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FAMILY PLANNING MANAGEMENT TRAINING PROJECT

MANAGEMENT NEEDS ASSESSMENT

FAMILY PLANNING PROGRAM

MINISTRY OF PUBLIC HEALTH

ECUADOR

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INTRODUCTION

A first edition of this report, Management Needs Assessment of the Family Planning Program within the Ministry of Health, was written in April 1988. It was a description of the status of the program, as perceived by the FPMT team, at that point in time. Since then a new Ecuadorian President and government have taken over. This change has had impact upon the proposed AID project described in the report. It appears there will now be a stronger emphasis on family planning as a component of child survival. There may be a geographic shift in the focus of project activities with the new government. The assessment of the management training needs outlined in this report remain unchanged however.

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December 1988

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 management training needs in the family planning program of the Ministry of Health. This needs assessment is linked to AID's proposed Family Planning project that will cover six of the 20 provinces. The training needs identified here respond to and are linked directly to the proposed project. The assessment was carried out 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 family planning at the national level: lack of supplies and lack of IEC 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 Ganar and Azuay who had more stable personnel confront a more conservative population where family planning 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, organizational 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. programs should be assured, by the central office, of a continuity of supplies and explicit endorsement of the family planning program component;

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

3. training should be appropriate to the level of program maturity in the province; skills learned should be applied 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 should come from all relevant levels of the health system, including subsecretariats, zonal, province, canton; and

6. training should foster collaboration and cooperation among the Provinces and throughout the various levels.

The team has come up with a program of training activities that responds to the needs of the family planning programs and follows 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, subcenters 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 would be 60;

3. a basic "service center" management course for hospital directors, center and subcenter personnel which are permanent and who direct activities. The course should include planning, organizing and controlling, and be structured in modules; and

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 the 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 to evaluate the programs.

The team evaluated the management information systems for family planning. The information regarding coverage was poorly kept and inconsistent. It did not permit an accurate evaluation of the current situation. There are some areas where records of supplies are kept and others poorly so, or not at all.

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

1. the design and implementation of a basic but comprehensive MIS system; and
2. the design and implementation of 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 assessment that covered three public institutions and three private, not-for-profit organizations involved in family planning. This evaluation did not include the MOH.

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

Economic Situation

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

The inflation rate for 1987 was reported at a range of 35%-52% per annum and is expected to be negative from 1988 onward, barring any major success in the rescheduling of the Ecuadorian foreign debt now standing at nearly US$ 10 billion.

Politics and Government

Since 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 presidential elections. The first round, which took place in January 1988, resulted in the field being narrowed down 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. Regardless of who wins, it is expected that the new government will have a stronger interest in promoting better health conditions for the population at large and will welcome international donor assistance.

New Population Policy

In early 1988, the Ecuadorian government issued a 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:

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

* To reduce, to the lowest levels possible, the general indices of morbidity 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 diagnosis and treatment.

* To 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 family planning activities in the public sector. Steps are being undertaken by the National Development Council (CONADE) and the MOH to execute this policy. To support the execution of this policy, UNFPA and USAID are negotiating significant newly proposed 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 services began 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 FORDERUMA (a Central Bank of Ecuador in charge of financing rural development) and UNFPA. In 1984, the Government of Ecuador and UNFPA signed an agreement for population activities for two provinces that had already participated in the previous project: Guayas and Chimborazo. Since then, some activities have been carried out but their coverage has not been significant.

Estimates indicate that approximately 47% of women of fertile age, in union, desire to plan their families but do not currently use any family planning method. According to a recent ENDESA survey, of an estimated ten million Ecuadorians, it is expected that there are nearly 1.5 million women of fertile age in union, of whom approximately 688,000 do not use any method of family planning, and about 300,00 of these women are expected to be receptive to receiving family planning services.

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

Share of the MOH in the provision of the following family planning methods. Source: ININMS

Method	%
Contraceptive pill	31
IUD users	25
Sterilizations	55

Although care must be taken in using the following figures due to the collection and processing problems mentioned in the exe utive summary, it appears that in 1987 the MOH provided 167,000 family planning consultations, significantly more than the 50,000 provided in 1986. The increase was largely due to the availability of supplies provided through the UNFPA project. First visits in 1987 reportedly represented 71% of the total number of consultations.

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 MOH 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 family planning program at the MOH.

A. MOH

In 1972, the MOH as an organization was restructured and official authority was centralized in Quito. In 1976, the MOH 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 visits related to MCH, for example, would be for the program as a whole not for each specific part of the program.

