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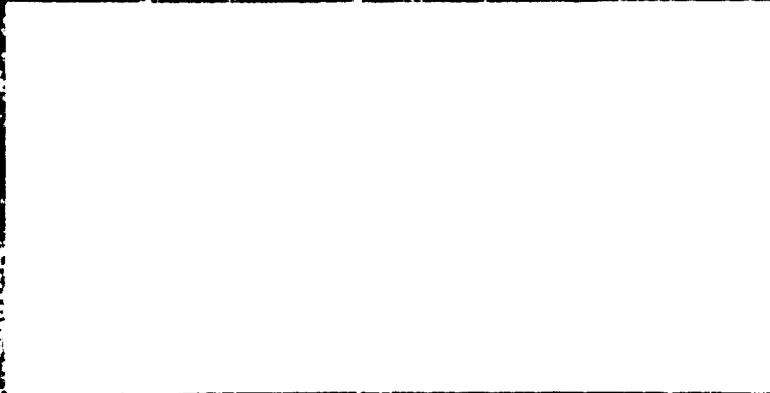
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INTEGRATED RURAL HEALTH IN ECUADOR:
A STUDY OF
PLANNING AND IMPLEMENTATION

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ABBREVIATIONS

GOE	Government of Ecuador
IRD	Integrated Rural Delivery
IRHDS	Integrated Rural Health Delivery System
MOH	Ministry of Health
PES	Project Evaluation Summary
PID	Project Identification Document
SSA	Social Soundness Analysis
USAID	United States Agency for International Development

Part One

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Background

The four cantons where the health service project will be implemented represent two major and distinct geo-cultural regions of Ecuador: the Sierra and the Coast. Among themselves, they differ considerably in their isolation from population centers, their ethnic composition, previous experience with health and development projects sponsored by the Government of Ecuador (GOE), and forms of social organization. Because of this variety, they are good sites for testing the GOE's promise to decentralize developmental planning and service provision and its ability to tailor projects to locally-specific conditions. Both the GOE and the United States Agency for International Development (USAID) have recognized the differences among the areas and the need for project implementers to be sensitive to the need to be flexible in order to adapt successfully.

The vast majority of people in the four cantons, both individually and as communities, now have limited access to the kinds of services this project will provide. This limitation results from lack of awareness, social and geographical distance from providers, and lack of financial and political capacity to bring services and providers closer to communities. The proposed project is designed to reduce distance from services, to increase awareness, and to ensure that the communities can maintain and control the services and facilities that are established by the project.

Each of the four project areas is predominantly rural, with 70 percent or more of the economically active population participating in agricultural activities. Nonetheless, the land holdings are generally too small to sustain families and, as a result, many men migrate seasonally to Quito or to other coastal areas to work as day laborers. The duration of their absences ranges from three to nine months. Such patterns of movement disrupt families and communities. In some instances, they prevent communities from generating power bases that will influence the government's consideration of and decisions about their interests. The agricultural development component of the integrated rural development (IRD) program should help to increase productivity, thus reducing the extent of seasonal migration. The health component, as well as the overall IRD program, will work to strengthen community organization through participation, thus ensuring that broader community interests are served.

Feasibility studies have been done in each of the cantons proposed as project implementation areas. These and other research studies show that there are many organizations through which the project can work to obtain community support and to adapt services to local conditions. Steps will be taken to create appropriate community organizations where they do not now exist. Further, having recognized that the different segments of the population do not have equal access to information, influences, and money, project personnel will work to ensure that the groups through which they work are representative of the population and that the interests of all segments are addressed by the project.

Socially Sensitive Features of the Project

Although the GOE and USAID have had considerable experience in planning and implementing projects designed to meet health and other needs of the rural poor, both are aware that each new project will confront novel situations, not all of which can be anticipated. For this reason, although certain methods will be used that have been proven to be satisfactory elsewhere, provisions for continuous evaluation and sensitization to possible negative social impact will be built into the project.

It is recognized that the project will have an impact on the communities that are covered by the program. Not only are changes in levels of health status anticipated, but it is expected also that the community structure will be affected, altered in form, extent, and influence as the project succeeds in enhancing the communities' ability to manage their own needs and resources. Some changes may be seen by both the recipient population and objective outsiders as salubrious, desirable, and progressive but, at the same time, socially disruptive.

