

**INNOVATIVE INTERSECTOR PRACTICES
FOR HEALTH AND EQUITY**

**THE CASE OF COTACACHI
ECUADOR**

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ACRONYMS

AUC	Asamblea de Unidad Cantonal [cantonal unity assembly]
CIS	Consejo Intersectorial de Salud [intersector health council]
CONAMU	Consejo Nacional de las Mujeres [National Women’s Council]
COPRES	conjunto de prestaciones esenciales de salud [set of essential health care benefits]
CSDG	Consejo Superior de Desarrollo y Gestión [senior development and management council]
IESS	Instituto Ecuatoriano de Seguridad Social [Ecuadoran Social Security Administration]
INEC	Instituto Nacional de Estadísticas y Censos [National Statistics and Censuses Administration]
LMGYAI	Ley de Maternidad Gratuita y Atención a la Infancia [Free Maternity and Child Care Law]
MSP	Ministerio de Salud Público [Ministry of Public Health]
PRODECI	Pro Derechos Ciudadanos Foundation [Pro Citizens Rights –Spanish NGO]
SCS	Sistema Cantonal de Salud [cantonal health system]
SSC	Seguro Social Campesino [rural social security program]
UNORCAC	Unión de Organizaciones Campesinas, Indígenas y Negras [Union of Rural, Indigenous and Black Organizations]

PRESENTATION

Since 10 August 1996, the municipality of Cotacachi (local government) has been building a new inclusive and transparent model for local development and participative democracy that promotes the exercise of the fundamental rights of its multiethnic population. The cantonal unity assembly (AUC), which is the chief participative body, established the Cotacachi intersector health council (1996) in conjunction with the local government, which is responsible for strengthening and institutionalizing the cantonal health system, allowing for the effective exercise of universal human rights and the collective right to health, well-being, and quality of life.

Since its creation, the intersector health council (CIS) has been working actively; its role is to coordinate and lead the work with the health sector and other sectors and players such as education, environment, labour, environmental sanitation, community organizations, women's and youth organizations and others, under the premise that health problems extend beyond curative care and welfare and that the health sector alone will never be able to respond to the problems related to the well-being of a population.

The CIS is the venue for dialogue and negotiation to design or agree on cantonal public policies, planning with a medium-term horizon (five years). Annual work plans are prepared, with the members contributing financial, human, material and other resources with the common objective of attaining the health and well-being goals established participatively and by consensus.

This document will give a summary account of the start-up of the CIS, the processes implemented, the strategies, achievements, and difficulties, as a contribution to enable other localities to share the dream of being shapers of their own development.

The document contains six chapters that describe the path travelled by the local government of Cotacachi.

The first chapter "When health was a problem" describes the geographic location of the canton of Cotacachi in Ecuador and refers to the serious problems affecting the national health sector, which had a determining influence on the canton, and discusses the origin of the participative process and the birth of the CIS.

Chapter II, "Building a new road to health," tells the story of the CIS and the local government from the time it declared health and education to be the basis for the strategic development of the canton and as civic right and duty.

Chapter III, "Shouldering new responsibilities together," recounts the struggle undertaken by the local government, with the support of organized civil society (AUC) to deliver health services from the standpoint of providing comprehensive well-being for the population, since although the CIS was able to coordinate with other sectors and achieve major goals, it could not do the same with the health sector, whose services were deficient and the public demanded improvements in them. Accordingly, the local government, based on the constitution and other related legislation, decentralized the administration of the Ministry of Public Health's health units.

Chapter IV "We are all responsible,"¹ discusses the changes made in the health care model to confer a systemic and participative approach. It describes how the cantonal health system was born, whose basic principles are primary health care and health promotion strategies, passing from an

¹ Chapter 4 in the present version is entitled "The first fruits". There is no Chapter 6. Translator

individualized approach to a family, community, and intercultural-oriented one. The chapter explains the process of coordinating the health system with the ancestral health system of indigenous peoples and other health providers.

Chapter V, “The first fruits,” describes the achievements in health, education, housing, environmental sanitation, and invigoration of the local economy.

Chapter VI, “The learning process,” describes the participative work with local, national, and international partners, the lessons learned, and the difficulties that remain.

METHODOLOGY

I have been part of building the participative process and creating and strengthening the CIS for 11 years now. To prepare the present document, I have used my memories and personal experiences, taken data from different documents that I have helped to compile, for example the cantonal plans, minutes of the canton assemblies and minutes of the meetings of the CIS, and I have reviewed secondary sources related to how other institutions see the participative process in effect in the canton.

CHAPTER I. WHEN HEALTH WAS A PROBLEM

The cantonal context

Geography

The canton of Cotacachi lies to the north of the city of Quito in the south-western part of the province of Imbabura; it is the largest of the six cantons that make up the province, with an area of 1,848.5 km² (40% of the province).² The topography is quite varied with altitudes ranging from 4,939 to 1,600 metres above sea level. The topographic and climate characteristics make it possible to clearly differentiate two zones, divided by the Cotacachi volcano: the Andean zone and the subtropical zone. For working reasons, the local government also distinguishes an urban zone.

The subtropical zone, known as Intag, runs from the western foothills of the Andes to the borders with the provinces of Esmeraldas and Pichincha. It is composed of the parishes of Apuela, Garcia Moreno, Peñaherrera, Cuellaje, Vacas Galindo, and Plaza Gutierrez.

In the rural area, the population is organized into communities and in the urban area into districts. The canton has eight rural parishes.

Political divisions



The Kichwa people live in the rural Andean zone, in territories called communities. The subtropical zone is fundamentally inhabited by settlers who migrated there from other cantons or provinces; small settlements of Blacks and Kichwas live there as well. The urban part of the canton is mainly populated by people of mixed origin (mestizos) and to a lesser extent by Kichwa.

Characteristics of the population

Population dynamics. In 2007, population was estimated to number about 42,000, based on the 2001 census.

² Includes the Golondrinas area which is not demarcated.

Rural and urban population. The urban population in the canton accounts for 43% of the inhabitants and the rural population for 57%.

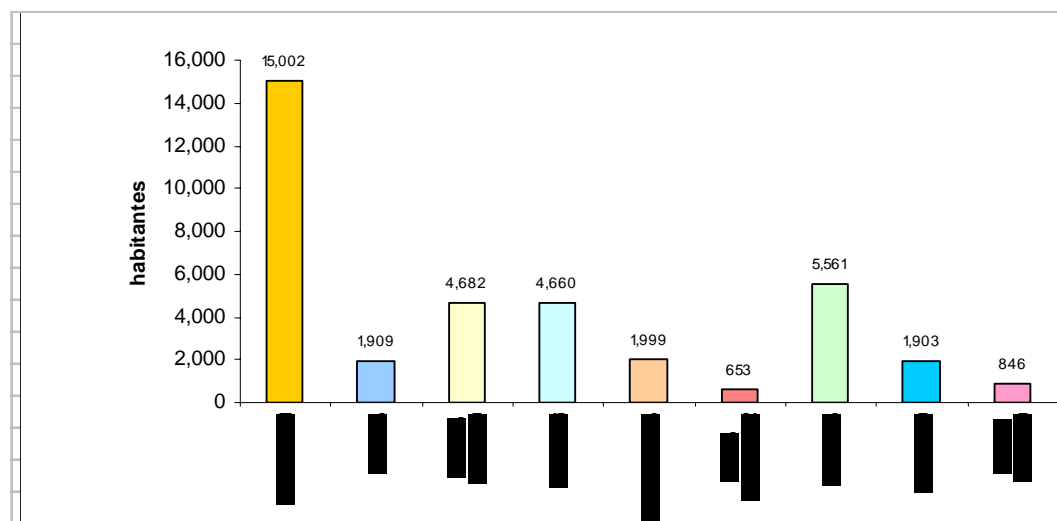
Population density. The canton presents a widely scattered population as can be seen from the following table:

Cotacachi. Population density by parish

ZONE	PARISH	AREA IN KM2	POPULATION	POPULATION DENSITY ³
Andean	URBAN			
	San Francisco and El Sagrario	70.9	15,002	211
	RURAL			
	Imantag	212.2	4,660	21.2
	Quiroga	68.2	5,561	81.5
Subtropical (Intag zone)	Apuela	222.2	1,909	8.6
	García Moreno	726.9	4,682	6.4
	Peñaherrera	122.4	1,999	16
	6 de Julio	181.8	1,903	10.5
	Vacas Galindo	41.2	846	20.5
	Plaza Gutiérrez	79.9	653	8.2
		1,725,7	37,215	21.6

Population by parish in Cotacachi. According to the 2001 census, the canton has the following population distributed among its nine parishes:

Cotacachi. Population by parish, 2001

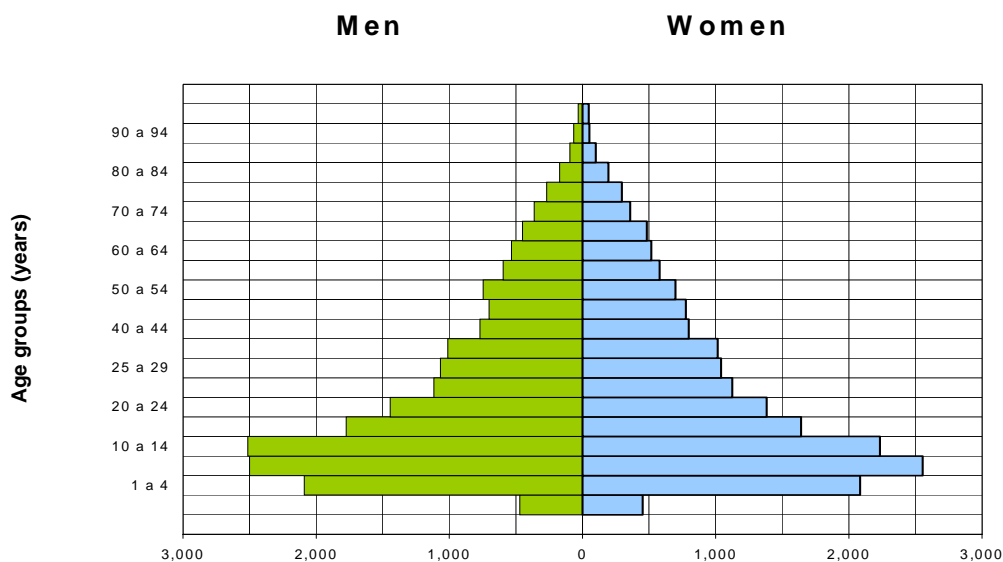


Source: INEC. Sixth population and fifth housing census, 2001

³ Population density is the numerical ratio between a population and the surface area inhabited by it (population per km²).

Population by age. Most inhabitants of the canton are between the ages of 5 and 49. This age group accounts for 68.4% of the total.

Cotacachi. Population pyramid, 2001



The population structure by five-year age groups consists of a broad base composed of children and youths (under 1 to 19 years), who account for 49.2% of the total population. The population pyramid lengthens at the tip, indicating that older adults have a growing presence in the population structure.

The following table shows the cantonal population by age groups and parish:

Cotacachi. Age groups by parish

PARISH	UNDER 1 YEAR	1 TO 4 YEARS	5 TO 9 YEARS	10 TO 19 YEARS	20 TO 59 YEARS	OVER 60
COTACACHI	349	1573	1961	3153	9453	1666
APUELA	50	260	266	415	662	256
GARCÍA MORENO	161	552	706	1111	1804	348
IMANTAG	146	577	711	1030	1733	463
PEÑAHERRERA	39	200	275	442	777	266
PLAZA GUTIÉRREZ	15	73	82	133	258	92
QUIROGA	99	618	664	1209	2296	675
6 DE JULIO	44	227	263	475	724	170
VACAS GALINDO	20	94	125	195	319	93
TOTAL	923	4.174	5.053	8.163	14.873	4.029
PERCENT	2.48%	11.22%	13.58%	21.93%	39.97%	10.83%

Source: INEC. Population and housing census, 2001

Twenty seven percent of the population is under 10 years and almost 50% is under 3 years. Accordingly, although people over 60 account for nearly 11%, it can be said that the canton's population is young.

Population by sex. There is a relative balance, with 49.56% of the population being women and 50.44% men.

Population by ethnic self-definition

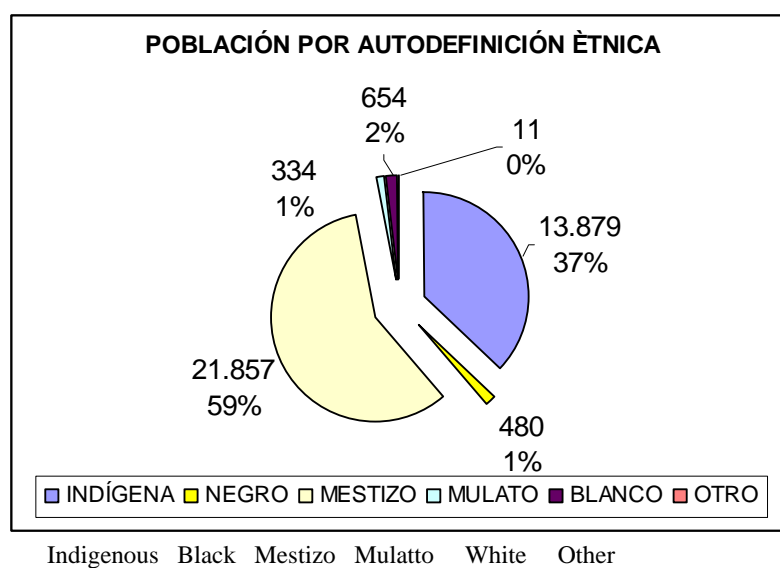
Kichwa account for 37.3% of the canton's population and 58.7% are mestizos.⁴ The Kichwa population in Cotacachi canton has a significant social and political presence through their second tier organization, the Union of Rural, Indigenous and Black Organizations (UNORCAC), which has offices in the cantonal capital, and in the parishes of Imantag and Quiroga. The mestizo population is present in all the parishes, particularly in the city of Cotacachi, and Garcia Moreno and Quiroga parishes.

⁴ INEC. Sixth Population and Housing Census.

Cotacachi. Population by ethnic self-definition and parish

PARISH	INDIGENOUS	BLACK	MESTIZO	MULATTO	WHITE	OTHER	TOTAL
COTACACHI	7,748	57	6,768	82	342	5	15,002
APUELA	72	16	1,726	41	51	3	1,909
GARCIA MORENO	142	254	4,170	81	34	1	4,682
IMANTAG	3,369	5	1,227	14	45	0	4,660
PEÑAHERRERA	30	98	1,784	81	6	0	1,999
PLAZA GUTIERREZ	182	0	464	2	5	0	653
QUIROGA	2,207	6	3,171	16	159	2	5,561
6 DE JULIO	76	2	1,807	6	12	0	1,903
VACAS GALINDO	53	42	740	11	0	0	846
TOTAL	13,879	480	21,857	334	654	11	37,215

Source: INEC. Sixth Population and Fifth Housing Census.



