El Salvador

El Salvador is located in Central America and shares borders with Honduras, Nicaragua, and Guatemala, and with the Pacific Ocean to the south. The country's territory covers 21,040.79 km^2; its topography is irregular, with six distinct regions characterized by mountains, plateaus, and coastal plains. A chain of volcanoes and geologic faults makes it particularly vulnerable to earthquakes. El Salvador is a representative and decentralized republic, with a democratically elected government and executive, legislative, and judicial branches. The country is divided into 14 departments and 262 municipalities; the capital is San Salvador.

The population of El Salvador as of 2011 was 6.2 million. The country has undergone political transition since the 1992 peace accords.

From 1960 to 2009, annual average growth of the per capita gross domestic product (GDP) was 1.1%, while unemployment and underemployment remained at around 50%. Between 2004 and 2010, public health expenditure as a percentage of GDP grew from 3.6% to 4.3%.

Between 1997 and 2008, exports were diversified: conventional products (coffee, cotton, and tobacco) declined from 25% to 7% and nontraditional products (vegetables, fruits, beans, and milk) grew from 32% to 50%. Before the 2008 economic crisis, remittances increased steadily for some 30 years, representing 18% of GDP in 2008; in 2009 they declined to 9.9%, a reduction of US$ 323 million.

Selected basic indicators, El Salvador, 2008–2011.

Indicator	Value
Population 2011 (millions)	6.2
Poverty rate (%) (2009)	37.8
Literacy rate (%) (2009)	84.1
Life expectancy at birth (years) (2010)	72.0
General mortality rate (per 1,000 population) (2008)	5.2
Infant mortality rate (per 1,000 live births) (2008)	16.0
Maternal mortality rate (per 100,000 live births) (2010)	55.8
Physicians per 1,000 population (2009)	2.0
Hospital beds per 1,000 population (2010)	1.0
DPT3 immunization coverage (%) (2010)	91.0
Births attended by trained personnel (%) (2010)	90.0

MAIN ACHIEVEMENTS

Health Determinants and Inequalities

In general, progress in socioeconomic development in El Salvador has been limited and slow, given the challenges related to poverty, unemployment, and other living conditions. There are major disparities between various population groups, with the poor, the indigenous population, and those who live in rural and marginal urban areas suffering the greatest disadvantages. The highest income quintile receives 52% of total national revenue.

The 2009–2014 Social Education Plan was implemented in 2009, giving priority to children who are not enrolled in school due to their socioeconomic situation.

The Environment and Human Security

In 2010, 92% of households had electricity (97% in urban areas and 82% in rural areas) and 83% had access to piped water (93% in urban areas and 64% in rural areas). In urban areas, 75% of households had waste collection services (7% in rural areas).

Health Conditions and Trends

There have been notable advances in the control of communicable diseases. Important unmet challenges are the control of neglected infectious diseases and the availability of the budget resources needed to reach 95% vaccination coverage.

The maternal mortality rate was 55.8 maternal deaths per 100,000 live births in 2010. In 2008, the infant mortality rate was 16 per 1,000 live births.

The number of annual cases of malaria dropped from 49 in 2006 to 24 in 2010 (33% imported cases), and the pre-elimination phase of this disease was declared in 2011. Seropositivity for Chagas' disease in blood donors declined from 2.9% in 2004 to 1.9% in 2009. From 2006 to 2010, there were 33,084 confirmed cases of dengue, with an endemic pattern associated with epidemic outbreaks, the last of which occurred in 2010.

Since 1987, there have been no autochthonous cases of poliomyelitis, and no autochthonous cases of measles have been reported since 1996. In 2006, four cases of rubella were reported and in 2010 there were two neonatal tetanus cases.

In 2009, the incidence of HIV infection was 0.8%, with 10.8% of cases in men who have sex with men and 5.7% in sex workers. The cases are concentrated in the 25–29-year age group with a male/female ratio of 1.7:1. As of August 2010, antiretroviral therapy had been prescribed for 7,000 people, although universal access has not been achieved.

Mortality from tuberculosis declined from 2.35 deaths per 100,000 population in 1997 to 0.76 in 2009, while morbidity in all forms of the disease declined from 45.7 cases per 100,000 population in 1990 to 27.6 cases in 2010.

