Annex 11. *EL SALVADOR*

Background

In 2010, the total population of El Salvador was estimated at 6.2 million,[149] with a natural growth rate of 1.4% in 2005-2010, and demographic dynamics influenced by high levels of emigration.[150] El Salvador has been classified by the World Bank as a lower-middle-income economy[151] with a GDP per capita (in current US$) of 3,519 for the year 2010.[152] Life expectancy at birth in El Salvador is currently estimated at 72 years.[153] In rural areas, where an estimated 37.3% of El Salvador's population lives, GDP per capita is only one third of that in urban areas, the literacy rate is almost 20% lower, life expectancy is six years shorter and the rate of chronic and global malnutrition is twice as high. Since the civil war ended in 1992, El Salvador has enjoyed progressive political stabilization and democratization, but still faces a series of challenges including: compliance with and application of labour legislation; enforcement of criminal law; dialogue with civil society about major pieces of legislation and institutional reforms; and financing for human rights institutions.

Morbidity and mortality

Non-communicable diseases and injuries are increasing steadily at national level, while in mostly deprived areas illnesses associated with poverty and underdevelopment still prevail; coordination between the public service providers is poor or inexistent; access to health services is limited; only about half of the population suffering from an illness or accident receive medical assistance; the allocation of resources amongst public health institutions is inappropriate; health spending is low and fragmented; and the quality of care provided to citizens is poor.[154] Lack of access to drinking water and basic sanitation together with malnutrition, environmental pollution and degradation are the primary causes of illnesses.[154] An estimated 35% of households remain in extreme poverty with limited access to health services and education.[154]

El Salvador is one the few countries in Latin America considered in crisis with regard to human resources for health (HRH).[155] HRH maldistribution is but one of those challenges to overcome in order to assure universal quality of health care.

The health system in El Salvador is largely centralized and administrative, fiscal, and political decisions related to health services provision and the health system are made at the central level.[156] Health in El Salvador is differentiated into public and private sectors. The public sector includes MSPAS (Ministerio de Salud Pública y Asistencia Social) which covers 80% of the country's population, ISRI (Instituto Salvadoreño de Rehabilitación de los Inválidos), ISBM (Instituto Salvadoreño de Bienestar Magisterial) which covers only teachers and their families, BSM (Batallón de Sanidad Militar) which covers only active and retired members of the Armed Forces, ISSS (Instituto Salvadoreño del Seguro Social) covering formal health workers and their families and FOSALUD (Fondo Solidario para la Salud); while the private sector includes for-profit and not-for-profit organizations.[157]

The MINSAL's National Health Strategy (2009-2014) has been launched by the government with the aim to address the issue of fragmentation of the health sector and ensure universal coverage, having as the most prominent aspect primary health care within an Integral and Integrated Public Health Care Service Network (*RedIntegral e Integrada de Servicios de Salud* or RIISS).[158] The Integrated health networks

comprise a group of organizations providing or making the necessary arrangements to deliver integrated health service to a population within specific boundaries, and it is accountable for its clinical results and fiduciary performance.[158] The National Health Strategy 2009-2014 seeks to increase coverage and equity of access to health services, improve the quality of services, and strengthen management of information systems to enhance the monitoring and oversight capacity of MINSAL.[158] Contrasting with the pyramidal health structure that predominates until now, the newly proposed health reform aims at constructing an integral and integrated health services network, close to the communities, families, and individuals, trying to make health equity a reality. In this new model, the primary health care level will be provided by the Family Health Community Teams (ECOS Familiares or Equipos de Salud Familiar or Family Health Teams) and the Specialized Family Health Community Teams (ECOS Especializados), which should be able to provide 95% of health care needs.[159] It is expected that each ECOS Familiares will be responsible for the provision of promotional and preventative health services to about 600 families, having the community health workers ("Promotores") as direct contact points with the community, similar to the Brazilian Family Health teams.

Significant inequalities in health care financing exist between the different health sub-systems, with the national health service (NHS) being persistently underfunded.[158] High out-of-pocket spending on health care has led to a reduced use of health services in El Salvador,[134] representing a serious barrier for financial access to health services.[158] According to the 2008 Multi-Purpose Household Survey, only 51% of people who became ill or were injured sought medical assistance, while the remaining chose to self-medicate or avoid assistance altogether.[158]

Decentralization policy

Ever since 1999, when the Council of Health Sector Reform was formed, the health system was described as being a centralist model, basically excluding a democratic health policymaking process.[156] In the National health System proposal (2007),[160] decentralization was conceived as a gradual transfer process of authority and policy decision-making attributions, with human, physical, technical, and financial resources transferred to other local levels closer to end users, with the aim to improve an equitable performance of the health system. It was also conceived as a process of responsibilities transferred to regional and local levels, as well as including accountability mechanisms. It acknowledged that explicit political, financial, managerial, and administrative mechanisms, goals, and instruments would need to be developed in order to fulfill the desired objectives. Hopefully the last changes proposed by the Ministry of Health as part of the new health reform will successfully face the remaining health inequities, and ECOs Familiares will truly provide health care to the communities by functioning closer to them.[159]

Situational analysis of MLHW

National HRH strategic plan and policy: MLHW

The new government has recently started the implementation of a Health Reform that introduced a new Human Resources Policy containing a strategic plan, which establishes four main areas of work: employment of sufficient personnel and adequate distribution of health staff as needed under geographic, demographic, and equity criteria; institutionalization of health public servant careers; establishment of adequate labour conditions and systematic training programs,[155] thus consolidating a previous proposal to address the scarcity of the health workforce in underserved areas of the country.[161]

In both the Health Reform and the concurrent HRH strategic plan primary health care is stated as the cornerstone aspect, and accordingly promotion and prevention are emphasized instead of an exclusive focus on curative health services, taking into account that health has social determinants. For accomplishing the task of elevating these aspects of health, the family health teams (ECOS Familiares) should work together, having the responsibility of a number of families each team. This new approach must take an innovative look at the long-term needs in terms of deployment and retention of the health workforce. Thus the policy also prioritizes full-time work contracts, as a way to reduce the side effects of part-time work and dual practice, although wage reform has so far not been envisaged. A thorough labour market study that considers offer and demand, pre-service and in-service training, professional development, continuous education, supervision, certification and other regulatory aspects have been identified as important components of the strategic plan. This policy is driven by the long-term goal of achieving universal access to quality health care and to accomplish the health-related Millennium Development Objectives (MDG) and beyond. Thus, maternal and child health, as well as prevalent communicable disease, non-communicable diseases and injuries are priority health problems that should be addressed by competent and motivated health workers deployed across the country, with focus on the neediest segments of the populations, located in rural areas and in urban slums. Particular incentives will also need to be created in order to retain health personnel in rural areas and underserved areas,[155] but evidence-based incentives and motivations need to be developed and implemented, most likely as comprehensive attraction/retention packages tailored to different health worker cadres, if maldistribution is going to be effectively overcome. Although it is not specifically addressed to MLHWs, this strategic plan is in line with the Health Reform that privileges universal coverage at primary level, where mid-level health professionals are considered key providers of health care services, along with doctors and other cadres such as community health workers.[155] The first phase of the Health Reform started in 74 municipalities, the second phase was implemented in 51 municipalities, in 14 country departments, with the establishment of 380 Family ECOS and 28 Specialized ECOS up to February 2011, with the stated goal of covering the whole country by 2014.[162]

This reinvigorated interest in human resources for health serving the interests of a reinvigorated primary health care philosophy has strong leadership coming from the central government, particularly from the Ministry of Healthm which started the process.[155] It is expected that the HRH strategic plan will also benefit from a wider consultation process with all stakeholders, particularly with civil society organizations. So far the original strategic plan has been the result of a comprehensive desk review and a national level consultation process promoted by a Special Commission on HRH, which reveals the utilization of a cross-sector participatory strategy at national level.[161] Sectors that have participated in the consultation process include the academic training institutions, those that provide health services, health workers' representative organizations, and national level experts.

Although the previous strategic plan[161] has underlined the importance of taking into account aspects such as planning, education, recruitment and retention, regulation, supervision, monitoring and evaluation, costing, as well as managerial aspects and the necessary equity lens, these still need to be concretely expressed in terms of clear objectives, tools, responsibilities and deadlines, particularly at local level.

Situation analysis

In the document describing the results of the first measurement of regional goals on HRH in El Salvador (*Resultados de la Primera Medición de las Metas Regionales de Recursos Humanos Para la Salud en El Salvador. Informe Preliminar*) recently elaborated by the Ministry of Health (MSPAS), aimed at serving as

a baseline on which monitor the progress achieved over time, an evaluation of the Institutional Information Systems on Human Resources of Health (SIRHI) is included.[162] There is a specific item asking about the existence of an updated information system that integrates the inventory of health workforce, including number of health workers, specific health cadres, place of deployment, and educational levels. The answer to that question was negative in the report, highlighting the pending task of strengthening the information systems so they can become fully functional and able to provide updated, reliable and accessible information on diverse aspects related to HRH, which is necessary to monitor and evaluate the effects of interventions already implemented and of those whose implementation is being considered. Actually, there is the explicit commitment of the diverse institutions of the public health sector to accomplish this task, and the development and maintenance of an institutionalized Observatory of Human Resources for Health is considered a key proposed component.[161]

Types of mid-level health workers

Mid-level health workers in El Salvador include mainly nurses, nurse technicians, technicians, nutritionists, dentists, and laboratory technicians. We will focus the analysis per cadre on nurses and nurse technicians, as they constitute the main health workforce in charge of health services provision, along with doctors.

Table 56 below shows the distribution of health workers in the public health sector of El Salvador, by institution to which they belong.[159] Clearly MSPAS emerges as the main employer for all health workers, followed by ISSS and FOSALUD. In MSPAS nurse technicians constitute the main workforce based on their number, followed by the nurses and then by general practitioners and specialist doctors. As it has been described above, a doctor, a nurse, a nurse auxiliary and a driver ("Motorista") compose each ECO Comunitario (Community Team), the basic health team considered by the new Health Reform for provision of primary health care.[159] We have not included the "Motorista" in the table below that, although we must underline that this cadre acts as the driver and also as an auxiliary with administrative duties, being an important member of the ECO team.

Table 56. Distribution of health workers in the public sector, by institution.							
Health cadre	**INSTITUTION**						
	MSPAS	**FOSALUD**	**ISSS**	**ISRI**	**ISBM**	**BSM**	**TOTAL**
General practitioners	1,663	482	741	7	113	42	3,048
Specialist doctors	1,618	87	2,435	45	145	126	4,456
Administrative doctors	222	0	0	0	0	0	222
Resident doctors	748	0	230	0	0	30	1,008
Medical students in social service	366	0	0	0	0	0	366
Interns	385	0	0	0	0	0	385
Dentists	468	222	169	5	65	59	988
Dentistry students in S.S	180	0	0	0	0	0	180
Nurses	2,412	322	1,039	15	0	79	3,867
Nurse technicians	3,468	46	1,876	47	0	207	5,644
Nutritionists	283	0	0	0	0	0	283
Anesthesiologists	321	0	128	0	0	22	471
Epidemiologists	18	0	0	0	0	0	18
Health educators	47	0	0	0	0		47
Other/technicians	2,230	58	756	8	4	106	3,162
Laboratory technicians	818	30	337	2	1	21	1,209
Physiotherapists	96	1	160	97	0	11	365
Pharmacists	104	0	386	0	2	3	495
Environmental specialists	792	0	0	0	0	0	792
Community Health Workers*	2,751	68	197	0	0	0	3,016
Psychologists	86	9	39	0	10	7	151
Maternal and child health workers	0	29	69	0	0	0	98
TOTAL	19,076	1,354	*8,562	226	340	713	30,271
Source: The World Bank. Republic of El Salvador. Strengthening Public Health Care System Project. 2011							

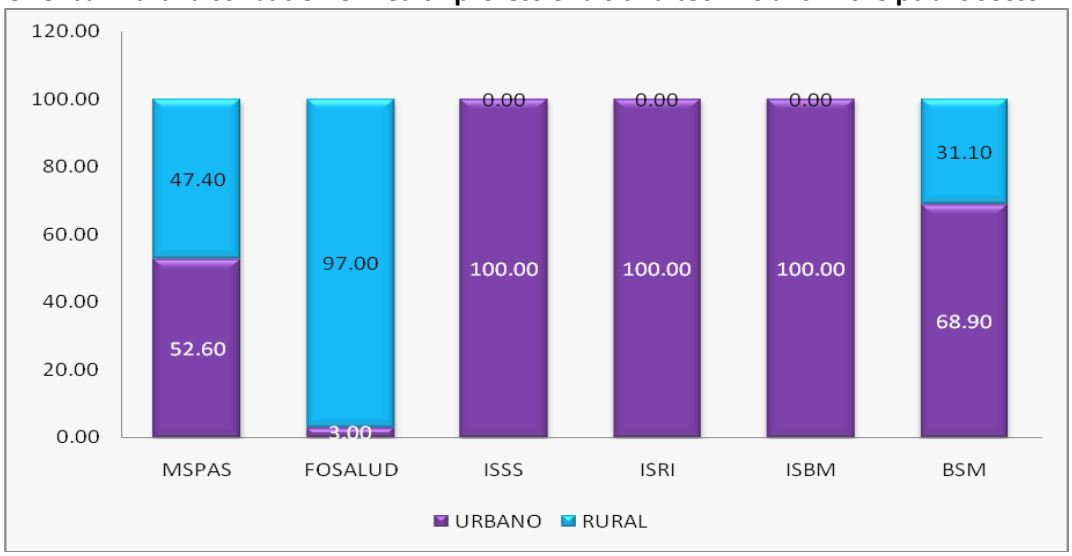
Table 57 displays the distribution of health workers by institution, distinguishing clinical professional and technical levels from those fulfilling administrative duties. MSPAS concentrates again 75% clinical professionals and technicians and 25% of administrative workers.[159] Similarly, we have not included the "Motorista" in this table, although this cadre is a member of the ECO team in the Health Reform recently launched.

