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STRATEGIES FOR FAMILY PLANNING, HEALTH, AND COMMUNITY DEVELOPMENT IN RURAL ECUADOR

A Report Prepared by:
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Volume One: Final Report

I. Purpose of the Consultancy

The AID/Ecuador Mission is now reinitiating project programming, having authorized no new major projects since FY 1970. The purpose of this consultancy was to assist the Mission in project development in --in order of priority--family planning, rural health, and community (agricultural) development. Practically, most of this consultancy was devoted to the first of these priorities, family planning strategies. The Scope of Work for this assignment is shown in Volume II. of this report, Reference Document No. 01.

II. Methodology

The findings of this report are based on extensive interviews with GOE authorities and on direct field observation in the rural area.

Interviews were conducted at virtually every level of responsibility and in nearly all agencies related to health, family planning, and agricultural development. In order to learn as much as possible about operational aspects of programs, a large number of these interviews were carried out with personnel at middle and lower management levels.

Field work was carried out in the Highland provinces of Chimborazo and Cotopaxi and in the coastal province of Manabí. Altogether, about 2,000 miles were covered during field visits to these three provinces. In the field, contact was made initially with provincial health authorities and site visits (accompanied and unaccompanied by MOH officials) were then arranged. In addition, extensive interviews were carried out with Ministry of Agriculture personnel, missionaries, drugstore owners, Peace Corps volunteers, community leaders, and health post clients. No attempt was made at systematic sampling or hypothesized scientific research.

III. Family Planning/Population in Ecuador

A. Family Planning and the Ecuadorian Government: Should AID pursue family planning programs?

The population of Ecuador is now increasing at about 3.2% per year, the highest rate in South America. In response, the GOE has allocated .0008 of the 1979 MOH budget to family planning - which is to say, putting it midly, that the government does not share AID's conviction that a growth rate of 3.2% represents a serious impediment to the economic development of the country.

Presently, family planning is viewed as a health-related activity condoned by the MOH solely within the context of maternal-child health care. The term "population control" is simply not

mentioned in polite circles.

There is a widespread notion in Ecuador that AID is wildly obsessed with family planning, either through economic naïveté, racism, or for sinister political ends. There is no doubt that AID's policies in regard to family planning are to some extent a calculated risk; they are conflictive; and the question is frequently raised: If the MOH does not want it, why should AID continue to promote family planning? Surely, the argument goes, there is enough to do in other areas where the government does want help without risking good-will and jeopardizing other AID priorities.

This is a more-than-reasonable question, and if only as a personal consideration, it ran like a troublesome loose thread through the two months of this consultancy.

Setting aside the knottier moral and political arguments, one might judge the simple expediency of a continued push for family planning in light of the following considerations:

1. It is possible that a policy shift may be in the offing. the Vice President-elect, Osvaldo Hurtado, who is expected to play a key role in policy formation, has indicated support of family planning --for demographic/economic reasons- in his writings and during the recent campaign. Presently Hurtado's left and popular support is unimpeachable. Were Hurtado to strongly endorse family planning, it is likely that present left-centrist opposition would be defused.

2. Despite the MOH's ideological coolness toward family planning, the 1979 Four-Year Plan of the MOH calls for a fairly substantial upgrading of family planning activity. Home visits by auxiliary nurses, for example, are expected to deliver educational information and referral coupons to 22% of the women of fertile age. Increased provision of oral and other contraceptive methods by the auxiliary nurses and home-visits to family planning drop-outs are now required. (Specific activities and norms for family planning for the Four-Year Plan are shown in Reference Document No. 02.)

3. The ideological issues - which are so apparent at the national level - tend to evaporate as one moves toward the campo and into the operational realm. From the point of view of the auxiliary nurse, the key person at the woman-to-woman operational level, the Ministry supports family planning, period. Otherwise, contraceptives would

not be provided at health posts. Accordingly, the first hurdle was also probably the worst - getting family planning out of the national male-dominated ideological domain (medical schools, the Ministry) and into the hands of women (auxiliary nurses and users). Having more or less gotten over that hurdle, now may be precisely the wrong moment to ease efforts.

4. During the past few years AID's activities in Ecuador have been mainly in family planning; therefore, it should not be surprising that AID and family planning are closely identified. Within the next few years AID will initiate major projects in other areas; and accordingly, the family planning image should give way to new associations.

5. To a large extent, many of the "differences" between AID and the Ecuadorian position in regard to family planning are semantic. In fact, AID has developed a variety of family planning delivery models fully consistent with the MCH approach advocated by the MOH. This obvious fact tends to be overlooked. Inherently, there is no reason that AID cannot and should not work well within the policy boundaries of the Ministry.

B. Delivery of Family Planning Services by the Ministry of Health: The Case of Manabí

The question of Ministry policy has been a persistent preoccupation for several years. To some extent, however, this preoccupation has tended to obscure a potentially more important question: Assuming a will to do so, how good is the MOH at actually delivering family planning services? What could be expected from the Ministry, given the present service delivery model coupled with hoped-for policy changes?

A case to consider is the province of Manabí. Manabí is a coastal province of approximately a million people - which is to say, nearly a seventh of the total Ecuadorian population. It is a hot, rapidly urbanizing area with high landlessness and a non-Indian population. Judged strictly on the basis of its similarities to other me tizo coastal populations, e.g., Salvador, lowland Guatemala, one would expect a reasonable receptivity to family planning programs - and this is the case.

The MOH policy of regionalization allows an individual jefatura a good deal of latitude in the programs it chooses to emphasize or de-emphasize. In Manabi, the jefatura has chosen to emphasize family planning. The director speaks proudly and enthusiastically about his program, his first "major push" in public health upon his arrival several years ago. He and other upper level administrators make no apologies for their program and are anxious to show it off.

Extensive field investigation in Manabí confirmed a commitment to family planning at all operative levels. An adequate supply of contraceptives, posters, and educational materials was found in all units visited. All health units had developed family planning programs matched to their degree of medical specialization, i.e., the rural health posts had contraceptives and a single poster in a one-room facility, the Bahía hospital had a sophisticated family planning-cancer detection program with a full-time U.S.-trained gynecologist. Moreover, the Manabí health education program maintains a workshop for the preparation of educational materials and 14 full-time health educators (compared to two, for example, in Canar, Cotopaxi, or Loja). The director of the program has received special IPPF training in family planning; and he, in turn, has trained and motivated his 13 health educators who work in the field.

The chart on the following page reflects the strong emphasis on family planning in Manabí. In a ranking of provinces by percent of doctors' well-patient consultations devoted to family planning, it will be seen that Manabí ranks second behind Guayas (province in which Guayaquil is located). In 1977, an impressive 13.1% of all doctors' well-patient consultations were devoted to family planning. This represents about 4% of all doctors' consultations (well-patient plus sick-patient). Similarly, it was determined that 10.4% of all well-patient consultations by nurses in Manabí were devoted to family planning.

Analysis of Ministry data for 1977 revealed that Manabí does in fact have the largest health education program in the country, measured by number of talks given, number of educators, etc. It was not possible to determine the percentage or number of talks devoted to family planning. Field observation, however, confirmed that the educators are active in family planning.

In short, relative to most of the MOH, Manabí has a near-model program. The bosses are encouraging the program; contraceptives are available at every service level; both doctors and nurses are providing a significant number of family planning consultations; and an active educational program is underway.

There is a fly in the ointment, however. No users.

According to 1978 figures, there were about 26,000 first-time family planning acceptors - or about 3,600 regular family planning users. Giver a population of a million - or about 200,000 fertile age women, approximately 1.5% of the fertile age female population is in control.

Which certainly prompts the question: If that's a good program, what are the bad ones like?

Doctors' Well-Patient Consultations Devoted to Family Planning, 1977

Region-Province	% of doctors' well-patient consultations devoted to family planning	Rank
Coastal Region		
Manabí	13.1%	2
Esmeraldas	1.8%	19
Los Rios	12.3%	3
Guayas	15.7%	1
El Oro	8.5%	5
Sierra Region		
Azuay	11.7%	4
Bolivar	2.0%	18
Canar	3.5%	14
Carchi	4.1%	12
Chimborazo	2.3%	17
Cotopaxi	6.9%	8
Imbabura	2.9%	15
Loja	2.8%	16
Pinchincha	4.0%	13
Tungurahua	4.9%	10
Oriente Region		
Napo	7.8%	6
Pastaza	1.2%	20
Morona Santiago	7.4%	7
Zamora Chinchipe	5.9%	9
Galapagos	4.4%	11
National Average	7.8%	--

Source: Derived from raw data provided by the MOH. The percentage of family planning consultations provided by nurses and obstetrices is not included here because gaps and jumps in the data make it suspect at the national level. This omission causes the Guayas program, clearly the most active in the country, to be somewhat under-represented, since Guayas has a large group of obstetrices engaged in family planning. Well-patient rather than total patient consultations were used because this provides a somewhat finer picture of priority given to family planning. In general, well-patient consultations account for about 30% of total consultations.

In trying to understand the obviously low productivity of the Manabí program, one explanation might be that there is simply no demand for family planning services, despite Ministry efforts. A brief survey of Manabí drugstores, however, indicates that this is probably not the case. In 19 drugstores queried, it was found that, on the average, 11 different brands of oral contraceptives were sold and that, estimating conservatively, each drugstore averages the equivalent of 93 users per month - or extrapolating to the total population, 17,000, i.e., 8.7% of the fertile age female population.* In other words, without educators, encouragement, and at a considerably higher price, the drugstores are apparently far out-performing the MOH in the number of persons who are actually supplied with contraceptives.

A similar indicator that lack of demand does not in itself explain the low level of usage of the MOH is that the Armed Forces' family planning program, with one clinic and three persons located in the provincial capital of Portoviejo, claims about 1,000 regular users - that is, nearly a third as many as the MOH.

A completely satisfactory explanation as to why an earnest program does not attract a respectable number of users is difficult to piece together. However, in considering the matter, what seems more likely than lack of demand is lack of quality in delivery of services. The MOH - big, new, and not fully engaged - has simply not yet reached the "confidence threshold" of the people it serves.

Observation at the health post level does not fully explain why this is so, but it does provide clues. Some of what one sees at health posts is the following:

1. Condescension/boredom on the part of personnel.
   An US-them paradigm pervades the health post. Personnel, especially the young doctors, are stiffly courteous when not outright rude. An often-bored and cheerless environment is made worse by the fact that personnel feel underpaid (which they are: young doctors, $325-$375 per

* For a more complete summary of the Manabí drugstore findings, see page 21 of this report or Reference Document No. 03. Although I believe that the 8.7% figure is conservative, it is based on a small sample and several generous assumptions (see discussion in ref. doc.). It's not gospel. Also, note that it measures only the theoretical number of users accounted for by monthly pharmacy sales, not the actual number of regular users.

month; auxiliary nurses, just over $100 to start; health educators with five years of college, $180) and poorly equipped with the basic resources necessary to do their jobs.

2. Forced Teaching.
To some extent, not only the health post client but also the auxiliary and health educator are captive to health post didactica - the client because she must submit to lectures in order to see the doctor or receive "free" leche avena, and the nurse/educator because of the quantitative rather than performance-oriented norms of the Ministry. The number, duration, and audience size of health talks, meetings, and programs are faithfully reported; only the impact is not known. Frankly, my own response to health post talks is to want to squirm, say "Yes'm," and head for the door. I cannot really say that health post audiences share this response; but numb expressions on faces and the number of family planning users are clues that they do.

3. Verguenza-pudor.
The sense of a woman's "shame" - at being seen naked, at the exposure of sexuality, at being spoken to and examined by a (male) physician - has been research in coastal Ecuador and described by Susan Scrimshaw. (See "Lo de Nosotras": Pudor and Family Planning Clinics in a Latin American City," 1972; research sponsored by USAID Contract No. 0113-26332-00, AID/csd-2479, Task Order #3B.) As far as I could tell, no special provisions have yet been made to protect a woman's modesty, e.g., drapes, curtains. Undoubtedly, the linking of family planning with the early detection of cancer program frightens some potential users and promotes the anxiety and embarrassment associated with the gynecological exam. Further, the requirement in many facilities that both spouses attend a counseling session and agree to family planning probably, in many cases, increases the embarrassment of the wife and discourages her away from the program.

4. Loss of time.
If she wishes to get out early, a patient must arrive at the health post as early as 5:30-6:00 a.m. Although waiting is hardly anything new in medical clinics, it is invariably the factor that offsets the contraceptive price advantage that the Ministry enjoys over drugstores (average price of MOH orals at 22¢ plus 18¢ consultation vs $1.16). The waiting situation is worsened, since some clinics reportedly will not give 3-month supplies but

require monthly visits. It is hard to see the justification for the amount of waiting that patients must endure. A fairly typical health center was visited in which women frequently begin their waiting by 5:30-6:00. The first doctor does not arrive until well after 9. During a day, the clinic sees 40-50 patients on the average. The staff consists of: a full-time doctor-administrator, two full-time and one half-time medico rurales, a private doctor who occasionally "helps out", four auxiliary nurses, and a full-time secretary.

In short, in reviewing the case of Manabí, one finds an active family planning program, probably as good a program as the MOH can now implement, which is not working. At the field level, the problem is not one of "anti-family planning policy", nor is it even necessarily one of de-emphasis. The problem is that the system is not yet fully engaged with the people it is designed to serve. Unfortunately, it is not just family planning - but the quality of the village-level health service environment - that must be improved.

C. Family Planning in the Sierra

In the Sierra, in respect to family planning the situation is worse.

In the first place, the same difficulties with "the system" that constrain family planning delivery in Manabí are present in the Sierra, only more so. For the most part, the Ministry is less well established. Coverage is thinner; and there are more problems with supplies and personnel.

In the second place, there is less inherent demand for family planning in the Sierra, particularly among Indians. The Ministry-pharmacy supply substitution observed in Manabí probably does not occur in the Sierra (although this was not carefully checked). The intermediate variables usually associated with high fertility are uniformly unfavorable, e.g., an infant mortality rate of 122.1/1000 in Cotopaxi, the highest in the country, vs 38.5/1000 in Manabí, the lowest (1974 MOH data). Education and literacy are low, lower still among women; contact with the outside is restricted, limited in part by language barriers; there are virtually no employment opportunities or expanding roles for women; and children probably retain their short-term utility in labor-intensive minifundista agriculture, particularly in the frequent absence of the migrating male adult (who appears none too anxious to have his wife introduced to contraceptives in his absence).

And finally, the cultural barriers and history of exploitation that separate whites from Indians exacerbate the already difficult problem of making the health system work. The health system is operated entirely by whites. No Indians work in paid positions; nor does anyone in the MOH apparently believe that "qualified" Indians can be found to fill job vacancies. It is considered progressive that Indians be allowed to work as volunteer health promoters in their own communities. There is no input from Indians at decision-making levels; nor is there any felt-need, since virtually everyone feel himself to be a self-taught or university-taught expert on "the problem".* A major step in one province is that Indians are now allowed an audience with the director of the jefatura to request that a doctor be sent to their village regularly, provided that the village provide the consultation room, buy a stock of medicines, and pay for the doctor's transportation.

Family planning is difficult to observe and study in the Indian areas since it is a non-phenomenon. User rates in Chimborazo were estimated by the jefatura to be about 1% in the urban Indian areas and .1% in the rural Indian areas. It is even difficult to discuss the idea since local health officials and community leaders - who frequently consider themselves to be guardians of the cultural and political purity of the flock - are quick to take offense at the notion that gringos are interested in introducing family planning instead of health programs.

It should be emphasized that it is not just family planning that is embraced unenthusiastically in the Sierra. Generally, Eduadorian Indians have a wary, if not antagonistic, relation with the outside world. Indians make polite listeners to outsiders who regularly come to offer programs, religion, and studies. They rarely say no; they rarely mean yes. Mostly, they are willing to wait and see, ready to absorb resources should any be offered. Since most programs offer few concrete resources, most programs move slowly.

Setting aside family planning programs that are very conflictive or very expensive, it is hard to create many new programming ideas for the Sierra - only two obvious first steps: (1) education in health and family planning, to introduce, broaden, and

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* The medical director of an extremely large and populous Indian area summed up the problem this way: "The Indian is a person who lives in a horizontal fashion --that is, he has no future and no past, only the present. He drinks without shame, fighting and killing who he's with and the next day they are friends; he sleeps in the street, in shit, in his own vomit and saliva; he doesn't like beds, he'd rather sleep on the ground; he likes to live with animals; he doesn't like to bathe, he has no reason to; he doesn't like to cure himself with a doctor, he prefers empirical medicine and his superstitions."

reinforce the idea in order to encourage choice and generate village-level demand, and (2) support the development of a sensitive and effective rural health infrastructure, which can introduce family planning among other badly needed preventative and curative health services.

D. Non-MOH Family Planning Services

Aside from private pharmacies and the MOH, at least five other entities within Ecuador provide family planning services: the Armed Forces, the Social Security System (including the Preventative Medicine Department and the smaller, semi-autonomous Campesino Social Security Program, described below), and the vertical private family planning programs, CEPAR, APROFE, and CEMOPLAF.

Of these, all but APROFE were contacted and representatives were interviewed and or clinics visited. However, the purview of these programs was limited, and no judgment is made here as to the relative strengths and weaknesses of each - much less, their potential as alternatives to the problemmatic MOH.

In general, my impression is that none are really strong or are geared for a Holy Family Planning War with the government; yet all appear serious, committed, and effective within the limited geographic areas or delivery-styles in which they specialize. It will be interesting to see how CEPAR handles the proposed Manabí community distribution project, which in its final phases, is expected to reach toward the national level.

As will be seen in the following section of this report, "A Strategy for Family Planning," it is foreseen that all of the organizations will play a continuing role. No centralization-consolidation effort is proposed at this time.

E. A Family Planning Strategy

Despite government policy constraints, despite weaknesses in the MOH delivery system, despite cultural conflict between Indian and white, and in the absence of strong private family planning organizations, it is possible to do something in family planning. Now. The Mission has developed, and the present report is helping formalize, a Five-Year Population/Family Planning Strategy. The basis of this strategy is a series of conceptually, if not administratively linked projects which are to be carried out through bilateral agreements with the government, through private intermediary organizations (Pathfinder-CEPAR), and through the private sector (commercial distribution).

THE ESSENCE OF THIS STRATEGY IS (1) TO BROADEN AND STRENGTHEN THE SUPPLY INFRASTRUCTURE AT ALL LEVELS, (2) TO GENERATE INCREASED DEMAND FOR FAMILY PLANNING SERVICES, and (3) PROMOTE A FAVORABLE GOVERNMENT POLICY AND MEDIA CLIMATE FOR FAMILY PLANNING.

The specific components and sub-components of this strategy are shown below:

1. TO STRENGTHEN AND BROADEN THE SUPPLY INFRASTRUCTURE.
   1.1 Install (through CEPAR) a community-based distribution program in the province of Manabí, which is to be extended to Azuay and other provinces.

   1.2 Strengthen the delivery of rural health services (especially by training auxiliary nurses) within the MOH and Social Security System; support the formation of a Network of community-level health promoters; and through the network, encourage a system of community distribution of contraceptives and educational materials.

   1.3 Initiate a program, to be expanded to the national level, of private commercial distribution of contraceptives. This implies the creation of a low-price, brand-name contraceptive (s) to be distributed buted through drugstores, and if feasible, other commercial outlets.

   1.4 Expand the training of midwives in family planning.

   1.5 Expand the training of obstetricians and gynecologists in family planning.

   1.6 Train druggists in family planning.

   1.7 Continue to support contraceptive distribution through the programs of APROFE, CEPAR, and CEMOPLAF.

2. TO GENERATE INCREASED DEMAND FOR FAMILY PLANNING SERVICES

   2.1 Carry out an information-education-communications project which will produce a high volume of materials in health and family planning. These will be disseminated widely in the rural, especially Indian, and poor urban areas.

   2.2 Generate greater familiarity and receptivity toward family planning - as well as population issues - in the modern sector through a mass media population information project.

2.3 As part of the private (CEPAR) community-based distribution project, train family planning "motivators" who will work to educate and generate demand for services at the grassroots community level.

2.4 As part of the proposed community-based distribution project within the MOH and Social Security Systems, improve the quantity and quality of educational materials available at the health post level, and train auxiliary nurses and community health promoters in the effective use of these materials.

2.5 As part of the proposed private commercial distribution program, prepare a mass media advertising campaign to advertise the brand-name contraceptive(s).

2.6 Carry out a project for the preparation of educational modules in demography and sexual education for use in the public schools.

3. PROMOTE A FAVORABLE GOVERNMENT POLICY AND MEDIA CLIMATE FOR POPULATION AND FAMILY PLANNING.

3.1 Carry out a population information project for opinion leaders and policy makers.

3.2 Continue informal efforts by the Mission, in dealings with Ecuadorian counterparts, to encourage and promote family planning; and to include family planning components within other projects that are being developed.

Major projects which comprise this strategy are summarized below.

1. <u>An Information-Education-Communications Project</u>.

1.1. Reference Documents.

1.1.1. U-Chicago "I-E-C 50-50 Proposal" (not included in Volume II of this report. On file, AID/Ec.

1.1.2. APROFAM (Guatemala) proposal for project in Indian area of Guatemala. (Ref. Doc. 04)

1.1.3. "Educational Materials for the Indigenous Area: Project Description: Draft for Discussion" (Annis/Guatemala: Ref. Doc. 05)

1.2 Summary Description

An I-E-C project, presently at the discussion and proposal stage, which proposes to produce and disseminate a high volume of educational and motivational materials in health and family planning. These would include pamphlets, posters, radio spots, t.v. spots, health post brochures, etc. The project would be directed primarily toward the rural and urban poor. Presumably the project will be done in collaboration with the MOH or private health/family planning organizations.

1.3 Present Status.

This project has been under discussion for well over a year. Drs. Donald Bogue and Jane Bertrand, of the Community and Family Studies Center of the University of Chicago (CFSC), visited the Mission last year and presented a 50-50 proposal (50% messages in family planning, 50% in health). The merits of percentages have been discussed, but at the present time no decision has been reached on this proposal or CFSC's role. A second visit by Dr. Bogue is pending.

1.4 Observations/Recommendations.

1.4.1. Lack of good educational and motivational materials is surely one of the major bottlenecks to a better understanding and increased demand for family planning and health services. This is amply apparent in carrying out field observations-where fogginess over the concept, complete dependence on the health post for information, lack of stimulus, lack of the idea are the real obstacles, not "political opposition." Some clear messages and straight forward how-to information must be "put out there," and until that happens, it is hard to imagine great leaps in demand. U-Chicago CFSC would seem like a logical choice for the project because of its unique experience in the area and well-established working relation with AID; never the less, if CFSC is <u>not</u> going to do this project, then an alternative should be found without further delay.

1.4.2. A key obstacle in developing the project has been apparent disinterest in collaboration on the part of the MOH. The CFSC proposal suggested one alternative. Understandably, Dr. Bogue of CFSC is reluctant to commit Chicago staff and resources to a project in which this key ingredient for

success - enthusiastic counterpart support - may be weak. The Ministry's needs, priorities, technical capacities in regard to communications materials must be determined, as well as its willingness to accept family planning themes. If an alternative institutional basis is to be arranged, then that must be investigated and decided upon.

1.4.3. The Mission has expressed concern that it might be offered a "pre-packaged deal" by Chicago - that is to say, an assembly line media package that is not specific to the needs and peculiarities of Ecuador. Whereas this is a realistic concern, the problem can be avoided by extensive pre-testing and field-testing of materials and a close working relation with well-attuned local counterparts.

1.4.4. The Indian population of Ecuador constitutes a special problem in IEC, and since nearly half the population is Indian, considerable thought must be given to tailoring the project accordingly. Some of the problems facing the project in this regard are similar to problems which APROFAM in Guatemala has been wrestling with. (See Guatemalan Reference Documents, Nos. 04 and 05.) APROFAM, with past and ongoing support from SFSC, is now beginning a specially-designed project in the Indian area in collaboration with Columbia University. It is recommended that as the project develops, particular attention be paid to the Guatemalan experience and that working contact be established with APROFAM. Both projects (as well as other countries with similar Indian populations) might benefit from a formal or informal coordination mechanism which could be established.

1.4.5. It should be emphasized that a considerable volume of materials in health and family planning does presently exist in Ecuador. The MOH has absorbed some technical assistance and has sent specialists outside the country for training in communications. The Peace Corps has helped produce high quality educational materials. What is striking, however, is the near-complete absence of such materials at the village level. It is rare indeed that the right materials filter down to the right place at the right time. The question of

dissemination must be given special consideration. It is recommended that in whatever proposal is next prepared, dissemination be treated as fully and explicitly as possible.

