

THE USAID POPULATION PROGRAM IN ECUADOR
A GRADUATION REPORT

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ACRONYMS

AFEME	Association of Ecuadorian Faculties of Medical Science
APOLO	Support to Local Organizations Project (Apoyo a Organizaciones Locales), managed by CARE International
APROFE	Asociación Pro-bienestar de la Familia Ecuatoriana (Association for the Well-being of the Ecuadorian Family)
AVSC	AVSC International (currently known as EngenderHealth)
BCG	Bacille Calmette-Guérin vaccine for tuberculosis
CA	Cooperating agency
CAATS	Centro de Aprendizaje Asistido por Tecnología en Salud (Technology-Assisted Learning Center)
CAD	Center for Demographic Analysis
CCMIS	Contraceptive commodities management information system
CDC/DRH	Centers for Disease Control and Prevention, Division of Reproductive Health
CEMOPLAF	Centro Médico de Orientación y Planificación Familiar (Medical Center for Family Planning and Counseling)
CEPAR	Centro de Estudios de Población y Desarrollo Social (Center for Studies in Population and Social Development), formerly known as Centro de Estudios de Población y Paternidad Responsable (Center for Studies in Population and Responsible Parenthood)
COF	Centro de Orientación Familiar en Servicios de Salud Sexual y Reproductiva (Center for Family Guidance in Sexual and Reproductive Health Services), formerly known as Centro Obstétrico Familiar (Center for Family Obstetrics)
CONADE	Consejo Nacional de Desarrollo (National Development Council)
CONAMU	Consejo Nacional de la Mujer (National Women's Council)
CP	Condition precedent
CPT	Contraceptive procurement table
CYP	Couple year of protection
DHS	Demographic and Health Survey
DPT	Diphtheria-pertussis-tetanus vaccine
ENDEMAIN	Encuesta Demográfica y de Salud Materna e Infantil (Demographic and Maternal and Child Health Survey)
ENJOV	Encuesta de Información y Experiencia Reproductiva de los Jóvenes Ecuatorianos en Quito y Guayaquil (Survey of Reproductive Information and Experience of Ecuadorian Youth in Quito and Guayaquil)
ESF	Economic support funds
FHI	Family Health International
FPIA	Family Planning International Assistance
FPLM	Family Planning Logistics Management
FY	Fiscal year
GOE	Government of Ecuador
G/PHN/POP	Bureau for Global Programs, Field Support and Research, Center for Population, Health and Nutrition, Office of Population
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
IACO	Información y Atención Comunitaria (Information and Services for the Community)
ICRW	International Center for Research on Women
IEC	Information, education and communication
IESS	Instituto Ecuatoriano de Seguridad Social (Ecuadorian Social Security Institute)
IMR	Infant mortality rate
INEC	Instituto Nacional de Estadísticas y Censos (National Institute of Statistics and Census)
INNFA	Instituto Nacional del Niño y la Familia (National Child and Family Institute)
INOPAL	Investigación Operacional para América Latina (Operations Research Project for Latin America)
IPPF	International Planned Parenthood Federation (headquarters in London)

IPPF/WHR	International Planned Parenthood Federation/Western Hemisphere Region (headquarters in New York)
IUD	Intrauterine device
JHPIEGO	Johns Hopkins University Program for International Education in Reproductive Health
JHU/PCS	Johns Hopkins University/Population Communication Services
JSI	John Snow, Inc.
LAC	Latin America and the Caribbean
LAM	Lactational amenorrhea method
MCH	Maternal and child health
MMR	Maternal mortality ratio
MOCA	Médicos y Obstetrices Comunitarios Asociados (Community Physicians and Midwives Associates)
MOF	Ministry of Finance
MOH	Ministry of Health
NGO	Nongovernmental organization
NPA	Nonproject assistance
PAHO	Pan American Health Organization
PHR	Partnerships for Health Reform Project
POPTECH	Population Technical Assistance Project
R4	Results Review and Resource Request
SO	Strategic Objective
SOMARC	Social Marketing for Change Project
SSC	Seguro Social Campesino (Rural Social Security)
TFR	Total fertility rate
UNESCO	United Nations Organization for Education, Science and Culture
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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EXECUTIVE SUMMARY

For nearly 30 years, the United States Agency for International Development (USAID) provided assistance for population, family planning, and reproductive health programs in Ecuador. Throughout the early years, USAID worked with both private and public sector institutions to establish a broad base for national awareness of and support for family planning and for the introduction of contraceptive services. USAID led all other donors in this sector in terms of financial, technical, and contraceptive commodity assistance. Upon reflection of the accomplishments of the USAID population program during these years and considering its most recent Strategic Objective of “increased use of sustainable family planning and maternal child health services,” it is apparent that the Agency was successful in this endeavor and has adequately provided for the graduation of its local partners, particularly those in the private sector, where USAID had directed the major focus of its assistance over the past decade.

During the last and final phase of assistance, 1992–2001, the USAID strategy focused primarily on assuring the financial and institutional sustainability of the two largest local nongovernmental organizations (NGOs) that provide family planning services. USAID/Ecuador worked in partnership with the Asociación Pro-bienestar de la Familia Ecuatoriana (APROFE), which is the Ecuadorian affiliate of the International Planned Parenthood Federation (IPPF), and the Centro Médico de Orientación y Planificación Familiar (CEMOPLAF)—institutions that provide contraceptive and other reproductive health services. At the same time, in order to assure that the necessary tools were in place for future program monitoring, planning, and evaluation, USAID assistance was provided to the Centro de Estudios de Población y Desarrollo Social (CEPAR).

Since the late 1970s, USAID’s population assistance increased noticeably. In the five-year period from 1987 to 1991, the value of USAID population assistance, including Mission–managed and USAID–centrally managed activities and contraceptives, totaled over US \$11.6 million, compared with the final five-year period, 1997–2001, which had more than \$22 million in estimated expenditures. As the major provider of contraceptives to Ecuador, USAID donated more than \$5.6 million in commodities in the past six years alone.

During the years of USAID support, the total fertility rate (TFR) decreased from 6.2 in 1970 to 3.3 in 1999. Over the same period, the prevalence of contraceptive use in Ecuador increased, from a 1979 level of 33.6 percent of women in union using a method to 66.3 percent in 1999. More dramatic were the changes among women in rural areas, where use increased from a low of 22.3 percent in 1979 to the 1999 level of 58.4 percent, representing a significant 162 percent increase. This compares with the rise in use in urban areas, from 47.7 percent in 1979 to 71.2 percent in 1999, or a 49 percent increase during those 20 years. These accomplishments reflect the emphasis placed by the USAID program on working in rural areas.

Through the nonproject assistance (NPA) mechanism, USAID provided support to numerous public sector institutions. Among the beneficiaries were the Ministry of Health, the Ministry of Finance, the Ecuadorian Social Security Institute, the Rural Social Security Program, and the National Development Council (CONADE). The intent of the NPA mechanism was to reduce the management burden on USAID while assuring a stable foundation for family planning and the population policy within official government of Ecuador (GOE) institutions. Although it eventually expended large amounts of funds, the NPA nevertheless lacked the ability to put many of the intended policies into action.

Among the highlights of the USAID/Ecuador legacy in the population and family planning sector are the following:

- The National Population Policy, issued in 1987, and Article 39 of the Ecuadorian Constitution of 1998, guarantee the right of all individuals and couples to space and plan the size of their families through access to information and the provision of safe, modern contraceptive services.
- Availability of a wide choice of safe contraceptive methods, presently used by more than 66 percent of women of fertile age, continues to expand through programs of public and private sector institutions.
- For the near future, the financial sustainability of the two key NGO providers of family planning services is assured, with each entrusted with a sizeable sustainability endowment fund: \$5,150,000 for APROFE and \$3,366,000 for CEMOPLAF.
- To ensure that future health leaders, staff, and students have access to the latest information on the advances in family planning and reproductive health, the computer-based technology-assisted learning centers at the Ministry of Health are in operation and are presently self-financing.
- The recently published and nationally disseminated, *Reproductive Health Services Delivery Guidelines*, serves as an essential tool for the provision of quality reproductive health care.
- The public and private sectors share a commitment to explore new family planning methods, such as emergency contraception, as well as new areas within reproductive health, such as assuring gender-based programming and improving postabortion care.
- The in-country technical capability developed by CEPAR for producing national demographic and reproductive health surveys, together with the political recognition of the critical importance of these tools, will contribute to their future replication.

- Despite the lack of future USAID assistance, the participation of other international donors, such as the United Nations Population Fund (UNFPA) and the European Economic Community, continues in the areas of sexual and reproductive health. USAID-funded logistics technical assistance and contraceptive deliveries to family planning NGOs, using unexpended fiscal year 2001 funds, will continue into 2002.

Throughout the years, USAID/Ecuador considered its population program among its highest priorities, assuring it adequate support, both in terms of funding and human resources. The program enjoyed the collaboration of public sector institutions, as well as the loyal commitment of those NGOs dedicated to the delivery of family planning services. As the USAID program graduates from Ecuador, 95.3 percent of the women of fertile age, married or in union, can identify at least one modern contraceptive method. This level of knowledge has been continuously high over the past 12 years and indicates that contraceptive knowledge in Ecuador is on a solid foundation. (In the 1987 survey, 90 percent of these women reported knowing of at least one modern method.)

At the same time, the sexual and reproductive health behaviors of the Ecuadorian population has improved dramatically, when compared with the situation a mere 30 years ago. USAID can be assured that the strong partnerships that have been developed in the area of population and family planning, as well as the sustainable programs and institutions that remain, will allow Ecuador to continue to improve the health and welfare of all its citizens.

I. INTRODUCTION

The intent of this report is to provide family planning and population program managers, policymakers, donors, and others with a summary of the nearly three decades of U.S. Agency for International Development (USAID) population assistance to Ecuador. It focuses on the successes of the program in establishing, on a national level, the individual right to family planning and access to safe, modern contraceptive methods. Documenting the graduation of the Ecuadorian institutions from USAID support, including, more importantly, the lessons learned, may prove to be an appropriate tool for use in other settings, in particular, for other USAID population programs facing phaseout. Consideration is also given to identifying some of the remaining challenges to Ecuador's population and family planning program.

In general, Ecuador has a public health infrastructure and private sector institutions with developed programs that can assure the delivery of family planning services to all of the estimated 12.6 million Ecuadorians. Over the years, efforts were made to reach special target groups, such as the poor living in rural and marginal areas. Efforts to reach underserved couples helped to reduce the large gap in contraceptive use between rural and urban populations. Nevertheless, and despite the major contributions made by USAID and other international donors, challenges remain in reaching those populations living in isolated rural areas, women with little or no education, indigenous groups, adolescents, and the very poor. With the termination of USAID assistance, addressing the needs of these groups becomes more difficult, but no less critical.

In the early 1990s, because of a major Agency-wide reorganization, USAID and the Department of State agreed to reduce the Agency's geographic presence by closing operations in those countries with minimal strategic priority. As a result, the Bureau for Latin America and the Caribbean was tasked with identifying country programs within the region that it determined would be closed. Plans were put in place to close out population programs over a short term (three to four years) in Chile, Costa Rica, the English-speaking Caribbean, and Colombia, and over the medium term in Mexico, Brazil, and Ecuador.

In turn, USAID/Ecuador was instructed to reduce its portfolio and staff. The Mission's Strategic Plan and its Results Review and Resource Request (R4) reflected the planned closure of the population program by September 30, 2000. This was subsequently extended by one year to September 30, 2001. To carry this out in a timely fashion and to leave behind a sustainable legacy in the reproductive health sector, the Mission targeted its activities in the health and population sector. In the health portfolio, the Mission focused on the development of maternal and child health service delivery models, particularly for rural areas. This was accomplished through a grant to CARE International and its Support to Local Organizations Project (APOLO). In the population sector, emphasis was placed on assuring the financial and institutional viability of the local nongovernmental organization (NGO) partners working in family planning and population.

With USAID technical and funding support, both Asociación Pro-bienestar de la Familia Ecuatoriana (APROFE), the Ecuadorian affiliate of the International Planned Parenthood Federation (IPPF), and Centro Médico de Orientación y Planificación Familiar (CEMOPLAF) were able to expand their programs while decreasing their dependence on donor assistance. Much of this was accomplished through increased locally generated income from clinic services, contracts with public as well as private sector institutions, and the expansion of marketed goods and services. At the same time, improved internal management of both institutions allowed for cost-cutting measures and increased service quality.

Today, the family planning programs offer a full choice of contraceptive methods, including male and female sterilization, intrauterine devices (IUDs), Norplant inserts, oral pills, condoms, vaginal foaming tablets, both 1-month and 3-month hormonal injectable contraceptives, and natural family planning methods, such as the lactational amenorrhea method and the more recent standard days method.

Despite the severe economic challenges that Ecuador has faced in recent years, the indicators on the acceptance and use of contraceptive methods reveal that family planning is well entrenched and the majority of the population is desirous of limiting family size. When considering some of the basic demographic and health indicators of other Andean neighbors (see table 1, page 43), it is evident that the situation in Ecuador is comparable to that of Peru and much better than the situation in Bolivia.

II. THE DEMOGRAPHIC AND HEALTH CONTEXT

For more than 20 years, Ecuador has suffered major political, environmental, and economic disruptions: five presidents in the last five years; coastal flooding with cholera outbreaks, landslides, and volcanic eruptions; closures of the entire banking system and conversion of the monetary system to the U.S. dollar; and major labor strikes, including workers in the public health sector. Such a situation has created havoc in the health system and has had a serious adverse impact on earlier gains made regarding the health indicators. Such an environment also made it extremely difficult, if not at times virtually impossible, for USAID and other donors to work with public sector institutions. Fortunately, the private nonprofit sector groups dedicated to family planning continued to expand service delivery.

The population of Ecuador is presently estimated at 12.6 million. The next national census is scheduled for November 2001. Based on past census and vital statistics data, the rate of natural increase is placed at 2.2 percent. However, large migrations, estimated at 1.5 million during the past few years, may reveal a dramatic change demographically, particularly in some rural areas. During the years of USAID support, the total fertility rate (TFR) decreased from 6.2 in 1970 to 3.3 in 1999. (See table 2 on page 43.) Over the same period, the prevalence of contraceptive use in Ecuador increased, from a 1979 level of 33.6 percent of women in union using a method to 66.3 percent in 1999. More dramatic were the changes among women in rural areas, where use increased from a low of 22.3 percent in 1979 to the 1999 level of 58.4 percent, representing a significant 162 percent increase. This compares with the rise in use in urban areas, from 47.7 percent in 1979 to 71.2 percent in 1999, or a 49 percent increase during those 20 years.

