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UNCLASSIFIED

UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
AGENCY FOR INTERNATIONAL DEVELOPMENT
Washington, D. C. 20523

ECUADOR

PROJECT PAPER

POPULATION AND FAMILY PLANNING

AID/LAC/P-075

Project Number:518-0026

UNCLASSIFIED

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE: A (A = Add, C = Change, D = Delete) — Amendment Number: _____

DOCUMENT CODE: 3

2. COUNTRY/ENTITY: 518 - Ecuador

3. PROJECT NUMBER: 518-0026

4. BUREAU/OFFICE: LAC

5. PROJECT TITLE (maximum 40 characters): Population and Family Planning

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 12 DD 31 YY 85

7. ESTIMATED DATE OF OBLIGATION (Under 'B.' below, enter 1, 2, 3, or 4)

A. Initial FY 81 B. Quarter 4 C. Final FY 85

8. COSTS ($000 OR EQUIVALENT $1 =)

A. FUNDING SOURCE	FIRST FY B. FX	C. L/C	D. Total	LIFE OF PROJECT E. FX	F. L/C	G. Total
AID Appropriated Total	62.4	152.6	215	1,200	4,400	5,600
(Grant)	(62.4)	(152.6)	(215)	(1,200)	(4,400)	(5,600)
(Loan)	(-)	(-)	(-)	( )	( )	( )
Other U.S. 1. DSB/POP	75.0	114.8			725	914.8
Other U.S. 2.						
Host Country GOE					3,800	3,800
Other Donor(s) Private Sector Counterpart					1,470	1,470
TOTALS						11,784,800

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	2. Loan	D. OBLIGATIONS TO DATE 1. Grant	2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	2. Loan	F. LIFE OF PROJECT 1. Grant	2. Loan
(1) PH	400	440						5,600	
(2)									
(3)									
(4)									
TOTALS								5,600	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): 450 | 420 | 410

11. SECONDARY PURPOSE CODE:

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code	BWW	RPOP	PVON	TNG		
B. Amount	5,600					

13. PROJECT PURPOSE (maximum 480 characters)

To expand demand for and availability of family planning information and services to low income populations, and to assist in the formulation of a population policy.

14. SCHEDULED EVALUATIONS

Interim MM 10 YY 82 | MM 11 YY 82 | Final MM 12 YY 85

15. SOURCE/ORIGIN OF GOODS AND SERVICES

[X] 000 [ ] 941 [ ] Local [X] Other (Specify) waiver

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a ____ page PP Amendment.)

17. APPROVED BY

Signature: John R. Stabrile

Title: Director, USAID/Ecuador

Date Signed: MM 06 DD 16 YY 81

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W AMENDMENTS, DATE OF DISTRIBUTION: MM DD YY

AID 1330-4 (3-79)

UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON D C 20523

PROJECT AUTHORIZATION

Name of Country: Ecuador

Name of Project: Population and Family Planning

Number of Project: 518-0026

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Population and Family Planning project for Ecuador involving planned obligations of not to exceed Five Million Six Hundred Thousand United States Dollars ($5,600,000) in grant funds ("Grant") over a five-year period from date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing foreign currency and local currency costs for the project. Obligation of funds for the commercial retail sales (CRS) component of the project is further subject to my approval of a detailed work plan for the CRS component.

2. The project ("Project") consists of (i) strengthening and expanding family planning (FP) delivery systems, (ii) expanding information and communication networks to increase awareness of population/FP among the leadership and general populace of Ecuador and (iii) strengthening the data collection and analysis capability in both the public and private sectors to assist in policy formulation. In order to implement the Project, Project Grant Agreements will be entered into with each of the Ministry of Public Health (MOH), the Ministry of Defense (MOD), the Social Security Institute (IESS), the National Development Council (CONADE) and the National Institute of Statistics and Census (INEC) of the Government of Ecuador and a Cooperative Agreement will be entered into with the International Planned Parenthood Federation (IPPF).

3. The above-described Project Agreements, which may be negotiated and executed by the officer to whom such authority is delegated in accordance with A.I.D. regulations and Delegations of Authority, shall be subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate:

a. Source and Origin of Goods and Services

Except as set forth in section d. below and except for ocean shipping, goods and services financed by A.I.D. under the Grant shall have their source and origin in the United States or in Ecuador, except as A.I.D. may otherwise agree in writing. Ocean shipping financed by A.I.D. under the Grant shall, except as A.I.D. may otherwise agree in writing, be financed only on flag vessels of the United States.

b. Conditions Precedent

(1) MOH Project Grant Agreement:

(a) Prior to any disbursement, or the issuance of any commitment documents under the Project Grant Agreement with the MOH, to

finance other than for procurement of imported equipment, the MOH shall, except as A.I.D. may otherwise agree in writing, furnish to A.I.D., in form and substance satisfactory to A.I.D., the detailed evaluation system that the MOH intends to use to assess the impact of the training activities which are to be financed under the Grant.

(b) Prior to any disbursement, or the issuance of any commitment documents under the Project Grant Agreement with the MOH, to finance training activities in Quito and Guayaquil, respectively, other than for procurement of imported equipment, the MOH shall, except as A.I.D. may otherwise agree in writing, furnish to A.I.D., in form and substance satisfactory to A.I.D.:

(i) a signed agreement with each participating university;

(ii) evidence that each academic coordinating unit has been established; and

(iii) the first annual workplan for training activities in Quito and Guayaquil, respectively.

(2) IESS Project Grant Agreement:

Prior to any disbursement, or the issuance of any commitment documents under the Project Grant Agreement with the IESS, to finance other than procurement of imported equipment, IESS shall, except as A.I.D. may otherwise agree in writing, furnish to A.I.D., in form and substance satisfactory to A.I.D., a detailed in-service training plan for the auxiliary nurses under the Campesino Program.

(3) CONADE Project Grant Agreement:

Prior to any disbursement, or the issuance of any commitment documents under the Project Grant Agreement with CONADE, CONADE shall, except as A.I.D. may otherwise agree in writing, furnish to A.I.D., in form and substance satisfactory to A.I.D., evidence that the Population Division has been established and that a staffing plan adequate for carrying out the CONADE subproject has been approved by CONADE.

(4) INEC Project Grant Agreement:

Prior to any disbursement, or the issuance of any commitment documents under the Project Grant Agreement with INEC, to finance other than procurement of imported equipment, INEC shall, except as A.I.D. may otherwise agree in writing, furnish to A.I.D., in form and substance satisfactory to A.I.D., evidence that arrangements for technical assistance have been made.

(5) IPPF Cooperative Agreement:

(a) Prior to any disbursement, or the issuance of any commitment documents under the Cooperative Agreement with IPPF, IPPF shall, except as A.I.D. may otherwise agree in writing, furnish to A.I.D., in form and substance satisfactory to A.I.D., an agreement or agreements between IPPF and the Association for the Welfare of the Ecuadorean Family (APROFE), the Medical Center for Family Planning and Orientation (CEMOPLAF) and the Center for the Promotion of Responsible Parenthood (CEPAR), pursuant to which APROFE, CEMOPLAF and CEPAR arrange for IPPF to work with them in Ecuador.

(b) Prior to any disbursement, or the issuance of any commitment documents under the Cooperative Agreement with IPPF, to finance other than procurement of imported equipment, IPPF shall, except as A.I.D. may otherwise agree in writing, name a project coordinator acceptable to A.I.D.

(c) Prior to any disbursement, or the issuance of any commitment documents under the Cooperative Agreement with IPPF, to finance activities to be carried out by APROFE, CEMOPLAF and CEPAR, respectively, IPPF shall, except as A.I.D. may otherwise agree in writing, furnish to A.I.D., in form and substance satisfactory to A.I.D., a first-year workplan for APROFE, CEMOPLAF and CEPAR, respectively.

(d) Prior to any disbursement, or the issuance of any commitment documents under the Cooperative Agreement with IPPF, to finance sub-grants to CEMOPLAF and CEPAR, respectively, IPPF shall, except as A.I.D. may otherwise agree in writing, furnish to A.I.D., in form and substance satisfactory to A.I.D., evidence that the accounting system of CEMOPLAF and CEPAR, respectively, is adequate for the accumulation and segregation of costs incurred under the Project and that the internal controls system of CEMOPLAF and CEPAR, respectively, is adequate.

c. <u>Covenants</u>

(1) MOD Project Grant Agreement:

The MOD shall covenant that, unless A.I.D. otherwise agrees in writing, it will establish the promoter and nurse midwife positions and will provide financing for these positions in accordance with the phasing contemplated in the MOD subproject.

(2) MOH Project Grant Agreement:

The MOH shall covenant that, unless A.I.D. otherwise agrees in writing, it will establish training positions and will provide financing

for these positions in accordance with the phasing contemplated in the MOH subproject.

(3) IPPF Cooperative Agreement:

IPPF shall covenant that, unless A.I.D. otherwise agrees in writing, it will improve the accounting systems of CEMOPLAF and CEPAR, in a manner satisfactory to A.I.D., during the life of the Cooperative Agreement.

d. Waiver

A.I.D. nationality requirements are hereby waived in order to permit Grant financing of technical assistance advisors from Latin American countries, in addition to Ecuador, in an amount not to exceed $191,000.

Acting Assistant Administrator
Bureau for Latin America
and the Caribbean

7/22/81
Date

Clearances:

GC/LAC:BVeret: date 7/20/81
LAC/SA:RLindsay: date 7/20/81
LAC/DR:MBrown: date 7/21/81

GC/LAC:GMWinter:gkg:7/17/81:23272

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SELECTED LIST OF ACTONYMS

APROFE	-	Ecuadorean Association for Family Walfare
CBD	-	Community Based Distribution
CEMOPLAF	-	Medical Center for Orientation and Family Planning
CEPAR	-	Center for Promotion of Responsible Parenthood
CONADE	-	National Development Council
CPS	-	Contraceptive Prevalence Survey
CRS	-	Commercial Retail Sales
FPIA	-	Family Planning International Association
ICEA	-	Intermediary Coordinating/Executing Agency
IESS	-	Ecuadorean Social Security Institute
INEC	-	National Institute of Statistics and Census
IPPF/WHR	-	International Planned Parenthood Federation/Western Hemisphere Region
IRD	-	Integrated Rural Development
MOD	-	Ministry of Defense
MOH	-	Ministry of Health
PAHO	-	Pan American Health Organization
UNFPA	-	United Nations Fund for Population Activities
WFS	-	World Fertility Survey

SUMMARY AND RECOMMENDATIONS

A. Introduction and Overview

The population of Ecuador is one of the fastest growing in Latin America. The present rate of population growth, estimated between 3.0 and 3.4 percent, severely hampers the GOE's ability to achieve its development goals as described in the 1980-1984 National Development Plan. In light of the public and private sectors' present incapacity to stay abreast of societal demands for employment, education, health services, basic shelter and adequate food production and distribution, continued high rates of population growth will widen further the existing gap between the country's social and economic needs and its ability to meet them.

To significantly close this gap, the GOE cannot rely only upon the very gradual decline in population growth rates resulting from the process of economic and social development. This process must be complemented with family planning (FP) interventions by both the public and private sectors. The estimated decreases in fertility during the 1970s were not only the result of rapid social and economic changes, but also ongoing, albeit modest, public and private family planning programs. This fertility decline has also been attributed to the widespread availability and utilization of private physicians and nurse midwives to deliver family planning (FP) services.

Therefore, to continue and to accelerate the decline in the population growth rate of the 1970s, Ecuador needs to respond directly to the growing demand for family planning services. Within the public sector, it appears that governmental institutions are prepared to address systematically the developmental impact of a high population growth rate and to increasingly support the integration of family planning information and services into national maternal-child health programs. The private sector also has identified opportunities to extend the provision of family planning information and services. Private sector family planning organizations have assumed the responsibility of demonstrating to the government that substantial demand exists for spacing and controlling family size in all segments of the population and filling the large gaps in public sector FP programs.

In summary, as Ecuador enters the 1980s there exists a more favorable socio-economic environment within which population programs can operate. There is evidence of a change in fertility behavior as well as implicit host country commitment to family planning as a basic human right. The present challenge is to accelerate the provision of FP information and services. In addition, there is a need for further analysis which will bring the multisectoral implications of Ecuador's high population growth rate to the attention of development and policy planners and other national

leaders. Data are now becoming available on which to base analytical efforts dealing with such issues as migration and spatial distribution trends in order to enable the government to develop policies and programs with respect to such population-related issues as urban planning. Setting priorities and planning programs will become easier if demographic realities are kept foremost in mind.

To many observers, Ecuador's extremely high population growth rate is the country's number one development problem. For this reason, USAID's approved CDSS has assigned highest priority to implementing a family planning program. Since A.I.D. is the only major international source of funding for FP programs, progress in this sector in 1981-85 will largely depend on Ecuadorean and A.I.D. resources.

B. Background and Conceptual Framework

The first Ecuadorean family planning program began in Guayaquil in 1965 with the establishment by Dr. Pablo Marangoni of the Association for the Welfare of the Ecuadorean Family (APROFE)-- a private voluntary agency. APROFE is the Ecuadorean affiliate of the International Planned Parenthood Federation (IPPF) and for the past fifteen years it has been one of the leading institutions promoting family planning in Ecuador. Dr. Marangoni attributes the development of APROFE to USG leadership on the population issue and to funding from IPPF and A.I.D.

A.I.D. bilateral family planning activities in Ecuador began in 1970 and extended through 1975. During this period, A.I.D. provided approximately $4.5 million which was instrumental in establishing most Ecuadorean family planning institutions, in both the public and private sectors. For example, in 1971, A.I.D. assistance led to the establishment of the Ministry of Health's (MOH's) Department of Family Welfare and to the integration of family planning in MOH programs. In this same year, A.I.D. provided financial and technical assistance to initiate and expand FP programs in both the Ministry of Defense (MOD) and in the Social Security Institute (IESS). This led to the establishment of 31 MOD clinics providing FP services and to the provision of FP in some MOH and IESS clinics. Bilateral A.I.D. funding also established a family planning motivation program in the Ministry of Labor and Social Welfare and led to the creation of a Demographic Analysis Unit in the National Institute of Statistics and Census (INEC).

In the private sector, USAID supported in 1971 the establishment of the Medical Center for Family Planning and Orientation (CEMOPLAF), a Quito based PVO, to complement and expand the work initiated by the Guayaquil based APROFE. In 1978, a small amount of USAID technical assistance led to the establishment of the Center for the Promotion of Responsible Parenthood (CEPAR) to advance public information and research

activities that would raise population/family planning awareness in Ecuador.* Unfortunately, since its establishment, CEPAR has not obtained adequate funding to expand its programs and thereby have a greater impact on the population debate in Ecuador.

As a result of the phase-out of the A.I.D. program in Ecuador during much of the 1970s, USAID bilateral support for Ecuadorean FP agencies was prematurely terminated in 1975. There was no bilateral FP project between 1975-80. During this period, DSB activities continued to provide some limited funding, but these relatively small contributions by themselves could not significantly accelerate the institution-building process. While most Ecuadorean FP agencies survived throughout the period 1975-80 (thereby demonstrating their long-run viability), their institutional growth and the coverage of their programs did not advance. Thus, while demand for FP services continued to rise in the late 1970s-- and the consequences of Ecuador's high population growth continued to worsen— both public and private sector delivery systems could not keep pace with the demand, resulting in the estimated low levels of contraceptive prevalence in Ecuador today.

Throughout the 1960s and 1970s, A.I.D. funding through intermediaries and directly through a bilateral program, provided the only major source of assistance for Ecuadorean family planning agencies. In an environment that has been either indifferent or hostile to family planning, A.I.D. has been able to identify important "islands of support" for FP and strengthen their institutional and technical capacities. This approach has successfully and strategically established within the Ecuadorean public and private sectors small, but important, groups strongly committed to family planning. As a result of A.I.D.'s pioneering FP efforts, all five Ecuadorean FP delivery systems were providing services to approximately 118,000 women at risk in 1980. These FP delivery systems now serve as a vital base for expanding and consolidating Ecuadorean FP programs in the 1980s.

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* With rapidly accelerating development problems in the 1970s, two important Ecuadorean PVOs were created in 1978 to raise public consciousness about important development problems and to lobby for more effective public policies to address these problems. One of these PVOs was CEPAR, the other was Fundación NATURA which is currently undertaking, with USAID-OPG funding, a public education campaign to raise consciousness about the country's growing environmental degradation problems. USAID believes that it is important to strengthen the public information functions of both CEPAR and NATURA and encourage them to work together on population issues.

The USAID strategy proposed herein is based on a full recognition that Ecuador, like many other countries, does not have an adequate national population policy (see Issue No. 1). However, the population policy constraint, while important, is not the highest priority problem. A policy could exist without adequate FP delivery systems, and little or no FP services would in fact be provided. On the other hand, it is clear that FP services can and are being delivered in Ecuador without a population policy. In USAID's view, the highest priority constraint that must be addressed in the 1980s is the need to expand coverage of the existing small FP delivery systems and further strengthen their institutional capacity. At the same time, the policy constraint needs to be addressed so as to ultimately provide an environment that will be more supportive to FP in Ecuador.

The comprehensive USAID strategy proposed above, builds upon, expands and better utilizes the FP institutions that A.I.D. successfully helped initiate in the 1970s. For the reasons outlined below, in Issue No.3, a multi-institutional FP program is an indispensable part of the A.I.D. family planning strategy in Ecuador. USAID believes that the resources proposed herein can serve as catalysts for a major expansion in the country's FP delivery systems and for a policy planning process that can lead to the emergence of a national population policy. However, this project should be seen as the first phase of a ten-year effort to expand and consolidate the institutional and policy framework that Ecuador needs to deal adequately with its population problem. With continuous bilateral and centrally funded assistance being provided to Ecuadorean family planning agencies through the 1980s, USAID is confident that Ecuador can enter the 1990s with a formal population policy and the necessary delivery systems to implement this policy nationwide.

C. Project Description

The purposes of the proposed project are to: (1) expand availability of family planning services offered by public and private sector agencies; (2) promote greater demand for these services; (3) increase national awareness of the multisectoral implications of Ecuador's rapid population growth; and (4) strengthen Ecuador's population planning capacity. This project will accomplish these purposes through a comprehensive multi-institutional approach involving five public and three private sector institutions.

Within both sectors, the project will emphasize the improvement and expansion of FP delivery systems. Five of the eight implementing institutions are service-oriented (MOH, MOD, IESS, APROFE, CEMOPLAF). Of these five, each requires assistance tailored to its particular institutional weaknesses or service delivery constraints. In the public sector, A.I.D. assistance will concentrate on strengthening the institutional capacity of the MOH, MOD, and IESS. Support to these agencies primarily will consist of training, technical assistance, and the provision of equipment and supplies. In the private sector, assistance will

be provided for operational support of the clinical program of APROFE and CEMOPLAF.

The functions of the three remaining agencies (CONADE and INEC in the public sector, and CEPAR in the private sector) are oriented toward data analysis, research, population planning and policy formulation. Specifically, this project will assist CONADE to fulfill its mandate to develop a population policy for Ecuador by providing training and research funds to its newly created Population Division. Technical assistance will be provided to INEC to improve the national vital registration system which will also serve as a valuable input to CONADE's research and population planning activities. Finally, CEPAR will directly complement and support the objectives of both CONADE and INEC with its information, education and research activities. Through these three activities CEPAR will concentrate on making government and political leaders aware of the national implications of Ecuador's high population growth rate.

In addition to these institution-specific subprojects, USAID and the DSB/Population Office*will finance, on a cost-sharing basis, the initiation of a commercial retail sales activity in Ecuador. The purpose of this activity is to provide a commercial source of contraceptive methods at prices affordable by Ecuador's low-income groups. Also, through its extensive advertising and promotional activities, a successful CRS program will further stimulate the demand for family planning information and services in Ecuador.

The success of these subprojects will be measured by the number of active family planning users reached at the end of this project in 1985. USAID estimates it will reach 31 percent of the women at risk or 398,900 active users. This would signify an increase of 55 percent coverage from the present 20 percent of Ecuadorean women at risk now practicing family planning. In providing annual incremental funding for each FP service agency, USAID will take into consideration whether the agency has met agreed upon annual targets of active FP users.

D. Implementing Agencies and Summary Financial Plan

The various population and family planning activities funded under the project will be implemented through five public sector and three private sector institutions. The implementation of each public sector project will be directly monitored by the USAID Population Officer. Since a large amount of project assistance to the public sector consists of training, USAID will also contract a FP Training and Coordinating Advisor to assist in coordinating and implementing public sector subprojects. In the private sector, USAID will contract with an Intermediate Coordinating/Executing Agency (IPPF) to assume direct responsibility for implementation of the private sector activities.**USAID will

*DSB has recently been renamed the Bureau for Science and Technology .
**USAID will contract with IPPF through a Cooperative Agreement between IPPF/WHR and USAID/Ecuador.

monitor the day-to-day performance of the private sector program through the Quito Office that will be established by the Intermediate Coordinating/ Executing Agency. In addition, USAID will work closely with DSB/POP and its contractors through joint financing and/or implementation of various subproject activities including three Contraceptive Prevalence Surveys, improvement of Ecuador's vital registration system, and a commercial retail sales activity designed to establish commercial outlets to provide contraceptives affordable to low-income groups.

The following agencies will participate in the project:

1. Ministry of Public Health (MOH)

The MOH will implement the largest training activity under the project. In collaboration with Ecuadorean universities in Quito and Guayaquil, the MOH will establish four new training centers to provide an innovative program of teaching/research/service in the field of maternal child health/family planning to medical nursing and nurse midwife students and MOH service staff. The MOH has the most extensive health delivery program nationwide and therefore providing this practical FP training to present and future health personnel will result in far reaching benefits to low-income Ecuadoreans presently serviced only by the MOH system.

2. Ministry of Defense (MOD)

The MOD will expand significantly its FP program by increasing the number of MOD health clinics offering FP services, training existing and new staff in the delivery of FP services and related family health needs and expanding information, education and communication (IE&C) activities at the field level.

3. Social Security Institute (IESS)

The IESS's health service programs (IESS/Preventive Medicine Division (MP) and IESS/Campesino Program) will strengthen and expand their delivery of FP and IE&C services. The IESS/MP is an urban-based service program that provides integrated health/FP services to urban affiliates through mobile health brigades. The IESS/Campesino program complements the urban coverage of the IESS/MP program by servicing the health and FP needs of rural affiliates through its clinics nationwide. Both service programs will receive institutional support mainly through the training provided under this project.

4. National Development Council (CONADE)

CONADE has been charged with the responsibility of developing Ecuador's national population policy. Under this subproject, CONADE will further strengthen the policy planning capabilities of its new Population Division through the training and research activities funded by A.I.D. and the extensive technical assistance provided by UNFPA.

5. National Institute of Statistics and Census (INEC)

INEC is the major government data collection and analysis agency. As a major input to GOE population planning and policy formulation, INEC will improve the country's vital registration system to provide a reliable source of demographic information.

6. Association for the Welfare of the Ecuadorean Family (APROFE)

APROFE is the strongest private sector FP organization in Ecuador today. A.I.D. will assist APROFE to extend its coverage of FP services and IE&C programs by financing its three ongoing clinics in Guayaquil, Quito and Cuenca thus enabling APROFE to divert its other sources of funding (mainly from IPPF) to support its expanding community based distribution (CBD) program.

7. Medical Center for Family Planning and Orientation (CEMOPLAF)

CEMOPLAF will expand its urban based clinical programs to Guasmo (a peripheral slum of Guayaquil), and to the cities of Esmeraldas and Tulcán. These new clinics will provide FP services and host extensive community based IE&C activities for low-income Ecuadoreans in each area.

8. Center for the Promotion of Responsible Parenthood (CEPAR)

CEPAR will contribute informational and educational support to the private sector and GOE service organizations as well as to GOE policy planning and data analysis institutions through its research, information dissemination and population awareness raising programs.

9. Intermediary Coordinating/Executing Agency (ICEA)

To implement private sector activities under this project, USAID plans to contract with the Western Hemisphere Region of the International Planned Parenthood Federation (IPPF/WHR) through a Cooperative Agreement. IPPF/WHR will provide technical assistance and training to all three Ecuadorean PVOs (APROFE, CEMOPLAF, CEPAR) in order to strengthen their institutional and technical capacity. IPPF/WHR will administer AID grant funds for the private sector component of this project, provide subgrants to the three participating Ecuadorean PVOs, supervise the implementation of each of these subgrants and facilitate better coordination of private sector FP activities. To carry out these responsibilities IPPF/WHR will establish an office in Quito staffed by a full-time Project Director. Technical assistance and training resources will be provided by IPPF/WHR from its Quito and New York Offices as well as from outside consultants contracted by IPPF/WHR. There will be close coordination and regular monitoring meetings between IPPF/WHR and USAID/Ecuador.

A summary budget for the proposed A.I.D. grant, and the GOE and private sector counterpart contributions is shown on the following page.

SUMMARY BUDGET
(in US $)

	Activities	A.I.D.*	Counterpart	Total
I.	Public Sector	2,011,200	3,437,900	5,449,100
	Inflation & Contingencies	198,800	362,100	560,900
	Subtotal	2,210,000	3,800,000	6,010,000
II.	Private Sector	2,842,800	1,315,270	4,158,070
	Inflation & Contingencies	547,200	154,730	709,930
	Subtotal	3,390,000	1,470,000	4,860,000
	TOTAL	5,600,000	5,270,000	10,870,000

The major portion of A.I.D.'s support to the public sector will strengthen the existing GOE family planning programs through the provision of training, technical assistance, and personnel and logistics support. In the private sector, A.I.D.'s inputs are for operational support of APROFE's three ongoing clinics and CEMOPLAF's three new clinics. With respect to CEPAR, A.I.D. will directly assist in developing its administrative structure and financing the operating costs of its three major activities: information, training and research.

The A.I.D. grant will be disbursed during the period 1981-1985. It will be incrementally funded over five fiscal years as follows: FY 1981, $215,000; FY 1982, $1,250,000; FY 1983, $1,350,000; FY 1984, $1,500,000; and FY 1985, $1,285,000.

E. Issues

1. Lack of a GOE Population Policy

The new Ecuadorean Constitution which took effect in August, 1979 mandated that CONADE establish the population policy of the country, "within the social and economic guidelines for solutions to national problems, in accordance with principles of respect for the sovereignty of the State and self-determination of the parents." A specific population policy chapter of the National Development Plan for 1980-84 was developed in late 1979. To deal with Ecuador's population problem, it

* Bilateral funding only. DSB/POP will contribute $914,800 to joint-finance INEC and commercial retail sales sub-projects.

concentrated on economic and social development plus the geographical redistribution of the existing population. In early 1980, there was an intense internal GOE debate over this draft population policy. One group opposed the policy because it made no reference to an active family planning program. Another group felt that a population policy should not be included in the Plan for political reasons. The two opposing sides agreed to disagree and the population policy chapter was eliminated from the Plan. As a result, the GOE does not have a specific population policy.

While the population policy gap in Ecuador is an important constraint that must eventually be overcome, it is not preventing the delivery and use of family planning services. As indicated in this PP, a number of public and private FP agencies are actively and openly promoting FP services and information. However, a positive population policy could greatly accelerate the growth and expansion of the existing small FP delivery systems. For this reason, a major objective of the USAID strategy is to promote, in a very low profile manner, the emergence in Ecuador of a population policy. This will be accomplished by supporting, with UNFPA, CONADE's Population Division, strengthening INEC's capacity to provide statistics for the policy planning process, and expanding CEPAR's activities in the areas of public education. USAID is hopeful that these inputs, plus the expansion of FP delivery systems, will serve as catalysts for the emergence of a population policy in the 1980s as called for by the new Ecuadorean Constitution.

2. Proposed Family Planning Strategy

The FP strategy outlined in this PP anticipates that a follow-on project will probably be necessary in the period 1985-90 to consolidate and further expand the efforts initiated in 1981-85. While any follow-on project would obviously depend on the progress made in the 1981-85 period, international sources of FP funding probably still will be necessary after 1985 to continue and to expand Ecuadorean FP programs. The private sector agencies (APROFE, CEMOPLAF, CEPAR) will not, and cannot, become financially self-sufficient in the period 1981-85. In the public sector, expanded Ecuadorean funding for FP programs after 1985 will depend largely on progress that can be made in the 1981-85 period to generate a positive population policy that will allocate additional GOE funds to these programs.

The future of the private sector program after 1985 will depend largely on how quickly public sector FP programs are expanded. USAID anticipates that the private sector in 1985 will still be required to play the role in FP programs. Through the project proposed herein, private sector agencies will be substantially strengthened; coordination among them will be improved; and major linkages (both technical and

financial) will be developed among all three private agencies and an international intermediary such as IPPF. By 1985, all three private agencies should be in a much better position to work together and to utilize funding and technical resources from the international intermediary system. Thus, if follow-on funding in the period 1985-90 is not provided directly by A.I.D., it is possible to envision intermediaries providing assistance to these private organizations so as to maintain the operational levels reached in 1985.

In the public sector, much needs to be done to strengthen and expand public sector FP delivery systems. Even if a positive population policy existed today in Ecuador, the ability of public sector agencies to implement such a policy is sorely limited by the small coverage of existing programs and serious institutional weaknesses. However, if a policy breakthrough should occur (possibly in the context of the 1984 election campaign and a new GOE Administration in 1985-90), it is possible to envision that GOE funding alone could continue FP programs at the operational levels attained in 1985.

While it is possible to anticipate various sources of follow-on funding for both public and private sector FP programs (other than a new A.I.D. bilateral project), USAID believes it is more realistic to utilize a ten year planning horizon (the decade of the 1980s) for its FP program in Ecuador. Even with a population policy breakthrough in 1984-85, a new bilateral project probably still will be necessary to consolidate and expand the gains of the 1981-85 period. USAID, therefore, believes that the project proposed herein should be seen as the first-phase (mainly catching-up with existing FP demand), and that a second phase should be anticipated in the period 1985-90. With continuous A.I.D. assistance provided, both bilaterally and centrally funded, to Ecuadorean family planning agencies througnout the 1980s, USAID is confident that Ecuador will enter the 1990s with a positive population policy and the necessary delivery systems to implement this policy nationwide.

3. Multi-institutional Family Planning Approach

The USAID strategy proposed herein will provide assistance to a number of different Ecuadorean agencies. Five FP delivery systems (MOH, MOD, IESS, APROFE CEMOPLAF) and three population policy institutions (CONADE, INEC, CEPAR) will receive funding. Given the dimensions and the seriousness of Ecuador's population problem, a multi-institutional approach is recommended for the following reasons:

--First, the population policy constraint cannot be adequately attacked through only one institution. CONADE is charged with population policy planning. It needs statistics that INEC cannot now produce. Both CONADE and INEC require substantial institutional strengthening to carry out these functions. Yet neither CONADE nor INEC can conduct

public awareness campaigns about population problems nor lobby for more effective population policies. A private organization like CEPAR is needed to generate greater public support for the population planning process in CONADE and INEC. A comprehensive attack on the policy constraint requires assistance to all three of these agencies. Removing any one agency could seriously reduce the effectiveness of the entire policy planning, data collection, and analysis effort.

--Second, the dimensions of the population problem in Ecuador (1.3 million women at risk in 1985) and the relatively limited coverage of the existing delivery systems mean that it would not be feasible for only one or two agencies to meet the current demand for FP services. In 1980, the five FP delivery systems (MOH, MOD, IESS, APROFE, CEMOPLAF) reached only 118,000 women at risk. Together, these same five delivery systems, with the A.I.D. assistance proposed in this project, will reach approximately 398,900 of the 1.3 million women at risk by 1985. It is not administratively feasible for only one, two or even three of these agencies to achieve this same rate of coverage. Moreover, if Ecuador ultimately is to extend FP to a majority of its women at risk, it will need to substantially strengthen and expand all five of the existing FP delivery systems.

--Third, open and active ministerial support for FP remains controversial. (However, a number of ministries are very willing to quietly support its expansion). If efforts were concentrated on developing only one or two large FP delivery systems, they could easily become "lightening rods" for those who might oppose FP. In USAID's view, it is much more difficult to attack and eliminate five smaller FP delivery systems than one or two large systems. Furthermore, should one or two systems become inoperative for any reason (which is not now expected), the other agencies could at least continue the FP movement in Ecuador. In addition, by backing only one or two FP delivery systems, USAID would alienate important centers of FP support. All five FP delivery systems are vital for building a stronger Ecuador FP movement.

--And finally, family planning is an unusual sector for A.I.D. operations because of at least two factors: (i) A.I.D. either directly through bilateral projects or indirectly through intermediaries is the major donor (in Ecuador, A.I.D. is virtually the only donor, particularly for the private sector); and (ii) relatively small amounts of funding, such as proposed in this PP, can have a significant impact on the delivery of FP services. Neither of these factors usually are applicable in other sectors in which A.I.D. operates. Within most sectors (agriculture, health, education, energy) there is financing by a number of different donors and A.I.D. inputs are usually the smallest. Most often, A.I.D. directs its financing to small pilot projects and institution-building activities with the full expectation that follow-on assistance for replication will be made available by other donors, once the technologies

or delivery approaches have been tested and institutionalized. This latter strategy permits A.I.D. to limit the scope and geographic coverage of many of its projects.

However, family planning, particularly in Ecuador, requires a different approach. Because of the sensitivity of FP, there is currently no expectation that other major donor assistance will be forthcoming in the near future, particularly for the private sector. (The only possible exception is some UNFPA funding for the MOH and CONADE, and assistance from the intermediaries.) If the existing Ecuadorean FP agencies are to expand their coverage, A.I.D. provides the only major source of funding --both now and possibly throughout the 1980s. Relatively small amounts of A.I.D. funding can mobilize local resources for FP programs and thereby have a significant impact on the expansion of FP services. If Ecuador is to make major progress in addressing its serious population problem in the 1980s, a comprehensive public and private sector program is necessary rather than a "token" effort in which A.I.D. directs funding to only one or two agencies. Thus, for all of the above reasons, USAID believes that assistance to a multi-institutional FP program is an indispensable part of an A.I.D. family planning strategy in Ecuador.

4. Processing of Project Agreements and Obligation of Project Funds

The individual components proposed in this PP are being viewed by both USAID and the GOE as separate projects. Funding will be obligated through individual agreements with each public sector agency (MOH, MOD, IESS, CONADE, INEC) as if each was a separate project. One USAID agreement will be executed with an international intermediary (probably IPPF) for the provision of all funding and technical assistance to the three private sector agencies described in this PP.

Prior to signature, the public sector agreements must pass through a formal GOE review and approval process directed by CONADE. Once approved, the agreement is signed for the GOE by the Minister of Foreign Affairs and the executing agency.

The USAID proposes to proceed as follows: the RLA will draft individual agreements for the MOH, MOD, IESS, CONADE, INEC and private sector projects. Depending on the availability of funding in FY-1981, the MOH and possibly the MOD agreements will be processed to obligate FY-1981 funds. (Some FY-1981 funds will also be obligated in an agreement with the international intermediary for the private sector program.) In accordance with Ecuadorean procedures, USAID will submit a draft agreement to the particular executing agency that will implement the project (e.g., MOH, MOD). After review and approval of the agreement by the executing agency, it will be presented by the executing agency to CONADE for processing through the formal GOE review and approval process. Each executing agency will be responsible for ensuring that its agreement gets through this process and is signed in time to obligate funds.

While USAID does not expect any difficulties in the processing of public sector agreements, unexpected GOE family planning policy concerns could be raised during the formal CONADE/Ministry of Foreign Affairs review process. MOH and MOD have assured USAID that they will get their agreements through the process and that they will be signed. The CONADE and INEC agreements should not cause any particular problems. However, should any unexpected problems arise in FY-1981, all available funding could be obligated through an agreement with the international intermediary to implement the private sector program.

F. Project Development Committee

1. The USAID Project Development Committee was composed of the following officers:

Mr. Manuel Rizzo, USAID Population Officer
Dr. Kenneth Farr, USAID Health Development Officer
Mr. Paul Fritz, USAID Capital Resources Development Officer
Mr. Carlos Luzuriaga, USAID Program Economist
Mr. Richard McClure, USAID Controller

2. The design and drafting of the Project Paper were carried out by the above committee with major assistance from the following A.I.D./W Officers:

Ms. Karen Peake --LAC/DR/SA
Dr. Robert Corno --LAC/DR/POP

3. The following Ecuadorean personnel assisted in the preparation of various project components:

MOH: Dr. Pedro Lovato, Chief of Maternal and Family Welfare Division
Dr. Rodrigo Yépez, Dean of Medical Faculty, Central University

MOD: Col. Dr. Guillermo Iturralde, Director of the Armed Forces Health Services
Dr. Eduardo Cevallos, Chief Departments of Family Welfare and Preventive Medicine

IESS/MP: Dr. Edmundo Montiel, Chief of Preventive Medicine Division
Lcdo. Mario Alarcón, Chief of Health Education Division

IESS/Seguro Campesino:
Dr. Galo Cordero, Chief of Social Security Campesino

Dr. César Cordero, Chief of Benefits
Lcda. Fanny Lascano, Chief of Social Work

INEC: Ec. Pedro Merlo, Chief of Surveys and Census
Ec. Alicia Alvarez, Chief of Social and Demographic Statistics Division
Dr. Ramiro Brito, Chief of Registration and Identification, National Directorate of Civil Registration
Ec. Raúl Stacey, Chief of Department of Health Statistics, MOH

CONADE: Arq. Teodoro Peña, Project Coordinator

APROFE: Dr. Pablo Marangoni, Executive Director
Ab. Eduardo Landívar, Chíef of Education Division
Ing. Jenny Duarte, Chief Accountant

CEMOPLAF: Dr. Ligia Salvador, President
Lcda. Teresa de Vargas, Coordinator

CEPAR: Dra. Betty Proaño, Executive Director
Dr. Roberto Díaz, Information Specialist
Lcdo. Francisco Aguirre, Demographer

4. The following consultants and A.I.D./W Officers also assisted in the design of various Project components:

Maura Brackett	LAC/DR/POP
Arthur Danart	DSB/POP
Bruce Carlson	APHA Consultant
Luis Daza	Colombian MOH Consultant
Ann Terbourg	DA Consultant
Lindsey Stewart	IPPF Consultant
Mark Oberle	CDC Consultant

5. The Project was reviewed and approved by the following USAID Officers:

John A. Sanbrailo, Director,USAID/Ecuador
Angel M. Díaz, Assistant Director,USAID/Ecuador
Patricio Maldonado, Program Officer

G. Recommendations

The project prepared herein was designed by a team composed of professionals from public and private sector Ecuadorean agencies, USAID/Ecuador, AID/W and private consultants. As part of the design process, specific project activities were identified for implementation shortly after the meeting of conditions precedent to disbursement. The project was reviewed and approved by a USAID Project Committee. Both the Project Development Committee and the Reviewing and Approval Committee conclude that the project and its components are technically, economically, socially, administratively, environmentally and financially sound, and recommend that the project be approved by AID/W and that an AID grant of $5.6 million be authorized.

I. BACKGROUND AND JUSTIFICATION

A. The Population Problem in Ecuador

1. Background

One of the most serious development problems facing Ecuador, with a current population of 8.3 million, is its extremely high rate of population growth. Although the country's GNP has been increasing annually by five to eight percent over the past ten years, Ecuador still has all of the indices of an underdeveloped country, including a majority of the population living in rural areas with low levels of education and poor health conditions. Among this group, GOE statistics show an infant mortality rate of 70 per 1000 (1977).* The country cannot now provide for the basic human needs of over half of its population who live in extreme poverty.

Ecuador's National Institute of Statistics and Census (INEC) has made population projections based on the 1974 census and several assumptions regarding fertility trends and mortality changes.** Assuming an influence on fertility of changes in education levels, economic activity rates, and urbanization, the population will increase to over 15 million by the year 2000. Even a substantial increase in family planning (FP) use, with lower fertility levels, is expected to result in 14 million people by this date.

The widespread negative social and economic effects of such population increases can, however, be lessened if the population growth rate is slowed. A slower rate of population growth would have a positive effect on the standard of living through higher per capita income, more savings, higher investment and a faster rate of economic growth.*** This, in turn, should result in a higher demand for labor, better income distribution and more government funds to provide social services. At the same time, better living standards are likely to produce lower fertility rates, thus further reinforcing the cyclical relationship between reduced population growth rates and improvements in socio-economic conditions.

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* Survey data indicate rural infant mortality is in excess of 100 per 1000. Widespread under-registration is primarily responsible for misleading official figures.

** INEC, Población, Proyecciones de Provincias Rurales y Areas Urbanas en Ecuador, 1978.

*** Based on Ecuador's National Development Council (CONADE), Ecuador: Estrategia de Desarrollo, 1979.

With respect to the delivery of specific social services, educational demands will be increasing rapidly due to the high population growth trends. By the year 2000, there will be an increase in the six to eleven year old population of 2.2 million primary school students, assuming a medium growth rate projection prevails. This translates into a requirement for thousands of new classrooms and hundreds of thousands of additional teacher-years. Similar large-scale construction, service and employment demands would face the government at all levels of the educational system, as well as in other public service areas such as health, housing, and social services.

Excessive fertility has had particularly negative effects on maternal and child health. High parity women who fail to adequately space their births experience elevated morbidity and mortality levels and, in so doing, place a heavy financial burden on limited health care resources. Deaths of children under one year of age in Ecuador constitute, even ignoring incomplete reporting of this group, about 26 percent of total deaths in the country; children dying under the age of five constitute about 42 percent of total deaths. The high percentage of deaths at early age is the product of high morbidity among these age groups and unfavorable living conditions.

The lack of access to land and employment opportunities in the countryside has caused rural land invasions and large scale migration to urban centers, especially the major metropolitan areas of Guayaquil and Quito. These cities have had to provide services to a population which has been increasing at nearly six percent per year. Their inability to provide adequate housing and essential services to migrants is also contributing to urban land invasions. Furthermore, the task of feeding this growing urban population is placing excessive demands on the country's agricultural system, already showing growing deficits in the production of basic commodities with resultant large scale imports and deteriorating nutritional status.

Growing negative effect on the overall physical environment are a by-product of current high population growth trends. More and more marginal lands are being inhabited and cultivated in the rural areas causing serious environmental degradation. Various environmental studies of Ecuador list the population growth rate as the greatest threat to Ecuador's natural resources.*

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* "Draft Environmental Report of Ecuador", prepared by the Science and Technology Division, Library of Congress, Washington, December 1979. Environmental Studies prepared by CHEMONICS, INC. and the Ecuadorean Fundación NATURA draw similar conclusions.

All of these effects have severely hampered the capacity of Ecuadorean public and private sector institutions to provide for basic human needs--food, clothing, education, health care, employment, housing and related services. The long-term development of Ecuador will require that more effective measures be taken during the 1980s and 1990s to lower the country's extremely high population growth rate.

2. The Present Challenge

Despite the continued high population growth rate, preliminary results of the 1979 Ecuadorean Fertility Survey show a decrease in fertility during the period 1970-1980. Some Ecuadorean institutions estimate that the population growth rate has declined from 3.4 percent in 1970 to about 3.0 percent in 1980.* This decline reflects both the rapid economic and social changes taking place in Ecuador during the 1970's and the ongoing, albeit modest, FP programs in the public and private sectors supported by Ecuadorean and international organizations. Continued progress in lowering the population growth rate will demand a major expansion in FP services and information programs.

Governmental institutions are prepared to increasingly support the integration of FP services and information into maternal/child health (MCH) programs. The private sector has also identified opportunities to extend the provision of FP information and services. Based on current commercial retail sales information, it is estimated that the commercial sector accounts for 6 percent of all current contraceptive users.** Given this commercial sales coverage and estimates of the current fertility decline, the current contraceptive prevalence rate is estimated to be about 14 percent among women in fertile age (15-49 years) and 24 percent among women at risk (women in fertile age who are either married or in union). The lack of a reliable data base, however, indicates the need for a contraceptive prevalence survey (CPS) and the collection and analysis of other data. Much needs to be done in the 1980's to extend FP coverage and to meet the demand that exists for spacing and controlling family size in all segments of the population.

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* Ministry of Public Health. National Health Plan. 1979, and INEC. Encuesta Anual de Estadísticas Vitales. 1977.

** Estimated number of active users receiving contraceptives through commercial channels divided by an estimated total number of active users.

B. Constraints to Addressing Ecuadorean Population Problems

A review of the current public and private sector policies, programs, and attitudes related to population growth or fertility regulation reveals a number of constraints which affect Ecuador's ability to expand the delivery of FP services and information. These include institutional, financial, socio-cultural, policy and legal factors.

1. Institutional Constraints

Despite its broad geographic coverage through a network of hundreds of operating units, the public sector FP programs suffer from deficient delivery system capacity. The public sector, at both the central and provincial levels, is characterized by insufficient trained personnel in management, planning, service delivery and supervision, as well as a weak contraceptive delivery logistic system. Its planning capacity in FP is hampered by the lack of an institutionalized process to monitor levels of contraceptive awareness, availability, and use. While results of the Ecuador version of the World Fertility Survey provide the opportunity to address these concerns, few actions have been taken by the government to carry out an in-depth analysis of the important socio-economic data in this document.

In the private sector the institutional problems are also serious, but very different. The two groups offering services, the Association for the Welfare of the Ecuadorean Family (APROFE) and the Medical Center for Family Planning and Orientation (CEMOPLAF), are both relatively small and geographically limited to certain regions of the country. It is important that these private groups become viable on a nationwide basis not only to fill the gaps where government health infrastructure is not yet in place, but also to ensure the provision of an adequate delivery system in the event the public sector does not expand as rapidly as planned. This will require additional resources and overcoming limited coordination and collaboration.

2. Financial Constraints

There are major financial constraints in both the public and private sectors to expanding FP programs in Ecuador. The public sector receives more support from international donor agencies, particularly the United Nations Fund for Population Activities (UNFPA)*. Most of these resources are provided to the Ministry of Public Health (MOH) for

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* Proposed reductions in UNFPA world-wide support and specific programs in Ecuador could change this situation substantially in the 1980's, however.

the expansion of its overall MCH delivery system. The Social Security Institute, Division of Preventive Medicine and Campesino Program (IESS/MP and IESS/Campesino) and the Ministry of Defense (MOD) also provide integrated health services. However, most local and international contributions to these programs are designed to meet a national need for health services with little emphasis on FP. Further international assistance is needed to complement host country and international donor support in the areas of training of personnel responsible for FP services, information dissemination, and improved delivery systems. Although it is expected that the government eventually will assume primary responsibility for the delivery of FP services, it is imperative that the private sector have the necessary resources to respond to the increasing demand for FP services in rural and urban areas. The lack of adequate financing for APROFE and CEMOPLAF, the two main private sector FP service organizations, largely accounts for the geographic limitations of both programs. As a result, neither organization can fulfill its mandate to provide services nationwide.

Despite a considerable percentage of users being covered by the commercial sector, it is probable that the retail prices for contraceptives are too high for many. While contraband sales reportedly represent 20 percent of total commercial pill sales to consumers, at a price significantly lower than that in the legal market, little is known about the magnitude and consequences of contraband distribution points, nor its reliability over time. A sound marketing program can help to bring the cost of contraceptives within the reach of low-income populations.

3. Socio-cultural Constraints

There are cultural and attitudinal factors among some subgroups of the society which constrain a comprehensive population/FP program. These factors range from the ideological objection of leftist university students and conservative religious groups to the traditional beliefs and ignorance of rural indigenous populations, notoriously difficult to reach with effective services or information. Particularly in less developed rural areas of Ecuador, knowledge and prevalence of use of FP is very limited. A MOH survey showed that twice as many rural women as urban women had more than seven children.*

This project will first aim at satisfying the extensive unmet demand among less difficult-to-reach populations, as well as direct effective information, education and communication (IE&C) activities to those segments of the population most susceptible to change FP behavior if informed. Although the magnitude of unmet demand can be estimated only roughly, given the lack of a contraceptive prevalence survey (CPS), a high percentage of women have voiced a desire and willingness to accept

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* MOH. "Conocimientos, Actitudes y Prácticas en el Area Rural". 1977.

FP practices.* Unmet demand is further made evident by the fact that out of 100 cases of abortions performed in a Guayaquil clinic, 59 were induced by the pregnant women themselves.** In light of the above, this project will mainly address the large existing target group.***

4. Policy Constraints

Under the new Constitution, which took effect in August 1979, the GOE supports responsible parenthood and appropriate education for the advancement of the family, including a guarantee of the right of parents to have the number of children they can support and educate. The Constitution also assigns the responsiblity to CONADE to establish the population policy of the country, within the social and economic guidelines for solutions to national problems, in accordance with principles of respect for the sovereignty of the State and the self-determination of the parents.

However, the GOE has not formulated a specific population policy. CONADE, in the draft population policy section of its new five-year Development Plan, concentrated on economic and social development and on geographical redistribution of the existing population. This approach is reflected in the GOE's programs of regional and rural development, which are designed to bring about a redistribution of income, and its colonizations programs, which are aimed at redistribution of population. A UNFPA Needs Assessment team confirms that the priorities of the new govenment include extension of health services to the poor and marginal populations and increased roles for women in the development process. Family planning is included as part of the government's MCH program, but vertical FP programs are not a priority of the MOH, IESS, or MOD.

In spite of the lack of an official population policy and the lukewarm attitude of the government toward FP, a relatively strong FP movement, working through the public and private sectors, is providing FP information, education and services. The MOH considers FP needs to be a legitimate health concern and acceptable within its broader MCH programs. The IESS and MOD also offer FP services in their clinics. Moreover, there exists some collaboration between the public and private sectors. For example, APROFE, the leading private sector FP service delivery organization in Ecuador, was able to sign an agreement in 1979 with the Government Maternity Hospital in Quito enabling it to provide FP services (including sterilization) at this facility. At present, the lack of an explicit population policy does not impede the efforts of organizations providing FP services, but certainly places a constraint

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* Ibid.

Scrimshaw, Susan. Culture, Environment and Family Size: A Study of Urban Immigrants in Guayaquil, Ecuador, 1974.

** Schrimshaw, Migration, Urban Living and the Family: A Study among Residents in the Suburbio and Tugurios of Guayaquil, 1973.

*** For quantitative estimates of this target group, see Social Soundness Analysis section of this Project Paper.

upon an openly aggressive approach to FP by public and private sector institutions conscious of potential opposition within high levels of the government and from leftist or populist political forces.

5. Legal Constraints

With respect to the delivery and use of contraceptives, certain legal guidelines exist to which this project will conform. The National Health Code, as approved in 1971, states that all drugs and medical devices can only be prescribed with the approval of a medical professional. In 1971, the MOH issued its official interpretation of the National Health Code, as it relates to the provision of FP services, by issuing a manual of norms, procedures and techniques regarding fertility regulation. This manual stipulates the conditions under which professionals can administer the various non-permanent contraceptives. However, the conditions under which auxiliary medical personnel, social workers and FP promoters can administer contraceptives are restrictive. With the expansion of community based distribution (CBD) services by APROFE and CEMOPLAF, these norms are increasingly being tested. Until such time that the legality of contraceptive delivery through alternative channels is clarified, A.I.D. will continue to support only clinic based programs in Ecuador.

C. Existing Ecuadorean Population/Family Planning Programs

1. Public Sector Programs

Theoretically, FP services are available to the Ecuadorean people through numerous public sector delivery systems. The MOH, MOD, IESS/MP, and IESS/Campesino have on-going FP programs. The extent to which these various institutions actually provide FP and IE&C services is limited by the different constraints outlined above.

At present, the MOH offers FP services at hospitals, urban health centers, and rural health subcenters and posts. Previous A.I.D. assistance in the period 1970-74 helped begin MOH family planning programs. FP services are officially provided as an integral part of the Ministry's MCH program, but in practice their availability is limited and their existence is not widely known due to limited knowledge and efforts on the part of MOH doctors and administrators to promote FP. This is partially explained by the fact that Ecuador, like many other Latin American countries, has not been able to organize an integrated program of medical research, training and services that addresses the major health needs of the country. In general, the training and teaching received by medical students at local universities do not adequately prepare doctors to function in service programs offered by the GOE or respond to the major health problems of the majority of Ecuadoreans.

In response to the existing non-complementarity between the medical curriculum orientation of the university and the practical needs

of the GOE health system, the Directorate for Family Health within the MOH provides training for medical, paramedical and related professional personnel. In addition, the MOH works closely with public and private agencies such as INEC, which collects and analyzes demographic data, and APROFE, which provides training for government personnel and serves as an advisory body to the GOE.

The Family Welfare Program of the Armed Forces has been providing FP services to military personnel, as well as civilians living in the areas of their clinics, since 1970. With assistance from A.I.D. (until December 1975) and the UNFPA (until June 1976), the number of new acceptors increased from almost 1,400 in the first year, 1971, to approximately 6,000 during 1975. Without continued external funding, however, recruitment under the program has plateaued in recent years at approximately 3,500 new acceptors annually. As a result, the Family Welfare Program is falling far short of its coverage in the early 1970's and its potential for expansion.

Within the IESS, the Department of Preventive Medicine is responsible for establishing the regulations and standards for the FP program within national norms established by the MOH. The FP program was initiated in 1966, but financial assistance from A.I.D. during 1970-1974 was the key factor in expanding this program. Presently, the program continues to function with some financial support for medical equipment and contraceptives from the Pathfinder Fund. It is currently estimated that the number of new acceptors per year is less than 2,000 and the total number of active users is 5,000, or about three percent of the women of fertile age affiliated with IESS.

The IESS/Campesino, a semi-autonomous organization associated with the broader IESS program, provides an existing infrastructure through which to expand FP services and related activities into the rural areas of Ecuador. The Campesino program, created in 1968, reached 110,000 affiliates in 1980 through 168 health outposts.

In addition to the provision of services and information, all of the public sector institutions provide limited in-country and/or overseas training depending on specific needs, to their respective professional and auxiliary staffs. However, lack of trained personnel is one of the major constraints in existing public sector programs and will require significant assistance under this project.

2. Private Sector Programs

Within the private sector, three major organizations provide family planning services and related support activities: APROFE, CEMOPLAF, and the Center for the Promotion of Responsible Parenthood (CEPAR). Founded in 1965 as the first Ecuadorean institution providing FP informa-

tion and services, APROFE, the International Planned Parenthood Federation's (IPPF's) affiliate in Ecuador, has been instrumental in training professionals, promoting FP awareness among government, general public and offering services via clinics, private physicians, nurse midwives and CBD programs.

By 1966, APROFE had established clinics in Ecuador's three largest cities (Guayaquil, Quito and Cuenca), and had initiated a system of collaborating doctors (primarily working out of government facilities) in other cities. In that same year, APROFE sponsored the first course on Population and FP for physicians. In 1967, APROFE began advising the MOH and MOD on FP matters, a role it has continued to play to the present time. In 1969, APROFE trained MOH personnel in FP and offered the first national seminar on FP for doctors (including military doctors) and nurse midwives.

In 1970, APROFE initiated its information and education program, aimed at making FP more familiar to the general populace and leadership groups. By the mid-1970's, APROFE was offering regular training to professionals, ongoing FP services in its three clinics, radio spot announcements, regular newspaper coverage of FP, frequent seminars to students, labor unions, and other groups, as well as continuing to advise various public and private agencies working in the field. In 1977, APROFE initiated the first IPPF Women in Development project in the Western Hemisphere, and has succeeded in training several hundred women in income-generating and money-saving skills, while at the same time providing them with FP and primary health care services.

By the late 1970's, APROFE had incorporated two of its clinics (Quito and Cuenca) into government hospital facilities and the third into the charity maternity hospital in Guayaquil. From 1966 to 1980, APROFE's three clinics registered 74,525 new acceptors of non-permanent contraceptive methods. In addition, voluntary sterilization operations, funded by IPPF and the Association for Voluntary Sterilization (AVS), were provided to 6,483 women in the 1976 to 1980 period. The collaborating doctors and nurse midwives (professionals in private practice to whom APROFE provides contraceptives and training in exchange for their offering services at low cost to their private patients) added another 18,171 new acceptors and 779 sterilizations to APROFE's rolls between 1976 and 1980.

In 1978, APROFE began CBD programs in the rural areas of Guayas province. This program now consists of 127 distribution posts in Guayas and neighboring Los Rios provinces, which provided contraceptives to 2,037 new and approximately 3,450 continuing acceptors in 1980, thus covering a total of 4,393 new acceptors in its three years of existence. A nurse midwife, working out of the CBD program's mobile van, offers pelvic examinations, inserts IUDs and does Pap smears for women in the CBD program. APROFE will expand the CBD project to two additional provinces (Esmeraldas and Manabí) in the coming year with funding from IPPF.

From 1966 to 1980, APROFE trained 2,301 people, including: 863 doctors and medical students in FP techniques, plus an additional 53 doctors in sterilization; 161 nurses and auxiliary nurses; 238 nurse midwives and midwifery students; 69 social workers; 456 educators, counselors and psychologists, and 461 others (including CBD program distributors).

CEMOPLAF was originally established through the efforts of the Quito Women's Medical Society. With A.I.D. assistance in 1971, CEMOPLAF opened its first FP clinic in Quito. In 1972, a second clinic was founded in Quito. This was followed by the establishment of additional clinics in Santo Domingo de los Colorados and Quevedo, in 1974. The FP program separated from the Women's Medical Society that same year, and became CEMOPLAF, a non-profit organization registered with the MOH.

From 1968 through 1980, CEMOPLAF provided contraceptive services to 27,003 new acceptors at its four clinic locations, and motivated 155,327 people through information and motivation seminars in the areas around these clinics. It also developed a network of 35 professional associates (doctors and nurse midwives) who provided services to 4,859 new acceptors in 1979-80. In addition, CEMOPLAF offered 18 training courses for urban and rural professional and community leaders, and conducted educational programs with provincial civil, municipal, and customs police, national railroad employees, and firemen. In 1978, CEMOPLAF established a laboratory to perform a variety of tests (Pap smear, pregnancy, V.D., blood tests, and others) at its main clinic in Quito. The laboratory is not only self-sufficient, but also provides additional local income for the institution. CEMOPLAF also conducts regular clinical and educational training for physicians, nurse midwives, auxiliary nurses and social workers.

CEMOPLAF's funding initially came from APROFE, the Pathfinder Fund and A.I.D. Since December 1973 most of CEMOPLAF's funding has come from Family Planning International Association (FPIA) and from its own locally-generated resources. Some training seminars have been funded by Development Associates (DA). It is anticipated that FPIA will continue to fund CEMOPLAF's four existing clinics during and beyond the life of this project.

CEPAR was founded as a non-profit institution in 1978 by a group of professionals working in health, sex education, FP and population. Its major purposes are to promote information, policy, and research activities to raise FP and population awareness in Ecuador, especially among leaders and decision-makers at all levels of Ecuadorean society. In the three years since its founding, CEPAR has carried out

several projects, including training of pharmacy owners and employees and published various research studies.*

In 1979-80, with a $40,000 grant from the Pathfinder Fund, CEPAR conducted 22 eight-hour courses for about 500 drugstore owners and employees from the provinces of Pichincha and Azuay, in coordination with the Ecuadorean Association of Pharmacy Owners. The courses focused on human reproduction and contraceptive methods. The project was renewed in late 1980 for an additional year at $35,000 to enable CEPAR to offer 13 more training courses to 332 pharmacists and employees from 166 pharmacies in eight inter-Andean provinces, ranging from Carchi (the northern-most province) to Loja (the southern-most province). As a result of these courses, pharmacists and drugstore employees are better able to manage the promotion and sales of contraceptives in their stores.

D. International Donor Assistance in Population

Major external assistance in the population field has been provided by A.I.D., UNFPA and IPPF. A.I.D. has been the major source of FP assistance in Ecuador. Bilaterally and through its intermediaries, A.I.D., over the years, has responded to both public and private sector needs. UNFPA has assisted a number of public sector institutions (MOH, MOD, INEC, and CONADE), and IPPF has primarily provided institutional and service support to its affiliate, APROFE.

A.I.D., in addition to providing general support to UNFPA and IPPF (approximately 25 percent of each organization's total income), support number of other intermediaries working in Ecuador through the DSB Popula-

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* With A.I.D. funding, CEPAR published two documents: (1) Manual de Consulta: Manejo de Anticonceptivos para Propietarios y Dependientes de Boticas, Farmacias y Droguerías, a 55-page manual on management of contraceptives for owners and employees of drugstores, which includes chapters on responsible parenthood, FP, the various methods of contraception and bibliographical listings; and (2) Encuesta a los Médicos Privados de la Sierra Ecuatoriana sobre Opiniones y Actitudes acerca del Crecimiento Poblacional y la Planificación Familiar, a 50-page sample survey of private physicians from the Ecuadorean sierra which summarizes their opinions and attitudes toward population growth and FP. The survey indicated that 92.4% of the physicians interviewed believe that they and their colleagues should be involved in fertility regulation programs. A large majority of them are willing to be trained and to participate in private FP programs. In addition, CEPAR has produced smaller reports in related areas such as adolescent attitudes toward FP.

lation Office (STB/POP).* Table I summarizes the estimated FY 1982 and FY 1983 costs of STB/POP support to these organizations, and provides a brief description of the specific roles of the intermediaries in USAID's overall population program in the short run.

In addition, the following provides detailed information on the larger programs of UNFPA and IPPF. UNFPA's assistance to Ecuador totalled $4,340,051 as of November 1980. This included support to the FP program of the MOD, the Demographic Analysis Unit in INEC to execute a national fertility survey and to train public school teachers in family life/sex education courses. UNFPA has also supported preparatory activities, jointly with A.I.D., leading to the creation of the Population Division within CONADE. UNFPA will build on these policy efforts by providing operational support of approximately $480,000 to CONADE over the next four years to further develop this Division.

From 1975 to 1980, UNFPA provided assistance amounting to $1,345,800 to the national MCH program. The Pan American Health Organization (PAHO) was designated as the executing agency for this assistance with the MOH as the Ecuadorean cooperating institution. This assistance supported the extension of health services to rural areas and low income populations, and training of both medical and paramedical personnel in MCH including courses in FP. UNFPA assistance, initially scheduled to end in December 1979, will be extended through mid-1985.

UNFPA plans to continue the program by providing the GOE with an additional $2,850,000 over the next four years to strengthen and expand health services to underpriviledged women of reproductive age and children. UNFPA's objectives are to: (1) maintain MCH/FP services to the population presently reached and extend coverage to dispersed groups in the rural areas through the MOH; (2) strengthen the administrative and logistical support system at the central, provincial and community levels; (3) promote community participation through non-formal education and communication activities; (4) improve training programs; (5) reach the adolescent population by adding teaching centers for adolescents to the MCH/FP system; and (6) conduct operational research. UNFPA assistance will specifically support international consultants, salaries for some national personnel, subcontracts for research and communications activities, training, supplies and equipment. These activities will be administered by a full-time resident UNFPA population officer in Quito.

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* These intermediaries include the Pathfinder Fund, Family Planning International Association (FPIA), Development Associates (DA), International Fertility Research Program (IFRP), the American Public Health Association (APHA), Westinghouse Health Systems (WHS), University of North Carolina (UNC), World Fertility Survey (WFS), Futures Group, John Hopkins University (JHU), Center for Disease Control (CDC), and the University of Chicago (UC).

TABLE I

ESTIMATED DSB SUPPORT REQUIREMENTS TO

POPULATION/FP INTERMEDIARIES IN ECUADOR

(in 000's $)

	Intermediary 1/	FY-82	FY-83	TOTAL
1.	FPIA	$ 136	$ 155	$ 291
2.	Pathfinder Fund	53	87	140
3.	DA	66	94	160
4.	WHS	—	160	160
5.	UNC	--	120	120
6.	Futures Group	362	387	749
7.	IFRP	15	15	30
8.	JHU	10	10	20
9.	UC	10	10	20
10.	WFS	10	10	20
11.	APHA	8	8	16
12.	CDC	5	5	10
	TOTAL	$ 675	$ 1061	$ 1738

1/ FPIA will continue to support CEMOPLAF's four existing clinics and corresponding community education activities as well as provide contraceptives to IESS/Campesino. The Pathfinder Fund will support APROFE's innovative CBD program as well as provide contraceptives to the MOD and IESS /MP; DA will support in-country training and observational trips fo community leaders, coordination among private agencies and between publ and private agencies, and technical assistance in the design of trainin programs for the public sector service delivery agencies; WHS and UNC will provide funds and technical assistance to the MOH to carry out two or three contraceptives prevalence surveys (CPSs) to help in project evaluation and design; Futures Group will initiate a commercial retail sales program with APROFE as well as carry out several RAPID presentations through CEPAR to educate Ecuadorean leadership in phasing the multi-sectoral implications of excessive population growth; IFRP will conduct a small in-country biomedical research program; JHU will provi training in program administration and in reproductive health managemen UC will provide training in the United States in FP communications; WI will support additional analysis of Ecuador's national fertility survey and APHA and CDC will provide technical assistance in logistics, projec evaluation and management.

IPPF has strongly supported its affiliate in Ecuador, APROFE, since 1965, as well as initially helped fund CEMOPLAF's activities. Over the past several years, IPPF has provided approximately $300,000 per year to APROFE to support clinical, CBD, IE&C and training programs. IPPF is committed to continuing its efforts to assist APROFE during and beyond the life of this project.

International donor assistance in population, as outlined above, will complement the FP activities of this project. The specific technical expertise and commodity contributions of the intermediaries support the institution building and delivery service activities of A.I.D.'s bilateral program. In particular, these organizations will respond to some of the more sensitive aspects of a comprehensive FP program such as the provision of contraceptives and direct support of CBD systems. Likewise, close coordination exists among the three major donors, A.I.D., UNFPA and IPPF. IPPF representatives and UNFPA's resident Population Officer frequently consult with USAID's Population Officer. This coordination is highlighted, under this project, by IPPF's and A.I.D.'s joint financing of APROFE's program, and UNFPA's and A.I.D.'s combined effort to strengthen the MOH's MCH/FP delivery services and develop CONADE's Population Division.

E. USAID's Population/Family Planning Strategy

1. Background

A.I.D. bilateral funding of FP programs in Ecuador began in 1970 and continued until 1975, when it was terminated as a result of the phaseout of all U.S. bilateral assistance to the country. During this period, A.I.D. provided approximately $4.5 million in family planning funds for public and private sector Ecuadorean agencies. This funding and A.I.D. technical assistance served as a catalyst for establishing most public and private sector family planning programs in Ecuador.

In 1971, the first A.I.D. bilateral agreement was signed with the MOH which created the Ministry's Department of Family Welfare. In addition, A.I.D. provided assistance to initiate and expand FP service programs in 31 MOD health clinics and the IESS's primary health program. Bilateral funds were also provided to INEC to create a Demographic Analysis Unit and to the Ministry of Labor and Social Welfare to establish a FP motivation program. In the private sector, A.I.D. supported the creation and expansion of CEMOPLAF in the early 1970s and financed the construction of APROFE's Guayaquil clinic which is still in use today.*

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* Moreover, the Executive Director of APROFE attributes the organization's development in the mid-1960s to USG leadership on the population issue and to A.I.D. support to IPPF.

After the phase-out of bilateral assistance, A.I.D. continued to support population activities, although at a much reduced level, through STB centrally funded activities. However, given the relative newness of many of Ecuador's FP programs, the very small centrally funded activities could not provide -- without complementary bilateral assistance -- the necessary support to continue the institutional development process that was initiated in 1970-75.*

In summary, in a period 1970-75, A.I.D. financial and technical assistance served as the main force for the creation and expansion of most Ecuadorean FP activities in the public and private sectors. This assistance has subsequently proven to be a successful institution building program. However, from 1975 to 1980, the termination of the USAID bilateral FP program cut off the only major source of funding that could have continued this institutional development process. While most Ecuadorean FP agencies have survived, their institutional growth has been stunted. Thus, while demand for services continued to rise in the late 1970s -- and the consequences of Ecuador's high population growth continued to worsen -- both public and private sector delivery systems could not keep pace, resulting in the estimated low levels of contraceptive prevalence in Ecuador today.

2. USAID Strategy in 1980-85

USAID formulated a population/family planning strategy simultaneously with the reactiviation of the USAID Ecuador program in FY 1980. Assistance in developing this strategy was provided by LAC/DR/POP and it was presented to AID/W in the context of the February 1980 review of USAID's CDSS. In this and subsequent CDSS reviews, AID/W approved the proposed strategy and supported the high priority that USAID was assigning to its FP program. A PID for this project was developed with technical assistance from LAC/DR/POP, and it was approved in December 1980. USAID also received assistance from LAC/DR in the preparation of this PP.

The USAID strategy is based on a full recognition that Ecuador like many other countries, does not have an adequate national population policy. While this policy is an important constraint that must eventually be overcome, it has not prevented the delivery and use of FP services. As indicated above, a number of public and private FP agencies are actively and openly promoting FP services and information. However, a positive population policy could greatly accelerate the growth and expansion of the existing small FP delivery systems. For this reason, a major objective

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* Likewise, the development of CEPAR, created with USAID assistance in 1978, has been stunted by scarce financial support during this period.

of the USAID strategy is to promote, in a very low profile manner, the emergence in Ecuador of a population policy. This will be accomplished by supporting, with UNFPA, CONADE's new Population Division strengthening INEC's capacity to provide statistics for the policy planning process, and by expanding CEPAR's activities in the areas of public awareness and consciousness raising about Ecuador's serious population problem. USAID is hopeful that these inputs will serve as catalysts for the emergence in the 1980s of a population policy as called for by the 1978 Ecuadorean Constitution.

However, in USAID's view, the population policy constraint, while important, is not the highest priority problem. A policy could exist without adequate FP delivery systems and little or no FP services would in fact be provided. On the other hand, it is clear that FP services can be delivered and expanded in Ecuador without a formal population policy. In USAID's view, the major constraint that must be addressed now is the limited institutional capacity to expand the coverage of the existing small FP delivery systems. At the same time, the policy constraint needs to be addressed so as to ultimately provide an environment that will be more supportive to FP in Ecuador. Thus, the major portion of USAID assistance is targeted at expanding FP delivery systems in three public sector agencies (MOH, MOD, IESS) and in two private sector agencies (APROFE, CEMOPLAF). These resources will provide for a major expansion in the FP coverage of these organizations.

The comprehensive USAID strategy proposed above builds upon and better utilizes the FP programs that A.I.D. successfully helped to create in the 1970s. The very fact that almost all these FP delivery systems are still alive and functioning (although not growing) is a testament to the success of the A.I.D. institution building strategy. Ecuador today is further along with operational FP programs because of A.I.D.'s pioneering efforts in the 1970s. Even without major financial inputs during the 1975-80 period, the FP delivery systems survived (often in an indifferent or hostile environment) and they continue today to provide limited FP services and information. The challenge of the 1980s is to build upon the efforts of the 1970s and to substantially expand the coverage of existing FP delivery systems while working quietly to improve the GOE policy environment.

The USAID strategy means providing assistance to a number of different Ecuadorean agencies. Given the dimensions and the seriousness of Ecuador's population problem, a multi-institutional approach is an absolute necessity for the following reasons:

--First, the population policy constraint cannot be adequately attacked through only one institution. CONADE is charged with population policy planning. It needs statistics that INEC cannot now produce. Both CONADE and INEC require substantial institutional strengthening to carry

out these functions. Yet neither CONADE nor INEC can conduct public awareness campaigns about population problems nor lobby for more effective population policies. A private organization like CEPAR is needed to generate greater public support for the population planning process in CONADE/INEC. A comprehensive attack on the policy constraint requires assistance to all three of these agencies. Removing any one agency from this component could seriously reduce the effectiveness of the entire policy planning,data collection and analysis effort.

--Second, the dimensions of the population problem in Ecuador (1.3 million women at risk in 1985) and the relatively limited coverage of the existing delivery systems, mean that it would not be feasible for only one or two agencies to meet the current demand for FP services. In 1980, the five FP delivery systems (MOH, MOD, IESS, APROFE, CEMOPLAF) reached only 118,000 women at risk. Together, these same five delivery systems, with the A.I.D. assistance proposed under this project, will reach approximately 398,900 of the 1.3 million women at risk by 1985. It is not administratively feasible for only one, two or three of these agencies to achieve these same rates of coverage. Moreover, if Ecuador ultimately is to extend FP to a majority of its women at risk, it will need to substantially strengthen and expand all five of the existing FP delivery systems.

--Third, FP in Ecuador remains controversial and risky for any Ministry to openly and actively support. (However, a number of Ministries are very willing to quietly support its expansion). If efforts were concentrated on developing only one or two large FP delivery systems, they could more easily become "lightening rods" for those who might oppose FP. In USAID's view, it is much more difficult to attack and eliminate five smaller FP delivery systems than one or two large systems. Furthermore, should one or two systems become inoperative for any reason (which is not now expected), the other agencies could at least continue the FP movement in Ecuador. In addition, by backing only one or two FP delivery systems, USAID would alienate important centers of FP support. All five FP delivery systems are vital for building a stronger Ecuador FP movement. Thus, USAID believes that assistance for a multi-institutional FP program is an indispensable part of the A.I.D. FP strategy in Ecuador.

Therefore, based on the expressed interest of public and private sector agencies to expand their FP programs and the preliminary results of the 1979 Ecuador National Fertility Survey which indicates a large unmet demand for FP information and services, USAID proposes to assist five public and three private sector institutions. The project is divided into three basic components as follows: (1) strengthening and expanding delivery systems, (2) extending information and communication networks to increase awareness of population/FP among the leadership and the general populace, and (3) strengthening the data collection,

analysis and planning capability in both the public and private sectors to assist in policy formulation.

This comprehensive USAID strategy of FP delivery extension, IE&C network expansion, and research and data analysis will be implemented in the public sector through the MOH, IESS/MP, IESS/Campesino, MOD, CONADE and INEC. USAID assistance to the public sector will address the constraint of an insufficient data base for analysis, policy making, and evaluation of contraceptive use; it will train and support an expanded pool of FP promotion and service staff in the delivery system; and it will reorient the training of both newly emerging doctors as well as those in service.

In the private sector, USAID will assist APROFE, CEMOPLAF, and CEPAR. Increased attention will be given to service delivery approaches, including the initiation of a commercial retail sales (CRS) program, and logistic support systems not yet tested in Ecuador. The planned activities will demonstrate the viability of new approaches and expand services to respond to the estimated large unmet demand for FP. The service-oriented organizations (APROFE and CEMOPLAF) and the public information programs (CEPAR) will create a broad-based coalition to support FP as a basic human right. USAID support is vital to overcome the major financial constraint to expanding FP activities by the private sector.

In particular, given the constraints that exist in the public sector, it is important that the private sector be strengthened in the delivery of services in urban and rural areas, the training of doctors and nurse midwives, the widespread distribution of contraceptives, the testing of innovative service delivery systems, and the development of a broad-based coalition to highlight the population issue and promote FP. This last endeavor will include support to the private sector to create an awareness among leaders in and out of the government about the progress other LAC countries have made by implementing FP programs to deal with high population growth rates. Networking with other LAC national population efforts, particularly the aggressive and successful programs in Colombia, should contribute to a better understanding of the support required by both the public and private sectors, regardless of the official position taken by the government.

Since each of these organizations, with the exception of the MOH, provides services to a specific clientele, their programs are complementary rather than duplicative. The MOD and IESS programs primarily service their respective affiliates, whereas APROFE and CEMOPLAF concentrate in specific geographical areas (APROFE along the coast, and CEMOPLAF in the sierra). Where cases of geographical overlap exist, as between the MOH (which is theoretically national in scope) and the other service organizations, the estimated demand for FP services so far exceeds the supply that duplication of FP services is not a concern. Likewise, both APROFE's and CEMOPLAF's plans to provide FP services in Guasmo, a slum

of Guayaquil, and in Esmeraldas, are complementary and reinforcing due to the distinctive nature of their respective services and the overwhelming demand in each of these areas. In both areas, CEMOPLAF will provide clinical services whereas APROFE will extend services through its CBD program to populations without easy access to the clinics.

With respect to USAID support to data analysis, research and IE&C activities, the project plans to work through public and private sector institutions whose major roles and comparative advantages are in one of these fields. In the public sector, the strategy is to institutionalize data collection and analysis directly with INEC and CONADE. In the private sector, USAID will provide institutional support to CEPAR to advance these programmatic areas. At present, the lack of statistics and analysis makes it difficult to accurately gauge the current population growth rate and the contraceptive prevalence rate. The availability of these data and analyses will contribute to a better understanding of the relationship between population dynamics and development and encourage the formulation of policies affecting national development goals.

The strategy outlined above will provide the resources that can serve as catalysts for the emergence of an Ecuadorean population policy and for supporting a major expansion in the country's FP delivery systems. The project will provide assistance to allow Ecuadorean FP delivery systems to respond to the large unmet demand for FP services that has rapidly grown -- or will grow -- in the period 1975-85. However, by the end of this project, Ecuador's population problem will not be solved. A new A.I.D. Family Planning Project in Ecuador will most likely be necessary in the period 1985-90 to consolidate and further expand the efforts initiated in 1981-85. With continuous A.I.D. assistance provided to Ecuadorean FP agencies throughout the 1980s by both USAID and STB/POP, USAID is hopeful that Ecuador will enter the 1990s with a formal population policy and the necessary delivery systems to implement this policy nationwide.

