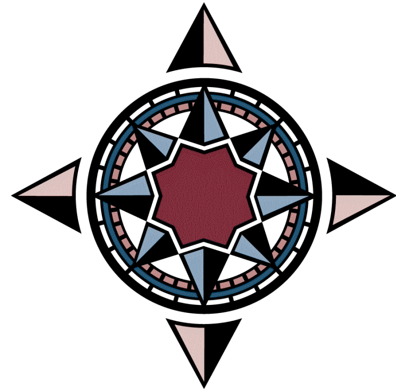

# COMMERCIAL MARKET STRATEGIES

*El Salvador Assessment Report*

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**ACRONYMS**

| | |
|---|---|
| ADS | Asociacion Demografica Salvadorena (Demographic Association of El Salvador) The principal NGO in El Salvador providing family planning services, methods, and social marketing. |
| ANSAL | Health Sector Analysis, El Salvador (USAID/ES, May 1994) |
| ARH | Adolescent Reproductive Health |
| ASAPROSAR | Asociacion Salvadorena Pro Salud Rural |
| CA | Cooperating Agencies |
| CELSAM | Centro Estrategico Latinoamericano Salud y Mujer |
| CMS | Commercial Market Strategies |
| FESAL | Encuesta Nacional de Salud Familiar (National Family Health Survey) |
| FP/RHC | Family Planning/Reproductive Counseling |
| FUSAL | Fundacion Salvadorena para La Salud y el Desarrollo Humano |
| GOES | Government of El Salvador |
| HMO | Health Maintenance Organization |
| HPN | United States Agency for Development/El Salvador, Office of Health, Population and Nutrition |
| IDB | Inter-American Development Bank |
| IEC | Information Education Communications |
| ISSS | Instituto Salvadoreno de Seguro Social (Salvadoran Social Security Institute) |
| MSH | Management Sciences for Health |
| MSPAS, MOH | Ministerio de Salud Publica y Asistencia Social (Ministry of Public Health and Social Assistance) |
| NGO | Non-Governamental Agency |
| OEF | Asociacion para la Organizacion y Educacion Empresarial Femenina |
| PAHO | Pan American Health Organization |
| PPO | Preferred Provider Organization |
| PROSAMI | Proyecto de Salud Materno Infantil |
| UNFPA | Fondo de poblacion de las Naciones Unidas (United Nations Populations Fund) |
| USAID/ES | United States Agency for Development, El Salvador |
| USAID/G/POP | United States Agency for Development, Office of Population, Washington |
| WB | World Bank |

# 1. EXECUTIVE SUMMARY

The Commercial Market Strategies (CMS) project is a five-year contract being implemented under the Commercial and Private Sector Strategies (CAPS) Results Package of USAID's Center for Population, Health and Nutrition (G/PHN/POP). As the "flagship" project of CAPS, CMS aims to increase the use of family planning and related health products and/or services through the private/commercial sectors.

In order to fulfill its mandate, CMS conducts technical assessments in selected countries to evaluate the current conditions and markets for family planning and related health care. Based on these conditions, the assessments recommend appropriate program interventions for the selected country. This report provides a rapid assessment by CMS of private sector family planning and reproductive health service delivery in El Salvador. Its purpose is to provide ideas and a guiding framework for future international assistance in this area, both from USAID and from other potential donors, public and private.

***Background***

El Salvador's population in 1998 was estimated at 6,031,326 inhabitants, with approximately 48% living in poverty. Total contraceptive prevalence is 59.7% of women of reproductive age. Female sterilization accounts for 32.4% of use; oral contraceptives 8.9%; injectables 8.1%, rhythm/billings 3.1%, condom 2.5%, IUD 1.5%, withdrawal 2.6%, and others 0.7%.

From 1993 to 1998, the Ministry of Health (MSPAS) has maintained its place as the primary source of contraceptive services for the country, with a slight decrease in urban areas. A similar pattern exists for Asociacion Demografica Salvadorena (ADS, the largest NGO provider of family planning services, methods and social marketing in El Salvador) in rural areas, where it continues to be the second most utilized source. The ISSS, however, increased coverage by 5 percentage points in urban areas and by 1.4 points in rural areas.

In El Salvador, as in many Latin American countries, the private sector has been relatively slow to develop because it has historically been crowded-out by free or low–priced Ministry of Health services and mandatory enrollment in social security systems with their own health care delivery systems. Although the environment in El Salvador is conducive to increasing the private sector role in health care provision, survey results show that the share of the private health sector has been steadily contracting over the course of the past decade.

A more strategic approach is needed to increase private sector participation and thereby expand the whole reproductive health market in El Salvador.

*Needs*

As a result of the rapid assessment conducted from May 14 – 25, the following needs emerged in the private sector:

- Policies inhibit growth in the private sector: There are some significant policy issues that inhibit the growth of the private health sector in general, and more specifically the private provision of family planning.
- Contraceptive security: All of the stakeholders interviewed in El Salvador were very concerned about the issue of contraceptive security.
- Unmet need in rural areas: According to the FESAL, the rural unmet need is 2.5 times greater than the urban rate (12.1% versus 4.9%). Lack of access and cultural barriers to use of family planning methods were cited as the principle reasons for this unmet need.
- Unmet need among adolescents: With over 50% of population under 20 years of age, adolescents are the population at greatest risk for reproductive health problems. The incidence rate of teenage pregnancy is very high, at 31%, with 9 out of 10 sexually active adolescent women reporting that they had used no protection during first intercourse.

***Proposed Strategy***

CMS recommends a private sector strategy that addresses the needs mentioned above. The comprehensive strategy would use a three-pronged approach to achieve results that correspond to USAID's health strategic objective, "Sustainable improvements in the health of women and children achieved." The approach would be to: 1) Bring all the major stakeholders to the table to address policy and contraceptive security issues; 2) Work with the private commercial sector to involve them in programs that address the unmet need in the rural areas and among adolescents, while at the same time illustrating how these programs can increase their "bottom line"; and 3) Provide assistance to the NGO sector so that they can implement programs that will increase their revenues, increase their institutional sustainability, and increase their share of the reproductive health market. This comprehensive approach will be carried out through the following initiatives:

**1. Policy initiative to address contraceptive security issues and change policies that inhibit growth of the private sector in providing reproductive health.** CMS will bring together all of the major reproductive health stakeholders in El Salvador to deal with the critical issue of contraceptive security and the policies that inhibit private sector provision of contraceptives. As USAID plans to phase out its donations of contraceptives to the public sector and NGOs, the Government of El Salvador (GOES), NGOs, and the commercial sector, as well as other donors and stakeholders, must be prepared to work together to ensure the supply of contraceptives is not interrupted. CMS will gather background information, calculate a 10-15 year projection of demand for family planning products in El Salvador, and convene the stakeholders to develop ways to satisfy the demand. Based on relevant information and necessary studies, CMS will work with the stakeholders to develop a strategy that ensures the population access to contraceptives by segmenting the market based on socio-economic status so as to improve

efficient and equitable resource allocation. New approaches that may be proposed in the market segmentation strategy, such as charging user fees, will be piloted and monitored. Based on the outcome of the dialogue among the different sectors, CMS will work with the GOES to change any policies that inhibit the growth of the private health sector.

**2. Rural program initiative**. This initiative is designed to utilize the well-documented excess of medical school graduates in El Salvador, as well as satisfy the unmet need in the rural areas. A model Rural Service Program could be established in the National Medical School that would provide a complimentary program for medical students that are willing to set up practices in the rural areas. To satisfying the demand among the agricultural workers, CMS would work with ISSS to facilitate contracting out to recent graduates or a local NGO to work at the Company Clinics on coffee cooperatives.

**3. Network of "Youth Friendly" providers**. There is an opportunity for collaborating with the Asociacion Salvadorena de Ginecologia, Obstetricia y Otras Disciplinas para la Infancia y la Adolescencia (ASOGIA) to quickly develop a network of "youth friendly" providers. Establishing such a network would enable capacity building, standardization of care, quality assurance, marketing, and potential partnerships with pharmaceutical companies to provide low-cost family planning services and products to adolescents.

**4. Corporate Social Responsibility (CSR) initiative to increase access to RH information in rural areas and to youth**. During the two-week assessment in El Salvador, CMS garnered great interest from the Avon Corporation and other corporations to participate in a corporate social responsibility initiative to increase in demand and use of family planning and reproductive health services. Avon would to be a sponsor of the interdisciplinary regional congress on Adolescent Health, sponsored by ASOGIA. In addition, they would like to collaborate with ADS Adolescent Health Program to develop and support a teen hotline, and include the hotline number and reproductive health information in the Avon catalogues distributed by 15,000 Avon vendors.

**5. Sustainability initiative to increase supply of RH services and products in NGO sector**. As the NGO sector has only 1% of the health market, this sector is ripe for intervention. The Asociacion Demografica Salvadorena (ADS) is one of the successful NGOs that has managed to create a niche for themselves in El Salvador. CMS would like to work with other NGOs to achieve the same results, and thereby increase their market share of the reproductive health market. This initiative would include technical assistance in fundraising/resource diversification, marketing, procurement, and access to credit.

***Results Expected from Private Sector Initiative***

- Improved environment for the utilization of the private sector for reproductive health products and services
- Sustained supply of contraceptives
- More efficient and equitable resource allocation for family planning products and services
- Increased access to health services in rural under-served areas

- Increased supply of providers trained to respond to the reproductive health needs of youth
- Increased demand for RH services among youth
- Increase long-term supply of reproductive health services and products by improving sustainability of RH NGOs

## 2. INTRODUCTION

The Commercial Market Strategies (CMS) project is a five-year contract being implemented under the Commercial and Private Sector Strategies (CAPS) Results Package of USAID's Center for Population, Health and Nutrition (G/PHN/POP). As the "flagship" project of CAPS, CMS aims to increase the use of family planning and related health products and/or services through the private/commercial sectors

CMS typically conducts a country assessment as a first step in designing an intervention. The assessment in El Salvador demonstrates how the CMS team evaluated the current conditions and markets for family planning and related health care and made recommendations for an appropriate CMS program based on the country needs.

CMS conducted a two-week assessment with the following objectives:

- Examine the country conditions to determine the need for a private sector initiative.
- Interview stakeholders such as USAID/El Salvador, the Ministry of Health (Ministerio de Salud Publica y Asistencia Social, or MSPAS), the Instituto Salvadorena de Seguro Social (ISSS) and others such as the medical associations, cooperatives, etc., to discuss and understand the Mission and Government of El Salvador (GOES) needs, strategies, and direction.
- Meet with other players in the health sector such as USAID Cooperating Agencies (CAs) and other donors to understand the overall context of health care in El Salvador, USAID's program activities, and to identify potential partnerships and coordination needs.
- Recommend areas for possible CMS initiatives.

Fieldwork was conducted from May 13 – 25, 2001 including interviews with over 57 entities (see Appendix A & B). The assessment team consisted of the CMS Regional Manager for LAC, Kelly Wolfe; a Senior Consultant for Policy and Health Financing, Jack Fiedler; and a Senior Consultant for Reproductive Health, August Burns. A list of references is attached as Appendix C.

The assessment responds to the USAID's health strategic objective, "Sustainable improvements in the health of women and children achieved," focuses mainly on rural women and children. USAID is providing assistance to the Salvadoran health sector to improve the quality and access to child survival and reproductive health services by the rural poor; and to improve the policy framework and institutional systems that support and sustain these services. USAID, in close coordination with other donors working in the health sector, is providing technical support, training and research to the Ministry of Health, and other public and private agencies to ensure the coverage of primary health care services in rural areas, and the continuation of the health sector modernization process.

# 3. BACKGROUND

## A. The Economy

Since the signing of the Peace Accords in the early 1990s, the Salvadoran economy has gradually improved. The country benefits from a commitment to free market and careful fiscal management that has helped to curb inflation, increase exports, and reduce trade deficits. The primary exports are coffee, sugar, shrimp, textiles, chemicals, and electricity. However, the economy currently suffers from a weak tax collection system, weak world coffee prices, and the aftermath of Hurricane Mitch and the recent earthquakes.

From 1979 to 1990, the impact of the civil war on El Salvador's economy was devastating. Losses from damage to infrastructure and means of production due to guerrilla sabotage as well as from reduced export earnings totaled about $2.2 billion. Since attacks on economic targets ended in 1992, improved investor confidence has led to increased private investment.[1]

During 1990 to 1995, the Salvadoran economy began to make gains. Much of the improvement in El Salvador's economy was due to free market policy initiatives, including the privatization of the banking system, telecommunications, public pensions, electrical distribution and some electrical generation, reduction of import duties, elimination of price controls on virtually all consumer products, and enhancing the investment climate through measures such as improved enforcement of intellectual property rights. In the early 1990s, the BDP had attained real growth (adjusted for inflation) of more than 7%. The driving force behind the economic growth from 1990-1995 was generated by an influx of foreign currency following the Peace Accords, and the growing stream of money sent home by Salvadorans residing in the U.S. and Canada—about US$1 billion a year—and the expansion of credit in the private sector.

In mid-1995 the Salvadoran economy began to decelerate again. By 1996, this rate had fallen to 3%, and in 1999 it was just 2.2%. The reduction was associated with a reduction in internal demand and a slow-down in exports of goods and services as well as a major shift in the business outlook. The post-war boom in the Salvadoran economy began to fade in July 1995 after an abrupt shift in monetary policy was followed by a June increase in the value added tax (VAT) and price hikes in basic public services. The 10% value-added tax, implemented in September 1992, was raised to 13% in July 1995.

The economic slowdown lingered into 1996. Growth in GDP in 1996 was only 2.1%, but by 1997 it had increased to 4%. In 1998, El Salvador's economy grew by 3.2%--the damage caused by Hurricane Mitch to infrastructure and to agricultural production reduced 1998 growth by an estimated .5%. Growth weakened further in 1999 due to poor international prices for

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[1]U.S. State Department Background Notes El Salvador, August 2000. Available online at www.state.gov/www/background_notes/

El Salvador's principal export commodities, weak exports to Central American neighbors recovering from Hurricane Mitch, and an investment slowdown caused by the March 1999 presidential elections and delays in legislative approval of a national budget. The most recent economic indicators are summarized below:

| Table 1. Key Economic Indicators[2] | |
|---|---|
| GDP real growth rate (1999 est.) | 2.2% |
| GDP per capita (1999 est.) | US$3,100 |
| Inflation (1999 est.) | 1.3% |
| Unemployment (1997 est.) | 7.7% |
| Agriculture value added, % of GDP (1999 est.) | 12% |
| Industry value added, % of GDP (1999 est.) | 22% |
| Services value added, % of GDP (1999 est.) | 66% |

It is estimated that almost half the population (48%) lives below the poverty line. Despite evidence that rural poverty has declined since 1992 (from 60 percent in 1990 to 47.5 percent in 1995), there was little change between 1998 and 1999. The Salvadoran economy's slow growth in 1999 (only 2.6 percent) was too low to have a major impact on poverty levels. The most dynamic growth during 1999 was in the agriculture (along with banking and finance) at 6.6%; the growth in agriculture—the primary source of employment for the rural poor—represents a rebound from negative growth levels in 1998 (Hurricane Mitch) and virtual stagnation in 1996 and 1997.

## B. External Technical and Financial Cooperation

In 1996, the Department of External Cooperation received international or foreign aid amounting to US$45.5 million; 86% was received through the execution of 57 projects. Funds were contributed by Germany, Canada, Denmark, Netherlands, Luxembourg, Norway, Sweden, Switzerland, Organization of American States, United Nations World Food Program, UNICEF, European Union, the World Bank, Social Investment Funds, United States Agency for International Development, GTZ, and the United Nations Population Fund.

## C. Investment Climate

The investment climate in El Salvador is very positive. Since the early 199s the GOES has undertaken massive economic reforms to limit the government to more of a regulatory and over-sight role, to encourage the private sector and to make the Salvadoran economy more market-driven. While the rate of growth of the economy has slowed in the mid-1990s, its pace of expansion has been slowly picking up since then, and the "dollarization" of the economy (which

2 World Fact Book 2000. Available online at http://www.cia.gov/cia/publications/factbook/geos/es.html.

is expected to be completed by the end of this year) will help bring greater price stability. In terms of tax policies that affect the health sector, prescription medicines are exempted from the 15% sales tax (IVA).

## D. Policy

El Salvador's National Population Policy was adopted in 1993. The primary policy objective is to balance the country's population growth with the country's development, guaranteeing at all times respect for individual choice and responsibility of the individual and couple in the number and spacing of their children. The Lines of Action related to family planning include:

- Expand the coverage and improve the quality of the delivery of family planning services by public sector institutions.
- Increase the family planning services in rural areas, among marginal urban and vulnerable groups.
- Promote the use of methods and family planning options in urban areas.

The most recent changes to the family planning norms occurred in April 1999 when community promoters were recognized officially as being able to dispense injectable and oral contraceptives.

Overall, the policy environment for family planning provision is very positive. Practice norms were reviewed for this assessment and found to be current and to contain few unnecessary barriers to the provision of care or to individual user's access to methods. (The only exception pertains to the adolescent population, and will be discussed later in this report). Interviews with service providers in all sectors demonstrated a consistent awareness of the new practice norms as well as agreement with their contents.

## E. Population and Growth rate

El Salvador's population in 1998 was estimated at 6,031,326 inhabitants. Approximately 98% of the population is Mestizo, 1% representing indigenous groups, and 1% Caucasian. The annual population growth rate is estimated at 2.3% with a population doubling time of 29 years.[3] The end of El Salvador's civil war caused an abrupt shift in Salvadoran population dynamics. During the civil war, higher mortality in men, combined with migration to other countries, and separation of couples all contributed to lower fertility levels.

Of the country's 14 departments, the most heavily populated is San Salvador—where approximately 30% of the population reside. La Libertad and Santa Ana are the next most populated departments (See Table 2). Approximately 58% of the population live in urban areas and 42% in rural areas.[4]

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[3] Population Reference Bureau, World Population Data Sheet, 2000.
[4] Ibid.

## F. Health Status and Indicators

El Salvador's estimated maternal mortality rate in 1998 was 120 per 100,000 live births. In 1998, the infant mortality rate was 35 per 1,000 with higher infant mortality in rural areas.[5]

In terms of reproductive health services, approximately 79% of all women from 15-49 that have ever had sexual intercourse reported having at least one PAP smear. From the period 1993-1998, approximately 76% of mothers had at least one prenatal care visit during their pregnancy, with 57.2% receiving the care in the first 12 weeks of pregnancy. Of all the births for which the mother had a prenatal care visit, 73.2% received their care from the MSPAS, 15.4% in ISSS, and 9% in private facilities. Among the births that were attended by trained personnel, 58% were delivered in hospitals. In MSPAS facilities, 1 out of every 5 deliveries was free of charge. The fact that free deliveries in hospitals and private clinics was slightly greater than in MSPAS facilities may be due to the delivery being covered by private medical insurance or because the hospital or clinic was affiliated with a subsidy program.