The designers of the project have considered the possibility that implementation will be disruptive, and they have incorporated a number of features that are intended to avoid, or mitigate, difficulty and to reduce sociocultural trauma. These may be thought of as the "socially sensitive features" of the project. They include the following:

- Respond to the perceived needs of the population.

Investigations in the proposed program areas and elsewhere in Ecuador have shown that conveniently accessible potable water and health services geared to providing basic care are high on the population's list of "felt needs." Although the particular form that the services take may vary among regions and communities, where services are provided, they should be well received. Experience has shown that it is possible to work closely with communities to design and implement acceptable forms of service.

- Use proven, acceptable and effective methods to provide services.

AID and the GOE have had considerable experience in implementing health service programs in different parts of Ecuador. They have also been effective in installing improved water supply systems that are supported by the communities. Community acceptance of simplified health service systems has been high, and these services have been designed to meet the objective health needs of the population. Through educational and promotional efforts, project staff have managed to generate community support for and participation in nutrition, environmental sanitation, and improved health service projects throughout the country.

- Encourage community participation.

In many areas of Ecuador, there is a well established tradition of community cooperation and participation in projects that affect the people. Projects that have incorporated a community participation component have been highly successful. The IEOS's experience in encouraging community participation in the development and maintenance of water supply systems is especially notable. The IEOS has tested various means of encouraging participation and support, and it has systematized the procedures so that they can be applied broadly. The current project will capitalize on this experience and will make community participation a central feature.

- Ensure that communities have the capacity to support services and facilities after initial funding has expired.

The IEOS's experience in conducting socioeconomic studies that are a part of feasibility investigations of rural sanitation work will be used in this project. Currently, the IEOS determines each community's potential for supporting projects and for maintaining systems before it installs potable water and excreta disposal systems. This organization has found that although it is sometimes necessary to postpone project

implementation, it is possible to work with communities to generate the necessary capacity. The development of appropriate community organizations must be supported and mechanisms must be developed to obtain the necessary funds and labor.

- Integrate health services with other developmental activities.

This health project is an integrated component of a broader scheme for rural development. While health and associated services are being implemented, other developmental activities will be carried out in the program areas. The rate and phasing of implementation of these efforts will vary among the locations, thus allowing for some experimentation in identifying the most promising patterns of implementation. By integrating development activities there is greater assurance that overall needs will be met and coordinated in a reasonable manner.

- Provide for continuous assessment of social impact.

All possible problems cannot be anticipated; therefore, a plan has been incorporated into the Integrated Rural Development Project to form a group of persons who will monitor continuously social impact and identify necessary changes in plans and operational features. The purpose of this group will be to ensure that social disruption is minimized at the same time that social benefits are enhanced. The composition of this group has not been determined, but it is expected that it will be composed largely of nationals who are concerned with social impact. It is also anticipated that some members will be women.

Impact on Women

Women in the rural areas of Ecuador are especially burdened with responsibilities to maintain their families. Because men often spend considerable time away from their families, women must handle agricultural tasks as well as respond to the persistent demands of bearing and raising children and maintaining the household.

In the majority of communities where the project will be implemented, potable water is not available. The drawing and hauling of water of any kind is a demanding and time-consuming task that often requires several hours of walking each day to obtain sufficient water for drinking and non-personal use. The provision of potable water close to women's residences will increase the time women have for other productive activities, and for leisure as well. It will also contribute to the reduction of the incidence of water-borne and water-wash diseases, thus enhancing the health of women and their families. With improved health, women will have more time for other personally and socially beneficial activities.

Because most of the communities are isolated, health care is secured at great expense of both time and money. Consequently, the health needs of the population often go unattended, and an even greater burden befalls the women, for women and their children are those most frequently in need of basic health services. Even where the people have access to services, the health facilities are often operated by physicians and nurses who do not speak the language, and social distance is particularly great. By locating services closer to the people and by providing those services through persons who understand the community, real access will be increased.

