

STRATEGIC OBJECTIVE 3
Sustainable Improvements in Health
of Women and Children Achieved

RESULTS PACKAGE 3.1
Increased use of appropriate child survival practices and services

Presented for Mission Review and Approval

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I. INTRODUCTION

In order to achieve "Sustainable Improvements in the Health of Women and Children", Strategic Objective 3 (SO3) considers that several new activities must be developed and current activities must be modified or reinforced. Considering the magnitude of the interventions necessary to reach the SO and the limited strategy time period, SO3 as a team has decided to develop three Results Packages (RPs), one for each of the primary level of intermediate results. These RPs are "increased use of appropriate child survival practices and services" (child survival RP 3.1), "increased use of appropriate reproductive health practices and services" (reproductive health RP3.2) and "enhanced policy environment to support the sustainability of child survival and reproductive health services" (policy and health reform RP 3.3).

RP1 (child survival) and RP2 (reproductive health) are strongly intertwined: in general, healthy mothers produce healthy babies, and as infants and children are healthy and their births are spaced these positively impact mothers' health. RP3 (policy) is the unifying force that will bring about a synergism in SO3's strategy to push these programs towards sustainability.

This Results Package (RP) document outlines the basic structure and possible implementation mechanisms for the proposed activities in support of Strategic Objective 3, "Sustainable Improvements in Health of Women and Children Achieved."

II. PROBLEM STATEMENT

The problem to be addressed by this Results Package is access to effective primary health care services for children under five and for rural women of reproductive age (as it relates to child survival).

A. Background

Of the 5,047,925 (1992 census) Salvadorans residing in country, approximately half the population lives in rural areas. It is predominately a young population: It is estimated that within 20-25 years, 40% of the population of El Salvador will be under the age of 15. This population pyramid is typical of a country in development. Likewise the diseases and principal causes of death among women and children are characteristic of a country in development. Women die from child birth related complications and infants and children die from preventable and treatable conditions, such as acute respiratory infections and environmentally related diseases such as diarrhea, all exacerbated by underlying malnutrition and parasites.

Major governmental and USAID efforts during the 1990-1996 period have resulted in improved health in El Salvador especially for women and children. According to the 1992 census, the life expectancy at birth (LEB) was estimated to be 60.5 years for men and 69.1 years for women. This is an improvement from 1971, when those values were 52.6 and 56.9 respectively (an increase of approximately 10 years). It is expected that the trend will continue and in 2010 the LEB will reach 72.7 years

(similar to developed countries). While infant (0-1 year) mortality is decreasing and child (under 5 years) mortality is decreasing nevertheless these vulnerable groups (women in reproductive age, infants, and children under five) deserve targeted health interventions as they suffer the most from preventable and child birth related illnesses and are protected the least.

B. Infant and child mortality

Infant (from birth to one year) mortality and child (1-5 years) mortality in El Salvador continues to decrease:

	<u>1960</u>	<u>1995</u>
infant mortality	130	34
child mortality	210	40

source: UNICEF, "Estado Mundial de la Infancia", 1997

Decreases are due to primary health efforts such as vaccines, oral rehydration therapy, breastfeeding and growth monitoring programs. Decreases in overall rates are due to fewer post neonatal deaths, since the neonatal death rate has not decreased. A little more than half of infant deaths occur neonatally (in the first 28 days of life). The three major causes of neonatal death are low birth weight/premature children (34%), delivery trauma/asphyxia (18%), and congenital birth anomalies 14% (The National Health and Demographic Survey, FESAL-93). The two most frequent causes of post neonatal death, are diarrhea/dehydration (51%) and acute respiratory infections (ARIs) 44%.

The infant mortality rate for the 1950-1955, 1970-1975 and 1985-1990 periods, and projections for the 2000 year, estimated by Centro Latino Americano de Estadística (CELADE) and the United Nations (1989) and cited in the "Health Conditions of the Americas" (Pan American Health Organization/World Health Organization, PAHO/WHO 1990), and are shown in the next Table.

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INFANT MORTALITY PER THOUSAND LIVE BIRTHS

Country or sub-region	1950-1955	1970-1975	1985-1990	2000
Latin America	127	82	55	41
El Salvador	151	99	60	36
Non-Latin Caribbean Region (Jamaica, Bahamas, etc)	83	40	21	15
North America	29	18	10	7

Source : PAHO. American Continent's Health Condition. *Scientific Journal* 524. 1990.

The primary causes of child deaths (1 to 5 years) are acute respiratory infections 28% and dehydration from diarrhea 24% and measles 13% (FESAL-93). In spite of improvements in the last 35 years infant and child mortality rates are still high, particularly in comparison with the non Latin countries of this region. These rates can be improved, especially for the rural population. The figures shown above are averages. For instance, the estimated infant mortality for 1990 is 50 per thousand live births, ranging from 44 per thousand in the metropolitan area, 60 per thousand in the peri-urban area and 73.1 per thousand in ex-conflictive zones. Just looking at death due to dehydration from diarrhea and comparing the rural and urban rates: 30% of infant deaths due to this cause were in rural areas versus 22% in the urban areas (FESAL-93).

C. Infant and child morbidity

Acute Respiratory Infections and Diarrheal Diseases

Respiratory infections and diarrheal diseases are the main infant and child health problems. The main reasons listed for 80% of outpatient visits for children under five in 1990 were Acute Respiratory Infections (ARIs), intestinal infections, and intestinal parasites. The lack of access to potable water, the inadequate disposal of sewage and garbage, and other contamination (both in food and water), contribute to the spread of infectious and parasitic diseases. In a 1992 study (in 80 sentinel locations), the prevailing diagnosis was diarrheal disease. The Metropolitan and Eastern areas of El Salvador had rates around 30%, while the other regions (Central, Paracentral and Oriental) had rates between 40% to 42%. Respiratory infections are exacerbated by poor air quality which in San Salvador is second only to Mexico City in excessive particulates (Miami Herald, January 1996). According to FESAL-93, ARIs are the second cause of death in infants and children. In the group from 1 to 4 years, ARIs are the primary cause of death, both in urban and rural areas. According to FESAL-93, 69% of children under 5 had had some sort of respiratory infection in

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the past 15 days before the FESAL interview, 94% of the cases received some kind of treatment, 44% were seen by a doctor or a nurse and antibiotics were used in 62% of the cases in the Metropolitan Area of San Salvador and 48% in the rural area. While some Non Governmental Organizations (NGO) are successfully using sulfa drugs in ARI with good results, Ministry of Health (MOH) health promoters are not permitted to use them. Non-governmental organizations (NGOs) that had used sulfa drugs in the past for ARI and are not allowed to use them anymore report higher numbers of cases that must be referred elsewhere for treatment in a system where it is often not known if the patient follows up on the referral or how the referral is managed. (Note: the World Health Organization recommends allowing health promoters to treat certain respiratory infections with sulfa drugs).

Vaccines

Immunization rates have increased in El Salvador. The country is now free of poliomyelitis, the last case having been detected in 1988. Diphtheria was detected for the last time in 1987. The rates (per 10,000 inhabitants) of immunization-preventable diseases, have decreased between 1988-1992 as follows: whooping cough: 1.2 to 0.5; Measles: 321.8 to 9.4; and Neonatal tetanus: 0.6 to 0.5. Child immunization coverage is over 80% (FESAL-93). The proportion of children under five with complete immunization in 1993 was the following: BCG: 87%; polio: 82% and measles 86%. Nevertheless health promoters continue to report situations where vaccines are not available.

Nutrition

Insufficient and incomplete nutrition for pregnant women¹, newborns, and children constitute one of the most important health problems in El Salvador. Insufficient nutrition causes growth retardation (affecting weight and height) and incomplete nutrition (the lack of certain nutrients such as iodine, vitamin A, iron, etc) can cause specific diseases (goiter, cretinism, xerophthalmia, and anemia). A child that at birth weighs less than 2,500 grams has higher possibilities of getting sick and dying in its first year of life. Figures on weight at birth are not complete in the country which constitutes an important lack of information. This is because almost half of the births occur at home (making the registry of weight more difficult). While there are not good statistics on the number of low birth weight infants or on the impact of low birth weight on disease rates it was shown in the section on infant mortality that low birth weight is the third most common cause of death in infants.

The last major nutrition survey which was an exclusive nutrition survey was done in El Salvador in 1988 during the 12 year civil war. The following deficiencies were detected: low caloric intake, low protein (especially of animal origin), and deficiencies of vitamin A and iron. The worst deficiencies were found in the most economically disadvantaged rural areas. Certain habits contribute to low nutritional status including inappropriate weaning practices where babies are given weak teas and soups as early as one month. Although peace accords were signed in 1992 when a follow up nutrition sampling was done to the 1988 survey in 1994 it was found there

¹There is a well established link between maternal nutrition during pregnancy and birth weight.

was no improvement in nutrition status especially in children, based on weight for height. High levels of moderate and severe malnutrition are still found especially in children under five. The Pan American Health Organization lists El Salvador as being on the borderline of countries at high nutritional risk.

Iodine deficiency: The MOH, UNICEF, and INCAP in 1990 found 25% of Salvadoran children 7-14 years old had some form of goiter. This percentage is very high. Iodine deficiency is of concern because another consequence is mental retardation. Goiter can be eradicated with low cost and easy to implement measures such as iodizing salt. The United Nations Children's Fund (UNICEF) supports domestic salt iodization programs, and with the support of the GOES and private industries, iodized salt was placed on the market in 1993. It is now estimated that 91% of Salvadoran families are using iodized salt (UNICEF, 1996).

The level of Vitamin A has not been improved among children under five since the first studies in El Salvador. In the 60's, 30% deficiency was found; in the 70s, 33%; and in 1988 36%. This is higher in the rural area than in the urban area. The problem is due to a diet poor in this Vitamin. There is a local program to fortify sugar with Vitamin A supported by UNICEF although some doubt exists as to the uniformity of the fortification and the Minister of Health has requested a study to determine levels of vitamin A in sugar. Other fortification programs include fortifying flour with iron, and fortifying flour with folic acid (to reduce birth defects and improve the mothers' health status).

In the "Evaluacion de la situacion alimentaria nutricional en El Salvador" (ESANES-88) anemia, measured by Hemoglobin deficit, was 23% among children under 5, the most vulnerable group being the children between 12 and 23 months of age.

D. Maternal morbidity

While maternal morbidity is discussed in the Results package "increased use of reproductive health practices and services", maternal morbidity will be briefly discussed here as it relates to child health. Malnutrition (especially iron deficiency) and low rates of education contribute to maternal morbidity as do frequent and closely spaced births. Women's inequitable social status put them at risk economically and health wise as they are unable to negotiate for safe sex or for desired number of children.

The limited coverage of prenatal care is due to a combination of unavailability of services and cultural practices. If more pregnancies were detected and monitored in the first trimester maternal and infant morbidity would decrease.

STD and AIDS are increasing in El Salvador. There is a resistance of the population to talk about such diseases. Currently HIV prevention is not a high priority for the MOH in spite of the fact the Red Cross is detecting one case of HIV positive blood per day.

For many women, prenatal controls constitute a diagnosis opportunity: almost 60% of the vaginal cytologies performed in the Maternity Hospital in the first semester in 1993 showed some pathogenic agent.

Other factors affecting the mortality and morbidity of both children and women is the legacy of violence from 12 years of conflict. Health promoters have reported that some men will hit their partners if she is found using birth control pills. Likewise many families have been torn apart by the conflict impacting the families' economics structure. In addition, low economic status compounded by lack of education impact the health of women and children most drastically.

III. RELATIONSHIP TO USAID/EL SALVADOR'S STRATEGY

The principal child survival health problems in El Salvador are:

- Low birth weight infants (risk for morbidity and mortality, and is related to maternal nutrition)
- Deaths during delivery due to trauma or asphyxia
- Preventable infant and child diseases, mainly diarrhea and Acute Respiratory Infections (ARI), (compounded by poor air quality and cooking practices which aggravates ARI)
- Maternal-infant malnutrition, lack of exclusive breastfeeding to 6 months, inappropriate weaning practices, lack of nutritionally adequate foods, and micronutrient deficiencies

The USAID El Salvador approved strategy for 1997-2002 describes its health Strategic Objective (SO) Three as one that will impact the health of infants, children and mothers by working in three critical areas, (a) Increased use of appropriate child survival practices and services, (b) Increased use of appropriate reproductive health practices and services, and (c) Enhanced policy environment to support sustainability of child survival and reproductive health programs. Points b, c, and Water and Sanitation will not be analyzed in this document as each of these is a separate results package for this SO, however all the RPs support each other: potable water is an important component of child survival and decreases morbidity and mortality associated with diarrhea, reproductive health decreases infant and child mortality as siblings' health is negatively affected by frequent and closely spaced births, and a favorable policy environment is necessary for all health impacts to be maximized and long lasting. The clearest mutual benefit of child survival on the other SO3 RPs is successful child survival programs decrease the number of children that a family feels they need to have because fewer children die.

Relationship to USAID global strategy:

USAID/W cites these specific steps in child survival to the year 2000 to improve child health:

1. Increase immunization coverage by 90%
2. Reduce deaths due to diarrheal disease by 50%
3. Reduce deaths due to acute respiratory infections by 33%
4. Reduce measles' deaths by 95%
5. Eradicate polio globally
6. Reduce malnutrition rates by 50%
7. Reduce maternal mortality rates by 50%

As a result of available technology being in concert--oral rehydration therapy, growth monitoring, immunizations---five million children's lives are saved each year and polio has been eliminated from the Western

hemisphere. For the new activity that will be developed to achieve this RP, USAID/ES strategies will directly support USAID/W strategies and USAID/ES will seek synergies between strategies, RPs and other SOs.

IV. ANALYTICAL/CONSULTATION PROCESS

A. External consultation

Between December 1995 and April 1997, SO3 Extended Team members, partners, customers, stakeholders and donors participated in several major presentations and discussions of the Mission's Health Strategic Objective Framework. At present, meeting with donors in the health field are taking place periodically to coordinate and maximize resource utilization in El Salvador and to coordinate areas of support for the health sector, principally via the Ministry of Health (who officially regulates health policy in El Salvador). In several extended team meetings, working groups were formed to critique the logic and validity of the entire Health SO Framework (Annex A) and all indicators of progress. Working groups also focussed on each of the Results Packages. As a result of these consultations, modifications were made to the Framework, intermediate results and indicators. The final Results Framework, intermediate results, and indicators identified to measure progress and impact are the result of a highly consultative process and consensus among local and international institutions (including donors such as PAHO, Interamerican Development Bank, UNICEF, etc.) In addition regular meetings with the donors listed above currently take place to coordinate and maximize resource utilization and to coordinate support for the MOH. The primary objective of donor meetings is to develop a common line of action to the extent possible to address the major health problems in El Salvador. The consultative process will continue via meetings with the Extended Team, partners, customers, stakeholders and donors to share goals and ongoing results, coordinate future activities and determine implementation corrections as needed. Customer satisfaction will be assessed through a variety of means, including surveys and reporting by Implementing Entities. (See Section VII, Customer Service Plan). The Mission has been seeking an approach that will coordinate health activities among donors, the MOH and other GOES agencies as well as the public and private sector to achieve greater sustainability of the health system.

B. Internal Mission Consultation

Within the Mission, SO3 is coordinating activities and efforts with other SOs. The activities of SO1, "Expanded Access and Economic Opportunity for El Salvador's Rural Poor" support SO3's RP and vice versa. As SO1 contributes to the improvement of the economic status of the rural poor, the poor are more likely to be able and willing to participate in the financing and maintenance of health systems in their communities. When women have more control over increased household resources they tend to spend it to improve the families' nutritional status. The Intermediate Indicator of SO1 "Improved curricula and training methods adopted", which includes hygiene education, reinforces the community education intervention of this RP. This RP contributes to SO1 by improving the health of the rural poor so they are better able to take advantage of basic education and work opportunities and spend less money and time caring for sick family members. Healthier people are more productive. SO1 also increases the diversity of available agricultural products in the market which benefits

the nutritional status of Salvadorans.

SO3 also contributes to the achievement of SO2's Intermediate Result "Increasing Citizen Participation in Strengthened Local Governments" by assisting citizen participation in civil society organizations through its support to communities to develop Community Health Committees. SO3 has seen that water committees can be a source for community organization for other development activities and plans to foment the use of health committees and other local community groups to manage medicines for the community and possibly to contract health promoters. Also contributing to SO2, the proposed New Activity would include a component on violence prevention which would improve women's knowledge about their human rights and thereby further SO2's "More Effective legal/judicial protection for all citizens" intermediate result. SO2 democracy activities would also improve women's status by placing particular emphasis on getting women to register to vote. SO3 and SO2 are currently exchanging ideas on how they may combine efforts to lobby the newly elected Health Committee in the Assembly to further a health agenda that increases health care availability to the rural poor.

SO3 is mutually supportive of SO4 in that all efforts to improve the quality of air and water improve child health. Further, a clean environment improves not only human health but is beneficial to the economy; resources are preserved and expanded.

There will be close coordination among all SO3 RPs as none of the RPs will be fully successful without the success of the other RPs. Several donor countries and organizations carry out interventions that contribute to the achievements of this RP: the European Community, Sweden, Germany (GTZ), Japan (JICA), Luxembourg and Spain, as well as the UNDP, PAHO, UNICEF, UNFPA, and the IDB. They are implementing activities with the MOH for example programs in reproductive health, nutrition, and improving administrative management. The Health Minister is assigning different departments to donors. For now, USAID has been assigned Cuscatlan as a test department for health reform. However, SO3 child survival and health programs are active throughout the country.

The GOES "Five Year Plan for 1994 to 1999 states specific objectives in health which are: (a) to improve health conditions of children under five years of age, of women in reproductive age, especially pregnant and breastfeeding women; (b) to improve nutrition levels of children under five and of pregnant and breastfeeding women, (c) to avoid proliferation of contagious diseases while consolidating the achievements in vaccination; (d) to improve environmental conditions of the population, especially those living in rural and marginal-urban areas; (e) to strengthen and expand community health education programs; (f) to establish a universal health insurance program. SO3's strategy is in harmony with the MOH plan.

C. Critical assumptions

A number of critical assumptions have been made that underlie the ability of this RP to contribute to the achievement of the overall Health SO. These include:

1. The GOES will increase its support to reform efforts that will lead to improved access to health services for the rural poor.

2. Other donors and USAID will continue to support the GOES in these activities.
3. USAID will continue to have adequate financial resources to complete its objectives in the strategy period.
4. The underlying social conditions leading to the civil conflict that still exist, such as environmental degradation and inequitable access to social services and economic opportunity, will be adequately addressed to avoid another period of civil conflict.

V. SUMMARY OF ACTIVITIES/EXPECTED RESULTS

A. Current Activities

The SO3 Intermediate Result "Increased use of appropriate child survival practices and services" has four sub-results:

1. Increased availability of Integrated Management of Childhood Illnesses (IMCI) at the facility level.
2. Increased care seeking behavior at the household level.
3. Improved services by health promoters at the community level.
4. Increased access to potable water and sanitation systems (to be addressed by the Water results Package).

To accomplish these results, the Child Survival Results Package manages four projects:

1. Maternal Health and Child Survival (PROSAMI) Project 519-0367
2. Family Health Services (with the Salvadoran Demographic Association, SDA) Project 519-0363,
3. Health Systems Support (APSISA) Project 519-0308
4. Public Service Improvement (The "Water" Project) Projects 519-0320 and 519-0394)

The following is a description of each one of these activities and its child survival activities.

1. Maternal Health/Child Survival (PROSAMI) Project 519-0367: This project is carried out by 12 local Salvadoran Non-Governmental Organizations (NGOs). It started in July 1990 and will end December 1998. The child survival activities of this project are implemented through health promoters, traditional birth attendants (TBAs) or midwives, and community participation is fostered via health committees and community volunteers. Promoters make home visits to detect family health and to provide individual education. Promoters also promote family planning activities and pre- and post-natal care.

The promoters, midwives, and NGO staff receive close monitoring and technical supervision from highly trained PROSAMI staff in the areas of child survival, information systems, logistics, and administration. The project has consistently demonstrated lower morbidity and mortality rates for children under five and for women than national health statistics.

(Note: At one time there were 35 NGOs in the PROSAMI network. In 1996 18 NGOs were 'graduated from PROSAMI and are currently being funded with ESF funds. Between the PROSAMI and the ESF funded NGOs 450,000 Salvadorans receive primary health care services.)

2. Family Health Services (SDA) Project 519-0363: This Project is carried out by the local International Planned Parenthood Foundation (IPPF) affiliate the Salvadoran Demographic Association (SDA). It started in July 1990 and it is expected to be completed by December 1998. The project purpose is to continue to expand the delivery of birth spacing and maternal child health services to high risk populations in rural and marginal urban communities, attending women in reproductive age and children under 5 years. The major emphasis of this project is family planning, however primary health care services are provided to children under five years. Community education is provided through Health Promoters and Community Based Distributors. The Health Promoters educate and inform the communities on the importance of reproductive health and child health care via individual and group talks using various educational materials. The SDA clinic system provides services such as distribution of contraceptives, treatment of immunopreventable and sexually transmitted diseases, birth spacing, maternal and child health, prenatal and post-natal care and nutrition. The satellite clinics provide patient referrals (family planning, pre- and post-natal care, and child health care) and continuous training to the physicians managing the clinics.

SDA health promoters also treat children with diarrhea, distribute ORS, refer children from vaccination and ARI, and distribute vitamins for children.

3. Health Systems Support (APSISA) Project 519-0308: This Project is carried out by the Ministry of Health (MOH). It started in August 1986 and is planned to be completed by August 1999. Following its original purpose, the project supports and strengthens the capability of the MOH to deliver basic health services and has improved the MOH's logistics' systems. Through this project the MOH has increased the responsibilities of the Community Health Promotor, including doubling the number of medicines they dispense, initiating a Community Contraceptive Distribution Pilot Project (using Community Health Promoters), and has revised the Integral Maternal Child Protocol to increase their service coverage. APSISA also provides support to vaccination campaigns via mass media efforts.

With the possible exception of APSISA, all other current USAID/ES health projects listed above are scheduled to end by December 31, 1998.

4. Public Service Improvement (The "Water" Project) Projects 519-0320 and 519-0394):

This project was begun in 1989 and was originally envisioned to be implemented through the country's government water agency ANDA

(Administracion Nacional de Acueductos y Alcantarillados). The purpose of the project was not only to repair infrastructure damaged by years of civil conflict but also to reduce diarrhea related deaths and illnesses in children under 5 years through access to potable water, improved hygiene practices and appropriate use of latrines. In 1993 the project underwent a major revision and was subsequently contracted out to three NGOs: CARE, PCI and CREA. The project not only has provided potable water and water systems to more than 100,000 beneficiaries nationwide (only considering the project 320) but also includes health education through health committees to reinforce preventive health practices and decrease diarrhea. The water project is vital for the achievement of SO3 and it will continue through this strategy period (2002).

Furthermore, USAID/Washington has several projects active in El Salvador which currently contribute to the achievement of this RP:

Access to Family Planning Through Women Managers No. 936-3059 implemented by the Center for Development and Population Activities (CEDPA): Has trained women NGO leaders in Health Program management skills and is currently organizing a seminar on the role of NGOs in Health Care Reform that will take place in El Salvador this August.

Opportunities for Micronutrient Interventions (OMNI): No. 936-5122. OMNI works with the MOH to decrease micronutrient deficiencies. Currently OMNI is providing technical assistance to the Ministry of Health on nutrition issues, specifically vitamin A education campaigns. They developed a packet of nutrition counseling cards for promoters and are currently developing a public awareness campaign for vitamin A scheduled to start September 1997.

Initiatives in Family Planning and Breastfeeding: No. 936-3061 : Contracted to Georgetown has trained a local NGO, CALMA, has been trained in natural family planning methods. CALMA has been training other NGOs in this method.

REGIONAL INITIATIVES:

Basic Support for Institutionalizing Child Survival (BASICS). With regional funds from LAC, BASICS and PAHO are training the MOH in most of Latin America in the WHO protocol for the Integrated Management of Childhood Illnesses. Health professionals at the clinic level are trained to identify and treat the major causes of infant and child illnesses and death with a comprehensive approach to child health. El Salvador is the regional center for IMCI and the first regional training is scheduled for June of 1997. USAID/ES is interested in the link between IMCI at the clinic and in the community via the health promoter and has contracted BASICS to develop this link.

Proyecto Accion Sida de Centroamerica (PASCA) : A regional Central American HIV Project to strengthen the capacity of Central America organizations to provide information and services of HIV/AIDS infections to risk populations. The project will focus on peer education and prevention. Pediatric AIDs is an increasing problem in El Salvador so this project directly supports child survival activities.

B. New Activities

The new activity or activities will be developed after this RP is approved. It/they will be designed and obligated in FY98 with an expected life of activity of five years, coinciding with the Mission's strategy period ending in 2002. The interventions that the new activity(ies) will develop to support child survival will include most of the features of the current activities but will incorporate the most successful aspects of current activities which will be determined during the design of the new activity(ies). Current approaches will be evaluated and as a result modified, improved, replicated or discarded.

The New Activity(ies) will continue to address the following technical interventions:

1. **Control and Prevention of Diarrheal Diseases:** training for health promoters and midwives on causes and methods of diarrhea prevention (e.g. washing hands, washing food (especially vegetables and fruits), boiling water), preparation and use of oral rehydration solutions and referral of high risk cases. Coordination with activities under the Water RP will be required.
2. **Control of Acute Respiratory Infections:** training for health promoters and midwives on identification of individuals at risk, detection of infection, simple treatment and knowing where and when to go to obtain medical attention and referral of high risk cases.
3. **Vaccination:** promotion of and support to national campaigns, training for health promoters and midwives on vaccinating against infectious diseases as a preventive intervention.
4. **Address Nutritional Needs of the At Risk Population** (malnutrition, micronutrient deficiencies): training of health promoters and midwives regarding assessment of nutritional status of children under age five, micronutrient activities, coordination with the MOH and other donors (World Food Program (WFP), PAHO, GTZ) in activities related to the Nutritional Rehabilitation Centers.
5. **Breastfeeding Promotion:** exclusive breastfeeding for at least the first four months, child feeding practices, healthy food options for weaning diets and breastfeeding to prevent ARI.
6. **Health and Nutrition Education and Counseling:** On topics related to the care of the newborn, hygiene education, waste disposal, use of clean water, maintaining a clean house, use of cooking stoves outside the house, avoidance of breathing cooking smoke (ventilation of the kitchen), balanced diets for the small children, prevention of malnutrition and other nutritional deficiencies, and appropriate feeding practices during illnesses.
7. **Growth Monitoring:** training of promoters, midwives, caregivers in techniques and counseling skills and the use of charts for observing the nutritional status of the children under age five, provision of some equipment (weighing scales and charts).

8. **Education for Prevention of Violence:** support educational activities of committees, volunteers groups, NGOs, etc. involving the prevention of violence and abuse in young children and women.

Other considerations include:

One key consideration of this/these new Activity(ies) is more intensive coordination with other Mission and USAID/Washington activities and other efforts. The New Activity(ies) will be an integrated approach to Child Survival. The intention is to create a synergistic effect in the community.

Another key consideration is the geographic focus. To define the primary geographic focus of the USAID/ES Child Survival Health Activities to be carried out under the new activity, the following will be considered:

- a) the MOH test department(s) for the implementation of the MOH "modernization plan" (health sector reform)
- b) "the USAID/ES modal municipalities, determined through poverty focus criteria as determined by the Mission
- c) areas where other USAID activities and donors are working to attain synergistic effects
- d) areas of greatest need as identified through surveys or studies: areas with high infant and child mortality and morbidity rates.

A key consideration is the target population: At this time the exact number of beneficiaries is unknown however the entire country has approximately 1,260,000 women in reproductive age and children under 5 years of age in rural areas and it is estimated this program will benefit at least 20% of this population.

This or these new activity(ies) allow the SO the opportunity to make the most of successful past programs and try new strategies in the future. The SO team will look for new partners to implement the activity(ies) and may or may not continue to work with current partners. Other potential partners include: The Secretariat for the Family, other Salvadoran NGOs, other International NGOs, The Social Security Institute (ISSS), and local community organizations.

VI. FEASIBILITY ANALYSIS

A. Current Activity

Numerous analysis, reports, and Project Evaluations have been conducted world-wide that have demonstrated that health prevention and promotion activities are critical to reach a reduction in infant and child mortality rates, diarrheal diseases, acute respiratory infections, and immune preventable diseases. In addition, other studies listed in Annex E.2 "Feasibility Analysis" were conducted in El Salvador and provided information that lead USAID to utilize the approach of working through health promoters and midwives to decrease infant and child morbidity and mortality in rural areas.

B. New Activity(ies)

No additional analysis are necessary at this time for the new Activity(ies)

however another FESAL National Health and Demographic Health Survey is planned for 1998.

VII. CUSTOMER SERVICE PLAN

SO3 has defined its customers as women in fertile age and children under five years old who are socially, geographically, economically and culturally disadvantaged Salvadorans who lack adequate access to health services. This Results Package has the same customers: the rural poor who lack adequate access to potable water, sanitation facilities, and infant and child health services in their communities.

To identify customer needs in this Results Package, the following, and possibly other, techniques will be used:

1. Informal Surveys: Informal surveys, i.e., those lacking statistical significance based on sample size and lacking conventional highly technical and sophisticated survey techniques but nonetheless are valuable tools for collecting customer service information. They will be conducted about every six months.
2. Formal Surveys: Professional researchers will be utilized to design client satisfaction surveys with statistical significance, conduct the surveys and analyze the findings.
3. Interviews: The informal and formal surveys will include interviews, and in addition, independent interviews will be conducted with randomly selected community members.
4. Home visits: Most of the previously mentioned methods of gathering customer information will include home visits to clients.
5. Focus groups: Professional researchers and or SO members will be utilized to conduct focus groups to obtain information on customers needs and opinions.
6. Community Meetings: Town meetings or meetings with various local civic groups will also provide means to understand client concerns.
7. Field visits: Periodic field visits by implementing staff, SO3 Team members, and contractors will provide valuable information on both customer needs and activity performance through direct observation, home visits, focus groups and/or interviews. Trip reports will contain a section on customer service.
8. Information exchange: Mechanisms to regularly exchange information with the Government of El Salvador, other donors, partners and stakeholders providing similar services will be developed and implemented (example, taking field trips together) and current regular meetings will continue.
9. Formal or conventional communication: Letters, phone calls and faxes between customers, community organizations, local press, implementing agencies and donors will also provide an avenue to understand customer views and concerns.

Sharing information with customers and providing feedback will be done on both an individual and community basis. For example, during field visits and via letters, the individual client will be able to receive a direct answer to his/her concerns. For the community at large and its many subgroups, public community meetings will be used to provide feedback on the findings and conclusions from formal surveys and focus groups. Such meetings will also be used to provide information to the community on the incidence and severity of diseases and other related health issues in their community, and the community will be encouraged to develop solutions.

To date, fieldwork by Mission staff and contractors, the 1994 National Health Sector Assessment (ANSAL), CID Gallup Polls, and informal focus groups and interviews conducted by Mission staff and partners, have provided information about our customers. As part of the ANSAL, ten community meetings held around the country in late 1993 and early 1994 which were attended by a wide variety of local citizens, health professionals, community leaders, and others. Also as part of the ANSAL, a study, "Community Perceptions and the Demand for Health Services" was prepared. It included the findings of personal customer interviews in eight departments which were analyzed in conjunction with several national surveys to assess the demand for health care services in El Salvador, community perceptions of illness and treatment, local perceptions and practices related to preventive health care, and the role of the health promoter. The report states:

"People consistently displayed their basic understanding of preventive health when they responded to the question, "What do you think is needed to improve peoples' health in your community?", with some variation most people responded "potable water, better personal hygiene," as well as "more clinics and doctors".

Several CID Gallup Polls have reported citizen knowledge about water's relationship to their health. An August 1996 CID Gallup Report on the results of a series of focus groups reported, "It is common for children to suffer from diarrhea, and parasites....." and "These ailments are due mostly to the lack of hygiene in homes and to water that is not safe to drink...."

The new activity(ies) will be designed and implemented with even greater attention to the gathering and use of customer information and feedback. The mechanisms discussed above will be used, including informal methods such as community meetings, informal interviews, home visits and direct observation, as well as more formal surveys and studies, such as CID Gallup Polls, the Demographic and Health Survey, specific health surveys, and evaluations. This RP will seek to strengthen customer services and provide timely feedback to ensure active and full participation by community men and women at every step in the planning, implementation and evaluation stages.