Postpartum care is the maternal and child health service used least frequently in El Salvador. Approximately 43.3% of mothers used this service aster a live birth. Its use is directly related to the urbanization level of the place of residence and the educational and socioeconomic levels of the mother.

| **Table 2. Key Demographic Indicators (FESAL 1998)** | |
|---|---|
| Crude Birth Rate (per 1000 pop.) | |
| Crude Death Rate (per 1000 pop.) | 6.1 |
| Contraceptive Prevalence all methods | 59.7% |
| Contraceptive Prevalence Modern methods | 53.4% |
| Total Fertility Rate (births per woman) | 3.58 |
| Life Expectancy at Birth for males (2000) [6] | 65.6 |
| Life Expectancy at Birth for females (2000): | 72.5 |
| Infant Mortality Rate (per thousand live births) (1993-1998) | 35 per 1,000 |
| Maternal Mortality rate (MMR) (1988-1998) | 120 per 100,000 |

A cumulative total of 1,789 AIDS cases were reported between 1984 and 1996 (some sources, however, report higher numbers). From 1991 onward there has been a steady increase in the annual incidence that went from 2.5 per 100,000 in 1992 to 7.6 per 100,000 in 1996. In 1996, there were 417 reported cases of AIDS and 264 persons diagnosed as HIV-positive.[7]

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[5] Encuesta Nacional de Salud (FESAL-98).
[6] Gobierno de El Salvador, Direccion General de Estadistica y Censos.
[7] Pan American Health Organization. *Health in the Americas*, 1998. Available online at http://www.paho.org.

## G. Contraceptive Prevalence

In the 1998, the results of the National Family Health Survey indicated that 97.1% of women of reproductive age (15-44 years of age) had heard of at least one method of family planning. The three most known methods of family planning among women of reproductive age were oral contraceptives (92.7%), sterilization (91.4%), condoms (90.5.2%), and injection (89.4%).

Female sterilization has been the most widely used method since 1975. The oral contraceptive was the most widely used temporary method up until 1993, and was replaced by the injection in 1998. Female sterilization was primarily responsible for prevalence increases until 1988, when the family planning program changed its focus to cover the young population through increased use of temporary methods. Since then temporary contraceptives represent the majority of increase.

Total contraceptive prevalence is 59.7% of women of reproductive age. Female sterilization accounts for 32.4% of use; oral contraceptives 8.9%; injectables 8.1%, rhythm/billings 3.1%, condom 2.5%, IUD 1.5%, withdrawal 2.6%, and others 0.7%.

Despite the relatively high overall family planning prevalence rate, the continued reliance on sterilization as the method of choice suggests that the majority of families have two to four children in rapid succession and then choose sterilization to avoid future pregnancies. There is therefore a great deal of room for increasing public awareness of the benefits of delaying first pregnancies, child spacing and planning the number of children a family wants.

The greatest promise for change in the low use of temporary methods has been the introduction of injectable contraceptives, particularly the progesterone only injectables, Noristerat and Depo Provera, which seem to have a high degree of acceptance by the community and are receiving positive reviews by users. Providers report that women like the convenience of the method but that the greatest advantage is the confidentiality that the method affords. In a culture that remains ambivalent about the use of family planning the ability of a woman to receive an injection every two to three months without the necessity of family, neighbors or a partner knowing is key to continued use, especially for the adolescent population.

## H. Family Planning Service Provision

From 1993 to 1998, the Ministry of Health (MSPAS) has maintained its place as the primary source of contraceptive services for the country, with a slight decrease in urban areas. A similar pattern exists for Asociacion Demografica Salvadorena (ADS, the largest NGO provider of family planning services, methods and social marketing in El Salvador) in rural areas, where it continues to be the second most utilized source. The ISSS, however, increased coverage by 5 percentage points in urban areas and by 1.4 points in rural areas.

The Ministry of Health is the primary provider of sterilization and IUD services, but also the primary source for oral contraceptives (40.3%). ADS, both through its social marketing products and community providers, is the primary provider of condoms (57.0%) and the second most common source for oral contraceptives (26.7%).

A small proportion of the provision of MSPAS clinical services, including family planning services, are contracted out to five NGOs: FUSAL, OEF, Calma, ASAPROSAR and ASM (Asociacion de Mujeres Salvadorenas). Rural services are largely provided by a network of 150 health clinics, 359 health posts (staffed by an auxiliary nurse) and 180 health promoters.

**Table 3.**
**Comparison of Key Family Planning Indicators 1993 and 1998 FESAL**

| Indicator | 1993 | 1998 |
|---|---|---|
| Knowledge of Contraceptives | 97.8% | 97.1% |
| Current Use (Total) | 53.3% | 59.7% |
| Current Sterilization Use | 31.5% | 32.4% |
| Current Injection Use | 3.6% | 8.9% |
| Current Oral Contraceptive Use | 8.7% | 8.1% |
| IUD Use | 2.1% | 1.5% |
| Condom Use | 2.1% | 2.5% |
| Source of Method (Total) | | |
| MSPAS | 48.9% | 47.1% |
| ISSS | 14.5% | 18.2% |
| ADS | 15.3% | 15.6% |
| Source of Sterilization Services | MSPAS 64.3%<br>ADS 16%<br>ISSS 15.7% | MSPAS 59%<br>ADS 12.5%<br>ISSS 23% |
| Source of IUD Services | MSPAS 45.7%<br>ISSS 30.4%<br>ADS 16.3% | MSPAS 37.8%<br>ISSS 42.5%<br>ADS 12.6% |
| Source of Oral Contraceptives | MSPAS 44.5%<br>ADS 9.8%<br>Pharmacy 26.7%<br>ISSS 13.1% | MSPAS 40.3%<br>ADS 35%<br>Pharmacy 11.9%<br>ISSS 9.1% |
| Source of Injections | MSPAS 4.4%<br>ADS 37.3%<br>ISSS 11.8%<br>Pharmacy 39.8% | MSPAS 42.3%<br>ADS 14.5%<br>ISSS 16.4%<br>Pharmacy 20.1% |
| Source of Condoms | MSPAS 15.1%<br>ISSS 17.2%<br>ADS 2.2%<br>Pharmacy 57% | MSPAS 22.4%<br>ISSS 13%<br>ADS 30.3%<br>Pharmacy 27.0% |

According to the 1998 FESAL, approximately 40% of women of reproductive age married or in union did not use contraception in the 30 days prior to the interview (17.6% has previously used and 22.7% had never used). Among women who had previously used contraceptives, the major reason cited for discontinuing use (after wanting to become pregnant 30.5%) was related to side effects (27.5%). The preferred method cited by women who want to use contraception in the future was the injection, female sterilization, and then oral contraceptives. The MSPAS was the most commonly cited source for future contraceptive use.

# 4. THE HEALTH SECTOR

In order to understand the factors that have influenced the coverage, level and composition of reproductive health services provided in El Salvador, it is necessary to become familiar with the general health care delivery system of the country; its principal actors; their institutions; missions and mandates; and their recent policy initiatives.

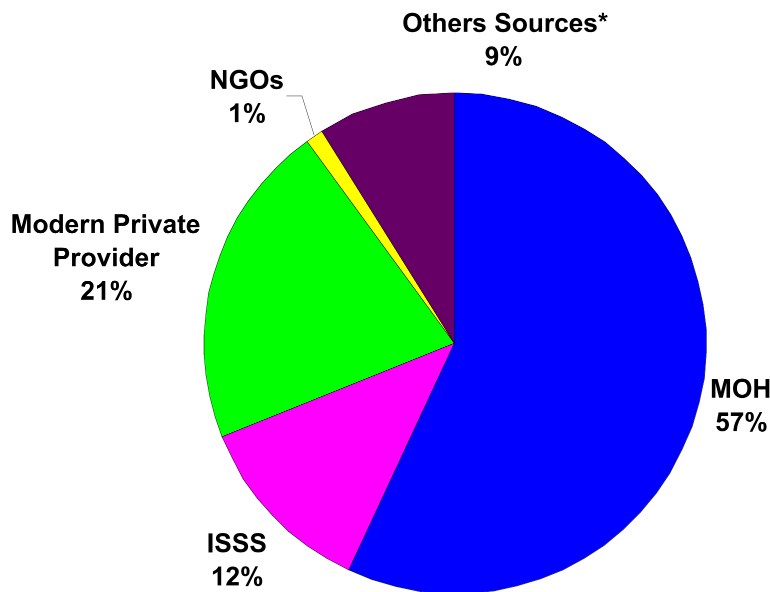
## A. Coverage by Source of Supply

There are three major sub-sectors in the health care market of El Salvador, the MOH, the ISSS and the private sector. The Ministry of Health is mandated to provide health care to the entire population of El Salvador, and has traditionally been regarded as the chief provider of 80 to 85 percent of the population. The Social Security Institute provides health care to its enrolled workers and retirees, their spouses and children up to the age of 6. Traditionally, ISSS coverage has constituted less than 10 percent of the population, but with the substantial number of changes in coverage that have been introduced since 1989 its coverage has increased. It is now generally regarded as providing care to 15 percent of the population, with the private sector accounting for the remainder; i.e., less than five percent. Data from several household health interview surveys, however, suggest that these traditional perceptions are no longer accurate.

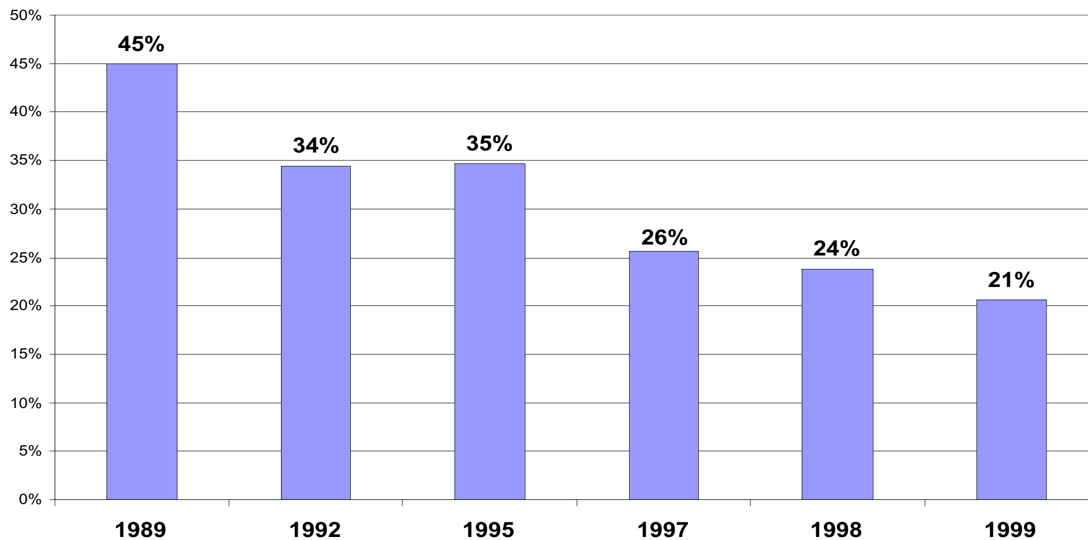
According to the Ministry of Economy's Multi-Purpose Household Survey (MPHS) of 1999, 57 percent of Salvadorans rely on the MOH for ambulatory curative health care, 21 percent rely on modern, private sector providers (exclusive of pharmacies and traditional healers), 14 percent turn to ISSS and other institutional providers, one percent go to NGO providers and the remaining seven percent use a variety of other sources.[8] Graph 1 shows where the self-reported ill persons interviewed in the MPHS reported they had sought care. Graph 2 shows the relatively greater importance of the MOH in rural areas vis-à-vis urban areas of the country.

[8] The "other institutional providers" that are combined with ISSS patients include the military system (Sanidad Militar), which has provided health care on a fee-for-service basis to the general public since the early 1990s, and the Teachers' Welfare System, a self-insurance scheme that provides care for the nation's teachers and their families through a network of accredited private providers.

**Graph 1: Market Shares of Coverage**
**Sources of Care of Persons Who Sought Care in the Previous Month**
**(Annual Household Income and Expenditures Survey Report 2000)**




Graph 2 shows the evolution of the size of the private sector, as measured by the proportion of Salvadorans who self-reported themselves to be ill and sought care. Although the absolute size of the private sector may be increasing, these survey results show that the share of the private health sector (in terms of the proportion of Salvadorans to whom it provides care) has been steadily contracting over the course of the past decade. By 1999 the market share of the private, commercial sector was about one-half of what it had been at the beginning of the decade. Hence, while the market share of the MOH is substantially less than is generally claimed by Ministry of Health officials, its relative importance has been increasing over the course of the past decade.




## B. Ministry of Health

This section presents a selective, broad-brush description of aspects of the Ministry of Health's structure, operations and financing.

### B.1 Health Reform

Since the 1994 Health Sector Assessment, there has been a great deal of discussion about health reform in El Salvador. In the last two years there has been a marked increase in the intensity of discussions and studies, as well as the development of a number of reform proposals. The Colegio Médico offered what it entitled a "Citizens's Proposal" ("Propuesta Ciudadana por la Salud") in 1999. Shortly thereafter a highly regarded Salvadoran think tank, FUSADES, published its own reform proposal. Then, in December 2000, after years of work, the Central Government-appointed Health Reform Group (Consejo de Reforma del Sector Salud) released the official Government of El Salvador (GOES) health reform document. The GOES proposal calls for a 15 year, three-phase reform process. Its publication was followed in February 2001, by the Colegio Médico's publication of a critical analysis of this plan (Mesa-Lago).

As in many countries, there is a relatively high degree of consensus about what the system should look like in 15 or 20 years. In contrast, however, there is much less consensus and relatively few specific concrete plans that map out beyond the next few years what the transition to that desired endpoint will look like; i.e., what is involved for all of the key actors and sub-sectors in constructing that new system. While many of the goals, objectives, criteria, values that will guide that process have been identified, and some of the types of likely changes that will be introduced have been identified, the number of reforms, counter-reforms and critiques that have been made in the last few months demonstrate that much remains to be determined, and it will be the outcome of a highly political process.

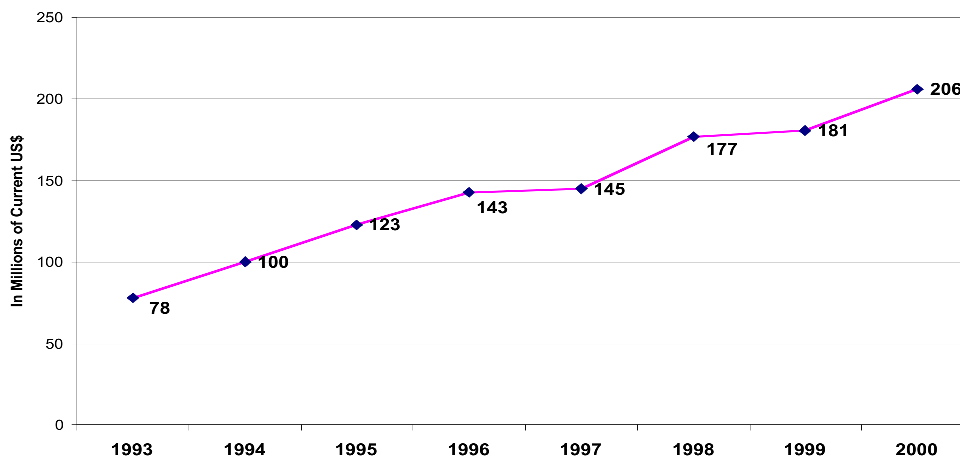
On the one hand, being at such a crossroads can be regarded as a time of great opportunity that persons working in the sector find exhilarating, energizing and challenging. Helping to construct a new order can be noble, rewarding activity, especially in a country that has recently suffered a decade long civil war. On the other hand, it can be difficult and trying, creating uncertainty and doubts about the future, threatening job security and careers, and undermining loyalty and morale. Looming monumental reform is the backdrop to the day-to-day operations of the Ministry. Recognizing this and recognizing that health reform is an inherently dynamic, political process underscores the importance of figuring out how a commercial market strategy proposal can be made compatible with the unfolding health reform.

## B.2 Positive Recent Developments

As demonstrated earlier, the MOH has an impressive recent performance record. In part, its rapidly growing level of service delivery has been due to GOES providing greater funding. The GOES has made a major commitment to restoring and improving the quality and coverage of public health care services delivery, which had been a casualty of the civil war. Each year from 1984 through 1991, an average of 91 percent of the monies the Ministry received from the GOES ordinary budget was spent on personnel. The Ministry was in a protracted recurrent cost crisis, and it remained a viable, credible provider of health care services largely due to the assistance it received from international agencies, most notably USAID. In 1991, USAID was financing three-quarters of the MOH's purchases of medicines and other medical supplies, and 20 percent of the Ministry's total operating costs. As USAID began to phase down its assistance, GOES has stepped in, picked up the difference and more.

As may be seen in Graph 3, from 1993 to 2000, the level of financing of the Ministry increased (in nominal terms) by nearly three-fold, demonstrating GOES commitment to rebuilding the Ministry. During the last seven years, GOES has annually spent an average of 9.2 percent of total central government expenditures on the Ministry of Health. Last year, this proportion increased to 9.9 percent.

**Graph 3: The Growing Level MOH Expenditures**
**(MSPAS Information website - www.mspas.gob.sv)**



In order to improve the Ministry's performance, the Ministry has also made a number of major changes in the way it has traditionally been structured and in its operations, including:

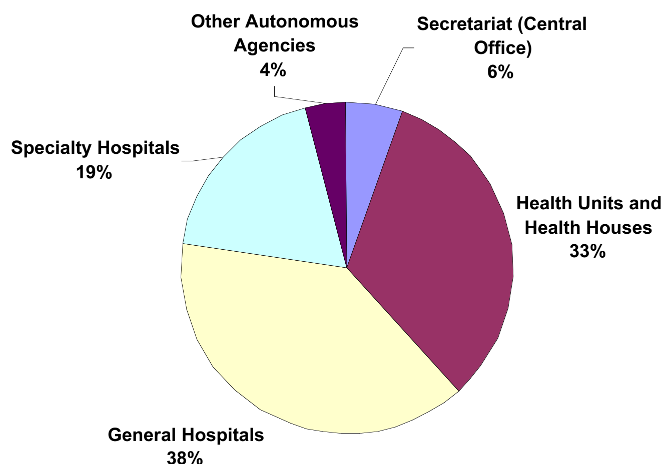
- The MOH took the politically difficult step of re-structuring workhours of its more than 20,000 employees, in order to be able to use its infrastructure more efficiently and to increase access. It extended the number of hours per day during which care is available during the week and now also provides services on Saturday mornings.
- The MOH installed of a new financial accounting system that provides a consolidated statement of its revenues and expenditures. Prior to this reform, the Ministry's financial system consisted of six distinct, unintegrated accounting systems, rendering financial planning impossible.
- With assistance from the Pan American Health Organization (PAHO), the Ministry has developed a cost accounting system that provides unit cost estimates of each type of service provided by the MOH. This system provides a fundamental building block for improving the management and efficiency of the Ministry, and can provide the basis for devising a performance-based reimbursement scheme.
- The Ministry has contracted five NGOs to provide services in areas where the MOH has never had adequate coverage.
- Working with the World Bank, the Ministry is developing an office that will have the capability of purchasing services/contracting out. Current plans call for the office to be fully operational by Spring 2002.
- The Ministry has re-organized and decentralized. The six regional offices have been decentralized to the department level. (There are 14 departments and San Salvador has been divided into four regional networks.)
- The MOH officially recognized legalized and established norms for the universal, but informal user fee system that had developed since the early 1980s.

