USAID/ECUADOR

STRATEGIC OBJECTIVE No. 2 – FAMILY PLANNING AND HEALTH

CLOSE-OUT REPORT (Health)

BACKGROUND DATA:

Title:	Child Survival and Health Project
Number:	518-0071
PACD: Original	December 31, 1994
Revised – Amendment # 8	May 31, 1999
Revised – Amendment # 9	September 30, 2000
Implementing Agencies Under the Bilateral Agreement:	Ministry of Public Health CEPAR CARE
Other Implementing Organizations/Institutions:	Center for Human Services/University Research Corporation Escuela Superior Politecnica del Litoral Academy for Educational Development The Pan American Health Organization

DISCUSSION:

The Child Survival and Health Project had to phases: (I) From June 7, 1989 through December 31, 1994 with a life-of-project funding of US$12,200,000 and a geographic coverage of eight provinces. (II) From January 1995 through May 31, 1999. Phase II was then extended through September 30, 2000. The life-of-project funding was increased to US$18,000,000 and a nationwide geographic coverage was authorized, but direct disbursements by Provincial MOH offices was eliminated in this phase.

Phase I was implemented through the Ministry of Health with technical assistance from Management Sciences for Health. A project implementation letter dated June 8, 1998 was prepared to summarize major accomplishments and formally close out Phase I.

Phase II was authorized as a response to the substantial changes that took place in the Ecuadorian health sector during the period 1989-1994, and also to bring the project into line with USAID's new health policies as described in "Strategies for Sustainable Development" issued in March 1994. Another factor that had major influence on reorienting the objectives of the USAID Child Survival Project was the design and initial implementation of a US$100 million public sector health project funded by the World Bank (FASBASE). In addition, the need to expand and improve the role of the private sector to serve as the principal producer of health services in the country, especially for population other than the poor, and least but not less the recommendations of the external evaluation of the project carried out in 1993

Current report will concentrate on activities carried out under Phase II. In order to define the activities to be performed under this phase, two main documents were prepared: (1) Amendment # 1 to the Project Paper signed on July 19, 1994, and (2) Amendment # 8 to the Bilateral Agreement dated January 31, 1995. Starting in 1995 three different components were identified: (1) A Ministry of Health Public Policy Reform; (2) Policy Analysis and Promotion, and

(3) A Nongovernmental Program Strengthening. For the initial implementation of Phase II, the project had a balance of approximately US$2,400,000.

Component two was implemented through a cooperative agreement No. 518-0071-A-005133-00 with a local nongovernmental organization (CEPAR) signed on May 2, 1995. The total funding was US$2,400,000. CEPAR was required to implement its activities in four specific areas: (1) Policy information and dissemination; (2) Policy advocacy; (3) Policy analysis, and (4) Policy database. Major accomplishments will be discussed under section “Accomplishments achieved”.

Component three was implemented through a cooperative agreement No. 518-0071-6-00-5126-00 with a private voluntary organization (CARE) signed on March 31, 1995. The total funding was US$3,535,450. CARE was required to develop replicable models of privately produced Child Survival/Primary Health Care (CS/PHC) services capable of recovering operational costs, which will serve as demonstration models and field experiments of new ways of producing and distributing primary health care services to poor populations. Major accomplishments will be discussed under section “Accomplishments achieved”.

Also, as a support to field activities and to the health reform process, some other contracts/grants were awarded, as explained below.

In March 1996 a contract with the Center for Human Services No. 518-0071-C-00-00-6047-00 was signed in the amount of US$169,884. The objective of this contract was to implement quality improvement activities in selected health areas through training activities. A total of twenty quality improvement microprojects were designed and developed in the provinces of Pichincha, Azuay, Guayas, Chimborazo, and Bolivar. The contractor was also responsible for the design and reproductiion of training materials and guidelines for quality assurance, and the execution of two projects on operational research in health services. This contract ended in June 1997.

