

*A USAID Health Profile*

# ECUADOR

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## Health Situation & USAID Health Projects Descriptions 1993



Center for International Health Information / ISTI  
USAID Health Information System  
1601 N. Kent Street, Suite 1001  
Arlington, VA 22209  
(703) 524-5225

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**The Center for International Health Information  
1601 N. Kent Street, Suite 1014  
Arlington, VA 22209  
(703) 524 - 5225  
FAX (703) 243 - 4669  
E-Mail address: [cihi@gaia.info.usaid.gov](mailto:cihi@gaia.info.usaid.gov)**

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# ECUADOR

## USAID Health Profile

**T**his is one of a series of USAID Health Profiles produced by the Center for International Health Information/ISTI (CIHI). Each profile contains descriptive information, tables, and graphs about the country's health and demographic conditions, health indicators and trends, and the health care system when available. The profile also provides an overview of USAID health assistance and descriptions of USAID-supported health activities. Profile information is compiled from CIHI's databases and reference library, as well as through analysis from additional data sources and reports.

The profiles are intended to provide current and trend data in a concise format to policy makers, consultants, evaluation teams, and other interested individuals and organizations. They are not intended to provide a comprehensive description of the total health sector of a country. Contact CIHI for information on the availability of other health profiles and standard reports.

This profile contains national level health and demographic statistics available in CIHI's databases as of the date noted in each section. In order to enable CIHI to report the most current health and demographic statistics, please provide any more recent or more accurate data by contacting the center at the address on the previous pages or through USAID, Bureau for Research and Development, Office of Health.

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## I: COUNTRY OVERVIEW

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Ecuador, named for its location on the equator, is one of the smallest republics in South America. Its geography and climate range from the desertlike southern coast, to the Andean Mountains, to the plains of the Amazon River Basin.(PRB9203)\* This geographic diversity divides the country into three distinct regions -- the Oriente (eastern region), the Costa (coastal region), and the Sierra -- all of which are characterized by differing ethnic and social groups as well as political and economic situations.(ECU9102)

Traditionally, the Oriente was isolated geographically and culturally from the rest of the nation, populated by dispersed groups of indigenous tropical-forest Indians. This changed in the 1960s when the region experienced exploration by oil companies and colonization by land-poor peasants from the Sierra. These events caused a dramatic change in the lives of the previously isolated indigenous people.(ECU9102)

The Costa and Sierra regions both have their roots in agriculture. The people of the Costa region focus primarily on large-scale export crop production and commerce while the Sierra region continues to operate through old-style haciendas or large agricultural estates. The volume of rural to urban migration has increased significantly in both the the Costa and Sierra regions: by the mid-1980s, nearly half of all Ecuadorians lived in cities.(ECU9102)

Ecuador's economy has primarily depended on the sale of agricultural products, with exports fueled by the large-scale agricultural enterprises, particularly those in the Costa region. Petroleum has also become a major export commodity and its revenues remain a key factor in Ecuador's economy.(LAC9301) These petroleum revenues have helped the republic finance such efforts as urban industrialization and an improved educational system. Ecuador has also taken advantage of its rich and varied offshore waters; fishing is now a growth sector of the economy.(PRB9203)

Ecuador was emancipated from three hundred years of Spanish colonial rule in 1822 and became an independent country in 1830 after leaving the short-lived Federation of Gran Colombia. Since 1830, Ecuador has seen 18 changes of its constitution and has had 91 heads of state.(GRI9301) The nation is now a democratic republic; its representative government includes the President, the National Congress and the Supreme Court of Justice.(PAH9002) In July 1992, Ecuador elected President Sixto Duran Ballen after a campaign in which he promised basic reforms. Accordingly, Duran immediately raised wages and dropped Ecuador's membership to OPEC in order to establish Ecuador's own quotas to market its petroleum. Despite these efforts, as 1993 began, fuel and electricity prices were rising and state spending was being reduced.(LAC9301) President Duran remains committed, however, to implementing his reforms and continuing the economic and infrastructural modernization of Ecuador.

\* Sources in this profile are referred to by a seven-digit code. Generally, the first three letters refer to an organization, agency, etc., and the first two numbers indicate the year of the publication or other source document. A complete list of sources appears at the end of the profile.



## II: HEALTH & DEMOGRAPHIC OVERVIEW

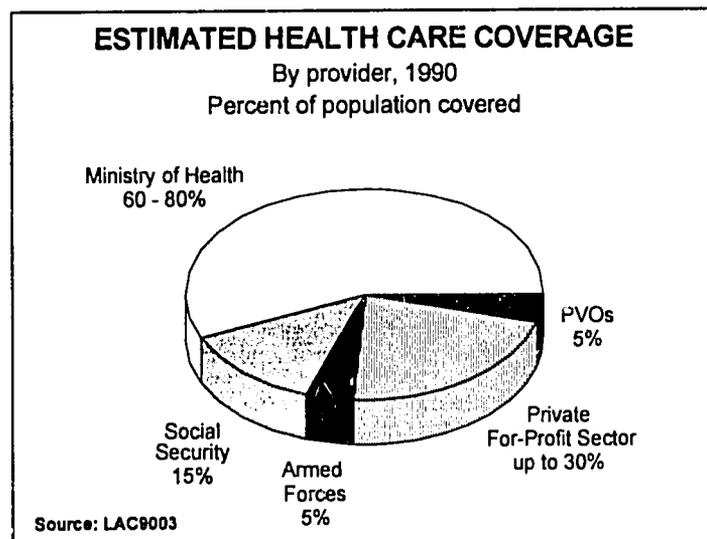
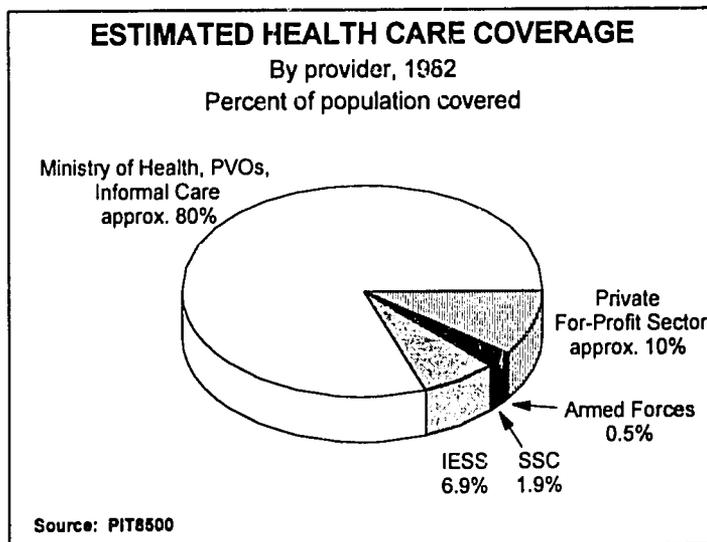
### Health Sector Description

DECEMBER 1993

Formal public and private health care services in Ecuador are concentrated in more economically developed provinces and particularly in the cities of Quito and Guayaquil. According to UNICEF, 25 percent of the national population lacked access to formal health care in the late 1980s, including eight percent in urban areas and 60 percent in rural areas.(UNI9312) Another source estimated the rural population without access to formal health services in 1985 at 50 percent.(LAC8900) A National Health Council (CNS) is responsible for coordinating public and private health care provision, but its ability to enact necessary policy reform has been limited. (PAH9002, LAC9003)

Ecuador's Ministry of Public Health (MOH) is responsible for the 70 to 80 percent share of the population not served by the for-profit private sector or social security programs. However, a 1985 assessment under the auspices of the World Bank found that it was largely unable to fulfill this mandate. The private sector was estimated to cover the most affluent 10 percent of the population while social insurance and armed forces programs covered an additional 10 to 20 percent in the early 1980s.(See figure at top right)(PIT8500)

More recent estimates cite higher coverage under social insurance and the armed forces (See figure at lower right). Some of the slack is picked up by private voluntary organizations (PVOs) and other non-profit entities while the remainder of the population has access only to informal health care, if any at all.



## II: Health & Demographic Overview

Ecuador: Major Public Health Care Providers and their intended beneficiaries		
Ministry of Health (MOH)	<i>Ministerio de Salud Publica</i>	All non-insured who cannot afford private sector care.
Social Security Institute (IESS)	<i>Instituto Ecuatoriano de Seguridad Social</i>	Employees in industry, commerce, and government; predominantly urban.
Rural Social Security (SSC)	<i>Seguro Social Campesino</i>	Rural laborers and their families.
Armed Forces		Members of armed forces and their families.

### Public Sector

The main components of the public health sector are the MOH and the separate urban and rural programs of the Ecuadorian Social Security Institute (IESS). Other public health providers are the Armed Forces Health Services (estimated to serve 2.5 to 5 percent of the national population with 5.6 percent of total hospital beds in the late 1980s),(PAH9002,LAC9003) the National Institute of the Child and the Family (INNFA), and the Ministry of Social Welfare, which administers programs for child day-care and for the elderly. Public agencies loosely connected to the MOH include the Ecuadorian Institute for Sanitation Works (IEOS), the National Malaria Eradication Service (SNEM), the National Institute of Hygiene, and the Generic Medicines program (one of five distinct supply systems utilized by the MOH).(ECU9100,LAC9003)

### Ministry of Health

Actual coverage by the MOH is thought to be between 20 and 40 percent of the national population.(ECU9100) Its services are predominantly urban and curative but include more preventive care than those of the IESS.(LAC8900) Investments in public health in the 1970s produced a network of regional and local MOH hospitals; the ministry now administers nearly 50 percent of total hospital beds.(PAH9002) More recent years have seen an externally-financed expansion in primary health care (PHC) activities: between 1979 and 1987 there were nearly 50 percent increases in facilities (mostly for PHC) and personnel.(ECU9100) By 1987, MOH facilities included 15 specialized hospitals, 21 provincial hospitals, 88 cantonal hospitals, 63 health centers, 870 urban and rural health subcenters, 236 rural health posts and 12 dispensaries.(LAC8804) In 1989, the MOH, with assistance from the Pan American Health Organization (PAHO), began to implement a regionalization program designed to decentralize program administration and create integrated health systems addressing local health problems.(ECU9100)

### Social Security System

Social insurance under the IESS covered the health care and pension needs of an estimated 28 percent of the labor force and 17 percent of the total population in 1992, one of the five lowest levels of social security coverage in the Latin America and Caribbean (LAC) region.(LAC9204) With 49 health dispensaries and 16 hospitals containing nearly 10 percent of the national total of hospital beds,(PAH9002) the institute's sickness and maternity



program covers private and public workers employed in industry and commerce as well as some artisans and construction workers. Some rural laborers and their families are covered under the separate Rural Social Security system (SSC), described below. Dependent coverage under the regular IESS program is particularly weak, extended to spouses only for maternity (not sickness) and to children under six months of age for curative care only.(IDB9101,ECU9204) IESS affiliates are predominantly urban males between 20 and 55 years of age, the population group with the lowest health risk. In 1982, 70 percent were located in the provinces of Ecuador's two metropolises, Pichincha (Quito) and Guayas (Guayaquil).(PIT8500)

### Rural Social Security

*Seguro Social Campesino* (SSC), the most dynamically expanding component of the public health sector, provides low-cost, PHC coverage to an estimated 14 percent of the rural population, including direct affiliates and their family members, and is projected to surpass IESS coverage by the mid-1990s.(LAC9204) SSC beneficiaries more or less represent the age and sex distribution of the general population. The system currently provides basic maternity, health and dental care to an estimated 800,000 rural residents through 540 health centers, each staffed by a full-time, often resident nurse, a part-time doctor and a part-time dentist. Local communities donate land, labor and other resources for health center construction.(CAB9303)

### Private Sector

The private health sector is thought to account for up to 30 percent of services and nearly half of all health expenditures.(LAC9003) Private, for-profit services in major urban centers include hospitals and clinics and medical offices providing individual, outpatient care. Informal healers and traditional birth attendants cover a significant but unquantified part of the population. Current strategies to expand public health coverage call for increased collaboration with for-profit entities and private voluntary organizations (PVOs) as implementing organizations for MOH programs.(CAB9201) PVOs presently account for an estimated five to seven percent of health services,(LAC9003) and include the Ecuadorian Red Cross, the Cancer Society and various religious organizations, some of which already receive funding from the MOH to carry out local health initiatives. The Welfare Board of Guayaquil, a private, non-profit entity alternately referred to as a public charity (it is supported by a lottery and a considerable state subsidy), operates four hospitals in Guayaquil with 15 percent of the national total of hospital beds.(PAH9002)

## **Health Situation Analysis**

**DECEMBER 1993**

Since the early 1970s, modernization of Ecuador and economic progress, due in part to petroleum revenues, have facilitated improvements in Ecuador's health, education, and physical infrastructure. Still, disparity in the distribution of wealth remains and continuing rural to urban migration has created underserved areas in marginal settlements around urban centers.(PRB9203)

Infant mortality in Ecuador declined by over one-third, from 72 deaths per 1,000 live births in 1979 to the current rate of 44 deaths. A 30 percent reduction in post-neonatal mortality (deaths occurring from the end of the first month of life to the end of the first year) contributed to this change. However, neonatal mortality remains high, totaling 47 percent of all under-five deaths. In rural areas of the Sierra region, probability of infant death is twice that of the region's urban areas.(AID8701)

