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AGENCY FOR INTERNATIONAL DEVELOPMENT PROJECT AUTHORIZATION AND REQUEST FOR ALLOTMENT OF FUNDS PART I		1. TRANSACTION CODE <input type="checkbox"/> A = ADD <input type="checkbox"/> C = CHANGE <input type="checkbox"/> D = DELETE	PAF 2. DOCUMENT CODE 5
3. COUNTRY/ENTITY <u>Ecuador</u> <u>OPG to the Vozandes Hospital</u>		4. DOCUMENT REVISION NUMBER <input type="checkbox"/>	
5. PROJECT NUMBER (7 digits) <input type="checkbox"/> 518-0002	6. BUREAU/OFFICE A. SYMBOL <u>LA</u> B. CODE <input type="checkbox"/> 05	7. PROJECT TITLE (Maximum 40 characters) <input type="checkbox"/> Rural Community Health Project	
8. PROJECT APPROVAL DECISION ACTION TAKEN <input type="checkbox"/> A A = APPROVED <input type="checkbox"/> D D = DISAPPROVED <input type="checkbox"/> DE DE = DEAUTHORIZED		9. EST. PERIOD OF IMPLEMENTATION YRS. <input type="checkbox"/> 0 <input type="checkbox"/> 3 QTRS. <input type="checkbox"/>	

10. APPROVED BUDGET AID APPROPRIATED FUNDS (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE		E. 1ST FY <u>78</u>		H. 2ND FY <u>79</u>		K. 3RD FY <u>80</u>	
		C. GRANT	D. LOAN	F. GRANT	G. LOAN	I. GRANT	J. LOAN	L. GRANT	M. LOAN
(1) PH	530	530		123		91		64	
(2)									
(3)									
(4)									
TOTALS				123		91		64	

A. APPROPRIATION	N. 4TH FY		O. 5TH FY		LIFE OF PROJECT		11. PROJECT FUNDING AUTHORIZED	
	D. GRANT	P. LOAN	R. GRANT	S. LOAN	T. GRANT	U. LOAN	(ENTER APPROPRIATE CODE(S)) 1 = LIFE OF PROJECT 2 = INCREMENTAL LIFE OF PROJECT	A. GRANT E. LOAN
(1) PH					278.0			
(2)								
(3)								
(4)								
TOTALS					278.0			C. PROJECT FUNDING AUTHORIZED THRU FY <input type="checkbox"/> 7 <input type="checkbox"/> 8

12. INITIAL PROJECT FUNDING ALLOTMENT REQUESTED (\$000)			13. FUNDS RESERVED FOR ALLOTMENT		
A. APPROPRIATION	B. ALLOTMENT REQUEST NO. _____		TYPED NAME (Chief, SER/IFM/FSD)		
(1) PH	C. GRANT	D. LOAN	SIGNATURE _____		
(2)			DATE _____		
(3)					
(4)					
TOTALS	278.0				
14. SOURCE/ORIGIN OF GOODS AND SERVICES			<input checked="" type="checkbox"/> 000 <input type="checkbox"/> 041 <input type="checkbox"/> LOCAL <input type="checkbox"/> OTHER _____		

15. FOR AMENDMENTS, NATURE OF CHANGE PROPOSED

FOR PPC/PIAS USE ONLY	16. AUTHORIZING OFFICE SYMBOL	17. ACTION DATE	18. ACTION REFERENCE (Optional)	ACTION REFERENCE DATE
		MM DD YY		MM DD YY

PROJECT AUTHORIZATION AND REQUEST FOR ALLOTMENT OF FUNDS

PART II

Name of Country/Entity: ECUADOR, Hospital Vozandes

Name of Project: Rural Community Health Project

Number of Project: 518-0002

Pursuant to the authority delegated to AID Principal Posts in cables numbered 77 State 136880 and 78 State 019667, I hereby authorize an Operational Program Grant (OPG) to the Ecuadorean private voluntary organization (PVO) named "Hospital Vozandes" in the amount of Two Hundred Seventy-eight Thousand United States Dollars (\$278,000), the "Authorized Amount" to assist in financing certain foreign exchange and local currency costs of goods and services required for the project as briefly described in the following paragraph.

The purpose of the project is to provide residents of four remote rural areas with access to primary health care services in order to improve their present precarious health condition. The population among whom the project is proposed to be implemented include the poorest rural Ecuadoreans who by reason of their geographical isolation have not been effectively helped by either private or public health services.

The four rural areas considered for inclusion under this project are: Morona-Santiago, Chimborazo, Pastaza and Loja. The entire amount of A.I.D. financing herein authorized for the project will be obligated when the Project Agreement is executed.

I approve the total level of A.I.D. appropriated funding planned for this project of not to exceed Two Hundred Seventy-eight Thousand United

States Dollars (\$278,000) grant including the funding authorized above during FY-1978.

I hereby authorize the initiation of negotiation and execution of the Project Agreement by the Officer to whom such authority has been delegated in accordance with A.I.D. regulations and Delegations of Authority subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate:

a. Source and Origin of Goods and Services

Except for Ocean Shipping goods and services financed by A.I.D. under the project shall have their source and origin in the Cooperating Country and in the United States, except as A.I.D. may otherwise agree in writing. Ocean Shipping financed under the Grant shall be procured in any eligible source country except the Cooperating Country.

b. Grantee shall covenant to adhere to and conduct the evaluation plan set forth in Section D-3 of the attached Project Proposal.

c. The Grantee covenants that funds will be utilized only for the stated purpose of this project, and that none of the project funds, will be used, directly or indirectly, to communicate, espouse, or propagate any particular religious doctrines, opinions, or views. The Grantee understands and agrees that violation of this covenant would be cause for suspension or cancellation of this grant.

	<u>Typed Name</u>	<u>Office Symbol</u>	<u>Date</u>	<u>Initials</u>
Clearances:	A. Patricio Maldonado	O/DP		
	B. Amada Falconí	EXO	6-12-78	

	<u>Typed Name</u>	<u>Office Symbol</u>	<u>Date</u>	<u>Initials</u>
Clearances:	C. Gloria Chacón	O/CONT	6/9/78	GC
	D. Manuel Rizzo <i>MJR</i>	FHD	6/9/78	MJR

June 14, 1978

Signature: *Joe J. Sonce*

Joe J. Sonce  
Name of Authorizing Officer

AAO/Ecuador  
Office Symbol

## ATTACHMENT "A"

PROJECT DESCRIPTION

A. The purpose of this Grant is to provide primary low cost health care services to residents of five rural areas in the Provinces of Morona Santiago, Chimborazo, Loja, Pastaza, and Bolivar. M.A.P. International, through the Vozandes Hospital and with the participation of five additional voluntary agencies (PVO's) --Gospel Missionary Union, Brethren, Free Will Baptist, Oriental Missionary Society and Berean Mission-- will work with the poorer people in the project target areas to increase their use of basic preventive health measures and locally available health services. The PVO's will also facilitate the access to higher level referral facilities for more acute disorders and will work closely with community leaders to improve environmental conditions such as water supply and basic sanitation facilities.

B. Project Objectives

By the end of the project, the following results are expected:

1. Availability of basic health services in 29 communities in Morona Santiago Province; 50 communities in Chimborazo Province; 20 communities in Loja Province; 12 communities in Pastaza Province; and 30 communities in Bolivar Province. These health services are expected to lead to:
  - a) the adoption of improved health behavior among the people in the participating communities;
  - b) a reduction of the most common prevalent health disorders; and
  - c) an improvement in health-related environmental conditions.
2. A health assessment of each community.
3. A health committee organized and trained to serve in each of the communities to carry on health education activities.
4. At least one locally selected health worker from each participating community trained to deliver primary health services. Each health worker will have basic equipment and medicines to serve his community.

C. Implementation Plan

The plan is described in detail in the M.A.P. Project Proposal of August 1978, pages 14, 15, 16, 17, 18, and 19, and in Appendices A through E.

D. Reporting

The M.A.P. will submit to the USAID:

1. Quarterly operation and financial progress reports. The first such report will be due December 31, 1978, for the period September-November 1978.
2. An Annual Report as of the close of each U.S. Government Fiscal Year-September 30.

The quarterly reports will be submitted within 30 days after the close of the quarter. The annual report will be submitted within 45 days after the close of the reporting period. All reports will be submitted in English. Progress will be measured against the Project Implementation Plan as detailed on pages 14, 15, 16, 17, 18 and 19 of Attachment B, and Appendices A through E, of the M.A.P. Proposal of August 1978. Following the preparation of the reports, either party may request consultation which shall then be held to review, implement or to discuss project problems and issues.

E. Evaluation

The M.A.P. will provide to AID copies of the three in-depth and impact evaluations planned for years one, two and three. Prior to undertaking each evaluation, A.I.D. and M.A.P. will: (a) discuss the composition of the evaluating team; (b) the nature and contents of the evaluation; and (c) the extent of A.I.D. participation in such evaluation.

F. Other Considerations

Funds provided by A.I.D. will be used strictly for non-religious, development purposes as detailed in the aforesaid Project Implementation Plan.

Project Title: Five Rural Health Projects

Project Location: Five Rural Areas of Ecuador  
Provinces of Morona-Santiago, Pastaza,  
Chimborazo, Loja and Bolivar

PVO Name & Location: MAP International  
P.O. Box 50  
Wheaton, Illinois 60187

Representative in Ecuador: Vozandes Hospital  
Casilla 691  
Quito, Ecuador

Contact Person: Sara Risser, RN, MS.- Quito  
  
Richard Crespo, MS.- Wheaton

Date of Submission: June, 1978

Funds Requested: \$278,000

## I. Project Purpose and Description

- A. Health conditions among rural populations of Ecuador are poor. Health services are not available to many rural populations. Some voluntary agencies that are already working among rural Ecuadorian populations are prepared to add a health component to their existing programs in order to improve the health of their target populations.
- B. The populations among whom this project is proposed to be implemented includes some of the poorer people of Ecuador who by reason of their ethnic backgrounds or geographical isolation have not been effectively helped by either private or public health services. With the introduction of primary health care at a low cost, it is desired that the individuals will become concerned about their health and begin to change their way of life.
- C. MAP International through Vozandes Hospital proposes to collaborate with other voluntary agencies already working among needy rural populations to plan and implement five low-cost, population-specific health programs which will:
- a. Address the health needs that are specific to each local target population.
  - b. Train locally selected community members (one from each community), as "Village Health Workers" to deliver primary health services in 29 communities in Morona-Santiago Province, 50 communities in Chimborazo Province, 20 communities in Loja Province, 12 communities in Pastaza Province and 30 communities in Bolivar Province by the end of the third year of the grant.
  - c. Include a major emphasis on community education for health issues which will include the topics of personal hygiene, healthy living environment, and nutrition. (Refer to the specific project descriptions in the appendix for a statement of measurable objectives in these areas.) The community education efforts will use culturally relevant learning methods.
  - d. Where communities express a desire for health-related community development projects (e.g. water, agriculture), link these with Ecuadorian based agencies which could provide assistance. Interested service agencies are:  
  
 CREA- Ministry of Agriculture  
  
 IEOS  
  
 Ministry of Health, Rural Division  
  
 As the projects develop and there is a necessity for these agencies to participate, a written agreement will be obtained.
  - e. Interface with the GOE health program so as to gain its support, enhance its effectiveness, and ultimately become integral to the GOE program.
  - f. Train cooperating GOE personnel to initiate and manage community-based health projects to the extent that at the end of the grant period they will be capable of initiating health projects.
- D. As a result of program activities proposed in this project it is expected that the populations of five rural areas will adopt new promotive health behaviors, utilize locally available health services, have access to higher level referral



## II. Project Background

Vozandes Hospital has functioned in Quito for 23 years and in Shell for 20 years. Out of concern for unreached, rural populations the hospital implemented a program of medical caravans to serve selected rural areas. But the need is far greater than existing institutions and even mobile medical caravans are capable of meeting.

As new models of primary health care were developed using minimally trained, local "Village Health Workers", Vozandes Hospital began health worker courses in the Oriente. MAP International began working with Vozandes Hospital in that project to help refine the planning and methodology, to assist with a community education program and to help design evaluation processes.

Other agencies became aware of Vozandes Hospital activities and have requested assistance in planning and implementing locally focused health programs similar to the Oriente project. The health projects on the local level will be a combined effort with other agencies, Vozandes Hospital and MAP International.

Following is a list of the areas and the agencies that are ready to begin health projects.

- |              |                 |   |   |
|--------------|-----------------|---|---|
| 1. Macuma-   | Morona-Santiago | - | GMU (Gospel Missionary Union)           |
| 2. Shell-    | Pastaza         | - | Brethren and Free Will Baptist          |
| 3. Colta-    | Chimborazo      | - | GMU                                     |
| 4. Saraguro- | Loja            | - | OMS (Oriental Missionary Society, Int.) |
| 5. Guaranda- | Bolivar         | - | Berean Mission                          |

MAP International through Vozandes Hospital proposes to expand its capacity to assist in the planning, implementation and coordination of local health projects in the above rural areas. Presently 4 staff members of Vozandes Hospital are working in the health project of Morona-Santiago and Guaranda. In the three other areas medical personnel are available to start the programs. MAP International will render consulting services specifically in planning and evaluation, community education and staff training. Each locally based agency will assume responsibility for management of the project in its area.

The health department, of the Government of Ecuador has encouraged these kinds of programs. They are now viewed as a linkage between the existing government health system and people who do not have easy access to existing government services. The GOE has agreed to extend its system to support the proposed rural health programs by accepting trainees from the areas into government-sponsored rural aide training programs and then establishing a government health sub-center or health post in the area, staffed by the rural aide trained from the area, or a rural doctor assigned to the sub-center. The health sub-center or health post will provide referral and support services to health workers who will function in outlying rural communities. Figure one shows the relationship that will exist between health workers and the government health system. (See Convenio, appendix B.).

Ever since the beginning of Vozandes Hospital, there has been a concern for the total man, physical, spiritual, socio-economic, and mental. The Universal Declaration of Human Rights (1948), Article 25 states, "Everyone has the right to a standard of living adequate for the health and well being of himself and his family, including food, clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control." Because of isolation, geographically and ethnically, many of the Indian tribes have not been considered within the Declaration of Human Rights. Our desire is to help translate and make available the right of health services.

One of the first attempts to provide health services by the national, himself, in the area of AIPSE (Asociacion Independiente de Pueblo Shuar del Ecuador), goes back to 1968. Formation of the Health Commission under AIPSE led to a desire to improve health services. Records and development of teaching material for the first course in 1968 and training 30 health workers has allowed the Morona-Santiago Province project to move rapidly in programming and planning for the future.

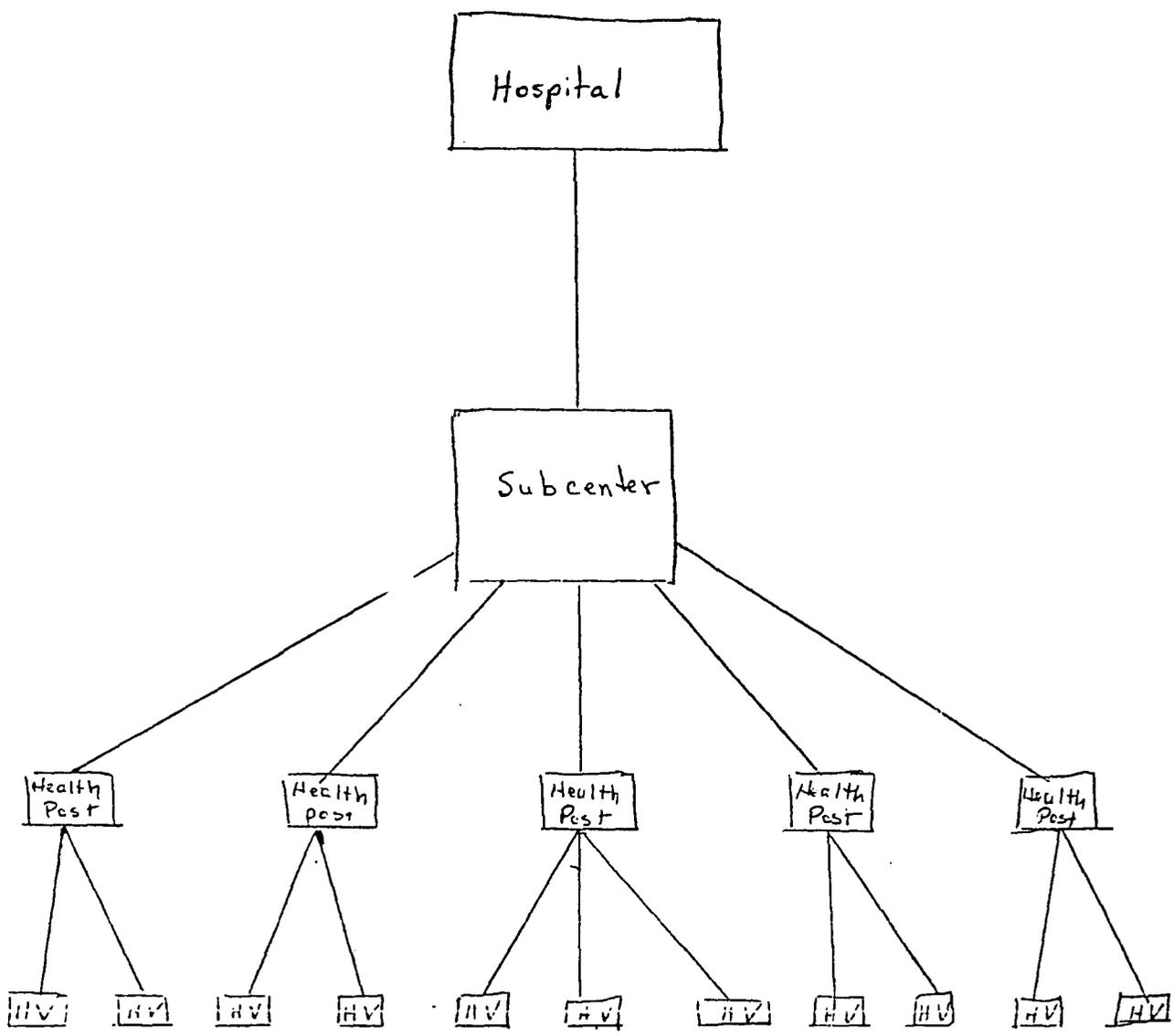


Fig. 1. Relationship of health volunteers to GOE health system.

Plans for 1978 include the following:

1. Continue to produce radio forums for health education.
2. Use schools for health education to provide an opportunity for behavioral change.
3. Provide training for new and advanced levels, four times this year (2 for each) to increase and reinforce knowledge.
4. Coordinate immunization program of health department with rural aides and health workers, so that 85% of population will receive preventive care.
5. Coordinate TB program with rural aides and health workers so that 95% of those under treatment will receive continued care.
6. Use records and monthly reports to continue supervision of health workers, with 95% usage by health workers.
7. Develop a plan of supervision for rural aides for visitation, reports, etc.
8. Make monthly visit to Macas.
9. Prepare to use the Child-to-Child Program for the International Year of the Child-1979.

Although behavioral changes are difficult to identify, there is a definite effort to provide better health service. Refer to Shuar Indian (appendix E) to understand the difficulty of seeing change over a three year period.

Method of Development of Health Workers:

1. Contact government officials to explain program (provincial medical chief, epidemiology chief, and health education).
2. Need and desire recognized by the community.
3. Selection of leaders of the communities (health commission, association, cooperatives, or any form of organization).
4. Discussion of Concept of Health and Systems of Health Care Delivery.
5. Formation of health committees in each community.
6. Selection of health worker candidate.
7. Health assessment of random selected communities.
8. Development of curriculum for training program of health worker from results of health assessment.
9. Plan of time for teaching program.
10. Supervision by visits, records, monthly reports, etc.
11. Include government programs such as maternal-child, nutrition, immunization,

health education, dentistry.

12. Include special emphasis program such as Year of the Child, 1979, and immunization program of OMS.
13. Provide educational opportunities to prepare the health worker as a possible candidate for the rural aides training program.

Our purpose is to connect the government system of health care with the community, thus providing health service to each individual. This proposal seeks funding to continue and expand the existing project in Morona-Santiago and start four more projects patterned after this project.

### III. Project Analysis

For too many years health has been equated with the operation of medical institutions. Whereas medical institutions are necessary to a total health system, they are inadequate by themselves to provide effective health delivery among large populations of people. Figure two visualizes a health system which integrates medical institutions with community education, primary health care and community development in a wholistic concept of health.

Programmatically, this model suggests the following kinds of things:

1. Communities need to be involved from the beginning in planning as well as implementing and utilizing health services designed for them.
2. An assessment of health conditions which exist in a specific community should precede and influence activities planned to promote health in that community.
3. Major emphasis should be given to non-formal, community education to help people adopt preventive and promotive health behaviors.
4. Primary health care, utilizing health workers from the community, must be combined with institutional services to make accessible curative services for rural populations.
5. Where environmental conditions exist that limit the potential for health in a community (e.g. contaminated water), community development projects should be implemented to improve those conditions.

This project proposes to encourage local agencies to design community health programs for their particular areas which take into account the above issues. The expected outcomes will be small scale, localized wholistic (integrated) health systems which should have considerable impact on local communities.

In order for that impact to occur, however, the following principles will need to be in effect.

Low Cost. The system will have to provide health services to local populations inexpensively enough that the people can afford them.

Need-specific. The needs addressed in each health program will be specific to the area. Community members will participate in deciding what needs exist and which

of those needs should receive priority attention in the programs. A participatory needs assessment will lead to an agreement between the community and the local agency about priority needs. Some of the communities have been included in the GOE epidemiology programs such as vaccinations, control for malaria, programs for tuberculosis, etc; but as a whole the concept of vaccinations for prevention of disease has not been understood, therefore not accepted. Well trained personnel for these programs have been on a very limited basis; therefore, abscesses has occurred and inefficient records have made the programs non-successful. With the involvement of the health worker, the coverage of the population should be greater and more effective.

Community participation. From the beginning the community will participate in the process. Organizers from different regions or health commissions are involved in forming health committees in the communities and will participate in learning programs. The community will interface with the government to request support services which are available.

Self-supporting. Whereas outside funding and staffing will be necessary to begin each program the plan will lead to self-support and self-sufficiency. That means that health workers will be able to live on income derived from the people they serve; the program will ultimately draw on GOE resources for referral services, supplies, salaries and other needed support. The strategy for accomplishing this is outlined below.

As defined in the budget breakdown on pages 23 and 24, the budget is divided into two major sections: I. Coordination/Supervision; and II. Community Health Projects. None of the coordination/supervision in Section I. which USAID/Ecuador will pay for will apply directly to the five community health projects. With the training and up-grading provided by grant funds, the PVO's and GOE's involved at the community level will have the personnel, facilities, and experience necessary to continue supporting the local health projects on their own after the USAID/Ecuador support

On the community health project level, the main costs for continuing the community health programs beyond the grant period will be: health worker training and materials, supervision, medical supplies and salaries of supervisors and training instructors. The support for these local programs will move through three phases.

In the first phase, funding will be provided jointly by grant funds, existing PVO operations and personnel, the GOE, and the communities involved. During this phase grant funds will be used for up-grading facilities, preparing curriculums and consulting services. (Refer to community health project budgets in the appendices for specific breakdowns.)

In the second phase at the end of the grant period, the PVO's, GOE and the communities will bear the full costs for continuing the community programs. The existing PVO staff and GOE resources will have been up-graded, training programs will have been established and supported by the PVO's with resources provided by the grant. Thus, during this phase it is expected that the PVO's will no longer need grant support for training, etc. As more rural aides trained by the GOE are available, these government personnel will assume more of the training and supervision of the health workers. Although small consulting fees charged by the health worker and through a small percentage charge above costs for medicines, the operational costs for the health worker will be covered. (This policy is in effect from the beginning of the projects.) In addition the health workers will derive income from their <sup>a</sup>forms since they are serving as part-time health workers. In all instances, only referral services are used, thus there will be no need for maintenance of these capital intensive services. Fees for referral services will in all cases be borne by the patients.

The third phase will occur as the GOE expands its health services over time, gradually replacing the PVO services in training and supervision. This of necessity will be a gradual process as GOE resources become available. The PVO's involved have been helping the GOE "fill in the gaps" for many years now, and their raison d'etre would confirm their doing so until that time when the GOE will be able to assume the major responsibility for the health needs of the rural poor.

Government integration. Each program will collaborate with the existing GOE health system and actually serve to extend that system to rural people it cannot now serve. GOE has recognized the necessity for the health workers, but has not been able to include them in the budget of the GOE health system as salaried personnel. Government-recognized facilities will be used for referral. Government supply lines will be tapped. Rural doctors and nurses have helped with some of the teaching in the Morona-Santiago Province. The program for training rural aides is being utilized to train health workers selected by the health commission or communities. The provincial health directors in the five provinces have been contacted and have enthusiastically agreed to cooperate. This provides guidance and cooperation of government officials for the incorporating of the programs into the government health system.

