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PD-AA6-332-B1

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EVALUATION REPORT

OPG-518-022 RURAL COMMUNITY HEALTH PROJECT

Prepared by  
Patrick J. H. Marnane  
Department of Sociology  
The University of Texas at Austin  
Under an agreement with  
The American Public Health Association

March 1981

## INTRODUCTION

Purpose of Consultation: This assignment was to evaluate OPG 518-022 with MAP International in Ecuador. The evaluation was undertaken at the request of USAID/Ecuador, MAP International and Vozandes Hospital, the primary subcontractor for the purpose of determining the justification for a fourth year of funding for the project. USAID/Ecuador is additionally interested in identifying project elements that should be incorporated into the Integrated Rural Health Delivery System (IRHDS) that is currently being discussed by the Mission.

Summary of Project Purpose and Background: The OPG project was planned to provide residents of selected rural populations in five provinces with primary health care services and to improve their health status. The target populations consist primarily of Quichua and Shuar speaking people who are geographically and culturally isolated from the mainstream of Ecuadorian society and, as a result, have not had access to health services and information provided by government agencies. Limited non-governmental health care has been afforded to these populations by expatriate missionary groups working in the area. In the past this care has been largely curative in character.

While accurate and precise information regarding morbidity and mortality levels in these populations has not been available, it is widely believed that their levels are intolerably elevated and that traditional, indigenous practices of hygiene and curing have not been able to improve or maintain health conditions as their settlement, behavioral, economic and contact patterns have changed. In order to improve this situation the project was designed to train persons from the communities in the provision of basic promotive, preventive and curative services. These health workers are, in turn, supervised by persons with more sophisticated medical and health care training, i.e. physicians, nurses and auxiliary nurses.

MAP International has been the grantee and has had responsibility for overseeing the coordination functions of Vozandes Hospital, the contractor. MAP International staff have also participated in health worker training and program design. Vozandes staff have provided the overall direction of training, placement, supplying and supervision in the provinces in which the program has been operating.

The project was not designed to implement a permanently independent health care system. From the beginning Vozandes and provincial level administrators of the project have coordinated their efforts with those of the MOH and the local government health systems. It was expected that the OPG project would complement the government's work and that it would provide an experimental outreach system that could be used to test the feasibility and effectiveness of particular techniques of health care provision. Prior to project implementation a seminar was held in order to inform government officials of the plans for the project. The GOE has since been kept up to date through informal consultations and sharing of project reports by project staff. Government officials have received many invitations to observe the project in operation and to participate in training sessions.

The initial project plan called for training and placement of volunteer health workers in 138 communities with a population then estimated to be about 43,700 persons. These were to be distributed as follows:\*

Chimborazo Province:	50 communities with 30,000 people.
Bolivar Province:	30 communities with 4,000 people.
M.-Santiago Province:	26 communities with 2,700 people.
Pastaza Province:	12 communities with 2,000 people.
Loja Province:	20 communities with 5,000 people.

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\*Revised estimates based on health workers' assessments of their catchment areas suggest that populations are somewhat higher than anticipated. It is now expected that a smaller number of communities but a larger population will be covered. Project plans for Loja Province have been cancelled.

The anticipated number of promoters to be trained was not stated in the initial project description.

The original three-year budget beginning in 1978 was set at \$581,000 with a USAID contribution of \$278,000. MAP International, Vozandes Hospital, Free Will Baptists, Gospel Missional Union, OMS International, the Berean Mission and the GOE were responsible for the remaining \$303,000, largely through contributions in kind.

Evaluation Procedures and Limitations: While an attempt was made to get as much information as possible about the program and its relations to other agencies and about the communities during field observations, interviews and document review, this report does not attempt to present a complete description of the project. Those who have been working with the project over a long period of time are much better able to provide that sort of description than could one who has had such a hurried, fragmentary view of its development and operations. Rather, this report focuses on those things that the project is doing and seeks to identify those aspects that were found to be different from many that characterize strategies for introducing primary health care in different countries, i.e. methods that have tended to capture ~~the~~ the fancy of national health planners. It seeks to point out characteristics that show evidence of promise in the planning and development of primary care programs that would be useful for others who will develop programs elsewhere. It takes the perspective that evaluation of an experimental program such as this can contribute most by identifying what the program is doing and suggesting means by which it might do better.

The evaluation of the project was done on an informal basis with the consultant making observations at various training and service sites in the four provinces in which the project has been implemented. He was accompanied on

these visits by personnel from Vozandes and MAP International as well as by local supervisors and USAID/Ecuador health staff members.

