Technical Report 13: Improving the Quality and Availability of Family Planning and Reproductive Health Services at the Primary Care Level: Institutional Capacity Building in the El Salvador Ministry of Health (MOH)

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PRIME is a project for training and supporting primary providers of reproductive health services around the world. PRIME is implemented by INTRAH in collaboration with ACNM, IPAS, PATH, TRG, Inc., OMG Booksource and AMZCO, Inc.

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Highlights from Interviews with PRIME El Salvador Project Participants

The greatest results of the project have been the increase in provider knowledge about methods and how to use them. Before we only knew about hormonal methods, not about injectables. Another key result is the training in counseling and side effects, and how to counsel a patient to not be afraid of side effects. Before clients would discontinue methods, so the training has reduced discontinuations. Another thing that has helped us greatly is the training not only of doctors and nurses, but also of parteras and promoters. We have new services and a new network [cadre] !

- Director of Client Care (FP/RH Services), MOH

[Family planning services] are much more feasible to the local population,who are quite dispersed and who don't have access to the Health Units. So, to be in the community [with newly trained promoters and parteras] greatly increases access.

- Department-level Nursing Supervisor, MOH.

We've seen [improved quaility of services] through the counseling - the client accepts the methods, and doesn't discontinue them. The people are more aware of side effects and they accept them.

-Department-level Nursing Supervisor, MOH.

Care of the patient has improved; It is more humane. The patient is receiving more integrated care, for example in counseling, which was practically unknown previously. The providers explain the side effects, and the patient can choose a method. Previously, we made the choice; now they can decide. For example, before the doctor would say, "here are the pills".

-Department-level Medical Supervisor, MOH.

In the approach to family planning - in whatever service, they (providers) provide counseling - you don't miss an opportunity - that's the impact that the project has had.

- Department-level Nursing Supervisor, MOH.

The [PRIME Project] philosophy is one of change, of doing, of expanding knowledge so that more people will understand what family planning is.

- Director of Family Planning, ISSS.

Having local staff is different from other international technical assistance agencies. We are always talking.

- A Senior Central-level MOH official.

"PRIME staff didn't say, "do this and this." It was a collaboration, sharing our/their experiences with those of the ADS, resulting in a project that we're all a part of."

- Executive Director, ADS.

Table of Contents

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Abbreviations

ADS	Salvadoran Demographic Association, the Local IPPF Affiliate (*Asociación Demográfica Salvadoreña*)
AID	United States Agency for International Development
APSISA	Project for USAID-funding of the MOH
CMT	Communication, Management and Training Division of AID, Washington, DC
COPE	Client-Oriented, Provider-Effective Approach
CPI	Client-Provider Interaction
CPR	Contraceptive Prevalence Rate
DA	Development Associates, Inc.
DHS	Demographic Health Surveys
EDD	Evaluation, Documentation, and Dissemination Initiative
FESAL	Demographic Health Survey for El Salvador
FHI	Family Health International
FP	Family Planning
IPPF	International Planned Parenthood Federation
LAC	Latin America and the Caribbean
IRH	Integrated Reproductive Health
ISSS	Salvadoran Social Security Institute (*Instituto Salvadoreño de Seguro Social*)
MOH	Ministry of Health (*Ministerio de Salud Pública y Asistencia*)
NGO	Non-governmental Organization
PATH	Program for Appropriate Technology in Health, a PRIME Partner
PHNC	Population, Health and Nutrition Center of USAID in Washington, DC
PRB	Population Reference Bureau
PRIME	Project for Training Primary Providers of Reproductive Health Services
RH	Reproductive Health
RPC	Resident Project Coordinator
SALSA	*Salvadoreños Saludables* Project (Healthy Salvadorans)
STI	Sexually-Transmitted Infection
TA	Technical Assistance
TBA	Traditional Birth Attendant (*partera*)
TNA	Training Needs Assessment
TFR	Total Fertility Rate
TOT	Training of Trainers Workshops
USAID	United States Agency for International Development

Executive Summary

In May 1999 Ms. Diane N. Catotti, INTRAH/PRIME Management and Training Specialist, traveled to El Salvador to begin documenting the impact of the PRIME El Salvador Project, entitled Strengthening the Quality and Availability of Family Planning and Reproductive Health (FP/RH) Services at the Primary Care Level of the Ministry of Health (MOH) of El Salvador. Ms. Catotti conducted 24 semi-structured interviews with project participants using an Evaluation, Documentation, and Dissemination (EDD) methodology as part of the EDD initiative of the PRIME Evaluation and Research Unit. Ms. Catotti interviewed central, Departmental, Health Unit and community level staff of the MOH, including the project director, physicians, nurses, promoters and *parteras* (traditional birth attendants, TBAs). Ms. Catotti also interviewed representatives of the APSISA Project, the Salvadoran Demographic Association (ADS), the Salvadoran Social Security Institute (ISSS), and USAID/El Salvador. Ms. Catotti applied an EDD training capacity building questionnaire with Ms. MariCarmen Estrada, Reproductive Health Officer, USAID/El Salvador and prior to the trip with Mr. William Cohn, Senior Program Officer for Latin America and the Caribbean (LAC), Family Health International (FHI). Local and regional PRIME staff were interviewed for background on the project.

This technical report will describe the components and early impact of the first phase of the PRIME El Salvador project, which was conducted under APSISA auspices, the project developed to implement USAID funding of the MOH. The report will also discuss the EDD methodology and will present a comparison of indicators of training capacity in 1997, prior to the initiation of the PRIME El Salvador project, and in 1999, after 12 or more months of PRIME Project activity.

Phase I PRIME El Salvador project activities included:

- Establishment of a local PRIME office in El Salvador, including the hiring of Dr. Douglas Jarquín as Resident Project Coordinator (RPC) and additional local staff
- Department, Health Unit, and community level FP/RH training for physicians and nurses, promoters, and *parteras*
- Development of training support and client education materials
- Contraceptive logistics and management.

In addition, PRIME El Salvador staff participated in an inter-agency technical working group that was charged with developing a consensus around FP/RH issues, and ultimately developed new FP/RH norms. The revised norms, which allow promoters to provide injectables and dispense oral contraceptives, were approved by the MOH in April 1999 and will be disseminated by PRIME within the MOH.

The project has trained more than 4,000 people at the Department, Health Unit and community levels over a 12-month period in FP/RH issues and has strengthened the contraceptive logistics and management system of the MOH. More than 100 Department level MOH staff were trained in training of trainer (TOT) workshops to conduct RH/FP training with PRIME oversight. PRIME developed several training support materials, including curricula for physicians/nurses, promoters, and parteras, on-the-job support materials, and client education materials thereby increasing the availability of quality FP method information for clients and providers. In an unprecedented effort of interagency collaboration, the three primary FP/RH service providers in El Salvador, the MOH, ADS, and ISSS, jointly participated in materials development and pre-testing.

PRIME worked within the existing MOH training, supervision, and service delivery structure, expanding access and availability, and resolving some barriers to FP service delivery, particularly at the community level. By working within the existing MOH structure, the project directly built capacity and helped to ensure the sustainability of training. PRIME training has improved the skills of community-based providers and their supervisors at the Health Unit and Department level, and has expanded their ability to provide quality FP services. Project personnel have noted early indications of increased access to FP services and improved quality of care at the primary level as a result of PRIME Project interventions, particularly in improved capacity to counsel clients and improved client-provider interaction.

MOH and other agency personnel were pleased with the technical assistance provided by PRIME, and spoke highly of both the local and regional PRIME staff.

OVERVIEW

In 1997, with technical assistance from PRIME, the Salvadoran Ministry of Health (MOH) developed a National Reproductive Health/Family Planning (RH/FP) Plan for 1998-1999, which identified weaknesses in FP/RH service delivery (See Appendix I.) Several problems were identified, including:

- Low contraceptive prevalence rates among low income and lesser educated women
- High sterilization rates
- Side effects as the primary cause of method discontinuation
- Medical and other barriers to service provision
- Out of date FP/RH norms, and
- Inadequate contraceptive supplies.

Data that illustrate these problems are provided for El Salvador and other comparison countries in Table 1 below. Demographic health survey (DHS) data illustrate a total fertility rate (TFR) in El Salvador of 3.85, and a contraceptive prevalence rate (CPR) of 53% (FESAL, 1993). But among less educated and low socio-economic status women, the TFR is 5.4, and the CPR is 38%. High sterilization rates also were identified as a problem. As noted in Table 1, nearly 60% of total family planning clients in El Salvador use female sterilization (65% among FP users in the lower socio-economic level), as compared with 33% in Honduras and 18% in the United States. Effective temporary methods are used by only 10% of women of lower socio-economic status.

Table 1: Population Data: El Salvador and Selected Countries.

	El Salvador		Guatemala	Honduras	USA
	Total	Low socio-economic status			
% Of All FP Users Using Female Sterilization	59	65	45	33	18
Total Fertility Rate	3.9	5.4	5.1	4.4	2
Contraceptive Prevalence Rate	53	38	31	50	71
Temporary Method Use (%)	–	10	–	–	–
Population (in millions)	5.8	–	11.6	5.9	270.2

Source: FESAL (DHS) 1993; World Population Data Sheet, Population Reference Bureau, 1998; National Center for Health Statistics, 1997.

Medical and other barriers to service provision also were identified as a problem. For example, rural clients must visit Health Units (clinics) for a medical examination prior to starting use of contraceptive methods. Community-based promoters can only re-supply methods once initiated by Health Unit staff. Promoters also are not allowed

to provide contraceptive injectables, although they do administer childhood vaccines by injection. These restrictions are noted in 1991 MOH service norms (*Normas técnicas de la atención en planificación familiar*), which contain very limited and out of date contraceptive information.

Another problem identified in the MOH RH/FP Plan was inadequate contraceptive supplies. There is a significant unmet demand for injectables throughout El Salvador; 32% of those wishing to use contraception and not presently doing so desired the injectable.

PROJECT GOAL AND STRATEGY

The MOH RH/FP plan proposed interventions and appropriate institutions to address the problems noted above. The MOH identified training of community-based promoters and *parteras* as a key intervention, since these FP/RH service providers were seen as the primary contact with rural, low socio-economic status and lesser-educated women. The MOH requested PRIME assistance to train community-based promoters and *parteras* in FP education, distribution and referral. In addition, PRIME was requested to train all Health Unit staff, especially partera and promoter supervisors. PRIME was identified as the appropriate institution for technical assistance in several other areas, including developing training support and client education materials.

Subsequently, PRIME developed a proposal for funding by USAID/El Salvador in early 1998. The goal of the PRIME Project was:

To expand and strengthen family planning services at the primary level and to improve the quality and range of FP/RH services provided by promoters and *parteras*.

The PRIME country strategy was:
To support MOH efforts to improve and expand FP/RH services at the primary level through an improved training program.

