

PD-MHF-765-B1  
5180002-2

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CLASSIFICATION  
PROJECT EVALUATION SUMMARY (PES) - PART I

Report Symbol: U-147

1. PROJECT TITLE Five Rural Health Projects			2. PROJECT NUMBER OPG-518-0002	3. MISSION/AID/W OFFICE ECUADOR
2-7-80			4. EVALUATION NUMBER (Enter the number maintained by the reporting unit e.g., Country or AID/W Administrative Code, Fiscal Year, Serial No. beginning with No. 1 each FY)	
			<input checked="" type="checkbox"/> REGULAR EVALUATION <input type="checkbox"/> SPECIAL EVALUATION	
5. KEY PROJECT IMPLEMENTATION DATES			6. ESTIMATED PROJECT FUNDING	
A. First PRO-AG or Equipment FY 78	B. Final Obligation Expected FY 80	C. Final Input Delivery FY 81	A. Total \$ 581,800 B. U.S. \$ 278,000	
			7. PERIOD COVERED BY EVALUATION	
			From (month/yr.) October, 1978 To (month/yr.) September, 1979 Date of Evaluation Review October, 1979	

E. ACTION DECISIONS APPROVED BY MISSION OR AID/W OFFICE DIRECTOR

A. List decisions and/or unresolved issues; cite those items needing further study. (NOTE: Mission decisions which anticipate AID/W or regional office action should specify type of document, e.g., airgram, SPAR, PID, which will present detailed request.)	B. NAME OF OFFICER RESPONSIBLE FOR ACTION	C. DATE ACTION TO BE COMPLETED
Unresolved issues and/or change in decision:		
1. Collection of baseline data-methodology of household survey changed to collection by promoter.	Jack Olinger Manuel Naula Robert Hostetter Lois Price Martha Craymer	March 1980
2. GOE program - still in the process of being developed, so waiting for manuals and curriculum.	Promoter Committee for GOE	March 1980
3. Personnel for Saraguro - decision to be made the beginning of 1980 - if personnel are available or not to proceed.	Sara Risser	Jan. 1980
4. Lack of infrastructure - more time is needed to develop the communities before continuing on with health training in some areas.	Same as listed above	indefinite

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS			10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT	
<input type="checkbox"/> Project Paper	<input type="checkbox"/> Implementation Plan e.g., CPI Network	<input type="checkbox"/> Other (Specify)	A. <input type="checkbox"/> Continue Project Without Change	
<input type="checkbox"/> Financial Plan	<input type="checkbox"/> PIO/T	_____	B. <input type="checkbox"/> Change Project Design and/or	
<input type="checkbox"/> Logical Framework	<input type="checkbox"/> PIO/C	<input type="checkbox"/> Other (Specify)	<input type="checkbox"/> Change Implementation Plan	
<input type="checkbox"/> Project Agreement	<input type="checkbox"/> PIO/P	_____	C. <input type="checkbox"/> Discontinue Project	

11. PROJECT OFFICER AND HOST COUNTRY OR OTHER RANKING PARTICIPANTS AS APPROPRIATE (Names and Titles)		12. Mission/AID/W Office Director Approval	
Sara F. Risser Sara F. Risser Director - Community Development		Signature	
Manuel Rizzo, Health Program Coordinator D/AR: AMDial O/DP: PMaldonado		Typed Name John A. Sambriolo, AID Represent	
		Date January 22, 1980	

## PROJECT EVALUATION SUMMARY (PES)

OPG5180002

### 13. SUMMARY

In reviewing each of the project areas (provinces), the differences existing within the communities themselves as well, the cooperation at the provincial levels of government agencies has caused variation in methodology used in achieving the purpose and goals. Each provincial area is in a different stage of development since they were started at different times throughout the year.

A field-based seminar was held for project and GOE personnel as an orientation to philosophy, purpose and goals. Government contact and permission was obtained at the national and provincial levels. Community contact had been established in all areas by mission organizations working for many years in the different provinces. National indigenous associations had been functioning in three of the five selected provinces.

