



Proyecto Fortalecimiento de la Salud, El Salvador, abril 2006 - septiembre 2009, Informe Final.

Strengthening Health Project, El Salvador, April 2006 – September 2009, Final Report.



**USAID** | **EL SALVADOR**  
DEL PUEBLO DE LOS ESTADOS  
UNIDOS DE AMÉRICA

## **STRENGTHENING HEALTH PROJECT**

**USAID / MOH**

**TASK ORDER “B”**

**URC, LLC TECHNICAL ASSISTANCE**

**APRIL 2006 - SEPTEMBER 2009**

## **FINAL REPORT**

**San Salvador, September 2009.**

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## 1 INTRODUCTION

This document is the Final Report of the Strengthening Health Project (SHP ), also known as Task Order “B” and it provides a narrative of the activities performed in response to the work contract between USAID El Salvador (Activity No. 519-0463) and University Research Co., LLC (URC).

This Project’s activity allowed for an interaction with most of the MOH agencies in the central level, and mainly with three of the five Health Regions. During the Project it was necessary for several of the interventions to be carried out throughout the country and not only for the geographic area of influence of the Project. This led to more coverage, and to support the development of health decentralization. These aspects are pointed out in every Component of the Project.

We make a review of the project structured in Intermediate Results and their subsequent division in secondary outcomes all of them aimed at attaining the global goal of improving the health of all Salvadorans who were defined as direct beneficiaries of this Project.

In this final report, we make specific reference to the Project’s achievements in its almost four years (42 months) of existence. It is difficult to point out the specific impact of this type of Social Projects, which may be attributed only to the implementation of a project, throughout this report we also give credit to the Ministry of Health and Social Welfare of El Salvador (MOH) for the achievements. Upon request from USAID, the Project worked closely with the MOH at its different levels. We believe that this was achieved in different degrees.

This final report is structured as specified in the Executive Summary, including all achievements against objectives established during the life of the project; the problems found are also specified in the corresponding section of the components. Also, this section of the Executive Summary discloses Lessons Learned and recommendations for future projects.

This Final Report provides a detailed account of the achievements from each Component and some tables with the summary of the percentages and explanations are also provided at the end of this document. Fortunately, during the life of this Project we made the preliminary printing of the data obtained in the National Survey of Family Health Care – FESAL 2008. We believe that this Project provided a significant contribution to the achievement of its goals. Nevertheless, there are still some health constraints the country must face, we hope for the continued provision of international technical and financial cooperation, especially from USAID to keep on fighting unfairness and improve the Salvadoran population health, especially of those who need it the most.

## 2 ACRONYMS

<b>AAP</b>	American Academy of Pediatrics
<b>ADESCO</b>	Community Development Association
<b>AIEPI</b>	Integrated Healthcare for Prevailing Infant Diseases
<b>AIN</b>	Integral Nutrition Care
<b>CAP</b>	Know-how, Skills and Practices
<b>CCC</b>	Communication for a Change of Behavior
<b>CONE</b>	Essential Newborn and Obstetrics Care.
<b>CPCIN</b>	Hospital Borne Infection Prevention and Control Committee
<b>CTOs</b>	USAID technical Officials for Task Order “B”
<b>CVN</b>	Volunteer Nutrition Collaborators
<b>ESC</b>	Community Health Care Team
<b>GAT</b>	Technical Advisor Group
<b>IEC</b>	Information, Education and Communication
<b>ITU</b>	Urinary tract infection
<b>IVU</b>	Urinary System infection
<b>JICA</b>	Japanese Agency for International Cooperation
<b>LM</b>	Breastfeeding
<b>MADLAC</b>	Monitoring and Direct Support to Breastfeeding
<b>MCC</b>	Continuous Quality Improvement.
<b>MOH</b>	Ministry of Public Health and Social Welfare.
<b>NRP</b>	Neonatal Resuscitation Program
<b>OL</b>	Local Office
<b>NGO</b>	Non-Government Organization
<b>PAO</b>	Annual Operational Program
<b>FP</b>	Family Planning.
<b>SHP</b>	Strengthening Health Project
<b>PI</b>	Infection Prevention.
<b>PMP</b>	Performance Monitoring Plan
<b>PS</b>	Health Promoter
<b>RHESSA</b>	Hospital Reconstruction and Extension of Health Care Services
<b>SIBASI</b>	Basic Integral Health Care System
<b>SNS</b>	National Health System
<b>PIS</b>	Perinatal Information System.
<b>SISMOB</b>	MOH Morbi-mortality System
<b>SISVIN</b>	Nutritional Surveillance System
<b>STABLE</b>	Stabilization and Transportation of Critical Newborn
<b>HU</b>	Health Care Unit
<b>URC</b>	University Research Co., LLC.
<b>USC</b>	Community Health Unit.
<b>USAID</b>	United States Agency for International Development.
<b>USANYM</b>	Mother-Infant -Friendly Health Care Units.
<b>VMM</b>	Maternal Mortality Surveillance.

### 3 EXECUTIVE SUMMARY

This Final Report describes the main interventions and the degree of compliance with Intermediate Results (**IR**) proposed by USAID's Strengthening Health Project and agreed upon by the Task "B" Offer with the Technical assistance from University Research Co. LLC., during the period April 2006 to September 2009. This is presented from the point of view of the executing officials of the Project, employees of the contractor URC.

All activities carried out by the Project belonged to MOH priorities set forth in annual plans, by counterparts of higher, regional and local levels in common agreement with the technical assistance of URC and supported by USAID. This enabled the mutual cooperation to achieve outcomes, which match those set forth in the annual plans and agreement executed between the two governments.

Cooperation provided through the Project benefited 3 Health Regions, 8 SIBASI's, 29 hospitals, 96 Health establishments of the first level of assistance and 100% of Health promoters from 72 municipalities of the geographic area assigned to the Project, known as USAID priority areas with a total population of about one million direct beneficiaries.

The Project was structured by Components according to IR to be reached. These were: Family Planning, Maternal health, Infant Health, Nutrition and Hospital Borne Infection Prevention and Control. Additionally, we also defined other components with their own specific objectives, to support the main Components in attaining their expected outcomes. This transversal axis included Information, Education and Communication for a change of Behavior (IEC/CCC), Continuous Quality Improvement (MCC), Monitoring and Evaluation and Community Health, even though MCC's was mainly focused on Maternal -neonatal health, and in the last term of the Project, for Hospital Infection Prevention.

The main objective of the Project in setting these Components was to strengthen basic health and the shared goal was to increase coverage and quality improvement. The main Intermediate Results of USAID El Salvador to be reached were IR 3.3 "Improve Integral Management of Children and Reproductive Health Care" and IR 4: "HIV/AIDS and other illnesses controlled, and impact mitigated". These indicators would measure the impact: global fertility ratio reduced and infant mortality rate reduced. It is noteworthy that every IR also had secondary-Intermediate Results which lead to have specific activities to be carried out.

In order to reach these goals and outcomes, and to comply with indicators, we used methodologies and interventions that promoted empowerment at all levels of the Health System. We made use of the most recent, local or international, clinical evidence for a continuous update of various instruments and documents and we sought quality and institutionalization of Continuous Quality Improvement in service provision; starting from the experiences generated by previous Projects and in association with other partners. Working closely with MOH Personnel at all levels lead to the achievement of goals set at various annual plans, and to a commitment from MOH, since they perceived this Project as their own, covering MOH urgent needs and those of the populations receiving its services. On the other hand, the permanent contact in tripartite

(MOH-USAID-URC) meetings enabled to continuously follow-up all activities of the Project and any constraints arising during the implementation of this type of Projects were presented and solved.

In general, our main achievements may be summarized as follows:

**Intermediate outcome 3.3: “Improve Integral Management of Child and Reproductive Health”.**

- Community Health Program implemented with the organization of the Community Health Unit in MOH central level and the application of the program in 72 priority municipalities.
- Perinatal information System used in techniques for decision-making in 28 hospitals with maternity wards.
- Surveillance System of Maternal /perinatal Mortality operating in 28 hospitals with maternity wards.
- Maternal and Perinatal Committees in operation in 28 maternity wards and participating in the quality standards follow-up in 13 hospitals of the first implementation phase of the MCC.
- Supervision carried out, pursuant to the MOH guidelines in 96 Health establishments of the first level and in 29 hospitals, mainly in the area of neonatal, Infant and children assistance.
- Sustainable Quality Program and operating in 13 hospitals of the first implementation phase of MCC.
- IEC/CCC Strategy created and being implemented nationwide, promoting key messages in Reproductive Health, Infant, and Infection Prevention.

**Sub Intermediate outcome 3.3.1: “Family Planning Services, information and education increased and expanded”.**

- Health personnel trained and providing consultancy and FP services according to MOH standards and complying with the provisions of the Tiaht law.
- FP consultancy on prenatal and post partum provided as a standardized service at the 28 maternity wards and Health Care Units of 72 municipalities supported by USAID.
- Physicians and nurses of the Health Care Units from USAID Priority municipalities, updated in contraceptive technology.
- Community-based programs addressed to teenagers with developed and implemented messages according to MOH standards through youth leaders in 72 municipalities supported by USAID.

**Sub Intermediate outcome 3.3.2: “Mother-Child Health Care Services, information and education, increased and expanded”.**

- We established quality standards for prenatal, obstetric, neonatal, delivery and infection Prevention assistance; as the beginning of a nationwide implementation of an MCC program.
- We worked in the area of maternal, prenatal and post partum assistance emphasizing on friendly services especially for teenage users.

- We strengthened the provision of prenatal, obstetrics, neonatal and post partum care, according to quality standards in 5 maternity wards and in 13 municipalities supported by USAID as a start up plan of a new prenatal Approach.
- We increased the rate of pregnant women from 71.2% to 78.3% (including pregnant teenagers) completing 5 or more prenatal controls. (Source: FESAL 2008)
- We increased the institutional delivery rate from 69.4% to 83.7%. (Source: FESAL 2008)
- We increased post partum control ratio from 48.2% to 52.8%. (Source: FESAL 2008)
- 100% of hospitals with maternity wards have now trained all personnel assisting deliveries in NRP and STABLE.
- Neonatal mortality rate reduced from 13 for every 1,000 Born Alive to 9 for every 1,000NV and infant mortality rate reduced from 25 per 1,000 Born Alive to 16 per 1,000 NV. (Source: FESAL 2008)

**Sub Intermediate outcome Sub-IR 3.3.3: “Best practices of nutrition, hygiene and Nutrition”.**

- 96 Health establishments from Priority municipalities have now trained leaders to spread messages to promote proper hygiene and practices of the proper use of water at home.
- We completed the first implementation phase for the SISVIN.
- We continued supporting the application of the AIN strategy in USAID priority municipalities to carry out the monthly monitoring of weight gain for children under 2 and pregnant women of the community.
- We increased the rate of exclusive breastfeeding from 24% to 31% and from 1.4 months to 1.9 months the term of such practice. (Source: FESAL 2008)
- Global malnutrition rate for children under 5 was reduced from 10.3% to 8.6% nationwide. (Source: FESAL 2008)

**Intermediate outcome 3.4: “Infectious illnesses controlled and impact mitigated”.**

**Sub Intermediate outcome 3.4.1: “Increase the use of infection prevention and services to fight other infections”.**

- We established Protocols and standards for Infection Prevention between mothers and newborns in 28 hospitals with maternity wards.
- We have Infection-prevention Committees working actively on prevention and reduction of hospital borne infections, jointly with perinatal committees, in 28 hospitals with maternity wards.
- We have standards for prevention and treatment of urinary tract infections and they are being applied at 28 hospitals with maternity wards.
- Institutional neonatal deaths as a result of sepsis have been reduced from 66% in 2007 to 38% in 2008 in 28 hospitals with maternity wards. (Source: SISMOB MOH)

During the execution of the Project there were some situations that influenced its implementation, the most relevant are: At organizational level, MOH introduced regionalization one year after startup of the Project. With this, the Project included in its

action plans some activities to strengthen, to a certain degree, the follow-up role of the programs assigned to this level. On the other hand, we had to face at least one epidemic a year, being the most relevant the pandemic of A H1N1 Influenza, started in April 2009. Also, one cannot omit the fact that the last year of Project was subject to a political environment of a presidential election which ended in the current year with the change in the government. This produces a disruption in the continuity of activities, expecting the approval of these by the new authorities of the ministry.

On the other hand, because the Project prioritized its work in 72 municipalities with greater poverty issues, and did not include complete sets of SIBASI's, and whole Regions, no further action was carried out on the Strengthening actions to decentralize Health administration. However, with all the achievements mentioned we were able to comply with impact indicators stated in the Project's agreement, achieving the following:

Reduction of the global fertility rate from 2.97 in 2004 to 2.5 in 2008; and infant mortality rate from 25 per 1,000 Born Alive in 2004 to 16 per 1,000 Born Alive in 2008. (Source: FESAL 2002-2003 and FESAL 2008)

## Lessons Learned and recommendations

### 3.1 Lessons Learned

- The commitment and the involvement of the different structures and counterparts from various levels of MOH administration are highly relevant –vital to continue achieving the Project's goals.
- Joint annual planning between counterparts of three MOH hierarchy levels and respect for its priorities facilitate determination of the operation plan and appropriation by MOH.
- It is relevant to have “flexibility” for the management and execution of the annual operation plan, because of emergency situations that arise in the country and affect MOH activities.
- Levels of direct rendering of service recognize the importance of the technical support to strengthen their skills for quality improvement and assurance of quality assistance to their users.
- The terms prescribed in a Project to reach expected outcomes must consider the rotation of personnel at a local level, multiple actors taking part, all of which have multiple agendas and fragmented availability, according to different priorities they are assigned
- Leaving out some agencies as counterparts of the Project negatively affected the opportunity to execute some outcomes. Therefore, it is necessary to make a proper review of key actors for every product expected.
- The structure of a Project must consider the technical assistance structure presented by the counterparts; since SHP Intermediate Results of the Project were very specific and rather than supporting the integral measuring of outcomes and effects in form, they resulted in some degree of fragmentation and affected integration of concepts and visions.
- Beneficiaries of the Project must be limited to complete areas, i.e., a whole department, one SIBASI, or one Health Region as a whole. Being too specific affects the process of reaching outcomes and their measuring. The Project prioritized disperses geographic areas based on the map of poverty.
- The implementation process of all strategies under execution should be accompanied to guarantee their success and sustainability, for which constant monitoring is required at all levels of assistance, regular evaluation meetings of the different indicators, at least quarterly or biannually; and Strengthening the same in site, taking into account the experiences at a local or operational level of the strategies.

- MCC methodology, besides measuring the performance through hospital standards, favored the search for solutions by those involved helping to turn them into more proactive agents within a hierarchical environment such as that in MOH.
- MCC methodology has contributed to create more awareness on topics quality, the search for evidence, the use of self-evaluation, display achievements and share small successful achievements, which are key to develop products to be institutionalized.
- Monitoring is a crucial tool to assure the proper provision of assistance and may be used as a means to provide know-how.
- To achieve impact in the educational interventions intended to reduce the levels of maternal and infant morbimortality, it is necessary to have Systematic methods to promote healthy behaviors such as the National IEC/CCC Strategy.
- The proper use of graphic educational material by health personnel becomes a didactic tool that facilitates the transfer of knowledge to the target audience.
- Identity is an important incentive for the performance of health professionals from the different administration levels, as it became evident from the reappearance of the Health promotion unit that strengthened with the implementation of the IEC Strategy, contributed to active and leading involvement of the national educator's network, as well as that of the IEC referring personnel at local level.
- Human Resources should be in an ongoing education process to guarantee their performance on behalf of the health service users.
- Limited coordination and/or communication between the members forming committees or between the different specialties within hospitals, as well as the amount of duties assigned to them, hinders the execution of activities and maximum attainment of results.
- The lack of a budget to procure basic supplies for the process of assistance turns into a risk for sustainability of the interventions.

### 3.2 Recommendations

- Mechanisms that may enable a better interaction with other cooperating agencies should be created to strengthen coordination of cooperation at MOH higher level and above all, in the operational level to learn about priorities, to prevent duplicities, and to make cooperation more efficient. In this activities SHP has follows USAID instructions closely.
- Involve the schools forming human resources in health in the different skill strengthening processes and provide them with the opportunity to gradually institutionalize MOH topics of interest.
- Consolidate regulatory features to facilitate institutionalization of approaches supported by SHP that generated successful results.
- Develop and apply a policy of incentives to comply with the regulating frameworks in the health establishments, increase responsibility in the use of evidence, and enhance quality. The experience of some programs proved is that it has a positive effect on personnel performance.
- Maintain, strengthen and spread monitoring as a performance assurance tool, to comply with standards and health personnel skills.
- Negotiate the necessary budget to provide all basic supplies that may enable to continue with the strategies and interventions that have been supported by foreign cooperation.
- Provide follow-up and support to complete the regulatory documents that were in process.
- Design a continuous education program based on weaknesses found through monitoring.
- Demarcate the duties and responsibilities of the different health actors and promote coordination and communication between them.
- Strengthen integration of the National Health System (SNS) members in operation and regulation processes that to date have been exclusive of MOH.
- Use the MCC methodology to integrate health service around the APS integral strategy, to promote responsibility and minimize damages, and promote users' rights for informed and quality assistance.
- Consider Family Planning as part of the assistance programs in the second and first level of attention.
- Consolidate the PIS at Health Care Unit level and have quarterly reports of data to the maternal and neonatal program authorities as well as higher authorities to

enhance its importance, bind it with the budget and achieve its institutionalization and have it remain as the standard duties of the three levels

- Continue accompaniment at regional and central levels, to advice on and to monitor execution quality projects.
- Enable implementation of new methodologies to accelerate the certification process of the health establishments with the initiatives of mother-infant friends to assure better indicators of exclusive breastfeeding.
- Provide especial assistance process of consolidation of the breastfeeding protection and promotion law.
- Provide follow-up to conclude the regulation on micronutrient supplement.
- Seek SNS support to consolidate national implementation of SISVIN.
- Carry out a fair distribution of over 2,600 health promoters existing to date at national level, standardizing the number of inhabitants that each health promoter must be responsible for, which may enable to benefit areas lacking this resource.
- Make a diagnosis of newly hired health promoters to learn about their training needs within twelve weeks.
- Preparing regulation documents should be made by suitable personnel and under an ample coordination process with the various technicians of the different health and social development programs involved, in order to gather all the knowledge and most recent evidence for a scientific basis of each work. Therefore, it is important to encourage a teamwork culture. This includes the experience of a horizontal culture in professional exchange.
- Guarantee that health promoters and community health supervisors at national level have the minimum suitable equipment and in good working order to perform their work in the households and the community.
- It should be taken into account that in the implementation of programs all actors somehow, even indirectly, are related to the topic.

## 4 INTRODUCTION

The Strengthening Health Project (SHP) is derived from the commitments set forth under agreement 519-0463, between the Government of El Salvador and the United States of America, undersigned in July 2005 and started in April 2006 to strengthen basic health which goal shared by the government was “3.3 Improvement in the Integral Management of Child and Reproductive Health” and 3.4 “HIV/AIDS And other illnesses controlled and impact mitigated”. The expected Outcome was the increase of access to quality services, and increase in demand for preventive, integrated, and improved health services, in order to reduce maternal morbidity and mortality ratios, global fertility rate, and reduce infant morbimortality ratio. All this leading to support the country to reach the Millennium Development Goals (MDG) number 4, i.e. reducing infant mortality, especially neonatal and number 5, i.e. improve maternal health.

The beneficiary areas of the project were defined according to the poverty level and those determined by MOH in accordance with USAID.

The Project was structured by Components according to IR to reach. Components were: Family Planning, Maternal Health, Infant Health, Nutrition and Hospital Borne Infection Prevention and Control. Additionally, we also defined other components with their own specific objectives, to support the main Components in attaining their expected outcomes. These transversal axis included Information, Education and Communication for a change of Behavior (IEC/CCC), Continuous Quality Improvement (MCC), Monitoring and Evaluation and Community Health.

For the execution of the Project, we developed annual plans defined jointly with the counterparts of higher and regional level, particularly of the beneficiary Regions and their corresponding SIBASI's, as well as hospitals with maternity wards. These plans took into account the emphasis on integration of services, experiences developed by former projects, the best clinical evidence, national and international experience and the permanent interest on a continuous quality improvement.

In the first year of the project, we emphasized the organization of the project's office, started cooperative work from the Work Plan that started in May until December 2006; we collected and adjusted the first baseline data that would be the basis for monitor the impact of the project. We reviewed the most recent evidences on the different topics to included in the review and updating of the regulatory documents. We kept as a goal the integrity of services; the creation or Strengthening of committees; identification of key behaviors to consider in the design of an IEC/CCC program, updating curriculum contents to design the training programs and program evaluation that would help adjust monitoring and supervision processes. Besides, in this first year, we systematized the local support by recruiting and training local URC facilitators (seven).

In the second year, we made heavy reviewing work of most regulatory documents which updating was a priority. We also increased the work in developing the human resources skills through a large number of trainings. A strong emphasis started

on monitoring, supervision, and evaluation activities. We worked arduously in designing all the materials to form the national IEC Strategy.

In the third year, we continued and strengthened the work started in the second year of the project within the regulatory framework set forth. We designed nine strategies, and we created the necessary instruments to apply and verify compliance with this regulation framework, and guarantee better knowledge and access to services by users. Besides, we started to obtain the activities outcomes and work on strategies to guarantee institutionalization and sustainability of interventions supported by SHP.

At the end of the Project there are many achievements attained, but there is also, some Lessons Learned that may be used in the future to strengthen resources and maintain or improve results.

## 5. BACKGROUND

The Strengthening Health Project (SHP) is a product of the agreement 519-0463, executed on July 11, 2005 between the Governments of El Salvador and the United States of America, it is a continuation of the support to the Ministry of Public Health and Social Welfare (MOH) and it is within the framework of Strategic Objective No. 3 of USAID Strategic Plan “**Healthier and better-educated population**”.

The objective of the Project is to contribute to improve Salvadorans health by means of Strengthening the quality in service provided at hospitals, Health Care Units and in the community, mainly addressed to maternal – Infant population of the least protected areas of the country; with this we expect to reduce infant mortality and the global fertility ratio.

In order to provide technical assistance for this Project, USAID hired University Research Co., LLC, an American company with forty years of experience in providing support to governments and private associations to design, execute and evaluate programs to cover public health needs. The execution was carried out from May 2006 to September 2009.

For an efficient operation of the Project, the technical assistance to support MOH was structured in Components, which was under the direction of local consultants with experience in the field of public health and with ample knowledge of MOH’s work. These were: **Maternal Health Component, Family Planning and Continuous Quality Improvement**, with three full-time advisors; **Infant Health and Nutrition Component**, with two full-time advisors; **Component of Hospital Borne Infection Prevention and Control**, with two full-time advisors, **IEC/CCC Component**, with two full-time advisors; **Community Health, Family Health Care and Monitoring and Evaluation Components**, under a full-time advisor. Moreover, in order to provide direct support for the work of the SIBASI’s which are beneficiaries of the Project, there was another group of local full-time consultants, known as Local Facilitators of the Project. Thus, the Central Region had the support of two advisors, the Paracentral Region had three advisors, and the Eastern Region had two advisors. Also, there was an administration structure formed by four employees that carried out all administration, accounting and procurement. All this work team was lead by an international consultant, who acted as a Technical Assistance Chief of Party.

Every year we prepared Action Plans with the active participation of multi-disciplinary and representative teams from every beneficiary public hospital, SIBASI, Health Regions, and MOH higher levels. These action plans responded to MOH priorities at all levels, pursuant to Intermediate Results and objectives of the Project. Implementation of said plans was a responsibility of MOH Health Personnel. This whole participative process was facilitated by the technical assistance group consultants.

At the outset of activities we created a baseline by a Community survey carried out in three Regions of influence of the Project. By the end of the project, even though no final survey was made, in general terms, the outcomes obtained were measured by the National Poll of Family Health Care 2008 (FESAL 2008), which is executed by the Asociation Demográfica Salvadoran (ADS), with the technical assistance from CDC Atlanta, USA, and USAID financial support. These outcomes were favorable concerning

coverage, for instance 93.7% of the women interviewed responded they have received prenatal assistance in their last pregnancy and 81.7% said they had received such assistance before their third month of pregnancy; also 88.3% of mothers responded they had enrolled their last child in the first 28 days of life, and infant mortality rate dropped to 16 per 1000 born alive. However, we found important gaps between the different Regions, and some indicators that still need improvement. These are presented below in this Report.

## 6. PROJECT OVERVIEW

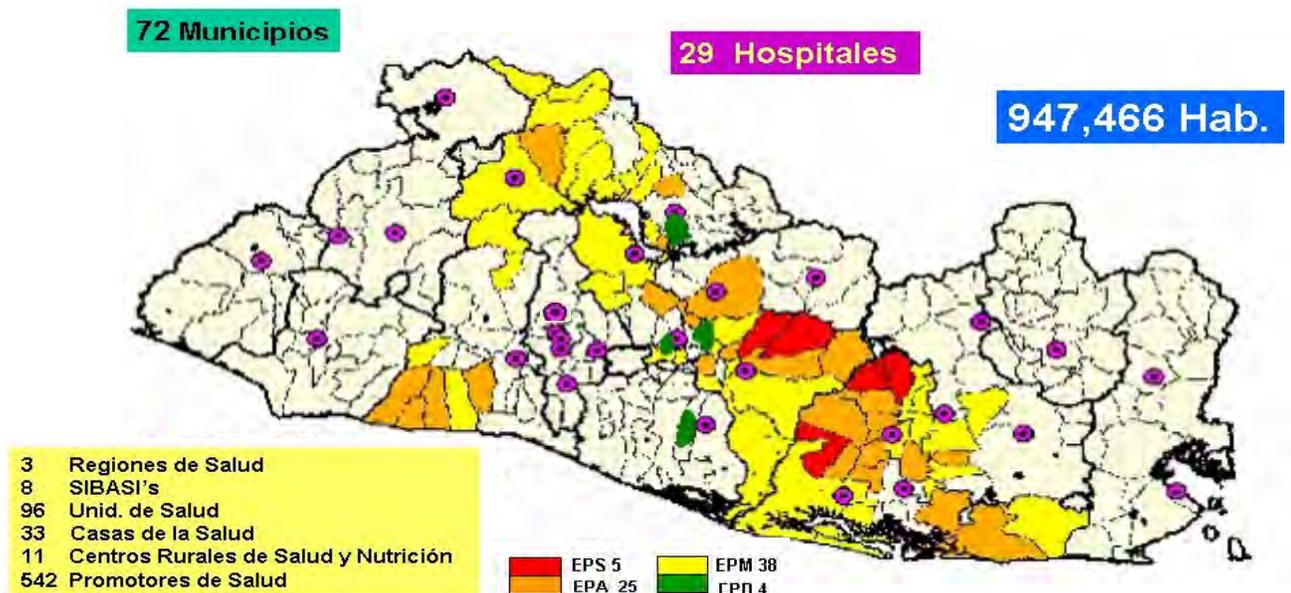
The primary beneficiaries of the SHP have been the people of El Salvador at the place of influence, which total 947,466 inhabitants from 72 municipalities that were assigned by MOH and that involve 8 SIBASI's from the **Central** (Chalatenango and La Libertad), **Paracentral** (Cabañas, Cuscatlán, San Vicente and La Paz) and **Eastern** (Usulután and San Miguel) Health Regions. About 60% of the total beneficiary populations of the Project reside in rural areas.

Out of a total of 72 municipalities, 4 are classified as Lower Extreme Poverty (EPB\*), 38 Moderate Extreme Poverty; 25 as High Extreme Poverty (EPA\*) and 5 Severe Extreme Poverty (EPS\*), according to the classification of the National Map of Extreme Poverty of El Salvador (Poverty Map), drafted by the Latin American Faculty of Social Science (FLACSO\*) in 2005. (\*Spanish abbreviations)

In this geographic-population space there are 96 Health Care Units, 33 Health Houses and 11 Rural Health and Nutrition Centers, and work 265 physicians (226 for 8 hours and 39 with less than of 6 hours), 171 professional nurses, 201 Auxiliary nurses and 542 health promoters.

Also, we have benefited 29 public hospitals with maternity wards and Neonatology, nationwide.

### SHP Geographic area of influence



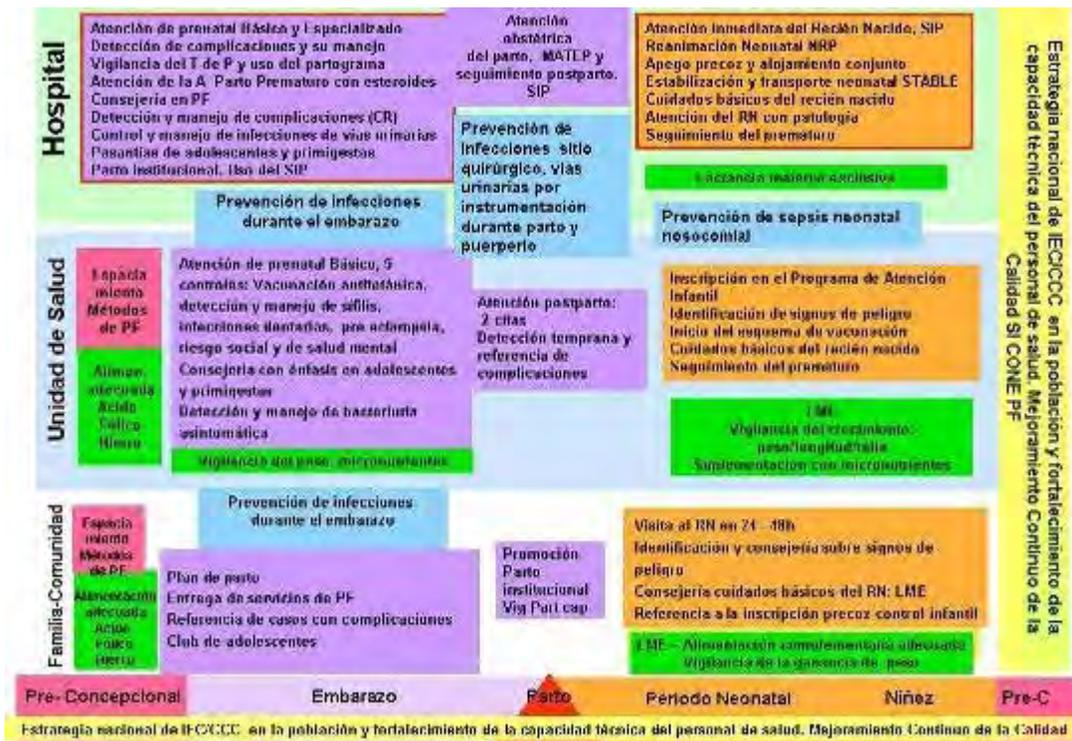
72 Municipalities, 29 hospitals, 947,466 inhabitants.

Secondary beneficiaries of the Project including **higher level** of MOH, where it has supported the review, creation, development, updating and printing of standard, guides, Protocols and other regulatory documents, based on the most updated scientific evidence. Also including **regional levels, SIBASI, local levels, and community levels,**

where it has supported numerous workshops and training sessions, cooperative monitoring visits, and holding evaluation sessions for an exchange of experiences to provide basic equipment to hospitals, some Health Care Units, CRSN, specific supervisors, and health promoters. We have emphasized the Strengthening of hospitals in their work on Hospital Borne Infection Prevention and Control, reactivating and/or promoting Hospital Borne Infection Prevention and Control Committees. Another topic related to this level was continuous Quality Improvement, in which, in direct coordination with the team in charge of the topic in central level, we involved hospital personnel in the quest for quality in the provision of services through the methodology of quick cycles of improvement based on previously set standards (in 13 hospitals).

The following diagram offers a summary of operative interventions that are supported through the execution of the Health Strengthening Project and scenarios where they are being implemented:

### Interventions in the different levels supported for MOH by SHP



## 7. MAIN SHP ACTIVITIES AND OUTCOMES

In general, the SHP was structured based on two major Intermediate Results, derived from the third strategic objective of USAID Plan, “**Health Investment: healthier and better educated people**”. These outcomes are:

- IR 3.3. Improved and integrated management of reproductive and infant health.
- IR 3.4. Controlled infectious diseases and mitigated impact.

Specific results for each component derive from these two general outcomes; and in some cases, sub-results are also defined in order to establish a difference within the activities of the same component.

All the activities performed with the support of the project were addressed to provide answers to these results and mainly to the three major areas of support:

**Technical assistance:** it refers to consultancy and active participation in the development of processes directly related to service rendering and health program management, such as: design, drafting, planning, scheduling, supervision, monitoring and evaluation.

**Developing human resources capacity:** include identification of training needs, design, execution and evaluation of training programs; attendees’ satisfaction with the quality of training, learning or acquiring knowledge, skills or attitudes, application on new knowledge at work, and impact perceived in the performance of programs or systems.

**Strengthening the structure:** it means supporting organization, premises, information, biomedical and computer equipment, as well as vehicles, furniture, supplies, and the printing regulatory documents, such as standards, manuals, guides, etc.

Below we present the main components, main achievements attained in complying with such results and those areas of support.

### 7.1 Family Planning, Maternal Health And Continuous Quality Improvement Component

This Component had an approach in systems and processes. It focused on Essential Obstetrics and Neonate Care System (SI-CONE in order to strengthen the integration of Maternal /perinatal attention based on the Cycle of Life, which was extended with Family Planning (FP) Components and Hospital Borne Infection Prevention and Control (IN). The latter was addressed to prevent sepsis in mothers and neonates related with unsuitable asepsis and antisepsis in obstetric practice resulting in the SI-CONE-FP-IN; Essential Obstetrics and Neonate Care Integrated System, Family Planning and Hospital Infection Prevention.

The processes addressed were selected jointly with the corresponding MOH counterparts and the strategy of Continuous Quality Improvement was applied in most of them. The processes selected were the following:

- Attention prior to conception with FP services.
- Prenatal assistance integrating other benefits such as FP, cervical-uterine and breast cancer detection, intra-family violence detection, preparation for breastfeeding.
- Labor, delivery and immediate post-partum attention.
- Newborn immediate attention.
- Attention of complications requiring clinical handling and manual procedures following asepsis and antisepsis criteria.
- Attention of complications requiring complex surgical or clinical procedures: anesthesia, obstetric surgery, transfusion under asepsis and antisepsis criteria.
- Referral and return of complications and transportation under suitable conditions.
- Actions in the community to increase demand and access to obstetric care services: delivery plan, apprenticeships, pregnant women circles with emphasis on teenagers.

