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# FAMILY PLANNING MANAGEMENT TRAINING

# MANAGEMENT DEVELOPMENT PLAN

# FOR THE

# MINISTRY OF PUBLIC HEALTH

# ECUADOR

Performed by

Management Sciences for Health

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# I. EXECUTIVE SUMMARY

The USAID Health and Population Officer in Ecuador asked the Family Planning Management Training Project to carry out a needs assessment to identify training needs of the Ministry of Health. This needs assessment is linked to AID's current Family Planning project that is being proposed and that will cover 6 of the 20 provinces. The training needs identified here respond to and are linked directly to the proposed project. The assessment was carried out during a number of days in March and April of 1988.

Following briefings with the Director of "Fomento y Proteccion" at the Central level and his personnel, the MSH team travelled to three provinces to examine the MOH family planning programs. Interviews and meetings were held with Provincial Health Directors, the person in charge of "Materno Infantil" (MCH), and other health officials to discuss their family planning management training needs. Medical facilities offering family planning services were visited in each province, and service providers were interviewed.

The situation of the health programs in general and the family planning programs in particular varied in the different provinces. All of the provinces suffered from the same fundamental problems that have hindered FP at the national level: lack of supplies and lack of IE&C materials. It was apparent that some provinces were at different stages of development and therefore have differing management training needs. For example, while the province of Guayas seemed to have little problem getting supplies, we perceived a larger problem of coordination of personnel to attend the target population. There was also a higher rotation of personnel in Guayas that makes continuity of program management difficult. On the other hand, provinces like Canar and Azuay who had more stable personnel confront a more conservative population where FP is not readily accepted.

Needed skills for all provinces include those to win support for family planning programs (skills in advocacy and communication, building constituencies, integrating family planning into other services, and basic planning); and those to manage expanding programs (i.e. problem identification and analysis, setting of objectives, manpower planning, delegation, organization analysis and development, and monitoring and evaluation techniques).

The team feels that training for the MOH in Ecuador should be guided by several general principles if it is to have a long-term impact. The guidelines are:

1. An assurance of continuity of supplies and explicit endorsement of the family planning

program component from Central office.

2. A sufficient number of personnel in each province must receive management training to ensure a "critical mass" able to affect family planning management;

3. Training be appropriate to the level of program maturity in the province; skills learned must be applied relatively quickly after training and future training should build upon previous activities;

4. Preference of training should be given to locations with more stable personnel (those provinces where personnel have not undergone high rates of rotation);

5. Trainees come from all relevant levels of the health system, including subsecretariats, zonal, province, canton;

6. Training fosters collaboration and cooperation among the Provinces and throughout the various levels.

The team has come up with a program of training activities that respond to the needs of the family planning programs and follow the above mentioned guidelines. The team proposes the following training activities:

1. An initial workshop in order to inform everyone about the program and to further develop each province's plan for family planning.

2. A basic "regional" management course for the provincial people who manage areas and hospital directors who under regionalization become area managers in charge of hospitals, centers, sub-centers and health posts in their area. The preference should be for participants who are in more permanent positions and directing activities in their units. The approximate number of participants for this course is 60.

3. A basic "service center" management course for the following: hospital directors, center and sub-center personnel that is permanent and directing activities. The course should include planning, organizing and controlling,

and structured in modules.

4. A program planning and evaluation workshop for hospital directors and provincial staff. Prior to this workshop it is imperative that an existing information system be determined with MOH and final definitions and interpretations unified throughout the country. Once this is done, this workshop can concentrate on how to set up programs, organize resources, do the record keeping, and learn to interpret the data and evaluate the programs.

As far as family planning programs goes, the information regarding coverage was poorly kept and inconsistent. This does not permit an accurate evaluation of the current situation. There are some areas where records of supplies are kept (kardex) and others poorly so, or not at all.

Technical assistance needs were also identified and following are those the team identified as necessary to increase FP activities and support its institutionalization.

1. Design and implement a basic but comprehensive MIS system;

2. Design and implement an inventory recording and reporting system.

The team was concerned with the difficult organizational situation observed at Zone II and the Guayas province. We suggest that AID concentrate its early efforts on those provinces that are more "ready" for further work and training and realize activities in Guayas once certain conditions are met. On the other hand, the team was favorably impressed with the management skills demonstrated by the personnel of the Provinces of Azuay and Canar in managing their health regions.

# II. COUNTRY SETTING

In February of 1987, a four member team of Management Sciences for Health (MSH) carried out and presented the results of a management development needs assesment that covered three public institutions and three private, not-for-profit organizations involved in family planning. This evaluation did not include the Ministerio de Salud Publica (MOH).

Since the initial evaluation, certain country characteristics have changed which are described below.

## Economic Situation

During 1987 and early 1988, the economic situation of Ecuador has worsened significantly due to the rupture of the oil pipeline in early 1987 and coming on-stream again only in the last trimester of that year. Real GNP (gross national product) decreased by 1.5% in 1987. With full pipeline operations and average US$ 13 dollars per barrel price for oil the whole year, GDP is expected to grow 7% in 1988.

The inflation rate for 1987 was reported at a range of 35 to 52% per annum and is expected to be a miniumum of 40% in 1988. Per capita GNP reached about S/. 16,435 in 1987, down from S/. 17,029 in 1983.

The balance of trade for 1988 is expected to be positive, but the balance of payments is expected to be negative from 1988 onward, barring any major success in the rescheduling of the Ecuadorean foreign debt now standing at about US$ 10 billion.

## Politics and Government

Late 1987 and early 1988 public attention has been focused on the political campaigns for elections at all regional government units (municipal and provincial) and the first round of President-Vicepresidential elections. This first round that took place in January of 1988 resulted in narrowing down the field to two parties (Izquierda Democratica and Partido Roldosista Ecuatoriano) and their respective candidates, Dr. Rodrigo Borja and Ab. Abdala Bucaram. The second round of elections is to take place on May 8 and the new government is to be inaugurated on August 10, both events being the focus of national and international interest during 1988. In either case, it is expected that the new government will have a stronger interest in

promoting better health conditions for the population at large and welcome international assistance.

New Population Policy

In early 1988, the Ecuadorean government issued its population policy for the first time in its history. The policy specifically supports and endorses family planning activities. The specific objectives found in the policy include:

* Regulate the growth of population, in order to fit it to the potential of resources and to national development, respecting the free, responsable and informed decisions of individual persons and their couples regarding the number and spacing of births.

* Reduce to the lowest levels possible the general indices of morbility and mortality, and particularly those affecting children less than five years of age, as well as the persistence of illness that may be prevented by timely medical diagnostic and treatment.

* Provide productive and adequately compensated employment to the economically active population, taking into account the increasing incorporation of youngsters and women

This new policy has laid the foundation for the strengthening of FP activities at the public sector. Steps are being undertaken by the National Development Council (CONADE) and the Ministry of Public Health (Ministerio de Salud Publica) to execute this policy. To support the execution of this policy, the United Nations Fund for Populations Activities (UNFPA) and the Agency for International Development (USAID) are finalizing negotiations for starting up new significant projects in family planning activities, covering a total of twelve provinces (out of 20). These projects are described in more detail in the following sections.

Family Planning in Ecuador

Family planning started in Ecuador in 1965 with the formation of APROFE, the IPPF affiliate. In July of 1980 the project for extension of services for integrated Family Attention was undertaken with the participation of FODERUMA (a Central Bank of Ecuador unit in charge of financing rural development) and UNFPA. In 1984, the GOE and UNFPA sign an agreement for

population activities for two provinces that had already participated in the previous project: Guayas and Chimborazo. Since then, some activities are being carried out but their coverage is not significant.

Estimates indicate that about 47% of women of fertile age, united in matrimony or free union, have the interest/need to plan their families and do not currently use any family planning method. According to a recent ENDESA survey, of the total 10 million population estimated for 1988, it is expected that there are about 1.5 million women of fertile in matrimonial or free union, of which about 688,000 do not use any method and about 300,000 women are expected to be susceptible of receiving family planning services.

The MOH is a significant provider of family planning services, supplying about 31% of the contraceptive pill users, about 25% of the IUD users, and about 55% of the sterilizations, according to the 1987 ININMS study. It has a total of about 1,257 service units about the country spread over 20 provinces, of which about 32% are rural service units, which include family planning in their range of services provided (see table 1).

Table 1

MOH Presence in Family Planning Services
Percentage of methods provided by MOH

| Method | % |
|---|---|
| Contraceptive pill | 31 |
| IUD users | 25 |
| Sterilizations | 55 |

Source: ININMS

In 1987 the MOH provided about 167,000 family planning consultations, significantly more than the 50,000 provided in 1986, largely due to the availability of supplies provided through the UNFPA project. First visits in 1987 represented about 71% of total consultations, although care must be taken to use these figures due to their statistical and interpretative inaccuracy.

# III. BACKGROUND AND HISTORY OF FAMILY PLANNING AT THE MINISTRY OF HEALTH

In this section we proceed to describe the organizational structure of the MOH and note some of the changes that the Ministry has been subjected to in the past couple of years. We found it important to mention these changes given the impact these have on the Family Planning Program which we were observing. In the second part of this section we describe the FP program at the Ministry.

## 1. MOH

In 1972, the MOH as an organization was restructured and official authority was centralized in Quito. In 1976, the Ministry was expanded and strengthened through the creation of seven Directorates, one of which was Family Welfare. In 1979 the MOH sought to decentralize the health care system as part of an overall strategy. The intent was to delegate program planning and decision making to the operating unit level.

Again in 1982 there was restructuring of the MOH. This new structure sought to implement what was termed as "integral supervision". For example prior to this change, the different programs under MCH (e.g. vaccinations, nutrition, Family Planning, epidemiology) functioned separately and with independent supervision. This meant that the operating units received a number of visits. Under the new structure, all of the programs related to MCH, for example, would be under one Division --Direccion de Programas Prioritarios-- and supervision would be for the program as a whole not for each specific part of the program.

The effort to decentralize continued and in Dr. Huerta's time (1983) a new subsecretariat for the coastal zone was established. The new organizational chart of the ministry is outlined in exhibit 1. In it we can observe that each of the subsecretariats is responsible for 10 provinces. There are some functionaries of the ministry who do not view the creation of the two subsecretariats as a positive innovation. International donors have also found it easier to concentrate their efforts on provinces in either subsecretariat but not to mix the two.

The official version of how the MOH is organized was published in December of 1986. In it the Ministry is said to be divided into

the following levels:

a. Political-Executive which includes the Minister, and the 2 Subsecretariats

b. Consultant Units which include the following divisions--planning, Legal, Audit, International Relations, Communications, and others.

c. Administrative Support which includes Finance (zone I and II), Human Resources (zone I and II), Operations

d. Technical-normative which includes the Welfare and Protection unit under which Family Planning is included as a component of Maternal Child Care

e. Operating Level

Finally, the current trend at the MOH is what is termed as "Regionalization". This term refers to the following process as defined by MOH representatives:

> "A functional organizational process which is geared towards the use of available resources within the current structure of the health services located in a geographical and demographically defined region. The goal is to relate the currently existing health service structure and the administration of services required in order to simplify, decentralize and perfect programmed activities. Operating mechanisms that guarantee the effective use of human resources and promote the collaboration of personnel to meet goals in the areas of: planning, training, research, and information; also need to be established. The overall objective is to make services available and accessible to the target population ."

