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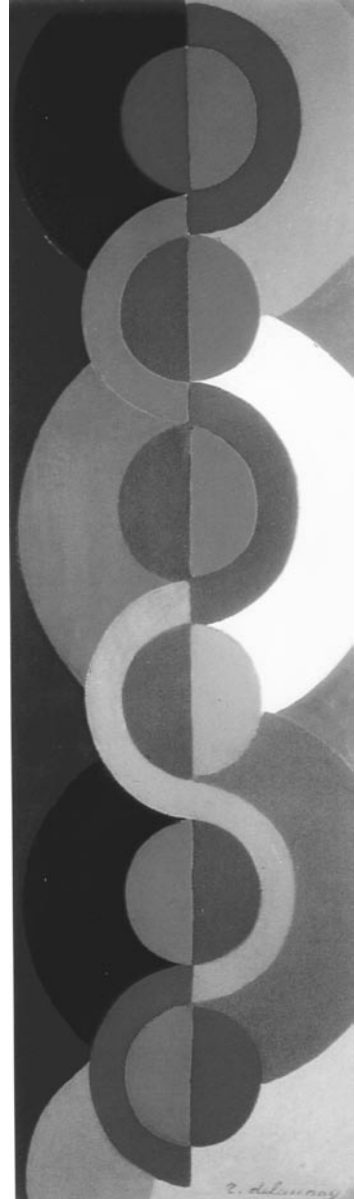
*Jill Murphy*

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**La importancia de la  
percepción de los stakeholders en la  
comprensión del impacto:**

**El programa del Sistema Básico de  
Salud Integral (SIBASI) y la calidad del  
servicio de salud  
primaria en El Salvador**

*Jill Murphy*



# The importance of stakeholder perception in understanding impact:

## THE BASIC INTEGRATED HEALTH SYSTEM (SIBASI) PROGRAM AND QUALITY OF PRIMARY HEALTHCARE IN EL SALVADOR

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### Abstract

Using a methodology which examines the perceptions of stakeholders, including policy-makers, healthcare professionals and community members, this paper details a preliminary evaluation of the impact thus far of the Basic Integrated Health System (SIBASI) program on quality of healthcare in El Salvador. The paper gives a brief overview of health systems reform in El Salvador, outlines the logic behind the sibasi and presents theoretical perspectives on quality in healthcare. The study found that although the sibasi was “good on paper” and had definite potential, it had not met with a great deal of success. Additionally, existing barriers in the health system in El Salvador- extreme poverty, ineffective governance, politicization, poor financing, and contention in the reform process- severely limited the success of the SIBASI program.

**Key words:** Quality of health care, health systems reform, stakeholder perception, health policy, access, El Salvador

### Resumen

El presente trabajo, desarrollado con una metodología que examina las percepciones de todos los interesados en el servicio de salud, incluyendo los creadores de las políticas en esta área, los profesionales de la salud y los miembros de la comunidad, representa una evaluación preliminar y detallada del impacto del Sistema Básico de Salud Integrada (SIBASI) en la calidad del servicio en El Salvador, esboza la lógica de este sistema y presenta perspectivas teóricas en materia de calidad en la prestación del servicio de salud. El estudio encontró que, si bien el sibasi parecía ser bueno “en el papel” y tenía potencial, en la práctica no ha obtenido mayores resultados. Adicionalmente, los obstáculos que actualmente enfrenta el sistema de salud en El Salvador, tales como la pobreza extrema, la falta de gobernabilidad, el clientelismo, la escasa financiación y la controversia alrededor del proceso de reforma del sistema, han limitado severamente el éxito del programa SIBASI.

**Palabras clave:** calidad de atención de salud, reforma de sistemas de salud, percepción de los actores, políticas de salud, acceso, El Salvador.

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## **Introduction**

The need to provide people with effective, equitable and accessible health services has led to much debate and contention over various approaches to appropriate health 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 Latin American 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 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 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). The complete study on which this paper is based draws upon three key variables- participation, access and quality in health-which were taken from the mandate of the MSPAS and its goals for the SIBASI program. This paper will focus on the dimension of quality and will examine the perceptions of various health system stakeholders in order to understand the preliminary effectiveness and impact of the SIBASI program.

## **Theoretical Perspectives of Quality in Healthcare**

'Quality' can be defined as "(...)the joined characteristics of goods or services that are able to satisfy the needs and expectations of a user or client" with a distinction made between technical and perceived quality in healthcare. 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, key to this analysis, comes from the users themselves. "This takes into account material, psychological, administrative, and ethical conditions(...)" of health care. (Ross and Zeballos, 2000: 93) Ross and Zeballos 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 (Ross and Zeballos, 94).

Access is also an important dimension of quality in healthcare. Campbell et al 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 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 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, such as 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. Effect-



tive policies and financing schemes are necessary to address the issue of quality in health care, both from a technical and perceived perspective.

## **Health Sector Reform in El Salvador**

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 Online: PAHO Regional Health Profile- El Salvador). Throughout the decade health reform was a controversial 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 conflict 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, complemented 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, 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). 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**

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 Ministerio 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, how-

ever, 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 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).

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 Ministerio 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). 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 that 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 (Sieber, 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 SIBASI 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 SIBASI 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 trucks, 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).

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 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 are 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 (DIGESTYC, "Encuesta de Hogares de Propósitos Múltiples", 2002), 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:

**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
Chaletenango	41.90%	116,579	Chaletenango: Population 30,671	1 hospital, 29 Health Units, 3 Health Posts, 6 Rural Nutrition Centres
Morazán	55.30%	168,983	San Francisco Go-tera: Population: 22, 324	1 hospital, 25 Health Units, 11 Health Posts, 4 Rural Nutrition Centres

Source: The El Salvador National Multi-Purpose Household Survey, 2002.



My research is concerned largely with the perceptions by various actors of the preliminary impacts of the SIBASI program on quality in healthcare. As discussed above in the review of literature, patient perceptions of quality are considered a crucial dimension of determining effectiveness of services, including access. Following the recognition of the importance of patient perceptions, the methodology of this study was designed to account for the importance the perceptions of numerous stakeholders in the health care system in order to create a comprehensive picture of effectiveness and impact. This study is not based in a traditional qualitative study of impact, but rather takes an approach that aims to draw out the different nuances of a complex system. While the methods do not lead to a conclusion on impact in terms of number of clients reached, for example, it does give an understanding of the many factors at play which may or may not make a health care program successful. The study reflects an interest in the goals of the SIBASI program, as outlined by the MSPAS, 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 interviews allowed me to draw out, through qualitative means, the perceptions of actors around the issue of quality. In order to understand 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, allow for an understanding of the nature of quality in the SIBASI program, as perceived by important

actors. 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? This focus recognizes that, while not necessarily numerically quantifiable, the perception not only reflects the impacts of the program, but may also impact on how the program is to succeed (or fail) in the future.

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.

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

#### **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. Sources remain nameless, with few identifying descriptors, to maintain confidentiality. When asked about

quality, respondents were reluctant to answer definitively due to a lack of data on quality improvements as a result of 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.

The significant challenges to successful health reform were universally mentioned by this group or respondents. However, one respondent said 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 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. This was also observed at a health centre in Santa Tecla, La Libertad, which 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 to 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, non- MSPAS doctors and health promoters were quite different from the responses given by SIBASI employees. 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 health-care are largely due to community effort 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.

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 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 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 limited quality of service.

The responses by different groups of actors lead to a number of overall observations about the SIBASI program and its impact on quality, as well as the health system overall. 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 its improvement. 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 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 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 is 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, and 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.

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