The effort to decentralize continued and in Dr. Huertas' time (1983) a new subsecretariat for the coastal zone was established. The new organization chart of the ministry is outlined in exhibit 1. In it we can observe that each of the subsecretariats is responsible for ten provinces.

There are some ministry functionaries 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, and Communications, among 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 family planning program in number of ways. For example, the director of a canton hospital would now be in charge of the units in his/her 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 she knew little or nothing about and had not done before. Other issues that have been considered in light of regionalization are discussed in the section on the family planning program in the area designated by the project.

B. History of Family Planning at MOH

In principle, family planning services are available to the Ecuadorian people through public sector delivery systems such as the MOH. The extent to which the MOH actually provides family planning and IEC 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 MOH's "Division de Fomento y Proteccion".

The department of Family Welfare was established in 1971, with assistance from AID, and family planning services have been integrated into the department's programs since that time. Even though the family planning 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.

AID's assistance served as the main force for the creation and expansion of most Ecuadorian family planning activities in the public sector. However, funding of family planning programs has not been continuous. AID's funding of family planning 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 major funding affected the growth of the program and during the period of little assistance form AID, it was UNFPA who supported the MCH division and the family planning program in particular. UNFPA contributions allowed the "Division de Fomento y Proteccion" to continue programs and to maintain a certain financial independence from the MOH.

C. 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 MOH, has undergone many changes in the past. At this very moment, (April 1988) 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 six departments reporting to it. These departments are:

Health Education
Pre-School
MCH
Adolescents
Nutrition
Community Development

Family planning is part of the MCH 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 family planning 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 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 who 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) (Within proposed USAID Project)	
40 Cantons: Azuay-5 Canar-1 Los Rios-5 El Oro-6 Manabi-8 Guayas-15	MATERNAL CHILD CARE (Family Planning) (reporting to Provincial director)*

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* This 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 centers, sub-centers and health posts. The total number of units in the project area is 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 units. The other provinces have the following number of units (see following table 2):

Table 2 *

PROVINCE	TOTAL	CANTON	CENTER	SUB-CENTER	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 are the following:

auxiliary nurse -- Health posts
rural medical doctor, auxiliary nurse, -- sub-centers
doctors, obstetrices, nurses, auxiliary nurses, -- 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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* The source for this data is a 1987 chart 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 (or an obstetriz) must see her and give a prescription for the method she chooses to use. 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. There is no charge for any method. In general, most units are dealing with "walk in" patients and do not go out to recruit 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 IUDs, 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 not yet 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 family planning systems is strained or bureaucratic. Until now, there has been a direct line of authority, but this may change with the new requirements made by regionalization.

D. The Family Planning Program in the Project Area

Although the provinces involved in the proposed 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 reasons, the description of the family planning organization which follows represents a summary composites of what we observed and were told rather than a description of any individual province.

TYPES OF SERVICES

Family planning services are generally integrated with other MCH services. Our observations showed that the MCH services are usually assigned a room or two and services are provided by a doctor, a nurse, or auxiliary nurse; this depends on the type of facility and the personnel available. Family planning services are provided to those who request them and 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 attempt 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. Supplies available to the various facilities consisted of IUDs, 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 exact number of sterilizations was not kept at the services units. At most, some of the centers we visited had an estimate, (based on memory) of the number done per month.
Following are these findings:

Hospital Provincial (Azogues)	60 sterilizations
Hospital Cantonal (Canar)	10 -12 sterilizations per month
Hospital Cantonal (Gualaceo)	12 - 15 sterilizations per month
Hospital Cantonal (Gualaceo)	8 - 10 IUDs 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 they purchased supplies at a local pharmacy. It is apparent that in most areas the private sector provides a significant portion of family planning 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

As stated, family planning services are integrated with other MCH services and are provided in one or two rooms in the same facility. The units visited in the provinces of Canar and Azuay were generally clean and adequate (with the exception of the Hospital Cantonalat Canar). The facilities visited in Guayas were poorly kept and at the hospital in Daule, they were inadequate.

