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 Report Symbol U-447

CLASSIFICATION  
**PROJECT EVALUATION SUMMARY (PES) - PART I**

<b>1. PROJECT TITLE</b> Integrated Rural Health Delivery System			<b>2. PROJECT NUMBER</b> 518-0015	<b>3. MISSION/AID/W OFFICE</b> USAID/Ecuador							
<b>5. KEY PROJECT IMPLEMENTATION DATES</b> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%; border-right: 1px solid black;"> <b>A. First PRO-AG or Equivalent</b>            FY <u>81</u> </td> <td style="width:33%; border-right: 1px solid black;"> <b>B. Final Obligation Expected</b>            FY <u>85</u> </td> <td> <b>C. Final Input Delivery</b>            FY <u>86</u> </td> </tr> </table>			<b>A. First PRO-AG or Equivalent</b> FY <u>81</u>	<b>B. Final Obligation Expected</b> FY <u>85</u>	<b>C. Final Input Delivery</b> FY <u>86</u>	<b>6. ESTIMATED PROJECT FUNDING</b> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;">A. Total</td> <td style="width:50%; text-align: right;">\$ <u>8,235,000</u></td> </tr> <tr> <td>B. U.S.</td> <td style="text-align: right;">\$ <u>8,365,000</u></td> </tr> </table>	A. Total	\$ <u>8,235,000</u>	B. U.S.	\$ <u>8,365,000</u>	<b>7. PERIOD COVERED BY EVALUATION</b> From (month/yr.) <u>October, 1981</u> To (month/yr.) <u>March, 1984</u> Date of Evaluation Review <u>May, 1984</u>
<b>A. First PRO-AG or Equivalent</b> FY <u>81</u>	<b>B. Final Obligation Expected</b> FY <u>85</u>	<b>C. Final Input Delivery</b> FY <u>86</u>									
A. Total	\$ <u>8,235,000</u>										
B. U.S.	\$ <u>8,365,000</u>										
<input checked="" type="checkbox"/> REGULAR EVALUATION <input type="checkbox"/> SPECIAL EVALUATION											

**B. ACTION DECISIONS APPROVED BY MISSION OR AID/W OFFICE DIRECTOR**

A. List decisions and/or unresolved issues; cite those items needing further study. (NOTE: Mission decisions which anticipate AID/W or regional office action should specify type of document, e.g., airgram, SPAR, PIO, which will present detailed request.)	B. NAME OF OFFICER RESPONSIBLE FOR ACTION	C. DATE ACTION TO BE COMPLETED
1. Need to program and/or reprogram project funds assigned to nutrition activities. a. Fund a National Nutrition Survey (P.I.L.) b. Contract long-term nutrition advisor for SEDRI	Farr/Wight  Farr/Wight Farr/Wight	  6/30/84 7/31/84
2. Review CIMDER contract TA mode.	Farr/Estrella	7/15/84
3. Revise functions of MOH Project Coordinating Office.	Estrella	7/31/84
4. Extend Mass Media and Health Contractor Reinaldo Pareja, incorporating immunization program duties.	Farr	6/30/84
5. Present recommendations for reprogramming of WS/S, health and nutrition to new GOE health authorities taking of- fice in August, 1984.	Farr	Sep. 84

<b>9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS</b> <table style="width:100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/> Project Paper</td> <td><input checked="" type="checkbox"/> Implementation Plan e.g., CPI Network</td> <td><input checked="" type="checkbox"/> Other (Specify) <u>CIMDER Contract</u></td> </tr> <tr> <td><input type="checkbox"/> Financial Plan</td> <td><input type="checkbox"/> PIO/T</td> <td><input checked="" type="checkbox"/> Other (Specify) <u>Letter of Under-</u></td> </tr> <tr> <td><input type="checkbox"/> Logical Framework</td> <td><input type="checkbox"/> PIO/C</td> <td><u>standing with MOH on Dr. Pareja</u></td> </tr> <tr> <td><input checked="" type="checkbox"/> Project Agreement (Annex 1 Description)</td> <td><input type="checkbox"/> PIO/P</td> <td></td> </tr> </table>	<input type="checkbox"/> Project Paper	<input checked="" type="checkbox"/> Implementation Plan e.g., CPI Network	<input checked="" type="checkbox"/> Other (Specify) <u>CIMDER Contract</u>	<input type="checkbox"/> Financial Plan	<input type="checkbox"/> PIO/T	<input checked="" type="checkbox"/> Other (Specify) <u>Letter of Under-</u>	<input type="checkbox"/> Logical Framework	<input type="checkbox"/> PIO/C	<u>standing with MOH on Dr. Pareja</u>	<input checked="" type="checkbox"/> Project Agreement (Annex 1 Description)	<input type="checkbox"/> PIO/P		<b>10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT</b> A. <input type="checkbox"/> Continue Project Without Change B. <input type="checkbox"/> Change Project Design and/or <input checked="" type="checkbox"/> Change Implementation Plan C. <input type="checkbox"/> Discontinue Project
<input type="checkbox"/> Project Paper	<input checked="" type="checkbox"/> Implementation Plan e.g., CPI Network	<input checked="" type="checkbox"/> Other (Specify) <u>CIMDER Contract</u>											
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<input checked="" type="checkbox"/> Project Agreement (Annex 1 Description)	<input type="checkbox"/> PIO/P												

<b>11. PROJECT OFFICER AND HOST COUNTRY OR OTHER RANKING PARTICIPANTS AS APPROPRIATE (Names and Titles)</b> Kenneth Farr, Chief, Health Office, USAID Herbert Caudill, PASA Sanitary Engineer, USAID Audrey Wight, Nutrition Advisor, USAID Gustavo Estrella, Ecuador, Ministry of Health, Project Coordinator.	<b>12. Mission/AID/W Office Director Approval</b> Signature <u>William D. Ross</u> Typed Name <u>William D. Ross, Act. Director</u> Date <u>June 27, 1984</u>
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EVALUATION OF ECUADOR INTEGRATED  
RURAL HEALTH DELIVERY SYSTEM PROJECT  
REPORT OF CONSULTANCY, ECUADOR, 11-24 MARCH 1984

by  
Robert Emrey  
Emrey Associates

30 March 1984

Prepared for PRITECH, Arlington, Virginia  
USAID Contract DPE-5927-C-00-3083-00; Task SS-13

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## PREFACE

This report presents a summary of consultant observations and recommendations from a midterm evaluation of the Ecuador Integrated Rural Health Delivery System Project (AID Project 518-0015 and Loan 518-U-040). Visits were made in various parts of Ecuador to observe activities at project sites during March 1984. The consultant had participated previously in the 1980-81 design activities for this project as leader of a management analysis team.

The work under this consultancy was conducted for PRITECH, as member of a three-person team for evaluation of the project. The team also included: Patrick J. H. Marnane, Team Leader, who was contracted to the USAID/Ecuador Mission, and Hugo Corral, M.D., who was contracted to the Ecuador Ministry of Health. The consultant wishes to extend thanks to the many individuals who provided ideas and assistance for this consultancy: Dr. Kenneth Farr, USAID/Ecuador Health Officer; Linda Morse and Paula Feeney, AID/Washington Bureau for Latin America and the Caribbean; and Dr. Anthony Meyer, AID/Washington Bureau for Science and Technology. The AID Project Manager for the PRITECH contract is Dr. Tina Sanghvi, Office of Health. While in Ecuador, the suggestions of several public health specialists made a valuable contribution to my work: Dr. Audrey White and

Dr. David Nelson, contracted to the USAID/Ecuador Mission;  
Dr. Reynaldo Pareja, Academy of Educational Development;  
and Dr. Frederick Hartman, Management Sciences for Health.

The many Ecuadorean colleagues who participated in the original effort to design this project were again of great help during this visit. Special thanks are due also to Eduardo Navas, M.D., consultant to the Minister of Health for Regionalization of Services, and Gustavo Estrella, Ph.D., consultant to the Minister of Health for Services Integration.

Lastly, many thanks are due to colleagues at PRITECH, under whose contract this work was completed: John Alden, PRITECH Director, Jeremiah Norris, Betty Booth, and Danielle Grant. Their new organization has begun work in a fine way, and I extend my best wishes for their continued success.

The opportunity in this assignment to revisit old friends who had labored to develop the project plans in Ecuador was an especially enjoyable one. It is hoped that the work reported here contributed positively to that of the many field workers participating in project implementation. To these above name people and the many others who now are engaged in the various worldwide efforts to expand and improve basic health services, I extend my encouragement.

Robert Emrey  
Management Counsel

Montgomery Village, Maryland  
30 March 1984

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EVALUATION OF ECUADOR INTEGRATED  
RURAL HEALTH DELIVERY SYSTEM PROJECT  
REPORT OF CONSULTANCY, ECUADOR, 11-24 MARCH 1984

Background and Methodology

This report presents the observations and recommendations from one consultant in the 1984 midterm evaluation of the Ecuador Integrated Rural Health Delivery System Project (AID Project 518-0015 and Loan 518-U-040). This report will be combined with the findings of other evaluation team members for presentation of the 1984 evaluation results.

The official project purpose is: "To develop a model low-cost health services delivery system, which can be replicated nationwide, in three Integrated Rural Development (IRD) areas." The project is being implemented by the Ecuador Ministry of Health (MOH), the Ecuadorean Institute for Sanitary Works (IEOS), and the Integrated Rural Development Secretariate (IRDS). Technical assistance is provided to the project by the Center for Multidisciplinary Investigations in Development (CIMDER) of the Universidad del Valle in Cali, Colombia, under host country contract with the MOH. The project began with initial obligations on 29 September 1981, and project assistance will continue until 31 December

1986.

The consultant was assigned the tasks of reviewing and making recommendations on the management and program development aspects of the project activities within the MOH and IRDS. This report does not contain observations for the water supply and sanitation improvement areas of the project, nor does it present findings concerning the work of IEOS, as these areas are being evaluated by other participants in the midterm evaluation effort.

#### Background

This report contains findings for the portions of the project aimed at developing institutional capacity for delivery of rural health services and for establishment of a model decentralized management arrangement within the MOH. The project was designed to strengthen delivery of services for three sections of rural Ecuador: Jipijapa on the coast, and Quimiac-Penipe and Salcedo in the Sierra.

During project design in 1980, Government of Ecuador (GOE) officials insisted that two design features were to be considered essential elements in the project: First, the integrated rural development scheme of the government was to be the vehicle for accomplishment of project activities and second, project implementation plans were to include support for the MOH decentralization and regionalization program. The importance of these two premises should not

be overlooked in any review of the project implementation process and of project achievements. A brief review of both these design elements is provided in the following paragraphs.

Integrated Rural Development. The Ecuador integrated rural development program was designed in the late 1970s using the best models and resources available from worldwide experience at that time. All of the 17 integrated rural development areas in Ecuador were selected on the basis of both technical and political criteria after extensive studies. The IRD areas were planned to receive special treatment from public and private agencies for the purpose of raising their agricultural and industrial productivity and their social, cultural, and health status. The areas selected were all of low income populations, but they were areas that also had some promise of improvement. That is, regions having extreme, seemingly hopeless development problems were not included among the IRD areas.

Implementation of the development interventions in the IRD areas was to be coordinated through a new, high level agency: the Integrated Rural Development Secretariate (IRDS). The agency was to be freed from slow-paced, restrictive practices and procedures used typically by regular cabinet-level ministries. The structure and policies of the IRDS were being developed at the time this project was under

design. Initial staff members were being selected also at that time so there was not an operating IRDS in place to observe in Ecuador at the time the project was presented and approved by the participating governments. Various plans and treatises on development in Ecuador (including notably papers by then Vice President Osvaldo Hurtado) gave the only available indication of how the scheme for IRD was going to be implemented. The health project being implemented here, then, grew up at the same time as the formal integrated rural development arrangement was coming into existence. (The IRDS was created with participation from AID under AID Project 518-0012 and Loan 518-T-038, which was approved in June 1980.)

Decentralized Health Administration. A number of international studies and many Ecuadorean experts in the 1970s had urged the government to adopt decentralization as a means of moving public systems to be more effective and responsive in delivery of services. Decentralization, of course, can mean many different things depending on local circumstances. In his several international studies of decentralization processes, Dennis Rondanelli, Syracuse University, identified the following distinct forms of decentralization ("Administrative Decentralization and Regional Planning for Rural Development," Unpublished, November 1979):

1. Deconcentration--redistribution of planning, decision-making or management responsibilities among levels of central government through shifting of workload, creation of field agencies or establishment of local administration;
2. Delegation--transfer of responsibility to perform planning and administrative functions to organizations not wholly controlled by the central government such as public corporations, regional development and planning authorities, multi-purpose or single purpose functional authorities, or project implementation units, over which the government maintains supervisory powers;
3. Devolution--authority for planning and management of functions is transferred entirely to autonomous units of government with corporate status over which the central government maintains little or no direct control.

These distinctions are of assistance in distinguishing the purposes and approaches found in decentralization efforts.

A model for decentralization of administration for the health sector in the form of "deconcentration" was debated during the 1970s in Ecuador, then introduced slowly during the years 1975-1980. The needs of urban versus rural populations were considered in these plans as were the different requirements for service programs located in the three distinct geographic

areas of Ecuador: Sierra, coast, and Amazon. The key element in the decentralization model was the provincial health office

The advisors to the MOH at that time had drawn up elaborate plans for improving the role of provincial offices in supervision and support of service units. These plans included specifications for a pattern of supervision and patient referrals from health posts up to higher facilities in the health services delivery system offering more extensive levels of treatment. The levels were designated in the following order:

- Health Post
- Health Subcenter
- Hospital Health Center
- Provincial Hospital
- Tertiary Care Hospital

Descriptions and specifications were given for each level in the service chain as they related to the roles of the MOH central office and the provincial health offices.

It should be noted that at that time and over several years the MOH was engaged in an extensive facility construction effort. Construction of those units and administrative offices was largely complete before development began on the present Rural Health Service Project. However, a project with Inter-American Development Bank funding for construction of numerous additional health posts and health subcenters was started during the time this AID-supported project was under design. The supervisory and logistics elements in the facility

system was only partially implemented during that time period. The problem presented to the project was to develop a responsive, locally active service system appropriate to rural populations.

Of key importance for the project, the supervision of health subcenters and health posts in many places was not working well. These units were under the responsibility, somewhat ambiguously, of both the hospital subcenter directors and the rural health chiefs in provincial offices. The project designers were given details of proposed directives by high MOH officials concerning the next stages of decentralization plans for the MOH. These plans were described to project designers as MOH policies about to be adopted, and they specified an arrangement for supervision of services within provinces. These plans contained the ideas for the sub-province districts that were to be called, microregions or simply areas. A new MOH official post was proposed to be created in these plans to supervise the microregion. The new post was to be called: the Area Chief. The MOH officials agreed at the time that the first Area Chiefs to be appointed would be those in the three sites selected by the government for the project. MOH officials expected that, by linking the next stage of their decentralization effort to the project, they would gain appropriate resources needed for design and execution of the initial training programs and related guidelines.

The features in place or available to the MOH at the start of the project included a large array of facilities

and offices, many assigned health workers, and a number of units providing somewhat uncoordinated logistical support. Missing from the model at the start of the project were: adequate numbers of health workers willing and able to provide services in deep rural areas, a supervisory system for ensuring quality services were being provided at low cost within rural areas, and an information handling arrangement for streamlining the assignment of resources and determining program needs. A few additional facilities in the form of subcenters and posts were also to be constructed where they were needed to fill voids within the project geographic areas.

In summary, the location of project sites in rural sections designated to participate in the national program of integrated rural development was mandated by national policymakers at the highest levels. Furthermore, the arrangement of the work as an element in the MOH decentralization scheme was mandated principally by MOH policymakers at the national level. Together, these two elements meant that the project design must take extra measures during implementation to meet the demands of these complex requirements.

Implementation Experience. Two factors outside the control of the project implementation team have affected progress in the project: the changes in top-level administration in the MOH and the effects of the 1983 rainfall on the project sites.

The time during which the project was being implemented thus far has seen a succession of five Ministers of Health. The people selected for the post of Minister have all been of great competence and interestingly each has come from a different part of the political spectrum of Ecuador. The significant factor here is that each new minister was obliged to learn about the project anew from the implementation team and the AID health officers. A great deal of attention was given by project participants to ensure that the needed understanding was given to each succeeding Minister. In one case, a new health minister and his deputies spent an extended period of time in intensive discussions with the implementation team and AID officials to ensure a smooth transition soon after they took office.

Secondly, during the year 1983, an exceptional and extended period of rain and accompanying damage were experienced by Ecuadoreans and residents of the other western regions of South America. These rains continued for a period of nearly 12 months. The evaluation team was present in some of the areas most affected by the rains and was able to see the suffering of people following these unprecedented rains. Ecuador is spending a great deal of its own resources as well as those of many donor nations and agencies to put the services and operations of the country back into working order. The involvement of these many agencies has in many ways affected the progress and results under the Integrated

Rural Health Delivery Systems Project. The extent of the delays and additional problems experienced throughout the rainy period are difficult to assess in any precise way. The consultant has provided, wherever possible, an indication in this report of unavoidable delays attributable to the 1983 rains.

#### Methodology

The report which follows then is a presentation of the findings as they were observed during the month of March 1984 in visits and interviews at various project sites in Ecuador. The consultant studied also a variety of documents in English and Spanish that bear on the development and implementation of the project, including a number of Spanish-language contractual and project implementation documents which were studied following the consultant's return from Ecuador. During the field visits, the consultant attempted to observe at first-hand the present process for implementation of the project and to gather data from project participants and community members as to the progress and problems in the project.

The work of the consultant was organized to follow the scope of work prepared by the USAID/Ecuador Mission in requesting these services. The work scope consisted of ten issues and questions (A-J), which were to be addressed by the consultant. Each of the ten issues requested both an assessment and recommendations. The recommendations are presented as tentative

and illustrative guidance, based on an admittedly short period of observations and a far from complete understanding of the many factors and forces affecting the work of the participants.

The official visits and interviews as planned for the evaluation team were prepared in an agenda by the evaluation leader, Patrick J. H. Marnane, covering the period 7 March to 5 April 1984 (a copy of that document is contained in Annex 1.) The visits in the official agenda were supplemented by additional interviews conducted with former project participants and with members of the communities in which the project is being implemented. The people contacted are listed in Annex 2.

The remainder of the body of the report contains the consultant's responses to the issues. Annexes are included at the end of the report, containing listings and reference materials of use to the reader in studying the evaluation findings.

A. Decentralized Service Delivery Model

What progress has been made in developing and implementing a model decentralized health delivery system which can be replicated nationwide?

Response. The Ecuador Ministry of Health (MOH) has made a continuing effort to develop greater decentralization since the Ministry was founded in 1972. The approach used was that known as deconcentration, as was discussed above. The effort to decentralize has proven to be complex and at times seemingly unpopular with various officials. The present situation, after the project's contributions over the last two years, can best be summarized as showing modest signs of progress but with many elements of the decentralization program remaining unimplemented.

Decentralization of a cabinet-level ministry in any country is a process that requires attention to numerous features of government-wide operation. The network of governmental procedures used in financial, logistical, and personnel administration transactions usually cannot be changed unilaterally by a single ministry. The Government of Ecuador places control of government financial transactions in the Ministry of Finance and control of personnel transactions in the Civil Service Commission. The decision-making process for problems arising in field programs requires that decisions be reviewed at several levels up to the MOH Central Office, then often reviews

are made also at other government agencies, too. Decentralizing any MOH operations must then accommodate these required decision points. This is not to say that decentralization cannot work but that its supporters must consider the effects of a single change in MOH procedures on the multiplicity of related other governmental processes.

The present formal decision structure in the MOH operates under the authority of the Minister with undersecretaries for each of the two main regions of the country: coast and Sierra. Next, the decision authority passes down through provincial health chiefs, who are responsible for all health activities in the province. These officials are non-permanent, political appointees and have authority over a wide range of local MOH financial and personnel actions. Although they prepare the proposed budgets for province health programs, they do not exercise final authority over certain key resources, such as the assignment of most classes of health workers and the arrangements for capital construction. These decision areas remain under MOH Central Office control. At the start of the project, then, many areas of action were assigned to the provincial offices, but little control in turn was given to operations below that level. The project focused on strengthening the decision-making and supervising authority and capacity at the sub-provincial level. The principal management officials at the sub-provincial level were the hospital director and the directors of hospital subcenters.

In most cases, these posts are filled by non-permanent, political appointees. These people were given regular salary, extra paid benefits, and were permitted also to hold private clinical services in their hours outside government duty.

The project design called for implementing a long-studied and debated concept of administrative directorates at the sub-provincial level, to be called "microregions" or simply "areas." These new directorates were to receive some of the authority previously vested in the province offices to plan and implement the health services. Under the project, attention was given to the remote, rural parts of the country within the IRD districts. The more urbanized sections in MOH programs were already provided with supervision from the local provincial office. The key element in the change, then, was that the "area" concept was seen as a means of improving effectiveness in rural services and in making those sites designated as "areas" more responsive to local service needs. Decentralization under the project's concept offered promise of improving rural community outreach for services.

The risk was high at the start of the Project that decentralization was not going to take place quickly. The MOH quest for decentralization had already taken ten years. In fact, all previous efforts to establish a balance of control between central and provincial offices in the MOH had required very great energy by supporters. The debate on decentralization that emerged in the MOH during the early stages of project

implementation focused on the post of Area Chief. The post of Area Chief became a rallying cry, or shiboleth, for much deeper, more entrenched values concerning the control of the system and its perquisites for individual officials. Area Chiefs marked, among other things, an effort to give greater attention to MOH rural services, thereby threatening some of those who sought to favor curative care facilities. The Area Chief represented a major incursion on the turf of some established officials in the MOH, and potentially would change the previous balance of attention in the services system between urban and rural areas.

The consultant believes, based on observations over the past three years, that the debates over decentralization policy will continue for several more years. Misunderstandings over the decentralization plans will probably continue to occur for a time also--such as the misinformation being spread last year concerning Area Chiefs' salaries which were claimed to be greater than provincial health chiefs' salaries. Those who support the intended ends of greater decentralization need not and should not be deterred by these debates from continuing to make progress. If attention is given mainly to seeking outward and visible signs of expanded local "area" authority, then the progress likely will be very slow. These visible authority symbols often include such matters as: budget preparation, hiring and firing, and other procedural responsibilities. Instead, major emphasis can and should

be given to strengthening local supervision, where the emphasis is on teaching skills to rural health workers and obtaining rapid feedback of information about problems experienced by the workers. Technical assistance in the field should give priority to improving supervisory performance in the "areas."

The allocation of budgets to the rural health services activity remains a critical problem. Under the present circumstances of tight national government budgets and difficulties with the availability of posts, the most likely situation over the coming two years is the continuation of budget allocations in more or less exactly the same urban-to-rural proportions as were present over the past five years. These proportions cannot and will not be changed solely by technical arguments over the benefits of greater community participation or the subjective benefits of greater involvements in the management of the health sector by rural specialists. Technical assistance to improve supervision in provincial offices and in field services can help improve service efficiency as well as to strengthen their effectiveness inspite of limited budgets.

The present strategy of the project directorate is to act forthwith on recent top-level decisions in the MOH to permit a new-type of designation of Area Chief to be given, to the present Hospital Subcenter Directors. These people would also receive additional pay and benefits. This new policy replaces the never-enacted one proposed at the beginning of the project, which was to have new area chief posts created.

These hospital subcenter managers will be given responsibility for both curative and preventive health services throughout their catchment area. A special new post will then be assigned, within the present personnel structure for clinical physicians in the Civil Service, for a public health physician as specialist in the "technical affairs" to supervise the rural, community health services activities. This model is similar to the U.S. Public Health Service organizational arrangement in the programs of direct health services to rural Indian populations. This arrangement emphasizes the overall management of the geographic area health needs for the higher-ranked area official. Then, a separate specialist in community health services is assigned immediately beneath that person. In the U.S. Public Health Service model, another person may also be put in charge of the operations of the hospital to oversee the day-to-day operations there.

The selection and development of the Area Chief and the new Technical Director are discussed further below, under Issue E.

B. Primary Health Care in Integrated Rural Development Areas

What progress has been made in improving PHC delivery and in providing new, low-cost services in IRD areas?

Response. The decentralized primary health care (PHC) delivery system being developed by the MOH aimed to provide services throughout the country on the basis of the needs of each region and area. These health needs differ greatly from Sierra to coast to Amazon, and therefore the approach was designed to accommodate these differences. The process of developing these services has to take many difficult steps before a fully functioning PHC system can be achieved.

The PHC system in Ecuador was established in a succession of developmental steps that predate the founding of the MOH, beginning in the 1940s. These steps to build a PHC capacity included the early operations of the Servicios de Salud and the Plan Andino. These former agencies each gave attention to such system elements as buildings, public sanitation improvements, and other similar resources. The PHC system development period included several recent years of relative prosperity for the country. During that time, many key elements were put in place: staffing, transportation, and additional buildings. Depressed international markets in petroleum have most recently put a squeeze on resources for the health sector at a time when additional population growth is increasing demand for delivery of all types of health services. Among the remaining

elements required for establishment of a full operational PHC service in underserved areas include: supervision, information feedback, and logistics.

The contribution of the Project toward this evolving model PHC delivery system lies in the risk capital provided to experiment with methods for meeting service needs in remote areas and with dispersed populations. The concepts to be tried in this arrangement include a variety of service outreach activities, various training arrangements for health promoters and others, and a variety of management development devices. These various project components are intended to provide the missing elements for the effective delivery of services to these underserved populations. The project is to focus also on development efforts at the mid-level, between MOH Central Office and the field units. These interventions are included under the improvements in planning and implementation of service operations and supervision. The project design included resources for provision of transportation and follow-up to permit close observation and early identification of problems in rural field services.

The present state of implementation in the project shows more evidence of progress with development of hardware (buildings, equipment, vehicles) than of software (training, supervisory systems, information handling). It is clear that many planned software elements will soon be in place, but at this time there can only be a series of presumptions about the future applicability of the model for replication to other parts of Ecuador.

There has been a great deal of debate already in the MOH as to the proper operation of their PHC model and as to what constitutes the "true" Ecuadorean model of PHC service delivery. With five different health ministers in the short history of the project, there has been a heroic effort expended just to keep the project on track and the MOH policy-level support for project implementation. The stability required for implementation of a fairly complex series of reforms such those in the project has been present only for limited periods of time during the implementation period.

The proposed model contains a series of reforms in the staffing of field level services and a number of changes in the arrangement of service provision. The staffing changes are to include the development of a complete complement of nurse auxiliaries and health promoters for delivery of services in the various rural areas. Then, a specially trained cadre of other health workers--including rural physicians, dentists, nurses, health educators, and sanitarians--is to be made available for service in clusters of service areas. The supervision by physicians and nurses that is to strengthen the service delivery system under this plan is to be given a special emphasis. The principal local PHC supervision was to come from some designated specialist in the delivery of effective rural health services, experienced in the delivery systems of the MOH and knowledgeable in the cultural and health situation of the geographic area. These area technical officers, as they are now proposed to be called, will develop

the community outreach that is missing from the present operation of services.

To consider the possibility of replication for the PHC model, it is important to consider the affordability and cost-effectiveness of the model. The services cadre described in the paragraph above could be fairly expensive when put into place--both as investment to develop and as continuing cost for the delivery system. Up to now, however, there is little cost data available to analyze the model since the full complement of workers is not established or in place at any of the project sites.

Operation of the project PHC model rests on a series of assumptions about conditions in the service areas. The assumptions included an assessment of health and social needs of rural community and of the feasibility of giving logistical and technical support in IRD districts from the MOH Central and provincial levels. These Project Paper assumptions about the need and feasibility of the model were examined. In the consultant's opinion, the available data still support those underlying assumptions.

On the other hand, the level of resources required to focus and coordinate PHC services into all IRD districts may eventually prove to be very high under the proposed resource mix. These relatively small IRD sites have little in common with each other or with the rest of the country. The IRD districts were selected for a variety of reasons, and the main feature they seem to have in common is that the political

decision-makers and economic analysts could agree that these areas should be given special attention. Resources for the integrated rural development districts (DRI) are coming from a variety of national and international sources. Each external donor agency is participating in a selected set of project sites. The types of interventions varies from one IRD site to another.

The DRI areas are administered by the new Integrated Rural Development Secretariate (SEDRI). The Secretariate did not exist at the time the health project was designed, and only conjecture was available to guide project designers as to the presumed eventual shape and style of the agency. The organization that became SEDRI has grown, learned, and adjusted during the two years that the health project has been operating. These adjustments by SEDRI were in many cases made in response to problems and difficulties experienced by project efforts in the health sector. The health sector became the main social-sector element in the SEDRI operation. The SEDRI mandate is similar to the mandates given to integrated rural development agencies in various countries during the 1970s. International experience in the meanwhile has shown that in many cases the social sector elements in many countries' integrated rural development schemes do not perform efficiently or effectively when managed under the same procedures as are used in agricultural or industrial sector programming.

The situation in the worldwide IRD movement is beyond

the scope of this inquiry, but many of the difficulties and obstacles faced by the health sector participants in the Ecuador IRD activity are to be found also in many other countries' experience. Cabinet-level ministries participating in IRD, such as the Ecuador MOH, must balance priorities within their legal mandates for services with the priorities set by the IRD agency. The IRD agency in Ecuador and often elsewhere as well finds the social sector ministries as not having sufficient responsiveness to the needs of their target populations. The constituents of the Ecuador MOH throughout the country demand that their needs be met as always and the IRD agency becomes just another constituent demanding services. Only with continuous attention by top government officials to arbitrate the conflicting needs of the IRD agency and the cabinet-level social sector ministries can either group perform effectively. Advice on how to accomplish this arbitration is outside the sphere of this report but seems crucial to long-term success of the IRD model being tried in Ecuador.

C. Institutional Coordination

What progress has been made in coordinating the efforts of health service institutions?

Response. There are over ten major public and private agencies active in the delivery or promotion of health services in Ecuador on a national scale and many others with more limited mandates. These agencies grew and flourished under a variety of historical forces and political motivations. The national development plan, enacted in the late 1970s, included a strong argument for the coordination of these agencies. The same document proposed the creation of a National Health Council (CNS) for the purpose of achieving some degree of coordinated effort, efficient use of resources, and forward planning of Ecuadorean health services development efforts.

The CNS was created prior to the implementation of the Integrated Rural Health Services project, and the project budget contained resources for strengthening the effectiveness of its operations. The Minister of Health is assigned to chair the CNS under the charter which led to its creation. Other coordinating mechanisms are in place for more limited purposes in the fields of health, population, and nutrition. Even the Integrated Rural Development Secretariate is, of course, an example of such a mechanism insofar as the 17 special development districts of Ecuador are concerned. Only the CNS, however, has the stature and mandate to provide overall

coordination of services.

During the life of the project, various arrangements are to be established to enhance the CNS capacity for policy formulation, coordination, and implementation. The types of coordination which can be envisioned would range from the short-range scheduling of disaster and epidemic relief efforts to the long-range considerations of research and development policies.

A recent case history may help to illustrate the situation of coordination at present. Of central importance to the rural health services needs of Ecuador is the present existence of two governmental and several private sector efforts to provide rural primary care services. Both the Ministry of Health and the Social Security Institute's Campesino Program are providing a service and outreach scheme in rural areas. These two efforts are in some cases providing services to very nearly the same catchment areas or service populations. The service modalities differ considerably between the two governmental programs--the MOH emphasizing more disease preventive elements, including an arrangement for immunization of children, which are not present in the Social Security campesino model. As a result, there has been some duplication of efforts, and a possibility exists for increasing public confusion and service problems in the future. Where is the coordination of these two service providers? Where is the sharing of operational experience to learn from each of the two agencies'

successes and failures? Up to now, there is little evidence available to suggest that such sharing or coordination is occurring in practice, and the CNS has not found a way to pursue this type of coordination. Instead, these two fairly well organized efforts to provide rural services that operate without benefit of much inter-communication. They use separate approaches to policymaking in competition to each other, as was the case also during the past ten years in their competing hospital programs.

This concrete situation, and numerous others, could be improved by use of a coordinating and deliberative mechanism such as the CNS for the health, population, and nutrition sectors. Such a mechanism would assist in the development of plans and implementation efforts in these sectors. In experience thus far, the CNS has fallen far short of providing such leadership. In the space of two years, there have been five new Ministers of Health chairing the organization, leading to future discontinuities in CNS efforts. The need to balance technical and political considerations in setting sector priorities is always a difficult problem for an organization such as the CNS. No such arrangement has yet been agreed on by CNS participating agencies for setting such technical and political priorities. Additional findings and recommendations concerning the CNS are provided below, under Issue I.

A brief summary can be given of coordination efforts outside the CNS framework. Most such coordination among agencies is dependent on interpersonal relations of various

health professionals representing the agencies whose service programs overlap or are interdependent in use of resources or share service populations. There is some amount of such subsector coordination, such as through the various committees established recently to coordinate immunization of children. There is also an improvement in the cooperative research efforts established among participating agencies in the sector. The list of such specific improvements could probably be made longer with some diligent study which was beyond the scope of work reported here. The point to be made is that national budgets are limited for health services, and the present budget situation for the MOH specifically cannot be expected to grow by any significant amount in the near future. Duplication of effort is not a suitable situation for the Ecuador health sector. Instead, the public and private sectors need a partnership to avoid duplication and maximize the benefits of resources available to each.

The consultant recommends that the CNS and the Central Bank staffs develop careful analyses of the situation with respect to use of resources in the health sector, using project funds already programmed wherever possible. The analyses can give a clearer picture than is now available of the present resource source and use situation in the public and private sectors. These data can help to create support for the CNS coordination efforts.

Finally, the development of greater coordination

is always a slow process and usually has a ceiling or limit beyond which the efforts to force coordination should not pass. There must be some room in health service to encourage experimentation and diversity in approaches. It would be disadvantageous to Ecuador for coordinators to try to strangle such efforts by maximizing coordination in rural or other health services programs.

D. Technical Assistance

How effective has the technical assistance provided by the Universidad del Valle been? Do the procedures being developed to decentralize the delivery of health services seem reasonable and workable? Has the Universidad del Valle coordination with various levels of the MOH been effective? i.e., is their work widely known within the MOH; is it becoming sufficiently accepted as a basis for the MOH's future regionalization plans?

Response. The technical assistance in health services development for the project was provided by Universidad del Valle, Cali, Colombia, under contract to the MOH and with funding provided through the AID project. The work is assigned within Universidad del Valle to the Center for Multidisciplinary Investigations in Development (CIMDER). Their contract contains a scope of work which emphasizes certain task areas as follows (as translated from the Spanish by the consultant):

"The Contractor will work directly for the Ministry of Public Health under the coordination of the Office of Regionalization (OR) and agrees to implement the work plan as determined in Section B of this number.

So that new strategies and other administrative and organic changes are introduced, the Contractor will give technical support to the OR in the following aspects and in those that have been determined necessary for said assistance:

- a. Development, implementation, and evaluation of the model for the microregion. It will give assistance to the OR and the Provincial Directorates of Cotopaxi, Chimborazo, and Manabí for implementation of the model and for regionalization of services for Levels

I, II, and III. This objective will be accomplished through: (a) development of a planning methodology for Levels I, II, and III; (b) elaboration of norms and procedures for said Levels; (c) elaboration of schemes of organization, direction, coordination, and implementation; (d) development of subsystems for information, supervision, and support resources; and (e) development of models for evaluation and control of interventions.

- b. Personnel development at the central and provincial levels. Give technical support for development of eight (8) seminars with the main purpose of improving inter-level coordination, homogenizing the lines of authority, and introducing a method of design.
- c. Integrated Primary Care (API). Give cooperation for implementing the program of API in the selected microregions, including: preparation of implementation teams for development of the programs, preparation of human resources for the API, and the establishment of a work plan and supervision scheme.
- d. Workshops in API. Give cooperation in the coordination and development of three (3) seminars in API."

For purposes of the contract with CIMDER, the concept of administrative level is defined as follows:

- o Level I--Health Post
- o Level II--Health Subcenter
- o Level III--Hospital Health Center

The work under the contract is specified to extend from 1 May 1982 to 30 April 1985. The contract contains a detailed schedule of work and a specification of the various written products to be produced during the life of the contract.

The contractor began work on schedule, but Ecuadorean counterpart participants were not provided to work with contractor staff as required, causing delays in several parts of the

work. At the present time, the work scope for the remaining period from March 1984 to April 1985 gives priority for contractor staff to extend use of the various methodologies to user officials and to evaluation of the results of their work. Due to delays at earlier points in the work which were largely outside the control of the contractor, several parts of the methodologies remain to be completed.

The effectiveness of CIMDER under this contract was extremely difficult to determine due to the many externally caused delays and changes in MOH policy occurring during their work. The various delays were in most cases caused by circumstances outside the contractor's control. Further, the contract funding envisioned no permanent, resident contractor technicians stationed in Ecuador, but rather services were to be provided on an itinerant basis from the CIMDER headquarters in Cali. Thus, the unexpected delays, changes in national and MOH policy, and various other circumstances which required a certain speed of response were not easily handled by the contractor as it was contracted to operate. On the other hand, the development of written materials and the management training provided on campus in Cali (outside the scope of the technical assistance contract) were accomplished with little apparent problem.

A small note is needed at this point. The consultant believes that it is essential in a situation such as is under discussion here (of evaluating a contractual element within

a larger development project) to be certain that a clear distinction is maintained between the contractor's negotiated contractual responsibilities and the overall project objectives. If after the contract is being executed, it is found that the contractual responsibilities were inadequately specified to meet project needs or that the situation has changed to make some of those responsibilities appropriate, then the needed action should be taken by the contracting agency (MOH) with the advice of knowledgeable contractor personnel (CIMDER). The findings in this section are presented, therefore, on the basis that CIMDER is obliged to execute the contract as it was negotiated, in the areas quoted at the beginning of this section. As a knowledgeable contractor, CIMDER is responsible also for advising the MOH on problems encountered in execution of its work. This advice concerning obstacles and problems has apparently been given on a timely basis by the contractor.

The CIMDER organization agreed to complete the work outlined above over a period of three years. In fact, the contract was let on a sole-source basis with the justification that CIMDER was knowledgeable both about the type work envisioned (management regionalization and rural health service system development) and about the history and conditions of the Ecuadorean health sector. As the contract states in part, it is the responsibility of the contractor to use knowledgeable senior professional staff to ensure that the complexities

of the work can be accomplished successfully. In fact, five well experienced experts were assigned and provided as essential personnel from CIMDER. Unfortunately, the in-country time assigned for each of these advisors was arranged in a rotation such that much-needed continuity of assistance was not always available. The consultant recommends strongly that any future or additional technical assistance provided to the project be arranged to permit either a resident advisor or longer, more frequent visits by a small number of part-time advisors.