The consultant also met with other USAID/Ecuador Health Office staff, provincial health directors in Pastaza, Chimborazo, and Bolivar provinces and the Director of the National Division of Community Development in the Ministry of Health. Project staff at all levels were interviewed both in the field and in the Quito offices. Discussions were conducted with health workers and community residents. Contacts with various other persons are noted on the list appended to this document.

Project documents including the initial proposal, a statistical summary from 1980, the 1979 Project Evaluation Summary (PES) and various other ad hoc reports were also consulted.

While the site visits and meetings were well planned and efficiently handled, it was possible to obtain only a very limited first-hand view of activities and personnel at each of the training and operational sites visited. This was due to the wide dispersion of locations and the fact that cycles of activities are necessarily spread out over a longer period than the duration of the evaluation visit. Community health programs dependent upon part-time workers where communication is severely restricted are difficult to observe during a brief sojourn. This is such a highly varied program tailored to the needs of individual promoters, regional and community interests and health problems that it is not truly possible to obtain a clear, detailed, first-hand picture of all activities and procedures without spending several months in the project areas. As noted later in this document, the ability of the project staff to adapt training, supervision and operations to these highly variable conditions is one of the projects major assets. At the same time it makes it difficult to provide general summary statements that convey the nature of the work being done.

## PROJECT STATUS

Operations: The project is currently operating in four provinces: Bolivar, Chimborazo, Pastaza and Morona Santiago. Plans for implementation in Loja province were cancelled because medical personnel were not available to train health promoters. The Statistical Summary produced in 1980 (attached), at the conclusion of two years operation, reports that 133 persons have received some promoter training and that 101 of those were active in 93 communities. The total population of those communities then being served was estimated to be 47,600 persons. The training of new promoters by programs operated by anyone other than the government itself has been curtailed since 1980, but the training of six persons who had already been selected in Bolivar province has been approved. Training to upgrade promoters already in place has been allowed and is continuing in all provinces.

Coordination in Chimborazo, Pastaza and Morona Santiago is provided by physicians with the help of other professional medical persons. In Bolivar province a registered nurse coordinates training and supervision for the 11 existing promoters and the six who are being newly trained.

The program seems to have altered its initial primary focus from that of providing personal health services to that of community development centering on health. While program personnel still feel that personal care and referral services are important for the health of the client populations and for the credibility of the project, there has been more emphasis placed on community education, the promotion of latrine construction and proper use, the promotion of home gardens with varied produce, and improved water supplies. This means that training programs had to be adapted to the changing focus and health promoters have alloted their time differently than was first anticipated.

Health workers are still in the process of obtaining censuses of their areas. These will include counts of population and assessments of the availability of appropriate latrines and water sources.

The number of health committees that were functioning when the 1980 statistical summary was produced was only nine. This number has been considerably augmented since then, but the total number was not known (by September 1980, there were 11 committees in Pastaza province alone).

Experimental gardens have been planted in each province and families are being encouraged to develop their own. Again, the total number of these gardens is not known. The report from Chimborazo indicates that 20 experimental gardens had been planted in that province in 1980.

While latrine construction and use is far from ubiquitous there is evidence that they are being accepted in communities where they had not existed before. Communities in Bolivar and Chimborazo are constructing them. In Chimborazo the project people have been working with local people to develop inexpensive methods of producing slabs to cover the pits.

Training programs to upgrade promoters in place are being continued in all provinces. During 1980 every promoter received at least several days of additional instruction in project training centers as well as on-the-job supervisory training. Several of the promoters who were first identified and trained by the project have been further trained in MOH programs and have been incorporated into the government system as health auxiliaries and, more recently, nurses aides. These persons are now paid by the MOH or by their communities with MOH contributed funds. The supervisory staff of the Vozandes project has been providing supervision to those now in the government system as well as the others. Vozandes promoters in Chimborazo province have been invited to participate in monthly training sessions offered by the MOH's rural health physicians.

Both the Vozandes and the MAP International central office personnel continue to be fully involved in the coordination and supervision of the project and they take part in staff development and promoter training as well. They, along with their regional supervisory staff, have insured that provincial and national level government health officials have been regularly informed of project activities.

Program Impact: There has been no attempt to assess quantitatively the changing levels of population health resulting from the program. Given the small sizes of populations involved and the lack of data collection abilities on the part of the field workers, this is understandable. It is doubtful, in any event, that health measurements would be sufficiently sensitive to changes that could be expected (in the short run at least) as a result of the program. To burden most of these health workers with additional data gathering responsibilities at this point would probably distract them from gaining and applying knowledge regarding appropriate health behavior.

