HEALTH SYSTEMS PROFILE
EL SALVADOR

MONITORING AND ANALYZING HEALTH SYSTEMS CHANGE

(Thrid Edition)
October, 2007

EL SALVADOR
un gobierno con sentido humano

HEALTH SYSTEM PROFILE
OF
EL SALVADOR
2000-2005

Monitoring and Analysis
of Change Processes

October 2007

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ISSS

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REPUBLICA DE EL SALVADOR
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INTRODUCTION

The Ministry of Public Health and Social Welfare is committed to implementing and reaching the goals of the Government's Plan for 2004-2009, "Safe Country," to attain the Millennium Development Goals, and to consolidate the health sector reform process, in order to contribute to the improvement of the quality of life of the people of El Salvador.

This "Health System Profile" provides a picture of the health situation in El Salvador, the effect that social indicators have on health indicators, and the progress that has been made through the health reform in El Salvador. Consequently, the report presents the accomplishments that have been made, but at the same time it identifies the challenges, which can be overcome with the involvement of all health sector institutions. These challenges compel us to continue working to improve efficiency and quality, in order to contribute to the improvement of people's health and living conditions.

I would like to take this opportunity to thank the MSPAS staff members who were responsible for preparing this report and to acknowledge the contributions made by institutions such as the ISSS and Bienestar Magisterial, and in particular the unconditional support that we have always received from the PAHO/WHO Country Office in El Salvador.

By working in the spirit of service we will make El Salvador the country of real opportunities that we all deserve.

THANK YOU AND GOD BLESS.

Dr. José Guillermo Maza Brizuela
MINISTER OF PUBLIC HEALTH AND SOCIAL WELFARE
EL SALVADOR, CENTRAL AMERICA

ACRONYMS AND ABBREVIATIONS

ADD Acute Diarrheal Disease
ANDA *Administración Nacional de Acueductos y Alcantarillados* / National Water and Sewerage Administration
ANES *Asociación Nacional de Enfermeras de El Salvador* / National Association of Nurses of El Salvador
ANSAL Analysis of the Health Sector in El Salvador
ARI Acute Respiratory Infection
BCR *Banco Central de Reserva de EL Salvador* / Central Reserve Bank of El Salvador
BM *Bienestar Magisterial* / Teachers' Welfare
CAE *Centro de Atención de Emergencias* / Emergency Services Center
CCS Country Cooperation Strategy
CNSPRIS *Comisión Nacional de Seguimiento a la Propuesta de Reforma Integral de Salud* / National Commission to Monitor the Integrated Health Reform Proposal
CONASA *Comisión Nacional de Salud* / National Health Commission
CORE DATA *Observatorio de los Recursos Humanos del Sector Salud* / Observatory of Human Resources in Health
CSSP *Consejo Superior de Salud Pública* / Higher Council for Public Health
DIGESTYC *Dirección General de Estadísticas y Censos* / General Bureau of Statistics and Censes
EAP Economically Active Population
EPHF Essential Public Health Functions
ETZ *Equipos Técnico de Zona* / Regional Technical Teams
FESAL *Encuesta Nacional de Salud Familiar* / National Family Health Survey
FOSALUD *Fondo Solidario para la Salud* / Health Solidarity Fund
FUSADES *Fundación Salvadoreña para el Desarrollo Económico y Social* / Salvadoran Foundation for Economic and Social Development
GDP Gross Domestic Product
GIDRHUS *Grupo Intersectorial de Recursos Humanos en Salud* / Intersectoral Group on Human Resources in Health
HA Health Authority
HDI Human Development Index
HIV/AIDS Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome
HSR Health Sector Reform
IDB Inter-American Development Bank
IEPROES *Instituto de Educación Superior de Profesionales de la Salud de El Salvador* / Institute of Higher Education for Health Professionals in El Salvador
ISRI *Instituto Salvadoreño de Rehabilitación de Inválidos* / Salvadoran Institute for the Rehabilitation of Disabled Persons
ISSS *Instituto Salvadoreño del Seguro Social* / Salvadoran Social Security Institute
LACAP *Ley de Adquisiciones y Contrataciones de la Administración Pública* / Public Sector Procurement and Contracting Law
MARN *Ministerio de Medio Ambiente y Recursos Naturales* / Ministry of Environment and Natural Resources
MDG Millennium Development Goals
MINED *Ministerio de Educación* / Ministry of Education
MINTRAB *Ministerio de Trabajo y Previsión Social* / Ministry of Labor and Social Security
MSPAS *Ministerio de Salud Pública y Asistencia Social* / Ministry of Health and Social

	Welfare
N/A	Not Available
NGO	Non-Governmental Organization
NHA	National Health Authority
NHP	National Health Policy
PA	Position of Actor
PAHO	Pan American Health Organization
PHC	Primary Health Care
RA	Role of Actor
RHESSA	*Proyecto de Reconstrucción de Hospitales y Extensión de los Servicios de Salud* / Earthquake Reconstruction and Health Services Extension Project
SIBASI	*Sistema Básico de Salud Integral* / Basic Integrated Health System
SIMETRISSS	*Sindicato de Médicos Trabajadores del Instituto Salvadoreño del Seguro Social* / Union of Physicians Working in the Salvadoran Social Security Institute
SIRHI	*Sistema de Información de Recursos Humanos Institucional* / Institutional Human Resources Information System
TB	Tuberculosis
UACI	*Unidad de Adquisiciones y Contrataciones Institucional* / Institutional Procurement and Contracting Unit
USAID	United States Agency for International Development
UTMIN	*Unidad Técnica de Medicamentos e Insumos Médicos* / Technical Unit for Drugs and Medical Supplies
WHO	World Health Organization

EXECUTIVE SUMMARY

El Salvador is a republic with three branches of government: the Executive, the Legislative, and the Judiciary. The offices of the first two are filled through popular elections; the president serves for five years and members of the legislature serve for three years. El Salvador is divided politically into 14 departments and 262 municipalities, governed by mayors who are elected every three years. The government's policies for the 2004-2009 period are embodied in the government's "Safe Country" plan. The priority for health in this plan is, "Carrying out consensus-based health sector reform that will enable us to attain an efficient, consolidated, decentralized national health system that provides universal coverage and guarantees services at no charge to anyone anywhere in the country who is unable to pay."

The population in 2005 was 6,874,926, of which 59.8% was urban; population density was 331.45 people/km^2. The population profile has the typical wide-based pyramid shape of a predominantly young population (approximately 40% of the population is under 19). During the last five-year period, the average life expectancy at birth was 70.6 years.

The country's epidemiological profile is in transition. Infectious diseases, primarily of the respiratory and digestive tracts, still persist; yet in the last decade, diseases such as hypertension and chronic, psychosomatic diseases, such as gastritis, have begun to appear. It is also worth pointing out that in the last few years, injuries from external causes have increased as a result of violence in the country. Other diseases are equally as important for epidemiological surveillance, because they are highly contagious- dengue fever, pneumonia, tuberculosis, and HIV/AIDS. As a comparison, among the causes of general mortality, perinatal causes of death persist, but deaths from cancers, such as leukemia and lymphomas, and other chronic diseases, such as diabetes mellitus and AIDS, have grown in importance.

During the 2000-2004 period, the public expenditure on health accounted for, on average, 3.5% of the GDP, and the private expenditure on health was 4.4%. Of the private expenditure, out-of-pocket spending by Salvadoran households was similar to the public expenditure on health during the same period. The high amount of private spending on health, especially by households, is related to the low coverage by health insurance systems (around 20%, including private coverage) and the high costs borne by households for purchasing drugs and laboratory tests, among other factors. International cooperation efforts place high priority on strengthening and complementing national economic and social development efforts in El Salvador. However, in the last five years, non-repayable aid for technical assistance from international cooperation agencies has been decreasing.

The country has made significant progress in reducing levels of relative and extreme poverty. As part of the 2004-2009 five-year plan, the *Red Solidaria* (Solidarity Network) Program was initiated in 2005, which is providing benefits to 100 municipalities classified as having severe levels of extreme poverty and relative poverty. The program gives conditional cash transfers to beneficiary families in return for health and education co-responsibilities. Worthy of note, is that during the 2000-2004 period, of all employment created in the country, 68% was in the formal sector, while the remaining 42% was in the informal sector.

Regarding health insurance coverage, the 2005 Multi-Purpose Household Survey (EHPM) found that 18.4% of the population is covered by the social security system (ISSS) as either subscribers or dependants, 2.1% is covered by private insurance, and the remaining 79.5% lies in the responsibility of the Ministry of Health (MSPAS). However, by law, anyone who seeks services at a MSPAS facility is seen independent of insurance status. With regard to the overall rate of health service utilization, data from nine private hospitals, ISSS, and MSPAS from 2004 gave an overall utilization rate of first level health care facilities of 1.26 per inhabitant, and an overall utilization rate of second level health care facilities of 1.3 per inhabitant. In general, of all people who were sick and sought care, 64% went to MSPAS facilities, 13% to the ISSS, 16.9% to a private hospital or clinic, and the remaining 4.6% went to NGOs, social programs, pharmacies, and other places.

As a strategy to expand health services coverage, in 2004, the Health Solidarity Fund (FOSALUD) was created, which uses different service delivery arrangements (24-hours-a-day, 365 days a year; 8 hours a day on weekends and holidays; and dental services on weekends and holidays). By December 2005, different service delivery arrangements had been implemented in 66 health facilities.

El Salvador's health sector is made up of two sub-sectors: the public sector, which includes MSPAS, ISSS, Military Health, Teachers' Welfare (*Bienestar Magisterial*-BM), the Salvadoran Institute for the Rehabilitation of Disabled Persons (ISRI), and the Higher Council for Public Health (CSSP); and the private sector, which includes for-profit and not-for-profit entities. Significant health reform efforts have been made since the 1999-2004 period, one of them was the ratification of the steering role of MSPAS. In 2003, the National Commission to Monitor the Integrated Health Reform Proposal (CNSPRIS) was formalized, and has already produced important documents, including policy proposals on human resources and social participation. The two evaluations of the EPHF, which have led to the "Plan for the Development of the Essential Public Health Functions," have provided important input into the reform process.

1. CONTEXT OF THE HEALTH SYSTEM

1.1 HEALTH SITUATION ANALYSIS

1.1.1. Demographic Analysis

The country of El Salvador covers 20,742 km^2, inhabited by 6.8 million people who live primarily in the urban areas of the departments of San Salvador, Santa Ana, San Miguel, Ahuachapán, Sonsonate, and Usulután. The average population density is 331.45 inhabitants/km^2; San Salvador is the most densely populated city (over 2,500 inhabitants/km^2), with consequent environmental hazards and problems from overcrowding.

The population pyramid reflects the typical demographics of developing countries, with its wide base depicting a predominately young population. Around 40% of the population is under 19 years of age and the population over age 60 has averaged 9% over the last three five-year periods. There are slightly more females than males in the total population, and there are more older women than older men; however, in the under-15 population, there have been more males than females throughout the 1990-2005 period (Table 1). Life expectancy at birth for the 2000-2005 period was 70.6 years for both sexes.

Table 1: Demographic Trends, by five-year periods: 1990-2005, El Salvador

Periods/ Indicators	1990-1994		1995-1999		2000-2005	
	Men	Women	Men	Women	Men	Women
Total population	2,489,516	2,736,720	2,802,219	3,070,401	3,106,928	3,414,505
Urban population	1,194,473	1,396,785	1,335,242	1,755,651	1,790,864	2,057,835
Indigenous population	N/A	N/A	N/A	N/A	N/A	N/A
Proportion of population under age 15	42.4	37.9	39.3	24.7	37.2	32.4
Proportion of population age 60 and over	7.5	8.2	8	9.2	8.9	10.1
Annual population growth rate	N/A	N/A	2.1	2.1	1.8	1.8
Total Fertility Rate	3.5	3.5	3.2	3.2	2.7 (1)	2.7 (1)
Crude birth rate per 1,000 inhabitants	N/A	N/A	28	28	25.6	25.6
Crude death rate	N/A	N/A	6	6	6	6
Life expectancy at birth	63.3	71.1	66.5	72.5	67.7	73.7
Migratory balance	N/A	N/A	4	3.6	4	3.6

Source: Dirección General de Estadísticas y Censos
(1) FESAL

Young people (<1 year to 19 years) make up 43.9% of the population, putting heavy demands on health, education, the environment, and the labor market. In looking at these two large age groups (<15 and >60 years), it can be seen that the standard curve is beginning to age, while still maintaining a pyramid shape. The figures below show the population pyramids in 2000 and 2005 (pink for women and blue for man).

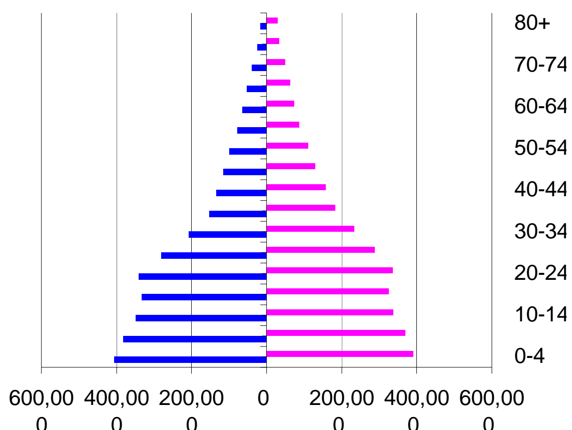


Figure 1. Population Pyramid 2000

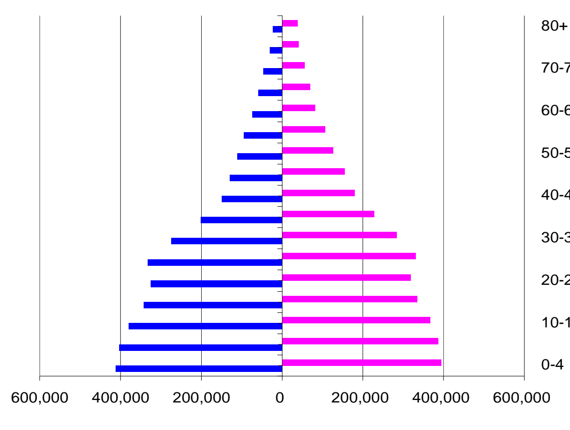


Figure 2. Population Pyramid 2005

The fertility rate has dropped from 5.74 children per woman in 1991 to 2.32 in 2001. Women with no schooling have an average of 5.74 children and women with 10 or more years of schooling have 2.32 children, according to FESAL 2002-2003.

The crude death rate estimated by DIGESTYC for the last two five-year periods is 6/100,000 inhabitants, without estimating the proportion of deaths in people over 50 years of age. According to average mortality data from MSPAS, in 2002, 48% of deaths occurred in people over 50, while the remaining 52% were in people under 50, indicating that deaths of young people are more frequent and do not follow the natural curve for deaths of the elderly population.

1.1.2. Epidemiological Analysis

The country's morbidity profile essentially remained the same from 1990 to 2005, dominated by infectious diseases, primarily respiratory and digestive tract infections in the most vulnerable population groups—children under 5 and the elderly. However, starting in the 1995-1999 period, hypertension appears on the list of leading causes of morbidity in sixth place as well as other chronic, psychosomatic digestive tract diseases, including gastritis, gastroenteritis,

colitis, and gastroduodenitis in people over age 30. It is important to note that trauma to different parts of the body appears on the list for the 2000-2005 period.