Intestinal infections, particularly diarrhea, accounted for 22 percent of child deaths in 1987. Diarrheal disease control efforts have included oral rehydration therapy (ORT), whose use rates rose from 13 to 70 percent between 1985 and 1991.(AID8701)

Vaccination coverage climbed steadily since 1984 to reach 1990 rates of 68 percent for DPT3, 67 percent for Polio3, and 61 percent for measles. Data for 1991 indicates that coverage slipped slightly for all antigens, but in 1992 coverage increased to 83 percent for DPT3 and Polio3 and to 66 percent for measles. (WHE9100, WHE9200, WHE9300)

The Government has finalized a national program of action to guide its efforts in achieving basic World Summit for Children goals.(UNI9312)

## Current Demographic and Health Indicators

DECEMBER 1993

Demographic Indicators			
INDICATOR	VALUE	YEAR	SOURCE
Total Population	11,312,000	1993	UNP9200
Urban Population	6,674,400	1993	UNP9200
Women Ages 15-49	2,844,600	1993	UNP9200
Infant Mortality	44	1992	ECU9200
Under 5 Mortality	60	1992	ECU9200
Maternal Mortality	300	1990	WHM9106
Life Expectancy At Birth	67	1993	UNP9200
Children Under Age 1	322,209	1993	CALXX01
Annual Infant Deaths	14,628	1993	CALXX01
Total Fertility Rate	3.8	1993	UNP9200

Child Survival Indicators			
INDICATOR	PERCENT	YEAR	SOURCE
Vaccination Coverage			
BCG	99	1992	WHE9301
DPT 3	83	1992	WHE9301
Measles	66	1992	WHE9301
Polio 3	83	1992	WHE9301
Tetanus 2	10	1991	WHE9301
DPT Drop Out	37	1989	PAH9100
Oral Rehydration Therapy			
ORS Access Rate	55.0	1991	WHD9201
ORS and/or RHF Use	70.0	1991	WHD9201
Contraceptive Prevalence			
Modern Methods (15-49)	42.0	1989	CEP9001
All Methods (15-49)	52.9	1989	CEP9001
Nutrition			
Adequate Nutritional Status	76.1	1987	WHA8916
Appropriate Infant Feeding	24.0	1987	DHS8803
A) Exclusive Breastfeeding	30.6	1987	DHS8803
B) Complementary Feeding	30.7	1987	DHS8803
Continued Breastfeeding	51.3	1987	DHS8803

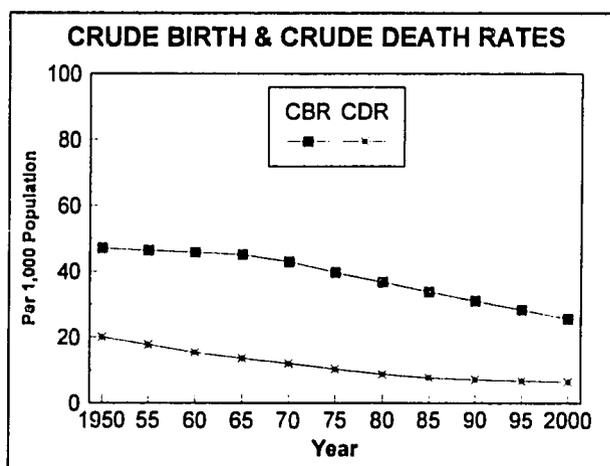
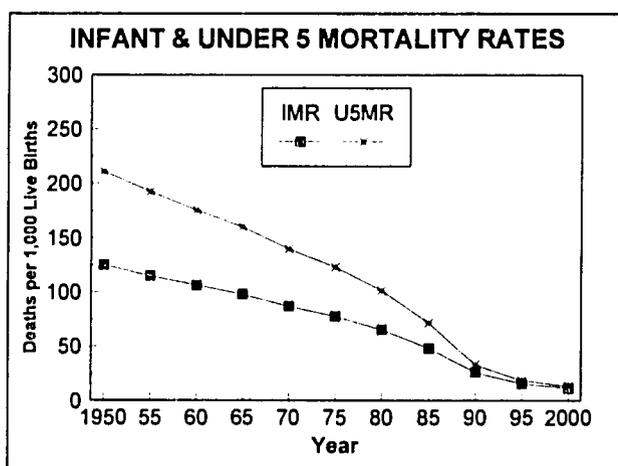
Other Health Indicators			
INDICATOR	PERCENT	YEAR	SOURCE
HIV-1 Seroprevalence			
Urban	NA		
Rural	NA		
Access to Improved Water			
Urban	80.0	1989	AID9009
Rural	40.0	1989	AID9009
Access to Sanitation			
Urban	79.0	1989	AID9009
Rural	37.0	1989	AID9009
Deliveries/Trained Attendants	62.0	1986	DHS8803

NA = Not available

## Trends in Selected Demographic and Health Indicators

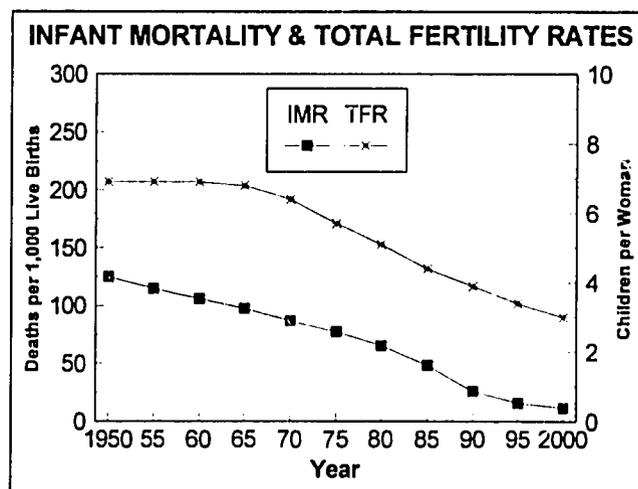
DECEMBER 1993

INDICATOR	1950	1955	1960	1965	1970	1975	1980	1985	1990	1995	2000	SOURCE
Infant Mortality	125.1	115.0	106.1	97.9	86.9	77.5	65.4	48.4	26.1	15.8	11.6	WBK9302
Under Five Mortality	210.9	192.3	175.4	160.0	139.8	122.9	101.3	71.6	33.1	18.7	13.3	WBK9302
Crude Birth Rate	47.1	46.4	45.8	45.1	42.9	39.7	36.7	33.8	31.0	28.3	25.6	UNP9200
Crude Death Rate	20.0	17.7	15.4	13.6	12.0	10.3	8.7	7.7	7.1	6.7	6.4	UNP9200
Avg. Annual Growth Rate	2.7	2.9	3.1	3.2	3.1	2.9	2.8	2.6	2.4	2.2	1.9	UNP9200
Total Fertility Rate	6.9	6.9	6.9	6.8	6.4	5.7	5.1	4.4	3.9	3.4	3.0	UNP9200



### IMR and TFR

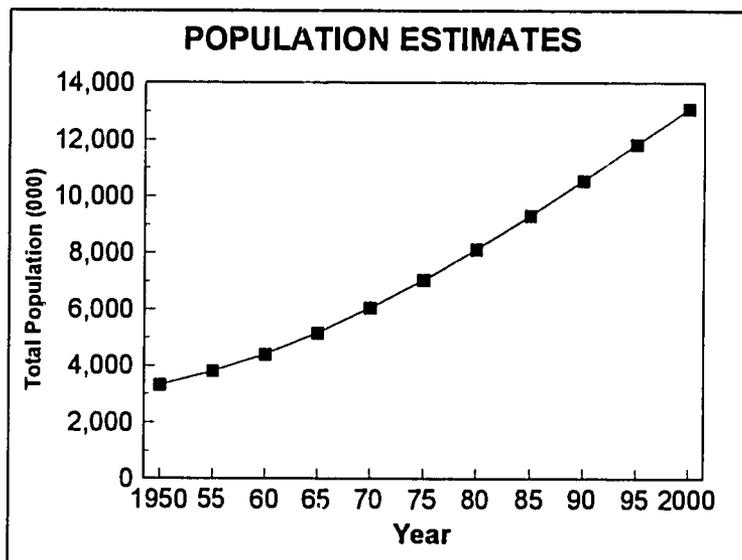
The relationship between IMR and TFR is currently a subject under review by the scientific community. While there is not conclusive evidence that the IMR and TFR are causally linked and necessarily decline together, there is empirical evidence for suspecting that such a reinforcing relationship exists as the pattern is observable in most countries.



### Population Estimates/Pyramid

DECEMBER 1993

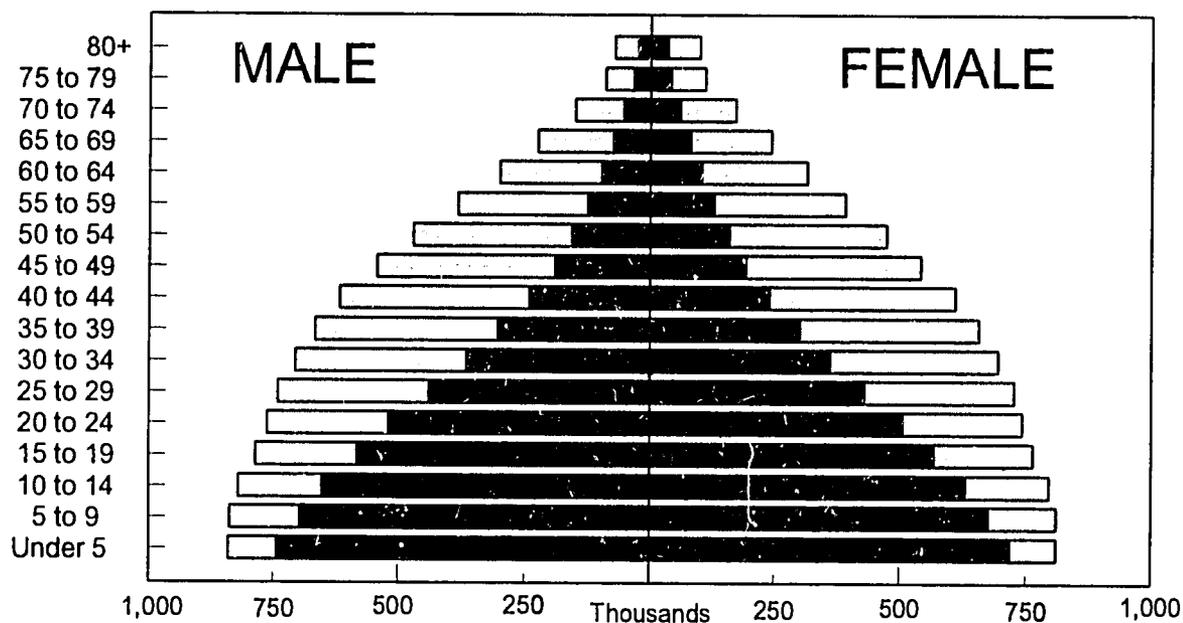
POPULATION ESTIMATES (000s)		
YEAR	VALUE	SOURCE
1950	3,310	UNP9200
1955	3,806	UNP9200
1960	4,413	UNP9200
1965	5,162	UNP9200
1970	6,051	UNP9200
1975	7,035	UNP9200
1980	8,123	UNP9200
1985	9,309	UNP9200
1990	10,547	UNP9200
1995	11,822	UNP9200
2000	13,090	UNP9200



### CURRENT & PROJECTED POPULATION

By Age & Gender: 1990 - 2020

Total Population 1990: 10,506,668 Total Population 2020: 18,028,525

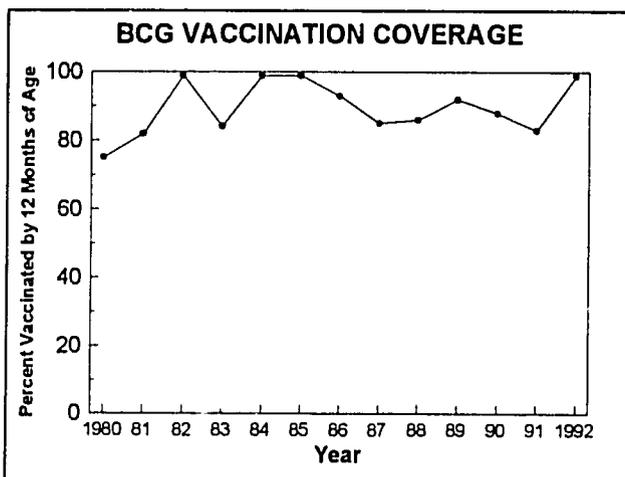


Source: BUC9105

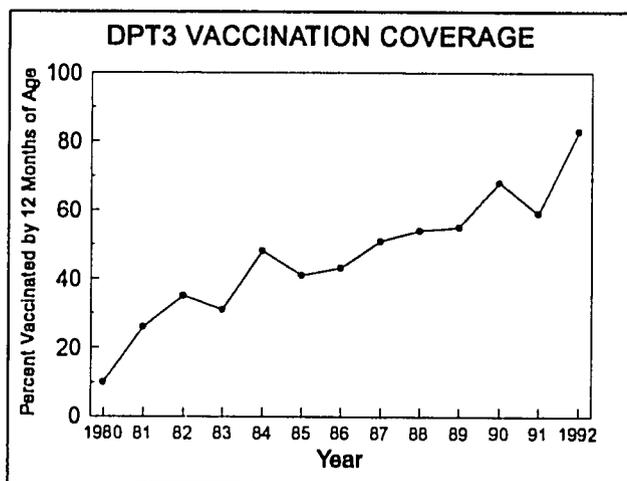
## Trends in Selected Health and Child Survival Indicators