### **7.1.1 Reproductive Health and Family Planning Component**

With the activities performed we contributed for the MOH, as the main provider of services nationwide and specially at rural level, to have an increase of 3.7 percentage points in the Method Usage Prevalence Rate from 67.3% to 71.0% in 2008 (Source: FESAL 2008), and an increase in Years of Protection for the Couple (YPC) from 335,561 in the 2005 baseline to 359,016 in 2008 according to data from MOH FP program.

#### **3.3.1: Family Planning, information and education services increased and expanded.**

##### **3.3.1.1. Physicians and nurses of the Health Care Units and health promoters from 72 municipalities of USAID providing consultancy and FP services according to MOH standards.**

We developed the “Technical Guide for FP Counseling”, addressed to health professionals, based on balanced technique and ACCEDA and relevant aspects on the legal framework (Tiahr Law, PD-3 and De Concini), ruling the use of funds from the US government for FP programs. Counseling privileges the principles of free and informed choice. We printed and distributed 5,500 copies. These tools were used in other Central American countries.

We prepared a training program for all the regions and a teaching guide to form facilitators. We trained 4,477 professionals among primary facilitators and providers in the use of this guide, including the use of informed consent for surgical methods.

We made 40 monitoring visits to establishments throughout the country. We found no failures to comply, but there were no IEC materials available to support the

subject because its preparation process and final distribution ended in April 2009. However, it is noteworthy that key conducts were being promoted although such materials were not available.

We held 5 workshops to compile successful FP experiences in which there were 97 attendees and we obtained 30 experiences related to the reduction of waiting time, access to IUD, inclusion of youth promoters, follow-up to users in the community, among others.

We reviewed along with representative obstetricians in hospitals the attention process for users of surgical methods, finding there were no homologated procedures for pre-surgical and post-surgical methods and no filing and subsequent consultations on temporary methods were provided, because during the former administration these services had been cancelled from hospitals because they were considered to belong to the first level. We homologated the procedure for Minilaparotomy and vasectomy, through trainings under short-term consultancy; we prepared teaching materials containing a unified procedure and standardized previous pre-surgical requirements.

MOH appointed 28 hospitals and 5 regional referring personnel, including physicians and nurses, to administer the Family Planning program. They were trained on operational planning and counseling with emphasis on surgical methods.

We delivered a 60-hour modular course on administration of programs for 32 attendees. The FP program strategic plan in Regions and the annual operation plan of 28 maternity wards were prepared in this course; besides, we strengthened managerial and administration knowledge and skills of attendees.

These activities have contributed to strengthen the knowledge on FP services. We have created a basic structure to manage the program in Regions and maternity wards and in 13 out of the 28 maternity wards. According to a decision of MOH, we are monitoring the delivery of FP services and counseling services using 5 standards: basic offer available, filing and subsequent control of FP users, counseling of obstetric and prenatal post-events. Specific data was discussed in RI 3.0.6.

**3.3.1.2.: FP consultancy on prenatal and postpartum, provided as a standardized service at 28 maternity wards and Health Units in up to 72 municipalities supported by USAID.**

This outcome has received input from other RI, so in preparing the model of the new approach to prenatal and the standards for prenatal, delivery and puerperium, a specific chapter was written on the different FP counseling methods, making emphasis on its use after delivery, and compliance with informed consent in permanent methods since prenatal control in the twenty-eighth (28) week of pregnancy. According to a decision of MOH, we applied this Approach in 13 of the 72 municipalities in a field test that was evaluated in the first quarter 2009.

There are two MCC standards on counseling through which we supervised and monitored compliance in obstetric post event and prenatal. The outcomes of these standards are provided in Outcome 3.3.0.6.

**Outcome 3.3.1.3.: Physicians and nurses of the Health Care Units in up to 72 municipalities supported by USAID, updated annually in contraceptive technology**

We developed a training curriculum on contraceptive technology based on a review of international evidence. We updated 766 employees among physicians and nurses through 25 workshops.

Furthermore, through a short term consultancy we strengthened and/or updated the skills of providers in surgical techniques and IUD insertion. We trained 58 physicians from national hospitals on Minilaparotomy and Vasectomy techniques and 57 physicians from hospitals in Cojutepeque, Santiago de María, Jiquilisco, Usulután, Nueva Guadalupe, San Miguel and Barrios Health Care Unit using the enclosed technique for IUD insertion.

We extended the updating to specialists attending patient with medical risks. There were 30 physicians including internists, endocrinologists and cardiologists, emphasizing on referral of cases to obstetricians from the same hospital.

We prepared a CD with audiovisual material as a support for trainings on contraceptive technology updating; this included updated criteria of medical eligibility, practical recommendations on the use of different methods, clearing myths and the latest in FP methods worldwide.

There is at least one person for each maternity ward, one specialist in internal medicine per hospital and two persons per region updated in contraceptive technology. We not only covered the Health Care Units but also hospitals throughout the country.

**Outcome 3.3.1.4.: Community-based programs addressed to teenagers with developed and implemented messages**

We worked on FP with youth, health promoters and midwives at community level with the following actions:

We formed 326 teenage primary facilitators on the use of the “Education for Life Guide”. We printed and distributed 1,500 copies for MOH. We trained 1,885 teenagers from the area of influence in the project, who prepared their plan for life.

We prepared and printed the “Practical Guide on FP Counseling for Teenage Promoters”, and distributed 1,000 copies.

We established criteria to form teenagers as youth promoters; we trained 75 institutional facilitators and we trained 245 teenagers in the 79 municipalities, of which two hundred ten remained active as of the date of this report.

We delivered the following promotional items: 500 t-shirts, 1000 pens, 500 backpacks and 500 caps for teenage attendees.

We prepared, printed and distributed 3,000 copies of the “FP Technical Guide for health promoters”. We trained 199 regional facilitators on the use of the guide, who

in turn, trained 1,919 promoters nationwide. The guide contains some aspects to strengthen FP services that promoters provide at community level, such as counseling, free and informed choice, medical eligibility criteria, checklists and basic technical aspects of the MOH medication offer, record keeping and logistics of the different FP methods.

We prepared, printed and distributed 1,500 copies of the FP Technical Guide to personnel working as midwives. We emphasized the free and informed choice and updated the criteria of eligibility of all methods. We trained 92 primary facilitators on the use of this guide by nursing assistants, nurses, promoters, promoter supervisors, health educators, and regional technicians in charge of the FP program.

Under coordination of the IEC/CCC Component we selected the key behaviors and IEC materials with messages directed with emphasis on teenage population, producing 3 Materials for this specific population. They were distributed to the establishments of all the Regions in the first quarter 2009. We also worked and produced IEC/CCC Materials for the rest of the target population: 2 REMINDER SHEETS for pre-surgery and post-surgery requirements on sterilization for Minilaparotomy and vasectomy; 3 POSTERS to encourage informed choice and partner involvement; 9 tri-fold leaflets concerning the use, mechanism of action, advantages and disadvantages of each method and one tri-fold leaflet concerning all the methods; one flipchart for providers on sexual and reproductive health counseling, 6 radio spots and 4 TV spots.

### **7.1.2 Maternal Health Component**

We have contributed with this component to increase qualified attention of delivery, 69.4% in 2003 to 87.3% in 2008, according to FESAL data. We continued encouraging the relationship between the hospital and future parturients through hospital apprenticeships. There is an increase of 8% between 2003 and 2008 in the attention during post partum in compliance with the standards prepared with SHP support, among others, both for the establishments and for health promoters. We favored approaching prenatal controls on critical dates to develop the neonate and to find complications in the mother instead of giving consultations by dates without following a system. We increased compliance with active handling of the third delivery stage (MATEP) for 17,859 cases in 2006 to 59,377 in 2008, that figure corresponds to 80.2% of the parturient women attended. After a Central American Meeting surgical deliveries are included since the second semester 2008.

#### **3.3.0.2: Perinatal Information System Developed Nationwide to consolidate information provided by the 28 maternity wards, for its analysis and decision-making techniques.**

We supported SIP in three levels; in the higher level, the Health Information Unit SIP within the Information Systems of MOH and appointed a computer technician as responsible for the System. At a Regional Level statistics clerks and coordinators of the maternal program and Maternal Mortality Surveillance program were appointed responsible for monitoring and consolidating regional SIP data.

SIP has been strengthened since early 2000, mainly renewing activities related to filling out forms, quality and inconsistencies of data, and we started with the use of outcome indicators. With this Project, we turned SIP into a management tool to set up a maternal-perineonatal monitoring Integrated System. We prepared the second edition of the "Technical Guide for the use of the Perinatal Information System", divided into two documents: the one for Health Care Units, intended to explain how to fill out and the one for hospital, addressed to the analysis and handling computer data. We printed and distributed 500 copies of the guide for hospitals and 1000 for Health Care Units. We strengthened the database to analyze and portray the trends of 18 maternal-perinatal indicators that are used for discussions in evaluation sessions.

Regions started monitoring and follow process. We provided training to 150 persons, from each of the 28 maternity wards and 5 Regions in charge of the program at higher level and URC on the use of the guide and management of the System.

We provided training to 558 attendees from Health establishments benefited by the Project on the proper filling out of the Perinatal Clinical Sheet (HCP).

We provided computers for 27 maternity wards and another one for the maternal program and in 2009 we installed the software with the latest version of the program produced by CLAP; this enables typing the actual sheet on a similar virtual sheet and crossing variables turns more practical and simple.

In the development of the Project we held 5 biannually evaluation sessions nationwide, in which we used perinatal outcomes to evaluate mainly the maternal program, but along with the Infant program; there is more active participation of pediatric personnel to evaluate indicators related to neonates. There was an average of 130 attendees per session including obstetricians, statistics clerks and regional and program supervisors. We provided training for 35 pediatricians in cooperation with the Infant Component. The results of these evaluations have contributed to identify constraints in Maternal /perinatal assistance that affect the results on newborns.

The maternal program is evaluated quarterly with SIP by maternal-perinatal committees, among them detection of RCIU, stillborns, neonatal resuscitation.

Within MCC standards, follow up is provided to the compliance with filling SIP at maternity wards with which the Information System is linked with the daily provision and we contribute to measure the information generated by SIP.

On a follow-up carried out in June 2009, it became evident that 27 maternity wards had updated their database up to the last month; one had a four month delay, but they were able to reduce this to 4 weeks, except for Hospital de Maternidad which lost one data entry operator, and has not been replaced.

At the end of the Project, according to 2008 SIP data for 73,856 deliveries, 90.4% was assisted by qualified personnel; 26.1% was assisted by cesarean; 17.2% ended in premature deliveries, 2.7% had low APGAR, 4.1% of cases presented preeclampsia and 0.2% eclampsia. A rate of 57.3% of cases had five or more controls and 38.8% had early enrollment.

The decisions that we have improved using the SIP, among others have been:

- Reduce the higher index of cesareans, especially by failed induction, through the request of purchase of Misoprostol.
- The use of antibiotic in membrane rupture, which has now an 18-hour protocol of use. To improve filling out control data, some management decisions have been made, such as stamping whatever has been reviewed by the committee, double control by the chief of residents, audit of production of services using the SIP, includes heads of the medical and administration division.
- Optimization of the use of oxytocines for the management of the third period.
- Improve the concentration of prenatal controls.
- It has turned imperative the lung maturity for babies, through the purchase and application of Betametasone.
- Deaths and still newborns are monitored.
- Follow-up is given to premature babies, taking note of typical users.
- Extreme pathologies are monitored, drawing graphics of all pathologies among patients during pregnancy (3 included in SIP).

One technical advisor of the maternal component was invited to the 25° anniversary of the Latin American Center of Perinatal Health (CLAP), in Uruguay to present the progress of the country on SIP issues.

The recommendations given by participants include: technical accompaniment to the countries by CLAP when new SIP versions are launched, encourage exchange of experiences between countries and create a support network by region.

CLAP helped following-up such recommendations, to form so that a SIP network of the Mexican, Central American and the Caribbean region were formed in the second quarter 2009 which main objectives are addressed to promote maternal-perinatal integration in maternity wards of these countries and the use of SIP data for decision-making.

**3.3.0.3: National Maternal Mortality Surveillance System in operation according to the MOH instructions and**

**3.3.0.4: Maternal-Perinatal Committees in 28 maternity wards nationwide, monitor implementation of quality assurance programs, and ensuring the liaison between Hospitals and Healthcare Units to reduce maternal and neonatal morbidity.**

The actions of these two outcomes were combined since the first semester of the Project according to work teams to discuss the topics on both outcomes. The committees have so far the responsibility to monitor Maternal Mortality in their SIBASI and hospitals, and monitor SIP and the referral and return sub-System.

The epidemiological stage included identification of cases, data collection, classification of deaths as maternal, and preparation of a database and notice. The implementation stage included analysis of the case, classification according to degree of prevention and delays, preparation of recommendations and definition of interventions as well as measuring achievements reached. This segregation in two stages delimited the duties of the different actors involved, such as mayor's offices

registrars, health care units, hospitals, regional epidemiologists, regional coordinators, Epidemiological Surveillance Agencies, Woman Integral Assistance Unit and the consultant for the safe maternity / maternal mortality.

We studied the role and performance of the maternal-perinatal committees, finding that the few that were active did not have specific duties and they only met if there was a maternal death. Therefore, in the technical Guide for surveillance we included a chapter on the texture of the committees: national, regional extended (education and other) regional, SIBASI, and local, as well as the roles of each level.

We provided training to 252 officials of the five Regions and mayor's offices registrars on the proper way to fill out the basic cause of death in the Death Sheet and we provided training to 135 officials in use of the Critical Link Technique to analyze maternal deaths.

We provided training to 35 epidemiologists on the use of the database for deaths of women from 10 a 45 of age.

We prepared six (6) forms for the survey on maternal death according to the RAMOS modified methodology that were distributed to all Regions.

We held community awareness sessions on maternal death in the SIBASI benefited by the Project with the participation of 200 attendees.

We first supported monthly and then bimonthly meetings of Maternal /perinatal / maternal mortality surveillance committees. In the third year of the Project we created the National Surveillance Committee of the Maternal /perinatal Health, formed by delegates from the Health sector which were supported in some biannual meetings. The lasts two years we also provided coverage for the Western and Metropolitan Regions for the quarterly meetings with regional extended committees with a total average of 470 attendees per quarter.

We held 9 biannually meetings nationwide to follow-up the Maternal Referral and Return Sub-System (R and R), in which there were initially 9 maternity wards and then 3 were added and incorporated to the implementation of the New Prenatal Approach. With this we were able to improve the assignment of reference, instructions during transfer and communication between hospitals, at all hospital locations.

In the period of the project, we analyzed maternal deaths. Among the impacts that the project has contributed in maternal area we may highlight two: reduction of maternal death because of obstetric hemorrhage caused by uterine atony, with 0 cases in four regions of the country, and 3 cases that occurred in the Western region, against 16 in the previous year; as well as the reduction of maternal death caused by self-inflicted poisoning, which has dropped from 15 cases in 2006, to only 3 cases reported in the last year of the project. Interventions that have contributed to these effects are the trainings at the skill centers, follow-up to MATEP compliance with monitoring, audit of records in 13 of the 28 maternity wards, evaluations of the Perinatal Data System at all maternity wards and prenatal counseling that emphasizes detection of biological, social, and mental health problems.

Currently MOH has regulatory instruments; the national, regional, and local structure for following-up and implementation, and personnel trained to develop SVMM according to the standard.

**3.3.0.5: Supervision, particularly in MOH establishments attending deliveries, also in Health Care Units of up to 69 municipalities supported by USAID, carried out pursuant to MOH guidelines.**

We reviewed the background in this issue and found there are 8 documents pending specific supervision by discipline and specialty.

We decided to approach the topic from a more integrating perspective choosing for this the coaching technique to apply with the supervision for compliance with quality standards. Therefore, this Outcome was integrated to the Quality Component.

The work environment was re-oriented towards hospitals, because MOH priority was the promotion of institutional deliveries at hospital level.

**Sub – IR 3.3.2.: Mother-Child Health Care Services, and information and education, increased and expanded according to MOH standards in up to 72 municipalities supported by USAID**

We prepared a survey to relieve biomedical equipment, this was made at hospitals of the country that lacked the support from another sponsor in the SIBASI's and a sample of health promoters and Nutrition Volunteer Advisors (CVN) of the geographic area assigned at the start of the project. Data collection was made between November 2006 and February 2007 from a total of 17 hospitals, 91 health care units and 7 health houses.

The survey included the amount, condition, location and technical descriptions from a list of equipment and surgical instruments agreed upon with the maternal and family planning program for prenatal assistance , labor and delivery at SIBASI's and labor and delivery for hospitals with maternity wards, as well as basic equipment for promoters and CVN. From these results, we prioritize such instruments and fundamental instruments to provide services, a purchase was made and items were distributed based on the same survey and the priorities identified by MOH. Moreover, municipalities benefited by the Project and 17 maternity wards received additional equipment to strengthen personnel working on FP Component.

**Outcome 3.3.2.1.: Quality Standards for Prenatal, Obstetric, Neonatal and Post-partum Care, emphasizing friendly services especially for teenage users.**

We created quality standards in prenatal, delivery, neonatal and postpartum attention as described in outcome 3.3.0.6. However, no special services for teenagers were created. They received the same interventions as the adult population; it was only focused on the specificity of the constraints of this age group.

Since the workload generated by the teenage population in the obstetric services is of about 32%, no friendly services were created in the strict sense of the word, which means having separate services only for teenagers. Through the trainings on

counseling all personnel from the Health establishments learned the know-how to assist the specific needs of teenagers, increasing their skills of assistance provided to this group.

**Outcome 3.3.2.2.: Provision of prenatal, obstetric, neonatal and post partum assistance, according to quality standards in 28 maternity wards and in up to 72 municipalities supported by USAID.**

Outcome incorporated to 3.3.0.6 associated with a quality System.

**Outcome 3.3.2.3.: At least 70% of pregnant women of the rural area (including pregnant teenagers) completing 5 or more prenatal controls in up to 72 municipalities supported by USAID.**

While using the prevailing model, pregnant women would miss controls at the center by the 36 week. Therefore, their main health problems were not focused specifically, and a risk focus was follows, which was, experience showed, of little benefit to reduce maternal mortality; the new focus was presented. This intended to integrate several interventions including detection of breast and cervical –uterine cancer and intra-family violence, consultancy in FP, nutrition, breastfeeding, asepsis and antisepsis measures and others; based on the fact that education of users favored the use of services and intra-hospital delivery considering the characteristics of each user and through screening identify the presence of complications signs and handle them until they were stabilized. We emphasized on a control at the 38-41 weeks of pregnancy to reduce the perinatal mortality which concentrated on those weeks.

The new approach was implemented in a 1-year field test in 3 SIBASI's benefited by the Project, covering a total of 6,648 pregnant women registered, located at 17 municipalities, assisted by 19 centers.

For this training, we prepared 8 skills based on the best evidences and their corresponding checklists. We designed 6 clinical cases and one pretest and post test. We trained and evaluated individually 28 primary facilitators in ten (10) 32-hour courses in a series of skills to be applied in the new focus, and later on, 250 officers were trained, at least one physician and one nurse from each health care unit and all obstetricians and nurses from the 3 hospitals and 3 regional teams. Additionally, we provided supplies and small medical equipment for the field test of the New Prenatal Focus.

This Approach has two limitations, one is the time dedicated to the medical and nursing assistance to users (which has been increased to 45 minutes this time includes the filling out instruments, and preparing the user) considering that all MOH Information and performance evaluation Systems are based on 15 minutes of assistance. The second constraint refers to the significance of cultural factors of women's view of pregnancy and that the approach reaches a limit in education and responsibility of patients. To solve this, it is necessary to increase community involvement and the cultural adjustment in this type of initiatives.

The most outstanding results in this pilot experience were the detection that between 15 and 17% of all users required specialized consultation; an increase in the

early enrollment between 15 and 20% of the cases. In some establishments the enrollment of pregnancies among youths increased in 12%, due to the early confirmation of pregnancy through rapid tests. 90% of the patients completed 5 controls and went to the control appointment in the referring hospital. When all the approaches were applied, no perinatal deaths were observed, such was the case of the SIBASI of Santiago of María. Concerning rapid tests, we were able to detect 17% of asymptomatic proteinurias, all of which were treated. Glycemia detection failed to produce the expected results, only 3 cases were found, with an expected prevalence in the general population of 10%; most of patients did not show up to their appointment on an empty stomach.

**Outcome 3.3.2.4.: At least 60% of pregnant women of the rural area (including pregnant teenagers) give birth with the help of qualified personnel, in up to 72 municipalities supported by USAID (Regional Centers).**

We organized a work team with which we designed the Technical Guide for prenatal, delivery and puerperium that was implemented as a field test in one SIBASI of each of the three regions beneficiaries of the Project.

Originally, we designed 11 skills were gradually increased to 36. These were grouped in 5 modules, in an effort that has integrated the different SI-CONE-FP Components. This ended with the inclusion of most recent evidence in procedures carried out within the processes of assistance: FP, prenatal, labor, delivery, puerperium, immediate attention of the newborn, management of complications and asepsis and antisepsis measures.

We prepared and tested the corresponding checklists following the steps of the technical assistance attention to evaluate attendees. We printed 500 of them copies and edited the “Dossier with technical material for obstetrics, neonatal, FP and Hospital Borne Infection Prevention and Control” skills, of which we printed and distributed 500 copies.

We provided every region with a training center to develop skills, in two Regions we provided Materials to improve infrastructure, and in three of them we provided materials for refurbishing (painting, electrical wiring), as well as air conditioning and audiovisual equipment. They were also, furnished with 10 torso mannequins for childbirth, 5 mannequins for breast palpation, 5 mannequins for intravenous use, 5 mannequins for intramuscular injections. We provided 10 boxes of materials and 1 box with educational materials and plasticized posters with the different instruments used in the process of obstetric attention.

We edited and distributed the “Guide to evaluate the obstetric, neonatal, FP and Hospital Borne Infection skills”; printing 1,000 copies. This provides a regulatory framework to the operation of centers, an essential requirement to progress in the institutionalization of this initiative.

We provided training to 35 professionals including physicians and nurses as regional facilitators on skills, and at the closing of the Project, 148 physicians and nurses from the 28 maternity wards had been evaluated and strengthened.

We made 26 hospital apprenticeships, favoring 370 pregnant teenagers with the purpose of promoting institutional delivery. This strategy consisted having pregnant teenagers –primiparas or not– made a round by the delivery route in the hospital where they have planned to have their babies. This enables them to become acquainted with personnel and the steps they will follow.

We defined and edited the “Guide to implement delivery”, in which the Community Health Component also took part.

We provided training to 106 persons from the SIBASI benefited by the Project on handling educational circles. Educational circles gathered pregnant women to extend their knowledge on pregnancy, breastfeeding, signs of complications in a mother and danger of the future baby, and they were fully delivered by local personnel.

**Outcome 3.3.2.5.: At least 60% of pregnant women of the rural area (including pregnant teenagers) receive post partum assistance within 6 weeks after delivery in up to 72 municipalities supported by USAID.**

Because that baseline showed that most deaths occurred during the immediate and mediate post partum, they were included in the workshops of Skills to follow-up postpartum. Additionally, because one of the causes of death was sepsis, which may show up to 7 days after delivery, we schedule a control within the first 7 days. Also, as a consequence of the integration of FP services with the prenatal, delivery and postpartum we schedule a control of 4 weeks of postpartum.

Also, we held 8 workshops at local level, with 200 attendees, on the importance of post partum control.

### **7.1.3 Continuous Quality Improvement Component**

**3.3.0.6: A quality assurance program operating in up to 72 municipalities supported by USAID**

We provided support in organizing the National Quality Committee (CNC by its abbreviation in Spanish) starting with 7 members, remaining active at the end only 2 persons of the project. They developed a Work Plan, which was validated by the international consultant on the topic.

CNC designed a Technical Guide for Continuous Quality Improvement (MCC) of which we printed and distributed 1,000 copies. The methodology explained on the guide was on the use of rapid of improvement, these were nothing but cycles, Planning, Executing, Verifying and Acting cycles (PEVA) which are applied after responding to three fundamental questions: What do I want to change? How do I know that change will lead to an improvement? What should I do to apply the change?

A team was nominated with representatives from the maternal, neonates, PF programs, regions and some hospitals, with these we defined 17 standards distributed as follows: 5 for PF, 3 for prenatal, 1 for labor, 1 for handling the third period of delivery, 2 for postpartum assistance and release, 3 for complications and 2 for neonates.

The General Health Directorate selected 12 maternity wards- 3 in the Eastern Region and 2 per each of the remaining regions and Hospital Nacional de Maternidad – to start the application of the methodology. The first steps were training in such methodology and the building the baseline. We designed a format for electronic data entry and a database to analyze outcomes.

We drafted an Executive Summary on the Baseline, and printed and distributed 200 copies. Hospitals selected those standards with the lowest compliance, reviewed the criteria that measured the lowest and prepared improvement Projects containing the proposal for changes, the activities to execute them and the indicators to determine whether they were on the right track. Outcomes of the baseline showed that no hospital complied 100% with the 17 standards, indicating poor compliance with the standard in force. Processes with lowest accomplishment belonged to PF, partly because of the lack of a structure in hospitals as explained in the corresponding outcome.

The main data of the baseline showed that the use of a partogram was performed only by one hospital, and none of the institutions showed that the decisions were based on the proper analysis and interpretation of the progress of care provided to women in labor. We found sub-records in the case of obstetric hemorrhages, according to the obstetricians' analysis because of poor definition of cases; standard criteria in the assistance of newborns were not applied in their entirety, particularly at the time of release.

As a product of the baseline, we started implementation of 35 MCC Projects at participating hospitals and 27 immediate measures in 2008. We have had 4 learning sessions covering 150 attendees. We held a workshop to induce induction of MCC methodology to URC personnel for 10 technicians and we held meetings with the colleagues from Hospital Borne Infection Component to apply the methodology, resulting in an infection prevention standard for newborns that is operational.

We carried out all the activities related to the organization of the National Quality Forum 2008 with the participation of two international speakers and two simultaneous workshops on patient safety and the importance of the use of quality standards. Likewise, we held 9 meetings to organize the International Quality Forum 2009, selecting the 12 best Improvement Projects, the design of promotional materials, the agenda and steps to follow for international participants. This was postponed because of the emergency decreed on account of the A H1N1 Influenza pandemic.

We drafted, printed and distributed 1,000 copies of the MCC workbook, autodidactic guide on the MCC methodology, planning and follow-up on improvement Projects on the use of the database, the Projects bank and the construction of timelines.

CNC and the Regions made at least 7 follow-up visits to 12 maternity wards.

We developed a course on technical strengthening addressed to members of regional quality committees for 32 attendees. This workshop strengthened skills to perform supervision and support to local quality committees and the technical skills to evaluate the quality level of a Project and whether it complies with fundamental principles and requirements of a Project.

The Metropolitan region held a regional workshop on MCC disclosure with the participation of 29 officials from the main health care units, CAE, Hospital Soyapango and Hospital Zacamil.

Concerning the progress and contributions of the improvement projects we may quote: the two most frequent projects under execution at hospitals were: partogram use, evaluation of newborns for release, and postpartum control. Some outcomes obtained included: In prenatal they are using 3 standards: proper assistance and registration in the Perinatal Clinical Sheet (HCP), compliance with steroids in threats of premature delivery and prenatal counseling. Five hospitals carried out Improvement Projects for these three standards, showing in the evaluation 90% compliance with the three standards using 2 MCC cycles.

While caring for women in labor (which in the baseline was the one with the poorest performance), we used the partogram to evaluate Labor and obstetric decision-making. We developed improvement Projects in 7 out of 12 hospitals to apply these standards. We included the national referral hospital; the Outcome was that we were able to increase of compliance with the use and interpretation of partogram graphs from 74% to 90%. The effects on users were: increase in detecting cephalopelvic disproportion (CPD), reduction in the indication of caesareans of up to 6 points, due to a reduction of indications of acute fetal suffering (AFS) and increase in the Active Handling of the Third Period (MATEP).

As for compliance with MATEP, these hospitals attained 100% compliance with this standard, after 6 months of applying the improvement project, some supply problems were also corrected.

Immediate postpartum process turned out the second standard with the worst performance in the baseline, 5 hospitals had a compliance under 50%. We designed Projects and carried out two improvement cycles, expanding immediate postpartum assistance between 90% and 100%. Application of MATEP and proper follow-up immediate puerperium has helped reduce obstetric hemorrhage to the fourth cause of maternal death.

Activities held, common to all Improvement Projects were daily monitoring by the staff, periodic training for rotating personnel for all services and the periodic audit of medical records by the Quality Committee. Service heads became involved in planning supplies such as steroids and the oxytocin, coordinating with the administration areas. And at the end, this follow-up activity was included in the daily routine of services, and personnel under post graduate academic formation joined in, creating a culture of quality.

By the end of SHP there were 78 improvement projects and the experience was extended to 16 of the 28 maternity wards and it may be said that there is a quality improvement program being applied at hospital level in the five regions of the country.

## **7.2 Infant Health and Nutrition Component**

### **7.2.1 Infant Health Care Component**

Many of the activities of this Component were defined from outcomes and secondary outcomes directly related to reproductive Health, since this affects Infant Health mainly in neonatal period.

#### **Outcome 3.3.1.2. A Perinatal Information System developed nationwide to consolidate the information gathered from the 28 maternity wards for the analysis and decision-making techniques**

A new coordination and integration work of maternal and infant programs starts, strengthening the proper use of SIP as a tool to improve decision-making in early perinatal and neonatal health. It starts with the review and updating of the PIS manual, this included the use of the new sheet, review of indicators and the evaluation methodology, specifically in the section related to newborns.

We also made joint evaluations of both programs, finding as the most outstanding discoveries related to neonates that pediatricians were not getting involved in following-up this program because there were some doubts concerning the definitions and concepts to enter data to the PIS. Upon analyzing data, we found that most fetal deaths occurred among full term deliveries, with good weight and mothers that had full prenatal control; that prematurity and low weight at birth occurred very frequently and it was associated with the lack of prenatal control that in some hospitals the second cause of Caesarean was fetal suffering, and that deaths were related to extreme prematurity and congenital malformations.

Because of these findings we designed some strategies intended to improve direct benefit from providing direct assistance to the patient. Besides we made a training process for 100% of the number of pediatricians at hospital level with the purpose of strengthening their participation in handling PIS of children under 1,500 grams and the use of this information for decision-making. This included dissemination of the new PIS manual, which was reviewed, updated and reprinted; as well as training on the use of the new sheet. This is complemented with the printing of plenty PIS sheets for children under 1,500 grams.

All this showed clear improvement in later evaluations concerning filling out data of the PIS sheet, more involvement of pediatricians in follow-up. It is also evident that most hospitals improve concerning the use of steroids for lung maturity of fetus and strengthen the application of MATEP. That is, SHP helped MOH to use Medicine Based on Evidence which has no doubt had direct impact in the improvement of quality in providing services and consequently the satisfaction of users.

#### **Outcome 3.3.2.1. Established quality standards, for prenatal obstetric, neonatal and post delivery assistance, emphasizing a friendly service especially for teenage users.**

In El Salvador, 54% of institutional infant mortality occurs as a result of neonatal mortality in 2005, particularly early neonatal and its primary causes: prematurity,

asphyxia at birth and congenital malformations. This condition, among others justified the support of actions addressed to this age group, specifically on such issues.

### Strengthening Neonatal Resuscitation Skills

This Outcome enabled the Strengthening of the Neonatal Resuscitation Program with the consolidation of the National Resuscitation Committee and Neonatal Transportation, which, besides enforcing compliance with the new guidelines for NRP and STABLE courses determined by the American Academy of Pediatrics, turned into an advisor agent of the MOH National Integral Health Care Program for children on topics related to neonatal health. This was attained through the support in holding monthly meetings of such committee.

As part of the work of this Committee, we were able to design a new training scheme for NRP, the progress of training courses nationwide and the forming new and different keys for the courses tests, to guarantee the quality of the course and attendees learning.

Moreover we developed a total of 115 NRP courses training a total of 3,414 professionals including physicians and nurses; some were being certified and others were being re-certified to comply with the mandatory re-certification every 2 years. ***This leads to a relevant achievement on December 2008, dropping asphyxia at birth from the second to the seventh cause of neonatal death.***

Also, the Project supported the first international course on formation of NRP instructors, where we provided training to 12 instructors of 4 Central American countries (Guatemala, Honduras, Nicaragua and Panama), which facilitated the start of the program in said countries.

All NRP courses were carried out using 520 issues of the new books of the ninth edition in Spanish purchased with AAP Project funds.

### Strengthening the conditions and skills of personnel for Stabilization and Transportation of Critical Newborn (STABLE)

SHP provided follow-up and strengthened training on Critical Newborn Stabilization and Transportation skills. To attain this, three neonatologists from the National Children Hospital Benjamin Bloom, MOH third level hospital for pediatric assistance, and members of the Committee mentioned above, were re-certified as STABLE instructors' leaders /teachers by the STABLE Program, associated with AAP in Florida, USA. ***This also enabled El Salvador to be nominated as the only country in Latin America to be certified for the formation of STABLE instructors.*** A most relevant achievement was to have this capacity installed in the country and institutionalized at MOH level.

After such recertification, we negotiated, purchased, and distributed 26 manuals for STABLE instructors. We developed a course for leading instructors, following the

new STABLE training scheme, providing training to 18 leading instructors and strengthening 105 instructors to support 29 hospitals and regions. Upon request from MOH, the Project provided an incentive and recognition, by making 125 polo t-shirts to be delivered to all instructors of the STABLE course.

After this Activity we started courses at hospitals and some at the regions, having developed 31 courses and trained 803 professional physicians and nurses, which covers about 85% of the total personnel that provide assistance to newborns at hospitals with STABLE training.

In order to provide a follow-up to the proper application of the program, we designed, printed, and implemented the instrument for condition control of Neonatal Transportation, which enables one to identify at any time the condition of a newborn being transported from the time he leaves the referring hospital until his arrival to the referral hospital. Besides, we provided all hospitals with glucose meters with their strips; this was the missing element to comply with 1005 of STABLE interventions.

