

**“The Impact of the Basic Integrated Health System (SIBASI) program on participation in, access to and quality of healthcare among public health care users in El Salvador”**

**Research Report**

**Jill Murphy**

**Completed as part of the IDRC Internship Programme, 2006,  
with the Governance, Equity and Health Programme Initiative**

**This report is presented as received by IDRC from project recipient(s). It has not been subjected to peer review or other review processes.**

**This work is used with the permission of Jill Murphy.**

**© 2006, Jill Murphy.**

## Table of Contents

Executive Summary .....	1
Introduction .....	1
Review of Literature- Theoretical Perspectives on Participation, Access and Quality:.....	3
Participation .....	3
Access:.....	8
Quality .....	12
History and Context.....	15
Health Sector Reform in Latin America and El Salvador: .....	15
Challenges in Health and Access to Health Care in El Salvador.....	19
The SIBASI: Framework and Structure .....	23
Methodology and Ethical Considerations:.....	29
Ethical Issues.....	32
Analysis- Perceptions of SIBASI Program by Various Actors.....	34
Policy Makers and International Organizations.....	34
SIBASI Employees .....	37
Civil Society and Other Experts.....	39
Community Members .....	42
Discussion and Conclusions: The Impact of the SIBASI Program on Participation, Access and Quality in Health .....	46
Works Cited.....	51

## **Executive Summary**

Health reform and policy development has been a challenge across Latin America since the 1970s. Reform in Central America has been more recent, and is the subject of intense debate and polarized opinion about the best approach to take. Health reforms, whatever their nature, take place in response to the need to improve services for the people in the region, the majority of whom live in poverty. In El Salvador, a part of the move toward reform is the recent Basic Integrated Health System (SIBASI), a decentralized model for primary healthcare that spans the country. I conducted a preliminary evaluation of the impact thus far of the SIBASI program on participation, access and quality of healthcare in El Salvador. My focus was on the perceptions of these variables by numerous stakeholders in the country. I found that although the SIBASI program was “good on paper” and had definite potential, it had not met with a great deal of success. Additionally, I found that existing barriers in the health system in El Salvador- extreme poverty, ineffective governance, politicization, poor financing, contention in the reform process- severely limited the success of the SIBASI program.

## **Introduction**

Health reform and the development and implementation of effective health policies and programs have been a challenge across Latin America since the 1970s. The need to provide people with effective, equitable and accessible health services has led to debate and contention over various approaches to reforms. Governments are faced with the challenge of financing and managing health systems in the context of great disparities in wealth and health problems that reflect the realities of the prevalent poverty in the region. At the same time, non-governmental organizations often play a role by filling the gaps in service in areas where government services do not reach or are ineffective. The proposed solutions to the challenge of health service delivery vary greatly depending on the source, and often appear very differently in theory and in practice.

In El Salvador, health reform has been in the forefront of political debate since the end of the civil war in 1992. The country has been engaged in contentious debate regarding the direction of the reforms, leading to conflict both in the streets and in the political arena. This contention continues while the majority of El Salvador's people live in poverty, with poor access to public health care. Health care services, when accessed, are frequently of poor quality, and services are run with little to no social participation. While the discussion around reform continues with no significant progress, a number of programs have been implemented in an attempt to cover the health needs of the population.

In 2000, the government of El Salvador and the Ministry of Health and Public Assistance (MSPAS) introduced the Basic Integrated Health System (SIBASI) in an attempt to address the shortcomings of the public system in providing health services for the majority of the population. The mandate of the SIBASI project, according to MSPAS and USAID, is to improve, through a decentralized and integrated health program, access to and quality of care for the poorest people in El Salvador, and to use social participation to inform the processes of policy development and implementation (MSPAS Online: SIBASI-Marco Conceptual y Operativo). My research aim is to understand if or how the project has been successful in doing so. Words and concepts such as 'participation' have become commonplace in mainstream development terminology, however implementing policies which create real health improvements for communities and reflect true democratic

principles has been a challenge in the LAC region. Through my research I sought to determine whether or not improvements have taken place, and why or why not.

The study draws upon three key variables- participation, access and quality in health- which were drawn from the mandate of the MSPAS and its goals for the SIBASI program. This study is preliminary and through it I hope to give an initial impression of the impact of the SIBASI program on participation, access and quality in health for users of the public healthcare system in El Salvador. Many users of the public system are not formally employed and live below the poverty line. In addition to lacking access to the Salvadoran Institute for Social Security (ISSS) system due to being informally employed, many public health users face challenges to accessing health services. Challenges to health access are common among people who live in rural areas, may be unable to afford to pay for health services should fees apply, and may lack access because of culture, gender or age. Public health users might also live in vulnerable circumstances due to natural disasters such as earthquakes, storms and heavy rains, or due to violence and crime in their area. This study seeks to determine the impact of the SIBASI program on participation, access and quality in health for the public health using population, taking into account that many may be underserved by the health system.

The following section gives an overview of the concepts of participation, access and quality in healthcare. This is followed by a discussion of the context of the health situation in El Salvador, reviewing the process of health reform, the challenges faced to healthy living and health care in the country. It also gives an overview of the SIBASI system, both in terms of its conceptual framework and its implementation so far. Details of the methods employed in this study and the ethical implications are followed by an analysis of research data. The report concludes with a discussion of results, conclusions and recommendations.

## **Review of Literature- Theoretical Perspectives on Participation, Access and Quality:**

In their overview of the SIBASI program, the MSPAS name increasing participation, access (universalidad) and quality as priorities for the SIBASI program (MSPAS Online: SIBASI Principios y Valores). An overview of theoretical concepts, and reflections on their potential for praxis, helps to understand these elements in terms of their importance for increased equity in health systems.

### ***Participation***

Participation has become a widely used, and broadly contested, term in many policy areas including healthcare since the 1950s and 1960s. In Latin America and other developing regions during this period, the adoption of Western health systems was common, and countries started trying to involve the population in health programs. Vásquez et al state that in this period “promotion of participation responded, on the one hand, to the necessity of introducing changes in the orientation of the health system and, on the other hand, tried to achieve an extension in coverage by services” (Vásquez et al, 31).

In the 1970s, the failure of the hospital-centred, Western style system to provide for the majority of people in Latin American countries was realised. This accompanied with the political context- of dictatorships and strong social movement oppositions, the Cold War and the petroleum crisis- meant that there was a need for a major change in the health systems of the region (Vásquez et al, 31-32). The primary health model became the alternative to the systems in crisis. According to the Alma-Ata Declaration of 1978, primary healthcare “...requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary healthcare, making fullest use of local, national and other available resources...” (Declaration of Alma-Ata 1978, World Health Organization Online). The Alma Ata Declaration marks the prioritization of the primary health model, which advocates community participation, decentralization, increased efficiency and responding to perceived needs and local conditions (Vásquez et al: 2002, 31). Under this model, participation was thought of as “the active process by which a relationship of collaboration is established between the government and the population in the planning, implementation and utilization of health services, with the

objective of achieving a better local autonomy and control over infrastructure and technology in primary healthcare” (Vásquez et al: 32).

Through the 1980s and 1990s, in the context of neo-liberal policy dominance, participation remained a main component of health policy. The nature of participation in these decades, however, changed to a conception of healthcare users as “clients” or “consumers” and could be defined, in broad terms, as “the incorporation of the population or a sector of it, in variable stages or forms, in some activity related to health” (Vásquez et al, 33). While the concept has been prioritized in the discourse surrounding health policy, determining a consistent definition of participation, and how to achieve it, remains a challenge.

Definitions of participation seem largely to draw attention to its ambiguity rather than to clarify the concept. The central questions when defining participation seem to be: who participates, to what extent and how do they become involved? Morgan outlines utilitarian and empowerment approaches to participation in health, which have very different meanings. The former is described as involving an effort by policy makers to use “community resources (land, labour, money) to offset the costs of providing services”, while the latter is described as a means “...through which local communities take responsibility for diagnosing and working to solve their own health and development problems” (Morgan: 2001, 221). Related to these two definitions are two approaches taken to participation in health also outlined by Morgan. The ‘Pragmatist Approach’ reflects a belief that it is necessary that agencies, communities and governments collaborate to “achieve mutual goals” while the ‘Activist Approach’ argues that social justice, structural change and commitment to stronger democracy are extremely important. Proponents of this approach support a social movement approach to participation and prioritize empowerment.

Vásquez et al identify a difference between collective and individual participation in health. They state that participation, in practice, can take place in various ways. Collective participation in health can take place in the form of commissions composed of representatives from health institutions and other social sectors or community organizations. Collective participation can also include the carrying out by organized groups of actions, such as petitions, demonstrations and marches, which demand or oppose a change in the system. During processes of health reform, there are several channels for collective participation, including the strengthening of local level structures that allow citizens to

express their opinions about health services and policy and the introduction of community members to the management bodies of hospitals and health centres (Vásquez et al: 2002, 33).

Individual forms of participation in health became more common during the 1980s under neo-liberalism. Individual participation can be expressed through the use of the health system and its services, the negotiation of “therapeutic options” between physicians and informed clients, the expression of opinions about health services by patients through suggestions or complaints and the development and support of specific components of health services such as prevention and education campaigns. Another common form of individual participation in health has become the financial contribution to health services by patients through user fees. (Vásquez et al: 2002, 32-33)

Power is a major factor in defining participation and in deciding who participates. On the subject of the power challenge that must accompany many forms of participation, Vásquez et al state: “Real processes of social participation in health should accompany an institutional development that includes changes in the structure and forms of work that permit a response to the changing needs of the population” (Vásquez et al: 2002, 33). Decentralization, for example, is one element of healthcare reform, common in Latin America, which is said to increase participation. Ugalde and Homedes (2002) describe one justification for the healthcare decentralization process in Latin America as “community participation and democratization”. They state that: “...community participation is a strategy for guaranteeing that primary services respond to the necessity of the users and are accepted by them” (Ugalde and Homedes: 2002, 21). They further state that proponents of decentralization argue that it increases the accountability of the health workers, even resulting in increased empowerment for the community, leading to better coverage and quality (Ugalde and Homedes, 21). Ugalde and Homedes, however, are sceptical about the success of decentralization policies in achieving this kind of participation. They argue that “true” participation requires a shift in power from the elite to the community level- this, they say, is not something that those in control are interested in achieving despite their use of rhetoric surrounding participation (Ugalde and Homedes, 23). This raises the issue of the ambiguity of participation in terms of the “community” being asked to participate in its own development by donors or elites, but perhaps being only invited to participate to the extent that those in control allow it. Morgan raises this in a discussion of the “mainstreaming” of



participation, citing as an example its adoption by the World Bank in the mid- 1990s. Participation, as it is practiced in mainstream development is often criticized for having no substance or for simply renaming old approaches. In his discussion of the criticism surrounding participation, Parfitt states: "...many of these critiques throw some level of doubt on the emancipatory claims of participation, arguing that, rather than empowering those at the grass roots, it simply provides alternative methods for incorporating the poor into the projects of large agencies which remain essentially unaccountable to those they are supposed to serve" (Parfitt: 2004, 537). Similarly, Vásquez et al suggest that community participation as a form of compensation for the chronic underfinancing in the health system is the most common form of participation in Latin America and that it becomes dangerous that "community participation" is encouraged as a replacement to the role of the state (Vásquez et al, 34). While much of the literature on participation in theory discusses its potential for empowerment, many of the discussions of its practice seem to be sceptical of its potential for success.