The impact of these community health projects on these Shuar and Quichua Indians will be significant considering the social and health conditions of these people. The Indian populations are some of the poorest in Ecuador. Because of their differing culture and language they have been isolated from the economic and social mainstream of Ecuadorian life. Even just in the area of health services the effects of this isolation from the mainstream of life are severe. Most of the government health services are in the urban areas. Thus the fact that the vast majority of the Shuar and Quichua live in rural communities means that they have no immediate access to health services. Not only do they not have immediate services for treating illness, but they have not had the opportunity to learn about methods of personal hygiene, healthful home environments, etc. They do have traditional healers but the scope of the health care they provide is rather limited. When the Indians do make special trips to government health facilities, the injury or illness is well advanced, thus complicating treatment. Yet the most severe limitation the Quichua and Shuar suffer is discrimination by non-Indians. Wherever they go they are treated as second class citizens. This makes them even more reluctant to turn to the existing health services. What this project will do is bring primary health care to the people, instead of them having to leave their communities to receive health care. A concurrent advantage is

that for the first time the target communities will learn about new health behaviors and better child care methods which will help prevent injury and illness, and help them lead healthier lives.

#### IV. Project Design and Implementation.

Each local project will follow a similar pattern of development. In general the implementation will proceed according to the following pattern:

Field-based seminar. Key people who will initiate the project, including agency representatives and community leaders, will come together for several days of workshop. During the workshop, participants will learn and discuss the wholistic health model (Figure 2) and its programmatic implications. Basic and broad objectives for community health projects will be identified and the next steps decided and scheduled. The fundamental purpose of the workshop will be to establish a sound conceptual understanding among key initiators which will facilitate further, theoretically-sound planning.

The workshop will be convened by Vozandes Hospital. MAP, International will design and facilitate the workshop(s). The first workshop in Ecuador is scheduled for July 31 to August 4, 1978.

Government contact. Appropriate government officials will be contacted and invited to participate as resources in the workshop. Cooperative relationships with government are being fostered throughout each project. Preliminary contacts have already been made in Pastaza, Loja and Bolivar. Participants in the Morona-Santiago, Chimborazo and Guaranda projects have already attended workshops sponsored by MAP, International in the United States.

Community contact. The communities (local) will be contacted early. They will be asked to form a village health committee that would become responsible for a great deal of community-level administration. Community input will be solicited throughout the project. The goal will be to establish working relationships with community leaders that will result in a truly reciprocal participation in the project.

The Morona-Santiago project is functioning under the control of a Shuar health commission and the Chimborazo project under a Quichua health commission. Where possible in the other project areas, the projects will work through similar indigenous agencies.

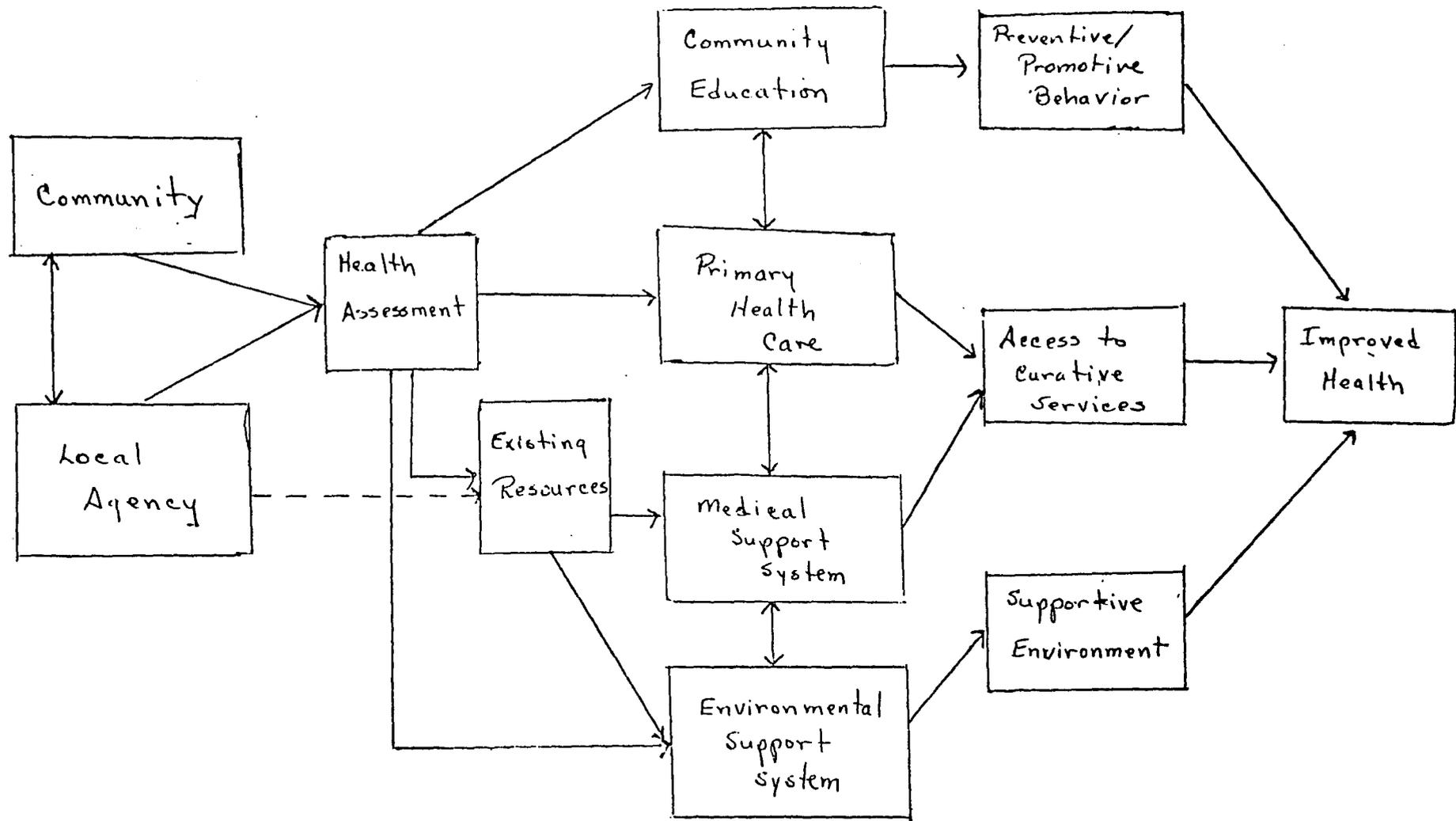


Fig. 2. Integrated Health System  
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Health Assessment. The health needs which exist in such specific areas will be identified in a process of interaction with the community. Community perceptions will be sought; household surveys will be conducted; needs will be prioritized and appropriate solutions selected in a process of agreement between the community and the implementing agency.

MAP International will assist in the design of participatory health assessment processes for each community and with processing of household survey data.

Planning. The health assessment will provide information which will allow firm planning of activities and resources appropriate for each local project. Planning will include the following:

1. Identification and description of specific beneficiaries.
2. Statement of intended outcomes in measurable terms.
3. Identification of programmatic activities which will cause the outcomes to occur. Specific activities will be designed for each major component of the intended health system including (a) community health education, (b) primary health care, (c) medical support system and (d) community development.
4. Identification of human, material and financial resources necessary for the implementation of the activities.
5. Accounting of important assumptions underlying the intended plan.
6. Charting of critical activities or an implementation schedule.
7. Identification of critical performance indicators for evaluations purposes.

Training. Training will be needed to implement the project. Following are the kinds of training which will be included in a project.

1. Training of local health workers will be part of every project. The specific content of that training will be decided on the basis of the health assessment.
2. Training of project directors and medical staff in the conceptualization and planning of community health. The decision on the extent of this need is contingent on the conceptual and planning skills already existing within the implementing agency.

Where they are deficient, training will be provided.

3. Management training, including accounting skills will be provided where needed.

4. Training of rural aides to assume supervision of the health workers.

This is an important step in making the projects self sustaining.

The workers training will be carried out at training centers in Macuma and Yapi (Morona Province), Puyo (Pastaza Province), Colta (Chimborazo Province), Saraguro (Loja Province), and Winchoa (Bolivar Province).

Cultural expectations and the general low level of education (illiterate to third grade level) have determined the length and frequency of the workers training. The training sessions will be held one week to three weeks at a time because the volunteers are reluctant to leave their families and their work for longer periods. The sessions are so spaced that the supervisors will be able to visit the workers between the training sessions to provide supervision and further education.

Thus, because of these factors, the health workers training will proceed at a slow pace. The pace of the training sessions will be determined by the rate at which the health workers are able to proceed and apply the content.

Funding. The projects will require outside funding for start-up costs. This proposal is requesting a bloc of project funds which can be allocated to specific local projects as needed. Break-down of funding can be seen in the overall budget presentation.

The funding strategy is as follows. The five PVO's cooperating with Vozandes, GBU, CMS, Brethren, Free Will Baptists and Berean have been functioning in the target areas for some years now with medical and support personnel (although with an institutional, curative approach). Thus the contributions of these PVO's are primarily in personnel, and training facilities in some cases, which are already in place and will be redirected to these community based efforts. The GOE contributions are as a result of the project taking advantage of the current Ministry of Health program to expand its health services. (Refer to pg. 5 and figure 1, pg 6).

The project will serve as a linkage to the Shuar and Quichuas for the government program. The GOE contributions will be village health workers training instructors, and training for rural aides and their placement and support.

The contributions of the beneficiaries are in small fees for the health workers consulting services, and a small surcharge for medicines (for expanding stock and purchase of basic equipment). The community health committee will contribute in kind through their participation in the community education program.

The OPG funds are to be used for covering the start-up costs for getting these community health projects going. This includes training of GOE staff in planning, implementation and evaluation of community health projects; the expense of supervising the development of the projects; and on the project level, up-grading facilities, curriculum and curriculum materials development, and local staff training, health workers training, and consulting services.

Implementation. Each local agency, in cooperation with community leaders will be responsible to implement the project in their area. Each plan will call for gradual withdrawal from implementation responsibilities on the part of the outside agency with the community, local indigenous agencies and/or GOE assuming responsibility

Evaluation. Evaluation processes will be designed as part of the plan. Critical indicators will be identified and stated in measurable terms. The household survey of health needs will provide benchmark data for evaluation purposes. Periodic review sessions will be scheduled for program updating and revision. Forms for control of work and progress will be used as a form of evaluation as well as supervision.

MAP International will assist in the design and implementation of evaluation processes for the projects.

Coordination. Vozandes Hospital will coordinate the overall project activities.

A coordinator will be appointed who will:

1. Provide liaison with GOE for all the individual projects.
2. Provide liaison with USAID and other donors.
3. Provide liaison with MAP International and other consulting/resource agencies.

4. Coordinate joint workshops and training programs across more than one local project where possible.
5. Receive and administer project funds.
6. Coordinate the implementation and evaluation processes for each project.

Figure three visualizes implementation processes proposed for each local project.

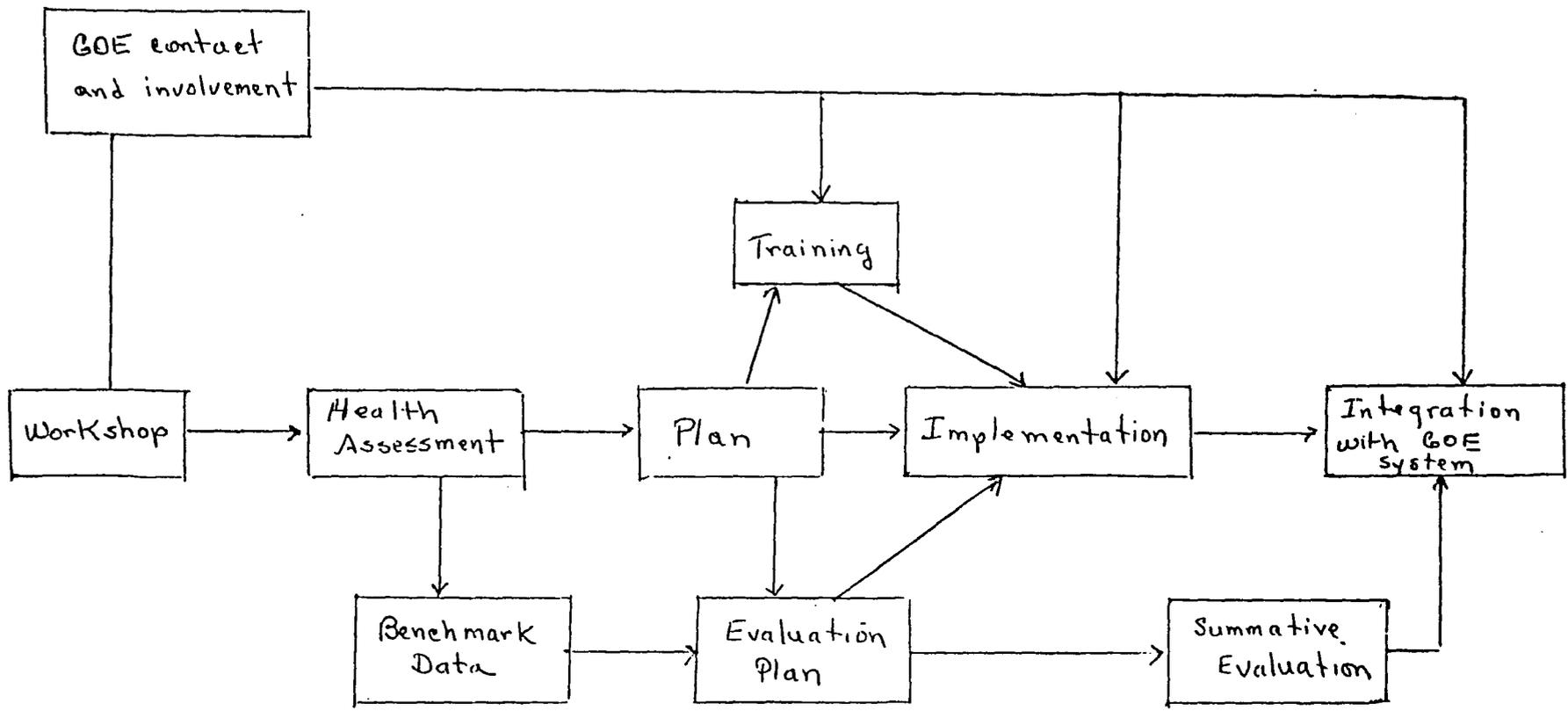


Fig. 3. Stages in the development and implementation of Four Rural Health Projects in Ecuador.

## Logical Framework Matrix

### A. 1. Goal:

That the health be improved in Indian populations of five rural areas of Ecuador where existing mission agencies are already working.

### 2. Measurement of goal achievement:

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

### 3. Assumptions (as related to goal):

- a. Communities will actively participate in the health programs.
- b. The health needs identified in the health assessment will be priority needs from the beneficiaries' point of view.

### B. 1. Purpose:

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

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

### 2. End of Project Status:

- a. Village health workers will be functioning in 100% of the target communities.
- b. Acutely ill people will utilize medical referral services at the village health worker's recommendation at least 80% of the time.
- c. Initiate health-related community development projects in the communities that have the organizational capacity to implement such projects.

### 3. Assumptions (as related to purpose):

- a. The GOE will recognize the program and view it as supportive of the government health system.

- b. Local leaders will legitimize the program and target communities will actively participate.

C. 1. Outputs:

- a. Participatory health assessment for each area.
- b. Community education (NFE) addressing prevalent, area-specific health issues.
- c. Training programs for health workers.
- d. Primary health system at the community level.
- e. Medical support system, including referral services and health workers supervision and medical supplies.
- f. More supportive environment conditions (e.g. water, housing, sanitation, etc.).

2. Output Indicators:

- a. Agreement between the community and facilitating agency on the prevalent crucial health needs.
- b. Community health committees functioning in the target communities agree with the community and village health worker on the specific health behaviors which need to be improved. Also that health committees in the above communities are taking leadership roles in the education programs.
- c. Functioning training programs.
- d. Health workers selected, trained, and functioning in 100% of the target communities.
- e. Referral facilities identified, approval of program from local health officials, health worker supervision plan implemented, and health workers pharmacy stock at each of the training centers.
- f. Specific resource commitments from each community where development projects have been initiated.

## 3. Assumptions (as related to outputs):

- a. Reciprocal relationships between communities and facilitating agencies.
- b. Communities will respond to educational efforts and adopt the agreed-upon health behaviors.
- c. The training that the health workers receive will enable the workers to give adequate primary health care.
- d. The communities will use this primary health system.
- e. The GOE will recognize and support the system by making government facilities available for training, supply supervision and referral.

## D. 1. Inputs:

- a. Grant manager and support services for the focus projects.
- b. Consulting assistance for planning, evaluation, health assessment, and community education.
- c. Training for facilitating agency staff.
- d. Resources for health workers training and supervision.
- e. Existing GOE health system for referral services.
- f. Planning assistance for health-related development projects.
- g. Project funds.

## 2. Budget:

## a. Three-year totals

- Coordination/supervision	\$101,279
- Project costs	<u>480,521</u>
	\$581,800

## b. Funding sources

USAID/Ecuador	\$278,000
Vozandes	135,900
MAP International	28,900
GOE	65,000
Brethren Mission	3,000

Free Will Baptists	18,000
Gospel Missionary Union	21,000
OMS International	24,000
Berean Mission	<u>7,500</u>
	\$581,800

3. Assumptions (as related to inputs):

- a. Vozandes Hospital will serve as the coordinating agency for the five projects, and will appoint a grant manager and provide support service
- b. MAP International will provide (or sub-contract as needed) consulting services.
- c. The existing staff and facilities will remain committed to the program for the length of the grant period. No more staff will be needed beyond those presently on site.
- d. The GOE referral system will cooperate with these projects.
- e. MAP will provide this planning assistance.
- f. Grant funds will be used to provide coordination for initiating the projects and improvement of staff, facilities and training; at the end of the grant period, existing agencies and infrastructure will be sufficiently strengthened so as to be self-supporting.

Total Budget-Health Projects

Funding Sources

I. Coordination/Supervision	<u>1-year</u>	<u>2-year</u>	<u>3-year</u>	<u>TOTAL</u>
MAP International				
Project Director (1/4 time)	\$7,500	\$7,500	\$7,500	
Staff training workshops (USA)	4,150			
Inflation factor (15%)		<u>1,125</u>	<u>1,125</u>	
	<u>11,650</u>	<u>8,625</u>	<u>8,625</u>	\$28,900
Vozandes				
Office expense	1,200	1,200	1,200	
Supplies	600	600	600	
Facilities (office space)	1,200	1,200	1,200	
Inflation factor (15%)		<u>450</u>	<u>450</u>	
	<u>3,000</u>	<u>3,450</u>	<u>3,450</u>	\$ 9,900
AID/Ecuador				
Travel (in-country)	2,000	2,000	2,000	
Training (in-country)	2,000	2,000	2,000	
Equipment (vehicle) expenses	500	500	500	
Consultative Services	4,040	4,040	4,040	
travel (international-2				
trips/year	(1,100)			
expenses (\$5 X 28 da/yr)	( 140)			
consulting fee (\$100 X 28 da/yr)	(2,800)			
Vehicle for project manager	10,000			
Administrative Costs @ 15%	5,032	5,456	5,456	
Contingency reserve @ 10%	2,277	1,800	1,800	
(10% of costs less salaries				
and vehicle)				
Inflation factor (15%)		<u>2,519</u>	<u>2,519</u>	
	<u>25,849</u>	<u>18,315</u>	<u>18,315</u>	\$62,479
TOTAL COORDINATION/SUPERVISION				101,279
TOTAL COMMUNITY PROJECTS				<u>480,521</u>
TOTAL BUDGET				\$581,800



TOTAL FROM FUNDING SOURCES

USAIL/Ecuador	\$ 278,000
Vozandes	135,900
GOE	65,500
Brethren	3,000
Free Will Baptist	18,000
Gospel Missionary Union	21,000
OMS International	24,000
MAP International	28,900
Berean Mission	7,500

TOTAL

\$581,800

Funding Sources Per Year

	<u>1-year</u>	<u>2-year</u>	<u>3-year</u>	<u>TOTAL</u>
<b>USAID/ECUADOR</b>				
Coordination/Supervision	25,849	18,315	18,315	62,479
Morona Santiago	27,575	20,625	22,625	70,825
Chimborazo	20,349	12,624	15,611	48,584
Pastaza	10,682	9,190	10,055	29,927
Loja	19,393	8,994	11,582	39,969
Bolivar	9,534	7,119	9,563	26,216
<b>MAP INTERNATIONAL</b>	11,650	8,625	8,625	28,900
<b>VOZANDES</b>				
Coordination/Supervision	3,000	3,450	3,450	9,900
Morona Santiago	16,500	16,500	16,500	49,500
Chimborazo	4,000	4,000	4,000	12,000
Pastaza	9,000	9,000	9,000	27,000
Loja	4,000	4,000	4,000	12,000
Bolivar	8,500	8,500	8,500	25,500
<b>G.M.U.</b>				
Morona Santiago	1,000	1,000	1,000	3,000
Chimborazo	6,000	6,000	6,000	18,000
<b>BEREAN</b>				
Bolivar	2,500	2,500	2,500	7,500
<b>O.M.S. INTERNATIONAL</b>				
Loja	8,000	8,000	8,000	24,000
<b>BRETHREN MISSION</b>				
Pastaza	1,000	1,000	1,000	3,000
<b>BAPTIST</b>				
Pastaza	6,000	6,000	6,000	18,000

G.O.E

Morona Santiago	5,000	7,000	7,000	19,000
Chimborazo	3,000	11,000	15,000	29,000
Pastaza	500	4,500	6,500	11,500
Loja	500	500	500	1,500
Bolivar	1,500	1,500	1,500	4,500

SHUAR RURAL HEALTH PROJECT (MORONO HEALTH PROJECT)  
HCJE/MAP International

Health Assessment Report  
and  
Revised Plans  
November 1977

Contents

White Pages . . . . . Health Assessment Findings  
Blue Pages . . . . . Volunteer Training Plans  
Yellow Pages . . . . . Community Education Plans  
White Pages . . . . . Implementation Schedule  
Budget

APPENDIX

- A. Project Program Designs, Budgets, and Maps:  
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Chimborazo  
Pastaza  
Loja  
Bolivar
- B. Convenio:  
AIPSE  
HCJB with Ecuadorian Government
- C. Forms and Records:  
Encuesta de Salud Rural  
Ficha del paciente  
Redidos de medicinas  
Informe Mensual  
Control de Vacunas  
Informe del paciente para el hospital  
Informe del trabajo del Promotor de Salud
- D. Goals reached in 1977- Morona-Santiago
- E. Description- Shuar Indian
- F. Description of MAP International
- G. Description of Hospital Vozandes

## SHUAR RURAL HEALTH PROJECT

### Health Assessment Findings

November 1977

The health system being designed for Shuar Indians in the Oriente of Ecuador intends to deal with the health needs which actually exist among the people. For that purpose health assessment processes were implemented to identify those needs. A health assessment plan was designed (February 1977) to collect community perceptions as well as medical specialist perceptions. Part of this process was to bring these two perceptions together such that there is agreement between the community members and the health professionals about what needs exist and which needs should receive priority attention.

Informal, unstructured group interview/discussion sessions were held in four communities. There was considerable consistency among community members about which health needs they felt were most crucial. (See Shuar Health Assessment First Community Visit; May 1, 1977.)

"Diarrhea and stomach problems," "fever" which was thought to be malaria, and "coughs" and other symptoms thought to be TB were the three most-mentioned health problems.

The first non-structured community meetings were followed by a household survey which included medical histories and stool tests. Following are the major findings of the household survey.

Parasites. Lab tests indicate that:

88% of those tested have some intestinal parasite.

70% of those tested have ascaris parasites.

50% of those tested have tricocefalos parasites.

13% of those tested have anquilostoma parasites.

46% of those tested have two parasites.

Present illness. Respondents were asked, "Are you sick now?" If yes, "What sickness?" Responses to this question indicated that:

63% of the population were sick at the time of the survey.

23% of the population suffered from amoeba\*. Symptomatic indications were confirmed by lab tests.

18% of the population had upper respiratory symptoms. Only one case (less than 1%) of TB was confirmed, however.

14% of the population had fevers. Less than half of those (7%) were diagnosed as malaria.

Other disorders included infrequent cases of anemia (3%), vitamin deficiency (1%) and injuries (4%).

When asked, "What was the cause of the sickness?" 42% of those who answered said, "contagion".

Following the survey, a small group of Shuar informants were asked to help amplify the many references to contagion that arose out of the survey interviews. They described many cultural beliefs and practices that supported the notion that the Shuar indeed understand the concept of contagion.