Table 2: Ten leading causes of illness seen in outpatient health clinics, by five-year periods: 1990-2005, El Salvador

Rank	Periods		
	1990-1994	**1995-1999**	**2000-2005**
1	Acute respiratory infections	Acute respiratory infections	Acute respiratory infections
2	Acute rhinopharyngitis	Intestinal parasites	Intestinal parasites
3	Influenza	Other disorders of the urethra and the urinary tract- urinary tract infections, site not specified	Other disorders of the urethra and the urinary tract- urinary tract infections
4	Intestinal parasites	Ill-defined intestinal infections or diarrheal disease	Ill-defined intestinal infections or diarrheal disease, or presumably infectious gastroenteritis
5	Ill-defined intestinal infections or diarrheal disease	Bronchitis not specified as acute or chronic, acute lower respiratory infections	Bronchitis not specified as acute or chronic, or bronchiolitis
6	Other disorders of the urethra and the urinary tract	Essential hypertension	Acute and chronic gastritis and duodenitis (diseases of the stomach and duodenum)
7	Acute pharyngitis or acute pharyngotonsillitis	Infection of the skin and subcutaneous cellular tissue, or skin infections	Mycosis
8	Bronchitis not specified as acute or chronic	Acute rhinopharyngitis	Non-inflammatory disorders (diseases) of the female genitalia
9	Colitis, enteritis, gastroenteritis	Asthma and unspecified bronchial spasm	Migraine – tension headache
10	Bronchopneumonia	Vaginitis	Trauma to different parts of the body

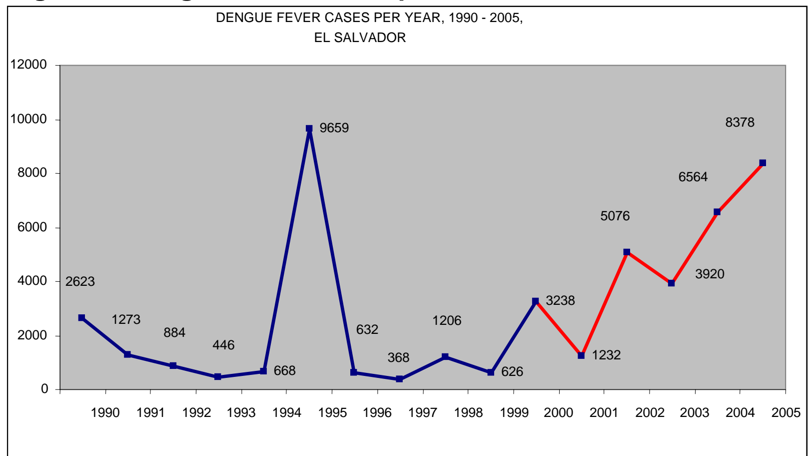
Source: Unidad de Información en Salud, Dirección de Planificación, MSPAS.

Other diseases, such as dengue fever and malaria (vector borne), tuberculosis and HIV/AIDS, hemorrhagic conjunctivitis, and cholera, are priorities for epidemiological surveillance because they are highly contagious, affect large population groups in a short time, and cause abrupt increases in demand for and saturation of health services that can rapidly overwhelm operating capacity. Some of these diseases have been appearing in cyclical epidemic patterns in the country for several decades, resulting in frequent declarations of national emergencies, and some have even turned into hemisphere-wide pandemics.

In the last five-year period (2000-2005), dengue fever in El Salvador has become an endemic disease, alternating with epidemic cycles; the most deadly epidemic in recent history occurred in 2000, when 26 deaths and 3,238 cases were reported and the presence of dengue

virus type 2 was detected. Since then, deaths have dropped considerably, in an inverse relationship to cases, which have been increasing sharply, from 5,076 cases with 11 deaths in 2002, to 6,564 cases with one death in 2004, and 8,378 cases with one death in 2005. During this period (2000-2005), circulation of the 4 dengue serotypes has been detected, which increases the risk of developing dengue hemorrhagic fever and as a consequence increasing the number of admissions due to this disease.

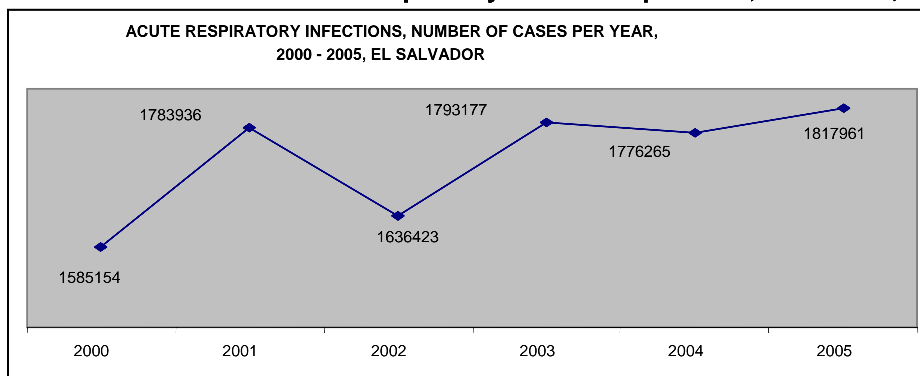
Figure 3: Dengue Fever Cases per Year, 1990-2005, El Salvador



Source: Unidad de Epidemiología, Dirección de Control y Vigilancia Epidemiológica, MSPAS.

During this same period, total respiratory infections increased slightly but steadily each year, starting with 1,585,154 in 2000 and reaching a high point in 2005 of 1,817,961.

Figure 4: Number of Cases of Acute Respiratory Infections per Year, 2000-2005, El Salvador



Source: Unidad de Epidemiología, Dirección de Control y Vigilancia Epidemiológica, MSPAS.

Between 2002 and 2005, pneumonia cases tended to level off; however, in 2003, there was an epidemic outbreak of this disease and 86,899 cases were recorded. The following year, there was almost a 50% reduction, but in 2005 the number increased again, with 52,641 cases.

Cases of acute infectious diarrhea showed a slight upward trend from June 2002 to June 2006; between June 2003 and June 2004 there was an epidemic outbreak with a total of 285,282 cases. The last cholera epidemic occurred in 2000, affecting 593 people; there have been no cases of cholera in the country since then.

Vaccine-preventable diseases have decreased markedly, dropping from an average rate of 416/100,000 in the 1990-1994 period, to 2003 in the period 1995-1999, to 102/100,000 in the 2000-2005 period.

Morbidity and Risk Factors

In the three five-year periods under study (from 1990 to 2005), the prevalence of low birth weight increased considerably, from 35.3/1,000 live births (1990-1994), to 71.6 (1995-1999), and 77.7 in the last period (2000-2005), which is an important risk factor for perinatal mortality. The prevalence of moderate nutritional deficiency in children under 5 years of age also increased somewhat between the 1990-1994 and 1995-1999 periods, but then improved significantly between the 1995-1999 and 2000-2005 periods, falling from 17.6 to 14.5. This might be related to improvements in exclusive breastfeeding up to 120 days of age. Likewise, the prevalence of serious nutritional deficiency in children under 5 has gone down (from 6.6 to 4.4) over the last 15 years.

Table 3: Risk Factors, by five year periods (1990-2005), El Salvador

PERIODS/INDICATORS	1990 - 1994	1995 - 1999	2000 - 2005	OBSERVATIONS
Prevalence of low birth weight /1 (a)	35.3	71.6	77.7	
Fertility rate in adolescent women (15-19 years old) /4	0.11	0.09	0.08	
Annual prevalence of moderate nutritional deficiency in children under 5 years of age /4 (c)	16.2	17.6	14.5	Indicator used: height/age
Annual prevalence of serious nutritional deficiency in children under 5 years of age /4 (c)	6.6	5.7	4.4	
Prevalence of exclusive breastfeeding up to 120 days of age /4	20.4	15.8	24.0	
Percentage of deliveries attended by skilled health attendants 2/	N/A	43.4	41.77	For the 1990-1994 period, the figure for expected deliveries is available

1/Source: Unidad de Información en Salud, 2/ Source: Unidad de Epidemiología
4/ Source: FESAL, a) Five-year rates per 1,000 live births, (c) Height/Age indicator

The pattern for general mortality is markedly different from that for morbidity. The causes of death that remained on the list of the 10 leading causes of general hospital deaths in

all the five-year periods are perinatal conditions, especially septicemia and prematurity; respiratory ailments such as bronchitis, pneumonia, and bronchopneumonia; ischemic heart disease and myocardial infarction; and external causes— homicides, self-inflicted injuries, head injuries, trauma to different parts of the body, and road accidents. External causes rose significantly, from being in eighth and fifth place in the 1990-1994 period to being the second cause of death in the 2000-2005 period.

The general mortality rate clearly increased from 1995 to 2005, going from 6.7 in the 1990-1994 period to 10.3 in the 1995-1999 period, while mortality rates for communicable diseases with compulsory reporting have remained steady. It is important to highlight that mortality rates related to the circulatory system (1995-99=23.28; 2000-05=46.24) are higher than the rates for communicable diseases. This reflects an important change in this period, where communicable and non-communicable diseases become a double burden on health, considering that acute diseases are usually more widespread in developing countries compared to chronic diseases as causes of morbidity and mortality. A similar trend is seen for malignant neoplasms.

Table 4: Mortality Rate, by five-year periods (1990-2005), El Salvador

	General	Maternal	Communicable Diseases (Compulsory Reporting)	TB	AIDS	Malaria	Circulatory System Diseases	Malignant Neoplas-tic Diseases	Exter-nal Causes
PERIODS									
1990-1994 (a)	6.7	155 (FESAL)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
1995-1999 (b)	10.3	61.6 /2	12.15	1.45	2.78	0.0	23.28	7.08	N/A
2000-2005 (b)	N/A	69.5 /2	12.15	1.5	9.73	0.0	46.24	15.29	N/A

(a) Source: Dirección General de Estadística y Censos.
(b) Source: Unidad de Información en Salud (institutional deaths).

Under-five mortality, in all its different sub-groups, shows a clear decrease in the last 15 years, which is reflected in the total mortality rate for 0-4 years of age; it dropped from 52 (1990-1994 period) to 31/1,000 in the 2000-2005 period. Infant mortality according to place of residence is higher in rural areas than in urban areas until the 2000-2004 period, when the rates are quite similar.

Table 5: Infant Mortality by Periods and Place of Residence

AGE / PERIOD	Neonatal (0 to 28 days)	Post neonatal (28 days to 1 year)	Post-Infant (1 to 4 years)	Total (0-4 years)
PERIODS (a)				
1990-1994	23	18	12	52
1995-1999	17	18	8	43
2000-2005	13	11	6	31
GEOGRAPHICAL AREA (a)				
URBAN 90-94	21	14	11	46
URBAN 95-99	12	15	6	33
URBAN 00-04	14	11	6	31
RURAL 90-94	23	21	14	58
RURAL 95-99	21	20	9	50
RURAL 00-04	13	11	6	30

1.1.3. Millennium Development Goals

In May 2004, the Government of El Salvador (GOES), through the Technical Secretariat of the Presidency, with support from the Inter-American Development Bank (IDB), the Japan International Cooperation Agency (JICA), the United Nations Development Program (UNDP), and an Academic Advisory Committee, prepared the first Millennium Development Goals (MDGs) Country Progress Report,[1] in compliance with its commitment to monitor the country's progress toward attaining the MDG targets by 2015. It also established the institutional and statistical groundwork for monitoring the indicators for each of the eight MDGs. The table below summarizes the main indicators for each of the goals and their status as of 2004.

[1] Avance de El Salvador en el Cumplimiento de los Objetivos de Desarrollo del Milenio (ODM).

Table 6: Progress toward achieving the MDGs, 2005, El Salvador

Indicators	1991	2002	2003	2004	2015 Target	Attainment status per 2004 report	Source
Goal 5: Improve maternal health							
Maternal mortality ratio (per 100,000 live births) FESAL [2/]	158 (1983-1993)	173 (1993-2002)	-	-	40	Probable	FESAL
Maternal mortality ratio (per 100,000 live births) MSPAS [3/]	120	62	71	65	30		MSPAS
Proportion of births attended by skilled health personnel FESAL	51(1988-1993)	69 (1997-2002)	-	-	100	Probable	FESAL
Proportion of institutional births MSPAS[4/]	67 (1997)	79.0	81	84	100		MSPAS
Goal 6: Combat HIV/AIDS, malaria, and other diseases							
Incidence of HIV/AIDS (no. of cases)	96 (1990)	1,598	1,510	2,025	Stop or reverse	Probable	MSPAS
Incidence of tuberculosis (no. of cases)	2,367 (1990)	1,551	1,383	1,407	Stop or reverse	Very Probable	MSPAS
Goal 7: Ensure environmental sustainability							
Energy supply in kg of oil per US$1,000 GDP (PPP)	145	141	-	-	Reverse	Probable	http//millenniumindicators.un.org
Proportion of households that use firewood for cooking	58	30	28	27		Very Probable	EHPM
Proportion of land area covered by forest	9.3 (1990)	5.8 (2000)	-	-	Reverse	Probable	http//millenniumindicat
Ratio of protected area to total surface area	0.5 (1995)	0.4	-	-	Reverse	Probable	World Bank WDI 2005
Carbon dioxide emissions (metric tons per capita)	0.5 (1990)	1.1 (2000)	-	-	Reverse	Probable	World Bank, WDI 2005
Population without access to improved water sources[5/]	23.9	11.9	12.5	14	11.9	Probable	EHPM
Population without access to improved sanitation services	21.9	7.0	7.9	6.7	11	Target attained	EHPM
Goal 8: Develop a global partnership for development							
Debt service as a percentage of exports of goods and services	18 (1999)	19	12.5	22	Sustainability	Probable	BCR
Unemployment rate of young people aged 15-24	14	12	11	11	Develop and apply	Probable	EHPM
Telephone lines per 100 population	2.5	23.9	28.7	40.3	Utilize ITC	Very Probable	SIGET
Internet users per 100 population	0.3 (1996)	1.4	1.7	1.7	Utilize ITC	Very Probable	SIGET

[1/] Proportion of children under 1 registered in MSPAS facilities who have received at least one dose of MMR vaccine.
[2/] The FESAL maternal mortality data lacks statistical precision due to the method use for its calculation.
[3/] Institutional maternal mortality rate from MSPAS.
[5/] In quantitative terms the country is very close to attaining the target for access to water; however, there are deficiencies in supplying the service and in the quality of the water.
-: Not available for the period.