The specific goal of training health workers in each area has been realized in Bolivar, Chimbo: 20, Morona-Santiago, and Pastaza. Loja is still pending. Major problems encountered during the year were: 1) although different organizations have been working years with the indigenous communities, change has been slow. Community organization and other infrastructure have not developed as anticipated, therefore making community participation difficult. 2) Resistance to "outsiders" still exists in giving basic information such as name, age, etc., therefore a person from the community had to be taught to do the needs assessment. This has prolonged the collection and tabulation of data. 3) A government program is being developed since January, 1979. Due to circumstances within the Health Ministry, there has been a delay in curriculum development and controlling standards. Although the basic government curriculum is being taught, difficulties at some of the local provincial levels has caused concern for the health workers in training. 4) Lack of personnel for Loja province--foreign doctors unable to get permission to practice, and no nurses available. 5) Transportation has been a problem, although hospital and personnel were usually available as well as buses, it was difficult not having the designated cars which were delayed for almost 1 year due to ordering, liberation, etc. 6) Change of government has caused unrest at the local and central levels within the Health Ministry and has caused delay in coordination as well. "Patience is the name of the game." 7) One very difficult area in coordination is the lack of communication between the national and local levels, as well as inter-departmental such as with IEOS, INNE, Salud Rural, Salud Comunitaria, Nursing, Epidemiology, Salud Familiar. The Health Ministry personnel recognize this deficiency and in general have tried to cooperate when necessary, particularly at the provincial levels.

### 14. EVALUATION METHODOLOGY

There has been continuous evaluation of the project design, particularly since this is considered a pilot project. Changes in approach in the health needs assessment had to be made so that an acceptable method could be used for collecting baseline data. Health workers are taught to collect data rather than an outside team.

In measuring progress the indicators have been:

- 1) The acceptability of the program by the communities.
- 2) Beginning to see behavioral changes, especially in the area of environmental health, such as having potable water sources, the building and utilization of latrines, and concern about nutritional needs.
- 3) The utilization of government programs such as leche avena, immunizations, and referral system.
- 4) The concern of community organization such as indigenous associations, health committees (if existent) and community leaders to have more control and management of the programs.
- 5) In reference to a decrease in morbidity or mortality, there really are no definite indicators as yet, since no accurate data was available.

In data collection, methodology and forms were developed so that the health workers could manage the computation of results. After one year the provinces of Morona-Santiago, Chimborazo, and Pastaza are beginning to process the data: total population, newborns to one year, pre-schoolers, school children, pregnant mothers, high-risk children, some of the more common diseases, births and deaths, water sources, number of latrines and utilization.

The goal of training a specific number of health workers in each province each year is another indicator of evaluation. See attached resume.

At the end of 10 months, a 2-day evaluation seminar was held in Quito with all project personnel, USAID, and Health Ministry representatives. Project personnel represented the organizations of HCJB, Gospel Missionary Union, Brethren, and Berean. Dick Crespo from MAP, International, directed the seminar.

#### 15. EXTERNAL FACTORS

Major changes in the project setting are the following:

1. The health needs assessment is being done by the health workers instead of an outside team. Due to resistance on the part of the communities because of other agencies, government or private volunteer trying to collect data, the methodology had to be changed.
2. Focus has changed to integral development rather than just health care, since much of the infrastructure of the communities is not developed. This is being done with the cooperation of the other missions or national associations working in the areas of ~~education and agriculture and community organization.~~

3. The project began officially in October, 1978, with verbal approval from the Health Ministry, and in December, 1978, written approval was obtained. Training had begun in some provinces before October, 1978. In February, 1979, the Health Ministry decided that they will also have a health workers' program. This has had quite an effect on the MAP project, since criteria for selection of health workers, standards of control, teaching curriculum and material, (a new health delivery system in general), had to be developed. A draft form of curriculum outline and criteria for selection of health workers was obtained. Although permission has been obtained for the MAP program, the unknown on the part of the Health Ministry makes progress a bit difficult.

4. Change of government personnel has caused delay in courses, or change in plans for supervision, but in general there has been good cooperation.