Women will surely benefit, both directly and indirectly, from efforts to improve the health of the population. The ability to improve the lot of women in the project areas will be enhanced, and the incidence and severity of disease experienced by women and their children will be reduced.*

Diffusion of Program Benefits to Other Populations

This program will diffuse services and activities that have, to some extent, already been tried in other parts of Ecuador and in other countries. It is proposed that the services now be extended to new areas of the country because their feasibility and effectiveness have already been demonstrated. This program will offer another opportunity to experiment with and refine the techniques of implementation and operation. By increasing the overall scale of operation of basic health service programs in Ecuador, it should be possible to stimulate and improve economies and to reduce per-person costs.

It should be noted that a large component of this project is the development of the GOE's institutional capacity to plan, train, implement, evaluate, and maintain health projects in the country. As a result of institutional development, the GOE should be able to support extensions and replications of the project.

* Additional information on the project's impact on women can be found on pages 98 and 99 of the IRD PID.

For some years, despite the manifest need for wider coverage of health care, the GOE Ministry of Health (MOH) has not been able to spend its annual allocation of funds. If the institutional capacity of the GOE and its associated agencies is improved, the MOH should be able to spend the monies allotted to it, spend these funds more effectively, and thus reach a larger share of the population with appropriate services.

Part Two

AN EVALUATION OF OPG 518-022,
RURAL COMMUNITY HEALTH PROJECT

I. INTRODUCTION

I. INTRODUCTION

Purpose of Consultation

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

Summary of Project Purpose and Background

The JPG project was planned to provide residents of selected rural populations in five provinces with primary health care services and to improve the health status of those groups. The target populations consist primarily of the Quichua- and Shuar-speaking people, who are geographically and culturally isolated from the mainstream of Ecuadorian society and, as a result, have had no access to the health services and information provided by government agencies. Limited non-governmental health care has been provided to these populations by expatriate missionary groups working in the area. This care has been largely curative.

Accurate and precise information on morbidity and mortality levels in these populations is not available, but it is widely believed that the rates are intolerably elevated and that traditional, indigenous practices of hygiene and curing have not contributed to the improvement or maintenance of health conditions as settlement, behavioral, economic, and contact patterns have changed. To improve this situation, the project was designed to train persons from the communities to provide basic promotive, preventive, and curative services. These health workers, in turn, are supervised by persons with more sophisticated medical and health care training (i.e., physicians, nurses, and auxiliary nurses).

MAP International, the grantee, has been responsible for overseeing the coordination functions of Vozandes Hospital, the contractor. MAP International staff have also participated in health worker training and program design. Vozandes staff have directed the training, placement, supply, and supervision of health workers in the provinces where the program has been operating.

The project was not designed to implement a permanently independent health care system. From the beginning, Vozandes and provincial-level administrators of the project coordinated their efforts with those of the Ministry of Health (MOH) and the local government health systems. It was

expected that the OPS project would complement the government's work and that it would provide an experimental outreach system that could be used to test the feasibility and effectiveness of particular techniques of health care provision. Before the project was implemented a seminar was held to inform government officials of the plans for the project. To keep the Government of Ecuador (GOE) up-to-date, project staff have held informal consultations and shared project reports. Government officials have received many invitations to observe the project in operation and to participate in training sessions.

The initial project plan called for the training and placement of volunteer health workers in 138 communities with a population that was then estimated to be approximately 43,700 persons. The distribution was to be as follows:*

<u>Province</u>	<u>Number of Communities</u>	<u>Population</u>
Chimborazo Province	50	30,000
Bolivar Province	30	4,000
M.-Santiago Province	26	2,700
Pastaza Province	12	2,000
Loja Province	20	5,000

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

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

Evaluation Procedures and Limitations

An attempt was made to obtain as much information as possible about the program and its relations to other agencies and about the communities through field observations, interviews, and reviews of documents. The author will not, however, try to present a complete description of the

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

project. Those who have been working with the project for a long period of time are more qualified to provide that kind of description than one who has only a hurried, fragmentary view of the project's development and operations. The author focuses on project activities and seeks to identify those aspects that differ from many of the characteristic strategies for introducing primary health care in different countries (i.e., methods that tend to capture the fancy of national health planners). The author aims to identify characteristics that show evidence of promise in the planning and development of primary care programs and that may be useful for others who will develop programs elsewhere. His premise is that an evaluation of an experimental program will be most useful if the evaluator identifies what the program is doing and suggests how it might do better.

