

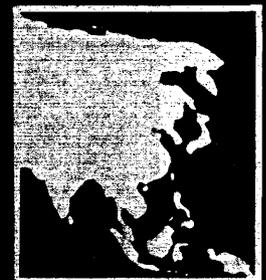
World Bank Identification Mission

working Paper

GUATEMALAN HEALTH

SECTOR PROGRAM

July, 1989



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GUATEMALAN HEALTH SECTOR PROGRAM

COMPONENT I:

DECENTRALIZATION OF THE MINISTRY OF PUBLIC HEALTH

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EXECUTIVE SUMMARY

This report examines how a Health Sector Program could assist the Government of Guatemala to strengthen its efforts to decentralize the Ministry of Health (MOH) and improve health services.

The key problems of the MOH which should be addressed in order to increase its capacity to provide appropriate and efficient health services are:

- 1) Highly centralized decision-making and approval processes for even routine decisions.
- 2) Fragmented, competing vertical administrative hierarchies which prevent integrated and efficient coordinated activities
- 3) High rates of personnel rotation and politicization of personnel selection at all levels, leading to incapacity to make decisions, insecurity and low motivation.
- 4) Lack of donor coordination.

Health Sector Program support should:

- 1) Support and strengthen the current decentralization process that has gained significant, if moderate, support throughout the government and from other donors
- 2) Encourage greater efforts to integrate MOH administrative programs and overcome fragmented and vertical programs.
- 3) Promote broader governmental legal and policy changes -- especially in the areas of budgetary and personnel processes.
- 4) Provide technical assistance, discretionary funds and materials for improved management and technical capacity at all administrative levels, with an initial focus on strengthening the region level.
- 5) Support effective planning and donor coordination.
- 6) Support expansion of the Rural Health Technician Program (TSR) and other community level programs.

DECENTRALIZATION COMPONENT REPORT

I. Objectives and Activities

The objective of this Identification Mission was to identify a program to support health and nutrition efforts of the Ministry of Health (MOH) in coordination with the pre-appraisal mission for the Social Investment Fund Project. The team included the Mission Coordinator, Carmen Hamann; economist, Tarsicio Castaneda; and Nutrition specialist, Judith McGuire from the World Bank; a representative of CARE, Salvador Baldizon; and a health sector administrative specialist, Thomas Bossert, consultant from AID, the author of this report.

With high levels of infant mortality (79% according to the latest survey), low levels of immunization coverage (24% of children under five years of age with complete coverage), and high levels of malnutrition (58% of children with growth retardation), it is clear that the Guatemalan health system is in need of reform to address fundamental problems.¹

The mission reviewed MOH policies, programs and projects, examined other donor support, identified issues and activities that the Bank program could support, reached agreement with MOH counterparts on basic areas for the program (included in the Ayuda Memoria -- see Annex II), discussed proposed issues with other donors, identified further preparation work for MOH and established a time table and responsible working groups to complete preparation prior to an anticipated program development mission in November, 1989.

This report covers the administrative issues of decentralization which were identified as one of five major components of the program. The other areas were: budgetary decentralization, hospital efficiency, improved availability of basic medicines, and nutrition and food supply.

This report is designed to give background and review the issues that should be considered in the future development and design of the decentralization component of this Sector Program.

II. Decentralization Concepts

Decentralization was chosen as a major component in this Health Sector Program because it was clear that one of the principle weaknesses of the MOH has been its centralized administrative structure. This section will discuss some of the principle conceptual issues of decentralization.

The central objectives of decentralization are to shift power and resources from the center of a bureaucratic structure to its periphery. This shift implies that authority and responsibility for decision-making is transferred from higher to lower levels in an administrative hierarchy and in

¹Ministerio de Salud Publica y Asistencia Social, Encuesta Nacional de Salud Materno Infantil, 1987, Guatemala, Mayo 1989.

some cases to other institutions at the periphery. Administrative structures are conceived in terms of a pyramid with decision-making power concentrated at the point, where there are fewest officials, and operations occurring at the bottom, where there are many. The top of the pyramid is also usually located in the capital city and the rest of the pyramid dispersed throughout the country -- adding a geographical dimension to the concept of decentralization. Decentralization generally does not mean the transfer of all control from the center to the periphery.² It means selection of appropriate areas of decision that should be made at the lower levels of the administration.

A first concern is to reduce the bureaucratic bottlenecks that occur when many routine decisions have to be made by the few central officials, delaying the approval of decisions that have been initiated at the periphery. For instance, the approval of routine personnel or maintenance decisions may be held up for months by the centralized approval process, even though the decisions made by local officials is routinely approved without revision. In this instance, the objective of decentralization is to increase efficiency of established policies by transferring authority and responsibility for routine implementation to those officials who are closest to the routine problems.

A second objective of decentralization is to strengthen the capacity of local peripheral officials to respond to the unique differences and needs of their local area that may not conform to a uniform national policy. This objective implies a somewhat higher order of authority and responsibility -- one that identifies the areas where decisions to alter national policy are entrusted to lower level officials. This level of authority and responsibility would allow some measure of innovativeness and initiative at the lower levels.³ Associated with this aspect is responsiveness to local technical needs and to local demands for services -- a political and participatory issue.

A third objective is to strengthen the capabilities and motivation of officials at the lower levels. Exercising authority brings responsibility and often motivation to learn, adapt, improve, and alter routine behavior in order to be more responsive to local needs.

²It should be noted that there is considerable confusion in Guatemala over the objectives and definition of decentralization. The decentralization process of the MOH distinguishes between "decentralization" -- the complete transfer of all authority and responsibility from the center to the periphery -- and "deconcentration" -- the transfer only of selected functions (e.g. budgetary or personnel control) from the center to the periphery, while the center retains others (e.g. planning, norm setting, policy). However, the terms are generally used interchangeably. Within the MOH there does not appear to be any plan to move toward complete transfer of authority so this report will continue to use the term "decentralization" in its common-sense meaning of the transfer of some functions and the sharing of others.

³See Final Evaluation of Comprehensive Health Improvement Project - Province Specific (CHIPPS), USAID/Jakarta, Indonesia, May 1989.

A program designed to enhance decentralization needs to address all of these objectives:

- 1) Increased efficiency of routine decision-making
- 2) Support for innovation and local responsiveness
- 3) Strengthening capabilities and motivation

It should be noted, however, that decentralization should not be an end in itself and that a decentralization process should not remove all control or authority from the center. Centralized control may be necessary to encourage greater equality of services so that areas with least resources are somewhat more favored than they would be if there were no central redistributive mechanism. It also imposes some technical rationality and quality control on policy that can limit local pressures for irrational, or corrupt, activities -- in health, for instance, central control may help officials resist local pressures for additional curative activities and encourage the promotion of preventive programs that are less popular. Equity and technical quality/rationality should be balanced against efficiency, responsiveness and motivation in any process of decentralization.

An additional concern should be with the role of middle level administration. A process that decentralizes from the center to the middle may do little to strengthening the periphery -- indeed, it may weaken or reduce the de facto authority that exists at the periphery. The creation of middle level authority may simply impose another inefficient bottleneck in the approval process.

It should also be noted that decentralization itself may not resolve other bureaucratic obstacles to an efficient and responsive administration. A second concept that should be associated with any administrative decentralization reform is the integration of separate program activities and administrative units. Integration is promoted in order to avoid duplication, take advantage of synergistic effects of the coordination of several related activities, increase flexibility and efficient use of scarce resources. Integration and cooperation may also reduce damaging bureaucratic infighting and the culture associated with it -- jealously guarded privileges, control of resources, and power to place obstacles in the path of rivals.⁴

Finally, it should be recognized that administrative reforms to encourage decentralization and integration involve a complex process of structural changes -- clearly defining tasks, authority, responsibilities at all levels -- training to strengthen personnel capabilities to assume responsibilities and exercise authority and changes in bureaucratic culture which has reinforced hierarchical authority. It is a difficult and complex process that requires significant time, technical assistance and funding support.

⁴For more discussion of the issues of decentralization and integration see: Thomas John Bossert, "Health Policy Innovation and International Assistance in Central America," Political Science Quarterly, 99, 3 (Fall 1985), pp. 441-453.

III. The Problem: Administrative Structure of the Ministry of Public Health

The Ministry of Health is a large, complex institution with nearly 18,000 employees scattered in more than 1,000 health facilities in 23 Health Areas corresponding to geographic governmental Departments.⁵ The system is managed by a highly centralized administration with various operational and normative units housed in offices spread throughout Guatemala City. Branching out from the central administration are the 23 Health Area offices, each with a team of an Area Chief, a physician, sometimes with no public health training; an Area Nurse, Area Environmental Sanitation Inspector, and Area Health Social Worker. This team is responsible for supervising, managing and often training the health staffs of the District Health Offices which are in turn responsible for the health centers, health posts and village volunteers in their districts. The area and regional hospitals are functionally, if not officially, beyond the jurisdiction of the Area Chiefs. The Area team until recently was supervised by six roving supervisors, many of whom have been appointed Regional Directors under the new reorganization program.

The Ministry is organized generally according to standard organizational charts that are common in Latin America. There is a central office of the Minister which is formally responsible for all activities within the Ministry and for coordinating with other health, governmental and international institutions. Within the Office of the Minister (Despacho Ministerial) are currently two Vice-Ministers, one for administrative affairs and one for technical affairs. Attached to each Vice Minister are separate support units, one for Administrative Services and one for Planning and Programming. The Planning and Programming Unit is responsible for preparing the MOH budget, yearly operational plans, periodic five year plans, and other special studies. It is only one of several information centers and is probably the most effective.