\*The doctor who helped design the survey instrument categorized amoeba separately from parasitic infections.

1. People will avoid sitting where a stranger has just sat. They may turn a stool over or put a clean banana leaf on a stool just used by a stranger.

2. When a person has vomited or deficated, especially where blood is evident, others will walk around the excrement and avoid it.

3. They may destroy plates and utensils that have been used by someone who is sick.

4. People will plug their nose when passing a watery or bloody stool thinking they might contract the illness through smell.

5. When a stranger comes, the host family may not sit near him; when he leaves they may wash the place where he sat or slept with hot water. They may even throw the bad mat away.

#### Discussion

There was considerable agreement between the information collected informally in community meetings -- the community's perceptions -- and the empirical data collected in the household survey -- the health professional's perceptions.

Stomach problems. The people complained of many stomach problems. The survey identified a very high prevalence of ascaris parasites and amoeba, both of which can cause severe "stomach" (intestinal) symptoms. The likelihood is that the majority of those infected could be considered acute.

Upper respiratory problems. The people complained of upper respiratory problems. The survey confirmed a high prevalence of upper respiratory infection. The endeavor to diagnose those symptoms did not produce clear conclusions. TB was not found to be as prevalent as had been thought.

It was noted that parasites could be linked to some URI in that a number of instances were cited when people coughed up worms. Furthermore, parasites are known to migrate through the lungs as part of their life cycle.

Fever. Fever was found to be less prevalent than was expected. Malaria accounts for slightly less than half the fever symptoms. It was observed by medical staff reviewing the raw data that acute cases of parasites and amoeba can cause a fever.

Contagion. The Shuar already have a concept of contagion from their cultural beliefs and practices. In some specifics their concept may not be supported by western scientific knowledge (e.g. contagion through smell). Nevertheless, they understand that disease can be communicated from one person to another through a medium which is to be avoided. This provides an excellent conceptual foundation on which to build community health education.

#### Programmatic Implications

The findings from both the community meetings and the household survey were discussed in a series of meetings attended by members of the Health Commission of the Shuar Association of Cooperatives and expatriate health professionals participating in the program. Out of those discussions grew an agreement about the specific thrust of the health program for the next year.

Intestinal infections. The single, most critical health need among the population of Shuar Indians relates to intestinal disorders caused by parasites, predominantly ascaris and tricocefalos, and amoeba. The following specific actions are recommended.

1. Help the people learn to improve the cleanliness of their houses and yards with special emphasis on the safe disposal of feces. Search the literature for alternative methods of waste disposal from which the Shuar may select the method (or methods) which are appropriate to promote within their cultural and environmental constraints.

Help the people to expand their concept of contagion so as to provide the motivation needed for the adoption of health-promoting waste disposal. Help them learn that animal waste, like human waste, can also communicate disease.

2. Test community water supplies for contamination. If (where) they are found to be contaminated, help the people of the affected communities to modify their practices such that they will draw uncontaminated water for household use.

3. Test chicha for contamination. If it is found to be contaminated, inquire further to identify the source of contamination. Discuss the issue with community members so they will adopt methods of chicha-making which will avoid contamination.

4. Emphasize in the training and supervision of health volunteers their roles in relation to parasitic and amoebic infections: i.e. community education, diagnosis and treatment. Be sure adequate supplies of appropriate medications are available.

Upper respiratory infections. It is possible that some of the upper respiratory complaints are related to intestinal infections. Therefore, if intestinal infections are reduced some upper respiratory complaints may be reduced also.

Medical staff of the Shell Hospital should do further research to diagnose the major cause of URI in order to make sound decisions about appropriate efforts to reduce its prevalence.

Fever. Nearly half the fever complaints were diagnosed as malaria. Training of Health Volunteers should re-emphasize the recognition, treatment and prevention of malaria. Anti-malarials should be available in adequate supply. Since malaria is not endemic, the training should also stress the avoidance of indiscriminate distribution of malaria medicines.

Some fevers may be related to the highly prevalent intestinal disorders. If intestinal infections can be reduced the number of fever complaints will likely be reduced also.

Medical staff at the Shell hospital may wish to do further research to diagnose the fevers which are not related to malaria or intestinal infections. Data would suggest, however, that only 7% of the population suffer from non-malarial fever. If some of those are caused by intestinal infection, relatively few people are afflicted by yet-unidentified fevers. Fever research should take a lower priority than URI research or testing water.

### Program Design

The following Program Design Frames outline the revised health systems designed for and with the Shuar population of the Oriente in Ecuador. The blue forms relate specifically to the training, deployment and continuing education (supervision) of health volunteers. Whereas the system includes content and skills above and beyond the implications highlighted in the health assessment, it is to be understood that the issues dealing with the above programmatic implications will be given special emphasis.

The yellow forms describe a Community Health Education program which will become central to the overall health system.

## PROGRAM DESIGN FRAME

PROJECT: Shuar Health Project - MacumaDATE/LIFE: November 1977SECTOR: Volunteer Training and Supervision

## RATIONALE AND CONTEXT:

The existing health care system for the Shuar volunteers was begun in 1968. There is a need to improve the education of the volunteers, make health care more accessible and effective, and increase the confidence of the community in the services and capability of the volunteers.

## BENEFICIARY TARGET GROUP(S):

1. Residents of Shuar communities served by the Association in Oriente province, Ecuador.
2. Health volunteers serving among the above population.
3. The Shuar Association.
4. Ecuadorian Government Health System.

## INTENDED OUTCOMES/BENEFITS

That the Shuar people will have access to health care which is increasingly accessible, affordable, and effective.

That over three years:

1. There will be a decrease in the prevalence of common disorders; e.g. parasites and amoeba.
2. There will be an increase in the number of patients receiving care by the volunteer.
3. There will be a decrease in the number of patients needing hospitalization.
4. There will be a decrease in the duration of a patient's stay in the hospital.
5. There will be a decrease in the infant mortality rate.

## ACTIVITIES

1. Train 1 or 2 volunteers from 26 communities to the second level (3 years) so they will:
  - a. See patients, recognize and treat common disorders
  - b. Refer more critical patients either to a sub-center or the hospital
  - c. Maintain records on community households and patients
  - d. Submit a monthly report to the supervisor
  - e. Head community education forums.
2. Supervise volunteers so that they will improve performance and communities will gain confidence in their skills.
  - a. Visit each practicing volunteer in 26 communities to: observe volunteer/patient interaction; assess accuracy of diagnosis, treatment, referral.
  - b. Collate, review and interpret:
    - 1) household records
    - 2) patient records
    - 3) monthly reports
    - 4) pharmacy orders
  - c. Conduct continuing education sessions at the sub-centers and require volunteers to attend three sessions a year.
  - d. Broadcast continuing education programs for volunteers based on site visits.

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    - 4) pharmacy orders
  - c. Conduct continuing education sessions at the sub-centers and require volunteers to attend three sessions a year.
  - d. Broadcast continuing education programs for volunteers based on site visits.

## RESOURCES

Curriculum and materials  
 Instructors  
 Trainees  
 Training facilities  
 Trainees/Instructors' expenses  
     Transportation,  
     Food, lodging  
  
 Sub-centers staffed by rural aids  
 Hospital  
 Patient transportation  
 Records and report forms  
 Community education system

Transportation  
 Food, lodging  
 Observation guide

Record/Report forms & system  
 Analysis system

see Above)

Broadcast time  
 Field recorder  
 Tapes

## ASSUMPTIONS

Communities will perceive the volunteers as credible and rendering a valuable service as indicated by increased utilization and willingness to pay for medicines and consultas.

The system is financially viable for the volunteers. The cost of medicines will include a service charge for consultas.

Patients are able (and willing) to pay for medicine.

Each supervisory visit, whether by doctor, nurse, or rural aid, will be done on a cooperative basis. The volunteer will always handle the primary dealings with patients and communities; the visitors will always assume a supportive role.

MAF flight services are available for remote visits.

## PROGRAM DESIGN FRAME

PROJECT: Shuar Health Project - Macuma  
DATE/LIFE: November 1977  
SECTOR: Community Education

## RATIONALE AND CONTEXT:

The major health hazards among the Shuar can be avoided.

It is important to help the population learn how to promote their own health.

A communication program using the Macuma radio station and village discussion groups seems to be appropriate.

The Shuar Health Commission is excited about this and is anxious to participate.

## BENEFICIARY TARGET GROUP(S):

Residents of Shuar communities served by the Association in Oriente, Ecuador.

## INTENDED OUTCOMES/BENEFITS

That Shuar families will begin to dispose of waste, especially feces, safely.

That they will acquire and/or intensify the following concepts:

That they will decide to adopt a method of waste disposal that will be safe and compatible with their own situations.

That they will adopt the practice they decided on.

## ACTIVITIES

Broadcast health programs in Shuar on the Macuma radio station. Use one program for one month, repeating the same program every week.

Convene community meetings to discuss the program and give feedback to the ideas.

The health promoter will facilitate the meetings. He will first review the program content (if the meeting is not at the same time as the broadcast), stimulate discussion and record feedback from the community. Some promoters will record feedback in writing, some on tape.

Broadcast community feedback on Macuma radio and respond to any issues which warrant a response.

Measure effects of the program by surveying households.

## RESOURCES

Radio time  
Program production  
Health program coordinator

4 field recorders and mics

"Mail" transportation

Survey instruments and system

## ASSUMPTIONS

Promoters will be trained to facilitate community meetings and record feedback.

Promoters will be trained to collect periodic survey data

IMPLEMENTATION SCHEDULE:

Time unit: Months

Project/Purpose: Shuar Health (MORONO HEALTH)

Date/Life: November 1977

ITEMS:	1978												1979												1980					
	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A
1 Training Course																														
2 1st level	Y			M				M							M					M					M					
3 2nd level				MY				MY							MY					MY					MY					
4 Plan Rec. System																														MY
5 Plan Com. Ed.																														
6 Supervision Visit						✓				✓			✓				✓				✓									
7 Test Water & Chicha													✓										✓				✓			
8 Diagnose URI																														
9 Investigate Feve																														
10 Prepare Com Ed Pgms.		4 mo						4 mo				4 mo			4 mo					4 mo				4 mo						
11 Implement C.E.																														
12 Quac Survey																														
13 Imp. MCH																														
14 Orient RA to Sup																														
15 Dev. Illiterate Mtl.																														
16 Lab. Conf. of Dx																														
17 Planning/Eval Mtg																														
18 Collect Eval. Data																														x
19																														
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DM/ 777 Note: Ø indicates MAP participation  
M = Macuma course  
Y = Yapi course

Shuar Health Project-Morona Santiago

I. Personnel	<u>1-year</u>	<u>2-year</u>	<u>3-year</u>	<u>TOTAL</u>
HV Project Director	\$ 2,000	\$ 2,000	\$ 2,000	\$ 6,000
HV Nurse/Supervisor	6,000	6,000	6,000	18,000
GMU Nurse/Instructor	1,000	1,000	1,000	3,000
HV Grant Manager	2,500	2,500	2,500	7,500
HV Administrative Assist.	1,000	1,000	1,000	3,000
HV Doctor/Instructor	5,000	5,000	5,000	15,000
GOE Rural Aides (2-3-3)	4,000	6,000	6,000	16,000
GOE Training personnel	1,000	1,000	1,000	3,000
	<u>22,500</u>	<u>24,500</u>	<u>24,500</u>	<u>71,500</u>
 II. Training				
USAID Curriculum Development	300	300	300	900
USAID Materials Developed and Rep.	150	150	150	450
USAID Workshop (GOE & PVO)	300	100	100	500
USAID Household Survey & Eva.	100	100	100	300
USAID Facilitator (Health Comm.)	100	100	100	300
USAID Evaluation	200	200	100	300
USAID Hospitality (workers, 15-25-45)	1,200	200	500	900
	<u>2,350</u>	<u>2,000</u>	<u>3,600</u>	<u>6,800</u>
		2,950	4,850	10,150
 III. Travel				
USAID Project site X 3 (GMU)	250	250	250	750
USAID Communities- Sup/IA. (25-30)	3,600	3,600	3,600	10,800
USAID Health workers (25-30-50)	1,200	1,200	1,200	3,600
USAID To Quito-Project Dir X 3	50	50	50	150
USAID Hospitality-GOE	200	200	200	600
USAID Instructors	800	800	800	2,400
	<u>6,100</u>	<u>6,100</u>	<u>6,100</u>	<u>18,300</u>
 IV. Equipment				
USAID Microscope (3)	600	600	600	1,800
USAID A/V Film Projector	500			500
USAID A/V Film Projector	250			250
USAID Filmstrips	50	50		100
USAID Recorders/Microphones	250	250		500
USAID Cassettes	100	50		200
	<u>1,750</u>	<u>950</u>	<u>650</u>	<u>3,350</u>

I. Facilities

USAID Training- \$80 per/wk.	880	880	880	2,640
USAID Radio Time \$15/15min.	780	780	780	2,340
USAID Storeroom	100			100
	<u>1,760</u>	<u>1,660</u>	<u>1,660</u>	<u>5,080</u>

VI. Supplies

USAID VHW Kits (30-40-50)	4,500	1,500	1,500	7,500
USAID Supervision (3)	600			600
USAID Medicine inventory	2,000			2,000
USAID Forms, Charts	300	400	400	1,100
	<u>7,400</u>	<u>1,900</u>	<u>1,900</u>	<u>11,200</u>
	(19,360)	(13,560)	(15,160)	(48,080)
GRAND TOTAL	41,860	38,060	39,660	119,580

VII. Consulting Services

Transportation	1,100	1,100	1,100	3,300
Expenses	140	140	140	420
Consulting fees	2,800	2,800	2,800	8,400
	<u>4,040</u>	<u>4,040</u>	<u>4,040</u>	<u>12,120</u>

VIII. Administrative Services

(15% of total)	6,279	5,709	5,949	17,937
	(19,360)	(13,560)	(15,160)	(48,080)

IX. Miscellaneous

Contingency (10% minus salary)	1,936	1,356	1,516	4,808
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TOTAL 142,325

Funding Sources

Hospital Vozandes	49,500
GOE	19,000
GMU	3,000
USAID	70,825
	<u>\$ 142,325</u>

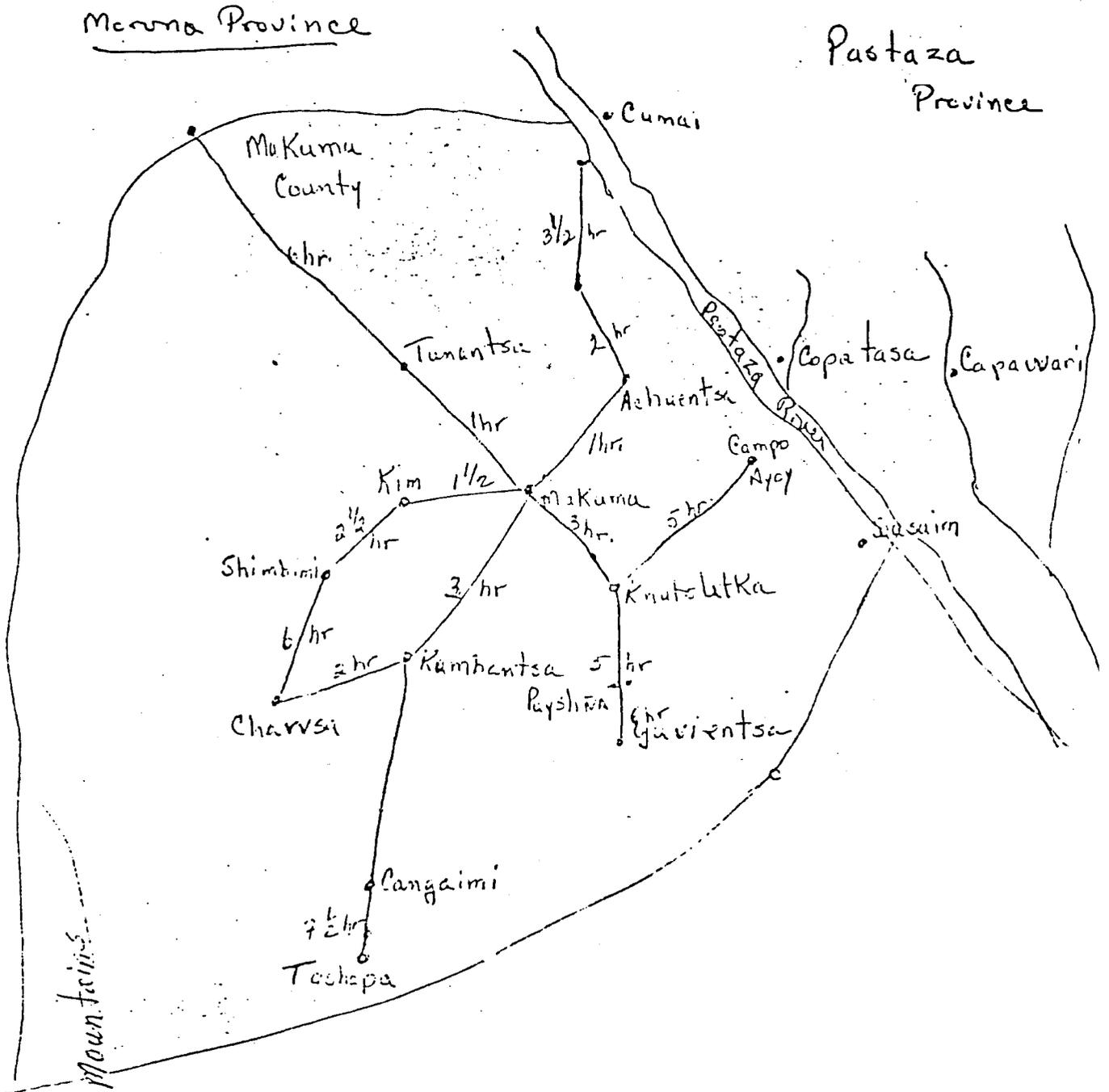
NOTE: In preparation of PVO personnel, MAP International invested \$2,100.





# MaKuma Area

February 1978



Not to scale, but gives an idea of area covered from MaKuma



CIRCUITO DE CUCHARILLA -



## PROGRAM DESIGN FRAME

PROJECT: Chimborazo Community Health  
DATE/LIFE: July 1, 1978 to June 30, 1981  
SECTOR: Colta

### RATIONALE AND CONTEXT:

The Association of Quichuas of Chimborazo Province, through their health commission have asked the Gospel Missionary Union (a Protestant missionary group) and Hospital Vozandes help them provide health services for rural, isolated Quichua Indian communities. The Gospel Missionary Union (GMU) has sponsored a clinic in Colta, but these services do not provide adequate primary health care for the isolated, rural poor. The government of Ecuador has a major hospital in Riobamba and sub-centers in a few major cities, but these health care services are not used except in critical cases by the rural Quichua because of their isolation, because they do not speak Spanish very well, and because they tend to be treated as second class citizens by the non-Indian Latins.

GMU is anxious to implement community based primary health care programs in at least some of these Quichua communities. They have asked Vozandes Hospital and MAP International to help them. GMU personnel attended a MAP workshop on "Community Health in Development", and a MAP consultant went to Ecuador to assist GMU personnel in planning a community health project.

(Refer to last part of the PDF for the evaluation plan)

### BENEFICIARY TARGET GROUP(S):

Rural, isolated Quichua Indian communities in the Province of Chimborazo. Communities which do not have immediate access to primary health care, and which request assistance will participate in the project. (Requests are already being made via the Association.) Teaching resources will limit participation to 30-50 communities for this three year project. Most communities have from 50 to 200 families.

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MAP INTERNATIONAL

INTENDED OUTCOMES/BENEFITS	ACTIVITIES
That the Quichuas in Chimborazo have primary health services in their communities.	<p>I.</p> <ol style="list-style-type: none"> <li>1. The association's health commission will sponsor organizers who will organize health committees.</li> <li>2. Village health workers will be chosen by their communities.</li> <li>3. A health assessment will be done in the communities.</li> <li>4. Village health workers will be taught through a series of short courses.</li> <li>5. Village health workers will be equipped with medicines, etc., which they will have in their own communities.</li> <li>6. Village health workers will be supervised on a regular basis.</li> </ol>
That the Quichuas in Chimborazo have access to a referral system.	<p>II.</p> <ol style="list-style-type: none"> <li>1. Obtain recognition from the government for this rural health program.</li> <li>2. Some village health workers will be trained as "auxiliares" (rural aides).</li> <li>3. Refer critical patients to government sub-centers and hospitals.</li> <li>4. Get puestos minimos established in the target communities.</li> <li>5. Quichuas will be trained as nurses and doctors to manage sub-centers and regional hospitals.</li> </ol>
That the Quichua living standards be improved such that they will live in healthy environments, practice good hygiene and will eat nutritional food (as these foods are available).	<p>III.</p> <ol style="list-style-type: none"> <li>1. The supervisors and village health workers will work with the communities to define good health habits which are feasible in the Quichua culture.</li> <li>2. The village health worker will carry on health education programs in their communities.</li> <li>3. Radio forums etc. will be created which will be directed towards health education to compliment the village health worker's efforts.</li> <li>4. The village health workers will train their health committees to carry on health education activities.</li> <li>5. GOE specialists in nutrition, agriculture etc., will assist in the training efforts as these personnel are available.</li> </ol>

RESOURCES	ASSUMPTIONS
<ol style="list-style-type: none"> <li>1. Health Commission of the Association of Quichuas Indians in Chimborazo Province.</li> <li>2. GMU and the Association</li> <li>3. GMU Village health workers Association Health Commission</li> <li>4. GMU Vozandes GOE MAP GMU training facilities, curriculum and materials.</li> <li>5. GOE Vozandes</li> <li>6. GMU Vehicle</li> </ol>	<ol style="list-style-type: none"> <li>I.           <ol style="list-style-type: none"> <li>1. The Quichuas in the target communities have already agreed amongst themselves that they have health problems and that they want to do something about those problems.</li> <li>2. The village health worker will be elected by a majority in each target community; health workers will serve everyone with no discrimination of religion, status, or sex.</li> <li>3. Medicines will be available from the GOE Ministry of Health and Vozandes.</li> <li>4. Road conditions will permit supervisors visit the target communities three times a year.</li> </ol> </li> </ol>
<ol style="list-style-type: none"> <li>1. Vozandes-Sara Rioser GOE</li> <li>2. GOE "auxiliar" training courses.</li> <li>3. GOE health system</li> <li>4. GOE Vozandes</li> <li>5. GOE financing for education (from other than project funds).</li> </ol>	<ol style="list-style-type: none"> <li>II.           <ol style="list-style-type: none"> <li>1. GOE Health officials will continue to be supportive of this and related community health programs with the Indians.</li> <li>2. There will be at least four village health workers with the minimum educational requirements for entering the "auxiliar" course.</li> <li>3. GOE will have the resources to continue to expand its referral system.</li> <li>4. Interested Quichuas will be encouraged to pursue further training and they will be helped to make arrangements to do so, but during this project's life Quichuas will only begin to work through the educational process.</li> </ol> </li> </ol>
<ol style="list-style-type: none"> <li>1. GMU and Vozandes supervisors Village health workers "Auxiliares"</li> <li>2. Village health workers Health educational materials appropriate a/v equipment</li> <li>3. HCJB producers GMU and Association radio station Money for air time.</li> <li>4. Village health workers Health committees MAP Learning Resources</li> <li>5. GOE Specialists</li> </ol>	<ol style="list-style-type: none"> <li>III.           <ol style="list-style-type: none"> <li>1. The community members will be more likely to adopt new health behaviors if they have a part in defining these behaviors.</li> <li>2. That most Quichua families have radios and the air time can be purchased.</li> <li>3. That the health committees will take this responsibility seriously.</li> <li>4. That the GOE personnel will be available to work with the village health workers in their communities.</li> </ol> </li> </ol>

## NOTES

### ACTION PLAN

ation processes are designed as part of the plan. Critical performance indicators will be identified and stated in measurable terms. A health survey will provide evaluation data throughout the project. In the last year a follow-up household survey will be conducted as part of a summative evaluation. Six month review sessions will be held with the projects manager, Quito (Sara Risser); a MAP consultant will attend the yearly review sessions.

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EVALUATION WORK SHEET

RE: \_\_\_\_\_

DATE/LIFE: \_\_\_\_\_ PERIOD: \_\_\_\_\_

SECTOR: \_\_\_\_\_ DUE DATE: \_\_\_\_\_

EVALUATOR: \_\_\_\_\_

INTENDED OUTCOMES/STATUS:  
(OBJECTIVELY VERIFIABLE INDICATORS)

ACTUAL OUTCOMES/STATUS:  
(MEASURED INDICATORS)

That the Quichuas in Chimborazo have primary health services in their communities.

That the Quichuas in Chimborazo have access to a referral system.