The project was evaluated informally. The consultant made observations at various training and service sites in the four provinces where the project was implemented. He was accompanied on these visits by personnel from Vozandes and MAP International, as well as by local supervisors and USAID/Ecuador health staff.

The consultant met with various USAID/Ecuador Health Office staff, provincial health directors in Pastaza, Chimborazo, and Bolivar provinces, and the director of the National Division of Community Development, Ministry of Health. Project staff at all levels were interviewed in the field and in the Quito offices. Discussions were conducted with health workers and community residents. (Contacts with various other persons are noted in the appendix.)

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

The site visits and meetings were well planned and efficiently handled, but it was possible to obtain only a limited first-hand view of activities and personnel at each of the training and operational sites because the locations are dispersed widely and cycles of activities are necessarily spread out over a longer period than the duration of an evaluation visit. Where communication is severely restricted, community health programs that depend on part-time workers are difficult to observe during a brief sojourn. This is such a highly varied program, a program so tailored to the needs of individual promoters, regional and community interests, and health problems, that it is not possible to obtain a clear, detailed, first-hand picture of all activities and procedures without spending several months in the project areas. The ability of the project staff to adapt training, supervision, and operations to these highly variable conditions is one of the project's major assets. At the same time, it makes it difficult to provide general summary statements that convey a suitable impression of the kind of work that is being done.

II. STATUS OF THE PROJECT

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Operations

The project is operating in four provinces: Bolivar, Chimborazo, Pastaza, and Morona-Santiago. Plans to implement the project in Loja Province were canceled because medical personnel were not available to train health promoters. The Statistical Summary, produced in 1980 at the end of two years of operation, reports that 133 persons received some promoter training and that 101 of these became active in 93 communities. The total population of the communities being served at this time was estimated to be 47,600 persons. The training of new promoters by programs operated by anyone other than the government has been curtailed since 1980, but the training of six persons who had already been selected in Bolivar Province has been approved. Training to upgrade promoters already in place has been allowed and is continuing in all provinces.

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

The program seems to have altered its initial primary focus, having shifted from the provision of personal health services to community development centered on health. Program personnel still feel that personal care and referral services are important for the health of the client populations and for the credibility of the project, but they now place more emphasis on community education, the promotion of latrine construction and proper use of latrines, the promotion of home gardens with varied produce, and improved water supplies. Training programs have had to be adapted to the changing focus and health promoters have had to allot their time differently than was first anticipated.

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

Only nine health committees were functioning when the 1980 Statistical Summary was produced. This number has been considerably augmented since then, but the total number is not known (by September 1980, there were 11 committees in Pastaza Province alone).

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

Although the construction and use of latrines is far from ubiquitous, there is evidence that latrines are being accepted in communities where they did not previously exist. Communities in Bolivar and Chimborazo are constructing latrines. In Chimborazo, project staff have been working with local residents to develop inexpensive methods for producing slabs to cover the pits.

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

The central office personnel in Vozandes and at MAP International continue to be fully involved in the coordination and supervision of the project, and they take part in staff development and promoter training as well. They and their regional supervisory staff ensure that provincial and national government health officials are regularly informed of project activities.

Program Impact

There has been no attempt to assess quantitatively the changing levels of the populations' health following implementation of the program. Given the small sizes of the populations involved and the inability of field workers to collect data, this is understandable. It is doubtful, in any event, that health measurements would be sufficiently sensitive to changes that could be expected (in the short term at least) as a result of the program. To burden most of the health workers with additional data-gathering responsibilities at this time would probably distract them from acquiring and applying knowledge of appropriate health behavior.

Changes in the communities have, however, been observed by those participating in the project. Although the statistics may not reveal a picture of dramatic change in the communities, the facts are that there are more people in each community who are better informed about health care and hygiene and there is increased interest in providing sanitary latrines and caring for children. The difference between present circumstances and conditions that existed before the program was implemented is notable.

