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FOSTER PARENTS PLAN, INC.  
MATCHING GRANT  
FINAL ANNUAL REPORT  
TO THE  
AGENCY FOR INTERNATIONAL DEVELOPMENT  
GRANT #<sup>110</sup>SOD/PDC-G-0421

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Foster Parents Plan, Inc.  
155 PLAN Way  
Warwick, RI 02887

THIRD ANNUAL REPORT TO USAID

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## A. SUMMARY

During the past three years, Foster Parents Plan International (PLAN) has made a major policy shift in its health care programming by beginning or expanding preventive health programs and de-emphasizing its focus on hospitals, clinics, and other curative facilities. The impetus for this changed direction of health programs has been based largely on the availability of \$1.9 million in matching funds over a three-year period from the USAID office of Private and Voluntary Cooperation. With these additional resources, PLAN has initiated or expanded primary health care projects in seven Field Offices in five countries. However, the impact of the grant has been much broader because the lessons learned, the availability of technical staff, and the visibility of the project has motivated at least 20 additional Field Offices to expand their primary health care focus.

The Health Matching Grant (HMGP) focused specifically on women of childbearing age and on children under five. In all programs community health workers were trained to identify common illnesses, provide first aid, design and implement community health education programs, and establish perinatal care programs. Recognizing that primary care requires effective secondary and tertiary backup, PLAN has also strengthened existing clinics or hospitals where they existed or built them where none existed.

In the PLAN Field Offices to which HMGP funds have gone, there are 67,376 Foster Children. If one assumes a typical family of five members, then the impact of the program has been felt by 336,865 people. Yet, in none of these Field Offices have the community health programs been limited to PLAN families but have been open to all families in the communities. Therefore, as many as 1,000,000 people in five countries now have primary health care programs where, three years ago, there were none.

In all five countries, the health programs were conducted in collaboration with the host government since in most countries there are standards for the training of community health workers and for the construction of health posts. The degree of collaboration varied from country to country but in all cases the training was planned and/or implemented in conjunction with representatives from the local Ministry of Health. In three sites (Jacmel, Haiti; Tumaco, Colombia; and Yogyakarta, Indonesia) the programs will be supported by the local MOH at the end of the funding period. In one (Bogota, Colombia), the program will be turned over to a private hospital. In the remaining three sites (La Paz, Bolivia; Bolivar and Guayaquil, Ecuador) the program will be continued with PLAN program funds, though all three continue to work very closely with the MOH.

A strength of the program has been its variability and flexibility to respond to local health needs and to expand existing health resources, however limited they were in some places. While all programs had the same target population and all used the Road-to-Health Chart as an educational and evaluative tool, in fact, the programs varied considerably from community to community.

- o La Paz, Bolivia was added to the grant in FY 1983 and since then ten community health workers have received training. Supplemental programs in water and sanitation have been undertaken and materials and assistance have been provided to four hospitals which will provide backup for people requiring medical care.
- o Bogota, Colombia: Twelve community health workers have been trained and are actively working in Suba, a low-income area near Bogota. A baseline study of 865 families identified 600 of them at high-risk of developing preventable illnesses. Health workers, now affiliated with a private hospital in the area, have developed mothers' clubs and community health committees and every month weigh children under five years of age. While focusing on the 600 at-risk families, the health workers also design and implement extensive community education programs. During the past year the program has been expanded into two new regions of the city, Bosa and Los Cerros.
- o Tumaco, Colombia: At the end of the third year, the program in Tumaco is being expanded into rural areas. In the urban area one new health post was built. The health workers surveyed 782 families to identify their health problems. They have implemented prenatal and well-child programs and participated in an immunization campaign to vaccinate 6,000 children. A research/treatment program for leishmaniasis has been established. Four hundred and fifty children under five are weighed each month. During the last year the program has expanded into rural areas with the training of rural health workers, the construction of three new health posts and the renovation of an existing post. Also, a new program of environmental sanitation and potable water was initiated this year.
- o Guayaquil, Ecuador: Unlike the other HMGP projects, PLAN/Guayaquil trained 15 social workers already on the staff to do primary health care. After some initial problems due to personnel changes, the Guayaquil program is now moving strongly ahead. Two community surveys, of 1,000 families in 1981 and 651 families in 1982, were undertaken. Three health posts have been built in Surburbio and community health committees representing over 18,000 people have been formed. The PLAN/Guayaquil program has been innovative in the organization of Casas de Salud where community volunteer's homes become centers for the weighing of children, the organization of community health education projects, and vaccination campaigns. The program is now under expansion to El Guasmo, another low-income area near the city, and Daule, a rural area near Guayaquil.
- o Bolivar, Ecuador: Added to the grant in FY '82, this PLAN sub-office works in over 60 rural communities in the Andes. As a new program office, PLAN/Bolivar began with a primary health care program in close collaboration with the local MOH. They have trained 23 community health workers, formed community health committees and established a full-time PLAN health worker to expand the program. Water and sanitation projects have also been an important component of the program here.

- o Jacmel, Haiti: The HMGP in Jacmel has progressed much faster than was expected at the time the proposal was submitted because the Government of Haiti undertook a rural health promoter program shortly after PLAN began its HMGP activities there. Many of the materials developed to train the health workers in Jacmel, including a Haitian Creole version of the Road-to-Health Chart, were also used by the government. As the government program has become stronger, PLAN has supported it through its own related activities. PLAN has paid the health promoters' salaries and provided them with scales and other materials. PLAN/Jacmel's health staff provide a family planning program to supplement government efforts. PLAN/Jacmel has, in the past two years, placed great emphasis on water and sanitation projects and built over 40 public water fountains, 900 latrines, drilled wells and built cisterns to provide potable water to several communities.
  
- o Yogyakarta, Indonesia: This HMGP site has been unique in that PLAN has played and continues to play a subordinate role to the Indonesian Government which has an extensive primary rural health care program. PLAN has assisted where government resources were limited. Eighteen trained health workers on PLAN's staff have participated in the training of over 1,400 volunteer community health workers in 900 communities. The volunteers weigh children under five and conduct nutrition education and community health education activities. Over 40,000 children under five are being weighed monthly at 638 weighing posts in PLAN's work areas. While continuing to participate in the training and supervision of these community volunteers, PLAN staff have surveyed the water sources of 15,000 families and, based on the findings, built 442 wells, 14 gravity water systems, 7 rainwater storage tanks and 689 latrines. The quality of water available to 14,500 families has been improved through these projects. In addition, PLAN health workers distribute iodized salt, vitamin A, and iron to families with deficiency diseases. They have also begun home garden projects and small animal-raising projects as part of the program's nutrition component.

## B. HISTORY OF THE GRANT

In March of 1979, Foster Parents Plan submitted drafts of two proposals to the Office of Private and Voluntary Cooperation at USAID. The first focused on primary health care projects and the second on income-generating projects. At that time, as a result of the Alma Ata conference, many development organizations were beginning to emphasize preventive over curative medicine.

Following discussions with USAID and among PLAN's own staff, it was determined that PLAN was best equipped to undertake the primary health care project. It was felt that, although PLAN had a variety of health and nutrition programs, more attention could be given to maternal and child health. Through discussions between USAID staff and PLAN International Headquarters staff, a proposal to undertake a community based primary health care project in Haiti (Jacmel and Croix-des-Bouquets), Indonesia (Bali), Colombia (Bogota, Tumaco and Buenaventura) and Ecuador (Guayaquil) was developed.

The thrust of the project was to train community health workers, establish effective secondary health care backup, and target women of childbearing age and children under five. The common criterion and evaluation mechanism was to be the collection of weight-for-age data on children under five through monthly weighing and the use of the Road-to-Health Chart as an educational and evaluative tool.

In September of 1980, a grant of \$1,678,136 in matching funds was provided for the establishment of the project. A condition of the funding was that one Colombian site be omitted so that the amount of money going to one country would not be excessive. Buenaventura was dropped because it already had an extensive health program and funds were to expand rather than initiate a project.

In December of 1980, a conference was held in Warwick to discuss the terms of the grant, establish reporting procedures, and coordinate the implementation of the grant. By April of 1981, Croix-des-Bouquets was dropped from the grant because it was felt that their existing health program with trained community health workers had no need for additional funding. At the same time, Yogyakarta was substituted for Bali, in Indonesia, because the Field Director in Bali believed that the project could not be implemented without interference from local officials who were carrying out a similar project at that time.

In August of 1981, Guaranda was added to the grant. Guaranda was the newly-opened, rural sub-office in Guayaquil. It was anticipated that staff and training materials from Guayaquil would be used in the new rural program. Also, as a new post, PLAN's health initiative could begin as a preventive rather than curative program. In February 1982, the final addition was made to the grant by adding La Paz, Bolivia. During the last year of funding, FY '83, the recipients of the HMGP funds have remained stable with seven Field posts in five countries included in the grants.

The adding and deleting of Field posts over the life of the grant has been one of the strengths of the project. It is the feeling at International

Headquarters that if the Field Director believes that additional funds are unnecessary or that a particular program cannot be implemented for political or other reasons, it is wise to remove that Field Office from the grant. At the same time, as lessons have been learned and as the grant has increased awareness of the importance of primary health care, other Field Offices have requested additional funds. As Field Offices withdrew from the grant, and as budgeting became more precise, the availability of funds allowed the extension of the project to additional Field Offices. This flexibility on the part of USAID has been a positive aspect of the funding.