In addition, in March 1996 a grant to the Escuela Superior Politecnica del Litoral No. 518-0071-G-00-6029-00 was awarded in the amount of US$110,152. This grant was modified in July 1996 and in June 1997 to increase the total life-of-funding to US$188,768. The purpose of this grant was to provide technical and financial support for the implementation of two post-graduate programs in Management of Health Services. The program was the answer to a serious shortage of expertise in management and health economics in the public sector. Both programs had a duration of one year. Participants attended a one-week course every month. A total of 28 scholarships to MOH employees were approved. Technical assistance was provided through the Association of University Programs in Health Administration (AUPHA). The program had local and international teachers and advisors. This program was also open to NGOs and private sector participants with different funding. A survey was prepared by the technical office and distributed among participants to evaluate the results of the programs. The results of the evaluation were positive. Participants indicated that all modules were very interesting, however they highlighted four areas in particular: (1) Strategic Planning; (2) Human Resources Management; (3) Information Systems; and (4) Financial Resources Management. A great percentage of participants is applying new techniques and skills in their current management positions. Some of them were promoted to senior positions. This grant ended in December 1997.

In September 1997 a task order to the Academy for Educational Development (AED) HNE-I-803-96-00018-00 was approved with a total funding of US$124,900.82. AED through the Global Communication and Learning Systems activity (LearnLink) provided technical support to a local NGO (CEPAR) to: (1) strengthen its ability to exchange information and utilize learning systems by enhancing its communications and networking capabilities, and (2) increase its sustainability option by developing information and education services with more efficient and efficacious processes. Technical assistance was provided through third country specialists in the following areas: Information systems; computer network/internet; telecommunications; information and communication, and web design. As a result of this activity CEPAR has strengthened its

informatics capability for internal use and is also able to offer their services to other NGOs. Some of the products developed under this activity are: (1) A webpage for CEPAR; (2) an online version of CEPAR's "Correo Poblacional y de la Salud" magazine for a broader national and Ecuadorian regional presence; (3) CEPAR's electronic network/linkages capabilities among different health and population NGOs and institutions in Ecuador. During the implementation process there were some delays in the procurement process. Some equipment purchased under AED order was the basis for the continuation of international technical assistance. In addition, the lack of a local AED representative made the implementation process much more difficult. This task order was originally approved for a period not to exceed 18 months, however it was implemented in 30 months, thus the task order ended in March 2000.

In September 1997 a contract with Basic Health Management, Inc. HRN-6006-C-00-3031-00 was signed in the amount of US$71,585.71. The purpose of this contract was to perform a mid-term evaluation of the bilateral agreement with the MOH, the cooperative agreement with CEPAR and the cooperative agreement with CARE. Findings and recommendations for each project component were identified and discussed with each coordinator. Many actions were taken as a response to the evaluation. For example, the signature of an agreement with the MOH to lease its subcenter in Chordeleg to avoid duplication of activities; greater attention to Sta. Elena as comprehensive model; and USAID intervention with CEPAR & CARE to more effectively work together. A recommendation that was not feasible to apply was the reactivation of the Project Executive Committee due to the instability of MOH authorities. The contract with Basic Health Management, Inc. ended in May, 1998 and the total amount spent was US$69,241.96,

In April 1998 a grant to The Pan American Health Organization (PAHO) No. 518-G-00-98-00014-00 was awarded in the amount of US$178,589. These funds were originally assigned to the MOH, however due to the low capacity of the MOH in the implementation of activities and the need to provide a response to El Niño phenomenon in Ecuador, the technical office suggested that MOH funds be used for the procurement of vaccines, syringes and cold chain equipment, as a multidonor effort to a vaccination campaign. This grant ended in June 1998.

ACCOMPLISHMENTS ACHIEVED:

A. CARE – Major outputs planned by the end of the agreement follow:

1. Approximaely 25 private sector entities engaged in expanding their CS/PHC service delivery base.

   A total of 75 local NGOs were strenghtened through specific technical assistance, training, and/or financial support. However, during the life of the project only 10 NGOs received the complete package. During the last year of implementation CARE/APOLO concentrated its efforts particularly in 4 NGOs: ASME-CX in Santo Domingo, Pichincha province; Clinica Cristo Redentor in Santa Elena, Guayas province; Fundacion Humanitaria Pablo Jaramillo in Cuenca, Azuay province; and a Health Project with the participation of the MOH, the Municipality and the Church, in Chordeleg, Azuay province.