Table 57. Professional, technician and administrative health workers in the public sector, by institution.					
INSTITUTION	**PROFESSIONALS AND TECHNICIANS**		**ADMINISTRATIVES**		**TOTAL**
	NUMBER	**%**	**NUMBER**	**%**	
MSPAS	19,076	75%	6,364	25%	25,440
FOSALUD	1,354	91.70%	122	8.30%	1,476
ISSS	8,562	67.10%	4,192	32.90%	12,754
ISRI	226	79.60%	58	20.40%	284
ISBM	340	100%	ND	0%	340
BSM	713	64.90%	386	35.10%	1,099
TOTAL	30,271		11,122		41,393
Source: Human Resources Units: MSPAS, ISSS, ISRI, ISBM, BSM (November 2010).					

With regard to urban-rural distribution of health professionals and technicians, this varies substantially by institution (Figure 19). Thus about 53% of them are working in urban areas in MSPAS, about 69% in BSM, 3% in FOSALUD, while ISS and ISRI do not display health workers in rural areas. This illustrates how primary level health care is limited to FOSALUD and MSPAS and to a lesser degree to BSM, whereas ISSS,

ISR and ISBM focus on curative health services provided mainly, if not exclusively, at the second and third levels of health system.

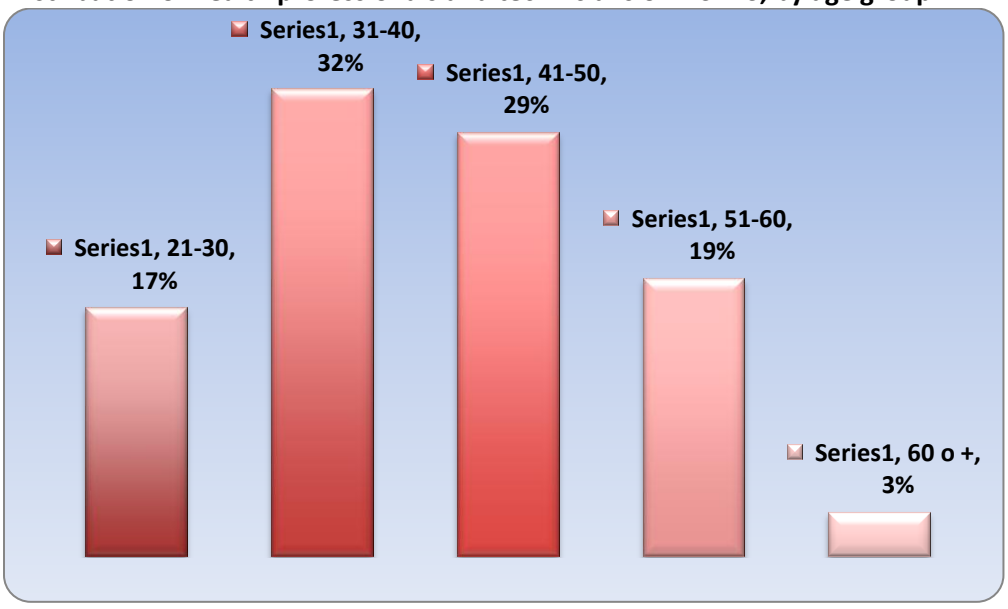
Figure 19: Urban-rural distribution of health professionals and technicians in the public sector.



Source: Human Resources Units: MSPAS, ISSS, ISRI, ISBM, BSM (November 2010)

Figure 20 shows that 80% of MSPAS health professionals and technicians are between 31 and 60 years old, while about 60% of them are between 31 and 50 years old. Although illustrative of the general situation, it would be important to disaggregate this analysis by health cadre, as along with other personal characteristics, it would provide important information about its influence on job choices when assessing potential attraction and retention strategies based on studies of stated job preferences.

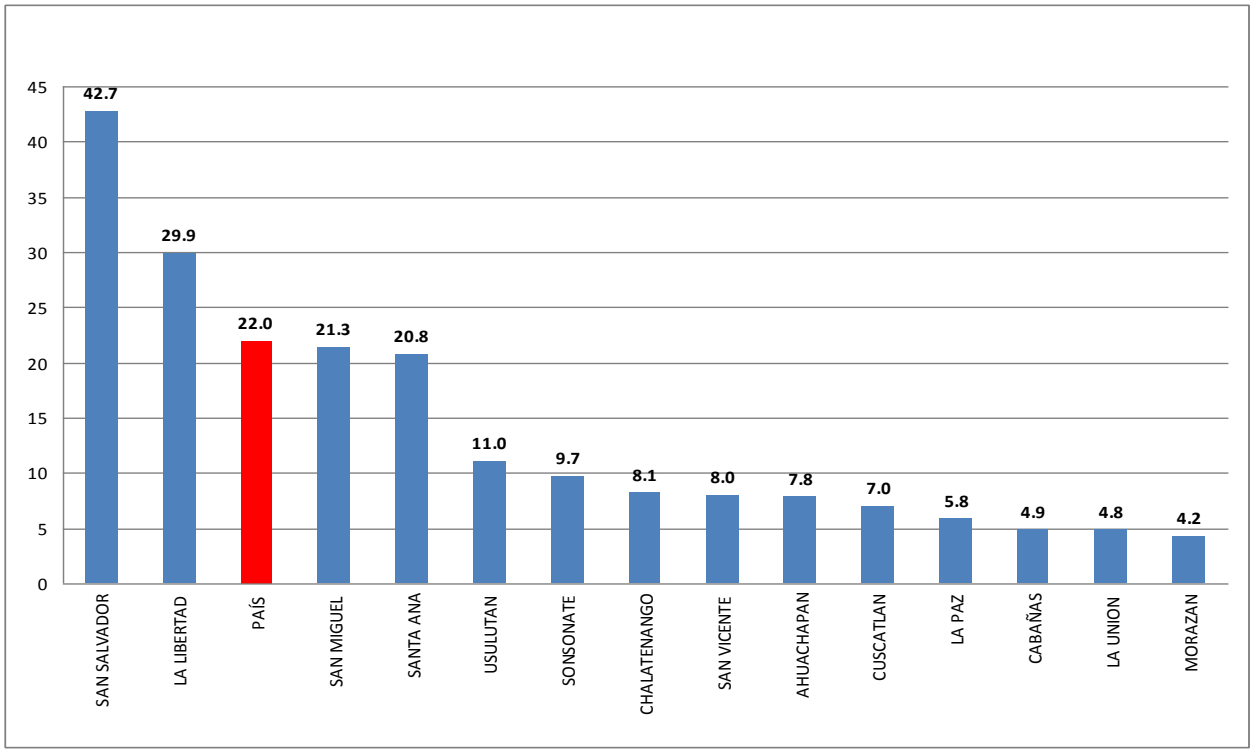
Figure 20. Distribution of health professionals and technicians of MSPAS, by age group



Source: Human Resources Unit: MSPAS, November 3 2010.

Figure 21 shows the density of all health workers by department in El Salvador, according to information obtained from 2007 National Census.[163] Health workers are concentrated in the capital city and other large inner cities of the country. Except San Salvador and La Libertad, all the departments fell below the minimum of 23 doctors, nurses, and midwives per 10,000 population recommended as the minimum threshold necessary to attain adequate coverage of some essential health interventions and core MDG-related health services. As all health workers were included in the calculations, the density of these three health worker cadres should be actually lower, illustrating thus the urgency of implementing adequate production, deployment, attraction and retention strategies aimed at achieving an improved distribution of essential health workers for providing universal health access. In addition, a more in-depth analysis of the workforce distribution that takes into account rural and urban distribution within each department is needed to reveal the magnitude of the inequities and to adequate planning the need of HRH at local level.

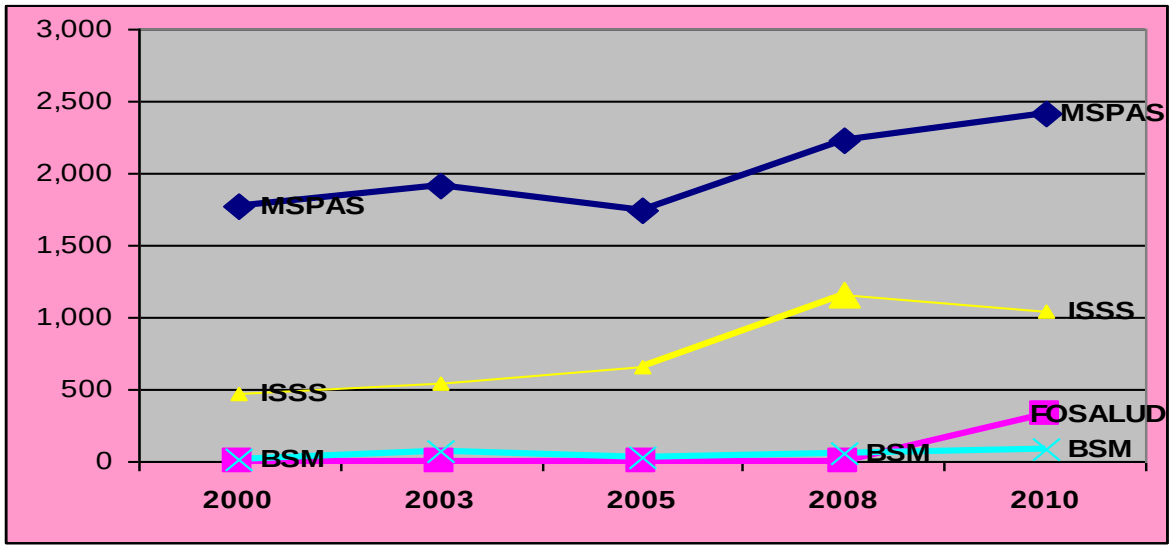
Figure 21. Density of health workers per 10 000 population by department, El Salvador, 2007.



Source: Dirección General de Estadística y Censos. VI Censo de Población y V de Vivienda. 2007.

Figure 22 shows the time trend in the number of nurses hired on a temporary basis ("contratadas") in the different institutions of the public sector. There is an increasing tendency in all of them, except for BSM, which is stagnated. With the progressive implementation of ECOS, a re-assessment of demand for HRH able to work together as a family team will need to be performed, along with an appropriate market labour study that determines demand and offer, contract and salary schemes, and the role that the public but also private sector will have in this new context. In addition, the profile of health workers needs an urgent re-appraisal, as they are expected to be prepared for providing more promotional and preventive services while at the same time the clinical performance at curative levels should be assured.

Figure 22: Time trend of nursing personnel hired on a temporary basis in the public sector, by institution.



Source: The World Bank

We were not able to obtain disaggregated information about the density of mid-level health providers by cadre/specialty, urban/rural, public/private or gender. Similarly, there was no disaggregated information on vacancy rates, turnover rates, attrition rates, absenteeism, or unemployment rates.