Cont. Table 6

Indicators	1991	2002	2003	2004	2015 Target	Attainment status per 2004 report	Source
Goal 5: Improve maternal health							
Maternal mortality ratio (per 100,000 live births) FESAL [2/]	158 (1983-1993)	173 (1993-2002)	-	-	40	Probable	FESAL
Maternal mortality ratio (per 100,000 live births) MSPAS [3/]	120	62	71	65	30		MSPAS
Proportion of births attended by skilled health personnel FESAL	51(1988-1993)	69 (1997-2002)	-	-	100	Probable	FESAL
Proportion of institutional births MSPAS[4/]	67 (1997)	79.0	81	84	100		MSPAS
Goal 6: Combat HIV/AIDS, malaria, and other diseases							
Incidence of HIV/AIDS (no. of cases)	96 (1990)	1,598	1,510	2,025	Stop or reverse	Probable	MSPAS
Incidence of tuberculosis (no. of cases)	2,367 (1990)	1,551	1,383	1,407	Stop or reverse	Very Probable	MSPAS
Goal 7: Ensure environmental sustainability							
Energy supply in kg of oil per US$1,000 GDP (PPP)	145	141	-	-	Reverse	Probable	http//millenniumindicators.un.org
Proportion of households that use firewood for cooking	58	30	28	27	Reverse	Very Probable	EHPM
Proportion of land area covered by forest	9.3 (1990)	5.8 (2000)	-	-	Reverse	Probable	http//millenniumindicat
Ratio of protected area to total surface area	0.5 (1995)	0.4	-	-	Reverse	Probable	World Bank WDI 2005
Carbon dioxide emissions (metric tons per capita)	0.5 (1990)	1.1 (2000)	-	-	Reverse	Probable	World Bank, WDI 2005
Population without access to improved water sources[5/]	23.9	11.9	12.5	14	11.9	Probable	EHPM
Population without access to improved sanitation services	21.9	7.0	7.9	6.7	11	Target attained	EHPM
Goal 8: Develop a global partnership for development							
Debt service as a percentage of exports of goods and services	18 (1999)	19	12.5	22	Sustainability	Probable	BCR
Unemployment rate of young people aged 15-24	14	12	11	11	Develop and apply	Probable	EHPM
Telephone lines per 100 population	2.5	23.9	28.7	40.3	Utilize ITC	Very Probable	SIGET
Internet users per 100 population	0.3 (1996)	1.4	1.7	1.7	Utilize ITC	Very Probable	SIGET

[1/] Proportion of children under 1 registered in MSPAS facilities who have received at least one dose of MMR vaccine.
[2/] The FESAL maternal mortality data lacks statistical precision due to the method use for its calculation.
[3/] Institutional maternal mortality rate from MSPAS.
[5/] In quantitative terms the country is very close to attaining the target for access to water; however, there are deficiencies in supplying the service and in the quality of the water.
-: Not available for the period.

Eradicate extreme poverty and hunger: Extreme poverty ($1 PPP) decreased from 32.6% to 15.8% from 1991 to 2005; this 17-percentage-point reduction indicates that the target can be met if progress continues at the same rate. In rural areas, poverty decreased 15% during the same period, and it is very probable that the target can be met. The child malnutrition rate was relatively stagnant from 1993 to 2003; however, the trend has been in the right direction, both in urban areas, where the indicator has dropped from 11.2% to 10.3%, and in rural areas, where the change has only been from 14% to 13.2%. It also seems quite probable that the target will be met for urban areas.

Achieve universal primary education: With regard to ensuring that, by 2015, all pupils who start grade 1 can complete grade 5, the trend has been positive in the 1991-2005 period, with the rate increasing from 58% to 72%, making it likely the target will be met. For the 1991-2005 period, the literacy rate of 15-24-year-olds increased from 82% to 94.9%, and the target of 100% is likely to be met.

Promote gender equality and empower women: The ratio between boys and girls in primary and secondary education remained between 101% and 97% from 1991 and 2005, with the gender equality target most likely to be met by 2015.

Reduce child mortality: Between 1990 and 2005, the infant mortality rate (<1 year) decreased from 44.91/1,000 live births to 24.3, a drop of 20 percentage points. The proportion of children under 1 immunized against measles did not increase substantially, since it was already at 98% in 1990; it went up to 99% in 2005, and it is quite probable the 2015 target will be met.

Improve maternal health: In June 2005, MSPAS coordinated a study to determine the Maternal Mortality Baseline in El Salvador, in which government institutions and external cooperation agencies participated. The study found that maternal mortality in the country is 71.2/100,000 live births, which will now serve as a reference point for monitoring in the coming years.

Combat HIV/AIDS, malaria, and other diseases: The proportion of HIV/AIDS has been clearly increasing in recent years, going from 2.8 HIV and 2.5 AIDS in 1991, to 20 HIV and 10.2 AIDS in 2004. However, in 2005, it went down to 17.3 HIV and 6.2 AIDS, making it possible to deduce that the reduction will probably be met since early detection and prevention actions have been increased. AIDS was number 8 on the list of the 10 leading causes of death in the country in the last five-year period. The prevalence of tuberculosis (TB) has been decreasing significantly in recent periods, going from a rate of 45.7/100,000 inhabitants to 26.0 in 2005. The number of malaria cases has also significantly decreased, going from 13,432 in 1987, to 67 cases in 2005. Since 1995, no autochthonous cases of *P. falciparum* have been reported; the national program is one of the most successful in the Region of the Americas (Figure 8 in Annex).

Ensure environmental sustainability: The percentage of the population that uses firewood and charcoal has gone down considerably, dropping from 64.2% in 1991 to 28.5% in 2005, meaning

that it is quite probable the target will be met. The proportion of the population without access to improved sanitation services has decreased considerably, since in 1991, 26.9% did not have access, while in 2005, only 13% did not, close to the target for 2015.

MDGs and International Cooperation[2]: The government is committed to reaching the MDG targets and has the support of the international cooperation community. The table below details the sources and destinations of technical and financial aid.

Table 7: Cooperation Agencies in El Salvador and Intervention Areas according to the MDGs

	MDG 1	MDG 2	MDG 3	MDG 4	MDG 5	MDG 6	MDG 7	MDG 8
AECI	X	X	X	X	X	X	X	X
CIDA	X		X	X	X	X	X	
E.C.	X						X	X
FAO	X		X	X			X	
GTZ	X		X	X	X	X	X	
IDB	X	X	X	X	X	X	X	X
IICA	X						X	
ILO	X	X	X	X	X	X	X	X
JICA	X		X	X	X		X	
OAS	X	X						
OEI		X						
PAHO	X		X	X	X	X	X	X
PRODECA	X		X					
UNDP	X	X	X			X	X	X
UNFPA	X	X	X	X	X	X	X	X
UNICEF	X	X	X	X	X	X	X	
UNOPS	X		X					
USAID	X	X	X	X	X	X	X	
WFP	X	X	X	X	X			

1.2. DETERMINANTS OF HEALTH

1.2.1. Political Determinants

The democratically elected government of El Salvador is made up of three independent branches: the Legislature, the Executive, and the Judiciary. It has a system of political parties, resulting from the Peace Accords, which participate in democratic presidential, legislative and municipal elections. The political system has been making firm strides toward developing a culture of citizen participation and of accountability to the electorate.

The Executive Branch has several institutions that represent the economic, political, and social sectors. The social sector is made up of the Ministry of Health and Social Welfare

[2] Country Strategy Paper 2005-2008. Spanish Cooperation, El Salvador.

(MSPAS), Ministry of Education (MINED), Ministry of Labor and Social Security (MINTRAB), National Water and Sewerage Administration (ANDA), Public Works, Transportation, Housing and Urban Development, and Foreign Affairs, which are represented by their respective ministers who debate and decide on social development policy. Government policies originate from the Office of the President, as in the case of the Government Plan 2004-2009: "Safe Country," which presents the social, economic and political vision for the country. Each government institution then analyzes and plans the actions for implementing the government's social policy.

In the social area, El Salvador aspires to become a modern, knowledge-based society rich in human capital that is socially and territorially integrated, where everyone has access to information; a country oriented to significantly reduce poverty, so that people are truly able to advance. In the Government Plan, MSPAS falls under action area 12, "Health, Quality, and Universal Coverage," which sets forth the following: "Carrying out consensus-based health sector reform that will enable us to attain an efficient, consolidated, decentralized national health system that provides universal coverage and guarantees services at no charge for anyone anywhere in the country who is unable to pay."[3]

On this basis, MSPAS prepared its Five-Year Strategic Plan (2004-2009),[4] with the objective of facilitating the full implementation and coordination of all the different health plans, projects, and programs being implemented nationally. To that end, it has set its policy as strengthening health promotion; the prevention of disease, environmental hazards, and damage; and rehabilitation with a Primary Health Care (PHC) focus. The plan also works toward achieving universal coverage, guaranteeing services free-of-charge to anyone anywhere in the country who is unable to pay.

In El Salvador violence is viewed as a political, social and economic problem, given that the different types of violence affecting individuals, families, communities, and society in general are all in some way related to social inequality, the lack of opportunities (especially for young people), the relatively easy availability of firearms, violence in the media, women's social position, the concentration of poverty, social isolation, weakness, and illegal drug trafficking, among other factors. This situation has a negative influence on investment opportunities, human development, economic growth, and public health. Government institutions, together with private enterprise and other civil society institutions, are joining forces to prevent and

[3] "País Seguro: Plan de Gobierno 2004-2009," p. 26.
[4] "Plan Estratégico Quinquenal 2004-2009," MSPAS, December 2004.

combat violence, promote peace, and create opportunities for employment and development, in order to counteract underlying factors.

1.2.2. Economic Determinants

Macroeconomic indicators, such as the Gross Domestic Product (GDP) per capita at constant prices, have improved in recent years in relation to the 1990-1994 average, increasing from $1,011 (1990-1994) to $1,199 (2000-2004). Likewise, the total public expenditure per capita at current prices went from $380 (1990-1994) to close to $600 (2000-2004). The "Total Public Expenditure" indicator includes all disbursements made by the central government; decentralized, non-business institutions; and public enterprises, and was 26% of the GDP in the 2000-2004 period, similar to that of the 1990-1994 period. According to figures from the Central Reserve Bank of El Salvador (BCR), remittances and the foreign debt amounted to, on average, 14% and 49% of the GDP, respectively, for the 2000-2004 period. The annual inflation rate has decreased in recent years, going from 12.7% in the 1990-1994 period to 3.3% in the 2000-2004 period.

Public expenditure on health, taken from the Health Accounts of El Salvador[5] studies, was 3.5% of the GDP for the 2000-2004 period, while the private expenditure on health was 4.4% of the GDP during the same period. This reveals the relative importance of private health spending in El Salvador, of which out-of-pocket household spending stands out, accounting for 53% of El Salvador's total national health expenditure. The relative importance of private health spending, especially household spending, has been constant.

Table 8: Trends for Selected Economic Indicators, by five-year periods, El Salvador

Indicator	1990-1994	1995-1999	2000-2004
GDP per capita in US$, in constant prices relative to the base year 1/	1,010.95	1,164.72	1,199.56
Public expenditure per capita 2/	379.69	435.90	578.63
Economically Active Population (EAP) (in thousands) 3/	1,600.02	2,289.68	2,623.74
EAP 15-59 years of age, in thousands 3/	1,372.42	2,023.00	2,326.94
EAP, population employed, in thousands 3/	1,457.64	2,122.48	2,446.62
Total public expenditure, as a percentage of GDP 4/	26%	23%	26%
Public expenditure on health, as a percentage of GDP 5/	N/A	3.24	3.50
Public expenditure on health services, as a percentage of GDP	N/A	N/A	N/A

[5] "Cuentas Nacionales en Salud: Estimación del Gasto Nacional en Salud en El Salvador," 2003.

Private expenditure on health, as a percentage of GDP 5/	N/A	4.65	4.40
Out-of-pocket expenditure (% of total health expenditure) 5/	N/A	57%	53%
Annual Inflation Rate 6/	12.70	4.78	3.28
Remittances as a percentage of GDP 7/	12%	11%	14%
Foreign debt, as a percentage of GDP 8/	N/A	39.75	48.55
Percentage of female-headed households 6/	27%	28%	34%
Service of the foreign debt, as a percentage of GDP 8/		4.5%	4.2%

Sources: 1/ Banco Central de Reserva de El Salvador. Revista Trimestral, several years.
2/ Source: Informe de Gestión Financiera del Estado. Ministerio de Hacienda. Total public expenditure includes budget execution by the central government, decentralized non-enterprise institutions (non-enterprise subsidized institutions and social security institutions), and public enterprises.
3/ DIGESTYC/Ministerio de Economía. Proyecciones de Población.
4/ Authors' calculations using total public expenditure figures from the Informe de Gestión Financiera del Estado (Ministerio de Hacienda) and Banco Central de Reserva de El Salvador (GDP at current prices).
5/ Cuentas Nacionales en Salud/MSPAS, several years. Estimates for 2004 are preliminary.
6/ DIGESTYC/Ministerio de Economía.
7/ Authors' estimates based on information on remittances and GDP from the Banco Central de Reserva de El Salvador. Revista Trimestral, several years.
8/ Banco Central de Reserva de El Salvador. Information from web page: www.bcr.gob.sv
(P): Preliminary figures, subject to change.
GMRE/

El Salvador has made considerable progress in improving its social indicators and in reducing relative and extreme poverty during the 1990s and in the 2000-2004 period, along with improving access to essential public services by the poor. The essence of the Government's Plan for 2004-2009 has been to create a social protection network including the institutions that provide essential services (education, health, rural electrification, roads, production training) to the most vulnerable population groups (*Red Solidaria* Program), by creating networks and sectoral and institutional alliances working in coordination to reduce vulnerability and poverty.

In the three periods examined (1991-1994, 1995-1999, and 2000-2004), total poverty (extreme and relative) has been greater in rural areas than in urban areas, and extreme poverty is much greater in rural areas. However, in relative terms, poverty levels in the country have decreased in recent years. During the 1991-1994 period, close to 32% of the population was living in relative poverty, while 30% lived in extreme poverty, for a total average of 63% of the country's population living below the poverty line during those years. For the 2000-2004 period, 25% of the population lived in relative poverty and 18% in extreme poverty. To sum up, the proportion of people living below the poverty line dropped from 63% to 43% in recent years. Despite this drop, this rate is still substantial in terms of its impact on the living conditions of the Salvadoran population.

Table 9: Poverty Levels by Place of Residence, El Salvador

AREA	PEOPLE LIVING IN POVERTY (1995-1999 AVERAGE)				PEOPLE LIVING IN POVERTY (2000-2004 AVERAGE)			
	poor	relative	extreme	not poor	poor	relative	extreme	not poor
TOTAL	3,115,540	1,774,447	1,341,094	2,757,079	2,800,071	1,627,603	1,172,468	3,721,363
URBAN	1,407,698	922,585	485,113	1,883,195	1,335,121	900,375	434,747	2,513,577
RURAL	1707841,8	851,861	855,981	873,884	1,464,950	727,228	737,721	1,207,785

Source: DIGESTYC/Ministerio de Economía. EHPM, several years.
GMRE. Information disaggregated by gender or ethnic group was not available for this indicator.

Of all new jobs in the country in the 1991-1994 period (947,642), 53% were in the formal sector and 42% in the informal sector. In recent years (2000-2004), the proportions shifted to 68% in the formal sector and 32% in the informal sector, with a total of 1,483,456 new jobs. Despite the foregoing and the fact that the gap between men and women in the formal sector has decreased, there continue to be more men than women in the formal labor market in absolute numbers, which implies that men continue to have better working conditions and benefits and higher income than women. During the 1991-1994 period, women got 35% of all new jobs in the formal sector; this percentage rose to 45% in the most recent period (2000-2004), indicating, as was mentioned, a decrease in the gender gap in the formal job sector.

Table 10: Employment Conditions by Gender and Income, by five-year periods, El Salvador

OCCUPATIONAL SECTOR	1991-1994 AVERAGE	1995-1999 AVERAGE	2000-2004 AVERAGE
TOTAL	947,642	1,229,406	1,483,456
FORMAL	500,362	694,495	1,017,120
INFORMAL	447,280	534,911	466,336
MEN			
FORMAL	322,327	426,056	561,873
INFORMAL	213,838	267,416	246,833
WOMEN			
FORMAL	178,036	268,439	455,247
INFORMAL	233,442	267,494	219,503

Source: DIGESTYC/Ministerio de Economía.
GMRE/

1.2.3. Social Determinants

It was not possible to obtain information disaggregated by sex or ethnic group regarding access to drinking water, excreta disposal services, the school dropout rate, etc. However, from the information that is available, it can be seen that there are still considerable social gaps to be overcome, despite the progress made in recent years. It is noteworthy that in the last five-year period studied (2000-2004), both access to drinking water (73%) and educational conditions (decreases in illiteracy and in the dropout rate) have improved considerably. Despite this, given that both variables have a direct impact on living conditions and the health of Salvadorans, efforts must continue in order to improve these indicators even more.

