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UNCLASSIFIED

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

ECUADOR

PROJECT PAPER

CHILD SURVIVAL AND HEALTH

AMENDMENT NUMBER 1

AID/LAC/P-896
CR-567

PROJECT NUMBER: 518-0071

UNCLASSIFIED

PROJECT DATA SHEET

1. TRANSACTION CODE

A = Add
 C = Change
 D = Delete

Amendment Number

1

DOCUMENT CODE

3

COUNTRY/ENTITY
Ecuador

3. PROJECT NUMBER
518-0071

4. BUREAU/OFFICE

5. PROJECT TITLE (maximum 40 characters)

Child Survival Project

6. PROJECT ASSISTANCE COMPLETION DATE (PACD)

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

MM DD YY
05 31 99

A. Initial FY 89

3. Quarter 3

C. Final FY 99

3. COSTS / \$000 OR EQUIVALENT \$1 =

A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AD Appropriated Total						
Grant	1,593.0	589.0	2,182.0	10,115.0	7,885.0	18,000.0
Loan						
Other 1.						
U.S. 2.						
Host Country					18,830.0	18,830.0
Other Donors)						
TOTALS	1,593.0	589.0	2,182.0	10,115.0	26,715.0	36,830.0

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROXIMATE PRIORITIZATION	B. PRIMARY PURPOSE	C. PRIMARY TECH. CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1)	CS	530	510	11,000.0		5,800.0		16,800.0	
(2)	HE	530	510	1,200.0				1,200.0	
(3)									
(4)									
TOTALS				12,200.0		5,800.0		18,000.0	

10. SECONDARY TECHNICAL CODES (maximum 5 codes of 3 positions each)

11. SECONDARY PURPOSE CODE

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

A. Code

B. Amount

15. PROJECT PURPOSE (maximum 480 characters)

The purpose of this project is to improve the effectiveness of child survival and primary health care programs and interventions nationwide, with a focus on the poor in rural and periurban communities.

14. SCHEDULED EVALUATIONS

Interim MM YY 11 19 95 MM YY 09 9 96 Final MM YY 10 9 99

15. SOURCE/ORIGIN OF GOODS AND SERVICES

300 741 Local Other (Specify)

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of 3 page PP. Amendment)

To extend the authorized life-of-project to May 31, 1999; to increase the authorized life-of-project grant funding by US\$5,800,000 from US\$12,200,000 to US\$18,000,000; to extend the geographic coverage from eight provinces to nationwide; and to amend the original project components with: 1) A MSP Public Policy Support, 2) Policy Analysis and Advocacy, and 3) A Nongovernmental (NGO) Program Strengthening.

Thomas Totino, Controller

17. APPROVED BY

Signature
John A. Sanbrailo

Title
Mission Director

Date Signed
MM DD YY
07 19 94

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION

MM DD YY

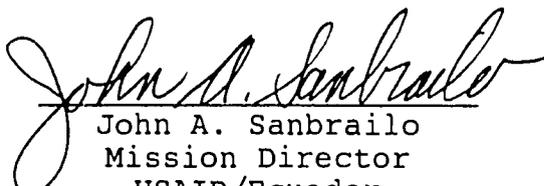
PROJECT AUTHORIZATION
(AMENDMENT No. 1)

NAME OF COUNTRY/ENTITY: Ecuador/Ministry of Health (MOH)
NAME OF PROJECT: Child Survival and Health Project
NUMBER OF PROJECT: 518-0071

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, the Child Survival and Health Project was authorized on June 7, 1989. The authorization is hereby amended as follows:

- a. The authorized life-of-project is extended to May 31, 1999.
- b. The authorized life-of-project grant funding is increased by US\$5,800,000 from US\$12,200,000 to US\$18,000,000.
- c. To extend the project geographic coverage from eight provinces of Ecuador to nationwide.
- d. To amend the original project components with: 1) A MSP Public Policy Support, 2) Policy Analysis and Advocacy, and 3) A Nongovernmental (NGO) Program Strengthening.

2. The Project Authorization cited above remains in force except as hereby amended.


John A. Sanbrailo
Mission Director
USAID/Ecuador

7/19/94
Date

CLEARANCE:

GDO/HFP: PMartinez: PM
A/GDO: KYamashita: KS
PPD: PLapera: PL
PPD: PMaldonado: PM 6/29/94
RCO: MStevenson: MS
RLA: JBornes: JB
CONT: TTotino: TT 6/29/94
Drafted by: PRodriguez PR
(6.14.94)

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LIST OF ACRONYMS USED IN THE PROJECT PAPER AMENDMENT

CA	Cooperative Agreement
CONADE	Consejo Nacional de Desarrollo
CS	Child Survival
ENDEMAIN	Encuesta Demográfica y de Materno-Infantil Nacional
FASBASE	World Bank Project: Fortalecimiento y Ampliación de Servicio Básicos de Salud en el Ecuador
GDP	Gross Domestic Product
GNP	Gross National Product
GOE	Government of Ecuador
HC	Host Country
HMO	Health Maintenance Organization
IDB	Inter-American Development Bank
IESS	Instituto Ecuatoriano de Seguridad Social (Ecuadorian Social Security Institute)
INEC	Instituto Nacional de Estadística y Censos
IPA	Independent Provider Association
JBG	Junta de Beneficencia de Guayaquil
LOP	Life of Project
MCH	Maternal and Child Health
MSP	Ministerio de Salud Pública (Ministry of Public Health)
NGO	Non-governmental Organization (for profit or non-profit)
PACD	Project Assistance Completion Date
PAHO	Pan American Health Organization
PC	Project Component
PHC	Primary Health Care
PPA	Project Paper Amendment
PVO	Private Voluntary Organization (non-profit NGO)
SAFYC	Salud familiar y comunitaria (World Bank project, phase 1: 1988-1992))
SILOS	Sistemas Locales (PAHO approach to local area administration)
SO	USAID Mission Strategic Objective
SSC	Seguro Social Campesino (Peasant Social Security)
TA	Technical Assistance
UCA	Unidad de Conducción de Area (MSP health area management unit)
UNICEF	United Nations Children's Fund
USAID	U. S. Agency for International Development

I. EXECUTIVE SUMMARY: CHILD SURVIVAL PROJECT PAPER AMENDMENT

Introduction and Overview

The purpose of this Project Paper Amendment is to redesign USAID Ecuador Project No. 518-0071, authorized on June 7, 1989, with a Life of Project Funding of \$12.2 million. The goal and purpose of the redesigned project remain essentially the same as the original project. This Amendment adjusts the project design to the substantial changes that have taken place in the Ecuadorian health sector during the period since project authorization, and brings the project into line with USAID's new health policies as described in *Strategies for Sustainable Development* issued in March of 1994. It also increases project funding from \$12.2 million to \$18 million and extends the Project Assistance Completion Date (PACD) by nearly four and a half years to May 31, 1999. As a result, this project will be USAID's principal investment in the 1990s for supporting Ecuador's implementation of its health sector policies and for supporting sustainable program strategies as outlined in new USAID guidelines.

This is a propitious time to amend the Ecuador Child Survival and Health Project in order to bring it more in line with recent developments in Ecuador, emerging GOE policies, and new USAID guidelines. Increasing the access, quality and sustainability of child survival and primary health care is the highest priority of the Government of Ecuador (GOE) for achieving greater health care coverage, improving national health indicators and enhancing the socio-economic well being of the Ecuadorian population. This requires more efficient and effective roles of health sector institutions and corresponding functions/services, which produce greater and more sustainable impact. The original Ecuador Child Survival and Health Project (referred to herein as the CS Project) has made advances toward strengthening and decentralizing the managerial and administrative capacity of the Ministry of Public Health, yet several key events have occurred that require the USAID mission to refocus and reorient the objectives and strategy of the Child Survival Project.

First, in 1993, as an outgrowth of the GOE's modernization and reform initiatives, the Ministry of Public Health (MSP) developed and issued a four year plan entitled *Basic Policy Guidelines for Health Programs: 1993-1997*. This plan represents the MSP's most progressive health sector policy planning document to date. The *Policy Guidelines* serve as a starting point toward structural change for health care institutions and sector coordination, in search of improved targeting of public resources for services for the poor. With further policy analysis, information and consensus building, these policies and their implementation will provide the foundation needed for greater targeting, effectiveness and sustainability of child survival and primary health care (CS/PHC) service delivery in Ecuador.

Second, the design and initial implementation of a \$100 million public sector health project funded by the World Bank (FASBASE) has had a major influence on reorienting the objectives of the USAID Child Survival Project. FASBASE will provide significant resources to increase the technical, administrative and infrastructural capacity of the MSP within a decentralized institutional framework, based on the MSP plan for self-contained PHC coverage in health areas throughout the country. FASBASE will duplicate somewhat, while greatly expanding, the original focus of the USAID CS project. However, FASBASE will not address all of the policy guidelines issued by the Ministry of Health, or the health sector policies and strategies supported by USAID. For example, FASBASE does not provide for policy reforms needed for structural change and greater sustainability in the health sector, nor does it support non-governmental organizations as a major vehicle for the delivery of CS/PHC services.

Third, an external evaluation of the CS Project, carried out in 1993, analyzed and documented project results over a 3 year period. The evaluation concluded that even though the project had provided significant support for improving MSP planning and administration, the project as designed would not

meet its objectives due primarily to a lack of strategic planning and absence of cohesive project activities needed to bring about sustainable, long-term benefits.

Fourth, new USAID health sector policies discussed below point the way to more effective strategies for achieving sustainable health sector development and alleviation of poverty.

There now exists a unique opportunity for USAID to support policy reform for health sector structural change. Improved allocation of health sector resources and increased fiscal savings are achievable through greater private sector participation in the delivery of health care services. There is also considerable potential for USAID project assistance to mobilize other donor resources for policy reform and increased CS/PHC services.

Redesigned Project Goal, Purpose, Components and Strategy

The **goal** of the amended CS Project remains the same: to improve the health of infants, children and mothers in Ecuador. The project **purpose** is to improve the effectiveness of child survival and primary health care programs and interventions nationwide with a focus on the poor in rural and peri-urban communities. Specific health services to be promoted as child survival and primary health care interventions include prevention, control and treatment of neonatal tetanus and other immunizable diseases, diarrheal diseases, acute respiratory infections, avitaminosis A, iron anemia and low birthweight; and increase in professional attended or institutional births.

The following three **project components** will address the primary constraints upon improving child survival indicators. 1) A **MSP Public Policy Support** component will provide assistance for MSP policy development to improve resource use, strengthen the production and distribution of PHC services in specific health areas, and to foment the expansion of private sector services. Policy development under the redesigned Child Survival Project is seen as a process beginning with identification of areas requiring improvement, analysis of options, articulation and implementation of new policies. When this Project Paper Amendment refers to policy developments, it is referring to achievement of articulation and implementation of new policies. 2) A **Policy Analysis and Advocacy** component will develop an independent private sector think tank capability for policy analysis, formulation, dissemination and advocacy. Primary emphasis will be on policies which support targeting and the other policy objectives discussed below. Policy development activities under this component will articulate with policy development objectives and activities under the MSP Public Policy Support component. The project counterpart for both the MSP Public Policy Support and the Policy Analysis and Advocacy components will be the Ministry of Health (Minister or his/her designates). 3) A **Nongovernmental (NGO) Program Strengthening** component will assist the private sector in developing mechanisms to provide more effective and sustainable CS/PHC health services. Private sector health care demonstration projects will be replicated in health areas throughout the country. The project counterpart for this component will be the recently established MSP/NGO Coordinating Office, and this component will be implemented by an international PVO.

The overall **strategy** of the amended project is to support the development of the MSP Policy Guidelines leading to a more efficient and effective health sector. While there are a number of important policy objectives, and while all objectives lead to the same overarching objective of improving availability of, access to, and impact of health services available for the poor, five specific objectives have been identified during the redesign process which are of the highest priority.

1. **Targeting and equity improvement:** targeting of **public** health resources on issues of public health and the needs of the poor. This involves improved targeting of public sector resources through policy articulation, planning, and so forth; and removal of subsidies to

the middle class (such as subsidization of the costs of individual curative services for middle class users who otherwise could and should pay)

2. **Improved role rationalization:** general improvement in the definition, demarcation and coordination of roles/functions between the major health sector institutions or subsectors (e.g. MSP, IESS, private sector), such that the public sector focuses on "public goods."
3. **Expanded and improved role of the private sector:** to serve as the principal producer of health services in the country, including CS/PHC services, especially for populations other than the poor; and the primary producer of "private goods."
4. **Decentralization:** local autonomy over programmatic and resource use decision making.
5. **Improvement of public sector financing of health services:** increased revenue generation and rationing of services through user fees, removal of hidden subsidies which exist due to current patterns of provision of free services for middle class populations, and improved allocation of resources toward appropriate services (i.e. reduction of public expenditure on tertiary facilities, increased expenditure on preventive and other essential services, interventions using appropriate levels of technology, and services benefiting greater numbers of people in target populations).

The **strategy for policy analysis and advocacy** is a two-pronged approach that will: 1) establish a local private sector "think tank" institutional capability to analyze policy options, disseminate information and facilitate the decision-making process; and, 2) provide technical assistance and training on behalf of the MSP in support of policies which rationalize the allocation of health resources in the public sector, and support public/private sector partnerships for more effective CS/PHC service delivery. The **strategy for strengthening private sector health care organizations** is to provide technical assistance training to a broad array of NGO health care providers, whose target populations are low- and marginal-income rural and peri-urban communities. This strategy grows out of and adapts the most recent strategy developed by USAID at the global, regional, and program level. The table on the following page shows relationships between project components and policy objectives.

Links to USAID Strategies

Links to Broad Agency Strategy: The Agency document *Strategies for Sustainable Development* (March, 1994) states that global threats to peace come from a multitude of sources, including continuing poverty, population growth, and new diseases. In order to address these threats, the Agency has focused on stabilizing world population growth and protecting human health as one of its four main goals. The operational approach of the Agency in this regard concentrates on the theme of sustainable development based on participation of the people (i.e. the beneficiaries), partnerships with host governments, NGOs, and other donors, and integrated approaches and methods which take into account programs and objectives of other USAID activities. The Project Amendment strongly supports these policy guidelines of the Agency through policy dialogue and advocacy for structural change and rationalization of resource allocation within the MSP and the public health sector as a whole. The project, through policy advocacy and NGO strengthening, will also support Agency objectives for sustainable development and public/private sector partnerships. Other donor mobilization of resources is also an important aspect of the project. In line with USAID/W's new *Implementation Guidelines* (distributed in draft form in January, 1994), The CS Project will contribute to the sustainable development of health services, both in the public and private sectors. The CS Project seeks to improve quality of life, broad-based participation, and effective institutions, corresponding generally to democratization goals. Activities contemplated within the project pursue a systemic effect within the health sector, including redefinition of institutional roles,

POLICY OBJECTIVE	INDICATORS	SIGNIFICANT RECENT DEVELOPMENTS	MAJOR STAKE-HOLDERS
Targeting	Reduction in the number of Ecuadorians not covered by health services from approximately 30% currently (3 million of the poorest Ecuadorians) to 20% in the year 2000.	Evidence of private sector responding to physician oversupply by moving away from large cities. MSP <i>Guidelines</i> and proclamations about focusing on populations in need.	Rural communities
Improved role rationalization	Articulation and implementation of an MSP policy stating its institutional mission as focusing on <i>public health</i> (i.e. immunizations, norms and standards, environmental control, vector disease, service provider of last resort). Articulation and implementation of an IESS policy to separate the functions of financing and producing health services, and to shift from being a major health sector service provider to major financier of services; and specific modifications in the structure of IESS benefits to include more CS/PHC services.	MSP pronouncements of role as "rector of the health sector." IESS reform issues. IDB design process considering IESS/SSC.	IESS affiliates IESS labor unions
Expanded and improved role of the private sector	Increased private sector production of health services through NGOs (for profit and non-profit), local municipalities and authorities, as evidenced by an increased number and proportion of health services produced and an increased number of people covered. Increased public/private sector collaboration in management of health areas, such as NGO involvement in the administration of public resources and programs in 10% of all MSP health areas. 500,000 previously uncovered people receiving coverage from private sector providers.	Evidence of private sector responding to physician oversupply by moving away from large cities. Policy observation tours by MSP policy and decision makers. Establishment of NGO liaison office in MSP.	MOH staff in health centers, subcenters, hospitals in which NGOs will be involved
Decentralization	Locally generated resources used for local level programming, to improve coverage and quality. Financial and personnel management decisions devolved to the health area or provincial level. Budgets and activities programmed and executed at the health area level.	Publication of <i>MSP Policy Guidelines</i> . Publication of <i>New Budgeting Law</i> ; new budgeting procedures within MSP supported by FASBASE to enable local level programming. Guidelines by MOF and MSP to allow local retention of user fee revenues.	Provincial level personnel Health area level personnel

Improvements in the availability and use of financial resources	10% of MSP facility-level operational costs recovered through fee for service mechanisms.	MSP decision to design and implement a user fee system.	General public which will lose access to free services
	Discontinuation of provision of free curative services for patients able to pay.	MSP decision to design and implement a user fee system.	Health center personnel
	Increased proportionate allocation of resources toward preventive services, interventions using appropriate levels of technology, and services benefiting greater numbers of people in target populations.	Policy statements about improving financing of health services and efficiency of resource use.	Hospital-oriented personnel

enhanced resource generation and improved resource allocation. The Project will contribute to economic growth in the tertiary (service) sector. The project will concentrate on catalytic programs. It will coordinate closely with other donor projects, and is fully consistent with policy objectives and strategies of other major donors, such as those described in the document World Bank Development Report 1993: Investing in Health.

Links to Agency Child Survival Strategy: USAID has recognized that a sustainable approach to child survival requires improving the ability of the health sector to produce and deliver child survival services. This involves technical, institutional and structural approaches. This has been articulated in the recent Child Survival Program evaluation entitled *A.I.D.'s Child Survival Program: A Synthesis of Findings from Six Country Case Studies* (USAID Office of Evaluation/CDIE, October 1993). As discussed in the body of this Project Paper Amendment, the redesigned project responds across the board to the recommendations made in the CDIE document.

Links to LAC Bureau Strategy: LAC Bureau strategy is to promote sustainable development based on broad participation of the citizenry, strengthening of partnerships, and the advancement of integrated approaches and methods. In this vein, the project amendment is in line with LAC's emphasis on increasing access to basic health services on a self-sustaining basis. Policy support for MSP initiatives to improve decentralization, quality, coverage, and cost recovery is clearly within the scope of LAC's intent. In addition, by engaging the private sector, including NGOs, community organizations, cooperatives, and other similar groups, to assume greater responsibility for delivery of health care, the CS Project will favor equitable access to services and empower communities to take charge of their own welfare. Support for an appropriate public-private mix of basic health services is a goal of the project; in this context, close coordination with other donors, such as the World Bank, IDB, PAHO, and UNICEF, is a critical requirement.

Poverty Alleviation: The redesigned Child Survival and Health Project will make a significant contribution to alleviation of poverty in three main ways. First, it will improve the conditions of poor health which contribute to poverty, enabling people to be more productive, and enabling families to generate more income while saving the scarce resource consumed on treatment of preventable diseases. Second, it will result in a direct transfer of benefits to the poor; for example, an Ecuadorian Institution (PREALC) estimated spending for mother-child health services alone represented an annual benefit of US\$ 38.2 for poor families in 1991, equal to 7.4% of average annual income. Third, by providing improved coverage and access specifically for the poor, the project will help alleviate the consequences of poverty, illness and death which afflicts the poor at rates much higher than the general population.

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Training

A number of training objectives are included in the project to address the dearth of trained professionals in the areas of health administration and health economics. First, support will be provided to an Ecuadorian University (e.g. Universidad Politécnica del Litoral in Guayaquil or Universidad San Francisco de Quito or others) to establish self-sustainable postgraduate degree or certificate programs in health administration and health economics. It is expected that the majority of trainees during the course of the project will be trained in health administration and health economics, and will be recruited from participating NGOs as well as other public and private institutions; beyond direct building of a skill base within the health system, their effect on the sector will be to establish formal training in health administration and health economics as a major factor in selection in key management and planning positions. Second, short term offshore training will enable leaders from governmental and community groups to develop an understanding of policy and managerial issues and alternative models, and to develop skills to improve their ability to develop and implement programs within Ecuador. Third, four individuals will be selected to pursue Master's degrees in health economics in U.S. universities; there are currently no health economists in Ecuador. These individuals will be selected from within the implementing institutions under agreements providing for their return to those institutions for the remainder of the project. Returning to work in 1996-1997, they will form a nucleus to establish economic analyses as well as university-based training in health economics. Offshore training will be implemented through a "buy-in" to the Mission's training program (e.g. the CLASP Project or and the upcoming Training for Development Project).

Project Implementing Agencies

To carry out the above strategy, the project will provide direct support to the Minister of Health and the MSP/NGO Coordinating Office through technical assistance and training initiatives. The project will fund a Cooperative Agreement with CEPAR, a local private, non-profit institution for establishing a policy analysis and advocacy capability, and another Cooperative Agreement with CARE, an international PVO, to serve as the primary channel of project NGO technical and financial assistance. All project counterpart entities will receive technical assistance and training from both offshore sources procured by the USAID and in-country expertise funded under the Cooperative Agreements.

End-of-Project-Status (EOPS)

The following verifiable conditions will be present by the end of the project.

- As a result of improved targeting and improved efficiencies, the non-covered population will be reduced from approximately 30% in 1994 to 20% in the year 2000, of which approximately one half, or 500,000 people, will be receiving coverage from private sector providers.
- Institutional role and functional definitions will be improved, as measured by the presence of policy statements within major institutions and by the presence of a draft unified national health sector policy and regulations. Specific content of these statements will include:
 - *MSP* -- articulation and implementation of a policy stating institutional purpose as focusing on *public health* (immunizations, norms and standards, environmental control, vector disease, service provider of last resort);
 - *IESS* -- articulation and implementation of a policy to separate the functions of financing and producing health services, and to shift from being a major health sector service

- provider to major financier of services; and specific modifications in the structure of IESS benefits to include more CS/PHC services;
- *Private Sector* -- assumption of the role of primary producer of health services through NGOs (for profit and non-profit), local municipalities and authorities, as evidenced by an increased number and proportion of health services produced and an increased number of people covered.
- The MSP will be recovering 10% of its health care facility-level operational costs through fee for service mechanisms. These new resources will be used for local level programming, to improve coverage and quality.
- An independent private sector policy analysis and advocacy capability will be established. This "think tank" will be promoting policies for more efficient institutional role definition, and improved market conditions for private sector participation.
- A mechanism for coordination among NGOs working in the health sector will exist.
- There will be increased public/private sector collaboration in management of health areas, to the extent that NGOs will be involved in the administration of public resources and programs in at least 10% of all MSP health areas; and within these areas, NGOs will be more involved in the production and delivery of health services.
- NGO health care delivery mechanisms will be strengthened, and replicable models of privately produced CS/PHC services will be developed which will serve as demonstration models and field experiments of new ways of producing and distributing primary health care services to poor populations. **Twenty-five** project NGOs will producing services with a mix of at least 20% preventive and 80% curative. **Ten** NGOs will be producing services which are 100% self-financing.

Legal Basis for Policy Changes

The legal basis for the changes to be pursued under the redesigned Child Survival Project exist under the Constitution of the Republic of Ecuador and the Health Code of 1971. Therefore there are no known legal barriers to the changes sought by the project. Policy changes sought will be brought about at the operational level, consisting of procedural and organizational changes that can be accomplished by mandates and decrees.

Amended Project Budget

The proposed Project Amendment will initially reprogram pipeline funds of approximately \$6 million to support project activities over a 2-3 year period. Beginning in FY 96, it is anticipated that an additional \$5.8 million will be added over the remainder of the project to enable full funding of the redesigned project at the level of \$12 million, bringing the total Life of Project (LOP) USAID funding to \$18 million. Counterpart contributions for the amended project are estimated at \$18.8 million (51% of total project budget), of which \$4.7 million correspond to the reprogrammed budget (28% of the reprogrammed amount). The Project Amendment will extend the LOP for four and a half years, from December 31, 1994, to May 31, 1999. The following tables provide summary budgets for reprogrammed activities and for the Life of Project (LOP), and a graphic depiction of the sequence of programming for the amended Child Survival and Health Project.

PROGRAMMATIC SEQUENCE AMENDED CHILD SURVIVAL AND HEALTH PROJECT				
Project Paper Amendment Authorization 				
Current Activities	\$6 million		\$2.1 million	
Redesigned Activities			\$9.9 million	
	1989 - 1993	1994	1995	1996 - 1999

CS PROJECT AMENDMENT SUMMARY BUDGET (In US\$ * 1,000)						
	REPROGRAMMED BUDGET			LIFE OF PROJECT BUDGET		
	USAID	COUN- TERPAR T	TOTAL	USAID	COUN- TERPAR T	TOTAL
ORIGINAL DESIGN ACTIVITIES	2,300	2,000	4,300	8,100	16,130	24,230
MSP SUPPORT	505	800	1,305	505	800	1,305
CEPAR CA	2,630	700	3,330	2,630	700	3,330
CARE CA	4,180	1,130	5,310	4,180	1,130	5,310
TRAINING	635	0	635	635	0	635
INTRN'L ADVISOR	1,155	0	1,155	1,155	0	1,155
OTHER	225*	30	255	225	30	255
CONTINGENCIES	570	40	610	570	40	610
TOTAL	12,200	4,700	16,900	18,000	18,830	36,830

* Includes Audit 120 and Evaluation 105.

Conclusion and Recommendations

The table on the following pages summarizes project strategy, activities and outputs. The redesign of the project responds to developments and opportunities in the health sector in Ecuador. It will support the GOE as it provides leadership in improving public policies, market conditions, and resource use, and it will improve coordination among major institutions and donors in the health sector. Through expanded coverage and improved efficiency, the CS Project will result in a decrease in maternal and child morbidity and mortality and help alleviate the conditions of poverty which

Addendum to pg. 37 of Project Paper Amendment.

CHILD SURVIVAL AND HEALTH
PROJECT NO. 518-0071

AMENDED PROJECT BUDGET (6.21.94)

ITEM	ACTUAL	CHANGES TO NON-EARMARKED FUNDS			NEW OBLIG.*	TOTAL
	BUDGET	CURRENT	CHANGES	REVISED	FY96-FY98	BUDGET
01 TRAINING	\$1,206,252	\$56,569	\$0	\$56,569	\$0	\$1,206,252
02 TECHNICAL ASSISTANCE	\$5,441,000	\$1,470,670	(\$1,000,000)	\$470,670	\$600,000	\$6,041,000
03 COMMODITIES	\$3,260,000	\$15,543	\$0	\$15,543	\$0	\$3,260,000
04 OPERATING COSTS	\$300,000	\$88,379	\$0	\$88,379	\$0	\$300,000
05 PRIVATE SECTOR INITIATIVES	\$1,436,979	\$531,909	(\$500,000)	\$31,909	\$0	\$1,436,979
06 EVALUATIONS AND AUDITS	\$210,000	\$71,096	(\$71,096)	\$0	\$75,000	\$285,000
07 CONTINGENCIES	\$265,769	\$23,082	\$21,096	\$44,178	\$60,000	\$345,769
08 AUDIT	\$80,000	\$46,634	\$0	\$46,634	\$40,000	\$120,000
09 HEALTH FINANCING	\$0	\$0	\$0	\$0	\$0	\$0
10 CEPAR CA	\$0	\$0	\$350,000	\$350,000	\$1,650,000	\$1,650,000
11 CARE CA	\$0	\$0	\$900,000	\$900,000	\$2,500,000	\$2,500,000
12 INTERNATIONAL ADVISOR	\$0	\$0	\$300,000	\$300,000	\$855,000	\$855,000
PROJECT TOTALS	\$12,200,000	\$2,303,882	\$0	\$2,303,882	\$5,800,000	\$18,000,000

* Subject to availability of funds.

place a constant drain on the ability of Ecuador to achieve sustainable development. And, owing to a highly collaborative redesign process which incorporated key GOE officials, representatives of the proposed implementing organizations, USAID management, staff and technical consultants, a sound working relationship and coordination mechanism between the various counterpart entities has already been established. It is expected that this will greatly facilitate project implementation.

The Project Redesign Committee^{*} recommends approval of this Project Paper Amendment in the amount of \$12.2 million, for a LOP USAID funded total of \$18 million, with a PACD extension to May 31, 1999.

^{*} Members of the Project Redesign Committee making this recommendation are: Ken Yamashita, Committee Chairperson, GDO; Peter Lapera, PPD; Paula Goddard, PPD; Patricio Maldonado, PPD; Guillermo Jáuregui, PPD; Ellen Leddy, GDO; Patricia Rodríguez, GDO; Paulyna Martínez, GDO; Laurence Day, GDO; Jeffrey Borns, RLA; Marcus Stevenson, RCU; Thomas Tottino, CONT; and James Watson, SEGO.

