actual or potential high fertility as described below. As discussed previously there are major differences in past and present fertility patterns between rural, urban and metropolitan areas. Moreover, for the country as a whole, 46% of the population is under 15 years of age implying a large potential for continued rapid population growth.

It is these two parameters -- location and age -- of the population that USAID has used as the basis for definition of target groups. Priorities assigned to the groups reflect a number of considerations, including GOES priorities, present program status, importance of the groups in terms of reproductive potential, and cost-benefit estimations of programs (given always present financial and personnel constraints).

B. Identification of Target Groups

The primary focus of the USAID/ES population program for the last two years has been and for the next five years will continue to be the rural populace. This emphasis reflects the priority which the Government has given to the rural population in its 1977-1982 Five Year Plan, as well as the U. S. Congressional Mandate that assistance be maximally directed to the rural poor. Within that group, USAID will be placing an emphasis on reaching rural males of all ages in view of their key role in determining the contraceptive practices and living conditions of their spouses as well as their own role in reproduction and contraception.

1. Rural Men

The rural male populace is estimated at 1.36 million, of whom approximately 30% over 10 years of age are functionally literate. ^{13/} Harrison's anthropological study conducted in Uluazapa found that only 55% of the men had some knowledge of family planning compared to 90% of the women. Men were found to have received their information from the radio as opposed to the

^{13/} USAID/ES, Education Division, 1978

health clinic, which was not surprising considering the low¹⁴ male attendance at clinics. 14/. (Harrison 127). Several studies have indicated that approximately 70% of the men in rural areas sampled considered family planning desirable compared to 85% of the women, both sexes basing their opinion on "economics." Health considerations constituted a positive rationale for family planning for only one man in a sample of 40 couples, compared to one fifth of the women. Nonetheless, men not in favor of family planning often based their opposition on health concerns, stating that the various methods were detrimental in a number of ways to a woman's health. Women who were opposed, on the other hand, resisted on religious grounds.

These same anthropological studies indicated, significantly, that it is most often the male who makes the final decision on contraception in rural areas.

According to Harrison's study, although men have less knowledge of methods of family planning, a majority of them (60%) were interested in further information compared to 38% of the women. It is, therefore, evident that informational and motivational campaigns should be directed at this key target as a means of increasing demand for services for both men and women.

Moreover, it is with this group that the impact of many measures aimed at developing modern values, particularly those designed to increase income, can be greatest. It is essential, however, that such programs be accompanied by specific motivational and services programs in family planning if the effect of the income producing measures is not to work at cross purposes with the family planning program. The caution is particularly relevant in the Salvadoran context where, in both urban and rural areas, the primary reason to limit children is often stated to be lack of money. Thus, it could be surmised that any increase in income might lead to more children in the absence of specific campaigns to urge other courses.

a. Current GOES Program

Although there are several family planning programs that are designed to reach the rural male with either information or services, to date the GOES has not made the rural male a strong focus of the official population program. The current program to influence rural males includes outreach (promotion and condom distribution), person to person communication (vasectomy promotion), and commercial approaches (condoms).

Outreach efforts are largely carried out by agricultural extension agents and home economists of the Ministry of Agriculture and Ministry of Health Rural Health Aides and malaria collaborators. The MAG program began

14/ Harrison, Social and Cultural Context.

in 1975, and today more than 200 agents have been trained and are distributing condoms and follow-up cycles of oral contraceptives to rural families.

A second outreach program was that begun in 1976 with a pilot group of the malaria volunteers. After receiving a short period of training the volunteers were given the right to sell condoms and subsequent cycles of pills for a small fee. Although this improved access to the rural populace to means of contraception, the fact that it was necessary for them to seek out the volunteer to purchase the contraceptives, and that the volunteers working out of their homes did little to promote their sale, led to a Ministry decision to train more aggressive outreach workers in family planning and health promotion. The program began with the training of 20 community leaders in the Eastern region of the country in a two week program of family planning and health promotion. An evaluation of the program indicated that to be effective in the community a more broadly-trained person was required. In response, the Rural Health Aide (RHA) Program was designed to begin in 1976 as a part of the Mission's Population and Family Planning project. The project was conceived as a means of providing an outreach arm to the national family planning program in a form most acceptable to the Salvadoran rural populace, i.e., a trained para-professional able to provide basic health services, to make referrals, and to promote and provide family planning services. Under the program, which will continue as the key outreach element of the National Family Planning Program, AID is providing funding for support of training and deployment of approximately 600 of a total of 1550 to be trained by 1982.

With increasing experience, RHAs are also becoming active promoters of male as well as female sterilization. Although the vasectomy procedure has long been used in El Salvador, it did not become an official part of the GOES family planning program until 1970 when the SDA launched a pilot program to provide the service. In 1974 the MOH and the ISSS agreed to incorporate the procedure in their activities, and also began training. During 1975, 507 vasectomies were performed at the MOH, ISSS and SDA institutions. The number increased to 660 in 1976 and to 818 in 1977. With assistance provided by the IPPF, the MOH is expanding the services to seven more facilities (five hospitals and two health centers in the interior of the country).

In the initial part of a commercial approach to the population problem, the SDA began installation of condom machines, now placed in 92 locations in and around the metropolitan area, and also have 9 pill machines in service. As a result of the publicity campaign launched to promote the commercialization campaign begun in May 1978 (discussed below), it is expected that demand for the machines and their products will increase.

To date the informational program to promote family planning measures for men has been only minimally directed at the rural level. The effort to convince the rural male to seek and obtain services either for himself or his spouse has been hampered by a variety of constraints, of which the most important has been lack of attention to this group. There is, however, an increasing recognition on the part of the various organizations involved in family planning of the importance to the success of reaching the rural woman of convincing the male of his need and that of his spouse for family planning advice and services. Even with such recognition, skills to design programs to reach them are lacking.

To the extent that there is opposition to family planning within this target group, the basis for the objection has been only vaguely determined. Objections seem to be based on a combination of fear of side effects and of the spouse's infidelity, as previously discussed, as well as a desire for male children, a fear of infant mortality, and an exaggerated idea of the economic value of children. Access to information and services has been limited since GOES clinic hours are generally inconvenient for them. Moreover, because the RHA and other extensionists make their visits during the work day, the rural male is also likely to be missed by these agents of family planning promotion.

b. USAID Role

USAID's strategy to improve coverage of rural males with services and information includes commercialization and community distribution as well as more focused mass media efforts. In addition, research efforts to ascertain more specifically the bases for opposition to family planning will be useful in targeting the program more effectively. Finally, educational and training programs as well as projects designed to increase income of rural families offer an indirect means of affecting desired family size, and a forum to provide family planning information. (See Section III. C.).