A discussion of who participates must also include a discussion of who makes up the community. It is common to discuss "community participation" as if the community is unified, egalitarian and understanding of its holistic needs. Communities are complex, however, and participatory approaches must take this into account. Robert Chambers (1997) states:

Policy documents and project proposals advocate 'community participation' and go no further. Visitors to villages and slums assume that those whom they meet represent 'the community'. Within communities, though, there are many obvious differences. Following Alice Welbourn (1991), four major axes of difference can be seen: of age, gender, ethnic or social group, and poverty; and there are always others: of capability and disability, education, livelihood strategy, types of assets, and much else. Those whom outsiders meet and interact with are most likely to be middle-aged or youths, male, from dominant groups, and economically better off. And often their criteria, preferences and priorities are taken as those of the whole community; but the community also includes those who are weaker and worse off—children, the very old, females, social inferiors, subordinate groups, the disabled and those who are vulnerable and poor" (Chambers, 183).

Other forms of participation may include political actors, business, community or local government leaders and civil society- they may not involve "community members" per se. For example, in the World Bank's "Participation Sourcebook", they outline the decision to commit to "Stakeholder Participation" rather than "Popular Participation". The reason they give for this approach is that: "sponsors and designers of development activities had to work

with and through powerful stakeholders to serve the needs of the poorest people. Attempts to bypass powerful stakeholders often resulted in opposition from them; this opposition usually compounded the problem of getting anything useful accomplished”. (World Bank Participation Sourcebook Online: 1996). Therefore they prioritise “borrowers, indirectly affected groups and the Bank” in their participatory activities. The difference between Chambers’ extensive description of community members with varying needs and the World Bank’s approach to “Stakeholder Participation” once again demonstrates the broad spectrum of what can be categorised as participation.

The final issue of contention in discussions of participation is that of whether it is a means to an end, or of its sustainability. This relates less to the question of who participates, and better approaches the issue of how they might do so. Morgan states: “The marriage of the concepts of ‘sustainability and participation’ has led analysts to add sustainability criteria to the list of points on which participation will be evaluated” (Morgan, 223). This raises the question of whether participation can be measured in a finite way. Can participation end with a project, or must it be a longer process which involves changes in power structures and policy processes? Parfitt states:

To the extent that participation is viewed as a means, this is indicative that power relations between those at the grass roots, or the target community, and the aid/ government agencies, will be left largely untouched. Project design (including definitions of project goals and targets) and management will be left largely in the hands of the traditional authorities, while the role of those mobilised to participate will simply be to rally around to work for the predetermined goals of the project. Power relations between aid donors and recipients remain essentially the same as in traditional top-down models of development. However, the view of participation as an end suggests a transformation in power relations between donor and recipient, with the latter empowered and liberated from a clientalist relation with the former (Parfitt, 539).

There seems to be a breach between the ideal of participation (as empowerment) and the mainstream of participation (as incorporation). The ambiguity of participation means that it is difficult to measure its success. It seems, perhaps, that for it to succeed there needs to be an agreement between the power holders, governments or agencies, and the stakeholders and community members, on what their goals for participation are. This lack of understanding seems likely to lead to less than satisfactory participation (see, for example, Cheolho: 2004).

***Access:***

I will also use the variable of access to healthcare as a means of evaluating the SIBASI program. Access, according to Rosenberg and Peña "...refers to the capacity of effective use of [health] services by the population as well as the ease with which they can be reached" (Rosenberg and Peña: 2000, 3). They also draw attention to the important difference between access and coverage: "Coverage in health describes the proportion of the population having health protection, in other words, those that have some measure of access to health services". They then call attention to the important distinction between theoretical and actual coverage- theoretical coverage refers to those that are covered legally and are counted in statistics as having access to health care. Actual coverage refers to those that have effective coverage and can access health care in practice (Rosenberg and Peña : 2000, 3). Haddad and Mohindra (2001) add to the definition of access in health: "Access is understood ... as the opportunity to use services that encompass the following attributes: availability, affordability, acceptability and adequacy. This means fair access equals health care services that are available within the community, absolutely affordable, socially and culturally acceptable, and of good quality" (Haddad and Mohindra: 2001, 9). This definition reflects the challenges faced to access by many people, especially those in vulnerable or marginalized circumstances.

The issue of access is tied to the issue of equity and of exclusion. Vargas, Vasquez and Jane (2002) state that one main question of debate during the health reform processes in Latin America was whether everyone should have the same access to health services according to their needs, or if there should be a basic package of services only for those with limited resources. They state that although the principle of equality was a major factor in the majority of Latin American reforms, only Chile, Costa Rica and Cuba have managed a somewhat universal healthcare system. When analysing equity in health policies, they call attention to the difference of approaches found in the 'egalitarian focus', which formulates objectives in terms of equality, and the 'neo-liberal focus' which is expressed in terms of "minimal levels and the maximization of aggregated wellbeing" (Vargas, Vasquez and Jane: 2002, 928). The major difference between these two is that egalitarian policies do not designate access to services based on how much a person can pay; the idea of equality in neo-liberal theory, however, is based on opportunity and not on an end result. Similarly and

on the subject of equity, Acuña draws on John Rawls' Theory of Justice to argue that all primary social goods should be equally distributed unless the unequal distribution of any good be in favour of the less privileged. Additionally, social and economic goods should be organized in such a way as to most benefit those who are disadvantaged (Acuña : 2005, 1). In the context of healthcare, she argues that this not only has normative value, but that increasing access to and equity in health also has benefits for whole societies—decreasing the number of people who are sick and requiring care means increasing the health of societies and decreasing overall costs (Acuña, 3).

Factors that are recognized as contributing to access, and which contribute to exclusion include: economic factors, location of residence and the ease or difficulty with which health centres can be reached (for financial or logistical reasons), people's perceptions of the gravity of illness they are suffering, education, language barriers, cultural, ethnic and gender issues, and people's perceptions of the quality of care they will receive (Rosenberg and Peña : 2000; Rosenberg and Andersson : 2000; Whitehead, Dahigren and Evans : 2001). Also affecting access are structural issues that occur within health systems. Common in the Latin American and non- English speaking Caribbean countries are issues of segmentation and fragmentation in health systems, often leading to poor efficiency, poor distribution of resources and vertical inequity between sub-sectors. These internal structural issues all have an impact on access and exclusion and should be addressed at the policy level, taking into account the barriers faced by populations to accessing health services (Rosenberg and Andersson: 2000; Vargas and Vasquez: 2002; Acuña: 2005). In their discussion of the creation of health policies that promote equity, Haddad and Mohindra state that policies should account for the challenges faced by users to access, and should focus on increasing users' *capability* to access health services. In other words, Haddad and Mohindra advocate policies that take aim to increase the potential of users to access services, a more holistic approach to health policy (Haddad and Mohindra: 2001, 7)

It is important to briefly explore the common barriers to access in health services. In terms of economic factors, those who are unable to pay for service, despite their formal coverage, may be unable to access health care. In their discussion of the equity in health in low- income countries, Whitehead et al (2001) name reduced access to healthcare as one major impact of user fees and out –of- pocket payments. Those unable to pay are frequently unable to access healthcare or delay seeking attention until an emergency situation occurs.

This often means that, in an emergency, poor people will have to pay more for services at a hospital as they were deterred from using a health centre or clinic due to cost when the illness was less severe (Whitehead et al: 2001, 834). Spending on medicines is also a major barrier to proper health treatment- spending on pharmaceuticals in lower income countries now makes up for 30- 50% of healthcare expenditure, whereas it previously made up approximately 15% (Whitehead et al, 833). These increased costs are a significant limitation to access by poor people to proper health treatment.

Other issues leading to limited access to healthcare by many people are what Rosenberg and Andersson name “disparities of access”. These involve not only the level of poverty, but also the geographical and/or cultural barriers to healthcare. They estimate that for the LAC region there are: 121 million people below the poverty line; 107 million people who, although they might have formal coverage, cannot access health services for geographical reasons; 43 million people who do not use health services for cultural reasons. As cultural reasons they list- preference for traditional healing, the belief that formal healthcare is not respectful of their culture, the fear of mistreatment and gender- based reasons (Rosenberg and Andersson: 2000, 120). They are also careful to indicate that these factors, and the factors listed above, are not mutually exclusive but are also not necessarily co-related.

Lack of access and equity can also be a result of the way that health systems are constructed. Acuña names issues related to health systems as “segmentation” and “fragmentation”. Segmentation, she argues, causes exclusion because it means that the conditions for accessing health systems are often only achievable by the most privileged groups in societies. The most serious aspect of this is that, while appearing in legal form as universal, factors such as employment or income level mean that health systems are actually segmented. She argues that segmentation creates a direct barrier to the exercise of the right to healthcare, and that in the region only a very small number of countries have made efforts to address the issue. She states that, according to PAHO, in the LAC region from 20%- 70% of the population do not have access to healthcare when they need it, and that an average of 78% of the population have no type of health security whatsoever. This has particularly been aggravated by a shift in the labour market to an informal economy. The principal barrier to accessing the health system is economic (Acuña, 3). This discussion by Acuña is interesting, as she places the responsibility for limited access to healthcare on the system, while the

majority of other analysts discuss the barriers from the point of view of those who are excluded. The two issues are obviously somewhat the same, however Acuña's analysis places the responsibility on a system that is inappropriate to the reality of LAC countries.

The second systemic factor impacting access to health care, according to Acuña, is "fragmentation". She argues that access to healthcare is prevented because many agents within the system operate with little to no coordination. This, she argues, "impedes an adequate standardization of quality, content, cost and application of health interventions, increases the cost of interventions and promotes an inefficient use of resources at the interior of the system". She draws on El Salvador as an example, discussing the low demand for hospital beds in the Social Security System, while the beds in the MSPAS system are overflowing (Acuña, 4). This indicates the need for the different components of national healthcare systems to work together so as to provide adequate service to the whole population.

Exclusion from healthcare is a major problem in the LAC region. The multiple types and reasons for exclusion from healthcare mean that it is difficult to quantify in a definite way. One way of estimating levels of exclusion from healthcare is to measure the number of people who are not covered by Social Security (SS) systems. This means, in theory, that they do have access to Public System (PS) care, but that they are excluded from what is generally considered to be the highest level of quality service in the public sector (Rosenberg and Peña, 6). Rosenberg and Peña state that SS does not cover 46% of the population in the LAC region, and that in El Salvador 86% of the population is excluded. This system covers formal workers, and in a region with a vast informal economy and a large number of female-headed households, exclusion is common. Amongst the significant population not covered by SS, exclusion from the PS exists for many of the reasons listed above. Limited access to healthcare not only has normative implications but also impacts the health of populations, public opinion, economic condition of individuals and families, and on the system's efficiency as a whole (Rosenberg and Andersson: 2000, 119).

## *Quality*

Finally, I will examine the issue of quality in healthcare in relation to the SIBASI program. It is extremely important to increase access by marginalised communities to healthcare, but access has limited meaning if the care is of poor quality. In terms of equity, it is of great significance that all sectors of society, regardless of income level, ethnic or cultural background, gender, age or geographic location have the right to quality healthcare in which they can feel confident and comfortable. As was mentioned above, one variable that affects access to health care is perceptions by people of the poor quality of care. Healthcare centres can be financially and geographically accessible, but if they do not provide the user with a sense of dignity and trust in a time when they are vulnerable access will continue to be limited.

Ross and Zeballos (2000) define 'quality' as "...the joined characteristics of goods or services that are able to satisfy the needs and expectations of a user or client". They make a distinction between technical and perceived quality in healthcare. They say that technical quality can be seen from the point of view of healthcare provision, and involves factors such as effectiveness, timely attention, efficiency and security of users. Perceived quality, they state, comes from the users themselves. "This takes into account material, psychological, administrative, and ethical conditions..." of health care (Ross and Zeballos, 93). They claim that it is a recent development for concerns with quality to move to the public and community level of healthcare from the hospital level. This, they argue, is largely a result of the increased education and demand of health care users, the growth of attention from the media about healthcare issues and increased ethical concerns by healthcare professionals (ibid, 94).

