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EL SALVADOR HEALTH SECTOR NEEDS ASSESSMENT

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USAID/EL SALVADOR: HEALTH SECTOR NEEDS ASSESSMENT

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ABBREVIATIONS AND ACRONYMS

ABT	Abt Associates
ADESCO	Community Development Association
ASAPROSAR	Salvadoran Health Association (Asociación Salvadoreña pro Salud)
ASPER	Association of Social Participation for the Health of Perquín (Asociación de Salud de Perquín)
BM	Teachers' Welfare Institute
CIF	Cost, insurance, and freight
COMISCA	Central American Health Ministers Commission
CSSP	High Council on Public Health (Consejo Superior de Salud Pública)
CSW	Commercial sex worker
cwt	Hundredweight, 100 pounds
DG	Democracy & Governance Team (in USAID/El Salvador)
EG	Economic Growth Team (in USAID/El Salvador)
FMLN	Farabundo Martí National Liberation Front (Frente Farabundo Martí para la Liberación Nacional)
FODES	Development Fund for municipalities
FOSALUD	Solidarity Health Fund
GNP	Gross national product
GIDRHUS	Coordinating mechanism for addressing human resource needs within government health agencies (Grupo Interinstitucional de Desarrollo de Recursos Humanos en Salud)
GOES	Government of El Salvador
HIO	Human Investment Office in USAID/El Salvador
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
ISRI	Salvadoran Institute for Rehabilitation of the Disabled (Instituto Salvadoreño de Rehabilitación de Inválidos)
ISSS	Salvadoran Institute of Social Services
MDG	Millennium Development Goals
MINED	Ministry of Education
MSM	Men who have sex with men
MSPAS	Ministry of Public Health and Social Assistance
NGO	Non-governmental organization
PAHO	Pan American Health Organization
PASMO	Pan American Association for Social Marketing
PSI	Population Services International

SEAM	Strategies for Enhancing Access to Medicines Program, MSH
SIBASI	Basic System of Integral Health
UES	National University of El Salvador
UME	Monitoring and Evaluation Unit of SIBASI
URC	University Research Corporation
USAID	United States Agency for International Development
WHO	World Health Organization

CONTENTS

ABBREVIATIONS AND ACRONYMS.....	i
EXECUTIVE SUMMARY.....	v
INTRODUCTION.....	1
BACKGROUND.....	3
HEALTH OUTCOMES.....	3
FINDINGS AND INTERPRETATION.....	9
CONTEXT.....	9
HUMAN RESOURCES.....	13
ADMINISTRATION AND MANAGEMENT.....	14
SERVICE PROVISION.....	16
DETERMINANTS OF DEMAND FOR HEALTH SERVICES.....	19
DETERMINANTS OF DEMAND.....	21
CONCLUSIONS AND RECOMMENDATIONS.....	23
POLICY AND LEGISLATION.....	23
EDUCATION.....	26
QUALITY OF SERVICES.....	27
INTERSECTORAL COLLABORATION.....	31
PRIVATE SECTOR.....	32
CONCLUSION.....	33

ANNEXES

ANNEX A: STATEMENT OF WORK.....	35
ANNEX B: TEAM PLANNING MEETING AGENDA.....	45
ANNEX C: LIST OF CONTACTS.....	47
ANNEX D: ILLUSTRATIVE INTERVIEW GUIDE.....	53
ANNEX E: DESCRIPTION OF THE CONCEPTUAL FRAMEWORK.....	55

EXECUTIVE SUMMARY

USAID/El Salvador requested this assessment to identify national health-sector needs that could be addressed in the next five-year strategy period. The assessment considered both strengths and weaknesses of the current program and gaps to be addressed in the near future. The assessment tracked USAID's three program areas: service provision, administrative and management systems, and human resources. The team also explored opportunities where synergies between health and other sectors could help achieve USAID's Intermediate Results: (1) increased and improved social sector investments and transparency; (2) improved integrated management of reproductive and child health; and (3) infectious diseases contained and impact mitigated.

The people of El Salvador receive health services from a mix of private (16%) and public (84%) providers. Among the public providers, the Social Security Institute, Military Health, and Teachers Welfare Institute (BM) attend their own closed populations (18%) and the Ministry of Public Health and Social Assistance (MPSAS) and the Social Solidarity Health Fund (FOSALUD) are responsible for the rest of the population (66%), although in practice they do not have complete coverage.¹ The recent National Health Policy groups all public health providers into a National Health Service. The fact that they keep their institutional identities with separate budgets and lines of authority complicates interagency coordination.

The High Council on Public Health (CSSP) is constitutionally charged with protecting the health of the nation by controlling health professionals, authorizing health facilities, and registering drugs. However, CSSP does not accredit establishments, certify professions, or conduct audits.

The intent of this study was to form recommendations for USAID's future health strategy based on qualitative information drawn from an array of stakeholders. Content was analyzed after initial interviews to identify prevailing themes. To learn from best practices, the evaluation team visited field sites with exemplary intersectoral collaboration. The conclusions and recommendations were organized according to five thematic areas: policy and legislation, education, quality of services, intersectoral collaboration, and private sector involvement.

In the area of policy and legislation, the presidential election in March 2009 will bring a change of government, including a new minister of health and CSSP president. While the outcome is not predictable, it seems likely to affect USAID's options for current and future health strategies because the major parties have differences in approach and health priorities. Pending legislation could impact drug prices, a major out-of-pocket expense.

Professional education was by far the theme of most concern to respondents. The basic problem is that doctors, dentists, and nurses are graduating from universities with no training on MSPAS norms, standards, and protocols; minimal training in public health; and no preparation in management and administration. This causes costly dislocations throughout the whole health sector. The universities and MSPAS need to communicate to facilitate new curriculum designs. All stakeholders recognize the urgency of making these changes.

The quality of services is a function of many variables related to management and administration, such as plans and budgets, personnel selection and deployment, training, monitoring and supervision, and regulation of norms, protocols, and standards. Of major concern to many respondents was the inability of the MSPAS to draw up strategic plans with long-term objectives that are costed out. As a result, MSPAS continuously requests resources to cover shortfalls, and health units suffer from inadequate resources. USAID should consider broadening the scope of its health system technical assistance to add technical assistance to the long-term MSPAS Strategic Health Plan and Budget.

¹ Dirección General de Estadística y Censos DIGESTYC, Encuesta de Hogares de Propósitos Múltiples 2006, pg. 10, Ciudad Delgado San Salvador June 2007.

One of the key interventions to improve the quality of services would be requiring pre-service qualifying exams. These would both reduce MSPAS training costs and force reorientation of the university curriculum. Examinations are currently used to qualify MSPAS specialists entering hospital residency programs but not social service-year candidates.

Because obstetricians, pediatricians, and anesthesiologists are in short supply in most hospitals and health units, general practitioners are filling the void and performing specialized tasks. In spite of increased coverage for maternal and child preventive services, perinatal and child (1–4 years) mortality are on the rise due to pneumonia and other infectious diseases. Specialists should be available around the clock.² The status of key indicators should be reported at all levels of the health system to instill accountability and identify needs for training and deployment.

There are no board certifications for health professionals. Upon graduation from a medical, dental, or nursing program, new health service providers are not required to sit for boards to be certified before commencing patient care. Similarly, health facilities are not accredited and are not regulated for quality control, although the CSSP does respond to problems brought to its attention.

This analysis found that the Monitoring and Evaluation Units of the Integral Basic Health System (SIBASI) do not systematically process information or make supervision and monitoring plans. USAID contractors should invite stellar professionals to mentor their peers on the advantages of using data for decision making. Incentives for better performance should be identified and applied consistently and fairly. Similarly, a methodology for ranking the quality of administrative systems and health facilities would not only provide positive incentives but be a step toward accrediting facilities.

A major opportunity for intersectoral collaboration is to improve health at the municipal level through city council adoption of health plans and formation of intersectoral committees that have budget line items for health. The evaluation team uncovered examples of successful intersectoral collaboration and model legislation that should be shared using a positive deviance approach. An important area for collaboration is adolescent health and sex education.

Finally, a major health challenge for USAID and all levels of El Salvador's government is to enlist the support of the private sector. Many company owners who aspire to be good corporate citizens could, and do, play an important role if health priorities are communicated. Public-private partnerships need more attention in the health arena.

Having achieved reasonable economic stability, El Salvador is classified by USAID as a transforming country, USAID should support higher-order reforms, such as decentralizing implementation of the National Health Policy, reordering pre-service education, and continued improvement of quality care, among the reforms that characterize countries in a sustaining partnership. These reforms must be supported by an efficient organizational structure capable of sector-wide strategic planning and budgetary defense of long-range health goals.

² In 2002 26 maternal deaths were recorded. Only 8% of those women were attended by trained obstetricians; and 76% were assisted by emergency room medical residents. (Source: MSPAS, "Evaluación de Disponibilidad y Uso de Cuidados Obstétricos de Emergencia en El Salvador en 28 hospitales y 5 Unidades de Salud," pg. 33, February 2004.

INTRODUCTION

This needs assessment was conducted as a formative evaluation to (1) assess the current strengths and weaknesses of the health system of the Government of El Salvador (GOES) and (2) identify gaps that might be appropriate for United States Agency for International Development (USAID)/El Salvador to address in the remaining years of the current program and in its next strategy (roughly 2010–2015). The study team was asked to assess both the health sector in general terms and specifically the Ministry of Public Health and Social Assistance (MPSAS)

The methodological approach followed USAID’s program areas: *Service Provision*: in hospitals, health units, and the community, including preventive activities; *Administrative and Management Systems*: supply management, information systems, budget, and finance; and *Human Resources*: training, deployment, and incentives.

The team was also asked to explore opportunities where synergies between health and other sectors could further achievement of USAID’s Intermediate Results—(1) Increased and improved social sector investments and transparency; (2) Improved integrated management of reproductive and child health; and (3) Infectious diseases contained and impact mitigated—and assess the implications for the follow-on strategy.

USAID presented the team with specific questions framed in terms of the technical areas currently supported by USAID (see Annex A: Scope of Work). These questions guided the drafting of the interview guides. The series of queries can be subsumed into the following three study questions:

- What are the strengths and weaknesses of the GOES health system and the lessons learned?
- What are the gaps in the GOES health system—both within the current results framework and in program areas not included in it?
- What solutions are recommended to address the gaps, and what resources may be needed to implement them?

The USAID Mission Director requested that this study be amplified to take a less conventional health-centered approach and identify new horizons for the health team to consider. With that as an additional mandate, rather than being simply an evaluation of progress to date on the USAID health portfolio, this study is instead a qualitative investigation of opportunities that would lead to healthier Salvadorans.

This report is organized as follows: The Background chapter gives a broad picture of key economic and wellness indicators, including morbidity and mortality data, and progress toward the Millennium Development Goals (MDGs). The Methods chapter describes the research approach, information sources, and sampling process. Next, a Conceptual Framework is presented that depicts the universe surrounding the supply and demand for services. This forms the foundation for presenting our Findings and Interpretation. In that chapter we distill the most salient results of our copious interviews, document review, and observations. Based on the findings, we identify gaps in the current GOES health system for each of USAID’s three program areas. This analysis directed us in our Conclusions and Recommendations to offer USAID a series of options to guide future programming. This guidance is framed within the GOES legislative and organizational structure and a changing political climate. The Human Investment Office (HIO) can best determine which recommendations are particularly relevant to the current program cycle and which apply more to the long-term strategic plan.

BACKGROUND

After seven years in the making, the GOES National Health Policy was launched in August 2008. With the objective of universal health coverage, this policy gives rise to a National Health System based on a family medicine service model. Five government agencies signed off on the National Health Service: MSPAS, the Salvadoran Social Security Institute (ISSS), the Military Health Service, the Salvadoran Institute for Rehabilitation of the Disabled (ISRI), and the Teacher's Welfare Institute (BM). (The Solidarity Health Fund, FOSALUD, did not sign.) These institutional members are assigned service delivery responsibility for their closed populations. No provision is made for shared coverage or resources, cross-financing, or coordinated planning; nor is there a plan of action that describes how the National Health Service will function.

El Salvador's population is 5.7 million³ (63% urban, 37% rural), and 38% are under the age of 19. More than one in three families are headed by women and 10% of households are severely impoverished (family income cannot buy the basic food basket, which costs \$139 in urban areas and \$101 in rural areas). However, almost 9 in 10 households have electricity, 8 in 10 have running water indoors, and 7 in 10 have telephones.

Health expenditures absorb 6.9% of the gross national product (GNP), with 4.1% coming from public institutions and 2.8% from personal expenses.⁴ Expenditures for health services are allocated accordingly: 46% by MSPAS, 48% by ISSS, and 6% each by all other government agencies and the private sector⁵—although according to a 2006 survey, only 55% of Salvadorans sought medical attention when faced with a health problem.⁶ In 2000–2004, MSPAS spent \$230 million and ISSS \$321 million.

HEALTH OUTCOMES

The primary cause of all deaths that occur in hospitals is trauma from accidents and violence, followed by cancer and pneumonia; perinatal deaths, to which 60% of all infant mortality is attributable, ranked eighth.⁷ There were 11,628 traffic deaths in 2006, 20.4/100,000 inhabitants, compared to 15.4 in the United States. However, using World Health Organization (WHO) figures, for every death 20 more victims are incapacitated, which means that 232,560 persons have some degree of disability that limits their earning power. In 2006 it cost MSPAS hospitals an estimated \$4.3 million⁸ to treat accident victims.

The primary reasons for hospitalization are pregnancy, delivery, and postpartum care; digestive system conditions; trauma; perinatal conditions; and pneumonia. The malnutrition rate in children under 5 is 10.3% and the acute malnutrition rate is 18.9%. This is more indicative of the burden of

³ VI Censo de Población V de Vivienda, El Salvador, 2007.

⁴ MSPAS, *Perfil del Sistema de Salud en El Salvador 2000-2005*, El Salvador, 2006.

⁵ MSPAS Social, Dirección de Planificación de los Servicios de Salud, Indicadores Económicos del Sector Salud, Gerencia de Información en Salud, Indicadores Económicos y Financieros 2006, www.mspas.gob.sv, Información, Indicadores Institucionales Enero Diciembre 2007

⁶ Director General de Estadísticas y Censos, Encuesta de Hogares, *Encuesta de Hogares para Propósitos Múltiples*, Ministry of Economics, 2006.

⁷ Abarca Mauricio Antonio, Suárez Rangel, Gloria; *Sistema de Vigilancia Nacional de Lesiones de Causa Externa*, Unidad Nacional de Epidemiología Dirección de Control y Epidemiológica Ministerio de Salud Pública y Asistencia Social El Salvador 2003.

⁸ Fondo de Prevención Vial, Bogotá, Colombia, "Políticas para mejorar la seguridad vial en América Latina y el Caribe", Brasilia, 28-30 de junio de 2004.

infection due to diarrhea and acute respiratory disease among children 6 to 24 months of age than of absolute food deficit.⁹

Health indicators have been steadily improving, and it is probable that the health-related Millennium Development Goals (MDGs) will be reached by 2015. Progress toward the four related to health are as follows¹⁰:

- *Reduce infant mortality by 2/3 between 1990 and 2015*: In 1990 the infant mortality rate was 52/1,000 live births, and in 2007 it was 24/1,000 live births.¹¹
- *Reduce maternal mortality by 3/4 between 1990 and 2015*: In 1993, the rate was 152/100,000 live births,¹² and in 2007 it was down to 55/100,000 live births.¹³
- *Halt the spread of AIDS by 2015*: The incidence of HIV among pregnant women had been on the increase until 1991 but dropped from 0.22% in 2004 to 0.14% in 2005.¹⁴
- *Halt the spread of malaria and other diseases by 2015*: Up to September 2008 there were no reported deaths from malaria, dengue, or tuberculosis.¹⁵

Methods

The methodology for this study was defined during a series of team planning meetings in the first days of the assignment (see Annex B: Agenda for Team Planning Meeting). Minor adjustments were made after the initial interviews to better meet the study objectives.