2. Population Information Project

2.1 Reference Documents.

2.1.1. Population Policy Information PID by John Paul James, AID/W. (On file in AID/E and AIE/W. Not included here.)

2.1.1. Population Information Project. First Spanish Draft. Ref. Doc. No. 06.

2.1.2. Population Information for Opinion Leaders and Policy Makers. First English Draft, AIE/E Ref. Doc. No. 07.

2.2 Summary Description.

A project designed to (1) increase knowledge of population/family planning issues among Ecuadorian opinion-leaders and policy makers, (2) create a media and public opinion climate which will encourage positive family planning policies and (3) generate through the mass media greater familiarity and interest in population issues as well as increase demand for family planning in the "modern sector." The project will consist of a small staff of communications specialists. They will establish a population/family planning documentation center and generate a steady flow of press releases, magazine artibles, newsletters, translations and reprints of technical articles, radio and t.v. messages, conferences, etc.

2.3 Present Status.

Several versions of this idea have been prepared in draft. (See Reference Documents.) The Mission has identified a well-qualified Ecuadorian mass media specialist, who has a working relationship with the MOH as well as an interest and training in population/family planning. He is a possible director for the project. With his input, the Mission is now revising the proposal and will submit a more finished draft, initially to AID/W and then to Pathfinder.

2.4 Observations/Recommendations.

2.4.1. A serious obstable to family planning in Ecuador is its unfortunate identification as American and imperialistic. This project could help to diffuse that notion, by showing concrete examples of how other Latin American countries have recognized and dealt with population questions; or it could make it worse, if the project is perceived as a U.S. media manipulation effort. In short, this project must find a delicate balance: to aggressively and openly promote, defend, and publicize family planning-to bring it out of the closet - yet at the same time, minimize and withstand political backlash. How? The project must be done openly, self-confidently, and with a willingness to "take the heat." The project must encourage open debate and a critical examination of the issues. Above all, it must be superbly well-prepared to defend its positions with scientific data, Latin America case studies, and well-informed analyses.

2.4.2. The organizational affiliation of this project is a key aspect. To be effective, the project must not only provide accurate and effectively-directed information, but it must establish credibility within Ecuador. To some extent, the "legitimacy" of the project is initially established by the names and institutions associated with it. This factor must be given considerable thought.

2.4.3. This project might be carried out more effectively if it were done with the project for "Educational Modules for Demography and Sexual Education." (Ref. Doc. No. 08) The same communications expert might serve as half-time director for both projects. If so, proposals for the two projects might be submitted simultaneously to Pathfinder.

3. <u>Community-Based Distribution in Manabi</u> (CEPAR)

3.1 Reference Documents.

Complete Project proposal is available in AID/W and AID/E. Not included here.

3.2 Project Summary.

To create, under the auspices of CEPAR, a model community-based distribution program in Manabí, later in Azuay,

and then in other coastal provinces. Initially, about 50 village-level "motivators" in Manabí will be responsible for generating demand at local levels. (No sales of contraceptives by motivators.) Pills will be distributed by supervisors (nurse obstetrices, who will also insert IUDs) and by pharmacist-distributers. Foam, condoms, and tablets will be distributed by both pharmacist and non-pharmacist distributers. CEPAR expects to attract 10,300 new users (6.2% of the fertile age women) or 4,870 acceptors during the project.

3.3 Present Status.

A finished proposal directed to Pathfinder has been prepared, and by this writing, should have been submitted. If approved, it is to be expected that the project will be implemented this year, and if successful, extended to other provinces.

3.4 Observations/Recommendations.

3.4.1. As discussed, the MOH may not have a particularly effective family planning program in Manabí, but at the jefatura level at least, it is taken seriously. As such, it is a kind of family planning beachhead within the Ministry. It is possible that the CEPAR projec will be viewed as competition; and realistically, it is. In order to minimize conflict, efforts should be made to establish a genuine working relationship with the Ministry. The Ministry may be albe to recommend, for example, motivators or supervisors to be employed by CEPAR. It may be possible to share educational materials and collaborate on promotional campaigns.

3.4.2. A rapid survey of Manabi drugstores showed that the two cheapest brands of oral contraceptives, which are currently available in most drugstores, are at a price near the proposed CEPAR CBD price (although the average price of commercial brands is more than 2 1/2 times the proposed CEPAR price). Similarly, MOH prices are about the same as the proposed CEPAR price (including the price of the contraceptives and the doctor's consultation fee, but not opportunity cost associated with waiting at the health post). In other words, the project does not enjoy an automatic price and competitive advantage. To gain users, the motivators will have to motivate.

3.4.3. It is not likely that the nurse obstetriz supervisors will be a major source of oral contraceptive sales, since (1) they have no significant price edge over the cheap drugstore brands and the MOH, and (2) a visit to the obstetriz will presumably involve a time loss not associated with the drugstore. However, the obstetrices may play crucial roles as educators and woman-to-woman legitimizers of family planning. Additionally, they may be able to attract and maintain a significant number of IUD users, a need which cannot be met by the drugstores and apparently is not now being met by the MOH. It may, however, be difficult to find and recruit the proposed number of obstetriz supervisors (9), unless new graduates can be found in the school in Guayaquil. If so, it may be necessary to hire young doctors (who are in ample supply), preferably women.

3.4.4. In terms of reaching the widest target audience, it would be desirable if all 200 drugstores and boticas in Manabí were CEPAR distributers (a secondary advantage would be the data and experience base this would establish for the proposed private commercial distribution project). Presumably, there would be no trouble recruiting all drugstores into the program since they are presently in the business, and will undoubtedly simply view the "CEPAR brand" as a new line. An important factor to consider is that the CEPAR brand will sell for about the same price as the current lowest-priced commercial brand, Anovulatorio MK - but the CEPAR brand will be provided free to the pharmacists. Since the profit margin on the CEPAR brand will obviously be much higher than on the commercial brand, the pharmacists will presumably "push CEPAR." Setting aside the question of unfair competition to the non-subsidized drug house, the problem facing the project is that the higher profit margin will simply cause brand substitution, with no necessary increase in the real number of family planning users.

To minimize this problem, it may be necessary to reconsider, once again, the pricing of oral contraceptives. Although not fully ideal, the simplest

solution would probably be to charge pharmacists for the contraceptives. The pharmacist's wholesale price would have to be low enough to encourage interest and sales but high enough to discourage excessive brand substitution. If this is to be the case, realistically it will probably also be necessary to relieve the pharmacist-distributers of the paper work now expected of the distributers. Practically, this would create two distinct kinds of distributers within the project, pharmacist and non-pharmacist distributers.

4. Community-Based Distribution through the GOE

4.1 Reference Documents.

4.1.1. Project Identification Document. First rough draft. Ref. Doc. No. 09.

4.1.2. "Training, Support, and Educational Materials for Auxiliary Nurses" (Appendix to PID). Ref. Doc. No. 10.

4.2 Summary Description.

This project proposes to establish, eventually, a community-based distribution system within the GOE rural health programs (the MOH and Social Security programs). In the process, it will strengthen the effectiveness of these programs in delivering quality health services to the rural poor. The project will consist of three phases: (1) provide training, support, and re-training to auxiliary nurses, (2) support the formation of a network of village health promoters, and (3) create a CBD network which incorporates these promoters. It is expected that AID's role will be to help plan and coordinate the larger project (strengthening and extension of rural health services) and provide financial and training inputs specifically for that part of the larger project which deals with family planning.

4.3 Present Status.

The present comments are based on a first rough draft of the PID - no more than a PID idea - that was written and discussed in the Mission at the end of April. By now a finished PID should have been written and submitted to AID/Washington.

4.4 Observations/Recommendations.

4.4.1. The MOH has a well-developed strategy for rural health. A major component is extension of services, especially maternal-child care. Family planning is subsumed conceptually and practically under maternal-child care. The MOH would almost certainly prefer that AID's contribution to rural health be in contributing to the financing of the logistical support and human infrastructure which will go along with the BID loan for health post construction. Beyond doubt, a program interpreted strictly as family planning would not be acceptable to the present MOH. For this reason, the present PID is a kind of compromise - as well as an act of faith. It is based on the conviction that government support for family will improve; and that in 3-4 years, when that stage of the project is ready for implementation, the CBD concept will be acceptable within the MOH. In the meantime, the PID proposes a first step which is both consistent with the present MOH needs and priorities and is also a logical first step toward CBD.

Obviously a certain degree of risk is inherent in this sort of planning, since the MOH may simply absorb grant resources and continue to reject non-clinical distribution. If so, however, it is still likely that a significant improvement in family planning delivery will have taken place through the strengthening of the health system itself; but more importantly, if <u>only</u> strengthening of the health system is achieved, a valuable and badly needed contribution will have been made to the rural poor of Ecuador.

4.4.2. Up until this point, the term "community-based distribution" has been used to describe the proposed project. Taking into account that the present Vice Minister of Health has already rejected, in writing, the concept of community-based distribution, it would seem unwise to continue with this rubric. The project should be given a different name.

4.4.3. The present PID suggests working through two institutions, the MOH and the Social Security campesino program. Institutional rivalries may prove to be a delicate matter. The feasibility of collaboration will have to be investigated in considably more detail during the Project Paper phase.

5. Program for Private Commercial Distribution.

5.1 Reference Documents.

5.1.1. Summary of Manabi Drugstore Data. Ref. Doc. No. 03.

5.1.2. "Ecuador: Drugstore Training." Proposal to Pathfinder. Ref. Doc. No. 11.

5.2 Summary Description.

There is general agreement that the private commercial sector offers strong possibilities for mass distribution of contraceptives. A project is envisioned in which there will be eventual commercial distribution of a low price brand name contraceptive(s) - in drugstores, and if feasible, in other types of private commercial outlets.

5.3 Present Status.

This project exists now only as an idea. A proposal draft has been written and is on file in AID/Ecuador. The Drugstore Training Project, now under consideration by Pathfinder, is a step toward a commercial distribution project, as is the CEPAR Manabi CBD project. Never the less, at the present time, there is no person, institution, or business enterprise that suggests itself as the obvious future sponsor for the project.

5.4 Observation/Recommendations.

5.4.1. Summarized below are some highlights from the field survey of 19 Manabí drugstores. (See Ref. Doc. 03 for more detailed information.)

i. Altogether, 20 different brands of oral contraceptives were identified. On the average, drugstores sold 11 different brands of orals and 2.5 different brands of condoms. Most of drugstores sold at least one brand of foam tablets. About half the drugstores provided Depo-provera injections.

ii. Prices for orals ranged from 44¢ to $2.18. The mean price of orals was $1.16 (with a high standard deviation of 10.4). Condoms sold for about 11-18¢; individual vaginal tablets

for about 13$. A three-month injection of Depo-provera costs $3.82.

iii. Druggists seemed to agree that there is a bimodal distribution of sales by price - that is, the most expensive and the cheapest brands sell best.

iv. On the basis of a rough estimation, average monthly sales of drugstores are: 69 cycles of pills, about a half gross of condoms, a "few" boxes of tablets of foam, and 1-2 injections. Calculating conservatively, this is the equivalent of about 93 "covered persons" per average pharmacy. Extrapolating from the sample to the province, about 8.7% of the women of fertile age would be covered by pharmacy-supplied contraceptives. (Note: This number, of course, is not the same as the number of regular users.)

5.4.2. It is reasonable to speculate that a major reason for the surprisingly high user level accounted for the drugstores in Manabí is that the MOH only weakly promotes family planning and does not provide an environment which encourages women to avail themselves of MOH services. The drugstores are apparently filling a gap.

It is recommended that a full feasibility study be carried out next year. Delay of this study for about a year should allow time for new government policy to be clear and for the Manabi CBD and the Drugstore Training project to be implemented.

6. Educational Modules for Demography and Sexual Education.

6.1 Reference Documents.

"Learning Modules for Demography and Sexual Education" A proposal idea; first draft. Ref. Doc. No. 05.

6.2 Summary Description.

This project which intends to integrate demographic and sexual education concepts into the curricula of public school. In addition, the project would contribute to upgrading the quality of public school teach-

ing materials. The project would train teachers, especially teachers in the rural areas, in the use of these new materials and in basic concepts of health, sexual education, family planning, and demography. It is expected that this program might be a basis whereby rural school teachers might be incorporated into the network of rural health volunteers, a component in the "community-based distribution" project through the GOE, proposed above.

6.3 Present Status.

This project is an idea. Ref. Doc. No. 05 is a first draft of a proposal. This proposal could be developed and submitted to Pathfinder with the "Population Information for Opinion Leaders and Policy Makers" proposal.

6.4 Observations/Recommendations.

6.4.1. The key to this project is the interest and cooperation of the Ministry of Education. The project might be developed as one component of a more ambitious project designed to strengthen the overall quality of educational materials available in rural schools.

6.4.2. It is expected that in its present form the project could be managed as a half-time responsibility by the communications expert who has been suggested as the possible director for the Population Information project.

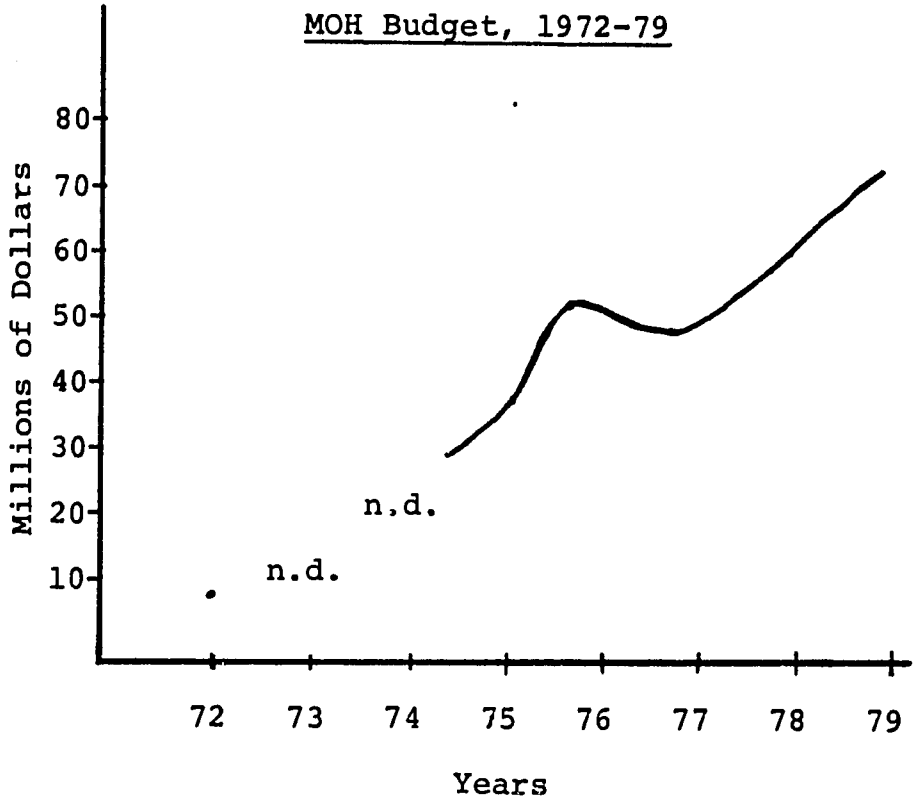
IV. Rural Health Care Delivery through the Ministry of Health

A. Growth and Financing of the Health System.

The Ecuadorian Ministry of Health was formally established in 1967. Until that time, health services were provided by various autonomous and decentralized agencies; and to a large extent, the work of the Ministry during the past ten years has been to unify public sector health into one agency. Since 1972, the Ministry has absorbed 18 Juntas de Asistencia Social, which formerly operated mini-health ministries and has incorporated the Ministry of Agriculture's rural health infrastructure (which it, in turn, had inherited from the Misión Andina, which had for many years been largely responsible for community-level health services in in community-level health services in the Sierra). During the past 12 years of consolidation, the Ministry has increased its

control from approximately 3% of hospital beds to well over 60% presently, and perhaps more importantly, has established its authority over nearly all health-related acyivities in the country.

The rapid growth of the MOH reflects the dramatic increase in its budget, which is shown in the graph below.



Source: MOH and Ministry of Finances
Note: MOH figures are higher than Ministry of Finance figures which accounts for the 1977 "dip"; a currency exchange rate of 27.5:1 was used for sucre-dollar conversion.

The MOH budget has increased relatively as well as absolutely - from approximately 2.6% of the national budget in 1972 to 6.7% in 1978. Which is to say: at the same time the national budget increased about 300%, from .3 billion to $.89 billion, the MOH budget increased about 700%, from $8.36 million to $59 million.

The expenditure for health has been almost entirely from public revenues. In 1979, the largest multilateral agency providing assistance will be PAHO, whose health-related assistance will approach a relatively modest half million dollars (well under 1%

of the budget). Bilateral assistance will be received from Britain, Israel, France, Japan, Canada, and Germany. Most of this assistance, however, is in the form of relatively small projects.

In dollar amounts, the largest international donor has been BID. Until 1978, however, BID lending was almost entirely devoted to loans for sanitary infrastructure. BID lending since 1970 is shown below:

Loan for sewerage facilities in Guayaquil (1970)	$7.6 million
Loan for sewerage facilities in 16 communities (1972)	$10.9 million
Loan for potable water facilities in 10 communities in El Oro province (1977)	$12.2 million
Pre-loan technical studies on rural health infrastructure carried out by PAHO (1976)	not available
Loan for sewerage facilities in Guayaquil suburbios (1977)	$17.0 million
Loan for sewerage and potable water facilities in Quito (1977)	$12.2 million
Loan for construction of rural health posts (1978)	$9.5 million
TOTAL*	$69.4 million

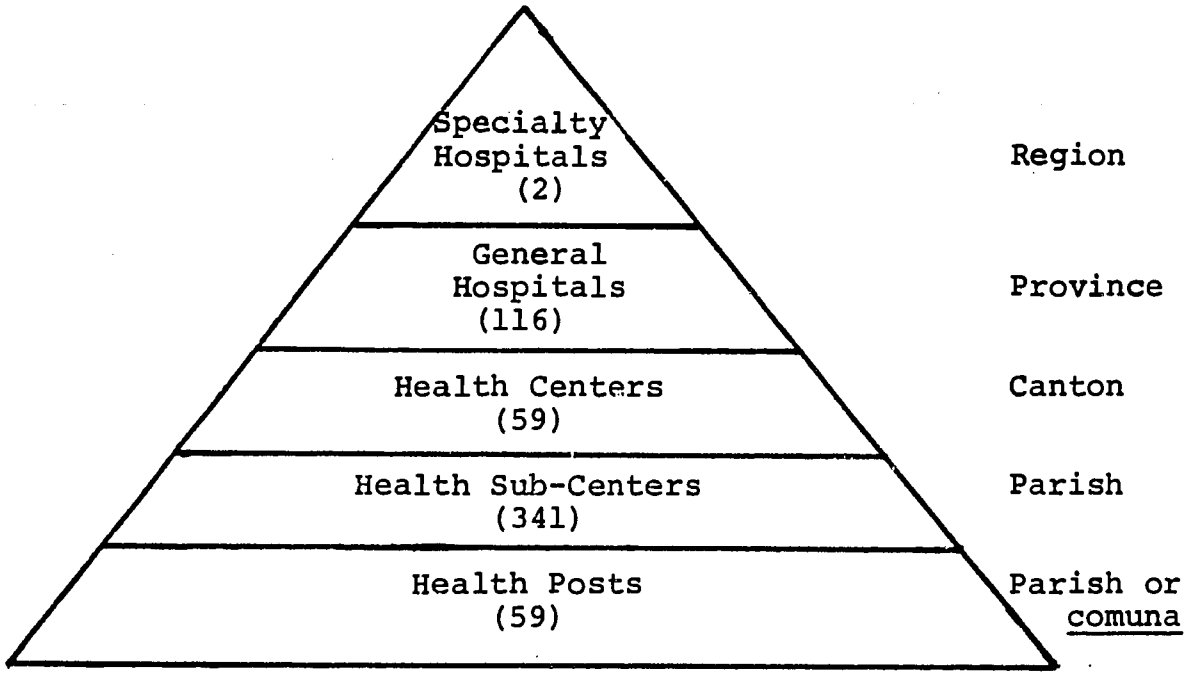
* Not including pre-loan technical study.

B. Regionalization of Services.

The Ministry, through its plan for regionalization of health services, has organized its facilities into what is frequentl described as a five tier pyramid. This is illustrated on the following page. The figures in parentheses are the number of each type of facility that existed in 1977.

Health centers, for the most part, are located in urban areas, usually with populations over 50,000. They provide a full range of curative medical and dental services.

REGIONALIZATION OF SERVICES



Sub-centers are located in parish seats or towns with populations of 1,500 - 5,000. Typically, they consist of auxiliaries, and full-time dentistas and medicos rurales (last year students who must spend an obligatory 9 months in the rural area).

Health posts are the smallest, minimal facilites, usually serving communities of 1,500 or less. Theoretically, a health post is staffed by an auxiliary nurse who provides basic maternal-child care, routine vaccinations, first aid, injections, nutrition and health education. Health posts are visited by medicos rurales. With recent over-production of graduates in the medical schools, many health posts have been assigned one, or even two, young doctors, automatically converting their classification to sub-centers. This accounts for the large number of sub-centers (341) and the small number of health posts (59).

Continued penetration of health services into the rural area is a high priority within the Ministry. The recently signed $9.5 million BID loan will allow a substantial extension of services. A total of 70 centers and 400 health posts are projected over three years. Nevertheless, the Mission CDSS estimates that this will provide coverage to only about 7% of the rural population.

C. Observations from the Field.

The general strategy of the Ministry in regard to the growth of the pyramid is : (1) completion of the physical infrastructure, (2) improved logistical support and supervision over the extended infrastructure, (3) upgrading of the human infrastructure, e.g. training of auxiliaries, more graduate nurses, training of young doctors in public health, training for administrators, and (4) inclusion of village-level health volunteers as adjuncts, or extension agents, for the system.

Observations from the Field: Weaknesses of the Program

That the health system needs considerable improvement is evident from field observation. Among other things, one notices the following:

1. The auxiliary nurse, who along with the medico rurale is the key person in the rural area, is passive. She rarely ventures outside the health post - not is she expected to by the community. For the most part, she is a social outsider, especially in the Indian areas. Generally she has a sixth grade education and a few weeks to a few months of nursing training. Few have had refreshers courses, in-service hospital training, or the sti ulation of continuing education via newsletters, correspondence courses, or mailed educational materials. No auxiliaries interviewed had had training in more esoteric subjects such as community organization, communications, and sociology. The most frequently expressed need by the nurses was hospital-based training in gyno-obstetrics. There is little esprit de corps among among auxiliaries or sense of professionalism. The young doctors, for the most part, are not good trainers and encourage the auxiliaries in their passive secondary roles. There are no performance incentives or possibilities for advancement. There is supervision but little support. Ministry paper work, which the auxiliary usually views as burdensome, requires detailed reporting on the number of her activities (how many injections, how many health talks, etc.) but never raises the question of their impact. She is supplied with virtually no educational materials to prepare her or support her in giving educational talks to the community. (For a more detailed discussion of auxiliary nurses and suggested means for improving their effectiveness, see "Training, Support, and Educational Materials for Auxiliary Nurses," Ref. Doc. No. 10).

2. Doctors are frequently absent during the hours which they are assigned to the health post. They invariable arrive late to work. It is given that patients will wait,

no matter how many doctors and how many hours of work are assigned to the health post. (See Manabí example, page 3.) Peace Corps nurses in one rural area of Cotopaxi estimated that "good doctors" are in the health posts about 80% or more of their assigned time; "bad doctors," which are common, as low as 40%. Doctors argue, not unreasonably, that since they are assigned to what are basically health post cachement areas, "there is nothing to do." Not only patients, they also lack the basic medications and medical equipment to effectively practice medicine. Furthermore, many have husbands and wives who cannot or will not live in isolated rural areas and children for whom there are no adequate schools. The result, often, is very long weekends in the provincial capital.

3. Basic medications are supposed to be supplied free or at cost to the patient. The patient is given a drugstore prescription for medicines not in stock or the doctor can give/sell at cost drug samples of medicines that he has purchased. This creates opportunity for doctors to sell medications at a profit, thereby raising an otherwise inadequate salary. Obviously, many doctors take advantage of this opportunity. It is likely that some doctors encourage scarcities in order to justify their own sales. Visual inspection of health post bodegas indicate that medications are scant (this was confirmed by the more knowledgeable Peace Corps nurses). In all three provinces visited, the charge was frequently heard that the jefatura bodegas are "filled" but they won't deplete their own supplies by sending medications out. In the one jefatura bodega that I asked to see, this did seem to be the case; but I cannot verify the general truth of the accusation. What is certain is that campesinos complain bitterly and invariably about the high cost of medications associated with visiting the health post (although, in fairness, it should be pointed out that campesinos, like most non-campesinos, complain bitterly and invariably about the high cost of everything).