Campbell et al (2000) include access as a dimension of quality in their definition. They argue that the two main aspects of quality are access and effectiveness and state that the main concern with quality of care is "...do users get the care they need, and is the care effective when they get it" Campbell et al, 2000: 1611). They break 'effectiveness' into dimensions of clinical effectiveness and interpersonal care, the first referring to the ability of the care provided to function technically, and the second referring to the ways in which health professionals interact with their patients. Their discussion of access as a sub-component of quality does not only refer to the issues of accessibility discussed above, but

also involves “the extent to which the health care system provides facilities (structures) and services (process) which meet the needs of individuals” (Campbell et al, 1615). As examples they include the ability of patients to access certain types of health professionals to better suit their needs. These include female general practitioners, specialists, counselors etc.

Campbell et al also make a distinction between the discussion of quality of care for individuals and quality of care for populations. To the population level they add the dimensions of equity, efficiency and cost and define this level as “the ability to access effective care on an efficient and equitable basis for the optimization of health benefit/ well-being for the whole population” (Campbell et al, 1617). This definition is useful for the discussion of quality in health for marginalized populations.

The issue of patient perceptions of health care quality is also important. Many dimensions of quality, as outlined above, are subjective but no less important than dimensions relating to efficiency and technical competence. The type of treatment received by patients is important in determining their likelihood to access formal health services. The perceptions by patients of healthcare quality are recognized in the literature as important (Hart, M: 1996; Seid, M et al: 2001; Sofear, S. and Firminger, K: 2005; Williams, S. 1998) and will be explored as an important aspect of the evaluation of the SIBASI program. For example, Creel et al (2002) state that: “Research highlights the benefits of addressing client perspectives on quality of care, since it leads to improved client satisfaction, continued and sustained use of services, and improved health outcomes” (Creel et al, 1). They also indicate the importance of considering patient perception before seeking treatment, not just during services. They argue, with relevance to the above discussion of access, that although many studies show that geographic and financial factors largely limit access to healthcare by women, “...the degree to which these barriers limit access is strongly influenced by clients’ perception of quality” (Creel et al, 2-3). Additionally, they indicate that client perceptions are influenced by their culture, experiences they had before with health services, such as experiences with health providers and other factors. Client satisfaction, due to past experiences with health services, may also not necessarily reflect health services that are of good quality. Satisfaction expressed by clients may simply reflect low expectations, a desire to please the interviewer, fear that they will have trouble accessing services in the future or reluctance to complain (Creel et al, 4).



There are similarities between what clients consider as necessary for quality healthcare services. Creel et al discuss, in their article on family planning access for women, identify appropriateness and availability of contraceptives as one dimension of quality. This could apply more universally to services of other types- the availability and accessibility of drugs and treatments. Other patient- identified dimensions of quality are respectful treatment during health services, privacy, confidentiality, technical competency in services and adequate information. Effective policies and financing schemes are necessary to address the issue of quality in health care, both from a technical and perceived perspective.

## History and Context

### *Health Sector Reform in Latin America and El Salvador:*

Health care reforms have been taking place in Latin America since the 1970s and 1980s, and have followed many types of approaches. States, social organizations and individuals have advocated for varying kinds of reforms in response to the need to improve health care systems. Health Sector Reform (HSR) can be defined as “a significant and intentional effort to improve the performance of the health care system”. Changes to health systems may affect financing, payments, organization, regulation, and may lead to changes in the behaviour of patients or of service providers (Institute for Equity in Health, 2006: 7- 8). The reasoning for reforms, to improve health systems, may be different according to the conception of what a health care system should do. Many reforms aim to increase efficiency and cost-effectiveness of systems, while others prioritize an increase in equity in health care and the improvement of citizens’ access and experience with care. The concern of this study is with increased equity in health care, which “...implies that the resources and services of the health sector are distributed and delivered in accordance to the needs of the population, and that they are financed in accordance with the population’s ability to pay” (Institute for Equity in Health, 2006: 8). It is important to distinguish between ‘equity in health care’ and ‘equity in health’, as the latter of refers to the health of populations rather than health systems specifically. Equity in health means that factors such as social status, wealth, geography, demographic characteristics or other non- biological factors do not combine with structural obstacles to hinder equal chances to a healthy life. Health sector reforms, while dealing specifically with health systems, may also have an impact on general equity in health.

There are a number of reform models that have been pursued in Latin America. These include the expansion of medical insurance, contracting services to private providers, increased funding of basic health packages, and various forms of decentralization. Through the 1990s, the Government of El Salvador (GOES) pursued reform under the Public Modernization Program. Elements of this program included: decentralization of healthcare delivery and administration; the introduction of private sector involvement (including private

insurance companies) in healthcare provision for all but the poorest of the population; and the promotion of civil society organizations as managers of “social welfare” programs (PAHO Regional Core Health Data System- Country Profile El Salvador). Throughout the decade health reform was a contentious topic, and many proposals for reform were advanced, with none finding universal and cross-sectoral support. In 1993- 1994, national and internationally-based consultants from USAID, the Inter-American Development Bank (IDB) and the Pan American Health Organization (PAHO) conducted an analysis of the health sector in El Salvador (ANSAL) and produced a document entitled “Health Reform: Towards Equity and Efficiency”, which read as a diagnosis of the health system and a proposal for its reform. The analysis demonstrated that the health system in El Salvador had many problems including “inequality, low coverage, mistreatment of patients, curative-centered treatment of low quality and accessibility, especially for the rural population and those with fewer resources” (Acción para la salud en El Salvador -APSAL: 2002, 9). In a move towards reform, the MSPAS began a series of organizational changes that were based on the ANSAL document, whose main background was World Bank and Inter-American Development Bank recommendations for developing countries. In 1994- 1995, the Group for Health Sector Reform created the “Guide for Health Sector Reform in El Salvador”. During this period the GOES also formed the “Government Plan for 1994- 1999: El Salvador, Country of Opportunities” which discussed the issues of health and nutrition.

In 1998 the contention around health sector reform culminated in a number of strikes and demonstrations protesting the lack of progress on the issue of reform and the poor state of the system. Five proposals for reform emerged out of this contention: The National Commission for Development (Mesa 13 de la Consultación Especializada), The Salvadoran Foundation for Economic and Social Development (FUSADES), the National Commission of Health (CONASA) and the citizen proposals, advanced by the Medical College Professional Association and the Union of Workers of the Salvadoran Institute for Social Security (STISSS) (Ministerio de Salud Pública y Asistencia Social: Propuesta Reforma Integral de Salud : 2006). A brief overview of the various reform proposals demonstrates the divergence of opinion from the various actors in terms of the approach to reform most appropriate for El Salvador. The Mesa 13 proposal promoted an integrated national health system, and emphasised the separation of the provision of services from the coordination and management of the system’s different components. The FUSADES proposed a market-

based solution, suggesting the purchase of mandatory insurance to cover primary, secondary and third tier levels of healthcare. This would be financed individually and by the state. Thirdly, the CONASA proposal advocated reform through the private provision of services to be mediated by the state, complimented by a universal insurance financed by the government. The Medical College, meanwhile, had conducted a participatory process that led to the proposal for a National Health Policy with special emphasis on participatory management and on decentralization without privatization, under the direction of MSPAS. The STISSS proposal suggested that the Salvadoran Institute for Social Security (ISSS) become the director of an integrated health care system, extending social security to the whole population. Under this model the MSPAS would be concerned with policies around health provision.

Out of the failure of the proposals to gain approval came the Council of Health Reform in 1999. The Council presented a reform proposal to the President of El Salvador in late 2000, which contained a basic outline for reform, and suggested the formation, within 90 days, of a Monitoring Commission to oversee the process. At the same time the MSPAS began to make serious changes in its organization and in the frameworks for institutional organization and for reform and modernization. As part of these changes, the MSPAS began to undertake a process of redistribution of management and control, and as part of this move towards decentralization came the Basic Integrated Health System (SIBASI) in December 2000.

In the meantime, the reform process has continued to unfold and to generate contention. In 2002- 2003, for example, the doctors and health workers of the ISSS engaged in a nine-month strike against the privatization of health care that they saw to be an integral part of the governments' proposal for reform. The strike was able to halt the privatization of the health system for the time being, although the issue remains at the forefront of the debate surrounding health care reform. The strike also led to an agreement on the formation of a multi-sectoral Monitoring Commission for Health Reform, convened by the president, which has yet to begin significant work (Murphy: 2006).

In May of 2006, the MSPAS submitted a "Proposal for Integrated Health Reform" to the executive, which the President sent to the Legislative Assembly for approval in mid-June (La Prensa Gráfica Online: June 2nd, 2006). The current proposal has nine main components: 1) The creation of an integrated national health system, which includes the

involvement of the public and private (lucrative and non-lucrative) sectors and draws on the participation of civil society and patients; 2) The creation of a model of attention based on prevention, promotion and primary attention to health; 3) The creation of a mixed model of service provision; 4) The creation a management structure that is under the direction of MSPAS. This management structure will regulate and direct the health system and will also deal with the financial management and the delivery of services; 5) The institutionalization of social participation across the health system; 6) The promotion of decentralization across the health system; 7) The investment in human resources in health; 8) The strengthening of inter-sectorality in the social organization response to the health challenge, through the promotion of all elements that relate to health, such as education, nutrition, housing and basic services, the environment and women's equality, especially at the local level; 9) Guaranteeing essential services for the whole population, through the implementation of the Essential Services Model from the initiation of the reform process. The proposal outlines three phases of reform, the first being the preparatory stage and short-term phase, involving institutional strengthening, the increase of coverage for basic services and the establishment of basis for the National Health System. The second phase will happen in the medium-term, and will develop the model of mixed service provision between the private and public sectors and implement the institutionalization of social participation. The third, long-term phase will involve decentralization and the formation of the National Health System (MSPAS Online: "Propuesta reforma integral de salud", 2006).

Since June, the legislative process around the proposal for reform has not advanced significantly. After it was sent the Legislative Assembly, the Farabundo Martí Nacional Liberation Front (FMLN) party called for a new draft as they saw it to represent the "road to privatization" to which the MSPAS responded that private-sector involvement would take place in extreme cases and not occur in place of the state (La Prensa Gráfica Online: July 3rd, 2006). The debate over the new proposal for reform and the privatization of health care has continued and since June the Legislative Assembly has not made significant progress with the proposal (La Prensa Gráfica Online: August 15<sup>th</sup>, 2006; La Prensa Gráfica Online: November 10th, 2006).

### ***Challenges in Health and Access to Health Care in El Salvador***

Health reform in Latin America, and in El Salvador specifically, is a response not only to the need to improve financing mechanisms and efficiency, but also to respond to the failure of existing structures to provide accessible and quality healthcare services to large numbers of people, who are very often poor. On the United Nations Human Development Index El Salvador ranks 101 out of 177 countries, with a Human Poverty Index of 34 out of 103 countries (UNDP Human Development Report Fact Sheet El Salvador: 2006) and has a total population of 6, 874,926 (Ministerio de Salud Publica y Asistencia Social: 2005) with 21% living on less than US\$1 a day (United Nations Population Fund Country Profile Online: 2006). The Salvadoran Ministry of the Economy, through the Director General for Statistics and Censuses (DIGESTYC) obtained statistics for 2004 through the Multi-Purpose Household Survey (EHPM). The EHPM defined poverty as the inability to cover the Extended Basic Basket (Canasta Básica Ampliada), which includes the Basic Nutritional Basket plus spending on living, health, education, clothing and other necessities. The basic monthly basket of food and nutrition in 2004 for urban areas was \$130.02 USD, and was \$96.28 USD for rural areas. The average national income was \$418.00 per month for 2004, with the highest incomes earned in the more densely populated urban areas such as San Salvador and La Libertad. Measuring according to those able to afford the Extended Basic Basket, there are approximately 562 thousand homes living in poverty in El Salvador, representing 34.6% of households. Of these, 12.6% of households live in extreme poverty, meaning that they cannot afford the Basic Nutritional Basket. Of households living in poverty, 29.2 % are in urban areas and 43.7% are in rural areas, with 21.7 % in the Metro San Salvador Area (AMSS). In rural areas, 19.3 % of households live in extreme poverty. (El Salvador Minsiterio de Economía, DIGESTYC: 2004). Based on figures from other sources, however, it seems that these figures may be somewhat conservative. Both the Extended and Basic Baskets are quite low in terms of the cost of living, particularly in urban areas and since the introduction of the American dollar as official currency.

