

Family Planning in
El Salvador

The Achievements
of 50 Years

April 2015

Roberto Santiso-Gálvez, MD
Victoria M. Ward, PhD
Jane T. Bertrand, PhD, MBA



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MEASURE Evaluation is funded by the U.S. Agency for International Development (USAID) under Cooperative Agreement AID-OAA-L-14-00004. MEASURE Evaluation, whose staff provided editorial, formatting, and distribution assistance, is implemented by the Carolina Population Center at the University of North Carolina at Chapel Hill, in association with Futures Group, ICF International; John Snow, Inc.; Management Sciences for Health, and Tulane University. The opinions expressed in this publication do not necessarily reflect the views of USAID or the United States government.



Preface

This publication is one of eight case studies that were developed as part of a broader review entitled *Family Planning in Latin America and the Caribbean: the Achievements of 50 Years*. As its title implies, the larger review documents and analyzes the accomplishments in the entire region since the initiation of U.S. Agency for International Development (USAID) funding in the early 1960s. The reader of this case study may wish to access the executive summary or the report in its entirety at:

<http://www.cpc.unc.edu/measure/publications/tr-15-101>

Acknowledgments

We want to thank the individuals who provided invaluable historical insight for this case study including José Mario Cáceres, Beatriz Galán de Alonzo, Luz Elda Luna, Maricarmen Estrada, Margarita de Lobo, José Ignacio Paniagua Castro, Esmeralda de Ramírez and Sarah Romorini. In addition, José Mario Cáceres and Maricarmen Estrada reviewed a previous version of this case study.

The co-authors owe a debt of gratitude to three individuals who devoted vast amounts of their time and energy to this case study and to the larger main report: Kime McClintock and Jerry Parks (lead research assistants at Tulane University School of Public Health and Tropical Medicine) and Maria Cristina Rosales (editorial assistant in Guatemala). Their dedication in conducting background research, fact checking, verifying references, and editing text greatly enhanced the quality of the final product. In addition, we thank Nicole Carter, Alejandra Leyton, and Maayan Jaffe for their contributions as research assistants to specific sections of the main report and/or case studies. Mirella Augusto and Maria Carolina Herdoiza provided valuable administrative and logistics support to this effort. At the University of North Carolina at Chapel Hill, we thank Erin Luben, Elizabeth T. Robinson, and Nash Herndon for their editorial assistance; as well as Denise Todloski, who designed the cover.

The USAID Latin America and the Caribbean Bureau (USAID/LAC) commissioned this work and provided constructive technical guidance in its development. We wish to thank Kimberly Cole for her skillful management of the process and detailed synthesis of reviewer comments. Other reviewers of this case study from USAID/LAC included Maggie Farrell, Amber Hill, Lindsay Stewart and Verónica Valdivieso. Finally, the authors thank a number of Latin American/Caribbean specialists from within and outside of USAID who reviewed the main report and are acknowledged by name in that document.

Suggested citations:

Bertrand JT, Ward VM, Santiso-Gálvez R. *Family Planning in Latin America and the Caribbean: The Achievements of 50 Years*. Chapel Hill, NC: MEASURE Evaluation; 2015.

Santiso-Gálvez R, Ward VM, Bertrand JT. *Family Planning in El Salvador. The Achievements of 50 Years*. Chapel Hill, NC: MEASURE Evaluation; 2015.

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OVERVIEW

COUNTRY SITUATION

El Salvador is the smallest country in Central America, with an area of 21,040 square kilometers (8,400 square miles). It has been undergoing a political transition since signing of the 1992 Peace Accords that ended a 12-year civil war between the government and the guerrillas, during which about 75,000 people lost their lives. From 1960 to 2009, annual growth in the gross domestic product (GDP) averaged 1.1 percent, while unemployment and underemployment remained constant at about 50 percent. Between 2004 and 2010, public expenditure on health as a percentage of GDP grew from 3.6 percent to 4.3 percent.¹ El Salvador's economy is lower middle income (gross national income per capita is U.S. \$5,915), although large socioeconomic disparities are present.² Poverty declined from just over 60 percent of households in 1991 to 35 percent in 2008, but increased to 38 percent in 2010, with higher levels in rural than urban areas.³ According to World Bank estimates for 2011, the country has 302 inhabitants per square kilometer and is the most densely populated country in Latin America.

El Salvador is in the midst of a demographic transition, with a population of 6.2 million people in 2011; the rate of natural increase or RNI (RNI = births minus deaths) decreased from 3.2 percent in 1960-1965 to 1.4 percent in 2005-2010.⁴ The total growth rate, which includes the impact of net loss due to migration, further decreased population growth during that period.

After a long series of dictatorships (1932-1979) and numerous political and social conflicts, there have been major migratory movements in El Salvador. Some are the result of the urban growth process and mass migration (displacement) of peasants caused by the armed conflict, while others are due to such processes as reintegrating former combatants and deportees from the United States. Yet others are caused by displacement as a result of natural disasters, to which El Salvador is extremely vulnerable. International migration is mostly towards the United States, consisting predominantly of undocumented or irregular migrants. Remittances constitute 18 percent of the GDP and are received by one in five households.^{5,6}

The data presented in table 1 were obtained through Demographic Healthy Surveys' STATcompiler, an online database, for the following years: 1985, 1998, 2002-03, 2008. Data on unmet need for 1993, 1998, 2002-03, and 2008 were not available in STATcompiler and instead were obtained directly from Reproductive Health Surveys (RHS).

¹ Pan American Health Organization (PAHO). *Health System Profile of El Salvador 2000-2005: Monitoring and Analysis of Change Processes*. Washington DC: PAHO; 2007/

² United Nations Development Programme (UNDP). Human development reports, El Salvador [database]. Available at: <http://hdr.undp.org/en/countries/profiles/SLV>.