4. It is common that health post doctors practice private medicine on the side, in some cases during the same hours that they are being paid by the MOH. The actual extent of this could not be verified, but certainly the practice is common. Doctors justify this on the basis of the fact that they are frequently paid late, or not at all. Some, faced with a long employment search and extreme difficulty in setting up an urban private practice, are probably simply experimenting with the possibilities of rural private practice. When asked how they (or rather, how "other

doctors") can effectively compete with themselves, i.e., why the patients would pay the same private doctor rather than going to him for near-free in the health post, they point to greater privacy, more medical time, and less waiting. This would certainly help explain the quality of medical services offered in many health posts.

5. Health education, including family planning (see page 7), is for the most part comprised of talks given to captive women who are waiting to see the doctor or waiting to receive free leche avena (an oat-based nutritional supplement supplied to lactating mothers, pregnant women, and malnourished children). Judging on no criterion other than glassy eyes, these talks do not appear to be particularly effective. According to Ministry theory, everyone in the health facility, from janitor to the doctor, is supposed to be a "health educator"; however, it is rare that anyone in the health facility, from janitor to doctor, has had any training in health education or is able to go beyond school-marm lectures.

6. The concept, if not the practice, of community participation has been warmly embraced by the Ministry. The Ministry would like to add another layer at the bottom of its pyramid: the informal health sector. The idea, essentially, is that the community will help the Ministry in carrying out its programs. It is repeated form the upper ministerial level to the health post auxiliary: we will organize them, to help us help them. To this end, doctors and auxiliaries are expected to "organize the communities" - specifically, to form health clubs and mothers' clubs. In accordance with Ministry performance norms (How many clubs did you organize?), these are then created, irrespective of other forms of community organization. This system overlooks the obvious: campesinos rarely need or want "organization"; what they do want is resources. When these clubs offer something concrete, e.g., leche avena, then they function; when they do not, they are paper fictions, operating to maintain stable status quo relations with the Ministry.

D. Possibilities for AID Action.

1. Goodies.

It is probably worth mentioning that what the Ministry wants- or at least what one hears repeatedly while cast as a potential AID Santa Claus - is material support to complement the BID infrastructure loan, i.e., jeeps, radio communications systems, health post furnishings, and salary support.

The scarcity of jeeps is especially painful to middle level administrators who feel they can hardly be expected to carry out their burdensome responsibilities for control and supervision without suitable transportation.

2. Management training.

Almost all MOH administrators are doctors, who lack training in health administration (as well as in public health). Several persons suggested that a management training program might be useful, especially if it were carried out with emphasis on problem-solving and upgrading of services at the village level.

3. Training, Support, and Re-Training for Auxiliary Nurses.

That the field auxiliaries need training and support is something that nearly everyone can readily agree on. The Boston University curriculum project is certainly a step toward increased AID involvement in this area. A project such as the one suggested in Ref. Doc. 10 might be included as a phase in the Population Project (CBD through the GOE, Ref. Doc. 09) or it might be proposed separately.

4. Health Promoters.

Various health promoter experiments are underway or are being discussed or proposed within the MOH. The most ambitious of these is a health promoter training project which is being done in conjunction with FODERUMA (see section VI.). The health promoter is an idea whose time appears to have come within the MOH, and encouraged by the success of the CVRs (training program for traditional midwives), it is likely that a fairly extensive program will be launched within the next few years. The use of health promoters is proposed as phase two of the population PID (Ref. Doc. 09) described herein; and given AID's broad institutional experience in this area, it is likely that a strong project could be developed. On the other hand, I saw little evidence that the MOH has the sensitivity or skill in community organization to effectively launch such a program. For the most part, its relations with the communities are weak and artificial, and such a project could well devolve into an expensive learning experience.

V. The Campesino Social Security Program (SSC) of the Ecuadorian Social Security Institute (IESS)

A. Introduction

The Campesino Social Security program is a small, semi-autonomous program within the larger Ecuadorian Social Security Institute. It is not affiliated with the Ministry of Health. The purpose of SSC is to extend primary health care services and minimal social security services. This target group - the rural poor - comprises most of the population of rural Ecuador.

SSC is an impressive program because, on first glance at least,* it seems to work. It provides surprisingly broad, high quality services which are cheap to the consumer, and as a program, cheap to operate. Community participation is not an ideal, it is the the practical basis of the program and the key to its success. With only a little imagination, it is easy to see that SSC has great potential for preventative as well as curative health care and is a natural take-off point for more ambitious community self-help development programs.

B. Services Provided by SSC.

In order to participate in the SSC program, a village must organize itself legally and functionally into a comuna**; it must contribute some funds and all the labor in the construction of a health dispensary; each participating family must pay a membership premium of 73¢ per month; and the community must help manage and continually support the program.

In return, the community receives the following:

1. A health dispensary.

   The community provides the site, locally available construction materials, some cash, and all the labor. SSC shares costs,

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* These impressions are based on interviews with SSC in Quito and site visits to three SSC dispensaries (health posts) in Manabí and four in Cotopaxi. Three of the seven are Indian communities. Ministry of Agriculture extension agents and other unaffiliated village-level workers were also interviewed.

** A comuna, which sometimes refers to a traditional form of communal landholding, is used here in its more modern legal sense, i.e., a community, smaller than a parroquia, which is legally organized and governed by a cabildo and recognized by the Ministry of Agriculture.

provides construction specialists, and supplies heavy construction materials and materials not locally available. Typically a community starts with a rustic dispensary, e.g., a couple of vacant rooms attached to the church, and gradually upgrades and then replaces it with a modern dispensary.

2. A graduate doctor, i.e., one who has completed his year as a medico rural.

The doctor usually lives in the provincial or canton capital and commutes to the village two or three times per week. The number of his weekly visits is based on demand.

3. An experienced (if not necessarily well trained) auxiliary nurse.

She lives in the dispensary, and perhaps unfairly to her, is on-call virtually 24 hours per day.

4. The dispensary is well-stocked with basic medicines, medical apparatus and instruments, reagents for simple lab tests, vaccines, and contraceptives.

5. Dental care, starting this year, is being offered in some facilities. It is expected that dental service will be expanded.

6. Financial assistance is provided to member families to help cover funeral costs.

7. Modest retirement benefits are provided to the head of household (after five years of participation in the program) and modest benefits in case of accident or disability.

8. Diapers are provided free to mothers of newborns.

9. A leche avena program is provided in some facilities and will be expanded.

10. Member families are guaranteed all hospitalization, lab tests, x-rays, special medications, and care by medical specialists in regional IESS facilities. All fees are covered for all members of participating families.

All elderly dependents and all children under 18 in participating families are covered for the participation premium of 73¢ per month. What they receive amounts to the equivalent of adequate health insurance and minimal retirement benefits and workingman's compensation.

C. Size Growth, and Geographic Distribution of the Program.

The larger IESS, of which SSC is a small part, is one of the largest and most powerful institutions within Ecuador. The total IESS budget in 1976, for example, was about 30% larger than the Ministry of Health. This budget is derived entirely from worker and employer contributions on wages.

IESS was given authority to intervene in health in 1945. At that time it began to build the middle and working class oriented urban health infrastructure that is today the basis of the social security health program. Althouth its national role has somewhat declined relative to the MOH, the social security system is still a major provider of health care in the country.

The SSC program was established by decree in 1963. Its first dispensaries began operation in four communities in 1968. As such, it pre-dates the MOH and it certainly pre-dates the MOH in its involvement in the rural area. Theoreticlaly, SSC and MOH activities in rural health are coordinated, in part through the National Planning Board. By the end of 1979, SSC will be providing services to nearly 100,000 participating individuals. The ten-year growth of SSC is shown in the chart on page The 60 units that are now operating are distributed fairly evenly geographically; this is shown in the chart below.

Coverage of SSC by Province*

Province	# Dispensaries	# Communities
Carchi	2	10
Imbabura	8	14
Pichincha	9	12
Cotopaxi	5	12
Tungurahua	5	15
Chimborazo	8	36
Azuay	2	3
Loja	2	3
Manabi	10	12
Guayas	5	10
Napo	3	10
Galapagos	1	1
Los Rios	1	1

Provinces without SSC coverage: Bolivár, Canar, Esmeraldas, Pastaza, Morona Santiago, and Zamora Chinchipe.

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* For a more complete listing, i.e., specific comunas, parroquias, contones covered by SSC and dates of incorporation, see Ref. Doc. No. 12.

Ten-Year Growth of SSC

Year	Number of Dispensaries	Number of Communities	Number of Affiliated Families	Number of Persons in Program	Number of Medical Consultations
1968	4	4	611	2,523	1,608
1969	4	4	536	2,696	5,888
1970	4	4	514	2,669	6,963
1971	4	4	637	3,124	6,582
1972	4	4	630	3,077	6,116
1973	12	14	1,660	8,251	7,905
1974	18	31	3,129	16,344	23,329
1975	37	83	8,445	44,291	45,322
1976	44	111	10,552	54,496	64,568
1977	59	143	13,668	71,878	81,344
1978	60	156	13,637	72,928	97,412

TOP TEN CAUSES OF MORBIDITY BY AGE GROUPS

Ranking	1 year	2-5 years	61-14 years	15-44 years	45 & up	ALL AGES
1.	Enteritis y otras enfermedades diarreicas	Enteritis y otras enfermedades diarreicas	Todas las demás enf. clasif. como infecciosas y parasitar.	Todas las demás enf. clasif. como infecciosas y parasitar.	Otras enfermedades del aparato genito urinario	Todas las demás enf. clasif. como infecciosas y parasitar.
2.	Influenza	Todas las demás enf. clasif. como infecciosas y parasitar.	Infecciones respiratorias agudas	Influenza	Artritis y espondilitis	Influenza
3.	Bronquitis Enfisema y asma	Bronquitis Enfisema y asma	Influenza	Otras enfermedades del aparato genito urinario	Todas las demás enf. clasif. como infecciosas y parasitar.	Enteritis y otras enfermedades diarreicas
4.	Infecciones respiratorias agudas	Infecciones respiratorias agudas	Síntomas y estados morbosos mal definidos	Infecciones Respiratorias agudas	Síntomas y estados morbosos mal definidos	Infecciones Respiratorias agudas
5.	Todas las demás enf. clasif. como infecciosas y parasitar.	Influenza	Enteritis y otras enfermedades diarreicas.	Síntomas y estados morbosos mal definidos	Influenza	Bronquitis Enfisema y asma
6.	Otras enfermedades de la piel y del tejido	Infecciones de la piel y del tejido celular subcutáneo	Bronquitis Enfisema y asma	Otras enfermedades del S. N. y de los órganos de los sentidos	Otras enfermedades del S. N. y de los órganos de los sentidos	Síntomas y estados morbosos mal definidos
7.	Síntomas y estados morbosos mal definidos	Síntomas y estados morbosos mal definidos	Infecciones de la piel y del tejido celular subcutáneo	Enteritis y otras enfermedades diarreicas	Enteritis y otras enfermedades diarreicas	Otras enfermedades del aparato genito urinario
8.	Avitaminosis y otras deficiencias nutricionales	Enfermedades inflamatorias del ojo	Enfermedades inflamatorias del ojo	Bronquitis Enfisema y asma	Bronquitis Enfisema y asma	Otras enfermedades del S.N. y de los órganos de los sentidos
9.	Infecciones de la piel y del tejido celular subcutáneo	Sarampión	Fiebre paratifoidea y otras Salmonelosis	Otras enfermedades del S.Osteo-muscular y tej. conjunt.	Otras enfermedades del S.Osteo-muscular y tej. conjunt.	Infecciones de la piel y del tej. celular subcutáneo
10.	Otras enfermedades del aparato digestivo	Otras enfermedades de la piel y del tejido celular subcutáneo	Anemias Otras enfermedades de la piel	Enfermedades inflamatorias del ojo	Infecciones respiratorias agudas Reumatismos no articulares y no espe[illegible]	Enfermedades inflamatorias del ojo

Note: based on diagnoses of medical consultations made at dispensaries

Growth and Indicators of Medical Services by SSC, 1968-1978

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
1968	1.608	0.64	-	-	$2.49	33	6.36	-	-	-
1969	5,888	2.18	-	7.5	$1.63	135	8.26	-	50.1	32.3
1970	6,963	2.58	-	5.2	$1.96	162	7.20	-	60.0	31.1
1971	6,582	2.11	-	5.1	$2.45	193	6.72	-	61.8	-
1972	6,116	1.99	-	6.1	$2.63	192	6.95	$35.65	62.4	17.5
1973	7,905	0.96	1.4	4.7	-	168	6.07	-	20.04	6.7
1974	23,329	1.43	1.5	5.0	$5.19	439	8.38	$70.38	26.9	5.3
1975	45,322	1.02	1.6	5.5	$4.16	811	7.94	$48.68	18.3	3.2
1976	64,568	1.18	1.6	5.2	-	952	7.85	$62.35	17.5	2.9
1977	81,344	1.13	1.7	-	$5.90	930	10.07	$86.15	12.9	1.2
1978	97,412	1.34	2.0	4.6	-	864	11.41	$77.02	11.8	1.3

Key: Column (1) - Year
Column (2) - Number of Consultations
Column (3) - Average Number of Visits per Persons Covered
Column (4) - Average Number of Visits by persons who visited at least once
Column (5) - Medical Consultations per hour
Column (6) - Cost of Consultation to SSC
Column (7) - Number of Hospitalizations
Column (8) - Average Number of Days in Hospital
Column (9) - Cost to SSC per Hospitalization
Column (10)- Rate of Hospitalization/1000
Column (11)- Rate of Birth/1000 in Hospital

In general, the kinds of morbidity that are treated by the SSC are the "morbidity classics" of rural Ecuador -enteritis, influenza, parasitosis, upper respiratory tract infaction, etc. This is shown in the chart on page 34, "The Ten Leading Causes of Morbidity by Age Group," which is the results of an analysis carried out by SSC on disease syndromes actually treated at the dispensary level by medical personnel.

The growth and measures of use of medical services is shown on the chart on page 36 . It will be seen in the chart that the average number of visits (Column 3) has seemingly varied in an inconsistent way - undoubtedly a result of starts and jumps in the extension of services. However, the average number of visits by persons who have visited the dispensary at least once (Column 4) has gone up steadily, from 1.4 in 1973 to 2.0 in 1978, suggesting a steadily growing acceptance by members. SSC tries to deploy personnel according to demand and level of training required. In other words, the auxiliary nurse "does most of the work" because most campesino health needs are accounted for by a few endlessly repeated but uncomplicated to treat disease syndromes. The doctor is there for what the nurse can't do; and the hospital is there for what the doctor can't do. As the dispensaries have become better equipped and supplied with medications, the doctor is able to use his consultation days for the more seriously will patients. This is reflected by the decrease in the number of medical consultations per hour (Column 5), from 7.5 to 4.6. The doctor handles more serious problems than he used to; but what he can't handle he refers to the hospital. This increasingly selective use of the hospital is reflected by the substantial decline in the rate of hospitalization (Column 10), from 50.1/1000 to 11.8/1000 and a corresponding ear doubling of the average number of days per hospitalization (Column 8), from 6.36 days to 11.41 days. Similarly, in regard to birth, SSC believes that if women are well cared for during the pre-natal period, there is usually no need for hospitalization - which is, of course, consistent with a widespread cultural preference for home births. Column 11 shows that the rate of hospital-attended births has declined from 32.3/1000 to 1.3/1000.

Both the priorities and the actual day-today work of the health post auxiliary is reflected in the following charts:

Major Auxiliary Nurse Activities, 1978

# Injections	# Treatments	# First-Aid Applications
117,271	27,846	69,156

Well-Child Consultations, 1978

Age in Yrs	1st Visit	Subsequent Visit	Total
1	3,207	1,331	4,538
2-5	2,188	2,171	4,359
6 &+	1,809	1,854	3,663
TOTAL	7,204	5,356	12,560

Maternal Care, 1978

	1st Visit	Subsequent Visits	Total
Pre-Natal	1,136	2,323	3,459
Post-Natal	836	1,085	1,921
Family Planning*	478	1,657	2,135

Place of Attended Births/Abortions, 1978

	Home	Dispensary	Referred to Hospital/Clinic
Births	508 (66%)	182 (24%)	78 (10%)
Abortions	56	48	37

* In regard to family planning, the SSC is positive, if not zealous. A family planning component was incorporated into the program on the basis of a felt-need, not because of AID prodding or the availability of funding. The present goal of 5% of fertile age women as new acceptors is not viewed as a maximum, but as a beginning. It is expected that targets will go up as coverage goes up. It does not appear likely that family planning, or opposition to it, will develop as a significant political issue within SSC.

D. Community Participation

Perhaps it is an anthropologist's bias, but what is striking about SSC is not just the breadth and relative quality of its services but the extent to which these services are directly dependent upon the participation of the communities served.

A SSC dispensary is built with a substantial cash investment (frequently $2,000 or more) and literally thousands of person hours of donated community labor. 73¢ a month is not merely a token payment to most campesino families; it's felt.* As a result, the community takes a proprietarial interest and managerial responsibility for the dispensary - that is - "We built it; we pay for it; and damnit, it's ours."

In one Highland Mestizo town, where the Ministry of Public Works arrived to summarily announce that the dispensary would be torn down for a new road, the town immediately united for formal protests to the Ministry. When protests failed, four community members offered to donate new sites. In meetings it was decided that a new dispensary would be built to double as a communal meeting house. SSC's role, at that point, was to send an engineer to evaluate the four sites and make a cost estimate (about $7,000 for the complete structure). It was then decided how much SSC would contribute and how much the town would bave to raise. As the road construction now draws nearer, the town is working to develop its building fund.

SSC will not operate a dispensary - nor can it - if it does not have sustained input from the community. The town, represented by the cabildo, must have a formal structure which takes responsibility for the dispensary. If the auxiliary has a problem, she is expected to take it to the cabildo, not the SSC. It is understood that she is an employee of both the town and SSC. The treasurer of the cabildo, not the auxiliary, is (usually) responsible for collecting the 20 sucre a month premium and depositing it with the regional office of IEES. If lights don't work or water is flooding the examining room, it is the president's job to do something about it.

In all communities visited there was ample evidence of active participation by the communities. All the cabildos meet at least monthly - and more often, especially in the Indian communities - to discuss the dispensary and dispensary-related projects. Most communities have mothers' clubs, church groups,

* $8.76 a year (73¢ x 12) on a $300/year income would be equivalent to $438 a year on a $15,000/year income (but is not taking into account the greater elasticity of a $15,000/year income).

or social clubs associated with the dispensary. All the communities reported regular mingas (days on which everyone shows up to work on a community improvement project). Two communities with active construction projects underway reported mingas two or more times a week (including an Indian hacienda community which had never had a minga prior to SSC).

Building and managing the dispensary help forge the cabildo into a more pragmatic, action-oriented organization. With SSC and Ministry of Agriculture support, three communities reported success in obtaining a village school or additional school teachers from the Ministry of Educaiton. One community was assigned a paid Ministry of Education teacher to take over an adult literacy class which had been started spontaneously by an SSC auxiliary. Every community visited had projects, at least under discussion. Five of the Seven communities mentioned some kind of water project -- potable water, installation of pumps, wells, tubing, repair of abandoned Misión Andina pumps, irrigation. Several communities were involved in latrine projects. In some cases this involved creation of a special latrinization fund, contact with CARE, requests and contacts with IEOSS, or informal "latrine demonstration projects" by village leaders at the prodding (in one case at least) of the auxiliary nurse. The role of SSC in these projects varies with the enthusiasm and organizing skills of the auxiliary and the doctor, and with their acceptance by the community. In some cases the auxiliaries are passive, limiting themselves to injections and first-aid on demand. In other cases they are somewhat like Peace Corps volunteers - pushing innovations, calling meetings, helping with paperwork, and acting as advocate for the community to gain access to government services. The doctor, depending on his time and interest, helps out.

Communities raise money for projects in many ways. In one case (an Indian community), a portion of the cash from communal crops was set aside for cabildo-dispensary projects. The same town provides a small fund to help families who can't manage or get behind on their 73¢ monthly payment. In another town, a woman's club sold seedlings to the community members, thus attempting to upgrade community nutrition and to raise a small amount of money for dispensary accessories. Several communities have added surcharges to the monthly premium (usually about one to five additional sucres) for maintenance or building funds. Another town, in violation of SSC rules, has imposed a 10 sucre (36¢) medical consultation fee in order to bolster its building fund.

In most cases the communities appear fairly effective in monitoring the performance and attendance of the doctor and the auxiliary. In one case where an auxiliary refused to treat members of a family with whom she was feuding, a complaint was

made to Quito, which brought an immediate reprimand. In only two communities were there dispensary complaints about excessive slowness or inadequacy of supply of drugs (for this study, an experienced Peace Corps R.N. confirmed the suitability of the drugs-on-hand to handle the normal range of campesino medical needs). In only one community were there complaints about the doctor not fulfilling his assigned hours (having just completed the 1 1/2 hour ride on an all-but-inaccessible road, I was sympathetic). In no cases could I detect - nor do I believe exist - cases of illegal private practice by SSC doctors or under-the-counter sale of medicines. Control over medications is so tight, in fact, that two auxiliaries complained that the assistant director of SSC (who regularly visits and is well known in all the communities I visited) had personally made them pay for and replace medications that they had allowed to expire.

E. Financial Aspects

The total 1979 SSC budget is $1.35 million - about 1-2% of the total IEES or MOH budgets. It would be interesting to analyze the relative investments in rural health by SSC and the MOH, but adequate comparable data were not obtained during this study.

SSC estimates that 97.5% of its operating expenses are provided by its annual budget allocation and 2.5% are provided by the monthly premium paid by campesino member families. (My own calculations indicate that 73¢ per month multipiled by 13,637 member families should account for about 10% of the SSC budget.) By way of comparison, about 90% of the MOH budget comes from the national treasury and the remaining 10% from fees for services, bonds, or other charges.

SSC funds are allocated by the Ministry of Finances from IESS revenues, which are largely produced by worker and employer contributions from urban wsge earners. Since SSC does not have the potential to become self-supporting, as are other social security programs, nor can it draw upon national treasury revenues, as does the MOH, it is in a weak and vulnerable position in regard to financing.

From an operations point of view, SSC appears remarkably, and admirably, "bottom heavy." Its central office in Quito is small, unadorned, and minimally staffed. Nearly all of its budget can be accounted for by the costs of direct services to campesinos.

In order to gain some perspective on the cost factors involved in operating SSC, the following cost breakdown shown on page was made for a single "typical" village dispensary. The figures were put together from mostly reliable and some "guesstimate" SSC data.

Breakdown of Costs for an SSC Dispensary: Start-Up Year and Operating Year

	Start-Up Year		Operating Year	
Central Office (Quito)				
Admin. Overhead	$1,700	(1,700)	$1,700	(1,700)
Despensary Personnel				
Doctor	2,500		2,500	
Dentist	800		800	
Auxiliary	1,800	(5,100)	1,800	(5,100)
Dispensary Costs				
Construction	5,500		---	
Maintenance & Improvement	---	(5,500)	1,100	(1,100)
Equipment				
Furniture	2,100		---	
Medical Instruments	1,600		---	
Dental Equipment	1,200		---	
Dental Instruments	300		---	
Audiovisual Equipment	200		---	
Replacement Costs	---	(5,400)	200	(200)
Medications				
Drugs	5,200		5,200	
Disposable Medical Supplies	400		400	
Disposable Dental Supplies	300		300	
Materials for lab tests	20	(5,920)	20	(5,920)
Infant Diapers	900	(900)	900	(900)
Purchased Services from IESS				
Lab Tests	200		200	
X-ray	100		100	
Hospitalizations	1,500		1,500	
Fees to Medical Specialists	100	(1,900)	100	(1,900)
Retirement Benefits (Only after 5 yrs membership)	---		---	
Funeral Expenses	50	(50)	50	(50)
Miscellaneous & Unforeseen Expenses (10%)	2,647	(2,647)	1,687	(1,687)
TOTAL	$29,117		$18,557	

Note that:

60 operating units (in 1979)	X $18,557 (operating costs/year)	=	$1,113,420
12 new units (projected for 1979)	X $29,117 (start-up year costs)	=	$ 349,404
			$1,462,824

In other words, $1.46 million would be the theoretical SSC budget for 1979 if these figures are approximately correct. In fact, the actual budget is $1.35 million, which is fairly close (and closer if dental costs are calculated more accurately).

This breakdown provides an approximate indicator of how the SSC budget is used. What it suggests is that most of the funds that SSC manages reach the campesino in a direct and concrete fashion - and are then "multiplied" by the labor, matching funds, and management contribution of the cabildo. If there is significant waste, it is hard to see where it might be. The Central Office, which appears to administer the program admirably well, accounts for only about 8.4% of the total budget ($1,700 X 72 units = $122,400). An impressive figure - particularly if one compares it to, say, the administrative overhead of a typical U.S. consulting contract or AID project.