All of the units visited had equipment and furniture consisting primarily of desks, chairs, an examining table, a scale, sometimes an autoclave, and 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". Staff members are supposes to work 5 days a week for 8 (or 4) hours* and schedules vary depending on the needs of the area. We were told that personnel try to schedule their free days jointly so as to assure that 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 a rural medical doctor (the reader can refer to exhibit 5 for description of this position and further information on this group). These doctors are temporary personnel who work for the MOH during one year in order to obtain a work certificate. 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 successful program execution is likely to occur when program planning and evaluation has been carried out with participation and commitment beginning at the lowest organizational managerial level. Although there are forms used for some family planning program planning and evaluation,

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* We 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.

the medical personnel in charge of managing the service units are not involved in the program planning of MOH family planning activities and have not been trained managerially to fulfill their roles as service center managers. Since the MOH has now embarked on a more "bottom-up" management process and this method simulates more the fulfillment of realistically set objectives, it is deemed appropriate that the directors of the service centers be trained in program planning and evaluation, as service center managers, in the specifics of the family planning program.

Program planning and evaluation should include all basic aspects of the structuring of policies goal and objective setting, 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 family planning. 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 family planning users in their area.

Supervision

It is our impression that in 1987 and 1988, supervision has been sporadic and is not adequate. Supervision is more than a process of receiving reports and delivering or authorizing the getting of supplies. Supervision should be done on a regular basis. Regular visits to all units however, while important to effective service delivery, will remain difficult and in some cases almost impossible, due to MOH constraints.

Those interviewed at the provincial level stated that the pattern of supervision is changing and therefore little had been done this year. For example in Azuay, supervision in the future 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; and
3. Relationship between services and inventory data.

Service Statistics:

Until 1982, service statistics at the service unit level were broken down by family planning method for first, subsequent and total consultations. Thereafter, due to a decision taken apparently at the central level, reporting was revised so that the monthly reports only show the number of new family planning users, subsequent and total consultations, without discrimination by method. Since this report is collected, consolidated and reported to each successively larger geographic level (now unit, provincial and national; later also by area) all statistics only report numbers of first, subsequent and total consultations of family planning services, without a method breakdown. The service unit statistics do not report the number of more permanent methods (such as IUD's, tubal ligations) utilized by patients in a particular area.

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 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.

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 family planning services) to service statistics so as to determine the real coverage (or market share) of that service unit within the catchment area of a service unit.

Due to these uncertainties and the ones mentioned below, we believe it is important that management information systems be defined and developed so as to produce reliable service statistics for management and impact evaluation. The relationship between programming and evaluation data and formats should be reviewed; programming formats now only consider total family planning 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 inventory movements on each corresponding card (for about five products). Where they kept, there were no monthly totals nor was information provided to the medical personnel of supplies rotation, prevalence and future needs. In a good number of cases, they were no records kept, apparently because these supplies are gratis, and were not required to be taken into account in the bonding of personnel responsible. This was the case at an otherwise well-organized hospital as well as at centers, subcenters and puestos.

family planning supplies were normally well stored at the pharmacy. In some service units, IUDs were stored and controlled by the obstetrician who was 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. The medical management information which would permit regular identification of resource utilization at each center and which would identify available/overworked physical and human resources was not readily available.

Logistics

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 requests supplies for three months. 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 IUDs 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 in detail but noted that supplies were treated differently from other supplies because they were free of charge to the MOH.

IEC

All of the units visited lacked material for IEC. Most units are involved, however, in meetings with mother's clubs, talks to groups of women coming to the units (approximately 30-40 women), talks in schools, etc.. where such IEC materials would be very useful.
Such meetings represent an untapped source of resources which could benefit the expansion of the family planning program. If this resource is to be incorporated in the family planning effort, they will require some training in concepts of communication as applied to family planning.

There have been, and still are, attempts at community mobilization for various health programs, through rural and urban-marginal promoters. The urban group, however has been canceled 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, contracting them for their services. This group became interested in obtaining employee, rather that contractor, status in their relationship with the MOH and pursued a legal/labor relations strategy for that. The MOH concluded that it would be inappropriate, inadvisable and non-affordable to establish this relationship.

and has cancelled all relations with this personnel, also cancelling thereby family planning services promotion with this method.

The rural promoters continue to work but they are paid by the community directly. The MOH does assign the community a salary for the promoter, but holds no labor relationship with these persons.

Community Distribution

Most clients receive family planning supplies by going to the MOH service centers, receiving a prescription from the attending doctors, obstetrician or nurse, and then going to the pharmacy section of the center to pick up the supplies prescribed, when available. Family planning supplies are also provided by the nurses who do home visits for service promotion.

The team found that supplies were not regularly available at rural clinics. Since rural services are of significant importance in the proposed USAID project, particular attention should be paid to appropriately stocking rural posts and subcenters.