³ Dirección General de Estadística y Censos (DIGESTYC). *Encuesta de Hogares De Propósitos Múltiples (EHPM)*. El Salvador: DIGESTYC; 2010.

⁴ United Nations Population Fund (UNFPA). *Plan de Acción del Programa de País (CPAP) 2012 – 2015 El Salvador*. San Salvador, El Salvador: UNFPA; 2011.

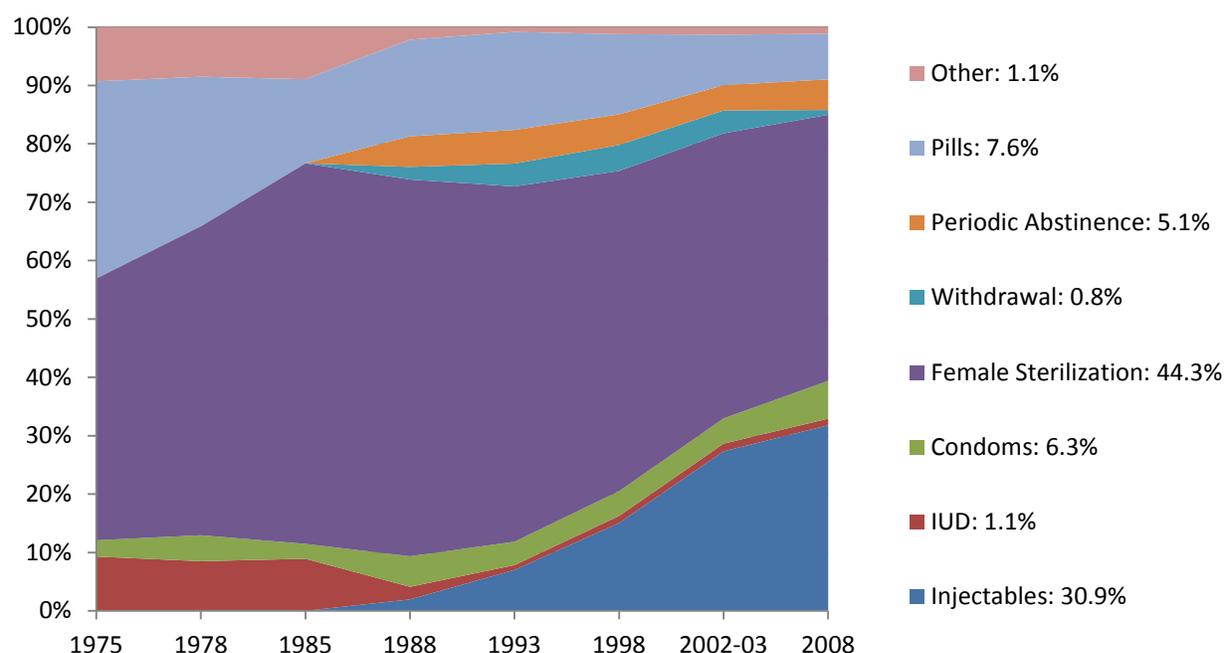
⁵ Banco Central de Reserva del El Salvador, 2013. Home page [Web site].

⁶ DIGESTYC, 2010.

The total fertility rate fell by 60 percent in 30 years, from 6.3 children per woman in 1978 to 2.5 children per woman in 2008 (table 1). Contraceptive prevalence among women married or in union aged 15 to 44 years increased from 21.6 percent in 1975 to 72.5 percent in 2008 for all methods, and from 19.6 percent to 66.1 percent for modern methods. El Salvador has one of the highest contraceptive prevalence rates (CPR) in Central America; Nicaragua and Costa Rica rank first, followed by El Salvador.⁷ Some of the factors that have contributed to this progress are discussed below.

Table 1: Trends in Fertility, Contraceptive Use, and Unmet Need for Women Married/in-Union Aged 15-44, 1975-2008, El Salvador

	1975	1978	1985	1988	1993	1998	2002-03	2008
Total Fertility Rate	6.3	6.3	4.2	4.2	3.9	3.6	2.8	2.5
Contraceptive Prevalence Rate (%)	21.6	34.4	47.3	47.1	53.3	60.0	66.9	72.5
Modern Contraceptive Prevalence Rate (%)	19.6	31.5	44.3	42.7	47.9	54.7	61.7	66.1
Unmet Need (%)	n/a	n/a	n/a	n/a	15.8	14.2	5.5	3.4



Source: FESAL data.

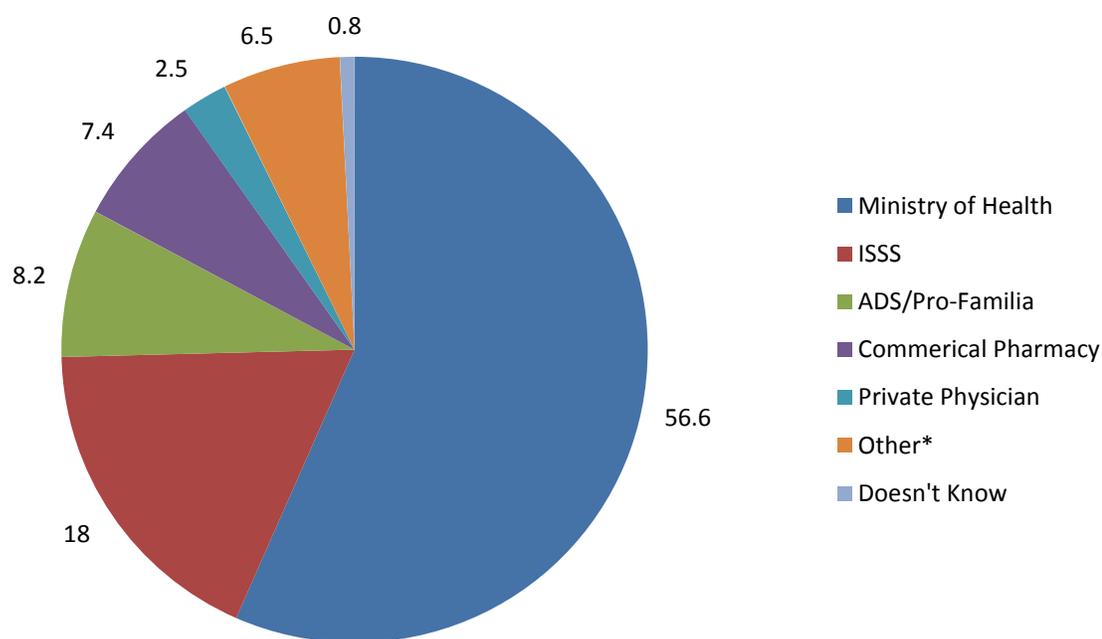
Note: The percentages in the legend refer to the most recent survey (2008).