These are major reforms. How well they are functioning and how much they have improved the performance of the MOH could not be ascertained in the course of this two-week consultancy. Nevertheless, the auger well about the future of the MOH, and together with the financial commitment that the GOES has made, suggests that the Ministry is becoming more capable, effective, efficient, flexible and pro-active.

### B.3 Areas of Concern, Impediments to Further Progress

There remain, however, areas of concern, particularly about how the MOH manages its resources. First, the Ministry continues to spend only one-third of its resources on the front-line facilities, those providing the overwhelming share of primary health care. See Graph 4. Second, the Ministry continues to try to be "everything" for "everybody," rather than identifying its service priorities and its target population. In an interview, an international agency official stated that "targeting, defining a basic package of services and contracting are considered "bad" words in the Ministry… "it doesn't want to hear about those concepts."

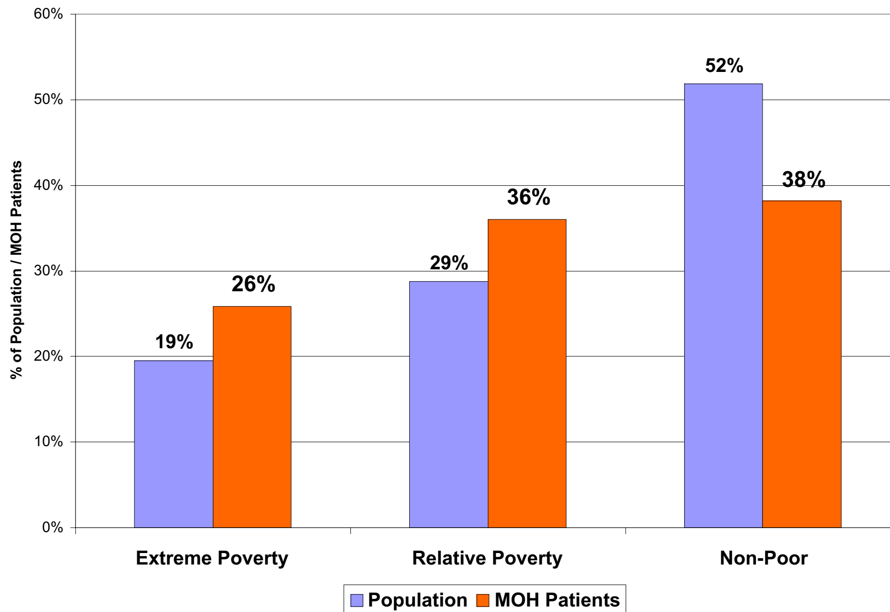
**Graph 4: Composition of MOH Expenditures, 1999**
**(MSPAS Information website - www.mspas.gob.sv)**




Within MOH there is inadequate appreciation that there is a private sector and that some people have the ability to pay for care and should be encouraged to use the private sector. Graph 5 shows the income class composition of the Salvadoran population and of MOH patients. While disproportionate numbers of persons who live in poverty (both extreme and relative) turn to the MOH for their care, 38 percent of all of the MOH's patients are non-poor. Consistent with its trying to do "everything for everyone," the MOH has a simple, universal 10 colones[9] user fee charge at health units and health houses and 15 colones for hospital-provided ambulatory care. These fee levels are about 10 percent of what is charged, on average, in the private sector. Their low relative levels discourage people from going to private physicians. The MOH's commitment to do "everything for everyone" means it serves more people with the ability to pay for care that could be served in the private sector. If those with the ability to pay were to frequent the private sector, then that would free up the Ministry providers' time and Ministry resources to provide greater access, more services and better quality services to persons who don't have the means to go to a private doctor. There is inadequate appreciation for the fact that by charging such low fees it contributes to the underemployment of the private sector

It would be advisable for the Ministry to introduce a sliding fee scale, and to charge those who have the ability to pay substantially more. This would generate more revenues for the Ministry, enabling it to purchase more medicines and other medical supplies, with which to improve the quality of care, while encouraging those with the ability to pay to go to private providers, thereby reducing costs.

[9] Current exchange rate as of 5/25/01 was 8.75 colones = $1




It is imperative to recognize the importance of user fee revenues. In two interviews—one with the director of the San Rafael Health Unit in Santa Ana, the other with the Director of the San Salvador Central Regional Office—it was reported that user fee revenues are used to purchase slightly more than half of the value of all medicines. To the extent that this is the norm (and there is no reason to believe otherwise), it demonstrates that user fee revenues are essential to providing an acceptable quality of care, and provides evidence that despite the large increases in MOH funding that have occurred, there remains a serious financing shortfall.

It is also important to recognize the political obstacles that instituting such a major change in the provision of health care services would face. Eliminating or decreasing free or low-cost services for the middle and upper classes would obviously be politically unpopular. We were told during interviews that few politicians are likely to be willing to take on such a task. It is therefore essential that such a proposal be followed up with careful planning in order to gain popular support for such a reform.

## C. Salvadoran Social Security Institute (ISSS)

The Salvadoran Social Security Institute was established in April 1954. The ISSS has two basic funds: a disability, retirement and death regime and a health services regime. Since its inception, ISSS has been funded by earmarked payroll taxes. The discussion here will focus exclusively on the health services component. Since its inception, ISSS has maintained its own health care delivery structure. Workers making payroll deduction contributions to the health component are, in effect, purchasing health insurance that entitles them to the use of ISSS's health care services, free of point-of-service charges. ISSS affiliates and their beneficiaries are entitled to as much ISSS-provided health care as they choose to obtain. There are no deductibles, no co-payments and no limitation on the amount of care that the insured may obtain. Everything is paid for by

ISSS; all consultation costs, the cost any surgery that may be required—including sterilization—as well as the costs of medicines, laboratory, x-ray and other ancillary examinations and all family planning supplies are provided free of point-of-service fees. The insured are required, however, to use ISSS providers and facilities—though there are some exceptions to this general rule that will be discussed below.

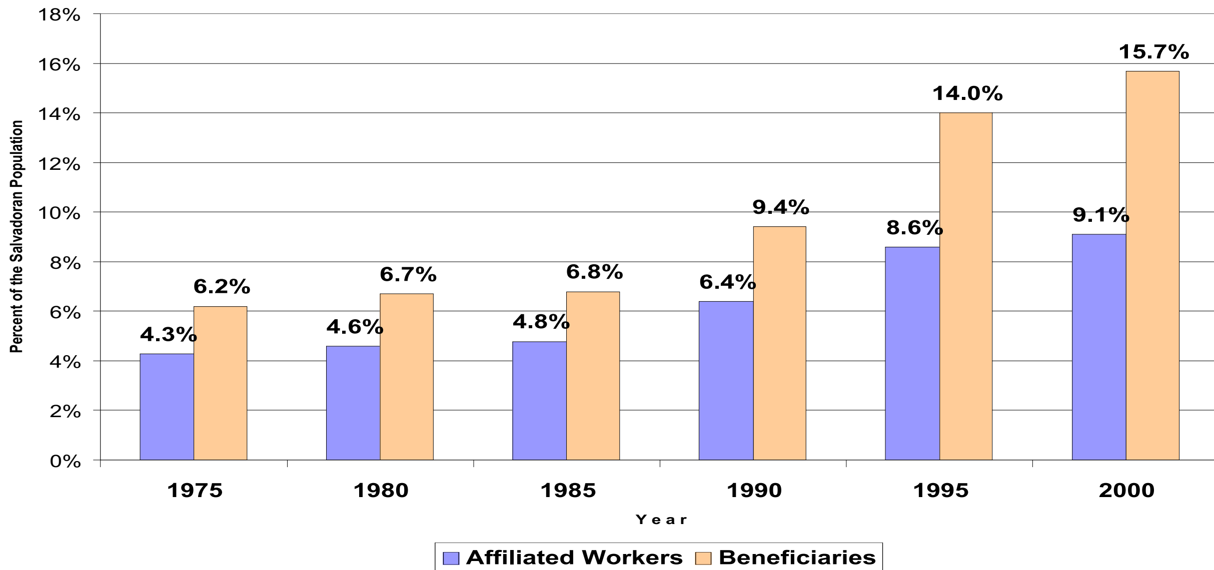
### C.1 ISSS's Coverage

The coverage of ISSS has expanded steadily since the program was first established. Initially ISSS coverage was limited to industrial, commercial and service establishments in only nine of El Salvador's 262 municipios (counties), and even there is was limited to companies with more than five and less than 250 employees, workers earning less than 500 colones monthly and it excluded employees of municipal governments and the central government. Since then there has been a series of amendments to Chapter III of the Social Security Law that has gradually extended the coverage of the program.

ISSS-affiliated, active workers as a proportion of the Salvadoran population has nearly doubled, from 5 to 9 percent, and the proportion of the economically active population which is affiliated has increased by more than one-third, reaching 22 percent in 2000. The various extensions of coverage have resulted in the total ISSS beneficiaries growing more rapidly than the number of affiliated workers. While the number of affiliated workers grew 152 percent from 1985 to 2000, the number of beneficiaries grew by 205 percent. The most dramatic change has been the six-fold increase in the number of beneficiaries who are children. Another important change has been the relatively rapid growth in the share of inscripted workers who are retired. These two groups—young children and retirees—are generally disproportionately heavy users of health care, and thus (other things being equal) their relatively faster increasing numbers has probably resulted in increasing average ISSS health care expenditures per beneficiary.

Graph 6 shows how the relatively stagnant levels of coverage of both workers and beneficiaries in the 1975-1985 era, was broken in 1990 with the substantial expansions in coverage. Starting that the same year, both the proportion of Salvadorans who are affiliated workers and beneficiaries has persistently grown. ISSS's current (1999-2004) strategic five-year plan calls for undertaking feasibility studies for further extending coverage. In an interview, ISSS's Director of Planning, Dr. Jose Antonio Pereira, reported that a feasibility analysis of establishing two rural-based clinics in the western region of the country had just recently been completed. The design called for the clinics to primarily service agricultural cooperatives. Dr. Pereira reported that the cooperatives rejected the offer on financial grounds. Even though ISSS offered to allow the cooperatives to affiliate by contributing only the health portion of the payroll tax (i.e., they were not going to be required to also participate in the old-age, disability and death component of the General Regime), the cooperatives maintained that their members could not afford to affiliate. Given the slogan that ISSS adopted in 1999, "Toward Universal Coverage with Solidarity" ("Hacia la Universalidad con Solidaridad"), and its record of other, more innovative initiatives, it should be expected that ISSS will continue to investigate new avenues for gradually extending its coverage.

Graph 6: Growth in the Number of ISSS Affiliated Workers and ISSS Beneficiaries as a Percent of the Salvadoran Population (Estadisticas, Table 12, 2000)




## C.2 ISSS's Efforts to Modify Its Largely Hospital-Based, Curative Care Services

The high concentration of ISSS facilities in San Salvador, and the Institute's traditional overwhelmingly hospital-based, curative care orientation have long been topics of public criticism. Partly in response to these criticisms, since the mid-1990s ISSS has been reforming its traditional modus operandi, and, among other changes has introduced the Community Clinics and the Company Clinics, mentioned earlier.

### *Company Clinic System*

Company Clinics grew out of dissatisfaction with the timeliness of ISSS outpatient care services. Long delays in obtaining care has prompted a substantial, but undetermined, number of business firms to establish their own health care delivery capacity, generally hiring one or more health care providers to provide care at the work-site (on either a part-time or a full-time basis) and other companies to provide their workers with private insurance, while they continue to meet their legal requirement to pay their ISSS health regime contribution. This decision is generally made on purely economic grounds: the value of work-time saved by providing workers with more expeditious care outweighs the cost of the insurance premium or of paying the provider and other costs of direct care provision. No systematic study has ever been conducted to identify the numbers and types of such arrangements, but they have been common since at least the mid-1980s and, since these companies pay for these arrangements in addition to having to continue to pay their ISSS health contributions, they clearly are a manifestation of perceived deficiencies in the ISSS health service delivery system.

Starting in 1994, several large companies made clear their dissatisfaction with the degree of access to and timeliness of ISSS health care delivery, proposed a new type of arrangement and entered into negotiations with ISSS. The discussions resulted in ISSS's 1995 introduction of a new health care delivery modality, the Company Clinic. In brief, the clinic facility is equipped and staffed by private health care providers who are paid employees of the company and ISSS provides the medicines, family planning and other medical supplies.

For its part, ISSS was reportedly motivated by its search for a low cost method to extend access and utilization, particularly given that its outpatient clinics were largely saturated at the time. The Company Clinic System offered a convenient, low cost way for ISSS to defuse criticism, avoid some of the cost of needing to build additional infrastructure, and, in effect, to partially privatize some of its outpatient care treatment costs.

Companies may voluntarily choose to participate in the Company Clinic modality, but they are not required to do so. Those electing to do so, must meet a series of requirements that ISSS has established, which constitute a type of certification process. The requirements stipulate that the company clinic have three service areas, a reception area, a consultation room and a nursing unit area, and it requires that certain types of equipment be provided and specified referral procedures be followed. Companies with certified clinics that want to participate in the program sign a cooperative agreement with ISSS, which is a formal, legal, one-year, renewable contract.

The Company Clinic System has evolved since it was first introduced. The requirement that companies had to have at least 200 employees has been eliminated. Companies now are free to join the program, regardless of the size of their workforce. Another change that has been made is in staffing. Initially in order to be certified a Company Clinic had to document that it had a medical staff consisting of a four-hour (i.e., a half-time) physician for every 1,000 employees, one full-time nurse and one full-time nurse auxiliary (both of the later independent of the number of employees). The clinics are no longer required to have a fixed number of physician hours. This staffing decision is now left to the company.

A third change in the system is in whom it covers. When the program first started, the company clinics were supposed to provide services to only the worker, and not his/her spouse or any children. This rule has been partially relaxed. Now, if companies choose to, they may also provide care to children (ISSS covers children only up to the age of six). If the company wants to incorporate children into is clinic program, however, ISSS requires that the company also hire a pediatrician. Fifteen company clinics (nine percent of the total) now provide pediatric services as well.

It is likely that the success of the Company Clinic System has contributed to the relative demise of a private company work-site focused initiative of ProFamilia. ProFamilia's began its program in 1996 with support from UNFPA, which provided contraceptives free of charge. The program consisted of establishing Reproductive Health Clinics in worksites. For the most part these consisted of a particular worker taking the lead in serving as a distribution point for contraceptives. At its zenith, the program was operating in about 45 companies. However, when UNFPA stopped providing free commodities and companies were asked to purchase the commodities, the number of companies interested in supporting the program quickly waned. The program is reported to still be functioning in 7 to 10 companies. It may well be that the

Company Clinic System, which provides some types of contraceptive commodities free-of-charge to company workers, has displaced some of the ProFamilia centers.

### *The Community Clinics Initiative*

The other major new modality initiative started by ISSS in the 1990s was the Community Clinic. The Community Clinics were an initiative prompted by a number of factors:

- the growing saturation in ISSS hospital outpatient departments and its medical clinics, combined with
- the Institute's search for ways to respond to widespread criticism that its approach was too hospital oriented,
- too curative care oriented, and
- that its services were inaccessible,
- too concentrated in San Salvador and
- too impersonal.

The Community Clinic initiative was started in 1995. It constructed or rented new facilities in the communities and in the neighborhoods where ISSS workers lived. Four physicians (all of whom are either general or family practitioners), and a team of nurses and nurse auxiliaries and a pharmacist staff the clinics. Each clinic is authorized to purchase some basic laboratory test services from nearby private clinics or labs. (The laboratory tests may only be purchased from laboratories that ISSS certifies and with which it then negotiates prices.) Patients are assigned to a particular facility in an effort to make the care more personal and to better ensure its quality. Patients in need of other laboratory examinations or x-rays or less common medicines are referred to ISSS medical units.

There are currently 31 community clinics and there are plans to add three more in the near future. With the introduction of the community and company clinic programs and continued growth in the number of ISSS medical units (now numbering 40) ISSS has discontinued the provision of outpatient services at all but one of its hospitals. This too is described as being part of the Institute's de-concentration strategy.

## *C.3 ISSS's Purchasing Agreements with Public and Private Sector Agents*

### Agreements with MSPAS

Since the mid-1970s there has been recognition of the need for MOH-ISSS coordination to reduce the unnecessary duplication of facilities and to promote the more efficient use of existing public health infrastructure. The most important of these arrangements is the MOH's sale of services to ISSS. The inter-institutional agreement establishing this coordination was first signed in 1978, and was subsequently revised in 1985 and 1993. This general agreement between the MOH and the ISSS establishes a framework and authorizes individual MOH facilities to enter into more specific agreements with the ISSS. A second set of agreements exists between ISSS and the particular MOH facilities from which it wishes to purchase services. This second set of

agreements itemizes the particular terms under which the general agreement will be operationalized, specifying the particular types of services that ISSS may purchase from the particular facility in question and the prices to be paid. The agreements are of a limited duration (usually two years) and do not discuss anticipated quantities of services to be purchased. They simply enable the ISSS to purchase these services, but do not commit it to purchasing any (even some base minimum amount) of care.

In 1986, following the devastating earthquake that killed more than 10,000 Salvadorans and destroyed the hub of ISSS's health care delivery system, its General Hospital, the Social Security Institute entered into many of these agreements with MOH facilities in order to restore its ability to provide services to its clientele.[10] In 1995, ISSS had such contracts with 30 MOH facilities. In interviews on this trip it was reported that this general set of arrangements exists, but it persons who were interviewed about it reported that there were only a handful (five or six) of these contracts. Most commonly ISSS is reported to rent hospital beds or, such as in the case of the San Rafael Hospital in Santa Tecla, where it rents an entire floor of the hospital and then assigns Social Security personnel to permanently staff the facility. Time constraints did not permit obtaining an appointment with Lic. Elmer Arturo Amaya, Chief of ISSS's Financial Division, who in the past has assembled information upon request about these contracts, including the ISSS's payments made to each MOH "partner" facility.