## C. REPORTS FROM THE FIELD

### 1. LA PAZ, BOLIVIA

PLAN/La Paz was included in the HMGP in October 1982. The inclusion of PLAN/La Paz in the last year of the HMGP made three important contributions to PLAN/La Paz during a period of significant program and administrative change. These factors--a concept of preventive health care, a technical assistant and funds--enabled the staff to transform the 13 year old curative health program into one which is now solely a primary health care program.

The goals of the PLAN/La Paz Health Program are as follows:

- o To improve the health and nutritional status of PLAN families and their neighbors, with particular emphasis on women, children and tuberculosis victims.
- o To carry out a program of health promotion, education and prevention within an integrated team-based community development Program.

PLAN has branch offices in three geographically distinct and economically marginal areas of metropolitan La Paz. In Villa Victoria, there are ample government and private medical services. In Villa Fatima, the PLAN clinic was a major provider of outpatient clinical services. In El Alto, a huge and growing quasi-squatter settlement which is technically autonomous from La Paz, medical and other infrastructure services are severely limited. At the branch offices a team of social workers, a community development promoter and a health auxiliary (promoter) work as a team in delimited zones wherein their technical skills are coordinated particularly in the area of education and promotion.

During the past year all of Bolivia has suffered from natural disasters, floods in the lowlands and drought in the highlands, which destroyed between 80% and 90% of the year's food harvest. These conditions have forced unprecedented numbers of rural migrants into the cities.

#### The Program in its First Year

USAID's agreement to include La Paz in the HMGP coincided with a change of International staff in La Paz. Consequently, a thorough examination and evaluation of the medical program was carried out. This proved to be a significant activity as it resulted in the introduction of the concept of primary health care to the local staff and decentralized service delivery to families. Potable water and appropriate sewage disposal projects were also established.

The Ministry of Education (MOE), which had recently decided to begin a School Health Program, requested staff and equipment. PLAN/Bolivia agreed, effective July 1, 1983, that:

1. The MOE, School Health Division, absorb the 10 PLAN medical staff as the basis of a new National School Health Program. Their position in the Ministry would be permanent and protected by law.
2. PLAN would donate four equipped medical examination units, three dental units and equipment, a laboratory and pharmacy, supplies, and a PLAN vehicle.
3. The new program, under the MOE, and only a short distance from the previous PLAN clinic, would continue to attend PLAN affiliated families on a curative basis, coordinated with the new PLAN preventive health care program.

The process of decentralization of service delivery extends to opening small community centers, to be staffed by an integrated team as described above. During the past year three teams have moved into community centers.

In the early months of La Paz' inclusion in the HMGP, a Health Trainer was hired. He has primary responsibility for the design of a program of health promotion and staff education by using:

- a. Technical expertise from the nurse-coordinators.
- b. Integrated community programming from the teams and team supervisors.
- c. Government standards from the MOH, and training and curriculum advice from the School of Public Health which will share in training the health promoters.
- d. Policy and program emphasis from the senior staff.

Two weeks of orientation to the new PLAN policies of decentralized community development work, including preventive health care, were offered to all program personnel in May and June. This was followed by a one-week course in health promotion and education for all staff in July. Training in preventive health care for the health promoters took place in August. The intensive, one-week course was designed, together with the School of Public Health and the MOH, and is being followed up by weekly on-the-job practical training and supervision for the following six months. Training in growth monitoring using the Road-to-Health Chart and in diarrhea control and rehydration therapy will be emphasized. Special community education programs directed at tuberculosis and scabies prevention will also be part of the first phase of the training program.

Training materials have been developed by the PLAN/La Paz program. In addition, materials from PLAN/HMGP posts in Ecuador and Colombia, as well as the Bolivian MOH, have been adapted for use. The

agreement between PLAN/La Paz and the MOE states that they will share teaching materials.

A referral system to handle cases of current illness has been established with the major medical institutions to which PLAN affiliated families must go for specialized treatment. These include all of the government supported hospitals and maternity clinics in La Paz. Through the agreement with the MOE, families can go to the facility established for the School Health Program to receive secondary treatment and tertiary referral. For El Alto and Villa Fatima, PLAN funds have been budgeted to support and improve the few extant public and private sector health facilities. Finally, the community health centers from which the PLAN teams will work will be provided with very basic primary health care equipment like scales, blood pressure cup, and stethoscopes.

Methods of data collection and of program evaluation at two different levels have begun.

First Level:

<u>Method</u>	<u>Indicator</u>
1. Monthly weighing of children monitored.	Number of children 0-5 years of age.
2. Road-to-Health Charts maintained.	Percent of reviewed charts compared to number of children seen.
3. Mothers' groups formed.	Number and size of groups. Number of meetings and talks.
4. Family and community education re: hygiene, nutrition, vaccination and other themes.	Number of meetings and educational sessions.
5. Diarrhea program.	Number of meetings and educational sessions.
6. Nutrition/Supplemental feeding program.	Number of children seen to whose families nutritional supplements were provided. Number of children in 2nd and 3rd degree malnutrition referred for treatment.
7. Hospitalization program.	Number of children hospitalized for malnutrition and other causes.

### Second Level:

1. Monthly tabulation by branch office of number and percentage of children seen in 2nd and 3rd degree malnutrition, of deaths from malnutrition and deaths from diarrhea, gastrointestinal and respiratory illnesses.
2. A report from each health worker on all deaths, including the history of the illness and treatment for the three months preceding death.

### The Future

The next two years will see strengthening of the health program in La Paz with continued staff training and deployment of community teams. By the end of next year new themes and community education techniques including accident prevention and first aid, prenatal care and monitoring, and dental hygiene will be added to the promoters' health repertoire. Support of environmental sanitation projects and curative medical services also will extend over the next two years in El Alto with its extremely inadequate medical services and lack of overall infrastructure.

The budget for PLAN/La Paz' health sector program will be assumed by regular PLAN funding as HMGP funds are exhausted. The cost of starting a new preventive program while maintaining, albeit in phaseout, a very expensive clinical program meant that HMGP funding came at a critical time and afforded significant improvements and changes in the PLAN/La Paz health program.

## 2. BOGOTA, COLOMBIA

The objectives of the Bogota HMGP are to motivate communities and individuals to seek solutions to their health problems through health education and to decrease the incidence of morbidity and mortality through preventive health measures, especially among the maternal and young child population with individualized attention to families identified as being at high risk of chronic, preventable health problems.

In 1981 twelve community members were selected and received training as health promoters. Their training was modeled after the program developed for training government health promoters. Through on-the-job training they were taught a variety of communication and community organization skills.

A baseline study of the health status and socio-economic conditions of 865 households was completed by the health promoters and their supervisors, a public health nurse and a professional social worker. These data were analyzed by a local health research affiliate of the Universidad Javeriana. A formula was developed to help identify those families most susceptible to chronic, preventable illnesses.

Approximately 600 families comprise the target population of high-risk households.

Although PLAN works in three geographically distinct areas of Bogota, during the first two years of the grant, the program was restricted to one sector known as Suba on the northern edge of the city. During the last year of the grant, limited preventive health projects were started in the other two areas: Bosa, in the Southwest, and Los Cerros, in the Northeast. In Suba the program was concentrated on 11 barrios with a population of approximately 48,000 inhabitants.

In October 1982, the program officially became the Community Development Department of the Hospital Vecinal San Pedro de Claver de Suba. Salaries and program support are funded by PLAN, but all staff and management have been transferred to the hospital. An administrative analysis of the hospital was performed by the PLAN/Bogota Personnel Director to assist the hospital in identifying solutions to some of its fiscal difficulties. The Community Health Department of the hospital in Suba has established, over the last two years, a stable and active program consisting of the following components:

1. Health attention for women of childbearing age, including family planning counseling and screening for uterine and breast cancer.
2. Attention to children aged five years and younger in the areas of immunization, prevention and treatment of diarrhea, intestinal parasites, growth and development monitoring, nutrition and oral hygiene.
3. Family and Group Education. Each promoter has a caseload of 120 households which are visited on an average of once a month. In

addition to individualized education for the at-risk family, the health promoter may also make referrals to secondary clinical services at the hospital or the nearest government health facility. Health promoters hold educational sessions with a variety of groups including mothers' clubs, school children, grandparents, other hospital personnel and PLAN's social work staff.

4. Health Committees. Parallel to many of the general health education activities, the program has promoted community organization and cooperation by forming health committees. A few of these committees existed before, but in name only, as adjuncts to the formal political organization of the various barrios. Now eight communities are, in fact, actively working to promote health-related projects and campaigns among their neighbors.

The health committees worked with the health promoters to identify health problems and resources and to establish priorities among alternative solutions in their home barrios. The committees promoted activities such as campaigns, recreation, and educational activities within their communities.

They also received ongoing, basic orientation on a variety of themes including first aid, nutrition, venereal diseases, immunization, and environmental sanitation.