Changes in the communities have, however, been observed by those participating in the project. While statistics may not yield a picture of very dramatic change in the communities, the fact that there are more people in each of them who are better informed about health care and hygiene and there is an increased interest in providing sanitary latrines, care of children, represents a notable difference between present circumstances and those prior to program implementation.

From discussions with community leaders and project personnel who have had longer experience in the areas, there is evidence that members of communities feel that they have a closer linkage to the services (of many kinds) offered by their government and they are beginning to recognize that they can make additional demands on those service providers.

## OBSERVATIONS AND RECOMMENDATIONS

Time constraints, the cross-sectional nature of observations and problems of transportation and communication among people spread over great distance and characterized by considerable cultural variation made it difficult to obtain a complete, integrated view of this small but complex project. While project personnel managed site visits with great efficiency and were always forthcoming in answers to questions the observations reported here must still be considered tentative and fragmentary. It would thus be useful and appropriate for project staff, AID personnel and relevant government officials to discuss the findings of this report to clarify points taken and recommendations made. It may be that a recommended course of action has already been tried and found unsatisfactory or that observations were too limited for making reasonable judgements.

Again, the evaluator was guided by specific questions raised by project and AID personnel in the preliminary briefings as well as some that emerged in reviewing project documents and in making site visits. There is an overall attempt to consider what the program is doing and to suggest means for doing those things better rather than to make comparisons between goals stated in the preliminary project documents and to compare progress with plans.

The following statements cover a limited set of project characteristics. For each of these, there is a statement of observation followed by a recommendation for action.

A. Coordination

Observations: Prior to project implementation missionary groups were providing some health services in each of the four provinces. These services were largely curative. There was also some training of health workers who acted as assistants to missionary physicians and nurses. The project has tried to coordinate these different missionary groups and, to some extent, to standardize methods and content of health worker training assuring that more emphasis is given to promotive and preventive activities in all areas. It has brought together the professional people working in the four provinces in order to share experiences and to develop improved methods of operation. The Vozandes staff has tried to coordinate efforts in the areas in order to create a more efficient and systematic operation.

Vozandes and MAP International personnel make frequent trips to the areas and participate in supervisory and training activities at all levels. They act as trouble shooters and facilitators and they work with field staff and government personnel making sure that there is cooperation and coordination of functions. They are also responsible for obtaining and summarizing periodic reports from the areas and for providing these to funding agencies and government offices. The coordinating staffs of Vozandes and MAP seem to have a good handle of the training and other procedural aspects of the program in the four areas including knowledge of the status of trainees, content of training, placement of personnel, and other implementation progress.

Recommendations: While, as noted above, the great variation of form and content among the project areas requires that useful description involve something other than overall summary statistics there should be a greater effort to standardize reporting formats among the provinces. In addition to providing some statistical information, these reports should offer much more detail regarding

problems, experiences, system needs and system changes so that areas can be compared and generalizations can be drawn. This practice should benefit the overall coordination effort and also provide other observers with a clearer idea of how the project is operating and how coordination is working.

It would be useful for the supervisory staff from the four provinces to meet more frequently as a group with the coordinating staff in order to develop more useful reporting procedures that would allow for better comparison among areas. Such meetings would also be used to share experiences and knowledge that could lead to overall project improvement.

The coordination function should also be seen as involving ongoing evaluations of practices that appear to be especially useful or inappropriate under the different conditions characterizing the project areas.

#### B. Selection of health promoters

Observations: Promoters participating in the project have generally been selected in some manner by the community itself. Some of the health workers in Pastaza and Morona-Santiago had already had some connection with the missionary health workers and had some previous training in curative practices.

In selected participants, the missionary groups have tended to work through the Indigenous Evangelical Association operating in their areas. The Associations in turn work with the communities to identify candidates for the program. In many cases it appears that the churches and associations may represent the only coherent means for outsiders to work with the communities. This is probably more true in Sierra where the dissolution of the hacienda system left an organizational void into which the Associations have moved. It may be that in the provinces of Pastaza and Morono-Santiago the Associations are trying to replace existing forms of community organization.

During the observations and questioning, it was not possible to determine if there were any conflicts within communities regarding the selection of promoters nor was there any indication that some groups were systematically excluded from participating either as promoters or as recipients of services as a result of the means of promoter selection. It was reported that not all promoters were members of Christian church groups.

Comment and recommendations: It would be worthwhile to investigate more closely the means by which health workers are selected by their communities and the relationship between the project and communities. It may be that the methods represent a most satisfactory and nondisruptive means of linking isolated communities with salubrious, adaptive influences. If certain segments of the population are not covered by services or brought into the participatory process, this should be known as well. In any case, other agencies interested in developing appropriate health and development programs along similar populations will need to have this kind of information.