#### 16. INPUTS

The major problem with commodity was waiting for available money, purchasing equipment in the States, and now waiting for arrival (shipping, liberation, customs, etc.). Having the things available will increase the quality of teaching. Although technical services are available in the country, there is some difficulty on the local level with participation in the program such as materials offered to build latrines or water storage tanks.

Training personnel for Pastaza and Saraguro have not been available as planned due to uncontrollable circumstances. For this reason, Saraguro is not functioning.

#### 17. OUTPUTS

Indicators from Logical Framework Matrix.

In reviewing the output indicators, each one is in a degree of implementation.

1) There is an agreement between the community and facilitating agency on the prevalent crucial health needs. Focus on preventative rather than curative has been difficult, but change is beginning as the promoters become examples for their communities.

2) Community health committees are difficult to form in some areas due to cultural beliefs of individuality and distances between houses of communities. Focus on mothers' clubs, "cabildos", and schools will help in the formation of health committees.

3) The training programs are functioning in varying degrees in each province. This depends on the support of the local health authorities.

4) Health workers have been selected (not always by the community), and are in the process of varying degrees of training. Most are functioning in the majority of the communities (see statistical resume).

5) Referral facilities have been identified and utilization of services is beginning; approval of program at local level was obtained; but due to change of government personnel, there will be a need to begin again in some provinces; supervision is being done and pharmacies are beginning (see statistical resume for referrals and supervision).

6) Different methods for community participation and commitment are being tried. Capital investment for a small pharmacy, letters from leaders for support of health workers, building small health posts, and school and church participation. This is a difficult area because they have been given things free by some agencies, so a new concept has to be introduced.

Management is difficult in the area of trying to coordinate the whole program with the Health Ministry. There are so many personalities involved, and it's difficult to please everyone accordingly, especially with the new government program for health workers.

#### 18. PURPOSE

That the residents of five rural areas will have access to basic health services and will utilize the services which include:

- community education for improved health services
- primary community level health services
- medical referral services
- health related community development assistance

In reviewing the statistical resume there is some progress being made even though minimal. The problem of lack of infrastructure and delay with the government program are two major factors in achievement of EOPS. These two areas have had priority in the management by the grant manager. The project EOPS are a good description of desired results and are attainable. There will be a need to continue some type of support system if the government program is delayed or does not extend to all communities.

#### 19. GOAL/SUBGOAL

That health be improved in Indian populations of five rural areas in five provinces of Ecuador where existing mission agencies are already working. To measure goal achievement the following indicators were stated:

- a. The adoption of improved health behaviors.
- b. The reduction of prevalent disorders.
- c. The improvement of health-related environmental conditions.
- d. The provision of health care services to isolated areas.

B. Government

1. Increase extension of health services to marginal groups.
2. Increase credibility of the existing government services.
3. Increase participation of government agencies in providing services.

21. UNPLANNED EFFECTS

A. To cause the GOE to begin their own program for training health workers was an unplanned result. It's really exciting that they would consider this level of health worker. At the same time, it has made implementation of the MAP (Vozandes) project more difficult as patience is developed in waiting for the GOE's plans and implementation.

B. The changes in social structure and economic situation have resulted in most areas as a result of the many years of work by Christian groups. Health care, education, and technical assistance complements the beginning of development and is a step in looking at the wholist approach which focuses on the whole person and an integral development program.

The effect is incredible; the indigenous are becoming more confident and credibility for their local organization increases. It doesn't happen overnight!

22. LESSONS LEARNED

A. Community Level

1. Accurate baseline data cannot be collected at the beginning of a program unless it's forced upon the community without concern for human dignity.
2. Change takes a longer time at the community level, even though funding agencies as well as GOE have time limitations; therefore, desired goals may not be reached or change in methodology are a necessity.

B. GOE Level

1. Coordination with GOE is time-consuming, as one has to find all the entities in one ministry with whom one has to interface. Be ready for change, conflict or refusal, since there is a definite lack of communication within the ministry, as well as with other ministries.