That the Quichua living standards be improved such that they will live in healthy environments, practice good hygiene and will eat nutritional food (as these foods are available).

MAKE NOTES AND RECOMMENDATIONS ON OTHER SIDE. ATTACH SUPPORTING DOCUMENTS.

Chimborazo Health Project-Colta

I. Personnel

	<u>1-year</u>		<u>2-year</u>		<u>3-year</u>	<u>TOTAL</u>
HV Project Director	1,500	\$	1,500	\$	1,500	4,500
GMU Nurse/supervisor	6,000		6,000		6,000	18,000
GOE Rural doctor	2,500		2,500		2,500	7,500
GOE Training personnel	500		500		500	1,500
GOE Rural aides (0-4-6-)			8,000		12,000	20,000
HV Grant manager/Ad. Assist.	2,500		2,500		2,500	7,500
	<u>13,000</u>		<u>22,000</u>		<u>24,000</u>	<u>59,000</u>

II. Training

USAID Curriculum Development (texts)	200		200		200	600
USAID Materials Development and Rep.	100		100		100	300
USAID Workshop - project personnel	300		100		100	500
USAID Household Survey	100		100		100	300
USAID Facilitator	50		50		50	150
USAID Evaluation	200		200		500	900
USAID Hospitality (workers, 25-50-75)	1,000		2,000		3,000	6,000
	<u>1,950</u>		<u>2,750</u>		<u>4,050</u>	<u>8,750</u>

III. Travel

USAID Project site	150		150		150	450
USAID Communities-Sup. (25-50-75)	500		1,000		1,500	3,000
USAID Health workers (25-50-75)	400		800		1,200	2,400
USAID To Quito-Project Dir.	100		100		100	300
USAID Hospitality (GOE, etc.)	160		160		160	480
	<u>1,310</u>		<u>2,210</u>		<u>3,110</u>	<u>6,630</u>

IV. Equipment

USAID Vehicle	8,000					8,000
USAID Operating and Maintenance	300		300		300	900
USAID A/V Films & Filmstrips	200		100		50	350
USAID Recorders	200					200
USAID Cassettes	100					100
USAID Equipment maintenance	50		50		50	150
	<u>8,850</u>		<u>450</u>		<u>400</u>	<u>9,700</u>

V. Facilities

USAID Training rental	250		250			
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VI. Supplies

USAID VHW Kits (25-50-75)	1,250	1,250	1,250	3,750
Supervisors Kit	200			200
Medical Inventory	1,000			1,000
Forms, Charts	300	400	400	1,100
	<u>2,750</u>	<u>1,650</u>	<u>1,650</u>	<u>6,050</u>

VII. Office Expense

Telephone	100	100	100	300
Correspondence	50	50	50	150
	<u>150</u>	<u>150</u>	<u>150</u>	<u>450</u>

(15,360)	( 7,460)	( 9,610)	(32,430)
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GRAND TOTAL

28,360	29,460	33,610	91,430
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VIII. Consulting Services

Transportation Expenses	1,100	1,100	1,100	3,300
Consulting fees	140	140	140	420
	<u>2,800</u>	<u>2,800</u>	<u>2,800</u>	<u>8,400</u>
	4,040	4,040	4,040	12,120

IX. Administrative Services

(15% of total)	4,254	4,419	5,041	13,714
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( 7,360)	( 7,460)	( 9,610)	(24,430)
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X. Miscellaneous

Contingency (10% minus salaries and vehicle)	736	746	961	2,443
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TOTAL	99,738
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Funding Sources

Hospital Vozandes	12,000
GOE	29,000
GMU	13,000
USAID	58,738
	<u>107,584</u>

\$ 107,584

## PROGRAM DESIGN FRAME

PROJECT: Pastaza Community Health  
DATE/LIFE: June 1978  
SECTOR: Puyo

### RATIONALE AND CONTEXT:

The health commission of AISFE which includes several communities in Pastaza and several Quichua Indian communities, asked the Brethren missionary group and Vozandes Hospital to provide health services for rural, isolated Indian communities. The provincial health department has begun to train some village health workers and some of the Indians from the Atsuar community have attended the classes in Macuna (province of Morona Santiago). There is a small hospital in the province capital in which an out patient service is functioning with limited in patient beds. Vozandes Hospital in Shell also serves as a referral center and has been supplying health services to these areas by medical brigades.

### BENEFICIARY TARGET GROUP(S):

Rural, isolated, Quichua and Shuar Indian communities in the Province of Pastaza. Communities which do not have access to primary health care and have requested assistance.

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MAP INTERNATIONAL

INTENDED OUTCOMES/BENEFITS

ACTIVITIES

That the Quichua communities have primary health services in their community.

- I. 1. AMEE will sponsor organizers who will organize health committees.
- 2. Village health workers will be chosen by their communities.
- 3. A health assessment will be done in the communities.
- 4. Village health workers will be taught through a series of short courses.
- 5. Village health workers will be equipped with medicines, etc., which they will have in their own communities.
- 6. Village health workers will be supervised on a regular basis.

That the Shuar communities have primary health services in their community.

- II. 1. The health commission of AIPSE will sponsor organizers who will organize health committees.
- 2. Village health workers will be chosen by their communities.
- 3. A health assessment will be done in the communities.
- 4. Village health workers will be taught through a series of short courses.
- 5. Village health workers will be equipped with medicines, etc., which they will have in their own communities.
- 6. Village health workers will be supervised on a regular basis.

That the Quichuas and Shuars have access to a referral system.

- III. 1. Obtain recognition from the government for this rural health program.
- 2. Some village health workers will be trained as "auxiliares" (rural aides).
- 3. Refer critical patients to government sub-centers and hospitals.
- 4. Get puestos minimos established in the target communities.

That the Quichuas and Shuars living standards be improved such that they will live in healthy environments, practice good hygiene and will eat nutritional food as available.

- IV. 1. The supervisors and village health worker will work with the communities to define good health habits which are feasible in the Quichua and Shuar cultures.

OVER

ENDED OUTCOMES/BENEFITS	ACTIVITIES
	<ol style="list-style-type: none"><li data-bbox="715 310 1401 409">2. The village health worker will carry on health education programs in their communities.</li><li data-bbox="715 424 1428 550">3. Radio forums etc. will be created which will be directed towards health education to compliment the village health worker's efforts.</li><li data-bbox="715 567 1364 667">4. The village health workers will train their health committees to carry on health education activities.</li><li data-bbox="715 682 1423 781">5. GOE specialists in nutrition, agriculture etc., will assist in the training efforts as these personnel are available.</li></ol>

RESOURCES	ASSUMPTIONS
<p>I.</p> <ol style="list-style-type: none"> <li>1. Indians of AUE (Asociacion Misionera Evangelica Ecuatoriana)</li> <li>2. Brethren Mission</li> <li>3. Free Will Baptist Mission</li> <li>4. Vozandes Hospital-Shell</li> <li>5. GOE personnel</li> <li>6. Training facilities-GOE Puyo</li> <li>7. MAF flight service</li> <li>8. Health workers</li> </ol>	<p>I.</p> <ol style="list-style-type: none"> <li>1. The Quichuas and Shuars in the target communities have already agreed amongst themselves that they have health problems and that they want to do something about those problems.</li> <li>2. The village health worker will be elected by a majority in each target community; health workers will serve everyone with no discrimination of religion, status, or sex.</li> <li>3. Medicines will be available from the GOE Ministry of Health and Vozandes.</li> <li>4. MAF flights will be available.</li> </ol>
<p>II.</p> <ol style="list-style-type: none"> <li>1. Health Commission of AUESE</li> <li>2. Brethren Mission</li> <li>3. Free Will Baptist Mission</li> <li>4. Vozandes Hospital-Shell</li> <li>5. GOE personnel</li> <li>6. Training facilities- GOE Puyo</li> <li>7. MAF flight service</li> <li>8. Health workers</li> </ol>	<p>II.</p> <ol style="list-style-type: none"> <li>1. The Quichuas and Shuars in the target communities have already agreed amongst themselves that they have health problems and that they want to do something about those problems.</li> <li>2. The village health worker will be elected by a majority in each target community; health workers will serve everyone with no discrimination of religion, status, or sex.</li> <li>3. Medicines will be available from the GOE Ministry of Health and Vozandes.</li> <li>4. MAF flights will be available.</li> </ol>
<p>III.</p> <ol style="list-style-type: none"> <li>1. GOE personnel</li> <li>2. GOE auxiliary course</li> <li>3. GOE health system</li> <li>4. MAF flight service-MAF</li> <li>5. Free Will Baptist nurse</li> </ol>	<p>III.</p> <ol style="list-style-type: none"> <li>1. GOE Health officials will continue to be supportive of this and related community health programs with the Indians.</li> <li>2. There will be at least four village health workers with the minimum educational requirements for entering the "auxiliary" course.</li> <li>3. GOE will have the resources to continue to expand its referral system.</li> <li>4. Interested Quichuas and Shuars will be encouraged to pursue further training and they will be helped to make arrangements to do so, but during this project's life the Quichuas and Shuars will only begin work through the educational process.</li> </ol>

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OVER

RESOURCES	ASSUMPTIONS
<ol style="list-style-type: none"> <li>1. Free Will Baptist nurse and Vosandes personnel.</li> <li>2. Health education material</li> <li>3. Appropriate a/v equipment</li> <li>4. Macana and Fuyo radio stations</li> <li>5. MAP</li> <li>6. GCE specialists</li> </ol>	<ol style="list-style-type: none"> <li>IV. <ol style="list-style-type: none"> <li>1. The community members will be more likely to adopt new health behaviors if they have a part in defining these behaviors.</li> <li>2. That most Quichua and Shuar families have radios and the air time can be purchased.</li> <li>3. That the health committees will take this responsibility seriously.</li> <li>4. That the GCE personnel will be available to work with the village health workers in their coordination.</li> </ol> </li> </ol>

NOTES

Communities located in the Pastaza Province are:

Capitana  
Capitane  
Bafeo  
Comientes

These are Atshuar communities

Conambo  
Morote Gacha  
Villano  
Chapana  
Mashinic  
Sungayacu  
Pillimashina  
Ampijaco

These are Quichua communities

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EVALUATION WORK SHEET

PROJECT: \_\_\_\_\_ TITLE: \_\_\_\_\_

DATE/LIFE: \_\_\_\_\_ PERIOD: \_\_\_\_\_

SECTOR: \_\_\_\_\_ DUE DATE: \_\_\_\_\_

EVALUATOR: \_\_\_\_\_

INTENDED OUTCOMES/STATUS:  
(OBJECTIVELY VERIFIABLE INDICATORS)

ACTUAL OUTCOMES/STATUS:  
(MEASURED INDICATORS)

That the Quichua communities have primary health services in their community.

That the Shuar communities have primary health services in their community.

That the Quichua and Shuars have access to a natural system.

That the Quichuas and Shuars living standards be improved such that they will live in healthy environments, practice good hygiene and will eat nutritional food as available.

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MAKE NOTES AND RECOMMENDATIONS ON OTHER SIDE. ATTACH SUPPORTING DOCUMENTS.

Pastaza Health Project-Shell

I. Personnel	<u>1-year</u>	<u>2-year</u>	<u>3-year</u>	<u>TOTAL</u>
HV Project Director	\$ 1,500	\$ 1,500	\$ 1,500	\$ 4,500
Brethren Facilitator	1,000	1,000	1,000	3,000
Baptist- Nurse/Supervisor	6,000	6,000	6,000	18,000
HV Doctor/Instructor	5,000	5,000	5,000	15,000
GOE- Rural Aides (0-2-3)		4,000	6,000	10,000
GOE Training personnel	500	500	500	1,500
HV Grant Manager/Ad. Assist.	2,500	2,500	2,500	7,500
	16,500	20,500	22,500	59,500
 II. Training				
USAID Curriculum Development	300	300	300	900
USAID Materials development	150	150	150	450
USAID Workshop (project personnel)	300	100	100	500
USAID Household Survey	100	100	100	300
USAID Evaluation	200	200	500	900
USAID Hospitality (4-8-12)	112	224	336	672
	1,162	1,074	1,486	3,722
 III. Travel				
USAID Communities/Supervisor	1,800	1,800	1,800	5,400
USAID Training center-workers	600	600	600	1,800
USAID Supervisor (road)	100	100	100	300
USAID Hospitality-Instructor	160	160	160	480
USAID COE Personnel	200	200	200	600
USAID To Quito-Project Dir.	100	100	100	300
	2,960	2,960	2,960	8,880
 IV. Equipment				
USAID A/V filmstrip projector	250			250
USAID A/V Films and filmstrips	200	100	100	400
USAID Microscope	600			600
	1,050	100	100	1,250
 V. Facilities				
USAID Training-\$80 per/wk.	400	400	400	1,200

VI. Supplies

USAID VHW Kits (3-4-5)	150	200	250	600
USAID Medicine Inventory	500			500
USAID Supervisors Kit	200			200
	<u>850</u>	<u>200</u>	<u>250</u>	<u>1,300</u>

VII. Office Expense

Telephone	100	100	100	300
Correspondence	50	50	50	150
	<u>150</u>	<u>150</u>	<u>150</u>	<u>450</u>
	(6,522)	(4,934)	(5,346)	(16,802)
GRAND TOTAL	23,072	25,434	27,846	76,302

VIII. Consulting Services

Transportation Expenses	1,100	1,100	1,100	3,300
Consulting fees	140	140	140	420
	<u>2,800</u>	<u>2,800</u>	<u>2,800</u>	<u>8,400</u>
	<u>4,040</u>	<u>4,040</u>	<u>4,040</u>	<u>12,120</u>
	(23,072)	(25,434)	(27,846)	(76,302)

IX. Administrative Services

(15% of total)

	3,461	3,815	4,177	11,445
	(6,522)	(4,934)	(5,346)	(1,680)

X. Miscellaneous Contingency (10% minus salaries)

	652	493	535	1,680
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TOTAL

89,427

Funding Sources

Hospital Vozandes	27,000
COE	11,500
Brothren	3,000
Tree Hill Baptist	18,000
USAID	<u>29,927</u>
\$	<u>89,427</u>



## PROGRAM DESIGN FRAME

PROJECT: Loja Community Health

DATE/LIFE: June 1978

SECTOR: Saraguro

### RATIONALE AND CONTEXT:

For several years personnel from the Oriental Mission Society (OMS) have been taking primary health care to different Quichua communities and white settlers by health brigades. The communities are interested in having someone trained so that health care can be continued after the brigades have gone.

### BENEFICIARY TARGET GROUP(S):

Isolated communities of Quichua Indians and new communities being formed by new settlers.



INTENDED OUTCOMES/BENEFITS	ACTIVITIES
<p>That the Quichua communities have primary health services in their communities.</p>	<p>I. 1. MS will sponsor organizers who will organize health communities in each community.</p> <p>2. Village health workers will be chosen by their communities.</p> <p>3. A health assessment will be done in the communities.</p> <p>4. Village health workers will be taught through a series of short courses.</p> <p>5. Village health workers will be equipped with medicines, etc., which they will have in their own communities.</p> <p>6. Village health workers will be supervised on a regular basis.</p>
<p>That the new communities of settlers have primary health care services in their community.</p>	<p>II. 1. CMS will sponsor organizers who will organize health communities in each community.</p> <p>2. Village health workers will be chosen by their communities.</p> <p>3. A health assessment will be done in the communities.</p> <p>4. Village health workers will be taught through a series of short courses.</p> <p>5. Village health workers will be equipped with medicines, etc., which they will have in their own communities.</p> <p>6. Village health workers will be supervised on a regular basis.</p>
<p>That the Quichua and "colonos" have access to a referral system.</p>	<p>III. 1. Obtain recognition from the government for this rural health program.</p> <p>2. Some village health workers will be trained as "auxiliares" (rural aides).</p> <p>3. Refer critical patients to government sub-centers and hospitals.</p> <p>4. Get puestos minimos established in the target communities.</p>
<p>That the Quichuas and "colonos" living standards be improved such that they will live in healthy environments, practice good hygiene and will eat nutritional food (as available).</p>	<p>IV. 1. The supervisors and village health workers will work with the communities to define good health habits which are feasible in the Quichuas and "colonos" cultures.</p>

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OVER

ENDED OUTCOMES, BENEFITS	ACTIVITIES
	<ol style="list-style-type: none"><li data-bbox="719 285 1382 379">2. The village health worker will carry on health education programs in their communities.</li><li data-bbox="719 395 1441 520">3. Radio forums etc. will be created which will be directed towards health education to compliment the village health worker's efforts.</li><li data-bbox="719 536 1441 629">4. The village health workers will train their health committees to carry on health education activities.</li><li data-bbox="719 646 1414 739">5. GGE specialists in nutrition, agriculture etc., will assist in the training efforts as these personnel are available.</li></ol>

RESOURCES	ASSUMPTIONS
<ul style="list-style-type: none"> <li>1. CMS personnel</li> <li>2. GCE personnel</li> <li>3. Community leaders</li> <li>4. GCE health system</li> <li>5. Vehicle</li> <li>6. Health workers</li> <li>7. Rural aides</li> <li>8. Training facilities (GCE c/u CMS)</li> <li>9. Quito coordinator-Vozandes</li> </ul>	<p>I.</p> <ul style="list-style-type: none"> <li>1. The Quichuas and "colonos" in the target communities have already agreed amongst themselves that they have health problems and that they want to do something about those problems.</li> <li>2. The village health worker will be elected by a majority in each target community; health workers will serve everyone with no discrimination of religion, status or sex.</li> <li>3. Medicines will be available from the GCE Ministry of Health and Vozandes, and CMS.</li> <li>4. Road conditions will permit supervisors to visit the target communities three times a year.</li> </ul>
<ul style="list-style-type: none"> <li>1. CMS personnel</li> <li>2. GCE personnel</li> <li>3. Community leaders</li> <li>4. GCE health system</li> <li>5. Vehicle</li> <li>6. Health workers</li> <li>7. Rural aides</li> <li>8. Training facilities (GCE c/u CMS)</li> <li>9. Quito coordinator-Vozandes</li> </ul>	<p>II.</p> <ul style="list-style-type: none"> <li>1. The Quichuas and "colonos" in the target communities have already agreed amongst themselves that they have health problems and that they want to do something about those problems.</li> <li>2. The village health worker will be elected by a majority in each target community; health workers will serve everyone with no discrimination of religion, status or sex.</li> <li>3. Medicines will be available from the GCE Ministry of Health and Vozandes and CMS.</li> <li>4. Road conditions will permit supervisors to visit the target communities three times a year.</li> </ul>
<ul style="list-style-type: none"> <li>1. CMS personnel</li> <li>2. APT auxiliar course</li> <li>3. GCE health system</li> <li>4. Vehicle</li> <li>5. Quito coordinator-Vozandes</li> </ul>	<p>III.</p> <ul style="list-style-type: none"> <li>1. GCE Health officials will continue to be supportive of this and related community health programs with the Indians.</li> <li>2. There will be at least four village health workers with the minimum educational requirements for entering the "auxiliar" course.</li> <li>3. GCE will have the resources to continue to expand its referral system.</li> <li>4. Interested Quichuas and "colonos" will be encouraged to pursue further training and they will be helped to make the arrangements to do so, but during this project's life Quichuas and "colonos" will only begin to work through the educational process.</li> </ul>

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OVER

RESOURCES

ASSUMPTIONS

- IV.
1. CMS personnel
  2. Village health workers
  3. Rural aides
  4. Health education materials
  5. Appropriate a/v equipment
  6. MAP
  7. GCE specialists
  8. Quito coordinator-Vozandes.

- IV.
1. The community members will be more likely to adopt new health behaviors if they have a part in defining these behaviors.
  2. That most Quichua and "colonos" families have radios and the air time can be purchased.
  3. That the health committees will take this responsibility seriously.
  4. That the GCE personnel will be available to work with the village health workers in their communities.

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## NOTES

This part of the project will take longer to start, since there are no organized cooperatives or associations.

EVALUATION WORK SHEET

PROJECT: \_\_\_\_\_ RE: \_\_\_\_\_

DATE/LIFE: \_\_\_\_\_ PERIOD: \_\_\_\_\_

SECTOR: \_\_\_\_\_ DUE DATE: \_\_\_\_\_

EVALUATOR: \_\_\_\_\_

INTENDED OUTCOMES/STATUS:  
(OBJECTIVELY VERIFIABLE INDICATORS)

ACTUAL OUTCOMES/STATUS:  
(MEASURED INDICATORS)

That the Quichua communities have  
no health services in their  
communities.

That the new communities of settlers  
have primary health care services in  
their community.

That the Quichua and "colonos" have  
access to a referral system.

That the Quichuas and "colonos" living  
standards be improved such that they  
will live in healthy environments,  
practice good hygiene and will eat  
nutritional food (as available).

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MAKE NOTES AND RECOMMENDATIONS ON OTHER SIDE. ATTACH SUPPORTING DOCUMENTS.

Loja Health Project-Saraguro

I. Personnel	<u>1-year</u>	<u>2-year</u>	<u>3-year</u>	<u>TOTAL</u>
HV Project Director	\$ 1,500	\$ 1,500	\$ 1,500	\$ 4,500
OMS Nurse/Supervisor	6,000	6,000	6,000	18,000
OMS Doctor/Instructor	1,000	1,000	1,000	3,000
GOE Training personnel	500	500	500	1,500
OMS Doctor/Instructor/Supervisor	1,000	1,000	1,000	3,000
HV Grant Manager/Ad. Assist.	2,500	2,500	2,500	7,500
	12,500	12,500	12,500	37,500
II. Training				
USAID Curriculum Development	300	300	300	900
USAID Materials Development and rep.	150	150	150	450
USAID Workshop-project personnel	300	100	100	500
USAID Household Survey	100	100	100	300
USAID Facilitator	50	50	50	150
USAID Evaluation	200	200	500	900
USAID Hospitality -workers (8-16-25)	640	1,280	2,000	3,920
	1,740	2,180	3,200	7,120
III. Travel				
USAID Project site X 3	195	195	195	585
USAID Communities	300	300	300	900
USAID Health workers course (6-15-30)	300	750	1,500	2,550
USAID To Quito- Project Dir.	130	130	130	390
USAID Hospitality-Instructors	160	160	160	480
	1,085	1,535	2,285	4,905
IV. Equipment				
USAID Vehicle	8,000			8,000
USAID Operation and maintenance	600	600	600	1,800
USAID A/V Projector	500	100	100	700
USAID Recorder and Cassettes	300	100		400
	9,400	800	700	10,900
V. Facilities				
USAID Training-\$80 per/wk.	480	480	480	1,440
USAID Storeroom	100			100
	580	480	480	1,540

VI. Supplies

USAID VHW Kits (6-15-30)	300	350	750	1,400
USAID Supervisors Kit	200			200
USAID Medical Inventory	1,000			1,000
USAID Forms, Charts	<u>200</u>	<u>200</u>	<u>200</u>	<u>600</u>
	1,700	550	950	3,200

VII. Office Expense

Telephone	100	100	100	300
Correspondence	<u>50</u>	<u>50</u>	<u>50</u>	<u>150</u>
	150	150	150	450

(14,655)	( 5,695)	(7,765)	(28,115)
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GRAND TOTAL

27,155	18,195	20,265	65,615
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VIII. Consulting Services

Transportation	1,100	1,100	1,100	3,300
Expenses	140	140	140	420
Consulting fees	<u>2,800</u>	<u>2,800</u>	<u>2,800</u>	<u>8,400</u>
	4,040	4,040	4,040	12,120

IX. Administrative Services

(15% of total)	4,073	2,729	3,040	9,842
	(6,655)	(5,695)	(7,765)	(20,115)

X. Miscellaneous

Contingency (10% minus salaries and vehicle)	665	570	777	2,012
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TOTAL	77,469
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Funding Sources

Hospital Vozandes	12,000
GOE	1,500
OMS	24,000
USAID	<u>39,969</u>
\$	77,469



## PROGRAM DESIGN FRAME

PROJECT: Bolivar Community Health  
DATE/LIFE: June 1978  
SECTOR: Guaranda

### RATIONALE AND CONTEXT:

Church groups in the Quichua communities have asked BMI to help them with health services. Vozandes Hospital has sent medical caravans to Guaranda, but there is no health care delivery between caravan visits.

Vozandes Hospital has assigned a community health nurse to the Province of Bolivar to implement a community health program. A local Ecuadorian doctor has volunteered his services for the program.

The government program does not reach into rural Quichua communities. The government has expressed its appreciation for private voluntary agencies to help link rural people with the government program by training health workers to work at the community level.

### BENEFICIARY TARGET GROUP(S):

The Quichua Indian population in the Province of Bolivar.



INTENDED OUTCOMES/BENEFITS

ACTIVITIES

The Quichua Indian population in the province will have access to health services so that there will be a measurable reduction in the more prevalent health problems.