### *Privatization Program*

Initially, the privatization scheme relied on physicians who worked for ISSS, but who were acting in a private capacity, providing services in their own offices to provide care to ISSS-insured patients. The physicians were paid a flat fee per consultation. In order to enter into this privatization scheme, patients were first required to visit a general ISSS physician. If they were then referred to a specialist and had to wait more than three days for an appointment, they became eligible for the privatized scheme. Initially patients were assigned to a particular physician, but in response to calls for increasing consumer choice starting in 1993 patients became able to select their private provider from a list of participating physicians. Eventually, the program was further modified to allow the participation of other than ISSS physicians.

The privatization program paid only private physician fees. It did not cover any other charges, such as complementary examinations incurred as part of the consultation. ISSS beneficiaries participating in the program had to obtain any required laboratory examinations, x-rays or prescriptions from ISSS facilities or pay for them. Participating in the program, therefore, was often cumbersome and time-consuming, and yet the program provided an estimated 10-15 percent of all ISSS consultations. ISSS officials were generally pleased with the program. The reimbursement fee paid physicians was low enough that ISSS officials maintained that the program was cost-effective and actually saving the Institute money by avoiding the hiring of additional staff and the construction of new facilities. ISSS beneficiaries were reportedly pleased with the program, as well. By 1996, many ISSS officials reported that they regarded the

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[10] ISSS is still recovering from the massive destruction and disruption of its services caused by this earthquake. In the years immediately after the earthquake, ISSS built the Medical-Surgical Hospital, which was intended to be a temporary structure. That structure soon became ISSS's key facility and it is only later this year or early next year due to be replaced when the reconstructed General Hospital is expected to open.

program as a permanent feature of the ISSS health system. (See Fiedler 1996 for a more detailed discussion.)

In 1999, however, ISSS terminated the privatization scheme. In interviews with three different ISSS officials, inquiries were made about what had prompted the Institute to abandon the program. Two different explanations were provided. One was that the scheme was a casualty of the labor unrest that rocked ISSS from 1998 through March 2000. Although the recurrent strikes of this era were described as initially being motivated primarily by unfulfilled demands for higher salaries, eventually they came to include other demands, as well, including the cessation of privatization efforts and other, non-traditional labor arrangements. The second explanation was that after carefully structuring and closely monitoring the scheme so as to ensure precise understanding of its costs, the ISSS was lulled into complacency with what looked to be a win-win-win situation, where the Institute, its enrollees/patients, and ISSS physicians were all generally pleased with the arrangement, ISSS opened participation in the program to all/any private physicians, and simply lost control of the system. Utilization rates and costs escalated rapidly and it appeared there was substantial abuse of the system. Eventually, driven by financial concerns, ISSS terminated the 10-year old program.

The lessons to be learned from this experience is that ISSS has had a generally favorable experience with privatization, that it is open to the purchase of services and it should be regarded as still being open to investigating other types of privatization schemes. Indeed, it still has a much more limited type of privatization scheme that was started five years ago, and which was able to survive the labor unrest of the past few years.

### *Contracts with NGO Sector (ADS/PROFAMILIA)*

In 1995, ISSS entered into a contract with the Asociacion Demografica Salvadorena (ADS, also uses brand name of ProFamilia, for clinics, hospital and pharmacies) to purchase hospital birthing services. ISSS was reportedly motivated to establish this arrangement because since the late 1990s, its Maternity Hospital has been persistently operating at near full capacity. According to ProFamilia, with the significant growth in the numbers of ISSS insured posted throughout the 1990s; demand now far exceeds ISSS's capacity. The two-year contract was reportedly awarded through an open, public competitive process. It was not ascertained if the contract is renewable or if there is a new competitive process every two years. ProFamilia reports that it believes it has won the contract both because of its equipment and facility (the ISSS solicitation specifies minimum structural and procedural requirements that the bidding hospitals must fulfill) and because of its lower prices. On average the daily hospitalization charge of ProFamilia is reported to be about one-third that of comparable private sector facilities (e.g., Hospital de la Mujer).

The ISSS-ProFamilia contract calls for ProFamilia to provide a minimum of 10 births daily, and ProFamilia reports that it admits an average of 13 ISSS-referred patients every day. The typical patient is hospitalized for 1.5 days, and ProFamilia is paid on average about 1,300 colones per admission. ProFamilia has dedicated one of its hospital's four floors to accommodating ISSS patients. Just as in its contracts with other MOH facilities, so too in its arrangement with ProFamilia, ISSS sends its own staff to the hospital to provide the services. In 2000, 4,008 (61 percent) of the 6,576 births delivered at the ProFamilia Hospital were provided to ISSS-referred

patients. ProFamilia delivered 14 percent of Social Security's total births last year. For ProFamilia, these births represent an important source of patients and revenues.[11] One cannot help speculating about the sustainability of this arrangement. Although ISSS's Director of Planning reports that this contract will be maintained indefinitely, that was also the plan for the now defunct specialty outpatient privatization scheme, as well.

### *Contracting with Private Management Firms*

A fourth and final example of ISSS purchasing services is the Institute's recent experiment with the private management of two clinics. The clinics, Monte María and San Cristobal, were run by private entities with their own, private sector staff, from May 17, 1999 until November 20, 2000. While both privatized clinic operations were regarded as successful by the two ISSS officials interviewed about them, they came to share the same fate as the specialty outpatient privatization scheme for presumably the same reason; viz., they were opposed by ISSS workers' two powerful labor unions.

ISSS's Director of Planning, Dr. José Antonio Pereira, was asked if ISSS would consider contracting private sector family planning services. He responded that the ISSS's commitment (as set forth in the "Strategic Five Year Plan 1999-2004") is to providing integrated health services, and, that to the extent that family planning services were to be contracted for, it would only be as part of a more comprehensive service package. CMS believes this is an area that merits further exploration.

## D. Private Sector

In El Salvador, as in many Latin American countries, the private sector has been relatively slow to develop because it has historically been crowded-out by free or low–priced Ministry of Health services and mandatory enrollment in social security systems with their own health care delivery systems. In El Salvador, as (again) in many other Latin American countries, this situation has often been compounded by the distribution of private physicians and hospitals, which are overwhelmingly concentrated in the capital city. The most recent available data, a 1994 survey found that two-thirds of Salvadoran physicians are in the San Salvador Metropolitan Area, which has 31 percent of the national population (Iunes, 1994). Market forces have probably reduced this percent since then, but it is still likely to be in the 55 to 60 percent range.

There are two distinct sets of actors in the private sector, the non-government organizations (NGOs) and the private, commercial sector. In general discussions about the private health sector the commercial sector, and particularly in policy-directed discussions, the commercial sector is generally conceptualized as consisting of private physicians, clinics and hospitals, and exclusive of traditional healers, informal sources of care and pharmacy-provided care. In the ensuing discussions here the private physicians, clinics and hospitals will be referred to collectively as the "modern, private commercial sector" to make this distinction.

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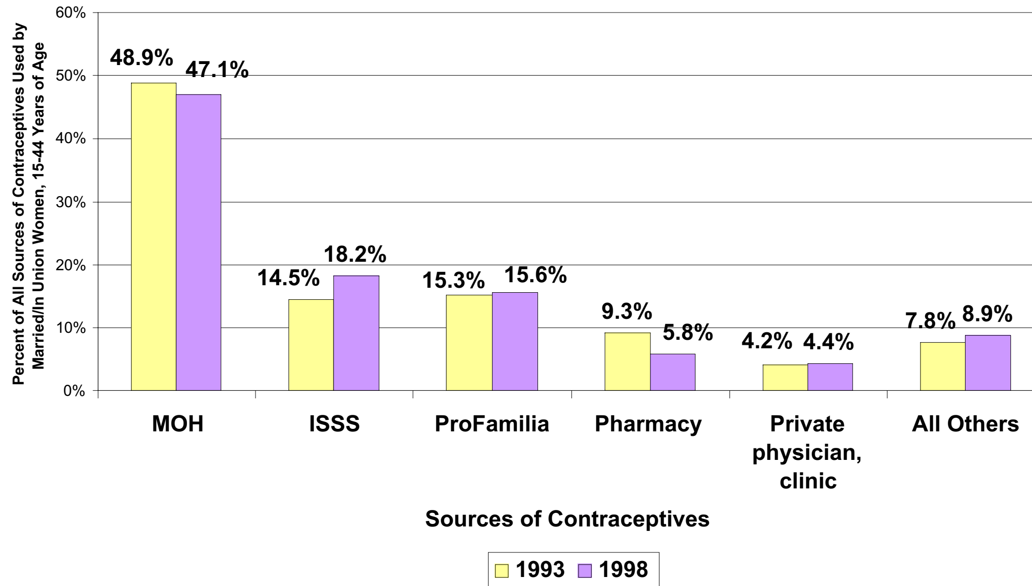
[11] ISSS reported that USAID/El Salvador sponsored an evaluation of this program.

### D.1 Non-Government Organizations (NGOs) Providing Health Care

The bulk of the discussion of the private sector focuses on the private commercial sector, but before turning to it, a few observations about the private, non-profit sector are warranted. The NGO sector is surprisingly small, given the level of public discourse about NGOs and their role in the health sector. In 1999, they were the source of care of only one percent of Salvadorans (refer back to Graph 1). The high profile of the NGOs working in health stems from several factors:

- their historic role as the primary providers of public health care services in the most conflictive rural zones of the country during the civil war,
- the substantial proportion of their assistance that comes from international and bilateral agencies, including home offices of parent or affiliated organizations,
- the much larger numbers of NGOs that were started immediately after the end of hostilities, coupled with the presumption of many analysts that most or all of them are still in operation and providing care (which is not accurate),
- the high visibility that the highly regarded USAID-financed PROSAMI (Proyecto de Salud Materno Infantil) Project (1993-1999) had as a cost-effective method for improving access and utilization of public health care services in rural areas, and
- the high visibility that five NGOs (all formerly participants in the PROSAMI Project) have played as a type of pilot project in the MOH's first foray into the realm of purchasing / contracting out health care services provision, which has been a much talked about, highly emotionally charged political topic in El Salvador for many years now.

The fundamentally important role that the Salvadoran Demographic Association/ProFamilia has long played in the reproductive health care market, and especially its contribution to the Salvadoran contraceptive prevalence rate, stands in sharp contrast to NGOs' small market share in the general health services market. As Graph 7 shows, ProFamilia, now 39 years old, is a major national player of still-growing importance in the provision of contraceptives.




## D.2 ADS Reproductive Health Programs

The Asociacion Demografica Salvadorena (ADS) was founded on May 7, 1972. The Association has 227 members, and is known as a services and research NGO. An IPPF-affiliate, they are a major player in reproductive health care in El Salvador. According to the 1998 FESAL, ADS provided approximately 15% of all family planning services in the country. The NGO maintains a private hospital in San Salvador and a network of 9 clinics. ADS also has a network of 30 private physicians that collaborate with the organization, and over 750 volunteer promoters that offer services at the community level. In 2000, the organization's overall self-sufficiency was reported at 80%.

ADS' healthcare services (both the clinic and hospital) are known under a separate name, Profamilia. Unlike some other NGOs in the region (e.g. MEXFAM in Mexico where the clinic network is part of the organization's revenue-generating strategy) ADS' clinic services are perceived by the institution to be part of its "social" mission—that is, the clinical services provided by ADS are subsidized by other sources. In 1997, for example, ADS lowered the prices of clinic services as a result of client research that cited cost as a major reason for non-use among potential clients of the facilities. During 1997, 46% of the consultations were related to gynecology, 27% family planning, 8% pediatric, 8% prenatal, 5% STIs, and 6% others.

In 1998, total clinical services offered by the institution were 69,304 consultations and 57,357 laboratory procedures with a value of ¢6,403,186 (approximately US$731,792). In 1999, consultations increased to 95,500 with 57,357 laboratory procedures for a total of ¢7,759,382 (approximately US$886,786).[12]

### *Profamilia Hospital*

The Profamilia Hospital located in San Salvador is an important source of revenue for the organization. The hospital provides a variety of services, ranging from emergency consultations to delivery and post-partum care to reproductive health care for women beyond their reproductive years. ADS has recently purchased sophisticated equipment including a mammography machine for early detection of breast cancer, a densiometer for detection of osteoporosis, and high-end ultrasound machines to detect gynecological problems and problems with the fetus during pregnancy. The Profamilia Hospital also provides delivery services as a subcontractor to ISSS, and the majority of their deliveries are ISSS patients. In 1997, the institution's gross revenues equaled ¢15,072,260; in 1998 ¢19,131,767, and in 1999 ¢23,935,671. In 1997, the hospital's estimated profit level was approximately 10% of gross revenues.

### *Profamilia Pharmacies*

In the last two years, ADS started a chain (3 thus far) of pharmacies branded with the PROFAMILIA name. By becoming owners of pharmacies, the organization had to register as a for–profit company in order to be able to import and sell pharmaceutical products. The pharmacies continue to give a 15% discount to the public, showing their social mission, but all in all, these pharmacies generate income for the organization. This program also provides ADS with the added advantage that they can promote their own products over other brands. It must be noted, however, that the pharmacies do not sell subsidized products. ADS has made agreements with major pharmaceutical companies in the region to obtain competitive prices on the products they sell at the pharmacies.

### *Social Marketing Activities*

Another important source of revenue for the organization is their social marketing program. In 1998, the social marketing program was completely self-sufficient and generated revenue for the organization used to cross-subsidize other programs and services. ADS distinguishes between its for-profit activities, it social marketing activities, and its purely "social" activities. The for-profit activities, such as the hospital and the pharmacies, do not offer subsidized products, and are in existence to cross-subsidize the social activities. The social marketing activities use subsidized products donated by USAID, but do not offer the consumer the lowest price possible. The social programs, such as the clinics and the rural program, offer contraceptives at the lowest price possible to the public. In this way, ADS is able to segment the market and reach the poorest of the poor with their clinic services and products provided in the remote rural areas.

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[12] Asociación Demográfica Salvadoreña, http://www.ads.org.sv.

As ADS becomes more and more diversified, both in products and services, they have recognized that there is a need to inform the public of the changes that have taken place in the organization. In 2001, they worked with their advertising agency to develop ways of differentiating the brand between the hospital, the clinics, and the pharmacies. Thus, ADS has a new marketing campaign to market itself as a multifaceted organization, addressing the needs of multiple target groups.

### *FESAL Survey*

ADS also conducts the National Family Health Survey in collaboration with the Ministry of Health and Social Welfare and the Center for Disease Control. ADS has been conducting the survey since 1973; in 1998, they conducted the 6th consecutive survey.

### *Rural Program*

The focus of ADS rural program is to increase community participation in sexual and reproductive service delivery. ADS uses approximately 800 Health Promoters to offer family planning, integrated maternal and child health education and referral services, as well as basic health services such as treatment of diarrhea, respiratory infections, and distribution of contraceptives. The program offers the following: a) Distribution of temporary contraceptives (Lo-femenal, condoms, Noristerat); b) Promotion of the IUD; c) Information, education and referral for other family planning services; and d) Information and referral for maternal/infant health services.

The Rural Services Program was able to contribute to increase CPR in the rural areas from 34% in 1988 to 51% in 1998. The FESAL also shows a corresponding reduction in infant mortality, which decreased from 55/1000 to 41 in 1998. Despite the limitations of only being able to provide temporary methods to the rural populations, the Rural Services Program contributed 33% of ADS couple years of protection.

Until 1995, the rural promoters received a monthly bonus of 460 colones (US$ 52.50) which was suspended in 1996 due to financial limitations within the USAID agreement. This caused an exodus of 34% of the promoters, and a change in the responsibilities of one third of the promoters. This third of the program was designated to work with child health.

The cost recovery rate of this program is approximately 20%. Sustainability is further guaranteed by a new trend among the promoters. Community involvement is emphasized, and many promoters have become entrepreneurs with the program. They sell other products such as Avon, and offer services at their homes such as haircuts or sales of tortillas. ADS also expects them to be more productive, and supervisors will be evaluating the promoters more often. The promoters will be encouraged to work in teams to improve quality. The Rural Program provides approximately one third of the service delivery impact of ADS.

### *Sustainability Planning*

USAID has informed ADS that they will terminate funding by 2002. In preparation for the withdrawal of their major funding source, ADS developed a Transition Plan that introducing mechanisms to assure the continuity of sexual and reproductive health social program, such as the Rural Services Program, while at the same time, reach sustainability.

ADS has five global strategies to assure maximum cross subsidization between the activities that generate income and those that cannot be self-sufficient: 1) Reduce activities that are not cost effective an essential to the ADS Mission; 2) Increase rational use of income; 3) Expand activities which have demonstrated ability to generate net income; 4) Incorporate new activities which offer increased net income; and 5) Launch effective publicity and promotion efforts which support the Association's income generating activities.

The overall objective of the program is to achieve a self-sufficiency rate of 101% by 2002. ADS plans to subsidize the Rural Services Program from the following programs: Social Marketing and Communications will support 21.8%; the PROFAMILIA Hospital will provide 27.9%, the Clinical Services Program will provide 13.5%. The balance of 36.8% will be generated by the Rural Service Program for its own expenses. The annual budget for ADS is approximately $6 million per year.

## D.3 Commercial Sector

The private, commercial sector is atomistic and relatively unorganized. The vast majority of private physicians work alone or with an auxiliary nurse or some other type of assistant in their own offices. There are only five major private hospitals in San Salvador. Although there are multi-physician practices, they are few in number and generally all of the physicians in the practice have the same specialty. Most of the larger of these multi-physician practices are affiliated with and usually physically part of a specialized private hospital.

The mindset of the private sector is a very traditional one: viz., that theirs is a noble profession and one that should not be sullied with the mundane and crass matters of business. The reader is reminded of the Colegio Médico's "Code of Medical Ethics" call to combat "mercantilism" in the profession. It further proscribes advertising that:

- "promises the provision of free services or that explicitly mentions fees,"
- announcements that are "transmitted by radio, loud-speakers, movie theaters, brochures or cards that are not distributed by mail or with a precise destination" (i.e., mass mailings are not permitted), or
- announcements "that are exhibited in inadequate places or sites that compromise the seriousness of the profession" (Article 66, items d, i and j).

At the same time, physicians maintain fee levels that are artificially high, result in excess supply and render much potential demand ineffective (because many people cannot afford them). The average price of a private general consultation in San Salvador is 75 to 125 colones, with specialists charging twice that amount. The only information that is available about the productivity and capacity utilization of the private sector in El Salvador comes from a 1994

World Bank/ANSAL survey. That study found that physicians saw an average of 1.18 patients every hour they worked in their private practices; one patient was seen for every 51 minutes worked. Thirty-eight percent reported they could increase the number of patients they see by at least 50 percent, and nearly half of these reported they could more than double their patient load. If physicians could treat on average five patients in an hour, the level of service delivery found in the survey is the equivalent of 24 percent of the private sector's capacity.[13] In other words, 76 percent of the productive capacity of the private sector was being squandered. That was seven years ago, when the market share of the private sector was larger and when there were an estimated 5,000 physicians.