In El Salvador the average life expectancy is 70 years overall, 67 for males and 73 for females. The most vulnerable groups of the population are children, women and the elderly.

The maternal mortality rate is 150 per 100,000 live births, considered to be “unacceptably high” by the Government of El Salvador (United Nations Population Fund Country Profile: 2006). The mortality rate for children under five years was 38.5 per 100,000 in 2001. In 1994, of 600 deaths in children under five years of age, 47% were the result of communicable diseases, 60% of which were from intestinal infections. In infants, visits to outpatient offices in 1996 were caused in the majority by acute respiratory infections, followed by intestinal parasites and other intestinal infections (Pan American Health Organization Country Profile- El Salvador: 2001). In 2001, PAHO indicated that, according to the last available data, the number of infants under one year old that were vaccinated for poliomyelitis, measles, diphtheria, pertussis and tetanus and tuberculosis ranged from 99% (for TB and DPT) to 97% for measles. Social Watch, however, indicates that the rates of vaccination are dropping, from an average of 93% in 2002 to 84% in 2004 (Social Watch Country Summary: 2005).

The elderly also make up a very vulnerable segment of the population in El Salvador. In 2005 the population was made up of 639 415 people over 60 years old, or 9.5% of the population. In 1994, 29.9% of the elderly had no income and 25.8% received no financial support from family members (PAHO Country Profile- El Salvador: 2001). The majority of deaths among elderly people are due to cardiovascular diseases, with neoplasms as the second leading cause. Other medical conditions of concern to the elderly population are diabetes, pneumonia and chronic renal insufficiency (PAHO Country Profile- El Salvador: 2001). People over 60 years of age face the challenges of low-coverage and barriers to access for issues of finance and mobility. Of the population over 60 years of age in 2005, only 13% were covered by a formal pension (Consejo Nacional de Atención Integral a los Programas de los Adultos Mayores: 2005).

For the general population, the MSPAS indicates that among users of the public health system, the ten leading causes for medical consultation are: 1) acute respiratory infections; 2) consultations for preventative programs (including maternal and child health, family planning and detection of cervico-uterine cancer); 3) urinary tract infections; 4) intestinal parasites; 5) diarrhoea and gastroenteritis caused by infections; 6) routine medical examination; 7) acute conjunctivitis; 8) acute bronchitis; 9) skin infections; 10) stomach and intestinal illnesses (MSPAS Estadísticas: 2002). Many of these factors are related to poverty and poor environmental quality. The United Nations Population Fund (UNFPA) indicates that 74% of the population have access to an improved water supply, with a significant

variation in coverage between urban and rural populations (UNFPA Country Profile- El Salvador: 2006). PAHO shows that 69% of the population in 1995 had access to human waste disposal. PAHO also indicates that nutritional deficiencies such as iodine, vitamin A and iron pose a significant public health problem (PAHO Country Profile- El Salvador: 2001). In terms of health access, the EHPM reports that 827,148 people indicated that they had suffered an illness or injury in the month preceding the survey, representing 12.2% of the population, 46.0% of whom were men and 54.0% of whom were women. Of the population affected by illness or injury, 50.5% looked for treatment through formal means such as consultations and private and public health institutions. The other 49.7% stated that they self-medicated or did not seek treatment either because they did not consider it necessary or because they lacked financial resources (El Salvador Minsiterio de Economía, DIGESTYC: 2004).

El Salvador's spending on social services is extremely low. In 1999 public spending in the social sector was 5.7 % of GDP (PAHO Country Report Online: 2001). In 2003, the total expenditure in health for El Salvador was 7.6%, with total public spending on health at 3.4% (MSPAS Online- Estadísticas: 2004). Social Watch shows that the government spending in health decreased to 3% in 2004, one of the lowest rates of investment in health in the Americas (Alvarado, Y: Presentation to II International Conference on Public Health in Central America, 2006), while the MSPAS indicates that the annual per capita spending on health is US \$168, which is very low by Latin American standards. PAHO country representative Eduardo Guerrero recently criticised the government's low investment in public health saying: "The financial resource of the Ministry of Health is not sufficient to cover the demand. There is a need to increase the resource so that they can give basic family health attention that is much more adequate" This was said in response to the proposed budget for health for 2007 of \$323 million dollars (La Prensa Gráfica Online: November 21<sup>st</sup>, 2006). Problems in the public health system in recent months reflect the insufficient resources, with many institutions putting in emergency requests to the MSPAS for extra resources, having run out of medications and supplies before the end of the fiscal year. The MSPAS put in a request with the Treasury Department for supplementary funds (La Prensa Gráfica Online: October 11<sup>th</sup>, 2006).

Despite high levels of poverty, household spending on health is greater than public spending, which, according to the MSPAS "demonstrates the enormous effort that families



make for healthcare, in detriment to other necessities” (MSPAS Online: “Propuesta reforma integral de salud”: 2006). The MSPAS covers 80% of the population and ISSS covers 17%, the two systems have 2,464 and 1,583 hospital beds, respectively. For every 10,000 people, El Salvador has 9.1 doctors, 5.4 midwives, 3.8 nurses and 2.1 dentists. In the public system there are 3473 doctors, 5274 nurses and 1499 health promoters. 60% of the country’s doctors and dentists work in the capital San Salvador (PAHO Country Profile- El Salvador: 2001).

The health system in El Salvador is marked by fragmentation, centralization, lack of public financial investment, and is unequipped to deal with the health concerns of the population. An MSPAS analysis of the health sector (2006) indicates that demographic and social conditions in El Salvador are reflected in the epidemiological profile of the country: a high prevalence of infectious diseases related to the environment, nutritional deficiency, poor consumption habits, lack of health education and the effects of the lack of basic services on the lifestyle of the population. They state: “[t]he levels achieved in maternal and infant mortality are still not acceptable. This coexists with the problem of mental health and the emergence of new diseases such as AIDS, in addition to the increase of chronic non-communicable diseases and damages to health brought on by injuries from accidents or violence. All of them [are] problems whose prevention and treatment require resources of increased quantity” (MSPAS Proposal for Integrated Reform Online: 2006). Currently, the coverage provided by the three sub-sectors of the health system only reaches approximately two thirds of the population, leaving more than two million people without health coverage (MSPAS Proposal for Integrated Reform Online: 2006). Systemic problems are combined with a burden of disease exacerbated by high poverty rates and incidence of violence, communicable diseases such as Dengue and natural disasters. It is obvious, and universally recognized by actors in the health sectors, that the current structure of the health system is ill equipped to provide for the Salvadoran population. While the debate around reform continues, the SIBASI program was introduced to help improve the health care situation for the groups most in need of attention at the primary and secondary level.

### ***The SIBASI: Framework and Structure***

The SIBASI program began with the institutional reorganization that was initiated in the 1990s with the division of 5 administrative health regions into more decentralised offices, which were chosen based on El Salvador's 14 provinces (departments). In the most recent reorganization, these 14 departmental administrations were further divided into the 28 SIBASIs, to match the 28 national secondary care hospitals. The SIBASI is defined as "...the basic decentralized operating structure of the National Health System, based in primary attention, that mediates the provision of integral and effective services and the correspondence of other sectors, and contributes to improving the level of health of a defined population" (APSAL: 2002, 21). In the report for a baseline analysis of seven SIBASIs, USAID's Program for Health Reform Plus (PHRplus) cites a belief among field staff in the centres that this model is the first program that reflects real change and will make a difference (Sieber, E.: 2002, 5-6). In their report on the program in its initial stages, however, the non-governmental network Action for Health in El Salvador (APSAL) displays scepticism about the program, stating, for example, that it was not a result of citizen participation or consultation with civil society as it claimed to be and the instead it was in-line with the priorities of financial institutions (APSAL: 2002, 7). Both PHRplus and APSAL conducted preliminary evaluations of the SIBASI in 2002.

The priorities considered integral to the SIBASI reflect many of the priorities for health reform discussed above. Integrated attention to health is one priority of the program, connecting education, prevention, curative care and attention to "physical, economic, social and cultural factors that affect the individual, the family, the community and the environment" through a network of establishments that are "accessible, equitable, participatory, continuous and of quality" (APSAL: 2002, 17). The integrated model for health reform, which is meant to inform the SIBASI's provision of care, aims to deliver specific attention to children, adolescents, women, adult males and seniors and to deal with the environmental aspects of health (Seiber, E: 2002, 27). The program is based upon decentralized management, and is intended to provide health services in a "joint public and private model, with autonomous management of health service provision" with a concern with efficiency, effectiveness and quality of service (APSAL: 2002, 18). Social participation was also integral to the original plans and justification for the SIBASI, reflecting a belief in community and inter-sectoral responsibility in social development and in decisions regarding

health. According to APSAL, “the MSPAS recognizes that the SIBASI should incorporate social participation through the implementation of methods of social consultation, and also supports other groups, such as: committees, assemblies, community development associations (ADESCO’s), self-help groups, etc...” They state that “[t]he proposal for social participation as a strategy in the SIBASI system is the strengthening of critical knowledge to improve decision-making processes in problem solving around health and self-care...” (APSAL: 2002, 18-19).

The SIBASI system is composed of several different types of health centres: hospitals, health units, health posts (“casas de salud”), rural nutrition posts and emergency centres. According to the MSPAS, the SIBASI program is intended to provide health care that mediates between the primary and secondary levels, involves community participation and awareness, and responds to the health needs of a specific population. The SIBASI program targets mothers, children and seniors in its programming. Among the main values identified by MSPAS for the program are quality of service, humane approaches, cultural acceptability and flexibility. They identify five major components in reference to the role of the SIBASI: 1) decentralized management which involves the transfer of human resources and financial management from the upper levels to the SIBASI level; 2) integrated attention to health, meaning provision of healthcare that is multi-sectoral and takes into account physical, economic, social and cultural factors; 3) provision of health services; 4) financing of health services; 5) social participation. (MSPAS Online, 2006).

The two preliminary studies on the SIBASI, done by PHRplus and Action for Health in El Salvador (APSAL), a network of health NGOs, provide useful information on the SIBASI program in its first years. Each study gives an overview of the framework of the SIBASI, its goals and purpose, and provides an assessment of the program in its early stages. Both proposals reflect a certain ambiguity around the populations targeted by the SIBASI. The SIBASIs took detailed steps to identify a target population, however this does not seem to have been done with a focus on specific groups, such as those who are underserved by the public health system. The SIBASI management identified catchment populations as a means of determining which geographical areas would be served by each SIBASI. The PHRplus report does not indicate measures taken to increase access to health services by those lacking access prior to the SIBASI’s implementation. Rather, when discussing target population they refer to catchment population and service targets that are based on averages

from previous years. Similarly, APSAL's report does not describe an attempt by SIBASI programs to target a specific population. They evaluate the issue of access from the point of view of users, but do not explicitly detail an attempt by MSPAS and the SIBASI program to reach specific populations.

PHRplus reports that the SIBASIs faced human resources, management and quality challenges in 2002. They found an imbalance in staffing across the SIBASI system, stating that: "the number of staff in each SIBASI's technical team does not correspond with population size and number of facilities within the SIBASI's geographic area". They also found that many SIBASIs relied heavily on medical students in management positions. This reliance on students was significantly greater in areas that were farther away from the capital. The SIBASI's are meant to draw upon the MSPAS protocols for integrated health, as elaborated above. In 2002 only the guidelines for children's and women's health had been completed, however there was limited access to these guidelines for SIBASI staff, meaning limited use of these approaches.