2. In general the GOE individuals in charge desire the benefits of the end results of the program, therefore, the cooperating agencies MUST always allow the GOE to receive recognition that this is their idea and program.

C. USAID-FUNDING AGENCY

1. I, personally, have learned about and found people who care and have benefited from interacting with them.
2. There is a lack of coordination between receiving agencies and available government resources. This could be a beneficial service on the part of USAID. It's understood that the OPG5180002 is a pilot project in the area of health care delivery, and that possibly new contacts were in order. My recommendation is that the agencies receiving funds would meet with each other such as CIM, Shoe Shine Boys, Agricultural, CARE, etc., and if there could be some type of coordination between them, this would increase EOPS condition of each project.

D. PERSONALLY

The strategy used in consideration of the health project has been successful, although not without problems. Consideration of the desires of a community (ethnic group or organizations such as indigenous associations or churches), and the programs of the GOE health systems are priorities in the philosophy of HCJB Vozandes Hospitals. For success, there needs to be continual interfacing with one another. Again, it's difficult and time consuming, but it's the marginal people who are going to gain the benefits of coordination and cooperation at all levels.

E. EVALUATION METHODOLOGY

1. Behavioral goals are hard to measure, but can be observed--time is needed.
2. Involving the health workers in the collection of data is very valuable, but again takes time.
3. Seminars for interchange in ideas and methodology with project personnel, GOE, and AID personnel is a

valuable tool. Comparison of provincial problems and results causes interesting interchange of ideas about geographical locations and ethnic groups.

23. SPECIAL COMMENTS OR REMARKS

Attached: Resumen Estadistico

October 16, 1979

SFR:sp

	<u>Bolivar</u>	<u>Chimborazo</u>	<u>Morona Santiago</u>	<u>Pastaza</u>	<u>Total</u>
<b>II. <u>Factores para que haya servicios básicos de salud.</u></b>					
1. Número de comités de salud	6	0	0	1	7
2. Número de comités de salud que participan activamente en los programas de educación comunitaria	2	0	0	1	3
3. Número de comunidades con programas de educación comunitaria en donde hay un acuerdo con los beneficiarios sobre los problemas específicos que hay que enfrentar	2	3	0	3	8
4. De cuantos días u horas es el programa básico de entrenamiento de los promotores	120 hrs. anuales	21 días	24 días	14 días	
NOTA: los cursos son por periodos de una semana, varias veces al año.					
5. Cuantas veces al año se supervisa a cada promotor <u>en su comunidad</u> (o es factible en el transcurso de un año)?	4	3	5	12	

Conformidad con Proyecciones del

ALCANCE DEL PROYECTO

	<u>Bolivar</u>	<u>Chimborazo</u>	<u>Morona Santiago</u>	<u>Pastaza</u>	<u>Total</u>
Proyección de número de comunidades	30	50	29	12	141
Número de comunidades alcanzado en el primer año	7	30	27	13	77
Proyección de número de beneficiarios	4,000	30,000	2,700	2,000	43,700
Número de beneficiarios alcanzados en el primer año	1,200	36,500	2,200	4,000	43,900

PROPOSITO	INDICADORES	Horona				
		Bolivar	Chimborazo	Santiago	Pastaza	
Que los residentes de cinco áreas rurales tengan acceso a los servicios básicos de salud y que utilicen aquellos servicios incluyendo:	a. Los promotores de salud estarán funcionando en el 100% de comunidades	100%	80%	94%	65%	
	b. La gente críticamente enferma utilizará los servicios médicos referidos, recomendados por el promotor de salud, por lo menos el 80% del tiempo.	10%	50%	No hay datos	No hay datos	Solo se aplica a los casos muy críticos, todavía no hay suficiente confianza en los centros de salud. También la baja tasa de ingresos perjudica. No se conocen los cifras exactos, siendo que no hay buen sistema de control todavía.
	c. Iniciar proyectos de desarrollo comunitario relacionados a la salud en las comunidades que tienen la capacidad organizacional para implementar tales proyectos.					
- educación comunitaria para mejorar la salud;						
- servicios de atención primaria de salud;						
- servicios de referencia médica;						
- ayuda de desarrollo relacionado a la salud de la comunidad.						
- de promotores			31	31	17	Se esta atendiendo a todos los que piden, pero hay limitaciones de bombas para pozos.
- de letrinas en proceso			15		5	
- de pozos en proceso			6		6	
- de comunidades con huertas familiares en proceso			0	27	1	
- de escuelas con programas de higiene escolar			3	27	5	
- de promotores que han hecho censo			31	27	5	