According to the Colegio Médico, there are now an estimated 7,000 private physicians in El Salvador. Unfortunately no information was obtained on the workforce of the MOH and ISSS, but neither is likely to have increased by anything approaching the 40 percent increase in physician manpower. Thus it may be inferred that a disproportionate number of this massive increase in physicians were forced into the private sector, further decreasing the proportion of the private sector's productive capacity. A conservative guess would be that private sector is operating at 10 to 15 percent of its capacity; that is, that it could be providing 7 to 10 times more consultations than it currently is providing. Furthermore, with the seven medical schools churning out what the Colegio Médico reports to be about 500 new physicians each year, this situation is growing worse each year.

Physicians cope with this situation, as they do in many countries of Latin America, by splitting their working time between their private practice and a job working either for the Ministry of Health or ISSS (see Table 4). No more recent data is available, although it is highly likely that the percent of physicians employed only in the private sector has increased.

Physicians seem reluctant to tread into the unknown and to experiment with new modes of organization or new business strategies, and they are discouraged from doing so by the Colegio Médico. In the private sector, the Colegio is bent on maintaining the status quo, which consists of patients paying relatively high prices, up front, out-of-pocket, and, if they are fortunate to have insurance, later being reimbursed for the expenditures. While the Colegio exerts its power and influence to uphold tradition, the people of El Salvador could be enjoying greater access to and more health care and the country of El Salvador is squandering resources training too many physicians.

**Table 4: Physician Work Patterns (Iunes, 1994)**

| Sector(s) of Work | Proportion of Physicians Surveyed |
|---|---|
| Only Private Sector | 37 % |
| MOH and Private Sector | 22% |
| ISSS and Private Sector | 22% |
| MOH and ISSS | 18% |

[13] Ministry of Health norms state that a physician should provide an average of six general consultations or 5 specialist consultations per hour.

### *Accreditation Standards*

Physicians are licensed through the process of completing their required courses, internships and residencies and completing their year of medical service. Physicians then have the option of joining the Medical College and/or their specialty organization and adhering to the related practice norms.

There is no legal mechanism for applying sanctions for malpractice and there are no requirements for continuing medical education. According to MSH there is no accreditation process currently in place. According to conversations with El Colegio Medico, La Junta de Vigilancia in non-functioning as it has no infrastructure and lacks government support.

### *Implications of the High Level of Under- and Unemployment of Physicians*

The exceedingly high level of under-employment and unemployment characterizing the physician market provides opportunities for those willing to break tradition, work in new organizations and trying to achieve a given income by reducing the prices charged for care and increasing their patient caseloads. There are a host of possible approaches that could be taken in attempting to address this health care market shortcoming. Interventions on the supply side could include providing technical assistance to help train and educate physicians in some fundamental health care economic issues, together training in business, to helping physicians organize into multi-physician practices or alternative delivery systems. Interventions on the demand side could include identifying pooling mechanisms by which to provide an adequate pool of persons for whom some type of delivery system could be developed. An association of agricultural cooperatives was visited and found to be a good and interested candidate for this type of program.

## D.4 Private Health Insurance

As noted in the discussion of Social Security's general health care services market share, there are a variety of different ways in which employers provide their employees some type of protection from the vicissitudes of health care costs, in addition to their legally mandated contributions to the provision of ISSS health care coverage. There is no systematic information about the numbers of these various arrangements, but they are common and widely discussed. In addition to purchasing ISSS health insurance, a substantial number of employers also hire a private physician and/or nurse who in some cases works in a clinic on the worksite, and in other cases they authorize their employees going to a private physician and pay the bills for them. Another approach is purchase health insurance for their employees. Note, that since most modern sector companies are mandated to pay Social Security taxes, they area already purchasing health insurance for their employees. The willingness of employers to provide private health insurance reflects dissatisfaction with ISSS services, as it constitutes paying for two health insurance policies. As the level of satisfaction with ISSS's health care services waxes and wanes—in part due to the ways in which the Institute reforms the way it provides care—its affects the number of persons with private health insurance.

### *Beneficiaries*

There is no systematically collected information available about the number of beneficiaries of private health insurance. This is primarily due to the fact that most private health insurance policies are collective, worksite-based policies. With the composition and number of workers and the size of their families constantly changing, tracking the number of beneficiaries becomes a relatively complex, expensive and never-ending task. Based on interviews conducted during this trip and an extensive series of interviews with private health insurance representatives conducted four years ago, it is estimated that the number of persons with private health insurance protection (counting only that of third party, indemnity plans) in El Salvador is currently about 100,000, two percent of the national population. This estimate was discussed with an official of the Superintendent of Financial Systems, the government agency responsible for overseeing the health insurance industry. The official said he thought the estimate was reasonable, and noted that he believed that while the absolute size of the market had grown in the last five or six years, but confirmed that the proportion of Salvadorans had probably remained about constant.

Health insurance is a “loss leader” for the private insurance industry; i.e., it is used as a marketing tool to attract more profitable lines of business, namely life insurance. In fact, no insurance company in El Salvador will sell a health insurance policy unless the client also purchases a life insurance policy. Health insurance company officials report that the costs of administering health insurance are substantially higher than the costs of administering other types of insurance. This is because claims are frequent, health care costs are notoriously inflationary and because each of the three companies interviewed on this consultancy reported that they have utilization review departments that are staffed by physicians.

One way in which the health insurance companies in El Salvador try to reduce risks and administrative costs is that they do not offer any individual policies; all private health insurance currently available in El Salvador are policies are collective policies, and generally they require a minimum of 100 persons.

### *Family Planning Services Coverage*

Family planning services are covered only in the relatively small, higher-end market policies. One insurance company official reported that she had proposed that her company provide coverage for more preventive health services, including family planning, arguing that these services would “pay for themselves.” Without actuarially investigating its merits, the company dismissed her proposal out of hand. It appears that there is an opportunity to encourage the private health insurance companies of El Salvador to provide coverage for family planning services by demonstrating to them that the provision of these services can be cost-effective. As will be discussed shortly, however, the size of the private health insurance market is small, suggesting that such an undertaking should not be accorded priority.

### *Patient Reimbursement Plans*

Another common characteristic of private health insurance in El Salvador is that the vast majority of plans work on a patient reimbursement basis. The patient must first pay for their care up-front and out-of-pocket, and then submit a claim and request for payment to the insurance

company. Insurance company interviewees reported using other cost control measures as well. One requires a photo ID that must be updated annually to discourage allowing other persons to use a policy. Another requires a second opinion for all surgery. One company sits down with persons who are identified as needed surgery and negotiate with the insured a fixed budget for the care. The patient then is expected to "police" the hospital and physician's behavior since the patient will be responsible for paying any expenditures beyond the agreed upon, negotiated budget. One insurance company reported that it uses the relative value scale of California to establish and update its reimbursement rates for different procedures. It was reported that the Ministry of Health working together with the Colegio Médico used to have a recommended price schedule (arancel) for different common procedures. That schedule, however, was reportedly not updated for at least three years, and is apparently irrelevant in today's market place.

Over the course of the 1990s, El Salvador has witnessed the introduction of new health care financing mechanisms, beyond the more traditional means of the patient paying directly "out-of-pocket" and third party indemnity health insurance. Two prepaid, capitated systems were established, Salud Total and H.M.O., vendors and brokers of insurance policies have developed, a company offering a credit card for charging health care fees has been established, and third party insurers have developed independent provider organizations or preferred provider (IPOs and PPOs).

### *Salud Total*

Salud Total is a prepaid, health maintenance organization- (HMO-) like entity that was founded in 1990. It has approximately 4,000 direct affiliates (exclusive of dependents). The plan has a closed panel of physicians, uses the Hospital Diagnóstico for all inpatient care and relies upon general practitioners and internists as gatekeepers to the system who must first be seen before referrals are made to specialists or a patient is admitted to the hospital. The plan offers two different, defined packages of services with no deductibles and no co-payments, but they also have a low maximum number of services that they cover. The basic policy's average annual premium for a healthy, single individual 30 years of age is roughly 2,500 colones. Preventive care, including family planning services, are covered under even the basic policy.

Several interviewees noted that another HMO, named H.M.O, was started in San Salvador in 1999. It was reportedly financed and managed by a U.S. company. In an interview, the President of the Colegio Médico reported that the Colegio's "Code of Medical Ethics" states that the Colegio has the responsibility to "Combat by legal means and associations the mercantilism… of the profession" (Article 5). The President reported that the Colegio has sponsored a negative publicity campaign against salaried physicians, managed care and HMOs. This appeared to be a thinly veiled attack on H.M.O. The President noted, that H.M.O. failed because they paid physicians poorly and did not fulfill its contracts. An insurance company executive, however, reported that the problem was that the system was poorly managed with little direct oversight of operations. While the excess supply of physicians provides an opportunity for organizing them into alternative delivery systems or finding other means to encourage physicians to cut their prices in order to be able to expand the volume of patients they serve, any such effort will likely face opposition from the Colegio Médico.

### *MEDICARD and SHWARTZ*

Another development in the private health market in the 1990s has been the establishment of a new financing mechanism by two companies, MEDICARD and SHWARTZ, for subscribers to third party health insurance policies. SCHWARTZ provides a credit card that may be used in the company's department stores, or to charge health care that is later reimbursed according to the characteristics of the specific insurance policy that the individual cardholder has with the La Centro-Americana Insurance Company. MEDICARD is a credit card that may be used exclusively to pay health care bills, which are later reimbursed in accordance with the cardholder's Pan American Life Insurance (PALIC) health insurance policy. The purpose of both MEDICARD and SCHWARTZ is simply to provide subscribers of third, party indemnity insurance plans with a convenient way of financing the up-front, out-of-pocket costs of private health care. They are mechanisms that have evolved in response to the way in which most health insurance companies do business in El Salvador; viz., requiring patients to pay for their care out-of-pocket and later being reimbursed upon submission of a claim. As is the case with all other third party, indemnity health insurance, the enrollees of these programs are required to purchase life insurance in order to become eligible for purchasing health insurance.

### *Regulation of Health Insurance Industry*

With the passage of Law 12s of November 25, 1996, the government overhauled the way in which it regulates the insurance industry. The Superintendent of Financial Systems (SFS) sees itself as the protector of the consumer and the general public. The SFS now has greater regulatory authority. Whereas prior to the new law, the extent of public oversight of health insurance companies' liquidity was primarily a requirement that they maintain a reserve deposit of 35 percent of the value of their premiums, now the SFS maintains monthly oversight on the cash flow of each company. In addition, the SFS must approve all new health insurance policies. It is currently in the conceptual stage of a new project that will provide consumers with a user-friendly comparative descriptive inventory of all health insurance policies offered in the country.

# 5. THE CONTRACEPTIVE MARKET

## A. Policy Issues

The National Population Policy of 1993 and the National Family Planning Norms of 1999 provide a supportive, general framework for family planning efforts. GOES has long been supportive of family planning programs, both by helping to foster demand and by directly providing family planning services. The Director General, the chief of the Integrated Care of Women Directorate and other MOH officials expressed support of the idea of CMS working with the private sector, and noted that indicated that they thought the high level of under-employed private physicians provided potentially fertile ground for developing an alternative delivery system. The Chief of Integrated Care of Women also pointed out that it was in the interest of the MOH to promote the private sector, as this lightened the load of the Ministry.

The support of the GOES, however, is probably best illustrated by the fact that it, through the MOH and ISSS, provides the contraceptives for nearly two-thirds (65.2 percent) of users (FESAL, 1998). While the MOH provides a wide variety of methods, the methods made available by ISSS are more restricted in terms of choices (proffering only one type of oral and one type of injectable). Another factor that constrains choice is physicians' inadequate level of knowledge about and training in the use of IUDs. The only other factors adversely effecting demand, are the powerful Catholic Church, which actively participates in setting the social agenda, and the Colegio Médico Code of Ethics' advertising restrictions.

One could say that the Ministry is actually too supportive of the demand for family planning services in the sense that although there is a user fee system, family planning services (and a few, other priority services) are supposed to be provided free-of-charge. While this increases access (which of course is the Ministry's intent), it does so at the expense of encouraging the utilization of Ministry services by persons who have the ability to pay, and undermines private sector opportunities for participating more vigorously in the family planning services market. By virtue of its large infrastructure, non-targeted clientele and indiscriminately provided low prices, the Ministry constrains options for private sector family planning initiatives. The Ministry's recent progress on decentralization, however, is likely to provide greater potential opportunities for more locally led initiatives.

The MOH currently contracts out/purchases services from five NGOs. The Ministry, with technical assistance from the World Bank, is also setting up a new purchasing office to provide it will greater capability for expanding this function. Nevertheless, the general impression that the CMS team culled from interviews with a variety of Ministry officials, is that the MOH does not have the political will to and is not committed to further developing these types of relationships in the near- and mid-term future.

## B. Contraceptive Market

The Ministry of Health is by far the single most important source of family planning methods in El Salvador. It was the source of contraceptives for nearly half of all users. The second most important source accounted for a share that was only about one-third as large as the Ministry's.

As the Table 5 shows, the shares of the different sources of care changed—in some cases substantially—over the five-year period between the two FESAL surveys.

| Table 5<br>Changes in Sources<br>Of Family Planning Methods<br>Percent of Married/In Union Women 15-44 Years Old<br>Currently Using Contraceptives | | | |
|---|---|---|---|
| | FESAL | Surveys | Percent |
| **Source** | **1993** | **1998** | **Change** |
| MOH | 48.9% | 47.1% | -3.7% |
| ISSS | 14.5% | 18.2% | 25.5% |
| ADS / ProFamilia | 15.3% | 15.6% | 2.0% |
| Pharmacy | 9.3% | 5.8% | -37.6% |
| Private clinic/doctor | 4.2% | 4.4% | 4.8% |
| Other | 7.8% | 8.9% | 14.1% |
| Total | 100% | 100% | |
| | | | |
| Private Sector | 28.8% | 25.8% | -10.4% |
| | | | |
| **CPR: All Sources** | **53.3%** | **59.7%** | **12.0%** |

Whereas the NGO, ADS was the second most reported source in 1993, by 1998 it had slipped to become the third most common source, displaced by the Social Security Institute. ISSS's share of CPR jumped by more than 25 percent in 1998.

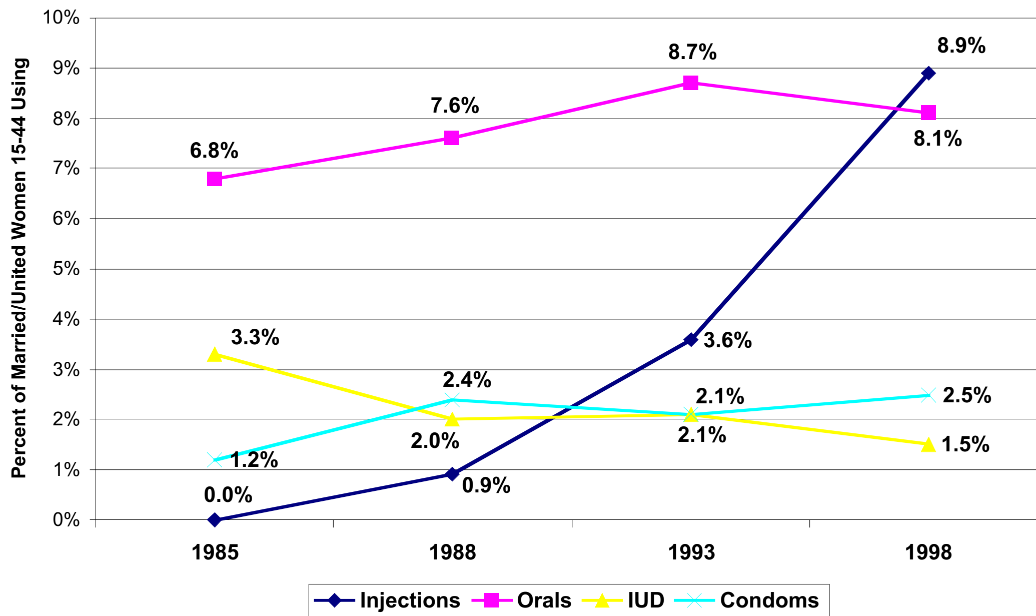
ISSS's introduction of the more readily accessible Community Clinics in 1996 was part of the reason for some of this increase. As may seen in Table 6, the Community Clinics accounted for a more than proportionate share of all ISSS family planning services. The Community Clinics' share of the four identified types of family planning services were from 36 to 91 percent more than their share of all ISSS medical consultations (11 percent). Also noteworthy in Table 6 is the near absence of family planning services being provided in the Company Clinics. This is surprising and warrants further investigation and follow-up. Given the large number of Salvadoran women who work in maquila and the substantial number of maquilas that are reported to participate in the Company Clinic program, this appears to be a missed opportunity. Another disturbing observation about ISSS family planning services is that the number of new users fell by 17 percent in 2000 from their 1999 level (see Annex C for details). This suggests that the ISSS contribution to CPR may have slipped since the 1998 FESAL was conducted. This too warrants further investigation.

**Table 6: ISSS Family Planning Services by Delivery Site (ISSS Estadisticas 2000)**

| Delivery Site/Program | All Visits (All Types) | IUD Visits | Orals Visits | Condoms Distributed | Injections Visits | Sterili-zations |
|---|---|---|---|---|---|---|
| **Medical Units and Hospitals** | 4,345,206 | 4,721 | 10,770 | 405,851 | 36,799 | 5,033 |
| **Community Clinics** | 629,768 | 808 | 2,460 | 108,968 | 9,464 | 0 |
| **Company Clinics** | 654,158 | 20 | 857 | 13,876 | 3,391 | 0 |
| **ISSS Total-All Sites** | 5,629,132 | 5,549 | 14,087 | 528,695 | 49,654 | 5,033 |
| **Medical Units and Hospitals** | 77% | 85% | 76% | 77% | 74% | 100% |
| **Community Clinics** | 11% | 15% | 17% | 21% | 19% | 0% |
| **Company Clinics** | 12% | 0% | 6% | 3% | 7% | 0% |
| **ISSS Total-All Sites** | 100% | 100% | 100% | 100% | 100% | 100% |

Adding the shares of the three private sector entities identified in Table 5, we see that the share of the private sector fell between 1993 and 1998, from 28.8 to 25.8 percent. This erosion of the private sector's share of CPR, however, was markedly less than the contraction of the private sector's share of total health services (refer back to Graph 3). The private sector's relatively better performance in family planning services owes largely to the stable performance of ProFamilia. While private physicians and clinics increased their share more rapidly than ProFamilia, they remain a relatively small player in the family planning market, accounting for only about one-quarter ProFamilia's share, and less than five percent of the CPR.