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SUMMARY OF PROJECT STRATEGY, ACTIVITIES AND OUTPUTS

COMPONENT AREA	PC1 PUBLIC POLICY SUPPORT	PC2 POLICY ANALYSIS AND ADVOCACY	PC3 PRIVATE SECTOR PROGRAMS
PROBLEM CLUSTER	Poor focus on public health and preventive services and uncontrolled production costs and inefficiencies limit public sector ability to sufficiently produce and deliver primary health care (PHC) services	Presence of poorly developed or unclear market signals and specific policy constraints which hinder the ability of both public and private sector providers to expand production of basic health services and to improve efficiencies	Inadequate availability of and access to (supply of and demand for) privately produced basic health services
PRINCIPAL CAUSES	<p>Closed production systems (i.e., both the MSP and IESS finance, produce and deliver their own services, even when there is widespread duplication)</p> <p>Expensive curative services and unproductive resource use result in excessive drain on public budget and insufficient allocations for primary health care services</p>	<p>Insufficient alignment of public sector policies with sector needs to ameliorate supply and demand problems and to foster private sector growth</p> <p>Lack of coordinated analysis and information dissemination to modify policy and regulatory constraints</p>	<p>Lack of technical and managerial expertise to plan, organize and produce affordable basic health services in the marketplace</p> <p>Poorly organized demand which limits the purchaser base for privately produced services</p>
PROJECT OBJECTIVES	<p>To improve health service financing in the MSP, primarily through user fees</p> <p>To increase public/private collaboration and privatization, particularly greater NGO involvement in the production of health services financed in the public sector</p> <p>To improve intrasectoral coordination, primarily involving support of improved MSP-IESS resource coordination</p>	To develop an independent research, analysis, information dissemination and advocacy capacity; in other words, a "think tank," which will be able to promote improved role definition in the public sector and improved market conditions in the private sector	<p>To develop a managerial and technical support organization which can provide information and technical assistance to NGO providers</p> <p>To develop replicable models of privately produced PHC services</p>
PROJECT INTERVENTIONS	<p>User fees for services to raise additional revenues and to decrease the hospital burden on the public budget</p> <p>Privatization or public/private collaboration to improve administrative efficiencies and lower costs</p> <p>Intrasectoral (MSP-IESS) coordination to decrease duplications and inefficiencies</p>	Development of research, analysis, information dissemination, and advocacy capability to address public policy and private production constraints	Development of private production and delivery models which produce low-cost services for the general population; models may include fees-for-services, prepayment, 3rd party payments, shared risk or publicly-financed purchases

<p>IMPLEMENTATION MECHANISMS</p>	<p>MSP Office of the Minister</p> <p>MSP Office of NGO Coordination</p> <p>USAID procured TA through buy-ins</p> <p>USAID managed observational study tours (offshore training)</p>	<p>Cooperative Agreement with CEPAR</p> <p>USAID procured TA</p> <p>USAID managed offshore training</p>	<p>Cooperative Agreement with CARE</p> <p>USAID procured TA</p> <p>USAID managed offshore training</p>
<p>END OF PROJECT STATUS</p>	<p>MSP will refocus resources on <i>public health</i>.</p> <p>IESS will develop policy of separating financing from production of health services, and shift from being a major health sector service provider to major financier of services.</p> <p>IESS benefits will include more CS/PHC services.</p> <p>The MSP will be recovering 10% of its health care facility-level operational costs through fee for service mechanisms.</p> <p>There will be increased public/private sector collaboration in management of health areas, to the extent of NGO involve in the administration of public resources and programs in at least 10% of all MSP health areas; and within these areas, greater NGO involvement in the production and delivery of health services.</p>	<p>An independent private sector policy analysis and advocacy capability will be established. This "think tank" will be promoting policies for more efficient institutional role definition, and improved market conditions for private sector participation.</p>	<p>The private sector will become the primary producer of health services through NGOs (for profit and non-profit), local municipalities and authorities.</p> <p>NGOs will be involved in the administration of public resources and programs in at least 10% of all MSP health areas</p> <p>A mechanism for coordination among NGOs working in the health sector will exist.</p> <p>Replicable models of privately produced CS/PHC services will be available to serve as demonstration models</p> <p>Twenty-five project NGOs will producing service with a mix of at least 20% preventive and 80% curative.</p> <p>Ten NGOs will be producing services which are 100% self-financing.</p>
<p>The non-covered population will be reduced to approximately 20%.</p>			

<p>PROJECT OUTPUTS</p>	<p>An NGO Coordinating Office will be established by the MSP, including systems for the analysis, documentation and practical application of public/private sector partnerships for the management, administration and delivery of CS/PHC services within designated health areas.</p> <p>CS/PHC services delivered by NGOs will be increased including immunizations, institutional births, diarrheal disease prevention and treatment, acute respiratory infection prevention and treatment.</p> <p>Project will provide technical and financial assistance to 25 NGOs with service catchment areas totalling at least 250,000 people;.</p> <p>10 out of 25 project NGOs will be capable of fully recovering facility level operating costs by PACD.</p>	<p>National health sector policy analyses will be completed.</p> <p>Policy fora will be held.</p> <p>Technical analyses will be carried out.</p> <p>Coordinated "message" dissemination activities will be carried out by CEPAR for public and decision-makers and health care service beneficiaries, including formative market research studies; policy options analysis and educational materials developed, field-tested and produced based on market research; media campaigns and media spot services.</p>	<p>CS/PHC services delivered by NGOs will be increased including immunizations, institutional births, diarrheal disease prevention and treatment, acute respiratory infection prevention and treatment.</p> <p>Project will provide technical and financial assistance to 25 NGOs with service catchment areas totalling at least 250,000 people;.</p> <p>10 out of 25 project NGOs will be capable of fully recovering facility level operating costs by PACD.</p>
<p>OUTCOMES</p>	<p>Increased access availability of and to PHC services resulting in lowered morbidity and mortality from diseases amenable to PHC interventions</p>		

II. BACKGROUND AND SETTING

A. Child Survival and Primary Health Care in Ecuador

1. *Economic Background and Health Status Indicators*

This section summarizes conditions, factors and institutions in the health sector. Greater detail can be found in the *USAID Mission Child Survival Redesign Concept Paper* (1994) and in the *USAID Mission Health Sector Strategy* (1993), provided as Bulk Annex B-8 and Bulk Annex B-9 to this Project Paper Amendment.

The quadrupling of oil prices during the mid-1970s propelled the Ecuadorian economy to an unprecedented economic boom. During the 1980s, however, a decrease in oil production and prices on the one hand, and an increase in interest rates and debt burden on the other, produced a series of severe fiscal crises. Over this period, *per capita* GDP declined from US \$1,415 to 1,000, such that *per capita* income in 1990 was below 1978 levels. At the same time, debt payments increased from 12% to 30% of the fiscal budget and *per capita* government social spending decreased from US \$161 to 115. In the 12 year time frame from 1978 to 1990, the incidence of poverty in urban areas increased from 45% to 52% of the population, while the informal sector expanded from 15% to 24% of the economically active population. In addition, the minimum wage declined by 64% in real terms.

Despite deteriorating economic indicators -- demonstrating that most Ecuadorians were economically worse off during the 1980s than in the 1970s -- health indicators show significant gains in health status. For example, infant mortality decreased from 72 to 53 per 1,000 live births, with rural infant mortality falling from approximately 70 to 63 and maternal mortality declining from 2.0 to 1.6 (per 10,000 births). In terms of total fertility, the rate declined from 5.35 in 1979 to 3.83 in 1989. Overall mortality rates due to transmissible and infectious diseases fell from 3.83 to 2.12, while mortality due to preventable diseases, representing nearly 50% of all mortalities in 1980/81, was reduced to 37% by 1990-91.

It is generally accepted that the above improvements in health status were the combined result of GOE policies and resources, and support from multilateral development organizations, which promoted the extension of low-cost basic health care services (e.g., immunization, prevention and treatment of infectious diseases) to specific low-income groups, rural residents, mothers and children. NGOs have also begun to focus their assistance programs on health care delivery services to low income population groups. Despite these improvements in the Ecuadorian health sector, it is widely held that the government has not been successful in addressing the primary health care needs of Ecuadorian children and infants, particularly within non-urban areas.

When comparing national health indicators in Ecuador there exist large statistical imbalances between urban and rural areas and indigenous and non-indigenous populations. Mortality rates suggest that Ecuador can be divided into two distinct epidemiological categories: one in which urban migration and an increase in basic health services in urban areas have prompted a transition in health status, suggesting more of the profile of a developed nation -- with an increasing incidence of chronic-degenerative disease; and the other a decidedly underdeveloped, rural and somewhat indigenous Ecuador, in which infectious and communicable diseases predominate and maternal-child mortality rates are high.

Although the infant mortality rate and incidence of infectious diseases in rural areas declined slightly during the 1980s, childhood diseases, together with nutritional deficiencies, remain the major causes of mortality. Most infant and child mortality in rural areas can be attributed to diarrheal diseases, vector-borne diseases, respiratory infections and protein-energy malnutrition. Tuberculosis is among the top five causes of adult mortality and is on the increase, especially in the Central Sierra region. In some coastal areas, particularly in the Esmeraldas Province, morbidity due to malaria has increased four-fold during the past decade.

Table II.1 compares selected economic, health status, and access indicators for both urban and rural areas. The table shows that rural residents have half the income, register double the poverty incidence, and suffer a significantly higher rate of infant mortality than their urban counterparts. The urban population also has considerably more access to basic water, sanitation, and PHC services. Moreover, health status indicators are alarmingly poor in areas where indigenous populations predominate. A case in point is the Central Sierra region which has the highest mortality rates in the country -- and where indigenous groups make up the majority of rural inhabitants (see Table II.2).

The current estimate of the infant mortality rate (IMR) for Ecuador is 53 per 1,000 live births. National statistics indicate that the IMR has decreased steadily over the past 20 years at an average of 2.4 deaths per 1,000 live births per year. However, while post-neonatal mortality has declined by 1.8 deaths per year or 70% over the last 20 years, neonatal mortality has declined by an average of only 0.6 deaths per year and now constitutes two-thirds of all infant deaths, up from one-half in the late 1960's.

TABLE II.1
SUMMARY STATISTICS ON URBAN AND RURAL AREAS, VARIOUS YEARS

INDICATOR	YEAR	URBAN	RURAL	SOURCE	
<i>General Development Indicators</i>					
% TOTAL POPULATION	1990	55	45	Census, 1990	
AVG. MONTHLY INCOME (US\$)	1980	1,746	799	Janvry, et al. (1991)	
POVERTY INCIDENCE (%)	1980	23.6	48.6	Janvry, et al. (1991)	
% EAP INFORMAL/TRADITIONAL	1990	39	65	INEC, 1992a,b	
<i>Health and Demographic Indicators</i>					
INFANT MORTALITY ¹	1979-89	34	58	ENDEMAIN, 1992	
CHILD MORTALITY ²	1979-89	10	21	ENDEMAIN, 1992	
TFR ³	1984-89	3.1	5.0	ENDEMAIN, 1992	
DIARRHEA PREVAL. CHILDREN <5	1989	23	27	ENDEMAIN, 1992	
CHRONIC MALNUTRITION	SIERRA COAST	1982 1982	50 42	70 47	CONADE/Freire, 1987
<i>Access Indicators</i>					
% SAFE WATER	1990	74.7	31.2	Census, 1990	
% SANITATION	1990	95	47	Census, 1990	
% PROF. ATTENTION AT BIRTH	SIERRA COAST	1984-89 1984-89	87 ⁴ 96 ⁵	48 60	ENDEMAIN, 1992

¹ Deaths of infants less than 1 year of age per 1,000 births. ² Deaths per 1,000 children 1-4 years of age. ³ Total Fertility Rate. ⁴ Quito. ⁵ Guayaquil

TABLE II.2
CENTRAL SIERRA REGION AND NATIONAL LEVEL
SELECTED DEMOGRAPHIC AND HEALTH STATUS INDICATORS, 1989/90

PROVINCE	% RURAL	% INDIGENOUS	INFANT MORTALITY RATE	GENERAL MORTALITY*	
				INDIG.	NON-INDIG.
IMBABURA	53	26	52.7	14.5	7.6
COTOPAXI	77	53	68.4	15.4	5.9
TUNGURAHUA	59	17	51.7	10.3	7.4
CHIMBORAZO	67	31	50.9	10.8	8.2
BOLIVAR	81	8	41.8	6.7	2.6
CAÑAR	71	37	38.4	4.7	7.0
NATIONAL	45	15	38.6	8.31	6.0

* Per 1,000 inhabitants.

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In addition, there are significant regional and socio-economic differences in mortality rates. The IMR in urban and rural areas of Ecuador ranges from 46 per 1,000 live births per year in Quito to over 80/1,000 in the rural highlands. In some rural areas of Chimborazo, Cotopaxi and Imbabura, the provinces with the highest infant mortality rates, the IMR is reportedly well over 100/1000. Child mortality rates are almost three and one-half times higher in rural areas than in urban areas. Data also show that the greatest declines in the last ten years have been in urban child mortality which declined 67%, and the least in rural infant mortality which declined only 22%. Thus, the statistics support the conclusion that any major reduction in overall infant and child mortality in Ecuador must come from a reduction in neonatal deaths, especially from delivery-related, perinatal conditions, and in rural areas.

The principal causes of death for children under five years, adjusted for under-reporting, are perinatal conditions, intestinal infections, enteritis and diarrhea, respiratory infections, and to a lesser extent malnutrition. The leading causes of neonatal deaths are hypoxia (a deficiency of oxygen reaching the tissues of the body), asphyxia and other respiratory dysfunctions, other perinatal conditions, respiratory infections and congenital anomalies. The underlying cause for a majority of early neonatal deaths is low birth weight and/or prematurity. Deaths from respiratory infections are the largest, single cause of reported infant deaths in Ecuador after perinatal conditions, of which the principal risk factors are young age, low birth weight and poor nutritional status. While the level of diarrheal disease deaths in Ecuador has decreased from 33% to 20% of infant mortality over the past 20 years, diarrhea is still a major killer in dispersed, rural areas, especially along the coast. Also, deaths attributable to vaccine preventable diseases account for about 3% of total mortality of under-fives, and neonatal tetanus may be an important cause of unreported neonatal deaths. Lastly, risk of infant and/or child death is related to a number of environmental, social and demographic factors, including maternal age, socio-economic status, education, parity and time-between-birth intervals.

2. *Health and the Public Sector*

The MSP, the IESS and the private sector, each manage roughly a third of the approximately \$450 million in health sector financial flows. Each of these subsectors are financiers and producers of parallel, closed subsystems of production and delivery of health services. The result of this structural problem is that the health resources used each year do not produce sufficient basic health services to cover the population. A cost comparison of health sector spending and results in Ecuador and Colombia reveals that spending per capita is comparable in these two countries (\$43 in Ecuador and \$49, or 14% more, in Colombia), and there are 20% more physicians per capita in Ecuador. However, as much as 30% of the Ecuadorian population lacks any access to health services, and public health indicators are far worse in Ecuador than would be expected with the level of resources available in the sector. The childhood (under 5) mortality rate is exactly double the rate reported in Colombia, the rate of growth deficiencies is 70% higher in Ecuador, and severe nutritional disorders occur at four times the rate in Ecuador (World Bank, 1993). Comparisons with many other countries with approximately the same levels of spending reveal similar patterns.

Ministry of Public Health: Established in 1967, the Ministry of Public Health (MSP) has traditionally operated through a highly centralized technical and administrative hierarchy, which has provided little operational flexibility to the provinces and local areas. As a result, MSP policy making, norm setting, and service delivery have been largely ineffective in addressing local needs.

With 24,400 employees and a network of 1,521 facilities, the MSP dominates the public sector and is the largest provider in Ecuador. In 1991, the MSP operated 54% of all government and parastatal health facilities, possessed two-thirds of public hospital beds (54% of total beds), and employed 56% of total health personnel in the public sector. According to the 1991 INEC national survey, the MSP provided 51% of public sector and 64% of total acute care hospital discharges (INEC, 1991).

The MSP has expanded its physical infrastructure and personnel considerably in recent years. Between 1981 and 1991, the number of physicians contracted by the MSP doubled while nursing personnel increased four-fold. Total MSP employees grew by two-thirds, from 14,652 to 24,418. Over this same period, the MSP added 1,400 acute beds and 400 ambulatory facilities, representing increases of 23 and 50% respectively (INEC, 1981, 1991).

Although the MSP is the largest provider of health care services in Ecuador in terms of infrastructure and personnel, it does not reach a majority of the population. MSP coverage ranges from one quarter to one third of all Ecuadorians. Approximately 80% of MSP professional personnel are concentrated in urban areas, and there is a considerable over-reliance on and over-supply of physicians at all levels of the health service system *vis-à-vis* nurses and other paraprofessionals.

Under the current GOE administration and its *1993-1996 Agenda for Development*, strategies seek to redefine the role of the public sector, towards a more rational allocation of resources and functions, simplification of institutional structures and administrative procedures, and improved management. Since the early 1990s, the central MSP has been moving to provide tentative norms for decentralizing some financial and administrative functions to the health areas.

Poor management, overly centralized decision making, political patronage, and restrictive labor codes make it extremely difficult to manage local operations efficiently and provide effective child survival services. MSP services are plagued by problems in productivity and sustainability. Facilities suffer from chronic stock-outs of drugs and other supplies and the consequent problems of health care quality. Some hospitals distribute lists of items that prospective inpatients must purchase (from private suppliers) before admission. Medical service delivery is inefficient and generally of poor quality, while medical personnel are often unproductive.

The over-concentration of medical personnel in urban areas, inefficiently produced curative medical care services and production bottlenecks clearly demonstrate that the MSP is not using its resources to their fullest potential for CS/PHC service delivery, resulting in severe impediments to efficiency and sustainability. By operating a vast network of hospitals, health centers, subcenters and posts, and by trying to provide subsidized health coverage for the entire population, the MSP dilutes its limited resources and management capacity to run an effective public health system. **A more appropriate role for the MSP is to focus its resources on providing more cost-effective public health and preventive services, with a special emphasis on impoverished rural areas and as a health service provider for specific target populations**

Ecuadorian Institute of Social Security (IESS): The IESS is an all-encompassing public insurance program that is restricted to employed members of the organized productive sector. Current registration is estimated at 1.8 million. The IESS controls approximately 25% of all health care resources in the sector. It theoretically covers 17% of the population and 28% of the labor force, and although some IESS non-health benefits may reach 17% of the population, actual health coverage falls far short of that figure even though all members have access to IESS services. Excluding the Seguro Social Campesino (SSC: see below) health care coverage and service provision, real or effective national health coverage by IESS may be as low as 4% or 5%.

The actual quality of health benefits provided to beneficiaries are also considered poor in comparison to the levels of financing available. Even though the IESS has a large amount of administrative personnel, hospitals, clinics, and medical staff, demand studies show that IESS health beneficiaries are the least satisfied of all clients seeking health care attention. Dissatisfaction with health service is so pervasive that at least 500,000 of IESS insured have alternative health coverage procured through the private sector. The IESS covers relatively few pregnancies since the majority of beneficiaries are males. Little or no money is spent on preventive care.

Inequalities abound in the IESS health system. Most of the best facilities, including all hospitals, are located in major cities while the poorest provinces have no IESS hospital facilities. Most new construction has also occurred in major urban areas in which are found the best health facilities, highest incomes and best health indicators for residents of these areas.

Seguro Social Campesino (SSC): Founded in 1968, the SSC is a social security regimen providing basic protection to a segment of the rural population against the risks of sickness, maternity, old age, and invalidity. Primary care services are provided by physicians (general practitioners), dentists, and nurse auxiliaries who staff multi-room dispensaries that dot the rural areas. SSC participants also have access to IESS specialty and hospital services in urban areas through a referral system. In 1991, the SSC registered nearly 800,000 affiliates, representing approximately 15% of Ecuador's rural population. SSC coverage has increased steadily since its founding, though coverage extension has fallen short of the goal of 1 million affiliates by 1986 (Resolution No. 413, 1981). SSC services are provided directly through a facility-based network of over 520 dispensaries distributed throughout the country. In 1992, 17% of the dispensaries were without physicians, in part because they are located in very remote, undesirable rural areas.

Although SSC is organizationally a dependency of the IESS, it is not under the direction of the IESS Director General. SSC retains considerable decision making autonomy in terms of planning, investment and operations, and represents a separate and streamlined social security scheme within the IESS social security system. The SSC enrolls workers and families whose major source of income is derived from agricultural activities, and provides them with a limited package of primary medical care. The IESS caters to formal sector workers (not their families) employed in private industrial and commercial firms as well as government agencies, with the objective being the provision of comprehensive coverage.

3. *Health and the Private, Non-profit and Commercial Sectors*

Private physicians: Even though the demand data show that private providers are the main source of health care in Ecuador, there is little information on their services. The following table provides estimates of the supply of physicians.

**TABLE II.3
GROWTH IN PHYSICIANS BY SECTOR, 1982-1990**

Type of Practice	1982/83 (Habis, 1984)	1990(PAHO\ WHO, 1992)	% Change
All Private:	3,675	9,074	147%
-Individual	n.a.	4,708	
-Group	n.a.	1,248	
-Hosp.& Clinics	n.a.	3,118	
All Government:	4,764	6,035	27%
TOTAL	8,439	15,109^{2*}	56%

^{2*} Since most physicians in the public sector are only employed on a part-time basis, there may be some over-estimation of the number of physicians in this category.

The table shows that private sector physicians are the largest and fastest growing cadre of providers in Ecuador. Most are in individual practices, simple one-person operations with little linkage to any kind of referral network. This reflects the most inefficient mode of health service production. There are several reasons for this pattern, but what is common to both individual and group practitioners is that they both are largely unorganized. Reasons for this lack of organization include:

- Absence of any tradition of group practice in Ecuador.
- Lack of management capability or training to organize group practices and provide market services.
- Physician need for two or three different sources of income.
- Lack of organized demand that in other countries stimulates the organization of health care supply.
- Private practitioners typically do not have admitting privileges at the larger private hospitals, and few of their patients can afford the fees of private institutions.

Private hospitals: There are several large private hospitals in Ecuador. The two best known are the Metropolitano in Quito with 126 beds, and the Voz Andes Hospital in Quito with about 75 beds. The remainder are small hospitals with 10-20 beds. In the 1991 INEC survey, a total of 235 private hospitals were listed in the country. As the following table illustrates this is a considerable expansion over the figure for 1981.

The table shows that the growth in private hospitals was greatest in the period 1981-1986. The same period also showed diversification away from the two main provinces of Pichincha and Guayas. Both trends slow considerably in the most recent five-year period. Private hospitals have an increasing share of the total bed capacity of the country. Moreover, the number of physicians employed by these hospitals has grown correspondingly with the increase in private facilities.

TABLE II.4
GROWTH IN PRIVATE HOSPITALS, 1981-1991

Year	Number of Private Hospitals	% in Pichincha and Guayas	% in El Oro, Manabi, Azuay, Tungurahua, Los Rios	% Other Provinces
1981	134	61.2%	29.1%	9.7%
1986	198	51.2%	33.9%	14.9%
1991	235	50.9%	34.0%	15.1%

Source: INEC, 1981; INEC, 1993.

Cooperative-based and employment-based services: There are a number of examples of cooperatives setting up small health care outpatient facilities for members and employees (a USAID sponsored study of cooperatives in Ecuador is currently underway). These usually take the form of small on-site clinics, or arrangements with local physicians and clinics for the provision of periodic services. In the case of large employers, clinics or dispensaries are set up in collaboration with IESS. There is little apparent emphasis on preventive and primary health care services, even though the main medical problems of cooperative families are communicable diseases such as acute respiratory infections, gastrointestinal infections, and parasitic infections.

Managed Care: There are three HMOs operating in Ecuador, covering less than one-half of 1% of the population. Two are affiliated with single, prestigious hospitals, and the other is a loosely structured independent provider association (IPA) with a relatively wide network of physicians and facilities. These HMOs are struggling even though they cater mainly to upper-income clientele.

Pharmacies and Laboratories: Little systematic information on pharmacies and laboratories is available. There are perhaps 2,000 or so retail outlets in Ecuador. It is safe to say that every city, town, and large village in Ecuador has at least one retail pharmacy. The revenues generated in 1983 amounted to US \$210 million. Undoubtedly, the figure today is closer to US \$400 million. Whereas medicinal drugs are available all over Ecuador, prices are very high. The Government of Ecuador has undertaken a series of programs aimed at keeping prices down and improving access to generic drugs. These programs are subject to the same budget crunch currently experienced by the MSP.

Not for profit PVOs: Private Voluntary Organizations (PVOs) in Ecuador have a variety of forms and funding arrangements, and offer many different types of services. This diversity is especially manifest among the health-related PVOs. There are organizations that specialize in family planning, research, mental health, dentistry, blindness, drug abuse, and alcohol abuse (Fundación Hermano Miguel, 1992). A few of these PVOs specialize in primary and preventive health care.

While only a small percentage of PVOs provide primary health services, some of these have fairly broad coverage in their areas of operation. The HCJB-Voz Andes PVO provides basic preventive and curative services to catchment areas of more than 50,000 people. Similarly, several international PVOs have wide coverage. Catholic Relief Services was serving an estimated 50,000 people, and Plan International 135,000 during the 1980s. CARE and HOPE are also involved in child survival and primary health care activities in Ecuador. Other major PVO providers include the two main family planning PVOs, APROFE and CEMOPLAF.

Armed Forces: Estimates are that the armed forces medical services, including the Military Hospital in Quito, produce somewhat more than 1% of all curative health care services in Ecuador, and less than 1% of preventive services.

Municipalities: Many municipalities in Ecuador produce and deliver health services, mostly limited ambulatory services. Data available from the Municipality of Quito on cost structure costs of production show that it is even more inefficient than the major public sector institutions described above.

Junta de Beneficencia de Guayaquil: Founded in 1888, the Junta de Beneficencia de Guayaquil (JBG) is a charitable society that was created by municipal ordinance to administer social services in the City of Guayaquil. The JBG derives its income from a combination of municipal and central government subsidies, special lottery concessions, municipal taxes and private contributions. Its main source of income comes from its monopolistic control over the national lottery (initiated 100 years ago in 1894), representing over half of its income. Only 2% of its annual income comes from direct central government subsidies. The JBG provides mainly curative services in hospital outpatient clinics. It does not possess ambulatory facilities, nor does it operate organized preventive and promotional care programs.

The JBG is perhaps the only Latin American charitable organization created in the 19th century that continues to provide public services while maintaining full autonomy from government. The founders were convinced that government was incapable of providing public services in a "consistent, effective, and efficient" manner (JBG, 1988). Taking advantage of a 1887 law directing municipalities to establish their independence, legislation (municipal and national) was approved which allowed for full autonomy from government oversight. Municipal codes delegate to the JBG the ownership and management of hospitals, orphanages, graveyards, and mental health institutions. JBG properties and responsibilities have been upheld by national legislation.

The JBG's Luis Venerza Hospital is the largest general hospital in the country, and its Hospital Enrique Sotomayor is the country's largest maternity facility. The JBG serves the population of the City of Guayaquil and its surroundings. It also possesses approximately 20% of public sector beds and

produces 15% of hospital discharges (excluding SOLCA). Demand studies show that it effectively covers between 3 and 5% of the population (i.e. roughly comparable to the IESS)..

B. Definition of the Problem

1. *Public Sector Policies and Production Inefficiencies*

The GOE's *Agenda for Development, 1993-1996* redefines the role of the State as one of "respect for individual freedom and rationality, whereby the government takes on a role as promoter of initiatives, coordinator of efforts, and process regulator." Greater participation of the private sector is called for, with incentives to participate as a partner or manager in health care service delivery.

The MSP policy framework developed in response to the new GOE policies involves the following principles:

- Shared responsibility and activities toward development of health programs with other public sector agencies (local government, NGOs, and community organizations) under MOH leadership.
- Decentralization of MSP administrative and financial operations for service delivery, including the strengthening of local health areas.
- An integrated health service delivery system, with a network of primary, secondary and tertiary levels.
- Development of management systems to achieve effectiveness and efficiency, including computer technology.
- Development of sustainable models of service production and delivery.
- Introduction of the concept of total quality.
- Initiation of a transfer of selected support services to the private sector.

It is apparent that the current set of policy and reform objectives which the MSP has outlined are overly ambitious and, as a set, have not been elaborated or sufficiently presented/promoted so that a consensus of opinion can be achieved. While stated policy is making some headway and the policy dialogue is progressive, innovative, and challenging, clear signs of implementation difficulties are already evident. This is evidenced by apparent contradictions between the MSP stated policies of decentralization, cost recovery and NGO participation, and the implementation mechanisms under discussion in the MSP for these areas.