C. Recognition of indigenous health practices and traditional curers

Observations: Project supervisory personnel have taken note of some traditional health practices that they have observed, but they do not seem to have tried to deal with them in their training. There seemed to be a tendency to treat traditional beliefs and practices as inappropriate or detrimental and there was little awareness of any research done on traditional medicine in Ecuador.

The evaluator was informed by medical people in Pastaza and Morona Santiago that delivery is a family affair and that there were no specialized traditional midwives. It was reported that in the Sierra there are such specialists (but that the family participates in the delivery as well). It appeared that there has been no attempt to bring traditional midwives into the training program

nor has there been an effort to educate others regarding delivery and care of mothers and the new born. In fact, because most of the promoters are men, it is argued that they have a hard time communicating with women other than their own family members regarding the birth process. There has been little success in attempts to create mothers' clubs in any of the provinces.

Comment and Recommendations: A major purpose in taking community members into the health care system is that they will be able to provide a means of translating modern health into practices and recommendations that are acceptable to the local populations. Failure of trainers to take traditional beliefs and practices into account in their training programs represents a serious deficiency. The project personnel should make an effort to understand local beliefs so that they can promote the incorporation of traditional health categories and practices into their training practices. They should also have knowledge of practices that are particularly inappropriate so that they can be displaced. Additionally, there should be a serious attempt to work with traditional health workers in the process of placing new health workers in the communities. Since it is estimated that over 80% of Ecuadorean births take place apart from any modern facility and close to 100% of the births in the project areas occur without attendance by any "trained" health worker it would be most appropriate to study traditional delivery practices and to take steps to train local midwives (or family members) in the most proper procedures regarding delivery and care of mothers and the new born.

#### D. Training

Observations: Training of promoters has taken longer than expected. Strict, didactic methods have not been successful and more informal means of training have been adopted. MAP International has scheduled technical assistance from

specialists in non-formal education from the University of Michigan to advise them on their training procedures. Health promoters typically had little previous experience with formal education. Several were illiterate and few had completed primary school.

The project has found that the promoters need more time to assimilate materials than was anticipated. They have also found that short periods of training, a few days to three weeks, repeated several times with new material being added after old material is reviewed is a more satisfactory than offering completely new material during each session. Promoters return to their training centers several times each year in order to receive additional training.

The project also depends heavily on field supervision for upgrading of promoter skills and review of procedures. This field supervision also brings the medical personnel into closer contact with the community in which the promoters are working.

With the exception of Dr. Naula, who is located in Colta, Chimborazo province, the training is provided almost exclusively by expatriates from the United States. And, almost all of the training is done by medical persons although increasing attention is being given to community development.

Comments and recommendations: It is a decidedly positive thing that the project operators have been able to tailor the training to meet the needs and abilities of the promoters. This flexibility may be essential for successful training of community health promoters and it would be advisable for them to document more closely just what their experience has been. Providing this kind of training and supervision, however, is time consuming and expensive. If it works where less expensive methods do not, this should be clearly demonstrated and documented. This information will be critical for future project planning and assessment of replicability.

The project should seek the assistance of more Ecuadorean personnel in the training of promoters. Additionally, more persons with experience in community development and community participation should be involved in this training.

E. Responsibilities and activities of the promoters

Observations: The promoters are trained in health promotion and prevention and curative care on both the community and the individual levels. It is believed by most program supervisors that the health workers are best able to gain credibility through their curative efforts and are then more able to introduce changes in beliefs and practices once this credibility is established. In Pastaza Province, however, promoters have been discouraged from providing such curative care and they are not now allowed to offer even the most simple drugs to patients.

An important part of all the promoters' work is considered to be the referral of patients to health centers. This, of course, is impractical for many maladies where access to such centers is impossible or severely limited.

Promotive efforts dealing with such things as home gardens, well drilling and hygiene seem to be undertaken on an ad hoc basis as a result of interest shown by the community (generally encouraged by the promoter and supervisors). Once interest is demonstrated, steps are taken to stimulate even more interest and understanding throughout the community and to offer information and assistance in carrying out specific projects. These include more participation of supervisory staff.

Health promoters are non-paid workers who have responsibilities other than those linked to their health work, therefore, they do not dedicate full time to this work. The manner in which they do divide their time among health and non-health activities is not known.

Recommendations: Sophisticated task analyses and time studies would be wholly inappropriate for promoters working in this project. It would, however, be desirable to know more about the time they do dedicate to their various activity categories and to determine if they can handle the responsibilities they are assumed to have in the time they have available. It is important to know if they do have time necessary to provide services they are trained to offer, at least to the theoretical extent necessary to have any impact.