Table 2 provides a comparison of the prevalence of the use of contraceptive methods in Ecuador and some other Latin American countries that receive USAID population assistance. The fact that 66.3 percent of Ecuadorian women are using a family planning method, compared with 64.2 percent in neighboring Peru, 60.3 percent in Nicaragua, and 48.3 percent in Bolivia, is a testament to the success of the Ecuador family planning program in raising awareness and in service delivery. Similarly, table 3 (page 44) presents trends over time in the increasing use of contraceptives in Ecuador, from the first study in 1979 to the most recent in 1999.

A noteworthy characteristic of the Ecuadorian population is its considerably high proportion of youth. Because of past high fertility levels and declining mortality, Ecuador's population is relatively young, with 34 percent of the population under 15 years of age. The most recent Encuesta Demográfica y de Salud Maternal e Infantil (ENDEMAIN) (1999) revealed that the average age for first sexual intercourse was 16.6 years. Based on these findings, it is estimated that 43.5 percent of young women 15 to 24 have had sexual relations. As a result, concern for unprotected sexual relations among this age group remains a major public health concern.

The 1999 ENDEMAIN provided useful information pertaining to where women obtain their contraceptive methods (see table 4 on page 44). Private sector institutions, including for-profit commercial providers of condoms and injectable and oral contraceptives, appear to supply the most temporary methods. NGOs are the leading providers of IUDs, primarily the Copper-T, whereas public sector institutions, including the Ministry of Health (MOH), account for 63 percent of female sterilizations. When comparing this information with similar findings from the 1987 survey, it appears that the percent of women receiving services from public sector institutions has remained about the same, at 38 percent.

In the delivery of reproductive health services, both the public and private sectors have come to rely increasingly on health personnel other than physicians and nurses. The university-trained midwives (obstetricians), who have five years of formal university preparation, compared with physicians who have nine years, continue to play a key role in the promotion and delivery of family planning services. In 1998, there were approximately 900 obstetricians working in health establishments in Ecuador, compared with nearly 16,000 physicians (general as well as specialists) and 6,000 nurses. Obstetricians have been hired by both CEMOPLAF and APROFE and are often assigned to work in rural towns. The APROFE Médicos y Obstetricias Comunitarios Asociados (MOCA) program, allows for contractual arrangements with 62 associates to the benefit of all involved, particularly the family planning clients.

MATERNAL AND CHILD HEALTH

The 1999 ENDEMAIN provided encouraging news: 81.7 percent of women received some type of prenatal care, up from 74.7 percent in the 1994 survey. However, one basic indicator regarding the quality of such care (i.e., those who come for their first control visit during the first trimester of pregnancy versus delaying until the second or third trimesters) was not very encouraging. Only 75.7 percent of women arrived for their first control visit in the first trimester, about the same (75.9 percent) as in 1994.

In recent years, the declining economic situation has increased the numbers of Ecuadorians living in poverty. As a result, the public health sector has taken on the additional burden of providing for prenatal care and deliveries that would have been received in nonpublic facilities. The 1999 ENDEMAIN survey reported an increase in the percent of women (67.6 percent, up from 58.5 percent in the 1994 survey) that received prenatal care in public institutions—mostly in those of the MOH (55.5 percent). Other sources report that during the period from 1971 to 1999, the maternal mortality ratio (MMR), has steadily decreased, from over 203 to the recent estimate of 160.

The 1999 survey also revealed that 70.7 percent of all deliveries are attended by trained health workers, an increase from 63.5 percent reported in the 1994 survey. Nevertheless, there remains a relatively high percentage of women (27.6 percent), primarily in rural areas, who are attended by a nonprofessional person. This reflects the dichotomy that exists in Ecuador as one moves away from urban centers and into rural areas. For

example, in Guayaquil, 94.7 percent of deliveries are attended by trained health professionals, compared with only 78.6 percent within the surrounding coastal region.

As prenatal and delivery care have gradually improved in Ecuador, so has postpartum care, although only slightly. The 1999 survey showed that 36.6 percent of the women that gave birth during the five-year period (1994–99) reported that they had received at least one postpartum control visit, compared with only 33.3 percent reported in the prior survey. Again, the urban areas, such as Guayaquil and Quito, with much easier access to health care facilities, reported higher rates of postpartum care (48.2 percent and 52.9 percent, respectively) in the 1999 survey.

From its earliest years in Ecuador, family planning support from USAID and other international donors focused on an expanded approach through improved maternal and child health (MCH). Funds from the United Nations Population Fund (UNFPA), administered through the Pan American Health Organization (PAHO), were used by the Ministry of Health MCH Division to promote well-baby clinics and services, including vaccination campaigns. In fact, one of the PAHO advisors responsible for the UNFPA program in Ecuador was a pediatrician, not an obstetrician or gynecologist, as was the case in most other country programs.

Because of this integrated MCH approach as well as other factors, Ecuador presently enjoys relatively high immunization coverage for children less than 5 years of age. For all completed vaccines (BCG for tuberculosis, diphtheria-pertussis-tetanus [DPT], polio, and measles), coverage increased from 78.3 percent in 1994 to 83.2 percent in 1999. Nevertheless, reviewing trends in infant mortality rates (IMRs) over the 20-year period (1978–97) gives cause for concern. In the late 1970s, the IMR was about 57 and dropped steadily every year, reaching a low of 25 in 1993. Since that time, the IMR climbed back up to 33.2 in 1994 and to 32.2 in 1997.

Among the explanations given for this reversal is the external migration of parents, that is, parents leaving young children in the care of friends and relatives who are not overly concerned for the child's health and welfare. Another suggested reason is that the public health care system is overloaded and seriously underfinanced, particularly in the area of preventive health care. In fact, only 2.6 percent of the national budget is allocated to the public health sector, of which 80 percent is spent on salaries and 16 percent is directed at hospital care. This leaves a very inadequate amount to carry out preventive care programs, such as child immunization and well-baby services. (When comparing the combined public and private per capita health expenditures for 1997 to 1998, Ecuador, at US \$71, is the sixth lowest among all other countries in the Latin America and Caribbean region (LAC)—higher only than Nicaragua, Bolivia, Honduras, Guyana, and Haiti.)

POSTPARTUM AND POSTABORTION FAMILY PLANNING

Abortion is illegal under most circumstances in Ecuador and there is strong resistance to discussing it openly. Such a situation often leads to neglect in the area of postabortion care. Unfortunately, many Ecuadorian women seek clandestine abortions, either because

they have not received adequate family planning information or because contraceptives are not easily accessible. As expected, a country with legal and cultural constraints on abortion, coupled with the strong influence of the Catholic Church, tends to have a very large number of underreported abortion cases.

The National Population Action Plan of 1994–96 clearly stated the government of Ecuador's (GOE) position regarding abortion. While the government does not consider abortion to be a family planning method, the action plan nevertheless formally recognized that 2 of every 10 women of fertile age has had an abortion. The World Health Organization (WHO) estimates that 1 out of every 8 maternal deaths worldwide was due to abortion-related complications.

The large maternity hospital, Enrique C. Sotomayor, operated by the Junta de Beneficencia in Guayaquil, treats approximately 2,800 women annually for complications arising from abortions. Based on this and other hospital data, it was estimated in 1998 that 20,000–30,000 Ecuadorian women clandestinely seek out abortions every year. In response to this need, USAID-supported programs through Pathfinder, AVSC International (now EngenderHealth), and the Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO) have worked with Ecuadorian hospitals (such as the Enrique C. Sotomayor Maternity Hospital) to offer training in postobstetrical event contraception and care.

Discussions with health providers at the maternity hospitals indicate their belief that postpartum and postabortion services (or more inclusively, postobstetrical event care) can reach women at an opportune time for contraceptive decision-making. Offering contraceptives concurrently with other medical services can be convenient and cost-effective. Many family planning methods are appropriate for postpartum and postabortion women, including the IUD, the lactational amenorrhea method (LAM), counseling, and surgical sterilization.

At present, the public sector in Ecuador offers some postpartum/postabortion services, including a wide range of contraceptive methods. But the public hospitals do not have specific programs designed to provide family planning services to women after pregnancy. As in most hospital settings, curative services take priority over preventive services, such as family planning. With USAID assistance, particularly through AVSC and JHPIEGO, a few institutions have developed postpartum/postabortion programs. The resident JHPIEGO technical advisor helped the Vicente Corral Moscoso Hospital in the city of Cuenca to design and implement the first phase of a postpartum/postabortion care program. At the same time, with JHPIEGO technical assistance, the MOH has prepared guidelines for postpartum/postabortion programs.

Only one third of Ecuadorian women seek postpartum care, although over 80 percent come in for prenatal services. The MOH has particular difficulties reaching postpartum women because its clients tend to be poor and live in rural areas. A primary barrier to care is lack of provider interest in postpartum/postabortion care. Many public sector

health care workers lack appropriate training in management, counseling, and promotion of services to meet the family planning needs of postpartum and postabortion women.

CEMOPLAF, with funding from a USAID cooperating agency, Family Health International (FHI), worked with the MOH in a pilot project for postpartum/postabortion family planning services at three MOH obstetric centers in Quito, Guayaquil, and Guamote, a rural indigenous area in the Andes. At the centers, medical and auxiliary personnel were trained in counseling and family planning methods with modules and materials developed by FHI. Clients at the centers chose the following contraceptive methods: IUD, 45 days postpartum (30 percent); progestin-only pills or injectable contraceptives (21 percent); LAM (20 percent); surgical sterilization (15 percent); barrier methods (10 percent); and IUD, immediately postpartum (4 percent).

The Ecuadorian public health agencies need to be involved in any meaningful effort to establish postpartum services, since they have primary access to the majority of women giving birth. Unfortunately, MOH postpartum and postabortion programs are considerably lacking, particularly with regard to the provision of family planning counseling and services. But the MOH is not alone regarding inadequacies in delivering quality postpartum care. The Instituto Ecuatoriano de Seguridad Social (IESS), with 90 health units and 16 hospitals across the country, does not have specific programs for postpartum or postabortion family planning services. Such services have not been given a high national priority, despite problems of maternal mortality and a high rate of illegal abortions.

III. THE LEGAL AND NORMATIVE CONTEXT

FAMILY PLANNING AND THE NATIONAL POPULATION POLICY

Ecuador has had a population policy since October 26, 1987. Its stated purpose is for planning and implementing activities that would promote a coherent and balanced relationship between the growth, size, structure, and territorial distribution of the population and the country's socioeconomic development. The intent of the policy is to improve living conditions and respect for the rights and obligations of all citizens. The population policy guarantees individual rights and encourages responsible parenthood and the provision of education necessary for the promotion of the family. The policy also guarantees the rights of a couple to decide on the number of children that they can educate and support.

Since 1988, the legal and statutory basis for family planning rights in Ecuador has been contained in the Ecuadorian Constitution. This provision has survived the various subsequent changes to the national Constitution and is presently contained as Article 39 of the August 1998 version. The Constitution recognizes the right of the couple to freely choose with regard to the spacing of their children and to decide on the number of children they desire. In order to guarantee that right, full information on the various options and maternal and child health services, including family planning, must be offered. The GOE justifies this position in accordance with the principles of the respect for the sovereignty of the state and the self-determination of the parents.

The recognition of the right to family planning resulted from Ecuador's long search for a national population policy, and USAID assistance was instrumental in that search. Many events led to the development of a national population policy. In 1972, the Center for Demographic Analysis (CAD) was created and served as a technical unit within the National Institute of Statistics and Census (INEC). It received funding support from UNFPA until 1981. During that period and as a result of Ecuador's participation in the 1974 World Population Conference held in Bucharest, the National Population Council (Consejo Nacional de Población) was established as an advisory body to the president of the republic, carrying with it both ministerial status and multisector representation.

In the formation of Ecuador's 1978 national Constitution, provision was made for the National Development Council (Consejo Nacional de Desarrollo [CONADE]). Among its functions was the establishment of a national population policy. It was not until four years later that CONADE assigned a population unit to study aspects of demographic growth and their relationship to economic, social, political, and cultural development of the country. Subsequently, in 1983, UNFPA approved assistance to CONADE to establish the fundamental precepts for a national population policy.

Throughout these formative years, USAID supported the creation of a population policy and provided assistance to local groups, such as the Center for Studies in Population and Social Development (CEPAR). Technical assistance came from USAID-funded

projects, such as the RAPID presentation developed by The Futures Group International. That computer model, which demonstrated the impact of population growth with and without family planning, was modified and adapted by CEPAR to the Ecuadorian environment. The RAPID tool was then used for presentations to leaders from among the various political parties, with excellent results. There was a noticeable change in the attitudes of those leaders and an appreciation for the need to include factors affecting population growth into any national development plans.

Over the 14 years since the population policy was established there have been numerous changes in the government, and no significant support for its implementation. In 1994, however, the general secretary for national planning issued a two-year national population action plan. Recognizing the importance of a population policy as an integral and critical part of the country's economic and development policies, the plan was to be carried out through five strategic programs:

- inclusion of demographic variables into all national development plans;
- maternal and child health and family planning;
- information, education and communication (IEC) in population;
- migration and internal population distribution; and
- population and the environment.

The GOE recognizes the valuable assistance that both USAID and UNFPA have given in developing the population action plan. Furthermore, attempts were made by USAID under its nonproject assistance (NPA) component, to provide for those institutions responsible for implementing the plan. (See section VIII on nonproject assistance). Unfortunately, in the years that followed, due in part to the continued national economic crises and political instability, there has not been the support nor the commitment necessary to carry out the programs envisioned under the plan.

LAW FOR FREE MATERNITY SERVICES (LEY DE MATERNIDAD GRATUITA)

In September 1994, the government issued the Ley de Maternidad Gratuita (Law for Free Maternity Services), which guarantees that all deliveries in public health institutions are to be completely free of charge, including costs for medicines, medical supplies, and even patient meals. Expanded in August 1998 to include infant health care and now known as the Ley de Maternidad Gratuita y Atención a la Infancia, the law covers prenatal health care costs; control of sexually transmitted infections, as well as treatment (except for human immunodeficiency virus/acquired immune deficiency syndrome [HIV/AIDS]); postpartum care; and the provision of contraception.