The goal of this study is to form recommendations for USAID/El Salvador's future health strategy based on qualitative information drawn from an array of stakeholders. The study team aimed to strike a balance between the different types of respondents and the depth to which each was interviewed. The range of respondents varied from members of high-risk vulnerable groups to the minister of health. All discussions with respondents took at least an hour and often two hours or more.

The data collection approach was structured around the levels of the health system where the USAID program operates; the units of analysis selected were the central, regional, municipality, and community levels. Because this is a qualitative study, generalizations cannot be made for any level, but the types of respondents selected at each level were carefully chosen to present a range of perspectives (see Table 1).

⁹ MSPAS, San Salvador, *Política Nacional de Salud*, 2008.

¹⁰ Secretaría Técnica de la Presidencia, *Informe de avance de El Salvador en el Cumplimiento de los Objetivos de Desarrollo del Milenio*, 2007.

¹¹ Secretaría Técnica de la Presidencia, *Informe de avance de El Salvador en el Cumplimiento de los Objetivos de Desarrollo del Milenio*, 2007. pg. 13

¹² Secretaría Técnica de la Presidencia, *Informe de avance de El Salvador en el Cumplimiento de los Objetivos de Desarrollo del Milenio*, 2007. pg.14

¹³ Línea de Base de Mortalidad Materna en El Salvador, 2007.

¹⁴ MSPAS Situación Epidemiológica del VIH/SIDA en El Salvador años 1984-2005

¹⁵ MSPAS, Dirección de Vigilancia Epidemiología, October 2008.

TABLE I: RESPONDENTS INTERVIEWED AT EACH UNIT OF ANALYSIS		
Type Group	Type of Respondent	Unit of Analysis
MSPAS	USAID Project Coordinator	Central
	Minister & Vice Minister Directorates: General, Planning, Epidemiology & Surveillance, Administration, and Regulation (represents all MSPAS directorates) Child Health Coordinator FOSALUD: Director and Communications Director	
	Regional & SIBASI (Basic Integrated Health System) Directors	Regional
	Hospital/Health Center Directors	Regional/Municipality
CSSP	President and Secretary of the High Council for Public Health (CSSP)	Central
ISSS	Director	Central
Education	MINED, National University of El Salvador and Evangelical University	Central
Donor	USAID (Health, Democracy & Governance, Education, Economic Growth) Pan American Health Organization (PAHO)	Central
USAID Contractors	University Research Corporation (URC) Research Triangle Institute Population Services International (PSI) ABT Associates (ABT)	Central
Non-governmental Organizations	FUSAL, CALMA, ADS	Central
	ASAPROSAR	Regional
	ASPER, ASPS	Community
Politicians	Arena and FMLN Political Party Health Advisors	Central
	Mayors	Municipality
Opinion Leaders	ADESCO (Community Development Association)/Health Promoters	Municipality/ Community
Beneficiaries	High school students Mothers (pregnant women and mothers of infants) Commercial sex workers (CSWs) Men who have sex with men (MSM)	Community

The sampling strategy used the “snowball” approach at the central level to identify informants who could speak knowledgeably about the status of the national health sector and assess its strengths and weaknesses. The HIO Team in USAID/El Salvador suggested most of the key informants at the

central level. From the interviews in the first few days, the study team then identified new informants, hence the snowball approach in which one respondent identifies another knowledgeable informant. Those interviewed also represented a range of groups beyond the walls of the MSPAS, among them the Ministry of Education [MINED], ISSS, universities, USAID contractors, politicians, non-governmental organizations, etc. (see Annex C: List of Contacts).

The next task was to determine a regional and local sampling strategy. The USAID program is active in all five of the nation's health regions. (ABT is in five regional directorates and University Research Corporation [URC] is in three.) The team selected three regions— Occidental, Paracentral, and Oriental—for cultural and geographic diversity. The other two were deemed by the Director General of Health in MSPAS to be similar to those chosen.

At the regional level the team conducted focus group discussions with regional directors and SIBASI and hospital directors, among others. (Each region has four to six SIBASIs that coincide with the region's departments.) We then asked to visit one municipality in each region where there is close intersectoral collaboration. The idea was to learn the elements of their success in the hopes that they would serve as models for other municipalities.

At the municipal level the study team split into two groups and visited the following respondents: the mayor, the Community Development Association (Asociación de Desarrollo Comunitario, ADESCO), the health center directors, and local NGOs to conduct interviews. We also conducted focus group discussions with health promoters, high school students, mothers identified at the health units, and CSWs and MSMs identified by PSI. In all cases, we went to municipalities with known success stories to learn about what led to the successful partnerships of health with other sectors.

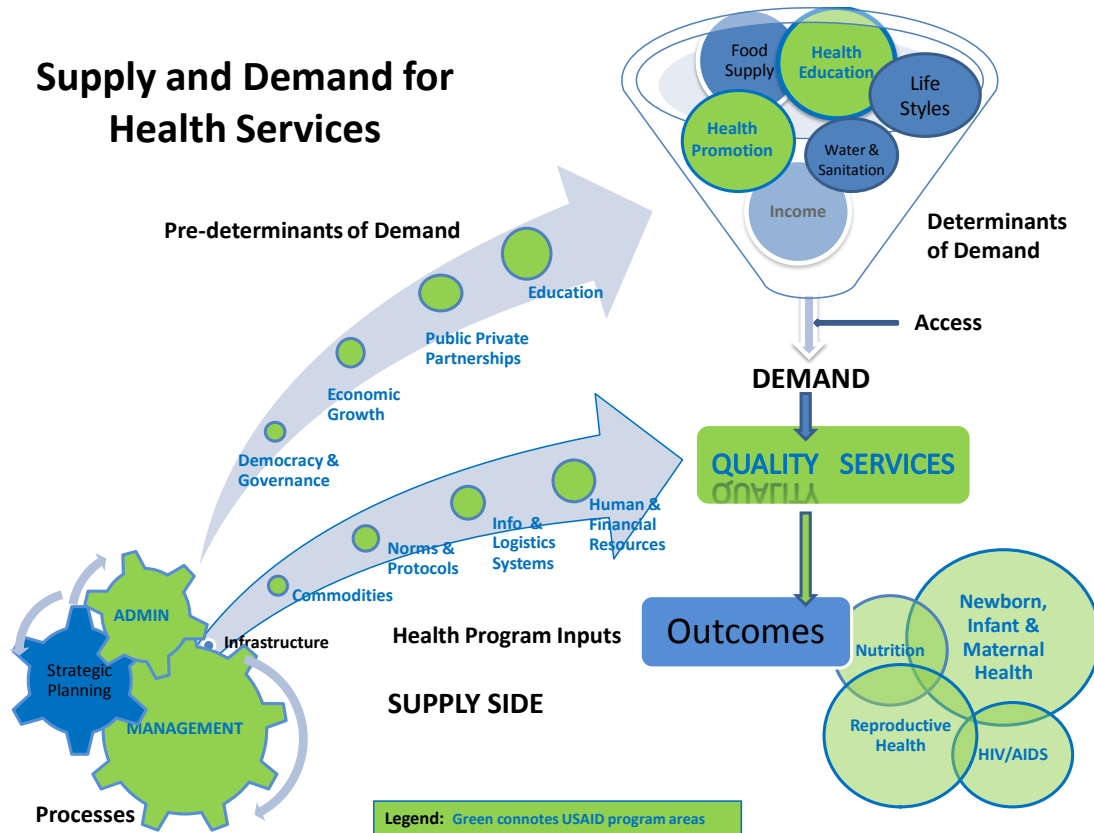
Given the purpose of the study and the type of data collected, the team's approach was to perform a content analysis to reveal patterns in the results in order to identify recurring themes. To improve the validity of the results, we triangulated our questions among an array of respondents. The fact that the study team was multidisciplinary enhanced the ability to interpret patterns and themes with increased confidence because of the differences in perspectives and backgrounds. Interview guides were tailored to the type of respondent interviewed (see Annex D: Illustrative Interview Guide—MSPAS Regulation Directorate).

Conceptual Framework

The team created a conceptual framework to depict principal determinants of demand for health services and factors that affect the availability, diversity, quantity, and quality of the services provided, primarily by MSPAS (see Figure 1). This framework determined the structure of the assessment, the choice of respondents, the organization of interviews, the structure of the analysis, and the flow of this report.¹⁶

¹⁶ For a full discussion of all the elements of this framework, see Annex E: Description of the Conceptual Framework—Supply and Demand for Health Services.

Figure 1: Supply and Demand for Health Services



FINDINGS AND INTERPRETATION

CONTEXT

Description of the National Health System

The GOES has a complex health system comprised of independent public agencies providing services for different sets of beneficiaries. The new National Health Policy creates a National Health System consisting of seven government agencies: MSPAS, FOSALUD, the ISSS, the Military Health Service, the BM, and the ISRI. All entities have their own budgets, personnel, information systems, etc. MSPAS, ISSS, and the Military Health Service have their own facilities; and all order their own drugs and supplies and hire their own personnel. By decree MSPAS is charged with the role of steward or “rector” to provide oversight and to integrate all government health agencies into one unified system.

FOSALUD is a separate agency under the auspices of MSPAS. It was created by law in 2005 to extend primary care to areas with high population, service demand, and epidemiological risk or difficult access and in response to emergencies. The FOSALUD by-laws seem to indicate that it would work through other entities, specifically SIBASI (the Integrated Basic Health System, an administrative level between the region and the municipality)¹⁷

Art. 6.- El FOSALUD aplicará un sistema permanente de monitoreo, evaluación e inspección de los programas y proyectos financiados por dicho Fondo que desarrollen los organismos encargados de la prestación de los servicios, verificando sus objetivos, metas y la calidad de los servicios esenciales de salud brindados.

However, FOSALUD is delivering service directly, hiring its own personnel for 6-month contracts, buying and distributing drugs and supplies, and operating after regular hours (nights, weekends, and holidays) in MSPAS health units. FOSALUD has a budget of \$20 million to operate in 148 of the 400 MSPAS units but has no responsibility for maintaining the property or paying rent. By law, it cannot commingle its funds with MSPAS, even though MSPAS is chronically short of personnel and drugs. MSPAS patients are often referred to seek services from FOSALUD after hours because it does not suffer stock-outs as often. Five mobile units provide services in underserved areas and at disaster sites.

ISSS has 804,000 paying subscribers, about 19% of the population, and covers approximately 1.3 million people, including subscribers’ children 6 to 12 years old, who became eligible in 2004.¹⁸ Of the insured, 83% are private and 17% public sector employees. ISSS has a network of service centers with 10 hospitals, 34 medical units, 38 communal clinics, and about 236 enterprise clinics located in private companies. The ISSS budget for 2007 was \$347 million, 2% of GNP, an amount very similar to the budget of the MSPAS, which is responsible for four times as many people.

ISRI provides rehabilitation services for handicapped persons, but 77% of them do not have access to these services. Of the 11 specialized ISRI units, nine are in San Salvador; the other two are in Santa Ana and San Miguel. Altogether it is responsible for 4.44% of the population. ISRI provides physical and occupational rehabilitation services through MSPAS hospitals and health units and private clinics.

¹⁷ Corte Suprema de Justicia, Decreto Ejecutivo No. 57, June 7, 2005, Reglamento de la Ley Especial para La Constitución del Fondo Solidario para la Salud, San Salvador, 2005

¹⁸ Instituto Salvadoreño del Seguro Social, Estadísticas 2007.

BM, which is under the auspices of the MINED, is in essence a form of health insurance for teachers and other MINED employees. BM reimburses MSPAS and private pharmacies for services and drugs. The majority of its providers are located in urban centers, mainly the larger cities.

The private sector provides approximately 15% of all health services, and NGOs account for approximately 7% of the total.¹⁹ In addition to providing their own services, NGOs under contract by MSPAS and ISSS complement and extend those services. Through RHESSA (Proyecto de Reconstrucción de Hospitales y Extensión de los Servicios de Salud) six NGOs have contracted with MSPAS—the Asociación Salvadoreña pro Salud ASAPROSAR), FUSAL, CALMA, AMS, FUNDEMUN, and SERAPHIM—to offer services through community health promoters and mobile medical teams who visit families in poor northern communities. Integrated services include health and nutrition for pregnant women, labor and delivery, postpartum care, and child health services. They also promote family planning and environmental health, provide cervical and breast cancer diagnostic services, and conduct epidemiological surveillance. With support from the Global Fund, more than 30 NGOs are working on the GOES National Fight Against AIDS²⁰. Through civil society, these NGOs advocate for the rights of persons living with HIV/AIDS.

The CSSP, the High Council on Public Health is constitutionally mandated to secure health by overseeing drugs, health professionals, and establishments through on-site inspections. The CSSP is a 53-year-old institution under the jurisdiction of the president; it is not part of the new National Health System. The Health Code²¹ mandates that CSSP operate Professional Vigilance Boards to register and oversee health professionals. CSSP also registers and monitors the operation of pharmacies and health establishments and registers all drugs (currently some 29,000) used in the country.

The annual fees the CSSP charges for registrations finance its operations. Six CSSP inspectors visit pharmacies and other establishments periodically to monitor compliance with regulations. For example, in a 2001 study, 19 of 29 pharmacies studied had been visited by inspectors in the previous year.²² CSSP senior management stated they follow the news media to determine when an investigation is needed. They did not have any proactive approach for conducting investigations. Nor do they inspect the medical practices of individual doctors.

The CSSP does not currently accredit establishments or certify professional competency. However, although no Salvadoran entity performs this vital activity, the Health Code implies that this is a function of the CSSP:

¹⁹ Comisión Nacional de Seguimiento a la Reforma Integral de Salud, El Salvador, Propuesta de Funcionamiento del Sistema Nacional de Salud, p. 19, marzo 2007.

²⁰ Noteworthy are FUNDASIDA, Asociación ATLACATL “Vivo Positivo,” PREVENSIDA, Asociación de Mujeres “Flor de Piedra,” Asociación Entre Amigos, the Pan American Association for Social Marketing (PASMO), Comunidad Internacional de Mujeres viviendo con VIH-SIDA, Cruz Roja Salvadoreña, Fraternidad Gay Sin Fronteras, Orquídeas del Mar, Red Salvadoreña de Personas Viviendo con VIH, and Vida Nueva Positiva.

²¹ Código de Salud, Decreto 955, May 11, 1988.

²² Center for Pharmaceutical Management. 2003. *Access to Essential Medicines: El Salvador, 2001*.

“Art. 17. Attributes of the Boards are: . . . c) To oversee the practice of the respective profession and its respective subsidiary activities referred to in the second part of Art. 5 of the present Code”

“Art. 23. The Boards referred to in article 5 of the present Code, regulate the practice of the respective professions and their technical and subsidiary activities. The authorization to control such practice will be given to and under the responsibility of the respective Board. The practice of each profession includes the prescription, elaboration, administration, indication, or application of any direct or indirect procedure destined to the diagnosis, prognosis, and treatment of diseases, in order to achieve the prevention, promotion, protection, and recovery of the health of the people, as well as providing public, private, and expert advice as related to each profession..”

Furthermore, the CSSP is supposed to coordinate the preparation of health professionals by Salvadoran universities with all health sector entities, as follows:

“Art. 4.c) Contribute to the progress of the studies of the professions and disciplines related to the public health, by whatever means that it considers most effective and practical, collaborating with the University of El Salvador and other universities and institutions devoted to professional education and indicating the improvements to be introduced in the curricula, methods of education, and other means to achieve that purpose.”

Decentralization

Several informants emphasized the need for the MSPAS to be decentralized and specific roles assigned to each level. “Decentralization is a proven means to achieve governance.”²³ The argument is that the central ministry should establish norms and procedures, monitor compliance, and evaluate results, and the health regions should administer resources and supervise their use by hospitals and, through the SIBASI, health units.