5. Campaigns: During the past year the following campaigns were conducted:
  - Dental Health. Under the supervision of a PLAN/Bogota dentist a program of fluoridization and basic oral hygiene education was organized for 2,400 school children from five barrios in Suba.
  - Cancer Detection. Three campaigns were conducted in coordination with the "League Against Cancer" during which approximately 1,200 cytologic exams were performed.
  - Immunization. Five vaccination campaigns for children and pregnant women, as well as one massive anti-rabies vaccination campaign, were conducted in coordination with the government's Ministry of Health.
  - Environmental Sanitation. Fourteen campaigns in eight different barrios were coordinated by their respective health committees, emphasizing garbage clean-up, appropriate trash burning techniques, street and housefront clean-up, and rodent eradication.
6. Community Projects. Two special projects were undertaken during the past year which included close collaboration with PLAN social work staff:

"HOGARES SOLIDARIOS." A committee of several other social service organizations was formed to seek solutions to the problem of a lack of day care for children. A nursery school has been established in one area of the sector.

Project "CHILD TO CHILD." In this program the activities are directed toward teaching an older child how he or she might tend for or play with a younger sibling for the good health of the whole family. It includes talks and recreational activities with the themes of accident prevention, nutrition, diarrhea, dehydration control, parasitism, and personal hygiene.

#### In Bosa and Los Cerros

The HMGP in Suba generated interest among PLAN staff working in other parts of the city to undertake preventive health projects. During the second year of the grant some funds from the HMGP were devoted to these projects.

In Bosa, social promoters worked with a dentist and a community health committee to implement a fluoridation and oral hygiene education campaign among 2,000 school children and their parents and teachers. The same committee received education in environmental sanitation, carried out a garbage clean-up campaign, and held educational sessions among their neighbors. During the coming year PLAN will continue to work with this committee on 1) a tree planting project, 2) the dental health program, and 3) the administrative skills of the committee relative to a small health post (one doctor and one dentist).

In Los Cerros, PLAN collaborated with the Community Health Division of a large hospital (Fundacion Sta Fe de Bogota) to train volunteers from ten communities and a total population of approximately 10,000. Training included water treatment in the home and at the well site, latrine construction and maintenance, garbage disposal, animal vaccination, and rodent eradication. The absence of garbage has become a striking and new feature in the landscape of these barrios. During the next year this program will be expanded to two additional communities.

Finally, PLAN will supply some materials and the community organizational work necessary to launch a six-month first aid course among the 70 volunteers involved with the environmental sanitation program.

#### The Future

In Los Cerros, PLAN will leave the program in the hands of the Community Health Division of a large, well-endowed hospital. In Bosa the well-organized and stable Community Health Committee will become responsible for its health program at the end of FY '84.

In Suba, the future of the Community Health Program depends on the ability of the hospital to assume funding. Although the Community

Health Program has generated an increased user rate, especially for outpatient and dental services, the hospital remains underfinanced. During the coming year PLAN will continue some assistance through its regular program operations budget. Because PLAN/Bogota is in the first stage of a two-year phaseout of the entire program it will help the hospital seek outside funding.

### 3. TUMACO, COLOMBIA

The objective of the PLAN/Tumaco program has been to introduce preventive health habits into the daily lives of the urban and rural population where PLAN/Tumaco has affiliated families. The target population is women of childbearing age and preschool-age children. PLAN/Tumaco has collaborated extensively with local Ministry of Health (MOH) efforts to join in the national primary health care program, in addition to maintaining and improving traditional curative services.

#### The First Two Years

The coastal sector of Narino Province, in which Tumaco is located, has a long tradition of being underfunded in provincial and national MOH budgets. Fourteen women were recruited from the Tumaco area to receive preliminary, though extensive, theoretical training from local MOH hospital staff and ongoing practical training and supervision from the PLAN HMGP Coordinator and Nurse-Assistant.

During the first year of the HMGP, baseline health data on 782 families in 15 barrios were collected by the promoters and yearly censuses in conjunction with MOH vaccination campaigns among the highly mobile, constantly shifting Tumaco population have been carried out. Record-keeping and monitoring systems were established as well as a system to evaluate health promoter performance.

Three health posts were constructed collaboratively by the PLAN health program staff, the communities, and the MOH.

Ten of the original 14 women selected for training were retrained after extensive observation and evaluation. Two health posts are staffed by three promoters. The third has had four promoters, one of whom has just been transferred to a rural post.

Each health post works with a committee composed of representatives from each barrio served by the post. The committees are responsible for security and maintenance for the health posts and for assisting the promoters with promotion of vaccination and sanitation campaigns.

For the first two years the program consisted of five major areas of activity:

1. Well-child clinics wherein weight-for-age and diet are monitored and children receive vaccinations. An average of 450 children are enrolled at all three health posts.
2. Prenatal and family planning clinics in each of which an average of 60 women have been enrolled. In the prenatal program, weight and blood pressure are monitored and nutritional counseling is given in addition to tetanus vaccinations. Women are urged to participate in the MOH cervical cancer screening program.

3. Community level health education, in the form of lectures, group discussions and participatory projects, has been a major goal of the program since its start. During visits to all the households in their territory, the health promoters identify families with a high risk of preventable illness. The promoter makes a minimum of three visits per year to high-risk families, encouraging them to participate in health post programs and giving individualized counseling.
4. The health posts are used extensively by the community as first aid posts, and as points of referral to secondary clinical services. They have also served as crisis centers during natural disasters. In February 1983, Tumaco was flooded by exceedingly high tides. For two weeks, the health posts extended their hours to provide first aid to people whose homes were damaged or destroyed.
5. The health promoters collaborate with the MOH in yearly vaccination campaigns. During the first three months of 1982, approximately 6,000 vaccinations of BCG, DPT, polio, measles and tetanus were administered. Although the population is constantly shifting, the best estimate, based on health post records and census data, indicates that 80% to 85% of Tumaco's under-five population has received at least one dose of the above vaccines since the start of the program when that figure stood at less than 20%.

#### During the Last Year

During the last year of the HMGP funding period the program underwent a change of supervisory staff, and a critical self-appraisal. Colombian nurses replaced the expatriot Program Coordinator and Nurse-Assistant who had started the program. PLAN/Tumaco contracted with a consulting geologist with special expertise in appropriate sanitation technology in estuary settings to evaluate and suggest alternatives for a potable water project as an adjunct to the HMGP.

This general reevaluation produced the following results during the past year.

1. A program of review training and improving promoter skills.
2. The record-keeping system has been modified to completely conform to that of the Ministry of Health.
3. The health education component of the program using puppet theater, dance group dramatizations, and slide shows has been expanded to a minimum of ten educational activities per month per health post.
4. The prenatal program has been expanded to include a regular monthly physical examination by the program nurse, who is also improving health promoters' knowledge of how to take better health and dietary histories of pregnant women.

5. Health promoters are now able to recognize the symptoms of leishmaniasis and make referrals to a special research and treatment program being run jointly by PLAN/Tumaco and the Universidad de Valle in Cali (in conjunction with Tulane University).
6. Realizing that intragovernmental negotiations to certify and fund urban health promoter positions in the Tumaco region were moving too slowly, PLAN/Tumaco and local Ministry of Health officials launched new initiatives. The final result was that national funds were procured for a three-month health promoter training course to run from September to November of 1983.

An important side benefit of this course is expected to be the mobilization of resources to facilitate a much needed retraining program for rural promoters in the coastal and inland sectors of the province surrounding Tumaco.

7. Four new rural health posts have been constructed. The PLAN/Tumaco HMGP Coordinator and Nurse-Assistant are responsible for retraining and supervising these rural promoters.
8. In accordance with recommendations of the consulting geologist, a potable water project has been implemented which employs three technological approaches:
  - i. Large rainwater catchment tanks. Annual rainfall in the Tumaco area exceeds 3,000 mm/year. The large rainwater catchment systems are attached to community meeting halls, churches, schools and health posts in seven urban and rural communities and have a total holding capacity of approximately 35,000 gallons.
  - ii. Demonstration models for household water catchment tanks and simple filters have been developed. These tanks have a holding capacity of 55 gallons.
  - iii. Five wells in two rural communities are being renovated.

Over 15 educational talks concerning the relationship between disease and contaminated water and methods to prevent water contamination have been held by the HMGP promoters in nine of the communities participating in the water program.

#### The Future

The Government will include the urban promoters' positions in their budget starting in January 1984. Under an agreement with provincial Ministry of Health officials PLAN/Tumaco will continue to provide supervisory staff for the urban program and an extensive retraining program for existing rural promoters.

Health education will continue to be the central focus of the urban program. In the rural areas, where there are no doctors or nurses, a greater proportion of the promoters' time will necessarily be devoted to screening and treatment. In one of the recently opened health posts the number of cases requiring first aid treatment for bites, cuts, minor fractures, burns, asphyxia, etc., were, on the average, three times greater than in the urban posts, i.e., between 30 and 45 cases per day. Rural promoters will be trained and supervised in community education activities, although on a more limited scale than their urban counterparts.

Plans are being developed to expand the scope of the urban program to include greater coverage and new programs monitoring hypertension, malaria, rabies, venereal diseases, leishmaniasis and tuberculosis.