The central official responsibility of this administrative level is to establish policy for the MOH. Unfortunately, the centralization of decision-making in the Office of the Minister has meant that even routine decisions on budgetary expenditures and personnel are made at this level. Reflecting in part the lack of delegation of authority and the fragmentation of the institution even at the highest levels, there are several distinct units which are directly responsible to the Minister's Office and not assigned to either of the Vice-Ministers or to the Director General of Health Services. These units include offices for personnel and financial control, the Procurement Office, the Office of International Affairs and the Office of Public Relations.

The third highest official is the Director General of Health Services who is responsible for five normative units and the Supervision and Evaluation Unit which oversees the operating line units of the health areas and hospitals. The Director General coordinates the technical and normative divisions to facilitate their application in the operational units responsible for implementing programs. The Director General's office is the central operational office of the MOH, it does not have sufficient administrative capacity to coordinate all the normative and programmatic activity of the MOH.

All observers of the MOH agree that bureaucratic centralization is a crucial problem. This centralization of even day-to-day routine decision-making means that lower levels of the ministry

⁵See Guatemalan Health Sector Assessment, USAID/Guatemala, 1989.

cannot make timely and appropriate decisions without first gaining approval at higher levels. Signatures from officials at policy levels are often required for the most elementary financial and personnel allocations. This process slows implementation and prevents officials at lower levels from taking initiatives and responsibilities for their programs. In addition, centralization places a tremendous burden on the time available for high level officials to make policy decisions and to coordinate activities with other institutions. With significant portions of each working day taken up with routine decisions, and with meetings with lower level officials who need to argue for approval of their decisions, less time is available for the appropriate types of policy-setting decisions.

While it is clear, as discussed below, that the current government is making a concerted effort to overcome this crucial problem, the government will need all the help it can get to change historical patterns, established bureaucratic culture, routines and habits, and institutional vested interests implied in the current centralized structure. Past efforts of administrative reform of the MOH -- including an ill-fated attempt to create Regional Offices in the 1970's -- have failed to be implemented.

A second problem in the MOH is the internal fragmentation of administrative units into vertical programs and competing departments. Divisions and departments in the MOH have had a long history of intra-institutional rivalry, bureaucratic "turf" struggles, and resistance to coordination and cooperation. At the central level many program activities are managed as separate vertical programs run by officials who often jealously guard their prerogative to control funds and activities related to each program. In some cases officials in the same office fail to communicate with each other about their separate projects, even when they are responsible for activities that require coordination. It is important to recognize that the international donors have contributed to the fragmentation of the MOH. Donors provide program funding and technical assistance that is often vertically administered through a government-assigned counterpart in a separate implementation unit. In almost all cases, separate budgetary and reporting requirements for donor projects reinforce the bureaucratic separation of each project from the normal administrative structure of the ministry. In many cases, projects become the employers of a large number of contractors who may out-number the salaried officials in a central division office.

A third serious problem that undermines effective administration is the rapid rotation of personnel in the MOH, especially at the central level. It is often common in Latin America for the top officials of the Ministry of Health to remain in office for only short periods. These officials, the Minister and Vice-Ministers are political appointees and must respond to the changing political situation. With twenty four health ministers over the last forty-four years, Guatemala is no exception. However, until the Rios Montt government began sweeping personnel changes in 1982, the technical level of the MOH from the Director General on down the administrative hierarchy remained relatively stable. One Director General remained in office over ten years. Since the Rios Montt administration and continuing in the current democratic government, there has been a rapid rotation of personnel throughout the central level of the MOH and in some cases down to the Area and District levels. Personnel decisions since the period of Rios Montt have become increasingly politicized, undermining merit selection and demoralizing technical staff.

This instability is undermining the effectiveness of programs, delaying decision-making, especially for the administrative reform efforts, increasing fear and caution among officials, and preventing the development of good working relations between consultants and counterparts.

As will be discussed in the report on the budgetary component of this Sector Program (Tarsicio Castaneda), the budgetary process is so rigid and complex that flexibility at lower levels is extremely limited by law and regulation. While the budget is developed through a programming exercise that allows some yearly in-put by the district and area officials, there is no flexibility in the use of programmed funds. The officials cannot shift funds from one line-item to another without initiation a significant amendment process. In any case, lower level officials are not able make even routine budgetary decisions without going through a lengthy review and approval process at the central level. The Finance Department of the Minister's Office (Despacho Ministerial) is often involved in approvals of requests that have begun at the district level and followed a lengthy approval process through the Area level and various finance departments at the central level. Repairs and maintenance, per-diem, and other routine budgetary expenses are often held up for months through this process.

Similarly, the personnel process involves a long approval process even for vacations and maternity leave, ending up also in the Minister's Office, in the Department of Personnel. In the case of maternity leave, usually the approval finally is granted after the mother has returned to work, having borrowed money to cover her absence from work.

In summary, the key problems of the MOH which should be addressed in order to increase its capacity to provide appropriate and efficient health services are:

- 1) Highly centralized decision-making and approval processes for even routine decisions.
- 2) Fragmented, competing vertical administrative hierarchies which prevent integrated and efficient coordinated activities
- 3) High rates of personnel rotation and politicization of personnel selection at all levels, leading to incapacity to make decisions, insecurity and low motivation.
- 4) Lack of donor coordination.

IV. Current Decentralization Process

A. National Processes in Administrative Reform

The 1985 Constitution which set in motion the current process of democratization gives a major mandate to the process of decentralization through a regional reorganization of the country. It mandates the formation of eight regions which will assume greater responsibilities from the national level for all administrative units in the government -- all governmental organization is to conform to these regional units. This Constitutional mandate was given force by a Preliminary Law of Regionalization (Decreto Legislativo No. 70-86), and by a Governmental

Accord (151-86) on Administrative Reorganization and Reform. The eight regions are: Metropolitan Guatemala, North (encompassing the Departments of Alta and Baja Verapaz), North East (Izabal, Chiquimula, Zacapa and El Progreso), South East (Jutiapa, Jalapa and Santa Rosa), Central (Chimaltenango, Sacatepequez and Esquintla), South West (San Marcos, Quetzaltenango, Totonicapan, Solola, Retalhuleu and Suchitepequez), North West (Huehuetenango and Quiche) and Peten.⁶

A second major effort in decentralization has been the constitutional mandate and law that provided for 8% of the national budget to be distributed directly to the municipalities through a redistributive formula.⁷ A recent evaluation of this program suggests that stronger accounting measures are necessary to determine what the 8% has been used to support. General impressions are that local roads -- which quickly generate local employment and have immediate political benefits -- have been the major activities and that the municipalities which are department capitals have utilized more of the funds than the smaller villages in their jurisdiction. It is expected that activities other than road construction will be supported by the 8% in the future. The law limits the use of these funds only to materials and construction. No salaries or services can be paid by the fund.

Third, decentralization of ministries should be associated with the incipient System of Consejos de Desarrollo Urbano y Rural. These advisory boards are established at the central, regional, department (in the Health Ministry this level is called an "area"), and district levels. These Consejos integrate the administrative head of each level with representatives of each ministry and with other agencies involved in development of the administrative territory. Recently established, these Consejos usually meet monthly and have reportedly been effective mainly in overcoming implementation problems as they arise. They are designed to facilitate coordination, integration and problem-solving at each level. They have no operational authority, no separate budgetary support and do not have planning and programming capability.

At the Presidential level, the Vice-President, as coordinator of the Cabinet of Ministers, is responsible for coordinating the decentralization/regionalization process, formally called the Programa de Reformas a la Administracion Publica. However, the broad guidelines from this office appear not to have provided sufficient guidance to coordinate a government-wide effort. Each Ministry appears to be following its own separate decentralization process.

B. Ministry of Public Health Administrative Reforms

1. Regionalization/Decentralization

The Ministry of Public Health, is one of the leading ministries which has initiated a program for decentralization. The technical Vice-Minister, as coordinator of the Comité de Gerencia, is responsible for overseeing the process of decentralization in the Ministry. The Comité de

⁶Vicepresidencia de la Republica, Ley Preliminar de Regionalizacion: Decreto Numero 52-87, Marzo 1988.

⁷Vicepresidencia de al Republica, Ley do los Consejos de Desarrollo Urbano y Rural y su Reglamento (Acuerdo Gubernativo 1041-87), Marzo 1988.

Gerencia is composed of the Technical and Administrative Vice-Ministers, the Director General of Health Services, the Chief of the Sectoral Planning Unit, and the Chief of the Unit for Administrative Development. This Comite works within the guidelines of a Master Plan for Institutional Development which defines the broad philosophy, conceptual framework, objectives and strategies and goals (including a Plan of Action) for the process of administrative reform during the period 1987-1990.⁸

The Master Plan was discussed, modified and approved in a Workshop/Seminar on Institutional Development in October 1987.

First the Administrative Development Unit, and later the Sectoral Unit, was responsible for designing and implementing the process of decentralization/regionalization. Technical assistance for this process has been provided by the Pan American Health Organization through its sub-regional Central American program.

With PAHO support, the Administrative Reform Unit developed and promoted the methodology of the reform process. Later the responsibility for managing the reorganization process was transferred to the Sectoral and Planning Unit. The process has been a broad participatory one, involving most departments and levels of the ministry in the design and implementation of the schemes of decentralization. Seminar/workshops have introduced the concepts of decentralization/regionalization at all levels. The process involves a "cascade" sequence in which administrative reforms occur at the highest levels and then move down through the administrative structure. The separate unions and associations of the different levels and types of officials (including Associations of Jefes de Area, Medicos, Public Health Doctors, Nurses, Auxiliary Nurses, etc.), have all had a chance to participate in the development of proposed restructuring, offer their criticisms of proposals, and modify the final proposals.