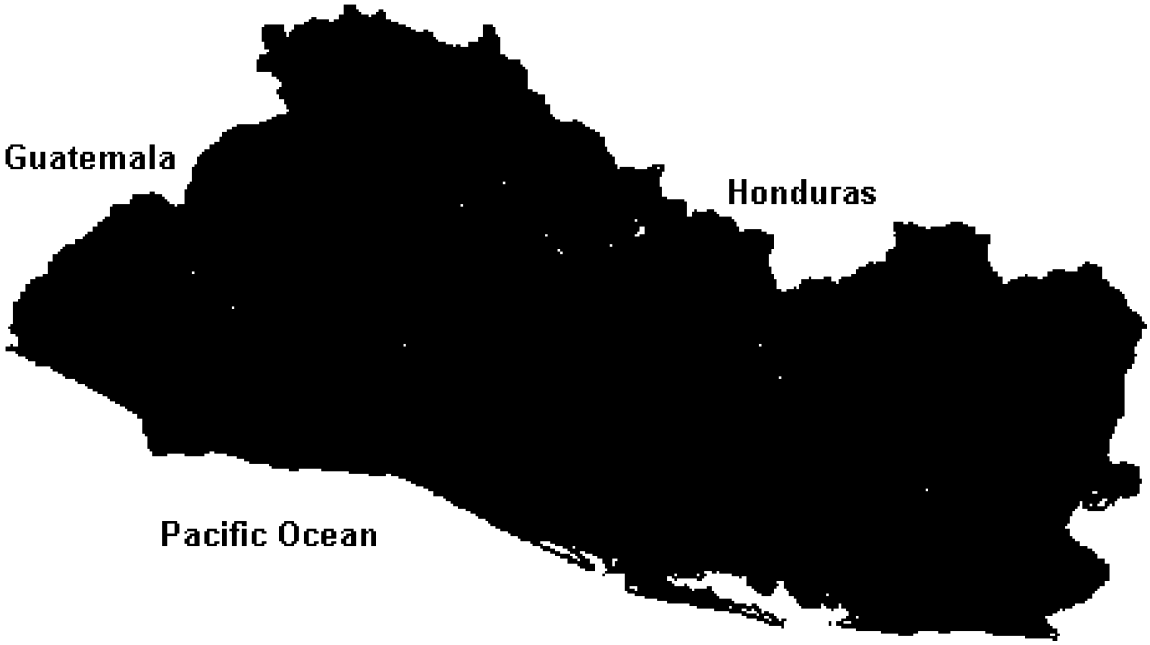
PROJECT DESIGN

Two proposals were approved and funded by USAID/El Salvador, the first on FP/RH training, and the second, expansion proposal on contraceptive logistics and project management. Subsequently, a third proposal (Phase II) was approved to conduct expanded RH activities under the SALSA project. However, those activities began in June 1999 and are beyond the scope of this technical report.
The first phase of the PRIME El Salvador project (March 1998 to September 1999) was conducted under APSISA, the project developed to implement USAID funding of the MOH. Phase I PRIME El Salvador project activities included:

- Establishment of a local PRIME office in El Salvador, including hiring Dr. J. Douglas Jarquín as Resident Project Coordinator (RPC) and additional staff
- Provision of Department, Health Unit, and community level FP/RH training for physicians and nurses, promoters, and *parteras*.
- Development of training support and client education materials, and
- Improvements in contraceptive logistics systems and management.

These activities will be discussed, in turn, below.

Figure 1: Map of El Salvador by Department



Source: USAID/El Salvador website, 1999.

In addition to these project activities, PRIME El Salvador staff participated in an inter-agency technical working group, led by Family Health International, that was charged with developing a consensus around FP/RH issues. The working group included representatives from the MOH, various non-governmental organizations (NGOs), the local International Planned Parenthood Federation (IPPF) affiliate, the Salvadoran Demographic Association (ADS); the Salvadoran Social Security Institute (ISSS); and the Obstetrician/Gynecologist (OB/GYN) society, among others. Ultimately the group was able to address medical and normative barriers to service provision, and developed new FP/RH norms. These revised norms reflect WHO eligibility guidelines, and allow promoters to provide injectables and dispense oral contraceptives. The new norms were approved by the MOH in April 1999. PRIME will disseminate the updated FP/RH norms nationwide within the MOH in August 1999.

Local PRIME El Salvador staff was hired beginning in April 1998. Subsequently, all project activities were conducted by in-country staff with technical assistance provided by PRIME LAC Regional Office staff and consultants. (For a complete list of key project participants, see Appendix II.)

FP/RH Training

Health services are provided by the MOH primarily at the Health Unit (local clinic) and community-level, with supervision and management units in each of the 18 Departments of El Salvador. (See Figure 1 above for a map of El Salvador by Department.) There are 14 Departments (states), plus 4 additional Departments in the capital area of San Salvador. There are training teams in each of the MOH Departments, composed of 1 to 2 medical and nursing supervisors, and sometimes an educator. These training teams conduct routine on-the-job training at the Health Unit level on a variety of topics, usually once a month. There are 350 MOH Health Units corresponding to the 18 Departments. For example, there are 24 Health Units reporting to the Department of La Libertad. In that Department, there are two medical supervisors and two nursing supervisors who each are responsible for training of physicians and nurses, respectively, in 12 Health Units. In turn, community-based promoters and *parteras* are supervised by staff in each of the Health Units.

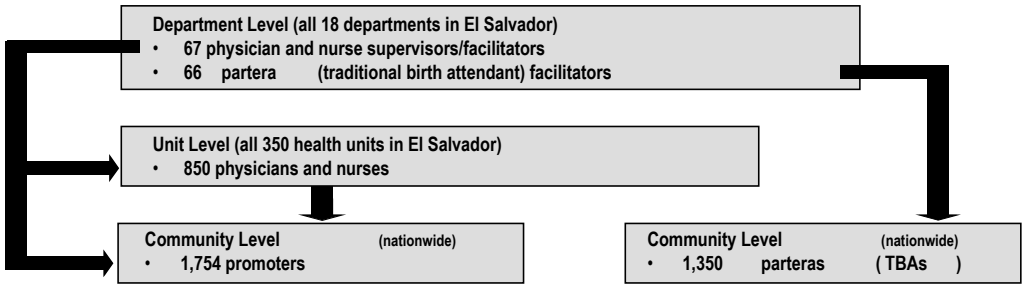
The FP/RH training program undertaken by PRIME in El Salvador was quite ambitious and detailed. More than 4,000 people were trained in more than 200 workshops at the Department, Health Unit and community level of the MOH in a 12-month period. More than 100 Department level MOH staff were trained in training of trainer (TOT) workshops to conduct the training with PRIME oversight. The training was conducted nationwide, at all levels, within the existing decentralized MOH training, supervision, and service delivery structure. Working within the existing MOH structure addressed access and availability issues, as well as resolved some barriers to service delivery. And, it directly built capacity and helped to ensure the sustainability of training.

Figure 2 below graphically illustrates the training conducted by PRIME in El Salvador. PRIME/El Salvador staff, Dr. Jarquín and Ms. Luz Elda Aguirre, and Dr. Milton Cordero, PRIME/LAC Reproductive Health Specialist, led the PRIME training efforts. Training was conducted at the Department, Health Unit and community level using 3 different curricula, all of which reflect the updated FP/RH norms. First, a curriculum was developed for Health Unit physicians/nurses that included updated contraceptive method information, and sections on counseling, communication and human sexuality. PRIME staff used this curriculum to train 67 Department level facilitators (medical and nursing supervisors) in all 18 Departments in 4 TOTs conducted from May to June, 1998. This exceeded the goal of training 56 trainers in TOT noted in the PRIME Project proposal. In turn, in conjunction with PRIME staff, these facilitators used that curriculum to train Health Unit physicians

and nurses. Specifically, 46 4-day workshops were conducted for more than 850 MOH physicians and nurses in all 350 Health Units from July to November, 1998.

In addition, 14 FP providers and program managers from the four geographic service delivery regions of the ISSS participated in the training (approximately 4 from each), thereby expanding the training methodology to another leading Salvadoran FP/RH service institution. The involvement of ISSS personnel was not originally planned for in the PRIME El Salvador project proposal, but was added later.

Figure 2: PRIME FP/RH Training in El Salvador



Training for community-based promoters was conducted by teams comprised of at least one Department level facilitator in combination with 1 or 2 Health Unit PRIME-trained staff, with oversight by PRIME/EL Salvador staff. Promoters were trained in a second curriculum developed specifically for them that emphasized birth spacing, human sexuality, contraceptive education, administration of specific contraceptive methods (pills and injectables), management of side effects, contraindications and referral. More than 1,500 practicing promoters and 240 new promoters were trained in FP/RH counseling and referral in 88 4-day workshops from March to June, 1999. This training exceeded the goal noted in the Phase I PRIME Project proposal to train approximately 1,450 promoters, and included an entire new cadre of 240 promoters.

A third curriculum was developed by PRIME for training of *parteras* (TBAs). Data indicate that 80% of the MOH *parteras* are illiterate, and only 5% have higher than a third grade education. Therefore, a low-literacy curriculum was needed. The PRIME partera curriculum is pictorial and emphasizes birth spacing, updated contraceptive method information; counseling and communication and human sexuality. For example, to emphasize the importance of birth spacing, two pictures of a cornfield are used. In the first image corn stalks are crammed together and some are falling over. In the second image of a healthy field, the stalks are spaced apart. In the partera training workshops, discussion involved a comparison of the images of the two cornfields, and their similarities to the importance of spacing pregnancies in order to have healthy children. A good harvest and a high crop yield would result from the well-spaced planting of seedlings, an image to which these rural women (predominantly from farming communities) could well relate.

Sixty-six Department level facilitators with experience in training *parteras* were trained in using this low-literacy curriculum in 3 TOT workshops in April 1999.

They subsequently trained 1,350 traditional birth attendants in 88 3-day workshops over a 10-week period from May to July, 1999. This training exceeded the PRIME Project goal of training 1,200 *parteras*.

Tables 1, 2, and 3 in Appendix III illustrate the schedule of PRIME training of Health Unit staff, promoters and *parteras*.

As noted above, the training intervention developed by PRIME was designed to improve the skills, and ultimately the quality of care provided by Health Unit and community-based providers of FP/RH services. In order to assure the quality of training, specific quality assurance measures were included in the project design. Baseline data collection was conducted on FP/RH service delivery prior to training. Specifically, an observational survey and client/clinic exit interviews were conducted in selected Health Units to measure user satisfaction and service quality. In addition, pre- and post-tests of participant knowledge and skills were conducted during training workshops. And, follow-up supervision visits were conducted on-the-job following training. Results of these evaluations are forthcoming. They are expected to provide quantitative data to support the qualitative data presented in this report.

Training Support Materials

In preparation for and in conjunction with the training, PRIME developed several training support materials, including the curricula mentioned above, on-the-job support materials, and client education materials (See Table 2: Training Support Materials, below, and Appendix IX for a reference list of PRIME Project documents.) Ms. Annie Portella, Materials Development Specialist, led PRIME efforts in this area under a subcontract with Development Associates (DA). The development of these materials directly addressed the lack of support materials for family planning services noted in the MOH National RH/FP Plan for 1998 - 1999. Specifically, PRIME developed two manuals for promoters to use on-the-job following training. The orientation manual provides information on contraceptive methods and counseling in accordance with the PRIME curricula and the new national FP/RH norms. The other manual contains technical information for easy reference on the job. PRIME also developed a low-literacy manual for Parteras to use "on-the-job". This manual contains flexible plastic pages about individual contraceptive methods that the *parteras* can use in promoting methods and counseling clients about them.

With technical assistance from Ms. Portella, PRIME developed numerous client education materials, including a FP methods poster, and three full-size "bed sheets" *(mantas)* painted with illustrative (graphic) information on FP methods, the menstrual cycle, and human reproduction that will be hung in the Health Units. These materials are geared toward educating clients and helping providers counsel them on contraceptive methods and birth spacing.

PRIME conducted interagency workshops for the development and validation of these educational support materials. In an unprecedented effort of interagency collaboration, the three primary FP/RH service providers in El Salvador, the MOH, ADS, and ISSS, jointly participated in materials development and pre-testing. This enabled the development of increased capacity and skills in materials development, and achieved a consensus among these institutions on the purpose, content and validity of the materials developed. All three institutions plan to use and distribute the client education materials nationwide, hence ensuring consistency in the FP/RH messages provided. As the Executive Director of the ADS noted, "This inter-institutional coordination was very good. Now we agree on content and use the same language in our educational materials." The FP/RH Director of the ISSS noted that they are now using the flip charts and drawings from the promoter manual in their educational sessions with clients.

Table 2: Training Support Materials Developed by PRIME

Curricula:

- Physicians and Nurses
- Promoters
- Parteras (low-literacy)

On-the-Job Support Materials:

- Promoter orientation manual
- Promoter reference manual
- *Partera* (TBA) orientation manual

Client Education Materials:

- FP methods poster
- Sheets *(mantas)*

- FP methods
- Menstruation
- Human RH

- - Pamphlets

Contraceptive Logistics and Management

As noted in the MOH RH/FP National Plan, the MOH wanted to improve their contraceptive logistics system to address temporary method supply shortfalls. USAID/El Salvador was to provide the commodities, specifically Depo-Provera®, and asked PRIME to help the MOH in improving logistics and contraceptive

management. First, PRIME staff, led by Mr. Sergio Lins, PRIME LAC Contraceptive Management Consultant, conducted an assessment of the contraceptive logistics system in El Salvador in October 1998 with visits to *bodegas* (local shops), pharmacies and warehouses throughout the country. Numerous problems were identified, including inadequate supplies, which were often out of proportion to clinic/client demand; lack of procedures for contraceptive method storage and inventory; unsorted and out of date contraceptive supplies; and inadequate climate control, among others. In response, PRIME developed a *Manual of Norms and Procedures in Contraceptive Method Administration*, and developed a plan for training of personnel involved in the storage and distribution of contraceptive supplies.