3. Relationship to Overall USAID Program

USAID's FY 1983 CDSS makes clear that population activities are to "receive high priority in the overall USAID strategy." Population/ concerns have thus been taken into account in the design of both the integrated rural and urban development (IRD and IUD) projects of the USAID program. Particularly in relation to the health component of integrated rural development, there are a wide range of mutually supportive activities.*

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* The IRD health project (518-0015) is described in a Project Paper to be submitted early July entitled "Integrated Rural Health Delivery System".

Training of health sector professionals in MCH/FP will be carried out in both this population project and the rural health project, in a carefully planned, coordinated package. Through the population project, four training centers will be established to provide eight-week practical training courses in MCH/FP to medical, nursing, and nurse midwife students (see Project Description for details). These centers will adequately train new rural health staff to provide FP services in rural health clinics and hospitals. The rural health project will provide funding for in-service training of existing medical and nursing staff in the geographical areas of USAID supported IRD projects at these same centers. This will ensure the incorporation of an adequate FP emphasis in the integrated health delivery model being developed through the rural health project. Further strengthening of the FP efforts of the IRD health activities in the Jipijapa IRD area will result from the operation of APROFE's CBD project in Manabí Province, which encompasses the Jipijapa cantón.

Additional examples of mutually reinforcing activities of health and FP projects include:

-- The creation of a FP delivery capacity within the IESS/Campesino health program to extend FP services to small rural communities served by nine IESS/Campesino dispensaries in the IRD areas of Salcedo, Quimiag-Penipe and Jipijapa.

-- Support for demographic and population studies, and data collection and analysis within INEC, CONADE and CEPAR. Specifically, fertility data, socio-economic variables of morbidity and mortality, and vital statistics information will be developed that will give health and population policy planning officials a solid informational base for programming.

-- Institutional strengthening of the MOH, especially at the local level, through the health project. This will greatly improve the effectiveness of MOH management of all its programs, including FP. At the local level alone, USAID will provide nearly $300,000 in loan and grant funds to strengthen integrated delivery system management. In addition, a large primary health care component of field level IRD activities will help extend FP information and services through health promoters, midwives and community drugstores.

-- Training of medical and auxiliary staff of the planned Solanda Health Center (component of USAID's IUD project) in MCH/FP at the MOH training centers funded under the FP project. These examples are illustrative of the direct relationship between USAID's population activities and other sector programs. Population concerns will continue at the forefront of all strategy planning, as also made evident by USAID's women in development activities and environmental assessment.

II. PROJECT DESCRIPTION

A. Introduction

The goal of the project is to decrease the population growth rate so as to improve the quality of life of the majority of Ecuadoreans. The project purpose is to expand demand for and availability of family planning information and services to low income populations, and to assist in the formulation of a population policy.

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1. Strengthening and expanding FP delivery systems will be the primary emphasis of this project. Within the public sector, A.I.D. assistance will concentrate on training, technical assistance, and the provision of equipment and supplies to permit the upgrading and expansion of existing FP services. Activities within the public sector will include: (i) establishing an innovative and coordinated program of training/service/research in the field of MCH/FP for MOH personnel and pre and post-graduate medical, nursing and nurse midwife students in Quito and Guayaquil; (ii) training medical personnel and support staff in FP techniques, and equipping clinics and/or mobile brigades to delivery FP services within the MOD, the IESS/MP and the IESS/Campesino.

Within the private sector, A.I.D.'s support under this component will include:

(i) budget support for the operation of APROFE's three existing clinics and CEMOPLAF's three new clinics to be established under this project;

(ii) training and administrative support to CEMOPLAF's staff; and,

(iii) implementation of a CRS activity. The supply of contraceptives, which is a critical complementary element of service delivery capacity, will be provided to all institutions by other donors and population intermediaries.*

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* UNFPA funds will meet the contraceptive needs of the MOH through 1985; Pathfinder will continue to supply IESS and MOD; FPIA will support CEMOPLAF; and IPPF will meet APROFE's contraceptive needs.

2. Expanding information and communication networks within the public and private sectors will increase national awareness of population/FP issues and further stimulate demand for FP services. The national constituency for FP program among acceptors, the media, opinion leaders and decision makers will be expanded. Activities within this component will include: (i) training FP promoters in educational and motivational techniques, designing and distributing promotional materials, and operating mobile units to supervise field activities in rural communities within the MOD program; (ii) training promotional personnel in the IESS/MP; (iii) organizing information/educational seminars for men and women in all IESS/Campesino health posts; (iv) expanding APROFE's community outreach programs with the hiring and training of new staff; (v) conducting information /educational seminars by social workers in CEMOPLAF's clinics; (vi) institutional strengthening of CEPAR whose two major areas of activity are information dissemination and education of national leaders through various means including roundtable discussions, seminars, and short training courses; and (vii) disseminating results of CONADE's population studies among Ecuadorean leadership.

3. Data collection and analysis capability within the public and private sectors will be strengthened. The conduct and dissemination of demographic and population studies and research will contribute to a better understanding of the relationship between population and development, and result in the formulation of policies that positively affect national development goals. Activities within this component will include: (i) improving the national vital registration system through INEC; (ii) performing demographic and population related studies in CONADE; and (iii) conducting seven research studies to serve as a basis for recommendations to those responsible for policy formulation and the establishment of a population/FP documentation center by CEPAR.

In summary. the three main project components will be implemented through the individual sub-projects of five public sector and three private sector organizations. The major objectives of the subprojects are summarized as follows:

-- Ministry of Health: To train approximately 8,800 medical, nursing, and nurse midwife students and 2,500 MOH personnel in MCH/FP service delivery by establishing four new MOH training centers affiliated with Ecuadorean universities.

-- Ministry of Defense: To strengthen the delivery of existing FP services in 31 MOD clinics and introduce FP services in 12 more MOD clinics, resulting in 23,900 active users in 1985.

-- Social Security Institute/Preventive Medicine: To increase the number of mobile brigades delivering FP services from 16 to 34, and improve the clinical services of the 34 dispensarios from which

these brigades operate, resulting in 41,700 active users in 1985.

-- Social Security Institute/Campesino Program: To increase the number of IESS/Campesino clinics delivering services from 168 to 290 and strengthen the existing delivery programs, resulting in 8,700 active users in 1985.

-- National Development Council: To develop CONADE's new Population Division.

-- National Institute of Statistics and Census: To improve the national vital registration system as one important input to GOE population planning and policy formulation.

-- Association for the Welfare of the Ecuadorean Family: To support APROFE's three ongoing FP clinics, resulting in 34,600 active users in 1985.

-- Medical Center for Family Planning and Orientation: To establish three new FP clinics in Guasmo, Esmeraldas, and Tulcán, resulting in 8,100 active users in 1985.

-- Center of Promotion of Responsible Parenthood: To strengthen CEPAR's information dissemination, research and national awareness/consciousness raising activities.

-- Commercial Retail Sales: To increase the distribution and demand for contraceptives through commercial channels, at prices affordable by low-income groups, resulting in 38,000 active users in 1985. It is currently planned for APROFE to administer the CRS program.

These sub-projects are described in the following "Project Activities by Institution" Section and in the Detailed Sub-project Descriptions in Annex V. Successful execution of these sub-projects, as well as APROFE's CBD program and CEMOPLAF's existing clinical services, will result in an estimated 398,900 active FP users by the end of 1985. Annual projections of active users from 1982 to 1985 are shown in Table II. Total funding for each institution's activities by A.I.D. and counterpart contributions is summarized in Table III. Each sub-project description identifies the A.I.D. and counterpart expenditures; detailed cost estimates are further broken down in Annex V.

TABLE II

PROJECTED ANNUAL ACTIVE USERS*

	1982	1983	1984	1985
MOH	106,700	117,800	129,500	143,800
MOD	14,100	17,800	21,100	23,900
IESS/MP	13,300	20,900	30,600	41,700
IESS/Campesino	3,200	4,900	6,700	8,700
APROFE (clinics)	26,100	28,600	31,500	34,600
APROFE (CBD)**	60,000	66,000	73,000	80,000
CEMOPLAF (new clinics)	1,700	3,800	6,100	8,100
CEMOPLAF (existing clinics) **	17,200	18,500	19,500	20,100
CRS	16,000	23,000	31,000	38,000
TOTAL	258,300	301,300	349,000	398,900

* Figures rounded to nearest hundredth.

** Activities not being funded under this project.

TABLE III

SUMMARY PROJECT BUDGET BY INSTITUTION

Institution	Funding Levels A.I.D. 1/	Funding Levels Host-Country	Total
A. Public Sector			
1. MOH	$715,500	$1,964,700	$ 2,680,200
2. MOD	378,700	233,200	611,900
3. IESS/MP	159,500	177,600	337,100
4. IESS/Campesino	239,300	245,700	485,000
5. CONADE 2/	124,000	333,000	457,000
6. INEC 3/	234,200	483,700	717,900
7. Training/Coordinating Advisor 4/	160,000	-	160,000
Inflation & Contingencies	198,800	362,100	560,900
Sub-Total	2,210,000	3,800,000	6,010,000
B. Private Sector			
1. APROFE	589,500	937,050	1,526,550
2. CEMOPLAF	545,900	155,320	701,220
3. CEPAR	551,500	222,900	774,400
4. Commercial Retail Sales 5/	450,000	-	450,000
5. Intermediate Coordinating/ Executing Agency (IPPF) 6/	688,400	-	688,400
6. Evaluation	17,500		17,500
Inflation & Contingencies 7/	547,200	154,730	701,930
Sub-Total	3,390,000	1,470,000	4,860,000
TOTAL	$5,600,000	$5,270,000	$10,870,000

1/ Bilateral funding only.
2/ UNFPA will supplement A.I.D.'s assistance with a contribution of $480,000
3/ DSB/POP will provide $114,800 to fund first year activities.
4/ See Administrative Arrangements section of PP.
5/ DSB/POP will provide $800,000 during first two years.
6/ USAID has received a proposal from IPPF/Western Hemisphere Region Office, Inc. (WHR) to serve as the ICEA for private sector activities. This proposal is included in Annex 5 Exhibit G, and is presently being revised based on USAID/WHR discussions in May 1981. The figure of $688,400 is still subject to further negotiations and to determination of an acceptable IPPF/WHR overhead rate.
7/ Pertain only to the Ecuadorean private sector organizations participating in the project.

B. Project Activities by Institution

1. The Public Sector

a. Ministry of Public Health (MOD)

The project will support the establishment and operation of an innovative program of integrated teaching/research/service in the field of MCH/FP. The MOH, in collaboration with the state universities in Quito and Guayaquil, will establish four new government training centers, staffed by twelve person teams. These teams will train approximately 8,800 medical, nursing, and nurse midwife students from the participating universities in MCH/FP during the life of this project. This approach will allow students for the first time to gain both theoretical and practical understanding of MCH/FP delivery and, in doing so, better prepare them to complete one year of obligatory service in rural areas. In addition, approximately 2,500 MOH personnel (doctors, nurses, nurse midwives and auxiliary nurses) will be trained in the four MOH model clinics. Likewise, the MOH personnel will have the opportunity to observe a well-functioning MCH/FP delivery system and gain much needed practical training.

A.I.D. provided the MOH with some $40,000 in P. D.and S. funds to field test for four months the above described training program.* An experimental health team was established and began training activities in two high volume health centers in low-income communities in Quito. Training curriculum and methodology were assessed and refined. The experience acquired during this testing phase demonstrated to the MOH and the universities the feasibility of the approach, and prompted the design of an expanded program for presentation to USAID for funding.

A.I.D.'s contribution consists of training ($32,000) and salary support ($628,600) of the 48 persons recruited to staff the four training centers, audiovisual equipment ($20,000), educational publications ($21,900), and evaluation ($13,000). (Evaluation funds will be used to organize two national seminars to inform key ministry and university professionals of the successful training centers begun under this project.) The GOE will gradually assume the costs of personnel salaries ($196,200), as well as provide funding for the operating expenses of the training centers ($1,080,000), logistics support to university coordinating offices in Quito and Guayaquil ($13,500) and per diem ($625,000) and transportation ($50,000) for the 2,500 MOH personnel receiving training. These expenditures amount to an A.I.D. contribution of $715,500 and GOE counterpart equivalent to $1,964,700, totalling $2,680,200. Detailed cost estimates are included in the Financial Plan.

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* In January 1981, the MOH and Faculty of Medical Sciences of the Central University in Quito signed an agreement activating this pilot effort.

This project will complement the MCH/FP activities financed by UNFPA, the health delivery project being financed by the IDB. and the proposed FY 1981 A.I.D. IRHDS project. Personnel working in these other projects will be trained in centers established by the activity described above. By the end of 1985, these centers will have trained a significant part of the future health manpower in FP service delivery; the medical programs of two major universities will have integrated a quality practical training element into their MCH program; and the MOH and universities will have combined forces to provide better training for MOH personnel and university students.

The success of this sub-project will be partially evaluated by the actions taken by the MOH to establish, with its own funds, regional training centers in other cities, such as Loja and Cuenca. This is presently being considered by the MOH. In addition, this sub-project will be evaluated by the results of the national contraceptive prevalence surveys (CPSs) to be carried out by the MOH with centrally funded A.I.D. assistance. DSB/POP, through its WHS and UNC/POPLAB contracts, will provide funding for these surveys ($350,000). Using a widely tested methodology, the CPS is designed to provide program administrators and policy planners with the most current information on fertility/contraceptive behavior. The CPS will be conducted at the outset of this project to establish baseline data against which to partially measure project success. Two subsequent surveys are planned at two year intervals to closely monitor project implementation. Building this evaluation and planning tool into the project is important for all service agencies given the inherent limitations of service statistics.

b. Ministry of Defense (MOD)

The MOD is seeking external assistance to expand significantly its FP program and strengthen related family health activities, including the prevention of venereal diseases, detection of uteral cancer and integration of sex education and modern contraceptive methods into the training of conscripts. The general objective of the MOD is to increase the number of new FP acceptors to an average of 11,000 per year and to increase the number of active users from the current estimated 9,200 to 23,900 over the next four years. This represents an increase of 160 percent in active users over the life of the project.

Major sub-project outputs are categorized within three broad components: (1) service delivery: expanding the number of clinics offering FP services from 31 to 43; (2) training: providing training to 115 physicians and 63 paramedics in advanced contraceptive methods, 14 FP promoters in educational and motivational techniques, three cytologists in the detection of uteral cancer, program administrators in supervision and promotion, and military leaders in population/FP issues; and (3) IE&C activities: designing and distributing promotional materials, and

operating five mobile units to disseminate information at the field level. The total cost of carrying out these activities is estimated at $611,900.

A.I.D. support will assist the MOD in its start-up costs of expanding its service program to 43 clinics in 18 of the 20 provinces of the country. This support includes:

-- Technical assistance ($31,000) to provide for three person months in the beginning of the project to assist in final project implementation planning, administrative support and initial training, and additional assistance throughout the life of the project in areas such as evaluation, logistics, administration and training.

-- In-country training ($35,450) to improve services delivered by 192 MOD field staff and for population orientation of five military leaders, and international training ($14,000) of three cytologists. Third-country training of cytologists is planned in Colombia, taking advantage of its long history of FP service and training programs relative to other Latin American countries.

-- Supervision and promotional activities ($30,680) will finance in-country travel and per diem of two supervisors and seven educational personnel to implement and evaluate field activities.

-- Procurement of five vehicles ($40,000), medical and laboratory equipment ($24,800) and audiovisual and educational materials ($60,000). Contraceptives will be supplied by the Pathfinder Fund.

-- Salaries and related costs of fourteen FP promoters and six nurse midwives ($142,770). These expenses, to be financed on a cost-sharing basis with the MOD, are to be phased out by the fourth year of the project. In addition to joint financing of salaries of auxiliary nurses and nurse midwives ($105,900), the MOD will pay salaries of all trainees in the various programs ($33,300), administration and logistical support costs ($44,000), including partial salaries of program directors and improvement of warehouse facilities, and operation and maintenance costs of purchased vehicles and equipment ($50,000).

Detailed cost estimates for A.I.D. and MOD counterpart are included in the Financial Plan. Total expenditures under this project equal an A.I.D. contribution of $ 378,700 and a MOD counterpart contribution of $ 233,200.

c. Social Security Institute (IESS)

i. IESS/Division of Preventive Medicine (IESS/MP)

The IESS/MP plans to strengthen and expand its Family Welfare Program with the objective of achieving a tenfold increase in the number of new acceptors or some 18,500 by the end of the project. Assuming

current continuing user rates, the number of active users in the IESS/MP program at the end of 1985, depending on method mix, will be approximately 41,700 or about 24 percent of the affiliated women in the IESS/MP program. This compares to only 3.1 percent of affiliated women receiving services in 1980.

To extend its coverage, the IESS/MP will increase the number of urban mobile brigades from 16 to 34 during 1981-1985. These brigades operate out of dispensaries, primarily located in Quito and Guayaquil, where they provide outpatient services and also travel to factories delivering services to affiliated workers. A.I.D. will assist the IESS/MP to expand these services (averaging about five new brigades per year) by financing the in-country training, per diem and travel of 68 medical and 96 paramedical and promotional personnel ($49,260) and purchasing two vehicles ($17,200), educational materials ($45,000), and equipment ($10,240) required by the brigades to service effectively and educate the target population. The Pathfinder Fund will supply contraceptives ($141,210) over the life of the project. The IESS/MP will contribute to the service delivery component by assuming the costs of the salaries of personnel while in training ($107,300) and paying for the operation and maintenance of vehicles and equipment ($46,800).

IESS/MP will complement the expansion of its service delivery program with institution building activities. Primarily, 20 person-months of overseas training, as shown in Table IV, is programmed to strengthen its administrative and technical capacity.

TABLE IV

OVERSEAS TRAINING IN IESS/MP SUB-PROJECT

	Course	Person-Months (p/m)	Timing	A.I.D. Costs
1.	Production of Audiovisual materials	2	first year	$ 3,700
2.	Management/Administration of FP Programs	8	first year	$15,300
3.	Design of FP Programs	4	second/third years	$ 7,200
4.	Communications in FP	2	second year	$ 4,400
5.	Medical Advances in FP	4	all four years	$ 7,200
	TOTAL	20		$37,800

Overseas training sites have not yet been determined for all the courses, but it is expected that most of training will take place in other Latin American countries. As with in-country training programs, the GOE will pay the salaries of the international trainees, amounting to $23,500 in counterpart for this component. (Total subproject costs shown in the Financial Plan, equal approximately $337,100 of which $159,500 is A.I.D. financed and $177,600 is GOE counterpart. A.I.D. financing of overseas and in-country training amounts to approximately 55 percent of A.I.D.'s total contribution to the project.

ii. IESS/Campesino Program (IESS/Campesino)

Few rural service organizations are as readily available to provide FP services as that of the IESS/Campesino. Through this project, the IESS/Campesino proposes to expand its present FP services to all of its health posts and into new programmatic areas such as screening tests for cervical cancer and IE&C activities. In 1985, with the assistance provided under this project, IESS/Campesino will offer integrated health/FP services in all 290 of its health posts.

Successful expansion of these services will result in the following coverage by the end of 1985: (1) Active users, totalling ten percent or 6,650 affiliated women of fertile age will receive FP services and screening tests for cervical cancer; (2) 75 percent of the total affiliates or approximately 52,800 men and 49,900 women will receive FP information and (3) 100 percent of the health posts will organize information and educational seminars for groups of men and women within the ages of 15 to 49. To meet these targets, IESS/Campesino has requested assistance from A.I.D. in training and the provision of vehicles and supplies, amounting to a total contribution of $239,300. IESS/Campesino also will request $54,700 of contraceptives from FPIA.

As in the IESS/MP program, a large amount of A.I.D.'s assistance (47 percent or $114,500) will provide in-country training for 180 medical professionals and 550 auxiliary nurses, at an average cost of $250 per medical doctor and $125 per auxiliary nurse. A total of 166 person-months of training will be provided. Consistent with its decentralized decision-making process, IESS/Campesino regional centers will assist its headquarters in the selection of personnel to receive training at all levels of its delivery system. To support the activities of this subproject, USAID will suggest to IESS/Campesino that it request technical assistance from a population intermediary to design training programs for IESS/Campesino's own training staff.

A.I.D. funding of four vehicles ($36,000) will facilitate the expansion of delivery services into more isolated areas of the Ecuadorean countryside. Likewise, the provision of clinical equipment and supplies ($88,800) for all 290 health posts will enable the IESS/Campesino to become a nationwide service organization, operationally as well as theoretically. A.I.D.'s total contribution will be $239,300.

The IESS/Campesino counterpart totals approximately $224,250. This contribution pays the trainee's salaries ($42,500), operation and maintenance of vehicles ($48,000) and provision of equipment ($19,250) and IE&C materials ($114,500). Total subproject cost is estimated at $482,050. Detailed cost estimates are included in Annex V, Exhibit D.

d. National Development Council (CONADE)

As mandated in the 1979 Constitution, CONADE is responsible for developing Ecuador's national population policy. To do so, a Population Division will be established within CONADE to address population issues systematically vis-a-vis the country's socio-economic development. This subproject will assist CONADE's Population Division to play an influential role in placing demographic concerns at the forefront of Ecuador's development plans. A promising institutional framework has been created in CONADE for the formulation and application of a population policy to be closely integrated in the implementation of these plans. The structure and functions of CONADE provide a closer relationship between the technical planning levels and the policy-making levels that previously existed. The Constitution specifically establishes that policies and plans adopted by CONADE, once approved by the President, must be executed and followed up by the respective Ministries and public sector entities.

With funds provided by UNFPA and A.I.D., CONADE's new Division will: (1) evaluate the demographic impact of the National Development Plan 1980-1984; (2) assess the national population distribution policy contained in the 1980-1984 Development Plan; (3) develop an analytical framework to quantify the effects of demographic variables on socio-economic indicators; (4) carry out special studies that will address important population/development issues; (5) carry out training activities for its staff and collaborators; and (6) educate Ecuadorean leadership in the relationship between population growth and national development.

To implement many of these activities, CONADE's Population Division will rely upon the data collecting and analysis exercises to be carried out by the MOH, INEC, and CEPAR.* CONADE will also have to expand its professional staff by eight to execute this ambitious program. During the first two years of the project, an office administrator and secretary as well as five professionals (economists, sociologists and demographers) will be hired. In the third year the professional staff will be increased

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* See subproject descriptions of each institution's activities.

by three. UNFPA will provide one full-time expert for two years, and part-time consultants for some 30 months over the life of the project.

The UNFPA, A.I.D. and GOE will contribute $480,000, $124,000 and $333,000, respectively to this project. A.I.D. will fund two research studies ($61,000), 40 person-months of overseas training for professional staff ($30,500), four in-country population workshops ($5,500), two GOE counterparts (eight p/m ; $10,000) to work with the UNFPA consultant to finalize project implementation plans, office equipment ($11,000), and publications ($6,000) for the new Population Division.

UNFPA will finance the same inputs although to a greater extent as well as finance long and short term technical assistance. The GOE will be the primary financer of personnel salaries of both the Population Division staff ($263,400) and support staff already on board ($60,000). The remaining small amount of GOE counterpart ($9,600) will buy equipment not provided by A.I.D. or UNFPA. Total A.I.D. and GOE counterpart provided under this project is equal to $457,000. Detailed cost estimates are included in the Financial Plan.

e. National Institute of Statistics and Census (INEC)

As part of the larger effort to address the institutional constraint of a weak planning capacity within the public sector, INEC proposes to improve its vital registration system through this project. This data collecting and analysis exercise will directly complement the CPSs to be carried out by the MOH with assistance from the DSB/POP funded Westinghouse Health Systems and UNC/POPLAB contracts. In addition, INEC's long working relationship with POPLAB in the design of survey methodologies should facilitate a coordination of efforts between INEC and the MOH through these two activities.

INEC, having reviewed the vital registration system, has determined that it is in the national interest to initiate a pilot project to improve the national system. The most serious deficiencies of the current system are incomplete coverage of vital events, incorrect or contradictory data, and lack of coordination among the three government agencies directing and executing the vital registration system.* Although

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* Direction and execution of the current vital registration system of Ecuador is shared among three government agencies: (1) the National Directorate of Civil Registration, Documentation and Identification (RC), which supports the infrastructure of registrars, maintains the archives of birth, death, marriage and divorce registration and issues certified copies of vital event records, (2) the National Institute of Statistics and Census (INEC), which prints and distributes to registrars the forms on which statistical data of individual vital events are recorded and, upon return of these forms, checks, codes, processes, and publishes vital statistical annuals, reports and analyses, (3) the National Division of Health Statistics (DNES), within the MOH, advises INEC on matters pertaining to content and coding of the statistical forms. Thus, DNES, apart from its advisory capacity, is not directly involved in the production or dissemination of vital statistics in Ecuador.

existing estimates of under-registration of vital events are tentative at best, evidence from several sources suggests that approximately 15 percent of births and 22 percent of deaths go unregistered. In less accessible and less developed areas of Ecuador these percentages are undoubtedly substantially higher.

This sub-project responds directly to these deficiencies in that it will: (1) evaluate the national system as it is currently functioning; (2) develop a model system, which will include three demostration areas, permitting the investigators to test various strategies for improving the system; (3) evaluate and improve the model system; (4) extend selected aspects of the model system to the national level; and (5) present a report to the GOE describing the relative advantages of the model system and suggesting appropriate steps for improving the national system.

Through this project, INEC, in close coordination with the National Directorate of Civil Registration and the MOH, will take steps to significantly improve the vital registration system. Clearly, in an undertaking of this magnitude, a thorough study of the existing system, the design and refinement of new procedures, and trials on a limited basis are indicated prior to suggesting or implementing changes at the national level. A.I.D. is providing $234,200 in grant funds under this project to INEC to carry out these activities. INEC will receive technical assistance from the National Center of Health Statistics (NCHS) of the U.S. Public Health Service through its Vital Statistics Improvement Program (VISTIM). NCHS has agreed to contribute $114,800 from a previous DSB contract to fund the first year of this sub-project.

A.I.D.'s contribution both bilaterally ($234,200) and centrally ($114,800) funded is broken down as follows: (1) personnel contracts ($136,640),* (2) office equipment and logistic support including rent of computer time ($79,160), (3) travel in-country for INEC personnel ($59,000) and internationally for NCHS consultants ($20,000) and miscellaneous expenses including rental cost of office space for Data Entry Unit and field staff ($41,200). Detailed cost estimates of A.I.D. funding are included in Annex V, Exhibit F, and in the DSB funded "Model Vital Registration Project: INEC - VISTIM" proposal made available as a bulk annex to the PP.

Counterpart financing will support nine professionals ($171,800) and 145 field staff to collect data ($241,400), as well as contribute to office logistical support at headquarters and in the field

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* Throughout the life of the project, INEC will contract one biostatistician, one administrator, nine field staff and four support personnel. Also, consultants will be provided as necessary by NCHS/VISTIM.

($70,500). The total costs to be funded through this project (A.I.D. bilateral contributions and GOE counterpart) equals $717.900.

2. The Private Sector

a. Association for the Welfare of the Ecuadorean Family (APROFE)

The project will fund APROFE's ongoing clinical programs, thereby enabling APROFE to use its present financial resources (mainly provided by IPPF) to expand significantly its CBD program. USAID has decided not to direct its bilateral support to the CBD program, given the yet unresolved questions of contraceptive delivery through this channel as described in the constraints analysis.

With funding through this project, APROFE's three clinics in Guayaquil, Quito and Cuenca will be able to continue operating their regular programs, providing non-permanent contraceptive methods to a target of 45,825 new and 113,000 continuing acceptors over the next four years. In doing this, APROFE will expand activities in Quito and Guayaquil by hiring additional staff, while maintaining current staff levels in Cuenca. Medical students, physicians, and some nurse midwives and social workers will continue to receive FP training at these clinics.

APROFE's three clinics have existed since 1966. Therefore, there are no clinic start-up costs, and the project can take advantage of APROFE's experience in developing ever more cost-effective methods of service delivery. Each clinic is overseen by a medical director who is responsible for all service activities, although all clinic activities are the final responsibility of APROFE's Executive Director. The activities of the individual clinics are described below.

In Guayaquil, APROFE will continue to provide services to new and continuing acceptors during the four years of the project. The Guayaquil clinic, the most important of APROFE's three centers in terms of numbers of acceptors served, functions as a demonstration and training center for physicians, nurse midwives and social workers from both the public and private sector Services are offered five days a week, with the majority of acceptors attended by eight half-time nurse midwives. Two half-time physicians deal primarily with the more complicated cases. A supervisor, based in Guayaquil and charged to the Guayaquil clinic, oversees the administrative functioning of APROFE's three clinics. APROFE charges nominal sums for its services in this clinic, (S/ 60 for a first visit, and S/ 30 for each subsequent visit) and a total income of US$ 189,850 in service fees is projected over the four year period of this project. An interviewer does motivational work in the Maternity Hospital and within the clinic, while a social worker, to be hired through this project, will do outreach work in the community and assist acceptors with family and personal problems. The Maternity Hospital will continue

to provide the clinic space, while APROFE will pay for electricity and water.

Like the Guayaquil clinic, the Cuenca clinic operates a very efficient service delivery program. The clinic will continue to provide basic FP services five days a week, while at the same time serving as a training center for sixth-year medical students who choose to intern in the clinic as part of their training. Services will be provided by a half-time doctor and two auxiliary nurses, while a full-time motivator will recruit new acceptors from within the hospital and from the community. The Cuenca clinic seeks to reach 3,970 new and 5,800 continuing acceptors during the project period. As this clinic is located within a government facility, it cannot charge for services. The hospital will provide clinic space and utilities.

The Quito clinic presently functions at less than capacity, in part because it is understaffed. In order to strengthen this clinic, APROFE plans to hire four new staff members: a half-time physician to provide FP services, a professional nurse, an auxiliary nurse and a secretary/receptionist. They will join the current staff: a half-time physician, one nurse, two auxiliary nurses, and a motivator. It is anticipated that the larger staff will increase the effectiveness of the clinic, resulting in the ability to provide services to 7,996 new and 11,690 continuing acceptors by the end of the project. Services will continue to be offered five days a week.

As this clinic is within a government facility, APROFE must abide by the recent government ruling to provide all health services free of charge, which rules out the possibility, as in the Cuenca clinic, of generating income from this clinic. A full-time motivator will work on the post-partum, post-abortion wards of the hospital to inform potential acceptors of the clinic's existence. The hospital will provide clinic space and utilities.

Required funding for this sub-project amounts to $1,526,550 A.I.D.'s contribution ($589,500) will support operational costs for all three clinics, including salaries of 37 personnel in all three clinics ($538,420), clinical supplies and equipment ($ 9,510), and utilities of the Guayaquil clinic ($ 41,570). Service fees charged at the Guayaquil clinic ($189,850) will be applied toward the operational costs of the clinic. IPPF will also provide counterpart funding ($937,050) by financing APROFE's core administrative costs ($246,000) IE&C program ($380,000), some training ($20,000), commodities including all contraceptives and major medical equipment ($89,200), and evaluations ($12,000). Detailed cost estimates of A.I.D. and counterpart contributions is included in Annex V, Exhibit G.

b. Medical Center for Family Planning and Orientation (CEMOPLAF)

Based on the success of its IE&C and service programs to date and the urgent need for FP services in other parts of the country, CEMOPLAF has presented a proposal to USAID to fund the creation of three new FP clinics in Guasmo, Esmeraldas and Tulcán. These clinics will offer FP motivation to 30,000 people in 600 groups, and FP services to new acceptors, of whom at least 50 percent will continue yearly as active acceptors.

In order to ensure sufficient time to establish well-functioning clinics, CEMOPLAF will phase the opening of these clinics over the first three years of the project in the following order: Guasmo, Esmeraldas and Tulcán. It will take about three months to select and train the staff and remodel and equip each of the clinics. At the start-up of each clinic, CEMOPLAF will request funding from Development Associates (DA) in order to provide FP and motivational training to community leaders in each of the three locations. DA has expressed an interest in supporting this activity. The location and activities of the individual clinics are described below.

The Guasmo area of Guayaquil is a slum with a population of about 250,000 people of which approximately 65,000 women are in fertile age and 42,250 women are at risk. CEMOPLAF held a leadership training program is September 1980 for community leaders from Guasmo, resulting in a request to establish a FP clinic there. The MOH has just opened a health subcenter in Guasmo, but it appears that little attention will be given to FP. APROFE has a FP clinic in the Enrique Sotomayor Maternity Hospital in the center of Guayaquil, but offers no services in the Guasmo area. Based on its success in another slum area of Guayaquil, APROFE plans to establish a Women in Development (WID) project in Guasmo, and will refer women participating in that program to the CEMOPLAF clinic.

In Guasmo, CEMOPLAF will work closely with both the "pre-cooperatives" (organizations not yet officially recognized as cooperatives) of the area and with APROFE's WID project. The clinic will be open five days a week, utilizing a staff of two half-time doctors, and auxiliary nurse and a secretary. CEMOPLAF plans to reach continuing FP acceptors in the four year project period, with approximately 55 percent using IUDs, 30 percent using orals, and the remainder employing other non-permanent methods. Gynecological and pre-natal services will be offered to about 35 women per month as well. Charges for clinic services will be according to CEMOPLAF's usual fee schedule (S/ 50 for registration of a new acceptor and each follow-up visit).

A full-time social worker will identify community groups and coordinate two-to-three hour meetings on FP with 50 community groups per year (attended by 2,500 people in total). She will also make house to house visits and follow-up drop-outs from the program. During the first two years, she will concentrate on the Guasmo Sur area; during 1984 she will work in the Guasmo Central area; and during 1985, she will work in Guasmo Norte.

Esmeraldas is a northwestern coastal city with a population of approximately 130,000 of which approximately 33,800 women are of fertile age and 21,970 women are at risk. Existing government clinics in Esmeraldas give little emphasis to FP. APROFE will initiate a rural CBD program in 1981 which will benefit from the back-up support which CEMOPLAF's clinic can provide once established. During the first year of the project, CEMOPLAF will identify existing community resources in Esmeraldas, select staff and a clinic site. The clinic will be established during the latter part of 1982, and will be functioning in early 1983. Initially the clinic will be open four hours a day, five days a week, staffed by a half-time doctor and a nurse's aide. In the second year, when service demand is expected to increase to a level requiring a full-time clinic, a half-time nurse midwife and a secretary/treasurer will be added. In the three years this clinic will function within the project, it will provide FP services to 5,368 new and 2,499 continuing acceptors. A full-time social worker will conduct IE&C sessions with 50 groups per year of approximately 50 people each. During the first two years, she will concentrate on working with urban parents, the police, neighborhood groups and other local institutions. During the last year, she will also work with rural groups. The social worker will also motivate 100 groups of 15 people each within the clinic. Charges in Esmeraldas will also follow the usual CEMOPLAF fee schedule referred to above.

The third proposed project site is the northern Andean city of Tulcán with a population of approximately 63,000, of which approximately 16,380 women are of fertile age and 10,650 women are at risk. The CEMOPLAF clinic will provide the only private subsidized source of FP services. During 1983, CEMOPLAF will identify existing resources in Tulcán, select and train staff, choose a clinic site, and remodel the facilities as necessary.

The Tulcán clinic staff will include a half-time doctor, a nurse's aide, a half-time nurse midwife and a secretary/treasurer (the latter two to be hired in the clinic's second year, when clinic business is anticipated to be heavy enough to require full-time services). They will provide FP services to 2,198 new and 812 continuing acceptors during the two years the clinic will function under this project. A full-time social worker will work with community groups with the goal of reaching 50 groups of 50 people each per year. She will also work with 100 groups yearly within the clinic, reaching about 1,500 people annually.

CEMOPLAF has proposed to work in these three areas because of the local needs of each and the networks established through medical professionals associated with the organization. Either as members of the Women Doctor's Medical Society or as associates, these contacts will serve as facilitators to the program in each area. CEMOPLAF's records show that many people travel from Tulcán to Quito for FP services. A similar journey is undertaken by those desiring FP services in Esmeraldas. (Both of these trips imply distances of several hundred kilometers.) By offering convenient low-cost FP services to people living in these three cities and surrounding areas, CEMOPLAF will expand FP coverage considerably, as quantified above.

Total funding for this sub-project equals approximately $701,220. A.I.D. funding ($545,900) will support operational costs for all three clinics, including the salaries and benefits of 17 new personnel ($279,720), equipment and supplies for all three clinics ($ 65,300), evaluations ($ 27,730), rent and renovation costs ($ 61,550) and administrative support ($111,590). Administrative costs for the project include two new staff members, supervision, travel and per diem related to supervision, and other costs incurred by the Quito headquarters of CEMOPLAF (rent, utilities, etc.).

Counterpart financing includes projected service fee income from all three clinics ($ 70,120), administrative support ($ 68,000), office logistic support ($ 12,000) and commodities, including contraceptives ($ 5,200). It is expected that FPIA will continue to support CEMOPLAF's existing clinics as well as supply contraceptives for the new clinics proposed under this project. Total counterpart financing equals $ 155,320. Detailed cost estimates are included in Annex V, Exhibit G.

c. Center for Promotion of Responsible Parenthood (CEPAR)

In late 1980, USAID provided a $5,000 grant to CEPAR to "determine possible areas of action for development of a research, information and training project in population". With this grant, CEPAR hired three part-time staff members who prepared and presented a proposal to USAID for funding under this project. The general objective of CEPAR's proposal is to encourage Ecuador's opinion leaders and policymakers to become sensitized to population issues and their socio-economic impact on the Ecuadorean family, thereby creating a favorable atmosphere which will stimulate the development of population and family welfare policies.

By strengthening the knowledge and understanding of the relationship between socio-economic development and population, CEPAR hopes to enable Ecuador's political, scientific, technical and other leaders to establish policies and program which take into account population factors and the need for FP information, education and services. This project is based on presenting realities which will create an at-

mosphere conducive to establishing whatever population policies are most appropriate for Ecuador. CEPAR plans to achieve this by acting in three areas: information, training, and research. Each of these areas of activity has specific objectives as outlined below.

i. Information:

-- Organizing a documentation center on population and FP.

-- Identifying policy-makers and other leaders who will make up the project's chief audience.

-- Conducting an inventory of the mass media.

-- Developing information resources, including press and magazine articles and other printed materials.

-- Disseminating information to political and other leaders on world and national population problems and projections, and motivating the general public about FP.

ii. Training:

-- Organizing a training program, with eight to ten professionals as instructors, to carry out six roundtable discussions, eleven seminars, four short courses, and a panel discussion throughout the life of the project.

iii. Research:

-- Conducting seven research studies (four studies related to population problems and three to FP) and making concrete recommendations to those responsible for setting population and health policies.

CEPAR's objectives in information, training and research are closely linked throughout the life of the project. For example, people attending the roundtable discussions of the training activity will be contacted regularly through the letters, publications and personal contacts developed as part of the information activity. The results of the research program will be utilized in rountable discussions, press, publications and other activities of both the information and training areas.

A final activity delegated to CEPAR under this project is the supervision of regular coordination meetings with APROFE and CEMOPLAF. Development Associates will provide a small grant ($ 16,000) to CEPAR to finance the administrative and logistic costs of this task.

As arranged by CEPAR, the three private sector institutions (APROFE, CEMOPLAF, CEPAR) will hold periodic meetings to coordinate their efforts, discuss their respective programs, and provide mutual support and assistance.* It is expected that they will rotate responsibility for conducting these meetings and take turns visiting each other's programs.

Unlike APROFE and CEMOPLAF which have had years to develop their administrative structures, CEPAR has not yet had sufficient financing to develop the administrative infrastructure necessary to oversee a project of this magnitude. Thus, it is essential that CEPAR's administrative capacity be strengthened so that it can play the role delineated in this project. A.I.D. support is needed to employ qualified staff not only in the programmatic areas, but also in administration. To do this, CEPAR will employ the following administrative staff: a half-time executive director, a full-time project administrator, a half-time financial administrator, three full-time secretaries to work in a secretarial pool to all CEPAR activities, and a full-time messenger-concierge. A.I.D. will also contribute to the costs of rent, telephone, and utilities necessary for CEPAR to carry out the project. After establishing this administrative structure, CEPAR will have the capability of conducting regular public information, education and research programs.

Total cost of this sub-project amounts to $ 774,400. A.I.D. support will fund three professional, three administrative, and six support staff ($ 201,130), operating costs of the information ($ 37,850), training ($ 31,170) and research ($ 41,510) programs, and the establishment of the basic administrative infrastructure necessary to oversee all of CEPAR's functions ($239,840). Administrative costs will be about 30 percent of the total, somewhat higher than the norm, but a necessary expenditure to develop an administrative structure from scratch. Some administrative costs (for example, the three secretaries forming the secretarial pool and the messenger/concierge, rent, telephone, utilities and mail) will be used by all project activities, but have been placed in the administrative category for ease of control. Total A.I.D. support amounts to $ 551,500.

CEPAR's contribution to the project amounts to $ 222,900. The total consists of processing and publishing materials ($ 50,500), media expenses ($ 135,000), volunteer time ($ 35,000), and membership fees ($ 2,400). All cost estimates are broken down in greater detail in Annex V, Exhibit G.

d. Commercial Retail Sales (CRS) Activity

On a cost-sharing basis with DSB/POP USAID will initiate a contraceptive CRS program through existing promotional and distribution

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* USAID also plans to promote a closer working relationship between CEPAR and the Ecuadorean Fundación Natura, a PVO whose mandate is to conduct environmental information and educational programs.

systems in Ecuador. The purpose of this subproject is to establish commercial outlets to sell contraceptives at prices significantly lower than those of the commercial brands now available, thereby making them affordable to low-income consumers. Furthermore, through an extensive advertising campaign, a major component of this project, the CRS activity will further stimulate demand for FP services.* The CRS approach of using existing strengths of the private sector can effectively complement the strategies of public and private PF programs in a cost-effective manner.

In Ecuador, there are approximately 1,110,800 women at risk, the majority of which are not covered by contraceptive use. Demographic estimates place 60 percent of these women in the category of the poor majority. Of these 660,500 women, this sub-project proposes to reach 50,400 new users or 7.6 percent of the potential market within the first three years (an estimate based on the experiences of CRS programs in other developing countries). By the end of 1985, this activity will add 38,000 active users to the total reached by this project.

It is currently planned that APROFE assume responsibility for the implementation of Ecuador's CRS program given its administrative structure, managerial capacity and leadership role in family planning. Also, with its contacts in the public sector, APROFE is the most able to acquire the necessary support from the GOE.

Because the CRS concept is untried in Ecuador, preliminary steps will be taken before the CRS program is implemented. DSB/POP under a separate central contract, has already begun to carry out the following steps:**

i. key representatives of APROFE, other possible sponsoring organizations and perhaps a representative of the GOE will visit existing CRS programs in this hemisphere. The purpose of such a visit is to observe the functioning of other CRS programs and apply these lessons to Ecuador.

ii. The next step is to carry out a market research study to determine the extent of need for such a program and the perceived limitation from the targeted population and the marketplace.

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* See Annex VI. DSB/POP "Commercial Retail Sales Report", February 1981.

** DSB will contribute $75,000 from a separate central contract which is not included in this project's financial plan. This contract is with the Futures Group.

The proposed contraceptive prevalence studies to be carried out by the MOH can provide useful information that will complement the proposed market research.

iii. The market research and CPS will provide the foundation for project implementation. When the legal and technical issues have been cleared (i.e., selection of appropriate contraceptives for distribution, prescription requirements, advertising restrictions, and assured sufficient supply of contraceptives, CRS activities will begin.

Central bureau funds ($ 725,000) will also be provided to cover all costs in the first two years of the project. DSB/POP has requested USAID bilateral funds ($ 450,000) during the final two years of this project.* Both central and bilateral funds will pay for advertising and promotion, contraceptives and a long-term resident advisor with full back-up support. Based on DSB funded CRS programs elsewhere, contraceptives account for 30 percent, contractor costs for 30 percent, and advertising and promotion expenses for 40 percent of total program expenses once implementation begins. Applying these percentages to Ecuador's planned CRS program results in approximately $ 350,000 for contraceptives, $ 350,000 for direct contractor costs, and $ 470,000 for advertising over the life of the project.

e. Intermediary Coordinating/Executing Agency of Private Sector Activities (ICEA)

Given the scope of the project and the large amount of staff time required of the USAID staff to monitor the public sector program, USAID will seek outside assistance to implement and coordinate the private sector activities. For this reason, USAID reviewed a detailed proposal from the International Planned Parenthood Federation/ Western Hemisphere Office, Inc. (WHR).** Through the proposed plan, WHR, under a contract with USAID/Ecuador will assist in implementing and funding the activities of APROFE, CEMOPLAF, and CEPAR as well as providing technical assistance and encouraging coordination among these three organizations. In the past, APROFE, CEMOPLAF, and CEPAR have acted fairly independently of each other. Recently, however, they have sought to increase their cooperation through coordinating meetings to discuss unmet needs and exchange ideas and information about program activities.

WHR will maintain a small office in Quito which will have operational responsibility for project execution within the private sector. The office will have two staff members: a Project Coordinator,

* A final implementation plan and detailed project description will be prepared and submitted to A.I.D. prior to obligation of bilateral funds included in the PP.

** This proposal is attached in Annex V, Exhibit G.

to be hired internationally as a WHR employee, and an administrative aide to be hired locally. The Project Coordinator will work closely with each of the sub-grantees to assist in the institutional development of their respective organizations. The Quito office will monitor the development of the sub-grants to ensure efficient and effective project implementation and coordination. The Project Coordinator will file periodic reports with the WHR New York Office and USAID, and make recommendations on the project and the budget. There will be a close working relationship between the coordinator and USAID's Population Officer. The administrative aide will report to the Coordinator, and will do secretarial and bookeeping work.

The IPPF/WHR New York Office will provide operational support to its Quito Office as well as provide technical assistance and training for the Ecuadorean PVOs. (For example, IPPF/WHR Controller personnel will work to upgrade the accounting systems of CEMOPLAF and CEPAR) This staff consists of the UHR Regional Director, assisted by the Director of Program Coordination, program advisor, a financial analyst, the deputy financial analyst, the deputy financial controller and the commodities coordinator. The New York Office will also sign the grant agreements with the sub-grantees, APROFE, COMOPLAF, and CEPAR. These will be renewed yearly, depending upon an annual review of compliance with the prior year's grant agreement, and taking into account significant changes in the national environment as advised by USAID and the Quito Office. As appropriate, other UHR staff will contribute to the project and outside consultants will be hired to provide technical assistance.

To fulfill the role of the ICEA as outlined above, the WHR has submitted a proposal to USAID requesting approximately $3.0 million. Over 50 percent of this amount goes to the three private sector organizations to carry out their activities: APROFE ($ 589,500), CEMOPLAF ($ 545,900) and CEPAR ($ 551,500). The remainder will pay for project management responsibilities including the provision of technical assistance and training to the three Ecuadorean PVOs, direct costs of WHRs Quito and New York Offices, and inflation and centingencies. The amounts for each of these latter components is under final negotiation. SER/CM has scheduled an audit to determine an acceptable IPPF/WHR overhead. Upon this determination final negotiations will be completed and a Cooperative Agreement will be signed between IPPF/WHR and USAID/Ecuador.

III. PROJECT ANALYSIS

A. Technical Analysis

1. Contraceptive Technology and Delivery

This project will rely on the standard variety of non-permanent modern contraceptive methods: pills, IUDs, condoms, jellies, foams, and diaphrams. These contraceptive methods are beyond the experimental stage and their effectiveness under a variety of conditions is known. Each of the programs supported under this project will offer the full array of methods. Obviously, the relative safety of the various methods will depend on particular characteristics of the users with respect to age, health, parity, personality, user application, etc. While the theoretical effectiveness of contraceptive methods is known, failure resulting from the way a method is used is very difficult to ascertain. Careful education and counseling is necessary to ensure correct usage. The numerous IE&C activities in the project will make use of several good manuals on contraceptive use. Continuation of effective use will depend, in part, on effective counseling efforts.

To ensure effective delivery of FP services, special attention will be paid to training and supervision as indicated in the sub-project descriptions of this PP. With regard to training, the content is rather standardized, some aspects will remain flexible. For example, training will be designed to meet the needs of the target community. Training, especially of local community agents, will be carried out reasonably close to work locations, whereas, training of trainees will be more centralized. As a more diverse mix of health workers is trained to implement FP services, supervision becomes more problematic. As the network of service points increases, so will the supervisory network. Supervision planned under this project will be regular, will take place in the field, and will be used as a performance audit as well as a feedback mechanism for local level concerns. Project funds will support site visits of MOD supervisors and educators and purchase vehicles to increase the mobility of IESS supervisory staff in both the urban and rural oriented programs.

The channels through which education and information will be disseminated is also a key issue in this project. Ideally, it is desired to introduce basic instruction of reproduction and FP into primary and secondary school curriculums. But, even if begun today, results would be several generations away. Problems related to rapid population growth will not allow us to wait this long and, therefore, these longer term impact programs will be substituted in this project for non-formal education for adults and adolescents. All of the service organizations will carry out IE&C activities as a major component of their overall FP programs.

Fortunately, due to technological advances, effective mass media communication systems in health, nutrition and related fields exist

in Ecuador. Several basic themes can be conveyed to the general population through mass media: human beings have the means of controlling their fertility, FP services are available in the local community, and FP improves the prospects for better health. Politicians, economists, and community leaders can also be meaningfully informed through the media, i.e., demographic, political, and economic arguments favoring the provision of FP services. It is this latter audience to which CEPAR will direct its population awareness raising activities.

Mass media efforts will be effectively reinforced and broadened by points-of-service information, motivation, counselling and education. In hospitals, clinics and pharmacies motivated personnel, using IE&C materials, can effectively relay FP messages. Pharmacists, with the support of modern marketing techniques, will enhance information levels and improve contraceptives sales. Moreover, person-to-person communication, especially by informed and satisfied users, serves as an inexpensive and effective information network. To conclude, the recommended IE&C techniques are not only feasible, but also effective and available in Ecuador.

With respect to the CRS program, the necessary conditions for implementation exist in Ecuador. For example, the capacity for packaging, promoting, and distributing contraceptives is more than sufficient. There are a large number of capable advertising agencies that can develop a promotional campaign that will satisfy consumer interests and governmental concerns. Also, a market research company (DATOS ECUADOR) exists with experience and knowledge to do the studies necessary to design the proper promotional campaign as well as provide attitudinal information to lend support to a social marketing program. Finally, there is a sufficient number of distributors to provide nationwide coverage in a relatively short period of time (30-60 days).

2. Applied Research Techniques

Several principles will be followed to make applied research as programmatic, relevant, and effective as possible. Research topics will be carefully chosen for their policy relevance as determined by the Ecuadorean leadership. Program managers, in generating the kinds of questions to be raised in applied research, will investigate parameters which are manipulative. Analysis will, for the most part, be kept simple with policy and program recommendations as clear as possible. Whenever possible, policy makers will rely on existing research rather than asking for additional research which may take several months or years to complete. Proper attention will be paid to dissemination. In Ecuador, although a reasonably applied research infrastructure exists, i.e., data collection and analysis capabilities, including computers, only a limited number of qualified researchers are available to produce relevant studies. Through

the activities planned by CONADE, INEC, and CEPAR under this project, this constraint will be addressed resulting in higher quality research related to population issues.

In summary, as Ecuador enters the 1980s there exists a more favorable socio-economic environment within which population programs can operate, and there is evidence of a change in fertility behavior. The present challenge is to accelerate the provision of FP information and services. In addition, there is a need for further analysis which will bring the multisectoral implications of Ecuador's high population growth rate to the attention of planners and other leaders. Data are now becoming available upon which to base analyses addressing such issues as migration and spatial distribution trends. Setting priorities and planning programs will become easier if demographic realities are kept foremost in mind.

B. Institutional Analysis

1. Public Sector Entities

a. Ministry of Public Health (MOH)

Although the MOH was officially created in 1967, numerous other public health agencies (including the US/Ecuadorean Health Service which served as the country's de facto Ministry of Health (MOH) from 1942 to 1964) were functioning prior to that year. As a result, the MOH remained a highly fragmented institution of autonomous central and provincial boards with no clear lines of authority. In 1972, the organization was restructured and official authority was centralized in Quito. In 1976, the MOH was significantly expanded and strengthened through the creation of seven Directorates: (1) Financial Administration, (2) Planning, (3) Health Services, (4) Family Welfare, (5) Sanitary Control and Surveillance, (6) Rural Development, and (7) Technical Services. A Personnel Directorate has since been added and the former Family Welfare Directorate, responsible for family planning, has been incorporated into a new broader Family Health Directorate, which covers MCH, and nutrition as well as family planning (see organizational chart in Annex V, Exhibit 1).

The latest evolution in the MOH's development process began in 1979 with the promulgation of the current National Health Plan which delegated program planning and decision making to the operating unit level, as part of an overall strategy to decentralize the health care system. A detailed analysis of this strategy and the MOH's strengths and weaknesses is provided in the Integrated Rural Health Delivery System Project Paper to be submitted for A.I.D./W approval in early July 1981.

The MOH family planning subproject will be carried out under the responsiblity of the Maternal Health and Family Welfare Chief of the Family Health Directorate. The current chief, a pediatrician, has over eight years of experience with the MOH. The bulk of the subproject activities provide practical FP training to pre-and post-graduate medical students and in-service training of MOH technical personnel. Arrangements will be made with the MOH provincial health chiefs in Quito and Guayaquil to obtain approval to establish the training centers in their respective cities. The Family Health Directorate will be responsible for contracting the training teams to staff these centers. Initially, A.I.D. funds will be used to pay for the salaries of the four training teams. During subproject implementation, the MOH and the universities will gradually assume the salary costs of these positions. By the end of the subproject, it is expected that 48 new positions will be established to cover the staffing needs of the training centers (12 per center, two centers each in Quito and Guayaquil). The project agreement with the MOH will specifically recognize both the Ministry's and universities' obligations to create and maintain these positions beyond the life of the project.

At the same time that A.I.D. is assisting in technical training of the new staff, the UNFPA will be providing institutional support to the MOH in MCH and primary health care delivery. The UNFPA will finance MOH salaries, equipment, technical assistance, training in public health management, evaluation and demography, and special seminars and courses to encourage application of skills obtained in the MOH training centers.

The Maternal Health and Family Welfare Chief will also be responsible for administering the Contraceptive Prevalence Surveys (CPS) to be carried out with DSB funding during the life of this project. To implement this activity, the Chief will enter into agreements with the National Institute for Social, Medical and Nutrition Research (ININMS), a semi-autonomous research arm of the MOH, and the DSB contractor(s).

In sum, the MOH will be able to rely on assistance from several sources to execute its proposed subproject. The institutional arrangements and staffing requirements of the subproject have been fully identified and budgeted in the proposal. USAID concludes that the MOH has the capacity to carry out its responsibilities under this project.

b. Ministry of Defense (MOD)

In 1970, the MOD's family planning activities began with A.I.D. support to the Family Welfare Program under the MOD's General Health Directorate. While the program continues to provide FP services, the termination of the A.I.D. assistance in 1976 stunted the program's

institutional development. The proposed subproject is designed to accelerate the program's development and expand delivery capacity.

The MOD currently operates 31 clinics offering FP services. During the life of this project, the number of clinics offering FP services will be expanded to 43 and the entire MOD FP system will be strengthened through training and the provision of technical assistance. The staffing requirements for operating the new FP service points include doctors, paramedics, nurses, auxiliary nurses, FP promoters, health educators, and cytologists. The MOD will finance all personnel to be funded on a cost sharing basis with A.I.D. By the end of the project, the MOD will have assumed total financial support for these positions.

All subproject activities will be under the supervision of the Director of the Department of Family Welfare and Preventive Medicine. The Director, a medical doctor, is a civilian employee with over ten years of experience with the MOD. The Director has an adequate administrative staff to carry out the subproject activities and enjoys direct access to the Director General of Military Health Services when support and consultation is needed.

Some potential implementation problems have been identified in the design of the MOD's proposal to USAID. These concerns include a defective contraceptive storage and logistic system and an inadequate administrative structure to execute the expansion of FP services planned under this project. However, a recent consultant's report concludes that only minor improvements are needed to make the contraceptive storage and logistic system a good one and a management expert will be hired at the beginning of the project to provide administrative and managerial assistance.* Follow-up consultations will be made available during the life of the project.

c. Social Security Institute (IESS)

IESS was established in 1928 as an autonomous organization to provide medical care and retirement benefits to public and private sector workers. The organization is self-financed with employee contributions collected from approximately 20 percent of the economically active population presently covered by the IESS program.

IESS is headed by a Superior Council presided over by the Minister of Social Welfare and representatives from the Supreme Court, IESS's employers, affiliated workers, retired persons, and the Armed Forces. (The MOH designates a medical doctor to participate with

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* Mark Oberle consultant report, Center for Disease Control, 1981.

voice but no vote). The Superior Council appoints and provides policy guidance to a Director General who is in charge of overall administration. The three principal operating Directorates are the National Medical and Social Directorate; General Administration Directorate; and National Economic and Financial Directorate . (See organizational chart in Annex V, Exhibit 3).

The National Medical and Social Directorate is responsible for all medical services provided by IESS except for the rural outreach services of the Campesino Program. Its staff of over 5,000 is distributed among four divisions: Medical and Dental Services, Complementary Technical Services, Medical Planning, and Medical Infrastructure. The Department of Preventive Medicine (MP) of the Medical and Dental Services Division will be responsible for carrying out the IESS subproject activities described in the IESS/MP description section of the PP.

IESS/MP provides an outreach service through 16 mobile brigades which operate out of IESS urban medical service facilities. IESS/MP has a staff of 34, including 18 medical doctors, and draws on health education services and personnel from the Health Education Department of the Complementary Medical Services Division. By the end of the project, the IESS/MP subproject plans to increase the number of mobile teams to 34. This expansion will require increasing medical and auxiliary personnel and providing vehicles and equipment for the mobile brigades. While this represents a sizable staff expansion for IESS/MP, it is small compared to the overall staffing levels of the National Medical and Social Directorate in which the Division of Preventive Medicine is located. In USAID's judgement, the increased importance IESS/MP is being assigned within the IESS will ensure that these new positions will be created and filled in a timely manner.

The subproject will finance the training of the mobile teams. IESS/MP will organize the training courses and make all administrative arrangements. The trainers will be selected from the specialized operating units of IESS, as well as from the MOD, MOH, CEPAR and other Ecuadorean FP organizations. The subproject will strengthen IESS/MP's institutional capacity to organize and implement in-service training programs by financing 20 person months of overseas training in management and technical areas of family planning. In view of the above, USAID concludes that IESS/MP will be able to carry out its responsibilites under the subproject.

The IESS/Campesino program is a separate unit in one of the other two main operating Directorates: General Administration Directorate. In addition to curative health services, the program provides retirement and death benefits. The program evolved from a 1968 pilot project initiated in four campesino communities in different rural zones of the country. By early 1981, the program had extended coverage to over

100,000 people serviced by its 168 rural health posts. Of this serviced population, only five percent were affiliated women receiving FP services.

The in-service training to be financed by A.I.D. under the subproject is intended to upgrade the program's FP effectiveness. The program currently has a staff of 185 (including 42 doctors, 16 dentists and 96 auxiliary nurses). This staff will be increased significantly with the planned expansion to 290 health posts in 1985. Under this project the IESS/Campesino is to carry out in-service training as well as delivery of services. It's institutional capabilities will have to be strengthened in order to meet subproject objectives. For this purpose, DSB/POP is being called on to provide immediate technical assistance to help the IESS/Campesino program staff to prepare a detailed implementation plan for in-service training. Such a plan will be a condition precedent to first disbursement under this subproject. It is expected that the program will be able to draw on the training experiences and arrangements to be made under the IESS/MP subproject. In any event, given the existing weak capacity and the planned staff expansion, USAID will have to work closely with the IESS/Campesino Program to assure the success of the proposed training efforts.

d. National Development Council (CONADE)

CONADE was created by the 1978 Constitution, although much of CONADE's institutional and human resource base has been carried over from its predecessor organization, the National Planning Board, which dates back to 1954. The Vice-President of Ecuador serves as the head of CONADE and exercises authority over its staff of 600. Its operations are headed by a Technical Director and divided into an Administrative Department and a General Directorate which oversees the planning functions. There are four planning directorates: (1) Medium and Short Term Global Planning, (2) Coordination and Fiscal Policy, (3) Regional Planning and Studies, and (4) Sector Planning. (See organizational chart in Annex V, Exhibit 5). In addition, there is a regional office in Guayaquil.

CONADE's Population Division, to be supported under the subproject, will be located in the Social Development Division of the Regional Planning and Studies Directorate. The Social Development Division received financial and technical support from the UNFPA and the Latin American Demographic Center (CELADE) to define the overall work plan and develop the proposal for the establishment of the Population Division. Continued inputs from UNFPA, including technical assistance, will be available during the subproject. Given the overall prestige of CONADE, no difficulty is anticipated in finding qualified Ecuadorean candidates to staff the Population Division. USAID is satisfied that the level of UNFPA support is adequate to ensure that the Population Division will be administratively and technically capable of carrying out the subproject.

e. National Institute of Statistics and Census (INEC)

The National Institute of Statistics and Census (INEC) was formed in 1976 through a merger of the Census Office and the Statistics Institute in an attempt to better coordinate the GOE's data collection and analysis activities. INEC is headed by a Director General who reports to the Vice-President of the country who is also the head of CONADE. Four technical divisions and one administrative division report to the Director General. The four technical divisions and respective staffing levels are: Research and Development, 29; Census and Surveys, 16; Operations, 91; and Data Processing, 74. (See organizational chart in Annex V, Exhibit 6). A large percentage of the Operations and Data Processing Divisions are comprised of part-time students. The Administrative Division has over 40 staff members. In addition, INEC has four regional offices, one in Guayaquil, Quito, Cuenca and Ambato, with a total staff of 35.

To carry out its subproject responsibilities, INEC will establish two units--a technical group and an operations group. The technical group, headed by a full-time INEC staff professional from the Census and Survey Division, will provide overall program coordination and guidance. Staff professionals from Ecuador's National Directorate of Civil Registration, Documentation and Identification (RC) and the MOH's Health Statistics Division (DNES) will participate in this group. Also, a bio-statistician will be contracted to work full-time. The technical group also will be responsible for organizing a training unit, drawing on the expertise from the RC and the DNES staffs to upgrade the skills of the field personnel participating in this activity.

The operations group will be in charge of overseeing the field work and the data entry/processing/storage activities. The Chief of the Department of Identification and Registration of the Civil Registry will be in charge of the operations group as well as serve as a member of the technical group. The field work will be carried out in three model demonstration areas. A total of three area chiefs and six inspectors will be contracted under the project to work with the RC field staff at the local level within these demonstration areas. This staff also will receive training from the training unit organized by the technical group. For data entry/processing/storage activities, the operations group will utilize the facilities at both INEC and RC. A technical analysis of these facilities has been prepared by U.S. experts and they are deemed satisfactory for carrying out the planned activities with rental of some minor additional equipment to be funded under this subproject.

Thus, while INEC will take the lead role in carrying out the subproject, it will have to rely on the active participation of RC and DNES staff. INEC has involved these entities closely in the development of the subproject. All these organizations are fully aware of the staff contributions and inter-institutional collaboration required to make this subproject a success. In USAID's judgement, it is reasonable

to expect that the necessary collaboration envisaged will be forthcoming.

Moreover, this subproject was developed with assistance from the DSB funded VISTIM activity of the U.S. Public Health Service. The continued availability of technical assistance from VISTIM will tend to reinforce INEC's ability to exercise technical supervision over RC and DNES staff during project execution. Accordingly, USAID foresees no serious obstacles to INEC's ability to carry out the subproject as planned.

2. Private Sector Entities

a. Intermediary Coordinating/Executing Agency (ICEA): International Planned Parenthood Federation (IPPF)/ Western Hemisphere Region Office, Inc. (WHR)

USAID plans to contract WHR to serve as an administrative mechanism to channel A.I.D. funds to the private sector implementing entities and also to provide them with technical and managerial backstopping. Based in New York, IPPF was founded in 1952 as a non-governmental voluntary organization dedicated to family planning. IPPF is composed of member FP associations in 95 countries and provides grants to 88 associations (not all of which are members). The WHR office of IPPF, also founded in 1952, is composed of 39 members in 39 countries and provides grants to 33 associations. Although the WHR receives most of its income from IPPF, recently it has obtained funds from several other sources, including: the H.R. Hewlett Foundation, the Kellogg Foundation, USAID Regional Development Office/Caribbean, and the UNFPA.

The Regional Council of the WHR consists primarily of representatives from member organizations. The Council's primary functions are to set general policy guidelines, encourage the spread of FP programs, and assist member associations which already exist in the Region. The Regional Council meets at least once per year. Management of business, funds, property and affairs of the Corporation is vested in the Board of Directors of the Corporation, which is elected by the Regional Council. The Board of Directors usually meets four times per year. Between meetings, the affairs of the corporation are guided by the Standing Management Committee and by the Chairman of the Board of Directors. The day to day operations are managed by a small staff in the New York office consisting of the WHR Regional Director, assisted by the Director of Program Coordination, Program Advisor, Financial Analyst, Financial Controller, and Commodities Coordinator.

WHR will maintain a small office in Quito which will have operational responsibility for project execution within the private sector. The office will have two staff members: a Project Coordinator, to be hired internationally as a WHR employee, and an administrative aide

to be hired locally. The Coordinator will work closely with APROFE, CEMOPLAF, and CEPAR to assist in the institutional development of their respective organizations. The Coordinator will be able to draw on the staff in the New York office to help provide training and technical assistance. Also, through the WHR office, the Coordinator will have access to specialists and experts from member associations throughout the hemisphere.

WHR has ample experience in family planning activities throughout the LAC region, including more than 15 years of service in Ecuador. It is familiar with A.I.D. program and financial management requirements. The organization offers a strong technical and managerial staff in New York and an extensive network of high-level volunteers and competent professionals throughout the hemisphere available to assist this project. There is no question of WHR's institutional capability to serve as the ICEA for the project's private sector activities. The proposed administrative arrangements and the waiver justification are contained in Section IV below.

b. Association for the Welfare of the Ecuadorean Family (APROFE)

APROFE, initiated with IPPF assistance in 1965, is a legally chartered non-profit private organization. It is governed by an Executive Council which meets quarterly and a General Assembly which meets annually. The Executive Council is made up of five community leaders from various sectors who volunteer their time. All program activities are under the responsiblity of the Executive Director who has served in that capacity since APROFE's establishment.

With funds other than those to be provided by this project, APROFE operates a number of family planning activities (see p. 8 through 10). To manage these activities as well as to carry out the program planned with A.I.D. financing under this project, the Executive Director will be assisted by a small headquarters staff consisting of a Chief of Administration and Finance, a Chief of Education and Motivation, and a Chief of Community Services. A small secretarial and support staff of approximately six persons is available on a full-time basis.

The A.I.D project will enable APROFE to continue and expand the FP services and information activities it provides at its three ongoing clinics. To assist with program management, a clinic supervisor, working out of the Guayaquil clinic but responsible for assisting the Executive Director to monitor all three clinics, will be added to APROFE's staff. As discussed in the project description, a few additional staff will be hired to operate the clinics at the levels planned under the project. APROFE has sufficient experience in clinical activi-

ties to effectively absorb the new staff into their established organizational procedures. No major assistance will be necessary to overcome administrative problems. Since these three clinics are presently operational, there will be no start-up costs or problems. Accordingly, APROFE is not expected to encounter any major difficulties in continuing its clinical program under this project.

c. Medical Center for Family Planning and Orientation (CEMOPLAF)

Although CEMOPLAF was not legally registered with the MOH as a non-profit organization until 1974, its origin dates back to the establishment of FP clinics by the A.I.D. assisted Women's Medical Society of Ecuador in 1968. With further expansion of the FP clinics in the early 1970s, a group broke away from the Society and formed CEMOPLAF to assume control over these operations.

CEMOPLAF is headed by a President who, together with a full-time coordinator (who is also a lawyer and social worker), manages and directs CEMOPLAF's operations. The President is guided by a five member Central Committee which meets every two months. The members of the Central Committee are periodically elected by the General Assembly which meets twice yearly. The General Assembly is comprised of twenty-two dues paying members, most of whom are employees of CEMOPLAF. Thus, in some aspects, CEMOPLAF functions as a worker-owned cooperative.

To date, the organization has functioned well. Its staff is highly motivated and dedicated. CEMOPLAF now operates four clinics and a network of 35 associates (doctors and nurse midwives) who provide FP services. Its laboratory, opened in 1978 at is main clinic in Quito to do a variety of tests (pap smear, pregnancy, V.D., etc.), is not only self-sufficient but generates local income to finance other activities.

The staffing requirements for the establishment of the three additional clinics to be financed under the project are based on CEMOPLAF's actual operating experience. In order to help administer and manage the project, CEMOPLAF also will use A.I.D. funds to hire a full-time administrative aide and a part-time accountant. With these additions, together with the technical assistance and managerial guidance provided by WHR, USAID concludes that CEMOPLAF will have adequate institutional capability to carry out its responsibilities under the project. However, USAID is concerned that the limited make-up of CEMOPLAF's General Assembly may not be the most appropriate for attracting future Ecuadorean sources of financial support for its expanding program. WHR will review the organizational structure of CEMOPLAF and discuss possible modifications with its leaders.

d. Center for Promotion of Responsible Parenthood (CEPAR)

CEPAR was founded as a non-profit institution in 1978 by a group of professionals working in health, sex-education, family planning and population. The Pathfinder Fund has been CEPAR's principal provider of funds to date (over $60,000), and recently USAID contributed a small grant ($5,000). CEPAR's thirty members form a General Assembly which meets annually. It elects CEPAR's five member Board of Directors who serve two year terms. The Board of Directors meets monthly and plays an active role in overseeing the operations of CEPAR.

CEPAR's Executive Director is a physician who also serves as Director of an MOH center in Quito. She has worked on a volunteer basis to develop CEPAR, receiving minor reimbursement for professional services through the small USAID grant. Despite being available only half-time, she has been the prime mover of CEPAR's activities. CEPAR also has a Financial Administrator, an Information Director, and a Research Director, all of whom work on a half-time basis. This key staff of four half-time professionals is supported by a full-time secretary and messenger.

The four professional positions identified above will be funder under the project as regular half-time staff. The ability to offer regular salaries will enhance the Executive Director's capacity to obtain the active participation and help ensure staff continuity. In addition, the project will fund a full-time administrator to function as CEPAR's project manager. This administrator will receive on the job training and technical assistance under the WHR contract. The secretarial staff will be increased to three full-time positions.

CEPAR is the youngest of the private sector entities to be supported by the project. Nevertheless, it has proven to be operated by energetic and dedicated people who are already familiar with working with the sensitive public information and education field of family planning. A significant expansion in CEPAR's activities is planned, and the organization undoubtedly will mature during the course of project implementation. The institutional requirements have been identified and are provided for within the project design. Accordingly, USAID concludes that CEPAR will be able to effectively execute its responsibilities under the project.

C. Social Soundness Analysis

1. Target Population and Beneficiaries

In 1981, there are approximately 1.1 million females at risk in Ecuador. Of these, it is estimated that only about 20 percent or 220,000 women are currently using some form of contraception. In 1985, the number of women at risk will have increased to approximately 1.3 million. Through the efforts of this project, approximately 31 percent or 398,900 women at risk will be practicing family planning in 1985.* Within this group, the service programs of this project will mainly concentrate on reaching poor women, heretofore a largely by-passed group in the development process. By improving Ecuadorean women's ability to control their fertility, it is expected that other areas of their lives will also improve, i.e., employment opportunities, health, education, leisure and family life. In addition, this project will reach an even broader target group with family planning IE&C programs. Most men and women aged 15-49 in Ecuador are in need of some FP information, whether it is motivational information or information relating where to secure services. Approximately 3.8 million persons make up the target group for information programs.

2. Socio-cultural Feasibility

Over time, demand for FP information and services has been increasing in Ecuador as the preference for large families continues to diminish. Attitudinal changes have had a significant impact on the desire for smaller families among a growing segment of the Ecuadorean population. These attitudinal changes are reflected in greater receptivity to external influences (both national and international), less rigid religious beliefs, and a broader concept of family welfare giving greater importance to the well-being of the children.

Studies indicate that large families among low-income groups in Ecuador are more the result of ignorance, "machista" attitudes, and/or non-availability of services than choice to have such families.** Yet, even among these groups, a growing demand for and use of FP services has been observed. Among the women residing in a poor "suburbio" of Guayaquil,

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* See Projected Annual Active Users on page 24 of this PP.

** Scrimshaw, Susan, Culture, Environment and Family Size: A Study of Urban In-migrants in Guayaquil, Ecuador. 1974.

41 percent were users of some form of contraception and nearly half had actually tried to prevent pregnancy. Similarly, 77 percent of the women and 60 percent of the men interviewed in various "suburbios" of Guayaquil declared that the ideal family size consisted of three or less children. Yet, the average number of completed pregnancies was seven and the average number of children was five, two more than the stated maximum ideal number.* In rural Ecuador, 47 percent of the mothers interviewed in a MOH study declared their willingness to plan their families; along the coast, 66 percent of rural mothers expressed such a desire. This desire for smaller families is further substantiated by reported incidents of female infanticide especially in the rural sierra region.**

The project will respond to this demand for FP in a culturally sensitive and acceptable fashion. For example, factors such as "pudor", a traditional form of modesty among women, inhibits them from undergoing necessary pelvic examinations and engaging in open conversations about sexuality. This project has been designed to take into consideration such sensitivities by employing community members as FP promoters to facilitate open consultation on family planning matters and providing multiple service options from which women can select the method most appropriate to their individual needs and family circumstances. Through the provision of culturally sensitive services the number of satisfied users will increase and, by word of mouth, inform friends and family, thereby enhancing demand.

Furthermore, the service and IE&C activities will be coordinated closely with grassroots organizations such as women's groups, father's clubs, labor unions, agricultural cooperatives and community groups. Community leaders expressing the FP needs of their neighborhoods, will also play a key role in the project. By taking into account the user's perspective, less social tension will be created by the service activities supported by this project.

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* Scrimshaw. Migration, Urban-Living in the Family: A Study Among Residents in the Suburbios and Tugurios of Guayaquil, Ecuador. 1973. Also, Centro Latinoamericano de Demografía (CELADE). "Ecuador: Análisis de la Encuesta de Fecundidad Urbana y Rural Realizada en el Año de 1966-68" by Pedro Merlo J. , December 1971. This study found the expressed ideal number of children to be 3.2 in Quito and Guayaquil, 3.9 in other urban areas, and 4.5 in rural areas.

** --Bonifaz, Emilio. "Los Indígenas de Altura del Ecuador". 1976
--Aguilo, Federico. "El Hombre del Chimborazo y su Mundo Interior". 1978.
--MOH, "Conocimientos, Actitudes y Prácticas en el Area Rural. 1977.

In summary, applied research and program experience suggests that a large percentage of Ecuadorean women want to limit their family size and have at least some knowledge of contraceptive methods, but find services either inaccessible (geographically, financially, etc.) or unacceptable (quality, style, etc.). When contraceptives are made available, Ecuadoreans respond, causing a minimal amount of social disruption because the service programs have, for the most part, been designed to take into account the values, beliefs, and social structure of the target population. Recipients of FP programs have generally perceived the services as beneficial to their health, family lives and economic conditions. Since all programs are voluntary, only those truly desiring FP services receive them.

3. Coverage through a Multi-institutional Approach

Ongoing Ecuadorean family planning programs and numerous research studies have demonstrated the socio-cultural acceptability of FP services.* At this time in Ecuador it is important to expand the coverage so that a larger number of active users can be reached. As more Ecuadoreans practice FP, national leaders and politicians will view support for FP as less of a political liability, and increased public support and demand for FP will encourage greater amounts of public funding to be allocated to FP programs. This scenario has occurred in numerous LAC countries where pro-family planning constituencies have made their voices heard.

In Ecuador, there are a number of FP providers, each with their relative advantage in reaching particular subpopulations (constituencies):

- The MOH health program, by increasing its delivery of FP services, will benefit the poor populations living within a reasonable distance of one of the 557 existing MOH centers, subcenters or health posts. At this time, the MOH serves mainly urban areas and conentrated rural populations, leaving a significant portion of the dispersed rural poor without accessible service.

- The MOD program will benefit mainly military personnel in frontier posts. Some contiguous civilian populations will be served. The majority of military personnel are of poor rural background.

- The IESS/MP activities will benefit its affiliates, mainly middle and low-income groups working in the urban industrial sector.

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* See sub-project descriptions of service organizations and studies cited previously in this PP.

- The IESS/Campesino program will benefit poor campesinos who have become affiliates.

- APROFE programs will benefit mainly the poor and middle classes of Guayaquil and poor rural populations in Esmeraldas, Guayas, Los Ríos and Manabí provinces.