The ultimate goal shared by both the government and PLAN/Tumaco is for the Ministry of Health to assume total financial and supervisory responsibility for both the urban and rural health promoter programs. To that end, PLAN/Tumaco is helping local Ministry of Health officials build a well-prepared, relatively self-sufficient staff.

#### 4. GUAYAQUIL, ECUADOR

The purpose of the HMGP in Guayaquil has been to provide community health education and thus promote self-reliance in communities for improved health. In Guayaquil, unlike other HMGP field sites, social workers who were already on PLAN's staff were trained in primary health care and to integrate health education into the other services they provide to affiliated families and their communities. Since secondary care and tertiary referral facilities were inadequate, the construction of clinics has been one aspect of the referral system.

##### During the First Two Years

The PLAN/Guayaquil program covers three separate geographic areas with a total enrollment of about 16,000 children, and, in addition, has oversight responsibilities for the program of about 3,000 affiliates in the highlands of Bolivar Province. The three sites within the Guayaquil program proper are Suburbio, a dense slum area established about 40 years ago with about 200,000 inhabitants; the Guasmo, a ten year old, quasi-squatter settlement of over one-quarter million people; and, finally, Daule, a rural, agricultural town about one hour's drive from Guayaquil.

In the first year of the HMGP, 15 social workers who were stationed in Suburbio received theoretical and some practical training in preventive health concepts. It proved very difficult to locate a department chief with all the attributes necessary to design and implement a successful preventive health program. Consequently, the first year was hampered by a few false starts. Also, during the first year, Guayaquil's program was in a period of expansion, almost doubling the number of affiliates by opening the program in Guasmo and Daule. Nevertheless, a baseline survey of 1,000 affiliated families was completed by the 15 health-social workers, and an agreement was settled wherein a local government clinic would accept referrals from PLAN personnel. In addition, the former PLAN medical department, which had been totally curative in nature, was dismantled.

By the beginning of the second year of the HMGP, expansion into the Guasmo was nearly complete, and a structure for the health department had been established. A technical health team initially consisting of a Pediatrician-Director, in charge of training and overall administration of the Health Department and a Sociologist-Assistant, in charge of evaluation and interinstitutional relations, were added to PLAN/Guayaquil's middle management staff to design and direct the program. Later in the year a Sanitation Engineer and two Social Worker-Coordinators were added to the team.

The principal vehicle for community education has been the "Road to Good Health House" ("La Casa del Camino ala Buena Salud") which is usually shortened to "Casa de Salud." Individuals in nine sectors of Suburbio volunteered their homes as meeting places for their neighbors. These homes serve as first aid posts in the neighborhood, and here, the PLAN social worker meets with mothers and children for

monthly health talks, growth and prenatal monitoring, vision tests, dental checks and referrals to medical centers. Each "Casa de Salud" has a steering committee of six community volunteers who promote the health activities of the "Casa de Salud."

When the first "Casa de Salud" started in July 1982, PLAN decided to offer each committee approximately US\$30.00 to start a revolving fund for whatever activities the participants desired. Women now contribute from one to eight sucres (2¢ to 16¢ U.S.) every month depending on the rules of their respective "Casa de Salud." Revenues usually go to social events like Christmas or Mothers Day parties, but there is always a little health message included in the party.

Each "Casa de Salud" is provided with a basic first aid kit, scales for measuring height and weight and a bulletin board. All mothers maintain the Road-to-Health height and weight charts for their children. The social workers are teaching mothers to weigh their children and mark the charts. The response to the growth monitoring program was so overwhelming that each "Casa de Salud" had to be divided into at least two separate sessions to accommodate all the families wishing to attend.

Of the more than 900 children between one month and six years who participated in the original nine "Casas de Salud," 12 have been found with third degree malnutrition (according to World Health Organization standards of weight-for-age). All those with second and third degree and some with first degree malnutrition were referred for immediate medical attention. In the last quarter of 1982, 60 mothers of the children suffering second degree malnutrition attended special sessions on child nutrition and received baskets of basic foodstuffs as well as a home follow-up visit by a social worker.

PLAN has provided financing for 100 pairs of corrective eyeglasses as a follow-up to the vision testing program, and induced the MOH to offer a fluoride program with free toothbrushes for the dental check program.

A major effort was made by PLAN staff to promote the MOH vaccination campaigns. During 1982, PLAN launched an intensive community education project which helped to bring 7,168 children to the MOH vaccination posts supported by PLAN.

One of the special and most popular of the informal education techniques learned by the staff has been street theater. A local theater company holds workshops with all the workers to teach them basic verbal and nonverbal communication techniques used in theater and how to develop short dramatic and humorous sketches. Under the supervision of these theater professionals, PLAN staff incorporated community members into the sketches as actors. Sketches have been developed on the need for vaccination, the importance of oral rehydration to counteract the effects of diarrhea, and different nutrition themes.

During 1982, important links of cooperation were forged between PLAN and the provincial MOH resulting in vaccination campaigns, rabies eradication campaigns, an exchange of educational materials, the construction of four small health sub-centers. Two additional health posts were built in conjunction with local priests. Five of the posts are located in the sectors of Suburbio and the Guasmo where transportation is poor, population dense and other medical services nonexistent. The sixth is in the rural area of Daule. Arrangements were also made so that other, preexisting clinics and hospitals accept referrals from PLAN staff.

A small, long-neglected government hospital exists in Suburbio. PLAN's Health Department has used its influence to call MOH attention to the hospital's many deficits, and PLAN made selective contributions to it, especially to the ophthalmology department which is the only referral point for vision problems in the area.

Also in 1982, an outside consultant completed a month long study of the sewage disposal problems in Guayaquil. Better communication with the Municipal Sewer Authority and a pilot project for a latrine construction program were among the results of the study. The consultant also recommended the addition of a Sanitation Engineer to the technical team of the Health Department.

#### During the Last Year

The end of 1982 and first four months of 1983 were remarkable for the record rainfall, high tides and flooding that hit the Ecuadoran coast. For almost seven months PLAN was involved in disaster relief working with the MOH, Municipal government and communities to alleviate flooding conditions and consequent damage and sickness. The MOH organized health brigades and PLAN social workers worked with doctors, nurses and community leaders to teach people appropriate hygienic measures and to refer people for medical attention. Skin and intestinal infections were particularly prevalent. PLAN social workers referred over 2,500 people in need of treatment. The health brigades and vaccination campaigns prior to the flooding were credited as the major reasons that no serious epidemics occurred in Guayaquil.

Throughout this crisis the "Casas de Salud" continued functioning and ten more were organized. The growth data for the original nine "Casas de Salud" indicated increased low level malnutrition following the flooding. As a consequence of monitoring this data, more emphasis and resources were allotted to the nutrition education program. A survey conducted by PLAN social workers was completed. The results of these surveys were used to refine the nutrition education program.

In the highly politicized atmosphere of Guayaquil's slums, the collaboration of elected barrio level leaders is essential to any community undertaking. As a prelude to opening new "Casas de Salud," PLAN has been conducting special week long courses in preventive

health for groups of community leaders. These leaders, in turn, are supporting and working with the committees which form around the "Casas de Salud" to determine self-financed community level projects related to improving health conditions. Latrines and mosquito abatement are favorites.

A model garbage incinerator was installed for the small urban hospital mentioned above after it was discovered that no health facility in the city had an appropriate means of disposing of tissue, used syringes, bandages, etc.

The health program in rural Daule was started with the training of 11 social workers. Working with a PLAN Agricultural Advisor, the Health Team designed a home garden nutrition program to be tried in the coming year. A well improvement and maintenance program was also designed and is under discussion with community residents.

#### The Future

In Guayaquil, the HMGP has resulted in an internal restructuring of PLAN's health sector work with extensive and positive integration with the provincial MOH. PLAN/Guayaquil will continue to support the efforts of the Ecuadoran Government to start a National Primary Health Care System.

5. BOLIVAR PROVINCE, ECUADOR

Bolivar Province is a highland, rural area about 100 miles north of Guayaquil. A PLAN sub-office was established three years ago in Guaranda, a small town and administrative center for the Province. The HMGP was extended to this new PLAN Field post in January 1982. Although the Bolivar HMGP has received technical support from the PLAN/Guayaquil Health Department, the rural nature of the population and distance from Guayaquil necessitated that it be set up as an independent program.

The principal purpose of the HMGP in Bolivar Province was to establish a Health Department to give technical and fiscal assistance to the MOH rural health promoter program. PLAN also has devoted some resources to improve those existing but inadequate MOH facilities to which the rural health promoters refer sick and high-risk individuals. One of the most serious problems in Bolivar Province was lack of access to potable water. Therefore, an environmental sanitation project was integrated into the activities of the program.

Since January 1982

A Health Department Chief, with extensive experience in community organization, was hired in January 1982. The recruiting process followed by PLAN involved election by the community and careful explanation to both candidate and community of the expected roles for the health promoter and the community.

A total of 23 trainees spent five days per week in Guaranda, returning to their villages on weekends. The course adhered strictly to the training manual distributed by the Ecuadoran Development Bank and the MOH. Greatest emphasis was given to first aid treatment. The issues of community organization and education skills were touched upon only briefly and theoretically.