VIII. HUMAN CAPACITY DEVELOPMENT NEEDS

The human capacity development needs under this Results Package are in the areas of: a) increased use of appropriate child survival practices and services b) increased IMCI skills c) increased care seeking behavior at the household level and d) improved services by health promoters at the

community level. Human capacity development will be addressed through on-site technical assistance, one-on-one communication, group talks and formal institutional based training. Community members who are most likely to be included and directly benefit from this human capacity development intervention include adolescents, men and women in fertile age, community leaders, Health Committee members, local government representatives, NGO and MOH Health Promoters, school teachers, mothers and fathers, and other community members directly involved in the design, implementation monitoring and evaluation of the new activity(ies).

For the Child Survival primary health providers at all stages, the need for knowledge and improved skills in the areas of technical, service provision, interpersonal relationships, communications, and organizing the community must first be determined using many of the same techniques that will be utilized to develop a base for customer information, such as: focus groups, direct interviews, direct observation and surveys.

Once specifics are determined for each health provider, human capacity development interventions and techniques including (but not limited to the following) will be used as needed and appropriate:

1. Seminars or workshops for community leaders, Water Committees, Health Committees, and local government representatives,
2. Refresher training for NGO/MOH Health Promoters working in the communities,
3. Pamphlets and brochures for residents,
4. Observational travel to other areas of El Salvador or to other countries if appropriate,
5. Technical assistance, and
6. On-the-job training.
7. Non traditional education: community development planning, Non written communication methods if appropriate.
8. Peer education (for example, mother to mother support for breastfeeding, child to child teaching of preparation of ORS)

Additional in-country training will be provided to customers/partners of the Results Package from the new Human Capacity Development (HCD) Activity (519-0432) core funds in cross-cutting topics such as leadership, empowerment skills, NGO strengthening, conflict resolution, self-esteem, strategic planning, total quality management, customer service, sustainability approaches, etc.

On the other hand, both technical training and cross-cutting topic seminars will closely follow reengineering training guidelines which include: (a) agreements with stakeholders, (b) change agent concept (leadership, training of trainers, action planning), (c) training needs assessment for annual training plan, (d) critical mass approach and multi-level training, (e) multi-level training, and (f) group dynamics.

All these training activities will be coordinated/channeled through the HCD Activity and with the Mission's Training Unit by developing and submitting annual training plans responsive to the specific Activity under this Results Package. Once the Activity is developed, it is envisioned that the annual contributions for specific training activities will be facilitated through MAARDS/Delivery Orders for implementation of customized training during each Fiscal Year. Moreover, the Activity will take advantage of cross-cutting topic seminars offered by the HCD Activity and its core funding to improve/advance human capacity building of key institutional personnel as well as rural end-customers.

The result of all these training activities will be significant contributions to Intermediate Result 3.1 "increased use of appropriate child survival practices and services" with its corresponding sub results.

IX. IMPLEMENTATION MANAGEMENT PLAN

A. Team Members and Responsibilities

In order for the RP to achieve expected results, not only will the RP Team members need to fulfill their obligations as described below, it is essential that customers commit to fulfilling a number of actions. They must actively participate in Health Committees or some other community organization that solves problems locally, foster beneficial health habits with family members, and in other ways cooperate with the community to protect and properly make use of health services, for example, facilitate the transportation of sick community members when a referral is required. In addition, the RP partners also need to commit themselves to fulfilling a number of actions. They are key to achieve RP results. USAID will need to improve and maintain regular coordination in planning, financing and implementing rural activities in child survival with other donors such as the Interamerican Development Bank (IDB), the GTZ, the European Union (EU), UNICEF, PMA, UNDP, PAHO, international NGOs such as Plan International, Save, CRS, with the host country government's Ministry of Health (MOH), and local NGOs providing health services.

Specific responsibilities of all RP Team members are described below, but will be modified as needed per any revised Mission Delegation of Authorities. RP Team Members are:

1. Meri Louise Sinnitt:

As the RP Team Leader and one of the coactivity managers for the New Activity(ies), assumes complete responsibility for the full range of supervision, management, monitoring, reporting, and evaluation of the technical program and financial data of the current and future activities of the RP.

Ensures broad information sharing focused on RP purpose and results to all SO3 members and others as appropriate.

Reviews all RP activities and takes actions, including recommending activities modifications and measures to correct or improve implementation, monitoring and reporting.

Acts as official USAID representative on field visits to activity sites in coordination with other members of the RP, ascertains progress, identifies delays and problems and recommends solutions to resolve them.

Takes the lead in drafting and presenting for clearance and approval, any administrative action necessary.

Provides follow-up to coordination meetings between RP members and SO3 partners, customers, USAID/W staff and its activity implementors staff, and other possible collaborators, to ensure efficient and appropriate planning, and productive working relationships and coordination.

Will prepare all required RP reports for this RP such as the R2, the R4, and other reports, tables, and narratives for Mission and Agency reviews as required.

2. Margarita de Lobo

As the RP Team Leader for the Reproductive Health Results Package (RP3.2) and as one of the coactivity managers for the New Activity(ies), Ms. Lobo will be responsible for assuring her results package supports this results package in achieving the overall SO.

Will coordinate all child survival aspects of her results package with this results package and ensures broad information sharing.

3. Terry Tiffany:

As Team Leader for SO3 provides leadership to the SO3 Team to enable each RP Team member to contribute fully and meet RP and SO3 commitments once agreed upon.

Represents the SO to the Mission and the Agency.

Is the principal donor coordinator for SO3.

4. Raul Toledo

As the Policy and Health Reform Team Leader and one of the coactivity managers for the New Activity(ies), Dr. Toledo is responsible for developing and managing policy strategies that will ensure sustainability for child survival programs and overseeing implementation of the activities.

Initiates and follows up on donor coordination activities and in keeping SO3 informed about them.

Is responsible for assuring his results package supports this results package in achieving the overall SO.

Will work closely with other RP Team Leaders and Deputy Team Leaders to ensure that all aspects of implementation, monitoring and reporting are harmonized between RPs and for the SO.

As the technical advisor for the SO and RP will review all program strategies and indicators for medical soundness, accuracy and feasibility.

5. Jack Dale

As a Deputy Team Leader of the Policy and Health Reform Results Package (RP3.3) will assist Dr. Toledo in the duties described above.

As the sustainability point person for SO3, will coordinate sustainability technical assistance for all health activities as necessary.

As one of the coactivity managers for the New Activity(ies), Mr. Dale will be responsible for assuring his results package supports this results package in achieving the overall SO.

As the key contact person with the MOH, Mr. Dale will spearhead data collection with the MOH.

6. Maricarmen Estrada

As the Deputy Team Leader for the Reproductive Health Results Package (RP3.2) will assist Ms. Lobo with the duties described above.

As the SO3 person responsible for coordinating family planning efforts through out the SO will communicate all relevant family planning technical information to all activity managers and will monitor family planning efforts in all activities.

As one of the coactivity managers for the New Activity(ies), Ms. Estrada will be responsible for assuring her results package supports this results package in achieving the overall SO.

7. Jose Antonio Ramos Chorro

As the RP leader for water, Mr. Ramos will be responsible for assuring his results package supports this results package in achieving the overall SO.

Will coordinate all child survival aspects of his results package with this results package.

Will works closely with other RP Team Leader to ensure that all aspects of implementation, monitoring and reporting are adequately covered.

The achievement of the Water results package is critical to the success of this RP. It is Mr. Ramos responsibility to ensure his RP's success.

8. Elizabeth de Tercero and Martin Schulz:

As Controller representatives to SO3 are responsible for maintaining the integrity of the accounting system, identifying potential financial problems and for proposing possible solutions.

Provide advice and assistance in all financial and accounting issues, budget reprogramming and assume responsibility for funds control management.

Coordinate the accrual process and resolve inconsistencies.

Carry out the 1311 review process twice a year.

Develop and prepare special customized financial reports and document, review and verify financial data and present information to SO team.

Review, process and transmit all vouchers to ensure accurate payments and assume lead in resolving vendor payment problems.

Review and clear financial, audit and implementing documentation and coordinate the "Recipient Contracted Audit Program" for the Mission, including HCOLC audits.

Assist in the design of any SO3 new RPs under approved SO, amendments of RPs, amendments of existing activity designs within approved RPs, etc.

Verify overhead adjustments of contracts and cooperative agreements.

Perform internal control reviews of prospective as well as current local beneficiaries as applicable.

Perform necessary review/analysis to provide for the commodity management system certification of prospective recipients as applicable and participate in the Host Country Contracting certification process.

Perform field trips to observe implementation of activities.

9. Ileana Parraga:

As the Office of Contracts and Grants representative to SO3:

Provides guidance and assistance to RP team members regarding contracting/procurement guidelines and requirements, including issues that might arise during contract performance, such as assessment of liquidated damages for late delivery, waivers of source and origin requirements, past performance requirements and its importance, performance based contracting, etc.

Is a resource for guidance on contractor performance issues and procurement questions.

Provides the same type of guidance and assistance to RP team members regarding agreements with local NGOs and international PVOs.

Suggests appropriate actions to meet RP goals, including reviewing statements of work to determine whether the needs of the RP have been adequately defined; determining the most appropriate contractual or agreement arrangement, i.e. contract versus cooperative agreement and brings irregularities to the attention of the RP leader with recommendations for corrections.

Coordinates implementation of the Annual Procurement Planning System (APPS).

10. Ana Cristina Mejía and Silvia de González:

As Strategic Development Office representative to SO3:

Provide assistance and guidance to the RP team to ensure activity design and implementation documentation is timely and prepared in accordance with the Automated Directives System (ADS) guidance.

Assist in ensuring inter-SO coordination.

Review funding actions and other documents (as specified in the Mission Delegation of Authority) for quality, compliance with Unit and Agency policies and procedures, and adherence to the Unit's Strategic Plan.

Provide guidance for the Semi-Annual Results Review (R2) and annual (Results Review and Resource Request, R4) to ensure that RP teams comply with recommendations and actions to be taken after R2 or R4 review. Assist in strategic planning and new activity design planning for the RP and coordinate RP input to the R2 and R4 process and other Mission documents.

Provide guidance on programming and implementation to assist in achieving results and coordinate RP budget and obligation planning.

Coordinate activity evaluations and provide guidance as necessary to the overall RP monitoring and evaluation process.

Keep RP team updated on USAID's policies and Mission wide guidance.

11. Ana Cecilia Villalta

As the only secretary for all four SO3 RPs, Ms. Villalta will provide all administrative support to the SO (coordinate meetings, send and receive correspondence, etc).

Ms. Villalta will be responsible for other administrative tasks associated with the RP and SO such as timekeeping.

Ms. Villalta will assist all RP team leaders, the SO team leader, and other SO members with any relevant administrative tasks necessary for the day to day functioning of the SO.

B. Implementation Mechanisms

The RP Team recommends that the new Health Activity(ies) will be implemented through either (a) Cooperative Agreement(s) and/or (a) Contract(s) for the primary implementation mechanism with a combination of local and/or international NGOs, local and/or private companies, and/or the Host Government. Coordination between multiple implementors if that is the final awarded mechanism, will be ensured by language in each agreement and/or contract that requires each one to coordinate with each other, other USAID project implementors, other donors and USAID staff.

A full and open competitive process is also recommended to award the implementation of this/these new Health Activity(ies).

Because this major new Health Activity will incorporate all activities that support the achievement of the results of RP 3.1, RP 3.2 and RP 3.3, replacing four activities that the SO3 is implementing, these RP Team Leaders and RP Deputy Team Leaders will oversee and co-manage the implementing entity(ies) of the Cooperative Agreement(s) and/or Contract(s)

through site visits, regular financial and progress reports from the implementing entities, and monthly staff meetings between USAID and implementing entities representatives to focus attention on immediate, short-term, and future needs and issues.

Listed below are the current activities which support this RP and their implementation mechanisms:

ACTIVITY NUMBER AND NAME	IMPLEMENTATION MECHANISM	ACTIVITY START-END
519-0367 Maternal Health and Child Survival	Cooperative Agreement with Medical Services Corporation International (MSCI)	07/27/90 - 12/31/98
519-0308 Health Systems Support	Bilateral Grant Agreement with the GOES through the Ministry of Health	08/29/86 - 09/27/99
519-0363 Family Health Services	Cooperative Agreement with the Salvadoran Demographic Association	07/31/90 - 12/31/98
519-0430 New Health Activity	To be determined	10/01/98 - 09/30/2002

C. Measurement of Progress

Many features of the system to monitor, measure and report on implementation progress in the current activities will continue to be used for the new activity. However, a number of changes will be made to strengthen and improve the system. For example, monitoring will be improved as the RP and SO3 Team members try to increase the number of field visits and as the RP Team meets regularly with the implementing entity(ies) to discuss progress and problems. Measurement of progress will continue to use the Intermediate Indicators in the SO3 (see Performance Monitoring Plan page 24). Additional indicators may be selected as necessary. Reporting on progress will be standardized if there is more than one implementing entity and a combined report between entities will be produced.

X. FINANCIAL PLAN

This RP will be obligated under new activity No. 519-0430, which also supports RP 3.2 and 3.3. The total amount to be obligated for the new activity is \$37,449,000 over a five year period. Amounts to be obligated for each RP will be detailed in the new activity document. Counterpart contribution from various sources (GOES and NGO's) are estimated to be \$12,484,000 over the same period. In addition to the new activity(ies), each current activity that supports this RP, will obligate a total of

\$13,994,000 in FY97 and FY98 to accomplish the goals of the SO, as follows:

<u>ACTIVITY</u>	<u>USAID/ES (*)</u>	<u>COUNTERPART (*)</u>	<u>TOTAL (*)</u>	<u>PACD</u>
519-0308	1,885	(**)	1,885	08/28/99
519-0363	3,653	1,214	4,867	12/31/98
519-0367	5,992	1,250	7,242	12/31/98

TOTAL -----
13,994

(*) Thousands of dollars

(**) LOP Counterpart Contribution for Activity No. 519-0308 has been met.

In order to provide for correct implementation and management of USAID funds, the Mission provides Activity follow-up by the Activity Manager (AM) and each of the RP team leaders and members. In addition, recipients are required to carry out annual audits that meet generally accepted government auditing standards as promulgated by the United States General Accounting Office. Counterpart contribution reports are required every quarter and are followed up by the offices of SDO and CONT together with the AM.

For new starts under the Activity, in order to determine if the prospective recipient is eligible to receive funding from USAID, a pre-award survey will be conducted by the Office of the Controller and the Office of contracts and Grants, as applicable. With regards to counterpart contributions, it is the policy of the Mission to negotiate and try to obtain as much counterpart contribution as possible to obtain maximum impact from the assistance, subject to the minimum of 25% mandated by law or USAID regulations. This requirement is not applicable, as a matter of law, to non-profit organizations or Economic Support Funds (ESF). However, USAID/El Salvador has administratively determined to apply this requirement whenever possible.

The obligation plan (USAID contribution) by fiscal for the New Health Activity (RP 3.1, RP 3.2 and RP 3.3) for SO3 is the following (in US\$000):

	FY-97	FY-98	FY-99	FY-00	FY-01	FY-02	TOTAL
519-0430	0	5,466	6,483	8,500	8,500	8,500	37,449

Recurrent cost analysis will be performed during the design phase of the New Activity.

USAID management costs directly charged to resources of the RP, are approximately \$453,526 for USAID personnel. Personnel costs directly attributable to SO#3 technical staff are \$338,618 and \$114,908 attributable to SO#3 support offices. The figures allow for a yearly increase of 10% for FSN personnel and 2% for USDH. The detail for the first year is as follows:

Category SO/ or Office	Person years	FUNDING SOURCE			AMOUNT
		OE	TF	SO	
USDH SO3	0.15	X			12,698
USDH SO3	0.70	X			27,195
FSN SO3	0.10		X		4,581
FSN SO3	0.10			X	3,835
FSN SO3	0.15			X	4,127
FSN SO3	0.10			X	1,573
FSN SO3	0.05			X	1,474
FSN SO3	0.20		X		3,302
FSN SDO	0.15		X		4,422
FSN SDO	0.15		X		2,409
FSN OCG	0.15		X		2,177
FSN CONT	0.15		X		3,384
FSN CONT	0.15		X		4,718
TOTAL	2.30				\$75,894

It is important to emphasize that the budget presented here is based more to reflect what the Mission and the SO3 Team believes might be available, not the full extent of the need. The amount budgeted for the new activity(ies) is believed to be adequate to make a contribution to achieving the strategic objective; additional funds would make a greater contribution.

The counterpart contribution for the new activity(ies) is expected to be provided mainly by the partner organizations who implement the new activity, and not solely by the Government of El Salvador. It is not possible to provide a written commitment from these prospective counterparts at this time, but it will be obtained once the implementing entity and beneficiary communities are selected.

Based on these facts and previous experience, the RP team recommends waiving the need to obtain a formal written agreement as part of authorizing the new activity. However, despite this waiver, the subsequently the Agreement would include a clause specifying that the implementing entity require counterpart participation from each of the beneficiary communities. The implementing entities of the new activity(ies) will be required to include USAID funds' financial data, reflecting expenditures and pipelines of approved line items, in the quarterly progress reports.

XI. PERFORMANCE MONITORING PLAN

Data will be regularly collected and analyzed to enable the Activity Managers and the SO Team track performance and objectively report the progress in achieving the strategic objective and intermediate results. The Activity Managers will also track inputs, outputs and processes to insure activities are proceeding as expected and are contributing to intermediate results and strategic objective as anticipated. The data will be collected by gender to demonstrate impact.

Evaluations will be used to ascertain why unexpected progress, positive or negative, is being made towards a planned result. When performance monitoring systems or other feedback mechanism indicate that expected

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results are not being achieved, the Activity Managers and the SO team shall seek to determine the reason, usually through the use of one or more activities. Evaluation will also be used to explore issues related to sustainability and customer focus.

Although it is difficult to estimate the cost of monitoring and reporting of performance because this task will be carried out by the implementing entities as part of their routine work, a rough estimate could be 10 percent of the total life of project. The RP Team suggests that an independent evaluation should be used in addition to the implementing entity's reports on the secondary level indicators. Other relevant sources of information to improve understanding of performance and to inform planning and management decision will be sought and used by the Activity Managers and the SO team. Both formal (research findings, customer surveys, experience of other development organizations) and informal (unstructured feedback from customers and partners, site visits) sources will be considered.

The Activity Managers and the SO Team will remain informed of all aspects of performance relating to USAID-funded assistance in order to effectively manage for results. Performance information, evaluation findings and information from additional formal and informal sources will be used regularly throughout planning and management processes. Specifically, the SO team will use such information to: improve the performance, effectiveness, and design of existing development assistance activities; revise strategies where necessary; plan new strategic objectives, results packages (RPs) and activities; make decisions whether to abandon program strategies, strategic objectives or results packages which are not achieving intended results; and to document findings on the impact of development assistance.

The Activity Managers and the SO team will involve USAID customers and partners to plan approaches to monitor performance, to plan and conduct evaluation activities, as well as to collect, review and interpret performance information. The following indicators will be measured on an annual basis:

- percent of children under one year vaccinated for DPT3
- percent of MOH and USAID funded NGO facilities implementing IMCI
- percent of children under two months exclusively breastfed
- percent of children under 5 enrolled in growth monitoring by health promoters

Even though these indicators will not be reported annually to USAID/Washington, the implementing entities will include this data in their quarterly reports to USAID/ES.

Indicators for the Results Package that will be collected every five years but will not be reported to USAID/Washington are:

- Incidence of diarrhea and
- Percent of children under five who have had diarrhea in the last two weeks and were treated with ORS

They will be collected through special studies such as the FESAL. This information, along with lessons learned, will be shared with partners and customers.

The following tables depict the indicators which will be tracked:

STRATEGIC OBJECTIVE 3: SUSTAINABLE IMPROVEMENTS IN HEALTH OF WOMEN AND CHILDREN			
APPROVED: 06/07/96 COUNTRY/ORGANIZATION: USAID/El Salvador.			
INDICATOR No. 2: Infant mortality rate (IMR).			
UNIT OF MEASURE: Number.	YEAR	PLANNED	ACTUAL
SOURCE: FESAL	1985 (B)		65
INDICATOR DESCRIPTION: Number of children under one year who die per 1000 live births per year.	1988		50
COMMENTS: See comments for Indicator No.1. A 1994 mid-term PROSAMI Project evaluation found an IMR of 16.5/1000 live births in project areas compared to 1993 National IMR of 41.	1993	51	41
	1998	35	
	2002 (T)	30	

STRATEGIC OBJECTIVE 3: SUSTAINABLE IMPROVEMENTS IN HEALTH OF WOMEN AND CHILDREN			
APPROVED: 06/07/96 COUNTRY/ORGANIZATION: USAID/El Salvador.			
INDICATOR No. 3: Child mortality rate (CMR).			
UNIT OF MEASURE: Number	YEAR	PLANNED	ACTUAL
SOURCE: FESAL	1985 (B)		29
INDICATOR DESCRIPTION: Number of children one through five years who die per 1000 live births per year	1988		16
COMMENTS: See comments for Indicator No.1. A 1994 mid-term PROSAMI Project evaluation found a CMR of 6.5/1000 live births compared to the 1993 national CMR of 52	1993		12
	1998	11	
	2002 (T)	10	

STRATEGIC OBJECTIVE 3: SUSTAINABLE IMPROVEMENTS IN HEALTH OF WOMEN AND CHILDREN			
APPROVED: 06/07/96 COUNTRY/ORGANIZATION: USAID/El Salvador.			
RESULT No. 3.1: Increased use of appropriate child survival practices and services.			
INDICATOR No. 1: Percent of children under one year vaccinated for DPT3 .			
<p>UNIT OF MEASURE: Percent.</p> <p>SOURCE: FESAL and MOH service statistics</p> <p>INDICATOR DESCRIPTION: DPT3 includes three doses each of the vaccine for diphtheria, pertussis and tetanus</p> <p>COMMENTS: 1975, 1985, 1988 and 1993 data are from FESALs of the same years and will be recollected in the 1998 FESAL. Beginning in 1996, annual MOH service statistics will also be used.</p> <p>MOH reported that in 1996, 100% of children were vaccinated. However, the Mission believes that 100% is overstated and that the 1996 rate is closer to the projected target of 64%.</p>	YEAR	PLANNED	ACTUAL
	1975 (B)		71
	1985		64
	1988		61
	1993		62
	1996	64	100 See comments
	1997	66	
	1998	69	
	1999	72	
	2000	75	
	2001	78	
	2002 (T)	81	

STRATEGIC OBJECTIVE 3: SUSTAINABLE IMPROVEMENTS IN HEALTH OF WOMEN AND CHILDREN			
APPROVED: 06/07/96 COUNTRY/ORGANIZATION: USAID/El Salvador			
RESULT No. 3.1: Increased use of appropriate child survival practices and services			
INDICATOR No. 2: Incidence of diarrhea in the last two weeks among children under five years			
<p>UNIT OF MEASURE: Percent</p> <p>SOURCE: FESAL</p> <p>INDICATOR DESCRIPTION:</p> <p>COMMENTS: Contractor reported diarrheal incidence data in three clusters of communities that received potable water systems and latrines, indicated the following decreases: 112/1,000 to 45/1,000 from 1994 to 1995; 14/1,000 to 4/1,000 from 1994 to 1995; and 16/1,000 to 12/1,000 from 1995 to 1996.</p>	YEAR	PLANNED	ACTUAL
	1985 (B)		36
	1988		29
	1993		24
	1998	21	
	2002 (T)	18	

STRATEGIC OBJECTIVE 3: Sustainable Improvements in Health of Women and Children Achieved.			
APPROVED: 06/07/96 COUNTRY/ORGANIZATION: USAID/EI Salvador.			
RESULT No. 3.1.1: Increased availability of integrated management of childhood illnesses (IMCI) at facility level.			
INDICATOR No. 1: Percent of MOH and USAID funded non-governmental organizations (NGOs) facilities implementing IMCI. (AI)			
UNIT OF MEASURE: Percent.	YEAR	PLANNED	ACTUAL
SOURCE: MOH and NGOs service statistics.	1996 (B)	See comments	
INDICATOR DESCRIPTION:	1997	1	
COMMENTS: The baseline number of MOH facilities is 375 (30 hospitals and 345 health units and posts). The baseline number of NGOs includes two clinics among the 12 PROSAMI Project NGOs; six clinics among the 18 SETEFE funded NGOs formerly of the PROSAMI Project and 26 clinics from the SDA. The total base number is 409.	1998	3	
	1999	8	
	2000	13	
	2001	17	
	2002 (T)	20	

STRATEGIC OBJECTIVE 3: Sustainable Improvements in Health of Women and Children Achieved.			
APPROVED: 06/07/96 COUNTRY/ORGANIZATION: USAID/EI Salvador.			
RESULT No. 3.1.2: Increased care seeking behavior at household level.			
INDICATOR No. 1: Percent of children under five years who have had diarrhea in the last two weeks and who were treated with oral rehydration salts (ORS). (QI)			
UNIT OF MEASURE: Percent.	YEAR	PLANNED	ACTUAL
SOURCE: National Demographic and Health Survey (FESAL).	1985 (B)		26
INDICATOR DESCRIPTION:	1988		13
COMMENTS:	1993		47
	1998	52	
	2002 (T)	62	

STRATEGIC OBJECTIVE 3: Sustainable Improvements in Health of Women and Children Achieved. APPROVED: 06/07/96 COUNTRY/ORGANIZATION: USAID/El Salvador.			
RESULT No. 3.1.2: Increased care seeking behavior at household level.			
INDICATOR No. 2: Percent of children under two months exclusively breastfed. (AI)			
UNIT OF MEASURE: Percent.	YEAR	PLANNED	ACTUAL
SOURCE: National Demographic and Health Survey (FESAL) and MOH and NGO service statistics. INDICATOR DESCRIPTION: COMMENTS: 1993 baseline data is from the 1993 FESAL and will be recollected in the 1998 FESAL. Beginning in 1997, annual MOH and NGO services statistics will also be used.	1993 (B)		23
	1997	24	
	1998	25	
	1999	26	
	2000	27	
	2001	28	
	2002 (T)	29	

STRATEGIC OBJECTIVE 3: Sustainable Improvements in Health of Women and Children Achieved . APPROVED: 06/07/96 COUNTRY/ORGANIZATION: USAID/El Salvador.			
RESULT No. 3.1.3: Improved services by health promoters at community level.			
INDICATOR No. 1: Percent of rural children under five years enrolled in growth monitoring by the health promoter. (AI)			
UNIT OF MEASURE: Percent.	YEAR	PLANNED	ACTUAL
SOURCE: MOH and NGO service statistics. INDICATOR DESCRIPTION: COMMENTS: The baseline and planned targets are estimated at this time based on incomplete data and 1991 census data. It is expected that by late 1997, more accurate and complete data will be available and the baseline and projected targets (both numbers and percent) will be adjusted accordingly. The total number of children under five enrolled in growth monitoring in 1995 reported by the MOH and 30 USAID funded NGOs, was 294,892 and decreased to 275,682 in 1996.	1995 (B)		39
	1996		36
	1997	41	
	1998	46	
	1999	51	
	2000	56	
	2001	61	
	2002 (T)	66	

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USAID/El Salvador

STRATEGIC OBJECTIVE 3
Sustainable Improvements in Health
of Women and Children Achieved

RESULTS PACKAGE 3.2

Increased Use of Appropriate Reproductive Health
Practices and Services

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I. INTRODUCTION

In order to achieve "Sustainable Improvements in the Health of Women and Children", the Strategic Objective No. 3 (SO3) considers that several new activities will have to be developed and current activities will have to be reinforced and/or re-oriented. Considering the magnitude of the interventions needed to reach this goal, the SO3 team has decided to develop three Results Packages (RPs), one for each first level Intermediate Results. These RPs are: "Increased use of appropriate child survival practices and services" (Child Survival) RP 3.1, "Increased use of appropriate reproductive health practices and services" (Reproductive Health) RP 3.2 and "Enhanced policy environment to support sustainability of child survival and reproductive health programs" (Policy and Health Reform) RP 3.3.

The Reproductive Health Results Package (RP 3.2) will closely coordinate actions with the Child Survival Results Package (RP 3.1) and the Policy and Health Reform Results Package (RP 3.3). Under this Reproductive Health (RP 3.2), not only is maternal health an important priority in its own right, it is also the essential foundation for all successful child survival programs, because it affects child's health and the woman's ability to nourish and nurture her children. Healthier mothers save children's lives and produce healthier children. Given that maternal health and child survival are so intimately interlinked, this RP 3.2 will closely work with the Child Survival RP 3.1 to join efforts to reduce maternal and child mortality and morbidity. Additionally, the Reproductive Health RP 3.2 will also support all activities carried out under the Policy and Health Reform RP 3.3, for all changes made to improve the health care system to provide a sustainable, equitable and efficient service to the population, which will immediately impact the health of the women and children benefited by this.

This Results Package (RP) document outlines the basic structure and possible implementation mechanisms for the proposed Reproductive Health activities in support of the Strategic Objective 3, "Sustainable Improvements in Health of Women and Children Achieved."

II. PROBLEM STATEMENT

The problem statement has been divided into several specific problems according to the different expected results stated in the United States Agency for International Development (USAID) 1997-2002 health strategy.

A. Epidemiological Profile.

El Salvador is a small densely populated country (240 inhab./km²), with 50% of the population in rural areas. The annual growth rate is 22%. The population living in communities with more than 2,000 inhabitants are considered urban population. Some health indicators improved over the 1988-1993 period,

despite the war and its devastating impact on income and the health service delivery systems. However, the health sector still faces serious problems, in spite of the important achievements in the control of transmissible diseases, fertility, malnutrition, and other problems of epidemiological pre-transitional profile (characteristics of an agrarian society) prevail. All of these conditions threaten the health status of Salvadoran citizens, particularly those whose health is complicated by their poverty, nutritional status, immunological status, and lack of access to basic health care services. There is a marked contrast in the health of rural and urban residents.

The 1992 population census states that El Salvador's population is 5,047,925 inhabitants, of which nearly 65% are women of fertile age (20 to 49 years) and children under fifteen. This group has the major health problems and at the same time this group is the one which is relatively less attended. Their main problems are primary health, which may become more serious if they are not prevented nor treated.

Women are especially vulnerable to illness and death due to mistimed and too frequent pregnancies and the additional stresses which these impose on what is frequently an already compromised health status. The most recent maternal mortality data comes from the National Demographic and Health Survey (FESAL) 1993, which indicates a national estimated rate of maternal mortality in 158 deaths per 1,000 thousand live births recorded. This is similar to that reported by Ministry of Health (MOH) (147 per 1,000 live births recorded), but it is significantly lower than the one estimated by the Pan American Health Organization (PAHO) (300 per 1,000 live births recorded).

The main causes of maternal mortality in 1992¹ as reported by the MOH were: hemorrhages (34.04 %), pregnancy toxemia (34.0), postpartum sepsis and post-abortion complications (10.63%).

B. Principal Reproductive Health Problems.

The most important Reproductive Health Concerns to be addressed in El Salvador are: *pre-natal care, deliveries, post-natal care, family planning, sexually transmitted diseases (STDs) including AIDS, and others such as cervical cancer and violence in women and children.*

Pre-natal Care: Defined as the health care provided to the pregnant mother to decrease the risk of death for the mother, leading to proper care during the delivery. Pre-natal care favors the patient's referral to an adapt level of care when risk is detected. A large number of women who deliver in health facilities or at home in El Salvador never receive prenatal care. For many women the first contact with a health facility or provider is during delivery. The Integrated Norms of Maternal

¹ ANSAL Final Report, May 1994. Page 15.

and Child Care of the MOH define early prenatal care to mean care given preferably during the first twelve weeks of pregnancy. According to the FESAL 1993, in El Salvador only 45% of pregnant women meet this norm, and compliance with this norm decreases in the rural areas (38%). Poor prenatal attention is a common occurrence in El Salvador, especially among women for whom hospitals are too distant and who also experience economic or cultural barriers to seeking professional care.

The limited coverage of prenatal control is due to a combination of unavailability of services and cultural practices. If more pregnancies were detected and monitored in the first trimester, morbidity to mother and newborn would decrease.