F. Weakness of the Present Program

1. Ineffective in preventative health care

SSC is convinced that it must substantially expand its program in preventative rather than curative health, if it is to have a real long-term impact on community well being. In most villages, the most tangible step toward preventative health is sanitary infrastructure, specifically latrines adn potable water. In their absence, charlas on hand washing have little practical impact. The agency with major responsibility for installation of sanitary infrastructure in rural Ecuador is IOES (Instituto Ecuadorinao de Obras Sanitarias, a semi-autonomous agency that is technically under the jurisdiction of the MOH). To date, SSC relations with IEOS have not been particularly productive. At the national level SSC has not been able to establish close working relations. At local levels, contacts are personal and greatly dependent on whim. As a result, SSC has not been able to dependably help its member communities carry out the sanitary infrastructure projects which they uniformly identify as priority need.

2. No health promoter program.

Similarly, SSC is committed in principle to the extension of services through village health promoters; and certainly it is in a strong position to do so. As a basis for a

health promoter program, SSC is in many respects ideal. Nevertheless, to date, SSC has found neither the funds nor the administrative personnel to launch a program. There is hope of utilizing promoter graduates from the proposed FODERUMA-MOH promoter project, but as yet contacts have not been made with these two institutions.

3. Funding Insecurity

Funding for SSC is unsure, and apparently represents an annual trauma. The program has received no outside assistance and is completely dependent on what it considers to be the whim of the Ministry of Finances and the parent-IESS. Since SSC is not self-supporting, it represents a drain on the IESS, which is an institution based on the principle of self-maintenance. As a subsidized program, it is necessarily in a weak competitive position for funds. For this reason, it has been difficult for SSC to do long-term planning. It may have an inherent financial constraint on the size to which it can expand, and accordingly, the magnitude of national coverage which it can expect to achieve.

4. Health Education

Programs, in health education have been especially weak - in fact, nearly non-existent. Because of lack of funds there are virtually no films, posters, pamphlets, projectors, and training materials. Materials in use have largely been received through the MOH. There are no "health educators," as there are in the MOH, and village auxiliaries have received no special training in community health education. Doctors are expected to involve themselves in health education, when there are no patients. Auxiliaries are expected to give talks to mothers' clubs and community meetings and to do home visits.

5. Dependency on the MOH and Potential for Conflict and Incorporation

Because its own resources are so limited, SSC depends on the MOH for educational materials, contraceptives, leche avena, and some vaccines and medications. To date, there has been little conflict between SSC and MOH, largely because SSC has served a target population that the MOH has been unable to reach. As MOH continues to expand into the rural areas it is probable that competition will arise, and that the MOH, claiming authority and seeking hegemony in the rural area, will attempt to absorb SSC. Because SSC is not a classic social security program, i.e., it is not self-supporting, it will have little leverage in defending its autonomy and may not be strongly supported by the IESS. Whether or not such incorporation is a good

idea depends ultimately on whether or not the MOH can replicate on a large scale the apparent efficiency and quality services that SSC is able to deliver on a small scale. The SSC may reappear reincarnated in the MOH; it may altogether disappear; or it may maintain itself in an uneasy perpetual stand-off with the MOH.

6. Lack of contact and coordination with other institutions
Although admirable the extent to which SSC focuses its attention directly on the campesino, it is also conspicuous that the program has little contact and coordination with other institutions. This includes international agencies, i.e., PAHO, AID, BID, as well as local Ecuadorian institutions, i.e., IEOS, Ministry of Agriculture, Ministry of Education, FODERUMA, etc. SSC could greatly strengthen its services - and probably help solidify its own institutional position - by expanding its contact with these agencies. In particular, FODERUMA (briefly described in Section VI and Ref. Doc. 14) is an institution similarly dedicated and well adapted to direct sercices to campesinos. A joint SSC-FODERUMA project would appear to be "a natural" (one such idea is presented in Ref. Doc. No. 13).

G. Possibilities for AID Action

1. Further study
The present study was done in a rapid and ad hoc fashion. The ten-year experiment of SSC deserves a better study - not only to further investigate possibilities for AID action but as a model for effective delivery of health services to the rural poor. In particular, the cost factors and socio-bureaucratic organizational features of SSC merit much closer analysis. It would be interesting, for example, to compare cost factors and output of SSC, the rural health program of the MOH, and a private program such as the missionary clinic in Colta. It would be interesting to try to examine the "multiplier" of community participation in a more quantitative fashion and to examine the incentives which encourage real rather than paper participation by the community. And finally, the question of scale should be addressed, i.e., to what extent does SSC work precisely because it is small, and the applicability of SSC lessons to other institutions, especially the MOH.

2. Small-scale support for upgrading of programs.
An OPG, possibly, for overcoming certain obvious weaknesses in the present program, e.g., lack of educational materials, projectors, family planning materials, etc.

3. Extension of coverage
At the present time the major constraint to extension of coverage is budgetary. AID could assist in expanding the number of operating units, possibly supporting these new units with special family planning or nutrition services.

4. An integrated rural health/rural development project
Such a project might involve SSC and FODERUMA (as suggested in Ref. Doc. No. 13) or it might be designed in numerous other ways. The key to such a project would be to use the organizational and project base which SSC establishes in a community as a take-off point for other kinds of community-level self-help projects.

5. Involvement in population project or auxiliary nurse training project
SSC might easily be included in the population project proposed in the PID (see Ref. Doc. No. 09) or in an auxiliary nurse training project (Ref. Doc. No. 10).

VI. Community Development

A secondary objective of this consultancy was to provide assistance to the Mission in the general area of community (agricultural) development - more specifically, ideas on how to reach campesino communities with information, projects, and new technology.

Aside from minor editorial assistance on the proposed Technological Access Networks PID and the speculative possibilities of an SSC-based community development project, the major inquiry of this phase of the consultancy was FODERUMA (The Fund for Campesino Development).

FODERUMA is a special credit fund established within the Central Bank which has as its objective massive and direct transfer of capital (mostly petro-dollars) directly to the campesino.

To do so, FODERUMA has devised a "methodology" which is either brilliant or naive. Working with a near-skeleton staff in Quito, FODERUMA makes it known to campesinos that it will provide loans or direct grants to poor communities, with practically no paper work, waiting, or credit guarantees. More or less, the community identifies a project and FODERUMA provides the money to do it.

FODERUMA dogmatically insists that campesinos are the best (and only) experts in their own communities; and accordingly, it disdains technicians and feasibility studies. Essentially, FODERUMA believes that communities know their own needs and can manage their own programs, that experts and administrators drain rather

than generate resources. If the project is such that campesinos can't do it themselves - or can't do it with the help of technicians whose need they identify - then the project is wrong. Success for projects rests on campesinos wanting to get things done. For the most part, the imperative to repay a loan or carry out a project is a moral commitment (de confianza) there are few legalistic or bureaucratic controls. If that doesn't work, says FODERUMA, at least it is better than the money be wasted by campesinos than be Quito bureaucrats and foreign consulatnts.

FODERUMA has now been implementing projects for less than a year. About 60 projects are underway. Most projects are in a $10-20,000 range. Some are much smaller (elders in primitive Indian groups in the Amazon basin teaching youngsters how to make and play traditional musical instruments). Some projects - the project around Guamote, for example - are mini-regional development projects. Other projects are being planned in conjunction with government institutions, e.g., the MOH. The idea is to start small with community projects and let the community build upon them as it develops skills and experience.

The concept is a challenging one, for it implicitly disputes much of the conventional wisdom underlying traditional development projects. But is it too esay ananswer? a somewhat romantic and pleasingly cynical notion that offers a cop-out on all-too-real problems?

To answer this question, one would want to know a great deal more about FODERUMA. What kinds of projects do communities identify? Do these projects run contrary to expert-identified projects, e.g., Would a campesino community, for example, choose to cut trees for agricultural expansion where a forestry specialist might advise tree planting? Who in the community does "the community" represent? On what basis does FODERUMA accept/reject projects? Are loans repaid? Are project objectives achieved? How does FODERUMA interact at the grassroots level with other government agencies.

The Mission has considerable interest in questions of this sort, and for this reason (and with an eye for future technical assistance), it was proposed to FODERUMA that an Ecuadorian economist and I carry out a brief field and desk study of three or four ongoing projects. After initial approval, and then delays, the request was turned down by FODERUMA. At this writing, the actual internal reasons that the study was turned down are not known (the short formal letter simply stated that the study did not conform to FODERUMA's "methodology"). The best guess is that lower level staff, who are mostly recent university graduates

and politically left young intellectuals, vetoed the study after it was presented to them. They distrust the U.S., particularly AID which is invariably associated with CIA. It is probable that they viewed the study as a possible spy attempt, or more likely, they feared their credibility with campesinos would be undermined by association with AID. Rather than risk a conflict with its field staff, the upper level officials, who doubtlessly do not share these fears and had initially approved the study, then turned it down. since FODERUMA appears well supported by the Central Bank and has already stirred considerable interest among international donor agencies (it had just signed a large intermediate technology project with UNDP), there was no reason to run needless risks.

FODERUMA is a fresh idea, and it is worth some pursuit. The Mission will undoubtedly continue its efforts at (r)aprochement Justifyably so. New ideas are rare, and this one has enough novel aspects that it merits further exploration. In initially approaching FODERUMA, it may have been an error to have proposed a general study which appeared to them as a look-see exercise. For this reason it is suggested that when/if a second approach is made, it be done in the context of a specific project proposal, e.g., AID interest in a health project or development of a specific province.

VII. Summary

The purpose of this consultancy was to assist the Mission in project development in family planning, rural health, and to a lesser extent, community (agricultural) development. The findings in the report are based on extensive interviews with GOE authorities and 2,000 miles of direct field observations in the Highlands provinces of Chimborazo and Cotopaxi and the coastal province of Manabí.

The population/family planning situation in Ecuador is reflected by its growth rate of 3.2% per year, the highest in South America, and a MOH allocation for family planning of .08% of its 1979 budget. In response to the question, Is it sensible to promote family planning in the apparent absence of strong MOH support, the following observations were made:

1. The Vice President-elect, Osvaldo Hurtado, who is expected to play a key role in policy formation in the new administration, has publically supported the notion of restricted population growth, and a policy shift may be in the offing.

2. The new Four-Year Plan of the MOH shows an upgrading of family planning.

3. Family planning is now more or less installed at the field level; to some extent, it is now in the hands of women, i.e., auxiliary nurses and women users, and thus the worst hurdle has probably now already been overcome.

4. It is to be expected that the AID family planning image will be reduced in coming years as AID activities in other sectors becomes more visible.

5. Many of the "differences" between AID and Ecuadorian positions on family planning are semantic.

An interesting study is Manabí. Manabí, a coastal province, has an MOH jefatura which appears to be making a genuine effort in family planning. Upper-level health officials undoubtedly support family planning. Contraceptives are available at every level of health facility. In 1977, doctors devoted 13.18% and nurses devoted 10.4% of their well-patient consultations to family planning. The health education program, which is probably the largest and most ambitious in the country, is particularly active in family planning. Nevertheless, even when trying, the MOH has been successful in attracting only a miniscule number of users - about 1.5% of the fertile age female population.

Why? The constraint is very likely not demand, since drugstore sales are reasonably high and the Armed Forces family planning program, with a single clinic, is successful in attracting users. Based on field observations, the reason is more likely low level of quality and lack of acceptance of MOH family planning services. Reasons for this include: (1) condescension and boredom on the part of health post personnel, (2) forced teaching to captive audiences, (3) shame/embarassment (verguenza/pudor) on the part of women users, and (4) time loss and waiting associated with a health post visit.

These same factors also constrain family planning in the Sierra, only they are exacerbated because (1) MOH coverage is far thinner in the Sierra, (2) there is less inherent demand for family planning, and (3) formidable cultural barriers separate the white MOH from the predominately Indian target population.

No judgement is made here on the effectiveness or the potential for the non-MOH family planning delivery institutions, e.g., CEPAR, APROFE, etc. Superficially at least, all appear serious and effective within their limited geographic areas or delivery styles. No centralization-consolidation effort is proposed.

A Five-Year Population/Family Planning Strategy is presented, which consists of a series of conceptually, if not administratively linked projects, which are to be carried out through bilateral agreement with the government, through intermediary organizations, and through the private sector. Specific components of the strategy are:

1. TO STRENGTHEN AND BROADEN THE SUPPLY INFRASTRUCTURE

1.1. Install (through CEPAR) a community-based distribution program in the province of Manabí, which is to be extended to Azuay and other provinces.

1.2. Strengthen the delivery of rural health services through the MOH and social security system, especially by training and supporting field auxiliary nurses. support the formation of a network of community-level health promoters; and through the network, encourage a system of community distribution of contraceptives and educational materials.

1.3. Initiate a program, to be expanded to the national level, of private commercial distribution of contraceptives. This implies the creation of a low price, brand name contraceptive(s) to be distributed throgh drugstores, and if feasible, other commercial outlets.

1.4. Expand the training project of midwives.

1.5. Expand the training project of obstetricians and gynecologists

1.6. Train drugstore owners and employees in family planning

1.7. Continue to support contraceptive distribution through programs of APROFE, CEPAR, and CEMOPLAF.

2. TO GENERATE INCREASED DEMAND FOR FAMILY PLANNING SERVICES.

2.1. Carry out an Information-Education-Communications project which will produce a high volume of materials in health and family planning. These will be disseminated widely in the rural, especially Indian, and poor urban areas.

2.2. Generate greater familiarity and receptivity toward family planning - as well as population issues - in the modern sector through a mass media population information project.

2.3. As part of the private (CEPAR) community-based distribution project, train family planning "motivators" who will work to educate and generate demand for services at the grassroots community level.

2.4. As part of the proposed community-based distribution project within the MOH and social security system, improve the quantity and quality of educational materials available at the health post level, and train auxiliary nurses and community health promoters in the effective use of these materials.

2.5. As part of the proposed private commercial distribution program, prepare a mass media advertising campaign to advertise the brand name contraceptive(s).

3.6. Carry out a project for the preparation of educational modules in demography and sexual education for use in public schools.

3. PROMOTE A FAVORABLE GOVERNMENT POLICY AND MEDIA CLIMATE FOR POPULATION AND FAMILY PLANNING

3.1. Carry out a population information project for opinion leaders and policy makers.

3.2. Continue informal efforts by the Mission, in dealings with Ecuadorian counterparts, to encourage and promote family planning; and to include family planning components within other projects that are being developed.

In the text of the report, the following specific projects are described and discussed: Information-Education-Communications, Population Information, Community-Based Distribution in Manabi (CEPAR), Community-Based Distribution through the GOE, Private Commercial Distribution, and Educational Modules for Demography and Sexual Education.

From a near-standing start twelve years ago, the MOH has rapidly expanded to become the major provider of health care in Ecuador. The present policy of regionalization of services, supported by a recent $9.5 million health infrastructure loan from BID, is rapidly extending, or planning to extend, services into the rural area. In the field, the following weaknesses in the rural health delivery system were observed: (1) auxiliaries are passive, undertrained, and without incentives for success-oriented performance, (2) doctors (medicos rurales) are frequently absent during their assigned hours, (3) medicines are frequently not available or are sold illegally for profit by health post

doctors, (4) many health post doctors practice private medicine illegally, (5) health education programs are weak, dependent on captive audiences, and (6) community participation, which is a Ministry goal, is superficial.

Possibilities for AID action in support of the MOH are: (1) logistical support to complement the BID infrastructure loan, (2) management training, emphasizing service upgrading at the lower levels, (3) training, support, and re-training of auxiliary nurses, and (4) a health promoter promoter project.

The Campesino Social Security Program (SSC) of the Ecuadorian Social Security Institute (IESS) is a small semi-autonomous program not affiliated with the MOH. The purpose of the program is to extend minimal social security coverage and primary health care to campesinos.

To participate in the SSC program, campesino communities must organize into a comuna; they must participate in the construction and management of a health dispensary; and member families must pay a monthly premium of 73¢. In return, the community receives: (1) help and materials to build the health dispensary, (2) a graduate doctor who visits the community two-three times per week, (3) a full-time resident auxiliary nurse, (4) an adequate and well-maintained stock of drugs and medical supplies, (5) dental care (in some facilities), (6) help to member families for burial expenses, (7) modest retirement benefits to heads of member households, (8) free diapers to newborn infants, (9) a leche avena program (in some facilities), and (10) completely paid-for hospitalizations, lab test, x-rays, special medications and treatments, and specialized medical care. There are no charges for any members of the family beyond the 73¢ per month premium.

SSC is a very small component of one of the largest and most powerful institutions in the country, the IESS. SSC began work in the rural area in 1968 with the construction of four dispensaries. By the end of 1979, there will be 72, serving nearly 100,000 persons in about 160 communities (in 13 provinces). SSC offers relatively high quality curative health services.

SSC has developed a service model which not only encourages but is dependent upon community participation. "We built it; we pay for it; it's ours" is the community attitude toward its dispensary. All communities visited during field researhc showed active participation in the dispensary and dispensary-related projects. Even more so in Indian communities. Communities share administration and act as effective monitors on the performance and attendance of the doctors and auxiliaries.

The total SSC budget for 1979 is about $1.35 million, a tiny fraction of either the IESS or MOH budgets. Almost all SSC

operating funds come from worker contributions to the IESS, not the campesino monthly premium; therefore, SSC is a subsidized social security program.

A breakdown of operating costs for a single SSC dispensary and comparison of this breakdown to the 1979 budget confirm, superficially at least, that SSC is directing a high proportion of its resources into direct services to the campesino.

Weaknesses in the present SSC program are: (1) ineffectiveness in preventative health, (2) lack of a promoter program, (3) funding insecurity, (4) weakness in health education, (5) dependency of the MOH and potential for conflict and absorption, and (6) lack of contact and coordination with other institutions.

Possibilities for AID action in support of SSC are: (1) further study, especially of cost factors and the community participation model, (2) small-scale support for the upgrading of programs, (3) support for extension of coverage, (4) an integrated rural health/rural development project, and (5) inclusion into the proposed population project or auxiliary nurse training projecg.

FODERUMA is a new community-rural development program created by the Central Bank of Ecuador. It makes loans and grants directly to campesino communities - with practiclaly no paper work, waiting, credit guarantees, or expert planning. More or less, the community identifies a project and FODERUMA provides the money to do it. A field study by the consultant of three-four actual projects was proposed to FODERUMA - and was turned down. It is recommended that the Mission continue its efforts to learn about the practical workings of the FODERUMA concept. Future contracts should center around specific project ideas, e.g., a health project.

Volume Two: Reference Documents

UNCLASSIFIED

REFERENCE DOCUMENT 01

VV EBASSIDIA25
PP RUESGT
DE RUESDI #0365 0171537
ZNR UUUUU ZZH
P R 171504Z JAN 79
FM AMEMBASSY QUITO
TO RUEHC/SECSTATE WASHDC PRIORITY 0555
INFO RUESGT/AMEMBASSY GUATEMALA 467
BT
UNCLAS QUITO 0365

17 JAN 79 15 42Z

ACTION TAKEN:
DATE:
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	ACTION	INFO
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DATE:		
INITIALS:		

AIDAC

E.O. 12065: N/A
SUBJECT: SHELDON ANNIS CONSULTANCY

REFS: (A) BAIR-DIAZ TELCON JAN 12; (B) GUATEMALA 0026

1. MISSION MOST INTERESTED IN VISIT BY ANNIS FOR APPROXIMATELY THREE WEEKS TO ASSIST MISSION IN DEVELOPING ELEMENTS OF ITS FAMILY PLANNING STRATEGY.

2. SCOPE OF WORK ENTAILS THE FOLLOWING:

A. ASSIST MISSION IN DESIGNING A STRATEGY TO PROMOTE AND STRENGTHEN AMONG GOE AUTHORITIES THE IMPORTANCE OF MORE ACTIVE FAMILY PLANNING PROGRAMS IN RURAL AREAS. SUCH STRATEGY WOULD INCLUDE WAYS TO INVOLVE POOR PEOPLE IN THE MAJOR RURAL REGIONS OF THE COUNTRY IN UNDERSTANDING THE REASONS FOR REDUCING FAMILY SIZE; WOULD ENCOURAGE AUTHORITIES IN VARIOUS RURAL SECTOR ENTITIES TO DEVELOP FAMILY PLANNING PROGRAMS; AND WOULD ENCOURAGE THE HEALTH AUTHORITIES TO FACILITATE CONTRACEPTIVE DISTRIBUTION IN RURAL AREAS.

B. ASSIST MISSION IN INCORPORATING FAMILY PLANNING COMPONENTS INTO PROJECTED ACTIVITIES IN OTHER SECTORS. THIS INCLUDES DEVELOPING WITHIN FORMAL AND NONFORMAL EDUCATIONAL PROJECTS FAMILY AND SEX EDUCATION PROGRAMS ACCEPTABLE TO ECUADOREAN EDUCATIONAL AUTHORITIES. IT ALSO INCLUDES INCORPORATING FAMILY PLANNING INTO PROPOSED RURAL DEVELOPMENT ACTIVITIES.

C. BASED ON ANNIS' EXPERIENCE WITHIN INDIAN COMMUNITIES, ASSIST MISSION IN DEVELOPING BEST WAYS TO DISSEMINATE INFORMATION (NOT ONLY FAMILY PLANNING BUT A WHOLE RANGE OF SOCIAL AND PRODUCTIVELY ORIENTED INFORMATION PACKAGES CONTEMPLATED WITHIN THE PROPOSED FY 1980 TECHNOLOGICAL ACCESS NETWORKS PROJECT) TO MARGINAL CAMPESINOS IN THE SIERRA OF ECUADOR.

3. MISSION UNDERSTANDS THAT ANNIS WILL BE AVAILABLE STARTING LATE FEBRUARY OR MARCH, AND THAT HIS VISIT WILL BE CENTRALLY FUNDED. PLEASE CONFIRM AVAILABILITY AND ADVISE ETA. THANK YOU.
GONZALEZ
BT
#0365

ACTION Hank Diaz
INFO Adm
Comptroller

EXCERPTS FROM MOH 4-YEAR PLAN

REFERENCE DOCUMENT 02

NORMS FOR HEALTH CENTER DOCTORS

SUBPROGRAMAS COMPONENTES Y ACTIVIDADES	1979 NUMERO ACCIONES	1979 PROMEDIO MINUTOS POR ACCION	1979 TOTAL MINUTOS	1979 TOTAL HORAS	19 NUMERO ACCIONES	19 PROMEDIO MINUTOS POR ACCIO
(0)	(1)	(2)	(3)	(4)	(1)	(2)
2. SALUD MATERNO INFANTIL Y BIENESTAR FAMILIAR						
2.1. SALUD MATERNA						
2.1.1. Control pre-natal						
b) Actividades directas						
- Control Pre-natal por médico						
- Demanda local		10				10
- Demanda referida		20				20
d) Visita domiciliaria por médico a embarazadas de alto riesgo		60				60
2.1.2. Atención del parto						
a) Atención del parto por médico en el hogar según demanda y norma		120				120
c) Control de Parteras Empíricas						
- Reunión con CVR para revisión y abastecimiento de maletines, revisión de técnicas de asepcia y actualización de conocimientos		15				15
2.1.3. Atención del Post-parto						
e) Control médico de la puérpera (Local y refer.)		15				15
SUBTOTAL COMPONENTE 2.1.						
2.2. REGULACION DE LA FECUNDIDAD						
2.2.2. Consulta médica (primera) para selección y prescripción del método		20				20
2.2.3. Consulta médica (Subsecuente) para control de método según norma						
- D I U		10				10
- GESTAGENOS ORALES Y OTROS METODOS		10				10
SUBTOTAL COMPONENTE 2.2.						
2.3. DETECCION OPORTUNA DEL CANCER CERVICO UTERINO						
2.3.2. Toma de muestra PAP, fijación y envío a laboratorio		10				10
SUBTOTAL COMPONENTE 2.3.						
2.4. SALUD INFANTIL						
2.4.2. Control médico de menores de un año		15				15
SUBTOTAL COMPONENTE 2.4.						
2.5. SALUD PREESCOLAR						
2.5.2. Control médico de niños preescolares		15				15
2.5.4. Control de niños desnutridos (Grado II) y referencia al C.S.H.		5				5
SUBTOTAL COMPONENTE 2.5.						

METODOLOGIA : a) Llene en la COLUMNA 1, el Número de Acciones que se calcularon en el Formulario P.S. 1.1.2. (Columna 5
b) Multiplique el dato de la COLUMNA 1 por el dato de la COLUMNA 2, y anote el resultado en la COLUMNA 3.
c) Divida el dato de la COLUMNA 3 entre 60 y anote el resultado en la COLUMNA 4.

IMPORTANTE: SUME LOS DATOS OBTENIDOS EN LA COLUMNA 4 (Total Horas) COMPONENTE POR COMPONENTE Y ANOTE EN LAS FILAS DE SU
(Estos datos serán trasladados al Formulario P.S. 1.4.2.)