### Vaccination Coverage Rates

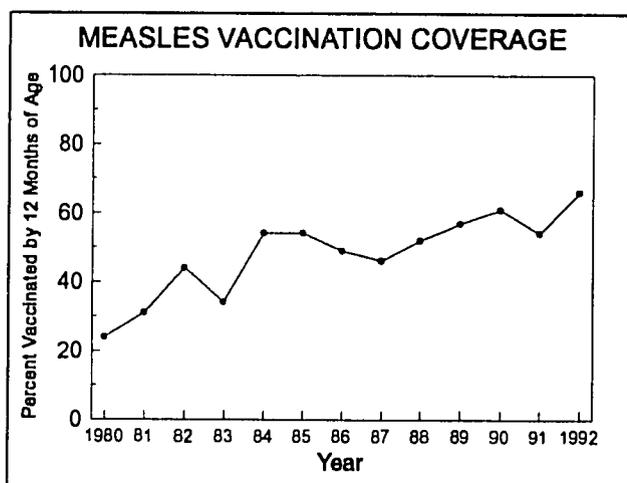
DECEMBER 1993



BCG COVERAGE		
YEAR	PERCENT	SOURCE
1980	75	WHE8700
1981	82	WHE8700
1982	99	WHE8700
1983	84	WHE8900
1984	99	WHE8700
1985	99	WHE8700
1986	93	WHE8800
1987	85	WHE8900
1988	86	WHE8900
1989	92	QUE9105
1990	88	WHE9100
1991	83	WHE9200
1992	99	WHE9301

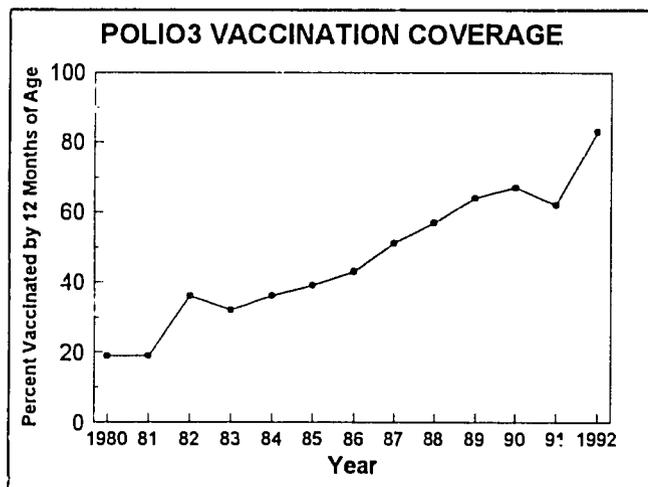


DPT3 COVERAGE		
YEAR	PERCENT	SOURCE
1980	10	WHE8700
1981	26	WHE8800
1982	35	WHE8700
1983	31	WHE8700
1984	48	WHE8700
1985	41	WHE8700
1986	43	WHE8800
1987	51	WHE8900
1988	54	WHE8900
1989	55	QUE9105
1990	68	WHE9100
1991	59	WHE9200
1992	83	WHE9301

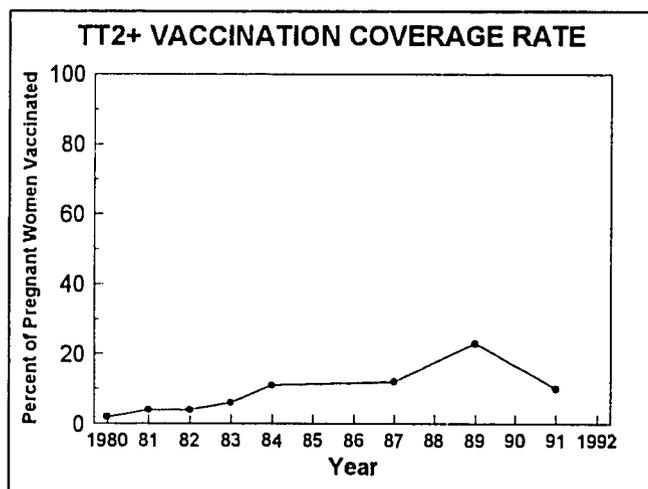


MEASLES COVERAGE		
YEAR	PERCENT	SOURCE
1980	24	WHE8700
1981	31	WHE8700
1982	44	WHE8700
1983	34	WHE8700
1984	54	WHE8700
1985	54	WHE8700
1986	49	WHE8800
1987	46	WHE8900
1988	52	WHE8900
1989	57	QUE9105
1990	61	WHE9100
1991	54	WHE9200
1992	66	WHE9301

Vaccination Coverage Rates, continued



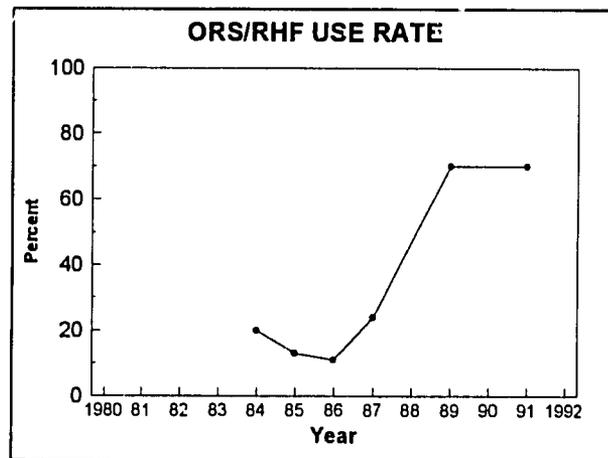
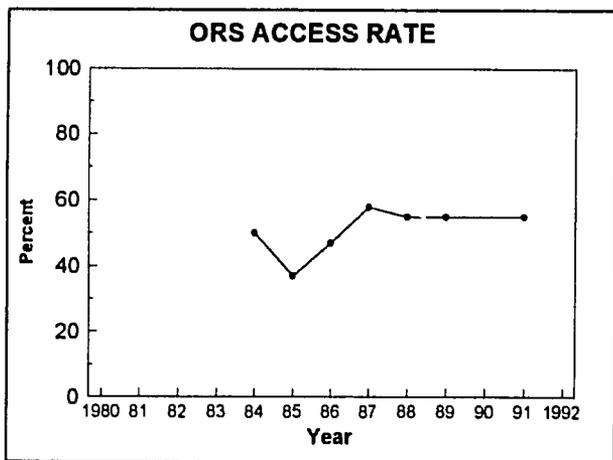
YEAR	PERCENT	SOURCE
1980	19	WHE8801
1981	19	WHE8700
1982	36	WHE8700
1983	32	WHE8900
1984	36	WHE8700
1985	39	WHE8700
1986	43	WHE8800
1987	51	WHE8900
1988	57	WHE8900
1989	64	QUE9105
1990	67	WHE9100
1991	62	WHE9200
1992	83	WHE9301



YEAR	PERCENT	SOURCE
1980	2	WHE8700
1981	4	WHE8700
1982	4	WHE8700
1983	6	WHE8700
1984	11	WHE8700
1985		
1986		
1987	12	WHE8900
1988		
1989	23	QUE9105
1990		
1991	10	WHE9301
1992		

### ORS Access, ORS and/or RHF Use Rates

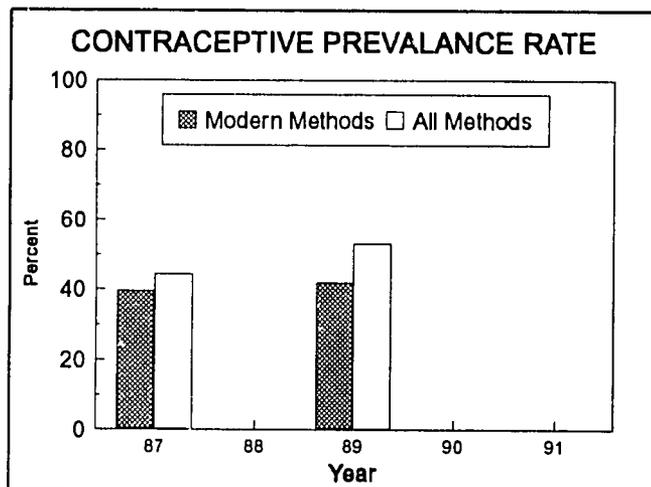
DECEMBER 1993



INDICATOR	1984	1985	1986	1987	1988	1989	1990	1991	1992
ORS Access	50	37	47	58	55	55		55	
Source	WHD8601	WHD8700	WHD8800	WHD8900	WHD9000	WHD9100		WHD9201	
ORS/RHF Use	20	13	11	24		70		70	
Source	WHD8601	WHD8700	WHD8800	WHD8900		WHD9100		WHD9201	

### Contraceptive Prevalence Rate

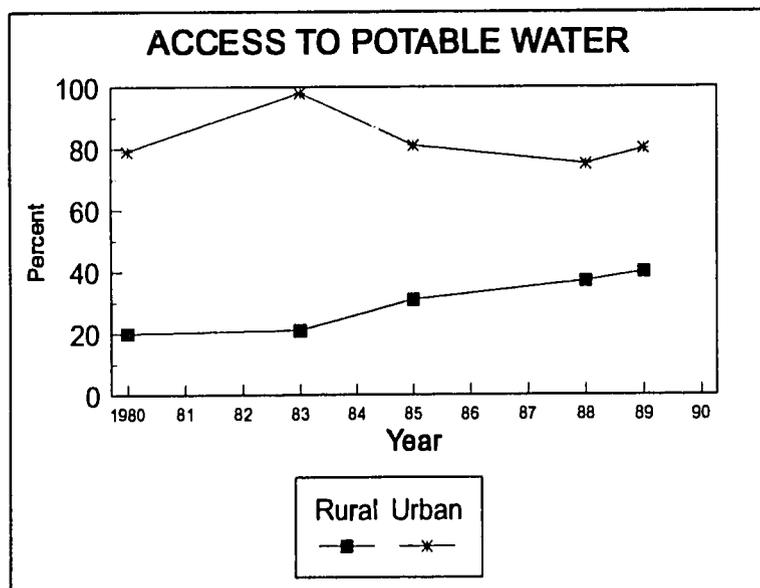
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YEAR	MODERN METHODS	SOURCE	ALL METHODS	SOURCE
1987	35.9	DHS8803	44.3	DHS8803
1988				
1989	42.0	CEP9001	53.0	CEP9001
1990				
1991				

### Access to Potable Water

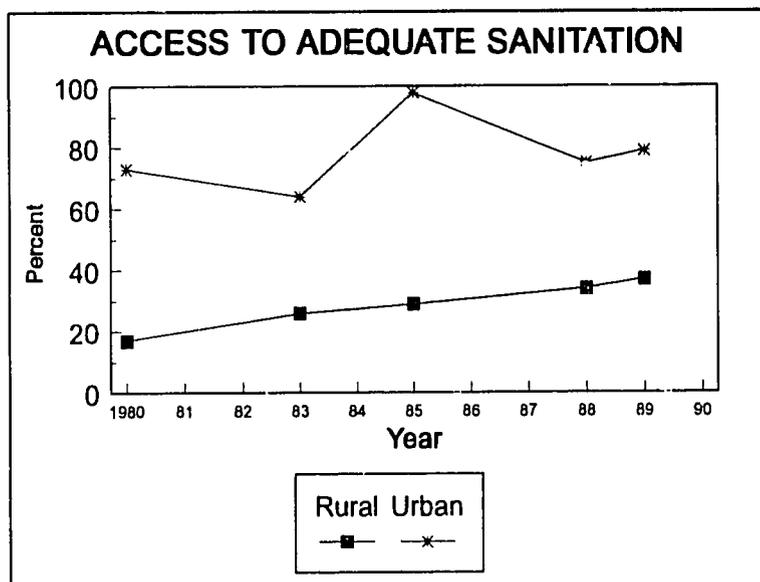
DECEMBER 1993



YEAR	RURAL SOURCE	URBAN SOURCE
1980	20 AID9009	79 AID9009
1981		
1982		
1983	21 WHO9101	98 WHO9101
1984		
1985	31 WHO9101	81 WHO9101
1986		
1987		
1988	37 WHO9101	75 WHO9101
1989	40 AID9009	80 AID9009
1990		