☒ **Deliveries:** According to FESAL 1993, delivery rates are distributed as follows: inpatient (51%); midwife assisted (36.4%); and inadequate or no attendance (12.6%). Maternal morbidity is directly related to pregnancy problems. It is known that approximately 30% of deliveries occur in girls under 20 years of age, which categorize them as high-risk pregnancies. The MOH has more than 3,268 registered birth attendants, but not all of them report their job activities. Continued education is not universally available and, therefore, their actions are restricted to care and follow-up of normal deliveries.

Delivery assistance is mainly provided by midwives who attend 36.4% of all deliveries. At the rural level, midwives attend 49% of total deliveries. A significant proportion (12.6%) of total deliveries are not attended by midwives; some are attended at the midwife's house, and others are attended at the woman's house assisted by a relative or a friend and even by herself.

From most of the deaths that occurred in hospitals, the mothers were given health assistance from the beginning. The great majority of these deaths occur among women that have received delivery assistance elsewhere, and go to the hospitals due to complications, and die between the first 24 hours. Most of the MOH's inpatient maternal deaths occur because mothers are taken to the hospital when complications arise at home.

☒ **Post-natal Care:** defined as the health care provided to the woman that has just had a delivery, to evaluate the involution of the uterus, to detect and treat complications during this period, and to promote adequate care of the infant. The demand for postpartum care is lower than the demand for prenatal care. Low postpartum care, especially in rural areas, does not allow early problem detection; therefore many maternal and neonatal deaths occur. According to FESAL 1993, more than half (56%) of infant deaths occur in the neonatal period (defined as the first 30 days of life of a child) and the main infant mortality causes are: low birth weight or prematurity (34%), birth trauma or asphyxia (18%) and congenital anomalies (14%).

Family Planning:

Fertility Levels and Trends. Fertility is defined as the real procreation of an individual, couple, group or population. In El Salvador there are approximately 1.2 million women in fertile age. The 1992 census shows a decrease in fertility: from 6.1 children per women of fertile age in 1971 to 3.5 in 1992; FESAL 1993 estimated 3.85 for 1993. The projected fertility to the year 2000, if the trend during 1971-1992 continues, indicates that there will be a decrease in fertility to 2.9 children per woman. This decrease in fertility is related in part as a result of a wider use of contraceptives, including sterilization.

Despite the reduction of fertility rates, the Global Fertility Rate (GFR) is still high. As with other factors, the population in the rural area is at a disadvantage relative to the rest of the population, and has the highest GFR. The largest differences in fertility rates in El Salvador are seen between the Metropolitan Area of San Salvador (AMSS) at 2.69 children per woman and the rural areas at 4.96. Differences among areas of residence are broad, but fertility rates are high enough in all areas so as to produce a very high annual population growth.

Early Age of Childbirth. The use of family planning methods has spread in El Salvador, but despite the increase in the use of contraceptives the fertility rate among young women from 15 to 19 years of age is high (124 TFR). Also, in all geographic areas of El Salvador, women between the ages of 20 and 25 have more frequent pregnancies. Nationally, for every 1,000 women between 20 and 24 there are 221 deliveries. This represents a risk both for the mother and the child considering that many of them do not live in a stable union. The high fertility rates at early ages are reflecting that many women start sexual activity very young and they do not use methods to prevent or adequately space their pregnancies, making themselves a higher risk population than other women.

Contraceptive Prevalence Rate (CPR). Contraceptive use within the framework of family planning programs constitutes an essential component in providing reproductive health services to a population, in the sense that postponement, spacing, or limitation of pregnancies can significantly influence mother and child health. In 1993, 53% (CPR) of the women in fertile age were sterilized or used some method of family planning. If only efficient methods are considered, the rate of usage decreases to 48%. In 1975 the prevalence was 22%, and 46% in 1985. The increase in contraceptive prevalence in the country was mainly due to the increase of feminine sterilization; from 10% in 1975 to 32% in 1993. Approximately 46 of women from 15 to 44 years of age who have a partner are currently using some type of effective contraceptive method. More than two thirds of these women have already been sterilized and less than one third use an effective temporary method. The use of birth spacing methods was practically unchanged for the last 20 years. In fact, in 1975, 9% of the women used temporary methods (oral and Intra Uterin Device IUD); this proportion increased only 15% in 1993.

This indicates that effective but reversible methods of family planning do not have enough acceptance by fertile women or the medical community, and are not fully available, as in the case of injectables (FESAL 1993 states that injectables are the preferred method by 32% for nonusers who would like to use a family planning method).

Less than 40% of the women in the rural area have effective contraceptive protection. Of which 2/3 have been sterilized, perhaps after having the children they wanted. Barely 11% use temporary effective methods. In the rural area fertility is higher and health problems related to the mothers and infants are more frequent and more serious.

Role of Men. Another factor that highly affects family planning is male involvement. Ancestral customs in El Salvador give men rights over women's procreative power. In such situations, it is expected that the husband's approval may often be a precondition for a woman to use family planning.

In El Salvador men participation as recipients and responsible for the process of communication and shared decision making regarding family size, and family planning matters between partners is insignificant, mainly due to cultural reasons.

STDs and HIV/AIDS: Sexually Transmitted Diseases (STDs) including HIV and AIDS, have increased significantly. Since the appearance of the first official case of AIDS in El Salvador in 1984, the number of reported AIDS and HIV cases has increased to approximately 1,629 as of the end of 1996.

The main factors affecting this problem are sexual social patterns; age at which sexual contact starts; number of sexual partners; and especially the lack of health and sexual education. Due to cultural factors, the population is reluctant to talk about these diseases which difficults the search and treatment of vectors. For many women the prenatal control visit constitutes an exceptional diagnosis opportunity, unfortunately, the limited coverage of this control restricts better utilization of this opportunity to diagnose HIV/AIDS. Almost 60% of the vaginal cytologies performed in the Maternity Hospital in the first semester in 1993 showed some pathogenic agent.

Sexual activity begins early among teenagers and young adults in El Salvador. According to FESAL 1993, the average age for the first sexual encounter is 18.5 years. This, coupled with low use rates of barrier methods increases the risk for STDs (including HIV/AIDS) and cervical cancer, a serious health problem. The most frequent and important health problems of adolescence, youth and adults are related to sexual activity.

The transmission patterns of STDs and HIV/AIDS have changed from homosexual to heterosexual (59%) mostly in women in fertile age. The most affected ages are between 15 and 24 years (28%), 25-34 years (43%), and 35-39 years (11%). Out of the total AIDS cases,

25% have resulted in death².

Unfortunately, the infection by the HIV/AIDS virus is of low priority in government policies as well as for those NGOs that work in health.

Other Reproductive Health concerns:

Cervical Cancer. El Salvador has one of the highest cervical cancer rates in Latin America. The rate in El Salvador is 84 per 100,000 women (35 to 60 years) and the majority die within five years after diagnosis. The Metropolitan Area of San Salvador (AMSS) is the one that presents the higher rates of 126 per 100,000. In FESAL 1993 reported that 67% of women in fertile age have had a cervical cancer detection exam (PAP smear) at some point in their life. This percent decreases to 57% among those women living in rural areas. The use of this service increases as education and socioeconomic levels improve, going to 57% among women with no formal education to 83% among those who had 10 or more years of schooling.

The associated factors of cervical cancer are known: repetitive vaginal infections, early sexual activity, multiplicity of sexual partners and non use of barrier family planning methods.

Violence in women and children: Many Salvadoran women and children are abused in many ways, including: battery, sexual abuse, rape, and psychological abuse.

According to an investigation done by the University Institute of Public Opinion (IUDOP), in 1995, violence and abuse were the principal problems identified by women, although statistically this problem is under reported due to the fundamental characteristic that this is invisible and that women are afraid to report it. In 1995 the Institute of Legal Medicine attended 667 cases of family violence, of which 84% were women that had been abused by their husband, boyfriend or father.

III. RELATIONSHIP TO USAID/EL SALVADOR'S STRATEGY

Considering then, that in El Salvador the priority reproductive health problems are:

- The lack of integral health care during pregnancy, delivery and puerperium.
- Multiple deliveries and frequent pregnancies, mainly among young women.
- Sexually Transmitted Diseases (STDs), AIDS, cervix-uterus cancer.
- Violence against women and children.

² ANSAL "Maternal and Child Health" Final report, May 1994. Page 20.

- Lack of early detection of cervical cancer and STDs.
- Poor nutrition among women

The Mission Strategy for 1997-2002 describes its **Health Strategic Objective (SO) No. 3** as one that will impact on the health of infants, children and mothers by working in three major critical areas, (a) Increased use of appropriate child survival practices and services, (b) Increased use of appropriate reproductive health practices and services, and (c) Enhanced policy environment to support sustainability of child survival and reproductive health programs.

The Reproductive Health Results Package has an immediate positive impact in improving the safety of motherhood, reducing unplanned and/or mistimed pregnancies and decreasing HIV/AIDS and other STDs transmissions. Through increasing the use of child spacing practices, deliveries attended by trained personnel, improving health care during pre- and post-natal period, reducing the prevalence of Sexual Transmitted Diseases (STDs) and HIV/AIDS, Salvadoran women and children will be less vulnerable to preventable illnesses and death.

IV. ANALYTICAL/CONSULTATION PROCESS

The USAID Mission to El Salvador started a consultation process in December 1995 (which continues today) to discuss, analyze and make plans for supporting corrective measures to improve the El Salvador's health sector. This consultation process included: (A) *External Consultation* and, (B) *Internal -Mission- Consultation*. As a result of this on-going consultation process, some critical assumptions have been elaborated below to set the basis for a more realistic view of the social economic environment for the implementation of current and future activities.

A. External Consultation.

Between December 1995 and February 1997, the SO3 Extended Team members, partners, customers, stakeholders and donors participated in several major presentations and discussions of the Mission's Health Strategic Objective (SO3) Results Framework. In these meetings, working groups were formed to critique the logic and validity of the entire SO3 Results Framework and all progress indicators, focusing on each of the Results Packages. As a result of these consultations, modifications have been made to the Framework and indicators. The final SO3 Results Framework, intermediate results and indicators (See Annex A) identified to measure progress and impact have been the result of highly consultative process and consensus among local and international institutions including donors. Institutions present at these meetings included; locals: the Ministry of Health, the Salvadoran Social Security Institute, several local NGOs including the Salvadoran Demographic Association (local IPPF affiliate); US contractors; working with projects supported by the Mission, as well as other international donors such as United Nations Fund

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for Children (UNICEF), Pan American Health Organization (PAHO), United Nations Fund for Population (UNFPA), Japan International Cooperating Agency (JICA), World Food Program (WFP), Germany Cooperating Agency (GTZ), Interamerican Development Bank (IDB), etc.

In addition, regular meetings with the donors listed above in the health field are taking place periodically to coordinate donor's efforts in the health sector. The primary objective of the donors meetings is to maximize resources provided by each donor in its area of influence, as well as having -in the extent possible- a common line of action to address the major health problems in El Salvador, within the mandate each donor agency has. Several donors carry out different interventions that contribute to the achievements of this RP: the European Union (EU), Sweden, Germany (GTZ), Japan (JICA), Luxembourg and Spain, United Nations Development Program (UNDP), PAHO, UNICEF, UNFPA, IDB. They are implementing activities mostly through the MOH in areas such as reproductive health, nutrition, family planning, etc. in specific departments of the country, providing technical assistance, training, equipment, infrastructure and commodities.

The Health Strategic Objective SO3 works closely with the MOH to support the goals the Government of El Salvador (GOES) has in improving the health of the population. The GOES "Five Year Plan for 1994 to 1999 states specific objectives in health which are: (a) to improve health conditions of women in reproductive age, especially pregnant women and those breastfeeding; (b) to improve nutrition levels of pregnant women and those breastfeeding; (c) to improve physical and environmental conditions of the population, especially those living in rural and marginal-urban areas; (d) to strengthen and expand community health education programs; (e) to establish health insurance for all. Therefore, this Reproductive Health RP also contributes to the achievement of the GOES objectives in health, by providing support to local institutions to improve the health of women in fertile and children under five years.

The External Consultative process will continue with meetings with the Extended Team, partners, customers, stakeholders and donors to share ongoing results, coordinate future activities and determine implementation corrections if and as needed. Health providers and communities will be monitored and evaluated, and assisted if necessary, to help ensure maximum health impact. Customer satisfaction will be assessed through a variety of means, including surveys and reporting by Implementing Entities (see Section VII. Customer Service Plan).

B. Internal -Mission- Consultation.

SO3 is also coordinating activities and efforts with other SO teams. The activities of SO1, "Expanded Access and Economic Opportunity for El Salvador's Rural Poor" also support SO3's RP and vice versa. As SO1 contributes to the improvement of the economic status of the rural poor, the poor are more likely to be able and willing to participate in the financing and maintenance

of health systems in their communities, contributing to the achievement of SO3. The SO1 Intermediate Result of "Improved curricula and training methods adopted", which includes hygiene education, reinforces the community education leading to a better health in the communities. Moreover, SO3 contributes to the overall SO1 by improving the health of the rural poor so they are better able to take advantage of basic education and work opportunities and spend less money and time caring for sick family members.

SO3 also contributes to the achievement of SO2's Intermediate Result of "Creating and strengthening participation mechanisms" through the development of Community Health Committees, and also requiring substantial women's participation as members, leaders, health providers or as the family's responsible for health decision making. SO2 Democracy activities would also improve women's status through promoting voter registration and community participation. In addition, SO3 and SO2 are exchanging ideas on how they may combine efforts to lobby the newly elected health committee in the Assembly for further a health agenda that increases health care availability to the rural poor.

Two Intermediate Results of the SO4, "Increased Use of Environmentally Sound Practices in Selected Fragile Areas", have an impact in the general health of the communities by supporting a cleaner and better environment. The Intermediate Results are: "Increased Awareness and Understanding of the importance of Environmental Issues", one of which is health, and "Increased Knowledge of Environmentally Sound Technologies and Practices", through which the communities are given a tool to improve their environment and therefore their health.

A total of 7 G/PHN/HN-USAID/Washington's projects active in El Salvador will continue contributing to the achievement of this RP. These projects are described in greater detail in page 15. But in short, family planning services will be reinforced through the provision of contraceptives to local selected organizations (Central Contraceptive Procurement). Technical assistance is provided to increase the availability and use of contraceptives among lower and middle income groups (Social Marketing Project, SOMARC) and to expand commercial sector's involvement in family planning (PROFIT and INITIATIVES Projects). The capacity of family planning programs will also be enhanced through the implementation of evaluation and research analysis in this area (Contraceptive Technology Research Project, carried out by Family Health International, FHI). Regional C.A. AIDS Project (PASCA) also contributes to this RP, through the reduction of the prevalence of STDs and HIV/AIDS infections. Finally, reproductive health programs management will improved through surveys to collect vital information for decision making (Demographic and Health Survey Project, DHS) for this area.

C. Critical Assumptions.

A number of critical assumptions have been made that underlie the ability of this RP to contribute to the achievement of the overall Health SO. These include:

1. The GOES assumes an increasingly larger role in reproductive health activities and increasingly supports the involvement of NGOs, including fulfilling its contraceptive procurement agreements of providing full coverage of the Ministry of Health (MOH) contraceptive needs.
2. The GOES will increase its support to the reform efforts that will lead to improved access to health services to the rural poor.
3. Other donors and USAID will continue to support the GOES in these activities.
4. USAID will continue to have adequate financial resources to assist in improving reproductive health services to target populations.
5. The underlying social conditions leading to the armed conflict in El Salvador that still exist, such as environmental degradation and inequitable access to social services and economic opportunity, will be adequately addressed to avoid another outbreak of another conflict.

V. SUMMARY OF ACTIVITIES/EXPECTED RESULTS

A. Current Activities

The SO3 Intermediate Result "Increased Use of Appropriate Reproductive Health Practices and Services" has identified the following expected results to be achieved through this RP: "Increased Pre-and Post-Natal Care", "Increased Family Planning Services" and "Increased Public education on HIV/AIDS".

To accomplish these results, the Reproductive Health Results Package manages four projects: Family Health Services with the Salvadoran Demographic Association (SDA) Project 519-0363, Health Systems Support (APSISA) Project 519-0308, Maternal Health and Child Survival (PROSAMI) Project 519-0367 and the Displaced and Street Children (PROCIPOTES) Project 519-0420.

The following section is divided into the description of each one of these activities and its areas of interventions regarding Reproductive Health. These projects are complementary to each other in the actions they implement, since current SO3 activities supported by USAID have integrated approaches to improve the health status of the Salvadoran population.

Family Health Services (SDA) Project 519-0363: This Project is carried out by the local International Planned Parenthood Foundation (IPPF) affiliate the Salvadoran Demographic Association (SDA). It started in July 1990 and expected to be completed by December 1998. The project purpose is to continue to expand the delivery of birth spacing and maternal child health services to high risk populations in rural and marginal urban communities, serving women in fertile age and children under 5 years.

The SDA expands Reproductive Health and Family Planning services through its Rural Program, Clinical Program and the Social Marketing Program.

SDA improves the use of Reproductive Health practices in rural communities through its Health Promotor network and their supporting Health Committees formed by community members. This network of Health Promoters and Health Committees promote prenatal care among pregnant women, safe deliveries and the importance of post-natal care, and also refer to a health facility those cases that are evaluated as at risk. In addition, SDA increases the use of voluntary family planning practices by providing contraceptives and family planning community education through Health Promoters and Community Based Distributors. The Health Promoters educate and inform the communities on the importance of reproductive health care via individual and group talks, use various educational materials and distribute temporary contraceptives. Through all of these educational and informational activities among the members of the communities where SDA works, the Project helps to overcome socio-cultural constraints to the use of modern contraception.

The SDA clinic system provides services such as distribution of contraceptives, treatment of immunizable and sexually transmitted diseases, birth spacing, maternal and child health, prenatal and postnatal care and nutrition. The private physician referral network provides reproductive health services to the highest risk and most underserved areas of the country. The SDA satellite clinics provide contraceptives, patients referrals (family planning, pre- and post-natal care) and provides continuing training to the physicians managing the clinics.

The Social Marketing Program involves the sale of modern contraceptives through local retail outlets.

Health Systems Support (APSISA) Project 519-0308: This Project is carried out by the Ministry of Health (MOH). It started in August 1986 and is planned to be completed by August 1999.

Following its original purpose, the project supported and strengthened the capability of the MOH to deliver and support basic health services and improved the MOH's logistics systems. Activities under this project include: maternal health, pre and post natal care, attended deliveries, family planning increasing the mix of temporary contraceptive methods available, education and promotion in family planning, and STDs and HIV/AIDS community

based programs for the prevention, detection, treatment and control of STDs including HIV/AIDS.

The MOH provides family planning services that promote the use of modern temporary methods by holding promotional meetings in the community, educational promotion for men in vasectomies, training nurses and doctors on child spacing, carrying out prenatal and postnatal control activities (vaccination against tetanus for pregnant women, and promoting prenatal and regular control visits from pregnant women).

The MOH trains nurses to be mid-wife trainers and community health members to be midwives in their own communities and health promoters at all levels.

Maternal Health/Child Survival (PROSAMI) Project 519-0367: This project is carried out by 12 local Non-Governmental Organizations (NGOs). It started in July 1990 with the participation of 35 NGOs and will end in December 1998. The Reproductive Health activities under this project are implemented by their Health Promoters, traditional birth attendants (TBAs) or midwives, health committees and community volunteers.

PROSAMI NGOs hold group education sessions and promoters make home visits to detect family needs and to provide individual education. Promoters also promote family planning activities and pre- and post-natal care.

Currently PROSAMI NGO Network is prioritizing and strengthening NGOs' efforts in reproductive health including family planning, they are distributing oral contraceptives and condoms and promoting exclusive breastfeeding as a family planning method.

All PROSAMI NGOs are working in both primary and secondary prevention related to the prenatal, postpartum and birth. Primary prevention includes community and individual education, and provision of prenatal vitamins and iron. In secondary prevention, home visits are made to pregnant women to detect risk and facilitate early care and referral.

PROSAMI attends birth deliveries through their midwives trained in conjunction with the MOH.

Displaced and Street Children (PROCIPOTES) Project 519-0420:

This project is carried out by 5 local Non-Government Organizations (NGOs). It started in September 1994 and will end in December 1998. The Reproductive Health Activities are carried out through the NGOs' health clinics. They develop a health education component in the area of reproductive health including family planning and test the adolescents for HIV/AIDS and other STDs.

If an adolescent becomes pregnant, PROCIPOTES refers her to the NGO or MOH clinics for pre- and post-natal care.

USAID/W Centrally funded activities: G/PHN/HN-USAID/Washington has seven projects active in El Salvador which contribute to the achievement of this RP.

1. *Central Contraceptive Procurement No. 936-3057:* It provides contraceptives to the MOH, SDA, ISSS and PROSAMI NGO's to reinforce their family planning programs.
2. *Contraceptive Social Marketing (CSM II) No. 936-3051:* Improve the capability of the SDA to sell contraceptives through commercial channels to increase their national coverage and increase SDA income generation in order to contribute to their sustainability.
3. *Promoting Financial Investments and Transfers (PROFIT) No. 936-3056:* To expand commercial sector's involvement in health care and family planning in rural areas. This project provides support to the local association of coffee cooperatives (UCRAPROBEX) to develop a private medical plan to provide maternal and child care, and family planning services to unprotected rural population at a per capita cost lower than the Salvadoran Social Institute (ISSS) and/or other private sector providers.
4. *Initiatives No. 936-5074.07:* To promote quality private services provision of preventive and curative care in the urban and semiurban areas. This Project analyzes the possibility of developing an HMO-like system in El Salvador which could provide high quality medical services at a lower cost than current private medical providers and to a wider range of beneficiaries.
5. *Contraceptive Technology Research No. 936-3041:* To enhance the capacity of the SDA family planning and maternal health and child survival programs through technical assistance in the calculation of their fee per services and the analysis of the ability of their clients to pay these services.
6. *Regional C.A. AIDS Project (PASCA) and Panamerican Social Marketing (PASMO):* To strengthen the capacity of C.A. organizations to provide information, education, investigation and services of HIV/AIDS infections to risk populations.
7. *Demographic Health Survey (DHS) No. 936-3038:* To improve health programs and reproductive health programs management through a national health survey, collecting vital information for monitoring, evaluation, and decision making.

B. New Activities.

General Aspects. The future Reproductive Health interventions of USAID/El Salvador will be developed through a major new Health Activity or Activities, which will integrate all Child Survival RP 3.1, Reproductive Health RP 3.2 and Policy and Health Sector Reform activities RP 3.3. This major Activity or Activities will be designed and obligated in FY98 with an expected life of five

years through the Mission's current strategy period to the year 2002.

Description of Probable areas of action. Based on the problem description as stated in Section II of this RP, and on the analysis made of past and current Reproductive Health interventions in El Salvador, it can be concluded that there are five essential components to develop adequate provision of Reproductive Health services, addressing the most important problems and facilitating the implementation of the needed changes. This five essential components would be:

1. Pre-natal Care.
2. Safe Deliveries.
3. Post-natal Care.
4. Family Planning.
5. STDs including HIV/AIDS.

The specific interventions that the new Health Activity or Activities will develop to support the Reproductive Health RP will incorporate the most successful aspects of current activities and current approaches to developing activities will be evaluated during the design phase of the new Health Activity or Activities, as a result they will be modified, improved, replicated or discarded as the case may be. Therefore this new Health activity will include some of the features of the current activities in its five components with emphasis in several areas as follow:

Pre-natal Care: More extensive and earlier pre natal care, strengthening the referral system to adapt the level of care when risk is detected, reinforce actions aimed at vaccinating women in fertile age with tetanus toxoid vaccine, and provide training to midwives and health promoters to identify women at risk, to refer high risk cases to health facilities and to promote midwives and health promoters participation in detecting any pregnancy problems.

Safe Deliveries: Raise awareness of women and especially adolescents regarding the importance of having a delivery attended by trained personnel, better training and supervision to midwives, doctors and nurses and personnel that attend deliveries not to focus on rural home based deliveries or small rural birth centers, identify women at risk and to refer high risk cases to health facilities.

Post-natal Care: More extensive and earlier post-natal care, inclusion of family planning counseling among the women who seek post-natal care, and training to midwives and health promoters to identify women at risk, to refer high risk cases to health facilities.

Family Planning: Provide more family planning services to the unmet population, emphasizing family planning activities to

involve adolescents, this include training, education, service provision especially in rural areas. In addition, promote more male involvement with reference to family planning, including activities such as: family planning training of community male leaders, couple and male counseling, motivational talks, promotion of husband-wife communication about family planning, etc.

Improve access of rural population to contraceptives, through Health Promoters and Community Based Distributors and offering to the population a wider range of modern temporary methods of contraception (especially injectables), with appropriate counseling including information on choices, advantages and disadvantages, side effects, etc.

Expand family planning awareness and knowledge among the population especially in rural areas and intensify training to the promoters, community based distributors and midwives, to provide better quality family planning services.

STDs including HIV/AIDS: More education to adolescents and women in fertile age with reference to HIV/AIDS, emphasize community participation in HIV/AIDS educational activities and peer counseling, coordinate and support activities with the Regional C.A. AIDS Project (PASCA) and improve the detection and reporting of infectious diseases, especially HIV/AIDS.

The above mentioned features should be developed in a general framework taking into account the following additional considerations:

1. Significant behavioral modifications and cultural changes should be emphasized through extensive and prioritized health community education in all new Health Activity or Activities components.
2. More intensive coordination with : a) the MOH, b) health NGOs, c) International Donors, and d) Among the different activities implemented by USAID/W and USAID/El Salvador SOs.
3. Extensive training directed to health providers to enable them to provide a higher quality service to the beneficiaries.
4. Special attention will be given to development a gender sensitivity focus.

Geographic Focus. To define the primarily geographic focus of USAID/El Salvador Reproductive Health activities to be carried out under the new Health Activity or Activities, some considerations should be taken into account: a) The MOH's Test Department(s) for implementation of the Health Sector Reform, b) The USAID/El Salvador municipalities that qualified under the Mission Poverty Focus strategy and model municipalities, c) Areas where other USAID activities and donors activities will focus

their efforts, trying by this to integrally impact the health condition of the population and d) Geographic areas where studies or surveys show with high mortality and morbidity rates among children under five years and women in fertile age, specifically among the rural population.

Health education and assistance in community organization will be expanded to involve additional local groups, such as municipal government staffs, local NGOs, and others, that perhaps should be involved in health care provision. The intention is to provide a higher coverage and higher quality services to rural undeserved populations of El Salvador.

Target Population. It is difficult to define at this moment the expected number of beneficiaries as result of successful implementation of adequate new activities to improve the health of rural women in fertile age and of children under 5 years of age.

VI. FEASIBILITY ANALYSIS

A. Current Activities

All maternal health and family planning interventions of SO3 were tested, well-known, and feasible responses to the leading causes of mortality and morbidity among women. Interventions have evidenced that emphasizing preventive rather than curative care is a more effective method for improving the health status, especially in women and children. Moreover, numerous analysis and reports have been published worldwide in the last five to seven years proving which are the key interventions to improve the reproductive health of women in fertile age and the impact this has on the health of their children and to raise public awareness about the need and the importance of appropriate Reproductive Health practices and services. Some documentation on this subject has also been published in El Salvador by USAID, as well by other international donors, the MOH an local NGOs. An illustrative list of those documents is contained in Annex E.2 (Feasibility Analyses) of the attached document of this RP.

B. New Activities

For the new Health Activity or Activities additional analysis and studies may be necessary such as the National Family Health Survey (FESAL) and the measurement of the Maternal Mortality Ratio. During the implementation of this activity and when appropriate the implementing agency(ies) will conduct studies and research as needed.

VII. CUSTOMER SERVICE PLAN.

The SO3 Team has defined its customers as Salvadoran women in fertile age and children under five years that are socially, geographically, economically and culturally disadvantaged who

lack adequate access to health services. For this Results Package, SO3 customers are a sub-universe of the general customer group; women in fertile age, males and adolescents who are the most vulnerable group needing Reproductive Health interventions.

To identify customer needs in this Results Package, the following, and possibly other, techniques will be used:

1. Formal Surveys: Professionals researches utilized to design surveys to gather valuable data for monitoring and decision making.
2. Interviews: Informal and formal surveys will include interviews, and in addition, independent interviews will be conducted with randomly selected community members.
3. Home visits: Most of the previously mentioned methods of gathering customer information will include home visits to clients.
4. Community Meetings: Town meetings or meetings with various local civic groups will also provide means to understand and address client concerns.
5. Field visits: Periodic field visits by implementing staff, SO3 Team members, and contractors will provide valuable information on both customer needs and activity performance through direct observation, home visits, focus groups and/or interviews.
6. Information exchange: A mechanism to regularly exchange information with agencies of the Government of El Salvador, other donors, partners and stakeholders providing similar services will be developed and implemented.
7. Formal or conventional communication: Letters, phone calls and faxes between customers, community boards, local press, implementing agencies and donors will also provide an avenue to understand customer views and concerns.

Sharing information with customers and providing feedback will be done on both an individual and community basis.

To date, fieldwork by USAID/ El Salvador staff and contractors, the 1994 National Health Sector Assessment (ANSAL), CID Gallup Polls, and informal focus groups and interviews conducted by USAID/El Salvador staff and partners, have provided information about our customers. As part of the ANSAL, ten community meetings held around the country in late 1993 and early 1994 which were attended by a wide variety of local citizens, health professionals, community leaders, and others. Also as part of the ANSAL, a study, "Community Perceptions and the Demand for Health Services" was prepared. It included the findings of

personal customer interviews in eight departments which were analyzed in conjunction with several national surveys to assess the demand for health care services in El Salvador, community perceptions of illness and treatment, local perceptions and practices related to preventive health care, and the role of the health promoter.

Several CID Gallup Polls have reported citizen's knowledge about and concern with their health problems. For example, October-November 1993 CID Gallup Poll provided information regarding communities' perceptions of the health problems as perceived in El Salvador specially in women and children, as well as the quality of services in health.

An August 1996 CID Gallup Mission Customer Assessment reported that the most common reasons for a woman to participate in family planning mentioned by the respondents were: the economic factor, "have the children that you can take care of"; health reasons, and birth spacing. The ideal number of children per family recommended by 53% of respondents is two to three. Most of the respondents in this group were under 24 years of age with high school and/or university studies. A second group (19%) mentioned that the ideal number of children is 4 or more. Respondents in this group were mostly housewives, residents in rural areas, and persons that have only completed elementary school but not high school. The third group of respondents who were mostly residents of rural areas with very low level of education (28%), mentioned that they didn't know if 8 or more, and "those sent by God". Sixty three percent of the respondents agreed the women should be the ones to practice family planning and 64% that men. The most common methods for family planning known by the respondents were: pills, injectables, IUDs and female sterilization. Eighty three percent of the respondents knew or have heard about AIDS. The means of transmission mentioned were: sexual relations (promiscuous, with prostitutes, homosexuals, due to infidelity), use of syringes, contaminated blood, and pregnant women.

The Survey "Encuestas de Hogares de Propósitos Múltiples" done in 1995 and financed by the Ministry of Planning, analyzed the reason why the population seeks health care assistance, problems they have in receiving the assistance, cost of the services provided, and the reasons why they do not seek those services.

Informal interviews and focus groups conducted in February 1996 by USAID and its partners in three regions of the country (easter, western and central), had among other findings, specific and repeated expression by customers of their priority need for basic health services including Reproductive Health assistance in their communities.

During the design and implementation of the current activities, customer satisfaction information was used to evaluate client satisfaction, quality of services and clients perception on the provision of services. Some of these surveys and studies carried out under the current activities are:

- 1) Salvadoran Demographic Association (SDA) Clinical Service Evaluation, October 1994-July 1995. This study includes interviews with clients of the four main SDA regional clinics and six satellite clinics to determine client perception about the services and how they can be improved.
- 2) Salvadoran Demographic Association (SDA) Cojutepeque Satellite Clinic Study, March 1993-August 1994. This study assessed the service statistics and the patients files. Personal clients and general public interviews were carried out to determine which are the client's view of key quality service factors that affect the utilization of the clinic and how.
- 3) Salvadoran Demographic Association (SDA) Client Satisfaction Survey among the Rural Health Promoters, September 1994-July 1995. Using the Rural Health Promoters of the SDA and its clients as a sample in the four regions, interviews were made to determine service coverage and acceptance of the promoters and their services in the communities.
- 4) Maternal Health and Child Survival (PROSAMI) Project No. 519-0367 Midterm Evaluation, November 1994. The Evaluation Team met and interviewed clients benefited under PROSAMI to find out their level of satisfaction regarding the services that PROSAMI provides and the beneficiaries also indicated the type of services for which they have unsatisfied demand.

