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## An Internship in Otavalo, Ecuador

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**An Internship in Otavalo, Ecuador**

**Senior Honors Project  
Winter Quarter 1999**

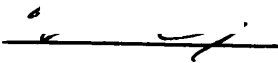
**Prepared by**

**Travis Ning**

**January 1999**

## ***HONORS THESIS***

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## **Preface**

As a student of Fairhaven College, I have the unique opportunity to formulate my own major that caters to my specific interests and needs. "Latin American Social Issues: Population and Health" is the interdisciplinary concentration that I have created. This focus consists of a few different components that are intended to give me a well-rounded view of contemporary Latin America and the best approaches to servicing the health problems of the region. Classes relating to the rich past of the region, such as Mexican History and Latin American History, have played an important role in developing this perspective. Knowledge of the past and the reasons behind the creation of current conditions in Latin America is imperative in devising new approaches towards complex health problems. Similarly, I have found that studies relating to the social issues of Latin America are also an invaluable aspect of this major. I have undertaken several independent studies to focus in on specific details of development that are not fully covered in conventional classes. Family planning, microcredit programs, and structural adjustment loans are all topics that I have researched through independent studies at Fairhaven College.

In addition to the academics at Western Washington, travel and study abroad programs have proven to be other extremely effective methods of researching this concentration. I realized the value of foreign experiences while traveling throughout Central America during the spring of 1996 and studying in Morelia, Mexico during the winter of 1997. Fortunately, I had another chance to continue my research while studying in Latin America last year.

During the winter and spring quarters of 1998, I had the opportunity to conduct my studies in Ecuador. The winter quarter was spent in the capital, Quito, attending classes at a small foundation called CIMAS (Centro Investigación de Medio Ambiente y Salud or Center of Environment and Health Investigation). These classes were taught in Spanish and focused primarily on the history of Latin America, particularly Ecuador, as well as the contemporary issues that face the region today. Topics such as environmentalism, economics, and health were thoroughly covered in these seminars.

The spring quarter entailed a student-designed internship to be conducted anywhere within the country. This project challenged the student to explore a specific and individual interest that could not be fully examined in the classroom. As a student of Latin American health, this internship offered me the unique and invaluable opportunity to work in the field and to be a part of something that before, had only been available through books and lectures.

My interest in children's health and family planning among the marginalized population of Ecuador directed me into the northern province of Imbabura. This mountainous area is predominantly inhabited by Otavaleños, the Quechua-speaking indigenous population. I lived in

the small city of Otavalo, a town famous for its immense Saturday market where travelers can purchase the trademark Ecuadorian sweaters and crafts. Many studies have been conducted regarding the market, as some of the Otavaleños have prospered a great deal from the worldwide demand for the colorful indigenous goods. Within the city, there exists a rare phenomenon where the indigenous population controls economic and social powers. This characteristic is virtually unheard of anywhere else in the country, where the majority of the indigenous suffer from a grave maldistribution of resources.

Race relations among the groups of Ecuador are poor. Although there is a substantial indigenous population in Ecuador (40%), they have a serious lack of governmental representation. Since the country's inception, the mistreatment of the native population has created a widespread mistrust of outside efforts to improve conditions among the indigenous. The agrarian reforms of the 1970's, which were advertised as great equalizers for the rural indigenous farmers, were false and only exacerbated their existing problems by forcing them into the highlands. Today, among the towering Andes of Ecuador, one can see small plots of corn on seemingly inaccessible mountainsides where families have been forced to relocate. Similarly, unfulfilled promises from campaigning politicians have contributed to this wariness of other racial and economic groups.

This history makes Otavalo's success all the more extraordinary. The tourist industry fuels this phenomenon. People come to Otavalo for the sole purpose of purchasing the indigenous goods from the Otavaleños themselves. For many foreigners, Otavalo is their only opportunity to see the indigenous culture, and the Otavaleños are very aware of this. Numerous tourist agencies offer trips into some of the larger communities to see the "typical indigenous lifestyle." Among the local people, there seems to be a universal awareness of the importance of tourists, and the city is set up to cater to the foreigners. Touristed areas are kept clean and safe. Many menus offer English translations. Otavaleños spend their weekdays preparing for Saturday's influx of tourist buses. During Saturday's market, the city population grows by thousands.

Outside of the famed city of Otavalo exists a very different reality, and it is there that I conducted the majority of my research. Otavalo's fame and fortune do not extend into all of the surrounding communities. I spent the spring quarter internship with CEMOPLAF-Ecuador. CEMOPLAF (Centro Médico de Orientación y Planificación Familiar, or Center for Medical Orientation and Family Planning) is a private, non-profit organization that works within Ecuador to provide health and family planning education.

This paper is a description of the internship: the conditions I saw, the work, the rewards

and pitfalls, some reflections, and finally, the conclusions gleaned from the experience.