Comprehensive and Integrated Health Services Networks (RIISS)

The Ministry of Public Health has reactivated the National Health Council in order to promote health policies and programs. The Interinstitutional Health Commission, another strategic platform for developing intersectoral activities, is led by the Ministry of Public Health. It brings together 38 governmental and nongovernmental agencies, unions, private associations, and civil society groups.

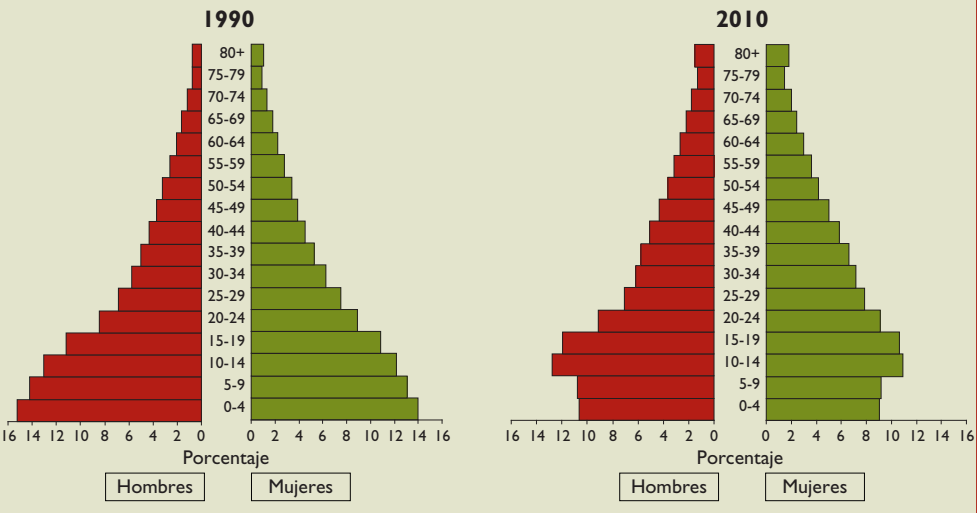
The Comprehensive and Integrated Health Services Networks (RIISS), which are based on primary care, establish community health teams that are progressively integrated into other institutions of the health system. This strategy was chosen as a way to reverse the effects of the fragmentation of health care and improve its efficiency and quality.

The Ministry of Public Health is transitioning toward management models as part of the reform of the sector. Within this framework, a results-based budget process has been initiated. Procedures are in place to improve the competence and capacity of managers of services and to update RIISS clinical guidelines, regulations, and treatment protocols.

Health Policies, the Health System, and Social Protection

Major health sector reform was initiated by the government that took office in 2009. Beginning in 2010, reform was directed to strengthening Ministry of Public Health leadership; developing human resources and capacity for data analysis and research; building comprehensive and integrated health services networks; and developing mechanisms for intersectoral action and citizen participation.

Population structure, by age and sex, El Salvador, 1990 and 2010.



National health expenditure increased from US$ 990 million in 1998 to US$ 1.4 billion in 2009. Public expenditure increased from US$ 490.9 million in 2001 to US$ 912.8 million in 2010, with annual average growth of 7.3%. The combined share of the Ministry of Public Health and the Salvadoran Social Security Institute represented 91% of public expenditure in 2010.

The delivery of services through the Comprehensive and Integrated Health Services Networks (RIISS) has been formulated with three levels of complexity. Based on primary care, the RIISS include community health teams that are progressively integrated with other institutions into the system. From 2010 to 2011, 380 community health teams and 28 specialized teams were established, with coverage of 1,234,000 people in 141 low-income municipalities (20% of the population). In 2010, 94% of pregnant women received at least one prenatal check-up and 78% were seen four times. Twenty-four percent of all pregnancies were among women from 15 to 19 years old.

The Interinstitutional Health Commission was established to more effectively address the social determinants of health through intersectoral action and social participation. The Commission provides the opportunity for dialogue and consensus-building on intersectoral health strategies. Forums were established for citizen participation at the national, regional, and local levels.

Knowledge, Technology, and Information

The health authorities created the National Institute of Health in order to promote research on health policies, systems, and services. El Salvador allocates 8% of its education budget to research, although only 35% of the researchers have master's or doctoral degrees.