Table 11: Trends in Selected Social Indicators, by five-year periods, El Salvador

	Position that the country occupies according to the HDI	Population with access to drinking water (%)	Population with access to excreta disposal services (%)	Illiterate population (%) 2/	Crude rate of primary schooling 2/	School dropout rate 2/	Child labor rate 2/	Ratio for the income of the top 20% and the bottom 20% of the population 2/	Prevalence of domestic violence	Prevalence of depression
PERIODS										
1991-1994 Average	90/150	52.0	N/A	24.14	105	2.0	20.1	13.9	N/A	N/A
1995	112/173	55.5	N/A	21.01	111.4	N/A	18.1	11.5	N/A	N/A
1995-1999 Average	112/174	61.1	N/A	19.7	105.1	2.4	16.15	12.6	N/A	N/A
2000-2004 Average	102/172	73.0	N/A	16.4	105.8	1.6	12.7	13.3	N/A	N/A

Sources: 1/UNDP
2/ DIGESTY/EHPM
GMRE

An important variable directly linked to risks to children is the child labor rate. The data indicate that this has gone from 20.1 in the 1991-1994 period to 12.7 in the most recent five-year period, reflecting the efforts the country has been making to decrease the worst forms of child labor. The Human Development Index (HDI) provides a picture of the changes from year to year in the overall status of a number of variables associated with living conditions, income, and life expectancy. In general, El Salvador's place in the HDI shows a gradual, but constant, improvement in the world ranking, going from 59 out of 108 countries in 1990 to 104 out of 177 countries in 2005.

1.2.4. Environmental Determinants

One of the government's strategies has been to produce a poverty map, which provides vital input for the *Red Solidaria* program. The map identifies the needs in each of the municipalities for essential services: access to water, sanitary excreta disposal, solid waste collection, housing, and others. The central government has given a mandate to the social sector ministries to join forces in giving priority to communities in extreme poverty.

In 2006, total access to improved water sources was 75.69% (urban: 89.74%; rural: 47.61%), and safe water coverage was 72.15% (urban: 86.94%; rural: 51.98%).[6] Access to improved sanitation was 69.55% in rural areas and 93.1% in urban areas. Nationally, the percentage of urban homes that have solid waste collection service is 63.3%. Final sanitary disposal only occurs for 35% of solid waste.[7]

Coverage for essential services is disrupted during the national emergencies caused by natural disasters, such as the earthquakes in 2001 and Hurricane Stan in 2005. These conditions cause people to migrate away from the affected areas to less hazardous areas, generally in cities. This leads to a negative impact on the cities from unplanned settlements lacking essential services, which also has environmental repercussions. Water resources are significantly affected by inadequate solid waste disposal and inadequate excreta disposal. Both are sources of bacteriological contamination of water, causing many gastrointestinal diseases, which are high on the list of the 10 leading causes of morbidity in El Salvador.

The "Air Quality Assessment, Survey of Sources of Contaminants, and Design of a Monitoring Network" done by the Ministry of Environment and Natural Resources (MARN) in 2005, showed that 51% of air pollution in the San Salvadoran metropolitan area comes from vehicular traffic, 13% from the handling and final disposition of solid waste, 10% from the cooking of food in homes, 10% from steam-generated electricity using fossil fuels, 7% from dust particles from paved roads, and the remaining 9% from other sources.

According to the industry map, current as of April 2006, industries are primarily located in the departments of San Salvador (municipalities of San Salvador, Soyapango, and Mejicanos), Santa Ana (municipality of Santa Ana), Ahuachapán (municipality of Ahuachapán), and Sonsonate (municipalities of Sonsonate, Acajutla, and Armenia).[8] It is estimated that 43% of industries in the country do not currently treat their sewage and the remaining 57% only provide

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[6] Source: GAISA-MSPAS website.
[7] Source: Coberturas Urbanas de País, MSPAS, 2002.
[8] Source: Mapa de Coberturas, GAISA-MSPAS website.

primary treatment to their discharge before it is released into the receiving bodies of water.[9] This situation could be contributing to the contamination of water resources.

The impact of industry in the country is concentrated in urban areas, which often has repercussions on the quality of life of the people who live in these cities, since the quality of the environment is affected by air, soil, and water pollution. In late 2005, a review was conducted of the Salvadoran regulations establishing the guidelines for the discharge of sewage into receiving bodies of water, and in 2006 they went through a national and international consultation process.

Deforestation is another large-scale problem caused by economic growth that is spurring new construction. This is contributing to worsening environmental quality, including the decrease in and pollution of ground water and environmental warming. Therefore, the development and implementation of an urban development plan that includes environmental compensation measures to minimize burden on the environment is needed.

Across the country, psychosocial and socio-cultural contamination, as an environmental determinant, have increased following events related to natural disasters, which, added to urban growth and population growth, are causing social stress and uncertainty in the population, increasing migration, transculturation, and unplanned settlements, with the ensuing impact on the environment.

2. FUNCTIONS OF THE HEALTH SYSTEM

2.1. STEERING ROLE

The State's responsibilities in the health arena have undergone significant changes. The monitoring and evaluation of Health Sector Reform done in the Region of the Americas from 2000 to 2003 uncovered a growing trend to separate health system functions, which manifests itself in the weak capacity of the countries to exercise the steering role and effectively lead the sector.

In March 2004, a meeting was held in El Salvador with countries from Central America, the Dominican Republic and Puerto Rico to broadly discuss the concepts related to the dimensions of the Steering Role and the importance of Mapping the Health Authority, using the

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[9] Source: Actualización de inventario industrial, 2005, GAISA.

"Methodological Guidelines for the Performance Evaluation of the National Health Authority Steering Role," which was successfully pilot tested. The meeting developed the groundwork for building a line of technical cooperation for strengthening the leadership and steering role capacity of the HA.

Another important effort made by El Salvador was the two performance evaluations of the EPHFs—the first in May 2001 and the second in April 2005—which demonstrated that the health system is segmented institutionally and has fragmented health services. In addition to the efforts aimed at modernizing and integrating the sector's institutions; decentralizing management to spur efficiency, effectiveness, and equity; and strengthening the steering role of MSPAS, legal and organizational gaps and political resistance have been present and the consensus necessary for enabling the health sector to move toward the integration of the system has not been achieved. Likewise, institutional roles and separation of functions are not well defined.

These exercises were based on national and local experiences and included participants from different sectors and disciplines. The exercises showed that the functions related to the steering role—EPHF 5: Development of policies and institutional capacity for public health planning and management; and EPHF 6: Strengthening of public health regulation and enforcement capacity—showed decreased performance in 2005 compared with the first evaluation. However, their final score was above the overall average, with moderate performance.

For the adequate performance of the EPHF, MSPAS, as the National Health Authority (NHA), needs certain roles and duties that are now assigned by law to other institutions, both outside and inside the health sector, to be assigned to it as the governing body for the health system. In addition, health sector reform should continue to focus on the challenge of strengthening the steering role of MSPAS as the HA and its role in fulfilling the EPHF as part of the government's responsibility at the different levels—central, intermediate, and local.[10]

2.1.1. Mapping of the Health Authority

The health sector is made up of two sub-sectors: the public sub-sector, composed of MSPAS, Salvadoran Institute for the Rehabilitation of Disabled Persons (ISRI), Teachers' Welfare, Military Health, as well as the Salvadoran Social Security Institute (ISSS); and the

[10] Evaluación del Desempeño de las Funciones Esenciales de Salud Pública. April 2005.

private sub-sector, which includes for-profit and not-for-profit entities. The for-profit entities follow a business model dominated by independent professional practices. Private, not-for-profit agencies tend to be NGOs with external funding, public subsidies, or private funds, working in specific geographical areas or on specific issues.

Ministry of Health and Social Welfare (MSPAS): Article 65 of the Constitution of El Salvador sets forth that "the State shall determine national health policy and shall monitor and supervise its application," where it corresponds to MSPAS, as a government ministry, to fulfill this mandate. Article 40 of the Health Code establishes that "MSPAS is the agency in charge of determining, planning, and implementing national health policy; promulgating the applicable standards; and organizing, coordinating, and evaluating the implementation of health-related activities."

Salvadoran Social Security Institute (ISSS): The ISSS, under its Law and Regulations,[11] functions as an autonomous public corporation, linked to the Executive branch through the Ministry of Labor and Social Security, responsible for carrying out the social security functions provided for by law, in order to provide services to employees who work for an employer, regardless of the payment mechanism.

Higher Council for Public Health (CSSP): Article 68 of El Salvador's Constitution says that "A Higher Council for Public Health shall safeguard the health of the people." The CSSP is a public corporation with the legal capacity to acquire rights and contract obligations and intervene in actions, and both the CSSP and its Oversight Boards have autonomy in their functions and resolutions. The CSSP relates to public agencies through MSPAS. The CSSP[12] oversees the exercise of the professions concerned with the health of the people: medicine, dentistry, pharmaceutical chemistry, veterinary medicine, clinical laboratory, psychology, and others at the licentiate level. Its organization is determined by law.

Military Health: The Military Health Command is part of the structure and organization of the Armed Forces, responsible for medical combat service support to the Armed Forces. It is in charge of directing and implementing medical aid programs, the supply and maintenance of

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[11] Ley del Seguro Social y Reglamentos del Régimen de Salud y Riesgos Profesionales, Legislative Decree No. 1263, 1997, Art. 2 and 3.

[12] Ley del CSSP: Art. 1 and Art. 2.

specific materials, and the management and administration of the resources placed at its disposal. The Military Health Command's components are the Health Units, Hospitals, and Schools that are part of the military. The Schools are under the coordination of the Military Doctrine and Education Command.[13]

Teachers' Welfare: The health system of the Ministry of Education was created in February 1968 with passage of the "Law for Medical and Hospital Services for the Teaching Profession." In 2003, this program was redesigned and renamed the Teachers' Welfare Program, which was defined as a health care program for teachers and their families, and which established the health benefits to which teachers are entitled (Decree No. 379). This healthcare sub-system contracts with family physicians and specialists, and provides drugs through pharmacies under contract across the country.

The Private Sector: The private sector has clinics and general and specialty hospitals concentrated in the country's capital and other large cities. The main hospitals are the Hospital de Diagnóstico, Hospital de la Mujer, Centro Pediátrico, and Centro Ginecológico. The main insurers are SISA, Pan American Life, ASESUISA, and Salud Total. These are all private, for-profit corporations. Private hospitals sell services to the ISSS and Teachers' Welfare. Non-profit private institutions offer medical and preventive services in rural areas around the country and hospitalization services in the capital through NGOs. The main hospital of this type is the Hospital Pro-Familia. NGOs are covered by the Law of Non-Profit Associations and Foundations.[14]

International Cooperation

El Salvador has established relationships with different countries, regions, and agencies through successive agreements that bring together efforts contributing to the fight against poverty and to sustainable development, pursing common objectives for the benefit of all. Cooperation includes the transfer of financial, material, and technological resources and is geared to priority projects for social and economic development to support and aid the actions in the Government's Plan "Safe Country." Cooperative activities target the most vulnerable groups

[13] Ley Orgánica de la Fuerza Armada de El Salvador, Section Four, Art. 65, 66, and 67.

[14] Legislative Decree No. 894 of 21 November 1996, published in the Official Gazette, No. 238 Vol. 333, of 17 December 1996.

in the population, joining forces to address their needs for health, education, nutrition, water, rural electrification, roads, production training, and other things.

The management, negotiations, and contracting involved in non-reimbursable international technical and financial cooperation is the responsibility of the Ministry of Foreign Affairs and of the Technical Secretariat of the Presidency, the entity that sets the priorities for investment program activities. In the past five years, resources from non-reimbursable international cooperation and technical assistance have been decreasing, due to, among others, two main factors: a) other countries with emergencies or geopolitical conditions that are a higher priority for donors; and b) macroeconomic indicators classify El Salvador as a lower-priority country for sources of cooperation assistance.

The Ministry of Foreign Affairs maintains opportunities for dialogue through conferences, meetings, and forums for addressing, among other issues of interest, those concerning health, water, and sanitation, of which the following are noteworthy:

- Cooperation Partner Country Annual Meeting with Luxembourg, where priorities are discussed for meeting the basic needs of the population through multi-year programs with joint responsibility.
- Spanish Joint Commission, for preparing issues for negotiation, maintaining the priority objective of promoting democracy and fighting poverty.
- Political Dialogue and Cooperation Agreement between the European Economic Community and the Republics of Central America.
- Intergovernmental Negotiations with Germany every other year and a prior round of Consultations on alternate years. Cooperation is aimed at institutional reform programs and social and production infrastructure works.

2.1.2. Conduct/Lead

The Government's Plan, "Safe Country 2004-2009," is structured around action areas and programs. For the implementation of this plan, MSPAS developed its "Five-Year Strategic Plan 2004-2009,"[15] linked to the action area "Health, Quality, and Universal Coverage." The MSPAS plan sets forth its mission, vision, policy, and its strategic objective: "Carrying out consensus-based health sector reform that will enable us to attain an efficient, consolidated,

[15] Plan Estratégico Quinquenal 2004-2009, MSPAS, December 2004.

decentralized national health system that provides universal coverage and guarantees services at no charge for anyone anywhere in the country who is unable to pay."

In order to carry out this plan, strategic actions have been mapped out that prioritize preventive aspects that will have an impact on reducing maternal, perinatal, and infant mortality; reducing the total fertility rate, primarily in adolescents; expanding coverage in rural areas through programs to expand community services with the participation of community members and medical students; promoting programs to encourage exclusive breastfeeding; and quality programs in all health facilities; among others.

It is noteworthy that each institution in the sector has its own information system, but in the case of national contingency, or at the request of MSPAS as the NHA, official channels are used to solicit information from other institutions to consolidate information on the sector.

One of the bodies in the NHA that is responsible for monitoring the nation's health goals and objectives is the Planning Directorate in the MSPAS. This office is in charge of advising officials on the development of national health policy and facilitating, formulating, and evaluating strategic plans and investment programs and projects on health, on the basis of the needs, priorities, principles, values, vision, and mission of the institution, in order to provide direction and leadership to the sector, consistent with national policies and plans.

The heads of the health sector represent the country internationally in meetings with different international agencies at global, regional, and sub-regional levels. At these forums, they present the policies and strategies used by the country and submit different health projects for the consideration of external cooperation agencies, seeking support for their implementation. The Director General of the ISSS represents the country at meetings on specific issues with social security agencies (Ibero-American Social Security Organization, Inter-American Center for Social Security Studies, Central American Council of Social Security Agencies, among others).

In an effort to encourage and foster civil society participation in health, MSPAS designed the SIBASI (Basic Integrated Health System), an inter-institutional, inter-sectoral structure, which also has different community committees that are involved in identifying health problems and designing strategies to promote social participation as a mechanism for facilitating the improvement of people's health. In December 2005, MSPAS prepared a Manual on Social Participation in Health, containing tools and instruments for facilitating responsible participation, to encourage people to get involved in processes that contribute to improving the quality of life.