Ultimately health goals will be achieved at the community level, where individuals and local governments make decisions about life styles, environmental conservation, and sanitary services. One MSPAS official explained that “the future of health lies in a grand alliance with municipalities” to undertake local health plans, with a major role for schools to teach health and nutrition and sex education. The Health Code provides that:

“Art. 337. The national, regional and local authorities of health must coordinate with the respective municipalities in the execution of work plans in order to avoid the creation of parallel services, duplication of services, or interference in activities which are conducted concurrently.”

²³ COSUDE, Berne, *Descentralización: Documento de orientación*, 2001.

The Municipal Code establishes the following health-related competencies for municipalities:

- “Art. 4.*
- 4. 2 Supervision of prices, weights, measures, and quality*
 - 4.5 The promotion and development of health programs, such as environmental cleaning [and] prevention and combat of diseases*
 - 4.13 The regulation of the obligatory operation (extraordinary) of pharmacies and similar businesses for the benefit of the community*
 - 4.19 The provision of the cleaning services, street sweeping, collection and final disposition of solid waste*
 - 4.25 Planning, execution and maintenance of all sorts of public works necessary for the municipality”*

Within their municipal development plans, towns and cities can participate in formulating health plans and oversee their implementation. However, municipalities sometimes need technical strengthening, especially in managing their local health units, as a few already do. Support can and should come from health units exercising their role of “micro rector,” as one informant put it.

One regional director indicated that the previous attempt of the MSPAS to decentralize led to mismanagement and waste. For example, in 2001, “at the MSPAS, purchasing has been decentralized, decreasing the ability to negotiate prices for pharmaceutical drugs in large volume and providing little ... capacity for inventory management.”²⁴ This informant suggested that in the future regional personnel be adequately prepared before delegation and devolution to avoid a similar outcome.

A first step toward decentralization might be that suggested by SEAM in 2003²⁵ for drug purchases, which is to select preferred providers and competitively establish prices for all drug purchases by agencies, both public and private.

Political Context

There will be a presidential election in March 2009. The two contending parties are the incumbent conservative ARENA party and the FMLN (Frente Farabundo Martí para la Liberación), a leftist party. The assessment team recognizes that the outcome of the election seems likely to affect USAID’s options for current and future health strategies because the parties have differing health priorities and approaches to health problems. While the party plans have substantial differences in programs, particularly as they relate to social participation, both agree that the government should increase investment in health; build health management capacity, especially fiscal; assume more leadership in the health sector; and exercise its regulatory role. Regardless of who wins the elections, this will likely require dynamic legal reforms by both the presidency and the legislature. This might be a condition that USAID will need in order to harmonize its next strategic plan with long-range GOES plans.

FMLN has published a plan of government with health sector priorities. Party members described their principal differences with ARENA to be a focus on reducing out-of-pocket expenditures and an emphasis on preventive health through intersectoral collaboration. ARENA’s is a more vertical and curative model. The MSPAS as rector must get other sectors to put health on their agenda. FMLN suggests that MSPAS must also regulate private medical practice in terms of quality, infrastructure, referrals, and counter-referrals. FMLN would also pass drug legislation. To finance a national health plan will require fiscal reform and a sustainable debt policy.

²⁴ Center for Pharmaceutical Management. 2003. *Access to Essential Medicines: El Salvador, 2001*.

²⁵ *Ibid.*

ARENA has prepared its campaign proposal based on consultations with over 100 health professionals and soundings by the presidential candidate in town meetings. Its methodology is to ask informants to identify problems so that the party can propose solutions. ARENA proposes to double the MSPAS budget in five years and prepare a long-term health plan through 2030. “More and better medicines” is the slogan that covers joint purchasing and a law for generic drugs. The party proposes to “validate” university programs and provide academic incentives to prepare mental health professionals. It also offers to harmonize salaries between ISSS and MSPAS and incorporate such welfare innovations as specialized centers for the handicapped and senior citizens, improved emergency response, and a regional training center on HIV/AIDS.

Mayors and deputies will also be elected in 2009, which will determine governance in the National Assembly (legislature) and local governments and affect their approaches to health problems.

HUMAN RESOURCES

The topic of human resources entered into most conversations no matter who the respondent was, in terms of training, employment and deployment, and personnel performance. Pre-service training was discussed primarily in terms of the knowledge base and skill sets needed for employment. This is inextricably linked to deployment, which in turn led to discussions on incentives, or lack thereof, for personnel performance.

Training Service Providers

Training was by far the theme that resonated through most interviews. The basic problem is that students of medicine, nursing, and dentistry are not trained on MSPAS protocols and norms and the clinical and counseling skills they learn are outdated. They also have had only nominal training in public health and no preparation for management and administration. To remedy this, MSPAS trains students during their social service tour, but the training is informal, not standardized, and often deficient. Time spent on training takes away from on-the-job provider time. And after each year MSPAS loses this investment in human capital, so the vicious cycle repeats itself. Indirect costs include the absence of training staff from health units, which limits service. One informant declared that between October and December health units are empty because of staff training.

The National University of El Salvador (UES) graduates approximately 50% of all health personnel. At the moment, there is no correspondence between the professional profiles of medical and paramedical personnel produced by the universities and the job descriptions used by the MSPAS, which is the main health sector employer. In spite of the importance of education, neither the National Health Policy nor the National Health System recognizes training institutions as members or collaborators. In central teaching hospitals where professors are also practitioners, the students learn better, as in the Convenio Zona Sur, which gives students practical field experience before graduation. Both the UES and Evangelical University see the clear need for curricular reforms and changes in pre-service preparation to build competence in public health. The Evangelical University has agreed with MSPAS to design and implement a postgraduate masters program in family health and field epidemiology, mainly to prepare personnel for the MSPAS. The UES already has postgraduate programs in public health and hospital administration.

Employment and Deployment

Each year some 500 medical students perform their social service year, occupying 416 posts in MSPAS health units. While the MSPAS cannot reject anyone performing mandatory service, it can determine who will be paid. It pays students who accept the more rural and challenging posts. No pre-service examinations are administered before these students embark on their assignments.

All new MSPAS hires are vetted by the minister after the Administration Directorate presents three applicants for each post. FOSALUD does not evaluate candidates for contract positions; it takes all applicants regardless of their qualifications and offers six-month contracts that can be renewed depending upon performance and demand for services. FOSALUD states that it conducts

programmed supervision twice a month and more frequently when special circumstances require. Considering the limited number of supervisors, this would keep them continually on the road.

A critical subject related to service quality in relation to essential obstetric care is the shortage of obstetricians, pediatricians, and anesthesiologists. Among the 28 maternity wards in the nation, only six have obstetricians available 24 hours a day (four in San Salvador, one in Santa Ana, and one in Sonsonate) Filling this void are general medical residents, who perform highly specialized tasks such as cesarean sections (the percentage of caesarean sections runs above 30% and is increasing because of adolescents and previous caesarean operations). This situation complicates efforts to diminish perinatal mortality, which has been increasing in all regions despite training in neonatal resuscitation and monitoring of the third stage of delivery by medical and paramedical personnel. On the other hand, in FOSALUD, unemployed specialists (obstetricians, pediatricians, surgeons, and others) are being contracted to work as general physicians. This is a serious waste of resources.

Gaps in Human Resources

In summary, the gaps affecting human resources are:

- *Medical and Nursing School Pre-service Training: Inappropriate curricula and lack of forums to discuss and resolve differences between universities and MSPAS*
- *Selection and Deployment of Personnel: Lack of pre-service examinations, staff not assigned according to need, and specialists working at general medical posts while general practitioners function in specialist posts*
- *Evaluation and Performance Incentives: No competency evaluation for licensing; no certification for specialists; no accreditation for establishments; and no clear criteria for performance-based bonuses*

Personnel Performance

The major challenge for personnel performance is to improve staff efficiency, but a related struggle is the consistent and fair application of salary incentives. Annual salary increases for health-care personnel are mandated at 3% for cost of living plus performance-based merit increases of up to 5%. Performance that is rated excellent will yield a 5% increase, very good 4%, and good—in practice the lowest rating—3%. Since ratings are subjective and pro forma, there is no incentive to improve staff efficiency or rigorously apply salary incentives.

ADMINISTRATION AND MANAGEMENT

Administration and management are the hallmarks of any system. Organizational structures can facilitate smooth service delivery or navigate the system into dangerous waters. Repeatedly the team was alerted to the inability of the MSPAS to plan and budget effectively and the impact this has on resource allocation. The team also heard a great deal about the importance of health system integration.

Planning and Budgeting

High-level MSPAS informants expressed the need for a 10-year strategic plan that can survive changing governments. For one reason or another MSPAS has not been able to use its wealth of information to advocate and formulate plans and link them to budgets. The health system is at no loss for information; in fact, that is one of its strengths. Although the various information systems need to be linked together to optimize efficient use of data, at least it is readily available. For the moment, however, the MSPAS “strategic plan” is a collection of campaign promises adjusted to budgetary constraints without long-term objectives that could justify real investment in health. The Financial Planning and Health Economics System can assign resources but because there is no strategic plan needs cannot be defined or financial requirements calculated. As a result the Ministry

of Finance provides support on an ad hoc basis, making up for shortfalls and drug outages along the way.

From 2005 to 2007 the MSPAS budget increased from 1.70% to 1.73% of GNP, and its share of the GOES budget (excluding debt service) went from 16.9% to 18.7%. Budget execution for operations and investment improved from 93.2% in 2005 to 97.8% in 2007.²⁶

Both ARENA and FMLN promise to gradually increase the health budget beginning in 2009. Regional health directors and their technical and administrative teams declare that if annual budgets are increased (for example, doubled in four years, as ARENA promises), they could solve many of their problems. However, at first glance insufficient funding does not jump out as a major impediment. Instead, it is the planning, allocation, and management of budgets and information that draws attention. A discussion on increasing budgets is premature until there are observable advances in the efficient use of current budgets.

Resource Allocation

The GOES offers ready online access to many of its information systems, although use of the data is questionable. There is information on morbidity and mortality, service production, logistics and supplies, and management and administration. However, these are vertical systems; cross-referencing and linking information from different systems is tedious at best, making it hard for a manager to compare costs to production. There is no personnel information system.

On paper, there is a classification that ranks health units according to type of services available (e.g., A centers provide more than B, etc.), but the classification system is neither being observed with regard to personnel assignments nor related to epidemiologic need. In short, the validity of the classification system for resource allocation is questionable. The functional roles and interrelationships of the 28 hospitals have not been defined either.

Central referral hospitals eat up a disproportionate bite of the budget because they absorb the brunt of cases that cannot be treated at secondary and primary levels of care. One reason patients cannot receive appropriate care at lower levels is a lack of supplies and drugs. Poor planning for resources at all levels of care perpetuates patient overload for hospitals, which continually request additional funds. And since resources are limited, the funds are diverted from health units, exacerbating their deficiencies. Thus the door continues to revolve.

Drugs, equipment, and supplies are inefficiently distributed. For example, some hemodialysis and radiology units are underutilized, but the units are scarce where they are needed most. A study the UES conducted in 2006 on drug pricing and availability showed that 44% of 43 essential drugs studied were not adequately available in MSPAS units vs. only 23% in ISSS units.²⁷

Health System Integration

The fragmentation of the health system was a concern for many respondents. The new National Health Policy and Health System Law should facilitate harmonization of the six government agencies responsible for providing health services, but it is incumbent upon MSPAS to take the lead. On the surface, there does not appear to be duplication of services, but neither are economies of scale optimized. Four of the six agencies have their own information systems, their own procurement mechanisms, and their own personnel recruitment procedures.

²⁶ R. Meerhoff, "Bases para Establecer las Meta de Logro en los Objetivos de Proyecto, Dirección de Planificación," MSPAS, 2006.

²⁷ E. Espinoza and G.F. Guevara, *Disponibilidad y precio de medicamentos esenciales en El Salvador durante el segundo semestre de 2006* (San Salvador: Universidad de El Salvador, 2007).

The one instance where the agencies unite with one voice is the mandatory reporting of 78 diseases to the MSPAS Directorate of Epidemiologic Surveillance and Information. This directorate tracks communicable diseases weekly, reporting on 10 of them daily online.

The ISSS director believes that integration of the six health agencies should follow lines set down during health reform deliberations since the late 1990s in which ISSS would assume responsibility for all public hospitals and MSPAS for all primary health units.

Gaps in Administration and Management

Gaps in administration and management are found in two areas:

- *Strategic Planning and Budgeting:* At the MSPAS central level, there appears to be a lack of understanding about what a strategic plan is, how to make one, and how to use it as the basis for operational plans and budgets.
- *Using Data for Decision Making:* Data are not used to build a strategic plan; nor does MSPAS make full use of its information systems to allocate resources.

SERVICE PROVISION

Implicitly discussions of service provision relate to quality. However, little mention was made in these interviews about quality; issues related to capacity and coverage of services dominated the discussions. Respondents were mostly focused on services that were missing and the endemic problem of drug shortages. Approximately 80% of the pharmaceutical market consists of medicines sold in the open market, and the remaining 20% of public sector use in health facilities.

Respondents had to be prompted for opinions on monitoring and supervision and to a lesser extent accreditation of health facilities and certification of health providers. While this opened some discussion, these themes did not seem to have high priority.

One of the main premises behind this study was that services are best delivered through intersectoral collaboration. To confirm this hypothesis, the team sought to visit municipalities that might serve as best practices. Examples are offered at the end of this section.

Capacity and Coverage

According to MSPAS data, between 2005 and 2007 institutional prenatal registration of women 10–49 years increased from 51% to 73% and early registration of pregnancy went from 44% to 48%. During the same period, coverage for postnatal care for women 10–49 years increased from 48% to 62% and deliveries by qualified personnel went from 44% to 58%. The percentage of childbirths by caesarean seems to be stuck at around 28%; the basic essential obstetric care package (e.g., obstetrician, pediatrician, anesthesiologist on call 24 hours) is absent in the majority of hospitals. Infant care coverage is down from 64.55 to 57.6% and coverage with pentavalent vaccination is down from 90% to 77%. In spite of increasing coverage for maternal-child care, low birth weight still hovers around 7–8%. Maternal mortality is 50/100,000 live births and fetal mortality is 10/1,000 live births, with neonatal mortality at 9/1,000 live births and infant mortality at 13/1,000 live births. In fact the mortality rate for children 1–5 increased, from 13/1,000 live births in 2005 to 15/1,000 live births in 2007.^{28 29}

²⁸ MSPAS, *Coverage Trends for Institutional Health Indicators*: 2005 and 2007.

²⁹ Total fertility has been on the decline. Due to the decreased birth rate, denominators for key child health indicators are getting smaller, and due to an increase in infectious diseases affecting children 0–5 years, the numerators for perinatal and child health indicators are getting larger. The combination of these factors has helped increase perinatal and child mortality. Norms and protocols used at the local level do not allow for early

In the Occidental, Paracentral, and Oriental Regions, the technical staff indicated that perinatal mortality is rising, and in some cases so is maternal mortality, due to obstacles in applying treatment protocols at hospital level, since the majority of the deaths were in hospitals, not the community.

Implementation of the Family Health Model has been a factor in increased preventive services and coverage. Nevertheless, there are structural obstacles to its universal viability, at least for the most vulnerable population. The file for family records is designed to show the family health diagnosis in the home and to identify health problems. It includes a tool for planning interventions that describes the problems and interventions to be applied but it does not define who is responsible, when the intervention should take place, or how health promoters should follow up.

The minister and several other respondents mentioned insufficient or missing services and poor coverage. The minister highlighted the need for better services for handicapped persons, especially the visually impaired, and oral health, as well as keeping pace with the country's epidemiological transition to chronic and degenerative diseases. Many reiterated the importance of safe water and solid waste removal.

There is consensus that the GOES has done an excellent job controlling dengue fever outbreaks and malaria, and clearly infant diarrhea and acute respiratory disease have been kept at bay, as witnessed in the dropping mortality rates.