CONDICIONES	INDICADORES	Morona Santiago				Pastaza	
		Bolivar	Chimborazo	Santiago	Pastaza		
a. Contribución de salud participativa de cada área.	a. Numero de comunidades donde se ha llegado a un acuerdo sobre las necesidades comunes de salud.	5	20	27 (100%)	10		El énfasis en los tres proyectos nuevos (menos Forora) ha sido en mejoramiento ambiental, y se ha logrado un acuerdo sobre necesidades de sanamiento. Falta más concientización en el área de enfermedades, para que haya acuerdo en esto también.
b. Educación comunitaria dirigida a una área específica.	b. Número de comités de salud participando en educación comunitaria	2	0	0	0		
c. Programación de entrenamiento para promotores de salud.	c. Programas de entrenamiento de promotores	si	si	si	si		
d. Sistema primario de salud a nivel comunitario.	d. Facilidades de referencia identificadas	si	si	si	si		
e. Sistema de ayuda médica, incluyendo servicios referidos, supervisión de promotores de salud e implementos médicos.	Aprobación de los funcionarios locales de salud	si	si	si	si		
f. Condiciones ambientales de más apoyo (Ej: agua, hospedaje, saneamiento, etc.)	Supervisión de promotores	si	si	si	si		
	Provisión de farmacia en cada área	si	en proceso	si	si		
	e. Compromiso de recurso específico de cada comunidad donde proyectos de desarrollo han sido iniciados.	si	si	si	si	Mayormente de obra de mano. Algunas comunidades han contribuido dinero también.	

PROMOTORES Y LOS LUGARES EN DONDE ESTAN TRABAJANDO

LA PROVINCIA DE CHIMBORAZO

Promotores de Colta

<u>Comunidad</u>	<u>Nombre</u>
Achullay	José Chicaisa S.
Basquitai	José Gualli
Zambrano	Telmo Cuvi
Pulingui	Ignacio Pacheco G.
Gatazo Chico	Rosa María Pahuay
Majipamba	José Remachi
Cintagozo	José Manuel Guaman
Coto Juan	Angel Yépez
Laimi	Victor Guaminga
Cebollar	Juan Gualli
Rumiloma	Manuel Chimbolema
San Juan	Laura Yuquilema
S. Antonio	José Guaman
Calera	Lourdes M. Guttiopala
Rosas	Luis Yuquilema
Gahuin	Manuela Copa
Castuj Tungurahilla	María Juana Guapi
Nisag	Segundo Juan Mendoza
Cochaloma	Antonio Lema
Pila Huaicu	Manuel Coba Ch.
San Vicente	Antonio Caguano
Cochahuajchu	José Morocho
Majipamba	Santiago Maji
Huacuna Chico	Gustavo Tenelema
Flores	Toribio Yuquilema

Promotores de Columbe

Llinllin	Nicolosa Sayay
Llinllin	Alejandro Morócho
Sanguizel	Miguel Pilamunga*
Miraflores	Juana Pucuna
San Bernardo	Rosa Inguilay
San Martín	Mercedes Huajcha
San Martín	Antonio Curichumbi*
San Bartolo	Jacobo Chimbolema
Pulucate	José Yupanqui**
Curiquina	José Vicente Guacho**
Sasapud	Benjamin Cepeda**
Pulucate	Carlos Yautibuj