Policy constraints

- *Closed public sector production system:* the lack of public demand for privately produced services, as discussed above, is a result of policies on the part of the MSP which have kept the MSP system "closed" to outside producers, and the IESS nearly as closed. Policies to obtain needed and acceptable services at the lowest possible cost, wherever those services are produced, need to be developed and implemented.

- **Public sector policies toward NGOs:** While NGO involvement in the administration of public sector facilities and services is ostensibly an objective of MSP policy, the current details of this evolving policy impede NGOs with overregulation and micro-management, limiting the willingness and ability of NGOs to participate.

In addition to policy developments, the most significant recent development has been the advent of the FASBASE Project and concomitant shifts in the MSP toward the local area, in line with the FASBASE focus and the PAHO "SILOS" (*sistemas locales*, or local area systems) strategy. This is predicated upon a belief that operational decisions, planning, procurement and implementation can be handled more effectively at the local level. These programmatic developments, as currently implemented, include discussion of the issues raised above (inefficiency, cost recovery, the role of the private sector, NGO involvement in public sector service delivery, etc.), but include little in the way of concrete plans and strategies to address these problems. Thus, there are key opportunities being missed by the MSP, FASBASE and PAHO to direct resources and activities to address fundamental constraints which limit the expansion and sustainability of primary health care services.

2. *Private Sector Supply and Demand Inefficiencies*

While the public sector experiences a host of difficulties in setting strategies and priorities for using its resources effectively, the private sector also faces a series of constraints which impede its ability to expand its capacity to provide more services to the general population and alleviate the constraints to service delivery by the public sector. Groups of constraints currently affecting the private sector can be described as those affecting supply and those affecting demand.

Supply constraints

- **Inefficient organization:** as discussed above, the private sector is currently unorganized, or rather is organized along the most inefficient production modes of individual practices. There is no significant organization of supply along the lines of expanded group practices, managed care (such as HMOs), network or brokered services (such as IPAs or PPOs), or shared risk.
- **Production below capacity:** mirroring this lack of efficient organization is the poor use of personnel, as the surplus of private sector physicians, and of half-time public sector physicians, is not efficiently used in the production of health services.
- **Poor distribution:** there is no rationalized distribution of supply outside of primary and secondary urban areas though, as discussed above, an observable trend in this direction is already underway.
- **Cost and price inefficiencies:** as a result of the above three factors, the private sector is largely unable to produce services at a cost and price which would increase access and effective demand.
- **Deficiencies in technical skills:** managerial and financial skills which would enable individuals and groups to ameliorate many of the supply and demand constraints are generally lacking in

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Ecuador. There is a lack of professional health care administrators, as well as any formal health administration training program in the country.

Demand constraints

- **Lack of organized or volume purchasing:** there is a general lack of broad-based private financing of health services other than fees-for-services. Cooperative-purchased services, third party payments, and capitation or prepaid services, are very limited in scope.
- **Lack of public demand for privately produced services:** the MSP and IESS could potentially purchase tens of millions of dollars of primary care and hospital services from the private sector, at costs lower than they are able to produce those same services themselves. This market for privately produced services represents an untapped potential which could significantly expand the private sector production base (and control public sector costs).
- **Absence of effective individual financing:** even without third party or public payments, individuals can increase their access to services through deferred payments or other simple financing techniques which are not commonly practiced in Ecuador.

III. PROJECT RATIONALE AND STRATEGY

A. Project Rationale

Conditions in Ecuador have changed since the original Child Survival and Health Project was designed. The government, and particularly the MSP, have developed new policies significantly different from those in place in 1989. The epidemiological profile of the country has changed as well.

MSP Developments

The current GOE administration, through the MSP, initiated its new policy directions in July 1993, entitled *Basic Policy Guidelines for Health Programs: 1993-1997*. This and other documents issued by the GOE describe the health care access and sustainability problems encountered by the public sector and outline areas in which the government intends to respond to contain costs and improve the resource base. The focus of the new policies is on the local level (health areas), and the strategy involves introducing new health service production relationships within the public health sector and between the public and private sectors. These new directions are endorsed by USAID/Ecuador based on their expected impact on access and quality of basic health/child survival services in priority areas of the country.

Another development in the public health sector in Ecuador has been the advent of the FASBASE Project. This \$100 million project is funded with \$70 million in World Bank reimbursable funds and \$30 million in GOE direct contributions. The objective of this eight year project is to expand and improve the MSP infrastructure in 40 health areas and to strengthen health service delivery, including administrative systems in these areas. The scope of FASBASE overlaps in several areas with the current Child Survival Project.

The most important part of FASBASE will be a Basic Health Care component of \$70 million that will support the MSP in strengthening the organization and use of resources for delivering primary health care services. This component emphasizes the provision of services that integrate health promotion, disease prevention, early detection and treatment interventions at MSP facilities. Interventions would include pre-natal, delivery, and post-partum care; promotion of reproductive care including family planning services; child development, including vaccination and nutritional control and supplementation; and prevention of waterborne and acute respiratory infections, including cholera. Many of these proposed activities are similar if not repetitious of the original CS Project, and are programmed at many times the resource levels planned for the CS Project. Other aspects of FASBASE will include a Nutrition component of \$6.4 million, a Basic Sanitation and Safe Water component of \$13.2 million, and a Sectoral Policy and Institutional Strengthening component of \$12.8 million.

CS Project Evaluation

An external project evaluation of the CS Project was carried out in September, 1993, which assessed progress and made recommendations based on the three-year track record of the project. The original project design was built upon lessons learned under the prior child survival project (PREMI). The design recognized that the sustainability of child survival and health interventions at the local

level required **strengthening the administrative and management capabilities of the Ministry of Health** as the key implementing institution. The project included design elements, such as the use of provincial health advisors, to ensure that the institutional strengthening component of the project would reach the provincial and local levels.

The evaluators' findings showed that the original project design failed to clearly identify linkages between institutional strengthening activities and the achievement of the child survival outcomes as specified in the Project Purpose. Without significant child survival activities, it is unlikely that the EOPS indicators could be attributed to the institutional strengthening component of the project. Another major design flaw was the failure to provide for long-term technical assistance inputs for the child survival interventions themselves. Moreover, the technical composition of the project's technical assistance team also emphasized expertise in institutional strengthening. This design flaw resulted in a mismatching or isolation of project activities from both key MSP counterpart units and the established child survival programs.

Although many of the technical assistance activities of the project were considered to be of good quality, they lacked strategic planning and focus. The long-term advisors had a high turnover rate, and left no global vision of how the activities would coalesce to accomplish project objectives. Given the magnitude of technical assistance inputs within the overall project implementation strategy, the evaluators considered the lack of vision and global planning of the technical assistance team as the weakest part of the implementation of the project.

Project implementation delays and management difficulties led to the accumulation of a significant pipeline (approximately \$7 million) of project funds. Ministry counterpart contributions, on the other hand, actually exceeded projections. The current opportunity costs of the project to the Ministry support a decision to refocus the project to improve allocation of MSP resources, reduce the cost of service delivery in many health areas, and leverage other donor resources for more effective provision of health care services.

Private Sector and Demand

Source of Care by Households: A composite of available data show that consumers in Ecuador use the private sector health care services more than any other source. Specifically, they rely heavily on private clinics and private doctors' individual practices. This is especially true for outpatient care including less serious illnesses, and MCH and family planning care. The Fundación Eugenio Espejo (1988) survey is the only one which contains data on source and income data and which projects trends. Higher income groups rely more on the private sector and the IESS, while lower income groups tend to use more MSP and SSC services. Nevertheless, the data show that more people in the lowest income group rely on the private sector than the middle income groups. These findings suggest that the public services may not be as accessible to lower income groups as they are to the middle and higher groups, and that lower income people are choosing the private sector based on the availability and quality of service.

Type of Care: Although there is a high demand for private sector health services, most services provided by the private sector are defined as curative. Even though private sector services tend to be curative, the private sector does produce a significant volume of preventive services; approximately

17% of all preventive services are provided by NGOs. The private sector is the major provider of combined maternal child health and family planning services, though in the area of maternity services and well-baby care the public sector (MSP and IESS together) significantly exceeds the provision of care by the private sector (67% versus 31%, and 59% versus 27%, respectively). For prenatal care, the differences between public and private provisions are minimal (49% versus 44%). For family planning, treatment of child diarrheal disease, and other selected services, the private sector is the provider of choice for the majority (1991 INEC Survey). Among lower income groups, the private sector accounts for 43% of services delivered in the rural coast, and 31% in the rural Sierra.

The experience of the recent past, through the CS Project and through other contacts with institutions in the health sector, and available data and analyses, yield several lessons which have implications for the USAID strategy and activities in this sector.

- Limited impact has been achieved by pursuing direct programmatic activities within the MSP. Those resources dedicated to specific program interventions, training and so forth, show little promise of changing MSP administration or resource allocation, or of being fully integrated into MSP operations on a lasting basis. In short, there is little likelihood of sustainability of current activities.
- Policy dialogue with the MSP can yield results with relatively little investment. For example, largely as a result of USAID policy dialogue, plans the MSP had to hire several thousand additional personnel under the FASBASE Project (with implications of millions of dollars of additional recurrent costs) have been modified. While this dialogue helped to prevent future recurrent cost increases, policy dialogue in the area of user fees is promising to raise future revenues.
- Close collaboration with the MSP and with FASBASE show that USAID can work with health sector institutions (MSP, IESS) and donors (World Bank, IDB) to help mobilize non-USAID funds and programs. USAID is actively involved with the World Bank project in its activities, and with the IDB in identifying strategic areas for its project support.
- The private sector, while it is the largest and fastest growing part of the health sector, has received little technical or financial support, and is excluded from project activities designed and undertaken by the World Bank, the IDB, PAHO, UNICEF and others. Nevertheless, the private sector provides a large portion of preventive services, and is responding to market conditions such as physician oversupply to extend the supply of basic health services into underserved areas.

The redesigned CS Project will foster movement toward structural improvements by supporting public sector policy decisions and programs, and private sector organization of supply and demand, in such a way that the sector as a whole is able to improve efficiencies and produce more primary health care services for a greater proportion of the population. The project will result in a changed health care market, developing roles and institutions which will be able to continue the process of change after this project has ended. This will lead to a market where both the public and private sectors are able to produce more primary health care services, where supply and quality of services are improved, and where the MSP is better able to focus its declining resources on public

health/public good services. The end result of project activities will be greater availability of and improved access to child survival and primary health care services in both the public and private sectors.

B. Project Conceptual Approach

The following conclusions characterize the overall health sector as it currently stands.

- The three major players in the health sector (the MSP, the IESS and the private sector) currently manage roughly equal thirds of the nearly \$450 million resources available in the sector.
- All three major players are plagued by problems in the production and delivery of health services, including primary health care, which result in underproduction of services and undercoverage of the population.
- All three major players are already beginning to move in directions which can potentially improve their ability to produce more basic health services, thereby improving availability, access, and impact:
 - **The MSP** is moving to improve its resource base through user fees, to involve the private sector in administration and service delivery, and to contain costs, especially for curative and hospital services. This will lead to a better capacity to produce preventive health care and child survival services.
 - **The IESS** is beginning to consider restructuring of its health services, which may include financing non-IESS produced services, and to explore ways to expand rural peasant coverage through SSC.
 - **The private for-profit sector** is already demonstrating a market response to the oversupply of physicians by expanding to new cities, and by reorganizing supply and demand through nascent group practices, cooperative programs, and other models. PVOs are continuing to provide significant preventive services, and to enter into the intersectoral dynamic by coordinating and entering into agreements with the MSP.

From the discussion of problems in the preceding sections, three overriding problems, or problem clusters, describe the fundamental issues from which the specific problems above derive. Following are the three main problem clusters identified, and for each, their most significant causes.

Problem Cluster 1: PUBLIC SECTOR POLICIES AND PRODUCTION INEFFICIENCIES

Description: Poor resource allocation and uncontrolled production costs and inefficiencies, which contribute to insufficient production and distribution of primary health care (PHC) services.

Primary cause: Closed production systems (i.e., both the MSP and IESS financing, producing and delivering their own services, even when there is widespread duplication).

Secondary cause: Expensive curative services and unproductive resource use result in excessive drain on public budget and insufficient allocations for primary health care services.

Problem Cluster 2: SECTOR-WIDE MARKET CONSTRAINTS

Description: Presence of poorly developed or unclear market signals and specific policy constraints which hinder the ability of both public and private sector providers to expand production of basic health services and to improve efficiencies.

Primary cause: Insufficient alignment of public sector policies with sector needs to ameliorate supply and demand problems and to foster private sector growth.

Secondary cause: Lack of coordinated analysis and information dissemination to modify policy and regulatory constraints.

Problem Cluster 3: PRIVATE SECTOR SUPPLY AND DEMAND INSUFFICIENCIES

Description: Inadequate availability of and access to (supply of and demand for) privately produced basic health services.

Primary cause: Lack of technical and managerial expertise to plan, organize and produce affordable basic health services in the marketplace (supply constraints).

Secondary cause: Poorly organized demand which limits the purchaser base for privately produced services (demand constraints).

USAID's conceptual approach to the sector is to foster movement toward structural improvements by supporting public sector policy decisions and programs, and private sector organization of supply and demand, in such a way that the sector as a whole is able to improve efficiencies and produce more primary health care services for a greater proportion of the population. The project will result in the initial stages of a changed health care market, developing roles and institutions which will be able to continue the process of change after this Project has ended. This will lead to a market where both the public and private sectors are able to produce more primary health care services, where availability, access and quality of services are improved, and where the MSP is better able to focus its declining resources on public health/public good services. The result of Project activities, therefore, will be improved availability of and access to child survival and primary health care services in both the public and private sectors.

C. Project Implementation Strategy

The CS Project implementation **strategy** is based on the following approaches to carrying out the objectives of the project: 1) policy analysis and dissemination activities in support of movement toward structural change among the major actors in the health sector; and 2) increased participation by the private sector in CS/PHC services, including the strengthening of public/private sector partnerships and NGO delivery mechanisms for increased interventions, effectiveness, and sustainability of maternal-child health care services.

The project will build on the MSP *Policy Guidelines* in support of more efficient role definition and functional demarcation and coordination between the major health sector institutions (e.g. MSP, IESS), and greater participation by private sector providers of CS/PHC services. To accomplish this, the project will establish a private sector "think tank" capability within CEPAR to analyze policy options and disseminate information, leading to the development of a draft unified national health care policy and regulations. The project strategy will focus on the provision of technical assistance and training for strengthening private sector health care organizations. TA and training will address the technical and financial management assistance and sustainability constraints for a broad array of NGO health care providers, whose target populations are representative of low-income, peri-urban and rural clientele.

To carry out the above strategy, the project will fund a Cooperative Agreement with CEPAR for establishing a policy analysis and dissemination capability, and a Cooperative Agreement with CARE/Ecuador to serve as the primary channel of project NGO assistance. The CEPAR policy analysis group, the CARE managed NGO network, the MSP Office of the Sub-Secretary General and the MSP NGO Coordinating Office and its constituents will receive technical assistance and training from both offshore sources procured by the USAID and in-country expertise funded under the cooperative agreements.

Implementation Strategy Summary

- The project will employ a broad-based approach to addressing, alleviating and resolving problems and constraints to achieving the project purpose. Leaders and experts representing both the private and public health sectors have actively participated in the project design process. As a result, the project objectives are reflective of the aspirations and priorities of Ecuadorians for improving the health status and socio-economic well being of low income families.
- The project will fund a Cooperative Agreement with CEPAR to develop a private sector, independent think tank capable of analysis, education and dissemination of health care information and policy options for improved definition of roles and functions among the major health care producers, and for increased private sector participation in health care service delivery. Another project-funded Cooperative Agreement will be signed with CARE, an international PVO, which will be responsible for managing an assistance program geared toward strengthening a broad array of NGO health care providers. The project strategy will build on and expand Ecuadorian initiatives to improve the **access, quality and sustainability** of CS/PHC services for a significant percentage of low-income peri-urban and rural populations.

Optimum use of project resources will be gained by utilizing existing, effective institutions (i.e. CEPAR, CARE), and providing innovative assistance for establishing an information, education and communications system to be operated and maintained by CEPAR and utilized by key organizations within the Ecuadorian health sector.

Several buy-in mechanisms will be used by USAID to provide technical expertise and training programs to the project's beneficiary population. The primary buy-in will assist in the administration of all activities pertaining to NGO health care service strengthening and CEPAR policy analysis, data collection, mass media campaigns and institutional implementation support.

- The project will improve peri-urban/rural CS/PHC health care access and achieve other project technical objectives by focusing on activities which produce the greatest multiplier effect: e.g. policy dialogue and support; increasing the administrative and technical capacity of health care NGOs; forging public/private sector partnerships for more effective CS/PHC service delivery systems; outreach training and skills development; and health sector inter-institutional collaboration.
- Enhanced program sustainability will be achieved through the application of innovative, diversified financial planning systems with assistance to NGOs in financial administration and management.
- A system will be in place early on to identify and target project beneficiaries, assist in modifying program emphasis as changes in data occur, and as a mechanism for guiding and coordinating the direction of NGO programs assisted under the project. Monitoring and evaluation will also be used to enhance project economies of scale, and to help establish incentives for motivating the implementing and policy-oriented entities to collaborate and support one another in the achievement of project outputs and EOPS.
- A system of Information, Education and Communication (IEC) will be established by CEPAR in conjunction with the project implementing and policy-oriented organizations to ensure effective and timely diffusion of project messages to target audiences. The project NGOs have placed a high priority on technical assistance in the area of health management, financing and communications.
- Collaboration and coordination by the project implementing and policy entities will ensure that project NGO activities benefit from international program experience and resources, and are capable of increasing their national level profile in this area through demonstration projects and replication.
- The project's primary participating organizations (i.e. MSP, NGO representatives and USAID) will establish a Steering Committee for the purpose of coordinating project activities among all entities, ensuring that the public/private sector partnership activities for improved service access and sustainability within health areas are well coordinated and fully integrated into the programs of local NGOs.

IV. PROJECT DESCRIPTION

A. Project Goal and Purpose

The **goal** of the amended project is the same as the original project: to improve the health of infants and children in Ecuador. The project **purpose** is to improve the effectiveness of child survival and primary health care programs and interventions nationwide with a focus on the poor in rural and peri-urban communities.

B. Project Components

The CS Project will focus on selective policy development in the public sector and improved organization and delivery of services in the private sector. This will involve addressing the three major problem clusters identified in the previous section: public sector policies and production inefficiencies, sector-wide market constraints, and private sector supply and demand insufficiencies. A set of interventions will be pursued to address each of the three problem clusters identified above; amelioration of these problem clusters will support the process by which the health sector moves toward restructuring along the lines of improved role definition and specialization, while making more primary health care services available to more people. There are, therefore, three project components which correspond to the three problems clusters discussed above.

1. *MSP Public Policy Support*

Description

This component will develop and support policies which improve efficiencies in the production and distribution of child survival services in the public sector, and which foster expansion of production and distribution of child survival services in the private sector. The institutional counterpart for this component will be the Minister of Health or his/her designates. The office of the Minister of Health will be instrumental in coordinating and facilitating the implementation of all project activities involving policy analysis and inter-governmental health sector agreements, in particular between the MSP and the IESS. This office will also help bring about greater private sector participation in the delivery of CS/PHC services. While there are a number of important policy objectives, and while all objectives lead to the same overarching objective of improving availability of, access to, and impact of health services available for the poor, five specific objectives have been identified during the redesign process which are of the highest priority.

1. **Targeting and equity improvement:** targeting of **public** health resources on issues of public health and the needs of the poor. This involves improved targeting of public sector resources through policy articulation, planning, and so forth; and removal of subsidies to the middle class (such as subsidization of the costs of individual curative services for middle class users who otherwise could and should pay)
2. **Improved role rationalization:** general improvement in the definition, demarcation and coordination of roles/functions between the major health sector institutions or subsectors (e.g. MSP, IESS, private sector), such that the public sector focuses on "public goods."

3. *Expanded and improved role of the private sector*: to serve as the principal producer of health services in the country, including CS/PHC services, especially for populations other than the poor; and the primary producer of "private goods."
4. *Decentralization*: local autonomy over programmatic and resource use decision making.
5. *Improvement of public sector financing of health services*: increased revenue generation and rationing of services through user fees, removal of hidden subsidies which exist due to current patterns of provision of free services for middle class populations, and improved allocation of resources toward appropriate services (i.e. reduction of public expenditure on tertiary facilities, increased expenditure on preventive and other essential services, interventions using appropriate levels of technology, and services for target populations).

Support will be provided to the Ministry of Health primarily through technical assistance in policy analysis, dissemination and advocacy activities. The project's long-term Child Survival Advisor (TACS, PSC or other appropriate mechanism) will play a key role in the management of this component through regular communication, coordination and documentation of project activities with the office of the Minister.

Importantly, the Minister and the MSP/NGO Coordinating Office, and key representatives from other government and congressional offices which have an impact on the health sector, will be potential candidates for project-funded observational travel to other countries in the hemisphere. The purpose of this is to strengthen the consensus building process and expose key decision-makers to the success stories and lessons learned of other countries in developing public/private sector partnerships, and the privatization of health care services and delivery mechanisms.

Representatives of the office of the Minister, the Subsecretary-General, the newly established MSP/NGO Coordinating Office, and the IESS and other governmental health related entities will be encouraged to participate in technical assistance and training activities under the project, as appropriate. These activities will primarily be managed and carried out by CEPAR for policy analysis and dissemination, by CARE for the NGO strengthening component, as well as by USAID directly through the provision of international technical assistance.

A major aspect of the MSP Policy Analysis and Support component will be the development of working/operational relationships between the MSP health areas and NGOs supported under the project. Each health area is governed by an Area Management Unit (or UCA -- Unidad de Conducción de Area), which currently has some jurisdiction over MSP health care entities within certain geographical health areas. It is the project's intent to focus NGO strengthening and demonstration activities within the UCA. It is envisioned that project assistance applied in this way, with close coordination between the CS Advisor, the Director General of the MSP and the MSP/NGO Coordinating Office will yield significant results in terms of forging public/private sector operational and management partnerships within the project designated UCAs.

Part of this component involves on-going dialogue and coordination among USAID, Ecuadorian institutions, and other donors. USAID will assist other donors in identifying appropriate interventions, and as such is working and will continue to work closely with the World Bank and the

IDB, among others, as they design and implement public sector assistance projects. Specifically, USAID will use its policy dialogue, coordination and technical support capabilities to assist the FASBASE project to improve its planning and implementation. USAID will also continue to actively encourage the IDB to direct a substantial portion of its new project resources toward support for the reform and development of the IESS and the SSC. These activities constitute USAID objectives which will be pursued both inside and outside of a project framework.

MSP public policy support will provide targeted analyses, study tours, and information dissemination, and will accomplish and carry out the following **objectives, activities/mechanisms and outputs**:

Component Objectives

- (1) To improve health service financing in the Ministry of Public Health (MSP), primarily through policies and procedures which authorize and deregulate user fees, and rationalize the allocation and budgeting of resources.
- (2) To increase public/private collaboration and privatization, particularly greater NGO involvement in the public sector production and delivery of health services.
- (3) To improve intrasectoral coordination, primarily involving support of improved resource coordination between the MSP and the Ecuadorian Institute of Social Security (IESS).

Activities/Implementing Mechanisms

The activities and implementing mechanisms supported under this component will include seminars, workshops, policy observation tours, and targeted studies. These activities will strengthen the MSP-NGO partnership and enable the MSP to strengthen its role as a rector of the health sector and provider of public health and primary health care services. Policy areas selected will be based on the convergence of emerging MSP and USAID objectives, and involve controlling curative care costs, improving the MSP revenue base, and improving the environment for the private sector. The targeted analyses, study tours, and information dissemination will focus on improving public sector resource availability and production, and on creating a more productive relationship between the public and private sector.

Policy support study tours: small groups (two to four persons) of policy makers and decision makers, or other influential persons, will travel with project and/or USAID personnel to other countries to view aspects of policy formulation, development and implementation, and the results of beneficial or detrimental policies. For example, a visit to Bolivia can enable a positive policy decision about the role of NGOs, or about user fees as a means to improving access and quality; a visit to Chile can facilitate dialogue on issues relating to the role of the municipality, private alternatives to social security, or local financial autonomy; a visit to Costa Rica can help inform policy makers about the importance of progressive social security reforms and possible models to consider; a visit to Colombia can demonstrate the process of decentralization of the Ministry of Health and the reform of Social Security; and a visit to Jamaica can show the benefits and difficulties of privatizing hospital services.

Targeted studies and analyses: at times when the MSP is at an impasse or otherwise unable to take progressive steps toward a policy objective such as privatization or price deregulation, project technical assistance will be used to carry out specific studies to enable informed decision making and further policy implementation. As an example of how this can support policy implementation, the IESS reached an agreement with the Armed Forces to purchase services from the Military Hospital in Quito for civilian employees in military institutions; however, implementation broke down when the two institutions were technically unable to determine the pricing basis upon which these services would be provided and reimbursed. In such a situation, a targeted study will provide technical information to permit policy implementation.

Information dissemination: information dissemination is key to project implementation, as effective functioning of the market depends on clear "market signals"; market forces can stimulate demand through private sector responses, and improve competition in the private sector. This component will support information dissemination such as awareness raising among leadership groups, technical information, conferences and workshops, and consumer/public education and information.

Component Outputs

The following project component outputs are anticipated:

- (1) An effective user fee system (e.g., generating 10% of MSP facility level operating costs) will be developed and in place by the PACD.
- (2) A functioning NGO Coordinating Office in the MSP.
- (3) A mechanism (i.e., a set of agreements) for private sector involvement in the production and distribution of public sector services (e.g., through NGO management of public sector resources or public purchase of privately produced services) will be developed and implemented.

Additional outputs linked to primary technical areas include the following:

Financing of health services:

- User fees
- Improved resource use (e.g. budget allocation and expenditure decisions).
- Decreasing hospital costs and other curative care costs.
- Strategic financial planning and cost containment.
- Removing hidden public expenditures for private services (e.g., expenditures on patients in public hospitals who are currently eligible for public services, but could or would otherwise pay).

Fostering of private sector growth:

- Privatization of selected services (e.g. hospital departments, support services such as laundry and food, logistics, MIS, accounting).
- NGO involvement in management of facilities or health areas.

- Public purchase of privately produced health services.
- Policies which can facilitate private sector expansion (e.g. tax incentives).

Intrasectoral coordination:

- MSP-IESS coordination and cross-purchasing
- Modifications to the structure of production and purchasing of health services

2. *Policy Analysis and Advocacy*

Description

This component includes support for several activities, including an open, democratic dialogue about national health care policies and priorities; gathering and publishing demographic and policy-related statistics as a vehicle for both political and technical decision making; and, private and public sector coordination to support the advancement of effective health care policies which promote the participation of the private sector. Targets for this project component during the first year include both institutional awareness and practical implementation of policy guidelines, as well as those to be defined after conducting the initial assessment of current policies and the development of a strategic plan for policy analysis and dissemination.

CEPAR will conduct policy analyses and dissemination activities toward the final objective of preparing, by the end of the second year of project, a draft proposal for a unified national health sector policy and corresponding regulations. Activities will be organized in coordination with other donor organizations which currently support the MSP and the IESS health care programs. Technical assistance support will be provided from both international and local sources.

At a technical level, CEPAR will obtain and analyze health sector policies and conditions from other Latin American countries, provide technical assistance and prepare outlines for discussion to be distributed and carried out at a national level. The project will also provide the necessary environment to promote dialogue among all national sectors involved in health care, and to facilitate decision making processes. Seminars, conferences, and debates will be financed under the CEPAR Cooperative Agreement. CEPAR is expected to actively participate in all dialogue and policy advocacy activities; an example of approaches suggested by CEPAR for different policy advocacy objectives is provided as a matrix in Annex F. CEPAR will coordinate with the INCAE and Fundación Ecuador in order to assure that policy reform agendas and priorities are consistent across institutions.

Component Objectives

- (1) Development of Policies for Improved Public Institutional Role Definition and Allocation of Resources, and Expanded Maternal-Child Health Care Services through the Private Sector.
- (2) A draft unified health sector policy and regulations which have gained national level consensus.

CEPAR's program for bringing about improved institutional role definition and private sector CS/PHC service delivery will be the key to accomplishing the objectives of this component. A major

portion of CEPAR's budget will be directed toward activities which impact on policy consensus building.

Activities/Mechanisms

- **Policy Analysis and Discussion**

As a contribution to the analysis, design and implementation of health policies, and to strengthen advocacy for the national agenda on health, CEPAR's analyses and information will assist the public sector and NGOs to better define their sector responsibilities. CEPAR's research activities will stimulate public fora for the democratic discussion of health care policies between the public and private sectors, political parties, health-related professional associations, universities, learning centers and community groups.