- CEMOPLAF's program will concentrate on serving low-income urban women through its ongoing clinical programs in Quito, Quevedo, Santo Domingo, and its new clinics in Guasmo, Esmeraldas and Tulcán to be funded under this project.

- The commercial sector, now mainly serving the urban middle class with its higher priced brand contraceptives, will also, through the efforts of this project benefit the urban poor with other less expensive, but equally effective brands.

As this project progresses, the many pro-family planning constituencies will be united into a larger united coalition. Within the LAC context, Ecuador is considered to be only beginning this evolutionary process.

D. Economic Analysis

This section addresses (1) the macroeconomic benefits to society and the microeconomic benefits to family units of a decrease in Ecuador's population growth rate; and (2) the cost-effectiveness of the delivery systems of the two private sector service organizations, APROFE and CEMOPLAF. Cost-effectiveness analyses have been performed for APROFE and CEMOPLAF given the availability of information required to do the necessary calculations. Data on method mix and program costs for public sector service programs were not available.*

Macroeconomic Benefits

Ecuador's inability to provide for the basic human needs of its people is largely a function of its rapid population growth. The majority of Ecuadoreans live without adequate housing, clothing, food, and health and educational services. An improvement in these quality of life indicators is made difficult under present demographic trends. Based on demographic trend projections made by INEC, Ecuador will have a population greater than 15 million by the year 2000.**

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* To have calculated FP program costs of the MOH, MOD, IESS/MP and IESS/Campesino would have yielded results limited in value given the nature of the assumptions that would have had to be made to separate the costs of FP services from the overall costs of health care delivery. The FP services are provided as an integral part of the health programs of the government institutions receiving funding under this project.

** INEC, Población, Proyecciones de Provincias Rurales y Areas Urbanas en Ecuador, 1978.

The magnitude of the social and economic demands of this population is illustrated by the following estimates: (1) primary school enrollment will increase from 1.4 to 3.0 million children between 1979 and 2000, secondary school students will increase from 521,000 to 1.4 million, and university students will increase from 168,000 to 590,000; (2) an additional 2.9 million jobs will be required to provide employment for a labor force of 5.2 million; (3) housing and essential services will be required for an additional 7.9 million people; and (4) the number of non-producers, of societal dependents, will grow from 5.6 million to 10.9 million.* Based on these estimates, an investment of $428.3 million to construct and equip primary schools, $8.1 billion to provide 1.5 million additional houses, $13.9 billion in productive investment to reach full employment, and $9.6 billion to provide for society's non-producers will be required through the year 2000.**

A decrease in Ecuador's population growth rate will reduce these investment demands. Assuming a decline in the population growth rate to 2.7 percent by the year 2000, $123 million in school construction and equipment, $2.8 billion in housing costs and $1.9 billion in support of dependents will be available for investment in other sectors. Moreover, present levels of un- and underemployment (estimated at 50 percent by CONADE) indicate a decreasing per capita income given a continuation of Ecuador's high rate of population growth. In contrast, achievement of a 2.7 percent population growth rate by the year 2000 would result in a 24 percent increase in per capita income.***

Microeconomic Benefits

An inverse relationship exists between family income and family size. It is a documented fact that poorer families in Ecuador have more children. A recent USAID study, for example, indicates that lower income groups have a higher median number of children: 4.23 per family among the urban sierra poor, 4.84 among the urban coastal poor,

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* INEC, National Census, 1974. Non-producers or dependents are defined by the Ecuadorean Census as outside of the "labor force" and include mainly children, elders and the majority of women. The estimated number of dependents is based on the assumption that the percentage of the total population comprised of this group remains constant at the 1974 level of 67 percent. This, in turn, is based on the latest national census carried out in 1974.

** The $9.6 billion estimate is based on the observation that, on the average, a dependent consumed $876 in 1979.

*** Based on CONADE, Ecuador: Estrategia de Desarrollo, 1979. Increase in per capita income is based on a GNP projection of $30.6 billion in the year 2000.

and 5.07 among the rural poor.* The correlation that exists between these two factors indicates a reinforcing cycle of large families and poverty. To break this cycle with income raising and/or family planning interventions would result in the improvement of the socio-economic well-being of the family. In particular, the reduced fertility of the mother enables her to devote more time to productive activities and less time on child care responsibilities. The USAID study cited above reports that 53 percent of the women surveyed declared that because of economic reasons (household finances), it was not a good idea to have too many children. Furthermore, 68 percent in the coastal region and 47 percent in the sierra expressed a willingness to plan their families.

Some simple assumptions make it possible to obtain a rough estimate of the actual cost of each additional child to the average family. The 1975 Urban Areas Survey indicated the average annual expenditure per household in Ecuador's cities to be $3,626.** Dividing this average by the number of members of each household results in an average per capita expenditure of $1,813 for a family of two, $1,209 for a family of three, $907 for a family of four, and so on. If it is assumed that a child from birth to age 15 consumes 7.5 times the average adult consumption levels then, on the average, for the 15 years, an extra child "costs" one-half the present per capita adult consumption per year.*** In Ecuador, this means that the cost of raising an extra child is roughly $907 annually.****

In addition to the income savings to families of fewer children, economic benefits will be realized from lower "costs" of obtaining FP services as a result of this project. For example, it is estimated that the opportunity cost of a woman taking a day off from her daily chores to obtain such services is at least equal to a day's pay or

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* Luzuriaga, "Situación de la Mujer en el Ecuador", April 1980, Quito.

** INEC, Survey of Household Finances, Area Urbana, 1975.

*** Based on American Public Health Association, "A Study of Economic Evaluation Procedures for Population-Related Projects", November 1979. This study assumes that a child aged 0 to 4 consumes roughly one-quarter the average level of adults: children aged 5 to 9, about one-half; and children aged 10 to 14, about three-quarters. These relationships imply that a child from birth to age 15 consumes 7.5 times the average present adult consumption levels.

**** Based on INEC Household Surveys, 1975.

$7.30 at the present minimum wage.* Since services will be more readily accessible through the delivery expansion planned under this project, the opportunity cost of obtaining them will be reduced. Further more, since more services will be made available at nominal fees or free-of-charge, acceptors now acquiring services from high cost commercial or private sources will pay less to obtain them. This service savings can range from four to five dollars for a visit with a private practitioner to 40 to 50 dollars for the insertion of an IUD at a private clinic.

Cost-Effectiveness of APROFE and CEMOPLAF

The cost-effectiveness of APROFE's and CEMOPLAF's FP service programs is measured by the cost per unit of output under each program. Output, in turn, is measured by the magnitude of specific units of the services generated, i.e., the number of IUD's inserted, pills and condoms administered, etc. Measurement of these direct, "intermediate" outputs serves as a proxy for the number of births averted.** All of these service outputs are combined into a single output measurement called the couple years of protection (CYP) index. The concept of the CYP index was developed specifically as a way of combining various contraceptive services generated into a standardized measure of practice.

Using this approach, the costs of a CYP to APROFE, through its ongoing clinics, and to CEMOPLAF, through its new clinics, in 1985 are $5.90 and $10.63, respectively. These costs are based on the calculations and assumptions shown in Tables V and VI. To USAID's knowledge, APROFE operates the least-cost clinical services program in Ecuador.*** In

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* Although $7.30 is the official minimum wage in Ecuador, daily wages vary according to the nature of the job and whether it is rural or urban based.

** It is this output, births averted, we are really interested in and from which the final benefits flow. However, quantifying the number of births averted is a difficult process based on questionable assumptions. Furthermore, for the purposes of this analysis, measurement of the specific services delivered is relevant and methodologically sound since it enables us to evaluate each program's operational efficiency in terms of delivery of specific outputs relative to quantifiable specific inputs.

*** APROFE's well-respected program was developed over 15 years of service to low-income populations. Operating as a non-profit organization, APROFE receives financial and technical assistance from international donors, especially IPPF, to improve and expand its service capabilities. During the life of this project, APROFE will request technical assistance from IPPF to make its clinical programs even more cost-effective.

Table V

Cost of CYP to APROFE[1/]

A.	(1) Acceptors by Method[2/]		(2) CYP Index[3/]	(3) CYP[4/]	(4) Annual Frequency of Use/Method to Produce One CYP[5/]	(5) Unit Cost/Method[6/]	(6) Contraceptive Cost/CYP[7/]
1. New	(IUD)	4,400	3	13,200	1	$ .20	$ 2,640
	(Orals)	3,500	2	7,000	13	.50	45,500
	(Barrier Methods)	2,100	1	2,100	100	.04	8,400
	Subtotal			22,300			56,540
2. Continuing	(IUD)	11,300	1.5	16.950	1	$ .20	$ 3,390
	(Orals)	10,800	.7	7.560	13	.50	49,140
	(Barrier Methods)	3,000	.5	1,500	100	.04	6,000
	Subtotal			26,010			$ 58,530
	TOTAL			48,310			$ 115,070

B. Cost/CYP = Total program costs (Contraceptive + Operating) ÷ Total CYP

= $ 115,070 + $ 170,200 ÷ 48,310

= $ 285,270 ÷ 48,310

= $ 5.90

1/ APROFE administers the most cost-effective clinical delivery program in Ecuador today. Given 15 years of improving its service delivery and the fact that APROFE does not have to pay rent for any of its clinics minimizes its start-up and operating costs under the project.

2/ Method mix observed in 1981 (44 percent IUDs, 35 percent orals, 21 percent barrier methods) is assumed to be the same in 1985 and the same among new, as well as continuing users.

3/ Based on findings of a 1979 A.I.D. Study in Guatemala, the assumed couple-years of use of the IUD is three years; the pill, two years; and barrier methods, one year.

4/ Total CYP is equal to column (1) times column (2).

5/ Based on Guatemala findings cited above, it requires one IUD inserted, 13 oral pill cycles distributed, and 100 condoms distributed to result in one CYP using each method.

6/ 1981 prices used.

7/ (6) = (3) x (4) x (5)

8/ The CYP Index varies between new and continuing users and between clinical and community-based distribution (CBD) programs. Based on Guatemala results, the assumed couple-years of use of continuing acceptors and acceptors reached by CBD programs is less. This

Table VI

Cost of CYP to CEMOPLAF[1/]

A. Acceptors by Method[2/]		CYP Index	CYP	Annual Frequency of Use/Method to Produce One CYP	Unit Cost/Method	Contraceptive Cost/CYP
1. New (IUD)	2,800	3	8,400	1	$ .20	$ 1,680
(Orals)	1,500	2	3,000	13	.50	19,500
(Barrier Methods)	800	1	800	100	.04	3,200
Subtotal			12,200			24,380
2. Continuing (IUD)	1,700	1.5	2,550	1	$ .20	$ 510
(Orals)	900	.7	630	13	.50	4,095
(Barrier Methods)	500	.5	250	100	.04	1,000
Subtotal			3,430			$ 5,605
TOTAL			15,630			$ 29,985

B. Cost/CYP = Total program costs (Contraceptive + Operating) ÷ Total CYP
= $ 29,985 + $ 136,200[3/] ÷ 15,630
= $ 166,185 ÷ 15,630
= $ 10.63

1/ CEMOPLAF, unlike APROFE, will have high start-up costs since new clinics will be financed under this project. Also, CEMOPLAF's new clinics will be operating in lower volume service areas.

2/ Method mix projected by CEMOPLAF during life of project: 55 percent IUDs, 30 percent orals, 15 percent barrier methods.

3/ Projected costs of operating CEMOPLAF's new clinical programs in 1985.

addition, in comparison to clinical FP delivery services in other Latin American countries, APROFE's cost per CYP is competitive with other well-respected programs. Under this project, APROFE's cost per CYP will serve as a standard for evaluating the cost-effectiveness of other Ecuadorean clinical programs. However, it should be noted that costs per CYP of other programs, e.g., CEMOPLAF's new clinics, will be higher because of start-up costs and lower initial volume of acceptors.

E. Financial Analysis and Plan

The total cost of activities to be financed under this project is $10,870,000, of which the A.I.D. grant will contribute $5,600,000 (51.5 percent) and the GOE and private sector organizations will provide $3,800,000 (35 percent) and $1,470,000 (14 percent), respectively. The public sector component totals $6,010,000 or 55 percent of the project and the private sector accounts for the remaining $4,860,000 or 45 percent.

1. A.I.D. Contribution

The A.I.D. financial support will provide for the costs of: training ($350,000); technical assistance ($260,000); commodities ($380,000); personnel support ($880,000); administrative and logistic support and research ($2,980,000). The balance is for a ten percent contingency and inflation factor. Estimated foreign exchange and local currency costs are approximately $1,200,000 and $4,400,000, respectively.

Obligations are scheduled under the project as follows: FY 1981, $215,000; FY 1982, $1,250,000; FY 1983, $1,350,000; FY 1984, $1,500,000; and FY 1985, $1,285,000. The estimated obligation schedule is based on the premise that first quarter obligations beginning with FY 1982 will be adequate to cover the estimated disbursements for the calendar year. For example, the obligations to be made from October to December of 1981 will be expended during calendar year 1982 and thereafter throughout the project. The estimated disbursement of A.I.D. funds by calendar year is shown in the Table VII. *

2. GOE Contribution and Recurring Cost Analysis

The GOE counterpart ($3,800,000) is 63.2 percent of total costs of the public sector portion of the project. Counterpart costs include the following types of expenditures to be incurred by the five public sector institutions:

- salaries, travel and per diem of employees receiving training;

- salaries of administrative personnel lending direct support to particular activities funded under this project;

* Annex VIII outlines the contraceptive requirements for the life of the project (estimated at $ 2.21 million). These contraceptives will be provided through AID regionally funded contracts. However, during the life of the project USAID will engage the GOE in discussions about assuming all or part of the contraceptive costs beginning in 1985 or earlier if possible.

TABLE VII

Estimated A.I.D. Disbursement Schedule
(U.S.$000)

	1981	1982	1983	1984	1985	TOTAL
Public Sector						
MOH	57.0	124.0	251.0	183.0	100.5	715.5
MOD	-	187.0	77.4	62.8	51.5	378.7
IESS/MP	-	87.3	45.1	15.2	11.9	159.5
IESS/Campesino	-	98.5	71.0	35.8	34.0	239.3
CONADE	-	25.0	40.0	35.0	28.0	124.0
INEC	-	140.8	93.4	-	-	234.2
Training/Coordination Advisor	-	40.0	40.0	40.0	40.0	160.0
Contingency/Inflation	-	-	57.8	69.3	71.7	198.8
Subtotal	57.0	700.6	675.7	439.1	337.6	2,210.0
Private Sector						
APROFE	-	89.3	163.1	166.9	170.2	589.5
CEMOPLAF	44.2	98.7	129.9	136.9	136.2	545.9
CEPAR	51.4	128.1	134.9	117.2	119.9	551.5
Retail Sales	-	-	-	350.0	100.0	450.0
ICEA	62.4	208.8	163.0	131.7	140.0	705.9
*Contingency/Inflation	-	24.5	83.4	158.2	281.1	547.2
Subtotal	158.0	549.4	674.3	1,060.9	947.4	3,390.0
TOTAL	215.0	1,250.0	1,350.0	1,500.0	1,285.0	5,600.0

* Applies to in-country program costs and ICEA, Quito office.

MINISTRY OF HEALTH (MOH)

ANNUAL BUDGET BY CATEGORIES (IN US$)

	1981	1982	1983	1984	1985	Total
1. Personnel	43,600	111,400	222,100	157,550	93,950	628,600
2. Training Abroad	8,400	7,600	3,700	10,200	2,100	32,000
3. Audividual equip.	5,000	5,000	10,000	-0-	-0-	20,000
4. Publications	-0-	-0-	8,700	8,750	4,450	21,900
5. Evaluations	-0-	-0-	6,500	6,500	-0-	13,000
TOTAL	57,000	124,000	251,000	183,000	100,500	715,500

MINISTRY OF DEFENCE (MOD)

ANNUAL BUDGET BY CATEGORIES (IN US$)

	1982	1983	1984	1985	
1. Technical Assistance	20,000	-0-	6,000	5,000	31,000
2. In-country Training	15,730	6,574	6,587	6,559	35,450
3. Training Abroad	4,655	4,666	4,668	11*	14,000
4. Supervision and Promotion	7,670	7,670	7,670	7,670	30,680
5. Equipment **	61,800	-0-	-0-	8,000	69,800
6. IEC Materials	15,000	15,000	10,000	15,000	55,000
7. Personnel	62,145	43,490	27,875	9,260	142,770
Total	187,000	77,400	62,800	51,500	378,700

* For rounding purposes only.

** List attached

ECUADOREAN INSTITUTE OF SOCIAL SECURITY

PREVENTIVE MEDICINE

ANNUAL BUDGET BY CATEGORIES (IN US$)

	1982	1983	1984	1985	
1. In-country Training	19,385	9,975	9,800	10,100	49,260
2. Training Abroad	21,375	9,225	5,400	1,800	37,800
3. Equipment*	19,540	7,900	-0-	-0-	27,440
4. IEC Materials	27,000	18,000	-0-	-0-	45,000
Total	87,300	45,100	15,200	11,900	159,500

SEGURO CAMPESINO

	1982	1983	1984	1985	
1. In-country Training	30,070	44,030	20,200	20,200	114,500
2. Equipment-Vehicles*	18,000	18,000	-0-	-0-	36,000
3. Clinical and Lab.*	46,430	6,970	13,600	13,800	80,800
4. Audio Visual*	4,000	2,000	2,000	-0-	8,000
Total	98,500	71,000	35,800	34,000	239,300

* List attached

NATIONAL DEVELOPMENT COUNCIL (CONADE)

ANNUAL BUDGET BY CATEGORIES (IN US$)

	1982	1983	1984	1985	TOTAL
1. Research Studies	8,000	27,500	15,200	10,300	61,000
2. In-country Training	-	3,000	1,500	1,000	5,500
3. Training abroad	4,000	4,000	10,800	11,700	30,500
4. Personnel	10,000	-	-	-	10,000
5. Office equipment*	-	3,500	3,000	-	6,500
6. Office materials	-	1,500	1,500	1,500	4,500
7. Publications	1,000	500	1,000	3,500	6,000
TOTAL	23,000	40,000	33,000	28,000	124,000

* Commodities will be purchased locally. Therefore, no description is prepared.

NATIONAL INSTITUTE OF STATISTICS (INEC)

ANNUAL BUDGET BY CATEGORIES

	1982	1983	1984	1985	TOTAL
1. Technical Assistance	-	25,000	5,000	-	30,000
2. Personnel	-	50,900	49,200	-	100,100
3. Supplies	-	25,600	16,500	-	42,100
4. Field operations	-	24,300	6,800	-	31,100
5. Miscellaneous	-	15,000	15,900	-	30,900
TOTAL	-	140,800	93,400	-	234,200

- Equipment costs US$15,000 will be bought with central funds.

ASSOCIATION FOR THE WELFARE OF THE ECUADOREAN FAMILY

(APROFE)

ANNUAL BUDGET BY CATEGORIES (IN US$)

	1982	1983	1984	1985	Total
1. Personnel	76,220	148,930	153,230	160,040	538,420
2. Clinical Supplies	2,240	3,300	2,900	1,070	9,510*
3. Operational Expenses	10,840	10,870	10,770	9,090	41,570
TOTAL	89,300	163,100	166,900	170,200	589,500

* Clinic supplies, instruments and cytology materials for 8 years of clinical services to be bought locally.

MEDICAL CENTER FOR FAMILY PLANNING AND ORIENTATION

(CEMOPLAF)

ANNUAL BUDGET BY CATEGORIES (IN US$)

	1981	1982	1983	1984	1985	Total
1. Personnel	10,000	43,700	61,500	79,600	84,930	279,730
2. Equipment	13,500	16,300	19,000	8,250	8,250	65,300
3. Rent/Renovation	12,960	22,660	17,960	7,550	420	61,550
4. Administrative Support	7,740	14,800	26,000	32,850	30,200	111,590
5. Evaluations	-0-	1,240	5,440	8,650	12,400	27,730
TOTAL	44,200	98,700	129,900	136,900	136,200	545,900

* Equipment to be purchased by ICEA.

Commodities List:

	Amount
- 3 Medical equipment for FP services	9,890.00
- 3 Office equipment for clinics (desks, file cabinets, etc.)	5,670.00
- 3 Audiovisual equipment for clinics (movie projectors, screens, slide	16,690.00
- 4 clinical supplies	33,050.00

CENTER FOR PROMOTION OF RESPONSIBLE PARENTHOOD

(CEPAR)

ANNUAL BUDGET BY CATEGORIES (IN US$)

	1981	1982	1983	1984	1985	Total
1. Personnel	11,830	44,200	46,600	48,900	49,600	201,130
2. Information	3,600	8,800	9,400	7,400	8,650	37,850
3. Training	610	6,800	12,700	4,400	6,660	31,170
4. Research	3,530	11,700	10,730	7,350	8,200	41,510
5. Administration	31,830	56,600	55,470	49,150	46,790	239,840
TOTAL	51,400	128,100	134,900	117,200	119,900	551,500

- Equipment to be purchased by ICEA or PVO locally.

Commodities List:

	Amounts
- Office equipment (desks, file cabinets, etc.)	7,100
- Adiovisual equipment (movie projectors, slide projects)	1,340
- Office supplies	5,300
TOTAL	13,740

MINISTRY OF HEALTH

COUNTERPART FINANCING

1. Personnel	
- Salaries of Training Teams 1/	
Quito Team (8 doctors, 4 nurses, 4 obstreticians, 8 auxiliary nurses)	134,200.00
Guayaquil Team (8 doctors, 4 nurses, 4 obstetricians, 8 auxiliary nurses)	62m000.00
- Trainees	
Per diem: 2,500 MOH personnel x $25/day x 10 days	625,000.00
Transportation: 2,500 MOH personnel	50,000.00
2. Operating Costs of Training Centers/ Satellites 2/	
- 2 centers in Quito x 4 yers. X $145,000/ yr. x 10	116,000.00
- 2 centers in Guayaquil x 2 yrs. x $145,000/yr. x 10	580,000.00
- 4 satellites in Quito x 4 yrs. x $16,000/yr. x 10	256,000.00
- 4 satellites in Guayaquil x 2yrs. x $16,000/yr. X 10	128,000.00
3. Logistic Support of University Offices	
- Quito Office: $2,250 x 4 yrs.	9,000.00
- Guayaquil Office: $2,250 x 2 yrs.	4,500.00
TOTAL	1,964,000.00

1/ GOE will gradually assume total costs of salaries over four year LOP, GOE will begin constributions to Quito team second year of project and to Guayaquil team third year of project.

2/ Partial operating costs for activities under this project equal 10% of total costs.

MINISTRY OF DEFENSE (MOD)

COUNTERPART FINANCING

1. Personnel	
- Salaries of Directors 1/	
5 x $1,500/mo. x 3 mos. x .25 (while in trng.	5,600
5 x $1,500/mo. x 48 mos. x .10 (admin. sup.)	36,000
- Salaries of Trainees	
115 doctors x $40/day x 5 days	23,000
63 paramedics x $20/day x 5 days	6,300
3 cytologists x $450/month x 3 months	4,000
- Salaries of New Staff (14 Auxiliary Nurses/6 Obstetricians) 2/	105,900
2. Logistic Support for Training Programs	
- 8 courses x $300/course	2,400
3. Equipment Operation/Maintenance	50,000
TOTAL	$233,200

1/ All figures rounded to nearest hundredth.
2/ MOD will gradually assume total costs of salaries over from year LOP, beginning in second year.

ECUADOREAN INSTITUTE OF SOCIAL SECURITY

PREVENTIVE MEDICINE

COUNTERPART FINANCING

1. Personnel

- Salaries of Trainees

68 doctors x $60/day x 8 days	32,600.00
10 nurses x $30/day x 8 days	2,400.00
96 paramedics x $30/day x 8 days	23,000.00
14 overseas trainees x $1,200/ months x 1.4 months	23,500.00

- Salaries of Project Administrators 1/

2 x $15,400/yr. x 4 yrs. x 40	49,300.00

2. Equipment Operation/Maintenance

- Vehicles 2/	45,800.00
- Audiovisual equipment	1,000.00
TOTAL	$ 177,600.00

1/ Project Administrators will lend 40% of their time to this project.

2/ Includes salaries of 2 chauffeurs x $4,800/yr. x 3 yrs.

ECUADOREAN INSTITUTE OF SOCIAL SECURITY

"SEGURO CAMPESINO"

COUNTERPART FINANCING

1. Personnel	
- Salaries of Trainers	
65 doctors x $50/day x 5 days	16,000.00
175 paramedics x $30/day x 5 days	26,300.00
2. Equipment Operation/Maintenance	
- Vehicles 1/	69,600.00
- Audiovisual equipment	16,300.00
3. Laboratory Equipment	3,000.00
4. Publicity Materials	114,500.00
TOTAL	245,700.00

1/ Includes salaries of 4 chauffeurs x $4,800/yr. x 3 yrs.

NATIONAL DEVELOPMENT COUNCIL (CONADE)

COUNTERPART FINANCING

1. Personnel	
- Salaries	
8 Professionals x $16,460/yr. x 4 yrs.	526,700.00
2. Office Logistic Support	
5 x $3,000/yr. x 4 yrs.	60,000.00
3. Equipment	9,600.00
TOTAL	596,300.00

NATIONAL INSTITUTE OF STATISTICS (INEC)

COUNTERPART FINANCING

1. Personnel

- Salaries

9 Professionals x $57,250/yr. x 3 yrs.	171,8000.00
145 Field staff x $5,550/yr. x 3 yrs. x 10 1/	241,400.00

2. Logistic Support

- Area Chief Level: 3 x $3000/yr. x 3 yrs.	27,000.00
- 145 x $1000/yr x 3 yrs. x 10	43,500.00
TOTAL	483,700.00

1/ Field staff will spend 10% of their time devoted to this project.

ASSOCIATION FOR THE WELFARE OF THE ECUADOREAN FAMILY

(APROFE)

COUNTERPART FINANCING

1.	Administrative Support	
	$61,500/yr. x 4 yrs.	246,000.00
2.	Training	20,000.00
3.	I.E & C. Activities	380,000.00
4.	Evaluation	12,000.00
5.	Commodities	89,200.00
6.	Service Income	189,850.00
	TOTAL	937,050.00

MEDICAL CENTER FOR FAMILY PLANNING AND ORIENTATION

(CEMOPLAF)

COUNTERPART FINANCING

1. Personnel	
- Salaries	
2 x $17,000/yr. x 4 yrs. x 50 1/	68,000.00
2. Office Logistics Support	
2 x $ 3,000/yr. x 4 yrs. x 50	12,000.00
3. Commodities	5,200.00
4. Service Income	70,120.00
TOTAL	155,320.00

1/ Project Director and Project Coordinator will devote 50% of their time to this project.

CENTER FOR PROMOTION OF RESPONSIBLE PARENTHOOD

(CEPAR)

COUNTERPART FINANCING

1. Logistic Support (processing/publishing)	40,000.00
2. Education Materials	10,500.00
3. Media Campaigns	135,000.00
4. Volunteer Professional Assistance	35,000.00
5. Members fees	2,400.00
TOTAL	222,900.00

- gradual assumption of total cost of salaries of new personnel hired as a result of this project:

- the FP related portion of operating costs and logistic support of centers, offices and physical plants to house the various project activities;

- operation and maintenance costs of equipment and vehicles;

- IE&C materials and supplies.

These costs do not include operating and investment costs of the related MOH, MOD and IESS health facilities of which the project funded FP activities are a part. Since the GOE's FP activities are fully integrated in health care programs, their operating and investment costs would likely be incurred even without this project. Consequently, the recurring costs due to the FP activities are minimal. The principal costs are related to the increased FP staff in MOH and MOD and the additional professionals assigned to the Population Division in CONADE. The added IESS personnel are all related to health service delivery and their positions are planned regardless of this project. Although INEC will add staff to carry out its subproject, they will be on a contract basis only for the time necessary to test a model in three demonstration areas. If the model proves successful, its implementation on a national scale may result in additional recurring costs, but some of these costs would be offset partially through cost savings resulting from improved operating efficiencies.

The additional salary costs of the MOH are for the 48 trainers that will be established collaboratively with the universities. These trainers will address MCH concerns as well as FP. The total annual costs of these trainers are estimated to be approximately $196,200 at the end of the project. As designed, the MOH will gradually assume these salary expenses over the life of the project. As more fully discussed in the Integrated Rural Health Delivery Project Paper, the MOH's share of the total GOE budget has been steadily increasing since 1970. Further, if the A.I.D. project is successful, it will generate even greater support for FP activities on the part of GOE authorities. Thus, USAID believes that it is reasonable to expect the MOH to be able to provide the resources necessary to support these trainers.

The increased FP staffing requirements resulting form the MOD subproject are for 14 FP promoters and six nurse midwives. The estimated annual cost of supporting these additional positions is $105,900. This represents a 1.5 percent increment over the health portion of the MOD budget for 1981. Given the high degree of MOD interest in and support for the subproject activity, USAID is confident that MOD will take the

necessary action to assure the continued availability of this level of funding.

The additional salary costs of the eight professional positions required for CONADE's Population Division are estimated at $131,680 annually. The UNFPA project to support CONADE's Population Division undoubtedly will add significantly to the priority assigned to this unit and thereby further assure its continued existence. Moreover, CONADE has over 600 employees and its 1981 budget is almost $5,000,000. If necessary, it seems likely that adjustments can be made within other units of CONADE to support the increased staffing needs of the Population Division. USAID believes that, given these factors, it is reasonable to expect that the level of recurring costs required for CONADE will be forthcoming.

The only other significant recurring costs to the GOE specific to FP activities may be for the procurement of contraceptives. During the life of the project it is planned that contraceptives will be furnished through A.I.D. supported international intermediaries. The value of this support will run about $140,000 annually. USAID recommends that such support continue indefinitely beyond the completion date of the project.

3. The Private Sector

The private sector organizations will contribute $1,315,270 (27 percent) of the total private sector budget. APROFE will contribute $937,050; CEMOPLAF $155,320; and CEPAR $222,900. Their contributions are divided mostly among the following components:

- administrative support for clinical operations
- salaries of personnel
- commodities, including all contraceptives
- service income generated for FP clients
- information, education and communication activities including mass media campaigns and publications.

The following provides a detailed financial analysis of each of the three service organizations.

a. APROFE

Recent management reviews by the UNFPA Needs Assessment team and IPPF indicate APROFE's planning, programming, budgeting and reporting are good and this organization has been successful in achieving or surpassing program goals. APROFE has a formalized accounting system with a chart of accounts adequate to perform project accounting. In view of the small size of the headquarters staff, the Finance Director performs all

the financial functions; and there is thus a lack of internal controls. This, however, is compensated for by the fact most payments are made by check requiring the signature of both the Executive Director and a Director. In addition, the Executive Director reviews the monthly bank account reconcilliations. Upon approval of the expanded program, APROFE intends to hire an additional accountant. Since APROFE is an IPPF affiliate, annual audits are required. Financial statements included herein for the years 1977-1979 have been compiled from the reports of the auditors, Peat Marwick and Mitchell and Co. The 1980 financial statements have not yet been audited. Comparative Profit and Loss and Balance Sheets are presented in Tables VIII and IX, respectively.

The major source of APROFE's income is received from international organizations. Local fund raising continues to be difficult because in Ecuador there is no tax exemption for donations to charitable organizations. Patient fees recover only 19 percent of total expenses. This is due in part to the fact that approximately 40 percent of the total expenses relate to a considerable training and IE&C activities. In the event of declining donations, APROFE could reduce these expenses and cover a greater portion (30 percent) of total expenses with patient fees. Although APROFE must rely on donations for carrying out operations, its success in managing these donations and designing projects in such a way so as to maintain a sound financial condition is evidenced in the financial statements.

APROFE's equity account as of year end 1980 is estimated to be approximately $100,000. Of this amount, approximately $11,000 represents accumulated fixed assets and $18,500 in marketable securities which are not available to finance current operations. Interest earned on marketable securities is credited directly to the provision for employees severance. Thus, there are adequate funds available to finance current operations, as reflected in the cash account.

APROFE's income increased from $192,000 in 1977 to $367,000 in 1980. Estimated income for 1981 is $485,000. This reveals a steady increase in donations based on solid performance. It should be noted that administrative expenses as a percent of total expenses have declined from 17.6 percent in 1977 to 15.9 percent in 1980 and are projected to be 13.5 percent for 1981. This further reveals the soundness of the organization and indicates that funds are being directed to proper purposes. Current income trends indicate that APROFE's proven performance can attract sufficient resources. With administrative expenses declining as a percentage of total expenses, they have the capability to retrench by reducing IE&C and training costs in the event of a decrease in donations.

b. CEMOPLAF

As a private, non-profit social service organization

TABLE VIII

APROFE

COMPARATIVE INCOME STATEMENTS

(US$)

	12/31/77	12/31/78	12/31/79	12/31/80
INCOME				
IPPF	167,078	187,258	232,976	249,442
SERVICE FEES	22,218	25,732	38,230	65,314
MISC. DONATIONS	1,364	5,905	9,391	26,738
ADVERTISING	1,389	740	- o -	- o -
SALE OF EQUIPT	- o -	- o -	9,424	- o -
AVS				7,684
IDRC				3,087
IFRP				15,613
Total Income	192,049	219,635	290,021	367,878
EXPENSES				
Operations:				
Clinics	80,578	89,083	110,320	131,237
Administration	35,032	39,653	47,784	55,893
IE&C	51,001	62,819	71,854	102,603
Training	305	9,142	6,216	34,677
Community Programs	3,495	13,378	15,249	23,913
Evaluation	- o -	1,722	2,989	3,134
Fund Collection	- o -	- o -	- o -	- o -
Supplies	4,223	5,167	- o -	- o -
Volunteers Program	3,894	2,927	- o -	- o -
Medical Collaboration	6,543	- o -	- o -	- o -
Women Programs	7,326	8,482	10,964	- o -
Sterilization Conf./Prog.	1,765	1,340	- o -	- o -
Depreciation	4,167	4,489	1,481	1,509
Total Expense	198,329	238,202	266,857	351,457
NET INCOME	(6,230)	(18,567)	23,164	16,421

TABLE IX

APROFE

COMPARATIVE BALANCE SHEETS

(US$)

	12/31/77	12/31/78	12/31/79	12/31/80
ASSETS				
CASH	62,608	38,775	52,683	85,206
ACCOUNTS RECEIVABLE	15	129	577	1,443
INVENTORIES	20,817	15,650	23,170	19,800
MARKETABLE SECURITIES	- o -	18,519	18,519	18,519
GUARANTEE DEPOSITS	167	167	834	834
Total Current Assets	83,607	73,240	95,783	125,802
PLANT & EQUIPT.	44,320	51,110	47,763	48,000
LESS ACCUM. DEPRECIATION	33,994	38,463	35,654	37,154
Net Plant & Equipt.	10,326	12,647	12,109	10,846
Prepaid Expenses	965	404	1,222	1,153
TOTAL ASSETS	94,898	86,291	109,116	137,801
LIABILITIES & EQUITY				
ACCOUNTS PAYABLE				
ACCRUED EXPENSES	1,136	8,067	3,490	12,629
RESERVE FOR SOCIAL BENEFITS	14,954	17,983	22,220	25,345
EQUITY	78,808	60,241	83,406	99,827
TOTAL LIABILITIES & EQUITY	94,898	86,291	109,116	137,801

which relies on donations from international donors, CEMOPLAF does not have a fixed annual budget. However, from 1978 to 1981 donations have increased steadily from Family Planning International Assistance (FPIA), and the $51,589 received in 1978 has grown to an approved 1981 budget of $90,542, an increase of more than 75 percent.

CEMOPLAF does not currently have a formalized accounting system with journals and Balance Sheet and Profit and Loss charts of accounts. Monthly bills are accumulated and costs are assigned to either FPIA or CEMOPLAF in the FPIA reimbursement voucher. Annual audits are not conducted. The minimal accounting that is done is performed by the headquarters secretary. There are inadequate internal controls in that the secretary performs the accounting, receives revenues, makes petty cash payments, and reconciles the bank account. The majority of payments however are made by check and require the signature of the President.

With the expansion of CEMOPLAF's clinics from four to seven under this project there will be a requirement to (1) install a formalized accounting system and publish periodic financial statements, (2) hire an accountant for the home office, and (3) conduct annual external audits. CEMOPLAF is receptive to this idea and it is planned that these expenses will be included as project costs. It is contemplated that the design and installation of an accounting system will be accomplished under the direction of IPPF/WHR, with annual audits required thereafter.

Comparative income statements for the period 1978-1980 follow. Income was derived from CEMOPLAF's records and expenses were taken from their report to FPIA. Currently 60 percent of income is donated by FPIA and 40 percent is generated by CEMOPLAF. FPIA donations are made on a costs reimburseable basis. Net income increased from $3,790 in 1978 to $9,228 in 1980. Based on current income trends, the annual audit is likely to reveal a respectable equity account.

c. CEPAR

CEPAR has not yet had sufficient funding levels necessary to develop formalized financial procedures and therefore does not have a formalized accounting system with a chart of accounts and specialized journals. Monthly expenditures are recorded in a general journal each for Pathfinder and A.I.D. funds. There are no balance sheet accounts, and the accompanying Income Statement reflects only the extent of financial information currently available. The Pathfinder portion of the Income statement was audited by Price, Waterhouse & Company. There is a significant internal control weakness in that checks are frequently made payable to and cashed by the Administrative/Finance Director, with corresponding payments made for expenses in cash. Although the documentation supporting cash disbursements appeared to be adequate, it is difficult to ascertain if the funds disbursed were effectively collected by the beneficiaries.

TABLE X

C E M O P L A F

COMPARATIVE INCOME STATEMENTS (UNAUDITED)

	1978	1979	1980
INCOME			
FPIA Donations	$ 51,589	$ 60,948	$ 76,577
CEMOPLAF	25,699	34,708	51,719
Total Income	$ 77,288	$ 95,656	$128,296
EXPENSES			
Salaries & Benefits	$ 52,246	$ 66,350	$ 88,776
Consultants	1,567	- o -	- o -
Travel	7,361	3,086	3,848
Equipment & Supplies	4,935	3,685	5,452
Other Direct Costs	7,389	18,462	20,992
Total Expenses	$73,498	$ 91,583	$119,068
NET INCOME	$ 3,790	$ 4,073	$ 9,228

TABLE XI

CEPAR

Income Statement (10/15/69 - 10/15/80)

(US$)

Income	
Pathfinder	38,520
A.I.D.	15,000
Total Income	53,520
Expenditures	
Salaries and Wages	16,388
Fringe Benefits	7,232
Fees for Investigation	6,776
General & Administrative	5,926
Travel	6,913
Commodities & Equipment	3,411
Purchased Services	4,441
Training	269
Total Expenditures	51,356
Fund Balance	2,164

With the significant expansion of CEPAR funding under this project, it will be necessary to install a formalized accounting system and publish periodic financial statements, conduct annual external audits, and create a division of internal controls by delegating certain financial monitoring functions to the project administrator.

4. Conclusion

In sum, the FP strategy outlined in this PP anticipates that a follow-on project will probably be necessary in the period 1985-90 to consolidate and further expand the efforts initiated in 1981-85. While any follow-on project would obviously depend on the progress made in the 1981-85 period, international sources of FP funding probably still will be necessary after 1985 to continue and to expand Ecuadorean FP programs.

In the public sector, continuation of further increases of Ecuadorean funding for FP programs after the project will depend largely on progress that can be made in the 1981-85 period to generate a positive population policy that will allocate additional GOE funds to these programs. The project is designed specifically to address these policy development needs; USAID is optimistic about the ability to make the necessary impact by the end of the project. In any event, it is possible to envision that GOE funding alone could continue FP programs at the operational levels obtained in 1985.

The private sector agencies (APROFE, CEMOPLAF, CEPAR) will not, and cannot, become financially self-sufficient in the period 1981-85 if they are to maintain the increased operations levels created under the project. Through the project, however, the private sector agencies will be substantially strengthened, coordination among them will be improved, and major linkages (both technical and financial) will be developed among all three private agencies and an international intermediary such as IPPF. By 1985, all three private agencies should be in a much better position to work together and to utilize funding and technical resources from the international intermediary system. Thus, if follow-on funding in the period 1985-90 is not provided directly by A.I.D., it is possible to envision intermediaries providing assistance to these private organizations so as to maintain the operational levels reached in 1985.

IV. PROJECT IMPLEMENTATION

A. Implementation Plan

1. Implementation Schedule

The project is scheduled for FY 1981 authorization with an initial A.I.D. obligation of $215,000. These funds will be obligated by the signing of the MOH subproject agreement and the agreement with the private sector Intermediate Coordinating/Executing Agency (ICEA) during the last quarter of FY 1981. The subproject agreements with the remaining public sector institutions will be signed during the first quarter of FY 1982. The schedule for the key project events and annual evaluations is shown below.

Event	Date
Project Authorization (AID/W)	July, 1981
MOH Agreement Signed (USAID)	August, 1981
Agreement with Intermediate Coordinating/ Executing Agency (ICEA) signed (USAID)	September, 1981
Agreement between MOH and DSB contractor for CPS signed (DSB)	September, 1981
ICEA Quito Office established (ICEA)	October, 1981
ICEA subagreements with APROFE, CEMOPLAF, and CEPAR signed (ICEA)	October, 1981
Training/Coordinating Advisor contracted (USAID)	November, 1981
Agreements with remaining public sector entities signed (USAID)	December, 1981
PIO/Cs for initial public sector procurement issued (USAID)	January, 1982
MOD short term advisor contracted (USAID)	February, 1982
Implementation Plan for CRS activity completed (DSB)	February, 1982
First Annual Review/Performance Evaluation	October, 1982

Funding arrangements completed between USAID and U.S. Public Health Service (VISTIM) for second year INEC subproject	November, 1982
Second Annual Review/Performance Evaluation	October, 1983
Third Annual Review/Performance Evaluation	October, 1984
Final Project Evaluation	November, 1985
Project Activity Completion Date	December, 1985

A summary workplan of each public sector institution, except CONADE and INEC, is shown in the following Table XIL. A time series analysis of CONADE's and INEC's activities would not prove valuable given the similarity of events of each from year to year during the life of the project. CONADE's major single ongoing activity to be funded under this project will be research; INEC's will be to improve the vital registration system. The key activities of each private sector agency are shown in Annex V, Exhibit G.

2. Administrative Arrangements and Procurement Plan

As indicated above, separate agreements will be signed with each public sector implementing entity. Each of these agreements will be processed through the normal CONADE procedures for reviewing technical assistance programs. While no substantive problems are anticipated, the procedural aspects are sometimes time consuming requiring close monitoring by each public sector entity with respect to its particular subproject.

Each of these agreements will be incrementally funded based on annual reviews of performance. Workplans will be prepared annually for USAID review and use in determining yearly funding requirements. USAID will undertake all imported procurement directly for the public sector implementing entities. Table XIII summarizes the principal equipment procurement planned by the public sector under the project.

USAID will directly contract a long term Training/Coordinating Advisor. The long term advisor will work directly with the USAID Population Officer to assist in implementing the public sector activities. Given the large amount of training to be carried out within the public sector subprojects, the major criterion upon which this advisor will be hired will be his/her technical capabilities to design, manage and evaluate in-service training programs. Secondary responsibilities will include providing assistance to the implementation and coordination of all other government activities. This advisor will be contracted for 48 person months and will be physically located in the USAID Office of Health and Population in Quito.

TABLE XII

Public Sector Workplan

(by year)

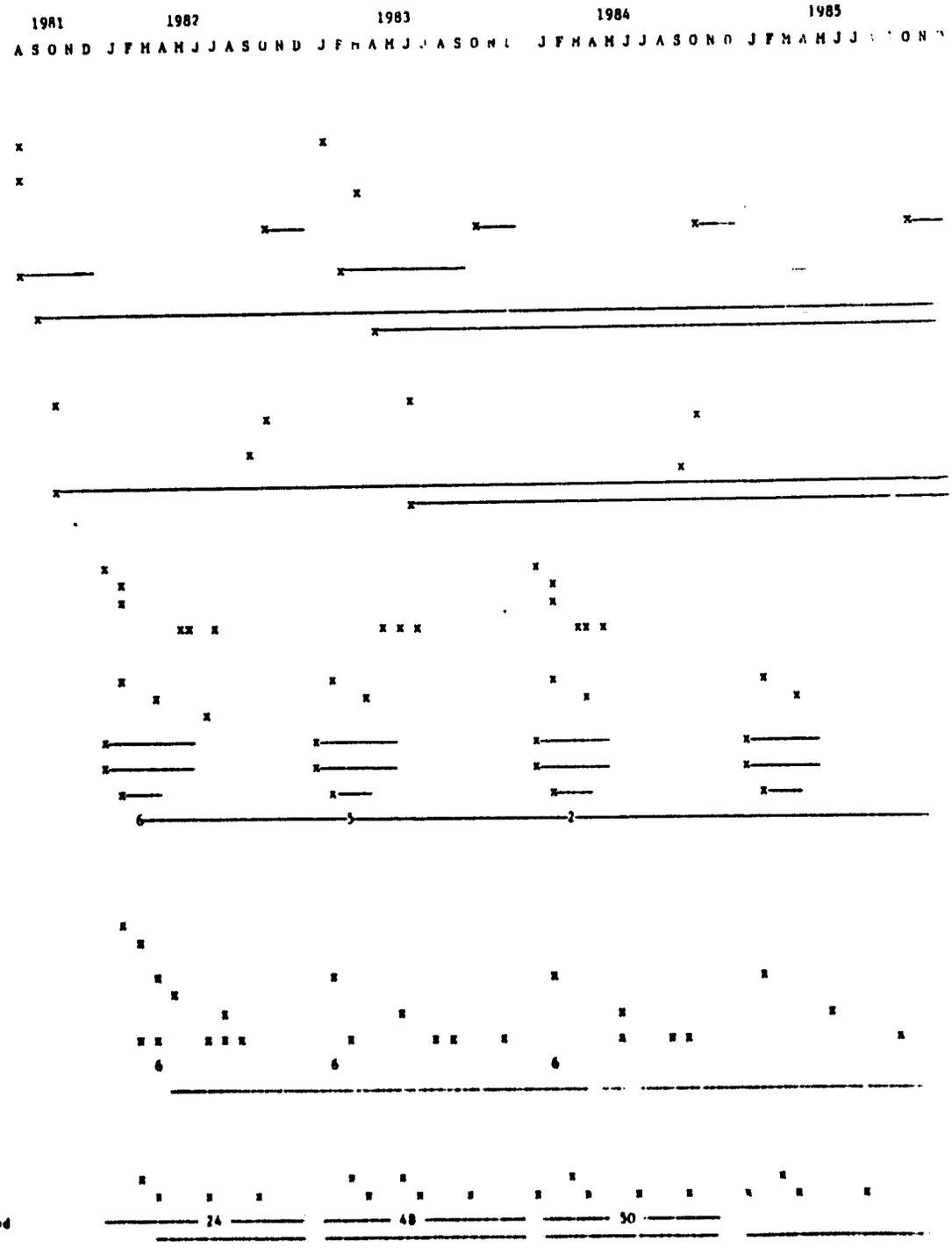

TABLE XIII

MAJOR PUBLIC SECTOR PROCUREMENT

ITEMS	MOH	MOD	IESS	INEC	CONADE	TOTAL
1. Audio-visual Equipment	$ 6,750 Movie projectors (5) 4,000 Slide projectors (5) 1,250 Overhead projectors (5) 1,250 Easels (5) 250	$ 5,000 Movie projectors (4) 3,200 Slide projectors (4) 1,000 Overhead projector (11) 200 Easels (4) 200 Movie screens (4) 400	$10,240 Movie projectors and spare parts (4) 3,900 Slide projectors (17) 3,640 Tape recorders (17) 1,700	--	--	$ 21,990
2. Vehicles	--	Utility vehicles (5) 40,000	Field vehicles (6) 53,200 Utility (5) 43,900 Van (1) 9,300	--	--	$105,600
3. Clinical and Laboratory Equipment and Materials	--	24,800 Microscope (4) 4,800 Medical kits (43) 15,000 Lab. supplies (micro slides, staining material, etc.) 5,000	80,800 Dry clave sterilizers (290) 24,650 Medical kits (histerometers, forceps, etc. (290) 51,330	--	--	$139,250
4. Other	Educational Mater. $13,250 Locally produced booklets, posters and publications 7,250 Imported training films, slides and teaching aids 6,000 $20,000	Educational Mater. 55,000 Locally produced booklets, posters and publications 33,000 Imported training films and slides 22,000 $124,800	Educational Mater. 53,000 Locally produced booklets and slides (10 titles) 40,000 Posters (6 themes) 2,000 Imported training films 11,000 $197,240	Office Equipment $15,000 Portable typewriters (120) 12,000 Desks, cabinets and files (5 each) 3,000 $15,000	Office Equipment $ 6,500 Desks and files (5 each) 2,000 Miscelaneous 4,500 $ 6,500	$ 21,500 $381,540

A short term advisor(s) will also be directly contracted to provide technical assistance exclusively to the MOD. The advisor(s) will be contracted at the beginning of the project for three person months to work closely with the MOD to upgrade its administrative capacity, expand its service delivery network, and implement and evaluate in-service training programs. Selection of the advisor(s) largely will be based on his/her technical knowledge and experience in administering and evaluating in-service training programs.

USAID will also arrange the technical assistance required from the U.S. Public Health Service (VISTIM) for the INEC subproject by either amending the existing DSB funded PASA or by entering into a separate PASA. International travel and training required under the project will be administered by USAID in accordance with normal A.I.D. procedures. Local currency costs (e.g., salaries, per diems, in-country travel, supplies, etc.) will be paid by establishing accounts with an initial advance for each public sector entity and subsequent reimbursements based on documentation of actual expenditures.

The Intermediary Coordinating/Executing Agency will assume responsibility for much of the administrative support required to implement the subprojects of the three private sector entities. The ICEA will enter into subagreements with APROFE, CEMOPLAF, and CEPAR which will describe each subproject objectives and how A.I.D. funds will be used. The ICEA will administer the disbursements to these entities for which an initial advance will be made. The advance will be periodically replenished by USAID based on presentation of documentation evidencing actual expenditures.

USAID plans on making direct procurement of the minor amount of imported equipment needed for the three private sector entities in order to facilitate the importation procedures. The principal items are medical equipment, clinical instruments and supplies, and audio-visual equipment. The total estimated costs of such items is only US$37,430. Thus, the additional administrative burden to USAID will be minimal.*

All contraceptive supplies will be provided through various population intermediaries and funded through DSB/POP. The sources of the specific contraceptive needs of each implementing agency providing FP services are as follows: Pathfinder Fund will supply the MOD and IESS/MP; FPIA will supply CEMOPLAF and IESS/Campesino; IPPF will meet APROFE's needs; and UNFPA will supply the MOH. All contraceptive methods, including surgical methods, offered will be used on a voluntary basis consistent with the requirements of A.I.D. Policy Determination 70.

3. Waivers

* Detailed equipment lists are shown on the following pages.

MINISTRY OF HEALTH (MOH)

COMMODITIES LIST AND DATE OF PURCHASE

Description	Quantity	Amount	Date of Purchase
- Audiovidual Equipment			
- Movie projectors	3 ea.	2,400	1981
- Slide projectors	3 ea.	750	1981
- Overhead projectors	3 ea.	750	1981
- Easels	3 ea.	150	1981
- Movie projectors	2 ea.	1,600	1983
- Slide projectors	2 ea.	500	1983
- Overhead projectors	2 ea.	500	1983
- Easels	2 ea.	100	1983
TOTAL		6,750	

MINISTRY OF DEFENSE (MOD)

COMMODITIES LIST AND DATE OF PURCHASE

Description	Quantity	Amount	Date of Purchase
- Utility vehicles	4 ea.	32,000	1982
- Medical Kits			
- Pan	43 ea.		
- Cover	43 ea.		
- Forceps, dressing, 5 1/2 "	43 ea.		
- Forceps, dressing (thumb), 10"	43 ea.		
- Forceps, tissue, std. pattern, 5 1/2"	43 ea.		
- Forceps, artery, Kelly, straight, 5 1/2"	86 ea.		
- Forceps, artery, Pean, straight, 6 1/4	86 ea.		
- Forceps, Rochester-Carmalt, curved, 8"	86 ea.		
- Forceps, mosquito, Hartman, curved, 3 1/2"	172 ea.		
- Forceps, sponge, Foerster, straight, 9 1/2	43 ea.		
- Forceps, intestinal tissue, Allis, 6"	86 ea.		
- Forceps, intestinal, Babcock, 8 1/2"	43 ea.		
- Forceps, (clamp), towel, Backhaus, 3 1/2"	172 ea.		
- Forceps, hemostatic, Rochester-Ochsner, curbed, 8"	86 ea.		
- Syringe, control,5cc	43 ea.		
- Syringe, control,10cc	43 ea.		
- Syringe, hypodermic, reusable, 5cc	172 ea.		
- Syringe, hypodermic, reusable, 10cc	172 ea.		
- Retractor, Thyroid, gree, 8 1/2"	86 ea.		
- Retractor, Richardson-Eastman, 10"	86 ea.		
- Retractor set, double-ended, U.S. Army	43 sets		
- Holder, needle, Collier, 5"	43 ea.		
- Holder, needle, Mayo-Hegar, 7"	43 ea.		
- Hook, Tubal, Ramathibodi	43 ea.		
- Needle, abdominal, Keith, traingular point, straight, 2 1/2"	43 doz.		
- Needle, catgut, Mayo, 1/2 circle, taper point, regular eye, size 6	43 doz.		
- Needle, surgeons, regular design, w/cutting edge, 1/2 circle,size 6	24 doz.		

Description	Quantity	Amount	Date of Purchase
- Needle, hypodermic, reusable, 22 gauge x 1/2"	43 doz.		
- Needle, hypodermic, reusable, 22 gauge x 1 1/2"	130 doz.		
- Needle, hypodermic, reusable, 25 gauge x 1/4	24 doz.		
- Scissors, Iris, Knapp, curved, 4"	43 ea.		
- Scissors, dissecting, Mayo, straight, 5 1/2"	43 ea.		
- Scissors, operating, std. pattern, straight, 4 1/2"	43 ea.		
- Scissors, operating, std. pattern, straight, 6"	43 ea.		
- Scissors, tonsil, Metzenbaum, 7"	43 ea.		
- Speculum, vaginal, Graves, medium	43 ea.		
- Handle, surgical knige, size #3	43 ea.		
- Blades, surgical, stainless steel, sterile, size #15	86 doz.		
- Catheter, urethral, female, #14 French	43 ea.		
- Ramathibodi uterine elevator	43 ea.		
- Bowl, sponge, 625 qt. capacity	43 ea.		
- Glass, medicine, 1 oz., with pouring lip	43 ea.		
- Gynecological tables and lamps	13 ea.	15,000	1982
- Microscopes	4 ea.	4,800	1982
- Movie projectors	4 ea.	3,200	1982
- Slide projectors	4 ea.	1,000	1982
- Overhead projectors	1 ea.	200	1982
- Easels	4 ea.	200	1982
- Movie Screens	4 ea.	400	1982
- Laboratory materials (micro slides, staining materails		5,000	1982
- Utility vehicle	1 ea.	8,000	1985
Total		69,800	

ECUADOREAN INSTITUTE OF SOCIAL SECURITY

A. Preventive Medicine Department (IESS/MP)

Description	Quantity	Amount	Date of Purchase
- Vehicle	1 ea.	9,300	1982
- Movie projectors and spare parts	4 ea.	3,900	1982
- Slide projectors	17 ea.	3,640	1982
- Tape recorders	17 ea.	1,700	1982
- Camera	2 ea.	1,000	1982
- Vehicle	1 ea.	7,900	1983
Total		27,440	

B. "Seguro Campesino" (IESS/SC)

Description	Quantity	Amount	Date of Purchase
- Vehicles	2 ea.	18,000	1982
- Clinical and Laboratory equipment:			
- Dri Clave sterilizers	168 ea.	14,280	1982
- Pan and cover	168 ea.	5,712	1982
- Forceps, uterine tenaculum, Braun	168 ea.	6,216	1982
- Jars	168 ea.	5,316	1982
- Speculum, vaginal, Graves	168 ea.	2,016	1982
- Speculum, vaginal, Graves	168 ea.	2,520	1982
- Histerometer	168 ea.	2,352	1982
- Forceps, sponge, Foerster	168 ea.	5,544	1982
- Cyto spray, cans	168 ea.	1,989	1982
- Microslides, boxes	50 ea.	425	1982
- Audio-visual materials:			
- Films 16 mm.	10 ea.	2,500	1982
- Set of slides	10 ea.	1,500	1982
- Vehicles	2 ea.	18,000	1983
- Clinical and Laboratory equipment: Same as for 1982 but for 24 clinics		6,970	1983

Description	Quantity	Amount	Date of Purchase
- Audio-visual materials:			
- Films 16 mm.	5 ea.	1,250	1983
- Sets of slides	5 ea.	750	1983
- Clinical and Laboratory equipment:			
Same as for 1982 but for 48 clinics		13,600	1984
- Audio-visual materials:			
- Films 16 mm.	5 ea.	1,250	1984
- Sets of Slides	5 ea.	750	1984
- Clinical and Laboratory equipment:			
Same as for 1982 but for 50 clinics		13,800	1985

Note: Costs for transportation is included.

APROFE
ASOCIACION PRO BIENESTAR
de la FAMILIA ECUATORIANA

Seis de Marzo No. 610 P. O. Box 5954 Cable: APROFE
GUAYAQUIL - ECUADOR

CONTRIBUCION DE ASOCIACION PRO BIENESTAR DE LA FAMILIA ECUATORIANA
PARA PROYECTO DE AUSPICIO DE SERVICIO CLINICO

DURANTE CUATRO AÑOS

	US$
- Aporte Administrativo	246.000,00
- Entrenamiento	20.000,00
- Información y Educación	380.000,00
- Evaluación	12.000,00
- Commoditics	89.200,00
- Cobros por Servicio	189.850,00
	937.050,00

Guayaquil, Junio 15 de 1981

Dr. Paolo Marmanni S.
DIRECTOR EJECUTIVO

Nationality Waiver US$ 191,000

The MOD subproject calls for short term third-country technical assistance (US$31,000) to improve the institution's administrative capability. Also, USAID will contract a Training/Coordinating Advisor to assist with the implementation of all the public sector subprojects, (US$160,000). USAID's preferred source of expertise for such consultants will be other Latin American countries. Qualified Latin American consultants are in fact available, they can be more effective than U.S. counterparts not only because of fluency in Spanish but also because they are normally more familiar with the bureaucratic and socio-cultural environments in which the subprojects will be implemented. Moreover, given the potential sensitivity of FP work in Ecuador, USAID prefers to minimize the use of U.S. consultants. Accordingly, USAID requests a nationality waiver be included in the project authorization to permit use of Latin American nationals as consultants under the project.

4. USAID Monitoring

This project will be monitored by USAID's Office of Health and Population. The project manager will be USAID's Population Officer, an Ecuadorean national. With respect to monitoring the public sector activities, the Population Officer will work closely with the Training/Coordinating Advisor. Between them, they will be able to perform the extensive in-country field travel necessary to evaluate public sector subproject achievements, identify problems and determine solutions to meet objectives.

USAID's Population Officer also will be able to draw heavily on the Project Coordinator provided by the Intermediary Coordinating/Executing Agency to obtain information on the performance of the private sector entities. They will meet twice monthly on a regular basis to

discuss subprojects' status. Additionally, the Population Officer will make regular site visits to APROFE's and CEMOPLAF's clinics and CEPAR's headquarters.

Periodically, USAID also will call on LAC/DR and DSB/POP technical personnel to help monitor project progress. The participation of such consultants will be particularly useful during the regular evaluations described in the following sections. Similarly, the centrally funded consultants, to be utilized from time to time in project implementation (e.g., Development Associates, Westinghouse Health Systems, etc.), will provide USAID with independent assessments of subproject performances.

The Population Officer's project monitoring tasks will be facilitated with the personnel assistance outlined above. Furthermore, each implementing agency (public and private) will be required to submit quarterly reports to USAID evaluating its subproject progress to date. These formal reports will be based on internal monthly reviews carried out by all organizations.

In summary, USAID monitoring of this comprehensive project has been carefully planned to include both written and personal contact, as well as formal and informal communication between USAID and all participating agencies. Furthermore, coordination among the public and private sector entities themselves will be encouraged through self-initiated workshops. The USAID Population Officer will be invited to these meetings as an observer.

B. Evaluation Plan

Periodic evaluations will be an important tool for USAID to measure project progress and to determine what modifications might be made in the project components. The evaluations will measure (1) progress toward the main objective of the project: to decrease the population growth rate so as to improve the quality of life of the majority of Ecuadoreans, and (2) the performance of the public and private sector implementing agencies.

Achievement of the project's objective will be evaluated by the published results of Ecuador's national fertility survey, the three contraceptive prevalence surveys to be carried out in 1981, 1983, 1985, and the increased flow of reliable statistical information generated by INEC, CONADE and CEPAR.

The performance of each of the implementing agencies will be evaluated by its success in meeting its projected annual number of active users during the life of the project. In sum, the projected number of annual active users to be reached by all the organizations is 258,300 in 1982; 301,300 in 1983; 349,000 in 1984; and 398,900 in 1985. (See Table II, Projected Annual Active Users, p. 24 of this PP, for a break down of targets by institution.).

In addition to evaluating the project for purposes of measuring project success, evaluation activities will serve the equally important purpose of monitoring the implementation of each subproject. Evaluation networks have been established and meetings have been planned over the life of this project for this purpose. Table XIV displays the focus and timing of the evaluations over the five years.

In addition to the annual user targets to be reached by each institution by the end of the project, successful implementation of the subprojects will be measured in 1985 as follows:

--MOH: 8,800 medical, nursing and nurse midwife students and 2,500 MOH personnel will be trained in MCH/FP services.

--MOD: 43 health clinics will be offering FP information and services.

--IESS/MP: 32 urban mobile brigades will be operating.

--IESS/Campesino: 290 rural health posts will be offering FP information and services.

--CONADE: The Population Division will be functioning and an official national population policy will either exist or be in the process of formulation.

--INEC: Improvement in the vital registration system will be completed and the system will provide a complete and reliable information base for use in GOE program planning and policy formulation.

--APROFE: All three clinics will have expanded their FP user coverage; the Quito clinic will be operating at least as efficiently as APROFE's "model" Guayaquil clinic.

--CEMOPLAF: Three new clinics will be established and operating on full-time schedules.

--CEPAR: Seven research studies will be completed; five national newspapers, three national magazines, and four radio and TV stations will be communicating population/FP information; and, government and political leaders will be better informed of multisectoral implications of Ecuador's high population growth rate.

--CRS: An active commercial retail sales program, affordable to low-income groups, will be operating nationwide.

The evaluation of the project will also include a reexamination of the FP method mix proposed herein, 12-18 months after initiation of the proje

TABLE XIV

TIMETABLE

Evaluation Schedule

	1982												1983												1984												1985											
	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
I. Public Sector																																																
Joint evaluation of public sector activities (USAID/MOH, MOD, IESS, INEC, CONADE). *										x												x												x														x
II. Private Sector																																																
Separate evaluations of CEMOPLAF and CEPAR activities (ICEA/CEMOPLAF, CEPAR).				x												x												x												x								
Separate evaluation of APROFE activities (ICEA/APROFE).**										x												x												x														x
Joint review of private sector activities (ICEA/USAID/APROFE, CEMOPLAF, CEPAR).										x												x												x														x
Independent consultant evaluation of private sector activities (ICEA).																		x																								x						

* In addition, USAID's Population Officer will request outside assistance in December 1981 to help the MOH develop evaluation criteria to assess the performance of the Training Centers.

** APROFE will be evaluated separately due to its delayed start-up date under this project. A.I.D. will assume financial responsibility for APROFE's clinics in May 1982. Until that time IPPF will continue to fund these clinics.

C. Conditions and Covenants

In addition to the standard conditions and covenants, the various project agreements will contain the following:

MOH

-- Before first disbursement, other than for procurement of imported equipment, the MOH shall present the detailed evaluation system it plans to use to assess the impact of the training activities to be financed under the project.

-- Before disbursement for training activities in Quito, other than for procurement of imported equipment, the MOH shall present:

(i) a signed agreement with the participating university;

(ii) evidence that the academic coordinating unit has been established; and

(iii) the first annual workplan for training activities.

-- Before disbursement for training activities in Guayaquil, other than for procurement of imported equipment, the MOH shall present:

(i) a signed agreement with the participating university;

(ii) evidence that the academic coordinating unit has been established; and

(iii) the first annual workplan for training activities.

-- There shall be a specific covenant that the MOH will establish training positions and provide financing for them in accordance with the phasing contemplated in the subproject.

MOD

-- There shall be a specific covenant that the MOD will establish the promoter and nurse midwife positions and will provide financing for them in accordance with the phasing contemplated in the subproject.

IESS

-- Before first disbursement, other than for procurement of imported equipment, IESS shall present a detailed in-service training plan for the auxiliary nurses under the Camp sino Program.

INEC

-- Before first disbursement, other than for imported equipment, INEC shall present evidence that arrangements for technical assistance have been made.

CONADE

-- Before first disbursement CONADE shall present evidence that the Population Division has been established and that a staffing plan adequate for carrying out the subproject has been approved by CONADE.

Intermediary Coordinating/Executing Agency

-- Prior to first disbursement, other than for imported equipment, the ICEA will name a project coordinator acceptable to USAID.

-- Prior to first disbursement for activities to be carried out by APROFE, CEMOPLAF, or CEPAR, the ICEA will present a first year workplan for the relevant institution.

-- Prior to the first disbursement for any CEMOPLAF activity, the ICEA shall present a plan approved by CEMOPLAF to improve CEMOPLAF's accounting system.

-- Prior to the first disbursement for any CEPAR activity, the ICEA shall present a plan approved by CEPAR to improve CEPAR's accounting system.

CERTIFICATION PURSUANT TO SECTION 611 (e) OF THE FOREIGN ASSISTANCE ACT OF 1961, AS AMENDED

I, John A. Sanbrailo, the Mission Director of the Agency for International Development in Ecuador, having taken into consideration among other factors, the maintenance and utilization of projects in Ecuador previously financed or assisted by the United States, do hereby certify that in my judgement Ecuador has the technical capability and the physical, financial, and human resources to utilize and maintain effectively the proposed grant of five million, six hundred thousand United States dollars ($5,600,000) from the Government of the United States of America to the Government of Ecuador for the development of an institutional capacity to plan and execute Population and Family Planning projects in a manner involving the active participation of the intended beneficiaries, including, among other things, the implementation of a project to strengthen and expand family planning information and service programs and improve the data analysis and population planning capability in the public and private sectors.

This judgement is based on the facts presented in the Project Paper and USAID's previous experience with the Ministries of Health and Defense, Ecuadorean Social Security Institute, National Development Council, National Institute of Statistics and Census, and the various private voluntary organizations - APROFE, CEMOPLAF and CEPAR.

John A. Sanbrailo

John A. Sanbrailo
Director, USAID Ecuador

June 15, 1981

ANNEX II

AID 1020-20 (11-78)
SUPPLEMENT 1

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Project Title & Number: Population and Family Planning - 518-0026

Life of Project:
From FY 81 to FY 85
Total U.S. Funding $5,600,000
Date Prepared: June 12, 1981

PAGE 1

NARRATIVE SUMMARY Program or Sector Goal: The broader objective to which this project contributes: (A-1)	OBJECTIVELY VERIFIABLE INDICATORS Measures of Goal Achievement: (A-2)	MEANS OF VERIFICATION (A-3)	IMPORTANT ASSUMPTIONS Assumptions for achieving goal targets: (A-4)
To decrease the population growth rate so as to improve the quality of life of the majority of Ecuadoreans.	1) Decrease in the birth rate..	1) Contraceptive Prevalence Survey (CPS) results.	1) The service delivery system will expand to meet demand.
	2) Greatly expanded utilization of FP services by 1985. (Target: 398,900 annual active users in 1985).	2) Vital Registration Statistics.	2) No major political opposition arises to thwart public and private sector FP activities.

AID 1020-20 (11-78)
SUPPLEMENT 1

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project: From FY 81 to FY 85
Total U.S. Funding $5,600,000
Date Prepared:

Project Title & Number: Population and Family Planning - 518-0026

NARRATIVE SUMMARY Project Purpose: (B-1)	OBJECTIVELY VERIFIABLE INDICATORS Conditions that will indicate purpose has been achieved: End-of-Project status. (B-2)	MEANS OF VERIFICATION (B-3)	IMPORTANT ASSUMPTIONS Assumptions for achieving purpose: (B-4)
To expand demand for and availability of family planning information and services to low income populations, and to assist in the formulation of a population policy.	1) Increased access to FP services by target populations of each institution.	1) -CPS. -Examination of records of clinics. -Site visits.	1) Public/private sector delivery systems exist.
	2) Increase in number of new and active users (latter by 35% over LOP amounting to approximately 398,900 active users by end of project)	2) Records of service organizations, CPS. Private/Public sector studies. Media coverage of population /FP issues.	2) Receptive population to FP exists in Ecuador.
	3) An increase in GOE budget for population analysis and policy, and family planning programs is evident.	3) Official GOE position taken on population budget records.	3) Reasonable degree of receptivity among public and private sector leaders and policy-makers.
	4) Integration of population factors into development planning.	4) Inspection of GOE planning documents for the incorporation of demographic analyses generated by public and private sectors.	

AID 1010-20 (11-70)
SUPPLEMENT 1

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Project Title & Number: Population and Family Planning - 518-0026

Life of Project: From FY 81 to FY 85
Total U.S. Funding $5,600,000
Date Prepared: June 12, 1981

NARRATIVE SUMMARY Project Outputs: (C-1)	OBJECTIVELY VERIFIABLE INDICATORS Magnitude of Outputs: (C-2)	MEANS OF VERIFICATION (C-3)	IMPORTANT ASSUMPTIONS Assumptions for achieving outputs: (C-4)
1) Increased number of clinics, mobile brigades and commercial retail sales activities.	1) a. Expanding number of MOD clinics offering FP services from 31 to 43. b. Increasing number of mobile brigades from 16 to 32 in IESS/MP. c. Providing FP services at all 290 IESS/Campesino health posts. d. Expanding FP coverage of three existing APROFE clinics. e) Establishing three new CEMOPLAF clinics. f) Initiating new CRS program.	1) Evaluations, reports, records, and site visits. - Organizations' records of new and continuing acceptors.	1) Sufficient levels of funding. - Institutional capacity will be strengthened to expand/initiate activities by each organization.
2) Establishment/Operation of MCH FP Training Centers providing theoretical and practical FP training to current and future health manpower.	2) 4 training Centers - 2 in Quito - 2 in Guayaquil	2) Site visits	
3) Newly trained health manpower in both the public and private sectors to deliver high quality FP services throughout the country.	3) Approximately, 8,800 medical, nursing and nurse midwife students and 2,500 MOH personnel will receive training in these centers.	3) Records of Training Centers - Student/personnel files of participating universities and MOH. - Site visits to clinics staffed with graduates from training programs.	
4) Trained motivational personnel in service programs.	4) - 14 FP promoters in MOD - 72 social workers and health educators in IESS/MP.	4) Trained personnel in place.	

AID 1020-25 (11-79) SUPPLEMENT 1

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project: From FY 81 to FY 85
Total U.S. Funding $5,600,000
Date Prepared: June 12, 1981

Project Title & Number: Population and Family Planning - 518-0026

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Outputs: (C-1)	Magnitude of Outputs: (C-2)	(C-3)	Assumptions for achieving outputs: (C-4)
	4)- 550 auxiliary nurses in IESS/Campesino. - Three social workers and community leaders in areas of CEMOPLAF's new clinics.		
5) I E &C seminars, chats and/or informal sessions through service programs.	5)- 100% of IESS/Campesino health posts will organize seminars to reach 75% of affiliates (52,800 men and 49,900 women). - Seminars directed at groups of 50 people by CEMOPLAF social workers, reaching 30,000 people.	5)- Site visits to health posts and clinics. - Records' of IESS/Campesino and CEMOPLAF - CPS.	
6) Radio, press and other media publishing population information made available through project activities.	6) CEPAR will identify and provide information through five national newspapers, three national magazines, four radio and TV stations (two on the Coast and two in the Sierra). - Each service organization will have its own I E &C materials published and disseminated.	6)- Conducting a survey of mass media coverage newspaper clippings, etc. - CEPAR's records of publications. - Visibility of posters, pamphlets, etc. in drug stores, clinics, TV and radio spots.	

AID 1020-20 (10-81)
SUPPLEMENT 1

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Project Title & Number: Population and Family Planning - 518-0026

Life of Project: From FY 81 to FY 85
Total U.S. Funding $5,600,000
Date Prepared: June 12, 1981

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Outputs: (C-1)	Magnitude of Outputs: (C-2)	(C-3)	Assumptions for achieving outputs: (C-4)
7) A population information, communication and dissemination system functioning.	7) A Population/FP Documentation Center will be established by CEPAR. A Population Division will be established in CONADE.	7) Site visits.	
8) Data collection, analysis, and research carried out by public and private sectors.	8) -Three CPSs to be conducted by MOH* -Improvement of vital registration system by INEC -Demographic studies by CONADE -Seven Population/FP research studies by CEPAR.	- Published reports, studies and surveys. - Better coverage of vital events.	

* DSB funded

AID 1020-20 (5-79)
SUPPLEMENT 1

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Project Title & Number: Population and Family Planning - 518-0026

Life of Project: From FY 1981 to FY 85
Total U.S. Funding $5,600,000
Date Prepared: June 12, 1981

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS		MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Inputs: (D-1)	Implementation Target (Type and Quantity) (D-2)		(D-3)	Assumptions for providing inputs: (D-4)
	A.I.D.*	Counterpart	Review of project financial records, A.I.D. project agreements, other donor project agreements.	Inputs are made on a timely basis. No unanticipated problems in meeting conditions set forth in project agreements. Continued other donor willingness and capacity to meet commitments.
A. Public Sector				
1. MOH	$ 715,500	$1,964,700		
2. MOD	378,700	233,200		
3. IESS/MP	159,500	177,600		
4. IESS/Campesino	239,300	245,700		
5. INEC	234,200	483,700		
6. CONADE	124,000	333,000		
7. Training/Coordinating Advisor	160,000	--		
Inflation/Contingencies	198,800	362,100		
	$2,210,000	$3,800,000		
B. Private Sector				
1. APROFE	$ 589,500	$ 937,050		
2. CEMOPLAF	545,900	155,320		
3. CEPAR	551,500	222,900		
4. CRS	450,000	--		
5. ICEA	705,900	--		
Inflation/Contingencies	547,200	154,730		
	$3,390,000	$1,470,000		
T O T A L	$5,600,000	$5,270,000		

* Bilateral funding.

ANNEX III

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E.O. 12356: N/A

AGS:

SUBJECT: DAEC REVIEW OF ECUADOR INTEGRATED RURAL HEALTH DELIVERY SYSTEM AND POPULATION AND FAMILY PLANNING PIDS

SUBJECT PIDS WERE REVIEWED AND APPROVED ON DECEMBER 4, 1979. THE FOLLOWING GUIDANCE IS PROVIDED FOR PP PREPARATION.

PART I

INTEGRATED RURAL HEALTH DELIVERY SYSTEM GUIDANCE

1. DONOR COORDINATION: THE PID STRESSES THAT PROJECT ACTIVITIES WILL FILL THEQUOTE GAPS UNQUOTE IN OTHER DONOR PROGRAMS. THE DAEC SUGGESTS THAT THE PP CAREFULLY REVIEW THE RELATIONSHIP BETWEEN THIS PROJECT'S AND THE OTHER DONORS'ACTIVITIES TO AVOID OVERLAP AND ENSURE COORDINATION. THE PP SHOULD EXPLICITY DEMONSTRATE COMPLEMENTARITY IN PROGRAM STRATEGY AND ACTIVITIES AMONG ALL DONORS INVOLVED IN THE ECUADOREAN HEALTH SECTOR. THIS REVIEW SHOULD INCLUDE A DISCUSSION OF OTHER DONORS' ACCEPTANCE OF THE QUOTE MICROREGIONAL UNQUOTE APPROACH, THE DEGREE TO WHICH THE SUCCESS OF THIS PROJECT DEPENDS UPON THE PERFORMANCE OF OTHER DONORS AND HOW THE VARIOUS ACTIVITIES OF ALL

DONORS FIT TOGETHER TO CREATE A WORKING INTEGRATED RURAL HEALTH DELIVERY SYSTEM AT THE NATIONAL, PROVINCIAL AND LOCAL LEVELS. IN PARTICULAR, THE PP SHOULD CLARIFY THE DISTINCTION BETWEEN THE TRAINING PROVIDED BY UNFPA AND THIS PROJECT, AND JUSTIFY THE NEED FOR CONSTRUCTING ADDITIONAL HEALTH FACILITIES (5 HEALTH POSTS AND ONE OR TWO SUBCENTERS) IN LIGHT OF THE DOLS 9.5 MILLION IDB LOAN/GRANT FOR 320 HEALTH POSTS AND 70 SUBCENTERS. REASONS WHY THE IDB LOAN CAN NOT BE REPROGRAMMED TO PROVIDE INFRASTRUCTURE IN THE A.I.D.-ASSISTED IRD AREAS SHOULD BE DISCUSSED.