In March 2005, the National Commission to Monitor the Integrated Health Reform Proposal (CNSPRIS) prepared a proposal for a National Policy on Social Participation in Health,

which fosters civil society participation in identifying health problems, and in planning and implementing health-related actions. It defines the scope and content of social participation in the sector, proposing the creation of institutionalized mechanisms to facilitate the inclusion of the public in processes for understanding the health situation, defining problems, and establishing priorities, and that also serve to design, implement, and monitor health policies, programs, projects, and public services.[16]

The Health Authority exercises its leadership in the developing of standards and interventions that foster health promoting activities through the Directorate of Regulation, which coordinates, runs, and directs the processes for developing the regulatory framework for health. This framework serves to guide health service delivery in the MSPAS network of facilities by formalizing technical standards on integrated care of people and the environment.

Given that the health sector institutions already have a number of regulations that govern them, during the past five-year period, MSPAS has made efforts to standardize these regulations, encouraging the participation of the different bodies involved. These have included standardization of the official drug list and the development of clinical care guidelines for the leading obstetric complications at the third level of care.

These are the mechanisms through which the HA guarantees the right to health, which is enshrined in the Constitution of El Salvador and the Health Code, for everyone in the country.

2.1.3. Regulation

MSPAS relies on two crucial technical bodies to guide its work: the Directorate of Regulation, in charge of overseeing the development of the entire regulatory framework, and the General Directorate of Health, responsible for ensuring the application of these regulations in service delivery facilities. The specific legal provisions that determine MSPAS's steering role and regulatory function in the health sector are the Internal Regulations of the Executive Branch,[17] the Health Code, and the Law of the Basic Integrated Health System.[18]

However, the CSSP has several regulatory powers, which it exercises through its oversight boards. For this purpose, following a favorable report from the respective oversight board, the CSSP has the authority to authorize the opening and operation of health care

[16] CNSPRIS, Propuesta organización y funcionamiento del sistema nacional de salud.
[17] Art. 42 et. seq. of Executive Decree No. 24 of 18 April 1989, published in the Official Gazette No. 70, Vol. 303 of the same date.
[18] Legislative Decree No. 775 of 25 August 2005, published in the Official Gazette, No. 161 Vol. 368 of 1 September 2005, Art. 3.

facilities and training centers for health professionals,[19] following the issuance of a health certificate from MSPAS. In addition, the CSSP, through its boards, is in charge of registering professionals who have graduated with degrees in different health disciplines, authorizing and overseeing the practice of the corresponding profession, and also overseeing and monitoring the work of pharmaceutical distributors (*droguerías*), pharmacies, dental prosthetic laboratories, chemistry laboratories, pharmaceutical laboratories, biological laboratories, clinical biological laboratories, radiology laboratories, hospitals, health clinics, optical laboratories, and all other establishments specifically devoted to public health service and care.

The Directorate of Regulation does not have a consolidated database of information on the impact on the health of the population of its exercise of the regulatory function. However, this information is collected by the different healthcare programs that implement these regulations around the country.

Title III of the Health Code establishes health infractions and sanctions, jurisdiction, and procedures for investigating these infractions. Enforcement is done by regional and local levels, which are in charge of creating the administrative legal case files for gathering evidence in support of the sanctions that could eventually be imposed. Part of the national health authority's oversight function is set out in Health Code provisions that regulate the functioning of public and private facilities, which are audited by technical personnel from the Health Units. In addition, complementary technical regulations govern the application of the Health Code and are used at the operations level for supervising the work of these public and private facilities.

Accreditation of health professional training institutions is the responsibility of the MINED.

2.1.4. Development of the Essential Public Health Functions

The second workshop to evaluate the EPHF, in April 2005,[20] provided an opportunity for the 35 institutions that responded to the invitation from MSPAS to demonstrate their involvement, interest, and initiative. The evaluation revealed that the weaker functions did not change much since the first workshop in 2001. However, progress was seen in some of the functions and their specific indicators. On the other hand, certain functions revealed worse performance. The higher scoring functions were those that are most strictly related to "Health Intelligence," in all cases with the institutions' capacity to become more efficient and effective. The EPHFs that received the best evaluation are the following:

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[19] Código de Salud, Art. 14, sections: b, ch, and d.

[20] Memoria técnica, "Evaluación del desempeño de las FESP en El Salvador" (Second workshop, April 2005).

- EPHF 1: Monitoring, evaluation, and analysis of health status.
- EPHF 2: Surveillance, research, and control of the risks and threats to public health.
- EPHF 5: Development of policies and institutional capacity for public health planning and management.
- EPHF 6: Strengthening of public health regulation and enforcement capacity.
- EPHF 11: Reduction of the impact of emergencies and disasters on health, including prevention, mitigation, preparedness, response, and rehabilitation.

Other essential functions that are in general subject to budget allocations and interinstitutional and intersectoral activity and that are also dependent on civil society attitudes and practices scored the lowest: health promotion, social participation in health, evaluation and promotion of equitable access to necessary health services, human resources development and training in public health, quality assurance in personal and population-based health services, and research in public health.

Substantial improvements can be seen in certain EPHFs, which scored higher than in the previous evaluation: monitoring, evaluation, and analysis of health status; health promotion; research in public health; reduction of the impact of emergencies and disasters on health, including prevention, mitigation, preparedness, response, and rehabilitation. However, several functions, despite remaining in the same range as 2001, did score lower in this evaluation:

- EPHF 4: Social participation in health.
- EPHF 7: Evaluation and promotion of equitable access to necessary health services.
- EPHF 9: Quality assurance in personal and population-based health services.
- EPHF 10: Research in public health.

Despite the fact that considerable progress and achievements have been made on some of the EPHF indicators, the functions are still only partially developed, and, due to the fragmentation of the health system, sectoral unity is difficult on important issues; these are health promotion, social participation in health, human resources development and training in public health, quality assurance in health services, and research in public health.

One of the actions taken to improve the performance of the EPHF was the preparation of the Plan for Developing the Essential Public Health Functions,[21] in November 2005, which maps out the strategic framework of actions necessary for improving the public health practices of health sector institutions.

[21] Plan de Desarrollo de las FESP, November 2005, MSPAS.

2.1.5. Orientation of Financing

In El Salvador, one of the mechanisms for monitoring health sector financing and expenditures is the Health Accounts information, which provides an overview of the sources and amounts of financing available, the allocation of the expenditures, and both the total and institutional per capita health expenditure.

The Multi-Purpose Household Survey (EHPM), done by the Ministry of Economy, probes the reasons why people do not use health services and inquires into user satisfaction with these services (quality parameters). However, there are no specific studies for monitoring sector financing from the perspective of quality, efficiency, and transparency.

The different funding sources and legal frameworks of health service providers do not allow for mechanisms to transfer funding; likewise, there are no transfers of subsidies among the different subscriber and subsidy systems. However, there are several agreements between provider institutions, especially MSPAS and ISSS, for serving patients in specific cases and in emergencies.

The ISSS covers employees for work-related accidents and occupational hazards; it covers 75% of temporary sick leave from these incidents, starting the first day of the sick leave, while the employer covers the remaining 25%. With regard to the creation of national solidarity funds, the ISSS has an occupational hazard reserve fund, which, as its name implies, is for subsidizing the pensions of workers who are disabled due to an occupational hazard.

In 2004, the Health Solidarity Fund, FOSALUD, was created as a public corporation and governing body that operates autonomously under MSPAS. Its three main objectives are the following: a) facilitate the creation of special programs for expanding health services coverage; b) develop and implement integrated programs that address the basic health needs of the country's most vulnerable people; and c) promote health education campaigns. Funding for FOSALUD comes from tax revenues collected by the Ministry of the Treasury on the sale of alcohol and alcoholic beverages; tobacco products; and firearms, ammunition, explosives, and other related materials.

MSPAS holds talks and negotiates with the Ministry of the Treasury during the annual budget process in order to ensure financial resources for the year that will enable the health services network to function. However, given the financial limitations of the treasury, the budget allocation to MSPAS does not meet current resource needs, nor does it cover its historical deficit. This situation makes it imperative to prioritize the use of resources, in line with national policy and the most cost-effective interventions.

2.1.6. Guarantee of Insurance

Each of the different health service providers (MSPAS, ISSS, Teachers' Welfare, Military Health, private providers, NGOs) guarantees the offer of its own service mix, which each one publicizes using posters, newsletters, and television and radio ads. However, it should be underscored that no integrated plan exists for publicizing the health goods and services to which the population is entitled under the benefits plan of each of the providers in the sector.

Different laws that include the rights mentioned have been published, including the Health Code, General Hospital Regulations, and Consumer Protection Law. In addition, each service program has its own educational materials. In 2004, user rights and responsibilities statements were introduced in several MSPAS facilities.

El Salvador has a Consumer Protection Office, created in August 2005 by Legislative Decree No. 776, which is a decentralized government agency with legal status and its own endowment and administrative and budgetary autonomy. It has the authority to coordinate the consumer protection system and has a penalty board that is in charge of hearing penalty proceedings on consumer protection issues, imposing sanctions, and hearing other proceedings as authorized by law.

2.1.7. Harmonization of Service Provision

MSPAS and ISSS are implementing the Five-Year Strategic Health Plan, which includes working on standardization with the providers in the health services network. The Directorate of Regulation has established basic health care standards,[22] which are applicable nationwide in all public, autonomous, and private (including NGOs) first, second, and third level health care service delivery facilities. The entry into force of the SIBASI Law provided legal recognition for the structure of the first, second, and third levels of care, their coordination, and their hierarchical rank under the authority of the system's Superior Level and the Regional Directors' Offices. These levels are integrated through the referral and counter-referral systems.

[22] See Annex C— Regulatory Documents.

2.2. FINANCING AND ASSURANCE

2.2.1. Financing

Health Accounts information gives us an in-depth picture of health financing and expenditures in the countries. Out-of-pocket household spending on health is estimated to be US$581,002,053, which is quite close to the public expenditure in health (including MSPAS, ISSS, Military Health, and Teachers' Welfare) of $586,842,028. This situation demonstrates the relative importance of household spending in financing the health sector. It is important to point out that the high amount of private spending on health, especially household spending, has to do with the low coverage of the health assurance systems (around 20%, including private coverage) and the high costs borne by households for purchasing drugs and laboratory tests, among other factors.

The table below gives detailed health expenditure figures. These show that public spending has accounted for less than half of the total national health expenditure over the entire period, dropping even lower in 2004, when the public expenditure was only 38% of the national expenditure. Precisely one of the intentions of health reform in the coming years is to reverse this trend, so that the contribution from public spending on health increases while direct out-of-pocket household spending on health decreases. In general terms, the national health expenditure dropped to 7.6% of the GDP in 2004, following a trend over prior years (except 2001 and 2003) when it was close to 8% of the GDP. The health expenditure per capita went from $161 in 1999 to $184 in 2004.

Table 12: Health System Financing, by five-year periods, El Salvador

Category	1990-1994	1995-1999	2000-2004
Central Government Budget (In US$) 1/	759,274,837	1,726,461,505	2,416,760,901
National Budget Assigned to the Health Sector	144,265,030	369,838,521	586,842,028
Public Sub-Sector			
Ministry of Health 2/ 3/	74,391,583	155,757,773	229,653,928
ISSS (social security) 2/ 4/	69,873,447	196,016,958	321,318,810
Others (Military Health and Teachers' Welfare) 5/	N/A	22,579,738	35,869,290
Private Sub-Sector			
Private Insurers 6/		13,430,857	33,479,656
Private Providers			N/A
Contractual Services			N/A
Out-of-Pocket Expenditure 6/		413,854,251	581,002,053
Private Companies			

DONATIONS (other funding sources)		55,086,141	54,937,169
International Organizations (external cooperation) 6/		23,947,459	10,519,760
Others (local resources, investment income, others) 6/		31,138,683	44,417,409

Sources and Technical Notes:
1/ The central government budget does not include ISSS, FISDL, municipal government, and others in the general government. The total national budget is not available.
2/ Budget Acts, several years.
3/ Does not include hospitals' own funds; only funds from GOES, loans, and donations reported in the Budget Act.
4/ This only includes the budget for the ISSS health system, not the ISSS system for disability, old age, and death.
5/ The available information has been obtained through the studies of the Health Accounts of El Salvador. In the Budget Act, the amounts allocated to these systems in particular are not specified, because they are part of the Ministry of Defense and the Ministry of Education. For 1996 and 1997, the hospital for telecommunications workers (Hospital de ANTEL) was included, in addition to Teachers' Welfare and Military Health.
6/ Estudios de Cuentas en Salud/MSPAS, several years.

Table 13: Health Expenditures over the Past 5 Years, El Salvador

INDICATOR	1999	2000	2001	2002	2003
Public expenditure on health per capita in US$	70	76	71	79	78
Public expenditure on health / Total public expenditure	43%	45%	42%	45%	45%
Total expenditure on health per capita in US$	161	168	167	176	172
Total expenditure on health, as a % of GDP	8.0	8.0	7.8	8.0	7.6
Foreign health debt / Total foreign debt	N/A	N/A	N/A	N/A	N/A

Sources: Estudios de Cuentas en Salud/El Salvador/MSPAS, several years.
(p): Preliminary figures, subject to change.
GMRE/

Finally, the estimates indicate that external cooperation financing for the health sector decreased noticeably during the final five-year period under study.

2.2.2. Assurance

The Constitution of El Salvador, in Article 65, sets forth that "...the health of the inhabitants of the Republic constitutes a public good. The State and the people are obligated to safeguard its conservation and restoration." The Health Code[23] provides that "The Ministry, through the Directorate General of Health as the Technical Agency, shall be in charge of implementing actions for the promotion, protection, recovery, and rehabilitation of the health of the inhabitants, as well as relevant complementary actions in the entire territory of the Republic, through its regional and local units...."

The social security system (ISSS) provides progressive coverage for the hazards to which workers are exposed from disease, common accidents, work-related accidents, occupational diseases, maternity, disability, old age, death, and involuntary unemployment. Pension recipients and family members of the insured are also covered for illness, common

[23] Código de Salud, Legislative Decree No. 955, May 1988, Art. 42.

accidents, and maternity. However, only children under the age of 12 are covered, and they only receive preventive services and treatment for common health problems.

In May 2003, Teachers' Welfare was redesigned to create a program to provide comprehensive health care to the family (teacher, spouses, and children up to 21 years of age), using a community-based Family Health strategy. Coverage is provided to this population group through the purchase of medical services from the private sector and from public and private hospitals.

The Armed Forces has the Military Health program, aimed at armed forces personnel, their family members and pensioners, supplying outpatient and inpatient preventive and curative services. In recent years, it has opened its doors and now offers services to the public through direct payment for services.

Private institutions operate under the principle of free contracting and determine the services they offer and fees they charge.

"The exercise of the professions that bear a direct relationship to the health of the people shall be overseen by legal agencies, comprised of academics belonging to each profession....they will have the authority to suspend professional practice...when ... immorality or incapacity are demonstrated." Likewise, the Health Code, beginning in Article 278, establishes the infractions and applicable sanctions for all actions or omissions that violate the provisions of the Code and its Regulations.

In 2001, the Directorate of Regulation was created to be the unit responsible for developing legal instruments including proposed laws, regulations, technical health standards, protocols, guidelines, manuals, and other related instruments. It coordinates across institutions and sectors to ensure standardization. The Directorate also develops proposals for licensing, certification, authorization, and accreditation of health professionals and facilities. For this purpose, priority is being given to developing 260 regulatory documents in the areas of women, children, adolescents, the elderly, men, environmental sanitation, nursing, mental health, drugs, ionizing radiation, tuberculosis, STIs/HIV/AIDS, epidemiology, and others.[24]

As part of the effort to strengthen the steering role of the Ministry of Health, the Directorate of Regulation has set up the Interinstitutional Standards Harmonization Committee, through which it has implemented unified clinical practice standards for each of the institutions on the committee: ISSS, Military Health Command, Teachers' Welfare, and MSPAS.