1. That each community health committee and EMI will come to an agreement on the most pressing health needs.
2. The community will agree upon the actions they will take to meet the agreed upon needs.
3. That communities will have primary health services.
4. That communities will have access to referral services.

- I. 1. Assess health needs in the communities.
  - a. Train facilitator appointed by the association.
  - b. The trained facilitator and EMI will conduct an appraisal of each proposed community where health services are planned.
  - c. Convene a community meeting to discuss health needs as perceived by the community.
  - d. Create a community health committee.
  - e. A meeting be held with facilitator and EMI to agree on the health needs.
2. Select village health workers from each community.
3. In order to provide primary health services
  - a. Design and conduct a training program for village health workers.
  - b. Provide necessary first aid equipment and medicine for each village health worker.
4. That primary education will be accessible to the village health worker.
5. Visit the village health workers on site for 2 to 3 days every 6 months.
6. Channel qualified village health workers into the government rural aides course.
7. Utilize qualified rural aides for supervision of the village health workers.
8. Refer critical patients to existing government sub-centers.

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RESOURCES	ASSUMPTIONS
<p>A. 1. Transportation, food, lodging  2. Indian Center facilities  3. Instruments  Data collection  Data processing  Transportation  4. BMI personnel  5. Quichua facilitator</p> <p>B. Quichua village health workers.</p> <p>C. 1. Curriculum  Materials  Facilities  Instructional staff  Transportation  Food and lodging  2. Pharmaceutical houses  3. Outside funding</p> <p>D. 1. Curriculum  Materials  Facilities  Instructional staff  Transportation  Food and lodging</p>	<p>I. A. 1. Hospital Vozandes will place a vehicle in the project.  2. MAP will give technical assistance.</p> <p>B. That the community health committee will nominate qualified volunteers.</p> <p>C. 1. There will be an existing curriculum available.  2. That Hospital Vozandes will appoint a staff community health nurse supervisor for the project.  3. That Dr. Cevallos will help with training.</p> <p>D. 1. BMI will set up a program for primary education.  2. The government will accept village health workers into the rural aides program and will appoint them to positions in the communities.  3. That these referral agencies will accept and treat critically ill patients.</p>

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## NOTES

The Association will appoint three facilitators for each area- North, South, East and West.

A two week initial course and one week every two months.

Emphasize teaching on treatment of needs identified in the health assessment.

## EVALUATION WORK SHEET

PROJECT: \_\_\_\_\_ RE: \_\_\_\_\_

DATE/LIFE: \_\_\_\_\_ PERIOD: \_\_\_\_\_

SECTOR: \_\_\_\_\_ DUE DATE: \_\_\_\_\_

EVALUATOR: \_\_\_\_\_

INTENDED OUTCOMES/STATUS:  
(OBJECTIVELY VERIFIABLE INDICATORS)

ACTUAL OUTCOMES/STATUS:  
(MEASURED INDICATORS)

The Quichua Indian population in the province will have access to health services so that there will be a measurable reduction in the more prevalent health problems.

1. That each community health committee and EMI will come to an agreement on the most pressing health needs.
2. The community will agree upon the actions they will take to meet the agreed upon needs.
3. That communities will have primary health services.
4. That communities will have access to referral services.

MAKE NOTES AND RECOMMENDATIONS ON OTHER SIDE. ATTACH SUPPORTING DOCUMENTS.

BOLIVAR HEALTH PROJECT-Guaranda

I. Personnel	<u>1-year</u>	<u>2-year</u>	<u>3-year</u>	<u>TOTAL</u>
Berean Project Dir.           \$	1,500	\$ 1,500	\$ 1,500	\$ 4,500
HV Nurse/Supervisor	6,000	6,000	6,000	18,000
Berean Nurse/Instructor	1,000	1,000	1,000	3,000
GOE Doctor/Instructor	1,000	1,000	1,000	3,000
GOE Training Personnel	500	500	500	1,500
HV Grant Manager/Ad. Assist.	2,500	2,500	2,500	7,500
	<u>12,500</u>	<u>12,500</u>	<u>12,500</u>	<u>37,500</u>
 II. Training				
USAID Curriculum Development	300	300	300	900
USAID Workshop-project personnel(GOE, etc)	300	100	100	500
USAID Materials development and rep.	150	150	150	450
USAID Household Survey	100	100	100	300
USAID Evaluation	200	200	500	900
USAID Hospitality (6-12-30)	168	336	840	1,344
	<u>1,218</u>	<u>1,186</u>	<u>1,990</u>	<u>4,394</u>
 III. Travel				
USAID Project site (\$50 X 3/yr.)	150	150	150	450
USAID Communities-Supervisors	300	300	300	900
USAID Health workers course (6-15-30)	300	750	1,500	2,550
USAID To Quito-Project Dir.	100	100	100	300
USAID Hospitality(GOE, Grant Man., etc.)	160	160	160	480
	<u>1,010</u>	<u>1,460</u>	<u>2,210</u>	<u>4,680</u>
 IV. Equipment				
USAID Operating and maintenance- veh.	600	600	600	1,800
USAID A/V Film projector	600			600
USAID A/V Filmstrip Projector	250			250
USAID A/V Filmstrips and Films	200	50	50	300
	<u>1,650</u>	<u>650</u>	<u>650</u>	<u>2,950</u>
 V. Facilities				
USAID Training-\$80 per/wk.	400	400	400	1,200
USAID Storeroom	200			200
	<u>600</u>	<u>400</u>	<u>400</u>	<u>1,400</u>

VI. Supplies

USAID VHW Kits (6-15-30)	300	350	750	1,400
USAID Supervisors Kit	200			200
USAID Medical Inventory	<u>1,000</u>	<u>350</u>	<u>750</u>	<u>1,000</u>
	1,500		750	2,600

VII. Office Expenses

Telephone	100	100	100	300
Coorespondence	<u>50</u>	<u>50</u>	<u>50</u>	<u>150</u>
	150	150	150	450
	( 6,128)	( 4,196)	( 6,150)	(16,474)

VIII. Consulting Services

Transportation Expenses	1,100	1,100	1,100	3,300
Consulting fees	<u>140</u>	<u>140</u>	<u>140</u>	<u>420</u>
	2,800	2,800	2,800	8,400
	<u>4,040</u>	<u>4,040</u>	<u>4,040</u>	<u>12,120</u>
GRAND TOTAL	18,628	16,696	18,650	53,974

IX. Administration Services

(15% of total)	2,794	2,504	2,798	8,095
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X. Miscellaneous

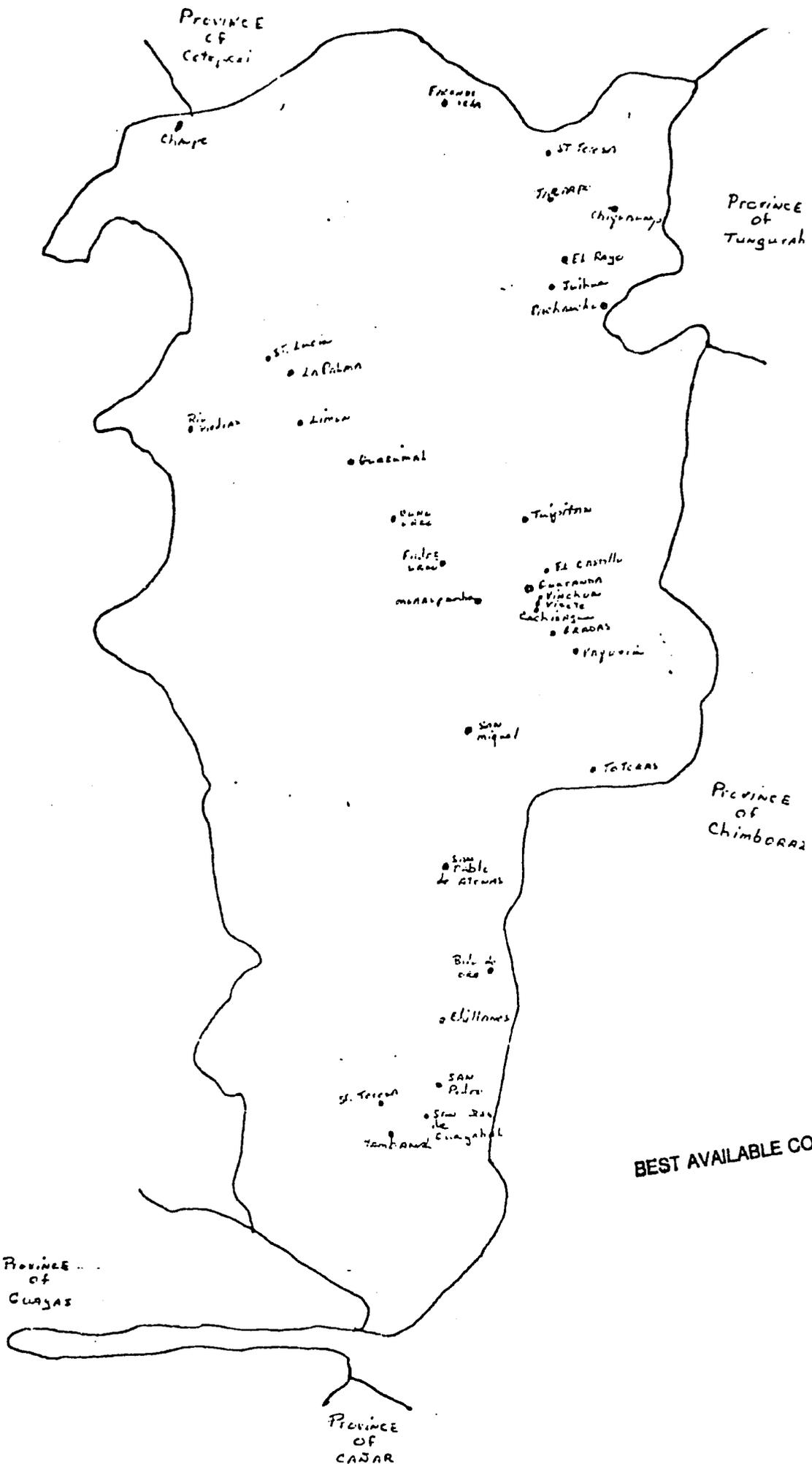
Contingency (10% minus salaries and vehicle)	612	419	615	1,647
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Funding Sources

Hospital Vozandes	25,500
GOE	4,500
Berean	2,500
USAID	<u>26,216</u>
	\$ 63,716

NOTE: In preparation of PVO personnel, MAF International invested \$700





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TIME TABLE FROM VINCHCA

Chaupe -  $2\frac{1}{2}$  hours by car ; then 10 - 11 hours by foot  
Facundo Vela -  $6\frac{1}{2}$  hours by car  
St. Teresa de Simiatug - 5 hours by car; then 3 hours by foot  
Tacarpo - 5 hours by car; then 2 hours by foot  
Chiquisungo -  $2\frac{1}{2}$  hours by car; then 3-4 hours by foot  
El Rayo -  $2\frac{1}{2}$  hours by car  
Juñhua - 2 hours by car  
Pachancho -  $1\frac{1}{2}$  hours by car  
St. Lucia -  $\frac{1}{2}$  hour by car; then 3 hours by foot  
La Palma - 3 hours by car  
Rio Piedras -  $3\frac{1}{2}$  hours by car  
Limon -  $1\frac{1}{2}$  hours by car  
Guarumal -  $\frac{3}{4}$  hour by car; then 1 hour by foot  
Cuno Urco -  $1\frac{1}{2}$  hours by car; then 3 hours by foot  
Padre Urco -  $1\frac{1}{2}$  hour by car; then 2 hours by foot  
Tuitipan -  $\frac{3}{4}$  hour by car  
El Castillo -  $\frac{1}{2}$  hour by car; then 1 hour by foot,  
Moraspamba - 1 hour by car  
Vidote - 15 min. by car; then 15 min. by foot  
Cachisagua - 20 min. by car; then 25 min. by foot  
Gradas - 15 min. by car  
Vaqueria - 20 min. by car  
San Miguel -  $\frac{3}{4}$ <sup>M</sup> by car  
Totoras - 1 hour 10 min. by car  
San Pablo de Atenas - 2 hour by car  
Bolo de Oro -  $2\frac{1}{2}$  hours by car; then 3 hours by foot  
Chillanes -  $2\frac{1}{2}$  hours by car  
San Pedro - 3 hours by car  
St. Teresa de Chillanes - 3 hours by car; then 1 hour 10 min. by foot  
San Jose de Guayabal - 3 hours by car  
Tambanal - 3 hours by car; then 1 hour 10 min. by foot

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**ANTECEDENTES:** La Asociación Independiente del Pueblo Shuar del Ecuador, - cuyos propósitos son los de la superación social, económica y moral de sus integrantes, así como el desarrollo de proyectos de colonización y vivienda.

Por otra parte, el Ministerio de Salud Pública, tiene previsto la extensión de servicios básicos, sobre todo Puestos de Salud para la Región Oriental y sucesivos cursos de capacitación de Auxiliares de Enfermería para atender a éstos, dentro de la política nacional de cobertura del área rural.

**PROPOSITO:** Integrar las acciones de salud del Ministerio de Salud Pública, con las que realiza la Asociación Independiente del Pueblo Shuar del Ecuador, para dar atención a poblaciones menores del área rural de la Provincia Morona Santiago.

**OBJETIVO:** Movilizar a la comunidad Shuar en su responsabilidad frente a la Salud, dentro del marco de la política de Salud Rural.

**NOMBRE DEL CONVENIO:** "Convenio de cooperación para el desarrollo de acciones de salud en el área rural y comunidades shuaras de la Provincia Morona Santiago.

Para el desarrollo del propósito general, ambas Instituciones convienen en suscribir un convenio de acuerdo al tenor de las cláusulas siguientes.

**CLAUSULA PRIMERA:** Intervienen en la suscripción del presente Convenio, - por una parte, en nombre y representación del Ministerio de Salud Pública, el Señor Doctor Armando Patiño V., Jefe Provincial de Salud de Morona Santiago, y a quien para efectos del presente Convenio se lo denominará "La Jefatura de Salud", y por otra parte la Asociación Independiente del Pueblo Shuar del Ecuador, representada por su Presidente Señor Samuel Wampari, a quien se lo denominará simplemente "La Asociación".

**CLAUSULA SEGUNDA:** Obligaciones del Ministerio:

- 1.- Reconocer la existencia de la Comisión de Salud de la Asociación Independiente del Pueblo Shuar, la misma que está formada por un médico y una Enfermera del Hospital "Venados" del Oriente, y pueblo shuar.
- 2.- Proporcionar asistencia técnica, a través de la Jefatura Provincial de Salud de Morona Santiago, a los servicios rurales donde trabajan Promotores de Salud.
- 3.- Cooperar con personal de Salud Rural para el funcionamiento de la Asociación Independiente del Pueblo Shuar, dentro de las posibilidades y disponibilidades de este recurso humano.

**CLAUSULA TERCERA:** Obligaciones de la Asociación:

- 1.- Prestar facilidades de comunicación a través de la Radio "Río Azuara" de Macoma, al personal de Salud que trabaja en diferentes Puestos de la Provincia y facilitar esta comunicación para la difusión de Programas Educativos de Salud; Además dar facilidades de movilización a través de las avionetas de "Alas de Socorro", en el marco de sus posibilidades.
- 2.- Contribuir a la construcción y equipamiento de los Puestos de Salud, dentro de las proyecciones que tiene el Plan Nacional de Salud Rural en la Provincia Morona Santiago.
- 3.- Participar, cuando sea necesario, en todos los Programas de Salud proyectados por el Ministerio y que se realicen a través de sus servicios cantonales y parroquiales y de los Promotores de Salud actualmente en función.

4.- Entrenar y supervisar a los Promotores de Salud.

CLAUSULA CUARTA: Duración del Convenio

El presente Convenio tendrá la duración de dos años y podrá ser renovo y ampliado de acuerdo al criterio de las partes contratantes.

Leído que fué el presente Convenio, en señal de asentimiento y aprobación, suscriben en tres ejemplares del mismo tenor, en Laeas, a 15 de Marzo de 1.978.

.....  
Dr. Armando Patiño V.  
JEFE PROVINCIAL DE SALUD DE  
NORONHA, SANTIAGO.-

.....  
Samuel Weipani  
PRESIDENTE DE LA A.I.P.S.D.



.....  
Carlos D. Howard  
ADMINISTRADOR DEL HOSPITAL  
VOZANDES DEL ORIENTE.-

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# REGISTRO OFICIAL

ORGANO DEL GOBIERNO DEL ECUADOR

EL ECUADOR HA SIDO, ES Y SERA PAIS AMAZONICO

Administración del Señor General de Brigada Guillermo Rodríguez Lara,  
Presidente de la República

AÑO III — QUITO, MARTES 22 DE OCTUBRE DE 1974 — NUMERO 664

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- 479 Autorización provisional para la constitución de la compañía "Retomas C. Ltda." ..... 15
- 561 Négase la autorización a la empresa "Techint Engineering Co." para que participe en la constitución de la empresa "Techint Compañía Técnica Internacional S. A." ..... 16

Quito, a 23 de septiembre de 1974.

Es fiel copia del original que reposa en los archivos del Ministerio de Relaciones Exteriores.

Lo certifico.

f.) Rodrigo Valdez B., Subsecretario General de Relaciones Exteriores.

Nº 151

**GENERAL GUILLERMO RODRIGUEZ LARA,**  
Presidente de la República,

En consideración a que el señor Econ. Jaime Moncayo García, Ministro de Finanzas, ha retornado al País luego de cumplir en el exterior las misiones que le fueron encomendadas; y,

En ejercicio de sus atribuciones,

Decreto:

Art. Único.— Reasuma a partir de la presente fecha las funciones de Ministro de Finanzas, el Titular de ese Portafolio Economista Jaime Moncayo García.

Dado en el Palacio Nacional, en Quito, a 10 de octubre de 1974.

f.) General Guillermo Rodríguez Lara, Presidente de la República.

Es copia.— Lo certifico:

f.) Coronel Carlos Aguirre Asanza, Secretario General de la Administración Pública.

Nº 1654

**GENERAL GUILLERMO RODRIGUEZ LARA,**  
Presidente de la República,

Considerando:

Que las aportaciones de los afiliados al Instituto Ecuatoriano de Seguridad Social deben guardar relación con los ingresos que perciben;

Que los Notarios y Registradores, vienen aportando al Régimen del Seguro Social, sobre montos calculados en forma estimativa que no guardan proporción con los derechos arancelarios que reciben en conformidad con la Ley;

Que tales aportaciones menores perjudican a los afiliados al momento de recibir las prestaciones que ofrece el mencionado Instituto; y,

En uso de las facultades de que se halla investido,

Decreto:

Art. 1º.— Los Notarios, Registradores de la Propiedad y Registradores Mercantiles aportarán al régimen del Seguro Social, sobre los ingresos declarados para efectos del pago del impuesto a la renta.

Art. 2º.— Tales aportaciones no podrán ser superiores a las de los Ministros Jueces de las respectivas Cortes Superiores, ni menores a las cantidades que aportan en la actualidad.

Art. 3º.— El Consejo Superior del Instituto Ecuatoriano de Seguridad Social, reglamentará el régimen de aportaciones de los funcionarios mencionados en el artículo primero de este Decreto.

Art. 4º.— De la ejecución del presente Decreto, encárgase a los señores Ministros de Gobierno y Justicia y de Trabajo y Bienestar Social.

Dado, en el Palacio Nacional, en Quito, a 10 de octubre de 1974.

f.) General Guillermo Rodríguez Lara, Presidente de la República.— f.) Calm. Alfredo Poveda B., Ministro de Gobierno y Justicia.— f.) Dr. Ramiro Larrea S., Ministro de Trabajo y Bienestar Social.

Es copia.— Lo certifico.

f.) Coronel Carlos Aguirre Asanza, Secretario General de la Administración Pública.

Nº 1055

**GENERAL GUILLERMO RODRIGUEZ LARA,**  
Presidente de la República,

Considerando:

Que la Radiodifusora H.C.J.B. la Voz y Ventana de los Andes, operada por The World Radio Missionary Fellowship, viene prestando desde hace muchos años, invalorable servicios al País, tanto en el aspecto cultural como en el educativo;

Que es deber del Estado incentivar y apoyar a estas entidades para que puedan acrecentar su aporte y colaboración a los intereses de la Patria; y,

En uso de las facultades de que se halla investido,

Decreto:

Art. 1º.— Facúltase al señor Ministro de Gobierno para que, a nombre y representación del Gobierno Nacional, celebre un contrato con el señor Abraham Van Der Puy, en su calidad de Representante legal de The World Radio Missionary Fellowship propietaria de la Estación Radiodifusora HCJB la Voz y Ventana de los Andes, cuyas atribuciones de representación deberán justificarse con el respectivo documento o documentos habilitantes, contrato que será sustitutivo del que, autorizado por Decreto Ejecutivo Nº 523, de 20 de diciembre de 1943, publicado en el Registro Oficial Nº 96, de 28 de los mismos mes y año, se ha otorgado entre el Gobierno Nacional y la ya indicada Entidad, contrato que se contendrá en las siguientes cláusulas:

PRIMERA.— Antecedentes.— The World Radio Missionary Fellowship, Entidad Cultural ajena a toda actividad política y lucrativa, ha venido prestando al País, por intermedio de su Estación Radiodifusora HCJB la Voz y Ventana de los Andes y del Hospital Vezandes, y en base a los contratos anteriormente vigentes, de los cuales el último fue autorizado

por el ya mencionado Decreto N° 523, los más positivos beneficios de carácter cultural, social, educativo y sanitario, debiendo en adelante sus actividades llevarse a cabo de conformidad con el presente contrato.

**SEGUNDA.— Obligaciones de The World Radio Missionary Fellowship.—** Con estos antecedentes The World Radio Missionary Fellowship, con respecto a las actividades de su estación radiodifusora HCJB la Voz y Ventana de Los Andes, se obliga para con el Gobierno Nacional:

a) A someterse, dentro de sus actividades específicas, a todas las disposiciones y regulaciones contenidas en la Constitución Política de la República del Ecuador, en vigencia y a las demás leyes y normas jurídicas aplicables;

b) A continuar cumpliendo con las obligaciones de que se hizo cargo, conforme a la cláusula octava del ya mencionado contrato, autorizado por el Decreto N° 523, expedido el 20 de diciembre de 1943 y publicado en el Registro Oficial N° 97 de 28 de los mismos mes y año, a saber: Dedicar la quinta parte del tiempo que dura las transmisiones de todas sus estaciones a la propaganda del País y a asuntos de interés general, tales como conferencias de índole pedagógica, agrícola, industrial, etc. Al efecto, el Gobierno proporcionará a HCJB la Voz y Ventana de Los Andes, el material de información, programas, etc. para estas transmisiones, y no podrá HCJB rechazar informaciones de propaganda que el Gobierno le presentare para su radiodifusión, debiendo más bien dar preferencia a su transmisión, sobre cualquier otra, empleando el tiempo a que tiene derecho el Gobierno;

c) A servir en todas las cadenas radiales nacionales, cediendo todos los espacios que el Gobierno Nacional juzgue conveniente, a través de los diversos Ministerios del Estado y de los Departamentos y entidades públicas;

d) A transmitir la propaganda cultural, social y turística del País, en beneficio de su desarrollo integral, en todas las bandas del sistema y en diversos idiomas;

e) A poner a órdenes del pueblo necesitado caravanas médicas y sus hospitales, en completa coordinación con el Ministerio de Salud;

f) A promover y establecer una Escuela del Aire en la que se llevarán a cabo programas de desarrollo social, de servicio a la comunidad, de orientación del hogar, etc.;

g) A llevar a cabo, con el empleo de todos los medios a su alcance, campañas cívicas de conocimiento de la realidad geográfica, histórica y económico social de la nación ecuatoriana; y,

h) A contribuir, con todos sus recursos, en los casos de emergencia, cataclismo y otros de carácter fortuito.