IV. FUTURE EXPANSION OF FAMILY PLANNING ACTIVITIES AT THE MOH

The Ecuadorian MOH has become dependent on international agency cooperation in order to carry out family planning programs, including the provision of family planning 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, 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 MOH to Family Planning, the budgetary restrictions and the expectation of receiving continued international agency support.

The MOH is negotiating concurrently the approval of family planning supporting agreements with two international agencies: UNFPA and USAID.

A. THE UNFPA PROJECT

This new project was conceived in June 1987, at the end of the previous project. It was 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, and is programmed for two two-year cycles. The budget includes the balance from the last project plus a ceiling of about US$ 600,000 per year of new funds. If the first cycle is successful, an extension is considered probable.

The overall thrust of the proposed agreement is maternal health and family planning areas; it does not include child health. 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 areas of 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.

<u>Program for Selected Project Area</u>

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, subcenters and centers, 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 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, a population universes and establishments (provincial and canton hospitals, centers, subcenters and posts) of the MOH. See Table 3

Table 3

Province	Population Universe *	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

* Universe of Women of Fertile Age, in Union, Receptive to Family Planning Services. Source: "Proyecto de extension de Cobertua de servicio para el bienestar familiar en las provincias del Canar, Aguay, Napo, Los Rios, El Oro.", Draft proposal agreement MOH - AID, 1987. That report cites ENDESA 1987 as source.

The MOH 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 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 when UNFPA supplies were regularly available. see table 4.

Table 4
Service Statistics for UNFPA Project Provinces
Total Consultations

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

In addition, the proposed UNFPA program contemplates supervising and supplying the maintenance of family planning activities in the province of Chimborazo, which was equipped during the previous program. Equipment to be purchased is for primary preventive services 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 proposed UNFPA project includes:

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

b. Providing family planning supplies worth US$700,000 during the life of the two year project. Women of fertile age number 2.1 million; a part of whom will be served with UNFPA project 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 the end of March 1988, two versions of the proposed agreement have been reviewed with the MOH and a thirtu 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. 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, in order to facilitate project administration. Following is a list of the team members:

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

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

2. Work in One MOH Zone

Six provinces which fall under one geographic area and are administered by one of the two subsecretariats were selected. This selection will facilitate project execution. Previous UNFPA projects which required multi-regional authorizations at the MOH were bogged down administratively.

3. 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 that much equipment was stored and unused.

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

4. Targeted Training

Training is to be provided to personnel who are interested in providing and expending family planning service, and who are stable at the MOH service units (subcenters, centers and hospitals). These 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 obstetrices. The doctors are to participate in training as needed to support the project.

Based on experience with the previous project and the initial activities of the current UNFPA project-to-be, the UNFPA Coordinator identified the following management weaknesses:

1. Logistics

Logistics management for continued and controlled supply to the MOH centers is a major need. During the needs assessment team visit, recording and reporting of supplies at the service centers appeared adequate in some areas and poor in others (especially so with family planning supplies which are free of charge to the MOH). The continuity of supply was deficient.

2. Statistics

A system for reliable up-to-date and appropriate statistics generation and recording should be developed which would include:

* a system for collection of quality data
* capacity to analyze 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 marshal efforts and resources to accomplish the project goals in an institutional setting.

4. Personnel Administration

Assignment of personnel appropriately qualified to carry out their functions is necessary; for example hospital directors who have had 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 appropriate personnel to be UNFPA and USAID project counterparts.

5. Family Planning 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 family planning 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 family planning services as a high priority, to be accomplished, if need be, with support of MOH funding during times of limited or no international agency support.

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

B. THE PROPOSED USAID PROJECT

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

* To promote a responsible family planning 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.

Specific objectives refer to providing services to women of fertile age and to improving the quality of care to women and children, thereby reducing indices of child and perinatal morbidity and mortality. Other objectives focus on: attaining attitudinal changes in the population; improving and extending family planning services to both rural and urban sectors; incorporating adolescents; strengthening logistics; and improving coordination with other family planning participating organizations.

Six provinces are the geographical coverage of this proposed 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.

The proposed project would be carried out over a seven 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 equipment 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 in addition to the above budget are family planning supplies.

Specific goals to be achieved during the seven semester duration of the proposed project include;

1. Increase, by at least 50%, the use of some specific family planning method among fertile women in union receptive to the use of family planning methods.