In terms of quality of maintenance and infrastructure, PHRplus indicates that in 2002 100% of SIBASI health centres had electricity and 83% had a phone or short wave radio. Only 58% had access to clean water, a major problem for the delivery of care. 97% of the centres were rated as clean, 99% had sheltered waiting areas and 96% had working toilets for patients. Only 65%, however, had proper medical waste disposal, burying, covering or incinerating the waste. Transportation was an obstacle for many of the health centres, with less than 1/3 of centres having access to an ambulance, some relying on motorcycles or pick-up, or with no transportation at all. Only 17% of centres had a computer. The study indicated that interruptions in electricity and water were frequent, with average service interruption lasting 4.2 days. There was no SIBASI- wide maintenance system, and very few individual SIBASIs had their own systems for maintenance and repair. (Seiber: 2002, 47-48).

In their analysis of quality in the SIBASI, APSAL used different indicators than PHRplus. They found that education in health, focusing on cholera prevention, household hygiene, lowering mortality and morbidity rates and lowering Dengue rates, was generally perceived to have improved by SIBASI management personnel, management committees and by social consultation committees. They also indicated a perceived improvement in prevention programs, based on factors such as the reduction of mortality and morbidity and the reduction of incidence of infectious diseases. In terms of curative medicine, they

indicated a majority believed that it has improved, but that 33% indicated that it had not. They based these results on increases in the hours of service, the number of new doctors hired, increase in the basic supply of medicine and proximity of consultations to the communities that use them (APSAL: 2002, 24-25).

Social participation was identified as one of the priorities of the SIBASI program. According to PHRplus, community participation in the SIBASIs focused on communication with community leaders. An example of participation given is supplementary funding provided to health centres by local governments. Many of the SIBASI staff, however, spoke of the lack of guidelines on the actual implementation of community participation, which led to varying approaches across the system, ranging from “communicating the SIBASI concept, obtaining resources from the community, involving the community in decision-making [and] involving the community in oversight of the providers” (Seiber: 2002, 46). At the time of the PHRplus study, the SIBASI directors had frequently asked the MSPAS for direction on involving the community in decision-making. The directors felt they should wait to start participatory approaches with the community until receiving concrete guidelines, should they have to change their strategy and thus lose credibility with the community (Seiber: 2002, 46).

APSAL largely bases its analysis of social participation on the Social Consultation Committees, which are intended to be a part of each SIBASI. They indicate that both the management committees and social consultation committees indicate that “social participation in the SIBASI is passive, only as a receptor of health services, which is reinforced by the opinion of the users/ interviewees who expressed in a high percentage that there is no individual or community participation.” They also state that although the study found that there is a great deal of community organization around health, it is not linked to the SIBASI structure. Both reports reflect an ideological commitment to participation as part of the SIBASI, but found it in practice to be either ambiguous or to be very limited. This seems to be reflected in the statements of SIBASI staff as well as patients and community members.

The approach to service provision, as indicated above, reflects the MSPAS integrated approach to healthcare, across various ages and both sexes, and through health centres, schools, families, communities and work places (Seiber: 2002, 51). The SIBASI largely offered extended hours of service, with 98% of centres open five days a week, 14% open seven days a week, 100% open from 8:00 a.m. until 3:00 p.m. and 90% open from 8:00 a.m.

until 4:00 p.m. 33% of health facilities had an on-call staff person working after hours. Every SIBASI facility offered family planning, sick child consultations, growth monitoring, oral rehydration therapy, and prenatal care for five days of the week. Vaccinations were available slightly less frequently, ranging from 98- 91% of the time. Family planning availability ranges by facility and method. Pills were available in 100% of facilities, injectibles in 99%, condoms in 99%, counselling for natural family planning in 91%, and the IUD in 56% (Seiber: 2002, 52). The study also indicates that the majority of facilities had adequate child health service provision. The types of services offered, and the percentage of facilities that offered them five days a week are also indicated in the report. 93% offered oral rehydration therapy five days a week, 68% offered sick child consultations, 72% offered growth monitoring, 49% offered routine vaccination, 12% offered BCG (tuberculosis) vaccination and 74% offered respiratory infection treatment.

The APSAL report takes a different approach to evaluating services offered by looking at access to health services in the SIBASI from the point of view of the users and community members interviewed. They looked at geographic access to health services, indicating that in the five SIBASIs studied patients had to travel between half an hour and one and a half hours to reach health centres. When asked about average waiting times in health centres, between 38% of interviewees said they had to wait for 2-3 hours, ranging from 27- 50% depending on the SIBASI. 51% of respondents indicated that their appointments generally lasted less than ten minutes, and many respondents indicated that one of their major complaints about the health services was the long waiting time compared to short amount of time with the doctor (APSAL: 2000, 38). APSAL also looked at economic access to health services, asking respondents about voluntary fees (*cuotas voluntarias*). The majority of respondents indicated that voluntary fees were less than 10 *colones* (approximately USD 1.00). Respondents from Sonsonate and Cuscatlán, however, indicated that 50% had to pay from 11- 20 *colones*. (APSAL: 2002, 39).

APSAL also looks at access to specific health services, focussing on maternal and child health services. Unlike the PHRplus report, they did not look at percentage of centres providing services, but rather at the number of users who considered themselves to have access to certain services. Of the interviewees, 14% indicated that they had access to post-partum services, 30% to family planning, 35% to pap testing, 24% to infant nutrition

services and 42% to pre-natal services. APSAL indicates that they believe these percentages to be quite low. (APSAL: 2002, 36, 42).

Both the PHRplus and the APSAL documents show that the SIBASI had positive impacts in its first years, but that improvements were still needed. The area of participation seems to be elaborated conceptually in SIBASI documents but not to have been developed in practice through the SIBASI system. The data on quality shows that waiting times are a significant problem, as are human resources, infrastructure and maintenance. In terms of access, there seems to be lack of data on if or how the SIBASI has changed the level of access to services by those who may have lacked access in the past for geographic, economic or other reasons. Neither study details the dimensions of inclusion and exclusion in health that might improve an understanding of the actual impact of the SIBASI on access to healthcare.

## **Methodology and Ethical Considerations:**

The primary research for this project was carried out in El Salvador for three months in 2006. My research was based out of San Salvador, but involved a fair amount of travel to other departments. As there are 28 SIBASI areas and my research time was limited, I narrowed my focus area to four SIBASIs (see Table 1). Two are populated by over 200,000 people, while the others have populations under 200,000. Under the system, SIBASI areas cover a number of municipalities in one area and the geographical scope and population size is large for each SIBASI. The two less- populated SIBASIs, however, can be considered largely rural as they contain only one and two municipalities with over 15,000 inhabitants. The four areas were also decided based upon socio-economic factors. A breakdown, by department, of the numbers of homes under the poverty line in El Salvador (National Multi- Purpose Household Survey 2004), showed that there are two departments in the higher income category, seven in the mid-income category and 5 in the lowest income category. Following this, I selected SIBASI areas that matched departments, selecting one from the higher income category, two from the mid- range (one on the higher end, one on the lower) and one from the low- income range. The selected SIBASIs are outlined in the following table (page 30):



**Table 1**

<b>SIBASI Name</b>	<b>Percentage of Households below the Poverty Line</b>	<b>Total Population</b>	<b>Main Municipality</b>	<b>Healthcare Centres</b>
La Libertad	28.8%	783,926	Nueva San Salvador/ Santa Tecla: Population 186,636	1 hospital, 28 Health Units, 5 Rural Nutrition Centres, 1 Centre for Emergency Attention
Santa Ana	38.80%	428,385	Santa Ana: Population 277,627	1 hospital, 21 Health Units, 6 Health Posts (Casas de Salud), 6 Rural Nutrition Centres
Chalatenango	41.90%	116,579	Chalatenango: Population 30,671	1 hospital, 29 Health Units, 3 Health Posts, 6 Rural Nutrition Centres
Morazán	55.30%	168,983	San Francisco Gotera: Population: 22,324	1 hospital, 25 Health Units, 11 Health Posts, 4 Rural Nutrition Centres

From: The El Salvador National Multi-Purpose Household Survey, 2004.

My research is concerned largely with the perceptions by various actors of the impacts of the SIBASI program on participation, access and quality in healthcare. My interest is in the goals of the program and in the ways different groups, such as policy makers or patients, perceive its success (or failure). For this reason, my research is largely qualitative, but is complimented by quantitative data. Field research consisted largely of one-on-one, semi-structured interviews with four categories of participants: 1) Policy Makers or Institutional Representatives: this includes representative from international funding and development agencies; 2) Civil Society Members/ Other Experts, including health NGO representatives, doctors or health workers working with the NGO sector and members and

academics; 3) SIBASI Administration and Staff: this includes SIBASI directors, sub-directors, and technical staff; and 4) Patient or Potential Users/ Community Members, including members of the community who are technically covered by the system but may or may not use it.. I also used focus groups when talking to community members, as a means of creating discussion amongst the participants regarding their experiences with the health system. While I was able to complete a significant amount of interviews, I encountered a challenge with accessing participants from the Ministry of Public Health and Social Assistance, and from the director of the SIBASI in Santa Ana. Both committed to interviews that were later cancelled and were reluctant to reschedule.

The interview questions reflect a concern with the variables of participation, access and quality. The interviews allowed me to draw out, through qualitative means, the perceptions of all actors around these issues. The earlier discussion of participation focused on its ambiguity. For this reason, the interviews centred on goals for and perceptions of participation in the planning and implementation of the SIBASI program. That is: do all sectors feel as if they participated in the program development and implementation; who participated in the process; was their participation informed by their own priorities or was there a degree of ‘tokenism’? Additionally, I asked whether this participation has carried into the implementation of the program- has it been sustained? This was addressed by examining, through interviews with policy makers, managers, doctors, workers and patients, whether and how SIBASI users have been given opportunities to provide feedback on the program since it has been running, whether and how the SIBASI program reflects community priorities. This variable is important as a means of determining whether the SIBASI program has been developed and is being implemented based on actual community health and health care priorities, or whether ‘participation’ has been used by the MSPAS as a phrase which reflects little shift in power. Through this aspect of the analysis, I sought to determine whether participation in health by various communities has achieved some degree of success under the SIBASI program in El Salvador.

I also used the interviews to obtain data on access. I interviewed policy makers, managers, doctors, members of civil society and community members to determine their impressions of impacts of the SIBASI program on access. These interviews focused on perceived impacts on access. Patients and community members were asked whether they feel they had adequate access to health services prior to the SIBASI, and if they feel as if this

access has changed since the program was initiated. They were also asked what they feel affects or affected their access to healthcare. Policy makers, managers, doctors and workers were asked the same questions.

In order to analyse the impact of the SIBASI program on quality of health care at the primary level in El Salvador, I asked policy makers and managers what measures were taken in the planning and implementation to increase quality through the program, how the priorities for quality were established, and if they think that the program has been successful in improving quality. Of doctors and other experts I asked similar questions, and asked them how and if they feel there is a difference in quality under the SIBASI, what tools and resources they feel are necessary to improve quality, and what factors they feel are essential for quality healthcare. Of the community members I asked what, if any, concerns they had regarding quality prior to the SIBASI, if and how they feel these have changed, what factors in general they feel are necessary for quality healthcare, and if and how they feel the current care under the SIBASI program provides quality health care. These interviews allowed for an exploration of both technical quality and perceived quality.