To address the problems of insufficient coverage and inability to reach all the catchment population, MSPAS and ISSS contract for services to NGOs, such as CALMA, the Association of Salvadoran Women (AMS), ASAPROSAR, Fusal, Seraphim, and Fundemun. These NGOs are providing primary care services in underserved areas. GOES demands a 10% performance guaranty, and banks are requiring real property as collateral, which some NGOs, such as CALMA, do not have. MSPAS pays out after 90 days but makes no advances. It reimburses at the rate of \$16 per person/year for the whole population in a catchment area if certain performance goals are achieved (e.g., 90% of pregnancies identified and recorded in first trimester, 90% of newborns seen and registered in first 28 days, etc.) MSPAS withholds 10% of payment against proof of goal achievement. However, MSPAS does not hold itself to the same standards it expects of contractors. There is no NGO coordinator or office for outsourcing contracts in the MSPAS.

Monitoring and Supervision

The directors of the Occidental and Oriental Regions presented summaries of the health situation in their areas using coverage and mortality indicators with a good level of analysis. In none of the regions did we observe that the Monitoring and Evaluation Units of SIBASI systematically process evaluation information and make supervision and monitoring plans based on the results, although the units do have a document to evaluate management commitments for follow-up use. All the health units visited had a situation room with graphs showing local disease trends, coverage of preventive services, and maps of obstetric risk to ensure timely labor and delivery care. However, other processes related to pregnancy, such as postpartum and perinatal care, did not make use of these maps, even though health promoters do use integrated community maps to monitor maternal and child care as well as conditions in the home.

The best example of a situation room was in the El Congo Health Unit in the Department of Santa Ana, Occidental Region. The information it contains is useful and continuously updated to make decisions in the municipality, down to the detail of showing addresses of pregnant women according to probable date of delivery. The systematization of this situation room surpasses MSPAS standards as a result of the initiatives of the directors of nursing and medicine and their health team in the community. However, in the health units of Apastepeque in San Vicente (Paracentral) and

detection of infectious disease or malnutrition in children. Children treated at late stages of an infection or who are malnourished are at increased risk of death.

Chinameca in San Miguel (Oriental Region), the tools in the situation rooms were dispersed and out of date, with errors in graphing some coverage indicators.

In the maternity ward of San Vicente Hospital, personnel stated that committees monitoring maternal and perinatal mortality and the committee for prevention of hospital-acquired infections are operating. However, the committees are not multidisciplinary (e.g., resident nurses, epidemiologists, obstetricians, and pediatricians) and cannot provide a multifaceted analysis of the information produced by the Perinatal Information System and the Epidemiological Surveillance System to deal with quality of preventive care and maternal and perinatal mortality and morbidity and their causes.

Accreditation and Certification

Once they graduate and are registered by the CSSP, to maintain their licenses nurses and doctors are only required to pay an annual fee. There is no requirement for updating skills or knowledge, which means there is no incentive for them to continue learning after graduation. Furthermore, doctors and nurses who specialize in pediatrics, obstetrics/ gynecology, nurse midwifery, etc. are not required to sit for competency examinations in their specialty once they have completed their residencies. CSSP seems to have interpreted its legal mandate of professional control as mere registration, with no certification and accreditation. Neither CSSP nor its Professional Boards (“Juntas”) have resources or procedures in place to ensure the quality of professional practice. Further, they do not maintain collaborative relationships with universities or professional societies to improve curricula, instructional methodologies, or assessments of professional competencies.

Similarly, maternity wards are not classified according to the level of care they are prepared to provide. Health units have such a classification on paper but it does not seem to be relevant or functional.

Intersectoral Collaboration

The central MSPAS has minimal ties to development sectors that affect health status (the economy, agriculture, education, public works, housing, basic services, safe water, environmental health), and the assessment did not detect any proclivity to establish or tighten such ties. On the other hand, we visited local MSPAS units that have considerable experience in intersectoral collaboration, working in coordination with municipalities and departmental governments on projects like mosquito eradication, sex education, emergency planning, rescue of street children, and trauma prevention.

Local governments have a legal mandate to protect and promote the health of their citizens. In El Congo municipality the mayor uses a portion of her FODES (Development Fund for Municipalities) funds to provide transportation to the health center. In addition to patient referrals to the next level of care, the health center also provides weekly transport so health providers can carry out community outreach. All municipalities are supposed to have a municipal development plan and budget, but observance of the mandate seems sketchy. However, some plans do have a health component.

In the Occidental Region the NGO ASAPROSAR is using a municipal law as a platform for two health projects. Santa Ana and Sonsante municipalities have enacted ordinances to protect the rights of marginalized children and adolescents. The law calls for an intersectoral commission comprised of the mayor’s office, MSPAS, the police department, and schools to advise on the use of allocated funds. One ASAPROSAR project, *Brotos de Esperanza*, benefits children 0-6 years and their families through education and nutrition. The other, *Angeles Descalzos*, is oriented to eradicating child labor among those 6-18 through education and psychological support.

Municipalities can also promote health by providing transport to hospitals for pregnant women and newborns. The municipality and health unit in Perquín operates a waiting home for pregnant women, who reside there for a few weeks before their due dates. When they go into labor the municipality provides transport to a nearby hospital.

A rich area for intersectoral collaboration is programs directed at high-risk adolescents to prevent gang violence, early pregnancies, and unsafe sex. High school children interviewed spoke at length about friends in gangs who were murdered and the ubiquity of illicit drugs and alcohol. One boy said, “My friend is an alcoholic and can’t stop drinking because there is alcohol everywhere—even where we eat our lunch. . . . And many of us have parents who drink heavily.” All adolescents interviewed were intensely interested in getting accurate information on sex, contraception, and HIV transmission.

Gaps in Service Provision

The main gap in service provision can be summarized in one word: quality.

Compliance with norms at all levels is largely determined by the knowledge, attitudes, and practices of professionals in health units and hospitals, and these seem to be spotty at best. Verification of compliance and correction of bad practices is a function of monitoring and supervision. Here there are severe limitations, both in using information to detect problems and in reaching sites to correct problems with hands-on in-service training. Gaps in service quality are also caused by inadequate management of human resources (training, selection, deployment, and performance evaluation and incentives) and lapses in administration and management (planning, budgeting, and information-based decision-making).

Despite high demand for interventions to reduce gang violence and drug use, decrease adolescent pregnancies, and educate youth on HIV transmission, services to benefit adolescents tend to be insufficient.

DETERMINANTS OF DEMAND FOR HEALTH SERVICES

Democracy and Governance

USAID/El Salvador’s Democracy and Governance (DG) team works at the central level to strengthen justice and the rule of law through electoral monitoring and to combat corruption through promotion of accountability and transparency. The DG team sees opportunities for tying its work to health issues through its efforts to monitor and lobby the Commission on Environmental Protection and Public Health of the National Assembly for health-related legislation.

Economic Growth

The USAID/El Salvador Economic Growth (EG) team implements three projects that directly or indirectly are tied to the promotion of health by improving economic conditions for the rural population.

The Artisan Development Program arose as a mitigation strategy to reactivate local economies in communities affected by earthquakes. It has become a permanent program in the EG strategy that has evolved into Aid to Artisans (ATA), a US private voluntary organization. Through 2009, 7,434 new jobs were created and accumulated sales and exports totaled \$5.7 million. In this program there are no direct experiences of sponsoring or subsidizing health services.

The Agricultural Diversification Program promotes development of small and medium-sized companies that will eventually abide by the labor law with payment of a minimum wage and affiliation with the ISSS. The program is based on fair-trade certification, for which foreign importers pay a premium of \$5/cwt of coffee that must be invested in the community; cooperatives decide where to make the investment (water, sanitation, roads, health, medicines, etc.). Farms are certified by the local NGO, Salvanatura, to assure international buyers that standards have been met for housing, potable water, and labor rights. There are also labels for organic products like coffee, sesame, and vegetables that certify that the producers do not use pesticides.

The third EG activity contributes more directly to public health. It is Improvement of Health and Phytosanitary Measures of Central America and the Dominican Republic, which promotes both plant and animal health and food inspection services.

Public-Private Partnerships

The USAID-supported Alianzas Project aims to stimulate funding of health projects by private companies. Companies match USAID funds two to one. RTI, the implementing partner, claims that this seed capital has built social responsibility in private companies by involving their customers, employees, and suppliers. However, the assessment team concluded that many of the projects are not directed to specific health goals.

The MSPAS has had success with social participation and intersectoral alliances. In the municipality of Perquín, the health unit has managed to be a dynamic part of a process of social participation, achieving alliances with different public and private entities to create and operate a maternity waiting home (*Casa de espera*) for the eight municipalities of northern Morazán. The Association of Social Participation for the Health of Perquín (ASPER), which supports community health management, operates the Casa, which was inaugurated in January 2007 in the village of Tejera. The Casa provides lodging for pregnant women from the eight municipalities plus several small villages in Honduras. It receives pregnant women one or two weeks before delivery and refers them to the hospital for attended births. In the Casa they receive care from maternal and child health staff from the Perquín Health Unit. ASPER provides food, which the women prepare. As a result, the percentage of hospital deliveries increased from 52% in 2004 to 98% in 2008. The perinatal mortality rate of the poorest municipality of the country, Torola near Perquín, went from 60/1,000 live births in 2005 to 11.7/1,000 live births in 2007.

Education

MINED, as the steward of the education sector, decides the health curriculum for all levels of education. The curriculum for middle schools and high schools covers human sexuality. In focus group discussions, high school students revealed that their parents refuse to discuss sex, pregnancy, and HIV/AIDS. They feel they need the straight facts on these subjects and underscored the need for their parents to also be educated. They feel that they have access to more information than their parents (e.g., through the Internet). Reliable information will help to dispel such myths as that taking a Valium with a cola drink will avoid pregnancy and that the pill and injectables cause sterility.

Earlier this year the president proclaimed that sex education should be incorporated into the public high school curriculum. This is significant given that the average age of sexual debut is estimated to be 15 for boys and 16.4 years for girls.³⁰ The USAID regional project, PASMO, is mandated to target only high-risk and vulnerable groups (MSM and CSWs); it cannot intervene directly with adolescents. However, through non-USG funding sources PASMO is now working with 12–24 year olds in public schools in three cities.³¹

³⁰ FESAL 2002/03, page viii.

³¹ PSI's preventive model uses participatory learning modules on self-esteem, "Knowing my Body," sexually transmitted infections, HIV/AIDS, courtship and love including pregnancy, human rights and discrimination. The Project for Your Life addresses problems with drugs, violence, and use of weapons. PSI's strategy is to train youth leaders, who receive diplomas and are committed to replicating the training for their peers in the same school. The content of the modules has been incorporated into school curricula nationwide in collaboration with MINED. Extracurricular activities are also included. There are Schools for Parents in high-risk communities to educate parents on family skills. PSI collaborates with children of ISSS beneficiaries in its communal clinics and also with the Youth Secretariat. The latter includes coordinating with school teachers to monitor the work of the youth leaders. (Source: Interview with Dr. Guadalupe Somoza, PSI's Adolescent Project Coordinator, November 10, 2008.)

DETERMINANTS OF DEMAND

Life Styles and Environment

Informants mentioned that municipalities have the principal role in providing conditions that favor a healthy lifestyle and environment that can reduce the incidence of chronic and degenerative diseases and control violence. In El Congo and Astapeque, the mayors report that urban areas have potable water and sewerage and that the municipality has constructed sports facilities and has a House of Culture where residents can exercise, spend leisure time, learn arts and crafts, and use computers and the Internet. The city of Santa Ana has an inter-sector health committee that has motivated the city council to provide lighting in dangerous areas and ensured police presence to control arms in difficult neighborhoods.

Food Supply and Income

Per capita GNP for El Salvador in 2004 was \$2,337. In 2006 average household income was \$442 per month,³² and the basic family food basket cost \$139 per month in urban areas and \$101 in rural areas.³³ The 10% of the population living in severe poverty cannot afford the food basket. The government is making efforts to draw new industries into the country to create jobs. For example, a Brazilian firm has located in El Congo and will employ some 5,000 people. The municipality holds biweekly labor fairs where employers can meet aspiring employees and give entry tests.

From 1992 to 2001 per capita food energy availability decreased slightly, from 2,492 kcal/person per day to 2,460 (the same as Venezuela and slightly higher than Panama, Guatemala, and Honduras)³⁴.

The major out-of-pocket health expense is for drugs. A 2006 study found that generic drug prices in El Salvador were two to four times higher than in Perú and five to ten times higher than in India. Bringing drug prices down to the level of Perú might save Salvadorans about \$75 million annually—an average of \$12 a person.³⁵ The Consumer Defense Center of El Salvador compared drug prices among all the Central American republics and found that of 20 name-brand drugs, eight were most expensive in El Salvador and six were most expensive in Costa Rica. In contrast, in Nicaragua 10 drugs were the least expensive in the region. For 20 generic drugs, El Salvador had the highest prices for seven, and Guatemala for five. Meanwhile, 16 generic drugs were least expensive in Nicaragua. As an example, one tablet of hydrochlorthiazide costs \$0.32 in El Salvador and \$0.03 in Nicaragua.³⁶ Several informants suggested that the few Salvadoran drug makers and importers collude on pricing, and retail drug stores make huge markups.³⁷

Water and Sanitation

Although MSPAS and municipalities seem to have conflicting mandates for environmental sanitation, the latter have all undertaken to provide potable water, sewer systems, and solid waste removal. With guidance from the health unit and the participation of the community and schools, the municipalities have controlled mosquito breeding and dramatically decreased the transmission of dengue.

³² Encuesta de Hogares de Propósitos Múltiples, Ministerio de Economía, DIGESTYC, San Salvador, 2006

³³ Política Nacional de Salud, MSPAS, San Salvador, 2008.

³⁴ The State of Food and Agriculture 2003-2004, FAO, Rome, Italy, 2005.

³⁵ Ibid.

³⁶ Centro para la Defensa del Consumidor <http://www.cdc.org.sv/noticias/News-23>

³⁷ Espinoza, E and G.F. Guevara, *Disponibilidad y precio de medicamentos esenciales en El Salvador durante el segundo semestre de 2006*, Universidad de El Salvador, San Salvador, El Salvador, 2007.

Health Education and Promotion

Municipalities and the MSPAS sometimes undertake health promotion. In El Congo, the town has a disaster preparedness plan and is preparing a development plan with a local advisory committee, which consists of representatives from health, education, ADESCO, public safety, emergencies, businesses, and tourism. The municipality has constructed sports facilities, operates a soccer school, and offers artistic and recreational outlets for all citizens.

Interinstitutional alliances to promote health include “My First Steps,” convened by Save the Children with the participation of MINED, MSPAS and the National Secretariat of the Family to promote good child-raising practices by explaining nutrition, vaccinations, risk signs, and first aid.

CONCLUSIONS AND RECOMMENDATIONS

This section describes the team’s conclusions and corresponding recommendations, along with their estimates of the feasibility and impact of each suggested intervention. The conclusions are organized in the following categories (see Figure 2): (1) policy and legislation, (2) pre-service education, (3) quality of care, 4) intersectoral collaboration, and (5) the private sector.

Figure 2: Conclusions and Recommendations—Themes



Clearly, policy and legislation and pre-service education are high priorities. Improvements in any one of the other themes ultimately will lead to improved quality of care. Notwithstanding, quality of care is next in terms of priority, and efforts here would probably yield more immediate gains because it is here that USAID can have the greatest and most direct influence. However, continuing to improve only the quality of care—a traditional role for USAID health programs—will not ensure sustainability. Services need to be supported by an efficient organizational structure and effective policies.

POLICY AND LEGISLATION

Conclusions

Health sector reform has led to the law creating the National Health System and its by-laws and to the National Health Policy, which provides a platform for integrated strategic planning. This is important because the current MSPAS plan does not specify long-range strategic objectives with corresponding budgetary allocations. The result has been a budgeting process that is haphazard at best and reacts to shortages rather than allocating resources based on need.

USAID should fully support implementation of the National Health Policy because it has been ratified by all six government health agencies. The policy presents 17 strategic directions that are a point of reference for all parties. As these directives are operationalized, it will become evident whether any of them require further consideration. The National Health Policy is a GOES priority, and lack of support from USAID would limit its impact.