Figure 1: Method mix (El Salvador, 1975-2008).

⁷ Asociación Demográfica Salvadoreña. *Encuesta Nacional de Salud Familiar FESAL-2008*. San Salvador, El Salvador: Asociación Demográfica Salvadoreña 2009.

According to the 2008 Encuesta de Salud Familiar (FESAL, National Family Health Survey), the two most prevalent contraceptive methods in this country were female sterilization (44.3 percent) and injectables (30.9 percent), as shown in figure 1. Oral contraceptives, male condoms, and periodic abstinence lag behind with 7.6 percent, 6.3 percent, and 5.1 percent, respectively. Other methods, such as intrauterine devices (IUDs) and withdrawal made up 1 percent each of the method mix. Women who opted for female sterilization had an average of 3.2 live births, were 26.3 years old, and had been living in union for 7.6 years at the time of sterilization.

Increases in contraceptive prevalence between 1975 and 1985 were mainly due to the uptake of female sterilization. In the following 20 years, however, temporary methods came to outnumber permanent methods, particularly beginning in the 1990s, after Depo Provera was approved in the United States and Latin America increased its use.⁸



* "Other" includes military hospitals, overseas hospitals, employer, stores, and supermarkets.
Source: FESAL data.

Figure 2: Method source (El Salvador, 2008).

According to data from FESAL 2008, (see figure 2), the Ministry of Health (MOH) is still the main source of contraceptive services in all health areas and geographic regions. The Instituto Salvadoreño del Seguro Social (ISSS, Salvadoran Social Security Institute) ranks as the second source in urban areas and in nine of the country's 14 departments (states); the Asociación

⁸ Asociación Demográfica Salvadoreña. *Encuesta Nacional de Salud Familiar FESAL-2008*. 2009.

Demográfica Salvadoreña (ADS, the Salvadoran Demographic Association, also known as Profamilia, the local International Planned Parenthood Federation member association) and private pharmacies tie for third place, with 8.2 percent and 7.4 percent, respectively.⁹

Adolescent pregnancy remains a major challenge. One in 12 adolescents has been pregnant by age 15, and four of 10 in the 15-to-19 years of age group.¹⁰ According to the 2008 FESAL, adolescent fertility was high (89 births per 1,000 women per year); one in three babies are born to teenage mothers in the country. Among women aged 15 to 24 years who had been pregnant at least once, 43 percent said they did not want to get pregnant when they did. The use of family planning methods by adolescents was reported to be 20 percent for the first intercourse before age 15, rising to 26 percent among women aged 15 to 17. Of the adolescents who were in school when they became pregnant, 41 percent dropped out of school, and 25 percent of those who were working when they became pregnant did not return to work. This has a strong impact on their lives, not only in terms of reproductive health, but also in increasing their risk of sexually-transmitted infections (STIs) and HIV.¹¹

THE EARLY YEARS (1962-1980)

As in other countries in the region, the family planning (FP) movement began in El Salvador at the initiative of a group of professionals concerned about rapid population growth and the high rate of illegal abortions due to unplanned pregnancies.¹² The ADS was thus founded in 1962.¹³ In the beginning, it sought to raise awareness and motivate Salvadoran society regarding the impact of rapid population growth on development and the need to provide family planning information and services in this densely populated country, where the government showed little interest in the topic.

Some of the founding members of ADS had important links with the School of Medicine of the Universidad Nacional de El Salvador (UES, the Salvadoran National University) and the ISSS. These connections helped persuade government authorities to open the first maternal health clinic in the Department of Preventive Medicine of UES School of Medicine in 1964.¹⁴ This clinic began to provide information and offered contraceptive methods as part of an effort to improve maternal and child health. In 1971 ADS became a permanent member of the International Planned Parenthood Federation (IPPF).

In those early years, services focused on producing and distributing information, education, and communication (IEC) materials about responsible parenthood and family planning, providing

⁹ FESAL, 2009.

¹⁰ UNFPA, 2011.

¹¹ FESAL, 2008.

¹² Armijo R. 27, abortion in Latin America. In: *Proceedings of the Eighth International Conference of the International Planned Parenthood Federation, Santiago, Chile, 9-15 April, 1967*. London, United Kingdom: International Planned Parenthood Foundation; 1967:154.

¹³ The Salvadoran Demographic Association (ADS) is also known as PROFAMILIA, but is only referred to as ADS in this paper.

¹⁴ Asociación Demográfica Salvadoreña (ADS). *Memorias de Labores*. San Salvador, El Salvador: ADS: 2013. Retrieved from <http://www.ads.org.sv/intro.asp?contenido=memorias>

counseling, as well as detecting cervical cancer, diagnosing gynecological diseases and making referrals to medical centers, and providing FP methods. Facilities were established to provide and monitor contraceptive use among women who sought out these services.¹⁵ The U.S. Agency for International Development (USAID) provided technical and financial support to perform these activities and donated all FP methods, both to the MOH and to ADS.