The first administrative reform occurred at the level of the Vice-Ministries --within the Despacho Ministerial. At this level it was decided to create three Vice-ministers, in essence moving the Director General up to the level of a third Vice-minister. This effort was justified in part as a means of decentralizing power that had been centralized in the Director General, since currently vice ministers have no direct line control over operations. The vice-ministers are to all have normative, policy, advice and coordination roles; however, the responsibility for implementation/operations are to pass to the regional level directly from the Minister. The expectation is that the Regional Directors will each act as the equivalent of the Director General in the region. Currently the Sectoral Unit, working closely with each existing administrative unit is drafting several options for the organization of the Vice-Ministries, simplifying department organization and modifying unit objectives and lines of vertical authority

⁸Unidad Sectorial de Planificacion, Informe del Proceso de Reestructuracion del Ministerio de Salud Publica y Asistencia Social, Julio 1989; Republica de Guatemala, Desarrollo Institucional del Ministerio de Salud Publica, 1989.

and horizontal cooperation. These options include the creation of organizational manuals for each vice-ministry.⁹

The Regional Directors have recently been nominated and are beginning to operate in their regions. Their current task one of finding office space and secretarial support and to begin defining their tasks and activities. A series of workshops in August and September is to review their activities and begin defining their tasks. These workshops are also to be participatory, with all regional directors, area and district chiefs and officials from the central level. The process then anticipates reorganization at the area and district levels at later dates.

Along with this internal, and informal process, officials have been studying the legal changes necessary to put the plans into final legislation. This effort has focused on several laws that must be changed in order to formally approve the anticipated reforms. This process is far from unusual, indeed, the current MOH structure has not been approved by law, and rests only on temporary governmental accords. Laws that are being reviewed are the Organic Law of the Executive Branch, the Organic Law of the Ministry of Health, the Health Code, the Civil Service Law, and the Law of Purchases and Payments. It is expected that these changes will take a long period for final adoption and that the reorganization will occur as a Ministerial Accord or a Governmental Accord pending the formal legislative approval.

It is too soon to evaluate this reform. At the time of this review, the official transfer of the Director General to vice-ministerial status has yet to occur. The Regional Director have only recently been appointed (July 1989) and are only beginning to locate themselves in the regions. However, there are several observations to make at this stage.

The overall process seems to be a good one. Reorganization through participation of officials who are to be affected is an important process and one that should be supported. This participation has been through various forums -- seminar workshops, commentary by unions, etc. PAHO technical assistance has been well received and has been responsive to the Guatemalan initiatives. It appears not to have been too directive -- focusing more on definition of concepts, frameworks and methodology for the process than on the substance of the reforms themselves. This approach respects and may overcome a general resistance of the ministry to technical assistance (as noted above, this resistance is due in part to some consultants taking too active a decision-making role). However, it is a mixed blessing since there are some aspects of the reorganized structure that to this consultant appear ill-advised.

First, however, a comment on the process itself. It has been a long process that has, to date, not advanced very far. The process began to take shape in the Ministry in 1987 and anticipated many of the activities of the process to take place before the end of 1988, but has only recently produced any significant reorganization plans and appointments. Officials who have worked on the process are frustrated by the lack of decisions at the highest levels that are necessary to chose options and to move forward with the process. Part of the delay is due to the change

⁹Ministerio de Salud Publica y Asistencia Social, Estudio de Organizacion de los Servicios de Salud con base en la Deconcentracion y Descentralizacion de Actividades, Documento Preliminar, Enero 1989; Unidad Sectorial de Planificacion de la Salud, Ministerio de Salud Publica y Asistencia Social, Manual de Organizacion del Viceministerio de Apoyo Tecnico (propuesta), Junio 1989.

in personnel and the shifting of responsibility for the reforms from the Administrative Development Unit to the Sectoral Planning Unit. However, there has been some continuity in that the Vice-Minister responsible for overseeing the process is still involved, the new Director General had previously been a consultant for PAHO assigned to assist in the design of the decentralization methodology, and the current central members of the Sectoral Planning Unit had previously been involved in the Administrative Development Unit. Other members of the Administrative Development Unit, however, including some local consultants, have been dispersed throughout the ministry and are no longer directly involved.

In addition, the slow process has left all levels unsure of the implications of the changes for them and has led to added insecurity for personnel (for instance some officials in the central level fear that they will be moved from Guatemala City to the regions, uprooting their families, etc.) and contributing to delays in implementing current programs.

The process has also been somewhat formalistic and confined to the top-down cascade process. While this approach may bear fruit, it also has some disadvantages:

- 1) there is a tendency to focus too much on formal organigrams -- defining unit goals and objectives, vertical and horizontal interrelationships, and shifting units from one authority line to another -- and less attention to defining personnel needs, qualifications, tasks and roles within each unit. These task definitions may come later, along with clearly defined authority and responsibility for areas of decision-making, however, for decentralization it would seem more appropriate to analyze these tasks at the same time as the formal unit organigram is being developed.

- 2) the cascade sequence is a useful process if the process proceeds rapidly enough for revisions to be made at higher levels as changes occur in the lower levels. However, it is not yet clear that the reorganization of the central ministry will be implemented in such a way as to allow for changes as the regions and area levels are reorganized. More participation of the lowest levels would have been appropriate throughout the process.

There is also a lack of guidance from the Vice-Presidency that would put the Ministry's process in conformity with the rest of the government. Currently each ministry is developing its own process and there is little knowledge or coordination among the ministries in this process. Where there a stronger governmental commitment to decentralization then the efforts of each ministry could be coordinated and the broad obstacles -- legal, personnel and budgetary constraints that cut across all ministries -- could be addressed in a consistent fashion.

As the current process proceeds, there is a tendency to avoid addressing the extra-ministerial issues of reform -- such as changes in laws of the executive branch, general governmental budgetary processes, civil service personnel processes, etc.. This lack of a broad focus means that the current MOH process proceeds within these existing governmental constraints. If legal, budgetary and personnel reforms occur across the board (at least in the budgetary process, fiscal reforms are anticipated in the coming years with AID assistance) further reorganization and adjustment might have to occur within the Ministry in the future. The choice to move basically within the given governmental constraints is probably a reasonable one given the difficulties in changing legal structures in the up coming, highly politicized election year. However, the

development of the loan might consider influencing this broader process during the period of anticipated disbursement of funds. If these general administrative constraints can be addressed, then within the Ministry of Public Health, definitions of responsibilities, tasks and perhaps even organizational units would have to change according to the broader administration changes.

Finally, the current process of decentralization has largely ignored reforms necessary to encourage integration and overcome the current fragmented and vertical administrative structure. While decentralization is considered to be part of a general process of administrative development and reform, little direct attention has been directed to reforming the vertical project administrations, and to overcome the rivalry and lack of communication among different divisions, departments and units.

In terms of the substance of the anticipated reform of the central and regional levels, there are several problems with the current design.

It is not clear how moving the functions of the Director General up to Vice-minister will in fact reduce the concentration of power in the hands of that position. Indeed, the role of each of the current vice-ministers is nebulous and without line authority. It is unclear that there is any need for the current vice-ministers, who function without clear authority -- often duplicating and competing with other unit activities.

Even in a decentralized structure, there is clear need for central coordination of policy, norms and information, planning and budgeting. This function should probably be under a single Director General with separate units for purely administrative functions and others for normative, policy and planning and budgetary functions. Without a strong central organizational Director General, the lower levels may have to respond to three different types of directives from competing and uncoordinated vice-ministers. However, this concentration of power in the Director General makes sense only if the rest of the ministry is integrated into that central structure and if many of the routine decisions can be made at lower administrative levels. Otherwise the concentration of power and responsibility will create an even more centralized bottleneck.

Examples of other countries with several vice-ministers is not encouraging -- Costa Rica has tended to have more efficient administrations when its second vice-ministry has been left vacant. This consultant knows no other health ministry that has attempted an administrative structure with three vice-ministries.

It seems most likely that the administrative reform of creating three vice-ministries will simply exist on paper and that the vice minister for technical affairs will act as the current Director General does -- in other words there will be no real functional change resulting from the central level administrative reforms.

At the regional level, there are other concerns. It seems ill advised and awkward to appoint regional directors without defining their tasks and responsibilities. The concept here is that the regional directors will in a sense grow with their positions. In fact officials tend to discuss this process as one of observing a child learning to walk. However, the analogy is not quite appropriate since we tend to have a clear idea of what the child will be able to do when he/she

finally does walk. In the regionalization program there is no clear definition of whether the regional directors are expected to crawl, walk or run. It seems a rather timid way of proceeding and one fraught with potential problems.

A more appropriate strategy would have been to define some clear areas of responsibility and expectations, and have several optional alternatives for other areas, so that some operations research could be applied to determine which options are more likely to be effective.

Currently the fear is that these officials will at best be officials without significant duties or capabilities and at worst will become an additional layer of bureaucracy, without capabilities but with responsibilities that could turn them into bottlenecks between the periphery and the center.

While there is some gain from the center relating only to eight regions, instead of the current 24 areas, it is not clear that the potential gain is worth the risk that these units become bottlenecks. Only if these units are strengthened, given appropriate personnel, training, material and resources can they exercise the anticipated responsibilities that would accompany a real decentralization of power from the center to this level.

However, it is clear that the regional level will be formed and will exist as long as the current governmental process proceeds.

2) Associated Efforts of Decentralization

Within the MOH there have been several specific efforts to enhance decentralization through budgetary changes. These efforts will be discussed in full by another team member (Tarsicio Castaneda) in his review of budgetary decentralization; however, a brief summary of these efforts here will give some idea of the potential control that lower level administrators may be able to exercise as the decentralization process proceeds.