**The Lonely Planet's "Facts at a Glance"**

**Full Country Name: Republic of Ecuador**

**Area: 283,520 km**

**Population: 11,700,000**

**Capital City: Quito**

**People: 40% mestizo, 40% Indian, 15% Spanish descent, 5% African descent**

**Language: Spanish, Quechua, Quichua, other indigenous languages**

**Religion: Over 90% Roman Catholic, small minority of other Christian denominations**

**Government: Democracy**

**President: Jamil Mahuad**

**(source: Lonely Planet Website. <http://www.lonelyplanet.com>)**

## **Introduction**

**CEMOPLAF-Ecuador began in 1974 and today maintains clinics in fifteen cities throughout the country. Due to its status as a private organization, CEMOPLAF receives no public funding from the Ecuadorian government. Instead the majority of the funds come from outside donors such as USAID and CARE, which are government and private agencies based in the United States. CEMOPLAF-Otavallo began in 1984 with a staff of three workers and has grown annually. Today there are thirteen employees and the clinic provides dental, pediatric, prenatal, gynecological, and family planning services.**

**Because of my interest in children's health and family planning among rural populations, I devoted the majority of my time and energy to the sector of CEMOPLAF responsible for conducting house calls in the poor communities situated around Otavallo. In these communities CEMOPLAF seeks to improve the level of health among the inhabitants, especially among the children and their mothers. To achieve this goal the staff members emphasize both education and treatment; these efforts take place almost entirely among those within their target group and rarely involve men. In a strongly patriarchal society like that of Otavallo, the health needs women and children are more acute than those of the men.**

**Through my participation in the activities of CEMOPLAF, I could see first-hand how the organization strives to bridge the gap between the traditions of the isolated communities and the benefits of modern health practices. CEMOPLAF maintains a respect for the traditional customs while providing an education of contemporary methods of preventive health. In this paper I will attempt to explain this process which took place in a few of the communities of Imbabura, Ecuador. There are two aspects of the internship: children's health and family planning. Each possesses their own distinct characteristics and merit separate descriptions.**

**With only one academic quarter's worth of experience in a place entirely foreign to me, it is impossible to truthfully say that I am now an expert in the field of development. What I seek to convey is the experience from my point of view. Even though a few months are not an extensive quantity of time, there is ample information to describe and explain. First I will detail our activities in both the health and family planning areas, including the effective and hindering factors that influenced our work.**

**After this section, I will give my thoughts and feelings regarding the experience in general. In Otavallo, I lived a life completely different from what I had previously known. To work full-time dealing with issues to which I connect with personally, as well as being immersed in an entirely new culture was an experience that will never be forgotten. My time in Ecuador**

**was invaluable, putting my previous studies right in front of my eyes for the first time. In the paper's conclusion, I will share how the project in Imbabura, Ecuador has affected my attitudes towards humanitarian efforts as well as my desires to continue this type of work.**



## **Salud- Health**

Otavalo is notorious for its gigantic marketplace full of colorful clothing and unique arts and crafts. Almost all foreigners who visit Ecuador spend at least one day walking the streets of this city admiring and purchasing the well-made and inexpensive goods. It is the famous market, or “fería” that has distinguished the indigenous Otavaleños as successful members of the capitalist system and tourist industry. There is an abundance of literature and discussion concerning the Otavaleño’s ability to integrate themselves into the modern market system, and they are recognized worldwide as an example of an indigenous population that has successfully adapted to the global economy.

After one brief visit to the Saturday market, it would be easy to assume that the fairly comfortable conditions that exist in the city would also extend into the outlying communities where many of the items are produced. However, a short stay in one of these remote places would quickly dispel this false notion and harshly remind the visitor of Ecuador’s sobering economic problems. Not all Otavaleños have experienced the monetary successes of the famous market. Instead of the modern two-story houses of Otavalo, there are two-room mud homes without the luxury of windows or doors. Blocks of stores selling brightly colored clothing are replaced with small plots of corn stalks. These are places that lack the steady influx of tourist dollars brought by the buses full of camera-toting foreigners as in the city of Otavalo. Here exists a life much further away from Otavalo than indicated by the short distance that actually stands between the city and these communities.

These isolated communities are small and difficult to access. Some have only 400 inhabitants and can only be reached by foot or 4-wheel drive vehicle. The mountainous geography hinders the passage to and from these places, as do the seasonal rains that transform dirt roads into difficult or impassable mud pools. Due to this separation and small size, most visitors to the region are oblivious to the existence of these small communities. As a result, external assistance to these areas is minimal or non-existent.

Problems of poverty affect children first. More than 50% of the children in these communities are malnourished. Nearly sixty per cent (59.9) of adolescents have a respiratory infection of some kind<sup>1</sup>. Many families lack the money and time to sufficiently care for their sick children. Without the resources to prevent illness and without proper nutrition, there are an abundance of children who fall victim to illness. The mortality rate of infants under one year of age is 11%, many dying of infections which are easily curable with common medicines and

age is 11%, many dying of infections which are easily curable with common medicines and education<sup>2</sup>. Of the children who die in their first year of life, 40% die of diarrhea, 10% fall victim to measles and 30% do not survive respiratory infections<sup>3</sup>.