Graph 8 shows the changing contraceptive methods mix of the four most numerically important re-supply methods from 1985 through 1998. Already low IUD use slipped further over the period, virtually exchanging places with condoms, which gained over the period, but still was the choice of only 2.5 percent of contraceptive users. The most dramatic change was the sharp rise in injectables as the method of choice. This unavailable, unused method in 1985 had catapulted to become the most popular method by 1998, and indications are that its share has probably continued to grow since then. In just the five years between the two FESAL surveys, injectables tripled their share of the re-supply contraceptive method market. After posting steady gains from 1985 to 1993, the proportion of contraceptors who used orals fell in 1998.




The massive shift to injectables was due to two factors:

(1) for personal and cultural reasons (discussed elsewhere in this report), injectables are a convenient, highly popular method, which many Salvadoran women were first becoming familiar with during this period, and

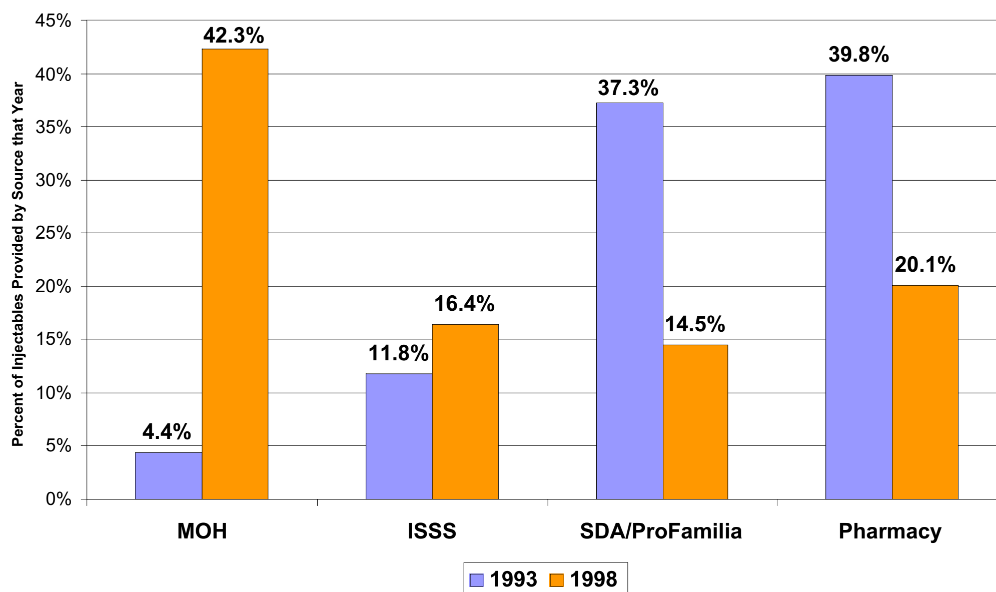
(2) large supplies of inexpensive or free injectables became available during this period, as USAID donated large quantities of noristerate and Depo-Provera to the MOH and ISSS.

As may be seen in Graph 9, these donations resulted in dramatic changes in the market shares of injectables between 1993 and 1998. The MOH share jumped nearly ten-fold, from 4.4 to 42.3 percent, while ISSS's share increased more than 25 percent, from 11.8 to 16.4 percent. The increase in the MOH and ISSS shares was achieved at the expense of the market shares of what had theretofore been the two principle private sector sources, ProFamilia and pharmacies. ProFamilia's share fell the most, by 61 percent, while the pharmacies' share was cut to half its former level.

## B.1 The Hormonal Market

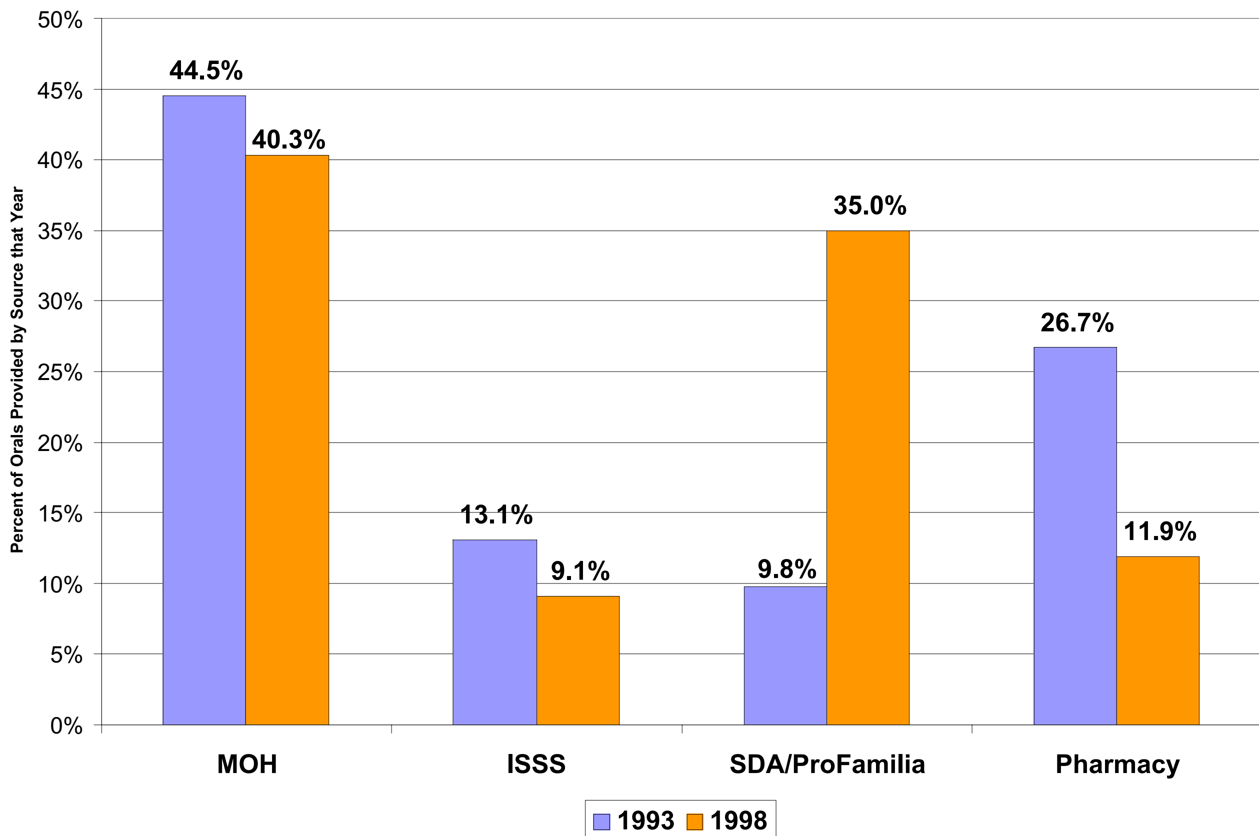
The MOH and ISSS grew at the expense of the private injectables market because they either gave their injectables away, or sold them at significantly lower prices than the private sector agents. ISSS provides its family planning patients with contraceptives completely free of point-of-service charges, and although many Ministry officials claim the MOH provides all contraceptives free-of-charge, the 1998 FESAL reveals that in fact, many people reported they paid for their MOH-provided contraceptives. The prices they paid, however, were markedly less than what they would have had to pay in the private sector.

**Graph 9: Changes in the Market Shares of Injectables, 1993-1998 (FESAL 1998)**




The rapid growth in the use and market share of injectables reflected both new family planning users and women who formerly used orals switching methods, both contributing to the fall in the proportion of CPR accounted for by orals. Graph 10 shows the changing sources of orals between 1993 and 1998. Three of the four principle sources of orals experienced falling market shares, as ProFamilia's market share shot up by more than three-fold to 35 percent. Even though the market share of orals was falling, the absolute number of women using orals grew slightly over 1993-98 as the number of women of child-bearing age and the CPR both grew. Thus the marked growth in ProFamila's market share, in large part, consisted of its winning over users of orals from other sources. This is a testament to its highly effective social marketing of its Perla brand. The other private sector source, pharmacies, experienced a 56 percent contraction in its market share of orals, even greater than the 50 percent reduction its injectables market suffered. That ProFamilia did relatively much better (or not as badly in the case of injectables) than the other primary private source, pharmacies, is noteworthy. It is also important to bear in mind that it was during this same era that USAID began phasing out its support of ProFamilia. While, on the one hand, the Agency was encouraging the NGO to become more financially independent

and sustainable, on the other hand, USAID's donations of contraceptives—and especially injectables—were inadvertently undercutting ProFamilia in one of its most important product lines. Given this challenging context, ProFamilia's general performance over the last five years has been remarkable.




Contraceptive Prices

As noted earlier, contrary to what many MOH officials maintained in interviews conducted during this consultancy, data from the 1998 FESAL shows that a substantial number of women report they pay for Ministry-provided contraceptives. The proportion of users who pay and the prices they pay vary substantially by source of care, as may be seen in Graphs 11.

As one would expect the vast majority of private patients pay for their orals or their injectables. Among MOH clients, the most commonly used method, injectables, is the one women are most likely to be charged for and, among re-supply methods, they are more likely to be charged more for it. Nearly half of women obtaining injectables from the Ministry pay for them and, on

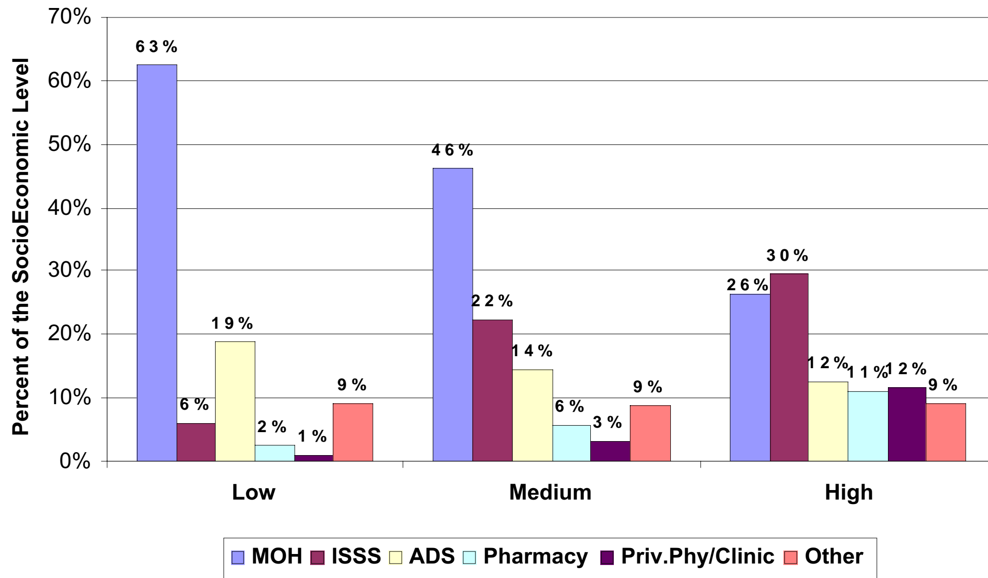
average, they pay 7 colones. Only 18 percent of women obtaining orals from the MOH pay for them, and they pay an average of just one colon.

In making their selection of a source of contraceptives, the degree to which consumers regard different sources as substitutes for one another depends on a number of factors, but one important consideration is the variation in their prices. As may be seen in Graph 11, the prices paid for orals and injectables vary substantially by source. The least expensive source of orals and injections is the MOH, followed by ProFamilia and the pharmacies are the most expensive. PROFAMILIA's orals are eight times more expensive than the Ministry's and its injectables are three times more expensive. The Ministry's lower tendency to charge and its low prices are, no doubt, important factors that ProFamilia must take into account in its pricing strategy. The low MOH prices constrain ProFamilia's efforts to increase its prices and to becoming more financially self-sustainable.

A fundamental role of the Ministry of Health is to provide access to care to the sizeable portion (48 percent) of Salvadorans who are impoverished (PAHO, 2001). Yet, while the MOH must ensure that the health care needs of the poor, it can and should charge persons with the ability to pay for care. As already noted, dating from the early 1980s, the Ministry has had a largely informal, yet near-universal, user fee system, that was officially established in 1998. The fee structure adopted in 1998, however, is too simple. It charges everyone the same amount low amount (10 colones in health units and health houses and 15 colones in hospital outpatient departments), and is suppose to exonerate the poor. As already noted (refer to Graph 5), a large proportion of the non-poor obtain their care from the MOH. Too much of the Ministry's resources are devoted to providing care to people who can and should pay more for their care. After all, despite the fact that the MOH's budget and expenditures have been increasing for most of the past decade, the reader will recall that there is evidence that MOH facilities are purchasing a major portion of their drugs and medical supplies with these fees. The Ministry must do a better job of recovering some of its costs and generating revenues. USAID has informed the Ministry that it is phasing out contraceptive donations, and that the MOH will have to start paying for them. Hopefully the Ministry will allocate adequate resources earmarked for purchasing contraceptives so that there is no disruption in the supplies and availability.

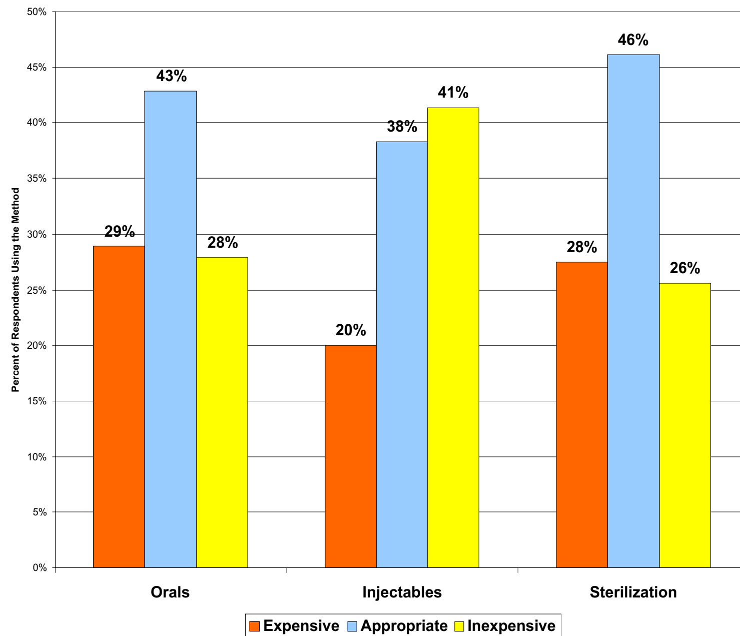
There is some family planning-specific information on this topic, as well. Graph 12 provides information about the source of family planning services by socioeconomic class (FESAL, 1998). The most common source of family planning services of the highest socioeconomic class is ISSS. Thirty percent of this class uses ISSS, but trailing closely behind is the Ministry of Health. Twenty-six percent of the highest socioeconomic class obtains its family planning services from the MOH, more than twice the proportion using any of the other four sources identified.

Graph 12: Sources of Family Planning Method by Socio-Economic Level
(FESAL 98)




Moreover, information from the FESAL suggests that the prices of contraceptives (in general; i.e., independent of source) are regarded as reasonable or inexpensive, even by the vast majority of members of the lowest socioeconomic class. See Graph 13.

Graph 13: Opinions of Members of the Lowest Socioeconomic Class about the Price Paid for Contraceptives in the Past 30 Days
(FESAL 98)



## C. Commercial Sources for Family Planning Products

The commercial markets for family planning and reproductive health products in El Salvador are relatively well developed, including a variety of different products with a strong commercial distribution infrastructure. Unlike many countries in Latin America, however, the commercial sector provides a relatively small segment of the total contraceptive markets (whereas MSPAS continues to be the major source, even among temporary methods).

In 1998, the total commercial market for condoms was estimated at approximately 10.5 million units, with socially marketed products representing approximately 30% of the market share. There were approximately 16 different brands available in 1998, with ADS marketing Condor, Panther, Prime Colores, Rough Rider, Prime with Spermicide, and Contempo. Other commercial distributors of condom products included C. Imberton, D. Grimaldi, and Fasani.

The commercial market for oral contraceptives was estimated at slightly over 1 million cycles in 1998, with socially marketed products representing approximately 40% of the total market share. Available brands included Microgynon, Microgynon CD, Ovral 21, Ovral 28, Denoval 21, Nordette 21, Nordette 28 Trinordil Neogion, Triquilar, Minulat, Neogynon, Progyluton, Gynovin, and Diane. These brands are marketed by Bayer/Santa Lucia, Americana, and D. Americana. The socially marketed brands included Perla and Minigynon—and are both commercially sourced by ADS.

The commercial market for injectables was estimated at approximately 350,000 units in 1998. The brands include Novular, Ciclo-nor, Nomagest, Deprozone, Mesigyna, Topasel, Yectames, Ciclofemina, Depoprovera, and Noristerat.

### C.1 Pharmaceutical sector

The large pharmaceutical companies have representatives in El Salvador, but their headquarters for Central America are either in Guatemala or in Mexico. According to interviews the team had with the international pharmaceutical companies and local manufacturers, distribution of contraceptives is conducted through medical detailers to private providers or through distributors that sell directly to the pharmacies.

The team was able to meet with Schering, Pharmacia/Upjohn and Wyeth during the visit. Schering sells injectables and oral contraceptives to the MOH, ISSS and to private providers. Schering sells a one-month injectable, Mesigna to the ISSS. The MOH Central Office purchases the two-month injectable, Noristeradt, for all their hospitals in San Salvador. Over the past year, however, Schering has noted an increase in procurement requests from hospitals and clinics outside of San Salvador. Oral contraceptives (OCs) are also sold to both public sector entities. The ISSS purchases Gynovin, and the MOH purchases Microgynon. Schering has not had any success selling IUDs in El Salvador, although they do sell them in Guatemala and Costa Rica. Prices are set for all products in Schering's Guatemala offices, but they are willing to negotiate if large procurements are solicited. The Schering representative was also interested in initiating a CELSAM program to increase awareness of reproductive health issues in El Salvador. CELSAM is the NGO created by Schering to increase awareness of women's reproductive health

issues in Latin America. CMS, CELSAM and the local IPPF affiliate collaborated to implement a youth awareness campaign in Guatemala City in early 2001.

Pharmacia/Upjohn, the distributors of the 3-month injectable, Depo Provera, have had limited success in El Salvador. They sell approximately 25,000 units to the ISSS per year. Otherwise the bulk of their sales are to private providers and pharmacies. The Pharmacia representatives attributed the poor sales of Depo Provera to misunderstanding of the side effects. Women discontinue use because of fears that they will become infertile if they do not experience menstruation for many consecutive months. Pharmacia also is competing with the free distribution of Depo by the Ministry of Health. USAID has also donated large quantities of this product to the MOH for free distribution.

Wyeth sells oral contraceptives in El Salvador. The brands are Trinordiol , Nordette, Minulet, and Ovral . They sell to pharmacies and private sector doctors. They did not mention sales to the ISSS or the MOH.

Local manufacturers of contraceptives have had limited success in carving out a market share when faced with the competition of the international manufacturers. The local manufacturer, Paill, has developed a one-month injectable, Novular, that they market directly to the medical providers.

