

XD-APP-492-B

ISN = 35408

EVALUATION  
OF  
INTEGRATED RURAL HEALTH DELIVERY SYSTEM

ECUADOR

May 1984

Loan Number: 518-U-040  
Project Number: 518-0015

By Patrick J.H. Marnane  
P. O. 518-4-III-L

Evaluation Team

Hugo Corral  
Robert Emrey  
Frederick Hartman  
Patrick Marnane

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## PREFACE

This report provides background on the DRI-Health project and a discussion of the evaluation strategy including its assumption and expectations. It also addresses concerns not elsewhere covered by the other outside evaluators.

Initially, the plan for this report was to have a single document incorporating the observations, analyses and conclusions of three consultants. Because of the exigencies of other commitments and the physical separation of the consultants following our work in Ecuador we have produced three documents. This is the third of the set. Additionally, during our evaluation visit there was another special evaluation of the diarrheal disease and immunization program conducted by Dr. Fred Hartman of PRITECH. Dr. Hartman has provided another separate report.

During the conduct of the field work the three consultants worked together on a daily basis. While we focussed in part on separate concerns there was close cooperation and persistent sharing of observations. There was also general concurrence on concerns we had the opportunity to consider mutually.

Because of different experiences and different perspectives, however, there were necessarily some differences as well. Some of these differences are a matter of emphasis others stem from the specialized interests and skills of the evaluators.

It is not the purpose of this document or the three reports to generate absolute consistency and agreement. That was less the point of this evaluation exercise than was identifying issues, illuminating problems of both plan and implementation and to suggest possible ways of altering the program to improve its effectiveness in doing what the GOE, project administrators and the people being served want it to do. This perspective will be elaborated more fully below.

We want to acknowledge the spirit of full cooperation and help on the parts of these with whom we worked in carrying out this evaluation. Without their openness, their willingness to point out problems, mistakes, and lessons learned and their insight, the entire process would have been considerably less valid.

With negligible exceptions, busy people with important jobs to do graciously rearranged schedules, offered resources and assistance, and otherwise responded with alacrity to what should probably be considered inconvenient requests. Even these without continuing vested interests in this particular project graciously gave of their knowledge, insight and time. Their kindness, interest and patience are warmly appreciated.

## INTRODUCTION

The overall purpose of the Project is to develop a nationally replicable low cost health service delivery model in three Integrated Rural Development areas of Ecuador. To do this the Project has established three integrated objectives that form the basis for project design and implementation. While they have in some places been spelled out slightly differently, the goals these have enjoyed are the following:

1. To create a regional (decentralized) organization for the administration of health services.
2. To develop a model for the provision of primary health care.
3. To incorporate health services into the integrated rural development sector.

The basic elements of the Project model are, briefly stated:

1. Establishment of area chiefs
2. Expansion of primary care
3. Extend coverage of pure water supply and sanitation
4. Nutrition activities to improve availability and distribution of basic foods.

The expected outcomes of these include

- . Extend health services delivery and provide additional resources in high priority rural areas.
- . Promote the utilization of lower cost primary care service
- . Rationalize health service delivery by coordinating efforts of health services institution in geographic areas.
- . Facilitate extension of low cost water and sanitation services by using low cost technologies.

- . Incorporate nutrition concerns in program design and implementation.
- Decentralize decision-making responsibility and facilitate community participation in the decision-making and implementation process.

### Background

The Rural Health services project emerged out of the interest of the Roldos-Hurtado administration which was concerned with rationalization and expansion of government services aimed at the rural poor of Ecuador. AID's strategic focus during the 1970s was also concerned with providing better services to the poor majority, with the aim of improving health and well-being and enhancing the ability of the poor to meet their own needs in AID assisted countries. This correspondence of interests first became manifest in Ecuador in the funding of a pilot project for integrated Rural Development.

This health project was viewed as a one that would have its own integrity, but would also be part and parcel of an overall scheme for integration of development efforts. Health was considered to be a specialized concern that could not be totally subsumed under fully independent local development agencies. It required special links to more sophisticated and broader health service facilities and administrative system. At the same time a need was seen for decentralization of that administrative structure for purposes of regional and micro-regional adaptation to special circumstances. The regionalization plan allowed for the development of close ties with other regional programs and

local conditions while maintaining a rational vertical support system as well.