F. Supervision

Observations: Supervision is a primary means of influencing health workers, checking and upgrading their knowledge and encouraging them in their work. It is treated as an essential component of the project. Supervision is carried out during site visits and in the centralized training location when promoters are brought in for additional training.

While attention is given to promoters' written reports that provide information regarding some of their activities most supervision is based on first-hand contact with the workers. Supervisors discuss problems that the workers encounter and observe them in work situations in order to assist them in improving performance. The supervisors also meet with other community representatives to learn whether their perceived needs are being met. These contacts serve not only as a basis for improving the effectiveness of the individual promoters. Information obtained is also used in the design of additional training efforts for all promoters.

Comments and recommendations: The supervisory component of the project is expensive. It consumes valuable time of highly trained medical personnel and requires costly transportation. In the Sierra provinces, the supervisors have

four-wheel drive vehicles. In the Oriente, many communities are accessible only by small plane. In both areas there are communities that can be reached only by walking several hours.

While supervisors seem able to handle their responsibilities now, it is doubtful that they could be stretched much further if the program were to be expanded. It should be noted that the program could be expanded de facto if the supervisory staff are asked to take more responsibility for working with government trained community health workers in their areas and they could easily become over extended.

In presenting this project as a model, the cost of the supervision must be considered. Now, these costs appear quite low because they are borne by outside funding agencies and include persons from the missionary groups who work for very low salaries (and, their training and overhead costs are not included).

Because supervision is expensive, the project would do well to experiment with different patterns and to determine if supervision (1) is now adequate, and (2) could be reduced if workers have more training. Utilization of persons with intermediate level training should also be tested as a means for reducing costs. The recently trained nurse aides (mentioned below) will be used for such supervisory work. Their activities and utility should be closely monitored.

#### G. Cooperation with government health systems

Observations: From the beginning the Vozandes group has taken steps to inform provincial health chiefs and MOH personnel of their project plans and accomplishments. They have taken steps to assure that there is integration and cooperation between government provided services and personnel and those offered by the project.

Some project promoters have been selected for further training within the government's health promoter program and have been functioning under continuing

supervisions of Vozandes medical workers. Four additional workers have recently completed a seven-month government sponsored training program for nurse aides. It is assumed that these people will have supervisory as well as promotive and curative responsibilities in the Vozandes project area. While they will be responsible to the provincial health office they could also oversee project promoter work.

The Vozandes staff seem to have no expectation that their own project will remain independent. Rather they see it as filling an existing gap and as providing an experimental laboratory from which communities and future government programs can benefit.

Comments and recommendations: Government officials have not taken full advantage of the opportunity to observe conditions and activities in the project area. While the project personnel have kept the government officials informed and they have responded to requests for cooperation and coordination, this has been largely informal. There has been no formal presentation of project plans and progress since the first year when a workshop held with representatives from Vozandes, government and USAID personnel.

The project staff should have annual workshops at which provincial and national level health officials would participate. The purpose of such workshops would be to present findings regarding project experimentation and development and to provide technical advice that would be useful in future operations and planning for all Ecuadorean health care programs.

It would also be useful for project staff to develop a brief overview presentation that could be used to inform new officials, interested outsiders, and funding agency representatives. It should be expected that as knowledge of the program is broadcast more widely there will be more persons who are interested

in knowing about its operations. Unless there is a prepared, brief presentation that could be used to keep such persons up-to-date the project could easily be overwhelmed trying to provide a comprehensive tour of projects areas.

#### H. Data collection and reporting

Observations: Little systematic data on the activities of health workers, client utilization of services and local health problems has been collected by the project. While generally significant health problems and service needs are recognized and addressed, it is difficult to determine if some problems are emerging as more critical and if others are declining in importance. It is impossible to determine if some portions of the population are, for whatever reasons, excluded from service coverage.

Early efforts were made to conduct population censuses and health assessments of the communities prior to project implementation. These proved unsuccessful, because of heavy resistance from the communities. One of the responsibilities of the health workers has been to map their communities (catchment areas) and to obtain counts and age and sex distributions of their populations. This appears to be progressing reasonably but counts of those not covered are not being estimated.

Patterns and levels of morbidity in the communities are still assessed through largely informal means in consultations among community residents, supervisors and health workers.

Comments and recommendations: It was probably wise to have avoided burdening health workers who have limited awareness of community health, epidemiology, the use of systematically obtained data and medical categories before they had a grasp of their own function. Some important problems, i.e. diarrhea, respiratory problems, parasites, are already sufficiently well recognized so that a

reasonable beginning can be made in planning a rural primary health care program even without systematic epidemiological investigations.