Financing for the implementation of the Ley de Maternidad Gratuita was contemplated from both the Fondo de Solidaridad (National Solidarity Fund) that was created in 1998 as a national social welfare fund and through a 3 percent luxury item tax. The 1998 law was developed in collaboration with the then evolving decentralization policies of the MOH, creating fondos solidarios locales de salud (local health solidarity funds). At the

municipal- and local-government levels, the mayors and heads of the local health areas (jefes de area de salud) were to oversee the expenditure of these funds.

The Ley de Maternidad Gratuita is very noble in its desire to reduce maternal and infant mortality. It is explicitly inclusive, by involving multiple institutions, such as the MOH, the Instituto Nacional del Niño y la Familia (National Child and Family Institute [INNFA]), Consejo Nacional de la Mujer (National Women's Council [CONAMU]), and CONASA. In addition, it is very democratic in its intent to delegate responsibilities to the local levels. It is also ambitious, in that it assigns a portion of the Fondo de Solidaridad as well as taxes on designated items for purposes of implementation. Unfortunately, the severe budgetary constraints facing the GOE have made it extremely difficult, if not impossible, to implement the scheme. The country finds itself in the present dilemma of having elaborated a politically powerful health plan, but not having the funding nor institutional capacity for implementation.

By issuing the nationwide Ley de Maternidad Gratuita, but by not having in place the sufficient budgetary and human resources nor the infrastructure at all levels, particularly at the local implementation levels, the GOE has created a situation that adversely affects both the quantity and quality of reproductive health care, including family planning. For those women able to access the public facilities, many do not receive the family planning method of their choice, while others find clinics without contraceptive supplies. Many other women who have not been able to access the free public sector services may find themselves in an unfortunate situation that can easily lead to an unwanted pregnancy or abortion. Others are turning to the facilities of the private sector institutions where they are asked to pay. Early on, the USAID Mission had recognized the shortcomings of the proposed Ley de Maternidad Gratuita, but unfortunately it was not successful in dissuading the GOE.

IV. ASSOCIATION FOR THE WELL-BEING OF THE ECUADORIAN FAMILY (APROFE)

The Association for the Well-being of the Ecuadorian Family (APROFE) is a private, nonprofit organization providing family planning and other reproductive health services through its 21 standing clinics, community outreach distributors, a marine unit, and a mobile clinic. Its activities are carried out in 15 cities, located in 10 of the 22 Ecuadorian provinces, including the remote Galapagos Islands. APROFE's annual budget of nearly \$6.7 million for the year 2000 reflects the growth that the institution has had since its early beginnings in 1966, when it received its first annual grant from IPPF in the amount of \$9,000.

From its inception, APROFE has had a close relationship with the U.S. government and USAID. The founding directors, two young physicians interested in providing family planning services in the port city of Guayaquil, were advised by the local U.S. consular officer to contact the regional offices of IPPF in New York. Subsequently, APROFE was officially created in 1965 as an IPPF affiliate and the first family planning NGO in Ecuador. In the early years, APROFE expanded beyond Guayaquil and operated clinics in Quito and Cuenca, offering services in family planning counseling and the provision of contraceptives.

The APROFE facilities also served as training centers for physicians interested in family planning. Among the physicians were those working in the medical facilities of the armed forces, who in turn were very appreciative to APROFE for the training they received. As a result, family planning services were eventually offered in 13 of the military camps throughout the country. Given the strong influence of the armed forces in Ecuadorian politics, the relationship that APROFE maintained with the armed forces over the years proved beneficial to the institution and to family planning.

In recent years, JHPIEGO provided assistance to develop APROFE's pilot clinic as a national family planning and reproductive health training center. USAID funding allowed for the purchase of training equipment and remodeling of the APROFE facilities. The center also conducts training-of-trainers activities that focus on quality of care and incorporate gender issues and considerations in the provision of all reproductive health services. APROFE is one of the strongest advocates in the LAC region for promotion of gender awareness.

APROFE also served as a strong advocate for the promotion of family planning rights and their adoption in the national population policy and eventually as part of the national Constitution. Since the mid-1970s, APROFE was also one of the first family planning groups in the LAC region to open discussions for sex education and the importance of meeting the reproductive health needs of adolescents. It hosted international conferences to explore mutual interest in the increasing awareness of and concern for adolescent

reproductive health. The promotion of family life education was the main objective of the APROFE program, covering such themes as the prevention of unwanted pregnancies, self-esteem, domestic violence, and alcohol abuse.

With funding from the Hewlett–Packard Foundation, APROFE is presently participating in a program in which Panama, Venezuela, and Colombia share experiences in the area of adolescent sexual and reproductive health. The APROFE adolescent program has more than 90 adolescent promoters working as peer counselors with high-school students.

In 1975, faced with increasing demands for services, APROFE entered into an agreement with the Junta de Beneficencia de Guayaquil to provide family planning services at the large Enrique C. Sotomayor Maternity Hospital. A separate facility was envisioned and external funding assistance was required. USAID was approached and agreed to fund the construction and equipping of the new facility. The clinic, strategically located on the grounds of the maternity hospital, continues to function under a perpetual no-cost lease to APROFE as its pilot clinic.

At all levels, APROFE physicians, midwives, and other service delivery staff are well trained for the performance of their administrative and clinical responsibilities. As a result, preparation of reports is done completely and in a timely manner. Centralized computerization of the APROFE information system provides an efficient operation. This is supported by regular supervisory visits by APROFE central and regional staff. The same high level of quality care is shared throughout APROFE facilities in Ecuador, including the marine unit that delivers family planning services to inhabitants on the island of Puna in the Guayas region.

As a pioneer in the area of community-based distribution of contraceptives, APROFE created the Information and Services for the Community (IACO) and Community Physicians and Midwives Associates (MOCA) programs to provide services to hard-to-reach rural populations. These programs were originally financed by Pathfinder International; in the early 1990s, APROFE assumed full responsibility. The IACO activity involves the use of promoters working out of their homes or small businesses, which are identified by a sign stating that family planning supplies can be purchased at a very low, subsidized cost. IACO promoters, some of whom have been involved in the program for more than 25 years, retain a portion of their sales as an incentive. Similarly, MOCA associates earn modest amounts for their delivery of services. Since 1976, the IACO and MOCA programs have delivered more than 3.1 million cycles of oral contraceptives and 3.1 million condoms.

A demonstration of APROFE's institutional capacity can be appreciated by the fact that in the year 2000, despite the country's economic difficulties caused by bank closures and the conversion to the U.S. dollar, APROFE was able to meet the increased demands for contraceptive services, reporting over 63,000 couple years of protection (CYPs)—nearly 10 percent above its 1999 levels.

In preparation for the termination of USAID/Ecuador assistance, APROFE initiated a strategic plan to strengthen its financial and administrative management. It has been proactive in seeking out contracts with industries and commercial sector institutions to provide their personnel with family planning and other services. The new entrepreneurial direction being taken by APROFE is exemplified by the recent contractual arrangements with private laboratories that provide specialized tests. These arrangements will provide additional business for the laboratories and discounts for APROFE clients and will generate a modest income for APROFE.

The financial management at APROFE has allowed the institution to reach a significant degree of sustainability, including the creation of a sustainability fund in the amount of \$5.15 million and additional reserve accounts for purposes of contraceptive procurement, construction of new facilities, and an employee retirement fund.

At all levels of the Ecuadorian community, APROFE has maintained its position as a recognized leader and authority on matters related to family planning and reproductive health. APROFE staff is regularly consulted regarding new reproductive health technologies and proposed policies and norms in this and related areas, such as sexual education, women's rights, and domestic violence.

V. MEDICAL CENTER FOR FAMILY PLANNING AND COUNSELING (CEMOPLAF)

The Medical Center for Family Planning and Counseling (Centro Médico de Orientación y Planificación Familiar [CEMOPLAF]) is a private, nonprofit organization offering reproductive health and family planning services. CEMOPLAF, officially established in September 1974, began its operations as part of an agreement between USAID and the MOH, managing four clinics: two in Quito, one in Santo Domingo de los Colorados, and one in Quevedo. CEMOPLAF and the MOH developed a working relationship by which CEMOPLAF provided training for MOH staff on family planning methods. Throughout the years, CEMOPLAF has been recognized by the MOH as a leader in family planning and reproductive health. Most recently, in 1999, CEMOPLAF, along with other reproductive health service providers, was invited by the MOH to participate in the preparation of the national reproductive health service delivery guidelines.

In the early years, USAID assistance, provided through Family Planning International Assistance (FPIA), allowed CEMOPLAF to train other physicians and midwives in family planning. Until the early 1980s, CEMOPLAF collaborated with the national police and the armed forces, providing family planning education and services to their staffs and families.

The major expansion of CEMOPLAF occurred during the period 1982–91, when USAID/Ecuador financed activities through a grant to IPPF's Western Hemisphere Region (WHR). Technical and other support was provided to CEMOPLAF as well as to the other two NGOs working in the area of family planning and population (i.e., APROFE and CEPAR). During that period, 10 additional clinics were opened throughout the country: Guayaquil, Esmeraldas, Quinde, Ibarra, Tulcan, Riobamba, Latacunga, Ventanas, Guaranda, and Quito Norte, as well as the clinic at the Colegio de Obstetricas de Pichincha (the Pichincha Midwives Training College).

As a result of an operations research activity carried out in 1986, CEMOPLAF began offering family planning methods to the underserved indigenous communities in Otavalo, Cajabamba, and Pujili. The services initially focused on promoting oral contraceptive and condom use through community-based distributors. After three years and in response to community requests, services were expanded to include testing for cervical cancer (i.e., Papanicolaou smear cytology [Pap test]), and treatment of reproductive tract infections.

In 1988, the armed forces transferred four medical centers to CEMOPLAF to offer family planning and reproductive health services. In the same year, Pathfinder International, with USAID funding, assisted CEMOPLAF in initiating its voluntary sterilization program. In 1998, a new CEMOPLAF clinic was opened in Quito, as well as a clinic with maternity services in Lago Agrio. And in 1999, a clinic in Pillaro and a second Guayaquil facility were installed. At present, CEMOPLAF manages 23 clinics located in 10 of the 22 Ecuadorian provinces. The clinics, staffed with qualified physicians and

midwives, provide services for family planning, gynecology, prenatal care, pediatrics, pregnancy testing, cervical cytology, adolescent services, laboratory services, and in some centers, colposcopy and ecosonography. CEMOPLAF clinics also have small pharmacies that are successful in generating additional income.

In 1995, USAID funded a social marketing program with CEMOPLAF through The Futures Group International—the Social Marketing for Change Project (SOMARC). Despite some administrative difficulties at the beginning, the program became very successful in marketing contraceptive methods and medicines related to maternal and child health. The products are sold mostly through pharmacies, which are a major source of supply for Ecuadorian women.

Condom marketing and generic family planning mass media campaigns were the two main project activities. Condom marketing, which included brand-name advertising in the mass media, was successful, and today the social marketing brand condom, PROTEKTOR, is widely recognized and requested by consumers. CEMOPLAF has full management responsibility and has continued to expand the program throughout Ecuador. Pharmacies and wholesalers serve as distribution points of all products marketed in the program. Social marketing now represents a considerable income for the institution and has helped CEMOPLAF achieve greater financial sustainability than it had.

In 1996, CARE's Support to Local Organizations project (CARE-APOLO), which was financed by USAID/Ecuador bilateral child survival funds, entered into a partnership with CEMOPLAF to implement and test two community health models in rural areas. One model, the Expansion of the Package of Services to Include Child Care, was carried out in Otavalo; the second model, Expansion of the Women's Care Service Package, was carried out in the Lago Agrio clinic.

The model implemented in the Otavalo clinic was aimed at expanding the package of health services to include integrated child health care, thus contributing to the reduction of child mortality rates through an efficient, effective, and sustainable primary health care system. Otavalo is characterized by a predominantly indigenous rural population. The extremely high incidence of poverty for this population (87.7 percent) directly affects the health condition of women and children. Respiratory infections, malnutrition, parasitism, and tuberculosis are the principal morbidity causes, especially among children under 5 years of age. CEMOPLAF received technical assistance from CARE covering the management of financial systems and the redesign and optimization of community promotion and social marketing areas, as well as the introduction of central and peripheral child care service. Among the major benefits of the Otavalo model were the increased demand for family planning services, which in turn produced higher cost recovery for the clinic.

The service delivery model implemented at the Lago Agrio clinic was intended to increase service coverage with an emphasis on activities contributing to the reduction of maternal morbidity and mortality. Lago Agrio, situated in Sucumbios Province on the

border with Colombia, is in an area suffering violent armed conflict. Given this situation, the CEMOPLAF clinic staff confronts physical insecurity and an increasing demand by refugee women from both Ecuadorian and Colombian border towns. Services provided include prenatal control, delivery and post-delivery care, gynecological care, and family planning. Assistance provided by the CARE–APOLO project to the Lago Agrio clinic included health promotion and prevention, gender focus, design and sales of service packages, cost monitoring and recovery, studies on service subsidization, and financial sustainability follow up.

Both the Otavalo and Lago Agrio model programs were considered successful in increasing the use of services that reduce the causes of maternal mortality. Unfortunately, because of the previously mentioned external constraints at Lago Agrio, clinic attendance has dropped. Nevertheless, the model as such will be replicated by CARE and CEMOPLAF in the southern provinces of the country, fully financed by the European Economic Community.

CEMOPLAF had also partnered with World Neighbors to implement two distinct service delivery strategies in 12 communities located in the rural Bolivar province, which has a very high indigenous population. Selected communities engaged in a health-only intervention approach, while others experimented with a broader integrated program addressing not only health activities, but also agriculture and natural resource management. The communities participating in the integrated program were historically more underserved and more rural than the health-only communities. The natural resources component included soil and water conservation, farmer experimentation with varieties of wheat and potato, the use of cover crops, vegetable production, and small livestock improvement. Preliminary results indicate that integrated service provision can produce benefits for agricultural and natural resources improvements, as well as significant increases in family planning knowledge and use among the rural and indigenous population.

Since 1986, a variety of USAID–funded technical assistance activities were provided to CEMOPLAF that included some type of staff training. The Population Council worked in the area of operations research and cost analysis; Futures, in contraceptive social marketing; AVSC International (now EngenderHealth), in improving the quality of female sterilization and counseling services; JHPIEGO, in developing training capacity and in the training of trainers of selected health providers; the International Center for Research on Women (ICRW), on the study for the introduction of emergency contraception; and the Johns Hopkins University/Population Communication Services Project (JHU/PCS), in the effective delivery of appropriate IEC on family planning and reproductive health.