PRIME conducted contraceptive management and logistics training in six 3-day workshops from December 1998 through February 1999 for 101 supervisors, and pharmacy and warehouse-keepers. Eighty-nine percent of the 113 invited technicians from the different Health Departments and several hospitals participated in the workshops. The main objective of the workshops was to present the contraceptive logistics system as a management tool for sexual and reproductive health programs, and assure the effectiveness of the selection, acquisition, distribution and use of contraceptives. Specifically, participants were trained in selecting contraceptive methods, projecting future supply needs, selecting sources of supplies, establishing procedures for logistics management, assuring reliable transport for contraceptive supplies, developing a system of appropriate storage of supplies, assuring quality in handling of supplies and assuring the availability of supplies at service delivery points. Additional information on PRIME contraceptives logistics training can be found in *Ministry of Health El Salvador Final Evaluation Report, Contraceptives Logistics Workshops,* Sergio Lins, March 1999 (See Appendix IX.)

In subsequent, on-going activities, PRIME is helping to refine MOH supervision and physical inventory instruments in order to streamline the flow and recordkeeping for contraceptive supplies. In addition, in April 1999, PRIME/El Salvador staff trained 44 national level warehouse keepers in how to conduct a national physical inventory (*conteo físico*) of contraceptive supplies. And, in May 1999, PRIME facilitated the formation of a central-level logistics committee to deal with aspects of contraceptive procurement, storage, and pipeline management. With PRIME technical assistance, the committee is examining procedures and will make recommendations for changes to help address distribution and reporting requirements between the central warehouse, individual Departments, and the MOH.

EDD Methodology

In May of 1999, Ms. Diane N. Catotti, PRIME Management and Training Specialist, traveled to El Salvador to interview participants in the PRIME El Salvador Project as part of the Evaluation, Documentation, and Dissemination (EDD) intervention of the PRIME Research and Evaluation Unit. Ms. Catotti conducted 24 semi-structured interviews. The majority were with central, Departmental, and community-level staff

of the Ministry, including the project director, physicians, nurses, promoters and *parteras*, as well as representatives of APSISA, the ADS, the ISSS, and USAID/El Salvador. Ms. Catotti interviewed PRIME El Salvador and LAC staff for background on the project. (See Appendix IV for a list of persons interviewed.)

A Spanish-language INTRAH/PRIME EDD Impact Interview Guide was used to structure the interviews. An English copy of the Interview Guide is in Appendix VI. Interview questions focused on MOH training and service delivery, and the content and impact of the PRIME Project. For training participants, the purpose of the interviews was to get a first-hand impression of their experiences and their perceptions of the impact of the project.

Ms. Catotti also applied a more formal, in-depth EDD questionnaire methodology (Fort, 1998) with Ms. MariCarmen Estrada, Reproductive Health Officer, USAID/El Salvador, and prior to the trip with Mr. William Cohn, Senior Program Officer for LAC, Family Health International (FHI). USAID and FHI were selected in order to gain the perspective of others with direct knowledge of the PRIME project, but who were external to the MOH. Ms. Catotti included questions covering EDD questionnaire topics in interviews with MOH personnel, and used responses to complete an EDD questionnaire, representing an "aggregate" MOH response.

The EDD questionnaire was designed to assess capacity building in training. A copy of the EDD questionnaire is in Appendix VI. The questionnaire allowed for a comparison of indicators in 1997, prior to the initiation of the PRIME El Salvador project, and in 1999, after 12 or more months of PRIME Project activity. Indicators include the status of FP/RH service norms/guidelines, MOH training policy, budget, facilities, materials and equipment. Other indicators include the use of training needs assessment (TNA), the presence of decentralized training units, evidence of public-private collaboration in training, community involvement, public MOH statements in support of training and training replication, among others.

The focus of the PRIME El Salvador project was not to strengthen the MOH training system per se, but rather to strengthen MOH FP/RH services. However, training was a large component of the PRIME intervention, and the EDD methodology was useful in helping to assess and describe the impact of PRIME's involvement in strengthening MOH training.

A comparison of the EDD questionnaire responses is presented in Table 4 and Graph 1 in Appendix VII. EDD questionnaire responses (on a scale of a to d) were converted to numeric scores (of 1 to 4) and an average of responses was calculated. Specifically, a score of 1.8 was generated for the status of MOH training capacity in 1997. In comparison, a score of 2.8 was generated for 1999, less than 18-months after

initiation of PRIME Project activities. Hence, there is an indication of improvement in training capacity as a result of PRIME Project activities.

As noted in Table 4, in most cases there was consistency among the responses. In only a few cases did responses vary markedly. Some of these resulted from the interpretation of the question, re strictly defined MOH training systems, policies or plans versus PRIME FP/RH training interventions. Other responses with less correspondence, for example, the existence of adequate training venues, were beyond the scope of the project, and were not critical to its assessment. In other cases, there would be agreement on the "current" status of indicators for 1999, but some disagreement on where the MOH was in 1997, prior to PRIME Project intervention.

A summary of the status of the MOH training environment is presented here, and follows the order of indicators in Table 4.

(1) Updated FP/RH Guidelines: As noted earlier, in 1997, the MOH service norms were out of date, mandated that clients visit a Health Unit for contraceptive methods, and did not allow the provision of injections or pills by promoters. These norms have been updated, were approved by the MOH in April 1999, and will be disseminated within the MOH by PRIME in August 1999.

(2) Official Training Policy: Training policy was ad hoc.

(3) Positive Public Statements: Political support for FP/RH prior to PRIME was minimal or non-existent, and improved markedly under the PRIME Project with the full support of the Minister of Health and the Director of MOH FP/RH Services (*Departamento de Atención a la Persona*).

(4) Internal Training Budget: Historically, the MOH training budget comes primarily from USAID, through the APSISA and SALSA projects. The MOH supports staff and recurrent costs, as well as local training logistics costs. USAID supports all technical assistance, training materials development, production and distribution. This was consistent in 1997 and 1999.

(5) Adequate Training Venues: Training venues in El Salvador are adequate, but mostly private (hotel) facilities. This did not change during PRIME nor was it a component of the PRIME Project.

(6 & 7) Materials, Equimpment and Supplies (MES) and Capability for Updating MES: PRIME technical assistance was key to updating training and educational materials and curricula. Workshops were held for the development and validation of training and educational materials, and helped to build capacity in this area.

(8) Updated Trainer Knowledge and Skills (TOT): Under the PRIME Project, Department-level MOH training teams were trained in TOT and have replicated training with Health Units.

(9 & 12) Training Plan Exists and Training is Part of Strategic Plan: Training plans are required by USAID, and are produced annually by the MOH. This was consistent prior to and during the PRIME Project.

(10) Standard Training Curricula: Curricula existed for some cadres (physicians and nurses), but were out of date, had minimal FP method information and did not address counseling or side effects. Under the PRIME Project, new curricula were developed for Health Unit doctors and nurses, and community-based promoters and *parteras*.

(11) Quality of Care is Linked to Training Plans: Under the PRIME Project, all MOH training and training plans are linked with strategies for improved quality of care and increased service access.

(13) Public-Private Collaboration: There was minimal or no public-private collaboration regarding FP/RH issues prior to PRIME. There was improvement during the PRIME Project, most notably in the interagency collaboration on the development of educational materials and the revised FP/RH norms.

(14) Decentralized Training Units: Regarding training, the MOH system was decentralized but functioned in a cascade pattern where central level staff determined content of training which was then administered by departmental staff to Health Unit Staff.

(15) Human Resource Development as Part of Performance Improvement: Follow-up and supervision post-training is a component of the PRIME Project, and was part of standard MOH supervision prior to PRIME involvement.

(16) Training Needs Assessment (TNA): TNA is done on an ad hoc basis by the MOH, and was part of PRIME Project development.

(17) Management Information Systems (MIS) for Training: MIS for training exists only on paper at the Department level, and not at the central level. Information collected is limited to the name and position of trainees, dates and duration of training, and a notation of the training topic. Trainee pre and post-tests also are kept at the Department level. Central level reporting is limited to a notice that training was completed on a given topic for a certain number of people.

(18) Evaluation and Research (E&R) Feeds Training: The MOH does not routinely incorporate evaluation or research findings into training improvement. There has been some improvement in this area as additional information becomes available and is shared with the Ministry.

(19) Replicate Training Independently: As noted earlier, PRIME worked within the existing MOH training and service delivery structure. Training courses that use the PRIME curricula are currently being replicated by MOH staff with PRIME supervision.

(20) Community Involvement: Prior to PRIME there was little or no community involvement in training activities. Under the PRIME Project, community focus groups were conducted, primarily to validate educational materials.

Preliminary findings on the impact of the PRIME Project are described in more depth below.

PROJECT RESULTS

The PRIME El Salvador Project has had a considerable impact on the scope and quality of MOH FP/RH service delivery. The project interventions have directly addressed the "weaknesses" identified by the MOH in the 1998-1999 National Plan. Specifically, PRIME has helped to reduce medical and other barriers to service provision, revised out of date service norms, and improved management and logistics of contraceptive supplies. Through training of primary-level, community-based providers in temporary FP methods, counseling, and side effects, PRIME has helped to address low contraceptive prevalence rates among low income, rural women, high sterilization rates, and side effects as a leading cause of method discontinuation. Interviews with MOH personnel, at the central, departmental, Health Unit, and community level provide early anecdotal evidence of improved availability and access to FP services as a result of PRIME training and supporting interventions. There also is some evidence of improved quality of FP care, especially in improved counseling of clients and better client-provider interaction. In addition, training skills and methods have been improved through the project. By working through the existing MOH training and service delivery structure, these efforts have built training capacity and will be sustainable beyond the PRIME Project. Interviews with project participants indicate their enthusiasm for the project, including their high regard for the PRIME technical staff involved, and their optimism for expanded service access and availability. These findings are discussed, in turn, below.

The MOH Director of FP/RH Services (Client Care) summarized the success of the PRIME Project saying, "The greatest results of the project have been the increase in provider knowledge about methods and how to use them. Before we only knew about hormonal methods, not about injectables. Another key result is the training in counseling and side effects, and how to counsel a patient to not be afraid of side effects. Before clients would discontinue methods, so the training has reduced discontinuations. Another thing that has helped us greatly is the training not only of doctors and nurses, but also of *parteras* and promoters. We have new services and a new network (cadre)!" She continues, "The training has improved the referral system and has achieved its objectives. In the Health Units, they are masters of the same

methodology; they speak the same language on FP/RH. It has helped us greatly to work together. Now each department facilitates the process and they've formed their groups in the Health Units. They are well accepted. Before the hospitals would say the Health Units didn't know anything. "

Capacity Building

The PRIME Project has trained more than 4,000 people at the Department, Health Unit and community level of the MOH in FP/RH issues in a 12-month period, as well as providers of the ISSS. More than 100 Department level MOH trainers were trained in training of trainer (TOT) workshops on FP/RH concepts, and in turn, conducted the training of primary level staff with PRIME oversight. PRIME also has strengthened the contraceptive logistics and management system of the MOH through training and policy and procedural changes. Ministry staff considered the project to have contributed greatly to the training of Department and primary level staff in reproductive health and family planning concepts, as well as in logistics and management of contraceptive supplies. The training was perceived as having expanded the capacity of Ministry staff to conduct training and to provide family planning services at the community level, and improve the quality of services provided. The MOH Director of Client Care noted, "the technical personnel are very committed to improving reproductive health. Previously they weren't. In six months, I've seen the change."

USAID/El Salvador, the ADS, and the ISSS, who also had staff participate in the training, expressed support for the PRIME Project. USAID staff summarized the key results of the PRIME Project, noting that the project has empowered the Health Unit physicians and nurses. "They can now talk about family planning. They feel that they are building their capacity to conduct training. They feel better trained. And the promoters now feel like their colleagues." The Director of FP Services for the ISSS noted that her staff are now replicating the FP/RH training in each of the ISSS service regions. She noted, "this training has helped us greatly. The people attending the training shared the information. Now we are all speaking the same language."