The present situation with respect to the methodological documents required under the contract needs to be addressed. These documents were to include: operating manuals, survey instruments, and other related parts of the above regional services model. Because these materials really have not been put fully into action in actual worksites as yet, it is difficult to assess at this point what will be their impact on services. The methodology manuals are now about half completed, and they have been field tested. The development of these manuals was envisioned from the earliest stages of the project design as an important contribution of the project. The operational usefulness of such manuals will be highly dependent on their capturing the various special needs and approaches to the work as conducted in the three provinces having project sites. There is no perfect approach, certainly, to developing such planning and administrative procedures. There usually is a large payoff, however, from careful participant observations or other careful analysis

of the actual administrative units where the methods will be used. The consultant was given the impression that a major emphasis by the CIMDER team thus far has been on the operations and priorities as seen by the MOH Central Office personnel, with less attention given to direct observations of day-to-day operations in provincial and area units. It is strongly recommended that the CIMDER staff make an effort to conduct more of its methodological development efforts in consultation with provincial and area personnel. The relatively low visibility of CIMDER staff in these field site locations during the earlier period of the project should be changed, even if this requires less visibility by CIMDER staff in the MOH Central Office.

Training and workshop activities by CIMDER have been presented very effectively in the various parts of the system-national, provincial, and service unit levels. On balance, the contractor has attempted to ensure that there was adequate understanding of the regionalization and PHC models and that there was a level of coordination provided at all levels. The consultant recommends, however, that contact with provincial and area personnel is needed at the worksite beyond the meetings involved with the training programs.

A special feature of the project is the combining in one program both multisectoral rural development and administrative regionalization. The contract required CIMDER to participate in the DRI multisectoral development effort. The CIMDER

contract does not require their technical assistance specialists to participate, either in Quito or in the field, in any direct relations with the DRI agencies. The contract does specify, however, that the MOH will be given assistance in its efforts to develop integrated primary care in the project sites.

The consultant could not find evidence that this responsibility was yet being carried-out by the contractor. The responsibility to participate in PHC development depends on the availability of staff members in each planned post where training or direct interaction is to be provided. Health personnel in the DRI areas have not as yet been provided by the MOH in the quantities planned for the project nor have the various disputes over the role and posting of a sub-provincial rural health supervisor (referred to as Area Chiefs) been resolved in a manner that permitted the contractor to perform properly.

The summary findings with respect to technical assistance are that CIMDER has been highly effective under difficult circumstances that were not predictable by them in advance. Their work at the MOH Central Office level has been given emphasis over observations and assistance at provincial and service unit levels. The remaining needs for technical assistance in management, logistics, information systems, and various clinical health services activities cannot be provided under the present contract structure of visits. The project managers and directors will need to give careful attention to establishing a more effective way to provide those services and to make good use of the expertise that CIMDER has in this and its Colombia

projects shown it is able to provide.

E-1. Preparation of Health Area Chiefs

Have (health area chiefs) been delegated sufficient authority in areas of planning, budgeting, personnel, and other technical/administrative matters to play a central role in the health affairs of their areas? Have the area chiefs been adequately trained? Do they have a clear understanding of their function? What is their formal and informal authority relationship(s) with provincial health chief, regional health center hospital director, and rural doctors in their areas?

Response. Please note: The consultant has taken the liberty of reordering the questions given in Issue E. These in Part E-1 concern the preparation of health area chiefs while those below in Part E-2 are focused on in-practice experience of those in the new posts.

Preparation to establish the new administrative layer in the MOH structure was started several years before the project was planned. The definitions of roles and authority relationships were developed in the mid-1970s as part of a larger effort to establish a more responsive delivery of services outside the capitol. Before the decision in the early 1970s to establish a national health ministry, all health services were operated through provincial boards and their related hospitals and clinics. As the new administrative structure was brought into being with the formal establishment of the MOH, more uniform procedures and reporting arrangements were put into place. At the same time, provincial health chiefs were placed under the technical authority of the Minister.

The focus of the project area chief concept was on the development of a capacity to supervise and direct the non-hospital services under the provincial chiefs. The project designers intentionally left flexible the exact arrangement of reporting and authority for the area chiefs, expecting that each provincial chief would participate with their staffs in the development of the final arrangement with the project participants.

It became clear at the time of project design that provincial chiefs had known about the concept of the new sub-provincial administrative level but were not necessarily enthusiastic about the whole concept. Nonetheless, the concept's merits were explained to each provincial chief of health, and eventually the three provincial chiefs with project sites accepted the project experiments with this new administrative layer.

The project implementors have pursued actively a dialogue with various officials in the MOH to establish the dimensions, roles, and activities of the chief of the sub-province rural services, now known as an "area." The immediate problem in preparing a working arrangement for the new area chief was that the existing physician hospital subcenter directors in the project areas grew uneasy about the possibility that their jobs and perhaps their pay and benefits was redundant with the proposed new area chiefs. At the time the project was implemented in 1982, the expectation was that the MOH would complete arrangements for formal area chief posts.

fund the posts from new budgetary allocations immediately, and provide the new job-holders with a decree defining their authorities and responsibilities.

The experience during implementation was that various changes were made in the group directing development of the concept at the Central MOH level. Various other agencies became involved in arguing over the issue of creating the area chief post, there was a government-wide hiring freeze, and several other individual officials raised questions as to specific details of the new post's arrangements. At the same time, the first three designated area chiefs were being sent for training under the terms of the project for the purpose of developing their skills in planning and management of services. The training program the people attended was 3 months, conducted by the technical assistance contractor, outside their project contract, as an executive development-type arrangement for health services managers. There was no request for and no arrangement for the three to receive any special training or to coordinate their training with additional provincial officials with in the provinces where they would be working.

The trainees were given training without there being posts established by the MOH. This step was taken early in the project in an effort to ensure rapid progress in implementation. Assurances were made by the government that such new posts would soon be arranged, but various impediments

were raised by the national personnel agency. As of March 1984, the new posts have as yet not been approved, and a new set of decisions has been taken recently by the MOH to cease further pursuit of these new posts. It should be noted that a total of seven people have now held the three area chief posts under various contractual arrangements. The people were given office space and vehicles under the project funds to permit them to conduct their work in an effective manner.

Rather than trace further the difficulty of authorizing and arranging for this new post, which is mostly an interesting artifact of management development at this point, let us turn to the proposed new arrangement of authority and responsibility as defined in the latest accords. The diagram in Annex 3 shows the proposed new organizational structure of the MOH, as of March 1984, from the Minister at the top to the operating units. The MOH Central Office specialists in decentralization and regionalization are reclustered, and the area officials are at the bottom of the diagram. The diagram in Annex 4 gives then the structure of the proposed new area chief which is proposed to be combined with the post of hospital subcenter director position. A new deputy for technical support will be created for community health responsibilities and hospital management. The proposed new arrangement in this second diagram is not yet implemented anywhere in Ecuador, but it is expected to be executed in the next few months only in the three project sites.

Under the proposed arrangement in Annex 4, the person who formerly held the post of chief of the hospital health center would assume the area-wide responsibilities for health services. The post was designated previously as a political appointment with the added option for the office-holder also to operate his or her own private clinic after hours. The proposed new arrangement would eliminate the political status and the option for private practice for the chief of the hospital health center. Instead, additional pay and emoluments would be added to those already paid for that post.

All the arguments and counter-arguments that passed during the two years since the project started were, in the opinion of the consultant, extremely important to developing a consensus definition for the community health service in the MOH. In fact, the process was apparently successful in helping MOH community health advocates to identify individuals whose vested interests and priorities led them to oppose the increased role for community and rural health in MOH programs. It now is quite clear that little if any forward movement was likely to occur in strengthening rural health services activity if those changes would threaten the interests of the hospital service staff members or their private medical colleagues. Furthermore, in spite of the priorities expressed by high-level government officials favoring improvement of PHC services, government regulations were not changed to permit adoption of the new "area" level community health posts.

The crucial underlying matter in the debates that was missed apparently by many of the participants in the two years of discussions is that close supervision and active outreach of MOH services can be arranged successfully without threatening the success of the hospital program. This staff member must have the authority to direct the work of rural physicians, nurses, sanitarians, and others. Since the time this project was under design, it has mattered not at all what title or level is assigned to that supervisory position. The debates over who is to be on top--hospital director or area chief--were apparently a smokescreen to impede progress toward the underlying purpose of strengthening community health delivery systems. The added burden of planning, budgeting, personnel relations, and other administrative functions can be added in the future as the potential benefits are permitted to materialize. In the meantime, the main idea all along was to ensure the close supervision by a person not afraid to act in the field with technical competence and a genuine concern for rural populations--while probably also having to get involved directly in going to work with the health workers in the field.

Finally, the place for training these people responsible for making community health services work in the field should be located as close as possible to the eventual worksite. The consultant was originally an advocate during the project design phase for the out-of-country training arrangement

as executed thus far in the project for area chiefs and now accepts part of the blame for the jealousies that have arisen in their relations with often less-well trained provincial office personnel. The local jealousies over pay, status, and authority can be reduced with training done closer to home, and there will be less likelihood that the training will make the job-holders quite as mobile as they are at present. The area chiefs' foreign education, among other factors, seems to be making them especially marketable for acquiring posts in other parts of the Ecuadorean health system.

The content of training for these people should be based in the future on the same basic concepts being taught to previous area chiefs in the program at Cali. Insofar as possible, however, the programs should be arranged as on-the-job training. The curriculum should be made up of a combination of topics in: primary care, rural sociology, and supervisory skills. The manuals being prepared under the technical assistance contract should be used to supplement and extend the effectiveness of the training given to the area person.

E-2. Practices of Health Area Chiefs

What role are health area chiefs playing in the planning, implementation, and evaluation of health programs in IRD areas? To what extent is their role constrained pending completion of UV's work noted above? Are they effectively coordinating health programs with the IRD executive units?

Response. The project is being implemented at one site on the coast and at two sites in the Sierra. A permanent health area chief post was to be created by the MOH at each site, working as regular MOH staff members. These posts were never created due in part to a government-wide hiring freeze. Contract posts with AID funding are being used to hire people as an interim measure. The instability of work arrangements and the uncertainty of the salary, which was supplied under three-month contracts from project funds, are the reasons most often cited for turnover of the people in these posts. To date, there have been seven holder of these three posts. The consultant was above to interview five of the seven past and present health area chiefs.

The health area chiefs have had little success thus far in exercising much supervisory authority over MOH staff members, owing in part to their impermanent, contractual attachment to the MOH. They have in many cases been successful as planners and expeditors for services offered within the project areas. The importance of continuing to pursue a strengthening of the supervisory, service improvement role

at the "area" level cannot be over-emphasized. The working relationships established by some of the area chiefs have extended to local officials, IRD executive units, and the provincial MOH staffs as well.

Each of the three project provinces has offered their health area chiefs a different degree of support for extending rural health services and provided them with a different working environment within which to operate. In the most hospitable and supportive case, the area chief was provided with an excellent opportunity to develop services and gain resources for their local service populations. The less supportive case demonstrates how easily the needs of rural populations can be ignored and how local MOH staff members can place resources to assist hospital service programming ahead of those in primary health care.

The CIMDER role in furthering the role of the area chief cannot be expected to precede the MOH policymaking process. That is, until the MOH develops a consensus and policy as to the role of the area technical chief, area chief, and hospital health subcenter director, CIMDER technical assistance work cannot successfully be completed. It is inappropriate and in the long-term dysfunctional for the foreign technical assistance team to enter the debate as advocates on one side or the other of a largely political issue such as that involving the area chief. To their credit, the CIMDER staff has managed to assist the process of the debate without being sucked

into the center of the argument. Unfortunately, the CIMDER role in on-the-ground assistance to the Area Chiefs has also been hampered by this necessary arms-length relationship.

Documentation of procedures and concepts was intended to lay a permanent foundation for improving rural service supervision. The documents that are being prepared by CIMDER, such as manuals and training materials, can help to strengthen the work of the community health supervisor--whoever that person eventually is. Delays in completing preparation of the planned document series as scheduled has been somewhat detrimental to development of effective action roles by the area chiefs. The delays were, however, largely due to factors outside the control of the contractor. As the materials are now being brought into their final form, it is recommended that the preparers and editors should be especially careful to ensure that they are all given a practical, applied point of view. All examples and illustrations used in the documents should be drawn from the immediate local situations being faced in rural Ecuador.

F. Health Area Concept Acceptance

Do provincial and national authorities understand and support the area concept? What support or training do they require to be able to replicate the area model outside of IRD areas?

Response. The area concept, as it is now understood by the consultant, is proposed to be made up of both a structure and a process whose aim is to ensure cost-effective rural services are delivered by MOH. The structural features of the area concept are contained in the idea that services covering an entire province of Ecuador cannot be kept at top effectiveness and within budget from a single management service delivery location in the capital. Experience in Ecuador during the more than ten years since the founding of the MOH bears out the accuracy of such a finding. Services have varied greatly from one rural area to another, and there is reason to believe that rural services have not received sufficient management attention or other resources needed to permit cost-effective delivery of services in all rural areas. The process features of the area concept are embodied in the idea that supervision must be given regularly, close to the worksite, and by people knowledgeable about the immediate area where the workers, such as rural physicians and nurses, are practicing. Furthermore, the process of conducting area-wide (i.e., subprovincial) services is to include provision for efficient referral of patients needing more elaborate services.

The present attitude concerning the area concept among many provincial and national health officials seems to be that the status quo is acceptable in a time of tight budgets. The status quo in this case means that the provision of services is to continue as an arrangement favoring hospital-based care. There is no hard data to support this opinion, but the consultant's impression is that not many more MOH officials now support the idea of strengthening area-level supervision and service operations than did five years ago.

The problem here of course is that there is a lack of hard data to demonstrate the need for a change. Often it is only epidemics and disasters that cause officials to see existing public services--particularly primary health care services--in a new way. There was a decline in support relative to inflation for the various vertical disease control and environmental health services during the past ten years. There was to have been a counteracting strengthening of the community health and local sanitation programs of the MOH. The MOH seemingly has lacked an urgent reason for diverting resources from other priorities to the work of the primary health care services and therefore to the area concept. A change may be on the way to force a change in those policies. There is at present an overwhelming problem of malaria outbreaks in the coastal zones since the 1983 rainfall. This increased disease incidence may provide some additional motivation for considering a stronger non-hospital service delivery system.

In any event, there is a need to provide documentation of the cost-effectiveness of services delivered by the MOH. It is recommended that studies be conducted of cost-effectiveness under the various organizational models now in place for sub-provincial service, including a comparison of the MOH and Social Security campesino program models. The MOH officials who are in a position to study and use such data are well-trained and knowledgeable about health policy analysis. It seems unlikely that action for national replication of a strengthened sub-provincial primary health care program will occur without such studies and well-organized data. The consultant recommends that a health economist, knowledgeable about the Ecuadorean health system, prepare data for use in further development of the system and for orientation of MOH officials.

G. Food Policy Studies

What has constrained the design of food policy studies and pilot food/nutrition activities by the IRDS? Should funds for this activity be reprogrammed?

Response. The situation with the food policy studies and pilot activities is somewhat confusing. The Integrated Rural Development Secretariate (IRDS) takes the general perspective that without an emphasis on food the work of the other health activities in integrated rural development are of lesser value. On the other hand, the IRDS has repeatedly refused to move forward with the planned food policy studies and related activities in the project.

A workshop was held during June 1983 to discuss nutrition and primary health care, during which a number of food policy issues was presented. The expectation by most observers after those sessions was that the IRDS would soon begin to move forward with the development of these studies in conjunction with Ecuadorean researchers. Up to now, there has been little additional effort shown in developing the studies. The only available explanation for the lack of progress was the suggestion that the host government's portion of the funding for the studies and for the pilot activities might not be immediately available to pay the matching costs. AID requirements for satisfying the counterpart contribution aspects of the funding are quite flexible, though, so other reasons must be affecting progress.

The recently arrived contract nutrition advisor in AID/Ecuador is attempting to uncover the cause of the delays and should be encouraged to continue the pursuit for a time to get an explanation for the seeming lack of action with respect to this project element. Unfortunately, during the short time in country, the consultant was unable to uncover much new information of value in understanding this problem. If a prolonged additional delay appears to be likely in development of this work, the funds definitely should be reprogrammed.

#### H. Supplementary Feeding Program

What activities should be programmed, in conjunction with a separately funded evaluation, to improve the supplementary feeding program? How can the local administration of this program and broader nutrition concerns be integrated within the area model?

Response. The supplementary feeding program in Ecuador dates back many years, using a food supplement product known as leche avena. The product contains oats (70%), milk (15%), and defatted soy flour (15%). An effort has been made, with AID assistance, to shift the mix of ingredients to ones which are locally produced, thereby reducing or eliminating a future demand on foreign exchange to sustain the program. The redesigned product consists of: rice (70%-65%), milk (15%-17%), and soy (15%-18%). This product is called leche arroz.

Many factors have affected the logistical and administrative aspects of the MOH program for supplementary feeding. Most recently, the 1983 rains caused destruction of rice and soy crops. There is no doubt about the political popularity of the program. In a broader perspective, the effectiveness of the program in economic or nutritional terms has never been confirmed. A series of special evaluations was designed with AID funding during the past year for the purpose of determining the effectiveness of supplementary feeding programs in Ecuador. Progress has been very slow in completing the arrangements for the evaluation research. The central questions of the

studies are ones such as: What is an adequate ration per month (in kilos) for the target population? Is it better to target the distribution to specially selected, high risk population groups rather than the present broader distribution arrangement? Are there discontinuities in the distribution chain that are affecting the effectiveness of supplementary feeding?

Several options are being considered for the final design of the evaluation research. These options actually would produce quite different types of research findings and are likely to require quite different amounts of time to complete properly. Without getting into the details of the research designs, one school of thought is that the evaluations should aim to determine the effectiveness of the program by use of extensive national surveys that will require a number of years to produce results. Another approach to the design being considered would instead aim to produce valid but less exhaustive findings about key variables which will affect the near-term operation of the supplementary feeding program. The consultant recommends adoption of this latter approach, because it offers much greater utility within the time and funding constraints for results to be produced that are useful to policymakers.

With this background information, the supplementary feeding program as it has evolved can and should become an integral part of the area model for primary care services.

The local units in the MOH system, including health posts and health subcenters, are already distribution points for the food products. Their involvement in nutritional education can be strengthened by additional training for the local nurse auxiliaries and for other service provider staff members. The eventual resolution of how the sub-province or "area" will be supervised for MOH programs should contain an arrangement for supervising nutritional education, surveillance, and supplementary feeding responsibilities.

## I. National Health Council

What has been the National Health Council's role in formulating national health policy? How might this role be strengthened? What studies/workshops has the NHC conducted? What impact have they had? What future studies/workshops are needed or planned?

Response. The National Health Council has a mandate to provide the government with policy studies and a forum for resolution of policy problems in the health sector. The Council was created under the terms suggested in the last national development plan with membership from the major health service provider agencies. The Minister of Health chairs the Council and the MOH has recently arranged for a secretariate to provide support in addition to the small professional staff that was hired at the time of its creation.

During the last two years, there have been three studies and workshops conducted by the Council:

1. Priorities for health research (1982). The final that seminar was published in early 1984. Attendees included members of the Association of Medical Faculties and others from the Council's membership. The meeting recommended approaches to strengthening health research of all types and proposed establishing two awards for research excellence--clinical research and socio-cultural research.
2. Uniform service norms workshop (1983)
3. Training of auxilliary nurses workshop (1983)

The Council proposes in the coming year to conduct studies and workshops in the areas of: revising the national sanitary code, development of health planning information systems, supply and demand studies of human resources in health, supply and demand for health services, and further studies of service system norms (including geographic service levels, facility coverage, and other resource levels).

The operations of the Council are hampered by difficulty in reaching consensus on the procedures to be used in resolving conflicting views among members and the exact relationship between Council actions and those of the member organizations. The discussion of complex issues which affect the Council's member organizations in various different ways is bound to make the operations difficult. The council has had its greatest success as a forum for communicating upcoming actions and identifying cross-cutting problems shared by members. The Council has not had much impact to-date in getting adoption of government-wide policy that involves compromises for member organizations.

A key role of the council, which has as yet remained unused, is that of broker for administering policy studies in which several agencies have an interest in the results. The workshops held thus far provided some opportunity for sharing of information and opinions among participants. Council-directed research has yet to move forward. The agenda of policy studies planned for the future, as outlined above,

can provide a valuable service to member organizations if the studies are conducted with a view to the practical application of their results. It is recommended that the secretariate of the council do all in its power to avoid further delays in the initiation of these studies and the rapid distribution of their findings (including interim findings) to ensure that members do not lose interest in the Council's activities.

J. Programming Changes Recommended

In accordance with experience realized thus far within the components of the project, what changes are recommended, if any, in programming funds or modifying the project agreement?

Response. The project was designed to meet several objectives which in some ways are in conflict with one another. Many agencies were brought to administer the project on a joint basis. The result has been an understandable difficulty in keeping the project schedules and in maintaining complete cooperation among the participating agencies. To begin any discussion of programming changes or modifications to the project agreement, it is necessary to establish a clear, up-to-date picture of the various objectives being sought and their present merits. There may be a need to simplify and sharpen the objectives of the project with respect to the MOH and SEDRI responsibilities which are discussed above in this report. The objectives as interpreted by the consultant are now as follows:

- Create a regional administrative model for the MOH
- Develop a primary health care model for rural areas
- Operate health services within the Integrated Rural Development Scheme of the national government

Because only a few interested people apparently know about and understand all three objectives, often the participants'

policies and perspectives have tended to focus on one or at most two of the objectives. For example, the lengthy debate over proper roles and employment rules for area chiefs of health appears to have been prolonged due to a tendency for different participants to hold one or another of the objectives as a higher priority than the others.

The consultant would advise the reduction from three to at most two of the above objectives if the present government policy directions will so permit. This would permit the concentration of funds and attention on a less contentious set of activities. It is not appropriate for the consultant to take a decision here in favor of one or another of the objectives. It is appropriate to say that the present team of host country project directors has demonstrated a competence that should permit excellent progress to be made in pursuit of such a more sharply focused set of project objectives.

The proposals being discussed at this time for redirection of work in general terms would focus project implementation activities on other IRD areas or on full provinces where there now are project sites. Either of these arrangements could be appropriate, depending first on the decision of project participants as to the specific objectives that they are trying to reach. Reprogramming of funds and effort should flow from decisions taken with respect to the objectives and sites to be given attention. These decisions should be taken as soon as possible.

The next step in considering reprogramming options is to determine the resource requirements and potential benefits from the options. These analyses will require review of present project costs and expected recurring costs of the elements in the delivery system models. A preliminary cost assessment should be prepared in the immediate future by a financial analysis specialist.

There is a problem that will inhibit the completion of such an analysis, however. A considerable lag is being experienced in clearing vouchers to cover expenditures under the project in all components and with all participating agencies. In general, the flow funds requests runs from participating entities through the SEDRI central office to AID. There are several present problems and several underlying difficulties in the present arrangements.

There were advances of funds provided to several project components for use in implementing the project. The use of the advanced funds is then to be followed-up by expense vouchers documenting their expenditures. In several large-scale spending units of the project, such as water supply, the advances are processed so slowly in SEDRI that the operating agencies nearly or actually run out of money. AID officials have been very diligent in tracing each step in the processing of financial papers to detect where there are delays, but the delays persist.

Another problem in other parts of the

project, including the MOH activities, has been that financial papers are not processed by the implementing agencies to document expenditures until long after the spending action is completed. In some cases this delay was found to be caused by multiple rejections of vouchers submitted by them to SEDRI for processing.

SEDRI officials have adopted in their operations a very strict, rigid process for approving the submitted financial vouchers for all their international projects, including the health project. The result is that large amounts of documentation are being required from implementing agencies (much more than is required by AID), and often the entire package of voucher papers is returned to the submitting agency for lack of a single receipt. The effect of this procedure has been that agencies are reluctant to submit papers on a timely basis. Classes have even been held to train personnel responsible for preparing and processing financial documents under this and other AID integrated rural development projects, but the problem persists. It is claimed, perhaps with some justification, that the regular routines followed by cabinet-level ministries such as the MOH are much slower and complex for processing financial papers than are those of SEDRI. These commentators suggested that slow administrative procedures of all types in ministries were one of the bases for justifying the establishment of a freestanding SEDRI, which is permitted to develop its own administrative processes.

The result of this set of procedures used during the first two years is that, while many improvements in processing were already accomplished, it is very difficult to determine precisely what is or is not spent by participating agencies from project funds. The consultant recommends that a brief meeting be held with all implementing agencies to explain again the nature of the problem and its consequences. The meeting should be followed by a thorough joint USAID-Ecuadorean review of the present spending levels and budgeted amounts to determine the exact situation with respect to each project component.

The reprogramming can then be considered on the basis of concrete financial information. The reprogramming should be conducted to give a high priority to needs for additional technical assistance as described above during the remaining 2.5 years of the project. Attention should be given especially to ensure that provincial-level technical operations are strengthened.

ANEXO No. 1

PROYECTO 518-0015 y 518-U-040

EVALUACION

AGENDA DE TRABAJO

Marzo 7 - Abril 5, 1984

Martes 6 de marzo

Mañana

- 08:00 - 12:00 Reunión Preparatoria:
- Aprobación de la Agenda de Trabajo
  - Discusión y aprobación de la metodología y de los instrumentos para recolección de datos.

Tarde

- 12:30 - 16:30 Estudio de la documentación disponible.

Miércoles 7

- 08:00 - 11:00 Preparación de entrevistas
- 11:00 - 12:00 Visita de cortesía al Ministerio de Salud y autoridades del Ministerio.
- 12:30 - 16:30 Entrevista con el C.N.S.:
- Dr. Fausto Andrade
  - Dr. Eduardo Navas
  - Dr. Oswaldo Egas
  - Dr. Crnl. Guillermo Iturralde

Jueves 8

- 08:00 - 12:00 Entrevista con autoridades del Ministerio de Salud Pública - Nivel Central.
- Subsecretaria de Salud: Dra. Guadalupe Pérez de Sierra
  - Director General de Salud: Dr. Mauro Rivadeneira
- 12:30 - 16:30
- Director del ININMS: Dr. Julio Alvear
  - Director de Planificación: Dr. Enrique Vera
  - Anterior: Dr. Fausto Andrade
  - Director de Programas Prioritarios: Dr. Ricardo Freire
  - Director de Servicios Médicos: Dr. Ricardo Freire
  - Lda. Isabel Sandoval

Viernes 9

- 08:00 - 14:00 - Jefe del programa de control de diarreas: Dra. Ligia Salvador

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- Jefe del PAI: Dr.  
Anterior: Dr. Humberto Baquero
- Coordinador con Proyecto DRI - Dr. Edgar Moncayo
- Jefe de Educación para la Salud: Lcdo.

14:00 - 16:30 Entrevista con personas de la OPS/OMS.  
- Representante: Dr.  
- Asesor: Dr. Merlin Fernández

Sábado 10 Análisis de la información obtenida.

Lunes 12

08:00 - 12:00 Entrevista con funcionarios de SEDRI  
- Director Ejecutivo:  
- Anterior: Econ. Fausto Jordán  
- Funcionarios: Jaime Borja - *2000*  
- Lcda. Susana Larrea  
- Econ. Rodrigo Ricaurte  
*Carmen Carosco*

12:30 - 16:30 Entrevista con personeros de CIMDER:  
- Director: Jorge Saravia  
- Esmeralda Burbano  
- Lcda. Yolanda Romero  
- Dra. Diana Zapata

Martes 13

08:00 - 12:00 Análisis de la información obtenida.

12:30 - 16:30 Preparar visita de campo Area DRI-JIPIJAPA

Miércoles 14

07:00 Viaje a MANTA - TAME vuelo No.

09:00 - 12:00 Entrevistas y discusión sobre el Area DRI-JIPIJAPA con funcionarios de la Dirección Provincial de Salud de MANABI.

- Director Provincial: Dr. Villacrés
- Jefe de Programas Prioritarios:
- Jefe de Finanzas:

12:30 Viaje a JIPIJAPA

14:00 - 16:30 Entrevista con funcionarios del Area DRI  
- Jefe de Area: Dra. María Elena González  
- Anterior: Dr. Abelardo Andrade - *2000*

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Jueves 15

- 08:00 - 10:00 Entrevista con:  
- Jefe del Proyecto SEDRI: Ing. Angel Orlando  
- Director de CSH: Dr.
- 10:00 - 16:30 Visita a Subcentros de Salud y Puestos de Salud entrevistando a:  
- Médicos de Subcentros  
- Promotores de Salud  
- Dirigentes de UPOCAM  
- Otros líderes de la comunidad y autoridades civiles.
- (Los evaluadores se dividirán en grupos según su interés.)
- (Se pernoctará dos noches en MANTA - Hotel GAVIOTA)

Viernes 16

- 08:30 Viaje de regreso MANTA-QUITO, Vuelo TAME No.
- 10:00 - 16:30 Análisis de la información obtenida.

Sábado 17 Análisis de la información obtenida.

Lunes 19

- 08:00 - 14:00 Preparar visita de campo Áreas DRI QUIMIAG-PENIPE y SALCEDO.
- 14:00 Viaje a Riobamba - vía terrestre - Hotel Galpón.

Martes 20

- 08:00 - 10:00 Entrevista con autoridades provinciales de Salud de Chimborazo:  
- Director Provincial: Dr. Gualberto Mariño  
- Jefe de Programas Prioritarios: Dr.
- 10:00 - 16:30 Visita al DRI QUIMIAG-PENIPE y entrevista con:  
- Jefe de Área: Dr.  
Anterior: Dr. Marco Quintana  
- Representante de Director Provincial en AREA DRI:  
- Jefe del Proyecto SEDRI:  
- Médicos de Subcentros y Puestos de Salud:  
- Promotores de Salud:  
- Líderes Comunitarios:

- Autoridades Civiles:
- Miembros de la Comunidad:

(Los evaluadores se dividirán en grupos según su interés.)

17:00 Viaje de regreso a LATACUNGA, vía terrestre - Hotel Rumipamba de las Rosas

Miércoles 21

08:00 - 10:00 Entrevista con autoridades provinciales de Salud de Cotopaxi

- Director Provincial: Dr. Ramiro Parreño
- Jefe de Programas Prioritarios: Dr. Barrezuete

10:30 - 16:30 Visita al Area DRI SALCEDO y entrevista con:

- Jefe de Area: Dr. Anterior: Dr. Jaime Valencia
- Jefe de Proyecto SEDRI: Ing. Oscar Escola
- Educador: Lcdo. Jaime Arias
- Director del CSH de Salcedo: Dr.
- Médicos de los Subcentros y Puestos de Salud
- Promotores de Salud
- Líderes comunitarios
- Autoridades civiles
- Miembros de la comunidad

(Los evaluadores se dividirán en grupos según su interés.)

17:00 Viaje de regreso a QUITO.

Jueves 22 Análisis de la información obtenida.

Viernes 23 y Sábado 24

Preparación del borrador del documento

Lunes 26 - Viernes 30

Discusión del borrador y redacción final del documento en español e inglés.

Lunes 1ro de abril

Presentación de las conclusiones y recomendaciones al Señor Ministro de Salud.

Jueves 4 - Viernes 5

Seminario para análisis del documento y búsqueda de nuevas estrategias para aproximadamente veinte funcionarios responsables del Proyecto del MSP-SEDRI-CIMDER y el grupo de Evaluación.

Annex 2

LIST OF PEOPLE CONTACTED

National Health Council

Fausto Andrade, MD, Deputy Director

Ministry of Health, Central Office

Guadalupe Perez de Sierra, MD, Subsecretary  
Edgar Moncayo, MD, Planning

Ministry of Health, Province of Manabi

Julio Villarreses Colmont, MD, Province Director  
Maria Elena Lopez, MD, Jipijapa Area Chief (Contractor)  
Alvarado Andrade, MD, Former Jipijapa Area Chief (Contractor)

Ministry of Health, Province of Chimborazo

(Province Director Absent)  
Marco Quintana, MD, Former Quimiac-Penipe Area Chief  
Alfredo Naranjo, MD, Quimiac-Penipe Area Chief (Contractor)  
Jorge Araujo, Engineer, Quimiac-Penipe DRI Area  
G. Vilema, Nurse, Quimiac-Penipe DRI Area  
Julio Cesar Proaño, IEOS

Ministry of Health, Province of Cotopaxi

Ramiro Parreño, MD, Province Director  
Jaime Arias, Health Educator  
Dr. Jijon, Salcedo Hospital  
Dr. Malasareas, Rural Physician  
Max Arias, MD, Salcedo Area Chief

Integrated Rural Development, Secretariate (SEDRI)

Jaime Borja, Engineer  
Susana Larrea, Nutrition  
Carmen Carasco, Finance

Integrated Rural Development, Jipijapa

Angel Orlando, Engineer, Chief

Integrated Rural Development, Salcedo

Oscar Escola, Engineer, Chief

Universidad del Valle, Cali, Team (CIMDER)

Jorge Saravia, Ph.D.  
Yolanda Romero

USAID/Ecuador

Paul Fritz, Ph.D., Deputy Mission Director  
Kenneth Farr, Ph.D., Chief, Health  
Robert Jordan, Ph.D., Capital Development  
Herbert Caudill, Sanitary Engineer  
Manuel Rizzo, Population  
Jean Audrey White, Ph.D., Nutrition (Contractor)  
Eduardo Navas, MD, Health Advisor (Contractor)  
Gustavo Estrella, Ph.D., Health Project Coordinator  
(Contractor)

Project Evaluation Team

Patrick J. H. Marnane, Team Leader  
Hugo Corral Ruivola, MD, MPH

Others

Reynaldo Pareja, Academy for Educational Development  
Frederick Hartman, MD, MPH, Management Sciences for  
Health  
David Nelson, Ph.D., Nutrition Advisor (Contractor)

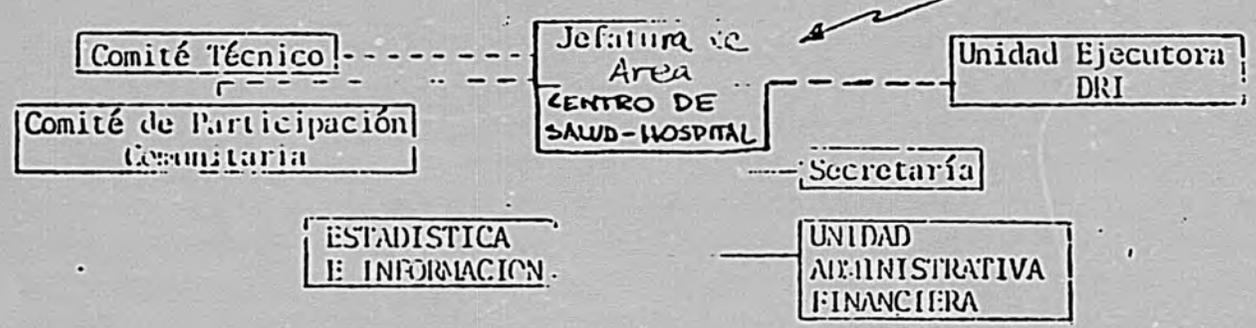
Facilities

Quimiac Health Subcenter, Chimborazo Province  
Cinco de Julio Health Post, Manabi Province  
Penipe Health Subcenter, Chimborazo Province  
Cusubamba Health Subcenter, Cotopaxi Province  
Province Health Office, Cotopaxi  
Province Health Office, Chimborazo  
Province Health Office, Manabi  
Integrated Rural Development Office, Jipijapa  
Integrated Rural Development Office, Quimiac-Penipe



Franco Sarcosio / Navas  
23, 1984

### ORGANIGRAMA DEL AREA DE SALUD

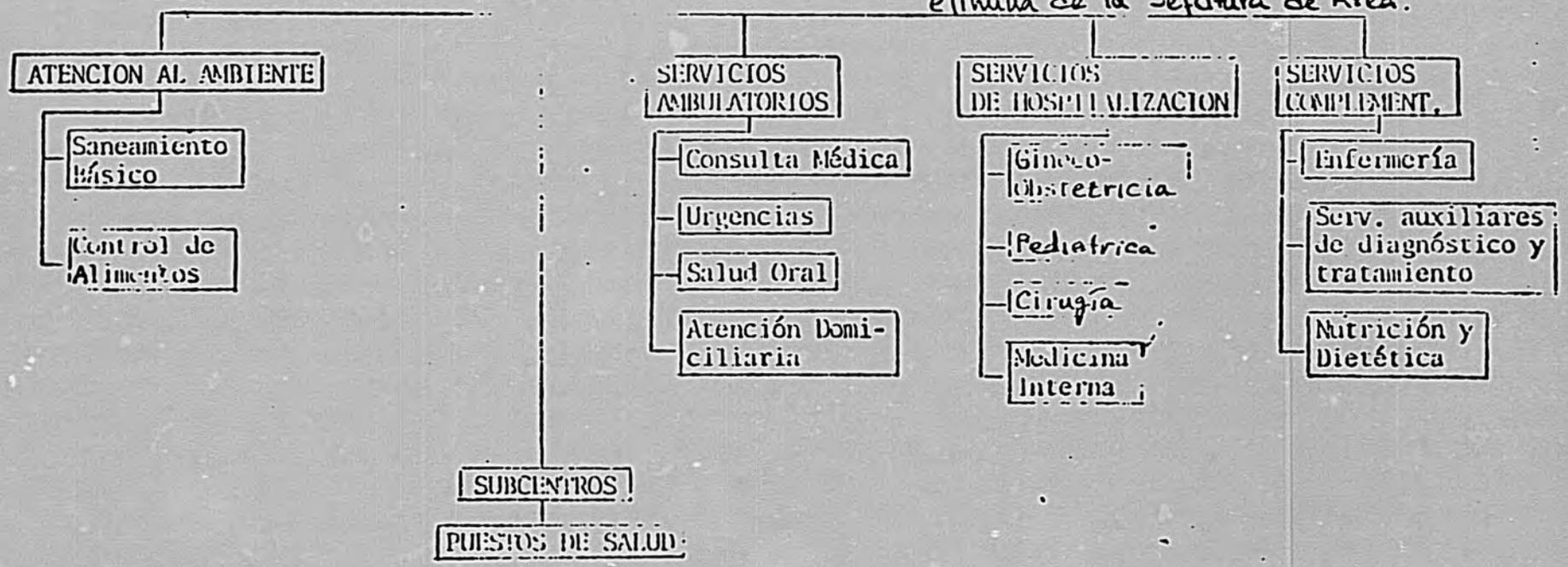


*cambio*

*Nueva unidad*

UNIDAD DE APOYO TÉCNICA

La responsabilidad del trabajo en las áreas pasa a esta Unidad (Dpto?) y se elimina de la Jefatura de Área.