2. Rural Women

The second target group of USAID's Population Strategy is rural females of whom there are an estimated 1,350,000 (30% of the population). Approximately 505,000 of these are estimated to be in the fertile age groups. ^{15/} Rural female literacy is estimated to be below 30%. ^{16/} Rural women usually marry or become "acompañada" (consensual union) at very early ages (15 to 16), remaining in this status throughout their reproductive period.

^{15/} Bureau Census Tables, DS/POP/DEA, June 1977

^{16/} USAID/ES/EDUC, 1978

Although as mentioned earlier, most rural women are acquainted with family planning, the FESAL 1975 survey estimated contraceptive prevalence in this group at only 9% of women in the fertile ages compared to 16% in urban areas other than the Metropolitan Region, and 29% in the Metro Region. Although undoubtedly religion has some effect, the Harrison and Murray anthropological studies have indicated that greater significance should be attached to the fears and rumors of side effects. Table 8 from the Harrison study presents the fears attendant to the use of the various methods of contraception.

These studies thus illustrate the need for new emphasis in mass media and outreach campaigns designed to reach rural women that aim specifically at the effect of methods on female health.

Significant in the rural woman's reluctance to accept family planning is the limited role definition of herself as a decision-making person on matters that fall outside the strict confines of the home routine. Risk-taking on her part is considered more deviant than on his. To expect her to make a decision to take a new action (pill every day, physical exam including pelvic, operation) that will affect her entire family and her partner's desires and life view, is expecting more than is within the realm of possibilities for most rural women, unless someone guides her toward this decision. The means of modern family planning are generally obtained from outside the home, i.e., from the government clinic and hospital through a doctor or nurse or, in more limited fashion, through the commercial pharmacy. Thus, the importance of two indispensable elements of the current approach to the rural women comes into view: 1) outreach from the governmental agencies (clinics, extension offices, schools) into her home, and 2) the couple as the focus of both information with convincing rationale for acceptance and access to services.

Particularly relevant is the fact that although 70% of all children born are from consensual unions rather than marriages (1973), knowledgeable Salvadorans consider that a surprisingly high degree of family stability does in fact exist. Rather than a statement on Salvadoran morals, the "out-of-wedlock" phenomenon reflects the vacuum caused by weak and nominal Catholicism, which has allowed the status of "acompañado" or common law union to become the norm with relatively little implication of a transitory nature of these unions.

Thus, mass media efforts to be used in attracting rural women to family planning must clearly place the responsibility for action in a joint and collaborative context, even though the methods being promoted

TABLE 8

Rural Beliefs About Family Planning Methods

| THE PILL | I.U.D. | CONDOM | INJECTIONS | STERILIZATION | ALL METHODS |
|--|--|--|--|---|---|
| Causes cancer (<u>Da cancer</u>) | Causes hemorrhage during menstruation | Causes urinary infections | Causes hemorrhaging | Ruins the woman (<u>Arruina la mujer</u> /men only/) | Ruin the woman (<u>Arruina la mujer</u>) |
| Causes urinary infections (<u>mal de orin</u>) | Causes cancer | Damages or tears the womb (<u>daña/rompe la matriz</u>) | Cause menstrual disorders (<u>transtornos en la menstruación</u>) | Requires special regimen (<u>ocupa dieta</u>) | Lower the number of red corpuscles (<u>glóbulos rojos</u>) |
| Causes hemorrhage during menstruation (<u>flujo abundante en la menstruación</u>) | Causes uterine pain (<u>dolores del vientre</u>) | Causes headache | Causes stomach ache | Makes the woman incapable of performing her household duties for a long time. | |
| Requires extra food/vitamins because debilitating (<u>Requiere alimentos porque debilita</u>) | Causes vaginal infections (<u>da picazón</u>) | | Cause uterine pain | Requires strong blood | |
| Causes infection of the uterus (<u>dá infección en el vientre</u>) | Causes urinary infection | | | Requires blood transfusions | |
| Causes headaches | | | | Wound hurts for months | |
| Causes pains in the neck | | | | Uses electricity on one's body | |

are, of course, applicable to only one sex. The exception to this philosophy will be attempts to reach young females who are in more fluid and unstable sexual relationships and therefore cannot depend upon concurrence of their partners for contraceptive protection.

Special attention is needed for this group of younger rural females since the problem of continuing high birth rates among rural inhabitants is estimated to be related to the age at which the campesina begins her reproductive life. The detrimental impact of excessive adolescent fertility of the rural woman's health and nutrition and that of her children, educational achievement and entire "life-set" is yet to be systematically analyzed in the El Salvador setting. Enough is known, however, to generalize nationally that: a) for ever-married women (includes consensual unions) the highest pregnancy rate is in the 15 to 19 year age group (see Table 9); b) prejudicial dietary and health beliefs are perpetrated by these young mothers because of lack of "better" knowledge through education 17/, and c) fully 44.5% of this age group who were married or in union and not pregnant did not want more children at the time of interview 18/. Finally, gaps in the program are reflected by the fact that abortion rivalled the pill and sterilization as the "contraceptive method of choice" in El Salvador in 1975 (8,000 hospitalized abortions plus an estimated 15 to 20,000 non-reported cases, compared to 15,000 sterilizations), with the highest percentage among married women of low educational level from rural areas (27.4%) 19/, many of them young.

USAID Role

If the family planning program is to reach rural females, three approaches should be made. First, within the current mass media campaign for family planning, messages explicitly aimed at the young campesina woman should be aired on radio, television and movie theaters, challenging the status quo expectation of early and multiple pregnancies. The mass media campaign is the closest approximation thus far in El Salvador of a vehicle for forming a new community consensus, designed to develop basic attitudes in favor of smaller families. Second, these public messages must be reinforced by the personal follow-up of rural change agents (Rural Health Aides, agricultural agents, home economists, teachers, etc.). Third, more impulse should be given to increase the supply and availability of temporary contraceptive methods that are within the economic possibilities of the rural family's budget and can be obtained from known and personally trusted channels. Particularly relevant in this respect is the SDA commercialization project through which condoms and oral contraceptives will be sold in neighborhood pharmacies and small shops. Improved clinic services, especially through

17/ Harrison, Women of El Salvador.