The qualitative interviews, complimented by quantitative data when available, will allow for an understanding of the nature of participation, access and quality in the SIBASI program. Due to the concern with equity that is embedded in this research, the concept of perceived success by the users themselves is of great importance. Do the patients feel that their health- based security has improved, do they feel as if they receive adequate, respectful and accessible care within the public system?

### Ethical Issues

This research involved interviewing human participants, some of whom are health care service users, making a discussion of ethical considerations important. All participants for this study were over the age of 18 and were asked to provide informed consent, either written or verbal in cases where the participant was not literate. In this case the written consent form was read out loud by the interviewer and all questions were answered verbally by the participant and noted by the researcher. The majority of contacts were made through connections with international organizations or community organizations and did not infringe on the privacy of the participants. The interviews with community members did not take place within the health centres in order to protect their privacy.

I believe that the research results will be beneficial to the participants in the study, as its intention is to provide a voice for all stakeholders regarding the SIBASI program and how it has worked so far. Interviews with policy makers and participants from organizations such as UNFPA and PAHO provided an opportunity for these stakeholders to voice opinions and concerns as well as to discuss success and failures in order to contribute to research that aims to add to a broader field of knowledge on the nature of health program reforms in the Central American region. For SIBASI staff members, including directors, participation in the study provided them with an opportunity to voice concerns and impressions of the program to an impartial audience. Finally, for the SIBASI users and community members, participation in the study provided an anonymous forum for them to discuss their experience with health care in El Salvador, and to be critical or complimentary of the SIBASI system. It allowed for their opinions and statements to interact and balance the statements of those in positions of power, either through policy formation or funding or by nature of being members of the medical profession or the employed. The statements of community members and patients are treated as equally important in the analysis as those of the other participants.

The broad goal of this research project is to provide a primary overview of the impacts of the SIBASI program on participation in, access to and quality of health care in El Salvador. As health reform is of utmost importance, and is under constant debate, in the Central American region, I feel that this study could be important in terms of providing a window on the successes and challenges of a particular type of program, which could be used to inform other cases. This study is also important as it seeks to juxtapose the opinions and statements of policy makers, healthcare workers, patients, civil society and community members to provide a holistic understanding of what participation, access and quality mean for different stakeholders and if or how this is reflected in the policy and practice of the SIBASI.

## **Analysis- Perceptions of SIBASI Program by Various Actors**

An overview of the responses of the different groups of actors when asked about the SIBASI's impact on participation, access and quality provides an understanding of the success of the program, as it has existed in practice since 2001.

### ***Policy Makers and International Organizations***

The first category of respondents was made up of policy-makers and participants from international organizations that are working in health care issues. When asked about participation in the process surrounding the formation of the SIBASI program and its legal framework, many of the respondents talked about the lack of transparency around the SIBASI Law, passed in 2005. Many of the respondents said that they had been very optimistic about the SIBASI from its inception, as it had included dimensions of multi-actor participation. They were disappointed, however, when the program was made legal through the Legislative Assembly. According to this group of respondents, the Law was introduced in the Assembly behind closed doors and was passed with little debate and without the participation of others actors, such as members of civil society or health workers. Many felt that the way in which this Law was passed changed the nature of the SIBASI for the worse.

Another common response in terms of participation was around the failure of the decentralization process under the SIBIAS program. As discussed above, decentralization is one of the main components of the SIBASI, intended to make primary care provision more efficient and to increase participation through the promotion of an integrated approach to health care provision. Many respondents, however, indicated that the management and control of financing remains at the level of the executive and of the MSPAS central office.

Some respondents mentioned the existence of the Participation Committees, which are supposed to be part of every SIBASI in order to have multi-actor participation. One respondent indicated that these committees operate in some SIBASI's, to varying degrees. When they do exist, he said, they consist of doctors, municipal politicians, community leaders and other local level actors. He indicated, however, that these committees did not exist universally and that their quality varies a great deal across the country.

When asked about access, the majority of respondents from international organizations indicated that they were unable to make definite statements due to a lack of empirical data on access and the SIBASI system. One representative stated that he could assume that access had improved somewhat with the SIBASI, but that he had not seen evidence that could make him sure. Another respondent stated that despite programs like the SIBASI, major gaps in access to health care, particularly to preventive programs, continue to prevail due to gender inequalities and poverty, which pose major barriers to access to health. He said that women in particular continue to face major barriers to access to reproductive and sexual health services, to prevention and family planning, despite the existence of the SIBASI program.

When asked about quality, the responses from this category were quite similar to those on access. Respondents were similarly reluctant to answer definitively due to a lack of data on quality improvements due to the SIBASI. Responses were somewhat inconsistent, as one respondent said that there had been definite improvements in technical standards of care under the SIBASI. Another respondent, however, talked about the major infrastructure problems in health centers that continue under the SIBASI, and have implications for the quality of care. She stated, for example, that a lack of access to water means that in many health centres doctors cannot properly wash their hands between appointments. Another example given by this respondent was the shortage of adequate laboratory services. Even if women may have access to pap testing, the shortage of labs means that they may never receive results from the test, or that there is a high likelihood of false results. She gave the example of Ahuachapan, in the west of the country, where test for cervical-uterine cancer return with a 70% accuracy rate. She added to this that if a woman should test positive for cancer, there is rarely access to treatment. Therefore, she indicated a firm belief that, despite the SIBASI program, quality in health care was still a major challenge, due to problems with infrastructure and technical quality.

In general, the respondents from this category focused on the failure of decentralizations in the management and financing of the SIBASI program as the major impediment to its success. They all indicated that it is “good on paper” but there are many obstacles to its success: concentrated power at the executive level, lack of infrastructure affecting quality, poverty issues in the country that continue to pose significant barriers to health access

Importantly, while all respondents were willing to discuss the SIBASI program, they were insistent in the need to understand the general challenges to having an effective health system in El Salvador. Primarily, many indicated that lack of consolidation between the many different parties with a stake in the health system and reform debate is one major challenge. There are many actors involved in health issues in El Salvador: the government and the MSPAS, NGOs, the Human Rights Ombudswoman (PDDH), and the various parties within the Legislative Assembly. The many actors cannot or will not collaborate, meaning that reform has very little chance of success. The political divide between the left and right is a particular challenge. For example, many of the NGO and left-wing community see the SIBASI program, and all government proposals for reform, as steps towards privatization.

Respondents also focused on the low investment in health and the poor distribution of health within the health system, which creates major barriers to improvements. As discussed above, the national budget for social spending is one of the lowest in the Americas and the MSPAS covers the majority of the population with the same budget as the ISSS, which covers only 15-17% of the population.

Despite the significant challenges to successful health reform however, one respondent said that that despite the many challenges around the health system in El Salvador, and in the SIBASI program, the positive side is that the healthcare issue is not stagnant. Many issues have entered the agenda that were never considered before. For example, the SIBASI program was introduced, and despite its practical challenges it represents an acknowledgement by the authorities of the importance of decentralized, integrated, primary care. This respondent was involved in working on a new model of reproductive and sexual health, which was brought to the SIBASI in 5 zones since its publication in 2005. He considered this to be a success, as it would lead to improvement in these areas. He said that despite the challenges faced by the program that it is necessary to acknowledge that the prioritization of participation and improvements to access and quality through an integrated approach does indicate progress in the governance of the Salvadoran health system.

## ***SIBASI Employees***

Interviews with employees, including the directors, brought about different types of answers from those of international organizations and policy-makers. On participation, SIBASI staff indicated that there is a Manual on Participation that was created by the MSPAS in response to the problem of the lack of guidelines for participation at the start of the implementation of the SIBASI. As was discussed previously based on the reports by PHRplus and APSAL, at the beginning of the SIBASI program many staff indicated that they felt that there was a lack of information on the meaning of participation and of guidelines for its implementation. This manual, published in 2005, indicates a step towards a standardization of participation. Respondents from this category felt this was an improvement coming from the program.

When asked about participation in policy formation, responses ranged from saying that there was no participation by anyone aside from MSPAS authorities to statements that the policy formation process “took into account” the opinions of different actors (municipalities, communities, civil society). None of the respondents gave specific examples of how these actors were considered during the process.

When asked about participation in the implementation of the SIBASI program, the SIBASI employees described it as ranging from community members volunteering, municipalities giving funds or helping with fund raising, to education and prevention programs that incorporate health promoters. For example, the technical director for the SIBASIs in the Western region gave examples of Sonsonate’s town hall investing in an anti-vector program, and in a transportation program for pregnant women. SIBASI Morazán seems to have invested a great deal in citizen participation and in participation by local municipalities in health care. For example, one municipality, through community involvement, has invested in creating a “healthy community” and has been named one of the cleanest communities in El Salvador. The SIBASI is also developing its own guidelines for participation and has invested a lot in making sure participation is prioritized. Despite the success of participation in this SIBASI however, the director stresses that much more work needs to be done on participation, so that it is “normalized” and becomes an integral part of local health care delivery.



When asked about access, the “medical brigades”, which involve doctors and/ or health workers travelling to rural low-access areas to provide health services, several respondents considered them universally successful and said that the SIBASI has increased access to rural people. The director from Morazán says that she feels they have been very successful but that there are still significant challenges (for example Morazán has 26 municipalities and 17 lack access to health services). One respondent from La Libertad said that the brigades have increased access, but that a lack of vehicles and the poor conditions of existing vehicles and roads are a barrier to the brigades. The brigades are intended to reach communities once a month, and while some respondents see this as a real success of the SIBASI, others state that their success is limited.

Every respondent stated that there is a universal, basic package of care that is non-discriminatory (although prevention and education programs target mothers, children and seniors). They also stated that user fees do not exist and that patients are asked for a “voluntary donation” to help cover the costs of running the health centres but that they are not turned away if they are unable to pay.

The respondents said that access has improved with decentralization. For example in La Libertad the SIBASI has Redes de Servicios (smaller centres that have management bodies, each with a head office that also has 24 hour services) that deal with the large size of the SIBASI (28 health centres). The respondents generally feel that the SIBASI has expanded the number of health centres available to the population

Several respondents mentioned the cultural barrier to accessing health services, saying that people prefer to use traditional medicines and self-care and therefore do not access health services. One respondent in Santa Ana also mentioned political culture as a barrier, stating that the political affiliation of a health centre may impede people from using it.

Similarly to the comment made by a respondent from an international organization, one employee respondent pointed out that despite the needs for improvement in access (difficulty sending regular brigades to rural areas, or lack of proper human resources), the existence of brigades and promoters in areas where there once were none must be seen as a success of the program as they were previously completely absent.

On the question of quality, one common response was that there was nothing in place to define, measure or prioritize quality in health before the SIBASI was put in place in 2001. Now the MSPAS has published two manuals on quality in public health and some SIBASIs have begun doing quality surveys for their patients. For example the SIBASI in La Libertad had done a quality survey with patients, while the entire Western region is in the process of undergoing a large quality survey this year. Many of the respondents thus saw the recent introduction of quality as a consideration in health policy and programming as an advance.

Many respondents also said that the SIBASI has led to a more integrated approach to health issues (for example in maternal and child health) and has involved different government sectors in health. For example in Santa Ana a respondent said that the MSPAS is no longer the only body responsible for health care and that now the Ministries of the Environment and Education are involved as well. The respondents also said there is an increase in prevention and education programs. For example a health centre in Santa Tecla, La Libertad was holding a pre-natal workshop for pregnant girls when I visited, with a focus on nutrition and post-natal care. In Sonsonate a family practice program has been introduced for children, and Rincón de Alegria (Happy Corner) has also been introduced as a program for seniors to promote healthy living and deal with isolation. These examples show that respondents from this category believe that advances have been made in quality as a result of the SIBASI program.