From discussions with community leaders and project personnel who have long been working in the areas, it is evident that members of communities feel that they are more closely linked to the services (of many kinds) offered by their government and that they are beginning to recognize that they can make additional demands on the service providers.

III. OBSERVATIONS AND RECOMMENDATIONS

III. OBSERVATIONS AND RECOMMENDATIONS

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

Again, the evaluator was guided by specific questions raised by project and AID personnel in the preliminary briefings and by questions that emerged during reviews of project documents and site visits. An attempt has been made to consider what the program is doing and to suggest how these things can be better done, but the comparison of goals stated in the preliminary project documents and of progress with plans has not been undertaken.

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

Coordination

A. Observations

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

Vozandes and MAP International personnel make frequent trips to the areas and participate in supervisory and training activities at all levels. They act as trouble-shooters and facilitators, and they work with field

staff and government personnel, making sure that there is cooperation and coordination of functions. They are also responsible for obtaining and summarizing periodic reports from the areas and for providing these reports to funding agencies and government offices. The coordinating staffs of Vozandes and MAP seem to have a good handle on the training and other procedural aspects of the program in the four areas. They are knowledgeable about the status of trainees, the content of the training, the placement of personnel, and other progress in implementation.

B. Recommendations

The great variation in form and content among the project areas requires that a useful description include more than overall summary statistics. There should be a greater effort to standardize the reporting formats used in the provinces. In addition to providing some statistical information, reports should offer much more detail on problems, experiences, system needs, and system changes so that areas can be compared and generalizations can be drawn. This practice should benefit the overall coordination effort and also provide other observers with a clearer idea of how the project is operating and how coordination is working.

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

The coordination function should be seen as involving ongoing evaluations of practices that appear to be especially useful or inappropriate, given the conditions peculiar to each project area.

Selection of Health Promoters

A. Observations

The promoters who are participating in the project were, for the most part, selected in some manner by the community itself. Some health workers in Pastaza and Morona-Santiago already had some connection with the missionary health workers and some previous training in curative practices.

In selecting participants, the missionary groups tend to work through the Indigenous Evangelical Association operating in their areas. The associations, in turn, work with the communities to identify candidates for the program. In many cases, it appears that the churches and associations represent the only coherent means for outsiders to work with the communities. This is probably more true in Sierra, where the dissolution

of the hacienda system left an organizational void into which the associations moved, than elsewhere. It may be that in the provinces of Pastaza and Morona-Santiago the associations are trying to replace existing forms of community organization.

During the periods of observation and questioning, it was not possible to determine if there were any conflicts within communities over the selection of promoters. Nor was there any indication that some groups were systematically excluded from participating either as promoters or as recipients of services as a result of using a particular method to select promoters. It was reported that not all promoters were members of Christian church groups.

B. Comment and Recommendations

It would be worthwhile to examine more thoroughly the methods communities use to select health workers and to study the relationship between the project and communities. It may be that the methods are the most satisfactory and non-disruptive means of linking isolated communities with salubrious, adaptive influences. If certain segments of the population are not covered by services or brought into the participatory process, this should be made known. Other agencies interested in developing appropriate health and development programs for similar populations will need this kind of information.

Recognition of Indigenous Health Practices and Traditional Curers

A. Observations

Project supervisory personnel have taken note of some traditional health practices, but they have not, it appears, tried to cover them in their training. There seems to be a tendency to treat traditional beliefs and practices as inappropriate or detrimental. There is little awareness of any research on traditional medicine in Ecuador.

The evaluator was informed by medical people in Pastaza and Morona-Santiago that delivery is a family affair and that there are no specialized traditional midwives. It was reported that such specialists are available in the Sierra but that there also the family participates in the delivery. Apparently, no attempt has been made to bring traditional midwives into the training program. Nor has there been an effort to educate others in the delivery and care of mothers and the newborn. In fact, it is argued that because most promoters are men, they have difficulty communicating with women, other than women who are members of their own families, about the birth process. Few attempts to create mothers' clubs in any of the provinces have been successful.