18/ FESAL - 75

19/ Ibid

better use of clinic personnel and improved logistic support, mainly transportation, are also aimed at making family planning services more acceptable to busy rural women.

3. Adolescents

The third major target group of the USAID population strategy is the adolescent population, both urban and rural, which in 1976 comprise 16.5% of the total population. The fact that it is in the 15-19 year age group that the pregnancy rate is highest for women in union (Table 9) make it crucial that an effective and aggressive adolescent fertility program be developed and implemented under the leadership of the National Population Commission.

This is particularly imperative during the years to come since the prevailing youthful age structure in which 46% of the population is less than 15 years will produce progressively larger groups entering the reproductive age. Because of this influx of the highly fertile, the brunt of El Salvador's population growth, as the IDB recently said of the entire Central American Region, is still to be faced (see Table 10).

To date the GOES has not been involved in any serious organized program to specifically address the problems of adolescent fertility.

The Population Policy places responsibility for "family education and ecology" on the Ministry of Education, and in the 1978 Operation Plan, targets 1.5 million youth between 7 and 18 years of age for such instruction. Unfortunately, neither has curriculum been designed nor textbooks or other materials provided to put such a plan into operation, and because the equivalent of only \$147,000 has been budgeted for such a task on a national scale, the target seems more an aspiration than a program goal.

Although, as described above, sex education is not a part of the official curriculum of the GOES primary or secondary schools at present, the Government-owned Educational Television Station does periodically present films on the subject. In addition, some private schools provide counseling in this area. A few private institutions such as the Family and Population Center, a lay-group affiliated with the Catholic Church, provide courses in sex education, family life and responsible parenthood to teenagers and parents.

Finally the SDA has been active since 1972 in this field, sponsoring films and talks to teenage audiences in both rural and urban zones; for example, contact with 5,250 persons in 1976 and 4,140 persons in 1977 was

TABLE 9

**Ever-Married Women Actually Pregnant At Time Of Survey,
By Age Groups And Residence (1975)**

| <u>AGE COHORTS</u> | <u>EVER-MARRIED WOMEN (includes consensual unions) BY PERCENTAGE</u> | | | |
|--------------------|--|--------------|---------------------|--------------|
| <u>YEARS</u> | <u>RURAL</u> | <u>URBAN</u> | <u>METROPOLITAN</u> | <u>TOTAL</u> |
| 15 - 19 | 24.6 | 28.6 | 10.5 | 23.4 |
| 20 - 24 | 20.3 | 11.7 | 9.3 | 16.6 |
| 25 - 29 | 22.0 | 17.1 | 5.5 | 18.2 |
| 30 - 34 | 9.3 | 5.2 | 8.9 | 8.2 |
| 35 - 39 | 10.7 | 3.4 | 0.0 | 7.3 |
| 40 - 44 | 3.2 | 9.5 | 1.9 | 4.6 |
| 45 - 49 | <u>3.3</u> | <u>0.0</u> | <u>0.0</u> | <u>1.9</u> |
| T O T A L S | 13.8 | 10.7 | 5.2 | 11.6 |

Source: FESAL-75

TABLE 10

Distribution by Age of Women in Fertile Age
1971, 1973, 1975, 1976

| AGE COHORTS | WIFA-Number | 1971 | 1973 | 1975 | 1976 (est.) |
|-------------|-------------|-------|-------|-------|-------------|
| | | % | % | % | % |
| (10 - 14) | (230,068) | | | | |
| 15 - 19 | 184,268 | 23.2 | 25.1 | 26.0 | 23.9 |
| 20 - 24 | 152,901 | 19.3 | 20.2 | 17.1 | 19.2 |
| 25 - 29 | 120,741 | 15.2 | 14.8 | 13.9 | 15.9 |
| 30 - 34 | 100,631 | 12.7 | 12.8 | 12.8 | 12.6 |
| 35 - 39 | 95,412 | 12.0 | 11.4 | 12.7 | 10.5 |
| 40 - 44 | 76,661 | 9.7 | 8.7 | 9.9 | 9.9 |
| 45 - 49 | 62,773 | 7.9 | 7.0 | 7.6 | 8.0 |
| 15 - 49 | 793,387 | 100.0 | 100.0 | 100.0 | 100.0 |

Sources: Estimate for 1976 by SDA and CDC;
1971: Fourth National Census;
FESAL-73; FESAL-75.

made. In an attempt to generate greater interest in this field, the SDA donated hundred of sets of a sex education series for children to the MOE; however, little follow-up resulted due to the lack of commitment and budget allocated to this subject.

The above illustrates the absence of an effective approach to confront a major contributing factor to El Salvador's population problem. The lack of programs to reach rural areas is further exacerbated by socio-cultural constraints to discussion of sexual matters between parents and children. There is little awareness in both urban and rural Salvadorean society of the need to provide information and services to this actually and potentially fertile group, which has resulted in reluctance to push for official authorization to include the subject as a part of the curriculum. Finally, any major program in this area is constrained by a lack of trained personnel to design and implement programs.

USAID Role

USAID views this age group as crucial and plans to support public or private efforts in the field of sex and contraceptive education, family life and ecology/demography directed toward adolescent populations and will motivate policy makers at various levels in the GOES and the private sector to recognize the need for action.

The institution with greatest influence is obviously the Ministry of Education, although Mission experience has shown that it may be the most difficult and slow-moving Salvadoran Ministry to deal with. Be that as it may, the fact that many rural youth attend schools in urban areas, making it relatively easier to reach them through consolidated programs initiated in urban facilities, cannot be overlooked. Technical assistance in curriculum development, simplified teacher training, and instructional material can be provided to the MOE to develop its public program of sex education and demographic awareness. As part of the official program, the Council for the Protection of Minors (Consejo de Menores) and the Office for Improving Marginal Communities (OMCOM) have each expressed interest in designing and implementing educational programs and activities for adolescents in their respective zones of influence.

USAID support to the SDA as leader of the private sector in this field will continue. During 1978 the SDA plans to expand its outreach program of youth leader training and community courses and to commence a pilot clinic with special services and information geared to an adolescent clientele.

The USAID will also promote the participation of other international donors with experience in this area, such as FPIA and World Education, in the development of projects targeted at adolescents.