Population by language. The population distribution by language in the different parishes is as follows:

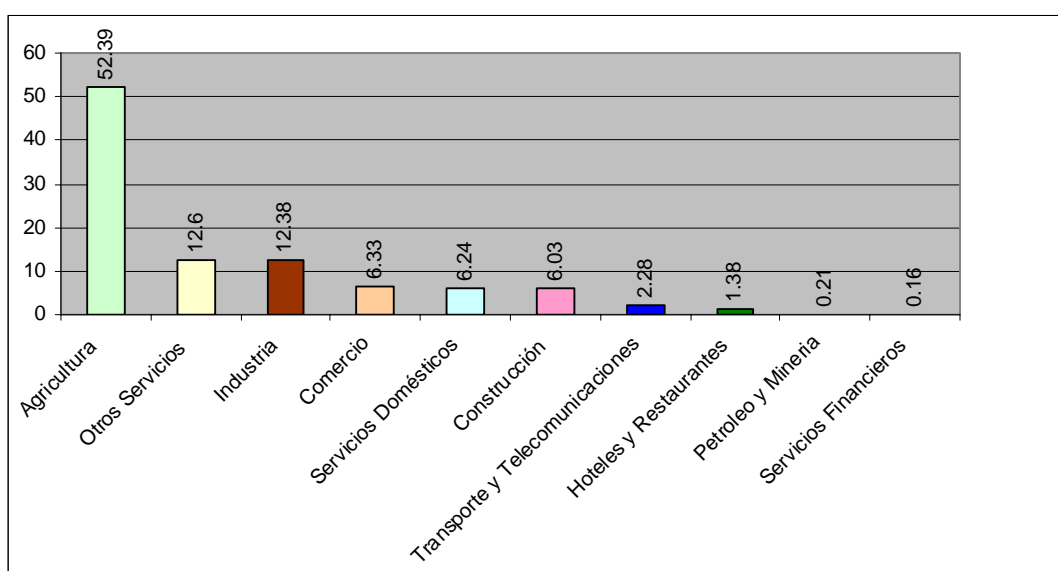
Cotacachi. Language by parish

PARISH	SPANISH	NATIVE (Kichwa)	BOTH	OTHER	TOTAL	N/A
COTACACHI	8,101	1,678	4,789	85	14,653	349
APUELA	1,801	4	50	4	1,859	50
GARCÍA MORENO	4,423	45	40	13	4,521	161
IMANTAG	2,360	606	1,526	22	4,514	146
PEÑAHERRERA	1,946	8	-	6	1,960	39
PLAZA GUTIÉRREZ	462	22	152	2	638	15
QUIROGA	3,414	524	1,501	23	5,462	99
6 DE JULIO	1,843	2	11	3	1,859	44
VACAS GALINDO	776	-	50	-	826	20
TOTAL	25,126	2,889	8,119	158	36,292	923

Ninety-two percent of the population speaks Spanish or is bilingual. Eight percent speak [only] their native tongue. Most indigenous communities are located in the rural area in the parishes of Imantag and Quiroga.

Economically active population

The economically active population in the canton (10 years of age and over) mainly works at farming (52%), about 12% in manufacturing and crafts, and a similar percentage work in other services. About 6% of the population works in construction, commerce, and domestic services, while 1% works in the tourism (hotels and restaurants) and transportation sectors.



Agriculture Other services Industry Commerce Domestic services Construction Transportation and communications Hotels and Restaurants Oil and mining Financial services

Housing

According to the 2001 population and housing census, 93.1% of housing in the urban area consists of houses, villas or apartments. The percentages are similar in the other parishes.

Percentage of houses, villas, or apartments by parish, 2001

Parish	Percentage	Number	Total housing
Cuellaje	81.15	310	382
Apuela	68.36	296	433
Cotacachi	82.98	2849	3433
Garcia Moreno	71.77	679	946
Imantag	73.2	724	989
Peñaherrera	92.24	428	464
Plaza Gutiérrez	80.51	124	154
Quiroga	85.79	1087	1267
Vacas Galindo	65.12	127	195

Source: INEC. Sixth Population and Fifth Housing Census.

Basic services

Water. In 1997, a study conducted by CIS indicated that just 34.8% of the population had drinking water, while 16.4% of families used irrigation or ditch water. In the parishes of Peñaherrera and Cuellaje, no houses had internal drinking water taps.

Sewage disposal. 93.9% of the houses in the urban area had sewage disposal systems, while the figure for the rural area was just 21.4%. In 2001, 37.69% of houses had sewer services while 62.31% did not.

Electricity. Electrification coverage in the canton in 1996 was 35%.

Illiteracy. According to data from the 1990 census and a CIS study conducted in 1998, the illiteracy rate was 25.33%.

Poverty. Until the year 1996, living conditions in Cotacachi were extremely difficult, which can be seen even more clearly in the field of health. Poverty and indigence levels were highly evident, particularly in the rural parishes, where the poverty rate was 94.4%, making Cotacachi the poorest canton in the province of Imbabura.⁵

Social security. Out of the total population of Cotacachi canton which was 37,215 people according to the 2001 population census, 9.78% were covered by the IESS (Ecuadoran Social Security Administration) and about 90% had no insurance or social protection.

⁵ Geography of Poverty in Ecuador, UNDP-FLACSO, Quito, 1996.

Health profile. The health profile in Cotacachi canton is the result of a series of health determinants⁶ identified from the general characteristics of geography, population dynamics, basic services, education, poverty, etc.

Ten leading cause of disease in the canton health system—health area No. 3, 1998

CAUSE	CASES 1998	%
Acute respiratory, without pneumonia	1,104	26.8%
Parasites	707	17.2%
Skin diseases	494	12.0%
Gastrointestinal diseases	230	5.6%
Trauma	199	4.8%
Urinary tract	171	4.2%
Malnutrition	165	4.0%
Gynaecological diseases	102	2.5%
Other, unclassified	941	22.9%
TOTAL	4,113	100.0%

Source: Statistics Department, Health Area No. 3. Cotacachi.

In 1998, the main causes of hospital admissions were gastrointestinal diseases, followed by acute respiratory infections, and kidney ailments.

Domestic violence. No work was done in Cotacachi on domestic violence until 1998 and therefore no data are available.

Health services supply

A summary of the public and private facilities in the canton is given in the following table:

FACILITIES	No	OPERATING UNITS AND PROVIDERS	
		First level	Second level
PUBLIC (Ministry of Health)	11	6 health subcentres 2 health posts	1 cantonal hospital
IESS/SSC (Social security)	5	1 central dispensary 4 SSC dispensaries	
PRIVATE	2	Private clinics	

Source: CIS, 2001

Human resources. Health human resources in 1996 were: 1 urban physician and 3 rural physicians. The lack of human resources was very serious at that time and is still a problem but not quite as serious.

⁶ The collective name assigned to the factors and conditions that are believed to influence health. One crucial element in this definition is that the factors do not act in isolation. The complex interactions between them have an even deeper impact on health.

Ancestral practitioners. Traditional health providers were not viewed in 1996 as a human talent capable of providing health care and well-being for the population. There was no information on how many there were or where they were located.

Access to health services in 1996 was a serious problem from the geographical, economic, social, and cultural standpoints. Access has been gradually improved during 11 years of participative management.

National health context, 1994-1998

In 1995, 75.8% of Ecuadorans lived in poverty in rural areas and 42.4% in urban areas. Extreme poverty affected 33.9% of the rural population and 10.6% of the urban population.⁷

In 1995, the 10 leading causes of infant mortality included: respiratory infections (42.2 per 10,000 live births), slow fetal growth, malnutrition and prematurity (24.9), pneumonia (23), intestinal infections (5.7), chronic bronchitis (8.9).⁸

Among the general population, the 10 leading causes of death were: pneumonia (27.2 per 10,000 population), cerebral-vascular diseases (23.1), high blood pressure (19.4), traffic accidents (15.6), diabetes (15.4), homicide (13.4), malignant tumours of the stomach (12.7), ischemic heart disease (12.6), intestinal infectious diseases (12.2) and tuberculosis (10.2).

For every 100,000 Ecuadorans, there are 13.3 physicians, 4.6 nurses, and 1.6 dentists.

In general, the Ecuadoran health sector, which is composed of a host of public and private institutions, particularly those reporting to the Ministry of Health and the Ecuadoran Social Security Administration (IESS), did not and still do not have even minimum levels of health human resources. Out-of-pocket spending by individuals was and continues to be high, generally to buy inputs (cotton, gauze, gloves) for treatment in addition to buying all their own medicine. In reality, the only advantage of being seen at the Ministry of Public Health's (MSP) facilities is the fact that consultations are free.

The health management model is not consistent with the care model proposed by the MSP as the health authority, nor does it respond to the public's health needs. The MSP has designed its care model exclusively from a biologicistic and welfarist approach that attempts to solve to the major problems facing the sector in isolation and singly.

Health in Cotacachi, 1994-1998

The epidemiological profile in the canton was similar to the rest of the country, with the presence of diseases that are typical of poverty prevailing (respiratory, diarrhea, tuberculosis, chronic and general malnutrition)⁹ that coexist with modern diseases (cardio-circulatory and osteo-muscular, accidents, etc.). Maternal and child mortality rates were high and the causes were completely preventable; deaths occurred owing to lack of timely care. For example, maternal mortality in the province was 85 per 100,000 live births compared to 35 per 100,000 nation-wide. There are no data available broken down

⁷Marco General de la Reforma Estructural de la Salud en el Ecuador, Ministerio de Salud Pública, p. 9 [General framework for structural reform in the health system in Ecuador], Ministry of Public Health.

⁸ Ibid

⁹ CIS. Diagnóstico Situación de Salud de Cotacachi 1997 [Health situation analysis of Cotacachi].

by canton, but given the geographic conditions of the area and the scattered and isolated communities it can be inferred that Cotacachi contributed significantly to the high provincial maternal and child mortality rates.

The Ministry of Public Health (MSP) had only one staff physician for the entire population. Occasionally up to a maximum of four physicians were assigned to the rural zone. There were no inputs or drugs in the cantonal hospital or in the operational health units.

Attendance at deliveries by qualified personnel or deliveries at health care facilities accounted for barely 15%, while 75% of deliveries were assisted by midwives or relatives. Most of the population was unable to resolve their health problems at public establishments, and access to health care services was a need felt and a service demanded by the population.

The canton had eight MSP health units, 1 hospital (only for internal medicine), six health subcentres, and two health posts. Although there were 282 traditional medicine practitioners in the canton there was no linkage whatsoever between Western medicine and ancestral medicine.

There were also problems with scant coordination between the health services and providers, limited financing, inefficiency in the use and distribution of health resources, and the lack of equity, quality, and warmth in the delivery of services.

Given this difficult health situation, the canton proposed to radically change the sector by creating a cantonal health system.

CHAPTER II. CONSTRUCTION OF A NEW PATH TO HEALTH

Political framework of the new model for participative local government

Since 1996, mayor Auki Tituaña Males has been promoting the construction of a new participative, democratic, transparent, supportive, and inclusive management model.

The construction of participative democracy is based politically and ideologically on the three ancestral principles of the indigenous peoples. The first is **Ama Killa** (do not be idle), which promotes active and organized participation by civil society. The achievements in health, education, housing, environmental sanitation, and better working conditions, would have been impossible without the participation of and contribution by the citizens of Cotacachi. The principle **Ama Llulla** (do not lie), promotes the design, implementation, and evaluation of cantonal and sector strategic development plans; it allows for objectivity when it comes time to prioritize investment plans (needs versus financial, material, and human resources). Planning is a tool that combats patronage, populism, and paternalism. Under principle **Ama Shua** (do not steal), the participative budget was designed and implemented which, linked to planning, allows the general activities of the canton to be prioritized and harmonized with planning in other sectors, in broad processes of agreement with civil society, which uses citizen oversight to ensure the transparent, efficient, and effective use of resources. The participative budget is a powerful tool in the fight against corruption.

Rise of the participative process in Cotacachi

In 1996, the only important organization in the Andean zone of Cotacachi was the Union of Indigenous and Rural Organizations (UNORCAC) and some sports organizations that engaged in isolated activities and had no links to the local government.

In 1996, the municipal government called on hundreds of citizens to participate in a great assembly whose purpose was to identify the main lines for cantonal development jointly with civil society. This assembly determined that the cornerstones of development are health, education, invigoration of the productive sector, and economic reactivation.

One of the main decisions by the first cantonal assembly in 1996 was to establish the Intersector Health Council (CIS) on the premise that health and well-being are the responsibility of all sectors and players and that health problems can never be resolved exclusively by the health sector. The assembly also directed the CIS to prepare a baseline on the health sector in order to respond to and solve the population's real problems.

Another important decision by the assembly was to institutionalize the participative process, to which end the local government undertook to hold an assembly annually and to promote participative processes in smaller territorial units (urban districts, communities) and support the organization of new players (youths, children, women, etc.). More than 700 people participated in the first assembly.

The cantonal unity assembly (AUC)

A brief description is necessary of how the assembly became institutionalized followed by a description of institutionalization of the CIS, since they are both products of the participative process and are closely interrelated organizationally and operationally.

The case of Cotacachi, Ecuador

In 1996, the civic event held in September was called the cantonal unity assembly and it has maintained the name since then. It is held each year and, unlike the first assembly in which citizens participated individually but not in representation of organizations, entities, sectors, or groups, today the delegates are designated in pre-assemblies of sectors and organized bodies. Citizens not linked to such organizational structures are also permitted to participate.

A broad range of players, approximately 59 social organization, 20 trade associations, 19 public institutions, 52 communities, 15 urban districts, 25 schools, 10 private companies, and 24 foundations and private institutions participate in the AUC.

The assembly was legalized in January 2000 (it already had social legitimacy) under a municipal ordinance and the local government allocated 10% of its budget to spur the participative process and guarantee financial sustainability, given that social sustainability should come from citizens with support from the local government. The assembly is a venue for accountability, planning, prioritization of annual activities; it approves or rejects taxes and charges by consensus.

The cantonal assembly monitors and puts into effect its annual decisions through the senior development and management council (CSDG) and intersector councils such as the intersector health, education, environment, tourism, and production councils.

Organizational structure of the cantonal unity assembly

Annual general assembly						
Advisory council		CSDG, UNORCAC, district federations, Intag, municipality, cantonal association, rural parish board, youths, children, women, committees				
Technical team						
Directors CSDG-AUC					Social oversight	
Intersector councils						
Health	Tourism	Education	Environment and natural resources	Production	Childhood and adolescence	Participative municipal budgeting

The **senior development and management council (CSDG)** is responsible for coordination, building partnerships, and implementing the decisions of the annual assembly. It is composed of 18 members elected by the annual assembly, representing the territory (urban districts and communities), gender, age groups, sectors (health, education environment), and state (local government).

Intersector councils. These are bodies that collectively implement the policies, projects, and activities in their sector, guided by the CSDG. The intersector councils are: education and culture, health, tourism, production, environmental and natural resources management, participative budgeting, childhood and adolescence. They are composed of public, private and social institutions, organizations, and bodies. The representatives on the intersector councils each elect a representative to the CSDG.

Advisory council. Provides support and guidance for the cantonal unity assembly (AUC) and mediates conflicts among the organizations that are represented in the assembly. It is composed of former mayors, former councillors who have been members, and former presidents of the CSDG, and professionals who represent organized social sectors.

The **technical team** is composed of local experts who have risen from the process; they are responsible for administrative and operational management of the AUC and provide technical support and relevant information for the directors of the CSDG.