In late 1988 the Ministry, with PAHO and AID support, initiated an Accelerated Immunization Program targeted to the Health Areas with the lowest immunization coverage. This 6 month program provided a lump sum support to the Area Chiefs that was to be used for programmed activities developed by the Area Chief with central level health officials of the Department of Epidemiology. The Area Chief was able to control the funds and disburse them according to the programmed activities. No prior approval by central level officials was necessary for disbursement of funds. There were two audits carried out during the six months to assure that the funds were being used for accelerated program activities. This mechanism appears to have encouraged the Area Chiefs to take more responsibility for the immunization campaign, provided significant motivation, and resulted in significant increases in coverage in these Areas. Although there was no formal evaluation of the process, it seems likely that this experience demonstrates the effectiveness of reducing the approval process for disbursement of programmed funds, and assigning this responsibility directly to the Area level.

It should be noted, however, that the authority granted was extremely restricted, allowing little independent initiative by the Area Chief, who could use the funds only for programmed activities that had been worked out with the central level. The mechanism mainly reduced the

blockages and delays that accompany the normal centralized approval process -- it did little to widen the scope of decision-making power at the Area level.

A second effort to decentralize budgeting had broader implications for Area level decision-making. The PAI/TRO Project (Immunization and ORT) supported by AID has provided a petty cash fund to each Area Chief for activities related to routine immunization and oral rehydration programs. These funds (Q3,000 per month) are advanced to the Area Chiefs on a two month basis. The program has trained accountants at the Area level to comply with the complex Ley de Compras y Pago which restricts the types of activities and materials that can be purchased with the funds. Within the constraints of this law and the objectives of the PAI/TRO project, the Area Chiefs have formal discretion to control the funds without higher level approval. The funds are very small and therefore the authority granted to the Area level is limited, however, this step implies a first attempt to allow lower levels independent discretionary authority over their budget.

The technical assistance recently provided through the PAI/TRO project is beginning to contribute to the strengthening of the MOH capacity and to support decentralization. This program emphasizes 1) problem identification and solution development for administrative constraints; 2) assistance in development of management information systems; 3) support for logistic system improvement; 4) training and community development support. The technical assistance team of Management Sciences for Health has only been in-country for 8 months but is a resource that has considerable potential influence.

There are two other areas of decentralization within the MOH that are being discussed: the decentralization of maintenance units and the decentralization of pharmaceutical warehousing. This mission was unable to explore these issues in any detail. It seems, however, that there are better alternatives to creating decentralized maintenance units -- such as utilization of local private sector mechanics. The issue of decentralized pharmaceutical warehouses will be addressed in the program component on Medicines.

3) Community Level Activities

At the community level there is little direct attention yet established in the decentralization program. PAHO has begun its region wide program of SILOS -- Sistemas Locales de Salud.¹⁰ This program encourages the development of integrated health activities at the community level -- involving all agencies (public and private) and community leaders in local programming and coordinated activities. Generally, it appears that this program has done little to alter the existing government programs at the community level. Indeed, the most frequently heard comment from government officials is: "SILOS is another term for what we have been doing already." Others suggest that the SILOS emphasis is on smaller local units than those established by the Ministry, leading to potential conflicts.

¹⁰Organizacion Panamericana de la Salud, Desarrollo y Fortalecimiento de los Sistemas Locales de Salud, 1989.

There are other local level initiatives that are being discussed, and in some instances implemented, in pilot areas. One is the Unidad de Desarrollo Rural Integrado en Salud (UDRIS) which is being developed conceptually by the Vice-Minister of Technical Support. The central concept is to provide support for dispersed populations which do not have any direct access to health services. These communities will be encouraged to develop integrated means of self-help to improve health in the communities. A second, and perhaps related effort, is a pilot project in Alta Vera Paz, with around 50 villages which are implementing a program similar in concept to the UDRIS. These efforts, however, have not become widely known and have not yet been monitored or evaluated. It is not clear how different they are from the general community participation models already supported by the MOH through the TSR program, discussed below.

An important resource at the community level is Guatemala's unique Rural Health Technician (Technicos en Salud Rural --TSR). The TSRs are the logical starting point for major efforts to involve the community in decentralization efforts such as SILOS and others. The TSR program began in the 1970's and has currently over 400 TSR located in communities across the country. The TSRs have three years of high school education and are trained for two years in a rural school in Quirigua. The curriculum emphasizes basic primary care, including a major focus on water and sanitation. The TSRs also receive training in community organizing and motivation. The TSRs have been particularly effective in organizing village level health committees, training and supervising volunteer health promoters, and coordinating community water and sanitation activities. They support other MOH village level programs such as the jornadas for immunization campaigns, in coordination with the auxiliary nurses of the health posts. Nevertheless, the TSRs continue to be hampered by transportation problems -- caused in part by the awkward and time consuming centralized process of maintenance and repair of their motorcycles. They also tend to lack materials necessary for performing health education for the community and promotor training, except in areas where NGO's provide such support or where donor supported projects -- such as the INCAP/AID SINAPS program -- are implemented.

Training of TSRs was suspended in the mid 1980's when the health system failed to absorb the recent classes -- leaving over 500 trained workers to seek employment in other development activities. In 1989 there are plans -- which have yet to be initiated -- to begin training 100 new TSRs in an abbreviated one-year program with a commitment to employ all the graduates the following year.

V. How Can the World Bank Help?

The Bank can approach the decentralization issues best by supporting the current process. The process is currently well along its anticipated plan of action. It has generated considerable motivation, activity, interest and good will that should be capitalized on. It involves the Ministry in the general governmental reform process as a "pioneer" Ministry and it has gained significant donor support from PAHO, and to a lesser extent AID. Despite some of the weaknesses of the process, it would be viewed as an unwanted intrusion and would be counterproductive now to promote a different process.

The Bank can assist in three interrelated ways.

- 1) Participate in the current process, and attempt to strengthen it during the negotiating process of the loan.
- 2) Provide technical assistance, material support, and training at all administrative levels as part of the implementation of the decentralization itself.
- 3) Through Sector Loan conditions, support policy changes that can strengthen the process of decentralization by addressing directly the legal, budgetary and personnel constraints both within the purview of the MOH and at a larger governmental level.

A. Participation in Current Process (1989-1991)

During the process of loan design and approval, the Bank missions can encourage officials to design the decentralization process in more advantageous ways. Teams should review progress in the process and make comments and suggestions for further advances. Data collected for the loan should also have the purpose of providing information that might alter, refine and improve the current process. National working groups that are established as counterparts for the Bank missions can also form constituencies for initiatives that might influence the process.

Expectations for future missions might set time tables that could encourage decision-makers to address the accelerate the current slow pace of the process.

It would be useful for the Bank to encourage greater attention to the issue of integration of fragmented division and program activities as part of the reorganization process and link this objective to the decentralization process.

Finally, efforts to develop the other components (budgetary decentralization, pharmaceutical, hospital efficiency, and nutrition and food supply) should be coordinated with decentralization objectives to enhance synergistic effects of the Sector Program.

B. Support for Implementation (1992-)

With the anticipated start date in late 1991 at the earliest, the following support could be provided to the decentralized structure that by that date should have emerged from the current process. The Bank support, as described in the Ayuda Memoria of July 10, 1989, should be provided at all levels of the administrative structure of the Ministry of Health: Central, Regional, Area, District, and Community.¹¹

¹¹For detailed description of current understanding between World Bank Program Identification Mission and the Ministry of Health, see attached Ayuda Memoria, July 1989. The following discussion gives background and arguments for some of the issues presented in the Ayuda Memoria.

1. Regional Emphasis

Currently it appears that support for the regional level could be a central focus in order to implement the current emphasis on developing this level. However, by providing support to all levels, decisions at later stages could shift this emphasis if conditions are more propitious for an emphasis on the Area, or lower, levels.

Arguments in favor of supporting the regional level are:

1) the current MOH process is coordinated with a national emphasis on developing regions which is gaining support from other donors and other sector activities. It makes sense to take advantage of the broader process and to reinforce it in order to gain momentum for other decentralization efforts (such as legal changes and administrative reforms that cut across sectors).

2) strengthened regional offices might demonstrate sufficient capability to allow clear transfer of personnel and some normative and operational control away from the central level. Without sufficient resources at this level there will be little incentive for shifting authority and personnel from the centralized offices in Guatemala City.

3) while the Areas may be strengthened by greater flexibility in use of local funds and in mid-year adjustments of activity programming it would be uneconomical and inefficient* to have normative and supervisory capability shifted significantly to this level. If the normative, monitoring and supervisory capability is established in the 8 regions then some of these functions can more easily be transferred from the central level.

4) if the regional capabilities are not strengthened, they may arbitrarily impose obstacles and bottlenecks to the communication between the center and the regions.

5) the Regional level might be an appropriate arena for encouraging the integration of project and program activities and a crucial step in the process of overcoming the vertical project administrative structure.

Arguments against supporting the regional efforts are:

1) it might be better to allow the regional offices simply to wither away. They have received only modest support up to now and, as noted above, the current process has yet to establish clear responsibilities, roles and tasks for this level. Very little budgetary support has been granted to the regional officials. If the current situation is an indicator of the future commitment, there is only moderate evidence that the government and the MOH is significantly behind the creation of regions.

2) it is difficult to shift power and personnel away from the center and there are no clear mechanisms for assuring that the creation of the regions will really mean that the center will give up control or personnel to these offices. If the center does not transfer authority and personnel, then the regional office becomes only another bureaucratic office

to pass on orders from above and requests from below. At best it would slow the process of approvals, at worst, it would impose arbitrary obstacles to implementation.