In these communities have a low level of health education exacerbated by an almost complete lack of financial resources. Contaminated water is not boiled before being consumed and food is undercooked to conserve fuel. Meals are prepared in unsanitary conditions, often alongside the family's dogs and chickens, which meander in and out of the kitchen periodically. Children do not maintain balanced diets. There are no treatments available to cure even common illnesses, nor is there money to purchase any from the Otavalo pharmacies. Under these circumstances, it is obvious that an organization like CEMOPLAF would have their hands full.

CEMOPLAF seeks to provide an option for the families where before there was none. The goal of CEMOPLAF is to be like a neighbor to the people of the communities, a relationship that depends largely on trust. An outside organization cannot simply wander into these tight-knit groups and start dictating the way things should be done. A relationship of confidence must be created first, then delicately maintained. To achieve this standing, CEMOPLAF has undertaken the task of visiting individual homes in the poorest communities.

Our typical day was full of activities. We would convene in the morning at the main clinic in Otavalo. After preparing our equipment and files, we would load everything into the back of a pick-up truck and depart for one of the designated communities. Our group usually consisted of three people. Rosa Mygwa, CEMOPLAF-Otavalo's "Family Planning Officer" and only indigenous employee, played a crucial role in maintaining the confidence of the community members with her first-hand knowledge of the indigenous customs and language. She possessed an awareness of the social boundaries that CEMOPLAF could not cross while visiting the indigenous in their homes. Mariana Quelal played another key part as the "Health Educator." Her background education in rural health issues provided us with an important source of information in combating the health problems that afflicted many in the communities. Mariana was responsible for the educational aspect of our work, teaching mothers how to properly feed their children and how they could prevent illness among their families. This job required creativity and energy due to the fact that most adults in the communities were illiterate. I was the third member of the group, "El Gringo." My role developed as time progressed, from a mere observer to an active educator. I shall explain this evolution in more detail at the conclusion of this paper.

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<sup>2</sup> Alban, Jorge. Línea de Base Cantón Otavalo. CARE-Ecuador. March 1997. Page 19.

<sup>3</sup> Ibid. Page 20.

in the community. There we did one of a few things. Sometimes we would go directly to the small schoolhouse usually located in the center of the community where a meeting with parents and children had been prearranged. CEMOPLAF's target group and primary focus in the communities are children up to the age twelve. CEMOPLAF attempts to maintain files for every child within this range. This file should contain a complete description of the child such as weight, height, the presence of anemia, medications being taken, and diagnosed illnesses. All of this information had to be taken and updated during these brief and hectic visits to the schoolhouse where sometimes forty or fifty children would need exams.

During these meetings, Rosa would record the data gleaned from the exams. Meanwhile, Mariana was responsible for taking blood samples that would later be examined in the laboratory in Otavalo. I took the height and weight measurements of the children. Sometimes a doctor would accompany us and in this case the children would also receive a brief exam and be prescribed treatments. We would generally return the following week to distribute the medications.

During these visits it was possible to observe the interaction between CEMOPLAF and the people of the community. Usually, Rosa would translate many of the recommendations into Quechua to ensure that there was no confusion or miscommunication (While the majority of the people spoke both Spanish and Quichua, Rosa's ability to speak the indigenous language was imperative in communicating with the young children and the elderly). The participation of the people was strictly voluntary, and rarely did we encounter problems of mistrust among the people. This confidence of the people was undoubtedly improved by the high degree of respect for the indigenous point-of-view that the staff members of CEMOPLAF consistently displayed. When we communicated with the people, our recommendations were generally accepted without hesitation.

Likewise, these visits also illustrated first-hand the health problems that CEMOPLAF attempted to combat. The majority of the children who were examined received some kind of treatment. Intestinal parasites, respiratory infections, and malnutrition were the most common ailments. Often times, we would examine children with skin infections of varying degrees. There is also a lack of complete vaccinations among a large percentage of the children. All of these factors made for a busy and hectic morning that often extended into the late afternoon.

There were problems during these visits as well. Despite the fact that a few days earlier a CEMOPLAF worker had promoted our upcoming visit, there was sometimes a lack of participation among the people. At times, a large percentage of the community's children were

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<sup>3</sup> Ibid. Page 20.

absent. Other times, parents would not be present and only the children would attend the meeting. In this situation we would have to explain the sometimes-complicated indications of a prescription drug to a four-year-old. Another difficulty would occur when a mother would bring her children to the initial exam and be prescribed some medications, then fail to return for the next meeting to receive them.

After these visits to the schoolhouse, we would return to the main clinic in Otavalo. The blood samples would be given to the laboratory for anemia tests (which frequently test positive, more than 55% of children under one year of age have anemia<sup>4</sup>). After receiving the results from the laboratory, we would enter this data as well as the other information recorded during the visit into the computer files. Later, all of this information would be sent to the donor organizations like CARE and USAID.