When the trainees returned to their villages as certified rural health promoters, they were to devote two hours per day to their health promoter responsibilities. They were to organize community health committees, and start a revolving fund for supplies, projects and compensation to the rural health promoters. The MOH provided about US\$35.00 to each community with a health promoter and PLAN matched that amount for all 23 communities. In addition, PLAN staff worked with the eight communities where PLAN had helped recruit the health promoters to help establish functional health committees with specific projects. The first project in all eight cases (as well as three others which solicited help) was to establish a means of administering the revolving fund within the community to insure that the promoters would always have a sufficient supply of first aid materials. Some communities also requested funds to build a room (usually no bigger than 4' x 8') for the health promoter's activities.

While the rural health promoter program was getting underway, PLAN's Community Development and Health Departments were collaborating on 16 water and sanitation projects. In keeping with PLAN/Bolivar's Family and Community Development approach, PLAN social promoters had taught communities to design project proposals. The MOH, however, determined in which villages PLAN would support rural health promoters. It, therefore, was impossible to coordinate water and sanitation projects with health promoter support. This proved to be a strain on PLAN's Health Department manpower resources. Better coordination between these two aspects of the health program has become an explicit objective.

The water and sanitation projects vary from a gravity-fed system of cisterns supplying spring water to the front doors of about 90 households in one village to a simple, vented pit latrine for the school of another community. All of these water and sanitation projects involved an input of community labor. Inspection and approval came from the Government agency, Ecuadoran Institute for Public Sanitary Works (IEOS). In some cases the community and PLAN provided the technical expertise needed for design and construction, while in other cases, IEOS had sufficient resources to provide an engineer.

The MOH maintains small health sub-centers in Bolivar Province and one hospital in Guaranda. The sub-centers are staffed by young medical and nursing school graduates serving their required one year of civil service. Although many of them have high ideals and enthusiasm for helping their rural countrymen, none of them have been prepared to effectively practice medicine armed with only a stethoscope. The sub-centers to which they are sent in Bolivar Province were underequipped and undersupplied. Under technical supervision from the PLAN/Cuayaquil Health Department, equipment for a basic field laboratory was provided to four sub-centers. These sub-centers offer the rural health promoters their only source of medical attention for referrals. At present there are no plans to incorporate traditional curers or midwives into the program. It is hoped that access to simple diagnostic laboratory procedures will reduce the amount of possible indiscriminate drug prescriptions by the inexperienced doctors.

As a follow-up to the MOH rural health promoter training program, PLAN/Bolivar has undertaken two health education projects during 1983. The first was a first aid course for 58 school teachers throughout the Province. First aid kits also were provided to the schools. Additional courses on hygiene and environmental sanitation were offered to 15 communities.

The second project was a week long intensive course for 20 rural health promoters who had continued their work through the preceding year. The course served as a review of well-child care, rehydration therapy, first aid, child nutrition, and introduced the use of various teaching materials including flipcharts, puppet theater, and game playing. Teaching techniques, such as participatory discussion, practical demonstrations and other group dynamics were also demonstrated.

PLAN/Bolivar's Health Department has collaborated with other PLAN departments and with PLAN/Guayaquil to build a library of resource and teaching materials.

They have also developed several slide and cassette shows for use by the rural health promoters.

#### In the Future

Having gotten started with HMGP funding, PLAN/Bolivar's health program will be continued with regular PLAN funding.

One of the results of the mid-program evaluation done by PLAN/Guayaquil for PLAN/Bolivar in September 1982 was the realization that the program was 1) understaffed, 2) lacking sufficient technical assistance for village projects, 3) lacking reliable data on current community health status, and 4) requiring more emphasis on community level health education.

Efforts have recently been made to hire additional staff with experience in environmental sanitation and primary health care. Maintaining a qualified health staff will be an ongoing concern for PLAN/Bolivar.

The long-term program plan provides for greater emphasis on teaching health education techniques to both the MOH rural health promoters and to PLAN social promoters. Depending on community demand, this program also expects to continue assisting with water and sanitation projects. A clear need is for the PLAN Health Department to develop a program of maintenance education for these projects. Finally, PLAN/Bolivar needs to work with local MOH officials to improve the data base describing community health status in order to better allocate resources in the future.

6. JACMEL, HAITI

The objective of the Jacmel HMGP has been to support the Government of Haiti's Rural Health Promoter Program. The target population is children under six and women of childbearing age. PLAN/Jacmel has provided back-up to this effort by developing potable water resources, constructing latrines, and providing a mobile health and educational unit. The government assumed financial and technical responsibility for the program in Jacmel before expected. Jacmel now has 29 trained and supervised health agents who are employed by the Ministry of Health. Their salaries have been supplemented by PLAN from HMGP funds but after 30 September 1983, the MOH will assume these expenses.

The health agents work under the supervision of a government appointed supervisory team who work at St. Michel Hospital, Jacmel's main Hospital. PLAN has provided the health agents with scales for weighing children, with vitamins, with Road-to-Health Charts, and other supplies which could not be paid for by the MOH.

The health agents work in rural communities surrounding Jacmel. They provide first aid and refer sick people to the hospital. Their role in motivating people to seek medical attention is important in Haiti where many people are reluctant to visit the hospital when they are ill.

The program has experienced improvements in 1983 due to the arrival of a new regional supervisor for the Rural Health Program. The new supervisor, a public health physician, has placed a stronger emphasis on health education and preventive measures. He has also strengthened the recordkeeping system. He has upgraded the supervision of the health agents and more accurate data are now kept on their activities. Previously, health promoters came from the field to the Regional Hospital to report their activities and collect their salaries, usually no more than once or twice per month. The new supervisor provides better supervision of agents. Much of this in-field supervision is done while accompanying the PLAN and Division of Public Health medical team on their regular visits to rural communities in PLAN's mobile health clinic vehicle, bought originally with HMGP funds.

The resulting, generally accurate statistics pertaining to rural health promoters' activities in Jacmel between October 1982 and July 1983, can be reported as follows:

Home Visits (including some of the activities listed below)...	28,449
Prenatal Related Consultations.....	1,921
Postnatal Related Consultations.....	931
Individual Family Planning Consultations: Females.....	604
Individual Family Planning Consultations: Males.....	765
Vitamin A Distribution.....	5,285
Preventive Health Community Orientation Sessions.....	599

During these, health promoters also discussed preventive health sanitation measures vis-a-vis PLAN's Potable Water and Latrine Projects.

Hospital Referrals.....	4,306
Post-hospitalization Home Visits.....	2,856
Number of Children Weighed.....	7,864
Number of Children Vaccinated.....	(statistics incomplete at reporting date).

In October 1982, the 29 health promoters commenced improved systematic monitoring of nutritional status of children aged zero to five years via regular weighing on PLAN donated scales at weighing posts (i.e., the health promoters' homes).

Review and new training sessions have been conducted for the rural health promoters since September 1982. PLAN and the Division of Public Health have provided four formal seminars to the rural health promoters: 1. a one-week seminar on preventive and curative anti-malarial measures; 2. a two-week seminar on Family Planning education and methods; 3. a general reorientation session concerning all aspects of the Rural Health Promoter Program; and 4. a one-week seminar on family hygiene with special emphasis on nutrition education, food preparation and family planning.

Throughout FY '83, PLAN/Jacmel has continued to provide supplies to the Rural Health Promoter Program. These included condoms, contraceptive creams and pills for the family planning program, vaccines for the vaccination program, and basic prescription medicines (i.e., chloroquine phosphate, vitamin syrup, anti-bacterial topical cream, oral rehydration salts, anti-inflammation pills, and worm medicines) for use in the rural health promoters' curative treatment procedures. Vitamin A capsules and anti-malarial drugs have been supplied by the Haitian Government with relative regularity.

PLAN/Jacmel's water and sanitation program continued at full steam during 1983. Three projects, started in 1982, were completed. One consisted of a capped spring, offering six public fountains, making potable water available to 2,524 individuals. Another extended an existing system by two additional public fountains making potable water available to 1,895 individuals. A third consisted of a drilled well, pump, generator, cistern and piping, providing 3 public fountains to a community of 750 individuals.

During 1983, six other water projects were started, which will provide a total of 20 additional public fountains to various rural communities surrounding Jacmel.

In addition, a project of construction and distribution of prefabricated latrines to 200 families was completed. This project may be noted for high participation of families who dug the holes and installed the units.

#### The Future

In July 1983, the Jacmel Regional Supervisor for the Rural Health Promoter Program submitted to the Division of Public Health in

Port-au-Prince a budget to commence in October, 1983, which includes the original 30 rural health promoters, plus 27 new health promoters to serve new areas (most of which are beyond PLAN/Jacmel's operational areas.) The Division of Public Health in Port-au-Prince has acknowledged responsibility for the original 30 promoters to begin October 1, 1983, and has tentatively approved the proposal to add 27 new promoters.

Although the Government of Haiti has already assumed a large degree of technical and financial responsibility for the Jacmel Rural Health Promoter Program, two major problems have occurred and could potentially continue to occur after September 1983. Despite many requests to the Division of Public Health in Port-au-Prince, no substantial amounts of medical supplies or materials have ever arrived in Jacmel for health promoters' use. Significant previous amounts of supplies and materials were provided by PLAN via HMGP funds. Should the Division of Public Health in Port-au-Prince continue its lack of support in this area, the impact of the rural health promoters will assuredly be significantly diminished. So, also will the impact of PLAN/Jacmel's rural preventive health efforts, including the water and sanitation program, be diminished, as it depends heavily on the health promoters. At present, the solution is for the regional supervisor to continue soliciting supplies and materials from Port-au-Prince, and for PLAN's Field Director in Haiti to do some soft lobbying in Port-au-Prince for the program.