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XD-APP-492-B

ISN = 35408

EVALUATION  
OF  
INTEGRATED RURAL HEALTH DELIVERY SYSTEM

ECUADOR

May 1984

Loan Number: 518-U-040  
Project Number: 518-0015

By Patrick J.H. Marnane  
P. O. 518-4-III-L

Evaluation Team

Hugo Corral  
Robert Emrey  
Frederick Hartman  
Patrick Marnane

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## PREFACE

This report provides background on the DRI-Health project and a discussion of the evaluation strategy including its assumption and expectations. It also addresses concerns not elsewhere covered by the other outside evaluators.

Initially, the plan for this report was to have a single document incorporating the observations, analyses and conclusions of three consultants. Because of the exigencies of other commitments and the physical separation of the consultants following our work in Ecuador we have produced three documents. This is the third of the set. Additionally, during our evaluation visit there was another special evaluation of the diarrheal disease and immunization program conducted by Dr. Fred Hartman of PRITECH. Dr. Hartman has provided another separate report.

During the conduct of the field work the three consultants worked together on a daily basis. While we focussed in part on separate concerns there was close cooperation and persistent sharing of observations. There was also general concurrence on concerns we had the opportunity to consider mutually.

Because of different experiences and different perspectives, however, there were necessarily some differences as well. Some of these differences are a matter of emphasis others stem from the specialized interests and skills of the evaluators.

It is not the purpose of this document or the three reports to generate absolute consistency and agreement. That was less the point of this evaluation exercise than was identifying issues, illuminating problems of both plan and implementation and to suggest possible ways of altering the program to improve its effectiveness in doing what the GOE, project administrators and the people being served want it to do. This perspective will be elaborated more fully below.

We want to acknowledge the spirit of full cooperation and help on the parts of these with whom we worked in carrying out this evaluation. Without their openness, their willingness to point out problems, mistakes, and lessons learned and their insight, the entire process would have been considerably less valid.

With negligible exceptions, busy people with important jobs to do graciously rearranged schedules, offered resources and assistance, and otherwise responded with alacrity to what should probably be considered inconvenient requests. Even these without continuing vested interests in this particular project graciously gave of their knowledge, insight and time. Their kindness, interest and patience are warmly appreciated.

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## INTRODUCTION

The overall purpose of the Project is to develop a nationally replicable low cost health service delivery model in three Integrated Rural Development areas of Ecuador. To do this the Project has established three integrated objectives that form the basis for project design and implementation. While they have in some places been spelled out slightly differently, the goals these have enjoyed are the following:

1. To create a regional (decentralized) organization for the administration of health services.
2. To develop a model for the provision of primary health care.
3. To incorporate health services into the integrated rural development sector.

The basic elements of the Project model are, briefly stated:

1. Establishment of area chiefs
2. Expansion of primary care
3. Extend coverage of pure water supply and sanitation
4. Nutrition activities to improve availability and distribution of basic foods.

The expected outcomes of these include

- . Extend health services delivery and provide additional resources in high priority rural areas.
- . Promote the utilization of lower cost primary care service
- . Rationalize health service delivery by coordinating efforts of health services institution in geographic areas.
- . Facilitate extension of low cost water and sanitation services by using low cost technologies.

- . Incorporate nutrition concerns in program design and implementation.
- Decentralize decision-making responsibility and facilitate community participation in the decision-making and implementation process.

### Background

The Rural Health services project emerged out of the interest of the Roldos-Hurtado administration which was concerned with rationalization and expansion of government services aimed at the rural poor of Ecuador. AID's strategic focus during the 1970s was also concerned with providing better services to the poor majority, with the aim of improving health and well-being and enhancing the ability of the poor to meet their own needs in AID assisted countries. This correspondence of interests first became manifest in Ecuador in the funding of a pilot project for integrated Rural Development.

This health project was viewed as a one that would have its own integrity, but would also be part and parcel of an overall scheme for integration of development efforts. Health was considered to be a specialized concern that could not be totally subsumed under fully independent local development agencies. It required special links to more sophisticated and broader health service facilities and administrative system. At the same time a need was seen for decentralization of that administrative structure for purposes of regional and micro-regional adaptation to special circumstances. The regionalization plan allowed for the development of close ties with other regional programs and

local conditions while maintaining a rational vertical support system as well.

Decentralization was viewed as institution building in the health sector of Ecuador. The new position of Area Chief was viewed as the keystone of the revised institutional arrangement. Area chiefs were to be given intensive training in health administration and then they would have primary responsibility for all extra-hospital health concerns in the selected micro regions.

The already existing positions of Provincial Chief was also to be strengthened under this project. They were to be given greater autonomy and control over a pyramidal health service/facility system that had as its base the local health promotor and health posts building through ever increasing level of sophistication to health subcenters, hospital health centers and provincial hospitals. Tertiary care hospital were located only in major urban areas, i.e. Quito and Guayaquil. Rationalized referral mechanisms would channel patients to appropriate care facilities.

This hierarchical referral structure had been developed during the 1970s. Although many facilities had been constructed. The operational mechanisms and administrative personnel were lacking. The regionalization plan was an attempt to put major administrative responsibility at the provincial level, closer to the level of operations and thus more responsive to local concerns.

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At the time the health services program was initiated the seventeen areas (or micro-regions) in which the Integrated Rural Development Project was to be implemented had already been selected. The criteria for selection of the seventeen were largely economic and agriculturally based. A major criterion was anticipated cost per-capita for implementation. They are scattered among several provinces in Ecuador.

From the original set, the health project decided on three in which to implement its plan. These were selected so as not to conflict with health projects supported by other international donors and as representative of the two most popular regions of the country the coast and the sierra. Jipijapa in Manabí was chosen as a coastal area. Quimiaz-Penipe in Chimborazo and Salcedo in Cotopaxi were selected in the sierra.

The health project has involved not only the Integrated Rural Development secretariat but draws on the Ecuadorian Institute for Sanitary works (IEOS) as well. IEOS has major responsibility for letrization, water support system development and health service facility construction and refinishing.

It should be mentioned that IRD and the Integrated Rural Health Delivery projects are not Ecuador's only experience with integrated development schemes. Mision Andina was the most notable recent experience. This was a program that was developed and operated during the 1960s and incorporated developments of agriculture, health, manual arts, sanitation,

water supply. The present health project has been able to draw on the experience of some who were involved in Mision Andina. Some community programs begun under that program were continued under other local and provincial auspices.

Evaluation Assumptions and Setting

At our initial meetings the evaluation group agreed to an evaluation strategy that would involve program personnel from all levels in a fully participatory manner. We also agreed that the process of evaluation and the exchange of information regarding ideas, perspectives, experience, problems, conclusions and recommendations among program personnel would constitute the major contribution of the evaluation process. The documents that were to be written by the outsiders were of importance largely to the extent that they reported and introduced systematic focus to those concerns. We also agreed that our success should be measured in terms of the fullness of debate and elaboration generated on the parts of those responsible for continued project operation. It was in this spirit that we tried to work. It is to the credit of all those with whom we worked that they showed genuine openness and awareness to one another and to us as outsiders. Project leaders are to be thanked for having engendered an environment which supports such openness.

The evaluation considers the program in terms of its plan and stated goal, but has the benefit of being able to see contextual conditions more fully than was possible in the planning phase. We tried to take into account the limiting contextual factors and to understand better how the program had influenced its environment, its impact on political, social and health awareness.

Necessarily, an evaluation is a critical process. This does not mean that it is wholly negative, however. It means that we look at criteria and standards and try fairly to find where program have not met expectations. It also means that problems that have emerged both within the program and in its context will be identified. Much of this was simply not anticipated prior to program implementation and increased awareness on the parts of those involved. Evaluation then is at least partly a matter of assessing the extent to which planned activities can work in a world of limits, of competing expectations, of resource availability and of changing needs and awareness.

Viewed this way, evaluation is not only a matter by which quantitatively measured achievements. It is more a reflective process of reconsidering performance, (expected or not), plans and goals, resource capacity, and the needs of policy makers and of those who are expected to benefit from the services system.

Although this project, as any other organizational systems, is viewed here as a means of checking prior assumptions and hypotheses and an opportunity for revising these, it is not evaluated as a tightly controlled "scientific" experiment which offers a chance for looking only at a few neatly measured variables. We consider the program a system of considerable complexity which operates in a complex environment.

Our evaluation was both intensive and extensive. Still, the analysis represents only a partial view: We observed operations for a relatively

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short period in March 1984: We visited only a few service sites: We talked with and observed only a few of the program personnel a few members of the communities served and a few of those whose decisions immediately or ultimately will have effects on the program. Many persons who had been key in the earlier phases of design and implementation had moved to other jobs. The tragic weather conditions of 1983 had left immeasurable impact on the service areas and their populations, especially Jipijapa.

These evaluation reports must therefore be treated as tentative, suggestive, partial. Perhaps it is not possible to have a definitive analysis. In any case, the reports do not stand alone. They are part of a process, points of departure. These more fully involved can and should add considerably to the analyses of conclusions presented in these reports.

The evaluation lacked what is elsewhere identified as a problematic concern of the project itself, the involvement of many persons whose communities one expected ultimately to benefit from its implementation. Although we think we did cover as much as possible in the time available and we were given good guidance by program persons we do feel that we may have overlooked the needs of the people and served more the bureaucratic interests. Although we did not cover fully every level of the program, we tried to make contact and to have open the possibility for project personnel to work more closely among the other workers, policy and decision-makers, people from other programs and agencies and those in the communities to be served.

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Evaluation, however, is not a neutral activity, we are interested in seeing the project achieve its goals, to succeed in its regionalization strategy, to combine realistically the rationed and indeterminate in ways that exploit technical knowledge and human resources to the fullest, at the same time leaving the Program open to further exploration and evaluation. We wanted to see what is working, to see what is not working and to increase understanding in each case.

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Community Participation-Primary Health Care

In the planning of this Project community participation was considered essential feature, formal involvements of the communities in primary health care, facility construction and maintenance and water supply and sanitation development were considered critical aspects of goal realization. It was implicit also that the process of decentralization would reach the community level, offering a greater influence to the people and expecting their assistance to make the system operate.

Water supply and sanitation will be covered by another group. Here I will focus on the participation of communities in the primary health care aspects of the Project.

Promotores: The PHC system plan calls for the training of health promoters who will serve the communities from which they are selected. It also specifies the creation of a special program for school children who will become health communicators, encouraging better health habits and identifying problems. At the time of our observations neither of these activities seems to have been carried out by the Project.

In Manabi 24 promoters were trained and 19 of them were posted in the area of Jipijapa. Whether this was happenstance of the product of Project influence was not clear. Only one promoter was identified as working in the other two Project areas.

Although the project budget allocated funds for promoter training and salary, it was not clear that the Project was expending its money on these items. Funds continued to come from MOH proper and from FODERUNA. Since

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the Project does have funds it would seem that it should be more aggressive in obtaining cooperation of other responsible offices in the MOH and would provide more training for promoters in the DRI-Health Areas.

The MOH had scheduled training for 120 promoters during 1984 but at the time we talked with the MOH representative they did not know for sure when and if that training would take place. They had apparently given no thought to giving special consideration to DRI-Health Project areas and were not aware that the Project could provide funds for the training or had the means for supervising promoters and following up on their work.

If PHC is going to be a realizable goal of the Project there will have to be a concerted effort to obtain the cooperation of others in the MOH and means for working with other promotor sponsoring agencies will have to be developed.

Rural Physician Orientation: It will also be necessary to work more closely with the rural physicians and to provide them training and supervision aimed at getting them more fully involved with the communities in which they live.

In Salcedo some community health education of rural doctors is being conducted at the provincial level and it seems to have stimulated some to undertake more community outreach activities but I could not determine that this outreach was systematic or monitored in any way by the Project. The physicians were unaware that their efforts might have in any way been guided by project goals. In fact, the three physicians with whom I spoke in the Salcedo area were not aware of Project goals beyond the establishment of the post of Area Chief.

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Rural physicians in the other areas seemed less aware of possibilities for working with communities apart from their clinic activities.

The effectiveness of all health service people in generating a good PHC program will depend on early orientation continuing training and serious supervision and motivation of area chiefs who are themselves motivated to work with communities and to promote preventive health care.

Botiquines: Although 40 community supported pharmaceutical botiquines were scheduled to be installed by the program, none had been established at the time of our observation. In two health posts we observed there had been such botiquines in the past and auxiliaries indicated that they had been successful but had faltered for lack of funds in recent years.

Oral Rehydration Therapy: A separate report by Dr. Hartman deals with the ORT program in considerable detail. As an important contextual element, however, some comment is appropriate here.

The ORT program has seriously involved communities in the selection of persons to be trained in ORT education and electrolyte distribution. The program has conducted several training sessions in the DRI areas. It seems to have met with marked success in making communities aware of the benefits of oral rehydration and in appropriately distributing material to be used by families. Community interest in the program is notable. Everyone asked knew of its existence and knew where to secure electrolyte materials distributed by those trained.

Health workers in Salcedo and in Quimia -Penipe have participated in the ORT training and are participating in distributional and promotional activities.

The training and promotion efforts of the ORT program could be used as a model by the Projects in efforts to address other health concerns of the DRI-health areas as well. Iodized salt distribution, immunization promotion, and general health education could be addressed in similar fashion. Perhaps this method of dealing with those problems would show less dramatic short run results but their overall health benefits could be significant. Possibilities for employing the model to deal with these other important health problems should be given high priority in considering future Project design and prospects for working with communities.

Save the Children: An ancillary aspect of the Project has been the support of the Save the Children Foundation as an agency interested in fomenting community level leadership in development and health related activities. Save the Children has been operating in two of the Project areas for the past year. There is evidence that several small, community level projects have been implemented and that Save the Children has been working closely with campesino groups and leaders to create more interest in community development and self-help activities. It did not appear, however, that communication and cooperation with health people had been significant.

Assistant Health Educators: The position of Assistant Health Educator has not yet been approved by the GOE Personnel Office. In Salcedo we found the Provincial Health Educator did participate in training of all levels of health workers and was sensitive to the special interests of the Project. His staff played principle roles in the ORT training activities.

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Using the Salcedo situation as possible model it would appear that the special title of Assistant Health Educator along with its need for complicated bureaucratic approval would be superfluous. It would be more appropriate to use funds to fortify the existing staff and to use that staff as appropriate and needed by the Project.

Drawing on Provincial Office capabilities to support community (and Project) activities should help to increase their awareness of the special focus of the Project and potential advantages of cooperation, it should also be less threatening to the provincial administrators, a very desirable condition at this point in Project development.

Goiter Control: The Project has not yet given attention to implementing goiter control activities although goiter and associated health problems rank as severe in the two DRI-Health areas in the Sierra. This lack is often attributed in part to assumption that there is no agreement between two camps of goiter control strategists in Ecuador, those who favor insuring distribution of high quality iodized salt and those who want to provide iodized-oil injections.

In fact, discussions with goiter specialists and MOH staff suggested that there was less conflict than outsiders thought. As a long term solution all recognize the need for appropriate iodized salt consumption and all recognize that iodized-oil has considerable short-run advantages for health. The question is a matter of what can be afforded.

But it is not a simple question. It is evident that all things being equal, assuming availability of high quality iodized salt and high quality



iodized oil, the ongoing use of the salt would be cheaper and more effective as a national strategy. There seems, however, to be some question of whether existing government and commercial mechanisms can insure the quality of the salt. Secondly, distribution techniques often involve so many middle-men that the relative prices of iodized salt makes it inaccessible or, at least, unattractive to the consumers who would benefit most from using it.

Because none of the evaluators are expert in goiter control we cannot ourselves assess the benefits of oils and salt on the incidence and severity of goiter and other iodine deficiency problems. It would appear, however, that promotion of the use of iodized salt, especially in goiter endemic areas, would be a possible and appropriate aspect of PHC educational activity. This assumes that quality is insured and that consumers would actually receive efficacious substances.

If Ecuadorian producers are unable to provide salt of efficacious quality and importation is not possible, the only available alternative appears to be iodized-oil injections.

The iodized oil treatment program that was conducted in Ecuador was reported to have produced significant, positive results in goiter control and the reduction of congenital problems. We do not know the complexity of that project and what is required to administer such a project effectively.

Because the local level aspects of the DRI-Health Project are not yet well coordinated it might be appropriate to strengthen that component prior to embarking on another complex activity. Certainly, however, the prevalence of iodine deficiency within the Project areas does justify addressing the

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problem as a priority concern, and the treatment should be incorporated into the service system.

#### CONCLUSIONS

Lack of attention to PHC and CP has been far from absolute. It has been a goal toward which the project has been striving. Our critical emphasis here is more to encourage the persistence of this concern and to insure that they are maintained as a high priority within the Project.

It has been largely because of overall Project strategy and some difficult obstacles imposed externally that community level, service level, concerns have been addressed less forcefully up to this point. Many of these have resulted from conflict over what decentralization will mean within the MOH and at the Provincial level. Certainly the difficulty in establishing formally the role of Area Chief and in retaining these who had been hired and trained have been serious impediments to Project implementation.

If the revised roles of CSH director and technical field director can be worked out, community level operations should be easier. Permanency of these positions is critical for the Project.

Until the time of our observation most of the attention of Project implementers and of CIMDER technical assistance group had focussed on higher levels of administration and on the formal aspects of regionalization, giving less attention to local level implementation and monitoring field operations, necessarily leading to less concern for participation. Up to that time, then, this lack of attention may be considered less a fault than a matter of experimental strategy that involved strengthening

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the administrative super structure prior to creating a strong local element. It would be worth evaluating further, on a comparative basis, to assess whether this strategy reduces the probability of undercutting PHC projects, many of which have been left foundering after external support has run out and the host country government has no means of responding to service and support demands.

We judge the goal of providing PHC and attendant community participation to be appropriate aspects of the program designed to decentralize health service administration. Indeed, if health programs are to meet changing demands and interests of the people they are intended to serve, then those people must be fully involved. Provincial officials, area chiefs, rural physicians, other health workers and Ministry officials all must be concerned for administering their technical skills in terms that are desired and accepted by those they expect to serve.

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RECOMMENDATIONS REGARDING REPROGRAMMING OF FUNDS

Due to cumbersome accounting procedures and failure to report expenses and incumbrances as they occur it is not possible to determine just how Project funds have been spent. This concern is addressed more fully in Robert Emrey's reports.

The lack of MOH attention to the training of promoters for the DRI-Health areas suggests that the Project is not using its financial strength to influence this MOH activity. The training of such promoters is, however, a primary immediate concern as set forth in its plan.

The inability of the National Health Council to set forth a clear set of research priorities suggests that another mechanism for deciding on research needs would be appropriate. Operational research studies suggested by and assisted by AID contracting organizations such as PRITECH and PRICOR should be given serious attention as candidates for Project support. These would focus research more directly on project capabilities and avoid the conflicting political interests of the CNS representatives some of whom are only marginally concerned with this particular project.

Training costs for seven area chiefs who have since abandoned the Project are sunk and cannot be retrieved. Part of the reason for failure to retain those persons in the Project was the weak contracting arrangements they had with MOH. It is expected that this will be overcome under the planned restructuring of the role of the CSH Directors who will also act as area chiefs. Although these persons in the new role will be expected to have already administrative, social and service skills to justify their assuming this broader responsibility they would doubtless benefit from additional

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training that is consistent for all Area Chiefs. Such training should be provided with in Ecuador rather than in Colombia or elsewhere. The CIMDER staff and the use of the CIMDER technical manuals should provide the core of this training. It should be supplemented with additional theoretical and practical instruction in administration, focusing on the needs of the Project. Such training should be provided as soon as the roles of Area Chief and the technical assistance unit have been formalized by the GOE and longer term contracts for area chiefs have been signed.

Given that iodine deficiency is considered a major concern of the project and the known efficacy of iodized salt for long term solution an investigation should be made of quality control in the production of such salt. The Project cannot itself undertake a quality assurance program but it can support a technical team to investigate and to make recommendation for improving conditions if they are indeed found lacking.

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REPORT ON  
PRITECH PROMOTION AND EVALUATION OF  
ORT/EPI ACTIVITIES IN ECUADOR

MARCH 12 - 24, 1984

Submitted to:

Ministry of Public Health, Ecuador

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## EXECUTIVE SUMMARY

This consultancy was developed as a promotional visit for PRITECH to assess current Oral Rehydration Therapy (ORT) and Expanded Program in Immunization (EPI) activities in Ecuador and to identify areas of future collaboration for PRITECH. An additional task, evaluation of the ORT/EPI activities in the Integrated, Rural Health Project, was requested to assist the Mission develop strategies for effective use of their resources in these programs.

The Diarrheal Disease Control Program of the MOH has existed for five years and is quite impressive. All health personnel have been trained in ORT and adequate stocks of oral rehydration salts exist at all levels. Community participation is a key component. Over 9,000 literacy educators (25% of which speak Quichua) have been trained in ORT, as have been community leaders in some Provinces and all DRI areas. A health education and promotion campaign began last year utilizing radio spots, printed material, and training of community leaders. These efforts have received considerable support from the ST/Health project on communications and mass media and the presence of an advisor from the Academy for Educational Development. Ciba-Geigy plans to produce ORS in the same packets as the MSP, but market it through private sources, thus assisting in national coverage.

The EPI program, on the other hand, has not achieved good national coverage, even though it has existed since 1977. For DPT and polio there is a profound drop-off in coverage from first to third doses from 60% to 28%. Coverage rates for measles are approximately 32%. Morbidity and mortality from the immuno-preventible diseases has not changed in ten years.

For both ORT and EPI programs, the health education and promotion activities are most important. The Mission should consider providing funds and negotiating with AID/W and the AED to extend services of the advisor to assist in expansion of this campaign nationwide for both programs. Management support systems within the MSP need strengthening, especially supervision, information, and operations research. Vaccine logistic and cold chain effectiveness, especially in rural areas, needs further investigation. Promotion of breast-feeding needs reinforcement. Cost-effectiveness analysis of ORT/EPI programs compared to other MSP services, such as Hospital Health Centers, may be useful in assisting the MSP make decisions about resource allocations. PRITECH can provide consultants in all these areas, if requested.

The AID Integrated Rural Health Project has existed for two years and made impressive gains in ORT and community organization. On the other hand, administrative problems with the Area Chief; competition between SEDRI and MSP personnel and programs (in some areas); and the improvement in MSP capabilities during this time have produced a situation where there is little difference in ORT and EPI activities between DRI areas and other areas of the Provinces. The Mission might consider expanding the project to include the entire Province (and possibly expand to more Provinces) and channeling Project funds directly to the MSP to support these expanded efforts. By focusing on improving ORT/EPI programs in the activities noted above, the Mission could assist the MOH produce significant improvements in morbidity and mortality within the next few years.

Several non-governmental agencies show promise for expansion of these programs and may benefit from additional support. Seguro Social Campesino, MAP International, CRS, and the Peace

Corps are all willing to participate and have a substantial national presence. Future analyses should identify ways of assisting these agencies.

I. Introduction

A. Scope of Work

1. Promote PRITECH Project to AID Mission, MOH, and other agencies.

2. Identify current ORT/EPI activities in public and non-governmental agencies and analyze achievements and constraints.

3. Examine the Integrated Rural Health Project in conjunction with the Project Evaluation Team to assess ORT/EPI activities.

4. Identify key personnel in public and non-governmental agencies who can influence ORT/EPI activities.

5. Develop strategy for future PRITECH collaboration and develop scopes of work for future consultants.

6. Submit this report.

B. Activities

This two week consultancy was initially developed as a promotional visit for the PRITECH Project to assess current ORT/EPI activities in Ecuador and to identify areas of future collaboration. However, an additional task in the scope of work added another level of complexity to this visit, that was the request to evaluate ORT/EPI activities in the Integrated Rural Health Project. This was appropriate since AID/Ecuador health resources can significantly advance these programs, and

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PRITECH resources should be complementary. The project evaluation did, however, significantly add to the work load in the short time available.

During this time period, the following activities were completed.

1. Interviews with key personnel in the MSP at the Central and Provincial levels.

2. Review of pertinent documents available in AID and the MSP, including results of previous EPI and ORT evaluations.

3. Interviews with key personnel in agencies other than the MSP. The results of this are presented in Section VI.

4. Field visits to:

- a. Province of Cotopaxi and the Project area of Salcedo, March 15-16.

- b. Province of Chimborazo and the Project Area of Quimiag-Penipe March 20-21.

Annex I is a list of people interviewed and places visited.

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ANNEX 1

PEOPLE INTERVIEWED

MSP, Central Level

1. Dra. Magdalena Banoni, Director of Priority Programs.
2. Dr. Humberto Baquero, Chief, División de Fomento y Protección.
3. Dra. Ligia Salvador, Chief, Division of Frequent Morbidity.
4. Dr. Oswaldo Barrezueta, Chief, EPI.
5. Dr. Edgar Moncayo, Chief, Programming and Planning.
6. Lcdo. Eduardo Salazar, Health Educator assigned to D.D.C.
7. Dra. Carmen Laspina, Physician assigned to Respiratory Infections.
8. Lcda. Teresa Tapia, Nurse in charge of Oral Rehydration Units.

MSP, Province of Cotopaxi

9. Dr. Parreño, Director.
10. Lcdo. Jaime Arias, Chief, Health Education.
11. Lcda. Lola Albán, Provincial Educator.
12. Lcda. Villagómez, Nurse for Rural Health.
13. Director of Department of Epidemiology.
14. Provincial Statistician.
15. Director of EPI programs.

MSP, Province of Chimborazo

16. Dr. Puslio Escobar, Chief of Priority Program.
17. Dr. Max Santillar, Chief of Epidemiology.
18. Dr. Marco Quincana, Chief of MCH (former Chief of Area, Quimiag-Penipe).

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19. Lcdo. Hector Alvarado, Educator.
20. Provincial Statistician.

Integrated Rural Development Area, Salcedo

21. Ing. Oscar Escola, Chief, Executive Unit, IRD, Salcedo.
22. Dr. Max Arias, Area Health Chief, IRD.
23. Lcda. Susana Larrea, Health Representative from SEDRI.

Integrated Rural Health Development Area, Quimiac-Penipe

24. Dr. Naranjo, Area Health Chief.
25. Lcda. Vilena, Area Nurse.
26. Ing. Araujo, Sanitary Inspector.

AID/Ecuador

27. Dr. Kenneth Farr, Chief, Health Office.
28. Dr. Jean Audrey Wight, Nutrition Advisor.
29. Dr. Juan Londoño, Population Advisor.
30. Dr. Eduardo Navas, Advisor in Regionalization.
31. Dr. Gustavo Estrella, Project Coordinator.

Evaluation Team

32. Mr. Patrick Marnane, Team Leader.
33. Mr. Robert Emrey, Management Consultant.

Other Agencies

34. Dr. Nancy Andrade, Health Advisor, UNICEF.
35. Mr. Brian Cavanagh, Director, CARE.
36. Dr. Miguel Artola, Health Officer, Peace Corps.
37. William Senn, Director, MAP International.

38. Dr. Galo Cordero, Seguro Social Campesino.
39. Dr. José Torres, Ciba Geigy.
40. Dr. Pettigiani, Representative of PAHO.
41. Dr. Alvaro Rueda, Epidemiology Advisor, PAHO.
42. Dr. Merlin Fernández, Management Advisor, PAHO.
43. Lcdo. Roberto Unda, EPI/DDC Advisor, PAHO.

SITE VISITS

Hospital Health Center, Salcedo.  
Sub-Centro de Salud, Cusubamba.  
Sub-Centro de Salud, Mulalillo.  
Sub-Centro de Salud, Panazallo.  
Sub-Centro de Salud, Quimiag.  
Sub-Centro de Salud, Penipe.  
Provincial Health Office, Cotopaxi.  
Provincial Health Office, Chimborazo.  
IRD Headquarters, Salcedo.  
IRD Headquarters, Quimiag-Penipe.  
Ciba-Geigy Production Facility, Quito.

## II. BACKGROUND

### A. The Setting

#### 1. General

Ecuador is a country of contrasts. Although one of the smallest South American Countries with a territory of only 284,000 km<sup>2</sup>, it contains enormous geographic and cultural differences. The Cordillera of the Andes bisects the country, from the Columbian border in the North to Peru in the South, and has many peaks ranging up to 6,000 mts. This mountainous zone, called the Sierra, has numerous pockets of population located between 2,800 and 4,000 mts. elevations. Nearly 3,000,000 people in this area speak Quichua, a dialect of Quechua.

To the east of the Andes is the Oriente, that forms part of the headwaters of the Amazon River. This is sparsely populated with a high percentage of Amerindians who have retained their traditional way of life. To the west of the Cordillera lies the Pacific Coastal plain, which frequently receives heavy rains and subsequent flooding. The largest city of Ecuador (and its principal port) Guayaquil is located here.

Politically, Ecuador is divided into twenty Provinces. Each Province is divided into Cantons, and Cantons are further divided into Parroquias.

#### 2. Demographic Indicators

Approximately 49% of the population lives in the coast, 47% in the Sierra, and 4% in the Oriente. During the last ten years, an accelerated migration of the population has

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occurred to urban areas, as shown by the differences between the census of 1974 and one recently completed in 1982:

	<u>Population</u>		
	<u>URBAN (%)</u>	<u>RURAL(%)</u>	<u>TOTAL (No.)</u>
1974	41.4	59.7	6,830,000
1982	49.7	50.3	8,072,000

Current growth (based on the 1982 census) is 2.7%, down from the 3.3% rate found in the 1974 census. Approximately, 40% of the population is indigenous, 40% mestiza, 10% caucasian, and the rest of African and Asian descent.

Obviously, a country with such geographical and cultural diversities, difficulties with transportation and communication and limited infra-structure poses a tremendous challenge for development.

In 1982, the per-capita GNP was US\$1,337. The literacy rate has improved substantially, reflecting a national commitment to improved education. In 1974, 24.6% of people over age 12 were classified as illiterate, compared to 14.5% in 1982. Rural areas have four times the illiteracy rate of urban areas (26% vs. 9.3% in 1982).

### 3. Health Indicators

Data on health status have shown similar improvements, but mortality rates are still high:

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<u>Age</u>	<u>1955-59</u>	<u>1975-79</u>	<u>1982</u>
- 1	122.4	84	72
1-4	22.3	9.8	*
Total	14.0	7.9	*

Rural areas have 50% greater mortality rates than urban areas. Nearly 50% of mortality occur in children under five years old. Nearly 1/3 of the deaths are attributed to infectious diseases.

The first six causes of morbidity recorded by the MOH are what one would expect of a country in this stage of development:

1. Diarrheal Disease.
2. Respiratory Diseases.
3. Immuno-preventibles.
4. Endemic Goiter (Sierra).
5. Malnutrition.
6. Malaria (Pacific Coast).

Nearly 80% of births are attended by parteras empíricas or other untrained people. Only 10.3% of the rural population has access to potable water.

The burden of providing services for these diverse health problems falls on the MOH for 85% of the population. The Ecuadorean Social Security System provides services to 7.5% of the population, and the private sector to 7.5%.

## B. The Health System

### 1. History of Public Health Services

The MOH is the youngest institution of its kind in South America, since it was officially created in 1972. From 1942 to 1964, a joint U.S./Ecuadorean effort developed the Ecuadorean Public Health Services. With generous financial assistance from the U.S., tremendous strides were made in public health. However, after 1964, U.S. financial assistance was withdrawn, and the Government of Ecuador could not provide sufficient support to continue this centralized Public Health Service. From 1964-1972, the responsibility for organized health services fell on the provinces. Thus, each province developed their own programs according to their perceived needs and the resources available. This, of course, created marked irregularities in the quantity and quality of health services. Recognizing these inequities, the GOE created the current MSP in 1972.

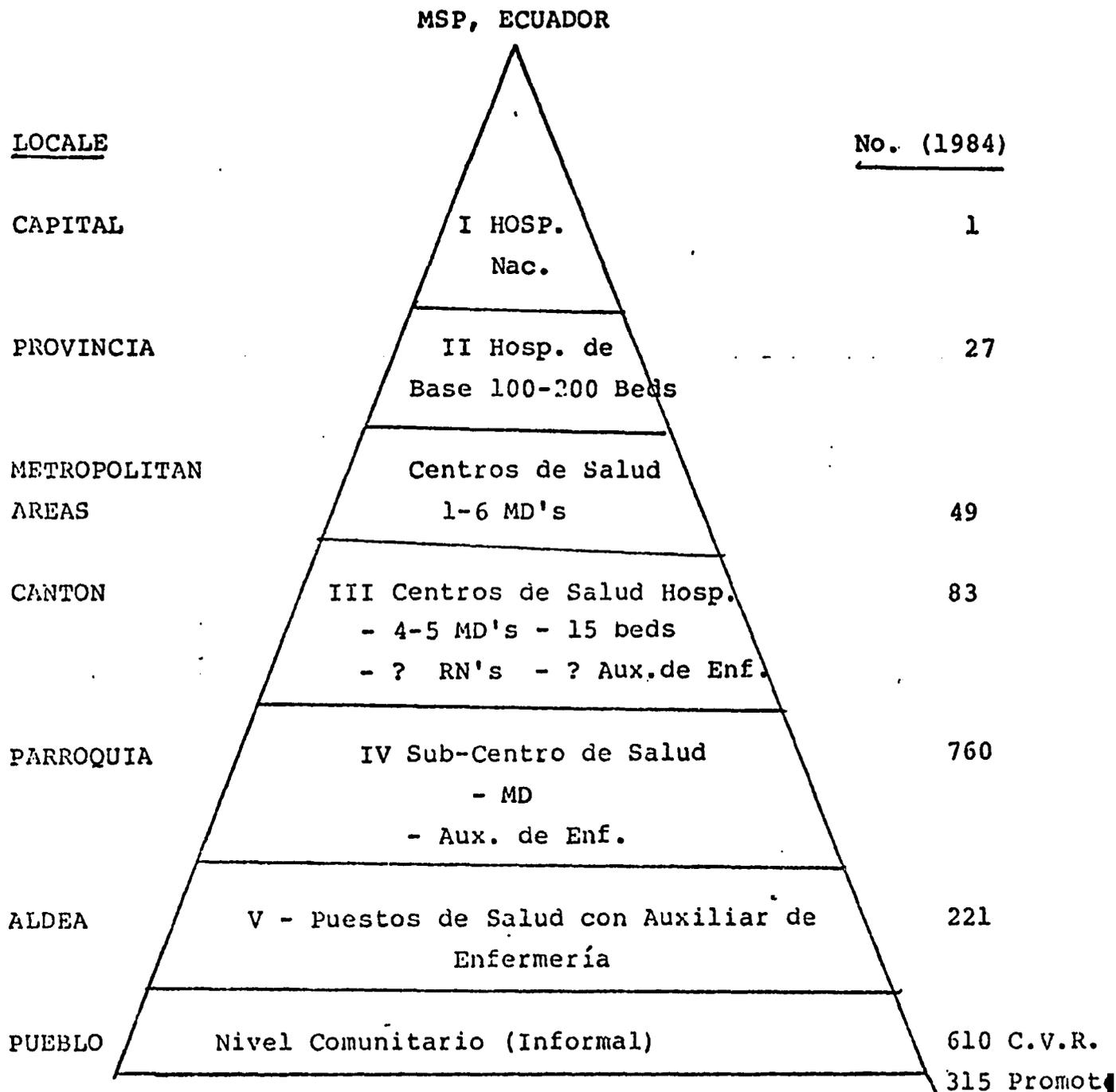
### 2. MOH Structure

The first National Health Plan was developed in 1973, and created the structure of health services presented in Figure 1.

From 1973 to 1978, MOH employees doubled from 6,000 to 12,000. Few of the new personnel had any formal training in public health or administration. Given this rapid growth, multiple charges in administrative structure are the rule. The most recent reform occurred in late 1983, and is presented schematically in Figure 2.

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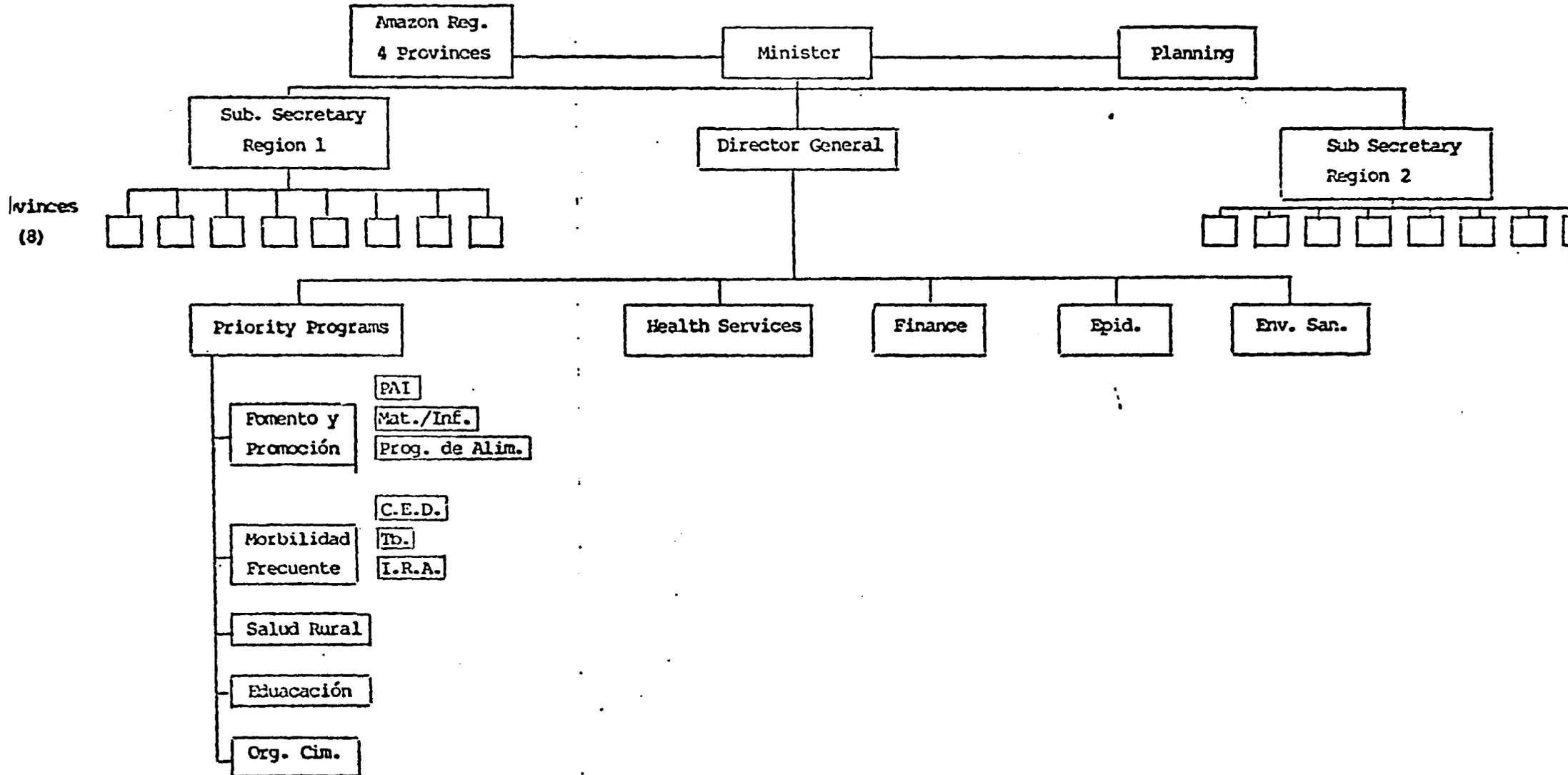
PYRAMID OF SERVICES



1. Colaboradora Voluntario rural (Partera Empírica)
2. Promotores = Trained VHWS.

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FIGURE 2  
 ORGANIZATIONAL STRUCTURE  
 MSP/ECUADOR, MAFCH, 1984



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### 3. Other Agencies

#### a. Instituto Ecuatoriano de Seguridad Social

Historically, the IESS has covered only 7.5% of the population, basically workers in urban areas. However, in the past two years several new initiatives have developed that could have a major impact on extension of services. Convenios have been established with cooperatives to provide services near the work place. In addition, 1% of the cuota of the insured urban population goes to the Seguro Social Campesino for services in rural areas. Conversations with field workers for this agency indicate interest and enthusiasm for extending oral rehydration and immunization programs through Campesino organizations. These efforts definitely merit further investigation and, if feasible, support.