We supported implementation of the transportation network in the Central Health Region, therefore, newborns at national hospitals of Chalatenango and the Nueva Concepción may be referred to Hospital Nacional San Rafael in La Libertad and not as far as the HNNBB.

#### Improve the quality of assistance of the newborn at risk (premature)

Because prematurity was the first cause of neonatal and Infant death in El Salvador, MOH decided to implement an intervention for a follow-up of premature babies that were released from the neonatal care units of national hospitals, having provided assistance to prepare and officialize the “Technical Guidelines to Follow-up Premature Babies under 2,000 grams at birth”. Likewise, we prepared different instruments that will support implementation of the intervention above, such as: control file cards for premature babies, referral Sheet for premature, identification cards for children under 1,500 grams, Identification card for children 1,500 to 2,000 grams at birth, posters and plasticized sheets for evaluation of gestational age according to Ballard.

We carried out training by pediatricians that will implement the Premature Follow Up Guide at 28 maternity wards. The topics delivered were related to ophthalmologic, neurologic, audiologic, and early stimulation follow-up. Moreover, we worked in the process of coordination to expedite referrals and returns. We provided training to 40 physicians and nurses from Regions, SIBASI and hospitals.

**Outcome 3.3.2.2. Provision of prenatal, obstetric, neonatal and post delivery care, according to quality standards in 28 maternity wards and in up to 72 municipalities supported by USAID.**

#### Strengthening and standardizing neonate health care

To improve the quality of assistance of neonates, the neonatal Resuscitation Committee decided to review and update with the support of the Project the “Clinical Guide for Newborn Care with Pathology”, which were made in 2002. Therefore, we

organized a Committee of review integrated by representatives from different MOH hospitals, as well as from the Neonatology Association and the Salvadoran Social Security Institute. Moreover, this Committee decided to integrate in the same document the Technical Guide for healthy child assistance, starting at birth. Therefore, the updated document will be called "Clinical Guide for Hospital Assistance to Neonates". So far, it is completed and validated, ready to be reprinted.

Also, in this Outcome we identified the need to have instruments that standardize and facilitate activities to monitor the quality of neonate assistance. Therefore, we prepared the following instruments: the neonatal clinical history sheet, since birth, the hospital release evaluation sheet for newborn assessment, these two are also being used to follow-up compliance with quality standards determined by the Children Assistance Program, the evaluation sheet of the newborn assistance quality at that stage of delivery and the children file control card with prematurity background. Moreover, we updated and we supported implementation of the sheet for surveillance of the mortality perinatal, Infant and the children.

On the other hand, a significant progress for the country resulted from implementing a neonatal screening program, which was financed by the project. This included 16 training workshops, developed with 666 nurses from the health care units at national level, improving their skills for blood taking. Currently, we have taken 40,000 tests; of which 15 were positive, representing an incidence of 1/2667, this figure is above the international standard, i.e. 1/3,000 tests. All the fifteen children that resulted positive are under the necessary treatment. This testing was made on neonates from 3 to 28 days of birth.

Within the MCC of neonate assistance, the SHP contributed with a constant monitoring action at hospitals of the public sector, in such a way that 24 monitoring visits were made with the main purpose of assessing compliance with the Assistance Guides, their having the necessary supplies, their compliance with NRP and STABLE programs and compliance with defined quality standards. We had also worked with the Quality Component and established two standards that were used to determine the quality of hospital assistance of neonates, these were: immediate evaluation of newborns at the stage of delivery and evaluation of neonates at the time they are released from the hospital; we also made the necessary measuring instruments.

Likewise, with the Maternal Health Component we worked the chapter concerning newborn assistance at the stage of delivery to include in the training dossier to be used at obstetric, neonate, Family Planning skills-formation, and infection Prevention centers.

Along with the Infection Prevention Component, we supported the execution of the survey on neonatal mortality baseline related to hospital sepsis in 29 hospitals and the promotion and surveillance of clinical hand-washing among Neonatology Units personnel to prevent Hospital Infections. This support consisted in training Neonatology Unit personnel and delivery of the necessary instruments to follow-up compliance with this practice.

Also, we strengthened assistance to newborns, by training 35 nurses from the Hospital de Maternidad newborn wards covering several clinical topics. We also trained 100% of Health promoters from USAID priority areas, enabling them to identify danger signs and to improve consultancy on basic care of newborns.

Concerning structure, several MOH hospitals were strengthened with the provision of neonatal assistance equipment, which included: umbilical cord clamp, suction pumps, and orotracheal tubes, scale for newborns, pediatric/ neonate stethoscope, neonatal laryngoscope, radiant heat lamp, secretions pump, infusion pumps, cephalic chamber, incubator for Neonatal Transportation.

All activities were carried out with SHP support contributing to improve neonatal indicators set forth by MOH. Therefore, in the last quarter of 2008, the Integral Assistance Program on children health held a national forum with the attendance of MOH high authorities and representatives from different institutions forming the SNS to disclose the progress attained in this area of assistance, highlighting the improvement of their indicators: perinatal mortality rate dropped from 23 to 19 per 1,000 born alive and neonatal mortality rate dropped from 13 to 9 per 1,000 born alive. (Source: FESAL 2002-2003 and FESAL 2008)

**Outcome 3.3.3.3. All children under 2 years of age, and breastfeeding women –specially teenage mothers–from the 72 municipalities supported by USAID, are being monitored once a month regarding their nutrition and growth status, with the suitable equipment, in the AIEPI-AIN strategy.**

With this Outcome we supported the different interventions addressed to improve assistance provided to children under 5.

#### Strengthening health personnel skills for assistance provided to children under 5

Since the end of the 90's, MOH defined the strategy of Integral Care for Prevailing Infant Diseases, as a model of assistance provided to children under 5 both at institutional, and community level, making an integration with the principles of Integral Nutrition Care strategy to monitor weight gain among children under 2. Therefore, a priority of this Project is having Infant Program, under the consultancy of AIEPI National Committee, take advantage of SHP to review and update the AIEPI assistance guide, changing its name to Integral Care Guide for Children under 5. Besides, technical assistance adds to the effort lead by other cooperation Projects to review the simplified development scale. We held 12 Committee meetings to work on updating the guide, planning and organizing the different extension courses of training and in their evaluation. Moreover, this Committee had the direct responsibility in forming 240 local facilitators.

We also supported MOH in designing the new training methodology, in such a way that the "AIEPI" course was shortened to 2 days and the teaching-learning process was made more dynamic. We designed the methodology of the skill tables, in which trainees learn or strengthen their skills in a practical way to provide daily assistance to children under 5 and practice the lesson in the Assistance Guide.

Afterwards, we developed the formation process of national facilitators on the skill tables of the Assistance Guide for children under 5, developing 4 courses to form 240 national facilitators to train physicians and nurses from local levels, so that 100% of the health care units may have at least one trained employee to provide assistance may feedback the remainder personnel from that establishment. Afterwards, some training courses were developed with local levels, having completed 7 courses, training 350 technical from the central level. These were supplemented with courses at regional level that are included in the URC local facilitators report. As an incentive strategy, the project supports manufacturing 175 polo shirts to be distributed to facilitators of the course as an appreciation for their work in forming skills for infant care of local personnel.

We also provided training to 58 employees from 7 NGO's that are working for MOH on Coverage Extension Projects. On the other hand, we worked with Universities that have Medical and Nursing careers, training 50 teachers, with the objective of helping these universities include the AIEPI course in their syllabus rather than having the MOH train graduate students to work for HU.

The application of the new assistance guide reveal the need to work on updating the record assistance sheets provided to children under 5. We worked on three assistance sheets: Enrollment Sheet for children under 8 days, Enrollment Sheet for children under 8 days to children under 5 and Subsequent control sheets. These were updated, reproduced and distributed to all HU of the national level.

As a result of the Program evaluation sessions, we decide to complement and standardize Protocols of assistance provided to children under 5. Therefore, we designed and prepared the Guide to manage major non prevailing illnesses among infants, containing instruction to handle pathologies leading to consultation in the first level of assistance.

***Outcomes reflected by FESAL 2008 show that, with the contribution of activities developed by SHP, diarrhea prevalence was kept under 5 in 13.8%, but there was an increase in the use of oral rehydration salts from 51.4% to 55.6% and there was a drop in prevalence of ARI among children under 5 from 42.3% to 28%.***

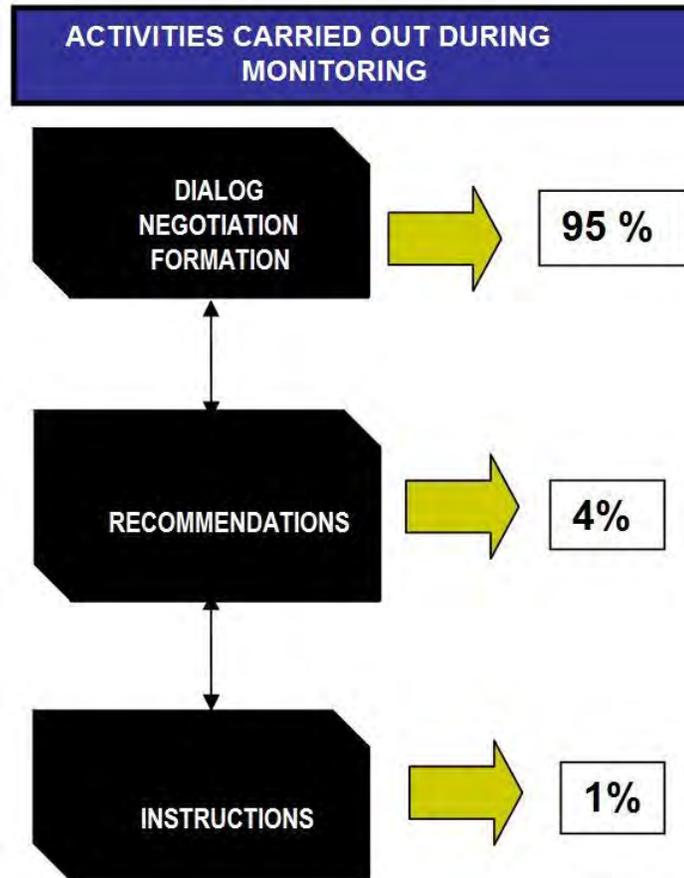
#### Improve the quality of assistance to children

One of the priority activities for the Children Health Care Program and for the Project is monitoring the Conditions of efficiency for Quality Assistance provided to children under 5. We reviewed and updated monitoring instruments, having so far those necessary for monitoring areas of children assistance: delivery room, neonate unit, emergency, and pediatric services for second and third level hospitals, and the instrument to perform such monitoring at Health Care Units. This measures certification of human resources and application of the regulation, the stock of basic supplies for assistance, administration of head offices, the operation of oral rehydration and respiratory therapy areas and reviews 10 clinical records, all of this associated with assistance provided to children under 5.

Each parameter has a numeric value and the total obtained is used to rate health care establishments as efficient, mildly efficient and inefficient, according to the number of positive indicators. At the end of each monitoring visit, we feedback with the

entire health personnel from the establishment and defined agreements to improve any deficient areas identified. What is relevant in monitoring is that it results in an integration of the different activities included in monitoring process. Also, when made properly, it becomes a service training tool, because it makes actual communication between the monitor and the personnel receiving said monitoring possible.

### DIAGRAM OF EFFECTIVE COMMUNICATION DURING MONITORING



Concerning this topic we trained regional and SIBASI levels on the application of monitoring instrument –for the first time in the last 14 years all regional levels have monitored 100% of their health care units. SHP supported 114 monitoring visits.

In order to analyze monitoring outcomes we held 8 feedback sessions at the USAID priority SIBASI's. In these sessions, we performed an inspection of the health care unit condition in each SIBASI, the areas to strengthen in the establishments and the methodology to use. The Paracentral and Eastern regions scored the best. Also and as an incentive to the effort, we supported the Program by awarding the “Quality Pin” to all health care establishments that scored efficient for three monitoring visits in a row. At the end of the project, 96 USAID priority health care units were evaluated with the following results: 29 units scored efficient, 57 mildly efficient and 10 inefficient.

Another relevant Activity was related to evaluation sessions. We held 2 evaluation sessions on infant mortality with the participation of 29 national hospitals, regional directors, MOH and URC Children Health Care Unit. We held 6 program evaluation sessions. These sessions analyzed the trends of perineonatal and Infant morbi-mortality data, enabling decision-making concerning prioritization of strategies and priority geographic areas of the program.

Priority Health Care Units of the Project are benefited, just like hospitals, with equipment Children Health Care, procuring and distributing: 30 pediatric tables, 70 pediatric stethoscopes, 49 pediatric resuscitators, 91 pediatric blood pressure meters, 93 full kits to provide oral rehydration therapy and 420 measuring tapes for cephalic perimeter.

Health service providers attending children were strengthened with the supply of graphic educational material to support all counseling and health education actions. This material was produced under coordination of the IEC/CCC component and specifically for infant health, it consisted of: a flipchart "Promoting integral health among children"; six reminder sheets: "For Your Son Or Daughter To Grow and Develop Healthily", "Signs of Danger in the Newborn", "If Your Child Has Diarrhea", "What to do If Your Child Has A Cough or Trouble Breathing", "Hand Washing Prevents Illnesses", "Maintaining Hygiene At Home Is A Family Responsibility..."; five brochures: "Basic care of the newborn", "Identify signs of danger in the newborn and take it to the nearest hospital right away", "For your baby to grow and develop healthily", "That should we know about diarrhea and dehydration?", "Basic care of the newborn"; five Posters: "If your new born shows one or over the following danger signs take it to the nearest hospital right away", "Do you want your child to grow and develop healthily?", "Hand Washing Prevents Illnesses", "*If Your Child Has Diarrhea*", "If your child breathes heavily," and a flyer called "The use of PURIAGUA, protects your family health."

We also supported MOH Personnel attendance to the different medical updating events, tales as 6 attendees to the Central American Neonatology Congress, in Guatemala; 166 physicians and nursing to the National Pediatrics Congress held in El Salvador and 4 Pediatricians in the Ibero-American Neonatology Congress, Argentina.

With all this support we contributed for MOH to reach MDG 4 in Metropolitan, Central and Paracentral Health Regions, through the Integral Children Health Care Program in the last Family Health Care survey. This reports official data of the country including reduction of infant mortality rate from 25 per 1,000 born alive (FESAL 2002-2003) to 16 per 1,000 born alive (FESAL 2008).

## **7.2.2 Nutrition Component**

**Outcome 3.3.3.3. All children under 2 years of age, and breastfeeding women –specially teenage mothers–from the 72 municipalities supported by**

**USAID, are being monitored once a month regarding their nutrition and growth status, with the suitable equipment, in the AIEPI-AIN strategy.**

Strengthening the Integral Nutrition Care strategy of (AIN- C)

Along the Project we strengthened development of Integral Nutrition Care strategy at communities nationwide and mainly in the 72 municipalities supported by USAID, through quarterly evaluation meetings of baseline indicators that are held every year at SIBASI level. Also, within said strengthening we reviewed, updated and validated the volunteer advisor manual which is now ready for printing.

We extended the strategy to 107 new AIN communities, providing training to 65 new facilitators and train around 450 new AIN volunteer advisors.

We carried out the review, updating, validation, and printing of the list of children under 2 and pregnant women, as well as the minimum expected weight table. We supported in printing the stationary to be used, such as monthly reports, monthly community graphs and forms for building and consolidating the baseline.

We included counseling for timely identification of danger signs among children under 5 and complications in pregnancy in AIN counseling illustrations, to support counseling for mothers in the community level through the Nutrition Volunteer Advisor. We drafted and printed 2,000 illustration sets on danger signs and basic care of the newborn and 1,000 counseling illustration flipcharts on AIN -C strategy.

We held 33 work meetings as part of the technical assistance to review and update all the material used in the strategy.

As part of the follow-up to the strategy we made 27 monitoring visits, addressed to provide technical assistance in monthly monitoring sessions of the growth; courses on formation of volunteer nutrition advisors (CVN), continuous education meetings and gatherings held with volunteer advisors.

We provided the Nutrition unit with 300 Salter scales to support Monitoring of weight gain of children under 2 at community level. We also provided, of 2,000 vests, caps and backpacks to be distributed among volunteer advisors nationwide.

### Strengthening Rural Health and Nutrition Centers

We supported all 52 CRSN nationwide with the purchase and distribution of furniture, kitchen utensils and educational material. In these, care is provided for children between 2 and 7 years of age, benefiting about 780 children.

We made direct monitoring visits to 5 CRSN of USAID priority SIBASI, holding feedback sessions with volunteer ladies responsible for such centers on balanced nutrition issues, techniques for taking anthropometric measurements and proper handling of food.

**Outcome 3.3.3.4.: At least 50% of the women gain adequate weight during their pregnancy, according to MOH standards, in up to 72 municipalities supported by USAID.**

### Review and Update the Nutrition guide for the Salvadoran Family

During the Project we held 17 meetings to review and update the Salvadoran Family Nutrition Guides for age groups, printing 1,000 copies to be used in the first level of assistance.

We also carried out 9 validating and training workshops on the use of the guide carried out with physicians and nurses from various levels of assistance.

### Printing and Dissemination of the Teenagers Nutrition guide

We supported the printing and dissemination of the teenager's nutrition guide and, trained all personnel from hospitals and SIBASI's nationwide on the use of such document.

**Outcome 3.3.3.5. 30% of children receive exclusive breastfeeding up to the age of 6, in up to 72 municipalities supported by USAID.**

We worked on updating monitoring and Direct support to the Breastfeeding System –MADLAC– supporting the process of review, updating, printing and dissemination of the MADLAC questionnaire with 5 work meetings. Likewise, we supported building the database in the updated version Epi Info 2000; we printed the new questionnaire for about 100% of hospitals and we developed 2 updating workshops with representatives of Breastfeeding Committees from all hospitals nationwide and statistics personnel from 27 maternity wards nationwide.

We strengthened the promotion of breastfeeding practice, supporting holding activities celebrating the Worldwide Breastfeeding Week, including the drafting and printing of material such as banners, information trifold leaflets and folders related to the topic of each year.

We accompanied the certification process of some hospitals and Health Care Units from the Eastern and Central Regions with the initiatives of children friendly hospitals (IHAN) and the Mother-Infant -Friendly Health Care Units (USANYM), making 21 external evaluations to 3 hospitals and 18 Health Care Units.

We were able to reactivate the National Breastfeeding and Infant Nutrition Committee, CONALAMI, with the participation of representatives from ISSS, CALMA, PAHO, Universidad de El Salvador, Universidad Evangélica, USAID, Children Health Care Units and Nutrition Unit by MOH and URC. Its main goal was completing the draft bill of the Breastfeeding Law, including the observations made by the Government Social Committee from the previous administration, an effort that was also supported by the Regulation Directorate and MOH Legal Unit, holding 8 work meetings.

We carried out an International Consultancy on breastfeeding; to review and advice on the evaluation of hospitals and Health Care Units with IHAN and USANYM initiatives and consultancy for the nutrition unit work on Breastfeeding Component in general.

Moreover, as part of the consultancy, we held a workshop with technical advisors from the IHAN and USANYM initiative to review and update the forms used for external evaluation of centers.

We carried out the second national workshop of external evaluators of the Children Friendly Hospital (IHAN) strategy and Mother-Infant -Friendly Health Care Units (USANYM), forming 26 evaluators, including general doctors, pediatricians, obstetricians, nurses, and nutritionists, which was facilitated by the International Consultant.

As part of the Development of skills of human resources, we provided training to 100% of personnel from hospitals on the use of the updated MADLAC questionnaire.

We developed two workshops to disseminate "Module III, of the USANYM document", on recommendations for feeding the child and mother, addressed to personnel from the first level. We supported a workshop on Breastfeeding addressed to administration personnel from Hospital San Rafael/ Central Region.

We carried out 6 courses on breastfeeding consultancy, providing training to 120 new counselors.

Concerning the support provided by the SHP to MOH – FESAL 2008 – showed an improvement concerning breastfeeding practices, so prevalence increase from 24% to 31% in exclusive breastfeeding and from 1.4 months to 1.9 months the term of such practice.

However, it is necessary to continue forming more breastfeeding counselors, because they are the ones who do the promotion and education work for mothers on this practice. Likewise, we should also maintain CONALAMI active and consolidate the Breastfeeding law draft bill.

Also, we must continue crediting or renew their crediting hospitals and HU as mother-child friendly institutions, because these initiatives show that such centers are making interventions addressed to promote, protect, and support breastfeeding with the quality focus that may be emphasized through the definition of standards and follow-up.

**Outcome 3.3.3.6. Reduce the Global Malnutrition Rate for children under 5 from 10.3% to 9%, in up to 72 municipalities supported by USAID.**

Implementation of a Nutritional Surveillance System (SISVIN)

Implementation of the SISVIN substituted the Outcome referring to the formation of surveillance sites for nutritional supervision. SHP supported the whole process to design and implement the first phase SISVIN along with the World Food Program and the Nutrition Unit.

As a product of this support we drafted the SISVIN technical regulation document and the support document, which describes the guidelines for health promoter and to execute the Nutritional Surveillance System at community level.

The System receives as input anthropometric measurements data of children under 5 and pregnant women at community level. In the first phase of SISVIN made in SIBASI La Libertad in the third quarter 2008, we obtained and entered a total of 10,453 entries. These data served as reference to calculate the number of data entry operators necessary to implement the System nationwide. At the end of the first phase, it was presented to the ministry Authorities and they endorsed the implementation of the System and requested to do it as the National Health System. Submission to the new authorities and later to other SNS members is pending.

As part of the technical assistance provided in compliance with of this Activity, we supported in 50 work sessions between reviewing, correcting, and including of observations, reviewing the methodological component of the technical document and reviewing the web platform to upload data, support process of SISVIN validation and dissemination, coordination regions with the Technical Nutritional Surveillance Committee (COTEVIN).

We developed the skills of nursing personnel and health promoters in standardizing taking anthropometric measurements (weight and size) developing as central level the standardization of 120 specific supervisors from USAID priority SIBASI's. As well as 29 standardization workshops for 689 health promoters, and 17 standardization workshops to nursing personnel having standardized 330 nurses from the Central Health Region.

Also, we provided training in 2 workshops to 57 clinical laboratory staff at the Health Care Units of the SIBASI La Libertad on the use of the Hemocue to evaluate hemoglobin levels of children and pregnant women.

We made 17 monitoring visits to Support standardization workshops on taking anthropometric measurements and Nutritional Surveillance sessions of the first phase of implementation.

We provided MOH with 6,500 cardboard tallimeters that will be used in measuring size.

The standardization of the remaining personnel involved in taking anthropometric measurements and proper filling out of surveillance forms, as well as in blood taking to determine the anemia are pending.

#### Updating the Growth Graphics for Children Under 5 (P/E)

A relevant progress in the country was introducing the use of size within growth surveillance of children under 5, so that evaluation is now made using three indicators: weight/age, weight/size and size/age. Moreover we updated the growth graphics based on the curves presented by PAHO/WHO; we worked on them based on the new reference populations. Therefore, we supported 5 work meetings to design, print, and distribute 1,000,000 Growth Graphics for children under 5. These we designed for age groups of 0 to 24 months; and children from 2 to under 5 years of age (we prepared 4 different graphics).

Afterwards, we provided training to 35 facilitators to evaluate the nutritional condition using the new growth graphics. Moreover, we organized the skills table which integrally in training in AIEPI had the objective of training on the use and handling of these graphics.

#### Assistance Guide for Children with Severe Malnutrition at Hospital Level

Infant Malnutrition prevails in El Salvador; therefore, it was necessary to work on a guide to standardize management of children with severe malnutrition at hospital level. We developed a process to review, prepare, print, disseminate, and train on the "Assistance Guide for Children with Severe Malnutrition at hospital level".

We held 5 training workshops providing training to 120 facilitators including pediatricians, nutritionists, and head nurses from hospitals providing Pediatric services to implement the guide nationwide.

Afterwards, we supported the training of 100% of personnel (physicians, nurses, physiotherapists, social workers and nutritionists) of the pediatric areas of 28 hospitals nationwide, and we also provided training to all kitchen personnel in charge of preparing diets (menus) for said hospitals.

#### III Census of School Children Sizes

Upon request from MOH we supported the development of the III Census on Size of School Children in First Grade in El Salvador, carried out in April 2007, for which we supported the training of 7,200 first grade teachers for 100% from public and private schools of the country. We also held 2 training sessions for MOH nutritionists and education supervisors of the departments.

We supported with the printing of one promotional and one educational Poster, on the process of taking measurements. We also printed the documents on the results of the Census: the Report, a summary brochure and a promotional dossier.

We carried out an official session to present the outcomes; this was presided by the First Lady of the Republic. The main Outcome presented was the reduction of chronic malnutrition from 19.5% in the 2000 Census to 15.52% in Census.

### Growth and Development Manual

We provided technical assistance in 5 work sessions to review and update the manual on growth and development of children from 0 to 9 years, which closed with 70% progress.

### Updating Micronutrient Standard

We supported the process of updating 4 MOH employees on know-how and techniques for sampling and made a survey on vitamin A among children under 5 (in Guatemala) in order to support implementation of the survey of vitamin "A" in children under 5, held in El Salvador between April and June 2009. We also supported feedback to all nutritionists and laboratory heads from the Regions and SIBASI on the process of preparing this vitamin "A" survey.

We supported the reviewing and updating process of the manual to supplement with micronutrients for different age groups holding three work meetings.

In general, in the Nutrition Component, we also worked jointly with IEC/CCC in designing and drafting the graphic material to support educational activities on priority topics of the Component, preparing six posters: "Salvadoran Family Nutrition Guide", "A healthy family takes vitamins and minerals on time", "if you answer "yes" to any of these questions, seek help at the nearest Health Care Unit", "Beware family! let's take care of our teeth", "Recommendations for a sound oral health of the family", and "smiling from the womb"; four brochures: "Sound nutrition ...sound life for the Salvadoran family", "What is high blood pressure and juvenile diabetes?", "Chronic renal insufficiency during adolescence" and "A family that cares for their teeth protects their health " and two flipcharts: "Nutrition guide for the Salvadoran Family" and "The Salvadoran Family caring for their oral health".

## **7.3 Infection Prevention and Control Component**

To respond to the commitments undertaken concerning Infection Prevention and Control Component of the SHP, we started establishing a baseline on the work of Hospital Borne Infection Prevention and Control Committees (CPCIN) in 28 maternity wards covered by the Project, the Outcome was used as an input to design and develop the activities that lead to attain the achievements along the Project.

**Outcome 3.4.1.: Protocols and standards for Infection Prevention between mothers and newborns have been established in 28 maternity wards and up to 35 Health Care Units attending deliveries.**

We developed an international short-term consultancy which started with *reconnaissance* visits in maternity wards of regional reference (5) in order to reconnoiter Protocols to defined and compile information for their construction. This information was used to hold a workshop to prepare Protocols for Hospital Infection Prevention related

to mothers and neonates with the participation of 25 attendees from 21 hospitals, getting as a result some protocols, standards, prevention guides, criteria of definition and monitoring activities for prevention, detection and control of Hospital Infections related with mothers and newborns, which were validated in participating hospitals on topics of maternal Infection and neonatal sepsis, hospital Pneumonia and surgical site infection, specifically for the hospital area.

After that, we carried out 22 Training sessions addressed to 250 hospital officials on Hospital Infection Prevention standards; main topics were related to legal and economic implications of incompliance with Hospital Infection Prevention standards, the use of sterile clothing, equipment to protect personnel and management of sterile material, asepsis techniques, use of antiseptics and disinfectants.

We drafted in coordination with the Reproductive Health Component, and the educational methodology; and on Infection Prevention during pregnancy, which was incorporated in the new model of prenatal assistance.

We translated 3 technical instruments from English to Spanish: Handling Infected Children and the Children with Severe Malnutrition, Paperback for Hospital Care of Children, and Manual of Children with Problems: sepsis, asphyxia and other pathological conditions.

We also developed workshops at local levels, to review current standards, Protocols and procedure manuals for Hospital Infection Prevention for the mother and the newborn and to define standards for Mother-infant Infection Prevention, at delivery rooms and puerperium rooms.

We delivered 24 sessions on standards on Infection Prevention, personnel from the region and members of local Hospital Borne Infection Committees, training 663 employees on the topic and with material available for their replication.

SHP supported building a baseline on flora and antibiotic resistance in urocultures of women in fertile age at 20 MOH hospitals.

On the other hand, we supplied with 4 Reference books of the Education for Infection Prevention Program (EPI) of the Association of Professionals on Infection Control and Epidemiology, Inc. (APIC); 13 books on Infection Prevention, of Engender Health; 68 books on the Control of transmissible illnesses and 40 Guides for hospital borne infection Control, at local officials levels, Regions and MOH higher level.

In cooperation with the Women Management and the Epidemiology Unit, we prepared the guides for Maternal Infection Prevention (infection of surgical site in cesarean and urinary tract infections related to vesical catheter), and also monitoring sheet, and survey of cases pending validation. Also, we drafted the chapter on asepsis and antisepsis to be included among materials and training of obstetric, neonate, Family Planning and infection Prevention skills development centers.

We provided technical support to the group in charge of building National Biosafety Measures Standard.

We validated the “Manual for Technical Guidelines for Hospital Borne Infection Prevention and Control Surveillance System” which was drafted with the technical multi-disciplinary participation of MOH, which later passed to the Regulation Directorate. This was then made official and published in the webpage of the Ministry of Health.

Concerning the continuous quality improvement, we constructed standards and established integration and monitoring indicators to validate quality in processes of the Infection Prevention and Control Component, with the commitment of including these in the Technical Procedures Manual for Hospital Borne Infection Prevention and Control.

Within this Outcome, we attained sponsoring 100% of members in coordination level of the Hospital Infections Committees to participate in the VII Congress of Infectology. As well as sponsoring to enroll 2 nurses from the National Children Hospital “Benjamín Bloom” for the Latin American Congress of Hospital Infections in Santiago de Chile.

**Outcome 3.4.2.: Infection-prevention Committees working actively on prevention and reduction of hospital borne infections, jointly with perinatal Committees, in 28 maternity wards.**

SHP, started by establishing a baseline on the work of CPCIN at 28 maternity wards covered by the Project, which showed that not all hospitals had an Infection Committee, and most of those that did have one their activities were carried out by a single person. There were no definitions of “case” or “approach”; neither did they know what data to search and report in a standardized way. Very few were supported by local authorities and operation personnel had limited supplies to apply the prevention measures. The great majority of Reports remained only at a local level. Moreover, there were but a few employees trained.

Based on the outcomes of the baseline, we defined the areas that had to be strengthened, based on compliance with international standards weighing the effort carried out by the various Infection-prevention Committees to keep surveillance according to standard. Compliance with these standards was evaluated by a weighting system created ad hoc by URC infections Component. The Report was accompanied by a photograph, and both were disclosed to the higher, regional and local level. As a result, we established the expectation from the Epidemiological surveillance of Hospital Infections, which favored Health services’ quality of assistance, because it considered the infection rate, antibiotic resistance of controlled bacteria, the record of work-related accidents with the risk of infection, control on the use of antibiotics, the amount of days/bed use because of hospital borne infections, etc.

To support this surveillance, we held a theoretical-practical workshop addressed to the members of the local and regional Committees, on levels of effectiveness of prevention and control of IN, to comply compulsorily.

We held an advocacy and review session on legal aspects of the hospital borne infections, addressed to hospital directors, regional directors, directors of schools forming nursing and medical personnel of the country.

We supported holding a course on Hospital Borne Infection Prevention and Control of the Nursing unit, training 40 nurses on prevention and Control of IN, from national hospitals, social security and military health care.

We compiled updated information for the first draft of the Dossier of the Standardization Manual to Address Hospital Borne Infections.

We contributed to prepare the Guide of Prevention and Management of Neonatal Sepsis and training Neonatology personnel on Infection Prevention.

We supported the course on Hospital Borne Infection Prevention and Control of the Nursing unit, requested by the Directorate of control and Epidemiological surveillance to strengthen Infections Committees. A total of 32 nurses forming the Infection Committees at hospital level were trained. The course lasted five months in weekly one-day training sessions.

We prepared and delivered a dossier of the support and consultation material on levels of efficiency in Hospital Borne Infection Prevention and Control; this includes the sheet for registration of patients in risk and identification of cases of Hospital Borne Infections and the case study sheet of hospital borne infections.

We have held theoretical-practical training sessions for the regional and local operational levels on maternal and neonatal hospital borne infection prevention and control having trained a total of 752 persons.

An important achievement of this outcome, was forming and officializing the 27 hospital borne infections committees of the Westerner, Paracentral, central, Eastern and metropolitan regions, besides the regional commissions for IN prevention and control, except for metropolitan health region which trained all its medical personnel; more than 140 members of the operational personnel officialized by MOH; exposition of achievements and successful experiences of CPCIN.

We formed or reactivated (wherever necessary) the operation of infections Committees, in 22 of the 28 hospitals, which are currently about to finish the project performing active surveillance of infections, complying with the existing infections and control guides and generating reports for decision-making.

We also encouraged generation of quarterly reports on Maternal- Neonate Hospital Borne Infections at the 28 MOH maternity wards.

We held a workshop on standardization and approach of IN addressed to local and regional CPCIN, where definitions of cases were agreed upon, reconnaissance of risks and preventive measures for PCIN; the methodology of this included theory, classroom laboratories, discussions, hospital practice with collection of information for point prevalence surveys with regional, higher level and URC support, drafting the report, drafting the intervention proposal, presentation of outcomes. In these shops and as part of the methodology we made initial, in process and final evaluations of attendees and found improvements in knowledge in each of the attendees during the training process.

We carried out the “Workshop for standardization in the approach of Hospital Borne Infections” for all Health Regions besides the inclusion of new personnel in charge of hospitals, in response to regional director’s request.

We coordinated through the Epidemiology Unit of the Health Surveillance Directorate to complete the first data collection for punctual prevalence nationwide in the 28 maternity wards of the country; said survey validated the findings in the punctual prevalence survey that was made individually in the same maternity wards. For this activity we were able to reintegrate the nursing referring personnel as a counterpart of the Infections component.

The project strengthened the work of hospitals with the delivery priority inputs to prevent hospital borne infections in maternal-infant areas in the 28 maternity wards, to strengthen the input in the prevention processes, mainly to startup the essential measures of asepsis and antisepsis to prevent hospital borne infections such as: iodized soap, surgical and clinical masks, steel brushes, reusable surgical brushes, sterile gloves and plastic containers for cold sterilization and 2,100 liter water collection tanks.