Given the current size of the Rural Health Promotor Program and the territory to be covered in supervision, plus the proposed expansion of the program in October 1983, additional supervisory staff have been and will be even more essential. Previous requests by the regional supervisor to the Division of Public Health in Port-au-Prince have been fruitless. Presently, it is agreed that PLAN/Jacmel's Health Department Chief will assist the regional supervisor.

A third area of concern regarding termination of HMGP funding is with regard to PLAN/Jacmel's water and sanitation program. A significant decrease in the incidence of gastroenteritis among the residents of the Jacmel area has been confirmed by the doctors who work at the regional government hospital in Jacmel. This has been attributed to the PLAN Potable Water Project (funded through the HMGP) over the past two and a half years.

However, potable water projects are costly and require long and careful planning with communities. What has been achieved to date represents a small percentage of what must be achieved to provide all the rural communities served by PLAN/Jacmel with safe water. The effects on PLAN's future potable water efforts because of HMGP funding termination will be a necessary decrease in these activities, provided that other requested outside funding does not arrive. This is due primarily to the financial limitations of PLAN, the high costs of this kind of program, lack of government support to date, and the fact that PLAN/Jacmel affiliated families do not yet have the experience and confidence to decide to invest their limited funds in this as a community project which would take priority over individual family projects.

In the future, PLAN/Jacmel will be working closely with Community Councils and rural health promoters to change this situation of community and individual perception. The benefits derived from the water and sanitation projects already constructed in other communities will serve as object lessons.

Meanwhile, PLAN's International Headquarters (IH) directed the HMGP Evaluation Advisor to undertake an extensive evaluation of PLAN/Haiti's water program. The study was done with an engineer from WASH (Water and Sanitation for Health) and the report was completed in September 1983. The report recommends the immediate hiring of an outside engineer-consultant to work with the PLAN/Jacmel staff to plan and design a long-term water and sanitation program for the area. At this writing, PLAN has adopted this recommendation and is searching for someone with appropriate experience and language ability to fill this position.

7. YOGYAKARTA, INDONESIA

The HMGP in Yogyakarta, throughout the funding period, has been a collaborative effort with the Government of Indonesia's primary health program which focuses on volunteer community health workers, community nutrition centers with weighing posts, and the bolstering of community clinics. PLAN has collaborated in all aspects of this program by assisting in the training of the community health workers, supporting and providing supervision to the nutrition programs and weighing posts, and providing material assistance to the community health centers.

In addition, PLAN undertakes a number of activities which focus on particular health problems such as iodine deficiency, dental problems and tuberculosis. During the final fiscal year, a special emphasis has been placed on environmental sanitation through an expanded water project and an extensive latrine program. PLAN/Yogyakarta's integrated health program has four goals:

1. That PLAN families have a convenient, clean source of water and a latrine so as to minimize water-related illnesses and decrease the amount of time needed to carry water.
2. That no member of a PLAN family will die from nutritional deficiency and that the number of children suffering from malnutrition be reduced.
3. That the health status of women of childbearing age and of children under five years of age be improved.
4. That the housing conditions of PLAN families be upgraded to reduce health problems and create a more pleasant living environment.

In order to achieve these objectives, PLAN/Yogyakarta has undertaken the following activities:

- o Technical Assistance: PLAN/Yogyakarta maintains 18 trained health workers on its staff who work out of the 12 sub-district offices located throughout the PLAN/Yogyakarta work area. The PLAN health workers counsel families who come for bimonthly financial assistance, participate in the training of community health workers, make referrals to specialists and hospitals, and plan and carry out community health education.
- o PLAN/Yogyakarta supports and helps supervise over 800 community nutrition posts at which community health workers train mothers to prepare nutritious meals for children, and at which children under five are weighed and their weights recorded on the Road-to-Health Charts. Seventeen sessions to upgrade the training of the nutrition workers have been carried out by PLAN health workers. In connection with these programs, 2,130 kgs. of peas have been distributed to those

families with severely malnourished children, 652 rabbits have been distributed as seed stock for home rabbit projects and a home garden project has been started.

- o The dental program has been upgraded and expanded during this year with a mobile dental care unit visiting schools and providing examinations, educational programs and treatment for school children. The children in 18 schools have been provided with toothbrushes and toothpaste and instructed in dental hygiene. Ten groups of teachers were trained in dental education. Three sets of dental equipment have been given to different dental clinics. This project will provide dental education or care for 22,000 people.
- o Tuberculosis screening and treatment has been upgraded and 966 people received X-rays to diagnose the illness. Medication has been provided to 4,450 people suffering from the disease. Nine hundred thirty-eight glass roof tiles have been distributed to those families with tuberculosis victims.
- o Goiter prevention and treatment has remained a strong aspect of the program as over 80% of the women in PLAN/Yogyakarta suffer from iodine deficiency. Over 5,743 kgs. of iodized salt have been distributed to families with deficiency problems, and the role of iodized salt in goiter prevention is stressed in health education presentations to PLAN families.
- o PLAN/Yogyakarta health workers referred 351 individuals for treatment by medical specialists and costs of the consultation were paid for by PLAN.
- o PLAN paid the hospital bills of 552 individuals requiring tertiary medical care.
- o PLAN provided polio vaccinations for 3,100 children.
- o Upgrading of the facilities at the community health posts has included the purchase of first aid kits, tables, benches and other furniture for the health posts, and roofing material to repair and improve 30 existing health posts. These community health centers are the first line of referral for PLAN families needing medical attention.
- o Family Planning education and services are an important part of the primary health care effort. Family planning education and supplies have been provided to 2,000 families and 102 voluntary sterilizations of men and women have been paid for by PLAN.
- o Latrine construction is usually carried out in connection with bathhouse construction. During the past year 125 bathhouse-latrines combinations have been constructed for individual families, 50 community latrines have been

constructed, 221 latrines have been constructed for individual families. In addition, 786 concrete latrine tops have been constructed and are being distributed to PLAN families who agree to dig the pit and build a shelter around the latrine.

- o Following typhoid epidemics in villages with poor drainage, PLAN provided the materials for 110 meters of drainage ditches to community groups who furnished the labor for these projects.
- o Potable water has been a major thrust of the health program this year and will continue through the next year. PLAN has built over 500 well/bathroom/latrine combinations and anticipates the construction of 100 more this year. In addition, 594 existing wells have been improved by deepening, lining, and the construction of sealed parapets to keep out debris and contaminated water. Fifteen water reservoirs have been constructed for gravity water systems and nearly 6,000 meters of pipe have been laid which will bring potable water closer to people's homes. Forty-five rainwater catchment tanks have been built and training of three people to repair them has taken place.
- o PLAN/Yogyakarta's Senior Technician for water projects has attended an intensive supplemental training program from Dian Desa, the local appropriate technology work group.
- o The homes of 1,497 PLAN families have been repaired or improved and 41,200 glass roof tiles have been distributed. Indonesian homes tend to be dark, damp, and unhealthy. The addition of the few glass roof tiles in each room improves the health conditions considerably.

It is anticipated that all of PLAN/Yogyakarta's health programs will continue at the current level through the next fiscal year. Recent changes in the program management may presage changes in the focus of the program over the next few years, however. The two public health physicians have left the program after having provided training to all of PLAN's health workers and set up the infrastructure for continued training of community health workers. It is anticipated that the program will fall under the general management of the dentist who will expand the dental health programs. Since dental health is directly related to sound nutrition, that aspect of the program will receive continued attention.

As a result of the HMGP, the health program of PLAN/Yogyakarta has made dramatic changes, moving from a restricted curative program to an extensive primary program with community health workers in over 1,000 communities. PLAN's close collaboration with the government health program is a strength of the program and will certainly continue.

#### D. EVALUATION

It had been anticipated that weight-for-age data would be the main criterion for evaluating the impact of this program. The use of weight-for-age data and Road-to-Health Charts has proven more difficult to introduce than might be expected. Initially, there was confusion over the type of scales to be used and whether Road-to-Health Chart standards applied in all countries. Training of health promoters and community organization were delayed in Guayaquil and Bogota due to changes in program management. In Indonesia, where weight-for-age data are available for over a year, the use of such data to evaluate the water and sanitation component of the project indicated that the data are of very poor quality. In Tumaco, Guayaquil, and Bogota, weighing programs are now underway and data are improving in both quality and quantity.

During the final year of the grant, the evaluation component of the project has focused on water and sanitation. By this time, health promoters were trained, backup secondary health care facilities were functioning, and the thrust of PLAN's programs expanded to include environmental improvement. Both Yogyakarta and Jacmel had water projects but both Field Offices raised questions about what impact their projects were having and whether they should be expanded.

Major evaluations of water projects were, therefore, undertaken in Yogyakarta and in both Croix-des-Bouquets and Jacmel, Haiti. In both cases a Consulting Engineer, supplied by Water and Sanitation for Health (WASH), was involved in the evaluation. Each evaluation involved about one month in the Field during which time original data were collected and existing data were analyzed. Copies of these reports were made available to all Field posts.