2. PROJECT DESIGN:

--A. THE LINKS BETWEEN THE NATIONAL, PROVINCIAL AND LOCAL LEVELS OF THE IRD/MOH SYSTEM ARE NOT WELL DEFINED. THE PP SHOULD INCLUDE SOME KIND OF DYNAMIC PRESENTATION (PERHAPS A FLOW CHART) OF THE CHANNELS THROUGH WHICH INFORMATION WILL BE COMMUNICATED AND ACTIVITIES COORDINATED BETWEEN THE DIFFERENT LEVELS OF THE SYSTEM, I.E., HOW THE DECENTRALIZATION STRATEGY IS TO BE IMPLEMENTED. INCLUDED IN THIS DISCUSSION SHOULD BE A CLARIFICATION OF THE LINES OF AUTHORITY AMONG THE DIFFERENT OFFICIALS, PARTICULARLY AT THE PROVINCIAL LEVEL. FOR EXAMPLE, THE PP SHOULD EXPLAIN THE CHAIN OF COMMAND BETWEEN IRD COORDINATORS AND IRMDS AREA CHIEFS. DURING THE DAEC IT WAS STATED THAT DELEGATION OF IRD PROJECT MANAGEMENT RESPONSIBILITIES AT THE PROVINCIAL LEVEL IS TO BE ONLY TEMPORARY FOR PURPOSES OF GETTING THE SYSTEM IN PLACE AND FUNCTIONING. THE PP SHOULD EXPLAIN HOW THE TRANSITION IS TO BE MADE FROM THIS INITIAL PHASE OF IRD INVOLVEMENT TO THE PERMANENT PROVINCIAL OPERATION IN TERMS OF SHIFTS IN AUTHORITY AND RESPONSIBILITIES.

--B. THE LEGAL RESTRICTIONS ON THE DISTRIBUTION OF CONTRACEPTIVES AND INSERTION OF IUCD'S NEED TO BE CLARIFIED. FOR EXAMPLE, IT SHOULD BE DETERMINED WHETHER A LAW, REGULATION, ETC., GOVERNS SUCH ACTIVITIES, AND THE SCOPE OF THE LAW/REGULATION SHOULD BE CAREFULLY REVIEWED. ONCE CLARIFIED, PP SHOULD DISCUSS STRATEGY PROPOSED TO DEAL WITH THE IDENTIFIED CONSTRAINTS TO ENSURE THAT FAMILY PLANNING SERVICES CAN BE MADE AVAILABLE TO THE TARGET GROUP. THE PP SHOULD NOTE WHETHER THIS STRATEGY INVOLVES CHANGES IN ECUADORIAN LAWS AND/OR CREATING A MECHANISM TO WORK IN COMPLIANCE WITH THE LAWS AS THEY NOW EXIST. TO WHAT DEGREE SHOULD NATIONAL HEALTH NORMS BE CHANGED SO THAT PARAMEDICS CAN OPERATE AS PLANNED IN THE IRD AREAS, E.G., IN THE DELIVERY OF CONTRACEPTIVES, DISTRIBUTION OF CERTAIN PRESCRIPTION DRUGS, ETC. HOW WILL THE PROJECT ADDRESS THIS ISSUE?

--C. THE PP SHOULD FURTHER DEVELOP THE QUOTE FUND UNQUOTE CONCEPT AS A MEANS OF PROVIDING FLEXIBILITY TO THE SYSTEM IN ORDER TO HANDLE UNFORSEEN PROBLEMS THAT MIGHT ARISE AT THE VARIOUS LEVELS OF THE HEALTH DELIVERY SYSTEM. MEANS OF MONITORING AND FINANCING THE VARIOUS FUNDS PROPOSED IN THE PID NEED TO BE EXPLORED DURING THE INTENSIVE REVIEW.

--D. THE PP SHOULD DISCUSS MORE EXPLICITLY THE MECHANISMS THROUGH WHICH COMMUNITY PARTICIPATION IS TO BECOME AN INTEGRAL PART OF THE PROJECT. FOR EXAMPLE, SHOULD A.I.D. ASSISTANCE IN THE POTABLE WATER PROJECT BE CONTINGENT ON THIS PARTICIPATION?

--E. GIVEN THE EXPECTED HIGH COST OF MOBIL HEALTH EDUCATION UNITS, THE MISSION SHOULD LOOK AT SIMILAR EXPERIENCES IN OTHER COUNTRIES TO JUDGE HOW THIS APPROACH COMPARES WITH MORE COST-EFFECTIVE ALTERNATIVES SUCH AS RADIO COMMUNICATIONS OR COMMUNITY BASED HEALTH EDUCATION PROGRAMS USING PARAMEDICAL PERSONNEL.

--F. SCHOOL FEEDING: CONCERN WAS EXPRESSED ABOUT THE PROPOSED SCHOOL FEEDING COMPONENT IN LIGHT OF AGENCY POLICY TO REDUCE SUPPORT FOR SCHOOL FEEDING IN FAVOR OF PROGRAMS LINKED TO MCH. PL. 480, SECTION 206 FUNDS ARE NOT AVAILABLE FOR THIS COMPONENT. THEREFORE, THE PP SHOULD DESCRIBE HOW THIS COMPONENT RELATES TO OVERALL IRD PROGRAM AND HOW THE GOE WILL USE LOAN FUNDS IN IRD AREAS TO CARRY OUT THEIR SCHOOL FEEDING PROGRAM. WHY CAN'T GOE RESOURCES BE REDIRECTED TO SUPPORT THIS SMALL PILOT PROGRAM?

PART II

POPULATION AND FAMILY PLANNING GUIDANCE

1. PROJECT STRATEGY: A.I.D. ASSISTANCE IS TO BE DISBURSED THROUGH NUMEROUS PUBLIC AND PRIVATE SECTOR FAMILY PLANNING-RELATED INSTITUTIONS. THE PP SHOULD DESCRIBE THE MECHANISM THROUGH WHICH THIS MULTI-INSTITUTIONAL EFFORT WILL WORK.

RELATED TO THIS ISSUE IS THAT OF FUNDING STRATEGY. GIVEN THE SCARCITY OF LAC BUREAU GRANT FUNDING AND THE UNCERTAINTY OF THE PERFORMANCE CAPABILITY OF ALL INSTITUTIONS TO RECEIVE A.I.D. ASSISTANCE, PROJECT SHOULD PROVIDE FOR AN ANNUAL REVIEW OF PROGRESS ACHIEVED BY THE RESPECTIVE INSTITUTIONS AGAINST PREESTABLISHED PERFORMANCE OBJECTIVES. ON BASIS OF THESE REVIEWS, MISSION WOULD MAKE ITS CASE TO THE BUREAU FOR ANNUAL FUNDING INCREMENTS.

IT WAS ALSO SUGGESTED, IN LIGHT OF LIMITED GRANT MONEY, THAT THE MISSION FORMULATE A PRIORITY RANKING OF PROJECT ACTIVITIES IN CASE FUNDING CONSTRAINTS LIMIT AVAILABLE ASSISTANCE. THIS RANKING REQUIRES A JUDGMENT OF THE RELATIVE EFFECTIVENESS AND EFFICIENCY OF THE VARIOUS INSTITUTIONS TO DETERMINE WHICH INSTITUTIONS WOULD SURVIVE A NARROWING IN PROJECT SCOPE. THE INSTITUTIONAL ANALYSIS SECTION OF THE PP SHOULD ADDRESS THESE STRATEGY CONCERNS.

DOCUMENT IN ENVELOPE

2. PROJECT MANAGEMENT: THE PP SHOULD CLARIFY AND EXPAND ON THE PROPOSED REQUIREMENT OF AN ANCILLARY CONSULTANT AS PROJECT MONITOR, AND ALTERNATIVES TO THIS PROPOSAL SHOULD BE DISCUSSED. THIS DISCUSSION SHOULD INCLUDE HOW THE MISSION PLANS TO UTILIZE THIS ASSISTANCE, I.E., WITHIN OR OUTSIDE OF THE MISSION. THE MISSION IS REMINDED THAT IF AN ECUADOREAN IS RECRUITED A JUSTIFICATION FOR LOCAL CURRENCY FINANCING WILL NEED TO BE INCLUDED IN THE PP. IF A THIRD COUNTRY NATIONAL CONSULTANT IS SELECTED, A WAIVER OF A.I.D. NATIONALITY REQUIREMENTS WILL BE REQUIRED.

3. BILATERAL FUNDING OF COMMERCIAL RETAIL SALES (CRS) OF CONTRACEPTIVES: IF DSB FUNDS ARE NOT AVAILABLE TO INITIATE A CRS PROGRAM, IT IS DOUBTFUL THAT LAC WILL ASSUME FUNDING RESPONSIBILITY. IF FUNDING BECOMES AVAILABLE, THE PP SHOULD REVIEW SUCCESSFUL CRS PROGRAMS IN OTHER COUNTRIES AND DISCUSS THE POSSIBILITY OF INCORPORATING EFFECTIVE COMPONENTS IN THIS PROJECT. WILL ADVISE OF DSB ACTION.

4. PROJECT BENEFICIARIES: THE PP SHOULD CLEARLY DELINEATE THE DIFFERENT GEOGRAPHIC AREAS OF SERVICE DELIVERY AND THE ELIGIBILITY CRITERIA FOR THE SERVICES OF EACH PARTICIPATING INSTITUTION. THIS, IN TURN, SHOULD HELP IDENTIFY THE PROJECT BENEFICIARIES AND ASSIST IN COORDINATING ALL INSTITUTIONS' ACTIVITIES TO REACH AS MANY BENEFICIARIES AS POSSIBLE BY AVOIDING OVERLAP OF EFFORTS IN SOME AREAS AND ABSENCE OF FAMILY PLANNING SERVICES IN OTHERS.

PART III

GENERAL GUIDANCE ADDRESSING BOTH PROJECTS

1. INTEGRATION OF HEALTH AND POPULATION PROJECTS: THE PP SHOULD DISCUSS HOW THESE TWO RELATED PROJECTS ARE TO FUNCTION AS A COORDINATED DEVELOPMENT EFFORT. BOTH PIDS MAKE LITTLE, IF ANY, REFERENCE TO COMPLEMENTARY PROJECT COMPONENTS SUCH AS THE DELIVERY OF FAMILY PLANNING SERVICES (PART I, 2B OF CABLE APPLIES TO BOTH PROJECTS), TRAINING OF HEALTH PERSONNEL, AND INSTITUTIONAL STRENGTHENING. THE PP SHOULD CLEARLY DESCRIBE HOW THESE ACTIVITIES AND OTHERS ARE TO BE COORDINATED TO AVOID DUPLICATION OF EFFORTS AND PROMOTE MUTUAL REINFORCEMENT.

2. GRANT-FINANCING OF TA: THE MISSION IS URGED TO REVIEW CAREFULLY GRANT REQUIREMENTS OF BOTH PROJECTS IN LIGHT OF SCARCE LAC BUREAU BUDGETARY RESOURCES.

3. PROJECT DEVELOPMENT PLANS: GIVEN THE SUBSTANTIAL AMOUNT OF TECHNICAL ASSISTANCE, BASELINE STUDIES, AND ANALYSES REQUIRED DURING INTENSIVE REVIEW, THE MISSION IS ENCOURAGED TO FINALIZE DETAILED PROJECT DEVELOPMENT PLANS AS SOON AS POSSIBLE. IN PARTICULAR, GIVEN THE CRITICAL ROLE OF PROVINCIAL LEVEL ACTIVITIES IN THE HEALTH PROJECT, THE SELECTION PROCESS FOR AREA HEALTH CHIEFS SHOULD BEGIN ALMOST IMMEDIATELY. THE PP SHOULD ALSO INCLUDE AN EVALUATION PLAN SPECIFYING THE PERFORMANCE INDICATORS THAT WILL DEMONSTRATE THE RESULTS PRODUCED SPECIFICALLY BY A.I.D.'S INPUTS. BASELINE AND EVALUATION STUDIES SHOULD INCLUDE APPROPRIATE MEASURES OF NUTRITIONAL STATUS.

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UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D.C. 20523

ANNEX IV

LAC/DR-IEE-81-10

ENVIRONMENTAL THRESHOLD DECISION

Project Location	:	Ecuador
Project Title and Number	:	Population Family Planning Assistance
Funding	:	$ 5.6 million (Grant)
Life of Project	:	Five years
IEE Prepared by	:	Maura Brackett, LAC/DR August 17, 1980
Recommended Threshold Decision	:	Negative Determination
Bureau Threshold Decision	:	Concurrence with Mission recommendation
Action	:	1) Copy to USAID/Quito John Sanbrailo 2) Copy to Maura Brackett, LAC/DR 3) Copy to IEE file

Date 5 Feb 81

Robert O. Otto
Chief Environmental Officer
Bureau for Latin America
and the Caribbean

NOTATION FOR ANNEX V

Annex V (Exhibit A - G) contains the subproject budget requests presented to USAID from participating GOE agencies (MOH, MOD, IESS, INEC and CONADE). Once these requests were submitted to USAID/Ecuador they underwent further negotiation, refinement and reductions. The final negotiated costs for each public sector subproject as included in the body of this Project Paper, is attached. This supplementary Budget Information for each public sector subproject is used throughout the Project Paper.

The IPPF subproject (Exhibit G) also underwent similar negotiations and reductions from the IPPF/WHR proposal shown herein. The final IPPF/WHR proposal will come in at or below $3.0 million as shown in the body of this PP. The final proposal will depend on that IPPF/WHR overhead rate is agreed upon. A final IPPF proposal is being prepared.

ANNEX V - A

República del Ecuador
Ministerio de Salud Pública
Dirección Salud Familiar

Programa de Integración Docente-Asistencial en Salud Materno Infantil y Bienestar Familiar en Quito y Guayaquil

1981 - 1985

MINISTERIO DE SALUD PUBLICA

Of. No. 121-81-DNSMI

Quito, a de 1 - JUL. 1981 de 198

Sección:

Asunto:

Señor
JOHN A. SAMBRAILO
Director de la Agencia para el
Desarrollo Internacional (AID)
Ciudad

Señor Director:

El Convenio para un Proyecto de Integración Docente- Asistencial, suscrito el 23 de septiembte de 1980, entre el Ministerio de Salud Pública y la Misión AID, finalizó el 30 de junio de 1981.

De acuerdo a la evaluación realizada se deduce que se han cumplido todos los términos de referencia del mencionado Proyecto experimental, destacándose aspectos positivos que inciden favorablemente en la docencia y en los servicios.

Entre los términos del señalado documento se contempla el desarrollo de un programa para expandirlo a otras Universidades del País, el mismo que se halla en fase de formulación. Cuando este Proyecto haya sido aprobado, de acuerdo a los trámites regulares del país, le haré llegar a usted con la debida oportunidad .

Estas consideraciones justifican y hace necesaria la continuidad de dichas actividades , por lo cual solicito a usted y a la Agencia de su digna Dirección la cooperación financiera. a fin de llevar adelante el mentado Proyecto que prodría iniciarse el 1ero. de agosto de 1981 y tendría una duración de 5 años , tiempo a partir del cual el país asumiría el costo total.

Con esta oportunidad, reitero a usted, mis sentimientos de consideración.

Atentamente,

Dr. Miguel Coello Fernández
MINISTRO DE SALUD PUBLICA

Oficio No. 548-80-

REPUBLICA DEL ECUADOR
MINISTERIO DE SALUD PUBLICA
DIRECCION NACIONAL DE SALUD FAMILIAR
Apartado No. 4801
Quito

Quito, 20 de agosto de 1980

ASUNTO:

Señor
John A. Sambrailo
Representante de AID
Presente

Señor Representante:

En relación con su oficio No. SHD 80-033 de abril 14 de 1980, me place iformar a usted que la Misión de Población ha realizado sesiones de trabajo con la División Nacional de Salud Materno Infantil, y conjuntamente, después de un análisis de necesidades se ha formulado un anteproyecto de integración docente-asistencial para la enseñanza en servicio de la Salud Materno Infantil y Bienestar Familiar.

Este documento, me permito enviarle para su consideración. Si es aceptado en los términos que se plantea, se elaboraría el Proyecto Final, conformando para ello un grupo de trabajo integrado por los funcionarios del Ministerio de Salud y los docentes de acuerdo al Cronograma de actividades adjunto.

Con esta oportunidad saludo a usted.

Muy atentamente,

Dr. Carlos Henríquez Coello
Subsecretario de Salud Encargado

1 adjunto

I. ANTECEDENTES Y JUSTIFICACION:

El Ministerio de Salud Pública, a través de sus dependencias técnicas, viene desarrollando un Programa de Capacitación en Salud Materno Infantil para los profesionales que egresan de las facultades de Ciencias de la Salud (médicos, enfermeras, obstetrices que van a cumplir su año de práctica rural), destinado a proporcionar información sobre las diferentes actividades de atención a la madre y al niño que ejecuta el Ministerio de Salud, y de esta manera complementar los programas de enseñanza de la entidad formadora con los programas de servicios del Ministerio de Salud Pública, especialmente en lo relacionado con la prevención, protección y mantenimiento de la salud de la madre y el niño.

Por otra parte, las Facultades de Ciencias de la Salud, se encuentran empeñadas en armonizar sus planes de estudio con los programas de salud del Ministerio y fortalecer la relación entre docencia y servicio.

Las facultades de Ciencias Médicas han reconocido la necesidad de expandir el ámbito formativo profesional para insertar el proceso de enseñanza-aprendizaje en la situación real de salud de la comunidad.

En el Proyecto para un modelo de integración docente-asistencial preparado por AFEME, se establecen los siguientes propósitos:

1. Superar el ámbito tradicional hospitalario de formación que ofrece una visión parcial de los problemas de salud del país.

2. Estimular la inquietud científica en los núcleos básicos de la red de servicios a fin de suscitar transformaciones importantes en el nivel de prestación.

3. Promover en las comunidades la utilización de los servicios a través de una genuina vinculación de los programas académicos de prevención y medicina social con la realidad concreta de las poblaciones.

4. Insertar precozmente al estudiante en tareas de servicio e investigación en una nueva tendencia metodológica que posibilite cambios profundos de los contenidos académicos a partir de la constatación vivencial que el mismo proceso genere.

5. Alentar una evaluación crítica de los sectores participantes (de servicio y de formación) cuya referencia esté dada por el contexto mismo en el que se desenvuelven.

En un estudio sobre la realidad pedagógica entre los docentes de la Facultad de Ciencias Médicas de la Universidad Central, se pone en evidencia que el método docente predominante es la clase magistral y la práctica dirigida con la presentación de casos. El trabajo con comunidad representa un pequeño porcentaje (3.2%) de los métodos utilizados.

Sobre estas bases, las Facultades de Ciencias Médicas guardan consenso alrededor de la necesidad de fusionar la formación de personal de salud con la prestación de servicios, en un esfuerzo para superar las actuales tendencias de la educación superior en ciencias de la salud. Sin embargo, buena parte del proceso de enseñanza-aprendizaje en salud materno infantil, mantiene los moldes tradicionales y poco se ha logrado en las prácticas y desarrollo de la enseñanza extramural.

En base a lo expuesto, en septiembre de 1980, la Agencia Internacional para el Desarrollo, proporcionó al Ministerio de Salud Pública la cantidad de US$40.480 para cumplir con el objetivo de implementar y desarrollar un Proyecto Experimental de Integración Docente-Asistencial entre el Ministerio de Salud Pública y la Universidad Central del Ecuador, por un período de 4 meses, en dos servicios ambulatorios del área urbana de Quito.

En base a los fondos proporcionados en el primer trimestre de 1981, se suscribió el respectivo Convenio entre las instituciones mencionadas y se dió inicio a las actividades programadas para dicho Proyecto, el mismo que se encuentra ejecutándose en los Centros de Salud N° 6 y 8 de la ciudad de Quito.

La experiencia adquirida en esta etapa, muestra resultados favorables a nivel de docencia y de servicios, y se estima conveniente expandir progresivamente este Proyecto experimental de Integración Docente Asistencial a otras áreas urbanas y periurbanas del país, para mejorar la enseñanza a nivel nacional en Salud Materno Infantil Integral; disminuir paulatinamente los costos del adiestramiento complementario que viene realizando el Ministerio de Salud Pública, y sobre todo aumentar significativamente la efectividad del proceso formativo y de los niveles de aprendizaje en servicio.

II. OBJETIVOS

1. Objetivos Generales o de Largo Plazo

1.1. Contribuir a la integración entre la formación del personal de salud y la prestación de servicios, para responder mejor

a las necesidades de salud de la población con actividades intra y extramurales proyectadas a la comunidad.

1.2. Establecer una unidad de coordinación académica en Salud Materno Infantil a nivel de las Facultades de Ciencias de la Salud con un enfoque integral (biológico, social y epidemiológico) en la que se integren progresivamente las actividades de docencia, servicio e investigación en salud de la madre, del niño y de la familia.

1.3. Procurar la integración temprana y sistemática de los estudiantes al servicio de salud y al trabajo en comunidad, en atención materno infantil.

2. Objetivos Específicos

2.1. Establecer un esquema de regionalización docente-asistencial en el área de influencia de la red de servicios de salud de la ciudad de Quito.

2.2. Desarrollar un modelo de enseñanza integrado en salud materno infantil basado en módulos interdisciplinarios de aplicación en toda la red de servicios y en población urbano marginal y rural.

2.3. Ampliar y descentralizar las áreas de práctica extramural en atención materno infantil a nivel de pre y post-grado en las profesiones vinculadas a las ciencias de la salud.

2.4. Integrar al proceso de enseñanza-aprendizaje:

- Programación, ejecución y evaluación de servicios de atención materno infantil integral y de bienestar familiar.

- Organización de servicios de atención materno infantil.

- Conocimientos y destrezas adecuados en el manejo del paciente ambulatorio e identificación (Screening) y seguimiento de casos en domicilio y comunidad.

- Planeamiento del trabajo comunitario en salud materno infantil (Cartografía, censos de población y vivienda, encuestas, etc.)

- Trabajo de revisión bibliográfica y actualización materno infantil.

2.5. Desarrollar la formación de un grupo de docentes para la enseñanza de la salud materno infantil y de bienestar familiar en número y calidad necesarios, facilitando su capacitación científica y académica dentro o fuera del país.

III. PLAN OPERATIVO

1. Regionalización Docente Asistencial

El Proyecto de integración docente-asistencial propone la definición de unidades operacionales incorporadas al Sistema regionalizado de servicios (ver gráfico N° 1) en las áreas urbanas y periurbanas de las ciudades de Quito (1era. etapa) y Guayaquil (2a. etapa).

1.1. Región I: Quito

El sistema regionalizado del área de Quito, define dos microregiones docente-asistenciales compuestas por Centros de Salud N° 6 y 8, y las unidades periféricas del área de influencia de estos centros que comprenden 4 unidades satélites de servicio ambulatorio, ubicadas en áreas satélites densamente pobladas y que serán incorporadas durante los primeros 18 meses de operación del proyecto (ver gráfico N° 2).

Estas dos microregiones, mantendrán una relación de referencia y supervisión docente-asistencial con los hospitales docentes: Hospital General "Eugenio Espejo", Maternidad "Isidro Ayora" y Hospital "Baca Ortíz".

1.2. Región II: Guayaquil

El Sistema regionalizado del área de Guayaquil definirá en una segunda etapa del proyecto dos microregiones homólogas a las de la Región I, compuestas por los Centros de Salud N° 10 y 7, y las unidades satélites del Guasmo central, Guasmo norte y las dos del área de influencia del Centro N° 7. Las dos microregiones estarán vinculadas con el Hospital Guayaquil, Hospital de Niños y la Maternidad Enrique Sotomayor. Esta Maternidad es una dependencia de la Junta de Beneficencia de Guayaquil y tiene alrededor de 35.000 egresos obstétricos al año. En el área de Consulta Externa, APROFE mantiene una clínica de planificación familiar y atención gíneco-obstétrica, que debiera integrarse al programa

de actividades docente-asistencial a elaborarse en la segunda etapa, con participación de la Universidad de Guayaquil, la Junta de Beneficencia y el Ministerio de Salud Pública.

1.3 Recursos Humanos

A nivel de cada Centro de Salud, se implementará un equipo docente-asistencial compuesto por:

2 gíneco-obstetras
2 pediatras
2 enfermeras
2 obstetrices
4 auxiliares de enfermería

Estos recursos humanos desarrollarán sus funciones en cada microregión de integración, teniendo como base el Centro de Salud, correspondiente. Se establecerá un sistema rotativo de servicios y enseñanza en cada unidad satélite por las que rotarán los estudiantes de medicina, obstetricia y enfermería.

Los internos rotativos participarán en las actividades de servicio/docencia tanto a nivel del Centro de Salud como en las Unidades satélite parroquiales en lapsos definidos de acuerdo con las características de las diferentes unidades operativas.

La participación del interno rotativo en las unidades satélites, se orientará principalmente a tareas de comunidad, es decir a diagnosticar el "perfil de salud" de las poblaciones, a educación y promoción de los servicios, evaluación de coberturas, acciones de saneamiento ambiental, capacitación de personal auxiliar y paramédico, etc. Se trata de una vinculación que no repite las acciones del internado rotativo tradicional, sino que amplía el campo de acción hacia un contacto vivencial con situaciones de salud que no ofrece la educación hospitalaria.

Además la participación del interno es una respuesta a la demanda de recursos en este tipo de servicios; constituye el eslabón indispensable para el formal nexo docencia-servicio, situación que permitirá un real ejercicio de tareas de educación médica continuada por parte de las Facultades de Ciencias Médicas.

Por fin, la inserción de personal en formación en los servicios, repercutirá indiscutiblemente en la elevación de la calidad de los mismos, lo que constituye un mecanismo de promoción, que dinamizará el sistema global.

El sistema propuesto en lo que concierne a la participación del internado rotativo comporta una ampliación del lapso dedicado a esta fase de la formación que de acuerdo con las expectativas planteadas no deberá ser menor de 3 meses (AUME, 1976).

2. Contenidos de la Enseñanza-Aprendizaje

1. Actividades en servicio
2. Trabajo en comunidad

Actividades en Gineco-Obstetricia
Rendimiento Por Unidad Docente Asistencial

N° Médicos	N° H. x día	Total H.día	N° Pac. hora	Total Pac.día	Total Pac.mes	Total Pac. Unid/mes	Atenc. Cam.T.	Atenc. C.Ext.T.
4	4	16	3	48	1.056	528	576	480

NOTA: En lo que concierne a la actividad de la Obstetriz, estará sujeto a cambios a las necesidades de servicio.

Para cumplir actividades en:

I. Embarazo, Parto y Puerperio

II. Planificación Familiar

III. Detección oportuna del Cáncer (DOC)

1. En el Embarazo, Parto y Puerperio

Diagnóstico del Embarazo

a. Signos presuntivos
b. Signos de probabilidad
c. Signos positivos

Control Prenatal

1. Anamnesis general (Historia clínica)
2. Anamnesis Obstétrica

   a. Embarazos anteriores
   b. Partos anteriores
   c. Alumbramientos anteriores
   d. Puerperios anteriores

3. Antecedentes del embarazo actual

   a. Fecha de la última menstruación
   b. Fecha probable del parto
   c. Edad del embarazo
   d. Síntomas de embarazos complicados

4. Examen físico

   a. Signos vitales
   b. Examen físico general
   c. Examen físico obstétrico

      - Utero: forma, tamaño, consistencia, contractibilidad
      - Maniobras de Leopold
      - Auscultación fetal
      - Examen pélvico
      - Exámenes de laboratorio: sangre y orina
      - Exámenes especiales: radiografía, ecografía, amniocentesis

5. Embarazo de alto riesgo - Evaluación y referencia a centro especializado.

6. Visita domiciliaria: Motivación a la paciente y referencia al Centro de salud, seguimiento de casos.

PARTO DOMICILIARIO

1. Trabajo de parto

   a. Definición
   b. Fenómenos activos del trabajo del parto
   c. Fenómenos pasivos del trabajo del parto

2. Períodos del parto. Borramiento y dilatación del cuello expulsión del producto y alumbramiento.

3. Preparativos generales para la asistencia del parto domiciliario

4. Asistencia del parto domiciliario

a. Conducción al iniciarse el parto
b. Examen completo de la parturienta
c. Conducta en el período de dilatación

- Gobierno y dirección del parto
- Conducta general desde la iniciación del período dilatante
- Conducta especial durante el período dilatante

d. Conducta durante el período expulsivo

- Conducta durante la primera parte
- Conducta durante el desprendimiento

5. Período Placentario

a. Signos de desprendimiento (observaciones)
b. Recepción de la placenta
c. Examen de la placenta

PUERPERIO

1. Visita domiciliaria a los 8 días

2. Control en el Centro de Salud a los 45 días

a. Examen de útero: volumen, consistencia, sensibilidad
b. Examen de región anoperineo o vulvar
c. Loquios
d. Examen de senos

3. Explicación de métodos de planificación familiar y captación de nuevas aceptantes

4. Captación del recién nacido para el Centro de Salud

5. Examen de Pap Test.

PLANIFICACION FAMILIAR

1. Anamnesis: examen físico y exámenes complementarios (Historia Clínica)

2. Indicaciones y contraindicaciones

Normas técnicas y procedimientos en regulación de la fecundidad.

3. Efectos secundarios y tratamiento de los efectos secundarios

4. Efectividad de cada método

5. Métodos anticonceptivos

   a. Fisiológicos: Ritmo y Billings
   b. Hormonales: orales y parenterales
   c. Métodos de barrera: jaleas, óvulos, cremas diafragmas
   d. Intrauterinos: inertes: Lippes C y D
      combinados: T de cobre 200, 7 de cobre, Progrestasert (ALZA-T)
   e. Quirúrgicos: Hombre, Vasectomía: Ligadura, Fulguración y Anillo
      Mujer, Ligadura, Fulguración y Anillo

6. Patología anticonceptiva

7. Revisión bibliográfica de estudios de planificación familiar

DETECCION OPORTUNA DEL CANCER (DOC)

a. Técnica
b. Clasificación
c. Manejo
d. Otros métodos: Colposcopía - Test de Shiller - Biopsia y Conización

Actividades en Pediatría
Rendimiento Docente Asistencial

N° médicos	N° H. x día	Total H.día	N° Pac. Hora	Total Pac. día	Total Pac. mes	Total paciente Unidad/mes.
4	4	16	4	64	1.408	702

Población beneficiada:

Niños de 0 - 15 años de edad
Para cumplir actividades de:

1. Prevención — Control de niño sano
2. Fomento — Salud Escolar
3. Recuperación
4. Rehabilitación — Atención del niño enfermo

La atención del niño en unidad operativa se la realizará junto al personal de pregrado, postgrado y del Ministerio de Salud Pública para cumplir funciones de docencia y elevar calidad de atención cumpliendo los siguientes parámetros:

1. Historia clínica: llenado del motivo de consulta y anamnesis anteriores
2. Manejo y graficación de curvas de crecimiento y desarrollo
3. Examen físico general
4. Tratamiento y administración de medicamentos en el niño enfermo
5. Recomendaciones sobre:

   a) Alimentación b) Normas higiénicas y c) Cuidados generales

6. Indicaciones de vacunación, ingreso a programas específicos como: PAAMI, ORALITE
7. Referencias a Centros especializados: Hospital "Baca Ortíz", Eugenio Espejo y otros, según regionalización
8. Entrenamiento a dicentes en técnicas mínimas de laboratorio y mantenimiento y aplicación de vacunas.

SALUD ESCOLAR

Entrenamiento para formar un equipo de salud para la atención integral del escolar.

Escuelas beneficiadas: Fiscales del área de influencia

Los grupos de cada escuela son los alumnos de primero y sexto grados.

Actividades a cumplirse:

1. Educación al grupo escolar y padres de familia
2. Indicaciones generales para prevención de accidentes y enfermedades comunes en este grupo etáreo como: fiebre reumática, glomerulonefritis, parasitosis.
3. Atención médica del niño con historia clínica única, examen físico y evaluación de crecimiento y desarrollo.
4. Aplicación de pruebas específicas como test de agudeza visual y auditiva
5. Examen bucal y selección de prioridades para tratamiento
6. Enjuagatorios a cargo de odontología.
7. Aplicación de vacunas BCG y DT
8. Detección y referencia de problemas de conducta y mal rendimiento escolar

Actividad de Enfermería
Rendimiento Docente Asistencial

# Enfermera	# H. día	Total H.día	# Pac. x M. Preconsulta	# Pac. x M. Post. cons.	# Inmuni-zaciones	# visitas domicil./mes
4	4	16	2.464	2.464	660	130

POBLACION BENEFICIADA

Niños de 0 a 15 años de edad, mujeres en edad fértil

Para cumplir actividades de:

PREVENCION	Inmunizaciones Control de niño sano Salud escolar PAAMI
FOMENTO	Visitas domiciliarias Charlas educativas
RECUPERACION Y REHABILITACION	Visitas domiciliarias Postconsulta Curaciones e inyecciones

La atención de enfermería en la Unidad Operativa se realiza junto con el personal de:

Pregrado
Postgrado
Estudiantes Auxiliares de Enfermería
Personal del Ministerio de Salud
Cumpliendo funciones de docencia y elevando la atención de enfermería en el servicio

Actividades a realizar:

I. PROGRAMA GINECO-OBSTETRICO:

1. Preparar a la usuaria para la consulta médica:

   a. Toma e interpretación de datos vitales
   b. Toma e interpretación de peso

c. Revisión de dema
d. Orientación pre consulta

2. Realizar examen gíneco obstétrico

a. Realizar anamnesis
b. Evaluar condición de mama y pezones
c. Calcular edad gestacional y FPP
d. Realizar maniobras de Leopold
e. Auscultar FCF
f. Referir o solicitar exámenes de laboratorio de diagnóstico de embarazo y control
g. Descubrir signos de anormalidad y referir a los distintos servicios de especialidad

3. Examen Post-parto y Planificación Familiar. Entrega de métodos anticonceptivos

4. Entrevista post-consulta médica
- Reforzar indicaciones médicas
- Normas de higiene y nutrición
- Referir casos al PAAMI

5. Planificar, ejecutar y evaluar V.D.

6. Manejo de informes y registros

II. PROGRAMA INFANTIL

1. Preparación del usuario para consulta médica:

a. Toma de datos vitales
b. Toma e interpretación de peso, talla y perímetros
c. Orientación pre-consulta médica

2. Realizar u observar control de crecimiento y desarrollo del niño

a. Examen físico a niño sano
b. Aplicación y graficación de curvas de crecimiento
c. Aplicación de curvas de desarrollo psicomotor en niño sano

3. Realizar entrevista post-consulta médica

4. Planificar, ejecutar y evaluar V.D.

5. Manejo de informes y registros

III. PROGRAMA DE INMUNIZACIONES

1. Analizar situaciones para indicar o contraindicar vacunas
2. Aplicar vacunas:

   - BCG
   - DPT ... Contraindicaciones
   - Antisarampionosa
   - Antipolio Procedimiento
   - Antirrábica

3. Conservar y mantener vacunas utilizando red de frío
4. Manejo de formularios y registros

IV. PROGRAMA ALIMENTARIO (PAAMI)

1. Identificar problemas de tipo alimentario en usuarios y referirlos al PAAMI

2. Programar, ejecutar y evaluar charlas de educación nutricional

V. PROGRAMA EDUCATIVO

Planificar, ejecutar y evaluar charlas educativas a grupos de:

- Madres embarazadas
- Madres lactantes
- Escolares

EVALUACION

1. Establecer una reunión mensual para auto evaluación del Programa
2. La evaluación del programa estará a cargo de representantes de cada una de las entidades auspiciadoras.

TRABAJO EN COMUNIDAD

La participación del Grupo docente asistencial en trabajo comunitario se orientará principalmente a tareas dirigidas a diagnosticar el perfil demográfico y de salud de la población de área de influencia de la unidad operativa, a la educación y promoción de los servicios, evaluación de coberturas, acciones de saneamiento ambiental, capacitación de personal paramédico y de líderes comunitarios.

Se trata de una actividad que amplía el campo de acción hacia un contacto vivencial con situaciones de salud que no son experimentadas en el ámbito hospitalario y constituye el eslabón indispensable para el mejor nexo docencia-servicio.

Este es un programa con miras a preparar el futuro médico rural para acciones más adecuadas y efectivas a nivel de un Subcentro de salud en área rural.

Además posibilita la participación efectiva del dicente en las discusiones de planes y programas ajustados a las reales necesidades de la población.

La experiencia obtenida con el transcurso de los años en el área Pediátrica en los centros de salud y en esta última etapa con la ampliación a la atención de la salud materna en el Proyecto Experimental financiado por el Minsiterio de Salud Pública nos habla de la elevación de la calidad de las prestaciones de Salud, de una entrega integral de acciones de una mayor cobertura del grupo programático y de una indiscutible mejoría de la unidad operativa, producto de la inserción de este nuevo recurso docente y de servicio.

3. UNIDAD DE COORDINACION ACADEMICA

Para la coordinación del Proyecto Experimental, se designó un Coordinador General, el que actualmente se encuentra en funciones.

Para el Proyecto de 4 años, se requiere de la consolidación de una Unidad compuesta por: un coordinador, un asistente y una secretaria, a medio tiempo.

La Unidad así estructurada tendrá las funciones de:

- Dirección del Proyecto
- Coordinación interdepartamental universitaria y con el área de servicios
- Enlace con Organismos nacionales e internacionales de financiamiento
- Planeamiento docente-asistencial
- Control y evaluación de la gestión técnica y administrativa del Proyecto en coordinación con las Unidades respectivas del MSP y de la Universidad
- Diseño, ejecución y control de investigaciones operativas en las áreas asignadas para el proyecto.

- Organización y Normatización de las actividades docente-asistenciales.
- Preparación de informes técnicos de avance del proyecto.
- Publicación de resultados (Manuales, Guías, Normas, etc.).
- Organización de seminarios y reuniones de capacitación para el personal docente y de servicios.
- Adjudicación de becas cortas en el exterior.

Esta Unidad de coordinación será creada en el año I en Quito, y en el año II en Guayaquil

4. EQUIPO DOCENTE ASISTENCIAL

Hay un grupo de docentes cuya inquietud es desarrollar nuevas formas de enseñanza especialmente a nivel comunitario. Para ello en el Proyecto experimental se constituyó un cuadro de profesionales integrados por un Coordinador y docentes de la Facultad de Medicina, este grupo trabajó en abril de 1981 un Proyecto para la realización de actividades Materno Infantiles Integrales con carácter experimental que incluye acciones de Bienestar Familiar. El equipo es multidisciplinario y está conformado por micro regiones con:

2 gínecoobstetras
2 pediatras
2 enfermeras licenciadas
2 obstetrices
4 auxiliares de enfermería

Todos trabajan con objetivos comunes y han recibido de una manera general adiestramiento en aspectos relacionados con la enseñanza de la Salud Materno Infantil Integral de acuerdo a los contenidos de enseñanza/aprendizaje explicitados.

La experiencia del Proyecto inicial ha permitido demostrar que un modelo de enseñanza extramural de la Salud Materno Infantil, basado en la integración de conocimientos provenientes de los distintos departamentos especialmente de Gínecoobstetricia y Pediatría y Salud Pública, determinó en los estudiantes un enfoque integral de la salud y de la enfermedad y del concepto de atención médica en la comunidad.

La enseñanza fragmentada de los elementos orgánicos, psicológicos y ambientales que condicionan el fenómeno salud-enfermedad así como el estudio por separado de las conductas para la prevención y curación de las enfermedades y la rehabilitación de sus secuelas,

expone a los alumnos a un aprendizaje disociado de dicho fenómeno el que puede ser superado con esta nueva metodología propuesta con gran enfoque social y comunitario y con exposición precoz de los dicentes a estos servicios.

Estas unidades docentes harán énfasis en las áreas de destrezas, y actitudes para el trabajo en comunidad y en el manejo de la situación de salud y enfermedad en las áreas de reproducción humana y del crecimiento y desarrollo.

5. PROGRAMA GENERAL

El programa general establece el desarrollo de actividades globales por año del proyecto, y se especificarán en un plan anual operativo detallado, antes de la iniciación de actividades, previa evaluación.

AÑO 1: Julio de 1981 - Junio 1982

1. Elaboración y suscripción del Convenio Ministerio de Salud Pública/ Universidad Central.

2. Creación e instalación de la Unidad de Coordinación Académica, a cargo de la dirección, coordinación, planificación-evaluación y control del proyecto en sus distintas fases y componentes.

3. Estructuración de la Región I: Quito

   3.1. Selección y estructuración de equipos docentes Centros N° 6 y 8

   3.2. Capacitación local y adjudicación de 8 becas de corta duración

4. Programación de actividades docencia/servicio en las 2 micro regiones (Región I)

   4.1. Cartografía y censo

   4.2. Planeamiento de actividades de servicio en centros, unidades satélite y comunidad.

   4.3. Subsistema de información-evaluación.

   4.4. Subsistema de supervisión asistencial y académica.

   4.5. Planeamiento curricular.

5. Incorporación programada de estudiantes e internos rotativos, según los contenidos de enseñanza-aprendizaje.

   5.1. Medicina: 500 a 600 estudiantes de pregrado por año académico y 650 internos rotativos.

   5.2. Obstetrices: 60-60 estudiantes de obstetricia por año académico.

   5.3. Enfermeras: 130-160 estudiantes de enfermería por año académico.

6. Equipamiento y adecuación de planta física e instalaciones en los Centros y unidades satélites.

7. Diseño de la Etapa II del Proyecto, para la extensión de actividades de integración docente-asistencial a la Región II: Guayaquil.

8. Elaboración y suscripción del Convenio Ministerio de Salud Pública/Universidad de Guayaquil.

AÑO 2: Julio 1982 - Junio 1983

9. Evaluación intermedia y reprogramación de actividades para la Región I: Quito.

10. Elaboración y publicación de Manuales de enseñanza-aprendizaje en Salud Materno Infantil y Bienestar Familiar.

11. Primer Seminario Nacional de Integración Docente-Asistencial en Salud Materno Infantil y Bienestar Familiar, en Quito, para 50 participantes.

12. Creación e instalación de la Unidad de Coordinación Académica en la Universidad de Guayaquil.

13. Estructuración de la Región II: Guayaquil (actividades homólogas a las descritas en el numeral 3).

14. Programación de actividades docencia/servicio en las 2 micro regiones (Región II).

15. Incorporación programada de estudiantes e internos rotativos de la Región II (cantidades a determinarse).

16. Equipamiento y adecuación de planta física e instalaciones en los Centros y Unidades Satélites

17. Evaluación intermedia y reprogramación de actividades para las Regiones I y II.

AÑOS 3 y 4: Julio 1983 - Junio 1985

18. Segundo Seminario Nacional de Integración Docente Asistencial en Salud Materno Intantil y Bienestar Familiar, en Guayaquil, para 50 participantes.

19. Elaboración de bases legales y normas técnicas y administrativas para el mantenimiento y operación del Proyecto, con incorporación progresiva de otras unidades operativas urbanas y rurales.

20. Consecución del financiamiento nacional para la absorción progresiva de los costos de sueldos y de operaciones del Proyecto.

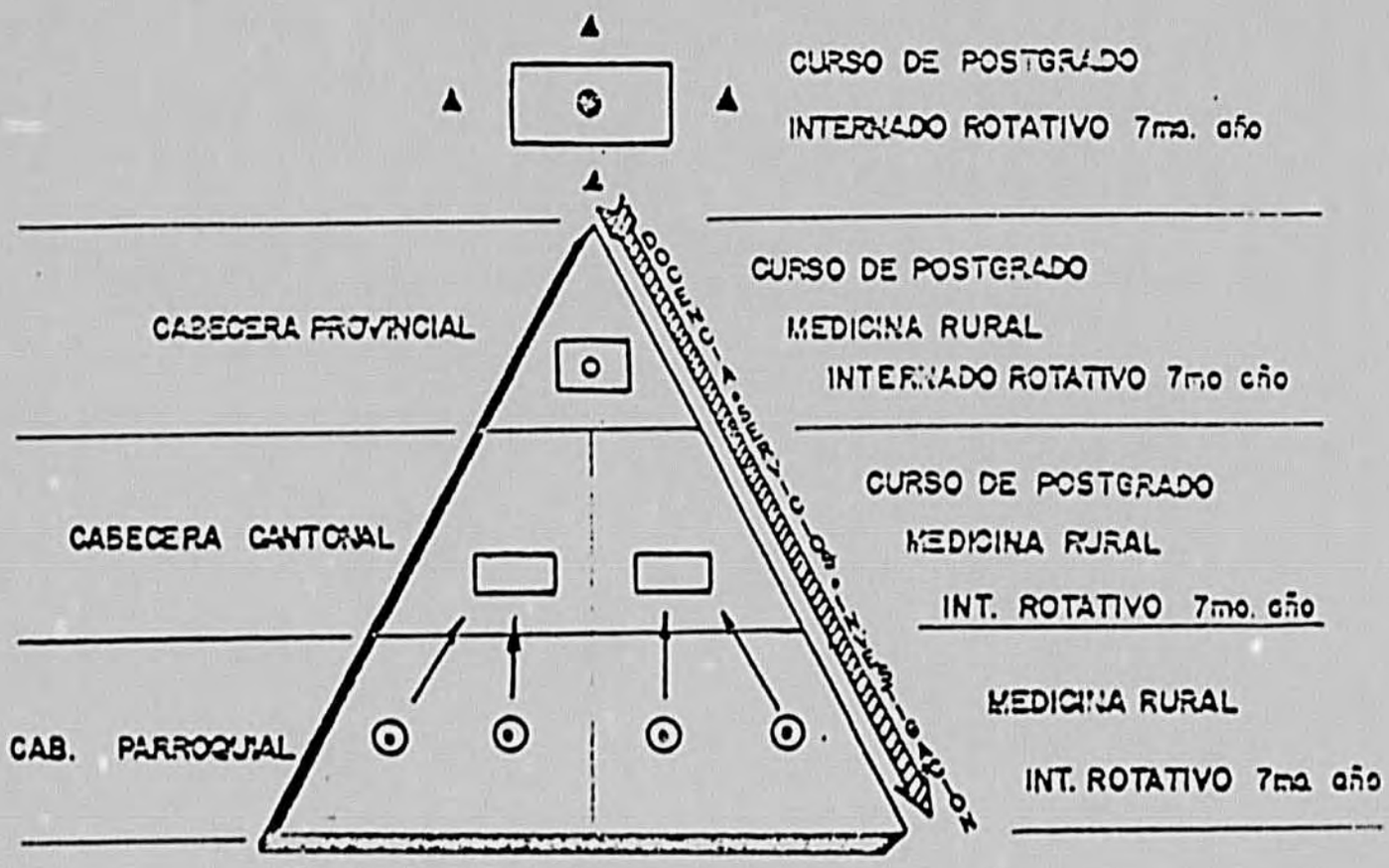
IV. PRESUPUESTO (EN US$)

	Año 1	Año 2	Año 3	Año 4	Totales
1. Personal					
- Equipo docente-asistencial (Regiones I: Quito)	120,000	100,000	80,000	60,000	360,000
- Equipo docente-asistencial (Región II: Guayaquil)	-	120,000	100,000	80,000	300,000
- Unidad de Coordinación Académica (U. Central)	16,800	14,800	11,800	9,600	53,000
- Unidad de Coordinación Académica (U. Guayaquil)	-	16,800	14,800	11,800	43,400
2. Capacitación					
- Primer Seminario Nacional (Quito)	-	6,500	-	-	6,500
- Segundo Seminario Nacional (Guayaquil)	-	-	6,500	-	6,500
- Becas al exterior	16,000	-	16,000	-	32,000
3. Equipo					
- Equipos audiovisuales y de enseñanza					
Región I	10,000	-	10,000	-	20,000
Región II	-	10,000	-	10,000	20,000
- Publicaciones					
Región I	8,750	-	8,750	-	17,500
Región II	-	8,750	-	8,750	17,500
TOTAL	171,550	276,850	247,850	180,150	876,400

DEPARTAMENTAL EN FORMACION Y SISTEMA DE REGIONALIZACION DE SERVICIOS

(Modelo de Integración)

REGION FACULTAD DE MEDICINA



SIMBOLOGIA

- HOSPITALES UNIVERSITARIOS
- HOSPITAL BASE
- CENTRO DE SALUD URBANO
- CENTRO DE SALUD HOSPITAL
- SUBCENTRO DE SALUD

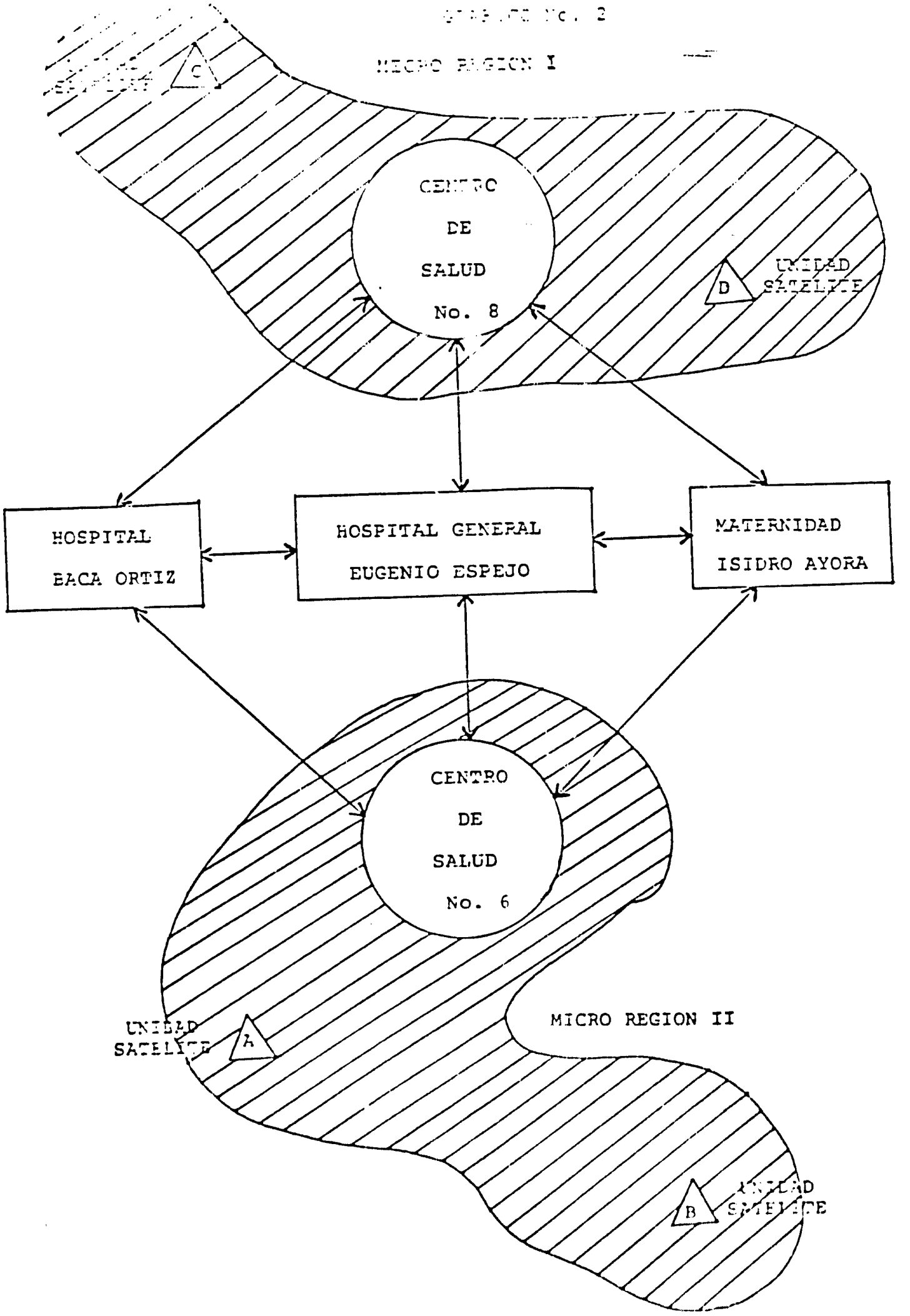
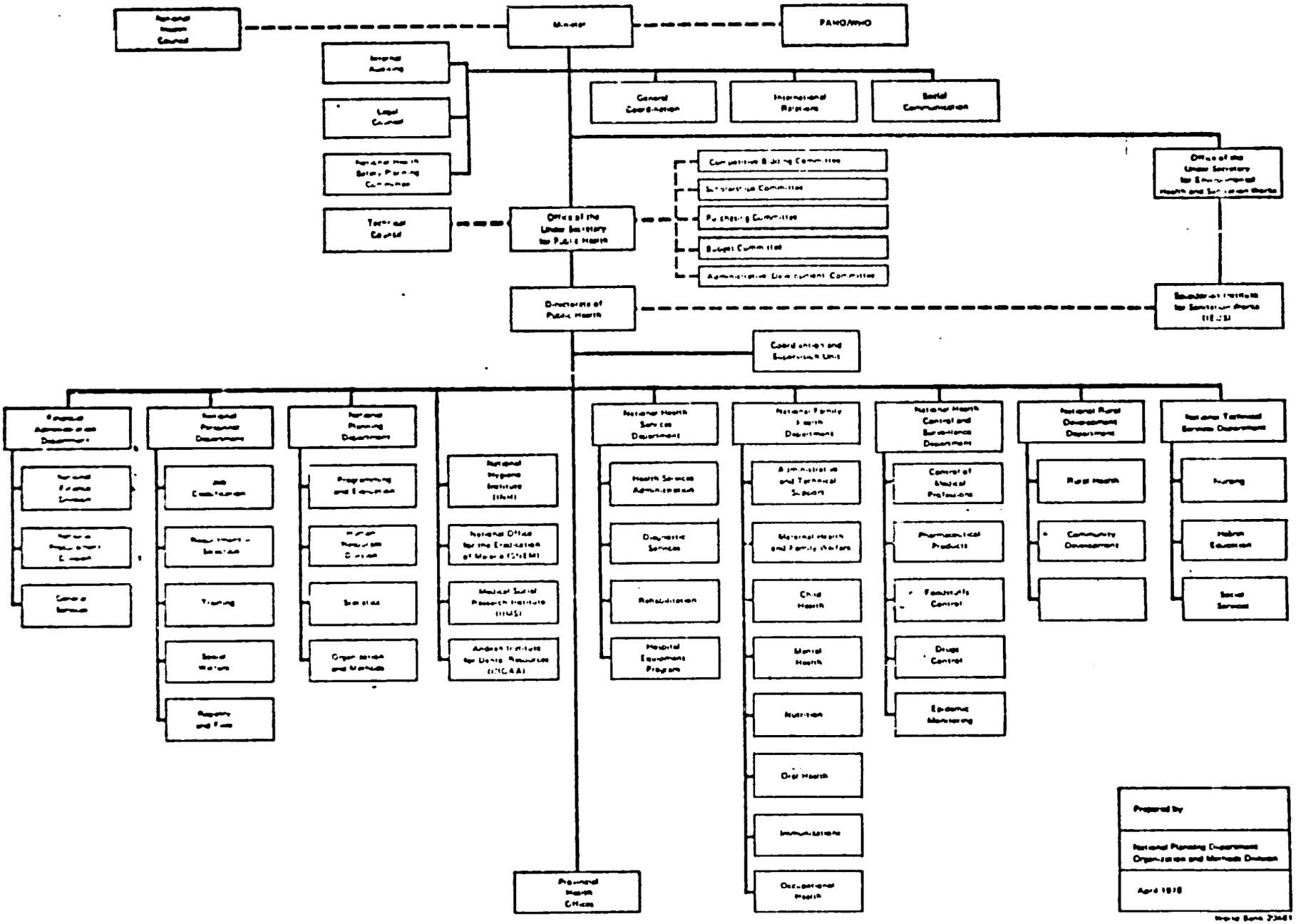

MICRO REGION I
C
CENTRO
DE
SALUD
No. 8
D
HOSPITAL
BACA ORTIZ
HOSPITAL GENERAL
EUGENIO ESPEJO
MATERNIDAD
ISIDRO AYORA
CENTRO
DE
SALUD
No. 6
MICRO REGION II
A
B

CHART A-1

ORGANIZATIONAL CHART OF THE MINISTRY OF HEALTH



ANNEX V -B

República del Ecuador
Estado Mayor Conjunto de las Fuerzas Armadas
Dirección General de Sanidad de Fuerzas Armadas

Programa de Bienestar Familiar de las Fuerzas Armadas

1981 - 1985

El Ecuador no es solo. Es y será País Amazónico

Oficio No. 81-131-G-7-2

REPUBLICA DEL ECUADOR

ESTADO MAYOR CONJUNTO DE LAS FUERZAS ARMADAS

ASUNTO : Enviando Proyecto de Convenio

Quito, a .... de ...5..... de 1981 de 19....

DE : DIRECCION GENERAL DE SANIDAD DE FF.AA.

A : SR JOHN A. SANBRAILO-REPRESENTANTE DE AID

DE : Su Despacho.-

Me es placentero enviar a Ud., Sr. Representante, el Proyecto definitivo de Convenio entre AID, Institución que Ud. tan dignamente representa, y la Dirección Gral. de Sanidad Militar a mi cargo.

Con referencia al mismo, mucho agradeceré darnos a conocer los resultados de su análisis y estudio, ya que de ellos dependerá la futura realización de nuestras actividades y el buen éxito que pueda alcanzar nuestro Programa de Bienestar Familiar de FF.AA.

Sin otro particular, reitero a Ud., Sr. Representante, el testimonio de mi más alta consideración.

DIOS, PATRIA Y LIBERTAD
EL DIRECTOR GRAL. DE SND. DE FF. AA.

DR. GUILLERMO ITURALDE A.
Coronel EMS SND. Avc.

Distrib:
o-1 SR. REPRESENTANTE DE AID
c-2 G-7 2
Anexo: lo indicado
GIA/aa.

ANNEX V - B

Proyecto de Convenio entre USAID y FF.AA. del Ecuador

1. JUSTIFICACION

Después de 10 años de existencia del Programa de Bienestar Familiar de FF.AA., en los que se ha brindado a la Familia militar y a la población civil en áreas de influencia servicios de Planificación Familiar; se ha visto la necesidad no sólo de renovar e incrementar estos servicios, sino también de incursionar en otras áreas de salud indispensables para mejorar el nivel de vida de dichos grupos poblacionales.

En efecto, a partir de 1976, el Programa entró en una franca crisis no sólo por el deterioro de los cuadros de personal, sino por la falta de renovación del material, equipos y unidades móviles; por la irregularidad o interrupción de los cursos de adiestramiento a personal médico y para-médico, y por la interrupción o discontinuidad en las actividades tanto de motivación y educación como de supervisión. Las consecuencias aparecieron, lógicamente, en el bajo rendimiento de usuarias nuevas y en las metas menos optimistas que cada nuevo año tenía que señalarse el Programa.

Si bien, un comienzo de recuperación de esta crisis se apunta en junio de 1979, los nuevos esfuerzos no logran a la fecha subsanar el deterioro acumulado.

Para solucionar estos problemas y determinar en el futuro un nuevo despliegue de actividades, no sólo en el campo de la planificación familiar sino en otros afines, como Educación Sexual, se hace necesaria la ayuda externa, objeto del presente proyecto.

2. OBJETIVOS

2.1 Revisar bajo asesoría externa la política, metas y resultados obtenidos por el Programa de Bienestar Familiar de FF.AA. en el período 1970-1980, en orden a establecer una reorientación de las actividades del Programa con extensión a otras áreas afines.

2.2 Robustecer las actividades administrativas del Programa fijando sus nuevas políticas y metas de trabajo en el próximo quinquenio.

2.3 Satisfacer en mejor forma la demanda de la población militar y civil dependiente por servicios de planificación familiar y control de cáncer cérvico-uterino.

2.4 Fortalecer el desarrollo de las actividades educativas, con el propósito de que constituyan un factor decisivo para el incremento del número de usuarias del Programa.

2.5 Extender las áreas de cobertura del Programa incrementando el número de Centros y Subcentros de atención en Planificación Familiar.

2.6 Robustecer la acción de información y motivación en áreas principalmente rurales mediante la creación de 14 Auxiliares Sociales.

2.7 Capacitar al personal médico y para-médico en base a cursos y seminarios que permitan mejorar sus conocimientos científicos y técnicos e intercambiar experiencias de trabajo.

2.8 Orientar a los niveles militares de decisión, a fin de que conozcan los objetivos y actividades que desarrolla el Programa de Bienestar Familiar y, en consecuencia, coadyuven para la obtención de las metas propuestas.

2.9 Mejorar la supervisión y evaluación anual de las actividades que realiza el Programa en orden a reorientar acciones.

2.10 Realizar actividades de investigación sobre riesgo reproductivo en mujeres en edad fértil, y estudio sobre características de usuarias.

3. DESCRIPCION DEL PROYECTO

3.1 Asesoramiento Técnico

Una de las acciones fundamentales del Proyecto consiste en la revisión técnica de todas las actividades del Programa de Bienestar Familiar de FF.AA. realizadas en el período 1970-1980, la misma que hace referencia a las siguientes áreas:

-Administración y logística
-Prestación de servicios
-Educación y actividades afines
-Capacitación y readiestramiento de personal
-Investigación
-Evaluación

Personal técnico en áreas de administración, atención médica y educación, realizará los análisis respectivos en base a:

1. Datos estadísticos facilitados por la Dirección, y
2. Observación de la marcha de las operaciones de Programa.

Su objetivo será determinar las condiciones actuales en las que se desarrolla el Programa y sus necesidades principales. Este estudio constituirá la base sobre la que se establecerán las acciones necesarias que correspondan.

3.2 Duración del asesoramiento

El asesoramiento se extenderá por 90 días luego de la aprobación del proyecto. El personal técnico estará constituído por:

-Asesor con experiencia administrativa;
-Especialista en actividades educativas y de capacitación de personal, y;
-Otro personal que se encargará del desarrollo de investigaciones, evaluación del Programa y otras actividades afines.

De ser necesario, estos asesores podrán trabajar simultáneamente, en diferentes etapas del Programa o ser requeridos según exijan las necesidades.

Los períodos que aquí se sugieren para la evaluación del Programa se cumplirán a principios del 1er. año, a fines del 2do. y 4to. años del Proyecto y por el tiempo total de 30 días/H. en cada uno de ellos, total, 3 meses/H. en los 5 años.

3.3 Componentes del asesoramiento

3.3.1 Administración y Logística:

-Revisión de normas, métodos y procedimientos administrativos en los que se basa el Programa.
-Determinación de estrategias a seguirse en su conducción.
-Revisión del Sistema Logístico del Programa.
-Diseño de los cursos de adiestramiento.

Estas actividades se realizarán en la Dirección del Programa en Quito y en las Unidades operativas que se estime conveniente.

3.3.2 Prestación de Servicios:

Actualmente, el Programa de Bienestar Familiar cuenta con 30 Centros de atención médica ubicados en Hospitales, Enfermerías militares y locales especiales, con un personal

de 29 médicos, 4 obstetrices, 10 Trabajadoras Sociales, 12 Auxiliares de Enfermería y 3 Educadores para la Salud.

En los 5 años del Proyecto, el número de Unidades deberá incrementarse progresivamente hasta llegar a 43. (Ver Anexo No. 1).

Considerando que algunos Subcentros subirán a la categoría de Centros, se alcanzará, al 5to año del Proyecto, el siguiente volumen de personal: 43 Médicos, 9 Obstetrices, 10 Trabajadoras Sociales, 46 Auxiliares de Enfermería y 14 Auxiliares Sociales, estos últimos, para trabajar preferentemente an áreas rurales. (Ver Anexo No. 2).

Esta ampliación de la estructura del Programa permitirá incrementar el número de usuarias de aproximadamente 4.000 alcanzadas en 1981 a un promedio anual de 11.900 en los 5 años de duración del Programa, y a un total aproximado de 26.300 usuarias activas para 1986.

La asesoría técnica procederá finalmente a la revisión de la mecánica de atención médica del Programa y de los métodos, normas y procedimientos que se usan en la prestación de servicios de planificación familiar.

3.3.3 Educación y actividades afines:

-Revisión de la metodología educativa que lleva a cabo el personal de Educación y de Trabajadoras Sociales.

-Cursos de adiestramiento a Educadores y Trabajadoras Sociales de conformidad con los objetivos planteados.

-Actualización de normas, métodos y procedimientos que deban seguirse para el desempeño de las funciones educativas.

-Adaptación de las funciones y actividades de las Trabajadoras Sociales al medio social en que están encuadrados los Centros y Subcentros.

-Revisión de las técnicas educativas a ser empleadas en áreas urbanas y rurales.

-Técnicas en la elaboración y uso de material impreso y audiovisual.

3.3.4 Adiestramiento de Personal:

-Cursos de adiestramiento en el Exterior para 3 para-médicos.

-Cursos y seminarios dentro del País para personal médico en servicio y nuevo que ingresare y para personal para-médico, donde:

a) se fomente el intercambio de experiencias de tipo científico y técnico;

b) se estudie los nuevos avances en metodología anticonceptiva y educativa.

c) se examine la problemática del seguimiento a usuarias que abandonan el servicio.

-Curso de capacitación para auxiliares sociales con el objeto de que sean capacitados adecuadamente para un trabajo en áreas rurales.

3.3.5 Investigación:

Se desarrollarán dos temas de investigación:

a) Sobre alto riesgo materno-infantil cuyo objetivo es descubrir una metodología de servicios para proveer a su vez un servicio integral de atención en salud a mujeres en edad reproductiva que permita prevenir el embarazo de alto riesgo, y;

b) Un estudio sobre características de las usuarias de los Servicios de Planificación Familiar/FF.AA., que haga posible su conocimiento y facilite la determinación de estrategias para implementación de otro tipo de acciones de salud.

4. DURACION DEL PROYECTO

El Proyecto tendrá una duración de 5 años.

5. IMPLEMENTOS DEL PROYECTO

5.1 Estructura

La parte administrativa y de ejecución del proyecto se estructura en base a una Oficina Central, sede de la Dirección, ubicada en

la ciudad de Quito y de Clínicas que prestan servicios de planificación familiar, ubicadas en 18 de las 20 provincias del País, como se puede apreciar en el Organigrama que trae el Anexo No. 3.

El Programa de Bienestar Familiar de FF.AA. depende directamente de la Dirección General de Sanidad Militar, que será responsable de la ejecución del presente proyecto. Dependiente de aquella, la Jefatura del Departamento con sus Secciones lleva la responsabilidad de la ejecución técnica del Proyecto, al que prestarán su apoyo los Directores de Sanidad de las 3 Ramas: Ejército, Marina y Aviación.

Finalmente, la ejecución de todas las actividades de Planificación Familiar a nivel de Centros y Subcentros, estará bajo la responsabilidad directa de sus médicos Jefes, de acuerdo con las normas emanadas de la Dirección General de Sanidad Militar.

5.3 Personal

El Programa de Bienestar Familiar de FF.AA. contará con el siguiente personal: en cada año del período 1982-1986 del Proyecto.

Personal	1981	1982	1983	1984	1985	1986
5.3.1 Of. Dir.						
Médicos	2	2	2	2	2	2
Educador	1	1	1	1	1	1
Estadístico	1	1	1	1	1	1
Contador	1	1	1	1	1	1
Secretarias	2	2	2	2	2	2
Bodeguero	1	1	1	1	1	1
Chofer	1	1	1	1	1	1
5.3.2 Centros y Subcentros						
Médicos	29	35	40	42	42	42
Obstetrices	6	9	9	9	9	9
Educadores	2	2	2	2	2	2
Trab. Social	10	10	10	10	10	10
Citotecnól.	4	4	4	4	4	4
Aux. Enfer.	20	33	38	40	40	40
Aux. Social	-	9	14	14	14	14
Choferes	-	4	4	4	5	5
TOTAL	80	115	130	134	135	135

5.4. PLAN DE TRABAJO DEL PROYECTO

TIEMPO DE DURACION Y LUGARES

ACTIVIDADES	1981 1.982	1.983 1.984	1.985 1.986	DIAS
	PRIMER PERIODO (45 días)	SEGUNDO PERIODO (30 días)	TERCER PERIODO (15 días)	TOT. 90
5.4.1. Asesoramiento Técnico:				
- Administración y Logística	(13-26) X-81 (13 días Quito)	( ) X-83 (10 días Quito)	( ) X-85 (10 días Quito)	33
- Prestación de Servicios médicos	(9-26) XI-81 (15 días Quito)	( ) XI-83 (10 días Quito)	( ) XI-85 (5 días Quito)	
- Capacitación a personal médico y Obstetrices.	(9-26) XI-81 (3 días Quito)			33
- Investigación	(9-26) XI-81	( ) XI-83	( ) XI-85	
- Evaluación	(9-26) XI-81	( ) XI-83	( ) XI-85	
- Educación	( )I-82 (10 días Qto)	( ) X-84 (6 días Qto)		
- Capacitación Personal Paramédico	( ) I-82 (4 días Qto)	( ) X-84 (4 días Qto)		24

A C T I V I D A D E S	1.981	1.982	1.983	1.984	1.985	1.986
5.4.2 Adiestramiento en el Exterior						
- Curso para Citotecnólogas		III-V-84 (3 meses BOGOTA)	III-V-83 (3 meses BOGOTA)	III-V-84 (3 meses BOGOTA)		
5.4.3 Adiestramiento Nacional:						
- Seminarios para Médicos y Obstetrices		VIII-82 (4 días Quito)	VIII-83 (4 días Guayaquil)	VIII-84 (4 días Cuenca)	VIII-85 (4 días Quito)	VIII-86 (4 días Quito)
- Seminario para Paramédicos			III-83 (4 días Pasaje)	III-84 (4 días Gyquil)	III-85 (4 días Cuenca)	III-86 (4 días Quito)
- Seminario para Auxiliares Sociales		III-82 (4 días Quito)	V-83 (4 días Gyquil)	V-84 (4 días Loja)	V-85 (4 días Quito)	V-86 (4 días Pasaje)
5.4.4 Apertura de Clínicas Nuevas		III-82 (6 clínicas)	III-83 (5 clínicas)	III-84 (2 clínicas)		
5.4.5 Motivación y Educación	I-XII-81	I-XII-82	I-XII-83	I-XII-84	I-XII-85	I-XII-86
5.4.6 Supervisión		I-XII-82	I-XII-83	I-XII-84	I-XII-85	I-XII-86

.../...

A C T I V I D A D E S	1.981	1.982	1.983	1.984	1.985	1.986
5.4.7 Investigación			I-XII-83	I-XII-84		
5.4.8 Suministros de Equipos y materiales						
- Vehículos		III-82 (4 unidades)			III-85 (1 unidad)	
- Equipos y materiales		V-82				

6. EVALUACION E INFORMES

6.1 Evaluación

Esta actividad deberá ser realizada al término de cada año para orientar la replanificación subsiguiente, y al término de los 5 años de duración del Proyecto a fin de conocer los logros alcanzados.

6.2 Informes

Fuera de los mensuales y trimestrales de rutina que realice el Programa a lo largo de los 5 años del Proyecto, el equipo asesor realizará sus informes de evaluación propios, en los períodos señalados en el Plan de Trabajo de este documento, los mismos que ayudarán a orientar y conducir mejor el Programa.

7. PRESUPUESTO DEL PROYECTO

7.1 Cuadro Resumen:

	1	2	3	4	5	TOTAL
1. Asesoría Técnica	$ 20.000	- . -	6.000	- . -	5.000	31.000
2. Adiestramiento Nacional	15.740	6.580	6.580	6.580	6.615	42.095
3. Adiestramiento Exterior	4.656	4.656	4.658	- . -	- . -	13.970
4. Supervisión y Promoción	7.670	7.670	7.670	7.670	8.420	39.100
5. Investigación	15.000	15.000	- . -	- . -	- . -	30.000
6. Equipos y Materiales	76.800	15.000	10.000	18.000	5.000	124.800
7. Personal	62.145	43.490	27.875	9.200	- . -	142.710
8. Alquiler de locales de Clínicas	10.000	10.000	10.000	10.000	10.000	50.000
S U M A N	$212.011	102.396	72.783	51.450	35.035	473.675

7.2 Detalle del Presupuesto

7.2.1 Asesoría Técnica:

90 días x $ 200 diarios	$ 18.000	
Viáticos (90 días)	6.500	
Pasajes (3)	3.000	
Suministros y equipos	600	
Transporte local	2.000	
Secretaria-3 meses	900	
Subtotal:		$ 31.000

7.2.2 Adiestramiento Nacional:

7.2.2.1 Honorarios profesionales

-Seminarios para Personal Médico (115) 6 profesores nacionales 18 horas a $ 20 cada una x 3 seminarios	$ 1.080	
2 profesores extranjeros 4 días x $ 200 cada día x 3 seminarios	4.800	
-Seminarios para Personal para-médico (63) 6 profesores nacionales 18 horas x $ 20 cada una x 3 seminarios	1.080	
-Seminarios para Auxiliares Sociales (14) 6 profesores nacionales 18 horas x $ 20 cada una x 2 seminarios	720	
Subtotal:		$ 7.680

7.2.2.2 Viáticos para Cursantes.

-Médicos y obstetrices 35 x $35 diarios x 4 días	4.900	

	-Paramédicos 63 x $35 diarios x 4 días	$ 8.820	
	-Auxiliares Sociales 14 x $20 diarios x 4 días	1.120	
	Subtotal		$ 14.840
7.2.2.3	Pasajes para Cursantes		
	-Médicos y Obstetrices 17 médicos a Quito	$ 350	
	18 médicos a Guayaquil	650	
	-Para-médicos 63 en Pasaje y Loja	2.000	
	-Auxiliares Sociales(14)		
	-Otro personal (6) 6 profesores en Pasaje y Loja	400	
	Subtotal		$ 3.850
7.2.2.4	Suministros y otros para los cursos		
	-Cursos y Médicos: Papelería $200/Seminario x 5	$ 1.000	
	Correo y teléfono $100/Seminario x 5	500	
	Carpetas 117 x $15 c/u	1.755	
	-Cursos a Para-médicos Papelería $200/Seminario x 3	600	
	Correo y teléfono $100/Seminario x 3	300	
	Carpetas 70 x $10 cada carpeta	700	

-Cursos a Auxiliares Sociales
Papelería
$200 x 2 Seminarios $ 400
Correo y teléfono
$100 x 2 Seminarios 200
Carpetas
18 x $ 15 c/u 270

-Cursos de Orientación a líderes Militares 10.000

Subtotal $ 42.095

7.2.3 Adiestramiento Internacional

7.2.3.1 Cursos para Citotecnólogas (3)

-Viáticos 4.440/9 m/h $ 13.320
3 pasajes 215,60 c/u 650

Subtotal $ 13.970

7.2.4 Supervisión-Promoción

7.2.4.1 Supervisión:

-Viáticos
1 Médico x $ 35 diarios x 40 días x 32 visitas $ 4.480
1 Administrador para la Salud x $25 diarios x 4 días x 24 visitas 3.200

-Pasajes
2 personas x 32 pasajes 2.500
Transporte local 1.500

Subtotal $ 11.680

7.2.4.2	Actividades Educativas:		
	-Viáticos Educadores para la Salud 3 x $21 diarios x 5 días x 60 meses	$ 18.900	
	Trabajadoras Sociales 4 x $ 07 diarios x 5 x 18 meses	6.120	
	-Pasajes 3 Educadores para la Salud zonas 1, 2, 3 $500 por año x 3 años	1.500	
	4 Trabajadoras Sociales	900	
	Subtotal		$ 39.100

7.2.5 Investigación

7.2.5.1	Encuesta:		
	Características socioeconómicas de las usuarias del Programa de Bienestar Familiar de las FF.AA.	$ 10.000	
7.2.5.2	Plan Piloto de Investigación sobre embarazo de alto riesgo	20.000	
	Subtotal		$ 30.000

7.2.6. Equipos y Materiales

7.2.6.1. Cuadro Resumen:

	1	2	3	4	5	TOTAL
- Vehículos						
5 Jeeps	32.000	- . -	- . -	8.000	- . -	40.000
- Equipos Médicos						
Instrumental 43	15.000	- . -	- . -	- . -	- . -	15.000
Microscopes	4.800	- . -	- . -	- . -	- . -	4.800
- Equipo Audiovisual	5.000	- . -	- . -	- . -	- . -	5.000
- Materiales						
Laboratorio	5.000	- . -	- . -	- . -	- . -	5.000
Educativos	15.000	15.000	10.000	10.000	5.000	55.000
	76.800	15.000	10.000	18.000	5.000	124.800

....