Information was available about projection of health personnel needs in the different institutions of the public health sector (Table 58), and about the geographical distribution of health workers by cadre and according to the established phases of the Health Reform. Thus Table 58 shows the number of appointed health workers on a temporary basis ("contratados"), by region, as part of first phase implementation of the Health Reform, which started in July 2010 and was aimed at reaching 72 municipalities with a high prevalence of extreme poverty and child chronic malnutrition. All these newly deployed health workers were assigned to primary level facilities.

Table 58. Deployment of health professionals and technicians by region, as part of implementation of first phase of Health Reform, MSPAS.						
Health cadre	**1st Phase 2010, Community Health teams**					
	Regions					
	Occidental	**Central**	**Metropolitan**	**Paracentral**	**Oriental**	**TOTAL**
General practitioners	21	32	21	35	52	161
Pediatricians	1	4	1	2	6	14
Obstetricians	1	4	2	2	6	15
Medical internists	1	4	1	2	7	15
Nurses	16	40	8	31	64	159
Nurse technicians	15	26	8	24	37	110
Psychologists	2	6	3	3	7	21
Nutritionists	3	6	2	3	7	21
Dentists	3	6	4	6	0	19
Lab Technicians	1	1	2	2	1	7
Polyvalent health workers	16	55	8	39	68	186
Statisticians	2	4	5	3	6	20
Community health workers	67	136	57	129	174	563
Physiotherapists	0	0	0	0	0	0
Trainers/Teachers	1	4	2	2	1	10
Other technicians	0	0	0	0	0	0
TOTAL	150	328	124	283	436	1321
Source: Direction of first level health care, MSPAS, December 2010.						

Table 59 shows the projected needs of health personnel for staffing Specialized Community Health Teams (Specialized ECOS) for 2011, as planned for the second phase of the Health Reform. “Motoristas” (drivers) were not considered in this table, although they are also members of each ECO at this level as well.

Table 59. Projected positions for Specialized Community Health Teams, second phase of Health Reform, MSPAS 201.							
Health cadre	**Specialized Community Health Teams (Specialized ECOS)**						
	Region						
	Occidental	Central	Metropolitan	Paracentral	Oriental	Central level	TOTAL
General practitioners	12	4	0	9	15	---	40
Pediatricians	4	2	1	3	3	1	14
Obstetricians	4	2	0	3	4	---	13
Medical internists	4	2	1	3	3	---	13
Nurses	10	4	1	23	20	---	58
Nurse technicians	19	5	2	19	14	---	59
Psychologists	3	2	0	2	2	---	9
Nutritionists	2	2	1	2	2	---	9
Dentists	2	3	1	1	9	---	16
Lab technicians	7	4	0	7	8	---	26
Polyvalent health workers	47	15	1	40	44	---	147
Statisticians	2	1	1	2	2	---	8
Community health workers	25	22	5	45	79	---	176
Physiotherapists	5	6	2	5	10	---	28
Trainers/Teachers	4	2	0	3	9	---	18
Other technicians	52	56	57	52	60	7	284
TOTAL	202	132	73	219	284	8	918
Source: Direction of first level health care, MSPAS, December 2010.							

MLHW typology

The exact number, typology and distribution of health workers en El Salvador is not available, and a census with updated information at national and local level is overdue.[164] Nurses and Nurse technicians constitute the main health workforce in addition to doctors, community health workers and the driver or "Motorista", particularly for the accomplishment of the objective of achieving universal health coverage through the most recent Health Reform launched by the government.[156] Actually each ECO (or Community Team), the key health team for providing health care at primary level in the new Health Reform, will work on the basis of a doctor, a nurse, a nurse auxiliary, community health workers ("Promotores") and a driver ("Motorista") as core members.[159] As this case study refers to the role of mid-level health workers, the following sections are specifically referred to nurses and nurse technicians. Maternal and Child health workers (*Materno Infantiles*) are also mid-level health workers trained by the Universidad de El Salvador, the state university. Their primary responsibility is to provide basic health care to the low risk pregnant women and to provide basic child health care limited to monitoring growth of children (at first and second level of health system), and they are not allowed to be in charge of deliveries. In Table 56 they appear identified as a differentiated health cadre in FOSALUD and ISSS. They are included as technical level health workers in MSPAS, as the institutional information system does not include this level of information. Of note in El Salvador there are not midwives trained at university level that can provide prenatal care of pregnant women, be in charge of deliveries and of postnatal health care of women, like in other countries. *Materno Infantiles*, as it was just mentioned, play a rather limited role in the provision of basic maternal and health care.

Nurses

Demographics/Background

Nurses are also commonly called *Tecnólogos en Enfermería* (if they are males) or *Tecnólogas en Enfermería* (if they are females). There are seven universities in El Salvador with medical health sciences schools able to provide professional training of human resources for health in El Salvador, namely Universidad de El Salvador, Universidad Evangélica de El Salvador, Universidad Dr. José Matías Delgado, Universidad Andrés Bello, Universidad Dr. Alberto Masferrer, Universidad Nueva San Salvador and Universidad Autónoma de Santa Ana.[159] The nurse schools of the universities provide a 5-year nursing program plus one year of social service leading to a Bachelor's degree (Licenciatura en Enfermería) The National Nursing School provides a 4-year nursing program leading to the title of Nurse Technician. For training of technician level health workers and technologists, there are also technological institutions, among them the Instituto Tecnológico de Educación Superior and the Instituto de Formación de Profesionales de la Salud.[159]

Recruitment

The academic institutions in charge of providing nurse training (universities and institutes) determine the entry quota and requirements, which need further progress in establishing highly acceptable uniform standards. Coordination between the Ministry of Health and the training institutions to establish a recruitment policy and entry standards and quotas in agreement with health needs of the population is rather weak. Also, there are no pre-specified bonus points for applicants from rural and remote areas or from urban disadvantaged areas, or for those coming from ethnic minorities.

Training

Nursing pre-graduate training takes 4 years, the first cycles being devoted to what are considered the foundations of the career, and the later ones aimed at putting students in direct contact with health facilities and patients. The typical pre-graduate training program (*Pensum de Estudios*) for Nurses at Institutes is presented below.

First Year:

a. Cycle I: Sociology, Psychology, Biostatistics, Clinical Microbiology and Parasitology, Anatomy and Physiology
b. Cycle II: Human Biochemistry, Epidemiology, Pharmacology, Foundations of Nursing I

Second Year:

a. Cycle III: Nutrition and Dietary Therapy, Methodology of Investigation, Nursing Ethics and Legislation, Foundations of Nursing II, Physiopathology
b. Cycle IV: Attention of Emergencies and Disasters, Didactic Technology, Adolescent and Adult Nursing I, Computing, Technical English I

Third Year:

a. Cycle V: Adolescent and Adult Nursing II, Community Health Nursing I, Geriatrics Nursing
b. Cycle VI: Maternal and Child Nursing I, Community Health Nursing II, Technical English II

Fourth Year:

a. Cycle VII: Maternal and Child Nursing, Surgical Nursing
b. Cycle VIII: Administration and Management of Nursing Services, Mental Health and Psychiatric Nursing

After satisfactorily completing their 4 years of pre-graduate training, nurse students perform one year of non-paid social services at the periphery or in rural areas. They can graduate with a Bachelor's degree upon finishing the social service period. The 5-year program offered by universities has a curriculum basically similar to that shown for the 4-year programs offered by institutes and the national Nursing School.

An evaluation of the pre-graduate training program is performed every 5 years by the representatives of the different institutions in charge of providing nurse training, in order to assure that it is in agreement with the aimed performance profile and the health needs of the population,[159] although such assessment may not be as regular and rigorous as it would be expected. A recent report underlines "inappropriate curricula and lack of forums to discuss and resolve differences between universities and PSPAS."[165]

On-going training is not as clearly defined as the pre-graduate training. It basically depends on the interest and capacity of the academic institutions, which most often focus on doctors´ needs. Refresher courses may also be offered by the different institutions of the public sector and to a much lesser extent by the private sector, but they are mainly planned and designed at central level, and may not be in accordance with the continuous education needs of mid-level health workers, particularly of those working in rural and underserved areas.[159]

Accreditation/Licensing bodies

A Public Health Superior Council (Consejo Superior de Salud Pública, CSSP), was established in 1956. It is composed by 7 professionals surveillance bodies (Professional Boards), each representing Medicine, Dentistry, Psychology, Veterinary Medicine, Chemistry and Pharmacy, Clinical Laboratory, and Nursing that includes technical careers.[159] The surveillance bodies have the responsibility of maintaining a record of all registered professionals and providing authorization for practice. In 2009, the numbers registered reached 58,763 health professionals authorized for practicing. The Council has also the function of authorizing, controlling and monitoring the health facilities, and the provision of drugs, equipment, and supplies.[159]

The standards and the periodicity of certification/accreditation processes are not clearly defined, however, and thus assuring an adequate performance of health workers and of the health system for providing quality health care is a remaining challenge. Once they graduate and are registered by the CSSP, both doctors and nurses are only required to pay an annual fee for maintaining their licenses.[165] There is no requirement for updating skills or knowledge, and therefore there is no incentive to continue learning and training after graduation.[165] Moreover, doctors and nurses who specialize are not required to sit for competency examinations in their specialty once they have completed their residencies or specialties. CSSP acts then as a mere registration body, without real accreditation and certification attributes.[165] Neither CSSP nor its Professional Boards have resources or procedures in place to ensure the quality of professional practice, and they do not maintain collaborative relationships with academic institutions or professional societies to discuss and implement improvements in curricula, instructional methodologies, or to implement assessments of professional competencies.[165] It is unclear from the consulted sources whether the existing standards were developed according to global recommendations such as those from the International Council of Nurses.

Training of trainers

Although there are postgraduate courses for nurses working as trainers at universities and institutes, formal and standardized programs tailored to their needs have not been implemented in El Salvador. Hopefully the new emphasis on primary health care through the introduction and expansion of Family Health Community Teams (ECOS Familiares or Equipos de Salud Familiar or Family Health Teams) and the Specialized Family Health Community Teams (ECOS Especializados) will stimulate a renewed interest in providing continuous training of nurse trainers, focused on reinforcing their expertise in primary health care teaching and practicing.[159] The ECOS or Community Teams included in their basic composition a doctor, a nurse, a nurse auxiliary, community health workers ("Promotores"), and a driver ("Motorista") who also accomplishes some auxiliary administrative duties.

Workplace

Nurses in El Salvador can work in the public or the private sector, at all levels of health care delivery (primary, secondary, and tertiary). Like doctors, nurse technicians, community health workers and "Motoristas", they are being incorporated at all levels of health care, but mainly at primary health level in all regions of El Salvador, as members of ECOS or Community Teams (Equipos de Salud Familiar).

Equipment and supplies

While provision of equipment, drugs, and supplies is reportedly acceptable in quality and periodicity at health facilities located in the main cities, it is perceived as being less than adequate at the primary health care level, where nurses and nurse technicians, together with community health workers, are being deployed, as part of the Health Reform aiming at emphasizing primary health care for reaching universal access to health care.[159]

Responsibilities

Nurses should be qualified to provide all phases of nursing intervention, at individual, family, and community level. They should be able to address both individual and public health problems. Individual health problems that are within their responsibilities are those of low and median risk and complexity. Specific clinical and surgical nursing responsibilities are dependent on the complexity of the health facilities where they work. Within the framework of the new health care model relying on Community ECOS, the nurse together with the rest of the family health team should remain at the basic community units of family health (Unidades Comunitarias en Salud Familiar, UCSF) so as to provide outpatient consultation care, while the remaining 2 days they are expected to make domiciliary visits, while the nurse and the nurse technician should remain at the health facility whenever the doctor makes a field visit.[162] Nurses should perform an integrated assessment of maternal and child health problems, as far as possible together with the doctor, and are supposed to perform home follow-up visits whenever deemed necessary.[162]

Health Worker Performance, Cost Effectiveness

We were not able to find information about formal assessment efforts of mid-level health workers' performance, nor about cost-effectiveness studies of programs relying on mid-level health workers, although this is one of the objectives of the newly launched Health Reform.[159]