We also worked with the IEC Component in defining key behavior, media and target groups, as well as methodological guides, video scripts, proposal of images, for the content and type of educational material for Infection Prevention: infection prevention of the surgical site, placing Biosafety equipment, three different hand-washing techniques (social, clinical, and surgical), cleaning techniques and disinfection of surfaces, disposal of hospital solid waste, producing two flipcharts, five posters, one reminder sheet, one reminder plate for incubators and two videos.

Computer equipment, printers, licenses, voltage regulators and operation system were provided to the 28 Hospital Borne Infection Committees, as a Support to the administration, analysis and program reports processes. We prepared a regulation on the proper use of computers by Committees, which was accepted and put into practice by MOH.

#### **Outcome 3.4.3.: Standards for prevention and treatment of urinary tract infections in up to 72 municipalities supported by USAID**

We made a national multicentre survey that provided the updated information on bacterial flora in urine of fertile women or child-bearing age women and their level of resistance in Vitro, this could be considered in preparing the treatments for pathologies such as asymptomatic bacteriuria and urinary tract infection and extra and intra hospital scenarios, reducing the complications derived from them during gestation.

We supported work meetings and follow-up with the Maternal Assistance Program and the Epidemiology Unit to prepare the Hospital Infection Prevention Protocols in women which provided significant progress in Protocols concerning prevention of surgical site infection in cesareans, soft tissue (episiotomy dehiscence) and urinary infection caused by vesical catheter. However, they are all pending technical validation.

Currently, in the new prenatal assistance standard and in the training program on said model of assistance that was implemented as part of the counseling several key behaviors were highlighted to prevent of IVU, such as: consultation in presence of urinary symptoms and the consumption of plenty of liquids as measures to prevent Urinary Tract Infections. Likewise, it was recommended to determine bacteriuria in asymptomatic pregnant women in two prenatal controls, as routine and fundamental tasks for early detection of Urinary tract infection.

We developed a workshop in each maternity ward, on compliance with standards to prevent Hospital Borne Infection, use of sterile clothing, personnel protection equipment and handling sterile material, asepsis and antisepsis, antiseptics and disinfectants, levels of scientific evidence of standards to prevent hospital borne infections, proper use of the chlorine (lye) in coordination with personnel from the corresponding health regions.

**Outcome 3.4.4.: Neonatal deaths as a result of hospital sepsis, reduced in 28 maternity wards and up to the 35 Health Care Units attending deliveries**

We defined the methodology to obtain a baseline of the cases and identification of risk spots in attention from an analysis workshop and determining recommendations for a plan to reduce hospital mortality because of hospital borne infections among mothers and neonates.

We supported the Children Health Care Program in 2 advocacy sessions with regional, hospitals and UAISN directors to present the intervention of hand-washing techniques to prevent hospital borne neonatal sepsis. Moreover, we provided the necessary material to perform the baseline on hand-washing in the hospital and for subsequent monitoring actions.

We also provided technical assistance in the process of reviewing and updating the guide to prevent and handle neonatal sepsis with the attendance of 8 hospitals of the country.

We worked in coordination with the BASICS project, according to the basic agreement undersigned between URC and BASICS which was duly endorsed by USAID in the survey of baseline on the knowledge, attitudes and practices of hand washing in five hospitals. This showed that only 71% of the personnel working in the areas of maternal and neonates assistance washed their hands. Afterwards, training was provided to 22 hospital officers on IN prevention and control related to: catheters, surgical wound, diaper rash, and technical review of hand washing, using the technical guides prepared by URC. This training resulted in an increase in the percentage of hand washing from 71% to 84.6% in the five hospitals.

Support was also provided to prepare a technical guide and three short videos on hand-washing using soap and alcohol gel and training personnel to implement these guides.

With the Direct Support from URC technical assistance, training was provided to pharmaceutical technicians of 29 national hospitals to manufacture alcohol gel locally.

We drafted a survey on bacteria resistance in neonates from 20 hospitals of the country, the Neonatal mortality Baseline because of Hospital borne sepsis.

Also, with URC support and general coordination from BASICS we made 4 video conferences with the participation of Dominican Republic, Honduras and Washington DC, where the outcomes and experiences on neonatal sepsis prevention were shared.

We drafted a baseline survey on flora and bacteria resistance in newborns of 20 MOH hospitals. There, 8207 culture results from 6931 newborns were analyzed, out of these, 2090 were used for analysis (25.4%), no duplicated analysis were included, without bacteria growth, with normal growth of flora, and classified as secretions besides, antibiograms with non-approved products in newborns and other without report of antibiogram. The result showed that the main agents were Staphylococci sp (34.3%), Escherichia coli (21.3%), Klebsiella sp (18.5%), Pseudomona sp (8.5%) and Enterobacter spp (8.4%).

In cultures of newborns from hospitals of the 2<sup>o</sup> level we identified levels of resistance against Ampicillin Sodium above 76% for enteric bacteria, Gentamicin sulfate presented acceptable levels of resistance in vitro only against Escherichia coli and enterobacter spp. The performance of cefotaxime was not satisfactory.

A significant contribution within this outcome was the development –in coordination with the Integral Child Health Care Unit– of the “Neonatal mortality baseline survey associated with hospital infections”, which established the starting point data on the situation of neonatal mortality for this cause, demonstrating that 40.2% of neonatal deaths occurred in 2006 were due to a hospital borne infection, thus justifying the continuous promotion of actions addressed to their prevention.

#### **7.4 Component of Information, Education and Communication for a change of behavior**

##### **Outcome3.3. (0).7: a strategy of communication promoting key messages in Reproductive and Infant Health, created and implemented nationwide.**

The national strategy of Information, Education, and Communication for a change of behavior (IEC/CCC) is created and is being implemented in 100% of Health establishments of the national network. Moreover, it has been provided with graphic material as support to develop activities to promote health and Health prevention of maternal, infant, family planning, nutrition, and Hospital Infection Prevention Components.

Some byproducts of the IEC/CCC National Strategy included the building of Regional and local Operation IEC plans sustained on the local epidemiological profile and the key conducts to promote through the national strategy. We also established the figure of the “IEC Referral” in every Health center, Hospital, SIBASI and Health Region, to keep a permanent monitoring of execution of the local IEC plans.

All 28 hospitals with maternity wards were provided with CD's with two videos of Hospital Infection Prevention: a) “How to put on surgical wear” and b) “Cleaning and terminal disinfecting in the surgical area”; addressed to secondary

audience (health personnel from direct assistance, support personnel, and administration personnel).

The IEC/CCC National Strategy provided the technical input to create an extensive amount of educational graphic, radio and television material which would become didactic tools to develop information, education, and Communication activities for a change of behavior. This material amounts to 68 pieces of graphic material, 19 radio spots, 4 television spots and 2 educational videos. All the campaign was managed under the slogan “**You and I Decide Responsibly**”. We must highlight that this Educational Campaign on radio and television, was also used to support the prevention program designed by MOH to reduce the risks of expansion of the A H1N1 Influenza epidemic.

We believe that the implementation of the IEC/CCC National Strategy has contributed to the achievement of the Millennium Development Goals as follows:

**MDG 4: Reduce by two thirds the mortality ratio of children under 5:** by promoting key conducts, to prevent illnesses and death of children under 5, through the implementation of the IEC plans.

**MDG 5: Reduce by three quarters Maternal Mortality ratio:** by promoting of key conducts, to prevent illnesses and death of mothers, through the implementation of the IEC plans.

We also provided consultancy and workshops to make a Monitoring and Evaluation Guide of the IEC/CCC National Strategy, which involved the participation of multi-disciplinary health personnel and health educators nationwide. This document is still in process of drafting due to the difficulty in gathering health personnel on account of different situations unique to MOH, such as the emergencies driven by the A H1N1 Influenza.

It is noteworthy that all material that was drafted for the national strategy, in support of Infant Component was reviewed, updated, and printed for MOH, including the following educational material: 500,000 Reminder sheets “Proper Handling and Preservation of Food”. 100,000 Reminder sheets “If your child has diarrhea”, 1,500 Posters “Diarrhea and Nutrition” and 2,000 posters “If your child breathes heavily”.

On the other hand, and taking into account that the Component of Information, Education and Communication for a change of behavior (IEC/CCC), is a key stone of the maternal, Infant, nutrition, Family Planning, and Hospital Infection Prevention components; the technical support was oriented to developing a Work Plan with the participation of technical teams of the central level which integrated the interventions for the promotion and education for Health to reduce morbimortality ratios of the target population.

At the same time, we reorganized the health promoting unit within the MOH, which identifies both technical and financial needs in areas of health promotion, with the support of the Project.

To begin the work with the Component, we made an inventory of Educational material and radio products from IEC in a sample of Health establishments located in 72 municipalities and 28 maternity hospitals of the country; visiting also, San Esteban

storehouse of San Salvador and regional storehouses. This information enabled to identify the needs for educational material in Components included in the Project.

The technical support to the health promoting unit started with the construction of the methodological model to prepare a National Information, Education, and Communication Strategy for a change of behavior (IEC/CCC), this is a tool to develop systematic processes, and implement educational interventions to promote healthy behaviors. Their importance lies on the fact that they have matched the epidemiological profile and the most urgent needs for a change of behavior in Health establishments and hospitals and it focuses on Health promotion and prevention, placing users in their right dimension within the Health System. Once this model was available, we proceeded to organize a multi-disciplinary team that included technicians from all MOH levels of administration.

The first workshop enabled the identification of health constraints in each Component, the audiences to whom it is addressed, the interventions of promotion and education, key conducts, IEC objectives, key messages, strategic tactics and media plan that are defined based on key conducts, Educational graphic material and material for radio and television to be designed. This workshop leads to the first version of five strategic plans that form the IEC/CCC National Strategy.

The IEC/CCC National Strategy comprises five strategic plans, one for each Component. These were the basis to make an IEC operation plan per region and these in turn to prepare the local IEC plans and hospital plans.

Afterwards, the strategy lead to the integration of a single plan of educational interventions for the different Components supported by the Project, based on key conducts and the epidemiological profile presented by all health establishments at the time of making it and at the same time, educational activities must be programmed according to resources available. Such educational activities aimed at increasing the knowledge of the population on how to care for their health.

To support this effort, we provided training to more than 400 health workers on how to prepare local IEC plans, and 260 on educational techniques and the use of educational material in IEC/CCC activities based on the guide for the use of educational material prepared for this training; regional personnel from maternity hospitals and Health Care Units participated in the event.

The objective of the strategy is to achieve measurable changes of behavior and attitude in the specific audiences, based on the survey of their requirements and perceptions, although it is certain that the strategy began in 72 municipalities at the end of three years of life of the project, we completed its implementation at national level.

There is an IEC Referral nationwide useful to strengthen the implementation of local IEC plans at Health Care Units and hospitals, each referral was selected on the basis of a profile and its activities were framed within functions that were prepared by the Promotion Unit personnel with the support of educators of the regional and local levels. Such functions were socialized through workshops made at a Regional Level.

With the purpose of promoting health personnel and the work on community intersector by health personnel, the Eastern Region development the First Regional Forum for Health promotion, called “Reorientation of health services towards Health Promotion”, This Forum constituted a historical event given the initiative and effort carried out by the regional team to improve population health.

Within the framework of the strategy, we developed four workshops to make 70 pieces of graphic material (flipcharts, posters, brochures, reminder sheets, kit of counseling illustrations and tracts), 19 radio spots, 4 TV spots and 2 educational videos to support the execution of the local IEC plans. This material was created and validated with the most ample participation of personnel from all levels of MOH administration and the community.

Afterwards, the validation of the, radio, television, and graphic educational material was carried out in two features:

- Technical validation: through 16 focal groups with 78 technicians, Health Care Units, hospitals, SIBASI, Regions, and MOH Central Level.
- Community validation: We developed 33 focal groups in the rural area and 19 focal groups in urban areas, and semi-urban areas.

Concerning the purpose to review outcomes of the process of validation and guarantee compliance with the changes suggested by health personnel and members of the community, it was necessary to hold 35 technical meetings with MOH personnel and with technicians from the company hired to prepare the material.

After all the art work was approved by the Ministry of Health and USAID, we contracted the company that produced the material. This was received and delivered to the storehouses of the Ministry; the last delivery of educational material corresponding to the Nutrition component was made in April 2009.

In the same month we finished the distribution of all the graphic material in 404 Health Care Units and 28 hospitals with maternity wards.

It is necessary to mention that other Materials designed were draft sketches of 4 reminder sheets pre and post female and male sterilization; and a kit of illustration for pre and post interventions consultancy.

To assure implementation of the IEC Strategy, we carried out 37 monitoring and technical assistance visits to regional teams to socialize and create awareness of health personnel on the benefits of the strategy and to prepare regional and local plans that facilitated its implementation.

Moreover, for monitoring of timely distribution of graphic educational material, we made visits to the San Esteban warehouse, the Regions, SIBASI, and Health establishments. We made a total of 9 visits to the Health Regions, 16 visits to SIBASI and 36 visits to Health Care Units; the distribution was made to 404 Health Care Units and 28 hospitals with maternity wards. Currently, the availability of the educational material in infirmaries is considered acceptable according to the assistance provided and their distribution at educational activities.

Likewise, we supported Health Regions in their biannual evaluation meetings, making a total of 12 meetings in two years. In some evaluations we highlighted common issues such as suitable areas to apply the strategy mentioning the family health model; support or empowerment of Community Health to cover a larger population with the promotion of key behaviors, the direct participation of groups organized for the application of the strategy in specific regions (pregnant women clubs, teenagers, infants, AIN consultants, senior citizens, health committees, etc.)

We held a workshop with 34 attendees to prepare monitoring and Supervision plan of the IEC/CCC National Strategy, addressed to Educators for Health Regions and SIBASI, and regional epidemiologists. We defined indicators to monitor the different intervention levels; however, it was not completed.

As part of the support in this Component, we provided the health promoting unit with computer equipment and a modern and complete video equipment, lights and sound, as well as its corresponding computer equipment to process digital images and sound and the furniture necessary for the set of interviews with health personnel. Additionally, we provided computer equipment with their corresponding licenses to regional educators. As well as 145 didactic briefcases to the same number of local IEC referring personnel.

In the first semester 2009, the country did not escape the pandemic of Influenza A H1N1, and because of the first cases of presumed Influenza A H1N1, the situation turned into an emergency, MOH through the Project Coordinating Unit and upon request from the new officials of the area, coordinated and requested technical and financial support from USAID through the SHP run by University Research Co., LLC to strengthen the preventive measures with the delivery of educational material during educational interventions in health care units and hospitals; therefore, we financed the printing of posters, flyers, and reminder sheets for delivery nationwide.

Right afterwards, we requested technical and financial support to broadcast radio educational campaigns. To respond to these requests we identified the materials produced within the IEC strategy that promotes relevant preventive measures related to Influenza A and we worked on the terms of reference for the radio campaigns.

Additionally a campaign was requested through which the message may be disclosed attractively and that it would lead to a change of conduct of the target population. The result was the production of a radio “jingle” for the prevention of the A H1N1 Influenza.

At the end, four radio campaigns were sponsored for the Prevention of Influenza A H1N1, these were developed along with 24 radio stations having nationwide and local coverage, also the production of a radio jingle was also sponsored, which was used since the end of the third educational campaign and broadcasted for a period of 2 weeks in 21 local radios.

The following are the periods in which we have developed radio campaigns:

- 1<sup>a</sup>. Educational Support Campaigns from May 26 to June 7
- 2<sup>a</sup>. Educational Support Campaigns from June 29 to July 12
- 3<sup>a</sup>. Educational Support Campaigns from July 22 to August 4
- 4<sup>a</sup>. Educational Support Campaigns from August 5 to 19

Also, we supported the printing of printed material that promoted the preventive measures against this illness, these were:

- Printing of 3,500 thousand flyers "Washing your hands prevents illnesses".
- Printing 25 thousand posters "Washing your hands prevents your getting sick".
- Printing 50,000 POSTERS "Preventive measures to prevent acquiring influenza".
- Printing 2,500,000 flyers "Let's prevent influenza".
- 5 vinyl banners, in roll up structure, with messages in English.
- Printing 20,000 brochures of measures to prevent and Control Influenza A (H1N1) for health personnel.
- 1,000 CD – RW, to reproduce radio spots.
- 1,000 DVD – RW, to reproduce educational videos.

The promotion and prevention campaign was strengthened with the purchase and provision to MOH of medical supplies, which are itemized below:

- 1,000 surgical masks and ear-loop face masks.
- 500 3M masks model 8210.
- 500 3M conical masks.
- 12 digital ear thermometers
- 363 gallons of Gram- Field antiseptic liquid soap (USA)
- 1,351 gallons of liquid soap.
- 2,463 250 ml bottles of alcohol gel 70%.
- 3,040 N95 particulate respirators.
- 3,769 bottles of instant hand antiseptic.
- 97,020 N95 respirators.

**Radio and television material printed by Component**

<b>Type of Material</b>	<b>FP</b>	<b>Maternal health</b>	<b>Infant Health</b>	<b>Infection Prevention</b>	<b>Total</b>
Radio spots	6	6	7	-	19
TV Spots	4	-	-	-	4
Educational videos	-	-	-	2	2
<b>Total Materials by Component</b>	<b>10</b>	<b>6</b>	<b>7</b>	<b>2</b>	<b>25</b>

**IEC/CCC Graphic material printed by Component**

<b>TYPE of Material</b>	<b>Maternal</b>	<b>Infant Health</b>	<b>FP</b>	<b>Nutrition</b>	<b>Infection Prevention</b>	<b>Total amount printed</b>
Brochures	4 topics	4 topics	9 topics	4 topics	0	2,044,050
Posters	4	5	6	6	5	27,301
Flipchart	1	1	1	2	2	6,558
Reminder sheets	5	7	-	-	1	1,409,500
Fliers	-	1	-	-	-	100,000
Illustration Kit	1	-	-	-	-	937
Reminder Plate	-	-	-	-	1	1,000
<b>Total Materials by Component</b>	<b>15</b>	<b>18</b>	<b>16</b>	<b>12</b>	<b>9</b>	<b>3,589,346</b>

## **7.5 Community Health, Family Health and Monitoring and Evaluation Component**

### **7.5.1 Community Health**

The total rural population of the country, according to figures of the last population census in El Salvador developed in 2007, was of 2,145,277 inhabitants. MOH has been covering in stages the increasing percentages of population since 1975. The first health promoters of the country were formed that year under the strategy of extended coverage. To date at national level, MOH has a little more than of 2,600 health promoters distributed throughout the country, although some municipalities do not have this type of health resource in their communities yet. Since its beginning, this important area of the health field has been supported by USAID.

#### **Outcome 3.3. (0).1: the Community Health Program fully implemented in 72 municipalities.**

Concerning technical assistance, we worked on a systematic and methodic evaluation process of the Community Health Program activities and the main Health indicators at community level was always the starting point to plan and reformulate its goals and strategies in the Health Regions and the different Beneficiary SIBASI's. Preventive activities, particularly those related to pregnant women, and puerperae and newborn, had predominance in daily performance of health promoters. However, we must acknowledge that because of the discretion of some Health Care Units or Health Regions directors and the limited presence of Community Health Supervisors in some areas, health promoters used to be assigned tasks beyond their duties and their communities. Because of this, the monthly schedule of the health care promoter was many times totally or partially modified and, therefore, they could not meet their annual goals set in the area of preventive activities to puerperae and newborn as well as immunizations.

From 2006 until June 2009 we held 54 quarterly evaluation sessions, with an average attendance of 40 persons per session. Sessions centered mainly on the presentation and analysis of information of activities carried out by health promoters and the definition of an intervention plan based on results found by community health supervisors. The analysis included comparisons and trends in time and place and, for some indicators, a combination of complementary variables related to preventive assistance in health and those determinants of health at community level. Although these sessions were held mainly with health promoters' supervisors, some regional directorate authorities, SIBASI offices, Health care unit directors and many Health Promoters also attended. Each session was a participative and interactive activity for learning and consolidating a culture of decision-making based on evidences.

The effect of this systematic, periodical and methodical evaluation exercise of PSC activities was reflected in the Final Report of the survey "Use of Information System in Health for decision-making, and perception that personnel from the MOH three Health Regions of El Salvador, supported by the "Strengthening Health" Project, Activity 519 – 0463", held at the end of 2008, which sixth conclusion reads: "in approaching the topic of changes from the analysis of the information, the different

levels of decision-making from the regional level and SIBASI, refer more to the quality processes of data collection and processing; however, operational personnel of the first level, particularly community health, do prefer to work more in improving the provision of services and coverage as an object of their analysis of the information processed”.

It was in those quarterly evaluation sessions that the enhancements were evident from a closer supervision of field personnel and the application of the new monitoring and evaluation model, verifying a better quality of data and better coherence of community data with the trends of health establishments and SIBASI's, mainly concerning coverage in preventive programs but also in maternal, infant and perinatal mortality surveillance.

In order to strengthen the aforementioned process, the project supported the printing of a significant amount of forms for records, and the analysis guides of evaluation indicators.

At the same time, but more dynamically and frequently, we developed a monitoring process of the Community Health Program activities, through the periodical review of the data recorded in the health promoters' monthly tabulators.

The whole process was completed with the field supervision visits, a very important intervention to attain community work excellence, based on the most elemental parts of the coaching theory (summarized in the Spanish acronym OPERA [Observe, Ask, Listen, Feedback and Agree), through which personnel is helped, right at the work place, to identify opportunities for improvement and agree on a specific personnel improvement plan. At the end of 2008, we reached a record figure of nearly 8,700 supervision visits, throughout the national territory made by specific supervisors at a rate of 1 visit per month for each health promoter. As a result of this, we started to see changes of behavior in health personnel and Supervisors.

The use of tools to document the supervision process has reduced the culture of arrogance (by the supervisor) or their being defensive (by the health care promoter). It is evident that when the community worker knows the instrument with which he is to be measured during monitoring and supervision visits, the process will be more expeditious and objective, because on the one hand, the supervisor may not go too far in the exercise of his duty, besides having to document the process, and on the other hand, the promoter may not claim he does not know what aspects of his performance will be measured, or the supervisor's subjectivity. The last stage in facilitating supervision is to make agreements, which are recorded in the books of supervision, promoter's book and supervisor's book. The supervisor takes a copy of it.

In the management dimension of the Community Health Program, these interventions have been very important because they helped redo what disappeared in 1995, when MOH authorities dismantled the Community Health Department, and “demobilized” a whole network of Community Health specific supervisors. Only 35 out of almost 110 persons kept —ever since— their official appointment of Community Health Supervisor, many of them in duties as health promoters or sanitation inspectors. During the next 12 years, the health promoters worked on their own —literally speaking—, feebly linked to the health establishments through coordination with the establishment Director (or the person appointed for such task). Promoters virtually began to depend

technically and administratively on the establishment directors. Many times, this situation created a discretionary handling of community employees who were even assigned duties beyond their usual community work.

To sum up, the changes found in the last year, suggest an encouraging future to strengthen a Community Health Program at local level.

During the last three years, work sessions were held at all Regions to plan basic preventive actions of the Community Health Program. The Project supported holding annual workshops on planning and scheduling community health activities (Operational Annual Scheduling – PAO, Spanish initials) involving Specific and Department Supervisors of Community Health from the beneficiary Health Regions, based on data provided by all health promoters. The USC of MOH higher level participated in most of said workshops as a technical advisor.

Concerning the Development of Human Resources skills, since the start of the Project, i.e. 2006, we insistently advocated for MOH to open a department to coordinate the work of more than 2,000 health promoters. Such opening took place the following year (2007) at MOH higher level, through the formation of the community health unit formed by 5 Technicians and one (1) administration person, besides the appointment of one (1) Community Health Regional Supervisor in each health Region. We have technically supported this team with trainings and field practices supervised to strengthen management skills, which are key abilities to carry out their work in planning, monitoring, evaluation, and supervision.

To direct the activities of this new structure, we organized and supported a workshop on management skills, in which, among other products, we prepared a preliminary strategic plan, with the participation of 4 USC technicians, 6 Regional Supervisors and 5 Department Community health supervisors and the URC technical advisor. In such plan we defined the following as the most important keystones: facilitating supervision, monitoring and evaluation, updating the health promoter's formation plan, strengthening the community organization and social involvement. We included the review of regulatory documents under the light of the new approach of Family Health Care and its subsequent updating under the focus of labor skills. Additionally, we saw the need to provide training in AIEPI/AIN – C, as a remedial action for newly hired employees that were hired by FOSALUD and the Project RHESSA without to have a certificate of Basic Course of Health promoters.

To start the operation of this preliminary strategic plan of the USC, we supported training of 120 new and experienced Community Health Supervisors on topics related to the facilitating and novel supervision model of monitoring and evaluation (of activities carried out by health promoters), in 6 successive 3-day workshops, with the participation of a maximum of 20 attendees, per workshop. We also updated, the supervision and monitoring tools —which printing was supported by us— and we activated monitoring field visits to health promoters, which became more frequent, the gap between the number of these health promoters and Community Health Supervisors was reduced from 40:1 to 17:1, with this we were able to carry out, at least one monitoring visit a month per healthcare promoter. The first field monitoring visits were useful to build a baseline on the performance of health promoters in relation to their duties and knowledge applied under a family focus in the household. Once the

performance map was completed, we gave priority to community workers that required more monitoring and supervision to strengthen their expertise and technical skills.

It is evident that there are differences between the various Health Regions of the country especially on the level of empowerment of the new facilitating, monitoring and evaluation supervision model, by Specific Community Health Supervisors. The level of acceptance, involvement, and training achieved by the Department or Regional Supervisor, and the technicians who have the commitment of modeling and providing all the necessary assistance has a bearing on making Supervisors achieve the optimum level of performance in the exercise of their duties at local level.

Although Health promoters are better trained in several topics than most workers who are part of the local health teams in the history of MOH, it is also true that in the last years the percentage of rotation has reached 10% annually. This implies that year after year, some health promoters, are hired with no previous formation to carry out their duties; therefore, all along the project we supported training for more than 200 newly hired health promoters, in community AIEPI and AIN – C, neonatal health and Family Planning.

The support of the Project on this topic including financing local training, meals and, in some cases, room and board for the attendees; and in many cases printing the necessary materials for their training, in this particular case we also printed 1,000 copies of the following documents: Community AIEPI Procedures chart, Flipchart of preventive measures in Community AIEPI and participant's guide for the Community AIEPI Course, we also burned 500 sets of DVD's with educational material for the Community AIEPI Course, and 400 CD's with the picture album of said Course. It is noteworthy that all this material has been used to support the training of newly hired promoters in all the country and not only those working at the 72 beneficiary municipalities.

In the area benefited by the Project, over 540 Health experienced promoters were trained on an updated version of newborn handling in the community, with emphasis on the topic of danger signs and basic care to be provided in the household.

Likewise, with the support of the Project we provided training to over 540 health promoters, 120 Community Health Supervisors and 50 Health Care Unit Directors, on use of manuals on technical duties and administration standards of health care promoter.

Other relevant topics of their training were: techniques for a balanced consultancy on FP methods, use and management of the medical eligibility criteria checklists for the use of Oral Contraceptives, Injections of progestin, for the use of IUD and the lists of reasonable certainty that the woman is not pregnant. Particularly, over 2,300 active Health promoters from the Family Planning Component had been trained as of the end of 2008.

We disseminated the new approach of maternal assistance with PS for 17 municipalities in which this pilot experience had been implemented.

At least 60 Specific Community Health Supervisors and over 600 Health promoters were trained, in a process of standardization, to take anthropometric measurements to children under 5. Some of these were involved in an activity located in the department of La Libertad. This was called First Implementation Phase of the Nutritional Surveillance System (SISVIN).

In 2008 we carried out the process of updating the duties of health care promoters, which ended with the drafting of the manual on technical duties of the health care promoter. This document generated the need to update the basic formation plan for health promoters, within the framework of the model of Integral Care with family approach, in view that it included new duties related with users that were not directly attended by them.

Therefore, we carried out a review of the formation plan and we updated it on the basis of new competences that, according to the new manual, all field personnel should have to carry out their duties set forth in the new regulation. The renewed formation plan will start being implemented with the new health promoters that have been hired since January 2009.

In relation with the plan of formation of Community Health Technical level, to this date, only representatives from the Public Health Department of Universidad Centroamericana “José Simeón Cañas” showed any interest in including it in their technical careers. Therefore, consolidation of this request is still pending because it still needs to be presented before the new authorities of MOH.

Another relevant support to respond to another strategic keystone of the Community Health Program (Strengthening the community organization and the social involvement) we focused on the construction of an Intervention planning guide for Health and Development with Community Participation, through a participative process that generates a series of input were later included in the Health Promoter Management System Manual. In this last process, we emphasized on the management focus of community employee's work, in the need to strengthen organized social involvement (in ADESCO or any other type of viable organization), setting a solid basis for health promotion, addressing local health determining factors and constituting a healthy community, stronger aspiration to promote it at rural and urban communities of the country.

These last two strategic axes (updating the health care promoter formation plan and the strengthening community organization and social involvement), have remained at technical fundamental level without developing the operational section. Although we must admit that during 2008, some departments of the country partially reactivated community involvement, through the organization of assemblies to return community diagnosis and setting in common the condition of health through participative presentation and analysis of the most important health indicators at community level, these are but minute steps still very closely directed by the health personnel and with a reactive character by the population that do not go beyond the sanitation environment. Additional efforts may be identified in the community strategies of Delivery Plan, NEPRAM (model of negotiation of improved practices in the prevention and control of dengue) and AIN-C, among others, which have been running since the beginning of the decade, but are handled in a disorganized and vertical way.

Finally, it is necessary to recognize that the findings in the last Family Health Survey FESAL 2008 provide sufficient evidence on the impact caused by the application of a sanitary intervention having components of promotion, prevention and basic attention, such as the AIEPI community strategy. Specifically concerning diarrhea, prevalence of cases remains constant in 13.8% since the date of FESAL 2002/2003. However, according to the official institutional data, the cases of diarrhea have a significant decrease from 2007 to 2008. The reason for this apparent decrease in the incidence of cases, is because they are now less severe and people have more knowledge of the signs of danger and how to treat diarrhea at home, searching a health establishments (where the "new case" statistic data originates) is performed having more information available. If illnesses are solved at home, people's contact with health establishments is reduced in number, but not necessarily, because fewer cases occur. Another interesting and not less important fact is the increase in the use of oral rehydration therapies in the treatment of diarrhea and the evident decrease of death because of dehydration.

In the short, mid and long term, this situation must be supported with sustaining measures at community level and in the first level of health assistance, guaranteeing the permanent stock of oral rehydration therapy and keeping a process of continuous training with Health promoters, physicians, and nurses with the purpose of keeping a high standard of know-how for an efficient, effective, and timely intervention, so that they in turn, may share such knowledge with the population and then finally generate the best practices to maintain and care for health.

Concerning strengthening of the structure, USAID has been the external cooperation agency that has supported Community Health Programs more strongly and with a long story of over 30 years of evolution. The support has spanned from advocacy to the restoration of the Community Health Department in 2007, with the opening of the Community Health Unit, under the General Health Directorate. Simultaneously, new community health supervisors were gradually included, at regional, departmental and local level, positions covered by health promoters that were seeking to become supervisors.

The project donated for each USC member, a computer with a printer. Besides, for the use of the new office, they were provided a fax, a scanner, a digital camera, and a laptop and a multimedia projector for management and training presentations. On the other hand, MOH has invested on training them in the use of computer software (Word, Excel, Power Point, and Internet) which has strengthened technicians capabilities and make the best use of the equipment donated. Today, each technician has his own password to access the on-line data system of morbidity and mortality and MOH production of services. These has improved their capacity to follow-up and analyze vital information in conducting the Community Health Program and writing reports of all kinds is faster, both internal and those for the different external cooperation entities with which the Community Health Program coordinates.

Each Community health supervisor from the Health Regions and SIBASI beneficiaries of the project, were given computer equipment, with this improved their efficiency at work and the way to report their activities.

All the 540 health promoters from the 72 benefitted municipalities were provided with basic equipment consisting of tension meters, stethoscopes, scales and other essential elements to find signs, complications, and epidemiological risks among members of the families they visit daily, with emphasis on pregnant women, puerperae, newborns, and children under 5 years. Additionally, they were provided annually with stationery to record community activities vital for monitoring and evaluation.

Throughout the execution of the project, we supported updating and printing regulatory documents for Health Promoter. The documents updated are Manual of Technical Duties (formerly called Occupational Profile), and the Management System Manual for Health Promoters. A result of this update was the renewal of the health promoter formation plan; it was prepared based on competences, which is the most modern trend on this topic related with the development of human resources worldwide. We prepared a formation plan for health promoters so they may apply for a technician degree in community health.

### **7.5.2 Family Health Component**

The activities supported in this area, were within the Community Health Component, because by mid 2006, MOH started to consider giving a different focus to the model of health assistance in force to that date, that were more consistent with one of the articles of what was at that time a draft law to create the national health system: it was sought that SNS were established on a model of assistance with the family health focus. therefore, they requested USAID technical assistance and they hired a consultant to support the creation of such model which main fundamentals were the experiences of family medicine in diverse countries, as well as family health models of Colombia and Mexico

The main objective of the international consultancy was to adapt the model in El Salvador, supporting, during the last 3 months of 2006, the development of the technical proposal (foundations and contents of the model) along with a team of Salvadoran professionals; a proposal that, once it was validated, was disclosed in the first semester of 2007, starting to implement the model, as a pilot experience in 10 Health care units and the same number of municipalities beneficiaries of the project.

Although it was anticipated that 2007 would be a year of adjustments for the model, with the imminent approval of the law for the creation of SNS, MOH authorities determined that the implementation process of the model should extend rapidly to more municipalities and in all Health Regions of the country. Officialization of the model took place on August 10, 2007 in a session and most members of the intra and intersector were invited with an attendance of over 300. Among them were several diplomats accredited in the country, representatives of foreign cooperation, all SNS members and people from all MOH management and operation levels.