7.2.6.2. Equipo y Materiales (Detalle)

7.2.6.2.1. Vehículos

Para Quito, Guayaquil, Cuenca, Pasaje, Tipo Jeep 5 Unidades x	$ 8.000	
		$ 40.000

7.2.6.2.2. Equipo Médico

Instrumental 43 clínicas	15.000	
Microscopios 4 x 1.200	4.800	
Mesas Ginecológic. (12)	— . —	$ 19.800

7.2.6.2.3. Equipo Audiovisual

Proyectores de slides (4)	1.000	
Proyectores de cine (4)	3.200	
Pantallas de cine (4)	400	
Reproyectores (1)	200	
Caballetes Flip Chart (4)	200	
		5.000

7.2.6.2.4. Materiales

-Placas, colorantes, alcohol y materiales de laboratorio para 4 Centros	5.000
-Educativas Plegables Folletos Carteles Películas Diapositivas	55.000
Subtotal	**$ 124.800**

7.2.7. Personal

7.2.7.1. Auxiliares sociales

1er. año		
14 Aux. Sociales 169/m/m.		
Salario Básico	29.400	
Beneficios	13.500	
		$ 42.900
2do. año		
10 Aux. Sociales 120/m/m.	21.000	
Beneficios	9.660	
		$ 30.660
3er. año		
7 Aux. Sociales 84/m/m.		
Salario Básico	14.700	
Beneficios	6.760	
		$ 21.460
4to. año		
3 Aux. Sociales 36/m/m.		
Salario Básico	6.300	
Beneficios	2.900	
		$ 9.200

7.2.7.2. Obstetrices

3 Obst. 36 meses/obst.	19.245	
2 " 24 " "	12.830	
1 " 12 " "	6.415	
		$ 38.490
Subtotal		$ 142.710

7.2.8. Alquiler de locales para Clínicas

7.2.8.1. 4 clínicas (Santo Domingo, Esmeraldas, Quevedo, Ambato) $ 208 x 60 x 4	$ 50.000	
Subtotal	$ 50.000	
Gran Total		$ 473.675

ANEXO N° 1

INCREMENTO DE UNIDADES ASISTENCIALES O CLINICAS EN EL PERIODO DE 1982 - 1986.

UNIDADES	Antig.	NUEVAS					TOTAL
	1981	1982	1983	1984	1985	1986	
CENTROS:	12						12
No. 13 Sto. Domingo		1					1
No. 14 Esmeraldas		1					1
No. 15 Quevedo		1					1
No. 16 Taura	1						1
No. 17 Portoviejo	1						1
SUBCENTROS.	16						16
1-A Quito		1					1
1-B Ibarra ( )				1			1
1-F Latacunga		1					1
2-B Manta			1				1
3-A Cuenca			1				1
4-F Macará			1				1
5-A El Guabo			1				1
6-C Mecan (¿)				1			1
10-A El Coca		1					1
10-B Tena			1				1
TOTAL	30	6	5	2			43

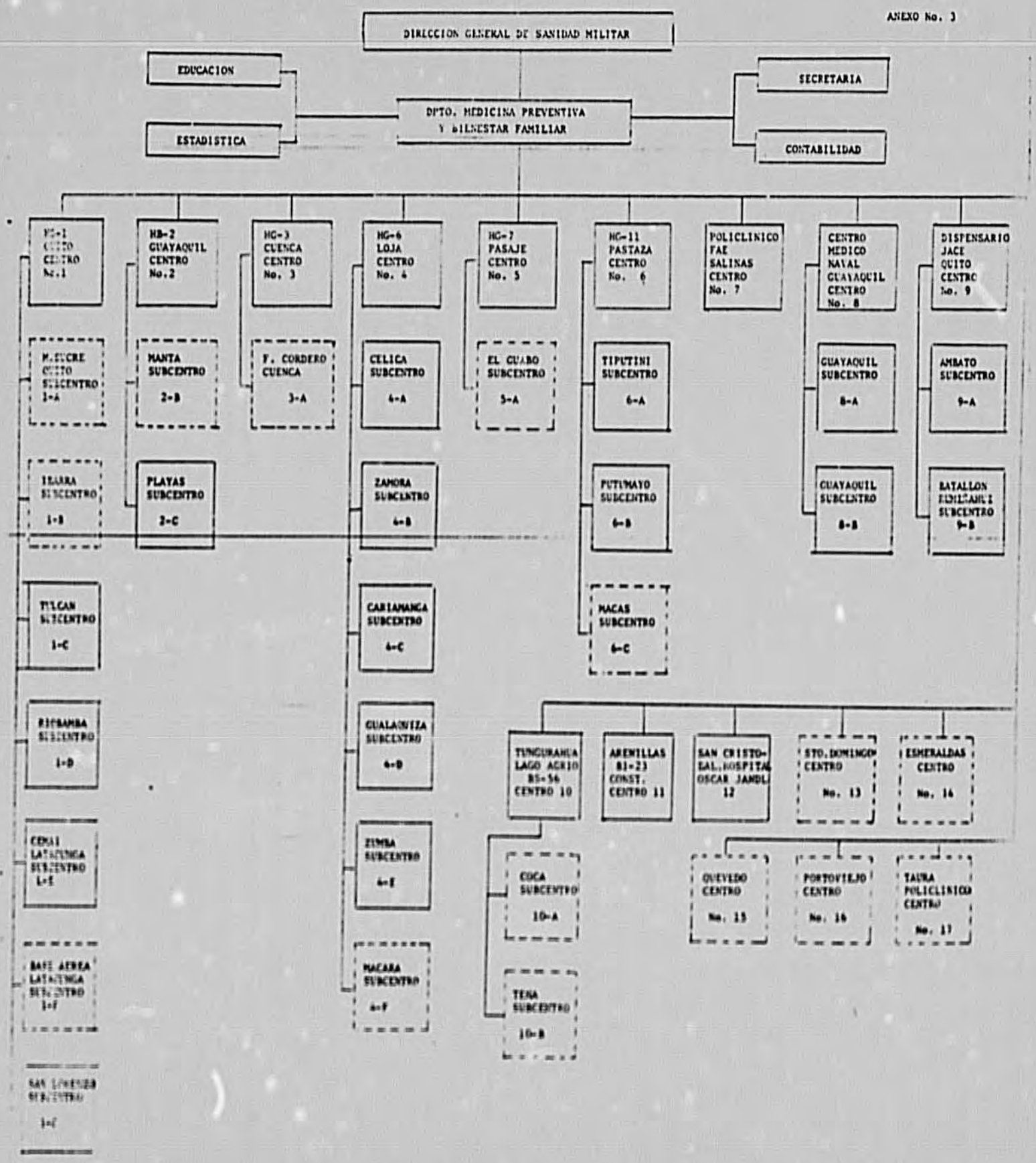
ANEXO N° 2

INCREMENTO DE PERSONAL DEL PROGRAMA DE BF/FF.AA.

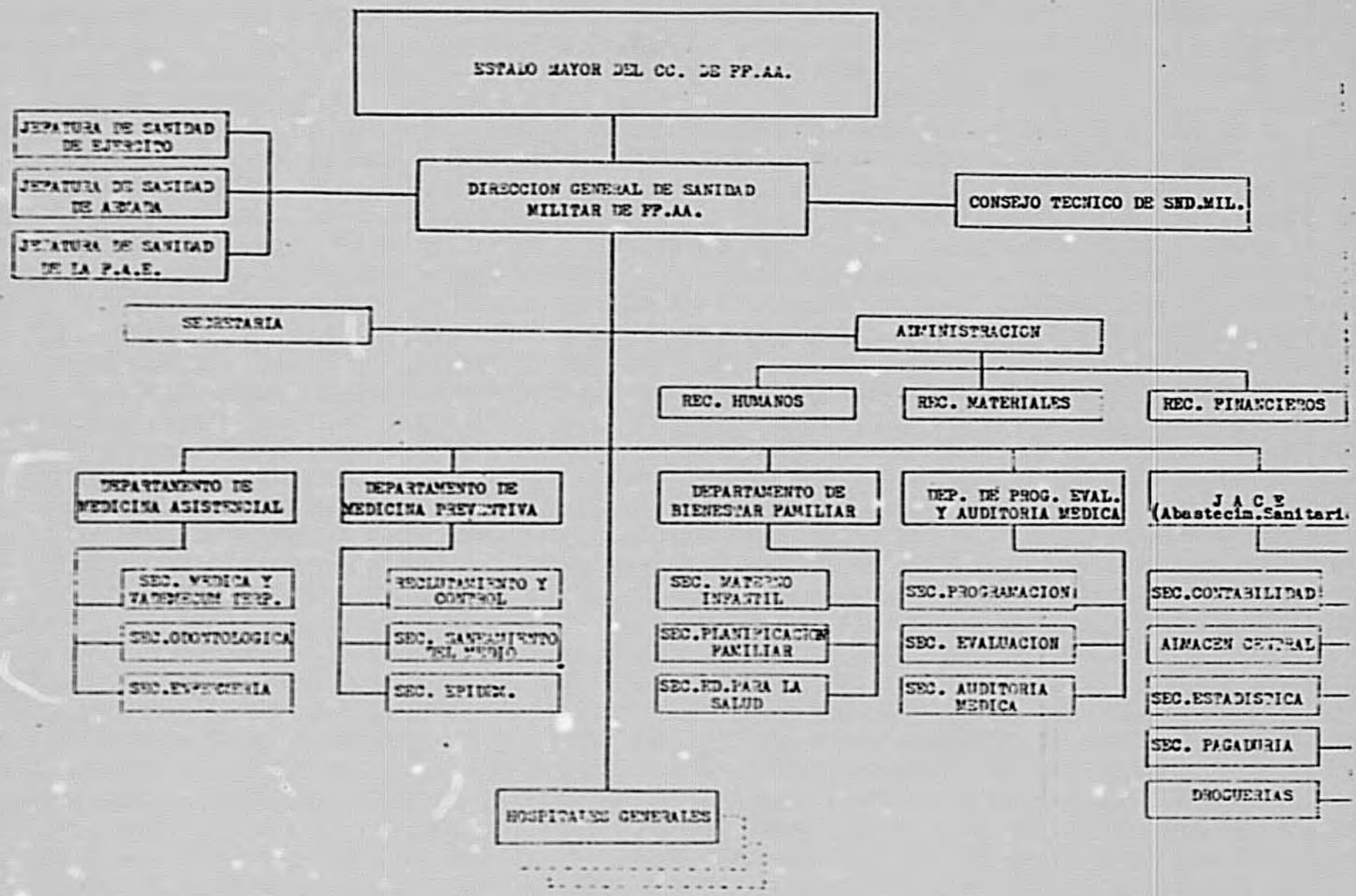
PERSONAL	Antig.	NUEVO					TOTAL
	1981	1982	1983	1984	1985	1986	
OF. Dirección:	9						9
Centros y Sub.	71						71
Médicos	-	6	5	2			13
Obstetrices	-	3					3
Aux. Enferm.	-	13	5	2			20
Aux. Sociales	-	9	5				14
Choferes	-	4			1		5
TOTAL	80	35	15	4	1		135

DIRECCION GENERAL DE SANIDAD DE FF.AA.

ANEXO No. 3



O R G A N I G R A M A



Oficio No. 81-177-G-7-2.

REPUBLICA DEL ECUADOR

ESTADO MAYOR CONJUNTO DE LAS FUERZAS ARMADAS

ASUNTO : Enviando Resumen Económico.

Quito, a .... de 17 JUN. 1981 de 19....

DE : DIRECCION GENERAL DE SANIDAD DE FF.AA.

PARA : SR. JOHN A. SANDRAILO-REPRESENTANTE DE USAID EN EL ECUADOR.

EN : En su Despacho.-

Adjunto al presente me es grato enviar a Ud., Sr. Representante, un resumen de los rubros económicos a los que el Ministerio de Defensa Nacional del Ecuador se compromete, en calidad de contrapartida, para dar cumplimiento al Convenio Bilateral con la Misión USAID. que Ud. tan dignamente la preside, y cuyo objeto será la ampliación y asesoramiento técnico al Programa de Bienestar Familiar de FF.AA. en el período 1.982 - 1.985, a tenor del Proyecto de Convenio enviado a Ud. en fecha 5 de Mayo del año en curso..

Sin otro particular, reitero a Ud., Señor Representante, el testimonio de mi más alta consideración y estima.

DIOS, PATRIA Y LIBERTAD

EL DIRECTOR GRAL. DE SND. DE FF. AA.

DR. GUILLERMO ITURRALDE A.
Coronel MAS:SND. Avc.

Distrib:
O-1. Destinatario
C-2. Archivo G-7-2.
ANEXOS: lo indicado.
GIA/rlr.

CONTRIBUCION DEL MINISTERIO DE DEFENSA NACIONAL DEL ECUADOR AL PROYECTO DE CONVENIO DE BIENESTAR FAMILIAR PARA EL PERIODO 1.982-1985

1.-. Pago de salarios al personal del Programa de Bienestar Familiar de FF.AA. que participará periódicamente en los cursos de adiestramiento.	$ 33.300,oo
2.- Pago de salarios a personal de Promotores Sociales y Obstetrices en base de desescalamiento.	105.900,oo
3.- Apoyo administrativo al desarrollo de los cursos de entrenamiento.	2.400,oo
4.- Gastos de mantenimiento y operación de los vehículos y equipos.	50.000,oo
5.- Apoyo administrativo al Programa de Bienestar Familiar de FF.AA.	41.600,oo
TOTAL DE CONTRIBUCION :	$ 233.200,oo

Quito, a 16 de Junio de 1.981

DIOS, PATRIA Y LIBERTAD

EL DIRECTOR GRAL. DE SND. DE FF. AA.

DR. GUILLERMO ITURRALDE A.
Coronel. EMS. SND. Avc.

ANNEX V-C

República del Ecuador
Instituto Ecuatoriano de Seguridad Social
Dirección Nacional Médico Social
Departamento Nacional de Medicina Preventiva

Programa de Medicina
Preventiva/Bienestar Familiar

1981 - 1984

INSTITUTO ECUATORIANO
DE SEGURIDAD SOCIAL
DIRECCION TELEGRAFICA IESS • TELEFONO 230 320 Y 547-400 • CASILLA 8
TELEX 2200 • AVDA. 10 DE AGOSTO Y BOGOTA • QUITO-ECUADOR S.A.

Of. No. 026-1-613-80

Quito, septiembre 5 de 1.980

Señor
John A. Sanbrailo,
Jefe de la Misión de la A.I.D. en el Ecuador
CIUDAD

De conformidad a las reuniones sostenidas entre los representantes del Instituto Ecuatoriano de Seguridad Social y de la Agencia para el Desarrollo Internacional, esta Institución considera apropiado el solicitar la cooperación técnico-económica para la ejecución de un programa complementario en el área de Paternidad Responsable, a las acciones de salud que el Instituto Ecuatoriano de Seguridad Social está desarrollando y para las que encontrándose en etapa de planificación sean puestas en práctica una vez que cuenten con la decisión de ser ejecutadas por parte de esta Institución y del Gobierno Nacional.

Consideramos adecuado en primera instancia, el determinar las áreas específicas de cooperación a través del diseño de un proyecto que se elaboraría con la participación de nuestro personal profesional en coordinación con los funcionarios que usted se dignará designar. Esta actividad conjunta nos permitiría la preparación de un documento que cuente con el aporte técnico de A.I.D.

Sin embargo, deseamos expresar algunos criterios que servirán de pauta para la elaboración del mencionado documento:

1. A través del Servicio de Medicina Preventiva, el Instituto ha venido prestando servicios de Bienestar Familiar a trabajadores fabriles en las diferentes secciones geográficas del país. Consideramos que estas acciones deben ser reforzadas procurando la capacitación técnica del personal médico y paramédico encargado de la prestación de estos servicios; la dotación de material promocional que informando sobre las prestaciones del Instituto constituya un instrumento a la vez que informativo, que facilite el acceso del grupo de afiliados con un conocimiento cabal de la capacidad de la Institución para satisfacer sus necesidades.

2. Esta administración además, considera que los servicios de sa-

Form. Nº 0-1-B.A.-100.000.- 5-01-01 12/72

INSTITUTO ECUATORIANO
DE SEGURIDAD SOCIAL

DIRECCION TELEGRAFICA IESS • TELEFONO 510 320 Y 507 400 • CASILLA 8
TELEX 2280 • AVDA. 10 DE AGOSTO Y BOGOTA • QUITO - ECUADOR S.A.

lud no han llegado en calidad y cobertura como era de desearse al campesinado. Consecuentes en nuestros planteamientos de incorporación del marginado al desarrollo del país, estamos considerando la ampliación de nuestras actividades hasta alcanzar con servicios, una cifra de población rural que llegue al millón de habitantes.

Esto constituirá un esfuerzo de gran envergadura, en razón de la fuerte inversión necesaria para llevarlo a cabo. Consideramos que el área de capacitación de personal de campo a nivel formativo requerirá dentro de un consorcio de entidades que deseen cooperar en este esfuerzo una magnífica colaboración que prestaría a los afnaes del Instituto un componente del Proyecto Paternidad Responsable y complementaría la formación que este tió de personal necesitaría.

El proyecto en cuestión y para el que nos hemos permitido delinear estos planteamientos contaría de nuestra parte con el concurso de representantes de esta entidad en las áreas del Seguro Campesino, del Servicio de Medicina Preventiva y de la Jefatura de Educacuón para la Salud, funcionarios que contaría con la coordinación directa del señor Director General de los Servicios Médicos. Para este efecto quedan designados los señores doctores: Octavio Valencia, Edmundo Montiel, César Córdova y Lcdo. Mario Alarcón.

Es de nuestro interés, el que este trabajo se desarrolle a la brevedad posible por lo que manifestamos a usted, señor Representante, que una vez que usted haya designado las responsabilidaddes por parte de A.I.D., se inicien las sesiones respectivas.

Muy atentamente,

Dr. Raúl Arturo Carrera
DIRECTOR NACIONAL ADMINISTRATIVO
DEL I.E.S.S.
ENCARGADO DE LA DIRECCION GENERAL

Dr. RAC/gtm.

Form. Nº 061-B.A.—100.000.- 30-01-09—12/72

ANNEX V-C

Proyecto de Asistencia al Programa de

Medicina Preventiva/Bienestar Familiar

1. Resumen

Este proyecto se propone extender la cobertura de los servicios, mejorando la calidad de la prestación, del programa de Medicina Preventiva/Bienestar Familiar hasta alcanzar un incremento de la tasa actual de nuevas atenciones a la población afiliada en un 10.7% respectivamente, hasta 1984.

El objetivo de extensión de cobertura será logrado a través del incremento en el número de brigadas de medicina preventiva, tanto a nivel nacional como regional que se extenderá a un total de 14 provincias del país, alcanzando 32 unidades de servicios.

El objetivo de mejoramiento de la calidad de los servicios prestados, será alcanzado a través de la capacitación del personal médico como paramédico y de una acción de información y motivación a la población afiliada que propenderá a un acercamiento entre el servicio y la población atendida.

2. Antecedentes y Justificación

2.1 Antecedentes

El Servicio de Medicina Preventiva fue constituído de manera legal, dentro de la Dirección Médico Social en el año 1964 en que se iniciaron la parte administrativa y de organización.

Los servicios a la población afiliada comenzaron una vez que, se conformaron dos Brigadas Móviles para ejecutar un programa de control médico y odontológico periódicos en el lugar de trabajo de la población servida, modalidad que se mantiene hasta la actualidad.

Este servicio se vió incrementado a partir de 1966, por el establecimiento de un consultorio médico fijo, encargado del programa de detección de cáncer cérvico-uterino y de mama y de la prestación de servicios de planificación familiar. Actividad similar fue iniciada por la Regional establecida en la ciudad de Guayaquil. El IESS, fue la primera entidad gubernamental en el país en incluir los servicios de planificación familiar, dentro de atención

general en salud. El IESS solicitó colaboración al Ministerio de Salud Pública para procurar el fortalecimiento de esta última actividad mantenida siempre dentro del servicio de Medicina Preventiva, apoyo que se obtuvo de USAID y se ejecutó con la colaboración del mencionado Ministerio.

Esta cooperación que se mantuvo entre 1970 y 1974 mayormente consistió en donación de algún equipo médico y audiovisual, y de colaboración para la ejecución de actividades de entrenamiento y promoción hacia la población servida.

Una vez terminado este período de colaboración, la responsabilidad de conducción de la actividad fue retomada nuevamente por el Instituto, y mantenida en similares condiciones hasta la actualidad, iniciándose un período en el que se ha contado con la donación de material anticonceptivo por parte de la Fundación Pathfinder y del auspicio de contados programas de entrenamiento en el exterior.

En razón de lo dispuesto en la Constitución vigente, aprobada en Referendum de 1978 en que se establece una determinación del Estado a este respecto, según lo señala el Art. 24, Sección II, de la Familia, que dice: "El Estado propugna la paternidad responsable y la educación apropiada para la promoción de la familia; garantiza el derecho de los padres a tener el número de hijos que puedan mantener y educar"; el Instituto Ecuatoriano de Seguridad Social, a través de la Dirección Médico Social, para ser ejecutado por su Departamento de Medicina Preventiva/Bienestar Familiar, propone el fortalecimiento de este programa para coadyuvar en la satisfacción de este planteamiento constitucional.

2.2 Justificación

En 1980 la prestación de Servicios de Medicina Preventiva cubrió solamente el 2.4% de la población afiliada en lo que se refiere a Examen Médico Periódico y el 0.4% del mismo Universo en lo relativo a Planificación Familiar y DOC. La relación población femenina afiliada/nuevas consultas de planificación familiar fue del 1.6%. Tal situación podría tener una explicación en que, el Servicio de Medicina Preventiva cuenta solamente con 7 Brigadas en toda la República y pocos Médicos Ginecólogos que colaboran con exclusividad en el Programa de Planificación Familiar.

El Departamento Nacional de Medicina Preventiva tiene en el Nivel Operativo, Servicios de Medicina Preventiva, que tucionan: 1ro. en forma móvil, desplazándose por las mañanas a los sitios de trabajo de la población afiliada; y 2do. en forma fija, por las tardes, para efectuar controles del Programa de Planificación Familiar y Examen Médico Periódico del personal de las empresas y otro tipo de establecimientos que por su número de trabajadores o por sus

condiciones de local no permiten el desplazamiento de la Brigada Móvil para prestar servicios en sus respectivas plantas físicas.

Los Colaboradores son Ginecólogos que trabajan en los diferentes Dispensarios, Clínicas u Hospitales del IESS y que prestan servicios de Planficación Familiar, reportando sus acciones al Departamento Nacional de Medicina Preventiva.

3. Objetivos

3.1 Objetivo General

Incrementar el número y ampliar la cobertura de los Servicios de Medicina Preventiva/Bienestar Familiar a la población afiliada al IESS.

3.2 Objetivos Específicos

1. Elevar el nivel de atención de los Servicios de Medicina Preventiva/Bienestar Familiar.

2. Ampliar el Servicio de Medicina Preventiva/Bienestar Familiar a las áreas de mayor concentración de población afiliada a través de la implementación de nuevos servicios.

3. Informar y motivar a la población blanco para obtener su participación en las acciones del programa.

4. Fortalecer el sistema administrativo y logístico a nivel central y operativo.

5. Adiestrar al personal del nivel administrativo y de los Servicios de Medicina Preventiva y de Educación para la Salud, así como también Ginecólogos colaboradores actuales y a los que se incrementen por el aumento de brigadas.

6. Buscar los mecanismos apropiados que permitan el establecimiento de un nivel de Coordinación adecuada con el Seguro Social Campesino.

4. Descripción del Proyecto (Componentes)

4.1 Capacitación

1. Establecer un sistema de capacitación continuada para personal médico y paramédico que trabaja en los Servicios de Medicina Preventiva y para los que ingresaren en razón de la creación de nuevas Unidades.

2. Capacitar al personal directivo del programa para lograr una administración adecuada.

3. Establecer un sistema de información por objetivos que promueva en los niveles superiores y de conducción de las políticas del IESS su participación en el desarrollo del programa.

4. Capacitar Educadores para la Salud y otro personal que colabora en acciones de Bienestar Familiar dentro del sistema de capacitación establecido para los servicios de Medicina Preventiva/Bienestar Familiar.

4.2 Extensión de Servicios

Implementar con recursos humanos, físicos y de equipamiento un promedio anual de 6 nuevas unidades del Servicio, y/o complementar las existentes que carecieran del personal adecuado.

4.3 Educación e Información

1. Elaborar y distribuir material educativo dirigido a la población blanco y al personal ejecutor.

2. Promover el uso adecuado de material educativo disponible.

5. Duración

Este programa tendrá la duración de cuatro años a partir de la fecha de firma del Convenio entre el IESS y AID.

6. Implementación del Proyecto

6.1 Organización: Ver Organigrama.

6.2 Funcionamiento

Los Departamentos Nacionales de Medicina Preventiva y Educación para la Salud son técnico normativos y están compuestos por una Jefatura, Personal de Supervisores, Personal Administrativo y Operativo.

A nivel operativo, el personal de la Brigada depende administrativamente del Jefe de la Unidad Médica en la que funciona y a la que está adscrito. Consta del siguiente personal:

1 Médico Jefe Tratante
1 Médico Tratante
1 Enfermera

1-2 Trabajadoras Sociales
1 Odontólogo
1 Auxiliar de Odontología

En el Litoral existe una Jefatura Regional de Medicina Preventiva con sede en Guayaquil, bajo cuya supervisión funcionan dos Brigadas con personal no completo. El Departamento Nacional de Educación para la Salud dispone en la Jefatura Nacional de una Unidad de Producción de impresos y de una sala de Dibujo y Ayudas Audiovisuales. Todos los Educadores dependen de este Departamento, y, realizan labores de información, motivación y educación a nivel de Patronos y de afiliados.

6.3 Operación

El programa ha sido diseñado para ser desarrollado en secuencia de actividades, relacionadas unas a otras que permitan su mejor desenvolvimiento.

6.3.1. Se considera que el aspecto al que se debe proporcionar atención prioritaria constituye el de los programas de entrenamiento y capacitación nacionales, tanto para personal médico como paramédico y de educación para la salud; por tal, se ejecutarán:

1) Cinco Cursos para personal médico, con la participación de profesionales del Servicio de Medicina Preventiva y de colaboradores de los otros servicios, hasta alcanzar un total de 68 participantes.

2) Cuatro Cursos de entrenamiento para 96; Educadores para la Salud, Trabajdores Sociales y Enfermeras. Los Cursos se ejecutarán anualmente y participarán tanto el personal que actualmente se encuentra en servicio como el que ingresare conforme los servicios vayan estableciéndose.

6.3.2. A través de la capacitación en Cursos fuera del país, se programa 19 m/h de entrenamiento en el exterior que contemplarían: Preparación de material audiovisual; manejo y administración de programas y comunicaciones en planificación familiar, y participación en programas específicos en el área para personal directivo/administrativo.

Este componente será igualmente desarrollado durante la totalidad del período de ejecución del programa.

6.3.3. El componente de información reforzará las acciones del personal que ha sido capacitado, en su relación de servicios promocionales con la población afiliada.

Esta área dará énfasis tanto a la producción de material de transparencias, en un número de 10 series, como a la preparación y publicación de folletos informativos sobre las áreas de acción que son responsabilidad del Programa de Medicina Preventiva/Bienestar Familiar.

El Subprograma contempla además, la preparación a nivel central, de afiches sobre los temas indicados con anterioridad que se constituirán en una ayuda promocional al ser expuestos en las respectivas unidades. La preparación de este material hace necesaria la complementación con un equipo de proyección y grabadoras, que en este último caso a más de permitir la utilización del material preparado, podrían ser utilizados para promover la aportación de ideas del personal de campo en cuanto a temas nacionales y/o locales de promoción. Esta contribución se verá facilitada con la dotación de una cámara fotográfica a nivel de campo, que permitirá captar imágenes con características típicas del país. Se ha considerado además un pequeño número de proyectores de películas, que pudiendo utilizar el material producido en otros países, que por la información que poseemos no existe en variedad de temas adecuados, roten por los Servicios.

6.3.4. Se desea de manera final, reforzar el componente de Supervisión con la adquisición de dos vehículos, uno de los cuales se espera sirva además para transportar el equipo clínico de atención con el que las brigadas presten servicios en los lugares de trabajo de los afiliados y el otro sea utilizado en labores de supervisión de acciones educativas.

6.4 Administración

Los Departamentos Nacionales de Medicina Preventiva y Educación para la Salud realizan:

a) Una labor técnico normativa.

b) Trámites administrativos de su nivel, necesarios para mantener la coordinación de acciones, planes y programas con las otras divisiones de la Dirección Médico Social.

c) Supervisión directa a través de visitas a las Unidades Operativas o sitios de trabajo en fábricas, establecimientos, etc., tanto a las Brigadas como a los Educadores para la Salud.

d) Estudio de informes remitidos por las Brigadas que permiten medir el rendimiento o tomar acciones apropiadas para un mejor funcionamiento.

7. Evaluación

Se realizará mediante:

7.1 Detalle de avance de implementación del número de brigadas.

7.2 Número de nuevas atenciones y de aceptantes nuevas.

7.3 Número de personal administrativo y operativo capacitado.

7.4 Número de afiliados que han recibido información y motivación sobre el programa.

8. Informes

Los informes se harán tanto del aspecto programático como del aspecto financiero.

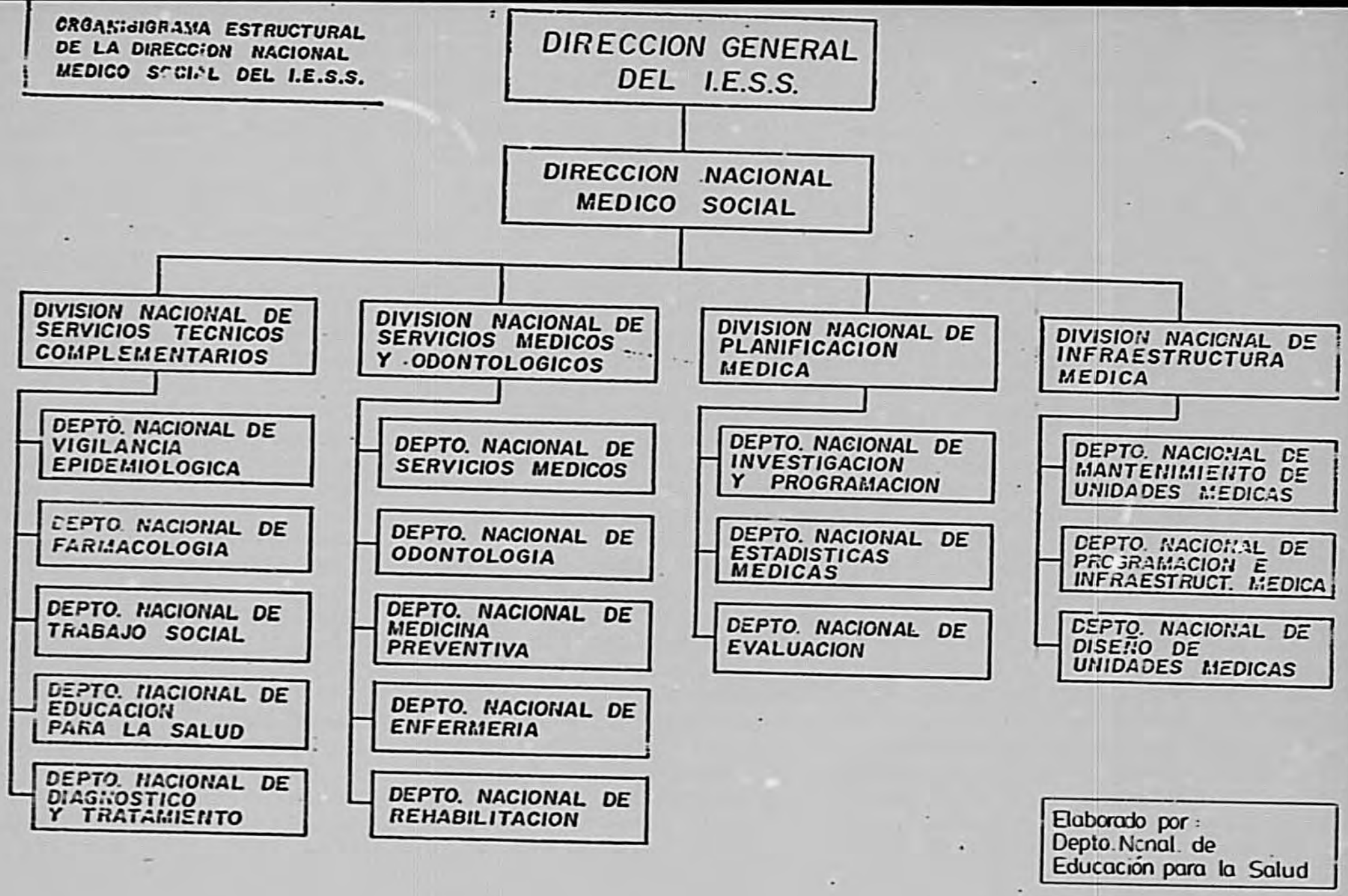
En el aspecto programático, se tendrá un cronograma de acción en los diferentes aspectos que comprenden los componentes del proyecto, es decir capacitación, extensión de servicios y componente educativo.

9. Presupuesto del Proyecto

9.1 Cuadro Resumen

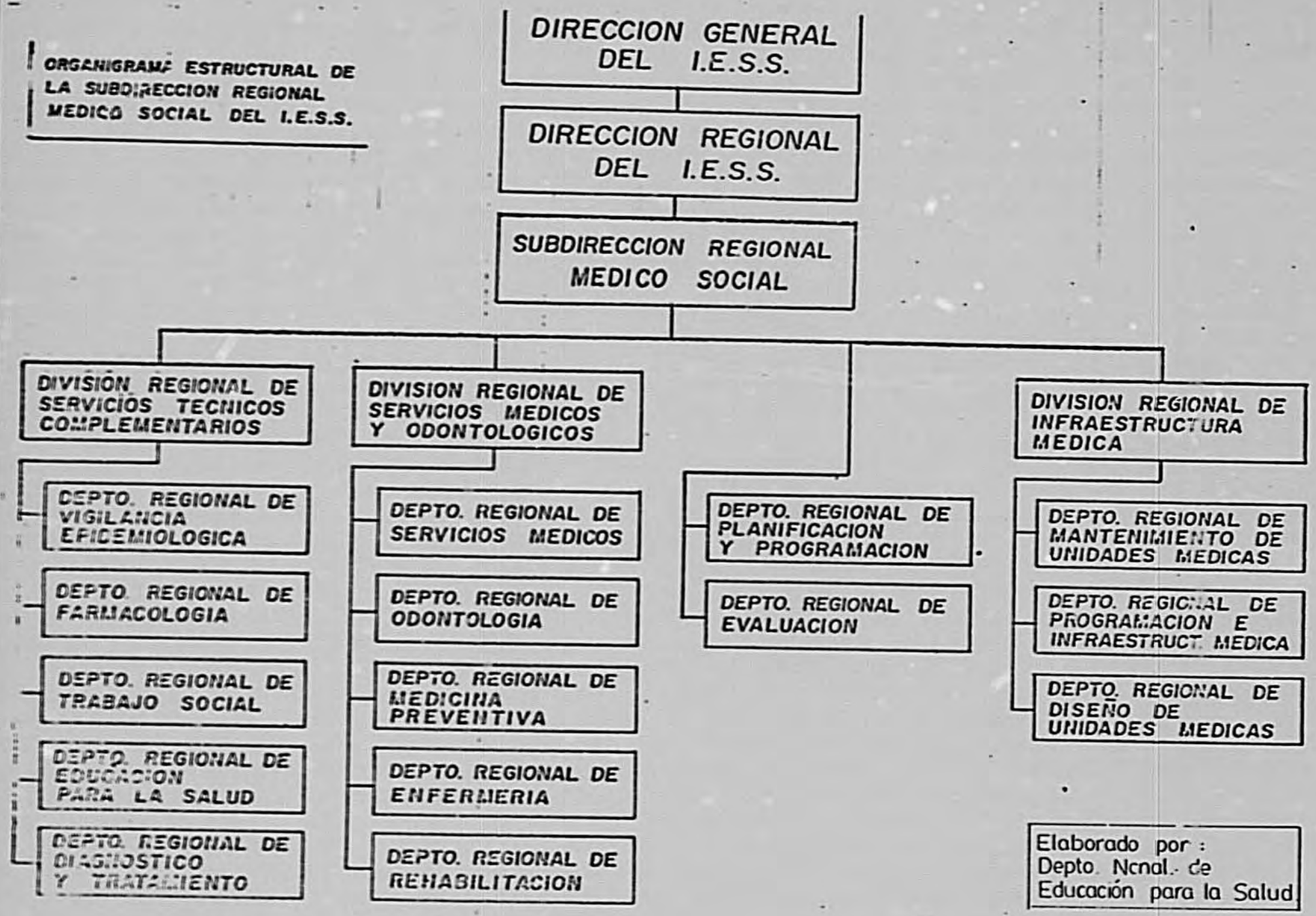
	1	2	3	4	TOTAL
Adiestramiento en el País	19.322	9.970	9.766	10.072	49.130
Adiestramiento en el Exterior	21.375	9.225	5.400	1.800	37.800
Equipo y Materiales	46.540	25.900			72.440
	87.237	45.095	15.166	11.872	159.370
Anticonceptivos	4.050	26.890	44.930	65.340	141.210

ORGANIGRAMA ESTRUCTURAL DE LA DIRECCION NACIONAL MEDICO SOCIAL DEL I.E.S.S.



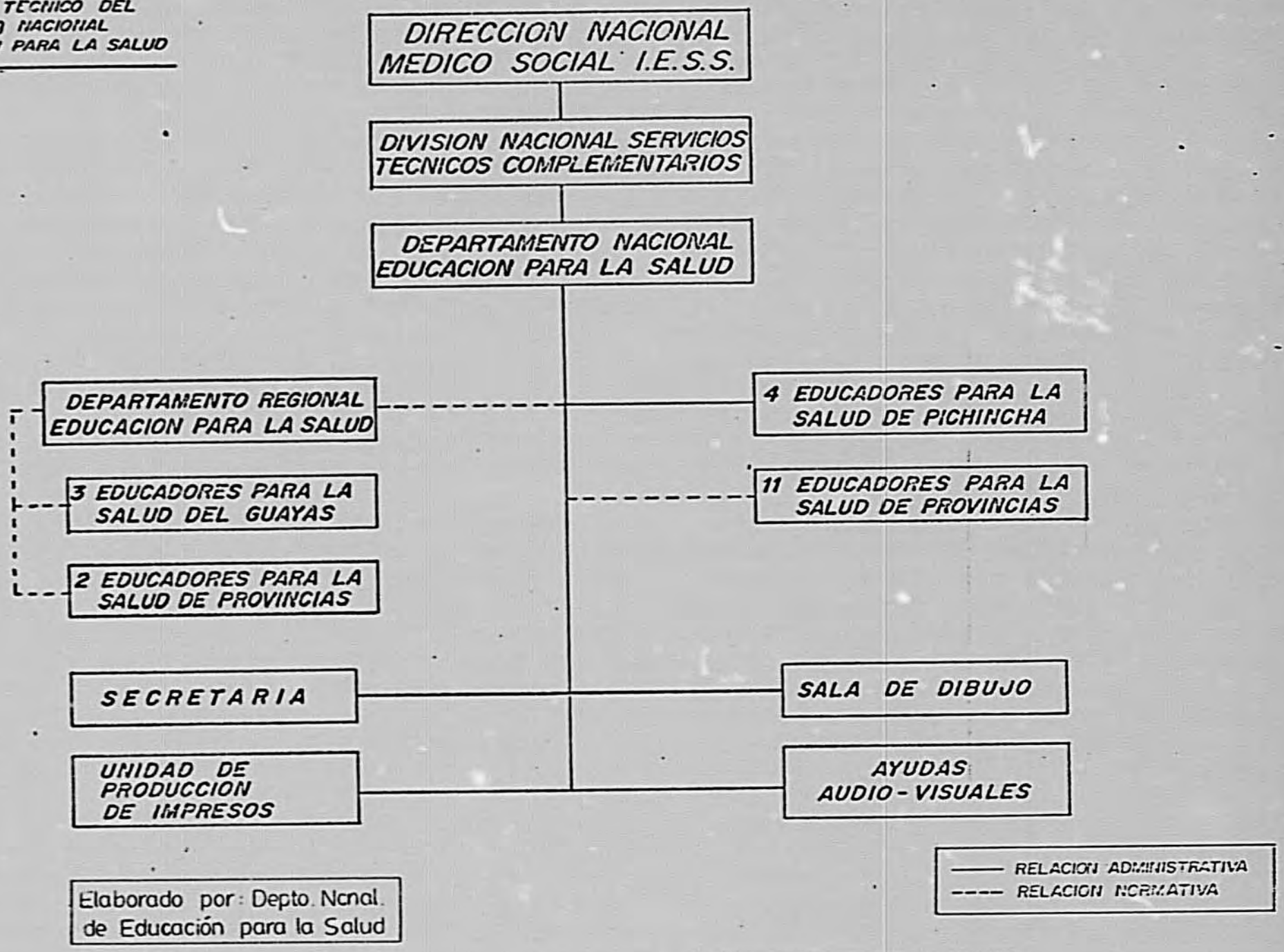
Elaborado por:
Depto. Nonal. de
Educación para la Salud

ORGANIGRAMA ESTRUCTURAL DE LA SUBDIRECCION REGIONAL MEDICO SOCIAL DEL I.E.S.S.



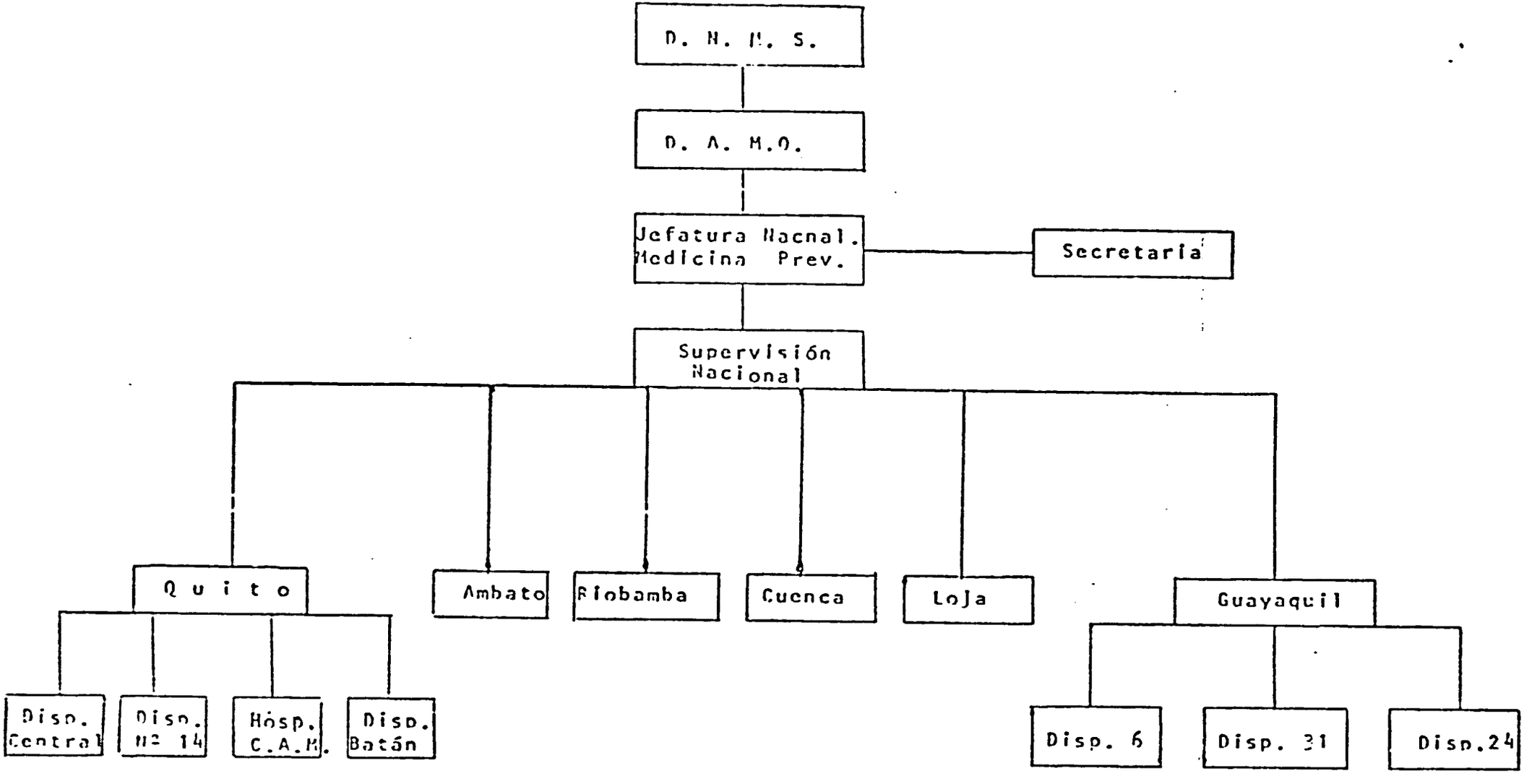
Elaborado por :
Depto. Nonal.- de
Educación para la Salud

ORGANIGRAMA ESTRUCTURAL
Y NORMATIVO TECNICO DEL
DEPARTAMENTO NACIONAL
DE EDUCACION PARA LA SALUD



Elaborado por: Depto. Nonal. de Educación para la Salud

ORGANIGRAMA DEL DEPARTAMENTO NACIONAL DE MEDICINA PREVENTIVA



9.1 Adiestramiento en el País.

A. Honorarios a Profesionales

1. Personal Médico (68), 40 horas/curso, $22 c/h, 5 cursos	4.400	
8/horas/motivación/curso $160 c/sesión, 5 cursos	800	
2. Personal paramédico (96), 40 horas/curso, $22, c/h, 4 cursos	3.520	
8/horas/motivación/curso, $160 c/sesión, 4 cursos	640	9.360

B. Viáticos y Pasajes

1. Personal Médico (68), viáticos: 49 médicos de 8 provincias, app. $34 diarios por 8 días c/curso	13.066	
Pasajes: 49 médicos de 8 provincias fuera de Quito y Guayaquil.	983	
2. Personal Paramédico (96), viáticos: 72 enfermeras, Trabajadoras Sociales y Educadores para la Salud, provenientes de 8 provincias, app. $34 diarios por 8 días c/curso	19.200	
pasajes 72 paramédicos de 8 provincias fuera de Quito y Guayaquil.	2.582	
	1.239	37.070

C. Materiales

Papelería para cursos y material para estudiantes , 9 cursos, $300 por reunión	2.700	2.700
Total de Entrenamiento en el País		49.130

9.2 Adiestramiento Fuera del País:

Producción de material audiovisual 2 m/h (1er. año)	3.700

Manejo y Administración de programas de planificación familiar (1er. año), 4 m/h	8.800	
Desarrollo de Programas de Planificación Familiar, 2do. y 3er. años, 4 m/h	7.200	
Comunicaciones en Planificación Familiar, 2 m/h 1ero. y 2do. años	4.400	
Nuevos adelantos médicos en Planificación Familiar, Programa Anual, 4 m/h	7.200	
Personal Directivo/Administrativo, 4 m/h	6.500	37.800
Total entrenamiento fuera del país		37.800

9.3 Equipos y Materiales

Vehículos: 2 vehículos - tipo club Wagon	9.300	
tipo Jeep	7.900	17.200

Equipo Audiovisual

Proyectores de películas (4)	3.400	
Proyectores de transparencias (17)	3.640	
Grabadoras (17)	1.700	
Cámaras fotográficas (2)	1.000	
Repuestos para proyectores	500	10.240

Materiales Educativos

Folletos (10 Títulos)	35.000	
Sets de transparencias (10 Títulos)	5.000	
Afiches (6 tipos)	2.000	
Películas educativas	3.000	45.000
Total Equipos		72.440

AMPLIACION DE LOS SERVICIOS DEL DPTO. NACIONAL DE MEDICINA PREVENTIVA 1980-1984

UNIDAD MEDICA	1980	1981	1982	1983	1984
Hospital C.A.M.	x				
Hospital Cuenca		x			
Hospital Riobamba			x		
Clínica de Ambato	x				
Clínica de Atuntaqui					
Clínica de Esmeraldas		x			
Clínica de Latacunga			x		
Clínica de Manta			x		
Clínica de Loja		x			
Dispensario Central Quito	x				
Dispensario 14 Quito	x				
Dispensario Batán Quito	x				
Dispensario Sur Occidental Quito		x			
Dispensario Cotocollao Quito		x			
Dispensario Sangolquí					
Dispensario Amaguaña Uyumbicho					
Dispensario Ibarra		x			
Dispensario Alausí					
Dispensario Tulcán				x	
Dispensario Portoviejo				x	
Dispensario Guaranda					x
Dispensario Otavalo					
Dispensario Cayambe					
Dispensario San Gabriel					
Dispensario Santo Domingo de los Colorados			x		
Dispensario Bahía de Caráquez					
Dispensario de Chone					x
Dispensario Jipijapa				x	

LA AMPLIACION DE LOS SERVICIOS DEL DPTO. NACIONAL DE MEDICINA PREVENTIVA 1980-1984

UNIDAD MEDICA	1980	1981	1982	1983	1984
Dispensario Puyo					
Dispensario Baños					
Dispensario Azoguez					
Dispensario Cañar					
Dispensario Macará					
Dispensario Zamora					
Dispensario El Angel					
Dispensario Cotacachi					
Dispensario Pasaje					
Dispensario Santa Rosa No. 19					
Dispensario Portoviejo					
Dispensario Zaruma No. 7					
Dispensario Piñas No. 36					
Dispensario San Juan Quito					
Dispensario Ecuatoriana Quito					x
Clínica Machala			xx		
Dispensario Central No. 6 Guayaquil	x	x			
Dispensario No. 31 Guayaquil	x	x			
Hospital Regional					
Hospital Babahoyo			x	←------x	
Hospital Milagro			x	←------x	
Hospital Ancón					
Hospital Durán			x	←----------x	
Disps. No. 24 Guayaquil			xx		
Disps. No. 26 Bucay					
Disps. No. 29 Libertad					
Disps. No. 40 Quevedo				x	
Disps. Daule					x
Disps. Vinces					x

CRONOGRAMA DE ACTIVIDADES

	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12
Adiestramiento fuera del País																																				
Producción de Material Audiovisual				x																																
Manejo y Administración de Programas de Planificación Familiar		x						x																												
Desarrollo de Programas de Planificación Familiar																			x				x							x			x			
Comunicaciones en Planificación Familiar						x								x																						
Adelantos Médicos en Planificación Familiar									x																									x		
Curso para Personal Administrativo		3x																																		
Adiestramiento en el País																																				
Curso Médicos - Quito				x									x												x											
Curso Médicos - Guayaquil					x																															
Curso Personal Para-Médico - Quito								x									x													x						

SEGURO SOCIAL

	Población Afiliada	Población Afiliada Femenina	Meta de Atenciones en Medicina Preventiva		Meta de Atenciones en bienestar familiar			Personal	
			#Aten.	Relación con pob.afiliada	#Aten.	Relación con pob.afiliada F	Relación con pob.afiliada PT	M.P.	Col.
1981	585.397	138.505	42.240	7.2	5.943	4.3	(1)	16	30
1982	616.434	145.848	66.000	10.7	11.428	7.8	(1.9)	25	33
1983	648.446	153.442	76.500	11.8	15.742	10.3	(2.4)	29	33
1984	681.434	161.227	89.760	13.2	21.371	13.2	(3.1)	34	33

1/ 3 atenciones hora x 220 días años 2.640.

DPTO.NACIONAL DE MEDICINA PREVENTIVA

EMB/ecn.

INSTITUTO ECUATORIANO DE SEGURIDAD SOCIAL

Form. Nº 818-1000-818-81 1471

INSTITUTO ECUATORIANO
DE SEGURIDAD SOCIAL

IESS

DIRECCION TELEGRAFICA: IESS CASILLA 2840 TELEX 2290 TELEFONO 230 920
AVDA 10 DE AGOSTO Y BOGOTA QUITO ECUADOR S.A.

I.E.S.S. MEDICINA PREVENTIVA

Presupuesto para Programa de Medicina Preventiva - Bienestar Familiar

A. Personal

-Salario del Personal a entrenarse

68 médicos x $60/día por 8 días	32.600
10 enfermeras x $30/día por 8 días	2.400
96 personal paramédico x $30/día por 8 días	23.000
14 personas entrenadas fuera del país x $1.200/mes x 14 meses	23.500

-Salario de Administradores del Proyecto

2 x $15.400/año por 4 años x 40	49.300

B. Mantenimiento y Operación de Equipos

-Vehículos	45.800
-Equipo Audiovisual	1.000
SUBTOTAL:	$177.600 dólares.

Instituto Ecuatoriano de Seguridad Social

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Forma. Nº 061-6A —(1 y 8 —100.000 —76-02-18 —6.192

ANNEX V - D

República del Ecuador
Instituto Ecuatoriano de Seguridad Social
Dirección Nacional Administrativa

Seguro Social Campesino

Subprograma Cuadrienal de Planificación Familiar

1981 - 1984

ANNEX V - D

País: ECUADOR
Institución: INSTITUTO ECUATORIANO DE SEGURIDAD SOCIAL
Area: ADMINISTRATIVA
Programa: SEGURO SOCIAL CAMPESINO
Subprograma: PLANIFICACION FAMILIAR
Años: 1981 - 1984

1. Antecedentes

1.1. Situación actual

El Instituto Ecuatoriano de Seguridad Social a través de la División del Seguro Social Campesino, desde el año 1968 se halla brindando atención primaria de salud en el área rural del Ecuador al campesino sin dependencia patronal, llegando el 1980 a una cobertura de 107.900 personas que corresponde al 2.2% de la población rural.

El Consejo Nacional de Desarrollo en su Plan de Acción, indica que el Gobierno Nacional ha manifestado en sus declaraciones que las condiciones de salud del pueblo ecuatoriano principalmente del área rural no son satisfactorias y que ante esta situación es necesario promover una medicina acorde con los adelantos de la ciencia. Indicando además como objetivos, mejorar las condiciones de salud y de vida, así como alcanzar el cuidado integral de la salud y de la población dando énfasis al fomento y ampliando los campos de acción de la medicina preventiva.

Según datos proporcionados por INEC, para 1984 se prevee una cobertura del 6.2% de la población rural, lo que representaría una afiliación de 355.000 personas. La prestación se ejecutaría en 290 dispensarios. (anexo No. 1, Página 10).

Esta atención procura facilitarse con la descentralización en cuatro regiones con sedes en Quito, Guayaquil, Cuenca y Ambato, dentro de los criterios de centralización normativa y descentralización operativa (Resolución No. 413).

La política del Instituto Ecuatoriano de Seguridad Social y del Seguro Social Campesino hace necesario brindar una atención médica integral, por lo cual se debe reforzar las actividades en los aspectos preventivo y de fomento para la salud, de entre estas tienen prioridad las del grupo materno infantil y particularmente uno de sus componentes: planificación familiar.

La planificación familiar permite a la pareja ejercer libre, responsable y concientemente su derecho a determinar el número de hijos y el espaciamiento entre ellos. Como derecho humano por razones económicas, sociales y culturales no debe existir limitaciones al acceso de conocimiento y servicios en esta materia y si la mayoría no puede procurar-

se este conocimiento y este servicio, el negarles equivale a sostener una descriminación no justificada.

El Ecuador al año 1980 esta experimentando una tasa de crecimiento poblacional del 3.2% hecho que da origen a un problema demográfico. El aumento acelerado y cambio en la composición poblacional origina en la mayoría de los casos desniveles en relación con el incremento de factores de producción, vivienda, educación, salud, infraestructura. Esta situación se ve agravada cuando un grupo minoritario es el poseedor de la mayor parte de la riqueza, mientras que el mayor porcentaje de la población no tiene posibilidad de satisfacer sus necesidades básicas. El medio rural y particularmente los sectores marginados son los que experimentan con mayor gravedad esta condición.

Considerando que la tasa global de fecundidad para el Ecuador varió de 6.8 en 1970 a 5.2 en 1980, hijos nacidos vivos por mujer, esta tasa permanece aún notablemente alta.

La tasa específica de fecundidad en 1978 cae dentro de esta categoría, el 85.5 por mil en el grupo etáreo de mujeres de 40 a 44 años y el 87.6 por mil en el grupo de 15 a 19 años, edades consideradas de alto riesgo de embarazo y parto.

Natalidad:

En el país para 1974 la tasa fue de 44.7 por mil y para el medio rural de 48.5 por mil, constituyendo una de las más altas de América Latina.

Mortalidad infantil:

Para 1974 la tasa de mortalidad infantil fue de 70.2 por mil. Estos dos últimos índices determinan una baja esperanza de vida al nacer, de nuestra población que está calculada para 1974 en 59.1 años para el hombre y 61.8 para la mujer.

Mortalidad materna:

La tasa a partir de 1979 no presenta mayor modificación hasta 1978, fluctuando entre 2.3 a 2.0 por mil.

1.2. Situación esperada

En términos generales las condiciones de vida de la población campesina están relacionadas con la estructura socio-económica del país y con la política que se desee implementar.

Al implementarse el subprograma de planificación familiar, y disponer de recursos humanos, materiales y financieros suficientes es probable ob-

tener coberturas aceptables y sobre todo eficacia en el desarrollo del subprograma, consiguientemente mejores niveles de vida, en la población afiliada al Seguro Social Campesino.

En el período cuadrienal 1981-1984 se espera alcanzar coberturas del 10% de la población de mujeres en edad fértil, en planificación familiar y detección oportuna del cáncer.

Es evidente que para alcanzar estas metas, es indispensable la asignación de todos los recursos necesarios, la consolidación, unificación y coordinación del subprograma a nivel nacional, central y regional, el mantenimiento de los programas de entrenamiento, supervisión programada y continua, de manera especial la intensificación y el mejoramiento del sistema y metodología de la promoción y educación para la salud.

2. Base legal

Como expresión de hacer realidad la necesidad de atención médica integral de actividades de educación y servicio de planificación familiar a la población ecuatoriana, la Constitución vigente del país, en el artículo 24, señala "El Estado propugna la paternidad responsable y la educación adecuada para la promoción de la familia; garantiza el derecho de los padres a tener el número de hijos que pueda mantener y educar".

La Ley del Seguro Social Obligatorio, dentro de los estatutos del Departamento Médico, en el artículo 19 dice: "El Departamento establecerá gradualmente el servicio de medicina preventiva, que tenga por objeto mantener el nivel de salud de los afiliados". "El Departamento del Seguro Social Campesino en el Plan Piloto aprobado mediante resolución A-91 en el numeral 3, prestaciones a otorgarse, señala en el Literal a) "Medicina Preventiva" y la resolución No. 113 - Art. 25, literal a), asigna como funciones del Departamento Médico "El cuidado y promoción de la salud de los miembros de las comunidades afiliadas" y para la Jefatura técnico-administrativa del Seguro Social Campesino el literal a) dice: "Planificar las acciones de salud integral para las comunas integradas al Plan Piloto del Seguro Social Campesino, de acuerdo con la política trazada por la Comisión de estudios y aplicación del Seguro Social Campesino.

Son estas las bases legales que dieron origen a la creación del Departamento de Medicina Preventiva del Instituto Ecuatoriano de Seguridad Social, que ejecuta actividades en materia de planificación familiar, actividades que igualmente son desarrolladas por el Seguro Social Campesino.

3. Objetivos

Con estos antecedentes la División del Seguro Social Campesino conside-

ra imprescindible la ejecución del subprograma de planificación familiar y detección oportuna del cáncer (DOC), por la íntima relación entre ellos.

3.1. Objetivo general

Fortalecer el subprograma de planificación familiar y detección oportuna del cáncer establecido para el cuadrienio 1981-1984 contribuyendo así al fomento de la salud y bienestar de la familia afiliada al Seguro Social Campesino.

3.2. Objetivos específicos

3.2.1. Incorporar en los dispensarios que se crearen en el cuadrienio 1981-1984 el subprograma de planificación familiar y DOC de acuerdo a las normas.

3.2.2. Incrementar la cobertura propendiendo al cumplimiento de las metas de planificación familiar y DOC programadas para el cuadrienio.

3.2.3. Robustecer el sistema de promoción desarrollando actividades que incrementen los beneficios y características del subprograma, de tal manera que mantengan o eleven los niveles propuestos.

3.2.4. Elaborar los mecanismos apropiados que permitan un sistema de coordinación eficaz con los Departamentos de Medicina Preventiva y Educación para la Salud del Instituto Ecuatoriano de Seguridad Social.

3.2.5. Elaborar un plan de seguimiento que identifique las restricciones que obstaculicen el cumplimiento del subprograma y que señale las alternativas de acción para superar las limitaciones detectadas.

3.2.6. Desarrollar y capacitar al personal administrativo y operativo de los diferentes niveles y a los que se incorporen en el período 1981-1984.

3.2.7. Procurar a través del conocimiento, información y educación, la aceptación de las actividades de planificación familiar y por ende el mantenimiento del subprograma.

3.2.8. Incrementar el desarrollo de actividades de educación para la salud con participación comunitaria, procurando el mantenimiento de grupos y de acuerdo a la libre decisión conyugal.

3.2.9. Otorgar los servicios de planificación familiar y DOC a la población afiliada que libremente lo solicita.

3.2.10. Evaluar las actividades del subprograma para establecer los cambios necesarios para el mejoramiento del Servicio.

4. Metas

4.1. Implementar el subprograma de planificación familiar y detección oportuna del cáncer en 100% de las unidades operativas del Seguro Social Campesino, 290 dispensarios.

4.2. Proporcionar atención en los servicios de planificación familiar al 10% de la población de mujeres en edad fértil, afiliada al Seguro Social Campesino, lo que significa atender a 6.650 mujeres.

4.2.1. Realizar la inserción de 3.650 DIU (55%) a mujeres en edad fértil que espontáneamente soliciten.

4.2.2. Incorporar a 2.000 (35%) nuevas usuarias al método de planificación familiar, mediante anovulatorios.

4.2.3. Proporcionar atención de planificación familiar mediante otros métodos y/o transferencias a 990 (15%) mujeres en edad fértil.

4.3. Otorgar atención en detección oportuna del cáncer al 10% de la población de mujeres en edad fértil que corresponden a 6.650 mujeres.

4.4. Organizar en el 100% de los dispensarios del Seguro Social Campesino grupos de hombres y mujeres comprendidos entre 15 y 49 años, para acciones educativas.

4.5. Proporcionar información sobre los servicios de planificación familiar al 75% de la población blanca afiliada, equivalente a 52.810 hombres y 49.890 mujeres.

4.6. Ejecutar cursillos de capacitación en planificación familiar y DOC: 4 cursillos para 100 médicos, 4 cursillos para 290 auxiliares de enfermería.

5. Estrategia

5.1. Suscripción de convenios inter-institucionales que brinden asistencia técnica y financiera al subprograma.

5.2. Establecimiento de un sistema de coordinación del subprograma entre los niveles central, centros regionales y unidades operativas.

5.3. Definición, revisión y actualización de funciones para el recurso humano que intervendrá en la ejecución del subprograma en los diferentes niveles.

5.4. Elaboración, revisión y actualización del manual de normas y técnicas para educación de las actividades de planificación familiar y DOC para el personal administrativo de los niveles, regional y operativo.

5.5. Implementación de los dispensarios del Seguro Social Campesino con material y equipos indispensables para el normal desenvolvimiento del subprograma.

5.6. Afianzamiento del subprograma mejorando el sistema de promoción y dando a las familias la oportunidad de obtener información y servicios adecuados sobre situaciones relacionadas con planificación familiar y esterilidad.

5.7. Información y educación de la comunidad sobre la implementación, características y desarrollo del subprograma.

5.8. Concientización en la comunidad para que reconociendo, demande expontáneamente sus servicios y participe en el desarrollo de sus actividades.

5.9. Preparación de un plan de seguimiento para evaluar la efectividad del subprograma y estudiar los limitantes que lo restringen.

6. Universo

6.1. En el espacio

Areas de influencia de 290 dispensarios del Seguro Social Campesino a nivel nacional.

6.2. En el Tiempo

Subprograma a ejecutarse a partir de la aprobación del subprograma y firma de convenios hasta el 31 de diciembre de 1984.

6.3. En la población

Población abierta comprendida en el grupo etáreo, de 15 a 49 años de edad para acciones de educación y población afiliada del mismo grupo etáreo para la prestación de servicios, calculado a 84-06 en 70.410 hombres y 66.520 mujeres.

7. Descripción del subprograma

Actividades del subprograma.

El subprograma de acuerdo a sus objetivos comprende el desarrollo de las siguientes actividades (Ver anexo No. 2, página 11).

8. Metodología

8.1. Capacitación

8.1.1. Se desarrollará programas de capacitación y adiestramiento para perso-

nal de los niveles profesionales, administrativo y auxiliar de acuerdo con la filosofía y política nacional e institucional. La capacitación será ejecutada por personal de la Institución, pudiendo contarse con la asesoría y participación inter-institucional.

8.1.2. La capacitación para la ejecución de los subprogramas será en base a normas técnico-médicas.

8.1.3. La capacitación se hará mediante cursillos, seminarios, talleres, etc.

8.1.4. Los centros regionales en coordinación con el nivel central participarán en la selección del personal a capacitarse.

8.2. Información y motivación.

8.2.1. Del Universo poblacional a desarrollarse exclusivamente por el personal administrativo y operacional del Departamento del Seguro Social Campesino, bajo normas y técnicas entregadas en los cursillos. Estas actividades serán desarrolladas en población abierta.

8.2.2. Desarrollo de programas intensivos de promoción y educación dirigidos a incrementar el nivel de conocimiento sobre salud en la comunidad y procurar la asistencia a los servicios de P.F. y D.O.C.

8.3. Administración

Dentro del desarrollo de la infraestructura de la División se propenderá al desarrollo del proceso administrativo a través de normas nacionales del subprograma, así como regionales que conlleven a una supervisión eficaz, evaluación y a la implementación de los recursos necesarios a nivel operativo.

8.3.1. Se describirá, revisará y actualizará las normas técnicas de atención y administración que se refieren al subprograma.

8.3.2. La elaboración y revisión de las normas del subprograma será responsabilidad de la Sección de Coordinación Médica.

8.3.3. La supervisión será del nivel central, a los centros regionales y de éste a las unidades operativas.

8.3.4. El desarrollo del subprograma será controlado mediante evaluación mensual indirecta, a través del sistema de información y evaluación programada directa (supervisión).

8.3.5. La evaluación global del subprograma se ejecutará semestralmente por parte del equipo responsable de la División del Seguro Social Campesino, pudiendo contar con la participación inter-institucional involucrada en el subprograma.

8.3.6. Las organizaciones inter-institucionales podrán llevar a efecto observaciones del subprograma en el tiempo que creyeren oportuno y proponer modificaciones exclusivamente a nivel administrativo y técnico normativo.

8.4. Otorgamiento de servicio, exclusivamente para población afiliada

8.4.1. La población usuaria recibirá el servicio sólo bajo demanda libre y espontánea.

8.4.2. Será el criterio del médico tratante en mutuo acuerdo con el usuario, el que determine el método a usarse.

8.4.3. Las consultas subsecuentes podrán ser realizadas por el médico o la auxiliar de enfermería, de los dispensarios del Seguro Social Campesino.

9. Recursos

9.1. Recursos humanos

9.1.1. A nivel nacional serán responsables de la ejecución del subprograma de planificación familiar, el Jefe de la División y el Jefe del Departamento de Prestaciones del Seguro Social Campesino, en estrecha coordinación inter-institucional; el Jefe y el personal de la sección de Atención Médica y Odontológica; el Jefe y personal de la sección de Asuntos Sociales; el Jefe y personal del Departamento de Abastecimientos.

9.1.2. A nivel regional, el profesional asignado a la Jefatura de los centros regionales.

9.1.3. A nivel operativo, los médicos tratantes y auxiliares de enfermería de los dispensarios comunales.

9.2. Recursos materiales

Se enumeran los específicos para el subprograma. La implementación será paulatina hasta 1984, de acuerdo al cuadro de programación general (ver anexo No. 3, página 10).

9.2.1. A nivel regional: (4 regionales)

20 películas de 16 mm., diferentes temas,
20 juegos de diapositivas, temas preseleccionados.

9.2.3. A nivel operativo: (290 dispensarios)

- Instrumental

290 esterilizadores (tipo autoclave)

290 cubetas de acero inoxidable con tapa para cánula
290 tambores medianos porta-gasa
290 pinzas tirabalas de 25 cm.
290 pinzas de aro de 25 cm.
290 histerómetros
290 espejos vaginales medianos, tipo graves
290 espejos vaginales grandes, tipo graves

- Material de laboratorio

290 tarros de fijador cyto spray
159 cajas de lámina porta-objetos

- Anticonceptivos

30 Grs. DIU ASA de Lippes Loop, tipo A
35 Grs. DIU ASA de Lippes Loop, tipo B
150 Grs. DIU ASA de Lippes Loop, tipo C
75 Grs. DIU ASA de Lippes Loop, tipo D
6.500 sobres anovulatorios Norgestrel + etinilestradiol de 21 a 28 tabletas
400 Grs. Preservativos.
30 Grs. Tabletas anticonceptivas, tubos 20 tabletas.

9.3. Recursos financieros

9.3.1. Costos de capacitación:

- 4 cursillos para 100 médicos de cinco días de duración, S/. 2'000.000.

- 4 cursillos para 290 auxiliares de enfermería de cinco días de duración S/. 2'000.000.

9.3.2. Costo de equipo y materiales:

A establecer de acuerdo a necesidades planteadas en 9.2 (recursos materiales).

Instituto Ec[illegible]iano de Seguridad [illegible]cial
Seguro Social Campesino

METAS PLAN CUADRIENAL 1981-1984

Plan \ Años	1981	1982	1983	1984
Dispensarios	163	192	240	290
Organizaciones campesinas	440	461	576	690
Familias	34.455	44.370	55.460	67.000
Personas a 12 - 30	180.000	235.200	294.000	355.000
Cobertura poblacional *	2.9%	4.2%	5.2%	6.2%
Subprograma: Planificación familiar **	5.0%	7.5%	9.0%	10.0%
Detección oportuna del cáncer	2.5%	5.5%	8.0%	10.0%

* Base poblacional rural proyectada por INEC.

** % en relación con MEF afiliados.

FLP/pbc.

INSTITUTO ECUATORIANO DE SEGURIDAD SOCIAL

Seguro Social Campesino

			1981					1982					1983					1984					
			[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	1.-[illegible]	2820	5.0	1440	4.4	6340	42560	7.5	319	4.4	1470	[illegible]	9.0	680	4.4	2147	5520	10.0	657	[illegible]	[illegible]	[illegible]
		a- [illegible]	1440	45	650	3	1950	3190	50	1[illegible]	3	[illegible]	[illegible]	[illegible]	[illegible]	3	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
		b- [illegible]	1440	40	575	6	3450	3190	55	111[illegible]	6	6700	[illegible]	35	1703	6	[illegible]	[illegible]	[illegible]	1[illegible]	6	[illegible]	[illegible]
		c- [illegible]	1440	15	215	4.6	990	[illegible]	15	47	[illegible]	[illegible]	[illegible]	15	7[illegible]	[illegible]	[illegible]	[illegible]	15	677	[illegible]	[illegible]	[illegible]
		2.-[illegible] servicio de P.F.	55350	60	35598	1.0	35598	53607	70	55[illegible]	1	[illegible]	[illegible]	75	[illegible]	1	[illegible]	[illegible]	75	[illegible]	1	[illegible]	[illegible]
[illegible]	[illegible]	1.-[illegible]	28820	2.5	720	1.0	720	42552	5.5	35[illegible]	1	[illegible]	[illegible]	8.0	4339	1	[illegible]	[illegible]	1.0	7654	1	[illegible]	[illegible]
		2.-[illegible]	720	10	72	1.0	72	2340	10	234	1	[illegible]	[illegible]	10	473	1	[illegible]	[illegible]	10	555	1	[illegible]	[illegible]
		3.-[illegible] de mujeres y mujeres.	168	100	168	1.0	168	192	100	192	1	192	240	100	240	1	240	240	100	240	1	240	[illegible]

BEST AVAILABLE DOCUMENT

REQUERIMIENTOS Y PRESUPUESTO DE RECURSOS MATERIALES
Y CAPACITACION DEL SUBPROGRAMA CUADRIENAL DE
PLANIFICACION FAMILIAR 1981 - 1984

Años / Recursos Materiales	1981		1982		1983		1984		Total	Valores	
	No. Prog.	Valor $	No. Prog.	Valor $	No. Prog.	Valor $	No. Prog.	Valor $	Prog.	Unitar. $	Total $
1. RECURSOS MATERIALES											
1.1. Material Educativo.-											
- Películas de 16mm., diferentes temas.	10	2.500	5	1.250	5	1.250	-	-	20	250	5.000
- Juegos de diapositivas, temas preseleccionadas.	10	1.500	5	750	5	750	-	-	20	150	3.000
											8.000
1.2. Vehículos.-											
- Doble transmisión, 5 pasajeros, espacio carga.	2	18.000	2	18.000	-	-	-	-	4	9.000	36.000
1.3. Equipo Médico.-											
- Esterilizadores	168	14.280	24	2.040	48	4.080	50	4.250	290	85	24.650
- Cubetas de acero inoxidable con tapa para cánula	168	5.712	24	816	48	1.632	50	1.700	290	34	9.860
- Tambores medianos porta gasas.	168	5.376	24	768	48	1.536	50	1.600	290	32	9.280
- Pinzas tirabolas de 25cm.	168	6.216	24	888	48	1.776	50	1.850	290	37	10.730
- Espejos vaginales medianos tipo graves.	168	2.016	24	288	48	576	50	600	290	12	3.480
- Espejos vaginales grandes tipo graves.	168	2.520	24	360	48	720	50	750	290	15	4.350
- Histerómetros.	168	2.352	24	336	48	672	50	700	290	14	4.060
- Pinzas de oro 25cm.	168	5.544	24	792	48	1.584	50	1.650	290	33	9.570
											75.960
1.4. Material de Laboratorio.-											
- Tarros fijador cyto spray	168	2.016	24	288	48	576	50	720	290	12	3.600
- Cajas de láminas portaobjetos.	50	425	50	425	50	425	-	-	150	8.0	1.220
											4.820
1.5. Capacitación en el País.-											
- Cursos para médicos, 5 días de duración	1	11.270	1	19.030	1	7.700	1	7.700	4	-	45.700
- Cursos para auxiliares de enfermería, 5 días de duración.	3	18.000	4	25.000	2	12.500	2	12.500	11	-	68.800
											114.500
Subtotal											239.300
2. MATERIAL ANTICONCEPTIVO.											
- DIU ASA de Lippes Loop Tipo A.	10 Grs.	576	5 Grs.	288	5 Grs.	288	10 Grs.	576	30 Grs.	0.40	1.700
- DIU ASA de Lippes Loop Tipo B.	10 Grs.	576	5 Grs.	288	10 Grs.	576	10 Grs.	576	35 Grs.	0.40	2.000
- DIU ASA de Lippes Loop Tipo C.	40 Grs.	2.304	20 Grs.	1.552	40 Grs.	2.304	50 Grs.	2.880	150 Grs.	0.40	8.650
- DIU ASA de Lippes Loop Tipo D.	20 Grs.	1.152	10 Grs.	576	20 Grs.	1.152	25 Grs.	1.440	75 Grs.	0.40	4.300
- Sobres anovulatorios Norgestrel + etinil estradiol, 21 a 28 tabletas.	7.000	3.150	14.000	6.300	20.000	9.000	24.000	10.800	65.000	0.45	29.250
- Preservativos Grs.	90	360	150	600	120	480	40	160	400	4	1.600
- Tubos tabletas anticonceptivas. (Grs.)	10	1.440	15	2.160	15	2.160	10	1.440	50	1 tubo	7.200
											54.700
TOTAL											294.000

REQUERIMIENTOS Y PRESUPUESTO DE RECURSOS MATERIALES
Y CAPACITACION DEL SUBPROGRAMA CUADRIENAL DE
PLANIFICACION FAMILIAR 1981 - 1984

Recursos Materiales / Años	1981		1982		1983		1984		Total	Valores	
	No. Prog.	Valor $	No. Prog.	Valor $	No. Prog.	Valor $	No. Prog.	Valor $	Prog.	Unitar. $	Total $
1. RECURSOS MATERIALES											
1.1. Material Educativo.-											
- Películas de 16mm., diferentes temas.	10	2.500	5	1.250	5	1.250	-	-	20	250	5.000
- Juegos de diapositivas, temas preseleccionadas.	10	1.500	5	750	5	750	-	-	20	150	3.000
											8.000
1.2. Vehículos.-											
- Doble transmisión, 5 pasajeros, espacio carga.	2	18.000	2	18.000	-	-	-	-	4	9.000	36.000
1.3. Equipo Médico.-											
- Esterilizadores	168	14.280	24	2.040	48	4.080	50	4.250	290	85	24.650
- Cubetas de acero inoxidable con tapa para cánula	168	5.712	24	816	48	1.632	50	1.700	290	34	9.860
- Tambores medianos porta gasas.	168	5.376	24	768	48	1.536	50	1.600	290	32	9.280
- Pinzas tirabalas de 25cm.	168	6.216	24	888	48	1.776	50	1.850	290	37	10.730
- Espejos vaginales medianos tipo graves.	168	2.016	24	288	48	576	50	600	290	12	3.480
- Espejos vaginales grandes tipo graves.	168	2.520	24	360	48	720	50	750	290	15	4.350
- Histerómetros.	168	2.352	24	336	48	672	50	700	290	14	4.060
- Pinzas de oro 25cm.	168	5.544	24	792	48	1.584	50	1.650	290	33	9.570
											75.980
1.4. Material de Laboratorio.-											
- Tarros fijador cyto spray	168	2.016	24	288	48	576	50	720	290	12	3,600
- Cajas de láminas porta-objetos.	50	425	50	425	50	425	-	-	150	8.0	1.220
											4.820
1.5. Capacitación en el País.-											
- Cursos para médicos, 5 días de duración	1	11.270	1	19.030	1	7.700	1	7.700	4	-	45.700
- Cursos para auxiliares de enfermería, 5 días de duración.	3	18.800	4	25.000	2	12.500	2	12.500	11	-	68.800
											114.500
Subtotal											239.300
2. MATERIAL ANTICONCEPTIVO.											
- DIU ASA de Lippes Loop Tipo A.	10 Grs.	576	5 Grs.	288	5 Grs.	288	10 Grs.	576	30 Grs.	0.40	1.700
- DIU ASA de Lippes Loop Tipo B.	10 Grs.	576	5 Grs.	288	10 Grs.	576	10 Grs.	576	35 Grs.	0.40	2.000
- DIU ASA de Lippes Loop Tipo C.	40 Grs.	2.304	20 Grs.	1.552	40 Grs.	2.304	50 Grs.	2.880	150 Grs.	0.40	8.650
- DIU ASA de Lippes Loop Tipo D.	20 Grs.	1.152	10 Grs.	576	20 Grs.	1.152	25 Grs.	1.440	75 Grs.	0.40	4.300
- Sobres anovulatorios Norgestrel + etinil estradiol, 21 a 28 tabletas.	7.000	3.150	14.000	6.300	20.000	9.000	24.000	10.800	65.000	0.45	29.250
- Preservativos Grs.	90	360	150	600	120	480	40	160	400	4	1.600
- Tubos tabletas anticonceptivas. (Grs.)	10	1.440	15	2.160	15	2.160	10	1.440	50	1 tubo	7.200
											54.700
T O T A L											294.000

ANNEX V - E

REPUBLICA DEL ECUADOR

CONSEJO NACIONAL DE DESARROLLO

DIVISION DE POBLACION

SECRETARIA DE PLANIFICACION

VICEPRESIDENCIA DE LA REPUBLICA

Oficio N° 0518 VPR

Quito, a 28 Mayo 1981

Señor
John Sambrailo
Director
Misión de la Agencia para el Desarrollo
Internacional A.I.D.-Punto IV
en el Ecuador
P r e s en t e

De mis consideraciones:

De acuerdo a la conversación tenida el día de ayer con usted y con el representante de UNFPA en el Ecuador, en la que se hizo conocer la decisión de brindar la colaboración con la cantidad de CIENTO VEINTE Y CUATRO MIL DOLARES, para el proyecto ECU-80-P04; "Apoyo a la División de Población de la Secretaría de Planificación del Consejo Nacional de Desarrollo", en el período 1981-1984, me es grato manifestar a usted la conformidad con la colaboración ofrecida.