**TERCERA.— Obligaciones del Gobierno Nacional.—** El Gobierno Nacional, por su parte, se obliga:

a) A autorizar la libre entrada y salida del Ecuador, de los miembros de la Radiodifusora HCJB la Voz y Ventana de Los Andes y Hospitales Vozandes y de sus respectivas familias, así como de las personas cuyo concurso las indicadas Entidades consideren necesario, todos los cuales se someterán a las disposiciones de la Ley de Migración y de Extranjería vigentes al tiempo de su ingreso. Dichos miembros, sus familiares y más personal deberán llenar los siguientes requisitos: 1.— Certificado de buena conducta y antecedentes, conferido por la respectiva autoridad de su país o por el Cónsul del Ecuador en el lugar de donde vinieren. 2.— Petición escrita y firmada por el representante de la entidad dirigida al Ministro de Gobierno en la que consten los datos personales y de sus familias.— 3.— Garantía otorgada por el jefe y representante legal de la entidad, en la que ésta se responsabilice por la conducta de quienes ingresen al País así como de que no significarán carga para el Estado con ocasión de su permanencia en el País. 4.— Certificado Médico de que no adolecen de enfermedades infecto-contagiosas;

b) A conceder, durante todo el tiempo de la vigencia de este contrato, la importación libre de derechos arancelarios, con excepción del impuesto del 4% a las transacciones mercantiles y tasas por servicios, de los implementos, artículos, objetos y equipos que la Radiodifusora HCJB la Voz y Ventana de Los Andes y Hospitales Vozandes requieran para la ejecución y desarrollo de sus actividades específicas y para el cumplimiento de este convenio, siempre que dichos objetos o artículos no se produzcan en el Ecuador y sean utilizados exclusivamente en los fines que perseguen las indicadas entidades, así como los artículos de uso personal, traídos al país para sus miembros y sus respectivas familias y los vehículos a excepción de automotores del tipo Utility y Station Wagens; la exoneración comprenderá así mismo las máquinas, aparatos, equipos, vehículos y más objetos y artefactos de trabajo donados por las Instituciones y personas que colaboran desde el exterior para la mejor marcha de las entidades mencionadas;

c) A conceder exoneración de contribuciones, impuestos, derechos y tasas aduaneros a la introducción de las prendas de vestir, objetos de cocina y de mesa, tocador, joyas y vajilla de mesa, además de artículos de uso personal traídos por los miembros de las entidades y sus familiares en cantidades proporcionales a sus necesidades y siempre que no estén destinados al tráfico o a la venta, de conformidad con lo establecido en la Ley Orgánica de Aduanas y su Reglamento;

d) A exonerar de toda clase de impuestos, derechos y tasas aduaneros, a los artículos que se remitan a las indicadas entidades desde el exterior, con el carácter de donación y que no sean utilizados para otros fines;

e) A exonerar de toda clase de impuestos fiscales, municipales, especiales, adicionales, contribuciones y más gravámenes, los bienes inmuebles que en la actualidad sean de propiedad de The World Radio Missionary Fellowship, como aquellos que adquiriera en lo sucesivo, mediante donaciones, compra-venta, sucesión, etc. a título oneroso o gratuito, siempre que se destinen a los fines previstos en este contrato;

f) En fin, a garantizar a The World Radio Missionary Fellowship, en cuanto se relacione con las actividades de su estación radiodifusora H.C.J.B. la Voz y Ventana de Los Andes y Hospitales Vozandes, en el libre ejercicio de sus actividades, otorgándoles las concesiones y estímulos a que haya lugar, de conformidad con las disposiciones legales pertinentes.

**CUARTA.— Duración del Contrato.—** El plazo de duración del presente contrato será el de veinticinco años, firmes y obligatorios para ambas partes, plazo que se contará a partir de la fecha de suscripción y que podrá ser renovado por periodos iguales sucesivos, bajo las mismas condiciones, si ninguna de las partes comunicare a la otra, con seis meses de anticipación, por lo menos, a la expiración del plazo, y por escrito, su deseo y resolución de darlo por terminado.

**QUINTA.— Representación.—** Para todos los efectos del presente contrato The World Radio Missionary Fellowship Inc., así como su estación Radiodifusora H.C.J.B. La Voz y Ventana de Los Andes y Hospitales Vozandes, serán representados por el señor Abraham Van Der Puy, quien para este mismo efecto, señala su domicilio en la ciudad de Quito.— En el caso de cambiar la persona del citado representante, este particular, juntamente con los datos necesarios y la presentación de los documentos exigidos por las leyes aplicables, deberá hacerse conocer al Ministerio de Gobierno.

**Art. 2º.—** Declárase concluido y sustituido por el presente Decreto, el contrato celebrado entre el Gobierno del Ecuador y el entonces representante de The World Radio Missionary Fellowship Inc, cesionaria del original contratante señor Clarence Wesley Jones, conforme al Decreto Nº 523 de 20 de diciembre de 1948, publicado en el Registro Oficial Nº 95 de 28 de los mismos mes y año.

**Art. 3º.—** De la ejecución del presente Decreto, encárguese el señor Ministro de Gobierno.

Dado en Quito, en el Palacio Nacional, a 10 de octubre de 1974.

f.) General Guillermo Rodríguez Lara, Presidente de la República.— f.) Alfredo Poveda Burbano, Contralmirante Ministro de Gobierno.

Es copia.— Lo certifico.

f.) Crnel. Carlos Aguirre Asanza, Secretario General de la Administración Pública.

Nº 424

**EL MINISTRO DE FINANZAS.**

**Considerando:**

Que la empresa "Perla O Pacífico Cia. Ltda." ha presentado ante este Portafolio una solicitud y más documentos encaminados a obtener cupo de materias primas bajo el sistema de internación temporal y con gravámenes diferidos, para la elaboración y exportación de 1.600.000 galones de fruta procesada;

Que la Subsecretaría de Industrias mediante oficios Nos. 749735 de 5 de febrero y 749344 de 26 de abril de 1974, ha emitido informe favorable al respecto, conforme lo determina el Art. 5º del Acuerdo Ministerial Nº 071 de 18 de abril de 1969; y,

De conformidad con lo dispuesto en el Art. 6º del Acuerdo Ministerial Nº 071, publicado en el Registro Oficial Nº 105 de 24 de abril de 1969.

**Acuerda:**

**Art. 1º.—** Autorizar a la empresa "Perla O Pacífico Cia. Ltda." la internación temporal de las materias primas que se detallan a continuación, las que serán utilizadas en la elaboración de 1.600.000 galones de fruta procesada, destinada a la exportación:

Denominación	Cantidad
Azúcar citrico anhidrido	1.600 Kgs.
Borato de sodio	200 Kgs.
Cerezas enteras (Cherry)	1.600 Lbs.
Cerezas en mitades	400 Lbs.
Franco de vidrio de 1 galón	40.000 Unds.
Franco de vidrio de 1/4 de galón	1.600.000 Unds.

**Art. 2º.—** De conformidad con lo dispuesto en el Acuerdo Ministerial Nº 071, la internación temporal que se autoriza se mantiene sin nacionalizarse, bajo el principio de extraterritorialidad, en que se basan los fundamentos doctrinarios y legales aduaneros de este sistema.

**Art. 3º.—** De acuerdo con lo dispuesto en el Art. 42 de la Ley de Fomento Industrial, la indicada empresa presentará una garantía personal mediante escritura pública a favor del Ministerio de Finanzas, extensiva a todo el activo y patrimonio del que dis-

ENCUESTA DE SALUD RURAL

1. Nombre de la comunidad \_\_\_\_\_
2. Apellido \_\_\_\_\_
3. Nombre \_\_\_\_\_
4. ¿Quién es su esposo? \_\_\_\_\_ Esposa? \_\_\_\_\_
5. Edad: 0-1 \_\_\_ 1-3 \_\_\_ 3-5 \_\_\_ 5-7 \_\_\_ 7-9 \_\_\_ 9-12 \_\_\_  
                  12-18 \_\_\_ 18-30 \_\_\_ 30-50 \_\_\_ 50--- \_\_\_
6. Sexo: M \_\_\_ F \_\_\_
7. ¿Ha asistido a la escuela? Si \_\_\_ No \_\_\_  
    ¿Qué grado? \_\_\_\_\_
8. ¿Está Ud. enfermo ahora? Si \_\_\_ No \_\_\_
  - a.) Enfermedad \_\_\_\_\_ (refiérase a la lista de síntomas)
  - b.) ¿Cual fue la causa de la enfermedad?
    1. Contagio \_\_\_\_\_
    2. Ingestión \_\_\_\_\_ (intoxicación Alimentario)
    3. Curandero \_\_\_\_\_
    4. Otro \_\_\_\_\_
  - c.) ¿Quién fue la primera persona que le dió tratamiento?
    1. Curandero \_\_\_\_\_
    2. Doctor \_\_\_\_\_
    3. Me curé con hierbas \_\_\_\_\_
    4. Otro \_\_\_\_\_
- 9.) ¿Quién más le dió tratamiento?
  1. Curandero \_\_\_\_\_
  2. Doctor \_\_\_\_\_
  3. Me curé con hierbas \_\_\_\_\_
  4. Otro \_\_\_\_\_
9. ¿Ha estado Ud., enfermo durante el año pasado?
  - a.) Enfermedad \_\_\_\_\_ (refiérase a la lista de síntomas)
  - b.) ¿Cual fue la causa de la enfermedad?
    1. Contagio \_\_\_\_\_
    2. Ingestión \_\_\_\_\_
    3. Curandero \_\_\_\_\_
    4. Otro \_\_\_\_\_

c.) ¿Quién fue la primera persona que le dió tratamiento?

1. Curandero \_\_\_\_\_
2. Doctor \_\_\_\_\_
3. Me curé con hierbas \_\_\_\_\_
4. Otro \_\_\_\_\_

d.) ¿Quién más le dió tratamiento?

1. Curandero \_\_\_\_\_
2. Doctor \_\_\_\_\_
3. Me curé con hierbas \_\_\_\_\_
4. Otro \_\_\_\_\_

10. ¿Ha tenido otra enfermedad durante este año? SI \_\_\_\_\_ NO \_\_\_\_\_

Enfermedad \_\_\_\_\_

Enfermedad \_\_\_\_\_

Enfermedad \_\_\_\_\_

11. ¿Ha sido Ud, vacunado? SI \_\_\_\_\_ No \_\_\_\_\_

a.) BCG \_\_\_\_\_

b.) Triple \_\_\_\_\_

c.) Sarampión \_\_\_\_\_

d.) Polio \_\_\_\_\_

12. El lugar designado para sacar el agua potable está situado abajo del lugar donde hacen la deposición? SI \_\_\_\_\_ No \_\_\_\_\_

13. ¿A qué distancia se guarden los animales?

14. ¿Es más lejos al doctor o al curandero?

Doctor \_\_\_\_\_ Curandero \_\_\_\_\_

15. Gastos médicos durante este año: (aproximado)

a.) Cuenta del hospital \_\_\_\_\_

b.) ¿Cuánto ha gastado en comprar medicinas y por servicios del doctor? \_\_\_\_\_

c.) ¿Cuánto ha pagado Ud. al curandero? \_\_\_\_\_

16. ¿Qué hierbas usan y para qué son?

17. ¿Quién ayuda con los partos?

a.) Partera \_\_\_\_\_

b.) Doctor \_\_\_\_\_

c.) ~~Curandero~~ \_\_\_\_\_

d.) Otro \_\_\_\_\_

18. ¿Dónde bota la bazuza? \_\_\_\_\_

19. ¿dónde orina y hace la deposición?
- a.) Isterica \_\_\_\_\_
  - b.) En el campo \_\_\_\_\_
  - c.) Hago un hueco y cubre después de usarlo \_\_\_\_\_
20. ¿Cuántas veces come cada día? \_\_\_\_\_
21. ¿Qué comida come? \_\_\_\_\_
22. Economía:
- a.φ ¿Cuántas cabezas de ganado propio? \_\_\_\_\_
  - b.) ¿Cuántas ovejas tiene? \_\_\_\_\_
  - c.) ¿Qué otros animales tiene? \_\_\_\_\_
  - d.) ¿Cuántas hectáreas tiene? \_\_\_\_\_
  - e.) ¿Ha vendido algo durante el año pasado? si \_\_\_\_\_ no \_\_\_\_\_
  - f.) ¿En qué precio vendió? \_\_\_\_\_ (suma total de la venta)
  - g.) Deudas: \_\_\_\_\_ (suma total de deudas)

## FIEBRES

1. Por cuántos días ha tenido fiebre?
2. Es alta y fuerte?
3. Ligera y pasajera?
4. Duró varios días?
5. Los que duran varios días, vuelven a molestarle?
6. Los ataques de fiebre duran solo tres o cuatro horas?
7. Los ataques fuertes de tres o cuatro horas terminan con escalofríos fuertes?
8. Al pasar la fiebre, se siente mejor hasta el próximo ataque?
9. Tiene dolor de cabeza?
10. Se puso inconsciente?
11. Le dio convulsiones?
12. Hubo rigidez y dolor del cuello?
13. Le molesta la luz y se ponen rojos los ojos?
14. Se ponen amarillos los ojos y la piel?
15. Le da náusea y vómito?
16. Tiene dolor del abdomen?
17. Se hinche el abdomen?
18. Se hinche un lado de la cara?
19. Absceso?
20. Manchas negras?
21. Vómito con sangre o pintas negras?
22. Deposiciones negras?
23. Orina negra o roja?
24. Sangre por la nariz o por los oídos?

PIERRES CONT.

25. Manchas rojas abajo de las rodillas?
26. Manchas rojas por toda la piel?
27. Comezones de la piel.
28. La piel de la frente y las manos está negra?
29. Malestar del cuerpo fuerte?

FIEL

1. Tiene granitos en el cuerpo?
2. Por cuántos días?
3. Le da comezones?
4. Sale ampollas?
5. Manchas rojas en el cuerpo?
6. Manchas blancas en el cuerpo?

## QUELESTIAS DEL SISTEMA RESPIRATORIO

1. Dentro del Año; cuántas veces le da la gripe?
2. Se sanó entre ataques?
3. Cómo principio aquella gripe?
4. a) con catarro?  
b) con gargaajo que escupe?  
c) dolor de la garganta?  
d) dolor de los oídos?  
e) manchas?  
f) estuvo ronco?
5. Si está enfermo ahora, está mejorandose?
6. Epidemia?
7. Está pasandose la epidemia?
8. Ha tenido tos por más que un mes?
9. Tiene tos cada día?
10. Está empeorandose?
11. Tos seco?
12. Hay bastante esputo?
13. Hay pintas de sangre en el esputo?
14. Tiene dolor del pecho al toser?
15. Fiebre frecuente?
16. Suda por la noche?
17. Ha perdido el apetito?
18. Está más débil?
19. Ha recibido tratamiento para tuberculosis?
20. Terminó el tratamiento?
21. Tiene cicatriz de vacuna contra tuberculosis?
22. Tiene Ud. familia o vecinos con tuberculosis o tos crónico?
23. Otros sintomas?

## LISTA DE SINTOMAS

### DIARREAS

1. ¿Por cuántos días?
2. Fiebre, escalofríos, mal.éstar, dolor de cabeza durante los primeros días de la enfermedad?
3. Epidemia?
4. Náusea y vomito?
5. Diarrea fuerte?
6. Con sangre o moco?
7. Con dolor de garganta y tos?
8. Manchas o granitos?
9. Cólicos fuertes?
10. Cólicos livianos y pasajeros?
11. Estrenamiento entre ataques de diarrea?
12. Hinchazon de la barriga?
13. Pérdida de apetito?
14. Pérdida de peso?
15. Palidez?
16. Abortiguación de brazos o piernas?
17. Queman las palmas o plantas del pie?
18. Dolor del cuerpo?
19. Ictéricas?



NOMBRE DEL PRODUCTO	COMUNIDAD	PRECIO AL PRODUCTOR	PRECIO PEDIDO	PRECIO TOTAL
INV PUBLICO ANTIBIOTICOS	MEDICINA TUBERCULOSA BACTERIA	COMO VIENE		
___ \$1.20 c/u Terramicolina capsulas		20/funda	\$18.50/funda	
___ 4. c/u Ampicilina capsulas		20/funda	58.50/funda	
___ 0.80 c/u Sulfamatoxi p. tabs		30/funda	16.70/funda	
___ 23.10/cos Ampicilina fuerte ibn.		frasco	61.40	
CONTRA DOLOR - CONTRA FIEBRE - CALIANTES				
___ \$1/4tabs Mejunal tabletas		200/caja	32.50	
___ \$1/4tabs Mejunal para niños		200/caja	32.50	
ANTIACIDOS - CALIANTES		50 tabs	8.20	
___ 0.50 c/u Sal. Antra. sobres		60/caja	39.40	
CONTRA DIARREA - CALIANTE		10 sobres	6.60	
___ 13.00/cos Dactenocin - 2oz/fco		frasco	11.50	
___ 0.50 c/u Benda Especial		10 fundas	6.	
CONTRA PNEUMONIA - TRATAMIENTO				
___ 0.50 c/u Dipeto-Hidromiquin tabs		60/funda	23.30/funda	
___ 3.70 c/u Mintacol tabletas		50/caja	155.70	
___ 10/6tabs		8 tabs	24.90	
___ 8.50/cos Anti-helmintico 2oz/fco		frasco	15.80	
___ 2/sobre Enderax		50/caja	81.90	
___ 0.50 c/u Flomoxina tabletas		10 sobres	15.60	
CONTRA DOLORS - CALIANTE		10/sobre	6.30	
___ 9.20 Neo-aspasmol gotas		frasco	7.50	
___ 1. c/u Neo-aspasmol tabletas		10/sobre	7.70	
CONTRA ALERGIA - CALIANTE				
___ 0.90 c/u Hista 3 tabletas		10/funda	7.	
___ 4.70 Hista 3 libe 4 oz/fco		frasco	12.40	
CONTRA TCS				
___ 14.70 Expectorante Hista 3 4oz		frasco	12.40	
CONTRA HONGOS - TRATAMIENTO				
___ 12.90 Mergocid ung.		tubo	10.60	
___ Violata de genciann 2 oz		frasco		

TOTAL

CONTRA ESCASES

16.50	Benzoino de Bencilo 4oz	frasco	14		
	PARA LA PIEL				
	Mentiolato 4oz	frasco			
2./oz	Alcohol 8oz	frasco	15.20		
2./lata	Vick Vapo Rub	48/caja	83		
		10 latitas	17.30		
16.50	Metodov unguento	tubo	13.90		
	VITAMINAS Y HIERRO				
15/funda	Multivitaminas con hierro	30/funda	5		
39.30	Mol iron cbe. 230cc/fco	frasco	33		
21/4tabs	Calcio	60/funda	10		
	PARA OJOS Y OJOS				
13.20	Terramicina oft.	tubo	11.10		
22.90	Dibrosulfon 5cc/fco	frasco	19.20		
	PARA HEMORRAGIA DE LOS PARTOS				
9.20 c/u	Erpocovina tabletas	10/funda	5.		
	PLANIFICACION FAMILIAR				
12.40	Orvulatorios tabletas	20/caja	10.40		
	OTROS				

TOTAL

NOMBRE DEL PROMOTOR		COMUNIDAD	Precio al Promotor	Precio al Publico	Precio Total
17.50	Benzatinica 6-3-3	frasco	14.70		
30	Megaclina	frasco	25.20		
1.50 c/u	Novalgina tabletas	20/funda	25		
6.70	Novalgina 2cc amp	amp	5.70		
\$1/4tabs	Hidroxido de aluminio tabs	60/funda	11		
1.10 c/u	Capso tabletas	10/funda	9		
2.10 c/u	Enterosediv tabletas	10/sobre	18.40		
1.25 c/u	Metronidazol tabletas	60/funda	63		
0.65 c/u	Empo-paracetamol tabletas	8/sobre	3.40		
4.10	Neo-aspiramol amps	amp	3.40		
9.50	Plasil amp	amp	8.40		
2.40	Plasil tableta	8/sobre	16		
51	Plasil jarabe 4oz.	frasco	40.20		
2.50	Bisclapina tabs C.	20/caja 8/sobre	36.80 14.80		
18.80	Bisclapina C amps.	amp	15.80		
30	Tostac D 4oz/fco	frasco	25.20		
1.00	Benadryl capsulas	10/funda	9		
19.50	Fer-in-sol gotas 15cc/fco	frasco	16.40		
13.30	Dayamineral jbe 180cc/fcc	frasco	35.40		
12.50	Multivitaminas gotas 15cc	frasco	10.50		
5	Poljarin ref amp	10/cajita	41		
547.30	Suero antiofidico	amp	556.90		

1806





INFORME DEL PACIENTE PARA EL HOSPITAL

APELLIDO PATERNO (DEL PAPA): - \_\_\_\_\_

APELLIDO MATERNO ( DE LA MAMA): \_\_\_\_\_

NOMBRES: \_\_\_\_\_

DIRECCION: \_\_\_\_\_

PISTA: \_\_\_\_\_

EDAD: \_\_\_\_\_ FICHA DE NACIMIENTO: \_\_\_\_\_

QUEJAS DEL PACIENTE: (SINTOMAS):

OBSERVACIONES DEL PROMOTOR (SENALES FISICAS):

MEDICINAS Y TRATAMIENTOS RECIBIDOS:

PORQUE ESTA MANDANDO EL PACIENTE AL HOSPITAL?

FIRMA

ENCUESTA DEL TRABAJO DEL PROMOTOR DE SALUD

Nombre del Promotor de Salud. . . . .

Comunidad. . . . . Fecha actual. . . . .

Qué distancia vive el promotor del centro. . . . .

Fecha en que recibió el nombramiento de parte de la comunidad. . . . .

¿ Padres de Familia . . . . . Cuantos Cursos? . . . . .

¿ R.N. año \_\_\_\_\_ . . . . . Edad. . . . . Año que nació. . . . .

¿ Niños 1-5 años . . . . . Tiene cedula? . . . . .

¿ Niños escolares . . . . . Cuantos años de estudio. . . . .

¿ Adultos . . . . . Casado? . . . Niños? . . . . .

Total \_\_\_\_\_ Tiene radio? . . . . .

Provincia. . . . . Parroquia. . . . . Canton. . . . .

Ciudad del pueblo. . . . .

Ciudad? . . . Pista más cercano. . . . .

1. Tiene farmacia básica? . . . . .

De donde consiguió la plata para comenzar? . . . . . Cuanto? . . . . .

Donde guarda la medicina? . . . . . Cajón y cantidad? . . . . .

Lista de equipo. . . . .

2. Promotor más cerca. . . . . Distancia. . . . .

Qué convenio tiene entre Uds. los promotores en cuanto al trabajo? . . . . .

Tiene sistema de tarjetas? . . . . .

Día(s) de trabajo. . . . .

3. VACUNAS Cuales? . . . . . Cuanto? . . . . .

Que falta. . . . . Recibieron tarjetas? . . . . .

4. TUBERCULOSIS: Cuantos casos? . . . Con tratamiento? . . . . .

Hay casos sospechosos? . . . . . Qué hace por ellos? . . . . .

5. SALARIA

Hay otros sospechosos en su comunidad? . . . Qué hace por ellos? . . .  
Casos por seguro? . . . Cómo sabe? . . .  
Han visitado su comunidad los del Control de Malaria? . . . Cuando? . . .

6. Tiene convenio con la comunidad? . . .

Qué hace la comunidad? . . . . .  
El equipo es propiedad de la comunidad? . . . Cuánto vale? . . . . .  
Provee la comunidad una casa que sirve como Centro de Salud? . . . . .  
Cuántos días en la semana quieren que trabaje Ud? . . . . .  
Le ha dado préstamo para comprar los remedios la primera vez? . . . . .  
Cuánto era? . \$ En qué fecha? . . . . . Cuánto ha devuelto? . \$  
Cuanto debe todavía? . . . . . Para cuales otros gastos le ha prestado?  
. . . . . Los precios de las medicinas son fijos.  
Cobra por inyecciones? . . . Consultas? . . . Debe una ayuda mandar el  
dinero cobrado cada mes con pedido de medicina que ocupó? . . . . .  
Alguien le debe dinero? . . . . . Cómo podemos ayudarle solucionar este  
problema? . . . . . Le debe Ud. dinero? . . . . .  
Tiene ganado? . . . . .  
. Qué quiere hacer en su comunidad antes del otro curso? . . . . .  
Podemos ayudarle en alguna manera? . . . . .  
Como le ayudará el auxiliar rural? . . . . .  
En que nivel de promotor piensa que está Ud.? . . . . .  
Cómo va a entregar el informe cada mes? . . . . .  
Cual parte del curso le ayudó más? . . . . . Menos? . . . . .  
Qué quiere aprender en el proximo curso? . . . . .

BEST AVAILABLE COPY

8. Family or community oriented? Emphasis on curative or preventive?

Respected to be example and teacher? Water supply? Cat houses?  
Teacher? What grades?  
Records? Mods? Equipment?

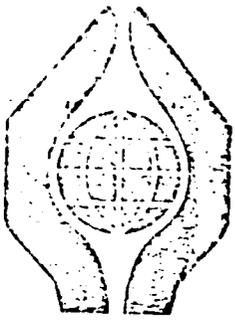
Goals reached in 1977:

1. Assignment of a Vozandes graduate nurse in Macuma to supervise the project.
2. Health assessment of three communities and tabulation of data.
3. Health workers training:
  - a. Advanced level- two times during the year.
  - b. Preparation of health workers for the advanced level- three times during the year.
4. Supervision of 30 health workers capable of diagnosing and treating minor illnesses. Some have learned to suture and do a fine job handling lacerations or even in setting fractures.
5. Organizations of records- immunization and family health records. The communities are from 50-350 in population.
6. Records developed for supervision of health workers (see appendix).
  - a. Monthly reports on illnesses and treatment.
  - b. Monthly report for medicines used.
  - c. Family health record.
  - d. Individual health record.
7. Health commission of AIPSE involved in decision making and health assessment.
8. Two Shuars received scholarships to enter training program for rural aides. They finished the course in December of 1977.
9. Rural doctor and nurses involved in teaching of health workers.