CEMOPLAF also conducted another type of community visit. Instead of meeting with the larger groups of people in one designated area, we would simply do house calls and visit families on an individual, house-by-house basis. This style of visit allowed us to spend more time with each mother and her children. We would walk through the community and stop at the houses occupied by couples with young children. Sometimes these types of visits were necessary when a child was too ill to attend the larger community meetings.

During these more tranquil visits, I learned more about the reasons for the high prevalence of illness among the children. By listening to the conversations between Rosa, Mariana, and the mother of the household, I could hear the description of the health problems as well as the actions that the family had taken to try to alleviate them. Again, I saw serious skin infections that had been left untreated due to a lack of resources. The wounds would be open, dirty, and obviously infected. Other times we would examine children with very serious ear infections in need of immediate treatment. I would listen, as the mothers would explain why they had not taken their children to the clinic to treat the problems. Usually the family had several other young children and the mother's busy work combined with her child care duties would not permit her to sacrifice a day to travel into Otavalo to see a doctor. Likewise, the cost of transportation, the consultation, and medication were too expensive for the family to bear.

These house calls gave me amazing insight into the living conditions of the typical family. The confusingly high prevalence of illness and infection were much easier to understand after a few visits to these homes. The large families were housed in small one or two bedroom buildings. The older homes were constructed of mud with dirt floors. Usually the kitchen and a

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<sup>4</sup> Quelal, Mariana. Interview. Health Educator, CEMOPLAF-Otavalo. April 4, 1998.

bedroom were one in the same, and the family members frequented this room as did the family dogs, chickens, pig, and guinea pigs. There was a lack of sanitation in most kitchens. Food was usually prepared on the floor over hot coals or a small gas stove. Smoke from the kitchen fires filled the house due to the absence of a chimney. There was limited access to potable water. There was no refrigeration, therefore food was left out in the open air much to the delight of many flies.

In light of these conditions, we would make recommendations to the mother regarding her children and the house. Whenever possible, we would encourage available and effective home remedies to cure some of the infections among the children. The combination of local remedies and modern medicines lessened the dependence of the poor families on outside assistance. One such remedy was the commonly grown “matico” plant to treat skin problems. In the case of a minor skin infection, we would advise the mother to keep the child’s clothing as clean as possible. Sometimes in cases where there was a serious health problem and no possibility of payment, we would ignore the normal prices for treatments and give them to the family free of charge. In these situations, we would return to the home within a week to monitor the child’s progress.

During these visits, we sought to preserve and improve the delicate relationship that existed between CEMOPLAF and the people of the communities. The majority of the time, we were accepted without complications. However, there were occasions where there was a lack of trust and we were forced to convince the family of our good intentions. Some people were very wary of outsiders, and maintained a fatalist attitude in respect to illness within their families. In these difficult situations, CEMOPLAF would attempt to gain the confidence of the parents through persistent visits.

In the small community of Angla, there was a case where CEMOPLAF had to persuade a family to accept outside help in order to cure the family’s dying child. “Panchito,” a four-year-old boy, had been sick for several months with gravely infected ears and skin. By luck, CEMOPLAF heard of the child’s poor condition from the family’s neighbor. The child’s parents had resigned themselves to the fact that “Panchito” was going to die, and he would have, were it not for the neighbor’s decision to contact outside assistance. With continued visits and conversations by CEMOPLAF, the mother of “Panchito” finally was convinced that her son could survive if he immediately went to the hospital. He spent a month in the Otavalo hospital and rehabilitated to the point where his life was no longer in jeopardy.

During the house visits, much of our time was devoted to the promotion of CEMOPLAF’s services. The name CEMOPLAF (Medical Orientation and Family Planning

Center) said little of our basic health services, and many falsely assumed that we only dealt with birth control assistance. As a result, the resources offered by CEMOPLAF often went underutilized by the clientele we aimed to serve: impoverished mothers and children. In an attempt to encourage the use of CEMOPLAF's services such as prenatal and pediatric exams, the cost of these services for those living in the outlying communities was drastically reduced. Likewise, the cost of vitamins and medications was almost nothing for those who lacked many financial resources.

One such activity that we undertook was the promotion of the small clinics that CEMOPLAF maintains in some of the larger communities. Rather than sacrificing a day to travel into Otavalo, those seeking CEMOPLAF's services could visit one of these smaller clinics which were more conveniently located for the communities. There were three such clinics, one in Iluman, the second in San Pablo, and the third in Quichinche. When I began my internship, these three clinics were not functioning due to a lack of interest on the part of the people as well as an absence of a doctor capable of staffing them. However, during my time there, CEMOPLAF hired a new doctor to work these clinics. We spent many afternoons handing out leaflets promoting the new hours of these clinics.

Perhaps the most important part of our jobs was preventive health education. Due to the high illiteracy rate in the communities, this task required a good deal of patience and creativity. Information had to be conveyed through drawings rather than words. This instruction taught the people the most effective and practical ways of preventing common illnesses like cholera and parasites. Also, we would explain to families the stages of a serious ailment, educating them on when it could be treated at home and when they should seek emergency medical attention. Sanitary food preparation and diet were also important health topics that required discussion and instruction.