Supervision and monitoring

Nurses are being hired and deployed and are being incorporated gradually as key members of Family Health Community Teams (ECOS Familiares) and the Specialized Family Health Community Teams (ECOS Especializados), launched as an important component of the recent Health Reform, which is in process of implementation. Supervision and monitoring of these teams and their activities have been considered as important programmatic components to assure health worker performance and the quality of health care provided by these teams, and also to introduce the necessary improvements to implementation efforts of ECOS. However, a recent assessment found that in actuality the monitoring and supervision activities are performed in a patchy and erratic way, that they do not have concrete goals and indicators, and that supportive supervision is finding huge challenges in terms of availability of capable and motivated supervisors that may perform regular evaluation of activities performed by nurses and other members of ECOS and provide meaningful feedback.[165] At regional level, this report found that the directors of the Occidental and Oriental Regions presented summaries of the health situation in their areas using coverage and mortality indicators with a good level of analysis. In none of the regions the Monitoring and Evaluation Units of SIBASI systematically process evaluation information and make supervision and monitoring plans based on the results, although the units do have a document to evaluate management commitments for follow-up use.[165] All the health units visited in the study had a situation room with graphs showing local disease trends, coverage of preventive services, and maps of obstetric risk to ensure timely labour and delivery care. However, other processes related to pregnancy, such as postpartum and perinatal care, did not make use of these maps, even though health promoters do use integrated community maps to monitor maternal and childcare as well as conditions in the home.[165] The best example of a situation room was in the El Congo Health Unit in the Department of Santa Ana, Occidental Region. The information it contains is useful and continuously updated to make decisions in the municipality, down to the detail of showing addresses of pregnant women according to probable date of delivery. The systematization of this situation room surpasses MSPAS standards as a result of the initiatives of the directors of nursing and medicine and their health team in the community.[165]

Remuneration

Remuneration schemes are variable for nurses working in the different institutions of the public sector and depending on the level of health facilities where they have been deployed. Thus in MSPAS, for nurses working in first level health facilities the salaries range from US$ 220 to $772.34; and for those working at secondary and tertiary level from US$ 285.75 to $502.29.[166] For all health personnel including doctors, nurses, and nurse technicians, annual salary increases for health-care personnel are mandatory at 3% for cost of living plus additional performance-based merit increases of up to 5%. Thus performance that is considered excellent would lead to a 5% increase, very good 4%, and good (the lowest rating), 3%. Ratings are subjective and pro forma, and therefore there is no a real incentive to improve health workers' performance and efficiency or to apply fair and effective salary incentives.[165]

Career Progress (professional advancement)

Nurses can pursue postgraduate training courses at university level leading to specialist diplomas, or they can follow courses leading to a Master degree, particularly in public health or related fields, and therefore they can become involved in managerial and policymaking activities, but also in sexual and reproductive health. Nurses can apply and have access to these master training programs only after they graduate as Bachelors ("Licenciatura en Enfermería"). Nurses can also follow one-year specialty training

courses in health education or health administration leading to the corresponding diploma. There are also regulations on annual salary increases and additional salary bonuses for performance-based merits. However, a clear career progress or professional advancement scheme that can act as a real package of incentives promoting a culture of continuous improvement, based on performance and merits, is still a pending task that the Health Reform should take into account.

Retention

Although there is not a program of retention interventions specifically designed for nurses, the government recently introduced a new Human Resources Policy, which establishes 4 main areas of work, that is expected to work as a set of incentives for health personnel to remain in place, especially in rural and remote areas.[165] They include employment of sufficient personnel and adequate distribution health staff as needed under geographic, demographic, and equity criteria; institutionalization of health public service careers; establishment of adequate labour conditions and systematic training programs. The policy prioritizes full-time work contracts, to counteract dispersion of efforts of health personnel involved in dual practice (which is a situation concerning mainly doctors). Thus far wage reform has not been envisaged. A package of incentives based on good evidence, context-specific and health cadre-specific also will need to be created in order to retain health personnel in rural areas. Regarding evaluation and performance incentives, there is lack of competency evaluation for licensing, of certification for specialists, and of clear criteria for performance-based bonuses.[165] We commented above in the Remuneration section that although bonuses to remuneration schemes are considered and mandated, in reality they are not implemented on the basis of merit and performance, and thus, they do not seem to work as an effective incentive.[165]

Nurse technicians

Demographics/Background

Formerly known as Nurse Auxiliaries, they are also called *Técnicos en Enfermería* (if they are males) or *Técnicas en Enfermería* (if they are females) in El Salvador.

Recruitment

The training institutions establish the entry quotas for nurse technicians' applications. The current needs of nurse technicians for becoming members of ECOS as basic health provider teams, particularly at primary health care level, highlight the need of a coordinated recruitment policy and of defined entry quotas and standards that are in agreement with such health reform needs, and with the population health demands.

Training

The same institutes that are able to provide professional training of nurses and other health workers of technical level also offer training for nurse technicians.[159] including the Instituto Tecnológico de Educación Superior and the Instituto de Formación de Profesionales de la Salud.[159] Pre graduate training of Nurse Technicians lasts 2 years.

Courses included in a typical training program (*Pensum de Estudios*):
First year:

a. Cycle I: Sociology, Psychology and Mental Health, Foundations of Nursing I, Anatomy and Physiology, Microbiology and Parasitology
b. Cycle II: Epidemiology, Ethics and Legislation in Nursing, Foundations of Nursing II, English (technical level), Educational Technology

Second Year:

a. Cycle III: Nursing in Medicine and Surgery, Maternal and Child Nursing I, Computing
b. Cycle IV: Maternal and Child Nursing II, Community Health Nursing

After finishing these 2 years and like the Nurses, Nurse Technician students perform a non-paid Social Service for one year, in peripheral areas, and then they can graduate.

Accreditation/Licensing bodies

Nurse technicians need authorization from the Public Health Superior Council (Consejo Superior de Salud Pública, CSSP) to start their practice.[159] The surveillance body for technical level health workers has also the responsibility of maintaining a record of all registered nurse technicians. The same limitations stated above for regulation of nurses activities can be applied to accreditation processes for nurse technicians. The standards and the periodicity of certification/accreditation processes are not clearly defined, and thus assuring an adequate performance of nurse technicians cannot be assured. Similarly to doctors and nurses, once they graduate and are registered by the CSSP, nurses auxiliaries are only required to pay an annual fee for maintaining their licenses,[165] and they are not required to demonstrate formally that they have updated skills or knowledge.

Training of trainers

Nurse technicians receive training from several health professionals, including doctors, nurses and other specialists. The universities and academic institutes are supposed to have training programs for those trainers that should be focused on pedagogical issues, and also on theme topics related to their particular expertise field. In actuality, training of trainers focused on improvement of abilities for preparing nurse technicians is not an integral part of the educational plans in these institutions.[159] As part of the planned activities that are being prepared for wider implementation of the on-going Health Reform that put ECOS or Family Health Teams or Community Teams as a core component having nurse technicians as key members, MSPAS is looking for the development of a comprehensive training program that includes refreshment courses for nurse technicians and for trainers as well. However, coordination with universities and academic institutions will be needed if these efforts are going to be successful and sustained. Practical problems related to absence at health facilities when attending courses and to covering of fees will also need to be addressed.

Workplace

Like nurses, nurse technicians in El Salvador can work in the public or the private sector, and can be deployed at all levels of health care delivery (primary, secondary and tertiary). Currently they are being actively hired mainly by the MSPAS, and in a lower extent by the other public institutions, to be part of ECOS or Family Health Teams or Community Teams.[156, 159]

Equipment and supplies provided to them or to the facilities

As nurse technicians are part of ECOS, the same problems reported in adequacy and periodicity of equipment, drugs and supplies for doctors and nurses are basically applicable to nurse technicians, also being perceived as less that optimal.[159]

Responsibilities

Nurse technicians should ensure that family and individual patient records are available as needed, and also to check out permanently that equipment, drugs and supplies stock are in order and report any disruption. In specifically defined circumstances, the nurse technician can participate in the administration of medication to low risk patients.[162] Nurse technicians also support and assist nurses in nursing care of patients, making sure that they feel comfortable and that their personal biological needs are taken care of, but they are not allowed to make diagnoses or administer medications, let alone to prescribe them.[162] As member of the ECOS that are being implemented through the country, they should assist in the appropriate risk evaluation and follow-up of families visited by community health workers, and they should also assist nurses, doctors and other health professionals of ECOS to provide an integral health approach to families and individual members of families, with promotion and prevention as the cornerstones of such approach.

Health Worker Performance, Cost Effectiveness

Studies of health worker performance of nurse technicians and of cost effectiveness of programs they are inserted in are lacking. This is one the main challenges that the new Health Reform should address in advance, by planning monitoring of the primary health care provision through implementation of ECOS, but also by promoting independent impact evaluation that may go beyond the experimental paradigm of randomized controlled trials by including alternative approaches that may provide answers about failure and success factors and system wide effects of such interventions. Once the role of nurse technicians as members of the ECOS or Community Teams is well defined, integral evaluations of ECOS performance but also specific evaluations of nurse technicians' performance should be assessed.

Supervision and monitoring

Monitoring and supervision activities of team performance of nurse technicians and other members of ECOS viewed as integral Family Health Teams is being considered as the most relevant task, rather than focusing on individual health worker cadres. Before the current Health Reform that is being implemented in El Salvador, supervision and monitoring activities of nurse technicians, like those of other health workers, have been inadequate, erratic and patchy, without clear objectives and goals, without relevant indicators, with scarcity of trained and motivated supervisors, and with insufficient managerial capacity for setting meaningful monitoring plans and supportive supervision, let alone for developing meaningful feedback activities that may feel nurse technicians and other health workers that they work matter to the health system, and that they are receiving appropriate reconnaissance and promotion if their performance is good.

Remuneration

Current remuneration schemes for nurse technicians include differentiated amounts depending on the level where they are deployed. Thus, in MSPAS, at primary health level their salaries range from US$ 220 to $772.34, and at second and third level they range from US$ 285.75 to $502.29.[166] Reference remuneration levels and ranges may be different in other institutions of the public sector.

Career Progress (professional advancement)

One of the main challenges that the implementation of ECOS will surely face is that a clear scheme of professional advancement or career progress will need be designed and put into practice, which should include all members of these family health teams, including nurse technicians, of course. Until now, one of the few opportunities for nurse technicians to make progress in their career was to pursue further nursing training, but this was left to their individual initiative rather to a well-planned strategy of incentives. Mandate of annual salary increases and additional salary bonuses for good performance was subject of subjective rating, as it was discussed above for nurses, and therefore there has been not a real incentive to improve health workers performance and efficiency, or to apply fair and effective salary incentives.[165] Hopefully the reform will implement in an effective way a coherent policy of career progress that is based on performance and merits, and that is intertwined with adequate incentive packages, financial and non-financial.

Retention

We were not able to find evidence on implementation of effective retention interventions for HRH in El Salvador, nor for nurse technicians. Thus rigorous study of incentives and motivations for nurse technicians working within ECOS is needed in order to design appropriate retention strategies that are able to keep nurse technicians and other health workers in place, particularly at primary level. When designing those strategies, both financial and non-financial incentives will need to be considered, as there is evidence showing that financial incentives alone are not sufficient.

Key challenges

The main challenges to HRH that the health sector El Salvador must face within the new health reform that is being implemented are basically the same for all the health worker cadres. In particular, challenges to face with regard to formation, deployment and retention of mid-level health workers (mainly but not exclusively nurses and nurse technicians) need a common an integral approach. Incorporation of nurses as key members of ECOS in the new Health Reform led under the strong leadership of the Ministry of Health is an important step forward. Coordinated improvement of pre-graduate training standards, clear accreditation, and certification processes regulating practice of nurses based on rigorous competency evaluation are needed to ensure provision of quality health care. Better coordination between the Ministry of Health and the universities and other academic institutions is a condition to achieve better pre-graduate, in-service and postgraduate training processes and ensure the maintenance of minimum standards of competency and performance of health workers. Identification of specific incentive packages for retaining nurses in rural and underserved areas as members of ECOS is urgently needed. Development and effective implementation of a professional advancement scheme based on merits is a challenge still to be faced by the health system in El Salvador. An effective monitoring and evaluation framework of ECOS needs to be developed and implemented, with clear goals and input, output, outcome, and impact indicators. Evaluation should be better performed by

independent evaluators. Moreover, if success and failure factors are going to be identified and utilized for introducing improvements in the implementation of ECOS and other aspects of Health Reform, alternative evaluation approaches should be incorporated to the traditional ones aimed only at assessing whether the intervention works or not. Managerial capacity building is another challenge that should be considered, if policymaking decisions are going to be taken by informed, capable and motivated health managers, at both central and local levels. Finally, intended and unintended effects of the new interventions on the health system and on its building blocks and vice versa need to be considered when monitoring and evaluating the new interventions being planned and implemented within the new Health Reform, in order to make the improvements deemed pertinent in the implementation and evaluation process, and to avoid unnecessary harms to the health system.