During the last four years, USAID placed special emphasis on assisting the institution to strengthen its administrative structure and financial management. Locally hired and highly qualified technical staff members from JHU/PCS and JHPIEGO worked closely and in a coordinated manner with the CEMOPLAF staff to enable the NGO to achieve a higher level of institutional sustainability and to improve the quality of services.

As a result, CEMOPLAF was able to develop a viable, long-term strategic plan. At the same time, it created two critical divisions: Finance and Marketing of Services. It set up a management committee and reactivated the technical committee responsible for the provision of medical services and policies. CEMOPLAF also incorporated new members into its General Assembly and elected a new board of directors, with a more entrepreneurial background. At the same time, a monitoring and evaluation system was implemented as a management tool to follow up on clinic performance.

Presently, CEMOPLAF clinics are well provided with medical and office equipment, including computer hardware and software. Contraceptives donated by USAID in 2001 will cover the institution's market demand for the following two years, which should be a great help in ensuring CEMOPLAF's sustainability.

CEMOPLAF has continued to recognize that its long relationship with USAID has been critical for the institution's growth and survival. It acknowledges the value of USAID support for its institutional strengthening, which included administrative, technical, and financial assistance. Recent achievements related to the legal structure of the institution will allow CEMOPLAF to continue as a solid nongovernmental organization, providing quality family planning and reproductive health services. Its financial sustainability has a strong foundation, with CEMOPLAF's sustainability fund presently estimated at a value of nearly \$3.4 million.

Over the years, CEMOPLAF has been transformed from a small, missionary-like organization of volunteer physicians and social workers intent on providing free family planning services to the poor and with a strong dependence on the largess of international donors into a large, entrepreneurial institution providing a vast array of reproductive and other health services to the middle class as well as the poor. A major outcome of this transition is the realization that CEMOPLAF is free from its financial dependence on outside donors and that it can still subsidize family planning services for the poor.

The transition process was not easy. Fortunately, USAID was present and held firm throughout the process and was able to provide the technical and financial support as needed. Although at times CEMOPLAF was reluctant to make the often difficult but necessary changes, it did implement the necessary measures or reforms. However, because of the high level of mutual respect on both sides and the universal commitment to attain for CEMOPLAF the necessary level of institutional and financial independence, CEMOPLAF successfully graduated from USAID assistance. It should prove to be a viable model and leader for other Ecuadorian institutions that work to serve the poor.

VI. CENTER FOR STUDIES IN POPULATION AND SOCIAL DEVELOPMENT (CEPAR)

The Centro de Estudios de Población y Desarrollo Social (Center for Studies in Population and Social Development [CEPAR]) was created as a private, nonprofit institution dedicated to investigating Ecuadorian demographic variables, including family planning, and their relationship to national development. With USAID financial and technical support, CEPAR periodically conducted national demographic and reproductive health surveys and related special studies. It has served as an effective advocate for national population and health reform, including the development of the national population policy, and conducted an intensive training program in this area. Through its conferences, workshops, and numerous publications, CEPAR has become an acknowledged leader in the area of health policy.

Since its inception in 1978 as the Centro de Promoción de Paternidad Responsable (Center for the Promotion of Responsible Parenthood), CEPAR has received USAID assistance both bilaterally and through USAID centrally managed projects. One of the earliest USAID-supported activities was the training of pharmacy owners and staffs in the provision of family planning services and counseling. In 1982, in order to more adequately reflect its work in demographic research, CEPAR changed its name to the Centro de Estudios de Población y Paternidad Responsable (Center for Studies in Population and Responsible Parenthood). More recently, in 1998, to reflect its expanded role in the health and social development sector, CEPAR took on its present name, the Center for Studies in Population and Social Development.

CEPAR has collaborated with many international institutions, such as UNFPA, the Pan American Health Organization, the United Nations Organization for Education, Science and Culture (UNESCO), the World Bank, and the Inter-American Development Bank. For example, it played a key role in the organization of international as well as national family planning conferences, such as the First South American Congress of the Society for the Study and Advancement of Contraception, held in July 1986. CEPAR had also actively participated in USAID-supported health reform programs, collaborating with the Ministry of Health and the World Bank in areas such as decentralization. Similarly, with assistance from the USAID centrally managed Partnerships for Health Reform Project (PHR), CEPAR had the primary role in the promotion of the national health accounts system in Ecuador.

Since 1987, the Division of Reproductive Health of the U.S. Centers for Disease Control and Prevention (CDC/DRH), through a partnership with USAID/Washington's Office of Population, has collaborated with CEPAR and provided technical assistance in carrying out four Demographic and Maternal and Child Health Surveys (Encuesta Demográfica y de Salud Materna e Infantil [ENDEMAIN]). CEPAR had the primary role in the design and implementation of these national surveys as well as in data analysis and dissemination of the survey findings. The CDC technical staff that collaborated in the

Ecuador surveys considers CEPAR's data processing and analysis capabilities of the highest quality among the LAC countries. Consequently, several CEPAR staff members have been recruited by CDC to assist in training survey staff in other countries, such as Paraguay and Honduras.

The most recent ENDEMAIN, conducted in 1999, was the first such national survey to cover the population within all Ecuadorian territory, including the Amazon and insular regions, and with a sample size adequate to provide province-specific data and to produce individual reports for 19 of the country's provinces. These reports are useful tools for those health and social sector planners and decision-makers working at the provincial level.

USAID/Ecuador has consistently contributed the major share of the costs for the various Ecuadorian national reproductive health surveys. For the 1999 ENDEMAIN survey, USAID donated US \$300,000 and UNFPA provided \$40,000 to produce the provincial reports and to conduct dissemination workshops. Other in-kind contributions included approximately \$1,250 from CEMOPLAF, over \$600 from APROFE, and \$8,755 from CEPAR. Although the numerous other users of the ENDEMAIN data (Ecuadorian as well as international public and private sector institutions) recognize the value of this tool, to date the principal ownership rests with USAID and in some part to UNFPA. In other countries, the local MOH, the local child welfare institutes, PAHO, IPPF, and the World Bank have contributed to similar surveys. Unfortunately, the capacity for CEPAR to raise contributions from sources other than USAID for the ENDEMAIN is extremely deficient. This situation does not bode well for the conduct of future national reproductive health surveys in Ecuador.

In addition to conducting the national demographic and reproductive health surveys, CEPAR has carried out special studies. One such study was the Encuesta de Información y Experiencia Reproductiva de los Jovenes Ecuatorianos en Quito y Guayaquil (ENJOV) (Survey of Reproductive Information and Experience of Ecuadorian Youth in Quito and Guayaquil). That survey of sexual knowledge, attitudes, and practices of youth in Ecuador's two largest cities was one of the first of such undertakings in Latin America conducted in collaboration with the CDC. Its findings helped to stimulate a greater public interest in addressing the growing reproductive health needs of this underserved segment of the population. As a result, both the public health sector and the private NGOs began to focus their work on reaching young adults with information and services, and requested USAID support for those activities.

CEPAR was also successful in disseminating demographic, reproductive health, and social data in innovative and informative ways. For example, using data from the INEC 1990 National Housing Survey, CEPAR produced and widely distributed a handy 1992 desk calendar, which included tables on both national population growth (from 3.2 million in 1950 to 9.6 million in 1990) as well as the quality of household services (only 40 percent of homes had indoor plumbing and less than 16 percent had telephone service). That creative calendar format served as daily reminders of the relationship between population growth and the quality of Ecuadorian life.

Most CEPAR publications are directed at high- and mid-level technicians, policymakers, community leaders, and students. The graphs, charts, and tables are clearly explained, together with a brief analysis of the data and interpretations about the implications of the findings. For example, the 1991 series, *Temas Poblacionales* (Population Themes), consisted of booklets (25–page average length) addressing the relationship between demographic and socioeconomic variables. Themes such as male sexuality and unplanned pregnancy were presented in a concise, informative, easily understandable format without overwhelming the reader.

Correo Poblacional y de la Salud, the quarterly journal published by CEPAR (with a distribution of approximately 2,500 copies), has been recognized as a valuable tool in providing national policymakers with basic information on all matters affecting health. The professional magazine format and the high quality of the articles, often supported with graphs or tables presenting recent data, have assured CEPAR's position as a respected national health advocate and as a reliable resource and institute of expertise.

Over the years, a wide range of articles included topics such as the benefits of breastfeeding, maternal mortality, adolescent sexuality, HIV/AIDS, health financing and reform, child labor, and the health implications of internal migrations. *Correo Poblacional y de la Salud* also served as a vehicle for highlighting USAID–supported projects, such as the CARE–APOLO rural health project, and for giving access of regional and international health programs to Ecuadorian policymakers. However, presently faced with no future USAID funding support, the magazine will be published only 3 times a year and with a reduced number of pages per edition.

In recent years, as CEPAR became increasingly aware of the reduction and eventual termination of USAID financial support and in order to assure its own institutional survival, the organization began to modify its structure and modus operandi. While maintaining its principal focus on demographics and the implications of population growth, in 1998, it expanded its scope beyond responsible parenthood to explore other factors influencing social development in Ecuador.

CEPAR has come to recognize that one of the shortcomings of its long relationship with USAID has been its high degree of dependence on USAID for the largest part of its funding. It had grown to accept as a false reality that USAID support would always be available. It was not until 1991, however, that the institution held a retreat to explore the need to diversify its sources of income and to reflect seriously on the possibility of a future without USAID assistance.

CEPAR is facing several challenges on all fronts. Over its 23–year history, the board of directors has remained basically unchanged, and has not recruited new, young members with a broad perspective towards institutional and financial sustainability. At the same time, the very existence of CEPAR is threatened. As founding members leave, the total membership is reduced. Currently, membership is down to only 17 individuals; by law, it must maintain a minimum of 15 members.

The difficulty of finding markets in Ecuador for CEPAR's training, research, and data analysis services has caused the institution to make some major organizational changes. In order to seek new funding support and contracts, the executive director (who had served in that position for nearly 10 years), has assumed a new role, that of coordinator for interinstitutional relations. He is charged with developing new projects and prospective donors. Meanwhile, since January 2001, CEPAR has been unable to recruit his replacement, and the president of the board has assumed the position of acting executive director.

CEPAR owns its office building with furniture, equipment, a training room, and excellent computer facilities. The institution appears at present to be financially solvent and does not need to use its reserve funds. Nevertheless, some of its very qualified talent has left and there may be more cost-cutting steps to be taken in the near future. At present, CEPAR has a total full time staff of only 15, including technical and support personnel. The organization has kept costly technical staff at a minimum by contracting those services on an as-needed basis whenever new projects were acquired.

The USAID centrally managed institutions that worked with CEPAR over the years were successful in transferring technology and in developing local technical capacity, particularly in areas of demographic research, analysis, communication, and policy reform advocacy. However, the degree of their success in developing CEPAR as an institution capable of assuring its sustainability beyond the termination of USAID assistance remains questionable. The skills and strategies that USAID had developed for the contraceptive service delivery organizations, APROFE and CEMOPLAF, to assure their self-sufficiency, had not been transferred to CEPAR.

The fate of any future national reproductive health survey in Ecuador also is in doubt. This valuable health planning and management tool, highly appreciated and utilized by health managers in both the public and private sectors and which might never again be updated in Ecuador, is instrumental in guaranteeing the long and costly USAID investment in family planning. The USAID/Washington Office of Population, in the design of its follow-on agreements with groups such as CDC and Macro International Inc., that are responsible for working with local institutions on reproductive and health surveys, should place greater emphasis on developing both the sustainable capacity of those local institutions as well as the assured continuation and funding for future national surveys.

VII. SUSTAINABILITY

Although the basic premise of all USAID-supported activities is sustainable development, it was not until the beginning of fiscal year (FY)1992 that USAID/Ecuador began to review its population program in this regard. Over the years, USAID/Ecuador had obligated and spent large amounts of its annual budgets on its family planning and population programs (see table 5 on page 45). The Mission became increasingly concerned; therefore, in FY 1992, it embarked on an innovative six-year health and family planning project that focused on both the financial and institutional sustainability of the two major family planning NGOs, APROFE and CEMOPLAF. To accomplish this, USAID sought out technical assistance in areas such as cost recovery, financial management, contraceptive marketing and procurement, and strategic planning, as well as sizeable USAID annual contributions of contraceptives and cash reimbursements for the establishment of sustainability endowment funds for each institution.

FINANCIAL SUSTAINABILITY

The most recent USAID Results Package provided for the creation of sustainability funds for both APROFE and CEMOPLAF. As agreed, USAID funded a proportion of the operating costs for each institution so that in turn, they could deposit income generated by the sale of services into their funds. During 1997, in designing the sustainability funds, the Mission negotiated with each NGO the development of bylaws to regulate the management of the funds and the use of the interest earned and capital. The funds would allow the institutions to replace USAID donations when that assistance terminated, and based on projections, would finance operations for a minimum of 15 additional years.

In their efforts to achieve greater financial sustainability, APROFE and CEMOPLAF diversified their services beyond family planning to include other reproductive health services, as well as pediatric care and dental services. They have discovered such valuable income-generating services as sonograms and laboratory testing. (For the year 2000, the APROFE sonogram services were 146 percent self-sustaining, and its laboratory services were 110 percent. At the same time, CEMOPLAF enjoys a 174 percent cost recovery from its sonogram services, and 135 percent from laboratory services). Both institutions also established systems of cross-subsidies; that is, services that generate funds in excess of cost will subsidize those that are not self-sufficient, such as contraceptives for the rural poor.

In 2000, despite the extreme poverty, high inflation rates, and economic chaos facing the country, both APROFE and CEMOPLAF made significant gains toward financial sustainability. They achieved an average of 90 percent cost recovery for services, and at the same time increased their individual sustainability accounts to several million dollars. For the near future, it would appear that the finances of the two NGOs are assured, as each is entrusted with a sizeable sustainability endowment fund: \$5.15 million for APROFE and \$3.366 million for CEMOPLAF.

These accomplishments need to be viewed with respect to the original targets as envisioned under the 1991 USAID/Ecuador Health and Family Planning Project. At that time, it was anticipated that by the end of the then planned six-year project, APROFE and CEMOPLAF would each have accumulated approximately \$100,000 per year in a trust or capital fund, for a total of \$600,000. Over the years, USAID assistance was extended until September 2001 and had more than doubled from the originally planned amount. Even taking into consideration these extensions in time and increases in funding, it is now evident that both APROFE and CEMOPLAF far exceeded their initial and adjusted targets.