The Ministry of Public Health, in collaboration with the National University and PAHO/WHO, has a health knowledge management unit with a complete research and information database.

MAIN CHALLENGES AND PROSPECTS

The country has been undergoing a process of political transition to

democratization since 1992, and continues to face challenges related to significant social and economic inequality, political polarization, high levels of violence, and a lack of security, aggravated by the current economic crisis.

In 2009, the average number of years of schooling was 7.2 years in urban areas and 4.1 years in rural areas; the illiteracy rate was 9.2% in urban areas and 22.7% in rural areas, and was 16% for women and 11.6% for men. Young people in the lowest income quintiles do not have access to postsecondary education, and consequently face lower incomes in the future. Salvadorans with less than four years of schooling have an average monthly income of US$ 184, in comparison with US$ 631 for people with 12 or more years of schooling.

Indigenous populations generally reside in rural areas, living from subsistence farming and consuming corn and vegetables they cultivate on leased lands. Women share their food with their partners and children. These groups do not have access to adequate education and lack basic water and sanitation services; 38% of them live in extreme poverty.

There are inequalities in access to safe water. It is necessary to strengthen the institutional capacity for monitoring and surveillance of wastewater and recreational water sources, as well as chemical and biohazardous waste. Only 81 of the 262 municipalities have sewage systems; 43% of urban dwellings and 98% of rural ones are not connected to a sewage network. In rural areas, 14% of the population does not have any sanitation services.

Strategies formulated for violence prevention include monitoring all forms of violence; implementing a management strategy to better understand violence and its determinants; strengthening the capacity to prevent gender violence and provide health care services to victims; and developing partnerships and collaborating with other sectors for prevention.

Between 1980 and 2008, an average of 1.5 disasters were recorded per year. During that period, the economic losses were estimated at US$ 16 billion (US$ 470 million per year, equivalent to 4.2% of GDP). These disasters took some 7,000 lives and affected 3 million people, especially in vulnerable populations.

There were 31,594 deaths recorded in 2008, for a crude mortality rate of 5.16 per 1,000 population. Due to problems of underreporting, the rate estimated for 2005–2010 is higher (689 per 100,000). There were 9,018 deaths from chronic, noncommunicable diseases reported in 2008. In 2010, chronic renal disease was the leading cause of death for the 25–59-year age group, with a rate of 6.3 per 100,000 (2.7 in women and 11.1 in men). Cerebrovascular disease was the second leading cause of death with a mortality rate of 9.3 per 100,000 population. Diabetes ranked fourth (7.1 per 100,000 population), ischemic heart disease ranked sixth (6.76), heart failure was tenth (5.76), and hypertensive disease ranked nineteenth (2.38).

The homicide rate in 2008 was 54 per 100,000 population. The average daily number of homicides in 2009 was 12. Among women, homicides increased from 6.5 per 100,000 population in 2001 to 17.5 in 2009, while among men they increased from 68.9 to 130.8 over the same period. Men from 15 to 38 years old had a rate of 224 homicides per 100,000 in 2008.

There were 5,275 traffic accident deaths recorded between January 2006 and July 2010 (men accounted for 79.7% of these deaths and women for 20.3%). The estimated mortality rate related to road accidents in 2010 was 16.9 per 100,000 population.

In 2008, 19% of 3–5-year-olds experienced growth deficiencies (13.5% in urban areas and 24.2% in rural areas). Almost one-third (31.4%) of children in the lowest income quintile had chronic malnutrition, compared with 5% in the highest quintile. Among children of women with no education, 37% had chronic malnutrition; that figure was 27% for children of mothers with less than three years of schooling.

In the area of maternal and child health, it is necessary to expand sex education and pregnancy prevention programs for adolescents, ensure that gender issues are addressed in health policies, and strengthen health promotion and universal access to quality services. With regard to chronic diseases, a national policy and program should be developed that uses an integrated approach to disease prevention and control.

Major challenges include strengthening the managerial capacity of the Ministry of Public Health, expanding coverage nationwide through development of the RIISS, and identifying financing mechanisms and sources that will ensure that program's sustainability.