2. Approximately 10 private sector entities capable of recovering 100% of their health service operational costs.

   Taking into account the level of development of the 10 organizations selected, CARE in coordination with USAID/Ecuador classified the NGOs receiving the complete package (techical assistance, training and financial support) in three differente categories, and agreed that 100% cost recovery not realistic (see targets in R4 tables as approved by AID/W). Data on cost recovery at the end of the project follow:

   Category A: 50 – 80% cost recovery:
   Fundacion Humanitaria Pablo Jaramillo, 75.8%

ASME-CX, 88.3%
CEMOPLAF/Otavalo, 82.6%
CEMOPLAF/Lago Agrio. 80.2%

Category B: 20 – 50% cost recovery:
Clinica Cristo Redentor, 90.6%
Chordeleg, 69.8%
Municipality of Bolivar, 43.1%

Category C: 0 – 30% cost recovery:
Funedesin, 20% (data FY99)
Diocesis of Riobamba, 20% (data FY99)
Pedro Vicente Maldonado, 20% (data FY99)

3. Development and market testing of approximately four currently non-existant (in Ecuador) PHC financing mechanisms, such as prepayment, shared risk, employer purchased services, and public sector purchasing of privately produced services.

   Four innovative financing mechanisms were developed: (1) Focalized subsidy through "Plan Carnet", Pablo Jaramillo; (2) Shared risk in Santa Elena, ASME-CX and Pablo Jaramillo; (3) Franchising in ASME-CX, and sales of services in Santa Elena and Bolivar.

4. Development of a package of programmatic and administrative tools which can serve as guidance to any private sector organization desiring to improve efficiencies and increase coverage of CH/PHC services.

   A total of 13 instruments were developed:

   1) Institutional analysis.
   2) Rapid feasibility study methodology.
   3) Qualitative research in social marketing.
   4) Focused subsidy model.
   5) "Plan Carnet".
   6) Decentralization of health services.
   7) Costs Handbook for Primary Health Services.
   8) Operationalizing Equity.
   9) Integrated Maternal Childhood Illness – a partnership working experience.
   10) Partnership Work and Health Reform in Latin America.
   11) Decentralization – From theory to practice and from practice to theory.
   12) Case Study - CEMOPLAF/Otavalo.
   13) Case Sutdy – CEMOPLAF/Lago Agrio.

5. Implement at least one pilot project which introduces the concept of "health vouchers" and other market mechanisms that improve the targeting of health sector expenditures to the poorest and most vulnerable population groups.

   CARE introduced the concept of "health vouchers" in two organizations:
   CEMOPLAF/Otavalo – focused subsidy to population at risk.
   Fundacion Pablo Jaramillo – applied to the marketing program.

6. Carry out at least six training events during each year (30 in total).

   During the life of the project a total of 117 training events were promoted. 1,848 women and 884 men participated. A total of 2,732 participants. Types of training provided included areas such as: strategic planning, costing, accounting, financial procedures,

risk assessment, primary health care, nutrition, reproductive health, health education, among others.

B. CEPAR: Major outputs achieved by the end of the agreement follow:

1. Preparation of a comprehensive analysis of the weaknesses of Ecuadorian health sector policies and a presentation of those policy reforms and structural changes ranked in priority order needed to modernize the health sector.

   This analysis was completed, published and diseminated during the second semester of the project.

2. Carry out a number of policy fora aimed at improving market conditions and market environment for greater private sector participation.

   CEPAR through its Information, Education and Communication component has supported a great number of publications, bulletins of public opinion and faxes to disseminate information regarding the health reform in Ecuador and other health issues of general interest. In addition, CEPAR has supported a number of fora/seminars to promote greater participation of the private sector and their commitment to improve health conditions in Ecuador. For further details please refer to number 4 below.

3. Carry out a select number of advocacy activities.

   During the life of the project CEPAR carried out a significant number of advocacy activities at central, provincial and local level. CEPAR has assisted different Ecuadorian institutions such as: The Ministry of Health; the National Health Council; the Health Commission of the National Congress; the Social Security; Municipalities in Cuenca, Cotacachi, Tena among others; Universities from different provinces and NGOs working in the health area. CEPAR has also assisted the Panamerican Health Organization, the World Bank, the Interamerican Development Bank. In addition, CEPAR has worked with international organizations/programs such as: Partnerships for Health Reform, Harvard University, among others.

   Below are some of the national processes supported by CEPAR :

   - ✓ Analysis of health sector reform proposals in Ecuador.
   - ✓ Formulation of the National Health Policy.
   - ✓ Definition of roles, functions and competences of the Ministry of Health.
   - ✓ Consensus on constitutional health reforms.
   - ✓ National Health Plan (Local Strategic Planning in Health).
   - ✓ Formulation of the Strategic Plan for the National Health Council.
   - ✓ Participative Formulation of the National Health System.
   - ✓ Conformation of the Health Sector Non-Governmental Organization Forum.
   - ✓ Network of Health Resouces Schools and Faculties.
   - ✓ National Human Resources Policy for the Health Sector.
   - ✓ Essential functions of the Public Health.