INSTITUTIONAL SUSTAINABILITY

In addition to focusing efforts on financial sustainability, for many years USAID was concerned over the continued institutional viability of both APROFE and CEMOPLAF. One concern was the fact that both share a similar organizational situation, in that their central leadership is vested in a strong charismatic individual, and over their long history, each institution has had only one executive director. They have yet to experience a transfer of leadership. Both institutions, however, have always been concerned for their need to continue as institutions dedicated to the delivery of family planning services, and therefore were receptive to USAID assistance to provide them with greater degrees of institutional sustainability.

APROFE and CEMOPLAF have always welcomed assistance to improve their internal management. Since its inception, APROFE, as an IPPF affiliate, received years of guidance towards improving its administrative and management systems. Although technically autonomous, each IPPF member association has to conform to basic and common organizational and management principles. The receipt of annual IPPF grants required submission of standardized reports, and in the early years, IPPF staff from the Western Hemisphere Regional Office made regular supervisory visits to APROFE.

In 1977, IPPF embarked on a major effort to assure uniform financial and accounting systems, as well as uniform formats for the designs of project proposals. It issued a programming guide and held affiliates accountable for assuring implementation. In view of its new obligations and its expanding role in the provision of clinical services as well as other activities, APROFE considered it necessary to improve its management and administrative capabilities, including the recruitment of skilled managerial staff and the creation of dedicated office facilities.

During the final years of USAID/Ecuador assistance, both APROFE and CEMOPLAF underwent internal structural changes to improve their management and to allow for greater transparency. They restructured in order to become more market oriented; each began operating more as a business and less as a philanthropic service organization. The membership on their boards of directors is a clear reflection of the changes in the institutions: fewer physicians and social workers and more financially astute businessmen. However, despite these internal changes and new corporate images, both

APROFE and CEMOPLAF remain solidly entrenched throughout Ecuador as the leaders in the delivery of quality family planning and reproductive health services.

VIII. PUBLIC SECTOR AND OTHER PARTNERS

MINISTRY OF HEALTH

During the 1970s, USAID/Ecuador invested heavily in the support of the MOH's integrated maternal and child health program, which included family planning services. Large supplies of oral contraceptives, condoms, and vaginal foaming tablets were shipped to the MOH for use in its health centers around the country. In addition to USAID donations, the MOH has received support from UNFPA and other international donors.

MOH public sector hospitals are the principal providers of the most popular contraceptive method—female tubal ligation—that accounts for 23.1 percent of contraceptive users. The 1999 ENDEMAIN revealed that 63.2 percent of women seek family planning for reasons of limiting family size (i.e., they do not want any more children). Furthermore, the survey showed that there is a great demand for sterilization. Nearly 47 percent of the women who were fertile and not sterilized said that they wanted the operation. Some 50.4 percent were in urban areas, while an impressive 42.4 percent were in rural areas.

Despite this high demand, only 23.1 percent of all women, either in union or married, have had a tubal ligation. It is recognized that all other contraceptive methods have some risk, however small, of patient or method failure. For those women who do not desire another child, such a failure could have dire consequences, such as unwanted pregnancy, child neglect, or abortion.

In earlier years, through its cooperating agencies (CAs), USAID provided technical training to public sector hospitals in the area of female sterilization. AVSC and JHPIEGO were actively involved in this training, providing some of the basic surgical equipment necessary. Unfortunately, during the last years of USAID population assistance, the Agency did not work with public sector institutions, which provide 62.7 percent of all female sterilizations. Rather, USAID supported the private sector NGOs, such as APROFE and CEMOPLAF, which have limited sterilization facilities in the larger urban centers and account for only 3.8 percent of total sterilizations in Ecuador.

From the perspective of the quality of clinical/surgical care for tubal ligations, there appears to be very limited technical assistance that might be offered by USAID or any other donor. However, given the recent problems regarding this method in other LAC countries, such as Mexico and Peru, some assistance should be considered to guarantee the aspects of informed choice and consent.

Before graduating from Ecuador, through the John Snow, Inc. [JSI] Contraceptives Logistics Management Project, USAID approached the MOH to explore the need for technical assistance in this area, in order to assure the availability of adequate contraceptive supplies, now that UNFPA donations have ceased. At the suggestion of USAID, the MOH has participated with other institutions, from both the private and

public sectors, to form an interinstitutional committee on contraceptive security. The intent is to explore possible joint efforts to assure the provision of contraceptive commodities for all participants.

NONPROJECT ASSISTANCE

In 1991, USAID/Ecuador entered into a new relationship with the GOE in the area of population and family planning assistance. At that time, the Agency was experimenting with an innovative way to transfer large sums of financial support in exchange for major national policy reforms in specific sectors. This new approach was called nonproject assistance (NPA). As agreed-upon policies were promulgated and conditions met, USAID would release large tranches of U.S. dollar funding to the Ministry of Finance (MOF) for distribution to four population programs administered by various GOE agencies.

USAID/Ecuador developed a six-year health and family planning project, which among other things, identified operational population policy reforms to be carried out by the major public sector institutions: the Ministry of Health (MOH), the Ecuadorian Social Security Institute (IESS), and the National Development Council (CONADE). The 1992 USAID population strategy planned a commitment of \$10.5 million, of which \$6.5 million was designated as project assistance for the two major family planning NGOs, APROFE and CEMOPLAF, plus an additional \$1.5 million for contraceptive commodities and technical assistance; \$2.5 million was identified as NPA for the public sector. The program with the NGOs was implemented through cooperative agreements, whereas the program with the public sector was implemented through NPA bilateral agreements, using economic support funds (ESF).

The NPA component required not only policy reform on the part of those public sector entities involved, but also close coordination among organizations that had long-standing rivalries and jealousies. Because of the nature of the NPA, the MOF was required to take on a much more active role in the coordination of public sector family planning programs, a role that in the past was carried out by the MOH. The MOF also was asked to take specific actions to improve the financial management capability of the MOH. The IESS, MOH, and CONADE were requested to coordinate efforts in population and family planning. In an effort to develop strong ties among all components of the USAID program, both the MOH and IESS were asked to involve the NGOs much more heavily in public sector family planning activities.

The conditions precedent (CPs) for the first tranche of NPA dollars included the establishment of family planning norms in the MOH and IESS, as well as the creation of a national population commission. Those CPs were met. The MOH prepared the family planning norms with the participation of the NGOs from the very beginning. The norms assure that access to contraception has no a priori limitations. Similarly, there are no age or number of children limitations to voluntary surgical contraception. The guidelines given to family planning providers are exceptionally clear, and supervisory and monitoring relationships are specific.

In addition to establishing the norms, the MOH has regularly taken the initiative to enter into agreements with NGOs, particularly with CEMOPLAF, for the provision of services, training, and communications. The MOH has also established the Family Planning Council, which includes public and private institutions. The council reviewed the norms and met on various occasions to discuss family planning technical and policy issues.

The IESS prepared its own family planning norms, which follow closely those of the MOH. The IESS also issued a decree requiring large firms with existing IESS dispensaries to include family planning services. Agreements between the IESS and NGOs allow for the provision of family planning services and training. The IESS agreed to purchase its own contraceptives with its own resources on an incremental basis so that by the end of the USAID project, the institution would be fully self-sustaining.

Nearly four years after the establishment of the national population policy, CONADE created the National Population Commission with the intent of implementing the policy. The commission included the major cabinet-level ministers of the social sector, representatives from the private sector, the NGOs, the Ministry of Defense and the MOF. Unfortunately, after only two meetings, the commission suffered an early demise. It had extremely high-level members who did not have the time, interest, or capacity for the daily implementation of the policy.

Other related activities that were financed under the NPA agreement included support for CEPAR. Using U.S.-donated food commodities under the PL-480 program, an endowment fund was eventually established to benefit CEPAR. Over the years and with additional funds provided by CEPAR, the value of that reserve fund is presently estimated at US \$700,000. Numerous other activities were implemented, such as the programs with the Roman Catholic Archbishops of Cuenca and Esmeraldas. Both groups were supported in the promotion of natural family planning methods. The fact that responsible parenthood was openly endorsed by these church organizations is evidence of the progress made in family planning.

OTHER LOCAL PARTNERS

Center for Family Guidance in Sexual and Reproductive Health Services (COF)

The recently expanded name for COF, the Centro de Orientación Familiar en Servicios de Salud Sexual y Reproductiva (Center for Family Guidance in Sexual and Reproductive Health Services), reflects the new direction being taken by the NGO that was founded in 1984. At that time, COF was known as the Centro Obstétrico Familiar (Center for Family Obstetrics). As a local NGO providing family planning services, although on a much smaller scale than APROFE and CEMOPLAF, COF has received occasional USAID assistance indirectly through various CAs.

Presently, COF has five medical facilities located in the greater Quito area, as well as clinics operating in seven of the provinces. The Quito clinics now operate at nearly a 98

percent level of cost recovery. Nonclinical COF programs include community-based distribution of contraceptives in the provinces of the Sierra and the eastern region of the country. In addition to 54 paid staff, COF programs are carried out by some 28 volunteer outreach workers and 125 promoters. The university trained health service providers, midwives, obstetrical nurses, and physicians offer services such as female sterilization and IUD insertion. In the main COF clinic in Quito, approximately 1,200 female sterilizations and 110 vasectomies were performed in the year 2000.

COF has been recognized for its work in providing reproductive health training for local groups, such as the Association of Ecuadorian Faculties of Medical Science (AFEME). Most notable has been COF's work with adolescents. Since 1991, COF has supported an integrated adolescent program, offering clinical, socioeducational, and recreational services to young adults. In its first six years, the COF program provided over 2,400 youth with contraceptive methods, mostly condoms, oral contraceptives, and IUDs. This program has grown significantly, and today COF staff and volunteers have reached more than 45,000 adolescents throughout the country. Funds from commercial sector sponsors, such as Schering Laboratories, have allowed COF to produce educational materials.

USAID has supported COF indirectly, either with technical assistance provided through the centrally managed cooperating agencies, such as Development Associates, Inc., which focused on the training of nonclinical family planning workers and trainers, or with contraceptives supplied through the grant to CEMOPLAF. Recently, USAID donated to COF 2 million condoms with an estimated value of \$120,000. (Of the youth who use COF services, 88 percent use condoms and 12 percent use oral contraceptives.)

Almost since its inception, COF has benefited from financial and technical support from the U.S.-based Family Planning International Assistance (FPIA). In the early years, USAID had funded the work of FPIA, until that organization opted not to accept the restrictions imposed by the Mexico City policy regarding abortion. Fortunately, over this period, FPIA was able to continue supporting projects with COF with private funding. However, it now appears that FPIA support is scheduled to end in 2002.

Junta de Beneficencia de Guayaquil

Since the earliest days of family planning in Ecuador, the powerful Junta de Beneficencia of Guayaquil has been actively involved. In the early 1970s, the junta began its close working relationship with the newly created local NGO, APROFE, which began offering family planning services in Guayaquil.

In 1975, to meet the increasing demand for services, APROFE entered into an agreement with the junta to provide family planning services at the large Enrique C. Sotomayor Maternity Hospital. To accomplish this, a separate facility was envisioned and external funding assistance was required. USAID was approached and agreed to fund the construction. That original facility, strategically located on the grounds of the maternity hospital, continues to function under a perpetual no-cost lease to APROFE as its pilot clinic.

In the late 1990s, the maternity hospital became increasingly concerned for the large numbers of women requiring postabortion care and not being provided with adequate contraceptive protection. The Junta requested and received a USAID donation of 10,000 IUDs, together with technical assistance in postobstetrical event care. Today, the maternity hospital has a successful program providing these services, and obtains its necessary contraceptive supplies through APROFE.

Rural Social Security (Seguro Social Campesino)

The Seguro Social Campesino (SSC) was created in 1968 as part of the larger Ecuadorian Social Security Institute. It is dedicated to providing for health and other social service needs of the rural population. SSC started its clinical operations with four dispensaries in rural areas. In 1981, a rural social security law was promulgated and the organization was recognized as a legal group with the right to apply for support of its health service programs. Today the SSC has a total affiliation of 719,000 members.

In 1986, USAID assisted the SSC as part of an interinstitutional agreement signed with the MOF. The objective of the program was to create greater awareness of family planning among the rural population, to provide clinical training in contraception for SSC staff, and to promote gynecological cancer screening. The USAID-funded equipment included slide projectors, portable electric generators, and megaphones. Through Pathfinder International, USAID also supplied condoms, contraceptive pills, IUDs, and vaginal foaming tablets.

In 1991, USAID signed a new interinstitutional agreement with the MOF, which included the SSC as part of the six institutions under the NPA agreement. Activities assigned to the SSC were aimed at reducing maternal mortality caused by pregnancy complications and at reducing high-risk pregnancies. In order to implement these activities, the SSC entered into agreements with APROFE and CEMOPLAF, who provided maternal health services and medical training. Through USAID NPA funding, SSC also obtained a computer, which has allowed the institution to prepare its activity reports and to perform other daily functions.

Presently, the SSC has 577 medical dispensaries distributing contraceptives. According to the 2000 annual activity report, the SSC had over 4,870 new family planning acceptors; however, there were only 4,381 follow-up visits, since many initial acceptors obtain their supplies from other sources, such as commercial pharmacies and the CEMOPLAF social marketing program.

The SSC recognizes that USAID support was instrumental in allowing the institution to offer family planning and related reproductive health services to its members and their families.

IX. OTHER DONORS

Various other donor organizations, bilateral and international, have collaborated in the success of family planning in Ecuador. Among the most notable are UNFPA and IPPF. There had been others who played a relatively minor but no less important role, such as FPIA and the European Economic Community (which is assisting the new project with CARE International).

UNITED NATIONS POPULATION FUND (UNFPA)

Over the years, UNFPA was, after USAID, the second largest international donor in Ecuador in terms of population and family planning assistance. As an official arm of the United Nations, until recently, UNFPA had always conducted its programs in collaboration with the GOE public sector institutions. In the 1970s, UNFPA assistance was provided to the MOH, using PAHO as the executing agency. Contraceptives, equipment, training, and even salaries of family planning health workers were funded by UNFPA.