### ***Civil Society and Other Experts***

The responses by members of Salvadoran civil society organizations and other experts such as academics and non- MSPAS doctors and health promoters were quite different from the responses given by SIBASI employees. When asked about participation, many respondents indicated that although all SIBASIs are supposed to have Social Committees, they have not been put in place across the whole system. One respondent said that usually when in place they are composed of MSPAS representatives and do not incorporate municipalities or communities. The respondents stated that participation exists on paper but has not taken place in practice. One contact said that the formal plan for establishing Social Committees is something that communities and municipalities need to take better advantage of as it could be used as an opening for multi-sector participation in

health care. According to respondents, the participation that does occur is generally limited, taking place in the form of mother's clubs or committees, for example. They state that participation has not taken place to the extent that local people have a stake in decision-making. The health promoters I interviewed indicated that there is no community participation that is linked to the SIBASI in their regions and that all participation in health care is a result of local community organizations or support by NGOs. For example, in San José Las Flores in Chalatenango, there is strong legacy of community participation and a very dedicated local nurse. In this community, for example, there is a local communal kitchen, which gives free food to seniors who cannot provide for themselves and a communal ambulance that is used by Las Flores and by other nearby communities should the need arise.

The initial SIBASI framework pleased a lot of the members of civil society because it outlined community and civil society participation in the policy process and in the programming. But, similarly to the respondents from international organizations, several people indicated that the 2005 SIBASI Law was passed without transparency or participation and changed the nature of the original program.

In terms of access, one source stated that approximately 1 million 400 people in El Salvador currently lack access to healthcare for geographic, economic and cultural reasons. This is especially a problem for rural people. He broke down the burden of accessing healthcare as an example: one woman with two children would have to pay \$3.00 for appointments. Additionally, transportation to and from a health centre may cost \$1.00-\$2.00, while prescribed medications might cost between \$10.00 and \$20.00. He used this example to demonstrate that health care can be extremely unaffordable for the majority of public health users in El Salvador and serious barriers to access remain. Several of the respondents stated that there is a lack in empirical evidence regarding the SIBASI's impact on access. Many argued that there is a need for a study on the need for improved access, which does not simply focus on coverage. Several stated that it is necessary to better institutionalize the issue of access in the SIBASI

When asked about barriers to access, respondents named user fees as a major obstacle. They stated that paying \$1.00 per person is the standard, although this seems to vary regionally and according to health centre. All participants stated that user fees were common in SIBASI health centres, contradicting what the SIBASI employees had said on this issue.

Similarly, they mentioned the cost of medications as an impediment to access, as many public health users cannot afford to fill prescriptions for necessary medications. Respondents also stated that the inconsistent quality of service impedes access. For example, one doctor from an NGO said that many people would travel to the public hospital in San Salvador (Rosales) because they believe the doctors there are of better quality. This leads to a bottleneck and increases waiting times, suggesting that decentralization has not worked, as there is a concentration of human resources in the capital. Many participants also mentioned the problem of the hospitals in terms of physical concentration in the capital. The SIBASI program is intended to decentralize and improve access to attention in local areas but regardless of perceptions of the quality of health care workers, many people need to travel to the capital for hospital attention. There is only one public children's hospital and public women's hospital in country, both located in San Salvador.

One health promoter said that she believes there have been improvements in the following areas with the SIBASI in her community: maternal and child health, vaccination for children, access to pap smears (although monitoring and treatment after the fact are not usually available), and healthcare for seniors. She was clear, however that she is not sure if this is due to the SIBASI or due to a committed and well-organized local nurse and health staff. When asked about the SIBASI medical brigades, believed to be a success by SIBASI employees, respondents stated that communities in rural areas often have to wait over a month before seeing a brigade. They did not believe that the brigades were overly successful as they were inconsistent.

When asked about impacts of the SIBASI on quality, some respondents said there have been no changes to quality, while others said there have been limited changes. One commonly mentioned topic was the increased hours of service at health centres that has occurred under the SIBASI program. Several participants say that this had made no difference to the overall ability of people to access care and to the quality of care, for example for waiting times and appointment times, but one health promoter said this had been one major positive of the SIBASI program. This promoter, however, is working in as urban area, which might mean that it is easier for people to use health centres in the evening.

Respondents spoke about other continued challenges to quality under the SIBASI program. There is still a major problem with infrastructure, the availability of supplies and medicine, as was also discussed by the respondents from international organizations. Many

participants also mentioned to continued issues of major human resources gaps, leading to shorter appointment times and longer waiting times

It is important to note that many of the respondents from this category, similarly to those from the international organizations, seem to see the SIBASI as largely beside the point in a much larger health problematic. They all said that the SIBASI was “good on paper” but that it does not measure up in practice. They believe that the SIBASI Law of 2005 took away from the positive nature of the original design and that it has not made significant changes in practice. Also similarly to the respondents from international organizations, they believe that it is not a real decentralization and lacks integration, remaining focused at the central MSPAS level. They all mentioned the lack of any monitoring of the SIBASI now that it is running, limiting accountability and potential for improvements. Several respondents said the SIBASI was nothing more than “government propaganda” and had made no changes to the health system whatsoever. It seemed a common belief in this category of respondents that the ARENA government was incapable of any advances in terms of health policy and provision. The general belief of these respondents was that any successes in participation, access and quality in healthcare are largely due to community and initiative in individual health centres and not a result of the SIBASI program as a whole.

### ***Community Members***

The interviews and focus groups with members of public health using communities were crucial for understanding the impact of the SIBASI program. Respondents generally came from communities that could be considered vulnerable, many were women, lived in very rural areas, and some came from a community that had been forced to resettle by natural disasters. It is important to note that none of the community respondents had heard of the SIBASI program by name. This meant changing my interview questions to refer to changes that might have occurred over the past five and six years (the time span of the SIBASI program) in order to discuss the impact of the program. Although the respondent's unfamiliarity with the SIBASI program is significant, it does not mean that the program did not reach them. It may mean that they are using non- MSPAS services, or simply that they are unaware that the services they use are part of the SIBASI.

The participants all indicated that they were not involved in participation in policy around the SIBASI or in health in general. One focus group respondent said, "...politicians talk a lot about changes and involving communities, but nobody is really involved, and nothing really changes. It is mostly just talk" (Respondent A, Personal Communication, September 28<sup>th</sup>, 2006).

The communities were involved in organizing themselves, to varying degrees incorporating health concerns into their organization. This was not linked to the SIBASI however, and was done with the support of NGOs and on community initiative. For example, the Santa Ana group was being supported by two NGOS in setting up community organizations, which would have Health Committees, involving selected community members taking on the role of health and sanitation promotion. The members of the Health Committees could also bring community health concerns to the political level. Similarly, the La Libertad group were setting up a women's group composed of women from various rural communities. They discussed collecting money to invest in community first aid kits and medicine supplies to make up for the shortage of medicine and infrequent visits by health promoters. There was clearly community organization around health in many of the communities, but it was not linked to the SIBASI. A notable exception, as mentioned above, was the level of participation through the SIBASI in Morazán. The successes of community participation in this SIBASI were not only mentioned by people in that department, but also by health promoters from different regional areas who had heard of their successes in participation.

The very poor, rural communities lack access to health care almost entirely. The La Libertad group said that the health promoters and medical brigaded frequently do not come, and that the NGOs have a limited presence in their communities and frequently only target specific families. One woman said that an NGO had been helping to build latrines in her community, but that she and her family were not chosen as beneficiaries. Both transportation and users fees were identified as major obstacles to using health services, especially when people are sick. All participants indicated that a user fee of at least \$1.00 applied when using all health services. This included at hospitals where employees had told me that user fees were not mandatory. In Santa Ana some people said that they would not be turned away for not paying, while others said they had. In La Libertad all the respondents said that they would not receive treatment without paying. For example, one woman told me that she had brought her daughter to see a doctor the week prior to the interview and had

seen a woman turned away because she was unable to pay. The others in the waiting room had tried to collect money for the woman but they were unable to collect sufficient money.

One other major issue for the respondents in rural areas was the shortage of transportation in an emergency. When ambulances actually exist they frequently lack gas or are broken down. When asked about what they do in an emergency, most of the respondents in one focus group joked about waiting a week to die. Although this seems to be a common challenge in rural areas, the community discussed above, San José Las Flores in Chalatenango, has a community ambulance for emergencies. This is, however, the product of community organization and dedicated local health workers, and not of the SIBASI program.

When asked about quality in health care, the availability of medicine was the highest concern of all respondents. Many of them indicated that medicines were generally not available at consultations, which seemed to make the other barriers to going to health centres not worth it. They indicated that doctors would not have the proper medicine in clinics, and that they would write a pharmacy prescription, which the people could not afford to fill. For example, a woman in one focus group was having chronic health problems. I asked her why she did not want to go to a medical clinic or hospital. She said “you have to pay, and paying is not worth it when they don’t have the medicine you need” (Respondent B, Personal Communication, September 28<sup>th</sup>, 2006). She also said that they would just tell her to rest and that she didn’t have the option to rest. She didn’t think that going to a doctor was worth the time and money that it would cost her. In another focus group, a respondent told me about her husband having had a very painful infection in his leg. When they went to the health centre, they were told he needed an injection but that the centre did not have the medicine. They had to travel to the departmental capital, where they were told they would have to wait for a week, as it was Holy Week at the time. She was afraid he would die, and he suffered a lot of pain.

The majority of participants indicated that visiting health centres was not worth the time, money and effort. This was largely linked to the association of “good” health services with available medications. They indicated that the distance traveled, the money paid and the time away from work was not worth it if there was not medicine available. One woman said,

“only people with small children go to the clinics” (Respondent C, Personal Communications, September 28<sup>th</sup>, 2006).

The participants from communities, importantly, did not equate health care with the government or government programs, but with NGOs and with basic services such as sanitation, clean water etc. The SIBASI program seems to be irrelevant to many poor people at the community level, since they did not even know it existed, think of health at a community level and generally associate access to health and health services with NGOs and health promoters.



## **Discussion and Conclusions: The Impact of the SIBASI Program on Participation, Access and Quality in Health**

The preceding overview of the responses of different actors on the impact of the SIBASI program demonstrates that the four groups perceive the program very differently. While the SIBASI employees are overall quite positive about the impacts and successes of the program, despite a recognition that challenges exist in the larger health situation in the country, the members of civil society and other experts are quite sceptical. The respondents from international organizations had mixed comments about the SIBASI, but in general focused on the broad problems facing the health system and the Salvadoran population. The community members, however, had not heard of the program and in fact seemed not to associate health services provision with the government at all. They all discussed significant barriers to access, and limited participation and quality.

The responses by different groups of actors lead to a number of overall observations about the SIBASI program and about the Salvadoran health system in general. In terms of participation, the results show that effective participation has not been a success across the four case-study areas. All groups, with the exception of SIBASI employees, indicated that the program has not been successful in terms of multi-actor or community participation. The responses show that despite the written intention of the SIBASI to engage in a participatory policy formation process all actors, except representatives from the MSPAS, were excluded from the policy formation process. This was stated in particular in relation to the closed-door process around the passing of the 2005 SIBASI Law. Similarly, despite the MSPAS's prioritization on paper of an integrated and participatory health care program, civil society and community members both stated that they were not involved. Respondents also indicated that the Participation Committees, meant to be a part of all SIBASI's, were inconsistent and largely ineffective.

Despite the overall failure of participation, however, it is worth mentioning the MSPAS's Manual for Participation, which outlines guidelines for participation in health care. Although participation cannot be considered a success in practice in terms of this study, the publication of the manual demonstrates an attempt by the MSPAS to standardize participation. This can be seen as an improvement, as the reports by PHRplus and APSAL from 2002 indicated that there were no guidelines for participation on which SIBASI staff could base the implementation of this aspect of the program. In this way, the manual can be

seen as a step in the right direction, despite the reality that there is much to be done to improve participation.