Sustainability

The PRIME Project has contributed to USAID G/PHNC strategic objective (S.O.) 1 (increased use by women and men of voluntary practices that contribute to reduced fertility) and intermediate results (I.R.) objective 1.3 (Enhanced capacity for public, private, NGO and community-based organizations to design, implement, and evaluate sustainable family planning programs). By significantly contributing to the enhancement of training capacity at the Department and Health Unit level, the PRIME El Salvador project directly addresses the CMT Division Training strategic objective of improved provider performance and sustainable, national systems for training and education in family planning and reproductive health.

Efforts have been made throughout the PRIME El Salvador project to make results and training capacity sustainable. By working within the existing MOH training, supervision, and service delivery structure, sustainability is inherent to the project. The more than 4,000 providers trained nationwide by PRIME are staff of the Ministry, in addition to 14 people from the ISSS. PRIME conducted training of trainers (TOT) workshops for Department level trainers, who in turn trained Health Unit staff. These staff, in turn, trained community-level providers. This model was consistent with and reinforced the existing MOH decentralized training model, where Department level training teams are responsible for the training of Health Unit (primary) personnel. The personnel in the project, therefore, are considered to be a "lasting" or sustainable resource, as well as the training curricula which the MOH will continue to use. As one senior central-level MOH official noted, "We don't have funds for training, and even less for contraceptive logistics. It comes from AID. The MOH covers staff, expendable materials, and local logistics. AID, through APSISA and SALSA, pays for the training manuals, materials and distribution. But, the bulk comes from the Ministry. The program will continue after PRIME." ADS officials also noted the important role of PRIME in helping to achieve the sustainability of ADS FP/RH services through the co-development of a three year sustainability plan.

Training Impact

Participants at the Department and Health Unit levels noted improved training skills and styles following training workshops. Ministry staff praised the participatory methodology of PRIME training. Many project participants have had the opportunity to apply the skills learned in the workshops, replicating trainings with Health Unit staff and their own staff. Many of those interviewed noted that they had incorporated more participatory methods in their own training sessions with their staff. Several noted that their training approach is more lively and participatory. As one Department-level nursing supervisor noted, "[The project] has changed our training approach - now it is different. Before training was more rigid. Now it is dynamic. It is more participatory and more active. The technique is different. Before we would impose the themes. Now we are raising awareness among participants that each of them can assess their own needs." A Department-level medical supervisor said "Before [in standard introductory MOH training] we would provide training in one day; now we take 4 days. Before in one day, we would push, and push, and push, under a lot of pressure. Now you can have a discussion. The project has opened up our training programs, to approach an issue or problem." Another Department-level medical supervisor noted in regard to improved training, "The difference is fundamental. Before I would arrive at training, put myself in front of the room and talk. Now it is more participatory. I clarify doubts and listen to the participants. Never before have we had this kind of exchange."

PRIME training design also has helped to reduce some barriers to service provision. In addition to working to revise service norms governing distribution of methods by community-based staff, training included supervisors of community-based staff and involved them in their training. Health Unit level doctors and nurses, who supervise

community-based promotors, were responsible for their training under the PRIME Project. They now support and encourage promoters in service provision, rather than acting as barriers to that. One Department-level medical supervisor noted, "Before the groups [receiving training] were just physicians and nurses. Now we include the promoter supervisors and the educators. We work in a more integrated way." And on changing promoter roles, he said, "Before the promoters didn't provide any FP care. If a client wanted FP, they needed to get a reference to be seen at the Health Unit. Now, they can see someone in their community. We've improved the ability to care for clients."

In the Department of La Libertad, the medical supervisor noted having revised the Ministry's curriculum for the 11-week basic (orientation) training of promoters (provided to all incoming personnel) to reflect enhanced RH concepts and include more participatory training approaches. This was seen to be in direct response to PRIME training, and further "solidifies" the expansion of PRIME training methodology and topics into ongoing MOH systems.

Expanded Access to FP/RH Services

Department and Health Unit level staff interviewed noted an increase in access to family planning services as providers have been trained by PRIME in FP and RH concepts and counseling. Many praised the PRIME role in providing training to community-based service providers (promoters and *parteras* (midwives)), which was perceived as greatly improving the access of rural clients to FP services, specifically with injectables and oral contraceptives. Many noted PRIME's role in changing National FP/RH norms, to allow promoters to provide (initiate) these methods. A promoter trained by PRIME noted, "There is going to be a lot of change. Before, a client had to go to the Health Unit for a contraceptive method. Now we can provide users with the pill, condoms, and injectables, which we've never had before. Promoters also will be able to refer clients for the more scientific methods [sterilizations, vasectomy and Norplant®]. We can counsel them and provide a referral to a doctor, who can send them to the hospital. The user will have more access to the methods, and it's going to be much easier."

A senior central-level MOH official explained his view of the impact of PRIME training on service availability, "It has improved, especially in counseling and in contraceptive management. There is more availability. The quality of attention has improved. We have interviews with users who say services have improved markedly at the hospital level, for example in the Maternidad Hospital here in San Salvador. There is greater acceptance [of methods] and indirectly in increased coverage." A Department-level nursing supervisor noted, "[Family planning services] are much more feasible to the local population, which is quite dispersed and doesn't have access to the Health Units. So, to be in the community [with newly trained promoters and *parteras*] greatly increases access."

USAID staff also shared their observations on the project, noting having visited a Health Unit in Usulután where a physician trained by PRIME was practicing. The physician had reproduced the training for people in his Health Unit, had created a poster on contraceptive methods, and had recruited trained staff to insert IUDs.

Preliminary results of a study conducted nationwide by Ms. Sandra Echeverria, PRIME LAC Evaluation Specialist, indicate that promoters are providing an important service at the primary level. Complete results should be available shortly and will provide quantitative data to complement the qualitative data presented in this report. (See *Assessment of Health Promoter Programs in Rural El Salvador: Preliminary Results*, PRIME, July 1999, and Trip Report, Ms. Sandra Echeverria, May 24 - June 4, 1999, for additional information. See Appendix IX.)

Training Support and Client Education Materials

PRIME has helped the MOH, as well as the other primary Salvadoran FP service delivery agencies (the ADS and ISSS), to develop and validate provider support and client education materials, thereby increasing the availability of quality FP method information for clients and providers. A senior central-level MOH official noted, "We never before had training materials for each cadre, except for doctors and nurses, and these were few. Now we have improved the process, organized, standardized and developed consensus on the topics, and they are very explanatory." A leading ADS official noted, "Agreeing on content, speaking the same language in materials and cost-sharing are all good. The inter-institutional coordination was very attractive and successful."

Improved Quality of Care

There are early indications of improved workplace performance and improved quality of care, especially in client-provider interaction and counseling in a full range of FP methods. Department and local level Ministry staff reported improved client-provider interaction at the primary care level, noting that PRIME-trained providers are listening to their clients and targeting client information, and increasing client involvement in method selection. They provide counseling on a range of methods, and assist clients in choosing a contraceptive method. This was noted to be in contrast to previous provider behavior, in which the provider determined the appropriate method for the client with little, if any, client input. One Department-level medical supervisor noted, "Care of the patient has improved; It is more humane. The patient is receiving more integrated care, for example in counseling, which was practically unknown previously. The providers explain the side effects, and the patient can choose a method. Previously, we made the choice; now they can decide. Before the doctor would say, 'Here are the pills'."

A community-based partera shared her experience with PRIME training noting, "The training we are receiving now is on counseling the community on family planning, and making referrals for the IUD and sterilization, and how to distribute condoms and

pills. Before we could only explain (methods) and send them to the Health Unit. The training is good. There are many people who haven't been counseled and who have erroneous ideas about starting family planning. These projects provide more counseling for the community. We share information with the community in a personal way, with better explanations."

Improved Contraceptives Logistics and Management

Some striking examples of impact of the PRIME contraceptive logistics and management training are available, as for example, in a *bodega* in Central El Salvador. Mr. Lins conducted a preliminary visit to the *bodega* in October 1998, and found considerable disarray. The *bodega* housed contraceptive supplies for 4 Departments, but there was no inventory system for the individual Departments. Supplies were mixed together and unsorted (by Department and by contraceptive method.) They had one staff person who was unaware of the volume, type, and expiration date of supplies. There also was no climate control for the supplies. When Mr. Lins returned to the *bodega* as part of a post-training follow-up visit in May 1999, he found surprising and encouraging improvement. There were now 4 people responsible for contraceptive inventory at the *bodega*, one for each of the 4 Departments storing supplies. They had constructed walls to separate the supplies and hung signs with the names of each of the Departments. Contraceptives were sorted by method and expiration date. Complete records were kept for all the supplies. And, they had installed an air conditioner to stabilize the temperature. Mr. Lins was impressed by these changes and the staff commitment to contraceptive management and logistics. One senior central-level MOH official said the following about the impact of PRIME logistics training, "before we only knew what [volume of contraceptives] was sent. Now we can track supplies available, and how much we need and use [and therefore order consistent with demand and usage]."

Increased Use of Temporary Methods

Several people interviewed provided anecdotal evidence of increased acceptance and continuation of temporary contraceptive methods. At the Department level, where service statistics are reported by the Health Units, staff reported seeing increased demand for injectables and increased usage of IUDs in their Health Units following the training of Health Unit physicians and nurses. For example, in the Department of La Libertad, the Medical Supervisor noted that previously where they might have done one IUD insertion per month, they had seen 6 or more insertions in April 1999.

At the community-level, one promoter explained, "In the rural areas, like my *cantón* (local district), family planning is very difficult. It is controversial to discuss family planning, but with the PRIME training and emphasis on counseling and clarifying doubts, some people have chosen a more reliable method. The people feel freer in

deciding what method they are going to use. Acceptance (method use) has increased because we are not imposing. There is more trust. The attitude of the people has changed away from sterilization." A Department-level medical supervisor noted that, "the users are more satisfied in choosing their own method. More are choosing the injectable. They think it is better because they don't have to worry about remembering to take the pill or getting pregnant."

Declining Method Discontinuation

There also is some indirect evidence of decreased method discontinuation as a result of PRIME training as reported by Health Unit, Departmental and central-level MOH staff. One Department-level nursing supervisor noted, "We've seen (improved quality of services) through the counseling - the client accepts the methods, and doesn't discontinue them. The people are more aware of side effects and they accept them." The MOH Director of FP/RH Services (Client Care) also noted declining method discontinuation among users. It is expected that survey results will confirm this.

LESSONS LEARNED

This project has been highly successful because of many key factors, including leadership support, local staff presence, a needs-based design, and a focus on improved quality of services. The project, and ultimately FP/RH services throughout El Salvador, was also strengthened by PRIME efforts to work with all 3 primary FP/RH service providers in El Salvador.

Local Staff

The local presence of PRIME staff was seen as an integral component of the project. PRIME/El Salvador staff are well-known and well-regarded by colleagues throughout El Salvador. Ministry and other agency staff spoke highly of both the local and regional PRIME LAC staff. Ministry staff highlighted the role of Dr. Douglas Jarquín, the PRIME/El Salvador Resident Project Coordinator, as a well-known and respected leader of the PRIME team.

Local staff provide a constant, readily-accessible and available presence in support of the project. They routinely meet with MOH staff and oversee training workshops, including more than 200 workshops conducted in a 12-month period. Local presence also was noted as an asset by the MOH, USAID, and other collaborating service institutions (ADS and ISSS) and USAID collaborating agencies (CAs), such as FHI. Even during disasters, such as Hurricane Mitch that devastated much of Central America, when it would have been difficult for external TA to get in-country, local staff were operational and provided needed assistance. One senior central-level MOH official noted, "Dr. Jarquín is a marvel. He knows this country. Having local staff is

different from other international technical assistance agencies. We are always talking." USAID staff noted, "An important factor in the project's success is having local staff to introduce and monitor the project, and having well-known and well-respected staff."