Decentralization was viewed as institution building in the health sector of Ecuador. The new position of Area Chief was viewed as the keystone of the revised institutional arrangement. Area chiefs were to be given intensive training in health administration and then they would have primary responsibility for all extra-hospital health concerns in the selected micro regions.

The already existing positions of Provincial Chief was also to be strengthened under this project. They were to be given greater autonomy and control over a pyramidal health service/facility system that had as its base the local health promotor and health posts building through ever increasing level of sophistication to health subcenters, hospital health centers and provincial hospitals. Tertiary care hospital were located only in major urban areas, i.e. Quito and Guayaquil. Rationalized referral mechanisms would channel patients to appropriate care facilities.

This hierarchical referral structure had been developed during the 1970s. Although many facilities had been constructed. The operational mechanisms and administrative personnel were lacking. The regionalization plan was an attempt to put major administrative responsibility at the provincial level, closer to the level of operations and thus more responsive to local concerns.

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At the time the health services program was initiated the seventeen areas (or micro-regions) in which the Integrated Rural Development Project was to be implemented had already been selected. The criteria for selection of the seventeen were largely economic and agriculturally based. A major criterion was anticipated cost per capita for implementation. They are scattered among several provinces in Ecuador.

From the original set, the health project decided on three in which to implement its plan. These were selected so as not to conflict with health projects supported by other international donors and as representative of the two most popular regions of the country the coast and the sierra. Jipijapa in Manabí was chosen as a coastal area. Quimiaz-Penipe in Chimborazo and Salcedo in Cotopaxi were selected in the sierra.

The health project has involved not only the Integrated Rural Development secretariat but draws on the Ecuadorian Institute for Sanitary works (IEOS) as well. IEOS has major responsibility for letrinizacion, water support system development and health service facility construction and refinishing.

It should be mentioned that IRD and the Integrated Rural Health Delivery projects are not Ecuador's only experience with integrated development schemes. Mision Andina was the most notable recent experience. This was a program that was developed and operated during the 1960s and incorporated developments of agriculture, health, manual arts, sanitation,

water supply. The present health project has been able to draw on the experience of some who were involved in Mision Andina. Some community programs begun under that program were continued under other local and provincial auspices.

Evaluation Assumptions and Setting

At our initial meetings the evaluation group agreed to an evaluation strategy that would involve program personnel from all levels in a fully participatory manner. We also agreed that the process of evaluation and the exchange of information regarding ideas, perspectives, experience, problems, conclusions and recommendations among program personnel would constitute the major contribution of the evaluation process. The documents that were to be written by the outsiders were of importance largely to the extent that they reported and introduced systematic focus to those concerns. We also agreed that our success should be measured in terms of the fullness of debate and elaboration generated on the parts of those responsible for continued project operation. It was in this spirit that we tried to work. It is to the credit of all those with whom we worked that they showed genuine openness and awareness to one another and to us as outsiders. Project leaders are to be thanked for having engendered an environment which supports such openness.

The evaluation considers the program in terms of its plan and stated goal, but has the benefit of being able to see contextual conditions more fully than was possible in the planning phase. We tried to take into account the limiting contextual factors and to understand better how the program had influenced its environment, its impact on political, social and health awareness.

Necessarily, an evaluation is a critical process. This does not mean that it is wholly negative, however. It means that we look at criteria and standards and try fairly to find where program have not met expectations. It also means that problems that have emerged both within the program and in its context will be identified. Much of this was simply not anticipated prior to program implementation and increased awareness on the parts of those involved. Evaluation then is at least partly a matter of assessing the extent to which planned activities can work in a world of limits, of competing expectations, of resource availability and of changing needs and awareness.

Viewed this way, evaluation is not only a matter by which quantitatively measured achievements. It is more a reflective process of reconsidering performance, (expected or not), plans and goals, resource capacity, and the needs of policy makers and of those who are expected to benefit from the services system.