NORMS FOR HEALTH CENTER AUXILIARIES

SUBPROGRAMAS COMPONENTES Y ACTIVIDADES	1979				19	
	NUMERO ACCIONES	PROMEDIO MINUTOS POR ACCION	TOTAL MINUTOS	TOTAL HORAS	NUMERO ACCIONES	PROMEDI MINUTOS POR ACCIO
(0)	(1)	(2)	(3)	(4)	(1)	(2)
2. SALUD MATERNO-INFANTIL Y BIENESTAR FAMILIAR						
2.1. SALUD MATERNA						
2.1.1. Control Pre-natal						
a) Actividades previas						
- Visita domiciliaria a embarazadas para inscripción y cita		60				60
b) Actividades directas						
- Colaboración en la consulta médica		20				20
c) Visita domiciliaria a embarazadas renuentes a control		60				60
2.1.2. Atención del parto						
a) Atención del parto en el hogar según demanda y norma		120				120
c) Control de parteras empíricas						
- Reunión con CVR para revisión y abastecimiento de maletines, revisión de técnicas de asepsia y actualización de conocimientos	11	60		11	11	60
- Supervisión de la CVR en la atención del parto (10 %)		60				60
2.1.3. Atención del post-parto						
b) Visita domiciliaria a puérperas para el control según normas		60				60
d) Colaboración en la consulta médica		15				15
SUBTOTAL COMPONENTE 2.1.						
2.2. REGULACION DE LA FECUNDIDAD						
2.2.4. Entrega de gestágenos orales y otros métodos según normas		5				5
2.2.5. Colaboración en la consulta médica		10				10
SUBTOTAL COMPONENTE 2.2.						
2.3. DETECCION OPORTUNA DEL CANCER CERVICO UTERINO						
2.3.3. Visita domiciliaria a casos sospechosos y positivos de Cáncer, para educación y referencia según normas		60				60
2.3.4. Colaboración en la consulta médica		5				5
SUBTOTAL COMPONENTE 2.3.						
2.4. SALUD INFANTIL						
2.4.1. Visita Domiciliaria para captación de menores de un año.		30				30
2.4.3. Colaboración en la Consulta médica (Incluye signos vitales, inmunizaciones y nutrición).		20				20
2.4.4. Visita domiciliaria para control de niños renu.		60				60
SUBTOTAL COMPONENTE 2.4.						

METODOLOGIA : a) Llene en la COLUMNA 1 , el número de Acciones que se calcularon en el Formulario P.S.1.1.2. (Columna
b) Multiplique el dato de la COLUMNA 1 por el dato de la COLUMNA 2, y anote el resultado en la COLUMNA 3
c) Divida el dato de la COLUMNA 3 entre 60 y anote el resultado en la COLUMNA 4.

IMPORTANTE : SUME LOS DATOS OBTENIDOS EN LA COLUMNA 4 (Total Horas) COMPONENTE POR COMPONENTE Y ANOTE EN LAS FILAS DE
(Estos datos serán trasladados al Formulario P.S. 1.4.2.)

SUBCENTRO DE SALUD:

PROVINCIA: CANTON:

CALCULO DE ACTIVIDADES, PERSONAS, CONCENT

NORMS FOR Sub-CENTER Auxiliaries

SUBPROGRAMAS COMPONENTES Y ACTIVIDADES	DEMANDA ESTIMADA SEGUN MODELO	1979						1980		
		DEMANDA ESTIMADA	% COBERTURA	Nº PERSONAS	CONCEN	Nº ACCION MED	Nº ACCION AUX	DEMANDA ESTIMADA	% COBERTURA	Nº PERSONAS
	0	1	2	3	4	5a	5b	1	2	3
- Entrega subsecuente de leche avena, hierro y vitaminas.		ACTIVIDAD CUMPLIDA EN LAS REUNIONES EDUCATIVAS A GRUPOS						ACTIVIDAD CUMPLIDA EN LAS REUNI A GRUPOS		
2.2. REGULACION DE LA FECUNDIDAD [redacted]										
2.2.1. Visita domiciliaria de información y entrega de cupones a solicitud de la madre. A.E.		ACTIVIDAD CUMPLIDA EN VISITAS DOMICILIARIAS PROGRAMADAS						ACTIVIDAD CUMPLIDA EN VISITAS PROGRAMADAS		
2.2.2. Consulta médica (1ra. consulta) para selección y prescripción del método. M.	7		100		1		P		100	
2.2.3. Consulta médica subsecuente para controlar uso de método según normas - DIU - G.O.M.	 3 4				 2 4		 P P			
2.2.4. Entrega por Auxiliar de gestágenos orales y otros métodos según normas. A.E.	4				3					
2.2.5. Colaboración de la Auxiliar en la consulta médica.	7				4					
2.3. DETECCION OPORTUNA DE CANCER CERVICO UTERINO.										
2.3.1. Visita domiciliaria para información y referencia al SCS, para toma de muestra PAP. A.E.		ACTIVIDAD CUMPLIDA EN VISITAS PROGRAMADAS						ACTIVIDAD CUMPLIDA EN VISITAS PROGRAMADAS.		
2.3.2. Toma de muestra PAP, fijación y envio al laboratorio de citología. M.	33				1		P			
2.3.3. Visita domiciliaria a casos sopechosos y positivos cáncer para educación y referencia según normas. A.E.	2				1					
2.3.4. Colaboración de la auxiliar en la consulta médica. A.E.	33				1					
2.4. SALUD INFANTIL										
2.4.1. Visitas domiciliarias para detección de menores de 1 año. A.E.	41				1					
2.4.2. Control médico de menores de un año. M.	41				3					
2.4.3. Colaboración de la Auxiliar en consulta médica: (inlcuye: signos vitales, inmunizaciones y nutricion). A.E.	41				3					
2.4.4. Visita domiciliaria para control de niños renuentes (50%). A.E.	21		100		3				100	
2.5. SALUD PRE-ESCOLAR										
2.5.1. Visita domiciliaria para captación inicial y referencia de niños de 1 a 5 años. A.E.							H			
2.5.2. Control médico de niños pre-escolares. M	149				1					
2.5.3. Control de crecimiento y desarrollo por enfermería. A.E.							H			

METODOLOGIA: a) LLENE LA COLUMNA 1 EN CADA AÑO, MULTIPLICANDO LA CANTIDAD ANOTADA EN LA COLUMNA 0 POR EL INDICE C
b) ANOTE EN LA COLUMNA 2 EL PORCENTAJE DE COBERTURA QUE ESPERA ALCANZAR HASTA LLEGAR A 100% en 19
c) MULTIPLIQUE EL DATO DE LA COLUMNA 1 POR EL DATO DE LA COLUMNA 2 Y DIVIDA ENTRE 100. EL RESULTADO
d) MULTIPLIQUE EL DATO DE LA COLUMNA 3 POR EL DATO DE CONCENTRACION EXISTENTE EN LA COLUMNA 4 Y ANOTE

PROVINCIA: CANTON:

NORMS FOR SUB-CENTER DOCTORS

SUBPROGRAMAS COMPONENTES Y ACTIVIDADES	DEMANDA ESTIMADA SEGUN MODELO	1979					1980		
		DEMANDA ESTIMADA	% COBERTURA	Nº PERSONAS	CONC.	Nº ACCIONES	DEMANDA ESTIMADA	% COBERTURA	Nº PERSONAS
	0	1	2	3	4	5	1	2	3
- Control de embarazadas en el establecimiento, según norma (incluye: Historia clínica, datos vitales, - peso, talla, observación de signos y síntomas, test de albumina y glucosa, toxoide tetánico, entrega de leche, referencia de gestantes con riesgo y referencia a C.V.R a solicitud de la madre.	47				2				
- Entrega subsiguiente de leche avena, hierro, vitaminas y educación	Actividad cumplida en reuniones de grupos						Actividad cumplida en reuniones de grupos		
c) Visita a embarazadas con riesgo o renuentes a control	23				1				
2.1.2 Atención del parto Normal a) Atención de partos normales por emergencia, en el domicilio	3				1				
b) Atención del parto normal por CVR (Ver manual de normas)						S			
c) Control de C.V.R Localizar, captar e inscribir parteras empíricas a través de visitas a la comunidad						H			
- Referir parteras empíricas para curso de adiestramiento en el nivel correspondiente.						H			
- Reunión de CVR para revisión y abastecimiento de maletines, revisión de técnicas de asepsia					1	12			
- Supervisión de la C.V.R. en la atención del parto: 10% de empíricas.	2				1				
2.1.3 Atención del Post Parto (Según normas) a) Detección de puérperas						H			
b) Visita domiciliaria para control de post parto y R.N.	43				1				
- Referir puérperas y/o RN con patología al SCS para examen médico.						H			
- Entregar leche avena hierro y vitaminas. (cada mes)	Actividad cumplida en reuniones de grupos						Actividad cumplida en reuniones de grupos		
2.2 REGULACION DE LA FECUNDIDAD 2.2.1. Promoción del programa mediante visitas domiciliarias y entrega de cupones a solicitud.	Actividad cumplida durante visitas domiciliarias programadas.						Actividad cumplida durante visitas domiciliarias programadas.		
2.2.2 Entrega de gestágenos orales y otros métodos a usuarios referidas por el SCS (1 trimestral)	7				4				
2.3. DETECCION OPORTUNA DE CANCER CERVICO UTERINO									

METODOLOGIA: a) LLENE LA COLUMNA 1 EN CADA AÑO, MULTIPLICANDO LA CANTIDAD ANOTADA EN CADA COLUMNA 0 POR EL INDICE DE
b) ANOTE EN LA COLUMNA 2 EL PORCENTAJE DE COBERTURA QUE ESPERA AL CANZAR HASTA LLEGAR AL 100% en 1983
c) MULTIPLIQUE EL DATO DE LA COLUMNA 1 POR EL DATO DE LA COLUMNA 2 Y DIVIDA ENTRE 100. EL RESULTADO AN
d) MULTIPLIQUE EL DATO DE LA COLUMNA 3 POR EL DATO DE CONCENTRACION EXISTENTE EN LA COLUMNA 4 y ANOTE E
NOTA: ESTOS CALCULOS SE HARAN EN LA MISMA FORMA PARA CADA AÑO.

FORM. P.S. 1.1.3.	Pág. 3
CENTRO DE SALUD HOSPITAL:	
PROVINCIA: CANTON:	

PLAN 0 0 1

CALCULO DE ACTIVIDADES, COBERTURA, CONC

ENFERMAS

SUBPROGRAMAS COMPONENTES Y ACTIVIDADES	DEMANDA ESPECIAL SEGUN MODELO	1979 DEMAN ESPER.	% COBERT	Nº PERS.	CON-CENT.	Nº DE ACCIONES MEDIC	ENFERM P	ENFERM A	ODONT/ GO	ODONT/ A.O	OBST	1980 DEMAN ESPER.	% COBER	Nº PERS.	CON-CENT/	Nº DE ACCI MEDIC	ENFERM P	ENFERM A	
	0	1	2	3	4	5	6a	6b	7a	7b	8	1	2	3	4	5	6a	6b	7a
2.1.3. Atención del post-parto																			
a) Detección de puérperas						H	H	H			H					H	H	H	
b) Visita domiciliaria a puérperas para control y referencia.(Incluye educación, registro clínico) OB/	86				1										1				
c) Control de la puérpera en estab:																			
- Demanda local: médico (40%)	172				1										1				
obstetriz (40%)	172				1										1				
- Demanda referida: (12 x G.C.S) M			100		1								100		1				
d) Colaboración de enfermería en la consulta médica: demanda local	344				1										1				
demanda referida			100		1								100		1				
2.2. REGULACION DE LA FECUNDIDAD																			
2.2.1. Visita domiciliaria de información y entrega de cupones a solicitud.(22% MEF) (2.200) AE.	484				1										1				
2.2.2. Consulta médica (primera consulta)para selección y prescripción del método.	70				1										1				
2.2.3. Consulta subsecuente según normas por método.																			
DIU: Médico (50%)	30				2										2				
· Obstetriz (50%)	30				2										2				
GO y OM: Médico (50%)	48				4										4				
Obstetriz (50%)	48				4										4				
2.2.4. Entrega de GO y OM por enfermería AE.	38				3										3				
2.2.5. Visita domiciliaria a renuentes de PF. AE.	38				1										1				
2.2.6. Colaboración de enfermería en la consulta médica. AE.			100		4								100		4				
2.																			
2.3. DETECCION OPORTUNA DEL CANCER CERVICO UTERINO.																			
2.3.1. Visita domiciliaria de información y referencia al Centro de Salud Hospital	ACTIVIDAD CUMPLIDA EN VISITA DOMICILIARIA DE REGULACION DE LA FE CUNDIDAD											ACTIVIDAD CUMPLIDA EN VISITA DOMICILIARIA DE LA DE LA FECUNDIDAD							
2.3.2. Toma de muestra PAP, fijación y envío al laboratorio de citología: médico 50%	165				1										1				
obst. 50%	165				1										1				
2.3.3. Visita domiciliaria a casos sospechosos o positivos para educación, por tratamiento y/o referencia a nivel superior (5% de pacientes PAP). AE.			100										100						
2.3.4. Colaboración de enfermería en la																			

NORMS FOR HEALTH POSTS

METODOLOGIA: 1) Multiplique el valor de columna 0, por el índice de cálculo de c/año y anote en la columna 1
2) Anote en la columna 2 de c/año el porcentaje de cobertura que espera alcanzar hasta llegar a 100% -
3) Multiplique el dato de la columna 1 por el valor de la columna 2, dividida para 100 y anota en la .
4) Multiplique el valor de la columna 3 por el valor de la columna 4 y anote en las columnas 5-6a-6b-

SUMMARY OF MANABI DRUGSTORE DATA

1. The Sample. Altogether, 19 drugstores in Manabí were surveyed. The geographic distribution and relative size of the sample is shown in Appendix A. It will be seen that 11% of the farmacias, 0% of the botiquines, and 9% of the total farmacias and botiquines were surveyed. The sample tends to somewhat over-represent the larger, better-known pharmacies (since they were easier to find). As a result, unadjusted extrapolations from the sample to the universe will doubtlessly tend to over-represent contraceptive sales and the number of brands of contraceptives.

2. Methodology. A list of commerical contraceptive brands was prepared. Pharmacists were asked which ones they had (at the moment of the interview), at what price they sell them to to public, and what their approximate monthly sales are. Annis interviewed drugstores outside of Portoviejo; an interviewer was hired for one afternoon from the Armed Forces family planning program to interview drugstore owners in Portoviejo. In addition, the drugstore owners were also informally asked their own attitudes on family planning.

3. Findings.

3.1. Prevalence of Contraceptives.

In the 19 pharmacies survey, there were 20 different commercial brands of oral contraceptives. The most common brands were Microginon, Nodiol, Ovral, Anovulatorio Denoval, and Nordete. (Appendix B)

There were 15 different commercial brands of condoms. The most common were Sultans, Tahiti, Stimula, and Fulex. (Appendix B)

10 drugstores (53%) sold Norfom tablets; 7 drugstores (36 sold Loronin: 5 drugstores (26%) sold Delfin foam; and 9 drugstores (47%) provide Depo-provera injections.

The "average drugstore" sold 11 different brands of oral contraceptives. In general, the Portoviejo drugstores contained more different brands than did the smaller rural drugstores.

The "average drugstore" sold 2.5 different brands of condoms (probably slightly under-reported)

3.2. Price of contraceptives.

The price of oral contraceptives charged by the pharmacies ranged from 44¢ to $2.18.

The least expensive brand of oral contraceptive is Anovolatoriio MK (44¢). The most expensive brand is Nordete $1.89.

The mean price of contraceptives available in these drugstores is $1.16 (standard deviation = 10.4).

Condoms sell for about 11-18¢. Vaginal tablets sell for about 11-15¢. A 3-month injection of Depo-provera costs $3.82

3.3 Relationship between price and sales.

Accurate information was not obtained on monthly sales by brand; however, the pharmacists seemed to agree that there is a bi-modal distribution of sales by price. In other words, the best-selling brand is not the average-price one; rather, the the very expensive and the very cheap brands sell best. Pharmacists explain this by saying that people simply ask for the cheapest brand (Anovulatorio MK and Nodiol) or the "best" brand. (People believe that the most expensive brands have the fewest side-effects associated with them. Also, private doctors tend to prescribe the more expensive brands.) In answer to the question, "Why do people buy here when they know that pills are available more inexpensively at the health center?", pharmacists tended to answer 1.) because women often finish a package of pills at a time the health centers is closed or at a time when they cannot go to the health center, or 2) that they are willing to pay the higher price in order to not lose a half day at the health center, or 3) privacy of the transaction. and confianza in the pharmacist.

3.4 Estimated number of pharmacy-supplied contraceptive Users in the sample.

17 of the 19 pharmacies were able to provide rough approximations of their monthly sales of oral contraceptives. Altogether, a total monthly sales of 2297 cycles were reported. ~~However,~~ 1200 (52%) of these sales were reported by a single ~~one~~ pharmacy. This pharmacy is probably the largest in Manibí. The exceptionally high sales of this pharmacy were explained by the

fact that [illegible] acts as a wholesale supplier for many rural boutiquines and that since it is near a market, it it has a very high number of [illegible] rural campesino users. Excluding the sales of this "special case" from the sample, 1097 pill users were supplied by the 16 remaining pharmacies -- or an average of 69 users per pharmacy.

Condom sales were difficult to determine. Women employees generally provided less specific information than did men employees. Nevertheless, on the basis of reported data, a total monthly sales of 18.5 gross of condoms (18.5 X 144 = 2664 units) were reported. Assuming an average coital frequency of 8 times per month (which may or may not be a reasonable assumption), the equivalent of 333 persons (2664 / 8 = 333) are theoretically "protected" by the 17 pharmacies -- or an average of 19 persons per pharmacy.

There is too little data on tablets, foam, and injections to make even rough approximations of number of users. However, a guess is that a minimum of 5-10 persons are covered per pharmacy by these three methods.

3.5. Estimated number of pharmacy-supplied contraceptives in the province of Manibi.

The following chart makes a rough estimate of the number of pharmacy-supplied contraceptive users in the Province of Manibi. IT SHOULD BE INTERPRETED WITH EXTREME CAUTION. It is based on many assumptions and partial data. Its purpose is only to estimate the order of magnitude of pharmacy-supplied contraceptive users. It is not "the" number.

	Pharmacies*	Boutiquines**	Total
Pills	69 x 177=12,213	23 x 26 = 598	12,811
Condoms	19 x177=3,363	6 x 26 = 156	3,519
Others	5 x177=885	1 x 26 = 26	911
TOTAL	16,461	780	17,241

* Average no. of users per method (calculated above) is multi[illegible] by the number of pharmacies (177) in the province.

** It is assumed that boutiquines have one-third the number of users per method of the pharmacies (ie., for the pill,

69 users/pharmacy X 33% = 23 users/boutiquine). This is a very approximate way of adjusting, of course; but since the number of boutiquines is relatively small (26), the actual error is probably not excessively large.

In general, an effort was ~~been~~ made to keep this estimate conservative. The pharmacy with the highest number of pill users (1200 per month reported) was excluded from the calculations as being atypical. The number of users of vaginal tablets, foam, and injections (911) is almost certainly on the low side.

It is estimated that the 1978 population of Manabi is 991,661. (calculated on the basis of 1975 Census estimate of 879,054 multiplied by an annual rate of increase of .641). Assuming that about 20% of the population consists of women in the fertile age group (15-45), there are about 198,332 women of fertile age.

According to the above calculations, about 8.7% of the women of fertile age would be covered by pharmacy-supplied contraceptives. This is a surprisingly high number. The actual number of completely protected regular users would, of course, be somewhat smaller.

APPENDIX A: Relative Size of the Sample of pharmacies & Botiquines

Farmacias	Número	Número en la Muestra	
Número de Farmacias de Manta	34		
Farmacias de Portoviejo	41	10	(24
Farmacias de Chone	23	2	([illegible]
Farmacias de Bahía de Caráquez	10	3	(30
Farmacias de Jipijapa	18		
Farmacias de Montecristi	3	2	([illegible]
Farmacias de Santa Ana.....	8		
Farmacias de 24 de Mayo.....	3		
Farmacias de Calceta	5		
Farmacias de Junín	3		
Farmacias de Rocafuerte	2	2	(100%
Farmacias de Paján	3		
Farmacias de El Carmen	9		
Farmacias de la Parroqui Pichincha	4		
Farmacias de Canuto	1		
Farmacias de la Parroquia Tosagua	3		
Farmacias de Pedernales	2		
Farmacia en la Parroquia Alajuela.....	2		
Farmacia en la Parroquia Calderón	1		
Farmacias en la Parroquia Picoazá.....	1		
Farmacia en la Parroquia Noboa.....	1		
	177	19	(11%
Botiquines			
Botiquín en la Parroquia Olmedo.....	3		
Botiquines de la Parroquia Picoazá	2		
Botiqúines de la Parroquia Riochico.....	1		
Botiquín de la Parroquia Pedernales.....	3		
Botiquínes de la Parroquia Jama	2		
Botiquines de la Parroquia Ayacucho.....	1		
Botiquín en la Parroquia Guale	2		
Botiquín en la Parroquia San Isidro	3		
Botiquín en la Parroquia Onegado (Jipijapa)	1		
Botiquín en la Parroquia Lasacano	2		
Botiquín en la Bramadora (El Carmen).....	1		
Botiquín en San Pedro de Suma.(El Carmen)	1		
Botiquín en Pedro Pablo Gomez (Jipijapa)	1		
Botiquín en la Parroquia Honorato Vásquez...	1		
Botiquín en San Plácido	1		
Botiquín en el Sitio El Bejuco (Chone) ...	1		
	26	0	0%
TOTAL	203	19	9%

APPENDIX B

Prevalence of Oral Contraceptive Brands

Brand Name	Number of drugstores reporting sales of this brand	Price range	Average price	Notes on sales
Microginon	17	$1.27-$1.96	$1.78	sold in 21' 28's. Also 3 month pac
Modiol *	17	$ .51 -.55	$ .51	High sales
Ovral	16	$1.24-$1.35	$1.31	
Anovulatorio M.M.	15	$ .44- .51	$ .44	High sales. C est bran
Denoval	15	$1.02-$1.35	$1.27	High sales.
Nordete	15	$1.31-$1.93	$1.89	High sales. " expensive b
Neoginogon	15	$1.09-$1.82	$1.31	
Anovalar(1mg)	14	.58 -.73	$ .65	moderate sa
Lindiol 2,5	13	.58-$1.02	$ .84	
Anovalar 21	13	$1.13-$1.45	$1.38	
Fusinon	15	.51 -$1.31	$1.20	
Gynovlar	10	$1.24-$1.64	$1.42	
Noraciclina	10	$1.02-$1.53	$1.27	
Norlestrin	9	$1.27-$1.53	$1.45	Low sales
Primoblar C.D.	8	$1.27-$2.18	$1.56	
Miniplanor	6	$1.24-$1.38	$1.27	
Rosanil-Simple	5	$1.02-$1.24	$1.20	Discontinue
Ortho-novum	4	$ .91	$ .91	
Rosanil-compuesto	2	$1.16-$1.24	$1.20	
Ovral 28	1	$1.02	$1.02	

* Now Being phased out

APPENDIX C

Prevalence of Condoms by Brand

Brand Name	No. of Drug-stores report-sale of this brand	Price Range	Notes
Sultan	10	11-18¢	Most popular bran
Tahiti	8	18-22¢	
Stimula	7	16-18¢	
Fulex	5	15-18¢	
Gato Negro	4	18-22¢	
Jontex	2	15-18¢	
Jellia	2	33-36¢	
Naturax	2	18¢	
Gallont	1	13¢	
Spermex	1	35¢	
Pagoda	1	36¢	
Samoa	1	18¢	
Conform	1	18¢	
Nuda	1	18¢	
Rositex	1	13¢	

Prevalence of Other Types of Contraceptives

Norfoms (tablets)	10	11-15¢	
Loronin(tablets)	7	11-15¢	
Delfin(foam)	5	$2.00-$2.73	Very slight demand
Depro-novera(injectn.)	9	$3.82	Decreasing demand and availability

APPENDIX D

Estimated Number of Users per Method

Pharmacy	Pill users*	Condoms** users	Tablets*** users	Injections**** users
(Portoviejo)	100	27	no information	no information
"	30	18	"	"
"	no information	18	"	"
"	100	18	"	"
"	15	18	"	"
"	175	36	"	"
"	150	18	"	"
"	36	9	"	"
"	100	54	"	"
"	1200	36	"	"
(Montecristi)	10	0	0	0
"	42	36	0	0
(Rocafuerte)	15	2	4	0
"	182	36	45	24
(Bahía)	27	6	0	3
"	15	0	0	0
"	54	2	0	12
(Chone)	46	no info.	0	0
"	no information	no info.	0	8

* calculated as reported monthly sale of pills

** calculated as no. of condoms reported sold (144 per gross) divided by 3

*** " " " " " " (12 per box) " " 8.

**** " " " " " /month multiplied x 3.

REFERENCE DOCUMENT 05

DRAFT/Feb. 1979

EDUCATIONAL MATERIALS FOR THE INDIGENOUS AREA:

Project Description

Project goal: To raise the level of information on health and family planning in the Highlands, thereby improving general health and increasing the number of Indian family planning acceptors.