B. Comment and Recommendations

Community members are taken into the health care system because they can provide a means for translating modern health into practices and recommendations that are acceptable to local populations. The failure of trainers to address traditional beliefs and practices in their training programs represents a serious deficiency. Project personnel should make an effort to understand local beliefs so that they can promote the incorporation of traditional health categories and practices into training. They should also have knowledge of particularly inappropriate practices that should be displaced. Moreover, they should seriously try to work with traditional health workers when placing new health workers in communities. It is estimated that more than 80 percent of Ecuadorean births take place outside a modern facility, and close to 100 percent of the births that occur in the project areas are not attended by any "trained" health worker. It would be most appropriate to study traditional delivery practices and to take steps to train local midwives (or family members) in the proper procedures of delivery and care of mothers and the newborn.

Training

A. Observations

It has taken longer than expected to train promoters. Strict, didactic methods have not been successful, and more informal training procedures have been adopted. MAP International has contracted for technical assistance from specialists in non-formal education from the University of Michigan. These specialists will advise the trainers on their training procedures. Typically, the health promoters had little previous experience with formal education. Several were illiterate and few had completed primary school.

Project staff have found that the promoters need more time to assimilate materials than was anticipated. They have also found that it is more satisfactory to conduct short periods of training, a few days to three weeks, and to repeat that training several times, adding new material after old material has been reviewed, than to offer completely new material at each session. Promoters return to their training centers several times each year to receive additional training.

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

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

B. Comments and Recommendations

The ability of project operators to tailor training to the needs and abilities of the promoters is a positive accomplishment. This flexibility may be essential for successful training of community health promoters. It would be advisable for staff to document more completely their experience. Providing this kind of training and supervision, however, is time-consuming and expensive. If this method works where less expensive methods do not, it should be clearly demonstrated and documented. This information will be critical for future project planning and assessment of replicability.

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

Responsibilities and Activities of the Promoters

A. Observations

The promoters are trained in health promotion and prevention and curative care at both the community and individual levels. Most program supervisors believe that the health workers are best able to gain credibility through their curative efforts and that once they have established credibility, they can then introduce changes in beliefs and practices. In Pastaza Province, however, promoters have been discouraged from providing curative care, and they are not allowed to offer even the most simple drugs to patients.

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

Efforts to promote home gardening, well-drilling, and hygiene seem to be ad hoc, a result of interest shown by the community (and generally encouraged by the promoter and supervisors). Once interest is demonstrated, steps are taken to stimulate even more interest and understanding throughout the community and to offer information and assistance in carrying out specific projects. These steps include the increased participation of supervisory staff.

Health promoters are non-paid workers who have other responsibilities that are not health-related. Therefore, they do not dedicate all their time to health work. It is not known how they divide their time among health and non-health activities.

3. Recommendations

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

Supervision

A. Observations

Supervision is a primary means of influencing health workers, checking and upgrading their knowledge, and encouraging them in their work. It is treated as an essential component of the project. Supervision is provided during site visits and at the centralized training center where promoters are brought for additional training.

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

B. Comments and Recommendations

The supervisory component of the project is expensive. It consumes valuable time of highly trained medical personnel and requires costly transportation. In the Sierra provinces, the supervisors have four-wheel-drive vehicles. In the Oriente, many communities are accessible only by small plane. In both areas, there are communities that can be reached only on foot after several hours of walking.

Supervisors seem to be able to handle their responsibilities at this time, but it is doubtful that they could be stretched much further if the program were expanded. The program could be expanded de facto if the supervisory staff were asked to assume more responsibility for working with government-trained community health workers in their areas, but they could easily become over-extended.

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

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

Cooperation with Government Health Systems

A. Observations

From the beginning, the Vozandes group has taken steps to inform provincial health chiefs and MOH personnel of their project plans and accomplishments. They have taken steps to ensure that government-provided services are integrated with project-provided services and that government and project staff cooperate.

Some project promoters were selected for further training in the government's health promoter program and have been functioning under the continuing supervision of Vozandes medical workers. Four workers recently completed a seven-month government-sponsored training program for nurses aides. It is assumed that these people will have supervisory, as well as promotive and curative, responsibilities in the Vozandes project area. Although they will be responsible to the provincial health office, they could oversee the work of project promoters.

The Vozandes staff do not seem to expect their own project to remain independent. Rather, they see their project as filling an existing gap and as providing an experimental laboratory from which communities and future government programs can benefit.