Appropriate Technical Assistance

The technical assistance provided by PRIME was responsive to the needs and wishes of the MOH, and was respectful of their expertise and training, supervision, and service delivery structure. The PRIME team worked closely with the MOH in the design and implementation of the project and its components. Ministry and other agency personnel, including ISSS, ADS, APSISA and USAID staff, were pleased with the technical assistance provided by PRIME. All those interviewed noted the participatory style of PRIME program development and management. They noted that PRIME was very collaborative, did not impose program designs or activities, and took into account the experiences of the target institutions. This was noted in the development of the PRIME FP/RH training activities with the MOH, as well as in the development of the ADS sustainability project proposal. The Executive Director of ADS explained, "PRIME staff didn't say, 'Do this and this.' It was a collaboration, sharing our experiences, resulting in a project that we're all a part of." A senior central-level MOH official noted, "PRIME would always ask to clarify the situation. They didn't come and say 'Here, do this'. They asked for explanation, looking at factors. That's what we didn't have before, comparing with what we need, and coming to consensus. It was all very good." The Director of the APSISA Project noted that, "The PRIME TA in FP/RH has revolutionized the methodology, the training and the motivation of the (MOH) staff."

Political Support of PRIME Training

PRIME has benefited from the enthusiastic support of Ministry of Health staff, including from Dra. Avalos, the Director of FP/RH Services (*Departmento de Atención a la Persona*), responsible for MOH FP/RH service delivery in El Salvador, and the Minister of Health. On occasion, MOH staff, including Dra. Avalos, traveled to PRIME training workshops to offer support and clarify policy related to MOH approval of new draft norms and resulting changes in roles and responsibilities of community-based providers. On several occasions, the former Minister of Health, Dr. Eduardo Interiano, attended the inauguration of PRIME training events and spoke to participants about the importance of their work and the training. For example, in late May 1999, Dr. Interiano attended the inauguration of the PRIME training of *parteras* held at the Hotel Bahia del Sol in the Department of La Paz in Southwestern El Salvador. Dr. Interiano spoke to the promoters and *parteras* attending the PRIME FP/RH training, along with students attending basic formative promoter training (by the MOH). He praised their work and that of PRIME in training primary level service providers in FP/RH and thereby increasing the quality of and access to these services. A transcription (in Spanish) of the Minister's remarks is in Appendix VIII, along with a copy of a plaque given to the Minister of Health by PRIME. The plaque was given

in appreciation of his role in support of the PRIME El Salvador project and in strengthening the quality and access to FP and RH services at the primary level.

The Director of FP/RH Services for the Ministry spoke about the importance of MOH support for the project, noting, "Ministry staff have lent political support to FP/RH. The Minister has participated in the inaugurations of the workshops. It is important to see his role and say that it should continue. In the provinces they talk about RH, and have made a commitment to the health and rights of women. There is a national commitment to Cairo. We evaluate every 6 months. The Minister requests information on the advances made in RH and FP."

Inter-agency collaboration

The PRIME Project expanded and reinforced opportunities for inter-institutional collaboration among the leading FP/RH service providers in El Salvador. PRIME worked with the MOH, ISSS, and the ADS in the revision of the new FP/RH national norms, in training of primary providers, and in the development and dissemination of educational materials. Such work is important in developing consensus and consistency in quality client care messages, in increasing access and availability of such care, and in building goodwill among agencies. A USAID official noted that, "PRIME was involved from the beginning in agreement with the MOH in producing materials. PRIME went to the field and involved them in the validation of the materials with the MOH and ADS and ISSS and people from different levels." The Director of FP Services for the ISSS noted that they hope to continue the inter-institutional collaboration begun in the PRIME Project, noting, "It has been an excellent year in the training and sharing of information. The materials we developed together are enormous and excellent."

CONCLUSION

PRIME is a well-respected technical assistance project in El Salvador. There is considerable enthusiasm for the project interventions and efforts to continue to improve the quality and scope of FP/RH services. Support for continued service expansion and quality improvement has been expressed both within and beyond the Ministry of Health, including by the ADS and ISSS.

Efforts to broaden the scope of services and project interventions should be continued, and are, in fact, underway in Phase II of the PRIME El Salvador Project. Numerous integrated RH PRIME Project activities have been approved through the new MOH-USAID SALSA Project (*Salvadoreños Saludables* or Healthy Salvadorans) (February 1999-December 1999). These include management assessment and training; improved adolescent services; cervical cancer detection and referral; prenatal, postpartum, and postabortion care; and improved quality of care through training in CPI, COPE, and structured supervision. PRIME management assessment and training efforts are in progress with the MOH with central and Departmental RH program managers to improve the overall quality of the RH

program, and to improve skills of managers to train and supervise Health Unit staff. Further improvements in contraceptive logistics reporting and planning also are ongoing. These efforts will be important for the true integration of FP/RH services in El Salvador.

The Director of Client Care for the MOH best summarized PRIME and MOH successes and hopes for the future, saying, "We've seen success in the process in counseling, training, contraceptive methods, and logistics. In a year, we'll see an increase in usage. "

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Appendices

Appendix I: MOH National RH/FP Plan, 1998-1999

Figure 1: MOH National RH/FP Plan 1998/1999

Identified Weakness	MOH Plan
1. No programs for high need groups (especially adolescents, rural)	1. Train all promoters and some TBAs in working with adolescents 2. Train all TBAs (mostly rural) in FP education, distribution and referral 3. Remove medical barriers to FP distribution by promoters and TBAs
2. Temporary method supply shortfall	1. Emergency donation of injections (USAID) 2. Negotiate all other methods with UNFPA 3. Improve contraceptive logistics systems (USAID)
3. Lack of support materials and activities for family planning in general, and to address myths specifically	1. Develop temporary methods example kit for promoters and TBA (PRIME) 2. Develop low literacy brochures of management of side effects, especially DMDA (PRIME) 3. Develop promoter manual which includes section on organizing satisfied user groups in community (PRIME) 4. Develop rotafolio on fertile period, advantages of spacing and FP methods (PRIME)
4. Medical and normative barriers	1. Allow promoters to dispense injectables 2. Allow promoters to give oral contraceptives complete medical visit
5. Lack of trained community level providers	1. Train promoters in importance of birth spacing, contraceptive methods, management of side effects, contra indicators, referrals, communication, especially techniques with adolescents, community organizing, establishing satisfied user groups (PRIME) 2. Train all TBAs (who meet training criteria in importance of spacing births, contraceptive methods, management of side effects, contra indicators and referral (PRIME) 3. Train all health unit staff, especially TBA and promoter supervisors in revised functions of promoters and TBAs (PRIME)
6. Lack of unified reporting mechanism	1. Change how family planning users are counted to better capture full service delivery picture

Appendix II: List of Key Project Participants

Key Project Participants

Ministry of Health, El Salvador

Dra. Avalos, Director, Departamento de Atención a la Personal

Dr. Morán Colato, Coordinator, RH Programs

Dr. Eduardo Interiano, Former Minister of Health

PRIME El Salvador

Dr. Douglas Jarquín, Resident Program Coordinator

Ms. Luz Elda Aguirre, Senior Technical Supervisor/Administrator

Ms. Beatriz de Alonso, Quality of Care Coordinator

Ms. Ana de Herrera, Adolescent Coordinator

Ms. Sonia Hernandez, Secretary

PRIME/LAC Regional Office

Ms. Ann Lion Coleman, Director, PRIME Regional Office for Latin America

Dr. Milton Cordero, INTRAH/PRIME Reproductive Health Specialist

Ms. Sandra Echeverria, INTRAH/PRIME Evaluation & Research Specialist

Dr. Dan Edwards, PRIME/TRG Management Specialist

Mr. Sergio Luiz Lins, PRIME Contraceptive Logistics Consultant

Ms. Annie Portella, PRIME Materials Development Consultant

Appendix III: Training Schedules

Table 1. Chronogram of FP Workshops (Health Unit Physicians and Nurses)

Table 2. Chronogram of Promotor Workshops

Table 3. Chronogram of Partera (TBA) Workshops

(Actual Tables in Hard copy only)

Appendix IV: List of Persons Interviewed by Diane N. Catotti, May 1999

Persons Interviewed

Ministry of Health (Ministerio de Salud Publica (MOH))
San Salvador (Central Level):
Dr. Maria Elena Avalos, Director, Departamento de Atención a la Persona (RH Services)
Dr. Morón Colato, National Reproductive Health Coordinator

Departmental Level:
La Libertad:
Licda. Marivel Salazar de Criollo, Nurse, Departmental Nursing Supervisor
Dr. Gustavo Arnoldo Ostorga Alvarado, Medical Supervisor

La Paz:
Licda. Rafaela Diaz de Molina, Departmental Nursing Supervisor
Dr. Rene Victorino Coto Portillo, Departmental Medical Supervisor

Zona Occidental, San Salvador:
Licda. Sonia De Sanchez, Nurse, Facilitator of PRIME Parteras Training

Zona Norte, San Salvador:
Lic. Ana Sofia Deabego, Nurse, Midwife Coordinator and Facilitator

Health Unit (Local)/Community Level:
Ms. Cecilia Esmeralda Sanchez, PRIME-trained Promotor, Canton La Zereto,
Unidad de Salud Nonualco

Parteras in PRIME Training:
Sra. Teodora Palacios Viuda del Amir, Unidad Mexicano
Sra. Ana Catalina Martinez, Canton: Arenales, Depto. De San Salvador, Central, Unidad:
Habito Confien

Promotors in Basic MOH Training:
Sr. Santo Alberto Jimenez Guerrero, San Vicente, Depto. De La Paz
Sr. Francisco Eduardo Rojas Garcia, Canton: Guagoyo

USAID/El Salvador
Ms. MariCarmen de Estrada, Reproductive Health Officer

APSISA
Licda. Patricia Portillo de Reyes Hernandez, Director, APSISA Project

ADS:
Dr. Jorge Hernandez, Director (interviewed by telephone, 5/27/99)

ISSS:
Dra. Leona Melendez, Director, Reproductive Health

FHI:
Mr. Bill Conn, Senior Program Officer for Latin America

PRIME/El Salvador Staff
Dr. Douglas Jarquin, Resident Program Coordinator, PRIME/El Salvador
Ms. Luz Elda Aguirre, Senior Technical Supervisor/Administrator
Ms. Beatriz de Alonso, Quality of Care Coordinator
Ms. Ana de Herrera, Adolescent Coordinator
Ms. Sonia Hernandez, Secretary

PRIME LAC Staff/Consultants

Ms. Ann Lion Coleman, Director, INTRAH/PRIME Regional Office for Latin America
Dr. Milton Cordero, INTRAH/PRIME Reproductive Health Specialist
Ms. Sandra Echeverria, INTRAH/PRIME Evaluation & Research Specialist
Mr. Sergio Luiz Lins, PRIME Contraceptive Logistics Consultant

Appendix V: INTRAH/PRIME EDD Impact Interview Guide

INTRAH/PRIME EDD IMPACT INTERVIEW GUIDE

Thank you for taking the time to meet with me. The purpose of this interview is to obtain some accurate information on the effect that the PRIME project has had on the work of your unit/office. The interview should take about an 1 hour or so, for which we much appreciate the time you are generously giving us. We ask you to provide sincere, candid answers to the questions posed. Please do not feel uncomfortable in expressing any critical views. Also, in order to better document responses, please provide examples and illustrations to your answers.

1. I would like to begin with several questions related to the RH/FP training system and strategy of your institution.

I. National FP and/or RH GUIDELINES

1. First, Can you clarify for me the status of updated FP/RH service (and training guidelines)? (Do they cover FP or RH or both?)

2. Are they completed or in process?

3. What was PRIME's role in developing and disseminating these guidelines?

4. What, if any, guidelines were in place/were you using in 1997 (prior to PRIME/FHI?)

5. What are your current plans for dissemination and use of guidelines? (clarify which version...)

II. TRAINING STRATEGY, PLANS, STANDARDS

1. Can you tell me about the MOH system of training providers in FP/RH?

2. Can you tell me a little about the decentralized process of training? Are there decentralized training units in all departments? And are they administratively/financially strong or weak?

3. Is there an official, written policy (strategy) for RH training?

4. Does the MOH have a written RH training plan? Is it reviewed annually?

5. Has PRIME played a role in strengthening or developing the training strategy, plans, policy?

6. What was the situation in 1997, prior to PRIME involvement?

7. Are quality of care and service improvement standards (as defined by the guidelines) used in the development of training plans? (CPI, increasing method mix, ...)