4. Carry out policy dialogue and policy leadership training activities.

   During the five years of project implementation, CEPAR carried out 259 policy dialogue and policy leadership training events per year. Participants included women (5353) and men (6630) from public and private institutions/organizations. Although, training events

took place in 19 provinces and 28 different cities, CEPAR made the necessary arrangements to have a nationwide coverage. Some of the topics of the seminars follow:

- ✓ Health policies and health sector reform.
- ✓ Roles and functions of the Government (Estado) in health.
- ✓ Health situation at national, provincial and local level.
- ✓ The burden of disease: indicators, problems and determinants.
- ✓ The National Health System: Population and health.
- ✓ Strategic Planning in Health.
- ✓ The Non-Governmental Organizations in the health sector.
- ✓ Economy and Health (National Health Accounts).
- ✓ Information systems in health.
- ✓ Information and Communication.
- ✓ Political Mapping.
- ✓ Health Education,
- ✓ Design and project evaluation.

5. Sponsor health policy analysis with participation from different national and private sector representatives.

CEPAR has promoted a series of policy analysis events with the participation of representatives from the Government at central, provincial and local level. Other participants included members of the Municipalities; the Church; Education sector; Social Communication; Social Welfare; Rural Development; Peasant Organizations; Women's Groups and different users of CEPAR's services. These events have been carried out in coordination with the Ministry of Health, the Social Security, the National Health Council, PAHO/WHO, universities and numerous local and international NGOs.

As a result of these events, there was a consensus on the need to reformulate the health sector by introducing a series of changes to improve its organization, management, financing and service delivery models. It was also decided that there is an urgent need to formulate State Policies in the health sector and improve the coordination levels among the different health actors.

As a response to the requirements mentioned above, four specific actions were taken:

1) The conformation of the Non-Governmental Organizations Forum in Pichincha province. Other forums are also in process in the Austral Region and Guayas. It is also expected the conformation of a National NGO Forum as a mechanism to improve coordination with the Ministry of Public Health.
2) In the decentralization perpective, it was important the actions taken by the project for the support and/or the generation of provincial and cantonal nucleus of participative management in health and sector reform. This initiative supported by CEPAR was approved by the National Health Council in 1996.
3) Support to the Ministry of Health in the formulation of National Health Policies through the organization and execution of regional seminars nationwide. This proces contributed to the formulation of a National Health Policy and the introduction of a Health chapter into the Public Constitution of the Republic.
4) Support to the National Health Council and to the National Health System. It is expected that after the corresponding analysis, this system be approved and enter into effect for the organization and functioning of the health sector.

6. Carry out at least two major national level surveys and at least five limited research activities. During the life of the project the national health and demographic survey (ENDEMAIN-94) was completed, published and disseminated. Specific reports by provinces were also published and disseminated in a series of training events.

The second survey corresponds to ENDEMAIN-99. The whole process was carried out by CEPAR with the technical assistance of the Centers for Disease Control. For the first time, this survey included the Oriente and Insular regions. A general report and a total of 19 provincial and regional reports have also been completed. This survey contains data to study the differences and fecundity tendencies; infant mortality, contraceptive prevalence; maternal and infant health. This last survey also includes: domestic violence; gender roles; practices, knowledge, and attitudes regarding sexually transmitted diseases and AIDS; health care; women labor aspects, among others.

Per the data provided by ENDEMAIN-99 the current infant mortality rate is 30/1000. Taking into account that in 1994 the infant mortality rate was 40/1000, there is an important 25% reduction. The goal of the project was precisely to reduce the infant mortality rate to 30/1000.