It seems prudent to follow the current regionalization process to evaluate its potential at a later date closer to the actual loan approval date. If this national level emphasis falters, then the project might consider shifting its focus to lower administrative levels, and encourage the MOH to abandon the efforts to create the regional offices. However, if the process actually results in the development of functioning regional offices, then the Health Sector Program should be designed to support this level, as well as the lower administrative levels.

2. Program Activities

The major activities of the Bank loan should provide significant levels of technical assistance, training, discretionary funds, and material support for each administrative level. This support would primarily be to develop capabilities at the regional, area and district levels for assuming greater responsibility for managing health activities of their administrative level, and to support the central level in shifting its responsibilities and authority to those levels. The Program should also develop additional capability for national level planning and coordination of donor support - responsibilities which in a decentralized ministry should be strengthened at the national level.

a. Technical Assistance

The Ministry of Health in Guatemala has had several unfortunate experiences with expatriate consultants and is understandably reluctant to accept significant levels of technical assistance in donor supported programs. However, it is important in this decentralization effort that major long-term technical assistance be provided and that the MOH be given a central role in selection and approval of the consultants.

Reasons for technical assistance:

- 1) inefficient administrative systems/routines and lack of management skills are central problems at all levels. Redesign of management systems and transfer of management skills can best be accomplished with consistent, long-term, carefully chosen consultants who emphasize transfer of problem-solving, supervisory, training, financial management skills.¹²
- 2) long-term consultants can provide a bridge between officials in a bureaucracy that is characterized by rapid rotation

¹²A particularly effective process of decentralization was supported by an AID province level project in Indonesia, in which long-term consultants assigned to each of three provinces were crucial in developing provincial level capacities and encouraging officials to take local initiatives. See Final Evaluation of Comprehensive Health Improvement Project -- Province Specific, USAID/Jakarta, Indonesia, 1989.

3) if, as many national officials note, there is a bureaucratic culture that has reinforced respect for hierarchy and a reluctance of officials to assume responsibility, long-term consultants may introduce alternative cultural models and challenge officials to assume the new authority that is granted under reorganization schemes

Caveats to consider with technical assistance:

1) there are several long-term consultant groups already working in the MOH:

PAHO has two consultants directly assigned to working with the MOH on decentralization, and one sub-regional consultant who supports their efforts.

AID has a team from Management Sciences for Health which is supporting management, health information systems, training, and logistics in the MOH. This contract is expected to end in 1991, probably before the initiation of the World Bank program.

Any long-term technical assistance should be coordinated with the existing consultants of the other donors.

2) one possible model for technical assistance is to have one long-term consultant assigned to each regional office (or to a pair of regional offices), with responsibilities to support both the regional office and the area offices within that region. Central responsibility would be to support use of data in problem identification and solution development, support for supervisory systems, and coordination of in-service management training.

3) given the past history of donor consultants, MOH should have a central role in establishing the scopes of work and selecting the consultants for this activity.

4) efforts to coordinate other component objectives -- such as improving nutrition education, or drug supplies -- might also be served with appropriate multi-functional consultants.

b. Training

Management training, training in financial control, HIS/MIS, supervision and some technical skills are necessary for the development of appropriate capabilities at the regional, area and district and health post levels.

Most of this training should be targeted to specific problems that arise during the process of decentralization (such as the training that was provided at the Area level for financing of PAI/TRO project). It should be in-place, in-service and short-term training. Modules could be developed with assistance of local institutions (National Institute of Public

Administration) or other training institutions (eg.INCAE), or consulting firms. MOH training institutions could be supported to sustain this activity by providing future continuing education with the modules and methodologies developed.

Currently, PAHO and the MSH team are providing some management training and any effort by the Bank should be coordinated to supplement and support these established efforts.

The Bank might focus on providing longer term sustained efforts by building the MOH Human Resources Division efforts to implement a National Plan for Continuing Education. Bank resources might support the development of special curriculum in that division for addressing specific decentralization and integration problems as they arise in the process of the administrative reform.

c. Discretionary Funds

Two objectives of decentralization are to:

- 1) allow lower levels to make routine decisions to respond to specific problems and needs and
- 2) motivate officials at all levels to seek and implement innovative solutions to their problems.

A major means of reaching these objectives is to give lower level officials some discretionary funds to 1) purchase materials and services to solve routine problems and 2) design innovative activities to solve locally identified problems.

Discretionary funds could be provided as local "block grants" to be used for specified routine problems and for creative proposals subject to a short simplified approval process. Such block grants have already been used in two immunization programs in the MOH - the Jornadas and PAI/TRO. These grants were targeted to specifically programmed activities and have had some restrictions (i.e. no salary support) which might be removed in a broader block grant program. AID is currently exploring mechanisms that could allow Regional Directors greater control over block-grant type funds.

Grants should be large enough to cover expenses that have been major bottlenecks in the past (i.e.at least one major vehicle repair) and one innovative local activity every 6 months. Rather than a single amount granted to each region or area, a standard formula based on number of health facilities, personnel, and other significant technical variables should be used in the assignment of funds

Caveats for block grants:

It is not clear what legal and budgetary processes would have to be addressed to facilitate these block-grants, however, it is clear that some form of block-grant can

be implemented even within the current restrictions. Once the review of the budgetary process is completed by November (see Ayuda Memoria point #8b) the constraints on block grants should be examined.

A clear, simple and short approval process for innovative proposals should be developed during program negotiation to avoid using current cumbersome hierarchies for approval.

d. Material Support

Offices at all levels, but especially at the regional level, lack basic materials and supplies which are necessary for efficient functioning of the decentralization plan. Particularly needed is support for transportation and per diem for supervisory and training purposes.

The Bank program could provide office materials and supplies, transportation and per diem for all administrative levels. Cost estimates for this support should be available in November from the MOH.

e. Support for Central Level Planning and Donor Coordination

Although the Ministry of Health has had donor support for its planning capacity in the past, in recent years planning has been abandoned and there is considerable need for enhanced and stable planning, monitoring and evaluation capability.

One particularly weak area is the lack of clear initiative on the part of the MOH to define and coordinate the separate efforts of different donors. Currently donor interests are the primary determinant of their interventions and the MOH is buffeted by shifts in donor policies and competition among donors. Often donor coordination occurs at the initiative of donors themselves rather than by the MOH.

Although the Office of International Affairs has an able staff, it has not developed the capability to define appropriate priorities for donor assistance within a detailed and logical health plan and to assign responsibilities to different donors to assure complementarity and avoid duplication.

Planning efforts require significant commitment of time to gain wide participation and develop consensus around specific priorities and programmed activities. Planning efforts could center on the next five year plan or specifically on areas for donor support over the next five years. In either case, it would be important for the MOH to begin to define its plans for donor support so that donor coordination takes place according to national priorities rather than primarily in response to donor priorities.

Planning should be coordinated with yearly programming activities and with the budgetary process. It could become a forum for increasing the integration of central level departments and divisions.

The Bank program could support the development of planning, programming and budgetary processes, probably within the Sectoral Planning Unit where current programming and decentralization efforts are being operationalized. Support for short-term technical assistance, training, workshops/seminars, materials and computers would be appropriate.

f. Support for Technicos en Salud Rural and other Community Level Personnel

The TSRs are a unique human resource in Guatemala. They are particularly appropriate for promoting decentralization efforts to the community level. They combine both technical primary health care skills and community organizing and motivating skills.

Currently there are too few TSRs in the country and they have severe limitations in essential transport and materials.

The current number of around 400 TSRs is insufficient for the needs throughout the country. It has been estimated that one TSR can effectively work in three villages (aldeas). To cover all villages in Guatemala, 6,000 TSRs would have to be trained and given positions. It is unrealistic to expect that the MOH would be able to provide salaries for such a large number in the near future, however, it is reasonable to assume that at least 100 positions per year could be assigned (through vacancies shifted from hospital and central level and through a modest expansion).

The TSR training facility (INDAPS in Quirigua) is currently being used to train other types of auxiliary personnel and it could easily accommodate re-initiation of TSR training - indeed there are current discussions of restarting an abbreviated one year program this year. The past curriculum could be reviewed and updated -- especially to encourage more nutrition education (see Ayuda Memoria #6c). Some of the previous faculty might also be utilized.

Bank support might be provided to assist start up and to encourage the full two year training program. It might also provide some line salary positions for TSRs if the government commits to gradually assuming salary responsibility over the life of the project.

Bank support could also address transportation bottlenecks (motorcycles, and their repair and maintenance) and lack of materials -- especially for health and nutrition education.

Some of this support might be initiated during the pilot phase of the FIS so that the institutional program support could be tailored to follow on the support and activities of the FIS programs.

The other major community level resources are the auxiliary nurses and the volunteer promoters. Future missions should explore the current donor and government activities involved in mobilizing and training these resources -- evaluating the efforts of the PAI/TRO and "channeling" activities. Future missions should also monitor the progress of

specific local programming efforts such as SILOS and UDRIS as they become more operational. Bank support for these efforts could strengthen local level programming, provide material and transportation support, and strengthen health and nutrition education.

C. Policy Changes

The general commitment to a policy of decentralization has been established by the Constitution and by several governmental and Ministry decrees. It seems likely that this policy commitment will be maintained throughout the current administration. There is no reason to expect that the subsequent administration, following elections in 1990, will change the broad commitment to decentralization, however, it is possible that the priority for decentralization might change depending on the program of the incoming government. The Bank should monitor governmental priorities for these potential changes and attempt to encourage continued efforts to implement the established decentralization process.

Several other policy areas should be addressed to facilitate the implementation of the decentralization process: 1) personnel policies; and 2) budgetary processes and priorities.