In 2009 there will be a change in the administration of El Salvador. The new government will be in a position to address gaps and to require long overdue checks and balances within the health system. It will be in a position to interpret and if necessary create legislation. For example, the 1997 the health

ministry tested decentralization, but in 2004 it once again became highly centralized. Another example is current legislation that supports a “stove-piped” administration of health services by four ministries (Labor, Education, Health, and Defense). Further, CSSP could have a greater influence on the quality of services if it followed the law that assigns it responsibility to accredit health facilities, certify professionals, and assure university preparation for service.

HIO has access to a wealth of expertise in the DG team, which understands legislative processes and could translate health priorities to the people in power who can best ensure their execution. Coordination between these two teams is integral to the success of any new HIO strategy.

Recommendations

1. Senior mission management should review coordination between the three internal program teams and develop more formalized processes to facilitate it, especially between the HIO and DG Teams. This recommendation holds for the immediate future onward.
2. Looking forward to the next strategic plan, the HIO team could collaborate with the GOES Commission on Environmental Protection and Public Health of the Legislative Assembly. With technical support from the DG team, the HIO team could lobby party advisors and build coalitions to back public health legislation. Concurrently, the HIO and DG teams could work with civil society NGOs that could advocate at the local level. Illustrative examples might be
 - applying existing laws that stipulate interagency coordination at the central level³⁸;
 - legislation to regulate drug price margins and make pricing information more transparent and available to the general public; through other channels—not the Commission—work is needed to apply anti-monopoly legislation and increase competition from drug distributors in other countries; and
 - supporting an NGO watchdog that would monitor enforcement of laws already on the books, such as the HIV/AIDS law. (NB: USAID’s Health Policy Initiative supports amendment of the law and issuance of regulations for the prevention and control of opportunistic infections.)
3. The HIO team should consider broadening the scope of its health system technical assistance by supporting a central MSPAS long-term strategic health plan and budget (both majority parties are projecting 10-year plans). This could be initiated after the new administration is appointed in March 2009.
4. USAID should seek opportunities to advocate for decentralization. In the interim, it should continue to prepare the regional health authorities by building their capacity to plan, budget, and administer health funds in case decentralization is actualized. This and #2 fall within ABT’s current scope of work
5. The HIO team should consider the viability and utility of reviving the Donor Coordination Committee. USAID should position itself in a leadership role, perhaps as the secretariat. The role for including representation from the government’s “rector” as described in the new National

³⁸ Republica de El Salvador en La América Central, Decreto No. 82—Reglamento de Ley de Creación del Sistema Nacional de Salud, July 17, 2008.

Health Policy should be considered after March 2009 when leadership changes.³⁹ USAID can have a determining role by convening donors in informal discussions that establish a common agenda for the Donor Coordination Committee outside the influence of the government.

6. The National Health Law calls for formation of a directorate tasked with operationalizing the National Health Policy. It is recommended to include donor agencies on this directorate, which is comprised of the government agencies involved. However, if that cannot be done, an important agenda item for the Donor Coordination Committee would be to form an advisory board to support implementation of the new National Health Policy. The board should include technical representatives from all six government health agencies and other prime actors, such as universities and CSSP. Given that the National Health Law and Policy became effective in the second half of 2008, this recommendation is immediately relevant.

Feasibility and Impact of Recommendations

Over the years the DG team has nurtured relationships with politicians, policy makers, and civil society groups. Because of their credibility and understanding of the legislative process in El Salvador, they are in the best position to facilitate the legislative and policy work needed to implement these recommendations. As the National Health Policy is put into action, topics such as interagency coordination and decentralization should be revisited. Because four independent ministries are involved, the likelihood of change in the first several years is minimal. Discussion on such topics arose during the years it took to draft the policy, but consensus was not reached. USAID should consider interagency coordination a long-range goal; its influence could possibly be marginal.

On the other hand, depending on the new administration, the time might be ripe for decentralization. There are past experiences to learn from, and accepting the reform mostly requires buy-in from MSPAS. The legislation has already been passed, and there is demand from regional directors to activate it. The impact would be far-reaching and could alleviate problems with resource allocation and shortfalls, especially since USAID has been strengthening regional management capacity. One advantage of decentralization is that because of their proximity to the end users of the system, civil society and municipalities are in a better position to exert pressure and demand quality.

The HIO team currently has a project focused on health systems strengthening. Its scope should be interpreted more broadly to include strategic planning, which is integral to the work on financing and administration. The next logical priority for MSPAS is to operationalize the National Health Policy. To improve the likelihood of its success, budget allocations will need to follow—especially to implement the outreach components of the family health model that requires household visits. HIO contractors can reinforce MSPAS analysis and capacity to use existing information systems, allowing MSPAS to justify budgetary allocations to the Ministry of Finance. USAID/DG, in coordination with the deputies of the Commission on Environmental Protection and Public Health, can work to facilitate passage of the annual budget and salary laws.

The resurrection of the Donor Coordination Committee is probably the easiest to implement, assuming that the Pan American Health Organization (PAHO) is willing to cooperate. However, the committee would need strong leadership if it is to have substantive impact. While including the

³⁹ Policy 4.5.1: "To develop the capacity of the MSPAS 'rectora in health' involves the development of leadership to guide the institutions of the sector and mobilize institutions and Social Groups in Support of the National Health Policy. This includes the coordination of technical inputs, and economic policies that can provide multilateral and bilateral agencies engaged in technical cooperation and / or financial health in the formulation and implementation of national health policies and strategies." Fiscal responsibility is another leading role that the MSPAS must exercise to "ensure, monitor and adjust the complementarity of resources from various sources to ensure equitable access of the population to health services" (Source: OPS-OMS-USAID-LACHSR, Función Rectora de la Autoridad Sanitaria Nacional, Desempeño y Fortalecimiento, Edición Especial No. 17, pg. 18.)

government on this committee might at times slow progress, its achievements would likely be more sustainable in the long run. Again, USAID can have a determining role by using informal discussions with donors to establish a common agenda.

EDUCATION

Conclusions

The problem of unprepared medical and nursing graduates perplexed almost every manager interviewed. The historical reasons for this go back to the civil war, when the military seized the universities, which they considered to be leftist hotbeds. Not unique to El Salvador, universities and ministries often do not invite each other to their symposia, workshops, etc. This divorce between MSPAS and the universities, especially UES, is causing costly dislocations to the whole health sector (e.g., training costs and time spent away from patient care while attending in-services, inaccurate diagnoses, and inappropriate treatments that require redoing). The Central American Health Ministers Commission (COMISCA) could also be a prod to form joint task forces. PAHO notes widespread cooperation for re-engineering to enable ministries of health to exercise their leadership role within the context of reform—a reform that has been in full swing in 20 countries in the Latin America and Caribbean region for over a decade.⁴⁰ Alas, in this trend El Salvador lags behind.

While pre-service examinations seem an obvious response to the problem, MSPAS political considerations have stymied it for now. But ISSS and MSPAS require universities to administer their own pre-employment examinations before resident physicians are allowed to practice. This experience should be reviewed more closely and might prove to be a model.

Apparently, current CSSP senior managers are not adhering to their legal mandate to collaborate with universities to improve education and have not identified the need for pre-service curricula to respond to MSPAS needs. Much of the success of this intervention hinges on the commitment of the new CSSP leadership after next March as well as the availability of resources.

Recommendations

1. Lines of communication need to be opened between UES and MSPAS. Separate task forces for medical and nursing curricula comprised of representatives from universities and principal service provider employers (MSPAS, ISSS) with donor support could be useful to facilitate new curricular designs. GIDRHUS (Grupo Interinstitucional de Desarrollo de Recursos Humanos en Salud) is currently the coordinating mechanism for addressing human resource needs within government health agencies. This interagency group regulates policies and administrative systems for human resources. GIDRHUS is comprised of representatives of MSPAS, ISSS, and other government health representatives; universities; health providers; and international donor agencies. The MSPAS, as part of GIDRHUS, regulates and promotes HR policies and administrative systems. Norms and protocols developed with USAID assistance could contribute to the implementation of the following actions:
 - Coursework in public health, including the Family Health Model as presented in the NHP
 - MSPAS standards, norms, and protocols
 - Student practicums in primary health care units
 - Creating work incentives for physicians to promote quality of care in the neediest communities. The MSPAS can assign jobs and pay doctors who go to work in the poorest, most remote towns.

⁴⁰ PAHO, Evaluation of the Strategic and Programmatic Orientations, 1999-202, Washington DC, 2002.

Feasibility and Impact of Recommendations

If USAID is to have a voice in the agenda of the task forces, it would need to provide funding. According to several key figures at UES and the Evangelical University and others, PAHO would be a better mediator than USAID, especially given the attitude of UES to the USG. USAID's work in improving clinical care and implementing norms and protocols might give it some leverage considering its first-hand experience with the problems in the facilities. The likelihood of success is low in the short term but this intervention is necessary to prepare for USAID phase-out. All training of health providers would eventually dissipate if the system continues to produce ill-prepared providers after USAID programming ends.

Pre-service testing by the universities is needed before students are deployed to their social service assignments. It is a focused and necessary precursor to delivering quality services. For this reason, it is a good starting point for USAID because it is in line with program goals and ultimately supports in-service training. Allowing high scorers to be paid higher salaries will be an incentive, but they likely would not consider it a plus to go to a hardship post. Yet it would be unethical to send the poorest performers to serve the populations who need the care the most. This is the rationale for a second incentive: to give them priority posts after their graduation. As long as there is a surplus of physicians graduating every year, the second incentive might suffice. But there is no surplus of nursing students graduating, so alternative incentives might be warranted. Agreement on the need and content of the pre-service exams might be easier than administration of the incentive structures.

USAID can have more direct and immediate impact by applying its distance learning experiences in the education sector to health facilities. This will relieve MSPAS training costs, decrease absenteeism, and allow for more flexible scheduling and self-paced learning. Investments in computers and Internet access will also optimize such other functions as data reporting, procurement requests, and communications.

QUALITY OF SERVICES

Conclusions

The trend to increase service coverage for maternal and child preventive services has not reduced maternal and perinatal mortality much. This is due to a lack of adequately trained service providers; inadequate monitoring and medical supervision; frequent shortages of medicines, supplies, and equipment; and the lack of essential obstetrical care services in maternity hospitals. An especially critical element is the distortion of staffing that FOSALUD contracting is causing. Unemployed specialists are being hired to perform general medical functions while generalists are attending obstetric and pediatric wards and performing caesarean sections—leading to complications and maternal and child deaths in more than 20 hospital maternity wards.⁴¹

MSPAS has not been successful in its attempt to classify health units or maternity wards according to the level of services they provide, as is evidenced by discrepancies in the resources allocated (e.g., specialists, equipment, medicines, etc.)

Another factor affecting quality assurance is the pay scale. The current MSPAS salary scale is quite generous, and it does not encourage high performance because at a bare minimum employees get 6% annual raises.

In addition to such deficiencies in quality from the in-service perspective, poor preparation for public health work is also a factor. CSSP appears to have little initiative, and perhaps little capacity, to institute accreditation of health facilities. Similarly it could, but does not, create board certification

⁴¹ MSPAS, "Evaluación de Disponibilidad y Uso de Cuidados Obstétricos de Emergencia en El Salvador en 28 hospitales y 5 Unidades de Salud ," pg. 33, Febrero 2004.

procedures for specialists (e.g., pediatricians, obstetricians, cardiologists, nurse midwives, etc.) although this could be done by the specialty colleges, with support from CSSP. Further, there is no requirement for continuing education to renew professional licenses. In short, CSSP is not regulating professional practice as the law requires.

Recommendations

Pre-service

1. As previously suggested, adapting university curricula to MSPAS needs will affect quality. To convince professors and students of this while simultaneously addressing the problem, invite the professors to provide in-service training beginning with pre-degree practicums through internships and social service and beyond with post-graduate specializations, primarily in obstetrics and perinatology. This recommendation can be best initiated after previous pre-service recommendations have been initiated.
2. Certification of health professionals is needed on many levels: (a) Health providers should be obligated to sit for board exams administered by professional institutions under the auspices of CSSP. In a decentralized system, this would fall to the regional level to administer and regulate. (b) Specialists (pediatricians, obstetricians, anesthesiologists, nurse midwives, etc.) should be certified to practice in their specialty area by their respective professional boards. Similarly, they should be required to provide evidence of continuing education or periodic re-examination to maintain their right to practice a specialty. The timing for this intervention will depend upon the new CSSP management after the March elections. Most likely this recommendation can be more fully addressed in the new strategy, but some preliminary steps could be taken within the scopes of work for ABT and URC.

In-service (all these recommendations can be incorporated into the current USAID program)

3. Improve supervision and monitoring and evaluation capacity by effectively using the existing information systems at all levels (central, regional, SIBASI, hospital, and health units) and emphasize the role of the hospital committees (maternal/perinatal and infection prevention) to monitor progress and identify problems.
4. Encourage exemplary “situation rooms,” such as the one in the El Congo health unit. Using the “positive deviance” approach, invite stellar professionals to mentor their peers on the advantages of knowledge management and using data for decision making.
5. All medical, nursing, and paramedical health personnel should be required to renew their licenses at specified intervals (e.g., biannually). They should be required to provide proof of having acquired a specified number of continuing education credits that will ensure they are keeping current in their field. This is also a role for CSSP. Technical assistance should be sought from similar governing bodies in other countries.
6. Given the surplus of medical students compared to social service placements, post-social service could be in the form of performance-based incentive contracts rather than fixed salaries.

By invigorating the classification system for hospitals and health units (e.g., maternity wards, A, B, C) specialists could be assigned according to need. Once again, there is a wealth of information available that would allow for appropriate allocation of resources. A personnel information system is still needed; a good starting point would be to build upon the one the Ministry of Finance uses. By using these data for decision making, specialists could be assigned and drugs and other supplies allocated based on need, and deployment of FOSALUD specialists could be reoriented. Work with FOSALUD needs to be done under the direction of MSPAS with adequate technical assistance to analyze maternal and perinatal mortality in relation to expanded emergency obstetric care. The

Minister of Health can direct FOSALUD⁴² to hire obstetric, pediatric, and anesthetic specialists to improve the performance of maternity units in the short term and reduce maternal and perinatal mortality.

Accreditation of health facilities (implemented in the new strategic plan)

7. To develop and implement a health facility accreditation program, CSSP should coordinate closely with MSPAS to understand the practical application of policies. However, the MSPAS should not exert influence or raise a conflict of interest that might impede objective evaluation of its facilities. Accreditation is a new area for USAID and should be initiated in the next strategic plan.
8. While it is within its legal purview, CSSP would need technical assistance to draft regulations and criteria to accredit all health facilities (public and private, at primary, secondary, and tertiary levels). MSPAS should establish standardized procedures, and, in coordination with CSSP, regulate building construction and installation of both public and private medical facilities and labs.⁴³ Organizations such as the Joint Commission that accredits healthcare organizations in the US would serve as a helpful point of reference. An external watchdog should also be considered to monitor how CSSP exercises its authority.
9. PAHO and COMISCA advocate national quality assurance programs for health services. Ten countries in the region have such groups, which are charged with regulation and management of infrastructure and medical technology, equipment, and devices. They also provide oversight for the development of treatment and clinical practice guidelines.

Management and administration (many of these apply to URC's mandate; those that apply to ABT's role are identified as such. Note other exceptions.)