Document: "Metodologia de Regionalizacion de Servicios de Salud--MODULO--Organizacion Funcional"

During our visits, many of the health officials spoke of "regionalization" and each had different interpretations of what the process was. Regardless of the differences in interpretations, we find it important to note that this process is taking place and would affect the management of the FP program

in a number of ways. For example, the director of a canton hospital would now be in charge of the units in his area and he/she would supervise and gather the data from those units in order to send it to the provincial level. The new chief of area would be involved in two activities (supervision and information reporting) that he knew little or nothing about and had not done before. Other issues that have to be taken into consideration given regionalization are discussed in the section on the FP program in the area designated by the project.

## 2. History of Family Planning at MOH

In principle, FP services are available to the Ecuadorean people through the public sector delivery systems such as MOH. The extent to which this institution actually provides FP and IE&C services is limited by the different constraints identified throughout this report. Family Planning services are offered at hospitals, urban health centers, and rural health subcenters and posts. These services are provided as an integral part of the Ministry´s "Division de Fomento y Proteccion". Care, Maternal and

The department of Family Welfare was established in 1971 with assistance from AID and FP services were integrated into the department´s programs since that time. Even though the FP services are said to be an integral part of the MOH´s program, in practice their availability is limited and their existence is not widely known. The MOH personnel do little in terms of promoting the program.

USAID´s assistance served as the main force for the creation and expansion of most Ecuadorean FP activities in the public sector. However, funding of FP programs has not been continuous. AID´s funding of FP programs in Ecuador was terminated in 1975 as a result of the phaseout of all U.S. bilateral assistance to the country. After the phase-out of bilateral assistance, AID continued to support population activities, although at a much reduced level. The termination of the source of funding affected the growth of the program and during the period of little assistance from AID, it was UNFPA who supported the MCH division and the FP program in particular. UNFPA contributions allowed the "Division de Fomento y Proteccion" to continue programs and to maintain certain financial independence from the Ministry.

## 3. Structure of Family Planning Program at the national level

It was obvious from our conversations with the person in charge of Welfare and Protection that this division, like the Ministry, has undergone many changes in the past. At this very moment, all of those involved in the division were aware that there is a new organizational chart being designed. The new organizational

structure of the "Direccion de Fomento y Proteccion" may be found in exhibit 2.

Note that the "Direccion de Fomento y Proteccion" reports to the Direccion General de Salud and in turn has 6 departments reporting to it. These departments are:

Health Education
Pre-School
MCH
Adolescents
Nutrition
Community Development

Family planning is part of the Maternal Child Health Division which has national coverage and also acts as the Zone I MCH department for 10 provinces. In the second zone which is the subsecretariat associated mostly with coastal provinces, one finds an MCH unit that has an FP component. The next level down is the provincial one. At the provincial level one also finds the MCH department reporting to the Director for the Province. The next level is the Canton and here it is the director of the hospital who is in charge. There is again, a person in charge of MCH in the hospital who reports to the director.

Under the current organization, the other centers, sub-centers, and health posts, are supervised directly by the provincial staff. These other centers, sub-centers, and posts do not have specially assigned MCH staff, but rather have personnel that perform functions for all programs and provide all health services. The idea of regionalization however, will make canton hospital directors responsible for their area as a whole and all of the health units inside the canton area. The following figure will help the reader understand this better.

NATIONAL LEVEL

DIRECCION NACIONAL FOMENTO Y PROTECCION

6 DIVISIONS

**MATERNAL CHILD CARE
Atencion Obstetrica
Ginecology (DOC)
Family Planning

(£ persons)

SUBSECRETARIATS

ZONES I/II

MATERNAL CHILD CARE
(Family Planning)
(reporting to Subsecretariat)

PROVINCES

20
(6 IN THE PROJECT)

MATERNAL CHILD CARE
(Family Planning)
(reporting to Provincial director)

CANTON (AREA)
(At USAID Project)

40 Azuay-5
Canar-1
Los Rios-5
El Oro-6
Manabi-8
Guayas-15

MATERNAL CHILD CARE
(Family Planning)
(reporting to Hospital Director)1

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1This hospital director is the person who will become chief of an area when regionalization takes place. For example, in Canar the person in charge of the Hospital in Canar now becomes responsible for all of the units in that geographical area.

At the Canton Area level is where we find the centros, subcentros and health posts. The total number of units in the project area are 492 of which 35 are centers, 382 are sub-centers and 46 are health posts. The province of Guayas is the largest and has 21 centers, 83 sub-centers, and 19 posts; totalling 123 units2. The other provinces have the following number of units (see following table 2):

Table 2

| PROVINCE | TOTAL | CANTON | CENTER | SUBCENTER | POSTS |
|---|---|---|---|---|---|
| Manabi | 116 | 8 | 6 | 99 | 3 |
| Los Rios | 48 | 5 | - | 32 | 11 |
| El Oro | 82 | 6 | 1 | 73 | 2 |
| Azuay | 60 | 5 | 3 | 52 | - |
| Canar | 63 | 1 | 4 | 43 | 11 |
| Guayas | 123 | 15 | 21 | 83 | 19 |
| Total Project Area | 492 | 40 | 35 | 382 | 46 |
| National | 1257 | 88 | 63 | 870 | 235 |

The personnel involved in the various units is the following:

auxiliary nurse -- Health posts
rural medical doctor, auxiliary nurse, -- sub-centers
doctors, obstetricians, nurses, auxiliary, -- centers
doctors (specialists), nurses, auxiliaries, etc.--hospital

See exhibits 3 and 4 for a description of each of the units and the personnel involved. In most cases, it is the auxiliary nurse who provides the patient with supplies.

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2The source for this data is a chart dated 1987 elaborated by the MOH's National Department of Statistics. We have corrected the figures where data gathered in the field differed from that in the chart. The 1987 chart is included in this report as exhibit 5.

When a patient enters any of the units for the first time a doctor must see her (or an obstetrician) and give her a prescription for whatever method she chooses. In some areas the husband is also called in and a discussion is held with the "responsible couple". The patient proceeds to the pharmacy where a person provides her with what she needs and there is no charge for any method. In general, most units are dealing with "walk-in" patients and do not go out to get new patients. Most people in the units commented that the other programs available for children (e.g. leche avena) are good to attract new clients.

It is the provincial level authority which sets up, staffs, and operates the units in its geographic region. Supplies do come from the central level however and we found that while one province lacked copper T's, another had a surplus. The field units and the provinces ask for supplies every three months from the MOH central offices, and base their requests on experience from previous years. When there are no supplies provided by the central level, or they are tardy in arrival, patients are told "there are none available". There does not appear to be geographic coordination of supplies at any level, nor much attention to what really happens at each service unit. Supplies inventories balances and shortages are not known beyond the unit level. Under regionalization, it is expected that each unit in an area will ask for its own supplies to the chief of the area (canton) who will in turn make his/her request to the Provincial level. Regional logistics and supplies management have yet not been mentioned as an improvement opportunity.

Until now, direct supervision was the responsibility of the provincial staff (e.g. the MCH team supervised the running of its programs and epidemiology did their supervision). Regionalization would mean that the person in charge of the Canton Hospital (chief of area) would be responsible for supervision of the units under his canton. At this point, it is not apparent that communication between the various levels of the FP system is strained or bureaucratic. There is (was until now) a direct line of authority but this may change with the new requirements made by regionalization.

## 4. The Family Planning Program in the Project Area

Although the provinces involved in the AID and UNFPA projects vary in terms of size, population, infrastructure, culture, etc., our goal is to provide a program flexible enough to meet the needs of all the provinces. For this reason, the description of the family planning organization which follows represents a summary composite of what we observed and were told rather than a description of any individual province.

services are generally integrated with other MCH observations showed that the MCH services are ›se for which people come to the various health ›. MCH is usually assigned a room or two and services ›vided by a doctor, obstetrician, nurse, or auxiliary , this depends on the type of facility and the personnel ›lable. FP services are provided to those who request them ›d in most facilities talks about family planning are given to mothers who come for other services. There are attempts to work through mother's clubs and home visits to increase the number of users but this is sporadic and usually done at the initiative of the person in the health facility.

Services include counselling, insertion of IUD's, distribution of other contraceptive materials, and as stated, in a few cases, outreach. The method of preference was available only through interviews ..because the information system does not allow one to obtain such information. Supplies available to the various facilities consisted of copper T's, "espirales", pills, condoms, and some creams. During 1987, some facilities did not get all of the above supplies and suffered shortages, while other facilities had a large supply that was unused.

Sterilization services are offered at the "Centro de Salud Hospital" level and the Provincial Hospitals. The other facilities also refer patients to the larger facilities. Exact information as to the number of ligations was not kept at the service units. At most some of the centers we visited had an estimate of the number done per month (based on memory). Following are these findings:

| | |
|---|---|
| Hospital Provincial (Azogues) | 60 ligations per month |
| Hospital Cantonal (Canar) | 10 - 12 ligations per month |
| Hospital Cantonal (Gualaceo) | 12 - 15 ligations per month |
| Hospital Cantonal (Gualaceo) | 8 - 10 DIUS per month |

None of the provinces visited had a CBD program but most did mention that when supplies ran out the patients were referred to either APROFE or CEMOPLAF; or purchased them at the local pharmacy. It is apparent that in most areas the private sector provides a significant portion of FP services. We were even told of cases where the MOH auxiliary was also a sales representative of one of these private institutions.

Resources for Family Planning Services

ıvices are integrated with other MCH services and .e one or two rooms in the same facility. The units the provinces of Canar and Azuay were generally clean ıte (with the exception of the Hospital Cantonalat The facilities visited in Guayas were poorly kept and in ɔpspital in Daule, they were inadequate.

.ıl of the units visited had equipment and furniture consisting primarily of desk, chairs, an examining table, a scale, (sometimes an autoclave), a lamp (some centers had problems with water and electricity).

All facilities were staffed by at least one auxiliary and the larger units had doctors and "obstetrices". Personnel is suppose to assist to work 5 days a week for 8 (or 4) hours3 and schedules vary depending on the needs of the area. We were told that personnel tries to schedule their free days jointly so as to assure someone is present at the center throughout the week. Unfortunately, during our visit we found 2 units closed because of lack of personnel. In most units (sub-centers and centers) there is what is termed as a rural medical doctor (the reader can refer to exhibit 5 for a description of this position and further information on this group). These doctors are temporary personnel who work for the ministry during one year in order to obtain a certificate for work. Various people commented that these doctors work approximately 150 days out of the year because they are allowed to assist all congresses and meetings held for them. They also have one month of vacation. Most central and provincial level personnel suggested that little funds should be spent on this group given their temporary status.

## Program Planning and Evaluation

The most succesful program execution is likely to occur when program planning and evaluation has been carried out with participation and commitment at the lowest organizational managerial level. Although there are forms and process used for some program planning and evaluation, applicable to the FP

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3We were told that the salary differentials between a person working a four hour shift and a person working an eight hour shift were not great. For example if someone in a particular category was earning $20,000 for working 4 hours, the person working 8 hours was only earning $24,000 or at most $25,000 Sucres. It is rather obvious that people would prefer to work a 4 hour shift and attend to their private practice. We would recommend that no person in charge of MCH in the provinces be working part-time. We did see an example of this in Canar and we did not feel that person was aware of what was happening in his province.

services activities at the MOH, it is also the case that the medical personnel in charge of managing the service units are not involved in the program planning of FP MOH activities and have not been trained managerially to fulfill their roles as service center managers. Since the MOH is now embarqued on a more "bottoms-up" management process and this method stimulates more the fulfillment of objectives set realistically, it is deemed appropiate that the directors of the service centers be trained in program planning and evaluation, as service center management, in the specifics of the FP program.