Early in 2008, 34 of the 72 municipalities' beneficiaries of the project had already started with the process of family adscription. At the same time, the implementation of the model had started in all departments of the country but because of the lack of resources, especially stationery, the process was halted and did not achieve the expectations the Regional Directors had proposed in the last assessment of the

implementation process in 2007. Because MOH could not afford this initiative, USAID financed printing the dossiers and family files to strengthen the work in the beneficiary municipalities. MOH also had the support from UNICEF and RHESSA project to print stationery for the remainder of El Salvador.

By early 2009, an affiliation process had started in at least one small village or a prioritized area in each of the 370 establishments of the local level within the country. Some establishments have affiliated more than 50% of their rural population although they are not the majority.

In all evaluations made to measure the progress of implementing the model of integral assistance with a focus on family health, the need for human resources has always appeared to carry out the implementation of the model effectively. Besides, there is a lack of an integrating guideline so that such process is not interpreted and executed as a separate program, this is currently happening and even the activities performed with this focus have been recorded independently from the rest of the health establishment activities. But the largest weakness of the implementation process of this model has been, from the start, the lack of a budget assigned to strengthen and make the program sustainable. However, we must bear in mind that family health does not depend solely on MOH, because the family is located in a community and this in turn, in a municipality; family health depends on many social, economic, and environmental determiners, among others and therefore, if it is not coordinated with this environment, the effect will be minimum.

Afterwards, and since February 2007, the project has been strengthening training of health teams from health establishments in the 72 beneficiary municipalities involved in the implementation process of the integral assistance model with a focus on family health. A total of over 500 persons (including physicians, Odontologists, nurses, sanitation inspectors, and health promoters, from the health establishments of the 72 beneficiary municipalities have been trained.

The support of the project to purchase the basic equipment to perform physical examination during the visits to homes was necessary to make the application of this model feasible. One of the most important benefits produced by the affiliation of families, when it has been made by the physician, odontologists and nurses, rather than only by Health Promoters, is that personnel has learned about the poverty conditions — sometimes extreme poverty—of the families, geographical inaccessibility or lack of transportation to visit the health establishment. When the personnel learn of this economic, social, and environmental condition, etc., it develops awareness, and this is why we have observed changes on warmth and quality of attention. However, the biomedical focus persists significantly, which is not consistent with the philosophy of the new focus that leads to more participation of the family and the community in solving health problems in maintaining and caring for their own health. In many places, the health promoter has been the one who makes the family affiliation process on his own, because of a lack of resources to perform this task.

The support of the project to purchase the basic equipment to perform physical examination during the visits to homes was necessary to make the application of this model feasible. We also provided support by supplying backpacks and office supplies to be used during the family affiliation process, in beneficiary municipalities of the project.

We printed 180,000 family dossiers and over 1.5 million of family and basic sanitation file cards, specifically for the family affiliation process. We also held more than 8 workshops and work sessions to prepare the regulatory documents related to this topic, (framework Document of the Model of integral assistance with the focus of family health, and guide for the operation of the integral model of assistance with family health focus). They featured the participation of health workers from different MOH levels and all Health Regions, two of which were conducted by an international consultant sponsored by the project.

### **7.5.3 Monitoring and Evaluation Component**

We started a monitoring and evaluation process in the Strengthening Health Project, this included: 1) the methodology, 2) staff in charge of compiling the information, 3) the time to carry it out and 4) a list of evaluation indicators. The plan was discussed, reviewed, modified, and validated involving URC, officials of various MOH management levels, and counterparts from the different Components of the Strengthening Health Project. Afterwards, it was sent to USAID and it was approved after incorporating some observations requested by the CTO's in charge of the Project.

After this, we presented it before the Planning Director. In such meeting we requested the timely and periodical support to feed the M&E System with data for indicators that would be provided to the corresponding persons in charge of all Components in the Project, in such a way that the periodic analysis of the project would be performed between MOH and URC officials in order to assure that all activities of the Project are carried out as planned, identify why some activities are not progressing as expected, proper any constraints and find new activities that require programming, based upon permanent monitoring findings from the special surveys and the evolution of the Project, so that opportune decisions may be taken.

The methodology included surveys to raise the baselines both in the area of results (through a KPC) applied to the process (by service provision assessment) and its structure (by inventory of equipment). The first and the last of the surveys mentioned were carried out, but we were unable to carry out the second one, i.e. service provision assessment, because we lacked MOH approval. For two years in a row we advocated its improvement, even by including it at the outset of the implementation of the Continuous Quality Improvement program, but of no avail. Even though the Ministry did perform monitoring on administration commitments, which are measured through indicators, several of them resumed from the project's monitoring and evaluation.

Objective evaluations and perceptions on the Health Information System and its use in following up administration commitments for decision-making in the field, lead to the conclusion that it was necessary to systematize the monitoring and evaluation process used. A specialized consultancy was planned and budget was allocated to carry out said work. But at the outset of all the preparation procedure of the term of reference for the consultant, some counterpart officials from MOH General Directorate presented some demands that were difficult to comply with because they were beyond the terms of the project contract. We sought an alternative to solve this through the Planning Directorate. Technicians from this Directorate were committed from the start to organize, plan, execute and evaluate an induction process that would result in having officials and technicians from all levels of management of MOH to appropriate a

monitoring and evaluation culture, focused on the results and seeking the continuous improvement of the processes whose limitations would be some times reflected in the local results.

The starting point was the promotion of MOH webpage, which has been in operation for some years but it has not been used in full, considering the statistics of use of information found.

The observations made by the technical team from MOH Monitoring and Evaluation Unit (UIME) and URC technical advisor during this induction process, prompted strongly the need to make a survey to enhance the reasons why most health workers and namely those in managerial positions do not make decisions based on the information they themselves generate. The step of simply passing on information to the next level was clearly shown during this brief period of induction.

This is how by the end of 2008 we were able to make the survey “Use of the Health Information System for decision-making, and perceptions thereof by personnel from the three Health Regions of the Ministry of Public Health and Social Welfare of El Salvador, supported by the Strengthening Health Project, Activity 519 – 0463”, which outcomes were disclosed in April 2009 by MOH higher and regional officials. The commitment to work complying with the recommendations of the survey was assumed in that occasion.

Almost at the same time, by the end of 2008, we started an integrated and coordinated process with one of ABT technical advisors to structure a follow-up and evaluation System for the National Health System. A Work Plan was drafted, but because of some constraints within MOH, the work was suspended.

It is evident that, to this date, there has been little interest in having a precise, practical and functional follow-up and evaluation system, most likely because of a lack of a strategic approach mainly oriented to results, and due to a lack of a scientific and rational planning of services.

As for training, between 2007 and 2008, we held eight workshops (each participant had his/her own computer) where they learned the necessary steps to look up information, transport it, share it, plot it, and analyze it. Attendants were from MOH Programs, support units, and higher level heads, Directors and technical personnel from the different Health Regions and personnel from the so called Monitoring and Evaluation Units having their basis in the SIBASI. Proficiency in the use of tools by attendees varied, some followed the steps without any help, and others were able to learn the whole process.

On the other hand, those in charge of the components and their counterparts responsible for MOH programs, provide training to personnel from various MOH levels to apply the corresponding monitoring and evaluation tools.

The pioneering programs in monitoring and evaluation processes were: children integral Assistance and Community Health. They consolidated the culture they have in practice since 2002, with the support from their corresponding advisors strengthening the training developed earlier in personnel from the regional and SIBASI level, as well

as URC Facilitators; and particularly Community Health, also that of Community Health Specific Supervisors.

The Hospital Borne Infection Prevention and Control Component created its own instrument for prevention and Control activities of Hospital Infection surveillance. They also provided training in the process of analysis and search for solution alternatives of the constraints found.

Meanwhile, for the Maternal Health Component, monitoring and evaluation process enhanced the strengthening of decision-making culture by improving the operation of a tool that has been applied since 1990 in our country: the Perinatal Information System (PIS). In the last three years, there was an important progress in terms of usefulness for specialists (gyneco-obstetricians and lately neonatologists) and for hospitals managers (administrators and directors) of the 28 maternity wards of the country, who have started to make changes on unwanted practices, which have become evident in the outcomes provided by PIS. Technical Advisors in charge of the Component in URC and their counterparts in MOH have provided training on best practices of PIS use through quarterly exercises of information analysis and identification of continuous improvement measures.

It is noteworthy that we also started with a monitoring process of quality standards in 12 hospitals of the country, in the framework of an emerging national continuous Quality Improvement Program. The process, facilitated by the making of a baseline, will be used to compare periodically and systematically the level of compliance and progress in the improvement of baseline condition of 17 selected indicators, in order to ensure that the changes are generating the expected outcome.

In the Family Planning Component we prepared checklists that were used mainly at hospital level and in some local health establishments. However, the priority for monitoring has been the logistic system; this activity was supported by another project supported by USAID, named DELIVER.

URC facilitators played an important role applying monitoring instruments and following-up the implementation process of the different methodologies. We paid close attention to the Infant Component due to the leadership of the Children Integral Care Program that was shown in this activity. The rest of the programs did not require the same involvement of Facilitators in its corresponding monitoring and evaluation processes.

Finally, the IEC/CCC Component started the construction of a monitoring and evaluation system of their actions in harmony with the objectives of the National IEC/CCC Strategy that we prepared along with the person in charge of MOH Health Promotion Unit. However, because of several reasons, the process did not have the expected outcome.

Although this will be covered in other sections of the report, we must highlight that the project donated complete computer equipment to the Maternal Health, Hospital Borne Infection Prevention and Control, Infant, Nutrition and Community Health components. This equipment helps to run PIS systems, keep control of Hospital Borne Infections, search and analyze general information of online systems MOH has, make

reports, graphics, that facilitate analysis of information. Therefore, monitoring and evaluation activity has been strengthened with the equipment provided by the Project.

We must also highlight that the Maternal component has updated and adapted the Manual for the use and management of PIS in El Salvador. The so-called Community Health indicators Workbook and the quarterly evaluation Matrix were prepared in Community Health and also the analysis guide included in the Health Promoter Management System Manual.

## 8. KEY ACTIVITIES AT SHP PRIORITY HEALTH REGIONS LEVEL

One of the objectives of the bilateral agreement with which USAID provided technical and financial support for MOH through the Project was the strengthening of basic health by increasing coverage, improving quality and effectiveness of mother-infant health, Family Planning, nutrition, Infection Prevention and Control and Community Health services, supported by an effective strategy of communication to change behavior, using methodologies that emphasized institutionalization, Continuous Quality Improvement and sustainability of results in the different levels of attention, mainly in the level of provisional services. Achieving this will depend largely on the ability of the Project to support MOH in making a series of priority interventions identified jointly in the different levels of provision and performance.

Besides, MOH was interested in strengthening monitoring and supervision duty of technical teams from Health Regions and SIBASI's as one of the efforts to strengthen decentralization in health administration. This is why the project intended to encourage, support and accompany a continuous monitoring process of components supported by the Project in the establishments designated as a priority for USAID. In answer to the above, SHP hired a team of 7 advisors early in 2007, that under the name LOCAL FACILITATORS were assigned to each of the regional teams or SIBASI supported by USAID. Their Mission was to fit in such teams to support the strengthening of a culture of monitoring and facilitating supervision and also to promote compliance of the Work Plan prepared jointly with the different MOH counterparts.

The distribution of geographic areas took place in such a way that 2 Local Facilitators were assigned to the Central Health Region, to cover Chalatenango and La Libertad SIBASI's; 3 facilitators for the Paracentral Health Region which included the Cuscatlán, Cabañas, San Vicente and later on, La Paz SIBASI's and 2 facilitators for the Eastern Health Region to support Usulután and San Miguel SIBASI's.

Insertion of Local Facilitators in their corresponding areas followed after a two-week induction section, in which each head office of the programs benefited by the Project made a presentation of their strategies, interventions and priorities in which they required support from them. Likewise, each component coordinator within the SHP presented his corresponding area within the action plan. Afterwards, the Coordinator of the Technical Assistance Group went to each area and introduced each facilitator with its Regional Director.

The facilitators' work in the Regions takes place in a series of phases that may be described as follows:

- **Incorporation and Integration Phase:** From the time he is introduced to the Regional Director, he joined the technical team of the SIBASI or Region, and he was introduced as an additional member of such team, performing some outstanding activities to obtain the desired effect, among which we may mention: presentation of the different programs to technicians as the one responsible for coordination of SHP actions and similarly, the physician directors and remaining personnel of the Health Care Units were introduced. In this phase, the facilitator started his duties by supporting with the identification, visit and request of a quotation of the most suitable

places in their corresponding areas to hold workshops, meetings and training activities, besides the identification of local suppliers in the different municipalities,

- **Refurbishing phase of the facilitator's office:** during this phase we negotiated with the Regional Directorate to identify the suitable physical space to improve the facilitator's office. This refurbishing enabled for such minister's offices to have a conference room and in some cases, auditoriums. This was done in order to provide the facilitator with the settings to hold workshops, meetings, and trainings. Besides the infrastructure, we also provided the necessary office equipment including laptops, multimedia Projector, PC, fax, etc. also telephone and internet service were hired. Then, we purchased some vehicles, two for each beneficiary region these would be used to support the local team in monitoring visits to Health care establishments.
- **Planning Phase and start up of technical activities:** we held meetings to coordinate and plan the activities included in the action 2007 Plan beginning at the end of March 2007. We held a monthly meeting in the Region with the region's personnel, from priority SIBASI's and facilitators to prepare the monthly monitoring schedule with the activities to be carried out.

There were several achievements in compliance with the regional action plans, in the period between February 2007 and June 2009. We were able to foster and strengthen a monitoring culture in the SIBASI technical team, setting clearly-defined objectives, and a careful planning of the establishments to be visited each week, and organizing multidisciplinary technical teams. But the different issues such as emergencies, natural disasters, and epidemics, affected several times the development of the schedule to visit health care units and the execution of the action plan.

Following is a summary of the main achievements:

## **MONITORING ACTIVITIES AT HEALTH CARE ESTABLISHMENTS**

In each of the SHP beneficiary Health establishments, we developed monitoring activities along with the health personnel from the Monitoring and Evaluation Units (UME) of SIBASI or with regional technicians specialized maternal and infant health, FP, Nutrition, as well as the infection Prevention and Control Component. By the end of the project, monitoring visits totaled 948, of which 11% belonged to hospitals and 89% to Health Care Units, making an average of 9 visits by center of the first level, and 6 visits per hospital, as shown in the following consolidated chart.

### SUMMARY OF MONITORING VISITS BY HEALTH REGION

Health Region	SIBASI	Health establishment		Total
		Hospital	Health Care Unit	
Central	Chalatenango	11	128	139
	La Libertad	6	142	148
Paracentral	Cuscatlán	21	177	198
	San Vicente	20	127	147
	Cabañas*	7	24	31
	La Paz*	6	5	11
Eastern	Usulután	13	135	148
	San Miguel	18	109	127
<b>Total</b>		<b>102</b>	<b>847</b>	<b>949</b>

Source: URC Facilitators Annual Reports

\* SIBASI with only one priority municipality

In general terms, the activities carried out in monitoring visits were:

#### Within the area of Health Care Units:

- Monitoring efficiency conditions, for quality in the assistance of children under 5.
- Evaluation of assistance provided in the maternal assistance component.
- Evaluation and technical support in the implementation of the “New Prenatal Control Focus”.
- Monitoring and feedback on compliance with principles of voluntary, free and informed choice of FP methods, compliance with of Tiaht Law, ACCEDA methodology and requirements in cases of female and male sterilization.
- Analysis of management commitment Indicators.
- Evaluation of continuous education plans for volunteer advisors on nutrition.
- Support in Integral Nutrition Care community sessions.
- Technical and logistics support in continuous education sessions for volunteer advisors nutrition.
- Technical and logistic support in educational sessions for community leaders.
- Support in preparing and progress of IEC /CCC plans of the Health center.
- Support in verbal autopsy in cases of infant mortality.
- Monitoring of Health promoter activities

- Evaluation of Family Health Care strategy
- Advice on standards established to prepare and update the situational hall of the health care establishment
- Support in the execution of “Healthy School” brigade.

**Within the Hospital field:**

- Support in periodical Evaluation Sessions of Maternal Perinatal Surveillance Committees.
- Support in Activities developed by Hospital Borne Infection Prevention and Control Committees.
- Support in Evaluation sessions of the Pilot plan of “New Approach to Prenatal Control”.
- Evaluation on principles of voluntary, free and informed choice of Family Planning methods, in compliance with the Tiaht Law, ACCEDA methodology and requirements in cases of female and male sterilization cases.
- Participation in auditing sessions for maternal mortality and Infant.

We made other types of visits to said establishments to coordinate the activities, deliver supplies, request for information, etc. that have not been reported as monitoring.

**Methodology used in monitoring visits**

- Use of monitoring instrument of efficiency conditions for Children Health Care.
- Direct Observation in assistance to users to evaluate compliance with the different Protocols of attention set forth by MOH.
- Interview with the person in charge of the Maternal, Infant, Nutrition, Family Planning and Infection Prevention and Control Component Programs.
- Interviews to users, with standardized instruments to evaluate the assistance provided.
- Review clinical records, daily and monthly tabulators.
- Household visits and direct observation of the attention provided by Health Promoters.
- Guiding and training supervision.
- Meeting with health personnel from the establishment in order to evaluate findings and determine commitments of improvements opportunities found.

## **TRAINING HEALTH PERSONNEL FROM MUNICIPALITIES OF THE SHP AREA OF INFLUENCE**

Concerning training the most relevant data may be summarized as follows:

### Family Planning Component

- Community Personnel trained on counseling for Family Planning.
- Strengthening FP referring personnel at hospital and Regions level
- Training 100% of health personnel on the monitoring system in compliance with legal standards, i.e. the Tiaht Law.

### Maternal Health and MCC Component

- New model of prenatal assistance , 100% of personnel from health establishments that have been prioritized for implementation have been trained. This also contributed to strengthen the referral and return system so it was not resumed yet by establishments that were not included in this first phase of the new prenatal.
- Perinatal Information System updated in all hospitals
- Maternal Perinatal Mortality Surveillance System active.
- Regional Centers for Development of Obstetrics, Neonate, Family Planning and Hospital Borne Infection Prevention skills installed and operating.
- Continuous Quality Improvement Program under application in the different levels rendering CONE-FP services and in use for making decisions in 100% of prioritized hospitals for implementation.

### Infant Health Component

- Training on NRP and STABLE for 90% of health personnel attending deliveries in hospitals. It was impossible to cover it 100% because the last courses were suspended after the Influenza A H1N1 epidemic.
- 100% of physicians and nurses from priority health units trained on the new guide for Integral Assistance to children under 5.
- 100% of physician directors and nurses from priority health units and SIBASI and Region technical teams trained on the use and application of the efficiency conditions monitoring instrument.
- Premature follow-up program operating in all hospitals.

### Nutrition Component

- 100% of community level personnel standardized in taking anthropometric measurements of children under 5.

### Infection Prevention and Control Component

- Regional and Hospital Technical Team of Infection Prevention and Control Component operating.
- Hand-washing practice effectively introduced in hospitals.

### IEC Component

- Health care establishments were strengthened with training of one of its employees as an IEC referring agent, enabling the preparation of an integral education plan.
- 100% of establishments strengthened with plenty of educational material to perform counseling, education and promotion activities.

#### Community Health-Family Health -Monitoring and Evaluation Component

- We trained 100% of promoters of priority areas concerning the duties manual. We also trained 100% of specific supervisors on facilitating supervision.
- Facilitator monitoring, evaluation and supervision of health promoters implemented in 72 municipalities.
- Training of 100% of health personnel, physicians, nurses, dentists, specific supervisor, health promoter and environmental sanitation inspector from each establishment prioritized for the implementation of the family health strategy within the priority areas of the Project.

In the annex section we present the charts consolidating trainings and personnel trained from hospitals and health care units of priority municipalities for the Strengthening Health Project.

## **9. ADMINISTRATION REPORT**

For a better relation of expenses with the execution times of the Project, this Financial Report is presented by budget lines and year of the Project.

It is important to highlight that all administration and financial processes summarized below have been made in compliance with USAID regulations and with the endorsement of the Project Headquarters in Bethesda and/or the local representation of this cooperation agency, whenever it is required.

One of the first activities was to prepare and review the Procedures Manual of the Project according to URC procedures and adapted for use in El Salvador.

### **9.1 Human Resources**

To develop the Project we hired personnel that have been defined in the work proposal and all necessary proceedings were made to hire the two chiefs of party who worked during the two periods of the Project and the local team to take care of the different components. All contracts were made according to the policies defined by USAID and according to URC procedures.

During the term of the Project, we have the support of MOH personnel on assignment and they returned to their original workplaces after their leave of absence expired. These officers were an important contribution for the Project. They were acting as field facilitators of the Project when they finished their tasks on the original date of the Project expiry, June 2009, and the Project has continued working with minimum personnel during the extension with no additional cost until its closing date in September 2009. An Annex contains the list of the officers of the Project throughout its entire life.

### **9.2 Support for trainings abroad**

The Project administration supported several MOH officers to attend training processes abroad, as listed below:

- Neonatal Central American Congress, Guatemala City, with attendance of 5 MOH Physicians and 1 URC Physician.
- Updating and Amendment of "STABLE" Program, Miami, Florida, with the attendance of 3 Physicians.
- Updating on knowledge and techniques to take specimens and vitamin "A" survey, Guatemala, with the attendance of 4 Nutritionists.
- Ibero-American Congress on Neonatology, Mar de Plata, Argentina, with the attendance of 4 Physicians.
- XXVI Central American Congress on Gynecology and Obstetrics, El Salvador, with the attendance of 27 Physicians.
- National Congress on Infectology, with the attendance of 68 Physicians and Nurses.
- XX National Congress on Pediatrics, with the attendance of 96 Physicians and Nurses.
- We financed the attendance of the Vice minister and two nurses to the 9<sup>th</sup> Congress of the International Federation of Infection Control in Santiago de Chile City in October 2008

- We financed three gynecologists to the XIX Latin American Congress on Gynecology and Obstetrics, in Mendoza City, Argentina, October 2008

### **9.3 Consultancies**

We provided administration support to perform the following international consultancies:

- Joanne Ashton, “Review of the Infection Prevention Strategy and Policy of the Ministry of Health, and Identify the Weak Areas in which it is necessary to change practices and policies”.
- Humberto Jaime, “Design of a Family Health Model for the community”.
- Paul Richardson, “Support the building of a baseline of the SHP in El Salvador”. Hire the winning company to perform the consultancy to build the baseline of hospital equipment inventory.  
Hire the selected consultant to perform the consultancy for the baseline on knowledge, practices, and coverage in 69 municipalities supported by SHP.
- Hire a company to perform the consultancy for the baseline to evaluate knowledge, practices, and coverage of health services addressed to users.
- Community participation to support the delivery and emergency plan.
- Training on qualitative methods of Family Planning.
- Drafting the healthcare promoter job profile.
- Hire the company “PRODUCTIONS MULTICOM, S. A. de C. V.” to perform a consultancy on creativity, design, outline, and delivery of final graphic materials, radio, and television of IEC/CCC Strategy in Maternal Infant, Nutrition, Family Planning, and Hospital Borne Infection Prevention Components.
- Design a model to evaluate and prepare community diagnosis and plan health actions in communities assisted by MOH health promoters.
- Consultancy to conduct the process of reviewing and redesigning basic and continuous training curricula of health promoter and the specific supervisor of Community Health.
- International consultancy to review the external evaluation process of Child Friendly Hospitals, and “Breastfeeding” initiatives.
- Consultancy on building the baseline of neonatal mortality by Hospital Borne Infections at hospitals of the national health network of El Salvador.
- Consultancy to gather information on the potential use of remittances to cover health services in the municipalities of Chinameca and San Rafael Obrajuelo, in the SHP framework.
- National consultancy to perform a survey on the use of the Health Information System in decision-making and classify the perception personnel from the different levels of MOH performance has on it.
- We contacted and followed proceedings for Dr. Salvador Villalpando’s to review and update the supplementation standard with micronutrients. This was suspended because of the Influenza A (H1N1) emergency.

### **9.4 Purchase of goods, services and refurbishing**

The administration made all the necessary proceedings to set up the office or local headquarters for URC technical assistance group with the corresponding purchase of equipment, furniture and office services and the procurement of vehicles (ten).

Additionally, the offices for SIBASI's facilitators were remodeled as part of the logistics support process to the SIBASI's from the three Regions covered by the Project and duly approved by USAID.

As part of the Support to the Health Regions, we remodeled and furnished the auditorium and conference rooms from La Libertad, Cojutepeque, San Vicente, and San Miguel SIBASI's; and also the SIBASI's headquarters of Chalatenango and Usulután.

We purchased and delivered the computer and training equipment to Community Health, Nutrition and Hospitals, we also configured the programs and delivered the equipment, as well as medical materials, supplies, forms, and printed technical materials for MOH. These equipment and supplies were officially delivered by the American Ambassador to the Ministry of Health in a special event held on May 21<sup>st</sup>, 2007.

We refurbished and equipped the Regional Training Centers on Obstetric, Neonatal, FP, and Hospital Borne Infection Prevention Skills in the five Health Regions.

For the Infection Component, we purchased 61 copies of the Transmissible Illness Control Among Men, 40 copies of Infection Prevention, 40 copies of the Guide for Hospital Borne Infection Control, 12 sets of "APIC TEXT of Infection Control Epidemiology" V1, V2 and author index (with CD).

We purchased and provided MOH with computer equipment listed in the 2009 Work Plan, (45 desktop computers, 1 laptop computer, 45 UPS, 46 Office licenses, 46 copies of antivirus software and 45 printers).

For the Influenza A (H1N1) emergency, we hired an advertising agency to launch 4 educational campaigns with the broadcast of radio spots and jingles "Let's Prevent Influenza A (H1N1)".

On account of the Influenza A (H1N1) emergency, we purchased and delivered to the Ministry of Health: 1,000 surgical masks and 1,000 3M N95 masks, 1,000 CD – RW to burn the radio spot, 1,000 DVD – RW to burn the educational video, ear thermometers, 363 gallons of liquid antiseptic soap, 228 gallons of liquid soap, 463 250 ml bottles of alcohol gel 70%, 3,040 N95 particulate respirators, double elastic band, 3 cone layers, 3,769 500 ml. bottles of hand instant antiseptic 61% ethyl alcohol, 1,123 gallons of liquid soap, 97,020 N95 AlphaPro Tech respirators purchased in USA, using MOH franchise.

## **9.5 Project Closing Plan**

A Project Closing Plan has been prepared by the administration according to the contract specifications and enclosed coordination with URC head office and USAID El Salvador.

We delivered with the corresponding minutes the furniture and equipment to be used by facilitators (work stations, conference rooms, and their furniture, white boards, A/C units, chairs, tables for auditoriums, furniture and equipment for regional centers for skill development) to the SIBASI's so they may be properly registered with MOH property. This work has been facilitated because of the outstanding cooperation of the counterpart office of the Project in MOH.

All materials produced by the Project as well as the annual reports were sent to Development Experience Clearinghouse in the United States according to the provisions in the contract.

The original documents of the Project were sent to URC office where they are kept and are available for any auditing process.

As of the date this report is drafted, the definition for the destination of the Project property is pending. There is a chance for URC to be awarded a new contract and this property would pass as an asset to the next Project. In any event, we have prepared a contingency plan to deliver all this property to MOH or any other institution as USAID may determine.

## 10. ANNEXES

### ***ANNEX 1: LIST OF SUPPORT DOCUMENTS, TOOLS AND MATERIALS DEVELOPED AT MOH WITH THE SUPPORT OF THE PROJECT***

#### **A. Regulatory Documents and Tools Created and/or Reviewed and/or Updated and Printed**

**Family Planning:** Rendering FP Services Guide for health promoters; rendering Family Planning Services Guide for personnel working as midwives; Counseling Guide on Family Planning; Counseling Guide on Family Planning for youth promoter, Education for Life Guide.

**Maternal health:** Technical Guide for the use of Perinatal Information System –PIS- for the first level, Technical Guide for the use of PIS for the second level of attention.

**Continuous Quality Improvement:** Technical Guide of Continuous Quality Improvement.

**Infant Health:** Follow-up Guide for premature babies with weight under 2,000 grams at birth.

**Nutrition:** Manual for the use of the MADLAC System, Final Report of the third national census on size of school children in first grade in El Salvador, Nutritional Guide for teenagers, Nutritional Guide for the Salvadoran Family.

**Community Health:** System Management Manual for Health Promoters, Manual of technical duties of health promoters.

**Family Health Care:** Integral Health Care Model focused on Family Health Care, integral care standard focused on Family Health Care, Technical Guide to implement the Integral Health Care Model focused on Family Health Care.

#### **B. Documents, Tools or Materials of Support Created and/or Reviewed and/or Updated and Reprinted for Provision of Services and/or Trainings**

**Family Planning:** Education for Life workbook, training material to update on contraceptive technology, on FP counseling and FP administration programs (in CD format), dossier of support material of obstetrics, neonatal, Family Planning and Hospital Borne Infection Prevention skills centers, DVD of intrauterine device insertion and removal using no-touch technique, laminated poster with the intrauterine device insertion technique, checklists for medical eligibility criteria for the use of oral contraceptives, checklists for medical eligibility criteria for the use of progestin injections, checklists of medical eligibility criteria for the use of IUD, checklists of reasonable assurance that she is not pregnant and forms to file inscription and subsequent control on Family Planning, teenage male and female Identification Card, CLAP Sheet of SSR, evolution and complementary for teenagers, evaluation of the teenage male and female body mass index (IMC).

**Maternal health:** Dossier of support material of obstetrics, neonate, Family Planning and Hospital Borne Infection skill centers, Manual for health personnel evaluation at regional training centers on obstetrics, neonate and Family Planning skills, Dossier to train on new prenatal focus; CLAP/PAHO/WHO Perinatal Clinical History Form, CLAP/PAHO/WHO partogram updated sheet, Plastic templates to draw CLAP/SMR partogram, Perinatal Identification Card, Obstetrics Measuring Tapes, Gestogram, Monitoring graphs of maternal weight gain, plasticized poster of uterine height graphs vs. weight gain for pregnant woman and amenorrhea, poster of active handling of the third period of delivery (MATEP), plasticized poster of Perinatal Clinical History, Identification Card and form of cervix-vaginal cytology, Screening sheet of the new prenatal focus, referral and return form; seven forms to define case, audit, institutional survey and maternal death report.

**Continuous Quality Improvement:** Dossier to train regional quality Committees; Database program to report compliance with quality standards; data collection form on compliance with quality standards; Continuous quality improvement workbook, Baseline report on MOH continuous quality improvement 2008.

**Infant Health:** Integral Care filing sheets for children under 8 days, Filing sheet for children 8 days old and under 5 years and Integral Care subsequent sheet for children under 8 days to children under 5 years old, CLAP Sheet for children under 1,500 grams, Premature file card, Premature referral sheet, Follow-up card of a premature girl weighing over 1,501 grams and under 2,500 grams at birth, Follow-up card of a premature boy weighing over 1,501 grams and under 2,500 grams at birth, Follow-up card of a premature girl weighing under 1,500 grams at birth, Follow-up card of a premature boy weighing under 1,500 grams at birth, Plasticized sheet to evaluate gestational age, Evaluation poster of gestational age by Ballard, Neonate Clinical History Sheet at birth and evaluation for release of neonates, Control Sheet for Neonatal Transportation conditions, Notification Sheet of perinatal, neonatal, Infant and children death, Audit instrument of perinatal, Infant and children death, Supervision sheet of RN attention, Monitoring instrument of efficiency conditions for quality of attention of children from 0 to 5 years (by age groups and by level of attention).

**Nutrition:** Counseling illustrations on proper feeding practices in children under 2 years, Counseling illustrations on care of pregnant women and children under 2 years, Counseling illustrations on danger signs of children under 5 years and pregnancy complications, Growth Graphics of boys from 0 to 24 months, Growth Graphics of children from 2 to 5 years, Growth Graphics of girls from 0 to 24 months, Growth Graphics of children from 2 to under 5 years, MADLAC Interview Form, Daily record sheet on nutrition activities, AIN Baseline Form, AIN Consolidated Baseline Form, AIN monthly report form, AIN monthly graphic of children under 2 years, AIN Consolidated Baseline, AIN monthly report on volunteer advisor, AIN minimum expected weight table, AIN community of children under 2 years lists, AIN community pregnant women lists, Identification cards for advisors and AIN volunteer advisors, diplomas for AIN facilitators and volunteers, Cardboard tallimeter with their corresponding triangle.

**Hospital Borne Infection Prevention and Control:** Baseline report on the performance of Hospital Borne Infection Prevention and Control Committees, Survey on bacterial resistance in neonates in 20 hospitals of the country, Baseline of neonatal mortality because of hospital sepsis 2008, Dossier of the support material and consultation on

efficiency levels in Hospital Borne Infection Prevention and Control, Dossier of support material on consultancy on standardization and approach of Hospital Borne Infections. Patient In Risk Registration Sheet and identification of cases of Hospital Borne Infections, Survey Sheet of Hospital Borne Infection cases.

**Information, Education and Communication/Communication for a Change of Behavior:** IEC/CCC Strategic Plans for Infant Health and nutrition, Maternal health, Family Planning and Hospital Borne Infection Prevention and Control components, Guide for the implementation, monitoring, and evaluation process of the National IEC/CCC Strategy. Graphic, radio and television educational material on maternal, Infant, Family Planning and Hospital Borne Infection Prevention and Control components: 68 pieces of graphic material, (flipchart, tri-fold leaflets, reminder sheets, posters and sets of counseling illustrations, handouts), 19 radio spots, 4 television spots and 2 educational videos to support the execution of IEC/CCC activities in Health Establishments and community.

**Community Health:** Proposal of syllabus for Technician in Community Health and Syllabus for Basic Course of health promoter (new). Managerial system of health promoter forms: Community surveillance sheet of pregnant women, puerperae and newborn, Daily record of activities, List of children under 5 years, Community referral sheet, Family record, Community diagnostic summary and other relevant sources of records.

**Family Health Care:** Family dossier, family file cards, Family and community intervention plan form, and classification sheet for family risks.

**Monitoring and Evaluation:** KPC Community Survey 2007; Survey of perception on the use of MOH Health Information System for decision-making 2008.