#### b. Private Sector

Private health services cover another 7.5% of the population, mostly in urban areas. One interesting factor is the overproduction of physicians. Ecuador produces 1000 new physicians per year, many of whom cannot find effective employment. There is an organization of unemployed physicians that exerts a major influence on the design and acceptance of any new health initiative. This is one reason why the MSP has based its health system on Sub-Centros de Salud with physicians (760 exist) instead of Puestos de Salud with Auxiliares (220).

Ciba-Geigy maintains a production facility in Ecuador, and has announced its intention to produce and market oral rehydration salts. This is discussed more completely in Section III.

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c. Secretaría de Desarrollo Integral (SEDRI)

The current National Development Plan for Ecuador is based on a concept of integrated rural development in agriculture, education, and health. SEDRI was formed in 1980, and 17 areas of the country were selected as Integrated Rural Development Areas (Areas del DRI). These areas contain a total of approximately 500,000 people and are designed to serve as a model for development efforts in other parts of the country. Since AID health funds are channeled through SEDRI, this project is discussed more fully in Section V.

d. PVO's

Numerous PVO's exist in the country. CARE and CRS, by virtue of participation in supplementary feeding programs, cover large areas of the country. Smaller PVO's have traditionally served specific segments of the population. The more promising of these PVO's are discussed in Section VI.

C. Constraints

1. Limited Coverage of Health Services

The MOH is responsible for health services for 85% of the population, and has focused most of its attention on development of physician - oriented services to the Health Sub-Center (parroquia). Services are quite limited beyond this level, and even these at the Sub-Centers need strengthening. The IESS has traditionally focused on urban areas, but recent initiatives with cooperatives and campesino organizations show potential. PVO's have filled some of the gaps in coverage, and could complement what exists within the MSP.

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## 2. Relative immaturity of MSP Management Systems

The MSP has formally existed only since 1972, and did not consolidate as an institution until the late '70's. Rapid growth in personnel and frequent organizational changes have strained their capacity to respond. Thus, critical management systems, such as supervision, information and evaluation, and logistics are weak. This has negative effects on all MSP programs.

## 3. Conflicting Policies

As identified in the organizational structure of the MSP in Figure 2, both immunizations and diarrheal diseases have been included as priority programs. Yet the MSP continues to pursue development of services through Centro de Salud Hospitales with only 15-20 beds. Financial analysis in other countries have consistently shown this type of services to be the least cost-effective and a drain of resources from other programs that could be substantially more cost-effective.

It would be wise to explore with the MSP their interest in completing a cost-effectiveness analysis of various health programs and levels of services.

## 4. Competition Between Agencies

In the limited time available to this consultant, it became abundantly clear that a fair amount of competition exists between the MSP and SEDRI at all operational levels, from the Central MSP through the Provincial Headquarters down to Centros de Salud. (Apparently, there does exist common agreement at the policy-making and Secretaría levels, but this has been difficult to translate into operational terms.) This

Competition does not exist in all Provinces but does tend to produce limited coordination and joint planning, duplication of efforts, inefficient use of resources, and raises questions about building long-term institutional capacities. Even where relationships are good and decisions are reached about location and types of services, Seguro Social Campesino locates its facilities wherever it pleases, thus disrupting the established pattern.

### III. Expanded Program in Immunization (EPI)

#### A. Background

##### 1. History

Ecuador was the first Latin American Country to officially establish an EPI in 1977. Originally implemented in only three Provincias, the program progressively extended to other areas, and by 1980 it was implemented in all Provincias. Between 1978-1981, the principal immunization strategy was house-to-house visits by auxiliaries or health inspectors. However, this strategy proved too costly to implement, especially in dispersed populations, and the MSP gradually shifted over to locating immunization services in areas of population concentration (e.g., Sub-Centros de Salud). The MSP then could focus resources on making immunization services available as an integral part of health services.

In addition to this latter emphasis, the MSP initiated in 1982 a national strategy of "fases intensivas". Each "fase intensiva" lasts one week, and all health personnel are requested to simultaneously participate in EPI activities. National promotion campaigns through radio and the printed media support these intensive periods. In 1982, three "fases intensivas" were implemented. However, in 1983 only one was implemented due to natural disasters that focused attention and resources on relief activities, and the lack of vaccines. These are discussed more fully in the "Problems" section.

Ecuador also has a unique resource related to EPI. The Instituto Nacional de Higiene de Guayaquil produces a limited quantity of BCG in liquid form, DPT, and TT. These quantities are not sufficient to meet all the needs of the MSP,

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out apparently the quality of production is high and could be expanded.

In 1981 and 1982, the MSP conducted two extensive evaluations of the EPI with PAHO assistance. These evaluations were very thorough and provided important information for this analysis.

## 2. Structure of the EPI

As illustrated in Figure 2, the EPI is assigned to the Division of Priority Programs, which is a clear policy statement by the MSP. However, implementation of EPI activities at the Provincial Level and beyond are the responsibility of the Minister in the Amazon Region and the Sub-Secretaries for Regions 1 and 2. Thus, organizational linkages between the Normative (Central) and Operational (Provincial) levels at times are difficult.

The functions of the Central EPI staff fall into five main categories:

- Establish norms and procedures for EPI activities.
- Training of personnel in application of the norms. This usually occurs on a national basis, but the staff does travel to provinces to assist at that level. However, since there are twenty provinces, they obviously cannot reach all of them.
- Supervision of provincial staff. They try to combine this with training and evaluation activities, but again

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coverage is limited by lack of personnel, per diems, and transportation.

- Vaccine management from Central to Provincial level. This includes purchasing, importation, central storage, and distribution to the provinces.

- Information and evaluation, including collecting of routine statistics and preparation of reports. Up to now, staff have been unable to implement special studies or operations research projects due to lack of resources.

Central staff appeared highly motivated, and were actively seeking ways to improve these functions.

The Provinces duplicate the central structure, so that under the Provincial Chief you will usually find a physician in charge of EPI activities, plus other staff responsible for rural health services. The provinces distribute vaccines to the Centros de Salud, who in turn distribute to Sub-Centers and Puestos. In the limited time available for field visits to this consultant, I was favorably impressed with what exists in the field. Centros de Salud have excellent cold storage equipment, including freezers for making ice for shipment to facilities without refrigerators. To my amazement, I often found, both in Centers and Sub-Centers, community maps (croquis) marking each house with pins identifying the children under 1 year of age and pregnant women, and flags on each pin representing the number of doses each child/pregnant woman had received. This was found in enough health facilities to indicate it has resulted from concerted Provincial EPI efforts and not from individuals within the health centers. These efforts are commendable and deserve reinforcement and expansion.

Clearly, in the Provinces I visited (see Annex 1), EPI activities were receiving priority attention, staff were in place, trained, and motivated.

### 3. External Assistance

Obviously, EPI activities have received significant resource allocation from the MSP. It is difficult to quantify this, since routine immunization activities are part of general health services and included in the regular operational budget. Nevertheless, external assistance often provides supplemental resources important for program implementation.

#### a. PAHO

i. Technical Assistance: PAHO provides a full-time technician just for the EPI (a sanitary engineer) plus an MD Epidemiologist, who generally works with the Division of Epidemiology.

ii. Cold chain equipment, specifically for a cold room in Region 2.

iii. Assistance with national evaluations in 1981/1982.

iv. Vaccines through the PAHO Rotating Fund.

b. UNFPA bought 250 electric refrigerators in 1980.

c. UNICEF has assisted in promotion of EPI activities through educational material, radio spots, and movie

shorts. Proposals for 1984 include thermos containers for vaccine transportation, thermometers, and twenty loudspeakers for promotion at the local level.

d. A.I.D.

The AID Integrated Rural Health Project is described in detail in Section V.

It does identify EPI activities as a priority program, and funds are available for them in each of the DRI areas. However, MSP/EPI staff have the very strong feeling that AID has provided no resources at all to the EPI, even though the project officer has apparently put considerable effort into assisting them to understand the resources available. In my opinion, this problem reflects the competition that exists among agencies described in Section II.C. of this report, since MSP staff would have to go to SEDRI for these resources. Apparently, this does not seem feasible at this time.

B. Experience to Date

1. Vaccination Coverage

Figure 3 shows the percentage of coverage for children under one year of age since 1972 for the six vaccines included in the EPI. Children under one have been selected as the priority target population for EPI activities. In addition, the coverage rate of this age group is a good indication of continuous activities, since a new population has to be immunized each year.

Analysis of Figure 3 shows several important trends. The first is that significant increases in coverage

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Figure 3  
 Cobertura de la Población menor de un año<sup>a</sup> con las  
 vacunas previstas en el PAI y tasas de deserción  
 Ecuador, 1972-1983

Vacuna	DPT				Antipoliomielítica				Antisaram- pionosa <sup>b</sup>	BCG
	1ra dosis	2da dosis	3ra dosis	% de deserción	1ra dosis	2da dosis	3ra dosis	% de deserción		
1972	10.5	6.7	1.0	90.4	12.3	16.3	2.5	79.9		16.5
1973	8.6	4.5	1.8	78.5	..	..	..	..		19.4
1974	10.4	6.7	1.2	88.4	4.6	4.6	4.1	11.3	..	23.8
1975	9.8	6.0	1.7	82.3	11.9	13.3	6.6	45.1	..	19.7
1976	17.3	10.8	.. <sup>c</sup>	..	30.0	17.0	11.1	62.8	2.1	29.5
1977	21.5	11.6	.. <sup>c</sup>	..	18.0	10.5	10.9	41.8	6.0	37.8
1978	24.9	15.9	.. <sup>c</sup>	..	22.0	11.9	6.9	68.6	10.6	41.8
1979	34.1	21.2	.. <sup>c</sup>	..	37.0	21.8	11.0	70.2	20.8	41.7
1980	33.1	19.9	6.8	79.3	37.3	26.2	13.4	64.1	16.8	52.5
1981	45.1	30.0	18.0	60.1	43.7	26.3	18.6	57.4	21.9	57.3
1982	87.9	58.2	35.2	..	87.0	59.2	34.8	..	44.5	103.6
1983	59.8	39.7	28.1	..	63.2	41.6	32.2	..	30.7	79.3

<sup>a</sup> Cálculo de la población menor de un año (División Nacional de Estadísticas).

<sup>b</sup> La vacuna antisarampionosa se comenzó a aplicar en 1974; no existen datos por edad para 1974 y 1975.

<sup>c</sup> Se recomienda una dosis de refuerzo (tercera dosis) después de los 12 meses de edad.

.. Datos no disponibles

Fuente: División Nacional de Estadísticas, MSP

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have occurred with initial doses, but a profound drop-off in coverage occurs in 2nd and 3rd doses. While a common problem in most developing countries, Ecuador may have some specific cultural constraints that are discussed in the problems section. It is of interest to note that measles, which requires application at nine months of age, has not shown a dramatic rise, whereas BCG, which can be applied at birth, has. Ecuador also requires proof of BCG immunization to register a birth, another factor stimulating BCG coverage rates.

Another point is the apparent dramatic rise between 1981 and 1982. There are probably two reasons for this: the first is the implementation of three "fases intensivas" increased coverage rates in 1982, whereas the implementation of only one in 1983 caused a fall-back in coverage. This explanation has merit, and lends support to the strategy of the "fases intensivas".

However, a second factor is that a national census was completed in 1982 that showed a growth rate of only 2.7%, as opposed to the 3.3% growth rate found in the 1974 census. Thus, the denominator in coverage rates (i.e., the number of children under age 1) was adjusted downward to reflect the revised population figures. This most certainly contributed to the "spurt" in coverage in 1982. This is important, since the MSP should rationally assess the cost-effectiveness of the strategy of "fases intensivas" and not just assume that it has produced a dramatic rise in coverage. 1983 rates may reflect a more realistic coverage rate given current resources available.

## 2. Incidence of Immuno-preventible Diseases

Figures 4-9 show morbidity and mortality rates for the major immuno-preventible diseases from 1972 to 1982.

Measles, pertussis, and tetanus have shown little change over ten years. In fact, in 1983 the highest rate of measles ever was recorded, indicating a major outbreak. Diphtheria has shown a downward trend until 1980, with a sharp rise since. Polio is an epidemic waiting to happen. Clearly even though immunization rates have shown a steady rise over the past ten years, they have not yet reached the level necessary to produce decreased morbidity. This is probably due to the drop-off in coverage between first and third doses, but I did receive some informal observations from field staff about measles occurring in previously immunized children. These reports came from rural health personnel, and may indicate a break-down in the cold chain. This may also explain some apparent resistance to immunizations, since families will obviously be reluctant to immunize their children when they have seen failures within their community. This problem deserves further study.

C. Problems/Constraints

1. Community Education/Promotion of EPI

With almost everyone I talked to, this is cited as the number one problem and the major reason for drop-offs between first and third doses. Patients will often bring their newborns in for an initial check-up, but have not been adequately motivated to return. Resistances to immunizations seem to be present, and mothers in particular cultural groups are reluctant to bring children in again for another "shot that made their child sick when it was supposed to make them healthy". The connection between immunizations and long-term health has not been made. Nearly 3,000,000 Ecuadoreans speak Quichua, and educational programs need to be developed in that language. Community level research needs to be done to identify the roots of "resistance," and programs designed to ameliorate it.

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## 2. Vaccine Logistics/Cold Chain

Mention has been made that some "resistance" to immunizations may well be due to cold chain failures. The links between Centro de Salud and Sub-Centros/Puestos appear to be particularly weak. Several years ago, the MSP decided to eliminate kerosene refrigerators, so locations without electricity must rely on weekly shipments in iced thermos. These are usually timed to coincide with market day, the day of greatest use, so vaccines will have their greatest potency. However, the cold chain and vaccine viability requires more investigation.

A second related problem is with the availability of vaccines in the country. In 1983, the MSP did not have enough vaccines to cover everybody due to a breakdown in the rotating fund of PAHO. Apparently the bureaucratic procedures related to purchasing vaccines and use of foreign exchange delayed arrival of vaccines. Strategies need to be developed to increase vaccine availability.

## 3. Extension of Coverage

Frankly, it is not quite clear to this consultant where the major gaps in coverage are. Evidence suggests that there is limited coverage beyond the immediate pueblo of the Sub-Centros. Puestos de Salud appear very weak in the MSP structure, and there is no extension at the community level where no formal MSP services exist. However, coverage with measles is only 30%. Since the country is 50% urban, then there must be obvious gaps in urban coverage. I was not able to pinpoint the source of these gaps, since the urban health centers visited seemed remarkably well-organized for covering their immediate catchment area. Perhaps this small sub-sample

does not represent the rest of the country. It is not clear if more effective use of auxiliary personnel, more Puestos, and trained community volunteers are needed, or if more emphasis should be placed in urban health centers. Identifying the gaps in coverage will require some additional investigation.

#### 4. Management Support Systems

As previously described, the relative youth of the MSP and frequent organizational changes have delayed development of effective support systems. This is most notable in two areas: Supervision and Information/Evaluation.

a. Supervision appears generally weak. Starting from the periphery, although Health Centers supply Sub-Centers and Puestos with vaccines, they have no responsibility, nor the resources, to do follow-up supervision activities. No national model or guidelines for supervision (in general) exist. Supervision from the Provincial Office to Centros de Salud appears good, but each Province has developed their own system. This makes it difficult for the Central Level to compare provinces and identify problems. The Central Level is limited in staff, but lack of viáticos and vehicles seems to be a greater restriction to improved supervision at all levels. In short, supervision seems to be an empirical process without specific guidelines, policies, activities, and resources.

#### b. Information/Evaluation

This can be separated into two components:

i. Management Information System

This is generally weak within the MSP, but some specific weaknesses apply to EPI. For example, in trying to identify the gaps in coverage, I asked for coverage rates by level of service. These are not, however, available at the Central level. Each Province keeps their own records. It will be difficult to make sound management decisions without more precise information.

ii. Operations Research

It would be helpful to identify the causes of "resistance" to immunizations; specific breakdowns in cold chain; vaccine viability; cost-effectiveness of alternative immunization strategies; etc. Each of these studies would provide valuable information for decision-making, but resources are quite limited in this regard.

5. Training

Training activities in EPI for MSP personnel have been well-developed in the past. However, with constant turn-over of personnel, especially at the sub-center level, a process of continuing education is required. This is restricted by lack of funds for training materials and viáticos for participants. Limited training activities translate into limited motivation of personnel for EPI activities.

D. Recommendations

With the infrastructure already in place in the MSP health services, coverage rates could be significantly improved in the next two to three years with appropriate strategies and

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ome essential external support. These recommendations are designed to achieve that purpose.

1. Implement National Community Based Health Education/Promotion Campaign for EPI Activities

This program can build on experience already gained in EPI promotion with UNICEF support, and the highly successful effort in promotion of oral rehydration should be expanded to include EPI. The word community-based is used to differentiate this from an ad campaign. Community-based implies initial research into such issues as the causes of "resistance"; the types of messages must likely to be successfully accepted by the target population; the appropriate use of language, music, etc., and evaluation of the results.

A successful methodology for this strategy has been developed by the Academy for Educational Development for diarrheal control and EPI activities. With assistance from AID/W Health Office, this strategy has been implemented in Ecuador for ORT only. These efforts should be expanded, and the scope of work of the A.E.D. advisor, Dr. Reynaldo Pareja, should be amended to include EPI activities. This will require some negotiation between AID/Ecuador, A.E.D., and AID/W Health Office, since the current agreement limits the amount of time Dr. Pareja can spend in Ecuador (almost all of the original seven months of T.A. allotted under this agreement has been expended. A minimum of six additional person-months will be needed to get this effort underway). This appears to be the most cost-effective way to assist the development of this national health education activity.

Activities in this campaign should include radio spots and programs in two languages; printed educational mate-

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rials for distribution; training of provincial health personnel and community leaders; and community-based direct educational activities. This latter activity will require, in addition to training of personnel, vehicles, loud-speakers, and tape recording equipment. There is some feeling that direct educational activities (e.g., vehicles with loud-speakers touring the community, tape-recorded messages in waiting rooms of larger health facilities) will be more successful than radio spots in Sierra communities where radio penetration is limited and people respond to a more personal approach. Obviously, the direct approach is more expensive, so it should initially be implemented in those provinces where serious gaps in coverage have been identified (see recommendation No. 3).

Funds for this campaign can come from a variety of sources, including the MSP itself, UNICEF, and AID Integrated Rural Health Project funds for replication activities (or other line item, if appropriate). If this recommendation is accepted in principal and an agreement is reached with all parties concerned regarding the use of Dr. Pareja, then he can assist the MSP to develop a work-plan and budget for this program that can be shared among the participating agencies.

## 2. Vaccine logistics/cold chain improvements

Efforts to improve the supply of vaccines and improve cold chain performance should include the following:

a. Analysis of the peripheral cold chain below the Centro de Salud (i.e., Subcentro, Puestos, and Comunidad), identifying gaps, suggesting alternatives, and assistance with purchase of equipment. The issue of non-electric refrigerators (kerosene, gas, solar) should be re-examined.

b. Vaccine viability, including some operations research activities with the recently developed time-temperature indicators to identify break-downs.

c. Training of Maintenance technicians at both the Provincial and Health Center levels in maintenance of refrigerators, including provision of tool kits. Initial training of Provincial personnel has been planned by PAHO and budgeted at \$30,000, but has not been implemented due to lack of funds. This training should be expanded to include health centers, who should also play a stronger support role to the Sub-Centers. If other forms of refrigeration are adopted (e.g., kerosene, refrigerator), then training of health personnel in preventive maintenance will be needed.

d. Increased production of biologicals by the Instituto Nacional de Hygiene in Guayaquil, especially DPT and a lyophilized form of B.C.G. This will require an initial needs assessment and some investment in equipment and training. I understand from conversations with PAHO officials that the Instituto has purchased the equipment necessary to expand production but has been unable to install or operate it. This deserves further investigation.

e. Technical Assistance

Analysis of these alternatives and design of interventions will require the services of a specialist in cold chain and vaccine production, who will work with MSP staff and existing PAHO advisors. PRITECH can provide such a consultant. This is described more completely in Section VII, strategies.

### 3. Identify gaps in coverage

This is an essential activity given current resource restrictions. With low rates of vaccine coverage, it is hard to argue against a national strategy of "fases intensivas". However, experience has shown that these are costly, and when national priorities are directed elsewhere (e.g., disaster relief), they do not occur. If gaps in coverage have been identified, then focused "fases intensivas" can still continue in the areas identified, and coverage rates can continue to improve.

Given the current state of the information system, this will require review of the records available only at the Provincial level, starting first with those Provinces who show the lowest coverage rates. The end result should be a list of specific priority geographic areas, and/or population groups, for intensive EPI activities. The previous two recommendations for health education and cold chain improvements can also be focused in these areas.

The recommendation can be implemented by current MSP/EPI staff with assistance from PAHO.

### 4. Management Support Systems

#### a. Supervision

A complete analysis of the MSP health structure will be necessary, including a task analysis of health personnel and review of job descriptions. Based on this, a model for supervision should be developed, identifying specific responsibilities for supervision by level of service and category of personnel. The model should also include norms, proce-

dures, and guidelines for supervision, so that some standardization between Provinces occurs. Training of personnel in modern concepts of supervision will be needed, as will budgetary supplementation for vehicles and viáticos. These can be phased by Provinces selected for expansion of AID integrated rural health activities (see sections V and VII).

PRITECH can provide a consultant to assist in the design of supervision activities.

b. Information/Operations Research

A thorough review of the current information system for primary care and EPI activities is needed, and information selected for "flow and analysis" based on some of the priorities presented above. Needs for operations research should be identified and the resources required to implement them elaborated. The MSP does have a division for investigations that could play an important role in O.R. activities, but time did not permit a thorough evaluation of this unit or its capabilities.

Although some work has been done in information system development, more needs to be completed. PRITECH can provide an information systems/operations research specialist to assist in this analysis.

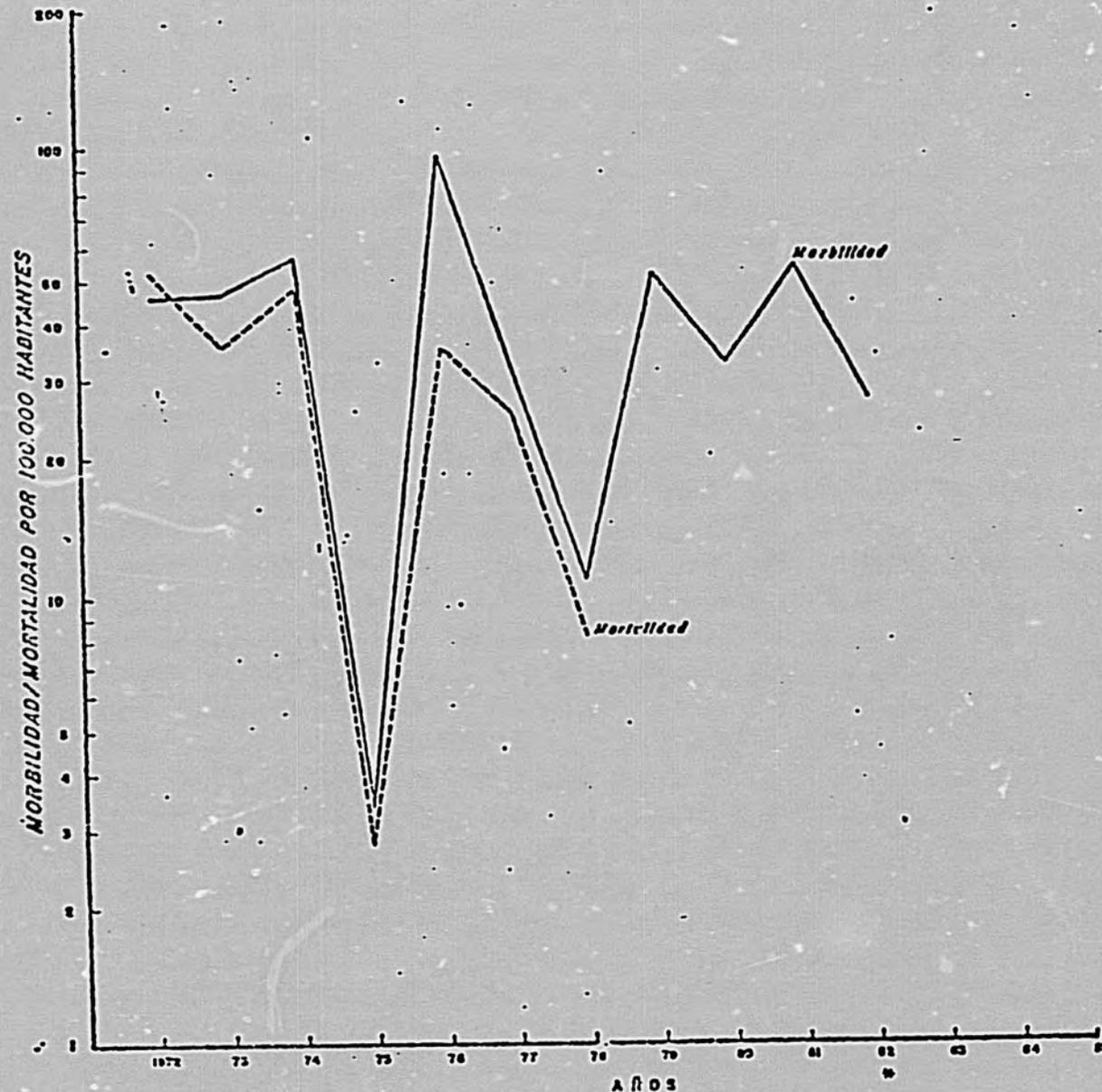
5. Training

Technical training in EPI activities seems to be well developed, although some adjustments will need to be made after the previous analyses have been completed. Financial support for development of materials, payment of viáticos, and evaluation of results could be provided by AID in the next

stage of expanded integrated rural health activities. The consultants described above, plus PAHO advisors, can help develop a training budget.

FIGURE 4

MORBILIDAD Y MORTALIDAD POR SARAMPION  
 (TASA POR 100.000 HABITANTES)  
 ECUADOR 1972-1985

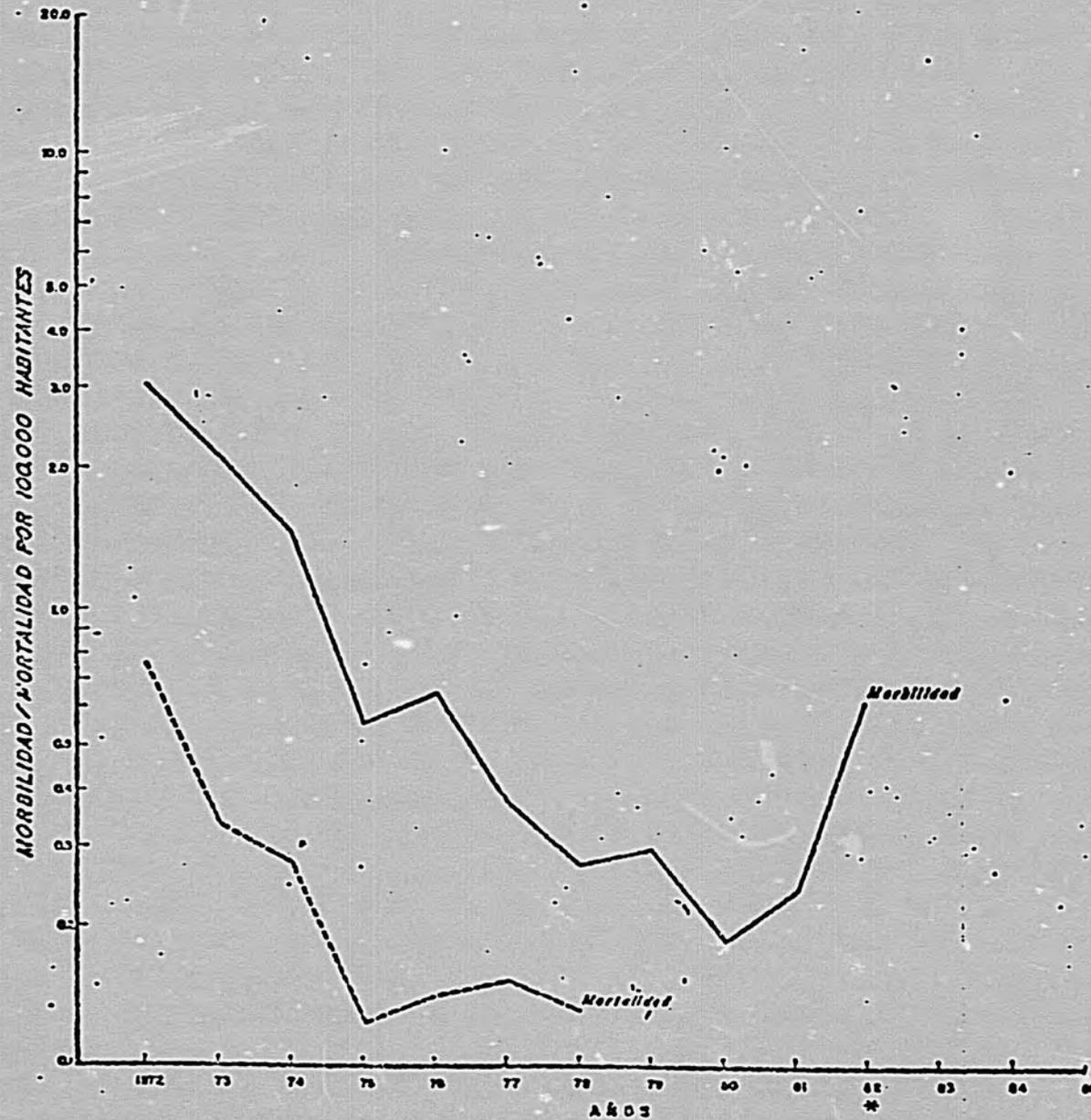


TASAS CALCULADAS CON LOS RESULTADOS DEL CENSO DE POBLACION DE 1972  
 ELABORACION Y FUENTE: DIVISION NACIONAL DE ESTADISTICA

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FIGURE 5

MORBILIDAD Y MORTALIDAD POR DIFTERIA  
 (TASA POR 100.000 HABITANTES)  
 ECUADOR 1972-1985

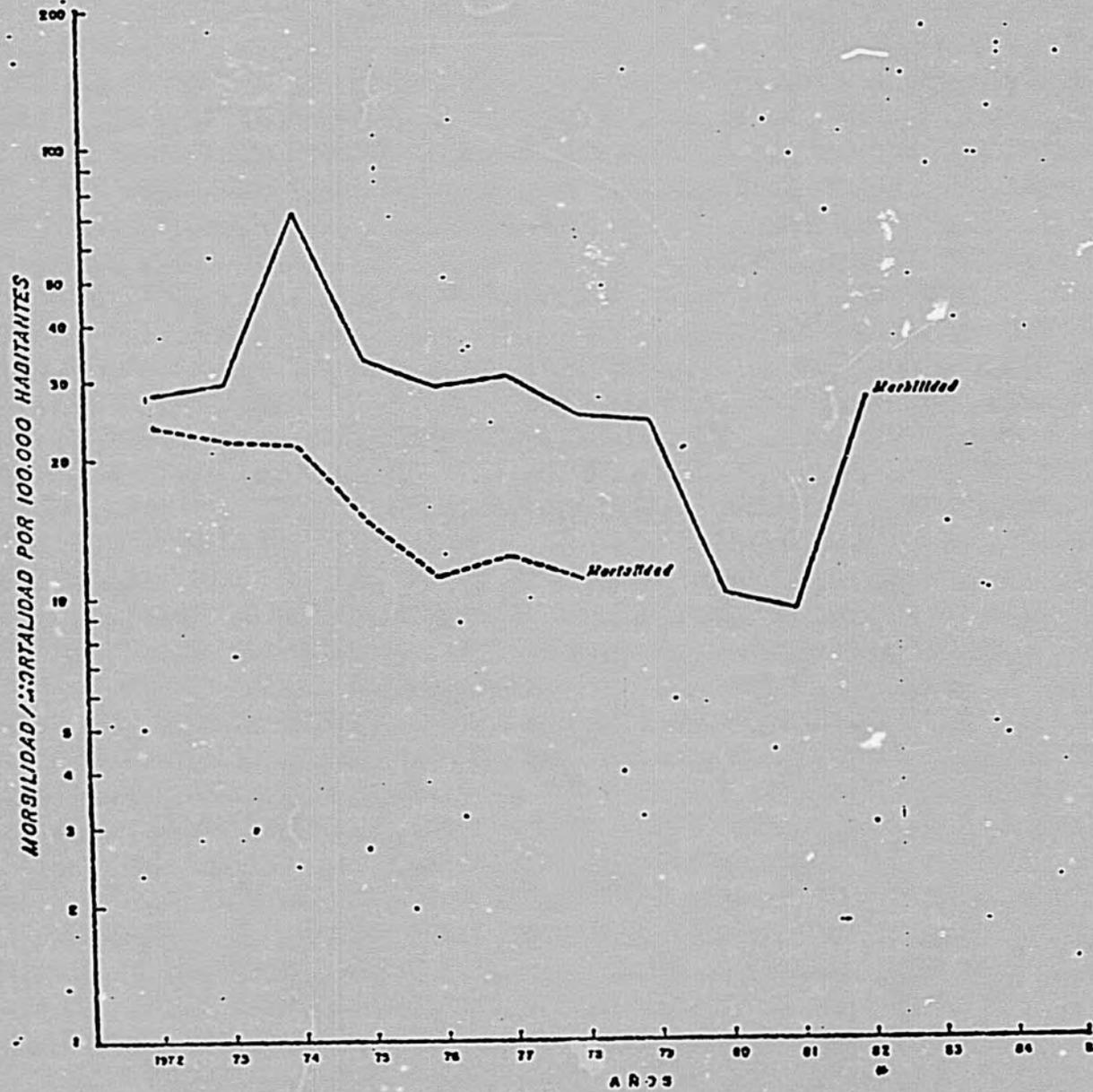


\* TASAS CALCULADAS CON LOS RESULTADOS DEL CENSO DE POBLACION DE 1981  
 ELABORACION Y FUENTE: DIVISION NACIONAL DE ESTADISTICA

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FIGURE 6

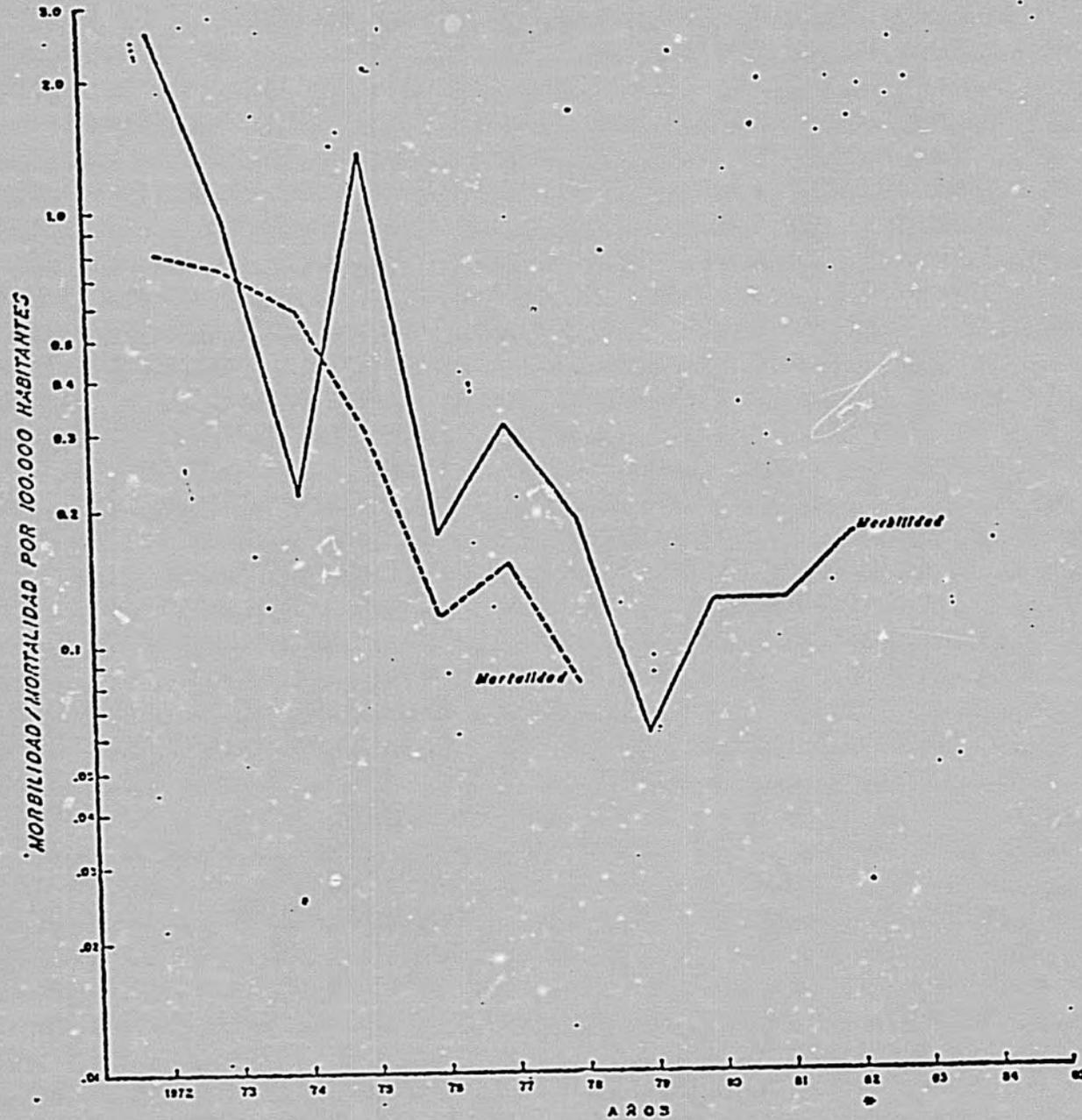
MORBILIDAD Y MORTALIDAD POR TOSFERINA  
(TASA POR 100.000 HABITANTES)  
ECUADOR 1972-1985