### Access to Adequate Sanitation

DECEMBER 1993

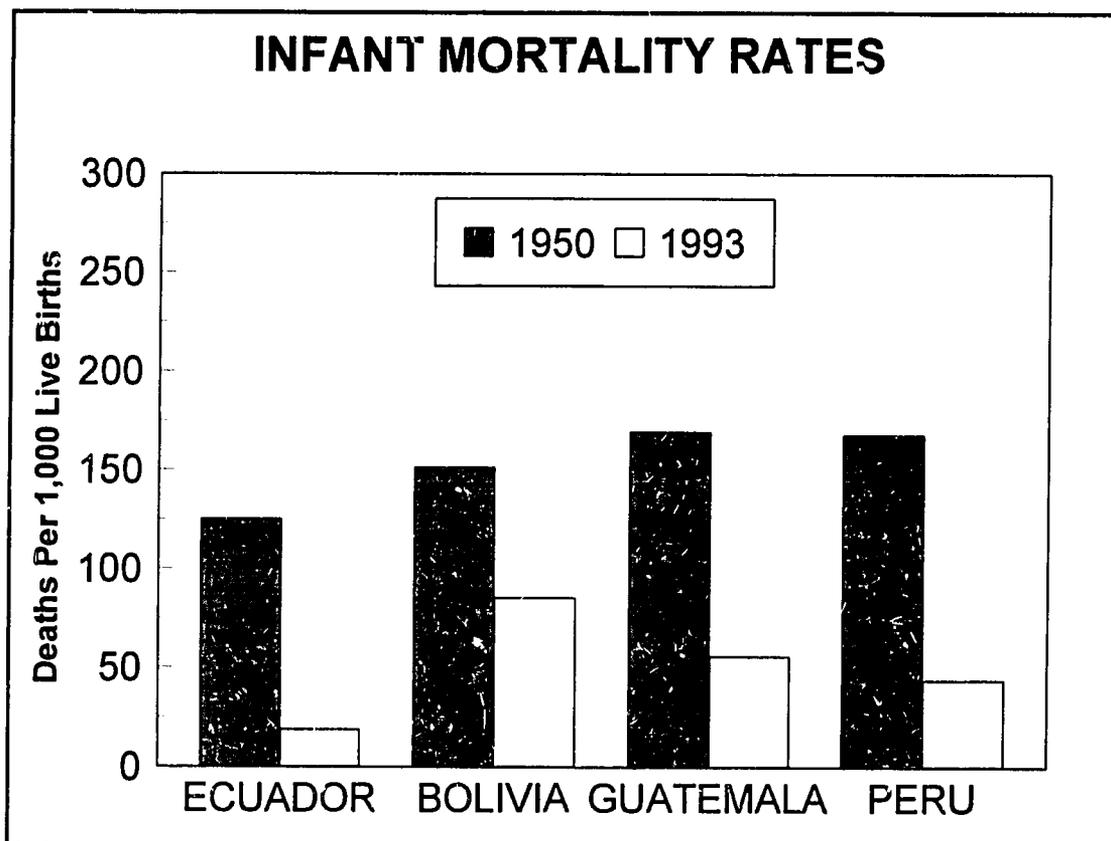


YEAR	RURAL SOURCE	URBAN SOURCE
1980	17 AID9009	73 AID9009
1981		
1982		
1983	26 WHO9101	64 WHO9101
1984		
1985	29 WHO9101	98 WHO9101
1986		
1987		
1988	34 WHO9101	75 WHO9101
1989	37 AID9009	79 AID9009
1990		

COMPARATIVE INDICATORS

Comparative IMR Rates

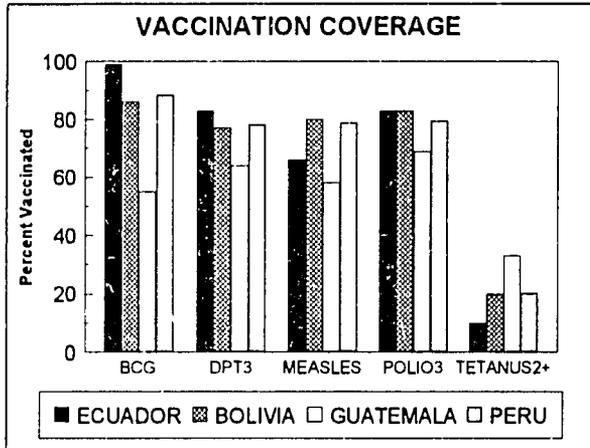
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COUNTRY	1950	SOURCE	1993	SOURCE
ECUADOR	125.1	WBK9302	18.9	WBK9302
BOLIVIA	151.2	WBK9302	85.4	WBK9302
GUATEMALA	169.3	WBK9302	55.8	WBK9302
PERU	168.0	WBK9302	44.0	WBK9302

### Comparative Vaccination Coverage Rates

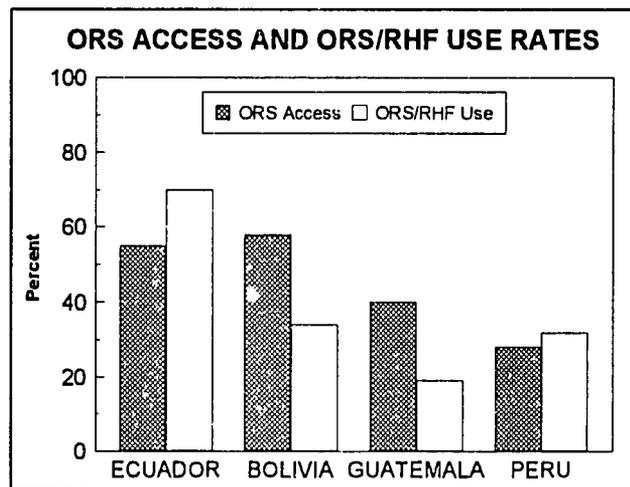
DECEMBER 1993



COUNTRY	INDICATOR	YEAR	VALUE	SOURCE
ECUADOR	BCG	1992	99	WHE9301
	DPT 3	1992	83	WHE9301
	Measles	1992	66	WHE9301
	Polio 3	1992	83	WHE9301
	Tetanus 2	1991	10	WHE9301
BOLIVIA	BCG	1992	86	WHE9301
	DPT 3	1992	77	WHE9301
	Measles	1992	80	WHE9301
	Polio 3	1992	83	WHE9301
	Tetanus 2	1989	20	WHE9001
GUATEMALA	BCG	1992	55	WHE9301
	DPT 3	1992	64	WHE9301
	Measles	1992	58	WHE9301
	Polio 3	1992	69	WHE9301
	Tetanus 2	1992	33	WHE9301
PERU	BCG	1991	88	DHS9207
	DPT 3	1992	78	AID9202
	Measles	1992	79	AID9202
	Polio 3	1992	60	AID9202
	Tetanus 2	1991	20	DHS9207

### Comparative ORS Access, ORS and/or RHF Use Rates

DECEMBER 1993



COUNTRY	INDICATOR	YEAR	VALUE	SOURCE
ECUADOR	ORS Access	1991	55	WHD9201
	ORS/RHF Use	1991	70	WHD9201
BOLIVIA	ORS Access	1991	58	WHD9201
	ORS/RHF Use	1989	34	DHS9001
GUATEMALA	ORS Access	1991	40	WHD9201
	ORS/RHF Use	1991	19	QUE9101
PERU	ORS Access	1992	28	WHD9300
	ORS/RHF Use	1991	32	DHS9207

### III: HIV / AIDS

DECEMBER 1993

The information below is based on reports to WHO through June 30, 1993: (PAH9318)	
Total reported AIDS cases	265
Deaths attributed to AIDS	192
1992 Incidence rate (per 1 million population)	5.1
Male/female ratio (1992)	8.5:1
Pediatric cases	4 (1.5% of total)
Perinatal cases	3 (1.1% of total)

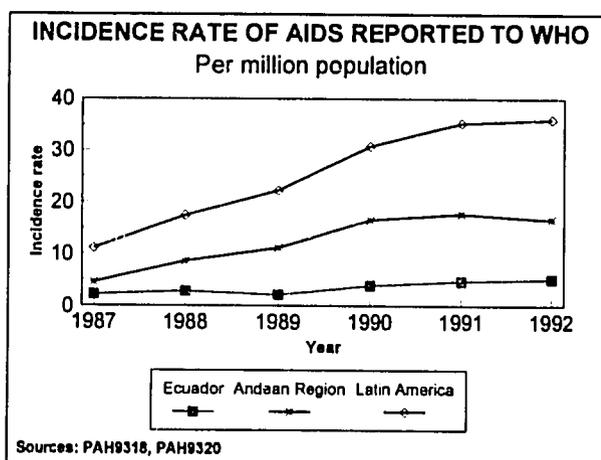
Ecuador has reported relatively few AIDS cases; annual rates of incidence of cases reported to the World Health Organization (WHO) remain among the lowest in Latin America.(PAH9318) HIV infection is primarily concentrated in Guayaquil.(AID0002) The majority of reported AIDS cases have been among homosexual or bisexual men, while women with AIDS continue to comprise roughly 10 percent of total cases reported.(PAH9318) Cultural disapproval of homosexuality has led to human rights abuses of gay men and public hospitals reportedly have refused to accept patients with AIDS. Access to target populations for preventive programs can be difficult to obtain and has been best pursued through non-governmental organizations (NGOs).(AID0002,PAN9200)

AIDS: New cases and incidence rates (PAH9318, PAH9320)				
Year	New cases	Comparative Incidence rates (per million)		
		Ecuador	Andean Region	Latin America
Through 1986	13			
1987	22	2.2	4.5	11.1
1988	29	2.8	8.6	17.4
1989	22	2.1	11.1	22.2
1990	42	3.9	16.5	30.8
1991	51	4.7	17.7	35.3
1992	57	5.1	16.6	36.0

#### National AIDS Control Program

##### Programa Nacional de Prevención y Control del SIDA, Ministry of Health, Quito.

The national program stresses education of the general population, improvement of blood screening mechanisms, and integrating HIV/AIDS prevention with general health services. Special projects include training workshops for regional outreach, sexual education in schools under the Ministry of Education, and quality control of laboratory tests for HIV, coordinated by the Red Cross of Ecuador. The MOH's Instituto Nacional de Higiene y Medicina Tropical operates a network of four laboratories performing ELISA tests for HIV. As of 1992, the National Blood Bank Network was reportedly screening 98.8 percent of blood for transfusions, performing HIV testing at 16 of its 33 banks.(AID0002) With assistance from USAID's AIDSTECH project, MOH personnel have upgraded the ministry's detection and surveillance capabilities through numerous workshops as well as visits to





HIV-1 Seroprevalence from selected studies (BUC9301)				
Population sampled	Sex	Year	% HIV-positive	Sample
Blood Donors (Volunteers), Nationwide	B	1987	0.0%	20282
Blood Donors (Volunteers), Nationwide	B	1988	0.0%	25358
Blood Donors	B	1989	0.0%	28672
STD Patients, Quito	B	1988-89	0.0%	159
Prostitutes, Quito	F	1990	0.0%	151
Prostitutes, Esmeraldas	F	1988	1.6%	64
Haemophiliacs	B	1988	1.8%	57

facilities of CONASIDA-Mexico. The MOH has also sponsored AIDS education, prevention and control workshops for public and private health care providers as well as members of high-risk groups. (PAH9310)

**Local Non-Governmental Organizations with AIDS Activities**

(PAH9310, AID0002, PAN9200)

**Cruz Roja Ecuatoriana** (Ecuadorian Red Cross) is coordinating a blood screening quality assurance project supported by USAID's AIDSCAP project.

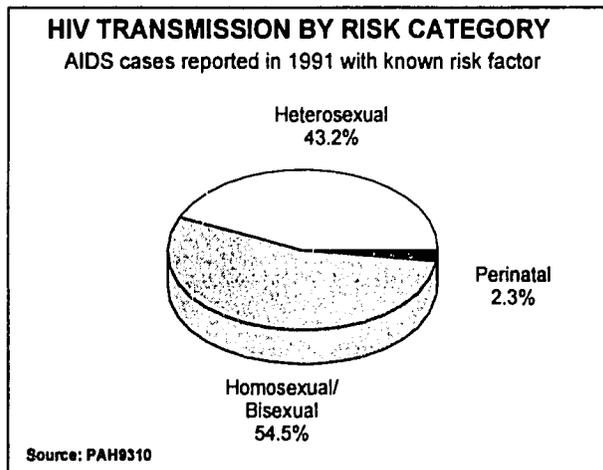
**Fundación Futura** conducts targeted education and condom social marketing programs for high-risk populations in Guayaquil.

**Fundación Ecuatoriana de Ayuda, Educación y Prevención del SIDA**, formerly named **Fundación SOGA**, has developed educational materials for homosexual and bisexual men and their physicians in Quito and is currently establishing a USAID-supported AIDS education and condom marketing project.

**VIVIR**. Fundación VIVIR offers counseling, education and prevention services and seeks to protect the human rights of people affected by HIV/AIDS.