Program planning and evaluation should include all basis aspects of objectives and goals setting, structuring of policies and all resources to meet expected results, qualitative/quantitative and time programming, and evaluation processes, benchmarks and forms.

None of the provinces visited had development plans for FP. Most officials interviewed informed us that they received their goals from the central level. Some did know information regarding the population in their area but had not proceeded to estimate the number of potential FP users in their area.

## Supervision

In particular, during 1987 and 1988, supervision has been sporadic and it is not adequate. Supervision is more than a process of receiving reports and delivering or authorising the getting of supplies. Supervision should be done on a regular basis but regular visits to all units will remain difficult and is almost impossible.

Those interviewed at the provincial level stated that the pattern of supervision is changing and therefore little has been done this year. For example in Azuay, supervision will now be done by teams of professionals from the different programs who will go out to a number of units and supervise all programs. A different team will visit another sector of the province and so on, always reviewing all programs. Apparently there is little time to do it all and some programs must suffer.

## Information Systems

Management information system considerations are divided into the following three parts:

1. Service statistics
2. Inventory management
3. Relationship between services and inventory data

### Service Statistics

Up to 1982, services statistics at the service unit level were reported by prevalence of FP method for first, subsequent and total consultations. Thereafter, due to a decision taken apparently at the central level, reporting was formulated so that the monthly reports only show numbers of FP new user, subsequent and total consultations, without discrimination by method. Since this report is collected, consolidated and reported to each succesively larger geographic level (now unit, provincial and national; later also by area) all statistics only report numbers of first, subsequent and total consultations of FP services ("regulation de la fecundidad").

At the service unit and the provincial level, there is no uniform definition applied to the terms "first" consultation and consequently, to the term "subsequent" consultation. In some service units, the statisticians collecting this information interpreted "first" consultation to be the consultation of a patient walking into a service unit for the first time in the history of that person at that unit. In other units, "first" was understood to be the first consultation by a patient in that calendar year at that unit.

Service unit statistics do not report the number of more permanent methods (such as IUD´s, copper T´s, ligations) utilized by patients incoming for permanent methods in a particular area.

There is no attempt made nor are personnel (medical or statisticians) at the service units we visited, aware of how to relate total target population numbers (of MEF or MEFCUL, women in fertile age and who are susceptible to FP services) to service statistics so as to determine the real coverage (or market share) of that service unit within the cachement area of a service unit.

Due to these uncertainties and the ones mentiones below. it is felt that also programming information needs to be revised, well-defined and uniformly adopted in order for program planning and control to be considered reliable in service statistics as well as impact evaluation. Also, the relationship between programming and evaluation data and formats should be reviewed. Programming formats now only consider total FP services, whereas reporting also divide the data by first and subsequent consultations.

Inventory management

Inventory information was not kept regularly and in some cases, not at all, in most service units visited. Where they were kept, they were up to nine months behind on recording supplies inventories´ movements at each corresponding kardex card (for about five products). Where they were kept, there were no monthly totals nor was information provided to the medical personnel to be aware of supplies rotation, prevalence and future

needs. In a good number of cases, there were no records kept apparently because these supplies are gratis, and were not required to be taken into account in the bonding of personnel responsable. This was the case at an otherwise well-organized hospital as well as at centros, subcentros and puestos.

FP supplies were normally well stored at the pharmacy. In some service units, copper T´s were controlled and stored by the obstetrician who was also responsible for them.

Relationship between services and inventory data

There was no attempt made at any service unit visited to cross-relate service statistics with inventory data that would permit better understading of the patient throughput in FP services, method prevalence, and possibly deduce the more permanent methods used. Medical management information was not readily available so as to permit regular identification of resource utilization of each center and identify available/overworked physical and human FP-related resources.

Logistics

Particularly in the absence of information and projections of commodity use, the logistics system is precarious at best. The present system seems to be that a unit in theory asks for supplies for three months. Also, the system seems to be that when a clinic runs low, the nurse travels to the provincial level and obtains what she needs directly. Again, the provincial level may go to the zonal level and ask the personnel reporting to the subsecretariat for supplies. For example, when copper t´s were needed in Canar, the provincial director got them personally from the Subsecretariat in Guayas and more specifically from the person in charge of MCH. The team found that at the service unit level, unavailability of supplies caused turning away of patients, rather than strong "pull or push" efforts to replenish supplies down to the unit level.

We did not attempt to study this system but noted that supplies were treated differently from other supplies because they were free of charge.

IE&C

All of the units visited lacked material for IE&C. Most units are involved in meetings with mother´s clubs, talks to groups of women coming to the units (approximately 30-40 women), talks in schools, etc.

In general, we feel that this represents an untapped source of resources which could benefit the expansion of the FP program. If this resource is to be incorporated in the FP effort, they will require some training in concepts of communication as applied to FP.

There have been and still are attempts at community mobilization for various health programs. This is done by the rural and urban-marginal promoters. The latter group was totally erased due to difficulties with labor relations in the Guayas province.

The MOH had established a group of health promoters for the urban marginal service centers of Guayaquil, contrating them for their services. This group became interested in obtaining employee, rather than contractor, status in their relationship with the MOH and pursued a legal/labor relations stategy for that. However, the MOH concluded that it would be innapropiate, inadvisable and unaffordable to a quire this relationship and has cancelled all relations with this personnel, also cancelling FP services promotion with this method.

The rural promoters continue to exist but these are paid by the community directly. The Ministry of Health does assign the community a salary for the promoter but holds no labor relationship with these persons.

Community Distribution

Clients largely now receive FP supplies by going to the MOH service centers, receiving a prescription by the attending doctors, obtetrician or nurse, and then going to the pharmacy section of the center to pick up the supplies prescribed, when available. FP supplies are also provided by the nurses that do home visits for services promotion.

The team found that supplies were not organized to be regularly available at rural clinics. Since this area is of significant importance in the USAID project, particular attention should be paid to appropiately stocking rural posts and subcenters.

# IV. FUTURE EXPANSION OF FAMILY PLANNING ACTIVITIES AT THE MOH

The Ecuadorean MOH has become dependent on international agency cooperation in order to carry out Family Planning programs, including the provision of FP supplies, equipment purchases, and funding of specialized personnel. The MOH has not assigned funds from its own resources, even when supplies dwindled, agreements with agencies ended, or external funds were used up, and continuity of services and supplies to patients was interrupted.

It appears likely that this will continue to be the future policy of the MOH, given the lack of public emphasis and internal priority given by the MOH to Family Planning, the budgetary restrictions and the expectation of receiving continued internatonal agency support.

The MOH is negotiating concurrently the approval of Family Planning supporting agreements with two international agencies: the United Nations Funds for Populations Activities (UNFPA) and the Agency for International Development.

## A. THE UNFPA PROJECT

This new project was conceived in June 1987, at the end of the previous one, presented in September and has been in negotiation since then. The UNFPA project coordinator in Ecuador expects it to be signed by June 1988. The project has a two-year budget of about US$ 1.4 million dollars, and is programmed for two two-year cycles. This budget includes a balance of the last project plus a ceiling of about US$ 600,000 per year of new funds. If the first cycle is succesful, an extension is considered probable.

The overall thrust of the proposed agreement ("convenio") is to cover the Maternal and Family Planning areas, and does not include the infant area. It is philosophically presented as part of an integrated program, but since in fact there are no integrated systems, personnel management and practices at the MOH, it concentrates on serving women in the Maternal and Family areas, in pre and post-partum care, and family planning.

There are two major components to the proposed agreement: one focuses on six provinces selected as part of the project area, and the other on the national level.

Program for Selected Project Area

In six provinces, the program contemplates training and equipping field personnel at the MOH service delivery centers. Very basic equipment is to be provided for puestos, subcentros and centros, and training is to be provided for stable personnel at those field posts (such as nurses at all levels, obstetricians and permanently assigned doctors, with little training to be provided for the one-year tour-of-duty rural doctors). The training is oriented to the technical areas and does not include management training of any kind.

The project provinces are under the administrative jurisdiction of Zone I and include the following provinces, universe of women of fertile age population to serve (1987 data) and number of establishments (provincial and canton hospitals, centers, subcenters and posts) of the MOH (see following Table 3):

Table 3

| Province | Population Universe(1) | Number of MOH Establishments |
|---|---|---|
| Carchi | 29.183 | 33 |
| Imbabura | 57.442 | 51 |
| Pichincha | 408.427 | 132 |
| Cotopaxi | 62.195 | 53 |
| Tungurahua | 80.967 | 65 |
| Esmeraldas | 67.177 | 85 |
| | --- | --- |
| | 705.391 | 419 |

(1) Universe of women of fertile age, in matrimony or free union,susceptible to FP services

The MOH services goal in the UNFPA project is to serve about 10% of the above-indicated total population during the two years of the project. This is equivalent to providing about 70,000 consultations, which appears to be a fairly doable undertaking, since the MOH provided about 16,777 consultations during 1986 (a year with supplies available only for the second semester) and about 44,861 consultations during 1987, a year with UNFPA supplies regularly available. See Table 4.

Table 4

Service Statistics for UNFPA Project Provinces
Total Consultations

| Province | 1987 | 1986 | Annual Average UNFPA Project |
|---|---|---|---|
| Carchi | 1,230 | 773 | |
| Imbabura | 5,331 | 1,333 | |
| Pichincha | 38,341 | 11,132 | |
| Cotopaxi | 4,156 | 808 | |
| Tungurahua | 9,024 | 1,180 | |
| Esmeraldas | 3,357 | 851 | |
| TOTAL | 61,439 | 16,077 | 35,000 |

In addition, the UNFPA program contemplates supervising and supplying the maintenance of FP activities in the province of Chimborazo, which was equiped during the previous program.

Equipment to be purchased is destinated to providing primary preventive service, with little budgetary attention to purchasing hospital services equipment.

About half of the budget (which is approximately $ 350,000 per year) is to be dedicated to this component.

Program on a National Level

At the national level, the UNFPA project includes:

a. Training about 400 mid-wives, and equipping them mostly with basic delivering kits. The average cost per kit is expected to be about US$ 29, totalling about US$11,600 for supplying them all.

b. Providing Family Planning supplies for about US$700,000 during the life of the two year project. Women of fertile age number 2.1 million of which part is to be served with supplies. Assistance is being obtained from USAID in the form of marketing information in order to evaluate and direct the supplies requests UNFPA receives from the MOH.

Current Status and Innovations

At 1988 march-end, two versions of the proposed agreement have been reviewed with the MOH and its third version was being refined at the MOH headquarters in Quito.

Applying some of the LESSONS LEARNED in their previous project, UNFPA has introduced several design innovations in this new project ("convenio"), as compared to the previous one. These are:

1. UNFPA Administrative Support

An UNFPA-paid 3 person team has been hired and is working on obtaining some base information and setting up some basic guidelines, before the work starts and in order to facilitate project administration. Following is a list of the team members:

a. One doctor (on leave from the Instituto Ecuatoriano de Seguridad Social).
b. One nurse.
c. One administrative office.