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← TASAS CALCULADAS CON LOS RESULTADOS DEL CENSO DE POBLACION DE 1981  
ELABORACION Y FUENTE: DIVISION NACIONAL DE ESTADISTICA

FIGURE 7  
MORBILIDAD Y MORTALIDAD POR POLIOMIELITIS  
(TASA POR 100.000 HABITANTES)  
ECUADOR 1972-1985

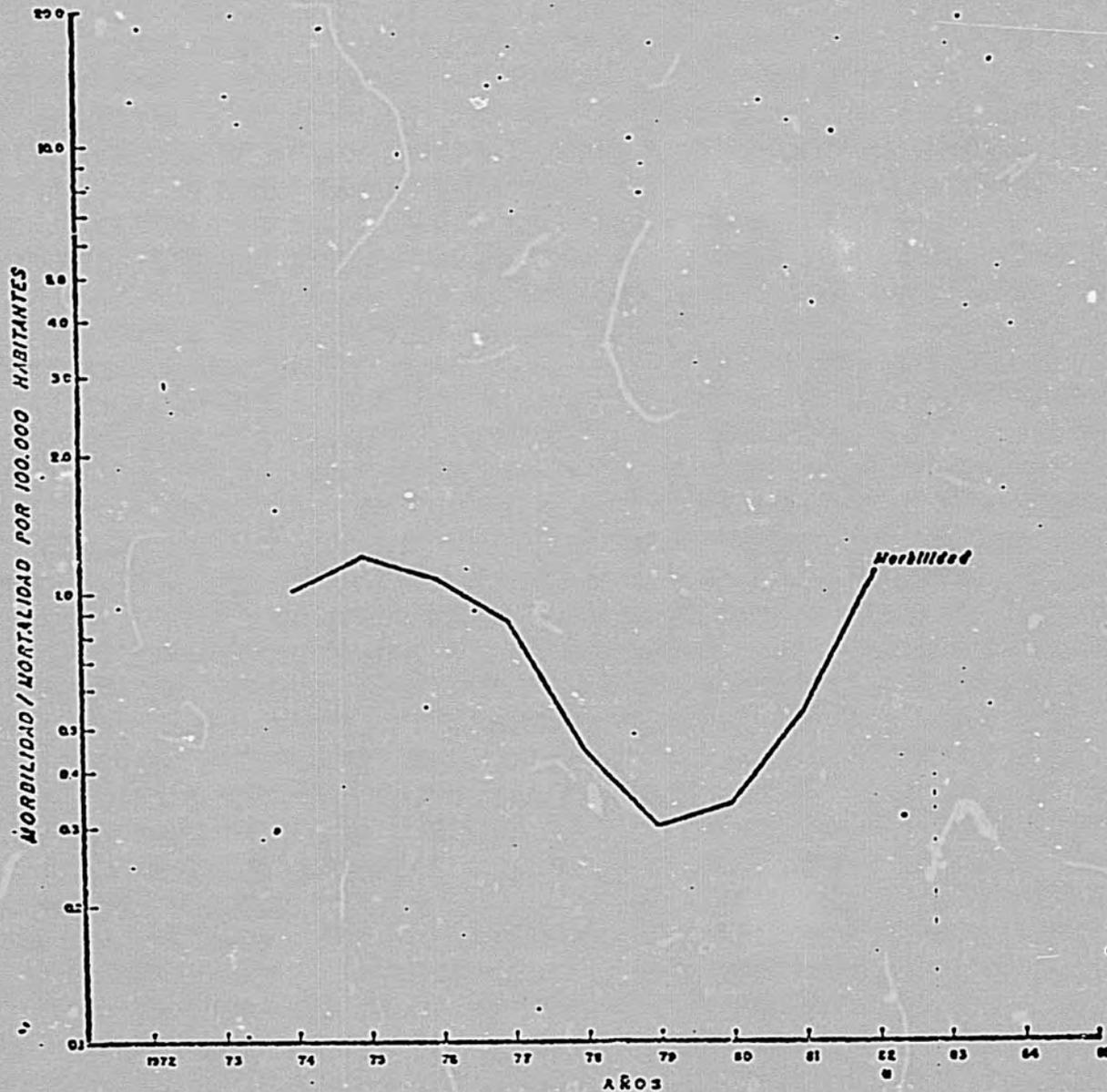


→ TASAS CALCULADAS CON LOS RESULTADOS DEL CENSO DE POBLACION DE 1974  
ELABORACION Y FUENTE: DIVISION NACIONAL DE ESTADISTICA

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FIGURE 8

MORBILIDAD Y MORTALIDAD POR TETANOS NEONATAL  
 (TASA POR 100.000 HABITANTES)  
 ECUADOR 1972-1985

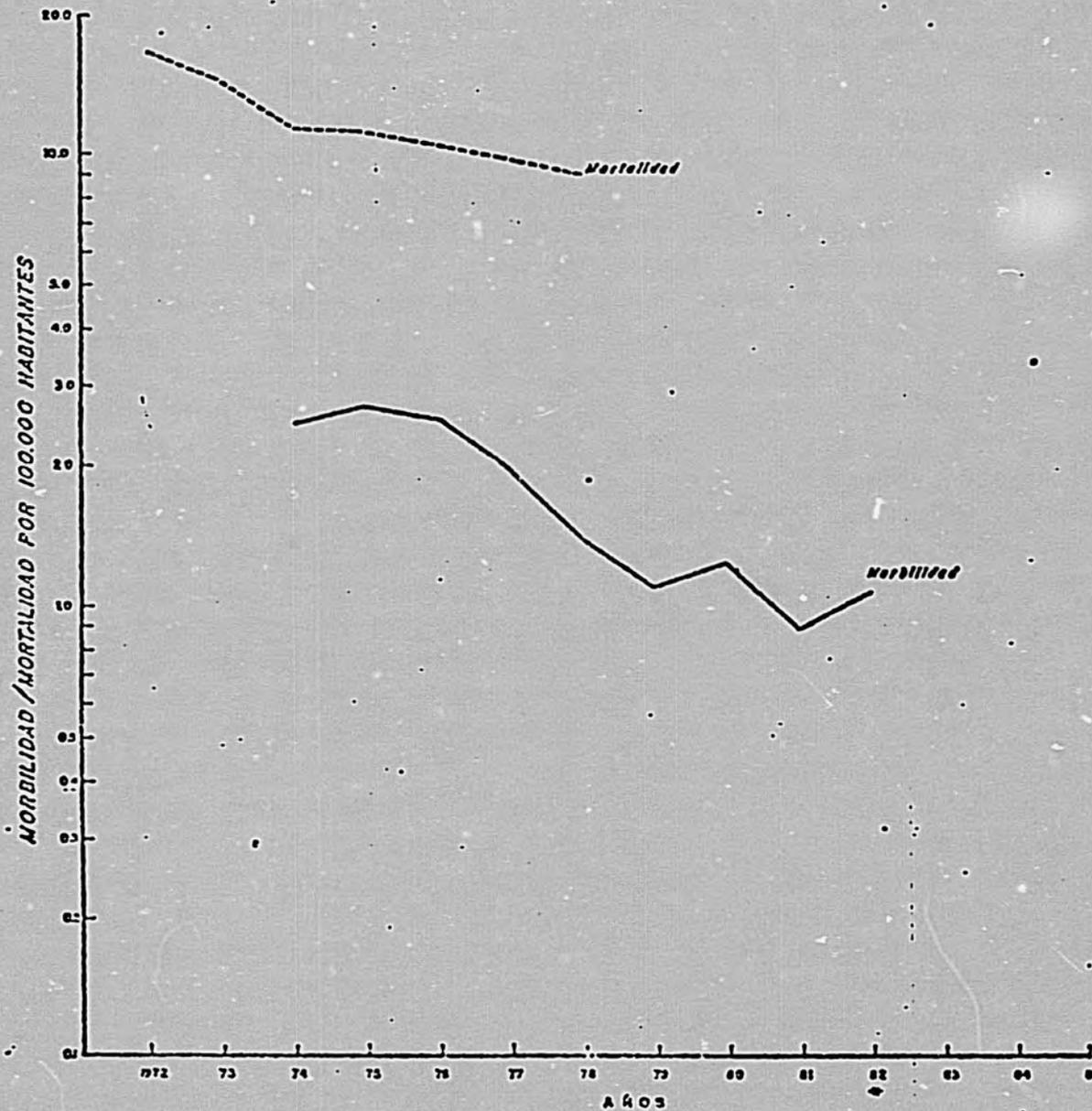


• TASAS CALCULADAS CON LOS RESULTADOS DEL CENSO DE POBLACION DE 1982  
 ELABORACION Y PUENTE: DIVISION NACIONAL DE ESTADISTICA

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FIGURE 9

MORBILIDAD Y MORTALIDAD POR TETANOS DE TODAS EDADES  
(TASA POR 100.000 HABITANTES)  
ECUADOR 1972-1985



← TASAS CALCULADAS CON LOS RESULTADOS DEL CENSO DE POBLACION DE 1962

ELABORACION Y FUENTE: DIVISION NACIONAL DE ESTADISTICA

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#### IV. Diarrheal Disease Control (DDC)

##### A. Background

##### 1. History

As in other countries at a similar stage in development, the primary cause of mortality (both general and infant) is diarrhea. In recognition of this situation, the MSP inaugurated in early 1979 its program for control of diarrheal diseases. Initially, the DDC program was part of the Division of Epidemiology. In 1982 it was re-assigned to the Directorate of Priority Programs, in the Division for Control of Frequent Morbidity.

The original objectives are still valid today. Within the overall goal to reduce morbidity and mortality in children under four years of age due to diarrhea, the following specific objectives were developed:

- Promote oral rehydration to prevent severe dehydration and/or death.
- Promote breast feeding as a preventive measure for diarrhea.
- Establish a surveillance system for diarrheal diseases.
- Involve the community in the DDC program.

The basis of this program was, and remains, distribution of oral rehydration salts (ORS) through the health system and community leaders. Health education and promotion

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of ORT, as well as environmental sanitation and personal hygiene, is viewed as an integral part of this effort, and received a substantial reinforcement with the arrival in August, 1983, of an advisor from the Academy for Educational Development, Dr. Reynaldo Pareja. Dr. Pareja had previously worked in the successful national health education effort in DDC in Honduras, and this experience has advanced the program considerably in Ecuador.

The MSP program was implemented in stages, with five provinces added each year since 1979. By 1982, the program was implemented in all provinces. Personnel at all levels were trained and supplied with ORS. Although initial problems with ORS supplies were encountered, this has now been resolved. In addition, the program developed relationships with the Facultad de Medicina, so that training in DDC and ORS is now an integral part of the curriculum for physicians and nurses. In a rather creative approach to DDC, the program also developed relationships with the national literacy program, and to date has trained over 9,000 literacy educators in basic DDC/ORT, 25% of which speak Quichua. Programs for training community leaders began in 1982, with support from the AID Integrated Rural Health Project and the aforementioned A.E.D. Project.

Thus, a wide-ranging, multi-disciplinary, multi-level program for DDC has been implemented on a national basis over the past five years.

Ciba-Geigy has recently announced plans to commercially produce ORS in Ecuador using the same formula and packaging as the MSP. Conversations with officials at Ciba-Geigy indicate a desire to market this product through private physicians, pharmacies, and small stores that sell simple medications. They are willing to use the same promotional

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strategies as the MSP via radio and printed material, but without the community component. The ORS will sell for approximately S/.25/packet, (US\$27), considerably cheaper than other diarrheal medicines on the market and affordable by most Ecuadoreans. Obviously, Ciba-Geigy feels they can make a profit at that price, or they would not try to develop the market. Ciba-Geigy has also offered to hold national ORT seminars for physicians and students and pay for radio promotion in urban areas. This initiative offers an exciting opportunity to develop a truly national DDC program with both public and private sector involvement, with a capacity for being self-sustaining in the future.

## 2. Structure of the MSP Program

As mentioned, the program for DDC is currently assigned to the Priority Programs Directorate, a clear policy statement of its importance to the MSP. Central staff consists of an MD chief and a nurse in charge of establishing Oral Rehydration Units (ORU's) in hospitals and Centros de Salud.

The functions of this central unit are similar to the counterparts in EPI:

- Establish norms and procedures;
- Training and supervision at the provincial level.
- Programming activities and supplies for each year.
- Evaluation.
- Coordination with other programs and agencies.

At the provincial level, DDC activities are supervised by a physician epidemiologist, as well as by personnel

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in the rural health division. They have the same functions, plus program implementation at sub-provincial levels.

The DRI project has created a new position - Area Chief - that is paid for by project funds. In the DRI areas where the AID project is functional the areas chiefs have taken a strong role in DDC activities and provide direct supervision to sub-centers and community personnel, who are also supplied directly by the DRI office. This system has in some respects developed in parallel to MSP efforts, even though substantial efforts have been put into project coordination and organizational linkages. This is discussed more fully in Section V.

### 3. External Assistance

#### a. PAHO

##### i. Technical Assistance

The technician assigned to EPI also shares some activities with DDC, as does the physician - epidemiologist.

##### ii. Assistance procuring ORS.

#### b. UNICEF

Initially, UNICEF also provided ORS, but this has been taken over by the MSP. UNICEF currently provides \$120,000/year in two areas:

- Establishment of ORU's.

- Training of personnel, including flip charts, posters, and plastic bags with printed instructions for distribution of the ORS.

c. AID

i. Integrated Rural Health Project (Mission funded)

Significant advances have been made through this project by providing financial support for health education/promotion activities via radio and printed material and for training of community personnel in DRI areas. Both of these activities are well developed and have had substantial impact on acceptance and utilization of ORT. The Project has also procured some ORS packets.

ii. Mass Media and Communication Project (AID/W funded)

This project provides the technical services of Dr. Pareja in design, implementation, and evaluation of the activities described above.

B. Experience to Date

These will be presented by the objectives outlined in the section on History.

1. Promote oral rehydration to prevent severe dehydration and/or death.

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a. Training

By now, all personnel at all levels of the health system have received training in the epidemiology of diarrhea, ORT, and education of the mother. The capacity now exists to continue re-training on a yearly basis in each Province. During the two days I was in Cotopaxi province to attend a training session for community leaders that was supported by DRI funds, the Province held one day of training for all physicians (with exception of MD's previously trained by DRI), and a second day for nurses and auxiliaries. The Province used their own funds and staff for this effort, and invited one of the best known pediatricians (an advocate of ORT) in the country to participate in the training.

b. Supplies of ORS

Ecuador currently has 2.5 million ORS packets in-country; 1.5 million are already in the system, and 1 million are in reserve at the central level. This should cover all needs for one year. Apparently, the MSP bought these with their own funds.

Field visits confirmed the presence of ORS at all levels. The provincial warehouses at Cotopaxi had 10,000 packets well organized and stacked on shelves. Each health facility visited had adequate stocks of salts, also well maintained on shelves. Health personnel noted that they used the salts a great deal and had no problem obtaining re-supplies. In the DRI area, DRI health staff provided ORS directly to sub-centros and community personnel.

c. Oral Rehydration Units

ORU's were originally developed as a concept for larger hospitals, and many have now been established and apparently are functioning. However, the MSP now considers this concept applicable to all health units, and has made specific metal plaques with the logo of the ORT program unit for permanent display. Radio spots reinforce this concept by telling people they can get "suero oral" for diarrhea wherever the plaque exists. These plaques are now available only in DRI areas, but will be expanded nationally.

Visits to health centers and sub-centers confirmed the existence of ORU's. Every facility visited had a small area set aside where mothers could rehydrate infants under supervision, complete with posters and other educational materials outlining the procedure in understandable terminology. Only in one health center visited (Salcedo) was the ORU non-functional due to lack of ORS, although all other elements were available.

d. Health Education/Promotion

As described before, each DRI area now has an intensive health education campaign to promote ORT through radio spots, printed material, and community leaders. These efforts are impressive, and deserve assistance for expansion on a national basis.

e. Impact of ORT

Given that personnel are trained, ORS are readily available, and each health unit now functions as an ORU, what has been the impact? We really don't know, since, as

described previously for EPI, the M.I.S. is not well developed. If anything, the number of diarrhea cases treated is rising, a good sign. In one Province visited, the number of children under five years of age treated by oral rehydration in 1983 was 1/2 the population in that age group. Not enough time has passed to measure changes in mortality.

However, it is worthwhile relating an interesting vignette. In late 1983, PAHO/W DDC staff visited Ecuador with a video team to make a movie on Ecuador's program. As part of this, they wanted to film a severely dehydrated child (Grade III) being successfully rehydrated by the mother. During two weeks, they visited all the major hospitals in four different provinces and could not find a child with anything greater than 3% dehydration. Although it is difficult to make any association with program services, it is a positive sign.

## 2. Promote Breast Feeding

Some effort has been put into educational activities related to breast feeding, but no true organized national campaign exists for this. This is understandable, since the program described above has required enormous commitment and resource allocation; however, promotion of breast feeding on a national basis will probably require additional resources.

## 3. Surveillance System for Diarrheal Disease

In January, 1984 the MSP implemented a new information system for treatment of diarrheal disease and included diarrheal diseases in the list of notifiable diseases. However, implementation has not been completed in all health units in all provinces.

#### 4. Community Involvement

In this consultant's opinion, this component of the program has been tremendously successful. Mention was previously made of the training of 9,000 community-based literacy educators. This required 1,590 courses, a phenomenal effort. In addition, training of community leaders has occurred in DRI areas supported by the AID integrated rural health project and the AED advisor. This consultant attended a re-training session of one of the original groups and was favorably impressed at the retention of knowledge and the reported level of use of ORS by the participants. Some even reported that they had trained others through Mother's Clubs, an unexpected multiplying effect (institution building, even where no institutions exist). A reporter from a local radio station that specializes in community news showed up spontaneously, and conducted interviews with participants in Quichua, asking such questions as, "what does 'suero oral' mean for the campesino". I must say I have never seen such spontaneous community interest in my career.

Each community leader was given a plaque designating them as an ORU, and sufficient packets for three to six months. This effort shows every sign of being self-sustaining with appropriate supports from the MSP.

#### C. Problems

##### 1. Management Support Systems

The same problems identified in EPI apply here. However, DDC activities have an additional problem in DRI areas. Here, DRI staff provide direct supervision and ORS to sub-centros and community leaders, thus by-passing regular MSP

channels. This probably allowed ORT activities to get off to a quick start, but raises questions about long-term continuity. The first area chief left in December after only one year on the job. A new one was not appointed to March, with a 2.5 month hiatus in supervision/re-supply activities. The new chief is contracted for only three months, and it is not clear what will happen after that.

Operations research is an important activity that needs strengthening. It would be nice to investigate why no severely dehydrated children were found at the hospitals, since this could help focus DDC activities. Unfortunately, the resources do not exist.

## 2. Health Education/Promotion

This is not a problem now. Quite the contrary, it is going remarkably well. However, the AED advisor is contracted for only a relatively short period of time (described in EPI section), and funds for radio spots and educational materials will eventually run out if not replaced. MSP funds are not sufficient for a national program. Therefore, other sources of funds and T.A. may need to be found to continue this apparently successful effort.

3. Resistance exists among medical staff, especially rural doctors. This should be reduced overtime with constant training and experience.

## D. Recommendations

The DDC program appears to be doing very well on a national basis, and shows promise to be self-sustaining. None-

theless, some adjustments can be made to improve program performance.

1. Improve Supervision and Information/Evaluation Activities

This is described in more detail in the EPI section and is equally applicable here. The suggested PRITECH Consultants in Supervision and Information/Operations Research should also investigate the DDC program and make specific recommendations for it.

A specific recommendation that can be implemented now is to integrate the trained community leaders into the MSP system. A simple way to do this would be to establish the Sub-Centro or puesto as the re-supply point (rather than DRI), and give only enough packets (e.g., 25/leader) to last two months. When the leader goes to the sub-centro for re-supply, and informal type of supervision will occur. This will also strengthen the referral system.

2. Health Education/Promotion

These AID assisted activities should continue. AID should consider liberating funds from DRI projects and provide them directly to the MSP for national education efforts. The aforementioned comments on the use of the AED advisor apply equally here.

3. Training

This appears to be going well, but some investigation is needed into the causes and patterns of resistance by rural MD's, and specific training programs designed to meet it.

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4. Breast Feeding Promotion

This deserved further analysis, and a program designed for national coverage. PRITECH can provide an initial evaluation, if desired, and help develop a PID for AID/W funding.

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V. AID Integrated Rural Health Delivery System, Project No. 518-0015

.. Background

1. Goals and Objectives

The AID Integrated Rural Health Project was developed under the framework of the previously described Ecuadorean Plan for National Development that stresses integrated development in rural areas. The project's overall goal is to improve the health of Ecuador's rural poor. The purpose of the Project is to develop a model for a low-cost rural health delivery system that is being implemented in three integrated rural development areas (DRIs) of the country-Jipijapa in the Pacific coast, and Salcedo and Quimiag-Penipe in the Sierra. Together, all three DRI areas contain approximately 100,000 people. The model is based on developing area level (Sub-Provincial) integrated services that could then be replicated on a larger scale.

The specific objectives of the Project are:

- Improve existing health services delivery and provide new integrated services in high priority rural areas.
- Improve utilization of low cost primary health care services through promotion and increased demand.
- Rationalize health services by coordinating efforts of all health institutions within the geographic area.
- Extend rural water and sanitation services.

- Incorporate nutrition concerns in programs.
- Decentralize decision-making and facilitate community participation.

2. Activities

Four major activity areas have occurred in the project.

a. Creation of the Area Chief

This is a new management post, designed to provide technical and administrative coordination for health service in DRI areas. Although assigned to work with DRI area staff, this new position is theoretically technically responsible to the Province Chief. The project has provided three months of training to candidates selected for the post, plus technical and material support for improved management systems.

b. Expanded Primary Care

The emphasis was to be placed on priority programs, such as DDC, EPI, and goiter control, that increase community participation and utilize community personnel. Funds were provided for training both MSP and community personnel, including educational materials and health promotion (radio spots), supplies (ORS), equipment for health centers, and vehicles were provided, and \_\_\_\_ sub-centers have been constructed.

Technical assistance has been provided by the project for management support, and by the aforementioned S/T Health/AED project for Health Education and Promotion.

c. Water Supply and Sanitation Projects, to extend coverage.

d. Nutrition activities, including supplementary feeding programs and activities to increase the availability of basic foods.

These last two activities are not covered in this analysis.

### 3. Project Implementation Arrangements

Four major Ecuadorean institutions are involved in implementation of project activities: the National Health Council (NHC); Ministry of Public Health (MSP); Ecuadorean Institute of Sanitary Works (IEOS); and the Secretariat for Integrated Rural Health Development (SEDRI). Project activities designed to strengthen the capacities of each of these institutions to support integrated rural health are managed by each institution. Funds for these activities include \$2.5 million in loan and \$475,000 in grant.

Funding for all field activities, including project implementation in the DRI areas, is channeled through SEDRI. These include almost \$4 million in loan and \$205,000 in grant funds. A contingency fund of \$715,000 does not have any specified channel for implementation.

The analysis that follows was requested in my scope of work, and is limited to DDC and EPI activities, plus those management activities, or constraints, that support, or hinder, those programs. As presented in Annex I, I visited only two DRI areas (Salcedo and Quimiag-Penipe), so this analysis is based on those visits, plus conversations with MSP per-

sonnel from the Provinces of Cotopaxi and Chimborazo and at the Central level.

B. Experience to Date

1. Development of the Area Chief

Posts were created, personnel assigned as Health Chief to each of the DRI areas, and three months of public health administration training was provided to the initial candidates.

a. Salcedo. The first area chief left after one year of work, in December, 1983, to study in Israel. A hiatus of 2.5 months occurred before the appointment of a new chief, who has a contract for only three months and arrived the day of my visit to Salcedo (March 16). No other health personnel had been assigned to this DRI area. Therefore, no one at the Salcedo DRI office was able to give me an accurate description of activities completed. However, review of records and conversations with personnel in Sub-Centers (see Annex I) give me the impression that the original Area Chief was quite dynamic and made repeated visits to the field to supervise Sub-Centers and hold community meetings. He seemed to focus in on two main activity areas: direct medical services and community organization/health promotion. He resupplied both sub-centers and community personnel with ORS when needed. However, all these activities stopped with his departure.

Conversations with MSP personnel, both at the Provincial office and at the Centro de Salud Hospital in Salcedo, indicate confusion over the role of the Area Chief and a fair degree of resentment. There appeared to be limited joint planning and coordination, and both the Provincial Chief and

director of the Health Center professed not to be aware of the Area Chief's activities, except as noted in periodic reports sent to the Jefatura after the fact. Both expressed concern that the Area Chief was providing direct supervision to health centers without coordinating efforts with nursing staff at the health center and Provincial offices, who also have this responsibility. A major source of resentment arose from a misunderstanding widely held that the Area Chief was paid almost 50% more than the Provincial Chief, even though he was considerably younger, less experienced, and was theoretically subordinated to him. This set of factors placed considerable strain on the relationships between the two people, and they apparently did not work well together. Concerns were also expressed about the relatively short period of time the Area Chief spent on the job and the ability of the new chief to improve relationships and coordination.

The Salcedo DRI office admitted that these problems existed, but felt they were due to personality differences and expressed hope that they could be resolved.

b. Quimiag-Penipe

Quimiag-Penipe is now on its third Area Chief. The first left before receiving training. The second was delegated from the Provincial Office, where he had been the head of Family Health. He received training in Cali, functioned for one year as Area Chief, then resigned to return to the Provincial Office as Chief of MCH Services. He apparently left because as an MSP employee he received his usual salary and felt the extra work (field trips, community organization, etc.) was not worth the pay. A third physician was appointed in January, a young medical graduate doing his required year of obligatory

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social service, which he will finish in August. This will then require a fourth person.

In contrast to Salcedo, this DRI Office had a complete staff, with the physician chief, a nurse, and a sanitary inspector. Their commitment and enthusiasm for their work was readily apparent. Frequent trips were made to the field by all, once again focusing on direct medical care and community health promotion. They had trained five nursing auxiliaries in the past year; however, none of them had been offered posts, and so were not functioning, with exception of one auxiliary who apparently volunteered as a distributor of O.R.S. The nurse indicated that she was trying to spend more time supervising auxiliaries and community personnel, but she had been there only three months and likewise was serving her year of social service. Therefore, she was just learning what the needs were and how to solve them.

Since the previous Area Chief had been (and once again is) a member of the Provincial staff with close ties to the Director, I saw none of the problems encountered in Salcedo with resentment and coordination. However, a very interesting dynamic developed when both the present and previous Area Chiefs expressed the opinion that their boss was the head of the DRI office, an Agricultural Engineer. The Project Coordinator and Regionalization Advisor (who had accompanied us on this evaluation trip) appeared irritated at this opinion and spent considerable time convincing the health staff that their "boss" was the Provincial Director, and they were supposed to "coordinate" efforts with the DRI Chief, with whom they worked daily.

In my opinion, this puts the Area Chief in an almost impossible position, and may be one of the intangible

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factors responsible for rapid turn-over. It points out the confusion that still exists (after two years of project implementation) over the role of the Area Chief. This was also apparent in Salcedo, even setting aside the issue of resentments. Does the Area Chief provide health services and promotion, or supervision, management support, and overall guidance? Who supervises the Area Chief - the DRI Chief or the Provisional Director? In both Salcedo and Quimiag-Penipe, it appeared to this consultant that the Area Chiefs reported to the DRI Chief, a fact which may account for a focus on curative services and community organization. These seem to be activities that DRI itself stresses.

## 2. Expansion of Primary Health Services

One of the stated objectives of the Project is to expand low-cost, highly effective services, such as EPI and ORT. This analysis looks only at those, and does not address the number or type of consultations or referrals provided by the Area Chief.

### a. EPI

To this observer, there did not appear to be any special emphasis on EPI activities. As part of equipping health sub-centers, some refrigerators have been provided where electricity was available. When staff went out to visit communities they often took vaccines along, but only visited about 1/3 of the communities a second time, so coverage was limited. Support was provided to the "fase intensiva" in 1983, and one recently completed in February, 1984, but no special education or promotion campaign for EPI activities was readily apparent.

This is reflected in the rates of coverage for children less than one year of age. Figure 10 shows the rates

for the Salcedo DRI area; a neighboring canton, Pujilí, that is similar in its rural demography but with normal MSP services, and the Provincia as a whole for 1982 and 1983. Figure 11 shows rates for Quimiag-Penipe (they are really two separate Parroquias) compared to the Province of Chimborazo for 1983. Time did not permit analysis of another area in Chimborazo.

These rates were taken from the basic monthly summary of immunizations recorded by each institution, and several hours were required in each Province to develop them. They were not prepared in advance, so there is no bias evident in them.

The data show no clear difference between either DRI area and the rest of the Provinces. This probably translates into no difference in morbidity rates for the six immuno-preventible diseases, although that data is not readily available, and it is really too early to expect any changes. This does, however, reflect the national pattern.

b. D.D.C.

In contrast to the EPI program, DDC activities have received considerable emphasis. All DRI health staff, plus Provincial staffs, and MD's at Sub-Centers in DRI areas, were trained in DDC activities and ORT in a Seminar in Riobamba held in September, 1983. Training of community leaders in ORT and promotion were conducted in both DRI areas visited. I attended an evaluation of community leaders six months after training, and their retention of knowledge was remarkable. Some of them had needed resupply from the DRI office, and were doing up to 6 - 10 ORT's/month. Considerable effort has been put into promotion and education, as described previously. Since October, radio spots in each DRI area has stressed ORT

FIGURE 10

PROVINCE OF COTOPAXI

COVERAGE OF CHILDREN 1 YEAR

1982

	BCG	DPT(3 <sup>o</sup> )	Polio (3 <sup>o</sup> )	Sarampión
Salcedo	57.9%	9.4%	9.2%	20.4%
Pujilí	57.3%	16.0%	14.2%	17.4%
Provincia	67.8	10.2%	9.8%	18.2%

1983

	BCG	DPT(3 <sup>o</sup> )	Polio (3 <sup>o</sup> )	Sarampión
Salcedo	70.8%	12.2%	12.5%	16.9%
Pujilí	50.4%	12.8%	13.3%	16.3%
Provincia	143.5%	22.3%	22.4%	29.8%

Population: Salcedo = 45,606  
Pujilí = 77,145  
Provincia = 279,622

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FIGURE 11

PROVINCE OF CHIMBORAZO

COVERAGE OF CHILDREN 1 YEAR

	BCG	DPT(3 <sup>o</sup> )	Polio (3 <sup>o</sup> )	Sarampión
1982	83%	25%	30%	27%
1983	92%	30%	31%	28%
Quimiag (1983)	100%	14%	17%	3%
Penipe (1983)	71%	23%	23%	12%

and early treatment, and the community leaders, spontaneously, reported that the radio spots considerably reenforced their efforts and elevated their stature in the community.

Every Sub-Center visited had adequate stocks of ORS and educational materials, including the sign announcing the O.R.U., posters, and plastic envelopes with instructions for ORS distribution.

As mentioned in the general discussion of DDC activities, there is a sense of momentum in this program with ever-expanding activities designed to increase the use of ORT. As aforementioned, these efforts have received considerable reinforcement from the AED advisor, who helped design both the promotional campaign and training of community leaders. More importantly, he has involved both Central and Provincial MSP staff in these efforts, not just DRI staff. Both Cotopaxi and Chimborazo have now completed training programs for community leaders in other cantons of the provinces without DRI assistance. However, limitation of funds have prevented expansion of the health education and promotion campaign.

What has been the result of this effort? In 1983, the Province of Chimborazo reported 12,380 children orally rehydrated. This is impressive, since census figures report a total of 56,043 children 0 - 4 years of age. Quimiag-Penipe reported 366 children rehydrated in 1983, or 3% of the total. Since Quimiag-Penipe contains 4.3% of the population of children in this age group in the Province, no increased effect of the DRI project on the number of children rehydrated can be demonstrated. In all fairness, the intensive activities described above have begun only in the last half of 1983, and it may be too early to show an effect. Better results should be anticipated for 1984, if the problems with the Area Chief can be solved.

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c. Community Organization

Since the EPI and DDC programs are most effective if community-based, it is worthwhile examining Project efforts in this regard. I am frankly most impressed with them, and they may be the most concrete result of integrated rural development.

The DRI strategy for community development is based on three stages.

Stage I activities involve developing an organization within each community with members responsible for each specific component, i.e., health, agriculture, education, etc. DRI staff provide support and training to improve the capacities of this organization, plus funds and supplies for community - initiated activities once the organization is functional. As stated previously, after medical consultations this is probably the largest activity for the Area Chief.

Stage II activities involve creating a federation of community organizations within each Parroquia.

Stage III involves creating a canton-wide cooperative of community organizations.

Stage II organizations now exist within some Parroquias. DRI hopes to reach Stage III by the end of Project in late 1985. DRI staff feel that once Stage III organizations are functional, community-based activities will be able to continue on their own, supported by the larger cooperatives. While my heart would like to agree with this concept, experience suggests community organizations involved in service-oriented activities (such as health), as opposed to product-ori-

ented activities (such as agriculture or handcrafts, where the product can be sold outside the organizational area), will require continual support, supervision, and supplies. This can only be provided over the long-term by the MSP.

Within each stage of organization people are responsible for health. They usually become the people selected for specific training. Various types of training does occur: the aforementioned training in ORT; training as a promoter, who receives a small stipend; or training in managing a "Botiquín Comunal". The first type of training is going well. The last two have run into some difficulties, usually with lines of authority. Physicians have not readily accepted promoters, nor do promoters appear to function well without adequate supervision. In Quimiag-Penipe none of the programmed "Botiquines Comunales" were implemented because the Area Chief did not feel the strategy was well developed as to how they should be managed, and he did not want to waste the resources.

However, even given these constraints, the process of community organization to support health services is impressive and would not exist in its present form without support from this Project. It is this type of community structure, combined with private initiatives and MSP efforts, that allows me to feel enthusiastic about Ecuador's prospects for national coverage of both EPI and DDC.

### C. Problems

Most of the problems are self-evident from the previous discussion.

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1. Area Chief

The Area Chief is the lynchpin around which all project activities resolve, yet a series of problems have developed:

a. Frequent turnover wastes investments in training.

b. Relative youth of chiefs, plus turn-over, results in inexperience and limited productivity.

c. Lack of definition of role (i.e., direct health services vs. supervision/management) produces confusion.

d. lack of clear lines of authority likewise creates confusion.

e. Resentments towards Area Chief for collateral issues (e.g., salary) hampers coordination and cooperation with MSP staff.

2. Duplication of Effort

The project design and MSP directives stipulate that all DRI health activities are MSP activities and supervised by them. However, this consultant has observed several activities that appear to be duplication of efforts.

a. Supervision

Health Centers provide vaccines and supplies to Sub-Centros, yet DRI staff provide direct supervision to Sub-Centros and communities. Would it not be better to

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strengthen the capacity of health centers to supervise sub-centros (since they provide supplies), and sub-centros to communities, rather than create a parallel system? Should not the Area Chief, if there is to be one, work out of the Health Center rather than be independent? Should not the rural Health Project strengthen the existing supervision structure to insure long-term continuity?

b. Training

The Project provided ORT training to all physicians working in the DRI areas visited. The Provinces subsequently trained the rest of their staff but without participation of the previously trained DRI staff. Would it not be more efficient and effective to do all the training on a Province-wide basis, thus reenforcing patterns of referral, and the chain of supervision and administrative authority?

c. Two Bosses

As discussed before, a horse with two riders does not perform well. There is evidence to suggest that even though Area Chiefs are supposed to be under the supervision of the Provincial Chief, the types of activities they complete seem to respond to DRI initiatives.

3. EPI Activities are weak, especially in education, promotion, and extension of coverage. The project needs to focus attention in these areas.

4. Limited Coverage

Given the amount of resources invested in this Project, the coverage in the three areas combined is only

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100,000 people. Given the analysis presented above, it would be appropriate to rethink Project strategy and reprogram the resources to achieve a much greater coverage in terms of population. The unexpended resources, wisely used, should catalyze a dynamic process of expanded health interventions that could significantly reduce morbidity and mortality in the next five years in Ecuador. This is discussed more fully in Section VII.

D. Summary

It appears to this observer that whatever gains have been made in priority primary health activities (EPI and DDC) through the Integrated Rural Health Project, could have been made just as easily by working directly within the MSP structure.

In fact, evidence suggests that for ICI and oral rehydration activities, the Provinces of Cotopaxi and Chimborazo have achieved similar success in Cantons outside DRI areas, but without the additional resources. This raises questions about the cost-effectiveness of the DRI project and the channeling of AID implementation funds in health through SEDRI.

One area of major project achievement is in community organization. It does not appear that the MSP structure is sufficiently developed to achieve much in this area. Therefore, this is one activity that deserves continued support through SEDRI.

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VI. Other Agencies

A. CARE

1. Contact

Mr. Brian Cavanagh, Director

2. Activities

CARE is currently phasing out of supplementary feeding programs and is focusing more on development of rural water supplies. They work in communities 300-500 population, usually in conjunction with Provincial Development Councils. In each site, they assist in developing community organizations for assistance with installation and maintenance. Each year 35 new sites are implemented. CARE has a staff of two international advisors and twelve nationals.