**Other Ecuadorian NGOs reported to be involved in HIV/AIDS activities**

- Asociación Pro-Bienestar de la Familia Ecuatoriana
- Centro de Investigación y Acción de la Mujer (CIAM)



### III: HIV / AIDS

Centro de Educación y Motivación para Planificación Familiar (CEMOPRAF)  
 Consejo Latinoamericano de Iglesias (CLAI)  
 Conferencia Episcopal Ecuatoriana  
 Organización de Trabajadores  
 Programa Muchacho Trabajador

#### International NGOs with HIV/AIDS activities in Ecuador

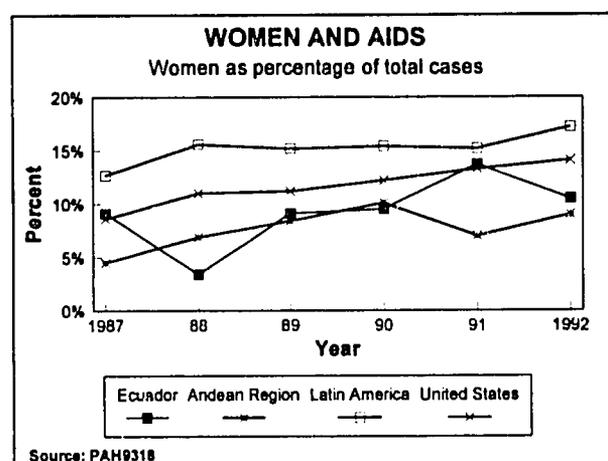
(NCI9201,CAR9300,PAH0001,WHO9102)

American Red Cross  
 CARE (plans to emphasize AIDS activities soon)  
 Centro Italiano di Solidarieta, Rome  
 Corporacion FIASAR, Bogota, Colombia  
 Family Health International  
 International Planned Parenthood Federation (IPPF)  
 MAP International

#### International Donors supporting AIDS activities in Ecuador

(PAH9310,UNI0000,UNF9200)

Pan-American Health Organization (PAHO)  
 United States Agency for International Development (USAID)  
 World Health Organization, Global Programme on AIDS (WHO/GPA)  
 UNICEF (Will classify Ecuador as a Strategic Programming Country for AIDS in 1994)  
 United Nations Population Fund (UNFPA)



Year	Ecuador	Andean Region	Latin America	United States
1987	9.1%	4.5%	12.7%	8.6%
1988	3.4%	6.9%	15.6%	11.0%
1989	9.1%	8.4%	15.2%	11.2%
1990	9.5%	10.1%	15.4%	12.2%
1991	13.7%	7.0%	15.2%	13.3%
1992	10.5%	9.0%	17.2%	14.1%



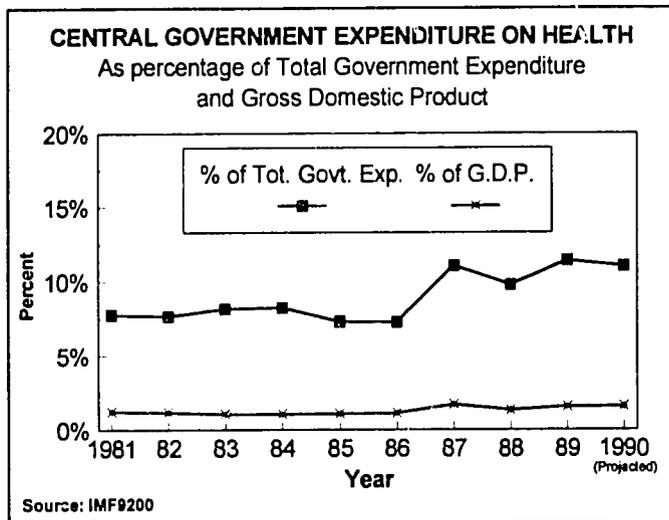
# IV: HEALTH CARE FINANCING

DECEMBER 1993

According to the World Bank, total health expenditures in 1990 amounted to 4.1 percent of Ecuador's Gross Domestic Product (GDP), just above the level of four percent calculated for the Latin America and Caribbean (LAC) region as a whole. Public outlays, including social security funds, amounted to over 60 percent of total expenditures on health, with the remainder derived from primarily out-of-pocket private revenues. Official external aid flows (classified within public expenditure) amounted to roughly seven percent of total expenditures.(WBK9303)

## Public Sector

Since the 1970s, when public health spending amounted to roughly two percent of GDP, Ecuador has consistently ranked among the countries spending the lowest proportion of GDP on public health care.(ECU9100) The figures in this section illustrate changing levels of public investment in health

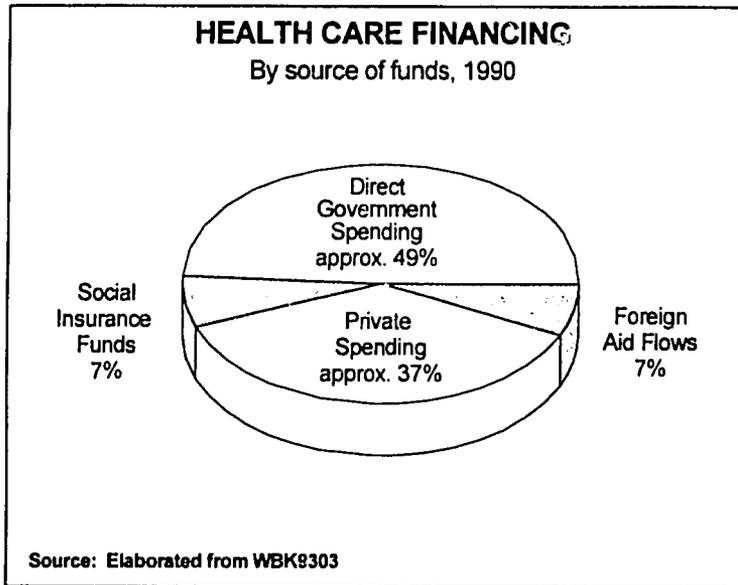


EXPENDITURES ON HEALTH As percent of:		
Year	Total Govt. Expenditure	G.D.P.
1981	7.78%	1.25%
1982	7.68%	1.19%
1983	8.18%	1.08%
1984	8.26%	1.08%
1985	7.31%	1.10%
1986	7.28%	1.15%
1987	11.09%	1.72%
1988	9.78%	1.34%
1989	11.43%	1.58%
1990	11.04%	1.59%

in the 1980s and -90s. Per-capita spending on public health care declined at both the Ministry of Health (MOH) and the social security institute (IESS) in the course of the 1980s. Personnel compensation has required an increasing share of available funds, accounting for well over half of expenditures at both institutions. Rationalizing the deployment and utilization of MOH and IESS personnel is regularly cited as a necessary, though politically difficult step to improve the overall efficiency of public health care.(LAC8900,LAC9003)

## Ministry of Health

The MOH generally received a six to eight percent share of the national budget from 1978 to 1987,(LAC8804) but increasing amounts of this share have been earmarked for special autonomous agencies, reducing the MOH's discretionary funds to less than 50 percent of its allocation by 1987. (ECU9100) Direct spending by the MOH on health services, as indicated by real expenditures at the provincial level, maintained a 7.4 percent annual rate of increase from 1979-1983 but subsequently dropped by 6.8 percent per year through 1988. This decline coincided with rising recurrent costs, particularly due to construction of new facilities and increases in personnel, producing a severe



financial crisis.(ECU9100) According to financial statements provided by the MOH to USAID's PRITECH project, recurrent costs accounted for roughly 90 percent of total MOH expenditures from 1985 to 1987.(LAC8804) The high percentage of expenditures allocated to personnel, reportedly exceeding 85 percent of the budget,(ECU9100) has resulted in shortages in funds for medical supplies and maintenance, particularly to the detriment of secondary and tertiary services.(LAC9003)

Provincial-level funding for hospitals, at over 65 percent of central MOH allocations, was five times greater than combined expenditures for health centers, subcenters and posts in 1985 and 1986.(LAC8804) Primary health care by the MOH has been supported, and improved, mainly through outside donor contributions.(LAC9003) Other sources of funding for provincial health services include medicine sales, charges for health examinations and sanitary inspections, and local taxes. Most of this income is retained in the provinces, where it provides roughly 10 percent of available funds (20 percent in the case of Guayas Province),(LAC8804) but the amount of income generated locally is reportedly subtracted from central budget allocations, reducing the incentive for facilities to collect such fees.(LAC9003)

### Social Security System

Social insurance was estimated by the World Bank to comprise 11 percent of public expenditure on health and seven percent of total health expenditures while covering the health care needs of nine percent of the population in 1990.(WBK9303) The sickness-maternity and pension programs of the IESS are funded through contributions by employers (seven percent of payrolls), employees (five to seven percent of earnings), and the government (40 percent of pensions paid),(IDB9101) though the state only began to fully honor its level of contribution in 1989. The total contribution level for combined IESS programs amounts to 20.5 percent of salaries, tenth highest among 30 LAC nations, but IESS coverage does not approach the scale achieved in countries which require higher levels of contribution.(LAC9204) In 1990, contributions by the state as a third party amounted to nine percent of total IESS revenue, while wage contributions comprised 51 percent, investment returns 27 percent, and other sources 13 percent.(LAC9204) In 1992, past outstanding payments by the state represented nearly 90 percent of the \$368 million in contributions owed to IESS.(LAC9204)

The sickness-maternity program ran deficits averaging 10 percent of total income from 1980 to 1987.(WBK8901) Combined IESS programs are facing an imminent financial crisis with various sources projecting overall deficits for fiscal years 1993 to 1995.(LAC9204) Administrative expenses reached 26 percent of total IESS costs in 1983, the highest in the LAC region,(WBK8901) and continued to account for over 20 percent of costs through the end of the decade.(IDB9101,LAC9003) Personnel increased by 60 percent between 1980 and 1991 to give the IESS a ratio of 13.4 employees per thousand insured (excluding SSC), one of the highest such ratios in the LAC region.(LAC9204)



USAID's Health Care Financing in Latin America and the Caribbean (HCF/LAC) project found in 1987 that IESS facilities cost nearly 50 percent more per comparable unit of service than those of the MOH, possibly provide better curative care, but offer a more limited range of services with little preventive care. Personnel accounted for more than 50 percent of costs, followed by supplies, which reportedly reflects the fact that IESS facilities are better supplied than those of the MOH.(LAC8900) Various studies supported by the World Bank and USAID have concluded that current IESS health care, with a budget that has approached the size of the MOH's, is expensive and inefficient and could never form a basis for universal coverage.(PIT8500,WBK8901,LAC9204) Current proposals to reform IESS health care financing focus on enhanced cost recovery and possible privatization of selected services.(CAB9201,CAB9304)

### **Rural Social Security (SSC)**

The SSC's basic rural health services are financed primarily through contributions from all employers and wage earners (rural and urban) and the state, though non-payment by the latter was a recurring problem in the 1980s.(IDB9101,WBK8901) Rural workers participating in the program also make prepayments equal to one percent of minimum wage earnings.(CAB9303) In 1980, IESS and general state revenues each provided 45 percent of SSC funding while participants' premiums amounted to five percent.(PIT8500) In 1979, the per-capita cost of SSC services was found to be one-seventh that of regular IESS services.(PIT8500) Research carried out in 1985 under the HCF/LAC project indicates that costs of SSC services were much higher than those for comparable MOH services, particularly those provided by physicians, who draw higher earnings from the SSC. Variations in spending patterns for different groups suggests that SSC services are less equitably distributed than those of the MOH.(ECU9101)

### **Private Sector**

A consultant to USAID's Health Financing and Sustainability (HFS) project estimated in 1990 that the private health sector accounts for nearly half of all health expenditures.(LAC9003) For the same year, the World Bank estimates that private expenditures in the form of out-of-pocket payments comprised nearly 40 percent of total expenditures on health.(WBK9303) Some prepayment plans are available for private sector care in Guayaquil and Quito, including at least one health maintenance organization (HMO) called "Operación Amigo."(LAC9003) Other private coverage is arranged by cooperatives and transnational corporations. The largest single private provider, the non-profit Welfare Board of Guayaquil, finances health care services through income generated from its own assets, a lottery, and a state subsidy providing 13 percent of its annual budget.(PAH9002)

# V: USAID PROJECT ASSISTANCE

## TIMELINE: USAID Activities Related to Health & Population

DECEMBER 1993

Project Information					Fiscal Year																	
Project #	Project Name	Life-of-Project	Begin FY	PACD	Pre 85	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	2000	
518-9999	Private Voluntary Organizations-OPG	*	1978	***																		
518-0000	Program Development and Support	*	1979	***																		
518-0004	Special Development Activities	*	1979	***																		
518-0002	Rural Community Health-OPG	\$173,000	1979	1981																		
518-0026	Population and Family Planning	\$14,000,000	1981	1990**																		
518-0015	Integrated Rural Health Delivery System	\$6,951,000	1981	1989																		
518-0033	Food and Nutrition	\$654,000	1983	1988																		
518-0049	Malaria Control	\$9,500,000	1985	1992																		
518-0060	Private Sector Health Delivery Model-OPG	\$745,000	1985	1991																		
938-0261	Matching Grant to Meals for Millions	\$500,000	1985	1988																		

(Timeline continued on next page)

This chart contains USAID-funded projects active since 1980 known to contain a child survival, HIV/AIDS, other health, or population component. The Life-of-Project (LOP) column indicates total authorized funding planned for all project activities from the beginning until the conclusion of the project, and not an amount allocated to a specific project component. The project beginning year and project completion date (PACD) appear after the LOP. OPG is the abbreviation for Operational Program Grant. Please see Data Notes.