In addition to these two important surveys, CEPAR has carried out far more than five research studies as indicated below:

- ✓ Health Reform in Ecuador: 1992-1997
- ✓ Decentralization of primary health care programs in Ecuador. Management of health areas.
- ✓ Subproject of decentralized health system in Cotacachi, Imbabura province.
- ✓ Major functions of the Public Health: Challenges for the development of human resources facing the health reform.
- ✓ Management capacity within health institutions in the public sector.
- ✓ Characterization of beneficiaries in health services.
- ✓ Ecuador: Demographic, socio economic and epidemiologial characterization.
- ✓ Women health situation.
- ✓ The burden of disease in Ecuador.
- ✓ Health conditions and life quality in Cotacachi.
- ✓ Estimation of national health accounts.
- ✓ Health financing study in Ecuador. Segment: household health expenses.
- ✓ Cost and effectiveness of health interventions. Methodological strategy for improving efficiency, allotment, distribution and use of health resources.
- ✓ Situation of the health international cooperation to countries in the Americas: Ecuador case.
- ✓ Health Reform in Ecuador 1997-2000.

7. Establish a data base of technical information on the health sector.

In response to one of the requeriments of the Cooperative Agreement, CEPAR during the life of the project significantly improved and expanded its informatics services. Actually, CEPAR has an Informatics System (SICEPAR) available for internal and external users.

The SICEPAR is an important instrument for the analysis, promotion and implementation of health policies, for institufional strengthening purposes and as a valuable support for project activities.

The SICEPAR is an intitutional system that makes possible the optimization of record processing and recovery of information on health, population and social development. The SICEPAR is a computarized system that allows the management of information for registering and data consultation. The SICEPAR consists of four major areas, as detalied below:

1) Statistical Information (data, graphics and summaries of studies produced by CEPAR);

2) Documental Information (reference material, national and international documents, mass media summaries, videos);

3) Health Information (epidemiological profiles with socio-economic and morbi-mortality data; financing information: costs of services by type of provider, financing schemes, actual patient expenses, payment capability, etc; quantification by type, location and characteristics of health human resources; quantification of providers by: type, location and health services provided up to cantonal level.)

4) External Information (data bases in magnetic forms such as: Popline by the John Hopkins University; Survey on Life Conditions by the Ecuadorian Statistics Institute-INEC; Population Projections of Latin American Countries by CELADE, among others.

SO 2 RESULTS

The health project is part of the whole SO2 "***Increased use of sustainable family planning/maternal child health services***". It has a common objective and four intermediate results, two for family planning and two for health.

SO Indicator: Number of visits by women and children 1-5 using improved/expanded MCH services.

From FY 1997 through FY 2000, there was a target of 352,000 visits by children and 694,000 by women. Final data indicates a total of 1,267,000 visits by children and 743,000 by women were registered. This represents a 359% of accomplishement in the first case, and 107% in the second case. This high totals were due to inclusion of all visits to MOH centers where any QA or RPM activities look place-a factor later discounted as appropriate in FY1999 and FY 2000.

IR3 – Improved quality and access of MCH services.
Indicator: Number of service delivery points with improved/expanded packages of maternal/child health services.

From FY 1997 through FY 2000, the target was 380 service delivery points (SDPs) improved. The results indicate that a total of 2,954 SDPs were improved/expanded. This represents an overall accomplishment of 777%. It is worth mentioning that in these figures also included activities implemented as part of the centrally funded projects, like IMCI, QA, and RPM that received additional funding from the bilateral agreement. The original target did not adequately take this into account.

IR4 – CARE-APOLO supported NGOs achieving specific degree of cost recovery.
Indicator: Number of NGOs recovering percentage of total budget.

In 1997 it was decided to divide the NGOs in three different categories depending on its level of development. By the end of the project it was expected the following percentajes:

4 NGOs at 80%
3 NGOs at 50%
3 NGOs at 30%

Per the information provided by CARE, 6 NGOs have an average cost recovery of 94%. For the other 4 final data for FY 2000 is not available, however in FY99, the remaining 4 NGOs exceeded the level planned.

INPUTS AND RESOURCES EXPENDED

During the life of the project international technical assistance and some training was provided to the three project components including technical assistance from: Quality Assurance/University Research Corporation; Integrated Maternal Childhood Illness/Basic Support for Institutionalizing Child Survival; Rational Pharmaceutical Management/Management Sciences for Health; Partnerships for Health Reform/Abt Associates Inc.; Harvard University; FUNSALUD; Clapp & Mayne Inc., Initiatives Project; Academy for Educational Development, among others.

In addition, as part of project activities some training events and observational visits were approved for MOH, CEPAR and CARE staff, as indicated below.

MOH

II Latin American Conference on Health Education and Promotion, Santiago, Chile.