3. Potential for ORT/EPI Involvement

The director expressed interest in having his staff participate in training sessions. They, in turn, could train others on the Provincial Councils and community leaders. Although their overall coverage is not very large, over time a large number of small communities could be incorporated into the program.

B. Peace Corps

1. Contact

Dr. Miguel Artola, Health Officer.

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## 2. Activities

The Peace Corps currently has 250 volunteers in Ecuador, of which 32 are assigned to the MSP. These health PCV's work principally in Sub-Centros de Salud in seven Provinces and barrios marginales of Quito and Guayaquil. Forty percent of activities are spent within the Sub-Centros de Salud and sixty percent outside. Priority activities are in the areas of community organization, health education, and frequent morbidity. Within these large areas, the PCV usually picks more specific projects appropriate to their locale. Thus, a wide range of activities occurs with variation between sites.

## 3. Potential Involvement in ORT/EPI activities

Dr. Artola appeared enthusiastic about assisting health PCV's to focus in on specific priority programs to reduce mortality. In addition, he feels it would be possible to identify other PCV's (who are not necessarily directly involved in the health sector) to receive training to serve as ORT/EPI promoters at the Area Level. Training of personnel, educational materials, and supplies will be necessary for this strategy to function well.

### C. MAP International

#### 1. Contact

Mr. William Senn, Director  
Dr René Manangón, Chief of Health.

## 2. Activities

MAP International started thirty years ago to distribute donated medicines and equipment. They still do this, but ten years ago, they started a program for international development with a health component. MAP works with church organizations, both missionary and indigenous. Their major effort is directed at thirteen Christian-Indian organizations developed on a province-wide basis. Each provincial organization belongs to a national federation.

Each Province tends to develop its program according to need, working with local community groups. In Chimborazo, as an example, MAP has assisted these organizations to implement a series of programs. Starting with increased agricultural production, the Provincial organization then developed a savings and loan association for credit and an agricultural store. Using the community organizations developed in these programs, community personnel were then trained as water technicians and solid-waste disposal technicians to assist villages with potable water and latrines. Currently, an intensive effort is underway to develop women's leadership training to focus on MCH issues and nutrition.

In Chimborazo there are currently 180 communities active in the program representing 10,000 families. In addition, each Christian-Indian organization has its own radio station with health programs.

MAP has a staff of six, including a physician and nutritionist. They are able to obtain additional staff for special projects through their network of contacts with missionary groups. They stress self-reliance of local groups and

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basically train community trainers. For this reason they promote suero casero, so isolated villages do not have to depend on unreliable logistics systems. If adequate and consistent supplies of ORS would be available, they would integrate into the national program. No programs exist for EPI activities, but they would like to start them.

### 3. Potential Involvement in ORT/EPI Activities

With its extensive network of grassroots community organizations and contacts with other campesino-oriented groups, MAP International offers an opportunity to expand the community base of these programs. Like the other agencies, MAP would require funds for training, materials, and supplies.

#### D. Seguro Social Campesino

##### 1. Contacts

Dr. Galo Cordero, Director

Dr. César Córdova, Chief of Family Health.

##### 2. Activities

Seguro Social Campesino is financed by a cuota of 1% of the payment by the urban insured, and notably payments by each campesino family of 1% of the minimum salary. These latter payments are often irregular. SSC currently covers 250,000 campesinos through a network of 239 Dispensaries. By December, 1984, they plan to have 375 Dispensaries covering 400,000 campesinos. Each Dispensary has at least one full-time nursing auxiliary, plus an itinerant doctor. Depending on demand, the doctor may work one day a week or full-time.

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SSC services are mostly curative, although they do offer MCH services, immunizations, and supplementary feeding. They use MSP guidelines for these programs, but the lack of vaccines in the country has seriously hampered this program. They would be willing to vaccinate anybody, even children of uninsured families, if they had enough vaccines. They have no health promotion campaign, and would be willing to work with the MSP in this regard. SSC also has weaknesses in their peripheral cold chain, supervision, and operations research. Thus, the previously proposed consultants from PRITECH can analyze SSC problems as well.

One interesting problem is that the Director of Family Health is strongly opposed to ORS, feeling that the mixture becomes contaminated and adds to the disease load of the child. In the dispensaries they use venoclysis, and recommend rice water or similar mixtures for use in the home.

### 3. Potential for Participation

With their extensive network of dispensaries the coverage of rural populations with EPI activities is possible (although a number of dispensaries are located in communities with Sub-Centros). Since the current national effort in DDC is based on ORS, it does not appear the SSC would be willing to participate in this program at this time. However, ways could be found to integrate their concepts of home rehydration into the national program. The needs of SSC for expanded EPI activities must await further analysis.

#### E. Catholic Relief Services

##### 1. Contact

Mr. Vernon Ficklin, Director.

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2. Activities

CRS is heavily involved in distribution of food supplementation and participates in over 400 Mother's Clubs around the country. Time did not permit personal investigation before this report went to press.

F. Ciba-Geigy

1. Contact

Dr. José Torres, Medical Advisor.

2. Activities

Ciba's plans to market ORS have been described in detail previously. They currently have sold 500,000 packets in the country. Their major efforts in education are directed at reducing resistance in physicians. As an interesting side-light, Dr. Torres used to be the chief of the pharmacology committee of the MSP, and is very interested in the production of basic drugs in the country. This is worth investigating further.

3. Potential for Participation

Ciba seems to be covering the private sector very effectively. The major assistance PRITECH could provide would be technical experts for national seminars.

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## VII. Strategies

### A. AID Rural Integrated Health Project

#### 1. Expansion

Where do we go from here? Experience and the results of this analysis, suggest that expansion of project activities to Provinces is a natural progression. The three Provinces of Cotopaxi, Chimborazo, and Manabí contain 25% of Ecuador's population, and re-enforcing MSP provincial activities, focusing in on EPI and DDC programs, could produce significant changes in morbidity and mortality patterns in the next few years in a good portion of the population. As the economic climate improves, the MSP may well be able to expand into other provinces with their own resource, thus achieving more national coverage.

Given this type of expansion, the concept of a separate Area Chief does not seem viable, unless the MSP is willing to create the posts and fund them with their own resources. A more viable strategy would be to strengthen the Health Centers to turn the Directors into functional Area Chiefs. This could be done by in-country public health management training; the addition of more cost-effective personnel, such as a nurse, administrator, and sanitary inspector; and vehicles and viáticos for supervision. With the exception of the personnel, the other components could be supported by AID.

#### 2. Suggested Project Activities

Given the analysis presented in their previous six sections, activities in the following area would consider-

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ably strengthen national-level efforts in EPI and DDC. The exact budget for each activity must await further analysis.

a. Health Education and Promotion

The successful experience in DRI project areas should be expanded to both include EPI activities and the wider geographic area of the Provinces.

The Project could fund radio spots, educational materials, and training and evaluation of both MSP and community personnel on a Province-by-Province basis. Continued technical assistance from the AED advisor, Dr. Pareja, would be an important adjunct to this process, and would considerably accelerate implementation and, thus, overall project success. The Mission should initiate negotiations with S/T Health and the A.E.D. in regards to the availability of Dr. Pareja.

b. Supervision

Supervision needs considerable strengthening for both EPI and DDC activities. PRITECH can provide some technical assistance in analysis and design of the system. The project can provide training in supervision; materials, such as manuals, guides, and check lists; vehicles, e.g., one for each Health Center in Project Provinces; and funds for per diems and gasoline for supervision.

c. Information/Evaluation

i. M.I.S.

Although good basic information exists, and the M.I.S. has just gone through a recent re-design, atten-

tion needs to be paid to the collection, formatting, flow, and use of this information. PRITECH can provide a technical analysis. The project could provide some micro-computers in key areas, such as the Divisions of Planning and Epidemiology, and the Project Provincial Offices. Micro-computerizing has advanced so rapidly that for \$5,000 one can buy the automated processing capacity that would have cost \$100,000 three years ago. Automated processing is essential if the MSP system is to provide timely and useful information. Funds could also be used for training, not only in the technical aspects of handling micro-computers, but in the use of the information produced in decision-making. Observational trips are often useful in this regard.

ii. Operations Research

The current capacity to do special studies in a short period of time oriented towards identifying and solving bottlenecks that prevent effective program implementation is limited. Analysis is needed to identify needs for this activity. The Project could fund field teams; data analysis or a mini-computer; training of personnel; and seminars/symposiums for presentation of results.

d. Vaccine Logistics/Cold Chain

It is unclear exactly what is needed until the recommended analysis is complete, but the Project could contemplate buying non-electric refrigerators or cold boxes; thermometers; time-temperature indicators; tools for refrigerator maintenance; and, if needed, special vehicles for vaccine transportation. Training of Provincial and Health Center maintenance personnel in refrigerator repair, and all health system personnel in preventive maintenance would significantly improve

cold chain function. It may be necessary to send several central maintenance personnel for advanced training in refrigeration for maintenance of cold rooms and large freezers. Stand-by generators at the Provincial level may be important.

Investment in the increased production of vaccines (lyophilized BCG and DPT) by the Instituto Nacional de Higiene in Guayaquil may be cost-effective, and deserves analysis.

### 3. Sources of Funding

The project currently has \$715,000 in unprogrammed contingency funds, plus whatever unexpended loan funds remain that could be reprogrammed for this effort. This consultant sees no advantage in channeling these funds through SEDRI, and recommends they be channeled directly to the MSP for use in Project Provinces.

PRITECH has a limited amount of funds available for specific activities designed to "bridge the gap" until the Pro Ag is amended or a new project developed. Use of these funds, of course, depends on the next stage of analysis. Ecuador could also be selected as one of the six final countries selected for intensive assistance. This I strongly support.

#### B. PRITECH

On the basis of this analysis, I believe that Ecuador has one of the best chances I have ever seen to implement national EPI and DDC programs, provided the country gets some critical support. This is not just rhetoric. The political and policy-level commitment exists; the physical infrastructure is in excellent condition; staff is in place; successful

and somewhat unique experiences have been obtained, especially in DDC; private sector initiatives through Ciba-Geigy and the Seguro Social Campesino show promise of achieving coverage through alternative systems; and the human resources I have met appear enthusiastic, capable, and committed. For these reasons, I recommend that PRITECH proceed with the next stage of analysis, and that Ecuador be given careful consideration as one of the final six countries selected for intensive assistance.

PRITECH should provide consultants in the following areas (oriented towards improved EPI and DDC programs):

1. Supervision

a. Scope of Work

Work with counterparts within the MSP and other agencies to:

- i. Review current supervision patterns.
- ii. Assist in design of a task analysis of key personnel.
- iii. Review and suggest changes in job descriptions of key personnel to improve supervision.
- iv. Suggest a basic model for supervision with guidelines for improved, supportive supervision; specific responsibilities and activities; check lists or supervision forms; and provide samples.

v. Identify needs for improved supervision in Project Provinces, including but not limited to:

- Training.
- Supplies.
- Vehicles.
- Per diems.
- Gasoline.
- Further technical assistance.

vi. Develop work plan for implementation:

vii. Coordinate activities in CIMDER, host country contractor in management.

Work with AID/Ecuador health staff to:

- Design project amendments.
- Develop budget.
- Submission of PID to PRITECH for complementary support.

b. Length of Time

Eight to ten weeks in divided visits.

c. Requirements

i. Minimum master's level in management or social sciences or MD-MPH with experience in public health administration.

ii. Experience in design and implementation of primary health supervision systems in LDC's.

iii. FSI-3 in Spanish.

2. Information/Evaluation

a. Scope of Work

Work with appropriate counterparts to:

i. Identify specific indicators for EPI and DDC program performance important for management decision-making.

ii. Review current primary health management information systems with regard to EPI/DDC activities.

iii. Assess appropriateness of current MIS for producing indicators and suggest improvements (if needed).

iv. Identify needs for improved information processing with the possibility of micro-computers in key areas (Provinces/Central Level).

v. Identify training needs for MIS and alternative processing.

vi. Identify needs for operations research or special studies in EPI/DDC programs.

vii. Identify resources needed to implement O.R. projects.

viii. Develop work plan for both MIS and O R. activities.

ix. Coordinate activities with CIMDER, host-country contractor in management systems.

Work with AID/Ecuador health staff to:

- i. Design project amendments.
- ii. Develop budgets.
- iii. Prepare PID for submission to PRITECH.

b. Length of Time

Four to six weeks.

c. Requirements

i. Minimum master's, preferably doctorate in management, public health or social sciences, with emphasis in evaluation. MD-MPH with appropriate experience acceptable.

ii. Experience in LDC's in design and implementation of information and evaluation systems, with particular emphasis on EPI/DDC activities.

iii. FSI-3 in Spanish.

3. Vaccine Logistics/Cold Chain

a. Scope of Work

Work with counterpart to:

i. Review cold chain, especially from Health Center to Sub-Centro, puesto and community.

ii. Identify potential failures, and suggest alternatives for:

- Equipment (non-electric refrigerator, cold boxes, thermos, etc.).

- Strategies for vaccine delivery.

- Temperature indicators.

iii. Identify needs for operations research in cold chain and vaccine viability or effectiveness.

iv. Identify needs of Instituto Nacional de Higiene in Guayaquil for increased production of DPT, TT, and lyophilized BCG.

v. Analyze strategies for vaccine procurement and suggest alternatives (if needed).

vi. Recommendations for improved cold-chain maintenance, including:

- Personnel by level.

- Training.

- Tools and equipment.

b. Length of Time

Four to six weeks.

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c. Requirements

i. Minimum master's in management or public health, or MD-MPH, with appropriate experience in cold chain/vaccine logistics.

ii. Experience in EPI's in LDC's with emphasis on cold chain development.

iii. FSI-3 in Spanish.

Note: after initial assessment of Instituto Nacional de Higiene, a second consultant with specific training and experience in vaccine production may be needed. This depends on what level of assessment has already been completed by the Instituto.

4. Financial Analyst

This consultant is suggested if the MSP and AID together decide that a cost-effectiveness analysis of various health programs would be useful to help resolve issues in implementation of policy.

a. Scope of Work

Work with appropriate MSP counterparts to:

i. Complete a cost-effectiveness analysis of investments in expanded EPI/DDC efforts compared to investments in other programs.

ii. Within DDC/EPI programs, assess cost-effectiveness of various alternative strategies for implementation.

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iii. Do financial projections of recurring costs of completed construction of planned Centro de Salud Hospitales.

iv. Discuss results with policy-level personnel within MSP and identify methods of dissemination of results for improved decision-making.

b. Length of Time

Four to six weeks; additional time may be needed.

c. Requirements

i. Minimum master's, preferably doctorate, in management, economics, or other social science with emphasis in financial analysis.

ii. Experience in cost-effective analysis in LDC's.

iii. FSI-3 in Spanish.

6. Promotion of Breast Feeding

a. Scope of Work

i. Analyze existing information about breast-feeding patterns in urban and rural areas;

ii. Identify institutional responses to problems in breast feeding.

iii. Suggest alternatives to Ecuadorean agencies and AID/Ecuador for development of national program for promotion of breast feeding.

iv. Assist in development of project amendments, proposals, budget, and PID as needed.

b. Length of Time

Four weeks.

c. Requirements

i. Minimum master's in public health, nutrition, nursing, or social sciences.

ii. Experience in national level breast feeding promotion in LDC's.

iii. FSI-3 in Spanish.

7. General

All consultants need to touch base with the other agencies identified in this report to identify their needs for expanded EPI/DDC activities. This includes IESS, the Peace Corps, MAP International, and CRS. They can then assist the Mission develop strategies and projects to re-enforce these agencies.

In addition, Mission requests a separate training report with training needs prioritized by component.

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iii. Suggest alternatives to Ecuadorean agencies and AID/Ecuador for development of national program for promotion of breast feeding.

iv. Assist in development of project amendments, proposals, budget, and PID as needed.

b. Length of Time

Four weeks.

c. Requirements

i. Minimum master's in public health, nutrition, nursing, or social sciences.

ii. Experience in national level breast feeding promotion in LDC's.

iii. FSI-3 in Spanish.

7. General

All consultants need to touch base with the other agencies identified in this report to identify their needs for expanded EPI/DDC activities. This includes IESS, the Peace Corps, MAP International, and CRS. They can then assist the Mission develop strategies and projects to re-enforce these agencies.

In addition, Mission requests a separate training report with training needs prioritized by component.

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The consultants identified above are placed in order of priority; in case resources are not sufficient for all of them. Dr. Pareja of AID should also participate with the survey team, since the major support the other agencies will need are in the area of health education and promotion. He can assist them to identify their needs and develop budgets. Because of his knowledge of these agencies and field conditions, probably two weeks of his time will be sufficient.

Addendum: Time did not permit inclusion of my analysis of CRS, but they seem the most promising of the PVO's. Not only are they in contact with 400 Mother's Clubs, CRS officials feel that the Cardinal, who strongly supports MCH programs, would encourage participation of the 2,000 parochial organizations in the country. CRS would need some staff support to do this, and is very enthusiastic about this program.

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MINISTERIO DE SALUD PUBLICA DEL ECUADOR

AGENCIA INTERNACIONAL PARA EL DESARROLLO DEL GOBIERNO  
DE LOS ESTADOS UNIDOS DE AMERICA

PROYECTOS:

A.I.D. 518-0015  
A.I.D. 518-U-040

*Evaluation of the Health Component of the DRI projects*  
EVALUACION DEL COMPONENTE DE SALUD DE LOS PROYECTOS DRI:  
SALCEDO, QUIMIAG-PENIPE Y JIPIJAPA

GRUPO DE EVALUACION:

- Hugo Corral Ruilova, MD-MPH
- Patrick Marnane, Asesor
- Robert Emrey, Asesor
- Fred Hartman, Asesor

Quito, Marzo de 1984

### AGRADECIMIENTO

- A los funcionarios del Ministerio de Salud Pública y de la Secretaría de Desarrollo Rural Integral.
- A la Oficina de Coordinación DRI del Ministerio de Salud Pública.
- A la División de Salud de la Agencia Internacional para el Desarrollo.

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- No. 1 - Agenda de Trabajo
- No. 2 - Lista de Entrevistados
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## I. INTRODUCCION

### A. Objetivos y Estrategias del Proyecto

- La provisión en áreas rurales de alta prioridad de nuevos servicios de salud integral y el mejoramiento de los servicios existentes mediante la provisión de recursos adicionales.

- La promoción e incremento de la demanda para la mejor utilización de servicios primarios de salud.

- La coordinación de esfuerzos con otras instituciones de servicios de salud, dentro de áreas geográficas específicas, a fin de racionalizar la entrega de servicios.

- La provisión de agua potable y servicios sanitarios básicos a través de tecnologías apropiadas y de bajo costo.

- La incorporación e incremento de aspectos nutricionales dentro del diseño y ejecución de programas de salud.

- La descentralización de la gestión administrativa y del proceso de toma de decisiones en relación a los programas de salud; y, la promoción de la participación comunitaria en dicho proceso y en la implementación misma de las actividades (Modelo de Regionalización).

## B. Antecedentes

Para cumplir con una de las prioridades del Plan Nacional de Desarrollo 1980-1984, se creó la Secretaría de Desarrollo Rural Integral (SEDRI), como dependencia de la Presidencia de la República, mediante Decreto Ejecutivo No. 637 publicado en el Registro Oficial No. 305 del 29 de octubre de 1980, asignándole funciones de programar, organizar y coordinar la formulación de los proyectos de Desarrollo Rural Integral; a su vez, a las "Unidades Ejecutoras" conformadas por funcionarios de los organismos públicos y privados se les responsabiliza por la ejecución de los Proyectos.

Con esta finalidad, el CONADE que según el Decreto citado tiene funciones de formular el "Programa Nacional de Desarrollo Rural Integral" y la SEDRI, seleccionaron 17 Proyectos DRI distribuidos en todo el territorio Nacional. De estos 17 proyectos, la SEDRI escoge tres: Jipijapa, Salcedo y Quimiag-Penipe, en los que se dará énfasis a un componente de salud, con financiamiento externo por parte de la A.I.D.

Hay que anotar que en la selección de estas áreas no intervino el MSP. Los parámetros de selección que inspiraron el decreto ya referido, es decir la marginalidad y el apoyo al campesinado de menores recursos, no fueron los únicos que

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sirvieron para la elección de las áreas, pues hubieron muchos factores circunstanciales que obligaron a escoger estas áreas específicas.

Cumpliendo con esta disposición legal, el MSP estableció en coordinación con la SEDRI el componente de salud que debía ser desarrollado en las áreas seleccionadas para apoyar al Programa DRI. Con esta finalidad solicitó y obtuvo de la A.I.D. la financiación parcial y el apoyo técnico necesario para llevar adelante este Proyecto.

La colaboración del Gobierno de los Estados Unidos de América, a través de A.I.D. se concretó con la firma de los Convenios A.I.D. 518-0015 y A.I.D. 518-U-040 de Fondos No Reembolsables y Préstamo, respectivamente, firmados el 29 de Septiembre de 1981. El Convenio tendrá una duración de 5 años, es decir hasta el 30 de septiembre de 1986.

Las actividades del Proyecto no se iniciaron en la práctica sino en los primeros meses de 1982 y a la fecha, habiéndose cumplido los 2 primeros años de ejecución, el MSP y A.I.D. han convenido en realizar una evaluación a mediano plazo que con el análisis de los resultados hasta hoy obtenidos, permita una reformulación de algunos de sus componentes y una reprogramación financiera que facilite el cumplimiento de los objetivos iniciales.

C. Componentes del Proyecto

1. Fortalecimiento Institucional. Incluyendo actividades de apoyo al CNS y al MSP, especialmente para el desarrollo del Modelo de Regionalización de Servicios y Capacitación de Personal.

2. Coordinación, Investigación y Promoción de Tecnología encargado a SEDRI y al MSP, instituciones que se consideran las con mayor responsabilidad en la ejecución del Proyecto.

3. Actividades de campo, a desarrollarse en las tres Areas DRI previamente seleccionadas y que se relacionan principalmente con actividades promocionales y entrega de servicios de Atención Primaria dentro de los programas definidos como prioritarios por el MSP y que son: Control de Diarreas, Programa Ampliado de Inmunizaciones (PAI), Control del Bocio (Quimiag-Penipe), Educación para la Salud y Actividades de Alimentación. También se incluye aquí un subcomponente de mejoramiento de la Infraestructura para construcción y equipamiento de Subcentros y Puestos de Salud.

4. Administración del Proyecto que incluye la creación de una Oficina de Coordinación de DRI en el MSP y la ejecución presupuestaria que se realiza a través de la SEDRI.

D. Actividades del Proyecto

1. Desarrollo de un Modelo de Regionalización con sus módulos de:

- Determinación del Sujeto de Trabajo
- Diagnóstico
- Toma de Decisiones
- Programación
- Organización
- Ejecución y Dirección
- Evaluación
- Supervisión
- Sistema de Información

2. Aplicación del modelo de Regionalización en las Areas DRI de Jipijapa, Salcedo y Quimiag-Penipe dentro de los lineamientos establecidos en la Política Nacional del Desarrollo Rural Integral. Esta actividad puede ampliarse a otras áreas por decisión de las Autoridades del MSP.

3. Fortalecimiento de los Servicios de Salud de las Areas DRI construyendo y equipando convenientemente unidades operativas del MSP.

4. Apoyar a la Administración Provincial mediante la contratación de consultores en los campos específicos de los programas prioritarios de salud.

5. Desarrollar actividades de investigación, especialmente de tipo operacional, para mejorar la entrega de Servicios de Salud Primaria a base de tecnologías de bajo costo.

6. Proporcionar entrenamiento al personal que labora en los niveles Central, Provincial y de Area para mejorar la administración y la entrega de los servicios.

7. Coordinar las actividades de salud con las Unidades Ejecutoras del Programa de Desarrollo Rural Integral a nivel de las Areas en los Proyectos DRI.

8. Colaborar con los Proyectos DRI en las actividades de organización y participación comunitaria como medio para conseguir la extensión de cobertura de salud.

E. Metodología de la Evaluación

1. Concluidos los dos primeros años de ejecución del Proyecto, las Partes han acordado realizar una evaluación del desarrollo del Programa para lo que se ha conformado una Comisión compuesta por tres expertos extranjeros contratados por la

A.I.D., (un Sociólogo, un Médico y un Administrador), venidos especialmente al País con esta finalidad y un tercer miembro, Médico Salubrista, designado por el MSP de una terna elaborada para el objeto.

Esta evaluación, de acuerdo con el Artículo 6 - Sección 6.1 del documento del Convenio deberá referirse especialmente a los siguientes puntos:

a. Evaluación del progreso alcanzado en la consecución de los objetivos del proyecto (Situación Actual).

b. Identificación y evaluación de las áreas conflictivas o limitaciones que pudieren obtaculizar dicho progreso (Análisis).

c. Apreciación de la forma en que puede usarse dicha información para ayudar a superar dichos problemas (Conclusiones y Recomendaciones).

d. Evaluación en la medida factible, del impacto general producido por el Proyecto, (Evaluación del Impacto), difícil de realizar cuando, apenas se ha terminado la fase de preparación y recién se inician acciones de prestación de servicios.

2. En el transcurso de tres semanas se han realizado entrevistas con funcionarios de los distintos niveles involucrados en el Proyecto y pertenecientes a las siguientes instituciones: Consejo Nacional de Salud (CNS), Ministerio de Salud Pública (MSP)-(Nivel Central), Secretaría de Desarrollo Rural Integral (SEDRI), Instituto Ecuatoriano de Obras Sanitarias (IEOS), Fondo de Desarrollo Rural, Urbano y Marginal (FODERUMA), Centro de Investigaciones Multidisciplinarios en Desarrollo (CIMDER), Direcciones Provinciales de Salud de Manabí, Chimborazo y Cotopaxi, Unidades Ejecutoras de los Proyectos DRI Jipijapa, Salcedo y Quimiag-Penipe. Jefes y Ex-Jefes de Area de Salud de dichos Proyectos. Directores y personal de las Unidades Operativas de las Areas DRI; Líderes comunitarios y de organizaciones campesinas y promotores de salud. En total se han entrevistado 62 personas con quienes se ha discutido especialmente los siguientes aspectos generales: Conocimiento sobre el Proyecto que se evalúa y las funciones que desempeñan en relación al mismo; Cumplimiento de los planes y metas del Proyecto y su participación en el mismo; Identificación de problemas, limitaciones y dificultades encontradas en la realización del Proyecto; Situaciones conflictivas relacionadas especialmente con la coordinación entre las distintas instituciones que laboran en las Areas DRI; Situaciones favorables que se presentan para la continuación del Proyecto y que permitirán un mejor cumplimiento de planes y metas en el futuro;

Relaciones de dependencia, subordinación y supervisión que se han establecido entre los distintos niveles e instituciones que laboran en las Areas DRI; Otras de tipo local y que se introducirían en cada caso particular. (Ver Anexo No. 2).

3. Recolección, revisión y estudio de documentos relacionados con el Proyecto y que permitan conocer documentadamente el avance del Proyecto, especialmente se han revisado planes, programas, informes y documentos específicos elaborados como parte constitutiva de las actividades del Proyecto. (Ver Anexo No. 3).

4. Visita de campo a los tres Proyectos DRI observando directamente la realización de las actividades del personal de salud, promoviendo reuniones de trabajo con los grupos involucrados y haciendo entrevistas personales a funcionarios y empleados de las Areas.

5. Posteriormente a la obtención de la información señalada, el Grupo de Evaluación realizó muchas sesiones de trabajo para analizar toda esa información, establecer su criterio sobre el progreso del Proyecto y señalar las conclusiones y recomendaciones que formarán parte de este documento.

6. Terminada esta primera fase, el grupo hizo una exposición verbal y resumida ante el señor Ministro de Salud

Pública, sobre sus observaciones y el criterio que como evaluadores se habían formado en el transcurso del estudio, lo que formaría parte del documento final.

7. Como complemento del estudio y una vez que el documento haya sido terminado se espera presentarlo a discusión en un Taller de Trabajo con las principales autoridades del MSP y la SEDRI, para poder estructurar en forma definitiva las recomendaciones finales que deberán implementarse en el futuro.

## II. SITUACION ACTUAL

Resumiendo las actividades señaladas en el Anexo 1 del Convenio A.I.D. 518-0015 y 518-U-040 se puede ver la situación actual de cumplimiento de las actividades programadas:

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COMPONENTE: A - FORTALECIMIENTO INSTITUCIONAL

ACTIVIDAD Y ENTIDAD EJECUTORA	LO OBSERVADO
<p>I. <u>FORTALECIMIENTO INSTITUCIONAL</u></p> <p>1. <u>CNS</u></p> <p>a. <u>Estudios</u></p> <ul style="list-style-type: none"><li>-Implicaciones de la extensión de cobertura del IESS.</li><li>-Sistema Nacional para la provisión de medicamentos.</li><li>-Participación de la comunidad.</li><li>-Factibilidad del S.N.S.</li></ul> <p>b. <u>Seminario y Visitas de Observación</u></p> <p>c. <u>Equipo y suministro</u></p>	<ol style="list-style-type: none"><li>1. Apoyo al "Seminario Taller Nacional sobre Líneas de Investigación en Ciencias de la Salud (Nov. 25-26, 1982).</li><li>2. Elaboración de un Convenio entre el IESS y el MSP sobre Seguro del Campesinado, 1983.</li><li>3. Seminario Nacional para el desarrollo e implementación de un Sistema Nacional de Vigilancia Epidemiológica de las Enfermedades Inmunoprevenibles.</li><li>4. Actualización: Diagnóstico de la Situación Epidemiológica del Bocio en el país INIMS, 1983.</li><li>5. Preparación del Nuevo Código de la Salud, 1983.</li></ol> <p>- Se han suministrado varios equipos de oficina y una copiadora xerox.</p>

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ACTIVIDAD Y ENTIDAD EJECUTORA	LO OBSERVADO
<p>2. <u>MSP</u></p> <p>a. <u>Ejecución del Módulo</u></p> <p>Subcontrato CIMDER</p> <ul style="list-style-type: none"><li>- Delimitación del sujeto de trabajo, mayo, 1982.</li><li>- Diagnóstico, agosto, 1982.</li><li>- Toma de decisiones (Acciones legales y técnico administrativas.</li><li>- Programación: (Módulo), enero, 1983.</li><li>- Módulos de Organización, Dirección y Ejecución, abril, 1983.</li><li>- Seminarios 4 + 5 Talleres - 2.</li><li>- Módulo del Subsistema de información, agosto, 1983.</li><li>- Módulo de Supervisión, octubre, 1983.</li><li>- Módulo de Evaluación, enero, 1984.</li> <li>- Informes de Progreso: Trimestrales.</li></ul>	<p>1. <u>Documentos elaborados:</u></p> <ul style="list-style-type: none"><li>-Manual sobre recopilación resumida y clasificada de Políticas, Normas y procedimientos de interés al Sector Salud en los programas de DRI, octubre, 1982.</li><li>-Síntesis de la Metodología de Regionalización de Servicios de Salud, junio, 1983.</li><li>-Metodología de Diagnóstico (incluye delimitación del sujeto de trabajo) terminado marzo, 1984 - Preliminar junio, 1983.</li><li>-Módulo de Organización, documento preliminar, junio, 1983.</li></ul> <p>2. <u>Reuniones y Seminarios</u></p> <ul style="list-style-type: none"><li>- Nivel Ministro: mayo, 1982; julio, 1983; noviembre, 1983.</li><li>- Nivel Directores MSP: octubre, 1982; noviembre, 1982; mayo, 1983; enero, 1983.</li><li>- Interinstitucionales: febrero, 1983; marzo, 1983; julio, 1983; noviembre, 1983.</li><li>- A nivel de Areas DRI: mayo, 1982, abril, 1983; agosto, 1983; marzo, 1984.</li></ul> <p>3. <u>Informes Trimestrales</u> - Enviados.</p>

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<p>ACTIVIDAD Y ENTIDAD EJECUTORA</p>	<p>LO OBSERVADO</p>
<p>b. <u>Capacitación</u></p> <p>(1) A NIVEL DE AREA:</p> <p>-Jefes de Area (CIMDER).</p> <p>-30 Médicos, Enfermeras y Obstetrices</p> <p>-30 Auxiliares de Enfermería</p> <p>-Formación 10 Auxiliars de Enfermería.</p> <p>(2) A NIVEL PROVINCIAL:</p> <p>-Jefes Provinciales</p> <p>-Otro personal administrativo</p> <p>-Provisión de asesores</p>	<ul style="list-style-type: none"> <li>- <u>Antes de iniciarse el Proyecto:</u> Drs. Santelices, Valencia y Del Salto.</li> <li>- <u>Con el Proyecto:</u> Drs. Martínez, Andrade, Quintana y Carrión.</li> <li>- Seminarios de inducción para el DRI, 2 días - mayo, 1982.</li> <li>- Seminarios sobre promoción del Programa de Control de Diarreas, julio-agosto, 1983 - con experto.</li> <li>- Un curso de entrenamiento para médicos en Salcedo, octubre, 1983.</li> <li>- Aprobado Proyecto para entrenamiento de Auxiliares de Enfermería Comunitaria con la PUCE, abril, 1983.</li> <li>- Formación de 5 auxiliares de enfermería para el Proyecto Qui-miag-Penipe.</li> <li>- Formación de auxiliares de enfermería, Manabí.</li> <li>- Seminario taller de Programación de Servicios de Salud para capacitación a Jefes de Afeá y Directores de SCS de los Proyectos DRI, noviembre, 1982.</li> <li>- Seminario de Control de Enfermedades Diarréicas en Riobamba, septiembre, 1983.</li> <li>- Curso sobre Control de Enfermedades Diarréicas en la Dirección Provincial de Salud de Manabí, octubre, 1983.</li> <li>- Consultor para promoción del Control de Diarreas, asignado a los Proyectos DRI por 6 meses - Dr. R. Pareja, 1983.</li> </ul>

ACTIVIDAD Y ENTIDAD EJECUTORA	LO OBSERVADO
<p>(3) A NIVEL NACIONAL MAESTRIA:</p> <ul style="list-style-type: none"><li>-Seis Funcionarios MSP.</li><li>-Dos de Universidades.</li></ul>	<ul style="list-style-type: none"><li>- Dr. José Avecilla del MSP participó en curso de Maestría en Salud Pública en Puerto Rico.</li><li>- Seminario Taller sobre Metodología de Administración de Servicios de Salud - AJAVI, julio, 1983.</li><li>- Participación del Dr. José Castro en el Seminario de Alta Gerencia organizado por INCAE en Ibarra, agosto, 1982.</li><li>- Participación de los Drs. Mauro Rivadeneira, Gustavo Estrella y Eduardo Navas, en el curso intensivo sobre Gerencia para Directores de Programas de Salud a Nivel Ejecutivo en Boston, octubre, 1982.</li><li>- Participación de 2 enfermeras de la Oficina de DRI al Seminario Reforma Curricular de Cursos de Auxiliares de enfermería del area rural. Los Chillos, Hotel Holiday, abril, 1983.</li><li>- Curso en Administración, Buenos Aires. Participación del Director del Hospital Baca Ortíz.</li></ul>

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COMPONENTE: B - COORDINACION, INVESTIGACION Y PROMOCION DE TECNOLOGIA

ACTIVIDAD Y ENTIDAD EJECUTORA	LO OBSERVADO
<p>II. <u>COORDINACION, INVESTIGACION Y PROMOCION DE TECNOLOGIA</u></p> <p>1. <u>SEDRI</u></p> <p>a. <u>Investigación en Políticas de Alimentación:</u></p> <ul style="list-style-type: none"><li>- Estudios en marcha.</li><li>- Consultoría.</li></ul> <p>b. <u>Promoción de Tecnología a bajo Costo:</u></p> <ul style="list-style-type: none"><li>- Para la salud.</li><li>- Producción alimentos.</li></ul> <p>2. <u>MSP</u></p> <p>a. <u>Investigación biomédica y socio-nutricional:</u></p> <ul style="list-style-type: none"><li>- Encuestas a nivel de área para-diagnóstico biomédicos, sociales y nutricionales.</li></ul> <p>b. <u>Investigaciones Operativas:</u></p> <ul style="list-style-type: none"><li>- Evaluaciones periódicas.</li></ul>	<ul style="list-style-type: none"><li>- No se han realizado actividades a través del Proyecto.</li> <li>- No se han realizado actividades con fondos del Proyecto pero se conoce de actividades de este tipo que SEDRI está desarrollando especialmente para la industrialización del pescado.</li> <li>- No se han realizado con fondos del Proyecto aunque hay varios estudios en marcha con el INIMS.</li> <li>- No se han reportado. Sin embargo, cabe anotar que se está desarrollando una evaluación sobre promotores de salud.</li></ul>

COMPONENTE: C - ACTIVIDADES DE CAMPO

ACTIVIDAD Y ENTIDAD EJECUTORA	LO OBSERVADO
<p>III. <u>ACTIVIDADES DE CAMPO</u></p> <p>1. <u>ATENCION PRIMARIA - MSP</u></p> <p>a. <u>Promoción:</u></p> <p>(1) 30 Promotores (Administración y salario).</p> <p>(2) Botiquines manejados por la comunidad.</p> <p>(3) Respaldo a comadronas.</p> <p>(4) Voluntarios de salud en las Escuelas.</p> <p>b. <u>Programas Prioritarios</u></p> <p>(1) Control de diarreas.</p> <ul style="list-style-type: none"> <li>- Sales orales</li> <li>- Material educativo</li> <li>- Seminarios</li> <li>- Visitas de observación</li> </ul>	<ul style="list-style-type: none"> <li>- 2 cursos de entrenamiento para 24 promotores en Jipijapa.</li> <li>- 1 promotor que trabaja en Tailin (Salcedo).</li> <li>- El MSP no ha asumido el pago de bonificación a Promotores. Lo sigue realizando FODERUMA.</li> <li>- El MSP ha programado para 1984 entrenar a 120 promotores con sus propios fondos.</li> <li>- No se han instalado con el Proyecto. Hay algunos que funcionaban desde antes.</li> <li>- Se realiza a través de las Direcciones Provinciales, no con fondos del Proyecto.</li> <li>- Se realizan muchas reuniones de entrenamiento y promoción en las Escuelas de las Area DRI.</li> <li>- La provisión de sales orales se realiza normalmente por parte del MSP.</li> <li>- Se ha preparado material educativo como rotafolios, cuñas radiales y otros, gracias al asesoramiento del Consultor de A.I.D., Dr. Reynaldo Pareja.</li> <li>- Se han realizado muchos seminarios y reuniones sobre el Programa en las Areas DRI y en las Direcciones Provinciales, con el apoyo del Asesor Dr. Pareja. Sólo en Salcedo se han realizado 30 reuniones.</li> <li>- Se conoce que en el Area de Quiamiag-Penipe se han rehidratado 366 niños con una tasa aproximadamente igual a la de toda la provincia.</li> </ul>