2. Attain that 100% of the operating units will provide ambulatory care, develop maternal health and perinatal activities, with an emphasis on family planning activities, and timely detection of mammary and cervical/uterine cancer.
3. Obtain that 100% of community resources (promoters, C.V.R., leaders) of the project areas are trained to develop IEC materials for MCH and family planning.

4 Train 100% of the project personnel who will carry out activities in Maternal-Child Health and Family Planning.

5. Train 100% of the students enrolled in freshman and junior year of high school on MCH and in aspects of paternal responsibility.

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 goal of a 50% increase in contraceptive usage is to be accomplished in the following provinces with the following population (of women in fertile age receptive to of family planning services) and number of MOH service centers: See Table 5.

Table 5

Provinces	Population Universe*	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
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Total	163,587	492

* Women in Fertile Age in Union, Receptive to Family Planning Services.
Source: same as Table 3.

The goal of a 50% increase in usage over the seven semesters of the proposed 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 provinces covered by the project was 27,158. During 1987, the number of annual consultations increased considerably by 37,280 to 64,438 consultations 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 appropriate conditions will be provided, it appears that this goal of increased services could be achieved.

Nevertheless, doing so will require a significant effort, since in 1987 the total number of new consultations in these six province was 25,618. The MOH central office staff considers that the centers have sufficient capacity available to accommodate the increased demand of family planning services. The MSH needs assessment 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 proposed 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 the proposed USAID project is extensive and expanded training activities. This training will necessitate considerable preparation of instructors, course materials, and IEC family planning materials. They are not currently available at the service centers, nor 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 potential student body to be trained, at:

* MOH service centers;
* MOH provincial and regional offices;
* Communities; and
* High schools;

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

V. RECOMMENDED MANAGEMENT TRAINING AND TECHNICAL ASSISTANCE ACTIVITIES

Management Training Needs

Following upon our assessment, we have developed a series of general objectives to which we feel all Management Training for the Family Planning program in the MOH 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 family planning program in the long run.

2. Training should be appropriate to the level of program in each province. Family planning 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 should include family planning 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 family planning program even though not directly related. Strong management skills at this higher level would benefit the family planning program by enhancing the overall resource management of the health system which is particularly important considering that here in the MOH the family planning programs are integrated into the other services.

5. Management Training should be as cost-effective as possible, seeking strategies 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 recommend 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 that they do not depend on the presence of any one individual. For this reason we suggested above assigning a person from each province to be at Training Coordinator. This person should attend the first workshop. The workshops recommended 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; three members of each of the six provincial staffs (director, and two 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 three 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 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 participant for this course is 60.

3. A basic "service center" management course for the following: hospital directors, center and subcenter personnel 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 preferably 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 outlines basic technical assistance activities to assist the increase of family planning 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 interpretation of what constitutes first and subsequent visits.
   - Establish the methodology to convert the number of visits (new and subsequent) per period to the 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 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 within 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 area, provincial and zonal levels to facilitate balancing of supplies 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

