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

by
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PREFACE

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

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

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

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

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

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

Robert Emrey
Management Counsel

Montgomery Village, Maryland
30 March 1984

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Background and Methodology

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

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

1986.

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

Background

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Methodology

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

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

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

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

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

A. Decentralized Service Delivery Model

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Primary Health Care in Integrated Rural Development Areas

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The situation in the worldwide IRD movement is beyond

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

C. Institutional Coordination

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

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

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

coordination of services.

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

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

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

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

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

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

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

Finally, the development of greater coordination

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

D. Technical Assistance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

projects shown it is able to provide.

E-1. Preparation of Health Area Chiefs

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

E-2. Practices of Health Area Chiefs

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

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

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

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

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

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

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

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

F. Health Area Concept Acceptance

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

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

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

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

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

G. Food Policy Studies

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

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

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

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

H. Supplementary Feeding Program

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

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

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

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

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

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

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

I. National Health Council

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

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

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

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

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

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

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

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

J. Programming Changes Recommended

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

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

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

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

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

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

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

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

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

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

Another problem in other parts of the

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

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

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

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

ANEXO No. 1

PROYECTO 518-0015 y 518-U-040

EVALUACION

AGENDA DE TRABAJO

Marzo 7 - Abril 5, 1984

Martes 6 de marzo

Mañana

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

Tarde

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

Miércoles 7

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

Jueves 8

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

Viernes 9

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

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

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

Sábado 10 Análisis de la información obtenida.

Lunes 12

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

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

Martes 13

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

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

Miércoles 14

07:00 Viaje a MANTA - TAME vuelo No.

09:00 - 12:00 Entrevistas y discusión sobre el Area DRI-JIPIJAPA con funcionarios de la Dirección Provincial de Salud de MANABI.
- Director Provincial: Dr. Villacrés
- Jefe de Programas Prioritarios:
- Jefe de Finanzas:

12:30 Viaje a JIPIJAPA

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

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Jueves 15

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

Viernes 16

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

Sábado 17 Análisis de la información obtenida.

Lunes 19

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

Martes 20

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

- Autoridades Civiles:
- Miembros de la Comunidad:

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

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

Miércoles 21

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

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

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

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

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

17:00 Viaje de regreso a QUITO.

Jueves 22 Análisis de la información obtenida.

Viernes 23 y Sábado 24

Preparación del borrador del documento

Lunes 26 - Viernes 30

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

Lunes 1ro de abril

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

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Jueves 4 - Viernes 5

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

Annex 2

LIST OF PEOPLE CONTACTED

National Health Council

Fausto Andrade, MD, Deputy Director

Ministry of Health, Central Office

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

Ministry of Health, Province of Manabi

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

Ministry of Health, Province of Chimborazo

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

Ministry of Health, Province of Cotopaxi

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

Integrated Rural Development, Secretariate (SEDRI)

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

Integrated Rural Development, Jipijapa

Angel Orlando, Engineer, Chief

Integrated Rural Development, Salcedo

Oscar Escola, Engineer, Chief

Universidad del Valle, Cali, Team (CIMDER)