At the same time, CEPAR will organize a number of conferences, workshops, and seminars each year to analyze and discuss specific issues related to maternal-child health and basic health. Special emphasis will be placed on incorporating profit and non-profit private sector institutions in programs designed to improve health services. Examples of discussion topics for conferences, workshops and seminars include: (1) the role of the private sector; (2) the role of the MSP; (3) cost recovery and equity of access; (4) revising norms and technical standards in maternal-child health; (5) analyzing the results of operations research studies conducted for NGOs; and (6) the role of medical insurance companies in providing preventive and primary health care services. It is expected that CEPAR's linkages with various institutions will allow its program to be implemented in collaboration with and using the infrastructure of universities, learning centers, and professional associations, thus reducing costs and promoting collaboration between relevant sectors.

- **Policy Advocacy**

Policy advocacy will include all strategies in the media in order to inform policy makers, decision makers and/or the public on issues of improving public sector role definition and strategies, improving market signals and stimulating private sector demand, and primary health care interventions and disease prevention through promotion and publicity. Other advocacy activities will include designing a program to promote awareness of health sector issues among public and private sector leaders and decision-makers who influence legislation and regulations in these areas.

- **Other Information, Communication and Dissemination**

Other uses of CEPAR produced information may include: (1) increasing coordination among participant organizations and stimulating joint development and use of materials; (2) eliminating weaknesses in participant organizations by encouraging mutual exchange of local and international technical assistance and training; (3) identifying private sector communication resources that may be useful to the public health sector; and (4) increasing project sustainability by helping participant organizations to plan communication strategies and activities that will generate more clients and increase service demand. Also, summaries of discussions and papers presented at the national fora on health, conferences, seminars and workshops, will be edited for distribution for sale (if appropriate) to health care related institutions. The production and distribution of information will be done so as to

minimize costs and maximize impact. Technical consultants will assist CEPAR in designing the necessary strategies and mechanisms for that purpose.

Component Outputs

CEPAR Think Tank:

- Policy analyses carried out and information disseminated
- Policy fora held on national and local levels

As a non-governmental institutional resource in support of health care policies and information dissemination, CEPAR will produce the following specific outputs: (1) sponsor health policy analysis, strategy, and program design and implementation with participation from different national and private sector representatives; (2) produce and disseminate health care policy information; (3) improve market conditions and market environment for greater private sector participation; and, (4) improve and design programs to develop technical resources for the health sector policy reform and expanded private sector participation.

3. Nongovernmental (NGO) Support

Description

This component is designed to assist the private sector in developing efficient and effective ways to organize the supply and demand of health services, through demonstration projects, small grants and technical assistance. For purposes of this project, "private sector" is used broadly to refer to non-central governmental entities, including nonprofit NGOs, for profit enterprises, and in some cases municipalities. Technical assistance and programmatic support will be used to improve models of organizing, financing, producing and delivering basic health care services.

Project component management and implementation will be the responsibility of CARE through a Cooperative Agreement funded under the amended project. CARE's local office in Quito will be responsible for the management of project funds for the purpose of channeling technical assistance, limited financial assistance and training activities to a group of broadly-based, NGO health care entities specializing in the provision of CS/PHC services to low- and marginal-income, peri-urban and rural communities. For purposes of the amended CS Project, NGOs are defined as non-profit and for profit entities, including groups, associations, companies and in some cases local municipalities.

CARE will also be responsible for the operational and program support of a selected number of NGO health care entities through the provision of limited amounts of subgrants included as part of the Cooperative Agreement. It is envisioned that a certain number of model NGO health care delivery mechanisms will be selected for demonstration activities and for replication in other areas of the country.

USAID/Ecuador has been providing support to NGOs working with CS/PHC delivery mechanisms since 1992. At present, five of these organizations are receiving continuing assistance through a mission buy-in to the centrally-funded Initiatives Project. Under the amended project, these

groups will continue to receive support, as well as technical assistance to improve their long-term program sustainability and capacity to serve as models for other demographic areas. They will also be able to modify and expand their activities to reach larger audiences in the health sector. As they identify and generate more permanent funding for their activities, project support will be phased out.

NGOs will be selected to participate during the initial stage of amended project activity based on a set of institutional criteria to be developed during the proposal presented by CARE. The project will also seek out other NGOs to become involved in CS/PHC service delivery activities. Technical assistance, training, materials, supplies and, in some cases a limited amount of direct program support (e.g. program and operational expenses directly related to project activities) will be provided to those NGOs interested in actively participating in the CARE managed program.

Component Objectives

- (1) To develop replicable models of privately produced CS/PHC services, which are capable of recovering all operational costs.
- (2) To establish a set of agreements/arrangements between the MSP (and other public sector health care service providers) and a sub-set of health care NGOs for the effective allocation of services and ownership authority within project-designated health area targets of opportunity.

Activities/Mechanisms

Technical areas will be addressed through three project activity modes:

Demonstration projects: approximately four small demonstration projects (e.g., with costs of under \$250,000) will be developed during the initial three-year implementation period to generate models of low-cost, high access production and delivery of primary health care services (including referral systems, etc.). Demonstration projects send market signals to potential investors and providers. Perhaps more importantly, demonstration projects provide planners and managers with experience and information about how the market responds, what unforeseen difficulties can arise, and what new opportunities are created out of the changing market. It may well be that the responses observed after a few years are very different from what is predicted at this point, or from responses in the first couple of years. A flexible approach to demonstration projects permits the cycle of (a) introducing new models, signals or stimuli, (b) monitoring and evaluating market response, and (c) modifying and redirecting the limited resources available.

Technical assistance to private sector groups: in addition to the demonstration projects, TA will be provided to an additional 20 private sector groups seeking to expand delivery of primary health care services. Under this subgrant mechanism, it is expected that support will be provided to a consortium of NGOs wishing to form an association (e.g. a trade group or an "umbrella" group).

Training and workshops: skill building workshops and other focused training will be carried out to improve the skill base of private sector managers.

More specific programs and models to be developed will include the following:

- Production and delivery models which produce a high volume of PHC services
- Models which develop services at low cost
- Activities which link to broader market development
- Models which are technically and managerially simple
- Innovative financing approaches which leverage USAID resources by obtaining financing from the MSP, FASBASE, FISE, etc.
- Services which demonstrate an ability to increase equity and access for target groups (rural populations, the poor, etc.)
- Services with clear quality improvement characteristics
- For those for-profit groups participating, models which can satisfy the above requirements *and* be profitable

Project Outputs

- (1) Approximately 25 NGOs engaged in expanding their CS/PHC service delivery base.
- (2) Approximately ten NGOs/PVOs capable of recovering 100% of their health service operational costs.
- (3) Increase in the number of PHC services produced by participating NGOs.
- (4) Development and market testing of currently non-existent PHC financing mechanisms, such as prepayment, shared risk, employer purchased services, and public sector purchasing of privately produced services.

Specialized technical assistance will focus on improving both the supply of and demand for health services in the private sector, yielding the following outputs.

Supply:

- Improved organizational models, as illustrated in the following examples:
 - Group practices
 - HMOs/managed care/capitation
 - Brokered services/PPOs/IPAs/etc.
 - Others
- Low-cost production of PHC services: managerial and financial techniques
- Quality improvements (as market signals, competition, etc.)
- Strategic financial planning, availability and use of credit

Demand:

- Group purchasers (cooperatives, employers, etc.)
- Third party coverage
- Marketing to groups
- Market to public purchasers
- Consumer education: availability, quality issues

C. End-of-Project Status and Outputs

End-of-Project-Status (EOPS)

The following verifiable conditions will be present by the end of the project.

- As a result of improved targeting and improved efficiencies, the non-covered population will be reduced from approximately 30% in 1994 to 20% in the year 2000, of which approximately one half, or 500,000 people, will be receiving coverage from private sector providers.
- Institutional role and functional definitions will be improved, as measured by the presence of policy statements within major institutions and by the presence of a draft unified national health sector policy and regulations. Specific content of these statements will include:
 - *MSP* -- articulation and implementation of a policy stating institutional purpose as focusing on *public health* (immunizations, norms and standards, environmental control, vector disease, service provider of last resort);
 - *IESS* -- articulation and implementation of a policy to separate the functions of financing and producing health services, and to shift from being a major health sector service provider to major financier of services; and specific modifications in the structure of IESS benefits to include more CS/PHC services;
 - *Private Sector* -- assumption of the role of primary producer of health services through NGOs (for profit and non-profit), local municipalities and authorities, as evidenced by an increased number and proportion of health services produced and an increased number of people covered.
- The MSP will be recovering 10% of its health care facility-level operational costs through fee for service mechanisms. These new resources will be used for local level programming, to improve coverage and quality.
- An independent private sector policy analysis and advocacy capability will be established. This "think tank" will be promoting policies for more efficient institutional role definition, and improved market conditions for private sector participation.
- A mechanism for coordination among NGOs working in the health sector will exist.
- There will be increased public/private sector collaboration in management of health areas, to the extent that NGOs will be involved in the administration of public resources and programs in at least 10% of all MSP health areas; and within these areas, NGO will be more involved in the production and delivery of health services.
- NGO health care delivery mechanisms will be strengthened, and replicable models of privately produced CS/PHC services will be developed which will serve as demonstration models and field experiments of new ways of producing and distributing primary health care services to poor populations. Twenty-five project NGOs will producing services with a mix of at least 20% preventive and 80% curative. Ten NGOs will be producing services which are 100% self-financing.

OUTPUTS

- 1) **CEPAR Think Tank:**
 - National NGO Health Sector Policy Analysis & Dissemination
 - Policy dissemination and advocacy activities carried out
 - Policy fora held
 - Technical analyses carried out

- 2) **NGO Profit and Non-profit health care entities:**
 - Increase in CS/PHC interventions in the following key areas:
 - Immunization coverage
 - Institutional births
 - Diarrheal disease prevention and treatment
 - Acute respiratory infection prevention and treatment
 - Providers increase coverage from 35% of population in 1994 to 45% by yr. 2000 (equivalent to coverage of 1 million additional people due to a combination of market share increase and expanded coverage);
 - Non-covered population reduced from 30% in 1994 to 20% by 2000 (of which approximately one half, or 500,000 people, are receiving first time coverage from private sector providers);
 - CS/PHC technical, managerial and marketing capabilities strengthened within a significant group of diverse NGO health care providers (i.e. 25 NGOs during five year LOP);
 - 10 project NGOs capable of fully recovering operational costs by the year 2000;

- 3) **TA and Training:**
 - TA and practical training in health care management, financing, sustainability and technical specializations, including four individuals receiving Masters degrees in health economics.
 - Establishment within an Ecuadorian university of a program in health administration.
 - Training materials, short course curricula and long-term programs developed;
 - MSP fee for service mechanisms, private/public collaboration and agreements, inter-governmental agreements, and strengthening of the MSP Policy-making process and the establishment of an NGO coordinating office to facilitate authority and policy decentralization, and eventual structural change within the public health sector;
 - Mobilization of other donor resources in support of project TA and Training initiatives, and policy analyses (e.g. IDB, IBRD).

D. Relationship of Project to GOE Health Policies and Programs, USAID and Mission Strategies and Projects, and Other Donor Assistance

1. GOE Health Policies and Programs

The GOE's *Agenda for Development, 1993-1996* redefines the role of the State as one of "respect for individual freedom and rationality, whereby the government takes on a role as promoter of initiatives, coordinator of efforts, and process regulator." Greater participation of civil society is called for (i.e. private sector), with incentives for the private sector to participate as a partner and/or manager in

service delivery. GOE proposes decentralization and deconcentration, as well as the rationalized management of public resources.

The MSP policy framework developed in response to the new GOE policies involves the following principles:

- Shared responsibility and authorities geared toward the development of health programs with other public sector agencies (local government, NGOs and community organizations) under MOH leadership.
- Decentralization of MSP administrative and financial operations for service delivery, including the strengthening of local health areas.
- An integrated health service delivery system, with a network of primary, secondary and tertiary levels.
- Development of management systems to achieve effectiveness and efficiency, including computer technology.
- Development of sustainable models of service production and delivery.
- Introduction of the concept of total quality management.
- Initiation of the transfer of selected support services to the private sector.

The amended project, through its three components of MSP Public Policy Support, Policy Analysis and Advocacy, and NGO Strengthening, will provide direct support to the GOE policy and modernization initiatives on both an individual basis as well as through the combined impact of all project activities and the leveraging of other donor support.

Three examples of project funded activities which provide support for the MSP Policy Guidelines and the proposed modernization initiatives of the GOE would include: 1) user fees for public sector services; 2) MSP/IESS inter-governmental health sector coordination of functions and services; and 3) development of private sector health care service models for replication in other demographic areas of the country.

2. Relationship of Project and USAID SO 2 to USAID Strategy and Policies

a) Relationship of the SO and CS Project to the Agency Goal: Stabilizing World Population Growth and Protecting Human Health.

Broad Agency Strategy

The Agency document *Strategies for Sustainable Development* (March, 1994) states that global threats to peace come from a multitude of sources, including continuing poverty, population growth, and new diseases. In order to address these threats, the Agency has focused on stabilizing world

population growth and protecting human health as one of its four main goals. The operational approach of the Agency in this regard concentrates on the theme of sustainable development based on participation of the people (i.e. the beneficiaries), partnerships with host governments, NGOs, and other donors, and integrated approaches and methods which take into account programs and objectives of other USAID activities.

The CS Project Amendment strongly supports the above policy guidelines and mandates of the Agency through policy dialogue and advocacy for structural change and rationalization of resource allocation within the MSP and the public health sector as a whole. The project, through policy advocacy and NGO strengthening, will also support Agency objectives for sustainable development and public/private sector partnerships. Other donor mobilization of resources is also an important aspect of the project. In line with USAID/W's new Implementation Guidelines (distributed in draft form in January, 1994). The amended project will contribute to the sustainable development of health services, both in the public and private sectors. The project seeks to improve quality of life, broad-based participation, and effective institutions, corresponding generally to democratization goals. Activities contemplated within the amended project pursue a systemic effect within the health sector, including redefinition of institutional roles, enhanced resource generation and improved resource allocation. The project will contribute to economic growth in the tertiary (service) sector. It will concentrate on catalytic programs, and will coordinate closely with other donor projects.

Agency Child Survival Strategy

USAID has recognized that a sustainable approach to child survival requires improving the ability of the health sector to produce and deliver child survival services. This involves technical, institutional and structural approaches. This has been articulated in the Agency's recent document *A.I.D.'s Child Survival Program: A Synthesis of Findings from Six Country Case Studies* (A.I.D. Office of Evaluation/CDIE, October 1993). Relevance to the CS Project Redesign are best demonstrated by excerpts from the findings and recommendations of that document.

Child Survival program Findings

" . . . institution building activities appear to be the untold success story of the Child Survival Program . . . innovative institutional arrangements have increased the coverage of low-cost services." (vi)

" . . . sustainability is a problem . . . where A.I.D. is experiencing difficulty phasing out support. However, as the Bolivia program demonstrates, financial sustainability is possible -- even with very poor clients living in very poor countries -- if it is a major program objective." (vi)

" . . . decentralization and private sector involvement are examples of A.I.D.'s policy dialogue successes. The Agency has had less success persuading host country governments to make major budget reallocations to provide more funding for primary health care." (vii)

" . . . the principal emphases of A.I.D.'s Child Survival Program in Bolivia are strengthening institutions and developing financially sustainable services . . . a major breakthrough for Bolivia and for child survival worldwide." (6)

" . . . A.I.D. is now hoping to phase out its support of child survival in Egypt but has run into sustainability problems." (6)

" . . .(in Haiti) A.I.D. shifted much of its child survival programming to PVOs. PVO's provide health services to 40 percent of the national population and 50 percent of the rural population." (6)

" . . . (in Morocco) the problem of financial sustainability has recently moved to the forefront of program concerns." (8)

" . . . (in Bolivia) private sector institution building activities have expanded coverage of services in several major rural and urban areas but not yet on a national scale." (11)

" . . . (in Haiti) PVOs have continued to increase coverage even when national rates declined because of political and economic conditions" (11)

" . . . where A.I.D. has tried to strengthen or create institutions to provide child survival services, evidence indicates that it has often been successful . . . A.I.D. has supported innovative institutions that represent breakthroughs in the cost-effective delivery of services." (13)

" . . . A.I.D. has special experience and capability in institution building that could be applied more broadly in its assistance to national child survival efforts." (20)

" . . . unless there is more creative and focused work in (institution building and financial sustainability) over the next decade, the health benefits that have been achieved over the last decade could be lost." (23)

" . . . innovative institutional arrangements (in Morocco, Indonesia and Bolivia) . . . lower the cost and expand the coverage of basic services." (23)

" . . . fees charged for curative services (in Bolivia) are high enough to subsidize basic child survival services . . . women in Bolivia prefer to pay for the services they receive and prefer higher fees to lower fees." (23)

Child Survival Program Recommendations

" . . . balance quick results with long-range developmental objectives." (viii)

" . . . country-specific policy dialogue agendas . . . should combine attainable operational policy changes with difficult to achieve policy objectives, such as budgetary reallocations." (50)

" . . . areas in which A.I.D. has the comparative advantage are . . . institution building, family planning, policy dialogue, private sector emphasis, and adaptability. . . develop country-program strategies that take advantaged of A.I.D.'s comparative strength. . ." (52)

"Provide assistance in country programs in all three activity areas -- health services for mothers and children, institutional strengthening, and financial sustainability . . . without feasible plans for developing a sound institutional base and permanent sources of funding, gains in the area of health services for mothers and children may prove transitory." (55)

" . . . emphasize A.I.D. support for institutional strengthening and financial sustainability." (56)

Poverty Alleviation: The redesigned Child Survival and Health Project will make a significant contribution to alleviation of poverty in three main ways. First, it will improve the conditions of poor health which contribute to poverty, enabling people to be more productive, and enabling families to generate more income while saving the scarce resource consumed on treatment of preventable diseases. Second, it will result in a direct transfer of benefits to the poor; for example, an Ecuadorian Institution (PREALC) estimated spending for mother-child health services alone represented an annual benefit of US\$ 38.2 for poor families in 1991, equal to 7.4% of average annual income. Third, by providing improved coverage and access specifically for the poor, the project will help alleviate the consequences of poverty, illness and death which afflicts the poor at rates much higher than the general population.

b) Relationships of the Project to LAC Bureau Strategy

LAC Bureau strategy is to promote sustainable development based on broad participation of the citizenry, strengthening of partnerships, and the advancement of integrated approaches and methods. In this vein, the project is in line with LAC's emphasis on increasing access to basic health services on a self-sustaining basis. Policy support for MSP initiatives to improve decentralization, quality, coverage, and cost recovery is clearly within the scope of LAC's intent. In addition, by engaging the private sector, including NGOs, community organizations, cooperatives, and other similar groups, to assume greater responsibility for delivery of health care, the amended project will favor equitable access to services and empower communities to take charge of their own welfare. Support for an appropriate public-private mix of basic health services is a goal of the project amendment; in this context, close coordination with other donors, such as the World Bank, IDB, PAHO, and UNICEF, is a critical requirement.

c) Relationship of the Project to USAID Mission Strategy (SO 2) and Projects

Stabilizing World Population Growth and Protecting Human Health

Mission Strategic Objective 2: Increased Use, Effectiveness, and Sustainability of Family Planning and Selected Health Services

The Mission's Strategic Objective 2 states that USAID/E will " . . . promote increased use, effectiveness, and sustainability of family planning and selected health services." This SO2 has served to direct the health and family planning support program in the Mission since 1990. The redesign is an appropriate evolution of SO2. By conducting policy dialogue to redefine institutional roles and improve the allocation and use of sector resources, and by promoting greater public-private partnerships, the redesigned project is a viable instrument for operationalization of SO2. The amended project will also articulate with the Fundación Ecuador Project in those areas where policy

objectives of the two projects intersect, and in other areas where related Mission policy objectives form a broad policy objective.

3. *Other Donor Assistance*

World Bank/FASBASE: The World Bank is the major international agency in the public health sector, with its broad-based, \$100 million FASBASE project (1993-1999). FASBASE represents approximately 10-15% of the MOH annual operating budget. Its stated purpose is to strengthen the MSP in its role as the leading service provider, while decentralizing administration to the local health area. MSP relies on FASBASE for facility construction, support for 1,600 MSP employees, institutional development, and programmatic support (nutrition, water and sanitation, and child survival). However, it appears that these activities may contradict some of stated MSP policies of modernization, restructuring, resource generation, and private sector participation. Recent USAID analyses point to concerns about the long-term recurrent costs incurred under this project, including the hiring of additional personnel; the difficulty of sustaining project activities beyond the life of the agreement; the emphasis on infrastructure at the possible expense of coherent policy development; and the overall lack of priority placed on health care financing and cost recovery issues.

In the first year of implementation of FASBASE, an effort has been made to address and ameliorate some of these concerns. Due to a slow start-up FASBASE was spending at a rate far below the level planned for the first year of activities. With plans to carry out activities work in 40 health areas (out of 184 health areas in the MSP), FASBASE is now only focusing on about six health areas. There are problems in the definition of a conceptual framework, articulation of an institutional development plan (\$14 million is budgeted for institutional development TA), and preparation of a clear implementation schedule. USAID is continuing to work closely with FASBASE to try to strengthen programming and sustainability of its activities.

Inter-American Development Bank (IDB): Past IDB investments in the Ecuadorian health sector have been mainly for infrastructure development, such as hospitals, other smaller health care facilities, and water and sanitation systems. In early 1993 the IDB prepared a Profile II Pre-investment Document which described a US \$45 million project surprisingly similar in scope and activity to the World Bank's FASBASE Project. This project would have developed infrastructure in 20 health areas, in addition to the 40 addressed by FASBASE. An IDB Design mission visited Ecuador in January 1994 to conduct preliminary interviews as part of a redesign process. The budget of the redesigned project, if approved, could be considerably higher than the original \$45 million, and it is possible that the project would include both MSP and IESS components as part of a public-sector wide policy reform project.

Pan American Health Organization: PAHO's main focus in Ecuador, as in other LAC countries, is to support Ministry of Health activities. Its working plans are based on Ministry policies, strategies, and programs. For 1994, PAHO identified 14 general areas and 5 emphasis areas, including primary health care, general health services, and MCH. PAHO's 1994 Ecuador program budget is about \$1.8 million in regular funds. Additional funds are provided by FASBASE through a cooperative agreement, whereby PAHO is primary source of TA for FASBASE under the \$14 million institutional development component.

UNICEF: Based on UNICEF's country program 94-98 statement, US \$1 million has been budgeted for health activities over the next five years, with expectation that \$3.2 million will be obtained in supplemental funding; \$400,000 is budgeted for nutrition, with an additional \$1.8 million to be sought in supplemental funding. In addition, a health education/social communications program (PROANDES) is planned; no regular budgetary funds are committed to this program, though \$11.4 million will be sought in supplemental funding. UNICEF in Ecuador has gradually specialized in providing TA for social communications/health education activities. As an example, its representatives coordinate a newly established social communications committee at MSP. Integration and coordination with other donor agencies has been improving, for example in cholera and certain child survival interventions.

Others: UNFPA supports family planning services in the MSP. Other donors are minor players in the health sector which have little impact on policy development or structural change. For example, the Japanese International Cooperation Agency (JICA) is providing medical equipment for several hospitals, and Belgian, Dutch and other European donors have small scale projects with the MSP and with PVOs.

V. FINANCIAL PLAN

A. Project Budget

The Child Survival Project Amendment (No. 518-0071) will be implemented over a period of approximately five and a half years (PACD of 12/31/99, for a total LOP of ten years) with a total amended LOP USAID funding level of US \$18 million and a total LOP project budget of \$36.8 million. This will be comprised of dollar appropriated funding for the reprogrammed activities totalling \$12 (72% of the reprogrammed amount) and counterpart contributions of \$ 4.7 million (28%). The dollar appropriated obligations schedule provides for \$6 million of approximately reprogrammed funds and \$ 5.8 million of new funding. A summary budget in thousands of US dollars, including disbursements by recipients and counterpart contributions, is shown in the table below. Detailed budget line items by fiscal years, institutions involved, functional accounts and project components are attached as Annex C of this Amendment.

CS PROJECT AMENDMENT SUMMARY BUDGET						
(In US\$ * 1,000)						
	REPROGRAMMED BUDGET			LIFE OF PROJECT BUDGET		
	USAID	COUN- TERPART	TOTAL	USAID	COUN- TERPART	TOTAL
ORIGINALLY DESIGNED ACTIVITIES	2,300	2,000	4,300	8,100	16,130	24,230
MSP SUPPORT	325	800	1,125	325	800	1,125
CEPAR CA	2,000	700	2,700	2,000	700	2,700
CARE CA	3,400	1,130	4,530	3,400	1,130	4,530
TECHNICAL ASSISTANCE	1,590	0	1590	1,590	0	1,590
MSP 180						
CEPAR 630						
CARE 780						
TRAINING	635	0	635	635	0	635
Offshore 530						
Ecuadorian Univer. 105						
INTRN'L ADVISOR	1,155	0	1,155	1,155	0	1,155
OTHER	225*	30	255	225	30	255
CONTINGENCIES	570	40	610	570	40	610
TOTAL	12,200	4,700	16,900	18,000	18,830	36,830

* Includes Audit 120 and Evaluation 105.

Addendum to pg. 37 of Project Paper Amendment.

CHILD SURVIVAL AND HEALTH
PROJECT NO. 518-0071

AMENDED PROJECT BUDGET (6.21 94)

ITEM	ACTUAL BUDGET	CHANGES TO NON-EARMARKED FUNDS			NEW OBLIG.* FY96-FY98	TOTAL BUDGET
		CURRENT	CHANGES	REVISED		
01 TRAINING	\$1,206,252	\$56,569	\$0	\$56,569	\$0	\$1,206,252
02 TECHNICAL ASSISTANCE	\$5,441,000	\$1,470,670	(\$1,000,000)	\$470,670	\$600,000	\$6,041,000
03 COMMODITIES	\$3,260,000	\$15,543	\$0	\$15,543	\$0	\$3,260,000
04 OPERATING COSTS	\$300,000	\$88,379	\$0	\$88,379	\$0	\$300,000
05 PRIVATE SECTOR INITIATIVES	\$1,436,979	\$531,909	(\$500,000)	\$31,909	\$0	\$1,436,979
06 EVALUATIONS AND AUDITS	\$210,000	\$71,096	(\$71,096)	\$0	\$75,000	\$285,000
07 CONTINGENCIES	\$265,769	\$23,082	\$21,096	\$44,178	\$80,000	\$345,769
08 AUDIT	\$80,000	\$46,634	\$0	\$46,634	\$40,000	\$120,000
09 HEALTH FINANCING	\$0	\$0	\$0	\$0	\$0	\$0
10 CEPAR CA	\$0	\$0	\$350,000	\$350,000	\$1,650,000	\$1,650,000
11 CARE CA	\$0	\$0	\$900,000	\$900,000	\$2,500,000	\$2,500,000
12 INTERNATIONAL ADVISOR	\$0	\$0	\$300,000	\$300,000	\$855,000	\$855,000
PROJECT TOTALS	\$12,200,000	\$2,303,882	\$0	\$2,303,882	\$5,800,000	\$18,000,000

* Subject to availability of funds.

1/2/94

PROGRAMMATIC SEQUENCE AMENDED CHILD SURVIVAL AND HEALTH PROJECT				
Project Paper Amendment Authorization 				
Current Activities	\$6 million		\$2.1 million	
Redesigned Activities			\$9.9 million	
	1989 - 1993	1994	1995	1996 - 1999

B. Pre-Award Surveys

No Pre-award surveys will be carried out for the two recipients of project-funded Cooperative Agreements, CEPAR and CARE.

In the case of CARE, a pre-award survey or financial review is not deemed necessary. As a U.S. registered PVO, CARE is monitored by USAID/W. Moreover, the several grants executed by the RCO with CARE over the last few years have been trouble free, and per IG/A/FA their A-110 audits are current and deemed acceptable.

Regarding CEPAR, a preliminary financial review conducted by the Controllors's Office, concluded that the institution has the administrative and financial capability to account properly for USAID funds. In addition, CEPAR has received USAID assistance through the Population and Family Planning Project and ESF funds through the Ministry of Finance. In these cases, CEPAR has been capable of properly expending and accounting for project funds.

The Controller's Office will conduct periodic in-house reviews of CARE and CEPAR, in order to evaluate the use of funds. When in-house reviews result in identified weaknesses and require corrective actions, the respective grantees will have a fixed period of time (to be agreed upon in consultation with the mission) in which to address the material recommendations to the satisfaction of USAID.

C. Audit Requirements

Beginning in project year two, annual financial and compliance audits will be contracted by the grantees with a U.S. affiliated independent audit firm. The USAID/Ecuador Controller's Office will provide guidance for the scope of work, review the draft reports, and track efforts to address all material recommendations. The audits will be performed in accordance with GAO standards and OMB Circular A-133, with copies provided to RIG/A/SJ.