1. Personnel Policies

The Health Sector Program should be used to leverage changes in personnel policy which would enhance decentralization and efficient administration. Conditions precedent or other covenants necessary for disbursement of tranches might be assigned to:

a) encourage the transfer of personnel from the center to regional and/or area offices and from hospitals to the village level. This might be accomplished by freezing positions at the central level and hospital units and transferring all vacancies to regional and TSR or health post positions.

It is not clear whether there is sufficient yearly vacancies for this policy to result in real shifts in personnel. The personnel review by MOH in preparation for the November Mission should provide this information. If it is insufficient, other incentives for personnel transfers (such as salary supplements for rural service) should be considered and perhaps supported by Bank funding.

b) rapid rotation of personnel in central offices has inhibited the design and implementation of many programs and projects. This rotation appears to have accelerated in the 1980's and the Ministry has become more affected by bureaucratic and electoral politics. Some commitment to a more stable personnel policy which could be monitored in a clear and unobtrusive way (e.g. no rotation for the first year in a position, or rotation of only 10% of positions during a three year period) should be established.

A broader policy commitment -- beyond the scope of the Ministry of Health -- would be a change in government personnel policy to allow decentralization of many routine personnel

decisions. Currently all significant personnel decisions -- even vacations and maternity leave - - must be approved by the Despacho Ministerial. The general civil service regulations and other pertinent legal and governmental regulations regarding personnel should be studied and reformed to encourage greater flexibility and decentralization of decision-making.

Legal changes and governmental accords to reform personnel administration will require significant consensus building within the public administration and with the employee unions and does not seem feasible at the current political juncture. However, if the decentralization process gains momentum, there may be opportunities for gaining political support in other sectors for significant changes in these regulations. This is an area for Bank negotiators to monitor during the process of development of the Health Sector Program.

2) Budget Process and Priorities

Another report (Tarsicio Castaneda) will be treating the general process of budgetary reforms that should be supported to facilitate decentralization. It will be important that these reforms be consistent with increasing the responsibility, authority and flexibility of the regional, area and district levels and that appropriate and simplified control mechanisms be developed and implemented.

Pilot efforts might provide the basis for establishing new policy and regulations. Major efforts should be made to demonstrate the utility and effectiveness of increasing cost-recovery mechanisms (such as the Q 0.25 charge per consultation) and allowing these charges to be retained at the Area, district or village level. Efforts to encourage cross subsidy from curative to preventive services at each level should also be made.

The MOH should be encouraged to shift budgetary priorities through shifts in personnel, investment and recurrent non-salary budgets from center to regions and from curative hospital care to primary care activities. The budgetary analysis to be completed for the November Mission should provide indicators that could be used as targets and for monitoring progress in these shifts.

It should be noted, however, that such shifts are extremely difficult to accomplish, even with the best intentions of top Ministry officials. There are many political and union pressures that encourage maintenance of the current budgetary distribution in favor of hospitals and the center bureaucracy. Given this realization, targets should be set with sufficient realism and recognition of the government's political constraints. Unrealistic targets could prevent disbursement and hurt other objectives of the program.

D. Linkages with the FIS

The Social Investment Fund (FIS) is currently being negotiated with the Ministry of Finance. It is likely to have three sources of funding, two of which will have health and nutrition sector support. The objective of the FIS is to provide funds directly to implementing agencies at the lowest administrative levels -- primarily the municipalities, villages, and NGO's who work at

these levels. The FIS has two phases: 1) the COFIS, which is support for pilot projects beginning in 1990; and the FIS, a 3-5 year program to disburse significant funding (perhaps as much as US\$120 million) through a semi-autonomous funding agency to be established by legislation. Currently there are discussions about relevant health and nutrition activities that could be used in the pilot phase. The FIS mission is also defining criteria for proposals in the health and nutrition area for the FIS phase.

For the purposes of decentralization there are at least three significant linkages that should be explored between the FIS and this Sector Program:

1) During the pilot phase, COFIS, might be able to fund training and material support for the TSR program that then would be supported on a longer-term basis through the Health Sector Program. It might be possible for the COFIS to provide support to assure that the renewed TSR training program could be a full two years, as in the original program (rather than the currently planned one year) and support curriculum revisions that would place more emphasis on nutrition education.

2) Area Chiefs might be incorporated into the review mechanisms for FIS proposals so that health activities are within the norms of the MOH, and so that the Area Chief can become involved in more community level activities.

2) Support for the Municipalities that is envisioned through one "window" of the FIS -- basically a topping off of the 8% and using the same disbursement mechanism -- could be used to encourage decentralization within the MOH. Current negotiations suggest that municipalities will be able to utilize their funds to contract services from TSRs, nurses, NGO's, etc. This alternative funding source for health activities would require local level MOH officials to coordinate with, and perhaps supervise these local authorities. As the FIS progresses, it may become necessary for the Health Sector Program to develop components that encourage such local level cooperation and supervision. This process might require special training activities in inter-organizational and multi-sectoral decision-making and administrative processes.

Other areas for linkage are to be treated by other reports -- in particular the budgetary decentralization (Tarsicio Castaneda) and nutrition (Judith McGuire).

ANNEX I
COST ESTIMATES

The Ayuda Memoria has asked the MOH to provide cost estimates for each aspect of the decentralization component as part of the preparation for the November Preparation Mission. Other estimates will be presented by Tarsicio Castaneda in his report on the budgetary component.

Included here are several preliminary estimates that this consultant was able to obtain during his investigation.

1) Technical Assistance.

A central element of the decentralization component will be the provision of long-term technical assistance -- which will probably have to be supported by grant (non-reimbursable) funds, rather than loan funds. Current AID estimates for long-term expatriate consultants -- including salary, benefits, differential, housing, shipping, etc. -- is US\$250,000 per year. If the project supports eight long-term external consultants to be assigned to the regions, then the total yearly cost for just this component would be US\$2 million. Savings could be gained through use of local Guatemalan consultants, or through fewer long-term consultants -- either by selecting regions for assistance, or by having consultants responsible for assisting more than one region. Several options might be reviewed in the November Mission.

2) Regional Offices

Support for Regional Offices -- including salary for five officials and support staff, materials, transportation, rent, and other operating costs -- is estimated by the Sectoral Unit to be Q80,000 per year (US\$29,630).

3) Management Training

Past estimates of short-term training at the Area level have been around Q8,000 for a five day course for 60 people, using MOH facilities and teachers. Recent increases in per-diem suggest that this estimate should be doubled. If hotel accommodations are used an additional Q150 to 200 per person per day should be estimated.

A basic estimate for five such courses (one each in general management, management information, financial control, logistics, and organizational development) for all Areas would be: Q16,000 X 5 courses X 23 Areas = Q1,840,000 or US\$680,000.

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4) Training for TSR

Current yearly budget for INDAPS (the TSR training school) is Q397,782 which does not include living or transport costs for students. If 20% is added for these expenses then the total yearly cost for TSR training would be: Q477,338 (US\$178,000).

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ANNEX II

GUATEMALA

PROPUESTA DE APOYO AL SECTOR SALUD

MISION DE IDENTIFICACION

AYUDA MEMORIA

A petición del Gobierno una misión del Banco Mundial visitó Guatemala del 9 al 21 de julio de 1989 con el objeto de identificar las formas en que el Banco, en coordinación con otros donantes, puede apoyar al Ministerio de Salud. La Misión estuvo compuesta por Carmen Hamman (Misión Líder), Judith McGuire, Tarsicio Castañeda, Tom Bossert (Consultor AID) y Salvador Baldizón (Consultor de CARE). El objetivo de la Misión era identificar un programa de apoyo al Ministerio de Salud que ayude a la descentralización y a los esfuerzos del Ministerio para fortalecer su capacidad de planificación estratégica, administración y apoyo logístico que llevan a una mejor y más efectiva provisión de servicios. La misión agradece mucho la colaboración del personal del Ministerio, que nos apoyó con ideas y sugerencias, especialmente la Oficina Coordinadora de Asuntos Internacionales (OCAI).

Al final se adjunta una lista de personas entrevistadas.

Resultados de la Misión

Como fue acordado en misiones anteriores, el Banco Mundial está interesado en apoyar al Gobierno en el desarrollo de su estrategia de inversión social que incluye la creación de un Fondo de Inversión Social y un préstamo para el Sector de Salud para mejorar significativamente y en el más corto plazo posible, los indicadores de salud de la población. En cuanto se refiere al sector salud, el Banco apoyará al Gobierno en el diseño y ejecución de una política y plan de acción para el sector que permita aumentar significativamente la cobertura de los servicios de salud en las áreas más pobres y donde la cobertura sea más deficiente enfatizando acciones preventivas, de atención primaria y de promoción del crecimiento y nutrición de madres y los niños.

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Paralelamente el Banco apoyará al financiamiento de las inversiones y gastos necesarios como sea acordado en las misiones futuras de preparación y evaluación del proyecto, incluyendo las acciones del Ministerio que puedan financiarse por los municipios y comunidades con fondos del FIS. La ligazón del Ministerio con el FIS podría ser de dos maneras (i) el Ministerio desarrolla un programa que pueda ser ejecutado o pagado por los municipios, aldeas y comunidades con recursos del FIS, supervisado por el Ministerio; o (ii) el Ministerio establece convenios con las anteriores entidades para conseguir ciertas metas (por ejemplo reducción de la mortalidad infantil y reducción de desnutrición a un porcentaje especificado) y se compromete a recomendar al FIS financiamiento y a monitorear el cumplimiento de las metas. En esta alternativa, los municipios, comunidades u ONG's tienen la libertad de buscar las formas más apropiadas y más baratas para lograr las metas establecidas.