This unit is to be the administrative arm of UNFPA for this project. It began three months before project start-up in order to identify existing and needed physical resources.

b. Work in One MOH Zone

Six provinces which fall under one geographic area and are administered by one of the two sub-secretariats (see exhibit 1) the organizational chart of the Ministry at the national level) were selected. This selection will facilitate project execution. Previous UNFPA projects that required multi-regional authorizations at the MOH have resulted in their bogging down administratively.

c. Complementary equipment purchases

Equipment purchases have been minimized, and are designed to fill in gaps and optimize existing equipment utilization. Preliminary surveys carried out by the UNFPA project coordinator showed much equipment to be stored and unused.

Under this same approach, UNFPA will try to avoid purchasing of vehicles and will instead reimburse all travel expenses that may be necessary to incurr by MOH personnel. The MOH, nevertheless, is interested in obtaining about six vehicules

using project funds.

d. Targeted Training

Training is to be provided to personnel interested in providing and expanding Family Planning service, and which is stable at the MOH service units (subcentros, centros and hospitales), as are auxiliary and principal nurses, and obstetricians. Doctors have traditionally shown reluctance and disinterest in providing these services and have delegated this work to the obstetricians. The doctors are to participate in training as needed to support the project.

Based on experience with the previous project and what has become known due to the initial activities of the current UNFPA project-to-be, the UNFPA Coordinator identified as traditional management weaknesses, including as applicable to this project, the following:

1. Logistics

Logistics management for continued and controlled supply to the MOH centers. During the needs assesment team visit, recording and reporting of supplies at the service centers appeared adequate in some areas and poor in others (specially so with Family Planning supplies which are free of charge). The continuity of supply was deficient.

2. Statistics

Reliable, up-to-date and appropiate statistics recording and generation that should include:

* a system for collection of quality data
* capacity to analize and interpret the data

Analytical and interpretative capacity appears to be scant at the MOH provincial and central levels.

3. Program Management

Medical personnel directing national, zonal, provincial, canton offices and supervising the provision of services at the MOH centers require program management training to implement the program not only from a technical approach but also from the managerial approach in order to marshall efforts and resources to accomplish the project goals in an institutional setting.

4. Personnel Administration

Assigment of appropiately qualified personnel as required by the function to be carried out (e.g. hospital directors that have some training in public health or basic management). This appears to be a need at central, regional, provincial and local level. This also appears to be applicable for choosing appropiate personnel to be UNFPA and USAID project counterparts.

5. FP Priority Motivation

Particular attention needs to be paid to the focus of the training so as to fulfill not only project goals but also those of institutionalization of the FP activities at the MOH, at a higher and more continuous activity level than before. If possible, these activities will contribute to having the MOH recognize FP services as a high priority, to be accomplished if need be with support of the MOH funding during times of limited or no international agency support.

It appears that the project requires Minister-level policy and program endorsement for the internal staff of the MOH to assign appropiate importance to the project. Given the expected turnover and uncertainty to be produced by the goverment change in August 1988, the combination of emphasis at the field level complemented by Minister-level endorsement, when it comes, is expected to produce overall project effectiveness in implementation.

B. THE USAID PROJECT

The general goals and specific objetives of the proposed MOH-USAID agreement (revised version dated early April 1988) in sum are:

* To promote a responsable FP program that takes into consideration the parent´s right to choose the number of children they wish;

* An adequate relationship between population growth and the socio-economic development process of the country, and;

* The incorporation of women into all aspects of society.

The specific objectives referred to providing services to women of fertile age and improve quality of care to the women and child component, thereby reducing indices of child and peri-natal morbi-mortality. Other objectives focus on not only attaining

attitude change in population but also in improving and extending FP services to both rural and urban sectors, incorporating adolescents, strengthening logistics, and improving coordination with other FP participating organizations.

Six provinces are the geographical coverage of this project, distributed as follows:

* In Zone I of the MOH administrative structure, the two provinces of Canar and Azuay.

* In Zone II, the four provinces of Manabi, Los Rios, Guayas and El Oro.

This project is to be carried out over a 7 semester period.

Current (early April 1988) MOH estimates of budgets average about US$ 2.1 million during the project period. This budget is under discussion and negotiation between the MOH and USAID. The activities estimated to be covered by this budget are:

* Equipment purchases for about US$ 1 million, to be used to complement the one now available at the service delivery centers. The MOH expects to include purchases of six vehicles, one to be assigned to each of the provincial offices.

* Supervision, in-service-training, monitoring and information generation.

* Training and materials.

Also to be provided but additional to the above budget are Family Planning supplies.

Specific goals to be achieved during the 7 semester duration of the project include:

1. Increase at least in 50% the use of some specific method among the women in the fertile age group, married or united, susceptible to the use of family planning methods.

2. Attain that 100% of the operating units that provide ambulatory care develop maternal health and perinatal activities with emphasis on fecundity regulatory activities and oportune detection of mammary and cervical-uterine cancer.

3. Obtain that 100% of comunity resources (promotors,C.V.R., leaders) of the project areas are trained to develop educational activities of information, promotion and follow-up on Maternal Child Health and Family Planning.

4. Train 100% of the formal and institutional resources that carry out activities in Maternal-Child Health and Family Planning, on the project.

5. Train 100% of the students enrolled in freshman and junior year of high school on Maternal-Child Health and in aspects of paternal responsability.

6. Train 100% of the provincial and area directors in management development aspects.

7. Assure that 100% of the operational units (involved in project execution) are equipped and have the materials necessary to accomplish their objectives, in accordance with their levels of complexity.

8. Implement in 100% of the operational units (executing the project) the needed instruments of information, training, supplies and records that will improve the quality of care"

The 50% increase in usage of some contraceptive method is to be applied at the following provinces over the following population (of women in fertile age susceptible of FP services) and number of MOH service centers as follows (see Table 5):

Table 5

| Provinces | Population Universe(1) | Number of MOH Establishment |
|---|---|---|
| Canar | 9,641 | 63 |
| Azuay | 27,120 | 60 |
| Manabi | 28,032 | 116 |
| Los Rios | 7,232 | 48 |
| Guayas | 79,633 | 123 |
| El Oro | 11,929 | 82 |
| Total | 163,587 | 492 |

(1) Women in fertile age in united in matrimony or free union, susceptible of FP services.

The goal of a 50% increase in usage over the 7 semesters of the project is equivalent to an increase in 81,793 consultations over the life of the project. In 1986, the number of consultations in the six providence covered by the project was 27,158. During 1987, the number of annual consultations increased considerably by 37,280 to 64,438 consultation per year, due to more regular availability of supplies. Given the availability of physical and

human resources that were observed at the MOH service centers by the MSH team and assuming appropiate conditions will be provided, it appears that this goal of increased services could be achieved.

Nevertheless, doing so will will require a significant effort, since in 1987 the total amount of new consultations in these six provinces was 25,618. The MOH central office staff considers that the centers have sufficient capacity available to acommodate the increased demand of family planning services. The MSH needs assesment team observed in some centers that there may be a need to better balance personnel and physical facilities resource utilization to serve the user better. See Table 6.

Table 6

Service Statistics in the USAID Project Provinces

| Province | 1987 | 1986 | Project Annual Average |
|---|---|---|---|
| Canar | 4,320 | 1,255 | |
| Azuay | 6,405 | 2,075 | |
| Manabi | 14,824 | 4,176 | |
| Los Rios | 4,812 | 1,146 | |
| Guayas | 53,679 | 16,559 | |
| El Oro | 6,017 | 1,947 | |
| TOTAL | 90,057 | 27,158 | 23,369 |

Another major goal of this project contemplates extensive and extended training activities. Achievement of this will require considerable preparation of instructors, course materials, and IEC family planning materials, which are not available of the service centers, not at central or provincial offices of the MOH. Preparation of these IEC materials will require taking into account the socio-cultural and geographic dispersion of the potencial student body to be trained, at:

* MOH service centers
* MOH provincial and regional offices
* Comunities
* High schools

all of which are spread over two different MOH administrative and geographic regions, and will present technical as well as administrative challenges.

# V. RECCOMMENDED MANAGEMENT TRAINING AND TECHNICAL ASSISTANCE ACTIVITIES

## Management Training Needs

Following upon our assessment, we have developed a series of General Objetives to which we feel all Management Training for the Family Planning program in the MOH-Ecuador should adhere. These General Objectives include:

1. Sufficient family planning personnel in each province should participate in Management Training to insure the existence of a "critical mass" able to affect the way in which management is carried out in the future. It is unrealistic to believe that training one or two people from any given province will have a significant effect on the FP program in the long run.

2. Training be appropiate to the level of program in each province. FP programs typically follow a pattern of organizational growth, with particular management skills more critical than others during each stage.

3. All course elements should be developed to facilitate their subsequent use by Trainers during abbreviated meetings or courses for groups not requiring the full course content. These modules should be of short duration.

4. Participants are to include FP program staff from all relevant levels of the health system. In addition, it would be useful to include training for all province executive level personnel with authority over the FP program even though not directly related. Strong managements kills at this higher level would benefit the FP program by enhancing the overall resource management of the health system which is particularly important considering that here in the MOH the FP programs are integrated into the other services.

5. Management Training be as cost-effective as possible, seeking stategies which provide the greatest managerial impact per unit of investment. This impact should be geared toward institutionalizing management behaviors and systems which will remain beyond the life of the project.

## General Considerations

First of all, in the initial training provinces should be grouped

according to their level of perceived management ability. Ideally, management training should be given on a province-by province basis, but this may be unreasonable in terms of cost. As a compromise, we suggest separating the Provinces into three general groups. The criteria for this division is quite simple, keep the provinces from the different zones together and group those provinces that are similar from the same zone. Finally, separate the Guayas province given its size and its particular complexity.

Secondly the separation of the provinces into three groups permits the inclusion in the initial training of province representatives from the groups to be trained later. This is important as it represents the basis for a multiplier effect within each province. For example, representatives from the Guayas province can attend the training oriented for Canar and Azuay and in turn be trained as trainers for their own provincial program. We also reccommend that a person be designated ultimately responsible for organizing and actually doing the training in his/her province (training coordinator).

This person will be responsible for coordination of activities for other levels of the provincial system.

Province-Level Courses

One of the primary objectives is to extend management training to a sufficiently large group in each Province to insure that the concepts and behaviors become institutionalized, and do not depend on the presence of any one individual. For this reason we suggested above assigning a person from each province to be a Training Coordinator. This person should attend the first workshop. The workshops reccommended and the suggested participants for each workshop are listed below:

1. An initial workshop in order to inform everyone about the program and to further develop each province´s plan for family planning.

   This workshop should be attended by all those involved in family planning at the central, subsecretariat, province (those in the project that respond to the previously annotated guidelines), and canton level.

   Approximately 72 people would be included in this workshop and they are: about 14 people from the central level including the two subsecretariats; 3 members of each of the six provincial staffs (director, and 2 MCH staff members) which totals 18 persons; 40 canton

hospital directors (they may also be accompanied by the person in charge of MCH.)

In the end, the total number of participants may well be over 100. Our recommendation would be to separate them into 3 or four groups maintaining the province personnel together. We suggest the following grouping of provinces:

Azuay and Canar - Zone I
Manabi, El Oro, Los Rios - Zone II
Guayas - Zone II

Guayas, due to its size, may be kept separate.