CEPAR

- Health in the development process of Chile, Santiago de Chile, Chile.
- Health Economics at the University of Liverpool, Manchester, London.
- VII Latin American Congress on Social Medicine, Buenos Aires, Argentina.
- Visit to Fundacion Mexicana para la Salud, FUNSALUD, Mexico.
- Training on Sociodemographic information for the health sector, Santiago de Chile, Chile.
- Observational visit to learn about the Bolivian experience in reform, decentralization and popular participation, La Paz, Bolivia.
- Management based on activities for NGOs, organized by INCAE, San Jose, Costa Rica.
- II Latin American Workshop on Health Reform, San Cristobal de las Casas, Chiapas, Mexico.
- Dialogue and Consensus Building on Health sector reform, Santo Domingo, Dominican Republic.
- V Latin American and the Caribbean Congress on Fund Raising, San Jose, Costa Rica.

CARE

- Observational visit to PROSALUD, La Paz, Bolivia.
- Monitoring and evaluation training in CARE/Peru.
- Management based on activities for NGOs, INCAE, San Jose, Costa Rica.
- National Conference on International Health, Washington, D.C.
- Family Planning Worshop, Guatemala.
- Executive Course in Health Financing and Sustainability, Boston, Massachusetts.
- Regional Worshop in Management, CARE/Guatemala.
- Workshop on Information, Education and Communication in Reproductive Health, Lima, Peru.
- Regional Workshop on Health Reform, CARE/Peru.
- Marketing of Health Services and Human Resources Management, PROSALUD, La Paz, Bolivia.

RESOURCES EXPENDED

Per the terms and conditions of Amendment # 8 to the Bilateral Agreement, it was agreed that the total life-of- project-funding would be US$18,000,000, that is, an increase of US$6,300,000 to the original budget, however by the end of the project the total funding obligated was US$17,573,853. It is worth mentioning that most of the technical assistance was directly financed through centrally funded projects.

A summary of obligations, commitments, expenditures and pipeline, as of 12/05/00 follow:

Project Elements	Authorized	Obligated	Committed	Expenditures	Pipeline
MOH Support	9,833,769	9,575,059	9,575,059	9,524,839	50.220
CEPAR Support	2,613,209	2,150,000	2,150,000	2,150,000	0
CARE Support	4,176,793	3,635,450	3,635,450	2,800,000	835,450
USAID Support	1,376,229	2,213,344	2,192,169	2,092,800	120,544
TOTAL	**18,000,000**	**17,573,853**	**17,552,978**	**2,092,800**	**1,006,214**

Under the line item MOH Suppport, there is still an expenses report that need to be submitted. In addition, the external audit for the period 1998-2000 will be covered with these funds. The unspent balance will be liquidated through a project implementation letter.

Under the line item CARE Support, there are several advice of charges that need to be submitted by AID/Washington. According to our records, expenses have been posted until December/99. Per the information provided by CARE/Ecuador, all remaining funds were fully liquidated by the end of the C.A.

Finally, the balance under the line item USAID Support will be reduced once all FSN salaries are fully liquidated. There is at least one FSN-PSC that will be partially paid with these funds until next September 30, 2001.

LESSONS LEARNED

1. The implementation of a project in an environment of political changes and economic and social crisis is really challenging. During the five years of the project Ecuador had five Presidents, six Ministers of Health, eight Subsecretaries and six General Directors. The counterpart authority for the project was the General Director. This instability has seriously limited the development and impact of project activities in public health reform and within the Ministry of Health. The health reform has been a difficult, long and awkward process.

2. Health reform implies a number of technical decisions, however it is necessary to point out that technical procedures are created and decided in conjunction with political authorities and in the middle of bureaucratic atmospheres. Although the Government has primary responsibility to implement changes and provide better access to services to the population, it seems the MOH can not given its political weakness in the sector, the lack of leadership, the crisis of the last years, the lack of human and financial resources and the social tension.

3. The country requires an agile and efficient Ministry of Health, in order to guarantee health protection to the Ecuadorian population, as a main condition for the health reform. The MOH also need to strengthen its management functions such as: planning, organization, coordination and evaluation.

4. The reform process needs to be able to continue with support from a wide variety of participants, regardless of the presence or absence of USAID, CEPAR and CARE.