Áreas de Apoyo al Sector Salud

Las áreas especificadas en que el préstamo sectorial podría apoyar, corresponden a las áreas programáticas del Ministerio como están expresadas en el documento "Políticas, Estrategias y Objetivos del Ministerio de Salud Pública y Asistencia Social, 1989". Las principales son las siguientes:

1. Apoyo a la Estrategia de Descentralización

El objetivo de este componente es apoyar los esfuerzos del Ministerio de Salud (MS) para fortalecer el proceso de reforma administrativa con énfasis en la descentralización. El Programa para el Sector Salud (PSS) propuesto, apoyará la descentralización e integración a través de un fortalecimiento de la capacidad técnica y administrativa en los niveles regionales, de área, de distrito y de la misma comunidad, a fin de que puedan asumir mayores responsabilidades en la implementación de servicios de salud. El PSS también incluirá fortalecimiento al nivel central del MS para que pueda delegar responsabilidades a los niveles mencionados.

El PSS prestará apoyo al Gobierno de Guatemala para lograr las modificaciones legales necesarias para facilitar la descentralización y, al mismo tiempo, proveerá al nivel central, al regional y a los niveles locales, los recursos técnicos, materiales y financieros para implementar el proceso de descentralización. Estas acciones serán coordinadas con las que actualmente realizan OPS, AID y otras instituciones técnicas y financieras a fin de que tales acciones se complementen. el PSS propuesto proveerá apoyo a:

Nivel Central

- (a) Asistencia para desarrollar y complementar el actual esfuerzo de descentralización e integración del MS/OPS, con énfasis en el monitoreo y evaluación del proceso. Apoyará el desarrollo de mecanismos de la supervisión central hacia las regiones y simplificación de los sistemas normativos de administración y logística en todos los niveles. Esto incluirá también, proyectos de investigación operacional para evaluar diferentes opciones de descentralización.
- (b) En coordinación con OPS apoyar programas de capacitación en manejo gerencial de corto y largo plazo, integrados con el proceso de descentralización e incluyendo seminarios/talleres para coordinar la integración de los esfuerzos del nivel central para delegar funciones a los niveles periféricos.
- (c) Desarrollo de sistemas de logística y los recursos necesarios para implementarlos.
- (d) Apoyar la capacidad de planificación y coordinación de ayuda externa en la estrategia de descentralización.

Nivel Regional

(a) Desarrollo de sistemas administrativos apropiados, integración de los sistemas normativos y de control financiero y análisis del sistema de información de salud y su manejo (SIS/MIS). También se proveerá asistencia a los recursos humanos, materiales y financieros para implementar el sistema en cada oficina regional.

(b) En coordinación con OPS apoyar la capacitación gerencial en planificación, programación, supervisión, logística y control financiero (cursos cortos). Esto podrá incluir, como mínimo, capacitación en recolección de datos, registro y análisis de información y apoyo para el mantenimiento de los equipos de oficina para el SIS/MIS.

(c) Fondos discrecionales para nuevas actividades e innovaciones que puedan realizarse a nivel regional (investigación operacional, proyectos piloto, manejo de emergencias causadas por epidemias, etc.).

Nivel de Area y Distrito

(a) Cursos cortos de capacitación en manejo gerencial y supervisión, programación, logística y control financiero para jefes y equipos del área de salud. Este nivel incluye por una parte, el desarrollo del SIS/MIS con computadoras a nivel de área y capacitación en recolección, reporte y análisis de datos y, por otra parte, los recursos humanos, materiales, equipo y transporte necesario para mejorar la presentación de servicios de salud.

(b) Materiales, viáticos y transporte para supervisión, talleres y otras actividades que se realizan a nivel del área.

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- (c) Fondos para nuevas actividades, programas e innovaciones a nivel del distrito.

Nivel de la Comunidad

- (a) Cursos cortos de capacitación técnica y administrativa para auxiliares de enfermería y TSR, capacitación y aumento en el número de TSR (incluyendo cambios en el curriculum).
- (b) Capacitación de promotores, comadronas y otros miembros representantes de la comunidad.
- (c) Asistencia de recursos humanos, materiales y equipo necesarios para implementar las nuevas estrategias.

2. Políticas de Apoyo

- a. Cambios en políticas de manejo de personal a fin de que plazas existentes puedan trasladarse del nivel central al regional, y del nivel curativo al de atención primaria (por ejemplo: congelamiento de plazas a nivel central y hospitalario y su traslado a nivel regional y de puestos de salud.
- b. Compromiso de promover mayor estabilidad del personal incluyendo una evaluación de puestos, funciones y rendimiento en todos los niveles.
- c. Flexibilidad en el manejo del presupuesto a nivel del área, para lograr una implementación efectiva y eficiente de la atención médica.
- d. Compromiso a nivel del presupuesto del MS para aumentar el apoyo en la línea de mantenimiento de vehículos y equipo, viáticos y uso de fondos discrecionales.

3. Apoyo Para Una Mejor Distribución y Asignación de Recursos Dentro Del Ministerio de Salud.

Los datos indican que el Ministerio de Salud ha recibido en los últimos años una proporción muy pequeña de Producto Nacional (menos del 1%), que no ha crecido con la población. Esto ha sido seguramente un factor importante en la baja cobertura del sector y los deficientes indicadores de salud especialmente en las zonas más apartadas del país. Esta limitación de recursos se ha visto agravada por una deficiente distribución y asignación de los mismos. Por ejemplo, cerca del 80% de los recursos totales se destinan a medicina curativa hospitalaria y poco a medicina preventiva y curativa simple en los puestos y centros de salud. Una gran proporción de recursos físicos y humanos se concentran en la Ciudad de Guatemala y en las cabeceras de los departamentos y poco va a las regiones más apartadas del país. Aún con los recursos existentes podría mejorarse mucho la atención primaria y preventiva si los recursos fueran mejor distribuidos entre niveles de atención y a las regiones más desprotegidas. El apoyo al Ministerio podría consistir en:

- (a) Ayudar a establecer y procurar ante las entidades competentes la necesidad de un programa de incremento en los recursos del sector, si es necesario, como contrapartida de recursos donantes, incluido el Banco Mundial.
- (b) Apoyar y asesorar al Ministerio en la simplificación de los procedimientos presupuestales que en el momento dificultan la autonomía y racionalización económica del Ministerio.
- (c) Apoyar al Ministerio en un programa de inversiones y reposición de equipo, si una evaluación exhaustiva de infraestructura y equipo así lo determina. Prioridad se daría a infraestructura de centros y puestos de Salud en áreas rurales con los peores indicadores de salud.

4. Apoyo para Mejorar la Eficiencia Hospitalaria

Como parte del apoyo a las actividades anteriores, el Banco asesoraría al Ministerio en la determinación de criterios y métodos para mejorar la eficiencia hospitalaria en coordinación con otros donantes, algunos de los cuales ya han prestado asesoría técnica en estas materias. El apoyo podría consistir en: (i) desarrollar mecanismos de administración y modernización hospitalaria; (ii) diagnóstico operativo, diseño e implementación de sistemas de información y (iii) material y equipamiento de computo y otro que sea necesario. Como parte del programa, se incluiría asistencia para determinar formas para recuperar parte de los costos y para la focalización de beneficiarios más necesitados.

5. Apoyo para Mejorar el Acceso de la Población de Bajos Recursos a Medicamentos Básicos

Como ha sido indicado a la Misión, el área de medicamentos necesita apoyo para mejorar la oferta oportuna de medicamentos de bajo costo y la eficiencia administrativa de los sistemas de control, almacenamiento y distribución de medicamentos. Esta es un área compleja que envuelve el estudio de la oferta local y externa, los procedimientos de compras, la distribución a la Droguería Nacional para su posterior distribución a droguerías estatales y municipales, hospitales, puestos y centros de salud.

Uno de los problemas encontrados a nivel del control de medicamentos es la falta de un sistema computarizado de inventarios en la droguería nacional que permita un mejor manejo de los stocks y evitar pérdidas por vencimiento de medicinas, otro problema es que las farmacias estatales y municipales que reciben medicinas de la Droguería Nacional no pueden hacer los pagos directos a la Droguería sino que deben depositar los fondos en cuentas del Ministerio de Hacienda. Esto no permite una mayor recuperación de fondos, un mejor control y una reposición más oportuna de medicinas en los tres tipos de droguerías.

6. Apoyo a Estrategia de Nutrición y Distribución de Alimentos

El Ministerio de Salud tiene un rol fundamental en la prevención del retardo de crecimiento de niños menores de tres años, con programas integrados de salud y nutrición, incluyendo prevención de embarazos múltiples de corto intervalo. La estrategia integrada de salud y nutrición constituirá uno de los componentes esenciales del Programa del Sector Salud (PSS), a continuación se describen las áreas propuestas para ser integradas dentro de este componente.

(a) Promoción y Monitoreo del Crecimiento

El Ministerio de Salud ha iniciado un programa de promoción del crecimiento y desarrollo, pero para lograr una efectiva promoción del crecimiento, el uso de las gráficas distribuidas debe ir acompañado de una capacitación intensiva de todos los niveles de personal de salud, desde los médicos hasta los trabajadores voluntarios de la comunidad. Además, los mensajes de salud deben ser desarrollados con participación de la población a la que van dirigidos (familias de escasos recursos del área rural). El uso racional de alimentos suplementarios (incluyendo alimentos donados) para corregir el retraso del crecimiento debe ser estandarizado y diseminado a todos los que trabajen en salud preventiva. Finalmente, dado que una pequeña proporción de los niños a quienes se les hace monitoreo del crecimiento puede, en algún momento, desarrollar desnutrición aguda (por ejemplo, debido a infección severa), el Ministerio de Salud tendría que desarrollar una metodología para el tratamiento de estos niños a nivel de la comunidad, utilizando al máximo los recursos locales.