\* Total LOP is not available

\*\* Fiscal year of final obligation

\*\*\* Project is ongoing

Source: AID0000



Project Information					Fiscal Year																
Project #	Project Name	Life-of-Project	Begin FY	PACD	Pre 85	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	2000
938-0502	Child Survival Grant to Save the Children Federation	\$724,000	1985	1988		■	■	■	■	■											
938-0515	FY 85 Child Survival Grant to Catholic Relief Services	\$361,000	1985	1988		■	■	■	■	■											
518-0067	Andean Peace Scholarships	\$6,879,000	1987	1989**				■	■	■	■										
518-0076	Shelter Sector Technical Assistance	\$1,500,000	1987	1995				■	■	■	■	■	■	■	■	■					
938-0515	FY88 Child Survival Grant to Catholic Relief Services	\$250,000	1988	1994				■	■	■	■	■	■	■	■	■					
938-0528	Child Survival Grant to Freedom from Hunger	\$440,000	1988	1989				■	■	■											
518-0081	Water and Sanitation for Health Education	\$4,000,000	1989	1993					■	■	■	■	■								
518-0071	Child Survival and Health	\$12,200,000	1989	1994					■	■	■	■	■	■	■	■					
938-HOPE	FY 89 Child Survival Grant to Project HOPE	\$750,000	1989	1992					■	■	■	■									
518-0093	Private Pharmaceutical Distribution	\$151,000	1990	1993						■	■	■	■								
518-0084	Population and Family Planning	\$10,500,000	1991	1994**							■	■	■	■	■						
518-0198	Cholera Control(OPG)	\$620,000	1991	1993							■	■	■								

(Timeline continued on next page)

Project Information					Fiscal Year																	
Project #	Project Name	Life-of-Project	Begin FY	PACD	Pre 85	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	2000	
938-HOPE	FY 92 Vitamin A Grant to Project HOPE	\$80,000	1992	1995																		
938-HOPE	FY 92 Child Survival Grant to Project HOPE	\$700,000	1992	1995																		
938-0CRS	FY 92 Child Survival Grant to CRS	\$350,000	1992	1995																		
938-0CRS	FY 92 Vitamin A Grant to CRS	\$30,000	1992	1995																		

# Fiscal Year Obligations for USAID-funded Projects Related to Health

DECEMBER 1993

Project #	Project Name	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92
518-0000	Program Development and Support	224	434	117	46	116	5	0	0
518-0004	Special Development Activities	0	0	0	0	0	63	0	0
518-0015	Integrated Rural Health Delivery Systems	4,130	0	1,821	0	0	0	0	0
518-0033	Strengthening Community Organization	0	155	0	0	0	0	0	0
518-0049	Malaria Control Project	5,000	4,500	0	0	0	0	0	0
518-0060	OPG:Private Sector Health Delivery Model	651	245	0	0	0	100	0	0
518-0067	Andean Peace Scholarships	0	0	100	623	360	0	0	0
518-0071	Child Survival	0	0	0	0	1,778	4,211	2,376	2,337
518-0081	Water Sanitation for Health Education	0	0	0	0	854	1,096	613	270
518-0093	Private Pharmaceutical Distribution	0	0	0	0	0	151	0	81
518-0108	Cholera Control	0	0	0	0	0	0	620	307
938-0502	FY 85 Child Survival Grant	724	0	0	0	0	0	0	0
938-0515	FY 85 Child Survival Grant to CRS	314	0	0	0	0	0	0	0
938-0515	FY 85 Child Survival Grant	47	0	0	0	0	0	0	0
938-0515	FY 88 Child Survival Grant to CRS	0	0	0	250	0	0	0	0
938-0528	FY 88 Child Survival Grant to FFH	0	0	0	440	0	0	0	0
938-HOPE	FY 89 Child Survival Grant to HOPE	0	0	0	0	750	0	0	0
938-OCRS	FY 92 Child Survival Grant to CRS	0	0	0	0	0	0	0	370
938-OCRS	FY 92 Vitamin A Grant to CRS	0	0	0	0	0	0	0	30
938-HOPE	FY 92 Child Survival Grant to HOPE	0	0	0	0	0	0	0	700
938-HOPE	FY 92 Vitamin A Grant to HOPE	0	0	0	0	0	0	0	80
Totals:		\$11,090	\$5,334	\$2,038	\$1,359	\$3,858	\$5,626	\$3,609	\$4,175

Funding is based on reported attributions for child survival, HIV/AIDS and other health activities from all funding accounts, except population account funding in FY 1985-91. FY 1985-92 funding figures are actual. Please see Data Notes.

Source: AID0000, AID9308



# USAID-Funded Health Projects Active During Fiscal Year 1992

DECEMBER 1993

Project #	Project Name	U.S. Contractor/Grantee
518-0000	Program Development and Support	Multiple
518-0004	Special Development Activities	Multiple
518-0049	Malaria Control	Ministry of Public Health
518-0071	Child Survival and Health	Ministry of Public Health, Management Sciences for Health
518-0076	Shelter Sector Technical Assistance	Ministry of Economy and Finance, Ecuadorian Federation of Credit Unions, Municipal Water Authority, Ecuadorian Housing Bank
518-0081	Water and Sanitation for Health Education	Ministry of Health, Instituto Ecuatoriano de Obras sa Nitarias
518-0093	Private Pharmaceutical Distribution	Asociacion de Industriales e Importadores de Productos Farmacerticos
518-0108	Cholera Control	CARE
938-0515	FY88 Child Survival Grant to CRS	Catholic Relief Services
938-0CRS	FY92 Child Survival Grant to CRS	Catholic Relief Services
938-0CRS	FY92 Vitamin A Grant to CRS	Catholic Relief Services
938-HOPE	FY89 Child Survival Grant to HOPE	Project Hope, Ministry of Public Health
938-HOPE	FY92 Child Survival Grant to HOPE	Project Hope
938-HOPE	FY92 Vitamin A Grant to HOPE	Project Hope

Please see Data Notes.

Source: CIH0001



## Descriptions of USAID-Funded Child Survival, HIV/AIDS, and Other Health Projects

DECEMBER 1993

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### Bilateral Projects

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**Project Number:** 518-0071  
**Project Title:** Child Survival and Health  
**Country:** Ecuador  
**Project Area:** Highland provinces -- Azuay, Imbabura, Chimborazo, Cotopaxi, Pichincha  
Coastal Provinces -- Esmeraldas, Guayas and Manabi  
**Project Duration:** FY 1989 - 12/31/94  
**Implementing Organization(s):**  
**Host Country:** Ministry of Public Health (MOPH), General Directorate of Health, Promotion and Protection Direction  
**U.S.:** Management Sciences for Health

#### Project Overview:

Child Survival and Health assists the Ministry of Health in three major areas: strengthening child survival programs; decentralized management and support services for sustainable child survival service delivery; and review of health financing initiatives. The project purpose is to improve the effectiveness of child survival programs in eight provinces with the greatest potential for infant mortality reductions to reduce neonatal mortality and rural/urban mortality differentials.

The project plans to develop an epidemiological surveillance system as a component of the health information system to serve as a base for decentralized planning. Key indicators include the infant mortality rate, number of prenatal visits, percent of births delivered by trained personnel, prevalence of malnutrition, prevalence of acute respiratory infections, use of oral rehydration therapy, and vaccination coverage. These indicators are being used for the establishment of intermediate targets as part of the provincial plans. Now that the use of relevant statistical information for planning is institutionalized at the provincial level, implementation has begun at the local level.

#### Project Highlights:

- The project has taken a number of steps in the area of training. Seminars and workshops on software applications, service quality improvement, health education techniques, maternal and child health issues, primary health care, and general management have been conducted. A training needs assessment, involving 1600 participants, was completed in all eight provinces. Six MOH staff members received training in the United States during 1992, bringing the total number to 17.
- Initial steps toward improved financial management have been made. Financial management software has been installed in four provinces, with plans to replace the manual accounting systems at the national level. Inventory management software has been installed in Chimborazo's Health Directorate to improve the procurement and supply of medicines.

#### Sources:

AID0001, QUE9100, QUE9200

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***No Longer Funded***

**Project Number:** 518-0093  
**Project Title:** Private Pharmaceutical Distribution  
**Country:** Ecuador  
**Project Area:** Urban marginal or rural areas  
**Project Duration:** FY 1990 - 9/30/93  
**Implementing Organization(s):**  
**Host Country:** Asociacion de Industriales e Importadores de Productos Farmaceuticos (ASOPROFAR), PROMESA  
**U.S.:** No organizations

**Project Overview:**

This project provides low-cost, high-quality, brandname drugs to underserved populations in marginal urban and rural areas on a self-sustaining basis. ASOPROFAR has established a non-governmental organization, PROMESA, which is implementing the program.

The project supports initial operational studies and market research in support of the opening of 66 new dispensaries (botiquines). Support was also provided for the development of improved drug control and distribution. In June 1992, ASOPROFAR submitted a proposal for expansion of the original grant in order to establish an additional 100 botiquines over the final year of the project. The new ASOPROFAR/PROMESA project greatly expands the activities to date in the following areas:

- The number of botiquines increases by 100, bringing the new project total to 166. The target population will also expand to approximately two million persons in rural and marginal urban areas.
- Increased emphasis is placed on health education and communication activities, with the objective of reducing mortality due to preventive diseases and increasing the correct use of prescription drugs.
- The industry expands its contribution beyond medication to include the establishment of at least eight health clinics.

**Project Highlights:**

- Sixty-six new botiquines were opened during the first two years of project implementation, meeting the project goals.
- The project developed administrative and financial systems and provided training in medical information systems, stock/inventory control, procurement and logistics, word processing, and spread sheet analysis.
- The success of this project has gone well beyond measurable goals. Headquarters' representatives of pharmaceutical firms have requested information on the PROMESA program so that it may be replicated in other countries.
- Over 20 local non-governmental organizations (NGOs) have participated in this program, and there is a long waiting list of additional NGOs that would like to take part.

The impact of this project's success is clearly felt in the most impoverished communities of Ecuador. The success has also not gone unnoticed by the international pharmaceutical industry.

**Sources:**  
AID0001, QUE9100, QUE9200



*No Longer Funded*

**Project Number:** 518-0060  
**Project Title:** OPG: Private Sector Health Delivery Model  
**Country:** Ecuador  
**Project Area:** Solanda and Marcabeli communities  
**Project Duration:** FY 1985 - 12/31/91  
**Implementing Organization(s):**  
Host Country: Solanda Community Clinic, Marcabeli Community Clinic  
U.S.: MAP International

**Project Overview:**

This project was designed to improve the health status of Ecuadorian people who do not have access to primary health care services and to facilitate the establishment of self-reliant and self-maintaining community organizations that will be able to conduct primary health activities without dependence on outside resources.

Originally the project had two purposes. The first was to develop, test, and place in operation models for privately financed primary health care among rural and marginal urban communities in Ecuador. The models designed in the proposed project would have added to the knowledge base of alternative ways to finance health care. The second purpose was to improve the health status of the people who did not have access to health care services.

The rural component of the project was the community of Marcabeli, in El Oro Province in 1987. Marcabeli is located several hours south of Machala, serving a population of 4,700. The urban component was located in Solanda, one of the most populous neighborhoods in south Quito. It is part of a government housing project for lower-income families.

Neither the Solanda nor the Marcabeli projects were implemented according to the time frame originally planned. The implementation delays were due to the sheer magnitude of the task of developing strong community organizations without which sustainability would be impossible. In addition, each project site had its particular obstacles. An extension of the project was recommended.

**Project Highlights:**

- In Solanda, a problem was created by the continuous increase of inhabitants and the formation of new organizations with different interests. A health committee was created to overcome this problem; the committee has representatives from 8 of 12 organizations. Community participation has been very strong here, with several health workshops, campaigns, and social events taking place.
- The Marcabeli project, on the other hand, initially demonstrated a lack of credibility with the community, resulting in a sluggish organizational process. Once a health committee was created, however, it received strong support from the community. All committee members demonstrated capability and willingness to contribute to the improvement of the community's health status. The community education activities included different workshops on nutrition, family gardens, personal hygiene, malaria, and diarrheal treatment. A basic lab was installed and was providing a valuable service to the community.
- Solanda, by the end of the project in 1991, was recovering about 30 percent of its total costs and Marcabeli, 90 percent. The Solanda health center suffered because prices of services provided were set too low to be financially sustainable, the medical clinic and lab were under-utilized, staff was inefficiently allocated, and nearby competition reduced demand. The activity was not carried out like a business. Solanda offered a large subsidy to all clients regardless of income level. The Marcabeli health center, on the other hand, was operated like a business. Part of the success was derived from its not operating a highly subsidized medical clinic. Subsidies were kept low compared to Solanda; discounts were offered to schools for block of exams; the community had control over decisions; and the Marcabeli case could be replicated elsewhere.

**Sources:**

AID0001, QUE9100, QUE9200

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**Project Number:** 518-0108  
**Project Title:** Cholera Control  
**Country:** Ecuador  
**Project Area:** A total of 430 rural communities in the following five provinces: Los Rios, Imbabura, Chimborazo, Loja and Azuay  
**Project Duration:** FY 1991 - 12/31/93  
**Implementing Organization(s):**  
    **Host Country:** Ministry of Health (MOH)  
    **U.S.:** CARE International (CARE)

**Project Overview:**

CARE works with the MOH to diminish cholera morbidity and mortality by 80 percent in 430 rural communities with the highest incidence of cholera. Using three main interventions -- construction of latrines, hygiene education, a mass media campaign -- it is anticipated that cholera incidence will drop to 100 cases in the last three months of the project and cholera deaths to less than 10.

The project planned to construct 28,500 latrines in a coordinated effort with the MOH, non-governmental organizations, and communities using appropriate technology for each geographical region.

**Project Highlights:**

- Physicians, nurses, and community health workers participated in various oral rehydration therapy seminars.
- Other workshops prepared community leaders who now are promoting cholera control in their communities.
- During the first year of the project, a total of 15,980 families were trained in seven hygiene health practices.

**Sources:**

QUE9200

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**Project Number:** 518-0076  
**Project Title:** National Shelter Delivery System  
**Country:** Ecuador  
**Project Area:** Major municipalities of the country such as Quito, Guayaquil and possibly Machala  
**Project Duration:** FY 1987 - 12/31/95  
**Implementing Organization(s):**  
    **Host Country:** Ministry of Finance, Ministry of Urban Development and Housing, Municipal Water Authorities, Ecuadorian Credit Union System, Ecuadorian Housing Bank  
    **U.S.:** Water and Sanitation for Health (WASH), AG International



**Project Overview:**

National Shelter Delivery System provides low-income, urban families increased access to upgraded and new housing financed by public and private sector institutions. The project also supports the Government of Ecuador's efforts to improve the quality of life by allowing these families access to financing for infrastructure (water and sewer system) improvements.