5. As it was mentioned, the bilateral agreement had three different actors, the MOH, CEPAR and CARE. Each one with specific activities to accomplish and the same overall objectives. In this perspective, it would have been much more valuable if the individuals responsible for the three components would have understood that they were members of a single Child Survival team. During the implementation process CEPAR and CARE sometimes gave the

impression that they were competing each other or ignored coordination opportunities. USAID intervention was necessary to develop an integrated vision of the project and instill a team approach. Although some adjustments were made by CEPAR and CARE, each organization had its particularities that not necessarily benefit the project. A permanent flow of communication between the three partners could have lead to a more effective integration of activities.

6. The coordination among different public and private health actors promoted byCEPAR has been valuable, particularly with the Ministry of Health, the National Health Council, the NGOs Forum, the Social Security, among others. CEPAR's initiative to promote partnerships among national and international organizacions to organize training events and the promotion of project results has been crucial in a period of continuous change.

7. The support provided by CEPAR to local demonstration projects, like the Decentralization of Health Services in Cotacachi has contributed to local development.

8. Although the crisis in Ecuador and the inconveniences within the public sector, CEPAR has been able to support national projects, such as: the Definition of roles and functions of the Ecuadorian Government (Estado) in the health sector; the strengthening of the National Health Council and the participation in the formulation of the National Health System.

9. The series of training events and worshops promoted and encouraged by CEPAR provided the opportunity to discuss and analyze different health reform proposals with a great number of health sector officials. As a result of these events the general consensus was the urgent need to reform health policies and modernize the sector. Some initial actions have heen taken, however the process still continues

10. A significant contribution to the country and the health sector in particular has been the delivery of information, education and health communication materials. The magazine "Correo Poblacional y de la Salud" was one of the mechanisms to share opinions about health conditions in Ecuador, social policies and health reform. This relatively expensive magazine will now be distributed at low cost electronically, to a much more targeted audience.

11. CEPAR has generated a significant number of studies and operational research analyses aimed at improving and designing service delivery programs and to educate Ecuadorians and authorities working in the health sector about specific topics such as: decentralization, primary health care, health reform status since 1992, historic development of health policies, health financing in Ecuador, among others. This information has been provided as a contribution to the health reform process.

12. The implementation of a project through contractors diminishes the involvement of USAID. This has both pros and cons. One of the negatives was that in several instances the source of financial support for CARE/APOLO activities was not sufficiently acknowledged. NGOs working under the umbrella agreement with CARE didn't know that USAID was the main financial source for the implementation of activities.

13. The indirect costs of an international NGO like CARE are relatively high and when applied to the management of subgrants directed at improving local organizations and services, may significantly reduce the amount of funds available for the local beneficiaries. It is therefore important that an umbrella grantee like CARE, carefully analyze the pros and cons of directly managing subgrants vs. transfer of funds and responsibilities to lower cost local organizations, both to reduce costs and develop local capability. USAID should closely monitor this issue during review of annual work plans and budgets of grantees.

14. A monitoring of the budget is required to clearly define the type of expenses that are expected under each line item, however, under a letter of credit (as authorized under the CARE CA), expense reports are not submitted on a regular basis. In the C.A. with CARE, eight line items were identified and each one with a very specific purpose. However the funds for the subgrants to local NGOs were also; directly managed by CARE and the organizations felt uninformed and having too little participation budget decisions.

15. A close monitoring of a project in each implementation phase is mandatory. Although USAID receives reports on a regular basis, it makes a significant difference when the officer goes to the field. It is the only way to keep a serious track of the activities and an alternative to show USAID's presence.

16. All demonstration models implemented under the C.A. with CARE have strengthened their organizational capabilities through technical assistance and training events. NGOs have increased services and coverage indicators. In addition, NGOs understand the importance of recovering costs and long-term sustainability. The demonstration models financed by USAID should be adequately analysed and evaluated by Government authorities to find out alternatives for its replication.

17. All demonstration models have some common characteristics: all are supporting in one way or another the health sector reform perspective because they propose innovative changes; all models have as center of its proposals the deconcentration and decentralization strategy; most of the models have considered the municipalies as key actors at local level; one of the main coincidencies of the different models is the concept of integrated health; a common characteristic in the statement of the supply of services at local level is the conformation of networks; social participation is another characteristic of demonstration models; most of the models are proposing insurance schemes in order to solve the problem of universal coverage with equity and efficiency in the financing of health care. It is also worth mentioning that all projects give particular attention to the financial sustainability of services. It is understood by all project implementers that a long-term sustainability that combines the solidarity principle is required.