2. A basic "regional" management course for the provincial people who manage areas and hospital directors who under regionalization become area managers in charge of hospitals, centers, sub-centers and health posts in their area. The preference should be for participants who are in more permanent positions and directing activities in their units. The approximate number of participants for this course is 60.

3. A basic "service center" management course for the following: hospital directors, center and sub-center personnel that is permanent and directing activities. The course should include planning, organizing and controlling, and be structured in modules.

   The total number of participants for this course may well be over 400. Again our suggestion would be to take each province separately and do a series of these workshops. It may even be possible to train trainers in each of the provinces and save substantially by having a multiplier effect.

Following the Basic Workshop, each Provincial Training Coordinator should plan activities for their province and begin to organize courses. He/she should have prior experience as a trainer, and preferrably have attended a Training-of-Trainers workshop. Nevertheless, we doubt that this person will be able to replicate the Basic Workshop the first time alone. In appendices D, E, F, and G, we have prepared a draft of training objectives; list of problem areas and management needs; and skills participants should have acquired in the courses.

Technical Assistance Needs

The following outline basic technical assistance needs to assist the increase of FP activities and support their institutionalization.

1. Design and implement a basic but comprehensive MIS system

   This effort should include a review, redesign and implementation, of the services activities recording and reporting at the service unit level (hospital, center, subcenter, post), that would:

   - Standardize the definition and count interpretation of what constitute first and subsequent visits
   - Establish the methodology to convert number of visits (new and subsequent) per period to number of users attended per period
   - Record, for the period and cumulatively, the number of users that use methods not requiring constant supply of contraceptives.
   - Design the forms (for recording and reporting), their contents, methodology and usage to be as simple as possible and, at the same time, be usable and used by service center managers to manage their unit, organize its resources, and maintain steady supplies.
   - Facilitate the consolidation at the area, provincial, zone and national levels.
   - Easily provide basic indices for regular analysis and interpretation of what is happening at each geographic grouping of service units, and stimulate forward thinking to improve service provision.

2. Design and implement an inventory recording and reporting system that would:

   - Apply to all service centers the basic inventory recording, used already in many service units
   - Stimulate forward planning of supplies needs and identify service gaps due to lack of supplies
   - Facilitate "squaring" of supplies consumed with users attended, and develop the indices needed to compare with application of norms.
   - Consolidate geographic information on available inventories at the are, provincial and zonal levels to facilitate balancing of suplies to fill gaps and better meet their scarcities.

## LIST OF EXHIBITS

1. Partial Organizational Chart of the Ministry of Health

2. New Organization Chart of the "Division de Fomento y Proteccion" provided by Dr. Lovato.

3. Description of Health units

4. Health System and position of different units

5. Description of the Rural Medicine Guidelines

## APPENDICES

A. List of Persons Interviewed

B. Bibliography

C. Health and Population Data

D. Training Objectives

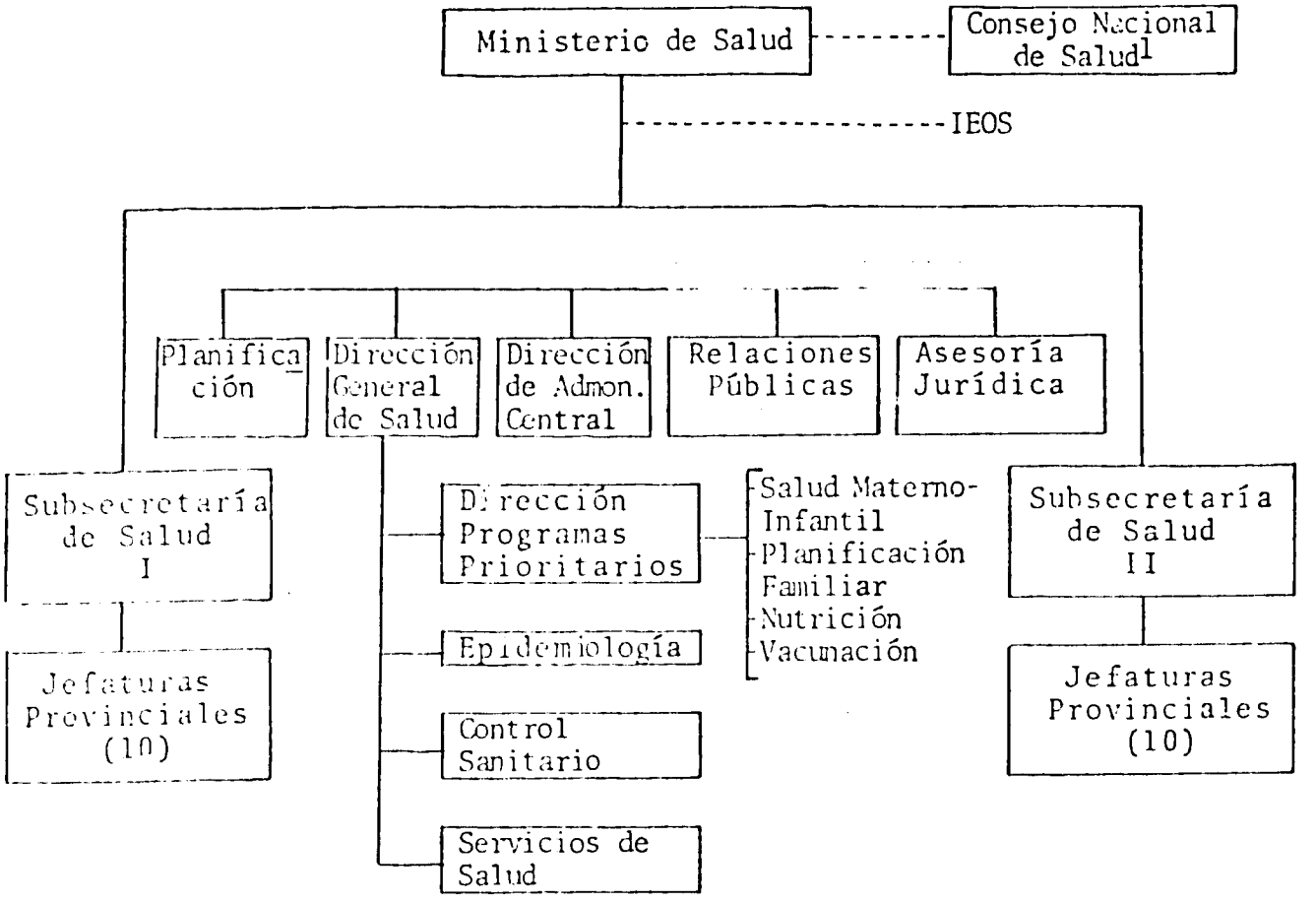
E. Problem Areas/Management Needs

F. Skills Acquired

G. Proposed Methodology for the workshop

EXHIBIT 1

## Organigrama Parcial Ministerio, de Salud




[1]El Consejo Nacional de Salud incluye los siguientes miembros: (1) El Ministerio de Salud Pública quien lo presidirá; (2) El Ministro de Bienestar Social o su delegado; (3) El Director del Departamento Médico Social del IEOS; (4) El Director General de Salud; (5) Un representante del Consejo Nacional de Desarrollo; (6) El Jefe de Sanidad Militar de las Fuerzas Armadas; (7) El Director Ejecutivo de la Junta de Beneficencia de Guayaquil; (8) El Presidente de la Cruz Roja Nacional; (9) El Presidente de la Sociedad de Lucha contra el Cáncer del Ecuador (SOLCA); (10) Un representante de la Asociación de Facultades Ecuatorianas de Medicina; (11) El Presidente de la Federación Nacional de Médicos del Ecuador.

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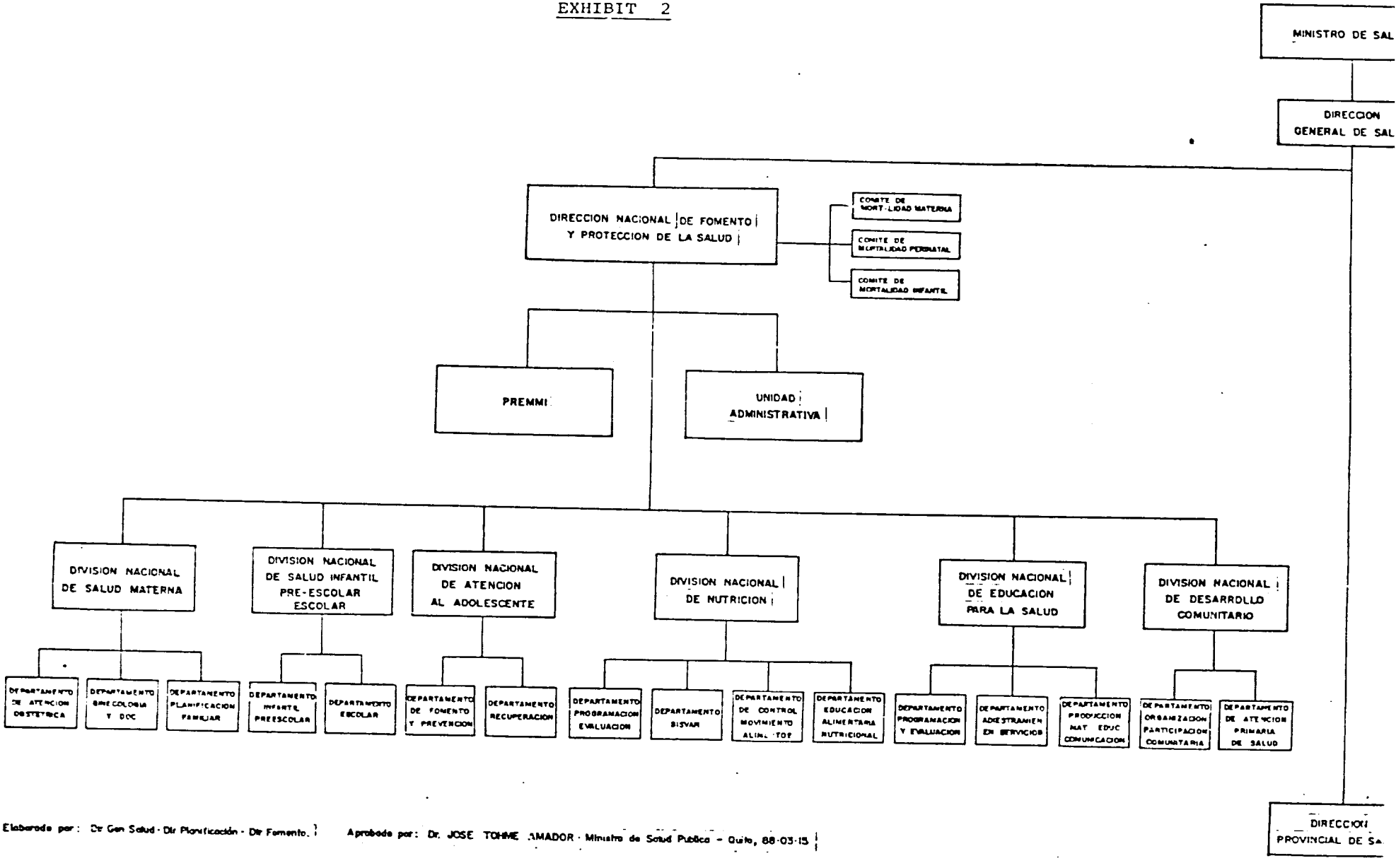
Elaborado con información del MSP y en base a observaciones del equipo de MSH, Abril 1988.