Although this project, as any other organizational systems, is viewed here as a means of checking prior assumptions and hypotheses and an opportunity for revising these, it is not evaluated as a tightly controlled "scientific" experiment which offers a chance for looking only at a few neatly measured variables. We consider the program a system of considerable complexity which operates in a complex environment.

Our evaluation was both intensive and extensive. Still, the analysis represents only a partial view: We observed operations for a relatively

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short period in March 1984: We visited only a few service sites: We talked with and observed only a few of the program personnel a few members of the communities served and a few of those whose decisions immediately or ultimately will have effects on the program. Many persons who had been key in the earlier phases of design and implementation had moved to other jobs. The tragic weather conditions of 1983 had left immeasurable impact on the service areas and their populations, especially Jipijapa.

These evaluation reports must therefore be treated as tentative, suggestive, partial. Perhaps it is not possible to have a definitive analysis. In any case, the reports do not stand alone. They are part of a process, points of departure. These more fully involved can and should add considerably to the analyses of conclusions presented in these reports.

The evaluation lacked what is elsewhere identified as a problematic concern of the project itself, the involvement of many persons whose communities one expected ultimately to benefit from its implementation. Although we think we did cover as much as possible in the time available and we were given good guidance by program persons we do feel that we may have overlooked the needs of the people and served more the bureaucratic interests. Although we did not cover fully every level of the program, we tried to make contact and to have open the possibility for project personnel to work more closely among the other workers, policy and decision-makers, people from other programs and agencies and those in the communities to be served.

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Evaluation, however, is not a neutral activity, we are interested in seeing the project achieve its goals, to succeed in its regionalization strategy, to combine realistically the rationed and indeterminate in ways that exploit technical knowledge and human resources to the fullest, at the same time leaving the Program open to further exploration and evaluation. We wanted to see what is working, to see what is not working and to increase understanding in each case.

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Community Participation-Primary Health Care

In the planning of this Project community participation was considered essential feature, formal involvements of the communities in primary health care, facility construction and maintenance and water supply and sanitation development were considered critical aspects of goal realization. It was implicit also that the process of decentralization would reach the community level, offering a greater influence to the people and expecting their assistance to make the system operate.

Water supply and sanitation will be covered by another group. Here I will focus on the participation of communities in the primary health care aspects of the Project.

Promotores: The PHC system plan calls for the training of health promoters who will serve the communities from which they are selected. It also specifies the creation of a special program for school children who will become health communicators, encouraging better health habits and identifying problems. At the time of our observations neither of these activities seems to have been carried out by the Project.

In Manabi 24 promoters were trained and 19 of them were posted in the area of Jipijapa. Whether this was happenstance of the product of Project influence was not clear. Only one promoter was identified as working in the other two Project areas.

Although the project budget allocated funds for promoter training and salary, it was not clear that the Project was expending its money on these items. Funds continued to come from MOH proper and from FODERUNA. Since

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the Project does have funds it would seem that it should be more aggressive in obtaining cooperation of other responsible offices in the MOH and would provide more training for promoters in the DRI-Health Areas.

The MOH had scheduled training for 120 promoters during 1984 but at the time we talked with the MOH representative they did not know for sure when and if that training would take place. They had apparently given no thought to giving special consideration to DRI-Health Project areas and were not aware that the Project could provide funds for the training or had the means for supervising promoters and following up on their work.

If PHC is going to be a realizable goal of the Project there will have to be a concerted effort to obtain the cooperation of others in the MOH and means for working with other promotor sponsoring agencies will have to be developed.

Rural Physician Orientation: It will also be necessary to work more closely with the rural physicians and to provide them training and supervision aimed at getting them more fully involved with the communities in which they live.

In Salcedo some community health education of rural doctors is being conducted at the provincial level and it seems to have stimulated some to undertake more community outreach activities but I could not determine that this outreach was systematic or monitored in any way by the Project. The physicians were unaware that their efforts might have in any way been guided by project goals. In fact, the three physicians with whom I spoke in the Salcedo area were not aware of Project goals beyond the establishment of the post of Area Chief.

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Rural physicians in the other areas seemed less aware of possibilities for working with communities apart from their clinic activities.