Of course, there were problems that impeded our health work. One major issue was a differing definition of "good health." Health was something difficult to promote when the people in the communities were not familiar with the merits of prevention. This contrast of traditions deserved and received a lot of attention. As a result of this variation, sometimes mothers were reluctant to seek out medical service for their children, especially if her son or daughter was not visibly sick. An example of this problem was vaccinations and the energy that we exerted trying to convince hesitant mothers of its necessity. Why, if my child is not ill, do I need to spend time and money on a shot that will only make my child cry? This is a question that we had to answer quite often.

Another hindrance to our work involved some of the cultural traditions that directly

conflicted with our ideas. One such custom was the strong patriarchy, or “machismo,” within Otavaleño society. This proved to be a very powerful force to oppose. There is a tradition in these families that prohibits anyone from eating dinner before the man of the family eats first. Should this male elect to arrive late or not at all, all must wait for him before eating. Also, meals and portions are distributed according to age, and the mother eats last. Often this custom prevents the smaller and more malnourished children from eating adequate amounts and can also damage the health of the mother who may be pregnant and in need of more sustenance.

CEMOPLAF also had its faults. The problems of participation among the people in the communities were compounded by occasional mistakes on our part. For example, a specific date and time would be scheduled and heavily promoted only to be rendered useless when we would arrive two or three hours late. Due to a lack of organization or communication, CEMOPLAF would finally reach its destination only to find that the people had come and gone. Mishaps like this seriously damaged the delicate trust on which CEMOPLAF depends. If a mother had sacrificed a large portion of her busy day to walk herself and her children from her distant home all the way into the community center only to find us absent, it is obvious that she will certainly hesitate to do so the next time.

Sometimes CEMOPLAF promoted events or services and failed to fulfill them. An example of this involved the extensive promotion of the re-opening of the smaller clinic in San Pablo. Through leaflets and loudspeakers, we informed the people of the new opportunity to receive care at this clinic. We encouraged mothers to take the time to visit the clinic with their children on Wednesdays when CEMOPLAF could provide a doctor to perform examinations. Then, due to a lack of time and communication, the doctor scheduled to work in the clinic was unable to do so in spite of all the promotion and promises. Again, in this situation CEMOPLAF lost its credibility among anyone who tried to visit the clinic that day and found it closed.

## Planificación Familiar- Family Planning

The other aspect of my internship in Ecuador was family planning. One can easily see the clear lack of common birth control practice in the communities. The average rural indigenous family in Imbabura had six or seven children<sup>5</sup>. Obviously, an impoverished family would be hard pressed to feed and care for so many offspring. The role of CEMOPLAF in this dilemma was an active one.

Prior to my internship with CEMOPLAF, I had not realized how children's health and family planning are so closely related. After the months of visiting homes and seeing the two aspects, it became obvious that they go hand-in-hand. Until the level of health among the children improves, family planning will be extremely difficult. As long as there is a high possibility of a child dying, parents will continue to have large families to assure that at least some will survive.

Approximately 30% of the families in the communities use some method of family planning<sup>6</sup>. In some communities this number is much greater, but in others it can drop to as low as 10%. According to a study conducted by CARE, 52.4% of the residents in and around Otavalo are aware of modern birth control methods<sup>7</sup>. Of this number, 72.3% are utilizing some form of family planning<sup>8</sup>. The majority of birth control use is conducted by females, despite the existence of affordable and accessible methods that cater to males. The most popular method is the birth control pill. These are available at the main CEMOPLAF clinic for 2.500 sucres (\$.50) for a months dosage. In the communities, the price is 1.000 sucres (\$.20). The second most popular method is the IUD (Inter Uterine Device). There are three different methods in this category: the "T" Cord, the Spiral, and Norplant. The prices for these items are the same both in Otavalo and in the communities. The third most popular method of birth control is the barrier method, which includes condoms, vaginal pills, and creams. Inexpensive prices for the items in this group are maintained in Otavalo as well as the communities. Among the 93 people who sought birth control from the CEMOPLAF-Otavalo clinic in April of 1998, 26 chose IUD's, 15 elected to take oral contraceptives, 5 took injections, and 6 were sterilized<sup>9</sup>.

During my time in Ecuador, I soon realized that family planning was much more complicated than preventive health. Luckily, CEMOPLAF had worked in the communities for

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<sup>5</sup> Quelal, Mariana. Interview. Health Educator, CEMOPLAF-Otavalo. April 4, 1998.

<sup>6</sup> Ibid. Quelal.

<sup>7</sup> Alban, Jorge. Línea de Base Cantón Otavalo. CARE-Ecuador. March 1997. Page 37.

<sup>8</sup> Ibid. Page 84.