From the beginning, volunteers were the champions of FP in El Salvador, most of them female ADS volunteers who had a strong sense of solidarity with the plight of other women and were convinced of the benefits of FP. They worked hard to provide information regarding its advantages within the context of responsible parenthood. They also encouraged couples to make free and informed choices regarding the number and spacing of their children. The Profamilia corps of volunteers started in 1967 with about 12 women who worked in clinics and in the communities. In just a short time, their number increased to 130.¹⁶

FP activity was limited during the period of 1964 to 1967. Observers cite a number of possible reasons: the influence of conservative orthodox opponents who defined FP as a form of social control and a simplistic solution to poverty; prejudices on moral grounds; and a culture of machismo. However, in 1968, government authorities decided to incorporate a family planning program into the MOH and ISSS primary health care units.

In 1974, the government endorsed a Comprehensive Population Policy. However, sources familiar with that period report that it was not implemented due to lack of political support.

ADS began the community-based distribution of contraceptives (CBD) in 1974, with support of influential local leaders (men and women). Volunteers provided educational talks and information on FP, responsible parenthood and reproductive health in general. They offered methods such as oral contraceptives, condoms, and vaginal tablets. Volunteers also distributed prenatal vitamins and supplies, and assisted the MOH with immunization campaigns for children and pregnant women.

ADS created the Reproductive Health Social Marketing Program in 1978 with the purpose of increasing FP service coverage. At that time, ADS offered two methods (oral contraceptives and condoms) that were donated by two international institutions (USAID and IPPF) and distributed them through commercial pharmacies.

By the end of the 1970s, the CPR among women married or in union of reproductive age was 34.4 percent, and the family planning program began to take shape in El Salvador with the active participation of the MOH, ISSS, and ADS.^{17,18} USAID provided technical and financial support, as did the United Nations Population Fund (UNFPA).

¹⁵ ADS, 2013.

¹⁶ ADS, 2013.

¹⁷ Asociación Demográfica Salvadoreña (ADS). *El Salvador Encuesta Nacional de Fecundidad, Planificación Familiar y Comunicación Masiva FESAL-78*. San Salvador, El Salvador: ADS:1979.

¹⁸ FESAL, 2009.

PROGRAM CONSOLIDATION (1981-2000)

As noted above, armed conflict began in El Salvador in 1970 between military governments and rebel organizations whose strategy involved using urban, suburban, and rural guerrilla groups. It reached its peak between 1980 and 1992, and negatively affected family planning service delivery, although officially the programs continued.

Tragically, in 1981, the executive director of ADS, Dr. Rosa Cisneros, was murdered, for motives that remain unclear. Despite the difficulties experienced during this turbulent socio-political period and strong threats to its leadership, ADS continued to provide both information and family planning services to the urban and rural populations.

Access to family planning information and contraception was limited during the civil war in the early 1980s, particularly in rural areas. However, USAID supported the strengthening of the CBD program for temporary FP methods and referred users to MOH and ADS clinics for permanent methods, in an effort to improve access to FP information, education, and services. The quality of services was evaluated periodically, with a particular focus on ADS clinical services.

During the 1980s and 1990s, the corps of ADS volunteers grew significantly. They focused on different sectors of society, including men and adolescents in rural areas. ADS was particularly concerned with adolescents because of the high fertility rates of this group, which accounted for almost a third of maternal deaths in El Salvador. Clearly, adolescents had a great need for information and education on family planning and reproductive health, all the more so with the spread of the sexually-transmitted HIV/AIDS epidemic.

The government strengthened the CBD program beginning in the 1990s. USAID also helped launch the project Pro-Salud Materno Infantil (PROSAMI, Project for Maternal and Child Health), which brought together about 35 nongovernmental organizations (NGOs) and operated successfully with community staff in all of El Salvador's 14 departments. During the eight years it operated, PROSAMI served hundreds of thousands of people, focusing mainly on four aspects: delivery of maternal and child health services, institutional strengthening of NGOs, policy development, and programmatic coordination. Upon completion of the project, the community's efficiency in providing quality services had been strongly reinforced.¹⁹

In the mid-1990s, IPPF urged its affiliated family planning associations to explore strategies to achieve financial sustainability through the USAID-funded Transition Project. The results of the 1993 FESAL showed that the use of private hospital services had declined in the past five years and that a significant sector of the population lacked access to these amenities. As a result, ADS designed a model private hospital to provide the middle-class population with access to quality hospital services at moderate prices. Thus, with technical and financial assistance provided under the Transition Project for developing and implementing a sustainability plan, the Profamilia

¹⁹ U.S. Agency for International Development (USAID), Medical Service Corporation International (MSCI). PROSAMI/MHCSP Project assistance completion report [memorandum]. San Salvador, El Salvador: USAID; 1999. Available at: http://pdf.usaid.gov/pdf_docs/pdabr624.pdf.

Hospital opened its doors in 1994 as a 32-bed general hospital. Currently, this hospital is one of the best in metropolitan San Salvador and offers high-quality services with advanced technologies at affordable prices, especially in maternal and child health, while it also contributes to ADS's financial sustainability.²⁰

As part of this USAID-supported sustainability plan, ADS undertook other initiatives to increase its financial sustainability, including contraceptive social marketing, a Profamilia pharmacy, and a network of clinics and laboratories that offer general health, gynecological, pediatric and prenatal consultations, screening and medication for STIs including HIV, infertility services, and menopause therapy.

During this period, international cooperation, mainly from USAID, provided major technical and financial assistance to ADS and the government of El Salvador through various projects and programs. These focused on training health personnel, counseling, integration of services, improving contraceptive security and logistics, establishing standards, guidelines and protocols, monitoring and evaluation, and upgrading quality of care. Operations research (OR) workshops were conducted to help refocus programmatic strategies, apply qualitative research methods and implement actions to improve service quality. This work focused on analyzing clients' and providers' needs from the client's perspective, and strengthening providers' knowledge and ability to deliver better services.^{21,22}

USAID also donated a large percentage of the contraceptive methods needed by the MOH, ADS and ISSS, while also coordinating efforts with other donor agencies in El Salvador in order to harmonize actions and avoid duplicating efforts.