This RP will seek to strengthen customer service and provide such services with transparent communications to process and provide timely feedback, to ensure active and full participation by health providers and community members at a every step in the planning, implementation and evaluation stages.

The new Health Activity or Activities will be designed and implemented with even greater attention to the gathering and use of customer service information and feedback. The mechanisms discussed above will be used including formal methods such as community meetings, informal interviews, home visits and direct observation, as well as additional surveys and studies.

VIII. HUMAN CAPACITY DEVELOPMENT NEEDS

The human capacity development needs under this Results Package are in the areas of: a) pre-natal care, b) safe deliveries, c) post-natal care, d) family planning and e) sexually transmitted diseases (STDs) including AIDS. The human capacity development will be addressed through on-site technical assistance, one-on-one communication, group talks and formal institutional based training. Community members who are most likely to be included and directly benefit from this human capacity development intervention include adolescents, men and women in fertile age,

community leaders, Health Committee members, local government representatives, NGO and MOH Health Promoters, school teachers, mothers and fathers, and other community members directly involved in the design, implementation monitoring and evaluation of the new activity.

For the Reproductive Health providers at all stages, the need of the knowledge and improvement of skill level in the areas of technical, service provision, interpersonal relationships, communications, community organizing, must first be determined using many of the same techniques will be utilized to develop a base for customer information, such as: focus groups, direct interviews, direct observation and surveys.

Once specifics are determined for each health provider level, human capacity development interventions and techniques including but not limited to the following, will be used as needed and appropriate:

1. Seminars or workshops for health providers, community leaders, Health Committees,
2. Refresher training for NGO/MOH Health Promoters working in the communities,
3. Pamphlets and brochures for residents,
4. Observational travel to other areas of El Salvador or to other countries,
5. Technical assistance, and
6. On-the-job-training

Additional in-country training will be provided to customers/partners of the Results Package from the new Human Capacity Development (HCD) Activity (519-0432) core funds in cross-cutting topics such as leadership, empowerment skills, NGO strengthening, conflict resolution, self-esteem, strategic planning, total quality management, customer service, sustainability approaches, etc.

On the other hand, both technical training and cross-cutting topic seminars will closely follow reengineering training guidelines which include: (a) agreements with stakeholders, (b) change agent concept (leadership, training of trainers, action planning), (c) training needs assessment for annual training plan, (d) critical mass approach, (e) multi-level training, and (f) group dynamics.

All these training activities will be coordinated/channeled through the HCD Activity and with Mission's Training Unit by developing and submitting annual training plans responsive to the specific Activity or Activities under this Results Package. Once the Activity or Activities are developed, it is envisioned that the annual contributions for specific training activities will be facilitated through MAARDs/Delivery Orders for implementation of customized training during each Fiscal Year. Moreover, the new Health Activity or Activities will take most advantage of cross-cutting topic seminars offered by the HCD Activity and its core funding to improve/advance human capacity building of key

institutional personnel as well as rural end-customers.

The result of all these training activities will be significant contributions to Intermediate Result 3.2 "Increased Use of Appropriate Reproductive Health Practices and Services", Sub-Intermediate Results "Pre/Post Natal Care" and "Increased Family Planning Services".

IX. IMPLEMENTATION MANAGEMENT PLAN

A. Team Members and Responsibilities

In order for the RP to achieve expected results, not only will the RP Team members need to fulfill their obligations as described below, it is essential that first customers commit to fulfilling a number of actions. They must actively participate in Health Committees or some other community organization that solves problems locally, foster beneficial health habits with family members, and in other ways cooperate with the community to protect and properly make use of health services, for example, facilitate the transportation of sick community members when a referral is required. In addition, the RP partners also need to commit themselves to fulfilling a number of actions. They are key to achieve RP results. USAID will need to improve and maintain regular coordination in planning, financing and implementing rural activities in reproductive health with the European Union (EU), UNICEF, UNFPA, IDB, PAHO, Plan International, other International NGOs, the MOH, and local NGOs providing basic health services.

Specific responsibilities of all RP Team members are described below, but will be modified as needed per the recently released revised USAID/El Salvador Delegation of Authority. RP Team Members are:

1. **Margarita de Lobo:** As the RP Team Leader assumes complete responsibility for the full range of supervision, management, monitoring, reporting, and evaluation of technical program and financial data of the current and future activities of the RP.

Ensures broad information sharing focused on RP purpose and results to all SO3 members and others as appropriate.

Reviews all activities and takes actions, including recommending activities modifications and measures to correct or improve implementation, monitoring and reporting.

Acts as official USAID representative on field and inspection visits to activity sites in coordination with other members of the RP, ascertains progress, identifies delays and problems and recommends solutions to resolve them.

Takes the lead in drafting and presenting for clearance and approval, any administrative action necessary.

Provides follow-up to coordination meetings between RP members and SO3 partners, customers, USAID/W staff and its activity implementors staff, and other possible collaborators, to ensure good planning, good working relationships and coordination.

Prepare RP reports, tables and narrative for Mission reviews as required, such as the R2 and R4 reports.

Work closely with other RP Team Leaders to ensure that all aspects of implementation, monitoring and reporting are harmonized between RPs and for the SO.

2. Maricarmen de Estrada: As the Deputy Team Leader for the RP, assumes partial responsibility for, and supports the Team Leader in, the full range of supervision, management, monitoring, reporting, and evaluation of technical program and financial data of the current and future activities of the RP.

With general guidance and supervision of the RP Team Leader, initiates drafts and activities' documents for clearance and consideration and approval, including PIOs, PILs, requests for purchases, and related Activity or Activities correspondence. Responsible for tracking all documentation through Unit clearance process.

Work closely with RP Team Leader to ensure that all aspects of implementation, monitoring and reporting are adequately covered.

As the responsible for the SO3 actions on Family Planning oversees, monitors, provides follow up to all the interventions that the RP implementing agency(ies) carry out in Family Planning.

Work closely with other RP Team Leaders to ensure that all aspects of implementation, monitoring and reporting are harmonized between RPs and for the SO.

3. Terrance Tiffany: As Team Leader for the SO3, of which this RP is a part, provides leadership to SO3 Team to enable each RP Team to contribute fully and meet RP and SO3 agreements and commitments once agreed.

4. Meri Sinnitt: As the Team Leader for the Child Survival RP 3.1, she will be responsible for coordinating with all Reproductive Health actions that relate to the health of children. She will oversee, monitor, and provide follow up to all the interventions that the RP implementing agency(ies) carry out that relate to or affect the health of children, such as nutrition among women and breastfeeding.

Is responsible for assuring her results package supports this results package in achieving the overall SO.

Work closely with other RP Team Leaders and Deputy Team Leaders to ensure that all aspects of implementation, monitoring and reporting are harmonized between RPs and for the SO.

5. **Jose Antonio Ramos:** As the Team Leader for the Water and Sanitation RP 3.1.4, he will be responsible for facilitating and overseeing all supporting activities that this Reproductive Health RP 3.2 may require from the existing and future water and health committees organized under the Water and Sanitation activities, in order to seek and promote community participation in improving the health of their women and children.

Is responsible for assuring his results package supports this results package in achieving the overall SO.

Work closely with other RP Team Leaders and Deputy Team Leaders to ensure that all aspects of implementation, monitoring and reporting are harmonized between RPs and for the SO.

6. **Raul Toledo:** As the Team Leader for the Policy and Health Reform RP 3.3, he will be key in coordinating activities that are related to other donors and keeping the RP members informed about policy issues and health sector reforms activities and advances that relate to this RP. He will be responsible for developing and overseeing the implementation of policy strategies that will ensure sustainability for Reproductive Health programs.

Is responsible for assuring his results package supports this results package in achieving the overall SO.

Work closely with other RP Team Leaders and Deputy Team Leaders to ensure that all aspects of implementation, monitoring and reporting are harmonized between RPs and for the SO.

7. **Jack Dale:** As the Deputy Team Leader for the Policy and Health Reform RP 3.3 and the responsible for the SO3 actions on Sustainability, oversees, monitors, provides follow up to all the interventions that the RP implementing agency(ies) carry out towards technical, institutional and financial sustainability.

Is responsible for assuring his results package supports this results package in achieving the overall SO.

Work closely with other RP Team Leaders and Deputy Team Leaders to ensure that all aspects of implementation, monitoring and reporting are harmonized between RPs and for the SO.

8. **Elizabeth de Tercero and Martin Schulz:** As Controller Office staff members, maintain the integrity of the accounting system, identifying potential financial problems and propose possible solutions.

Provide advice and assistance in all financial and accounting issues, budget reprogramming and assume responsibility for funds control management.

Coordinate the accrual process and resolve inconsistencies.

Develop and prepare special customized financial reports and document, review and verify financial data and present

information to SO team.

Review, process and transmit all vouchers to ensure accurate payments and assume lead in resolving vendor payment problems.

Review and clear financial, audit and implementing documentation and coordinate the "Recipient Contracted Audit Program" for the Unit, including HCOLC audits.

Assist in the design of new RPs under approved SO, amendments of RPs, amendments of existing activity designs within approved RPs, etc.

Verify overhead adjustments of contracts and cooperative agreements.

Carry out the 1311 review process twice a year.

Perform internal control reviews of prospective as well as current local beneficiaries as applicable.

Perform necessary review/analysis to provide for the commodity management system certification of prospective recipients as applicable and participate in the Host Country Contracting certification process.

Perform field trips to observe implementation of activities.

9. Ileana Parraga: As the Office of Contracts and Grants staff member: Provides guidance and assistance to RP team members regarding contracting/procurement guidelines and requirements, including issues that might arise during contract performance, such as assessment of liquidated damages for late delivery, claims of recovery under insurance, waivers of source and origin requirements, past performance requirements and its importance, performance based contracting, etc.

Provides the same type of guidance and assistance to RP team members regarding agreements with local NGOs and international PVOs.

Suggests appropriate actions to meet RP goals, including reviewing statements of work to determine whether the needs of the RP have been adequately defined; determining the most appropriate contractual or agreement arrangement, i.e. contract vs. cooperative agreement and brings irregularities to the attention of the RP leader with recommendations for corrections.

Coordinates implementation of the Annual Procurement Planning System (APPS).

10. Ana Cristina Mejía and Silvia de González: As Strategic Development Office staff members: Provide assistance and guidance to the RP team to ensure activity design and implementation documentation is timely and prepared in accordance with the Automated Directives System (ADS).guidance.

Assist in strategic planning and new activity design planning for the RP and coordinate RP input to the R4 process and other Unit program documents.

Assist in ensuring inter-SO coordination.

Review funding actions and other documents (as specified in the Unit DOA) for quality, compliance with Unit and Agency policies and procedures, and adherence to the Unit's Strategic Plan.

Provide guidance on programming and implementation to assist in achieving results and coordinate RP budget and obligation planning.

Coordinate activity evaluations and provide guidance as necessary to the overall RP monitoring and evaluation process.

Keep RP team updated on USAID's policies and Unit wide guidance.

11. **Cecilia de Villalta:** As the SO3 secretary she will be responsible for providing full administrative support to the SO and this RP.

B. Implementation Mechanisms

The RP Team recommends that the new Health Activity or Activities will be implemented through either (a) Cooperative Agreement(s) and/or (a) Contract(s) for the primary implementation mechanism with a combination of local and/or international NGOs, local and/or private companies, and/or the Host Government. Coordination between multiple implementors if that is the final awarded mechanism, will be ensured by language in each agreement and/or contract that requires each one to coordinate with each other, other USAID project implementors, other donors and USAID staff.

A full and open competitive process is also recommended to award the implementation of this new Health Activity or Activities.

Because this major new Health Activity or Activities will incorporate all activities that support the achievement of the results of RP 3.1, RP 3.2 and RP 3.3, replacing four activities that the SO3 is implementing, these RP Team Leaders and RP Deputy Team Leaders will oversee and co-manage the implementing entity(ies) of the Cooperative Agreement(s) and/or Contract(s) through site visits, regular financial and progress reports from the implementing entities, and monthly staff meetings between USAID and implementing entities representatives to focus attention on immediate, short-term, and future needs and issues.

Implementation mechanism for the activities under this RP are detailed as follow:

ACTIVITY NUMBER AND NAME	IMPLEMENTATION MECHANISM	ACTIVITY START-END
519-0363 Family Health Services	Cooperative Agreement with the Salvadoran Demographic Association	07/31/90 - 12/31/98
519-0308 Health Systems Support	Bilateral Grant Agreement with the GOES through the Ministry of Health	08/29/86 - 09/27/99
519-0367 Maternal Health and Child Survival	Cooperative Agreement with Medical Services Corporation International (MSCI)	07/27/90 - 12/31/98
519-0420 Displaced and Street Children	Operational Grant with Medical Services Corporation International (MSCI)	09/30/94 - 05/31/98
New Health Activity or Activities	To be determined	10/01/98 - 09/30/2002

C. Monitoring and Reporting on Progress

Many features of the monitoring system to measure and report on implementation progress in the current activities will be again utilized for the new activity. However, a number of changes will be made to strengthen and improve the system. For example, monitoring will be improved as the RP and SO3 Team members try to increase the number of field visits and as the RP Team meets regularly with the implementing entity(ies) to discuss progress and problems. Measurement of progress will continue to use the Intermediate Indicators in the SO3. Reporting on progress will be standardized if there is more than one implementing entity and a combined report between entities will be produced. Progress will be reported more extensively to RP, SO3 team members, partners including other donors, the GOES, local NGOs, stakeholders and customers.

X. FINANCIAL PLAN

This RP will obligate funds under the new Health Activity or Activities which also supports RP 3.1 and RP 3.3. The total amount to be obligated for the new Health Activity or Activities is \$37,449,000 over a five year period. Amounts to be obligated for each RP will be detailed in the new Health Activity or Activities Document. Counterpart Contribution from various sources (GOES and NGOs) for the new Health Activity or Activities are estimated to be \$12,484,000 over the same period. In addition to the new Health Activity or Activities, each current activity that supports this RP, will obligate a total of \$14,874,000 in FY97 and FY98 to accomplish the goals of the SO, as follows:

<u>ACTIVITY</u>	<u>USAID/ES*</u>	<u>COUNTERPART*</u>	<u>TOTAL*</u>	<u>PACD</u>
519-0308	1,885	(**)	1,885	08/28/99
519-0363	3,653	1,214	4,867	12/31/98
519-0367	5,992	1,250	7,242	12/31/97
519-0420	700	180	880	03/31/98
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T O T A L	12,230	2,644	14,874	

(*) Thousands of US dollars

(**) LOP Counterpart Contribution for Activity No. 519-0308 has been met.

In order to provide for correct implementation and management of USAID funds, the Mission provides follow-up of each Activity through the Activity Managers (AM) and the RP team members. In addition, recipients are required to carry out annual audits that meet generally accepted government auditing standards as promulgated by the **United States General Accounting Office**. Counterpart contribution reports are required every quarter and are followed up by the offices of SDO and CONT together with the AM.

For new starts under the RP, in order to determine if the prospective recipient is eligible to receive funding from USAID, a pre-award survey will be conducted by the Office of the Controller and the Office of Contracts and Grants, as applicable. With regards to counterpart contributions, it is the policy of the Mission to negotiate and try to obtain as much counterpart contribution as possible to obtain maximum impact from the assistance, subject to the minimum of 25% mandated by law or USAID regulations. This requirement is not applicable, as a matter of law, to non-profit organizations or Economic Support Funds (ESF). However, USAID/El Salvador has administratively determined to apply this requirement whenever possible.

The obligation plan (USAID contribution) for new Health Activity or Activities for SO3 is the following (in US\$000):

FY97	FY98	FY99	FY00	FY01	FY02	TOTAL
0	5,466	6,483	8,500	8,500	8,500	37,449

Recurrent costs analysis will be performed during the design phase of the new Health Activity or Activities.

USAID management costs directly charged to resources of the RP, are approximately \$ 505,093 for USAID personnel over the five year period. Personnel costs directly attributable to SO3 technical staff are \$390,185 and \$114,908 attributable to SO3 support offices staff. The figures allow for a yearly increase of 10% for FSN personnel and 2% for USDH. The detail for the first year is as follows:

Category	SO/ Office	Persons Years	Funding Source			Amount
			OE	TF	SO	
USDH	SO3	0.15	X			12,698
USDH	SO3	0.15	X			5,828
FSN	SO3	0.10		X		4,581
FSN	SO3	0.10			X	3,835
FSN	SO3	0.70			X	19,258
FSN	SO3	0.70			X	11,009
FSN	SO3	0.05			X	1,474
FSN	SO3	0.20		X		3,302
FSN	SDO	0.15		X		4,422
FSN	SDO	0.15		X		2,409
FSN	OCG	0.15		X		2,177
FSN	CONT	0.15		X		3,384
FSN	CONT			X		4,718
TOTAL		2.90				\$79,094

XI. PERFORMANCE MONITORING PLAN

The implementation of this RP will contribute to the achievement of the Intermediate Result (IR) No. 3.2 "Increased Use of Reproductive Health Practices and Services". Two first level indicators of the Results Package will be measured under this Intermediate Result: 1) Percent of deliveries attended by trained personnel, measured on an annual basis; and 2) Contraceptive Prevalence Rate, measured on a quinquennial basis.

The RP also has three additional and second level Intermediate

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Results with their respective indicators. Intermediate Result No. 3.2.1 "Increased Pre/Post Natal Care", with two indicators: 1) Percent of pregnant women with at least two doses tetanus toxoid, measured on an annual and quinquennial basis and 2) Percent of women who delivered receiving/seeking a post-natal visit from trained personnel, measured on an annual and quinquennial basis. Intermediate Results No. 3.2.2 "Increased Family Planning Services", with one indicator: Couple-Years of Protection, measured on an quinquennial basis. And finally, the third Second Level Intermediate Results of the RP, IR No. 3.2.3 "Increased Public Education on HIV/AIDS" with one indicator: Number of new HIV/AIDS infections per year per 100,000 people, even though this is an area where USAID has minor involvement and is mainly considered other donor's and partners activity.

The RP Team Leaders and the RP Deputy Team Leaders will monitor the implementation process through field visits, monthly progress meetings to be held with the implementing entities, and the review of quarterly progress reports. The RP Team Leader will keep the RP members promptly informed of progress, any weakness and any mid-course corrections needed to achieve projected results or to modify expected results.

Although it is difficult to estimate the cost of monitoring and reporting of performance because this task will be carried out by the implementing entities as part of their routine work, a rough estimate could be 10 percent of the total life of project. The RP Team suggests that an independent evaluation should be used in addition to the implementing entity's reports on the secondary level indicators.

Data will be regularly collected and analyzed to enable the RP Team Leaders and Deputy Team Leaders and the SO Team to track performance and objectively report the progress in achieving the strategic objective and intermediate results. The RP Team Leaders and RP Deputy Team Leaders will also track inputs, outputs and processes to insure activities are proceeding as expected and are contributing to intermediate results and strategic objective as anticipated. The data will be collected by gender to support the results and to demonstrate impact by gender.

Evaluations will be used to ascertain why unexpected progress, positive or negative, is being made towards a planned result. When performance monitoring systems or other feedback mechanism indicate that expected results are not being achieved, the RP Team Leaders, RP Deputy Team Leaders and the SO team shall seek to determine the reason, usually through the use of one or more activities. Evaluation will also be used to explore issues related to sustainability and customer focus.

Other relevant sources of information to improve understanding of performance and to inform planning and management decision will be sought and used by the RP Team Leader, RP Deputy Team Leaders and the SO team. Both formal (research findings,

customer surveys, experience of other development organizations) and informal (unstructured feedback from customers and partners, site visits) sources will be considered.

The RP Team Leader, RP Deputy Team Leaders and the SO Team will remain informed of all aspects of performance relating to USAID-funded assistance in order to effectively manage for results. Performance information, evaluation findings and information from additional formal and informal sources will be used regularly throughout planning and management processes. Specifically, the SO team will use such information to: improve the performance, effectiveness, and design of existing development assistance activities; revise strategies where necessary; plan new strategic objectives, results packages (RPs) and activities; make decisions whether to abandon program strategies, strategic objectives or results packages which are not achieving intended results; and to document findings on the impact of development assistance.

The RP Team Leaders, RP Deputy Team Leaders and the SO team will involve USAID customers and partners to plan approaches to monitor performance, to plan and conduct evaluation activities, as well as to collect, review and interpret performance information.

The following tables depict the indicators which will be tracked:

STRATEGIC OBJECTIVE : Sustainable Improvements in Health of Women and Children Achieved.			
APPROVED: 06/07/96 COUNTRY/ORGANIZATION: USAID/EI Salvador.			
RESULT No. 3.2: Increased use of appropriate reproductive health practices and services.			
INDICATOR No.1: Percent of deliveries attended by trained personnel. (QI) (AI)			
UNIT OF MEASURE: Percent. SOURCE: National Demographic and Health Survey (FESAL). Beginning 1997, MOH and NGOs service statistics will also be used. INDICATOR DESCRIPTION: COMMENTS: Data includes deliveries in hospitals and those attended by midwives. National data is not available for 1996. However from 1995 to 1996, the MOH reported an increase in hospital deliveries from 47% to 60%, all attended by trained personnel.	YEAR	PLANNED	ACTUAL
	1993 (B)		87
	1997	88	
	1998	89	
	1999	90	
	2000	91	
	2001	92	
	2002 (T)	93	

STRATEGIC OBJECTIVE : Sustainable Improvements in Health of Women and Children Achieved.			
APPROVED: 06/07/96 COUNTRY/ORGANIZATION: USAID/EI Salvador.			
RESULT No. 3.2: Increased use of appropriate reproductive health practices and services.			
INDICATOR No.2: Contraceptive prevalence rate (CPR) . (QI)			
UNIT OF MEASURE: Percent. SOURCE: National Demographic and Health Survey (FESAL). INDICATOR DESCRIPTION: COMMENTS:	YEAR	PLANNED	ACTUAL
	1975 (B)		21
	1978		34
	1985		46
	1988		47
	1993	51	53
	1998	57	
	2002 (T)	61	

STRATEGIC OBJECTIVE : <i>Sustainable Improvements in Health of Women and Children Achieved.</i>			
APPROVED: 06/07/96 COUNTRY/ORGANIZATION: USAID/EI Salvador.			
RESULT No. 3.2.1: Increased pre and post natal care.			
INDICATOR No.1: Percent of pregnant women with at least two doses of tetanus toxoid (TT) during last pregnancy. (AI)			
UNIT OF MEASURE: Percent. <hr/> SOURCE: MOH and NGOs service statistics. <hr/> INDICATOR DESCRIPTION: <hr/> COMMENTS: MOH data through September 1996 was 22.3% and projected through December 1996 at 30%; less than 34% for 1995. The Missions plans to support the MOH to determine the reasons for this low coverage and develop plans to increase it to an acceptable level.	YEAR	PLANNED	ACTUAL
	1995 (B)		34
	1996	34	30
	1997	45	
	1998	50	
	1999	55	
	2000	60	
	2001	65	
	2002 (T)	70	

STRATEGIC OBJECTIVE : <i>Sustainable Improvements in Health of Women and Children Achieved.</i>			
APPROVED: 06/07/96 COUNTRY/ORGANIZATION: USAID/EI Salvador.			
RESULT No. 3.2.1: Increased pre and post natal care.			
INDICATOR No.2: Percent of women who delivered, receiving/seeking a post natal visit from trained personnel. (QI)			
UNIT OF MEASURE: Percent. <hr/> SOURCE: National Demographic and Health Survey (FESAL) . <hr/> INDICATOR DESCRIPTION: <hr/> COMMENTS: The MOH reported 12% of women who delivered during the previous month received postnatal care by September 1996, and projected 16% through December 1996. The 30 NGOs from the PROSAMI Project reported 100% of women who delivered in their service areas received at least one post natal visit with most of them receiving four post natal visits. USAID believes 100% coverage is slightly over reported and finds 97-98% more likely.	YEAR	PLANNED	ACTUAL
	1993 (B)		30
	1996		See Comments
	1998	35	
	2002 (T)	50	

STRATEGIC OBJECTIVE : Sustainable Improvements in Health of Women and Children Achieved. APPROVED: 06/07/96 COUNTRY/ORGANIZATION: USAID/EI Salvador.			
RESULT No. 3.2.2: Increased family planning services.			
INDICATOR No.1: Couple-years of protection (CYP). (AI)			
UNIT OF MEASURE: Number. SOURCE: MOH and NGOs service statistics. INDICATOR DESCRIPTION: COMMENTS:	YEAR	PLANNED	ACTUAL
	1995 (B)	600,000	601,448
	1996	650,000	691,575
	1997	873,000	
	1998	960,000	
	1999	1,056,000	
	2000	1,162,000	
	2001	1,278,000	
	2002 (T)	1,406,000	

STRATEGIC OBJECTIVE : Sustainable Improvements in Health of Women and Children Achieved. APPROVED: 06/07/96 COUNTRY/ORGANIZATION: USAID/EI Salvador.			
RESULT No. 3.2.3: Stabilize HIV transmission rate.			
INDICATOR No.1: Number of new HIV infections per year per 100,000 people. (AI)			
UNIT OF MEASURE: Number. SOURCE: MOH service statistics. INDICATOR DESCRIPTION: COMMENTS: These data should be used cautiously as the MOH and USAID believe them to be incomplete due to reluctance to report HIV infections. Mission funded interventions will be limited, but Mission expects to utilize services of the USAID Regional HIV Project.	YEAR	PLANNED	ACTUAL
	1994 (B)		5.9
	1995		6.1
	1996		4.8
	1997	6	
	1998	6	
	1999	6	
	2000	6	
	2001	6	
2002 (T)	6		

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STRATEGIC OBJECTIVE 3
Sustainable Improvements in Health
of Women and Children Achieved

RESULTS PACKAGE 3.3
Enhanced Policy Environment to support sustainability of Child
Survival and Reproductive Health Programs

July 3, 1997

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I. INTRODUCTION

In order to achieve Sustainable Improvements in the Health of Women and Children, Strategic Objective No.3 (SO3) considers that several new activities will have to be developed and other current activities will have to be reinforced and/or re-oriented. Considering the magnitude of the interventions needed to reach this goal, the SO3 team has decided to develop three RPs one for each first level of intermediate results. These RPs are: "Increased use of appropriate child survival practices and services" (Child Survival) RP 3.1; "Increased use of appropriate reproductive health practices and services" (Reproductive Health) RP 3.2; and "Enhanced policy environment to support the sustainability of child survival and reproductive health programs" (Policy and Health Reform) RP 3.3.

The interrelationship between this RP 3.3 and the other two RPs (3.1 and 3.2) is vital for achieving the strategic objective; without an adequate political basis, all the activities developed in child survival and reproductive health would only be a continuation of current and old activities, perpetuating an inefficient and an inequitable health system.

This Results Package (RP) document outlines the basic structure and possible implementation mechanisms for the proposed activities in support of Strategic Objective 3, "Sustainable Improvements in Health of Women and Children Achieved." The next section (Problem Statement) outlines the basis for the Strategic Objective definition and goals as set.

II. PROBLEM STATEMENT AND CONSTRAINTS:

(1) **Background:** El Salvador is a small densely populated country (240 inhab/km²). The population living in communities with more than 2,000 inhabitants are considered to be urban population. The rural population is estimated to be 50% of the national total. The Population growth rate has been estimated at 2.1% for the period 1990-1995 by the General Directorate of Census and Statistics of El Salvador (DIGESTYC).

El Salvador's maternal mortality and infant and child mortality rates continue to be high despite progress achieved during the period 1988-1993. This demonstrates that women in reproductive age and children under five years of age are two population groups at severe risk.

Specifically, problems such as inadequate pre-natal care, low rate of institutional deliveries, very low post-natal care coverage, an inequitable use of family planning (higher in urban populations than in rural), increasing incidence of sexually transmitted diseases (STDs) especially HIV infections and AIDS, increased incidence of cervical cancer, increased incidence of violence among women and children; inadequate control and prevention of diarrheal diseases, inadequate control of acute respiratory infections, malnutrition, etc. all are the result of an inefficient and inequitable health system. The current health

system does not provide an adequate level of services to the poor population and it is estimated that about 20-30% of the country does not have health service coverage.

In part this is due to the fact the Government of El Salvador (GOES) has assumed an interventionist role in the health sector instead of a coordination role, with very low participation of private providers. The most important point is that through the MOH, the GOES should be the leader in the organization and functioning of the national health system, with a clear definition of the rules and responsibilities of all of the participating organizations, public and private.

Lack of effective personnel policies and coordination with the institutions responsible for their formation has resulted in asymmetry between supply and demand. In addition personnel management is centralized with inadequate incentives resulting in utilization inefficiencies. Existing legislation assigns multiple functions of the organization and functioning of the sector to the government, and primarily to the MOH. According to the Constitution, the government is responsible for the health of its citizens, even though the citizens also have the obligation to take care of their health. As the main organ of the state in the health sector, the MOH has a preponderant presence based on the delivery of health services by the MOH (with its own resources). It has had less marked involvement in the implementation of policies, particularly those which affect the health situation for mechanisms other than direct delivery of services. Because of this and as a result of the reordering of the functions and roles within the government, over time other public organizations have been created which fulfill some functions similar to those of the MOH; the Secretariat for the Family is an example of this.

The armed conflict and the economic recession of the 1980s brought about an important change in public spending. The MOH budget at the end of the decade represented less than half of what it had been ten years earlier in terms of the GNP. Foreign assistance did not fully offset this decrease. As a result, the MOH concentrated its efforts even more sharply on what it understood to be its top priority: direct delivery of health services to the population.

(2) El Salvador's Health Sector Description: The health services system in El Salvador consists of public and private institutions and individuals in private practice. In the public sector the major providers are the Ministry of Health (MOH) and the Salvadoran Social Security Institute (ISSS), and in the private sector the most important providers are the Non-governmental organizations (NGOs), pharmacies, and private physicians. A detailed explanation of the entire system is described in Annex E.1 - Institutional Analysis.

(3) Problem Statement: Inadequate reproductive and poor maternal and child health continues to produce high infant mortality rates, particularly among the rural poor in El Salvador. Although reproductive health and maternal-child health services

are available throughout El Salvador, service delivery has been mostly concentrated in urban areas while rural care is limited both in scope and geographic coverage. The current network of health care providers does not have the financial means to expand low-cost service and educational programs to areas most in need; and the public sector programs are further hampered by policies which give inadequate priority to reproductive health and maternal and child health services. Moreover, the economic situation of rural families continues to be difficult, reducing access to adequate medical care and increasing the risk of maternal and child malnutrition. Thus, there is a clear need for support for an appropriate policy framework in El Salvador that will constitute the basis for an equitable and efficient health system with broader participation of NGOs currently offering and providing services in geographic areas where the Ministry of Health has little or no access at all.

4) Constraints to developing an adequate policy framework for improving reproductive health and maternal-child health:

a) *Lack of leadership:* has jeopardized the development of an adequate legal framework which would allow the inclusion of private providers in the health system. Despite the fact that in October 1996, the MOH released a document entitled "Health in El Salvador: A View to the Future" which summarizes its goals and objectives for the period 1994-1999, emphasizing the "modernization of the system" and including contracting of services at the community level, just a few actions were taken by the MOH to allow NGOs to continue to provide health services in those rural communities where the MOH practically has no presence at all.

There is not a clearly defined coordination role by the MOH. The MOH faces some difficulties to develop this task for two reasons:

- a weak technical structure assigned to this responsibility, particularly in terms of human resources and support services; and
- limitations in the political strength to establish sanctions and force compliance if necessary.