Al mismo tiempo le comunico que la distribución de dichos fondos, que mejor se ajustan a los propósitos del proyecto, es el siguiente:

Estudios:	$61.000
Personal local:	10.000
Entrenamiento:	36.000
Equipamiento:	11.000
Misceláneos:	6.000
TOTAL	$ 124.000

Hago propicia la oportunidad para reiterar a usted los sentimientos de mi más alta consideración y estima.

Atentamente,

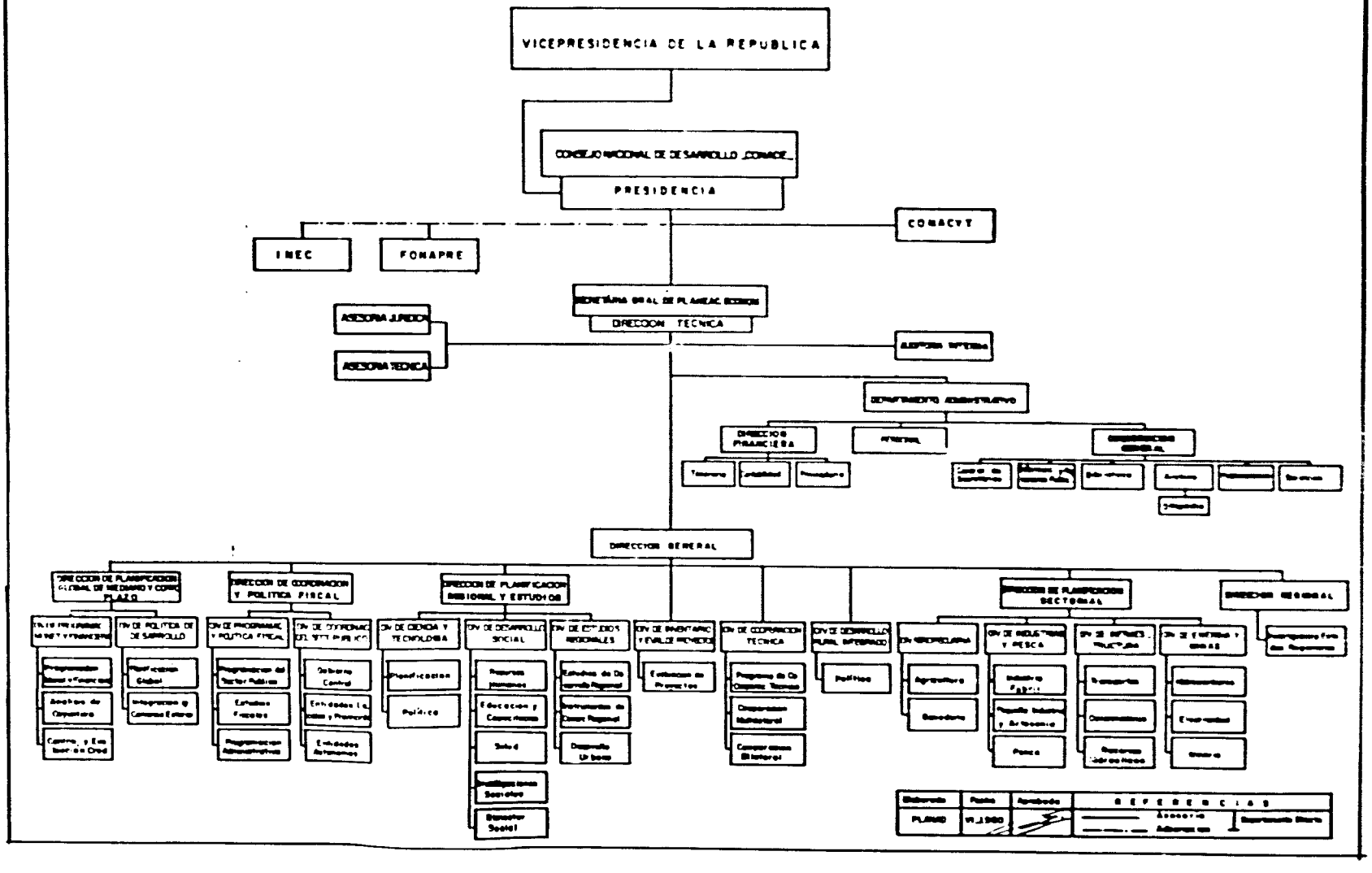
Arq. Teodoro Peña
COORDINADOR DEL PROYECTO
ECU-80-P04

UNIDAD DE POBLACION

DISTRIBUTIVO PRESUPUESTARIO, POR CATEGORIAS

1. Personal (bajo contrato		
2 Planificadores 8h/m		10,000
2. Investigaciones		61,000
a. Estudio de la mujer, familia y dinámica demográfica	25,000	
b. Evaluación de los efectos demográficos en los programas de desarrollo rural	36,000	
3. Capacitación		36,000
a. Beca de Estudios en el exterior sobre Demografía Social 24 h/m.	12,500	
b. 5 Pasantías, 3 meses c/u en el exterior 15 h/m.	12,000	
c. 5 viajes de obeservación, 7 días c/u	5,500	
d. 4 Seminarios-talleres, en el país por 5 días de duración c/u (80 concurrentes)	6,000	
4. Equipos y materiales		11,000
a. Material de Oficina, fungible	4,500	
b. Equipo de oficina: escritorios, archivadores, anaqueles, etc.	6,500	
5. Miscelaneos		6,000
a. Publicación de Informes	4,000	
b. Adquisición de libros	2,000	
TOTAL		124,000

ORGANIGRAMA ESTRUCTURAL DEL CONSEJO NACIONAL DE DESARROLLO _CONADE_



Quito, a 15 de junio de 1981

Señor Don
Manuel Rizzo
Misión de la Agencia para el Desarrollo
Internacional A.I.D. en el Ecuador
Punto IV.
Presente.

De mis consideraciones:

Tengo a bien enviar a usted una copia del Presupuesto del Proyecto ECU-80-P04, que corresponde a la contraparte nacional y aprobado por nuestro Gobierno, el 3 de diciembre de 1980.

Su distribución variará una vez que, juntamente con el Experto Internacional que UNFPA envía para mediados del presente año, se reformule el Proyecto en mención.

Sea propicia esta oportunidad para reiterar a usted los sentimientos de mi consideración y estima.

Atentamente,

Econ. Renán Oquendo
DIRECTOR DE PLANIFICACION
REGIONAL

10.2 INSUMOS DEL GOBIERNO

10.2.1. Presupuesto Gubernamental

	DESCRIPCION	1991		1992		1993		1994		TOTAL	
		m/h	S/.	m/h	S/.	m/h	S/.	m/h	S/.	m/h	S/.
10	Personal del Proyecto										
13	Costos Administrativos										
13.01	Secretaria(Oficial Adm. 3)	12	165.000	12	166.700	12	185.000	12	186.900	48	703.600
13.03	Otros Gastos Administ. (Administración Proyecto – Oficial Administración 3)	4	55.000	4	55.600	4	61.700	4	62.300	16	234.600
13.99	Sub-total	16	220.000	16	222.300	16	246.700	16	249.200	64	938.200
16	Resp. Personal Local										
16.01	Jefe de División	12	501.400	12	506.400	12	552.100	12	557.700	48	2'137.600
16.02	Jefe de Sección (Planificador 4)	12	464.800	12	471.300	12	523.100	12	528.300	48	1'987.500
16.03	Planificador 3					12	333.800	12	337.200	24	671.000
16.04	Asistente Planificador 2					12	212.000	12	214.000	24	426.000
16.05	Asistente Planificador 2					12	212.000	12	214.000	24	426.000
16.99	Sub-Total	24	966.200	24	977.700	60	1'843.000	60	1'861.200	168	5'648.100
19	COMPONENTE TOTAL	40	1'186.200	40	1'200.000	76	2'089.700	76	2'110.400	232	6'586.300

		1981		1982		1983		1984		Total	
		M/H	S/.	M/H	S/.	M/H	S/.	M/H	S/.	M/H	S/.
40	COMPONENTE EQUIPOS										
41	Equipo Fungible										
41.98	Equipo Fungible Otro		30.000		30.000		30.000		30.000		120.000
41.99	Sub Total		30.000		30.000		30.000		30.000		120.000
42	Locales										
43.51	Uso Sala de Reuniones		30.000		30.000		30.000		30.000		120.000
43.99	Sub Total		30.000		30.000		30.000		30.000		120.000
49	COMPONENTE TOTAL		60.000		60.000		60.000		60.000		240.000
99	GRAN TOTAL	40	1'246.200	40	1'260.000	76	2'149.700	76	2'170.400	232	6'826.300

ANNEX V - F

REPUBLICA DEL ECUADOR

CONSEJO NACIONAL DE DESARROLLO

INSTITUTO NACIONAL DE ESTADISTICAS Y CENSOS

PROYECTO VISTIM

MEJORAMIENTO DEL SISTEMA DE

REGISTRO DE ESTADISTICAS VITALES

República del Ecuador

INSTITUTO NACIONAL DE ESTADISTICA Y CENSOS

OFICIO Nº-DIREG-81 493

QUITO,

16 JUN. 1981

Señor
John Sambrailo
DIRECTOR DE LA AGENCIA
INTERNACIONAL PARA EL
DESARROLLO
Presente.-

De mi consideración:

El Instituto Nacional de Estadística ha considerado necesario la implementación de un proyecto, que permita obtener un Sistema de Registro de Estadísticas Vitales significativamente mejorado, para lo cual ha elaborado los documentos relacionados con el Proyecto VISTIM, a cargo de la Oficina de Estadísticas Internacionales (OIS) del Centro Nacional de Estadística de Salud (NCHS), de los Estados Unidos de Norteamérica.

En consideración a que AID es la Agencia coordinadora y financiadora de los Proyectos VISTIM, me permito poner en su conocimiento los documentos pertinentes, a fin de que se sirva considerar la posibilidad de otorgar el financiamiento.

Por la atención que se digne dar a esta solicitud, me es grato anticiparle mi reconocimiento.

Muy atentamente,

Instituto Nacional de Estadística y Censos
Quito - Ecuador

Econ. Gastón Acosta
DIRECTOR GENERAL DEL INEC

Cable INEC. "10 de Agosto 229" - Teléfono. 519422 - Quito Ecuador

ANNEX V - F

PROYECTO VISTIM

PLAN DEL PROYECTO

A. INTRODUCCION

1. Objetivos

El objetivo fundamental de este proyecto es suministrar la información necesaria para que el Gobierno del Ecuador mejore sustancialmente su sistema de registro vital. Dentro de este aspecto hay cinco objetivos intermedios: (1) evaluar el sistema nacional tal como está funcionando actualmente, (2) desarrollar un sistema modelo que incluya tres áreas de demostración, que permitan a los investigadores aplicar varias estrategias para mejorar el sistema, (3) evaluar y mejorar el sistema modelo, (4) extender aspectos seleccionados en el sistema modelo al nivel nacional y (5) redactar un informe que deberá presentarse al Gobierno del Ecuador, resumiendo los resultados del proyecto, describiendo las ventajas relativas del sistema modelo y sugiriendo las medidas apropiadas para mejorar el sistema nacional.

2. Antecedentes

2.1 Justificación

Los registros completos y exactos de eventos vitales, particularmente de nacimientos y defunciones, tienen una utilidad sustancial en los campos de análisis científico, planificación del desarrollo y evaluación, y pueden así mismo estar al servicio de numerosas funciones legales. De este modo, las estadísticas vitales deben utilizarse en estudios sobre la salud, la mortalidad y la fecundidad, y pueden suministrar datos importantes para la planificación y la evaluación de programas de acción relacionados con la salud y el desarrollo socioeconómico. Además de su utilidad estadística, los registros vitales están al servicio de una serie de funciones legales importantes para el individuo, la comunidad y la nación, siendo algunos ejemplos: el reconocimiento de la ciudadanía, las obligaciones de paternidad, los derechos de herencia, comprobación de la edad, identificación, etc.

Sin embargo, la utilidad de las estadísticas vitales y registros se ve severamente restringida cuando existe pérdida de información, la cobertura no es total, los datos no son fidedignos, el flujo de documentos es irregular, o si los datos no se encuentran fácilmente disponibles y accesibles para los usuarios.

2.2 Aspectos Generales del Ecuador y sus características de Población y breves rasgos de tipo económico.

Aspectos Generales

La República del Ecuador se halla situada en el sector noroccidental de la América del Sur y está limitada por Colombia, Perú y el Océano Pacífico. La división política-administrativa mayor es la provincia. El país tiene 20 provincias las cuales se agrupan en cuatro regiones geográficas, claramente diferenciadas por sus características geográficas e históricas: Sierra, Costa, Amazónica y Galápagos (Región Insular).

La Cordillera de los Andes atraviesa el país de norte a sur y establece las tres regiones del Ecuador Continental. La Costa comprende las zonas tropicales al occidente de la cordillera, y la Sierra, la franja montañosa central con valles altiplánicos formados entre los dos ramales en que se divide la cordillera. La Región Amazónica incluye las zonas subtropicales y tropicales al este de los Andes, que forman parte de la hoya amazónica.

La División Política Territorial de la República del Ecuador divide al país en 20 provincias, 118 Cantones y 936 Parroquias de las cuales 216 son urbanas y 720 rurales.

Algunas características poblacionales

a) Volumen y crecimiento

En la República del Ecuador se han realizado hasta la fecha tres censos: el primero de población el 29 de noviembre de 1950; otro de población y primero de vivienda el 25 de noviembre de 1962 y el último de población y segundo de vivienda el 8 de junio de 1974. Entre los tres censos media un período de 12 años. Las cifras resultantes de estos censos fueron, en los que se refiere a población, las de 3.202.800, 4.476.000 y 6.521.700 habitantes, respectivamente. Para el período 1950-1962, la tasa geométrica de crecimiento fue de aproximadamente 2.8 por ciento, pero para el último período intercensal de 1962-1974 llegó a 3.3 por ciento; de continuar este mismo ritmo de crecimiento, cabe esperarse que la población se duplique en apenas 21 años. Al compararse esta tasa de crecimiento observada en el Ecuador con las estimaciones para otras regiones del mundo para 1975, se pone en evidencia que éste es un país de rápido crecimiento demográfico.

El aumento de la tasa de crecimiento ha sido provocado por un descenso acelerado de la mortalidad, frente a una natalidad que no ha presentado disminuciones importantes. Por ejemplo, el promedio anual de nacimientos por mil habitantes fue de 50 por mil entre 1925 y 1930, y 45 entre 1970 y 1975, de donde se deduce que de un período a otro, sólo hubo una reducción de 5 nacimientos por cada mil habitantes. En cuanto a la mortalidad, la tasa promedio anual fue de 27 por mil en el primero de los períodos y 10 en el segundo, lo que representa una disminución de 17 defunciones por cada mil habitantes. Es decir, durante los últimos 50 años, el efecto combinado de las tasas de natalidad y mortalidad ha contribuído al aumento de la tasa de crecimiento en 12 por mil.

b) Distribución espacial de la población

Según los datos del censo de 1974, la densidad de población es de 23 habitantes por Km2 (en 1962: 17). Las provincias más densamente pobladas son: Tungurahua, con 85 personas por Km2; le siguen en importancia las provincias de Guayas y Pichincha, con 76 y 62 habitantes por Km2, respectivamente. Entre las provincias con densidad más baja están: Esmeraldas, Carchi, Imbabura y las cuatro provincias de la Región Amazónica con 1 habitante por Km2.

Respecto a la superficie de sus territorios, ocupa el primer lugar en la provincia del Guayas, cuya extensión abarca el 7.1 por ciento del área total del Ecuador, le sigue la de Manabí con casi un igual porcentaje; Pichincha con el 5.7 por ciento y Esmeraldas con el 5.3 por ciento, las cuales representan un poco más de la cuarta parte del territorio nacional. Las provincias que tienen una superficie menor son: Tungurahua, Bolívar, Carchi y Cañar, las mismas que representan en conjunto menos del 6 por ciento de la superficie del país.

Comparando las cifras de superficie con las de población, se observa que las provincias más pobladas y extensas están localizadas en la región de la Costa y las provincias de menor superficie y población se encuentran en la Sierra. En la región Amazónica y el Archipiélago de Galápagos, se hallan los extremos opuestos, o sea las regiones de mayor superficie y menor población.

c) Distribución geográfica

Si se compara la distribución de la población por regiones entre los dos últimos censos, se puede obsevar

que, en 1962, la población de la Sierra era el 51.7% del total, la de la Costa el 46.6% y las dos restantes (Amazónica y Galápagos) el 1.7%. De 1962 a 1974, la primera baja al 48.4% y la segunda sube al 48.9%. Las variaciones de una fecha a otra indican una disminución del 3.3% en la Sierra y un aumento del 2.3% en la Costa. En las otras dos regiones la proporción aumentó en un 1.0%.

d) Distribución de la población por áreas urbana y rural

En 1974, el 41.4% de la población vivía en el área urbana, lo cual constituye un aumento importante respecto a 1950, cuando representaba tan sólo un 28.5%. Esto significa que en las dos últimas décadas se ha producido un acelerado proceso de urbanización, el que se explica principalmente por los movimientos migratorios campo-ciudad. De continuar el ritmo de crecimiento experimentado en el período 1950-1974, la población urbana aumentará (según las proyecciones realizadas por el Proyecto Centro de Análisis Demográfico del INEC) de 2.811.000 en 1974 a 6.610.000 en 1994, con lo cual se contabilizaría un aumento de 3.799.000 personas en el curso de 20 años. Su importancia relativa en 1994 sería de un 50.0% con respecto a la población total.

A pesar de los significativos incrementos de la población en el área urbana, la población rural sigue superándola en volumen. Si continua creciendo como en los 24 años anteriores al último censo, la población rural se duplicaría en 26 años. Así por ejemplo, de 4.019.000 habitantes en 1974 pasaría a 6.715.000 en 1994. Su importancia relativa respecto a la población total descendería a causa del mayor ritmo de crecimiento de la población urbana.

e) Estructura por edad

La fecundidad elevada y constante, combinada con la mortalidad en descenso, además de producir altas tasas de crecimiento, también determina que la población se caracterice por elevadas proporciones de niños y adultos jóvenes y un porcentaje relativamente pequeño de personas de 65 años y más de edad (entre el 3 y 4 por ciento de la población total). Este fenómeno si bien se debe a la alta y sostenida fecundidad también se explica por la reducción de la mortalidad, ya que la mayor parte de las ganancias

en la esperanza de vida al nacer, resulta de reducciones en el riesgo de muerte, más entre los jóvenes que entre los viejos.

De 1950 a 1974, la proporción de menores de 15 años aumentó de 42.5% a 44.5%. A su vez, la población en edades activas (15.64 años) disminuyó de 54.0% a 51.7%, debido al mayor peso que tiene la población de 0-14 años. El grupo de 65 años y más de edad aumentó levemente con respecto a 1950 y 1962.

La estructura de la población del Ecuador en 1974 adopta la forma de una silueta semejante a una pirámide escalonada de contornos más o menos uniforme, con una base amplia que se reduce primero de manera lenta y al final muy rápidamente. En resumen esta población refleja las condiciones de un pueblo joven donde los nacimientos crecen progresivamente.

f) Perspectivas demográficas

Las proyecciones realizadas por el Centro de Análisis Demográfico del INEC al año 2000, suponen un descenso apenas moderado de la fecundidad como resultado del aumento del nivel de instrucción, de una mayor participación de la mujer en la actividad económica, así como también de un mayor grado de urbanización del país; y la continuación de la incidencia declinante de la mortalidad.

Ambos factores contribuirán a que la proporción de la población joven (menor de 15 años) se mantenga casi constante hasta fines de este siglo y que por consiguiente, la relación entre la población activa y no activa no se altere.

Según los resultados de la proyección elaborada por el CAD, la tasa bruta de natalidad en el país en los próximos 22 años, disminuirá en un 18 por ciento (de 44 a 38 mil). Esta a su vez se refleja en un descenso de la tasa bruta de reproducción desde 3.17 hijos por mujer en 1977 hasta un valor de 2.75 en el período 1995-1999.

La mortalidad seguirá disminuyendo hasta fines de este siglo, como resultado principalmente del mejoramiento de las condiciones sanitarias del país y del nivel de vida de la población ecuatoriana, lo cual significará una ganancia promedio anual de la esperanza de vida al

nacer de 0.30 años, lográndose en el año 2000 una esperanza de vida para hombres de 66 años y para mujeres de 68 (En 1977 se estima 60 años para hombres y 62 para mujeres).

Según estas proyecciones, la población ecuatoriana pasará de la cifra estimada de 7'814 mil en 1978 a 16'198 en el año 2000, lo cual representa un aumento de 107% en los 22 años. La tasa anual media de crecimiento de la población descenderá levemente de 3.4 por ciento en el período 1974-1979 al 3.2 por ciento en el período 1995-1999.

Comunicación

En el presente, el sistema de vías cubre alrededor de 21.150 millas de las cuales son asfaltados un poco más de 2.769 y otras 7.975 millas son carrozables a lo largo del año. Sin embargo cerca de 10.500 millas son transitables sólamente durante el verano debido a las lluvias de la estación invernal. El sistema está provisto de una red interconectada que alcanza todas las capitales de provincia. El servicio de bus está disponible para todos los centros poblados de la Costa, Sierra y para unos pocos lugares en la Región Amazónica.

Breves rasgos de tipo económico

La economía ecuatoriana depende del comercio exterior, ya que tanto la producción petrolera iniciada en 1972, como la tradicional actividad agrícola de productos tropicales de exportación, le reportan un importante rubro de ingresos. El sector manufacturero es uno de los mas dinámicos de la economía ecuatoriana y representa el segundo en orden de importancia en cuanto a valor de su producción. El comercio es la actividad económica que le sigue en importancia a la producción industrial y agropecuaria. Es notable también la actividad constructora, la misma que está influída principalmente por el proceso de urbanización de las principales ciudades del país.

He aquí algunos indicadores de la economía ecuatoriana

- Variación anual promedio del PIB entre 1974-1978 del 8.8%.

- La Agricultura registró en el año 1978 un crecimiento de 2.8 menor que el de la población.

- Tanto la industria manufacturera como electricidad,- gas y agua experimentaron una variación porcentual anual para 1978 de 12.9 y 12.0, respectivamente.

- El petróleo contribuye con un 10.0 a la generación del producto interno, habiendo proporcionado en el año de 1978, el 35.0% del total de divisas por exportaciones y el 16.5% de los ingresos fiscales.

- La población dedicada a la producción agropecuaria,en 1980 representa el 48.3 de la población económicamente activa del país.

DATOS GENERALES DEL ECUADOR

INDICADORES	AÑO	CIFRA
- Población censal (miles)	1974	6.522
- Porcentaje de población urbana (censo)	1974	41.4
- Porcentaje de población rural (censo)	1974	58.6
- Tasa de crecimiento poblacional intercensal 1962-2974	1974	3.3
- Tasa bruta de natalidad por mil habitantes (Estad. Vitales)	1977 (*)	29.6
- Tasa bruta de mortalidad por mil habitantes (Estad. Vitales)	1977	7.8
- Extensión territorial (Km2)	1978	270.670
- Densidad de población (habitantes por Kilómetro cuadrado)	1980	30.9
- Proyección de la población a mediados de año (miles)	1980	8.354
- Proyección de la población a mediados de año (miles)	2000	16.198
INDICADORES		
- Porcentaje de población menor de 15 años	1980	45.6
- Porcentaje de población mayor de 64 años	1980	3.2
- Porcentaje de mujeres en edad fértil (MEF)	1980	22.0
- Esperanza de vida al nacer:		
Varones (en años)	1974	59.5
Mujeres (en años)	1974	61.8

INDICADORES DE SALUD:	AÑO	CIFRA
- Tasa de mortalidad infantil por 1.000 nacidos vivos	1977	70.9
- Tasa de mortalidad neonatal por 1.000 nacidos vivos	1977	20.0
- Tasa de mortalidad de 1-4 años por 1.000 habitantes	1977	10.2
- Tasa de mortalidad materna por 1.000 nacidos vivos	1977	2.0
- Porcentaje de defunciones por enfermedades infecciosas y parasitarias, influenza, neumonía, bronquitis, enfisema y asma (GRUPO A)	1977	38.5
- Número de médicos por 10.000 habitantes	1977	6.2
- Número de odontólogos por 10.000 habitantes	1977	1.8
- Número de obstetricos por 10.000 habitantes	1977	0.4
- Número de enfermeras por 10.000 habitantes	1977	1.6
- Número de auxiliares de enfermería por diez mil habitantes.	1977	10.1
- Número de camas por 1.000 habitantes	1977	1.9
INDICADORES DEL MEDIO:		
- Porcentaje de población en localidades de más de 20.000 habitantes	1974	36.9
- Porcentaje de población servida con agua potable: total	1979	40.0
Area Urbana	1979	80.0
Area Rural	1979	10.3
- Porcentaje de población con servicio de alcantarillado: total (alcantarillado y letrinas)	1979	31.3
Area Urbana	1979	68.7
Area Rural	1979	3.5
INDICADORES DE EDUCACION: (Censo)		
- Porcentaje de alfabetos	1974	75.1
Porcentaje en primaria	1974	56.9
Porcentaje en secundaria	1974	12.2
Porcentaje en instrucción superior	1974	1.9

INDICADORES ECONOMICOS:	AÑO	CIFRA
- Producto Interno Bruto per Cápita (US$)	1978	907
- Porcentaje del PIB generado por el Sector II (manufactura y construcción)	1978	24.2
- Tasa global de actividad (censo)	1974	46.9
- Porcentaje de población económicamente activa que se dedica a:		
Actividades Primarias	1980	51.9
Actividades Secundarias	1980	16.8
Actividades Terciarias	1980	31.3

(*) Desde 1975 se tomó en cuenta a los nacimientos ocurridos o inscritos en ese mismo año.

FUENTES: Instituto Nacional de Estadística y Censos (INEC)
Ministerio de Salud Pública
Banco Central del Ecuador

2.3 Descripción del Sistema de Registro Vital Ecuatoriano

El Ecuador tiene dos sistemas relacionados con los eventos vitales: el sistema estadístico, el cual se refiere a la certificación de que ha ocurrido un evento, y el Registro Civil, que tiene que ver con aspectos legales de los mismos eventos.

En un sistema doble como éste, un evento no es reconocido por el Estado mientras no haya sido inscrito en el Registro Civil, aunque el sistema estadístico puede haber certificado que ha tenido lugar.

Existen, en realidad, tres agencias gubernamentales implicadas en el proceso de registro vital en el Ecuador: el Consejo Nacional de Desarrollo, a través del Instituto Nacional de Estadística y Censos (INEC), el Ministerio de Gobierno, a través de la Dirección General de Registro Civil, Identificación y Cedulación (R.C.) y el Ministerio de Salud (M.S.), cuyas tareas respectivas, tal como lo dictamina la Ley, son en síntesis.

El INEC diseña y distribuye todos los formularios relacionados con nacimientos, defunciones, defunciones fetales, matrimonios y divorcios a las oficinas del R.C. y al M.S. Una vez llenados y devueltos, los formularios son procesados, los datos son tabulados y publicados en varios informes y anuarios.

El Registro Civil es el responsable de la Inscripción legal de los eventos vitales y del mantenimiento de oficinas en cada una de las parroquias del país. También está bajo su responsabilidad el enviar los informes estadísticos al INEC.

En lugares que disponen de establecimientos de salud especialmente hospitales regionales y centros de salud hospital, ubicados en capitales provinciales y cabeceras cantonales, se envían al INEC únicamente los formularios de defunción fetal, de matrimonio y de divorcio. En los lugares que no disponen de tales establecimientos de salud, envían todos los informes estadísticos de nacimientos y de defunción a la Jefatura de Salud de la Provincia correspondiente, la cual remite los formularios al INEC, luego de utilizarlos para hacer análisis de uso interno.

El Ministerio de Salud, por intermedio de sus diversas oficinas, y establecimientos en todo el país, tiene la responsabilidad de llenar los informes estadísticos de nacimientos y defunciones atendidos y de remitirlos con el informador a la oficina correspondiente del R.C.

Hay tres formularios que deben ser llenados: (a) el certificado del evento vital (llamado también el informe estadístico) (b) el Libro de Actas de las Oficinas del Registro Civil y (c) la tarjeta de inscripción duplicada, que se convierte en parte integrante del archivo central que mantiene el R.C. en la Capital de la República. Para conveniencia de las personas que notifican un evento que no ha sido atendido médicamente, los registradores están autorizados a llenar los informes estadísticos.

Como una medida tendiente a facilitar la inscripción de los eventos atendidos médicamente ante las autoridades tanto de salud como civiles el R.C. ha instalado oficinas de registro en varios establecimientos principales de salud. Lamentablemente, ésto se ha hecho tan solo en seis hospitales, y se encuentran en las ciudades más grandes.

2.4 Deficiencias del sistema actual

2.4.1 Integridad:

Una de las más serias deficiencias del sistema actual constituye la cobertura incompleta de los eventos vitales. Mientras que las estimaciones existentes de omisión son bastantes imprecisas, la evidecia de varias fuentes sugiere que aproximadamente un 15 por ciento de los nacimientos y un 22 por ciento de las defunciones quedan sin registrarse. En regiones de menor accesibilidad y menos desarrolladas del Ecuador, estos porcentajes son sin lugar a dudas sustancialmente mayores. Se piensa que las tres mayores fuentes de omisión son:

a) De todos los nacimientos y defunciones registrados, una terecera parte, aproximadamente, es atendida por un médico diplomado. Si todos los eventos fueran atendidos y hubieran oficinas del Registro Civil instaladas en todos los establecimientos de Salud del país, la cobertura sería casi completa.

b) La distancia "efectiva" en términos de tiempo y costo, para muchos informadores, especialmente en zonas rurales de las regiones montañosas y selváticas, puede presentar un obstáculo insuperable.

c) La importancia de inscribir los nacimientos y las defunciones es evidentemente comprendida y apreciada en las ciudades y poblaciones grandes, sin embargo muchos ecuatorianos en las áreas

rurales desconocen o no están familiarizados con las leyes relacionadas con el registro civil o no tienen ninguna apreciación de su importancia y usos.

2.4.2. Muchos años de experiencia en el manejo de formularios de eventos vitales han demostrado que una parte de la información tiene datos incorrectos, contradictorios o incompletos.

Los datos estadísticos de los hechos vitales en general, y los datos de causa de defunción en particular, son los más susceptibles de errores. Se piensa que son tres las causas esenciales:

a) El bajo nivel de instrucción de la población rural es un factor muy importante que impide a los informantes proporcionar datos fidedignos y completos. Por ejemplo, hay personas que no informan con exactitud su edad o sobre la fecha de nacimiento, mucho menos fecha de eventos o edades relacionados con otras personas como es el caso en el cual el informante de un nacimiento es el familiar de uno de los padres.

   Bajos niveles de educación o barreras lingüísticas pueden incidir en una interpretación incorrecta de la información buscada. La sospecha injustificada del uso que se le puede dar a los datos puede conducir a la falsificación o rechazo a las preguntas formuladas.

b) La poca demanda de atención médica de eventos vitales tiene indudablemente un efecto adverso sobre la calidad y precisión de los datos. Este es el caso que ocurre particularmente con la información de las causas de defunción, puesto que es virtualmente imposible para el personal no médico el determinar las causas correctamente. Se encontró que el problema era tan serio en cuanto a estos datos, especialmente en el área rural, que el INEC está distribuyendo dos formularios distintos para certificación de defunciones, uno para eventos con atención médica y otro para eventos sin atención médica.

c) La falta de capacitación, motivación y estabilidad de los registradores en su trabajo y los escasos sueldos que perciben, pueden tener efectos perjudiciales en la calidad del registro. Problema fundamental es la usencia de entrenamiento y estabilidad de los registradores, debido a los cambios políticos en el gobierno local o nacional.

2.4.3 La falta de coordinación entre las tres agencias gubernamentales no permite obtener informes y datos dentro de un plazo razonable; una parte del problema proviene de la falta de capacitación apropiada de los registradores, pero se piensa que hay dificultades en al menos dos aspectos del sistema, a saber:

a) La pérdida de documentos en camino. Los registradores, en particular, tienden a echar la culpa de la pérdida de documentos a la falta de medios de comunicación confiable o al servicio de correos defectuoso. Mientras esto puede ser válido en algunos casos, en otros es simplemente una excusa.

b) Distribución de los informes estadísticos. Las tres agencias están de acuerdo en que el flujo de los informes estadísticos no es suficientemente ágil, particularmente los formularios de eventos atendidos por médico.

2.4.4 Un factor importante en la demora entre la llegada de los datos al INEC y la accesibilidad al usuario ha sido la falta de personal de computación y no disponer de una computadora. Felizmente, las agencias se dan cuenta de que estos problemas se están superando, aunque quedan otros, a saber:

Esfuerzo duplicado. Durante la creación de sus respectivos archivos de computación, tanto el INEC como el R.C. registran por lo menos en parte, los mismos datos: nombre, lugar y fecha de acontecimiento, edad, etc. Si hubiese un solo archivo con los datos, tanto legales como estadísticos, creado sin duplicación de esfuerzos, podrían extraerse después archivos de trabajo indipendientes mediante computadora, ahorrando un número significativo de horas/hombre y horas/computador.

2.5 Soluciones a las deficiencias:

Dada la gran importancia de las Estadísticas Vitales para el Gobierno, el INEC, en estrecha coordinación con el Registro Civil y el Ministerio de Salud Pública, ha decidido tomar las medidas que pudieran eventualmente conducir hacia un sistema de registro vital significativamente mejorado. Desde luego, en un esfuerzo de esta magnitud, el estudio detenido del sistema existente, el diseño y el refinamiento de nuevos procedimientos y ensayos a nivel experimental se indican antes de sugerir o llevar a cabo cambios a nivel nacional. Por estos motivos, el INEC está solicitando un convenio, con la Oficina de Estadísticas Internacionales, Centro Nacional de Estadísticas de Salud del Servicio de Salud

Pública de los Estados Unidos, dentro de los Proyectos Vistim de Mejoramiento de las Estadísticas Vitales.

3. Mejoramiento del Sistema

Hay cuatro alternativas para mejorar los sistemas de registros vitales: a) renovación total, b) correción de una deficiencia específica, c) Registro de áreas de muestra y d) áreas de demostración modelo.

3.1 Renovación Total

Si bien la renovación total de un sistema nacional existente es ciertamente una alternativa lógicamente posible, es considerada como totalmente falta de sentido práctico desde todo punto de vista. Supone tener recursos ilimitados y requiere un conocimiento completo de qué es lo que quiere ser cambiado y cómo cambiar en muy poco tiempo, en caso de existir, no sería aplicable en la práctica.

3.2 Corrección de una deficiencia específica

Una posibilidad más razonable de mejoramiento es atacar uno de los problemas seleccionados y deficiencias restringidas en el sistema de registro vital. Si un sistema adolece tan sólo de una o dos deficiencias principales, o los problemas se concentran en una etapa del proceso de producción únicamente, entonces pueden indicarse los medios encaminados para resolver este problema o serie de problemas. El caso del Proyecto VISTIM en Jamaica es un buen antecedente al respecto: la cobertura y el flujo de datos son bastante buenos, sin embargo, existía un cuello de botella en la producción de datos. Por consiguiente, el proyecto se enfocó únicamente en el registro de datos, en el diseño de tabulaciones mejoradas y en la publicación

Esta alternativa, sin embargo, en el caso del Ecuador no es recomendable como una solución práctica, ya que existen deficiencias en todos los aspectos del sistema que requieren atención. Sin embargo existe una consideración fundamental: las tres agencias (INEC, RC y MS) están de acuerdo en que muchos problemas en el Sistema de Registro Civil en el país provienen de la falta de coordinación entre sí y la carencia, en algunos casos, de líneas claras de autoridad y responsabilidad, surgiendo de esta manera la necesidad de una solución más global.

3.3 Registro de áreas de muestra

De todas las metodologías aplicadas en países en los que hace falta una cobertura adecuada de las estadísticas vitales, el registro de áreas de muestra es indudablemente la alternativa que se utiliza más comunmente. Como esta metodología se aplica generalmente en situaciones en las que el objetivo primordial es estimar las tasas de nacimientos, defunciones y crecimiento relativo a nivel nacional, se require de un cuidadoso diseño de muestra para asegurar un nivel razonable de representabilidad. Experiencias en este campo han sido proporcionadas por los laboratorios para el Estudio de la Población en la Universidad de Carolina del Norte a través de proyectos en América del Sur, Africa y Asia. India y Turquía utilizan actualmente este sistema en lugar de un sistema de cobertura total.

Esta metodología del registro de áreas de muestra si bien tiene indudablemente sus usos y ventajas relativas, se tiene conciencia de que no es la metodología indicada para el Ecuador. Debido al número necesariamente grande de áreas de muestra que deben ser utilizadas, el sistema es costoso de mantener, difícil de administrar, requiere un número excesivo de visitas de inspección y control, y aparentemente da lugar a celos profesionales en los registradores por parte de sus colegas fuera de las áreas de muestra. Además, si una meta del proyecto es desarrollar un sistema modelo, la alternativa del área de muestra parecería bastante difícil de controlar debido a la dispersión geográfica de las área. Finalmente, parecería que el sistema de áreas de muestra enfoca más los usos estadísiticos del registro vital con muy poco énfasis en el aspecto legal.

3.4 Area de demostración modelo

Si bien, la utilización de áreas de demostración modelo como el primer paso para mejorar el sistema de registro vital no se ha propagado mayormente, se tiene la impresión de que esta metodología es particularmente apropiada para el caso del Ecuador. El mayor inconveniente en comparación con el sistema de áreas de muestra es que no puede esperarse que rinda estimaciones de tasas vitales representativas de áreas fuera de los perímetros geográficos del proyecto, pues su objetivo se centra en tener en cuenta el desarrolo, a través de la experimentación, de un sistema eficiente y confiable que pueda posteriormente ser ampliado a nivel nacional.

Como el número de áreas de demostración es generalmente pequeño, cinco o menos (tres en el proyecto propuesto),

la administración del sistema es relativamente fácil. El viaje para controlar, comprobar, modificar o realizar inspecciones puede llevarlo a cabo eficientemente uno o dos inspectores situados en el área. El mantener la información completa, aparte de los documentos de áreas que no son de demostración, es indudablemente mucho más sencillo en el caso de proyectos de áreas de muestra. Otra ventaja, es la de brindar la oportunidad de tratar de todos los aspectos del sistema de registro vital, ya que es en realidad un sistema completo en miniatura, el cual proporciona al equipo del proyecto la oportunidad de experimentar y superar o por lo menos de dilucidar claramente cualquier deficiencia en el sistema nacional que sigue funcionando.

Por lo tanto, el INEC cree que la alternativa del área de demostración modelo es la metodología más apropaiada, considerando los principales objetivos y reconociendo las limitaciones del sistema actual.

B. METAS ESPECIFICAS

Dentro de los objetivos generales señalados en la sección A.1 hay una serie de metas específicas que se indican a continuación.

1. Evaluar el sistema nacional tal como está funcionando en la actualidad

   a) Revisar la legislación y reglamentos del Registro Civil.

   b) Revisar y analizar los procedimientos administrativos y la coordinación entre las agencias gubernamentales involucradas.

   c) Hacer un estudio de evaluación de los registradores de todo el país, incluyendo sus prácticas, antecedentes y capacitación.

2. Desarrollar un sistema modelo que comprenda tres áreas de demostración seleccionadas, para observar los distintos problemas en el sistema de registro

   Las estrategias serán aprobadas, modificadas o reemplazadas según fuera necesario con el fin de mejorar.

   a) La cobertura de eventos vitales.

   b) La calidad precisión e integridad de los datos recogidos en los archivos de registros vitales.

c) Flujo de expedientes entre las oficinas centrales y del campo.

d) Entrada de datos, exactitud y accesibilidad a los archivos centrales.

e) La cantidad de datos, tabulaciones, publicaciones y servicios, y hacerlos más ampliamente disponibles a los usuarios.

3. Evaluar las medidas tomadas para cumplir con las cinco metas detalladas en el punto 2

4. Aplicar ciertas estrategias desarrolladas y evaluadas en los puntos 2 y 3 a nivel nacional

Ni el tiempo ni los recursos permiten extender todas las estrategias desarrolladas durante el plazo del proyecto a nivel nacional, aún si se dispusiera de ellos tampoco sería prudente tal extensión. No se lograría una implementación nacional completa sin iniciar ciertas modificaciones legales, organizacionales y administrativas, cuya necesidad se manifestaría únicamente una vez que el sistema modelo haya sido totalmente probado y evaluado. No obstante, podría resultar factible instituir algunas modificaciones al sistema nacional, particularmente en lo que toca a las estrategias relacionadas con la entrada de datos, tabulación, análisis y publicación.

5. Preparar un informe final para el Gobierno del Ecuador

La meta final de este proyecto debe ser, más que un simple sumario de recomendaciones, servir como un documento a base del cual el Gobierno del Ecuador, a través de las tres agencias involucradas, pueda establecer cambios cuidadosamente analizados para mejorar el Registro Civil del país. Específicamente, este informe debería contener.

a) Descripción sumaria del proyecto.

b) Evaluación relativa de las estrategias ensayadas.

c) Evaluación del sistema modelo en comparación con el sistema existente.

d) Estimación del grado de mejoramiento en caso de que el sistema modelo fuera ampliado a nivel nacional.

e) Descripción de la mano de obra, equipos y de los incrementos presupuestarios o reasignaciones requeridas para ampliar el sistema modelo.

f) Sugerencias sobre cambios legales, organizacionales y administrativos adicionales, los cuales, debido a su complejidad, no podrían incluirse en el proyecto, pero cuya conveniencia fuera sin embargo puesta en claro.

g) Un plan de acción - incluyendo un cronograma - para llevar a efecto los cambios propuestos.

C. METODOLOGIA

Esta sección está destinada a la descripción de procedimientos que deben ponerse en ejecución para obtener las metas específicas mencionadas en las partes 1 a 3 de la sección anterior.

1. Evaluación del sistema actual

Basado en un examen de documentos oficiales y a través de entrevistas personales con funcionarios claves de los ministerios y agencias pertinentes del gobierno se elaborará un informe descriptivo que revise leyes, regulaciones, estructura organizativa y procedimientos administrativos.

Un estudio más analítico de la situación actual en el campo se realizará a través de un cuestionario a ser enviado por correo a todos los registradores en el país. Además del propósito obvio del cuestionario -obtener información directa de los registradores - también será utilizado para poner en evidencia la eficiencia comunicativa entre las oficinas centrales de Quito y las varias oficinas de registro en el campo. Para este fin, el cuestionario se enviará por las mismas rutas utilizadas por el INEC para el envío y recepción de formularios de hechos vitales. Se mantendrán archivos cuidadosamente a fin de localizar obstáculos, rutas no confiables y también registrar los tiempos de entrega desde y hasta el INEC.

Los cuestionarios se utilizarán para obtener información de los registradores en los siguientes campos:

a) Duración de la experiencia
b) Antecedentes educativos
c) Entrenamiento de registro recibido
d) Conocimiento de los procedimientos básicos de registro
e) Hacia y desde qué oficinas se envían documentos de registros vitales

f) Material instructivo disponible
g) Datos personales
h) Problemas encontrados al desempeñar las funciones de registro

El estudio del sistema actual será utilizado en el diseño del sistema modelo, y será particularmente útil para mejorar las prácticas de aquellas personas que llevan el registro para mejorar la confiabilidad en el flujo de documentos, introducir reformas administrativas y proporcionar datos básicos para evaluar el sistema modelo. Adicionalmente, los datos sobre los registradores en las áreas de demostración propuestas pueden ser relacionadas con su desempeño, criterio que será observado posteriormente en el proyecto.

Los inspectores de campo visitarán una muestra de 100 registradores a través del país, con miras a proporcionar información más completa concerniente a los problemas (item h anterior) mencionados en los cuestionarios y medir los conocimientos y actitudes del registrador relacionados con su trabajo. Se prestará especial atención a la entrevista de registradores que no respondieron al cuestionario para determinar la causa de no respuesta.

2. Elaboración de un sistema modelo

Como se había mencionado, la metodología básica de este proyecto es elaborar un sistema modelo de registros vitales, específicamente el "modelo" deberá incluir una oficina central responsable de dirigir, analizar, coordinar y administrar el proyecto y tres áreas de demostración que se describirán más adelante.

2.1 Promoción de la inscripción

A fin de mejorar la cobertura de los eventos vitales, se debe dar un paso básico, que es el de instruir a la población para que cumpla con la obligación de inscribir los eventos vitales. Procedimientos específicos serían los de poner anuncios en los medios de comunicación, particularmente por la radio, así como colocar anuncios en idomas que no sean el Español en comunidades específicas. La colaboración del Ministerio de Educación será importante a fin de conseguir que se incluya este tipo de instrucción en las aulas de escuelas primarias y dar a los educandos panfletos que pomocionen el registro vital, que deberán ser llevados a sus padres. La colaboración del Ministerio

de Salud tendrá que obtenerse a fin de contar con el apoyo de su personal médico y para-médico para que sus pacientes, particularmente en las áreas rurales, reciban instrucciones para que se haga efectivo el registro de los eventos vitales.

Para cumplir con los objetivos señalados, el Instituto Nacional de Estadística y Censos y la Dirección Nacional de Registro Civil, elaborará, en colaboración con el Ministerio de Salud, un programa de entrenamiento a sus funcionarios para instruir sobre el registro de eventos vitales.

El entrenamiento o motivación a los registradores, que también se describe más adelante, podría también tener el efecto de reducir prácticas incorrectas que tiendan a desalentar al público a reportar los hechos vitales.

2.2 Instrucción al informante

El mejoramiento de la calidad e integridad de la información está relacionado con el nivel de educación de la población, la atención médica durante el hecho vital y el entrenamiento adecuado del registrador. Si bien, el incrementar la atención médica o mejorar el nivel educativo del pueblo está claramente fuera del alcance del proyecto, por lo menos existen tres medidas que se pueden tomar para mejorar la calidad de los datos proporcionados por el informante, las mismas que deben incluirse en los programas educativos mencionados en la parte 2.1.

a) Asegurar que el informante esté estrechamente relacionado al evento. En la medida que sea posible, uno de los padres (antes que los abuelos, familiares o amigos) deben ser los que reporten el nacimiento. El familiar más cercano debe ser el que informe sobre la defunción.

b) Dar a conocer previamente a los informantes la información que deberán proporcionar.

c) Pedir al informante que proporcione y verifique con el registrador o funcionario que hace la certificación, cualquier información que no haya sido proporcionada al tiempo del registro.

2.3 Capacitación de registradores

Un impacto aún mayor sobre la calidad de datos debe idearse a través del mejoramiento de las condiciones de trabajo y motivación de los registradores. Para este fin se prepararán manuales de instrucción para distribución entre registradores de las áreas de demostración, durante un curso de motivación de tres días.

Se proporcionará dos niveles de cursos perfectamente diferenciables; uno para registradores provinciales y cantonales, quienes generalmente están mejor instruídos y cuentan con personal bajo su supervisión; y otro, para registradores de parroquia rural, cuyo nivel educativo es generalmenmás bajo y que por lo general no cuentan con personal bajo su supervisión. También se proporcionarán materiales diferentes para cada curso. Específicamente, los manuales de instrucción y materiales de entrenamiento incluirán:

a) Las funciones, valor y usos del Registro Civil y Estadísticas Vitales.

b) Las regulaciones para el registro vital, qué son, cómo interpretarlas y cómo ponerlas en práctica.

c) Cómo llenar los documentos de información vital.

d) La importancia de cada dato contenido en los documentos.

e) Relaciones públicas - cómo promocionar el registro y cómo tratar a los informantes.

f) Cómo detectar y rectificar errores e inconsistencias en los datos recibidos.

g) Procedimientos para el envío de los documentos llenados, a quién enviarlos, quién debe enviarlos y con qué frecuencia.

h) Cómo efectuar cambios y modificaciones en los documentos.

Especial atención se debe dar al adecuado registro de las defunciones infantiles omisión que es indudablemente responsable de una parte substancial del subregistro de los hechos vitales.

2.4 Capacitación en la evaluación

Adicionalmente a la instrucción y práctica en la llenada de documentos, se proporcionará práctica adicional en el proceso de evaluación. Se mantendrán grupos de discusión que ayuden a evaluar el curso y que propiciarán sugerencias y críticas respecto al sistema de registro. Se llevarán a cabo cursos rápidos, de dos días, al final de cada año de operaciones en el campo de las áreas de demostración. Esto nos dará la oportunidad de notificar a los registradores los cambios o ajustes efectuados al sistema, para corregir prácticas que no están de acuerdo con los procedimientos establecidos, y para dar la oportunidad a los registradores de que expongan resumidamente sus experiencias y opiniones respecto al sistema modelo.

Aunque la influencia de los cursos puede dar un cierto grado de motivación directa a los registradores, una fuerza adicional de motivación debe ser su participación activa. La atención por parte de sus supervisores, aún cuando sea a través de un curso, puede también ser un importante factor de motivación.

2.5 Diseño de documentos

El diseño y número de documentos que deben llenarse indudablemente redundan sobre la calidad y precisión de los datos. Una revisión de los libros de registro, tarjetas y certificados, así como visitas ocasionales realizadas en el área rural de algunas provincias a registradores locales, permitieron conocer que al momento en que se llenan los dos primeros documentos, algunos registradores se descuidan en llenar el informe estadístico correspondiente, el mismo que constituye la mayor fuente de datos estadísticos. Si bien, el entrenamiento adecuado de funcionarios del registro podría aliviar el problema, una mejor solución podría ser la de combinar la tarjeta y el formulario estadístico, de modo que no exista duplicación de la información.

Este formulario sería enviado directamente al Registro Civil para ser tomado en microfilms, registrar los datos y remitir al INEC para su procesamiento.

Una revisión de los documentos existentes sobre nacimientos y defunciones revela que muy poca o ninguna información debe añadirse u omitirse en este momento. Los datos incluídos para propósitos legales son todos los que

la Ley prescribe. Si bien, la información estadística no llega a completar la lista sugerida por las Naciones Unidas, esto no niega la importancia de los datos omitidos; en la opinión de las tres agencias, los datos generalmente no son confiables en algunos sectores, y por esta razón en la actualidad no se los incluye en los certificados.

2.6 Flujo de documentos

Quizá, las dos medidas más obvias que deben tomarse en cuenta para mejorar el flujo de documentos serían las de centralizar la responsabilidad sobre dicho flujo y la de reducir el número de estapas por las que debe pasar el documento hasta llegar a su destino final. Además, un entrenamiento y motivación adecuada para los registradores deberá ayudar a reducir las demoras en la remisión, producidas por el envío equivocado de documentos a otras oficinas, o por utilizar canales inapropiados para el envío.

a) El primer paso para mejorar el flujo de datos tendría que ser el asignar la responsabilidad de la distribución del informe estadístico al Registro Civil. Esto permitirá un control directo del envío y recepción de los documentos.

b) El siguiente y lógico paso sería la racionalización del flujo de documentos. Una vez que los documentos se han llenado, éstos serán enviados, con la frecuencia que deberá detallarse más adelante, directamente al Registro Civil y marcados de tal manera que puedan ser fácilmente distinguibles del resto de los documentos que procedan de otras áreas no incluídas en las de demostración. Cualquier procesamiento por parte de agencias de salud deberá mantenerse a un mínimo y deberá efectuarse antes de enviar los certificados a los registradores locales.

c) El personal de campo será responsable de asegurarse que las rutas alternas pueden proporcionar una transportación más rápida y confiable en aquellas áreas desprovistas de servicio adecuado de correo. En lo posible, dichas rutas alternas deberán ser objeto de pruebas para comprobar la posibilidad de obtener mejores resultados.

2.7 Procesamiento

La reducción en la demora para poner los datos a disposición de los usuarios puede lograrse de varias maneras, la primera de las cuales también constituye un paso lógico en la centralización del flujo de datos: la utilización del documento combinado legal-estadístico.

a) El eliminar la duplicación de esfuerzos, ya sea por el INEC o por el Registro Civil, en el registro de los datos, la responsabilidad de procesamiento será asumida por el INEC. Un archivo temporal combinado en cinta de computadora será creado y luego subdividido en dos archivos de trabajo (también en cinta), uno correspondiente a lo legal y otro para fines estadísticos.

b) Para facilitar el acceso a documentos individuales, el Registro Civil elaborará una serie de índices anuales - ninguno de los cuales se usa actualmente en el Ecuador - para utilizarse a cada nivel administrativo principal: nacional, provincial, cantonal y parroquial. Esto permitirá al funcionario localizar un documento de acuerdo al nombre, lugar de origen y lugar de inscripción, correspondiente a cada año.

c) Para fines demostrativos, el Registro Civil mantendrá tres archivos legales:

   - Utilizando la tarjeta original, según la práctica actual.

   - Utilizando la cinta de computadora a que nos habíamos referido con anterioridad.

   - Creando una copia del microfilm de la tarjeta original mencionada.

   En base a la experiencia obtenida al mantener y tener acceso a estos archivos, el informe final del proyecto podría incluir sugerencias para continuar o descontinuar cada tipo al nivel nacional.

2.8 Publicación

La reducción en los retrasos entre los eventos vitales y el registro de datos, así como la eliminación de

duplicación de esfuerzos permitirán al personal dedicar más tiempo a la producción efectiva de datos a las tabulaciones y publicaciones para los usuarios.

a) Las publicaciones anuales standard serán revisadas a fin de detectar posibles áreas de mejora.

b) Se identificarán las necesidades específicas del INEC y del M.S. en cuanto a datos estadísticos vitales y su análisis, de manera que se puedan proporcionar tabulaciones e informes adecuados.

c) De consultas con agencias gubernamentales pertinentes, organizaciones nacionales de investigación a instituciones de educación superior, se obtendrán sugerencias respecto a juegos de datos y tabulaciones especiales que les son necesarios al usuario.

d) En base a las sugerencias obtenidas en "c" y de acuerdo con las leyes y principios de protección con respecto al anonimato de los individuos, se crearán cintas de datos para el usuario provenientes del archivo estadístico, para distribución entre las agencias gubernamentales interesadas, los institutos superiores, organizaciones de investigaciones y todas las agencias internacionales pertinentes. También se establecerán procedimientos para proporcionar tabulaciones especiales solicitadas por los usuarios.

3. Evaluación del Sistema Modelo

Para evaluar y demostrar las mejoras obtenidas a través del sistema modelo y para permitir la selección racional entre las estrategias que se pueda escoger, hay necesidad de una evaluación. A medida de lo posible, se establecerá un mecanismo que evaluará cada una de las estrategias puestas en marcha y el grado en que cada meta específica se cumplió.

3.1 Evaluación de cobertura

De todas las metas del proyecto, la más problemática en cuanto a su evaluación es aquella de la mejora de la cobertura. Esto se deriva de la necesidad de tener una fuente adicional de datos relativamente independiente y completa para estimar la cobertura y sus cambios, siendo esto último de gran interés para evaluar el impacto del

proyecto. Una revisión de las diferentes metodologías disponibles para estimar la cobertura ha llevado a la conclusión de que ningún método por sí solo parecería dar resultados satisfactorios y al mismo tiempo será práctico para llevarlo a cabo. Las metodologías son tan o muy costosas o las estimaciones que ellas proporcionan son demasiado burdas para detectar los niveles y cambios en cobertura.

Desde el punto de vista analítico, existen dos metodologías que nos permiten estimar la cobertura. Una a través del uso de entrevistas llevadas a cabo a intervalos relativamente cortos - por ejemplo seis meses - para enumerar los eventos vitales ocurridos en los períodos intervenidos. La segunda es el bien conocido método de "registros dobles" o duplicados, altamente aceptado por algunas autoridades y severamente criticado por otras. De acuerdo a la descripción contenida en el libro Cálculo del Crecimiento Poblacional (Population Growth Estimation) de Katz, Seltzer y Marks, el sistema de "registro doble" requiere de una fuente de datos concurrente pero completamente independiente de eventos vitales recogidos interrumpidamente durante todo el proyecto. Los registros de cada fuente de datos son comparados y confrontados (aunque se puede utilizar la confrontación en una sola dirección en lugar de la confrontación en dos direcciones para reducir el considerable esfuerzo requerido) y por uso del llamado método "Chandrasekaran-Denming".

Se puede obtener una estimación de eventos omitidos, independientemente de los méritos científicos de los dos métodos, ambos requieren recursos por encima de este proyecto, investigaciones suficientemente grandes para proporcionar estimaciones razonablemente exactas, doblarían o triplicarían los costos. El desarrollo y mantenimiento de una fuente de datos permanente e independiente de los hechos vitales, sería no sólamente de costos prohibitivos sino que además dudoso que suficientes informantes o recolectores de datos puedan ser encontrados.

Mucho menos sofisticados y mucho menos exigentes en cuanto a recursos, son otros métodos que utilizan datos existentes para la estimación de la cobertura. Censos, encuestas demográficas nacionales, encuestas de fecundidad y de hogares, podrían utilizarse para proporcionar estimaciones generales de las tasas de eventos vitales en las áreas de demostración. Los riesgos de utilizar estos

métodos son el hecho de que generalmente se refieren a un solo punto de tiempo y es muy probable que las tasas vitales estén cambiando en las áreas de demostración. Además, las encuestas por muestreo son demasiadamente pequeñas para referirse a áreas geográficas tan específicas como las áreas de demostración y a menos que exista un censo reciente y completo puede ser casi imposible obtener estimaciones de tasas que impliquen el uso de un denominador especial (debido no sólamente al cambio de las tasas de eventos vitales sino especialmente a la migración) cualquiera que sea la tasa, estos son los métodos que el proyecto se verá forzado a utilizar si se piensan obtener estimaciones de cobertura en el mismo. Se consultará a expertos en la materia para efectos de maximizar la precisión de los métodos existentes para comparar los niveles de cobertura y sus cambios.

3.2 Evaluación de calidad e integridad de la información

La evaluación de la mejora en la calidad de datos y su ampliación es bastante más fácil que la de los parámetros de cobertura.

a) Para evaluar cambios en cuanto a la calidad e integridad de datos, se mantendrán tabulaciones de cinco y seis meses (empezando con los seis meses anteriores a la implementación del proyecto y continuando a lo largo del segundo año de operaciones) de datos omitidos en certificados.

b) De igual manera, se mantendrán tabulaciones de inconsistencias de datos o de errores para compararlos en los mismos períodos de cinco y seis meses.

c) Para comparar la confiabilidad de los datos se efectuarán dos visitas de aproximadamente el 10 por ciento de los eventos cubriendo intervalos apropiados. Obviamente el segundo intervalo ocurrirá durante los últimos meses de las operaciones de campo, mientras que el primero tendría lugar en algún momento durante los seis meses de la etapa preparatoria, previo a los cursos de motivación de los registradores y a la iniciación de las operaciones de campo.

3.3 Evaluación del flujo de documentos

La evaluación de la confiabilidad del flujo de documentos se basará principalmente en un sistema de recibos que

deberán llenarse cada vez que los documentos pasen de una oficina a otra. Los recibos firmados serán llenados en triplicado de la siguiente manera: el original va directamente a las oficinas del proyecto en Quito, una copia va a la oficina que recibe los documentos y la última copia se entrega a la oficina que proporcionó los documentos.

Estos recibos permitirá determinar el tiempo transcurrido en cada etapa a través de la cual pasan los documentos hasta ser tabulados con fines de comparación y análisis. También proporcionarán medios para localizar pérdidas y cuellos de botella en el sistema de flujo de datos.

Los datos básicos correspondientes a condiciones previas al inicio de operaciones en el campo, se obtendrá de registros mantenidos por el Registro Civil y el INEC.

3.4 Evaluación de Procesamientos

La evaluación de la reducción en las demoras en el procesamiento de datos, se llevará a través de registros llevados en la fechas de arribo de los certificados y de las fechas en las cuales los datos son colocados éxitosamente en la cinta del computador. Todos los datos serán almacenados en cintas para facilitar la tabulación y análisis. Pruebas períodicas se llevarán a cabo para determinar el tiempo promedio requerido para colocar los registros de los hechos vitales específicos en los archivos centrales así como en los locales.

3.5 Evaluación de la producción

La evaluación del mejoramiento de la producción, será directa y tan sólo necesitará un listado contínuo de documentos, conjunto de datos y los informes preparados y distribuídos.

4. Areas de Demostración

Se ha dedicado considerables deliberaciones y discusiones a la selección de las tres áreas demostrativas para este proyecto. Varios criterios fundamentales se utilizaron para llegar a la selección final:

a) Cada área debería representar un problema mayor en el sistema de registros vitales.

b) Cada área deberá contar con una base poblacional lo

suficientemente grande como para producir un número sustancial de eventos por año. Se estimó que la población de cada área debía ser entre 75.000 y 300.000 habitantes, para que se produzcan entre 3.000 y 12.000 nacimientos y de 900 a 3.600 defunciones por año en cada área de demostración (presumiendo que exista una tasa de nacimientos de 40 y una tasa de muertes de 12 por una población de 1.000).

c) Las áreas no deberán incluir ninguna de las dos áreas metropolitanas principales, es decir Quito y Guayaquil.

d) Las áreas deberán representar diferentes regiones geográficas.

e) Cada área de demostración deberá coincidir con una división político-administrativa claramente definida y preferiblemente al mismo nivel administrativo.

El INEC, la Dirección General de Registro Civil y Cedulación y el Ministerio de Salud, antes de llegar a la selección final con el fin de asegurar una selección de las áreas de demostración, además de las condiciones señaladas anteriormente, realizaron un estudio de todas las provincias del país, las que fueron sometidas a un prolijo análisis de las condiciones y necesidades vitales del Sistema de Registro y de las características socio-demográficas. Bajo estas consideraciones, se determinaron como áreas de demostración a las provincias de: Esmeraldas, Chimborazo y Cañar, cuya población suma aproximadamente 800.000 habitantes.

Esmeraldas provincia de agricultura mixta, caracterizada por la Refinería de Petróleo localizada al Norte de la Costa y por un clima tropical lluvioso, la atraviesan ríos navegables que facilitan el transporte y comunicación para el desenvolvimiento del sistema vital de registración. Esmeraldas incluye 5 cantones con 8 parroquias urbanas y 50 rurales, en estas últimas habitan el 38 por ciento de la población de aproximadamente 290.000 personas. El área de crecimiento más rápido es la capital de la provincia, Esmeraldas (población cercana a los 80.000 habitantes), que es un foco de migración.

Chimborazo una provincia con una población de más de la tercera parte del millón, se encuentra en la zona central de la Región Interandina, y consta de 6 cantones con 12 parroquias urbanas y 42 rurales. Cerca de una cuarta parte de los habitantes viven en áreas urbanas en las cuales se incluye

Riobamba, población de 71.104 y varios pueblos pequeños de 2.000 a 8.000 habitantes. El área rural está poblada por un alto porcentaje de comunidades indígenas.

Cañar provincia localizada al sur de la Región Interandina, poblada principalmente en la zona rural, consta de 3 cantones, y 33 parroquias 29 de las cuales se encuentran en las áreas rurales. Sólamente un 13% de la población de 177.471 habitantes viven en áreas urbanas, que corresponden a tres centros urbanos que varían de 2.500 a 13.000 habitantes.

5. Calendario de Actividades del Proyecto

A continuación se encuetra el calendario de las principales actividades que deben llevarse a cabo durante los tres años del proyecto.

5.1 Primer Semestre

a) Contratación y entrenamiento del personal de las oficinas.

b) Preparación y pre-prueba del calendario de entrevistas para los registradores.

c) Preparación del material de entrenamiento y manuales de instrucción para registradores.

d) Estudio de los aspectos legales y administrativos del sistema de Registro Civil.

e) Envío por correo de los formularios de entrevistas a los registradores.

f) Contratación y entrenamiento del personal de campo.

g) Determinación de procedimientos especiales del proyecto en áreas de demostración.

h) Preparación de materiales educativos y técnicos para el público.

i) Iniciación de las visitas de seguimiento para muestreo de registradores.

j) Entrenamiento de registradores.

5.2 Segundo Semestre

Primer período de implementación del sistema modelo.

a) Terminación de las visitas de seguimiento a los registradores.

b) Evaluación del primer período de implementación.

5.3 Tercer Semestre

Segundo período de implementación.

a) Ajustes y refinamientos.

b) Preparación de informe sobre análisis del sistema de registro de eventos vitales.

c) Evaluación del segundo período.

5.4 Cuarto Semestre

Tercer período de implementación.

a) Ajustes y refinamientos

b) Evaluación del tercer período

5.5 Quinto Semestre

Cuarto período de implementación.

a) Ajustes y refinamientos

5.6 Ultimo Semestre

a) Preparación de la evaluación final y de los informes.

b) Preparación del plan nacional de implementación para el Gobierno del Ecuador.

D. IMPORTANCIA DEL PROYECTO

Mientras que el mayor impacto del proyecto será la calidad y confiabilidad de los datos, su flujo, su registro y procesamiento, así como un incremento en el servicio a los usuarios si es que se llega a su culminación, también el sistema de registros vitales en el Ecuador

En tanto que los métodos desarrollados en el modelo pueden mejorar la cobertura hasta cierto grado si se aplica a nivel nacional, al alcanzar una cobertura completa debe ir acompañada por un incremento en el nivel de educación, prestación de servicios, posibilidades médicas y mejor comunicación.

Afortunadamente, Ecuador está dando importantes pasos en todas estas áreas. Por consiguiente, un proyecto tendiente a mejorar, el registro de estadísticas vitales que comience ahora vendría en la etapa más importante de desarrollo en que Ecuador se encuentra.

Ejemplos de los beneficios específicos que se obtendrán de un sistema mejorado, incluirán:

a) Una base de datos más adecuados que ayude a proyectar una imagen más clara del estado del país en cuanto a salud, y para evaluar los efectos de la expansión de los servicios de salud;

b) Mejora los datos para estudiar los cambios poblacionales;

c) Mejor protección de los derechos del individuo, incluyendo la comprobación de cuidadanía, obligaciones paternales con relación a los hijos y derechos de herencia; y

d) Mejor acceso a documentos y servicios por parte de los usuarios.

E. ORGANISMO RESPONSABLE DEL PROYECTO

Durante algún tiempo ha existido una amplia colaboración entre las agencias directamente involucradas en el sistema de registro de estadísticas vitales. Debida a su extensa experiencia en investigaciones de campo y de análisis, el Instituto Nacional de Estadística y Censos será el organismo responsable del proyecto. Sin embargo, las otras dos agencias (Registro Civil y Ministerio de Salud) han prestado colaboración en la planificación del proyecto y continuará haciéndolo hasta su éxitosa terminación. Los profesionales seleccionados y personal técnico de las tres agencias conformarán el personal del proyecto, y habrá un investigador co-principal de cada agencia. Los investigadores principal y co-principal de cada agencia se reunirán periódicamente para evaluar el progreso alcanzado por el proyecto y para tomar las decisiones administrativas y técnicas necesarias para el éxito del mismo. Los Directores de las tres instituciones involucradas han acordado prestar su apoyo al proyecto.

F. DERECHOS DE LAS PERSONAS Y CONFIDENCIALIDAD DE LA INFORMACION

Hay dos "poblaciones" de la cual se solicitará información en este Proyecto:

Los registradores, quienes son fincionarios del Registro Civil (Agencia que colaborará en este Proyecto), y todas las personas en áreas de demostración, en donde ocurre un nacimiento o defunción, incluyendo otras personas relacionadas a los eventos como se describirán más adelante.

1. A los registradores se les solicitará llenar y devolver un cuestionario (ver sección C. 1) que contiene información a la cual el Registro Civil que es el Empleador, tiene acceso. El registro Civil dispone de estos datos; pero no actualizados y ordenados en un archivo centralizado. Otros datos que no están ni actualizados ni centralizados en un archivo de datos se relaciona con la comprensión de los registradores y la ejecución de regulaciones del sistema de hechos vitales.

   El único próposito de recolectar estos datos es el de asistir al personal del proyecto en la preparación de cursos de entrenamiento para los registradores, en proporcionar información básica que sirva para la evaluación del rendimiento de los registradores en las áreas de demostración y para la evaluación del sistema nacional de Registro de los hechos vitales que se lleva en forma contínua.

   En base a estas consideraciones, los solicitantes están de acuerdo en que:

   a) Los registradores son una importantísima fuente de información con relación a las prácticas actuales en el tema de registro de hechos vitales. Ninguna evaluación del sistema nacional es factible sin su participación.

   b) La información solicitada a los registradores se relaciona sólamente a sus obligaciones oficiales y no irá más allá de aquella que corresponde a una relación de intercambio normal entre el empleador y el empleado y estarán completamente dentro de la estructura legal del Ecuador.

   c) Las evaluaciones del personal no serán usadas en detrimento de los registradores, sino solamente para su beneficio, con el próposito de ayudarles a mejorar su capacidad y eficiencia.

d) Toda la información solicitada será mantenida con carácter confidencial por el proyecto. Cualquier tabulación, análisis o informe que está basado en el cuestionario, se elaborará de tal manera que proteja el anonimato de los registradores individuales.

2. La población envuelta en el Proyecto comprende todas las personas cuyo nombre debe aparecer en los documentos del registro de hechos vitales y que están relacionados con los nacimientos y defunciones que ocurran en las tres áreas de demostración durante el período del Proyecto. Esta población incluye a las personas fallecidas y a los que nacen, familiares inmediatos (padre, madre, esposo, esposa, hijos), otros parientes, el informante y a las autoridades que diligencian los formularios.

Las agencias que participan en el sistema de registro de hechos vitales, fijan los siguientes criterios con relación a esta población.

a) Si bien, la participación en el registro de los eventos vitales es exigida por la Ley, depende de la voluntada del informante el proporcionar los datos.

b) La información obtenida no es de relevancia de por sí para el Proyecto, el acta del registro y la provisión de datos completos y exactos, cualquiera que estos puedan ser, son los factores relevantes.

c) La información recolectada durante el proceso de registro se tratará confidencialmente de acuerdo a las normas prescritas por las leyes ecuatorianas.

El acceso a los documentos y a la información que ellos contienen, es restringida a:

- La parte interesada o persona más allegada al hecho vital.

- Las autoridades de estadísticas de salud competentes.

- Los funcionarios competentes del Registro Civil y del INEC.

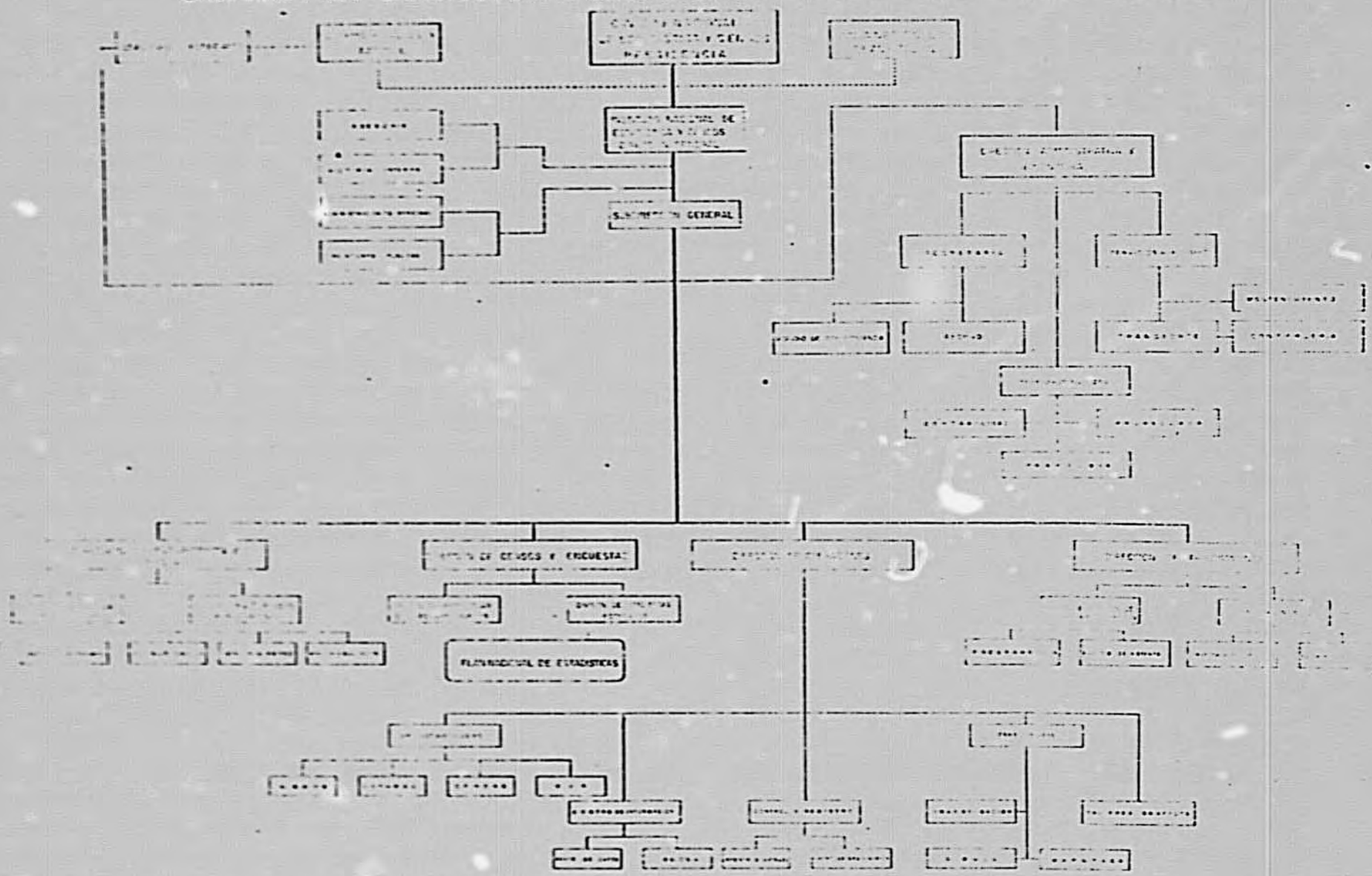
PROYECTO VISTIM: PRESUPUESTO POR AÑOS Y ORIGEN (VALOR CALCULADO EN DOLARES 2/)

GRANDES RUBROS	PRIMER AÑO			SEGUNDO AÑO			TERCER AÑO			COSTO TOTAL DEL PROYECTO		
	COSTO TOTAL	APORTE EXTRANJ.	APORTE 1/ NACIONAL	COSTO TOTAL	APORTE EXTRANJ.	APORTE 1/ NACIONAL	COSTO TOTAL	APORTE EXTRANJ.	APORTE 1/ NACIONAL	COSTO TOTAL	APORTE EXTRANJ.	APORTE 1/ NACION.
REMUNERACIONES	99.200	55.900	43.300	121.500	70.900	50.600	93.800	49.200	44.600	314.500	176.000	138.500
CONSULTORES		-	-	5.000	5.000	-	5.000	5.000	-	10.000	10.000	-
EQUIPOS	28.500	6.300	22.200	-	-	-	-	-	-	28.500	6.300	22.200
SUMINISTROS	38.200	16.100	22.100	56.400	25.600	30.800	46.000	16.500	29.500	140.600	58.200	82.400
OPERACIONES DE CAMPO	44.500	30.000	14.500	41.300	24.300	17.000	20.600	6.800	13.800	106.400	61.100	45.300
OTROS GASTOS	21.815	6.500	15.315	29.760	15.000	14.760	29.085	15.900	13.185	80.660	37.400	43.260
TOTAL	232.215	114.800	117.415	253.960	140.800	113.160	194.485	93.400	101.085	680.660	349.000	331.660

1/ INCLUYE EL APORTE DE LAS TRES INSTITUCIONES QUE PARTICIPAN EN EL PROYECTO:
INSTITUTO NACIONAL DE ESTADISTICA Y CENSOS
DIRECCION NACIONAL DE REGISTRO CIVIL, IDENTIFICACION Y CEDULACION
MINISTERIO DE SALUD PUBLICA.