Lessons learned

The following two sections refer to nurses and nurse technicians, unless otherwise stated. Although economic growth has shown a sustained tendency and poverty rates have decreased at country level, substantial socio-economic inequities persist at sub-national level, and also health inequities and insufficient access to quality health services. They are critical bottlenecks in the efforts to improve the health situation in El Salvador. The implementation of Family Health Community Teams (ECOS), which focus on primary health care and teamwork, is a fundamental step forward, and builds on national and international experiences such as the Brazilian Family Health Program. The HR information system is still far from being fully functional in spite of several health reform efforts. The progressive implementation of ECOS and its emphasis on primary health care has shown the need to reassess the demand for MLHW able to work together as a family team. It also highlighted the need to perform a labour market study that determines demand and offer, contract and salary schemes, and to reassess the role that public and private sector will have in this new context.

The new emphasis on primary health care is forcing reconsideration of the role of MLHW as members of teams (ECOS), which will need to be re-shaped during pre-service and in-service training of nurses and nurse technicians, so they are prepared for facing the resulting challenges and needs of teamwork.

In addition, the profile and scope of practice of MLHW needs a re-appraisal, as they are expected to deliver mainly promotional and preventative activities, while still maintaining clinical responsibilities. Inadequate provision of essential drugs, equipment, and supplies in inner regions has re-emerged as a limiting factor for a good performance of family health teams (ECOS). Lack of cost-effectiveness evaluations can prove to be dangerous and costly, avoiding the generation of local evidence on MLHW performance and performance of programs such as ECOS that rely on MLHW. Although widely considered important, monitoring and supervision activities of ECOS activities are proving a real challenge for the health reform implementation, due mainly to scarcity of trained and motivated supervisors. Integrated monitoring and supervision of whole family health teams (ECOS) should be considered instead of isolated supervision of individual cadres of such teams. Salary incentives can be stronger when implemented together with non-financial incentives in several settings. Rating for salary increase based on merits should be improved and the effects of these financial incentives should be evaluated along with those of other non-financial incentives.

Conclusions and recommendations for policy action

Social determinants of health including poverty and associated inequities are still serious limiting factors in the national efforts to improve the health situation in El Salvador. They should be effectively tackled with a multi-sectoral lens to increase the chances of success.

Implementation of Family Health Community Teams (ECOS) has benefited from a strong leadership of the MOH and from a wider consultation process with all stakeholders, particularly with civil society organizations. Sustainability of such leadership and commitment must be ensured. Adequate capacity building and funding are needed to strengthen the HR information system, in order to get timely and reliable information on HRH, in particular from MLHW. Coordinated efforts between the MOH and academic institutions are needed to successfully fulfill the pre-service and in-service training of nurses and nurse technicians beyond the clinical scope within the context of implementation of Family Health Community Teams.

Respected licensing and accreditation institutions and standards need to be clearly defined, to allow production of qualified MLHW and regular assessment of performance for license renewal. These standards should be further developed in concordance with the needs of the current reform, which focuses on primary health care and on teamwork.

Sustained support is needed for policymakers and researchers to perform formal evaluations of MLHW performance and impact evaluations of cost effectiveness of programs such as ECOS that rely on MLHW, as well as for effectively implementing integrated monitoring and supervision activities. Bundled attraction and retention incentives for MLHW based on adequate studies need to be designed, implemented and evaluated, to improve the deployment of a sufficient number where the needs are greatest, and to increase the chances for success of the current health reform relying on primary health care and teamwork.

Appendix 11.1

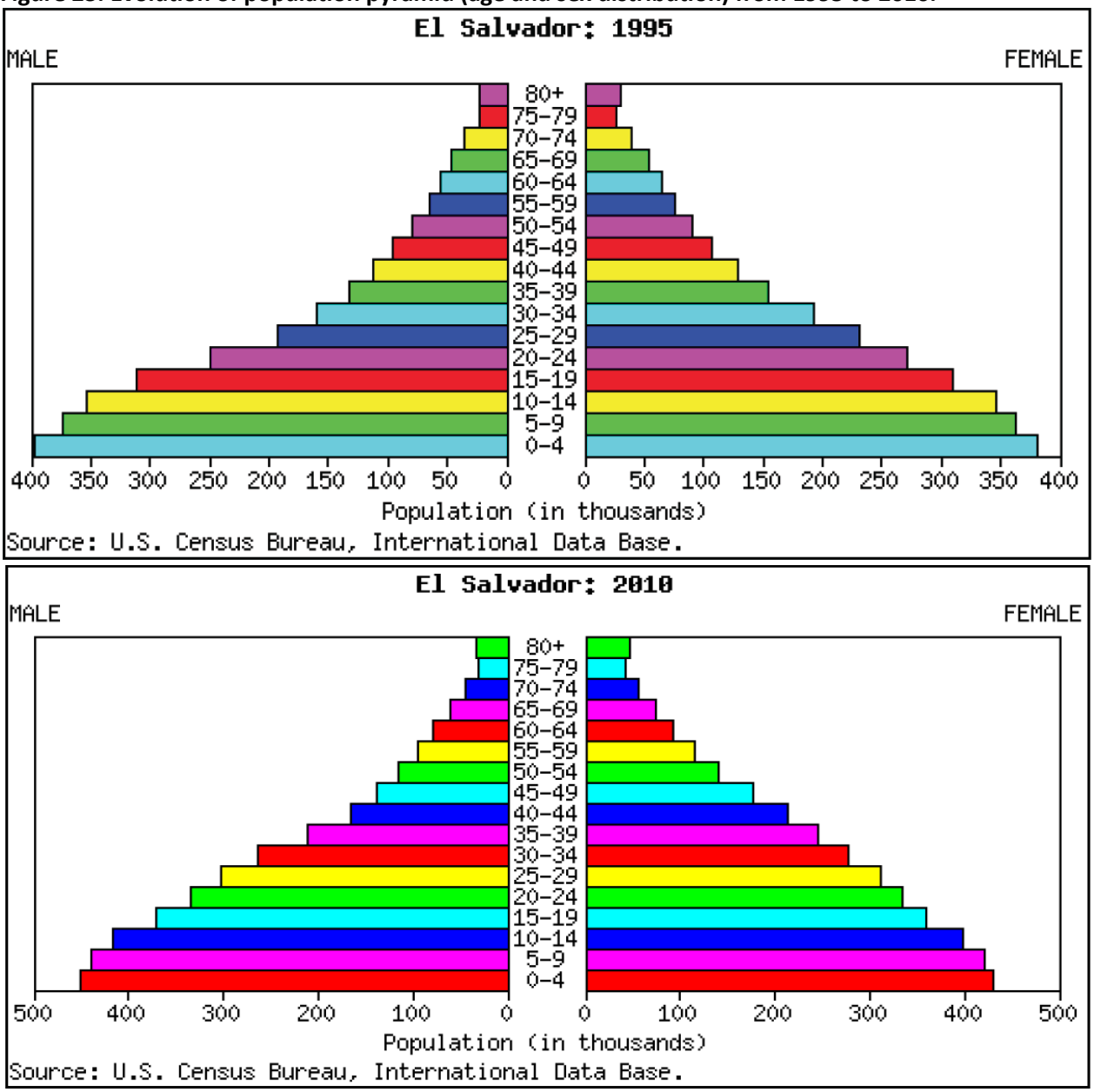
Country Context

Demographic information

Life expectancy at birth in El Salvador is currently estimated at 72 years.[153] In 2010, the total population of El Salvador was estimated at 6.2 million,[149] the natural growth rate decreased from 3.2% in 1960-1965 to 1.4% in 2005-2010, and since 1980, the demographic dynamics have been influenced by high levels of emigration.[150] The annual total population growth rate during the period 2005-2010 was 0.4 %, and there was a 75% reduction due to emigration.[150] An estimated 37.3% of El Salvador's population lives in rural areas.

Figure 23 shows how the population pyramid changed overtime, with a clear decrease of younger age groups and an increase of older age groups,[167] configuring a full epidemiological transition country.[150]

Figure 23. Evolution of population pyramid (age and sex distribution) from 1995 to 2010.



Source: U.S. Census Bureau

Geographical characteristics

El Salvador is located in Central America, bordering the Pacific Ocean, Guatemala and Honduras. In the southeast, the Golfo de Fonseca separates it from Nicaragua. El Salvador is the smallest Central American country in area and is the only one without a coastline on the Caribbean sea.[168] It is mostly mountainous with two mountain ranges running parallel to each other from east to west, with a narrow coastal belt and a central plateau between the mountain ranges. Most of the land of El Salvador is covered with mountains. There are two mountain ranges in El Salvador, which run parallel to each other from east to west of the country. The remaining portion of the landscape of El Salvador is covered with plains, known as Pacific lowlands. It has a tropical climate with pronounced wet and dry seasons,

temperatures varying primarily with elevation and showing little seasonal change. The Pacific lowlands are uniformly hot; the central plateau and mountain areas are more moderate.[168] It is characteristically tropical on the coast and temperate in the uplands. Most of the rain occurs during the winter season that commences in May and lasts until October. The dry season (summer) is from November to April. Rainy season is known as "invierno". The country lies along the Pacific Ring of Fire, and is thus subject to significant tectonic activity, including frequent earthquakes and volcanic activity.[169] El Salvador's position on the Pacific Ocean also makes it subject to severe weather conditions, including heavy rainstorms and severe droughts, both of which may be made more extreme by the El Niño and La Niña effects.[169] Likewise, El Salvador's location in Central America makes it vulnerable to hurricanes coming off the Caribbean, although this risk is lower than for other Central American countries.[169]

Socio-political profile

El Salvador is a democratic and representative republic with 3 branches of government. The Executive Branch, is headed by the President of the Republic who is elected by universal suffrage by absolute majority and remains in office for five years.[169, 170] He can be elected for only one term. A second round of elections is required in the event that no candidate receives more than 50% of the first round vote. The president has a Cabinet Minister, whom he appoints, who is also the General Commander of the Armed Forces. The other entities are the Legislative Branch (El Salvador's Legislative Assembly that is unicameral), composed of 84 deputies, and the Judiciary, headed by the Supreme Court, composed of 15 judges, one of whom is elected as President of judiciary.[169, 170] Members of the assembly are elected based on the number of votes that their parties obtain in each department (circumscriptive suffrage) and serve for 3-year terms. The country has an independent judiciary and Supreme Court. Legislative and municipal elections were held in January 2009, and presidential elections were held in March 2009.[169, 170]

After the civil war, the Peace Accords in 1992 were signed, and since then El Salvador has enjoyed progressive political stabilization and democratization, including the establishment and progressive strengthening of democratic procedures and key institutions, such as a national police force or an office specifically aimed to defend human rights.[154] Although the demilitarization process has been completed, the institutions responsible for ensuring the rule of law are still widely perceived as inefficient and corrupt, and the political system itself is marked by a high degree of polarization between the two dominant forces formed by the opposing sides in the armed conflict.[154] This hampers passing any legislation, which makes difficult adequately facing the country’s fundamental social and economic challenges, since a majority of two thirds is required for key government initiatives. Frequent electoral cycles (legislative and local elections take place every three years, Presidential elections every five years) further exacerbate the situation.[154] The increasing social inequality and the frustrated expectations created by the peace process also contribute to this situation. The political reforms promised by the Peace Accords are one of the points on which least has been done and expectations are rising with regard to the need to change the electoral and party systems.[154] Moreover, an estimated 25% of the population lives abroad and is not represented in the political system. As for non-state actors, non-governmental organizations (NGOs) have limited possibilities to influence public policymaking and to monitor actual implementation of the resultant policies.[154] On the other hand, in November 2005 the National Association of Private Enterprises (Asociacion Nacional de la Empresa Privada, ANEP) issued its vision for El Salvador in 2024, a document prepared after extensive consultations, including with the Government, and describing areas warranting the attention of the national authorities.[154]
From the human security perspective, El Salvador also experiences a series of challenges. The human rights situation has substantially improved, in particular respect for human life. However, further

progress is still required in the following areas: compliance with and application of labour legislation; personal security, by strengthening and achieving better interaction between security institutions to enforce criminal law; dialogue with civil society about the introduction of major pieces of legislation and institutional reforms; and financing for human rights institutions, including the Human Rights Ombudsperson.[154] As regards labour rights, the laws governing the right to freedom of association need to be reinforced, although the existing ones are being applied.[154] However, the international obligations in relation to the protection and promotion of workers' (including children's) rights in the public and private sectors need to be met.