A major component of the project focuses on financial management of municipal and provincial water and sewage authorities. Public water authority officials attended a workshop on a cost accounting system which properly tracks water authority pricing and collection of payments for services delivered to beneficiaries of the Municipality of Quito. Plans were made to promote the adoption of this system by other municipal infrastructure agencies throughout the country.

WASH will provide technical assistance in a number of different areas during the next phase of the project. Topics include the development of a national association of municipal infrastructure agencies; strategic planning and technology transfer; and an institutional development workshop for managers of water and sewer companies.

Discussions were initiated with municipal officials in Guayaquil and Machala on possible technical assistance for the privatization of municipal water and sanitation services.

**Sources:**

QUE9200

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**Project Number:** 518-0081  
**Project Title:** Water and Sanitation for Health Education  
**Country:** Ecuador  
**Project Area:** Highland provinces -- Imbabura, Pichincha, Cotopaxi, Chimborazo, Azuay, Tungurahua, Carchi  
Coastal province -- El Oro  
**Project Duration:** FY 1989 - 12/31/93  
**Implementing Organization(s):**  
**Host Country:** Ecuadorian Institute of Sanitary Works (IEOS), Ministry of Public Health (MOPH)  
**U.S.:** No organizations

**Project Overview:**

Water and Sanitation for Health Education continues activities begun under the Integrated Rural Health Delivery Systems project (#5180015). The project strengthens IEOS's capacity to assist rural communities with three main activities:

- to install cost-effective, technologically appropriate, safe water supply and sanitation systems;
- to use the water and latrines to improve family health status; and
- to maintain and improve the system in the future.

IEOS implements the project's construction, hygiene education, operations and maintenance, appropriate technology, and training components. Although some activities are conducted nationwide, emphasis is placed on the eight provinces of Imbabura, Pichincha, Cotopaxi, Chimborazo, Azuay, Tungurahua, Carchi, and El Oro.

The project strives to decentralize the construction, planning, and management process using a system initiated by IEOS in 1987. Under this system, IEOS delegates responsibility for construction planning and supervision to provincial-level staff. Responsibility for the promotion and construction of water supply and sanitation projects is then delegated to

“operational modules” or teams comprising a sanitary engineer, three promoters, and an administrative assistant. As of FY 1992, these teams, both at the managerial and operational levels have worked in coordination toward strengthening IEOS decentralization.

**Project Highlights:**

- The project intends to build approximately 640 rural water and sanitation systems to serve 320,000 persons. Community water boards are to be formed and communities will contribute 20 percent of costs. IEOS also plans to upgrade its project selection and budgeting processes, as well as develop formal operating and management policies and procedures.
- A social marketing hygiene education program is planned, using radio and television, school programs, and community-level interpersonal communications. Nearly 3,000 rural community members, including community leaders, school teachers, and mothers were trained at informal events during 1992.
- IEOS intends to convert 35 water and sanitation promoters to hygiene education promoters and to hire up to 70 additional community hygiene educators, predominantly women insofar as possible. Both the rural communities and IEOS are recognizing fieldwork accomplished by female sanitation promoters. A knowledge, attitudes, and practice (KAP) study on sanitary conditions in rural areas is scheduled to end in January 1993.
- IEOS also intends to establish central and provincial operations and management units to support the activities of community water boards, which will be responsible for preventive and emergency maintenance. These units will also assess the ability and willingness of communities to pay for water supply and sanitation services.
- IEOS plans to establish an Appropriate Technology Studies Coordination Unit to conduct applied research to test the applicability of alternative water and sanitation technologies to Ecuadorian conditions. Applied appropriate technology is currently promoting more practices to purify water and promote use of potable water and latrines. Three studies began in 1992 and are expected to be complete in the spring of 1993.
- The development of a cadre of national trainers is planned to provide technical and managerial training to some 2,000 IEOS and 5,000 other personnel, such as community water board members. IEOS staff will generally be trained in week-long workshops, with 20 to 30 participants each. Some staff members will also participate in U.S. or Latin America study tours. During FY 1992, 30 formal training events were completed, serving 967 provincial- and central-level IEOS personnel and village members.

**Sources:**

AID0001, QUE9100, QUE9200

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**No Longer Funded**

**Project Number:** 518-0049  
**Project Title:** Malaria Control  
**Country:** Ecuador  
**Project Area:** Santo Domingo, El Puyo, Loja, Los Rios, Manabi, Esmeraldas, Machala, Lago Agrio, Macas  
**Project Duration:** 1985 - 2/29/92  
**Implementing Organization(s):**  
**Host Country:** Ministry of Health (MOH), Servicio Nacional de Erradicacion de la Malaria (SNEM)  
**U.S.:** No organizations



**Project Overview:**

This project assisted the Government of Ecuador in its efforts to control malaria nationwide to a level at which it would no longer be a public health problem and to develop institutional capacities to maintain that level of control. Actual project activities took place in nine provinces where the populations were most at risk of contracting malaria. The five principal components were program management, operational research, training, evaluation, and commodity support.

**Project Highlights:**

■ Project activities in the prevention of malaria included the use of impregnated bednets and other personal protection methods as well as general vector control against adult mosquitos and larvae. The project also supported the provision of antimalarial drugs.

**Sources:**

QUE9200

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**Project Number:** 938-0CRS  
**Project Title:** FY 92 Child Survival Grant to Catholic Relief Services  
**Country:** Ecuador  
**Project Area:** Diocese of Cuenca, Province of Azuay,  
Diocese of Portoviejo, Province of Manabi,  
Diocese of Latacunga, Province of Cotopaxi  
**Project Duration:** 1985 - 2/28/94  
**Implementing Organization(s):**  
Host Country: Catholic Relief Services, Ecuadorian Bishops Conference through the Dioceses  
U.S.: Catholic Relief Services

**Project Overview:**

Catholic Relief Services (CRS) promotes diarrheal disease control, immunization, growth monitoring, and nutrition interventions through 250 community health workers in the dioceses of Latacunga, Portoviejo, and Cuenca. With low-interest loans for agricultural and animal husbandry activities, families have improved their nutritional intake and generated supplemental income.

CRS began implementing child survival activities in Ecuador in 1986. Nutrition and control of diarrheal diseases activities have been carried out through mother-infant centers previously created by the church to channel food donation.

**Project Highlights:**

■ To date, the project has worked with 87 communities and benefits 2,500 families and 4,800 children under six years of age. Two health and nutrition promoters have been trained in the project's activities per community. The project also coordinates its activities with local health offices in order to optimize results.

■ Control of diarrheal diseases activities emphasize prevention and to assure the proper use of oral rehydration therapy to prevent dehydration caused by diarrhea. During 1991, CRS took extra precautions with regards to cholera, as the epidemic began affecting Ecuador in February 1991. Educational programs emphasized the difference between common diarrhea and diarrhea produced by cholera. Over 10,000 oral rehydration salts packets were distributed among the population. Lastly, the project designed, produced and distributed pamphlets containing basic information regarding cholera control and prevention measures. The materials were written for use by health promoters and community leaders.

■ The rate of malnutrition for children between 12 and 72 months is over 50 percent according to a project study conducted in 1991. To combat the high rates of malnutrition, the project began a nutrition education strategy for pregnant and nursing women and mothers with children under two years old. A calendar with general nutritional key messages and a folder containing 14 sheets with nutritional messages for different audiences are used by health promoters and mothers.

■ Another very important component is the promotion of production of food for home consumption. Agricultural, small animal raising, and soil conservation are the main activities of this component. In cases of surplus production, families sell their products in the local market to generate income for other family expenditures. Beneficiary communities now have their own bank accounts with rotating funds averaging US \$250 and ranging from \$80 to \$2,000 per community. Each community decides who will receive loans and what the agricultural production activities will be.

**Sources:**

CRS9300, QUE9100

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***No Longer Funded***

**Project Number:** 938-HOPE.01  
**Project Title:** FY 89 Child Survival Grant to HOPE  
**Country:** Ecuador  
**Project Area:** Provinces of Azuay and Manabi  
**Project Duration:** 1989 - 2/28/93  
**Implementing Organization(s):**  
    **Host Country:** Ministry of Health  
    **U.S.:** The People-to-People Health Foundation, Inc. (Project HOPE)

**Project Overview:**

This project conducted vaccination, control of diarrheal diseases, and nutrition and growth monitoring activities and promoted birth spacing and exclusive breastfeeding in Azuay and Manabí provinces.

**Project Highlights:**

■ The training component was extensive: training was provided for 450 auxiliary nurses, 135 community health volunteers, and 20 traditional birth attendants (TBAs). Thousands of mothers were trained, thus strengthening local capacity to improve overall child health and reduce high risk pregnancies. Nearly one thousand of these mothers attended a 30-hour course that covered the following topics: diarrhea and dehydration, immunization, mother and child care, nutrition, breastfeeding and weaning, family planning and hygiene.

■ To reduce perinatal mortality, Project HOPE developed a strong training and supervision component for TBAs following the guidelines of the Ministry of Health (MOH). Project HOPE also worked to promote the TBA relationship with MOH staff through increased contact between TBAs and health facility staff.

■ Project HOPE worked with mothers' clubs and volunteers to improve nutritional practices. During educational sessions, mothers were taught to prepare locally available foods and to consume them. Yucca leaves had never been prepared by residents until a nutritionist demonstrated their use in soups and salads. Now that mothers have tasted the leaves, they have become very popular. During these sessions, mothers for the first time consumed grated raw carrots as well.



■ Breastfeeding and growth monitoring, and the development of home and community gardens were also part of the integrated nutrition promotion and education approach.

■ Immunization activities involved promotion and community education for vaccination of children and assistance in mass vaccination campaigns. The main activity was the administration of tetanus toxoid to pregnant women and women of childbearing age. The project demonstrated to the MOH that there is a great demand for such vaccinations.

**Lessons Learned:**

Young people, especially young women are more active and dynamic health volunteers. However upon marriage, husbands typically do not allow them to work. Taking into account the expense of training and then losing volunteers, the project prefers to recruit mothers and fathers with families. Although they are less active, they work for longer periods of time.

Coordination with NGOs is very important to avoid duplication of services. Project HOPE coordinates with other PVOs found in the communities to take advantage of the additional resources that are available.

**Sources:**

QUE9100, QUE9200

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**USAID/Washington Support (AID9300)**

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■ **Regional Projects**

**Accelerated Immunization II** contributed to efforts to control measles, neonatal tetanus, and other vaccine-preventable diseases and conducted surveillance to confirm the absence of wild poliovirus.

**Health and Nutrition Technical Services Support.** The LAC Regional Cholera program provided technical assistance and supplies of oral rehydration packets to help combat cholera; the LAC Health and Nutrition Sustainability project field-tested a method to assess pharmaceutical management and assisted with design of a future mission-sponsored project on health financing.

■ **U.S. Private Voluntary Organizations/FHS/PVC Projects**

**Catholic Relief Services** promotes diarrheal disease control, vaccination, growth monitoring, and nutrition interventions through over 250 community health workers in the dioceses of Latacunga, Portoviejo, and Cuenca.

**Project HOPE** conducts vaccination, oral rehydration, and nutrition and growth monitoring activities and promotes birth spacing and exclusive breastfeeding in Azuay and Manabí provinces.

■ **Bureau for Research and Development Projects**

**Applied Diarrheal Disease Research** supported research and technical assistance to control and treat diarrheal diseases and arranged for invaluable visits by cholera experts from the International Center for Diarrheal Disease Research in Bangladesh.

**Health Care Financing and Sustainability** conducted studies on hospital cost recovery and the social security system and assessed alternative health care financing methods for the MOH's child survival project.

**MotherCare (Breastfeeding and Maternal and Neonatal Care)** continued applied research on the "kangaroo mother method" to care for low birth-weight infants at Isidro Ayora Maternity Hospital in Quito.

**TAACS (Technical Advisor in AIDS and Child Survival)** provided technical assistance to the Child Survival and Health projects.

■ **Short-term technical assistance and support**

**HEALTHCOM II (Communication and Marketing for Child Survival)** conducted a communication planning workshop and a week-long seminar in social marketing and communications for health program designers and managers from Ecuador and other Latin American nations to control cholera.

**International Center for Research on Women (Women and Infant Nutrition)** supported research on nutrition for adolescent girls.

**Quality Assurance Project (Applied Research in Child Survival Services)** assisted in studies to control diarrheal diseases through ORT.

**Vector Biology and Control** supported efforts to control malaria.

**VITAL (Vitamin A for Health)** supported an MOH survey to test for vitamin A deficiency in highland regions.

**WASH (Water and Sanitation for Health)** assisted municipal institutions participating in the National Shelter Delivery System.

**Wellstart (Women and Infant Nutrition)** strengthened lactation education and breastfeeding programs through training and technical assistance.

## VI: DATA NOTES

DECEMBER 1993

### *Notes On Mortality Estimation*

Throughout this profile, references are made to infant and under 5 mortality rates for individual countries or groups of countries. In past years, the primary source of data on infant mortality was the World Population Prospects, a set of estimates updated every two years by the Estimates and Projections Section of the Population Division of the Department of International Economic and Social Affairs, United Nations. The primary source of data on under 5 mortality was a special report published in 1988 by the same group. Where another source, such as a recent Demographic and Health Survey or a national census, was available for a given country, the reported values from that source were cited in place of the United Nations estimates if the technical staff of USAID in the Country Mission and/or the appropriate regional bureaus confirmed the validity of the alternative source.