Following the International Conference on Population and Development, held in Cairo in 1994, UNFPA began to explore working with and assisting local NGOs in the provision of family planning services. USAID/Ecuador had been supporting these groups for years, and was pleased to have UNFPA as a new partner. UNFPA is presently supporting projects with CEMOPLAF and other NGOs in selected regions of the country.

In terms of UNFPA's resource allocation criteria, Ecuador is a category B country (i.e., the second highest degree of priority). The present UNFPA three-year budget for Ecuador (2001–03) provides only \$2.4 million in regular funds, and an additional \$3.6 million in cofinancing from multi- or bilateral resources, as available. (This averages only \$800,000 per year in regular budget funds.) The prior budget, a four-year (1997–2000) budget, was slightly higher and provided for \$4 million in regular funds, and an additional \$1 million in multi- or bilateral resources. (That averaged \$1 million per year in regular funds.)

Until 2000, UNFPA had been a major provider of contraceptive commodities for the MOH, donating oral contraceptives, condoms, injectable contraceptives, and IUDs. Under the new agreement, contraceptives will be provided in small quantities (up to \$250,000) and only for those local governments (cantones) that are participating in UNFPA's Sexual and Reproductive Health Project. That three-year program will work with four local NGOs (CEMOPLAF, Plan International, Fundación de Salud Amazónica, and the Fundación Esquel) to provide services in family planning and sexual education in 14 cantones located in rural areas. It is intended to benefit some 320,000 inhabitants.

One additional observation regarding UNFPA and other development programs in Ecuador concerns their recruitment of former USAID population and family planning staff. The UNFPA deputy country representative, responsible for the development and

implementation of UNFPA projects in Ecuador, had previously served at USAID/Ecuador for six years as a locally hired population and family planning assistant. The orientation and training that he received at USAID has definitely benefited UNFPA and its programs. In a similar situation, another former USAID locally hired population and family planning staff member had also moved on to become the executive director of an Ecuadorian NGO working in HIV/AIDS awareness and prevention programs. USAID should be pleased that its investments in recruiting and developing its local human resources, particularly in the population and health sector, have provided a long-term benefit to other related development programs in Ecuador.

INTERNATIONAL PLANNED PARENTHOOD FEDERATION (IPPF)

IPPF, through its regional office IPPF/WHR located in New York, was instrumental in working with the local affiliate, APROFE, to introduce family planning information, training, and services in Ecuador. The IPPF/WHR staff visited Ecuador in the early days to guide the founders of APROFE in structuring and establishing the organization. Over the years, funding, contraceptive supplies, and technical assistance have been provided to APROFE. Throughout that time, USAID/Washington supported IPPF and the regional office, which in turn assisted their affiliates worldwide, including APROFE. In recent years, however, USAID has curtailed its funding to IPPF, thereby limiting the support to Ecuador.

During the mid-1980s, as USAID/Ecuador became increasingly concerned for the future sustainability of its local NGO partners, it transferred funds through a grant agreement with IPPF/WHR to provide technical assistance focusing on improved management and greater self-sufficiency. A fully staffed IPPF project office was set up in Quito. That initial assistance encouraged the local partners to explore activities that would generate income and to prepare for the eventual cessation of USAID funding.

In recent years, IPPF has gradually reduced its funding support for APROFE. The IPPF annual grant (not including donated contraceptive commodities) was \$303,500 in 1981, dropping to \$204,865 in 1992, to \$157,000 in 1997, and to only \$80,000 in the year 2000. Over the years, as USAID/Ecuador increased its support to APROFE, IPPF reduced its grants. This has also been observed as being the case with other IPPF affiliates in the LAC region.

X. THE COOPERATING AGENCIES

During the 1980s and early 1990s, the number, size, and variety of the USAID–centrally managed grants and contracts in the population sector greatly increased. At the same time, Missions around the world were receiving larger amounts of population assistance funds, but did not necessarily receive the budgets needed for operational expenses and for the staff to manage the programs. Missions increasingly used the worldwide projects (buy-ins), thereby passing on a greater management burden of the local activities to the USAID Office of Population. In this regard, the Ecuador Mission was no exception.

For FY 1995, the first year that the field support funding policy went into effect, USAID/Ecuador assigned \$815,000 to 10 Bureau of Global Programs, Field Support and Research, Center for Population, Health and Nutrition, Office of Population (G/PHN/POP) projects. Amounts varied, from only \$15,000 for the POLICY Project to \$100,000 each for seven other CAs: Family Planning Logistics Management (FPLM), FHI, the operations research project with The Population Council (Investigación Operacional para América Latina [INOPAL–3]), the Commercial Social Marketing Project, JHU/PCS, AVSC (now EngenderHealth), and JHPIEGO. Other CAs included the EVALUATON Project and the Georgetown University Natural Family Planning Project.

To implement the new field support policy, G/PHN/POP entered into a memorandum of understanding with each USAID Mission, agreeing to provide the services and to monitor and account for expenditures. In subsequent years, the procedures for the transfer of field support funds no longer required a memorandum of understanding. But Congressional restrictions called for metering the obligations of population funds, placing additional administrative burdens and delays on the Mission and creating problems for program implementation.

As USAID/Ecuador began to close out both the health and population sectors, it gradually reduced the number of CAs in its portfolio. During those final years, only the JHPIEGO, JHU/PCS, and FPLM projects were actively involved in providing support in family planning. Moreover, with limited Mission staffing and the need to reduce its management burden, the Mission used the two in-country technical advisors from JHPIEGO and JHU/PCS (both Ecuadorian nationals) to support the various local institutions in diverse areas, often beyond their official scope of work.

During the 1990s and until the end of the USAID population program, JHU/PCS and JHPIEGO focused their assistance on assuring the institutional sustainability of the two local NGOs, APROFE and CEMOPLAF. Among the various CAs that were invited to help in this endeavor, JHU/PCS and JHPIEGO continued throughout the entire process. They participated in the initial meetings with USAID and all the local partners that established the commitment to sustainability of the NGO institutions.

The skills of the in-country technical advisors varied. The local JHU/PCS technical representative had previously worked with CEPAR as its communications director and the JHPIEGO advisor had a medical background. Each had good management skills and with assistance from their headquarters, both were able to contribute to the transition process. Furthermore, as has been appreciated among most USAID-supported programs, an in-country presence allows for the provision of more effective technical assistance. Not only was the JHU/PCS advisor able to work on a day-to-day basis with the Ecuadorian institutions, but whenever needs were identified, he was able to seek out resources available from the home offices in Baltimore. In this manner, JHU/PCS was used extensively by the USAID Mission and the local NGOs beyond their primary purpose of reproductive health communications. For example, JHU/PCS responded to a CEMOPLAF request to develop new descriptions of the roles of the CEMOPLAF board members.

The various CAs that have worked in Ecuador and who often have access to funding sources other than USAID have left a legacy of contacts for the Ecuadorian institutions to access in the future. At the same time, the CAs look to the local NGOs whenever opportunities arise to carry out activities of a worldwide or regional nature, such as clinical or operations research.

XI. CONTRACEPTIVE COMMODITIES

In the early 1970s, APROFE was the first recipient of USAID–donated contraceptives, with some supplies provided to a small program with the Armed Forces. The shipments consisted mostly of condoms and oral contraceptives. In 1989, USAID began donating contraceptives to CEMOPLAF and the Ecuadorian Social Security Institute. Subsequently, other groups were included, such as COF, the Fundación Futura, Seguro Social Campesino, the Junta de Beneficencia de Guayaquil, and CEPAR (see tables 6 and 7). Since 1998, as USAID/Ecuador began its phase down of its population program, only APROFE and CEMOPLAF have received commodities. (Through an arrangement with CEMOPLAF, some condoms are also being transferred to COF.)

Among the early methods provided by USAID were oral hormonal pills, condoms, IUDs, and vaginal foaming tablets. In 1995, USAID began providing CEMOPLAF with Depo-Provera, the 3–month contraceptive hormonal injection. Although CEMOPLAF was the only recipient of USAID–donated injectable contraceptives, other similar methods (1–month injectable contraceptives) were obtained by APROFE from IPPF.

Although the family planning institutions offered a variety of methods, neither Norplant (the slow-releasing hormonal rods inserted subcutaneously into a woman’s arm) nor the female condom was requested from USAID. APROFE imports its Norplant supplies directly from the manufacturer in Finland because APROFE is the licensed product representative in Ecuador and has the registro sanitario (official health registration required for importation of brand name pharmaceutical products). Faced with the recent difficulty in obtaining the necessary registro sanitario for the future importation of vaginal foaming tablets, APROFE will not be able to receive the USAID shipments of that product as originally planned. If APROFE does not purchase the tablets locally, it appears that this method might not be available for future APROFE programs.

At the same time that the two NGOs had to prepare for phaseout of USAID contraceptive donations, the public sector program was faced with the cessation of UNFPA–donated supplies. In 1999–2000, the final year of UNFPA–donated contraceptives, approximately \$200,000 worth of contraceptives were provided to the MOH. Unfortunately, no technical assistance was provided to the MOH to help that institution during the transition or prepare them for future years. The MOH must now purchase its contraceptive needs with its own funds, and at times has found it necessary to curtail other activities in order to provide for contraceptive supplies. Since the public sector institutions serve as the source for more than 20 percent of all temporary methods that require regular resupply, there remains concern for future access to these contraceptives by the rural poor, who are the principal beneficiaries of the public sector programs.

CONTRACEPTIVE SUPPLY MANAGEMENT

Since the late 1970s, the Division of Reproductive Health of the Centers for Disease Control and Prevention (CDC/DRH) provided technical assistance to those Ecuadorian

institutions receiving USAID–donated contraceptives. Among the areas covered were contraceptive logistics management, contraceptive procurement, and the design of logistics management information systems. For many years CDC staff assisted in the preparation of the contraceptive procurement tables (CPTs).

In 1986, the logistics staff from APROFE, CEMOPLAF, the Armed Forces, the IESS, and the SSC received training in an early version of the contraceptive commodities management information system (CCMIS). Unfortunately, the CCMIS was never fully implemented by the institutions. Nevertheless, a 1993 assessment by CDC found that both APROFE and CEMOPLAF maintained excellent supply records and as a result, they were able to forecast contraceptive requirements and to prepare their CPTs. This was reconfirmed as recently as May 2000, when CDC consultants found that both CEMOPLAF and APROFE had computerized systems that produce complete and reliable data. The organizations have skilled personnel who readily learn the application of new management software for the preparation of CPTs and who are receptive to expanding the range of software tools.

It was also found that the IESS and the SSC lacked the logistics management skills and did not have either a functioning manual or computerized system to manage and monitor the distribution of contraceptives and the supply status of their clinics. It also appeared that the situation at the IESS was jeopardized by severe underreporting.

In the case of the SSC, the need to assure coordination of all components of a family planning services program, including supply management, provided a valuable lesson. In 1989, after a five-year interruption, the SSC family planning program was reinstated. However, because of the lack of contraceptive supplies, program implementation was delayed by a year until supplies were borrowed from APROFE and CEMOPLAF. With additional donated supplies from USAID, the SSC filled its pipelines to the maximum capacity, even though the assigned medical personnel had not yet been trained to dispense the family planning methods. A few years later, faced with large oversupplies at its service delivery points, the SSC had to return many contraceptives to the central warehouse.

Despite years of USAID–supported technical assistance to design and improve the contraceptive supply management systems, the various institutions often suffered stockouts. In 1993, CEMOPLAF was out of condoms for about 3 months, and all other recipients of USAID–donated commodities were close to experiencing stockout conditions for some methods. At that time, to prevent stockouts, the organizations borrowed supplies from and loaned them to each other. While this was not an ideal situation, it serves to illustrate the importance of developing a good working relationship among institutions that share a common goal (i.e., the provision of family planning services).

Inappropriate management by CEMOPLAF of the USAID–sponsored Newvern contraceptives database, lack of an inventory control of maximum and minimum stock levels, and inadequate planning for sufficient end-of-year stock levels were among the

causes for the 1993 situation (as reported by a CDC logistics management consultant). Unfortunately, the locally developed 1993 CPTs had set stockout as the desired end-of-year stock levels for both 1993 and 1994. This adversely affected estimates for both commodity and budgetary requirements.

The 1993 crisis was normalized with the arrival of a large shipment of USAID–donated contraceptives. As a precaution and concerned for future budgetary constraints, USAID requested that the institutions set their CPT maximum and minimum levels at 6 and 3 months of supplies on hand, and that the desired end-of-year stock be set at 6 months. For the 1995 CPTs, it increased the maximum level to 12 months and the minimum level to 6 months. In order to minimize the difficulties in processing the importation of commodities through local customs, the institutions preferred receiving one large annual shipment rather than various smaller shipments.

CONTRACEPTIVE SUSTAINABILITY

Since 1985 and planned for delivery into the year 2002, USAID will have supplied over \$5.6 million in contraceptive commodities to Ecuadorian family planning programs (see tables 6 and 7). The two largest recipients undoubtedly have been CEMOPLAF (\$3.0 million) and APROFE (\$1.7 million). During the final phase of USAID population assistance, the dollar value of the contraceptives was matched by both APROFE and CEMOPLAF to capitalize a contraceptive security fund.

APROFE and CEMOPLAF are now arranging to enter into procurement agreements with contraceptive distributors to replace the USAID–donated commodities. For the NGOs to assure their contraceptive commodity security beyond the termination of the USAID–donated product, they must also obtain necessary registros sanitarios, as in the previously mentioned case of APROFE and the vaginal foaming tablets.

Experience with other LAC family planning programs that have graduated from USAID–donated contraceptive assistance has shown that this transition period can be very lengthy. Negotiations with providers and the provision of importation licenses involve many steps. In most cases, therefore, USAID has gradually reduced the donated product over a planned phase down that covers at least two to three years. This has allowed the recipient organizations the necessary time to learn, experiment, and adjust, gradually taking on increasing responsibility. In the case of Ecuador, the process allows for large inputs of USAID contraceptives, with a sharp reduction in less than two years. Fortunately, the Mission has made arrangements to provide technical assistance over the next year from the centrally managed Contraceptives Logistics Management project. It is expected that this assistance will include working with the two NGOs to enable them to better manage their contraceptive supply logistics systems.

XII. POPULATION AND THE ENVIRONMENT

In recent years, USAID/Ecuador was one of the few LAC Missions to support activities that linked population growth and its implications for environmental degradation and conservation. For several years, the USAID/Ecuador Strategic Plan included Strategic Objectives (SOs) in both the health/population and the environment sectors. The Mission encouraged approaches that would benefit from the synergies of these two SOs that managed programs to meet the needs of rural populations.