Social oversight. The bylaws of the AUC grant it autonomy to perform social oversight of the assembly itself. Municipal investments are monitored by the committee to monitor the participative budget.

Establishment and composition of the cantonal intersector health council (CIS)

The CIS was established in 1996 by the first cantonal unity assembly. It is composed of players representing community, public, and for-profit and not-for-profit private organizations or institutions.

Members of the CIS

- a. Local government representatives (subnational): mayor and one councillor. The mayor is the president of the CIS.
- b. Representative of the AUC. The president of the assembly is the vice-president of the CIS.
- c. Representative of the health sector (local level): the director of the cantonal health system, who acts as secretary or technical secretary of the CIS.
- d. Territorial representatives: local health committees from the parishes, federation of urban districts, UNORCAC, Intag zone committee.
- e. Gender representative: Women's coordination office of the canton and delegate of the solidarity funds management committee.
- f. Generational representative: canton youth coordination office.
- g. Representative of the provincial health sector: Provincial Directorate of Health of Imbabura, College of Physicians of Imbabura, General Social Security Administration, Rural Social Security Program, Jambi Mascaric (ancestral medicine).
- h. Representative of labour organizations: Canton Health Workers Union Area No. 3, and the Municipal Employees Association.
- i. Representative of private sector health professionals.
- j. Representative of social organizations and NGOs: Municipal Foundation, National Child and Family Administration (INNFA), the Comprehensive Rural Development Project (DRI)-Cotacachi, the Help in Action Project, Tierra Viva, and the PRODECI Foundation.
- k. Representative of other sectors: education committee, environmental management committee.
- l. Other: Cuban technical cooperation, National Commissariat.

Responsibilities of the CIS

- To formulate and implement health development policies in participative processes.
- To generate new thinking about health and well-being, promoting individual and collective co-responsibility.
- To lead the work on health in a holistic and comprehensive manner in order to influence the conditioning factors, determinants, and health risks.
- To steer the local government's financial, material, and human resources, national and international cooperation, etc., toward the objectives and goals of the cantonal health plan.
- To track, monitor, and evaluate compliance with the cantonal health plan.
- To mobilize permanent participation by its members and other sectors that contribute to health and well-being, to which end it will agree annually on a common health agenda, based on the policies and strategies of the cantonal health plan and the cantonal development plan.

Structure of the CIS

Cantonal unity assembly (AUC)				
Cantonal intersector health advisory council (CIS)				
Health services and medicines committee	Traditional medicine committee	Health promotion committee	Committee to manage the funds received under the Free Maternity and Child Care law	Research committee

Source: Cotacachi Cantonal Health Directorate, 2004.

How are delegates to the CIS selected?

The members of the CIS represent territorial, sector, and social organizations, and are appointed through an internal process. For example, the Barrios Federation groups together 12 urban districts. Each district names a president and the president of the federation is elected from among them, and is their delegate to the CIS. The Women's Cantonal Coordination Office groups together three zone offices: Andean, urban, and subtropical. The three coordinators elect the president of the cantonal coordination office who is the delegate to the CIS. The local health committees are territorial bodies organized with grass-roots organizations and technical teams from the health operating unit. The CIS delegate is chosen from among the coordinators. This form of selection increases the representation and participation of more remote or scattered communities.

The following local health committees currently exist:

Andes zone: 1 committee at Imantag and 1 at Quiroga

Subtropical zone—Intag: there are 6 parish health committees

The other intersector councils select their delegates from among their members, who may be the coordinator or another member of the council. The same applies to the other members.

How does the CIS implement its decisions?

The members of the CIS have a commitment to bring feedback to their groups and organizations on the decisions taken by the CIS. The reverse holds true if the urban districts or other members of the CIS require its support to suggest the implementation of new health services, develop productive projects such as the healthy spaces project or food security programs, obtain better quality health services, improve working conditions in flower-growing operations, and other projects. These aspects are discussed and resolved at the CIS' quarterly assemblies.

It is a two-way relationship, but the CIS also carries out actions and holds working sessions with each district, with each community, to monitor whether the channels of communications between the CIS and each of the 12 urban districts are effective, and whether they are informed and cooperate with the work of the CIS and the CIS with them.

The CIS works under the premise that health is the result of a set of factors—economic, social, cultural, environmental and biological risks—with socioeconomic and cultural aspects being the determining ones and the others conditioning ones, expressed in health problems that affect collectives of people and individuals.

Some examples of the decisions taken by the CIS are given below.

How does the CIS perform citizen oversight?

Citizen oversight of compliance with the Free Maternity and Child Care Law

To explain this section, we recall that one of the members of the CIS is the Women's Coordination Office. The Women's Coordination Office is composed of a committee of users of free maternity and child care. The specific functions of the committee include citizen oversight to ensure that the Free Maternity and Child Care Law is complied with and to support the health services in improving the quality of care. The users committees issue periodic reports on the quality of the services financed with funds provided under the law and present them to the Women's Coordination Office which, in turn, presents them to the CIS.

To ensure that the funds for free maternity and child care are effectively invested in the health of fertile and pregnant women and children under the age of five, a committee was established to manage the solidarity health funds. The committee is composed of a representative of the users committee, a delegate from the municipal government, and a delegate from the Cotacachi cantonal health system.

Participative management of funds

- The committee for the management of solidarity health funds decides on how to invest the funds, through the identification of health priorities in function of the information produced by the cantonal health system, which generally indicates what drugs to buy and the amounts, upgrades to minor equipment, etc.
- The committee also has the function of issuing reports on satisfaction with quality, promoting citizen and family co-participation in health care, and coordinating with the health units to improve the quality of care.

This committee exercises social oversight of the financial resources invested under the Free Maternity and Child Care Law and on the quality of the health services provided. In the event problems are encountered, the committee is able to bring its demands to several bodies, including the CIS assembly, the municipal council, or the senior development and management council of the cantonal unity assembly.

Coordination in the management, use and distribution of funds from the Free Maternity and Child Care Law between the municipalities and the local management committees

Mayor

Ministry of Health Representative

Local committee to manage the funds
provided under the law

Health areas

Hospitals

Civil society reps.

Source: LMGYAI

Citizen oversight of the budget of the health services network subsystem

The health services network subsystem manages a budget of about US\$200,000 a year. These resources are used to procure medicines, inputs, minor equipment, and minor physical infrastructure works. Prior to decentralization, these funds were managed exclusively by the director of the health system and the financial director.

With decentralization, a committee on investments in the cantonal health system was established, which is composed of one delegate from the CIS, one from the Municipal Department of Finance, one from the AUC, the Financial Director of the Cantonal Health System, and the system's director. Information on investment requirements is presented by the system's director; the other members review the supporting documentation, verify that the requirements correspond to system needs (which should respond to population needs) and, depending on the outcome, approve the investments. This committee also participates in the tendering process for procurements of medicines, equipment, and physical infrastructure works.

The participative process provides citizens with a better understanding of the canton's problems in the different sectors and supports the development of communications skills and the spirit of cooperation to reach agreements, often on challenging issues, such as properly allocating the budget. This individual and collective co-responsibility creates a feeling of ownership of problems and solutions, which is why we say that the participative process in Cotacachi really empowers citizens, since they are not mere spectators but key players in solving those problems.

The participative process and participative planning

Planning cantonal development

Cotacachi has had a cantonal development plan since 1997. This plan was updated in 2000 and has a horizon to 2015.

The cantonal development plan was prepared by the municipality of Cotacachi and the cantonal unity assembly, the different municipal departments, and the intersector councils.

The development plan covers the whole territory and started with a situational diagnostic of the different sectors. It identifies the main policies and guidelines to be implemented in each sector. The planning process was participative in all stages, ranging from the initial analysis, prioritization of problems, and identification of programs and projects to achieve the proposed goals.

In the urban area, work was done with each of the districts and subsequently the districts made joint proposals through their federation.

In the Andean zone, work was done with the communities and the final proposals were made jointly through the Cotacachi Union of Rural and Indigenous Peoples.

In the subtropical area (also known as Intag), work was done with each of the communities and subsequently they drew up their own organized proposals in the Intag zone development committee.

Once the proposals from all the zones were received, assemblies, workshops, meetings, and other participative events were held to agree on policies, programs, plans, and projects on the cantonal level.

- a. Improvement in the quality of life of the population for equitable human development based on multiculturalism.
- b. Ongoing quest for development that harmonizes human relations with nature and the cosmos as a daily practice.
- c. Consolidation of organized participation by the social sectors and citizens in decision making.
- d. Strengthening a new, modern, efficient and effective participative municipal model for administration, that invigorates cantonal development.

This experience of drawing up the cantonal development plan spurred the intersector councils to prepare sector plans. The sector plans take a territorial approach, starting with the smallest territorial units until they cover the whole canton, through participative processes that undoubtedly are longer and more costly, but the involvement and commitment of the different players lends greater social, technical, political, and financial sustainability to the plans.

The sector plans help a great deal in making the strategies and goals more concrete. Cotacachi currently has:

A cantonal health plan
A cantonal education plan
A cantonal tourism plan
A cantonal environmental protection plan
A cantonal production invigoration plan.

Implementation of the plans is led by the local government, which provides financial and other resources for carrying out the different projects and programs, and through the intersector councils it is able to coordinate with the other players that are active in the sector and channel efforts jointly, based on the objectives and goals of the cantonal development plan and the sector plans.

The Cotacachi cantonal health plan

The plan guides work in the field of health based on the idea that “health is the product of a series of conditioners and determinants that require integrated intersector interventions with the active participation of local players related to the field of health. The actions are based on primary health care strategies and health promotion, with the active contribution of other sectors.”

The guidelines for designing the health plan are:

- To intervene in factors linked to vulnerability and protection of the most vulnerable groups.
- To intervene directly on the problem but also on the determinants of health and well-being.
- To assign human, material, and financial resources with equity and efficiency, based on the situation in the different zones of the canton.

The objective of the plan is **to build a comprehensive and intercultural health model that guarantees optimum living conditions for the population for sustainable human development with equity and participative democracy in the canton.**

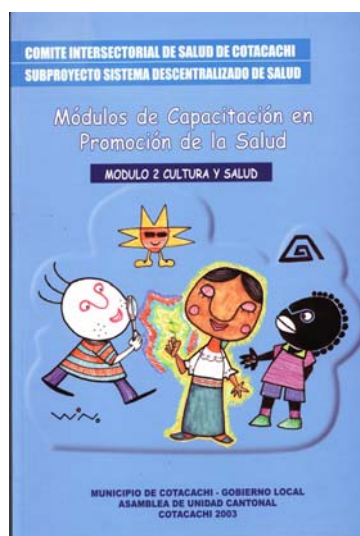
The lines of action include:

- Promoting life styles and environments through the implementation of health policies, healthy spaces, and health promotion

- Food security
- Family and citizen security
- Reorientation of health services
- Better access to health care services under the premises of quality, warmth, universality, solidarity, equity, comprehensiveness, and inter-culturality
- Strengthening of traditional Andean medicine
- Institutional development of health care services
- Development of support systems for management of the CIS and improvement in the quality of health services
- Information, education and training in health promotion (in 2003, the CIS developed the healthy schools program and the following training modules: Module 1, Building citizenship and health; and Module 2, Culture and health).



Module 1. Building citizenship & health



Module 2. Culture & health

The role of the CIS in coordinating with the other sectors

As described earlier, the role of the CIS is to offer a space where policy agreements are reached, common goals are established, and the members announce their budgets and orient them toward the cantonal health plan.

The CIS leads the other players in health-related issues, activities, and projects and uses its installed capacity and mobilization capabilities for that purpose.

The CIS' mobilization capacity stems from the fact that since the mayor is the president, he is able to mobilize municipal logistics. Also, since the vice-president is the president of the cantonal assembly, he is able to mobilize the sectors organized through the intersector councils; and because the technical secretary of the CIS is the director of the cantonal health system, she has the capacity to mobilize the health services and obtain their participation.

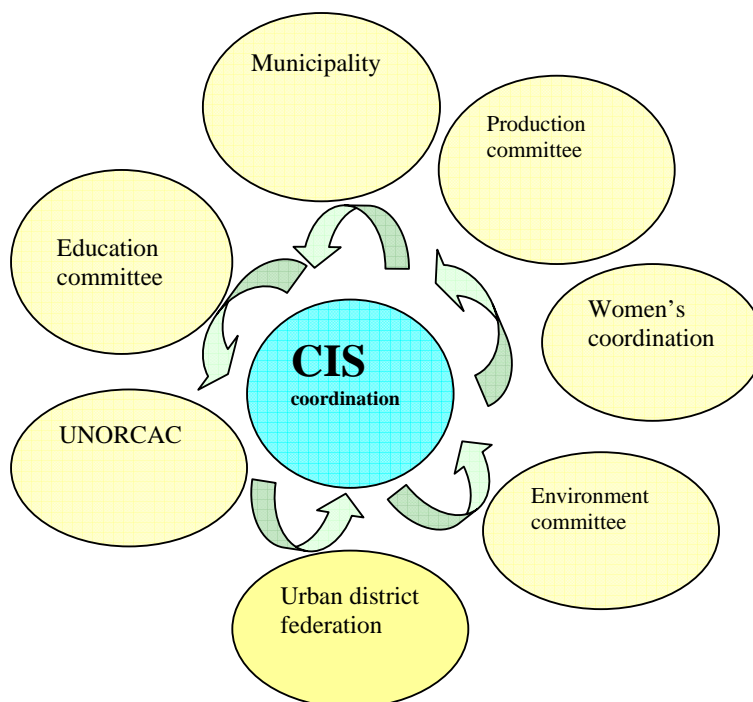
As an example of how this operates in practice, we will look at the case of the healthy schools program. At the CIS meeting, where all the members participated, the program components, objectives, and goals were determined. The municipality took responsibility for turning the healthy schools program into a public policy and assigned a budget to upgrade the sanitary infrastructure in

schools. The technical secretary of the CIS who is also the director of the cantonal health system worked with the other members of the CIS to develop standards, protocols, and rules to implement the healthy schools program operationally, and coordinated with the intersector education committee to socialize and sensitize school principals to implement this program with the consent and support of the teachers. Also, through the cantonal health system, disease prevention actions were carried out, such as annual deparasitization, oral health, height and weight control campaigns.

The cantonal assembly, for its part, mobilized the urban districts where the schools are located to support the program through monitoring, channelled the concerns of parents and district leaders, and held work parties to clean up or repair the schools.