In areas in which the MOH has been able to develop solid policies and regulations, substantial political difficulties have been encountered in the implementation; for example, the breastfeeding norms are being followed in all of the MOH health services, but not in those of the Salvadoran Social Security Institute. Noncompliance on the part of the ISSS, (which gives substitutes of maternal milk to newborns) is not due to any lack of will but rather to pressure from ISSS beneficiaries, who prefer milk substitutes.

b) *Accessibility:* to basic preventive and curative services for the high-risk population (rural and low income population). A series of factors play an important role here; distance to the health facilities, rural family income has remained very low,

reluctancy of the MOH to increase the number of services delivered by rural health promoters, no existence of health promoters in several rural communities, etc. All these factors are severely affecting the accessibility of poor rural populations to adequate health services provided either by public or private providers.

c) *Lack of equity, effectiveness and efficiency:* which exists due to the inverse relationship between the need for services and the availability of resources to pay for them. The population with the worst health indicators and with the most limited access to health services is composed of rural residents with low socio-economic status. This situation worsens because of the low productivity of human and physical resources (few consultations per hour, low occupancy rate of the hospitals) as well as the model of care which is based on an approach inappropriate for the epidemiological profile of the population (most of MOH budget supports hospitals over primary health care services)

d) *Financial Constraints:* Despite an increased budget in the last years, the public health system is inadequate with inequities and dependance on foreign sources which deals to a lack of sustainability to cover recurring costs, above all in key components of basic preventive and curative care: nutritional programs, essential medicines, and logistical support. Some steps have been taken by the MOH and NGOs to reduce dependency from external sources of financing; some actions include a cost-recovery system, drug revolving funds, social marketing programs for contraceptives, etc.

e) *Human resources:* the quality of health services depends heavily on the availability and productivity of human resources. In El Salvador, as in other Latin American countries, the involvement of the government in this area is not part of any rational policy. The government finances medical and health training through its support to the University of El Salvador, and yet it does not condition the funding to focus in health training that best addresses the health needs of the country.

The improvement of inter-institutional coordination and the development and implementation of policies for health sector human resources have been limited by the following factors:

- poor planning by the MOH regarding the human resource needs (levels and categories of workers);
- autonomous functioning of the University of El Salvador not linked to the national health priorities as established by the MOH; and
- an increase in the number of private medical schools and other private training institutions without adherence to any norms or standards and without responding to any training plan based on the most pressing health needs of the country.

To improve human resources efficiency, the MOH decentralized

their Central and Regional administrative areas in to 18 Departments; however, the lack of a defined line of action and of an adequate health policy framework elaborated by the MOH has resulted in a high turnover of qualified personnel which severely affects service delivery. USAID has identified and supported the training of high and medium level Department Officials to strengthen the leadership and management role of the MOH's departmental level health personnel to develop and coordinate services in an integrated manner with other entities in the department.

III RELATIONSHIP TO USAID/EL SALVADOR'S STRATEGY

El Salvador's health situation has improved over the last twenty years in spite of adverse political and social circumstances. The most important health indicators have registered significant improvement especially during the past seven years due to the economic recovery, the end of the conflict, and more effective MOH and NGO efforts in the health sector.

The change is notable when comparing data gathered by the 1988 Demographic and Health Survey (DHS) to the 1993 DHS survey carried out nationwide with USAID financial support, and CDC's technical support. The improvements noted in the 1993 DHS are doubtlessly attributed to USAID influence since the Government of the United States was the major (if not the only) contributor to the El Salvador's health sector for the period analyzed (1988-1993) in the DHS.

The Mission Strategy for 1997-2002 describes its **Health Strategic Objective (SO) No. 3** as one that will impact on the health of infants, children and mothers by working toward an enhanced policy environment to support sustainability of child survival and reproductive health programs. Through the activities described in this RP, USAID stands ready to support the health sector reform including decentralization with discrete but highly focused assistance in areas which will complement the actions of other partners. These areas include: support for broad-based dialogue of national health policies and reform, analyses, discussion of health policy issues, and training in support of decentralization, especially to staff at the departmental level. This RP will set the stage for an adequate policy environment which in turn, will allow sustainable health services focused on women in fertile age and children under the age of five in the poorest rural communities of the country.

IV. ANALYTICAL/CONSULTATION PROCESS

The USAID Mission to El Salvador started a consultation process in December 1995 (which continues today) to discuss, analyze and make plans for supporting corrective measures to improve El Salvador's health sector. This consultation process may be divided as (a) external consultation and, (b) internal - Mission's- consultation. Because of this on-going consultation process, some assumptions have been elaborated (see below) to help have a more realistic view of current and future activities

to correct those deficiencies of the health sector as described in the previous section of this document.

(A) *External Consultation Process:* Between December 1995 and April 1997, SO3 Extended Team members, partners, customers, stakeholders and donors participated in several major presentations and discussions of the Mission's Health Strategic Objective Framework. In these meetings, working groups were formed to critique the logic and validity of the entire Health SO Framework and all indicators of progress. Working groups also focussed on each of the Results Packages. As a result of these consultations, modifications were made to the Framework and indicators. The final Results Framework, intermediate results and indicators identified to measure progress and impact have been the result of a highly consultative process and consensus among local and international institutions including donors. Institutions present at these meetings included: the Ministry of Health, the Salvadoran Social Security Institute, local NGOs, the Salvadoran Demographic Association (local IPPF affiliate); US contractors working with water projects supported by the Mission, as well as other international donors such as United Nations Fund for Children (UNICEF), Pan American Health Organization (PAHO), United Nations Fund for Population (UNFPA), Japan International Cooperating Agency (JICA), World Food Program (WFP), Germany's Cooperating Agency (GTZ), Interamerican Development Bank (IDB), etc. In addition, regular meetings with donors listed above in the health field are taking place periodically to coordinate and maximize resource utilization in El Salvador and to coordinate areas of support for the health sector, principally the Ministry of Health. The primary objective of donor meetings is to maximize resources provided by each donor in its area of influence, as well as having -to the extent possible- a common line of action to support El Salvador's health sector, within the mandate each donor agency has. Several donors carry out different interventions that contribute to the achievements of this RP: the European Community, Sweden, Germany (GTZ), Japan (JICA), Luxembourg and Spain, United Nations Development Program (UNDP), PAHO, UNICEF, UNFPA, IDB. They are implementing activities through the MOH in areas such as reproductive health, nutrition, Integrated Management of Childhood Illnesses (IMCI), etc. in specific departments of the country. The external consultative process will continue meeting with the Extended Team, partners, customers, stakeholder and donors to share ongoing results, coordinate future activities and determine implementation corrections if and as needed. Communities will be monitored and evaluated, and assisted if necessary, to help ensure maximum health impact. Customer satisfaction will be assessed through a variety of means, including surveys and reporting by Implementing Entities.

In addition the GOES Five Year Plan for 1994 to 1999 states specific objectives in health which are: (a) to improve health conditions of children under five years of age, of women in reproductive age, especially pregnant women and those breastfeeding; (b) to improve nutrition levels of children under five and of pregnant women and those breastfeeding; (c) to avoid

proliferation of contagious diseases and to consolidate the achievements in vaccination; (d) to improve physical and environmental conditions of the population, especially those living in rural and marginal-urban areas; (e) to strengthen and expand community health education programs; and (f) to establish a national health insurance program.

(B) Internal consultation process: The Mission has had discussions to consider an approach that will coordinate all sector activities which will lead to the sustainability of the health system. This process includes consultations with virtual members of the extended team (LAC and other USAID/Washington's offices) as well as close coordination with other Mission strategic objectives and centrally funded activities -for instance, a G/PHN/HN-USAID/Washington project that will contribute to the achievement of this RP; this activity (ies), Partnerships for Health Reform (PHR) No. 936-5974.13. It will provide technical assistance via the Field Support Agreement mechanism in health policy and management, health financing, and health service improvement. In the Mission, the activities of SO1, "Expanded Access and Economic Opportunity for El Salvador's Rural Poor" also support SO3's RP and vice versa. As SO1 contributes to the improvement of the economic status of the rural poor, the poor are more likely to be able and willing to participate in the financing and maintenance of health systems in their communities, contributing to the achievement of SO3. While SO3 also contributes to SO1 by improving the health of the rural poor so they are better able to take advantage of basic education and work opportunities and spend less money and time caring for sick family members.

In addition, SO3 is coordinating with SO2 to work with other Salvadoran institutions which traditionally were not considered by SO3: the National Assembly and the Ministry of Finance. Close coordination with these two key GOES's institutions are basic for achieving sustainable reforms to the health sector with broader participation of the private sector.

SO3 will also contribute to the achievement of S)2's Intermediate Result "Increasing Citizen Participation in Strengthening Local Governments" by assisting local citizen participation through NOG's and other kind of associations to participate in local community health groups that oversee health care needs in their particular communities.

In order to achieve the expected results in new policies for the health sector, a very close relationship will be developed with SO2, to take the necessary actions to reflect these changes and reforms. Actions and strategies will need to be designed and identified both for the local and central level citizen participation, in order to overcome any possible resistance.

Coordination with other Mission SOs has been described in detail in the Results Package No.1 "Increased access to potable water and sanitation systems", which has been approved.

(C) *Critical assumptions:* As a result of a literature analysis and of various meetings with local counterparts and other donors of the health sector, a number of critical assumptions have been made. These include:

1. The GOES will increase its support to the Ministry of Health increasing its yearly budgets.
2. The MOH will increase sharing provision of services with local health NGOs to cover rural populations.
3. Other donors and USAID will continue to support the GOES in these activities. USAID will continue to have adequate financial resources to assist in expanding rural access through an adequate political and legal health environment.
4. The underlying social conditions leading to the conflict that still exist, such as inequitable access to social services and economic opportunity, will be adequately addressed to avoid another outbreak of civil war.

In addition, certain risks in the health sector which currently are present in El Salvador must be eliminated:

a) *Some institutions group their beneficiaries according to their income level or other categories.* This can result in unequal access to health services, as is the case in government companies (and the ISSS to a lesser extent), in which more complete services are provided to a group which already is privileged relative to the other beneficiaries. The Health Sector Assessment of El Salvador (ANSAL) carried out in 1994 recommends that access to at least certain basic health services should be a function of need and not of ability to pay or of place of residence.

b) *The growth of the sector through the creation of new institutions or programs favors inefficiency (through the duplication of structures and equipment) and gaps in coverage (through the exclusion of certain groups).* Often new institutions or programs are created because of the difficulties in resolving problems in existing organizations and the ability of a population group to pay for an alternate solution. In these cases, the problems in the older institutions are not resolved and the pressure to deal with them in the future decreases because many beneficiaries have already left the institution.

c) *Coordination of the development of health policies:* Modernization of a government involves the introduction of substantial changes in relation to its current functions. It consists of changing from an interventionist state which is a direct provider to a state which concentrates its actions on the development of policies, plans, and programs; the approval of standards; and in the supervision and determination of where public resources will be spent. A modern government will be able to guarantee access all the population, above all the poor, to efficient and equitable health services.

V. SUMMARY OF ACTIVITIES/EXPECTED RESULTS

A. Current Activities

This RP can be described as a coordinating mechanism for plans developed and implemented under other SO3 activities to obtain an enhanced policy environment in support of sustainability of child survival and reproductive health programs. This RP also serves as contact point for coordination with other international donors working in the health sector.

Current actions under this RP are focused in the coordination of specific sustainability plans that have been developed by the different activities managed under the Health Strategic Objective. Following is a short description of sustainability efforts carried out under each SO3 activity.

Activity No. 519-0308 (APSISA): In 1994, the APSISA Activity was amended to change the purpose of the project to support and strengthen the capability of the MOH to perform its role as leader of the health sector and to provide technical assistance to facilitate the decentralization process.

Through APSISA, greater emphasis was placed on the planning and management of health services; on the implementation of the cost recovery system; on the decentralization of health services; on the development and implementation of new health services and management models; on the development and implementation of policies, norms and standards for health service deliveries and on the strengthening of the MOH's warehouse management and medical supply distribution.

Regarding sustainability of health programs, a cost recovery scheme has been designed and is currently being implemented in selected MOH facilities. An evaluation will be carried out to adjust the system being tested and then it will be implemented nationwide. At present, the RP is coordinating health activities supported by other donors including IDB, GTZ, UNICEF, PAHO, PNUD, UNFPA, JICA, etc. oriented toward how the MOH will plan to cover operation costs for its programs once the international community withdraws its support as part of its sustainability efforts.

Activity No. 519-0363 (Family Health Services): Under this activity social marketing of contraceptives has contributed to the financial sustainability of the local IPPF affiliate - Salvadoran Demographic Association. In addition, this institution has on its own initiative, developed a private medical system selling services to the general public and governmental institutions such as the ISSS after the acquisition of a private hospital in 1994. The Salvadoran Demographic Association has been a pioneer in reproductive health and since its foundation has positively influenced the GOES in the way and type of family planning services that should be delivered based on population needs. One of this activity's components was designed to strengthen the policy framework of the country by more accurately identifying and targeting vulnerable population

groups.

Activity No. 519-0367 (PROSAMI): The local health NGO network is implementing rotating medicine funds as a cost recovery system. This modality was a result of technical assistance from UNICEF. In reference to health policy, PROSAMI is closely coordinating with the GOES, SETEFE and the MOH, to support those NGOs that have an adequate managerial and technical structure to deliver health services in those geographical areas of El Salvador where the MOH has little or not presence at all. PROSAMI has shown that private delivery of services is adequate since the communities where this activity has influence have developed remarkable health indicators when compared with the national average.

Activity No. 519-0420 (PROCIPOTES): The five NGOs working with PROCIPOTES will prepare a sustainability plan to be submitted for its approval this year; in addition, they are looking for ways to unit themselves to increase their possibility of obtaining funding from other sources than USAID. No technical assistance is being provided for these efforts. Each year the NGOs are required to decrease their dependence on USAID. This is done by utilizing volunteers and seeking local sponsors as well as by coordinating with town councils and the Ministry of Education.

Activities No. 519-0320 and 519-0394 (Public Services Improvement and Peace and National Recovery, respectively): These two activities train the communities to construct, manage, maintain, finance and repair the water and latrine systems. In addition communities learn how to improve their health conditions through hygiene education.

Three centrally funded activities contribute to this RP via Field Support Agreement: PROFIT (No. 936-3056), Data for Decision Making (No. 936-5991.01) and Initiatives (No. 936-5974.07).

PROFIT's objective is "to expand commercial sector's involvement in family planning service and product delivery, thus contributing to national family planning and reproductive health objectives." In this regard, PROFIT has been working in El Salvador with a budget of US\$400,000 since 1995 to help a local association of coffee cooperatives (UCRAPROBEX) to develop a private medical plan for its rural beneficiaries. Since the PROFIT activity is scheduled to end in September 1997, SO3 is helping UCRAPROBEX to find other financial sources such as PL-480 funds to develop the medical services plan designed by PROFIT and/or other external donors. This plan would initiate a pilot activity to provide high quality maternal, child and family planning services to unprotected rural populations at a per capita cost lower than what the Salvadoran Social Security Institute and/or other private service providers could offer.

In addition, the Initiatives activity, whose objective is to "test the extent to which the private sector can provide financially sustainable basic health services to low income populations in urban/periurban areas" has been working with a

budget of US\$100,000 with the private medical community of El Salvador (Colegio Medico and COMEDICA-Medical cooperative). The purpose of this activity is to study the feasibility of developing an HMO-like system in El Salvador which could provide high quality medical services at a lower cost than current private medical costs and to a wider range of beneficiaries. This activity is also ending this September.

With the DDM activity, technical assistance is being provided to the Ministry of Health of El Salvador "to assist in health sector reform, by developing and applying methods and technologies to help decision makers make informed policy decisions". Unfortunately, the lack of firm decisions on the MOH's side to implement an effective health reform has produced a serious delay in the developing of this central activity. DDM's budget was US\$200,000.

B. New Activities

An umbrella activity will be designed for the Strategic Objective which would have three major components to deal with each respective Results Package (Child Survival to 3.1, Reproductive Health to 3.2 and Policy and Sustainability to 3.3).
Policy and Sustainability Component:

1. *General aspects:* The objective of health sector reform is to correct structural problems in the sector so that improvement can continue at an accelerated rate and become self-sustaining for providing adequate and equitable high quality services to the SO target populations. In achieving this, the Mission will engage in policy dialogue with different governmental and non-governmental actors such as the Secretariat of the Family, the MOH, SETEFE, the Assembly, the Ministry of Finance, and a very strong and close coordination with the Mission's SO2.

An important factor in achieving this is the strong coordination that must exist between this RP and the Child Survival and Reproductive Health RPs since health activities described in these two RPs need an adequate, reliable, sustainable and solid health policy basis.

The Mission's health policy agenda is focused on the need to secure the sustainability of its previous substantial investments in maternal/child health (MCH). Although earlier health policy work was undertaken to address a continuing need for broader health reform, the current focus of the mission's health policy strategy on securing the sustainability of the MCH program is based on the fact that there are currently a number of policy-related obstacles to securing the sustainability of the MCH program, including continuing inequity in the geographical coverage of MOH services, reluctance on MOH's part to support critical NGO-provided MCH services, and weak political support for family planning and reproductive health.

Now that the NGOs have demonstrated their ability to provide high quality MCH services, it is important for USAID to gradually

transfer responsibility for funding these services to the NGOs themselves, to the communities they serve, and to the GOES via the MOH.

Although the primary focus of the Mission's health policy strategy is on establishing the sustainability of current and previous MCH program investments, there are still large numbers of poor rural residents who do not have access to cost-effective technologies for reducing infant/child and maternal deaths. The Mission strategy will address the needs of these undeserved populations by working closely with MOH to increase the accessibility and quality of its services and to strengthen the complementary role of the commercial sector as a source of MCH service.

To reduce inequities demands an increase in government spending, the concentration of expenditures on the low income population groups who are at the highest risk, and a focus of attention and resources on Primary Health Care (PHC). This strategy is expressed through the financing and total subsidy of PHC services for those people who are below the poverty line and through the partial or total subsidy by the government of a more complex level of services for the same group.

The lack of sustainability of the sector demands increased funding from the government and the users. The correction of both problems (inequities and the lack of self-sustainability) cannot be the full responsibility of the government. Improvement of the sustainability of the health system, therefore, requires a major financial effort on the part of the users who can afford to pay. This strategy is expressed in the proposed health reform by the elimination of the subsidy in specialized and hospital care for those who are not poor and who would have to finance their own use of the health services through cost recovery and a minimum mandatory insurance.

2. Description of Probable areas of action for Policy and Sustainability: Based on the problem description and on the analysis made in this section, one could conclude that there are essential areas of interventions necessary for developing an adequate reform of the sector:

- a) Policy Framework Development with a strong participation by the private sector
- b) Institutional reorganization of the sector especially of the Ministry of Health
- c) Reorganization of primary health care (PHC) with a greater involvement of municipalities which may end in a transferring of financial responsibilities for continuing providing health services to local governments. Communities will become also aware of what are their rights and will have an active participation in lobbying the government to provide health services.
- d) Reorganization of specialized and hospital care (SHC) specifically with an inversion of budget expenditures increasing the government's allocations for primary health care and reducing

hospital's

- e) Strengthening of environmental health activities
- f) Donor coordination will continue being a priority in all health actions supported by USAID with a greater emphasis in policy and sustainability.

This component proposes defining a basic set of health services centered on priority health programs, with activities in health promotion, prevention of common diseases, and basic curative care. One mechanism to assure the delivery of the services to the poor would be financed by the MOH through a transfer of resources to the health departments and municipalities; another mechanism could be the currently implemented Cost Recovery System developed by the MOH with USAID technical support; and/or the development of a sort of pre-paid insurance. Depending on their size, stage of development, and preference of the community, the municipalities would either provide services directly or would contract for the services through private organizations.

Proposed new activities planned to be developed should be differentiated between those developed with NGO's and those with the MOH; in addition, some changes would be made to current activities to start setting the stage for a sustainable MCH program to be reinforced in the near future with new actions in this area:

(a) NGOs: An important resource in developing policy and sustainability actions are the local health NGOs which, funded by USAID, currently providing primary health services at the canton level for approximately 10 percent of the total population through a network of NGO-supported health promoters. USAID has been assisting these NGOs to become self-sustaining for several years. Special attention will be given to assessing the ability of different communities to pay for basic health services and to testing and evaluating alternative approaches to community financing (e.g., user fees, revolving drug funds, mandatory capitation payments such as have been levied by community water and sanitation boards). Since the NGOs services complement rather than duplicate similar services provided by MOH in other parts of the country, it is reasonable for the MOH to provide at least partial financial support to the NGOs on a capitation basis to enable them to continue providing these services. Although MOH has not yet accepted the principle of supporting the activities of the NGO health promoters, some progress toward this goal has been experienced recently. Eighteen of the strongest NGOs previously supported by the PROSAMI project are currently working under the supervision of MOH funded through local currency; the Ministry of Health plans to evaluate their performance and make decisions whether to contract with some of the NGOs to provide similar services on an ongoing basis. However, the MOH does not offer realistic contracts, and one example is the contract signed with a local health NGO (FUSAL) to provide services in one area of the country (San Julián, Department of Sonsonate) including the use of FUSAL's health promoters at the canton level; however, the type of contract signed between both institutions is not cost effective for FUSAL since this organization shall pay for most of

its operating expenses.

The Salvadoran family planning association (SDA) has been partly funded by USAID for many years. Although with USAID encouragement and support it has succeeded in covering an increasing share of its budget from domestic sources, it will need to continue this process through the planning period. In addition to providing services to many couples, SDA carries out a successful social marketing program and supports a network of satellite clinics providing family planning and MCH services. As part of its policy strategy, USAID will assist SDA to increase its financial self sufficiency and will encourage MOH to supply contraceptives and other types of support to ADS.

(b) Ministry of Health: Most maternal-child health services are currently provided by the MOH and NGOs, and many of these subsidized services are for women and children who could afford to pay for them. The PROFIT and Initiatives projects pointed out, for example, that many middle- and upper-income women use deliver in heavily subsidized MOH facilities in order to receive free postpartum sterilizations. The commercial sector's role in providing MCH services is presently very limited. Strengthening this role could contribute to program sustainability in several ways. First, and perhaps most important, commercial providers would be expected to attract middle- and upper income clients and draw them away from subsidized services provided by MOH and the NGOs (particularly if fees are raised to full-cost levels for such clients in MOH and NGO facilities). This would improve the targeting of the limited subsidies available from MOH and other sources and contribute at least marginally to improving the overall equity of the MOH health system. Second, commercial providers of MCH services could effectively complement MOH and NGO providers in some currently underserved areas of the country, as discussed below. Third, effective competition from private providers would be expected set standards for quality and efficiency and stimulate the MOH to strive for greater quality and efficiency in the provision of its own MCH services.

Despite the impressive gains the MOH has made in establishing a strong MCH program, its commitment to primary and preventive health has been neither sufficiently strong nor sufficiently consistent to date to ensure that previous USAID investments are sustainable. As mentioned before, there are still important segments of the population without access to primary and preventive health care; and the MOH continues to allocate most of its budget to curative hospital services benefiting primarily the relatively affluent segments of the urban population. Its reluctance to provide partial support to NGOs providing MCH services to large segments of the population continues to be a barrier to securing the sustainability of these services. During the period of this strategy USAID will assist MOH to consolidate and extend coverage of basic primary and preventive services to a higher percentage of the population. USAID will assist MOH to develop a set of criteria to determine which cantons need health promoters and how much each canton can be expected to contribute to the financing of its health promoter. Also, technical

assistance will be provided in contracting health services. The PROSAMI project will assist MOH to apply the most successful approaches to community financing of health promoters to the communities served by MOH promoters (thereby freeing additional MOH resources to be used in expanding coverage). The MOH is already purchasing all vaccines and a significant share of the contraceptives used in its MCH program; and it has agreed to purchase all contraceptives used in its own program by 1998. USAID will monitor closely MOH's progress in these areas and will also encourage MOH to provide vaccines and contraceptives to NGOs providing MCH services.

USAID will also provide assistance for the definition and implementation of a basic package of health services (canasta básica) to help the MOH in defining the cost of the "canasta" to enable the payment of per capita services to NGOs.

(c) Proposed changes to current activities: The USAID strategy to strengthen commercial sector providers of MCH services includes the following measures:

Private providers would be trained and equipped by SDA and others to provide high quality family planning and reproductive health services.

USAID would continue to work with the MOH and SDA to establish fees which recover full costs for services provided to middle- and upper-income clients. In addition to improving the targeting of existing subsidies, this measure would encourage such clients to shift to commercial providers. The SDA is developing at present a series of studies with technical assistance from Family Health International (FHI) via Field Support Agreement mechanism to determine costs of services offered as well as payment capability of the SDA's clientele; the results would help the SDA in determining adequate fees which will increase its degree of sustainability.

The PROSAMI project might experiment in USAID's test areas with the use of vouchers (including transportation) to enable poor rural residents of underserved areas to utilize the services of SDA-affiliated commercial providers of family planning and reproductive health services. The voucher scheme would be administered and evaluated by SDA, with funding provided by the USAID current activity. Other area that needs to be addressed with technical assistance is cost recovery for both the MOH and NGOs.

SDA might experiment in USAID test areas with the use of private physicians to provide family planning and reproductive health services in MOH facilities not staffed by a doctor. An alternative would be to develop one or more mobile units to provide such services in remote rural areas. The cost effectiveness of these pilots would be evaluated carefully.

Social marketing activities would be broadened to include a wider array of MCH products, including contraceptives (IUDs,

injectable), ORS, iron/folic acid tablets, and fortified foods (e.g., vitamin-A fortified sugar and iodine-fortified salt). An important element in the strengthened social marketing program would be providing training and IEC to pharmacists and other pharmacy staff concerning the safe and effective use of contraceptives, ORS, antibiotics and other critical MCH products.

Mandatory changes: To achieve the changes proposed above as well as new proposed activities in the MCH and Reproductive Health areas, policy dialogue is an important and basic task to be achieved since profound legal changes will be needed to allow and secure sustainability of the programs for the poorest population, especially rural. In this sense, close coordination with other donors in the health area will also be crucial to achieve this goal, as well as with other GOES institutions such as the National Assembly, the Ministry of Finance and any other entity dealing with policy and legal aspects needed to assure sustainability of the reform changes that are and will continue taking place in El Salvador. The area of interest for an adequate sustainability policy will specifically be Reproductive Health and Maternal/Child Survival activities developed for the rural poor, especially those living in the Mission's poverty focus areas of El Salvador (See Geographic Focus Section below)

As mentioned before, donor coordination will continue to be led by USAID in this area. The SO will also request support from central activities, in particular from Activity No. 936-5974.13 (Partnerships for Health Reform-PHR) and the SO has budgeted a total of US\$230,000 for FY1997 and US\$200,000 for FY1998. The SO plans, using this central resource, to provide technical assistance, training and collaborative research regarding health policy and management, health financing and health service improvement in El Salvador to both public and private health institutions.

Summarizing, three major areas are expected to be addressed under this RP via (a) central projects, especially the Partnerships for Health Reform Activity starting September 1997, and (b) the new SO3 activity planned for 1998-2001; these areas are:

(a) Health Policy and Management: assistance will be provided to the Ministry of Health of El Salvador and the private medical sector to develop an effective institutional reform, decentralization, and management capacity-building as well as human resource development.

(b) Budgetary and Administrative Sustainability: this area will continue to be reinforced through resource generation via user fees, adequate health insurance schemes to be defined based on El Salvador's local health economics conditions; resource allocation, use and management; and finance, costing, and expenditure monitoring.

(c) Health Service Improvement: will be achieved through health care organization, quality and supervision; pharmaceutical policy and management; and private sector cooperation and initiatives.

3. *Geographic Focus:* Policy, reform, and sustainability efforts and changes supported by the Mission will focus primarily on the Mission's Poverty Focus areas as well as in the MOH's designated tests departments taking into consideration coordination with other USAID and other donor activities to maximize impact. Thus, communities that are located in the areas qualified under the Mission's Poverty Focus criteria and model municipalities will have the opportunity to be benefitted similarly to those cited in the MOH's test departments.

Health education and assistance in community organization will be expanded to involve additional local groups, such as municipal government staffs, local NGOs, and others, that perhaps should be involved in the health reform process. The intention is to determine alternative and perhaps better mechanisms than those developed to date in providing a higher coverage and higher quality services to rural undeserved populations of El Salvador.

4. *Target Population:* It's hard to define at this moment the number of beneficiaries that one could expect as result of a successful implementation of adequate new activities to improve the health of rural women in fertile age and of children under 5 years of age.

VI. FEASIBILITY ANALYSIS

A. Current Activities

Numerous documents and reports have been published worldwide in the last five to seven years proving that profound reforms are needed in the health sector of underdeveloped countries. Some documentation on this matter has also been published in El Salvador as well by international donors, the GOES and local NGOs. An illustrative list of that documentation is contained in Attachment E.2 (Feasibility Analyses) of this RP document. All these studies show that a policy change is both needed and capable of being implemented with appropriate sustainability mechanisms in underdeveloped countries.

B. New Activity

Additional analysis may be necessary such as the National Family Health Survey (FESAL) and the measurement of the Maternal Mortality Ratio and the establishment of an adequate maternal mortality national surveillance system. During the implementation of the new health activity (ies), and when appropriate, the implementing agency(ies) of the new activity (ies) will conduct studies as needed.

VII. CUSTOMER SERVICE PLAN

The SO3 Team has defined its customers as socially, geographically, economically and culturally disadvantaged Salvadoran women in fertile age and children under five years of age who lack adequate access to health services.

To identify customer needs in this Results Package, the following, and possibly other, techniques will be used:

1. Informal Surveys: Informal surveys, i.e., those lacking statistical significance based on sample size and highly technical and sophisticated survey techniques, will be conducted about every six months in previously identified communities.
2. Formal Surveys: Professional researchers will be utilized to design client satisfaction surveys with statistical significance, conduct the surveys and analyze the findings.
3. Interviews: Informal and formal surveys will include interviews, and in addition, independent interviews will be conducted with randomly selected community members.
4. Home visits: Most of the previously mentioned methods of gathering customer information will include home visits to clients.
5. Focus groups: Professional researchers will be utilized to conduct focus groups to obtain information on customers needs and opinions.
6. Community Meetings: Town meetings or meetings with various local civic groups will also provide means to understand client concerns.
7. Field visits: Periodic field visits by implementing staff, SO3 Team members, and contractors will provide valuable information on both customer needs and activity (ies) performance through direct observation, home visits, focus groups and/or interviews.
8. Information exchange: A mechanism to regularly exchange information with agencies of the Government of El Salvador, other donors, partners and stakeholder providing similar services will be developed and implemented.
9. Formal or conventional communication: Letters, phone calls and faxes between customers, community boards, local press, implementing agencies and donors will also provide an avenue to understand customer views and concerns.

Sharing information with customers and providing feedback will be done on both an individual and community basis. For example, during field visits and via letters, the individual client will be able to receive a direct answer to many if not all of his/her concerns. For the community at large and its many subgroups, public community meetings will be used to provide feedback on the findings and conclusions from formal surveys and focus groups, and how those effect the plans for water systems and latrines in that community. Such meetings should also be used to provide information to the community on the incidence and severity of diarrheal diseases and other related health issues in their community, and what progress has been made as a result of their

use of the new water and sanitation systems.

To date, fieldwork by the Mission staff and contractors, the 1994 National Health Sector Assessment (ANSAL), CID Gallup Polls, the 1996 Mission customer assessment (carried out by CID/Gallup), and informal focus groups and interviews conducted by the Mission staff and partners, have provided information about our customers. As part of the ANSAL, ten community meetings held around the country in late 1993 and early 1994 which were attended by a wide variety of local citizens, health professionals, community leaders, and others. Also as part of the ANSAL, a study, "Community Perceptions and the Demand for Health Services" was prepared. It included the findings of personal customer interviews in eight departments which were analyzed in conjunction with several national surveys to assess the demand for health care services in El Salvador, community perceptions of illness and treatment, local perceptions and practices related to preventive health care, and the role of the health promoter.

During the design and implementation of current activities in this Results Package, customer satisfaction information was used. Additionally, during implementation, ongoing customer information will be obtained informally through field visits and meetings with community representatives by the Mission and contractors staff, and adjustments will be made accordingly.

VIII. HUMAN CAPACITY DEVELOPMENT NEEDS

The human capacity development will be addressed through on-site technical assistance, one-on-one communication, group talks and formal institutional based training. Community members who are most likely to be included and directly benefit from this human capacity development intervention include adolescents, men and women in fertile age, community leaders, Health Committee members, local government representatives, NGO and MOH Health Promoters, school teachers, mothers and fathers, and other community members directly involved in the design, implementation monitoring and evaluation of the new activity (ies).

For the Reproductive Health providers at all stages, the need of the knowledge and improvement of skill level in the areas of technical, service provision, interpersonal relationships, communications, community organizing, must first be determined using many of the same techniques will be utilized to develop a base for customer information, such as: focus groups, direct interviews, direct observation and surveys.