In 1995, the Ecuador Mission welcomed the participation of the Population–Environment Fellows Program, located at the University of Michigan. That USAID–centrally managed activity places U.S. citizens with at least a master’s degree in population or a development-related field and with expertise in both population and environment to work with health and environment organizations in developing countries. Each fellow works in programs for two years. Activities include integrated community-based development programs that link population–environment with service delivery, securing buffer zone management, policy analysis and research of population–environment dynamics, and participatory rural analysis. Over the past six years, USAID/Ecuador sponsored three fellows that were assigned to the Ecuador Regional Technical Unit of The Nature Conservancy, which is headquartered in the United States. They worked in various sites, such as the national parks in the Galapagos Islands and Machalilla.

There were several other areas in which the Mission encouraged collaboration between the two SOs. In a joint effort with World Neighbors, CEMOPLAF has worked in six communities to integrate population and environmental issues by addressing health, agriculture, and natural resources. A CEMOPLAF study found that in only three years in the communities where the integrated approach was implemented, the level of family planning awareness rose from 35 to 78 percent, and at the same time, those farmers practicing soil conservation increased from 22.9 to 50 percent, and the use of chemical fertilizers for corn decreased from 55.6 to only 7 percent.

Another successful population–environment activity, funded by USAID through JHU/PCS, was Arcandina, a television program directed at children. The program uses a jaguar figure and other indigenous animals to promote conservation awareness. It helps children understand the links between population, health, and the environment, with the goal of achieving and sustaining positive environmental behavioral changes. With such programs as Arcandina, future generations of Ecuadorians will have greater appreciation for protecting the environment as well as protecting their health and that of their children through responsible family planning.

XIII. LESSONS LEARNED

GRADUATION FROM USAID ASSISTANCE

- In the design of a USAID Mission's Strategic Plan that intends to terminate assistance to the family planning and population programs, with assurance of sustainability beyond graduation, all parties involved, including public sector partners, local NGOs, cooperating agencies, and other donors, should participate fully in the process, providing input and reaching a general consensus.
- During the graduation period and the phaseout of USAID family planning and population assistance, which can take from three to four years, all parties involved need to stay on course.
- In addition to technical assistance provided in program areas such as social marketing, contraceptive technology, and IEC, USAID needs to assure that in preparing local NGOs for graduation, they receive assistance as needed in areas such as human resource management, leadership capacity, organizational values, and financial management.
- In preparing local NGO partners for graduation from USAID assistance, the creation of individual sustainability/endowment funds by which annual USAID contributions are linked to partner performance serve as a strong incentive for effecting necessary changes and as a useful tool in assuring financial sustainability.
- The Agency's requirements for immediate, measurable results, such as those submitted in the Mission's annual Results Review and Resource Request (R4) reporting document, are inconsistent with the inherently long process needed to achieve self-sufficiency of local NGOs that provide family planning services to the poorest segments of the population.

FAMILY PLANNING OR REPRODUCTIVE HEALTH NORMS AND SERVICE DELIVERY GUIDELINES

- In the design or update of national family planning or reproductive health norms and service delivery guidelines, full participation needs to be sought from service providers in the private as well as public sectors in order to assure ownership and full compliance.
- Prior to embarking on the preparation of family planning or reproductive health norms and service delivery guidelines, a strategic plan must be considered that will incorporate the three subsequent and critical phases:

dissemination of the norms and guidelines, implementation, and monitoring at the service delivery level.

- To allow for future modifications and/or changes to the often voluminous family planning or reproductive norms and service delivery guidelines, the printed copies should be bound in a format that allows for easy and inexpensive page replacement, such as a loose-leaf binder.
- As clinic-level family planning providers increase their access to computers and the Internet, the national family planning or reproductive health norms and service delivery guidelines need to be readily available on the web sites of all public and private health sector institutions.

NATIONAL POPULATION POLICY

- A highly professional, reputable, and technically well-prepared private nonprofit institution working in the field of demographic and health research and studies, coupled with its strong commitment to family planning, can have a valuable and effective role in formulating national population policies.
- A population policy that protects an individual's rights to plan family size and spacing and to have access to information and services in this regard, once incorporated into the national Constitution, provides the family planning programs with the highest level of legal protection and assures their survival, particularly in those developing countries susceptible to frequent changes of government.

NATIONAL REPRODUCTIVE HEALTH SURVEYS

- In programs in which USAID assists in health reform and the decentralization of public health systems, the investment in national reproductive health surveys or demographic and health surveys that produce provincial or state-level reports and analyses is beneficial to the process.
- As USAID and other donors continue to fund local organizations in carrying out national reproductive health and demographic and health surveys, additional technical assistance needs to be provided during the early stages to assure the institutional and financial sustainability of those organizations, to prepare them for marketing their services, and to allow them to conduct future similar surveys with or without international donor support.

INFORMATION, EDUCATION AND COMMUNICATION (IEC) ACTIVITIES

- Despite the long and costly investment of USAID and its cooperating agencies in the design and production of IEC materials, little attention is given to assure the future funding of these activities beyond the termination of donor support.

Technical assistance must be provided during the early stages to develop local capacity that will assure the future funding for and production of IEC materials.

- Consideration needs to be given by all donor and cooperating agencies that produce informational and educational materials on family planning and reproductive health to ensure that those materials are readily available to all relevant institutions in those countries in which USAID has graduated or terminated its population assistance.
- Training of family planning counselors should include direct observation of all interventions, such as Norplant and IUD insertions and male and female sterilizations, in order to provide them with knowledge of the methods offered, to allow them to advise with a strong sense of conviction, and to provide assurance and comfort to prospective acceptors.
- Posters and messages directed at sex workers and their clients in the promotion of condoms as prevention against HIV/AIDS and other sexually transmitted infections can unfortunately serve to dissuade responsible couples in condom use as a family planning method.

OTHER INTERNATIONAL DONORS

- Other international donors should consider the long experience of USAID and the more recent experience of UNFPA in Ecuador whereby, following the International Conference on Population and Development held in Cairo, UNFPA broadened its mandate to work with local NGOs, with excellent results.

WORKING WITH U.S. COOPERATING AGENCIES

- Because U.S. cooperating agencies in the population and family planning sector often have access to core and other USAID funds, they are able to keep activities on course, despite unavoidable delays in receiving Mission field support funds.

INVESTMENTS IN HUMAN RESOURCES

- USAID/Ecuador's investment in its locally hired staff working in the population and family planning sector can have a longer term benefit in relation to other development programs in the country.

CONTRACEPTIVE COMMODITIES

- Technical assistance in contraceptive commodity logistics management needs to be provided jointly with the provision of donated contraceptive supplies.

- Phaseover for the procurement of contraceptive commodities from a donor-supported program to that of local institutional responsibility is a long and difficult learning process and requires dedicated technical assistance and guidance.

POPULATION AND ENVIRONMENT LINKAGES

- For those USAID Missions that have Strategic Objectives in both the population and the environment sectors, consideration should be given to accessing such dual-purpose projects as the University of Michigan Population–Environment Program, which can be of mutual benefit to both SOs.

TABLES

TABLE 1
SELECTED DEMOGRAPHIC AND HEALTH INDICATORS
ECUADOR AND OTHER ANDEAN COUNTRIES

COUNTRY	INDICATOR					
	Percent of Population Under Age 15	Rate of Natural Increase (percent)	Infant Mortality Rate	Total Fertility Rate	Contraceptive Prevalence Rate	
					All Methods	Modern Methods
Ecuador	34	2.2	30	3.3	66	52
Bolivia	40	2.4	63	4.2	48	25
Peru	34	1.8	41	2.9	69	50
Colombia	32	1.8	21	2.6	77	63
U.S. (for comparison)	21	0.6	7	2.1	76	71

Source: Population Reference Bureau, 2001 World Population Data Sheet, PRB, Washington, D.C., 2001.

TABLE 2
PREVALENCE OF CONTRACEPTIVE USE AMONG SELECTED
LATIN AMERICAN COUNTRIES, BY METHOD USED
 (Percent of Women in Union, 15 to 49 Years of Age)

	Bolivia	Peru	Colombia	Nicaragua	Ecuador
USING A METHOD	48.3	64.2	76.9	60.3	66.3
Female Sterilization	6.5	9.5	27.1	26.1	23.1
Intrauterine Device	11.1	12.0	12.4	9.1	10.4
Oral Contraceptives	3.8	6.2	11.8	13.9	11.2
Rhythm	20.0	18.0	6.0	1.6	7.7
Withdrawal	2.3	3.2	6.3	1.0	6.3
Condom	2.6	4.4	6.1	2.6	2.7
Injection	11.1	8.0	4.0	5.2	3.4
Other	6.5	2.9	3.2	0.8	1.6
NOT USING A METHOD	51.7	35.8	23.1	39.7	33.7

Sources:

INE, DHS, *Encuesta Nacional de Demografía y Salud*, Bolivia, 1998.

INEI, DHS, USAID, UNFPA, UNICEF, Ministerio de Salud, *Encuesta Demográfica y de Salud Familiar*, Peru, 1996.

PROFAMILIA, DHS, *Encuesta Nacional de Demografía y Salud*, Colombia, 2000.

INEC, Ministerio de Salud, DHS, *Encuesta Nicaragüense de Demografía y Salud*, Nicaragua, 1998.

CEPAR, *Encuesta Demográfica y de Salud Materno e Infantil*, Ecuador, 1999.

TABLE 3
TRENDS IN PREVALENCE OF CONTRACEPTIVE USE IN ECUADOR, BY METHOD USED,
FOR THE COSTA AND SIERRA REGIONS*
(Percent of Women in Union, 15 to 49 Years of Age)

	ENF 1979	ESMIVD 1982	ENDESA 1987	ENDEMAIN 1989	ENDEMAIN 1994	ENDEMAIN 1999
USING A METHOD	33.6	39.2	44.3	52.9	56.8	66.3
Female Sterilization	7.8	12.4	15.0	18.3	19.8	23.1
Intrauterine Device	4.8	6.4	9.8	11.9	11.8	10.4
Oral Contraceptives	9.5	10.3	8.5	8.6	10.2	11.2
Rhythm	4.8	4.8	6.1	8.8	7.4	7.7
Withdrawal	2.3	1.5	2.0	2.5	3.5	6.3
Condom	1.0	1.1	0.6	1.3	2.6	2.7
Vaginal Methods	1.6	2.0	1.2	0.8	0.6	0.1
Injection	0.8	0.7	0.7	0.4	0.5	3.4
Other Methods	1.0	-	0.3	0.2	0.4	1.4
Modern Methods	26.5	32.9	36.2	41.6	45.9	52.3
Traditional Methods	7.1	6.3	8.1	11.3	10.9	14.0
NOT USING A METHOD	66.4	60.8	55.7	47.1	43.2	33.7
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0
Number of Women	3,919	1,113	2,957	4,776	9,146	8,668

* For purposes of comparison with prior surveys, the universe used in this table for 1999 includes only the Costa and Sierra regions, which represent 95 percent of the total population of Ecuador.

Source: CEPAR, Ecuador ENDEMAIN 1999, Informe General, enero de 2001, p. 8

TABLE 4
PERCENT DISTRIBUTION OF WOMEN IN ECUADOR USING MODERN
CONTRACEPTIVES, BY SOURCE OF METHOD, 1999

METHOD	PUBLIC SECTOR			PRIVATE SECTOR				Unknown/ No Response
	Total	MSP	Other	Total	Nonprofit	For Profit	Other	
Female Sterilization	62.7	37.2	25.5	36.6	3.8	32.6	0.3	0.7
Intrauterine Device	27.6	22.6	5.0	72.4	40.9	30.6	0.9	0.0
Oral Contraceptives	18.7	16.4	2.3	81.2	7.1	72.9	1.2	0.1
Injection	6.6	5.8	0.8	93.4	10.1	83.1	0.3	0.0
Condom	6.7	4.5	2.2	91.3	3.2	87.1	1.0	2.0
Other Methods*	4.0	2.5	1.4	96.0	41.5	54.5	0.0	0.0
Total, All Methods	38.5	25.5	13.1	61.0	12.8	47.5	0.6	0.5

*Other methods include vaginal methods, Norplant, and male sterilization, but do not include rhythm and withdrawal.

Source: CEPAR, Ecuador ENDEMAIN 1999, Informe General, enero de 2001, p. 93.

TABLE 5
TOTAL USAID POPULATION OBLIGATIONS AND EXPENDITURES IN ECUADOR
(in U.S. \$000s)

OBLIGATIONS FOR FISCAL YEARS 1997 TO 2001					
	1997	1998	1999	2000	2001
Bilateral	3,395	2,320	4,527	5,810	1,220
Field Support	405	380	978	990	27
Total	3,800	2,700	5,505	6,800	1,247
EXPENDITURES FOR FISCAL YEARS 1987 TO 2001*					
1987	\$1,973	1992	\$3,043	1997	\$3,800
1988	\$3,442	1993	\$1,100	1998	\$2,700
1989	\$1,817	1994	\$2,252	1999	\$5,505
1990	\$2,964	1995	\$2,944	2000	\$5,089
1991	\$1,425	1996	\$2,079	2001	\$4,949

*Amounts represent total USAID costs, including bilateral, regional, and USAID–centrally managed projects as well as costs for contraceptive commodities.

Sources: USAID Congressional presentations (various years); USAID/Ecuador: Financial Records; USAID Office of Population, *Population Projects Data Base, Annual Reports*.