After the armed conflict ended in 1992, a democratic transition process began. Various political sectors endorsed the ideas of "gender perspective" and women's empowerment. Organized civil society groups, including women's rights organizations, political and community organizations, committees, and local health boards contributed to the women's struggle for their right to sexual and reproductive health. Among them: The Instituto Salvadoreño para el Desarrollo de la Mujer (ISDEMU, the Institute for the Advancement of Women), the Asociación de Parteras Rosa Andrade de Suchitoto (Suchitoto's Rosa Andrade Midwives' Association), the Concertación Feminista Prudencia Ayala (CFPA, the Prudencia Ayala Feminist Coalition), and the Alianza por la Salud Sexual y Reproductiva en Salvador (Alliance for Sexual and Reproductive Health in El Salvador, which is an organization comprised of approximately 12 NGOs). They all supported the MOH in processes or initiatives such as adopting and disseminating reproductive health policies benefitting women's health.

²⁰ Asociación Demográfica Salvadoreña/Profamilia (ADS). *Incio*. San Salvador, El Salvador: ADS; 2013. Retrieved from www.ads.org.sv.

²¹ Vernon R, Brambila C. *Operations Research in Training and Technical Assistance in El Salvador*. San Salvador, El Salvador: U.S. Agency for International Development, The Population Council; 2000.

²² Asociación Demográfica Salvadoreña (ADS). *Trabajo Comunitario en Áreas Rurales-Programa con Base en la Comunidad (PBC)*. San Salvador, El Salvador: ADS; 2013.

POST-CONSOLIDATION (2001-2013)

At the beginning of the new millennium, El Salvador had achieved a sustained decrease in its total fertility rate to 2.8 children per woman. Knowledge of contraceptive methods had improved in the country, with CPR for all methods reaching 66.9 percent, modern contraceptive prevalence rate (MCPR) at 61.7 percent, and unmet need at 5.5 percent. Family planning constituted part of a holistic approach to sexual and reproductive health. Qualified technical health staff was available at the central and regional levels to deliver services, including counseling and contraceptive methods; in addition, guidelines had been issued and technical tools and IEC materials were available for providing quality services. Given these major strides, El Salvador became a candidate for “graduation” from USAID assistance for family planning.

The Graduation Process

The graduation strategy developed for El Salvador was carried out between 2006 and 2009. After more than four decades of USAID financial support for FP programs, according to sources familiar with the process, the government of El Salvador was surprised to learn that USAID planned to withdraw its FP funding. This presented a major challenge, but the country met it with determination and responsibility.

Prior to embarking on an action plan for the graduation process, USAID worked with senior officials from the MOH, ISSS, NGOs, and local consultants to conduct a situational analysis identifying the most important gaps to be addressed for successful graduation.

The team developed a financial feasibility plan for contraceptive procurement and it was implemented through gradual reduction of USAID funding during the period 2006 to 2009, with specific commitments from USAID and the MOH. Training, awareness-building, and advocacy activities with key actors from the MOH and the Ministry of Finance were conducted to ensure ongoing government financing for contraceptive procurement, which was fully achieved as of 2010.

Throughout this process, USAID provided logistical and financial assistance to health personnel at the technical and operations levels. This included training in new processes to improve the quality of care, logistics management, and forecasting of contraceptive needs in order to maintain a standardized institutional supply chain and adequate stocks of contraceptives throughout the entire health facility network. Training was expanded to the regional level, and USAID provided technical assistance to the MOH to this end. The objective was to improve these systems so as to meet increased demand and satisfy the needs of the entire population, with the MOH presumably responsible for monitoring this work in the future.

One of the key components of the graduation plan was contraceptive security. USAID’s Latin America and Caribbean (LAC) Bureau provided technical assistance through USAID Office of Population and Reproductive Health central projects, most notably in creating a Contraceptive Security (CS) or DAIA Committee (Disponibilidad Asegurada de Insumos Anticonceptivos:

Ensured Availability of Contraceptives) that played a very important role in ensuring contraceptive availability.^{23,24}

USAID also provided technical assistance to develop and implement an agreement in El Salvador between the MOH and UNFPA as a procurement agent to purchase high quality contraceptives at reduced prices on the international market. This led to significant economies of scale in the joint purchase of contraceptives, optimizing financial resources and ensuring quality, safety and efficacy standards.

Overall, the graduation process appears to have been successful, based on criteria of access, service integration, quality of care and program sustainability. The government has taken responsibility for contraceptive procurement; contraceptive stock-outs are relatively infrequent; and MCPR has increased. However, El Salvador still faces major challenges in its family planning program in terms of training of personnel, contraceptive procurement and logistics, as discussed below.

Policies, Leadership, and Governance

Despite the creation of the Comprehensive Population Policy in 1974, the government provided no subsequent evidence of a clear commitment to FP. Health policies in El Salvador were based on pledges made at international conferences. As in other countries in Latin America, poverty, rural residency, education level, machismo, cultural and religious beliefs, gender discrimination, gender-based violence, and medical barriers had affected the government's effectiveness in promoting family planning.

As a result of the 1994 International Conference on Population and Development in Cairo and the 1995 World Conference on Women in Beijing, reproductive health initiatives extended beyond a framework of reproduction to include human rights, gender equality, empowerment of women, reducing sexual violence and other social determinants of health, and to address the needs of traditionally excluded or underserved groups. This process culminated in the ratification of the Sexual and Reproductive Health Policy in El Salvador by Executive Decree 1181 of August 5, 2012.²⁵ This policy is considered a major achievement, given that it established governmental laws and regulations that promote gender equity and equality, the eradication of discrimination against women, the full protection of children and adolescents, free medical care and other important topics for improving the health status of the Salvadoran people.