Project objectives:

1. To produce a significant volume of culturally appropriate educational materials on health and family planning for use in the Indian area,

2. To distribute these materials as widely and effectively as possible,

3. To strengthen APROFAM's expertise in evaluating these materials and measuring their impact,

4. To improve APROFAM's working relationship with other organizations, public and private, who are also carrying out programs in the Indian area.

Project summar_.

The major activity of this project is the production and effective distribution of culturally appropriate educational materials for the Indian areas of Guatemala. These materials may be designed for use at various levels: by health paraprofessionals, by village health promoters, and village men and women. Materials might include training courses, audio-visual aids, radio spots, or printed materials. APROFAM may produce materials itself, sub-contract production to qualified individuals or institutions, or reproduce or adapt presently existing materials. The chief delivery mechanism for these materials will be a small, specially trained group of Indian "communicators", an occupational group which presently does not exist within APROFAM. These communicators, according to their individual backgrounds and linguistic skills, will help test, develop, and employ the materials at the village level. In order that the program may ultimately have impact on a potentially large population, the communicators will also act as trainers and disseminators of information to promoters who are presently working in villages under other institutional auspice. This would include governmental institutions such as the Ministry of Agriculture, Desarrollo de la Comunidad, and Educacion Extra-escolar, as well as the multitude of church and private programs that maintain village level promoters (Save the Children Fund, World Neighbors, Berhorst Clinic, missionary clinics, etc.

Additionally, one communicator may be assigned to work exclusively with the Indian distributers/promoters of APROFAM's Community-Based Distribution Program; and a second communicator may be assigned to work exclusively with health promoters who belong to the government Rural Health System. The Evaluation Unit of APROFAM will play a key role in this program by: 1.) diagnosing need at the village level for educational materials, 2.) providing ongoing feedback on the suitability and effectiveness of materials, and 3.) providing data which will be used in an evaluation of the program. It is expected that the Project would receive initial funding for a period of about 2 years, and that at the end of that time a fairly high volume of materials will have been produced, disseminated, and evaluated.

Project components:

1. Management
    - 1.1. Personnel
        - 1.1.1. Executive Director of APROFAM
        - 1.1.2. Project Director
    - 1.2. Responsibilities
        - 1.2.1. Define project
        - 1.2.2. Obtain funding
        - 1.2.3. Hire personnel
        - 1.2.4. Coordinate project with other APROFAM programs
        - 1.2.5. Monitor and review project

2. Production of Materials (Information and Education Division of APROFAM)
    - 2.1. Personnel
        - 2.1.1. Director, I&E
        - 2.1.2. Production Unit
            - •Artists -- permanent APROFAM staff artist, contract artists, village artists (?), communicators (?)
            - •Production technicians -- draftsmen, printers, designers
            - •Educational advisor
            - •Consultant linguist
    - 2.2. Responsibilities
        - 2.2.1. Create materials for unaided use by Indian "consumer"
            - °radio spots
            - °brochures, folders
            - °calendars
            - °posters, etc.
        - 2.2.2. Create materials for use by village health promoters
            - °short courses for promoters -- family planning techniques, need for family planning, elements of nutrition, community organization, giving injections, first aid, use of simple medicines, sex education and human anatomy & physiology, etc.
            - °printed materials for continuing education of promoters -- simple manuals, guides, how-to texts, etc.
            - °teaching materials for use by promoters working in the field -- flannelgraphs, flip charts, taped messages, story sequences, dramatizations.

2.2.3. Create materials for use by health paraprofessionals, e.g., Rural Health Technicians (TSR's), auxiliary nurses, professional nurses, nutritionists, social workers, teachers, health educators.

- °reproduction, adaptation, and wider dissemination of existing materials, eg. translations and re-prints
- °adaptation and opening of access to existing APROFAM training programs

2.2.4. Preparation of a training curriculum for Communicators, i.e., health, family planning, elements of social science research, interviewing, audio-visual techniques, how to physically produce educational materials

3. Dissemination of materials (the Communicators)

3.1. Personnel

3.1.1. 6 communicators. Each would be assigned a municipio as a test and work area, on the basis of his/her village background and language skills. In addition, each would be assigned responsibility for one of the following:

- °Supervision (one communicator would be chosen by the group as supervisor/spokesman)
- °The Ministry of Health -- to work with promoter of the the government Rural Health System (this communicator would probably be an ex-TSR)
- °APROFAM's CBD Program (This communicator might be an ex-APROFAM Promoter in the CBD Program)
- °Catholic Programs
- °Private health programs, e.g., non-catholic church programs (Clinica MAM, Clinica Evangelica Nahuala, Good Samaritan clinics, etc.), Berhorst, Project Concern, Save the Children, World Neighbors, etc. (The communicator would be someone who has several years experience working with one of these programs)
- °Other governmental programs, eg. Desarrollo de la Comunidad, DIGESSA, Ministry of Education, Educacion Extra-escolar, etc.

3.2. Responsibilities

3.2.1. As part of their training and in order to develop the program, collect baseline data in the "work/test" municipios to which they are assigned (home municipios, in most cases). This baseline data would consist of level of family planning CAP in the communities, activities of other institutions, educational materials in use, and health and family planning services.

3.2.2. After their initial training period and after the collecti[illegible] of community baseline data, make a "work sector diagnosis". i.e., an evaluation of the individual sector (the Ministry of Health, Catholic Programs, Private [illegible] etc.) to which they will be assigned. This would [illegible] identifying the institutions and programs; identifying receptive individuals and counterparts within the programs; diagnosing institutional politics, biases, needs; evaluating educational materials in use; identifying ways

that APROFAM can provide legitimate services to the programs; and devising a work strategy to be carried out in the "sector".

3.2.3. Work to develop educational materials for "sector" needs, with I&E providing back-up and technical assistance.

3.2.4. Help field-test and evaluate materials produced by I&E and by other communicators.

3.2.5. Make sure that contraceptive supplies and services are available, both in the communicator's work/test municipio and in his "sector".

3.2.6. Help in the collection of field data for project evaluation.

4. Evaluation of Materials and Project Effectiveness (Evaluation Unit of APROFAM)

4.1. Personnel

4.1.1. APFROFAM's Evaluation Unit

4.1.2. Indian Educational Materials Advisory Committee

- °Evaluation Consultant
- °Members of Private Voluntary Organizations who are working in preparing educational materials
- °members of governmental agencies who are working in preparing educational materials
- °Representative of Instituto Indigenista
- °Linguist
- °Communicator spokesman/supervisor

4.1.3. Materials "testers " -- At the village level, the communicators will establish a network of persons, both at the institutional and "consumer " levels, who will systematically be used as "guinea pigs" for testing materials.

4.2. Responsibilities

4.2.1. Advise I&E on the setting up of the program, including criteria for selection of communicators and the content of their training curriculum

4.2.2. Advise in the selection of work/test municipio and determine what baseline data is required in them for effective program evaluation.

4.2.3. Devise guides other other research instruments suitable for collection of data and provide assistance in the training of communicators in data collection.

4.2.4. Provide ongoing assitance in the development and evaluation of educational materials. To the extent possible, determine measurable criteria which may be used to evaluate the "quality" of given materials.

4.2.5. Collect and analyze data to be used in the final project evaluation.

V. Justificación

Durante 1973-74 y hasta 1975, con motivo de la realización de la Conferencia Mundial de Población, se realizó en el Ecuador una actividad de bastante intensidad, difundiendo información atinente al problema demográfico, en sus diferentes dimensiones, con el objetivo primordial de motivar al gobierno para que establezca las bases fundamentales de una política nacional de población y en razón de poner en marcha algunas de las recomendaciones emanadas de la conferencia de Bucarest.

La actividad que fuere de responsabilidad del Ministerio, y que se realizó a nivel interpersonal, con líderes en diferentes campos; a nivel de grupo, con organismos educativos o de trabajadores y; a nivel masivo, con la utilización de radio, se cumplió contando con la ayuda de organismos internacionales. Sin embargo, deberá anotarse que estas acciones se vieron obstaculizadas por problemas de tipo burocrático, que a esa fecha, hicieron pensar como oportuna, la transferencia de la responsabilidad a la iniciativa privada.

Con posterioridad si bien, los medios de comunicación han acogido versiones internacionales, tanto sobre el crecimiento de la población, y sus implicaciones,

como sobre algunos avances en el uso de anticonceptivos; su información, se ha limitado a apariciones esporádicas de artículos provenientes del cable internacional que proporcionan información no "elaborada" y muchas veces contraproducente a cualquier esfuerzo positivo que se desee emprender en este campo.

Si las actividades informativas sobre el problema contínuan al mismo nivel, el espíritu logrado con el esfuerzo inicial ya disminuído, va a perderse.

Además, en la actualidad la preocupación ministerial abarca aspectos de salud materno infantil, con mayor énfasis que en el campo poblacional.

La iniciativa privada deberá reforzar esta área, con propósitos de equilibrar la situación presente, y lograr mayor aceptabilidad del concepto. Este criterio es de más valor, en la época actual en que, se espera un nuevo gobierno y en que la constitución que deberá entrar en vigencia a su posesión, se preocupa de este problema y asigna al organismo de planificación del estado, la responsabilidad para determinar el tipo de política a seguir.

El Centro considera que esta es una coyuntura de la

que debe hacerse uso para crear un clima adecuado que por un lado induzca a los responsables de la política a tomar decisiones favorables y por otro permita que el público receptor de las determinaciones legales, las acepte y aún llegue a promoverlas.

Actualmente no existe un programa que promueva este objetivo, que deberá ser una de las principales preocupaciones para establecer un ambiente razonablemente adecuado que permita emprender una etapa de programas de servicio sistemático.

VI. Duración y Localización del Proyecto

Este proyecto, para no perder el máximo de impacto que se desea proprcionar, deberá tener una aprobación a la brevedad posible. No se ha diseñado un programa estático que puede tener una duración limitada, visto que, las acciones de comunicación deberán prolongarse la mayor cantidad de tiempo posible, capaz de que su impacto se refleje en un cambio de actitudes del público al que se va ha llegar.

Sin embargo, el proyecto ha sido diseñado para un año, luego del que, y tomando en cuenta la experiencia que se logre en el primero, se intentará un nuevo diseño, para un segundo año de operaciones. Se

espera realizar la actividad por un mínimo de tres años, período luego del que, se buscará otra fuente de financiación para continuar la actividad, si la política del país, a esa fecha lo permite. Durante el primer período ~~señalado~~ de financiación, el proyecto tendrá ámbito nacional y estará dirigido a los líderes de opinión, en los campos de la administración, economía, política, educativa, cultural, laboral, etc.

VII. Objetivos del proyecto

1. General

Difundir en forma sistemática y racionalizada, información relevante de tipo científico, acerca de los problemas relativos al crecimiento acelerado de la población y su asociación directa con el desarrollo del país.

2. Específicos

a) Realizar una tarea de recolección de información científica relevante, relativa a los problemas demográficos y de planificación familiar, del mundo y en particular de América Latina y del Ecuador, y promover su utilización por parte de investigadores nacionales interesados en la materia. Procesar convenientemente esta información para que pueda ser divulgada dentro del

marco cultural ~~cultural~~ del país y ser asimilada por los diferentes sectores a los que va dirigida.

c) Difundir periódicamente y en forma sistemática, la información procesada, a través de de diferentes medios de comunicación, entre varios sectores nacionales que participan del proceso de tomar decisiones y que posean interés científico o técnico sobre estas materias.

d) Lograr de manera inmediata: ~~lo siguiente~~:

i) Una concientización de los líderes de opinión, y

ii) Una formación de actitudes favorables a la planificación familiar.

VIII. Plan de Trabajo

Las actividades serán cumplidas con carácter sucesivo, en la secuencia que se describirá obteniéndose así una sistematización que permita una evaluación a la terminación del primer año de actividades.

Las actividades básicas que se ejecutarán son:

ACTIVIDAD	DESCRIPCION	RESPONSABILIDAD
1. Diseño final del proyecto.	Programación específica de actividades que se desarrollarán durante el primer año. Tres semanas.	Director del Proyecto.
2. Recolección del material.	Investigación sobre fuentes de producción de material, nacionales y extranjeras y selección de los apropiados a las condiciones socioculturales del país. Cuatro sesiones.	Director y Documentólogo - Bibliotecaria.

3. Clasificación del material.	Determinación de las áreas cubiertas por el material recolectado. Creación de un fichero de publicaciones. Seis semanas.	Director Documentóloga Secretaria
4. Selección del material a ser difundido.	Estudio y determinación del tipo de material a utilizarse en conformidad con las etapas del proyecto y el público al que está dirigido.	Director Documentóloga Secretaria
5. Selección de las audiencias para la difusión.	Selección de líderes-con determinación de nombres y direcciones, en los campos social, económico, cultural, político, intelectual, laboral, etc.	Director Documentóloga Secretaria
6. Procesamiento y producción.	Elaboración del material para ser enviado, a los medios de comunicación escrita del país, y o los líderes de opinión.	Director Documentóloga Secretaria
7. Difusión	Revisión a las fuentes de publicación y a los líderes seleccionados.	

Las actividades que han sido descritas, se repetirán en una segunda y tercera fases y así sucesivamente, con énfasis en las áreas de recolección, selección, procesamiento y difusión.

Una evaluación para determinar al respecto y aceptabilidad del programa será preparada a la finalización del primer año de actividades. (Ver cronograma)

IX. Informes y evaluación

1. Financieros.- Serán remitidos a Pathfinder de manera trimestral

y en conformidad con sus estipulaciones.

b) Programáticos.- Se espera la contribución de Pathfinder para el diseño del instrumento de evaluación. Sin embargo, de manera periódica, se remitirán informes de progreso.