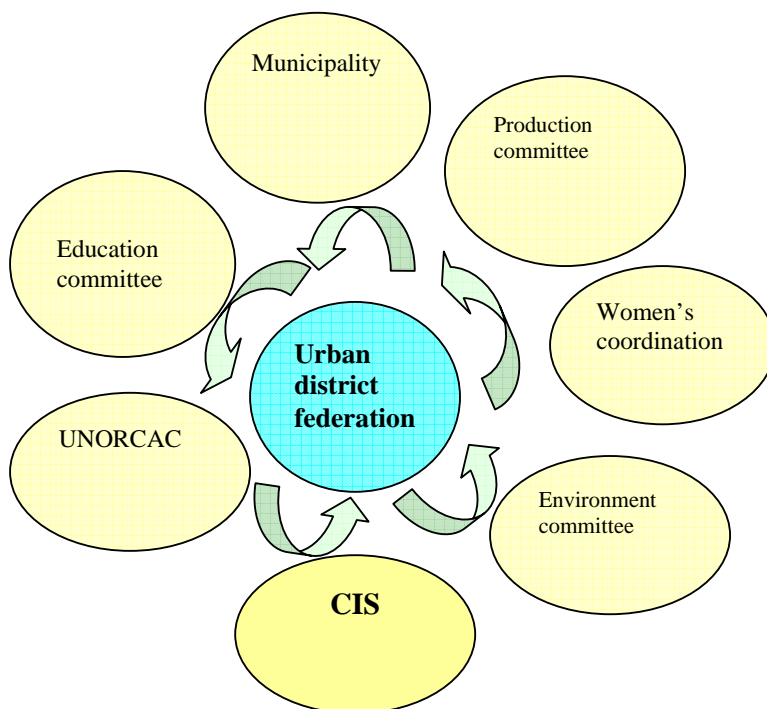
This type of coordination between government (municipality), civil society (cantonal assembly), and technical bodies (decentralized cantonal health system), where senior political, civil, and technical authorities participate, allows for a high level of institutionalization and sustainability of programs.

Thanks to this program, the public schools, although they are not the responsibility of the local government, have greatly improved their physical infrastructure, equipment (computers), furniture, and teacher training, with a view to reducing the symbolic violence [sic] that is still a problem in public schools.



Just as the CIS leads the other players, it can also be led. Take the example of the healthy spaces project. This project to implement urban agriculture was the initiative of the federation of urban districts. The municipality offered support by providing specialists in the field to assist the districts and implement the project. The federation obtained the donation of one hectare of land so that the different districts could plant demonstrate plots and use the space for donated plants for reforestation and seeds for urban agriculture.

The CIS, through the cantonal health system, incorporated a healthy eating habits component into the healthy spaces project to promote higher consumption of fruit and vegetables.



The role of the CIS in the health sector

The foregoing description shows how the CIS leads other sectors or players. We will now turn to how the CIS relates to the other health services providers.

First, it should be recalled that the CIS is a body for policy coordination and that its directors currently include the mayor, the president of the cantonal assembly, and the director of the cantonal health system as president, vice-president, and technical secretary.

Under the decentralization process, the local government and the intersector cantonal health council, through the cantonal health system, has a direct influence on the entire system of public providers in the canton and an indirect influence on other providers. The following scheme explains these relations:

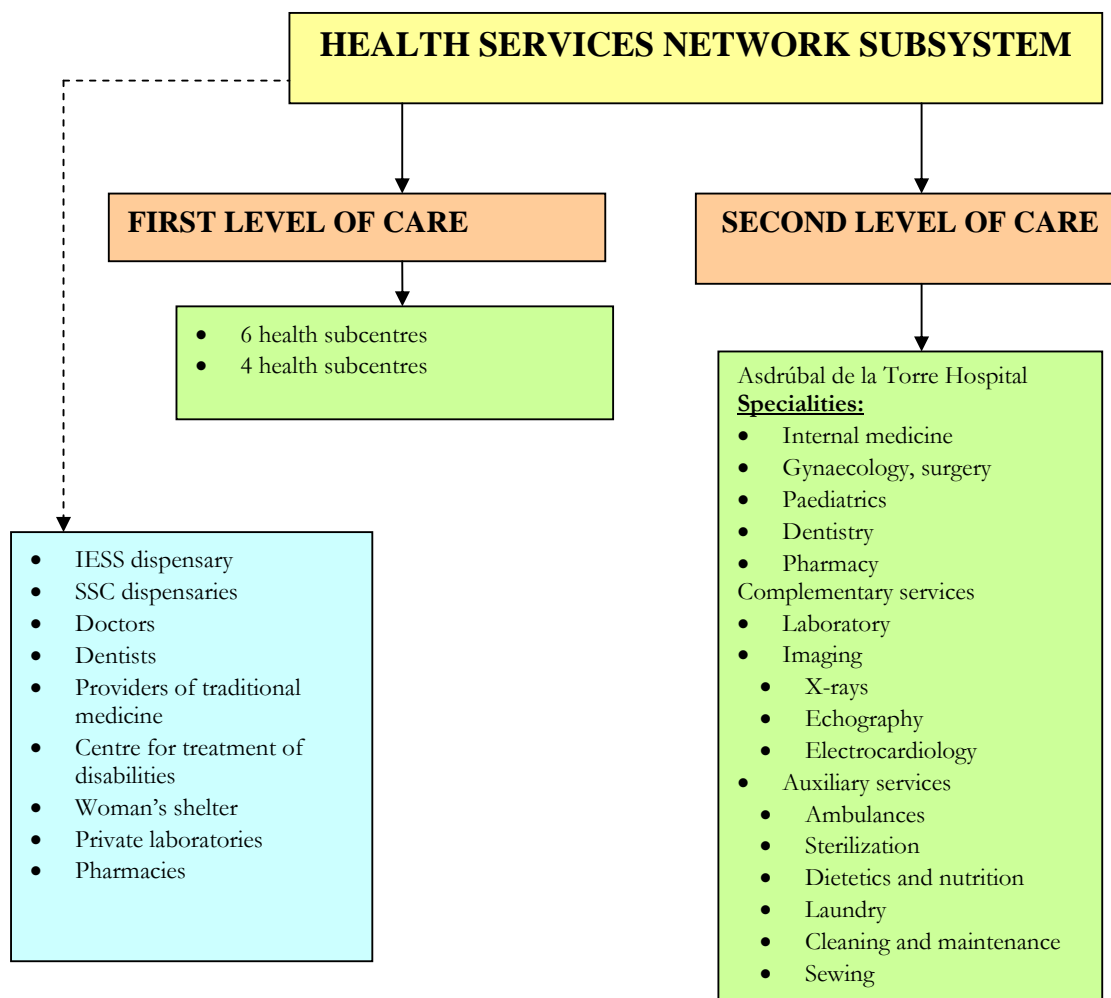
Municipality of Cotacachi (local government)		Cantonal intersector health council (CIS)
Decentralized cantonal health system		
Health services network subsystem	Health surveillance subsystem	Health promotion and collective prevention subsystem
Network of transferred health services IESS SSC Private Ancestral	Monitoring and evaluation Situation room Information system	Prevention and promotion for life styles Healthy spaces (families, schools, workplaces, communities) Health control of food stores, workplaces, basic services Control of vectors and animal- borne diseases Intersector relations (environment, education, production)

The technical secretary of the CIS is the director of the cantonal (decentralized) health system).

For greater clarity, we reiterate that the CIS is the senior policy coordination body and the decisions taken in the CIS regarding health services involve the direct operation of the cantonal health system, which is fundamentally an operational body that functions through three subsystems, as can be seen in the preceding table.

The cantonal health system brings together all the operational health units that are under the deconcentrated administration of the municipality and are directed by the cantonal health system.

Let us turn to what goes on specifically with the health services, by observing who forms part of the health services network subsystem:



As the table shows, the health services network subsystem is composed of two treatment levels: primary and secondary. The continuous lines show who has direct influence, while the dotted lines show the coordination established with other health care providers.

The coordination established with the operational units over which there is direct influence has to do with the interests of the canton and its authorities—mayor, president of the cantonal assembly, director of the cantonal health system—in achieving common objectives and goals. One goal to be attained every year is to mitigate risks to avoid maternal and child deaths as far as possible. The objective is to support achieving the Millennium Development Goal in 2015 related to the reduction in maternal and child mortality.

How is the cantonal health system organized to mitigate risks?

Maternal mortality affects women living in remote areas where there are no permanent health services or health professionals or means of mobilization. To correct these shortcomings the cantonal system did the following:

With regard to human resources

- Training for community personnel (midwives). The midwives are responsible for identifying pregnant women in their communities, taking them to the cantonal hospital at least for one professional check-up, clinical, laboratory, and imaging tests, providing vitamins, and urging mothers to continue going to the hospital.
- Training for midwives to detect risks during deliveries and transferring the women urgently to the hospital.
- Human resource training in the operational health units (doctors, nurses) to give priority care to the cases transferred by the midwives, not discriminating against or mistreating them.

Continuous operation of the cantonal hospital

- Continuous presence 24-hours a day every day of the year of health care professionals (doctors and nurses; in other cantons the lack of human resources is the main problem) to guarantee attention in emergencies. Any staff shortfalls are made up for by the local government.
- The hospital also provides drugs, blood, and by-products, and is equipped to respond to an emergency.

Guarantee the transfer of pregnant women in emergency situations

- Each of the community midwives is linked to the hospital, the municipality, the national police force, and different NGOs that work in the field of health services, through a radio communications system that is used to report emergencies (all types), so that whoever is closest and has an ambulance has the obligation to go to the site of the emergency.

This type of organization has meant that for three years, the canton of Cotacachi has not had any maternal or child deaths.

How does the CIS coordinate with health providers over whom it has no direct influence?

The CIS is responsible for applying and overseeing compliance with minimum standards for the provision of services. In participative processes, agreements have been reached with other providers, particularly the disability treatment centre, the women's shelter, and Jambi Mascaric (traditional medicine), on the following points:

- Use of a standard clinical history form
- Licensing of operational units (comply with minimum standards for infrastructure, equipment, human resources, and costs)
- Use of disease classifications based on international standards
- Remittance of production information following the rules issued by the statistics department of the CHS
- Referral and counter-referral of patients
- Use of the emergency system
- Placing their resources (human, physical, monetary) at the service of the canton in the event of emergencies

These arrangements are possible because they have been made by authorities on the highest level, placing the interests of the canton ahead of private interests. This has been possible thanks to the participative process that raises collective awareness of problems and the need to find collective solutions.

Public policies in other sectors

The organization of civil society in the cantonal unity assembly (AUC) and its institutionalization as part of government-civil society co-management permits public policies to be born out of the complicated web of relations and interactions between these two players.

As we saw in the structure of the AUC, it has other intersector councils—education, tourism, environmental and natural resources management, childhood and adolescence, and participative budgeting.

These intersector councils have mechanisms similar to those of the intersector health council to identify their respective public policies, i.e. this is done participatively.

Once a public policy is defined, its approval is taken up in coordination with the municipal council since by law, that council is the only body that can approve a public policy. Once a policy is approved, its implementation is the joint responsibility of the local government (municipality) and civil society (AUC).

Public policies in the education sector

Education is the responsibility of the central government; however the municipal government and the AUC identified that one of the obstacles to the development of human capital was illiteracy, which affected the indigenous population more severely and, among that group, indigenous women.

Therefore a public policy was designed to:

- Reduce illiteracy in the canton of Cotacachi, mobilizing and sensitizing civil society and national and international donors.

The result was that in April 2005, Cotacachi was declared by UNESCO to be a territory free from illiteracy, when the rate was reduced from 23% to 3.8%. The main beneficiaries are women and indigenous women. [sic]

- To ensure by 2009, that everyone in the canton has obtained primary level education, giving priority to men and women from the rural area and stressing activities for indigenous women.

To implement this policy the intersector education committee, supported by the Department of Education and Culture of the municipality of Cotacachi, encourages everyone who learned to read and write to continue with the post-literacy program. It is hoped that by 2009, the average for the canton will be completion of the full primary cycle.

Public policies in the environment sector

Because of its special geographic location, Cotacachi has three clearly differentiated zones—Andean, urban, and subtropical (the local government uses this division exclusively for working purposes).

The Andean and subtropical zones have enormous natural riches, such as primary forests and water resources; both zones contain geographic areas that have been declared reserves.

In about 1986, copper was discovered in the subtropical zone (the studies mentioned that it could bring in more money than oil). Since then, different explorations and studies have been conducted by mining companies with the consent of the Ecuadoran government but not of the community. Since that year, the level of conflict between the supporters of mining, the local government and the AUC has grown.

The copper mines are located in zones of high environmental impact. They contain primary forests, immense biodiversity in plants, animals and insects, a large number of waterfalls and water sources that provide water for three provinces—Imbabura (where Cotacachi is located) and the provinces of Pichincha and Esmeraldas.

The communities in the subtropical zone, even before Mayor Auki Tituaña was elected, had developed a responsible environmental awareness and they have been the main opposition to copper mining owing to its very high environmental impact which could have negative consequences for human health.

The unequal fight between the comuneros in the subtropical zone, supported by the municipality of Cotacachi, and the mining interests of transnationals, supported by the Ecuadoran government, has been very difficult. The municipality's strategies to impede mining included the issue of environmental protection policies and the creation of environmental solidarity on the international level.

The public policy issued under a municipal ordinance in 1999 was:

- Cotacachi is an ecological canton; protection of its natural resources is the responsibility of the municipal government of Cotacachi; no public or private natural person is allowed to carry out activities that could harm the environment, particularly in zones classified as protected.

Although Ecuador's Mining Act ranks higher than a municipal ordinance and permits the exploration and extraction of mineral resources, the promoters of mining have been unable to override the municipal ordinance since it is backed by more than 70% of the population of Cotacachi.

To counteract the offers of jobs by the mining companies, the local government has been developing different initiatives, such as the establishment of microenterprises, that create jobs for the inhabitants of the subtropical zone.

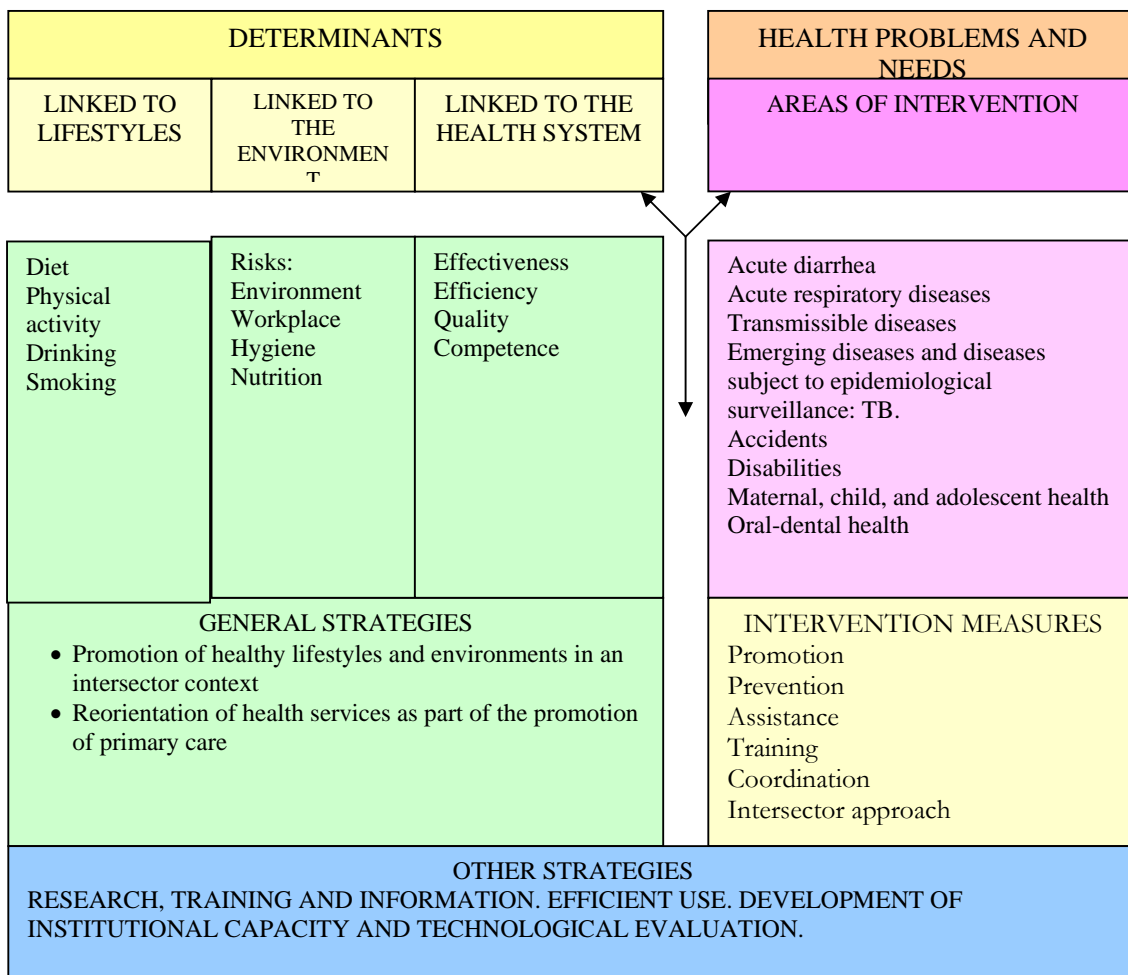
In the case of the Cotacachi local government, public policies arise from organized civil society and are based on the needs of the population, and although policies are born in a specific intersector council, the other councils are familiar with them and apply them in their areas, thanks to the coordination and information provided by the senior development and management council of the AUC.