The effectiveness of all health service people in generating a good PHC program will depend on early orientation continuing training and serious supervision and motivation of area chiefs who are themselves motivated to work with communities and to promote preventive health care.

Botiquines: Although 40 community supported pharmaceutical botiquines were scheduled to be installed by the program, none had been established at the time of our observation. In two health posts we observed there had been such botiquines in the past and auxiliaries indicated that they had been successful but had faltered for lack of funds in recent years.

Oral Rehydration Therapy: A separate report by Dr. Hartman deals with the ORT program in considerable detail. As an important contextual element, however, some comment is appropriate here.

The ORT program has seriously involved communities in the selection of persons to be trained in ORT education and electrolyte distribution. The program has conducted several training sessions in the DRI areas. It seems to have met with marked success in making communities aware of the benefits of oral rehydration and in appropriately distributing material to be used by families. Community interest in the program is notable. Everyone asked knew of its existence and knew where to secure electrolyte materials distributed by those trained.

Health workers in Salcedo and in Quimia -Penipe have participated in the ORT training and are participating in distributional and promotional activities.

The training and promotion efforts of the ORT program could be used as a model by the Projects in efforts to address other health concerns of the DRI-health areas as well. Iodized salt distribution, immunization promotion, and general health education could be addressed in similar fashion. Perhaps this method of dealing with those problems would show less dramatic short run results but their overall health benefits could be significant. Possibilities for employing the model to deal with these other important health problems should be given high priority in considering future Project design and prospects for working with communities.

Save the Children: An ancillary aspect of the Project has been the support of the Save the Children Foundation as an agency interested in fomenting community level leadership in development and health related activities. Save the Children has been operating in two of the Project areas for the past year. There is evidence that several small, community level projects have been implemented and that Save the Children has been working closely with campesino groups and leaders to create more interest in community development and self-help activities. It did not appear, however, that communication and cooperation with health people had been significant.

Assistant Health Educators: The position of Assistant Health Educator has not yet been approved by the GOE Personnel Office. In Salcedo we found the Provincial Health Educator did participate in training of all levels of health workers and was sensitive to the special interests of the Project. His staff played principle roles in the ORT training activities.

Using the Salcedo situation as possible model it would appear that the special title of Assistant Health Educator along with its need for complicated bureaucratic approval would be superfluous. It would be more appropriate to use funds to fortify the existing staff and to use that staff as appropriate and needed by the Project.

Drawing on Provincial Office capabilities to support community (and Project) activities should help to increase their awareness of the special focus of the Project and potential advantages of cooperation, it should also be less threatening to the provincial administrators, a very desirable condition at this point in Project development.

Goiter Control: The Project has not yet given attention to implementing goiter control activities although goiter and associated health problems rank as severe in the two DRI-Health areas in the Sierra. This lack is often attributed in part to assumption that there is no agreement between two camps of goiter control strategists in Ecuador, those who favor insuring distribution of high quality iodized salt and those who want to provide iodized-oil injections.

In fact, discussions with goiter specialists and MOH staff suggested that there was less conflict than outsiders thought. As a long term solution all recognize the need for appropriate iodized salt consumption and all recognize that iodized-oil has considerable short-run advantages for health. The question is a matter of what can be afforded.

But it is not a simple question. It is evident that all things being equal, assuming availability of high quality iodized salt and high quality

iodized oil, the ongoing use of the salt would be cheaper and more effective as a national strategy. There seems, however, to be some question of whether existing government and commercial mechanisms can insure the quality of the salt. Secondly, distribution techniques often involve so many middle-men that the relative prices of iodized salt makes it inaccessible or, at least, unattractive to the consumers who would benefit most from using it.

Because none of the evaluators are expert in goiter control we cannot ourselves assess the benefits of oils and salt on the incidence and severity of goiter and other iodine deficiency problems. It would appear, however, that promotion of the use of iodized salt, especially in goiter endemic areas, would be a possible and appropriate aspect of PHC educational activity. This assumes that quality is insured and that consumers would actually receive efficacious substances.

If Ecuadorian producers are unable to provide salt of efficacious quality and importation is not possible, the only available alternative appears to be iodized-oil injections.