Goals reached in January to May, 1978:

1. Provision of training for 15 new health workers (several illiterate).
2. Provision of training for advanced health workers.
3. Coordination of immunization program with the Health Department. Met with doctor in charge of epidemiology.
4. A more accurate census taken of 24 communities in which health workers are working.

5. Assignment of two Shuar rural aides to Yapi and Cuchaentza.
6. Involvement of provincial chief in program by his visit to Macuma.
7. Developed teaching aides for illiterates (to be compiled and reproduced).
8. Production of radio forums by rural aides and health workers to be aired on Radio Amazonas.



# HOSPITAL VOLZANDES

Casilla 691

Teléfono 241540

Quito, Ecuador

April 17, 1978

HCJB

## Shuar Indian-Jungle

They are a semi-nomadic tribe living in the southeast jungles of Ecuador, along the slopes of the Cutucu Mountains. They, years ago, were involved in murderous and constant warfare, hunting and shrinking heads, witchcraft and polygamy. Today approximately 30,000 roam an area of 10,000 square miles, but little by little are being forced to settle in smaller areas. A type of unwritten law called "Shuartica", which controls building of homes, weaving cloth, planting of food, giving of child brides in marriage, communicating with the evil spirits, and killing of enemies, causes difficulty and to change their ways because of "Shuartica", is not possible.

Characteristics: known as the people of the 3 S's (spitting, sleeping, sitting).

A. No known leaders- respect come from age, tradition, land owners, marriage, and family. Therefore, there are no leaders within the community, and there is a lack of respect for those entering leadership positions. The person who does have the leadership is expected to do all because of lack of trust, and he does not know how to delegate work.

### B. Value System:

1. Generosity high- giving without strings attached.

Problem: give away daughters, musical instruments, watches, etc.

2. Not lose face.

Problem: do not confront in front of everyone, do not tease, do not like to be laughed at.

3. Time is for listening.

Problem: too much in a rush, do not feel important, do not seem to be interested.

4. No value of money, items, etc.

Problem: exchange is very unfair.

5. Revenge still exists in some areas.

Problem: poisoning frequently.

3. Money obtained- did not bring happiness.

Problem: 1. Now demanding more- buildings, subcenters, roads.

2. Caused bad nutrition- buy coke, candy, bread first because it is the white man's food. They sell good meat to buy sugar, noodles, rice, oakmeal, and salt.

C. Rotating land plots- each family had two plots which allowed them to rotate over a four year period.

Problem: now settling with one plot, causing a need for fertilizer to be shipped usually by air. The food that the plot does not produce is flown in, and human competition and stealing has increased.

#### D. Nutrition

Meal cooking all the time for anyone who comes by.

Introduction of meat increased protein intake.

Introduction of sweets- do not really want to buy but want to do as the white man

Medical Problems Vary- most common:

1. Malnutrition- probably from parasites.
2. Dehydration- diarrhea.
3. Incomplete abortions.
4. General headache and over-all body pains on the part of women, possible mental health problem.
5. Tuberculosis
6. Cancer
7. Infections of lacerations, cellulitis.
8. Fractures
9. Snakebites

Changes over the past 20 years: SLOW (good and bad).

1. Homes with zinc roofs.
2. Education, 1944, causing them to settle.
3. Divided area for sleeping.
4. Sleeping area not elevated- boards, and some use mats.
5. Small decrease in the spitting habit- little by little.
6. Bad teeth- introduction of sweets.
7. Wear shoes or boots.
8. Human rights- to be equal, and money is available.
9. Rapid change from low, low class to high class.  
Now have to work with others where before they worked alone as a family.  
Not free like long ago when each man was his own authority.
10. Physical Stature- introduction of meat (better food) and exercise. They are now taller and have better muscular development.
11. Less infant mortality- immunizations.
12. Beginning to use letrines (schools especially), still believe that disease enters through the rectum, and therefore do not sit where others sat. Living close to the smell of urine and feces causes illness, and therefore use different methods of feces disposal. They bury in not frequented areas. School have taught the children to sit where others have sat.

13. Do not live in communes because of distrust and more disease.
14. Aluminum cooking pots, instead of pottery, still cook in the open and on the floor
15. Hang food from ceiling- protection.
16. Stealing increased- unable to produce what is needed.
17. Not as revengeful- still some poisoning.
18. Some use plates instead of leaves to eat from.
19. Water supply- usually look for springs and running streams. Do not live in communities. This causes immorality (distrust), sickness (crowded water supply and feces disposal).
20. Now buy clothes instead of making them. They are being taught to sew on machines
21. Community a bit more organized as associations and commissions developed for education, agriculture, cattle, health, social and spiritual.
22. Churches are more established- difficult because of mobility.

These people are now in bondage to cattle, associations, money, and people.

Submitted by Sara Risser  
April 17, 1978

# I N T R O D U C I N G M A P ' s

## DEPARTMENT OF INTERNATIONAL DEVELOPMENT

For over twenty years, MAP International has been assisting Christian medical ministries in the Third World. Initially, MAP helped mission installations procure needed medical supplies and equipment from donor companies. As additional needs became apparent in its work with missions, MAP added new services to help meet those needs. With the creation of the Department of International Development MAP International has added a new dimension to its service capabilities, offering assistance to development projects in the Third World.

### PURPOSE

The Department of International Development exists to assist medically oriented evangelical organizations to initiate community health care programs and to help these organization to be more effective in improving community conditions which affect peoples' health.

While focusing its attention on health, MAP espouses a holistic, integrated concept of development. MAP's focus on health comes out of a realization that MAP has something unique to offer in one aspect of international development. Its belief in holistic, integrated development is reflected in its understanding of community health programs. These are programs where a total health care approach is taken, integrating promotional, preventive and curative health actions in the community as a result of an informed and involved community. These programs deal not only with disease and illness, but may include wider issues such as productivity, education, community organization, self-sufficiency in the basics for living, ownership, and a sense of community pride and human dignity.

### BENEFICIARIES

MAP's primary emphasis would be directed to evangelical organizations with existing medical programs, to assist them in growing from institution-centered to community-centered programs.

MAP's secondary interest would be directed to evangelical organizations with an expressed interest or desire to become involved actively in community health projects.

### SERVICES

The following is a description of the services that the Department of International Development (DID) could provide:

- A. A medically oriented organization identifies a health-related development project and asks for MAP's assistance. Possible DID services:
  - a. pre-program planning, including needs assessment
  - b. feasibility study

- c. community health workshops
  - d. arrange funding
  - e. community health education curriculum development
  - f. community health staff training
  - g. project monitoring
  - h. evaluation
- B. A medically-oriented organization has a community health program and asks MAP for assistance in evaluation for program improvement. Possible DID services:
- a. evaluation
  - b. program planning
  - c. community health education curriculum
  - d. community health education training
  - e. community health workshops
- C. DID staff identify a community health project on behalf of a funding agency (e.g. Compassion International, TEAR, HEED, etc.) Possible DID services:
- a. feasibility study
  - b. pre-program planning including needs assessment
  - c. community health workshops
  - d. program planning
  - e. community health education training and curriculum development
  - f. management staff training
  - g. short-term implementation
  - h. project monitoring
  - i. evaluation
  - j. information services (re: appropriate technology, resources, etc.)
- D. DID staff sponsor educational workshops on community health development projects for evangelical mission executives and field staff. Possible DID services:
- a. workshop design and implementation
  - b. pre-program planning (if workshop is held in a developing country)
  - c. information services
- E. DID staff identify a community health project in cooperation with a specific community. Possible DID services:
- a. community health workshops
  - b. pre-program planning including needs assessment
  - c. feasibility study
  - d. secure funding
  - e. community health education curriculum development
  - f. community health staff training
  - g. short-term implementation
  - h. evaluation

## WHY DO WE EXIST?

The logic concerning special intervention in the Third World to improve the quality of life of the poor implies the provision of minimum standards of food, clothing, shelter, education and health. It is not enough to attempt to increase food production if there is only minimal labor productivity because of poor health inadequate shelter, clothing or education. As apparent as this may seem, an integrated approach toward improving the quality of life is a recent enough phenomenon that much still needs to be learned about its implementation. The nature, scale and complexity of the problem of poverty are such that there continues to be a gap between what ought to be and what is with regard to attaining of minimum standards of the essentials of life.

One element reinforcing poverty is that those who most need health services (the poor) are the ones least likely to receive them. One reason for this is the concentration of services in metropolitan areas even though sizable proportions of the Third World population are rural. The World Bank estimates that 80% of the rural population in the Third World does not have contact with formal health services. (Rural Development, 1975) Not only does distance isolate people, but for the poor the cost of services becomes a second factor that keeps them from obtaining adequate health care. Of those needing these services, children are among the most affected. In developing countries 20% of the population are children yet they account for 60% of all deaths. (ibid,p.26)

A third factor isolating the most needy is cultural difference between the rural poor and the rest of society. Differences in education, rural customs and social status create sub-cultures within a larger society. This affects health when technically-trained people entering a rural community are regarded as outsiders and consequently have little effect on the continuing health needs of the poor. (Berhorst, 1975, p.50). Cultural factors not only affect people's attitudes toward outsiders, they also affect their attitudes toward disease and illness. (Ben-Sira, 1977). A regard for health services will be influenced, at least in part, by people's own understanding of what they need.

Thus the issue is not simply the provision of more health care services, because the nature of poverty demands that factors of distance, cost, and culture be dealt with.

Until recently the trend has been to meet the health needs of the poor by increasing curative services. This has fostered a dependence on doctors and centralized facilities. But there is a growing conviction that this approach has not matched population growth and has made even less headway in meeting the needs of those who never had health care in the first place.

Medical care in developing countries has been likened to running an ambulance service at the bottom of a cliff. What is needed is not more ambulances to carry away the people who have fallen but rather a fence at the top of the cliff to prevent falls. But constructing fences is not common practice. "Approximately 70% to 80% of public health expenditures are usually allocated to curative services, even though it is generally recognized that preventive health programs, primarily environment-oriented, are essential to check the diseases which have contributed to the prevailing high rates of morbidity and mortality." (Rural Development, 1975, p.26)

This is not to say that curative services are not necessary. They are important to an effective health system. But it is evident that curative services alone are inadequate to promote the total health of a population.

One important aspect of prevention efforts is health maintenance. In order to be healthy, people must learn how to take care of themselves in such a way that disease will be prevented and health promoted.

Health maintenance, including the prevention of disease, does not occur primarily at the clinic or hospital -- it occurs in the home, on the job, wherever people move and function during their day to day living. People need to learn about nutrition, disease, sanitation and hygiene. In his preface to Health and the Developing World, Bryant says, ". . . the most serious health needs cannot be met by teams with spray guns and vaccinating syringes. The causes of malnutrition, gastroenteritis and pneumonia are embedded in the way people live -- customs, poverty and lack of education." (1975, p.x.)

Thus, for health maintenance to occur, people need to become aware of their own condition, the problems it causes, and learn what they can do to improve their own situation. A crucial need relative to promoting health maintenance in the Third World is for community education which will systematically help people learn to adopt preventive and promotive health behaviors.

Underlying this rising concern for health maintenance and its promotion (health education) is the conviction that, "the world is now at a stage when it should no longer cause surprise that something can be done and that simple primary health care works." (Korten)

The immediate community needs for nutrition, immunization, sanitation, etc., must be met by the people themselves. Health care traditionally has been inadequate because it has been limited to curative service. With wider acceptance of primary health workers in rural communities innovative approaches are emerging. These must be tested within each individual situation to prove their validity.

In view of the above MAP International has created its Department of International Development (DID). Through it it seeks to assist medically-oriented evangelical organizations to initiate community health programs and to help them to be more effective in improving those community conditions which affect people's health. Assistance is given in planning and evaluating health related programs, in development of community education curricula, and in training of community health workers. It further serves as a clearing house for information on continuing education opportunities for health professionals working overseas, and maintains a resource center of selected current materials in the international health and development field.

# MISIÓN DE DOS HOSPITALES HERMANOS

## (HOSPITAL VOZANDES DE QUITO)

Gracias a la fidelidad de muchos contribuyentes, el 12 de octubre de 1955 marca la inolvidable fecha de inauguración del Hospital Vozandes de H.C.J.B. Un tiempo antes habíamos abierto un dispensario para llenar la necesidad médica de los indígenas que venían de lejos a vender sus productos. En poco tiempo nuestro dispensario estaba completamente lleno de pacientes y se hacía necesario pensar en un local más grande; por eso nació el Hospital Vozandes.

El mismo día de su inauguración, a las 5:30 de la tarde, nuestro primer paciente, un anciano que sufría intenso dolor, ingresó al hospital para someterse a una difícil intervención quirúrgica; semanas más tarde salió del Hospital no sólo con salud física sino también con salud permanente, con vida eterna. Hoy día el Hospital Vozandes es un Hospital de 50 camas que ocupa tres pisos. Ofrecemos una gran variedad de facilidades médicas: oftalmología, servicio de emergencia, consulta externa, cirugía, diálisis renal, servicio radiológico y de laboratorio clínico, fisioterapia, cuidado intensivo, pediatría y obstetricia. En la sala de operaciones se atienden casos de muy variada índole, desde problemas de la vesícula y cirugía ortopédica hasta complicados casos cerebrales y oculares.

Abogados, zapateros, oficiales del gobierno, vendedores de fritada, administradores de empresas, el niño de 7 años atropellado por un camión, gente de toda clase social, económica, cultural y política entra y sale por las puertas de nuestro Hospital.

Pero no son sólo los pacientes los que vienen a nosotros; nosotros vamos a ellos.

Nuestro vehículo de brigadas médicas cargado de inyecciones, vendajes, pastillas, vacunas, un doctor, una enfermera, una auxiliar de enfermería y un evangelista viaja a las zonas rurales varias veces al mes y ofrece asistencia médica a los que no tienen ninguna.

En una de nuestras recientes brigadas médicas conocimos a Sixto, de tres años, quemado, deshidratado, infectado. Habría esperanza de que viviera? Envuelto en una frazada lo trajimos al Hospital Vozandes de Quito; después de varias operaciones, tratamiento de antibióticos continuo, fisioterapia diaria y otra intervención quirúrgica, el pequeño Sixto empezó a alimentarse solo, a pararse y finalmente, a caminar. Porque Cristo se preocupa por la gente, nosotros también nos preocupamos y hay muchos "Sixtos" más que necesitan ayuda; ellos son nuestra razón de ser.

## (HOSPITAL VOZANDES DE SHELL)

El Hospital Vozandes del Oriente, hermano del Hospital Vozandes de Quito, nació en Shell, en las puertas de la selva. Shell es un pequeño pueblo de 1400 habitantes situado al pie de los Andes aproximadamente a 225 kilómetros de Quito.

Quando la compañía petrolera Shell se estableció allí hace unos años en busca de oro negro, no sólo construyó una pista de aterrizaje que permitía proveer tratamiento médico para los que iban lejos de esas facilidades. En 1950, sin embargo, cuando la Shell salió de ahí, la zona se quedó sin ninguna atención médica, nadie se preocupaba de las necesidades físicas de la gente, nadie excepto Nataniel y Margarita Saint de la Misión Alas de Socorro.

Dispersos en las selvas orientales había 5.000 personas aisladas por días de viaje a través de los senderos de la selva.

Quién podría alcanzarlos? Algunos misioneros pioneros habían tratado ya de hacer lo que podían pero qué de los pacientes que necesitaban tratamiento médico mayor? Nataniel Saint sintió el impulso de ayudar a la gente e inició planes para construir un hospital en la selva; luego cinco organizaciones misioneras se unieron al esfuerzo y la "Biblia Dice" decidió dar un apoyo económico sustancial para realizar el proyecto.

El 10 de mayo de 1958 el Dr. Teodoro Epp de "La Biblia Dice" llegó al Ecuador para participar en la gozosa inauguración del Hospital Vozandes del Oriente. Un faro para alumbrar el camino a la recuperación, mejor higiene y el Gran Médico . . . por eso estamos aquí. Un hospital de 28 camas, bien equipado, con consulta externa y con personal médico bien calificado, ofrecemos cuidado de enfermería 24 horas al día. Ahora también tenemos un ministerio de brigadas médicas y viajamos a la selva, por los ríos, a pie y a caballo, para alcanzar a la gente donde está.

## ATTACHMENT "C"

STANDARD PROVISIONSa. Allowable Costs and Payment

The Grantee shall be reimbursed for costs incurred in carrying out the purposes of this Grant which are determined by the Grant Officer to be allowable in accordance with the terms of this Grant and Subpart 15.2 of the Federal Procurement Regulations (FPR) (Principles and Procedures for use in Cost Reimbursement Type Supply and Research Contracts with Commercial Organizations) in effect on the date of this Grant. Payment of allowable costs shall be in accordance with Attachment D of this Grant.

b. Accounting, Records, and Audit

The Grantee shall maintain books, records, documents and other evidence in accordance with the Grantee's usual accounting procedures to sufficiently substantiate charges to the Grant. The Grantee shall preserve and make available such records for examination and audit by AID and the Comptroller General of the United States, or their authorized representatives (1) until the expiration of three years from the date of termination of the program and (2) for such longer period, if any, as is required to complete an audit and to resolve all questions concerning expenditures unless written approval has been obtained from the AID Grant Officer to dispose of the records. AID follows generally accepted use of Grant funds. The Grantee agrees to include the requirements of this clause in any subordinate agreement hereunder.

c. Refunds

(1) If use of the Grant funds results in accrual of interest to the Grantee or to any other person to whom Grantee makes such funds available in carrying out the purposes of this Grant, Grantee shall refund to AID an amount equivalent to the amount of interest accrued.

(2) Funds obligated hereunder but not disbursed to the Grantee at the time the Grant expires or is terminated, shall revert to AID, except for funds encumbered by the Grantee by a legally binding transaction applicable to this Grant. Any funds disbursed to but not expended by the Grantee at the time of expiration or termination of the Grant shall be refunded to AID.

(3) If, at any time during the life of the Grant, it is determined by AID that funds provided under the Grant have been expended for purposes not in accordance with the terms of the Grant, the Grantee shall refund such amount to AID.

d. Equal Opportunity Employment

With regard to the employment of persons in the U.S. under this Grant, Grantee agrees to take all reasonable steps to ensure equality of opportunity in its employment practices without regard to race, religion, sex, color or

national origin of such persons and that, in accordance with Title VI of the Civil Rights Act of 1964, when work funded by this Grant is performed in the U.S. no person shall, on the grounds of race, religion, sex, color or national origin, be excluded from participation, be denied benefits, or be subjected to discrimination. In addition, the Grantee agrees to comply in accordance with its written assurance of compliance, with the provisions of Part 209 of Chapter II, Title 22 of the Code of Federal Regulations, entitled "Non-Discrimination in Federally Assisted Programs of the Agency for International Development - Effectuation of Title VI of the Civil Rights Act of 1964".

e. Termination

This Grant may be terminated at any time, in whole or in part, by the Grant Officer upon written notice to the Grantee, whenever for any reason he shall determine that such termination is in the best interest of the Government. Upon receipt of and in accordance with such notice, the Grantee shall forthwith take immediate action to minimize all expenditures and obligations financed by this Grant, and shall cancel such unliquidated obligations whenever possible. Except as provided below, no further reimbursement shall be made after the effective date of termination, and the Grantee shall within thirty (30) calendar days after effective date of such termination repay to the Grantor all unexpended portions of funds theretofore paid by the Grantor to the Grantee which are not otherwise obligated by a legally binding transaction applicable to this Grant. Should the funds paid by the Grantor to the Grantee prior to the effective date of this termination of this Grant be insufficient to cover the Grantee's obligations pursuant to the aforementioned legally binding transaction, the Grantee may submit to the Grantor within ninety (90) calendar days after the effective date of such termination a written claim covering such obligations, and, subject to the limitations contained in this Grant, the Grant Officer shall determine the amount or amounts to be paid by the Grantor to the Grantee under such claim.

f. Officials Not to Benefit

No member of or delegate to Congress or resident commissioner shall be admitted to any share or part of this Grant or to any benefit that may arise therefrom; but this provision shall not be construed to extend to this Grant if made with a corporation for its general benefit.

g. Covenant Against Contingent Fee

The Grantee warrants that no person or selling agency has been employed or retained to solicit or secure this Grant upon an agreement or understanding for a commission; percentage, brokerage, or contingent fee except bona fide employees or bona fide established commercial or selling agencies maintained by the Grantee for the purpose of securing business. For breach or violation of this warranty, AID shall have the right to cancel this Grant without liability or, in its discretion, to deduct from the Grant amount, or otherwise recover, the full amount of each commission, percentage, brokerage, or contingent fee.

h. Nonliability

AID does not assume liability with respect to any claims for damages arising out of work supported by its Grants.

i. Amendment

The Grant Agreement may be amended by formal modifications to the basic grant document or by means of an exchange of letter between the AID Grant Officer and an appropriate official of the Grantee.

j. Grant Agreement

The letter to the Grantee signed by the Grant Officer, the Program Description, the Project Proposal by Grantee and the Payment Provisions which have been reviewed and agreed to by the Grantee, constitute the Grant Agreement.

k. Notices

Any notice given by any of the parties hereunder, shall be sufficient only if in writing and delivered in person or sent by telegraph, cable, registered or regular mail as follows:

To the cognizant AID Grant Officer

To Grantee - At Grantee's address shown in the Grant, or to such other address as either or such parties shall designate by notice given as herein required. Notices hereunder, shall be effective when delivered in accordance with this clause or on the effective date of the notice, whichever is later.

1. Travel and Transportation

(1) The Grantee agrees to travel by the most direct and expeditious route, and to use less than first class transportation.

Scheduling and routing of official air travel:

Travelers are expected to make a conscientious effort to schedule travel to make use of American-Flag service where flexibility exists in the timing of initiation of travel. Where possible, travelers will use American-Flag airlines from origin to destination or to the furthest practicable interchange point on a direct route, consistent with scheduled connections and authorized stopovers (e.g. TDY, official rest stop). An interchange point shall not be considered practicable if it would involve a delay in excess of 6 hours.

In addition to the above, the following standards for determining acceptable routings will apply:

(a) When official travel originates, terminates, or involves authorized stopovers in the United States, and American-Flag carrier provides service on a direct route, this service must be used, unless travel on such airline(s) could not be performed in time or is otherwise incompatible with the official purpose of the travel.

(b) When the point of origin of travel is outside the United States and American-Flag carriers provide service, this service must be used, unless use of the American-Flag carrier at origin would cause the traveler to be delayed in excess of 6 hours at an interchange point or cause the total travel to be delayed in excess of 12 hours en route, or unless the mission to be performed required use of alternative foreign-flag service. When travel is interrupted for official purposes (TDY, rest stop etc.) outside the U.S. the above standards will apply, except that the traveler need not delay initiation of travel from the point of interruption by more than 12 hours to use an American-Flag carrier.

(c) When the point of origin overseas is not served by an American-Flag airline or where use of foreign-flag airline is unavoidable en route, the foreign-flag airline may be used, but only to the nearest practicable interchange point to connect with available American-Flag service, unless the total travel would be delayed in excess of 12 hours en route by using the American-Flag carrier or the mission to be performed required greater use of the foreign-flag carrier.

(d) When air travel is performed on an indirect route, or delayed or interrupted for personal convenience (e.g. annual leave, LWOP), employees are advised to schedule their travel on American-Flag airlines, since any reduction in the amount of travel performed on American-Flag airlines as compared with that required on a direct and expeditious route will be for the personal account of the traveler.

(e) When a foreign-flag airline is used for any reason, other than in those instances where no American-Flag airlines operate between any two points on a traveler's authorized itinerary, the traveler shall prepare a memorandum, stating the justification for the use of the foreign-flag airline. The justification is to be attached to the employee's travel voucher.

(f) Where no acceptable justification exists for using a foreign-flag airline over all or a part of the authorized route, or where a lesser amount of American-Flag travel occurs because of indirect or interrupted travel for personal convenience, the additional amount of foreign-flag travel is not payable by the Government.

(g) Certificated air carriers (those holding certificates under Section 401 of the Federal Aviation Act of 1958, 49 U.S.C. 1371 (1970) must be used for all Government-financed commercial foreign air transportation of persons or property if service provided by those carriers is "available".

(h) Generally, passenger or freight service by a certified air carrier is "available" if the carrier can perform the commercial foreign air transportation needed by the agency and if the service will accomplish the agency's mission. Expenditures for service furnished by a noncertificated air carrier generally will be allowed only when service by a certificated air carrier or carriers was "unavailable".