Additionally, it is important to acknowledge the successes in participation that were achieved by the SIBASI in Morazán. Although it was acknowledged, even by employees, that there was still a great deal to be done to “normalize” participation, this SIBASI is the most successful of the case studies in terms of participation. This shows, primarily, that there is no real standardization of participation across the program. It also suggests that successful programs seem to be the result of dedicated staff, and of committed local actors, rather than the program itself.

It is evident that access to healthcare remains a major challenge in El Salvador, despite the existence of the SIBASI program. Once again, all respondents except for the SIBASI employees indicated that access was a problem, particularly for people living in poverty, in rural areas or in other vulnerable circumstances. The existence of medical brigades is positive, however many respondents indicate that they are inconsistent in reaching communities the intended once per month. Similarly, the supposed decentralization of health care does not seem to have increased the access to health centres by people in rural areas, as they still face transportation problems and must travel great long distances for hospital care. Despite statements by SIBASI employees that user-fees are optional, many respondents indicated that they were essentially universal. It is important to note that in May 2006 President Antonio Saca announced that user fees were illegal. This announcement, however, was not accompanied by any increase in financial investment in health. The reality of this situation likely means that health centres may *need* to charge user fees in order to survive. Economic barriers therefore are an obvious impediment to healthcare access.

Many respondents commented on the lack of monitoring in the SIBASI in terms of access, and the failure of the program to institutionalize the prioritization of access as a separate issue from coverage. Of the three variables used for this study, access seems to have made the least progress in the SIBASI program. This may in part be due to neglect in the program of the issue, but is also due to the challenges created by extreme poverty and deep-rooted problems with the health system.

Finally, there are obvious impediments existing to quality under the SIBASI program, with continued problems of infrastructure and human resources. The major quality issue, which also affects access, seems to be the availability of medications. Universally,

community respondents expressed frustrations that health centres rarely had the necessary medications and that they could not afford to fill prescriptions at a pharmacy. Many respondents said that they would not seek medical care because they assumed they would not be able to access medicines. They associated quality health care with availability of medications.

Despite the problems that continue with quality, there seem to be steps taken by the MSPAS and the individual SIBASI's towards improving quality. There is certainly recognition of the importance of considering quality in healthcare. For example, the MSPAS has released two publications on quality, which were distributed to SIBASI staff. Additionally the SIBASI in La Libertad had done a quality survey with patients, and the Western region is now administering a quality study. Therefore, despite the significant continued challenges, there are tangible steps towards increased acknowledgment and the improvement of quality.

In addition to the specific conclusions regarding participation, access and quality, some important overall observations came from this study. Primarily, it is evident that there are major gaps between the SIBASI program's goals and conceptual framework and its practice. While the program looks "good on paper", it has had limited success in practice. Many respondents stated that they had been optimistic in its inception but were disappointed by how the program has been implemented so far. While the design of the program shows the prioritization of many important features, and seems concerned with genuinely improving public health care, the program has not made significant changes. The program needs to move beyond being simply positive in writing, to a real decentralization, to substantive participation and to achieving the integration that is a main component of its design.

Tangible impact of the SIBASI on access and quality is difficult to evaluate without extensive empirical evidence and program monitoring. This study aimed to provide an overview of the impact of the SIBASI based on the perception of diverse actors in El Salvador. In addition, there must be extensive data on the impact of the program in order to thoroughly evaluate its progress and to make the improvements that are clearly necessary. There is no standard monitoring process in place for the SIBASI, which seems necessary in order for the program to enjoy success. Ideally, there should be an integrated monitoring

process that accounts for regional diversity and combines the prioritization of participation and quality empirical evaluation.

Another overall observation that came out of the research experience and is obvious from the long and contentious reform process is the extent to which politics in El Salvador pose a challenge to moving forward in health care. The gulf between the left and the right and between the government and civil society leads to a lack of essential coordination and cooperation. This means that the potential for progress is limited, as the country as a whole cannot move forward without the engagement of all actors. Although a description of the political situation in El Salvador is beyond the scope of this paper, it is a crucial factor both in the growth and effectiveness of the health system, and in the research process itself. A more extensive study on the impact of the politicization of the health sector and its implications would be extremely relevant and important.

The SIBASI certainly has potential as a program, but it is impeded by many of the overall health system problems in El Salvador. Major improvements in governance are necessary in order for the SIBASI program, and the health system as a whole, to work. The continued power concentration at the executive level has meant that decentralization has not taken place effectively. Also, the health system overall suffers from the very small government investment in health, limiting its ability to provide adequately for the population, no matter what programs are in place. The SIBASI program is impressive and progressive in its design. Design, however, means little if not followed through in practice. Real effort and commitment to improvements, based on monitoring and evaluation of progress, are necessary in order to make programs such as the SIBASI relevant and effective for tackling the significant problems of providing health care to the majority of the population.

The problems facing El Salvador's public health system- extreme poverty, ineffective governance, politicization, poor financing, contention in the reform process- are common to many countries in the Latin American region. The SIBASI case, in its small successes and major challenges, can be drawn upon to increase health systems knowledge in countries facing similar challenges. The intention of this study is to provide a preliminary overview of the impact of one primary health care program in the context of a significant health system problematic, in order to add to larger debates regarding the continuous struggle involved

with effectively transferring ideals of democratic health care into programs that make real impact and reach those in most need.

## Works Cited

- Acción para la salud en El Salvador. Investigación De Los Sistemas Básicos De Salud Intergral- SIBASI- En El Salvador. San Salvador: Cooperativa Nueva Vida de R.L., 2002.
- Acuña, M. C. Exclusión, Protección Social y Derecho a La Salud. Unidad de Políticas y Sistemas de Salud, Area de Desarrollo Estrategico de la Salud, OPS-OMS, 2005. .  
[www.paho.org/Spanish/dpm/shd/hp/exclus-derecho-salud-art-1aca.pdf](http://www.paho.org/Spanish/dpm/shd/hp/exclus-derecho-salud-art-1aca.pdf). March 6, 2006.
- Campbell, S. M., M. O. Roland, and S. A. Buetow. "Defining Quality of Care." Social Science and Medicine 51 (2000): 1611-25.
- Chambers, R. Whose Reality Counts? Putting the Last First. London: Intermediate Technology, 1997.
- Coelho, V. S. P. "Brazil's Health Councils: The Challenge of Building Participatory Political Institutions." IDS Bulletin 35.2 (2004): 33-9.
- Consejo Nacional de Atención Integral al Programa de los Adultos Mayores.  
<<http://www.primeradama.gob.sv/conaipam.htm>>.
- Country Health Profile: El Salvador. Pan American Health Organization, 2001.

Creel, L., J. Sass, and N. Yinga. New Perspectives on Quality of Care: Client-Centered Quality: Clients' Perspectives and Barriers to Receiving Care. Ed. Population Council and Population Reference Bureau.

"Declaration of Alma Ata." World Health Organization. 1978.

<[www.who.int/hpr/NPH/docs/declaration\\_almaata.pdf](http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf)>.

Diario Oficial Republica De El Salvador En La America Central. Vol. 368. San Salvador, El Salvador:, 2005.

"Dirección General de Estadística y Censos." Ministerio de de Economía El Salvador.

<<http://archive.laprensa.com.sv/20060703/nacion/535173.asp>>.

Girón, G. "La Salud Pública Como Prioridad." La Prensa Grafica June 2 2006June 3rd, 2006

<<http://archive.laprensa.com.sv/20060602/nacion/506717.asp>>.

Haddad, S., and K. Mohindra. Public Policies and Equitable Access to Health Care.

University of Montreal/ IDRC/ MAPHealth2, 2001.

Hart, M. "Incorporating Outpatient Perceptions into Definitions of Quality." Journal of

Advanced Nursing 24.6 (1996): 1234-40.

International Society for Equity in Health- Chapter of the Americas. Equity and Health

Sector Reform in Latin America and the Caribbean from 1995 to 2005., 2006.

---. Equity and Health Sector Reform in Latin America and the Caribbean from 1995 to 2005: Approaches and Limitations., 2006.

Ministerio de Salud Pública y Asistencia Social. Evaluación De Disponibilidad y Uso De Cuidados Obstetricos De Emergencia En El Salvador: Población Asignada Por SIBASI. September 7th, 2006.

---. Marco Conceptual y Operativo Para El Desarrollo Del Sistema Básico De Salud Integral. March 15, 2006 <<http://www.mspas.gob.sv/sibasi1.asp>>.

---. "Propuesta reforma integral de salud." <[http://www.mspas.gob.sv/avance\\_reforma](http://www.mspas.gob.sv/avance_reforma)>.

Morgan, L. M. "Community Participation in Health: Perpetual Allure, Persistent Challenge." Health policy and planning 16.3 (Print) (2001): 221-30.

Murphy, J. "O Pago o Se Muere: The Salvadoran Health Care Worker's Strike Against Health Care Privatization and its Impact on Democracy." Master of Arts Saint Mary's University, 2006.

Palmer, Natasha, et al. "Health Financing to Promote Access in Low Income Settings-- how Much do we Know?" Lancet 364.9442 (2004): 1365-70.

Parfitt, T. "The Ambiguity of Participation: A Qualified Defence of Participatory Development." Third World Quarterly 25.3 (2004): 537-56.



Rosenberg H., and M. and Peña. "Dimensions of Exclusion from Social Protection in Health in Latin America and the Caribbean." The Year 2000 International Research Conference on Social Security. Helsinki, Finland, 25-27 September.

Rosenberg, H., and B. Andersson. "Repensar La Protección Social En Salud En America Latina y El Caribe." Revista Panamericana de Salud Pública 8.1-2 (2000): 118-25.

Ross, A., J. L. Zeballos, and A. Infante. "La Calidad De La Reforma Del Sector De La Salud En América Latina y El Caribe." Revista Panamericana de Salud Pública 8.1-2 (2000): 93-8.

Seiber, E. Baseline and Best Practice Assessment of Seven SIBASIs in El Salvador: Phase 1 and Phase 2. PHR Plus/ USAID, 2002.

Seid, M. et al. "Parents' Perceptions of Primary Care: Measuring Parents' Experiences of Pediatric Primary Care Quality." Pediatrics 108.2 (1998): 264-70.

Sofear, S. and Firminger, K. "Patient Perceptions of Healthcare Quality." Annual Review of Public Health 26.1 (2005): 513-59.

The World Bank Group. "The World Bank Participation Sourcebook." 1996.  
<<http://www.worldbank.org/wbi/sourcebook/sb0001.htm>>.

Ugalde, A., and N. Homedes. "Decentralización Del Sector Salud En America Latina." Gaceta Sanitaria 16.1 (2002): 18-29.

United Nations Population Fund. "Country Profile El Salvador." 2006.

<<http://www.unfpa.org/profile/salvador.cfm>>.

Valiente, B. "Asamblea Inicia Debate Sobre Sistema De Salud." La Prensa Grafica July 3 2006.

Vargas, I., M. L. Vasquez, and E. Jane. "Equidad y Reformas De Los Sistemas De Salud En Latinoamérica." Cadernos de Saúde Pública 18.4 (2002): 927-37.

Vásquez, M. L., et al. "Los Procesos De Reforma y La Participación Social En Salud En América Latina." Gaceta Sanitaria 16.1 (2002): 30-8.

Villatoro, C. "Bloom Pide \$2 Mill Para Terminar El Año." La Prensa Grafica November 10 2006.

---. "Las Carencias Afectan a Toda La Red Hospitalaria." La Prensa Grafica October 11 2006

.

---. "OPS También Ve Déficit En Presupuesto De Salud." La Prensa Grafica November 21 2006.

Whitehead, M., G. Dahgiren, and T. Evans. "Equity and Health Sector Reforms: Can Low-Income Countries Escape the Medical." The Lancet 358.September 8 (2001): 833-6.

Williams, S. "Quality and Care: Patients' Perceptions." Journal of Nursing Care Quality 12.6 (1998): 18-25.