10. Consider organizing health collaboratives like those implemented in the United States by the Department of Health and Human Services and adapted by URC in Nicaragua and other countries. These are multidisciplinary management teams that convene around a problem prevailing in a region (or SIBASI). For example, if neonatal mortality is particularly high, the management team would use epidemiological data to determine the magnitude and etiology of the problem (e.g., infection due to births not attended by skilled professionals). The collaboratives would make a sector-wide, comprehensive examination to identify solutions, which often extend beyond the health system.
11. Enforce application of the standards of essential obstetric and newborn care by reorienting FOSALUD contracts to extend the shifts of obstetricians, pediatricians, and anesthesiologists to allow for 24-hour coverage or according to an analysis of demand for these services.
12. Systematize the preparation of supervision plans based on monitoring and evaluation information (e.g., coverage, outreach, morbidity and mortality indicators, etc.) Monitoring and evaluation can also help to identify training needs to coordinate allocation of resources. These training needs could be communicated to professors to help them plan pre-service training courses and make adjustments to pre-service coursework. (*Begin with the pre-service education interventions.*)
13. Publicly recognize the performance of work teams in hospital and health units at public events (e.g., seminars, congresses, regional forums, etc.) and give them to share their successful experiences.

⁴²Corte Suprema de Justicia de El Salvador, Centro de Documentación Judicial, Ley Especial para la Constitución del Fondo Solidario para la Salud, art. 6, 17 de diciembre de 2004.

⁴³Código de Salud, 3ª Edición, octubre 1998, art. 195, pg. 63, art. 197, pg. 64, October 1998.

14. Reward good performance by sending exceptional professionals for postgraduate study, both in-country and abroad. Applying standardized criteria for objectively evaluating performance is essential to avoid nepotism. (*Next strategic plan.*)
15. Provide physical incentives for performance, such as supplies and equipment (e.g., air conditioning, situation room equipment for team meetings, computers, etc.).
16. Integrate, rather than duplicate, tools and information used by vertical programs. For example, interactively combine information collected by health promoters on home conditions and maternal and child behaviors. This information should be incorporated into the obstetrical risk maps in health unit situation rooms.
17. In order to promote competitiveness, create a methodology for ranking the quality of administrative systems. Criteria could measure variables related to supervision of personnel; efficient management of supplies, reception/storage, and “just in time” distribution of drugs and consumables, storage and maintenance; inter-sector collaboration initiatives, etc. Recognition plaques or banners could be given to regions based on their ranking (e.g., symbolized by stars, up to a Five Star facility). Again, criteria need to be standardized for consistency and fairness. (*ABT*)
18. Similarly, rank health units based on their level of complexity (e.g., second level, maternity, primary care) using coverage standards, morbidity reduction, decreased complications, use of situation rooms for decision making, outreach efforts (e.g., Family Health Model implementation), inter-sector collaboration initiatives, etc. User satisfaction could be measured through client exit surveys or consultation with ADESCOS and other civil society organizations. Rankings already exist for “Child Friendly Hospitals.” Additional criteria could include values like reduction in hospital-acquired infections and maternal, perinatal, infant, and childhood morbidity and mortality. This system of ranking should be in line with national norms and protocols and could therefore be a preliminary step toward accreditation of facilities. Publicizing the rankings would be beneficial. (*ABT*)

Feasibility and Impact of Recommendations

The greatest impact of the recommendations in this section will come from revisions to pre-service training (including primary-care practicums) and installation of pre-service qualifying examinations. These will reduce costs to the MSPAS and simultaneously improve quality of services. While they require some institutional adjustments, all stakeholders recognize the urgency of making changes. PAHO and USAID will have to open their own channels of communication, establish an agenda for dialog with universities and MSPAS, construct a plan and budget, and make the necessary commitment of resources within their mandates and capabilities. Recognizing that USAID’s influence in this arena is limited, it could still try to leverage support through PAHO.

Regarding the other recommendations, there are two levels of complexity: those that require institutional adjustments, such as CSSP reform, and those that can be undertaken within existing structures by raising expectations and tweaking performance. The impact of the former, higher-order, reforms will be significant but realistically can take many years to achieve, even in a conducive political environment. Significant technical assistance will be necessary, and if USAID decides to support such an effort, it will open an entirely new strategy.

The second level of recommendations can be feasibly applied in the current health strengthening project by USAID contractors during the extension period. The impacts of such interventions, taken collectively, can be very significant; they can raise the value of quality and provide a better understanding of processes for achieving it in the current setting. Since these would be essentially “no-cost” interventions, feasibility will be determined by adjustments to work plans and results reporting.

INTERSECTORAL COLLABORATION

Conclusions

This study found concrete examples of MSPAS health units that have had very useful experiences in inter-sector collaboration, working with municipalities and the departmental governments. This is not the case for the central level, which has weak ties to development sectors related to health status (e.g., economy, agriculture, education, public works, housing, basic services, safe water, and environmental health).

Inter-sector collaboration works at the local level when there is a defined cause, a mandate, an oversight council, and a budget line item. A common denominator is solid community involvement with dynamic leadership from health personnel. The health centers visited have very good relationships with schools and parents, mayors, and local development associations (ADESCO).

Conflicting and confusing legislation can impede health interventions from other sectors. Some commented that auditors objected to municipal spending on health activities. Also, the Health Code specifies that MSPAS is responsible for environmental sanitation although municipalities install potable water and sewer systems and collect garbage. This confusion can be clarified by advising the Legislative Assembly.

Lastly, turning attention toward adolescent education, the needs are quite distinct and tightly focused on issues surrounding sex education, HIV transmission, gang violence, and drugs. Teens are asking for sex education, including information on contraceptives, sexually transmitted diseases, and HIV/AIDS. After more than three years of negotiation, the president's recent edict to incorporate sexual and reproductive health into high school curricula will open up opportunities for donor intervention. The USAID PASMO program limits the HIO team's ability to reach this population because this regional initiative stipulates working with high-risk and vulnerable groups only (e.g., MSM and CSWs). Gang violence is running rampant and there is easy access to illicit drugs. We view this menagerie of adolescent problems as falling within the realm of inter-sector collaboration because they touch upon social issues that extend beyond the purview of the health sector (e.g., schools, police, municipalities, etc.)

Recommendations (To address in the next strategic plan.)

1. The mechanism for intersectoral collaboration should be through health plans adopted by city councils and formation of inter-sector committees with budget-line items for health. Following examples in Santa Ana and Sonsonate municipalities, the DG team could help the HIO team to study models for municipal legislation that provide for the needs of children and adolescents. In consultation with the DG team (through COMURES and ISDEM), the HIO team could identify health priorities that are manageable at the local level and advocate for municipal legislation that would promulgate inter-sector collaboration, including projects for youth development/youth at risk to combat gangs, early pregnancies, and the increased HIV/AIDS cases in youth. Other illustrative interventions include involving police support in transporting emergency obstetric cases to hospitals.
2. Promote the exchange of successful experiences in inter-sector collaboration (El Congo, Perquín, Apastepeque, and others) that have had a positive influence on local health. It is important to highlight the legal aspects that support collaboration and interchange of resources for local support. Other inter-sector experiences could be shared, such as PSI's training programs for youth leaders, which involve MINED, ISSS, and the Youth Secretariat.
3. Health plans that support healthy life styles and environments could be incorporated into municipal development plans and budgets within current FODES funding levels. If the HIO team were to contract with a civil society NGO, it would be able to help advocate for the inclusion of health priorities. The inter-sector collaboration should be inclusive of private companies when relevant, a possible role for the Alliances Project.

4. Develop local capacity to analyze the negative externalities of other sectors that impinge upon health outcomes (e.g., safe roads, violence). Health plans could include interventions aimed at response and prevention (e.g., stop signs, seat belts, control of firearms, parenting or partnership classes, etc.).
5. In coordination with the EG team, the HIO team could study the impact of economic growth in promoting community health. They could orient the investment of growth benefits to encompass health promotion and education activities in the workplace focused on topics such as lifestyles, nutrition, family health, sexual and reproductive health, HIV/AIDS, domestic violence, etc. One possible avenue might be to encourage universities with masters programs in public health to consider such topics for master's theses.
6. Future elements of HIO's health systems strengthening activities could be analysis of insurance models that would cover patient damages from traffic accidents to compensate for the cost of trauma services in MSPAS hospitals.
7. In reference to adolescent education, the PSI model (implemented through other-donor funds) is worthy of further consideration. On the surface it appears to precisely meet the needs of the children.

Feasibility and Impact of Recommendations

The impact of more municipal involvement in health cannot be understated. This needs to be achieved at the local, not the national, level. Towns with exemplary health plans have put additional resources and efforts into creating healthy environments and promoting positive lifestyles to their residents, building supportive relationships with communities and health units. These institutions go to the heart of preventive health. The HIO, DG, and EG teams in USAID will have to work together on a joint strategy that supports municipal health planning and budgeting. The biggest challenge might be to determine how to measure their shared ownership and successes when reporting within USAID.

Meanwhile, publicizing success stories and sharing experiences can go a long way toward forming opinions and cementing relationships. While the DG team no longer works at the municipal level, it could advise the HIO team, review proposals from civil society NGOs, and develop selection criteria for municipal promotions.

PRIVATE SECTOR

Conclusions

Some companies would like to work in their communities as responsible corporate citizens but have no contact with health agencies or municipal government. Company owners know that it is in their own best interest to provide health care for their employees to reduce absenteeism and maintain productivity. Employees in some of the factories seek care at MSPAS health facilities but do not present their social security cards. This places an undue burden on the MSPAS system.

The HIO team's current public-private partnerships are supporting interventions that have little chance of affecting their health priorities. Despite input from USAID's health experts on project development, the alliances appear more to reflect corporation priorities than USAID's. The absence of a health care specialist on the RTI amplifies this problem.

Recommendations

This is an area where the health and economic growth teams could join forces. The EG team is probably in a better position to convey messages from the perspective of the private sector to the health team, and vice versa.

1. Given that no one knows how many MSPAS services are provided to ISSS subscribers, it would be important to quantify this number, perhaps by cross-referencing information from the institutional information systems (identification of subscribers versus patients) or in exit interviews. Timing for this study would depend upon the availability of funds, but the results would be relevant immediately.
2. Public-private partnerships should focus on directing private companies to support USAID-proposed activities rather than expecting them to propose ideas spontaneously. They could also be used to pilot innovative interventions. Input from the EG team might elucidate other alternatives for these partnerships. This should be explored now before supporting new Alliance projects.
3. Given USAID/Washington's priority on public-private partnerships and the questionable effectiveness of the Alliance Project in general, it would be worthwhile to conduct a small study. USAID should assess how best to build public-private partnerships from the point of view of two target populations: (a) the corporate social responsibility of large multinational companies, and (b) local factory owners interested in protecting the health of their employees. Advice from the EG team would be helpful here. This study would be contingent upon the availability of funds but the sooner the better to improve current programming.
4. The HIO team could explore opportunities for health promotion and education through EG projects working with agricultural and handicrafts businesses. Large groups of people might thus be reached with nominal effort. Other options include talking to business owners about contributing to their employee's service provision (e.g., cover service costs through a form of insurance or provide direct support to the local health unit). This intervention could wait until the next strategic plan.

Feasibility and Impact of Recommendations

All the recommendations are aimed at testing innovative approaches to the private sector and setting the stage for more effective relations between employers, employees, and health service providers. Given the tentative nature of these interventions, it is difficult to estimate their impact. All are within the direct capacity of USAID to undertake, probably at relatively little expense.

In Central America there is a long history of corporate social responsibility in providing health services for employees. In the early nineties, coffee conglomerates, such as AgroSalud and AnaCafe in Guatemala and more recently another in Nicaragua, have seen the advantages of supporting health service delivery. Best practices from these examples and others would optimize the success of such strategies adapted to El Salvador. Again, the HIO team should take advantage of their colleagues' expertise in USAID/Nicaragua (the Project Hope Jinotega experience). The EG team also could elucidate its perspective on what motivates business owners.

CONCLUSION

In conclusion, as a transforming country El Salvador has achieved reasonable economic stability and progress in health status. In the health sector, future USAID assistance must aim at undertaking "the higher-order reforms needed to maintain progress toward faster and more sustained growth."⁴⁴ USAID should support El Salvador's National Health Policy, the reordering of pre-service education, and continued improvement of quality of health care as part of the higher-order reforms that characterize the transition from transforming country to a sustaining partnership. These reforms must be supported by an efficient organizational structure capable of sector-wide strategic planning and budgetary defense of long-range health goals.

⁴⁴ USAID, *A Strategy for Economic Growth*, 2007.

ANNEX A: STATEMENT OF WORK

EL SALVADOR: HEALTH SECTOR NEEDS ASSESSMENT

I. Introduction

Under the current USAID El Salvador Country Plan (2004-2010), the Human Investment Office (HIO) is responsible for implementing Activity No. 519-0463, Strengthening Health and Basic Education, which helps achieve Objective No. 3 “Investing in People” providing support to the programs of the Ministries of Health and Education in El Salvador.

In order to assist the Mission to determine the best approach to further improve the health of Salvadorans, the HIO intends to commission a Needs Assessment that will serve as a management tool to identify health needs that could be addressed by the USG in El Salvador in the next five-year strategy period. The assessment will report on main results achieved and lessons learned to date and will identify gaps that need to be addressed in the near future.

II. Background

A. Relationship to USAID/El Salvador Country Plan and Results Framework for the Investing in People Objective and to the new Strategic Framework for Foreign Assistance

Since the 1960s the Government of the United States has continuously supported different types of interventions in the public health sector in El Salvador.

USAID/El Salvador's current strategic objective agreement for health and education with the GOES for the period 2004–2010 builds on past achievements and aligns with USAID's CAM Regional Strategy, which provides the framework for regional and country-specific programs. El Salvador's Country Plan supports the three SOs of the CAM Regional Strategy:

SO1: Ruling Justly: More Responsive, Transparent Governance

SO2: Economic Freedom: Diversified and Expanding Economies

SO3: Investing in People: Healthier, Better-Educated People

To address SO3, USAID/El Salvador developed Activity No. 519-0463, "Strengthening Health and Basic Education." This activity supports focal areas within SO3's health portfolio, specifically through the following Intermediate Results:

Intermediate Result (IR) 3.1: Increased and improved social sector investments and transparency

Sub-IR 3.1.1: Increased and more efficient expenditures by the Ministries of Health and Education

Sub-IR 3.1.2: Increased and more effective decentralized investments in health

IR 3.3: Improved integrated management of reproductive and child health

Sub IR 3.3.1: Improved and expanded family planning services and information/education

Sub IR 3.3.2: Improved and expanded maternal/child health care and information/education

Sub IR 3.3.3: Better nutrition and dietary and hygienic practices

IR 3.4: Infectious diseases contained and impact mitigated

Sub IR 3.4.1: Increased use of prevention practices and services to combat HIV/AIDS and other infections

B. Foreign Assistance Reform

In early January 2006, Secretary Rice announced “a major change in the way the U.S. government directs foreign assistance.” The change would link foreign assistance to transformational diplomacy and make the assistance program more transparent and accountable. The reform addresses three issues: First, it seeks to make foreign assistance an instrument of the secretary’s “transformational diplomacy.” Second, the reorganization is designed to make U.S. foreign assistance more coherent. Third, the reorganization is designed at least to make this organizational cacophony more transparent as well as more coherent. The principles of the reform focus on:

1. Strengthening the strategic alignment of U.S. foreign assistance resources with U.S. policy goals;
2. Improving coordination and efficiency in the use of foreign assistance resources across multiple agencies and accounts;
3. Improving transparency in the allocation and use of foreign assistance resources; and
4. Improving performance and accountability for results.

Subsequently, it concentrates U.S. foreign assistance on five priority objectives to help meet the goal:

1. Peace and Security
2. Governing Justly and Democratically
3. Investing in People
4. Economic Growth
5. Humanitarian Assistance.

The new Strategic Framework for U.S. Foreign Assistance further focuses U.S. foreign assistance on a defined set of program areas⁴⁵ designed to advance the objectives identified above. Also, this new framework categorizes countries receiving foreign assistance according to shared characteristics with regard to their progress in achieving the transformational diplomacy goal.

The categories are:

1. Rebuilding countries
2. Developing countries
3. Transforming countries
4. Sustaining partner countries
5. Restrictive countries.

El Salvador is categorized as a “Transforming Country.”