The most important political challenge is internal security and the mounting social violence, fuelled by a proliferation of fire arms.[154] Violence committed by gangs of young delinquents ("*maras"*) is a major public concern with implications not only for personal safety, but also extending beyond El Salvador's borders through links established between local bands and foreign criminal organizations.[154] This hits foreign direct investment and local businesses hard, and the cost of violence in El Salvador is estimated at 11.5% of the GDP. The situation became so dramatic in 2006 that all segments of society reflected on their own possible role in confronting the phenomenon. There was general consensus that the challenge had to be met at State level, through combined efforts of the Government, the Congress and the Judiciary, and in constant dialogue with civil society."[154]

El Salvador has achieved important progress on democracy, and the human rights situation has also improved.[154] However, the political system is marked by a high degree of polarization and there is increasing discontentment with the political parties and state institutions, in particular at a time of heightened internal insecurity and social violence, which is proving negative for investment and has contributed to a negative impact on job creation.[154] One of the most important challenges for El Salvador remains the definition and implementation of a long-term development model that may ensure consolidation of democracy and good governance, offering the prospect of more inclusive, equitable and sustainable socio-economic growth and looking to greater regional and smoother international integration. The "Safe Country Plan" (*Plan Pais Seguro*), the Government's policy agenda for 2004-2009, includes social measures which, if implemented, could improve social conditions and reduce inequalities. This plan requires support from several sectors of the society if it is to be implemented successfully.[154]

El Salvador has a distinguished record of first generation structural reforms that include trade liberalization, re-privatization of the financial sector and other state enterprises, comprehensive tax reform and improvements in economic competitiveness for private investment.[153] After a costly decade-long civil war in the 1980s, the economic reforms that started since the early 1990s have resulted in major benefits in terms of improved social conditions, diversification of its export sector, and access to international financial markets at investment grade levels.[153] However, important development challenges still exist as a result of the slowdown in economic growth and social progress over the last few years, in addition to the persistent presence of high levels of crime and violence.[153] According to a World Bank country brief, macroeconomic stability, facilitated by a dollarized monetary regimen, has resulted in low inflation, reduced business uncertainty, and low interest rates.[153] With a strong commitment to an outward oriented development strategy, El Salvador has signed free trade agreements with various countries (the Dominican Republic, Mexico, Chile, and Panama). El Salvador was also the first country to ratify the Central America Free Trade Agreement (DR-CAFTA) with the United States and the first to begin its implementation on March 1, 2006.[153] The ultimate and long-term impact of such economic measures will need a thorough evaluation process.

Dominant and alternative languages, ethnic groups and minorities

The official language in El Salvador is Central American Spanish, which is spoken by virtually all inhabitants. Mestizos (those of mixed indigenous Native American and European ancestry), Whites, and indigenous peoples compose El Salvador's population, and at least 86% of Salvadorans are of mixed ancestry (Mestizos).[171] In the Mestizo population, Salvadorans who are of predominantly Mediterranean descent or of partially Nordic descent, all identify themselves as Mestizo culturally.[171] About 12% of Salvadorans are mostly of Spanish descent.[171] Small communities of French, German, Swiss, English, Irish, Italian, Danish, Swedish, Norwegian, Dutch and Central European ethnicity also exist within the country. The majority of Central European immigrants arrived during World War II as refugees from Austria, the Czech Republic, Germany, Hungary, Liechtenstein, Poland, Slovakia, Slovenia, Croatia, Romania, Serbia, and Switzerland, and their descendants are scattered all over El Salvador.[171] Russians came in during the Salvadoran civil war, concurrent with the U.S./Soviet Union cold war, to help the communist guerrillas in their struggle to seize the government. Americans, Australians, and Canadians assisted the military junta in their fight against the communists.[171] Only 1% of the Salvadoran population is indigenous, mostly Mayan, Pipil, Lenca, and Kakawira (Cacaopera),[171] which may be partly explained by mass murders during the 1932 Salvadoran peasant uprising (or *La Matanza*), in which up to 30,000 peasants were killed in what by modern standards would be considered genocide because of the Salvadoran army's efforts to exterminate a certain racial group.[171] Other ethnic groups include Arabs, Jews, other Central Americans, South Americans, Caribbeans, and a small group of Asians.

Of note, El Salvador is the only Central American country without a visible or significant African population today because of its lack of an Atlantic coastline and attendant access to the slave trade which occurred along the east coast for centuries.[171] This scarcity of Afro-Salvadoran population is also due to laws imposed by the Spanish and Criollos around the 17th century after a slave revolt, and which was sustained by authorities even after independence was won from Spain in 1821 and slavery was abolished.[171]

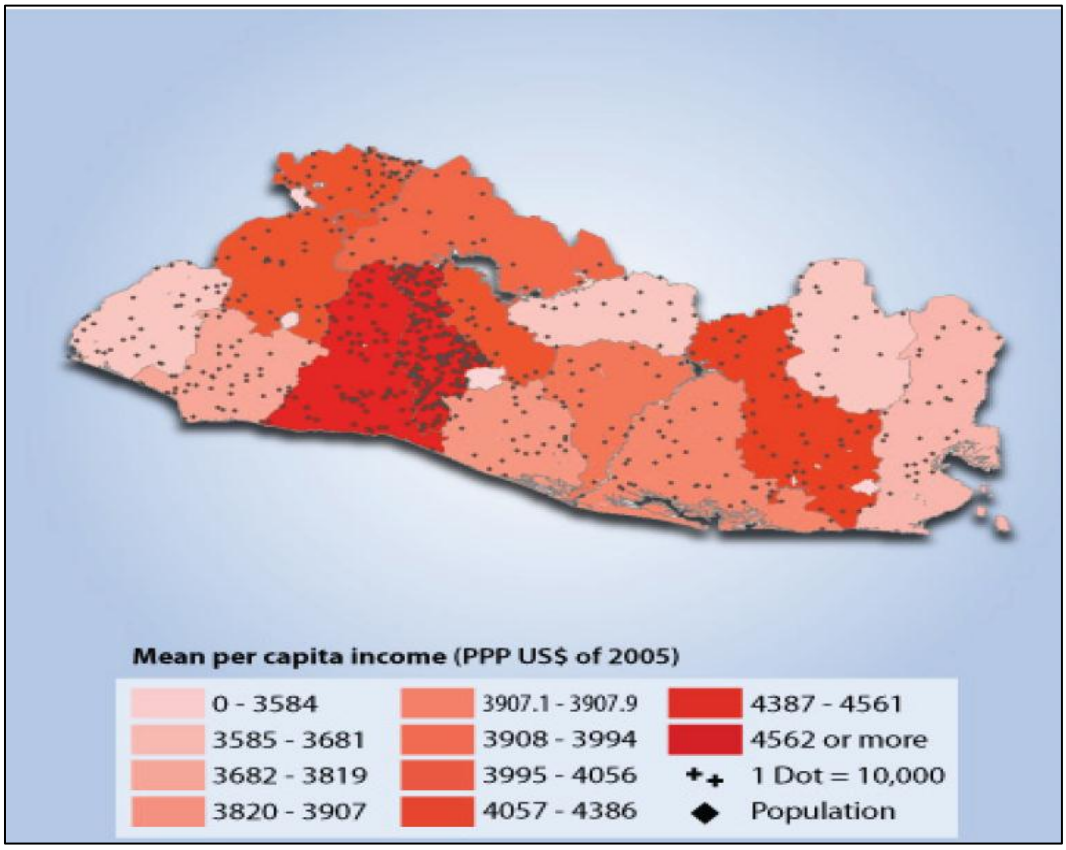
Gross Domestic Product (GDP) per capita over time

El Salvador has been classified by the World Bank as a lower-middle-income economy.[151] Its GDP in current US$ was $21,795,720,979 for year 2010, while evolution of GDP per capita over time (in current US$) was as follows:[152, 153] 3,071 for year 2006; 3,340 for year 2007; 3,607 for year 2008; 3,425 for year 2009; 3,519 for year 2010.[152]

Figure 24 below shows the distribution of income in terms of GDP at purchasing power parity per capita (PPP) for different geographic areas of El Salvador.[172] It illustrates that there are a few areas where the income is substantially higher than in the rest of El Salvador.

The economy of the country has shown signs of recovery in the last few years, with growth reaching 4.2% in 2006 and 4.7% in 2007, the highest growth rate since 1999[151] Also, indicators reveal an increase in broad economic activity since the end of 2005, particularly driven by a strong performance of the agricultural and construction sectors, as well as private sector services. In addition, the constant growth of remittances has been providing an added boost to consumption, reaching 18% of GDP in 2007. The increase in economic activity has occurred despite the sharp spike in oil prices, while tax revenues improved near expectations and public sector deficit tends to decline. For 2007 the public sector deficit was reduced to 2% of GDP compared with the average of 4.2% registered during the period 2001-2003.[152, 153]

Figure 24. El Salvador Poverty Map, 2005



Source: The World Bank. Data & Statistics.

Poverty rate

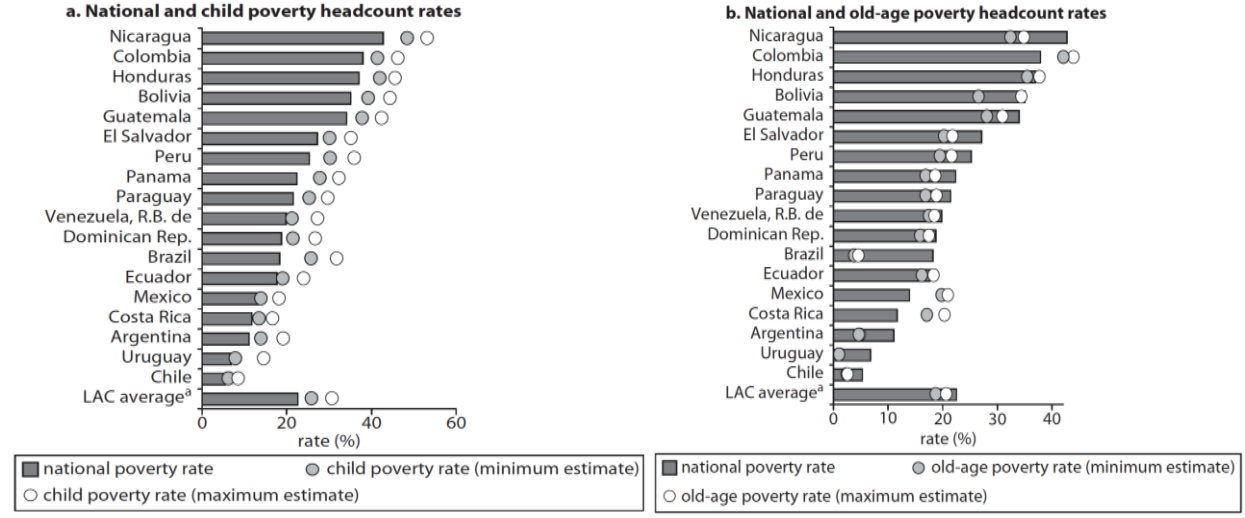
El Salvador is rated 104th out of a total of 173 countries in the UNDP 2005 Human Development Report, with a human development index of 0.722, which clearly indicate that social cohesion and drastic poverty reduction remain priority issues.[154] In order to make progress towards achieving the MDG, a national consensus is required on the structural reforms needed in the social services (education, health, and social security), and on employment, access to justice and fiscal matters.