During the third and the fifth years of the project, the Controller's Office will expand the audit scope of work to include the funds usually reviewed as a part of a Non Federal Audit.

D. Self Sustainability and Counterpart Contributions

The host country (HC) contribution for the LOP will be \$3.5 million. It will include cash provided by other donors and in-kind contributions.

In addition to funds provided under the Cooperative Agreement to CEPAR, CEPAR's program will be supported through the sale of different services and publications. This system is now in place in the institution. CARE activities are supported in a significant way through donations and programs of other donors. CARE will make counterpart contributions through human resources, physical plant and facilities, equipment, and specific TA from its offices in the United States.

In 1992, USAID/Ecuador contracted Price Waterhouse to evaluate the counterpart contribution of the Child Survival I Project No. 518-0071. The report disclosed that the recipients involved in this project, primarily the Ministry of Health, exceeded the amount required as a counterpart contribution to the project.

E. Methods of Implementation and Financing

The methods of implementation and financing for each component are summarized as follows:

COMPONENT	METHOD OF IMPLEMENTATION	METHOD OF FINANCING	ESTIMATED AMOUNT US \$000
Existing Obligations	Project Agreement	Direct Reimb. w/AID Advances	2,100
MSP support	Project Agreement	Direct Reimb. w/AID Advances	325
CEPAR	Coop. Agreement	Direct Reimb. w/AID Advances	2,000
CARE	Coop. Agreement	Direct Reimb. w/AID Advances	3,400
Intn'l TA	Buy-in	Direct Payment	1,590
Child Survival Advisor	Buy-in	Direct Payment	1,155
Offshore Training	Buy-in	Direct Payment	635
Evaluations	Direct AID procurement	Direct Payment	105
Audits	HC contract	Direct Payment	120
Contingencies			570
TOTAL			----- \$12,000

The possibility of including endowment provisions under the CEPAR Cooperative Agreement will be explored. Establishment of this endowment will be subject to USAID review and approval as a detailed proposal from CEPAR, in a process similar to that required of APROFE and CEMOPLAF in the Ecuador Family Planning and Health Project.

VI. PROJECT IMPLEMENTATION ARRANGEMENTS

A. Project Cooperative Agreements and Contracting Requirements

1. *MSP*

The amended Project Agreement will be signed between USAID and the Government of Ecuador as represented by the Ministry of Public Health (MSP). MSP will be required to meet all of the standard conditions of the USAID Handbook 3 Grant Agreement Amendment. The Agreement will include Annex A, Project Description, which details the activities and funding requirements of the project. Annex A will describe the relationship between USAID and the MSP, the Cooperative Agreements with CEPAR and CARE, and all procurement that will be made by the USAID for international technical assistance and training. The MSP is in agreement with the CEPAR and CARE Cooperative Agreements, the terms of which have been thoroughly discussed with the MSP.

2. *Cooperative Agreement with CEPAR; Cooperative Agreement with CARE and Sub-Agreement Authorization*

Cooperative agreements will be executed with CEPAR for implementation of the policy analysis and advocacy component, and with CARE for the NGO program support component. The arrangements for completing and signing the project subgrants between CARE and the health care NGOs will be the responsibility of CARE. The USAID technical office will approve each subagreement. All subagreements must meet criteria as established in USAID Handbook 13 for grants and cooperating agreements. (See Section VII.B., Summary Institutional Analysis, for selection criteria used in selecting the project institutions for cooperative agreements.)

B. Project Evaluation/Monitoring

1. *USAID Project Monitoring*

The USAID/Ecuador staff that will provide overall project monitoring will include a USDH Health and Population Officer, a Child Survival Advisor (TACS, PSC or other appropriate mechanism), and a resident Health Care Finance Advisor. All evaluation activities will be coordinated with the mission's Evaluation Officer.

Annual implementation plans and quarterly reports will be required for all project implementation organizations. These will be complemented by periodic visits to each participating institution. All of the participating institutions will organize an annual program review and workplan presentation that will assess the progress of outputs and purpose level indicators.

The plan for monitoring and evaluation arrangements is based on project performance and is focused on the need for close monitoring of inputs, and the on-going assessment of outputs. Interim process evaluations, and a mid-term and final impact evaluation are planned. Project reviews will be conducted annually with either local or international advisors to focus on process and problem solutions for both inputs and outputs. The results of the annual process reviews will be utilized in the mid-term evaluation to be conducted by an external evaluation team in 1997. The final impact evaluation will draw upon information contained in the 1994 DHS survey, and will update data on national and regional mortality and morbidity trends and on usage/coverage of basic child survival

and primary care services in the conjunction with the planned 1999 DHS. As policy development and reform are important project outcomes for CS Project, policy evaluation criteria such as formulation, consensus building and policy implementation, will be monitored on a regular basis.

2. Monitoring and Evaluation Elements

a. *Monitoring of Inputs*

The primary responsibility for procurement of local TA and training will be part of the Cooperative Agreements with CEPAR and CARE. The Health and Population Division Chief, and/or the Project Officer, will be responsible for tracking and monitoring the timely procurement, arrival, and utilization of all project inputs, including commodities, personnel, training, and financial resources. All offshore TA will be procured directly by USAID.

b. *Assessment of Outputs*

Output reports for this project are designed to monitor the extent to which the project generates the expected outputs and to determine shortcomings and possible bottlenecks in project implementation. These reports will be based on field data and on-site inspections that conform to USAID and counterpart institution (MSP, CEPAR, CARE) reporting requirements. The output reports will correspond to the output indicators in the logical framework. Project output data will be compiled quarterly and maintained by USAID.

c. *Evaluation of Process/Results*

To improve the project's ability to implement planned activities and assess problems relating to overall effectiveness, the monitoring and evaluation plan will emphasize regular data collection and analysis for each project component.

d. *Impact Evaluation*

The project will use the 1994 DHS survey, as well as specific NGO service area surveys, as baseline for assessing the project's impact. NGO service area surveys (market assessments) will be carried out as part of the overall planning phase for each of the participating NGOs, in the context of the NGO program support component. KAP surveys will be conducted in order to provide data for the design and/or evaluation of social communications activities, included to promote utilization of PHC services.

3. Evaluation Activity by Project Components

a. *MSP Public Policy Support Component*

Inputs/Outputs. USAID and MSP counterparts will monitor timeliness and appropriateness of input provision and output achievement at periodic meetings and take necessary actions to correct problems.

Process/Impact. USAID and counterparts will oversee policy development activities (process evaluation) and whether such activities have an effect on public sector policies (impact), particularly relevant to the Ministry of Health, the Ecuadorian Institute for Social Security (IESS), and the private sector. Process/impact evaluation will be approached based on the output indicators included in the logical framework. The results will be shared and discussed with officials and representatives of the MSP, CEPAR, and the NGO community.

b. Policy Analysis and Advocacy Component

Inputs/Outputs. CEPAR will hold semi-annual reviews of input provision and output achievement and will monitor input/output status on the basis of periodic reports.

Process/Impact. For the semi-annual reviews, CEPAR will provide update information on key indicators in the logical framework to determine results of technical and administrative interventions.

Annually, CEPAR will review reports to determine whether activities have been completed and interim objectives are being achieved as planned. Component outputs will be used to inform and orient policy makers in the public and private sectors. Impact will be measured in terms of policy development or achievement of changes in targeted policies.

c. NGO Program Support Component

Inputs/Outputs. The Project Steering Committee, comprised of representatives from MSP, CARE, CEPAR, and the USAID, will monitor input/output progress at periodic review meetings. Results will be discussed with the MSP office of the Minister, the MSP/NGO Coordinating Office, USAID and CARE.

Process/Impact. The Project Steering Committee will hold an annual evaluation review to assess operational achievements with respect to technical assistance areas. Causes for shortfalls will be analyzed and proposals will be discussed to remedy them.

The annual evaluation review will also assess progress in NGO outcomes, e.g. increased primary health care/child survival services, and their effect on health status indicators, e.g. maternal and infant morbidity and mortality; and financial outcomes, e.g. progress toward breakeven.

4. Women in Development Indicators

The project's goal of reducing maternal, infant and child mortality by improving the health of mothers and children contributes directly to the mission WID objectives. Data collected for the evaluation plan can also be used to assess WID objectives. The project will analyze data associated with these objectives on a regular basis. The analysis will focus on the project's impact on women's: a) participation in policy development activities; b) access to health care services; and c) involvement in organization of program support groups, such as health committees or mothers' clubs. To ensure that relevant data are collected for inclusion in a mission-specific, gender-disaggregated data base, survey instruments will be reviewed by the International Center for Research on Women (ICRW) team providing technical assistance to the mission for the development of its WID Action Plan.

C. Project Implementation Schedule

Project activities will take place for a period of 5.25 years (five years under the extended PACD and .25 years of overlap with the original or existing design) . Over this period, activities will fall into three broad stages.

Stage 1: During a six month period corresponding roughly to the second half of calendar year 1994, original CS Project activity transition and closeout will take place and amended project activity will begin. Those current implemented by the MSP will continue until May of 1995, overlapping with the amended project.

Stage 2: From 1995 through mid-1998, the development and application of a policy analysis and advocacy capability will take place and financial and technical support will be channelled to approximately 25 NGOs in three groups or cohorts. The first group will consist of five NGOs which have received technical assistance from the Initiatives Project since early 1993; it is anticipated that subgrants will be awarded to these groups by early 1995. This group will enable testing and refinement of approaches, studies, and procedures. The second group, 15 in number and representing the largest group and main focus of the NGO component, will receive subgrants by late 1995. The third group, which will consist of five additional NGOs, will be awarded subgrants by late 1996.

Stage 3: From late 1998 through 1999, project activities will emphasize consolidation and sustainability of those policy interventions and sustainable NGO delivery models which are most effectively reaching project objectives.

Table VI.1 on the following page provides a summary of USAID implementation steps. A detailed implementation plan for all project components is included in Annex E.

D. Procurement plan

Procurement will be carried out by CEPAR and CARE under the two Cooperative Agreements and by the USAID mission directly.

**TABLE VI.1
SUMMARY IMPLEMENTATION PLAN:
USAID RESPONSIBILITIES***

IMPLEMENTATION STEP	DATE		RESP.
PROAG Amendment	July	1994	USAID
Obligation of Year 1 funds	July	1994	USAID
CEPAR, CARE CAs signed	July	1994	USAID
Project Amendment Authorization	July	1994	USAID
Buy-in TA sources selected	July	1994	USAID
Project Steering committee convened	August	1994	USAID
Pre-award financial reviews of CEPAR and CARE completed	August	1994	USAID
Initial TA PIO/Ts completed	November	1994	USAID
Audit	January	1995	USAID
Obligation of Year 2 funds	February	1995	USAID
Internal review and evaluation	November	1995	USAID
Obligation of Year 3 funds	February	1996	USAID
External mid-term evaluation	September	1996	USAID
Obligation of Year 4 funds	February	1997	USAID
Obligation of Year 5 funds (final obligation)	February	1998	USAID
Audit	January	1999	USAID
Final external evaluation	April	1999	USAID
CA PACD	May	1999	USAID

* A complete Implementation Plan is provided in Annex E.

General Provisions

USAID Geographic Code 000 is the authorized code for source and origin of goods, and nationality for all services procured under the project. Medical supplies will be purchased under local cost rules (shelf items). All procurement under the project shall adhere to the following order of preference: (1) Code 000; (2) Host Country. Supplies to be purchased with USAID funds will be procured by CARE and CEPAR and transferred with legal title to the respective organizations with USAID acknowledgement.

Procurement Under the CEPAR and CARE Cooperative Agreements

Commodity procurement under the Cooperative Agreements will primarily consist of administrative equipment and supplies and medical equipment and supplies. In the case of CARE, equipment for use by NGOs will be budgeted within the subgrant agreements and procured by CARE. CARE may also subcontract to Ecuadorian nonprofit or commercial firms for specific technical services, such as development of and training in financial management systems. All equipment with a value of over \$500 will be of U.S. or Ecuadorian origin. Where this is not possible, required waivers will be obtained prior to procurement. No vehicles will be procured under the redesigned project; it is anticipated that several of the twelve vehicles already procured under the project will be transferred to CARE and CEPAR for the implementation of their programs.

It is expected that some NGOs will use TA to expand existing services, while others will have to develop more infrastructure. An illustrative cost structure for setting up a new facility within an existing building is as follows:

Building improvements	5,000
Medications	1,275
Medical equipment	875
Medical instruments	1,000
Disposable medical supplies	450
Medical clothing	400
Laboratory equipment	5,000
Laboratory supplies	750
Disposable laboratory supplies	550
Printed materia	4,400
Clinic furniture	
TOTAL (US\$)	20,000

Procurement by USAID

USAID will be responsible for procurement of all international long-term and short-term TA and for all offshore training. This will include

<u>ITEM PROCURED</u>	<u>MECHANISM</u>
TA from Initiatives	PIO/T - Add-on to centrally-funded project
TA from BASICS	PIO/T - Add-on to centrally-funded project
Other TA	PIO/T - Buy-in to centrally-funded project
Observations tours	PIO/P
Other offshore training	PIO/P
Public health biologicals	PIO/C

E. Technical Assistance and Training Plan

Technical Assistance Plan

Both CEPAR and CARE will require considerable TA to successfully implement their respective Cooperative Agreements. In addition, TA will be provided directly to the MSP and IESS to support policy development and decision making; this TA will be in the form of targeted studies and analyses, complemented by policy support observation tours.

Each of the three project components will involve three main areas of international technical assistance. For the MSP, international TA will be provided in developing a set of policies and mechanisms to collaborate with the private sector (six person months) and another policy set to collaborate with the IESS (three person months). The MSP will also receive technical assistance to implement a planned nationwide user fee system (three person months). Total TA for this project component will be 12 person months, with the majority of this TA concentrated in the first two years of project implementation.

Under the Cooperative Agreement, CEPAR will have a total of 46 person months of international TA focused on internal management, policy research and analysis, and dissemination, advocacy and IEC. During the first year, three months of TA will be provided in technical management to assist CEPAR to outline work plans, budgets and evaluation mechanisms. TA in policy analysis and advocacy of approximately 29 months, will be concentrated in the first two to three years. Likewise, 14 person months of TA will be allocated for dissemination, IEC and advocacy. Most of this assistance will be introduced during the first two years, but with the utilization of most person months in the second and third years as the bulk of policy analysis and advocacy results become available.

CARE will require a total of 55 person months of technical assistance. This will be divided between NGO management, administration and finance (34 months), child survival technical areas (15 months), and evaluation methods and systems (six months). A small part of this TA will be used to enable CARE to establish selection criteria and review systems for sub-grant donations, though the bulk of this work will be undertaken by CARE with the use of its own resources. The majority of TA and training will be provided directly to NGOs for the development of management capabilities in areas such as market analysis, preparation of business plans, strategic financial planning, pricing, financial management, logistical planning and management, quality control and service utilization monitoring. Additional support will also be provided in information, education and communications (IEC) and in technical child survival areas. This TA will correspond to the needs of the NGO subgrantees, and will be utilized most in project years two and three.

The services of a Child Survival Advisor will be obtained for a period of five years. This individual will work within the USAID mission as the CS Project Manager, though 50% of his/her time will be devoted to direct support for the policy development component, including both MSP policy support and technical assistance to CEPAR. Table VI.2 provides a summary of anticipated Level of effort for project TA.

TABLE VI.2
SUMMARY OF TECHNICAL ASSISTANCE LEVEL OF EFFORT
(In Person Months)

MSP/IESS (12 person months)	
Private sector collaboration	06
User fees	03
Intersectoral collaboration	<u>03</u>
SUBTOTAL	12
CEPAR	
Management	03
Policy analysis and advocacy	26
Dissemination / IEC	<u>13</u>
SUBTOTAL	42
CARE	
Management/admin./finance	32
Child survival technical areas	14
Evaluation and monitoring	<u>06</u>
SUBTOTAL	52
Local health admin. training	07
Child Survival Advisor	<u>60</u>
TOTAL (person months)	173

Sources of Technical Assistance

The sources of TA to be procured will be determined after project authorization. At this point, it is possible to identify possible or probable sources of TA, each of which has certain advantages and disadvantages. During a planned TDY the first week of July 1994, interviews will be conducted with all centrally-funded USAID projects to examine technical capabilities, language capabilities, project timeframe and budgetary or LOE ceiling limitations. Following are possible sources of TA, with advantages and disadvantages.

Centrally-funded USAID projects

LAC Health, Nutrition and Sustainability Project (LAC-HNS), a five year contract funded by the LAC Regional Bureau, is designed to provide technical support for LAC missions in the areas of health finance, health management, and nutrition. A policy component was added to the project after initiation, which has proved to be an extremely useful area of TA. Strengths of HNS are its LAC focus, roster of Spanish speaking consultants, and emphasis on technical areas of direct relevance to the redesigned project, namely, finance, management and policy. However, LAC-HNS commitments already meet LOE ceilings, and the project is scheduled to end in September, 1995. Buy-ins to the follow-on project could not come on-line until sometime in 1996.

Health Finance and Sustainability Project (HFS), a five year, R&D/Health funded contract designed to carry out worldwide applied research, analysis, and technical assistance in health finance

and hospital administration, has been the major source of TA for USAID/Ecuador in health care financing under the project so far. The mission has been satisfied with the technical quality of work performed under this contract, though there have been serious management difficulties and delays on the part of the contractor. In any event, due to both contact ceiling and timeframe, buy-ins to HFS are no longer possible, as the project is scheduled to end in September of 1994. A follow-on project is expected to be on-line in early FY95.

Private Sector Family Health Care Project (INITIATIVES) is a five-year Cooperative Agreement funded by R&D/Health designed to support expansion of self-financing primary health care services through private sector groups / NGOs. PACD is September, 1997. Advantages are (1) the purpose of the Initiatives Project is to provide TA for the kinds of activities to be carried out under the redesigned CS Project Component 3; (2) many of the NGO support modules have been applied in Ecuador over the past year; (3) Initiatives offers considerable capabilities in policy analysis and advocacy, particularly through the Rand Corporation, which is a project subcontractor. Disadvantages are (1) the current ceiling only allows a total of \$1.7 million in Add-Ons, though Initiatives is working in four countries, (2) PACD is scheduled for September, 1997, and (3) the core staff of Initiatives is small, with no core Spanish speaking staff.

Basic Support for Institutionalizing Child Survival (BASICS) is a five year contract with a joint venture led by Management Sciences for Health, John Snow, Inc. and the Academy for Education Development. BASICS was awarded in FY 1993. Advantages of BASICS are its focus on both institutional development and on technical areas of child survival; its broad consortium, with access to many consultants and to diverse corporate capabilities; its PACD, which is scheduled for September of 1998; and its high ceiling (approximately \$100 million). BASICS does not present any known disadvantages in terms of timeframe or budget ceiling.

Latin American Development Program (LADP) is currently in its seventh year and scheduled to end in September 1994. LADP is implemented by the LAC Bureau through a Cooperative Agreement with AUPHA. LADP is designed to develop health administration training in Latin American countries. The clear advantage with LADP is a technical one, as AUPHA is the sole international organization dedicated exclusively to development of professional health administrators. However, as LADP and the overall LAC-HNTSS Project are scheduled to end in September of 1995 under its current and second extension, it would not be possible to use an Add-on mechanism to access AUPHA services.

**TABLE VI.3
TECHNICAL ASSISTANCE MATRIX
IN PERSON MONTHS**

	DURATION		SOURCE OF TA		
	LONG TERM	SHORT TERM	INITIATIVES	BASICS HFS HNS *	OTHER (for CS Advisor)
MSP/IESS (12 person months)					
Private sector collaboration		6	6		
User fees		3	3		
Intersectoral collaboration		3	3		
CEPAR (46 person months)					
Management		3	3		
Policy analysis and advocacy		26	17	9	
Dissemination / IEC		13	4	9	
CARE (45 person months)					
Management/admin./finance		32	19	13	
Child survival technical areas		14		14	
Evaluation and monitoring		6		6	
Ecuadorian University		7		7	
Child Survival Advisor (60 person months)	60				60
SUBTOTAL	60	113	55	58	60

SOURCE OF TA BY PROJECT YEAR

	PY-1	PY-2	PY-3	PY-4	PY-5	TOTAL
INITIATIVES	23	26	6	0	0	55
BASIC/HNS/HFS*	0	12	19	15	12	58
OTHER (CS Advisor)	12	12	12	12	12	60
TOTAL	38	50	37	27	24	173

* To be determined

Project Training Plan:

The project will fund short-term observational training activities to take place primarily in third countries in the region. Funds will also provide for a participant training in the U.S. All of the offshore training will be contracted or financed by USAID direct mechanisms. HB 10 participant training regulations will be adhered to, including the use of a funded and non-funded PIO/Ps that will ensure that all preliminary clearances and reporting requirements to USAID in Washington are carried out in a timely manner.

In addition, the two Cooperative Agreements will include funding for in-country training activities to be organized and procured by the respective implementing entities. These will include seminars and short-courses and presentations, and other forms of appropriate training vehicles.

For both short-term and long-term training, it is envisioned that the project will take advantage of the CLASP Project and the to-be-designed Training for Development Project, with the CS Project in effect "buying-in" for training services.

In order to achieve long term improvements in organization of supply and demand in both the public and private sectors, a cadre of skilled health administrators and health economists is essential. This is a major constraint within the Ecuadorian health care system, as there is no health administration training capacity in the country and as a consequence, there is an absence of trained administrators and economists. Small health centers and clinics, secondary and tertiary hospitals, and health departments are normally managed by clinicians lacking formal management training. While there are a few internationally trained administrators scattered throughout the system, they are not adequate to have an impact on the improvement of health service administration. And, there are virtually no health economists in the country.

Assistance will be provided to an Ecuadorian university or other training institutions, to establish an independent and sustainable training capability in health administration and health economics. Development of a cadre of trained, professional administrators is considered essential to the sustainability of the nongovernmental health services, to improvements in the organization of supply and demand of health services, and to improved strategic planning in the public sector; in short, to development of the health care market. It is more cost effective to establish a local sustainable capacity which will be able to produce approximately 20 certified health administrators and economists per year, and preliminary estimates are that seven person months of TA will enable a private university (such as the Universidad Politécnica del Litoral/ESPOL or Universidad San Francisco de Quito) to establish this capacity. While Universidad Politécnica del Littoral is not the only university which will be considered for establishment of this program, that institution has demonstrated eagerness and ability to do so through short, high-quality self-financed courses in health administration training. As for health economists, there is less need to train the high numbers of individuals required to improve health administration, and there is less existing capacity to develop a health economics program. The project will therefore fund four economists to pursue master's level specialization in health economics. At least one each will be recruited from within the MSP, CEPAR and CARE networks, with the understanding that they will return to these institutions after completing their studies. In addition to immediately addressing a serious deficiency within the health sector, it is expected that these individuals will form a nucleus within a local university (e.g. Universidad de San Francisco de Quito) to begin a specialization in health economics.

For the kinds of change sought by the CS Project to come about in the health sector, key individuals must have skills in strategic planning, health service management, financial management, cost containment, and other related areas. This capability makes it possible for actors in the health market to improve production efficiencies and to respond to market signals. Eventually, the introduction of the profession of health administrator/health economist into the Ecuadorian health care system can be expected to have an impact both directly through improved management, and indirectly through market effects. That is, a sufficient supply of professional administrators would be expected to change the nature of competition for health services management positions, leading to increased demand for trained administrators/health economists.

It is essential, then, that health service administration be improved to enable implementation of policy objectives under Project Component 1, policy and market objectives under Project Component 2, and private sector management objectives under Project Component 3. Offshore training is not seen as a viable means to achieve the necessary impact, as the costs per trainee would severely limit the number of individuals that can be trained. Short term local training would establish improved management and administrative skills among individuals currently involved, for example, with project NGOs. However, this would not result in a sufficient scale to have a lasting effect on organization and management of the health care market. A preferred option is the establishment of a sustainable local capacity for training health care administrators.

A possible candidate for carrying out the health administration training activities is the Association of University Programs in Health Administration (AUPHA) which has worked in countries such as Costa Rica and Peru. AUPHA, under the Latin American Development Program cooperative agreement with AID/LAC, has established university level programs (certificates or Master's degrees) with universities. Under these arrangements, AUPHA has provided technical assistance and didactic materials within a university structure, typically within schools of business administration (see, for example, the Mid-Term Evaluation of the LAC-HINTSS Project, 1992). The result of these activities has been the creation of an on-going capability to train professional health care administrators.

In Ecuador, a similar approach has been tested with the School of Business Administration of the Escuela Politécnica del Litoral (ESPOL) in Guayaquil. With technical assistance from AUPHA, ESPOL organized short-term courses using national and international faculty, marketed the courses to groups including the FASBASE Project and the Junta de Beneficencia de Guayaquil, and successfully carried out the first round of courses in April of 1994. Fees charged to participants are sufficient to cover all costs including consultant fees, travel and per diem, materials, and overhead. The ESPOL School of Business Administration is structured to be self-financed. Preliminary discussions with ESPOL and with AUPHA suggest that a permanent capability can be established at ESPOL, and USAID estimates that approximately \$105,000 in project funds will be sufficient to implement this activity. It is expected that additional resources can be obtained with LADP/AUPHA core funds and from participant fees. This would serve as the primary technical training mechanism for participants under the CARE subgrants as well as from other public and private health service entities in the country. The result of this activity would be an on-going professional program in health administration producing approximately 20 degree or certificate graduates per year, with a greater number of individuals participating in short term training, meeting short term project strategic and operational needs. (Additional short term specialized and in-service training will be provided by CEPAR and CARE to meet implementation needs.) As a self-sustaining program, a continuous stream of trained personnel will enter into the health service careers marketplace during and after the life of the CS Project.

VII. PROJECT SUMMARY ANALYSIS

A. Technical Analysis

1. *Health Areas: current description*

Ministry of Health facilities are generally organized in terms of local health area, provincial level, and central level. Local health areas comprise basic health facilities, such as health posts, subcenters, and centers, located in a specific geographical site, up to and including canton hospitals (15-30 beds) in rural areas. The provincial level comprises the provincial health directorate and the provincial general hospital; and the central level includes the MSP national offices and the tertiary, referral hospitals.

One of the constraints the MSP has traditionally experienced is excessive centralization. Functions such as policy-making and standard setting, planning and administration, and financial management, for example, have been concentrated at the national/central level. This has often resulted in plans and programs not tailored to local needs, or communities being removed from active participation in solving local health problems.

Health areas are an attempt to provide effective and efficient services at the local level, making health providers accountable to the community and encouraging its participation. From a technical standpoint, health areas should be able to solve frequent, simple health problems, those which may require low medical technology and be comprehensive in nature (primary or basic health care). From an administrative standpoint, local health areas should be able to independently organize, plan, supervise, and evaluate health care activities at the local level. It is also plausible that health areas will become the MSP vehicle for sustainability based on the community's willingness to provide financial support in exchange for quality care.

The MSP currently lists 184 health areas nationwide. Roughly, the number of health areas in each province corresponds with population size. As an illustration, the top three provinces in population size, Guayas, Pichincha, and Azuay, have 40, 18, and 13 health areas, respectively, or almost 40% of the total of areas.

MSP strategy towards strengthening health areas

The concept of health areas is not new. Many attempts have been made over the last 15 years to consolidate local health services. The Pan American Health Organization, through its SILOS (Local Health Systems) program, has actively encouraged countries in the Latin America and Caribbean region, to adopt and institutionalize local health areas. USAID has also supported the health area concept. The 1989 Child Survival and Health Project Paper, for example, already indicated that "...project activities are aimed at strengthening area health teams to enable them to resolve the causes of infant mortality most prevalent in their area...The new health areas will subsume the rural operating units in their jurisdiction such that each subcenter and post will rely administratively, financially and logistically on the area headquarters, usually the cantonal hospital...The team collectively programs health services for the area, setting priorities, coordinating resource allocation, scheduling, monitoring and evaluating activities according to local requirements and possibilities. This should ensure that MSP services respond to the diverse local conditions, while

the team's internal cohesion should lead to stability and continuity in service programming and delivery."

In April, 1992, the GOE issued an executive decree establishing local health areas as the basic structural and functional unit for delivery of MSP services, in a regionalized and decentralized fashion. In July, 1993, the current MSP administration approved an operational manual making official the implementation of local health areas. Since then, the MSP has begun to emphasize local health area strengthening, particularly with support by the World Bank project (FASBASE).

The MSP strategy is that, by strengthening local health areas, local needs will be better addressed, community participation will be enhanced, and overall health indicators will improve. This process will be facilitated by private sector participation, including community organizations, NGOs, church groups, etc.