2/ COTIZACION DEL DOLAR: 26 SUCRES.- SEPTIEMBRE 1980.

ORGANIGRAMA ESTRUCTURAL DEL INSTITUTO NACIONAL DE ESTADISTICA Y CENSOS



BEST AVAILABLE DOCUMENT

ANNEX V - G

INTERNATIONAL PLANNED PARENTHOOD FEDERATION

STENGTHENING THE ROLE OF ECUADOR'S PRIVATE SECTOR

IN POPULATION AND FAMILY PLANNING

INTERNATIONAL
Planned Parenthood
FEDERATION

Western Hemisphere Region

FEDERACIÓN
INTERNACIONAL DE
Planificación de la Familia

Región del Hemisferio Occidental

EXEC/ECU/03/81

22 de enero, 1981

Mr. John A. Sanbrailo
AID Representative
United States AID Mission to Ecuador
International Development Cooperation Agency
USAID/Quito
Quito, ECUADOR

REF: FHD.01.81

Dear Mr. Sanbrailo:

Thank you for your letter of January 2nd concerning the possibility of your Mission providing "one large grant to a broad-based international population organization such as the Western Hemisphere Regional Office of IPPF." We certainly are interested in considering "assuming program implementation responsibility for assistance activities proposed for APROFE, CEMOPLAF and CEPAR."

In order to explore these possibilities further, Lindsay Stewart (Program Advisor for Ecuador) and I would like to visit you in Ecuador February 23rd and 24th and would appreciate knowing if such a visit would be convenient both for your Mission and for the local agencies involved.

We look forward to meeting with you and your staff and to developing a project which will contribute toward expanding family planning activities in Ecuador.

Thank you for providing us with this important opportunity.

Sincerely yours,

Hernán Sánchez
Regional Director

cc: Robert Corno, USAID/Washington

INTERNATIONAL
Planned
Parenthood
FEDERATION

Western Hemisphere Region

FEDERACIÓN
INTERNACIONAL DE
Planificación
de la Familia

Región del Hemisferio Occidental

PROJECT PROPOSAL

SUBMITTED TO

USAID/ECUADOR

BY THE

INTERNATIONAL PLANNED PARENTHOOD FEDERATION/WHR, INC.

STRENGTHENING THE ROLE OF ECUADOR'S PRIVATE SECTOR IN POPULATION AND FAMILY PLANNING

APRIL, 1981

105 Madison Avenue, New York, N.Y. 10010, USA Telephone: 212-879-2230 Cable Address: WHIPPFE / Telex: 620661

ANNEX V - G

PROJECT PROPOSAL SUBMITTED TO
USAID/ECUADOR BY THE
INTERNATIONAL PLANNED PARENTHOOD FEDERATION/WHR, INC.

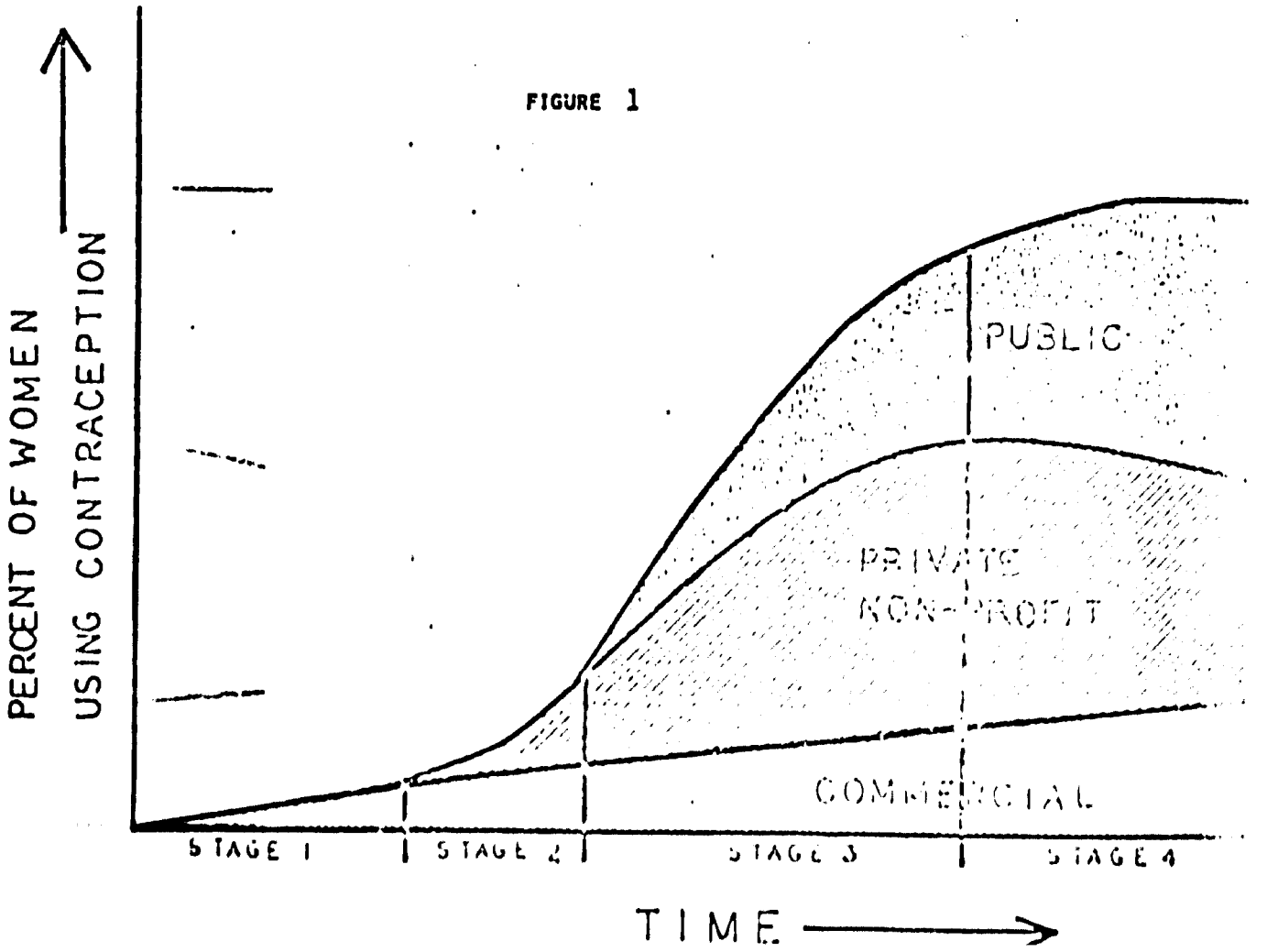
STRENGTHENING THE ROLE OF ECUADOR'S PRIVATE SECTOR IN POPULATION AND FAMILY PLANNING

INTRODUCTION

I. THE ROLE OF PRIVATE VOLUNTARY ORGANIZATIONS IN THE EVOLUTION OF FAMILY PLANNING

The recent evolution of family planning in the Western Hemisphere confirms our belief that there is a natural division of labor among the three major providers of family planning information and services: the commercial sector, the private non-profit sector, and the public sector. In the usual sequence of events, as represented schematically in Figure 1, these three sectors have different degrees of importance at different stages, and normally the information, the services, and even the challenge provided by the first two are key factors in the gradual involvement of the public sector. The formal or informal relationships which develop among the three sectors, heavily influenced by key individuals and institutions, condition the way in which family planning is eventually integrated into the social, economic, and political fabric of the nation.

FIGURE 1



Stage 1

Historically, the first sector to act is the commercial sector, consisting of private MDs, pharmacies, and other "full price" ventures. The commercial sector begins to supplement existing traditional or folk methods- such as abstinence, withdrawal, rhythm, herbs, and abortion - with barrier methods, spermicides, oral contraceptives, IUDs, injectables, and sterilization. By definition, the commercial sector serves only those who can afford to pay the full market price of these methods, and therefore the growth of commercial services is slow, especially in poor countries or countries with very uneven income distribution.

Stage 2

The timing of the next stage is highly variable, because it depends on the willingness of a few courageous individuals to claim for the poor the same reproductive freedom which the national elite has already begun to exercise, by creating private non-profit (PNP) organizations devoted to population and family planning. Concern with the growing incidence of induced abortion, and the consequent morbidity and mortality, has also been an important motive for the formation of these PNP institutions.

As PNP services steadily expand, and as private organizations awaken the national leadership to the national benefits of family planning, pressure begins to grow for government support of family planning services. The popular demand for PNP services, made evident by crowded clinics and rapidly expanding community-based programs, puts to rest a traditional argument of opponents: "our people don't want family planning". Likewise, the fact that the social and cultural qualities of the communities served by the PNP sector undergo no obvious deterioration undermines the credibility of other dire warnings against family planning.

Just as the commercial sector demonstrated the acceptability of "full-price" family planning among the elite, so the private non-profit sector demonstrates the acceptability of subsidized family planning for the rest of the nation. Even more important, PNP groups acquire experience in the design and implementation of family planning programs. Some ideas may be imported from programs in other countries, but very soon the PNP sector has built its own unique experience. After a few years, it becomes the major national repository of that experience, the only national sector that has experimented with different ways of offering family planning and related services. By virtue of their private status, the PNP organizations are also able to conduct large-scale information and education programs, not only for potential clients but also for national leadership.

Stage 3

Sooner or later, the government accepts the responsibility, and begins

to openly support family planning. Nevertheless, the nature of the government's participation is highly variable. The public sector is by definition the most politically vulnerable, and even quite promising government programs have been known to suddenly fail because finances were shifted to another sector, or because cabinet ministers or even middle level bureaucrats were shifted. A token government contribution, or a badly administered government program, may have very little effect on the national situation.

Stage 4

If all goes well, there comes a time when the growth of the public sector (and the expansion of the commercial sector) begin to reduce the service burdens which private voluntary organizations have developed during stages 2 and 3. On the other hand, it is seldom that the public sector is willing or able to cover all the needs unmet by the commercial sector. Generally there are population groups, or areas of the country, which the government does not reach. There may be types of service which the government cannot or will not provide. There is also a tremendous job to be done in training government MDs and paramedical personnel, evaluating the results of the national program, and providing information and education services.

II. THE CURRENT SITUATION IN ECUADOR

In terms of the theoretical model described above, Ecuador would appear to be in Stage 3, when government programs have begun but private efforts are still expanding. The problems faced by the nation are summarized as follows in the November 11, 1980 USAID Project Information Document:

> "The capacity of Ecuadorean public and private sector institutions to provide for basic human needs - food, clothing, education, housing, work, health care, transportation, electricity, water - has been severely hampered over the past three decades by a high population growth rate of over 3 percent a year. The current population is estimated at 8.3 million, with a projected population by the year 2000 of over 15 million."

The veracity of this statement is underlined by a few facts about the situation in Ecuador in 1979:

- Of the 351,000 women who needed pre-natal care, only 112,300 (32 percent) were able to obtain it; of these, only 69,400 (19.7 percent) gave birth with a professional in attendance;

- Of the estimated 1,084,000 women at risk of an unwanted pregnancy, only 62,949 (5.8 percent) new acceptors were provided with family planning services in public and private facilities (66.2 percent in the Ministry of Health, Armed Forces and Social Security services, and the rest in the 3 APROFE and 4 CEMOPLAF clinics);

- Of the 1,408,000 children aged 1-5 needing medical attention, only 59,100 (4.2 percent) were able to receive such attention from Government health facilities;

- 21.68 percent of the school-age population (aged 6-12 years) was not enrolled in school. In Los Ríos province, more than one-third of the school-age population (36.37 percent) did not attend school;

- Only 40.3 percent of the population had access to potable water (80 percent of the people in urban areas, but only 10.2 percent in the rural areas);

- Only 30.3 percent of the total population had access to sewers;

- For 1978, the housing deficit in urban areas was estimated to be approximately 250,000 houses. In rural areas, the deficit was considered to be even greater, not only quantitatively, but qualitatively.

Given these facts, it is clear that if Ecuador's population growth rate continues at its current accelerated pace, the provision of Ecuadorean education, housing and other public services can only worsen in the future. Steps must be taken in the public and private sectors to improve all these services. However, such steps will always be insufficient unless parallel actions are taken to: (1) increase the awareness of decision-makers about the impact population growth has on the nation's ability to provide essential public services, and (2) increase the availability of family planning services.

This project, then, will take up the challenge of assisting the private sector to contribute to both the awareness of the impact of population factors on development, and to improve and expand family planning services. It will do this through support during five years to three private Ecuadorean institutions.

A. APROFE - to provide family planning services to 35,807 new and 88,193 continuing acceptors through clinics in the three major cities of Ecuador: Guayaquil, Quito and Cuenca;

B. CEMOPLAF - to provide family planning services to 19,830 new and 9,800 continuing acceptors in three clinics to be established in Esmeraldas, Tulcán, and the Guasmo area of Guayaquil;

C. CEPAR - to increase knowledge and awareness of the interrelationship between population and development, with emphasis on reaching public and professional leaders as well as the media through information, training and research activities.

III. PRIVATE SECTOR COORDINATION

In the past, the three private institutions (APROFE, CEMOPLAF and CEPAR) have acted fairly independently of each other. Recently, however, they have sought to increase their cooperation through several coordinating meetings to discuss unmet needs and to exchange ideas and information about program activities. Through this grant, the WHR will assist these institutions to continue coordinating their activities as appropriate. The institutions will seek an additional grant from Development Associates to cover the expenses of regular coordination meetings.

IV. IPPF/WHR

The International Planned Parenthood Federation (IPPF) was founded in 1952 as a non-governmental voluntary organization dedicated to: (1) promoting family planning as a basic human right, and (2) recognizing that the equilibrium between world population, natural resources and productivity is a necessary condition for human happiness, prosperity and peace.

The IPPF is composed of member associations in 95 countries, and provides grants to 88 associations (not all of which are members).

The Western Hemisphere Region of the IPPF (WHR), also founded in 1952, is composed of 39 member associations in 39 countries, of which 33 receive grants. Fifteen of these members are grouped together in the Caribbean Family Planning Affiliation (CEPA). The WHR has been incorporated in the State of New York pursuant to the Not-For-Profit Corporation Law since 1955. The membership of the Corporation consists of Family Planning Associations (FPAs) affiliated to the IPPF and located in the Western Hemisphere Region, which embraces North, South and Central America and the Caribbean.

The Regional Council of the WHR sets general policy and consists of two representatives from each member organization plus ten members elected at large, as specified in the By-Laws of the Corporation. The Council's primary functions are to encourage the progress of family planning throughout the Region, and to aid and assist Associations which already exist in the Region. The Regional Council meets at least once per year.

Management of business, funds, property and affairs of the Corporation is vested in the Board of Directors of the Corporation, which is elected by the Regional Council. The By-Laws of the Corporation detail the powers and responsibilities of the Board of Directors, and of the officers of the Corporation. The Board of Directors usually meets four times per year. Between meetings, the affairs of the Corporation are guided by the Standing Management Committee and by the Chairman of the Board of Directors.

Staff operations in the Corporation are performed through the Re-

gional Office located in New York. The Chief Executive Officer of the WHR is the Regional Director. The Regional Office has four major functions:

- Program Development, Coordination and Monitoring
- Financial Development, Coordination and Monitoring
- Management and Institutional Coordination
- Communications.

The staff and volunteers of the WHR (including those of the Regional Office and the FPAs) will be available to provide technical assistance to the sub-grantees of this project.

Although the WHR receives much of its income from the IPPF, it has also obtained funds recently from many other sources, including the H.R. Hewlett Foundation, the Kellogg Foundation, USAID Regional Development Office/Caribbean, the UNFPA, the Population Crisis Committee, the Planned Parenthood Federation of America, and numerous individual and corporate donors.

GOAL, PURPOSES AND OBJECTIVES

I. PROJECT GOAL

As noted in USAID's November 18, 1980 Project Identification Document (PID): "USAID's Sector goal is to satisfy the basic human right to determine one's family size. The goal is derived from the Ecuadorean Constitution which guarantees this right. Achievement of this goal will be measured by a lowering in the rates of population growth and fertility and an increase in family planning activities."

This project will assist the fulfillment of these goals by supporting the efforts of three private sector agencies (APROFE, CEMOPLAF and CEPAR) to provide information, education, and services.

II. PROJECT PURPOSES

The purposes of the project are to:

A. Expand the availability of family planning services in Ecuador through private sector clinic activities;

B. Promote greater utilization of these services;

C. Increase awareness of the multi-sectorial implications in Ecuador of rapid population growth.

III. PROJECT OBJECTIVES

A. General Objectives

General objectives for the five years of this project include the following:

1. Strengthening and institutionalizing the family planning delivery systems of the private sector;

2. Increasing family planning practice by disseminating knowledge of family planning among disadvantaged sectors of the Ecuadorean population;

3. Developing a broad-based constituency to support family planning as a human right, and highlighting population issues among the media, opinion leaders and decision-makers;

4. Conducting and disseminating studies which will contribute to a better understanding of the relationship between population and development;

5. Assisting decision-makers to take population factors into account when formulating national development policies.

B. Overall Outcome Objectives

At the end of the project period, it is expected that there will be:

1. An increase in the number of family planning services available in the private sector through: (a) three new CEMOPLAF clinics; and (b) continuation and expansion of the three existing APROFE clinics;

2. An increase in family planning acceptors, with these clinics providing services to approximately 55,637 new and 97,993 continuing acceptors;

3. An increase of in-clinic and community information, education and promotion activities;

4. A population information and communications system in effect, utilizing its own publications, personal contacts, and the print and broadcast media;

5. An increase in awareness, among leadership groups and the general public, of population issues and family planning.

APROFE (ASOCIACION PRO BIENESTAR DE LA FAMILIA ECUATORIANA)

I. BACKGROUND

Founded in 1965 as the first Ecuadorean institution providing family planning information and services, APROFE has been instrumental in training professionals, promoting family planning awareness among government and other leaders and the general public, and offering services via clinics, private physicians and midwives, and CBD programs. By 1966, APROFE had established clinics in Ecuador's three main cities (Guayaquil, Quito and Cuenca), and had initiated a system of collaborating doctors (primarily working out of government facilities) in other cities. In that same year, APROFE sponsored the First Course on Population and Family Planning for physicians. In 1967, APROFE began advising the Ministries of Health and Defense on family planning matters, a role it has continued to play to the present time. In 1969, APROFE trained Ministry of Health personnel in family planning, and offered the First National Seminar on Family Planning for doctors (including military doctors) and midwives. In 1970, APROFE initiated its information and education program, aimed at making family planning more familiar to the general populace and leadership groups. By the mid-1970's, APROFE was offering regular training to professionals, ongoing family planning services in its three clinics, radio spot announcements, regular newspaper coverage of family planning, frequent seminars to students, labor unions, and other groups, as well as continuing to advise various public and private agencies working in the field. In 1977, APROFE initiated the first Planned Parenthood/Women's Development project in the Western Hemisphere, and has succeeded in training several hundred women in income-generating and money-saving skills, while at the same time providing them with family planning and primary health care services.

By the late 1970's, APROFE had incorporated two of its clinics (Quito and Cuenca) into government hospital facilities and the third into the voluntary maternity hospital in Guayaquil. From 1966 to 1980, APROFE's three clinics registered 74,525 new acceptors of non-permanent contraceptive methods. In addition, voluntary sterilization operations were provided to 6,483 women in the 1976 to 1980 period. The collaborating doctors and midwives (professionals in private practice to whom APROFE provides contraceptives and training in exchange for their offering services at low cost to their private patients) added another 18,171 new acceptors and 779 sterilizations to APROFE's rolls between 1976 and 1980. In 1978, APROFE began community-based distribution of contraceptives in the rural areas of Guayas province. This program now consists of 127 distribution posts in Guayas and Los Ríos provinces, and provided contraceptives to 2,037 new and approximately 3,450 continuing acceptors in 1980, thus covering a total of 4,393 new acceptors in its three years of existence. A midwife, working out of the CBD program's mobile van, offers pelvic examinations, inserts IUDs and does Pap smears for women in the CBD program.

In 1980, she inserted 246 IUDs. APROFE will expand the CBD project to two additional provinces (Esmeraldas and Manabí) in the coming year.

From 1966 to 1980, APROFE trained 2,301 people, including: 863 doctors and medical students in family planning techniques, plus an additional 53 doctors in sterilization; 161 nurses and auxiliary nurses; 238 midwives and midwifery students; 69 social workers; 456 educators, counselors and psychologists, and 461 others (including CBD program distributors).

APROFE is a legally chartered non-profit organization, governed by a volunteer Executive Council which meets quarterly and a General Assembly which meets annually. Since its inception, the major portion of APROFE's funds have come from IPPF. Additional funds have been provided by the Pathfinder Fund, CRESALC, IDRC, IPAVS, USAID and others, including funds generated locally through donations and charges for services.

II. JUSTIFICATION OF PROJECT

APROFE has shown the success of its clinics in Guayaquil, Quito and Cuenca, not only through the large numbers of acceptors served, but also as demonstration and training centers for government and private professionals. Of the women currently at risk in Ecuador, 7.5 percent have been provided with family planning by APROFE, 6.9 percent with non-permanent methods, plus an additional .6 percent by voluntary sterilization. With funding through this project, these clinics will be able to continue operating their regular programs, providing non-permanent contraceptive methods to a target of 35,807 new and 88,193 continuing acceptors during the next five years. In doing this, APROFE will expand activities in Quito and Guayaquil by hiring additional staff, while maintaining current staff levels in Cuenca. Medical students, physicians, and some midwives and social workers will continue to receive family planning training at these clinics. In addition, the clinics will provide back-up services to APROFE's collaborating doctors and midwives, community agents and commercial outlets.

III. OBJECTIVES

The main objective of this project is to enable APROFE's Guayaquil, Quito and Cuenca clinics to provide non-permanent contraceptive methods to 35,807 new and 88,193 continuing acceptors during five years, as noted in the charts below:

APROFE

TARGETS FOR NEW ACCEPTORS OF NON-PERMANENT CONTRACEPTIVE METHODS

Clinic	1982*	1983	1984	1985	1986*	Total
Guayaquil	4,700	4,900	5,100	5,300	5,500	25,500
Quito	900	1,100	1,500	1,800	2,000	7,300
Cuenca	544	571	600	630	662	3,007
TOTAL	6,144	6,571	7,200	7,730	8,162	35,807

APROFF

TARGETS FOR CONTINUING ACCEPTORS OF NON-PERMANENT CONTRACEPTIVE METHODS

Clinic	198* 1983	1984	1985	1986	Total
Guayaquil	13,000	13,800	14,200	14,800	15,500	71,300
Quito	1,100	1,400	1,800	2,300	3,000	9,600
Cuenca	1,288	1,393	1,463	1,536	1,613	7,293
TOTAL	15,388	16,593	17,463	18,636	20,113	88,193

* In order to allow comparisons from one year to another, the targets for the full calendar year are shown above. For 1982 and 1986, however, only 8 and 9 months respectively of these clinics' costs will be funded through this project.

Although the targets listed include only non-permantent contraceptive methods. APROFE will continue to offer voluntary sterilization in its three clinics, with funds provided by other agencies.

Based on calculations made in USAID's June, 1979 document "An Assessment of AID's Bilateral Population Program in Guatemala 1977-79"*, APROFE will offer an estimated 53,486 couple-years of protection through its new clinic acceptors.

COUPLE-YEAR PROTECTION OF NEW ACCEPTORS IN APROFE'S 3 CLINICS, 1982-1986

Clinic	Method	# New Acceptors	X	%Using** Method	X	Years of Use	=	Couple-Years of Protection
Guayaquil	Orals	25,500	X	16.5	X	2		8,415
	IUD	25,500	X	16.7	X	3		12,776
	Barrier	25,500	X	17.8	X	1		4,539
					Sub-Total			25,730
Quito	Orals	7,300	X	10.4	X	2	=	1,518
	IUDs	7,300	X	84.7	X	3		18,549
	Barrier	7,300	X	4.9	X	1		358
					Sub-Total			20,425
Cuenca	Orals	3,007	X	36.6	X	2		2,201
	IUDs	3,007	X	53.6	X	3		4,835
	Barrier	3,007	X	9.8	X	1		295
					Sub-Total			7,331
		Total Couple-Years of Protection						53,486

*The estimated average years of use, by method, is as follows:

Method	Years of Use
Orals	2
IUD	3
Barrier	1

**Based on actual 1980 new acceptor figures.

IV. PLAN OF ACTION

APROFE's three clinics have existed since 1966. Therefore there are no clinic start-up costs, and the project can take advantage of APROFE's experience in developing ever more cost-effective methods of service delivery. Each clinic is overseen by a Medical Director who is responsible for all service activities, although all clinic activities are the final responsibility of APROFE's Executive Director. The histories and activities of the clinics are described below.

A. Guayaquil

1. History: Initiated as APROFE's first clinic with two examining rooms in a private home, the Guayaquil clinic registered 1,280 acceptors in its first year of operation, and within a few years felt the need to establish a second clinic in Guayquil. By 1976, APROFE had succeeded in integrating these two clinics with the Enrique Sotomayor Maternity Hospital. The Maternity provided the land, and APROFE (with USAID funds), constructed a clinic still in use today. A second story was constructed by the Maternity and, since 1979, voluntary sterilization services have been provided there jointly by APROFE and the Maternity.

2. Plan for Project Period: In Guayaquil, APROFE aims to provide services to 25,500 new and 71,300 continuing acceptors in the five years of the project. The most important of APROFE's three centers in terms of numbers of acceptors served, the Guayaquil clinic functions as a demonstration and training center for physicians, midwives and social workers from the public and private sectors. Services are offered eight hours daily, five days a week, with the majority of acceptors attended by eight half-time midwives. Two half-time physicians deal primarily with the more complicated cases. A supervisor, based in Guayaquil and charged to the Guayaquil clinic, oversees the adminsitrative functioning of APROFE's three clinics. APROFE charges nominal sums for its services in this clinic, (S/60 for a fist visit, and S/30 for each subsequent visit) and a total income of US$321,000 is projected for the five-year period of this project. An interviewer does motivational work in the Maternity Hospital and within the clinic, while a social worker to be hired through this project will do outreach work in the community and assist acceptors to deal with family and other problems. APROFE's Information and Education Department provides additional motivational support with printed materials and radio advertisements and mini-dramas. The I&E costs will be supported by IPPF and local funds. The Maternity provides the clinic space, while APROFE pays for electricity and water.

B. Quito

1. History: The Quito clinic, initially located across the

street from the Isidro Ayora Maternity Hospital, registered 211 acceptors in 1966, its first year. In 1978, APROFE signed an agreement with the Ministry of Health, and in early 1979 incorporated the clinic within the Gynecological Department of the Maternity Hospital. The clinic is administered by the Technical Director of the Hospital, with APROFE providing equipment, supplies, and salaries for a small number of personnel.

2. Plan for Project Period: The Quito clinic presently functions at less than capacity, in part because its small staff has overwhelming responsibilities. In order to strengthen this clinic, APROFE plans to hire four new staff members: a half-time physician to provide family planning services, a professional nurse, an auxiliary nurse and a secretary/receptionist. They will join the current staff: a half-time physician, 1 nurse, 2 auxiliary nurses, and a motivator. It is anticipated that the larger staff will increase the effectiveness of the clinic, resulting in the ability to provide services to 7,300 new and 9,600 continuing acceptors in the five-year project period. These figures are almost double what would have been possible without the new staff. Services will continue to be offered five days a week, 8 hours a day. As this clinic is within a government facility, APROFE must abide by the recent government ruling to provide all health services free of charge, which rules out the possibility of generating income from this clinic. The full-time motivator will work on the post-partum, post-abortion wards of the hospital to inform potential acceptors of the service's existence. Back-up information and education support will be provided by APROFE's Information and Education Department, with IPPF and local funds. The Government provides clinic space and utilities.

C. Cuenca

1. History: The Cuenca clinic was established in 1966 in the most conservative of Ecuador's three major cities -- first in a private home, and shortly thereafter in the San Vicente Paul Hospital. In its first year, it registered 175 acceptors. In 1978, the clinic was incorporated into the new Vicente Corral Moscoso Hospital.

2. Plan for Project Period: Like the Guayaquil clinic, the Cuenca clinic requires little or no assistance to increase its efficiency of operation. The clinic will continue to provide basic family planning services five days a week, 7 1/2 hours a day, while at the same time serving as a training center for sixth-year medical students who pass through the clinic as part of their training. Services will be provided by a half-time doctor and two auxiliary nurses, while a full-time motivator will recruit new acceptors from within the hospital and from the community. APROFE's I&E Department, with IPPF and local funds, will provide support materials and some radio motivation. The Cuenca clinic seeks to reach 3,007 new and 7,293 continuing acceptors during the project period. As

this clinic is located within a government facility, it cannot charge for services. The hospital provides clinic space and utilities.

D. Overall Comments

The cost to this project per new acceptor is estimated to be as follows:

Guayaquil Clinic	US$ 21.32
Quito Clinic	US$ 41.86
Cuenca Clinic	US$ 56.18
Overall cost per new acceptor in the three clinics	US$ 28.44

It is interesting to note that the costs per new acceptor are considerably lower in Guayaquil than in Quito or Cuenca. The Guayaquil clinic, located within the Enrique Sotomayor Maternity Hospital, operates fairly independently of the Maternity, whereas the Quito and Cuenca clinics, located within Minsitry of Health facilities, must abide by Ministry of Health rules and regulations which result in higher costs per new acceptor. Because the Guayaquil clinic is independent, APROFE is able to charge for services there, thus generating an income which lowers the cost per new acceptor. Even without that income, APROFE's costs per new acceptor in the Guayaquil clinic would be US$33.91, still lower than in the other two clinics. This appears to be the result of both economies of scale and the use of midwives to deliver most family planning services in Guayaquil (in Quito and Cuenca, physicians provide the majority of family planning services).

While looking at the cost per new acceptor, one must also consider that, because APROFE's clinics have existed for fifteen years already, there are many continuing acceptors who must also receive services through this project -- almost three times as many as new acceptors, in fact. The cost of continuing to serve these acceptors is reflected in the cost per new acceptor.

During the life of this project, acceptors will bear about 38 percent of the costs of running the Guayaquil clinic. In Quito and Cuenca, where APROFE is unable to charge because of Ministry of Health rules, acceptors provide nothing. Overall, local income will pay for approximately 24 percent of all project-related costs. In addition, the Maternity Hospital in Guayaquil, and the Ministry of Health facilities in Quito and Cuenca provide in-kind contributions by offering the clinic space at no cost to the project.

V. EVALUATION

Ongoing evaluation will be conducted by APROFE's clinical and ad-

ministrative staffs, to ensure that the project objectives are being met on schedule. Half-yearly review sessions will be scheduled with the WHR Project Coordinator and APROFE staff to assess the levels of achievement, identify problems and determine solutions to meet the project objectives. APROFE plans to request technical assistance from WHR to conduct cost-effectiveness studies aimed at making these clinics even more efficient.

VI. MANAGEMENT CAPACITY

This project will be the direct responsibility of APROFE's Executive Director, Paolo Marangoni, M.D., one of the founders of APROFE and a leader in family planning in Ecuador for more than fifteen years. He will be assisted by the Program Coordinator, Abg. Eduardo Landivar, and by the APROFE Director of Administration and Finance, Ing. Jenny Duarte. They will be supported by an expanded APROFE office in Quito, and will travel as necessary to supervise the project. APROFE has a well-deserved reputation as a well-managed, cost-efficient organization. Curricula vitae of the staff are available upon request.

VII. BUDGET

Funding under this project will support operational costs for all three clinics, including personnel, clinical supplies and equipment, and utilities. Income from the Guayaquil clinic will be applied toward the payment of customs fees, the lunches required by law for those staff working the full eight-hour shift, and some staff salaries.

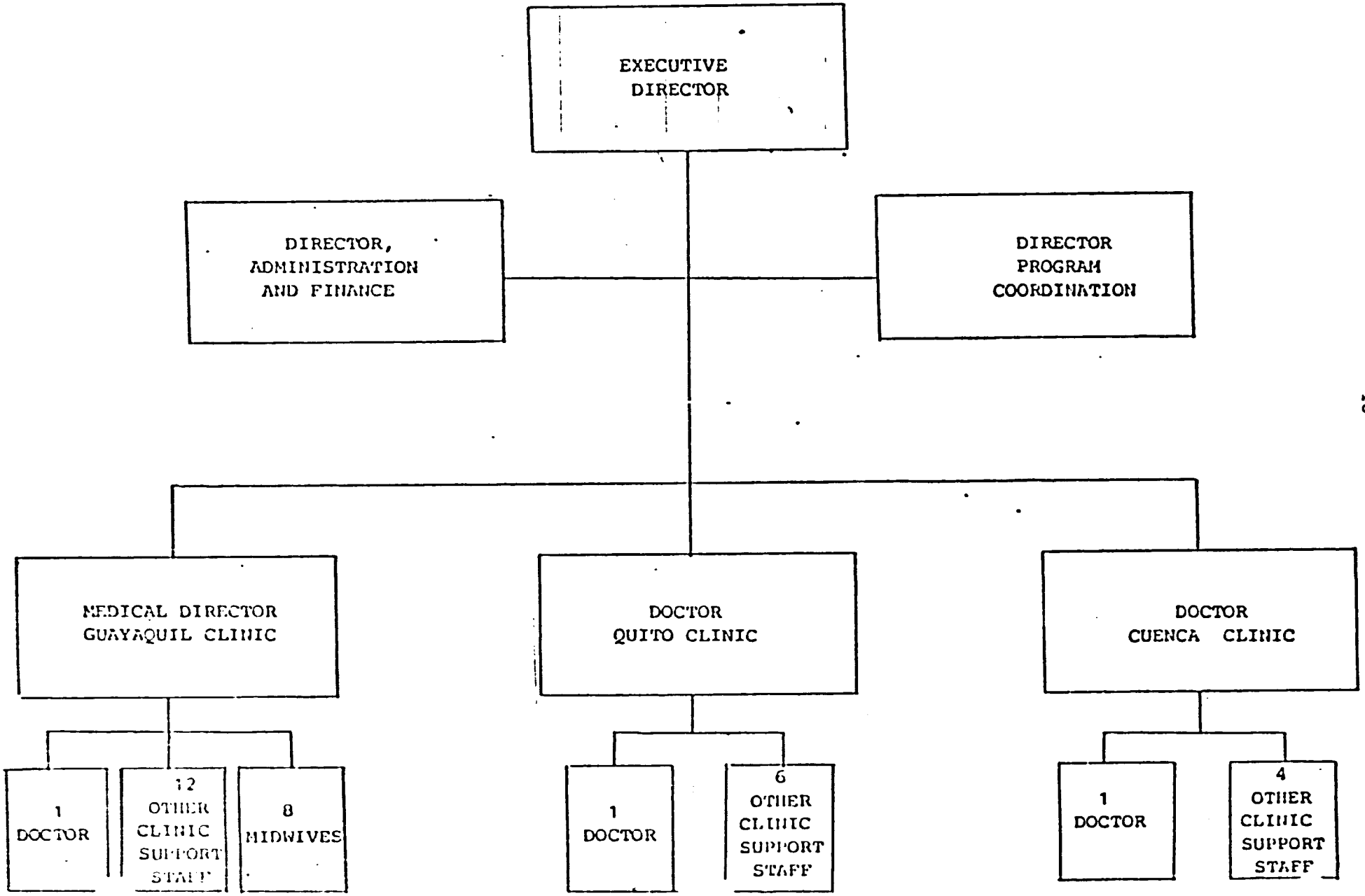
IPPF/WHR will provide counterpart funding by paying APROFE's core administrative costs for this project, as well as the contraceptives and major medical equipment needed for APROFE's three clinics.

APROFE

CALENDAR OF MAJOR PROJECT ACTIVITIES

CALENDAR YEARS	1982 (8 mos.)	1983	1984	1985	1986 (9 mos.)
ACTIVITY					
GUAYAQUIL CLINIC (I&E SERVICES)	May 1				September 30
QUITO CLINIC (I&E SERVICES)	May 1				September 30
CUENCA CLINIC (I&E SERVICES)	May 1				September 30

APROFE'S ORGANIZATION CHART FOR THIS PROJECT



CEMOPLAF (CENTRO DE ORIENTACION Y PLANIFICACION FAMILIALR)

I. BACKGROUND

The Women's Medical Society of Ecuador was founded in 1961, and in 1966 sponsored its First Medical Conference. One of the official themes of this conference was family planning. By mid-1968, following the training of several doctors by the IPPF affiliate in Chile, the Society opened a family planning clinic in Quito. In 1972, a second clinic was founded in Quito. This was followed by the establishment of additional clinics in Santo Domingo de los Colorados and Quevedo, in 1974. The family planning program separated from the Women's Medical Society that same year, and became CEMOPLAF (the Medical Center for Orientation and Family Planning), a non-profit organization registered with the Ministry of Health.

From 1968 through 1980, CEMOPLAF provided contraceptive services to 27,003 new acceptors at its four clinic locations, and motivated 155,327 people in the areas around these clinics. It also developed a network of 35 professional associates (doctors and midwives) who provided services to 4,859 new acceptors in 1979-80. In addition, CEMOPLAF offered 18 training courses for urban and rural professional and community leaders, and conducted educational programs with provincial, civil, municipal, and customs police, the National Railroad Company, and firemen. In 1978, CEMOPLAF established a laboratory to do a variety of tests (Pap smear, pregnancy, V.D., blood tests, and others) at its main clinic in Quito. The laboratory is not only self-sufficient, but also provides additional local income for the institution. CEMOPLAF also conducts regular clinical and educational training for physicians, midwives, nurses aides and social workers.

CEMOPLAF's funding initially came from APROFE, the Pathfinder Fund and USAID. Since December, 1973, most of CEMOPLAF's funding has come from FPIA and from its own locally-generated resources. Some training seminars have been funded by Development Associates. It is anticipated that FPIA will continue to fund CEMOPLAF's four existing clinics.

CEMOPLAF has twenty-two members representing a variety of professions. They form the General Assembly which meets twice yearly, and is the maximum policy-making authority of the institution. The General Assembly elects the five-member Central Committee which meets every two months, and deals with the day-to-day functioning of CEMOPLAF.

II. JUSTIFICATION OF THE PROJECT

CEMOPLAF, recognizing the success of its education and service programs to date, has identified three areas where the need for family planning services is especially urgent. These are Esmeraldas, Tulcán, and the Guasmo area of Guayaquil.

The Guasmo area of Guayaquil is a slum with a population of about 250,000 people, (approximately 65,000 women in fertile age and 42,250 women at risk). CEMOPLAF held a leadership training program in September, 1980 for community leaders from Guasmo, resulting in a request to establish a family planning clinic there. The Ministry of Health has just opened a health sub-center in Guasmo, but it appears that little attention will be given to family planning. APROFE has a family planning clinic in the Enrique Sotomayor Maternity Hospital in the center of Guayaquil, but offers no services in the Guasmo area. Based on its success in another slum area of Guayaquil, APROFE plans to establish a Planned Parenthood/Women's Development (PP/WD) project in Guasmo, and will refer women participating in that program to the CEMOPLAF clinic. (See the APROFE section of this project for more information on the PP/WD project.)

Another area is the northwestern coastal city of Esmeraldas (population approximately 130,000, with approximately 33,800 women in fertile age and 21,970 women at risk) where government clinics give little emphasis to family planning. APROFE will initiate a rural community-based distribution (CBD) program in 1981 which will benefit from the back-up support which the CEMOPLAF clinic can provide.

The third proposed project site is the northern Andean city of Tulcán (population approximately 63,000, with approximately 16,380 women in fertile age and 10,650 women at risk) where the CEMOPLAF clinic will provide the only private subsidized source of family planning.

CEMOPLAF has proposed to work in these three areas because of the local needs documented by the professional associates working with the organization in these areas. CEMOPLAF's records show that many people travel from Esmeraldas and Tulcán (distances of several hundred kilometers) to CEMOPLAF's Quito clinics to obtain family planning services. By offering convenient, low-cost family planning services to people living in these three cities and surrounding rural areas, CEMOPLAF will expand family planning coverage considerably, reaching 19,830 new acceptors and 9,800 continuing acceptors in the project period.

III. OBJECTIVES

The primary objective is to establish family planning clinics in Esmeraldas, Tulcán, and the Guasmo area of Guayaquil. These clinics will offer family planning motivation to 30,000 people in 600 groups, and family planning services to 19,830 new acceptors, of whom at least 50 percent will continue yearly as active acceptors. The I&E and service targets are detailed in the charts below.

INFORMATION AND EDUCATION TARGETS IN THE COMMUNITIES SURROUNDING THE CLINICS

AREA	1982 NUMBER GROUPS	1982 NUMBER PARTICIPANTS	1983 NUMBER GROUPS	1983 NUMBER PARTICIPANTS	1984 NUMBER GROUPS	1984 NUMBER PARTICIPANTS	1985 NUMBER GROUPS	1985 NUMBER PARTICIPANTS	1986* NUMBER GROUPS	1986* NUMBER PARTICIPANTS	TOTAL NUMBER GROUPS	TOTAL NUMBER PARTICIPANTS
GUASMO	50	2,500	50	2,500	50	2,500	50	2,500	50	2,500	250	12,500
ESMERALDAS	-	-	50	2,500	50	2,500	50	2,500	50	2,500	200	10,000
TULCAN	-	-	-	-	50	2,500	50	2,500	50	2,500	150	7,500
TOTALS	50	2,500	100	5,000	150	7,500	150	7,500	150	7,500	600	30,000

NEW ACCEPTORS TARGETS

CLINIC	1982	1983	1984	1985	1986*	TOTAL
GUASMO	1,650	1,980	2,376	2,851	3,421	12,278
ESMERALDAS	-	1,000	1,200	1,440	1,728	[illegible]
TULCAN	-	-	600	720	864	2,184
TOTALS	1,650	2,980	4,176	5,011	6,013	19,830

CONTINUING ACCEPTOR TARGETS

CLINIC	1982	1983	1984	1985	1986*	TOTAL
GUASMO	-	825	1,403	1,890	2,371	6,489
ESMERALDAS	-	-	500	851	1,148	2,499
TULCAN	-	-	-	300	512	812
TOTALS	-	825	1,903	3,041	4,031	9,800

*In order to allow comparisons from one year to another, the targets for the full calendar year are shown above. For 1986, however, only 9 months of these clinics' costs will be funded through this project. Three months are scheduled to establish each clinic. Therefore, targets are set for the calendar year.

IV. PLAN OF ACTION

In order to ensure sufficient time to establish well-functioning clinics, CEMOPLAF will open one clinic per year for the first three years of the project. It will take about three months to select and train the staff, and remodel and equip each of the clinics. Thus it is anticipated that the clinics will open about the first of the calendar year. Details of the background and plans for each center are listed below.

A. Guasmo

1. History: In September, 1980, CEMOPLAF sponsored a four-day training seminar on Group Dynamics and Family Planning for 30 leaders of housing and banana pre-cooperatives from the Guasmo slum area of Guayaquil. At the conclusion of this seminar, the participants recommended the creation of a family planning center in Guasmo, and promised their collaboration in planning the center. CEMOPLAF has two volunteers working in the Guasmo area presently, one a medical doctor, the other a sixth-year medical student living in the area. Since September, the doctor has offered talks on family planning, while the student provided contraceptives to 218 women and 129 men in the September, 1980 to February 15, 1981 period.

2. Plan for Project Period: During the first three months of the project, CEMOPLAF will select and train project staff, locate, adapt and equip a clinic, and will initiate family planning information and services during the fourth month. During this process, CEMOPLAF will work closely with both the "pre-cooperatives" (organizations not yet officially recognized as cooperatives) of the area and with APROFE which concurrently will develop a Planned Parenthood/Women's Development project in Guasmo. The clinic will be open 8 hours a day, utilizing a staff of two half-time doctors, an auxiliary nurse and a secretary. CEMOPLAF plans to reach 12,278 new and 6,489 continuing family planning acceptors in the five-year project period, with approximately 55 percent using IUDs, 30 percent using orals, and the remainder employing other methods. Gynecological and prenatal services will be offered to about 35 people per month as well. A full-time social worker will identify community groups and coordinate two-to-three hour meetings on family planning with 50 community groups per year (attended by 2,500 people in total). She will also do house-to-house visiting and follow up drop-outs from the program. During the first two years, she will concentrate on the Guasmo Sur area; during 1984 and 1985, she will work in the Guasmo Central area, and during 1986, she will work in Guasmo Norte. During the first year of the project, CEMOPLAF will request additional funding from Development Associates in order to provide further training to community leaders from the various sections of Guasmo. Development Associates has indicated an interest in supporting this activity. Charges for clinic services will be according to CEMOPLAF's usual schedule (see Attachment No.1).

B. Esmeraldas

1. History: Esmeraldas has one public health sub-center and two hospitals, all of which give very low priority to family planning services. No private family planning services exist at present, although APROFE is planning to extend its CBD program into the rural areas of Esmeraldas during the project period. CEMOPLAF has a staff member from Esmeraldas who will assist in establishing the Esmeraldas clinic.

2. Plan for Project Period: During the first year of the project, CEMOPLAF will identify existing community resources in Esmeraldas, select staff and a clinic site. In addition, funds will be requested from Development Associates to conduct a training seminar for about thirty community leaders who will then act as facilitators toward the development of a family planning clinic. Development Associates has expressed a willingness to support such a seminar. The clinic will be established during the latter part of 1982, and will begin functioning in early 1983.

Initially the clinic will be open 4 hours a day, 5 days a week, staffed by a half-time doctor and a nurse's aide. In the second year, when service demand is expected to increase to a level requiring a full-time clinic, a half-time midwife and a secretary/treasurer will be added. In the four years this clinic will function within the project, it will provide family planning services to 5,368 new and 2,499 continuing acceptors. A full-time social worker will conduct information and education sessions with 50 groups per year of approximately 50 people each. During her first two years, she will concentrate on working with urban parents groups, the police, neighborhood groups and other local institutions. During the last year, she will also work with rural groups. The social woerker will also motivate 100 groups of 15 people each within the clinic. Charges in Esmeraldas will also follow the CEMOPLAF fee schedule (See Attachment No. 1.)

C. Tulcán

1. History: Tulcán has a government health center and one public hospital, neither of which emphasizes family planning services. Tulcán is the capital of Carchi Province which has 17 government health subcenters and 4 rural health posts, none of which offers much family planning. No private family planning services exist in the Tulcán area. CEMOPLAF's vice-president has worked many years in Tulcán, and she will assist in establishing the clinic.

2. Plan for Project Period: During 1983, CEMOPLAF will identify existing resources in Tulcán, select and train staff, choose a clinic site, and remodel the facilities as necessary. During that same year, funds will be requested from Development Associates to conduct a training seminar for about thrity community leaders who will then assist in establishing a fam-

ily planning clinic during 1983-84. Development Associates notes its interest in assisting this effort. Clinic staff will include a half-time doctor, a nurse's aide, a half-time midwife and a secretary/treasurer (the latter two to be hired in the clinic's second year, when clinic movement is anticipated to be heavy enough to require full-time services). They will provide family planning services to 2,184 new and 812 continuing acceptors during the three years the clinic will function under this proejct (1984-86). A full-time social worker will work with community groups, concentrating on urban parents groups, the police, neighborhood groups, and other local institutions. She will aim at reaching 50 groups of 50 people each per year. She will also work with 100 groups yearly within the clinic, reaching about 1,500 people annually.

D. Other Comments.

CEMOPLAF will offer an estimated 47,593 couple-years of protection through its new clinic acceptors.*

The net cost to this project per new acceptor is estimated to be US$38.50. This estimate is based on the assumption that during the life of this project acceptors will bear about 14 percent of the total project costs.

When analyzing the cost per acceptor, one should bear in mind that CEMOPLAF is initiating three new clinics, involving considerable start-up costs, and that physicians will provide most of the services at the beginning of the project. Only after a clinic is well established in the community will a midwife offer services as well.

V. TRAINING AND EVALUATION

In accordance with current CEMOPLAF policy, six month and annual evaluation meetings will be conducted jointly by the clinic staff and the CEMOPLAF headquarters staff and volunteers. Evaluation will be based on attainment of objectives and analysis of the individual and group participation of project personnel. These sessions will also be used to train staff in CEMOPLAF procedures. Formal review sessions will be scheduled every six months with the WHR Project Coordinator and the CEMOPLAF staff, to review levels of achievement and to identify problems and solutions so that the objectives can be met.

VI. MANAGEMENT CAPACITY

This project will be the responsibility of CEMOPLAF's President Dr. Ligia Salvador, a physician, in collaboration with the Staff Coordinator, Lc. Teresa Alvarez de Vargas, a social worker and lawyer. Because both individuals work extensively with other projects, it will be necessary for CEMOPLAF to hire additional management staff, as follows: (a) a full-time Administrative Aide who will oversee the day-to-day functioning of this project; and (b) an Accountant (1/4 time) to set up and carry out proper accounting procedures in accordance with project requirements.

Curricula vitae of staff members are available upon request.

CEMOPLAF has acquired a good reputation in the donor community for being a well-managed institution which complies with all reporting requirements. FPIA, which has been CEMOPLAF's major donor to date, notes that CEMOPLAF consistently meets or surpasses most targets set for its ongoing activities.

VII. BUDGET

Funding under this project will support operational costs for all three clinics, including personnel (compensation and training), equipment and supplies, and evaluation expenses. Rent, adaptation and renovation, and other direct clinic costs are also included.

and other direct clinic costs are also included.

Administrative costs for the project include two new staff members, supervision, travel and per diem related to supervision, and other costs incurred by the Quito headquarters of CEMOPLAF (rent, utilities, etc.). CEMOPLAF projects and has budgeted an income from these three clinics of US$148,767. This income will be applied toward customs fees and some staff salaries. Clinic equipment and supplies are requested through this grant, as are contraceptives.

ATTACHMENT # 1

CEMOPLAF

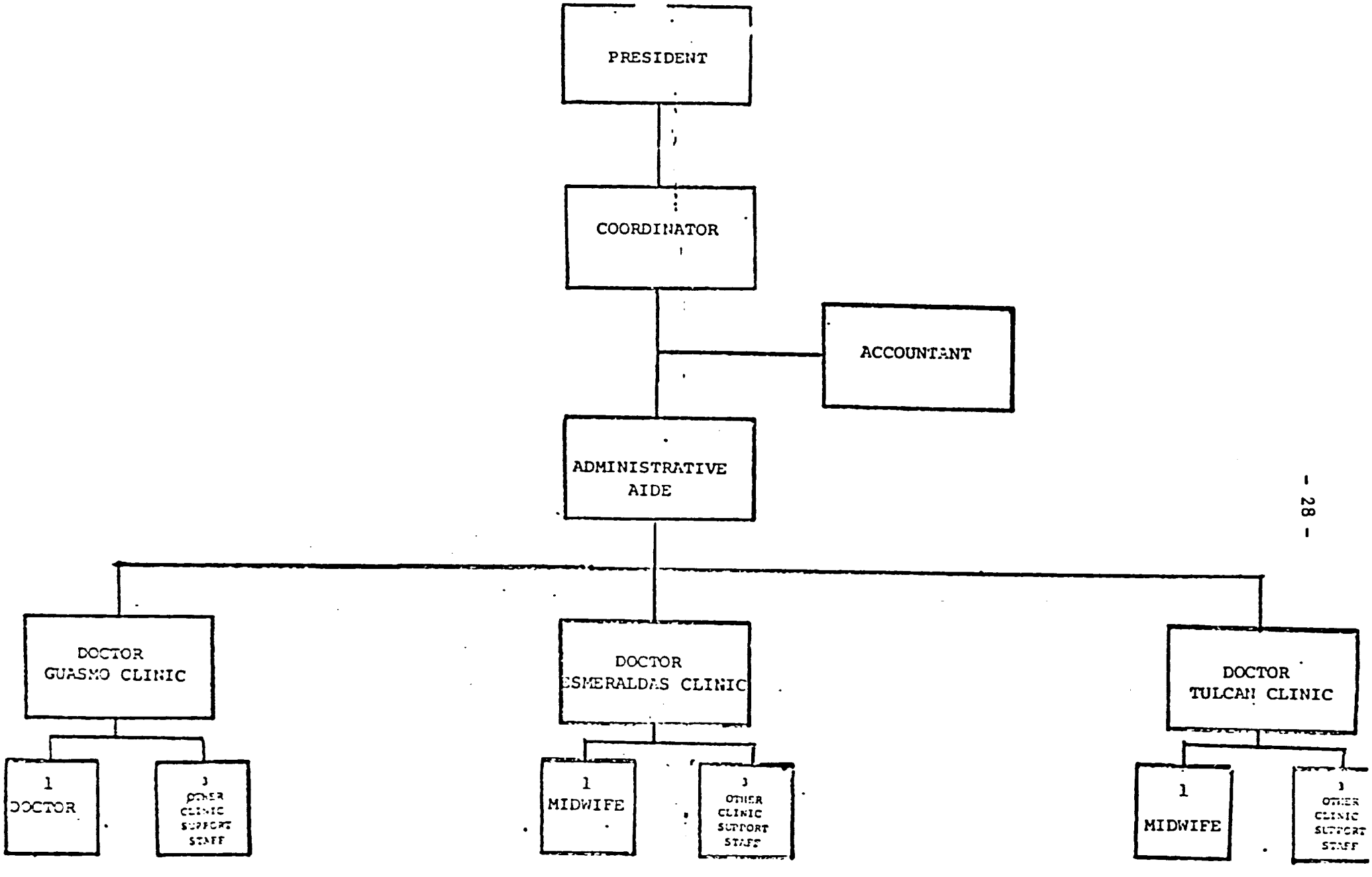
LIST OF PRICES FOR CLINIC ACCEPTORS

Registration for New Acceptors	S/ 50
IUD Removal	S/ 50
IUD Control	S/ 30
Cycle of Oral Contraceptives	S/ 15 per cycle
Condoms	S/ 1 per unit
Control: Jelly, cream, vaginal tablet	S/ 20
Diaphragm	S/ 50
Medical Consultation for Family Planning	S/ 50
Other Consultations - Pregnancy Check-up	S/ 50
Curative Medicine	S/ 20

CEMOPLAF

CALENDAR OF MAJOR PROJECT ACTIVITIES

Project Years	I (3 Months)	II	III	IV	V	VI (9 Months)
Calendar Years	1981	1982	1983	1984	1985	1986
ACTIVITY						
Recruit, Hire & Train Administrative Staff						
Establish Guasmo Clinic						
Guasmo Clinic (I&E Services)						
Establish Esmeraldas Clinic		Oct.				
Esmeraldas Clinic (I&E Services)						
Establish Tulcan Clinic			Oct.			
Tulcan Clinic (I&E & Services)						



CEMOPLAF'S ORGANIZATION CHART FOR THIS PROJECT

CEPAR (CENTRO DE PROMOCION DE PATERNIDAD RESPONSABLE)

I. BACKGROUND

CEPAR (The Center for the Promotion of Responsible Parenthood) was founded as a non-profit institution in 1978 by a group of professionals working in health, sex education, family planning and population. Its major purposes are to promote information, policy, and research activities to raise family planning and population awareness in Ecuador, especially among leaders and decision-makers at all levels of Ecuadorean society.

In the three years since its founding, CEPAR has carried out several projects, including training of pharmacy owners and employees, publications, and exploration of program alternatives.

A. Training of Pharmacy Owners and Employees

In 1979-80, with a US$39,426 grant from the Pathfinder Fund, CEPAR conducted 22 eight-hour courses for about 500 drugstore owners and employees from the provinces of Pichincha and Azuay, in coordination with the Ecuadorean Association of Pharmacy Owners. The courses focused on human reproduction and contraceptive methods. The project was renewed in late 1980 for an additional year at US$34,893 to enable CEPAR to offer 13 more training courses to 332 pharmacists and employees from 166 pharmacies in eight inter-Andean provinces, ranging from Carchi (the northern-most province) to Loja (the southern-most province). As a result of these courses, pharmacists and drugstore employees are better able to manage the promotion and sales of contraceptives in their stores.

Contraceptive sales have increased in most of the pharmacies since employees have been trained.

B. Publications

With USAID funding, CEPAR has published two documents:

- Manual de Consulta: Manejo de Anticonceptivos para Propietarios y Dependientes de Boticas, Farmacias y Droguerías, a 55 - page manual on management of contraceptives for owners and employees of drugstores, which includes chapters on responsible parenthood, family planning, the various methods of contraception (including indications and contraindications thereof), and bibliographical listings.

- Encuesta a Los Médicos Privados de la Sierra Ecuatoriana Sobre Opiniones y Actitudes acerca del Crecimiento Poblacional y la Planificación Familiar, a 50 - page sample survey of private physicians from the Ecuadorean sierra which summarizes their opinions and attitudes toward population growth and family planning. The survey indicated that 92.4

percent of the physicians interviewed believe that they and their colleagues should be involved in fertility regulation programs. A large majority of them are willing to be trained and to participate in private family planning programs.

C. Development Grant

In late 1980, USAID provided a US$5,000 grant to CEPAR to "determine possible areas of action for development of a research, information awareness and training project in population". With this grant, CEPAR hired several part-time staff members who have prepared the following project proposal.

CEPAR has thirty members who elect a General Assembly which meets annually. The General Assembly elects CEPAR's Board of Directors, which meets monthly and takes charge of day-to-day decisions. To date, its funding has come from USAID, the Pathfinder Fund, and members' donations.

II. PROJECT JUSTIFICATION

CEPAR plans to develop a wide-ranging information and education program directed at making public opinion and national policy-makers aware of the following:

A. The demographic situation of Ecuador and its effect on both the country's socio-economic development and the welfare of the Ecuadorean family;

B. At the 1974 World Population Conference in Bucharest, Ecuador promised to establish a population policy for the country. Since that time, no population policy has been enunciated;

C. The Government's family planning programs establish very low targets in relation to the country's unmet needs for family planning, and do not include systematic activities to inform and motivate the populace on family planning;

D. The mass media do not offer the kind of support on population and family planning issues which is necessary to create an informed public opinion, as demonstrated by the following: (1) the national press and other media offer little information on population problems and their repercussions on socio-economic development; (2) what information is published generally concerns population issues as they relate to the world or to other countries, and rarely takes note of the Ecuadorean reality; and (3) information and education programs related to family planning are minimal. They are generally found locally rather than nationally, and include training small numbers of leaders and interested groups. No large-scale campaign

has been possible to date, primarily because of funding limitations.

By strengthening the knowledge and understanding of the relationship between socio-economic development and population, CEPAR hopes to enable Ecuador's political, scientific, technical and other leaders to establish policies and programs which take into account population factors and the need for family planning information, education and services. CEPAR plans to achieve this by acting in three areas: information, training, and research.

CEPAR emphasizes that it does not propose, sustain or defend any particular popualtion policy. The project is based on presenting realities which will create an atmosphere conducive to establishing whatever population policies are most appropriate for Ecuador.

III. OBJECTIVES

A. General Objectives

1. To enable Ecuador's opinion leaders and policy-makers to become sensitized to population issues and their socio-economic and psychosocial impact on the Ecuadorean family, thereby creating a favorable atmosphere which will stimulate the development of population and family welfare policies.

2. To assist the Ecuadorean family to make conscious and responsible decisions about family size.

B. Specific Objectives

Each area of activity has specific objectives as noted below:

1. Information: (a) organizing a documentation center on population and family planning; (b) identifying policy-makers and other leaders who will make up the project's chief audience; (c) conducting an inventory of the mass media; (d) developing information resources, including press and magazine articles and other printed materials; (e) disseminating information to political and other leaders on world and national population problems and projections, and motivating the general public about family planning.

2. Training: The objective is to organize a training center, with 8-10 professionals as instructors, to carry out 6 roundtable discussions, 11 seminars, 4 short courses, and a panel discussion.

3. Research: With the general objective of utilizing research conducted by CEPAR and others as a base for reinforcing the knowledge of

opinion leaders and policy-makers on population and family planning, the research arm of CEPAR plans to carry out 7 research studies (four of these studies will be related to population problems and three to family planning) and to make concrete recommendations to those responsible for setting population and health policies.

IV. PLAN OF ACTION

CEPAR's objectives in information, training and research are intimately linked throughout the five years of the project. For example, people attending the roundtable discussion of the training activity will receive regular follow up through the letters, publications and personal contacts developed as part of the information activity. The results of the research program will be utilized in roundtable discussions, press, publications and other activities of both the information and training areas. A more complete description of each area of action follows.

A. Information

CEPAR will organize a Documentation Center, conduct inventories of leaders and the media, develop information resources and the means to disseminate them. A half-time Information Director, assisted by an office clerk and a messenger, will oversee all these activities. The specific actions planned are listed below.

1. A Documentation Center will be developed in CEPAR's headquarters in Quito in order to provide a source of information on population and family planning throughout the world, Latin America and Ecuador. The Center will offer its resources free of charge to opinion leaders, policy-makers, professionals, students, the media, and the general public. During the first year, and for each year thereafter, the Center will collect at least 150 documents on a regular basis, including books, pamphlets, reports, bulletins, studies, translations, commentaries, etc. These documents will come from world research and information centers, government and private agencies, libraries, etc. The center's full-time Librarian/Documentalist will be in charge of organizing and maintaining the Center's services, including cataloguing and filing systems, and circulation of the materials collected. The Librarian/Documentalist and the Information Director will promote the use of the Documentation Center's services by leaders, professionals, the media, students and the general public.

2. CEPAR will contract the services of a social worker and a journalist for three months during the first year of the project to identify national and local policy-makers and other leaders who will form the chief audience of the information campaign and the mass media which will constitute a major vehicle of the campaign. They will identify:

(a) 24 government officials from the Ministry of Health,

Ministry of Education, Ministry of Agriculture and Livestock, Ministry of Natural Resources, National Housing Institute, Ecuadorian Institute of Sanitary Works, and CONADE (the National Development Council.);

(b) 30 national political leaders from the legally-recognized political parties, such as the Izquierda Democrática, Frente Radical Alfarista, Demócrata Socialcristiano, Liberal, Democracia Popular, Concentración de Fuerzas Populares, Conservador, Comunista, and Movimiento Popular Democrático;

(c) 30 leaders from the Ecuadorean Confederation of Workers, the Confederation of Free Workers, the Confederation of Catholic Workers, the National Association of Public Servants, the National Union of Educators, the Production and Agricultural Chambers of Commerce, the Medical, Midwives, and Social Workers' Associations, and the National Union of Ecuadorean Women;

(d) Leaders of political groups in the National Congress;

(e) 60 provincial labor leaders, 3 per province;

(f) 5 newspapers with national circulation;

(g) 3 magazines with national circulation;

(h) 4 radio and television stations with regional coverage (2 on the coast and 2 reaching the sierra and eastern part of the country);

(i) 1 radio station with the largest listening audience per province.

After identifying the national, provincial and local leaders, CEPAR will select those leaders with whom the project will work, stratifying the list so that specific information and training activities will serve each leadership group. A kardex file will be established for each leader identified.

Once the mass media resources are identified, personal and written contact will be made with key people in the media to request their collaboration with the project. Specific media will be designated for continuing contacts. A kardex file will be maintained with information from the media inventory.

3. Specific information resources will then be developed, with content to be determined during the fifth month of activity according to the audience selected. In the sixth month of the project, systematic production of materials will begin, continuing throughout the remainder of

the project according to the changing needs of the audience. Among the types of information resources to be developed by journalists working on contract to CEPAR and by the Information Director are the following:

- One press article per month on population issues;

- A quarterly pamphlet on population problems and their implications for life in Ecuador, directed toward selected national and local leaders;

- A bi-weekly letter on population issues for national leaders, based primarily on summaries of reports, transcriptions, etc;

- A monthly letter to the editors of the leading newspapers, on population and family planning problems;

- Bi-monthly articles on family planning for publication in national magazines;

- Information sheets on press, radio and other coverage of CEPAR's roundtable discussions, for national and local leaders;

- Press articles and radio shows directed at leaders, to call attention to the findings and recommendations fo the research carried out by CEPAR and other agencies;

- 4 pamphlets annually for provincial leaders, with specific population and family planning information related to their geographical areas.

4. The Information Director (assisted by the office clerk and messenger) will disseminate the materials developed by systematically sending articles (selected or adapted from books and pamphlets, or prepared specially from CEPAR's own research) to national, provincial, and local leaders and by publishing articles on population and family planning in the press.

B. Training

The Training program will complement the Information program by providing more in-depth information on population and family planning for selected groups of leaders, and by allowing participants to discuss and debate ideas previously developed by the information program.

The Training Director will organize a training center by developing a core of 8-10 trainers who will be given a 6-day course during the first three months of the project. Subsequent training activities will include:

(a) Six roundtable discussions, each with 4-6 experts avail-

able to discuss the impact of Ecuador's population growth rate on socio-economic development, scheduled as follows:

- 1982: 2 rountable discussions, both in Quito: one for 40 leaders of the mass media and one for 40 national political, labor and professional leaders;

- 1983: 1 rountable discussion in Quito for 40 business leaders from such institutions as the Chambers of Commerce, Production, and Small Industry;

- 1984: 1 rountable discussion in Quito for 40 political leaders;

- 1986: 2 roundtable discussions, both in Quito: one for 40 government bureaucrats, and the other for 40 professional, political, labor and mass media leaders;

(b) Eleven one-day seminars which will include academic presentations and group work. The conclusions and recommendations of each seminar will be presented to the leaders of important sectors of society for their consideration. The seminars will be scheduled as follows:

- 1982: In Quito for 30 social workers;

- 1983: One seminar for 30 coastal area labor leaders, in Guayaquil; another for 30 labor leaders from the Northern and Central sierra, in Quito; and a third for 30 labor leaders from the Central and Southern sierra, in Cuenca;

- 1984: One seminar for 30 teachers in Quito, and another for 30 members of professional associations, including teachers, doctors, health workers, social workers, sociologists, etc;

- 1985: One seminar in Riobamba for 30 social workers from Chimborazo, Tungurahua and Cotopaxi provinces; another in Quito for 30 health workers (nurses, health educators, and others); and a third for 30 student leaders, in Quito;

- 1986: One seminar for 30 labor leaders fron the entire country, in Quito; and another for professionals.

(c) Four initial or remedial training courses for professionals who will collaborate with family planning programs. These 30-hour courses will be developed in coordination with APROFE and CEMOPLAF, and will be carried out as follows:

- 1982: a theoretical and practical training course in Quito for 30 doctors from Pichincha province, with practical training provided by CEMOPLAF in its Quito clinic;

- 1983: One course for 30 doctors, also from Pichincha;

- 1984: One course in Quito for 30 doctors from the provinces of Chimborazo, Cotopaxi and Imbabura; and a second workshop for 30 doctors from Quito;

(d) During 1985, CEPAR will sponsor a panel discussion for those political, labor and business leaders who have already participated in a CEPAR training program. This event will be aimed at reinforcing their interest and leadership in population and family planning issues.

All the training activities will be coordinated and supervised by the half-time Training Director, assisted by other CEPAR staff and volunteers, and by instructors who will be paid per session worked.

C. Research

The research program will provide specific documentation on population problems and issues in Ecuador. The data collected will be utilized in CEPAR's Information and Training programs, and given wide publicity throughout Ecuador, with emphasis on reaching leadership groups and the media. This is based on CEPAR's belief that there is a lack of realiable information in Ecuador on specific population problems, and, that in most cases (especially in the media), erroneous or incomplete information is present, usually without analysis. The lack of information among opinion deaders and policy-makers contributes to a lack of sensitivity about the demographic reality of tee country and, as a consequence, the continued lack of a national population policy.

To help combat these problems, seven types of research are planned, each to be reviewed periodically in terms of project and country needs.

1. A national survey will be conducted to determine the knowledge and attitudes of opinion leaders and policy makers on population and family planning matters. Scheduled to begin as soon as CEPAR receives funds, this study will be carried out in five of the major provincial capital cities (Quito, Guayaquil, Cuenca, Ambato and Portoviejo). Using a short questionnaire and direct interviews, the study will establish CEPAR's first official contact with leaders and decision-makers identified by CEPAR's Information division. It will also allow the institution to collect the maximum possible data to determine the existing atmosphere at high levels, and thus enable CEPAR to develop strategies for reaching these groups via information, training and further research.

2. A comparative study will be conducted on the socio-economic repercussions of the birth of a child on the life of Ecuadorian families in urban and marginal urban areas of Quito and Guayaquil. Pre-coded questionnaires and short interviews will be used.

3. Using anthropological techniques, a study will be carried out on the reproductive behavior of rural dwellers in four communities -- two on the coast (Guayas province) and two in the sierra (Tungurahua province). CEPAR hopes to identify in greater detail the criteria used in accepting contraceptives in these areas where high parity is the rule. Sociology or anthropology students from the geographical areas to be studied will be contracted to conduct this study.

4. A study will be conducted on "women, population and development", aimed at determining, according to socio-professional status, how and to what degree Ecuadorian women participate in the socio-economic development of the country, what determines adaptation to the mother-wife-worker role, and the criteria which determine the number of children these women have. A pre-coded questionnaire and recorded interviews will be applied to a sample of single and married women aged 18 to 30 in urban areas.

5. A compartive study will be made of human reproduction and contraceptive knowledge and practices in urban areas of Quito and Guayaquil, using a pre-coded questionnaire and a representative sample of the populations of those two cities. Based on the results, CEPAR will develop alternative family planning models which can be applied to programs for the least-favored populations.

6. A survey on the family and its ideal size in Ecuador will be carried out in three urban and rural zones. Comparative data based on socio-economic status will be collected and analyzed on family welfare and expectations about ideal family size;

7. A study will be conducted to determine the influence of economic and psycho-social factors on multiparous women and their families in rural zones of Quito and Chimborazo. The quantitative and qualitative impact on multiparity will be measured.

If additional financing can be obtained, CEPAR will also conduct research on:

- Empirical contraceptive practices in 3 rural zones of the Ecuadorian sierra;

- Knowledge and attitudes on sexuality and family planning;
- Religion and birth control in Ecuador;
- New generations and family planning in Ecuador;

- Ecuadorean institutions and family planning;
- The family in Ecuador; and
- A comparative study on infant mortality in Ecuador according to social status.

Implementation of the various research projects will include the following steps:

- Final selection of the study themes and research design;
- Selection of the geographical areas where the studies will be carried out and population to be studied;

- Selection and training of field personnel;
- Contact with community leaders in the areas selected;
- A pilot test and adjustment of the instruments;
- Development of a definitive research design;
- Application of the research design;
- Analysis of results;
- Publication of the study.

The entire research program will be overseen by the Research Director, with assistance from personnel contracted full-time for specific studies. These will include a project assistant specializing in statistics, 6 interviewers and 3 supervisors.

D. Administration

Unlike APROFE and CEMOPLAF which have had years to develop strong administrative structures, CEPAR has not yet had the financing to develop the administrative infrastructure necessary to oversee a project of this magnitude. Thus, it is essential that CEPAR's administrative capacity be strengthened so that it can play the role delineated in this project. Support is needed to employ qualified staff not only in the programmatic areas, but also in administration. To do this, CEPAR will employ the following administrative staff: a half-time executive director; a half-time financial administrator; 3 full-time secretaries who will work in a secretarial pool available to all CEPAR projects; and a full-time messenger-concierge. Also charge to administration are the rent, telephone, and utilities necessary for CEPAR to carry out the project. After establishing this administrative structure, CEPAR will have the capability of expanding into other program areas during the five-year project period.

V. Evaluation

Six-month and annual evaluation based on the achievement of objectives will be conducted by the CEPAR staff, and adjunstments will be made in

program design accordingly. During years three and five, a special evaluation study will be done, surveying the target population to determine the impact the project has had in terms of their knowledge, attitudes and actions regarding population nad family planning. Interviewers will be contracted to conduct the evaluation study which will be supervised jointly by the Information and Research Directors.

Formal review sessions will be scheduled every six months between the WHR Project Coordinator and the CEPAR staff in order to review the levels of achievement and identify problems and solutions so that objectives can be met.

VI. Management Capacity

This project will be the responsibility of CEPAR's Executive Director, Dr. Betty Proaño, a physician and director of a Ministry of Health Center in Quito. She has been the prime of CEPAR's activities to date. Dr. Proaño will be assisted by the following staff: (1) As Financial Administrator, Mr. Armando Reinoso an accountant employed by the Ministry of Finance; (2) As Information Director, Dr. Roberto Díaz, a psychologist and former Vice Minister of Education; (3) As Research Director, Lic. Francisco Aguirre, a sociologist/demographer working with the National Institute of Statistics and Census (INEC). The Training Director is still to be named. Curricula vitae of this staff are available upon request.

The Pathfinder Fund and USAID, which have funded previous CEPAR activities, note their satisfaction with CEPAR's management of its program and funds. However, because of the enormous expansion of CEPAR's activities which this project represents, CEPAR will need technical assistance to ensure that the administrative structure envisioned functions well, and that all terms and conditions of the project are met. All of CEPAR's top-level personnel will work on a half-time basis, primarily because of funding limitations. If CEPAR receives additional funds for projects beyond this one, CEPAR will probably have to hire full-time administrative staff.