Given the limited training and back-up that must characterize these programs, immediate, direct impact on difficult-to-measure health problems will be slight in any case. Measuring such impact in small populations may be impossible. Epidemiological investigations that could be appropriate for a few large, experimental projects operated with aid of research staffs are simply not reasonable for most others. They are simply too costly and there is not sufficient talent available. Still, there is more than can and should be done in this project now that it is underway.

Project staff should try to learn more about how health workers spend their time in the community. They should also find out what portions of communities are using the services offered by health workers and are participating in other health and development activities. In order rationally to revise program design it is important to know who is not using its services and why.

It is also time that the project began to note more precisely the levels of morbidity and mortality within the populations in order to make judgements about the adequacy of promoters training to deal with problems that do exist and to reestablish priorities for training and services.

Project personnel must make greater effort to provide a clear description of the project as it exists. While statistical summaries of implementation progress provide some useful information and should be repeated at least annually, the great variety in procedures, organization and supervisory patterns and training is itself an important aspect of this project and will require more narrative description of procedures and progress.

Without such descriptive and analytic materials, much of what the program has learned and experienced will be lost.

## CONCLUSIONS

This is an important project. It represents dedicated efforts to provide basic health services and health and development education to a segment of the Ecuadorean population that has been isolated and underserved. It is the result of serious planning and rational coordination of previously fragmented health activities carried out by a number of missionary groups in four provinces. The project is designed to provide trials of varied means of training, supervision, service provision, and community participation in different cultural, geographical and organizational conditions. The experience of this relatively intensively supervised project should be of great utility to the government in their efforts to provide effective primary health care to large portions of the Ecuadorean population.

There is no doubt that the pay off to the people in the service areas has already been important. If the project is viewed by the government, and there is evidence that it is, as an experimental activity, the results of which can contribute to improved government sponsored programs there is no doubt that it will be even more valuable.

This project has many advantages that would be difficult to replicate in a government sponsored project. Among these are its flexibility and the closeness of supervision by trained health professionals who are willing to live and work in rural areas and who can be expected to stay with the project over a long period of time. Also, given political and bureaucratic conditions that constrain government planning and programming efforts, it is doubtful that it could operate with the same flexibility and experimental orientation as can private voluntary organizations.

Continued funding of this project by A.I.D. is recommended. While there is no doubt that provision of health services by the groups involved in the Vozandes project would continue even without US A.I.D. funding for an additional year many potentially useful findings from the project would be lost, because there would be less coordination and documentation of the experiences. Funding for an additional year should cover close monitoring of process and communities, additional documentation and wide distribution of the findings of the project within the government of Ecuador. Responsible persons in the MOH should be given much more encouragement to observe more closely the operations of the project and to see how health workers perform in different geographical and cultural situations. These same officials should also have input into the project design regarding priority concerns and experimental features that could be incorporated.

Contacts with Project Related Persons

Vozandes Hospital: Sara Risser  
John Sevall

MAP International: Richard Crespo

Project Sites:

Macuma: Lois Price  
Steve Nelson  
Greer Dixon

Pastaza: Jack Olinger  
Alicia Ingram  
Lloyd Rogers

Chimborazo: Manuel Naula  
Roberta Hofstetter  
Karen

Bolivar: Dave Hansen  
Martha

Jefeturas Provincial in: Puyo, Pastaza  
Riobabma, Chimborazo  
Guaranda, Bolivar

MOH Director of  
Community Development: Jose Castro

USAID: Ken Farr  
Jay Anderson  
Manuel Rizzo

Also, presidents of the Indigenous Evangelical Association and several health workers.

RESUMEN ESTADISTICO

1980

	Bolívar	Chimb.	Pastaza	M. Stgo.	Total
<b>I. Acceso a servicio de salud</b>					
1. Número de promotores entrenados, o en proceso de entrenamiento	10	63	19	41	133
2. Número de los que están activos haciendo el trabajo de promotor	8	47	19	27	101
3. Número de comunidades que tienen la ayuda de un promotor	9	41	12	26	93
4. Porcentaje de personas que utilizan los servicios de referencia recomendado por el promotor.	10%	40%	40%	25-70%	30% promedio
5. Número de comunidades que han empezado con letrinas	4	14	8	2	28
6. Agua potable	3	10	12	7	32
7. Huerto Familiares	0	46	3	23	72
8. Construcción de puestos mínimos	2	11	5	31	49
9. Higiene escolar	6	10	12	10	38
10. El Censo	6	46	9	31	42
<b>II. Factores para hayan servicios básicos de salud</b>					
1. Número de comités de salud	0	4	5	0	9
2. Número de comités de salud que participan activamente en los programas de educación comunitaria	0	2	3	0	5
3. Comunidades con programas de educación comunitaria en donde hay un acuerdo con los beneficiarios que hay que enfrentar	4	10	3	0	17
4. De cuántos días u horas es el programa básico de entrenamiento de los promotores en 1980	120 hrs.	14 sem.	40 hrs.	24 día	
8. Hay una coordinación con la jefatura provincial para que los servicios de referencia provincial estén utilizados.	si	si	si	si	
9. Cuántas veces en el año se supervisa a cada promotor en <u>su comunidad</u> (o en factible en transcurso de un año?)	3-4	8	4	3-4	