Options to develop public-private partnerships in support of health areas

The Initiatives Project, a centrally-funded project to support development of privately-provided, sustainable primary care, has prepared a position paper which describes options to be considered when establishing private sector-public sector partnerships. This document lists the following seven options:

- Option 1: Complete transfer of assets, personnel, and authority to NGOs.
- Option 2: Transfer of management function, with ownership kept at MSP hands.
- Option 3: Gradual transfer of MSP facilities to NGOs over a five year period.
- Option 4: Lease arrangements under varying conditions.
- Option 5: A "minimal restriction" management contract.
- Option 6: Joint venture or shared risk contracts.
- Option 7: A "maximum restriction" management contract (fixed budget contract).

These options assume willingness on the side of public sector and private sector to pursue common health care delivery objectives, including improved coverage and efficiency, sustainability, and quality, for example. The MSP has limited experience with NGOs. However, this experience has indeed allowed identification of several constraints which hinder further growth. The purpose of the project redesign is to facilitate an improved interaction between MSP and NGOs, such that more and better primary care is available to populations at risk.

Estimation of potential health areas that could benefit from the amended project

Many health areas could benefit from the project amendment. However, given the limited availability of financial resources and the need to concentrate technical assistance in a few locations, explicit criteria must be established to focus CS activities in high priority areas. The criteria may

include: (1) the presence of other ongoing MSP programs (e.g. FASBASE); (2) established NGO activities; (3) the community's need, characterized by negative health status indicators; and (4) market conditions (e.g. ability to pay, sufficient demand, limited competition).

Provinces with the largest population concentration are Guayas and Pichincha. Selected areas in both of these provinces are priority FASBASE areas. Many of these areas have NGOs working in them. In addition, health care needs are certainly critical, particularly in peri-urban areas of Guayaquil (approximately 1 million people live in Los Guasmos, under extremely difficult conditions). An informal statement by the Minister of Health suggests that Guayas has 80% of the national morbidity, whereas it receives only about 30% of the MSP budget. Despite concentration of disease in Guayas and Pichincha, other areas in the country also depict negative health status indicators. These areas are located in the central Sierra provinces of Cotopaxi and Chimborazo, those with the largest indigenous populations. Maternal and infant mortality rates, for example, are highest here, and access to health care services may be limited due to geographical, socio-economic, or cultural barriers.

Content of PHC service to be delivered in health areas

The MSP has established the following list of priority activities to be offered by all health areas.

Maternal care: prenatal, natal, and postnatal care; family planning; cancer screening;

Infant/child care: immunizations; growth monitoring, breastfeeding, and nutrition; prevention and control of diarrheal disease, respiratory illness, and parasitic diseases;

Other: screening of hypertension; control and prevention of tuberculosis, cholera, and malaria; dental care; and health promotion.

This list of activities is defined as the "basic health care" package to be provided in all MSP health areas. From the above, it is clear that activities cover not only maternal and child care, but also care oriented to prevent chronic conditions. In the context of the overall MSP crisis, health area facilities are frequently understaffed, poorly equipped or maintained, and with shortages of basic drugs and supplies. This is precisely the reason why continued work on this issue is required. The original project had begun working with most health areas in the eight project provinces: medical equipment will be distributed shortly; computerized information systems and trained staff have been provided; and health care workers are trained regularly. Presently, these activities are being institutionalized into the MSP as part of its decentralization strategy, with assistance from the FASBASE project. At the same time, a plan to transfer current CS activities on to the MSP is underway. Both of these actions provide some assurance that health areas will continue to be strengthened in the near future.

Linkage between PHC and improved MCH indicators in catchment areas

As indicated above, PHC comprises a series of activities to satisfy basic health care needs at the community level. PHC is a strategy recommended by the World Health Organization since 1978 to achieve the objective of "Health for All By The Year 2000." In 1985 USAID launched its child survival initiative to improve the health of children in developing countries. This initiative includes health interventions such as vaccinations, oral rehydration therapy, nutrition, family planning,

treatment for acute respiratory infections, safe motherhood and breastfeeding, and water and sanitation. Most of these interventions are contemplated within the basic package of services offered at the local health area level, according to MSP norms.

An assessment done by USAID of the child survival program performance in six countries concluded that the program has generally been effective, efficient, and sustainable. Similarly, the World Bank recommends investment in "essential clinical services," i.e. PHC, due to their cost-effectiveness, i.e. less than \$50 per disability-adjusted year of life gained, as compared to curative interventions.

Although improvements in health status indicators are affected by a complex interaction of socio-economic, political, or cultural factors, worldwide evidence indicates that the provision of basic health services is an important factor. In Ecuador there are some examples which illustrate the value of PHC interventions. One clear instance is the experience of an NGO located in the Santo Domingo de los Colorados area. This NGO operates since 1983 in a deprived, rural area. Community health status indicators, particularly maternal and child health indicators, are significantly better in the areas where this NGO works. Pregnant mothers have easy access to prenatal care; the majority of children under five are fully immunized; and preventive dental services are increasingly becoming available. Moreover, this NGO recovers 100% of recurrent costs, while providing almost 30% of preventive care in its service mix. In contrast, similar basic MSP facilities often suffer from lack of personnel, inadequate amounts of drugs and supplies, and lack of confidence on the part of the host community.

This experience exemplifies the feasibility of CS/PHC services offered by the private sector. The amended project intends to capitalize on this potential, and thus contribute to expand coverage and access to quality PHC services among underserved populations.

B. Institutional Analysis

1. *The Ministry of Public Health*

Established in 1967, the MSP has traditionally operated through a highly centralized technical and administrative hierarchy which has provided little operational flexibility to the provinces and local areas. As a result, MSP policy making, norm setting, and service delivery have been ineffective in addressing local needs. This is reflected in MSP coverage of about 30-40% of the total population in the country, and public services plagued by problems in quality, productivity, and sustainability. Since the mid-1980s, the central MSP has been moving to provide tentative norms for decentralizing some financial and administrative functions to the health areas. Under the current GOE administration and its 1993-1996 Agenda for Development, the context is set to establish new relations among the state, society, and individuals, in order to promote improved living conditions. Strategies seek to redefine the role of the public sector, towards its rationalization, towards simplification of institutional structures and administrative procedures, and improved management.

Through its *Basic Health Policy Guidelines: 1993-1996*, the MSP defines health care as a responsibility of all, requiring concerted actions among other public sector institutions, non-governmental organizations, and society at large. In this context, the MSP is to actively pursue

decentralization, sustainability, efficiency, private sector participation, and community participation. In July, 1993, the MSP approved an operational manual for health areas, in order to initiate the re-organization and decentralization of MSP operations.

During its 25 years of institutional life, the MSP has been through many re-organizations. A major structural and functional re-organization is underway as a result of the modernization process. Six priority areas have been established: primary care; secondary and tertiary care; epidemics; generic drugs; food and nutrition; institutional development; and coordination. Accordingly, the traditional MSP divisional structure has changed into a functional structure, whereby a number of standing committees have been established. Each of these committees is responsible for planning, programming, and monitoring programs and activities in each of the priority areas.

As an illustration, the institutional development committee deals with overseeing FASBASE, evaluating MSP-wide MIS, including planning and financial management systems; and other mechanisms to improve MSP operations. The primary care committee handles issues related with basic health services, including local health areas. Donor agencies are involved in several of these committees in an advisory role. USAID participates in the institutional development committee. In practice, the committee structure of the 'new' MSP is yet to prove practical and useful. Given internal power struggles and resistance to change, committees are seldom effective. Scheduled meetings are put off or canceled; technical expertise is limited; the decision making process is confusing; and there is unclear authority to pursue adequate implementation at operational levels.

At the provincial and local level, changes are slow to come. Although the decentralization theme is part of all policy dialogue, practical implementation has not come about. Serious lack of local capability to assume responsibilities is evident; although some provinces have incorporated MIS systems, the majority are still without this technology. The CS Project has made significant contributions to improving provincial operations in 8 project provinces. However, dissemination of MIS technology is slow, and resources, e.g. hardware, software, trained personnel, are sorely needed.

A National NGO Coordination Office was established organizationally in April, 1994. The MSP is sensitive to the multiple constraints which NGOs face, including legal registration, oversight, overall support, and coordination. The MSP's intent is to have NGOs participate jointly to improve access and service delivery. In order to achieve this goal, MSP needs to be able to establish direct, but simple, relationships with NGOs. The coordinating office's basic function will be to facilitate NGO-MSP bridging, including the mechanisms that will allow cooperation at the operational level, e.g. agreements. This office will initially be staffed by four individuals. USAID will support the installation of the office as a first step in the transition.

2. *CEPAR*

CEPAR was established in 1978. It is a private, not-for-profit non-partisan organization, which offers research, information dissemination, and training services, in the areas of population and development and related subjects, e.g. planned parenthood, family planning, women's reproductive health, etc. CEPAR has been nationally and internationally recognized. In 1991, for example, it received the U.N.'s World Population Prize as well as the GOE's Honorato Vasquez Prize. During the last 15 years, CEPAR has become the leading institution for population policy analysis and advocacy in Ecuador.

Some of CEPAR's most successful initiatives in population and family planning policy analysis include assisting in the preparation of a national population policy; the execution of several demographic and health surveys; the execution of a reproductive health survey among Ecuadorian youth; and the publication of several reports of varied content and scope. These activities have supported the technical operations of CEMOPLAF and APROFE, in addition to helping formulate a national population policy. As an example of the technical capabilities of CEPAR, the unsolicited proposal submitted by CEPAR to USAID to carry out the policy analysis, dissemination and advocacy component of the amended project is provided as Bulk Annex B-6.

CEPAR's institutional structure is defined by a General Assembly, a five-member Executive Committee, a President, an Executive Director, and technical and support departments. CEPAR's Research Department has extensive experience in producing high quality studies which have served to support institutional policies and strategies. This department has experience in carrying out national demographic and health surveys; monitoring and evaluation of family planning programs; operations research; and literature reviews on diverse topics. Since 1991, the department has completed and published approximately 100 studies. The department's research activities are supported by an advanced Computer Center which includes top hardware equipment, software, and trained personnel.

The purpose of CEPAR's Training Department is to offer public and private sector leaders a series of opportunities to learn and discuss about topics related with demography, population and development, planned parenthood, and reproductive health. Between 1982 and 1993, an estimated 680 national and international events have been held, with approximately 59,000 participants. Event participants have included GOE cabinet members, congressmen, and other public sector high officials; also, professional associations, labor organizations, and higher education representatives. Dissemination activities have also been oriented towards "lay" information consumers such as parents and high school students. A series of relevant publications have been prepared and distributed.

CEPAR's Information Dissemination Department has been operative since 1982. The purpose of this department has been to provide and distribute population-related materials among priority target groups. The goal has been to create awareness among policy makers or among influential individuals, i.e. opinion leaders, with regard to population issues. Resources available to carry out these activities include a specialized information center and communications technology (e.g., radio and audiovisual media). An IEC strategy is actively encouraged.

The financial/administrative department seeks to maximize resource generation and utilization, as well as support the technical departments in their specific functions. This department includes the following systems: financial management, human resource management, and general services (e.g. procurement, inventories, maintenance, etc.).

3. *CARE*

CARE has had an active presence in Ecuador since 1962. CARE's objective is to help the poor of the developing world, in their efforts to improve their economic and social welfare. CARE supports actions that create competence and self-sufficiency for the participant communities.

CARE is an international Private Voluntary Organization, with headquarters in Atlanta, Georgia, and offices in 11 other countries. In Ecuador, CARE central offices are located in Quito, and maintains eight field offices in project implementation areas. These offices are responsible for direct project supervision and monitoring, and provide ample opportunity to learn and act upon local

needs. In addition, all of CARE projects are approved by the GOE and have a specific GOE counterpart. Staff in CARE/Ecuador are comprised of 7 international FTEs and 136 national FTEs.

CARE's initial program in Ecuador was food distribution, but it has since evolved to include rural primary health care training, water and sanitation service installation, nutritional interventions (e.g. family vegetable gardens), reforestation, land conservation, and small business development. In implementing this diverse portfolio, CARE receives financial support from donor agencies and governments such as USAID, WHO/PAHO, the Dutch Cooperation Agency, the Government of Sweden, among others. By 1993, CARE's donor-based operational budget for PHC was approximately \$4.5 million. PHC programs and activities are carried out in 10 provinces, serving approximately 22,000 families. A significant proportion of CARE's operating budget is provided by communities and local government agencies through cooperative agreements. Local communities are also actively involved in the design and evaluation of projects and contribute with labor and materials to infrastructure construction projects. All projects seek to enhance community organization and institutional strengthening with the ultimate goal of self-sufficiency and sustainability. Development of PHC services is a strategic objective for CARE for the 1990s.

In order to provide PHC services, CARE has been able to establish links with counterpart organizations, such as local government agencies, community organizations, or NGOs. CARE/Ecuador has multiple examples of this approach in different sites across the country. As an NGO coordinating organization, CARE has important experience in Bolivia and Peru. In Bolivia, CARE has played an important role in the implementation of an umbrella NGO coordinating organization (PROCOSI), which provides technical assistance to participating groups. In northern Peru, CARE is also instrumental in coordinating support for several family planning NGOs.

In terms of its ability to provide technical assistance, CARE enjoys a distinctive advantage in the conceptualization and implementation of PHC. CARE has a highly qualified technical team which may provide quality support to NGO PHC programs. CARE, however, may require external support in areas related with the business side of PHC delivery, such as financial management, marketing, or information systems. High level local and regional capability exists in these areas, and some consulting groups have indicated interest in the NGO support initiative.

4. *Non-governmental organizations*

As the main beneficiaries of USAID support through the CS Project, NGOs will play an essential role. Moreover, the MSP has stated an explicit strategy, within its sector modernization policy, to incorporate the private sector, i.e. NGOs, in the delivery of services. In order to understand the potential offered by NGOs, some basic information on their nature and scope is therefore needed, particularly as it relates to health care.

A survey conducted by PAHO in 1992 referred that approximately 8,000 NGOs existed in Ecuador by that time. Of these, 146 were NGOs working in the health care field, but 82 specifically stated health care as their institutional objective. Health NGOs are registered with the Ministry of Social Welfare, Ministry of Health, and Ministry of Education, Foreign Affairs, or Labor. This situation points to the need to standardize registration procedures for NGOs, a goal stated for the new NGO coordination office at the MSP. Most NGOs work in urban settings, with almost two

thirds being located in Quito, and the rest in Guayaquil, Cuenca, and other cities. Almost 40% of NGOs have 10 or more years of institutional life.

According to the survey, 44% of NGOs provide curative care, while only 13% focus on preventive care. Only about 7.5% provide "comprehensive care." Curative care includes areas such as cardiology, neurology, chronic metabolic diseases, and the like. Concurrently, NGO staff specializes according to the nature of services provided. As to financial resources available, about 22% of NGOs indicated a budget less than \$1,000 for 1992; and 17.5% indicated an annual budget of between \$1,000 and \$10,000. About 27% of NGOs had a budget over \$500,000 for 1992. A significant amount of funding is provided by international donors. In 1991, NGOs were estimated to mobilize approximately \$63 million. Physical infrastructure was obviously related to the availability of financial resources. When asked about the type of relationship NGOs kept with the MSP, 46% indicated no relationship at all, and 29% indicated an "occasional" relationship. Only 15% maintained a stable relationship, based on some budget or grant allocation, or because of a contract for specific services.

A number of strengths and weaknesses are generally associated with PVOs working in Ecuador.

Weaknesses of PVOs:

- **Limited Management and Technical Abilities.** PVOs have historically been weak in the areas of management and technical expertise. This has resulted in a number of poorly planned efforts and inefficient programs. A recent study of an internationally recognized PVO funded for five years by USAID showed that even though the project had considerable expatriate and domestic technical assistance, it largely failed because of inadequate management and technical skills, poor planning, and a virtual absence of fiscal analysis or understanding.
- **Limited Financial Sustainability:** While many PVOs demonstrate financial and technical maturity, most rely upon outside funding to maintain their programs. Outside funding is often not sustainable, and PVOs must make up for financial shortfalls through cost-recovery systems, and improved financial and technical management.

Strengths of PVOs: The following reflects a number of the demonstrated capabilities and the potential of PVOs to expand services and to make a positive change in the health service marketplace.

- **GOE policy support:** stated and emerging GOE and MSP policies favor PVO involvement and promise to create new demand for PVO-produced health services.
- **Targeting low-income families:** almost all PVOs operating in the health sector have low-income populations as their explicit targets, and are located in low-income areas.
- **Emphasis on preventive and child survival services:** as mentioned above, perhaps 17% of preventive health services in Ecuador are already produced by PVOs, reflecting the emphasis placed on primary health care programs by these organizations.

- **Few legal restrictions:** once chartered as nonprofit foundations, NGOs in Ecuador are generally unencumbered and able to participate in a range of activities (such as receiving funds from FISE and other public institutions).
- **Unaffected by public sector budgetary cycles or limiting enrollee requirements:** while the MSP is currently totally dependent on public budget cycles and therefore deeply affected by shortfalls, and whereas the IESS is currently limited to enrolling formal sector employees in their health programs, NGOs have the innate flexibility to explore new production models, limited only by technical and financial factors.
- **More efficient cost structure:** recent comparative studies in Ecuador have demonstrated that the cost structures in sampled NGOs differ from those in sampled public facilities in that relatively less is spent on personnel and administration, and relatively more on maintenance, drugs, supplies, and other nonpersonnel items. Such a cost structure enables NGOs to produce higher quality, lower cost services than public facilities.
- **High potential for cost recovery:** while not all NGOs in Ecuador recover a high percentage of their recurrent costs, much less recurrent and capital costs, many have indeed shown this ability. For example, there is evidence that at least one PVO is already producing effective PHC and basic health services with 100% cost recovery.

In sum, NGOs have significantly increased in numbers over the last 10-15 years in Ecuador. However, they constitute an extremely heterogeneous group with regard to their origin, mission, organizational structure, size, and source and amount of financial support. Most NGOs are small organizations, with limited operational capabilities, and short, unstable projects or programs. Health care NGOs are estimated to cover approximately 5% of the total population in Ecuador.

Given the MSP policy interest in private sector participation, and the availability of an array of potentially interested NGO groups, the purpose of the redesigned CS Project is to facilitate the interaction between these two actors. As mentioned above, registration mechanisms are not clear; bridging relationships are deemed unnecessary; and NGO coverage, combined with an MSP estimated coverage of 30%, adds little to meeting demand for health care. On the other hand, NGOs are a sprawling kind, serving mostly the urban poor. They constitute an untapped source of needed support to increase access to quality, affordable PHC, an objective clearly pursued by the MSP.

In this vein, USAID has made a strategic choice to work and support NGOs, as a means to expand privately produced PHC services, in the context of the existing MSP policy. This is perceived to be an unique opportunity to introduce reforms into the health sector, where the MSP focuses on policy making or regulatory functions, whereas the private sector becomes the major provider of direct, sustainable services. NGOs are also interested in this approach. Moreover, they realize their limited capability to respond to the MSP challenge, but are willing to receive outside support in order to enhance their institutional development and duly accomplish their objectives. All in all, it appears that the potential for a private sector-public sector partnership is ripe at this time and is worth investing in it.

5. Evaluation and selection of possible collaborating institutions for the amended CS Project

Short lists were prepared to identify potential collaborators under each of the two Cooperative Agreements, and evaluation matrices were developed to review characteristics of each potential collaborator against a set of criteria. The "Think Tank" short list included eight institutions, while the "NGO Management Unit" short list included seven.

Two institutions were dropped from each short list due to unreasonable difficulties in contacting key personnel. Interviews were held with the remaining eleven institutions, and scores were applied based on these interviews and on written capabilities statements provided by most of the groups. Sensitivity analysis was then performed on the data by first systematically eliminating and then doubling the values for each criterion to detect impact on the overall ranking; the rank orders did not change as a result of this sensitivity analysis. The resulting rank order results, and details of the evaluation based on initial weights, are shown on the following two pages.

For the Think Tank CEPAR most closely met the evaluation criteria; it is therefore recommended that CEPAR be chosen as the institution upon which to build the Think Tank. For the NGO Management Entity, there was no single institution which had a clear edge, as CARE, Stern & Compañía and Price Waterhouse received essentially the same scores. However, Stern & Compañía and Price Waterhouse are both commercial firms, while CARE is a non-profit NGO. For reasons of contracting ease, the result of this process is a recommendation that CARE be selected as the NGO Management Entity. Table VI.4 provides the summary scores assigned to organizations on the short lists.

TABLE VI.4 SUMMARY SCORES OF SHORTLISTED NGOs FOR AMENDED PROJECT COOPERATIVE AGREEMENTS		
RANK ORDER	INSTITUTION	SCORE
THINK TANK		
1	CEPAR	89
2 (Tie)	INCAE CEDATOS	76
4	CEPLAES	73
5	Universidad Politécnica del Litoral	68
6	Fundación Eugenio Espejo	63
NGO MANAGEMENT ENTITY		
1 (Tie)	CARE Stern & Compañía	77
3	Price Waterhouse	75
4	Fundación Hermano Miguel	58
5	ROPSI	0

C. Economic Analysis

The point of departure for the amended project is the identification of serious inefficiencies in the production and delivery of primary health care services in Ecuador, in both the public and private sectors; and the design of the project reflects a set of strategies to improve these conditions. In the public sector, policies and practices have made it difficult for the MSP and the IESS to provide the most effective coverage possible with the resources at their disposal, while a combination of public policies as well as managerial and financing constraints have limited the ability of the private sector to meet its production and coverage potential.

By identifying, developing and promoting improved production models within both the public and private sectors, the amended project will help improve policies and technical practices to enable both sectors to improve efficiencies and expand coverage of primary health care / child survival services. Facilities which can serve as "models" of improved production already exist in both the public and private sectors in Ecuador; the project will use all three components to further refine these models and, through dissemination, policy development, technical assistance and demonstration,

facilitate the adoption of elements of these models for service production and delivery in both sectors. In addition to quantitative improvements and production and coverage, the project will result in a number of significant benefits for the target population. A summary of the more salient benefits includes:

- ***Better mix of preventive services:*** In a sample of MSP and NGO facilities examined, there was a wide range of mix of services. The vast majority of private sector facilities emphasize curative services, and nearly all IESS/SSC services are curative in nature, while a majority of MSP services are curative in nature as well. However, among both MSP and NGO facilities there are examples, or models, of facilities in which preventive services (immunizations, well child care, and pre-natal care) represent a very high proportion of all outpatient or ambulatory care services. That is, in these "model" facilities, a greater number of cost-effective preventive services are produced with a given level of resources.
- ***Better quality:*** with an improved cost structure, more resources are available for "quality-enhancing inputs" (drugs, laboratory reagents and supplies, maintenance of equipment, etc.). For example, for the MSP as a whole, approximately 87% of all recurrent expenditures are used for personnel costs, leaving 13% for all other inputs. In a sample of MSP health centers, an average of 80% of recurrent costs were for personnel. In contrast, in a model NGO facility, less than 50% of all recurrent expenditures were for personnel, allocating a greater proportion of its resources for non-personnel inputs.
- ***Better coverage:*** more efficient cost structures enable greater coverage under the project model than would be possible under the existing MSP production modes.
- ***More services for the same expenditure for covered families:*** improved production efficiencies mean that, for a given level of expenditure per family, each family can receive more services. Or, under a total cost recovery structure, there is a higher cost effectiveness for a given family health expenditure.
- ***Demonstration effect:*** the self-financing model, combined with other project dissemination mechanisms, will have a "demonstration effect," enhancing its replicability and increasing the benefits from project activities.
- ***Improved competition in the health marketplace:*** Project supported health services will introduce greater competitiveness in those areas in which they are provided, resulting in further benefit to the priority populations living in areas affected directly or indirectly by project activities.
- ***Enhancing GOE/MSP policies:*** the development of private sector production capabilities will enhance the implementation of GOE/MSP policies on private sector involvement, and will enable the public sector to devote more of its resources to child survival services by relieving the burden currently created by MSP emphasis on outpatient and inpatient curative services.
- ***Mobilization of resources:*** Project activities will result in the mobilization of resources not only from the direct users of those services, but from other sources as well. For example, in late 1993 the MSP entered into an agreement with an Ecuadorian NGO to co-administer the

national pediatrics hospital, Hospital Baca Ortiz; this arrangement includes a new user fee system at the facility. By early 1994 this arrangement was generating approximately US\$30,000 per month in revenues, representing 12% of the hospitals operating budget; this amount virtually doubles the resources available for nonpersonnel recurrent costs such as maintenance, drugs and supplies, and anecdotal evidence suggests that quality improvements are already in evidence. The project will assist NGOs and the MSP to expand such cooperative arrangements and to implement cost recovery mechanisms in all levels of facilities through the Public Policy Support component, mobilizing resources in other facilities throughout the country.

- *Savings accruing to the health sector:* Adoption of improved cost structures along the lines of the "model" facilities will lead to widespread efficiency improvement. As a result, the costs of producing a given volume of services, within a facility or health sector wide, will decrease.

As "models," one MSP facility and one NGO self-financing facility have been identified. While both of these facilities are far from ideal and each leaves much room for improvement, for purposes of child survival service expansion their average unit costs of production, their preventive/curative service mix, and their quality levels are far better than the overwhelming majority of facilities in Ecuador. In the MSP, the Centro de Salud in the parish of Yaruqui in Pichincha Province provides such a model, while in the private/NGO sector, the Centro de Salud ASME-X (Asociación Médica Ecuatoriana Cristiana), which provides services to the parish of La Independencia in the western lowlands of Pichincha Province, serve as an examples. In terms of cost structure and cost recovery, the NGO spends less than 50% of its recurrent expenditure on personnel and is currently recovering over 100% of its operating costs; this is one area where the MSP facility at Yaruqui, spending 73% of recurrent costs on personnel and recovering 7% of operating costs, performs better than in most other public facilities but still requires stronger managerial and technical skills. The table below summarizes some of the vital characteristics of these two facilities, compared with a blend of three other MSP facilities; data on all these facilities come from the same source (Balarezo and Paguay, 1994).

The "model" facilities are well utilized; medical and other supplies are well stocked; equipment and vehicles are generally functional; personnel costs are kept relatively low; and cost recovery is more effective than in most other facilities providing similar services. These are used here as "preliminary models" because, though there is room for improvement, especially in the public sector model, they demonstrate the feasibility of combining the three fundamental characteristics which provide the basis for NGO service delivery supported under the amended project: (1) they serve a low-income population without access to other services; (2) a very high proportion of outpatient services are preventive in nature (this proportion is higher than in other public sector facilities studied in Ecuador, and higher than many other successful examples of private sector primary health care services from other countries such as PROSALUD in Bolivia); (3) in the case of the NGO model, over 100% of its recurrent costs are recovered through user fees, even though over 20% of all patients receive services with fees waived (fees are paid from a separate fund financed with revenues and set aside for this purpose). These are "preliminary models" because the project will develop different models of service production and delivery, such as prepayment and contact with group purchasers, which may improve the benefits and savings beyond the levels observed in this model.

**TABLE VI.5
COMPARISONS OF MSP AND NGO HEALTH FACILITIES**

CHARACTERISTIC	MSP HEALTH CENTER: YARUQUI	ASME-X (NGO) HEALTH CENTER: LA INDEPENDENCIA	OTHER MSP
Preventive as a% of all outpatient services	43%	32%	17%
Personnel as % of recurrent costs	73%	47%	76%
Average unit cost of outpatient service (in Sucres)	2,104	4,960	7,182
Average unit cost of dental services (in Sucres)	3,547	3,234	13,962
Levels of pharmaceutical stocks	Adequate	Adequate	Poor
Condition of medical equipment	Adequate	Adequate	Poor
%age of recurrent costs recovered	7%	104%	3%

The project benefits summarized above are for the most part self-evident. For purposes of this economic analysis, we need only consider in detail the last two benefits; that is: (1) the additional revenues which will be generated through user fees in the public sector; and (2) the savings which will accrue to the health sector during the five year of project activity as a result of the projected volume of services which will be produced under the improved or "model" production modes.

The complete Economic Analysis, with methodological description, data steps, and summary analysis table, is contained in Annex B. Based on this analysis, it is estimated that new revenues which are attributable to the project during the life of the project will total \$12,597,031; and that estimated savings will total \$2,405,556. The combined benefits of new revenues and savings therefore total \$15,002,587. Compared with a cost of \$9,100,000 for amended project activities, this results in a benefit:cost ratio of **1.65:1**.

D. Financial Analysis

For purposes of this project paper, financial analysis of nongovernmental organizations which are to provide child survival and primary health care services involves prognostication of the sustainability of those NGOs after PACD. NGOs health services are considered to be sustainable if financial projections

(projections of income and expenses) show breakeven prior to PACD. That is, the NGOs participating in sustainable child survival service delivery must be able to recover their costs (through a combination of user fees, other sales of services, and other reliable sources of income) at a level greater than the costs of operations (including salaries, other direct costs, overhead, and other indirect costs), while serving low-income populations and producing a significant level of preventive services.