X. Presupuesto

1. Personal

Director del Proyecto, comunidad

(4 horas/día

CRONOLOGIA DE ACTIVIDADES

```
      M E S E S               1       2       3       4       5       6       7       8       9       10    11       12

                              E       F       M       A       M       J       J       A       S       O     N        D

Organización               xx
Diseño de Proyecto           xxxxxx

1era. Etapa

Recolección de Material            xxxxxxxx
Clasificación de Material              xxxxxxxxxxxx
Selección para Difusión                            xx
Selección de Audiencias                              xxxxxxxx
Procesamiento y Producción                                 xxxxxxxx
Difusión                                                           xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

2da. Etapa

Recolección de Material                                    xxxxxxxx
Selección de Material                                              xx
Procesamiento y Producción                                           xxxxxxxx
Difusión                                                                     xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

3era. Etapa

Recolección de Material                                              xxxxxxxx
Selección de Material                                                        xx
Procesamiento y Producción                                                       xxxxxxxx
Difusión                                                                                 xxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
Evaluación                                                                                                         xxxxxx
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REFERENCE DOCUMENT 07

1. Project Title: Population Information for Opinion Leaders and Policy Makers (Ecuador)

2. Project Goals: 1) To increase knowledge of population/family planning issues among Ecuadorean opinion-leaders and policy makers, and 2.) To create a media and public opinion climate which will encourage positive population/family planning policies.

3. Project Summary:

Despite its population growth rate of 3.2% per year -- the highest in South America -- Ecuador remains a nation without a firm policy to reduce population growth. The present Ministry of Health target of 2.3% of women of fertile age as new family planning acceptors, if met, would hardly affect population growth; and surpassing that target appears hardly likely, given that the 1979 Ministry of Health budget allocation for family planning represents approximately 8 tenths of one-thousanth of the total Ministry budget.

Yet what is striking about Ecuador is not so much opposition to family planning but indifference. Following two or three years of moderate public interest in the wake of the Bucharest Conference -- to some extent

promoted within the Ministry by efforts of international institutions -- public dialogue has all but evaporated.

As the new constitutional government takes power, the next year or two will be a critical time in defining and debating national development priorities. In regards to the population issue, it is the purpose of this project to "stir things up" -- that is, to help create a serious and audible public dialogue on population.

It is expected that this project will generate a very high volume of press releases, magazine and newspaper articles, and newsletter. It will put into circulation international population news and and scientific advances in contraceptive technology. It will arrange media appearances for population experts and family planning spokesmen. ~~(It will generate educational materials for schools and will organize population conferences for health professionals~~

In short, it is the purpose of this project to -- in as short a time as possible -- to bring population and family planning "out of the closet" in Ecuador.

4. Duration of Project: Three years, with funding for second and third years contingent on satisfactory performance during the first year.

5. Project Organization: Tentatively, it is anticipated that the project will be administered by CEPAR, a non-profit Ecuadorean organization of professionals working in health, sex education, family planning, and population. The Pop Information Project Director will be directly responsible to the Board of Directors (?) of CEPAR; nevertheless, the project will also maintain a high degree of autonomy in its decision-making and program strategies. Two important elements of the project are:

5.1. Project Committee (of Sponsoring Agencies). An inter-institutional committee (tentatively, to be made up of CEPAR, CEMOPLAF, the Armed Forces Family Health Program, APROFE, Vozandes, and) will be made up. Although technically administered by CEPAR, the project will "working for" and with all these sponsoring organizations. It is expected that there would be a sharing of resources and contacts, and that there would be a mutual strengthening of all the organizations.

5.2. Eventual formation of an Ecuadorian Population Policy Citizen's Advisory Committee. It is to be hoped that such a committee will evolve, rather than be formed, sometime after the first year of the project. The committee would consist of well-known and respected members of Ecuador's scientific and professional community. It is hoped that members of the Project Committee -- aided by the public interest the project has generated -- would be influential in forming such a committee. The committee would be broad-based, ideally including members of the government and media. Members of this committee (rather than the project) would eventually become the "public image" or "spokesmen" for population policy in Ecuador.

6. Project Personnel.

6.1. Project Director (full time; a mass communications specialist, with experience in health and population; bilingual)

6.2. Project Manager (Part-time; a staffmember of CEPAR; to be funded by CEPAR)

6.3. Documentarian/librarian (full-time; bilingual)

6.4. Secretary/organizer (a secretary who can also set up news conference, organize conferences, etc.)

6.5. Editors/translators/scientific writers/journalists (several; part-time, as needed, to work on piece-work contract basis)

6.6. Ecuadorean educational consultant/writer. (part-time, to prepare family planning/population educational modules for the public schools, on contract basis)

6.7. Ecuadorean social scientist/researcher. (About 2 months; to work closely with project director to investigate Ecuadorean opinion leaders and policy makers , to investigate communications channels, and to develop a media penetration strategy)

6.8. International consultant. (About 2 weeks; a Washington or New York based population/family planning consultant who can make personal contacts for the project and "hook it in" to the international networks which generate population and family planning information.

7. Project Implementation Sequence.

Project Start-up.

7.1. Establish office work space ; meet with Project Committee to determine their needs and incorporate their ideas; hire secretary and documentarian; identify available part-time free-lance writers, editors, translators; finalize project design; program activities for first year.(first month)

7.2. International contact. International consultant, working in Washington or New York, will prepare bibliographies, forward publication price lists, and establish direct contact for the project with major population research centers, private and government agencies, libraries, and population reference services. The job of the consultant is to assure that the project has a large and steady supply of information from the international population community. (second month)

7.3. Set up "Family Planning/Population Documentation Center" and establish a Working System for Information Processing. While the international consultant is working in the US, the project director and documentarian will set up a filing and cataloguing system and begin collection of Latin American and Ecuador-specific materials. What is important to recognize at this point is that the project is not setting up a library or archive; rather, it is installing a system for collecting, processing, and disseminating information. This will require not only the skills of a trained librarian/documentarian, but also the imagination to go a step beyond the normal function of a library. An example of how this type of problem might be approached is given in APPENDIX A. (second and third month)

7.4. Inventory of Opinion Leaders, Policy Makers, and Media Communications Networks. The Ecuadorean social scientist, working closely with the Project Director, will prepare the following:

7.4.1. List of national opinion leaders. Political leaders, publishers, university intellectuals, scientists, journalists, labor leaders, church leaders, educators.

7.4.2. List of local opinion leaders. Local journalists, educators, cooperative and campesino leaders, political activists, etc.

7.4.3. Government policy makers. Names and offices of key national and local policy makers.

7.4.4. Professional organizations. Especially in health and fields related to economic development. Communications media, e.g., newsletters, used by the professional organizations.

7.4.5. The media. Newspaper, radio, television. Identify personal contacts as widely as possible within each media; collect basic information on the size and type of audience of each media.

Develop a specific strategy for the type of information best suited for each group and ways of conveying it. Develop a media penetration strategy. (third and fourth month)

7.5. Begin Information Dissemination. (5th through 12th month)

7.5.1. Newsletters. The project may wish to sub-contrac to a professional editor the responsibility of preparing 3-4 newsletter geared for different target groups. These newsletters might be distributed to each group 3-4 times per year -- or, an average of one newsletter sent per month.

7.5.2. Frequent press releases. Reporting for the news media on findings of international population conferences; reports on how Ecuadorean family planning programs and population policies compare to other Latin American countries; news activities of Ecuadorean family planning organizations; arrival in the country of population experts, etc.

7.5.3. Conferences and seminars. The project should help sponsor and publicize at least one population conference each year. Themes and

target audiences should be suggested and developed with the Project Committee.

7.5.4. Translation and scientific reprints. The project should sub-contract for translations and popularizations of important articles on demography and contraceptive technology. These should be directed to key target audiences. By its second year, the project should have established a catalogue of publications, reprints, and educational materials. These can be sold by the project and members of the Project Committee at nominal cost.

7.5.5. Education modules for schools. The project should subcontract with an educational materials specialist to develop educational materials appropriate for use in schools. The project would provide guidelines to the consultant on subject matter and curriculum levels, and the consultant would prepare materials following talks with personnel in the Ministry of Education. Simple demographic concepts, for example, might be presented in an elementary math module; basics of human reproduction might be included in a biology unit.

separate project

7.5.6. Arrange Press Conferences and Media appearances. The project would assist members of the Project Committee in arranging press conferences and identifying opportunities for public dialogue of family planning issues. One technique might be to form the equivilent of a Population/ Family Planning Speaker's Bureau.

8. Evaluation and Monitoring:

AID and the project funding agency will have responsibility for evaluation and monitoring. An evaluation of the project will be done at the end of the first year, at which time the project will be re-designed. To

facilitate evaluation, it is expected that the project will keep up-to-date files of press release, newspaper clippings, etc.

9. Budget:

Since this is only a first draft of a proposal, it would be inappropriate to try to calculate an actual budget. However, as an exercise in order to try to get a "ballpark estimate" or order of magnitude, the following Illustrative Budget was prepared.

Illustrative Budget:

Ballpark Estimates

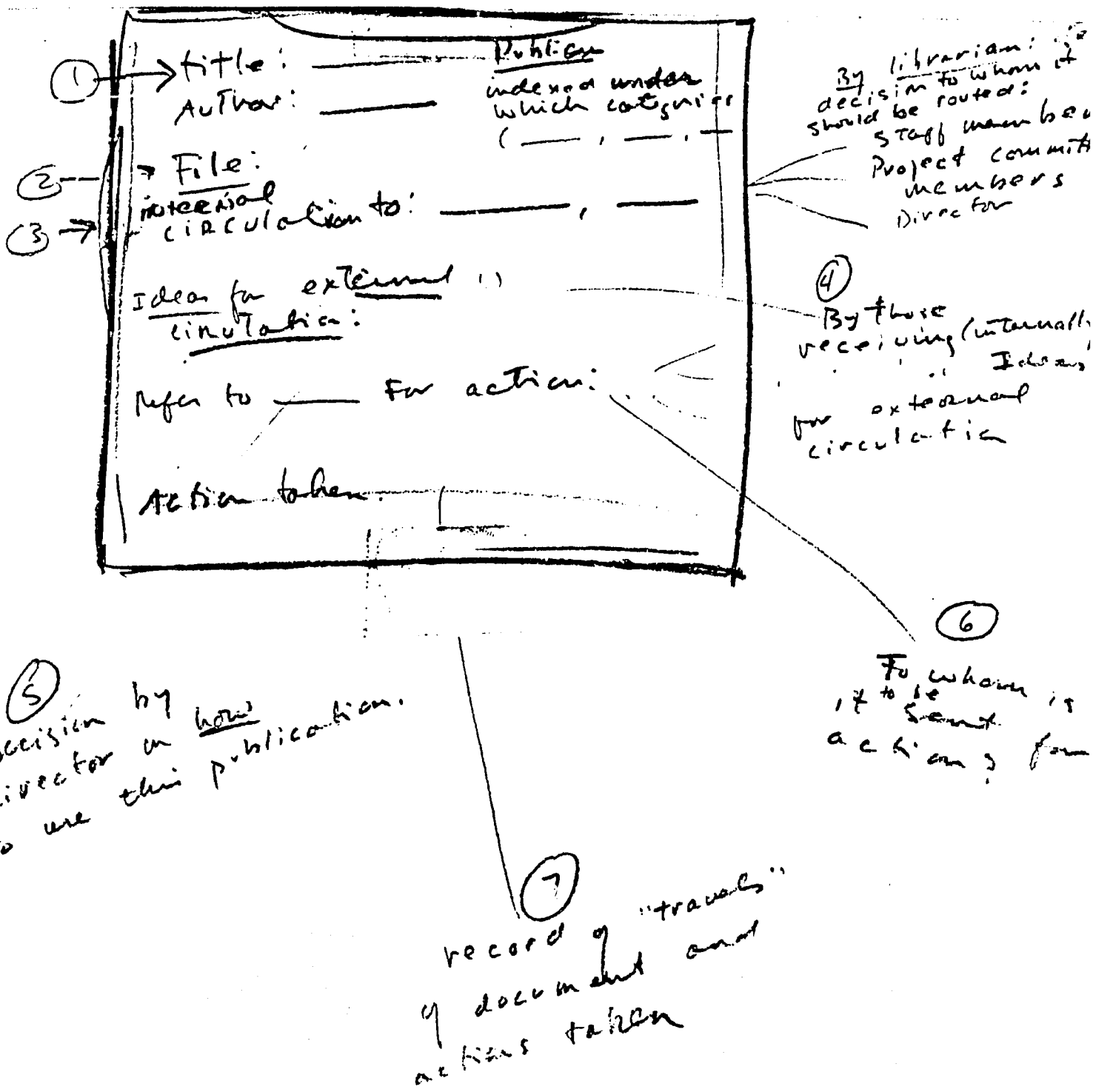
	1st yr.	2nd year	3rd year
1. Administrative by CEPAR, including accounting and audit	$ 4000	$4000	$4000
2. Personnel (full-time)			
Director	6000	6000	6000
Documentarian/librarian	4000	4000	4000
Secretary	2000	2000	2000
3. Office and operating costs.			
Office rental	2000	2000	2000
Files, typewriter, office machines	5000	1000	1000

Furniture	$1500	$ 500	----
Xerox rental	2000	2000	2000
Telephone, utilities, office supplies	1200	1200	1200
4. Editing/translating/ writing (subcontracts)	8000	7000	6000
5. Production of materials, copying, and mailing	6000	6000	6000
6. Documentation Center (books, journal subscriptions, memberships, costs of newsletters)	8000	3000	2000
7. Consultants			
Ecuadorean social scientists	1000	----	----
Ecuadorean educational materials specialist	1000	500	----
International	2500	----	----
8. Conference costs.	1000	1000	1000
9. Honoraria for speakers and travel expenses to attend meetings	500	1000	1500
to give talks	500	1000	1500
10. Misc., unforeseen, inflation (about 10%)	5000	5000	5000
TOTAL	61,200	51,700	45,200

GRAND BALLPARK TOTAL: $158,100

APPENDIX A:

Sample Routing/Filing Sheet for
All Publications Received



1. Project Title: Learning Modules for Demography and Sexual Education (Ecuador)

2. Project goals: 1) To integrate educational modules in demography and sexual education into public school curricula, and 2) To provide training to teachers, especially in the rural area, in the use of these materials.

3. Grantee and Project Management: It is tentatively expected that this project will be submitted for funding together with the "Population Information for Opinion Leaders and Policy Makers" project, and that the two projects will be managed by one full-time director and administrative staff.

4. Project Summary:

This project is intended to integrate demographic and sexual education concepts into the curricula of Ecuadorian public schools. The project is not intended to create"new subjects", but to introduce these concepts into existing curricula at various grade levels, i.e., mathematics, reading, social studies, home economics, biology. The Project expects not just to introduce demography and and sexual education, but to contribute to a general upgrading of educational materials in use in public schools. A team of Ministry of Education specialists, Project members, and an international consultant will analyse presently existing materials; create, modify, and test in the classroom

new materills; reproduce and dessiminate materials that are found acceptable to Ecuadorian educational authorities; and provide training to teachers (especially in the rural areas) in the use of these materials.

5. Project Duration: About two years, with gradual incorporation of the project into the Ministry of Education.

6. Project Personnel:

6.1. Project Director. Half-time; salary paid by Project.

6.2. Project Co-Director. Half-time; educational specialist working within the Ministry of Education; salary paid by Ministry of Education.

6.3. Educational Materials Specialist/Researcher. Part-time, on contract; paid by Project

6.4. Documentarian/Librarian. Half-time; salary paid by Project; person who is also in charge of the "Family Planning/Population Documentation Center" of the "Population Information" Project.

6.5. Educational writers/artists. Part-time, on contract; paid by Project

6.6. International Educational Materials Consultant. Speciali in demography, family planning, sexual education material Considerable experience with educational materials. Preferably Latin American. Paid by Project.

6.7. Participating Teachers. 20 or so classroom teachers who will participate in developing and testing materials.

6.8. Teacher Trainers. 4-5 trainers who will have responsibility for dessiminating materials and instructing teachers in how to effectively use them.

7. Project Implementation Sequence.

7.1. Establish Work Committee. The Project Director and Co-Director, Ministry of Education specialists, and international consultant will meet to form a Work Committee. The Committee will finalize design of the Project and assign specific tasks.

7.2. Evaluation of Presently Existing Curriculum Materials. The Work Committee will systematically evaluate materia that are now in use in public schools, determining ways that these materials can be upgraded and ways that demographic and sexual education concepts can be introduced.

7.3. Analyze Spanish-language materials available in other American countries which may have applicability to Ecuadorian needs.

7.4. On the basis of the foregoing analysis, identify those curriculum areas and those grade levels for which new materials might be produced. Identify areas where curriculum materials might be upgraded. Identify non-Ecuadorian materials that might be modified to Ecuadorian needs.

7.5. With the help of participating classroom teachers, begin the development and testing of materials.

7.6. Develop teachers manuals, classroom guides, supporting audio-visual materials, supplemental reading materials for students and teachers.

7.7. Test materials for their effectiveness and interest level. On the basis of classroom testing, assemble final learning modules.

7.8. Present learning modules to the Ministry of Education for approval. Revise, if necessary.

7.9. Begin reproduction of accepted materials and train teacher trainers.

7.10. Teacher trainers dessiminate materials. Training sessions held, especially in the rural areas.

7.11. Project resources are gradually absorbed by Ministry of Education.

FIRST DRAFT

PROJECT IDENTIFICATION DOCUMENT -- USAID / ECUADOR

(FY 1980-84 -- $. million Grant)

A. Project Description

Project Summary: an Overview

Ecuador has the highest population growth rate in Latin America and one of the higest in the world. The purpose of this project is to reduce the population growth rate, thereby promoting family wellbeing and facilitating the economic development of the country. The Mission recognizes that the ultimate solution lies in the reduction of the causes of a high growth rate -- poverty, ~~illiteracy,~~ lack of opportunity, lack of hope. The overall policy of the Mission, expressed in the FY 1981 CDSS, is to confront and seek solutions to these problems. ~~As a complement to the overall policy,~~ The Mission has also developed a 5-year Population Strategy which it believes can promote a shorter-term slowing of the population growth rate. The essential elemants of this strategy are: intensive educational efforts directed at generating a demand for family planning services; a coordinated effort to build a broad-based family planning supply infrastructure in both the public and private sectors; and an aggressive media program designed to generate public and government support for a slowed-growth population policy. In practical terms, this Population Strategy is designed as

a series of conceptually coordinated projects, in the public and private sector, employing both bilateral assistance and intermediary funding. The present PID addresses one part of the larger Population Strategy: A ~~four~~ three-phase Family Planning/Rural Health Project, within the GOE, which will begin with training for rural auxiliary nurses and lead to a community-based distribution system.

Background: The Mission 5-Year Population Strategy

Three factors interact to sustain Ecuador's present high population growth rate:

1. Lack of broad demand for family planning services. (blah, blah...)

2. Lack of broad, accessible supply infrastructure for family planning services. (blah, blah...)

3. Public disinterest and lack of a government policy to slow population growth. (blah, blah, blah...)

By supporting a series of population projects, which are conceptually if not administratively linked, the Mission believes it can systematically counteract each of these factors.

The general scheme for the Mission 5-year Strategy is as follows:

1. To generate demand for family planning services.

   1.1. A Communications Project (Bogue or otherwise). An intensive program of production and dissemination of health and family planning educational materials (See Appendix A) Bogue 50-50 proposal)

Such a project might include a special component for "Production and Dessimination of Educational Materials Appropriate to the Indian Areas" (See Appendix B: Example of a Similar Project proposed to APROFAM in Guatemala)

1.2. Project in preparation: ""Population Information for Opinion Leaders and Policy Makers". A secondary purpose of this project is generate discussion and interest in the mass media which will serve to generate demand (Appendix C: Rough draft of project, now being revised)

1.3. Education and Motivation via "motivators". CEPAR CBD Program in Manabí, to be extended to Azuay and other coastal provinces (See Appendix D: Project proposal ready for submission to Pathfinder)

1.4. Educational efforts on the part of the MOH. Included in present PID.

1.5. Project idea for public schools. "Learning Modulas for Demography and Sexual Education" Program for introducing family planning into public school curricula and training teachers, especially in rural areas, in family planning-related concepts. Project idea, now being developed. Possibly to be submitted for funding together with "Population

Information" proposal. (See Appendix E: rough draft of project)

1.6. Radio and other mass media advertising. To be part of projected Private Commercial Distribution of Contraceptives. (See Appendix F: Proposal for a PCD Project, and Appendix G: Draft, "Findings & Recommendations Based on Manabí Drugstore Data")

2. To create a broad-based family planning supply infrastructure The Mission proposes to build or build upon three separate but mutually interactive family planning delivery systems, which together constitute Ecuador's supply infrastructure.

2.1. Contraceptive distribution through private family planning programs.

2.1.1. The CEPAR CBD program, which will be initiated in Manabí in 1980, extended to Azuay in 1981, and to be extended to other coastal and highland provinces in the following years. (Appendix D)

2.1.2. Training in Obstetrics/Gynocology for medical doctors. Project to be initiated in Guayas in 1979 and thereafter extended to other provinces. (See Appendix H)

2.1.3. Training in Obstetrics for Midwives. Project begun in in 197 , to be extended to . (See Appendix I)

2.2. Private Commercial Distribution of Contraceptives. It is expected that by 1985 a full-scale PCD program will be implemented. This program will be based on mass-market brand-name pills and condoms, which are: inexpensive, widely available, and advertised according to mass media, high volume marketing principles. This program is being phased in in 1980 with the Training for Drugstore Owners Project in Pichincha and Azuay (See Appendix J: Proposal ready for submission to Pathfinder). It is expected that training of drugstore owners will be extended the following year to other provinces. A demonstration commercial distribution project will be carried out in 1981, followed by a feasibility study and design for a national project. (See Appendix F)

2.3. Distribution of contraceptives by government agencies

2.3.1. For the rural areas, create a community-based distribution infrastructure within the MOH and Social Security rural health programs (See present PID)

2.4. For the urban areas, continue to support the social security and armed forces family planning programs.

3. To generate public interest and a favorable government policy toward family planning.

   3.1. The Mission will continue to work informally, on a 1-to-1 basis with Ecuadorian government counterparts, expressing support for family planning and encouraging policies to reduce population growth.

   3.2. Project: "Population Information for Opinion Leaders and Policy Makers". A project designed to stir public dialogue on population/family planning and to create a media climate favorable to positive population policies. (See Appendix C: rough draft of project, now being revised.)

Background: The Present PID

The purpose of the project is to deliver family planning services as widely as possible in the rural area, i.e., a community based distribution. It is certain that the present MOH will not accept this concept, which it interprets to be a "vertical" family planning project. This project, therefore, is necessarily based on a conviction that government policy will -- must -- change. The operative principle of the project is to begin it, now, with what is possible, i.e., training of auxiliary nurses within the ~~MOH and Social Security~~ government rural health systems; to then create what does not now exist, but is potentially acceptable to the Ministry, i.e., a network of community-based health volunteers; and then move toward what is not now possible, but, the Mission believes, will be in three or four years, i.e., a community-based distribution program, utilizing auxiliaries as supervisors and health volunteers as distributers.

The ~~present~~ project proposed in this PID is addressed strictly to community-based distribution ~~with~~ within the MOH and Social Security rural health systems; however, it should be emphasized that the concept of "community-based distribution" is conceptualized by the Mission in a somewhat broader sense. That is to say, CBD is: family planning services widely available at the community level in a medically safe but non-clinical setting. In Ecuador, this includes: health volunteers distributing contraceptives under the auspices

of the government health system, 2.) distribution through CBD projects such as the CEPAR Mánabí Project, and 3.) distribution through private pharmacies or other ~~private~~ commercial sales outlets.

Project Elements.

The present project has three essential elements -- each of which corresponds to a separate implementation phase.

These elements are:

1. Training, Support, and Educational Materials for Auxiliary Nurses. (See Appendix G. This was written as a first draft of the PID, without including the following two phases.)

2. Formation of a Network of village health Volunteers, trained and supervised by auxiliary nurses. These volunteers would include: health promoters (in collaboration with the MOH-Foderuma Health Promoter Project), empirical midwives (continuation of MOH CVR program), Rural School teachers (to be phased with present project, "Learning Modules for Demography and Sexual Education". See Appendix E), and Community leaders (e.g., health committee or mother's clubs presidents).

3. Training these health volunteers in health education and family planning and supplying them with contraceptives and educational materials.

REFERENCE DOCUMENT 10

Note: This draft was written as a population PID.

Training, Support, and Educational Materials for Auxiliary Nurses

Project Summary

The purpose of this project is to strengthen rural family planning service at its most basic delivery level within the Ministry of Health: the village-based auxiliary nurse. Under the Project, auxiliary nurses will be provided with training and retraining; supervision, follow-up training, and performance incentives and educational materials for her own use and for the community. It is expected that the project will achieve four concrete objectives: 1.) to help de-sensitize and de-politicize family planning by operationally converting it from a male-dominated ideological issue to a female-dominated health issue, 2.) to provide village women with accurate and culturally appropriate information on health and family planning, 3.) to increase the number of family planning acceptors in the rural area, and 4.) improve the quality of health care by strengthening the human infrastructure upon which sustained expansion of the rural health system is to be based. AID funds will support that part of this project that is specifically concerned with family planning; MCH or international funds will support non-family planning aspects of the project.

Project description.

From a virtual standing start a few years ago, health services in rural Ecuador have expanded from approximately [illegible] units in 197[illegible] to a projected 1,000 units by 1981.* With a concurrent burgeoning number of medicos rurales (last year [illegible] final students) to staff these facilities, it can now be said that the basic elements of a health infrastructure are being installed in rural Ecuador.

Expansion of services has been so rapid that in some areas underutilization rather than absence of services has become a problem. The quality of services and acceptance by the community--rather than the presence of buildings and personnel--are becoming increasingly important issues.

Such is the case with the delivery of family planning services. Most rural facilities are now supplied with contraceptives, and there is a Ministry policy which nominally promotes their distribution. Nevertheless, despite availability, user levels are low, reflecting both lack of demand of a largely uninformed public and lack of training and interest on the part of health post suppliers.

At the health post level, the auxiliary nurse rather than the doctor is in many ways the key person. She is the link to the community, and to some extent, her day-to-day presence symbolizes the presence of health services.

* Big leap or $95 million.

Placed directly between the community and the ministry, the auxiliary holds enormous potential as a provider of preventative and curative health services and as a motivator for family planning. Nevertheless, for the most part auxiliaries stay in the health posts and play a passive role, "helping the doctor" or being on-call to give first-aid and injections.

There are several reasons for this:

1.) Lack of training. Most auxiliaries have a basic sixth grade education and a few weeks to a few months of formal vaccination-oriented nursing training. Many auxiliaries have worked in the field for years without refresher courses, in-service hospital experience, or the stimulation of reading materials for health paraprofessionals -- much less, reading in community organization, communications, and sociology.

2.) Lack of supportive supervision. Once an auxiliary arrives in the field she is usually on her own. A doctor supervises her, but essentially he encourages her to fulfill a strictly secondary role in the curative services that he offers. There is little esprit de corps or sense of professionalism among auxiliaries. What is lacking is not administrative direction but a supervised work environment that fosters imagination, incentive, and professionalism.

3.) Cultural barriers. Auxiliaries tend to come from small towns or cities, and for the most part, considerable social distance exist between them and the communities. Auxiliaries invariably share the paternalism and cultural biases of the larger society they represent. As a result, the auxiliary, like the village schoolteacher, maintains a specially defined social niche in the community. She is treated respectfully, as a useful necessity; but she is often isolated. From the community's point of view, she belongs in the health post, and is not necessarily welcome in homes, despite Ministry norms and her own good intentions.

4.) Lack of educational materials. It is expected that the auxiliary "give talks" on health, but there is very little material that actually filters down which might actually suggest form or content for talks. In the absence of substantive teaching materials, she relies on her own educational background and cultural biases. As a result, her platicas tend to be moralizing at a captive audience, i.e. waiting room or lecha avante, rather than the creation of a genuine learning environment for a receptive and willing audience. Effective visual aids rarely reach the village level. Ecuadorian villagers appear to enjoy films, yet the logistics -- ordering films through Quito and the Jefatura, getting the films, transporting them to the village, setting up