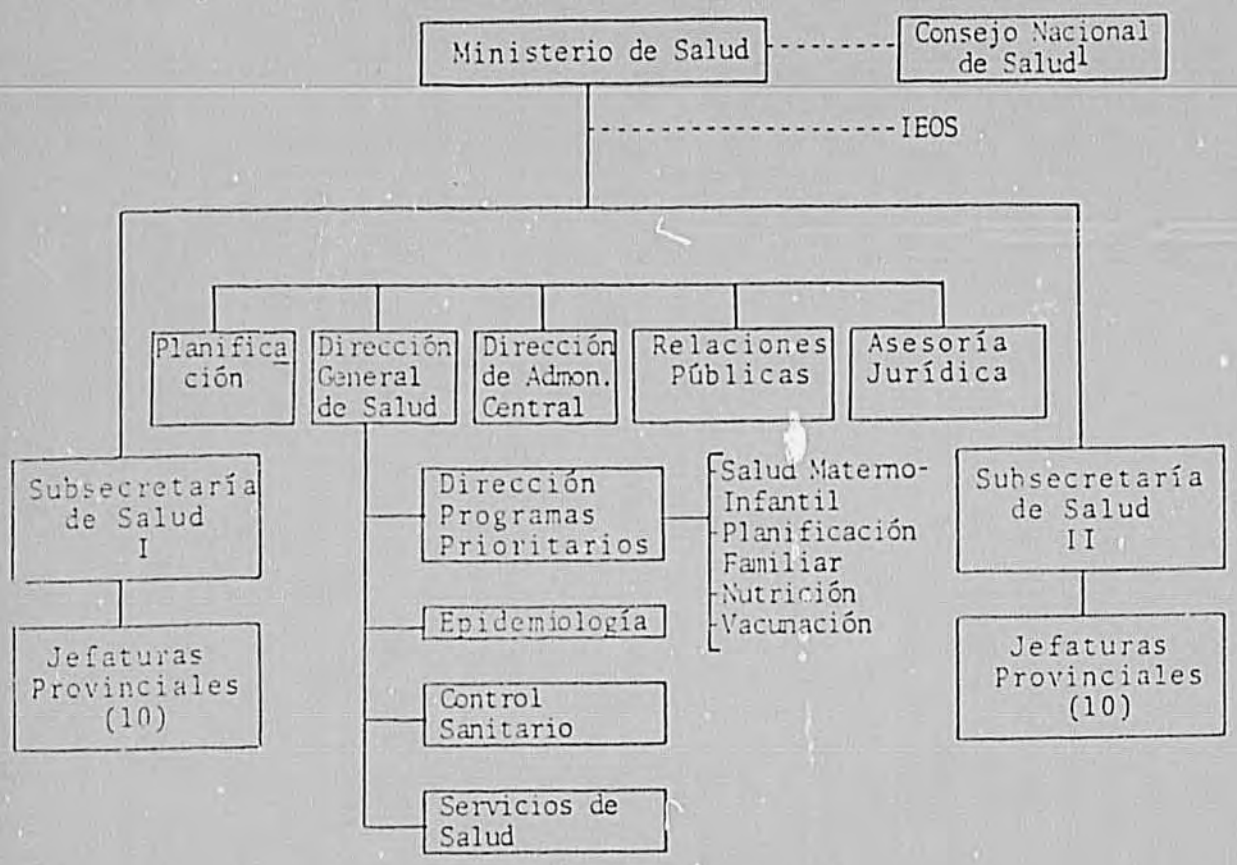
E. Problem Areas/Management Needs

F. Skills Acquired

G. Proposed Methodology for the workshop

EXHIBIT 1

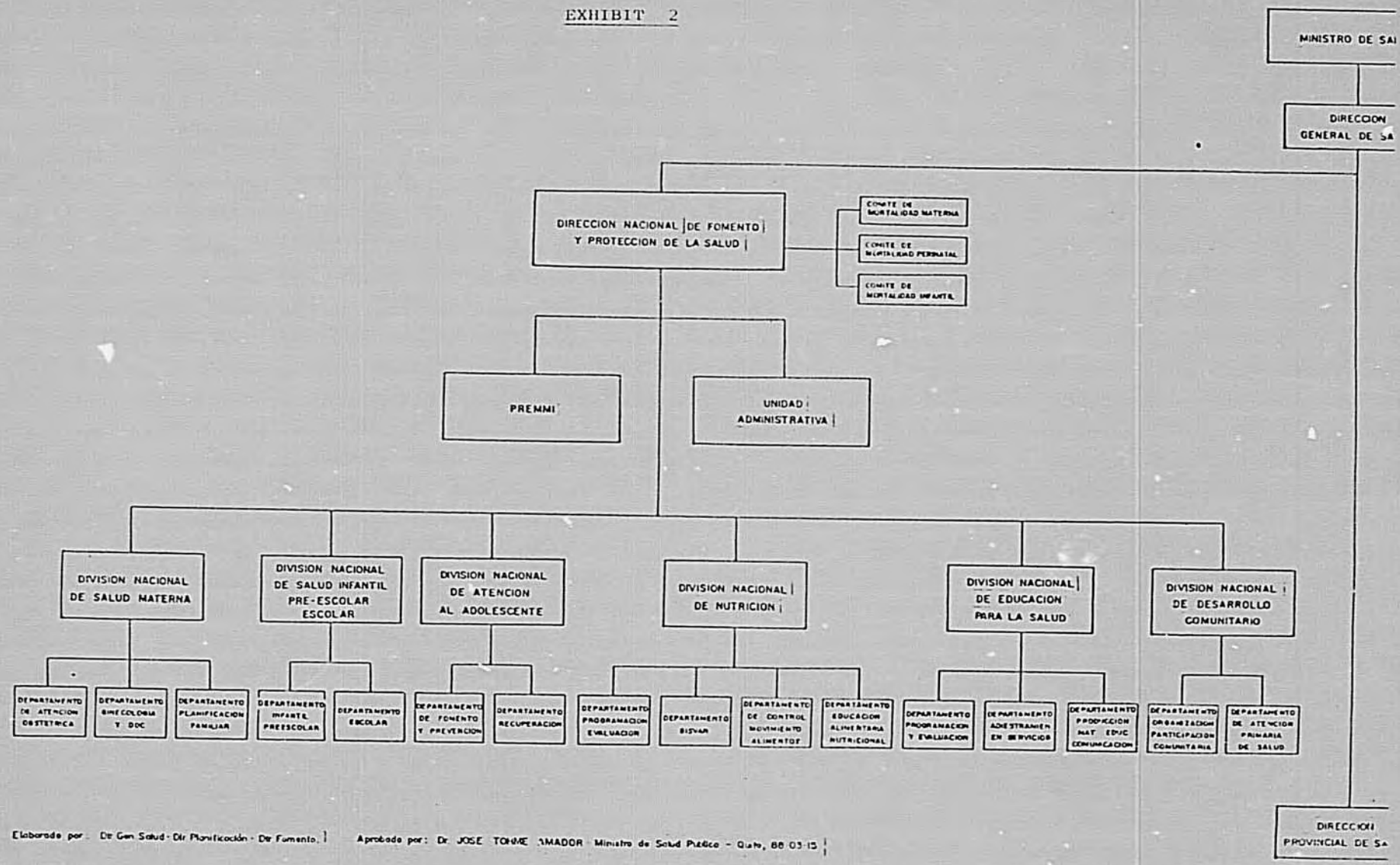
Organigrama Parcial Ministerio, de Salud