# 6. FACTORS THAT AFFECT DEMAND

## A. Unmet Need for Family Planning

According to the FESAL-98, there is an unmet need for family planning of 8.9%. The greatest need for services in El Salvador was found among women married/in union (14.2%), those with 5 or more living children (19.1%), those with no or less than 4 years of schooling (15% and 12.5%, respectively), and those of low socioeconomic level (13.2%).

Though contraceptives are not restricted and many governmental, as well as non- governmental, organizations are providing family planning services and products, there are many limitations on what is being offered where. For example, while the Ministry of Health offers all methods including the pill, one- two- and three- monthly injectables, as well as the IUD and Norplant, the available method mix varies between delivery points and supplies are inconsistent. The ISSS offers only one birth control pill option and does not carry either Noristerat or Depo Provera. ADS does not provide Depo Provera and Asaprosar, which contracts for service delivery with the Ministry of Health, does not provide family planning services at its main clinic.

### A.1 Unmet Need in Rural Areas

According to the FESAL, 1 in 5 rural women need reproductive health services. The CPR in rural areas is 51.2%, well below the urban rate of 67.8%. The rural unmet need is 2.5 times greater than the urban rate: 12.1% versus 4.9%. In urban areas temporary and permanent method use increased roughly the same amount. In contrast, in the rural areas, use of permanent methods declined from 29.3% to 27.5% whereas use of temporary methods increased from 16.4 % to 23.7%.

Unmet need is largely in the rural areas, where on average a woman must travel one hour to reach their source of contraception. In addition to lack of provision in the rural areas, women have stated that they are treated poorly and in a disparaging manner at the Ministry of Health facilities. Frequent stock-outs of contraceptives in the departments outside of San Salvador also affect use. The services and contraceptives available are very limited, and cultural barriers prevail in the rural areas. Women do not want to seek services because they do not want a doctor to see them unclothed.

### A.1 Unmet Need Among Agricultural Cooperatives

The Union of Agrarian Reform Cooperatives (UCRAPROBEX) is an umbrella association for coffee cooperatives. It has 60 member coffee cooperatives that range in size from 90 to 2500 members. The General Manager estimated that the cooperatives had 15,000 workers, forming a total beneficiary group of 70,000 people. Although these workers are part of the formal sector, they are not covered by ISSS. The Manager stated his interest in obtaining health care coverage for the employees and their families. Many of the workers will not seek services at the Ministry of Health clinics because of distrust in the quality of care and fear of poor treatment.

According to the Feasibility Study of Primary Health Care System for UCRAPROBEX conducted by the PROFIT Project in 1997, the UCRAPROBEX population had an unmet need for family planning and maternal and child health services and for other primary care services. Although the population was low-income, there was strong evidence that the cooperative members were willing and able to pay for health care. The cooperatives were spending significant and unpredictable amounts on medical care, mainly for secondary and tertiary care. The recommendation of the study was to establish a primary health care system that would offer improved access to primary health care and become financially self-sustaining. Trained health promoters supervised by circulating physicians would provide curative care, preventive care, health education services medications and referrals for specialized care. The Cooperatives would pay a fixed monthly fee per family, and patients would pay for their own medications. PROFIT proposal for a one-year pilot project involving 2000 families was never funded by USAID or any other donor.

UCRAPROBEX remains extremely enthusiastic about developing a sustainable program of delivering basic health and family planning services through the cooperatives. As stated earlier in the section regarding the ISSS extending its coverage to agricultural workers, ISSS offered to allow the cooperatives to affiliate, but the cooperatives maintained that their members could not afford to affiliate. Further investigation of how a private sector program might cover these workers needs to be explored. The program proposed by PROFIT could be pilot tested, or a new program could be developed and pilot tested.

### A.2 Unmet Need among Adolescents

Adolescents are the population at greatest risk for reproductive health problems including unplanned pregnancy, unsafe abortion and sexually transmitted diseases including HIV. Over 50% of population is under 20 years of age, and according to the National Health Survey (FESAL98), 40% of adolescent women between the ages of 15-19 are sexually active, with the average age of first intercourse being 16.4 years. Most significantly, 9 out of 10 sexually active adolescent women reported that they had used no protection during first intercourse. The majority of first sexual intercourse experience was pre-marital (59.2%).

The incidence rate of teenage pregnancy is very high, at 31%, and although the highest incidence of HIV/AIDS is found in women and men between the ages of 25 and 34, most of these people contracted the disease in their teens.

El Salvador, as in most countries, is experiencing a rapid change in social norms and structure. These changes put adolescents at risk for exposure to drugs, alcohol and the attendant health risks. According to recent studies, provider attitudes about adolescent sexuality often remain punitive and adolescents commonly wait until there is a crisis, such as unplanned pregnancy or symptoms of an STI to seek care. Provider awareness of the need for condom use to prevent STIs remain low.

The special needs of adolescents have only recently surfaced as a major public health focus in El Salvador, yet a great deal of work has been accomplished in a relatively short period of time, which leaves the country poised to actively address the needs of the adolescent population. The MSPAS has recently launched the Programa Nacional de Atencion Integral de la Salud de

Adolescentes which will seek to address not only reproductive health issues but also general health and development, mental health, violence and drugs as well as life skills and planning. Support for this program is broad-based and interdisciplinary. The MSPAS will be working with PAHO, UNFPA, USAID, GTZ, UNICEF, ADS, Catholic Relief Services, Ministry of Education, Secretaria Nacional de la Familia and the Evangelical University in El Salvador to implement this program.

Of particular interest is the recent formation of the Asociacion Salvadorena de Ginecologia, Obstetricia y Otras Disciplinas para la Infancia y la Adolescencia (ASOGIA) which brings together high-level, influential professionals including doctors, lawyers, teachers, counselors and members of the media. ASOGIA was started by a woman physician who recognized the unmet among adolescents for health services, and the lack of social response to the problems.

ASOGIA's mission is to contribute to the development of adolescents and children in El Salvador, by promoting their human rights and ensuring coverage of integrated health services. This organization has the potential not only to provide professional training and services, but also is positioned to positively influence public opinion as well as policy regarding adolescent issues. ASOGIA can also create demand among adolescents for integrated health services and products by working with parents and teachers to reduce the societal and cultural stigmas associated with adolescents seeking reproductive services

In addition, there are currently at least twelve NGOs with adolescent health programs in El Salvador. According to the literature regarding these programs, a majority of them focus on reaching kids with sexual health education and prevention, with very few programs provide direct services to teens. Time did not permit the team to interview the 12 NGOs and discuss the details of their programs.

## B. Barriers to the use of temporary methods

The main barriers to the use of family planning methods are cultural. El Salvador is a predominantly Catholic country and the church continues to exert a strong negative influence on the use of contraceptives including the use of condoms for the prevention of STIs including HIV. As a result, the open discussion of reproductive health and family planning is considered taboo.

A number of recent studies reviewed during this assessment indicate that the low use of family planning can also be attributed in large part to misinformation about the function and safety of methods. Both oral contraceptives and the IUD are particularly subject to misunderstanding and subsequent rejection. Myths remain stubbornly in place and include such beliefs as; birth control pills cause cancer, injectables cause infertility (and therefore should not be used by adolescents), and the IUD causes abortion.

In addition, machismo and the social acceptance of male domination, coupled with men's general lack of any access to reproductive health education, further decreases women's opportunities to seek accurate information and appropriate methods. Many males prohibit their partners from using contraceptives either out of genuine concern about the alleged negative health affects or out of fear that protection against pregnancy encourages female promiscuity.

Though the National Family Planning Norms were generally found to be consistent with up-to-date contraceptive management norms, they impose unnecessary barriers on adolescents. According to the National Norms oral contraceptives are recommended as the method of choice for adolescents who have not had children, injectables are not considered an appropriate first choice for this age group.

International experience indicates that injectables are the most appealing method for adolescents due to the privacy and convenience they afford. In contrast, many adolescents find oral contraceptives difficult to take consistently, difficult to take discreetly and to have more side effects than injectables. Reluctance to recommend injectables for this age group has been translated in the field to a prohibition on the use of injectables for any adolescent under the age of 16 or without children.

This type of misinformation is interpreted in the community as a danger signal and is translated into the next generation of myths and taboos. In interviews with community promoters we were told that their understanding of the reason for this prohibition is that the use of injectable prohibits the normal growth of the reproductive organs. Such misinformation, once generated, becomes difficult or impossible to dispel.

Though our interviews in various agencies suggested that the majority of providers handle family planning and reproductive health care in an objective and professional manner, adhering to the MSMAP practice norms, the studies reviewed indicate that providers remain a significant barrier to access to family planning and reproductive health services. Barriers identified by patients include poor treatment by providers and judgmental attitudes toward adolescents. Constraints identified by providers include the lack of time to provide adequate counseling. It is a normal impulse on the part of providers to provide methods that require the least amount of counseling and office time.

## C. Effective Demand Creation Campaigns

ADS' social marketing programs are very effective at creating demand shown by predominance in sales. ADS is the primary source of condoms in El Salvador (57%), and the second most common source for oral contraceptives (26.7%). Their campaigns have included both branded and generic IEC messages to a variety of target groups. Year after year, their T.V. ads have won awards. The global strategy for their marketing program has four components: a) strengthening ADS's own contraceptive brands; b) acquiring new market segments; c) product diversification; and d) expansion of the distribution network.

Currently, ADS social marketing program has achieved a sustainability rate of 161%. ADS has expanded their program by increasing the points of sale, expanding the range of products, segmenting the market, and aligning ADS's mission towards economic sustainability of programs. Products include 8 brands of condoms and 2 oral contraceptives (4 brands are their own) that are distributed through 873 different channels, such as pharmacies, motels, convenience stores cooperatives, and drugstores, among others.

ADS has a well-developed adolescent program. Clinical services targeting16-19 year olds provide family planning and reproductive health services including STD/HIV testing and

treatment. This is a fee-for-service program but adolescents receive a discount for lab costs and contraceptives. ADS provides approximately 5,000 visits per year to this age group. In addition a well-stocked library located at the entrance to the clinic provides health information as well as an alternate rationale for going to ADS. The obvious limitation is that the services are only available to adolescents who are able to pay for their services.

ADS's adolescent education program targets parents, teachers and teens. They have nine education centers as well provide reproductive health and sexuality education in the schools. Each year they train 225 teens, chosen by teachers as peers leaders, to provide outreach in the communities. One of the main issues for adolescents identified by ADS is the lack of places and activities for youth. There is a need for places for teens to go to learn skills, receive services and interact with peers in a drug and alcohol free environment.

# 7. CONCLUSION

CMS found that the country conditions and needs in El Salvador warrant a private sector family planning/reproductive health care initiative. As a result of the rapid assessment in El Salvador, the following primary needs emerged in the private sector:

1. Policies that inhibit growth in the private sector. There are some significant policy issues that inhibit the growth of the private health sector in general, and more specifically the private provision of family planning.

    - The private sector has been relatively slow to develop because it has historically been crowded-out by free or low–priced Ministry of Health services and mandatory enrollment in social security systems with their own health care delivery systems. In fact, 26% of the highest socioeconomic class obtains its family planning services from the MOH, more than twice the proportion using any of the other four sources identified.
    - The MOH's commitment to do "everything for everyone" means it serves people with the ability to pay for care who could be served in the private sector. If those with the ability to pay were to frequent the private sector, then that would free up the Ministry providers' time and Ministry resources to provide greater access, more services and better quality services to those who do not have the means to utilize the private sector. By virtue of its large infrastructure, non-targeted and low-priced structure, the Ministry constrains options for private sector family planning initiatives.

2. Contraceptive security. All of the stakeholders interviewed in El Salvador were very concerned about contraceptive security. From 1993 to 1998, the Ministry of Health (MSPAS) has maintained its place as the primary source of contraceptive services for the country, with a slight decrease in urban areas.

    - MSPAS receives over 80% of its contraceptives from USAID donations. Because USAID has stated that they will discontinue their donations to MSPAS in the near future, the concern arises as to how this will affect the overall contraceptive supply in El Salvador. At present, MSPAS does not have the capacity or the budget to procure their own supplies of contraceptive commodities.
    - Free donations of commodities to the public sector undercut the private sector and its ability to compete. For example, due to large donated quantities of Depo-Provera and Noristerat to the MOH and ISSS, dramatic changes occurred in the market shares of injectables between 1993 and 1998. The MOH share jumped nearly ten-fold, from 4.4 to 42.3 percent, while ISSS's share increased more than 25 percent, from 11.8 to 16.4 percent. These increases were achieved at the expense of the market shares of what had theretofore been the two principal private sector sources, ProFamilia and pharmacies. ProFamilia's share fell the most, by 61 percent, while the pharmacies' share was cut to half its former level.

3. Unmet need in rural areas. According to the FESAL, 1 in 5 rural women need reproductive health services. The CPR in rural areas is 51.2%, well below the urban rate of 67.8%. The rural unmet need is 2.5 times greater than the urban rate: 12.1% versus 4.9%. Lack of access and cultural barriers to use of family planning methods were cited as the principle reasons for this unmet need.

4. Unmet need among adolescents. Adolescents are the population at greatest risk for reproductive health problems including unplanned pregnancy, unsafe abortion and sexually transmitted diseases including HIV. Over 50% of population is under 20 years of age, and according to the National Health Survey (FESAL98), 40% of adolescent women between the ages of 15-19 are sexually active, with the average age of first intercourse being 16.4 years. Most significantly, 9 out of 10 sexually active adolescent women reported that they had used no protection during first intercourse.

# 8. RECOMMENDATIONS

CMS recommends a private sector strategy that addresses policy and contraceptive security issues as well as providing innovative ideas for initiatives to meet the unmet needs in the rural areas and among adolescents.

## A. Policy Reform and Contraceptive Security

### A.1 Objectives

- Improved environment for the utilization of the private sector for reproductive health products and services
- Sustained supply of contraceptives
- More efficient and equitable resource allocation for family planning products and services

### A.2 Implementation Strategy

a) *Gather Background information.*Using available data CMS will develop a presentation of the current situation and calculate a 10-15 year projection of demand for family planning and associated supply based on existing patterns of utilization and source of supply. This data will help illustrate the inequity of the current situation and the financial burden that the Ministry of Health will face if it is to finance the purchase of contraceptives and continue to maintain its share of service provision.

b) *Kick-off stakeholder meeting.* The Ministry of Health is a critical partner in effectively addressing contraceptive security. It will need to collaborate with non-profit and commercial providers and most importantly be willing to change its own marketing and service delivery practices. If government is comfortable with the status quo, it might be unwilling to participate in or support contraceptive security activities unless it's convinced that there is a pending change to the current environment, such as a phase-out of donated contraceptives by USAID. CMS will convene a meeting of key stakeholders. This initial meeting will be attended by high-level representatives of :

- the Ministry of Health
- ADS and other non-profit providers of family planning products and services
- key commercial manufacturers,
- private providers, and
- USAID and other key donors to El Salvador's health sector.

A crucial objective for this first meeting is to secure the government's support and participation, as well as the active involvement of the non-profit and commercial sectors.

Therefore, USAID needs to state its commitment to phasing out its donated products by a set date. Furthermore, USAID would emphasize that the phase out period provides an opportunity for the three sectors to come together as a team and develop a complementary strategy for providing family planning products and services to all Salvadorans. During this meeting, the background information will be disseminated and discussed and a process for continued dialogue and collaboration agreed to.

c) *Series of follow-up meetings.* CMS will facilitate a series of follow-up meetings and working groups to:

- Define information needs

  A market segmentation strategy needs to be based on data, but data needs may vary among the different sectors. Rather than defining information needs and a list of studies *a priori*, each of the sectors should contribute to a joint list of needed information. The final list of information needs and necessary studies will reflect the interests of all three sectors. Once the different sectors have defined their information needs, the studies will be conducted.

- Build consensus for segmented strategy

  As studies are completed and desired information compiled results will be disseminated and discussed. All sectors need to define which market segment it can serve, recognize whether this complements or conflicts with the other sectors, and propose how best to work together. The data from the studies and an appreciation for the objectives and strengths of each sector should inform this discussion. Through facilitation and negotiation, consensus on a common market segmentation strategy will be reached.

d) *Provide technical assistance.* Implementation of the strategy will likely require involvement by each sector in activities and approaches that are new to them. Sector specific technical assistance plans will be developed.

e) *Pilot test new approaches.* New approaches will likely be proposed during the development of the market segmentation strategy. The overall success of the strategy may depend on assumptions about the implementation of those approaches. Pilot testing the approaches, when successful, can contribute to building confidence in and support for the overall strategy. A less successful pilot provides crucial information for improving the strategy before rolling it out nationwide. Examples of new approaches that could be pilot tested include

- government providers charging user fees or
- government contracting with non-profit community promoters to provide family planning products to the rural poor.

***f)*** *Monitor progress and facilitate ongoing dialogue among the different sectors.* Agreement on the market segmentation strategy should include agreement on indicators for assessing

progress. These should be monitored regularly. It will be important for dialogue among the different sectors to continue. If progress targets are not being achieved as expected or other challenges arise, the three sectors must to work together to amend their strategy or devise a response.

***g)*** *Dialogue between CMS and GOES.* Based on the outcome of the dialogue between the different sectors and the market segmentation strategy, CMS will work with the Government of El Salvador to change any policies that inhibit growth of the private health sector with particular emphasis on family planning products and services.

## B. Rural program initiative

### B.1 Objectives

- To increase access to health services in rural under-served areas
- To increase incentives for physicians to work in rural areas
- To create a cadre of physicians with appropriate skills and preparation to provide appropriate health care services to rural populations

### B.2 Implementation Strategy

a) *Medical School Service Program in Rural Areas*. There is a well-documented excess of medical school graduates in El Salvador and yet there remains a shortage of physicians in the rural areas. Reasons for this discrepancy include: physicians accustomed to living in urban areas are unwilling to relocate to rural areas, MOH salaries are low; and most physicians supplement their MOH salary through small private practices.

Most doctors currently providing services in the rural areas are new graduates doing their required year of service. These young physicians are inexperienced and ill-prepared for the abrupt change from urban to rural life. The year of service is seen as a duty to be endured and most physicians return to the urban areas as soon as their obligation is fulfilled. This lack of preparation and commitment fosters poor quality services and poor relations between doctor and patient. Rural patients often site bad treatment as a principle reason for not seeking care.

In order to address these problems a model Rural Service Program could be established in the National Medical School that would provide a complimentary program for medical students that are recruited from the rural areas or show an interest in setting up practices in the rural areas. The program could:

a) provide special training in working in rural areas including sensitizing physicians to the special needs and perspective of the rural poor

b) guarantee employment upon graduation

c) provide a salary bonus for work in the rural areas that increases with longevity.

A parallel program could be set up for post graduates who want to return for perhaps a three month term that screens applicants for appropriateness and includes the info and skills an urban doctor would need to make the transition, plus provide the incentives for long term commitment. Priority would be given to those applicants who could demonstrate existing ties in a rural community in which they choose to work (if the position is available).