8. Do you have any plans to further strengthen or formalize these training services?

9. Is training combined with use of promotion, incentives, follow-up and/or supervision to encourage good performance?

10. Are trainings evaluated and do the results feed into program improvement?

III. TRAINING & CURRICULA:

1. Does the MOH use training needs assessment to assess the need for RH training?

2. Are there official standard training curricula used for RH training?

3. Are these reviewed periodically? At what level? (central or departmental)

4. Are trainers required to take and pass standard tests on FP/RH technical skills and knowledge?

5. Do the training units conduct periodic refresher courses?

6. Are trainees involved in the replication of these courses?

7. What has PRIME's role been in the development and standardization of these curricula?

8. Has working with PRIME made these more sensitive to quality issues, for example on counseling to provide more method choice?

9. What was the role prior to 1997?

10. Can you tell me about how PRIME may have affected the way you conduct training? For example, by incorporating CPI? supportive supervision? Participatory learning methodology? Adult Learning Methodologies?
11. Are quality of care elements reflected in training manuals as well?

12. Can you tell me a little about any inter-agency collaboration there has been in the development of these curricula and/or manuals?

IV. THE TRAINING BUDGET:

1. What is the basis of funding for MOH RH training?

2. Can you tell me what proportion of the RH training budget is provided by in-country resources?

3. What proportion is supported by foreign assistance?

V. CONTRACEPTIVE LOGISTICS

1. I understand that PRIME has helped to strengthen the contraceptive logistics system; Can you tell me about that?

2. What was the situation prior to PRIME involvement?

(Could I please get some examples, i.e., data for 1997, 1998 and 1999 if possible.

VI. COMMUNITY INVOLVEMENT

1. Are Community representatives involved in planning and conducting training activities, e.g., developing curricula content, developing training plans, are included in training needs assessments?

2. Are they involved in assessing provider performance? Are they aware of their rights and/or demand competent provider performance?

VII. POLITICAL SUPPORT

1. Have there been any public shows of support by MOH personnel re RH or FP training? Can you tell me a bit about what they said?

2. At what level (high, medium, national, central, departmental)?

3. Since PRIME?

4. What was the situation prior to PRIME?

5. Is there collaboration between the public and private sector in support for RH training? How extensive is this collaboration? Can you provide examples?

VIII. TRAINING INFORMATION/SYSTEMS

I have several questions relating to training information systems, training facilities and equipment. Who do you suggest I speak to about these?

1. Do you have a management information system for training, where the number and characteristics of trainees and materials are tracked?

2. Can I please get examples or look at your database reports, for example, of who is being trained, and what information you collect on them?

3. Do you also have a system that collects service level statistics, i.e., methods provided, couple years of protection (CYP), continuation & discontinuation rates?

4. Is this system (MIS for training vs. service statistics) maintained at the central level?

5. What was PRIME's role in developing/strengthening these systems?

6. What was the situation in 1997, prior to PRIME involvement?

IX. TRAINING RESOURCES

1. What facilities are available to the MOH for training?

2. Are these owned or rented by the Ministry?

3. Can you tell me about the facilities and equipment?

4. Are they working well for you?

5. Do they have adequate equipment, power supply, training materials, i.e., overhead projectors, flipcharts, markers, etc?

6. Are there systems in place to update/upgrade/resupply training materials?

7. What was the status in 1997, prior to PRIME involvement in El Salvador?

8. Can you please tell me what role PRIME has played in the provision or upgrading of training materials, equipment, or facilities?

2. Now I would like to talk about <u>access to health services...</u>

1. Have there been changes in the overall access of reproductive health services over the past 2 years?

2. Has the PRIME project contributed to increased <u>Access</u> of the population to reproductive health services offered by your institution and if so how? Please provide examples...

3. Can you tell me about PRIME's role in helping to increase the number of:

a) trained providers delivering services? (health unit personnel, promotors, TBAs)

b) service delivery points (SDPs) delivering services ?

c) programs organized to deliver services? In particular, it refers to the capacity to reach underserved populations (e.g. adolescents, men, rural).

4. What affect do you believe the PRIME training had on service delivery? Was it improved in any way? for example, with improved counseling elements? improved/expanded method mix?

5. Have the changes happened in a timely manner and according to your expectations?

6. Can you provide examples or reports to help us document these changes? Is there someone (else) I can get these statistics from, if there are any?

1. # of service providers formed by PRIME, by year and type (if possible, obtain figures from before 1997 and figures on trained providers from 1997 to 1999 from other agencies ***<u>and the rate of training, e.g., 30 TBAs trained per quarter);</u>***
2. # of <u>new</u> cadres of providers trained or providers trained in <u>new interventions</u>; see illustrative tables below]

3. Next, we would like to ask for your candid comments in terms of PRIME's intervention to provide an <u>Integrated Reproductive Health</u> framework to services that are offered through your organization, i.e., the addition of family planning services to other reproductive health services.

1. By cadre (doctors/health unit personnel; promotors; tbas): What services were they providing before?

2. What services are they providing now?

3. Has the integration of RH & FP services affected clinic management in any ways, e.g., change in clinic hours, or in requiring an upgrade of equipment?

4. Is this illustrated in service statistics? Can I get examples of reports of these data?

5. How have service providers responded to this new approach/emphasis on integrated RH services?

6. How many service providers were trained in the new curriculum (e.g., CTU & CPI for health units; adding FP services to RH for promoters & TBAs)? (see table)

7. Has this additional training made a difference in service delivery (methods being requested and provided)?

8. Are services being provided to additional underserved populations? Are we reaching more men, adolescents?

9. Is there any evidence of increased clinic caseload? Increased acceptance rates? Increased continuation rates?

4. Can you tell me a little about the <u>style used by PRIME</u> representatives and of the project's philosophy with respect to the your needs?

1. In particular, how participatory, democratic, appropriate, relevant have processes and interventions been?

2. Is there something that has characterized the work of PRIME during these years?

3. Do you have any suggestions for us, especially in terms of how to improve?

5. Finally, what do you think has been the most important <u>outcome</u> of the PRIME project and the main factors responsible for such outcome?

Is there anyone else you suggest I speak with while I'm here?

I want to thank you very much for your time and comments.

Appendix VI: INTRAH/PRIME Capacity Building in Training Questionnaire (EDD Instrument)

INTRAH/PRIME
CAPACITY BUILDING IN TRAINING QUESTIONNAIRE

Instructions: *These are the illustrative descriptions for each of the capacity building indicators. Please respond with the letter that describes as close as possible the status of your institution, providing examples and illustrations to your answers as required. Remember, what is needed is an* ***objective*** *assessment of where the institution stands on each indicator. There is no "positive" or "negative" answer, just a measure to help explain the present and real status of an institution. Do* ***NOT*** *leave any answers blank, as it would not permit completing the entire assessment. Thank you.*

COUNTRY: El Salvador **INSTITUTION:**

NAME AND POSITION OF THE PERSON COMPLETING THE REPORT:

I - LEGAL-POLICY SUPPORT

〈 **National FP/RH service guidelines and training are official**

1. Existence of updated official FP/RH service and training guidelines

Whether a) there are no guidelines for service delivery; b) guidelines are in initial/incomplete stage or are outdated; c) guidelines exist but have not been made official or have not been fully disseminated; d)guidelines are complete, updated, official and fully disseminated.

Status in 1997 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

〈 **Political support for training institutionalization**

2. Official (written) policy supporting institutional training capacity (e.g. training units, cadre of master trainers, venues, etc.) for health providers

Whether a) there is no written policy supporting development of a national training strategy/capacity; b) there is some policy but is timid, not enforced or has not translated into actual support; c) there is a definite policy but it has not been made official or has not been fully disseminated; d)there is a strong, official policy that is put into practice through norms, regulations and implementation plans.

Status in 1997 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

3. Favorable public statements on FP/RH training (for the improvement of services) at least twice a year by senior officials

Whether a) there has been no mention by senior officials favoring/supporting FP/RH training (related to the improvement of services); b) there has been an occasional, timid or "wishful" statements only; c) statements have been made by either medium ranking officials or by high level officials but not in public or only occasionally; d) high level officials mentioned their ample support for FP/RH training on several private and at least twice on public occasions.

Status in 1997 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

II - RESOURCES

Financial

〈 **Existence of sufficient and diversified Training Budget**

4. The training budget relies mostly on internal (in-country, institutional) sources

Whether a) Training relies entirely on foreign assistance and/or there is no training budget; b) training relies heavily (at least 50%) on foreign assistance and/or training funds are allocated on ad hoc basis; c) in-country resources/budget account from between 50 and 80% of total training funds; d) in-country budget for training provide more than 80% of the budget. (One other way of looking at it is whether budget covers all aspects of training (including materials and equipment, travel and per diem by consultants and staff, venue hire and maintenance, etc.).

Status in 1997 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

Venues/Equipment

〈 **Adequate venues**

5. Accessible and available (own, rented) venues (at least one local venue in each training area) that are of standard quality (continuous power, good lighting, acoustics and sufficient capacity), accessible to participants and available when needed

Whether a) there are no adequate venues for training of health providers; b) there are few occasional venues and/or often unavailable; c) there are venues of adequate quality but cannot be readily secured for training; d) there are local venues that are fully accessible, of high quality and sufficient capacity for training.

Status in 1997 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

<u>Materials, equipment and supplies</u> (MES)

〈 **Appropriate and cost-efficient MES (incl. AV equipment & teaching aids)**

6. MES are pertinent, updated and adapted to local culture (incl. locally produced)

Whether a) materials, equipment and supplies are outdated and/or not adapted/produced locally.... to d) MES are technically superior, updated/current and are adapted to the local/cultural context.

Status in 1997 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

7. Financial, printing and planning capabilities exist for replacing and upgrading MES

Whether a) there are insufficient means for making MES available and/or replacing old ones; b)MES are made available, but either insufficient or not of adequate quality; c) MES of standard technical and material quality and readability can be made available for each trainee, although there are occasional shortages; d) Systems are in place locally for continuous replacement and upgrading of quality MES, which are available as and when required.

Status in 1997 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

Human

〈 **Trainers/preceptors formed have updated and standardized technical and presentation K&S***

8. Trainers/preceptors are constantly formed (TOT) and do periodic refresher courses and pass standard tests on FP/RH technical & presentation K&S

Whether a) Trainers/preceptors are not regularly formed and/or do not update their technical & presentation K&S... to d) Trainers/preceptors constantly formed and undergoing periodic (at least once every two years) refresher courses.

Status in 1997 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

III - TRAINING PLANS & CURRICULUM

〈 **Updated and periodically reviewed training plans**

9. Training plan exists and is reviewed annually

Whether a) There is no training plan per se (training conducted on ad hoc basis), to... d) Training plans are drawn periodically (at least annually) and reviewed

Status in 1997 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

〈 **Updated curriculum is official standard for training institutions**

11. Existence of a standard official training curriculum guiding training institutions

Whether a) There is no standard training curriculum, or is inadequate/outdated, different ones used by different institutions, b) there are some updated curricula, but not standardized or officially endorsed, c) A standardized curriculum is in place, but either not reviewed periodically or is not officially used by training institutions, to d) There is a standard curriculum, reviewed periodically (at least once every 2 years) and used officially by training institutions

Status in 1997 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

IV - ORGANIZATIONAL

Leadership

〈 **Vision of training as a means to improve services**

11. Training plans are linked with quality of care and increased service access

Whether a) Providers' training plans are ad hoc-not coupled with service and quality of care objectives, to... d) Training plans form part of Quality of Care and service improvement strategies.

Status in 1997 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

〈 **Training is an integral part of organization's strategic planning**

12. A training plan and activities are part of the organization's strategic plans

Whether a) Training is not part of the organization's strategic plan (or the training institution has a strategic plan), to ...d) Training is part of the organization's long-term strategic plan (not yearly but multiannual)

Status in 1997 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

〈 **Promotion of public-private collaboration**

13. Evidence of public-private collaboration

Whether a) There is no (or no evidence) of public-private collaboration in training, b) there is some public-private collaboration, but is haphazard and loosely coordinated within the training institutions, c) public-private collaboration exist at different levels, however efforts are still disintegrated or not guided by joint planning/programming , d) there is ample public-private collaboration, guided by extensive planning/programming.