<sup>9</sup> Monthly Statistical Information of Family Planning. CEMOPLAF-Otavalo. April 1998.



many years and established a familiarity and a relationship with the people. Our work would have been nearly impossible without this existing rapport that had been established over time. But despite the years that had been devoted to family planning efforts, our work proved to be challenging for several reasons.

Among some of the people in the communities there is a sense of mistrust toward modern methods of family planning. This sentiment is complicated by a lack of familiarity and damaging rumors regarding the safety and purpose of the methods. Many fear the possible side effects and believe that there is a high potential of terminal illness, and therefore do not use them. Other families prefer to leave issues of childbirth to fate, and consider birth control to be meddling to God's will.

In addition to these problems facing CEMOPLAF, there is a high demand for children in the communities. It is very possible that a family would lose at least one of their children to some type of illness. As a result, many choose not to utilize any contraception to ensure that they will have many children and at least a few of their offspring will survive. Children contribute a good deal to the economic situation of a family. Sometimes this fact was glaringly obvious, as we would discuss birth control with a mother, while behind her we could see four of her children busily working away on looms, sewing products for the market. This demand for labor is especially prevalent around Otavalo where the Saturday market provided an economic opportunity for almost everyone.

Like our health work, family planning was greatly impeded by "machismo." Not only were men hesitant to use condoms, sometimes they also protested and outlawed their wives usage of methods to control their family size. Many males saw the constant possibility of pregnancy as a means of preserving a faithful wife. She would not participate in adulterous activities if there were a risk of pregnancy.

The disproportion of male/female contraceptive use is more evidence of the strong influence of "machismo" in family planning. Despite the affordability and easy access to condoms, this method is not widely utilized. The same holds true for other means of male contraception. In the past year, CEMOPLAF data reveals numerous female sterilizations were performed, while no vasectomies were recorded. While a vasectomy is a procedure of minimal risk that requires only 15-20 minutes, a hysterectomy necessitates a much more serious operation and many more resources. It soon became apparent to me that in the communities, the responsibility of family planning is almost entirely in the hands of the female.

Even with coercion, men were very reluctant to share this responsibility. During the time

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perform free vasectomies. For a few days, CEMOPLAF busily promoted this opportunity around the communities in an attempt to spark some interest from the males. There were no restrictions on participants, and they would be saving the time, money, and trip to Quito that would normally be required for a vasectomy. Despite these incentives, only two men volunteered and received the operation.

The correlation between health and family planning continued to resurface throughout the internship. Sometimes our work in both of these areas clashed. For example, in some cases the husband of a household would become angry that his wife had sought and received birth control methods from CEMOPLAF. As a result, he would forbid any further CEMOPLAF visits to his home, even to provide medical service to the children. This loss of trust on the part of the male head-of-the-family hampered any possibility of health improvements among the children, and CEMOPLAF would have to re-establish a working relationship with the family.

The strong interdependence of health and family planning proved to be the biggest revelation of the internship. Birth control practice will continue to be underutilized as long as children are dying of malnutrition and curable afflictions like measles. Outside assistance must be directed towards health education and prevention if it is to make any difference. To simply address family planning is not addressing the underlying issue, and therefore will not have a significant impact.

## **Reflection**

The task of evaluating how my internship and three months in the province of Imbabura have affected me is extremely difficult to narrow down and explain specifically. There are various levels of reflection in both my work and personal life that need exploration. The work itself consumed the majority of my time and energy, and directly applied to previous academic studies that I had undertaken.

Life beyond work was fascinating, equally educational, and merits a separate description. Personal interaction with a foreign culture for several months is incredibly informative, and also clarified some of the complex issues that I encountered during the internship. Relations between groups of different economic and racial class impacted my work a great deal, and the affects of these relationships were visible beyond my internship. Social issues that I had researched in Quito and in Washington State were suddenly a part of my everyday life. Not only was I being exposed to the various details of rural health on a daily basis, but life beyond work was impacted by many of these fascinating topics. The history and everyday life of the indigenous in Ecuador was no longer an abstract subject that I had to imagine, instead I witnessed these topics in my everyday life.

## **The Internship**

It would be unfair for me to evaluate CEMOPLAF-Ecuador from my brief internship with only one clinic. In an economically, racially, and geographically diverse country like Ecuador, it is obvious that each clinic will be unique to better serve their particular region. Furthermore, my time was spent almost exclusively with the health education and family planning services of the Otavalo clinic. My limited amount of time did not allow me to study the other aspects of CEMOPLAF such as the pediatric or dental services. However, the seemingly narrow focus on house visits provided me with ample ideas regarding health and birth control in the outlying, small communities around Otavalo.

I am in agreement with the concept and goals of CEMOPLAF. Their status as a non-profit organization is accurate, and among the workers I sensed an honest desire to improve the lives of families living in the communities. Those who represent CEMOPLAF during the house visits possess an obvious understanding and respect of the often-vast differences that exist between urban and rural lifestyles in Ecuador. CEMOPLAF does not seek a situation where the people are dependent upon the visits and treatments, but rather an improved awareness of health

issues among the people, with CEMOPLAF acting as a mentor or teacher. While some of the energy and resources of CEMOPLAF are directed toward treatment, there is also a clear recognition of the importance of prevention in the health area. A realistic view of both the present and the future keep CEMOPLAF from losing sight of its priorities.