projectors, setting up generators, getting the audience on the right night, getting relevant films, getting films in Spanish -- present formidable obstacles. Similarly, the rural school teacher -- who might collaborate with the auxiliary in health education -- is not supplied with curriculum materials or visual aids for health education. And finally, there are virtually no simple, Tonalá-specific educational materials for women to read and share in the privacy of their homes, e.g., information on family planning,

5.) Ministry norms. The Ministry, in its desire to expand services with minimal supervisory personnel, assigns work norms for the auxiliaries. This often has the effect of promoting a quantitative rather than a qualitative, evaluative approach to the auxiliary's work. For example, the number of injections that are given are carefully recorded, but not what is being injected. The number of health talks is recorded but there is no measurement of the impact of these talks. It is mandated that both doctors and auxiliaries participate in forming village health committees or mother's clubs; yet such organizations are frequently formed in disregard to pre-existing, or even competing, community organizations.

All the above factors contribute to a weakening of the effectiveness of the auxiliary and serve to promote her passivity. In family planning, for example, lack of training leaves the auxiliary with a somewhat hazy idea of human reproduction and exaggerated notions as to the side-effects and contraindications of contraceptive techniques. Lack of supervision and field support -- especially since her actual supervision is by the *médico rural*, who is usually opposed or indifferent to family planning -- discourages her from initiative and imaginative programming. Cultural barriers make it difficult for her to penetrate, even understand, the resistance of the community. The lack of educational materials -- especially educational materials that are appropriate to the specific needs of her community -- restrict her potential to act as a family planning motivator and communicator. And Ministry norms create a situation in which she typically gives a great many talks but has very few users.

Project Elements:

The project will consist of three main elements:

1. Training and re-training for auxiliary nurses.

1.1. Revise (in collaboration with the MSP and nursing schools) the curriculum for auxiliary nurses' training program. It is expected that such a curriculum re-design would de-emphasize rote memorization and encourage skills for problem-solving, i.e., techniques such as simulation learning, role playing, case studies.

..Include work in sociology

..Include work in techniques of community organization

..Include work in communications, especially communication at the village level

..Include work in the preparation and use of educational and audiovisual materials

..Include work in family planning

1.2. Re-design the curriculum and training process for trainers of auxiliaries (the Boston U. Project)

1.3. Create and improve opportunities for in-service training for auxiliaries, especially work in gyne-obstetrics

1.4. Design re-training and refresher courses for nurses who already have substantial field experience

1.5. Phase training courses so that short sessions extend over a 2-3 year period, allowing educationally-supervised field training and feedback by the auxiliaries into the curriculum

1.6. Provide financial support for living expenses and materials so that auxiliaries can attend sessions.

1.7. Special support for recruiting and training Indian women to work in their own communities as auxiliaries

2. Supportive Supervision, Follow-up training, and Performance Incentives.

2.1. Supportive Supervision.

..Create, on a regional basis, a supervisory system for nurses (Perhaps "supervisor" isn't the right word: something more to the effect of "coordinator", "motivator", "supporter", "backstopper", "encourager"....

Such "supervisors" would be woman doctors, obstetricians, or registered nurses who have had special training for this program, including intensive training in Maternal-Child health and family planning.

..Provide office space, secretarial support, and transportation for these "supervisors"

..To establish impact and performance-oriented norms for the programs

..In collaboration with the field auxiliaries, analyze the material resources necessary for this program (i.e., medicines, contraceptives, food-for-work, funds for community projects); analyze the supply system for these inputs; and take actions to facilitate the flow of material inputs (the Project can help in funding in this regard)

2.2. Follow-up Training

..Provide opportunites for experienced auxiliaries who are in the program to receive follow-up training and refresher courses

..Support the formation of a professional organization or a continuing education association for auxiliary nurses. Initial funds might be provided, for example, for a periodic newsletter, containing information on auxiliaries' activities, news of the MSP, public health news, medical advances, case studies of actual village projects undertaken by auxiliaries, how-to ideas, educational and employment opportunities.

..Provide scholarships for outstanding auxiliaries to continue their education in nursing or other fields

..Provide travel opportunities within Ecuador for auxiliaries to visit experimental or pilot projects. One or two such visits might be followed by a 1-2 day seminar.

2.3. Performance Incentives.

..Establish financial resources which will help auxiliaries help the communities to actually carry out projects

..At an administrative level in project areas, establi

CBW contact with service institutions (especially MAC, INCAP, INTRAC) in order to facilitate coordination and cooperation at the operative level.

..Establish means for public recognition (prizes, awards to villages or auxiliaries, newspaper articles, professional recognition) to outstanding auxiliaries or to communities who do outstanding projects.

..Provide means and incentives for nurses and community members (through school projects, perhaps) to participate in the production of educational materials

2. Educational Materials

2.1. Educational materials for auxiliaries

..Health Project ideas with how-to information, eg, water and latrines

..Simple pharmacology manuals, emphasing the use and abuse of injections

..Manual on parasitosis

..Manual on safe use of agrochemicals and treatment of toxification

..First Aid guide

..Family Planning guide

..Principles of village communications and community organizat

..Didactic materials for use in the health post, i.e., flannelographs, flipcharts, posters, outlines for talks, et

2.2. Educational Materials for use by community members

..(This could be supplmented by the "Bogue Project" or a similar non-Bogue project)

..On the basis of field diagnois and pre-testing of materials, create a body of educational materials that are appropriate to the needs and interests of the target populations. Such materials might include pamphlets, posters, dramatizations, guides for campesinos, schoolroom displays, radio massages. It is expected that auxiliaries, educational materials specialists, campesinos, and school groups might participate in the process of preparation of materials.

..Devise methodology for evaluating the effectiveness of these materials.

Beneficiaries

The rural poor, especially women and children, who are the major users of health post services

Relationship to CDSS and host country priorities

1. CDSS, page 40: " This (BID loan) will permit the MOH to extend its physical facilities, but USAID believes that gaps will remain for the preparation of the necessary human resources. USAID sees an opportunity to participate in the program in both the preparation of the technical personnel who organize, instruct in, administer, and evaluate the program and the training of the paraprofessionals themselves. The latter are members of the local communities who not only must be trained in health, nutrition, and family planning techniques but must be taught principles of community development and how to coordinate with other GOE entities (e.g., MOE, MAG)."

2. CDSS, page 51: "First, it (AID) will work with the MOH to extend family planning programs into the rural health centers where such programs are sorely needed."

3. The MOH has a clear, and for the timebeing, well accepted policy of supporting family planning <u>only</u> within the context of Maternal-Child Health Care. Family planning, as a demographic objective, is opposed by the Ministry. The Ministry will not accept a vertical family planning program of any sort. This project is one of a limited number of alternatives in which AID can support family planning within the Ministry in a way that is acceptable and unlikely to cause a political backlash.

4. This project fits squarely into the Ministry's overall strategy of extension of rural health services. It does not represent a significant change in programming nor is it likely to require high level policy decisions. BID has provided money for the construction of health posts. UNFPA is apparently willing

and possibly training;

to provide support for auxiliary salaries, It is likely that the Ministry, with its own funds or funds from other international donors, can co-finance this program. It is doubtful that shortage of funds is in itself a problem. In developing this project, an important consideration should be the Ministry's actual capacity to absorb funds and effectively manage the project. The speed at which the rural health system can actually be extended (of which, this project is a subcomponent) and 2.) the availability of other funds are crucial factors to be examined before determining the financial scale and phasing of this project.

PROJECT DESCRIPTION

I. Pathfinder Project Identification Number

II. Project Title

Ecuador: Drugstore Training

III. Grantee

Centro de Promoción de Paternidad Responsable (CEPAR)
Italia No. 788
Quito, Ecuador

Mr. Armando Reinoso, Administrator

IV. Project Summary

This project will provide 500 drugstore owners and employees in the most heavily-populated Andean provinces of Pichincha and Azuay instruction in human reproduction and contraceptive methods. Eighteen courses will be given in Pichincha and four in Azuay. Training activities will be closely coordinated with the Ecuadorean Association of Pharmacy owners.

If successful, CEPAR expects to offer the training in the other eight Andean provinces next year.

Pathfinder expects another Ecuadorean organization to provide drugstore training in coastal provinces.

V. Project Duration

The organization of the courses and their presentation will take one year.

Pathfinder only will fund first year activities under this grant. A second year of Pathfinder support will depend on the successful attainment of first year goals.

CEPAR is prepared to start project activities on notification of funding.

VI. Project Inputs

A. Inputs by Pathfinder

1.	Cash	$ 33,400
2.	Services (audit)	

VII. Personnel and Facilities

CEPAR is a non-profit Ecuadorean organization, legally sanctioned by the Government, whose principal objective is to promote responsible parenthood activities. Its members are professionals working in areas of health, sex education, and family planning and population. Mr. Armando Reinoso will be responsible for overall administration of this project.

Dr. Gustavo Valarezo will serve as Director of Project Activities. Dr. Valarezo is a general practioner who in addition to his private practice provides medical service to Military Personnel. He also owns and operates a pharmacy. Dr. Valarezo has attended three family planning courses in 1969, 1971, and 1977, sponsored by the Ecuadorean Armed Forces and was a participant in the Pathfinder-supported South American Drugstore Employees Training Seminar held in May, 1978 in Bogotá, Colombia.

Dr. Valarezo will be responsible for administration of the training program, coordination with CEPAR, and submission of timely and accurate progress reports to CEPAR.

Dr. Colón Cañizares, will serve as project coordinator. Dr. Cañizares is a graduate of chemistry and parmacy and was the first president of the Association of Pharmacy Owners. Dr. Cañizares will be responsible for motivation and selection of participants.

Drs. Valarezo and Cañizares will be assisted in project activities by a secretary and a projectionist/messenger. For presenting the courses, they will rely on assistance of professionals of other local family planning organizations such as the Asociación Pro-Bienestar de la Familia Ecuatoriana (APROFE - the local family planning association), and the Centro Médico de Orientación y Planificación Familiar (CEMOPLAF).

VIII. Plan of Action

The project will have two phases: One month for organization and eleven months to hold the courses. All organization activities and instruction will be completed in Pichincha before the program is extended to Azuay.

Organization phase: The following activities will be carried out:

1. Compilation of the number, location, and staffing of drugstores. This activity will be completed during the first mongth for Pichincha and the tenth month for Azuay.

2. Preparation of didactic material.

3. Preparation of a consultation manual to be given to all participants on completion of the courses for their use as a reference manual.

4. Preparation of a motivational poster to be given to participants for display in each drugstore.

5. Selection of instructors for each subject from organizations listed above. New instructors will be selected each trimester to maintain their enthusiasm.

Instruction phase:

The following activities will be carried out:

1. Presentation of one course every other week for 36 weeks (for a total of 18 courses) in Pichincha's capital city, Quito, followed by one course every other week for eight weeks (total of four courses) in Azuay's capital, Cuenca. During the lapses between each two courses, administrative staff will contact prospective participants. Each participant will attend one course.

   The course will be given on Sundays and will last eight hours. (A course schedule is included as Attachment I. Schedule and course content will be redesigned if necessary, as project develops).

   To determine participant understanding of course material, a pre- and post-course evaluation will be administered. The post evaluation will send by mail 15 days after each course termination.

   As an additional measure of course effectiveness, contraceptive sales in 10% of randomly- selected drugstores having participants in the course will be assessed one month prior to the course and three months after the training.

IX. Objective

The general objective is to correct drugstore owner and employee lack of knowledge of human reproduction and contraceptive methods so they can better attend their customers and favorably influence public opinion on contraception. Instruction should reinforce reputation of drugstores as being sources of information on health-related matters and should result in increased contraceptive sales.

The specific objective is to provide contraceptive instruction to the owner and one employee of the approximately 250 drugstores in Pichincha and Azuay. Four hundred eight owners and employees will receive training in Pichincha; 92 in Azuay.

X. Reporting

1. Financial: CEPAR will forward quarterly a completed Pathfinder Grantee's Cash Advance form.

2. Programmatic: CEPAR also will submit the following quarterly:

   - dates of courses held
   - names of participants and names and location of their pharmacy
   - results of pre- and post-course evaluation of participant knowledge of course material.

   In addition, six months after conclusion of the final course, CEPAR will forward results of pre- and post-course changes in drugstores contraceptive sales. A pre report will be submitted one month prior the conclusion of the final course.

XI. Budget

Mr. Armando Reinoso will be responsible for accounting for project funds.

1. Personnel

Project Director 4 hrs/day at $270	3,240
Project Coordinator 4 hrs/day at $250	3,000
Research Assistant (contraceptive sales study) 2 hrs/day at $100	1,200
Secretary (8 hrs/day) at $110	1,320
Messenger/Receptionist (8 hrs) at $100	1,200

2. Fringe Benefits (45.5% of basic salary, by law) 4,527

3. Administrative Expenses

Didactic materials	900
Student materials (pencils, paper, diplomas, manuals and poster)	3,993

4. Purchased Services

Mail, telephone, office supplies	1,550
Fees (lecturers) conference hour $10	1,770
Rent of training facility for 22 courses $40	880
Course evaluation	160

5. Travel and living

Travel (Azuay courses)

Administrative Staff

a. Four staff members, four courses at $33	528
b. One staff member, 2 promotional visits at $33	66
c. Research assistant 2 visits at $33	66
d. Instructors (six lecturers four courses at $33)	792
e. Local coordinator	463
f. Research assistant	92.50
g. Approximately 50 participants from rural areas (50 x 3.80 each)	190

Living

Azuay

a. Four staff members, four courses at $20	640
b. One staff member, 10 days promotional activities at $20	200
c. Research assistant, 2 visits 2 days at $20	80
d. Lecturers - 6 for four courses at $20	960
e. Participant lunch and snacks 408 x $7.40 (Quito)	3,019
92 x $7.40 (Cuenca)	681

6. Equipment

U.S. purchase

1.Slide projector	P.S.
1 Motion picture projector	P.S.

7. CEPAR Overhead (6%)		1,882.50
	Total:	$33,400.00

Attachment 1

COURSE SCHEDULE

8:00 - 8:10	Opening
8:10 - 9:00	Human relations/communications techniques
9:00 - 10:00	Anatomy and Physiology of Male and Female Reproductive Organs
10:00 - 10:15	Break
10:15 - 11:15	Development and Psychosexual Evolution
11:15 - 12:15	Family Planning as a Function of Preventive Medicine Abortion
12:15 - 1:00	Responsible Parenthood
1:00 - 2:30	Lunch
2:30 - 3:15	Contraception: Medical and Social Aspects
3:15 - 4:00	Contraception Methods
4:00 - 4:15	Break
4:15 - 4:45	Contraception Methods: Selection, Contraindications
4:45 - 5:45	"Socio Dramas"
5:50 - 6:00	Closing

REFERENCE DOCUMENT 12

GEOGRAPHIC DISTRIBUTION OF COMUNAS AND DISPENSARIES

No.	COMUNA	PARROQUIA	CANTON	PROVINCE	DATE ENTERED SSC
1	MONTE VERDE	San Gabriel	Montúfar	Carchi	74-Jun-14
2	CANCHAGUANO	San José	Montúfar	Carchi	74-Jun-14
3	EL CHAMIZO	San Gabriel	Montúfar	Carchi	74-Jun-14
4	EL ROSAL	San José	Montúfar	Carchi	74-Ago-27
5	LA DELICIA	Gon.Suárez	Montúfar	Carchi	76-Mar-13
6	CHUTAN BAJO	Gon.Suárez	Montúfar	Carchi	76-Mar- 13
7	YANAYACU	San Roque	Ant.Ante	Imbabura	68-Sep-01
8	AZAMA	San Luis	Otavalo	Imbabura	73-Dic-20
9	S.Vic.de OVALOS	Natabuela	Ant.Ante	Imbabura	74-Sep-27
10	SANTA ISABEL	Andrade Marín	Ant.Ante	Imbabura	74-Sep-27
11	LA CRUZ	San Antonio	Ibarra	Imbabura	74-Sep-27
12	QUINCHUQUI	Miguel Egas	Otavalo	Imbabura	75-Sep-18
13	AGATO	Miguel Egas	Otavalo	Imbabura	75-Sep-18
14	EL JUNCAL	Ambuquí	Ibarra	Imbabura	75-Sep-18
15	CHALGUAYACU	Pimampiro	Ibarra	Imbabura	75-Sep-18
16	CARPUELA	Ambuquí	Ibarra	Imbabura	75-Sep-18
17	S.FCO.de CALDERA	Monteolivo	Montúfar	Carchi	75-Sep-18
18	PIQUIUCHO	Los Andes	Montúfar	Carchi	75-Sep-18
19	EL CHOTA	Ambuquí	Ibarra	Imbabura	75-Dic-28
20	MASCARILLAS	Mira	Espejo	Carchi	75-Dic-28
21	TUMBATU	San Vicente	Montúfar	Carchi	75-Dic-28
22	LA VICTORIA	Pablo Arenas	Ibarra	Imbabura	76-Dic-11
23	S.LUIS de SALINAS	Salinas	Ibarra	Imbabura	76-Dic-11
24	S.JOSE de PUNGE	San Luis	Otavalo	Imbabura	77-Abr-30
25	CARRERA	Cangahua	Cayambe	Pichinch.	73-Jul-21
26	EL ESFUERZO	Sto.Domingo	Sto.Dom.	Pichinch.	75-Mar-14
27	Dr.J.R.CHIRIBOGA	Sto.Domingo	Sto.Dom.	Pichinch.	75-Jul-18
28	SAN MIGUEL	Sto.Domingo	Sto.Domin.	Pichinch.	75-Dic-02
29	J.MOR. ESPINOZA	Sto.Domingo	Sto.Domin.	Pichinch.	75-Dic-02
30	FLOR DEL VALLE	Sto.Domingo	Sto.Domin.	Pichinch.	75-Dic-19
31	S.PEDRO LAUREL	Sto.Domingo	Sto.Domin.	Pichinch.	76-Jun-27
32	EL PARAISO	Pacto	Quito	Pichinch.	77-Jun-25
33	EL PROGRESO	Pacto	Quito	Pichinch.	77-Jun-25
34	BUENOS AIRES	Pacto	Quito	Pichinch.	77-Jun-25
35	NUEVO AZUAY	Pacto	Quito	Pichinch,	77-Jun-25
36	VALLE HERMOSO	Sto.Domingo	Sto.Domin.	Pichinch.	79-Ene-13

No.	COMUNA	PARROQUIA	CANTON	PROVINCE	DATE ENTERED SSC
37	SAN SEBASTIAN	Guaytacama	Latacunga	Cotopaxi	75-Abr-11
38	PUPANA SUR	Guaytacama	Latacunga	Cotopaxi	75-Abr-11
39	PUPANA NORTE	Guaytacama	Latacunga	Cotopaxi	75-Abr-11
40	LA FLORESTA	Guaytacama	Latacunga	Cotopaxi	75-Abr-11
41	CUICUNO	Guaytacama	Latacunga	Cotopaxi	75-Abr-11
42	PILACOTO	Guaytacama	Latacunga	Cotopaxi	75-Abr-11
43	LA LIBERTAD	Guaytacama	Latacunga	Cotopaxi	75-Abr-11
44	LLACTAHURCO	Cusubamba	Salcedo	Cotopaxi	76-May-28
45	SAN JOSE DE RUBIOS	Cusubamba	Salcedo	Cotopaxi	76-May-28
46	ILLUCHI	Bel.Quevedo	Latacunga	Cotopaxi	77-May-01
47	CHIPE HAMBURGO	La Maná	Pujilí	Cotopaxi	77-Jul-02
48	EL GALPON	San Miguel	Salcedo	Cotopaxi	77-Jul-30
49	PUÑACHISA	Quero	Quero	Tungurah.	73-Dic-14
50	PUEBLO VIEJO	Quero	Quero	Tungurah.	74-Dic-01
51	EL PLACER	Quero	Quero	Tungurah.	74-Dic-01
52	SEGOVIA	Huambalá	Pelileo	Tungurah.	75-Feb-13
53	LA MERCED	Huambalá	Pelileo	Tungurah.	76-Jun-11
54	LA FLORIDA	Huambalá	Pelileo	Tungurah.	76-Dic-02
55	SURANCAY	Huambalá	Pelileo	Tungurah.	77-Abr-28
56	JALOA LA PLAYA	Quero	Quero	Tungurah.	75-Sep-26
57	JALOA EL ROSARIO	Quero	Quero	Tungurah.	75-Sep-26
58	SABAÑAG	Quero	Quero	Tungurah.	77-Sep-26
59	LLIMPE GRANDE	Quero	Quero	Tungurah.	77-Ene-05
60	S.RAFAEL BAJO	Patate	Patate	Tungurah.	77-Jun-16
61	S.RAFAEL ALTO	Patate	Patate	Tungurah.	77-Jun-16
62	PUÑAPI	Patate	Patate	Tungurah.	77-Jun-16
63	LEITILLO	Patate	Patate	Tungurah.	77-Jun-16
64	GUABUG	San Juan	Riobamba	Chimbora.	68-Sep-01
65	SHOBOL LLINLLIN	San Juan	Riobamba	Chimbora.	75-Mar-19
66	SHOBOL Alt.GUADA.	San Juan	Riobamba	Chimbora.	76-Nov-12
67	GUSO DE PENIPE	Penipe	Guano	Chimbora.	73-Oct-26
68	GUSO DE GUANANDO	Guanando	Guano	Chimbora.	73-Oct-26
69	AYANQUIL	El Altar	Guano	Chimbora.	75-Mar-20
70	PACHANILLAY	El Altar	Guano	Chimbora.	75-Mar-20
71	COLAYTUS	Bayoshi	Guano	Chimbora.	75-Mar-20
72	UTUGÑAG	El Altar	Guano	Chimbora.	76-May-13

NO.	COMUNA	PARROQUIA	CANTON	PROVINCE	DATE ENTERED SSC
73	GAMZI	El Altar	Guano	Chimbora.	76-May-13
74	NAHUANTUS	Bayushi	Guano	Chimbora.	76-May-13
75	CALSHI	Matus	Guano	Chimbora.	76-May-13
76	CAHUAJI	Bayushi	Guano	Chimbora.	76-May-13
77	MATUS ALTO	Matus	Guano	Chimbora.	76-Nov-12
78	AZACUCHO	Altar	Guano	Chimbora.	76-Dic-10
79	S.FCO.CUNUGUACH.	Calpi	Riobamba	Chimbora.	74-May-03
80	BAYUSHI CALPILO.	Calpi	Riobamba	Chimbora.	75-Mar-19
81	NITILUISA	Calpi	Riobamba	Chimbora.	75-Mar-19
82	CAPILLALOMA	San Juan	Riobamba	Chimbora.	75-Mar-19
83	BAYUSHI S.VICEN.	Calpi	Riobamba	Chimbora.	76-Nov-12
84	PALACIO REAL	Calpi	Riobamba	Chimbora.	76-Nov-12
85	GUSO DE QUIMIAG	Quimiag	Riobamba	Chimbora.	74-Jun-21
86	BALCASHI	Quimiag	Riobamba	Chimbora.	74-Jun-21
87	LA MOYA	Guasuntos	Alausí	Chimbora.	75-May-06
88	ZUNAG	Gonzal	Chunchi	Chimbora.	76-May-06
89	COBSHE	Achupallas	Alausí	Chimbora.	75-May-06
90	SHOBOL-PAMBA	San Juan	Riobamba	Chimbora.	75-Sep-02
91	BALLAGAN MURUQ.	San Juan	Riobamba	Chimbora.	75-Sep-02
92	CHAUPI-POMALO	San Juan	Riobamba	Chimbora.	75-Sep-02
93	PISICAS	San Juan	Riobamba	Chimbora.	75-Sep-02
94	CALERITA STA.RO.	San Juan	Riobamba	Chimbora.	76-May-13
95	CALERA GRANDE P.	San Juan	Riobamba	Chimbora.	78-Ene-27
96	MANZANO	Puela	Guano	Chimbora.	77-Jun-09
97	ANABA	Puela	Guano	Chimbora.	77-Jun-09
98	PUNGAL	Puela	Guano	Chimbora.	77-Jun-09
99	YUIBUG	Puela	Guano	Chimbora.	77-Jun-09
100	SAN LUIS	O.Cordero	Cuenca	Azuay	78-Dic-28
101	EL TABLON	O.Cordero	Cuenca	Azuay	75-Jun-11
102	SHIÑA	Nabón	Girón	Azuay	77-Ene-21
103	S.PEDRO MARTIR	Chile	Calvas	Loja	76-May-07
104	YAMBACA NONGORA	Cariamanga	Calvas	Loja	77-Ene-08
105	TABLONCILLO	Cariamanga	Calvas	Loja	77-Ene-08
* 106	LA PILA *	Montecristi	Montecris.	Manabí	68-Sep-01
107	BAJO DEL PECHIC.	Montecristi	Montecris.	Manabí	74-Jun-05
108	BAJO DE LA PALMA	Montecristi	Montecris.	Manabí	74-Jun-05

No.	COMUNA	PARROQUIA	CANTON	PROVINCE	DATE ENTERED
109	BAJO DE AFUERA	Montecristi	Montecri.	Manabí	74-Jun-05
110	EL PROGRESO	San Plácido	Portovie.	Manabí	74-Ago-27
111	LAS TUNAS	Puerto López	Jipijapa	Manabí	75-Jul-17
* 112	SANCAN *	Jipijapa	Jipijapa	Manabí	75-Dic-01
113	V.M.RENDON	Pajón	Pajón	Manabí	76-Jun-25
114	RIO CAÑA	Ayacucho	Santa Ana	Manabí	76-Jul-23
* 115	HIGUERON *	Rocafuerte	Rocafuer.	Manabí	76-Jul-24
116	EL PITAL	Puerto López	Jipijapa	Manabí	77-Ene-15
117	PACHINCHE	Colón	Portovier	Manabí	79-Feb-03
118	BUENA FE	Quevedo	Quevedo	Los Ríos	73-Sep-15
119	PALMAR	Colonche	S.Elena	Guayas	68-Sep-01
120	LA CHIQUITA	Chobo-Cone	Milagro Y.	Guayas	75-Oct-3
121	PETRILLO	Piedrahita	Daule	Guayas	76-Dic-28
122	EL AZUCAR	Santa Elena	S.Elena	Guayas	77-Jun-04
123	SAYA	Santa Elena	S. Elena	Guayas	77-Jun-04
124	SUBE Y BAJA	Julio Moreno	S. Elena	Guayas	77-Jun-04
125	CALICANTO	Colonche	S.Elena	Guayas	77-Jun-04
126	AGUADITA	Colonche	S. Elena	Guayas	78-Dic-23
127	BARCELONA	Manglaralto	S. Elena	Guayas	77-Jun-05
128	CINCHAL	Manglaralto	S. Elena	Guayas	77-Jun-05
129	J.SHIGUANGO	Archidona	Tena	Napo	75-Feb-12
130	MUYUNA	Tena	Tena	Napo	75-Nov-24
131	CAMPANACOCHA	Ahuano	Tena	Napo	78-Feb-12
132	DAYUNO	Ahuano	Tena	Napo	78-Feb-12
133	SANTA ROSA	Chontapunta	Tena	Napo	78-Feb-12
134	PUCA-CHICTA	Misahualli	Tena	Napo	78-Feb-12
135	CAMPO-COCHA	Ahuano	Tena	Napo	78-Feb-12
136	SUNINO	Chontapunta	Tena	Napo	78-Feb-12
137	BELLAVISTA	Chontapunta	Tena	Napo	78-Feb-12
138	DORADO HUAMBUNO	Ahuano	Tena	Napo	78-May-13
139	UNION Y PROGRESO	Progreso	S.Cristó.	Galápagos	76-Feb-14

Note: Communa name underlined indicates presence of a dispensary. Asterisk (*) indicates facilitity visited by consultant.

III. PROPOSAL FOR AN INTEGRATED RURAL HEALTH/RURAL DEVELOPMENT PROJECT

1. Project Title: Integrated Rural Health/Rural Development

2. Project goal: To develop a moderate-cost model -- replicable at a national scale -- ~~of~~ for improving health and income levels in poor rural areas of Ecuador.

3. Project Summary:

This project proposes an experiment with a bottom-up development model to be carried out in 15-20 small communities in one or more geographic areas. These communities (organized legally into comunas by MAG) and the SSC program of IESS will jointly install and progressively expand a community-based curative and preventative health infrastructure. On the basis of community needs and experience gained in the health phase, the communities will then develop individual small-scale community development projects (ideally, ~~within a~~ in a regionally collaborative, mutually interactive ~~framework~~ manner). It is to be expected that the Central Bank, through FODERUMA, ~~will be the~~ would be a key agency in providing credit and technical assistance. ~~in carrying out these projects.~~ The role of AID is to provide the financial incentive and organizational frame that will allow the two principal participating agencies -- SSC and FODERUMA -- to assist the communities in carrying out the

projects and in obtaining progressively broader services from other Ecuadorean service institutions, especially MAG, IEOS, ME, and INERH.

4. Project Discussion:

It is to be expected that a large amount of money invested in a relatively small geographic area will have a significant impact on levels of health and rural income. The recently approved World Bank Tungurahua Rural Development Project, for example, proposes to direct $30 million at 16,000 rural families living in a 300 km^2 area -- which is to say, $361 per person; or $2.3 million for each of the 13 villages located in the project area.

The purpose of this project is to determine whether a similar positive impacts on health and income levels can be achieved at a moderate cost, using a bottom-up rather than a top-down development model.

The three essential operating principals to these project are:

4.1. That the communty can and should share costs, labor, planning, and decision-making

4.2. That presently existing Ecuadorean institutions (especially SSC in rural health and FODERUMA in the financing of rural development) are developing

cost-effective techniques aimed at the marginal campesino; that these models can be integrated, expanded, and improved.

4.3. That cash inputs from AID should not be larger than the communities and Ecuadorean institutions can effectively absorb, administer, and realistically expect to replicate -- essentially, that AID is forwarding the model rather than financing the development.

5. Project Duration: 3-5 years.

6. Project Target Areas:

The overall project would consist of one or more project areas, each of which would cover the rural population of a small canton -- 15-20 communities with a population of approximately 10-15,000. On the basis of past SSC experience, it is estimated that about 50% of the families in these communities would directly participate. Cantones would be selected which are poor, rural, not now covered by the Ministry of Public Health, not now involved in other major projects, and which are interested in organizing and actively participating in the project. It is to be expected that 1 or 2 ~~target areas~~ cantones would be

initiated the first year and that additions be made in subsequent years.

7. Phases in implementation. (for each Project Target Area)

7.1. First phase: SSC and MAG legally organize the communities into comunas.

7.2. Second phase: SSC and the communities install 4-5 rural dispensaries, each of which serves 3-4 smaller communities. In establishing the physical health infrastructure, the communities gain organizational skills, develop a leadership structure, and develop an action-oriented forum for articulating their needs.

7.3. Third phase: Individual communities select health promoters, who are trained by SSC with support from other institutions. Each dispensary will have 3-4 health promoters, each of whom is largely supported by and assigned to his home community. The comuna leadership, health promoters -- supported but not directed by field workers from participating agencies -- identify, discuss, and give priorities to village-level development projects. These might include projects in environmental sanitation, potable water and irrigation, electrification,

agriculture, and small-enterprise development.

7.4. Fourth phase: As projects are identified, they are presented for financing to FODERUMA or to other institutions which can provide technical services or financial support. It is not the responsibility of the Rural Health/Rural Development Project itself to approve or reject projects; that is the function of FODERUMA or the local agencies involved. However, RH/RD may provide help in preparing projects (help in paperwork or legal support, for example); it may pressure or provide financial incentives to agencies to handle project requests expediously; and it will provide a regional development overview for individual village project planners (trying to coordinate 3 or 4 water projects into one, for example);

7.5. Fifth phase: As individual project are approved, it is the responsibility of the communities to implement them in accordance with the requirements of the sponsoring institutions and to re-pay loans. The number of small projects that a community can manage will depend on the skill which it evolves in project implementation and credit management.

8. Participation of AID.

8.1. Provide the initial impetus and coordination for the project.

8.2. Establish a special credit fund within FODERUMA to support project activities.

8.3. Provide support to SSC in financing health infrastructure costs (however, it is expected that SSC is able to support the greater part of its own programs with its own budgetary allocations and S/ 20 per month contribution from participating families).

8.4. Provide material inputs to strengthen those components of the project which include health education, family planning, and nutrition.

8.5. Provide support for the training of health promoters, auxiliary nurses, and village leaders; support for planning meetings and site visits by village leaders; support for a small regional project office.

8,6. Work with other agencies at the national and regional levels to encourage inter-institutional cooperation and collaboration (this might include actions such as providing construction materials for a local IEOS office, for example).

8.7. Evaluate the project.