Once specifics are determined for each health provider level, human capacity development interventions and techniques including but not limited to the following, will be used as needed and appropriate:

1. Seminars or workshops for health providers, community leaders, Health Committees,
2. Refresher training for NGO/MOH Health Promoters working in

- the communities,
3. Pamphlets and brochures for residents,
 4. Observational travel to other areas of El Salvador or to other countries,
 5. Technical assistance, and
 6. On-the-job-training

Additional in-country training will be provided to customers/partners of the Results Package from the new Human Capacity Development (HCD) Activity (519-0432) core funds in cross-cutting topics such as leadership, empowerment skills, NGO strengthening, conflict resolution, self-esteem, strategic planning, total quality management, customer service, sustainability approaches, etc.

On the other hand, both technical training and cross-cutting topic seminars will closely follow reengineering training guidelines which include: (a) agreements with stakeholders, (b) change agent concept (leadership, training of trainers, action planning), (c) training needs assessment for annual training plan, (d) critical mass approach, (e) multi-level training, and (f) group dynamics.

All these training activities will be coordinated/channeled through the HCD Activity and with Mission's Training Unit by developing and submitting annual training plans responsive to the specific Activity under this Results Package. Once the Activity (ies) is developed, it is envisioned that the annual contributions for specific training activities will be facilitated through MAARDs/Delivery Orders for implementation of customized training during each Fiscal Year. Moreover, the Activity (ies) will take most advantage of cross-cutting topic seminars offered by the HCD Activity and its core funding to improve/advance human capacity building of key institutional personnel as well as rural end-customers.

The result of all these training activities will be significant contributions to Intermediate Result 3.3 "Enhanced Policy Environment to support sustainability of Child Survival and Reproductive Health Programs".

IX. IMPLEMENTATION MANAGEMENT PLAN

A. RP Team members and their responsibilities

In order for the RP to achieve expected results, not only will the RP Team members need to fulfill their obligations as described below, but our partners are also key to achieve RP results. USAID will need to improve and maintain regular coordination in planning, financing and implementing health activities with other donors such as the Interamerican Development Bank (IDB), European Union (EU), UNICEF, Plan International, Ministry of Health (MOH), Peace Corps, and a series of local NGOs working in health, as well as with the for-profit medical sector of this country.

Specific responsibilities of all RP Team members are described below, but will be modified as needed per the recently released revised Mission Delegation of Authorities. The RP Team Members are:

1. **Raúl Toledo:** As the RP Team Leader assumes complete responsibility for the full range of supervision, management, monitoring, reporting, and evaluation of technical program and financial data of current and future activities of the RP.

Ensures broad information sharing focused on RP purpose and results to all SO3 members and others as appropriate.

Reviews all activities and takes actions, including recommending activities modifications and measures to correct or improve implementation, monitoring and reporting.

Acts as official USAID representative on field and inspection visits to activity (ies) sites in coordination with other members of the RP, ascertains progress, identifies delays and problems and recommends solutions to resolve them.

Takes the lead in drafting and presenting for clearance and approval, any administrative action necessary.

Prepare RP reports, tables and narrative for Unit reviews as required.

Provides follow-up to coordination meetings between RP members and SO3 partners, customers, USAID/W staff and its activity (ies) implementors staff, and other possible collaborators, to ensure efficient and appropriate planning, and productive working relationships and coordination.

Is responsible for assuring his results package supports the other results packages in achieving the overall SO.

2. **Jack Dale:** As the Deputy Team Leader of the RP No.3, assumes partial responsibility for, and supports the RP Team Leader in, the full range of supervision, management, monitoring, reporting, and evaluation of technical program and financial data of the current and future activities of the RP.

With general guidance and supervision of the RP Team Leader, initiates drafts and Activity (ies) documents for clearance and consideration and approval, including PIOs, PILs, requests for purchases, and related correspondence. Responsible for tracking all documentation through Unit clearance process.

Works closely with RP Team Leader to ensure that all aspects of implementation, monitoring and reporting are adequately covered.

As the responsible for the SO3 actions on Sustainability, oversees, monitors, provides follow up to all the interventions that the RP implementing agency (ies) carry out towards technical, institutional and financial sustainability.

Is responsible for assuring his results package supports the other results packages in achieving the overall SO.

3. **Terrence Tiffany:** As Team Leader for the SO3, of which this RP is a part, provides leadership to SO3 Team to enable each RP Team to contribute fully and meet RP and SO3 agreements and commitments once agreed.

4. **Maricarmen de Estrada:** As Deputy Team Leader for the SO3 activities in Reproductive Health and responsible for all SO3 actions in FP, oversees, monitors and provides follow up to all interventions that the RP 3.2 implementing agency (ies) carry out especially in the area of FP in relation to policy, health reform and sustainability. Will work closely with other Team Leaders and Deputy Team Leaders to ensure that all aspects of implementation, monitoring and reporting are harmonized between RPs and for the SO.

As the responsible for the SO3 actions on family planning oversees, monitors, provides follow up to all sustainability interventions carried out in family planning by the implementing units, in close coordination with this RP.

Is responsible for assuring her results package supports this results package in achieving the overall SO.

5. **Meri Sinnitt:** As Team Leader and responsible for the SO3 activities on Child Survival, oversees, monitors and provides follow up to all interventions that the RP implementing agency (ies) carry out in relation to policy, health reform and sustainability.

Will work closely with other Team Leaders and Deputy Team Leaders to ensure that all aspects of implementation, monitoring and reporting are harmonized between RPs and for the SO.

As the responsible for the SO3 actions on child survival oversees, monitors, provides follow up to all sustainability interventions carried out by the implementing units, in close coordination with this RP.

Is responsible for assuring her results package supports this results package in achieving the overall SO.

6. **Margarita de Lobo:** As Team Leader for RP 3.2 and responsible for the SO3 activities in Reproductive Health, oversees, monitors and provide follow up to all interventions that the PR implementing agency (ies) carry out in relation to policy, health reform and sustainability. Will work closely with other Team Leaders and Deputy Team Leaders to ensure that all aspects of implementation, monitoring and reporting are harmonized between RPs and for the SO.

As the responsible for the SO3 actions on reproductive health oversees, monitors, provides follow up to all sustainability interventions carried out by the implementing units, in close

coordination with this RP.

Is responsible for assuring her results package supports this results package in achieving the overall SO.

7. José Ramos Chorro: As team leader of the Water RP, José will be essential in assuring that adequate cost recovery and sustainability mechanisms developed as a result of this RP efforts, being adequately implemented in those rural communities where the new water activity is implemented.

As the responsible for the SO3 actions on water oversees, monitors, provides follow up to all sustainability interventions carried out by the implementing units, in close coordination with this RP.

Is responsible for assuring his results package supports this results package in achieving the overall SO.

8. Elizabeth de Tercero and Martin Schulz: As Controller Office staff members, maintain the integrity of the accounting system, identifying potential financial problems and propose possible solutions.

Provide advice and assistance in all financial and accounting issues, budget reprogramming and assume responsibility for funds control management.

Coordinate the accrual process and resolve inconsistencies.

Carry out the 1311 review process twice a year.

Develop and prepare special customized financial reports and document, review and verify financial data and present information to SO team.

Review, process and transmit all vouchers to ensure accurate payments and assume lead in resolving vendor payment problems.

Review and clear financial, audit and implementing documentation and coordinate the "Recipient Contracted Audit Program" for the Unit, including HCOLC audits.

Assist in the design of new RPs under approved SO, amendments of RPs, amendments of existing activity (ies) designs within approved RPs, etc.

Verify overhead adjustments of contracts and cooperative agreements.

Perform internal control reviews of prospective as well as current local beneficiaries as applicable.

Perform necessary review/analysis to provide for the commodity management system certification of prospective recipients as applicable and participate in the Host Country Contracting

certification process.

Perform field trips to observe implementation of activities.

9. **Ileana Párraga:** As the Office of Contracts and Grants staff member provides guidance and assistance to RP team members regarding contracting/procurement guidelines and requirements, including issues that might arise during contract performance, such as assessment of liquidated damages for late delivery, claims of recovery under insurance, waivers of source and origin requirements, past performance requirements and its importance, performance based contracting, etc.

Provides the same type of guidance and assistance to RP team members regarding agreements with local NGOs and international PVOs.

Suggests appropriate actions to meet RP goals, including reviewing statements of work to determine whether the needs of the RP have been adequately defined; determining the most appropriate contractual or agreement arrangement, i.e. contract vs. cooperative agreement and brings irregularities to the attention of the RP leader with recommendations for corrections.

Coordinates implementation of the Annual Procurement Planning System (APPS).

10. **Ana Cristina Mejía and Silvia de González:** As Strategic Development Office staff members provide assistance and guidance to the RP team to ensure activity (ies) design and implementation documentation is timely and prepared in accordance with the Automated Directives System (ADS) guidance.

Assist in strategic planning and new activity (ies) design planning for the RP and coordinate RP input to the R4 process and other Unit program documents.

Assist in ensuring inter-SO coordination.

Review funding actions and other documents (as specified in the Mission DOA) for quality, compliance with Mission and Agency policies and procedures, and adherence to the Mission's Strategic Plan.

Provide guidance for the Semi-Annual Review process and ensure that RP teams comply with recommendations and actions to be taken after SAR review.

Provide guidance on programming and implementation to assist in achieving results and coordinate RP budget and obligation planning.

Coordinate activity (ies) evaluations and provide guidance as necessary to the overall RP monitoring and evaluation process.

Keep RP team updated on USAID's policies and Unit wide guidance.

11. **Ana cecilia Villata:** As the SO3 secretary she will be responsible for providing full administrative support to the SO.

B. Implementation Mechanisms

The RP Team Leader and the Deputy Team Leader will oversee the implementing entities of the different Cooperative and Bilateral Agreements to be developed in the other health SO RPs (refer to each RP for specific insight of this section as well as to Section IX. A of this document).

Implementation mechanism for the current activities under this RP are detailed below:

ACTIVITY NUMBER AND NAME	IMPLEMENTATION MECHANISM	ACTIVITY START-END
519-0363 Family Health Services	Cooperative Agreement with the Salvadoran Demographic Association	07/31/90 - 12/31/98
519-0308 Health Systems Support	Bilateral Grant Agreement with the GOES through the Ministry of Health	08/29/86. - 09/27/99
519-0367 Maternal Health and Child Survival	Cooperative Agreement with MSCI	07/27/90 - 12/31/98
519-0420 Displaced and Street Children	Operational Grant with MSCI	09/30/94 - 05/31/98
519-0430 New Health Activity	To be determined	10/01/98 - 09/30/2002

C. Monitoring and Reporting on Progress

Many features of the system to monitor, measure and report on implementation progress in the current activities will be again utilized for the new activity (ies). However, a number of changes will be made to strengthen and improve the system. For example, monitoring will be improved as the RP and SO Team members try to increase the number of field visits and as the RP Team meets regularly with the implementing entity to discuss progress and problems. Measurement of progress will continue to use the Intermediate Indicators in the SO, but will be expanded to include other indicators for use by the SO Team only, including the correct use of the water supply and sanitation systems, changes in behavior, and decreased incidence of diarrheal diseases. Reporting on progress will be standardized if there is more than one implementing entity and a combined report between entities will be produced. Progress will be

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reported more extensively to RP and SO Team partners including other donors, the GOES and local NGOs, stakeholder and customers.

X. FINANCIAL PLAN

This RP will obligate funds under the new activity (ies) 519-0430, which includes RP 3.1 and 3.2. The total amount to be obligated for the new activity (ies) is \$37,449,000 over a five year period. Amounts to be obligated for each RP will be detailed in the New Activity (ies) Document. Counterpart contribution from various sources (GOES and NGO's) are estimated to be \$12,484,000 over the same period. In addition to the new activity (ies) each current activity (ies) that support this RP will obligate a total of \$12,230,000 in FY97 and FY98 to accomplish the goals of the SO, as follows:

<u>CURRENT</u>				
<u>ACTIVITY</u>	<u>USAID/ES*</u>	<u>COUNTERPART*</u>	<u>TOTAL*</u>	<u>PACD</u>
519-0308	1,885	(1)	1,885	08/28/99
519-0363	3,653	1,214	4,867	12/31/98
519-0367	5,992	1,250	7,242	12/31/98
519-0420	700	180	880	03/31/98
Totals:	12,230	2,644	14,874	

(*) thousands of US dollars

(1) LOP counterpart contributions for activity 0308 have been met

In order to provide for correct implementation and management of USAID funds, the Mission provides follow-up of the Activity (ies) through the Activity (ies) Manager (AM) and each of the RP team leaders and members. In addition, recipients are required to carry out annual audits that meet generally accepted government auditing standards as promulgated by the **United States General Accounting Office**. Counterpart contribution reports are required every quarter and are followed up by the offices of SDO and CONT together with the AM.

For new starts under the Activity (ies), in order to determine if the prospective recipient is eligible to receive funding from USAID, a pre-award survey will be conducted by the Office of the Controller and the Office of contracts and Grants, as applicable. With regards to counterpart contributions, it is the policy of the Mission to negotiate and try to obtain as much counterpart contribution as possible to obtain maximum impact from the assistance, subject to the minimum of 25% mandated by law or USAID regulations. This requirement is not applicable, as a matter of law, to non-profit organizations or Economic Support Funds (ESF). However, USAID/El Salvador has administratively determined to apply this requirement whenever possible.

The obligation plan (USAID contribution) by fiscal year for the New Activity (ies) (RP3.1, 3.2, 3.3) is the following (in US\$000):

	<u>FY-97</u>	<u>FY-98</u>	<u>FY-99</u>	<u>FY-00</u>	<u>FY-01</u>	<u>FY-02</u>	<u>TOTAL</u>
519-0430	0	5,466	6,483	8,500	8,500	8,500	37,449

Recurrent cost analysis will be performed during the design phase of the New Activity (ies).

USAID management costs directly attributed to resources of the RP, are approximately \$601,796 for USAID personnel. Personnel costs directly attributable to SO#3 technical staff are \$525,190 and \$76,606 attributable to SO#3 support offices.

The figures allow for a yearly increase of 10% for FSN personnel and 2% for USDH. The detail for the first year is as follows:

Category SO/Office	Person years	FUNDING SOURCE			AMOUNT
		OE	TF	SO	
USDH SO3	0.15	X			12,698
USDH SO3	0.05	X			1,943
FSN SO3	0.70		X		32,064
FSN SO3	0.70			X	26,844
FSN SO3	0.05			X	1,376
FSN SO3	0.10			X	1,573
FSN SO3	0.05			X	1,474
FSN SO3	0.20		X		3,302
FSN SDO	0.15		X		4,422
FSN SDO	0.15		X		2,409
FSN OCG	0.15		X		2,177
FSN CONT	0.15		X		3,384
FSN CONT	0.15		X		4,718
TOTAL	2.50				\$ 92,680

XI. PERFORMANCE MONITORING PLAN

The first level indicators of the Results Package will be measured on an annual basis: 1) Percent of USAID funded NGO's whose budget show decreased dependency on USAID funds; 2) Percent of "Cantones" served by MOH and/or NGO health promoters; 3) Percent of MOH facilities utilizing a cost recovery system for provision of child survival and reproductive health services; and 4) Percent of USAID financed NGO facilities utilizing a sliding scale fee for provision of child survival and reproductive health services.

The RP Team Leader and Deputy Team Leader will monitor the implementation process through field visits, monthly progress meetings to be held with the implementing entities, and the review of quarterly progress reports. The AM will keep the RP members promptly informed of progress, any weakness and any mid-course corrections needed to achieve projected results or to modify expected results.

Although it is difficult to estimate the cost of monitoring and reporting of performance because this task will be carried out by the implementing entities as part of their routine work, a rough estimate could be 10% of the cost of activities.

STRATEGIC OBJECTIVE : Sustainable Improvements in Health of Women and Children Achieved.

APPROVED: 06/07/96 **COUNTRY/ORGANIZATION:** USAID/EI Salvador.

RESULT No. 3.3: Increased policy environment to support sustainability of child survival and reproductive health programs.

INDICATOR No.1: Percent of USAID funded NGOs whose budget show 50% decreased dependency on USAID funds. (AI)

UNIT OF MEASURE: Percent.

SOURCE: NGO and USAID budget data.

INDICATOR DESCRIPTION:

COMMENTS: The baseline data is based on 12 PROSAMI Project funded NGOs, 18 SETEFE funded former PROSAMI NGOs, five PROCIPOTES funded NGOs and the SDA, totalling 36 NGOs. 12 NGOs work in the four test departments funded by USAID. The list of NGO names is available from the SO3 Team.

Decreased dependency on USAID should not result in reduced services. From 1995 to 1996, two of the PROSAMI NGOs increased their absolute contribution, one maintained the same level and nine have decreased contributions. Of the 18 SETEFE funded NGOs, 13 increased their absolute contribution, as did three of the five PROCIPOTES NGOs. SDA contributes 48% of the cash costs and 62% of all costs, if volunteer hours are included.

YEAR	PLANNED	ACTUAL
1995 (B)		
1996		
1997		
1998	4	
1999	8	
2000	25	
2001	42	
2002 (T)	50	

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STRATEGIC OBJECTIVE : Sustainable Improvements in Health of Women and Children Achieved. APPROVED: 06/07/96 COUNTRY/ORGANIZATION: USAID/EI Salvador.			
RESULT No. 3.3: Increased policy environment to support sustainability of child survival and reproductive health programs.			
INDICATOR No.2 : Percent of "cantones" served by MOH and/or NGO health promoters. (AI)			
UNIT OF MEASURE: Percent. SOURCE: 1995 Health Promoter Study and MOH and NGO service statistics. INDICATOR DESCRIPTION: COMMENTS: The baseline data is based on 1,732 "cantones" out of a total of 2,056 "cantones" in the country.	YEAR	PLANNED	ACTUAL
	1995 (B)		83
	1996		84
	1997	85	
	1998	86	
	1999	87	
	2000	88	
	2001	89	
	2002 (T)	90	

STRATEGIC OBJECTIVE : Sustainable Improvements in Health of Women and Children Achieved. APPROVED: 06/07/96 COUNTRY/ORGANIZATION: USAID/EI Salvador.			
RESULT No. 3.3: Increased policy environment to support sustainability of child survival and reproductive health programs.			
INDICATOR No.3 : Percent of MOH facilities implementing cost recovery systems. (AI)			
UNIT OF MEASURE: Percent. SOURCE: MOH service statistics. INDICATOR DESCRIPTION: COMMENTS: The baseline data is based on a total of 375 MOH facilities (30 hospitals and 345 Health Units and Posts) and 75 MOH facilities in the four test departments. The cost recovery system was developed and tested by the MOH and the APSISA Project implementing entity in 1994 - 1996.	YEAR	PLANNED	ACTUAL
	1995 (B)		2.6
	1996		4.8
	1997	25	
	1998	40	
	1999	55	
	2000	70	
	2001	85	
	2002 (T)	100	

STRATEGIC OBJECTIVE : *Sustainable Improvements in Health of Women and Children Achieved.*
APPROVED: 06/07/96 **COUNTRY/ORGANIZATION:** USAID/EI Salvador.

RESULT No. 3.3: Increased policy environment to support sustainability of child survival and reproductive health programs.

INDICATOR No.4 : Percent of USAID funded NGOs implementing cost recovery systems. (A1)

UNIT OF MEASURE: Percent.

SOURCE: NGOs service statistics.

INDICATOR DESCRIPTION:

COMMENTS: See comments for Indicator No. 3.3. The baseline data is based in 12 PROSAMI funded NGOs, 18 SETEFE funded former PROSAMI NGOs, and the SDA; totalling 31 NGOs.

As of 1995, most of NGOs had a form of cost recovery, but do not have a well researched and unified system; the indicator here refers to NGOs implementing a new unified cost recovery system.

YEAR	PLANNED	ACTUAL
1995 (B)		3
1997	3	
1998	10	
1999	25	
2000	50	
2001	75	
2002 (T)	100	

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**COMMON ANNEXES
TO THE THREE RP DOCUMENTS
(3.1, 3.2 AND 3.3)**

- ANNEX A: STRATEGIC OBJECTIVE FRAMEWORK**
- ANNEX B: COUNTRY CHECKLIST AND ASSISTANCE CHECKLIST**
- ANNEX C: CONGRESSIONAL NOTIFICATION**
- ANNEX D: INITIAL ENVIRONMENTAL EXAMINATION**
- ANNEX E: ANALYSES**
- E.1 INSTITUTIONAL ANALYSIS**
 - E.2 FEASIBILITY ANALYSIS**
 - E.3 GENDER ANALYSIS**
 - E.4 FINANCIAL ANALYSIS**

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Annex A: Strategic Objective Framework

STRATEGIC OBJECTIVE No. 3

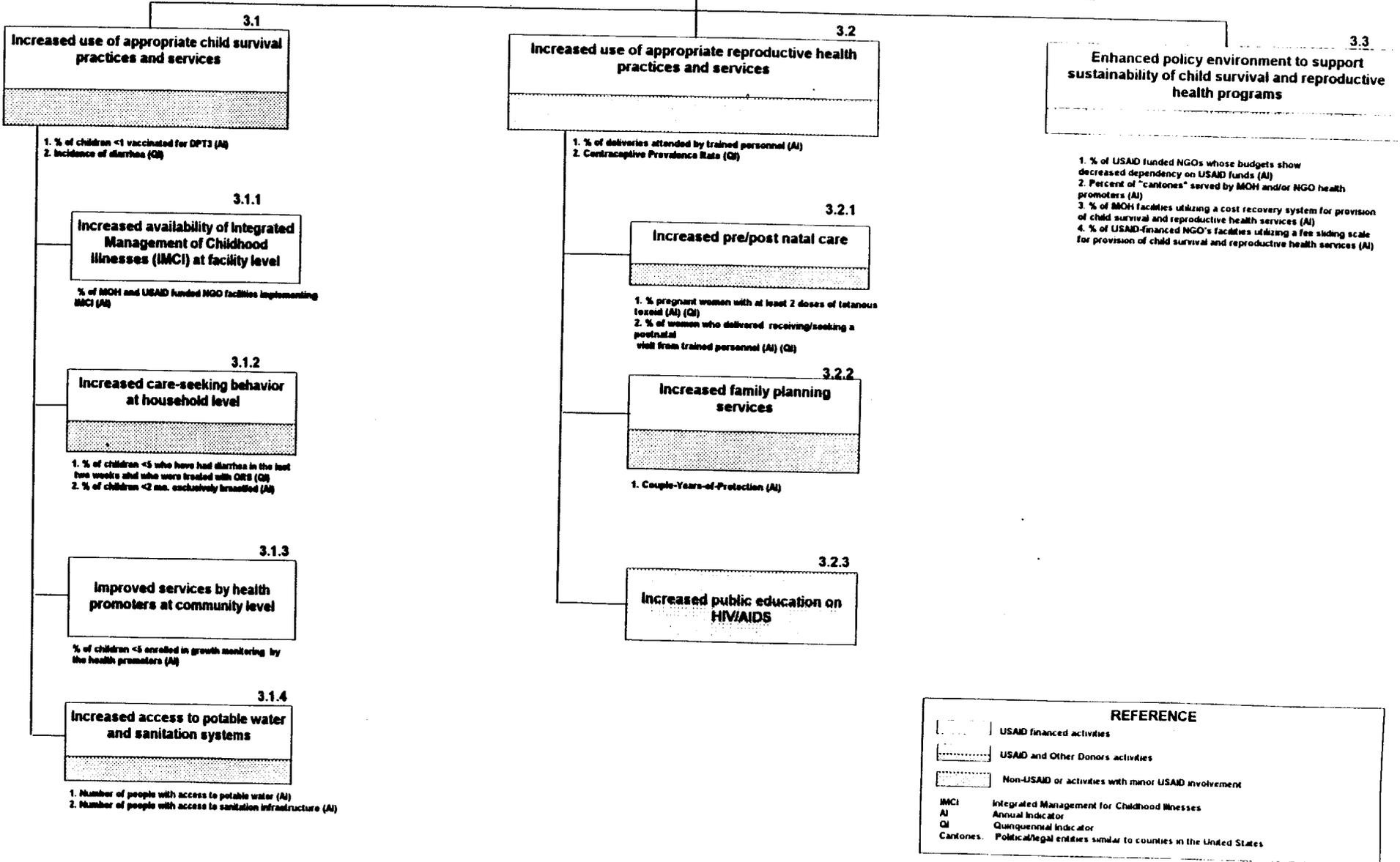
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December 12, 1996

Agency Goal 3:
World's population stabilized and human health protected in a sustainable fashion

Mission's Strategic Objective 3:
SUSTAINABLE IMPROVEMENTS IN HEALTH OF WOMEN AND CHILDREN ACHIEVED

- (a) Maternal Mortality Rate (QI)
- (b) Infant Mortality Rate (QI)
- (c) Child Mortality Rate (QI)
- (d) Total Fertility Rate (QI)



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REFERENCE	
	USAID financed activities
	USAID and Other Donors activities
	Non-USAID or activities with minor USAID involvement
IMCI	Integrated Management for Childhood Illnesses
AI	Annual Indicator
QI	Quinquennial Indicator
Cantones	Political/legal entities similar to counties in the United States

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Annex B: Assistance Checklist

"USAID Statutory Checklists will be prepared for all new activities supporting this results package. These statutory checklists will be incorporated in the Activity Documents prepared during the design of each new activity. All current ongoing activities supporting this results package have complied with such checklist requirements."

COUNTRY CHECKLIST FOR EL SALVADOR

A. DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUND

1. Narcotics Certification (FAA Sec. 490): If the recipient is a "major illicit drug producing country" (defined as a country in which during a year at least 1,000 hectares of illicit opium poppy is cultivated or harvested, or at least 1,000 hectares of illicit coca is cultivated or harvested, or at least 5,000 hectares of illicit cannabis is cultivated or harvested) or a "major drug-transit country" (defined as a country that is a significant direct source of illicit drugs significantly affecting the United States, through which such drugs are transported, or through which significant sums of drug-related profits are laundered with the knowledge or complicity of the government):

NA; El Salvador is not a major illicit drug producing or major drug transit country

a. Has the President in the March 1 International Narcotics Control Strategy Report (INCSR) determined and certified to the Congress (without Congressional enactment, within 30 calendar days, of a resolution disapproving such a certification), that (1) during the previous year the country has cooperated fully with the United States or taken adequate steps on its own to satisfy the goals and objectives established by the U.N. Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, or that (2) the vital national interests of the United States require the provision of such assistance?

NA

b. With regard to a major illicit drug producing or drug-transit country for which the President has not certified on March 1, has the President determined and certified to Congress on any other date (with enactment by Congress of a resolution approving such

NA

certification) that the vital national interests of the United States require the provision of assistance, and has also certified that (a) the country has undergone a fundamental change in government, or (b) there has been a fundamental change in the conditions that were the reason why the President had not made a "fully cooperating" certification.

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

3. **Seizure of U.S. Property (Foreign Relations Authorization Act, Fiscal Years 1994 and 1995, Sec. 527):** If assistance is to a government, has it (including any government agencies or instrumentalities) taken any action on or after January 1, 1956 which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without (during the period specified in subsection (c) of this section) either returning the property, providing adequate and effective compensation for the property, offering a domestic procedure providing prompt, adequate, and effective compensation for the property, or submitting the dispute to international arbitration? If the actions of the government would otherwise prohibit assistance, has the President waived this prohibition and so notified Congress that it was in the national interest to do so?

4. **Communist and Other Countries (FAA Sec. 620(a), 620(f), 620D; FY 1997**

We are not aware of any debts the Government of El Salvador owes to any U.S. citizen for goods or services that meet the criteria set forth in this section.

No.

Appropriations Act Secs. 507, 523): Will assistance be provided: (a) to China, Cuba, North Korea, Tibet, Vietnam or another Communist country; (b) directly to Cuba, Iraq, Libya, North Korea, Iran, Sudan or Syria; or (c) indirectly to China, Cuba, Iran, Iraq, Libya, North Korea, or Syria? If so, has the President made the necessary determinations to allow assistance to be provided?

No. El Salvador is not a communist country.

3. Mob Action (FAA Sec. 620(j)): Has the country permitted, or failed to take adequate measures to prevent, damage or destruction by mob action of U.S. property? [Reference may be made to the "Taking into Consideration" memo.]

No.

6. OPIC Investment Guaranty (FAA Sec. 620(l)): Has the country failed to enter into an investment guaranty agreement with OPIC? [Reference may be made to the annual "Taking into Consideration" memo.]

No.

7. Seizure of U.S. Fishing Vessels (FAA Sec. 620(o); Fishermen's Protective Act of 1967 (as amended) Sec. 5): (a) Has the country seized, or imposed any penalty or sanction against, any U.S. fishing vessel because of fishing activities in international waters? (b) If so, has any deduction required by the Fishermen's Protective Act been made? [Reference may be made to the annual "Taking into Consideration" memo.]

No.

8. Loan Default (FAA Sec. 620(q); FY 1997 Appropriations Act Sec. 512 (Brooks Amendment)): (a) Has the government of the recipient country been in default for more than six months on interest or principal of any loan to the country under the FAA? (b) Has the country been in default for more than one year on interest or principal on any U.S. loan under a program for which the FY 1995 Appropriations Act appropriates funds?

No.

9. **Military Equipment (FAA Sec. 620(s)):** If contemplated assistance is development loan or to come from Economic Support Fund, has the Administrator taken into account the percentage of the country's budget and amount of the country's foreign exchange or other resources spent on military equipment? [Reference may be made to the annual "Taking Into Consideration" memo.]

Yes. Taken into account by the Administrator at the time of approval of the FY 1997 OYB.

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

No.

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

El Salvador's U.N. arrearages, both in general and for purposes of Article 19 of the U.N. Charter, were taken into account by the Administrator at the time of approval of the FY 1997 OYB.

12. **International Terrorism**

a. **Sanctuary and Support (FY 1997 Appropriations Act Sec. 527A; FAA Sec. 620N):** Has the country been determined by the President to: (a) grant sanctuary from prosecution to any individual or group which has committed an act of international terrorism, or (b) otherwise support international terrorism, unless the President has waived this restriction on grounds of national security or for humanitarian reasons?

No.

b. **Compliance with UN Sanctions (FY 1997 Appropriations Act Sec. 534):** Is assistance being provided to a country not in compliance with UN sanctions against Iraq, Serbia, or Montenegro. If so, has the President

No.

made the necessary determinations to allow assistance to be provided?

c. Governments That Aid Terrorist States. (FAA Section 620G, added by section 325 of the Antiterrorism and Effective Death Penalty Act of 1996, P.L. 104-132, April 24, 1996): Is assistance being provided to a government which provides assistance to a country the government of which is a terrorist government under section 620A of the FAA? If so, has the President made the necessary determinations to allow assistance to be provided?

No.

13. Export of Lethal Military Equipment (FY 1997 Appropriations Act Sec. 552; FAA Sec. 620H, added by section 326 of the Antiterrorism and Effective Death Penalty Act of 1996, P.L. 104-132, April 24, 1996): Is assistance being made available to a government which provides lethal military equipment to a country the government of which is a terrorist government under sections 620A of the FAA, 6(j) of the Export Administration Act (50 U.S.C. App. 2405(j)) or 40(d) of the Arms Export Control Act? If so, has the President made the necessary determinations to allow assistance to be provided?

No.

14. Discrimination (FAA Sec. 666(b)): Does the country object, on the basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. who is present in such country to carry out economic development programs under the FAA?

No.

15. Nuclear Technology (Arms Export Control Act Secs. 101, 102): Has the country, after August 3, 1977, delivered to any other country or received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or safeguards, and without special certification by the President? Has it transferred a nuclear explosive device to a non-nuclear weapon

No.

state, or if such a state, either received or detonated a nuclear explosive device? If the country is a non-nuclear weapon state, has it, on or after August 8, 1985, exported (or attempted to export) illegally from the United States any material, equipment, or technology which would contribute significantly to the ability of a country to manufacture a nuclear explosive device? [FAA Sec. 6208(d) permits a special waiver of Sec. 101 for Pakistan.]

16. Algiers Meeting (ISDCA of 1981, Sec. 720): Was the country represented at the Meeting of Ministers of Foreign Affairs and Heads of Delegations of the Non-Aligned Countries to the 36th General Assembly of the U.N. on Sept. 25 and 26, 1981, and did it fail to disassociate itself from the communique issued? If so, has the President taken it into account? [Reference may be made to the "Taking Into Consideration" memo.]