More information on the U.S. Foreign Assistance Reform is found in http://www.usaid.gov/about_usaid/dfa/

C. Geographic Focus

In order to reach the poorest rural communities, the Government of El Salvador (GOES) developed a national poverty strategy for the development of 100 municipalities categorized as “extreme,” “severe,” or “high” poverty. The GOES focused investments in these 100 municipalities in two phases: 2005–2006 addressing 32 municipalities, and the other 68 during the period 2007–2009. USAID has supported community and primary health care activities in selected municipalities jointly identified with the MOH. However, some activities have nationwide coverage, such as the strengthening of MOH systems and the development of clinical norms and protocols. Efforts to improve obstetrical practices and postpartum

⁴⁵ The USAID/El Salvador Health program falls under the “Investing in People” functional objective.

and newborn care and to reduce hospital-acquired infections are carried out in all 28 maternity hospitals.

D. Current Program

USAID Health Program is assisting the MOH to strengthen its capacity to more effectively direct additional resources to public health through improved financial analysis and planning, improved capacity to present and defend budget submissions, and fostered alliances with private sector partners. Support will be provided to improve the utilization of resources through better monitoring and improved decentralization.

USAID Health Program also provides assistance to the MOH to improve the delivery of reproductive and child health services, especially to mothers and newborns at the primary care and community levels, including family planning, prenatal care, birthing plans, nutrition, and basic hygiene education. At the hospital level, assistance will be provided to improve the quality of obstetrical and neonatal services, as well as the development of interventions to reduce infections that affect the mother and the newborn.

In HIV/AIDS, USAID is supporting behavior change activities among high-risk groups, particularly commercial sex workers (CSW) and men that have sex with men (MSM), complementing the efforts funded through the Global Fund.

Technical assistance is provided by two US contractors, Abt Associates and University Research Corporation (URC) with additional support from the central DELIVER Project (carried out by John Snow Inc.). The regional HIV/AIDS prevention activity is carried out by Population Services International (PSI)/PanAmerican Social Marketing Organization (PASMO); the Health Policy Initiatives (HPI) project implemented by Futures Group; Centers for Disease Control (CDC); and the CAPACITY project implemented by IntraHealth. USAID is providing contraceptives through Global Health/Washington, under field support, as well as coordinating activities with the CDC for the provision of technical assistance to develop the National Demographic and Health Survey (FESAL) implemented by the Salvadoran Demographic Association (SDA). FESAL is conducted every five years to measure the current impact of public health policies and activities.

III. SCOPE

The assessment team will assess the current status of the health sector in general and of the Ministry of Health (MOH) in particular as the largest provider of health care in El Salvador. This assessment will provide information regarding gaps in the health sector and in the MOH that need to be addressed. The assessment will help USAID/El Salvador to have a clear understanding of the areas that still need to be addressed and might be considered for support under a future strategy, in agreement with the GOES. At the MOH level, the assessment will appraise the provision of services and the administration and management of those services nationwide.

The assessment team will differentiate findings and recommend proposed interventions within at least three major categories, based on current activities supported by USAID/El Salvador under its current strategy and the program elements of the results framework:

- A) **Service provision:** including preventive activities like information, education, and communication for the general public and service providers at community and facility levels.
- B) **Administrative and management systems:** encompassing supply management, management information systems, budgeting and financing, and human resources.

The assessment team should explore possible interventions in regulation of services, identifying gaps and opportunities to improve health services delivery.

- C) **Human resources:** although this system is presently included under the MOH's administrative and management system, USAID prefers to deal with it as a separate system rather than incorporate it with the others.

The assessment team should include other categories that need to be supported by the USG if they are not listed and/or included in the three major categorizations listed above, and if deemed appropriate.

USAID has provided support to the areas listed above; however, it is recognized that some gaps exist and improvements can be made. These three areas inter-relate with each other and are key to the sustainability of the gains obtained in the health sector. As an example, human resources are the key element of service delivery; it is well known that in El Salvador, MOH staff costs overwhelm health services expenditures (over 75% of MOH annual budget is utilized to pay salaries). Alternatives to reduce costs in order to free up funding for provision of services are crucial, and several are being explored by the current contractor and the Ministry of Health; however, to sustain the workforce with the skills and experience they need to deliver the services, an incentive plan needs to be explored, both financial and nonfinancial, and at the same measuring the impact that these incentives might have on the MOH budget, with the goal of reducing costs and freeing funding that could be utilized in service provision.

It is also expected that the assessment team will explore areas where synergies between the health and education sectors might be feasible.

The following questions are a baseline (and considered to be illustrative) for preparation of the assessment and are grouped by major categories based on current financial and programmatic support provided to the MOH by the United States Government.

Any additional information that the assessment team considers appropriate shall be included in the final report and discussed with USAID/El Salvador.

A. Service Provision

1. What are the lessons learned in the implementation of current activities supported by USAID/El Salvador by (a) type of activity and (b) level of implementation?
2. What are the existing gaps in service provision (curative and preventive) that need to be addressed in the future?
3. What USG interventions are proposed to address those gaps, based on USAID's pillars and mandate?
4. What will be the estimated cost to support the proposed interventions and for what period of time?

B. Administrative and Management Systems

1. What are the MOH's strengths and weaknesses with respect to carrying out planning tasks?
2. Does the MOH health strategy adequately respond to health needs of the country's population?
3. What are the strengths and weaknesses of the MOH's current human resources in charge of strategic planning in developing long-term planning for the Ministry nationwide?
4. Are there administrative and management systems gaps that USAID should consider for future investment based on USAID comparative advantage and on USAID's pillars and mandate?
5. Is the MOH capable of sustaining the improvements made to its administrative systems? What other administrative areas need assistance that might be provided by USAID?
6. Are there regulatory steps the MOH should establish in order to improve health service delivery?

7. What other Salvadoran institutions (governmental and private) are involved in the licensing process for medical and paramedical personnel?
8. Are there gaps in the licensing process in El Salvador?
9. Is the medical practice regulated? If so, how and by whom? Does the population have an active role in monitoring medical praxis in El Salvador?
10. Are there means that the population could utilize to protect itself against medical malpractice?

C. Human Resources

1. As a result of USAID support to MOH activities during the current strategy, are there lessons learned in reference to personnel motivation?
2. Can the human resource needs be analyzed and discussed by type of category, such as training, motivation, and incentives for personnel, communication, advancement, professional growth?
3. If so, is it valid to continue addressing medical and paramedical training at the MOH level (in-house/on-the-job)? Or is it more appropriate to consider other levels for medical and paramedical training, such as university studies? Are there regulatory or other incentives that could be established to enhance and encourage appropriate and continued training?
4. What are the organizations, public and private, which prepare and train medical and paramedical personnel in El Salvador?
5. Is there any post-graduate mechanism for medical and paramedical personnel to assure a continuous education process? How does it work?
6. What is the quality of those training programs?
7. What is the quality of ongoing continuous education for health professionals in El Salvador?
8. Are MOH personnel adequately trained at all levels to manage and administer efficiently and effectively the provision of medical care and the ministry itself as an organization?
9. What could be USAID's role in other proposed levels or models of personnel formation; how should this role be executed? If universities become an option for training, how could USAID become involved?
10. If incentives for MOH personnel need to be considered, what type(s) is (are) more appropriate for El Salvador to incentive health providers to use best health practices of care in their daily work?
11. How and what should be the involvement/support of USAID in developing and implementing an incentives strategy to stimulate the best professional practices in health care?
12. What will be the estimated cost to support these interventions related to human resources and over what period of time?
13. What type of training (ongoing and/or specific) is needed by medical and paramedical personnel? And, at what level should they be trained (in-house/on the job or university studies)? How and what type of incentives if any could be developed? And, are these sustainable?

The answers to the above questions should be included in the final report and be addressed in the context of the following broad programmatic and technical health areas as currently supported by USAID:

1. HIV/AIDS
2. Family Planning and Reproductive Health
3. Maternal and Child Health
4. Health Systems

The team may suggest and justify new areas of intervention (not mentioned above) as appropriate.

IV. Methodology

The assessment team should consider a range of possible methods and approaches for collecting and analyzing the information which is required. Data collection methodologies will be discussed with, and approved by, the USAID at the start of the assessment. They shall use facilitative methods and activities that will enhance collaboration and dialogue among counterparts, particularly partners. The HIO team leader will organize all internal USAID meetings, including linking the team with the HPN team leader.

The assessment team shall propose and organize the assessment process in collaboration with the HIO team leader. The design and plan shall be presented to the HIO team members for comments after the Team Planning Meeting. The HIO team leader will arrange for initial meetings with appropriate stakeholders and partners at the outset of the process. When appropriate, the HIO team leader may participate in meetings with relevant stakeholders and partners. A general list of relevant stakeholders and key partners will be provided to the assessment team by USAID at the time of arrival but the assessment team will be responsible for expanding this list as appropriate and arranging the meetings and appointments so as to develop a comprehensive understanding of the USAID program and services offered.

The final methodology and work plan will be developed as a product of the Team Planning Meeting (TPM) and shared with the Mission prior to application.

Document Review

- USAID/ES will provide the assessment team with the key documents prior to the start of the in-country work. All team members will review these documents in preparation for the initial team planning meeting.
- Prior to conducting field work, the assessment team will review existing literature and data, including program strategies, epidemiological information/DHS reports, PAHO and other materials that document donor health programs, and MOH program strategies in ES.

Team Planning Meeting

- A two-day team planning meeting will be held in ES before the assessment begins. This meeting will allow USAID to present the team with the purpose, expectations, and agenda of the assignment. In addition, the team will:
 - clarify team members' roles and responsibilities;
 - establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion;
 - review and develop final evaluation questions;
 - review and finalize the assignment timeline and share with USAID;
 - develop data collection methods, instruments, tools and guidelines;
 - review and clarify any logistical and administrative procedures for the assignment;
 - develop a preliminary draft outline of the team's report; and
 - assign drafting responsibilities for the final report.

Internal USAID/ES Meetings will include, at a minimum:

- Initial organizational/introductory meeting at which the assessment team will present an outline and explanation of the design of the assessment (refer to the TPM noted above);
- Mid-assessment debrief—discuss findings to date and resolve any outstanding questions/issues
- Final assessment debrief—summary of the data, draft recommendations, and draft report.

Field Visits/Key Informant Interviews:

- The assessment team shall arrange to visit selected sites in consultation with the HIO Team Leader as appropriate.
- The assessment team may be accompanied by a member of staff from USAID/ES, as appropriate. The site visits will involve interviews with MOH officials, other donors, various implementing partners, etc.
- Key informant interviews will be conducted as required. The assessment team will conduct interviews with donor organizations, selected NGOs, and other key respondents identified during the planning meeting.

Wrap-up and Debriefing:

- At the conclusion of the field visits/key informant interviews, there will be a debrief meeting at USAID/ES. The purpose of the meeting will be to share findings and get final inputs before preparing the draft assessment report.

V. Team Composition

The assessment to be carried out under this scope of work will be developed by a team of public health advisors with expertise in the areas listed below. These areas directly relate to the support provided to achieve the expected results listed in the previous sections.

The contractor shall propose how it will group the major programmatic areas in order to limit the number of evaluators on the team.

Areas currently supported by USAID/El Salvador include:

1. HIV/AIDS in high-risk groups
2. Maternal and child health
3. Prenatal care
4. Obstetrical care
5. Postpartum/neonatal care
6. Perinatal Information System
7. Maternal mortality surveillance
8. Quality assurance program
9. Nutrition of mothers and children
10. Breastfeeding
11. Child health/integrated management of childhood illnesses (diarrhea and respiratory infections)
12. Integrated nutrition strategy
13. Nutrition surveillance
14. Hygiene practices
15. Urinary tract infections in the mother
16. Hospital-acquired infections in pregnant mothers
17. Hospital-acquired infections in newborns
18. Communications strategy for all health services supported by USAID
19. Nosocomial infections in pregnant women and in neonates
20. Family and community health
21. Family planning service delivery

22. Contraceptive security
23. Adolescent reproductive health
24. Health economy and health financing
25. Logistics and supply management
26. Management information systems
27. Human resources
28. Alliances with the private sector.

Team Leader: The contractor will identify a Team Leader who will be the principal liaison with USAID/El Salvador’s HIO. The Team Leader will lead team efforts and coordinate the delivery of the final report to USAID’s HIO.

The following qualifications are required under this position: (a) fluency in English and in Spanish at FSI 3/3 level; (b) graduate degree in health or related field, with studies in health economics; (c) at least 10 years of experience in managing/assisting similar health programs in Latin America; (d) previous experience as COP of a similar multitask team in other Latin American country(ies); (e) experience in leading or participating in assessment teams for strategic planning purposes; (f) demonstrated analytical and writing skills.

All team members shall be senior-level health professionals with a master’s degree in public health or other related field and at least five years of experience in similar programs in other Latin American countries. The experience shall be consistent with the area of expertise to which she/he is being proposed, and the team members should be experienced in the development of assessments for strategic planning purposes. All consultants shall demonstrate fluency in English and Spanish at FSI 3/3 level.

The following documents are attachments to this RFTOP:

1. Current USAID/El Salvador strategy for health and education
2. SOWs of current contracts
3. Action Plans for each contractor for the period 2006–2009
4. Periodic status reports submitted by these contractors
5. Performance Monitoring Plan for the Human Investment Office

VI. Timeline and LOE

The following is an illustrative timeline.

Task/Deliverable	Duration
1. Review background documents & offshore preparation work	5 days
2. Travel to El Salvador	1 day
3. Team Planning Meeting and meeting with USAID/ES HIO team	2 days
4. Information and data collection. Includes interviews with key informants (including partners and USAID staff) and site visits.	18 days
5. Discussion, analysis, and writing draft assessment report in country	6 days
6. Debrief meetings with HIO team (preliminary draft report due to mission before departure from country)	1 day

7.	Depart El Salvador	1 day
8.	USAID provides comments on draft report (team out of country) – 5 days	
9.	Team reviews comments and revises report – final report (TL: 5 days; 3 days team members)	5 days /3 days
10.	USAID completes final review (10 working days)	
11.	GH Tech edits/formats report (3-4 weeks)	

Total Estimated LOE = 39 days (Team Leader; 37 days team member)

VII. Logistical Support

A six-day work week is authorized when working in country. The assessment team will be responsible for all off-shore and in-country logistical support. This includes arranging and scheduling meetings (with the exception of previously mentioned USAID set meetings and initial introductory meetings), international and in-country travel, hotel bookings, working/office space, computers, printing, and photocopying. A local administrative assistant/secretary may be hired to arrange field visits, local travel, hotels, and appointments with stakeholders.

VIII. Deliverables

The contractor shall be aware that any questions/information etc. must be channeled directly through USAID’s HIO and that they shall not be contacting the current contractors directly.

1. **Work Plan:** The Team will submit a detailed written work plan after the TPM and before the end of week one of work.
2. **Methodology Plan:** A written methodology plan (assessment design/operational work plan) will be prepared during the Team Planning Meeting and discussed with USAID prior to implementation.
3. **Coordination Meetings:** An entry conference with Mission Management and the office of Human Investment will take place during the first week in-country to delineate and summarize the work planned and expected results as well as the proposed timeframe..
4. **Mid-Assessment Briefing:** The contractor should also schedule a mid-assessment meeting with USAID’s CTO to provide an update on status of the assessment and discuss project performance.
5. **Debriefing with USAID (and stakeholders):** The team will debrief with USAID and stakeholders prior to submission of the draft report and the team’s departure from country. During the last week of the assignment, the contractor will provide an exit conference to include a summary of findings, conclusions and recommendations in a PowerPoint presentation to Mission Management. Comments generated during that presentation will also be incorporated into the final report.
6. **Draft assessment report** should be completed prior to the Team Leader’s departure from El Salvador. The written report should clearly describe findings, conclusions, and recommendations (using the report format provided in “Reporting Requirements” below). USAID will provide comment on the draft report within 5 working days of submission.