Significant progress was made on reducing poverty over the period 1991-2002: the share of the population living in poverty decreased from 58% to 35% and the share in extreme poverty from 33% to 14.4%.[154] Poverty has been falling, albeit at a slow pace and even with a disquieting tendency to some increase in the last few years,[173] but extreme poverty rates have remained stagnant since 2001. The poverty headcount ratio at national poverty line (% of the population living below the national poverty line) evolved in the last few years in this way: 30.7% in 2006, 34.6% in 2007, 39.9% in 2008, and 37.8% in 2009[173] This phenomenon, coupled with the recent increase in the levels of inequality of income distribution (in 1992 the per capita family income of the wealthiest 20% of households was 18 times higher than that of the poorest 20%; by 2002 this factor had increased to 24) and the high level of social violence also prevalent in rural areas, poses a challenge for improving social cohesion. Moreover, Government forecasts indicate that the MDG of halving, between 1990 and 2015, the percentage of the population with an income of below one dollar a day is unlikely to be achieved in the rural areas of El

Salvador.[154] Indeed, poverty, inequality and social and economic development show a deep and widening gap between urban and rural areas on various fronts: in rural areas GDP per capita is only one third of that in urban areas, the literacy rate is almost 20% lower, life expectancy is six years shorter and the rate of chronic and global malnutrition is twice as high. It is reported that poverty rates are high amongst populations of indigenous origin, although the Government argues that society is homogenous (*mestizo*) and that there are no indigenous related issues as such.[154]

The main findings are summarized in Figure 25 (a and b), and show first, that in all countries of the region children have systematically higher levels of poverty than other segments of the population, and second, that regional average for poverty among the aging is 10 to 20% lower than the overall poverty rate, which is the average of three different groups of countries.[174] A further analysis shows the existence of a group of "pro-aging" countries where the aging are significantly better off than the rest of the population; these are the countries with the largest and most generous pension systems in the region—Argentina, Brazil, Chile, and Uruguay—but also includes El Salvador and Nicaragua (two of the top receivers of international remittances in Latin America and the Caribbean) and Bolivia. At the other extreme, there are three countries where poverty among the aging is significantly higher than among the rest of the population—Colombia, Costa Rica, and Mexico. For the rest of the countries, the aging have poverty levels similar to the national average.[174] These findings open important questions about the underlying explanations, which will surely be important in informing policy decisions regarding the allocation of resources to these differing segments of the population in different areas in the different countries, including budget lines for health and education sectors.

Figure 25. Poverty among Children and the Aging in Latin America



Source: The World Bank. El Salvador Poverty Map 2005.

Health systems overview

Morbidity and mortality burden

Although the country situation in El Salvador has improved significantly in the last decades and years, there is still concern that it is one the most inequitable countries in the region together with Guatemala and Brazil, showing profound and persistent disparities that need to be addressed.[155] For instance, there

are an estimated 35% of households that remain in extreme poverty with limited access to health services and education.[154]

Recent country reports of the European Commission and Action For Global Health emphasize that the health sector in El Salvador shows currently various signs of concern.[154, 155] Whereas non-communicable diseases and injuries are increasing steadily at national level, in other mostly deprived areas illnesses associated with poverty and underdevelopment still prevail; also coordination between the public service providers is poor or inexistent; access to health services is limited; only about half of the population suffering from an illness or accident receive medical assistance; the allocation of resources amongst public health institutions is inappropriate; health spending is low and fragmented; the quality of care provided to citizens is poor.[154] It is also stressed that lack of access to drinking water and basic sanitation together with malnutrition, environmental pollution and degradation are the primary causes of illnesses.[154]

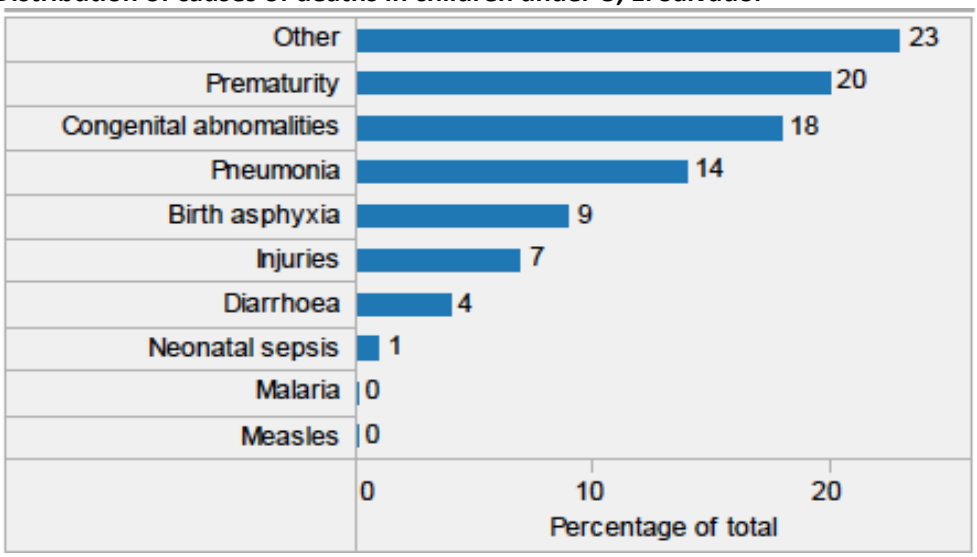
Maternal and child health

Summary maternal, neonatal and child health indicators for El Salvador provided by UNICEF are presented below.[175]
Maternal mortality ratio per 100,000 live births, 2005-2009, reported: 59
Maternal mortality ratio per 10,000 live births, 2008, adjusted: 110
Delivery care coverage (%), skilled attendant at birth, 2005-2009: 96
Delivery care coverage (%), institutional delivery, 2005-2009: 85
Under-5 mortality rate per 1,000 live births, 1990: 62
Under-5 mortality rate per 1,000 live births, 2009: 17
Infant mortality rate (under 1) per 1,000 live births, 1990: 48
Infant mortality rate (under 1) per 1,000 live births, 2009: 15
Neonatal mortality rate V, 2009: 7
% of under-fives (2003 -2009) suffering from moderate & severe stunting (WHO): 19

Communicable diseases

Figure 26 shows that childhood diarrhea and acute respiratory infections (specifically pneumonia) have declined significantly, although pneumonia still accounts for 14% of all deaths in children under-5, while prematurity and congenital anomalies account for more than a third of the death toll.[176]

Figure 26: Distribution of causes of deaths in children under-5, El Salvador



Source: WHO, 2008.

The 2009 estimated HIV prevalence rate for adults aged 15-49 years was 0.8 per 1,000 adults, whereas the estimated number of people of all ages living with HIV for the same year was 34,000 (low estimate 25,000 and high estimate 44,000).[175] According to a WHO world malaria report,[177] malaria transmission occurs in 23 countries and territories of the WHO Region of the Americas with approximately 20% of the total population at some degree of risk, and four of them (Argentina, El Salvador, Mexico, and Paraguay) are currently in the elimination or pre-elimination phase. El Salvador is among the America region countries where malaria cases have been reduced by more than 50% between 2000 and 2009.[177]

Table 60. Tuberculosis profile, El Salvador

Burden estimates	Number (thousands)	Rate (per 100 000 population)
Mortality (excluding HIV)	0.057 (0.04-0.093)	0.92 (0.65-1.15)
Prevalence (HIV included)	1.9 (0.53-3.3)	31 (8.6-53)
Incidence (HIV included)	1.8 (1.5-2)	28 (24-33)
Incidence (HIV-positive)	0.23 (0.2-0.27)	3.7 (3.1-4.4)
Case detection, all forms (%)	96 (83-110)	---
Source: WHO, 2010		

As for the situation with tuberculosis, Table 60 shows the burden posed by this disease. Estimates are for year 2010 and ranges represent uncertainty intervals.[178]

Non communicable diseases

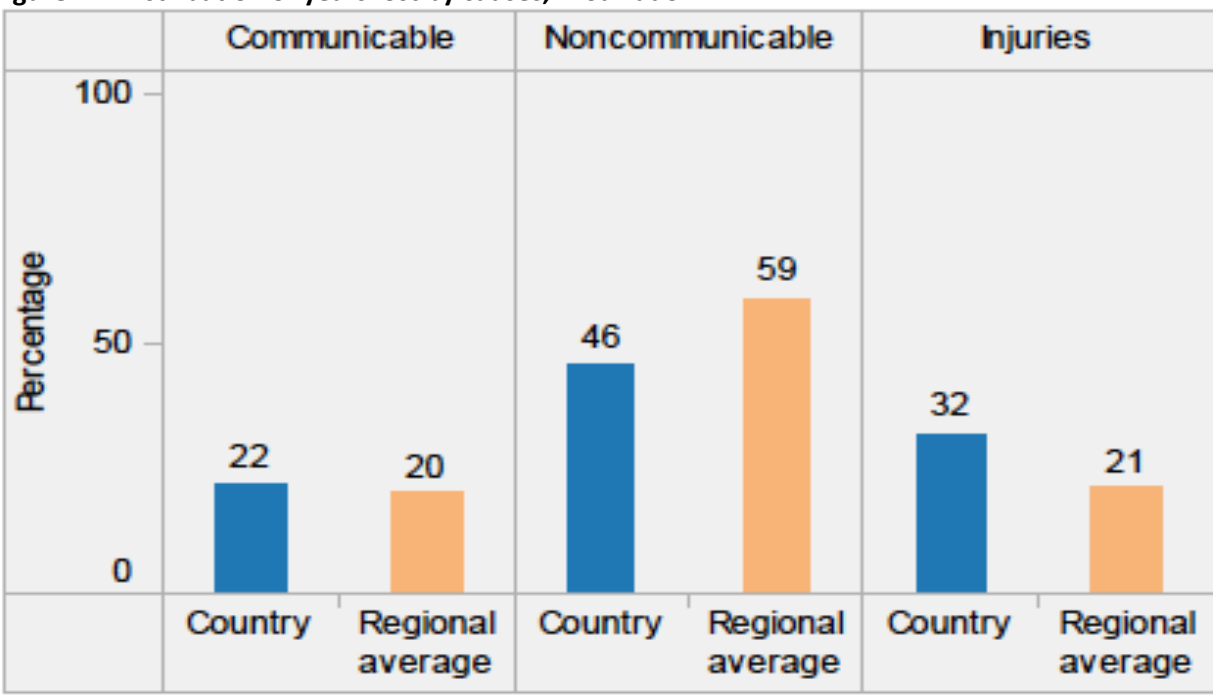
The most recent reports of WHO on mortality and morbidity burden attributable to non-communicable diseases (NCDs) in El Salvador are summarized below:[179, 180]

- Proportional mortality (% of total deaths, all ages): NCDs are estimated to account for 67% of all deaths.
- Total NCD deaths ('000s): Males: 13.5; Females: 15.0
- NCD deaths under age 70 (% of all NCD deaths): Males: 46.4; Females: 36.6
- NCD deaths under age 60 (% of all NCD deaths): Males: 30.3 Females: 21.7

- Age-standardized death rate per 100 000, for males: All NCDs: 539.3; Cancers: 78.5; chronic respiratory diseases: 29.0; cardiovascular diseases and diabetes: 201.0
- Age-standardized death rate per 100 000, for females: All NCDs: 449.4; Cancers: 113.2; chronic respiratory diseases: 27.0; cardiovascular diseases and diabetes: 203.6

The WHO reports also include information on metabolic risk factors for males and females.[179, 180] The 2008 estimated prevalence (%) figures are 35.6 (males) and 28.6 (females) for raised blood pressure; 10.0 (males) and 9.9 (females) for raised blood glucose; 57.5 (males and 64.4 (males) for overweight; and 19.2 (males) and 31.8 (females) for obesity. Behavioral risk factors are not reported. Figure 27 illustrates the comparative burden posed by communicable, non-communicable diseases, and injuries,[176] with communicable diseases still accounting for about a quarter of the burden, but non-communicable diseases and injuries already leading the toll.

Figure 27: Distribution of years lost by causes, El Salvador



Source: WHO,2008

Magnitude of health workforce crisis

El Salvador is one the few countries in Latin America considered in crisis with regard to human resources of health (HRH).[155]

Adequate mix of health workers cadres

Similarly, in-depth description of the mix of health worker cadres, focusing on mid-level providers is provided.

Main health problems according to the burden of disease

A detailed description of the mortality and morbidity burden is also described. In general terms, the health indicators have improved substantially in El Salvador during the last decades and years, but there remain important inequalities in access to health care that need to be addressed. HRH maldistribution is but one of those challenges to overcome in order to assure universal quality of health care.