No.

17. Military Coup (FY 1997 Appropriations Act Sec. 508): Has the duly elected Head of Government of the country been deposed by military coup or decree? If assistance has been terminated, has the President notified Congress that a democratically elected government has taken office prior to the resumption of assistance?

No.

18. Exploitation of Children (FAA Sec. 614): Does the recipient government fail to take appropriate and adequate measures, within its means, to protect children from exploitation, abuse or forced conscription into military or paramilitary services?

No.

19. Parking Fines (FY 1997 Appropriations Act Sec. 552): Has the annual assistance allocation of funds for a country taken into account the requirements of this section to reduce assistance by 110 percent of the amount

FY 1997 obligations will be reduced by 110% of the amount of any unpaid parking fines owed to the District of

Country Checklist

of unpaid parking fines owed to the District of Columbia as of the date of enactment of the FY 1997 Appropriations Act, September 10, 1996?

Columbia as determined by N/B.

20. Delivery of Humanitarian Assistance (FAA Sec. 6201, added by FY 1997 Appropriations Act Sec. 559-562): Has the government prohibited or otherwise restricted, directly or indirectly the transport or delivery of United States humanitarian assistance? If so, has the President made the necessary determination to allow assistance to be provided?

No.

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21. Nuclear Power Plant in Cuba (Sec. 111 of the LIBERTAD Act, P.L. 104-114, March 12, 1996): Has the country or any entity in the country provided on after the dates of enactment of the FY 1996 Appropriations Act, January 27, 1996, or the LIBERTAD Act, March 12, 1996, assistance or credits in support of the Cuban nuclear facility at Juraguá, Cuba. If so, has the overall assistance allocation of funds for that country taken into account the requirements of this section to withhold assistance equal to the sum of any such assistance or credits?

no.

22. Harboring War Criminals (FY 1997 Appropriations Act Sec. 568): Has the government knowingly granted sanctuary to persons in its territory for the purpose of evading prosecution, where such persons--

No.

a. have been indicted by the International Criminal Tribunal for the former Yugoslavia, the International Criminal Tribunal for Rwanda, or any other international tribunal with similar standing under international law, or

No.

b. have been indicted for war crimes or crimes against humanity committed during the period beginning March 23, 1933, and ending on May 8,

1945 under the direction of, or in association with (1) the Nazi government of Germany; (2) any government in any area occupied by the military forces of the Nazi government of Germany; (3) any government which was established with the assistance or cooperation of the Nazi government; or (4) any government which was an ally of the Nazi government of Germany?

B. DEVELOPMENT ASSISTANCE ONLY

Human Rights Violations (FAA Sec. 116):
Has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, can it be demonstrated that contemplated assistance will directly benefit the needy?

No.

C. ECONOMIC SUPPORT FUND ONLY

Human Rights Violations (FAA Sec. 502B):
Has it been determined that the country has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, has the President found that the country made such significant improvement in its human rights record that furnishing such assistance is in the U.S. national interest?

No.

LAC/CEN:Ksmith/cklist.esn/11/12/96:7-4535

Clearances:

Clearance	Date	By
LAC/CEN:LAYALDE		
LAC/SAN:TKellerman	12/4/96	John Fuchs
LAC/SPM:JWeber	12/4/96	John Fuchs
LAC/DPB:RJordan	12/9/96	John Fuchs
LAC/GC:SAllen	12/12/96	John Fuchs
ARA/CEN:JFeeley	12/6/96	John Fuchs
State/IO/S/B:DLeis	2/5/96	John Fuchs
State/INL/P:KBryson	7/3/96	John Fuchs
State/DRL/AAA:PLahey	8/5/96	John Fuchs
State/M/OFM/VTC:JCintron	8/5/96	John Fuchs

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Listed below are criteria applicable to the assistance resources themselves, rather than to the eligibility of a country to: (A) both DA and ESF assistance; (B) DA only; or (C) ESF only.

CROSS REFERENCE: IS COUNTRY CHECKLIST UP TO DATE?

A. DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUND

1. Congressional Notification

a. **General Requirement** (FY 1997 Appropriations Act Sec. 515; FAA Sec. 634A): If the obligation has not previously justified to Congress, or is for an amount in excess of the amount previously justified to Congress, has a Congressional Notification been made?

YES.
Appro
and
updat
of
12/12,

No

b. **Special Notification Requirement** (FY 1997 Appropriations Act, "Burma" and "NIS" Title II headings and Sec. 520): For obligations for NIS countries, Burma, Colombia, Guatemala (except development assistance), Dominican Republic, Haiti, Liberia, has a Congressional Notification been submitted, regardless of any justification in the Congressional Presentation?

N/A

c. **Notice of Account Transfer** (FY 1997 Appropriations Act Sec. 509): If funds are being obligated under an appropriation account to which they were not appropriated, has the President consulted with and provided a written justification to the House and Senate Appropriations Committees?

N/A

d. **Cash Transfers and Nonproject Sector Assistance** (FY 1997 Appropriations Act Sec. 531(b)(3)): If funds are to be made available in the form of cash transfer or nonproject sector assistance, has the Congressional notice included a detailed description of how the funds will be used, with a discussion of U.S. interests to be served and a description of any economic policy reforms to be promoted?

N/A

2. **Engineering and Financial Plans** (FAA Sec. 611(a)): Prior to an obligation in excess of \$500,000, will there be: (a) engineering, financial or other plans necessary to carry out the assistance; and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

YES

3. **Legislative Action** (FAA Sec. 611(a)(2)): If the obligation is in excess of \$500,000 and requires legislative action within the recipient country, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance?

N/A

4. **Water Resources** (FAA Sec. 611(b)): If the assistance is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)?

N/A

5. **Cash Transfer/Nonproject Sector Assistance Requirements** (FY 1997 Appropriations Act Sec. 531). If assistance is in

<p>the form of a cash transfer or nonproject sector assistance:</p>	
<p>a. Separate Account: Are all such cash payments to be maintained by the country in a separate account and not commingled with any other funds (unless such requirements are waived by Congressional notice for nonproject sector assistance)?</p>	N/A
<p>b. Local Currencies: If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies:</p>	
<p>(1) Has A.I.D. (a) required that local currencies be deposited in a separate account established by the recipient government, (b) entered into an agreement with that government providing the amount of local currencies to be generated and the terms and conditions under which the currencies so deposited may be utilized, and (c) established by agreement the responsibilities of A.I.D. and that government to monitor and account for deposits into and disbursements from the separate account?</p>	N/A
<p>(2) Will such local currencies, or an equivalent amount of local currencies, be used only to carry out the purposes of the DA or ESF chapters of the FAA (depending on which chapter is the source of the assistance) or for the administrative requirements of the United States Government?</p>	N/A
<p>(3) Has A.I.D. taken all necessary steps to ensure that the equivalent of local currencies disbursed from the separate account are used for the agreed purposes?</p>	N/A
<p>(4) If assistance is terminated to a country, will any unencumbered balances of funds remaining in a separate account be disposed of for purposes agreed to by the recipient government and the United States Government?</p>	N/A
<p>6. Capital Assistance (FAA Sec. 611(e)): If capital assistance is proposed (e.g., construction), and total U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the assistance effectively?</p>	The recipient will contribute an estimated of counterpart funding.
<p>7. Local Currencies</p>	
<p>a. Recipient Contributions (FAA Secs. 612(b), 636(h)): Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.</p>	N/A
<p>b. US-Owned Foreign Currencies</p>	
<p>(1) Use of Currencies (FAA Secs. 612(b), 636(h)): Are steps being taken to assure that, to the maximum extent possible, foreign currencies owned by the U.S. are utilized in lieu of dollars to meet the cost of contractual and other services.</p>	NO
<p>(2) Release of Currencies (FAA Sec. 612(d)): Does the U.S. own non-PL 480 excess foreign currency of the country and, if so, has the agency endeavored to obtain agreement for its release in an amount equivalent to the dollar amount of the assistance?</p>	

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<p>own non-PL 480 excess foreign currency of the country and, if so, has the agency endeavored to obtain agreement for its release in an amount equivalent to the dollar amount of the assistance?</p>	
<p>8. Trade Restrictions - Surplus Commodities (FY 1997 Appropriations Act Sec. 513(a)): If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?</p>	N/A
<p>9. Environmental Considerations (FAA Sec. 117; USAID Regulation 16, 22 CFR Part 216): Have the environmental procedures of USAID Regulation 16 been met?</p>	YES
<p>10. PVO Assistance</p>	
<p>a. Auditing (FY 1997 Appropriations Act Sec. 550): If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of USAID?</p>	YES
<p>b. Funding Sources (FY 1997 Appropriations Act, Title II, under heading "Private and Voluntary Organizations"): If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government? If not, has the requirement been waived?</p>	N/A
<p>11. Agreement Documentation (Case-Zablocki Act, 1 U.S.C. Sec. 112b, 22 C.F.R. Part 181): For any bilateral agreement over \$25 million, has the date of signing and the amount involved been cabled to State L/T immediately upon signing and has the full text of the agreement been pouched to State/L within 20 days of signing?</p>	N/A
<p>12. Metric System (Omnibus Trade and Competitiveness Act of 1988 Sec. 5164, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance activity use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?</p>	YES
<p>13. Abortions (FAA Sec. 104(f); FY 1997 Appropriations Act, Title II, under heading "Development Assistance" and Sec. 518):</p>	

<p>a. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions? (Note that the term "motivate" does not include the provision, consistent with local law, of information or counseling about all pregnancy options.)</p>	NO
<p>b. Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations?</p>	NO
<p>c. Are any of the funds to be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization?</p>	NO
<p>d. Will funds be made available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services? (As a legal matter, DA only.)</p>	YES
<p>e. In awarding grants for natural family planning, will any applicant be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning? (As a legal matter, DA only.)</p>	NO
<p>f. Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?</p>	NO
<p>g. Are any of the funds to be made available to any organization if the President certifies that the use of these funds by such organization would violate any of the above provisions related to abortions and involuntary sterilization?</p>	NO
<p>14. Procurement</p>	
<p>a. Source, Origin and Nationality (FAA Sec. 604(a): Will all procurement be from the U.S., the recipient country, or developing countries except as otherwise determined in accordance with the criteria of this section?</p>	YES
<p>b. Marine Insurance (FAA Sec. 604(d)): If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company?</p>	N/A Commodities are insured in the US by suppliers prior to shipment
<p>c. Insurance (FY 1997 Appropriations Act Sec. 528A): Will any A.I.D. contract and solicitation, and subcontract entered into under such contract, include a clause requiring that U.S. insurance companies have a fair opportunity to bid for insurance when such insurance is necessary or appropriate?</p>	YES
<p>d. Non-U.S. Agricultural Procurement (FAA Sec. 604(e)): If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not</p>	N/A

commodity financed could not reasonably be procured in U.S.)	
<p>e. Construction or Engineering Services (FAA Sec. 604(g)): Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible under Code 941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries.)</p>	NO
<p>f. Cargo Preference Shipping (FAA Sec. 603)): Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates?</p>	NO
<p>g. Technical Assistance (FAA Sec. 621(a)): If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? Will the facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?</p>	YES
<p>h. U.S. Air Carriers (Fly America Act, 49 U.S.C. Sec. 1517): If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available?</p>	YES
<p>i. Consulting Services (FY 1997 Appropriations Act Sec. 549): If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)?</p>	YES
<p>j. Notice Requirement (FY 1997 Appropriations Act Sec. 561): Will agreements or contracts contain notice consistent with FAA section 604(a) and with the sense of Congress that to the greatest extent practicable equipment and products purchased with appropriated funds should be American-made?</p>	YES
15. Construction	
<p>a. Capital Assistance (FAA Sec. 601(d)): If capital (e.g., construction) assistance, will U.S. engineering and professional services be used?</p>	N/A
<p>b. Large Projects - Congressional Approval (FAA Sec. 620(k)): If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million (except for productive enterprises in Egypt that were described in the Congressional Presentation), or does assistance have the express approval of Congress?</p>	N/A
<p>16. U.S. Audit Rights (FAA Sec. 301(d)): If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights?</p>	YES

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does Comptroller General have audit rights?	
17. Communist Assistance (FAA Sec. 620(h)). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries?	YES
18. Narcotics	
a. Cash Reimbursements (FAA Sec. 483): Will arrangements preclude use of financing to make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated?	NO
b. Assistance to Narcotics Traffickers (FAA Sec. 487): Will arrangements take "all reasonable steps" to preclude use of financing to or through individuals or entities which we know or have reason to believe have either: (1) been convicted of a violation of any law or regulation of the United States or a foreign country relating to narcotics (or other controlled substances); or (2) been an illicit trafficker in, or otherwise involved in the illicit trafficking of, any such controlled substance?	YES
19. Expropriation and Land Reform (FAA Sec. 620(g)): Will assistance preclude use of financing to compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President?	YES
20. Police and Prisons (FAA Sec. 660): Will assistance preclude use of financing to provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs?	YES
21. CIA Activities (FAA Sec. 662): Will assistance preclude use of financing for CIA activities?	YES
22. Motor Vehicles (FAA Sec. 636(i)): Will assistance preclude use of financing for purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained?	YES
23. Export of Nuclear Resources (FY 1995 Appropriations Act Sec. 506): Will assistance preclude use of financing to finance, except for purposes of nuclear safety, the export of nuclear equipment, fuel, or technology?	YES
24. Publicity, Propaganda and Lobbying (FY 1997 Appropriations Act Sec. 546; Anti-Lobbying Act, 18 U.S.C. § 1913; Sec. 109(1) of the Foreign Relations Authorization Act, Fiscal Years 1988 and 1989, P.L. 100-204): Will assistance be used to support or defeat legislation pending before Congress, to influence in any way the outcome of a political election in the United States, or for any publicity or propaganda purposes not authorized by Congress?	NO
25. Commitment of Funds (FAA Sec. 635(h)): Does a contract or agreement entail a commitment for the expenditure of funds during a period in excess of 5 years from the date of the contract or agreement?	NO

<p>26. Impact on U.S. Jobs (FY 1997 Appropriations Act, Sec. 538):</p>	
<p>a. Will any financial incentive be provided to a business located in the U.S. for the purpose of inducing that business to relocate outside the U.S. in a manner that would likely reduce the number of U.S. employees of that business?</p>	NO
<p>b. Will assistance be provided for the purpose of establishing or developing an export processing zone or designated area in which the country's tax, tariff, labor, environment, and safety laws do not apply? If so, has the President determined and certified that such assistance is not likely to cause a loss of jobs within the U.S.?</p>	NO
<p>c. Will assistance be provided for a project or activity that contributes to the violation of internationally recognized workers rights, as defined in section 502(a)(4) of the Trade Act of 1974, of workers in the recipient country, or will assistance be for the informal sector, micro or small-scale enterprise, or smallholder agriculture?</p>	NO
<p>B. DEVELOPMENT ASSISTANCE ONLY</p>	
<p>1. Agricultural Exports (Bumpers Amendment) (FY 1997 Appropriations Act Sec. 513(b)), as interpreted by the conference report for the original enactment): If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities: (a) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (b) in support of research that is intended primarily to benefit U.S. producers?</p>	N/A
<p>2. Recipient Country Contribution (FAA Secs. 110, 124(d)): Will the recipient country provide at least 25 percent of the costs of the activity with respect to which the assistance is to be furnished or is this cost-sharing requirement being waived for a "relatively least developed" country?</p>	YES
<p>3. Forest Degradation (FAA Sec. 118):</p>	
<p>a. Will assistance be used for the procurement or use of logging equipment? If so, does the an environmental assessment indicate that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems?</p>	N/A
<p>b. Will assistance be used for: (1) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas; (2) activities which would result in the conversion of forest lands to the rearing of livestock; (3) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded forest lands; (4) the colonization of forest lands; or</p>	N/A

<p>(5) the construction of dams or other water control structures which flood relatively undergraded forest lands? If so, does the environmental assessment indicate that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?</p>	
<p>4. Deobligation/Reobligation (FY 1997 Appropriations Act Sec. 510): If deob/reob authority is sought to be exercised under section 510 in the provision of DA assistance, are the funds being obligated for the same general purpose and for countries within the same region as originally obligated, and have the House and Senate Appropriations Committees been properly notified? [Note: Compare to no-year authority under section 511.]</p>	N/A
<p>5. Capital Assistance (Jobs Through Export Act of 1992, Secs. 303 and 306(d)): If assistance is being provided for a capital activity, is the activity developmentally sound and will it measurably alleviate the worst manifestations of poverty or directly promote environmental safety and sustainability at the community level?</p>	YES
<p>6. Loans</p>	
<p>a. Repayment Capacity (FAA Sec. 122(b)): Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest.</p>	N/A
<p>b. Long-Range Plans (FAA Sec. 122(b)): Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities?</p>	N/A
<p>c. Interest Rate (FAA Sec. 122(b)): If development loan is repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter?</p>	N/A
<p>d. Exports to United States (FAA Sec. 620(d)): If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest?</p>	N/A
<p>7. Planning and Design Considerations. Has agency guidance or the planning and design documentation for the specific activity taken into account the following, as applicable?</p>	N/A
<p>a. Economic Development. FAA Sec. 101(a) requires that the activity give reasonable promise of contributing to the development of economic resources or to the increase of productive capacities and self-sustaining economic growth.</p>	YES
<p>b. Special Development Emphases. FAA Secs. 102(b), 113, 281(a) require that assistance: (1) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (2) encourage democratic private and local governmental institutions; (3) support the self-help</p>	YES

dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (2) encourage democratic private and local governmental institutions; (3) support the self-help efforts of developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries.

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

YES

d. **Agriculture, Rural Development and Nutrition, and Agricultural Research.** FAA Secs. 103 and 103A require that: (1) **Rural poor and small farmers:** assistance for agriculture, rural development or nutrition be specifically designed to increase productivity and income of rural poor; and assistance for agricultural research take into account the needs of small farmers and make extensive use of field testing to adapt basic research to local conditions; (2) **Nutrition:** assistance be used in coordination with efforts carried out under FAA Section 104 (Population and Health) to help improve nutrition of the people of developing countries through encouragement of increased production of crops with greater nutritional value; improvement of planning, research, and education with respect to nutrition, particularly with reference to improvement and expanded use of indigenously produced foodstuffs; and the undertaking of pilot or demonstration programs explicitly addressing the problem of malnutrition of poor and vulnerable people; (3) **Food security:** assistance increase national food security by improving food policies and management and by strengthening national food reserves, with particular concern for the needs of the poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution.

YES

e. **Population and Health.** FAA Secs. 104(b) and (c) require that assistance for population or health activities emphasize low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems, and other modes of community outreach.

YES

f. **Education and Human Resources Development.** FAA Sec. 105 requires that assistance for education, public administration, or human resource development (1) strengthen nonformal education, make formal

YES

education more relevant, especially for rural families and urban poor, and strengthen management capability of institutions enabling the poor to participate in development; and (2) provide advanced education and training of people of developing countries in such disciplines as are required for planning and implementation of public and private development activities.

g. Energy, Private Voluntary Organizations, and Selected Development Activities. FAA Sec. 106 requires that assistance for energy, private voluntary organizations, and selected development problems may be used for (1) data collection and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test new methods of energy production; and facilitative of research on and development and use of small-scale, decentralized, renewable energy sources for rural areas, emphasizing development of energy resources which are environmentally acceptable and require minimum capital investment; (2) technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations; (3) research into, and evaluation of, economic development processes and techniques; (4) reconstruction after natural or manmade disaster and programs of disaster preparedness; (5) special development problems, and to enable proper utilization of infrastructure and related projects funded with earlier U.S. assistance; (6) urban development, especially small, labor-intensive enterprises, marketing systems for small producers, and financial or other institutions to help urban poor participate in economic and social development.

N/A

h. Appropriate Technology. FAA Sec. 107 requires that assistance emphasize use of appropriate technology (defined as relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor.

YES

i. Tropical Forests. FAA Sec. 118 and FY 1991 Appropriations Act Sec. 533(c) as referenced in section 532(d) of the FY 1993 Appropriations Act) require that:

(1) **Conservation:** assistance place a high priority on conservation and sustainable management of tropical forests and specifically: (i) stress the importance of conserving and sustainably managing forest resources; (ii) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (iii) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (iv) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (v) help conserve forests which have not yet been degraded by helping to increase production on lands already cleared or degraded; (vi) conserve forested watersheds and rehabilitate those which have been deforested; (vii) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (viii) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation;

YES

(ix) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (x) seek to increase the awareness of U.S. Government agencies and other donors of the immediate and long-term value of tropical forests; (xi) utilize the resources and abilities of all relevant U.S. government agencies; (xii) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land; and (xiii) take full account of the environmental impacts of the proposed activities on biological diversity.

(2) **Sustainable Forestry:** assistance relating to tropical forests assist countries in developing a systematic analysis of the appropriate use of their total tropical forest resources, with the goal of developing a national program for sustainable forestry.

j. Biological Diversity. FAA Sec. 119(g) requires that assistance: (i) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (ii) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (iii) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (iv) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas.

k. Benefit to Poor Majority. FAA Sec. 128(b) requires that if the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, it be designed and monitored to ensure that the ultimate beneficiaries are the poor majority.

l. Indigenous Needs and Resources. FAA Sec. 281(b) requires that an activity recognize the particular needs, desires, and capacities of the people of the country; utilize the country's intellectual resources to encourage institutional development; and support civic education and training in skills required for effective participation in governmental and political processes essential to self-government.

m. Energy. FY 1991 Appropriations Act Sec. 533(c) as referenced in section 532(d) of the FY 1993 Appropriations Act) requires that assistance relating to energy focus on: (1) end-use energy efficiency, least-cost energy planning, and renewable energy resources, and (2) the key countries where assistance would have the greatest impact on reducing emissions from greenhouse gases.

n. Debt-for-Nature Exchange. FAA Sec. 463 requires that assistance which will finance a debt-for-nature exchange (1) support protection of the world's oceans and atmosphere, animal and plant species, or parks and reserves; or (2) promote natural resource management, local conservation programs, conservation training programs, public commitment to conservation, land and ecosystem management, or regenerative approaches in farming, forestry, fishing, and watershed management.

YES

N/A

YES

YES

N/A

N/A

or regenerative approaches in farming, forestry, fishing, and watershed management.

C. ECONOMIC SUPPORT FUND ONLY

1. **Economic and Political Stability** (FAA Sec. 531(a)): Does the design and planning documentation demonstrate that the assistance will promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part I of the FAA?

YES

2. **Military Purposes** (FAA Sec. 531(e)): Will this assistance be used for military or paramilitary purposes?

NO

3. **Commodity Grants/Separate Accounts** (FAA Sec. 609): If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made? (For FY 1997, this provision is superseded by the separate account requirements of FY 1997 Appropriations Act Sec. 532(a), see Sec. 532(a)(5).)

N/A

4. **Generation and Use of Local Currencies** (FAA Sec. 531(d)): Will ESF funds made available for commodity import programs or other program assistance be used to generate local currencies? If so, will at least 50 percent of such local currencies be available to support activities consistent with the objectives of FAA sections 103 through 106? (For FY 1997, this provision is superseded by the separate account requirements of FY 1997 Appropriations Act Sec. 532(a), see Sec. 532(a)(5).)

N/A

5. **Capital Activities** (Sec. 306, Jobs Through Exports Act of 1992, P.L. 102-549, 22 U.S.C. 2241a): If assistance is being provided for a capital project, will the project be developmentally-sound and sustainable, i.e., one that is (a) environmentally sustainable, (b) within the financial capacity of the government or recipient to maintain from its own resources, and (c) responsive to a significant development priority initiated by the country to which assistance is being provided.

N/A

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Annex C: Congressional Notification

- **Family Health Services Project No. 519-0363**
Last Congressional Notification (Exp. Date) June 1995.

- **Health Systems Support Project No. 519-0308**
Last Congressional Notification Date (Exp. Date) February 1992.

- **Maternal Health and Child Survival Project No. 519-0367**
Last Congressional Notification (Exp. Date) April 1991.

- **Displaced and Street Children Project No. 519-0420**
Last Congressional Notification (Exp. Date) September 1994.

Annex D: Initial Environmental Examination



Agency for International Development
United States of America A.I.D
c/o American Embassy
San Salvador, El Salvador, C.A.

So4 -- Environment Office

INITIAL ENVIRONMENTAL EXAMINATION



Agency for International Development
United States of America A.I.D.
c/o American Embassy
San Salvador, El Salvador, C.A.

Environmental Office SO#4

CATEGORICAL EXCLUSION OF INITIAL ENVIRONMENTAL EXAMINATION

Activity Location: El Salvador
Activity Title: Displaced And Street Children's Project
Project Number: 519-0420
Funding: \$1,705,500 (LOP)
Project agreement Signed: Sept. 30, 1994
PACED: March 31, 1998
IEE Prepared by: Peter Gore
Environmental Officer
USAID El Salvador
Recommended Threshold Decision: Categorical Exclusion
Mission Threshold Decision: Concur with Recommendation
Date Prepared: July 18, 1997


Kenneth C. Ellis
Mission Director

31 July, 1997
Date

CATEGORICAL EXCLUSION OF INITIAL ENVIRONMENTAL EXAMINATION

Displaced And Street Children's Project (PROCIPOTES)
(519-0420)

I. Activity Description

Medical Service Corporation International (MSCI) submitted an unsolicited proposal which resulted in an AID Grant of \$1,705,500 million from the Displaced Childre and Orphan's Fund (DCOF). The purpose of the Activity is to develop a community-based PVO network to promote and increase access to educational, recreational, mental, and physical health services and non-exploitative income generating strategies for street children and children at high risk of becoming street children. The project's goals, based on the needs of the children, are structured to provide and increase access to literacy skills and education/recreation, vocational skills and employment opportunities, awareness of children's rights through public education, health care services and support, and psychological support. Project activities are grouped in four components:

Component 1. Education\Recreational Component

Under this component, the activity seeks to improve the literacy level of the target population by evaluating children to determine cognitive development and vocational aptitudes in order to place them in vocational training or jobs. Strategies will be implemented which schooling (formal or informal) and provide tutoring services and other support mechanisms for the target population enrolled.

They will evaluate the physical motor development of each child and establish recreational objectives and promote integral growth through activities that stimulate emotional, cognitive, physical, motor and social development. In this component, they will involve the community in carrying out programs that promote the concept of social integration, and those which promote civic and cultural development.

Component 2. Psycho-Social Development

In this component, they seek to improve the physical and emotional health of the population by carrying out individual medical evaluations. They implement strategies for the prevention and control of sexually transmitted diseases and preventing early pregnancies; strategies on how to decrease the use of inhalants (glue), drugs, and alcohol consumption. In the area of mental health, they will provide group therapy to the target population and try to improve communication between family members through counseling sessions.

Component 3. Socio-Economic Development

Under this component, the activity will try to improve the quality of life of the street children through access to formal and non-formal education (vocational training). There is a fund for scholarships and they promote work study programs income generating projects that emphasize small business concepts and community participation.

Component 4. Community Participation Component

The community actively participates in the analysis of the local situation and searches for solutions concerning children and youth at risk and in crisis. The activity created a community inter-institutional committee that supports the Convention of the Rights of the Child. They also established close collaboration between private business and local government representatives and the NGO in order to make Project implementation a community priority.

II. Recommendation

Since the actions contemplated under this activity will not have an effect on the natural or physical environment, this activity qualifies for Categorical Exclusion of Initial Environment Examination under Section 216.2(c)(2)(i), "Educational, technical assistance, or training..." and (iii) "Analyses, studies, academic or research workshops and meetings," of 22CFR.

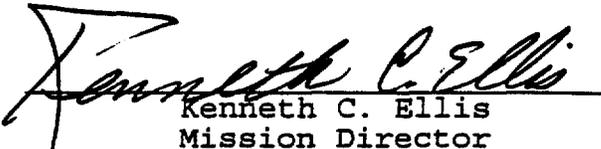


Agency for International Development
United States of America A.I.D.
c/o American Embassy
San Salvador, El Salvador, C.A.

So4 -- Environment Office

INITIAL ENVIRONMENTAL EXAMINATION

Activity Location: El Salvador
Activity title: Sustainable improvements in Health of Women and Children
Project Number: 519-0430
Funding: \$37,449,000
Life of Project: 5 years
IEE Prepared BY: Peter H. Gore
Environmental Officer
USAID, El Salvador
Recommended Threshold Decision: Positive Determination
Mission Threshold Decision: Concur with Recommendation
Date Prepared: June 30, 1997


Kenneth C. Ellis
Mission Director
31 July, 1997
Date

Sustainable improvements in Health of Women and Children

(519-0430)

I. Activity Description

The new activity will include most of the features of the current child survival and reproductive health activities, incorporating their most successful aspects. For the child survival area, the new activity will include technical interventions such as:

Control and prevention of diarrheal Diseases
Control of acute respiratory infections
Vaccinations
Breastfeeding promotion
Health and nutrition education and counseling
Growth monitoring
Education for prevention of violence.

Control and prevention of diarrheal Diseases will include interventions such as: training of health promoters and midwives on causes and methods of diarrhea prevention, preparation and use of oral rehydration solutions and referral of high risk cases.

Control of acute respiratory infections includes training on identification of individuals at risk, detection of infection, simple treatments and referral of high risk cases.

Vaccinations will include the promotion of and support to national campaigns and training for health promoters and midwives.

Breastfeeding promotion will include child feeding practices, healthy food practices and breastfeeding.

Health and nutrition education and counseling will promote hygiene education, waste disposal, use of clean water, maintaining a clean house, use of stoves outside the house with appropriate ventilation, balanced diets for small children, prevention of malnutrition and appropriate feeding practices during illnesses.

Growth monitoring activities will include training of promoters, midwives and caregivers.

Education for prevention of violence will include support for educational activities in the prevention of violence and abuse in young children and women.

For the reproductive health area, the new activity will include five essential components:

- Pre-natal care
- Safe deliveries
- Post-natal care
- Family planning
- Sexually transmitted disease education including HIV/AIDS

Prenatal care interventions will deal with activities such as: strengthening the referral system, reinforcing actions aimed at vaccinating women in fertile age with tetanus toxoid vaccine, etc.

Safe deliveries interventions will consist of activities such as but not limited to: raising awareness of women and adolescents regarding the importance of having a delivery attended by trained personnel, better training and supervision to midwives, doctors, nurses and personnel that attend deliveries, and identification of women at risk and referral of high risk cases to health facilities.

Post natal care interventions will include more extensive and earlier post natal care, inclusion of family planning counseling among the women who seek post-natal care, and training to midwives and health promoters to identify women at risk, to refer high risk cases to health facilities.

Family planning interventions will focus on activities such as but not limited to: providing more family planning services to the population, training, education and service provision for the rural areas, as well as promoting more male involvement with regard to family planning.

Sexually transmitted diseases including HIV/AIDS interventions will consist in education activities, community participation, peer counseling, coordination and support of activities with the Regional C.A. AIDS project, (PASCA) and improve the detection and reporting of infectious diseases.

Current approaches will be evaluated during the activity design phase, and as a result will be modified, replicated and improved.

For policy activities, these will be the coordinating mechanism for plans developed and implemented under other SO3 activities to obtain an enhanced policy environment in support of the sustainability of child survival and reproductive health programs. Policy activities will be developed to correct structural problems in the health sector so that this improvement can continue at an accelerated rate and become self-sustaining.

The method of implementation of the new activity will be chosen during the design and it may include US and local NGO's, as well as US and local contractors.



Agency for International Development
United States of America A.I.D.
c/o American Embassy
San Salvador, El Salvador, C.A.

So4 -- Environment Office

INITIAL ENVIRONMENTAL EXAMINATION

Activity Location: El Salvador

Strategic Objective Title: SO#3 Sustainable Improvement
in Health of Women and
Children

Results Package Title: RP#3.1 Increased use of
appropriate child
survival practices and
services.

Results Package IEE Prepared BY: Peter H. Gore
Environmental Officer
USAID/El Salvador

Recommended Threshold Decision: Positive Determination

Mission Threshold Decision: Concur with Recommendation

Date Prepared: June 23, 1997

Attachments: Current Activities
Proposed Activities
New IEE for 519-0430


Kenneth C. Ellis
Mission Director


31 July, 1997
Date

INITIAL ENVIRONMENTAL EXAMINATION

Strategic Objective Title: SO#3 Sustainable Improvement
in Health of Women and
Children Achieved

Results Package Title: RP#3.1 Increased use of
appropriate child
survival practices
and services.