## ANNEX 2: TABLE OF SHP MONITORING PLAN INDICATORS

### INTERMEDIATE RESULTS STRENGTHENING HEALTH PROJECT

#### IR 3 INTEGRATED MANAGEMENT OF REPRODUCTIVE HEALTH AND CHILDREN, IMPROVED

#### IR 3.3. SPECIFIC RESULT FOR REPRODUCTIVE HEALTH AND CHILDREN

	INDICATOR	AT THE END OF THE PROJECT	OBSERVATIONS	PROJECT'S ACTIONS TO ATTAIN THIS OUTCOME	RECOMMENDATIONS TO MAINTAIN OR IMPROVE ACHIEVEMENTS
1	Community health program fully implemented in 72 municipalities.	98%	<ul style="list-style-type: none"> <li>This has made it possible for health promotion and prevention actions to reach more Salvadorans in the rural area. The only two municipalities of the 72 beneficiaries where the health program has not been implemented yet are Suchitoto, department of Cuscatlán, and San Francisco Lempa in the department of Chalatenango.</li> <li>It is a priority to make a new analysis of the community health resources to benefit the population in these municipalities, as well as in others, that demand access to health services although they are not in the priority areas of the Project.</li> </ul>	<ul style="list-style-type: none"> <li>We have supported reorganizing the strengthening management skills for Community Health Unit and providing such unit with computer equipment and others.</li> <li>Health promoters have been provided with Basic equipment for community surveillance for women, mainly pregnant women and puerperae and children under five, consisting of blood pressure meters, stethoscopes, scales, and other essential elements.</li> <li>The Project has supported training on community AIEPI and AIN – C, neonatal health, FP, and newly hired Health Promoters.</li> <li>We have also supported the updating and printing of regulatory documents for Health Promoters as well as key stationary to record the most relevant activities of community work.</li> <li>We have also supported structuring the first curricula for an academic degree of Community Health Technician, in order to provide training community employees on these techniques.</li> <li>We have supported training Specific Supervisors of Community Health for them to support the fieldwork.</li> </ul>	<ul style="list-style-type: none"> <li>Update the Health Promoters national census and relocate employees where they are needed the most when there is excess of such employees in a geographical area.</li> <li>Perform an advocacy process at the highest level of USAID, MOH or GOES in order to recruit Health Promoters for the municipality of Suchitoto or any other that may require them.</li> </ul>

	INDICATOR	AT THE END OF THE PROJECT	OBSERVATIONS	PROJECT'S ACTIONS TO ATTAIN THIS OUTCOME	RECOMMENDATIONS TO MAINTAIN OR IMPROVE ACHIEVEMENTS
2	A perinatal information system developed nationwide to consolidate the information gathered from the 28 maternity wards for analysis and decision-making	100%	<ul style="list-style-type: none"> <li>To date, all hospitals with Maternity Services have a new SIP version installed in new computer equipment to enter data, prepare SIP reports, and train personnel to process and analyze the information system. Throughout the evaluations made by Women and Children Integral Care Unit, we have been able to verify the level of independence that officers using the system have developed concerning decision-making to correct or improve the use of SIP results.</li> <li>A key feature to institutionalize SIP (besides providing personnel with equipment and training) is that we constituted</li> </ul>	<ul style="list-style-type: none"> <li>The Project has been provided with modern computers and they have software provided by CLAP/PAHO/WHO installed. We have also trained a considerable number of personnel to enter HCPB data in order to process and analyze all information collected in the System. This last process is performed mainly by medical personnel, in charge of the program in the different Maternity Services of public hospitals. Additionally, we have supported MOH in printing over 300,000 HCPB sheets; the manuals for SIP training, and other educational material required.</li> <li>The Project has also supported periodical evaluations from which we have created a <i>critical mass</i> to analyze data. This in turn has prompted participating officers to acquire the skills to identify constraints, determine measures to improve the situations found, and to evaluate whether any actions taken have had the expected effect. One of the most important achievements has been incorporating pediatricians/neonatologists from hospitals in the evaluation sessions, thus consolidating an integrated approach of perinatal health.</li> <li>Another important factor to highlight is that since 2006, SIP has been included in MOH Information System's database of the Information, Monitoring and Evaluation Unit. In this unit there is a person in charge of receiving information from all hospitals of</li> </ul>	<ul style="list-style-type: none"> <li>Procure any necessary resources (stationary or technical assistance) to continue the actions after the end of the project.</li> </ul>

	INDICATOR	AT THE END OF THE PROJECT	OBSERVATIONS	PROJECT'S ACTIONS TO ATTAIN THIS OUTCOME	RECOMMENDATIONS TO MAINTAIN OR IMPROVE ACHIEVEMENTS
			<p>an indicator incorporated to quality standards of maternal care: "All pregnant women receiving prenatal assistance in the Hospital would have the proper record in their HCP", thus linking them to prenatal assistance being periodically and permanently monitored. Additionally we updated the regulation framework to handle this.</p>	<p>the country and prepare reports as they are requested by MOH technical personnel. SIP has helped to find information gaps and lack of data in SIEES (information system related to producing services at local and hospital level).</p> <ul style="list-style-type: none"> <li>• One more element on the way to institutionalization is the increasing involvement of neonatologists in the use and analysis of the information provided by SIP. Evaluation of the SIP quarterly outcome has led to identify constraints in prenatal assistance and during delivery, which affect neonatal health. Such analysis has been the basis for decision-making to solve the problems identified.</li> </ul>	
3	National maternal mortality surveillance System operating according to MOH guidelines	100%	<ul style="list-style-type: none"> <li>• At this time, all Regional Health Directorates have a Maternal Mortality Surveillance Committee. These committees have referring personnel which is permanently monitoring every case, so do the 28 maternity wards. This has guaranteed a better surveillance of both institutional maternal and community deaths, which, according to MOH data, are now are less frequent. The National Maternal Mortality Surveillance System has been a priority for</li> </ul>	<ul style="list-style-type: none"> <li>• One of the elements that has leveraged attaining this outcome has been institutional and government interest to reduce maternal death cases, in the framework of ODM. An additional ministerial advisor was appointed for this particular objective to the Women Assistance Units, which have been substantially supported in the last two years to comply with the objective of reducing maternal mortality in El Salvador.</li> <li>• We have provided support in drafting the Technical Guide for Maternal Mortality Surveillance, a process that has been implemented with the support of the project.</li> <li>• On the other hand, maternal mortality surveillance has also been performed by the communities from</li> </ul>	<ul style="list-style-type: none"> <li>• Attain a common vision concerning the need for more maternal mortality surveillance by the main agencies involved: General Health Directorate, through the Women Assistance Unit and the Health Surveillance Directorate through the Epidemiology Unit.</li> </ul>

	INDICATOR	AT THE END OF THE PROJECT	OBSERVATIONS	PROJECT'S ACTIONS TO ATTAIN THIS OUTCOME	RECOMMENDATIONS TO MAINTAIN OR IMPROVE ACHIEVEMENTS
			the Health Strengthening Project.	the rendering of accounts health promoters have made of events occurred. During the evaluations of community health activities we have monitored the occurrence of cases nationwide. Evidence shows that most deaths have occurred in hospitals after the community was able to persuade the pregnant woman and her family to give birth at the hospital. Such a situation has negatively affected the morale of community personnel, because they will have a hard time persuading other pregnant women to deliver at the nearest hospital.	
4	Maternal perinatal Committees in the 28 maternity wards nationwide monitor the implementation of quality assurance programs, and they ensure the liaison between the Hospital and Health Care Unit to reduce maternal and neonatal morbimortality.	100%	<ul style="list-style-type: none"> <li>• MOH defined 12 maternity wards to apply the Continuous Quality Improvement program; Maternal Perinatal Committees monitor 17 quality standards. These hospitals have a permanent monitoring by self evaluation, and they all have at least two improvement projects. This resulted from an analysis of results and the application of the Quick Cycle methodology.</li> </ul>	<ul style="list-style-type: none"> <li>• The project has supported organization of the National Quality Committee. Thus, the committee drafted the Technical Guide for the Application of Continuous Quality Improvement at Health Care Establishments. This outlines the fundamental methodology in the use of Quick Cycle and measuring standards, detection of gaps between planning and actual outcomes. Besides, we have supported training Higher Level Personnel and from Regional Directorates sharing experiences between the maternity wards of each region. The best projects were to be presented at the 2009 Quality Forum but were postponed because of A H1N1 influenza.</li> </ul>	<ul style="list-style-type: none"> <li>• Maintain experience and extend it gradually to the 28 maternity wards.</li> </ul>

	INDICATOR	AT THE END OF THE PROJECT	OBSERVATIONS	PROJECT'S ACTIONS TO ATTAIN THIS OUTCOME	RECOMMENDATIONS TO MAINTAIN OR IMPROVE ACHIEVEMENTS
5	Supervision particularly at MOH establishments attending deliveries, as well as Health Care Units of up to 72 municipalities supported by USAID performed according to MOH guidelines.	100%	<ul style="list-style-type: none"> <li>• It was possible to attain this outcome with the interventions lead by the Infant Health and Community Health Programs which developed supervision and monitoring actions of the efficiency conditions at local level, both in hospitals and in health care units in the case of the Infant Health Program, and at community level in the case of the Community Health Program. Both programs developed their own monitoring and evaluation instruments, as well as methodologies.</li> <li>• In the specific case of Community Health, the supervision model is based on five skills of Coaching (OPERA).</li> <li>• Most programs have their own supervision monitoring and evaluation methods, however, although some of them have it written in a regulatory document, not all of them enforce its application, let alone provide training and follow up the same. Some methods are</li> </ul>	<ul style="list-style-type: none"> <li>• With the support of Project we formed a Higher Level Committee, coordinated by Community Health, to review all existing initiatives seeking common and different points and we prepared terms of reference to hire an external consultant who would, through workshops, help build a new integrated model of Facilitating Supervision for the Institution. However, the counterpart changed and the process was interrupted.</li> <li>• We must also admit there were other limitations: each Attention Unit of MOH Higher Level had recent Supervision documents, with no integrating vision. On the other hand, the General Directorate requested to train in Supervision but was using a document recently drafted with the support from Grand Duchy of Luxembourg which did not respond to the field supervisor needs.</li> <li>• An important issue is that the Integral Care to Children Program focused its efforts in providing follow up to persons trained previously, besides monitoring the existence of essential conditions to work (personnel trained, stationary, medications and others). It only continued training newly hired personnel and recertifying in special cases required according to international criteria such as the case of the neonatal resuscitation course.</li> <li>• On the other hand, the project supported training of more than 120 Community Health Specific Supervisors in the Facilitating Supervision model. In 2008 the amount of supervision visits increased to</li> </ul>	<ul style="list-style-type: none"> <li>• Reclassify promoters that have become Specific Supervisors. There is a ministerial initiative in this issue but it has not been specified in the economic proposal to be submitted before the Ministry of Treasury.</li> <li>• See that Specific Supervisors have the required equipment and necessary supplies to perform their work.</li> <li>• Make sure that the Community Health Care Unit team may provide more solid support to strengthening managerial skills of Regional and Specific Supervisors and the development of a dynamic follow up and evaluation system (such as the one carried out complement the Facilitating Supervision model).</li> </ul>

	INDICATOR	AT THE END OF THE PROJECT	OBSERVATIONS	PROJECT'S ACTIONS TO ATTAIN THIS OUTCOME	RECOMMENDATIONS TO MAINTAIN OR IMPROVE ACHIEVEMENTS
			unfeasible, few are not practical at all or are too expensive because of the amount of paperwork required to implement it.	<p>more than 17,000 all year round performed for 2,300 Health Promoters.</p> <ul style="list-style-type: none"> <li>The URC facilitators appointed in each SIBASI played an important role in promoting monitoring culture of processes, accompanying (and many times "pushing") the SIBASI supervisor teams on this activity.</li> </ul>	
6	A quality assurance program operating in 72 municipalities supported by USAID	<ul style="list-style-type: none"> <li>100% in accordance with MOH priorities.</li> <li>71% pursuant to municipalities within the area of the Project that have hospitals</li> </ul>	<ul style="list-style-type: none"> <li>According to MOH priorities, an assurance program lead to implementation of a Work Axis: Continuous Quality Improvement and selection of 12 hospitals, extending coverage to 5 Regions, not only to the 3 where municipalities supported by USAID are located. We able to train, schedule, and implement Projects for the end of the Project at 15 of the 28 maternity wards.</li> </ul>	<ul style="list-style-type: none"> <li>The National Quality Committee decided to set up a pilot experience in 12 public hospitals, before extending the quality assurance program to the rest of health establishments.</li> <li>We prepared an MCC technical guide, and a workbook to apply the contents of the guide.</li> <li>We built a baseline and applied improvement Projects in 12 maternity wards. We included new maternity wards in the second quarter 2009 making a total of 15 maternity wards nationwide.</li> </ul>	<ul style="list-style-type: none"> <li>Extend the experience gradually to 28 maternity wards and other attention processes.</li> <li>Extend the concept of quality to certification and accreditation duties.</li> </ul>

	INDICATOR	AT THE END OF THE PROJECT	OBSERVATIONS	PROJECT'S ACTIONS TO ATTAIN THIS OUTCOME	WHAT IS RECOMMENDED TO KEEP ON IMPROVING THE ACHIEVEMENTS REACHED
7	A communication strategy promoting key messages in Reproductive and infant Health, created and implemented nationwide.	100 %	<ul style="list-style-type: none"> <li>• The national strategy was implemented initially in 3 Health Regions supported by the project, after the first year of implementation it was extended nationwide.</li> <li>• Educational material of the five components was distributed and is actually in use nationwide.</li> </ul>	<ul style="list-style-type: none"> <li>• We have supported implementation of a training process to prepare Regional IEC/CCC Operation Plan, local operation plans and for hospitals.</li> <li>• The Project has supported the health promotion unit with audio and video equipment; computer equipment for the unit coordinator and for Educators of the five Health Regions.</li> <li>• We also provided basic equipment to IEC Referring personnel, i.e., and didactic briefcases with assorted material.</li> <li>• We also supported the printing of a considerable amount of educational material, i.e., supporting the work on education for health and change of behavior of local IEC plans.</li> <li>• Hospitals with an IEC plan to be implemented internally, addressed mainly to secondary health care for training on Hospital Borne Infection Prevention and Control.</li> </ul>	<ul style="list-style-type: none"> <li>• Ensure that regional educators comply with their duty in technical advisory and in monitoring implementation of the national strategy.</li> <li>• Guarantee that each Region and health establishment may have an IEC operation plan founded on its epidemiological profile and monitoring and compliance.</li> <li>• Ensure the existence of a referring agent or someone responsible for coordinating, motivating, and monitoring compliance with IEC plan in each establishment.</li> <li>• Create a continuous training package on service, provided in the corresponding health establishment by referring personnel, in order to strengthen skills and abilities on educational technology and proper use of material.</li> </ul>

**SUB IR 3.3.1. Family Planning Services, information and education increased and expanded.**

	<b>INDICATOR</b>	<b>AT THE END OF THE PROJECT</b>	<b>OBSERVATIONS</b>	<b>PROJECT'S ACTIONS TO ATTAIN THIS OUTCOME</b>	<b>WHAT IS RECOMMENDED TO KEEP ON IMPROVING THE ACHIEVEMENTS REACHED</b>
3.3.1.1.	Physicians and nurses from Health Care Units and Health promoters from 72 USAID municipalities providing counseling and FP services according to MOH standards	<b>90%</b>	<ul style="list-style-type: none"> <li>We trained to within the Project physicians and nurses from 72 municipalities and maternity wards nationwide.</li> </ul>	<ul style="list-style-type: none"> <li>We created a counseling technical guide using ACCEDA and Balanced methodologies.</li> <li>We monitored health establishments on a random sample for a year within the specific project to verify compliance with a legal framework (Tiaht Law).</li> <li>We had a curriculum to replicate training and included one standard in Continuous Quality Improvement to verify that all sterilizations made in the group of 12 maternity wards were provided informed consents from patients receiving counseling.</li> <li>Some newly hired health promoters have not been trained.</li> </ul>	<ul style="list-style-type: none"> <li>Have health regions maintain capacities to manage FP Component and follow-up achievements, and ensure there is institutional budget to keep the same level of training and stationary available, especially at hospital level.</li> </ul>
3.3.1.2.	FP counseling in prenatal and post partum, provided as a standardized service in 28 maternity wards and Health Care Units in up to 72 municipalities supported by USAID	<ul style="list-style-type: none"> <li><b>42% of hospitals</b></li> <li><b>27.5% of municipalities</b></li> </ul>	<ul style="list-style-type: none"> <li>We monitored compliance through MCC 8 standard. Twelve maternity wards are working with an improvement Project on this issue. This corresponds to 42% of all maternity wards, according to the original indicator.</li> <li>Fully complied pursuant to MOH priority.</li> </ul>	<ul style="list-style-type: none"> <li>MOH defined applying prenatal counseling in a field test that included 19 establishments located in 17 of the 72 municipalities.</li> <li>We implemented measures to record evidence: stamping the clinical record. This is a standard procedure followed since the last PIS version 2009 and follow-up.</li> <li>Skill workshops trained in 2009 the first group of professionals of 28 maternity wards on FP counseling in prenatal.</li> <li>In the maternal technical guide and standard there is a mandatory activity FP counseling in prenatal from the twenty-eighth week.</li> </ul>	<ul style="list-style-type: none"> <li>Have health regions maintain capacities to manage FP Component and follow-up achievements, and ensure there is institutional budget to keep the same level of training and stationary available, especially at hospital level.</li> </ul>

	INDICATOR	AT THE END OF THE PROJECT	OBSERVATIONS	PROJECT'S ACTIONS TO ATTAIN THIS OUTCOME	WHAT IS RECOMMENDED TO KEEP ON IMPROVING THE ACHIEVEMENTS REACHED
3.3.1.3.	Physicians and nurses from Health Care Units in up to 72 municipalities supported by USAID, updated annually on contraceptive technology	98%	<ul style="list-style-type: none"> <li>We trained physicians and nurses from 72 municipalities and 28 maternity wards, including internists.</li> <li>FOSALUD and RHESSA personnel were not trained as programed for the last quarter 2009.</li> </ul>	<ul style="list-style-type: none"> <li>We designed a curriculum for this training. We prepared a CD with the contents to support replications.</li> </ul>	<ul style="list-style-type: none"> <li>Health Regions maintain trainings to manage FP Component and follow-up achievements and ensure there is institutional budget to maintain the level of training and stationary, especially at hospital level.</li> </ul>
3.3.1.4.	Community- based programs addressed to teenagers with messages developed and implemented according to MOH standards in up to 72 municipalities supported by USAID	86%	<ul style="list-style-type: none"> <li>Out of 245 Youth Promoters trained as facilitators, 210 are active in Health establishments of the municipalities benefited by the Project, performing training activities with other youth on topics related to sexual and reproductive health and ending a life plan</li> </ul>	<ul style="list-style-type: none"> <li>We created a guide to train teenagers to perform counseling activities</li> <li>We designed a training curriculum</li> <li>A facilitator was trained per SIBASI in charge of following-up these youths.</li> </ul>	<ul style="list-style-type: none"> <li>Strengthen counseling provided to pregnant teenagers with the use of educational material.</li> <li>Support the development of skills on counseling health promoters.</li> <li>Strengthen volunteer leader network to support the work performed by the health promoter.</li> </ul>

**3.3.2. Mother-Infant Health Care Services, and information and Education, increased and expanded.**

	INDICATOR	AT THE END OF THE PROJECT	OBSERVATIONS	PROJECT'S ACTIONS TO ATTAIN THIS OUTCOME	WHAT IS RECOMMENDED TO KEEP ON IMPROVING THE ACHIEVEMENTS REACHED
3.3.2.1.	Quality standards determined for prenatal, obstetrics, neonatal and postpartum attention, emphasizing friendly services especially for teenage users	<b>100%</b>	<ul style="list-style-type: none"> <li>Seventeen (17) quality standards in maternal perinatal attention</li> </ul>	<ul style="list-style-type: none"> <li>We supported the creation of 17 standards forming the actions of attention in prenatal (3), obstetrics (5), neonatal (2), post partum (2) and FP (5).</li> <li>We built a baseline and supported the drafting of the executive report of same. Sixty-two Quality Improvement projects have emerged from its analysis 12 of the 28 maternity wards of the country.</li> <li>We have supported monitoring Health Region and 12 maternity wards by the National Quality Committee.</li> </ul>	<ul style="list-style-type: none"> <li>Expand Improvement Projects to 17 quality standards as the basis for a future accreditation process.</li> <li>Ensure that the National Quality Committee is strengthened, and has the necessary resources to perform proper and timely monitoring.</li> </ul>
3.3.2.2.	Delivery of prenatal, obstetrics, neonatal and post partum attention, according to the quality standards in 28 maternity wards and in up to 72 municipalities supported by USAID.	<b>70-100%</b>	<ul style="list-style-type: none"> <li>Twelve (12) maternity wards delivered attention complying with 17 standards; each of them measured by a series of criteria assessed through audit to clinical records. Technical quality is determined. These standards are only applied in hospitals not in Health Care Units, according to MOH decision.</li> <li>Compliance with standards varies from 70-100% at the end of the first semester</li> </ul>	<ul style="list-style-type: none"> <li>We determined the gaps in compliance with standards.</li> <li>We prepared Improvement Projects to overcome the gaps.</li> <li>We prepared a procedure to measure compliance with self-evaluation.</li> <li>We prepared forms to collect data on criteria.</li> <li>We made monitoring visits to verify the proper use of instruments and the progress of improvement Projects.</li> </ul>	<ul style="list-style-type: none"> <li>Maintain the integration of services network (hospitals and Health Care Units).</li> <li>Create conditions to change planning of resources by consultation in the framework the new Integrating Prenatal Focus.</li> <li>Keep training of personnel at their workplaces, minimizing their rotation.</li> <li>Guarantee a budget line to institutionalize this experience, including supplies required.</li> <li>Integrate these activities within MOH operation plan as one the</li> </ul>

	INDICATOR	AT THE END OF THE PROJECT	OBSERVATIONS	PROJECT'S ACTIONS TO ATTAIN THIS OUTCOME	WHAT IS RECOMMENDED TO KEEP ON IMPROVING THE ACHIEVEMENTS REACHED
			2009 and according to complexity of the standard and rotation of new personal.		commitments of the administration.
3.3.2.3.	At least 70% of pregnant women in the rural area (including pregnant teenagers) completing 5 or more prenatal controls in up to 72 municipalities supported by USAID.	<b>78%</b>	<ul style="list-style-type: none"> <li>Indicator measured by FESAL, and nationwide according to USAID agreement.</li> </ul>	<ul style="list-style-type: none"> <li>The Project supported a field experience in 17 of the 72 municipalities on prenatal with a focus on the needs of each pregnant women.</li> <li>Skill workshops strengthen 9 skills related to prenatal assistance.</li> <li>For the first time, we designed the Technical Guide for pregnancy, delivery and puerperium attention.</li> <li>We monitored prenatal assistance using PIS.</li> <li>Health promoters at rural level encourage compliance with prenatal consultation.</li> </ul>	<ul style="list-style-type: none"> <li>Ensure the stock of necessary supplies to provide prenatal assistance.</li> <li>Extend the strategy of the new prenatal focus, since it has been successful, according to the evaluation made.</li> </ul>
3.3.2.4.	At least 60% of pregnant women in the rural area (including pregnant teenagers) in up to 72 USAID municipalities give birth with the aid of trained personnel.	<b>87%</b>	<ul style="list-style-type: none"> <li>Indicator measured by FESAL, and nationwide according to USAID agreement.</li> </ul>	<ul style="list-style-type: none"> <li>The Project has supported activities that encourage institutional attention, so they go directly to the hospitals where qualified personnel may be found. Among these actions we have the delivery plan, the apprenticeships of pregnant women to hospitals located in the SIBASI supported by the Project.</li> <li>Prenatal counseling and promoters work that encourage institutional delivery.</li> </ul>	<ul style="list-style-type: none"> <li>Keep personnel trained at their workplaces, minimizing their rotation.</li> <li>Guarantee a budget line to institutionalize this experience, including supplies required.</li> <li>Integrate these activities within MOH operation plan as one the commitments of the administration.</li> </ul>

	INDICATOR	At the end of the Project	OBSERVATIONS	PROJECT'S ACTIONS TO ATTAIN THIS OUTCOME	WHAT IS RECOMMENDED TO KEEP ON IMPROVING THE ACHIEVEMENTS REACHED
3.3.2.5.	At least 60% of pregnant women in the rural area (including pregnant teenagers) receive post partum attention within 6 weeks after delivery in up to 72 municipalities supported by USAID.	58.5%	<ul style="list-style-type: none"> <li>FESAL 08 is used as the source.</li> </ul>	<ul style="list-style-type: none"> <li>This is the indicator with lowest compliance. The Project focused its activities to prevent maternal death, which occurs at institutional level because of the low medical control in immediate postpartum. However, this activity is encouraged through promoters, prenatal counselors, and IEC materials addressed to change behaviors in favor of attending their puerperium control.</li> </ul>	<ul style="list-style-type: none"> <li>Promote attendance to postpartum control since the prenatal period.</li> <li>Take advantage of the newborn enrolling consultation at health establishments to provide postpartum control for the mother.</li> </ul>
<b>3.3.3. Best practices of food hygiene and nutrition.</b>					
3.3.3.1	AIEPI and AIN strategies and materials containing messages to promote proper hygiene at home and practices of proper use of water.	100%	<ul style="list-style-type: none"> <li>All AIEPI community and AIN materials contain messages to promote proper hygiene at home and practices of proper use of water.</li> </ul>	<ul style="list-style-type: none"> <li>We have supported the design of infant and nutrition components educational material.</li> <li>Among materials produced to promote infant health we included those promoting proper personal hygiene and at home.</li> </ul>	<ul style="list-style-type: none"> <li>Maintain a continuous education process and implementation of IEC/CCC.</li> <li>Monitoring should be performed to ensure proper use of educational materials at local level.</li> </ul>
3.3.3.2	At least 14 surveillance sites to monitor the nutritional status on all pregnant women and children under 5 within 72 municipalities supported by USAID.	N/A	<ul style="list-style-type: none"> <li>This indicator was rejected from the start because we will not work with Surveillance Sites. This method was substituted with the Nutritional Surveillance System (SISVIN).</li> <li>The SISVIN has been implemented in its first</li> </ul>	<ul style="list-style-type: none"> <li>The Project has supported the whole process of building the technical foundations of the system, validation and drafting the regulatory technical documents, and training all personnel involved (health promoters, nurses, medical, clinical laboratory and statistics personnel) in implementing the System. This included</li> </ul>	<ul style="list-style-type: none"> <li>Ensure systematic and periodical monitoring of the implementation of activities related to SISVIN.</li> <li>Assure financing from MOH budget is included to guarantee permanent training of personnel, stock of stationary, equipment, and perishable supplies to implement SISVIN.</li> <li>Ensure Internet service to the</li> </ul>

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			<p>phase, in La Libertad SIBASI, Central Health Region. It has involved 100% of Health promoters and physicians, nurses, and clinical laboratory personnel from Health Care Units.</p>	<ul style="list-style-type: none"> <li>• training on topics of standardization in anthropometric measurements (weight and size) and blood taking for hemoglobin in blood evaluation and filling out data collection instruments.</li> <li>• We supported monitoring process of data collection in the field and data entry at SIBASI level.</li> <li>• We have provided cardboard tallimeters, hanging scales and pathroom scales, and personal computers.</li> </ul>	<p>SIBASI's so they may effectively access virtual software where field data must be uploaded.</p> <ul style="list-style-type: none"> <li>• Guarantee that health personnel have the necessary equipment and that it is in good conditions to take anthropometric measurements.</li> <li>• Make sure personnel are aware of the importance of applying proper techniques in taking anthropometric measurements.</li> <li>• Monitor data collection process in surveillance sessions nationwide to ensure the quality of information collected in the surveillance sessions.</li> </ul>
3.3.3.3	All children under 2, breastfeeding women, especially teenagers from the 72 municipalities supported by USAID, are monitored on their nutrition and growth status once a month with the proper equipment and the AIEPI-AIN strategy.	83%	<ul style="list-style-type: none"> <li>• Only twelve municipalities do not have communities implementing the AIN-C strategy.</li> </ul>	<ul style="list-style-type: none"> <li>• We have supported the updating of Nutrition Volunteer Advisor Manual (CVN), counseling illustrations and AIN-C record keeping instruments.</li> <li>• We have supported the printing of the CVN Manual, counseling illustrations on danger signs of the Newborn and pregnant women, and stationary to keep record of information of AIN-C activities and we have provided hanging scales.</li> <li>• We have supported training of Facilitators of the strategy and new CVN and continuous CVN training for experienced personnel.</li> <li>• We have supported the extension of the strategy to new communities and we</li> </ul>	<ul style="list-style-type: none"> <li>• Permanent monitoring and follow-up of different attention levels.</li> <li>• Evaluation meetings to review strategy progress at various levels of assistance. Drafting the baseline annually, and evaluating its community level indicators, Health Care Unit, SIBASI, Region, and Central levels.</li> <li>• Updating monitoring instruments and following-up of the strategy.</li> <li>• Maintain motivational activities for volunteer advisors with the purpose of encouraging and strengthening volunteer work performed in the communities.</li> </ul>

	INDICATOR	At the end of the Project	OBSERVATIONS	PROJECT'S ACTIONS TO ATTAIN THIS OUTCOME	WHAT IS RECOMMENDED TO KEEP ON IMPROVING THE ACHIEVEMENTS REACHED
				<p>have strengthened the existing communities through the training of volunteer advisors and continuous education meetings in health establishments.</p> <ul style="list-style-type: none"> <li>• We have contributed to make regional evaluations of AIN achievements to follow-up a baseline that was built at the outset of the Project.</li> <li>• We have developed motivational CVN gatherings.</li> </ul>	
3.3.3.4	At least 50% of women gain proper weight during pregnancy, according to MOH standards, in up to 72 municipalities supported by USAID.	<b>73%</b>	<ul style="list-style-type: none"> <li>• Percentage is apparently higher than the one scheduled, however, because of the information used - which lacks quality in its records - (as well as breastfeeding data in the case of children under 6 months), it may not be sustained reliably that such outcome is correct.</li> </ul>	<ul style="list-style-type: none"> <li>• It did not affect Health Care Units.</li> <li>• See item 3.3.3.3.</li> </ul>	<ul style="list-style-type: none"> <li>• Technically determine the criteria for the proper classification of variable measure (Proper weight gain).</li> <li>• Monitor the procedure to classify proper maternal weight gain while assisting pregnant women.</li> <li>• Improve monitoring the quality of data recorded at local level.</li> </ul>
3.3.3.5	<b>30%</b> of children receive breastfeeding up to 6 months of age, in up to 72 municipalities supported by USAID.	<b>31.4%</b>	<ul style="list-style-type: none"> <li>• Global goal of this outcome was proposed in 30%. According to FESAL 2008 outcome, there was 31.4% of prevalence at the time of the survey nationwide. In</li> </ul>	<ul style="list-style-type: none"> <li>• We have contributed to form Breastfeeding Advisors for the different levels of attention (from hospitals to communities).</li> <li>• We have supported the formation of external evaluators to certify hospitals</li> </ul>	<ul style="list-style-type: none"> <li>• Keep training of personnel at their workplaces, minimizing their rotation.</li> <li>• Guarantee a budget line to institutionalize this experience, including supplies required and the personnel for permanent monitoring.</li> </ul>

	INDICATOR	At the end of the Project	OBSERVATIONS	PROJECT'S ACTIONS TO ATTAIN THIS OUTCOME	WHAT IS RECOMMENDED TO KEEP ON IMPROVING THE ACHIEVEMENTS REACHED
			<p>the rural area, the level attained was 38.5%, exceeding 8.5 percentage points of the goal set by MOH and the Project.</p> <ul style="list-style-type: none"> <li>• We had to use this national figure of this indicator because FESAL may not make a representative estimate for Health Regions nor for Departments, let alone for municipality level because the measuring of this indicators requires a very large subsample, impracticable to obtain under the conditions of this survey.</li> </ul>	<p>and Health Care Units as mother-infant friendly establishments, as well as self-evaluations required in the accreditation process.</p> <ul style="list-style-type: none"> <li>• We have supported celebration of the worldwide breastfeeding week for three consecutive years.</li> <li>• We supported MADLAC System updating, and training of hospital personnel in the use and management of such update.</li> <li>• We have also continued supporting quarterly evaluations at hospital level on progress in compliance with indicators of then ten steps toward a successful breastfeeding.</li> </ul>	<ul style="list-style-type: none"> <li>• Integrate these activities within MOH operation plan.</li> <li>• Turn this into a quality process.</li> </ul>

	INDICATOR	At the end of the Project	OBSERVATIONS	PROJECT'S ACTIONS TO ATTAIN THIS OUTCOME	WHAT IS RECOMMENDED TO KEEP ON IMPROVING THE ACHIEVEMENTS REACHED
3.3.3.6	Global malnutrition rate for children under 5 down to 9%, in up to 72 municipalities supported by USAID.	<b>15.5%</b>	<ul style="list-style-type: none"> <li>Data provided by the III National Census on School Children Size made in 2007, dropped 4 percentage points against the II census.</li> <li>This is a national data; no data may be provided for specific municipalities globally.</li> </ul>	<ul style="list-style-type: none"> <li>The Project has supported the implementation of the National Census on School Children Size in the First Grade nationwide, and printing the final document and disclosure of its results.</li> <li>We have supported updating and printing of new Growth Graphics for children under 5.</li> <li>We have supported training health personnel in the use and handling of the new Growth Graphics.</li> </ul>	<ul style="list-style-type: none"> <li>Attain development of management skills by the Nutrition Program, effectively linking it to Food Safety; also creating mechanisms for higher level management (National Inter-institutional Commission).</li> <li>Incorporate a clear policy to effectively integrating this component in each health care program.</li> </ul>