It is expected that, of the 25 NGOs receiving support under the amended project, 10 will be able to achieve full financial sustainability while providing low-cost child survival and primary health care services. While the 10 NGOs are yet to be selected (under the CARE component of the project) and therefore cannot be identified with any certainty at this point, preliminary financial data projections from two NGO's which are likely to participate in the project give an adequate indication of sustainability potential.

ASME-X: as described in the preceding section, ASME-X meets project criteria of serving a low-income population and producing a significant level of preventive and child survival services. And, as described above, the ASME-X model is currently able to recover 100% of its recurrent costs.

Fundación Metrofraternidad: this Quito-based NGO affiliated with the Hospital Metropolitano has been receiving technical support from USAID to develop a capacity to deliver sustainable primary health care services. Metrofraternidad began service delivery in the area of Calderón just outside Quito in early 1994. As part of the planning carried out prior to initiation of service delivery, Metrofraternidad prepared projections of income and expenses based on a simple user fee schedule (e.g., a medical consultation has a single price of S/ 4,800, or about \$2.20). Under these projections, Metrofraternidad is projecting breakeven in its third year of operations. At that time, with coverage of 15,000 people (50% market share), Metrofraternidad projects a total annual cost of S/ 161,383,798 (fixed and variable, including salaries, and depreciation of infrastructure, totalling at a little over \$10 per beneficiary) and revenues of S/ 70,873,375. Of the revenues, 16% are projected as returns from an endowment and 84% are projected as user fee revenues. By the fifth year, income is projected as breakeven plus 8% (totalling S/ 216,216,312), of which 90% of all operating costs are met from user fees.

Detailed spreadsheets from Metrofraternidad, with a five-year projection of income and expenses is provided in Bulk Annex B-2. At the time these projections were prepared, reliable market or demand data were not available in the area Metrofraternidad is working; projections therefore are based on more assumptions than would be desirable. At the time of the preparation of this Project Paper Amendment, demand studies are under way in the Metrofraternidad catchment area as well as in catchment areas four other Initiatives-supported NGOs, and strategic financial planning spreadsheets with breakeven analysis based on market research data will then be prepared.

E. Social Soundness Analysis

The Social Soundness Analysis carried out for the original Child Survival Project is a comprehensive social assessment of the rural and marginally urban areas of six provinces targeted for the original design. The project will be focused on at least 2-3 of the same provinces as proposed for the original CS Project. The proposed amended project target population of peri-urban and rural residents is also viewed as comparable to the populations assessed in the original social soundness analysis conducted in 1989, with the only significant difference being a trend toward urban migration. As such, the original analysis is considered both valid and highly relevant to the successful operation of the amended project.

The following is a summary of the recommendations and findings contained in the original Social Soundness Analysis:

- 1) The project should focus assistance in support of greater rationalization and coordination among the state health care institutions, in particular for: the delivery of PHC services, increasing productivity, and for improving the technical and managerial/administrative skills of health care professionals.
- 2) The selection process for appropriate health services and programs should be highly democratic, with maximum participation of local users, provincial and regional authorities and MSP decision makers.
- 3) Conditions for social accessibility and acceptability of PHC services must be improved through quality of health care attention and adoption of sustainable changes in the attitudes and behavior of health care personnel.
- 4) The project should not be based on a strategy of predefined solutions and proposals. The target populations are heterogeneous in nature with health care needs that are constantly changing. The project must take this into account, and provide for a flexible approach based on a highly participatory design and implementation strategy.
- 5) It is essential that a permanent research and monitoring capability be instituted in the project to maintain and track the progress of project interventions and services.
- 6) The project should promote the decentralization of power from the central to the provincial level, as well as from the provincial to the local level. This is not to be confused with the delegation of authority, but rather should reflect a significant transference of administrative and technical skills and responsibilities to both the intermediate and local levels. The project should move away from the authoritarian model of traditional health administration, and remain flexible enough to adopt to the heterogeneity of various forms of governmental and municipal operation and management.
- 7) Promotion of broad-based social participation in the design and evaluation of project activities is critical to the success of project activities. The active participation of women, family members, and the community as a whole, viewed as social institutions which bring to bear various points of view and roles which are integral to the planning, execution and evaluation of project supported PHC services, are essential for measuring health care risk and addressing the most critical constraints to effective services.
- 8) The strategy for developing and motivating social participation in all project activities should be based on the following elements:
 - A) An active and deliberative process involving communities and institutions in the discussion of and search for solutions to the constraints to high quality, cost effective health care delivery, is essential to the social soundness of the project. The target population must have a sense of ownership of project activities, and have a channel for communicating their needs and aspirations.
 - B) There must be coordination and consensus building between diverse social elements (groups and institutions) about what has to be done to improve health care attention, and the ways

in which compromise and shared responsibilities can be achieved. Continuous consultations with the local beneficiary populations through existing organizations in each province is a necessary part of ongoing project activities.

- C) Mechanisms must be developed to elicit information from distinct groups and health care institutions within the sector and in each respective Health Area in which the project operates.

Recommendations for Peri-urban and Rural Priority PHC Services

- Pre-natal care and improved attention at birth
- Promotion of Breastfeeding
- Birth Spacing
- Nutrition for Children
- Acute Respiratory Disease Control
- Diarrheal Disease Control
- Diseases Preventable by Vaccination
 - Neo-natal tetanus
 - DPT-Polio



ANNEXES ATTACHED

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- B-1. PROJECT FINANCIAL ANALYSIS
- B-2. PROJECT TECHNICAL ANALYSIS
- B-3. SOCIAL SOUNDNESS ANALYSIS
- B-4. INSTITUTIONAL ANALYSIS
- B-5. STATUTORY AND COUNTRY CHECKLISTS
- B-6. CEPAR PROPOSAL
- B-7. CARE PROPOSAL
- B-8. USAID CS PROJECT REDESIGN CONCEPT PAPER (1994)
- B-9. USAID MISSION STRATEGY DOCUMENT (1993)

ANNEX A: LOGICAL FRAMEWORK

LOGICAL FRAMEWORK CHILD SURVIVAL II PROJECT 518-0071

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>GOAL:</p> <p>To improve the health of infants, children and mothers in Ecuador.</p>	<ol style="list-style-type: none"> 1) Reduction in the Infant Mortality Rate from 49 deaths/1000 live births to 40 deaths/1000 live births by the year 2000. 2) Reduction in the Childhood Mortality Rate from 81 deaths per 1,000 live births to 65 deaths by the year 2000. 3) Reduction in the Maternal Mortality Rate from 120 per 100,000 births to 105 by the year 2000. 	<p>Demographic and Health Surveys and other national statistics.</p> <p>Special studies.</p> <p>Demographic and Health Surveys and other national statistics.</p> <p>Project Evaluations.</p>	<p>GOE continued support for health sector modernization and policy reform.</p> <p>Continued democratic political stability.</p> <p>Continued economic stability and growth.</p> <p>National disasters do not affect project target populations.</p>

<p>PURPOSE:</p> <p>To improve the effectiveness of child survival and primary health care programs and interventions nationwide, with emphasis on poor (lower quartile) segment of the population.</p>	<p>EOPS:</p> <ol style="list-style-type: none"> 1) As a result of targeting and improved efficiencies, the non-covered poor population will be reduced from approximately 30% in 1994 to 20% in the year 2000, of which approximately one half, or 500,000 people, will be receiving coverage from private sector providers. 2) Institutional role and functional definitions will be improved, as measured by the presence of policy statements within major institutions and by the presence of a draft unified national health sector policy and regulations. Specific content of these statements will include <ul style="list-style-type: none"> • <i>MSP</i> -- articulation and implementation of a policy stating institutional purpose as focusing on <i>public health</i> (immunizations, norms and standards, environmental control, vector disease, service provider of last resort); • <i>IESS</i> -- articulation and implementation of a policy decision to separate the functions of financing and producing health services, and to shift from being a major health sector service provider to major financier of services; and specific modifications in the structure of IESS benefits to include more PHC/CS services; • <i>Private Sector</i> -- assumption of the role of primary producer of health services through NGOs (for profit and non-profit), local municipalities and authorities, as evidenced by an increased number and proportion of health services produced and an increased number of people covered. 3) The MSP will be recovering 10% of its health care facility-level operational costs through fee for service mechanisms. These new resources will be used for local level programming, to improve coverage and quality. 4) An independent private sector policy analysis and advocacy capability will be established. This "think tank" will be promoting policies for more efficient institutional role definition, and improved market conditions for private sector participation. 5) A mechanism for coordination among NGOs working in the health sector will exist. 6) There will be increased public/private sector collaboration in management of health areas, to the extent that NGOs will be involved in the administration of public resources and programs in at least 10% of all MSP health areas; and within these areas, NGO will be more involved in the production and delivery of health services. 7) NGO health care delivery mechanisms will be strengthened, and replicable models of privately produced CS/PHC services will be developed which will serve as demonstration models and field experiments of new ways of producing and distributing primary health care services to poor populations. Twenty-five project NGOs will producing services with a mix of at least 20% preventive and 80% curative. Ten NGOs will be producing services which are 100% self-financing. 	<ol style="list-style-type: none"> 1) Project evaluations, annual reports, small-scale assessments, market survey reports; project audits; agency reports. 2a) Project evaluations, annual reports/surveys 2b) Budget allocations by the GOE/MSP; policy work plans, separate contract agreements 2c) Draft package of unified national health sector policies and regulations which support improved role definition of MSP and IESS and public/private sector partnerships for the management, admin. and delivery of CS/PHC services 3) Project and MSP audits, budgetary information, project records. 4) Project evaluations, project reports. 5) Project evaluations, CARE reports 6) Project evaluations, project reports, reports of the MSP Office of NGO Coordination, reports and surveys of NGOs. 7) Project evaluations, project audits, project reports, reports of NGOs 	<ol style="list-style-type: none"> 1b) GOE continues to support targeting, efficiency improvement and NGO participation in health care sector. 2a) Management commitment to self-sufficiency among NGOs. 2b) Continued GOE Policy of Modernization. 3) No significant deterioration of consumer purchasing power. 6) GOE continues to support NGO participation in health care sector.
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NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>OUTPUTS:</p> <p>1) Improved policy environment for CS/PHC service delivery through private entities (e.g., health care NGOs, private/public sector partnerships)</p> <p>2) Increased and improved coverage, quality and sustainability of PHC/CS services through NGO (non-profit and profit) delivery mechanisms.</p>	<p>OUTPUT INDICATORS:</p> <p>1a) <i>MSP NGO Coordinating Office</i>: A system in place for the analysis, documentation and practical application of public/private sector partnerships for the management, administration and delivery of CS/PHC services within designated health areas.</p> <p>1b) <i>CEPAR Think Tank</i>:</p> <ul style="list-style-type: none"> • National NGO Health Sector Policy Analysis & Dissemination • Policy fora held • Technical analyses carried out <p>1c) <i>Coordinated Information, Education and Communication (IEC)</i>: "message" dissemination activities undertaken by CEPAR for public and decision-makers and health care service beneficiaries, including:</p> <ul style="list-style-type: none"> • Formative market research studies; policy options analysis and educational materials developed, field-tested and produced based on market research; media campaigns and media spot services. <p>2) <i>NGO Profit and Non-profit health care entities</i>:</p> <ul style="list-style-type: none"> • <i>Increase in PHC/CS interventions</i> in the following key areas: <ul style="list-style-type: none"> • Immunization coverage • Institutional births • Diarrheal disease • Acute respiratory infection • <i>Project NGO coverage</i>: assistance to 25 NGOs, service catchment areas total 250,000 people; • <i>CS/PHC technical, managerial and marketing capabilities</i> strengthened within a significant group of diverse NGO health care providers (e.g. 25 NGOs during five year LOP). • <i>Financial sustainability</i>: 10 out of 25 project NGOs capable of fully recovering facility level operating costs by the year 2000. <p>3) <i>Training</i>:</p> <ul style="list-style-type: none"> • <i>Health economics</i>: four individuals receiving Master's level training in health economics • <i>Health administration</i>: establishment of a program of health administration training within an Ecuadorian university. 	<p>1) Project evaluations and annual reports, surveys of policy makers and leaders, case studies.</p> <p>2) Project evaluations, project reports, audits and financial surveys, coverage surveys.</p> <p>3) Project evaluations, project reports.</p>	<p>1-2) Coordination/ collaboration among the project's implementing agencies.</p> <p>1-2) Subsidized goods/ services do not compete on price with commercial sector.</p> <p>1-2) Government continues to be receptive to policy dialogue and coordination with private sector and NGO communities.</p> <p>3) Ecuadorian university</p>

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<p>2) TA and Training for NGO management and health care staffs</p>	<p>2) <i>TA and Training:</i></p> <ul style="list-style-type: none"> • TA and practical training in health care financing and sustainability; • Training materials and short course curricula developed; • MSP fee for service mechanisms, private/public collaboration and agreements; • Leveraging of other donor resources in support of project TA and Training initiatives (e.g. IDB, IBRD) 	<p>2) Service statistics, project reports.</p>																																													

ANNEX B: ECONOMIC ANALYSIS

1. Overview

The point of departure for the CS-II Project is the identification of serious inefficiencies in the production and delivery of primary health care services in Ecuador, in both the public and private sectors; and the design of the Project reflects a set of strategies to improve these conditions. In the public sector, policies and practices have made it difficult for the MSP and the IESS to provide the most effective coverage possible with the resources at their disposal, while a combination of public policies as well as managerial and financing constraints have limited the ability of the private sector to meet its production and coverage potential.

By identifying, developing and promoting improved production models within both the public and private sectors, CS-II will help improve policies and technical practices to enable both sectors to improve efficiencies and expand coverage of primary health care / child survival services. Facilities which can serve as "models" of improved production already exist in both the public and private sectors in Ecuador; CS-II will use all three components to further refine these models and, through dissemination, policy development, technical assistance and demonstration, facilitate the adoption of elements of these models for service production and delivery in both sectors. In addition to quantitative improvements and production and coverage, CS-II will result in a number of significant benefits for the target population. A summary of the more salient benefits includes:

- ***Better mix of preventive services:*** In a sample of MSP and NGO facilities examined, there was a wide range of mix of services. The vast majority of private sector facilities emphasize curative services, and nearly all IESS/SSC services are curative in nature, while a majority of MSP services are curative in nature as well. However, among both MSP and NGO facilities there are examples, or models, of facilities in which preventive services (immunizations, well child care, and pre-natal care) represent a very high proportion of all outpatient or ambulatory care services. That is, in these "model" facilities, a greater number of cost-effective preventive services are produced with a given level of resources.
- ***Better quality:*** with an improved cost structure, more resources are available for "quality-enhancing inputs" (drugs, laboratory reagents and supplies, maintenance of equipment, etc.). For example, for the MSP as a whole, approximately 87% of all recurrent expenditures are used for personnel costs, leaving 13% for all other inputs. In a sample of MSP health centers, an average of 80% of recurrent costs were for personnel. In contrast, in a model NGO facility, less than 50% of all recurrent expenditures were for personnel, allocating a greater proportion of its resources for non-personnel inputs.
- ***Better coverage:*** more efficient cost structures enable greater coverage under the Project model than would be possible under the existing MSP production modes.

- *More services for the same expenditure for covered families:* improved production efficiencies mean that, for a given level of expenditure per family, each family can receive more services. Or, under a total cost recovery structure, there is a higher cost effectiveness for a given family health expenditure.
- *Demonstration effect:* the self-financing model, combined with other Project dissemination mechanisms, will have a "demonstration effect," enhancing its replicability and increasing the benefits from Project activities.
- *Improved competition in the health marketplace:* Project supported health services will introduce greater competitiveness in those areas in which they are provided, resulting in further benefit to the priority populations living in areas affected directly or indirectly by Project activities.
- *Enhancing GOE/MSP policies:* the development of private sector production capabilities will enhance the implementation of GOE/MSP policies on private sector involvement, and will enable the public sector to devote more of its resources to child survival services by relieving the burden currently created by MSP emphasis on outpatient and inpatient curative services.
- *Mobilization of resources:* Project activities will result in the mobilization of resources not only from the direct users of those services, but from other sources as well. For example, in late 1993 the MSP entered into an agreement with an Ecuadorian NGO to co-administer the national pediatrics hospital, Hospital Baca Ortiz; this arrangement includes a new user fee system at the facility. By early 1994 this arrangement was generating approximately US\$ 30,000 per month in revenues, representing 12% of the hospitals operating budget; this amount virtually doubles the resources available for nonpersonnel recurrent costs such as maintenance, drugs and supplies, and anecdotal evidence suggests that quality improvements are already in evidence. CS-II will assist NGOs and the MSP to expand such cooperative arrangements and to implement cost recovery mechanisms in all levels of facilities through the Public Policy Support component, mobilizing resources in other facilities throughout the country.
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examples. In terms of cost structure and cost recovery, the NGO spends less than 50% of its recurrent expenditure on personnel and is currently recovering over 100% of its operating costs; this is one area where the MSP facility at Yaruqui, spending 73% of recurrent costs on personnel and recovering 7% of operating costs, performs better than in most other public facilities but still requires stronger managerial and technical skills. The Table below summarizes some of the vital characteristics of these two facilities, compared with a blend of three other MSP facilities; data on all these facilities come from the same source (Balarezo and Paguay, 1994).

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the NGO model, over 100% of its recurrent costs are recovered through user fees, even though over 20% of all patients receive services with fees waived (fees are paid from a separate fund financed with revenues and set aside for this purpose). These are "preliminary models" because the Project will develop different models of service production and delivery, such as prepayment and contact with group purchasers, which may improve the benefits and savings beyond the levels observed in this model.

The Project benefits summarized above are for the most part self-evident. For purposes of this economic analysis, we need only consider in detail the last two benefits; that is, (1) the additional revenues which will be generated through user fees in the public sector, and (2) the savings which will accrue to the health sector during the five year of Project activity as a result of the projected volume of services which will be produced under the improved or "model" production modes.

2. *Methodological Approach*

Preliminary data from Ecuador (Balarezo and Paguay, 1994; la Forgia and Balarezo, 1993; Moncayo *et al*, 1993) provide evidence that there is a wide range of production costs within both the public sector and the private sector. Of any public sector facility reported in the literature, one health center, the Centro de Salud Yaruqui in Pichincha Province, has been shown to have the lowest average unit costs of production and the highest level of preventive services as a proportion of total outpatient services. At the same time, the health center run by the NGO ASME-X health center in La Independencia has been shown to have high rates of cost recovery in addition to service production which is much more cost efficient than other typical facilities.

Focusing on revenue generation potential and production efficiencies, this section presents an economic analysis based on two factors: (1) revenues which are expected to be generated during Project lifetime and (2) estimates of the level of savings which will result from service production increases under improved production modes identified in Ecuador. If the level of resources generated plus the level of savings achieved by PACD are greater than Project costs, then the economic return on Project investment is considered to be positive. A positive rate of return can be expressed as

$$C < Bf(R_p + S)$$

where C is the total cost of CS-II new activities (including Cooperative Agreements, technical assistance, training, commodities and other direct costs, but not including current CS-I obligations), and B represents the benefits quantified; in this case, the benefits are limited to (a) resources generated and (b) savings accrued to the health sector during the life of the Project;

and where benefits (B) are a function (f) of

R_p which are Project-attributable new revenues
and S which are savings accrued as a result of improved production modes.

Estimation of revenues generated: It is estimated that, as a result of new policies being developed by the MSP which will receive Project technical support, and as a result of preliminary user fee system design already initiated by the MSP which will also receive Project technical support, the MSP will achieve a level of cost recovery of 10% of facility-level operating cost MSP-wide. Of course, not all of this will be attributable to Project activity, and some level of cost recovery is already being achieved in isolated examples (such as 7% in Yaruqui and 3-4% in a few other facilities). Since cost recovery revenue data is not routinely reported to the central ministry, no MSP-wide data exists. Nevertheless, it is estimated that for all facilities cost recovery is currently at less than 1%. A reasonable expectation, therefore, is that Project "value added" contribution to revenue generation will be equal to 50% of increased revenues, the remaining 50% being attributable to non-Project factors such as MSP activities already underway. Revenue estimations can therefore be expressed as

$$R_p = R_n - R_{np}$$

where

R_p are Project-attributable new revenues, equal to 50%,
 R_n are all new revenues generated by the MSP through user fees
and R_{np} are new revenues not attributable to the Project, equal to 50%

Estimation of Savings: savings are calculated by comparing estimates of the costs of services to be produced under the improved production modes in the public and private sectors support by the Project with estimates of the cost of producing those same services under existing production modes in the public and private sectors. This assumes that the Project will result directly in the production of 2 million services under improved production modes. (This is based on 25 Project NGOs producing an average of 12,500 services per year for an average of 3.2 years for a total of 1 million services, and production of 1 million public sector services under improved production mode resulting from a combination of (1) technical assistance, (2) Project demonstration effect and (3) other changes resulting from improved policy environment and market conditions, and from dissemination. This can be expressed as:

$$S = NS (PC_e - PC_i)$$

where

NS is the number of New Services projected
 PC_e the average unit cost of an outpatient service produced under existing "typical" production modes in the public and private sectors
and PC_i is the average unit cost of production under the improved production modes, based on the models of Yaruqui Health Center in the public sector and ASME-X La Independencia in the NGO/private sector.

This is of course a conservative estimate of savings, as additional savings will accrue to the health sector. We could consider, for example, savings on other services such as births; costs averted due to disease prevention; and improved cost effectiveness resulting from improved quality. However, for reasons of simplicity, this analysis is limited to the savings resulting from improved production efficiencies for outpatient services.

3. Sources of Data

Input data for new revenues (R_n) is calculated as a percentage of the estimated current facility-level operating cost; this cost is assumed to be 80% of non-special program MSP costs (that is, excluding SNEM, INH, CEMEIN and other programs which are included in the MSP budget). Of this amount, new revenues resulting from user fees are projected to be 2% in 1995, 4% in 1996, 6% in 1997, 8% in 1998 and 10% in 1999.

Input data for calculation of production costs under the predominant (MSP) existing production mode (PC_i) and the improved production mode (PC_e) are derived from a recent cost analysis carried out by Balarezo and Paguay (1994) in a sample of MSP and NGO facilities. Input data for calculation of PC_i (average unit cost of production under the existing public sector production mode) is based on the production model observed in one public facility, the Centro de Salud de Yaruqui, and one NGO facility, ASME-X in la Independencia.

4. Results

Summary results of this analysis are presented in Table XX. As shown in this Table, it is estimated that new revenues which are attributable to CS-II during the life of the Project will total \$12,597,031; and that estimated savings will total \$2,405,556. The combined benefits of new revenues and savings therefore total \$15,002,587. Compared with a cost of \$9,100,000 for CS-II new activities, this results in a benefit:cost ratio of 1.65:1.

CS-II SAVINGS AND COST ESTIMATES

I. MSP REVENUE GENERATION ESTIMATES

Year	1995	1996	1997	1998	1999	TOTAL
Estimated facility-level operating costs	73600000	77280000	81144000	85201200	89461260	406,686,460
Estimated average recovery in %	2%	4%	6%	8%	10%	10%
Estimated average recovery in \$\$	1472000	3091200	4868640	6816096	8946126	25,194,062
Project-attributed recovery in \$\$ @ 50%	736000	1,545,600	2,434,320	3,408,048	4,473,063	12,597,031

II. MACRO LEVEL SAVINGS AND COST ESTIMATES

MSP EXISTING PRODUCTION MODE COSTS

Number of visits	2,000,000
Average unit cost	7,182
Cost in dollars @ 2,160:1	3,325
TOTAL PRODUCTION COST	6,650,000

MSP IMPROVED PRODUCTION MODE COSTS

Number of visits	1,000,000
Average unit cost	4,208
Cost in dollars @ 2,160:1	1.95
TOTAL PRODUCTION COST	1,948,148

PRIVATE SECTOR PRODUCTION COSTS

Number of visits	1,000,000
Average unit cost	4,960
Cost in dollars @ 2,160:1	2.30
TOTAL PRODUCTION COST	2,296,296

EXISTING MODES: 4,000,000 services	6,650,000
IMPROVED PUBLIC MODE: 2,000,000 services	1,948,148
IMPROVED PRIVATE MODE: 2,000,000 services	2,296,296
TOTAL IMPROVED MODE: 4,000,000 services	4,244,444
SAVINGS	2,405,556

CS-II Project Activity Cost:	9,100,000
Benefits:	
Revenue Generated:	12,597,031
Savings Accrued:	2,405,556
Total benefits:	15,002,587
Cost: Benefit Ratio:	1: 1.65

ANNEX C - DETAILED ILLUSTRATIVE BUDGETS

CS-II ILLUSTRATIVE BUDGET

IN US\$ 1,000; ALL NUMBERS ROUNDED TO THE NEAREST 1,000

CALENDAR YEARS

I. FINANCIAL PLAN

	1994	1995	1996	1997	1998	1999	TOTAL
PUBLIC POLICY (MSP:PC-1)	1,973	533	333	226	195	187	3,447
THINK TANK (CEPAR:PC-2)	186	603	583	477	459	434	2,742
NGO SUPPORT (CARE:PC-3)	247	986	973	918	881	327	4,332
USAID	220	195	235	135	135	188	1,108
CONTINGENCIES	120	116	106	88	84	57	571
TOTAL	2,746	2,433	2,230	1,844	1,754	1,193	12,200

II. SUMMARY BUDGET

	1994	1995	1996	1997	1998	1999	TOTAL
CS-I OBLIGATIONS	2,300	200	0	0	0	0	2,300
MSP DIRECT SUPPORT	18	6	6	11	5	4	50
CEPAR CA	136	385	379	377	374	349	2,000
CARE CA	182	757	760	733	726	242	3,400
OFFSHORE TRAINING	20	184	184	60	50	31	529
INTERNATIONAL TA	150	710	665	500	440	385	2,850
OTHER	20	75	130	75	75	125	500
CONTINGENCIES	120	116	106	88	84	57	571
TOTAL	2,746	2,433	2,230	1,844	1,754	1,193	12,200

III. FINANCIAL MATRIX

	MSP	CEPAR	CARE	USAID	TOTAL
CS-I OBLIGATIONS	2,300	0	0	0	2,300
MSP DIRECT SUPPORT	50	0	0	0	50
CEPAR CA	0	2,000	0	0	2,000
CARE CA	0	0	3,400	0	3,400
TRAINING	264	112	153	0	529
INTERNATIONAL TA	180	630	1,357	578	2,745
OTHER	275	0	0	330	605
CONTINGENCIES	0	0	0	571	571
TOTAL	3,069	2,742	4,910	1,479	12,200

IV. FUNDING BY PHASES

PHASE 1: reprogrammed funds	2,746	2,433	1,020	0	0	0	6,200
PHASE 2: new funds	0	0	1,210	1,845	1,753	1,193	6,000
TOTAL REPROGRAMMED	2,746	2,433	2,230	1,845	1,753	1,193	12,200

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V. DETAILED BUDGET

	1994	1995	1996	1997	1998	1999	TOTAL
V.a. CS-I OBLIGATIONS	2,100	200	0	0	0	0	2,300
V.b. MSP DIRECT SUPPORT							
NGO Liaison office	17	6	6	10	5	4	48
Computer	3			2			
Printer	2			2			
Software	1						
Admin. TA/prog. (local)	2						
Office remodelling	4						
Supplies	2	2	2	2	2	2	
Travel/per diem (local)	2	2	2	2	1	1	
Communications	1	2	2	2	2	1	
5% Contingencies	1	0	0	1	0	0	2
SUBTOTAL	18	6	6	11	5	4	50
V.c. CEPAR CA							
Personnel	23	67	67	67	67	67	358
Director	10	25	25	25	25	25	
Senior analyst	5	15	15	15	15	15	
Analyst	3	10	10	10	10	10	
Analyst	3	10	10	10	10	10	
Support	2	7	7	7	7	7	
Fringe @ 50%	12	34	34	34	34	34	179
Admin./overhead	50	100	100	100	100	100	550
Equipment	8	2	2	5	2	2	21
Computers	5	2	2	2	2	2	
Software	1	0	0	1	0	0	
Printer	2	0	0	2	0	0	
Supplies	5	5	5	5	5	5	30
Travel + per diem (International)	5	20	20	15	15	10	85
Travel + per diem (local)	5	15	15	15	15	10	75
Conferences	0	50	45	45	45	45	230
Dissemination	10	50	50	50	50	50	260
CEPAR procured local TA	13	25	25	25	25	10	123
5% Contingencies	6	17	17	17	17	16	89
SUBTOTAL	136	385	379	377	374	349	2,000
V.d. CARE CA							
Personnel	33	88	88	88	88	88	470
Coordinator	10	25	25	25	25	25	
Assistant	5	15	15	15	15	15	
Training/comm. spec. (.5 FTE)	3	8	8	8	8	8	
Management analyst	5	15	15	15	15	15	
Financial analyst (.5 FTE)	3	8	8	8	8	8	
Fringe @ 50%	7	17	17	17	17	17	
Equipment	8	1	3	3	1	0	16
Computers	5	0	2	2	0	0	
Software	1	1	0	0	1	0	
Printer	2	0	1	1	0	0	
Supplies	8	8	8	8	8	5	45
Travel (International)	5	15	15	15	15	15	80
Travel (local)	5	15	15	15	15	15	80
TA (CARE procured, local)	35	75	75	75	75	45	380
Training	10	75	75	75	75	45	355
Conferences	0	20	20	20	20	20	100
Pass through	70	430	430	405	400	0	1,735
Large grants	50	350	350	330	325	0	
Small grants	20	80	80	75	75	0	
5% Contingencies	9	31	31	30	29	9	139
SUBTOTAL	182	757	760	733	726	242	3,400