I also agree with the methods of servicing the communities. The house visits accomplish some of the important goals that CEMOPLAF strives to achieve: treatment and education. Both of these tasks are made easier by the house visits as they permit the families to stay within their own environment. Likewise, the visits also maintain the crucial relationship between CEMOPLAF and the people in the communities. It would be very easy to stay within the comfort of their offices and go through the motions of working to improve others lives without actually doing anything. However, CEMOPLAF is not a humanitarian organization that exists only on paper. There is an obvious dedication to the cause and a minimal amount of indolence.

My co-workers demonstrated to me the manner in which one should conduct themselves when entering a community as an outsider. My supervisors maintained an important respect for the indigenous ways of life, despite the fact that some of these distinct characteristics impeded our efforts to improve the health situation in the communities. I never heard or witnessed any discrimination or value judgments on the part of my co-workers, only sincere respect for the families. This esteem kept CEMOPLAF mindful of the desires of the families and prevented any forced adherence to our advice. We never entered a home without the consent of the family. When confronted with blatant sanitation dangers like animals living in a family's kitchen, CEMOPLAF would mindfully make suggestions without criticism or haughtiness. There was a clear understanding of the circumstances and limited resources in the communities, and thus only practical recommendations were made.

As a result of this understanding, CEMOPLAF utilizes methods that effectively aid the communities. An example of this idea is the medications that CEMOPLAF distributes to mothers to treat parasite problems. These treatments are almost always sold rather than donated. Obviously the mothers lack many financial resources, but a symbolic fee is charged for the medication to preserve the value of the treatment. A price of \$.20 for a few months of parasite medicine does not pay for the cost of the remedy, but it assures that it will be valued and not discarded. To simply give the treatment away would increase the risk of it being lost or misused.

Of course no organization is perfect and my internship shed some light on a few negative aspects within CEMOPLAF. Sometimes I was a bit disappointed to see how my co-corkers would tolerate a lack of professionalism on the part of another CEMOPLAF worker. The work that is done by CEMOPLAF has no foreseeable end, and this lack of urgency hampered our

efficiency and necessity to remain on task at all times. Malnutrition is not a problem that will be solved quickly. While one child may be improving, it is likely that in another village the condition of three others are worsening. Every day is full of new challenges and discouraging situations, and sometimes it was challenging to maintain a high level of enthusiasm. Strict schedules were not observed, and planned events not always completed.

Another key aspect of the internship involved the development of my own role with CEMOPLAF and its work. I had a unique position as a result of my lack of experience and my gender. Initially, everything was overwhelming. Fortunately, my co-workers had a good deal of patience. Despite my constant barrage of questions, my co-workers always answered insightfully and urged me to ask more.

I worked with women and for women. Our work in health and family planning was conducted almost entirely with the female heads of the family. We spent the majority of our time conversing with mothers and rarely did we ever see the father of the family during the visits. Understandably, it is difficult for me to truly see the point-of-view of an indigenous, Quechua-speaking mother of six, nor fully comprehend her feelings toward various family planning methods that may affect her body. I can, however, see the potential for a male in this type of work. Someone is needed to converse with men about the same information. As it is between women, men can identify with one another's bodies and understand the fears and feelings toward family planning that may exist.

I witnessed an example of this notion when the doctor from the U.S. visited CEMOPLAF to perform vasectomies. One patient was full of fear, as the time for his operation grew nearer. I watched as my supervisor, Mariana attempted to pacify his concerns and convince him of the safety of the procedure. He remained unconvinced, and Mariana asked me to speak with the man. I spoke with him, reiterating many of the same words I had heard Mariana use. He listened intently and then confided in me with his more personal anxieties. After informing him of the facts, he finally elected to have the vasectomy.

Sometimes, especially during the house visits, my lack of experience and my gender bothered me. In my mind, both of these characteristics posed a threat to the delicate trust between CEMOPLAF and the mothers. I was keenly aware of my presence as a foreigner and as someone different, and I did not want to do anything that would magnify my differences. The first few weeks were challenging, as I searched for my place amid the often-personal topics involved with discussions of family planning. Little by little, these fears gradually subsided and I became more comfortable with my differences, although I never fully forgot them.

## Otavalo- Outside of Work

The majority of Otavalo's tourists stay for a night or two, shop the Saturday market, and leave. My extended amount of time there gave me the unique opportunity to see more than the typical foreigner. I lived in the center of the small but fascinating city. In contrast to what I had seen in Quito, the indigenous lifestyle is appreciated and romanticized in Otavalo. Never before in Ecuador had I seen indigenous bank-tellers permitted to wear their traditional dress, or heard so much traditional Andean music. Despite my years of Spanish classes, I was often unable to communicate due to the widespread use of Quechua. Because of this appreciation for the indigenous culture, Otavalo is a rare city where economic power is firmly in the hand of the Otavaleños.