	<b>IR 3.4 Infectious illnesses controlled and impact mitigated.</b>		
3.4.1	<b>Increased use of services and practices of prevention to fight HIV/AIDS and other infections.</b>		
3.4.1.1	<p>Protocols and standards for Infection prevention among mothers and newborns have been established in the 28 maternity wards and up to 35 Health Care Units attending deliveries.</p>	<p><b>100%</b></p>	<ul style="list-style-type: none"> <li>• Protocols were integrated in a document issued to train personnel at Obstetrics and Neonate Skills Centers, this material was used to train personnel attending deliveries in maternity services (Specialists, Gynecology Residents, Obstetrics and Pediatrics) and nurses from 28 hospitals and personnel at Regional level.</li> <li>• SHP Project has supported MOH by training 100% of operation personnel at the local Hospital Borne Infection Prevention and Control Committee (CPCIN), from 28 maternity wards, and regional personnel in two theoretical-practical workshops: “Levels of efficiency in Hospital Borne Infection Prevention” and “Standardization in Addressing Hospital Borne Infections”, this knowledge has been used as input for CPCIN activities; it was included in the “Technical Procedures Manual for Surveillance System of Hospital Borne Infection Prevention and Control”.</li> <li>• They were also provided with supporting bibliographic material.</li> <li>• We also trained 2800 operation officials from 28 maternity wards in local sessions on compliance of “Levels of Efficiency in Hospital Borne Infection Prevention”, which included physicians, nurses, technicians, cleaning personnel, dentists, HIV/AIDS referring personnel, administration personnel and others of direct attention.</li> <li>• Hospital borne infection rate associated with cesarean dropped from 46.76% to 43.2% in the second quarter; post vaginal partum endometritis dropped from 5.02% to 4.0%.</li> </ul>
			<ul style="list-style-type: none"> <li>• Update, edit, print and disseminate “Technical Procedures Manual for Surveillance System, Hospital Borne Infection Prevention and Control”</li> <li>• Implement the Surveillance System in Hospital Borne Infections.</li> <li>• Create a position for IN coordinating nurse according to international standards (one eight-hour nurse for every 250 beds) and create the position of Coordinating Physician and accredit them in order to prevent frequent dismissals of trained personnel to ensure continuity of their performance.</li> </ul>

3.4.1.2	Infection Committees working actively on prevention and reduction of hospital borne infections, along with perinatal Committees, in 28 maternity wards.	<b>85.7%</b>	<ul style="list-style-type: none"> <li>• Committees have at least knowledge on epidemiological and monitoring instruments used to prevent and identify early Hospital Borne Infections; these were transferred by the training team formed by URC Advisors, Personnel from the Health Surveillance Directorate, and the nursing unit of MOH higher level.</li> </ul>	<ul style="list-style-type: none"> <li>• Besides training provided to CPCIN, and having provided the necessary supplies and tools for their performance, it was necessary to negotiate their forming and reactivation of some, and also to get officialization of 28 Committees, and form 4 Regional Commissions. However, 14.3% of the Committees nationwide, only the nurse assumed full responsibility and in most of the hospitals, she has multiple duties. Also, there is little supervision in the higher and regional levels.</li> <li>• There was a drop of the global rate of hospital borne infections per 1000 patients supervised for 27.65 x 1000 to 13.7 by 1000.</li> </ul>	<ul style="list-style-type: none"> <li>• Maintain continuous education providing tools and necessary input to strengthen the activities of the Committees and Commissions.</li> <li>• Monitor compliance with prevention measures IN control.</li> <li>• Provide the necessary supplies to comply with prevention and control measures.</li> <li>• Obtain effective support from authorities to CPCIN and include CPCIN technical assistance in decision-making concerning IN.</li> <li>• Regulate PCIN measures.</li> </ul>
3.4.1.3	Standards to prevent and treat urinary tract infections in up to 72 municipalities supported by USAID.	<b>75%</b>	<ul style="list-style-type: none"> <li>• Protocols and guides have not been edited. They are pending to be reviewed by the Regulatory Unit.</li> </ul>	<ul style="list-style-type: none"> <li>• Along with MOH Women Management, we prepared and validated prevention guides, monitoring sheets, case study sheets, building of indicators and case definitions for maternal hospital borne infection prevention, surgical infection prevention in cesareans, prevention of urinary infections associated with a urinary catheter during cesarean. These were validated at hospitals by CPCIN members.</li> <li>• We trained CPCIN coordinators on maternal and</li> </ul>	<ul style="list-style-type: none"> <li>• Review and update documentation for printing and dissemination process.</li> <li>• Monitor compliance with procedures.</li> </ul>

				<p>neonate infection prevention measures, detection procedures and report and specific intervention measures.</p> <ul style="list-style-type: none"><li>• The asepsis and antisepsis chapter of the Training Manual for Obstetric Skill Centers was drafted, it is used for theoretical and hands-on training of operation personnel from neonatal and maternal care .</li></ul>	
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	INDICATOR	At the end of the Project	OBSERVATIONS	PROJECT'S ACTIONS TO ATTAIN THIS OUTCOME	WHAT IS RECOMMENDED TO KEEP ON IMPROVING THE ACHIEVEMENTS REACHED
3.4.1.4	Neonatal deaths caused by sepsis reduced in 28 maternity wards and up to the 35 Health Care Units attending deliveries.	<b>40.2%</b>	<ul style="list-style-type: none"> <li>Number of deaths (107 of 252) associated with Hospital Borne Infections, taking as platform the 2006 baseline, shows that 40.2% of deaths had as a basic or contributing cause a hospital borne infection.</li> </ul>	<ul style="list-style-type: none"> <li>The Project has supported the health surveillance director in the development of a series of actions aimed at preventing and controlling Hospital Borne Infections, which have been systematized in different regulation documents.</li> <li>We have trained personnel on basic aspects to develop skills to monitor behavior of Hospital Borne Infections through the surveillance of processes and procedures, mainly surgical ones, related to the parturient and newborns. For this purpose they were provide with updated computer equipment to systematize such process efficiently.</li> <li>We provided supplies to 28 hospitals with maternity wards.</li> </ul>	<ul style="list-style-type: none"> <li>Train personnel on the definition of the standard case, and preventive and control measures of infections as a way to report them.</li> <li>Protocols for IN prevention should be approved by MOH Regulation Directorate.</li> <li>Encourage monitoring and evaluation compliance with standards, guides, and protocols.</li> </ul>

**OTHER INDICATORS (PMP)**

	<b>INDICATOR</b>	<b>AT THE END OF THE PROJECT</b>	<b>OBSERVATIONS</b>	<b>PROJECT'S ACTIONS TO ATTAIN THIS OUTCOME</b>	<b>WHAT IS RECOMMENDED TO KEEP ON IMPROVING THE ACHIEVEMENTS REACHED</b>
1	Infant mortality rate (nationwide)	<b>16 per thousand born alive</b>	<ul style="list-style-type: none"> <li>• There is an evident drop of infant mortality rate as compared to FESAL 2002/2003 outcome, even way below the goal the country has set. Among the relevant questions to make is if it was at the expense of the results in the urban and rural areas, what were the most frequent causes of death, what interventions affected most to attain these good results (and that is necessary and relevant to maintain in time), what percentage of it represents neonate mortality rate, among others.</li> </ul>	<ul style="list-style-type: none"> <li>• We have supported the Infant Strengthening Health through: 1) providing equipment to hospitals and Health Care Units, 2) review, update and print regulation documents related to Infant Health, 3) training of human resources at hospital and local level, 4) monitoring efficiency conditions to provide health services, 5) Printing and supply of instruments to provide infant health care.</li> </ul>	<ul style="list-style-type: none"> <li>• Continue prioritizing actions addressed to children in neonatal period.</li> <li>• Maintain a training program for newly hired personnel and recertification of permanent personnel.</li> <li>• Promote a review and periodical updating of regulation documents related to infant Health.</li> <li>• Ensure that GOES budget for MOH provides the necessary funds to guarantee the required supplies to provide services.</li> <li>• Guarantee permanent monitoring of efficiency conditions for infant health care in the different levels of health services.</li> </ul>

	INDICATOR	AT THE END OF THE PROJECT	OBSERVATIONS	PROJECT'S ACTIONS TO ATTAIN THIS OUTCOME	WHAT IS RECOMMENDED TO KEEP ON IMPROVING THE ACHIEVEMENTS REACHED
	Global fertility rate (nationwide)	2.5	<ul style="list-style-type: none"> <li>We trained physicians and nurses in the Project, these were from 72 municipalities and maternity wards nationwide.</li> </ul>	<ul style="list-style-type: none"> <li>We created the technical guide for counseling using the ACCEDA and Balanced methodologies.</li> <li>We monitored a random sample of health establishments within the specific project for one year to verify compliance with a legal framework (Tiaht Law).</li> <li>We had a curriculum to replicate training and included a Continuous Quality Improvement standard to verify that all sterilizations made in the group of 12 maternity wards had informed consent resulting from counseling.</li> <li>We have added some new promoters among the newly hired personnel in the second quarter of the year, these have not been trained.</li> </ul>	<ul style="list-style-type: none"> <li>Ensure that Health Regions maintain capabilities to negotiate the FP Component and follow-up the achievements and that there is institutional budget to maintain the level of trainings and stationary, especially at hospital level.</li> </ul>

	INDICATOR	At the end of the Project	OBSERVATIONS	PROJECT'S ACTIONS TO ATTAIN THIS OUTCOME	WHAT IS RECOMMENDED TO KEEP ON IMPROVING THE ACHIEVEMENTS REACHED
	Prevalence of use of contraceptives methods (nationwide)	<b>72.5%</b>	<ul style="list-style-type: none"> <li>We provided training within the Project to physicians and nurses from 72 municipalities and maternity wards nationwide.</li> </ul>	<ul style="list-style-type: none"> <li>We created the technical guide for counseling using the ACCEDA and Balanced methodologies.</li> <li>We monitored health establishments on a random sample within the specific project for a year to verify compliance with a legal framework (Tiaht Law).</li> <li>There was a curriculum to replicate training and included one standard in Continuous Quality Improvement.</li> <li>New health care personnel with no training.</li> </ul>	<ul style="list-style-type: none"> <li>Ensure that Health Regions maintain capabilities to negotiate the FP Component and follow-up the achievements and that there is institutional budget to maintain the level of trainings and stationary, especially at hospital level.</li> </ul>
	Years Protection of the Couple (nationwide)	<b>349,528</b>	<ul style="list-style-type: none"> <li>We provided training within the Project to physicians and nurses from 72 municipalities and maternity wards nationwide.</li> </ul>	<ul style="list-style-type: none"> <li>We created the technical guide for counseling using the ACCEDA and Balanced methodologies.</li> <li>We monitored health establishments on a random sample for a year within the specific project to verify compliance with a legal framework (Tiaht Law).</li> <li>There was a curriculum to replicate training and included one standard in Continuous Quality Improvement to verify that all sterilizations made in the group of 12 maternity wards had an informed consent as a result of counseling.</li> <li>We have added some new promoters in the newly hired personnel in the second quarter of the year, these have not been trained.</li> </ul>	<ul style="list-style-type: none"> <li>Ensure that Health Regions maintain capabilities to negotiate the FP Component and follow-up the achievements and that there is institutional budget to maintain the level of trainings and stationary, especially at hospital level.</li> </ul>

	INDICATOR	At the end of the Project	OBSERVATIONS	PROJECT'S ACTIONS TO ATTAIN THIS OUTCOME	WHAT IS RECOMMENDED TO KEEP ON IMPROVING THE ACHIEVEMENTS REACHED
	Percentage of deliveries attended by qualified personnel (nationwide)	83.7%	<ul style="list-style-type: none"> <li>Indicator measured by FESAL, and nationwide according to USAID agreement.</li> </ul>	<ul style="list-style-type: none"> <li>The Project has supported activities that encourage institutional health care, so they go directly to the hospitals where qualified personnel may be found. These actions include delivery plan, the apprenticeships of pregnant women at hospitals located in the SIBASI supported by the Project.</li> <li>Prenatal counseling and the work of promoters that encourage institutional delivery.</li> </ul>	<ul style="list-style-type: none"> <li>Maintain personnel trained at their workplaces, minimizing their rotation.</li> <li>Guarantee a budget line to institutionalize this experience, including the supplies required.</li> <li>Integrate these activities to MOH operation plan as one the commitments of the administration.</li> </ul>

	INDICATOR	At the end of the Project	OBSERVATIONS	PROJECT'S ACTIONS TO ATTAIN THIS OUTCOME	WHAT IS RECOMMENDED TO KEEP ON IMPROVING THE ACHIEVEMENTS REACHED
	Health care attention provided in the first 3 days after delivery, puerperium and newborn health care (in 72 municipalities supported by USAID)	<b>8,207</b>	<ul style="list-style-type: none"> <li>The goal was 7,430 attentions. We have exceeded 9.5 percentage points the proposed goal. One of the elements that may have contributed to this is that Specific Supervisors have more time to oversee health promoters as well as the emphasis the Program (Community Health) has given during puerperium and for the newborn.</li> </ul>	<ul style="list-style-type: none"> <li>The Project has supported training of Health Promoters and Specific Health Community Supervisors on danger signs and basic care of the newborn.</li> <li>Also, we updated the Technical Duties Manual for Health Promoters, MOH regulatory document, emphasizing the priority of puerperium and the newborn that must be visited within 24 hours after delivery, before 72 hours, after one week, after fifteen days and before the newborn is 28 days.</li> <li>We have supported MOH to develop a monitoring guide to verify actions performed by the health care promoter, in which we prioritized early detection and timely attention during puerperium and to the newborn.</li> <li>We also supported development of analytic skills and decision-making by Community Health Supervisors, through participating evaluation sessions.</li> </ul>	<ul style="list-style-type: none"> <li>Health Care Unit Directors should understand that a health care promoter work in rural areas is part of the global work they perform in the geographic area of the program; and if they fail to work with the Community Health Promoter – providing support to urban areas –the micro-system between them and the Health Care Unit will be weakened.</li> </ul>
	Number of prenatal controls given by qualified personnel (in 72 municipalities supported by USAID)	<b>92,520</b>	<ul style="list-style-type: none"> <li>The gap between the scheduled goal for 2008 is 28,635 attentions, in the area of the 72 municipalities supported by USAID. The department with more beneficiary population is Usulután, and it reported one case of death due to human rabies in the second quarter of the fiscal year 2008;</li> </ul>	<ul style="list-style-type: none"> <li>The Project supported a field experience in 17 of the 72 municipalities on prenatal with a focus on the needs of each pregnant woman.</li> <li>Skill workshops strengthen 9 skills related to prenatal care.</li> <li>A Technical Guide for pregnancy, delivery and puerperium attention was designed for the first time.</li> <li>We monitored prenatal assistance using PIS.</li> </ul>	<ul style="list-style-type: none"> <li>Ensure the stock of necessary supplies to provide prenatal assistance .</li> <li>Extend the strategy of the new prenatal focus, because according to the evaluation it has been successful.</li> </ul>

	INDICATOR	At the end of the Project	OBSERVATIONS	PROJECT'S ACTIONS TO ATTAIN THIS OUTCOME	WHAT IS RECOMMENDED TO KEEP ON IMPROVING THE ACHIEVEMENTS REACHED
			therefore, all personnel participated in a canine and cat vaccination campaign for prevention.	<ul style="list-style-type: none"> <li>• Health promoters at rural level encourage compliance of prenatal consultations.</li> </ul>	
	Number of women that received active assistance during the third period of their delivery (in 72 municipalities supported by USAID)	<b>59,377</b>	<ul style="list-style-type: none"> <li>• Increases in the use of oxytocin have been gradual but significant after we provided a general guideline for its application in the third period of delivery, a dose of such drug may be applied to any puerperium attended in the hospital. For 2009, the goal will be modified as it will only include 2 quarters in 2009. This estimate is made based on the achievement for 2008 plus 2%. The new goal for 2009 will include 30,200 women that will be injected with Oxytocin as part of the active management during the third period of delivery.</li> </ul>	<ul style="list-style-type: none"> <li>• Already discussed in PIS outcome</li> </ul>	<ul style="list-style-type: none"> <li>• Considered in the PIS outcome.</li> </ul>

	INDICATOR	At the end of the Project	OBSERVATIONS	PROJECT'S ACTIONS TO ATTAIN THIS OUTCOME	WHAT IS RECOMMENDED TO KEEP ON IMPROVING THE ACHIEVEMENTS REACHED
	Number of deliveries attended by qualified personnel (in 72 municipalities supported by USAID)	<b>75,910</b>	<ul style="list-style-type: none"> <li>After comparing achievements with the proposed goal, we identified a small gap of 240 deliveries for 2008, according to the observations in FESAL 2008 and in the field: more women are going to hospitals for deliveries.</li> </ul>	<ul style="list-style-type: none"> <li>The Project has supported activities that encourage institutional attention, so they go directly to the hospitals where qualified personnel may be found. Among these actions we have the delivery plan, the apprenticeships of pregnant women at hospitals located in the SIBASI supported by the Project.</li> <li>Prenatal counseling and promoters work that encourage institutional delivery.</li> </ul>	<ul style="list-style-type: none"> <li>Keep training of personnel at their workplaces, minimizing their rotation.</li> <li>Guarantee a budget line to institutionalize this experience, including supplies required.</li> <li>Integrate these activities within MOH operation plan as one the commitments of the administration.</li> </ul>

**ANNEX 3: SUMMARY OF PERSONNEL FROM PRIORITY ESTABLISHMENTS OF THE THREE HEALTH REGIONS TRAINED ON SHP COMPONENTS**

**Family Planning and Maternal Health Component**

	Physicians	Nurses	Auxiliary nurses	Community Health Supervisors	Health promoters	Odontologists	Sanitation Inspectors	Other personnel	Volunteers (Youth Promoters)
Trained on handling the FP Program	123	56	9	1	25	N/A	N/A	N/A	N/A
Trained on balanced counseling on FP methods according to the new Family Planning Consultancy Guide	61	70	28	N/A	10	N/A	N/A	N/A	N/A
Trained in fundamental aspects of the Tiaht Law related to FP	153	147	108	2	450	N/A	N/A	N/A	N/A
Trained on the most up-to-date of Contraceptive technology	110	104	4	1	33	N/A	N/A	N/A	N/A
Trained on topics of sexual and reproductive health for teenagers	113	136	86	20	156	8	11	12	1
Trained on the health care promoter's Guide to provide Family Planning Services	30	23	1	N/A	126	N/A	N/A	N/A	N/A
Trained on the Guide to provide Family Planning Services for personnel working with midwives	N/A	2	1	N/A	N/A	N/A	N/A	N/A	20
Trained on the Guide of consultancy in Family Planning for youth promoters	2	2	4	N/A	N/A	N/A	N/A	N/A	20

	Physicians	Nurses	Auxiliary nurses	Community Health Supervisors	Health promoters	Odontologists	Sanitation Inspectors	Other personnel	Volunteers (Youth Promoters)
Trained on the Guide of Education for Life	16	41	8	N/A	1	N/A	N/A	N/A	286
Trained on Intrauterine Device Insertion Technique (Removal using no-touch technique)	74	45	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Trained on use and management of checklists of medical eligibility criteria for the use of Oral Contraceptives	49	46	16	1	54	N/A	N/A	N/A	N/A
Trained on use and management of forms for the registry of enrollment and subsequent Family Planning control.	49	49	13	1	2	N/A	N/A	N/A	N/A
Trained on use and management of men and women teen-agers card, CLAP development Sheet of and complementary of SSR	37	33	10	N/A	N/A	N/A	N/A	N/A	N/A
Trained on Technical Guide for the use of PIS for the first level of assistance	32	27	2	N/A	N/A	N/A	N/A	N/A	N/A
Trained on Technical Guide for the use of Perinatal Information System for the second level of assistance	23	22	N/A	N/A	N/A	N/A	N/A	4	N/A
Trained on Obstetric, Neonate, Family Planning and Hospital Infections skills	111	52	38	N/A	N/A	N/A	N/A	N/A	N/A
Trained on the use and management of CLAP/PAHO/WHO Perinatal form of Clinical History	118	84	39	N/A	N/A	N/A	N/A	N/A	N/A

	Physicians	Nurses	Auxiliary nurses	Community Health Supervisors	Health promoters	Odontologists	Sanitation Inspectors	Other personnel	Volunteers (Youth Promoters)
Trained on use and management of updated CLAP/PAHO/WHO deliverygram Sheet	54	36	1	N/A	N/A	N/A	N/A	N/A	N/A
Trained on the use and management of obstetric tapes, Gestogram and maternal weight gain monitoring Graphics.	193	176	49	2	83	4	N/A	N/A	N/A
Trained on Active Management of the third delivery period (MATEP)	63	70	11	N/A	N/A	N/A	N/A	N/A	N/A
Trained on cervical -vaginal cytology Card and form	96	93	27	1	N/A	N/A	N/A	N/A	N/A
Trained on new prenatal Approach and its main instruments: screening Sheet and the referral and return form	80	49	12	1	83	3	2	N/A	N/A
Trained on the use and management of seven forms to define case, audit, institutional survey, and maternal death report	28	25	2	N/A	N/A	N/A	N/A	N/A	N/A
Trained on maternal mortality surveillance	153	100	6	N/A	N/A	N/A	N/A	N/A	200
Trained on application of the key Link model	37	17	N/A	N/A	N/A	N/A	N/A	4	N/A
Trained on proper record of the basic cause of death	85	50	1	N/A	N/A	N/A	N/A	4	N/A
<b>TOTAL (5553)</b>	<b>1890</b>	<b>1555</b>	<b>476</b>	<b>30</b>	<b>1023</b>	<b>15</b>	<b>13</b>	<b>24</b>	<b>527</b>

**CONTINUOUS QUALITY IMPROVEMENT MCC COMPONENT**

	Physicians	Nurses	Auxiliary nurses	Community Health Supervisors	Health promoters	Odontologists	Sanitation Inspectors	Other personnel	Volunteers (Youth Promoters)
Trained on MCC (100)	52	29	3	3	1	N/A	N/A	12	N/A

**INFANT HEALTH CARE COMPONENT**

	Physicians	Nurses	Auxiliary nurses	Community Health Supervisors	Health promoters	Odontologists	Sanitation Inspectors	Other personnel	Volunteers (Youth Promoters)
Trained on Integral Care Guide for children under 5 and main instruments	265	192	65	20	6	N/A	N/A	N/A	N/A
Trained on Guide to follow-up prematures with weight under 2,000 grams at birth and main instruments	87	52	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Trained STABLE	173	211	71	N/A	N/A	N/A	N/A	13	N/A

	Physicians	Nurses	Auxiliary nurses	Community Health Supervisors	Health promoters	Odontologists	Sanitation Inspectors	Other personnel	Volunteers (Youth Promoters)
Trained on use and management of the perinatal, neonatal, Infant and children death notification sheet	58	26	1	N/A	N/A	N/A	N/A	N/A	N/A
Trained on use and application of monitoring Instrument on efficiency conditions for quality in assistance provided to children 0 to 5 (by groups of age and by level of assistance )	125	57	25	N/A	N/A	N/A	N/A	N/A	N/A
Trained on neonatal Resuscitation (NRP)	510	556	65	N/A	N/A	N/A	N/A	15	N/A
Trained on blood taking from the ankle of neonates within the neonatal screening program	115	123	24	N/A	N/A	N/A	N/A	N/A	N/A
Trained on handling safe water and other environmental sanitation topics	N/A	N/A	N/A	N/A	N/A	N/A	20	N/A	667
<b>TOTAL</b>	<b>1333</b>	<b>1217</b>	<b>251</b>	<b>20</b>	<b>6</b>	<b>N/A</b>	<b>20</b>	<b>28</b>	<b>667</b>

Nutrition Component

	Physicians	Nurses	Auxiliary nurses	Community Health Supervisors	Health promoters	Odontologists	Sanitation Inspectors	Other personnel	Volunteers
Trained on topics of breastfeeding	65	161	18	7	20	N/A	N/A	5	5
Trained on use and management of new Growth Graphics of children of 0 a 24 months and Growth Graphics of children 2 to 5	86	78	19	10	18	1	N/A	N/A	N/A
Trained on use and management of the Counseling charts on health care of pregnant women and of children under 2 years,	37	74	9	N/A	134	4	N/A	N/A	206
Trained on AIN -C	6	54	6	N/A	95	4	N/A	N/A	207
Trained on standardization of taking anthropometric measurements (weight and size) as part of the SISVIN	10	88	N/A	N/A	628	N/A	N/A	N/A	N/A
Trained on handling malnourished children in hospitals	30	22	N/A	N/A	N/A	N/A	N/A	5	N/A
<b>TOTAL (2112)</b>	<b>234</b>	<b>477</b>	<b>52</b>	<b>17</b>	<b>895</b>	<b>9</b>	<b>N/A</b>	<b>10</b>	<b>418</b>

## HOSPITAL INFECTIONS COMPONENT

	Physicians	Nurses	Auxiliary nurses	Community Health Supervisors	Health promoters	Odontologists	Sanitation Inspectors	Other personnel	Volunteers (Youth Promoters)
Trained on standards and guides of Hospital Borne Infection Prevention and Control	57	58	27	NA	NA	NA	NA	NA	NA
Trained on techniques and actions of Hospital Borne Infection Prevention and Control	67	187	177	NA	NA	NA	NA	NA	NA
Trained on surveillance of Hospital Infections (including survey on outbreak, surveys of punctual prevalence, etc.)	59	102	100	NA	NA	NA	NA	25	NA
Trained on use and management of tubes and catheters	72	118	NA	NA	NA	NA	NA	35	NA
Trained on hand-washing, waste disposal and Biosafety	161	207	NA	NA	NA	NA	NA	67	NA
Trained on production of alcohol gel	25	4	NA	NA	NA	NA	NA	3	NA
<b>TOTAL (1551)</b>	<b>441</b>	<b>676</b>	<b>304</b>	<b>NA</b>	<b>NA</b>	<b>NA</b>	<b>NA</b>	<b>130</b>	<b>NA</b>

**IEC/CCC COMPONENT**

	Physicians	Nurses	Auxiliary nurses	Community Health Supervisors	Health promoters	Odontologists	Sanitation Inspectors	Other personnel	Volunteers (Youth Promoters)
Trained to prepare IEC/CCC strategic plans	33	27	7	2	74	5	2	2	NA
Trained on Technical education and use of educational material at IEC/CCC activities	52	44	47	1	NA	1	2	47	NA
Trained on the storage and proper use of IEC Materials	36	24	18	7	9	1	2	23	NA
<b>TOTAL (466)</b>	<b>121</b>	<b>95</b>	<b>72</b>	<b>10</b>	<b>83</b>	<b>7</b>	<b>6</b>	<b>72</b>	<b>NA</b>

**COMMUNITY HEALTH COMPONENT**

	Physicians	Nurses	Auxiliary nurses	Community Health Supervisors	Health promoters	Odontologists	Sanitation Inspectors	Other personnel	Volunteers (Youth Promoters)
Trained on Manual of technical duties of the health promoter	45	15	7	15	288	13	N/A	N/A	N/A
Trained health care promoters on how to facilitate supervision	1	N/A	N/A	38	1	N/A	N/A	N/A	N/A
Trained on Community AIEPI know-how and skills	N/A	N/A	N/A	1	187	13	N/A	N/A	N/A
Trained on danger signs and basic care of the newborn	N/A	N/A	N/A	N/A	529	N/A	N/A	N/A	N/A
<b>TOTAL (1153)</b>	<b>46</b>	<b>15</b>	<b>7</b>	<b>54</b>	<b>1005</b>	<b>26</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>

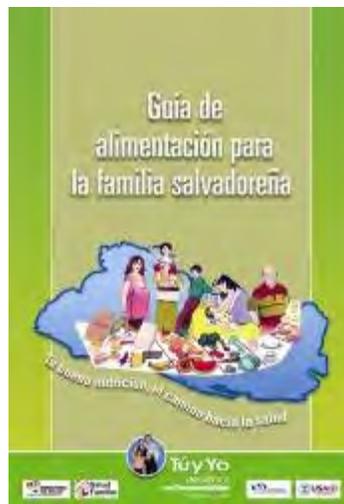
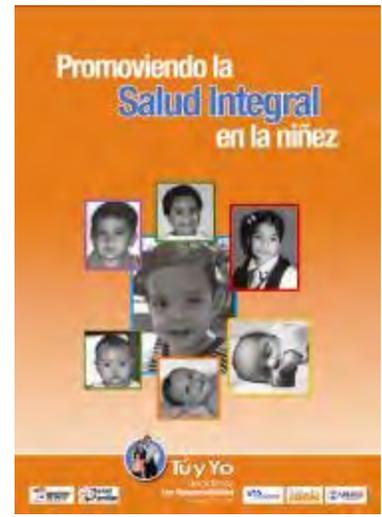
**FAMILY HEALTH CARE COMPONENT**

	Physicians	Nurses	Auxiliary nurses	Community Health Supervisors	Health promoters	Odontologists	Sanitation Inspectors	Other personnel	Volunteers (Youth Promoters)
Trained on the new model of Integral Care with Family Health Care Approach (365)	68	83	21	18	112	35	28	N/A	N/A

**MONITORING AND EVALUATION COMPONENT**

	Physicians	Nurses	Auxiliary nurses	Community Health Supervisors	Health promoters	Odontologists	Sanitation Inspectors	Other personnel	Volunteers (Youth Promoters)
Trained on use and management of data on the webpage	24	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

**ANNEX 4: MATERIAL FROM IEC/CCC PRINTED BY TYPE OF MATERIAL  
FLIPCHART:**





### RECUERDEN

Para que su niño o niña crezca y se desarrolle saludable



Llévelo en los primeros 7 días de nacido a la Unidad de Salud para inscribirlo en el Programa de Atención Infantil. No olvide que debe asistir a todos los controles hasta los 5 años

**FAMILIAS RESPONSABLES. NIÑOS Y NIÑAS SALUDABLES**

**Túy Yo**  
 con Responsabilidad  
 (Promoviendo la vida)



### RECUERDEN

Si su niño o niña tiene diarrea

Puede perder muchos líquidos y deshidratarse

**¿Qué hacer?**

- Comience a darle su leche o leche materna
- Déle al menos 2 litros de agua por día
- Alimentarlo como de costumbre

Vigile si aparecen estos signos de deshidratación:



• Ojos hundidos y mates  
 • Labios e interior de la boca secos  
 • Bata con mucha sed  
 • Hiel arrugada y seca

Si tiene 2 ó más de estos signos, busque ayuda de inmediato en la Unidad de Salud más cercana

**Túy Yo**  
 con Responsabilidad  
 (Promoviendo la vida)



### RECUERDEN

¿Qué hacer si su niño o niña tiene tos o dificultad para respirar?



• Controle el estado de su niño o niña  
 • Déle abundantes líquidos  
 • Alimentarlo como de costumbre

• Si respira con dificultad...  
 • Después de cada día lleve a su niño o niña a la Unidad de Salud

**Túy Yo**  
 con Responsabilidad  
 (Promoviendo la vida)



### RECUERDEN

Lavarse las manos evita enfermedades



Hay que lavarse y frotárselas bien las manos con agua y jabón

**¿Cuándo debe hacerlo?**

- Antes y después de lavar y cocinar los alimentos
- Antes y después de alimentar al niño o niña
- Antes y después de usar la cocina

**Túy Yo**  
 con Responsabilidad  
 (Promoviendo la vida)



### RECUERDEN

Mantener la higiene en el hogar es responsabilidad de la familia por eso debemos:



• Limpiar los muros  
 • Limpiar con alcohol



• Lavar las verduras y frutas con agua hervida y purificada  
 • Hervir el agua o ponerla en un galón de Purigagua

**Túy Yo**  
 con Responsabilidad  
 (Promoviendo la vida)



### El uso de PURIGAGUA, protege la salud de tu familia



**¿Cómo utilizar el PURIGAGUA?**

- Agregar 1 litro de Purigagua a 10 litros de agua para lavar y cocinar los alimentos
- Agregar 1 litro de Purigagua a 10 litros de agua para lavar y cocinar los alimentos

• Después de preparar, desinfectar el agua por 30 minutos antes de utilizarla

**Desinfección de frutas y verduras:**

- Lavarlas con agua hervida y purificada
- Hervirlas por 10 minutos en agua hervida y purificada
- Colar las verduras y frutas en un colador por 10 minutos en el agua hervida y purificada
- Usar el agua de este proceso para hacer los jugos de frutas de PULGAS

El PURIGAGUA: No es químico puro. No se debe almacenar de los niños

**SOLICITA PURIGAGUA AL PROMOTOR DE SALUD O EN CUALQUIER UNIDAD DE SALUD, ES GRATIS**

**Túy Yo**  
 con Responsabilidad  
 (Promoviendo la vida)



### HOJA RECORDATORIA

Reconozca signos y síntomas de peligro de su herida



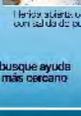
• Dolor o aumento de la herida



• Fiebre o cansancio



• Hay una olor en la herida



• El herido siente un cambio de su estado de salud

Si presenta uno o más señales, busque ayuda en el establecimiento de salud más cercano

**Túy Yo**  
 con Responsabilidad  
 (Promoviendo la vida)



### RECUERDE

Para cuidar su herida operatoria necesita:

**HIGIENE**



• Lávese las manos antes de tocar la herida



• Póngale todos los días

**TRATAMIENTO**

- Tome el antibiótico si lo recibió
- No espere o corra a ningún otro establecimiento de salud por el médico

**ALIMENTACIÓN**

- Tome el desayuno
- Come frutas, verduras, panes, cereales, queso, leche y huevos

**Túy Yo**  
 con Responsabilidad  
 (Promoviendo la vida)



**POSTERS:**

## Calendario de controles durante el embarazo

**1** control Antes de los 3 meses de embarazo

**2** control A los 4 meses de embarazo

**3** control A los 7 meses de embarazo

**4** control A los 8 meses de embarazo

**5** control A las 30 semanas de embarazo

Toda mujer embarazada debe ir a sus controles prenatales a la Unidad de Salud, acompañada de su pareja o un familiar.

Unidad de Salud

**Tú y Yo** decidimos con Responsabilidad

UNEP, Salud y Familia, MEX, USAID

## ES IMPORTANTE QUE TÚ Y TU FAMILIA RECONOZCAN LAS COMPLICACIONES DEL EMBARAZO

Anemia (debilidad)

Hipertensión (presión alta)

Fiebre (infección)

Uterino y dolor (parto prematuro)

Edema (hinchazón)

Convulsiones (epilepsia)

Faltas de memoria (déficit de hierro)

Anemia del recién nacido

La salud de la mujer durante el embarazo, contribuye al bienestar de la familia.

**Tú y Yo** decidimos con Responsabilidad

UNEP, Salud y Familia, MEX, USAID

## ASISTE AL CONTROL DE EMBARAZO CON TU PAREJA O UN FAMILIAR Y RECIBIRÁS LOS SIGUIENTES BENEFICIOS...

Atención médica

Atención del parto

Exámenes de laboratorio

Información sobre el embarazo

Educación sobre higiene y alimentación

Atención del recién nacido

La salud de la mujer durante el embarazo, contribuye al bienestar de la familia.