EXHIBIT 2




Elaborado por: Dir Gen Salud - Dir Planificación - Dir Fomento.

Aprobado por: Dr. JOSE TOHME AMADOR - Ministro de Salud Pública - Quito, 88-03-15

EXHIBIT 3

## Definición de los Establecimientos de Salud del Sistema de Servicios del Ministerio de Salud Pública de Ecuador

1. Puesto de Salud

Es una unidad operativa del sistema de servicios del MSP de atención primaria* implementada para prestar acciones de salud integral enfatizadas en salud Materno-Intantil, inmunizaciones, nutrición, atención sintomática de pacientes y mejoramiento del medio ambiente rural.

Se encuentra ubicada en cabeceras parroquiales con una población menor de 1,500 habitantes y en localidades rurales: recintos o anejos importantes.

Cuenta permanentemente con personal auxiliar de enfermería, y planta física y equipamiento para cumplir los programas correspondientes al Nivel I del Sistema de Servicios, constituyendo la base de la pirámide de regionalización y del sistema de referencia, sirve de puerta de entrada al sistema, dentro del cual refiere los pacientes al Nivel II (SCS) recibe la supervisión técnico-administrativa de este nivel y del CSH; estimula la organización de la comunidad y se apoya en la participación activa del sistema informal de prestación de servicios.

2. Subcentro de Salud

Es una unidad operativa del sistema de servicios del M.S.P. implementada para prestar acciones de salud integral, con énfasis en Salud Materno-Infantil, inmunizaciones, nutrición y atención médica básica, exclusivamente ambulatoria, con equipo de apoyo de diagnóstico elemental; así como acciones de mejoramiento del medio ambiente.

Se encuentra ubicada en cabeceras parroquiales con una población mayor de 1,500 habitantes y cuenta permanentemente con personal médico, odontológico y auxiliar de enfermería, planta física y equipo para cubrir los programas contemplados en el Nivel II del Sistema de Servicios de Salud.

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*"Atención primaria es aquella que satisface necesidades de salud simples, generalmente agudas y muy frecuentes; con una combinación de recursos simples, fácilmente accesibles y de corta utilización".

EXHIBIT 3 (Continued. . .)

Atiende la referencia técnica del Nivel I y refiere pacientes a los niveles III, IV y V.

Participa la supervisión del Nivel I y es supervisada por personal de los establecimientos del Nivel III.

Constituye el primer escalón de la integración docente-asistencial del sistema, para la formación de los recursos humanos de salud.

3. Centro de Salud Hospital

Es una unidad operativa del sistema de servicios del Ministerio de Salud Pública, implementada para prestar acciones de salud integral con énfasis en salud Materno Infantil, inmunizaciones, nutrición y atención médica básica, fundamentalmente ambulatoria y hospitalización de corta estancia ginecoobstétrica, pediatría y emergencias médico-quirúrgicas, así como acciones de mejoramiento del medio ambiente.

Se encuentra ubicada en cabeceras cantonales con una población mayor de 5.000 habitantes o en localidades importantes por su desarrollo socio económico.

Cuenta permanentemente con personal médico, odontológico, de enfermería, obstetricia y personal de apoyo técnico, administrativo y general, así como planta física y equipo, inclusive de equipo básico de apoyo para el diagnóstico y tratamiento de enfermedades con todo lo cual está en capacidad de cumplir los programas contemplados en el Nivel II del sistema.

Constituye el segundo escalón de la integración docente-asistencial del sistema para la formación de los recursos humanos de salud.

Atiende la referencia técnica de los Niveles I y II y refiere pacientes a los Niveles IV y V.

Comanda la planificación y ejecución de las acciones en las unidades de los niveles I y II de su jurisdicción y realiza la supervisión técnico-administrativa programada de las mismas.

Es supervisada por personal de los establecimientos del Nivel IV o de la Jefatura Provincial de Salud.

Colabora con las acciones de investigación clínica epidemiológica y social programadas.

EXHIBIT 3

4. Hospital Base

Es una unidad operativa del sistema de servicios del Ministerio de Salud Pública, implementada para prestar acciones de salud integral, con énfasis en acciones de recuperación de las cuatro especialidades básica, inclusive psiquiatría de agudos, y en acciones de salud Materno Infantil, inmunizaciones, nutrición, así como acciones de mejoramiento del medio, con la participación de los centros de salud urbanos de su jurisdicción.

Se encuentra ubicada en cabeceras provinciales o en localidades que sirven de base para la organización de áreas programáticas.

Cuenta con personal médico para la prestación de especialidades básicas, de odontología, enfermería y obstetricia, al igual que otro personal de apoyo técnico, administrativo y auxiliar para el cumplimiento de sus actividades; así como planta física y equipo, inclusive equipo de apoyo para diagnóstico y tratamiento especializado, con todo lo cual está capacitado para cumplir los programas, contemplados en el Nivel IV del sistema.

Constituye el tercer escalón de la integración docente-asistencial del sistema para la formación de los recursos humanos de salud.

Atiende la referencia técnica de los Niveles II y III y de los Centros de Salud urbanos, y refiere pacientes a los establecimientos de Nivel V.

Supervisa la realización de las acciones del Nivel III.

Es supervisada por personal técnico-administrativo de la Jefatura Provincial y por personal técnico del Nivel V.

Realiza acciones de investigación clínico-epidemiológica y social programadas de acuerdo a las necesidades del sistema.

5. Hospital Especializado

Es una unidad operativa del sistema de servicios del Ministerio de Salud Pública, implementada para prestar acciones de salud integral, con énfasis en las acciones de recuperación en las especialidades básicas y de alta complejidad médico-quirúrgica y acciones de salud materno infantil, inmunizaciones y nutrición, así como acciones de mejoramiento del medio, con la participación de los centros de salud urbanos de su jurisdicción.

EXHIBIT 3 (Continued. . .)

Se encuentra ubicada en cabeceras provinciales que cuentan con facultades de Ciencias de la Salud. Cuenta con personal médico y odontológico apropiado para la prestación de las especialidades de alta complejidad y personal de enfermería, obstetricia, al igual que otro personal de apoyo técnico, administrativo y auxiliar para el cumplimiento de sus actividades; así como planta física y equipos, inclusive equipo de apoyo para diagnóstico, tratamiento, investigación y docencia especializados; con todo lo cual está capacitado para cumplir los programas contemplados en el Nivel V del sistema.

Constituye el cuarto escalón de la integración docente-asistencial del sistema para la formación y especialización de los recursos humanos de salud.

Atiende la referencia técnica de los otros niveles y de los centros de salud urbanos. Su opinión científica será la base para la futura referencia internacional por insuficiencia de tecnología médica nacional.

Supervisa las acciones médico asistenciales de los establecimientos del sistema dentro de la jurisdicción que para el efecto establezca el Ministerio.

Programa, dirige, coordina, supervisa y evalúa las acciones de investigación clínica-epidemiológica y social, de acuerdo con la política de Salud Nacional y las necesidades del sistema.

EXHIBIT 4

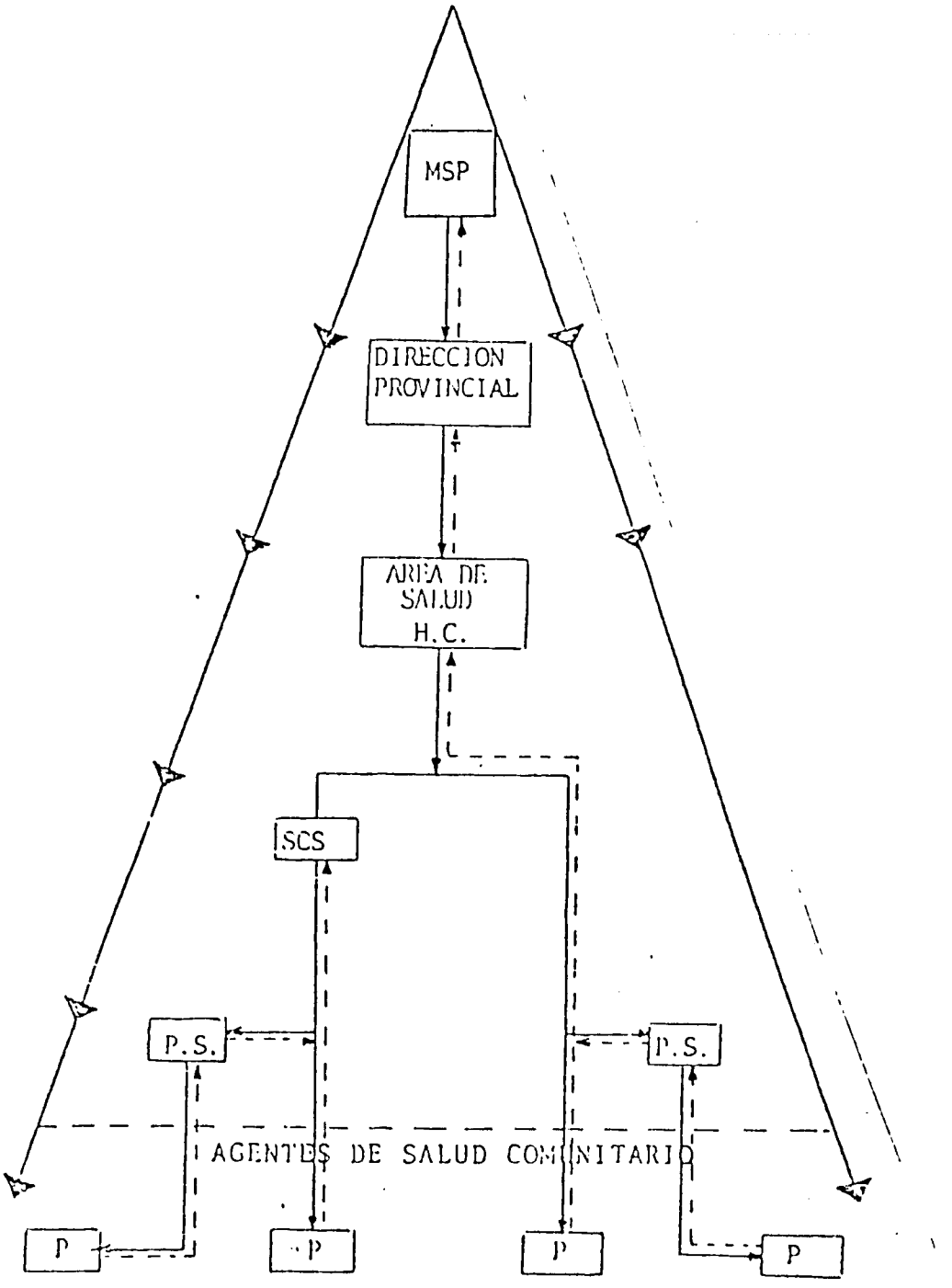
MSP
DIRECCION PROVINCIAL
AREA DE SALUD H.C.
SCS
P.S.
P.S.
AGENTES DE SALUD COMUNITARIO
P
P
P
P

EXHIBIT 5

## Reglamento para el Ejercicio de la Medicatura Rural

### I. Introducción

Las acciones del médico en el área rural, están destinadas a mejorar el nivel de salud de la comunidad, trabajando con ella y para ella, orientando sus aspiraciones y desarrollando una Medicina Social e Integral, dentro de los conceptos de universidad y continuidad.