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ACTIVIDAD Y ENTIDAD EJECUTORA	LO OBSERVADO
<p>(2) P.A.I.</p> <ul style="list-style-type: none"><li>- Equipos</li><li>- Capacitación</li><li>- Provisión de vacunas</li></ul> <p>(3) Control del Bocio (Q-P)</p> <ul style="list-style-type: none"><li>- Aceite yodado</li><li>- Estudios relacionados</li></ul> <p>(4) Educación para la Salud</p> <ul style="list-style-type: none"><li>- Asistente Educador en cada Area DRI</li><li>- Vehículos</li><li>- Equipo Educativo</li><li>- Suministros</li></ul>	<ul style="list-style-type: none"><li>- Las Areas DRI han sido las mejor dotadas en cuanto a cadena de frio, sin embargo existen deficiencias que deben ser inventariadas.</li><li>- La capacitación de personal para el manejo del programa dentro de las actividades usuales del MSP.</li><li>- La provisión de vacunas ha sido regular con algunas excepciones en el tiempo y tipo de vacunas.</li><li>- Las estadísticas no señalan un mejoramiento de la cobertura en las Areas DRI en relación al resto de las Provincias o del país.</li></ul> <ul style="list-style-type: none"><li>- No existe problema en cuanto a la provisión de aceite yodado que lo hace el MSP.</li><li>- Con algún retraso se ha iniciado un estudio apoyado por el CNS y el ININMS.</li><li>- En Penipe se maneja este Proyecto a través de la Curia.</li></ul> <ul style="list-style-type: none"><li>- No se han contratado los Asistentes de Educación para las Areas DRI, por no existir el personal con esa calificación ni los correspondientes cargos. Los inspectores de salud cumplen sus funciones en forma parcial.</li><li>- El Programa proveyó de 4 vehículos, tipo Jeep Bronco de los cuales sólo uno en Quimiag-Penipe se encuentra prestando servicios en el Programa, dos han sufrido accidentes y no han sido reparados y uno fue destinado a otras funciones en el MSP.</li><li>- Se ha provisto de algún equipo educativo menor y suministros de acuerdo a los requerimientos.</li></ul>

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ACTIVIDAD Y ENTIDAD EJECUTORA	LO OBSERVADO
<p>c. <u>Infraestructura</u></p> <p>(1) Construcción - 6 Subcentros - 7 Puestos</p> <p>(2) Equipamiento - 6 Subcentros - 19 Puestos</p> <p>(3) Red de Radio</p> <p>(4) Gastos de Operación</p> <p>(5) Medicinas</p>	<ul style="list-style-type: none"><li>- El SCS de 5 de Julio (En Jipijapa) no ha sido terminado por retraso en la asignación de los fondos por parte de SEDRI.</li><li>- Se han construido dos SCS en el area de Q-P en las poblaciones de Quimiag y Penipe terminados pero sin funcionar.</li><li>- Uno en la localidad de Holguín en el Area DRI Salcedo que está funcionando.</li><li>- Está autorizada la construcción de un SCS en Matus (Area de Q-P).</li><li>- Los PS de acuerdo con SEDRI se instalan en las "Casas Comunales" algunas de las cuales están siendo completadas en las tres Areas DRI.</li><li>- En Jipijapa se encuentra autorizada el equipamiento de los SCS de 5 de Julio, La Unión, Vargas Torres, Comuna Sucre y Las Delicias.</li><li>- En Salcedo se ha equipado el SCS de Holguín, que está funcionando y está previsto el equipamiento de otros cuatro SCS y diez PS.</li><li>- En Quimiag-Penipe se encuentra enbodegado en la Dirección Provincial el equipo para los tres 3 SCS de Quimiag, Penipe y Matus y para los PS de LLucut, Naguso y Palitagua.</li><li>- No se ha programado ni estudiando su instalación.</li><li>- Los provee el MSP.</li><li>- Dificultades en la adquisición por parte de las Direcciones Provinciales por incumplimiento de los distribuidores que deben entregar los medicamentos de bajo costo.</li></ul>

<p style="text-align: center;">ACTIVIDAD Y ENTIDAD EJECUTORA</p>	<p style="text-align: center;">LO OBSERVADO</p>
<p>2. <u>ACTIVIDADES DE ALIMENTACION:</u></p> <p>a. <u>MSP</u></p> <p><u>Apoyo al Programa de Asistencia Alimentaria</u></p> <ul style="list-style-type: none"> <li>- Educación para la salud</li> <li>- Administración</li> <li>- Logística</li> </ul> <p>b. <u>SEDRI</u></p> <p><u>Programas Piloto</u> (En base a los estudios del Componente B)</p> <ul style="list-style-type: none"> <li>- Puestos de expendio comunitarios</li> <li>- Procesamiento local</li> <li>- Utilización de la producción local</li> <li>- Alimentación Escolar y Materno-Infantil</li> <li>- Otros</li> </ul>	<ul style="list-style-type: none"> <li>- Las actividades de nutrición los desarrolla el MSP de acuerdo con su propia programación. En las Areas DRI el equipo de salud dentro de sus POA realizan alguna actividad de este tipo de acuerdo a sus recursos.</li> <li>- AID tiene un proyecto (separado del que estamos evaluando) para un estudio de evaluación del PAAMI en tres Provincias.</li> <li>- El PAAMI ha dotado a las Areas DRI del equipo completo que comprende balanzas y un equipo de demostración.</li> </ul> <ul style="list-style-type: none"> <li>- No se ha realizado el Programa piloto a través del Proyecto, sin embargo el ININMS ha realizado un Proyecto piloto sobre nutrición en las tres Areas DRI.</li> <li>- Se han instalado (con fondos de SEDRI) algunas tiendas comunitarias: 18 en Quimiag-Penipe y 2 en Salcedo, además se encuentran en construcción dos centros de acopio para esas Areas.</li> </ul>

ACTIVIDAD Y ENTIDAD EJECUTORA	LO OBSERVADO
<p>IV. <u>ADMINISTRACION DEL PROYECTO</u></p> <p>1. <u>Oficina de Coordinación del Proyecto DRI</u></p> <p>-Organización -Funciones</p> <p>2. <u>Ejecución Presupuestaria</u></p> <p>-Ver cuadros demostrativos en las siguientes páginas.</p>	<ul style="list-style-type: none"><li>- Coincidiendo con la iniciación del Proyecto, se contrata un Asesor ecuatoriano a tiempo completo, el Dr. Gustavo Estrella, un año después se completa con un Asesor Técnico, Dr, Eduardo Navas y personal de Secretaría.</li><li>- Tiene a su cargo desarrollar el modelo de Regionalización de Salud para lo que cuenta con el grupo asesor de CIMDER.</li><li>- Planificar y organizar las actividades de investigación y entrenamiento.</li><li>- Manejo Administrativo-Financiero del Proyecto en lo que se refiere al componente de Desarrollo Institucional canalizando los fondos provenientes de AID para las distintas actividades.</li></ul>

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NOMBRE DEL PROYECTO: Sistema de Servicios de Salud Rural Integral FONDOS DURANTE LA VIDA DEL PROYECTO - PRESTAMO: US\$ 7.235.000  
 NUMERO DEL PROYECTO: 518-0015 (518-U-040) FONDOS NO REEMBOLSABLES: US\$ 750.000  
 FECHA DEL CONVENIO: 29 de Septiembre de 1981 FONDOS AUTORIZADOS A LA FECHA - PRESTAMO: US\$ 7.235.000  
 FICP: 30 de Septiembre de 1986 FONDOS NO REEMBOLSABLES: US\$ 630.000

COMPONENTES Y SUBPROYECTOS	FONDOS NO REEMBOLSABLES					P R E S T A M O					CONTAPARTIDA		
	PRESU- PUESTO (1)	RESER- VADO (2)	COMPRO- METIDO (3)	DESSEM- BOLSOS (4)	SAJDOS (5=1-4)	PRESU- PUESTO (1)	RESER- VADO (2)	COMPRO- METIDO (3)	DESSEM- BOLSOS (4)	SAJDOS (5=1-4)	PRESU- PUESTO (1)	DESSEM- BOLSOS (2)	SAJDOS (3=1-2)
<b>A. ACTIVIDADES PARA EL FORTA- LECIMIENTO INSTITUCIONAL</b>	<u>500.6</u>	<u>208.9</u>	<u>208.9</u>	<u>108.0</u>	<u>392.6</u>	<u>2,565.0</u>	<u>1,625.2</u>	<u>1,512.0</u>	<u>1,098.3</u>	<u>1,466.6</u>	<u>3,090.0</u>		
1. Consejo Nacional de Salud	<u>140.0</u>	<u>1.0</u>	<u>1.0</u>	<u>1.0</u>	<u>139.0</u>	<u>100.0</u>	<u>12.5</u>	<u>12.5</u>	<u>8.1</u>	<u>91.9</u>	<u>160.0</u>		
2. Ministerio de Salud	<u>160.6</u>	<u>160.6</u>	<u>160.6</u>	<u>66.6</u>	<u>92.2</u>	<u>525.0</u>	<u>366.4</u>	<u>347.6</u>	<u>283.6</u>	<u>241.4</u>	<u>540.0</u>		
a. Nivel de Area	<u>125.6</u>	<u>160.6</u>	<u>160.6</u>	<u>66.6</u>	<u>92.2</u>	<u>330.0</u>	<u>324.9</u>	<u>316.8</u>	<u>260.6</u>	<u>69.4</u>	<u>350.0</u>		
b. Nivel Provincial	<u>35.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>35.0</u>	<u>50.0</u>	<u>7.6</u>	<u>7.6</u>	<u>3.8</u>	<u>46.2</u>	<u>50.0</u>		
c. Nivel Nacional	--	--	--	--	--	<u>145.0</u>	<u>33.9</u>	<u>23.0</u>	<u>19.2</u>	<u>125.8</u>	<u>140.0</u>		
3. Instituto Ecuatoriano de Círculos Sanitarios	<u>200.0</u>	<u>47.3</u>	<u>47.3</u>	<u>40.4</u>	<u>159.6</u>	<u>1,940.0</u>	<u>1,246.1</u>	<u>1,151.9</u>	<u>806.6</u>	<u>1,133.4</u>	<u>2,390.0</u>		
a. Actividades a Nivel Nacional	<u>125.0</u>	<u>34.3</u>	<u>34.3</u>	<u>34.4</u>	<u>90.6</u>	<u>610.0</u>	<u>383.6</u>	<u>383.6</u>	<u>46.5</u>	<u>563.5</u>	<u>710.0</u>		
b. Actividades a Nivel Provincial	<u>75.0</u>	<u>13.0</u>	<u>13.0</u>	<u>6.0</u>	<u>69.0</u>	<u>1,330.0</u>	<u>862.5</u>	<u>768.3</u>	<u>760.1</u>	<u>569.9</u>	<u>1,680.0</u>		
<b>B. ACTIVIDADES DE INVESTIGA- CION Y PROMOCION DE TECNO- LOGIAS</b>	<u>179.4</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>179.4</u>	<u>255.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>255.0</u>	<u>230.0</u>		
1. A cargo de SEDRI	<u>175.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>175.0</u>	<u>225.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>225.0</u>	<u>200.0</u>		
a. Invest. de Políti- cas de Alimentación	<u>175.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>175.0</u>	<u>100.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>100.0</u>	<u>125.0</u>		
b. Promoción de Tecno- logías a Bajo Costo	--	--	--	--	--	<u>125.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>125.0</u>	<u>75.0</u>		
2. A cargo del MSP	<u>4.4</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>4.4</u>	<u>30.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>30.0</u>	<u>30.0</u>		
Investig. Biomédica y Operacional	<u>4.4</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>4.4</u>	<u>30.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>30.0</u>	<u>30.0</u>		

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PROYECTO: Sistema de Servicios de Salud Rural Integral

COMPONENTES Y SUBPROYECTOS	FONDOS NO REEMBOLSABLES					PRESTAMO					CONTRAPARTIDA		
	PRESU- PUESTO (1)	RESER- VADO (2)	COMPRO- METIDO (3)	DESEM- BOLSOS (4)	SALDOS (5=1-4)	PRESU- PUESTO (1)	RESER- VADO (2)	COMPRO- METIDO (3)	DESEM- BOLSOS (4)	SALDOS (5=1-4)	PRESU- PUESTO (1)	DESEM- BOLSOS (2)	SALDOS (3=1-2)
<b>C. ACTIVIDADES DEMOSTRATIVAS</b>													
<u>A NIVEL DE CAMPO</u>	--	--	--	--	--	<u>3,700.0</u>	<u>899.2</u>	<u>899.2</u>	<u>727.1</u>	<u>2,972.9</u>	<u>4,260.0</u>		
<u>A cargo de la SEDRI:</u>													
<u>1. Atención primaria de salud</u>	--	--	--	--	--	<u>870.0</u>	<u>278.9</u>	<u>278.9</u>	<u>179.9</u>	<u>690.1</u>	<u>630.0</u>		
a. Programas de atención prim. de salud	--	--	--	--	--	325.0	99.0	99.0	0.0	325.0	260.0		
b. Infraestructura para la salud	--	--	--	--	--	545.0	179.9	179.9	179.9	365.1	370.0		
<u>2. Suministro de agua y saneamiento para el sector rural</u>	--	--	--	--	--	<u>2,630.0</u>	<u>620.3</u>	<u>620.3</u>	<u>547.2</u>	<u>2,082.8</u>	<u>655.0</u>		
<u>3. Activ. Piloto de campo para nutrición</u>	--	--	--	--	--	<u>150.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>150.0</u>	<u>165.0</u>		
<u>A cargo del MSP:</u>													
<u>4. Apoyo al Prog. Asiat. Alimentaria Materno-Inf. del MSP</u>	--	--	--	--	--	<u>50.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>50.0</u>	<u>35.0</u>		
<b>D. IMPREVISTOS</b>	<u>70.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>715.0</u>	<u>0.0</u>	<u>0.0</u>	<u>0.0</u>	<u>715.0</u>	<u>655.0</u>		
<b>TOTALES</b>	<u>750.0</u>					<u>7,235.0</u>					<u>8,235.0</u>		
<b>VALOR OBLIGADOS Y SALDOS A LA FECHA</b>	630.0	208.9	208.9	108.0	522.0	7,235.0	2,524.4	2,411.2	1,825.4	5,409.8			
<b>ANTICIPOS A LA FECHA</b>				6.2					687.7				

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### III. ANALISIS DE LA INFORMACION

#### A. Fortalecimiento y Coordinación Institucional

El propósito general del Proyecto que estamos evaluando es el de apoyar al MSP en el fortalecimiento de su capacidad institucional mediante el desarrollo de un Modelo de Regionalización de Servicios que aplicado inicialmente en las tres Areas DRI, Jipijapa, Quimiag-Penipe y Salcedo y posteriormente replicado a nivel nacional, permitirá el mejoramiento de las condiciones de salud del sector rural, expandiendo los Servicios de Atención Primaria de Salud a las áreas rurales, dando énfasis a los programas definidos como prioritarios por el MSP (Control de Diarreas, PAI, Educación para la Salud y Mejoramiento de las Condiciones Alimentarias) y basándose en una activa participación comunitaria, tanto para el diseño de los Programas como para la entrega de servicios.

Las actividades más sobresalientes que se han desarrollado en los dos primeros años del Convenio para cumplir con este propósito han sido:

- Desarrollo del Modelo de Regionalización de Servicios.
- Nombramiento de Jefes de Area o Microregión.

- Inicio de la aplicación del Modelo de Regionalización.

En el proceso se han identificado algunas limitaciones y dificultades que podrían resumirse en los siguientes puntos:

1. Mediante un subcontrato con el Centro de Investigaciones Multidisciplinarias en Desarrollo de la Universidad del Valle (CIMDER), firmado el 19 de marzo de 1982, se inició la preparación del "Modelo de Regionalización" que según el cronograma fijado, debió estar terminado para enero de 1984; sin embargo, el cronograma fue cumplido sólo hasta finales de 1982 con la elaboración de los cuatro primeros módulos (Delimitación del Sujeto de Trabajo, Diagnóstico, Toma de Decisiones y Programación), luego faltó la aprobación por parte del MSP que no nombró personal permanente de alto nivel como contraparte y al hacer la revisión se sugirieron muchos cambios que han obligado a rehacer varias veces el trabajo. El documento debía prepararse con la participación de un equipo de técnicos del MSP, pero la falta de recursos humanos técnicos ha impedido que se cumpla este requisito. Al momento, se encuentra aprobado solamente el Módulo de Diagnóstico que se integró con el de Delimitación del Sujeto de Trabajo, y que luego de la última reunión en el MSP con funcionarios del más alto nivel, realizada en diciembre de 1983, se resolvió autorizar su aplicación no sólo en las provincias de las Areas DRI, sino en tres provincias adicionales: Guayas, El Oro e Imbabura. Esta quizá es la decisión más importante en todo el proceso.

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2. A pesar de conocerse la existencia de estudios anteriores de regionalización realizados por otras instituciones, éstos no fueron puestos a disposición de CIMDER, lo que impidió utilizar dichos trabajos para evitar duplicación de esfuerzos. Este es el caso del documento para extensión de cobertura de OPS/BID. Se espera que por lo menos el módulo del Sistema de Información pueda aprovecharse en el futuro.

3. El diagnóstico de salud de las Areas DRI fue preparado por CONADE, la selección de las áreas lo hizo la SEDRI sin participación del MSP en ninguno de los dos casos. Los parámetros de selección usados por la SEDRI fueron más bien relacionados con las facilidades de financiamiento, proyectos iniciados, etc. Es por esto, que las tres Areas DRI no pueden ser consideradas como una muestra representativa que permita implementar el Modelo de Regionalización a nivel nacional. Felizmente el MSP ha resuelto probarlo en una muestra muy amplia de seis provincias, lo que si permitirá sacar conclusiones de tipo general.

4. En cumplimiento con la disposición legal que organiza las Unidades Ejecutoras de los Proyectos DRI, el MSP con suficiente anticipación seleccionó los Jefes de Area para las tres Areas DRI quienes fueron entrenados en un curso de Administración de tres meses en Cali, aún antes de firmarse el

Convenio, utilizando para ello fondos extra-proyecto de la A.I.D.

Se solicitó luego la creación de los cargos para "Jefes de Area", pero la Dirección Nacional de Personal y el Ministerio de Finanzas no dieron trámite a estas creaciones por tratarse de una nueva escala en la clasificación de cargos. Esto obligó a contratar a los Jefes de Area, creando inseguridad en el trabajo que dió como consecuencia el abandono de los puestos. Fue necesario entrenar a siete personas en Cali para Jefes de Area y sin embargo al momento (marzo de 1984), ninguno de ellos se encuentra en esas funciones, aunque vale la pena anotar que cuatro ex-Jefes de Area están prestando servicios en otras funciones del MSP y así no se ha perdido su entrenamiento, solamente uno de los siete médicos entrenados está definitivamente fuera del MSP, los dos restantes se encuentran realizando cursos de salud de mayor nivel en Bélgica e Israel y se espera sean contratados a su regreso.

5. La falta de Jefes de Area estables ha sido otro factor negativo para la aplicación del Modelo de Regionalización, por lo menos del Módulo de Diagnóstico que se encuentra listo, conocemos de la última resolución del MSP de encargar las funciones de Jefe de Area al Director del Centro de Salud Hospital (CSH), reforzando el nivel administrativo de esta Uni-

dad Operativa. Si es así, será necesario preparar urgentemente una clara definición de funciones para este personal. El criterio casi unánime de los entrevistados a nivel del MSP excepto la Dirección de Servicios de Salud, coincide en reconocer que éste no es el mejor sistema y que lo ideal habría sido la creación de los Jefes de Area. Sin embargo, considerando las limitaciones presupuestarias, creemos que el sistema adoptado tiene mejores probabilidades de llegar a la práctica; pero nos parece conveniente iniciar cuanto antes una prueba del sistema, por lo menos, en Salcedo y Jipijapa, nombrando Jefes de Area a los respectivos Directores de los CSH, previa coordinación con las Unidades Ejecutoras y el conveniente refuerzo técnico en el CSH con un médico, en lo posible Salubrista, que colabore con el Director del CSH, una enfermera y un estadístico.

6. Creemos que la nominación del Director del CSH como Jefe de Area facilitará la conexión indispensable de los niveles superiores e inferiores de atención. En la actualidad esta situación se ha visto dificultada por el nombramiento de médicos muy jóvenes e incluso médicos rurales (como en el Proyecto Quimiag-Penipe) en donde a pesar del entusiasmo demostrado por el médico, la supervisión a los SCS y al CSH no se realiza por falta de autoridad de quien ejerce funciones de Jefe de Area.

Esta misma situación a dado lugar por otro lado a que el médico nombrado Jefe de Area sea absorbido por la Unidad Ejecutora y trabaje aisladamente de la Dirección Provincial de Salud preparando sus programas sin la debida subordinación a la programación provincial con grave detrimento de la integralidad de las acciones de salud en la Provincia. Aunque el Convenio entre el MSP y la SEDRI señala la dependencia del Jefe de Area de la Dirección Provincial de Salud, formando incluso parte de su Comité Técnico, en la realidad esto no se da.

7. Otro aspecto que juzgamos está incidiendo en el avance del proceso de regionalización, es el de no contar con una definición sobre la regionalización geográfica de las áreas de salud; se han definido algunos criterios al respecto, como el mantenimiento de la división político-territorial del País y que el CSH debe ser considerado como la cabeza del área, pero hay casos en que esto se ve dificultado por problemas de accesibilidad como en algunos SCS y PS de Jipijapa que no pueden derivar sus casos al Hospital de esa localidad, sino que tienen que hacerlo al CSH de Paján. En otros casos como Quimiag-Penipe no tienen CSH. Creemos que es urgente conformar una comisión que estudie este problema, para establecer un criterio de coordinación entre provincias.

8. La dependencia y relaciones entre la SEDRI y el MSP en sus diferentes niveles, aunque son cordiales, en la mayoría de los casos no han sido claramente establecidos a pesar de existir dos Convenio bilaterales entre estas dos instituciones. El flujo de la información especialmente a nivel de área, por esta razón, no ha tenido la fluidez necesaria que permita acciones correctivas inmediatas. Esta situación podría mejorar al encargar las funciones de Jefes de Area a los Directores de los CSH.

B. Actividades de Investigación

El Proyecto que estamos evaluando, considera un importante componente de investigación que debió completarse mediante la realización de varios estudios médico-sociales de tipo general y otros de tipo operacional referentes a nutrición, provisión de medicamentos, etc. Estos estudios, en el Proyecto han sido encargados para su ejecución a tres entidades: CNS, MSP y SEDRI.

No puede negarse la importancia que un eficiente y oportuno completamiento de este componente tendrá para la programación y reajuste de las actividades de entrega de servicios que desarrolla el Proyecto y su eficacia va a permitir conocer con exactitud las perspectivas y necesidades de la comunidad,

los recursos con los que se cuenta, y las facilidades de implementación de tal o cual actividad, mediante encuestas y estudios en el terreno que permitan establecer definitivamente el tipo de actividades que le conviene a una u otra comunidad en particular.

En el caso que nos ocupa, y refiriéndonos a los dos primeros años de ejecución del Proyecto, encontramos que se consideraban los siguientes estudios como necesarios y factibles para desarrollarse:

1. A cargo del CNS: (A-1-a.)

Asuntos relacionados con políticas de salud como: (1) las implicaciones de la extensión de cobertura prevista en el programa del Instituto Ecuatoriano de Seguridad Social (IESS), en lo que se refiere al Seguro Campesino, a la extensión de la prestación de servicios médicos a los familiares y a la incorporación de nuevos contingentes de afiliados; (2) la factibilidad de desarrollar un sistema nacional para la provisión de medicamentos; (3) la participación adecuada del usuario en la entrega de servicios de Atención Primaria de Salud y de agua potable; (4) la factibilidad para la organización y desarrollo del Sistema Nacional de Salud y otros que si bien no están específicamente definidos, podrían ser considerados por el CNS.

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2. A cargo de la SEDRI: (B-1-a.)

Investigación en políticas de alimentación.

3. A cargo del MSP: (B-2-a-b.)

a. Investigaciones Biomédicas y socio-nutricionales a través del ININMS y en coordinación con las Unidades Ejecutoras de los Proyectos DRI, que realizarán encuestas para actualizar los diagnósticos de salud de las tres Areas DRI.

b. Investigaciones operativas para evaluar la implementación del módulo de área.

En este caso hay que hacer notar que el programa piloto nutricional que debía desarrollarse, basaba su ejecución en el resultado de los estudios de investigación previos.

Hasta la fecha de la evaluación (marzo de 1984), los estudios o actividades previas que se han realizado para dar paso al componente de investigación del Proyecto y que se encuentran descritos en el Numeral II, Situación Actual, demuestran un considerable retraso en su realización.

Sin embargo, es necesario considerar las dificultades y limitaciones que han existido en el camino para que este componente haya tenido un desarrollo tan modesto en los dos primeros años del Proyecto:

1. Al iniciarse el Proyecto a fines de 1981 y comienzos de 1982, el CNS se encontraba en fase de organización, y no disponía por tanto de los instrumentos administrativos ni técnicos que le permitieran iniciar estudios de investigación por su propia cuenta, ni movilizar fondos para subcontratarlos.

2. La SEDRI, según la filosofía de su creación es la encargada de programar, organizar y coordinar la formulación de los Proyectos de Desarrollo Rural Integral y controlar la ejecución de los programas a cargo de las Unidades Ejecutoras. Por tanto, al nivel central, la SEDRI no está en capacidad de desarrollar (por lo menos hasta el momento) por su propia cuenta proyectos de investigación multisectoriales; las Unidades Ejecutoras de acuerdo a su conformación actual, tampoco tienen la capacidad operativa para desarrollar estudios de investigación ni de tipo operativo, ni de tipo formal como se propone en el Literal B. 1 del Convenio.

3. El ININMS que puede considerarse como la Unidad Ejecutora de proyectos de investigación en el MSP, ha tenido

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copada su capacidad en los dos últimos años; pudo ampliarla utilizando los recursos del Convenio que nos ocupa pero no hubo la decisión ni el mecanismo adecuado para canalizar los estudios hacia el Instituto. Sin embargo, está colaborando con un estudio sobre bocio en el Area de Quimiag-Penipe.

4. La iniciativa de los estudios operacionales debía haber nacido de los niveles de ejecución de los Proyectos, para asegurar su aplicación práctica, pero al no existir los instrumentos indispensables de diagnóstico y programación, que recién a principios de este año están siendo aplicados, no existieron esas iniciativas.

Las condiciones actuales (marzo de 1984) han cambiado fundamentalmente y se ha reconocido por parte de las autoridades, la necesidad de iniciar cuanto antes los estudios de investigaciones médico sociales que permitan una mejor programación y utilización de los recursos. Para esto, será necesario tomar algunas medidas como las que nos permitimos sugerir:

1. El CNS debe escoger entre las muchas alternativas que tiene definidas en su programa para 1984, aquellos estudios que sean de más rápida aplicación práctica y resolver su realización ya sea encargando a una de las Instituciones que conforman el Sector Salud, subcontratando con el ININMS o con alguna otra agencia especializada nacional o extranjera.

2. La SEDRI, de acuerdo con su filosofía y el criterio expresado por su Director Técnico de Proyectos, Lcdo. Jaime Borja, esta dispuesta a delegar la actividad de investigación constante en el Proyecto (B-1) al MSP, el cual podrá establecer las prioridades y encargar al ININMS o a otra agencia especializada la realización de los mismos.

3. El ININMS, por intermedio de su Director, el Doctor Julio Alvear, ha expresado su disposición para aceptar algunos de estos encargos del MSP y ha demostrado contar con infraestructura suficiente y la posibilidad de ampliación de sus grupos técnicos para iniciar cuanto antes el trabajo que se le asigne.

4. La decisión del señor Ministro de Salud, para iniciar la aplicación del Módulo de Diagnóstico en seis provincias del País da la oportunidad a los niveles nacional, provincial y de área, para definir los campos prioritarios para los proyectos de investigación general y operacional que lleven a una acertada toma de decisiones.

#### C. Entrenamiento de Personal

El Proyecto incluye un importante componente de entrenamiento de personal como parte de su apoyo al desarrollo ins-

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titucional que es el objetivo de mayor beneficio para el Sector Salud. Podemos decir que este componente es uno de los que mayor desarrollo ha tenido en los dos años de ejecución del Proyecto.

Efectivamente, como se puede ver en el Numeral II. (Situación Actual), el MSP especialmente con el apoyo del Proyecto y de CIMDER ha realizado o auspiciado una serie de cursos, cursillos, seminarios, talleres, etc. que se han desarrollado en todos los niveles.

Sin embargo, es necesario puntualizar algunas dificultades y limitaciones que se han debido afrontar:

1. Aun antes de iniciar el Proyecto, la A.I.D. con fondos fuera del Convenio consiguió entrenar en Administración, a través de un curso de alta gerencia en Cali, a tres médicos que debían ser nombrados como Jefes de Area de los Proyectos DRI. Posteriormente, fue necesario entrenar en el mismo curso a cuatro médicos más, por cuanto los primeros habían dejado sus funciones y al momento como se anotó anteriormente, ninguno de ellos presta sus servicios en el Proyecto.

Con la decisión del señor Ministro de Salud de encargar las funciones de Jefes de Area a los Directores de los CSH, es necesario pensar urgentemente en el entrenamiento de

estos funcionarios y también de quienes colaborarían con los Directores de CSH en las acciones de regionalización. Considerando que se ha decidido es la implementación del Modelo, no sólo en las Areas DRI sino en un buen sector del País, es necesario pensar en la necesidad de organizar a nivel nacional, con la presencia de un grupo de asesores internacionales, uno o varios cursos diseñados especialmente para cubrir las necesidades del Plan de Regionalización en que se halla empeñado el Ministerio. Esto significaría un considerable ahorro al País al no enviar muchas personas a cursos en el extranjero, a la vez que aseguraría que las enseñanzas impartidas serán de inmediata aplicación en el medio de trabajo en que desarrollarán sus actividades.

2. La extensión de cobertura, política vigente en el MSP, exige la creación de nuevos puestos para trabajadores de la salud, especialmente en el área rural en que este personal es muy escaso o no existe. La creación de SCS y PS exige paralelamente contar con elemento preparado en el nivel de auxiliares, ya que el médico es solamente un eslabón del equipo de salud. La situación económica por la que atravieza el País hace que la solución a este problema sea difícil, pero habrá que buscar la solución para poder cubrir las necesidades de este personal. En el Area de Quimiag-Penipe se entrenaron cinco auxiliares de enfermería para cubrir un número igual de PS, lamentablemente al no ser contratadas por falta de presupuesto,

se corre el peligro de perder el esfuerzo de entrenamiento o que sean contratadas por otras instituciones.

3. El esfuerzo que ha realizado el País en la preparación de 350 promotores de salud es otro aspecto que requiere una definición sobre su utilización y especialmente sobre su remuneración; posteriormente haremos un análisis más detenido sobre este punto.

4. Del inventario y análisis de las actividades de entrenamiento llevadas a cabo con el Proyecto, creemos que el nivel intermedio (Directores Provinciales y Funcionarios Técnicos de las provincias), son los que menos se han beneficiado de esta acción. Consideramos que un amplio conocimiento de este personal sobre los pormenores del Sistema de Regionalización y de la filosofía del Proyecto DRI es fundamental para conseguir el apoyo necesario de este nivel y evitar que las Area DRI se vayan convirtiendo en islas dentro de las provincias.

D. Servicios e Infraestructura

El Proyecto provee (C-1) la realización de "Actividades Demostrativas de Atención Primaria de Salud (APS), con el fin de proporcionar servicios más eficaces, para incrementar la demanda con una participación activa de la comunidad", mediante tres tipos de actividades:

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- Actividades de promoción de la APS.
- Programas prioritarios de APS.
- Dotación de infraestructura para la APS.

1. La Programación de estas actividades, según el Convenio que traduce la filosofía de la descentralización administrativa y la participación comunitaria, estaría a cargo del Jefe de Area dentro de las políticas generales y la programación de la provincia (Dirección de Salud) y coordinando con la Unidad Ejecutora del respectivo Proyecto DRI. Justamente en este punto es en donde han surgido a nuestro parecer las mayores dificultades por falta de una definición clara de las relaciones entre la SEDRI y el MSP; las Unidades Ejecutoras de los Proyectos DRI y las Direcciones Provinciales de Salud.

En la realidad la programación a nivel de Micro-región (POA), se realiza de acuerdo al criterio del Jefe de Area de Salud bajo la dirección del Jefe de la Unidad Ejecutora, sin una base técnica adecuada y a veces fuera de la Programación de la Provincia, lo que ha hecho que dichos programas no se cumplan en su totalidad.

Para normar estas relaciones, se han firmado dos Convenios entre la SEDRI y el MSP. El primer Convenio es de tipo general y el segundo específico, para el desarrollo de ac-

tividades de salud en las tres Areas DRI: Salcedo, Quimiag-Penipe y Jipijapa.

En el primer documento-convenio firmado el 2 de julio de 1981, en sus antecedentes, se reconoce que según el decreto de creación del MSP, éste es el "responsable de las políticas, planes y programas de Salud" del Gobierno Nacional, a continuación, en el Literal b. Propósitos del Convenio, se dice textualmente: "Definir la "participación" del MSP en la programación, organización, implementación, ejecución, seguimiento y evaluación del componente de salud y saneamiento ambiental de los Proyectos de Desarrollo Rural, como dejando entrever que dentro de estos Proyectos, el decreto de creación del MSP no tiene completa vigencia.

El segundo convenio firmado entre el MSP y SEDRI el 8 de febrero de 1982 para regular las actividades de los Proyectos DRI: Salcedo, Quimiag-Penipe y Jipijapa, establece concretamente en su Tercera Cláusula que las "anteditas proformas (se refiere a los Planes Operativos Anuales (POA) de Salud en las Areas DRI) serán discutidas con los niveles nacional, provincial y operativo del MSP contando con la participación activa de los beneficiarios, que tendrán voz y voto en las discusiones. Al final, deberá elaborarse un informe o documento adjunto."

Más adelante, en la Cláusula Cuarta se establece que "los Jefes de Area de Salud asumirán funciones de Dirección Técnica y Administrativa sobre todos los Servicios de Salud comprendidos dentro del área asignada al respectivo Proyecto DRI .....

Estas disposiciones no se han cumplido a cabalidad en ninguna de las Areas DRI, en Quimiag-Penipe por ejemplo el POA de 1984 no era conocido en el nivel provincial, a la fecha de nuestra visita.

Los Jefes de Area en ningún caso han ejercido la Jefatura técnica y administrativa de los Servicios de Salud del área, ni siquiera de los SCS, peor de los CSH y esto, porque la preparación y juventud de quienes ejercen estas funciones, especialmente en Salcedo y Quimiag-Penipe, no les da el soporte técnico suficiente para ejercer esa autoridad.

Estas circunstancias han incidido en la prestación de Servicios de Atención Primaria de Salud que ha impedido cumplir con el objetivo de "Expansión de los Servicios Primarios" señalado en el Convenio. Efectivamente la recopilación, aunque incompleta, de algunos datos estadísticos extra-oficiales pero recolectados de los informes que reposan en las Direcciones Provinciales, nos permiten concluir que la cober-

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tura de esos servicios no tiene un mejoramiento importante en las Areas DRI con relación al resto de la Provincia o áreas similares. Adjuntamos algunos datos que confirman nuestra impresión.

COBERTURA DE VACUNACIONES EN MENORES DE 1 AÑO - 1983

EN LA PROVINCIAS DE CHIMBORAZO Y COTOPAXI

	<u>BCG</u>	<u>Sarampión</u>	<u>DPT(3a)</u>	<u>Polio.(3a)</u>
Chimborazo	92%	28%	30%	31%
-Quimiag	100%	31%	14%	17%
-Penipe	71%	12%	23%	23%
Cotopaxi	143.5%	29.8%	22.3%	22.4%
-Salcedo	70.8%	16.9%	12.2%	12.5%
-Pujilí	50.4%	16.3%	12.8%	13.3%

Si comparamos el número de niños rehidratados en la Provincia de Chimborazo que en 1983 suman 12.380 niños menores de un año, con los 366 de Quimiag-Penipe encontramos que éstas corresponden al 3% de las realizadas en toda la Provincia, mientras que la Población de esta área equivale al 4.3% de la Provincia. ( Datos obtenidos por el Dr. Frederick Hartman Asesor de A.I.D.).

Estamos concientes que estos datos no son definitivos y además están sujetos a una serie de variables que deben ser analizadas exhaustivamente antes de emitir un criterio defi-

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nitivo, pero los consignamos para crear la inquietud en las autoridades de establecer un mecanismo idóneo que de aquí en adelante permita ir evaluando el "impacto" del Programa, único medio de establecer su efectividad.

Transcurridos los primeros dos años, cuando los funcionarios del MSP han comprendido mejor la filosofía del Desarrollo Rural Integral y la SEDRI empieza a concederle a la salud el situual preponderante que tiene en el bienestar del hombre, las posibilidades de una mejor comprensión se han hecho presentes en las tres provincias, quizá con mayor énfasis en Cotopaxi, en donde los problemas iniciales se han superado con la buena voluntad de sus directivos.

## 2. Actividades de Promoción

### a. Promotores de Salud

-El Proyecto asume que se capacitarían por lo menos 30 promotores de salud que serían entrenados y empleados en las tres áreas. Durante el período que evaluamos se han entrenado 24 promotores en dos cursos realizados en Manabí y 19 de ellos se encuentran trabajando en el Area de Jipijapa. En el Area de Salcedo hay un promotor trabajando en Tailin y en Quimiag-Penipe no hay ninguno. El MSP tiene programado para

1984 entrenar a 120 promotores aunque, se anticipa que tendrá dificultades económicas para cumplir con esta meta.

-Según un convenio existente entre el MSP y FODERUMA, se conoce que esta última institución asumió el pago de bonificaciones a los promotores en 1980 con el 100% de su valor, en los años siguientes el MSP debió asumir paulatinamente el pago, de manera que en 1984 el MSP debía estar pagando el 80% y FODERUMA el 20%. Sin embargo, hasta la fecha esto no se ha cumplido por falta de financiamiento en el MSP, problema que deberá ser solucionado lo antes posible para evitar la paralización del Programa en los próximos años.

-Debe considerarse además que el éxito de los Promotores de Salud se basa en un buen control y supervisión realizado por los niveles técnicos correspondientes y una oportuna referencia de casos a los servicios formales de atención médica.