Jorge Saravia, Ph.D.
Yolanda Romero

USAID/Ecuador

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

Project Evaluation Team

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

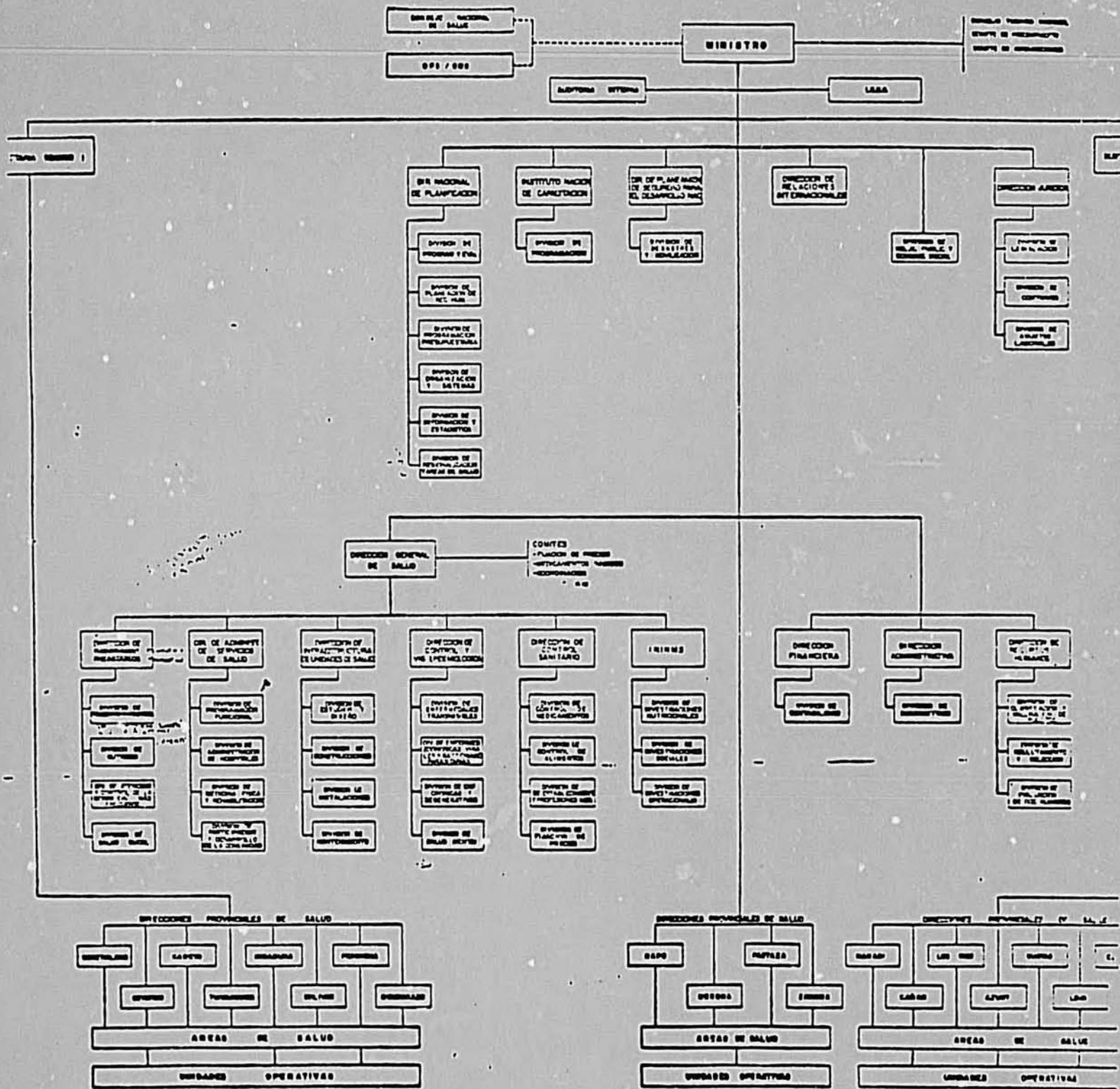
Others

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

Facilities

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

ORGANIGRAMA ESTRUCTURAL DEL MINISTERIO DE SALUD PUBLICA



PLANTILLA CLASIFICADA	DIRECCION NACIONAL DE PLAN.
SIGUROS	DIVISION NACIONAL DE INFORM. Y ESTADISTICA
APROVISION	DE LAS UNIDADES DE SALUD

WV 23,1499

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Franco Sarcosio / Navas
23, 1984

ORGANIGRAMA DEL AREA DE SALUD

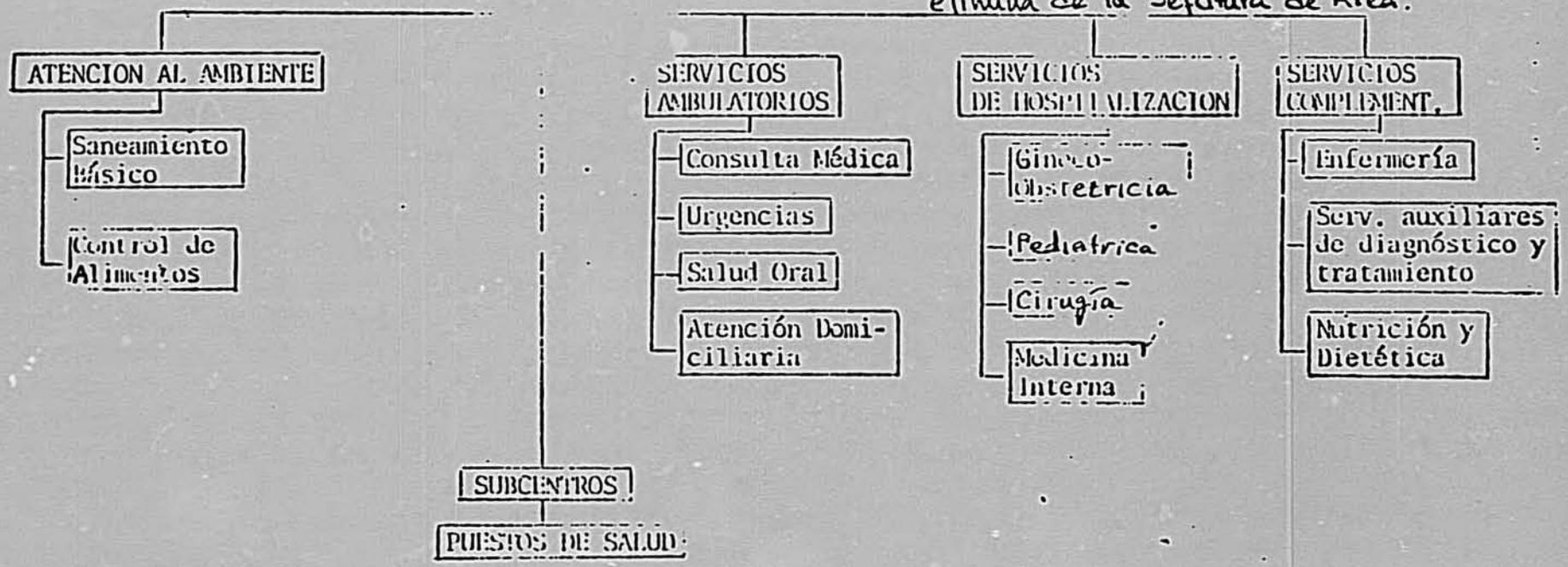


cambio

Nueva unidad

UNIDAD DE APOYO TECNICA

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



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