La presencia del médico en esta área le convierte en un líder comunitario, situación a través de la cual deberá realizar acciones que le permitirán orientar al equipo de salud bajo su responsabilidad, a la comunidad por medio de sus organizaciones reconocidas, siguiendo las instrucciones, normas manuales y otros procedimientos que del Nivel Central le llegaran a través de las Jefaturas Provinciales, que constituyen su inmediato superior.

### II. Antecedentes

a) El Decreto Supremo N°44 del 3 de julio de 1970, publicado en el Registro Oficial N°13 del 8 de los mismos mes y año, establece la obligatoriedad para los graduados en medicina, odontología, obstetricia y enfermería para que presten sus servicios profesionales en el Plan Nacional de Medicina Rural, como requisito previo a la inscripción de sus títulos, para que puedan ejercer su profesión.

b) El (proyecto de) Acuerdo suscrito entre el Ministerio de Salud y AFEME, que establece que el ejercicio del año de medicatura rural forma parte de programas de educación médica continuada y como tal, se le considera una Residencia Médica Rural.

### III. Funciones

En virtud de los antecedentes expuestos, el Médico Rural, cumplirá por el lapso de un año, actividades de Director Médico tratante del Subcentro correspondientes, con exclusión de otro tipo de actividades, sujeto a las siguientes obligaciones y derechos:

a) Trabajar ininterrumpidamente cinco días a la semana, que responderán a las necesidades de la demanda y programación, de acuerdo al calendario que fijará la Jefatura Provincial de Salud respectiva.

b) Residir obligatoriamente en el lugar asignado para que cumpla sus funciones específicas.

EXHIBIT 5 (Continued. . .)

c) Someterse a un horario de 8 horas diarias, y en las 16 horas restantes atender todos los casos de emergencia que se presentaren.

d) Siendo el representante legal del Ministerio de Salud Pública, cumplirá las delegaciones emanadas de la Ley, frente a situaciones jurídicas que le fueren requeridas tales como el realizar reconocimientos médicos, autopsias y otras disposiciones del Código de la Salud y más leyes en vigencia.

e) Realizar las actividades programadas por el Ministerio de Salud y AFEME, tendientes al mejoramiento de la Salud Rural, en los campos científico, administrativo, técnico y de cualquier otro orden.

f) Aceptar la delegación de autoridad que fuera conferida por Autoridad competente.

g) Bajo su responsabilidad actuará el personal médico y paramédico y cuanto personal de salud trabaje en la zona y supervisará y controlará las actividades técnico-administrativas del personal del Subcentro.

h) Asistir a reuniones académicas, administrativas, programadas por la Jefatura Provincial y el Subcomité de Salud Rural de su jurisdicción.

i) Presentar mensualmente la información estadística de sus actividades y la del personal de servicio a la Jefatura Provincial respectiva.

j) Realizar el pedido de equipo y material de salud indispensable, a las Jefaturas Provinciales, justificando éstos con las actividades de los programas que ejecuta.

k) Anualmente, el profesional cesante en sus funciones deberá verificar el inventario de bienes y medicinas del Subcentro del cual es responsable en calidad de cuenta-dante con el visto bueno de la Jefatura de Salud Provincial correspondiente y luego, con el médico entrante, deberá realizar un acta de entrega-recepción. Asimismo el Director del Subcentro deberá llevar el estado de cuentas diario por concepto de servicio, expendio de medicinas y otros, y a fin de mes, el respectivo balance.

l) Presentar, por requerimiento del Ministerio y Asociación de Facultades de Medicina, un informe final sobre las actividades y observaciones de carácter biopatológico y otras que le fueron encomendadas; requisito sin el cual, la Jefatura Provincial correspondiente no le acreditará el año de trabajo rural.

EXHIBIT 5 (Continued. . .)

m) El médico, no podrá abandonar el área de su residencia, sin previa autorización de la Jefatura Provincial. La concesión de licencia, menor de tres días, le será dada por la Jefatura Provincial y cuando el lapso fuere mayor se deberá resolver de acuerdo a trámites legales correspondientes.

n) No podrá en ningún momento, realizar más cobros de dinero que los autorizados en el arancel fijado en la Jefatura Provincial correspondiente y estos fondos deberán emplearse para cubrir las necesidades del Subcentro.

Exclúyese del pago a las personas indigentes que soliciten atención en el Subcentro.

IV. Derechos Durante el Ejercicio del Año de Salud Rural

a) Por el desempeño de sus labores, el Estado, a través del Ministerio de Salud Pública, reconocerá un salario mensual fijado en el presupuesto.

b) Tendrá derecho a la internación gratuita de todo su grupo familiar dependiente (esposa e hijos) en los servicios de hospitalización del Ministerio, ya sea en los hospitales provinciales o los especificados de la capital.

c) Asimismo, el Ministerio, a través de las Jefaturas Provinciales, proporcionará vivienda dentro de las características locales, que permitan al profesional, gozar de independencia habitacional.

d) Podrá referir enfermos a los hospitales del Estado y conducir directamente su tratamiento clínico o quirúrgico, si así lo estimase, en colaboración con los médicos responsables de los servicios correspondientes del hospital.

e) Tiene derecho a reclamar en caso de considerar injusta una sanción.

V. De las Sanciones

El incumplimiento de las disposiciones anteriores está sujeto a las siguientes sanciones:

a) Por la primera vez que se incurra en el incumplimiento de cualquiera de las obligaciones, será objeto de una amonestación verbal por parte de la Jefatura Provincial con acción de personal.

b) Por la segunda vez, recibirá una amonestación escrita, cuya copia deberá ser enviada a la División Nacional de Salud Rural.

EXHIBIT 5

c) Por la tercera vez, será sancionado económicamente de acuerdo a la gravedad de la falta y al criterio del Jefe Provincial respectivo.

d) El abandono injustificado de su lugar de trabajo en forma reincidente dará lugar a la suspensión temporal y aún a la cancelación de su cargo, sin perjuicio de que el Ministerio de Salud Pública, de acuerdo a la magnitud de la falta, pueda seguir la acción legal correspondiente.

VI. Derechos del Profesional que Cumplió el Año de Salud Rural

El cumplimiento satisfactorio de sus obligaciones, debidamente certificado por los Departamentos correspondientes del Ministerio de Salud y AFEME, a través de la Facultad respectiva, acreditará al Médico Rural los siguientes derechos:

a) El libre ejercicio de la profesión.

b) Optar por residencias hospitalarias a otros niveles.

c) Optar por becas para adiestramiento en el país o en el exterior, de acuerdo a las necesidades nacionales.

d) Optar por la docencia.

e) Posibilidad de continuar ejerciendo sus funciones como Director del Subcentro.

## APPENDIX A

## LIST OF PERSONS INTERVIEWED

MINISTRY OF HEALTH - Quito

DIRECCION DE FOMENTO Y PROTECCION
Dr. Pedro Lovato, director
Dr. Pedro Luna
Dr. Hernan Moscoso
Lic. Consuelo de Bejarano
Dr. Jose Castro Luna
Dr. Jorge Avencillas
Lic. Nelly Gallardo
Dr. Jose Castro Luna - Community Development

SUB-SECRETARIAT ZONE II (Guayaquil)

DEPARTAMENTO DE FOMENTO Y PROTECCION
Dr. Hernan Toledo,
Lic. Lema Segura

CENTRO HOSPITAL DAULE
Enfermera Laura Molina de La Vera
Estadistica Austria Bajana
Administrador Sr. Recalde

SUBCENTRO SANTA LUCIA
Dra. Jenny Macio

CENTRO DE SALUD No. 7 - MAPASINGUE
Dr. Jimenez
Estadisticas Fatima

DIRECCION PROVINCIAL - AZUAY (Cuenca)
Dr. MarceloAguilar, Director
Dra. Libia Cueva, Jefe de Materno-Infantil

CENTRO DE SALUD HOSPITAL MORENO VASQUEZ (Gualaceo)
Dr. Marco Zamora, Director
Sr. Lituma, Administrator

VISITA A CENTRO DE SALUD SAN JUAN
Ausentes Medica y Auxiliar

SUBCENTRO DE SALUD CHORDELEG
Auxiliar Narcisa Flores

SUBCENTRO DE SALUD EL VALLE
Dos estudiantes de Enfermeria

DIRECCION PROVINCIAL CANAR (Azoguez)

Dr. Oscar Martinez, Director
Dr. Marcelo Sarato, Jefe Materno-Infantil
Lic. Blanca Toledo
Estadistica Sr. Edgar Pesantes

HOSPITAL PROVINCIAL HOMERO CASTANERO CRESPO
DR. Victor Crespo, Director
Sor Cecilia

HOSPITAL CANTONAL LUIS F. MARTINEZ
Dr. Hernan Padron, Director

CENTRO DE SALUD HOSPITAL CANAR
Dr. Milton Romo, Director

PUESTO DE SALUD SAN RAFAEL
Auxiliar Mariana de Jesus Chuma

CENTRO DE SALUD BIBLIAN
Dr. Milton Romo, Director

## APPENDIX B

## LIST OF DOCUMENTS CONSULTED


1. Country Profile 1987 - 1988 - The Economist Intelligence Unit.

2. Family Planning Program 1980 Project Paper - USAID.

3. 1984 Directorio y Codificacion de los establecimientos de Salud - Division National de Estadistias, Ministerio de Salud Publica, Republica del Ecuador.

4. La Situacion de Salud en el Ecuador1962 - 1985 - Ministerio de Salud Publica, Instituto de Investigaciones Nutricionales y Medio Sociales ININMS, Orgnaizacion Panamericana de Salud OPS, Organizacion Mundial de la Salud OMS, Quito-Ecuador, abril de 1987.

5. Metodologia de Regionalizacion de servicios de Salud, Modulo: Organizacion Funcional, Ministerio de Salud Publica/USAID, Quito-Ecuador.

6. Metodologia de Regionalizacion de Servicios de Salud, Modulo de Evaluacion, Ministerio de Salud Publica/USAID, Quito-Ecuador, abril de 1987.

7. Metodologia de Regionalizacion de Servicios de Salud, Modulo: Manual para el Supervisor de Salud, Ministerio de Salud Publica/USAID, Quito-Ecuador, abril de 1987.

8. Metodologia de Regionalizacion de Servicios de Salud, Modulo: Diagnostico del Subsistema de Informacion, Ministerio de Salud Publica/USAID, Quito-Ecuador, abril de 1987.

9. Metodologia de Regionalizacion de Servicios de Salud, Modulo: Programacion Ministerio de Salud Publica/USAID, Quito-Ecuador, abril de 1987.

10. Poblacion por Provincias y Cantones segun Grupos Programaticos, 1988,Constantes de Distribucion 82-95, Division Nacional de Estadisticas, Direccion Nacional de Planificacion, Ministerio de Salud Publica.

11. Establecimientos del Ministerio de Salud Por Tipo y Numero de Camas 1987,Division Nacional de Estadisticas, Ministerio de Salud Publica.

12. Proyecto de Extension de Cobertura de Servicios Para el Bienestar Familiar en las Provincias del Canar, Azuay, Napo, Los Rios y El Oro - USAID, 1988.

13. Cobertura de Univesos y Metas Observados por Provincias, Porgrama Materno Infantil, Ministerio de Salud Publica, 1986.