The Health Sector uses a mixed approach, in which responsibility for health coverage of the population is distributed among the public institutions described above and private entities.

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[24] www.mspas.gob.sv/regulación, Virtual regulatory documentation center.

With regard to health assurance, according to the EHPM 2005, 18.4% of the population is covered by the ISSS as subscribers or dependants, 2.1% has private health insurance coverage, and the remaining 79.5% is covered by MSPAS.[25] However, by law, any person who requests care at a MSPAS facility is seen, regardless of insurance status.

This mixed approach uses the following mechanisms for payment to health services providers: MSPAS—free of charge; ISSS, Military Health, and Teachers' Welfare—prepayment; and private providers—sale of services.

2.3. SERVICE PROVISION

2.3.1. Supply of and Demand for Health Services

Demand for health services refers to the use of health services by the population when some problem arises. According to the EHPM,[26] of people who were affected by some health problem, 53.7% sought help through consultations with private parties or public and private health institutions, while the remaining 46.3% self-medicated or did not consult anyone. Of the people who sought services, 61.3% went to MSPAS facilities, 13.6% to the ISSS, 18.9% to a private hospital or clinic, and the remaining 6.3% went to an NGO, social program, pharmacy, etc.

[25] Source: Encuesta de Hogares de Propósitos Múltiples, 2005. División de Estadísticas Generales, Dirección General de Estadística y Censos del Ministerio de Economía.
[26] Encuesta de Hogares de Propósitos Múltiples, 2005, pp. 211-212.

Table 14: Access to the Health System

	Percentage of population that uses the health system (total)	Percentage of population that uses MSPAS facilities	Percentage of population that uses the Salvadoran Social Security Institute	Percentage of population that uses the private sector	Percentage of population that uses others (NGOs, Social Programs, Pharmacies, etc.)	Percentage of population that does not use the health system
Periods						
1990-1994	N/A	N/A	N/A	N/A	N/A	N/A
1995-1999	N/A	N/A	N/A	N/A	N/A	N/A
2004	51.10%	64.0%	13.0%	16.90%	4.6%	48.90%
2005	53.70%	61.30%	13.60%	18.90%	6.3%	46.30%
Geographical Areas						
Urban (2005)	60.40%	53.50%	18.60%	23.20%	4.70%	39.60%
Rural (2005)	48.30%	74.00%	5.40%	11.80%	8.80%	51.70%

Sources: 1. EHPM 2004, 2005, Ministerio de Economía DIGESTYC.
N/A: Data not available or insufficient. Information disaggregated by age, gender and ethnic background was not available for these indicators.

There are differences in health service utilization between urban and rural areas: 60.4% of the urban population seeks services in the health system when sick (primarily the ISSS and the private sector), while only 48.3% of the rural population uses the system when sick, mainly seeking care at MSPAS facilities. The total rate of health service utilization, based on 2004 data from nine private hospitals, ISSS, and MSPAS, was 1.26 per inhabitant for first level facilities and 1.3 for second level facilities.[27]

The female population seeks care more frequently when sick. When women get sick, 52% see a doctor, nurse, or health promoter, and 0.7% consult with a traditional healer, family member, or neighbor. Even with these figures, it is worrisome that 47% of sick women do not seek care. In turn, only 47.9% of men went to see a doctor, nurse, or health promoter; 0.9% saw a traditional healer, family member, or neighbor; and 51% did not seek care despite being sick[28].

[27] Source: Data from nine private hospitals, ISSS, and MSPAS in 2004.
[28] Source: Encuesta de Hogares de Propósitos Múltiples (EHPM), 2004.

Table 15: Access to Health Services

TOTAL PERCENTAGE OF USE 2004 +	Gender		Total
	Men	Women	Percentage of Care +++
Patients who saw a doctor/ nurse/ health promoter ++	47.8%	52.4%	50.3%
Patients who saw a traditional healer, family member, or neighbor	0.9%	0.7%	0.8%
Patients who did not seek care	51.3%	46.9%	48.9%
	100.0%	100.0%	100.0%

N/A: Data not available / insufficient.
Sources: 1. Encuesta de Hogares de Propósitos Múltiples EHPM 2004, Cuadro GO2A: Población que se enfermó por persona o profesional que indicó el tratamiento, Cuadro GO2B: Población que se enfermó por lugar o establecimiento de salud al que asistió; Sección 3. Características de la Salud. 2. Proyecciones de Población de El Salvador 1995-2025, Dirección General de Estadística y Censos- DIGESTYC.
+ The figures are totals (independent of the level of care).
++ "Of the population that sought care, 64% went to MSPAS facilities, 13% to the ISSS, 16.9% to a private hospital or clinic, and the remaining 4.6% went to NGOs, social programs, pharmacies, etc." Características de la Salud, EHPM 2004.
+++ Regarding total health service utilization: Data obtained in 2004 from 9 private hospitals, ISSS, and MSPAS showed a total rate of use of first level facilities of 1.26 visits/inhabitant, and a total rate of use of second level facilities of 1.3 visits/inhabitant.

Of the total population of sick people who sought care (EHPM 2004), 64% went to MSPAS facilities, 13% to the ISSS, 16.9% to a private hospital or clinic, and the remaining 4.6% went to NGOs, social programs, pharmacies, etc.

The public sector has 44 hospitals across the nation, which have a total of 6,516 beds. There are 39 private sector hospitals (the ten hospitals that provided information reported 425 beds.)[29] The public sector also has 883 ambulatory care centers with 6,585 beds (MSPAS: Health Units, Employee Clinics, Emergency Care Centers (CAE), Health Posts, and Rural Nutrition Centers; ISSS: Worksite Clinics, Community Clinics, and Medical Units).

In the public sector, hospital capacity is 0.006 hospitals per 1,000 inhabitants and 0.95 beds per 1,000 inhabitants, and outpatient center capacity is 0.13 outpatient centers per 1,000 inhabitants. In the private sector, hospital capacity is 0.005 hospitals per 1,000 inhabitants and 0.06 beds per 1,000 inhabitants. Together, both sectors have 966 centers with 7,010 beds.

[29] Source: MSPAS 2005, ISSS Boletín 2005, Unidad de Estadísticas ISSS 2005, Hospital Militar: obtained from the 2001 update of the PAHO/WHO El Salvador Profile of Health Systems and Services, Salud para un país de futuro 2004-2009 OPS-OMS, and the interviews and reports received from 10 private hospitals in November 2005.

Table 16: Number and Capacity of Treatment Facilities, 2004, El Salvador

PUBLIC SECTOR		
Hospitals	**No. Centers / 1,000 Inhab.**	**No. Beds / 1,000 Inhab.**
High Level Complexity	0.002	0.32
Medium (basic specialties)	0.001	0.18
Low (general medicine)	0.004	0.44
Total Hospitals	**0.006**	**0.95**
Outpatient Centers	**No. Centers / 1,000 Inhab.**	**No. Beds / 1,000 Inhab.**
Specialty Centers ++	0.005	---
General Primary Level Centers +++	0.091	---
Non-Professional Personnel Primary Level Centers ++++	0.032	---
Total Outpatient Centers	**0.128**	**---**
Total Public Sector	**927**	**6585**
Source: MSPAS June 2005, ISSS Boletín 2005.		
PRIVATE SECTOR		
Hospitals	**No. Centers / 1,000 Inhab.**	**No. Beds / 1,000 Inhab.**
High Level Complexity	0.0006	0.0000
Medium (basic specialties)	0.0044	0.0000
Low (general medicine)	0.0007	0.0000
Total Hospitals	**0.0057**	**0.0000**
Outpatient Centers	**No. Centers / 1,000 Inhab.**	**No. Beds / 1,000 Inhab.**
Specialty Centers	N/A	---
General Primary Level Centers	N/A	---
Non-Professional Personnel Primary Level Centers	N/A	---
Total Outpatient Centers	**N/A**	**---**
	0.14	**0.96**

Sources: 1. MSPAS, 2005. 2. ISSS Boletín, 2005. 3. Unidad de Estadística, ISSS, 2005. 4. Military Hospital data obtained from the PAHO/WHO El Salvador profile, 2001 modification, and Salud para un País de Futuro 2004-2009 OPS-OMS - Inventario de Infraestructura de Establecimientos del Sector Salud El Salvador 2003. 5. Interviews and reports from 10 private hospitals, November 2005.

---: Not Applicable

N/A: Data not available / insufficient

+ Data on Public Sector includes MSPAS, ISSS, and Military Health.

++ Includes ISSS Medical Clinics and the two MSPAS Emergency Care Centers, which have 12 and 4 observation beds, respectively.

+++ Includes MSPAS Health Clinics and Employee Clinics, and ISSS Workplace Clinics and Community Clinics.

++++ The first level centers with non-professional personnel include Casas de Salud and Rural Nutrition Centers.

+++++ Insufficient data for number of beds in the private sector; of the 36 private hospitals, information was only available from 10 hospitals for calculating the number of beds.

2.3.2. Human Resources Development

The health system is made up of entities that train human resources and entities that employ them. The first are responsible for university and technical level training of people who choose health careers, where they receive an education that prepares them to join the public and private labor market. The employing entities are responsible for providing health services at the different levels of service, for which they hire human resources that are graduates of the training entities.

2.3.2.1. Human Resources Training

For human resources training there are seven universities that have schools of medicine and health sciences: Universidad de El Salvador, Universidad Evangélica de El Salvador, Universidad Dr. José Matías Delgado, Universidad Andrés Bello, Universidad Alberto Masferrer, Universidad Nueva San Salvador, Universidad Autónoma de Santa Ana, Universidad Centroamericana José Simeón Cañas, and Universidad Don Bosco. For the training of technicians and technologists there are the Instituto Tecnológico de Educación Superior, de Profesionales de la Salud de El Salvador, and the Instituto de Formación de Profesionales de la Salud. It is important to point out that every five years a curriculum review is done by the respective commissions to ensure that the training curriculum corresponds to job descriptions and that these both meet the health needs of the people. The only school of public health was created in 1997 by the University of El Salvador, which is why there were only 192 graduates during this last five-year period.

Table 17: Human Resources in the Health Sector

Period / Type of Human Resource	1990-1994	1995-1999	2000-2005
Ratio of physicians per 10,000 inhabitants	4 MSPAS 14 ISSS	6 MSPAS 16 ISSS	8 MSPAS 20 ISSS
Ratio of professional nurses per 10,000 inhabitants	3 MSPAS	3 MSPAS 5 ISSS	5 MSPAS 9 ISSS

No. who have completed graduate-level training in Public Health	N/A	N/A	(26)
No. with graduate-level degrees in Public Health	N/A	N/A	192 (2002-2003)
No. of Schools of Public Health	Not applicable	Not applicable	Not applicable
No. of Universities offering a Master's Degree in Public Health			3
Contracting Modalities	Salary Law / Contracts Law GOES:MSPAS/ISSS Own funds for MSPAS	Salary Law / Contracts Law GOES:MSPAS/ISSS Own funds for MSPAS	Salary Law / Contracts Law GOES:MSPAS/ISSS Own funds for MSPAS

Source: Salud Pública en Cifras-1997-2003, Dirección de Planificación.
Observatorio de Recursos Humanos-GIDRHUS.

2.3.2.2. Management of Human Resources and Employment Conditions

The MSPAS participated in the Seventh Regional Meeting of the Observatories of Human Resources in Health, held in Toronto, Canada in October 2005 and sponsored by PAHO/WHO, where it pledged to disseminate nationwide the Challenges for a Decade of Human Resources in Health. Important intersectoral actions have been taken, including the following: a) intersectoral efforts set out in the Plan for Developing the EPHF, specifically function 8: "Human resources development and training in public health," which spells out the indicators and their respective interventions for improving the performance of this function;[30] b) strengthening GIDRHUS, responsible for developing the Observatory of Human Resources in Health, by collecting, analyzing, and disseminating up-to-date Core Data information to the training and employing entities for decision-making; and c) representation on the special committee on human resources of the CNSPRIS.

The health labor market and conditions of employment are varied and changing. There are 15,406 health professionals in the public and private sectors together. MSPAS and ISSS are the main employers. For the 2003-2005 period, 63% of medical personnel was working for MSPAS (including personnel for the RHESSA Project, FOSALUD, ISRI, and the Salvadoran Red Cross), 31% for ISSS, 1% for Military Health, 1% for Teachers' Welfare, 1% for the Supreme Court, and the remaining 3% for training institutions.

[30] Plan de Desarrollo de las Funciones Esenciales de Salud Pública, November 2005, MSPAS, pp. 30-31.

Table 18: Professionals and Technicians with Health Degrees in the Health Sector Employing and Training Institutions, El Salvador

Discipline	MSPAS	ISSS	Military Health and Hospital	Supreme Court of El Salvador	Ministry of Education	Training Institutions*
	2000-2005	2000-2005	2000-2005	2000-2005**	2000-2005	2000-2005**
Doctor of Medicine	3,248	1,500	145	80	273	385
Doctor of Dentistry	245	109	34	9	52	51
Licentiate in Nursing	480	273	20	1	-	57
Licentiate in Chemistry and Pharmacy	89	251	3	2	1	38
Licentiate in Anesthesiology	97	63	8	-	3	2
Licentiate in Clinical Laboratory	203	196	24	2	16	40
Licentiate in Physical Therapy	41	49	9	-	0	19
Licentiate in Psychology	59	22	4	29	7	18
Licentiate in Radiology	115	66	7	-	3	7
Licentiate in Nutrition and Dietetics	57	22	1	1	-	17
Licentiate in Maternal and Child Health	-	17	-	-	-	7
Licentiate in Social Work	56	67	2	38	0	8
Nurses	1,801	221	54	5	3	41
Auxiliary Nurses (technician)	3,158	1,165	209	0	-	3
TOTALS	**9,649**	**4,022**	**519**	**167**	**357**	**692**

Sources: Training institutions (Universidad de El Salvador, Universidad Evangélica de El Salvador, Universidad Autónoma de Santa Ana, Universidad José Matías Delgado, Universidad Alberto Masferrer, Universidad Nueva San Salvador, IEPROES).
* Data from 2003.
** No data for 2000.

The country does not have studies on the types and conditions of health-related employment with information on multiple employment, job flexibility, shift work, outsourcing, and lack of labor protection systems. The only information available is that health and administrative staff at the first level of services work eight-hour daytime shifts and that there is a system of evening and night shifts for medical, administrative, nursing, and support services personnel in specialty and regional hospitals. With the implementation of the FOSALUD strategy for expanding coverage of essential health services in rural and urban areas, 1,193 people from different disciplines were hired in 2005. Of these people, 40 work in administration, 683 work in

66 Health Units, and the remaining 470 were hired on temporary contracts to work on joint activities with MSPAS.[31]

In MSPAS, the relationship between income and hiring level is determined by the Wage Law and the Contracts Law. The ISSS has a salary scale that went into effect on 1 November 2004, in which the average income for the different professions is $580 and medical personnel start with a wage of $126 per hour. In MSPAS there are no processes underway for repositioning or reclassification. Buyouts occur only through government-issued decrees. The last decree of this type, No. 678 in 2002, used this kind of buyout, handling it as voluntary retirement. With regard to dismissals, these occur only through dismissal procedures, following the Civil Service Law for central and municipal government officials and employees. In the ISSS, there are job swaps and transfers, and reclassifications, as well as dismissals with employer liability and without employer liability.