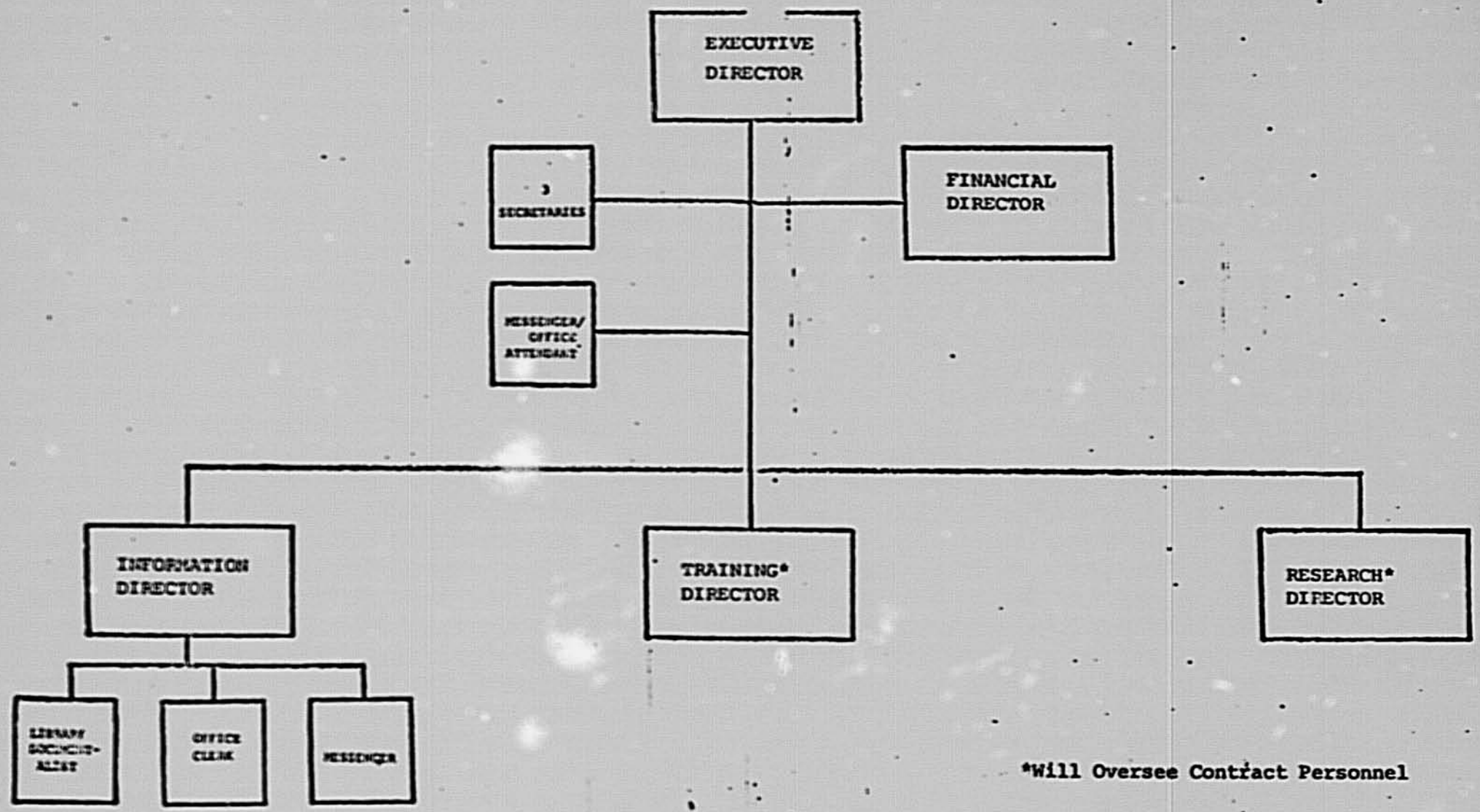
VII. Budget

Funding for this project will support personnel, equipment and supplies, operating costs of the various project activities, and the establishment of the basic administrative infrastructure necessary to oversee all of CEPAR's functions. Administrative costs will be about 40% of the total, somewhat higher than the norm, but a necessary expenditure to develop an administrative structure from scratch. Some administrative costs (for example the three secretaries forming the secretarial pool and the messenger/concierge, rent. telephone, utilities and mail) will be used by all project activities, but have been placed in the administrative category for ease of control.

CEPAR

CALENDAR OF MAJOR PROJECT ACTIVITIES

Project Years	I (3 Months)	II	III	IV	V	VI (9 Months)
Calendar Years	1981	1982	1983	1984	1985	1986
ACTIVITY						
Establish Office	Oct.					
Information						
- Establish Documentation Center	Nov.					
- Documentation Center Services for Public		Feb.				
- Inventory - Public Leaders & the Media	Nov.					
- Develop Information Resources		Feb.				
- Disseminate Information Resources		Mar.				
Training						
- Train Trainers						
- Roundtables		Dec.				
- Seminars						
- Training Courses						
- Panel Discussion						
Research						
- Two Studies						
- One Study Per Year						



*Will Oversee Contract Personnel

CEPAR'S ORGANIZATION CHART FOR THIS PROJECT

INSTITUTIONAL FRAMEWORK AND PROJECT IMPLEMENTATION MECHANISMS

The Grantee will be the IPPF/Western Hemisphere Region, Incorporated (WHR). The WHR, represented by the Chairman of its Board of Directors and by its Regional Director, will formally accept and execute the grant.

This project will be implemented by the WHR, in collaboration with the three private Ecuadorian organizations which will be sub-grantees: APROFE, CEMOPLAF and CEPAR. The staff of the WHR will have operational responsibility for program execution, as delegated by the WHR Board of Directors. The Project Coordinator, based in Ecuador and under the supervision of the WHR, will monitor the development of the sub-grants and ensure efficient and effective project implementation by establishing appropriate managerial systems. The project's organizational chart is shown below.

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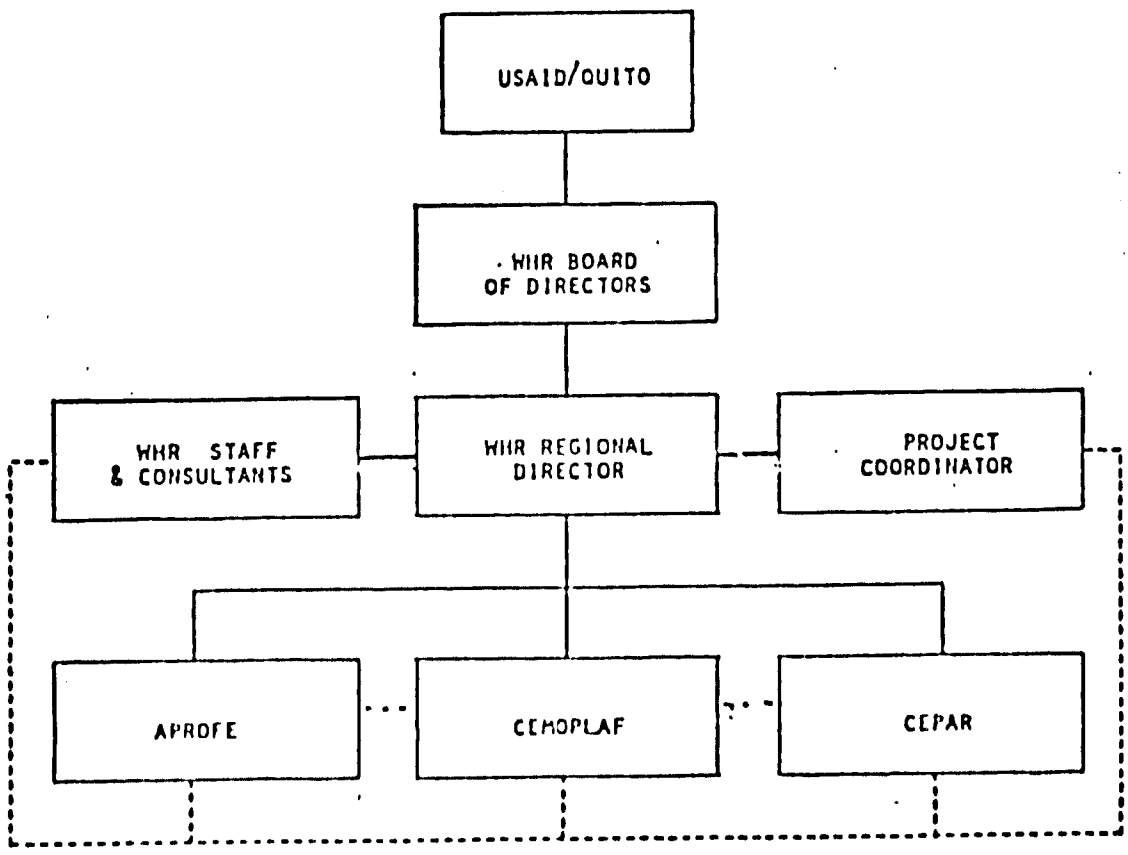

Solid Line = responsibility
Dotted Line = collaboration

I. STAFF RESPONSIBILITY

Staff reponsibility within each agency will be as follows.

A. WHR. The Regional Director, (assisted by the Director of Program Coordination, a Program Advisor, a Financial Analyst, the Deputy Financial Controller and the Commodities Coordinator) will administer and monitor the Ecuador project. Curricula vitae for these staff are attached (Attachment #4). As appropriate, other WHR staff will contribute to the project. Outside consultants hired by the WHR will provide technical assistance when necessary.

B. Coordination Office. WHR will maintain a small office in Quito to oversee the day-to-day functioning of this project. The office will have two staff members: a Project Coordinator, to be hired internationally as a WHR employee, and an Administrative Aide to be hired locally. The Project Coordinator will be responsible for establishing the Quito office. The Project Coordinator will be responsible for program coordination of the three sub-grants, and will generally oversee project functioning, file periodic reports with the WHR, and make recommendations on the project and project budget. The Administrative Aide will report to the Project Coordinator, and will do secretarial and bookkeeping work. Job descriptions of these two staff members are attached (Attachment #5).

C. Sub-Grantees. The Directors of APROFE, CEPAR and CEMOPLAF will be responsible for the implementation of each sub-grant, and will report to the WHR on project implementation.

II. GRANT AGREEMENTS

The WHR will sign grant agreements with the sub-grantees (APROFE, CEMOPLAF and CEPAR). These will be renewed yearly, depending upon an annual review of compliance with the prior year's grant agreement, and taking into account significant changes in the national environment. The following documents related to the sub-grantees are attached:

1. "Standard Provisions for Sub-Grantees" (Attachment #1);
2. The "General Subgrant Terms of Reference (GSTR) Letter of Intent", including reporting forms (Attachment #2);
3. "Annual Sub-Grant Agreement (ASA), including reporting forms, Accounting Procedures and Sample Payment Voucher (Attachment #3).

III. COMMUNICATIONS, REPORTING AND AUDIT

A. Communications. While informal contacts between USAID/Quito and the Project Coordinator and sub-grantees will be welcome, all

official communications about the progress of this project should be addressed to the grantee, WHR.

B. Reporting. WHR will submit reports to USAID/Quito as follows:

1. Financial reports will be submitted quarterly within 45 days after the completion of the quarter. Financial reporting will include: fiscal data such as amount authorized; disbursement progress; accrued expenditures to date; percentage of grant disbursement; disbursements during the quarter; and problems in disbursement. Reports will be submitted in U.S. dollars at the actual rate of exchange for the period reported, using FIFO allocation. Reporting formats will conform to the approved budget.

2. Project status reports will be submitted half-yearly and yearly, within 45 days after the completion of the six-month period, and will include the following:

a. Major activities undertaken during the past six months, by budget category;

b. Comments on implementation, including assessment of progress toward achievement of objectives, personnel changes, consultants utilized, progress of sub-grantees, etc.

c. Problems and delays in implementation;

d. Major activities expected in the next six months.

C. Audit. WHR will hire international auditors to carry out an audit at the end of each calendar year and at the end of the project. Audit reports will be submitted to USAID/Quito within five months after the close of the calendar year in question. The audit will include all sub-projects and all administrative costs, including those of the Project Coordination office. Audit guidelines will be those of the WHR.

IV. COMMODITIES

Procurement of goods and services shall be made in Ecuador in accordance with the USAID Standard Provision for U.S. Grantees and U.S. Subgrantee, Annex B #15C and D, which states the following:

"... equipment, materials and supplies... shall be purchased in and shipped from only Special Free World countries (AID Geographic Code 935-941)..."

Further, "the procurement of locally available goods or services, as opposed to procurement of U.S. goods and services, /_ is allowed if it / would best promote the objectives of the Foreign Assistance Program under the Grant."

Based on the Grantee's experience, shipments of commodities into Ecuador entail numerous bureaucratic procedures which cause delays of up to one year before the goods are in the consignee's possession. This is due mainly to the consularization of shipping documents which is required for non-profit organizations in Ecuador. This consularization process is costly and usually offsets any savings in dollars and time that could be had if the goods were purchased in the U.S.

For the sub-projects to proceed on schedule, * local purchase of all administrative, surgical and audio visual equipment would be to the advantage of all concerned.

If goods were purchased in the United States, the only way to avoid long delays in initiating the sub-projects would be by utilizing the Grantor as the ultimate consignee of the merchandise.

The cost of local purchase of contraceptives is excessive in comparison to international purchase. Therefore, contraceptives will be purchased by the grantee in accordance with the procurement policies and procedures set forth in the IPPF/WHR Procurement Procedures.

V. TECHNICAL ASSISTANCE

Technical assistance will be provided by WHR staff and volunteers, by those of Family Planning Associations in the Region, and by outside experts hired as consultants by the WHR, who will be paid for travel and per diem expenses and honoraria.

VI. EVALUATION AND REVIEW

Evaluation and reviews will be conducted regularly throughout the life of the project, and will include self-evaluation, outside evaluation, and reviews conducted by the grantor, grantee, and sub-grantees.

A. Self-Evaluation

Ongoing evaluation will be conducted by the sub-grantees as denoted in the project descriptions.

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*Schedule of initiation of sub-projects in terms of commodities:

Coordinator's Office in Ecuador		- 1981
CEPAR subgrant		- 1981
C.E.M.O.P.L.A.F. subgrant	(Guasmo)	- 1981
" " "	(Esmeraldas)	- 1982
" " "	(Tulcán)	- 1983

B. Grantee-Sub-Grantee Review

Half-yearly review sessions will be conducted by the WHR Project Coordinator, WHR staff, and the staff of each sub-grantee in order to assess the levels of achievement, identify possible problems and design solutions so that project objectives can be met. Both process and impact of the sub-projects will be assessed.

C. Outside Evaluation

Prior to each joint review, (see Section D, below) WHR will hire an independent evaluator or evaluators to conduct an overall evaluation of each sub-project, based on a determination of the operations and effects of each, relative to the objectives each set out to reach. The evaluator's(s') report will provide a basis for discus sion at the joint review.

D. Grantor-Grantee-Sub-Grantee Review

Three joint reviews will be carried out: at 21 months, 43 months, and 62 months, with representatives of USAID, WHR and the three sub-grantees participating. Outside evaluators will assist as appropriate. Each review will last approximately two weeks. The review will look at both process and impact of the sub-projects, and include an assessment of program achievements and problems, the extent to which objectives are being met, and the financial aspects of project implementation. Any major programmatic change needed will be discussed at the review. The review will also determine the appropriateness of the next period's budget in view of the changing program and economic environment.

VIII. CALENDAR OF ACTIVITIES

Calendars of activities for each sub-project are included within the descriptions of those sub-projects. The work plan presented below outlines the activities to be undertaken to complement and coordinate the sub-projects.

CALENDAR OF MAJOR ACTIVITIES

Activity	Month of Implementation
Signing of Grant Agreement Between WHR and USAID/Quito	Month 1
Recruit, appoint and train Project Coordinator	Month 2

Establish Quito Office (rent and equip premises, arrange visa, recruit, appoint and train Administrative Assistant, etc.)	Month 3
Establish financial and accounting procedures	Month 3
Sign sub-grant contracts with APROFE, CEMOPLAF and CEPAR	Month 3
Establish coordinating mechanisms among WHR, Coordinating Office and sub-grantees	Month 3
Commence CEMOPLAF and CEPAR projects	Month 4
6-month Evaluation review: Project Coordinator with CEMOPLAF and CEPAR	Month 9
Commence APROFE project	Month 11
Yearly evaluation review: Project Coordinator with CEMOPLAF and CEPAR	Month 16
Independent Consultant(s) Evaluation	Month 19-20
6-month evaluation review: Project Coordinator with APROFE	Month 21
Joint review (WHR, USAID, APROFE, CEMOPLAF, CEPAR)	Month 21
Evaluation review: Project Coordinator, with APROFE, CEMOPLAF and CEPAR	Month 29
Evaluation review: Project Coordinator, with APROFE, CEMOPLAF and CEPAR	Month 35
Independent Consultant Evaluation	Month 41
Evaluation review: Project Coordinator with APROFE, CEMOPLAF and CEPAR	Month 43
Joint review (WHR, USAID, APROFE, CEMOPLAF and CEPAR)	Month 43
Evaluation review: Project Coordinator with APROFE, CEMOPLAF and CEPAR	Month 49
Evaluation review: Project Coordinator with APROFE, CEMOPLAF and CEPAR	Month 55
Evaluation review: Project Coordinator with APROFE, CEMOPLAF and CEPAR	Month 61

Independent Consultant Evaluation	Month 61
Evaluation review: Project Coordinator with APROFE, CEMOPLAF and CEPAR	Month 62
Final Joint review: (WHR, USAID, APROFE, CEMOPLAF and CEPAR)	Month 62
Project implementation and monitoring	Ongoing throughout project period
Financial reporting	Quarterly throughout project period
Program implementation reporting	Half-yearly throughout project period

IV. BUDGET

Funds from this grant will be used to finance the items listed in the attached budget subject to adjustments of up to 15% among the individual budget categories. Any adjustment among the categories which exceeds fifteen percent (15%) must be approved in advance by the USAID Grant Officer.

The budget year will be equivalent to a calendar year. Any project under this grant which beings in mid-year will have its budget pro-rated on a calendar-year basis.

WHR will establish accounts for all project expenditures within its ledgers, and will segregate project-related expenses at reporting time. A clear audit trail will be provided from original documentation through accounting books to reports. Each sub-grantee will also segregate sub-project grants and expenditures within institution's books of record.

WHR will make monthly payments to the sub-grantees, which will be given sufficient funds so that two months' project expenditures will be available at any given time. The sub-grantees will submit monthly project expenditure reports to the Project Coordinator who will review them and submit his/her recommendations to the WHR. The WHR, in turn, will review the reports and recommendations, revise them as necessary, and process disbursements directly to the sub-grantees.

X. FOLLOW-UP

During the third joint review, the agencies involved will determine what follow-up actions need to be taken.

NOTES ON THE BUDGET

A. Difference between PID and Budget Submitted

In attempting to incorporate the guidelines set forth in the Project Information Document (PID), the WHR and its proposed sub-grantees faced the following difficulties:

1. The overall budget figures shown in the PID's Financial Plan are significantly lower than the programs' actual financial requirements. Consequently, additional funds are requested from AID to accomplish the programmatic objectives described in the PID.

2. In accordance with the instructions of the USAID/Ecuador Mission Director, the WHR has used the official exchange rate of 25 sucres to 1 US dollar when translating local currency costs. The dollar cost of the project is therefore greater than would be the case if projected rates of 27 to 28 sucres per dollar had been employed in the budget calculation.

3. The PID provided for an annual inflation/contingency rate of 7.5%. This rate appears unrealistic given Ecuador's average inflation rate of 11.62% over the past five years 1/ Consequently, the proposed sub-grant and Quito management budgets allow for an annual cost of living increase of 12%, based on the experience of the past five years and taking into consideration future inflation estimates 2/. Expenses (such as WHR Direct Costs, Evaluation, Technical Assistance and Commodities) which are to be incurred in dollars have been adjusted by a 10% annual inflation factor.

4. Contingencies, which include unanticipated or under-budgeted expenditure items, have been calculated at 10% per year. This factor is essential since expenses over a five-year period cannot be foreseen with great precision.

5. WHR project management costs were not included in the original PID. Project management costs (both in Quito, Ecuador and WHR's New York office) have been included in the attached budget, and are about 25% of the total project cost.

1/ Data source was the International Monetary Fund's "International Financial Statistics", April 1981.

2/ "Business Latin America" (January 7, 1981 issue) estimates that "Inflation /is/ not likely to drop below 15%, /but/ may be higher if government overspends."

6. Please note that the project budget is calculated on a calendar year basis so that it coincides with WHR's and sub-grantees' record keeping and fiscal procedures.

B. WHR Direct Costs

WHR Direct Costs include the following:

1. Portions of salaries and fringe benefits for the following WHR staff: *

a. Program Coordination. The Director of Program Coordination will give 10% of his time in the first two years of the project, and 5% thereafter. The Program Advisor and Secretary will provide 25% of their time in 1981 and 1982, 15% in 1983, 1984, and 1985, and 20% in 1986. From the Regional Office, with travel to Ecuador as necessary, they will act as coordinators of the project, training the Project Coordinator, monitoring the project and sub-project activities in terms of program management and implementation, reviewing reports from the Quito office and sub-grantees, making recommendations to the Regional Director, preparing reports for USAID, providing technical assistance to the Project Coordinator and sub-grantees on program matters, hiring and overseeing consultants' work, coordinating project needs, and participating in the evaluation and review process.

b. Financial Analysis/Assistance and Accounting Services

(i) The Financial Analyst and Grants Accountant (15% of their time in 1981, 1982 and 1986, and 10% in 1984 and 1985), will oversee the financial aspects of the project from the WHR office, with field visits by the Financial Analyst. The Financial Analyst will set up accounting procedures for sub-grantees, advise on record-keeping procedures for the Quito office and sub-grantees, assure adequate financial controls in the management of the grant and sub-grants, provide technical assistance on administration and personnel matters, including management information systems, review monthly expenditure reports of the sub-grantees, and make recommendations to the Deputy Financial Controller for reimbursement of project expenses. In all these tasks, the Financial Analyst will be assisted in the Regional Office by the Grants Accountant.

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* Salary and fringe benefits have been determined based on the number of days yearly to be devoted to this project, both in the WHR and in Ecuador.

(ii) The Deputy Financial Controller and Junior Accountant (5% of their time throughout the project) will make all remittances related to the project, the Quito office and the sub-grantees. They will also do all the WHR bookkeeping related to the project, will participate in the annual project audit, and prepare financial statements both for this office and for reports to USAID.

c. Commodity Services. The Regional Supplies Coordinator and Assistant (10% of their time in 1981 and 1982, 5% of their time in the remaining project years) will supervise supplies management from the Regional Office in relation to the Quito office and sub-grantee, ensuring compliance with WHR supplies procedures. This includes: for local purchase, reviewing pro forma invoices and, when appropriate, authorizing purchase; for international purchases, ordering contraceptives and other supplies and overseeing their shipment; monitoring reports and making recommendations to the Regional Director regarding commodities. During trips to Ecuador, the Regional Supplies Coordinator will provide technical assistance to the Quito office and sub-grantees to ensure proper usage, distribution, and storage of commodities.

2. Consularization of Documents. This item includes consularization fees for letters of donation and pro forma invoices for all shipments, as required by the Ecuadorian Government for non-profit organizations.

3. Travel and Per Diem. Travel will be undertaken as necessary by the aforementioned WHR staff and other Regional staff, in order to monitor project implementation and procedures, provide technical assistance, and participate in evaluation and review sessions.

4. WHR Specialists in Technical Assistance (other than WHR staff listed above) are charged to the project based on the number of person days to be spent providing advice and technical assistance to the project in Ecuador and during 1981-1985. They include the Regional Director, Information and Education Associate, Medical Associate, Evaluation Associate, and their staffs.

5. Office Services. This is 10% of the WHR office operational costs, and includes rent, utilities, communications, audit fees, photocopying, insurance, etc. This ratio was reached by comparing this project's costs (less its management expenses) to the Regional Office budget (less office services). This is a very modest figure, and represents an estimated average of all years of the project budget.

When reporting on this and other WHR support costs, the WHR Accounting Office will apply the proportions noted above to the total actual WHR office service expenditures.

SUPPLIES

Centro de Promoción de Paternidad Responsable

CEPAR

Description	Purchase: Year End 1981 Total Price (US$)
Office Equipment	7110.00
Audio Visual Equipment	1340.00
Total:	$8,450.00 *

Project Coordinating Office: Quito

Description	Purchase: Year End 1981 Total Price (US$)
Vehicle	$10,000.00
Office Equipment	12,880.00
	$12,880.00 **

Annually indexed at 12%

* This amount is shown in the CEPAR Project Summary section of the budget.

** This amount is shown in the Project Coordinating Office budget, under Item 3, Operational Expenses.

CONTRACEPTIVES FOR CENDPLAF **

Clinic: Guasmo — **Year: 1981**

AMOUNT	DESCRIPTION	UNIT PRICE (US$)	TOTAL PRICE (US$)
6500 cycles	Noriday	.17	1100.00
1500 units	Lippes Loop	.12	180.00
60 gross	Condoms	4.50	270.00
300 cans	Enko Foam	1.50	450.00
1000 tubes	Neo Sampoon	1.20	1200.00
		Sub-Total:	$3,200.00

Clinic: Guasmo/Esmeraldas — **Year: 1982**

13,000 cycles	Noriday	.17	2,210.00
2,500 units	Lippes Loop	.12	300.00
160 gross	Condoms	4.50	720.00
700 cans	Enko Foam	1.50	1,050.00
2,200 tubes	Neo Sampoon	1.20	2,640.00
		Sub-Total:	$6,920.00 *
		Indexed Sub-Total:	$7,610.00

Clinic: Guasmo/Esmeraldas/Tulcán — **Year: 1983**

22,000 cycles	Noriday	.17	3740.00
3000 units	Lippes Loops	.12	360.00
280 gross	Condoms	4.50	1260.00
1000 cans	Enko Foam	1.50	1500.00
3500 tubes	Neo Sampoon	1.20	4200.00
		Sub-TOTAL:	$11,060.00 *
		Indexed Sub-Total:	$13,380.00

Clinic: Guasmo/Esmeraldas/Tulcán — **Year: 1984**

29,000 cycles	Noriday	.17	4930.00
3,300 units	Lippes Loops	.12	396.00
370 gross	Condoms	4.50	1665.00
1,200 cans	Enko Foam	1.50	1800.00
4,500 tubes	Neo Sampoon	1.20	5400.00
		Sub-TOTAL:	$14,191.00 *
		Indexed Sub-Total:	$18,900.00

Clinic: Guasmo/Esmeraldas/Tulcán — **Year: 1985**

25,000 cycles	Noriday	.17	4250.00
50 gross	Condoms	4.50	225.00
400 cans	Enko Foam	1.50	600.00
1,000 tubes	Neo Sampoon	1.20	1200.00
		Sub-TOTAL:	$6,275.00 *
		Indexed Sub-Total:	$9,200.00
		Indexed Total:	$52,290.00

(Annually indexed at 10%)

* Expressed in 1981 Dollars.

** The costs of these contraceptives are listed in the Commodities section of the Project Summary Budget sheet.

SUPPLIES

Centro Médico de Orientación y Plan Familiar

CEMOPLAF

Guasmo:	Purchase:	Year End 1981
	Description	Total Price (US$)
	Audio Visual Equipment	4950.00
	Office Equipment	1680.00
	Medical & Surgical Equipment	3340.00
	Sub-Total:	$9,970.00 **

Esmeraldas:	Purchase: Year End 1982
Audio Visual Equipment	5540.00
Office Equipment	1880.00
Medical & Surgical Equipment	3090.00
Sub-Total:	$10,510.00 **

Tulcán:	Purchase: Year End 1983
Audio Visual Equipment	6200.00
Office Equipment	2110.00
Medical & Surgical	3460.00
Sub-Total:	$11,770.00 **

Grand Total: $32,250.00

Annually indexed at 12%

** These amounts are shown on the budget page for each clinic, under Item 2, Operational Expenses.

TECHNICAL ASSISTANCE

(IN U.S. DOLLARS)

	1981 (3 MONTHS)	1982 (12 MONTHS)	1983 (12 MONTHS)	1984 (12 MONTHS)	1985 (12 MONTHS)	1986 (9 MONTHS)	TOTAL (60 MONTHS)
CONSULTANTS							
- Travel and Per Diem	3,610	6,590	7,250	5,650	5,450	-0-	28,550
Number of visits	(1)	(2)	(2)	(2)	(2)		(9)
Number of days	(12)	(24)	(24)	(16)	(10)		(86)
- Fees	4,800	7,480	8,230	4,790	4,980	-0-	30,280
CONSULTANT TOTALS	8,410	14,070	15,480	10,440	10,430	-0-	58,830

INDEPENDENT EVALUATION

CONSULTANTS							
- Travel and Per Diem	-0-	-0-	4,730	5,210	-0-	6,300	16,240
Number of visits			(2)	(2)		(2)	(6)
Number of days			(24)	(24)		(24)	(72)
- Fees	-0-	-0-	5,810	6,390	-0-	7,730	19,930
EVALUATION TOTALS	-0-	-0-	10,540	11,600	-0-	14,030	36,170

WESTERN HEMISPHERE REGIONAL HRD DIRECT COSTS

(IN U.S. DOLLARS)

	1981	1982	1983	1984	1985	1986	TOTAL
1. PROGRAM COORDINATION							
- Director of Program Coordination Program Advisor and Secretary	11,200	24,660	15,450	17,000	18,700	25,650	112,660
- Percent of salary and Fringe Benefits							
Director of Program Coord.	(10%)	(10%)	(5%)	(5%)	(5%)	(5%)	
Program Advisor & Secretary	(25%)	(25%)	(15%)	(15%)	(15%)	(20%)	
2. FINANCIAL ANALYSIS/ASSISTANCE & ACCOUNTING SERVICES							
- Financial Analyst and Grants Accountant	4,020 (15%)	8,800 (15%)	6,460 (10%)	7,110 (10%)	7,820 (10%)	8,600 (15%)	42,810
- Deputy Financial Controller and Junior Accountant (5%)	1,690	3,700	4,070	4,480	4,920	5,420	24,280
3. COMMODITY SERVICES							
Regional Supply Coordinator & Assistant	3,140 (10%)	6,900 (10%)	3,790 (5%)	4,170 (5%)	4,590 (5%)	5,050 (5%)	27,640
Consularization of Shipping Documents	1,000	1,100	1,210	-	-	-	3,310
4. TRAVEL AND PER DIEM	15,340	25,210	23,740	9,270	12,160	10,900	96,620
- Number of visits	(10)	(15)	(13)	(5)	(6)	(4)	(53)
- Number of days	(72)	(107)	(90)	(28)	(33)	(36)	(336)
- Number of travellers	(8)	(8)	(7)	(3)	(4)	(4)	
5. HRD SPECIALISTS IN TECHNICAL ASSISTANCE (other than those in items 1,2 &3) -($150/day indexed x 239 man days)	5,850 (39)	12,710 (79)	12,890 (71)	5,190 (26)	5,710 (26)	-0-	42,350
6. OFFICE SERVICES (including rent, utilities, communications, audit fees, photocopying, insurance, etc.)	17,900	39,300	43,200	47,500	52,200	57,500	257,600
HRD DIRECT COSTS TOTAL	60,140	122,380	130,810	94,720	106,100	113,120	607,270

PROJECT COORDINATING OFFICE - QUITO
(IN U.S. DOLLARS)

EXCHANGE RATE US$1 = 25 SUCRES

	1981 (6 MONTHS)	1982 (12 MONTHS)	1983 (12 MONTHS)	1984 (12 MONTHS)	1985 (12 MONTHS)	1986 (12 MONTHS)	TOTAL (66 MONTHS)
1. PERSONNEL							
- Project Coordinator (100%) ($2500 x 12)	15,000	33,000	36,300	39,930	43,930	48,320	216,480
- Administrative Aide (100%) ($520 x 12)	3,120	7,000	7,830	8,770	9,820	11,000	47,540
SUBTOTAL	18,120	40,000	44,130	48,700	53,750	59,320	264,020
- Social Benefits	4,720	10,450	12,140	13,440	14,870	16,460	72,080
- Personnel SUBTOTAL	22,840	50,450	56,270	62,140	68,620	75,780	336,100
2. TRAVEL & PER DIEM	2,580	5,510	6,170	6,910	7,740	8,670	37,580
3. OPERATIONAL EXPENSES							
- Rent ($250 x 12)	1,500	3,360	3,770	4,210	4,720	5,290	22,850
- Relocation	9,000	-	-	-	-	-	9,000
- Communications	1,500	3,360	3,760	4,220	4,720	5,290	22,850
- Office Supplies	500	1,120	1,260	1,400	1,570	1,770	7,620
- Insurance	130	280	320	350	390	440	1,910
- Utilities	230	500	560	630	710	800	3,430
- Audit Fees	2,000	2,240	2,510	2,810	3,150	3,530	16,240
- Bank Services	100	230	250	280	320	350	1,530
- Cleaning	830	1,850	2,080	2,320	2,600	2,920	12,600
- Hospitality	200	230	250	280	320	350	1,630
- Maintenance and Fuel	350	780	880	980	1,100	1,240	5,330
- Vehicle	10,000	-	-	-	-	-	10,000
- Office Equipment	2,880	-	-	-	-	-	2,880
SUBTOTAL	29,220	13,950	15,640	17,480	19,600	21,980	117,870
PROJECT COORDINATING OFFICE TOTAL	54,640	69,910	78,080	86,530	95,960	106,430	491,550

CENTRO DE PROMOCION DE PATERNIDAD RESPONSABLE (CEPAR)

ADMINISTRATION

(IN U.S. DOLLARS)

EXCHANGE RATE US$1 - 25 SUCRES

	1981 (3 MONTHS)	1982 (12 MONTHS)	1983 (12 MONTHS)	1984 (12 MONTHS)	1985 (12 MONTHS)	1986 (9 MONTHS)	TOTAL (51 MONTHS)
1. PERSONNEL EXPENSES							
- Executive Director (50%) ($720 x 12)	2,160	9,680	10,840	12,140	13,600	11,420	59,840
- Finance Administrator (100%) ($500 x 12)	1,500	6,720	7,530	8,430	9,440	7,930	41,550
- 3 Secretaries (100%) ($240 x 12 x 3)	2,160	9,680	10,840	12,140	13,600	11,420	59,840
- Messenger/Porter (100%) ($176 x 12)	530	2,370	2,650	2,970	3,330	2,790	14,640
	6,350	28,450	31,860	35,680	39,970	33,560	175,870
- Social Benefits	2,890	12,950	16,890	18,910	21,190	17,790	90,620
- Personnel SUBTOTAL	9,240	41,400	48,750	54,590	61,160	51,350	266,490
2. OPERATIONAL EXPENSES							
- Rent ($600 x 12)	1,800	8,070	9,030	10,120	11,330	9,520	49,870
- Communications	360	2,690	2,210	2,480	2,770	2,330	12,840
- Utilities	300	1,350	1,500	1,590	1,690	1,590	8,020
- Audit fees		1,700	1,900	2,140	2,400	2,700	10,840
- Furnishings	5,270	-0-	-0-	-0-	-0-	-0-	5,270
- Office Supplies	5,920	-0-	-0-	-0-	-0-	-0-	5,920
- Transport/Messenger	100	200	230	260	290	250	1,330
SUBTOTAL	13,750	14,000	14,870	16,690	18,680	16,390	94,390
ADMINISTRATION TOTAL	22,990	55,410	63,620	71,280	79,840	67,740	360,880

CENTRO DE PROMOCION DE PAZ Y DESARROLLO RESPONSABLE (CEPAR)

TRAINING PROGRAM

(IN US. DOLLARS)

EXCHANGE RATE US$1 = 25 SUCRES

	1981 (3 MONTHS)	1982 (12 MONTHS)	1983 (12 MONTHS)	1984 (12 MONTHS)	1985 (12 MONTHS)	1986 (9 MONTHS)	TOTAL (60 MONTHS)
1. PERSONNEL EXPENSES							
- Director (50%) ($600 x 12)	1,800	8,070	9,030	10,120	11,330	9,520	49,870
- Social Benefits	820	3,680	4,790	5,370	6,010	5,050	25,720
- Personnel SUBTOTAL	2,620	11,750	13,820	15,490	17,340	14,570	75,590
2. OPERATIONAL EXPENSES							
- Consultant fees	350	1,570	1,760	1,970	2,210	1,850	9,710
- Training Expenses (including travel, per diem, & facility rental)	160	7,010	14,720	3,370	6,270	-o-	31,530
- Educational Materials	100	450	500	560	630	530	2,770
SUBTOTAL	610	9,030	16,980	5,900	9,110	2,380	44,010
TRAINING TOTAL	3,230	20,780	30,800	21,390	26,450	16,950	119,600

RESEARCH PROGRAM

1. PERSONNEL EXPENSES							
- Director (50%) ($600 x 12)	1,800	8,070	9,030	10,120	11,330	9,520	49,870
- Social Benefits	820	3,680	4,790	5,370	6,010	5,050	25,720
- Personnel SUBTOTAL	2,620	11,750	13,820	15,490	17,340	14,570	75,590
OPERATIONAL EXPENSES							
-Fees: assistant	720	3,230	3,610	2,020	2,270	1,900	13,750
- 6 interviewers	1,440	6,450	7,220	4,050	4,530	3,810	27,500
- 3 supervisors	600	2,690	3,010	1,690	1,890	1,590	11,470
- travel and per diem	770	3,440	1,930	2,160	2,420	2,030	12,750
SUBTOTAL	3,530	15,810	15,770	9,920	11,110	9,330	65,470
RESEARCH TOTAL	6,150	27,560	29,590	25,410	28,450	23,900	141,060

CENTRO DE PROMOCION DE PAT. AD RESPONSABLE (CEPAR)

INFORMATION PROGRAM

(IN U.S. DOLLARS)

EXCHANGE RATE US$1 = 25 SUCRES

	1981 (3 MONTHS)	1982 (12 MONTHS)	1983 (12 MONTHS)	1984 (12 MONTHS)	1985 (12 MONTHS)	1986 (9 MONTHS)	TOTAL (60 MONTHS)
1. PERSONNEL EXPENSES							
- Director (50%) ($600 x 12)	1,800	8,070	9,030	10,120	11,330	9,520	49,870
- Clerk (100%) ($172 x 12)	520	2,310	2,590	2,900	3,250	2,730	14,300
- Librarian/Documentalist (100%) ($320 x 12)	960	4,300	4,820	5,400	6,040	5,080	26,600
- Messenger (100%) ($160 x 12)	480	2,150	2,410	2,700	3,020	3,390	14,150
SUBTOTAL	3,760	16,830	18,850	21,120	23,640	20,720	104,920
- Social Benefits	1,710	7,660	9,990	11,200	12,530	10,980	54,070
- Personnel SUBTOTAL	5,470	24,490	28,840	32,320	36,170	31,700	158,990
2. OPERATIONAL EXPENSES							
- Fees (journalist & social workers)	1,000	4,440	3,620	4,050	4,540	3,810	21,540
- Printing (3,600 pamphlets)	1,520	3,230	3,620	4,050	4,540	3,810	20,770
- Office supplies	100	450	500	560	630	530	2,770
- Media/radio & Newspaper)	600	2,690	2,260 (9 mos.)	-0-	-0-	-0-	5,550
- Travel & Per Diem	200	690	770	860	970	810	4,300
- Library materials (newspapers)	100	360	400	450	500	420	2,230
- Evaluation interviewers	-0-	-0-	1,540	-0-	1,930	-0-	3,470
SUBTOTAL	3,600	11,860	12,710	9,970	13,110	9,300	60,630
INFORMATION TOTAL	9,070	36,350	41,550	42,290	49,280	41,080	219,620

CENTRO MEDICO DE ORIENTACION Y PLANIFICACION FAMILIAR (CEMPLAF)

ADMINISTRATION

(IN U.S. DOLLARS)

EXCHANGE RATE US$1 = 25 SUCRES

	1981 (5 months)	1982 (12 months)	1983 (12 months)	1984 (12 months)	1985 (12 months)	1986 (5 months)	TOTAL (60 months)
1. PERSONNEL EXPENSES							
- Administrative Aide (100%) ($360 x 12)	1,080	4,840	5,420	6,070	6,800	5,710	29,920
- Accountant (25%) ($160 x 12)	480	2,150	2,410	2,700	3,020	2,540	13,300
SUBTOTAL	1,560	6,990	7,830	8,770	9,820	8,250	43,220
- Social Benefits	710	3,180	3,560	4,650	5,200	4,370	21,670
- Personnel SUBTOTAL	2,270	10,170	11,390	13,420	15,020	12,620	64,890
2. TRAVEL & PER DIEM							
- To supervise clinics	600	2,690	3,010	3,370	3,780	3,170	16,620
3. OTHER OPERATIONAL EXPENSES (related to the administration of subproject from Quito. Eg. Communications, office supplies, utilities, audits, etc.)	1,500	8,620	9,660	10,820	12,110	10,930	51,640
ADMINISTRATION TOTALS	4,370	21,480	24,060	27,610	30,910	26,720	135,150

CENTRO MEDICO DE ORIENTACION Y PLANIFI II FAMILIAR (CEMOPLAF)

TULCAN CLINIC

(IN U.S. DOLLARS)

EXCHANGE RATE US$1 = 25 SUCRES

		1983 (3 MONTHS)	1984 (12 MONTHS)	1985 (12 MONTHS)	1986 (9 MONTHS)	TOTAL (36 MONTHS)
1. PERSONNEL EXPENSES						
- Physician (50%) ($400 x 12)		1,510	6,740	7,550	6,340	22,140
- Social Worker (100%) ($352 x 12)		1,320	5,930	6,650	5,580	19,480
- Midwife (50%) ($240 x 12)			1,010	4,530	3,810	9,350
- Secretary-Cashier (100%) ($264 x 12)			1,110	4,980	4,190	10,280
- Nurse's Aide (100%) ($200 x 12)		750	3,370	3,780	3,170	11,070
	SUBTOTAL	3,580	18,160	27,490	23,090	72,320
- Social Benefits		1,630	8,260	14,570	12,240	36,700
- Personnel	SUBTOTAL	5,210	26,420	42,060	35,330	109,020
2. OPERATIONAL EXPENSES						
- Rent ($200 x 12)		750	3,370	3,780	3,170	11,070
- Remodeling & Installation of Fixtures		14,090	700	-0-	-0-	14,790
- Traveling to promote clinic services		380	1,690	1,890	1,590	5,550
- Warehousing, Transport of Materials & Customs		5,020	6,320	3,150	2,640	17,130
- Promotion of Clinic via Media		130	560	630	530	1,850
- Utilities and Communications		380	1,690	1,890	1,590	5,550
- Office Supplies & Stationery		950	2,250	2,520	2,120	7,840
- Educational Materials		1,510	6,040	4,050	3,700	15,300
- Clinic Supplies		1,240	4,500	5,040	4,230	15,010
- Equipment Maintenance & Repair Supplies		130	730	1,390	1,160	3,410
- Equipment		11,770	-0-	-0-	-0-	11,770
	SUBTOTAL	36,350	27,850	24,340	20,730	109,270
3. TRAINING AND EVALUATION						
- Training of Personnel		500	600	190	160	1,450
- Partial Evaluation		380	1,690	1,890	1,590	5,550
- Annual Evaluation		500	2,250	2,520	2,110	7,380
	SUBTOTAL	1,380	4,540	4,600	3,860	14,380
TULCAN CLINIC	TOTAL	42,940	58,810	71,000	59,920	232,670

CENTRO MEDICO DE ORIENTACION Y PLANIFICACION FAMILIAR (CEMOPLAF)

ESMERALDAS CLINIC

(IN U.S. DOLLARS)

EXCHANGE RATE US$1 = 25 SUCRES

	1982 (3 months)	1983 (12 months)	1984 (12 months)	1985 (12 months)	1986 (9 months)	TOTAL (48 months)
1. PERSONNEL EXPENSES						
- Physician (50%) ($400 x 12)	1,350	6,050	6,780	7,600	6,380	28,160
- Social Workers (100%) ($352 x 12)	1,180	5,300	5,940	6,650	5,590	24,660
- Midwife (50%) ($240 x 12)	-0-	910 (3 mos.)	4,060	4,540	3,820	13,330
- Secretary/Bookkeeper ($264 x 12)	-0-	990 (3 mos.)	4,480	5,020	4,220	14,710
- Nurse's Aide (100%) ($200 x 12)	670	3,000	3,360	3,770	3,170	13,970
SUBTOTAL	3,200	16,250	24,620	27,580	23,180	94,830
- Social Benefits	1,460	7,390	13,050	14,620	12,290	48,810
- Personnel SUBTOTAL	4,660	23,640	37,670	42,200	35,470	143,640
2. OPERATIONAL EXPENSES						
- Rent ($320 x 12)	1,080	4,820	5,400	6,040	5,080	22,420
- Remodeling & Installation of Fixtures	12,580	630	-0-	-0-	-0-	13,210
- Travel for Promotion of Clinic Services	340	1,500	1,690	1,890	1,590	7,010
- Warehouse, Transport of Materials & Customs	4,480	5,640	2,810	3,150	2,640	18,720
- Promotion of Clinic via Media	110	500	560	630	530	2,330
- Utilities & Communications	340	1,500	1,690	1,890	1,590	7,010
- Office Supplies & Stationery	870	2,010	2,290	2,520	2,120	9,810
- Educational Materials	1,340	5,390	3,930	4,400	3,700	18,760
- Clinic Supplies	900	4,010	4,500	5,040	4,230	18,680
- Equipment Maintenance & Repair Supplies	110	650	1,240	1,380	540	3,920
- Equipment	10,510	-0-	-0-	-0-	-0-	10,510
OPERATIONAL SUBTOTAL	32,660	26,650	24,110	26,940	22,020	132,380
3. TRAINING & EVALUATION						
- Training of Personnel	450	540	170	190	160	1,510
- Partial Evaluation	340	1,510	1,690	1,890	1,590	7,020
- Annual Evaluation	450	2,010	2,250	2,520	2,110	9,340
TRAINING SUBTOTAL	1,240	4,060	4,110	4,600	3,860	17,870
ESMERALDAS CLINIC TOTALS	38,560	54,350	65,890	73,740	61,350	293,890

CENTRO MEDICO DE ORIENTACION / PLANIFICACION FAMILIAR (CEMOPLAF)

QUASIO CLINIC

(IN U.S. DOLLARS)

EXCHANGE RATE US$ 1 = 25 SUCRES

	1981 (3 months)	1982 (12 months)	1983 (12 months)	1984 (12 months)	1985 (12 months)	1986 (9 months)	TOTAL (51 months)
1. PERSONNEL EXPENSES							
- Physician (50%) ($400 x 12)	1,200	5,380	6,020	6,740	7,550	6,340	33,230
- Physician (50%) ($380 x 12)	1,140	5,110	5,720	6,410	7,180	6,030	31,590
- Social Worker (100%) ($352 x 12)	1,060	4,730	5,300	5,930	6,650	5,580	29,250
- Secretary/Cashier (100%) ($266 x 12)	790	3,550	3,970	4,450	4,980	4,190	21,930
- Nurse's Aide (100%) ($200 x 12)	600	2,690	3,010	3,370	3,780	3,170	16,620
SUBTOTAL	4,790	21,460	24,020	26,900	30,140	25,310	132,620
- Social Benefits (45.5%)	2,180	9,760	10,930 (53%)	14,260	15,970	13,410	66,510
- Personnel SUBTOTAL	6,970	31,220	34,950	41,160	46,110	38,720	199,130
2. OPERATIONAL EXPENSES							
- Rent ($350 x 12)	900	4,030	4,520	5,060	5,660	4,760	24,930
- Remodeling & Installation of Fixtures	12,730	1,120	-0-	-0-	-0-	-0-	13,850
- Travel to Promote Clinic Services	400	1,790	2,010	2,250	2,520	2,110	11,080
- Warehousing, Transport of Materials & Customs	4,000	5,040	2,510	2,810	3,150	2,640	20,150
- Promotion of Clinic via Media	100	450	500	560	630	530	2,770
- Utilities & Communications	350	1,570	1,760	1,970	2,200	1,850	9,700
- Office Supplies & Stationery	860	2,240	2,510	2,810	3,150	2,640	14,210
- Educational Materials	1,170	4,300	3,410	3,820	4,200	3,600	20,660
- Clinic Supplies	2,000	3,360	5,020	5,620	6,290	5,290	27,580
- Equipment Maintenance & Repair Supplies	100	580	1,100	1,240	1,380	1,160	5,560
- Equipment	9,970	-0-	-0-	-0-	-0-	-0-	9,970
SUBTOTAL	32,580	24,560	23,340	26,140	29,260	24,580	160,460
3. TRAINING AND EVALUATION							
- Personnel Training	200	260	150	170	190	160	1,130
- Partial Evaluation	-0-	1,250	1,400	1,570	1,760	1,970	7,950
- Annual Evaluation	-0-	1,250	1,400	1,570	1,760	1,970	7,950
TRAINING SUBTOTAL	200	2,760	2,950	3,310	3,710	4,100	17,030
QUASIO CLINIC TOTALS	39,750	58,540	61,240	70,610	79,080	67,400	376,620

(3) CEMOPLAF and CEPAR will be employing new personnel for their subprojects. Therefore the first two years of a subproject's operations will have social benefits calculated at 45.5%. Following two full years of employment, social benefits will equal 53% of the gross salary.

ASOCIACION PRO-BIENESTAR DE LA FAMILIA ECUATORIANA

CUENCA CLINIC

(IN U.S. DOLLARS)

RATE OF EXCHANGE US$ 1 = 25 SUCRES

	1982 (8 MONTHS)	1983 (12 MONTHS)	1984 (12 MONTHS)	1985 (12 MONTHS)	1986 (9 MONTHS)	TOTAL (53 MONTHS)
1. PERSONNEL						
- Physician (50%) ($460 x 12)	4,120	6,920	7,760	8,690	7,300	34,790
- 2 Nurse's Aides (100%) ($192 x 12 x 2)	3,440	5,780	6,470	7,250	6,090	29,030
- Secretary/Receptionist (100%) ($240 x 12)	2,150	3,610	4,050	4,530	3,810	18,150
- Promoter (100%) ($240 x 12)	2,150	3,610	4,050	4,530	3,810	18,150
SUBTOTAL	11,060	19,920	22,330	25,000	21,010	100,120
- Social Benefits	6,290	10,560	11,840	13,250	11,140	53,080
- Personnel SUBTOTAL	18,150	30,480	34,170	38,250	32,150	153,200
2. OPERATIONAL EXPENSES						
- Office Supplies & Stationery	300	500	560	630	530	2,520
- Communications	190	320	350	390	330	1,580
- Transport and Customs	490	820	910	1,020	860	4,100
- Cytology Material	450	750	840	940	790	3,770
- Cleaning & Laundry	450	750	840	940	790	3,770
SUBTOTAL	1,880	3,140	3,500	3,920	3,300	15,740
CUENCA CLINIC TOTAL	20,030	33,620	37,670	42,170	35,450	168,940

ASOCIACION PRO-BIENESTAR DE LA FAMILIA ECUATORIANA (APROFE)

(IN US DOLLARS)

QUITO CLINIC

EXCHANGE RATE US$ 1 = 25 SUCRES

	1982 (8 MONTHS)	1983 (12 MONTHS)	1984 (12 MONTHS)	1985 (12 MONTHS)	1986 (9 MONTHS)	TOTAL (53 MONTHS)
1. PERSONNEL EXPENSES						
- 2 Physicians (50%) ($460 x 12 x 2)	8,240	13,840	15,520	17,380	14,600	69,580
- 3 Nurse's Aides (100%) ($192 x 12 x 3)	5,160	8,670	9,710	10,880	9,140	43,560
- 2 Nurse s (100%) ($120 x 12 x 2)	5,730	9,630	10,790	12,080	10,150	48,380
- Promotor (100%) ($240 x 12)	2,150	3,610	4,040	4,530	3,810	18,140
- Receptionist (100%) ($220 x 12)	1,970	3,310	3,710	4,150	3,490	16,630
SUBTOTAL	23,250	39,060	43,770	49,020	41,190	196,290
- Social Benefits	12,320	20,700	23,200	25,980	21,830	104,030
- Personnel SUBTOTAL	35,570	59,760	66,970	75,000	63,020	300,320
2. OPERATIONAL EXPENSES						
- Office Supplies & Stationery	180	300	340	380	320	1,520
- Communications	310	520	580	650	540	2,600
- Transport	130	220	240	280	240	1,110
SUBTOTAL	620	1,040	1,160	1,310	1,100	5,230
QUITO CLINIC TOTALS	36,190	60,800	68,130	76,310	64,120	305,550

(IN U. LARS)

GUAYAQUIL CLINIC

EXCHANGE RATE US$ 1 = 25 SUCRES

	1992 (8 months)	1993 (12 months)	1994 (12 months)	1995 (12 months)	1996 (9 months)	TOTAL (53 months)
1. PERSONNEL EXPENSES						
- Supervisor (100%) ($440 x 12 months)	3,940	6,620	7,420	8,310	6,980	33,270
- Medical Director (50%) ($480 x 12 months)	4,300	7,220	8,090	9,060	7,610	36,280
- Physician (50%) ($460 x 12 months)	4,120	6,920	7,760	8,690	7,300	34,790
- 8 midwives (50%) ($320 x 8 months)	22,940	38,540	43,160	48,340	40,600	193,580
- 6 Nurse's Aides (100%) ($192 x 12 x 6)	10,320	17,340	19,420	21,750	18,270	87,100
- Receptionist (100%) ($220 x 12 months)	1,970	3,310	3,710	4,150	3,490	16,630
- File Clerk (100%) ($192 x 12 months)	1,720	2,890	3,240	3,630	3,050	14,530
- Office Attendant/Messenger (100%) ($192 x 12 months)	1,720	2,890	3,240	3,630	3,050	14,530
- Janitor (100%) ($192 x 12 months)	1,720	2,890	3,240	3,630	3,050	14,530
- Interviewer (100%) ($220 x 12 months)	1,970	3,310	3,710	4,150	3,490	16,630
- Social Worker (100%) ($320 x 12 months)	2,870	4,820	5,400	6,040	5,080	24,210
SUBTOTAL	57,590	96,750	108,390	121,380	101,970	486,080
Social Benefits (53%)[1]	30,520	51,280	57,450	64,330	54,050	257,630
SUBTOTAL	88,110	148,030	165,840	185,710	156,020	743,710
2. OPERATIONAL EXPENSES						
- Office Supplies & Stationery	3,140	5,270	5,900	6,610	5,550	26,470
- Clinic Supplies & Instruments	1,120	1,880	2,110	2,360	1,980	9,450
- Communications & Utilities	2,240	3,760	4,210	4,720	3,970	18,900
- Clinic Cleaning Maintenance, Laundry & Uniforms	2,240	3,760	4,210	4,720	3,970	18,900
- Transport and Customs	1,720	2,890	3,230	3,620	3,040	14,500
- Snack/ Lunches[2]	2,760	4,640	5,200	5,820	4,890	23,310
- Cytology Materials	1,120	1,880	2,110	2,360	1,980	9,450
SUBTOTAL	14,340	24,080	26,970	30,210	25,380	120,980
GRAND TOTAL	102,450	172,110	192,810	215,920	181,400	864,690

(1) All the above APROFE personnel have been employed by the institution for more than two years. National labor laws require that an additional 8% of salaries must be paid into a benefit funds for employees with two or more years of service.

(2) All full-time employees (working 8 hours per day) are entitled by law to receive a mid-day meal or snack.

PROJECT SUMMARY

(IN U.S. DOLLARS)

EXCHANGE RATE US $1 = 25 SUCRES

	1981	1982	1983	1984	1985	1986	TOTAL	%
SUBPROJECTS TOTALS	94,010	350,870	533,190	587,260	666,140	526,190	2,757,360	62.6
TECHNICAL ASSISTANCE	8,610	14,070	15,480	10,440	10,430	-0-	58,830	1.3
INDEPENDENT EVALUATION	-0-	-0-	10,560	11,600	-0-	14,030	36,170	.8
COMMODITIES	3,200	7,610	13,380	18,900	9,200	-0-	52,290	1.2
PROJECT MANAGEMENT								
- PROJECT COORDINATING OFFICE, QUITO	54,640	69,910	78,080	86,530	95,960	106,430	491,550	11.2
- NON DIRECT COSTS, NEW-YORK	60,140	122,380	110,810	94,720	106,100	113,120	607,270	13.8
MANAGEMENT SUBTOTAL	114,780	192,290	188,890	181,250	202,060	219,550	1,098,820	25.0
TOTALS	220,400	564,540	761,480	809,450	887,830	759,770	4,003,470	
CONTINGENCY (10%)	22,040	56,460	76,150	80,950	88,780	75,980	400,360	9.1
GRAND TOTAL	242,440	621,000	837,630	890,400	976,610	835,750	4,403,830	100.0

PROJECT SUMMARY

(IN U.S. DOLLARS)

EXCHANGE RATE US$ 1 = 25 SUCRES

	1981	1982	1983	1984	1985	1986	TOTAL
SUBPROJECTS							
APROFE							
- GUAYAQUIL CLINIC	-0-	102,450	172,110	192,810	215,920	181,400	864,690
- QUITO CLINIC	-0-	36,190	60,800	68,130	76,310	64,120	305,550
- CUENCA CLINIC	-0-	20,030	33,620	37,670	42,170	35,450	168,940
LESS: LOCAL INCOME	-0-	(58,740)	(61,980)	(64,020)	(66,660)	(69,600)	(321,000)
SUBTOTAL	-0-	99,930	204,550	234,590	267,740	211,370	1,018,180
CEMOPLAF							
- GUASMO CLINIC	39,750	58,540	61,240	70,610	79,080	67,400	376,620
- ESMERALDAS CLINIC	-0-	38,560	54,350	63,890	73,740	61,350	293,890
- TULCAN CLINIC	-0-	-0-	42,940	58,810	71,000	59,920	232,670
- ADMINISTRATION	4,370	21,480	24,060	27,610	30,910	26,720	135,150
LESS: LOCAL INCOME	-0-	(8,040)	(19,510)	(30,620)	(40,350)	(50,240)	(148,760)
SUBTOTAL	44,120	110,540	163,000	192,300	214,380	165,150	889,570
CEPAR							
- INFORMATION PROGRAM	9,070	36,350	41,550	42,290	49,280	41,080	219,620
- TRAINING PROGRAM	3,230	20,780	30,800	21,390	26,450	16,950	119,600
- RESEARCH	6,150	27,560	29,590	25,410	28,450	23,900	141,060
- ADMINISTRATION	22,950	55,410	63,620	71,280	79,840	67,740	360,880
- EQUIPMENT	8,450	-0-	-0-	-0-	-0-	-0-	8,450
SUBTOTAL	49,890	140,100	165,560	160,370	184,020	149,670	849,610
SUBPROJECT TOTALS	94,010	350,570	533,190	587,260	666,140	526,190	2,757,360

Centro Médico de Orientación y Planificación Familiar

C. E. M. O. P. L. A. F.

QUITO - ECUADOR

APORTE QUE PROPORCIONARA CEMOPLAF, DENTRO DEL CONVENIO DE EXTENSION DE PROYECTOS A REALIZARSE ENTRE IPPF Y CEMOPLAF.

- Fondos Locales recaudados por concepto de prestación de servicios clínicos en los Tres Centros: Guasmo, Esmeraldas y Tulcán, por cuatro años:	70.120 dólares
- El 50% de trabajo de dos funcionarios de CEMOPALF, por cuatro años:	68.000 dólares
- Colaboración logística:	12.000 dólares
- Colaboración en Equipo, tanto del área administrativa como de clínica:	5.200 dólares
TOTAL:	155.320 dólares

Lcda. Teresa de Vargas
COORDINADORA DE CEMOPLAF

Flores 912 y Manabí Casilla 3549 Teléfonos: 518-251--519-500—269-0

CEPAR

CENTRO DE PROMOCION DE PATERNIDAD RESPONSABLE

Se detalla a continuación la contribución que CEPAR espera realizar para el programa: "Proyecto sobre Investigación, entrenamiento y capacitación e información - comunicación en población y planificación familiar para líderes de opinión y autores de políticas."

a. Apoyo logístico (procesamiento y publicación	$ 40.000,00	U.S.
b. Materiales educativos	10.500,00	
c. Uso de medios de comunicación para actividades informativas	135.000,00	
d. Asistencia voluntaria profesional	35.000,00	
e. Contribuciones de miembros	2.400,00	
T O T A L	$ 222.900,00	

Dra. Betty Proaño R.
DIRECTORA EJECUTIVA

CEPAR
CENTRO DE PROMOCION DE PATERNIDAD RESPONSABLE

Commercial Retail Sales Report*

* Available in LAC/DR/SA files.

5C(1) - COUNTRY CHECKLIST

Listed below are, first, statutory criteria applicable generally to FAA funds, and then criteria applicable to individual fund sources: Development Asistance and Economic Support Fund.

A. GENERAL CRITERIA FOR COUNTRY ELIGIBILITY

1. FAA Sec. 116. Can it be demonstrated that contemplated assistance will directly benefit the needy? If not, has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights?	1. It can be demonstrated that a major share of the proposed assistance will be directly benefitting the needy. In any event, the Department of State has not determined that Ecuador is a violator of human rights.
2. FAA Sec. 481. Has it been determined that the government of recipient country has failed to take adequate steps to prevent narcotics drugs and other controlled substances (as defined by the Comprehensive Drug Abuse Prevention and Control Act of 1970) produced or processed, in whole or in part, in such country, or transported through such country, from being sold illegally within the jurisdiction of such country to U.S. Government personnel or their dependents, or from entering the United States unlawfully?	2. It has not been so determined. The GOE has an active narcotics control program with USG support.
3. FAA Sec. 620(b). If assistance is to a government, has the Secretary of State determined that it is not controlled by the international Communist movement?	3. The Secretary of State has so determined.
4. FAA Sec. 620(c). If assistance is to government, is the government liable as debtor or unconditional guarantor on any debt to a U.S. citizen for goods or services furnished or ordered where (a) such citizen has exhausted available legal remedies and (b) debt is not denied or contested by such government?	4. No such case is known.
5. FAA Sec. 620(e)(1). If assistance is to a government, has it (including government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities?	5. No.

A.

6. FAA Sec. 620(a), 620(f); FY 79 App. Act, Sec. 105, 114 and 116. Is recipient country a Communist country? Will assistance be provided to the Socialist Republic of Vietnam, Cambodia, Laos, Cuba, Uganda, Mozambique, or Angola?

6. No.

7. FAA Sec. 620(i). Is recipient country in any way involved in (a) subversion of, or military aggression against, the United States or any country receiving U.S. assistance, or (b) the planning of such subversion or aggression?

7. No.

8. FAA Sec. 620 (j). Has the country permitted, or failed to take adequate measures to prevent, the damage or destruction, by mob action, of U.S. property?

8. No, the GOE is taking measures considered adequate by the USG.

9. FAA Sec. 620(l). If the country has failed to institute the investment guaranty program for the specific risks of expropriation, inconvertibility or confiscation, has the AID Administrator within the past year considered denying assistance to such government for this reason?

9. The A.I.D. Administrator has so considered.

10. FAA Sec. 620(o); Fishermen's Protective Act of 1967, as amended, sec. 5. If country has seized, or imposed any penalty or sanction against, any U.S. fishing activities in international waters:

a. has any deduction required by the Fishermen's Protective Act been made?

10. a. No.

b. has complete denial of assistance been considered by AID Administrator?

b. Yes.

11. FAA Sec. 620; FY 79 App. Act, Sec. 603. (a) Is the government of the recipient country in default for more than 6 months on interest or principal of any AID loan to the country? (b) Is country in default exceeding one year on interest or principal on U.S. loan under program for which App. Act appropriates funds?

11. No.

12. FAA Sec. 620(s). If contemplated assistance is development loan or from Economic Support Fund, has the Administrator taken into account the percentage of the country's budget which is for military expenditures, the amount of foreign exchange spent on military equipment and the

12. Not applicable.

A.12.

amount spent for the purchase of sophisticated weapons systems? (An affirmative answer may refer to the record of the annual "Taking Into Consideration" memo: "Yes, as reported in annual report on implementation of Sec. 620(s)." This report is prepared at time of approval by the Administrator of the Operational Year Budget and can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.)

13. FAA Sec. 620(t). Has the country severed diplomatic relations with the United States? If so, have they been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?

13. No.

14. FAA Sec. 620(u). What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the AID Administrator in determining the current AID Operational Year Budget?

14. Payment status is current.

15. FAA Sec. 620A, FY 79 App. Act, Sec. 607. Has the country granted sanctuary from prosecution to any individual or group which has committed an act of international terrorism?

15. No.

16. FAA Sec. 666. Does the country object, on basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. there to carry out economic development program under FAA?

16. No.

17. FAA Sec. 669, 670. Has the country, after August 3, 1977, delivered or received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or safeguards? Has it detonated a nuclear device after August 3, 1977, although not a "nuclear-weapon State" under the nonproliferation treaty?

17. No.

B. FUNDING CRITERIA FOR COUNTRY ELIGIBILITY

1. Development Assistance Country Criteria

a. FAA Sec. 102(b)(4). Have criteria been established and taken into account to assess commitment progress of country in effectively involving the poor in development, on such indexes as: (1) increase in agricultural productivity through small-farm labor intensive agriculture, (2) reduced infant mortality, (3) control of population growth, (4) equality of income distribution, (5) reduction of unemployment, and (6) increased literacy?

B.1.a. AID/W has established such criteria and they have been taken into account in reinitiating an A.I.D. program in Ecuador.

B.1.

b. FAA Sec. 104(d)(1). If appropriate, is this development (including Sahel) activity designed to build motivation for smaller families through modification of economic and social conditions supportive of the desire for large families in programs such as education in and out of school, nutrition, disease control, maternal and child health services, agricultural production, rural development, and assistance to urban poor?

B.1.b. Yes, directly through maternal and child health services, family planning programs and education activities.

2. Economic Support Fund Country Criteria

a. FAA Sec. 502B. Has the country engaged in a consistent pattern of gross violations of internationally recognized human rights?

2.a. Not applicable.

b. FAA Sec. 533(b). Will assistance under the Southern Africa program be provided to Mozambique, Angola, Tanzania, or Zambia? If so, has President determined (and reported to the Congress) that such assistance will further U.S. foreign policy interests?

b. Not applicable.

c. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made?

c. Not applicable.

d. FY 79 App. Act.Sec. 113. Will assistance be provided for the purpose of aiding directly the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights?

d. Not applicable.

e. FAA Sec. 620B. Will security supporting assistance be furnished to Argentina after September 30, 1978?

e. Not applicable.

5C(2) - PROJECT CHECKLIST

Listed below are statutory criteria applicable generally to projects with FAA funds and project criteria applicable to individual fund sources: Development Assistance (with a subcategory for criteria applicable only to loans); and Economic Support Fund.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE?
HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PRODUCT?

A. GENERAL CRITERIA FOR PROJECT

1. FY 79 App. Act Unnumbered; FAA Sec. 653 (b); Sec. 634A. (a) Describe how Committees on Appropriations of Senate and House have been or will be notified concerning the project; (b) is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than $1 million over that figure)?

1. (a) The project was included in the FY-1981 Congressional Presentation, at a lower amount, a Congressional Notification is being processed.
(b) Yes.

2. FAA Sec. 611(a)(1). Prior to obligation in excess of $[illegible], will there be (a) engineering, financial, and other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

2. (a) Relevant financial plans have been prepared.
(b) Reasonably firm estimates of costs had been made and are summarized in this Project Paper.

3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?

3. No such action required.

4. FAA Sec. 611(b); FY 79 App. Act Sec. 101. If for water or water-related land resource construction, has project met the standards and criteria as per the Principles and Standards for Planning Water and Related Land Resources dated October 25, 1973?

4. Not applicable.

5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed $1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project?

5. Not applicable.

6. FAA Sec. 209. Is project susceptible of execution as part of regional or multilateral project? If so why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.

6. No, the project is Ecuador specific in its institution building aspects.

A.

7. FAA Sec. 601(a). Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

7. The project will foster private initiative through its support to three private sector family planning organizations and the initiation of a contraceptives commercial retail sales activity.

8. FAA Sec. 601(b). Information and conclusion on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

8. Many goods and services under the project will be supplied by the US private sector.

9. FAA Sec. 612(b); Sec. 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized to meet the cost of contractual and other services.

9. Host country contributions are 48 percent of the project costs.

10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

10. No.

11. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

11. Yes.

12. FY 79 App. Act Sec. 609. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar, or competing commodity?

12. Not applicable.

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FAA Sec. 102(b); 111; 113; 281a. Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained

B.1.a. The project will have a direct impact on the quality of life of the target group by improving the accessability and affordability of family planning services and information. This will involve expansion of these services into secondary cities and rural areas through cost efficient delivery systems. By encouraging smaller families, the project directly promotes the integration of women into the national econ-

B.1.a.

basis, using the appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries?

omies and improves their social and economic status within the society.

b. FAA Sec. 103, 103A, 104, 105, 106, 107. Is assistance being made available: (include only applicable paragraph which corresponds to source of funds used. If more than one fund source is used for project, include relevant paragraph for each fund source.)

B.1.b. This assistance is being made available for population planning under Sec. 104 (b) of the FAA.

(1) [103] for agriculture, rural development or nutrition; if so, extent to which activity is specifically designed to increase productivity and income of rural poor; [103A] if for agricultural research, is full account taken of needs of small farmers;

(2) [104] for population planning under sec. 104(b) or health under sec. 104(c); if so, extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems and other modes of community research.

(3) [105] for education, public administration, or human resources development; if so, extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, or strengthens management capability of institutions enabling the poor to participate in development;

(4) [106] for technical assistance, energy, research, reconstruction, and selected development problems; if so, extent activity is:

(i) technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;

(ii) to help alleviate energy problems;

(iii) research into, and evaluation of, economic development processes and techniques;

(iv) reconstruction after natural or manmade disaster;

B.1.b.(4).

(v) for special development problem, and to enable proper utilization of earlier U.S. infrastructure, etc., assistance;

(vi) for programs of urban development, especially small labor-intensive enterprises, marketing systems, and financial or other institutions to help urban poor participate in economic and social development.

c. [107] Is appropriate effort placed on use of appropriate technology?

B.1.c. Not applicable.

d. FAA Sec. 110(a). Will the recipient country provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or has the latter cost-sharing requirement been waived for a "relatively least-developed" country)?

d. Yes, host country contributions amount to 48 percent of the costs of the project.

e. FAA Sec. 110(b). Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to the Congress been made, and efforts for other financing, or is the recipient country "relatively least developed"?

e. The project does not involve grant capital assistance.

f. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental and political processes essential to self-government.

f. The project addresses a high priority development need as made evident by Ecuador's high population growth rate. Ecuadorean private and public institutions were involved closely in its design. The project will be executed through six public and three private sector organizations, including close coordination with institutions of higher education.

g. FAA Sec. 122(b). Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase or productive capacities and self-sustaining economic growth?

g. Yes, by encouraging smaller families, each family member will have more food, clothing and other basic needs leading to his/her increased productivity. In particular, the reduced fertility of the mother enables her to devote more time to productive activities.

2. Development Assistance Project Criteria (Loans Only)

a. FAA Sec. 122(b). Information and conclusion on capacity of the country to repay the loan, including reasonableness of repayment prospects.

2.a. Not applicable.

b. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete in the U.S. with U.S. enterprise, is there an agreement by the recipient country to prevent export to the U.S. of more than 20% of the enterprise's annual production during the life of the loan?

b. Not applicable.

B.

3. Project Criteria Solely for Economic Support Fund

3.a. Not applicable.

a. FAA Sec. 531(a). Will this assistance support promote economic or political stability? To the extent possible, does it reflect the policy directions of section 102?

b. FAA Sec. 533. Will assistance under this chapter be used for military, or paramilitary activities?

b. Not applicable.

5C(3) - STANDARD ITEM CHECKLIST

Listed below are statutory items which normally will be covered routinely in those provisions of an assistance agreement dealing with its implementation, or covered in the agreement by imposing limits on certain uses of funds.

These items are arranged under the general headings of (A) Procurement, (B) Construction, and (C) Other Restrictions.

A. Procurement

1. FAA Sec. 602. Are there arrangements to permit U.S. small business to participate equitably in the furnishing of goods and services financed?

A.1. In accordance with A.I.D. regulations, procedures encouraging small business participation will be followed.

2. FAA Sec. 604(a). Will all commodity procurement financed be from the U.S. except as otherwise determined by the President or under delegation from him?

2. Procurement is planned from host country and United States for grant funds. Waivers from such sources will be requested as required.

3. FAA Sec. 604(d). If the cooperating country discriminates against U.S. marine insurance companies, will agreement require that marine insurance be placed in the United States on commodities financed?

3. Not applicable.

4. FAA Sec. 604(e). If offshore procurement of agricultural commodity or product is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity?

4. Not applicable.

5. FAA Sec. 608(a). Will U.S. Government excess personal property be utilized wherever practicable in lieu of the procurement of new items?

5. Yes.

6. FAA Sec. 603. (a) Compliance with requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 per centum of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S.-flag commercial vessels to the extent that such vessels are available at fair and reasonable rates.

6. Such provisions will be written into the Project Agreement.

7. FAA Sec. 621. If technical assistance is financed, will such assistance be furnished to the fullest extent practicable as goods and professional and other services from private enterprise on a contract basis? If the

7. Technical assistance is expected to be contracted primarily from private firms and individuals. Assistance from the United States Public Health service will be required to assist INEC to improve its vital registration system. The provision of these services are appropriate, not competitive with private enterprise, and made

A.7.

facilities of other Federal agencies will be utilized, are they paritcularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?	available without undue interference with domestic programs.
8. International Air Transport. Fair Competitive Practices Act, 1974. If air transportation of persons or property is financed on grant basis, will provision be made that U.S.-flag carriers will be utilized to the extent such service is available?	8. Yes, the Project Agreement will so state.
9. FY 79 App. Act Sec. 105. Does the contract for procurement contain a provision authorizing the termination of such contract for the convenience of the United States?	9. Yes, it will.
B. Construction	
1. FAA Sec. 601(d). If a capital (e.g., construction) project, are engineering and professional services of U.S. firms and their affiliates to be used to the maximum extent consistent with the national interest?	B.1. Not applicable.
2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable?	2. Not applicable.
3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the United States not exceed $100 million?	3. Not applicable.
C. Other Restrictions	
1. FAA Sec. 122 (e). If development loan, is interest rate at least 2% per annum during grace period and at least 3% per annum thereafter?	C.1. Not applicable.
2. FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights?	2. No such fund will be established.
3. FAA Sec. 620(h). Do arrangements preclude promoting or assisting the foreign aid projects or activities of Communist-bloc countries, contrary to the best interests of the United States?	3. Yes, arrangements preclude activities as stated.
4. FAA Sec. 636(i). Is financing not permitted to be used, without waiver, for purchase, long-term lease, or exchange of motor vehicle manufactured outside the United States, or guaranty of such transaction?	4. Yes.

C.

5. Will arrangements preclude use of financing: 5. Yes.

a. FAA Sec. 104(f). To pay for performance of abortions or to motivate or coerce persons to practice abortions, to pay for performance of involuntary sterilization, or to coerce or provide financial incentive to any person to undergo sterilization?

b. FAA Sec. 620(g). To compensate owners for expropriated nationalized property?

c. FAA Sec. 660. To finance police training or other law enforcement assistance, except for narcotics programs?

d. FAA Sec. 662. For CIA activities?

e. FY 79 App. Act Sec. 104. To pay pensions, etc., for military personnel?

f. FY 79 App. Act Sec. 106. To pay U.N. assessments?

g. FY 79 App. Act Sec. 107. To carry out provisions of FAA sections 209(d) and 251(h)? (Transfer of FAA funds to multilateral organizations for lending.)

h. FY 79 App. Act Sec. 112. To finance the export of nuclear equipment, fuel, or technology or to train foreign nations in nuclear fields?

i. FY 79 App. Act Sec. 601. To be used for publicity or propaganda purposes within United States not authorized by the Congress?

CHART

Estimate Of Contraceptive Needs For USAID/E Supported Family Planning Programs

(MOH Not Included)

	IUD		ORALS		CONDOMS		TABLETS		FOAM			
	Amount Needed	Estimated Costs	Amount Needed	Estimated Costs	Amount Needed	Estimated Costs	Amount Needed	Estimated Costs	Amount Needed	Estimated Costs	Total Costs	Rounded
1982	29,200	13,411.56	900,900	172,972.80	2,910,000	134,878.50	87,225	126,650.70	34,875	50,743.13	498,656.69	498,700
1983	21,800	11,013.36	659,100	145,661.10	2,323,000	127,741.77	69,700	111,171.50	27,870	44,619.87	442,207.60	442,200
1984	26,800	14,892.76	725,400	176,272.20	2,782,000	168,255.36	83,450	146,454.75	33,390	58,799.79	564,674.86	564,700
1985	21,400	13,109.64	799,500	213,466.50	3,246,000	215,956.38	97,400	188,079.40	38,940	75,426.78	706,038.70	706,000

Stock needs (y X 1.5) included for first year only

Includes Transportation Costs

IUD	10%
Orals	5%
Condoms	12%
Tablets	10%
Foam	15%

CHART

Estimate of Contraceptive needs for USAID/E supported family planning programs.

(MOH not Included)

	IUD		ORALS		CONDOMS		TABLETS		FOAM			Total	
	Amount Needed	Estimated Costs	Amount Needed	Estimated Costs	Amount Needed	Estimated Costs	Amount Needed	Estimated Costs	Amount Needed	Estimated Costs		Costs	Rounded
1982	29,200	13,411 56	900,900	172,972 80	2,910,000	134,878 50	87,225	126,650 70	34,875	50,743 13		498,656 69	498,700
1983	21,800	11,013 36	659,100	145,661 10	2,323,000	127,741 77	69,700	111,171 50	27,870	44,619 87		442,207 60	442,200
1984	26,800	14,892 76	725,400	176,272 20	2,782,000	168,255 36	83,450	146,454 75	33,390	58,799 79		564,674 86	564,700
1985	21,400	13,109 64	799,500	213,466 50	3,246,000	215,956 38	97,400	188,079 40	38,940	75,426 78		706,038 70	706,000

Stocks needs (y X 1.5) included for first year only

Includes transportation costs

IUD	10%
Orals	5%
Condoms	12%
Tablets	10%
Foam	15%