(i) Passenger or freight service by a certified air carrier is considered "available" even though:

1. comparable or a different kind of service by a noncertificated air carrier costs less; or,
2. service by a noncertificated air carrier can be paid for in excess foreign currency; or,
3. service by a noncertificated air carrier is preferred by the agency or traveler needing air transportation; or,
4. service by a noncertificated air carrier is more convenient for the agency or traveler needing air transportation.

(j) Passenger service by a certificated air carrier will be considered to be "unavailable":

1. when the traveler, while en route, has to wait 6 hours or more to transfer to a certificated air carrier to proceed to the intended destination; or,
2. when any flight by a certificated air carrier is interrupted by a stop anticipated to be 6 hours or more for refueling, reloading, repairs, etc., and no other flight by a certificated air carrier is available during the 6-hour period; or
3. when by itself or in combination with other certificated or noncertificated air carriers (if certificated air carriers are "unavailable") it takes 12 or more hours longer from the origin airport to the destination airport to accomplish the agency's mission than would service by a noncertificated air carrier or carriers.

4. when the elapsed traveltime on a scheduled flight from origin to destination airports by a non-certificated air carrier(s) is 3 hours or less, and service by certificated air carrier(s) would involve twice such scheduled traveltime.

(k) The Comptroller General will disallow any expenditures for commercial foreign air transportation on noncertificated air carriers unless there is attached to the appropriate voucher a certificate or memorandum adequately explaining why service by certificated air carriers is "unavailable".

(2) Travel allowances shall be reimbursed in accordance with the Federal Travel Regulations (FTR).

m. Regulations Governing Employees Outside the United States

(1) The Grantee's employees, when employed in work overseas, shall maintain private status and may not rely on local U.S. Government Offices or facilities for support while so engaged.

(2) The sale of personal property or automobiles by Grantee employees and their dependents in the foreign country to which they are assigned shall be subject to the same limitations and prohibitions which apply to direct-hire AID personnel employed by the Mission, except as this may conflict with host government regulations.

(3) Other than work to be performed under this Grant for which an employee or consultant is assigned by the Grantee, no regular or short term employee or consultant of the Grantee shall engage, directly or indirectly, either in his own name or in the name or through an agency of another person, in any business, profession, or occupation in the foreign countries to which he is assigned.

(4) The Grantee's employees, while in a foreign country, are expected to show respect for its conventions, customs, and institutions, to abide by its applicable laws and regulations, and not to interfere in its internal political affairs.

(5) On the written request of the Grant Officer or of a cognizant Mission Director, the Grantee will terminate the assignment of any individual to any work under the Grant and, as requested, will use its best effort to cause the return to the United States of the individual from overseas or his departure from a foreign country or a particular foreign locale.

(6) Allowances for employees assigned overseas shall be reimbursed in accordance with the Federal Travel Regulations (FTR).

n. Subordinate Agreements

The placement of subordinate agreements (e.g., leases, options, etc.), grants or contracts with organizations, firms or institutions other than the ones mentioned in the attachment "A" "Project Description", and the provisions of such subordinate agreements are subject to prior written consent of the Grant Officer if they will be funded hereunder. In no event shall any such subordinate agreement, grant or contract be on a cost-plus-a-percentage-of-cost-basis. Subordinate contractors (including suppliers) shall be selected on a competitive basis to the maximum practicable extent consistent with the obligations and requirements of this Grant.

o. Publications

(1) If it is the Grantee's intention to identify AID's contribution to any publication or audio-visual teaching material resulting from this Grant the Grantee shall consult with AID on the nature of the acknowledgement prior to publication or distribution.

(2) The Grantee shall provide the Project Manager with one copy of all published work developed under the Grant. The Grantee shall provide the Project Manager with lists of other written work produced under the Grant.

(3) In the event Grant funds are used to underwrite the cost of publishing, in lieu of the publisher assuming this cost as is the normal practice any profits or royalties up to the amount of such cost shall be credited to the Grant.

(4) The Grantee is permitted to secure copyright to any publication of film produced or composed under the Grant, provided the Grantee agrees to and does hereby grant to the Government a royalty-free, non-exclusive and irrevocable license throughout the world to use, duplicate, disclose, or dispose of such publications in any manner and for any purpose and to permit others to do so.

p. Patents

(1) Grantee agrees to notify the Grant Officer, in writing of any inventions or discovery conceived or first actually reduced to practice in the course of or under this Grant. The Grant Officer will determine the patent rights to be afforded the Grantee in accordance with Presidential Memorandum and Statement of Government Patent Policy 36 FR 16887.

(2) Nothing contained in this clause shall imply a license to the Government under any patent or be construed as affecting the scope of any license or other rights otherwise granted to the Government under any patent.

q. Procurement of Equipment, Supplies, Materials and Services

(1) Except as may be specifically approved or directed in advance in writing by the Grant Officer, goods and services financed by A.I.D. under this Grant shall have their source and origin in the United States of America or in Ecuador. Commodities of U.S. source and origin shall be purchased in and shipped from the United States. Additionally, for any purchase transaction in excess of \$2,500 the Grantee shall notify the seller that the item (s) must be of U.S. source and production and comply with the componentry limitations and other requirements applicable to suppliers under AID Regulations.

(2) All international air shipments made by the Grantee, to be financed hereunder, shall be made on U.S. flag carriers unless such service is "unavailable" as stated in C.1, 1 above. All international ocean shipments made by the Grantee, to be financed hereunder, shall be made on U.S. flag vessels. Where U.S. flag vessels are not available, or their use would result in a significant delay, the Grantee may obtain a release from this requirement from the Grant Officer, USAID, Ecuador.

(3) The Grantee shall obtain competition to the maximum extent possible for any procurement to be financed hereunder. Procurement by the Grantee without consideration of more than one source must be approved by the Grant Officer. In no event will any procurement be on a cost-plus-a-percentage-of-cost basis. The Grantee shall take all reasonable steps necessary to insure that subgrantees procuring in accordance with Paragraph (2) obtain competition to the maximum extent possible. In addition to the foregoing, for purchases made in the United States the cost of which are to be attributed to this Grant, the Grantee shall comply with the following requirements:

To permit AID, in accordance with the Small Business Provisions of the Mutual Security Act, to give United States Small Business firms an opportunity to participate in supplying commodities and services procured under this Grant, the Grantee shall, to the maximum extent possible provide the following information to the Office of Small Business, AID, Washington, D.C. 20523 at least 45 days prior to placing any order to contract in excess of Five Thousand (\$5,000) Dollars, except where a shorter time is requested of, and granted by the Office of Small Business:

- (a) Brief general description and quantity of commodities or services;
- (b) Closing date for receiving quotations or bids;
- (c) Address where invitations or specifications may be obtained.

(4) Funds provided under this Grant shall not be used to procure any commodity-related services furnished by any supplier whose name appears on the list of Ineligible Suppliers under AID Regulation 8, "Suppliers of Commodities and Commodity-Related Services Ineligible for AID Financing", Grantee agrees to review said list prior to undertaking any procurement the cost of which is to be attributed to this Grant. AID will provide Grantee with this list.

r. Prohibition on Abortion Related Activities

No funds made available under this Grant will be used to support the following activities: 1) procurement or distribution of equipment intended to be used for the purpose of inducing abortions as a method of family planning; 2) special fees or incentives to woman to coerce or motivate them to have abortions; 3) payments to persons to perform abortions or to solicit persons to undergo abortions; 4) information, education, training, or education programs that seek to promote abortion as a method of family planning.

s. Title to and Use of Property

Title to all property financed under this Grant shall vest in the Ecuadorean institutions with active participation in all phases of the project. An exchange of correspondence between such institutions and the Grantee shall be sufficient for the assignment of individual units of equipment to the various institutions involved. In the following paragraphs, "Proprietor" shall mean the institution so designated as legal owner of the property.

(1) The Proprietor shall not, under any Government contract or sub-contract thereunder, or any Government grant, charge for any depreciation, amortization, or use of any property title to which remains in the Proprietor under this clause.

(2) The Proprietor agrees to use and maintain the property for the purpose of the Grant, and, with the express written consent of AID, for any other purpose consistent with AID policy and programs.

(3) With respect to items having an acquisition cost of \$1,000 or more, title to which vests in the Proprietor, the Proprietor agrees to report such items to the Grant Officer from time to time as they are acquired and to maintain a control system which will permit their ready identification and location.

t. Salaries

All salaries, wages, fees, and stipends reimbursed under this Grant shall be in accordance with the Grantee's policy and practices as reviewed and approved by the Grant Officer. In the absence of an approved policy the Grantee shall follow the regulations contained in Section 7-15, 205-6 of the Agency for International Development Procurement Regulations.

## ATTACHMENT "D"

BUDGET AND PAYMENT PROVISIONSA. Funding

The USAID contribution to the Project will be provided in annual increments. The overall sum shall not exceed US \$278,000 for the financing of the thirty-six months duration of this program in accordance with the costs shown in the Budget (Summary and Detail), and according to the following financial plan: Fiscal Year 1978: US \$123,000; Fiscal Year 1979: US \$91,000; Fiscal Year 1980: US \$64,000. Subsequent increments to FY 1978 will be subject to availability of funds to AID for this purpose, and to the mutual agreement of the Parties at the time a subsequent increment is negotiated.

B. Payment Provisions

Monthly, the MAP will present to USAID a U.S. Government "Public Voucher for Purchases and Services Other Than Personal" (Standard Form 1034) in an original and three copies, requesting reimbursement for disbursements made for purposes herein authorized, supported by a certified statement of expenditures in the format shown in Exhibit D-6. Normally, A.I.D. will reimburse in dollars those expenditures made in Ecuador. Vouchers should be submitted to A.I.D. within 15 days after the close of each month. Within 45 days after the expiration or termination of this Grant Project the M.A.P. will submit a Voucher marked "Final Voucher".

C. Accrued Expenses Reports

By the 30th calendar day of the months December, March, June and September, the M.A.P. will provide to USAID a brief report of its best estimate of the total amount of expenses that have been incurred to date plus those expected to be incurred through the last day of that calendar quarter. These accrued expenses are the cost or value (whether paid for by the M.A.P. or not) of all eligible goods and/or services that have been delivered to the Project but for which Grantee has not yet requested reimbursement from the USAID.

D. Cash Advance

Upon presentation of a SF-1034 voucher, the A.I.D. will make available to the M.A.P. an advance of US \$56,000 to enable the M.A.P. to initiate the program.

This advance will be placed in a separate non-interest bearing bank account. After making this initial advance, A.I.D. will reimburse the M.A.P. an amount equal to reported allowable expenditures in order to replenish the fund, up to a final advance account of US \$30,000, on a monthly basis (or at any other agreed interval) until such time as the total reimbursements effected, added to the initial advance equals the amount of US \$83,386.

Thereafter, vouchers for expenditures submitted by the M.A.P. will not be reimbursed, but will be applied as "no-pay" vouchers to liquidate the remaining outstanding advance. In the event that the amount of subsequent vouchers are insufficient to liquidate the amount of the outstanding advance, the M.A.P. will refund the difference to the Controller of the A.I.D. upon request.

## ATTACHMENT "D" - Exhibit 1

First Year: (all figures in US\$)

	<u>USAID FUNDED</u>	<u>LOCAL FUNDED</u>	<u>TOTAL</u>
<b>I. <u>Personnel</u></b>			
Project Director/Advisor		15,500	15,500
Nurse Supervisor Instructor		26,000	26,000
Grant Manager Admin. Asst.		13,500	13,500
Medical Doctor/Instructor/Rural		15,500	15,500
Rural Aides		4,000	4,000
Consultant Services	4,040		4,040
<b>II. <u>Training Costs</u></b>			
Staff Training Workshop (USA)		4,150	4,150
Teachers/Facilitators	200	10,000	10,200
Cost of Training and Facilities	7,530		7,530
Curriculum Development	1,400		1,400
Materials Development	700		700
Workshop (Project Personnel)	1,500		1,500
<b>III. <u>Commodities</u></b>			
Vehicles	26,000		26,000
A. V. Equipment	3,950		3,950
Microscopes	1,200		1,200
<b>IV. <u>Other Costs</u></b>			
Household Survey	500		500
Evaluation	1,000		1,000
Radiotime	780		780
Travel & Vehicle Expenses	16,465		16,465
Office Expenses	600	1,200	1,800
Office Space		1,200	1,200
Supplies	14,200	600	14,800
Storeroom and AV Equip. Maint.	550		550
<b>V. <u>Administrative Services</u></b>			
Administrative Services	32,771		32,771
<b>TOTALS FOR FIRST YEAR:</b>	<u>113,386</u>	<u>91,650</u>	<u>205,036</u>

## ATTACHMENT "D" - EXHIBIT 2

Second Year: (all figures in US\$)

	<u>USAID FUNDED</u>	<u>LOCAL FUNDED</u>	<u>TOTAL</u>
<b>I. <u>Personnel</u></b>			
Project Director/Advisor		15,500	15,500
Nurse Supervisor/Instructor		26,000	26,000
Grant Manager/Admin. Asst.		13,500	13,500
Medical Doctor/Instructor Rural		15,500	15,500
Rural Aides		18,000	18,000
Consultant Services	4,040		4,040
Inflation Factor		1,125	1,125
<b>II. <u>Training Costs</u></b>			
Staff Training Workshop (USA)			
Teachers/Facilitators	200	10,000	10,200
Cost of Training and Facilities	10,250		10,250
Curriculum Development	1,400		1,400
Materials Development	700		700
Workshop (Project Personnel)	500		500
<b>III. <u>Commodities</u></b>			
Vehicles			
A.V. Equipment	800		800
Microscopes	600		600
<b>IV. <u>Other Costs</u></b>			
Household Survey	500		500
Evaluation	1,000		1,000
Radio Time	780		780
Travel and Vehicle Expenses	18,265		18,265
Office Expenses	600	1,200	1,800
Office Space		1,200	1,200
Supplies	4,650	600	5,250
Storeroom and AV Equip. Maint.	50		50
Inflation Factor		450	450
<b>V. <u>Administrative Services</u></b>			
	32,535		32,535
<b>TOTALS FOR SECOND YEAR:</b>	<u>76,870</u>	<u>103,075</u>	<u>179,945</u>

## ATTACHMENT "D" - Exhibit 3

Third Year: (all figures in US\$)

	<u>USAID FUNDED</u>	<u>LOCAL FUNDED</u>	<u>TOTAL</u>
<b>I. <u>Personnel</u></b>			
Project Director/Advisor		15,500	15,500
Nurse Supervisor/Instructor		26,000	26,000
Grant Manager/Admin. Asst.		13,500	13,500
Medical Doctor/Instructor/Rural		15,500	15,500
Rural Aides		24,000	24,000
Consultant Services	4,040		4,040
Inflation Factor		1,125	1,125
<b>II. <u>Training Costs</u></b>			
Staff Training Workshop (USA)			
Teachers/Facilitators	200	10,000	10,200
Cost of Training and Facilities	14,186		14,186
Curriculum Development	1,400		1,400
Materials Development	700		700
Workshop (Project Personnel)	500		500
<b>III. <u>Commodities</u></b>			
Vehicles			
A. V. Equipment	350		350
Microscopes	600		600
<b>IV. <u>Other Costs</u></b>			
Household Survey	500		500
Evaluation	2,500		2,500
Radio Time	780		780
Travel and Vehicle Expenses	20,665		20,665
Office Expenses	600	1,200	1,800
Office Space		1,200	1,200
Supplies	5,500	600	6,100
Storeroom and AV Equip. Maintenance	50		50
Inflation Factor		450	450
<b>V. <u>Administrative Services</u></b>			
Administrative Services	35,173		35,173
<b>TOTALS FOR THIRD YEAR</b>	<u>87,744</u>	<u>109,075</u>	<u>196,819</u>

## ATTACHMENT "D" - Exhibit 4

Total Budget for Three Years (all figures in US \$)

	<u>USAID FUNDED</u>	<u>LOCAL FUNDED</u>	<u>TOTAL</u>
<b>I. <u>Personnel</u></b>			
Project Director/Advisor		46,500	46,500
Nurse Supervisor/Instructor		78,000	78,000
Grant Manager/Admin. Asst.		40,500	40,500
Medical Doctor/Instructor/Rural		46,500	46,500
Rural Aides		46,000	46,000
Consultant Services	12,120		12,120
<b>II. <u>Training Costs</u></b>			
Staff Training Workshop (USA)		6,400	6,400
Teachers/Facilitators	600	30,000	30,600
Cost of Training and Facilities	31,966		31,966
Curriculum Development	4,200		4,200
Materials Development	2,100		2,100
Workshop (Project Personnel)	2,500		2,500
<b>III. <u>Commodities</u></b>			
Vehicles	26,000		26,000
A.V. Equipment	5,100		5,100
Microscopes	2,400		2,400
<b>IV. <u>Other Costs</u></b>			
Household Survey	1,500		1,500
Evaluation	4,500		4,500
Radio Time	2,340		2,340
Travel and Vehicle Expenses	55,395		55,395
Office Expenses	1,800	3,600	5,400
Office Space		4,500	4,500
Supplies	24,350	1,800	26,150
Storeroom and AV Equipment Maint.	650		650
<b>V. <u>Administrative Services</u></b>			
Administrative Services	100,479		100,479
<b>TOTALS:</b>	<u>278,000</u>	<u>303,800</u>	<u>581,800</u>

ATTACHMENT "D" - Exhibit 5

Total Project Budget Reconciliation (all figures in US \$)

	<u>USAID FUNDED</u>	<u>LOCAL FUNDED</u>	<u>TOTAL</u>
Totals for First Year	113,386.00	91,650.00	205,036.00
Totals for Second Year	76,870.00	103,075.00	179,945.00
Totals for Third Year	<u>87,744.00</u>	<u>109,075.00</u>	<u>196,819.00</u>
GRAND TOTALS FOR LIFE OF THE PROJECT:	278,000.00	303,800.00	581,800.00

M.A.P. INTERNATIONAL

INVOICE AND STATEMENT OF EXPENDITURES

GRANT No. \_\_\_\_\_

Invoice No. \_\_\_\_\_

Period: \_\_\_\_\_

Budget Items	Budget Amount	Project Costs		Balance
		To Date	This Period	
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Total U.S.           \$ \_\_\_\_\_  
 Amount Claimed       \$ \_\_\_\_\_

The undersigned hereby certifies that:

- 1) Payment of the amount claimed under the cited Grant is proper and due and that appropriate refund will be made promptly to A.I.D. upon the request of A.I.D. in the event of non-performance, in whole or in part, under the Grant, or for any breach of the terms of the Grant.
- 2) The information herein is correct and such detailed supporting information as A.I.D. may require will be furnished promptly to A.I.D. on request and,
- 3) All requirements called for by the Grant Agreement to the date of this certification have been met.

\_\_\_\_\_  
 M.A.P. International

By \_\_\_\_\_  
 Position \_\_\_\_\_  
 Date \_\_\_\_\_

518-0002

UNITED STATES AID MISSION TO ECUADOR  
AGENCY FOR INTERNATIONAL DEVELOPMENT  
QUITO ECUADOR

A.I.D. Project No. 518-000

PROJECT GRANT AGREEMENT

Original Grant dated: September 15, 1978

Amendment No. 1

Dated: March 30, 1979

Between

Medical Assistance Program International ("M.A.P.")

and

The United States of America, acting through the Agency for International Development ("A.I.D.")

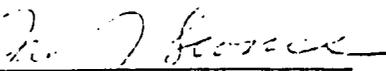
The purpose of this amendment is to provide second year funding of US\$ 91,000 to the original grant, increasing the amount of A.I.D.'s contribution to a total of US\$ 214,000.

This increment will be effective on September 16, 1979, and will allow M.A.P. the continuation of the non-religious health development activities described in annexes A and B of the original document, for one more year.

A.I.D.'s agreement to provide additional funding has been based upon its review of a progress report showing satisfactory development of project activities to date.

Therefore:

1. The amount shown in the last line of the second paragraph of Clause D, attachment D is hereby changed to read US\$ 214,000.
2. In all other respects the terms and conditions of the original agreement shall remain in full force and effect.

  
\_\_\_\_\_  
For the US Agency for  
International Development  
(signature)

Name: Joe J. Sconce Title: AID Affairs Officer

Date: March 30, 1979



For the Medical Assistance  
Program International  
(signature)  
Date: March 30, 1979

Name: Douglas C. Peters

Title: Official Representative M.A.P.

Amount obligated: US\$ 91,000  
Allot.: 948-54-518-00-69-91  
Appr.: 72-1191021.8

ASSURANCE OF COMPLIANCE WITH THE AGENCY FOR INTERNATIONAL DEVELOPMENT

REGULATION UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

Medical Assistance Program ("M.A.P.") (hereinafter called the "Grantee")  
(Name of Grantee)

HEREBY AGREES THAT it will comply with Title VI of the Civil Rights Act of 1964 (P.L. 88-352) and all requirements imposed by or pursuant to the Regulation of the Agency for International Development (22 CFR Part 209, 30 FR 317) issued pursuant to that title, to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subject to discrimination under any program or activity for which the Grantee receives Federal financial assistance from the Agency; and HEREBY GIVES ASSURANCE THAT it will immediately take any measures necessary to effectuate this agreement.

If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Grantee by the Agency, this assurance shall obligate the Grantee, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Grantee for the period during which it retains ownership or possession of the property. In all other cases, this assurance shall obligate the Grantee for the period during which the Federal financial assistance is extended to it by the Agency.

THIS ASSURANCE is given in consideration of and for the purpose of obtaining any and all Federal grants, loans, contracts, property, discounts or other Federal financial assistance extended after the date hereof to the Grantee by the Agency, including installment payments after such date on account of applications for Federal financial assistance which were approved before such date. The Grantee recognizes and agrees that such Federal financial assistance will be extended in reliance on the representations and agreements made in this assurance, and that the United States shall have the right to seek judicial enforcement of this assurance. This assurance is binding on the Grantee, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this assurance on behalf of the Grantee.

\_\_\_\_\_  
(Grantee)

BY (Signature)

Douglas C. Peters

TITLE: Official Representative  
M.A.P.

NAME: Douglas C. Peters

DATE: March 30, 1979

UNITED STATES AID MISSION TO ECUADOR  
AGENCY FOR INTERNATIONAL DEVELOPMENT  
QUITTO, ECUADOR

A.I.D. Project No. 518-0002

PROJECT GRANT AGREEMENT

Dated: SEP 15 1978

Between

("M.A.P." International)

and

The United States of America, acting through  
the Agency for International Development ("A.I.D.")

Pursuant to the authority contained in the Foreign Assistance Act of 1961, as amended, the Agency for International Development (hereinafter referred to as "A.I.D." or "Grantor") hereby grants to the Medical Assistance Program International (hereinafter referred to as "M.A.P." or "Grantee") the sum of U.S. \$123,000 to cover implementation activities during the first year of the project summarized below which is more fully described in Annex "B". The project seeks to: (a) provide primary health-care services to residents of five rural areas; (b) promote referral services to higher level health facilities for cases requiring professional treatment; (c) stimulate the adoption of improved health behaviors; (d) increase the utilization of locally available health services; and (e) create better environmental conditions necessary for health.

This grant and the initial obligation of U.S. \$123,000 for the first twelve months of the project are effective as of the date of signature and acceptance of this Grant Agreement by a duly authorized representative of the M.A.P. The funds provided herein shall be used only to finance development, non-religious activities carried out by the Grantee, M.A.P., in furtherance of program objectives as described in Annex "B". Additional financing for the project will be provided by A.I.D. in annual increments, as described in Attachment "D", subject to availability of funds and to the mutual agreement of the parties, at the time of the subsequent increment, to proceed.

This Grant is made to the M.A.P. on the condition that the funds will be administered in accordance with the terms and conditions set forth in Attachment "A" "Program Description" and as described in the August, 1978, proposal submitted to A.I.D. by the M.A.P. and made a part of this Grant Agreement as Attachment "B". Attachment "C", entitled "Standard Provisions" and Attachment "D" "Payment Conditions" are also made part of this Agreement.

IN WITNESS WHEREOF, the Grantee and the United States of America, each acting through its duly authorized representative, have caused this Agreement to be signed in their names and delivered as of the day and year first above written.



For the US Agency for International Development (signature)

Date: September 15, 1978

Name: Joe J. Sconce

Title: AID Affairs Off



For the Medical Assistance Program International (sign.)

Date: September 15, 1978

Name: Douglas C. Peters

Title: Official Representative M.A.P.

- Annexes: A. Program Description  
B. M.A.P. Project Proposal  
C. Standard Provisions  
D. Payment Provisions

Project: Rural Community Health 518-0002  
Agreement No. FY 1978-2  
Amount Obligated: \$123,000  
Allotment No. 848-50-518-00-69-81-PVO/OPG  
Appropriation: 72-1181021.8