4. Marginal Urban Groups

While the Mission is developing new programmatic emphases to direct increased attention toward the underserved rural population, it recognizes that further work must be done to strengthen coverage of the urban poor. Although greatest program success thus far has been evidenced in the urban and especially metropolitan zones, the SDA estimates that the urban poor make up a disproportionately small share of the 16% and 29% contraceptive prevalence rates corresponding to those zones. Further, Salvadoran program leaders consider it important that the momentum of the urban program be sustained, maintaining that the behavior model represented by urban dwellers is crucial to greater acceptance of family planning by the rural population since social innovation generally flows from cities through towns to the countryside.

Observation quickly shows that people living in the urban marginal zones (zonas marginales) manifest socio-cultural characteristics that are more rural than urban in nature. Pigs and chickens and small gardens abound where space permits it, and open sewerage is the norm. The main differences between the rural and marginal urban way of life are the source and availability of employment, income potential, opportunity for schooling of children and recreational outlets.

All these factors are enhanced by an individual's presence in the city and lead to his generalized feeling of increased potential for economic advancement and social mobility (although limited).

As mentioned earlier, increased income may work against the lowering of actual fertility unless the advantages of limiting children are made obvious. There are pressures, however, both positive and negative, at work in the urban environment conducive to the formation of smaller families that seem stronger than the more traditional attitudes that many have carried from the countryside.

There is one major organization devoted exclusively to dealing with the problems of the urban marginal populations: the Office for Improvement of Marginal Communities (OMCOM). Started in 1972 as an opposition group of the Christian Democrat party control over the San Salvador mayoralty, it is a political dependency of the Ministry of the Presidency. Its sole function is to develop social service programs, exclusively for the metropo-

litan San Salvador marginal zones, whose populations are estimated to total over 300,000 in approximately 125 low-income areas.

Water supply, garbage collection, electric line installation, food distribution and sports/recreation projects have constituted the organization's main activities over the years. Works are conducted based upon community development principles in which communities benefitted contribute labor manpower and whatever other material costs may be within their economic possibilities.

USAID Role

Periodically OMCOM has drawn upon the services of the Demographic Association to provide family planning orientation and promotional talks in the marginal communities. This collaboration could very easily be expanded, now that the SDA is gearing up its staff to develop a major community-based distribution department. OMCOM, in fact, has made overtures to the SDA regarding program development for family planning services. Cooperation could feasibly take the form of integration of information and service-referral on family planning into the mother clubs, sewing cooperatives and other community member programs underway. Although resistance is still manifested by CRS/CARIAS, education on responsible parenthood could be programmed to accompany the food commodities (Title II) being provided to pregnant and lactating women, prime candidates for family planning.

Equally promising would be the development of a closer working relationship between OMCOM and the Ministry of Health which has at least seven clinics operating in reasonable proximity to major concentrations of urban poor in the Metropolitan area.

Finally, the SDA is considering the expansion of an informational program that has proved to be successful with teenage children of factory workers, called Juvenile Promotors (Multiplicadores Juveniles). Since OMCOM has traditionally been involved in sports programs, the organizational structure and mutual confidence exists to deal with problems of adolescent sexuality, through sex education orientation and information, and services on fertility control technologies.

USAID/ES is prepared to support the SDA in specific new initiatives, particularly in league with OMCOM and others, to reach the marginal urban populations which constitute a small but disproportionately important segment of society.

C. AID Program Priorities

1. Operational Services Program

From the adoption of a target group approach as a keystone of the Mission's population strategy over the next five years falls a number of program emphases described below.

a. Community and Commercial Distribution

The most important of these is a continuation of the emphasis on provision of family planning services, but with a strengthened focus of the services to target groups. First among these target groups is the rural populace with a particular stress on rural men and younger women. Current constraints to reaching these two groups have been described earlier. The Mission believes that an out-reach program to bring services to them must include not only community and commercial distribution, but also promotion and an effective referral system for both clinic service provision (sterilization and IUD insertion) and handling complications. Certain issues affect the potential of each of these activities which AID will help the GOES address.

1) Liberalization of Distribution of Oral Contraceptives

Restrictive regulations regarding the initial distribution of oral contraceptives have slowed acceptance of this method and contribute to a high attrition rate. The process of official liberalization seems to be less of a constraint in fact than in theory since, in many cases, overly busy physicians are informally delegating authority to prescribe orals to paramedical personnel. It is, however, a severe restriction to wider adoption of orals in rural areas. Outreach agents, including Rural Health Aides, while allowed to distribute follow-up cycles of orals, can not provide initial cycles and are permitted only to refer interested women to health centers where they are given a first cycle after receiving a pelvic examination and pap smear. The policy has also been criticized from the point of view that the pelvic/pap requirement tends to associate cancer with the pills in the minds of these women who often have a reluctance to visit the health center.

Removal of the restriction is important as well for the success of the commercialization program since the distribution of orals outside pharmacies is not officially approved at present. It should be noted that the inclusion of orals in the commercialization activity is scheduled even with the restriction, on the basis that the subsidized commodities will be sold by the pharmacists informally to non-pharmacy outlets.

The Mission is encouraging the Minister of Health to take more aggressive steps to gain support for liberalization of the policy. Shortly, the MOH will begin training a pilot group of forty indigenous midwives to make initial distribution of orals to women whom they have screened for contra-indications. The program will then be broadened to include selected Rural Health Aides and malaria collaborators early in the following year.

The Ministry expects the success of these programs to provide support for liberalization of regulations. Whereas we are encouraged by the Ministry's adoption of a plan to that end, we believe it is overly cautious. The Mission's strategy to stimulate more rapid change includes intensified sharing of experiences of other projects and countries in this area. We also plan to provide technical assistance from the centrally supported DAI contract to the Minister to hold a series of seminars on oral contraceptives and the risk of pregnancy, and on the advantages and disadvantages of other methods.

To the same end, the Mission is providing similar kinds of information to the National Population Commission and the Ministry of the Presidency.