14. Total Consultas Brindadas por componentes - 1987, Division Nacional de Estadisticas, Ministerio de Salud Publica.

15. Family Planning Management Development Plan for Ecuadorean Family Planning Organizations, February 1987, Management Sciences for Health.

MINISTERIO DE SALUD PUBLICA

## TOTAL CONSULTAS REGISTRADAS POR COMPONENTES

AÑO: 1987 *

DIVISION NACIONAL DE ESTADISTICA

| PROVINCIAS | PRE-NATAL | POST-PARTO | REGULACION DE LA FECUNDIDAD | DOC. | -1 AÑO | 1-4 AÑOS | ESCOLAR | OTROS Y CERTIFICADOS DE SALUD | * MORBILIDAD | ODONTOLOG. | TOTAL CONSULTAS |
|---|---|---|---|---|---|---|---|---|---|---|---|
| CARCHI | 8.333 | 2.659 | 1.230 | 300 | 11.232 | 10.609 | 3.657 | 7.433 | 48.344 | 22.059 | [illegible] |
| IMBABURA | 15.852 | 5.475 | [illegible] | 1.379 | 21.821 | 21.725 | 6.636 | 11.541 | 131.932 | 64.644 | [illegible] |
| PICHINCHA | 63.275 | 6.376 | 38.341 | 12.796 | 65.412 | 42.165 | 49.707 | 122.157 | 687.483 | 197.569 | 1'[illegible] |
| COTOPAXI | 13.797 | 2.207 | 4.156 | 1.415 | 23.691 | 35.952 | 19.116 | 25.679 | 131.500 | 60.055 | [illegible] |
| TUNGURAHUA | 17.772 | 3.271 | 9.024 | 2.719 | 20.322 | 24.259 | 15.776 | 9.269 | 139.019 | 48.975 | [illegible] |
| BOLIVAR | 6.199 | 2.633 | 2.399 | 360 | 9.635 | 11.979 | 4.423 | 6.143 | 69.011 | 38.215 | [illegible] |
| CHIMBORAZO | 14.337 | 3.771 | 3.677 | 1.167 | 24.716 | 34.051 | 13.441 | 15.720 | 123.275 | 63.245 | [illegible] |
| CAÑAR | 8.435 | 3.543 | 4.320 | 1.451 | 10.840 | 16.200 | 20.103 | 13.735 | 117.995 | 40.281 | [illegible] |
| AZUAY | 12.585 | 3.221 | 6.405 | 1.672 | 16.047 | 18.705 | 21.517 | 17.237 | 211.845 | 40.471 | [illegible] |
| LOJA | 9.404 | 3.276 | 3.383 | 152 | 7.032 | 13.099 | 5.836 | 18.832 | 126.712 | 23.953 | [illegible] |
| PASTAZA | 14.393 | 4.059 | 3.357 | 395 | 5.536 | 4.151 | 1.247 | 12.428 | 157.327 | 43.345 | [illegible] |
| MORONA | 51.038 | 5.748 | 14.824 | 28.773 | 42.907 | 33.751 | 24.819 | 24.369 | 502.532 | 74.257 | [illegible] |
| LOS RIOS | 20.731 | 1.833 | 4.812 | 339 | 5.684 | 6.564 | 6.765 | 8.671 | 232.033 | 52.965 | [illegible] |
| GUAYAS | 67.268 | 11.557 | 53.679 | 9.355 | 43.313 | 34.971 | 68.273 | 75.305 | 1'050.411 | 205.135 | 1'614.[illegible] |
| EL ORO | 12.369 | 1.221 | 6.017 | 1.709 | 4.051 | 5.125 | 10.153 | 28.293 | 161.694 | 36.409 | [illegible] |
| NAPO | 7.269 | 992 | 1.133 | 223 | 2.924 | 3.731 | 3.368 | 7.933 | 113.917 | 22.917 | [illegible] |
| PASTAZA | 2.497 | 584 | 1.208 | 30[illegible] | 1.771 | 3.005 | 2.629 | 3.292 | 39.937 | 16.847 | [illegible] |
| MORONA SANTIAGO | 3.272 | 1.765 | 529 | 132 | 4.513 | 7.079 | 5.865 | 3.309 | 53.495 | 20.336 | [illegible] |
| ZAMORA CHINCHIPE | 3.581 | 561 | 2.185 | 303 | 2.237 | 2.975 | 2.563 | 1.215 | 46.812 | 11.101 | [illegible] |
| GALAPAGOS | 628 | 108 | 473 | 47 | 452 | 373 | 240 | 764 | 15.299 | 3.975 | 22.359 |
| T O T A L | 373.950 | 66.830 | 166.533 | 64.990 | 325.047 | 320.168 | 285.179 | 412.325 | 4'160.553 | 1'030.904 | 7'2[illegible] |

* Incluye consultas de Emergencia y Sintomáticos

NOTA: Se excluye 35 unidades operativas.

Proyección refiérase al 75% de información enviada de las provincias.

ELABORACION: División Nacional de Estadísticas de Salud.

# APPENDIX D

## TRAINING OBJECTIVES

### General Considerations

The general objective of the proposed training is to help the Provincial FP personnel and some of their co-workers acquire certain skills to solve the critical management problems they face in performing their daily tasks. The first step in this process is to tell them about the program and in particular the projects being implemented. The first workshop should be oriented to accomplishing this.

The problems selected are those that urgently require intervention if the given program is to meet its objectives. There are, of course, other problems which are not acute in a given program at this time; they may well develop as the various programs and will have to be dealt with at a later time.
The problems selected have been separated into the following categories according to the management component into which they fall:

- Planning;
- Organization;
- Evaluation and Monitoring
- Supervision

We reccommend that these problem be dealt with in the training courses. We suggest the following to be included in an initial design of the courses:

- the writing of training objectives
- the identification and selection of the proper course content;
- the selection of the most appropriate training strategies
- the determination of an estimates development phase of the project.

More specific course objectives, activities, and materials should be developed during the curriculum development phase of the project by the group that will do the training. Following is a list of management needs and problem areas that can be targetted by the training.

# APPENDIX E

## LIST OF MANAGEMENT NEEDS/PROBLEM AREAS

### A. Planning

1. Problem identification
2. Problem analysis (the tendency to identify a solution prior to a thorough analysis of the situation)
3. Generation of alternative solutions before selecting one
4. Setting of attainable objectives
5. Analysis of resources needed; determination of those available and those to be acquired
6. Short - and long-term planning for manpower development
7. Management of financial resources (development of budgets and budgeting procedures ans of activities to generate financial resources)
8. Planning for cost-effective use of time (organization of individual work and relationship with donor organizations)

Deficiencies in general planning and programming, though common to most provinces, varied in their importance according to the level o managerial skills observed in each province. These problems often seemed to be more the result of external causes than of a lack of skills on the part of the staff (i.e., lack of transportation, breakdown of the commodity distribution system), in some provinces and a lack of management skills particularly in the Guayas province.

### B. Organization

1. Operating FP program within a complex structure
2. Development of clearly defined job descriptions
3. Dealing with the multiplicity of roles assigned to some of the staff, especially the State FPCoordinator
4. Management information systems
5. Commodity Management (planning, improving distribution and storage systems)
6. Transportation
7. Integration of support systems for family planning

### C. Supervision (at various levels)

1. Technical skills for gaining support for the FP program (especially in the States where the programs are at the

initial stages of development)

2. Design of structures and mechanisms (i.e. job descriptions) for delegating tasks
3. Development of improved supervisory structures and mechanisms, with clear distinctions among supervision, control and evaluation
4. Coordination among national and international agencies intervening in FP program
6. Coordination between the public and private sectors

D. Evaluation and Monitoring

1. Operations research to provide information for decision-making
2. Procedures to monitor the evolution of activities and utilization of resources
3. Procedures to evaluate on a regular basis the achievements of the programs

## APPENDIX F

At the end of the proposed training, the participants should have skills in the following areas:

1. Planning

Identify specific management problems facing their programs;

Analyze these problems, identify their causes and outline the possible ways to solve them;

Rank problems by priority in terms of impact on the program, urgency, and possibility of resolution;

Identify possible ways to solve them;
Select an appropriate solution after a through analysis of pertinence, adequacy, feasibility, effectiveness, efficiency, acceptability, possible side outcomes and eventual integration with other programs from MCH

Set specific objectives that are feasible and measurable;

Identify the type and timing of appropriate activities that will be undertaken to reach the objectives;
Determine the material resources, expendable and nonexpendable, necessary to undertake each activity (including evaluation and monotoring) taking into account the resources already available;
Determine the human resources necessary to undertake the activities, taking into account the different duty stations, the tasks to be performed at each duty station and the number and category of staff needed;

Develop a coherent plan for manpower development based on tasks to be performed, the categories and number of personnel available and needed, and the skills needed;

Use basic programming techniques to optimize time management in terms of the organization of work.

2. Organization

Analyze the structure within which the FP program operates; identify the different elements composing it, determine the lines of authority and communication between them and the funtions of each level;

Whenever the structure is to complex or not clear, propose changes to make it more operational and effective;

Write job descriptions for staff operating within the various elements (e.g. FP Training Coordinator), specifying areas of responsibility, specific tasks, relationships with others within the structure, as well as the conditions under which the tasks are to be performed;

Identify after thorough analysis, areas of possible integration with other programs and propose mechanisms for such integration.

3. Supervision

Analize a working group to identify its power structure, the decision-making process, the communication network ad the relationships among its members. Identify within the group the members who are favorable to FP and those who are opposed; and
Operate as a change agent within the group to build consensus by using group dynamics and communication principles;

Establish open mechanisms for delegating responsabilities based on job descriptions, qualifications, personnel qualities, and workload of staff members;

Establish mechanisms and procedures to monitor the performance of staff to whom tasks have been delegated;

Conduct task analysis for development of standardized check lists to determine job performance and to identify areas where staff can improve their work through feedback and/or training;

Establish procedures and mechanisms for coordination among persons invloved in the FP program (e.g., regular meeting where plans, progress, and problems of the program are discussed and decisions are made by consensus);

Develop procedures and mechanisms for coordination between the public and private sectors;

4. Evaluation and Monitoring

Undertake operations research as a tool to generate data useful in the management of the FP program;

Develop an operational plan with procedures and mechanisms for monitoring progress. Determine indicators and data needed in terms of target population covered, activities undertaken and resources used;

Determine how to collect the data, with what resources and how often;

Develop an operational plan including procedures and mechanisms to measure the results obtained and follow the progress of the FP program.

# APPENDIX G

## Proposed Methodology for the Worskshops (One Alternative)

As the participants in the workshops are professionals already involved in carrying out the FP program, the methodology reccommended should be highly participatory, based on the discovery method using the experiences of each participant. This approach means that the trainers and trainees will serve as learning/teaching resources, making the learning experience more meaningful and more adapted to the needs of the participants. It should make use of teaching exercises and mostly case studies. There are a number of case studies on FP programs in Latin America. Role playing exercises are useful to teach communication skills.

Reading material containing basic concepts on each topic ought to be handed out to the participants prior to each session, with the expectation the materials will be read beforehand.
One way of organizaing the sessions may be:

- Presentation and discussion of the objective(s) of the session;
- Analysis and clarification of the reading material through questions and answers;
- Group work around a case study, teaching exercise or role play;
- Presentation, discussion and analysis of group productions by the participants;
- Summary by the participants;
- Writing up of analysis of group productions and summary, typed and distributed to each participant.