In addition to carrying out two major water project evaluations, an important part of the work of the Project Evaluator this year has been in assisting Field staff in developing alternative research methods based on existing data or on collection methods which are nondisruptive. These methods were used in both water and sanitation evaluations and two papers were delivered at professional meetings and disseminated to all Field posts. The Project Evaluator also presented, with PLAN's Director of Research and Evaluation, a day-long workshop on research methods at a conference for Asian Field staff in Singapore. At the same conference, the Project Evaluator presented a session on long-range planning for water and sanitation projects.

The results of the studies undertaken by the Project Evaluator and by the Consulting Engineers have been disseminated as widely as possible both to PLAN's Field staff and through WASH to USAID offices and libraries. The following publications and reports have grown out of the HMGP during this fiscal year:

Buzzard, Shirley

1982 Appropriate Research in Primary Health Care Projects. Invited Paper for session on Anthropology and Primary Health Care for AAA meetings. (Accepted for publication in forthcoming volume of Social Science and Medicine).

Buzzard, Shirley and Chris Rice

1983 The Role of Research in a Private, Voluntary Organization.  
International Consortium of Voluntary Agencies Bulletin: Geneva. January.

Buzzard, Shirley

1983 The PLAN Wells and Water Project: Yogyakarta, Indonesia. A:  
Evaluation Report. Warwick, RI: Foster Parents Plan International  
Headquarters.

Buzzard, Shirley and Bob Gearheart

1983 Evaluation of Foster Parent's Plan Water and Sanitation Projects in  
Yogyakarta, Indonesia. WASH Field Report No. 71. Washington, D.C.: Water and  
Sanitation for Health Project.

Buzzard, Shirley

1983 Evaluation of Foster Parents Plan's Spring Capping Projects in  
Croix-des-Bouquets, Haiti. Warwick: R.I.: Foster Parents Plan International  
Headquarters.

Buzzard, Shirley and Anthony J. DiBella

1983 The Use of Quantative and Qualitative Data in a Primary Health Care  
Project. Paper read at International Congress of Anthropological and  
Ethnological Sciences, Quebec City, August, 1983.

Lauria, Donald T.

1983 Water Supply Program of Foster Parents Plan in Haiti. WASH Field  
Report No. 96. Water and Sanitation for Health Project: Washington D.C.

Rice, Chris and Shirley Buzzard

1983 A Review of Yogyakarta Self-Help Projects: Wells, Latrine and  
Bathhouse Units. Warwick, RI: Foster Parents Plan International Headquarters.

## E. LESSONS LEARNED

Through the HMGP, PLAN has learned that it can implement health sector prevention programs at the family and community levels. Indeed, because of the close staff-client relationship and the shift in focus from family level donor services to community-wide development programs which is rapidly evolving in most Field posts, PLAN has discovered that in some settings it has been at a unique advantage.

PLAN/IH introduced the HMGP to seven Field posts in five countries. Two of those countries, Indonesia and Colombia, had well-established primary health care programs. In Haiti, a vigorous, well-funded national primary health care program and PLAN's HMGP in Jacmel started simultaneously. Ecuador and Bolivia both had embryonic, struggling rural primary health programs based on new and relatively vague national policy, uncertain funding and shortage of supervisory personnel. The HMGP program promulgated in each of the seven posts represents an adaptation to different national and local circumstances spanning a range of support for government programs to establishing a program wholly encompassed within the private sector.

### Collaborating with Government Programs

The HMGP in Yogyakarta, Java, Indonesia, has been the most closely integrated into a functioning national level program. In this case PLAN supplied designated sectors of Yogyakarta Province with the supplies used by the health volunteers and government health workers, as well as the backup promotional support of PLAN social, community development and medical workers. Included in the promotional support was a specific program of health education and referral conducted at PLAN sub-offices and in communities.

In some settings PLAN can significantly improve the quality of a government primary health program through active participation in promotional and educational activities. This will almost always be accompanied by more fiscal contributions as well, but need not be in the more conventional form of medications or vehicles, which may not always result in services reaching the people.

In Yogyakarta, all health promoter work was to be supervised by the physician-directors of regional clinics. Some of these doctors are responsible for more than 100 volunteers and promoters. The HMGP Program Coordinator in Yogyakarta quickly detected that these doctors had not been adequately prepared for nor integrated into the national program, and were alienated by their sense of being exploited. In Yogyakarta, extra diplomatic effort was exerted by the PLAN professional staff first to educate these doctors concerning the value of primary health care, and secondly, to use some HMGP funds to improve the clinics, usually in ways the doctors had vainly fought for.

Most government primary health care programs depend on using doctors or nurses from the lower echelons of the medical hierarchy as supervisors of primary health care workers. The lesson learned in Yogyakarta concerning the importance of their understanding, integration and cooperation proved

to be invaluable and relative to all the other HMGP Field posts. This lesson learned early on was disseminated to the other HMGP posts.

In Haiti, PLAN support to the Jacmel health promoter program was an acknowledged aid to freeing resources for starting the national primary health program in other, less accessible parts of the country. When, two-thirds of the way through the HMGP, the government was able to supply competent, indeed excellent, supervisory and training staff, PLAN stepped into the background providing only the administrative support to ensure that funds reached their intended destiny, e.g., the health promoters.

The lesson was learned that there are circumstances in which it is beneficial to do what it seems a government should be doing. In Haiti, as in the other HMGP countries, access by the PLAN country Field Director to the Ministry of Health officials and advisors provided the communication necessary to make informed judgments about how much and when to give. Although PLAN always has official government permission to work in a country, the lines of communication are not always open between a Field Director and a particular Ministry. The HMGP has taught the importance of forging good relations and clearly delineated cooperation at the national as well as the local level of the relevant Government agency.

In Jacmel, while good supervisory support was long in coming and health promoter morale declined, the program was never in danger of becoming nonfunctional because PLAN provided reliable salaries and supplies directly to the health promoters and held them accountable for their activities. In areas of the world where corruption is institutionalized, PLAN sometimes may play the distasteful role of administrative intermediary.

Tumaco is an area of Colombia neglected by one of the most advanced and internationally respected national primary health care programs. In this case PLAN worked very closely with local health officials to design and implement a health promoter program. PLAN provided virtually all staff and funding to start the program. The lesson that there are circumstances appropriate for innovative ventures is tempered by the need for close collaboration and knowledge of local officials and MOH politics.

The Tumaco HMGP highlighted the problems of depending on expatriots if competent national personnel is available. Ironically, it was in Colombia, a country well stocked with primary health specialists, that PLAN fell into the trap of relying on non-nationals. The two expatriots who headed the program in Tumaco did an excellent job of implementation, but, specifically because of their non-Colombian nationalities, they were unable to assist local health officials negotiate with the regional MOH for Government support. This situation changed dramatically when a Colombian public health nurse was hired as the HMGP Coordinator.

The HMGP in Bolivar Province, Ecuador, taught that PLAN Field posts, if properly prepared and funded, can serve as a safety net for a Government program. Bolivar was included in the HMGP during the second year of funding and just before the MOH started a rural health promoter program in the area. It was immediately evident to PLAN staff and local MOH officials that the program was doomed to failure because of inadequate

resources and misperceptions about local needs and customs on the part of central planners back in the capital city. By anticipating these circumstances PLAN/Bolivar was able to divide labor with the local MOH officials and provide necessary resources where central planners had not seen need. Two areas where PLAN played a vital role in what was the future success of the program were inclusion of community participation and, once again, of integrating local government doctors who were to serve as supervisors.

Both Bolivar and Tumaco represent areas where living conditions are rough and unattractive to most national professionals. Both represent examples of the difficulty of finding competent supervisory staff for work in the health sector. This is especially true in Ecuador, which unlike Colombia or Indonesia, has virtually no tradition of training public health or primary health care professionals. The HMGP has demonstrated the need for sufficient funding to be able to attract qualified professionals to direct such programs as the HMGP. This need not be a long-term condition, but it may be essential during the first two to four year period of intensive training and planning until a program structure is well-established.

The Guayaquil HMGP is currently undergoing a change in program coordinator, as has Yogyakarta. Time will tell how the programs will fare under the leadership of people who are the trainees of former, strong program coordinators.

Guayaquil is the only Field post where PLAN attempted to reprogram its own workers to include health education among their other duties. It was quickly learned that changing any aspect of employee role perception is extremely difficult among employees of long tenure and higher educational status. What was presented to the employees as a training opportunity to learn new social work skills was resented as an attempt to get more work from them. On the other hand, new employees hired directly from the communities in which they were to work and with lower formal educational background eagerly accepted their health sector training and community education responsibilities.

It is difficult to predict if this lesson is equally applicable to other PLAN Field posts. Some evidence of resistance to changing work patterns among employees who already have established areas of responsibility seems to exist in other Field posts.

In La Paz, where a team approach is used and which includes a PLAN health promoter, it was found that the critical first step to achieving change in work patterns and concepts about appropriate community development work among employees was to convince supervisory staff. Supervisory staff often serve as employee advocates, even where PLAN employees are unionized. Without their full comprehension and cooperation, programs like the Guayaquil and La Paz HMGP, which rely on PLAN line staff, could not function.