[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.

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

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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 gineco-obstétrica, 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

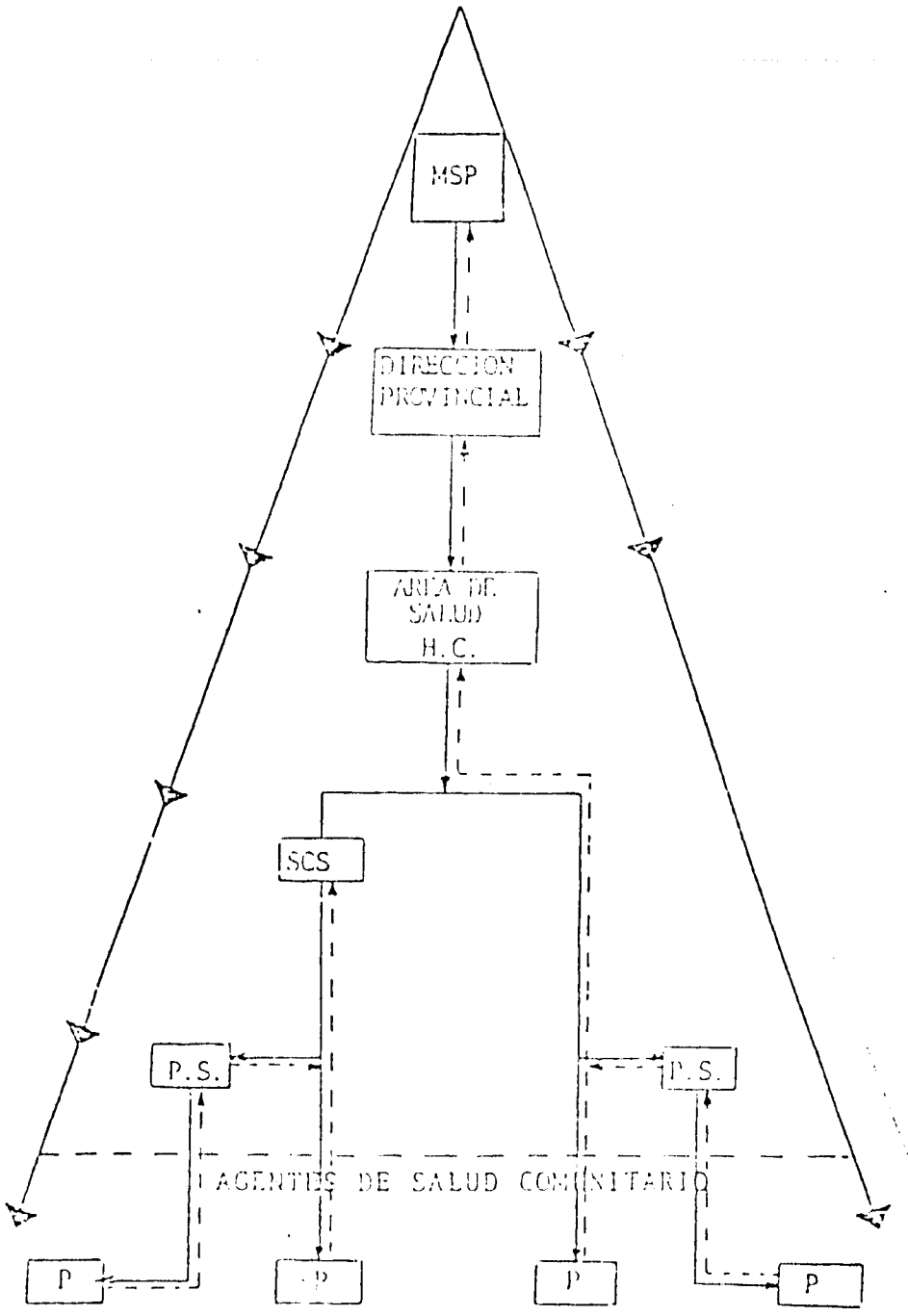
MSP
DIRECCION PROVINCIAL
AREA DE SALUD H.C.
SCS
P.S.
P.S.
AGENTES DE SALUD COMUNITARIO
P
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EXHIBIT 5