18. An objective of the project was to decrease the gap between the population that usually has access to health services and the population with no access at all. Although the coverage has increased in the NGOs working with CARE, poor populations are still far away of the services. Some projects in an effort to achieve an economic-financial sustainability are applying cost recovery formulas or co-payment systems that may harm an equity access. Given the social and economic crisis of Ecuador, NGOs under the C.A. with CARE are serving patients that in the past used to go to private physicians.

19. The services provided by the NGOs working under CARE and the increase in their coverage are an example of how the private sector can contribute to health reform. In the Azuay province, Fundacion Pablo Jaramillo Crespo is currently participating as one of the health providers for the MODERSA project. Something similar may occur in the Clinic Cristo Redendor in Sta. Elena, Guayas Province. Negotiations among CARE, Cristo Redentor and the World Bank through the MODERSA project are stilll in process. MODERSA has expressed strong interest in funding the activities in on-going years. This type of intervention may contribute to the replication of project activities in other provinces.

20. Particular attention should be given to the formulation of project indicators. They have to be established in coordination with counterparts at the outset, and keeping in mind that they need to be measured and validated. An accomplishment of more than hundred percent is not really an indicator that the work was satisfactorily achieved; it could be a misunderstanding in the formulation of indicators, or poor planning.

POST COMPLETION ACTIONS

1. A series of field visits were planned to seven out of ten NGOs working under the C.A. with CARE to validate project indicators, perform a physical inventory of equipment purchased with USAID funds and obtain recommendations from project coordinators. Appropriate reports were written and submitted to CARE/APOLO for response.

2. Inventories submitted by CARE were incomplete and some adjustments are still required. RCO in coordination with the technical office should be responsible for the official transfer of goods and equipment to each NGO and CARE. According to the regulations for C.A.s USAID shall issue disposition instruction within 120 calendar days after receipt of a final inventory.

3. It is worth mentioning that during the last visit to the project in Bolivar, Carchi province, the equipment was not serving the purpose established by the project. It is either not in use because of the minimal number of patients on still in the municipal warehouse awaiting decision by new mayor on whether to proceed with the model. Project expectations were extremely high at the beginning of the project, however during the implementation process there were many political and technical inconveniences. The decentralization model is not working and in fact there are two health providers, one is the MOH subcenter and the other one the municipal health unit. Both centers are "competing" for the same population. Last August another Mayor entered and the health coordinator resigned. There is not follow-up of project activities due to the lack of support from the Municipality. It would be convenient to consider the transfer of goods and equipment to another NGO or health provider that is going to give appropriate use, i.e. Palmar, Manglar Alto. USAID has written instructions to CARE requesting this equipment be transferred to a more appropriate site.

4. Final reports from CARE and CEPAR were received and reviewed. A financial statement of expenses incurred under the C.A. with CARE is still pending. In addition, advice of charges (AOC) submitted from AID/W are still pending. Last AOC from CARE corresponds to expenses incurred until December/99.

5. Expenses reports to liquidate the bilateral agreement with the MOH and the C.A. with CEPAR were submitted. CEPAR received the corresponding refund. A final expenses report from the MOH is underway.

6. An audit of the CEPAR component is required for the period Janauary – September/00. Appropriate funds were assigned for this purpose, however CEPAR during the last month of activities fully spent the budget without considering that an external audit is still required. CEPAR should consider using its own funds to contract the external audit or the Mission could use unspent funds under the bilateral agreement. A decision has been taken at SO2 team level to write CEPAR (O/CONT) stating CEPAR's obligation to finance this audit.

7. An external audit of the MOH component will be carried out for the period January 1998 – September 2000. RCO has selected and contracted the firm of Deloitte to do this audit. A final report is be expected by about March 31, 2001.

8. An implementation letter need to be prepared once all MOH expenses are fully liquidated in order to deobligate unspent funds under the bilateral agreement.

9. Official transfer of goods and equipment to the MOH and CEPAR should also be completed.

10. Deobligation of funds under the USAID line item will be required by the end of FY 2001, once all FSN contracts have been fully liquidated.

11. Final disposition of project files. It is recommended that all reports, studies, research, and publications be kept in the Mission for future reference or be delivered to CEPAR's library.

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File:cs\pacr0071
December 14, 2000 2nd version 12/20/00 3rd version 12/22/00
Last version 2/28/01