²³ USAID | DELIVER Project. USAID/DELIVER Project, 2010. *Compendio de Consejos Útiles, Mejorando los Mecanismos de Compra de Insumos Anticonceptivos*. Washington, DC: USAID | DELIVER Project; 2010. Available at:

http://deliver.jsi.com/dlvr_content/resources/allpubs/logisticsbriefs/MejoMecaCompInsumAntic.pdf.

²⁴ In July 2003, with support from UNFPA and USAID, the ministries of health in various Latin American countries met in Managua, Nicaragua, to launch an initiative known as Disponibilidad Asegurada de Insumos Anticonceptivos or DAIA (Assured Availability of Contraceptive Products). Later, each participating country developed its own national committee.

²⁵ Ministerio de Salud (MOH). *Política de Salud Sexual y Reproductiva*. San Salvador, El Salvador: MOH; 2012. Available at <https://www.salud.gob.sv/servicios/descargas/documentos/Documentaci%C3%B3n-Institucional/Pol%C3%ADtica-de-Salud-Sexual-y-Reproductiva/Politica-de-Salud-Sexual-y-Reproductiva/>.

The Plan for the Reduction of Maternal and Perinatal Mortality, in which FP plays a major role, was launched in 2010 and is a cornerstone for achieving safe motherhood. This plan is being implemented by the MOH and is scheduled to operate until 2014. Progress will be evaluated at the end to determine future actions.

El Salvador's legal framework reflects a clear commitment to FP as part of the National Health Agenda, and it is a priority for the MOH. However, budgetary constraints remain for ensuring the availability of supplies, human resources, infrastructure, and management information systems.

FAMILY PLANNING AND THE HEALTH SYSTEM

Service Delivery

Service delivery in El Salvador has followed the same pattern as elsewhere in Latin America, starting with clinical services offered by ADS, followed shortly thereafter by the MOH and the ISSS. Since 2007, the ISSS has increased its share as a source of FP services considerably.

The MOH is the main provider of female sterilization, and oral and injectable hormonal methods; ISSS is the leading source for IUDs; and the private pharmacies are the principal source for condoms.

In 1978, ADS established a social marketing program, which continues nationwide to sell oral methods, condoms, and vaginal tablets, mainly through pharmacies, convenience stores, and cooperatives.

The MOH community-based distribution strategy includes distributing oral contraceptives, condoms, and barrier methods, as well as information on natural methods, by MOH promoters, midwives, and youth volunteers. Primarily, these are distributed to low-income clients.

Starting in 2001 until graduation of FP assistance in El Salvador, USAID supported a social marketing strategy through the Pan American Social Marketing Organization (PASMO), which focused in condom distribution and promotion.

PASMO, with the support of a large anonymous donor, has increased the visibility and availability of the IUD in El Salvador, and is the only institution providing training and services for IUD insertion. It focuses on improving quality of care. The PASMO Red Segura Project (social franchise) promotes the use of long-acting, reversible methods (IUDs and subdermal implants) through partners (medical practitioners) who receive preferential rates for supplies, receive training, supervision and monitoring; PASMO offers slightly higher prices to non-members and promotes these methods through interpersonal communication and mass media.

A market segmentation analysis, carried out in El Salvador in June 2011 with USAID support, divided the population into three priority age groups: 15-19, 20-24, and 40-45; by area of residence; and by wealth quintiles to identify the characteristics of the groups most in need of FP

services and to develop specific strategies to meet their needs, so as to ensure contraceptive availability for all population segments and reduce unmet need.²⁶

In summary, FP service delivery currently reaches all parts of the country through different mechanisms with a variety of methods.

Human Resources

As of 2014, the MOH had 30 national hospitals of second and third level of attention, 377 Health Units and 692 Community-based Family Health Units. The number of ambulatory health units between MOH and ISSS was 1,241. FP services are offered free of charge in all units. The MOH has a health workforce of 28,948 human resources among doctors, professional nurses and maternal child health care workers. Of the total, 75.4 percent were professional staff and 24.6 percent, administrative staff. Only 3.5 percent of the health workforce was working at the central level; 52.7 percent worked in the 30 hospitals that correspond to the second- and third-levels of attention. The remaining 43.8 percent worked in different categories that corresponded to the first level of attention. This included 3,320 health promoters that integrate family planning in their activities. The MOH has technical personnel at the central and regional levels, and service providers are trained to provide counseling and FP technology in all its units. El Salvador has 20 doctors per 10,000 inhabitants.²⁷

ADS provides services at 11 clinics in major cities and through a network of volunteer promoters at the community level. ADS has a cadre of 808 health promoters who work in FP and sexual and reproductive health (SRH), 651 multipliers, promoters and youth leaders that work with youth and adolescents, 165 peer multipliers who work in information, education, and communication activities for STI/HIV-aids prevention, and 36 male promoters who work in awareness raising and training activities in SRH and masculinidades (masculinities), in particular in the rural areas.

For decades, El Salvador received technical assistance from USAID to train staff working in family planning and to provide continuing education with updates on new methods and findings from evidence-based medicine. However, since 2010, USAID has discontinued its funding of these activities, leaving the local institutions with the responsibility of keeping staff updated and ensuring adequate monitoring and supervision to the service provider institutions.

Since 1998, the MOH has implemented specific guidelines and standards of care for FP users in the primary and secondary levels of attention and at the community level. FP services reflect the new approach based on sexual and reproductive rights, adequate counseling and the principles of free and informed choice, among others. Care guidelines were updated as WHO medical eligibility and informed consent criteria evolved, particularly with regard to voluntary surgical contraception. The technical skills of primary and secondary health care providers were

²⁶ USAID | DELIVER Project. *El Salvador: Análisis del Mercado de Anticonceptivos por Grupos Etarios: una Herramienta para Mejorar la Disponibilidad de Insumos*. Washington, DC: USAID | DELIVER Project; 2011.