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.

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) Realiza 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.

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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 Sacoto, 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

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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 EFECTUADAS POR COMPONENTES

AÑO: 1987 *

DIVISION NACIONAL DE ESTADISTICA

PROVINCIAS	PRE-NATAL	POST PARTO	REGULACION DE LA FECUNDIDAD	DOC	1 AÑO	1-4 AÑOS	ESCOLAR	OTRAS Y CENTRICADOS DE SALUD	* MORBILIDAD	ODONTOLOG	TOTAL CONSULTAS
CARCHI	8.333	2.659	1.280	380	11.202	10.609	3.637	7.433	48.344	22.059	[illegible]
IMBABURA	15.832	5.475	5.331	1.079	21.881	21.735	6.636	11.541	131.932	64.644	[illegible]
PICHINCHA	83.275	6.376	38.341	12.756	65.412	42.165	49.707	122.157	687.483	197.569	1'[illegible]
COTOPAXI	13.787	2.237	4.156	1.415	23.891	35.952	19.116	25.679	121.500	63.055	[illegible]
TUNGURAHUA	17.772	3.271	9.024	2.729	20.352	24.259	15.776	8.269	129.019	48.975	[illegible]
BOLIVAR	9.199	2.635	2.399	360	9.635	31.979	4.428	6.143	69.011	38.215	[illegible]
CHIMBORAZO	14.537	3.771	3.677	1.167	24.715	34.651	13.441	15.720	120.275	68.245	[illegible]
CAÑAR	8.435	3.543	4.320	1.451	10.840	16.230	23.103	13.735	117.995	40.281	[illegible]
AZUAY	12.585	3.221	6.405	1.672	16.017	18.735	21.517	17.237	211.845	40.471	[illegible]
LOJA	9.404	3.276	3.383	152	7.032	13.595	5.836	18.832	126.712	23.993	[illegible]
PASTAZA	14.363	4.059	3.357	395	5.536	4.131	1.247	12.428	157.027	43.345	[illegible]
MANABI	51.988	5.748	14.024	28.773	42.987	33.751	24.019	24.369	502.532	74.357	[illegible]
LOS RIOS	20.731	1.033	4.812	339	5.634	6.564	6.765	8.671	222.033	52.935	[illegible]
GUAYAS	67.268	11.557	53.679	9.355	44.313	34.971	68.273	75.305	1'050.411	200.135	1'6[illegible]
EL ORO	12.369	1.221	6.017	1.709	4.061	5.125	10.153	28.293	161.654	36.409	[illegible]
NAPO	7.289	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	3.252	39.937	18.847	[illegible]
ISLAS GALAPAGOS	3.272	1.765	529	132	4.513	7.073	5.865	3.309	58.495	20.336	[illegible]
ZONA CONCHAPE	3.581	561	2.185	303	2.237	2.975	2.563	1.215	46.912	11.101	73.533
EXTRANJEROS	628	108	473	47	452	373	240	764	15.299	3.975	22.359
T O T A L	373.950	65.830	166.533	64.990	325.047	320.168	285.179	412.325	4'160.593	1'000.904	7'2[illegible]

* Incluye consultas de Emergencia y Sintomáticos

NOTA: Se excluye 35 unidades operativas.

Proyección Refiere 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 problems 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 of 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 rescurces 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.