2) Commercial Retail Sales

As described earlier, a constraint to greater popularity of contraceptives in the private sector (primarily pharmacies) of El Salvador has been their high prices set to take advantage of the considerable purchasing power of the upper and middle class consumers, the principal clientele. A sample taken in June 1977 of the retail market for oral contraceptives in San Salvador, showed a price range of from (US) \$0.90 for a locally manufactured brand to \$2.64 for a Swiss product, averaging around \$2.00. The most popular brand of condoms, SULTAN, costs (US) \$0.40 per 3 pack (or about 13 cents a unit) with \$0.20 - \$0.24/3 pack being charged for lesser known brands. The mark-up on these two products, pills and condoms, from the importer to the retailer fluctuates around 100%. The most common injectable on the market, "Depoprovera," is manufactured in Guatemala and costs \$3.82 for a three month protective dose.

With a notable exception -- the low frequency advertising campaign for "Protex" condoms begun in 1977 -- there has been no advertising of contraceptives. Nevertheless, even without advertising, the SDA estimated that in the early 1970's, the amount of contraceptives being purchased from private sources was equal to the contraceptives being distributed through the public program. As the public program expanded its coverage, this ratio had dropped to 3.6 to 1 (public-private) by 1975, according to the Salvadorean Fertility Survey (FESAL 1975, SDA-CDC).

With this potential market in mind, the Mission requested a centrally funded contract to initiate a Commercial Retail Sales Project. Representatives of Development Associates, Inc. (DAI) arrived in early 1977 to lay the groundwork with the local counterpart, the SDA, for the subsidized sales of condoms, pills and eventually foaming tablets and other contraceptives. Product launch of condoms occurred in May 1978, offering the public a three pack of condoms for \$0.12. Later in 1978, pills will be put on the market at \$0.32 per monthly cycle. These prices were set by DAI based on a consumer survey which indicated that the media prices that potential users were willing to pay were \$0.26 for condoms (3 pack) and \$0.45 per cycle of pills. The advertising strategy will be directed in part toward convincing the public that a low price should not automatically be equated with poor quality of product.

The CRS program is designed to recruit new acceptors from the private sector and increase contraceptive use through strictly commercial means. The program, dependent upon managerial and financial support from DAI initially, is to be progressively phased over the SDA responsibility until the end of 1979 when complete operational control is to be assumed by SDA. It is planned that all local costs are to be self-financing, without AID/W or Mission support (excepting commodities), by 1982 or earlier. The project is a key part of USAID's approach to assuring the necessary contribution by the private sector to achievement of the overall prevalence goals.

b. Clinic Improvement

A second priority area of the Mission's strategy is improvement of services, especially those that are clinic based. Identified as a major constraint to efficient and effective clinic services is an over dependence on physicians in provision of routine family planning services. To urge the MOH to adopt a more cost-effective approach to service delivery, AID assisted the MOH in developing a training program for nurse practitioners, the MOH version of a women's health care specialist. Thirty-four such nurses have been graduated and are assigned to the mobile medical teams that visit rural health posts and units two to three times a week. This paramedical worker is trained to handle routine MCH and FP care, including prescription of orals and IUD insertions. To date, however, physicians have been unwilling to allow them to insert IUD's, thus limiting accessibility to this form of contraception since the doctor's schedule is usually filled with more urgent kinds of care. The nurse practitioners have, however, been well received by the public and MOH physicians and the MOH has decided to continue the program, training 90 by the end of 1979 to serve as the chief providers of non-surgical contraception in rural and semi-urban marginal zones. USAID plans to continue to urge the MOH to provide team training to its physicians and nurses to encourage delegation of the IUD insertion to the nurse practitioner, and a greater recognition of her capabilities in family planning consultation and services.

To assist the MOH in monitoring its clinic family planning services, the Mission will provide technical assistance in the analysis of computerized monthly reports for the six metropolitan clinics. It is planned that this management information system will systematically be broadened to cover fixed units and increasingly outreach agents thus giving the MOH an improved idea of its progress toward goals and more important problem areas in clinic performance and in supporting logistics and transportation systems.

Through its Rural Health Aide Project and the planned Rural Health Improvement Grant, the Mission is assisting the MOH in an analysis of all support systems for delivery of integrated health, population, and nutrition services in rural areas. These steps are directly related as well to improved support of the family planning program.

c. Voluntary Sterilization

The third part of the Mission's strategy under the heading of Operational Services is the continued promotion of voluntary sterilization. The Mission believes that substantial gains in the program would result from a stronger focus on male sterilization, especially within the Ministry of Health. Such a focus could be the outcome of an integrated campaign to promote this method of fertility control among the rural populace through a combination of mass media, community activities and person-to-person contacts. The above is reflective of the Mission's belief that although there are undoubtedly strong socio-cultural barriers to vasectomy, a major constraint is the lack of administrative focus which, in turn, prevents a concentration on developing means to attack these barriers. The Mission will, therefore, attempt to encourage the MOH to appoint a single individual to be responsible for coordination of joint programs to promote voluntary male and female sterilization with the SDA and ISSS, both of which have taken lead roles in designing mass media programs. The Mission will also stimulate the Population Commission to take a stronger leadership role in this area.

d. Adolescent Fertility

Under this category, the Mission's strategy is to motivate policy makers to develop adolescent fertility programs. Such programs would include sex education, family planning promotion and services. The Mission will try to coordinate efforts in this area by working through the National Population Commission to the extent possible since decisions to be made cover a variety of Ministry and government programs. This is a key area in which the Mission will be seeking technical assistance to advise GOES elements at an appropriate time. In the meantime, the Mission

intends to continue working informally with several private groups on this subject, and especially to encourage activities in sex education.

2. "Population Policy" Development

a. Demography/Evaluation/Research

The second major and new emphasis of the Mission Strategy is very broadly termed "population policy." Aware of the faulty nature of much of the demographic goal setting and thus of the alignment of integrated programs to reach these goals, the Mission proposes to work with the National Population Commission and its various elements in a technical advisory capacity to develop and improve the coordination of national policies and programs that are likely to lead to a lowered birth rate. We believe the focus of such an effort should be an improvement of the family planning program, although we plan to address other aspects of population as well. Thus, the Mission is providing, through the use of centrally-funded contracts, assistance to the Commission, the Salvadoran Demographic Association and the Ministry of Health to develop the capability to evaluate the operations, problems and effectiveness of the current National Family Planning Program. The evaluation will then serve as a basis for revision of program goals and improvement of programs to reach those goals.

Both the USAID and the Commission continue to be hampered by the non-standardization of existing demographic data and its lack of specificity below the national level. For instance, although crude birth rates for urban and rural areas are available, they reflect place of birth rather than residence. Thus, these types of estimates have to come from household surveys.