7. **A final report** that incorporates the team responses to Mission comments and suggestions. The draft final report should be completed within 5 days after USAID provides its feedback on the draft report incorporating the comments received from the review of the draft and sent to the Mission. The final report (excluding executive summary and annexes including List of citations: List of all reviewed/cited sources in final report) should be no more than 30 pages.
8. After the final but unedited draft report has been reviewed by USAID, GH Tech will have the documents edited and formatted, and will provide the final report to USAID/ES for distribution (10 hard copies and a CD ROM). It will take approximately 30 days for GH Tech to edit/format and print the final document.

The Contractor will submit written reports in English as follows and all English reports, interim and final, must contain as a minimum:

- a. Executive summary
- b. Copy of program plan
- c. Timeframe
- d. Detailed description of activities developed by program area
- e. Findings by program area
- f. Gaps identified by type of program area
- g. Recommendations/justifications for areas proposed to be addressed in the future under USG support listed in priority order (this section is not essential in the interim report but it must be an essential part of the final report).
- h. Estimated cost for activities proposed and estimated length for implementation.

X. OVERSIGHT AND MANAGEMENT

The GH Tech team will work under the direction of the USAID/ES HIO Team Leader: Dr. David Losk, Director, Human Investment Office, USAID/EI Salvador

Responsibilities:

USAID/ES will be responsible for the following:

- Obtain country clearances for travel.
- Coordinate and facilitate initial assessment-related field trips, interviews, and meetings.

GH Tech will be responsible for the following technical and logistical support:

- Identify and recruit team members—international and local consultants.
- Provide funds to the team for all in-country logistics.
- Provide administrative, operations, and logistical support to the team while on assignment
- Assist with report finalization, editing/formatting, and production

ANNEX B: TEAM PLANNING MEETING AGENDA

OBJECTIVES

1. Review the background, history, and current status of USAID/El Salvador health program.
2. Reach a common understanding and approach to the assessment.
3. Define the methodology of the assessment.
4. Define and outline the report including writing assignments for each team member.
5. Plan how the team will work together (including communication).
6. Define and agree on the roles and responsibilities of team members.
7. Develop a workplan and time line to carry out the assignment.

DAY ONE: September 29, 2008

9:00–12:00	USAID Briefing: background, history, status, key players, significant events, critical issues related to USAID program. (Reference: Assessment Team Questions)
1:45–2:00	TPM objectives and overview
2:00–2:45	SOW: purpose, primary users of the findings, in-depth review of questions—aggregate into 3-5 main questions
2:45–3:45	Conceptual framework
3:45–5:30	Methodological approach
5:30–6:00	Report outline (chapters)
6:00–6:15	Assignments for evening

DAY TWO: October 1, 2008

09:00–10:00	Methodology (continued)
10:00–10:30	Review report outline
10:30–11:00	Team member/team leader roles and responsibilities (including report writing)
11:00–12:00	Workplan (begin) <ul style="list-style-type: none">– Scheduling and sequencing of events and appointments (e.g., discuss pros and cons of “snowball” methodology for identifying new key informants)– Assignment milestones– Contact and document list– Individual work schedule updates
12:00–12:50	LUNCH
12:50–3:00	Meeting with USAID Front Office
3:00–5:00	Work plan (continue)
5:00–5:30	Individual working styles and preferences
5:30–6:00	Review achievement of TPM’s Objectives Discuss relevant issues “Parking Lot”
6:00–6:15	Next Steps: Data collection instruments—agree on process for developing the instruments (e.g., meet Wednesday on types of instruments needed for groups of stakeholders; site visits; purpose and associated inputs that will result for each instrument, etc.)

ANNEX C: LIST OF CONTACTS

MSPAS

Lic. Patricia de Reyes

Project Manager, Strengthening Health Project

Dr. Humberto Alcides Urbina

Director General

Dra. Ena Garcia

Directorate of Planning

Dr. Mario Vicente Serpas

Director of Epidemiological Surveillance & Control

Dr. Roberto Rivas

Director of Regulation

Dr. Patricia Martínez

Medicines

Dr. Jorge Roldán

Norms and Protocols

Dr. Carlos Melendez

National Coordinator of Child Health Service Unit

Dr. Judith Zarate de Lopez

Director of Administration

Dr. José Guillermo Maza Brizuela

Minister of Health

Dr. José Navarro Marín

Vice Minister of Health

Dr. Ricardo Lara

Director of FOSALUD

HIGH COUNCIL ON PUBLIC HEALTH

(Consejo Superior de Salud Pública)

Sra. Lilia Avendao de Guerrero

President

Sr. Daniel Quintero

Secretary

SALVADOR INSTITUTE OF SOCIAL SECURITY

Dr. Nelson Nolasco Perla

Director General, Oficina Administrativa ISSS

Dr. José Eduardo Avilés Flores

Subdirector of Health

MINISTRY OF EDUCATION

Ing. René Perla Salomón.

Institutional Management

Lic. Iris Carrillo de Reyes

Education for Life

DONORS

USAID/EI Salvador

Front Office

Larry Brady, Mission Director

Carl B. Derrick, Deputy Mission Director

Human Investment Office

David Losk, Chief

Raúl Toledo, HIO

Margarita de Lobo, HIO

Maricarmen Estrada, HIO

Carmen Henriquez, HIO

Democracy & Governance

Mauricio Herrera, Deputy Director

Economic Growth

Rafael Cuellar

Mauricio Bustamonte

PAHO

Dra. Priscilla Rivas-Loria

USAID CONTRACTORS

Dr. Francisco Vallejo

University Research Corporation (URC)

Dr. Carlos Alberto Bonilla

Facilitator, URC San Vicente

Dr. Josué García

Facilitator, URC, San Miguel

Ing. Carlos Castaño

Abt Associates

Ing. Verónica Olivares

Research Triangle Institute (RTI)

Lic. Gerardo Lara

PASMO (Pan American Association for Social Marketing)

Dra. Guadalupe Somoza

Coordinadora del Proyecto de Adolescentes, PASMO

Lic. Manuel Beltrán

PASMO, San Miguel

NGOs

Sra. Beatriz Carvajal

FUSAL

Lic. Ana Josefa de García

Centro de Apoyo de Lactancia Materna (CALMA)

Ing. Rafael Avendaño

Director, Asociación Demográfica Salvadoreña (ADS)

Dr. Jorge de Luna

Director, ASAPROSAR

Sra. Ana Gloria Aragón

Program Coordinator, ASAPROSAR

MAJORITY POLITICAL PARTIES

FMLN

Sr. Zoila Quijada

Deputy of Legislative Assembly

Sr. Tomás Chávez

Health Advisor

Sra. Adelaida de Estrada

Sra. Danette de Flores

ARENA

Sr. Guillermo Galván, Health Advisor

OCCIDENTAL REGION, MSPAS

Santa Ana Regional Office

Dr. Sandra Marroquin

Occidente Regional Health Director

Dr. Domingo Figueroa

Santa Ana SIBASI Coordinator

Occidental Regional Health Staff (14)

Hospital Directors (5)

SIBASI Coordinators (3)

Administrator

Information, Epidemiology and Service Coordinator

Environmental Health Coordinator

El Congo Municipality

Dr. Carlos Avilés

Director of El Congo Health Unit, Santa Ana

Hon. María Isabel Barahona

Mayor of El Congo, Santa Ana

Sr. Israel Serrano

Environmental Unit, El Congo, Santa Ana

PARACENTRAL REGION, MSPAS

San Vicente Regional Office

Dr. Dolores Evangelina García de Contreras

Director in Charge and Coordinator of Health Services Div., San Vicente

Paracentral Regional Health Staff (5)

Hospital Directors (2)

SIBASI Coordinators (3)

Administrator

Information, Epidemiology and Service Coordinator

Environmental Health Coordinator

Dr. Alfredo Portillo

Director Unidad de Salud de Apastepeque, San Vicente

Sr. Juan Pablo Herrera

Alcalde Municipal de Apastepeque

Dr. Donato Vaquerazo.

Deputy of the Legislative Assembly for San Vicente

ORIENTAL REGION, MSPAS

San Miguel Regional Office

Dr. María Elizabeth Flores Zelaya

Director

Oriental Regional Health Staff (14)

Hospital Directors (4)

SIBASI Coordinators (4)

Administrator

**Information, Epidemiology and Service Coordinator
Environmental Health Coordinator**

Dr. Melvin Láinez

Director of Health Unit
Chinameca.

Dr. Erick Gómez

Director of Health Unit, Perquín

UNIVERSITIES

Universidad Evangélica

Dr. Concepción de Herrera Rebollo

Coordinator, Post Graduate School of Health

Dr. Darío Chávez Siliézar

Head, Department of Public Health.

Universidad de El Salvador

Dr. Fátima Valle de Zúñiga

Dean, Faculty of Medicine

Lic. Julio Ernesto Barahona Jovel

Assistant Dean

Dr. Elena Polanco

Director, School of Medicine

Lic. Sofía Cabrera

Director of Medical Technology

Dra. Ena Córdón

Coordinator of Public Health Masters Program

Dr. Eduardo Espinoza

Professor of Public Health

ANNEX D: ILLUSTRATIVE INTERVIEW GUIDE

MSPAS INTERVIEW GUIDE

Regulation Directorate

A. OVERVIEW

Please describe the function of your Directorate. [*Note to Interviewer: Check the relevant cell to refer to each time the respondent mentions the topic. See Definition of Themes below. The purpose is to understand the relative weight a respondent places on a particular theme based on the number of times he/she mentions the topic.*]

Program Area	DDM	Strategic Planning	Training	Regulation	Coordination	Private Sector	Commodities
Service Provision							
Admin. & Mgmt.							
Human Resources							
Other							

Definition of Themes:

DDM—Using Data for Decision Making; includes analysis and interpretation of information

Strategic Planning—Refers to strategy, planning, budgeting

Training—Refers to pre-service and in-service education. Discussions of training will not always fall under the program area of Human Resources. For example, if the respondent mentions training in relationship to personnel needs for increased management capacity, this would fall under Administration & Management.

Regulation—This theme is specific to accreditation institutions (hospitals), certification of personnel, and supervision of personnel and institutions.

Coordination—Specific to collaboration within MSPAS and also with other sectors, such as education, transportation, etc.

Private Sector—Any mention of the private sector (NGOs, private medical practices, companies, small businesses, etc.) would fall.

Commodities—This theme concerns discussion about supplies, equipment, logistics, medications. Based on the response, it could fall under any program area. For example, inappropriate prescription of medicines would be under Human Resources.

B. ADMINISTRATION & MANAGEMENT

1. Are Ministry personnel adequately trained in management and administration? Please explain.
2. Are there gaps related to administration and management?
3. What are your Directorate's strengths and weaknesses with respect to carrying out planning tasks?

4. In regard to the gaps mentioned, do any of them fall under the mandate of USAID assistance? If so, please describe how USAID could provide support.

C. HUMAN RESOURCES

5. What type of training is needed by doctors, nurses, and paramedical personnel in order to provide quality services after they graduate?
6. What are the organizations (public and private) that train doctors, nurses, and paramedical personnel in El Salvador?
 - i. *Probe:* Is there a mechanism that provides continuing education after graduation for these personnel? Please describe in terms of the quality of these training programs.
7. What other Salvadoran institutions are involved in the licensing process for medical, nursing, and paramedical personnel (include both government and private institutions)?
8. Are there any gaps in the licensing process in El Salvador for the above-mentioned personnel?
9. Is the medical practice regulated? If so, how and by whom?
 - i. *Does civil society have a role in monitoring medical practices?* Please explain.
 - ii. *Probe, if needed:* Are there ways the population could protect themselves against medical malpractice?
10. Are doctors, nurses, and promoters motivated? Please describe:
 - i. *Probe after the initial response:* Do you believe that any of the USAID interventions influenced personnel motivation? Please explain.

D. SERVICE PROVISION

11. What are appropriate incentives or disincentives to encourage health personnel to provide quality services?
12. Are there regulatory mechanisms for health service delivery? Please describe.
13. Are there any regulatory steps the Ministry should establish in order to improve health service delivery?

E. OTHER PROGRAM AREAS

14. The current USAID program focuses on the following three areas: Service Provision, Administration and Management, and Human Resources. Do you have any suggestions for other program areas where USAID should place their focus in the future?
15. What could be USAID's role in the professional development of health personnel?
 - i. If universities were involved in the continuing education of personnel, what would be an appropriate role for USAID?
16. How could USAID be involved in the development of an incentive system for health personnel that would encourage adherence to best practices in service delivery?

ANNEX E: DESCRIPTION OF THE CONCEPTUAL FRAMEWORK

SUPPLY AND DEMAND FOR HEALTH SERVICES

(See Figure 1, page 7)

The arrow along the upper left of the diagram indicates some of the macro socioeconomic conditions as “pre-determinants” of service demand. Economic growth can lead to increased incomes, which translate into safer and more sanitary living conditions, better food availability, and higher educational achievement, especially for women. The arrow also suggests a pre-determinant role for democracy and good governance, understood as freedom from corruption and social participation in local decisions, including accountability of officials and service providers. Public and private partnerships and alliances can strengthen and complement the educational, infrastructural, and nutritional conditions which are proximal determinants of service demand. To a greater or lesser degree, these pre-determinants of demand provide employment opportunities; develop productive and educational infrastructure and services and communication channels; and affect attitudes and behaviors that set the stage for the health conditions of the populace.

Probably the most effective intervention for maternal and child health is female education. The longer girls remain in school, the smaller and healthier their families are and the better the educational achievements of their offspring. Educated women have more prenatal coverage; they are more likely to give birth in health facilities and have more post-partum follow-up care. Their infants have less diarrhea and respiratory disease and more vaccinations and grow taller. All these conditions reduce demand for curative health services.

Demand for health services occurs when patients with illnesses seek treatment and rehabilitation. However, the funnel in the top right corner suggests that a number of factors conspire to determine the burden of disease in a population, and principal among these is life styles, reflected by knowledge, attitudes, and practices, which presumably can be modified by health education. Life styles affect diet, exercise, drug use, and behaviors that can lead to obesity, chronic degenerative conditions, disability, and death. Ultimately, the burden on health services from these conditions may be more costly than acute diseases and injuries. Demand can be reduced by health promotion of preventive measures such as vaccinations, promotion of healthy life styles, and safe water supplies, all of which reduce the burden of disease.

Food supply refers to availability at the family and individual level of sufficient, diverse, and nutritious foods to cover all the growth, maintenance, and activity needs of each family member. The food supply is principally determined by agricultural production, roads, and markets for distribution and income. Furthermore, dietary beliefs often condition which foods are appropriate at certain critical moments in life (childbirth, diarrheal episodes, etc.).

A healthy, living environment is the result of infrastructure and services to provide safe water and sanitation and disposal of solid waste, including sewage, garbage, and toxic or noxious chemicals. Healthy living conditions also ensure protection from disease-transmitting vectors, disaster-prone locations, violence, and accidents.

An important variable in controlling demand for services is access as determined by physical distance of patients from health units, the cost to patients to reach units and pay for services and medicines, and finally cultural impediments to using facilities based on western medical concepts and procedures.

On the bottom left of the diagram are the gears of management and administration, which grind out health services in response to strategic planning. Analysis by management of data derived from the information systems may determine specific health needs that establish requirements for infrastructure, and commodities. These can be met if financial resources are sufficient. A major portion of financing and administrative effort is absorbed by the human resources, those who directly provide services with supplies from logistics systems and in accord with norms and protocols. Adherence to these norms is what determines the quality of services as delivered in hospitals and health units around the country. Adherence must be constantly measured

(monitoring and supervision) in order to ensure quality and to adjust norms and protocols when necessary. Furthermore, quality must be recognized by management and communicated to practitioners and users in order for it to be maintained in the services and appreciated by users.

Finally, in the lower right corner, the outcomes of health services are depicted as nutritional status, maternal and newborn infant health, and reproductive health as well as prevalence of HIV/AIDS and other infectious diseases. Morbidity and mortality from these conditions can be evaluated through information systems to improve planning and management.

For more information, please visit
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