-En el Area de Jipijapa en donde pudimos observar este programa, encontramos que no existe una conveniente referencia de casos ni una supervisión adecuada por parte de los médicos Jefes de los SCS. En Puerto Cayo, por ejemplo, el médico rural nunca recibió una referencia de pacientes por parte de sus promotores, tampoco realiza visitas de supervisión porque la organización campesina a la cual pertenecen (UPOCAM)

exige que cualquier trámite con los promotores se realice a través suyo, inclusive para citarlos a la Jefatura de Area tienen que hacerlo con previa solicitud a UPOCAM.

-El nivel de Area y Provincial tiene igualmente problemas para realizar la supervisión, por dificultades financieras y de movilidad. Algunos promotores han abandonado sus puestos por falta del incentivo económico adecuado. Quizá debería pensarse en la posibilidad de utilizar a algunos de estos promotores como auxiliares de enfermería de comunidad, cuando haya deficiencia de este personal y previo el entrenamiento adecuado.

-Es necesario que el MSP realice una evaluación integral del programa de Promotores de Salud, por lo menos en algunas áreas o provincias, para reorientar sus actividades y normalizar sus funciones de manera que se constituyan en valiosos elementos de apoyo al sistema formal de salud como lo han demostrado en muchos países del mundo y desaparezca el peligro de convertirlos en ejercitantes de un empirismo legalizado con el consiguiente peligro para la salud de la comunidad.

#### b. Botiquines

No se han instalado con el Proyecto, se aduce que aunque existe un reglamento expedido para su funcionamiento

to, se han detectado muchos problemas en la administración por parte de la comunidad. Se dice también que al tratar de adquirir los medicamentos de "bajo costo" que por ley están obligados a producir ciertos laboratorios farmacéuticos, éstos se niegan a venderlos, aduciendo que no les resulta rentable. La solución podría ser instalarlos como parte de las "Tiendas Comunitarias" que se están organizando en los Proyectos DRI.

c. Respaldo a Colaboradoras Voluntarias Rurales (CVR) Parteras Empíricas y Voluntarios de Salud.

De acuerdo con las regulaciones del MSP, esta actividad se ha desarrollado en las Areas DRI y tal vez con mayor éxito debido a que el personal de salud se beneficia de la organización comunitaria que realizan los Proyectos DRI.

3. Programas Prioritarios de Atención Primaria de Salud

a. Control de Diarreas

Aunque el incremento de cobertura en las Areas DRI no ha podido ser probado, este programa ha tenido un importante avance especialmente en lo que a promoción se refiere con la asignación de un asesor de A.I.D. a tiempo completo, el Dr. Reynaldo Pareja, con quien se han realizado reuniones, semina-

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rios y se está preparando abundante material audio-visual como rotafolios, (se ha preparado un rotafolio en tela que lo consideramos muy práctico tanto por el material empleado como por su contenido), cuñas radiales y otros materiales interesantes. Se nos ha hecho conocer que no existe problema en la provisión de las sales de rehidratación por parte del MSP a las Areas DRI, aunque se distribuyen casi exclusivamente a nivel de SCS, pues no se ha podido contar aún con la comunidad para su distribución por la falta de los botiquines comunitarios. Los fondos asignados en el Proyecto han sido utilizados en un alto porcentaje.

b. Programa Ampliado de Inmunización (PAI)

Este programa ha mantenido sus actividades dentro de las Areas DRI como parte de su actividad normal. Parece que existió desconocimiento de las autoridades de la posibilidad de utilizar fondos del Proyecto para incrementar sus acciones a nivel de esas áreas:

Se han detectado algunas deficiencias, especialmente en la cadena de frío y en entrenamiento de personal que podría ser solucionado a corto plazo con la utilización de fondos del Proyecto. A este respecto y considerando que existe aun una deficiencia de la red de frío en todo el país que llega a un 30% a 40%, es indispensable considerar un fortalecimiento

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del nivel provincial para obtener la conveniente continuidad de la cadena de frio, lo que podría hacerse si es aceptada una re-programación en este sentido.

c. Control del Bocio

-Este subcomponente se encuentra desarrollándose a través de un proyecto independiente que lo realiza la Curia de Riobamba y que tiene avanzada la implementación de un Centro Vicarial del Campesino -CEVICAN - que se encuentra en construcción.

-El Proyecto está financiando el estudio sobre control del bocio en el área de Quimiag-Penipe que lo realiza ININMS.

d. Actividades de Nutrición

-Como acciones realizadas a través de los Proyectos DRI se debe citar la instalación de "Tiendas Comunes" de las cuales se han instalado con buenos resultados 18 en el Area de Quimiag-Penipe y 2 en Salcedo, además se está implementando un "Centro de Acopio" en cada una de dichas áreas. Estas tiendas tienen financiamiento de SEDRI, y colaboran ENPROVIT, SENDIP y el Instituto Nacional de Pesca que está probando tecnologías baratas para la industrialización del pescado. Hasta la presente fecha no se han utilizado fondos del préstamo para

esta actividad, debido a que dentro del nivel de decisión de la SEDRI se ha considerado que las tiendas son más bien un proyecto de comercialización antes que un programa de nutrición.

-El Programa PAAMI (Programa de Asistencia Alimentaria Materno-Infantil), ha dotado con sus fondos a las Area DRI de los equipos requeridos para la realización del Programa a todos los SCS y que consiste de: balanzas con tallímetro, balanzas de campo, equipo de demostración con cocineta y menaje de cocina.

-El proyecto piloto que tiene programado la SEDRI para realizarlo en las Area DRI no se ha cumplido como tal, pero la Dirección del PAAMI desarrolló un Proyecto piloto en las tres área que fue financiado por el ININMS y cuyo informe final ha sido ya presentado.

#### e. Educación para la Salud

-La contratación de un Asesor para el Programa de Control de Diarreas ha permitido un avance significativo en las actividades de Información, Educación y Comunicación. El MSP ha designado la correspondiente contraparte que con el asesoramiento del consultor se encuentra desarrollando su propia metodología, especialmente en la elaboración de material audiovisual y el contacto directo con la comunidad. Se espera que estos logros puedan luego ser replicados a nivel nacional.

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Convendría considerar la continuación de este asesoramiento para apoyar a otros programas prioritarios especialmente el PAI.

-El Proyecto incluye también la contratación de un "Asistente Educador para la Salud" para trabajar en cada Area DRI, ésto no ha sido posible por no existir ni el cargo, ni la "categoría" en el Manual de Clasificación de puestos de la Administración Pública, creemos que podría suplirse esta necesidad prestando un adecuado entrenamiento a los demás miembros del equipo de salud que laboran en las Area DRI, especialmente al Inspector Sanitario.

-Los informes de los Proyectos coinciden en confirmar la realización de una intensa actividad educativa en las escuelas de las comunas pertenecientes a las Area DRI con el apoyo de los médicos de los SCS, el personal de Salud de las Area DRI y los educadores para la salud provinciales. La actividad educativa con líderes de la comunidad y organizaciones campesinas también ha sido informada.

-En lo referente a preparación de material audio-visual ya quedó señalado lo que se ha realizado para el Programa de Control de Diarreas.

-Un aspecto que debe ser considerado como limitante en este subcomponente de Educación para la Salud constituye la falta de vehículos para la movilización.

El Proyecto dotó con la debida oportunidad los cuatro vehículos considerados en el Convenio, los que fueron distribuidos así:

- Uno para la Oficina de Coordinación DRI del MSP (1).
- Uno para cada una de las Areas DRI (3).

El vehículo de la Oficina de Coordinación fue asignado a otras funciones en el MSP. De los tres vehículos asignados a las Areas DRI, sólo se encuentra funcionando el del Proyecto Quimiag-Penipe, los otros dos a poco de haber sido entregados sufrieron accidentes graves que los han mantenido inutilizables por más de un año. Los vehículos no han sido matriculados hasta la fecha y por lo mismo no han sido asegurados. Las Direcciones de Salud de Manabí y Cotopaxi no han querido asumir los gastos de reparación por no haberlos asignado reglamentariamente y porque existen problemas judiciales por dilucidarse sobre la culpabilidad de los accidentes.

Parece que al momento existe ya la fórmula para solucionar este problema y debe darse el trámite adecuado para eliminar esta limitante que impide, a no dudarlo, un normal avance del programa.

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Debe prepararse, en coordinación con la SEDRI, las normas para utilización y conservación de estos vehículos.

#### f. Participación Comunitaria

-La filosofía misma del DRI hace de esta condición la principal estrategia para lograr los objetivos y metas del Proyecto y hay que reconocer que las Unidades Ejecutoras han dado gran impulso tanto a la organización como a la participación comunitaria. Practicamente todos los días se están desarrollando actividades tendientes a lograr este objetivo. Creemos que esta actividad de los Proyectos DRI es el mayor aporte que han hecho al Sector Salud que está beneficiándose de la motivación de la comunidad y su organización para introducir los programas de salud.

-Sin embargo, no se puede desconocer que han habido problemas derivados en su mayoría de las relaciones con las organizaciones campesinas como es el caso de Manabí que ya quedó señalado.

### 3. Infraestructura de Salud

Como quedó señalado en el Numeral II. Situación Actual, éste componente ha tenido un progreso que puede consi-

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derarse bueno, con ciertos aspectos que deben tomarse en cuenta para el futuro.

a. Construcciones

-Los SCS de Quimiag y Penipe se encuentran terminados desde hace varios meses y su equipo listo en la Dirección Provincial. Sin embargo, no se ha puesto a servicio de la comunidad por detalles de menor importancia que han impedido la entrega-recepción definitiva entre el IEOS y el MSP. Sería conveniente que estas situaciones administrativas menores no entorpezcan y retracen la prestación de un servicio deseado por la comunidad.

-Hay otras construcciones que estando programadas y contando con la financiación respectivas no se inician o no se terminan como es el caso del SCS de Matus (en Quimiag-Penipe) y el de 5 de Julio en Jipijapa. Si el IEOS no tiene capacidad operativa para realizar estas obras, deberían ser subcontradas con empresas especializadas para evitar el incremento de los costos con el pasar del tiempo y sobre todo que se priven a las comunidades de un servicio al que tienen derecho.

-Hemos conocido que según un acuerdo con la SEDRI los PS serán instalados en las "Casas Comunales", no estamos en desacuerdo con este criterio, al contrario lo apoya-

mos, pero hasta la fecha son pocos los PS instalados a pesar de haber muchas Casas Comunes que han sido terminadas y existir el correspondiente equipo en las Direcciones Provinciales. La razón ya fue identificada anteriormente y se relaciona con la falta de la auxiliar de enfermería comunal que no ha podido ser contratada por los motivos conocidos.

#### b. Equipamiento

-La adquisición de equipos para SCS y PS ha sido cumplida quizá con ventaja sobre las metas programadas, lamentablemente no se puede decir lo mismo de la utilización de esos equipos, pues la mayoría se encuentra enbodegado en las Direcciones Provinciales, con la misma justificación de falta de personal idóneo para hacerse cargo del equipo, especialmente a nivel de PS.

-La eficiencia de un sistema de salud depende de la capacidad operativa de todos sus niveles. No se puede mejorar la salud de una comunidad con una buena Atención Primaria si no se cuenta paralelamente con una unidad bien dotada en el siguiente nivel de complejidad para atender la patología referida de los niveles inferiores. Algunos CSH, especialmente el de Jipijapa tiene importantes deficiencias que no han podido ser solucionadas por el nivel Provincial, como es la falta de equipo de Rayos X. Se debe pensar con la colaboración de la

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A.I.D. en una reprogramación de estos fondos, para ayudar a nivel de área en los CSH y en algunos casos a nivel provincial como en la dotación de la cadena de frío ya expuesto.

E. Administración del Proyecto

1. Oficina de Coordinación DRI

-Consideramos un acierto la creación, por parte del MSP de la "Oficina de Coordinación de DRI" que está en condiciones de contribuir a la eliminación de la mayor parte de las dificultades señaladas.

-Las principales funciones que ha venido desempeñando esta oficina se resumen así:

-Manejo financiero de los fondos del Proyecto asignados al componente de Desarrollo Institucional permitiendo cumplir con las estrictas normas administrativas y de reembolso de fondos de la A.I.D.

-Prácticamente ha constituido la contraparte permanente del MSP en la elaboración del Modelo de Regionalización de Servicios que se realiza con el asesoramiento de CIMDER y constituirá el elemento indispensable en la aplicación del mo-

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delo en las Provincias mediante el adiestramiento oportuno del personal encargado de aplicar el Modelo.

-Ha tenido parte activa en la selección de personal para entrenamiento, así como en la organización de cursos, seminarios o reuniones para la discusión de los diferentes módulos del Modelo de Regionalización.

-Debe constituirse, debidamente reforzado, en el elemento técnico de apoyo para las Areas y las provincias en la selección de temas y en algunos casos inclusive del diseño de las investigaciones operacionales que se programen de acuerdo con la recomendación que estamos haciendo.

-Deberá intervenir, de acuerdo con el convenio entre el MSP y la SEDRI en la elaboración anual de los POA, por lo menos en los aspectos generales, constituyendo el lazo de unión entre los Proyectos DRI y las Direcciones Provinciales de Salud.

-Una función inherente a esta oficina debe ser la supervisión técnica y evaluación continua de las actividades de salud en las Areas DRI para sugerir a los niveles respectivos los reajustes necesarios y la reprogramación respectiva. Esta función no ha podido cumplirse a cabalidad por la falta de medios de información oportuna y de recursos de movilización,

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pues como dejamos aclarado, el vehículo asignado para el Proyecto fue destinado a otras funciones por el MSP.

-La resolución del MSP de crear una División de Regionalización basada en la estructura de la actual Oficina de Coordinación creemos que dará estabilidad y continuidad a las actividades del Proyecto.

## 2. Sistema de Información, Supervisión y Evaluación

-El Convenio no especifica en forma concreta los mecanismos de control del Proyecto porque se supone que los mismos van a formar parte del Modelo que está siendo elaborado como componente del Modelo de Regionalización. De todas maneras, se han elaborado informes mensuales de los tres Jefes de Area que han sido analizados en la Oficina de Coordinación DRI del MSP. Se espera que en los próximos períodos se pueda contar con informes concentrados, tanto descriptivos como estadísticos, que faciliten la labor de evaluación.

-Las actividades de supervisión se han visto dificultadas por dos razones fundamentales, la una es la falta de una definición clara de las dependencias técnico-administrativas a nivel de área de salud, y la segunda las dificultades financieras y de movilización que han afectado a varios programas del MSP.

-Las actividades de evaluación periódica también se han visto limitadas por las consideraciones anteriores y sería de desear que en adelante se realice una evaluación anual incluyendo ya, en lo posible, algunos aspectos de la evaluación del impacto en la morbilidad o por lo menos en la cobertura de los servicios, como única forma de verificar el verdadero rendimiento del programa.

### 3. Administración Financiera

Se ha detectado algún retraso en el trámite de los fondos, especialmente en aquellos que se manejan a través de la SEDRI con la intervención de FONADRI, como en el caso de los fondos asignados para infraestructura de salud (construcciones y equipamiento) seguramente atribuible a la demora en enviar los comprobantes de gastos para ser reembolsados por la A.I.D. (Se adjunta un informe detallado, elaborado por el Sr. Robert Emrey).

## IV. CONCLUSIONES Y RECOMENDACIONES

El MSP considera que la salud es el bien supremo del hombre y así lo reconoce nuestra Constitución al considerar que el derecho a la salud es uno de los derechos fundamentales de todo ecuatoriano. El desarrollo integral debe pues conside-

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rar a la salud como un fin primordial y no como un medio o incentivo para desarrollar programas económicos o agrícolas, por importantes que éstos sean.

Bajo este principio expondremos las conclusiones y recomendaciones de nuestro estudio.

1. -La incoordinación detectada entre las autoridades de los Proyectos DRI y los del MSP, especialmente del nivel provincial, está ocasionando un fraccionamiento de los Programas de Salud de las Areas DRI que se escapan de la unidad y coherencia necesaria que debe primar en la programación de salud.

-Se sugiere una revisión del Convenio entre el MSP y la SEDRI de manera que se establezca la jerarquización justa del sector salud, estableciendo los puntos de convergencia de las instituciones y permitiendo que la programación y ejecución de las acciones de salud se encuadren dentro de sus políticas y planes nacionales y provinciales.

2. La organización y participación comunitaria, estrategia fundamental de la SEDRI, constituye para la salud un valioso elemento para el cumplimiento de sus objetivos.

-El MSP debería apoyar y participar en todas las acciones que conduzcan a ese fin, pero estableciendo normas

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claras y precisas especialmente para la utilización de los promotores de salud, tanto para su remuneración como para sus funciones y obligaciones, desarrollando un sistema de supervisión directa e indirecta que verifique su utilidad como colaboradores del sistema y no se favorezca el empirismo.

3. El desarrollo del Modelo de Regionalización, que significará la descentralización administrativa de las Areas o Microregiones puede convertirse en el mayor logro del Proyecto cumpliendo así una de las más antiguas aspiraciones del MSP.

-Se sugiere iniciar cuanto antes con la aplicación del Módulo de Diagnóstico en las areas que sean escogidas pero sin descuidar que paralelamente se aprueben los módulos de organización y programación que son los que definitivamente le darán forma a las Microregiones. La cúpula técnica del MSP debería estar directamente comprometida con esta labor. El Proyecto, mediante una reprogramación adecuada deberá apoyar las actividades de entrenamiento y de supervisión en el proceso de implementación del Modelo.

4. La decisión del MSP de nombrar Jefes de Area de Salud a los Directores de los CSH parece ser la única alternativa factible de llevarse a cabo.

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-Será necesario establecer un cronograma para el ingreso de las provincias al nuevo sistema, encontrar la fórmula legal y económica para poder fortalecer a la Jefatura de Area con la inclusión de personal técnico de apoyo para la Administración de la Microregión: por lo menos un médico y una enfermera, con preparación en administración de servicios y un estadístico.

-Se va a requerir además proporcionar entrenamiento al personal de las Areas incluyendo al Director del CSH. Creemos que la mejor alternativa será organizar cursos en el País para una o varias Provincias paralelamente con la incorporación al sistema. Los fondos del Proyecto podrían refinanciarse para esta actividad.

5. La condición política de mantener la división territorial político-administrativa del País, no puede cumplirse a totalidad en muchos casos por problemas de accesibilidad.

-El Proyecto podría ayudar en el establecimiento espacial o geográfico de las áreas, estudiando un mecanismo idóneo para solucionar los casos en que este principio tendría que ser alterado en beneficio de la eficiencia de la atención y la coordinación a establecerse entre provincias.

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6. Un pequeño muestreo estadístico de las actividades de APS ha demostrado que la labor de educación y motivación de las comuniades no han resultado en un incremento significativo de la cobertura y el verdadero impacto del Proyecto sólo podrá ser juzgado cuando obtengamos una disminución en la morbi-mortalidad de la patología que atacamos.

-Un desarrollo paralelo de la capacidad provincial para apoyar con los insumos necesarios el aumento de la demanda de la población es indispensable, sólo así se evitará el peligro que significa dejar insatisfecha una demanda que nosotros hemos originado.

-Así mismo se requiere mediante entrenamiento adecuado crear en el nivel directivo provincial una clara conciencia de apoyo al Proyecto, demostrando los beneficios técnicos y administrativos que se derivarán para su propia administración provincial.

-El fortalecimiento y equipamiento adecuado de los niveles de referencia de pacientes, en este caso de los CSH es otra necesidad que hay que preveer para evitar el deterioro de la cadena de referencia de pacientes.

-El Proyecto podrá considerar en su reprogramación algún apoyo de este tipo.

7. Las actividades de investigación han tenido, durante el período de la evaluación un desarrollo modesto. Las dificultades detectadas explican suficientemente su escaso desarrollo pero concientes del papel que ellas desempeñarán en el futuro del Programa, nos permitimos sugerir que una Comisión especial quizá con el asesoramiento adecuado (provisto por el Proyecto) debería analizar a fondo los requerimientos y factibilidad de estudios concretos y de inmediata aplicación práctica, de manera que la reprogramación del Proyecto en esta área pueda hacerse sobre una base cierta.

8. El subcomponente de Nutrición durante el período no revela ninguna actividad nueva o preponderante en las Areas DRI, excepto la realización de un programa piloto del PAAMI.

-Considerando que los Proyectos DRI le dan una especial importancia a estas actividades, es necesario en coordinación con las autoridades respectivas del MSP y de SEDRI buscar el mejor campo de apoyo en que podría intervenir el Proyecto.

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9. El PAI ha hecho conocer algunas deficiencias de su red de frío incluso en las provincias de las Areas DRI, lo que está disminuyendo la eficacia del programa. El Proyecto debería apoyar en la solución de esta deficiencia para que las Areas DRI puedan ser realmente "Areas de Demostración" a copiarse posteriormente en otras regiones del País.

10. Los botiquines comunitarios no han podido ser implementados por problemas administrativos, pero se ha reconocido su conveniencia especialmente en sitios alejados de los SCS o de difícil accesibilidad.

La sugerencia sería aprovechar la infraestructura de las "Tiendas Comunales" que ya se encuentran funcionando y han superado el problema administrativo.

11. La falta de recursos de movilización ha dificultado el cabal cumplimiento de las actividades programadas de educación para la salud.

-Es urgente que a cualquier costo se proceda a la reparación de los vehículos averiados sin perjuicio de las acciones legales que deben continuar para establecer responsabilidades.

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-Los vehículos deben ser entregados a las Jefaturas de Area a través de las respectivas Direcciones Provinciales, pero estableciéndose claramente las actividades a cumplir, las disposiciones para mantenimiento y las responsabilidades consiguientes. Se impone la contratación de un seguro.

-Nos permitimos sugerir que el vehículo asignado a la Oficina de Coordinación de DRI sea devuelto a sus funciones, especialmente ahora que se iniciarán las actividades de campo en la aplicación del Modelo de Regionalización.

12. Todo lo anterior nos hace concluir que será necesario realizar una reprogramación importante del Proyecto, orientando los recursos hacia las áreas que se juzgan prioritarias y más relacionadas con los objetivos del proyecto.

-Esta reprogramación deberá hacerse previo un estudio detallado realizado con la participación de las instituciones comprometidas.

-Una evaluación anual a partir de la fecha en que entre en vigencia la reprogramación señalada, deberá ser prevista, la misma que deberá incluir un estudio de profundidad en las áreas para determinar el incremento de cobertura de las acciones de salud que en definitiva es lo que requiere el MSP.

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13. Para que esta evaluación que se propone sea efectiva, la reprogramación deberá incluir mecanismos de control más adecuados. El Sistema de Información del Modelo de Regionalización facilitará esta acción, pero se debe establecer en el Proyecto requerimientos concretos de informes periódicos y concentrados que estudiados y analizados por la Oficina de Coordinación DRI facilitarán, a su tiempo, la labor de los evaluadores.

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ANEXO No. 1

PROYECTO 518-0015 y 518-U-040

EVALUACION

AGENDA DE TRABAJO

Marzo 7 - Abril 6, 1984

Martes, 6 de marzo

- 08:00 - 12:00 Reunión Preparatoria:  
- Aprobación de la Agenda de Trabajo  
- Discusión y aprobación de la metodología y de los instrumentos para recolección de datos.
- 12:30 - 16:30 Estudio de la documentación disponible

Miércoles, 7 de marzo

- 08:00 - 11:00 Preparación de entrevistas  
11:00 - 12:00 Visita de cortesía al señor Ministro de Salud y Autoridades del Ministerio  
12:00 - 16:30 Entrevista con el C.N.S.:  
- Dr. Fausto Andrade, Director Ejecutivo  
- Dr. Eduardo Navas, Ex-Coordinador  
- Dr. Oswaldo Egas, Delegado del IESS

Jueves, 8 de marzo

- 08:00 - 12:00 Entrevista con Autoridades del Ministerio de Salud Pública - Nivel Central  
- Dra. Guadalupe Pérez de Sierra, Subsecretaria de Salud de la Región I  
- Dr. César Troncoso, Director Técnico de la Subsecretaría - Región I  
- Dr. Mauro Rivadeneira, Director General de Salud
- 12:30 - 16:30  
- Dr. Julio Alvear, Director del ININMS  
- Dr. Enrique Vera, Director de Planificación  
- Dr. Edgar Moncayo, Director de Programación  
- Dra. Magdalena Vanoni, Directora de Programación Prioritarios  
- Dr. Ricardo Freire, Director de Servicios Médicos

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Viernes, 9 de marzo

08:00 - 14:00

- Dr. Humberto Baquero, Jefe de la División de Fomento
- Dra. Ligia Salvador, Jefe de la División de Morbilidad más Frecuente (Encargada del Programa de Control de Diarreas)
- Dr. Alfredo Jara, Jefe de la División de Desarrollo Comunitario.
- Dr. Oswaldo Barrezueta, Jefe de PAI
- Lcdo. Carlos Rosero, Jefe de Educación para la Salud

14:00 - 16:30

- Entrevista con personeros de la OPS/OMS
- Dr. Carlos Pettigiani, Representante
  - Dr. Merlin Fernández, Asesor

Sábado, 10 de marzo

Análisis de la información obtenida

Lunes, 12 de marzo

08:00 - 12:00

- Entrevista con funcionarios de la SEDRI
- Lcdo. Jaime Borja, Director Técnico
  - Lcda. Susana Larrea, Nutrición
  - Sra. Carmen Carrasco, Contabilidad

12:00 - 13:30

- Entrevista con funcionarios de FODERUMA
- Dr. Miguel Almeida, Jefe de Salud
  - Lcda. Alicia Balsaca, Enfermera

14:00 - 16:30

- Entrevista con personeros de CIMDER
- Dr. Jorge Saravia, Director
  - Srta. Esmeralda Burbano, Asesora
  - Lcda. Yolanda Romero, Contraparte
  - Dr. Luis Vásquez, Contraparte

Martes, 13 de marzo

08:00 - 12:00

Análisis de la información obtenida

12:00 - 16:30

Preparar visita de campo Area DRI-Jipijapa

Miércoles, 14 de marzo

07:00

Viaje a Manta - TAME Vuelo No. 131

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- 09:00 - 12:00 Entrevistas y discusión sobre el Area DRI-  
Jipijapa con funcionarios de la Dirección  
Provincial de Salud de Manabí  
- Dr. Julio Villacrés, Director Provincial  
- Sr. Publio Villavicencio , Jefe de  
Finanzas  
- Dr. Juner Falfan, Jefe de Programas  
Prioritarios
- 12:30 Viaje a Jipijapa
- 14:00 - 16:30 Entrevista con funcionarios del Area DRI  
- Dra. María Elena González, Jefe de Area  
- Dr. Abelardo Andrade, ex-Jefe de Area

Jueves, 15 de marzo

- 08:00 - 10:00 Entrevista con:  
- Ing. Angel Orlando, Jefe del Proyecto  
SEDRI
- 10:00 - 16:30 Visita a Subcentros de Salud y Puestos de  
Salud entrevistando a:  
- Director del CSH  
- Médicos de Subcentros  
- Promotores de Salud  
- Dirigentes de UPOCAM  
- Otros líderes de la comunidad y autorida-  
des civiles
- (Los evaluadores se dividirán en grupos se-  
gún su interés).  
(Se pernoctará dos noches en Manta - Hotel  
Gaviota)

Viernes, 16 de marzo

- 08:30 Viaje de regreso Manta-Quito, Vuelo TAME  
No. 130
- 10:00 - 16:30 Análisis de la información obtenida.

Sábado, 17 de marzo

Análisis de la información obtenida.

Lunes, 19 de marzo

Preparar visita de campo Areas DRI  
Quimiag-Penipe y Salcedo

- 14:00 Viaje a Riobamba vía terrestre - Hotel  
Galpón

256

Martes, 20 de marzo

08:00 - 10:00

Entrevista con autoridades provinciales de Salud de Chimborazo

- Dr. Gualberto Mariño, Director Provincial
- Dr. Publio Escobar, Jefe de Programas Prioritarios
- Dr. Marco Quintana, Jefe de Materno Infantil
- Ing. Milton Silva, Director Provincial del IEOS

10:00 - 16:30

Visita al DRI Quimiag-Penipe y entrevista con:

- Jefe de Area
- Jefe del Proyecto SEDRI
- Médicos de Subcentros y Puesto de Salud
- Promotores de Salud
- Líderes Comunitarios
- Autoridades Civiles
- Miembros de la Comunidad

(Los evaluadores se dividirán en grupos según su interés).

17:00

Viaje de regreso a Latacunga, vía terrestre

- Hotel Rumipamba de las Rosas

Miércoles, 21 de marzo

08:00 - 10:00

Entrevista con autoridades provinciales de Salud de Cotopaxi

- Dr. Ramiro Parreño, Director Provincial
- Dr. Arturo Ortíz, Jefe de Programas Prioritarios
- Ing. Julio César Proaño, Jefe IEOS

10:30 - 16:30

Visita al Area DRI Salcedo y entrevista con:

- Dr. Máx Arias, Jefe de Area
- Ing. Oscar Escola, Jefe de Proyecto SEDRI
- Lcdo. Jaime Arias, Educador
- Director de CSH de Salcedo
- Médicos de los Subcentros y Puestos de Salud
- Promotores de Salud

251

- Líderes Comunitarios
- Autoridades Civiles
- Miembros de la Comunidad

(Los evaluadores se dividirán en grupos según su interés.)

17:00 Viaje de regreso a Quito.

Jueves, 22 de marzo Análisis de la información obtenida.

Viernes, 23 a Miércoles, 29 de marzo

Preparación del borrador del documento

Jueves, 29 de marzo

18:00 Presentación de conclusiones y recomendaciones al señor Ministro de Salud

Viernes, 30 de marzo a Viernes, 6 de abril

Discusión del borrador y redacción final del documentos en español e inglés en Quito y Washington.

NOTA: Cuando el documento haya sido completado y entregado a las autoridades, se establecerá una fecha para realizar un Seminario para el análisis del documento y búsqueda de nuevas estrategias con funcionarios responsables del Proyecto en los varios niveles, pertenecientes al MSP, SEDRI, AID y CIMDER.

ANEXO No.2

LISTA DE PERSONAS ENTREVISTAS

- Dr. Luis Sarrazín Dávila                    Ministro de Salud Pública
- Dra. Guadalupe P. de Sierra                Subsecretaria de Salud Región I
- Dr. Mauro Rivadeneira                    Director General de Salud
- Dr. Gustavo Estrella                    Director de la Oficina de Desarrollo Rural Integral - Salud
- Dr. Eduardo Navas                    Director Técnico de La Oficina de Desarrollo Rural Integral - Salud
- Dr. César Troncoso                    Director Técnico de la Subsecretaría de Salud - Región I
- Dr. Fausto Andrade                    Director Ejecutivo del Consejo Nacional de Salud
- Dr. Enrique Vera                    Director de Planificación, MSP
- Dra. Magdalena Vanoni                    Directora de Programas Prioritarios
- Dr. Ricardo Freire                    Director de Servicios de Salud
- Dr. Julio Alvear                    Director del ININMS
- Dr. Edgar Moncayo                    Jefe de Programación MSP
- Dr. Edmundo Betancourt                    Jefe de la División de Nutrición, MSP
- Dr. Humberto Baquero                    Jefe de la División de Fomento para la Salud
- Dra. Ligia Salvador                    Jefe de la División de Morbilidad más Frecuente
- Dr. Oswaldo Barrezueta                    Jefe del PAI
- Dr. Alfredo Jara                    Jefe de la División de Desarrollo Comunitario

- Lcdo. Carlos Rosero Educador para la Salud de la Dirección de Programas Prioritarios
- Dr. Oswaldo Egas Funcionario de la Dirección Médico Social del IESS, Delegado a CONADE
- Dr. Miguel Almeida Jefe de Salud de FODERUMA
- Lcda. Alicia Balseca Enfermera Salubrista FODERUMA
- Lcdo. Jaime Borja Director Técnico de SEDRI
- Lcda. Susana Larrea Nutricionista de SEDRI
- Sra. Carmen Carrasco Funcionaria de Contabilidad de SEDRI
- Dr. Kenneth Farr Jefe de Salud de A.I.D.
- Dr. Frederick Hartman Asesor de A.I.D.
- Dr. Reynaldo Pareja Asesor en IEC para el Programa de Control de Diarreas
- Dr. Carlos Pettigiani Representante de la OPS/OMS
- Dr. Merlin Fernández Asesor de la OPS/OMS
- Dr. Jorge Saravia Director de CIMDER
- Srta. Esmeralda Burbano Funcionaria de CIMDER
- Lcda. Yolanda Romero Funcionaria de la División de Estadística, MSP. Asignada a CIMDER
- Dr. Luis Vásquez Funcionario de la División de Desarrollo Comunitario. Asignado a CIMDER
- Lcda. Nelly Gallardo Enfermera de la División de Desarrollo Comunitario. Asignada a CIMDER

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- Lcda. Marcia Gordillo Enfermera de la División de Desarrollo Comunitario. Asignada a CIMDER
- Dr. Julio Villacrés Director de Salud de Manabí
- Dr. Juner Falfan Jefe de Programas Prioritarios de Manabí
- Sr. Julio Villavicencio Jefe de Finanzas de la Dirección de Salud de Manabí
- Dr. Abelardo Andrade Funcionario de la Subsecretaría de la Región II, ex-Jefe del Area DRIJipijapa
- Ing. Angel Orlando Jefe de la Unidad Ejecutora del Proyecto DRI, Jipijapa
- Ing. Roberto González Consultor de (ICCA)
- Médicos y Odontólogos Rurales Area DRI, Jipijapa
- Personal de Salud, Líderes Comunitarios y Promotores Area DRI, Jipijapa
- Dr. Publio Escobar Jefe de Programas Prioritarios Dirección de Salud Chimborazo
- Dr. Marco Quintana Jefe de Salud Materno Infantil de la Dirección Provincial de Salud Chimborazo - ex-Jefe de Area DRI, Quimiag-Penipe
- Ing. Milton Silva Director Provincial del IEOS Chimborazo
- Ing. Alfredo Naranjo Médico Rural, Encargado de la Jefatura del Proyecto DRI Quimiag-Penipe
- Enf. Grimaneza Vilema Enfermera Rural. Asignada al Proyecto DRI, Jipijapa
- Sr. Jorge Araujo Inspector Sanitario de la Dirección Provincial de Salud Chimborazo. Asignado al Proyecto DRI, Quimiag-Penipe



- Curso sobre conocimientos básicos de salud. (Una experiencia de capacitación en el Proyecto Salcedo).
- Políticas y Normas de Atención Primaria de Salud. (Reunión de fin de semana) y formularios (Promotores).
- Contrato entre el MSP y CIMDER para el Diseño e Implementación de un Sistema de Servicios de Salud regionalizado en 3 microregiones de los Proyectos DRI con una estrategia de extensión de cobertura, 19 de marzo, 1982.
- Enmienda al Contrato anterior del 23 abril de 1982.
- Decreto Ejecutivo No. 637, que establece el subsistema de Desarrollo Rural Integral dentro del Sistema Nacional de la Administración Pública, Presidente Jaime Roldos - 29 de octubre, 1980.
- Metodología de Diagnóstico para Areas DRI. (Metodología y 2 Anexos). Documento preliminar, junio, 1982.
- Diagnóstico de la Situación de Salud en áreas DRI: Salcedo, Químiag-Penipe y Jipijapa, agosto, 1982.
- Manual sobre recopilación resumida y clasificada de Políticas, Normas y Procedimientos de Interés al Sector Salud en los programas de Desarrollo Rural Integral. Documento preliminar, octubre, 1982.
- Módulo de Programación. Primera versión, noviembre 1982.
- Manual sobre Recopilación Resumida y Clasificada de Políticas y Normas de Interés al Sector Salud en Areas de Desarrollo Rural. Revisión documento preliminar, marzo, 1983.
- Metodología de Diagnóstico para áreas de Salud.
  - Revisión documento preliminar - junio, 1983
  - Revisión documento preliminar - noviembre, 1983.
- Módulo Delimitación del Sujeto de Trabajo - Documento preliminar, junio 1983.
- Síntesis de la Metodología de Regionalización de Servicios de Salud - Documento preliminar, junio 1983.
- Módulo de Toma de Decisiones. Documento preliminar, junio, 1983. Revisión documento preliminar, diciembre, 1984.

- Documento de Regionalización de Servicios de Salud - Documento preliminar, agosto, 1983.
- Módulo de Organización. Documento preliminar, junio 1983. Revisión documento preliminar (Dirección Provincial y Areas de Salud) diciembre, 1983.
- Metodología de Diagnóstico (Metodología y 2 Anexos), marzo, 1984.
- Proyecto Piloto de Programa de Asistencia Alimentaria Materno Infantil en su Primera Fase para las Zonas DRI de Salcedo y Quimiag-Penipe - Dr. Guillermo Troya, MPH - JUNAC, 1983. Anexos - JUNAC, 1983.
- Anuario de Estadística, Programa de Asistencia Alimentaria Materno-Infantil, División Nacional de Nutrición, Ministerio de Salud, 1982.

ANEXO No. 3

DOCUMENTOS

- Programas Operativos Anuales (POA): 1982 y 1983 de las tres Areas DRI.
- Informe de Reuniones de CIMDER.
- Informe de Adiestramiento de CIMDER.
- Informe de Reuniones e Investigación CNS.
- Convenio Proyecto A.I.D. 518-0015 - A.I.D. 518-U-040 y sus Anexos.
- Informe de Consultor sobre Promotores de Salud, Sr. Sam Haight -A.I.D.
- Convenio entre el MSP y SEDRI - (Convenio General).
- Convenio entre el MSP y SEDRI para la ejecución de actividades de campo para APS en las Areas de los Proyectos DRI: Salcedo, Quimiag-Penipe y Jipijapa.
- Programa del Seminario Taller sobre Líneas de Investigación en Ciencias de la Salud. AFEME 25-26, noviembre, 1982.
- Informe del anterior - septiembre 1983.
- Directorio y Codificación de los Establecimientos de Salud, 30 junio, 1980 MSP.
- Proyecto de Desarrollo Rural Integral - Quimiag-Penipe, Volumen I - Diagnóstico.
- Programación para 1984 de la División de Desarrollo Comunitario MSP.
- Juego de Formularios para Informe de Promotores de Salud.
- Encuesta Nacional de Salud Materno-Infantil y Variables Demográficas - Ecuador, 1982.
- Informes trimestrales de Progreso del Proyecto preparado por A.I.D. desde septiembre, 1982 a diciembre, 1983.
- Extensión de Cobertura Médica (una experiencia en el Proyecto Salcedo.

*JG*