The Mission has defined and assigned priorities to various segments of the population (target groups) to which programs of family planning information, motivation and services and of general development should be directed to lower overall fertility. To do this, it is necessary to understand various factors affecting the behavior of the groups in relation to reproduction and contraceptive use as well as their characteristics. Efforts thus need to be made to direct data gathering and analysis of existing data to fill these gaps as a primary aspect of the population program.

A recurring problem that has plagued efforts to monitor program progress, and particularly the key concept of prevalence coverage, is the variation in definition of "active acceptor" within the three agencies comprising the organized family planning program (MOH, ISSS, SDA) and the over-reporting of active users associated with manual data systems 20/.

Rather than to continue insisting on agency reporting standardization, which has been relatively fruitless, the Mission has encouraged two measures designed to tighten report validity. The first is the improvement of internal statistical reporting, according to each agency's own criteria, through redesign of forms and procedures. The other more important measure is the biannual Contraceptive Prevalence Survey (the next scheduled for July-September 1978) conducted by the SDA with technical assistance from CDC, designed to provide national data on actual contraceptive usage by method, age, geographical residence, and sources of service (both public and private) and of information on family planning. These surveys allow program planners and implementers to correct agency counts and adjust prevalence rates to serve as benchmarks for future projections.

Through a Battelle Memorial Institute contract with the SDA, the Mission will be supporting efforts to determine the actual barriers to adoption and practice of effective family planning. The Mission plans to encourage strongly the SDA to concentrate first on analysis of studies already made of such barriers and of fertility determinants, before initiating new research in these areas. Already scheduled to be added to the 1978 Contraceptive Prevalence Survey are questions designed to evaluate past family planning, including communications efforts and indicate current perceived obstacles to family planning use.

The information from the CPS will serve as a basis for illuminating policy decisions and programs in other areas that could affect the birth rate. These could include housing, tax and education policies, industrialization, migration schemes and training programs. Particularly important will be identification and support of activities, laws and economic policies that explicitly or implicitly would encourage smaller family size through changes in labor laws, age, marriage, women's education and employment opportunities, tax structure, incentives or subsidies for smaller families, and old age support systems.

Throughout this period the Mission will be working with the National Population Commission to revise and improve its data bases and its methodology for reviewing programs as groundwork for improved goal setting and program design.

b. Other Development Programs

The work that the Mission is carrying out in this area broadly termed "policy" is related to our interest in assuring that the combined impact of the Mission's projects leads to reduced fertility, whether directly or indirectly. In this regard, the Mission believes that it is essential that priority be given to Mission programs that affect

education and women's development due to their known and close correlations with reduced fertility. To this end, the Mission is placing a major emphasis on a Rural Primary Education Grant/Loan Project, which is designed to improve and expand education in grades 1-6. The Mission, as a part of its overall advisory effort in curriculum development, will work with the GOES to assure that a sex education component is added to the curriculum of these rural schools. Furthermore, the project includes a large scale (10,000 teachers) instructor training effort in which the USAID will try to include training in techniques of family planning promotion as a means of using these potential change agents as community family planning promoters.

In an attempt to help the GOES develop incentives for the rural populace to keep their children in school, the Mission is again exploring the possibilities of a school lunch or nutritional snack program using PL-480 foods. In view of the spotty history of this program in El Salvador, however, we will also be looking at alternative incentives.

A second major Mission program expected to affect fertility both directly and indirectly is the Occupational Skills Training Program. The rural women participating in the program will gain a skill with which they can earn a living and will thereby be more highly motivated to use modern family planning methods.

The Mission is further supporting the development of women through its work with the cooperative movement and particularly with the Unión Comunal Salvadoreña, as with the National Women's Institute being developed as a part of the Ministry of Planning.

The Mission is continuing its emphasis on family planning through rural development efforts by maximizing the use of the Agricultural Extension Service (CENTA) through the Multicropping, Irrigation, and Small Farmer Development Projects. These projects could be expected to lead to reduced fertility in the benefitted families, especially if specific efforts are made to promote family planning among them. To the degree that these families serve as models for a wider rural populace, a broader fertility impact can be expected as an offshoot of the project. Moreover, efforts will be made to take advantage of the harmonious working relationship between CENTA and AID based on these projects by encouraging greater involvement by CENTA in family planning training and educational activities.

Finally, the Mission is interested in developing a small scale industrialization strategy, believing that it is only through such means in the long run that the Salvadoran economy will be viable and the living standards of the Salvadoran populace raised. Such a strategy is likely to result in increased urbanization leading to reduced fertility.

c. Migration

A factor of potentially high impact on the population situation in El Salvador, and one that has been overlooked as a programmatic alternative thus far, is international migration. As the third demographic force (with natality and mortality) determining population size and composition, migration is already playing a significant role in El Salvador, with net outward migration averaging 3/1000 over the last few years.

Recently, recognizing the need for immediate action to ameliorate overcrowding, the GOES has entered into negotiations with various countries concerning the feasibility of Salvadoran colonists settling on their lands. For instance, investigation teams have visited Bolivia and have received invitations from Saudi Arabia, although the latter seems willing to accept only non-permanent workers rather than settlers.

International migration being politically sensitive, USAID would carefully consider any proposal made by the GOES for direct assistance in facilitating broader and more systematic migratory transfer. Yet, the Mission would attempt to identify and provide technical advisors knowledgeable in colonization schemes if the GOES continues its interest in implementing an international migration program as an integral part of its Population Policy.

3. Coordination of U.S. Resources

a. Country Team

To increase Mission consciousness of the dimensions of the population problem, its impact on development, and the consequences of various programs and policies on fertility, the USAID Population Office will schedule a series of seminars to be held in the next year for Country Team members. Whereas there is widespread recognition of El Salvador's population problem throughout the Country Team, there is a lack of sophistication about its various components, the GOES and AID strategy to address it, and of the interrelationship of policies and programs in other sectors to the success of the strategy. The USAID will require high caliber technical assistance from AID/W and central contracts to carry out such an orientation.

b. Other Donors

The Mission will continue to rely heavily on AID/W resources which are essential to maximizing impact of the bilateral program inputs. A brief resume of the more important of these resources currently

providing support to the program is illustrative of the Mission's approach to their use.