MSPAS has started outsourcing in the areas of training, cleaning services, security, and equipment and vehicle maintenance. The main services that the ISSS purchases are care from medical specialists, elective surgery, clinical laboratory services, imaging, Pap smear reading, vaginal birth, food service, security, cleaning, and others. MSPAS and ISSS are the institutions that employ the most people. MSPAS, from 2000 to 2005, had, on average, 4,086 physicians, 2,843 graduate nurses, and 3,304 auxiliary nurses. The ISSS had 2,058 physicians, only 889 graduate nurses, and 1,695 auxiliary nurses. Teachers' Welfare contracts with family physicians and dentists, but not nursing personnel.

Table 19: Human Resources in the MSPAS- ISSS

Time Period / Institution	1990-1994			1995-1999			2000-2005		
	Doctors	Nurses	Aux. Nurses	Doctors	Nurses	Aux. Nurses	Doctors	Nurses	Aux. Nurses
MSPAS	2,366	1,541	2,608	3,126	1,770	3,181	4,086	2,843	3,304
ISSS	1,512	N/A	N/A	1,667	483	1,271	2,058	889	1,695
Teachers' Welfare							283*	**	***
Total	3,878	1541	2,608	4,793	2,253	4,452	6,144	3,732	4,999

Sources: Informe de Labores MSPAS 1990-2005, SIRHI Secretaria de Estado, MSPAS.
Inventario de Recursos Humanos y Físicos 1999, 2005; - ISSS, Estadística 2004, ISSS.
Ministerio de Educación, Programa de Salud Magisterial, 2003.
* Family Medicine doctors hired in 2003.
** and ***: These disciplines not required.

[31] Capitulo IX, Informe de Labores 2005-2006, Ministerio de Salud Pública y Asistencia Social.

The average ratio of physicians per inhabitant has increased in the last five-year period, when it was 8/10,000 inhabitants, which is much lower than the ratio in the ISSS, where it is 20. With regard to nurses, the MSPAS has 3 per 10,000 inhabitants and the ISSS has 5.

2.3.3. Medicines and other Health Products

During the last three years, different governmental, non-governmental, private, and academic social actors have been involved in a process to develop a proposal for a National Drug Policy. Each health sector institution has its own drug policy, each with its own strategic guidelines.

The country does not have an essential drugs observatory; however, the Institutional Drug Treatment Committees determine and implement drug monitoring activities as part of the program on spontaneous reporting of suspected adverse drug reactions, spontaneous reporting of suspected treatment failures, and on the rational use of drugs. MSPAS evaluates the critical aspects of drug management through the "Management Survey of the Medical Supplies System," done during the monitoring visits to health facilities conducted quarterly by the Technical Unit for Drugs and Medical Supplies (UTMIN).

There is no agency that regulates the process of the purchase and distribution of essential drugs in the country. However, drug purchasing and distribution in each individual institution is done through the Institutional Procurement and Contracting Units (UACI) and the administrative offices responsible for this function, in accordance with the guidelines set forth in the Public Administration Procurement and Contracting Law (LACAP).

There is no Drug Pricing Policy or National Essential Drugs List. However, each institution has its own list in accordance with its epidemiological profile, the needs of the prescribers and users, and its financial capacity, which is reviewed periodically, at least once a year.

The country has made progress in the use of treatment protocols for pathologies prevalent in first, second, and third level health service delivery institutions. These protocols include Clinical Guidelines for Newborn Pathology, National Guidelines for the Integrated Management of Childhood Illnesses, Treatment Guidelines for the Leading Adolescent Health Problems, Clinical Care Guidelines for the Leading Causes of Obstetric Morbidity at the Third Level of Care, Clinical Guidelines for Primary Health Care of the Elderly, among others. However, not all of these have been standardized.

Article 32 of the Pharmacy Law[32] provides that each pharmaceutical distributor or pharmacy must have a professional pharmacist, and where subordinate employees are needed, they must be qualified in pharmacy, with a certificate issued by a competent authority. The respective board of oversight oversees compliance in the private sector. The ISSS and Military Health have chemists and pharmacists in charge of all their pharmacies.

The total number of pharmaceutical products registered in the CSSP in the past three five-year periods has been increasing. In the 2000-2005 period, there were 5,983 products, of which 60% were brand name products and 40% were generics. There has been a slight decrease in the percentage of the public expenditure that goes for these medicines, going from 11.99% in the 1995-1999 period to 11.96% in the latest period.

Table 20: Medicines

INDICATOR	1990 - 1994	1995 - 1999	2000 - 2005
Total number of registered pharmaceutical products	3,500	4,000	5,985
Percentage of brand name medicines	80%	80%	60%
Percentage of generic medicines	20%	20%	40%
Percentage of public expenditure in health that goes to medicines	N/A	11.99%	11.96%

Source: Consejo Superior de Salud Pública.

2.3.4. Equipment and Technology

With regard to the availability of technological resources, in the 2001-2004 period the public sector had 0.01 basic diagnostic imaging machines per 1,000 inhabitants, 2.41 clinical laboratories per 100,000 inhabitants, and 0.44 blood banks per 100,000 inhabitants, lower than what was reported for 2000 in the November 2001 El Salvador Profile of Health Systems and Services.[33] The private sector had 0.013 basic diagnostic imaging machines per 1,000 inhabitants, 4.22 clinical laboratories per 100,000 inhabitants, and 0.1 blood banks per 100,000 inhabitants. The national total for both sectors of available technological resources is 0.03 basic

[32] Ley de Farmacias, 9 July 1927.
[33] Perfil del Sistema de Servicios de Salud El Salvador. 1st ed., 10 Dec. 1998; 2nd ed., 15 June 2001; slightly modified 26 November 2001, PAHO.

diagnostic imaging machines per 1,000 inhabitants, 6.63 clinical laboratories per 100,000 inhabitants, and 0.46 blood banks per 100,000 inhabitants.

Table 21: Availability of Equipment in the Health Sector 2001-2004

2001-2004 Type of Resource	Number of beds per 1,000 inhabitants	Basic diagnostic imaging equipment per 1,000 inhabitants ++	Clinical laboratories per 100,000 inhabitants	Blood banks per 100,000 inhabitants +++
PUBLIC SUB-SECTOR				
MSPAS	0.68	0.01	2.50	0.38
ISSS	0.2	0.004	0.19	0.03
Military Hospital	0.038	0.001	0.03	0.03
TOTAL PUBLIC SECTOR	0.95	0.01	2.72	0.44
PRIVATE SUB-SECTOR (for and non-profit)				
Red Cross	Not Applicable	Not Applicable	Not Applicable	0.01
Private +	N/A	0.013	4.22	0
TOTAL PRIVATE SECTOR	0.000	0.013	4.22	0.01
TOTAL	0.95	0.03	6.94	0.46
POPULATION IN 2004	**6,757,408**	**6,757,408**	**6,757,408**	**6,757,408**

Sources: Laboratorio Central MSPAS, Diagnóstico Situacional de Red Nacional de Bancos de Sangre y Servicios de Transfusión, Nov. 2005. ISSS Unidad de Estadística, 2004. Junta de Vigilancia de la Profesión en Laboratorio Clínico, Nov. 2005. Unidad Reguladora de Radiaciones Ionizantes UNRA, Nov. 2005. Population projections for El Salvador 1995-2025, Dirección General de Estadística y Censos—DIGESTYC.
Notes: The total number of laboratories registered with the Board of Oversight of the Clinical Laboratory Profession in Nov. 2005 was 789. + For profit and non-profit private laboratories, including private hospital laboratories. ++ Basic diagnostic imaging equipment includes conventional and fluoroscopic equipment. In the country, there are also 108 mobile diagnostic imaging units, 18 CAT scanners, and 39 mammography units. +++ In addition, there are transfusion services at ISSS (4), MSPAS (4), and private (20). There are 18 blood banks in clinical laboratories.

2.3.5. Quality Assurance

In order to strengthen efforts for improving the quality of health services, in 2005 MSPAS developed, validated, and launched the National Program for Health Services Quality Assurance in El Salvador as an instrument to track health work for the purpose of reducing health care hazards and improving user satisfaction. The Program contains an analysis of health sector quality issues, a definition of the concept, priorities, objectives, quality improvement intervention areas that have been mapped out, strategies for achieving the

objectives, and the organization of a National Quality Committee that will be the entity to facilitate the process in health service facilities.

MSPAS has documents, standards, and specific guidelines for direct health care service delivery. These have been designed by and for each program, department, unit, or branch of MSPAS with the involvement of other health sector institutions (Annex A: Regulatory Documents).

User perception surveys were done on this topic, which identified several problems with lack of satisfaction. This led to the development of a proposal to encourage a change in the mindset of health providers through training sessions on quality improvement topics. With assistance from international cooperation agencies, courses on quality issues were held for personnel from different disciplines and different hospitals around the country. One of these, the German technical cooperation agency, supported training on quality management using the model of the European Foundation for Quality Management (EFQM), teaching workshops on Quality Management for Public Health (*Calidad Aplicada a Salud Pública*- CALSAP). Three forums on quality management were held around the country as an outcome of this training, at which the results of the best quality management project were presented.

The government of Japan allocated technical and financial cooperation funds for implementing a project to improve the quality of nursing personnel training and performance, in which trainers were trained in the EPQI (Evidence-Based Participatory Quality Improvement) model. This model was mainly used in hospitals in the Central SIBASI and in the Health Units in 2005. Along the same lines of quality training, certificate courses on management have been given, which included units on quality improvement. The courses also included the Management Commitments tool, which adopts a quality improvement approach that uses user satisfaction surveys, reduction in waiting times, the Director's Link (*Ventana del Director*), and suggestion boxes, along with training to develop health worker skills in several care areas including emergencies, neonatal resuscitation, obstetric skills, and others.

Since 1997, courses and training sessions on pediatric emergency care have been given at the Benjamín Bloom Hospital (the public children's hospital): a Basic Life Support (BLS) course and a Pediatric Advanced Life Support (PALS) course. In September 2004, the resuscitation courses received international certification from the American Heart Association (AHA) and the American Academy of Pediatrics (AAP). In addition, 23 physicians from the national hospital network were certified as PALS instructors, with the intention of standardizing the approach to pediatric emergencies and strengthening the knowledge of MSPAS health workers that treat children.

Continuous monitoring is done of the quality and efficiency of the treatment of children with pneumonia and diarrhea in MSPAS Health Units and Hospitals. In addition, in 2005, a national workshop was held on evaluating the quality of medical care. In several regions of the country, efforts were made to standardize management criteria in selected hospital services.

In 2004, Statements of User Rights and Responsibility were introduced in two national referral centers (the maternity hospital and the Benjamin Bloom national children's hospital), five general hospitals, and one health unit. Four hospitals in western El Salvador were added in 2005.

In 2005, MSPAS, through the UCP/PAM-BID Project, conducted a consultancy on quality improvement, which identified five priority areas for short and medium-term improvement in each SIBASI. Respective implementation plans were drawn up for these initiatives and every six months their progress is evaluated in each of the SIBASIs.

With regard to the referral and counter-referral system, documents for implementing the system between the first and second levels of care were previously written. Since 2005, monthly discussion have been held for the purpose of improving the referral and counter-referral of patients to and from the third level of care (Benjamin Bloom National Children's Hospital, Maternity Hospital, and Rosales Hospital), resulting in a decrease in the day-to-day difficulties faced with these referrals.

In 2005, the performance of the Essential Public Health Functions was measured. Function number 9, "Quality assurance in personal and population-based health services," received one of the lowest scores. The EPHF Development Plan[34] mapped out four indicators for this function, and interventions were developed for each indicator to improve their performance.

Although the country does not have criteria and procedures for accrediting public and private health institutions, the National Health Services Quality Assurance Program, launched in November 2005,[35] includes the following in its seven intervention areas: Area 2: Classification of health care facilities; Area 3: Authorization of health facilities; Area 4: Certification of health human resources; and Area 5: Accreditation of health institutions.

At present, a range of disperse instruments and tools exist for measuring compliance with quality standards at health facilities and services at the different levels of MSPAS. However, despite this diversity, an effort is beginning to standardize these instruments.

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[34] Plan de Desarrollo de las Funciones Esenciales de Salud Pública, November 2005, MSPAS, pp. 33-34.

[35] Programa Nacional de Garantía de la Calidad de los Servicios de Salud en El Salvador, November 2005. MSPAS, pp. 22-22.

Channels for complaints from health services users include interactive techniques, such as the Director's Link (*Ventana del Director*), suggestion boxes, satisfaction surveys, the customer services office, the MSPAS telephone line *Teléfono Amigo*, and the ISSS *Punto Seguro* (customer service).

2.4. INSTITUTIONAL MAPPING OF THE HEALTH SYSTEM

The following table lists institutions and agencies and their involvement in the health system:

Organizations	Steering Role		Financing	Assurance	Service Provision
	Conduct/Lead	Regulation and Enforcement			
MSPAS	X	X	X		X
Military Health		X	X	X	X
FOSALUD		X	X		X
CSSP		X	X		X
Teachers' Welfare		X	X	X	X
ISRI		X			X
ISSS	X	X	X	X	X
NGOs			X		X
Municipal Governments	X	X	X		X
Human Resources Training Institutions	X	X	X		
Private Insurers	X	X	X	X	
Private Providers	X	X	X		X
External Cooperation	X	X	X		

3. MONITORING HEALTH SYSTEMS CHANGE / REFORM

In 2001, MSPAS, in line with the Proposal for Comprehensive Health Reform presented by the National Commission on Health Reform, defined its mission as follows: "The State's governing body on health, which guarantees the inhabitants of the Republic of El Salvador coverage with timely and comprehensive services, with equity, quality, and warmth, sharing

responsibility with the community, including all social sectors, in order to contribute to achieving a better quality of life."

MSPAS, consistent with this statement of intent and commitment, intends to convert itself in the future into the strengthened governing body of the health sector, efficiently and effectively leading the national health system, and adding social auditing as a mechanism for promoting community participation through deconcentrated units or sub-national levels, the "Basic Integrated Health Systems," SIBASIs.

In 2003, the National Commission to Monitor the Integrated Health Reform Proposal (CNSPRIS) was formed, for the purpose of ensuring the comprehensive health reform process proposed by the National Health Reform Board (CNRS), as well as disseminating and creating venues for discussion and consultation for these purposes.[36]

3.1. IMPACT ON THE "HEALTH SYSTEMS FUNCTIONS"

For some 13 years, a series of actors and sectors from the country's social and political life have been involved in an initiative to design a reform process, also called a change process, for the health sector in El Salvador. Technical actors have also come into this process, who, with a political approach, have developed the different proposals mentioned in the previous System Profile of November 2001, along with the proposals mentioned below. In 2002, the President of El Salvador presented a reform proposal, "Democratization of the Health Protection System," which favored private participation in service delivery by introducing private entities into the public system through a free choice approach. This proposal, added to the prevailing economic and social conditions, along with harsh criticism of health conditions and of initiatives that attempted to favor the private sector in health service delivery triggered a mass movement of social organizations that kept up their protests for nine months, until 13 June 2003.

On that date, delegates and representatives of the President, MSPAS, ISSS, the Medical Society of El Salvador, and SIMETRISSS, signed the "Agreement for the Resolution of the Health Conflict and Initiation of the Integrated Health Reform Process," which included providing continuity to the Integrated Health Reform Proposal and institutionalizing the National Commission to Monitor the Integrated Health Reform Proposal (CNSPRIS).