The CIS strengthens, deepens, and leads intersector relations

Through its members, the CIS mobilizes families, communities, urban districts, and organizations and links them to specific projects or programs. Some of them are described below:

- The healthy spaces program, that is carried out in the urban districts of Cotacachi and is intended to recycle social waste to produce fertilizer. It encourages urban agriculture and the products are currently sold at the Jatuk Cem Andes market. This program develops information, communications, and education in lifestyles and healthy environments.
- Schools that promote health and schools that promote development. This program is carried out by the intersector education council with support from the CIS and has three lines of action: (a) upgrading the physical infrastructure of schools and continuous improvement in their hygiene and sanitary conditions; (b) support for teachers to improve teaching quality and incorporate self-esteem techniques to improve the emotional status of their pupils; and (c) promotion and responsible exercise of the rights of children. The first phase is called schools that promote health, in which certain goals must be achieved. Once that has been done, the program will move to the second phase, called schools that promote development, in which a productive component will be incorporated.
- Establishment of specialized networks, such as the domestic violence network, given that domestic violence against women and children is high in the canton. The zone women's coordination offices, supported by the municipality's women and family committee and the National Women's Council, now provide general and psychological care, rehabilitation and legal support in reporting abuse, and case monitoring.
- Extramural health teams composed of a doctor, nurse, dentist, health promoter or volunteer, midwife, and community leader. These teams perform horizontal intervention in programs that are priorities for the Ministry of Health, including enforcement of the Free Maternity and Child Care Law and the nutrition program for children under five.
- The inclusion in the extramural health teams of people from the community as health promoters or volunteers, midwives, and/or community leaders, allows for activities that encourage families and the community to share responsibility for their individual health care by promoting healthy lifestyles and environmental protection.

The following table presents the CIS' strategy for health promotion, primary health care, relationships between determinants, health problems and interventions.



Source: Cotacachi Health Plan, 002-2006

Tool for identifying health determinants and risks

This tool is used to prioritize health actions. The decentralized cantonal health system is responsible for operational execution under the leadership of the CIS, which evaluates and monitors the status of health risks and determinants through information that is processed in the situation room.

VARIABLE	DIMENSION	POINTS			
		0	1	2	3
Environment	Presence of vectors		*		
	Air pollution		*		
	Soil pollution			*	
	Water pollution				*
	Subtotal Environment	Quantitative = 7 Qualitative = Average risk			
Workplace	Labour protection measures				*
	Presence of biological risks				*
	Presence of physical risks			*	
	Presence of chemical risks				*
	Subtotal Labour	Quantitative = 11 Qualitative = High risk			
Family	Family migration				*
	Alcohol consumption and smoking				*
	Practices sports/recreational activities				*
	Domestic violence			*	
	Subtotal Family	Quantitative = 11 Qualitative = High risk			
Socio-community	Safe drinking water				*
	Sewerage				*
	Electricity			*	
	Recreational areas				*
	Subtotal Socio-community	Quantitative = 11 Qualitative = High risk			

STRATIFICATION OF EPIDEMIOLOGICAL RISK	VARIABLE	NO RISK	LOW RISK	MED. RISK	HIGH RISK
	ENVIRONMENT			*	
	WORKPLACE				*
	FAMILY				*
	SOCIO-COMMUNITY				*
TOTAL	Quantitative = Qualitative = High risk				

The CIS and the cantonal health system follow the approach of health determinants and risks in their interventions, taking a comprehensive approach that goes beyond the biomedical and health services approach.

In function of the risk classification in a parish, sector, or district, interventions are carried out to improve the general living conditions of the inhabitants of Cotacachi. The points obtained in a sector guide us in deciding who is responsible for providing a solution (municipality, health system, district, or individual). For example, in a rural locality in Cotacachi, the neighbours often complained about the presence of flies. To learn the causes, a study was conducted and it was found that in virtually every case, hogs were being raised under inadequate sanitary conditions. The solution to the problem was:

- The neighbours continue to raise hogs, but under better sanitary conditions.
- The municipality supports the improvement in the conditions under which the hogs are raised through upgrading by the Department of Public Works.
- The health system trains the owners of the animals in the health risks and is responsible through the health promotion subsystem for ensuring that the neighbours maintain good sanitary conditions for raising animals.

Social determinants and inequity in health care

The health activities carried out by the municipality of Cotacachi, the CIS, the AUC, and the cantonal (decentralized) health system are based on recognition that inequalities in health care are “*unnecessary and potentially avoidable differences in one or more aspects of health in population groups defined socially, economically, demographically, or geographically*” and it is precisely on this basis that primary health care and intersector relations have been strengthened, and conditions have been created to reduce the risks of inaccessibility of health care services to a minimum. Actions are targeted to the rural and poor population and to indigenous groups, since these are the groups that suffer from inequity and social exclusion.

Through implementation of the primary care strategy, the cantonal health system (SCS) acts to prevent the appearance of health problems, particularly among individuals whose socioeconomic condition makes them vulnerable. It mobilizes other sectors, for example literacy, which is targeted to the rural, poor and indigenous population and helps to increase their participation in education for individual and collective self-care, exemplified by working with the health determinants and risks approach, healthy spaces, schools that promote health, schools that promote development, etc.

The SCS has also improved its treatment capabilities and offers essential medical services free of charge in order to resolve health problems when they arise.

Since Cotacachi is one of the poorest cantons in the country and the public policies that allow for comprehensive actions by players and sectors are fashioned by public policy exclusively on the local level, they are not supported by the central level and it is understandable that the capacity of the local government to influence social determinants is limited.

For the Cotacachi local government, working on health from the primary health care and promotion approach is fundamental, since this can minimize the damage that can be caused by risk factors, helping people to cope with them better, and reducing the probability of falling ill in situations of deprivation (therefore the matrix for classifying the health risk of a given geographic space is fundamental for the SCS) and the other is to ensure that the quality and quality of the services provided is aligned with the increase in the volume and complexity of health problems in the population groups that face excessive risk of a disease (the efforts by the local government to promote accessibility are apparent in the chapter on interventions in health services). In other words, it is an effort to address the increase in needs and the types of health care services that inequalities create. [sic]

Another aspect is that the health services network subsystem includes Kichwa-speaking staff in its operational units, which has been crucial in favouring access for population groups suffering from social exclusion. The interrelationship with services on the second level of treatment, plus the association with NGOs (members of the SCS) makes it possible to treat a larger percentage of the excluded population. To that end intersector social services and health actions have been improved and deepened with the objective of creating accessible social support systems for the neediest population groups.

As for the adoption of healthy lifestyles, the subsystem for health promotion (which is part of the SCS) is responsible for coordinating and mobilizing other players and sectors. To that end it carries out information, education, and communications campaigns through its own services network and the networks of other players. This is a long-term activity since the adoption of a healthy lifestyle involves convincing individuals to adopt our [sic] behaviour, attitudes, and practices.

CIS strategies to mobilize citizen participation. Social inclusion

The CIS is a policy coordination body; its president is the mayor, its vice-president is the president of the AUC, and its technical secretary (advisor) is the director of the cantonal health system (we will explain later what the system consists of). It implements actions through its members. Its relations with the other sectors are horizontal and its strength is that once actions, activities, programs or projects are agreed on, the directors mobilize their federations which, in turn mobilize their smaller member organizations, and they mobilize families. The result is that a large and complex network of social players works to improve health and living conditions under the leadership of the CIS.

- **Social inclusion of children**

The CIS supports work with children, promoting healthy recreation, knowledge of their rights, and projects involving painting, music, and art. The children's organizations are currently becoming consolidated their organizations with the support of different entities; they have held cantonal and zone congresses and development plans for children have been drafted.

- **Social inclusion of adolescents**

Work with adolescents was promoted by the AUC and the CIS, as a member of the assembly, contributed by seeking financial resources and technical assistance for actions with youths. Soccer and basketball tournaments and music competitions have been held. In 2000, the young people came up with their development proposal through workshops with the youth coordination offices in the Intag zone, the urban zone, and the Andean zone. The youths elect the president of the cantonal youth coordination office from among the three coordination offices, and the president is an automatic member of the AUC's development and management council.

In 2001, as a reward for its hard work, the cantonal youth coordination office was recognized on the national level and was awarded the prize "El duende soñador participación de la niñez y juventud."

Today two of the three coordination offices have legal status granted by the Ministry of Social Welfare.

- **Gender inclusion**

The 1999 assembly established a gender committee as part of the coordination committee. Women's organizations arose in 1997 and 1998, led by women who participated extensively in the assembly in the different venues. Awareness was raised of the need to carry out specific work with women as a result of the participative process in general.

The appearance and strengthening of women's organization has been and continues to be supported by the CIS. Today there is a women's shelter for victims of domestic violence. The shelter, in turn, is part of the SCS. The members also carry out productive activities to improve their family incomes.

- **Cultural inclusion**

The CIS promotes and coordinates links between the ancestral medicine of the indigenous peoples and the SCS. The system has incorporated instruments that permit referrals and counter-referrals, designed educational materials targeted to the indigenous population, and prepared standards for licensing midwives so they can enjoy social and legal legitimacy as ancestral health care providers.

CHAPTER III. SHOULDERING NEW RESPONSIBILITIES TOGETHER

The CIS and the decentralized SCS

Since the CIS is a policy body whose function is to coordinate and lead the health process. Out of its concern over the lack of health services and the continuous mistreatment of users, it made a preliminary decision (CIS assembly) to decentralize the operational units of the Ministry of Public Health and took its proposal to the eighth AUC, which was held in 2001. The CIS's proposal was unanimously supported by the citizenry.

Up until 2002, the CIS had successfully engaged in coordination and leadership of actions to improve the health and living conditions of the population, but given the dearth of health services provided by the Ministry of Public Health and in response to explicit demand by citizens, it determined to take over decentralized administration of all the health units.

With the general support of the AUC and technical advisory services by the CIS, the municipality of Cotacachi formally applied on 19 July 2002 to have health responsibilities transferred, in accordance with the legal framework in effect at the time.

The process of transferring responsibilities was long and difficult. More than 96 meetings were held to review the agreement. Finally, in July 2003, an agreement was signed between the Ministry of Public Health and the municipality of Cotacachi, in the midst of a national protest by health syndicates.

The CIS, the decentralized SCS, and Ministry of Health leadership on the local level

With the delegation of certain leadership functions by the Ministry of Public Health to the municipality of Cotacachi it, in turn, shared those responsibilities with the CIS. Shared leadership was made feasible by the composition of the council which, in summary, is composed of the local government (municipality), organized civil society, the AUC, and the SCS—Health Area No. 3.

Ministry of Public Health leadership in the SCS

Delegates leadership	Ministry of Public Health (MSP)
	Provincial Health Directorate of Imbabura (DPSI)
Shared Leadership Municipality Of Cotacachi	
Intersector cantonal health council:	
	<ul style="list-style-type: none">• Municipality of Cotacachi• AUC• Cantonal Health System—Health Area No. 3

CANTONAL HEALTH SYSTEM

For the municipality of Cotacachi (local government, the CIS, AUC, SCS—Area No. 3), recognizing the leadership role of the MSP is a fundamental premise that reflects in practice the mandates contained in the Basic Law governing the National Health System and national health policy.

The main guidelines for the practical application of leadership are defined in the cantonal development plan and the cantonal health plan and are co-executed by the CIS and the cantonal health system (SCS).

Construction of the decentralized SCS

The cantonal health system is an operational entity composed of the same institutions or organizations as the CIS, with the difference that its members work on the operational level, i.e. the directors and/or coordinators.

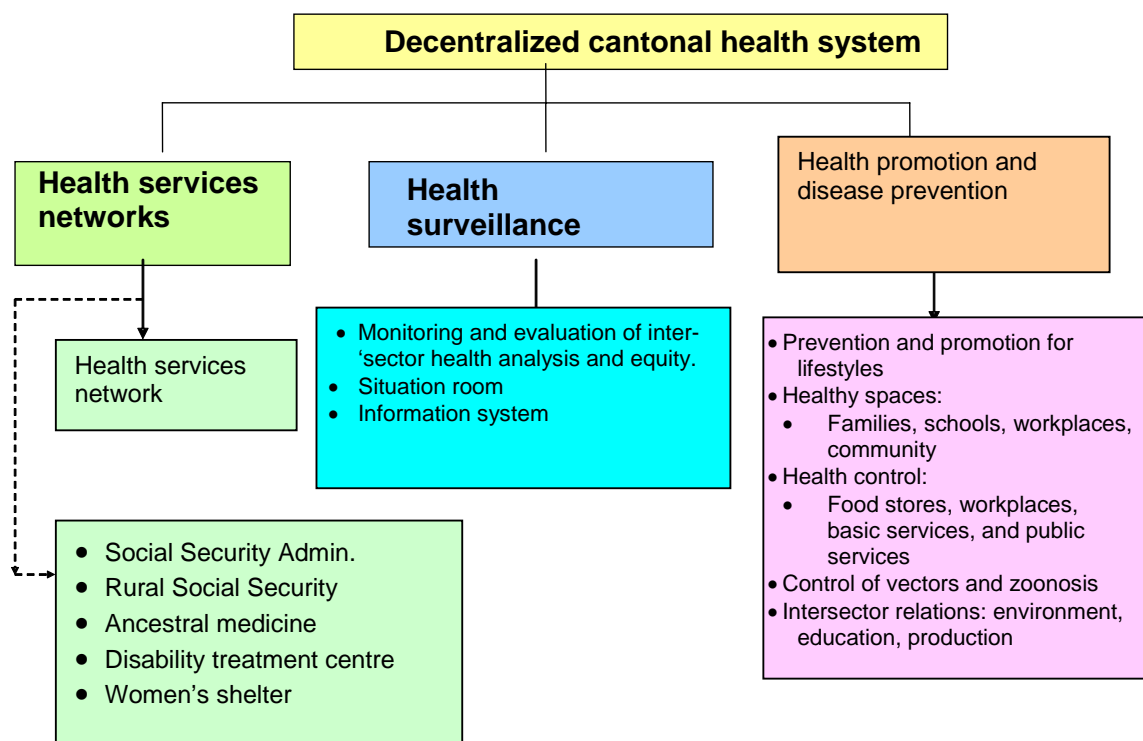
Members of the decentralized SCS

The members of the SCS are the same as the members of the CIS, but on the operational level:

- a. Representation of the local government: departmental directorates
- b. Representation of the AUC: technical team
- c. Representation of the local health sector: director of the system, zone directors, hospital manager, and other departments of the operational health units
- d. Jambi Mascaric coordinator of the union of rural and indigenous organizations of Cotacachi (UNORCAC), Intag zone committee
- e. Director of the women's shelter of the cantonal women's coordination office and delegate of the solidarity funds management committee
- f. Director of the disability treatment centre
- g. Director of the institute of childhood and adolescence

Organization of the decentralized cantonal health system

The decentralized cantonal health system (DSCS) is composed of three subsystems: the health services network subsystem, the health surveillance subsystem, and the subsystem for health promotion and disease prevention.