Status in 1997 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

Infrastructure

〈 Existence of decentralized training units in all areas

14. Active training units exist at central and peripheral levels

*Whether a) There are no decentralized training units (even if there is one at central level, b) there are a **few** training units at peripheral levels but are administratively/financially weak (incl. documentation center and computerized equipment), c) **several** decentralized training units exist but are administratively/financially weak, d) Active and strong training units exist in central and peripheral levels.*

Status in 1997 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

Human Resource Development

〈 **Training (TOT, formative and refresher courses) is an integrated part of a Human Resource Development/Performance Improvement system (e.g. promotion and incentives, follow-up & supervision, efficacy)**

15. HR development is part of a HRD/PI strategy

Whether a) Training is not coupled with HRD or providers' improvement objectives, ...to d) Training is part of HR development and performance improvement system

Status in 1997 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

Administration

〈 Existence of a reporting system for tracking number and characteristics of trainees and materials, according to needs

16. Existence and use of a Training Needs Assessment (TNA)

Whether a) There training is not based on some form of TNA, b) TNA is seldom done, or on a casual basis or results are not fed into the training plans, c)TNA is a regular practice in the institution, however their results are not fully exploited, d)TNA is customarily done to tailor training strategies and improve performance.

Status in 1997 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

17. Existence of a Management Information System (MIS) for training that includes information on trainees and materials

Whether a) There is no MIS for tracking training progress, b)there are some data on courses, trainees, materials, etc. but not integrated in a system, c)there is initial integration of data into an information system that helps evaluate progress and assists planning, to d) There is a fully automated and effective MIS for training.

Status in 1997 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

Technical Capability

〈 **Technological transfer and development through networking, evaluation & research (E&R)**

18. Contacts with other training institutions and institution's E&R feed into training improvement (e.g. trainee selection, training contents and formats)

Whether a)there is no/little use of E&R or information from other national/international training institutions to improve and update training capabilities... to d) Extensive use is made of internal and external data & resources for quality assurance and technical improvement of the institution.

Status in 1997 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

Track Record

〈 Proven capacity to conduct/replicate courses autonomously

19. Replica/other courses carried out independently (w/institutional resources)

Whether a)There have been no replica or independent courses carried out by the organization (or only done with foreign assistance)... to d) There is ample evidence of ongoing replica/expansion of courses to wider areas and with institutional resources.

Status in 1997 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

V - COMMUNITY DEVELOPMENT-PARTICIPATION

〈 **Community representatives are involved in planning and execution of training activities, are aware of their rights and/or demand competent provider performance**

20. Evidence of community involvement in providers' training and/or performance assessment (e.g. quality of care circles)

Whether a)There is no/little community involvement contributing to curricula contents, drawing of training plans, or provider performance b)community representatives are included in training needs assessments and/or are aware of their rights in relation to CPI; c)Initial community involvement in shaping provider training and service needs, to d) Extensive involvement/participation in provider training and/or performance assessment; organized demand/petitions to improve services, etc.

Status in 1997 (a-d):	**Status in 1999 (a-d):**
Explain:	**Explain:**

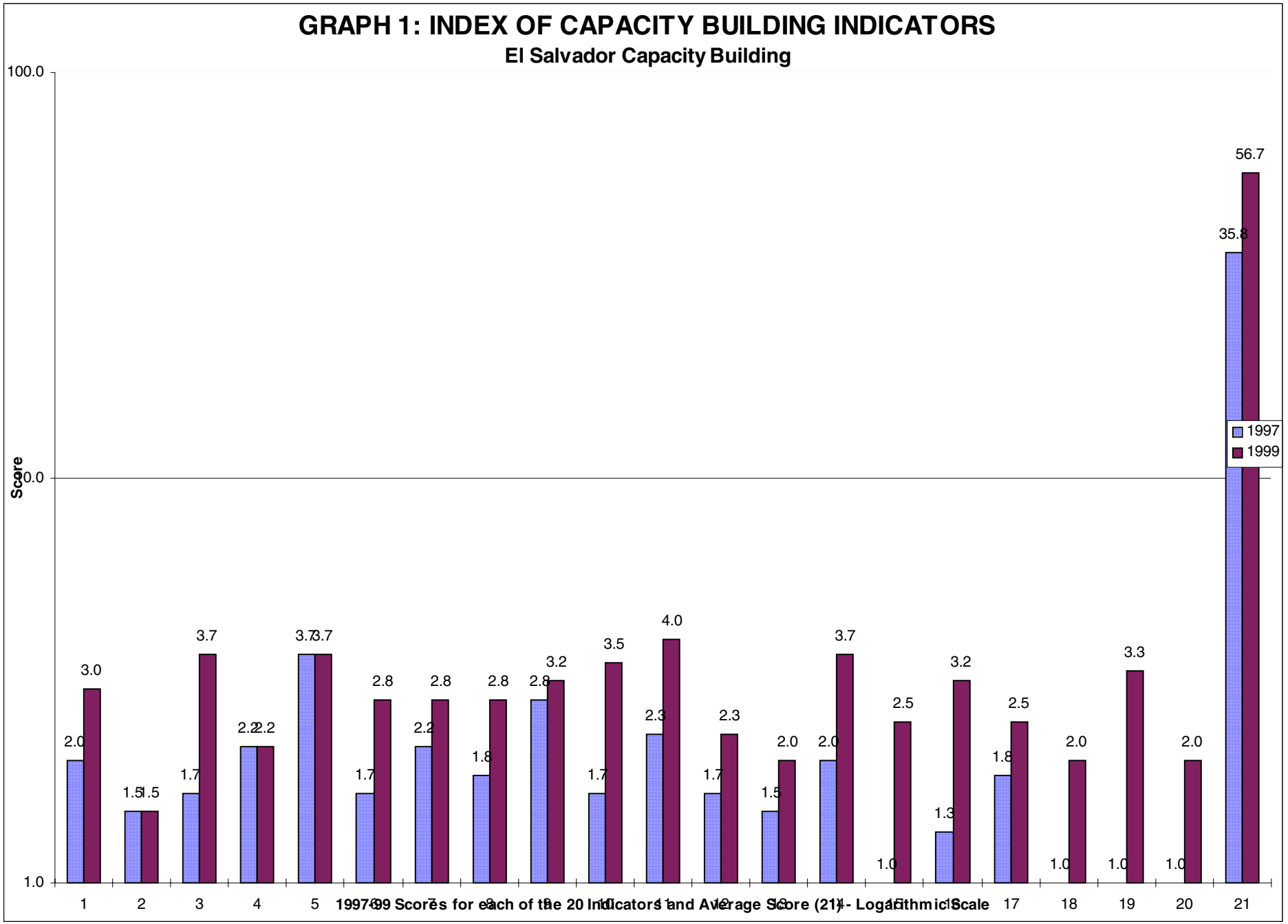
Appendix VII: Table 4: INTRAH/PRIME Comparison of EDD Capacity Building in Training Questionnaire Responses

TABLE 4: Comparison of EDD Capacity Building in Training Questionnaire Responses

		MOH Aggregate		USAID/EL Salvador		W Conn, FHI		Average Score	
	INDICATOR	1997	1999	1997	1999	1997	1999	1997	1999
1	Updated FP/RH Guidelines	2	3	2	3	2	3	2.0	3.0
2	Official Training Policy*	2	2	1	1	1.5	1.5	1.5	1.5
3	Positive Public Statements	1	4	1	4	3	3	1.7	3.7
4	Internal Training Budget	2.5	2.5	2	2	2	2	2.2	2.2
5	Adequate Training Venues	4	4	4	4	3	3	3.7	3.7
6	Materials, Equipment & Supplies (MES)	2	3	2	3	1	2.5	1.7	2.8
7	Capability for Updating MES	2	3	2	3	2.5	2.5	2.2	2.8
8	Updated Trainer Knowledge & Skills (TOT)	2	3	1	3	2.5	2.5	1.8	2.8
9	Training Plan Exists	2	3	4	4	2.5	2.5	2.8	3.2
10	Standard Training Curriculum	1.5	4	1	4	2.5	2.5	1.7	3.5
11	QOC Linked to Training Plans	1	4	2	4	4	4	2.3	4.0
12	Training Is Part of Strategic Plan	2	3	1	2	2	2	1.7	2.3
13	Public-Private Collaboration	1.5	2	1	2	2	2	1.5	2.0
14	Decentralized Training Units	3	4	1	4	2	3	2.0	3.7
15	Human Resource Development as Part of PI	1	3	1	3	1	1.5	1.0	2.5
16	Training Needs Assessment	2	4	1	4	1	1.5	1.3	3.2
17	MIS for Training	2	2.5	2	3	1.5	2	1.8	2.5
18	E&R Feeds Training	1	2	1	2	1	2	1.0	2.0
19	Replicate Training Independently#	1	3	1	3	1	4	1.0	3.3
20	Community Involvement	1	2	1	2	1	2	1.0	2.0
								35.8	56.7
								1.8	2.8

Scores are translated from the EDD Questionnaire on a 4 point scale: a=1; b=2; c=3; d=4.

* Because FHI entered a don't know response, the average score for MOH and USAID was used.
# Because FHI and USAID entered a don't know response, the score for MOH was used.


GRAPH 1: INDEX OF CAPACITY BUILDING INDICATORS
El Salvador Capacity Building
100.0
Score
0.0
1.0
1997
1999
1997-99 Scores for each of the 20 Indicators and Average Score (21) - Logarithmic Scale
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21
2.0 3.0
1.5 1.5
1.7 3.7
2.2 2.2
3.7 3.7
1.7 2.8
2.2 2.8
1.8 2.8
2.8 3.2
1.7 3.5
2.3 4.0
1.7 2.3
1.5 2.0
2.0 3.7
1.0 2.5
1.3 3.2
1.8 2.5
1.0 2.0
1.0 3.3
1.0 2.0
35.8 56.7

Appendix VIII: Remarks of Outgoing Minister of Health Dr. Eduardo Interiano, May 26, 1999, and Plaque presented to him by PRIME Project

Transcripción
Remarks of Sr. Ministro de Salud Dr. Eduardo Interiano, May 26, 1999,
Hotel Bahia del Sol, Depto. de La Paz, El Salvador.

Queridos amigos de PRIME, Ann Lion Coleman, Milton Cordero, compañero del Ministerio, Dr. Jarquín, Señora partera Doña Gloria de Machuca. Quizás más que venir a inaugurar una capacitación más, vengo a hacerle una petición muy formal a la gente de PRIME. Dentro de 48 horas termino mis funciones como Ministro de Salud. Por lo menos el día viernes a las 4 de la tarde nos vamos para nuestra casa y ya no volvemos a regresar más porque entramos en el período de vacaciones, dado por la toma de posesión, aunque mantengamos el cargo hasta el 1o. porque el 31 a las 12 de la noche ya no nos acercaremos nuevamente al Ministerio. Pero vengo a pedirle algo a PRIME y que ojalá que así como ellos nos buscaron hace año y medio. Hoy yo vengo a buscarlos a ellos para plantearles un proyecto que creemos que puede ser exitoso. Cuando tomamos posesión de nuestro cargo nos dimos cuenta que no era posible mejorar las condiciones de salud de los Salvadoreños si seguíamos creciendo desmedidamente y que las mujeres tuvieran hijos como conejos y que los hombres tuvieran cientos de mujeres al mismo tiempo. No era posible. No había presupuesto que alcanzará. Y pedíamos incremento de presupuesto. Y nos salía mucho más gente demandando el servicio. Pedíamos más dinero. Y había que comprar más medicamento porque había 160 mil por 200 mil niños que nacían cada año en El Salvador. Y que gracias a la atención que se estaba dando, ya no se morían en ésta profesión. Antes nacían 200 mil y se morían 200 mil. Hoy nacen 200 mil y no se mueren ni siquiera 10 mil. Entonces era un problema. Ya no cabemos. Ya no sabemos a dónde vamos a colocar a los Salvadoreños. Usteden miren que hasta nuestras costas. Están ya llenas. Y dentro de poco, vamos a estar encaramados en una ballena porque no hay espacio para construir una casa acá.

Entonces dijimos que la solución es trabajar en ese tema tan espinoso, en ese tema tan difícil como es la salud reproductiva, pero especialmente el tema de planificación familiar. Por un lado, los médicos pedriatas queriendo tener más niños. Yo soy pediatra. A mi me gusta que nazcan doscientos mil niños en El Salvador. Quisiera que nacieran 400 mil porque más van a llegar a este consultorio. Los gineco-obstetras queriendo que hayan más para seguir atendiendo más partos. Y seguramente las parteras empíricas tambien queriendo que los Salvadoreños se reproduzcan como cuyos alla en los cantones y en los caserillos porque más trabajito les iba a llegar. Sin embargo El Salvador estaba más emproblemado. Y no podiamos seguir creciendo. Ustedes miren que entran 30 mil carros todos los años. Y todos compran carro ahora. Y ya no alcanzan los carros, pero las calles se hicieron cada vez más estrechas. No alcanzan las escuelas. No alcanzan las clínicas. En fin, ya no nos alcanza nada y seguimos convirtiendonos en más pobres en la medida que sigamos con esa política. Eso lo entiende uno cuando ya llega a este cargo cuando uno está metido en este problemón de ser Ministro de Salud Publica.