*b) ISSS contracting recent graduates or a local NGO to work at Company Clinics on coffee cooperatives.* Based on the feasibility study by the ISSS of establishing two rural-based clinics in the western region of the country, CMS would like to facilitate further discussion between the ISSS and UCRAPROBEX to provide coverage to employees and families of the coffee cooperatives. UCRAPROBEX remains extremely enthusiastic about developing a sustainable program of delivering basic health and family planning services through the cooperatives.

## C. Network of "Youth Friendly" providers

### C.1 Objectives

- Increase supply of providers trained to deal with youth appropriately
- Increase adolescent access to RH services
- Increase demand for RH services among youth

### C.2 Implementation Strategy

*a) Creation of "Youth Friendly" network of providers.* There is an opportunity for collaborating with ASOGIA to quickly develop a network of "youth friendly" providers. ASOGIA is a professional association whose mission is to ensure coverage of integrated health services to adolescents and children in El Salvador. Their membership currently includes over eighty physicians who have already demonstrated an interest in Adolescent Reproductive Health (ARH). ASOGIA is in the process of developing plans to train and certify professionals in ARH (including the above-mentioned congress scheduled for this coming November).

The development of such a network would require the establishment of accreditation criteria, the development of a recognizable "Youth Friendly" logo and the public promotion of the concept. Establishing such a network would enable capacity building, standardization of care, quality assurance, marketing, and potential partnerships with pharmaceutical companies to provide low-cost family planning products for adolescents. It would increase access for adolescents to reproductive health services with an assurance that they will be treated with respect and confidentiality.

*b) Link ADS Pharmacies and Peer Promoters to Youth Friendly Service Providers.* ADS has a well-developed adolescent program. ADS' adolescent education program targets parents, teachers and teens. They have nine education centers as well provide reproductive health and sexuality education in the schools. Each year they train 225 teens, chosen by teachers as peer leaders, to provide outreach in the communities.

These peer leaders can serve as extension agents to create demand for the youth friendly provider network. They would be posted in selected pharmacies during "youth week" and provide information, samples and leaflets regarding the reproductive health in general, and health services available at the provider network.

## D. Corporate Social Responsibility

### D.1 Objectives

- Increase demand for contraceptives, particularly in rural areas
- Reduce misconceptions of contraceptives through effective IEC material.
- Increase knowledge regarding RH among youth

### D.2 Implementation Strategy

*a) Avon Initiative.* During the two-week assessment in El Salvador, CMS garnered great interest in a corporate social responsibility initiative. There is a significant window of opportunity because Avon is about to launch a new line of products targeting women's health and they are interested in creating links to the health sector in Latin America. Avon already has a network of over 15,000 Avon distributors in El Salvador, particularly in the maqiladora population.

CMS would create a partnership with Avon Corporation to increase in demand and use of family planning and reproductive health services. Potential program collaboration ideas include:

- Support for an interdisciplinary regional congress on Adolescent Health, sponsored by ASOGIA and scheduled to be held in El Salvador in November 2001.
- Collaboration with ADS Adolescent Health Program to develop and support a teen hotline. Discussions included placing the Avon trademark on hotline promotional materials as well as inclusion of the hotline number in Avon catalogues directed at the youth market. Whether Avon would provide funds to set up and run the hotline needs to be explored further.
- Development of appropriate health information materials that can then be inserted in Avon catalogues and distributed through Avon's already established market niche.

CMS also received a positive response from the private telephone company, Telecom, regarding sponsorship of the youth hotline. Telecom will need a formal proposal from CMS to move forward on this.

*b) Pharmaceutical sector sponsorship of activities.* Discussions with the pharmaceutical representatives resulted in positive responses regarding the possible sponsorship of reproductive health activities in El Salvador. Pharmacia/Upjohn expressed interest in being a sponsor for the ASOGIA conference on adolescent reproductive health. Schering has recently created a regional NGO, CELSAM, that promotes awareness of women's reproductive health issues in Latin America. Schering is interested in having CELSAM collaborate with CMS to implement adolescent reproductive health activities in San Salvador.

## E. Sustainability initiative in the NGO sector

### E.1 Objective

- Increase long-term supply for reproductive health services by improving sustainability of RH NGOs

### E.2 Implementation Strategy

*a) Fundraising Workshop.* CMS has had a great deal of success guiding local NGOs on the path to sustainability. The NGOs in El Salvador are mature NGOs, in the respect that all of those interviewed had an updated sustainability plans. Although some of them had done some fundraising in the past, they recognized the need for a more formalized approach to fundraising and diversifying their funding base. CMS has conducted Fundraising Workshops in Latin America and Africa and would be willing to offer this course to local NGOs in El Salvador.

*b) Assist ADS in Marketing Services to ISSS's Company Clinics Program.* ADS is by far the strongest NGO in the health sector in El Salvador. Even so, they realize that they need assistance with marketing their services to the ISSS and local manufacturers in order to provide services at the textile factories (maquilas) in the zona franca. A potential opportunity exists for an organization such as ADS to facilitate and manage the development of new company clinics in the free zone outside of San Salvador. Currently ISSS does very little outreach to the business community to advertise this potential service delivery system. In addition, the business has the burden of developing and equipping the facility, as well as hiring the staff. Such an NGO could provide the information about the opportunity to have an on-site clinic as well as a "package" of required equipment and staff. The NGO could then contract with the business for continued management. Providing such as service could not only expand health services but also provide the NGO with an untapped source of income for their own sustainability.

*c) Marketing T.A. to ADS.* Although ADS' marketing for branded contraceptives and high-end market services is very well done, from interviews conducted of the stakeholders, it appears that ADS is now perceived as a high-end private sector provider with sustainability as its main objective. ADS would do well to market its middle class services/prices in its clinics, as well as its pharmacies and high-end hospital. ADS also needs to be concerned about the downsizing of its regional/departmental services due to efforts to increase cost-effectiveness. These departmental clinic services need to be marketed as integrated services, affordable to the "guy next door."

*d) Creating an Association of Health NGOs to increase coverage in rural areas, and to procure large quantities of low-cost contraceptives.* For years USAID supported a network of 35 NGOs that provided extensive coverage of the rural areas. Based on discussions with local NGOs, these organizations would be interested in creating a similar network to reach the poorest of the poor in the rural areas. Five of these NGOs already are contracted by the Ministry of Health to provide services in specific geographic zones, but they need additional work to increase their revenues. The network could also offer its own solution to contraceptive security in the NGO sector. The network could create a type of "procurement cartel" to obtain reasonable prices on contraceptives from the major pharmaceutical companies. CMS discussions with the pharmaceutical companies, they also were open to reducing prices for the social sector.

*e) SUMMA Loans.* Finally, some of the NGOs were interested in applying for a SUMMA loan from CMS. The SUMMA foundation can offer the NGOs low interest loans to give them credit to support their activities.

## ANNEX A: AGENDA

**Sunday, May 13:**

| | |
|---|---|
| **6 – 8 pm** | **Hotel Princess, Zona Rosa** – Assessment team arrives<br>Blvd. Del Hyprodromo y Av. Las Magnolitas<br>Col. San Benito<br>San Salvador<br>Tel. 503-298-4545<br>FAX 503-298-4500 |
| **8:00pm** | Meeting – Assessment Team<br>(If one member arrives late, we can meet at 8:30pm) |

**Monday, May 14:**

| | |
|---|---|
| **8am** | **ADS -** Meeting with Jorge Hernandez (NGO Sector)<br>Jorge will pick us up at the hotel<br>ADS tel. 225-0047 |
| **10am** | **ADS –** Meeting with Samuel Castro & Dr. Valle |
| **1:30pm** | **FUSADES –** Meeting with Lic. Anabela de Palomo<br>Frente Edificio AID, Santa Elena<br>Tel. 278-3366 |
| **3pm** | **USAID –** Briefing with Maricarmen de Estrada and Karen Walch<br>Embajada Americana<br>Boulevard Santa Elena Sur<br>Antiguo Cuscatlan<br>Tel. 298-1666 |
| **5pm** | **Hotel Princess -** Assessment Team Meeting |

**Tuesday, May 15:**

| | |
|---|---|
| **9:00am** | **MSH** – AB, KW meet with Dr. Manuel Beza<br>Laboratorio Central Dr. Max Bloch<br>Alameda Roosevelt, Frente Parque Cuscatlan<br>Tel. 271-1277<br>JF – a private insurance company, not yet scheduled |

**11am** **PRIME -** Team meeting with Dr. Douglas Jarquin
77 Ave. Norte, Pje. Istmania #304
Colonia Escalon
Tel. 264-7525

**1:30pm** **Ministerio de Salud (MSPS)** Team meeting with Lic. Haydee de Escobar
Gerencia Programa Atencion Integral a la Mujer
Calle Arce No. 827
Tel. 222-4827

**4pm** **3M** Meeting with Lcda Marisela de Gattas
Urbanizacion Industrial Santa Elena
Calle Chaparrastique #11
Tel. 210 - 0888

**6pm** Meeting – Assessment Team

**Weds, May 16:**

**8:30am** **Ministerio de Salud Publica** Team meeting with Dr. Carlos Rosales
Direccion General
Calle Arce No. 827
Tel. 222-7360

**12pm** **Ministerio de Salud Publica –** Dra. Nieto, Planificacion

**2pm** **Ministerio de Salud Publica –** Programa Integral de la Mujer
Lcda. Maria Celia Hernandez, Coordinator of Prenatal y Postpartum Services
Dr. Moran Colato, Coordinator of Family Planning

**3pm** **Ministerio de Salud Publica –** Programa de Adolescentes
Lcda. Concepcion de Flores, Nutricionista, Programa Nacional de Atencion Integral de la Salud de Adolescentes, (MSPAS)

**7pm** Assessment Team Meeting

**Thursday, May 17:**

**8:30am** **Colegio de Quimicos y Farmaceuticos** with Lcdo Anaya ***(tentative)***
Colonia San Francisco
Calle Los Abetos y Calle Los Bambues
Tel. 224-0980

**11am** **Consejo Superior de Salud** with Lcda Lolly Claros de Ayala ***(tentative)***
Paseo General Escalon No. 3551
Tel. 298-2576

**2pm** **Avon -** KW, AB with Lcda Rodrigo Delgado
Calle Conchagua y Blvd. Santa Elena
Antiguo Cuscatlan
La Libertad
Tel. 289-4343

**4:30pm** **Sociedad de Ginecologia y Obstetricia (SOGOES)** AB, KW with
Dr. Perez Arce
Col. Medica, Urbanizacion La Esperanza
Centro Ginecologico de El Salvador, 5a Planta
Tel. 225-3122

**7pm** Assessment team meeting

**Friday, May 18:**

**8:30am** **ISSS** – Team Meeting with Dra. Marina Padilla de Gil
Jefatura Programa de Salud Reproductiva
Prolongacion 65 Av. Sur, frente Hospital
Roma, Calle El Progreso
Tel. 279-3417

**11am** **USAID Private Enterprise Division**
Sandra Duarte – 298-1666

**2pm** **ADS Adolescent Program**
Lcdo. Luis Eduardo Rivera

**4pm** **UNFPA** –Fresia Serna – 263-3490
Tercera Calle Poniente #4048
Colonia Escalon

**6pm** **ASOGIA –** Meeting with Dra. Miriam Oliva de Navarete Hotel Princess

**Saturday, May 19:**

**7:30am** **Excursion to rural areas around Santa Ana**
**ADS rural program**
Lcdo. Ricardo Emiliano Palacios

**7pm** Assessment Meeting – Evaluation of fact-finding thus far; Brainstorming for program initiatives.

**Sunday, May 20:**

**Throughout day** Write up findings from meeting during the week

**Monday, May 21:**

**8am** **IDB** – Lcda Isabel Nieves

**9:30am** **ISSS –** Dra. Reyes
Clinicas Empresarias

**11am** **OEF.** Lcda Emma Mendez
Tel. 221-0957, 222-7384
Primera Calle Poniente #1108

**4pm** **UCRAPROBEX –** Lcdo Ulises Palma
Ciudad Merliot, Polignio C
Edificio UCRAPROBEX
A la par de la Farmacia Beethoven
Tel. 278-6388

**Tuesday, May 22:**

**8:30am** **FUSAL** - Lcda Celina de Choussy
Final Boulevard Santa Elena
Urb. Santa Elena
Tel. 289-1100

**2pm** **Colegio Medico**
Colonia Miramonte
Final Pasajes #10
Tel. 260-8111

**Throughout Day** Write up findings

**Wednesday, May 23:**

**12:30pm** **ASAPROSAR –** Lcda Claudia Zaldana
Meeting at FUSAL Conference Center

**3:30pm** **Wyeth –** Lcdo Elmer Campos
Meeting at Princess Hotel

**6:30pm** Team Meeting to analyze findings and prepare presentation

**Thursday, May 24:**

**12pm** **Pharmacia/Upjohn** – Ernesto Gamero

**2pm** **ADS –** Lcdo Jorge Hernandez and Cosette Ramirez

**5pm** **Schering –** Lcdo. Jorge Escamilla

**Friday, May 25**

**9am** **Presentation to Mission**

**11am** **Airport – departure for U.S.**

**Friday, June 2:**

Report write-ups due to KW in Washington, DC

**Friday, June 8:**

*Report due to USAID*

# ANNEX B: PERSONS CONTACTED

Jorge Hernandez Isussi, Executive Director, ADS

Licda. Rony Cossette Ramirez, Director, Marketing and Communications, ADS

Dr. Jose Valle, Medical Director, ADS

Dr. Samuel Castro, Director of Clinics, ADS

Lcdo. Ricardo Palacios, Director of Rural Programs, ADS

Lic. Anabella de Palomo, Director, Department of Economic and Social Research, FUSADES

Maricarmen de Estrada, Reproductive Health Officer, USAID/El Salvador

Karen Welch, Health Officer, USAID/El Salvador

Dr. Manuel Beza, Project Director, MSH

Dr. Douglas Jarquin, Project Director, PRIME

Lic. Haydee de Escobar, Gerencia Programa Atencion Integral a la Mujer, Ministerio de Salud Publica (MSPAS)

Lcda. Marisela de Gattas, Coordinator of Pharmaceuticals, 3M

Dr. Teddy Albayero, Professional Relations, 3M

Dr. Carlos Rosales, Director, MSPAS

Dra. Nieto, Director of Planning, MSPAS

Lcda. Maria Celia Hernandez, Coordinator of Prenatal y Postpartum Services, Gerencia Programa Atencion Integral a la Mujer, Ministerio de Salud Publica (MSPAS)

Dr. Moran Colato, Coordinator of Family Planning, Gerencia Programa Atencion Integral a la Mujer, Ministerio de Salud Publica (MSPAS)

Lcda. Concepcion de Flores, Nutricionista, Programa Nacional de Atencion Integral de la Salud de Adolescentes, (MSPAS)

Lcda Lolly Claros de Ayala, President, Consejo Superior de la Salud

Rodrigo Delgado, Administrative Director, Avon

Dr. Carlos Perez Arce, President, Asociacion de Ginecologia y Obstetricia (ASOGOES)

Dra. Marina Padilla de Gil, Director of the Reproductive Health Program, ISSS

Lcda. Sandra Duarte, USAID Private Enterprise Section

David Shroeder, USAID Private Enterprise Section

Licdo. Luis Rivera, Director of Youth Programs, ADS

Lcda. Fresia Cerna, Program Officer, UNFPA

Christian Saunders, UNFPA/NY

Dra. Miriam Oliva de Navarrete, President, Asociacion Salvadorena de Obstetricia y Ginecologia de la Infancia y Adolescentes (ASOGIA)

Dr. Henry Agreda, ASOGIA

Dr. Milton Ramirez Montoya, Director of ISSS Hospital, Santa Ana

Dra. Luz Carballo de Hernandez, Director of Unidad de Salud, Santa Ana

Dr. Samuel Duenas, Director of PROFAMILIA clinic in Santa Ana

Lcda Ana Graciela de Carranza, Director of Laboratory, PROFAMILIA/Santa Ana

Celia Rosa Flores de Flores, Technical Coordinator for Rural Promoters, Santa Ana

Ena Gladys Arteaga Duke, Rural Promoter, near Santa Ana

Maria Sara Arce, Rural Promoter, near Santa Ana

Dra. Ana Maria de Henriquez, Director of MSPAS Clinic, San Rafael

Lcda de Chanta, Nurse at MSPAS Clinic, San Rafael

Lcda. Isabel Nieves, Sector Development Specialist, IDB

Dra. De Reyes, Clinicas Empresariales, ISSS

Mayra Hernandez, Direccion de Planificacion en Salud, Unidad de Informacion en Salud, ISSS

Lcda. Emma Dinora Mendez, Executive Director, Asociacion para la Organizacion y Educacion Empresarial Femenina de El Salvador (OEF)

Lcdo. Nestor Ulises Palma, General Director, Unidad de Cooperativas de la Reforma Agraria, Productoras, Beneficiadoras y Exportadoras (UCRAPROBEX)

Dra. Ana Gloria Quintanilla de Reyes, Coordinator, Sistema de Atencion de Salud Empresarial, ISSS

Lcda Celina de Choussy, Executive Director, Fundacion Salvadorena para la Salud y el Desarrollo Humano (FUSAL)

Lcda Claudia Patricia Zaldana, Project Coordinator, Asociacion Salvadorena Pro Salud Rural (ASAPROSAR)

Lcdo Carlos Salvador Melgar C., Jefe de la Seccion Metodología, Dirección General de Estadísticas y Censos (DIGESTYC), Ministerio de Economía.

Lcdo Edgar Soto Menjivar, Jefe Departamento de Estadística, ISSS, Tel: 260-5044, Ext. 268, email: estadist@quik.elsv.com and menjivar@tutopia.com.

Lcda. Zoila Dinora de Guardado, Subgerente Servicio al Cliente, Aseguradora Agrícola Comercial (ACSA), Tel 260-3344, Ext. 238, email: dguardado@acsasal.com.sv.

Lcdo Efraín E. Corleto Merlos, Gerente de Ventas, Pan American Life, Tel 245-2727, 245-2905, email: palices.vtas_izalco@salnet.net.

Lcdo Mario Ramírez, Asistente Gerencia General, Seguros e Inversiones (SISA), tel 298-1199, 298-1484.

Lcda. Ada Marisol Cruz de Samayoa, Sub-jefe, Unidad de Asesoría Jurídica, MOH, tel 222-1710, 221-0966.

Lcdo E. Reyes, Jefe de Sección de Seguros de Salud, Superintendencia del Sistema Financieros, Tel: 298-0133

Useful Websites:

Ministry of Health: www.mspas.gob.sv
Superintendencia del Sistema Fiancieros: www.ssf.gob.sv
Ministry of Hacienda (Treasury): www.mh.gob.sv
Central Bank: www.bcr.gob.sv

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