In Bogota, PLAN has involved the HMGP in a private sector experiment. Because of inadequate relations between PLAN and the MOH, PLAN/Bogota was unable to interest the Government in collaboration. However, a local community supported hospital was very interested in establishing a Community Health Department.

PLAN turned over to the hospital a ready-to-work program replete with trained health promoters from the same community as served by the hospital, full funding for two years, supervisory staff and some ancillary equipment to improve overall hospital services. Under the direction of a former PLAN social worker and her nurse-assistant, the program truly became a Community Health Program by pulling together other agencies and government services working in the area and incorporating full community participation in project planning and implementation.

While the Bogota situation is unusual, such factors as the low socio-economic status of the population served by the hospital, a general lack of access to other medical services and economic uncertainty for the hospital's future operations are certainly to be found in other PLAN Field posts. At a minimum the Bogota HMGP has taught PLAN to carefully observe potential opportunities for working with the private sector in health.

#### Complementary Programs

Through the course of implementing the HMGP, each of the seven participating Field posts became involved with adjunct environmental sanitation projects. A potentially expensive lesson learned is the extent of interest that a health education program can generate for environmental sanitation projects. An unanticipated value of the HMGP has been the experience gained in implementing these environmental sanitation projects.

To differing degrees, the HMGP posts realized the benefits of integrating the HMGP with preexisting programs. Home improvement, vocational and literacy education, day care and basic community organization programs became integrated with health education activities. The Field staff also adopted some of the training techniques used by HMGP staff to run workshops and on-the-job orientation and training related to non-health aspects of PLAN work. Although some staff from other departments initially resented the large budget and special attention given the Health Department, it was learned that mutually beneficial sharing could be realized.

#### Issues Related to health promoters

Health promoters are at the core of this project. It is around their selection, training and supervision that PLAN has gained considerable insight that is of value to other Field posts. Some of these findings follow:

- a. Community acceptance of the health promoters is critical to their effective functioning. Members of the community should be involved in their selection and evaluation. When collaborating with a government primary health care program, PLAN should diplomatically lobby for full community participation in the recruitment of health promoters, and education of the community concerning the role of a health promoter.
- b. Serious consideration must be given to the role and previous work or profession of the prospective health promoter and supervisor. Early role identification and motivation should be built into training

programs. The individuals chosen to become health promoters have often not had any public roles before. An important component of their training must be to build their confidence so that they can take on new and different roles.

- c. Often both trainees and the community expect a rigid, formal lecture format; however, the training of health promoters should be conducted in the manner in which health should be taught to the community. Innovative, participatory, highly visual (films, demonstrations, models) methods are preferred.
- d. Interpersonal skills, including the ability to listen to people in the community, should be a component of training. Trainers should be screened for sensitivity to this facet of their teaching responsibilities.
- e. Training must be both technical and practical. It is best to begin with a short core curriculum and begin practical work in the community from very early on. This allows the health promoters to develop community relations skills and build confidence while they are learning. This approach requires long-term planning for continuous training and review.
- f. Supervision of the health promoters is very important. Ideally, the relationship between the supervisor and the health promoters is open and positive, but this must not obfuscate strict discipline and authority on the supervisor's part. It is very easy for the health promoters to slip over into diagnosis and cure. Supervisors must be continually on guard to be sure the health promoters are first class educators, not mediocre nurses or modern day folk curers.
- g. The routine collection of simple data and record keeping should be incorporated into the training program from the beginning, not added after initial training is finished. Road-to-Health Charts have proven to be useful educational devices, although their use requires a relatively high level of supervisory monitoring and discipline.

#### Prevention vs. Curative

Although PLAN has been designing, implementing and evaluating humanitarian and development programs for a long time, sometimes one can forget that real change can be slow. It was more difficult to create a consciousness of prevention than was anticipated. For most people in the communities where PLAN works, and frequently among the staff, curative medicine is all that is known, and therefore has a much higher priority than does prevention. The first priority of any preventive health program must be to develop the consciousness that disease is preventable by readily accessible means. This, of course, is the focus of health education. The process is slow when real community participation and development is sought.

## Effect of HMGP on PLAN Structure and Operations

The HMGP represents a rare deviation from the field-up program planning which normally characterizes PLAN programs. The top-down nature of the HMGP proved to be disruptive in the short-term, but constructive in the long-term. It was learned that for such special projects as the HMGP, it is a mistake to assume that staff with other responsibilities can give adequate attention to both. A project coordinator at IH would provide for better communication, more coordination and probably more leadership. On the other hand, one of the dangers not suffered by Field staff was too much centralized decision making. The maximum of Field autonomy worked to favor Field-based judgments, some experimentation and fostered self-confidence, innovation and enthusiasm in International and national staff as they ventured into a new area of community work.

The Project Evaluator contributed significantly to qualitative evaluation of the implementation process. It was determined early in the course of the HMGP that a quantitative evaluation of program impact is necessarily a long-term activity. She was, however, able to assist local staff with their attempts to set up baseline data studies. Both the Project Evaluator and the Technical Advisor were advocates of systematic evaluation of local health beliefs and practices. It was learned that a concentrated effort would be necessary to guide local staff in such studies. This was in spite of specific recommendations from both advisors, and probably occurred because of the mistaken belief on the part of local staff that they already knew all that they needed to know of local customs.

The HMGP Evaluation Advisor was particularly instrumental in evaluations of water and sanitation projects. These evaluations demonstrated the need for special expertise and offered guidelines for long-term project planning.

The contribution of the HMGP Evaluation Advisor has been most timely since PLAN has been working on its own evaluation process for the past several years. Her advice and guidance not only affected the HMGP, but has had a spin-off on the overall evaluation process of the agency in other areas of our work.

While the Evaluation Advisor was based at IH, the Technical Advisor was based in the Field and travelled among the HMGP posts.

Teaching materials have been one focus of the HMGP Technical Advisor's responsibilities. In her work in each of the HMGP Field posts she has advised PLAN staff and even government training staff about curriculum content. As in all development work, caution, diplomacy and patience are necessary when introducing change. The Technical Advisor has shown this is possible and helped local staff in this regard as they dealt with Government officials.

An important, although unanticipated element of the Technical Advisor's work, was to assist Field staff with program design and planning. In spite of a general program outline developed at IH, very few of the Field staff involved with the HMGP had any first-hand knowledge or experience with primary health programs. Also, because of the top down nature of the original program planning, many Field Directors found themselves with directions to implement a preventive health program when they sometimes

had other priorities and program changes in process which were requiring all of their time and ingenuity. In addition, the HMGP at each Field post took unexpected twists and turns, and one of the values of the Technical Advisor was to have someone experienced and available to the Field to troubleshoot.

In general, PLAN has learned to better use technical advisors in the Field and at IH.

#### Working with USAID

The HMGP was PLAN's first collaboration with USAID. On the whole, USAID was a generous resource to PLAN. In addition to the matching grant funding which gave PLAN the financial freedom to experiment and build a model for restructuring our health sector work, we also were able to make use of USAID funded resource agencies including WASH and Resource Reports.

Three problematic issues came to light through the HMGP. They were:

1. Because USAID and PLAN operate on different fiscal years, budgets were not ideally well-aligned. This meant adjustments on the part of Field staff as they projected their annual budgets, and complementary adjustments at IH on the part of the Finance and Accounting Department.
2. Because of the reimbursement system employed by USAID in this grant, an extra burden was placed on the Field and IH Accounting Departments, which normally does not exist.
3. In spite of advice from the USAID Program Officer to use PLAN's internal program evaluation system, PLAN elected to try using logical frameworks as the basis for program evaluation. Although this was dropped in the third year in favor of PLAN's internally developed system, it did result in lengthy, time-consuming and, for some Field staff, painful extra reporting requirements.

PLAN learned the benefit of close communication with Washington to avoid unnecessary time lost. The annual reviews have served PLAN as a time of general summary and review, particularly for IH Program staff.

F. FINANCIAL STATEMENT

HEALTH MATCHING GRANT PROJECT - PLAN/USAID  
 SUMMARY OF PROJECT EXPENDITURES - October 1, 1982 to June 30, 1983

<u>LOCATION</u>	<u>BUDGET FY'83</u>	<u>EXPENDITURES THROUGH JUNE 30, 1983</u>	<u>BALANCE TO SPEND</u>
La Paz, Bolivia	\$ 83,000	\$ 33,032	\$ 49,968
Bogota, Colombia	111,748	52,221	59,527
Tumaco, Colombia	165,134	142,673	22,461
Bolivar, Ecuador	44,857	23,309	21,548
Guayaquil, Ecuador	147,476	75,545	71,931
Jacmel, Haiti	55,221	38,410	16,811
Yogyakarta, Indonesia	122,856	74,298	48,558
IH	<u>119,485</u>	<u>68,250</u>	<u>51,235</u>
TOTAL	\$849,777	\$507,738	\$342,039
OVERHEAD	<u>86,841</u>	<u>58,900</u>	<u>27,941</u>
<u>GRAND TOTAL</u>	<u>\$936,618</u>	<u>\$566,638</u>	<u>\$369,980</u>