I. Results Package Description

The Package presently consists of three projects: 519-0308 Health system Support with the Ministry of Health, 519-0363 Salvadorean Demographic Association, and 519-0367 MSCI/PROSAMI.

Project 519-0308 MOH, supports the MOH to strengthen the capacity and responsibilities of the health promoters including doubling the number of medicines he/she dispenses. The project also supports mass media efforts to promote vaccination campaigns.

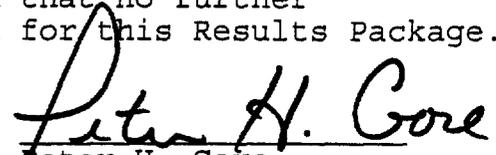
Project 519-0363 provides primary health services through community education (via health promoters), regarding birthspacing, maternal and child health, pre and post-natal care, nutrition and referral of children to health facilities, treatment of imunopreventable and sexually transmitted diseases and of diarrhea, and through distribution of contraceptives.

Project 519-0367, is implemented by 12 local NGOs to provide primary health services via health promoters and midwives to rural areas. A second purpose of the project is to strenghten the administrative and technical capacity of these NGO's so they may continue as viable organizations.

The new activities under this RP will address all aspects of child survival as well as education for preventing violence in the family.

II. Recommendation

Based on the information attached which documents the current activities being implemented under this Results Package, and the description of proposed future activity, we recommend a Positive Determination for this Results Package. Nevertheless, since the activities currently being implemented in support of this Results Package operate under approved IEEs, (LAC-IEE-91-36, positive determination), (LAC-IEE-90-08, negative determination), (LAC-IEE-91-05, positive determination), and approved Environmental Assessments (STATE 254773) (STATE 353499), and that the new activity (519-0430) is linked to those approved Environmental assessments, we recommend that no further environmental investigation be required for this Results Package.


Peter H. Gore
Environmental Officer
USAID/El Salvador

Concurrence:


Kenneth C. Ellis
Mission Director
USAID/El Salvador

Current Activities

Activity Title:	Health System Support
Activity Number:	519-0308
Funding:	\$77,000,000
Original IEE Number:	LAC-IEE-91-36
Recommended Threshold Decision:	Negative Determination
Bureau Threshold Decision:	Positive Determination (for Malaria Component April 1991)
Environmental Assessment Approval:	CABLE -- STATE 254773
Date Approved:	April 1990
Activity Title:	Family Health Services
Activity Number:	519-0363
Funding:	\$27,000,000
Original IEE Number:	LAC-IEE-90-08
Recommended Threshold Decision:	Negative Determination
Bureau Threshold Decision:	Negative Determination (2/90)
Activity Title:	Maternal Health/Child Survival
Activity Number:	519-0367
Funding:	\$34,000,000
Original IEE Number:	LAC-IEE-91-05
Recommended Threshold Decision:	Positive Determination
Bureau Threshold Decision:	Positive Determination (10/90)
Environmental Assessment Approval:	Cable -- STATE 353499
Date Approved:	October 1990

Proposed Activities

Activity Title:	Maternal Health/Child Survival
Activity Number:	519-0430
Funding:	\$37,449,000
Original IEE Number:	Not yet assigned
Recommended Threshold Decision:	Positive Determination
Bureau Threshold Decision:	



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So4 -- Environment Office

INITIAL ENVIRONMENTAL EXAMINATION

Activity Location: El Salvador

Strategic Objective Title: SO#3 Sustainable Improvements
in Health of Women and
Children achieved

Results Package Title: RP#3.2 Increased use of
appropriate
reproductive health
practices and
services

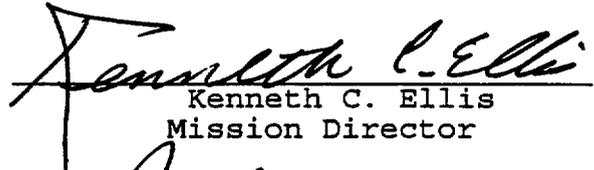
Results Package IEE Prepared BY: Peter H. Gore
Environmental Officer
USAID/El Salvador

Recommended Threshold Decision: Positive Determination

Mission Threshold Decision: Concur with Recommendation

Date Prepared: June 23, 1997

Attachments: Current Activities
Proposed Activities
New IEE for 519-0420
New IEE for 519-0430


Kenneth C. Ellis
Mission Director


Date

INITIAL ENVIRONMENTAL EXAMINATION

Strategic Objective Title: SO#3 Sustainable Improvement in Health of Women and Children Achieved

Results Package Title: RP#3.2 Increased use of appropriate reproductive health practices and services.

I. Results Package Description

The Package is presently supported by four projects: Health Systems Support Project No. 519-0308 with the Ministry of Health (MOH), Family Health Services Project No. 519-0363 implemented by the Salvadorean Demographic Association (SDA), the Maternal Health and Child Survival Project No. 519-0367 implemented by 12 local NGO's, and 519-0420 the Displaced and Street Children implemented by 5 local NGO's.

Project 519-0308 with the MOH, addresses RP related activities in areas such as: maternal health, pre and post natal care, attendance of deliveries, family planning, increasing the mix of temporary contraceptive methods available, education and promotion in family planning, and STD's and HIV/AIDS community based programs for the prevention, detection, treatment and control of STD's including HIV/AIDS.

Project 519-0363 provides risk populations in rural and marginal urban communities, attending women in fertile age and children under 5 years. The SDA expands Reproductive Health and Family Planning services through its rural program, clinical program and the social marketing program. The network of rural health promoters and health committees promote prenatal care, safe deliveries and the importance of post-natal care, contraceptives, and Family Planning community education. The SDA clinic system provides services such as distribution of contraceptives, treatment of immunizable and sexually transmitted diseases, birth spacing, maternal and child health, pre and post natal care and nutrition.

Project 519-0367 PROSAMI, is implemented by 12 local NGO's through community participation with Health Promoters, traditional birth attendants or midwives, health committees and community volunteers. In addition these NGO's hold group education sessions and promoters make home visits to detect family health care needs and to provide individual education. All PROSAMI NGO's are working in both primary and secondary prevention related to the prenatal, postpartum and birth. PROSAMI attends birth deliveries through their midwives trained in conjunction with the MOH.

Project 519-0420 - PROCIPOTES, is implemented by five local NGO's throughout El Salvador. The project has developed a community based NGO network to promote and increase access to education, health services, recreation and non exploitative income generating strategies.

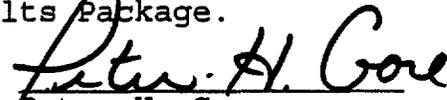
The new activities under this RP will address the adequate provision of Reproductive Health services by concentrating in the following areas:

- Pre-natal Care
- Safe Deliveries
- Post-Natal Care
- Family Planning
- STD including HIV/AIDS

New activities will include most of the features of the current activities incorporating their most successful aspects in the above mentioned areas. Current approaches will be evaluated during the design phase, and as a result will be modified, replicated and improved.

II. Recommendation

Based on the information attached which documents the current activities being implemented under this Results Package, and the description of proposed future activity, we recommend a Positive Determination for this Results Package. Nevertheless, since the activities currently being implemented in support of this Results Package, operate under approved IEEs (LAC-IEE-90-08, negative determination), (LAC-IEE-91-36, positive determination), (LAC-IEE-91-05, positive determination), (LAC-IEE-Categorical Exclusion recommended) and approved Environmental Assessments (STATE 254773) (STATE 353499), and that the new activity (519-0430) is linked to the approved Environmental Assessments for 519-0308 and 519-0367, we recommend that no further environmental investigation be required for this Results Package.


Peter H. Gore
Environmental Officer
USAID/El Salvador

Concurrence:


Kenneth C. Ellis
Mission Director
USAID/El Salvador

Current Activities

Activity Title:	Health System Support
Activity Number:	519-0308
Funding:	\$77,000,000
Original IEE Number:	LAC-IEE-91-36
Recommended Threshold Decision:	Negative Determination
Bureau Threshold Decision:	Positive Determination (for Malaria Component, April 91)
Environmental Assessment Approval:	CABLE -- STATE 254773
Date Approved:	February 1990
Activity Title:	Family Health Services
Activity Number:	519-0363
Funding:	\$27,000,000
Original IEE Number:	LAC-IEE-90-08
Recommended Threshold Decision:	Negative Determination
Bureau Threshold Decision:	Negative Determination
Activity Title:	Maternal Health/Child Survival
Activity Number:	519-0367
Funding:	\$34,000,000
Original IEE Number:	LAC-IEE-91-05
Recommended Threshold Decision:	Positive Determination
Bureau Threshold Decision:	Positive Determination (10/90)
Environmental Assessment Approval:	CABLE STATE 353499
Date Approved:	October 1990

Activity Title: Displaced and Street Children
Activity Number: 519-0420
Funding: \$1,305,500
Original IEE Number: Not yet assigned
Recommended Threshold Decision: Categorical Exclusion
Bureau Threshold Decision:

Proposed Activities

Activity Title: Maternal Health/Child Survival
Activity Number: 519-0430
Funding: \$37,449,000
Original IEE Number: Not yet assigned
Recommended Threshold Decision: Positive
Bureau Threshold Decision:



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So4 -- Environment Office

INITIAL ENVIRONMENTAL EXAMINATION

Activity Location: El Salvador

Strategic Objective Title: SO#3 Sustainable Improvements
in Health of Women and
Children achieved

Results Package Title: RP#3.3 Enhanced Policy
Environment to
support
sustainability of
Child Survival and
Reproductive Health
Programs.

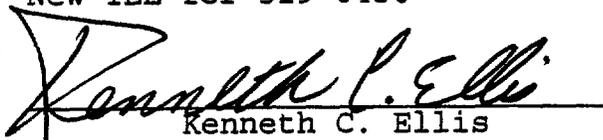
Results Package IEE Prepared BY: Peter H. Gore
Environmental Officer
USAID/El Salvador

Recommended Threshold Decision: Positive Determination

Mission Threshold Decision: Concur with Recommendation

Date Prepared: June 23, 1997

Attachments: Current Activities
Proposed Activities
New IEE for 519-0430


Kenneth C. Ellis
Mission Director

31 July, 1997
Date

INITIAL ENVIRONMENTAL EXAMINATION

Strategic Objective Title: SO#3 Sustainable Improvement
in Health of Women and
Children Achieved

Results Package Title: RP#3.3. Enhanced Policy
Environment to
support
sustainability of
Child Survival and
Reproductive Health
Programs.

I. Results Package Description

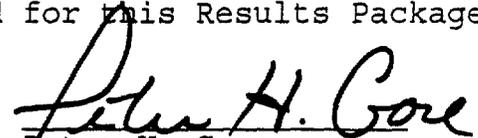
This RP can be described as a coordinating mechanism for plans developed and implemented under other SO3 activities to obtain an enhanced policy environment in support of sustainability of child survival and reproductive health programs. This RP also serves as the contact point for coordination with other international donors working in the health sector. Current actions under this RP are focused in the coordination of specific sustainability plans that have been developed by the different activities managed under the health strategic objective which are: activity 519-0308 (APSISA/MOH), activity 519-0363 (Salvadorean Demographic Association), and activity 519-0367 (PROSAMI/MSCI).

The proposed activity contemplated under this RP is being developed to correct structural problems in the sector so that improvement can continue at an accelerated rate and become self sustaining. To achieve this, four essential components will be addressed under this RP:

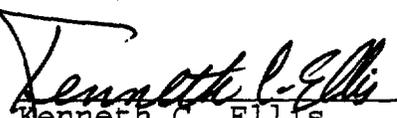
- Institutional reorganization of the health sector
- Reorganization of primary health care (PHC)
- Reorganization of specialized and hospital care (SHC)
- Strengthening of environmental health activities

II. Recommendation

Based on the information attached which documents the current activities being implemented under this Results Package, and the description of proposed future activity, we recommend a Positive Determination for this Results Package. Nevertheless, since the activities currently being implemented in support of this Results Package operate under approved IEEs, (LAC-IEE-91-36, positive determination), (LAC-IEE-90-08, negative determination), (LAC-IEE-91-05, positive determination), and approved Environmental Assessments (STATE 254773) (STATE 353499), and that the new activity (519-0430) is linked to those approved Environmental assessments, we recommend that no further environmental investigation be required for this Results Package.


Peter H. Gore
Environmental Officer
USAID/El Salvador

Concurrence:


Kenneth C. Ellis
Mission Director
USAID/El Salvador

Proposed Activities

Activity Title:	Maternal Health/Child Survival
Activity Number:	519-0430
Funding:	\$37,449,000
Original IEE Number:	Not yet assigned
Recommended Threshold Decision:	Positive Determination
Bureau Threshold Decision:	

Current Activities

Activity Title:	Health System Support
Activity Number:	519-0308
Funding:	\$77,000,000
Original IEE Number:	LAC-IEE-91-36
Recommended Threshold Decision:	Negative Determination
Bureau Threshold Decision:	Positive Determination (for Malaria component, April 91)
Environmental Assessment Approval:	CABLE -- STATE 053129
Date Approved:	February 1990
Activity Title:	Family Health Services
Activity Number:	519-0363
Funding:	\$27,000,000
Original IEE Number:	LAC-IEE-90-08
Recommended Threshold Decision:	Negative Determination
Bureau Threshold Decision:	Negative Determination (2/90)
Activity Title:	Maternal Health/Child Survival
Activity Number:	519-0367
Funding:	\$34,000,000
Original IEE Number:	LAC-IEE-91-05
Recommended Threshold Decision:	Positive Determination
Bureau Threshold Decision:	Positive Determination (10/90)
Environmental Assessment Approval:	STATE 353499 CABLE
Date Approved:	October 1990

Annex E : Analyses

E.1 Institutional Analysis:

The health services system in El Salvador consists of public and private institutions and individuals in private practice. In the public sector the major providers are the MOH and the ISSS, and in the private sector the most important providers are the NGOs, the pharmacies, and private physicians. The system is not integrated or coordinated in any formal sense, which is similar to the situation found in other Latin American countries with the exception of Costa Rica, and Cuba. Though this situation does not necessarily eliminate the possibility of providing high quality and efficient care to the population, certain risks are present in El Salvador and should be eliminated:

- a) Some institutions group their beneficiaries according to their income level or other categories. This could result in unequal access to health services, in which more complete services are provided to a group which already is privileged relative to the other beneficiaries. ANSAL recommended that access to at least certain basic health services should be a function of need and not of ability to pay or of place of residence.
- b) The growth of the sector through the creation of new institutions or programs favors inefficiency (through the duplication of structures and equipment) and gaps in coverage. Often the new institutions or programs are created because of the difficulties in resolving problems in existing organizations and the ability of a population group to pay for an alternative solution. In these cases, the problems in the older institutions are not resolved and the pressure to deal with them in the future decreases because many beneficiaries have already left the institution.

In order to avoid these risks the GOES has assumed an interventionist role in the health sector. Both the current normative framework and the sectoral policies developed by the GOES and the MOH recognize the need for greater presence of the state. The 1991-1994 National Health Plan has as one of its seven basic strategies to develop a national health system. It is not easy to develop a system which favors efficiency, effectiveness, and equity in the delivery of health services while remaining pluralized and respectful of individual choice; nor is it enough to create the formal structure. In many countries the health system was established at an official level but the institutions have not changed how they function. The most important point is that through the MOH, the GOES should be the leader in the organization and functioning of the national health system, with a clear definition of the rules and responsibilities of all of the participating organizations. The MOH was not able to develop the national system during the first three years of the 1991-1994 National Plan. This was due to the emphasis the MOH placed on the functioning of its own establishments and services with very limited financial resources throughout the period.

Organizations providing health services

Public sector health services are provided by the MOH, the ISSS, and seventeen other government institutions that provide services to its employees and family members. This group includes: Bienestar Magisterial (Ministry of Education), the National Telecommunications Administration (ANTEL), the Executive Hydroelectric Commission of the Lempa River (CEL), and others.

The MOH's constitutional mandate permits it to provide care for the entire population of the country; traditionally it has been the principal provider of health services for 85 percent of the population. The ISSS provides services to workers enrolled in the system, retired workers, and workers' spouses and children up to the age of three. ISSS coverage has traditionally been 6 or 7 percent of the population, with the MOH and the private sector covering the rest. As the result of a series of changes in the criteria for coverage, however, the ISSS currently covers approximately 12 percent of the population (1993 data). The health programs of several state companies and other organizations dependent upon government funding cover their own employees and dependents; these organizations together with the ISSS cover approximately 15 percent of the population. Finally, many NGOs play an important role in the delivery of basic health services to low-income rural residents, while private physicians and pharmacies provide many health services to people of all income levels living in urban areas.

In 1989 a household survey on the demand for health services was carried out (REACH). The data showed that the traditional view of the relative importance of the health subsectors was inaccurate. There are two different markets for health care in El Salvador, one for ambulatory care and one for hospital care. The data on hospital care supported the common views; approximately 76 percent of those hospitalized were treated by MOH establishments, 13 percent by the ISSS, and 9 percent by private sector institutions. The data on outpatient care, however, showed a surprising pattern; 40 percent of outpatient care was provided by the MOH, 13 percent by the ISSS, and 45 percent by the private sector. Other GOES studies carried out at a later date partially confirmed these findings.

The GOES surveys found that the proportion of outpatient care provided by the private sector was higher than traditionally believed, but lower than that claimed by the REACH survey. The 1991-1992 MIPLAN survey showed that 34 percent of outpatient care was provided by the private sector, 10 percent by pharmacies and other private sector providers, and 56 percent by the public sector (with no data on the breakdown by institution). According to these results, MOH coverage varies greatly between outpatient care (which covers basic services and preventive health care) and hospital care. The MIPLAN and REACH studies were consistent in their findings that residents of metropolitan San Salvador tended to use the private sector, while rural residents were more likely to receive care from public sector institutions. The data for urban areas outside of San Salvador indicated a more equal distribution of care provided by the private and the public sectors.

Public Sector Institutions

Ministry of Health

This is the largest health care organization in the system. It has 374 health establishments and 21,253 employees, of which 2,556 are physicians. Among public sector institutions, the MOH has the largest presence in rural areas. The network of MOH establishments consists of dispensaries, health posts, health units, health centers (inpatient care), regional hospitals, and specialized hospitals. Financing for the MOH comes from the government budget, from international agencies, and in the case of the hospitals, from user fees to a very limited extent.

Salvadoran Social Security Institute

The ISSS was created in 1954 through the 1953 Social Security Law and the 1954 Law for the Application of Social Security. The basic function of the ISSS is to provide two types of coverage for workers: immediate risks (health and pregnancy) and social security risks (disability, retirement, and death). Workers in the private sector receive coverage under both categories; retired workers and public sector employees receive coverage only for the immediate risk category.

The ISSS is currently responsible for coverage of approximately 580,000 people, which accounts for 12 percent of the total population in the country. ISSS funding comes from contributions from workers, from employers, and from the government, which provides 5 million colones annually in addition to its contributions as the employer of all public sector workers.

ISSS services are provided through its own establishments and human resources. Its network is much smaller than that of the MOH; it has 44 health establishments (concentrated in the MASS) and 1,386 doctors. The ISSS also contracts for hospitalization services at a regional level provided by the MOH. To reduce the waiting time for specialized health care, it contracts private physicians throughout the country.

Other government institutions

- **Ministry of Education:** MINED provides hospital care through Bienestar Magisterial, a teachers' organization which was created by the Law for Teachers' Hospital and Medical Services. It is financed by contributions from teachers (2 percent of salary with a maximum contribution of 20 colones/month) and by the government which provides 98 percent of the funding. Bienestar Magisterial contracts for the delivery of health services with the private sector; these contracts are renegotiated periodically. There are no restrictions on the use of the health services.
- **National Telecommunications Administration (ANTEL):** ANTEL health services are only for ANTEL employees. It has a hospital in San Salvador and seven outpatient clinics. Financing is through contributions by the employees (3 percent of salary with a maximum per month) and by ANTEL, which provides 97

851

percent of the budget.

- Executive Hydroelectric Commission of the Lempa River (CEL): CEL health services covers its 3,280 employees and their spouses and children. It has 15 clinics and 45 doctors; it also contracts for the services of 500 specialized doctors from the private sector.
- National Sewage and Aqueduct Administration (ANDA): ANDA health services consist of six clinics and dispensaries which provide basic medicines.
- Ministry of Defense: The Ministry provides health care through Military Health (Sanidad Militar) to its employees, both active and retired, and to their dependents. A full range of health services is provided through two hospitals and 40 clinics throughout the country.

Private Sector Institutions

Private sector health care providers can be divided into two groups: for-profit institutions and individuals (private hospitals, laboratories, pharmacies, and physicians and other health professionals in private practice); and not-for-profit institutions (NGOs). The first group of providers is especially important in the provision of outpatient care in urban areas, whereas the impact of the services provided by the second group is felt primarily in rural areas, where the NGOs complement MOH care and provide preventive and basic curative health care to the rural poor.

Private for-profit subsector

Between 2,800 and 3,000 physicians are currently practicing in El Salvador, 66 percent in the department of San Salvador and 10 percent in the department of Santa Ana. These figures make it apparent that a very small number of physicians service other cities and the rural areas. Almost 40 percent of the doctors work exclusively in private clinics, while a similar number work exclusively for the public sector, divided in equal parts between the MOH and the ISSS. Private clinics tend to be organized very simply, both in terms of personnel (fewer than 3 percent have a nurse) and equipment. Productivity is low, with an average of 1.18 consultations per hour.

In terms of volume and complexity, most hospital care is provided by the MOH and the ISSS. There are a small number of private hospitals and they tend to be small (less than 30 beds); 70 percent are located in the department of San Salvador, and eight of the fourteen departments in the country do not have any private hospital. The level of occupancy is low (53.5 percent) and the average stay is only 3.6 days. The procedures performed in these hospitals are not complicated. This reflects the epidemiological profile of El Salvador as well as the limited income levels of the users. Both characteristics, together with the fact that many people have access to the subsidized hospital care provided by the MOH and the ISSS, explain the low level of investment in private hospitals.

Laboratories (for clinical analyses, pathological tests, and radiological exams) are also included in this subsector. They occupy a relatively prominent place, both in number and in complexity, above all in San Salvador.

Pharmacies are an important part of the health system because they provide the easiest access to health care in the MASS and in other cities. The high proportion of the population that self-medicates (close to 50 percent), the consultations with pharmacists, and the purchase of prescription drugs without a prescription indicate poor functioning of the health system. Pharmaceutical products are sold in approximately 1,044 locations, which amounts to a ratio of 5,500 people per pharmacy. The pharmacies are supplied by 225 distributors and wholesalers who obtain their supplies from outside of the country or from the 30 pharmaceutical companies which have local production facilities.

It is hard to obtain accurate data on the sale of pharmaceutical products in Latin America. The following estimates are based on figures from International Marketing Statistics provided during ANSAL interviews in 1994. The per capita value of pharmaceutical sales in the private sector was US\$11.09. Using estimated figures from the MOH and the ISSS on the use of pharmaceutical products, the total per capita value of pharmaceutical products in the private and the public sector was US\$16.05. This represents a high level of expense relative to the level of development of the country. Some of the expense may be unjustified. An analysis of the therapeutic value of private sector sales shows that:

- the 1991 sale of 35 subgroups of pharmaceutical products considered of doubtful therapeutic value totalled US\$10,250,000, or 20 percent of all sales in 1991 (US\$50,500,000);
- the sale of vitamins and other supplements amounted to an additional US\$3,800,000 or 7.5 percent of the 1991 total;
- diet products totalled US\$1,450,000 or 3 percent of the 1991 sales; and
- antibiotics, which have a great potential of being misused, amounted to US\$6,000,000 or 12 percent of 1991 sales.

To summarize, up to 42 percent of the sales of pharmaceutical products may have a doubtful effect, if not a negative effect, on the health of the users.

Non Governmental Organizations (private non-profit subsector)

There are approximately 100 NGOs dedicated to activities related to health. These NGOs provide a wide range of health services, from health education and training of midwives, volunteers, and health promoters to care in a hospital with 200 beds. In general, the NGOs are well integrated in the communities that they serve and their efforts are focussed on geographic areas of high risk. Approximately 71 percent have

basic curative programs and 62 percent have preventative health programs.

The United States Agency for International Development (USAID) provides funding for many NGOs operating efficiently in the health sector. One important effort is the Project for Family Planning Services, which is implemented through the Salvadoran Demographic Association (ADS). Family planning services, maternal and child care, and medicine are delivered through a network of 12 clinics and community workers.

Another USAID project in the health sector is the Project for Maternal Health and Child Survival (PROSAMI). The purpose of this project is to improve the health of the rural and marginal populations through improved access to basic health care. The health services are provided by 36 NGOs. Project activities include: the delivery of maternal health and child survival services; NGO institution strengthening; coordination of NGOs; and the development of policies and research related to maternal and child health.

E.2 Feasibility Analysis:

This is an illustrative and not exhaustive list of documentation consulted/reviewed during the preparation of the three Results Packages documents (3.1, 3.2 and 3.3). Since several documents and reports were the same for each RP, we have consolidated all reports in one single list.

- 1) Project Paper, Maternal Health and Child Survival Project No. 519-0367, June 1992.
- 2) Project Paper, Family Health Services Project No. 519-0363, June 1990.
- 3) Project Paper, Health System Support Project No. 519-0308, May 1991.
- 4) Review and Assessment of Community Health Promoters, Investigaciones de Población y Mercadeo, September 1995.
- 5) Diagnostic Survey on Family Planning for the PROSAMI NGO Network, Katia Hogan, April 1995 through December 1995.
- 6) Maternal Health and Child Survival Project No. 519-0367 Midterm Evaluation, Health Technical Services Project, November 1995.
- 7) Health Sector Assessment Project of El Salvador (Análisis del Sector Salud, ANSAL), USAID, World Bank, PAHO/WHO, IDB, May 1994. Including the following reports: Community Perceptions and the Demand for health Services, The Financing of the Health Sector, Health Infrastructure, Epidemiological Profile, Health Services System, Maternal Child Care, Management of Pharmaceuticals, an Executive Summary and a Final Report.
- 8) Family Health Services Project No. 519-0363 Interim Evaluation, Development Associates, October 1995.
- 9) Health Systems Support Project No. 519-0308 Midterm Evaluation, Cambridge Consulting Corporation, July 1990.
- 10) Health Systems Support Project No. 519-0308 Second Evaluation, Cambridge Consulting Corporation, January 1994.
- 11) Cost per services of the Ministry of Health of El Salvador, Clapp and Mayne Inc., July 1992.
- 12) Analysis and Diagnostic Survey of the health Sector in El Salvador, Dr. Fabio Molina Vaquerano, May 1994.

- 13) National Family Health Survey (FESAL), Centers for Disease Control and Prevention (CDC) and Salvadoran Demographic Association (SDA), 1975, 1978, 1983, 1988 and 1993.
- 14) Proyección de la población de El Salvador al año 2025, DIGESTYC, 1995
- 15) Atlas demográfico, DIGESTYC, 1996
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E.3 Gender Analysis

Women are significant users of health care. The rates of perceived illness, hospital care, and consultation are higher among women (stated in PP Amendment for Project 519-0308). Consequently, an increased access to health care services will substantially benefit the women of the country, particularly those in rural areas. Women and young children are more vulnerable to illness and death from preventable diseases. Women are especially at risk due to mistimed and frequent pregnancies.

Women's educational and economic status is directly related to the use of health services (e.g. use of modern contraception - cost of the method). Women who are literate and have attained higher levels of education are more likely to understand advice and instruction, which is critical to their role as primary care-giver to small children in home.

One in five households in rural areas is headed by women. In rural households, women and girls spend much of their time undertaking home production tasks, particularly childcare, food preparation, and gathering water and fuelwood. Such demands often crowd out time available for cash income production on the part of the women, and for schooling of girls. Since women's income tends to contribute more to family member's education, nutrition and health care, the obstacles to women's income affects both current standards of living and the potential productivity of the next generation. (USAID/ES Strategy 1997-2002).

Since women are more socially involved than men (e.g., neighbors committees, school committees, health committees, etc.) they perform a multiplier effect within their community, sharing with others the knowledge they have obtained from the information or training received. (USAID/ES Strategy 1997-2002).

Adult men and adolescents are sometimes overlooked in health and family planning activities, due to the fact that Salvadoran women and girls are primarily responsible for the health decisions in the home. Men frequently express the same fears as women concerning the well-being of their spouse or future child. One fear which is specific to men is that modern contraceptive methods will cause a change in the personality of the woman. They fear that she will become angry and difficult to live with or, even more commonly, that she will become promiscuous. This concern increases as more and more men must leave the community for periods to seek outside employment. Among male reasons for opposing contraception are also concepts of ownership and "maleness" associated with having many children. Also, men who do not understand the serious health risks of too many too closely spaced pregnancies are less likely to support the use of contraception. However, there is some indication that male awareness of contraception has increased in recent years. (Stated in PP for Project 519-0363.)

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E.4 Financial Analysis

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WATER & SANITATION					POLICY		CSMH		REPRODUCTIVE H.		NON SO		TOTAL	TOTAL		
TYPE	CLASS	CURRENT NAME	OFFICE	GRADE	PERSON/YEAR	FIRST YEAR COST	PERSON/YEAR	FIRST YEAR COST	PERSON/YEAR	FIRST YEAR COST	PERSON/YEAR	FIRST YEAR COST	PERSON/YEAR	FIRST YEAR COST	TOTAL	TOTAL
OE	USDH	TIFFANY	SO3	FS 1	0.15	12,698	0.15	12,698	0.15	12,698	0.15	12,698	0.4	33,860	1.00	84,651
OE	USDH	SINNIT	SO3	FS04/02	0.05	1,943	0.05	1,943	0.70	27,195	0.15	5,828	0.05	1,943	1.00	38,850
TF	FSNDH	TOLEDO	SO3	12/13	0.05	2,290	0.70	32,064	0.10	4,581	0.10	4,581	0.05	2,290	1.00	45,806
PROJ	FSNPSC	DALE	SO3	11/15	0.05	1,917	0.70	26,844	0.10	3,835	0.10	3,835	0.05	1,917	1.00	38,349
PROJ	FSNPSC	LOBO	SO3	11/04	0.05	1,376	0.05	1,376	0.15	4,127	0.70	19,258	0.05	1,376	1.00	27,512
PROJ	FSNPSC	ESTRADA	SO3	09/02	0.05	786	0.10	1,573	0.10	1,573	0.70	11,009	0.05	786	1.00	15,727
PROJ	FSNPSC	JARCH	SO3	11/06	0.80	23,586	0.05	1,474	0.05	1,474	0.05	1,474	0.05	1,474	1.00	29,483
TF	FSNPSC	VILLALTA	SO3	07/11	0.20	3,302	0.20	3,302	0.20	3,302	0.20	3,302	0.20	3,302	1.00	16,508
SUB-TOTAL	SO3				1.4	47,898	2	81,273	1.55	58,783	2.15	61,984	0.9	46,948	8	296,886
TF	FSNPSC	MEJIA	SDO	11/06	0.15	4,422	0.10	2,948	0.15	4,422	0.15	4,422	0.45	13,267	1.00	29,483
TF	FSNPSC	GONZALEZ	SDO	08/07	0.15	2,409	0.10	1,606	0.15	2,409	0.15	2,409	0.45	7,226	1.00	16,058
TF	FSNPSC	PARRAGA	OCG	08/04	0.15	2,177	0.10	1,451	0.15	2,177	0.15	2,177	0.45	6,531	1.00	14,514
TF	FSNPSC	TERCERO	CONT	10/03	0.15	3,384	0.10	2,256	0.15	3,384	0.15	3,384	0.45	10,153	1.00	22,563
TF	FSNPSC	SCHULZ	CONT	11/08	0.15	4,718	0.10	3,145	0.15	4,718	0.15	4,718	0.45	14,154	1.00	31,453
SUB-TOTAL	SUPPORT OFFICES				0.75	17,111	0.5	11,407	0.75	17,111	0.75	17,111	2.25	51,332	5	114,071
GRAND TOTAL	AL SO3 AND SUPPORT OFFICES				2.15	65,009	2.5	92,680	2.3	75,894	2.9	79,094	3.15	98,280	13	410,957

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