Y déjenme recordar un poco el tiempo. Hace treinta y tantos años mi padre fue Ministro de Salud Publica. Y las cosas desagradables que el vivio fue cuando tuvo que entrarle de lleno al uso más frecuente diria yo de los metodos de planificación familiar, sobre todo el condón que era lo que se estaba usando en el aquel entonces. Imaginense hace treinta años, si ahora los curas son recalcitrantes, hace treinta años eran más recalcitrantes todavía. Y empezaba el conflicto de conciencia si lo hago o no lo hago.

He querido tomar esto porque yo creo que ahora estamos cada vez más convencidos de que la solución del problema en El Salvador es trabajar en este aspecto, en este campo. Y dandole pensamiento a como resolver la problematica. Creo tener yo alguna idea y aquí es donde viene el pedimento a PRIME. De contarles un poquito de la historia del Ministerio muy resumidamente que algo lo debian de saber ellos. Nosotros en el Ministerio de Salud fuimos los creadores, los fundadores de programa de *Escuela Saludable*. Empezamos atendiendo a 27 mil

niños en el departamento de La Libertad y los seguimos incrementando y ahora atendemos a 200 mil niños que están en el area rural y en el area urbano marginal. Le hemos dado una atención medica integral. Se les ha dado alimentación. Se han mejorado las condiciones de infraestructura de las escuelas. Y se han mejorado los accessos para que los niños puedan ir a la escuela. Y hoy tenemos cada vez menos repitencia escolar. Tenemos menos ausentismo escolar. Tenemos niños más saludables, más sanos en esas areas donde está la gente más marginada, la gente más postergada. Por el otro lado, también creemos en las parteras empíricas y yo recuerdo el primer curso al que fuimos de capacitación, allá donde tienen los curas en camino a La Libertad, donde inexplicamente decia como es posible que los curas nos hayan prestado esto para capacitar a las parteras empíricas. Pero allí se hizo la capacitación y empezamos a ver el rol importante que tenían las parteras empíricas. En el transcurso de los años hemos ido apreciando cada vez más el trabajo y el valor que tienen nuestros promotores de salud y que creemos que juntos se puede ir resolviendo la problematica. Pero hay un problema en que nosotros lo están capacitando para atracar y enfrentando básicamente aquella mujer que está en la edad fertil y esa mujer que ya tiene un niño y que tiene dos y que le vamos a decir que hay que espaciarlo, que en vez de tenerlo año con año cada diez meses. Déjenme contarles que yo soy el producto del segundo embarazo de mi madre y de mi padre y me llevo diez meses y medio con mi hermano y no habia metodos de planificación familiar en aquel entonces. Entonces, empeze a preguntarme y tengo esa inquietud y he conversado con alguna gente de la OPS. Y no se si va a resultar o no, pero voy a tocar también las puertas de PRIME porque siento que el AID en alguna medida no ha tenido un feliz resultado de todo este esfuerzo grande que se ha hecho en el tema de salud reproductiva y planificación familiar. Y no lo tenemos porque quizas no hemos considerado factores culturales que tiene cada uno de los Salvadoreños o que tenemos los Salvadoreños. El dia lunes, el martes o el miercoles convencemos a una señora para que tome un método de planificación familiar - un condón, una pastilla, una tableta, una injección, y casi la convencemos que se esterilize. Pero el día sábado va a la misa y le dicen es pecado. Se volvio pecadora, y ya regreso otra vez y ya no toma ninguna pastilla. Y al mes siguiente nos regresa con una hermosa barriga cargando el producto de un nuevo Salvadoreño. Esta es la historia. Porque no hemos concientizado, les damos, les queremos dar condones, pastillas, injecciones, métodos definitivos, vasectomía, etc. Pero creo que la solución está en que empecemos a trabajar con las niñas y los niños en el programa de escuelas y a eso le he apostado. Estoy llevándome toda la documentación, estoy haciendo una ONG para trabajar con ese dato. Como pediatra tengo, diría la facilidad de hacerlo, como el suministro también se a donde se debe de llegar, y como se debe de tocar. Y que si queremos resolver el problema de El Salvador, tenemos que ir a educar a nuestra población rural. Tenemos que ir a educar a las niñas y a los niños desde los 10, 11 o doce años. Porque a los doce o trece, ya tiene una criatura en su vientre o ya tuvo un niño y el problema ya no lo resolvimos. El problema lo empeoramos esa niña abandono la escuela. Esa niña se volvio una carga en el hogar. Y cada vez esa familia se convirtió en más pobre de los pobres. Es de más que llevemos esfuerzo si a esa edad están ya embarazadas o con su futuro truncado porque no hubo alguien que le explicara con claridad como podria si quiere disfrutar de la vida sexual pero no saliendo embarazada. No es que la estemos induciendo a pecado, sino que la estamos induciendo a que se cuide porque de todas maneras si quiere pecar es ella y su conciencia. Pero si no se quiere terminar de arruinar su vida que no salga embarazada. Y yo creo que ahí debería estar el enfoque nuestro y el esfuerzo nuestro.

A veces es muy dificil hacerlo a través de un Ministerio porque empieza con confrontar Iglesia y gobierno. Pero creo que a nivel privado, a nivel de ONGs, es mucho más fácil que empezar a trabajar. Y allí nos ponemos a la disposición de PRIME, si creen que podemos trabajar. Ya nos vamos como al fin del dia primero que estamos ya. Ahora somos los del club del sueño, ¿Qué podemos hacer en este sentido? Hemos fortalecido nuestras parteras empíricas con muchas o con pocas capacitaciones. Pero tenemos gente muy capacitada y tenemos gente que quiere seguir aprendiendo, promotores queremos apostado que se conviertan en técnicos. Y tambien vamos a

seguir trabajando para ayudarlos a que se conviertan en técnicos. Y éste es un momento de que ésta capacitación les sirve para su curricula y estar pensando que el día en que hagamos la petición formal ante las autoridades haya un antecedente de que ya no es un simple promotor de salud que se nombro de dedos, sino que es una persona que ha recibido multiples cursos de capacitación que le dan la categoría y el derecho a considerarse técnico. Ya muchos son tecnicos y muchos son profesionales de otras disciplinas pero que están tan enamorados de la promoción de la salud que no se atreven o no quieren dejar su carrera de administración de empresas, de abogacía, de ingenería para ejercerla. Y siguen siendo esos grandes promotores de salud, prefieren trabajar con la población. Yo creo que a PRIME le dejamos la inquietud, sabrán donde encontrarme. Nosotros vamos a seguir tocando puertas. Pero creemos que en el programas de escuelas saludables, que es un programa que nacio en el Ministerio, que me cabe la honra que fuimos dos los autores, vamos a degalizarme a patentarlo como un proyecto de nosotros para que le podamos imprimir y agregar el tema de salud reproductiva. Si no, vamos a seguir curando niños. Y vamos a seguir curando bichitos y bichitas. Les vamos a desparacitar. Les vamos a quitar las caries. Les vamos a resolver sus problems de desnutrición. Pero entre más rapido les quitemos el problema de desnutrición, esa nina se va a poner más bonita y más rapido va a salir embarazada. Ese es el problema. Así es que le agradezco a PRIME. No se imaginan lo que les agradezco este reconocimiento, ésta placa, porque son los recuerdos que nos llevamos y los reconocimientos en que lo que hemos hecho en estos cinco años ha tratado de ser lo mejor posible en servir a los Salvadoreños. Ustedes deben seguir adelante. Deben de continuar haciendo ese esfuerzo para hacer de El Salvador, ese pais que todos queremos, en paz y progreso, en libertad y en democracia, ese El Salvador tan lindo que tenemos que lo puedan disfrutar nuestros hijos en mejores condiciones que la que nos tocó disfrutar a nosostros. Así es que no me queda nada más que darles las gracias por la oportunidad que nos permitieron. Lamentamos no haber estado muy puntuales, pero veniamos de hacer un recorrido de todo el oriente del país entregando las ultimas casas de salud, esas casas de salud que dejaron de ser una cliniquita para convertirse en una pequena maternidad. Porque ahora las hemos hecho todas las 80 que estamos inaugurado como una sala de parto, para que ustedes senoras parteras empíricas y los promotores tengan la oportunidad de ir a atender allí los partos. Y esas casas son de la comunidad. Esas casas son de ustedes. Y allí tienen todo para atender un parto limpio, un parto en buenas condiciones. Y ójala algun día las veamos a ustedes. Que es parte del sueno no cumplido, verlas a ustedes entrando a las maternidades de los hospitales como profesionales que son, sin temor sino que al contrario atendiendo con esas cualidades y características que ustedes tienen. Si lo vimos en Mexico y lo hacen los Mexicanos, ¿Porqué no lo vamos a hacer los Salvadoreños? Verlas vestidas a ustedes dentro de una sala de operaciones y que las complicaciones les vengan a ayudar los médicos especialistas. Pero la mayoría de los Salvadoreños hemos nacido en las manos de ustedes. Si somos un pais de progreso, somos un pais que ha ido caminando a pasos agigantados hacia adelante. Es porque la atención de los que han ido naciendo en las manos de ustedes son de verdad niños que nacen en buena condición. Y hoy cada vez vemos menos niños que cuando nacen lloran, ahora ya los Salvadoreños casi no lloran, sino que salen gritando “Viva El Salvador.” Muchas gracia

Appendix IX: References

Project Documents/Materials

Curricula:

Training of Trainers Manual in RH and FP (*Manual de Capacitación a Capacitadores en Salud Reproductiva y Planificación Familiar)*, (TOT/CTU)), PRIME, 1998.

Manual on Training of Promoters in RH and FP (*Manual de Capacitación a Promotores(as) en Salud Reproductiva y Planificación Familiar*), PRIME, 1999.

Manual for Training of Parteras in RH and FP (*Manual para la Capacitación de Parteras sobres Salud Reproductiva y Planificación Familar),* PRIME, 1999.

Training Support and Educational Materials:

Promoter Counseling Manual *(Manual de Orientación en Planificación Familiar para El Promotor*)

Promotor Reference Manual (*Manual de Consulta para el Promotor*).

3 Full-size Sheets (Mantas).

Contraceptive Method Poster.

Contraceptive Logistics:

Ministry of Health El Salvador Final Evaluation Report, Contraceptives Logistics Workshops , Sergio Lins, INTRAH/PRIME, March 1999.

Manual of Norms and Procedures in Contraceptive Method Administration, Sergio Lins, INTRAH/PRIME, 1999.

EDD Instruments:

INTRAH/PRIME Capacity Building in Training Questionnaire (EDD Instrument), May 1999.

INTRAH/PRIME EDD Impact Interview Guide (*Guía de una entrevista para determinar el impacto de INTRAH/PRIME en EDD*), May 1999.

PRIME LAC Staff/Consultant Trip Reports

Project Proposals:

APSISA Project Proposal: Improving the Quality and Availability of Family Planning and Reproductive Health Care at the Primary Level in El Salvador (March 1, 1998 -Sept. 30, 1999), INTRAH/PRIME, February 22, 1998.

Extension Project Proposal: Improvement of the RH/Family Planning Program in the MOH/El Salvador, INTRAH/PRIME, July 1998.

SALSA Project Proposal: Improving RH Care in the Ministry of Health through the USAID-funded SALSA project: PRIME Technical Assistance (February 1999 - September 1999), INTRAH/PRIME, January 20, 1999.

Proposal: Sustainability Project in Sexual and Reproductive Health, 1999-2002, Asociación Demográfica Salvadoreña, submitted to USAID/El Salvador, April 1999.

Other:

Promotor Effectiveness Study Report, Sandra Echeverria, submitted to USAID/El Salvador, July 1999.

Remarks of Outgoing Minister of Health, Dr. Eduardo Interiano, May 26, 1999