²⁷ Rodríguez M, Espinoza E, Menjivar E. *Informe de Labores 2012-2013*. San Salvador, El Salvador: Ministerio de Salud; 2014.

strengthened through training in the use of care and counseling guidelines to improve access in rural areas and to avoid the frequent staff turnover common in public services, which results in gaps in knowledge or skills among non-qualified staff.

Despite the government commitment to FP and implementation of appropriate guidelines, observers cite numerous persistent problems: inadequate compliance with norms and guidelines for multiple reasons (inadequate institutionalization, lack of training of new staff, lack of mechanisms to enforce compliance among service providers); overworked service providers in the MOH and ISSS who are unable to provide quality services to the large numbers of clients that seek them; and lack of availability of the client's preferred method, especially in rural areas. Finally, the bureaucratic structures of the MOH and the ISSS make it difficult to take action on this set of problems.

Information Systems

In 1973, with support from USAID, ADS conducted the first Encuesta Nacional de Salud Familiar (FESAL, National Family Health Surveys). Since then, these Demographic and Health Surveys (DHS) or Reproductive Health Surveys (RHS) were conducted regularly every five years until 2008. As in other countries, they have become the main source of health and demographic information for decision-making in the public and private sector.

After USAID's withdrawal of financial assistance for FP in El Salvador, the MOH replaced the DHS/RHS surveys with the MICS 2013-14 (known locally as the Encuesta de Indicadores Múltiples por Conglomerados, or Multiple Indicator Cluster Survey), with partial support from the United Nation's Children's Fund.

Apart from that, MOH FP logistics information systems have evolved systematically over time. A program module specific to FP was implemented in 1999 with USAID support to keep records on use of temporary family planning methods. Another module gathers information on use of permanent methods. Both provide logistical information that is crucial for monitoring and evaluating the program at the national level. According to local observers, this program works efficiently.

FP is the only institutional program that has a subsystem within the Sistema de Consumos y Existencias de Medicamentos (Medicine Use and Inventory System), with processes defined and standardized in a regulatory document at the ministerial level. In 2009, FP management reports on contraceptive supplies were incorporated into the Sistema Nacional de Abastecimiento de Medicamentos (SINAB, National Medicine Supply System).

It is necessary to maintain and update training for a cadre of qualified personnel to manage logistics at the local level, to ensure that timely and accurate information is always available for decision-making, and to ensure an adequate supply of contraceptives to meet user demand.

Faced with these challenges, the MOH has declared its commitment to elevate the issue of contraceptive security and logistics to the level of decision-makers; to maintain technical capacity at the national, regional and central level to ensure the smooth flow of contraceptive

logistics in a sustainable manner; and to track these processes in an effort to guarantee continuity in the system. However, at this time, many observers express considerable concern about the capacity of the MOH to successfully handle the contraceptive logistics process.

Commodities and Medical Supplies

Ministerial Resolution 2299 of the Ministry of Health, issued in September 2004 with USAID support, established an agreement between the MOH and UNFPA as a third-party procurement agent to take advantage of economies of scale and ensure branded and generic product quality. In 2005, this resulted in financial savings of about U.S. \$2 million. In 2008, an agreement was signed between the MOH and ISSS giving the latter access to the UNFPA procurement mechanism. The agreement stipulated that, when deemed necessary, both institutions may make joint purchases of medicines under the existing agreement with the MOH. This stipulation helped ISSS make cost-effective purchases and take advantage of the lessons learned from the MOH procurement process, without having to start from scratch.²⁸

In his inaugural speech in June 2009, President Mauricio Funes stated that the Ministry of Health would guarantee the supply of 100 percent of the items on the Essential Drug List, which includes hormonal contraceptives (injectables and oral pills). This was achieved as of 2010.

Contraceptive Security (DAIA)

As previously mentioned, a key intervention of the graduation strategy was the creation of the DAIA committee, for which USAID provided major technical support. This committee was formed in early 2005 and became official in September 2006, under Ministerial Resolution 2215. DAIA members were sworn in on January 23, 2007. Three specific areas of operation were established: (1) political commitment and leadership; (2) financing; and (3) family planning logistics management and market segmentation.

The committee's work plans have been reviewed and updated periodically since 2005. Some of its main achievements have been: the official appointment of the committee; recognition of the importance of the DAIA within the institutions represented in the committee; significant savings achieved by purchasing contraceptives through UNFPA; and monitoring the procurement agreement with UNFPA. As part of the graduation process, a FP market segmentation study was conducted and a contraceptive security plan established in 2006 between the MOH and USAID for gradual reduction of funding and progressive contribution of government funds for contraceptive procurement.

The DAIA committee achieved these and other outcomes as a result of multiple factors: the strong support of international organizations, particularly USAID and UNFPA, to working jointly in this area; committee members' ownership and empowerment; political will and support of FP as a pillar of safe motherhood; and participation in regional meetings where countries

²⁸ Olson N, Sanchez A, Reynoso A. *The Procurement of Contraceptives in Latin America and the Caribbean—An Analysis of Current and Future Options in Eight Countries*. Arlington, VA: USAID | DELIVER Project; 2010.

shared successful experiences. In the process, DAIA committee members became more aware of the importance of contraceptive security to maintaining high levels of MCPR and recommended that other sectors be included in the committee, such as other programs of the MOH (Adolescent Program, Regulations Directorate, Acquisitions and Institutional Contracting Unit), other government institutions (Military Health Board, Ministry of Finance, Congress), and members of the civil society. El Salvador also benefited from the lessons learned from the laws and policies that other countries have enacted.