\* Significa entrenado y pagado por Foderuma

\*\* Significa ahora auxiliar rural sin nombramiento

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LA PROVINCIA DE BOLIVAR

Promotores

Comunidad

Nombre

Pachanco	Esteban Ponina
Rayopampa	Amable Azas
Chaupi	Rafael Poaguiza
Tambanal	José María Toapanta
San José de Guayabal	Andrés Toalombo
Guarumal	Lorenzo Lea
Grada Chico	Gonzalo Toalombo

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LA PROVINCIA DE MORONA-SANTIAGO

Promotores

<u>Comunidad</u>	<u>Nombre</u>
Amazonas	Iquiam Puencher
Amazonas	Tiviram Sant
Achuentsa	Pedro Shakaim
Kim	José Tivi
Cuchaentsa	Ricardo Uuepa
Tunantsa	Calixto Tivi
Tunantsa	Luis Ramón
Kumbantsa	Pedro Mayacu
Charuza	Jaime Wisum
Cangaimi	Montalvo Jindiachi
Cangaimi	Reinaldo Canusa
Tashap	Antonio Sant
Manayak	Vicente Nuning
Chivientsa	Iquiam Tsamaren
Wisui	Tsamaren Anguash
Kusutka	Gonzálo Wampanti
Campo Ayui	Felipe Nahuech
Yuvientsa	Bolivar Jua Yangora
Tamantsa	Polivio Manchu
Campo Canusa	José Wisum Cayapa
Surikentsa	Rafael Masurash
Sasaim	Rafael Shirap
Mashumarentsa	Felipe Kaitian
Yaapi	Rafael Mashinkias
Yaapi	Carlos Agustín
Panientsa	Domingo Puenchera
Shiramentsa	Taijint Ampusha
Shiramentsa	Tomás Ayui Najande
Achuntsa	Humberto Tankamash
Mayalico	Luis Rodríguez
Warientsa	Alberto Tserempo
Cusuimi	Rafael Nunin
Corrientes	Luis Chiriap Naichapi

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LA PROVINCIA DE PASTAZA

Promotores

<u>Comunidad</u>	<u>Nombre</u>
Bufo	Eduardo Tangamash Salazar
Chapana	César Mario Inar Salazar
Capahuari	Elerio Gustavo Vargas
Conambo	Alcides Ignacio Ushigua
Copataza	Luis Illanes
Corrientes	Gonzales Mauro Santi
Moretecocha	Almeda Vargas
Villano	Lucio Benito Vargas
Vippano	Francisco Gonzales
Sarayacu	Elloy Gualinga, Amanda Santi
Shiguacocha	Samuel Colapucha
Yanesuno	Juan López, Jaime Alvarado
Quillucaspá	Abdón Grefa
Durán	Venancio Silverio López
Arajuno	Dinas Ruedas, María Licia de Tufior, Germán Grefa, Domingo Augusto López
Nushino	Humberto Andi
Curaray	Francisco Vespiano Fuentes
Cunai	Esteban Atanacio Anguash
Oglan	Juan Pedro Chermuchi

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LA PROVINCIA DE LOJA

Promotores de Saraguro

Comunidad

Gulacpamba  
Namarin  
San Vicente  
Gurudel  
Tuncarta  
Oñacapa  
Jumbilla  
Ilincho  
Gurudel  
Totoras  
Tambapamba  
Hierbabuena  
Las Juntas  
Sauce  
Pichig  
Pueblo Viejo  
Galaspamba  
Ramos  
San Lucas  
Pasquisshupa  
Canaro  
Quisquinchi  
Water  
Tucalate  
Tenta  
Gera  
Verbana

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Hay 7 recién graduadas del curso de auxiliares rurales de enfermería en Azogues quienes regresan a la área de Saraguro. Ellas son de los siguientes lugares:

Quisquinchi  
Totoras  
Oñacapac  
La Matara  
Yucucapac  
Tenta  
Gera

Otras áreas de consideración para promotores son las siguientes:

Zapallo Grande  
Esmeraldas  
Har en Cañar  
Mulalo en Cotopaxi  
Salasaca en Tungurahua  
Cayambe en Pichincha  
Lago Agrio en Napo

También estamos trabajando con un programa del municipio en San Antonio de Pichincha en la área de materno-infantil.