## BOLIVAR

## RESUMEN ESTADISTICO

1980

	Total	Compración positivo (negativo) del 1° al 2° año		Por lograr en 2 años más (porcentaje)	
			Meta		
I.1. Promotores entrenados, o en pro- ceso de entrenamiento	10	2	18	8	(44%)
2. Activos haciendo el trabajo de promotor	8	=	16	8	(50%)
3. Comunidades que tienen la ayu- da de un promotor	9	2	17	8	(47%)
4. Porcentaje de personas que u- tilizan los servicios de re- ferencia recomendado por el promotor	10%	=	30%	20%	
5. Comunidades que han empezado con letrinas	4	1	11	7	(64%)
6. Agua Potable	3	1	9	6	(66%)
7. Huertas familiares	0	(1)	3	3	(100%)
8. Construcción de puestos míni- mos	2	2	17	15	(88%)
9. Higiene escolar	6	5	17	11	(65%)
10. El Censo	0	(6)	2	2	(10%)
II.					
1. Número de comités de salud	0	(6)	9	9	(100%)
2. Comités de salud que parti- cipan activamente en los pro- gramas de educación comunita- ria	0	(2)	9	9	(100%)
3. Comunidades con programas de educación comunitaria en don- de hay un acuerdo con los be- neficios que hay que enfrentar	4	(2)	13	9	(100%)
4. De cuántos días u horas es el programa básico de entrena- miento de los promotores en 1980?	120 h	=	120 hrs.	=	
8. Hay una coordinación con la jefatura provincial para que los servicios de referencia provincial estén utilizados	si	=	si	-	
9. Cuántas veces en el año se su- pervisa a cada promotor en su comunidad (o es factible en el transcurso de un año?)	3-4	=	3	=	

## RESUMEN ESTADISTICO

1980

	Total	Comparación Positivo (negativo) del 1º al 2º año	Meta	Por lograr en 2 años mas (Porcentaje)	
I. 1. Promotores entrenados o proceso de entrenamiento	63	25	70	7	(10%)
2. Los que están activos haciendo el trabajo de promotor	47	16	70	23	(36%)
3. Comunidades que tienen la ayuda de un promotor	46	16	63	17	(27%)
4. Porcentaje de personas que utilizan los servicios de referencia recomendado por el promotor	40%	10%	80%	40%	
5. Comunidades que han empezado con programas de letrina	14	10	50	36	(72%)
6. Agua potable	10	5	50	40	(80%)
7. Huertas familiares	46	46	50	4	(8%)
8. Construcción de puestos mínimos	11	8	20	9	(45%)
9. Higiene escolar	10	7	20	10	(50%)
10. El censo	46	16	63	17	(27%)
II.1. Número de comités de salud	4	4	20	18	(80%)
2. Número de comités de salud que participan activamente en los programas de educación comunitaria	2	2	15	13	(87%)
3. Comunidades con programas de educación comunitaria en donde hay un acuerdo con los beneficios que hay que enfrentar	10	7	20	10	(50%)
4. De cuántos días u horas es el programa básico de entrenamiento de los promotores en 1980	14 semanas	4 semanas	12 sem.	=	
8. Hay una coordinación con la jefatura provincial de salud para que los servicios de referencia provincial estén utilizados	si	=	si	=	
9. Cuántas veces en el año se supervisa a cada promotor en su comunidad?	8	5	4	=	