**Tú y Yo** decidimos con Responsabilidad

UNEP, Salud y Familia, MEX, USAID

## ACOMPaña A TU PAREJA EN TODOS LOS MOMENTOS REPRODUCTIVOS, PARA QUE TU HIJO O HIJA CREZCA CON AMOR.

Si usted no vive en un ambiente seguro, su embarazo será difícil.

Ayuda a su pareja a reconocer los signos de alarma y a buscar ayuda.

Parto seguro y saludable.

Acompaña a su pareja en el parto y en el puerperio.

**Tú y Yo** decidimos con Responsabilidad

UNEP, Salud y Familia, MEX, USAID

## No se aceleren, disfruten de la vida

Hay más tiempo para compartirlo que se lo pierda.

Tienen el tiempo para la familia.

Esperando con el día que nace un hijo.

Resumen responsablemente las cosas.

Mejoren la salud de su familia, esperando de 3 a 5 años entre los embarazos.

**Tú y Yo** decidimos con Responsabilidad

UNEP, Salud y Familia, MEX, USAID

## Amigos, simplemente amigos

¡Hay tiempo para todo!

Disfrutamos los momentos juntos de la vida.

Evitamos el riesgo de un embarazo prematuro.

Mantén un buen estado de salud entre nuestros compañeros y compañeras.

**Tú y Yo** decidimos con Responsabilidad

UNEP, Salud y Familia, MEX, USAID

## No embarazarte a temprana edad te brinda oportunidades para ti, tu pareja y tu familia, como...

Participar en actividades religiosas, culturales y sociales

Completar el desarrollo de tu cuerpo

Continuar estudiando

Hacer una mejor elección de tu pareja

Lograr tus metas y proyectos de vida

**Tú y Yo**  
decidimos con Responsabilidad

## Participando juntos tomamos mejores decisiones

Definir en pareja cuando y cuánto tener hijos

Definir la información y servicios que les brinde su familia, su pareja y los servicios oportunos

Identificar el momento oportuno para tomar juntos la decisión de tener o no hijos y tenerlos de manera responsable

Consejarlos oportunamente para evitar el aborto de los hijos y tenerlos de manera responsable

Como pareja tenemos derecho a informarnos y decidir como planificar la familia

**Tú y Yo**  
decidimos con Responsabilidad

## Porque valoro mi vida, mi pareja y yo nos informamos antes de un embarazo

¿Cuándo corre peligro el estar embarazada cuando...

Cuando has tenido abortos anteriores

Cuando es madre de cuatro hijos o más

Cuando debe interrumpir o está desnutrida

Cuando es menor de 18 años y mayor de 35 años

La información oportuna me previene de riesgos

**Tú y Yo**  
decidimos con Responsabilidad

## ¿CÓMO EL CÉREBRO QUE MÁS LES CUIDA Y DESARROLLA LA VIDA CON RESPONSABILIDAD?

### Medios Anticonceptivos Temporales

**Condón**

**Diagnóstico**

**Medios Anticonceptivos Definitivos**

**Tú y Yo**  
decidimos con Responsabilidad

## Si su niño o niña recién nacido presenta uno o más de los siguientes signos de peligro, llévelo inmediatamente al hospital más cercano

Respira como conejito

No puede agarrar el pecho

El bebé tiene o está hinchado

El ombligo está rojo y se sale pus

Si se pone nervioso

**Tú y Yo**  
decidimos con Responsabilidad

## Cuidados básicos del niño y niña recién nacido

Lávase las manos antes de tocar al niño o niña

Evitar que los bebés y niños pequeños estén expuestos al sol

Alimentarlo con leche materna exclusiva por al menos los primeros 6 meses

Mantenerlo al aire libre

Darle una teta materna exclusiva que el bebé succiona hasta los 6 meses

Recuerde:  
Inscriba al niño o niña en el Programa de Atención Infantil

**Tú y Yo**  
decidimos con Responsabilidad

### ¿Quieren que su niña o niño crezca y se desarrolle saludable?

Para que su niño o niña crezca y se desarrolle saludable, lleve a los primeros 7 días de nacido a la Unidad de Salud, para inscribirlo en el Programa de Atención Infantil. No olvide que debe acudir a todos los controles hasta los 9 años de edad.

**Tú y Yo**  
Salud para todos

Ministerio de Salud Pública, UNICEF, USAID

### Lavarse las manos evita enfermedades

Antes y después de cocinar y preparar los alimentos

Antes y después de visitar al niño o niña

Antes y después de cambiar el pañal

Antes y después de usar la latrina

**¿Cuándo debemos lavarnos las manos?**

**Tú y Yo**  
Salud para todos

Ministerio de Salud Pública, UNICEF, USAID

### Si su niño o niña tiene diarrea

Déle muchos líquidos, suero oral y continúe alimentándolo

**Tú y Yo**  
Salud para todos

Ministerio de Salud Pública, UNICEF, USAID

### Una Familia Saludable Toma Con Puntualidad Sus Vitaminas y Minerales

**VITAMINA A**

- Previene enfermedades infecciosas comunes y las previene.
- Ayuda a fortalecer los huesos normales.

**HIERRO Y ÁCIDO FÓLICO**

- Previene la anemia.
- Previene los problemas de crecimiento.
- Mejora la capacidad de aprendizaje.
- Evita la anemia en la actividad diaria.
- Previene de los riesgos de parto al parto y del parto prematuro.

**Tú y Yo**  
Salud para todos

Ministerio de Salud Pública, UNICEF, USAID

### Si respondes "sí" a algunas de estas preguntas, busca ayuda en la Unidad de Salud más cercana

¿Dolor constante o fuerte en la barriga y/o vómitos?

¿Siempre me siento cansado después de comer y he perdido o estoy perdiendo peso?

¿Dolor de cabeza o mareos?

¿Cuando te ves al espejo, ¿tienes un cambio de peso?

¿Algunas preguntas son de carácter médica?

**Tú y Yo**  
Salud para todos

Ministerio de Salud Pública, UNICEF, USAID

### Guía de alimentación para la familia salvadoreña

¡Tu buena nutrición, el camino hacia la salud!

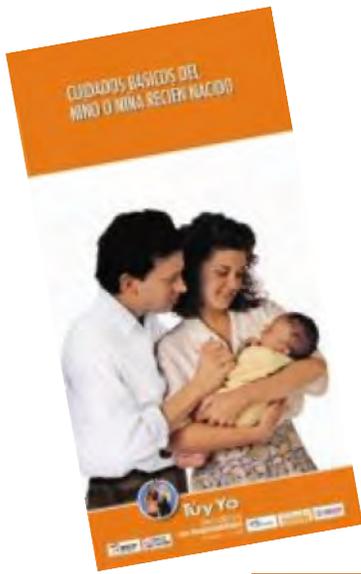
1. Consuma variedad de alimentos saludables: frutas, verduras, granos, proteínas y lácteos.
2. Incluye en tu dieta: frutas, verduras, granos y proteínas.
3. Consume alimentos saludables y evita los alimentos procesados.
4. Consume alimentos saludables: frutas, verduras, granos y proteínas.
5. Incluye en tu dieta: frutas, verduras, granos y proteínas.
6. Consume alimentos saludables: frutas, verduras, granos y proteínas.
7. Consume alimentos saludables: frutas, verduras, granos y proteínas.
8. Consume alimentos saludables: frutas, verduras, granos y proteínas.
9. Consume alimentos saludables: frutas, verduras, granos y proteínas.
10. Consume alimentos saludables: frutas, verduras, granos y proteínas.

**Tú y Yo**  
Salud para todos

Ministerio de Salud Pública, UNICEF, USAID



**BROCHURES:**



**Algunas situaciones que afectan al bebé en el control infantil**

**Si su bebé era enfermo o enferma:**

**CUIDADOS BÁSICOS DEL NIÑO O NIÑA RECIENTE NACIDO**

Montégalo abrigado. Continúe dándole pecho. No le automedique. Llévelo inmediatamente a la Unidad de Salud.

La asunción y el auto-alimento o enfermo, le son afectos malos.

La vacunación para prevenir enfermedades.

La pesen para ver su crecimiento y desarrollo.

**Padres y madres responsables, niños y niñas saludables**

**RECUERDE:**

Llevar a su niño o niña al hospital, puede salvarle la vida.

**RECONOZCA LOS SIGNOS DE PELIGRO EN EL NIÑO Y NIÑA RECIENTE NACIDO Y LLEVELO INMEDIATAMENTE AL HOSPITAL MAS CERCA.**

La familia debe estar alerta a los cambios que presentan los niños y las niñas recién nacidos.

**Los niños y niñas recién nacidos son muy delicados... ante cualquier signo de peligro, lívelos al Hospital.**

**Se le explica sobre la alimentación adecuada de acuerdo a la edad**

**Cuidados básicos de la niña y el niño**

**PARA QUE SU BEBÉ CREZCA Y SE DESARROLLE SALUDABLE**

Llévelo a celebrarlo cuando los padres y los hermanos ya estén acostumbrados a tenerlo.

**Recién nacido de 0 a 6 meses sólo leche materna**

**De 6 a 8 meses**

**De 9 a 11 meses**

**De 1 a 2 años**

**Alimentación del niño o niña de 2 a 9 años**

**Padres y madres responsables, niños y niñas saludables**

**¿Qué debemos hacer cuando el niño o niña empieza con diarrea?**

**La participación de la familia es importante para evitar la diarrea.**

**¿QUÉ DEBEMOS SABER SOBRE LA DIARREA Y LA DESHIDRATACIÓN?**

Si está recibiendo lactancia materna, déjela en sus brazos. Si no está recibiendo lactancia materna, déjela en sus brazos.

Dehidrate el agua que consumirá.

Tráele los medicamentos que le recetaron.

Tráele más líquidos de lo que tiene habitualmente, especialmente agua oral.

Tráele bien los frutos y verduras crudos de consumo.

Alimentarlo lo antes posible.

Cuando abandone el uso de pañales.

Realizando limpieza adecuada de la boca.

Utilizando adecuadamente la tierra.

**¡Úy Yé**

Logo:

**APRENDE A DECIR "NO" Y DECÍDETE A ESPERAR**

**Tú y Yo**  
 de **PREVENCIÓN**  
 de **EMBARAZOS**

**¿Qué le puede suceder a la o el adolescente cuando se convierte en madre o padre?**

**Las decisiones que se toman cuando se toma una decisión o se llega a ser padre y a ser madre.**

**Hay decisiones importantes que se toman:**

- La vida que se va a vivir
- Buscar soluciones a los problemas
- Preparar la vida de los hijos

**Hay que pensar en los temas de las decisiones:**

- Con la familia
- Con personal de salud capacitado

**Señal conmutable**

**Señal conmutable**

**Esperar a tener relaciones sexuales es una de las decisiones más importantes que tomarás en tu vida.**

**Tu decisión valer y es la más importante.**

**Tú y Yo**  
 de **PREVENCIÓN**  
 de **EMBARAZOS**

**VENTAJAS**

Es un método permanente y muy seguro para la mujer que no tiene el número deseado de hijos o hijos de poca número que se realizar la esterilización sólo una podría quedar embarazada.

El procedimiento es sencillo, seguro y rápido. La mujer puede volver a su vida al mismo día.

La mujer puede estar viva en cualquier momento siempre y cuando este segura de su esta esterilizada.

Después del parto, cesárea o aborto la mujer puede salir del hospital o estacionamiento de salud esterilizada, si lo desea.

**La esterilización femenina mejora la vida sexual de la pareja porque hay menos posibilidad de un embarazo no deseado.**

**LA ESTERILIZACIÓN FEMENINA**  
 Es un método de esterilización permanente que se realiza en el útero.

**TOMAR EN CUENTA QUE:**

- La esterilización femenina no afecta a la vida sexual.
- Como en una operación quirúrgica, se va a sentir dolor más tarde o más tarde, pero se va a sentir mejor con el tiempo.
- Puede haber de decisión de cualquier momento. La esterilización es permanente y no se puede volver a tener hijos.
- Este método es la mejor de las opciones de esterilización masculina, femenina o quirúrgica. Para protegerse, también debe usar el condón.
- Este método es una parte de los métodos de la vida, es importante que se habla de los riesgos de tener un embarazo no deseado, aborto o nacimiento de un niño.
- Después de la esterilización, se debe tener un control de salud.

**La planificación familiar contribuye al bienestar personal de la pareja y la familia.**

**Tú y Yo**  
 de **PREVENCIÓN**  
 de **EMBARAZOS**

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**LOS INYECTABLES**  
 Este método es una opción de esterilización permanente que se realiza en el útero.

**Tú y Yo**  
 de **PREVENCIÓN**  
 de **EMBARAZOS**



### ¿Quiénes pueden utilizar los métodos de planificación familiar?

Toda pareja sexualmente activa que quiera evitar un embarazo.

Quiénes. Además de usar un método antes, solo y efectivamente.

Los parejas con planes a largo plazo por los tiempos de primer embarazo.

Las parejas que ya tienen el número de hijos que desean.

### TOMAR EN CUENTA QUE:

- La planificación familiar es el derecho que, todo persona tiene de decidir cuántos hijos e hijas que quiere cuando lo quiere tener.
- Para elegir el método de planificación familiar que más le conviene, y para decidir correctamente, necesita tener información clara, completa y oportuna que parte del personal de salud.
- Para cuidar la salud de la mujer y sus hijos, la mujer más joven debería usar métodos que eviten el embarazo hasta los 20 años, también es mejor esperar de 1 a 3 años entre un embarazo y otro.
- La planificación familiar contribuye al bienestar del grupo familiar.
- Existen un libro de decisión de la elección de los métodos de planificación familiar y otros recursos. Puede consultar de cualquier momento antes de la decisión, sin que sea necesario en cualquier momento un embarazo.
- En los establecimientos de salud se ofrecen los métodos de planificación familiar que más le convenga.

Solo tú y tu pareja pueden decidir el método que más les conviene.

### ELIJA EL MÉTODO QUE MÁS LES CONVIENE Y DISFRUTEN LA VIDA CON TRANQUILIDAD

**Tú y Yo** de salud  
con información y apoyo

### VENTAJAS

- Protege de infecciones de transmisión sexual, incluyendo el virus del VIH/SIDA.
- Es un método temporal, a eso que si la pareja quiere un embarazo solo tiene que dejar de usarlo.
- Es un método de bajo costo y fácil de conseguir.
- El uso correcto del condón mejora la vida sexual de la pareja porque hay menos posibilidad de un embarazo no deseado, o de una infección de Transmisión Sexual.
- Puede ser usado con mujeres que están dando de mamar a su hijo o niña.
- Puede ser usado cuando la pareja necesita un método adicional por un tiempo corto.

### TOMAR EN CUENTA QUE:

Asegúrese de tener un condón antes de una relación sexual casual (relaciones sexuales).

Debe usar un condón nuevo por cada relación sexual casual (relaciones sexuales).

El condón debe fabricado correctamente, así es necesario usar la lubricación adicional.

El uso de métodos de planificación familiar contribuye al logro del bienestar personal y familiar.

Guarde los condones nuevos en un lugar fresco y seco, y no en la billetera.

### EL CONDÓN (PRESERVATIVO)

Es un método para evitar el embarazo y prevenir las infecciones de transmisión sexual.

**Tú y Yo** de salud  
con información y apoyo

### VENTAJAS

- Es más seguro de la pareja sexual, igual o mejor que antes porque no hay riesgo de un embarazo.
- Es un método muy seguro, de inmediato que lo usar y puede quedar embarazada.
- Es un método que no requiere de preservación.
- Puede ser usado por mujeres que están dando de mamar a su hijo o niña, antes o después de la lactancia o la cantidad de la leche materna.
- La mayoría de las mujeres pueden usar el DIU, no importa la edad.
- Puede ser usado por mujeres después del parto, cuando el bebé ha nacido.
- Es un método temporal. Puede ser retirado por el personal de salud cuando la mujer lo desea.
- La mayoría de las mujeres pueden usar el DIU, no importa la edad.

### TOMAR EN CUENTA QUE:

- Después de la colocación del DIU puede haber relaciones sexuales. Sin embargo, se debe tener cuidado y precaución de tener.
- El DIU debe ser colocado y retirado por el personal de salud capacitado.
- El DIU no protege cuando la mujer tiene sexo o cuando también su hijo a los 10 años.
- El riesgo de DIU por la vida protegida de un embarazo. Si hay otros métodos de planificación familiar que se combinan con el DIU a un nivel de planificación familiar.
- Cuando parte del los cambios de la salud, es recomendable que todas las personas se hagan un examen médico anual, tener un diagnóstico y acciones de tratamiento.
- Este método no le protege de infecciones de transmisión sexual, por lo tanto el DIU o DIU. Para protegerse, consulte con el personal de salud.

La planificación familiar contribuye al bienestar personal, de la pareja y la familia.

### EL DISPOSITIVO INTRAUTERINO (EL DIU O APARATITO)

El DIU es un dispositivo de salud que se coloca en el útero para evitar el embarazo y prevenir las infecciones de transmisión sexual.

**Tú y Yo** de salud  
con información y apoyo

**¡NO TE ARRIESQUES!**

**CUIDA TU SALUD Y LA DE TU BEBÉ**  
 Evitando los riesgos y la calidad de vida

Los efectos no deseados de los medicamentos durante el tiempo de todo el embarazo. Tu familia debe evitar el consumo de cigarrillos y otros sustancias tóxicas por el bienestar de la madre y al niño.

**RECUERDE**

- No fume cigarrillo al embarazarse o en cualquier momento de su vida.
- No consuma bebidas alcohólicas.
- Evite sustancias tóxicas.

• Datos del embarazo.  
 • Tipo parto y parto.  
 • Medicación completa.

**Tú y Yo**  
 el acompañamiento que necesitas

**Cuando haya nacido tu hijo o hija**

**TOMAR EN CUENTA QUE:**

- La atención de tu parto es gratuita.
- Recibirás educación sobre los cuidados y los del recién nacido.
- Tu hijo o hija será atendido por un médico especialista en niños.
- Recibirán consejo sobre lactancia materna exclusiva.

**Para sentirte a su parte falta lo importante la participación y apoyo de tu pareja y familia.**

Cuando haya nacido tu hijo o hija te enseñarán a cuidarlo y como alimentarlo.

También recibirán orientación sobre los cuidados necesarios para tener una mejor recuperación.

El mejor momento es la lactancia materna exclusiva.

**ATENCIÓN DEL PARTO EN EL HOSPITAL LA MEJOR DECISIÓN**

**Tú y Yo**  
 el acompañamiento que necesitas

**Me orientarán sobre:**

- Los métodos de planificación familiar.
- El caso personal.
- Los cuidados básicos del recién nacido.
- Los signos de peligro del recién nacido.
- La alimentación adecuada y cómo preparar alimentos.

**TOMAR EN CUENTA QUE:**

- Deben descansar mientras el bebé duerme.
- Tomar por lo menos 8 vasos de agua al día.
- Seguir siendo o cualquier complicación que presente.
- Si la lactancia continúa, mantener la buena leche y tiempo.
- Tomar vitaminas semanales hasta que se sienta feliz y normalmente bien.
- Debe aparecer en su hijo/a para seguir su recuperación.
- Si se siente bien o ligeramente cansado de tenerlo.

**ES TIEMPO DE REGRESAR**

**Tú y Yo**  
 el acompañamiento que necesitas

**Otros síntomas**

**TOMAR EN CUENTA QUE:**

Tu familia debe estar alerta ante la presencia de cualquier complicación después del parto y buscar ayuda oportuna en el hospital más cercano, así tendrás una Maternidad Feliz.

**¡ALERTA DESPUÉS DEL PARTO!**

• Está bien, quiere sólo dormir

• Sentimiento de desolación  
 • Irritabilidad  
 • Ansiedad  
 • Irritabilidad

**Tú y Yo**  
 el acompañamiento que necesitas

**RECUERDA QUE SI BUSCAS EL TRATAMIENTO CORRECTO DE TU DIABETES...**

**...SIEMPRE VA A SER COMER.**

### INSUFICIENCIA RENAL CRÓNICA EN LA ADOLESCENCIA

¡¡¡Evita más sales en tu alimentación!!!

- Este tipo de medicamentos no recetados por el médico.
- Si sales, día de festivo.
- Entre fajas y corsets o telas elásticas.
- En su caso, café.

**Alimentos y bebidas embalsada o azucarados, como: sorbetes, gaseosas, jugos, refrescos, helados, helados en polvo y otros.**

**Comidas rápidas y empaquetadas, hamburguesas, pizzas, helados, pasteles, fritos, dulces, chocolates, salsas, salsas, salsas, salsas y salsas.**

**Salsas, especias y condimentos.**

**El tratamiento correcto de una enfermedad como la diabetes es vital. Consulta con tu médico y sé más responsable para que tengas mejor información.**

**Tu y Yo**

**RECOMENDACIONES PARA TI Y TU FAMILIA**

**¿QUE ES LA HIPERTENSION ARTERIAL Y LA DIABETIS TIPO 2?**  
¡¡Descubre cómo prevenirlas!!

- Reduce el consumo de alimentos con mucha sal: sal, salsa y sal.
- Reduce el consumo de bebidas azucaradas y alcohol.

**Trata de incluir en tu alimentación diario uno o más de los siguientes alimentos:**

- Granos: maíz, frijoles y arroz.
- Legumbres: papa, yuca, camote.
- Plátano.
- Frutas: naranja, guineo, manzana, papaya y otros.
- Verduras y hortalizas verdes.
- Huevos, leche, queso fresco, yogur y derivados.
- Pollo, pavo y carne.
- Miel y aceites vegetales.

**¡¡¡Evita el consumo de bebidas azucaradas y alcohol!!!**

**¡¡¡Evita el consumo de bebidas azucaradas y alcohol!!!**

**¡¡¡Evita el consumo de bebidas azucaradas y alcohol!!!**

**Tu y Yo**

**RECUERDA QUE SI BUSCAS EL TRATAMIENTO CORRECTO DE TU DIABETES...**

**...SIEMPRE VA A SER COMER.**

### ALIMENTACION SANA... VIDA SANA PARA LA FAMILIA SALVADOREÑA

**¡¡¡Evita más sales en tu alimentación!!!**

**¡¡¡Evita el consumo de bebidas azucaradas y alcohol!!!**

**¡¡¡Evita el consumo de bebidas azucaradas y alcohol!!!**

**Tu y Yo**

**¿Cómo cuidar los dientes de tus hijos?**

**¡¡¡Evita más sales en tu alimentación!!!**

**¡¡¡Evita el consumo de bebidas azucaradas y alcohol!!!**

**¡¡¡Evita el consumo de bebidas azucaradas y alcohol!!!**

**Tu y Yo**

## ILLUSTRATION OF CONSULTANCY:

LÁMINAS DE CONSEJERÍA

### Orientación de las relaciones sexo-coitales (relaciones sexuales) en las diferentes etapas del embarazo y después del parto



Las relaciones sexo-coitales (relaciones sexuales) no se interrumpen con el embarazo, la condición es que deben ser conscientes y placenteras para los dos, y así fortalecer la relación familiar.

En embarazo, recuerda:

- Ambos deben estar de acuerdo para tener relaciones sexuales.
- Nunca se debe ejercer fuerza o presión para tener relaciones sexuales.
- Ser honesto con la pareja: comunicarle su placer y/o satisfacción.

**Ambos tienen el mismo derecho a obtener placer sexual.**

**Tú y Yo**  
decidimos con responsabilidad

1

Ministerio de Salud y Bienestar Social  
Ministerio de Familia y Bienestar Social  
USAID

**ANNEX 5: CATALOG OF DOCUMENTS PRINTED BY THE STRENGTHENING HEALTH PROJECT**

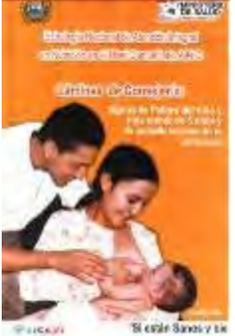
Title of the document	Description	Cover
<p><b>Family Planning</b></p> <p><i>Technical guide for counseling on Family Planning health services</i></p>	<ul style="list-style-type: none"> <li>• Regulatory and methodological document for balanced consultancy</li> <li>• Addressed to personnel in charge of FP services</li> <li>• Published in October 2007</li> <li>• 61 pages</li> <li>• Printing: 3,500 copies</li> </ul>	
<p><i>Practical guide on counseling for youth health promoters</i></p>	<ul style="list-style-type: none"> <li>• Technical document</li> <li>• Addressed to attendees working with teenagers and youth health promoters</li> <li>• Published in January 2009</li> <li>• 35 pages</li> <li>• Printing: 1,000 copies</li> </ul>	
<p><i>From teenagers to teenagers</i></p> <p><b>Workbook</b></p> <p><i>and</i></p> <p><b>Teenager's Manual</b></p>	<ul style="list-style-type: none"> <li>• Teaching document</li> <li>• Addressed to primary facilitators and teenagers</li> <li>• Published in December 2008</li> <li>• 98 pages</li> <li>• Printing: 3,000 copies</li> </ul>	
<p><i>Technical guide on Family Planning for personnel that works with midwives</i></p>	<ul style="list-style-type: none"> <li>• Regulatory document</li> <li>• Addressed to personnel that works with midwives</li> <li>• Published in December 2008</li> <li>• 59 pages</li> <li>• Printing: 1,500 copies</li> </ul>	

Title of the document	Description	Cover
<p><b>Guide on Family Planning Services addressed to the health promoter</b></p>	<ul style="list-style-type: none"> <li>Regulatory document</li> <li>Addressed to personnel that works with promoters, supervisors of promoters and health promoters</li> <li>98 pages</li> <li>Published in December 2008</li> <li>Printing: 3,000 copies</li> </ul>	
<p><b>Maternal program</b></p>		
<p><b>Technical guide on the use of the Perinatal Information System. Second Edition</b></p> <p><b>I. Health Care Units</b></p> <p><b>II. Hospitals</b></p>	<ul style="list-style-type: none"> <li>Technical document</li> <li>Addressed to obstetricians, pediatricians and data entry operators of the PIS at Health Unit and hospital levels</li> <li>Volume I: 48 pages</li> <li>Volume II: 157 pages</li> <li>Volume I was published in May 2008; Volume II was published in November 2008</li> <li>Printing Volume I: 1,000 copies</li> <li>Printing Volume II: 500 copies</li> </ul>	
<p><b>Manual to evaluate health care personnel at training regional centers on obstetrics, neonate and Family Planning skills</b></p>	<ul style="list-style-type: none"> <li>Regulatory document</li> <li>Addressed to regional personnel and skill facilitators-instructors</li> <li>39 pages</li> <li>Published in January 2009</li> <li>Printing: 1,000 copies</li> <li>ISBN 978-99923-57-21-7</li> </ul>	

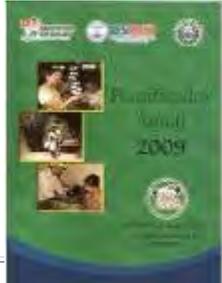
Title of the document	Description	Cover
<p><b>Technical material on Obstetrics , Neonate and Family Planning skills</b></p>	<ul style="list-style-type: none"> <li>• Consultation document</li> <li>• Addressed to providers, physicians, and nurses</li> <li>• 300 pages</li> <li>• Published in October 2008</li> <li>• Printing: 500 copies</li> </ul>	

Title of the document	Description	Cover
<b>Quality</b>		
<p><b>Technical guide on Continuous Quality Improvement</b></p>	<ul style="list-style-type: none"> <li>• Regulatory and methodological document</li> <li>• Addressed to programming personnel, providers, and regional supervisors</li> <li>• 75 pages</li> <li>• Published in January 2009</li> <li>• Printing: 1,000 copies</li> </ul>	
<p><b>Workbook. Continuous Quality Improvement: Rapid cycles of Improvement</b></p>	<ul style="list-style-type: none"> <li>• Methodological document</li> <li>• Addressed to programming personnel, providers at hospital level, regional supervisors</li> <li>• 43 pages</li> <li>• Published in April 2009</li> <li>• Printing: 1,000 copies</li> <li>• ISBN 978-99923-71-34-3</li> </ul>	

<p><b><i>Executive Report Building of a Baseline</i></b></p>	<ul style="list-style-type: none"> <li>• Methodological document</li> <li>• Addressed to programming personnel, providers at hospital level, regional supervisors</li> <li>• 35 pages</li> <li>• Published in January 2009</li> <li>• Printing: 200 copies</li> </ul>	
<p><b>Infant</b></p>		
<p><b><i>Technical guide to follow-up premature children weighing under 2,000 grams at birth</i></b></p>	<ul style="list-style-type: none"> <li>• Regulatory document</li> <li>• Addressed to health professionals attending premature children at second level hospitals</li> <li>• 88 pages</li> <li>• Published in November 2008</li> <li>• Printing: 1,500 copies</li> <li>• ISBN 978-99923-57-18-7</li> </ul>	

Title of the document	Description	Cover
<b>Nutrition</b>		
<p><b>Counseling Illustrations: “Danger signs, basic care of the newborn and pregnancy complications”</b></p>	<ul style="list-style-type: none"> <li>• Technical document</li> <li>• Addressed to community personnel in charge of home counseling</li> <li>• 22 pages</li> <li>• Published in August 2007</li> <li>• Printing: 2,000 copies</li> </ul>	
<p><b>Counseling Illustrations: “Care for pregnant women and children under two”</b></p>	<ul style="list-style-type: none"> <li>• Technical document</li> <li>• Addressed to community personnel in charge of home counseling</li> <li>• 22 pages</li> <li>• Published in August 2007</li> <li>• Printing: 2,000 copies</li> </ul>	
<p><b>III National Census on Size of School Children in First Grade in El Salvador</b></p>	<ul style="list-style-type: none"> <li>• Technical, information and consultation document</li> <li>• Addressed to health personnel at different levels of attention for consultation and decision-making</li> <li>• 192 pages</li> <li>• Published in February 2008</li> <li>• Printing: 1000 copies</li> </ul>	

<b>Community Health</b>		
<p><b><i>Baseline on knowledge, practices, coverage of different health topics addressed to the population of 69 municipalities supported by the SHP</i></b></p>	<ul style="list-style-type: none"> <li>• Information and consultation document</li> <li>• Addressed to health personnel at different levels of attention for consultation and decision-making</li> <li>• 57 pages</li> <li>• Published in March 2007</li> <li>• Printing: 2,000 copies</li> </ul>	

<b>Title of the document</b>	<b>Description</b>	<b>Cover</b>
<p><b><i>Use of the Health Information System for decision-making and how personnel from the three MOH Health Regions supported by the SHP perceive it</i></b></p>	<ul style="list-style-type: none"> <li>• Technical, information and consultation document</li> <li>• Addressed to health personnel at different levels of attention for consultation and decision-making</li> <li>• 57 pages</li> <li>• Published in March 2009</li> <li>• Printing: 200 copies</li> </ul>	
<p><b><i>Annual Planner of activities 2009</i></b></p>	<ul style="list-style-type: none"> <li>• Work Document</li> <li>• Addressed to health personnel from various levels of assistance</li> <li>• 29 pages</li> <li>• Published in January 2009</li> <li>• Printing: 2,750 copies</li> </ul>	

**Regulatory Documents of Family Health Care:**

***“Model of Integral Care with a Family Health Care Approach”***

***“Technical guide to implement the model of Integral Care with a Family Health Care Approach”***

***“Standard of Integral Care with model of Integral Care with a Family Health Care Approach”***

- Technical Document standardizing and regulatory
- Addressed to health personnel from various levels of community assistance to implement the model of Family Health Care
- 152 pages, a total 3 documents
- Published in September 2008
- Printing: 500 copies



**ANNEX 6: EXPENSES MADE IN THE PERIOD APRIL 2006 - JULY 2009  
AND FORECAST FOR AUGUST – SEPTEMBER 2009**

								2009	
Salaries and Wages	3,195,613	2,702,395	240,264	791,095	937,603	707,287	2,676,249	26,146	92,163
Social benefits	312,826	243,812	41,645	81,009	75,008	41,771	239,433	4,379	9,161
Local consultants : Salaries and Social Benefits	612,115	280,636	13,958	61,719	55,655	32,147	163,479	117,157	5,000
Allowances	195,070	161,232	31,399	60,596	48,949	20,512	161,456	-224	12,996
Overhead	518,491	435,051	43,863	130,587	148,619	107,740	430,809	4,242	16,004
consultants (including "Statutory Fringe")	35,159	1,532	1,261	271	0	0	1,532	0	0
Traveling, Subsistence Allowances and Tra	420,326	244,139	32,894	45,539	94,299	30,850	203,582	40,557	7,020
Equipment	1,723,850	2,118,920	118,926	435,186	1,322,752	173,309	2,050,173	68,747	6,750
Other Direct Costs	2,607,816	3,067,788	75,993	997,138	1,289,147	789,356	3,151,634	-83,846	439,665
Reimbursement of VAT (April 2006 - Januar			-13,247	-93,979	-117,785	-34,280	-259,291	259,291	0
Subcontracts		400,000	0	0	0	155,842	155,842	244,158	0
<b>Sub Total</b>	<b>9,621,266</b>	<b>9,655,505</b>	<b>586,956</b>	<b>2,509,161</b>	<b>3,854,247</b>	<b>2,024,534</b>	<b>8,974,898</b>	<b>680,607</b>	<b>588,759</b>
Administration Costs	1,731,828	1,697,589	108,035	468,564	714,966	363,041	1,654,606	42,983	117,891
<b>Total Estimated Costs</b>	<b>11,353,094</b>	<b>11,353,094</b>	<b>694,991</b>	<b>2,977,725</b>	<b>4,569,213</b>	<b>2,387,575</b>	<b>10,629,504</b>	<b>723,590</b>	<b>706,650</b>
Fixed Costs 6%	681,186	681,186	42,493	184,302	281,220	145,313	653,328	27,858	44,798
<b>Total estimated costs + Fixed Costs</b>	<b>12,034,280</b>	<b>12,034,280</b>	<b>737,484</b>	<b>3,162,027</b>	<b>4,850,433</b>	<b>2,532,888</b>	<b>11,282,832</b>	<b>751,448</b>	<b>751,448</b>