However, procurement problems have persisted both at the international and national level. Internationally, there have been delays resulting from UNFPA and manufacturers' processes, late delivery of products by UNFPA, and non-availability of certain contraceptives at the global level. At the national level, problems have included delayed budget approval by the Ministry of Finance, lack of administrative capacity for expediting the process, and turnover of specialized staff in public institutions working in these areas. Addressing the problems will require coordination among the international, governmental, and programmatic staff working to ensure contraceptive security.

ADS intends to continue to pursue sustainability strategies including “cross subsidies”, which use the profits of strategic business units such as the hospital, pharmacy, Profamilia clinical laboratory and marketing of contraceptives to finance social programs, including FP.

Financing

The MOH in El Salvador steadily increased the percentage of funding to procure the country's total contraceptive needs in the past decade from about 53 percent in 2006 to 62 percent in 2007, 75 percent in 2008, and 84 percent in 2009, at which time USAID funding ended. (The total requirements ranged between U.S. \$850,000 and U.S. \$975,000 for 2008 and 2009.) As of 2010, the ministry bought 100 percent of the required contraceptives for the public sector.

In recent years, the MOH has secured a minimum annual certified allocation of U.S. \$500,000 from the government for contraceptive procurement. However, the required amount has been higher. To fill the gap between total amount allocated and actual amount required, the MOH has met with the supply and financial units' staffs to justify the need to assign sufficient funds for timely procurement. If a gap persists, a yearly budgetary adjustment is usually requested by the MOH from the Ministry of Finance, and this is usually approved.²⁹

In short, problems in the timely procurement of adequate quantities of contraceptives continue. Although an annual allocation has been assigned, there is no budget line earmarked specifically for acquisition of family planning commodities. Funds have been allocated and political will is expressed at the presidential level. However, in practice, there are fluctuations in the program's resource allocations (e.g., human resources, commodities and supplies). The withdrawal of USAID financial assistance and an increased demand for FP services has added pressure on the MOH budget, making it difficult to cover all needs.

²⁹ Olson, Sánchez & Reynoso, 2010.

LOOKING TO THE FUTURE

Adolescent fertility remains a major challenge for FP programs in El Salvador. The widest bars on the 2010 population pyramid for El Salvador are for ages 10 to 24, representing young people entering their reproductive years who will require sexual and reproductive health services as well as jobs. Limited sexual education and low service coverage, coupled with an incomplete and unequal opportunity structure, has fostered early pregnancy.

Sources knowledgeable about internal migration from the countryside to the city state that change has influenced girls' and adolescents' behavior with regard to contraceptive use. San Salvador is one of Latin America's fastest growing capitals, and FP services are readily available in clinics. Although there are still traditional taboos against requesting information on contraception, young migrants are exposed to new social norms and behaviors and do not feel as constrained as their counterparts in rural areas in terms of seeking family planning.

Market research has been conducted to better understand the needs of this important but vulnerable population group and to design strategies to serve them. ADS has designed FP communication campaigns specifically aimed at young people, despite strong criticism from conservative groups that oppose sexual education for adolescents.

As of 2014, the government of El Salvador remains strongly committed to family planning, which has been integrated into health services provided by the MOH and ISSS. As other issues take on new importance on the health agenda (e.g., malnutrition, violence prevention, gender-based violence), it will be important for the MOH to maintain a strong focus on the delivery of quality FP services for all segments of the population.

Addressing Challenges

Several key steps must take place to ensure the availability of contraceptives and optimizing the family planning program in El Salvador include:

1. creating a budget line specifically earmarked for contraceptive procurement in the MOH, which anticipates future demand increases, and ensuring ongoing advocacy efforts to obtain it;
2. increasing access to sexual and reproductive health education for young people and adolescents to try to lower the high adolescent fertility rate;
3. ensuring sustainability of monitoring and supervision in the provision of family planning services and logistics management at the local level;
4. systematizing the process of forecasting of contraceptive needs at the regional level, with support from the central level, through sustained use of monitoring, forecasting and demand planning tools, such as PipeLine;³⁰
5. reducing contraceptive shortages, particularly in rural areas;

³⁰ PipeLine is a monitoring and procurement planning system designed by John Snow, Inc. Deliver Project to help program managers monitor the status of their product pipelines and product procurement plans. PipeLine provides information needed to ensure the regular and consistent stock of products at the program or national level.

6. increasing the availability of family planning methods, particularly in rural areas, where access is still difficult and quality services are scarce;
7. studying medical and cultural barriers in order to deliver culturally sensitive FP services, especially in rural areas;
8. maintaining an advocacy and IEC strategy to neutralize the opposition and increase access to broader information and quality education on sexual and reproductive health for male and female adolescents;
9. improving coordination and collaboration systematically and effectively among key actors in family planning and sexual and reproductive health, including the MOH, ISSS, ADS, PASMO, women's organizations, NGOs, service providers and international cooperating institutions; and
10. securing funding for a series of important activities, including research on fertility and FP (e.g., DHS), statistical analysis for decision making, staff training, and professional development to remain up-to-date on contraceptive technologies.

CONCLUSIONS

El Salvador has made enormous progress in terms of family planning over the past five decades. It has reduced fertility rates; it has developed a robust legal and regulatory framework for FP; it has allocated resources for procuring contraceptives for its population; it now offers information and contraceptive services to the entire population of the country with the active participation of civil society organizations, especially women's organizations. ISSS has increased contraceptive supply to its affiliates and their dependents and has become a model in the region in terms of the breadth of FP coverage provided.

Work with adolescents must be strengthened to promote responsible sexual behavior and parenthood. The awareness of officials of the different agencies involved in procuring contraceptives should be raised to ensure timely procurement. The political will of the current government and international efforts to improve health status and well-being should help ensure that health, economic and social development in this enterprising country becomes a reality for its entire population.

MEASURE Evaluation

Carolina Population Center
400 Meadowmont Village Circle, 3rd Floor
Chapel Hill, NC 27517

<http://www.measureevaluation.org>