## MORONA SANTIAGO

## RESUMEN ESTADISTICO

1980

	<u>Total</u>	Compración positivo (negativo) del 1° al 2° año	<u>Meta</u>	Por lograr en en 2 años más (Porcentaje)
I.1. Promotores entrenados, o en proceso de entre- namiento	41	8	41	logrado
2. Los que están activos haciendo el trabajo de promotores	27	(4)	32	5 (16%)
3. Comunidades que tienen ayuda de un promotor	26	(1)	31	5 (16%)
4. Porcentaje personas que utilizan los servicios de referencia recomen- dado por el promotor	35 %	=	80%	45%
5. Número de comunidades que han empezado con letrina	2	2	8	6 (75%)
6. Agua potable	7	7	12	5 (42%)
7. Huertas familiares	26	=	31	5 (16%)
8. Construcción de puestos mínimos	19	19	31	12 (39%)
9. Higiene escolar	0	=	10	10 (100%)
10. El censo	31	=	31	logrado
II. 1. Comités de salud	0	=	0	
2. Comités de salud que par- ticipan activamente en los programas de educación co- munitaria	0	=	0	
3. Comunidades con programas de educación comunitaria en donde hay un acuerdo con los beneficios que hay que enfrentar	0	=	0	
4. De cuántos días u horas es el programa básico del en- trenamiento de promotores en 1980	24 días	=	24 días	
8. Hay una coordinación con la jefatura provincial pa- ra que los servicios de referencia provincial es- tén utilizados?	si	=	si	
9. Cuántas veces en el año se supervisa a cada pro- motor en su comunidad?	4	1	4	

PASTAZA

RESUMEN ESTADISTICO

1980

	Total	Comparación positivo- (negativo) del 1° al 2° año	Meta	Para lograr en 2 años más (porcentaje)
I. 1. Promotores entrenados o en proceso de entrenamiento	19	(7)	12	7 (58%)
2. Activos haciendo el trabajo de promotor	19	2	12	1 (6%)
3. Comunidades que tienen la ayuda de un promotor	12	(1)	12	0
4. Porcentaje de personas que utilizan los servicios de referencia recomendado por el promotor	40%	30%	60%	20%
5. Comunidades que han empezado con letrinas	8	3	8	0
6. Con agua potable	12	6	12	0
7. Con huercas familiares	3	2	8	5 (63%)
8. Construcción de puestos mínimos	5	4	8	3 (38%)
9. Higiene escolar	12	7	12	0
10. El Censo	9	4	12	3 (25%)
II.1. Comités de salud	5	4	5	0
2. Comités de salud que participan activamente en los programas de educación comunitaria	3	2	5	2 (40%)
3. Comunidades con programas de educación comunitaria en donde hay un acuerdo con los beneficios que hay que enfrentar	3	=	6	3 (50%)
4. De cuántos días u horas es el programa básico de entrenamiento de los promotores en 1980	5 días	=	20 días	15 días
8. Hay una coordinación con la jefatura provincial para que los servicios de referencia provincial estén utilizados	si	=	50% cooperación	
9. Cuántas veces en el año se supervisa a cada promotor en su comunidad o es factible en el transcurso de 1 año	4	8	4	0

ALCANCE DEL PROYECTO

1980

	Bolívar	Chimbor.	M. Stgo.	Pastaza	Total
Proyección original de número de comunidades	30	50	29	12	141
Número de comunidades alcanzadas en 2 años	9	46	26	12	93
Proyecciones de número de beneficiarios	4.000	30.000	2.700	2.000	43.700
Número de beneficiarios alcanzados en 2 años	1.500	40.000	2.100	4.000	47.600

## OBSERVACIONES

En Resumen, en dos años:

Hay 101 promotores activos

Hay 93 comunidades con atención primaria

72 comunidades tienen programa de juertas familiares

28 comunidades tienen programa de agua potable

49 comunidades han construido puestos mínimos

38 comunidades tienen programa de higiene escolar

1. En general el proyecto ha tenido éxito en 2 años en lograr el número de comunidades y número de beneficiarios proyectados para 3 años. Más lento ha sido la toma de responsabilidad de parte de las comunidades en respuesta a los servicios.
2. La toma de responsabilidad de parte de las comunidades es mínima en lo que se refiere a comités de salud y la participación comunitaria en educación para la salud. La nueva estrategia de educación comienza a tener resultados, los cuales aparecerán en la estadística del próximo año.
3. En el próximo año hay que poner énfasis en el fomento organizaciones comunales que puedan tomar la responsabilidad en saneamiento ambiental y educación.
4. El número de comunidades que han empezado con programas de letrización y agua potable es menor de lo que se espera. Un factor que influye es la falta de bombas de agua y materiales para hacer letrinas. La cooperación de las agencias del gobierno no abastece para atender a todos los que quieren materiales básicos. El proyecto tendrá que tomar más iniciativa en conseguir bombas y materiales para hacer letrinas.
5. Todavía hay recelos de utilizar los centros de referencia del gobierno para el indígena el centro es lugar ajeno y a veces no se le trata como se debe.