Health networks subsystem

Coordinates health public services providers (cantonal health system—Health Area No. 3¹⁰) and the entire cantonal public network (over which it has direct control), providers of ancestral medicine, general social security, rural social security, private for-profit and non-profit. The members of this subsystem complement each other's health services delivery functions and financing.

Health surveillance subsystem

Includes the design and implementation of a common information system on the health services of the different providers and the prioritization of tracking indicators in the other sectors, such as education, the environment, production, tourism, basic services, electricity, citizen participation, and others.

The principle of this subsystem is to provide strategic, timely, and accurate information on the status of development of the different sectors, which will be used as the basis for planning cantonal development.

For the construction of this subsystem, a baseline has been prepared in which the variables and indicators have been prioritized. A multidisciplinary team has been established and it will begin operating in the coming months. The process has been and continues to be supported by the Pan American Health Organization.

¹⁰ This name comes from the transition to decentralization.

Health promotion and disease prevention subsystem

This subsystem organizes the contribution of organized civil society which has been participating actively in the CIS since 1996. Its contribution has been very important in improving the quality of life and well-being of citizens.¹¹

This subsystem coordinates the following programs:

- Information, communications and training, which is applied in practice through constant feedback among the different members of the SCS and which is supported by the different intersector councils, particularly the education council. The program is intended to promote healthy lifestyles and to reduce alcoholism, domestic violence, child abuse, promote healthy habits in hygiene, nutrition, and a host of strategies whose initiatives arise from the players.
- Promote healthy environments where actions are defined to reduce pollution by solid and liquid waste and to foster urban agriculture, etc. The responsibilities are defined jointly, for example, maintaining clean environments is the responsibility of the community, improvement of water quality is the responsibility of the municipality or partner NGOs.
- Health control: Actions to implement the cantonal health control directorate, integrating and coordinating responsibilities in this area with the Provincial Directorate of Imbabura and Cotacachi, in order to avoid unnecessary duplication and achieve greater efficiency and effectiveness.
- Relations with other sectors. Intended to mobilize the other sectors to improve well-being and the quality of life of citizens and influence the health determinants. In function of the 2001 baseline for the canton and with citizen participation, interventions have been targeted to improving the quality of water and housing, expanding electricity coverage, and developing the schools as promoters of development program, etc.

Levels of leadership of the decentralized cantonal health system

SCS Directorate

The SCS Directorate—Area No. 3 is the management structure of the system. It has basic responsibility for developing and consolidating the system in Cotacachi and complying with the mandates of the local government the AUC, and the CIS. Its basic activities include:

- Practical implementation of coordination with all cantonal health actors.
- Management of the different SCS subsystems: the health services network, health promotion and disease prevention, and health surveillance and control.
- Acting as technical secretary of the CIS (the director of the decentralized cantonal health system is the technical secretary of the CIS and acts as advisor).

Zone coordination offices

There are three zone coordination offices: Intag, Andean, and subtropical. They are responsible for guiding and implementing the work of the subsystems on the zone level.

¹¹ Revise the module on health promotion: citizenship and health. [sic]

Organizational structure of the SCS Directorate

Cantonal Health Directorate

Financial subdirectorate

Directing council

Ethics committee

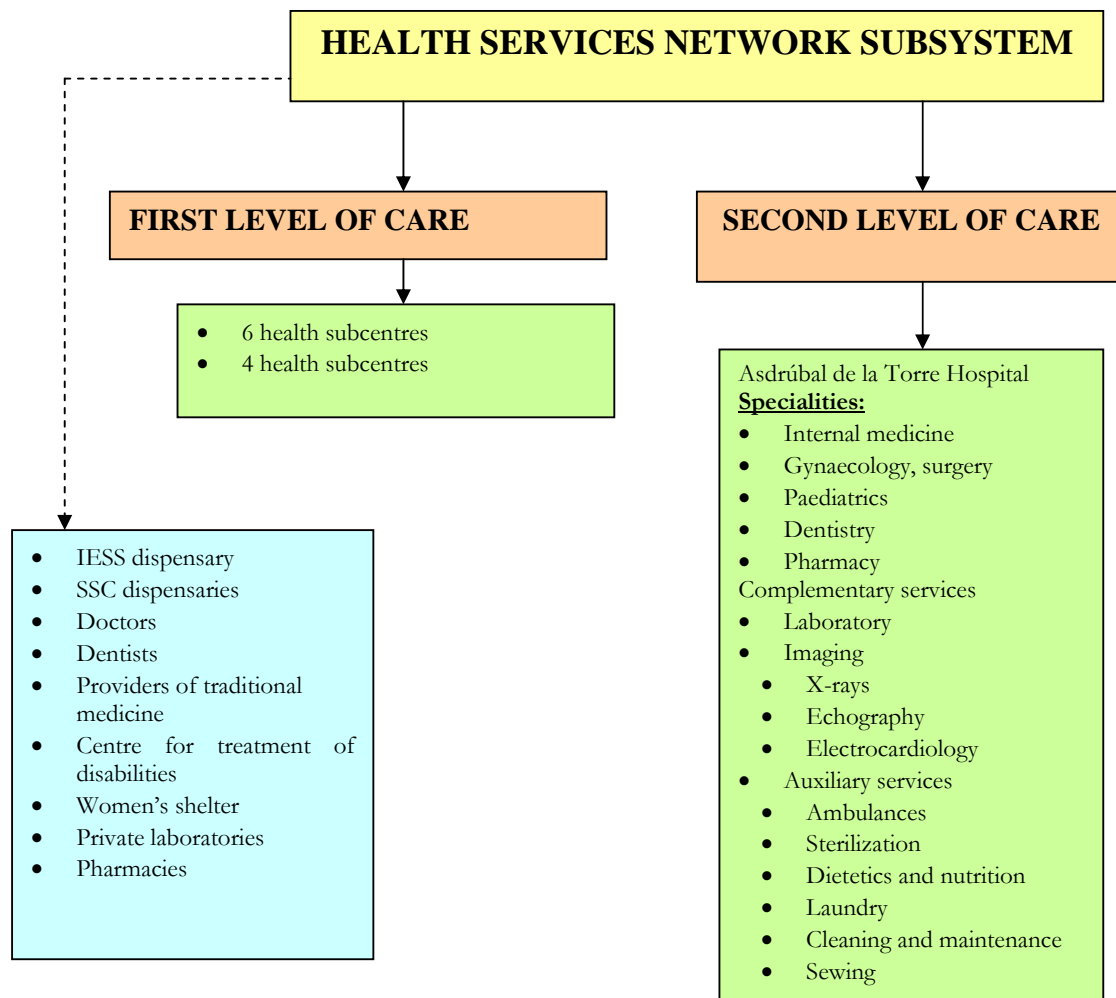
Pharmacology committee

Andean zone	Urban zone	Intag zone
Health promotion and disease prevention	Health promotion and disease prevention	Health promotion and disease prevention
Services networks	Services networks	Services networks
Health surveillance and control	Health surveillance and control	Health surveillance and control

Structure of the health services network subsystem

The responsibilities that have been transferred are implemented in this subsystem, which links and coordinates the health services providers (public, cantonal health system—Health Area No. 3¹²) and the entire cantonal public network (over which it has direct control), providers of ancestral medicine, general social security, rural social security, private for-profit and non-profit. The members of this subsystem complement each other's health services delivery functions and financing.

¹² This name comes from the transition to decentralization. [Footnote repeated in the original. Tr.]



Financial sustainability of the CIS and the decentralized cantonal health system

The CIS has a small technical team, a manager, a secretary, and a financial administrator. Thus far, it has maintained itself with counterpart funds from the local government and has been able to undertake small national and international cooperation projects. The team is responsible for the logistical and operational coordination of the CIS jointly with the president, vice-president, and technical secretary.

However, it has been necessary to seek alternative forms of financing for the decentralized cantonal health system. A local health fund currently exists that consolidates economic contributions and contributions in kind.

The characteristics of these sources are:

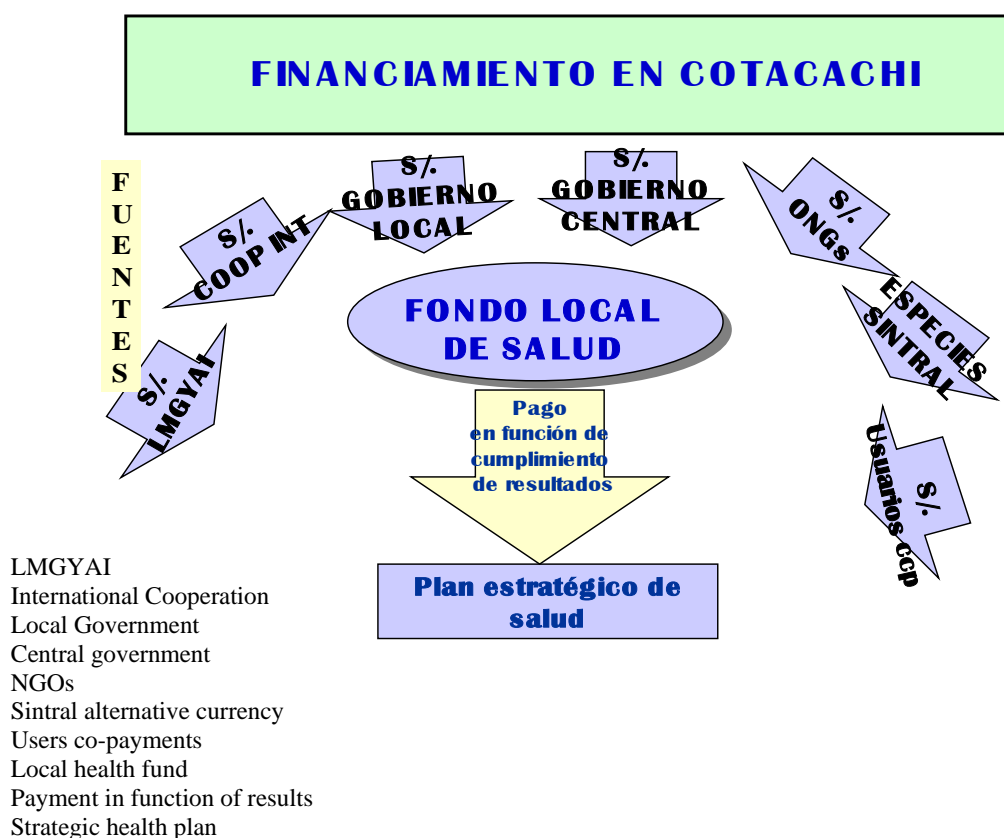
- Coordination of different sources of financing: fiscal resources on the central level (allocations from the Ministry of Public Health), municipal resources assigned under the participative budgeting process, resources from the municipal fund, and resources from the Free Maternity and Child Care Law.

- Coordination of private sources, mainly NGOs; the sources are virtual, in kind, and in cash. Support from families through co-payments for health services, except for people without the capacity to pay, who contribute in kind or with specific work (using an alternative currency).¹³
- External resources in the form of technical assistance from international cooperation or financial resources tied to specific projects defined in function of the priorities established by the AUC and the CIS.

The municipality of Cotacachi assigns 12% of its total budget for health services and an additional percentage is used for the investments established in the cantonal health plan.

The resources of the other health services providers, such as the IESS or Rural Social Security, are not coordinated, owing to their own dynamics. However, the health services network subsystem of the SCS permits any system to have access, regardless of whether they are insured or have the capacity to pay. This complies with the principles of accessibility, universality and others.

Financing for the Cotacachi SCS



¹³ The contributions from households without the capacity to pay can be made in kind and sold on a community market which operates with an alternative currency (promissory notes) created by the community itself. The health services network forms part of this system and therefore users can ‘buy’ health services with the alternative currency or in kind “I give you a hen and will take rice and sugar,” or “I am going to the hospital in exchange for ...” or they can also contribute work in the form of gardening, painting, repairs; they only need to register and become members of SINTRAL (local exchange and transactions system).

The health care model. Guidelines

The guidelines for the health care model are defined by the CIS and implemented by the SCS. The health care model is family- and community-based, and intercultural. It prioritizes primary health care strategies and health promotion.

- **Family health approach**

The health care model of the SCS conceives of the family as an active player that needs to be educated, informed, and made aware of the factors that contribute to its well-being and quality of life and the factors that can affect it negatively. Promotional work is done to inculcate a spirit of self-responsibility for one's own health, and to foster behaviours, patterns, or customs that lead to healthy life styles.

- **Community health approach**

The communities and urban districts in Cotacachi canton have their own administrative and managerial dynamics as well as participative expressions in which decisions are taken collectively. The indigenous communities of Cotacachi provide, maintain, and administer basic community services (water, road maintenance, maintenance of irrigation channels, etc.) and undertake community development projects. The districts, for their part, have undertaken productive projects (invigoration of production and sale of leather goods), urban agriculture (healthy spaces project) and other initiatives. This community and district mobilization to improve living and economic conditions, which has been strengthened in the participative process, steers the health model into promoting these characteristics and mobilizes communities and urban districts on behalf of their health.

This approach means that “giving or having health” is not the exclusive responsibility of the health sector, and helps to “discover” other health determinants, such as the environment, sociocultural and economic conditions, interpersonal relationships, emotional factors, all of which contribute to the quality of life.

This approach makes it possible to identify other “communities” such as schools and workplaces, so that a large number of initiatives can be undertaken.¹⁴

- **Intercultural approach¹⁵**

This approach leads us to recognize how diverse we are as individuals and peoples; the need to understand, respect values, customs, the cosmovision of health and life that human groups hold and interact with it by contributing and incorporating elements, approaches, knowledge, under equality of conditions. The concept of health held by indigenous peoples is a sum of balances between humans and their environment and in deep relationship to social, historical, and cultural elements and is a fundamental contribution to the health care model. It is in this framework that this approach led us to seek and identify meeting points between Western medicine and the traditional indigenous medical culture.