Heading the list of donor inputs to the national population program is the United Nations Fund for Population Activities (UNFPA), which has had a major project in operation with the Ministry of Health since 1975. The initial phase from August 1975 to December 1976, budgeted at approximately \$90,000, provided salary support to a small group of medical and paramedical personnel. An expanded plan to cover 1977-1980 was approved and is now being executed, with budget levels programmed at approximately \$800,000 yearly. Continued UNFPA assistance in this area of budget support is considered essential to the development of a larger core staff of MOH physicians and nurses, since Mission policy generally discourages salary support for permanent personnel of local counterparts.

IPPF as parent organization of the Salvadoran Demographic Association has traditionally contributed a large proportion of the outside assistance received by El Salvador. Current assistance of approximately \$300,000 per year is dedicated to staff and operational support, with some coverage of "special projects" such as the ongoing information program with market women. The combination of IPPF and AID support is an example of the complementary character of the assistance of each donor; i.e., the former helping the institution with the more stable costs of staff and maintenance functions, while the latter supports a complex of local project activities, requiring greater knowledge of the local situation.

Several other AID centrally-funded contractors and organizations are actively contributing to the balanced development of the El Salvador's population program. The Association for Voluntary Sterilization (AVS) is providing strong backing for the equipment requirements of an expanding sterilization program. Family Planning International Assistance (FPIA) is procuring equipment for the MOH's Maternity Hospital Master Clinic and Training Center, now under construction, as well as for the Social Security Institute program. In the research area, collaboration of the International Fertility Research Program (IFRP) has resulted in a number of published monographs on medical research by Salvadoran physicians. The Center for Disease Control (CDC) is providing technical assistance in the planning and design of Contraceptive Prevalence Surveys with the SDA, with periodic advisory services on health logistical systems to the Ministry of Health. Finally, as discussed earlier, a new project to investigate fertility determinants was begun in late 1977 under the financial sponsorship and technical direction of Battelle Institute.

Over the last several years, a centrally-funded contract with Development Associates, Inc., has sponsored short-term training and observational travel for local professionals in population. The organization continues

TABLE 11
DONORS TO FAMILY PLANNING/POPULATION ACTIVITIES: EL SALVADOR
 (in thousands of dollars)

| | <u>1976</u> | <u>1977</u> | <u>1978 (est.)</u> | <u>3 Year Total</u> |
|---|--------------|--------------|--------------------|---------------------|
| 1. UNFPA | 745 | 892 | 818 | 2,455 |
| 2. IPPF | 216 | 286 | 295 | 797 |
| 3. AVS | 62 | 305 | 200 | 567 |
| 4. FPIA | 1 | 77 | 244 | 322 |
| 5. IPRP | 84 | 86 | 103 | 273 |
| 6. CDC | 50 | 35 | 47 | 132 |
| 7. PIEGO | 28 | 27 | 42 | 109 |
| 8. DAI | 23 | 27 | 42 | 92 |
| 9. AIRLIE | 25 | 30 | 25 | 80 |
| 10. BATTELLE | -- | 10 | 45 | 55 |
| 11. PATHFINDER | 23 | 8 | --- | 31 |
| 12. UNIVERSITY OF CHICAGO | --- | --- | 18 | 18 |
| 13. APHA | <u>7</u> | <u>4</u> | <u>3</u> | <u>14</u> |
| SUB TOTALS | ,264 | 1,811 | 1,870 | 4,945 |
| USAID/EL SALVADOR (including contraceptives) | <u>781</u> | <u>775</u> | <u>654</u> | <u>2,210</u> |
| GRAND TOTALS... | <u>1,045</u> | <u>2,586</u> | <u>2,524</u> | <u>7,155</u> |

SOURCES: DS/POP/LA, September 1977;
 USAID/ES/H&

to provide key support to the service, IEC, and policy components of the program.

The Program for International Education in Gynecology and Obstetrics (PIEGO) of Johns Hopkins University has donated equipment needed to establish a maintenance center within the MOH for the laparoscopy sterilization program and provides opportunities for training of local physicians in the management of advanced fertility control techniques at Johns Hopkins University and other U. S. universities. Both JHU and the Pathfinder Fund are also actively involved in establishment of the Master Training Clinic.

Short term TDY assistance provided under the APHA and University of Chicago central contracts has allowed the Mission to respond positively on short notice to local requests in the areas of social/anthropological research and data analysis in the first instance, and of social communication/mass media techniques in the second.

Table 11 lists the most important donors to the El Salvador program in order of magnitude in recent funding levels, comparing them to USAID bilateral assistance, to provide a perspective on total external funding for Population.

D. Financial Resources Projections

To achieve the maximum impact of programmatic alternatives discussed above, sufficient financial resources, commensurate with the GOES' increasing technical and managerial capacity, must be made available on a timely basis and in the key areas identified. USAID/ES is now committing itself to the provision of bilateral funds through the development of a new project, "Population Dynamics," designed to cover the last three years (1980-1982) of the Five Year Strategy presented here.

Although at this point funding magnitudes and sources can only be estimated, the Mission believes that a combined effort of between approximately \$6 and \$7 million dollars per year is not unreasonable to expect, considering activities now underway and those projected. More specifically, approximately two thirds of this total, or \$4 million annually, will be generated by the various national entities involved in population work, led by the Ministry of Health, which in 1978 is estimated to be providing over \$3.5 million in counterpart funding. With considerable attention being drawn to El Salvador as having one of the most active population programs in Latin America, prospects are good that the other international donors will continue providing complementary assistance at the same level as in the recent past, described in Table 11. Table 12 gives estimates

of financial resources by year and source that most likely will be committed to the population program during the five years of this Strategy timeframe.

TABLE 12

Financial Resources Projected for Population Activities, 1978-1982
in thousands of dollars)

| | 1978 | 1979 | 1980 | 1981 | 1982 | TOTALS |
|---|--------------------|--------------------|--------------------|--------------------|--------------------|---------|
| <u>GOES</u> | 4,100 ¹ | 3,700 | 4,000 | 4,500 | 4,500 | 20,800 |
| Ministry of Health; Salvadoran Demographic Association; Social Security Institute; National Population Commission; other Ministries | | | | | | |
| <u>OTHER DONORS</u> | 1,870 | 1,500 ² | 1,500 ² | 1,500 ² | 1,500 ² | 7,870 |
| <u>USAID/ES</u> | 654 | 750 | 850 | 900 | 750 | 3,904 |
| Bilateral | (575) | (600) | (700) | (750) | (600) | (3,225) |
| Centrally-funded contraceptives | (79) | (150) | (150) | (150) | (150) | (679) |
| <u>TOTALS</u> | \$6,624 | 5,950 | 6,350 | 6,900 | 6,750 | 32,574 |

¹/ Higher level than 1979 due extraordinary equipment and infrastructure build-up costs.