The iodized oil treatment program that was conducted in Ecuador was reported to have produced significant, positive results in goiter control and the reduction of congenital problems. We do not know the complexity of that project and what is required to administer such a project effectively.

Because the local level aspects of the DRI-Health Project are not yet well coordinated it might be appropriate to strengthen that component prior to embarking on another complex activity. Certainly, however, the prevalence of iodine deficiency within the Project areas does justify addressing the

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problem as a priority concern, and the treatment should be incorporated into the service system.

#### CONCLUSIONS

Lack of attention to PHC and CP has been far from absolute. It has been a goal toward which the project has been striving. Our critical emphasis here is more to encourage the persistence of this concern and to insure that they are maintained as a high priority within the Project.

It has been largely because of overall Project strategy and some difficult obstacles imposed externally that community level, service level, concerns have been addressed less forcefully up to this point. Many of these have resulted from conflict over what decentralization will mean within the MOH and at the Provincial level. Certainly the difficulty in establishing formally the role of Area Chief and in retaining these who had been hired and trained have been serious impediments to Project implementation.

If the revised roles of CSH director and technical field director can be worked out, community level operations should be easier. Permanency of these positions is critical for the Project.

Until the time of our observation most of the attention of Project implementers and of CIMDER technical assistance group had focussed on higher levels of administration and on the formal aspects of regionalization, giving less attention to local level implementation and monitoring field operations, necessarily leading to less concern for participation. Up to that time, then, this lack of attention may be considered less a fault than a matter of experimental strategy that involved strengthening

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the administrative super structure prior to creating a strong local element. It would be worth evaluating further, on a comparative basis, to assess whether this strategy reduces the probability of undercutting PHC projects, many of which have been left foundering after external support has run out and the host country government has no means of responding to service and support demands.

We judge the goal of providing PHC and attendant community participation to be appropriate aspects of the program designed to decentralize health service administration. Indeed, if health programs are to meet changing demands and interests of the people they are intended to serve, then those people must be fully involved. Provincial officials, area chiefs, rural physicians, other health workers and Ministry officials all must be concerned for administering their technical skills in terms that are desired and accepted by those they expect to serve.

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RECOMMENDATIONS REGARDING REPROGRAMMING OF FUNDS

Due to cumbersome accounting procedures and failure to report expenses and incumbrances as they occur it is not possible to determine just how Project funds have been spent. This concern is addressed more fully in Robert Emrey's reports.

The lack of MOH attention to the training of promoters for the DRI-Health areas suggests that the Project is not using its financial strength to influence this MOH activity. The training of such promoters is, however, a primary immediate concern as set forth in its plan.

The inability of the National Health Council to set forth a clear set of research priorities suggests that another mechanism for deciding on research needs would be appropriate. Operational research studies suggested by and assisted by AID contracting organizations such as PRITECH and PRICOR should be given serious attention as candidates for Project support. These would focus research more directly on project capabilities and avoid the conflicting political interests of the CNS representatives some of whom are only marginally concerned with this particular project.

Training costs for seven area chiefs who have since abandoned the Project are sunk and cannot be retrieved. Part of the reason for failure to retain those persons in the Project was the weak contracting arrangements they had with MOH. It is expected that this will be overcome under the planned restructuring of the role of the CSH Directors who will also act as area chiefs. Although these persons in the new role will be expected to have already administrative, social and service skills to justify their assuming this broader responsibility they would doubtless benefit from additional

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training that is consistent for all Area Chiefs. Such training should be provided with in Ecuador rather than in Colombia or elsewhere. The CIMDER staff and the use of the CIMDER technical manuals should provide the core of this training. It should be supplemented with additional theoretical and practical instruction in administration, focusing on the needs of the Project. Such training should be provided as soon as the roles of Area Chief and the technical assistance unit have been formalized by the GOE and longer term contracts for area chiefs have been signed.

Given that iodine deficiency is considered a major concern of the project and the known efficacy of iodized salt for long term solution an investigation should be made of quality control in the production of such salt. The Project cannot itself undertake a quality assurance program but it can support a technical team to investigate and to make recommendation for improving conditions if they are indeed found lacking.

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