¹⁴ Health promotion module: Citizenship and health.

¹⁵ Health promotion module: Culture and health.

CHAPTER IV. THE FIRST FRUITS

In the health care model

To make the health care model respond to the principles of the SCS and its approaches, some changes were made in the organization, operation and financing of the previous model:

- Administrative and managerial reorganization of the services network.
- Improvement in treatment capabilities in the internal health network.
- Coordination of the internal health services network.
- Coordination of the ancestral medicine of the Kichwa peoples of Cotacachi.
- Coordination with other health services providers.
- Creation of a system of timely and real information for planned decision making based on the needs of the population.
- Strengthening and deepening the intersector relations promoted by the SCS based on the primary health care and health promotion strategies.

- **Administrative and managerial reorganization of the health services network**

The reorganization was based on the need to strengthen administrative and managerial performance in the health services network, since decisions had previously been made in the urban zone of Cotacachi, ranging from the smallest (paint a health unit) to the largest ones (actions in emergencies).

- **Creation of the SCS Directorate**

Creation of the SCS Directorate responds to the comprehensive approach to health taken by the canton. The responsibilities of this directorate, as was mentioned in another chapter, include guidance, coordination, design of strategies, plans and programs, monitoring, oversight, evaluation, etc. of the activities of the three subsystems, jointly with the CIS.

- **Internal organization of the network**

The first measure that was taken after the health services were decentralized was to organize the internal network based on the geographic division that the local government and the AUC defined as a strategy for reaching all corners of the canton more equitably and benefiting all its citizens.

For working reasons, the canton is divided into the Andean, urban, and subtropical zones.

- **Creation of the hospital management office**

Originally, the chief of health area No. 3 was responsible for administering the operational units distributed throughout the canton and the Cotacachi hospital. The area chief concentrated his work on the hospital and the urban zone and work was incipient in the other zones.

After the hospital was transferred to the local government, the hospital management office was created, while the administration of the operational units present in the Andean and subtropical zones are administered through the zone coordination offices which, in turn, are coordinated by the cantonal health directorate (see chart).

- **Greater management autonomy and deconcentration in decision making**

The guidelines and policies are clearly defined and established by the cantonal CIS, and are used to guide the actions of the SCS.

The SCS Directorate, the hospital management office, and the zone health coordination offices have administrative autonomy, although they are guided by the SCS Directorate.

This autonomy in decision making has resulted in the implementation of interesting initiatives such as the extra-mural health teams and others, depending on the dynamics in each zone.

Continuous improvement in the operational health units

- a. Improving treatment capabilities and moving from the first level of care to a second level with the creation of the internal medicine, paediatrics, gynaecological, and general surgery services.
- b. Increase in professional human resources
 - There was an increase of nine physicians. Six of them work full time at the hospital or in the extra-mural health teams; three work half time, and in the other half of their time they act as coordinators of the three zones established in the canton (the technical cooperation agreement and Cuban medical assistance provide: 1 gynaecologist, 1 paediatrician, 1 surgeon, 1 anaesthesiologist, 3 family doctors, 1 laboratory technician, 1 x-ray and imaging technician).
 - One physician is assigned full time to the Apuela and Garcia Moreno area.
 - One itinerant nurse is assigned to Chontal and Magdalena.
 - One nurse is assigned to the health post at Charguayacu Bajo.
 - Health care professionals are assigned to the travelling teams that consist of a physician, nurse, health promoter and dentist who visit the communities three times a year, following a schedule of priorities.
 - Three additional Ecuadoran physicians came to the area, adding to the original three.
 - One physician is assigned to manage the hospital.

Better access to generic drugs

- Generic drugs are prescribed in the health services subsystem and sold under the parameters of least-cost, quality, and effectiveness through the municipal fund's network of pharmacies in the cities of Cotacachi and Quiroga.
- Increase in financial resources to expand the generic drugs available at the Cotacachi hospital.

Improvement and expansion of physical infrastructure and medical and technological equipment for the hospital and all the operational health units

Health subcentres and posts

- Remodelling the subcentres at Garcia Moreno, Cuellaje, Apuela, Peñaherrera and Plaza Gutierrez.
- Construction of a health post at Magdalena Bajo.
- Rehabilitation of the Chontal health post and a health post is maintained at Chalguayacu Bajo. Basic equipment and a nurse were assigned.

Asdrubal de la Torre Hospital – 2004

- Expansion of outpatient consultation facilities, pharmacy, statistics.
- Increase in visits for vaccinations, cures, physical preparation which did not previously have a definite physical space.
- Expansion of the laboratory and increased space for the blood bank.
- Expansion of the physical area for emergencies.
- Rehabilitation of the hospitalization area and the nursing station.
- Physical improvement and modernization of the dental and X-ray services.

Equipment

- Equipment for the blood bank (its implementation is under way).
- Automation of the clinical laboratory (under way).
- Renewal of the X-ray equipment, the old machine will be sent to Apuela.
- Purchase of an ambulance with the existing one located in Apuela, which is a convergence point.
- Electrocardiograms by telephone
- Echosound equipment
- Minor equipment at subcentres
- Clinical laboratory equipment in Apuela
- Two mobile dental clinics for the Intag zone

Improvement in technology services

- Provision of a computer for each of the operational units
- Implementation of an electrical voice and data cabling system at the Asdrubal de la Torre Hospital
- Implementation of the EPIINFO WINSIG program at the hospital
- Implementation of the SIGEF program
- Radio communications equipment at fixed stations in all the operational units; two mobile stations for the two ambulances; fixed stations at city hall, the police station, and the fire station.

Improvement in treatment capabilities

- The EPIINFO WINSIG and the SIGEF programs at the hospital
- Doctors have been sent to specialized/upgrading courses in paediatrics, dentistry
- Attendance at medical congresses
- Upgrading nursing assistants and other administrative resources to the high school diploma level
- Health promoters and midwives trained at the Northern Technical University
- Expansion and redefinition of the set of essential health services, including individual and collective disease prevention, recovery and rehabilitation, focused by age groups and toward families and the community.

Internal coordination of the health services network

Public health services in Cotacachi canton are coordinated through different mechanisms:

- Radio communications system, which is an alternative means for responding to emergencies and for providing training for health personnel and social services for the community. There are two [sic] radio subsystems in the Intag zone, one in the hospital, one at city hall, and one at the police station.
- Emergency subsystem; an ambulance was provided for the largest referral centre, which is the hospital, and one for the parish of Apuela since the operational unit in this parish is a centre of confluence.
- Coordination through referral and counter-referral mechanisms and through the cantonal hospital is the main support. The hospital now operates 24 hours a day, year-round. The system currently functions as follows:

Coordination with the ancestral medicine of the Kichwa peoples in Cotacachi

- Community promotion of health through midwives.
- Monitoring of pregnant women through the midwives who report risk conditions to the hospital.
- Vertical delivery assisted by the midwife with problem cases sent to the hospital.
- Traditional medical care at the Sol de Vida Family Health Centre.
- Construction of a traditional medicine centre in Cotacachi.
- Coordination in management of the Free Maternity and Child Care Law.
- Coordination through certification and licensing of midwives.¹⁶
- Coordination in the health services subsystem with the providers of traditional medicine, such as midwives. They establish mechanisms for referral and counter-referral by agreement.

Coordination with other health services providers

- Coordination with other health services providers such as the IESS or the Rural Social security, despite the efforts made to integrate them into the SCS, has not been viable in practice. Those institutions are unable to take decisions since they depend totally on the central level which has no clear mechanisms for interrelationships or complementarity with other health care providers. However, the Rural Social Security Program (SSC) participates in planning in the health services networks subsystem on an ad hoc basis. In short, coordination is incipient.
- Standards are being designed by the health services subsystem to be applied to private suppliers. They are intended to ensure that private suppliers deliver their health production [sic] to the cantonal information system, so that statistical and epidemiological information will be more realistic and complete.

Creation of a timely and reliable information system for planned decision making based on the population's needs

- A statistical and epidemiological cantonal information system is being constructed which includes the compilation of the production of different organizations and institutions that

¹⁶ See the annex: Meeting points between traditional and Western medicine.

provide health care services. The system will also provide information on the situation in other sectors such as education, production, environment, and others that are priorities for the canton, and on the participative process.

Assistance in cases of domestic violence

- Domestic violence has been made a priority and 1,200 cases have been assisted since 2003-2004.

Maternal and child mortality

- In 2004, 2005, and 2006, Cotacachi had no cases of maternal or child mortality, thanks to coordinated, joint, and organized work. Strategies are currently being defined to declare Cotacachi as a territory free from malnutrition by 2010.

Evaluation of intersector activities

The decentralized cantonal health system is composed of three subsystems, one of which is the health surveillance subsystem. It consists of:

- Monitoring and evaluation of intersector health analysis and equity. This unit compiles information from the other sectors, such as education, gender activities, generational, production, tourism, environmental health (safe water, sewerage, solid waste removal). It processes the information and presents the results to different bodies: the assembly of the CIS, the municipal health council, the senior development and management council of the AUC, and the SCS.
- Situation room: This unit monitors the canton's epidemiological profile and tracks diseases whose reporting is compulsory. It processes the results and presents them to the same bodies mentioned above. However, it stresses analysis in the operational health units.
- Information system. This unit compiles the variables and indicators produced by the monitoring and evaluation unit and the situation room. The results are presented at the AUC and the budget is guided by those results.

The evaluation performed in 2004 of the cantonal health plan was not limited exclusively to the health services, but extended to intersector actions and broad participative processes, particularly with the members of the CIS, the municipal health council, and the AUC's development and management council.

In general, the evaluation process leads to better horizontal integration between the members of the CIS given that according to their roles and responsibilities, each player has its field of action which does not necessarily involve financial or material resources or installed capacity, but which contributes to the goals and objectives of the health plan, based on the responsibilities shouldered. For example, the Federation of Urban Districts does not provide financial resources for the health plan, but its capacity for social mobilization is highly appreciated. This form of relationship in functions of goals and objectives creates solidarity among the members and feelings of ownership of the actions proposed in the plan.

The results presented below are the fruit of the work by each and every member of the CIS.

PROGRAM	Components/Activities	Evaluation at 2004
Health policies	Review of health-related ordinances	Not reviewed; was not necessary
	Analysis of production, tourism and environmental activities and their impact on health	50% completed
	Negotiation and issue of new ordinances	No new ordinances have been issued
Healthy schools	Courses for teachers and students in nutrition and diet in schools	60%
	<ul style="list-style-type: none"> • Education for health incorporated into the curriculum of kindergartens and schools • Modules published and taught 	100%
	Construction and maintenance of all school toilets	30%
Healthy spaces and promotion of equity in basic sanitation	Five safe water systems in communities that had no service	100%
	Management of a cantonal alternative solid waste disposal system at strategic places	Implementation is beginning
	Provision of 1,500 family latrines for communities with none, based on designs tailored to the rural situation, and 500 repaired	5%
	Watershed recovery	30%
	Tree planting un urban and community areas	50%, in coordination with the Environment Club
	Rehabilitation of six public spaces for community recreation and sports	100%
	Alternatives for the construction and rehabilitation of healthy housing with local materials	50%
Health information, education and communications (cross-cutting implementation)	Sexual and reproductive education, family planning	80%, in coordination with CONAMU
	Promotion of LMGYAI services	80%, in coordination with CONAMU
	Protection of children's and adolescents' rights and information about them	80%, in coordination with the AUC
	Detection of signs of risk and violence	80%
	Mental health: Drug addiction	50%
	Environmental health: Water quality, adequate solid waste management and pollution reduction	70%
	Identification of risks and natural protection mechanisms	50%
	Diet and nutrition	70%
Community action for health	Implementation and participative evaluation of the cantonal health plan and the annual work plans	Programming 70% Evaluation 20%
	Institutional development, strengthening of the CIS and ... [sic]	80%
	100% of the eight rural parishes establish health committees for health services management and social oversight	100% of urban and rural parishes covered and committees have been established in three zones.
	Users committee established and forming part of the CIS, with mechanisms designed and implemented	

PROGRAM	Components/Activities	Evaluation at 2004
Food security	Feasibility study and three pilot projects on farms for the recovery of the Andean and tropical agro-ecological system	
	12 family and parish vegetable gardens	
	Control of food sales and handling	
	Coordination of diet and nutrition projects for vulnerable groups: school lunches, snacks, and dietary supplements < 1 year	100% integrated as components of healthy schools
Family and citizen security	Study and pilot project on the control and prevention of alcoholism and drug addiction	Yes
	Study and pilot project on the control and prevention of abuse and domestic violence	100%
	Study and pilot project on the control and prevention of street gangs	Yes
	Study and pilot project on protection and safety for urban districts and communities	Yes
Strengthening of traditional Andes medicine:	Study and pilot projects to strengthen the practice of a combination of traditional and Western medicine	70%
	Networked traditional medicine systems created and operating	70%
	Botanical inventory of medicinal plants	Initial implementation
	Certification of providers of traditional medicine and inventory of providers	30 midwives and health promoters have been licensed and issued identification cards in cooperation with the Imbabura Public Health Directorate

Source: Cantonal Management Team of Cotacachi, 2005

Evaluation of actions in accordance with the guidelines of the strategic health plan 2002-2006

Program/Project	Components/Activities	Evaluation at 2004
Incorporation of health promotion	Set of actions included in the tasks of the health services for community care; intersector in nature	80%
Better access to public health services	30% increase in the coverage of health services, based on complete COPRES, particularly promotion and prevention	100%
	A network of health services established and operating, particularly for maternal and child care.	75% not just formal services but also traditional medicine
	At least six mobile interdisciplinary teams, with a doctor, nurse, and health promoter or leader to provide health care for the community in schools and remote areas	75%
	Alternatives and/or modalities for paying suppliers	70%
	Strengthening the treatment capabilities of the public operational units; remodelling, equipment	80%

Program/ Project	Components/Activities	Evaluation at 2004
Disaster prevention and response	Necessary interventions for the prevention of natural disasters, including landslides, collapses, flooding, earthquakes, etc.	50%
	Preparation and implementation of a contingency plan in coordination with civil defence	50%
Improvement in the quality of health services	Establishment of quality control circles for health services processes and products	50%, particularly in relation to LMGYAI benefits
	Oversight of the process of licensing/accreditation of health services	100% of health units licensed in coordination with the Public Health Directorate (DSI), Imbabura
Ongoing training and education for human resources	At least 50% coverage of polyvalent training for community human resources and legal recognition	40%
	Training for 50% of midwives	70% with DSI-MSP Imbabura
	100% training for human resources in problem areas (malnutrition, environmental sanitation, sexual and reproductive health, child health) stressing training for community health professionals	30%
	100% training in health and gender in coordination with the CIS and other organizations	80%
	100% training for shamans, midwives and health promoters	50%
	100% training in administrative health functions	30%
Health research: design and execution	Research into the advantages of natural medicine designed and conducted	10%
	Priority research agenda prepared	5%
Monitoring and evaluation of programs and projects	System for monitoring and evaluation the plan	30%
	Health surveillance system	50%
Institutional development in health services	Strengthening the public health services system through infrastructure, equipment, furnishings, human resources	80%
Development of systems to support CIS and health services management	Referral and counter-referral system design and implemented	80% support by ambulances

Achievements by other players and sectors that belong to the CIS

- **Education**

In 2005, Cotacachi declared itself free from illiteracy in a ceremony recognised by UNESCO, having taught more than 6,000 illiterate people to read in approximately two years. It is currently in a post-literacy stage and by 2009, Cotacachi hopes to be able to declare itself a territory where the population has completed primary school (grade seven).