²/ Conservative estimates.

Sources: Other donor data: DS/POP/LA, Sept. 1977.
GOES and AID estimates by USAID/ES/H&P

IV. SUMMARY REVIEW OF EL SALVADOR POPULATION PROGRAM

The USAID has considered the task of revising this paper as an opportunity to orient an essentially new Mission staff to the Salvadoran demographic situation, to review the GOES and AID programs designed to address this problem, and to identify constraints to those programs. In its review of the Strategy, the Mission has examined its adequacy and that of the GOES National Population Program in six functional areas essential to an effective Population Program; i.e., demography, policy, research (both operational and technical), services, training, and information/education/communication.

A. Demography

As discussed in the AID priorities section, the Mission believes the coordination of data is a weak area of the GOES Population Program. To strengthen it, the Mission is providing technical assistance and long and short term training to the Population Commission, the SDA and the MOH. Such assistance is aimed particularly at increasing the capability of these groups to improve program planning and implementation on the basis of reliable data on the demographic situation and effectiveness of current programs.

B. Policy

The Mission regards this as another area in which the Salvadoran program has been weak to date, at least in terms of its neglect of various means to increase acceptance of family planning by actions other than provision of services. A discussion of the adequacy of policy should include an assessment of four areas which it has been shown in other countries vitally affect program impact; i.e., government commitment, community participation, the role and status of women, and the attitudes and roles of elites.

1. Government Commitment

Government commitment at the highest levels is not lacking; yet to date programs, although strong and active, have not been particularly imaginative and have largely focused on expanding services. The transfer of the Population Commission to the Ministry of the Presidency under the dynamic leadership of the Vice-President will enable the GOES to marshal its resources more effectively to strengthen the program and remove obstacles to it. Especially needed are stronger population motivation and services programs for military and national guard personnel, sex education programs, efforts to secure authorization for distribution of oral contraceptives without prescription, and wider use of non-medical personnel in family planning services.

The GOES reluctance to date to push the program to a greater extent takes into account the rather dormant attitude exhibited by the Church in recent years on population issues. The possibility, however, that the program could be used by the Church as a weapon against the Government is a real one which must be considered in urging a more activist and open role by the GOES. The GOES Population Commission, however, strongly supported the very explicit mass media campaign now in progress and is interested in upgrading the program as a whole. To this end, an especially to underline the importance of community participation in an effective program, USAID is encouraging a wider exchange of views and program information between policy leaders in El Salvador and other countries with successful programs.

2. Community Participation

There is a lack of genuine community participation in this field as in others key to development in El Salvador. The lack of a tradition of mutually supportive action in rural areas in this country has probably been exacerbated by the greatly worsened living conditions of recent years. Both in its population program and its health strategy, the Mission will be exploring means of stimulating peer example and cooperation to improve health status. It is likely that a crucial element to success in this effort is a recognition that such cooperation will lead to economic gain or visible improvement in health or living conditions; i.e., provision of potable and easily accessible water, schools, latrines, electricity, roads, housing, etc.

3. Role and Status of Women

Government actions to improve the role and status of women have been weak. Despite the existence of a complete legal code that in theory protects rights of and prohibits discrimination against women, the laws are generally not enforced. Moreover, in several cases their enforcement could lead to greater discrimination in practice since, for example, requirements for long periods of maternity leave tend to discourage employers from hiring females. In sum, both the program and AID's strategy in this area seem weak at present and dependent on activities such as female education and skills training combined with improved access to information and services. USAID will seek technical assistance to strengthen activity in this area.

4. Attitudes and Roles of Elites

Increasingly, Salvadoran elites have recognized the implications of excess population growth. Useful in stimulating such recognition have been press and mass media, including television coverage of

problem. The SDA has been particularly active with USAID and contractor support in encouraging family planning activities on the part of the associations of cattlemen, cotton, coffee and sugar growers. A series of SDA/USAID sponsored population seminars held during 1977 for businessmen, labor leaders, military leaders, and agricultural officials has also been an effective program stimulus. The mobilization of the elites to push policy changes such as removal of restrictions on orals and development of programs in sex education and adolescent fertility has been less successful and needs to be addressed. It is in these areas that USAID will encourage the Population Commission to focus its approach to elites.

C. Research

The possibilities for research in the Salvadoran program are numerous. Nonetheless, in the interest of applying resources to areas of greatest impact, the Mission will encourage the GOES and SDA to focus on analysis of present data, evaluative research of on-going programs, and program barriers, before embarking on new research projects. Possibilities for research, however, that could contribute to program impact and be carried out either by the SDA or the Population Commission include the use of injectable contraceptives in a controlled setting; the prevalence of abortion and its effect on the health system; the basis for opposition to family planning by rural males, etc. A recently completed study of characteristics of women undergoing sterilization in MOH service facilities over the past two years should provide especially useful data for program planning.

D. Services

As the area of primary GOES and USAID focus to date, it is certainly the strongest part of the program. Efforts to strengthen it, as described above, center mainly on improved coordination and support of services and increasing demand by actions in other areas. Particular emphasis will be placed on focusing service programs, including information and motivation, on the target groups.

E. Training

The Mission assessment of the training capabilities and plans of the GOES in family planning indicates that they are adequate. To provide effective support of family planning services, however, improved training in management, in family planning communication, and in team concepts of patient client care are required. The latter refers to the need for increased involvement of the Faculty of Medicine of the National University in family planning as a means of co-opting the more than 300 MD's

graduating annually as effective supporters and administrators of family planning programs. Only in this way will it be possible to stimulate more effective use of paramedical personnel for the bulk of family planning services.

F. Information/Education/Communication

With services, this is the other strongest area of the GOES Family Planning Program. Support initiated several years ago in this area has been greatly strengthened by consultant assistance received from the University of Chicago, funneled to all three service institutions. As a result of the success of this effort, the GOES led by the National Population Commission has just developed a long range mass media strategy which should reinforce service programs and increase their appeal.