Major drivers of the national health policy

Health in El Salvador is differentiated in public and private sectors. Public sector includes MSPAS (Ministerio de Salud Pública y Asistencia Social), ISRI (Instituto Salvadoreño de Rehabilitación de los Inválidos), ISBM (Instituto Salvadoreño de Bienestar Magisterial), BSM (Batallón de Sanidad Militar), ISSS (Instituto Salvadoreño del Seguro Social) and FOSALUD (Fondo Solidario para la Salud); while private sector includes for-profit and non-for-profit organizations.[157]

While in theory the MSPAS covers 80% of country population, actually only 40% receives health services on a regular basis.[181] ISSS is aimed at covering formal health workers and their families, who account for about 24% of total population. ISBM covers only teachers and their families; BSM covers only active and retired members of the Armed Forces. Although it is legally established that people without any insurance scheme should begranted access to public health services, the Demographic and Household Survey 2008 showed that among people reporting some health problem, 48.1% self-medicated or did not attend any health facility.[182]

The private sector follows basically the classic business model with free professional practice, regulated by market laws.[157] Non-for-profit activities are predominantly performed by nongovernmental organizations that operate mainly on the basis of external financial funding, public subsiding or private sponsorship, in specific geographical areas and in specific health areas that most frequently are in agreement with their own strategic plans.[157]

As a strategy to expand the health services coverage, the Fondo Solidario para la Salud (FOSALUD) was implemented in 2005.[157] The most recent health policy innovations in El Salvador include the approval of the Law for the creation of the National Health System, which intends to expand coverage, reduce health inequalities and improve the coordination of public health institutions.[156] FOSALUD has been conceived as a public entity attached to the MSPAS, with financial and administrative autonomy, having as main objectives to promote the creation of special programs aimed at increasing coverage of health services and to execute integral programs that can satisfy basic health needs of the neediest segments of the population, as well as to promote health education campaigns across the country.[162, 183] The most recent policy initiative is the National Integrated Health System (Sistema Nacional Integrado de Salud), launched recently by the new government, focused on full re-organization of the health system, based on the primary health care strategy. This is a milestone aimed to be implemented progressively, having as the fundamental starting point the direct contact with families and communities.[162]

The MINSAL's National Health Strategy (2009-2014) has been launched by the government with the aim to address the issue of fragmentation of the health sector and ensure universal coverage, having as the most prominent aspect primary health care within an Integral and Integrated Public Health Care Service Network (*RedIntegral e Integrada de Servicios de Salud* or RIISS).[158] The Integrated health networks comprise a group of organizations providing or making the necessary arrangements to deliver integrated health service to a population within specific boundaries, and it is accountable for its clinical results and fiduciary performance.[158] The National Health Strategy 2009-2014 seeks to increase coverage and equity of access to health services, improve the quality of services, and strengthen management of information

systems to enhance the monitoring and oversight capacity of MINSAL.[158] Within this framework, the Strategy supports the strengthening of the RIISS to deliver high quality services to underserved and vulnerable populations. This network currently provides health services through three levels of health care. The primary health care level includes (i) family and community health teams with medical specialization; (ii) family and community health teams without specialization; and (iii) health promoters and centers. They are located in municipalities and cantons, while the secondary level includes basic and general hospitals, which are located respectively in the departments and regions, and the third level includes highly-specialized and specialized hospitals, distributed at the national level.[158]

The newly elected government has started a major health sector reform, which has been piloted in the country's 63 poorest municipalities. The goal is to cover all 262 municipalities within the next three years.[155]

Accordingly, the new Minister of Health has released a program outlining the following first ten actions to be taken by the government during its first 100 days in order to overcome the current challenges of her country's health sector.[155]

1. Elimination of charges ("voluntary fees") or any other form of payment in the public system, offset by corresponding budget allocations that prevent deterioration of service quality.
2. Stocking of essential medicines and basic medical supplies in all Public Health System facilities, gradually and according to priorities, taking into account the assessment of the conditions in each facility.
3. Reduce waiting times for surgery and specialist care, which will require the hiring of additional personnel but which urgently needs to be done, since at present an individual must wait up to two years or more for cataract or hernia surgery.
4. Allocation of medical specialists to regional hospitals, which will decongest the national hospitals and resolve the needs of the public more quickly, increases public satisfaction.
5. Expand coverage of health services in rural areas and in more socially vulnerable urban areas across the country, which can be done through well-trained community health workers from the communities themselves.
6. The President shall lay the cornerstone for the new Maternity Hospital during his first one hundred days in office.
7. Institutionalize social participation through the formation of intersectoral committees at the local, municipal, provincial, and national levels, which shall identify the basic needs most affecting people's living conditions and prioritize their resolution, through communities working together with government institutions, where true community participation is crucial in decision-making and in resolving these problems.
8. Conduct a National Environmental Sanitation Campaign for the prevention of epidemics with the participation of all social leaders in the country, including government structures.
9. Initiate, as soon as possible, a process to reorganize the entire public sector (MSPAS, ISSS, FOSALUD), aimed at making services more efficient and at laying the groundwork to increase coverage.
10. Convene the National Health Forum."[155]

In addition, the Ministry of Health's most recent annual report 2009-2010 evaluates progress made in the health sector against these ten targets. This past year, the government not only achieved the abolishment of user fees for health services, but also made the first steps towards the establishment of a unified information system, as well as the extension of access of the most impoverished communities

to basic medical care, while enhancing the participation of civil society.[155]

Finally, a new National Health Policy 2009- 2014 came into force in February 2010, establishing 8 preliminary priority areas for the health sector reform process:

1. Construction of an integrated Network of health services;
2. Human Resource in Health as a cornerstone for the system;
3. Response to demand for medicines and vaccines;
4. Installment of the National Health Forum;
5. Establishment of a single information management system;
6. Strengthening the Medical Emergencies system;
7. Progressive coordination among all national service providers; and
8. Creation of the National Health Institute and strengthening of the National Association of Laboratories.

Contrasting with the pyramidal health structure that predominates until now, the newly proposed health reform aims at constructing an integral and integrated health services network, close to the communities, families, and individuals, trying to make equity health a reality. In this new model, the primary health care level will be provided by the Family Health Community Teams (ECOS Familiares or Equipos de Salud Familiar or Family Health Teams) and the Specialized Family Health Community Teams (ECOS Especializados), which should be able to provide 95% of health care needs.[159] It is expected that each ECOS Familiares will be responsible for the provision of promotional and preventative health services to about 600 hundred families, having the community health workers ("Promotores") as direct contact points with the community, similar to the Brazilian Family Health teams.

The new National Health Strategy launched by the government within the Health Reform framework is surely an important step forward, as El Salvador has not had previously any long-term plan for its health sector.[155]

Financing model for the health system

Most of MSPAS financing comes from the central government, and additional funds are obtained from loans provided by the international bank and resources of international cooperation.[183] Additional financing comes from the Cost Recovery Program (*Programa de Recuperación de Costos*), through which MSPAS gets funds through collection of "voluntary fees" from users of the public health system.[183] This last measure faced strong resistence among the general population, and thus it was abandoned in primary level health facilities, but still remains in second and third levels. This actually led to a financing deficit, as MSPAS did not provide the funds that were eventually notcollected from users. On the other hand, FOSALUD resources are mainly managed by the Ministry of Finance, and they should account for about 35% of incomes from taxing of alcohol beverages, tobacco, control and regulation of fire arms, explosives, and related items (*Ley Reguladora de la Producción y Comercialización del Alcohol y de las Bebidas Alcohólicas, la Ley de Impuesto sobre Productos del Tabaco y Ley de Gravámenes Relacionados con el Control y Regulación de Armas de Fuego, Municiones, Explosivos y Artículos Similares*).[183]

The ISSS receives contributions from the government, employers, and affiliated workers. It also received funds from interest rates of deposits made in the private banking system.[156] The military sector obtains funding from the central government and from the direct provision of health services to the general population.[156]

Finally, the private sector is financed mainly through international donations. This is particularly referred to NGOs, some of which also get funding from local private companies or from the church.[156] Most of them develop programs of cost recovery to supplement their incomes. The for-profit sector gets its funding directly from the paid provision of health services to private insurance companies.[156]

The total health expenditure as per cent of GDP has followed a decreasing trend.[156] Thus in 2000 it was 8% of GDP, while in 2008 it reached 6%. For 2008, the per capita expenditure in health was US$ 410. The public expenditure in health represented 59.6% of total health expenditure and the remaining 40.4% was private expenditure, mostly out-of-pocket expenditure. Notably, 3.5% of total expenditure came from external sources.

Clearly therefore significant inequalities in health care financing exist between the different sub-systems, with the national health service (NHS) being persistently underfunded.[158] Table 61 shows that over the years, the NHS has been persistently underfunded in comparison to the ISSS.[158] While it delivers health services to four-fifths of the population, NHS expenditures constituted only 1.5% of GDP in 2008. In the same year, the ISSS spent 1.4% of GDP to cover only 1/5 of the population.

High out-of-pocket spending on health care has led to a reduced use of health services in El Salvador,[134] representing a serious barrier for financial access to health services.[158] Out-of-pocket expenditures on health represent 37% of total health expenditures (or 2.4% of GDP in 2007).[158] According to the 2008 Multi-Purpose Household Survey, only 51% of people who became ill or were injured sought medical assistance, while the remaining chose to self-medicate or avoid assistance altogether.[158] Of those who sought assistance, the majority (65.7%) utilized services from the NHS, while 16.9% used services from a private hospital or clinic, 12.5% from the ISSS, and 4.9% from the Military Hospital, NGO health facilities or pharmacies.[158]

Table 61. Public Expenditures on Health in El Salvador *(In millions of US dollars and per cent of GDP)*

	2005	2006	2007	2008
Public Expenditures on Health (US$ millions)	**575.9**	**634.9**	**677.4**	**664.9**
National Health Service (NHS)	273.8	304.2	328.0	349.7
-Ministry of Public Health and Social Assistance	74.2	89.0	175.1	184.9
-National Hospitals	199.6	215.2	152.8	164.8
Salvadorian Social Security Institute (ISSS)	291.6	324.0	342.1	306.7
Public Health Expenditures as % of GDP	**3.4**	**3.4**	**3.3**	**3.0**
National Health Service (NHS)	1.6	1.7	1.6	1.5
-Ministry of Public Health and Social Assistance	0.4	0.5	0.9	0.8
-National Hospitals	1.2	1.2	0.7	0.7
Salvadorian Social Security Institute (ISSS)	1.7	1.7	1.7	1.4

Source: Ministry of Finance and Central Reserve Bank of El Salvador, 2010. El Salvador – Public Expenditure Review. The World Bank. Report No. 53500-SV

Thus despite the government's official commitment to health as a basic condition for social development, the national health budget in El Salvador is still only about half as high as its budget for education.[155] Even though there has been an increase in the absolute size of the budget of the Ministry of Health during the last few years, including an increase from USD 459 million in 2009 to USD 517.3 million in 2010, the share of the Ministry of Health's own budget within the public expenditure currently only represents 2.4% of GDP.[155] If increases continue to be made at the same pace as between 2008 and 2010 (i.e. by 0.3% per year) then the share could eventually reach 3.6 % by 2014.[155]

Decentralization policy

While general administrative and fiscal transfer process is explicitly included in the governmental political agenda, it is mainly related to production-related activities and to boost private investment at local levels.[184] The health system in El Salvador is largely centralized and administrative, fiscal, and political decisions related to health services provision and the health system are made at the central level.[156] Ever since 1999, when the Council of Health Sector Reform was conformed, the health system was diagnosed as being a centralist model, basically excluding a democratic health policymaking process.[156]

In the National health System proposal (2007),[160] decentralization was conceived as a gradual transfer process of authority and policy decision making attributions; and human, physical, technical, and financial resources, to local levels closer to final users, with the aim to improve an equitable performance of the health system. It was also conceived as a process of responsibilities transfer to regional and local levels, as well as of accountability mechanisms. It acknowledged that explicit political, financial, managerial and administrative mechanisms, goals, and instruments would need to be developed in order to fulfill the desired objectives.

Hopefully the last changes proposed by the Ministry of Health as part of the new Health reform will successfully face the remaining health inequities, and ECOs Familiares will truly provide health care to the communities by functioning closer to them.[159]

As the National Health System operates currently, MSPAS is organized at three levels: superior (central), regional, and local. The State Secretary, at central level, is in charge of planning and executing the national health policy, as well as to supervise and to control the implementation and the national management of the allocated financial resources.[159] The regional level is constituted by the Regional Directions, which represent the administrative technical level of the Basic and Integrated Health Systems (Sistemas Básicos de Salud Integral, SIBASI), responsible for the management of the hospital resources in a due geographic unit.[159] The local level constitutes basically the operational network of SIBASI and hospitals.

MSPAS health provision is delivered at three differentiated levels. Health units, health homes, and rural health and nutrition centers belong to the primary level. National and regional general hospitals belong to the second level. National specialized hospitals belong to the third level (including medical and surgical specialties, pediatrics, gynecology and obstetrics, psychiatry and neurology, amongst others).[156]

SIBASI is the local organizational structure where health services provision is delegated at primary level, in a coordinated way with the other two levels. ISSS offers recuperative health services to those affiliated, while retirement funds have been privatized since 1988.[156] ISBM is a managerial entity that provides second and third level health services with a family medicine approach, while the BSM provides health care at all three levels to its own affiliates, but it also offers paid services to the general population.[156]