El PSS apoyará un plan de acción para lograr cobertura universal del monitoreo del crecimiento como parte del Programa de Atención Materno-Infantil. Este apoyo incluirá: capacitación de personal y de grupos locales, estandarización de normas y procedimientos, desarrollo de una metodología para el tratamiento de la desnutrición aguda con recursos disponibles en la comunidad y provisión de materiales y equipo para complementar y extender las acciones de promoción del crecimiento.

(b) Distribución de alimentos a través del Sector Salud.

Aunque mucha de la ayuda alimentaria que llega a Guatemala se dirige a reducir el problema de la desnutrición, los alimentos se utilizan sin criterios para lograr la prevención de desnutrición, sin un componente efectivo de educación nutricional y sin promover una participación activa de la comunidad en el manejo del programa. Además, es necesario establecer un sistema de monitoreo y evaluación sistemático para la utilización de los alimentos donados y para desarrollar mecanismos para asegurar un abastecimiento oportuno de alimentos a los programas y áreas prioritarias. Debido a que la cobertura del MS es limitada y a que la extensión de dicha cobertura se logrará en un plazo muy largo, es necesario explorar con las municipalidades y con las mismas comunidades, otros mecanismos efectivos y de bajo costo que puedan utilizarse para canalizar las acciones de salud y nutrición.

El PSS apoyará el desarrollo de una ayuda alimentaria más efectiva y una estrategia de distribución más eficiente, incluyendo: estandarización de criterios, normas y procedimientos para canalizar la ayuda alimentaria dentro del sistema de salud, desarrollo de mecanismos de monitoreo y supervisión para mejorar la provisión y distribución de alimentos, capacitación de personal y de grupos de la comunidad, equipos, transporte y materiales.

(c) Educación Nutricional

La metodología y los materiales actualmente disponibles para educación nutricional tienen serias limitaciones para prevenir el retardo del crecimiento, lograr un uso efectivo de los alimentos donados, promover prácticas adecuadas de lactancia materna y de ablactancia para lograr un uso más efectivo de los recursos alimentarios a nivel del hogar. Capacitación en métodos y técnicas de educación nutricional es necesaria a todos

los niveles de personal de salud incluyendo médicos del sector público y privado, niveles intermedios y voluntarios de la comunidad. Los mensajes de educación nutricional deben ser desarrollados con participación activa de la población objetivo y adaptados para educación individual, educación de grupos y estimulación de la participación comunitaria. Es esencial que los mensajes sean consistentes a nivel del sector público, del sector privado y de las ONG's. Debido a la poca probabilidad de que la pobreza y la inseguridad alimentaria sean erradicadas a corto plazo y debido a la baja cobertura de los servicios de salud y de los programas de alimentación complementaria, resulta de absoluta prioridad el desarrollo de programas y materiales de educación nutricional que complementen las actividades de nutrición.

(d) Calidad de los alimentos

El MS es el responsable de garantizar la pureza y calidad de los alimentos para consumo humano. En los años recién pasados, problemas relacionados con la contaminación, adulteración y fortificación de alimentos han atraído la atención pública. Aparentemente, dos con los problemas principales que enfrenta el MS para lograr el cumplimiento de las leyes de pureza y calidad de alimentos. El primero es de tipo técnico, especialmente con respecto a la yodización de la sal. Las múltiples fuentes productoras de sal, incluyendo las de otros países, y el volumen relativamente pequeño de cada fuente, hace técnicamente difícil yodizar toda la sal a pesar de que la deficiencia de yodo es de alta prevalencia y considerable costo en Guatemala. El segundo problema radica en la capacidad de hacer cumplir la ley. Sea por insuficiente autoridad legal o por traslape de responsabilidades con el Ministerio de Agricultura, la calidad de ciertos productos alimenticios no puede ser garantizada.

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El PSS fortalecerá la capacidad del MS para lograr un efectivo cumplimiento de las leyes y reglamentos que garanticen la pureza y calidad de los alimentos. El apoyo en esta área incluirá: capacitación de personal, equipo, materiales y transporte necesario para supervisar y asegurar la aplicación de las medidas de control de calidad.

7. Estrategia para la Preparación del Proyecto

Responsabilidad por la preparación del proyecto corresponde al Ministerio de Salud. El Banco con el recurso de otros donantes y consultores, se compromete a apoyar al Ministerio en esta tarea. El Banco programa una serie de Misiones a Guatemala hasta que el proyecto sea evaluado y esté listo para presentación a donantes y al Comité Ejecutivo del Banco para su aprobación.

El calendario de visitas periódicas será determinando en conjunto con el Gobierno y va a depender del progreso obtenido en las tareas que deban cumplirse antes de las visitas. Tentativamente, la próxima visita del Banco podría hacerse en Noviembre/89.

La Misión sugiere que sean organizados grupos de trabajo, con oficiales del Ministerio, donantes y consultores para avanzar rápidamente en la preparación de las propuestas, bajo la coordinación de la Oficina de Coordinación de Asuntos Internacionales del Ministerio (OCAI).

8. Plan de Preparación de la Propuesta Sectorial

(a) Apoyo a Descentralización

(i) Situación actual de la descentralización administrativa del Ministerio, incluyendo análisis de los documentos que definen el proceso de descentralización (calendario, normas, ma-

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nuales, conclusión de los grupos que discutirán los documentos) y propuesta de descentralización de personas.

(ii) Preparación de un análisis detallado de políticas de personal, incluyendo número de plazas actualmente existentes en cada categoría de personal y en cada nivel administrativo, análisis de las funciones, descripción de las funciones actuales y propuestas planteadas de los cambios en estas funciones, responsabilidades y autoridad conferida a cada uno de los niveles (regional, área y distrito).

(iii) Estimativa de costos para las diferentes opciones para los componentes mencionados arriba.

(b) Apoyo a Descentralización Presupuestaria

Preparación de una propuesta de descentralización presupuestaria, incluyendo análisis del impacto de leyes y procedimientos que afecten una efectiva descentralización y ejecución presupuestaria.

(c) Apoyo al Incremento de la Eficiencia Hospitalaria

Preparación de un análisis diagnóstico de la eficiencia hospitalaria y del estado de la infraestructura y equipo.

(d) Apoyo al Sistema de Oferta y Distribución de Medicamentos

Preparación de un análisis de los problemas que afectan la oferta de medicamentos, incluyendo (i) producción local, regulaciones que afectan importación, disponibilidad de divisas, (ii) procedimientos de compras, sistemas de almacenamiento y control, y (iii) manejo presupuestario del ítem drogas y suministros y logística. Incluir una propuesta de descentralización presupuestaria de la Droguería Nacional.

(e) Apoyo a los Servicios de Salud

(a) Llevar a cabo un inventario nacional del estado de infraestructura física y equipamiento de centros y puestos de salud, lo cual es para saber si es necesario reparar, reponer, construir nueva infraestructura de este tipo en el país.

(b) Elaborar estudios para determinar la factibilidad de proyectos pilotos de traspaso de responsabilidad por atención primaria a las municipalidades (ver propuesta del Ministerio).

(f) Apoyo a Estrategia de Nutrición y Distribución de Alimentos

El MS, con la asistencia de consultores e instituciones especializadas (INCAP y otros donantes) necesita desarrollar una estrategia y preparar una propuesta detallada sobre cómo mejorar el manejo y la cobertura de las intervenciones nutricionales. Esto debe incluir las áreas siguientes:

(i) Propuesta sobre la interrelación entre acciones de salud y nutrición

Es necesario decidir si las actividades de nutrición formarán parte integral del sistema de atención primaria de salud. El componente de nutrición deberá incluir Monitoreo del Crecimiento y ayuda alimentaria y podrá ser implementado a través de la infraestructura de salud, municipalidades y/o las comunidades. De ser así, será necesario desarrollar una propuesta especificando la estructura orgánica y administrativa, así como los mecanismos de funcionamiento, coordinación y supervisión. El PSS proveerá apoyo para el desarrollo de un sistema de prestación de servicios de salud y nutrición que sea efectivo y duradero.

(ii) Promoción y monitoreo del crecimiento

Requiere el desarrollo de un plan de acción para lograr cobertura universal del monitoreo del crecimiento como parte de una estrategia mejorada de atención primaria de salud. La propuesta debe incluir: objetivos, metas, población, estrategia de implementación, personal, equipo

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y materiales para promover el crecimiento adecuado del niño y un detallado análisis de costo.

(iii) Ayuda Alimentaria

Desarrollo de una estrategia y de un plan de acción para un programa de apoyo alimentario a grupos seleccionados. Esto debe incluir: una revisión de los criterios que serán adoptados por todos los programas que utilizan alimentos para mejorar el estado de salud de los grupos identificados como prioritarios; una propuesta para establecer un sistema de información efectivo para la distribución de la ayuda alimentaria; criterios para lograr la participación de la comunidad y aumentar cobertura; estrategias para la supervisión del personal del MS. El plan debe incluir también, los recursos necesarios para implementar una efectiva estrategia de ayuda alimentaria y un detallado análisis de costos.

(iv) Calidad de Alimentos

Preparación de una propuesta detallada y de un plan de acción para incrementar la capacidad de la Oficina de Control de Alimentos para lograr el cumplimiento efectivo de las leyes y reglamentos para garantizar la pureza y calidad de los alimentos. El plan debe incluir alternativas para lograr yodización del 100% de la sal y la cantidad de recursos humanos, materiales y financieros necesarios para implementar el programa. Una propuesta adicional debe ser preparada proponiendo alternativas para fortificar la sal producida por pequeños salineros.

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