- **Basic sanitation**

Average drinking water coverage in the canton is 75%, which has been achieved through national cooperation and citizen contributions.

- **Electricity**

Ninety-eight percent of the canton has electric light.

In productive projects

- **Natural fibre crafts.** The products are exported to Italy and to the international fair trade network. This economic alternative is a response by the participative process to counteract job offers by mining transnationals.
- **Rio Intag organic coffee.** Initiative of the Rio Intag Coffee Growers Association, founded in 1998; the packaging is made of maguay fibres by women's groups. It is exported to Japan and is very well received on the domestic market. Approximately 500 families benefit from this project.
- **Natural shampoo and soap.** The El Rosal women's association of Garcia Moreno parish (Intag) makes natural soap and shampoo; the profits are shared communally and the products are mainly sold on the national market.
- **Organic sugar.** The El Cristal Artisanal Agricultural Association (Intag) produces organic granulated sugar; it has obtained health licensing and sells the product in Imbabura province.
- **Urban and Andean organic farming.** The Federation of Urban Districts promotes this project for self-consumption; any excess is sold on the Jatuk Cem Andes market.
- **Maguay fibre crafts.** There are a number of women's organizations in the Intag zone that engage in this activity. They use dyes from plants and trees native to the zone. They have a shop in Otavalo to sell their crafts.
- **Ecological tourism.** Several initiatives exist and some stand out for the social and community nature of their administration and their benefits, such as the ecotourism complexes at Junin, Reserva La Florida, Los Cedros, Cuicocha, Yana Yaku and Nangulvi; the latter two are administered by indigenous youths and by Intag, respectively.
- **Leather crafts.** The production of leather articles has grown significantly in the last three years. In addition to taking care not to pollute the environment, new products have been created to convey the image of Cotacachi. To date, two fairs have been held with very promising results for this economic activity.
- **Sewing workshop.** The Urban Women's Coordination Office has a workshop called "Creative Hands" whose production is sold on the local market. The activity helps to improve the income of the women members.

- **Joint ventures.** Joint ventures have been established for the Cuicocha complex and the municipal market, and approved by the Office of the Superintendent of Companies. The start-up capital is mostly public (municipality) and private; for example, in the case of the Cotacachi market, the shareholders are the vendors themselves. These are new experiences which originally encountered resistance and difficulties; now their positive results are being institutionalized.

The CIS and horizontal and vertical relations with the other players and sectors

The CIS is a key organization for the development of the health sector as such, and for mobilizing the other sectors that bring well-being to the population. We have pointed out that on the local level, the CIS has strengthened horizontal relations among its members, through the different decision-making mechanisms explained earlier.

Each member of the CIS represents a series of territorial and sector groups with which operational work is done.

The relations between the CIS and the other sectors are extremely varied and complex. To offer a graphic demonstration, we will describe the relationship of the CIS with the Cantonal Women’s Coordination Office and the disabled.

The Women’s Cantonal Coordination Office of Cotacachi is composed of the three zone coordination offices (Andean, urban, and subtropical). Each zone coordination office brings together territorial or sector women’s representatives; for example the users, committee of the Free Maternity Law. Each zone has a users committee and they belong to the zone’s women’s coordination office. In turn, the users committees in the zones are composed of women who represent their communities.

The situation with the disabled is similar. There is a committee representing them in each zone and in turn they are coordinated by the Disability Treatment Centre.

Horizontal Relations of the CIS

Senior Management and Development Council		Municipal Health Council		Other intersector committees		Canton Health System	
Cantonal Intersector Health Council (CIS)							
Cantonal Women’s Coordination Office				Disability Treatment Centre			
Andean coordination office	Urban coordination office	Subtropical coordination office					
Users’ Committee	Users’ Committee	Users’ Committee	Andean disabilities committee	Urban disabilities committee	Subtropical disabilities committee		

Vertical relations of the CIS

The members of the CIS, in turn, can establish relations with their peers on the national, provincial, or local levels, but more operationally.

Ministry of Public Health		Ministry of the Economy and Finance		Ministry of Education		Executing Unit Free Maternity Law		National Disabilities Council	
Policy agreements									
Cantonal Intersector Health Council (CIS)									
Operating Agreements									
Cantonal Women's Coordination Office					Disability Treatment Centre				
Local NGOs		Women's Shelter	Cantonal health system	Municipal gender committee	Municipalities, Social Development Depart.		Cantonal health system		Provincial Disability Directorate

Local goals in health, education and environment in relation to national goals

The cantonal development plan and the sector plans contain concrete objectives and goals and programs, activities, plans, projects, and financial, material and human resources are guided in function of them.

In the case of the health sector, the 1997 cantonal development plan establishes the need to “Create the physical, technological, and human conditions and resources to facilitate exercise of the right to health of the population of Cotacachi” and it makes the CIS responsible for implementing it.

In the early years, the CIS worked along this line up to 2003, when in application of the legal framework, it determined to advocate that the municipality of Cotacachi take over the administrative management of the public health services. Simultaneously, the CIS undertook intensive work with the other sectors, which continues, mainly in education and the environment, with which it works in coordination, mobilizing social players and their resources to support the goals in those sectors, such as the cases of eradicating illiteracy in the canton and declaring Cotacachi an “ecological canton.”

The planning of cantonal development and sector planning are tools that the municipal government of Cotacachi uses to achieve its goals and objectives and the policies established in the cantonal and sector plans are declared public policies in participative processes (described in the section on public policies).

Public policies are the guide for defining programs, activities, plans, and projects and each of them establishes its own specific objectives and goals. Some examples are given below:

Free maternity law

- To avoid maternal deaths. To reduce the possibility of maternal mortality to a minimum.
- To avoid deaths among children under five. To reduce the possibility of infant mortality to a minimum.

Healthy spaces program

- To implement urban agriculture in all the districts of Cotacachi by 2009. Each year 10% will be covered. In five years the urban agriculture program will cover 100% of the urban districts.

Disability assistance program

- To identify and issue identity cards for 100% of disabled persons by 2008.
- To prevent disabilities through on-going sensitization campaigns.
- To provide rehabilitation and treatment services for the disabled through the Disability Treatment Centre.

The health goals on the national level are general and do not determine time frames, responsibilities, or resources and therefore are merely declarations or formulae and this is precisely one of the reasons why, in practise, the national goals are not consistent with local goals.

The situation in the other sectors is similar. In the case of education, the Ministry of Education defines an agenda which has not been put into practice. In the case of illiteracy, the ministry does not even support the municipality's literacy program. Despite this difficulty, the municipality was able to declare Cotacachi canton free of illiteracy and by 2009 it aspires to having everyone complete primary school.

As for the goals and objectives in the environmental sector, by declaring Cotacachi to be an ecological canton, the municipality's goal was and continues to be to protect the Cotacachi reserve zone, which is located in the subtropical area of Intag, from mining operations, which has been made possible through the environmental protection measures carried out by the citizens of Cotacachi.

The canton's most significant achievements

In health

Undoubtedly, having zero maternal and child deaths for three consecutive years is one of the most significant achievements, given all the social, human, and economic implications of saving a woman from death during childbirth. The simple fact that this prevents her other children from becoming orphans fills the municipal government and civil society with pride and optimism, given that they are fighting for a fairer world.

In education

Demonstrating that with good organization, political will, and financial resources that are efficiently and effectively invested is another area that Cotacachi is proud of. [sic]

In the environment

Being able to rein in mining in zones with great environmental impact, despite pressure from the national government and the transnational companies, is another of Cotacachi's successes. Its actions have not been limited to opposition. It has also provided other productive alternatives, and the community companies, such as the company that produces organic coffee that is exported to Japan, the

company that makes crafts from natural fibres which are exported to Italy, the organic sugar company and many others are alternative responses which, in addition to improving the socioeconomic condition of families, strengthens their sense of self-worth and the participative process.

CIS actions and their influence on the other sectors

The CIS is a body that leads actions related to comprehensive health care, as we have already mentioned. Its success is undoubtedly due to the organizational and participative process in Cotacachi canton, in which the leadership of the municipal government through the mayor, and the very high degree of social commitment by civil society organized in the AUC, are the determinants of CIS achievements and the transformations achieved in each of the sectors.

Without the commitment and leadership of the municipal government and civil society, it would not have been possible to sustain processes such as the decentralization of health care, on account of opposition from health professional associations and unions. Therefore, the municipal government very rightly holds that processes such as decentralization are tools; they are the means that allow the municipality to ensure that the citizens of Cotacachi can exercise their right to health. Decentralization is not an end in itself, but a means of achieving goals and objectives.

Is the Cotacachi process replicable?

The replicability of processes depends on the political will of the authorities and the degree of organization and participation of civil society. The processes depend on social, political, and cultural contexts. Although the Cotacachi process has not been replicated, as we might think it out to be on account of its results, the mere fact that Cotacachi is visited and studied by many local governments in Ecuador and other countries, and by delegations from national and international donors has mobilized awareness.

In the case of the literacy process, the municipal government of Cotacachi contracted two national advisors to disseminate the methodology; its signed agreements with more than 120 municipalities and 12 intermediate levels of government, which it has supported with technical assistance, literacy materials, etc.

In the case of health, the municipal government of Cotacachi has provided assistance for more than 120 municipalities on building a cantonal health system and has done the same in the environmental, tourism and production sectors, among others.

The Cotacachi process has spurred healthy emulation among the country's municipalities, which are beginning to stand out, not just on account of the physical infrastructure works, but also on account of their social achievements. In this sense, Cotacachi's contribution to the province and the country is very large.

CHAPTER V. OUR LEARNING PROCESS

The process of decentralization of the Cotacachi health services was the result of a long learning process and a need felt and demanded by the population, which laid the groundwork together with the local government to exercise their inalienable right to improve their health and living conditions.

It has demanded maturation, political will, managerial capacity, honesty and transparency by all the parties involved, including the players on the local level and on the provincial and national levels.

Decentralization for Cotacachi has been a social, technical, and political negotiation process that has required a permanent exercise in consolidating participative democracy.

The main lessons have been:

- Simply increasing financial resources does not guarantee that things will be done properly. **Planning is necessary.**
- Increasing financial resources and planning does not guarantee that the expected outcomes will be achieved. **It is necessary to employ a suitable strategy, analyzing social structures, processes, and relations.**
- Increasing financial resources, planning, and following a suitable strategy does not guarantee that individuals will perceive that their needs are being satisfied. **A change in the attitudes of individuals and their social relations is necessary.**

The above cannot be done without real participatory mechanisms, achieving individual and collective co-responsibility in the process of local development and health.

Success factors

Citizen participation in the CIS has a marked impact, not just on the health sector. It promotes and mobilizes other sectors to build better health and living conditions together.

The success factors can be summarized as follows:

- Express political will by the local government, which led the process of citizen participation and created avenues for citizen expression, such as the AUC, as part of building true participative democracy.
- Institutionalization of the participative process, which allows for permanent and sustained participation by civil society.
- Individual and collective ownership of the participative process and citizen co-responsibility.

Graph 17
Summary of success factors

<ul style="list-style-type: none"> • Broad participation, inclusion of indigenous people, women, youths, children • Organization of civil society • Institutionalization of the process: AUC • Legal recognition: ordinance 	<p>Participative democracy</p>	<p>Citizen empowerment</p>	<ul style="list-style-type: none"> • Strengthening grass roots organizations, autonomy and respect for their own forms of decision making. • Feedback between government and civil society, with continuous and timely information. • Training and on-going development to improve the organizations' proposals. • Consistency between political discourse and the tasks of public management.
<p>POLITICAL WILL</p>			
<ul style="list-style-type: none"> • Involvement of civil society in strategic planning, programs, projects, activities. • Input into decision making through the channels created. • Organized civil society on committees and councils puts into effect the assembly's decision. • Accountability at the annual assemblies. 	<p>Permanent participation</p>	<p>Ownership of the process, citizen co-responsibility</p>	<ul style="list-style-type: none"> • Joint implementation between civil society and the government of the cantonal development plan, increasing citizen co-responsibility which gives them a sense of ownership of the process. • Credibility in the process since it is citizens who exercise social control. • Response of the process to individual aspirations: productive projects to improve income levels. • Real decision making power in public management.

Lessons learned

- a. **The political will of the local government** is important for institutionalizing the participative process, which has meant that citizens have become used to participating and forming part of public management.
- b. **Induce citizen participation and organization.** Citizen organization and participation do not arise on their own, it is necessary to support and guide them through mechanisms to provide logistical, technical, and financial support and continuous strengthening, and to link them to the real decision making power of local government.
- c. **Include new players.** The participative process has taught that new players need to be included, particularly those who have been traditionally excluded such as youths, children, women, indigenous people, Blacks. It has been necessary to invest more time in them, which has conferred greater social legitimacy on the process.
- d. **Exercising leadership means sharing power.** This lesson learned is one of the most important for the players in the Cotacachi process. Public co-management between the municipality and organized civil society (AUC) whose voluntary contribution is invaluable.
- e. **Building new models for democracy requires political will, technical knowledge, and social awareness.** The processes should start with the decision to take action, the knowledge to lead them, and social awareness. This holds true in Cotacachi, which is the only case of administrative decentralization in the country.

Difficulties

- It is not a national process. This situation causes permanent tension between the local government and the sector ministry, which is not open to the changes proposed by the cantonal health system.
- Transfers of financial health resources to the Cotacachi local government as established in the agreement assigned by the parties have not materialized. Therefore administration of resources is inflexible and does not fully reflect local needs.
- There are certain duplicated powers which, despite being transferred, continue to be exercised by the Ministry of Public Health.
- There is insufficient coordination with private health care providers and with other health care providers such as the IESS and the Rural Social Security Program. Although coordinated health services are being carried out in practice, this is insufficient.
- However, the greatest difficulty is that the process of building the Cotacachi cantonal health system **has a dynamic, a pace of construction, that differs from the national level, which stands in the way of national and local integration, even though the objectives are the same.**
- The other government sectors, such as education, must also overcome obstacles posed by the central level, that delays their plans and projects.

Relevant points for change

- A knowledge base has been created that permits the complex factors that determine health to be incorporated, going beyond the concept of health simply as the curing of disease.
- Based on national health objectives, Cotacachi has defined its own objectives that also respond to local realities.
- Cotacachi is rechanneling financing for actions in the health system in function of the objectives defined.
- In primary health care, better treatment capabilities, greater availability.

- Adjust national prevention and promotion plans to local realities.
- Incentives for preventive behaviour and actions in health plans, for both users and providers; for example traditional health care providers.
- Visualization by users of the quality of the public provider, which has made it possible to select public health services on the basis of quality and cost, and to ensure that national programs are offered free of charge.
- Creation of parameters to establish subsidies for users.
- The sectors in general take responsibility for their contribution to the health and well-being of the citizenry.

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