V.e. USAID MANAGED FUNDS	1994	1995	1996	1997	1998	1999	TOTAL
OFFSHORE TRAINING							
MSP/SSC Observation tours	10	40	40	30	20	11	151
CEPAR	5	10	10	10	10	10	55
CARE	5	20	20	20	20	10	95
Master's training in health econ.	0	114	114	0	0	0	228
SUBTOTAL	20	184	184	60	50	31	529
INTERNATIONAL TECHNICAL ASSISTANCE							
MSP/SSC	45	60	60	15	0	0	180
Private sector collaboration	15	30	30	15	0	0	
User fees	15	15	15	0	0	0	
Intersectoral collaboration	15	15	15	0	0	0	
CEPAR	45	180	165	90	75	75	630
Management	15	30	0	0	0	0	
Policy analysis / research	30	105	105	60	45	45	
Dissemination / IEC	0	45	60	30	30	30	
CARE	60	180	165	165	135	75	780
Management/admin./finance	30	120	105	105	75	45	
Child survival technical areas	15	45	45	45	45	15	
Evaluation and monitoring	15	15	15	15	15	15	
ECUADORIAN UNIVERSITY	0	60	45	0	0	0	105
RA/TACS/Project Manager	0	230	230	230	230	235	1,155
SUBTOTAL	150	710	665	500	440	385	2,850
VI. OTHER							
Public Health Emergencies	0	55	55	55	55	55	275
Evaluations	0	0	55	0	0	50	105
Audits	20	20	20	20	20	20	120
SUBTOTAL	20	75	130	75	75	125	500
VI. ANNUAL SUBTOTALS	2,426	2,317	2,124	1,756	1,670	1,135	11,428
VII. CONTINGENCIES @ 4.75%	120	116	106	88	84	57	571
VIII. GRAND TOTAL	2,746	2,433	2,230	1,844	1,754	1,193	12,000
CUMULATIVE TOTALS	2,746	4,980	7,210	9,054	10,808	12,000	

USAID AND COUNTERPART CONTRIBUTIONS

	REDESIGNED BUDGET			LIFE OF PROJECT BUDGET		
	USAID	CNTRPRT.	TOTAL	USAID	CNTRPRT.	TOTAL
CS-I OBLIGATIONS	2,300	2,000	4,300	8,100	16,130	24,230
MSP SUPPORT	505	800	1,305	505	800	1,305
CEPAR CA	2,630	700	3,330	2,630	700	3,330
CARE CA	4,180	1,130	5,310	4,180	1,130	5,310
TRAINING	635	0	635	635	0	635
INTERNATIONAL ADVISOR	1,155	0	1,155	1,155	0	1,155
OTHER	225	30	255	225	30	255
CONTINGENCIES	570	40	610	570	40	610
TOTAL	12,200	4,700	16,900	18,000	18,830	36,830
COUNTERPART AS % OF TOTAL		25%			37%	

BUDGET NOTES

I. FINANCIAL PLAN ALLOCATIONS

	ITEM	SPREADSHEET LINE
PUBLIC POLICY (MSP)	---> CS-I obligations	54
	+ MSP direct support	67
	+ MSP observation tours	118
	+ Masters training (50% of total)	121
	+ TA to public sector	125
	+ CS Advisor (50% of total)	138
	+ Public health emergencies	143
THINK TANK (CEPAR)	---> Direct CEPAR CA costs	89
	+ CEPAR offshore training	119
	+ Masters training 25% of total)	121
	+ TA to CEPAR	129
NGO SUPPORT (CARE)	---> Direct CARE CA costs	113
	+ CARE offshore training	120
	+ Masters training 25% of total)	121
	+ TA to CARE	133
USAID	---> Ecuadorian University Support	137
	+ CS Advisor (50% of total)	138
	+ Evaluations	144
	+ Audits	145
	CONTINGENCIES	---> All project contingencies

II. SUMMARY BUDGET

CS-I OBLIGATIONS	All of those funds currently managed by MSP and MSH under existing desi
MSP DIRECT SUPPORT	Support for the MSP Office of NGO Coordination
CEPAR CA	All funds to be managed directly by CEPAR
CARE CA	All funds to be managed directly by CARE
OFFSHORE TRAINING	Study tours, masters degrees, short term training outside of Ecuador
INTERNATIONAL TA	All buy-ins and add-ons to centrally-funded USAID projects
OTHER	Public health emergencies, evaluations and audits
CONTINGENCIES	4 75% of all other costs

V.b. MSP Direct Support (Office of NGO Coordination)

Computers	2 base 486 computers
Printers	1 laser printer, replacement in PY 4
Admin TA/programming	Local consultant to design database (2 months)
Travel/per diem	Local travel for coordination / monitoring of NGOs

V.c. CEPAR CA

Personnel	All positions at FTE
Fringe	Assumption of 50% of direct salaries
Travel + per diem (int'l)	Total of 18 international trips @ \$5,000 per trip
Travel + per diem (local)	Data collection costs + conference participant costs
Conferences	Two conferences per year averaging \$23,000 each
Dissemination	Printed materials, distribution, broadcasting
CEPAR procured local TA	Ecuadorian firms subcontracted by CEPAR

V.d. CARE CA

Personnel	Coordinator, Assistant, Mgt Analyst @ FTE, others @ 50% FTE
Fringe	Assumption of 50% of direct salaries
Computers	2 base 486 computers, replacement PY 3-4
Printers	1 laser printer, replacement in PY 3-4
Travel + per diem (int'l)	Total of 16 international trips @ \$5,000 per trip
Travel + per diem (local)	Field visits
Conferences	One conference per year averaging \$20,000 each
Dissemination	Printed materials, distribution, broadcasting
Pass through Large grants	14 grants averaging \$100,000 each
Pass through Small grants	11 grants averaging \$ 30,000 each

V.e. USAID MANAGED FUNDS

Offshore Training	
MSP/SSC Observation tours	50 person-visits averaging \$3,000 per person-visit
CEPAR	11 months of short term training @ \$5,000 per month
CARE	19 months of short term training @ \$5,000 per month
Masters training health econ	4 Master's degrees in U S universities + language training
International Technical Assistance	
MSP/SSC	12 person months @ \$15,000 in user fees, finance, private sector
CEPAR	42 person months @ \$15,000/month in analysis and dissemination
CARE	52 person months @ \$15,000/month in mgt, finance and CS/PHC
Ecuadorian University	7 persons months in health administration to establish Master's program
Child Survival Advisor	U S contractor for 5 years

V.f. OTHER

Public health emergencies	Biologicals and other epidemic assistance
Evaluations	One mid-term and one final evaluation

VI. CONTINGENCIES @ 4 75% of all other costs

ANNEX D - INITIAL ENVIRONMENTAL EXAMINATION

to FAX #: (202) 647-8098

FAX COVER SHEET

TO: Jeff Broken
AID/LAC/DR/E, Rm. 2242, N.S.
Washington, DC

routine__ urgent X

FROM: Howard L. Clark, AID Regional Environmental Advisor (REA/EA)
USAID/Quito/ANRO/REA phone: (593-2) 506-643 or 521-100, FAX 561 128
mail: casilla 17-01-438, Quito / or USAID/Quito, Washington, DC 20523-3430

NUMBER OF PAGES INCLUDING THIS COVER SHEET: 2

DATE: 4 May 1994

MESSAGE: ♦ ♦

♦ Attached for your approval is a request for Categorical Exclusion for an Ecuador project now being amended and extended. The original project received a CE. I foresee no problems in potential impacts of this project, as discussed in the "IEE" (of which I am an author).

AID/Quito would sincerely appreciate an immediate response to this request.

The original, signed IEE is being mailed to you for your records. ♦

no v. FAX



ANNEX H.

INITIAL ENVIRONMENTAL EXAMINATION (IEE)

PROJECT LOCATION: Ecuador

PROJECT TITLE: Child Survival II, Project Amendment

PROJECT NUMBER: 518-0071

FUNDING (LOP): \$17,200,000

LOP AMENDMENT: FY94-FY99 (5.25 years for PP Amendment)

IEE PREPARED BY: Howard L. Clark, Ph.D. *H-Clark*
 USAID Regional Environmental Advisor;
 Michael H. Lofstrom, PPA Consultant
 28 April 1994

RECOMMENDATION: CATEGORICAL EXCLUSION

This Project Amendment qualifies for Categorical Exclusion from further environmental examination, in accordance with Sec. 216.2(2)(i) of the Foreign Assistance Act. Sec. 216.2 states, "The following classes of actions are not subject to the procedures set forth in §216.3, except to the extent provided herein:

"(1) Education, technical assistance, or training programs except to the extent such programs include activities directly affecting the environment (such as construction of facilities, etc.) . . ."

This Project will provide support for the analysis, dissemination and advocacy of more effective and efficient health sector policies and greater participation of private sector health service providers, and for increasing the access, quality and sustainability of child survival and primary health care services through a stronger group of Non-governmental Organization health care providers. Project activities include policy analysis and dissemination, technical assistance and training for health sector, structural change, and participation of the private sector in health care services. The Project Amendment does not include construction of facilities or any other activities directly affecting the environment.

CONCURRENCE:

John Sanbrailo
 John A. Sanbrailo, Mission Director, USAID/Ecuador

date: 5-2-94

Ronald F. Ruppel
 Ronald F. Ruppel, Mission Environmental Officer, USAID/Ecuador

date: 5-2-94

APPR: JB *JB*
DRAFT: ASC *ASC*
CLEAR: ()
CLEAR: ()
CLEAR: ()
CLEAR: ()
CLEAR: ()

UNCLASSIFIED

AID/LAC/DR/E:ASEGARRA:IEE:IEE94-15.CAB
05/06/94 647-8047
AID/LAC/DR/E:JBROKAW

ROUTINE QUITO
ROUTINE PORT AU PRINCE

AIDAC QUITO FOR RUYBAL AND CLARK, HAITI FOR POITEVIEN

E.O. 12356: N/A

TAGS:

SUBJECT: ENVIRONMENTAL THRESHOLD DECISION FOR THE
CHILD SURVIVAL II, PROJECT AMENDMENT (518-0071)

1. LAC ACTING CHIEF ENVIRONMENTAL OFFICER, JEFFREY BROKAW, HAS REVIEWED AND HEREBY APPROVES MISSION REQUEST FOR A CATEGORICAL EXCLUSION.
2. IEE NUMBER IS LAC-IEE-94-15. COPY OF THE ENVIRONMENTAL THRESHOLD DECISION IS BEING SENT TO MISSION FOR INCLUSION IN PROJECT FILES. YY

UNCLASSIFIED

ANNEX E: PROJECT IMPLEMENTATION SCHEDULE

STAGE 1: CS-I CLOSEOUT AND CS-II STARTUP

CS-I CLOSEOUT	CS-II STARTUP	DATE MO.YR.	RESP.
CS-I close-out PIL delivered		04 94	USAID
CS-I transfer plan approved by USAID		05 94	MSH
TA closeout plan for CS-I approved by USAID		06 94	MSH
	MSP NGO office operational	07 94	MSP
	CARE CA signed	07 94	USAID
	Buy-in TA sources selected	07 94	USAID
	CS-II Project Authorization	07 94	USAID
	PROAG Amendment	07 94	USAID
	CEPAR CA signed	07 94	USAID
Final procurement for CS-I completed		08 94	MSH
	Pre-award financial review: CEPAR and CARE	08 94	USAID
	Steering committee convened	08 94	USAID
	CARE staff recruited	09 94	CARE
	CEPAR staff recruited	09 94	CEPAR
	TACS contracted	10 94	CDC/ CEDPA
	Semi-annual TA plan completed	11 94	CARE
	Initial TA PIO/Ts completed	11 94	USAID
TA contract closed-out		12 94	MSH
CS-I final year workplan completed		05 95	
CS-I activities terminated		05 95	MSP

STAGE 2: APPLICATION AND DEVELOPMENT

CEPAR	CARE	DATE MO. YR.	RESP.
Obligation of Year 1 funds	Obligation of Year 1 funds	07 94	USAID
	Baseline study on NGOs completed	10 94	CARE
	NGO short list criteria and selection procedure established	10 94	CARE
Design and initial implementation of IEC framework/program		10 94	CEPAR
Policy development priorities and workplan submitted		10 94	CEPAR
Annual Plan approved	Annual Plan approved	01 95	CARE, CEPAR
	Subgrants to five Group 1 NGOs	01 95	CARE
Private health market assessment completed		01 95	CEPAR
Audit	Audit	01 95	USAID
	Procurement plan completed	01 95	USAID
First policy analysis completed		02 95	CEPAR
Obligation of Year 2 funds	Obligation of Year 2 funds	02 95	USAID
	Group 1 organizational, strategic planning and business development activities completed	03 95	CARE
First policy-maker observational tour		05 95	CEPAR
MSP privatization/private-public collaboration plan completed		05 95	CEPAR
First awareness-raising event completed		05 95	CEPAR
GOE/MSP/IESS policy development objectives drafted		06 95	CEPAR
Opinion polls and media spots implemented		06 95	CEPAR
Semi-Annual Review completed	Semi-Annual Review completed	06 95	USAID
	Subgrants to fifteen Group 2 NGOs	07 95	CARE
GOE/MSP/MBES policy development plan adopted		08 95	CEPAR
First policy assessment completed		08 95	CEPAR

	Group 1 services implemented	09	95	CARE
First policy analysis disseminated		10	95	CEPAR
	Group 2 organizational, strategic planning and business development activities completed	11	95	CARE
Internal review and evaluation	Internal review and evaluation	11	95	USAID
Semi-Annual Review completed	Semi-Annual Review completed	12	95	USAID
Audit	Audit	01	96	
Annual Plan submitted	Annual Plan submitted	01	96	CARE, CEPAR
Obligation of Year 3 funds	Obligation of Year 3 funds	02	96	USAID
	Group 1 utilization and financial review	03	96	CARE
	Subgrants to five Group 3 NGOs	06	96	CARE
Second policy assessment completed		06	96	CEPAR
Second awareness-raising event completed		06	96	CEPAR
Semi-Annual Review completed	Semi-Annual Review completed	06	96	USAID
Second policy analysis disseminated		08	96	CEPAR
External mid-term evaluation	External mid-term evaluation	09	96	USAID
	Group 3 organizational, strategic planning and business development activities completed	10	96	CARE
Semi-Annual Review completed	Semi-Annual Review completed	12	96	USAID
Audit	Audit	01	97	
Annual Plan approved	Annual Plan approved	01	97	CARE, CEPAR
Third policy assessment completed		02	97	CEPAR
Obligation of Year 4 funds	Obligation of Year 4 funds	02	97	USAID
	Group 2 services implemented	03	97	CARE
Third policy analysis appropriately disseminated		04	97	CEPAR
Third awareness-raising event completed		06	97	CEPAR
Semi-Annual Review completed	Semi-Annual Review completed	06	97	USAID
	Group 2 utilization and financial review	08	97	CARE

Semi-Annual Review completed	Semi-Annual Review completed	12	97	USAID
Audit	Audit	01	98	
Annual Plan approved	Annual Plan approved	01	98	CARE, CEPAR
Obligation of Year 5 funds (final obligation)	Obligation of Year 5 funds (final obligation)	02	98	USAID
	Group 3 services implemented	03	98	CARE
Semi-Annual Review completed	Semi-Annual Review completed	06	98	USAID
	Group 3 utilization and financial review	08	98	CARE
Semi-Annual Review completed	Semi-Annual Review completed	12	98	USAID

STAGE 3: CONSOLIDATION AND SUSTAINABILITY

CEPAR	CARE	DATE MO. YR.		RESP.
	Report on coverage, production and sustainability of participating NGOs	12	98	CARE
Report on status of policy development		12	98	CEPAR
Annual plan submitted	Annual Plan submitted	01	99	CARE, CEPAR
Draft set of policies and regulations reflecting a unified national health sector policy with national level consensus		01	99	CEPAR
	Plan for sustainability	01	99	USAID
Audit	Audit	01	99	CARE
Final external evaluation	Final external evaluation	04	99	USAID
CA PACD	CA PACD	5	99	USAID

ANNEX F - CEPAR MATRIX OF POLICY ADVOCACY APPROACHES

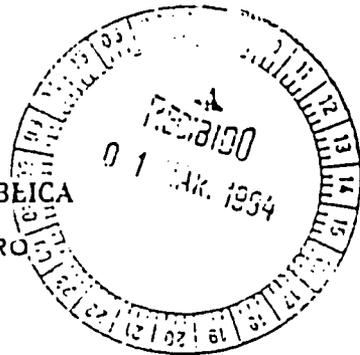
2.c) ESTRATEGIA DE INFORMACION, EDUCACION Y COMUNICACION EN SALUD

AUDIENCIA BLANCO	MENSAJES	MOTIVACION	CANALES	ACTIVIDADES	TECNICAS DE INVESTIGACION EVALUACION DE RESULTADOS	RESPONSABLES
Nivel de: Decisión Política	Políticas de Salud: Objetivos	Beneficios de racionalizar y optimizar los recursos para la salud	Medios impresos, comunicación interpersonal. Programas de opinión	Investigación y análisis; estudios, boletines, foros, seminarios, eventos de capacitación a líderes.	Sondeos de opinión pública, encuesta a líderes. Análisis de contenido de mensajes	Departamento de: Investigación Información Capacitación
Nivel de: Producción, distribución y consumos de servicios de salud	Alentar la diversidad y la competencia en la prestación de los servicios de salud y en la esfera de los seguros mediante políticas de salud	Políticas estables y de consenso que promuevan la competencia	Medios impresos, comunicación interpersonal. Programas de opinión, radio y televisión.	Investigación y análisis; estudios, boletines, foros, seminarios, eventos de capacitación a líderes	Estudios de mercado, práctica de los servicios	Departamento de: Investigación Información Capacitación
Nivel de: Agentes Institucionales y comunitarios. (Estado, Iglesia, Ong's, empresa privada, etc.)	Desempeño de los proveedores de los servicios, los equipos y medicamentos esenciales, los costos y la eficacia de las intervenciones, y sobre el nivel de acreditación de los establecimientos e instituciones que prestan los servicios	Sensibilizar y promover acciones para aplicar las políticas de salud	Campañas en medios masivos, foros y seminarios.	Capacitación a líderes de opinión que generen la discusión y el análisis de las políticas en salud. Programas y eventos de educación en comunicación para la salud.	Encuesta: CAP Conocimientos y actitudes prácticas sobre salud	Departamento: Investigación Información Capacitación
Nivel de: Beneficiarios	Educación para cambiar hábitos en salud	Sensibilizar sobre beneficios de prevenir las enfermedades en función del costo y el ahorro	Campañas en medios masivos sobre información, educación en salud	Procesos permanentes de uso de multimedia, seminarios de capacitación en educación para la salud a grupos multiplicadores de información	Estudios longitudinales del Estado de salud. (Cambios de actitudes)	Departamento de: Información Capacitación

ANNEX G - LETTERS OF APPLICATION



MINISTERIO DE SALUD PUBLICA
DESPACHO DEL MINISTRO



ACTION: 630
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Nº
Quito,

REPLY DUE 3/9
NO REPLY NEEDED
X REPLIED BY GDO/H.10 P.94
ON March 9/94
DATE / INITIAL
FILE: 518-004/USAID
Reclon pr

Oficio No. 94-EMA- 14655
Quito, 24 FEB 1994

Señor
John A. Sanbrailo
DIRECTOR DE LA MISION DEL
USAID EN EL ECUADOR
Presente.

Estimado Señor Director:

Doy respuesta a su oficio No. GDO/H.018.94, de 13 de enero de 1994, mediante el cual se presentó a consideración de este Despacho la propuesta oficial del USAID, de rediseño del Proyecto de Salud y Supervivencia Infantil financiado por el USAID.

A este respecto, me permito comunicar al señor Director la posición del Ministerio a mi cargo con relación a la propuesta en mención, la misma que corresponde a las conclusiones preliminares de las reuniones sostenidas entre el Econ. Ken Yamashita y el Dr. Patricio Murgueytio del USAID, y el Econ. Luis Roman y los Dres. Efraim Pacheco, Hernán Moscoso y Edgar Moncayo de este Portafolio:

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1. En terminos generales, los dos puntos de la propuesta del USAID (3a. y 3b.), se enmarcan dentro de la Política de Salud puesta en vigencia por la actual administración del Ministerio, especialmente en lo que se refiere a la modernización de la gestión y al apoyo a las ONGs que realizan tareas de salud en el contexto de las correspondientes políticas oficiales.
2. Con el objeto de optimizar las relaciones entre el Ministerio y las ONGs, en la ejecución del nuevo proyecto de salud apoyado por el USAID, sería importante la conformación de un Comité Ejecutivo, con representación de funcionarios del Ministerio, del USAID, de las ONGs que apoyarían al componente de desarrollo de políticas de salud y de las ONGs que se relacionarían directamente a programas de salud.

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MINISTERIO DE SALUD PUBLICA

DESPACHO DEL MINISTRO

Nº

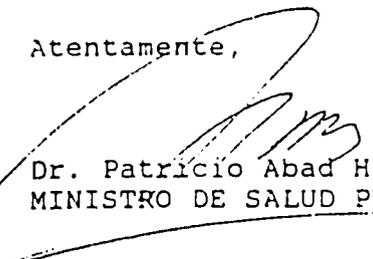
Quito,

3. Con relación a las actividades del Proyecto de Supervivencia Infantil que ya han sido programadas para el presente año, las mismas podrán ser financiadas con los fondos asignados con anterioridad para este efecto, pero en el entendido de que, se tratan de actividades de terminación de este Proyecto, las mismas que concluirán definitivamente, cuando más tarde el 31 de mayo de 1995. Notándose que, estas actividades no deben duplicar a aquellas programadas dentro del Proyecto FASBASE.
4. También deberán programarse para este año 1994, el financiamiento y ejecución de actividades de preparación o preliminares para los dos componentes de la nueva propuesta de Proyecto de Salud auspiciado por el USAID. Estas actividades serían financiadas con fondos provenientes de partidas distintas a las que actualmente financian el Proyecto de Supervivencia Infantil.
5. Se deberán mantener las actividades de emergencia financiadas por el USAID, en especial para el control de epidemias como la del cólera, la difteria, el dengue, etc.

Con estos antecedentes, el Ministerio a mi cargo reitera su decisión de continuar con el mismo equipo designado, las conversaciones con el USAID, para que en el menor tiempo posible pueda concluirse la preparación del nuevo Proyecto de Salud, el cual debería iniciar su ejecución en los primeros meses del próximo año.

Aprovecho la oportunidad para reiterar al señor Sanbrailo mis sentimientos de amistad y de la más distinguida consideración.

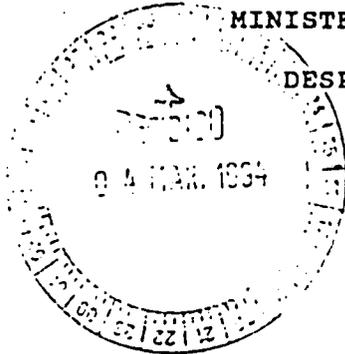
Atentamente,


Dr. Patricio Abad Herrera
MINISTRO DE SALUD PUBLICA DEL ECUADOR



MINISTERIO DE SALUD PUBLICA

DESPACHO DEL MINISTRO



Oficio No. 94-EMA- 14904

Quito, 04 MAR. 1994

Señor John A. Sanbrailo DIRECTOR DE LA MISION DEL USAID EN EL ECUADOR Presente.

REPLY DUE 3/15 NO REPLY NEEDED REPLIED BY GLO/H. H.S. 94 ON March 10/94 DATE / INITIAL FILE: SRK-0076 / H.S.P. / Real Design

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Estimado Señor Director:

En seguimiento de mi anterior Oficio No. 94-EMA-14655, de 24 de febrero pasado, me permito informar a Usted que, he decidido crear en este Ministerio, la Coordinación Nacional de ONGs, como dependencia directa de la Subsecretaria General de Salud.

Con esta oportunidad, y en razón de que, la propuesta de reprogramación del Proyecto de Salud y Supervivencia Infantil presentado por el USAID y que está siendo discutido por funcionarios de este organismo y del Ministerio de Salud, hace énfasis precisamente al apoyo a la colaboración entre los sectores público y privado, dentro del contexto de la Política de Salud en vigencia, considero que tendría importancia fundamental que el USAID diseñe e implemente actividades tendentes a consolidar la formación de esta nueva Coordinación Nacional.

Estas actividades podrían referirse a las siguientes líneas:

- 1. Apoyo a la adecuación y equipamiento de la nueva oficina.
2. Asistencia técnica especializada, especialmente en las áreas de desarrollo de sistemas de inventario y seguimiento de las actividades de las ONGs.
3. Apoyo a la realización de seminarios y eventos de difusión y capacitación dirigidos a personal clave del Ministerio y de las ONGs.

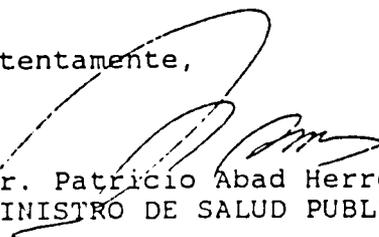
4. Apoyo a la realización de viajes de observación e intercambio.

El desgloce y concreción de estas líneas en actividades específicas, deberá acordarse entre funcionarios del USAID y los delegados del Ministerio que están asistiendo a las reuniones para la reprogramación del Proyecto de Salud y Supervivencia Infantil.

Como contraparte oficial del Ministerio para la ejecución de las actividades en mención he designado al Señor Subsecretario General de Salud.

Aprovecho la oportunidad para reiterar al señor Sanbrailo mis sentimientos de amistad y de la más distinguida consideración.

Atentamente,


Dr. Patricio Abad Herrera
MINISTRO DE SALUD PUBLICA DEL ECUADOR

PAH/EMG
02.03.94





CENTRO DE ESTUDIOS DE POBLACION
Y PATERNIDAD RESPONSABLE.

D.E. No. 162 -CEPAR-
Quito, abril 13 de 1994

Señor Doctor
Ken Yamashita
JEFE DIVISION DE PROYECTOS DE
SALUD Y PLANIFICACION FAMILIAR
OFICINA MULTISECTORIAL
USAID/ECUADOR

De mi consideración:

En días pasados el Comité Ejecutivo conoció por su intermedio la propuesta para que nuestra institución desarrolle un proyecto en el área de salud. Una vez que realizamos un estudio respecto a las características e implicaciones de dicho proyecto para el desarrollo social del país, quiero manifestarle que estamos interesados en su ejecución toda vez que el mismo concuerda con la misión y objetivos institucionales. Nuestra institución cuenta con una capacidad técnica y operativa la cual estará a disposición de este gran proyecto.

Adjunto se servirá encontrar la "Propuesta para el Establecimiento de una Institución Independiente para el Análisis y la Investigación de Políticas de Salud en el Ecuador" que ha sido desarrollada tomando como referencia la experiencia que CEPAR ha adquirido en el área de población durante los últimos 15 años y que a su vez la permitirá proyectarse a mediano y largo plazo.

Luego de la presentación del Proyecto estaremos dispuestos a complementar la información que fuera pertinente.

Atentamente,

Lic. María Elena Yépez
PRESIDENTA DEL COMITE
EJECUTIVO

c.c Dr. Patricio Murgeitio, ESPECIALISTA EN PROYECTOS DE SALUD

CARE INTERNATIONAL

ECUADOR BERLIN 180 entre Eloy Alfaro y 9 de Octubre
Telfs.: 549-469 563-935 231-579 Aptdo. 17-21-1901
Fax 593 - 2 - 565990 - Quito

Quito, 13 de abril de 1994
No. 12931

Señor Doctor
Ken Yamashita
Jefe de la Oficina de Salud
USAID/ECUADOR
Presente

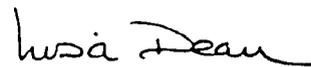
Estimado Doctor Yamashita:

Me es grato enviar a usted el primer borrador del Concept Paper del Proyecto de Fortalecimiento Institucional, para que se sirva someterlo a discusión y análisis.

Me permito informarle que el mismo documento se encuentra en discusión interna.

Esperamos recibir sus comentarios y sugerencias.

Atentamente,



Leo MacGillivray
Director
CARE-Ecuador

c.c. 115.1

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