B. Comments and Recommendations

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

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

It would be useful for project staff to develop and present a brief overview of the project that could be used to inform new officials, interested outsiders, and funding agency representatives. It should be expected that as information about the program is broadcast more widely, more persons will want to know about its operations. If staff do not prepare a brief presentation to keep such persons up-to-date, they easily could be overwhelmed by trying to provide a comprehensive tour of project areas.

Data Collection and Reporting

A. Observations

Few systematic data on the activities of health workers, clients' use of services, and local health problems have been collected by the project. Generally, significant health problems and service needs are recognized and addressed, but it is difficult to determine whether some problems are becoming critical while others are declining in importance. It is impossible to determine whether some portions of the population are, for whatever reasons, excluded from service coverage.

Early efforts were made to conduct population censuses and health assessments of the communities before the project was implemented. These efforts were unsuccessful because of strong resistance from the communities. One of the responsibilities of the health workers is to map their communities (catchment areas) and to obtain counts and age and sex distributions of their populations. This work appears to be progressing reasonably, but counts of those who are not covered are not being estimated.

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

B. Comments and Recommendations

It was probably wise to have avoided burdening health workers, who have limited awareness of community health, epidemiology, the use of systematically obtained data, and medical categories, with data collection before they had a grasp of their own function. Some important problems (e.g., diarrhea, respiratory problems, parasites) are so well recognized that a reasonable beginning can be made in planning a rural primary health care program even though systematic epidemiological investigations have not been undertaken.

Given the limited training and backup that must characterize these programs, immediate, direct impact on difficult-to-measure health problems will be slight in any case. It may be impossible to measure such impact in small populations. Epidemiological investigations that might be appropriate for a few large, experimental projects that are operated with the aid of research staffs are simply not reasonable for most other programs. The investigations are too costly, and sufficient talent is not available. Nevertheless, more can and should be done in this project.

Project staff should try to learn more about how health workers spend their time in the community. They should also find out which members of the communities are using health services and who is participating in other health and development activities. To rationally revise the program design, it is important to know who is not using the services and why.

It is time that project staff begin to note more precisely the levels of morbidity and mortality in the populations. This information is needed to determine whether promoters are trained adequately to deal with the problems that do exist and to reestablish priorities for training and services.

Project personnel must make a greater effort to provide a clear description of the project as it exists. Statistical summaries of progress in implementation provide some useful information and should be repeated at least once a year. Given the great variety in procedures, organizational and supervisory patterns, and training, which is itself an important aspect of this project, a well written narrative description of procedures and progress is needed. Much of what program staff have learned and experienced will be lost if descriptive and analytical materials are not produced.

IV. CONCLUSIONS

IV. CONCLUSIONS

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

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

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

Continued funding of this project by AID is recommended. Although there is no doubt that, even without AID funds, health services would continue to be provided for another year by the groups involved in the Vozandes project, many potentially useful findings from the project would be lost, because there would be less coordination and documentation of experience. Funding for an additional year should cover close monitoring of the process and the target communities, additional documentation, and wide distribution of the findings of the project within the Government of Ecuador. Responsible persons in the MOH should be given much more encouragement to observe more closely the operations of the project and to see how health workers perform in different geographical and cultural situations. These same officials should also provide input into the project design, suggesting which concerns should take priority and which experimental features could be incorporated.

APPENDIX

Appendix
LIST OF CONTACTS

Ministry of Health

Jose Castro, Director of Community Development

Vozandes Hospital

Sara Risser

John Sevall

Project Sites

A. Macuma

Lois Price

Steve Nelson

Greer Dixon

B. Pastaza

Jack Olinger

Alicia Ingram

Lloyd Rogers

C. Chimborazo

Manuel Naula

Roberto Hcfstetter

Karen

D. Bolivar

Dave Hansen

Martha

MAP International

Richard Crespo

USAID

Ken Farr

Jay Anderson

Manuel Rizzo

Note: Jafeturas Provincial in Puyo, Pastaza, Riobabma, Chimborazo, Guaranda, and Bolivar.

In addition, the presidents of the Indigenous Evangelical Association and several health workers were among the contacts.