TABLE 6
CONTRACEPTIVES DONATED BY USAID FROM 1985 TO 2000
AND PLANNED SHIPMENTS FOR 2001 AND 2002, BY YEAR
(Quantities Shipped and Value in U.S. \$000s*)

YEAR	CONTRACEPTIVES										TOTAL VALUE \$000
	Condoms		IUDs		Orals		Vag. Foam. Tabs		Injectables		
	Pieces (000s)	Value \$000	Units (000s)	Value \$000	Cycles (000s)	Value \$000	Tablets (000s)	Value \$000	Vials (000s)	Value \$000	
1985	270	11.3	5.0	3.7	40.8	6.3	-	-	-	-	21.3
1986	768	34.2	40.0	38.0	258.0	37.6	105.6	7.6	-	-	117.4
1987	150	7.0	20.0	20.0	31.2	4.6	-	-	-	-	31.6
1988	174	8.2	7.0	7.8	66.0	9.3	110.4	11.5	-	-	36.8
1989	1,962	96.1	57.4	62.3	199.2	27.0	120.0	12.2	-	-	197.6
1990	102	4.9	72.4	72.9	304.8	47.3	220.8	23.6	-	-	148.7
1991	2,562	139.7	62.4	69.3	188.4	30.8	168.0	18.6	-	-	258.4
1992	2,268	140.2	63.0	70.4	134.4	26.1	91.2	11.3	-	-	248.0
1993	3,180	191.2	69.6	79.5	328.8	61.5	278.4	27.3	-	-	359.5
1994	4,380	240.9	87.2	101.8	942.0	169.5	417.6	42.4	-	-	554.6
1995	3,672	190.0	149.4	181.6	217.2	42.2	48.0	5.1	21.2	24.3	443.2
1996	264	14.4	41.6	52.4	-	-	-	-	-	-	66.8
1997	1,224	74.4	87.2	113.6	-	-	-	-	-	-	188.0
1998	3,732	208.8	125.8	163.9	487.2	110.7	57.6	7.4	8.4	8.1	498.9
1999	4,914	283.6	186.8	256.6	1,156.8	294.3	19.2	2.6	17.2	17.5	854.6
2000	1,668	105.1	255.2	330.8	541.2	147.0	-	-	-	-	582.9
2001	8,358	541.5	101.2	169.8	732.0	177.5	-	-	-	-	888.8
2002	2,100	131.7	-	-	-	-	-	-	-	-	131.7
TOTAL	41,748	2,423.2	1,431.2	1,794.4	5,628.0	1,191.7	1,636.8	169.6	46.8	49.9	5,628.8

* Includes international shipping charges. Totals adjusted slightly due to rounding.

Sources: John Snow, Inc., FPLM Project, *NEWVERN Information System* Vol. 12, August 10, 2001; and USAID/Ecuador Revised CPTs, October 2001.

TABLE 7
CONTRACEPTIVES DONATED BY USAID FROM 1985 TO 2000
AND PLANNED SHIPMENTS FOR 2001 AND 2002, BY RECIPIENT INSTITUTION
(Quantities Shipped and Value in U.S. \$000s*)

RECIPIENT**	CONTRACEPTIVES										TOTAL VALUE \$000
	Condoms		IUDs		Orals		Vag. Foam. Tabs		Injectables		
	Pieces (000s)	Value \$000	Units (000s)	Value \$000	Cycles (000s)	Value \$000	Tablets (000s)	Value \$000	Vials (000s)	Value \$000	
APROFE	8,078	500.0	527	668.6	2,253	521.1	283	31.1	-	-	1,720.8
CEMOPLAF	25,708	1,463.4	763	967.6	2,016	449.5	854	87.3	47	49.9	3,017.7
CEPAR	24	2.0	12	12.0	-	-	-	-	-	-	14.0
COF	2,610	154.5	18	20.9	177	33.1	-	-	-	-	208.5
Armed Forces	720	31.4	29	28.2	240	32.4	216	19.1	-	-	111.1
FHI	-	-	-	-	1	.3	-	-	-	-	.3
FUTURA	3,006	181.9	-	-	-	-	-	-	-	-	181.9
IESS	1,146	63.7	24	28.6	403	71.6	29	3.8	-	-	167.7
Junta Benef. Guayaquil***	-	-	20	26.5	-	-	-	-	-	-	26.5
SSC	456	26.4	38	42.0	538	83.7	254	28.2	-	-	180.3
TOTAL	41,748	2,423.3	1,431	1,794.4	5,628	1,191.7	1,636	169.5	47	49.9	5,628.8

*Includes international shipping charges. Totals adjusted slightly due to rounding.

**Recipients: APROFE, CEMOPLAF, CEPAR, COF, Ecuador Armed Forces, FHI, Fundación Futura, IESS, Junta de Beneficencia de Guayaquil, SSC.

***The initial shipment of 10,000 IUDs to the Junta de Beneficencia de Guayaquil was lost in transit and replaced with a second shipment.

Sources: John Snow, Inc., FPLM Project, *NEWVERN Information System*, Vol. 12, August 10, 2001; and USAID/Ecuador Revised CPTs, October 2001.

APPENDICES

A. SCOPE OF WORK

B. PERSONS CONTACTED

C. REFERENCES

APPENDIX A
SCOPE OF WORK
(from USAID)

SCOPE OF WORK

FINAL REPORT ON FP/RH ASSISTANCE TO ECUADOR

Background: USAID assistance to Ecuador for family planning will end September 30, 2001. USAID/Ecuador is interested in carrying out a comprehensive review of accomplishments of the Mission's family planning program over the past twenty-five years, documenting contributions, accomplishments of the Ecuador Program to private sector family planning and reproductive health, and lessons learned, with emphasis on the most recent strategy period 1991-2001.

The current family planning activities are implemented primarily through two local NGOs, APROFE and CEMOPLAF, and field support contractors, two from Johns Hopkins University (JHPIEGO and the Population Communications Services Program, JHU/PCS). Over the years, Population Council, IPPF/WHR, John Snow, Inc. and other CA's have provided technical assistance with logistics, communications, social marketing and reproductive health services improvement. Note that the other major population NGO assisted by USAID, CEPAR, does not provide family planning services and will be a part of this evaluation mainly regarding its roles in providing survey data for reproductive health, and in reproductive health policy advocacy, development and results measurement. Reports from these CAs will be a source of data for the evaluation team, together with personal interviews and review of documents. Previous evaluations, assessments and reports should serve as reference documents and background for this final report.

Objective: The USAID Mission in Ecuador intends to review the legacy of family planning program in Ecuador after more than two decades of support. Each element should be evaluated in terms of whether strategic objective results have been met in a timely and effective manner, and how sustainable these achievements will be in the future without USAID presence. A consulting team, provided through the USAID/W managed contractor POPTECH, is required to evaluate the USAID Family Planning program. The team will visit Ecuador for a period not to exceed 25 workdays in country, under the supervision of USAID/Ecuador. Mission funding for this activity has been provided through Field Support funding to G/PHN.

I. STATEMENT OF WORK:

- A.** Activity to be evaluated: A consultant team, fluent in Spanish and English and knowledgeable of USAID's family planning activities, will examine the Agency's contribution to the Population/Family Planning Program of Ecuador during the past twenty years, with a primary focus on the private sector's role over the past decade. Ideal team composition would be one ex-pat Chief of Party and one Ecuadorian population specialist. From 1997 to 2001, the final years of this program, USAID concentrated its support in two elements: self-sustainability and institutional strengthening. The evaluation will also examine the program from a historical perspective and will focus on the USAID/Ecuador partner NGOs activities, effectiveness and sustainability, including lessons-learned.

- B.** Activity Management: Evaluate the adequacy and effectiveness of administration on the part of the partner NGOs, i.e., APROFE and CEMOPLAF. The focus should be on overall components management, meeting deadlines, monitoring and use of technical assistance.
- C.** USAID Role: Examine the effectiveness of USAID support, monitoring and management of the full program implementation. Special emphasis should be put on evaluating USAID's role in: 1) efforts to assure sustainability of APROFE and CEMOPLAF; 2) technical assistance coordination in organizing and coordinating external technical assistance for both NGOs; 3) support to strengthen each institution's capacity in terms of legal structure and administration.
- D.** Technical assistance/field support activities: To what degree have support activities conducted by Johns Hopkins University, JHPIEGO and other CAs been critical elements in the improved quality and access to family planning component.
- E.** Key questions to be answered: The evaluation team should place special emphasis on answering the following questions:

1. General Overview:

- 1.1 What is the history of USAID's involvement with the Ecuadorian population program, especially private sector's role?
- 1.2 What are the important lessons learned from the Ecuadorian experience?
- 1.3 Has there been collaboration between the public and private sectors? How has USAID worked with both sectors and encouraged or discouraged this collaboration?
- 1.4 What part have clinical services played in the overall strategy? (Not just those of APROFE and CEMOPLAF).
- 1.5 How programatically sustainable is family planning in Ecuador?
- 1.6 Has the program created economic access to services for low income populations and geographic/logistic access to under-served populations?
- 1.7 What part have demographic surveys (ENDEMAIN) carried out by CEPAR played, including their impact on policy, advocacy, sustainability?
- 1.8 How will the termination of USAID assistance likely affect the future of the program?

2. Project Management:

- 2.1 Have project management structures been functioning adequately? How have they improved in their ability to resolve funding and management problems? e.g., Management Committees; Sustainability Fund Committee.

- 2.2 Has USAID's effort to win the support of other donors for family planning activities been successful?
- 2.3 Have different USAID/E activities/projects been adequately coordinated resulting in mutual strengthening and more effective use of resources?
- 2.4 What is the institutional strength of these NGOs?

3. Quality and Access to Family Planning Services:

- 3.1 Have partner NGOs improved quality and access to family planning services?
- 3.2 How successful has the activity in clinics attending to indigeneous and rural populations been?

4. Technical Assistance:

With regard to the role of field support and CAs: Johns Hopkins University, JHPIEGO, John Snow, Inc., Population Council, IPPF/WHO, and other CA's providing technical assistance to improve reproductive health services, communications and management of contraceptive procurement:

Have field support TA activities had an impact on:

- 4.1 NGOs development of their capacity to train their own health and/or other personnel to promote, deliver, monitor and evaluate quality family planning services?
- 4.2 Marketing strategies, building capacity in Information, Education and Communication, strategic positioning and marketing of services.
- 4.3 Improvement in management of contraceptive procurement.

5. Cost Recovery/Self-sustainability:

- 5.1 How successful were both NGOs in achieving targeted percentages of sustainability? Including commodities and training.
- 5.2 How successful was CEPAR in achieving targeted percentages of sustainability?
- 5.3 Were sustainability issues addressed adequately?

6. Lessons Learned: Appendix

APPENDIX B
PERSONS CONTACTED

PERSONS CONTACTED

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT

USAID/Ecuador

Lars Klassen, Mission Director
Kenneth Farr, Population/Family Planning Strategic Objective Team Leader
Peter Natiello, Director, General Development Office
Paulina Martinez, SDE Office, Backstop on Population SO Team
Gustavo Carrera, Financial Director
Ken Yamashita, Deputy Mission Director, USAID/Peru (telephone interview)
(former USAID/Ecuador Health Population Officer)
Margarita Quevedo, former USAID/Ecuador Population Project Manager

USAID/Washington

Carol Dabbs, Bureau for Latin America and the Caribbean, Office of Regional
Sustainable Development (LAC/RSD), Regional LAC PHN Strategic Objective
Team Leader
Jennifer Luna, LAC/RSD, Ecuador PHN Coordinator
Lisa Luchsinger, G/PHN/POP, Ecuador PHN Country Team, G/PHN Point Person

GOVERNMENT OF ECUADOR

Ministry of Health

Carmen Laspina, National Director of Health Promotion and Protection
Patricio Jácome, Director of Health

Ministry of Economy and Finance, National Directorate of Health

Milton Coronel, Coordinator for World Bank Projects

ASOCIACIÓN PRO-BIENESTAR DE LA FAMILIA ECUATORIANA (APROFE)

Paolo Marangoni Soravia, Executive Director
Eduardo Landivar, Operations Director
Jenny Duarte, Finance Director
Miriam Becerra, Information, Education, Communication, and Training Director
Agustín Cuesta, Evaluation and Programming Director
Rita Perez, Director, APROFE Clinic, Milagro
Linda Rodríguez, Family Planning Counselor, APROFE Clinic, Milagro
Patricia Vaca, Supervisor, APROFE Clinic, Babahoyo
Francisca Aguilar, Information Promoter/Contraceptive Distributor, Tres Postes
Narcisa Archua, Information Promoter/Contraceptive Distributor,
Hacienda La Julia Medical Dispensary
Belgica Bajaña, Information Promoter/Contraceptive Distributor, El Porvenir, Baba

Rosa Villavicencio, Supervisor, APROFE Pilot Clinic, Guayaquil
Laura Silva, Supervisor Director, APROFE Clinic, Ambato
Marcelo Vaca, Pediatrician, APROFE Clinic, Ambato
Silvia Andrade, Family Planning Counselor, APROFE Clinic, Ambato

**CENTRO MÉDICO DE ORIENTACIÓN Y PLANIFICACIÓN FAMILIAR
(CEMOPLAF)**

Teresa de Vargas, Executive Director
Nadia Endara, Administrative Director
Mónica Arrellano, Technical Director
Edison Granda, Director of Finance
Alberto Loaiza, Director of Information, Education, Communication, and Training
María Eugenia Chávez, Director of Services Marketing
Gladys Mera de Matute, Medical Director, CEMOPLAF Clinic, Cajabamba
Natalia Espinosa, Medical Director, CEMOPLAF Clinic, Riobamba

CENTRO DE ESTUDIOS DE POBLACIÓN Y DESARROLLO SOCIAL (CEPAR)

María Elena Yépez, President and Acting Executive Director
Nelson G. Oviedo, Coordinator for Interinstitutional Relations

**CENTRO DE ORIENTACIÓN FAMILIAR EN SERVICIOS DE SALUD SEXUAL
Y REPRODUCTIVA (COF)**

Orlando Batallas, Executive Director
Ernesto Batallas, Deputy Director

JUNTA DE BENEFICENCIA DE GUAYAQUIL

Luis Torres, Technical Director, Enrique C. Sotomayor Maternity Hospital

**JOHNS HOPKINS UNIVERSITY/POPULATION COMMUNICATION
SERVICES PROJECT**

Pablo Palacios, Ecuador Technical Advisor in Residence
Alice Payne-Merritt, Baltimore, Maryland (telephone interview)
Marcela Aguilar, Baltimore, Maryland (telephone interview)

JHPIEGO

Edgar Nicochea, LAC Regional Advisor, Baltimore, Maryland
(telephone interview)

UNITED NATIONS POPULATION FUND (UNFPA)

Office of Ecuador Country Resident Representative
Mario Vergara, Deputy Country Representative

**CARE INTERNATIONAL—SUPPORT TO LOCAL ORGANIZATIONS
PROJECT (CARE—APOLO)**

Ivan Palacios, Project Director

SEGURO SOCIAL CAMPESINO

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APPENDIX C

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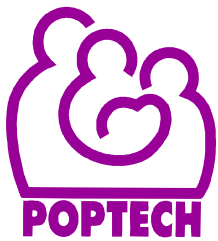
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