CNSPRIS is made up of actors who represent different sectors linked to health, who are working on developing a number of proposals, including the following: the proposal for the

[36] Executive Decree No. 51, 24 June 2003.

Organization and Functioning of the National Health System, Proposed Law for the Creation of the National Health System, Policy on Social Participation in Health, Policy on Developing Human Resources in Health, and the proposal for a financing model consistent with the objectives of the national health system.

The proposal for organization and functioning includes the need to form a "National Health System," (NHS) under the steering role of the Ministry of Public Health and Social Welfare, aimed at exercising regulation, implementation of the Essential Public Health Functions, modulation of financing, surveillance of health insurance and health services delivery, and the fulfillment of three strategic objectives.

It is noteworthy that one of the things CNSPRIS spelled out as being necessary for making the NHS operational is the need for a National Health Policy, which will include substantive elements such as goals and objectives, linking public and private efforts, consensus-building, and resource mobilization, all geared toward the health needs of the population with emphasis on the first level of care and primary health care.[37]

Likewise, CNSPRIS has said that along with the proposed law to create the NHS, there is also a need to allocate sufficient money for fulfilling the new system's objectives. However, each member of the NHS will continue to have its own sources of funding and will be responsible for executing the funds based on the objectives set out in the National Health Policy.

3.2. IMPACT ON THE "GUIDING PRINCIPLES OF HEALTH SECTOR REFORMS"

Despite the fact that several proposals exist, the Health Reform process has never been implemented, which is the reason why it is not possible to show how the guiding principles of health sector reform are contributing to improve the levels of equity, effectiveness and quality, efficiency, sustainability, and social participation and control in the country's health system.

In the conceptual framework of the proposal for the Organization and Functioning of the NHS, the strategic objectives are the expansion of coverage, improvement in the quality of care and of services, ensuring equity in care, and access to health as a human right.

Nevertheless, beginning in this five-year period, MSPAS has been implementing strategies for expanding coverage to rural areas where there was no access to health services,

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[37] CNSPRIS, Propuesta organización y funcionamiento del sistema nacional de salud.

through loans from the IDB and the World Bank, as well as funds from FOSALUD. These strategies have contributed to reducing functional barriers to access.

3.3. POLITICAL PROCESSES/ACTORS THAT GAVE RISE TO AND/OR ARE SUSTAINING THE HEALTH SYSTEM CHANGE PROCESS

As was explained in section 3.1, since the beginnings of the process of change in the health sector, a number of social and political actors and sectors in the country have participated actively or passively. Therefore, it is important to emphasize the analysis of the opinions that were solicited from a sample of 14 of these actors, who included health leaders, entrepreneurs, academics, professionals in professional associations, and officials from cooperation agencies on how they see and/or support the health reform process. The 14people who were interviewed can be grouped by the sector they represent—three from the public sector, three professionals from professional associations, two from private business, two academics, and five from the external cooperation community.

Analysis of Actors[38]

According to the majority of the people interviewed, the proposed reform or change processes respond to an initiative, in the first place, from international cooperation agencies, and secondly, from the political sector, understood as the work of the members of the Salvadoran legislature. They placed the executive branch in third place, though some stated that this is a duty of the executive (to approve reforms) as part of the loan granting process.

Most of the respondents agree that the change processes are the outcome of agreement among several actors who are involved; the others said that these processes respond to a decision by a central authority. The interviewees have a clear view of the need to implement change processes that enable building a less-fragmented health system aimed at promoting equitable access to comprehensive health services for the Salvadoran public. Even though 10 of the 14 people interviewed are very much in favor of the change process, some of these same people think that the existing proposals are not in keeping with the type of national health system that exists. The interviewees acknowledge that cooperation agencies, especially the

[38] Interviews conducted by Dr. Claudia Suárez and Ms. Marielos de Turcios.

World Bank, are the ones most interested in carrying out reform and therefore contribute financially to the process.

For the interviewees, there are three actors that are active in the process: the executive, organized civil society working on health issues, and academics. Several hold the opinion that the executive is the promoter of the change processes themselves. They see civil society groups as forming the opposition to change processes. In third place, they see the academic sector as an actor that has contributed to the development of proposals, but that its participation in the implementation of the process is weak, especially with regard to training the right kind of human resources for the system being proposed. There is a need for a current database with the number, distribution, and specialties of the human resources that the training institutions are supplying to the labor force.

One point that is important to make and that relates to the power struggle between the executive and legislative branches, and which gives somewhat of an idea about the knowledge that the actors have about the process, is the fact that for eight of the informants, the executive is the one that has the power of veto over decisions. The rest said that both branches can exercise veto power. This could be an indication that a minority of those interviewed is aware that both branches could have the right to veto the change process, which is why negotiation will become much more necessary.

As they are not aware or knowledgeable about the development of the present-day democracy, the majority of the informants indicated that the change process does not contribute to the construction of national democracy. In fact, two of the 14 respondents said that El Salvador is a country where there is no democracy. However, over half of those interviewed say that the change process has contributed in two ways to the democratic process: the existence of greater social oversight and free choice.

Greater social oversight could be said to be the result of the work of the media during the beginning of the processes and free choice could be related to the different consultations and roundtable discussions that have been held around the process. Regarding the process of governance in the country, most of the informants agree that it is under construction. However, three said that no such process exists. The same people who feel this way, who are representatives of organized civil society (professionals from professional associations), are those who also believe that there is no democracy.

The position of the actors[39] in the change processes in the health systems can be summed up in two points: first, most of the institutions/organizations that the interviewees represent are strongly in favor of the change process, and, second, there is a relationship between those who are in favor of the process and those who say they have a certain capacity for action. From this, it can be inferred that the greater the power of action the organization has, the more in favor it is of the processes of change.

Another proxy variable has to do with the control the actor has over the media. Ten of the interviewees said that they do have control in these areas and are strongly in favor of the process of change, that they have a very good reputation and image, and also have high or average capacity for action.

Regarding the role each of the actors has with regard to its capacity for action (power) in the reform process in order to negatively or positively affect the results for each objective in the process, they can be grouped as follows, according to their response:

- The convinced: Both the private and public health sectors and to a lesser extent international cooperation agencies, who do not need to be reinforced and informed, but who are convinced of the change process and have a high capacity for action.
- The convinced who have little or practically no capacity for action, which are the academics and civil society, given that even though they do not totally support the process, they are not against the initiative itself.

[39] It is important to mention that some of the questions on the position of the actors were reformulated to better elicit information. Likewise, the scales were redesigned to better categorize the position of the actors.

ANNEX A – REGULATORY DOCUMENTS

MSPAS has documents, standards, and specific guidelines for the direct provision of health services. These have been designed by and for each program, department, unit, or branch of MSPAS. The following is a list of these.

Integrated Child Health Care:

- Clinical Guidelines for Newborn Pathology
- National Guidelines for the Integrated Management of Childhood Illness (IMCI)
- Community IMCI Procedural Manual
- Manual on Growth and Development of Children Ages 0 to 9
- Basic Manual on Micronutrient Supplementation
- Facilitator's Manual for Integrated Nutrition Care (INC)
- Health Promoter Procedures Manual
- Mother-Baby Package: Implementing Safe Motherhood in Countries

Integrated Adolescent Health Care:

- National Program for Integrated Adolescent Health Care
- Standards for Integrated Adolescent Health Care
- Strategic Plan for Integrated Adolescent Health Care
- Treatment Guidelines for the Leading Adolescent Health Problems
- Educational Guidelines for Treating Adolescents with Reproductive Health Complications
- Tool for the Evaluation of Nutritional Status in 10-19 Year-olds
- Dietary Guidelines for Adolescents and Women of Childbearing Age
- Counseling Guidelines for Adolescent Health Care

Integrated Women's Health Care (and others):

- National Technical Directives on Caring for Women during Pregnancy, Delivery, Puerperium, and Care of the Newborn

Technical Standards for the Prevention and Control of Cervical Cancer

- National Health Care Standards for Individuals Affected by Family Violence
- Family Planning Standards
- Clinical Care Guidelines for the Leading Causes of Obstetric Morbidity at the Third Level of Care
- Instrument to Evaluate the Nutritional Status of People 20 to 60 Years of Age
- Program for the Prevention and Control of Cervical Cancer
- Salvadoran Technical Standard for Iodized Salt
- Salvadoran Flour Standard: Corn Flour
- Salvadoran Flour Standard: Wheat Flour
- Salvadoran Sugar Standard: Specifications

Integrated Men's Health Care:

- National Model for Integrated Men's Health Care
- National Intersectoral Plan for the Prevention and Control of Tobacco Use in El Salvador
- Manual of Guidelines for the Implementation of the Community-Based Rehabilitation Strategy
- Standards for Integrated Men's Health Care
- National Plan for the Prevention and Control of Chronic Non-Transmissible Diseases

Integrated Health Care for the Elderly:

- National Model for Integrated Health Care of the Elderly
- Operations Manual for Integrated Health Care of the Elderly
- National Program for the Prevention and Control of Hansen's Disease (Leprosy)
- Clinical Guidelines for Primary Health Care of the Elderly
- Standards for the Control of Hansen's Disease
- Procedural Manual for the Bacteriological Diagnosis of Hansen's Disease
- Clinical Care Guidelines for Hansen's Disease
- Technical Standards for Health Rehabilitation of the Disabled, CONAIPD 2005

Integrated Environmental Health Care (among others):

- Standards and Procedures for the Promotion of Environmental Health
- Salvadoran Required Standard for Potable Water Quality
- Salvadoran Required Standard for Bottled Water

Manual for Water Systems Operations

- Technical manual for the management of dangerous infectious solid waste generated by health facilities located in areas lacking systems for collection, transport, treatment, and final sanitary disposal.
- Manual for the control of fixed-source emissions.
- Technical manual for the management of dangerous infectious solid waste generated by health facilities located in areas that have systems for collection, transport, treatment, and final sanitary disposal.

Technical sanitary standards for authorizing and monitoring of food establishments

- Technical sanitary standards for the installation, use, and maintenance of dry (non-flush) latrines.
- Technical sanitary standards for the authorization of the installation and functioning of pig farms.
- Technical sanitary standards for authorizing the installation and functioning of apparel manufacturing industries.

Oral Health Unit:

- Technical Standards for Dental and Oral Health
- Dental and Oral Health Care Guidelines
- Oral Medicine Procedures Manual
- Infection Control Manual for Dental and Oral Health Practice
- Atraumatic Restorative Treatment (ART) for Dental Caries, Experience in El Salvador

National Mental Health Program (among others):

- Standards for Integrated Mental Health Care
- Standards for the Treatment of Personnel Addicted to Psychoactive Substances
- Clinical Care Guidelines for the Most Frequent Mental Health Problems
- Clinical Care Guidelines for Persons Addicted to Psychoactive Substances
- List of Medicines and Basic Equipment
- Recording and Notification Instructions
- Regulatory Law for Drug-Related Activities

Operating Regulations for Institutions and Facilities that Provide Care to Drug Addicts

- Clinical Care Guidelines for Persons with Epilepsy
- Model for Crisis Intervention in Emergencies and Disasters

National STI/HIV/AIDS Program:

- Integrated Care Policy for the HIV/AIDS Epidemic
- Treatment Protocols for Persons Infected with HIV
- Methods Manual and Educational Modules for Persons Living with HIV/AIDS
- Facilitators' Manual for HIV/AIDS Counseling
- Guidelines for Prevention of Mother-to-Child HIV Transmission
- Sexually Transmitted Infections: Treatment Standards and Procedures
- Guidelines for the HIV Post-Exposure Prophylaxis (PEP) Information System
- Guidelines for HIV/AIDS Pre- and Post-Test Counseling
- Law and Regulation for the Prevention and Control of the Infection Caused by the Human Immunodeficiency Virus
- Training Manual for HIV/AIDS Awareness and Education, emphasizing counseling and voluntary testing, for the national health sector
- Guidelines for Universal Biosafety Measures
- Guidelines for the Care of Mobile Populations
- Health Care Guidelines for Prisoners
- Nutritional Management Guidelines for Persons Living with HIV/AIDS
- Infection Control Manual for Dental and Oral Health Practice

Nursing Unit (among others):

- National Policy on the Training and Utilization of Nursing Human Resources
- Nursing Procedures Manual
- Technical Guidelines and Nursing Care: Dressing Procedures
- Code of Ethics for the Nursing Profession in El Salvador
- Nursing Care Guidelines for Patients with Surgical Drainage
- Nursing Protocols for the First and Second Levels of Health Care
- Technical Guidelines and Nursing Care in Dressing Procedures
- Guidelines for Applied Nursing Care of Children
- Guidelines for Applied Nursing Care of Adults
- Quality Standards and Indicators Manual for Nursing Care
- Hospital Nursing Supervision Manual
- Organizational and Operational Manual for the Hospital Sterilization Plant
- Nursing Manual: Technical Guidelines for the Prevention and Control of Nosocomial Infections
- Model: Teaching-Service Integration for Training Nursing Human Resources in El Salvador

National Tuberculosis Prevention and Control Program:

- Standards for the Prevention and Control of Tuberculosis
- Technical Guidelines for the Diagnosis of Tuberculosis by Direct Microscopy

DOTS Training Modules for the SIBASI

- Tuberculosis curriculum for undergraduate training in schools of medicine and nursing.

Technical Unit for Drugs and Medical Supplies (UTMIN):

- Official Drug List

- Official Medical Supplies List
- Official Orthopedics List
- Technical Guidelines for Reporting Suspected Drug Treatment Failure
- Technical Guidelines for Reporting Suspected Adverse Drug Reactions

Ionizing Radiation Regulatory Unit (UNRA):

- Special Regulations for Radiological Protection and Safety
- Technical Standards for the Operation of Industrial Gammagraphy Equipment
- Technical Standards for the Operation of Industrial X-Ray Radiography Equipment
- Technical Standards for the Use of Radioactive Sources in Brachytherapy
- Technical Standards for the Use of Unsealed Radioactive Sources in Nuclear Medicine
- Technical Standards for the Operation of Teletherapy Equipment
- Technical Standards for Quality Control Procedures for X-Ray Equipment Used in Medical and Dental Diagnosis
- Technical Standards for Diagnostic, Intervention, and Dental Radiology
- Documents containing administrative/operative aspects of the services provided and the systematization of the information they generate.

Health Information Unit:

- Technical Standards for the Departments of Statistics and Medical Documents in Hospitals
- Technical Standards for the Departments of Statistics and Medical Documents in the First Level of Care
- Standards for the Recording and Processing of the Causes of Morbidity and Mortality Treated in Health Facilities
- Guidelines for Priority, Standardized Health Indicators, 2004
- Instructions Manual for the Daily Activities Log
- Health Promoter Information System Manual

Directorates and SIBASIs:

- Manual for the Directorate of Planning
- Manual for the Directorate of Regulation
- Manual for the Directorate of Quality Assurance
- Manual for the Directorate of Administration and Finances
- Manual for the SIBASI
- Law of the SIBASI, 2005
- Code of Health, 1998
- Proposed Code of Health

Research and Evaluation Unit:

- Methodological Guidelines for the Development of Health Research Protocols
- Guidelines for the Development of Technical Standards for Health or Administration

Others:

- Operations Manual for the Expansion of Health Services Coverage, 2005
- Referral and Counter-Referral of Patients/Users, 2002
- “Standards for Referral and Counter-Referral” of the ISSS, MSPAS, Military Hospital, and Teachers’ Welfare, 2006 (in process)
- Methodological Guidelines: Community Organization and Planning for Disaster Reduction