Known as indirect estimates, those of the United Nations are generated from accepted demographic models which combine the results of all available surveys and censuses in a given country to produce a single time series of estimates and projections. When new empirical data becomes available for a given country, the entire time series of estimates and projections is updated. Thus, using conventional demographic approaches, a survey done in 1990 may generate a new estimate of a mortality rate for 1970 or 1980.

During 1993, a new set of estimates for mortality was generated for 82 countries for publication in the World

Development Report 1993 and a forthcoming UNICEF publication entitled The Progress of Nations. Based on a curve-fitting model, the methodology applied to generate these new estimates purports to depict more accurately the trend derived from all available data sources for a country. Like the estimates generated using conventional demographic models, the entire time series might change upon the addition of a new empirical source. These estimates were made available to USAID through the courtesy of the World Development Report of the World Bank and UNICEF.

The selection of the mortality rates was done through a consultative process involving representatives of the Office of Health in USAID's Research and Development Bureau, USAID's Regional Bureaus and, in many cases, the USAID Country Missions. The source determined to best reflect the reality in a country for the current values of infant and under 5 mortality was identified and one of a number of a computation procedures, depending on the source selected for the current value, was applied to estimate the longitudinal rates. The consideration of the additional source of data developed for the World Development Report and UNICEF during the consultative process has prompted some changes in the reporting of mortality rates from those reported in recent years.

### *Definitions*

#### *Demographic Indicators*

**Total Population:** The mid-year estimate of the total number of individuals in a country.

**Average Annual Rate of Growth:** An estimate of the rate at which a population is increasing (or decreasing) in a given year.

**Infant Mortality Rate:** The estimated number of deaths in infants (children under age one) in a given year per 1,000 live births in that same year. This rate may be calculated by direct methods (counting births and deaths) or by indirect methods (applying well-established demographic models).

**Under 5 Mortality Rate:** The estimated number of children born in a given year who will die before reaching age five per thousand live births in that same year. This rate may also be calculated by direct or indirect methods.

**Maternal Mortality Ratio:** The estimated number of maternal deaths per 100,000 live births where a maternal death is one which occurs when a woman is pregnant or within 42 days of termination of pregnancy from any cause related to or aggravated by the pregnancy or its management. Although sometimes referred to as a rate, this measure is actually a ratio because the unit of measurement of the numerator (maternal deaths) is different than that of the denominator (live births). The measure would be a rate if the units were the same. Extremely difficult to measure, maternal mortality can be derived from vital registration systems (usually underestimated), community studies and surveys (requires very large sample sizes) or hospital registration (usually overestimated).

**Crude Birth Rate:** An estimate of the number of live births per 1,000 population in a given year.

**Crude Death Rate:** An estimate of the number of deaths per 1,000 population in a given year.

**Life Expectancy At Birth:** An estimate of the average number of years a newborn can expect to live. Life expectancy is computed from age-specific death rates for a given year. It should be noted that low life expectancies in developing countries are, in large part, due to high infant mortality.

**Children Under Age 1:** Mid-year estimate of the total number of children under age one.

**Annual Infant Deaths:** An estimate of the number of deaths occurring to children under age one in a given year.

**Total Fertility Rate:** An estimate of the average number of children a woman would bear during her lifetime given current age-specific fertility rates.

#### *Child Survival Indicators*

##### **Vaccination Coverage In Children:**

An estimate of the proportion of living children between the ages of 12 and 23 months who have been vaccinated before their first birthday -- three times in the cases of polio and DPT and once for both measles and BCG. Vaccination coverage rates are calculated in two ways. Administrative estimates are based on reports of the number of inoculations of an antigen given during a year to children who have not yet reached their first birthday divided by an estimate of the pool of children under one year of age eligible for vaccination. Survey estimates are based on samples of children between the ages of 12 and 23 months.

##### **Vaccination Coverage In Mothers:**

An estimate of the proportion of women in a given time period who have received two doses of tetanus toxoid during their pregnancies. This indicator is being changed in many

countries to account for the cumulative effect of tetanus toxoid boosters. A woman and her baby are protected against tetanus when a mother has had only one or, perhaps, no boosters during a given pregnancy so long as the woman had received the appropriate number of boosters in the years preceding the pregnancy in question. (The appropriate number of boosters required during any given pregnancy varies with number received previously and the time elapsed.) The revised indicator is referred to as TT2+. Rates are computed using administrative methods or surveys.

**DPT Drop-out Rate:** An estimate of the proportion of living children between the ages of 12 and 23 months who received at least one DPT vaccination but who did not receive the entire series of three vaccinations before their first birthdays.

##### **Oral Rehydration Salts (ORS)**

**Access Rate:** An estimate of the proportion of the population under age five with reasonable access to a trained provider of oral rehydration salts who receives adequate supplies. This is a particularly difficult indicator to measure and, therefore, it may fluctuate dramatically from year to year as improved methods of estimation are devised.

##### **ORS and/or Recommended Home**

**Fluid (RHF) Use Rate:** An estimate of the proportion of all cases of diarrhea in children under age five treated with ORS and/or a recommended home fluid. ORT use may be determined using administrative means or surveys. In general, administrative estimates are based on estimates of the number of episodes of diarrhea in the target population for a given year and the quantity of ORS available. Thus, changes in the estimates of the frequency of diarrhea episodes can alter the ORT use rate as well as "real" changes in the pattern of use.

Surveys are more precise in that they focus on the actual behavior of mothers in treating diarrhea in the two-week period prior to the survey.

**Contraceptive Prevalence Rate:** An estimate of the proportion of women, aged 15 through 44 (or, in some countries, 15 through 49), in union or married, currently using a modern method of contraception. Where sources fail to distinguish modern and traditional methods, the combined rate is shown.

**Adequate Nutritional Status:** An individual child of a certain age is said to be adequately nourished if his/her weight is greater than the weight corresponding to "two Z-scores" (two standard deviations) below the median weight achieved by children of that age. The median weight and the distribution of weights around that median in a healthy population are taken from a standard established by the National Center for Health Statistics, endorsed by the World Health Organization (WHO). The indicator for the population as a whole is the proportion of children 12 through 23 months of age who are adequately nourished.

**Appropriate Infant Feeding:** A composite estimate of the proportion of infants (children under age one) being breastfed and receiving other foods at an appropriate age according to the following criteria: breastfed through infancy with no bottle-feeding, exclusively breastfed through four months (120 days) of age, and receiving other foods if over six months of age (181 days). Water is not acceptable in the first four months (120 days). ORS is considered acceptable at any age. Surveys are the only source of data to form this indicator. Surveys yield an estimate of how many infants are being fed correctly at the moment of the survey. They do not give an indication of the proportion of individual children fed appropriately throughout their first year of life. A number of sub-



indicators may be calculated from the data used to form the composite, of which two are presented in this report.

**Exclusive Breastfeeding:** An estimate of the proportion of infants less than four months (120 days) of age who receive no foods or liquids other than breast milk.

**Complementary Feeding:** An estimate of the proportion of infants six to nine months of age (181 days to 299 days) still breastfeeding but also receiving complementary weaning foods.

**Continued Breastfeeding:** An estimate of the proportion of children breastfed for at least one year. In this report, all values presented for this indicator are the proportion of children 12 to 15 months of age at the time of the survey still receiving breast milk.

#### *Other Health Indicators*

**HIV-1 Seroprevalence, Urban:** An estimate of the proportion of all persons (pregnant women, blood donors, and other persons with no known risk factors) living in urban areas infected with HIV-1, the most virulent and globally prevalent strain of the human immunodeficiency virus.

**HIV-1 Seroprevalence, Rural:** An estimate of the proportion of all persons living in rural areas infected with HIV-1.

**Access to Improved Water, Urban:** An estimate of the proportion of all persons living in urban areas (defined roughly as population centers of 2,000 or more persons) who live within 200 meters of a stand pipe or fountain source of water.

**Access to Improved Water, Rural:** An estimate of the proportion of all persons not living in urban areas with a source of water close enough to home that family members do not spend a disproportionate amount of time fetching water.

**Access to Sanitation, Urban:** An estimate of the proportion of all persons living in urban areas with sanitation service provided through sewer systems or individual in-house or in-compound excreta disposal facilities (latrines).

**Access to Sanitation, Rural:** An estimate of the proportion of all persons not living in urban areas with sanitation coverage provided through individual in-house or in-compound excreta disposal facilities (latrines).

**Deliveries By Trained Attendants:** An estimate of the proportion of deliveries attended by at least one physician, nurse, midwife, or trained traditional birth attendant.

#### *Notes on Project Information*

The primary source for information related to USAID projects is the USAID Health Projects Database (HPD) operated by the Center for International Health Information/ISTH.

The HPD tracks bilateral, regional and centrally-funded USAID projects and sub-projects with a health component, including child survival, HIV/AIDS, nutrition, water supply and sanitation, and other health related activities. Projects are identified for the HPD through the annual USAID Health and Child Survival Project Questionnaire, Annual Budget Submissions (ABS), Congressional Presentations (CP), and the Activity Code/Special Interest (AC/SI) System. Information on project activities, organizations implementing these activities, and project assistance completion dates is also taken from other official USAID documents such as project reports.

In the **Timeline: USAID Activities Related to Health and Population** table, Life-of-Project (LOP) funding indicates the total authorized funding

planned for all project activities from the beginning until the conclusion of the project. Projects may contain components which are not directly related to health, and therefore, LOP totals reported here may not be used to describe funding for health activities specifically. Please refer to the Fiscal Year Obligations for USAID-funded Projects Related to Health table to determine funding attributed to health activities. Where project assistance completion dates are not available, the timeline reports the planned final year of funding for the project and notes this with \*\*. Project activities may extend beyond this reported final year of funding.

The **Fiscal Year Obligations for USAID-funded Projects Related to Health** table does not include total project obligations; it includes only totals for health, child survival and HIV/AIDS activities. These funding totals are based on calculations of annual obligations reported in the USAID Congressional Presentation and on reported attributions for health activities. These attributions are reported through the annual USAID Health and Child Survival Project Questionnaires for Fiscal Year (FY) 1985-91, and the AC/SI System for FY 1992, with the exception of the Child Survival and Vitamin A grants as reported from FDC/PVC for all years. Reported obligations include all accounts except population account funds for FY 1985-91. Public Law 480 funding is not included in this report.

## VII: SOURCES

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- AID0000 Data for the timelines is a consolidation of data from: a) annual USAID Health and Child Survival Project Questionnaires, b) USAID Congressional Presentations (CPs), and c) the USAID Office of Private Voluntary Cooperation/Bureau for Food and Humanitarian Assistance.
- AID0001 Project description as reported in the USAID/CDIE/DISC Development Information System.
- AID0002 Family Health International. AIDSTECH and AIDSCAP Project Reports.
- AID8701 Rustein, O. Child Survival in Ecuador, Report to the USAID Mission in Ecuador 1987.
- AID9009 Water and Sanitation for Health Project, U.S. Agency for International Development. WASH Field Report No. 302: Planning For Water and Sanitation Programs in Bolivia, Ecuador, and Peru, June 1990.
- AID9202 MOH, Unidad de Investigacion y Analisis, Direccion General de Estadistica. Cited in USAID/Peru Mission Facsimile, 2/24/92.
- AID9300 United States Agency for International Development. Child Survival: An Eighth Report to Congress on the USAID Program. (Forthcoming)
- AID9308 The USAID Activity Code/Special Interest (AC/SI) System, July 27, 1993.
- BUC9103 Bureau of Census, Center for International Research, Recent HIV Seroprevalence Levels By Country, April, 1992
- BUC9105 Series of diskettes provided by Kevin Kinsella over a period of several months near the end of 1991 and the beginning of 1992. Data reported from the U.S. Bureau of the Census data base.
- CAB9201 USAID/Ecuador mission cable #11608, December, 1992.
- CAB9303 USAID/Ecuador mission cable #01431, February, 1993.
- CAB9304 State Department Cable #089166 to USAID/Ecuador, March, 1993.
- CALXX01 Calculated from the values for total population, crude birth rate and infant mortality from designated sources for those variables.
- CAR9300 CARE International, Headquarters, New York City. Personal Communication.
- CEP9001 Centro de Estudios de Poblacion (CEPAR), Ministerio de Salud Publica MSP, and Centers for Disease Control (CDC). Ecuador Encuesta Demografica y de Salud Materna e Infantil ENDEMAIN - 89. Quito, Ecuador: CEPAR, 1990.
- CIH0001 The Center for International Health Information. The Health Projects Database, an ongoing record of projects in the health portfolio of the Agency for International Development.
- CRS9301 "Report on Catholic Relief Services Child Survival Project in Ecuador", received by facsimile, 1993.
- DHS8803 Centro de Estudios de Poblacion y Paternidad Responsable (CEPAR), Instituto Nacional de Investigaciones Nutricionales y Medico Sociales, and Institute for Resource Development/Westinghouse. Ecuador Encuesta Demografica y de Salud Familiar 1987. Quito, Ecuador: CEPAR, 1988.
- DHS9001 Instituto Nacional de Estadistica, and Institute for Resource Development/Macro Systems, Inc. Bolivia Encuesta Nacional de Demografia y Salud 1989. Columbia, MD: IRD, 1990.
- DHS9207 Instituto Nacional de Estadistica e Informatica, Asociacion Benefica PRISMA, and Macro

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