This large and weekly Saturday market offered me an interesting look at the different economic levels among the Otavaleños. Sometimes while in a community, I would see a newly constructed, western-style home next to a typical, small, one-room house. I met a few Otavaleños who owned several of the city's large buildings. I also met people living in dilapidated, windowless homes who gained nothing from the famous market. Apparently, Otavalo is not immune from the grave problems of economic inequality that exist in Ecuador.

Among the poorer sectors of the rural indigenous population, there is a strong wariness of outsiders. For centuries, the indigenous population has been exploited and mistreated by outside forces. Dating back to the arrival of the first Spaniards and continuing into modern-day Ecuadorian society, the native population has repeatedly been deceived and abused. Unfulfilled promises and continued mistreatment of the indigenous have heightened this suspicion of outsiders and their motives.

During my months in Imbabura, I witnessed this mistrust in my internship as well as in my free time. At one point in April, the government of Ecuador announced that the social security taxes of indigenous farmers would be raised to an equal level with the urban population of the country. This incited nationwide protest, and a week long "paro," or strikes ensued. I was unable to work for the week because the indigenous farmers had blockaded all of the major roads across the country. In Otavalo, the indigenous citizens blocked Pan American highway with boulders, trees, and fires. I watched as men and women took turns digging a trench across the most important road in the country. Cars that tried to pass through were pelted with rocks. The

paralyzed condition of the country continued until the police violently ended the protest. Several deaths were reported across the country. The situation remained unsettled when I left and was just added to the long list of unresolved problems between the indigenous and mestizo population. This heightened sensitivity and spirited protectionism among the indigenous population is justified and extremely difficult to penetrate.

I could see this apprehension towards outsiders in my own personal life as well. I lived in a family-run hostel in Otavalo. The mestizo family employed two indigenous women, one of which had a four-year-old daughter named Nancy Monica. Nancy Monica's mother, Rebeca was an intensely shy woman who occasionally shared some of the details of her life with me. She was a mother of four, but two of her children had died as infants. While she lived with Nancy Monica at the hostel, her other younger child remained in her village with her husband. Her situation was distressed due to the fact that her husband was now living with another woman, and Rebeca was without her own home and one of her children.

Nancy Monica and I spent many hours playing in the hostel. Rebeca was often busy cleaning or cooking, and Nancy Monica was left to entertain herself. Countless early mornings were begun by Nancy Monica banging her tiny fist on my door, beckoning me to come brush my teeth with her or swing in the hammock. Many trips were made to corner market to purchase candy or ice cream, and many of our hours were spent playing in the hallways and rooms of the hostel.

As our time spent together progressed Nancy Monica's health and future began to concern me. Her swollen belly was reminiscent of the parasite problems that I had seen in the children living in the outlying villages. A few times, I tried to discuss the matter with Rebeca. I offered to take Nancy Monica to the CEMOPLAF clinic to receive a check-up, but was denied. The other indigenous employee of the hostel informed me of Rebeca's fears that I wanted to adopt Nancy Monica and take her to the United States. I asked my co-workers Mariana and Rosa to help me convince the mother of my good intentions. I hoped as women they could persuade Rebeca that I meant no harm. They visited the hostel to converse with Rebeca, but she locked herself in a room and would not allow visitors. I was hoping to establish a long-term relationship with Rebeca that would assure Nancy Monica's health and future education. In the end, I had to settle for just paying for Nancy Monica's school dues and uniform for the following year.

This pervasive mistrust of outside help, while completely understandable, was extremely difficult to accept. The temptation to take Nancy Monica to the clinic without Rebeca's consent was powerful. However, to make good decisions for someone else is not my goal, even when my heart pains me to do so. There is too much history in Rebeca's life for me to overcome in a few

months. Until oppressed populations have reason to trust others outside of their own group progress will be slow. I realize that extensive time is necessary to establish a relationship of trust. A foreigner who flies into a rural village for the weekend to make helpful suggestions will not have an impact. One who does their best to shed their identity as an outsider, who tries to comprehend the history and circumstances of the maltreated people, will be rewarded with more trust and progress.



## **Conclusion**

There is a profound difference between studies and experiences, and my time in Imbabura is an illustration of that fact. Prior to the internship, my only exposure to issues of development was obtained through books and lectures. Experience has taught me that confining one's learning to classroom studies can seriously damage any sense of hope and desire to make a difference, especially with development research. In books and classrooms, it is easy to forget the reality of the problems that are related to economically poor countries, especially when the answers to these questions are so elusive and complicated. When one studies the current crisis that exists in Ecuador, helplessness and frustration can easily ensue. In this case, apathy and ignorance can replace good intentions and energy.

I can identify with this. Throughout college I have had many classes that have examined the countless problems that currently afflict the world. This spawned a sense of hopelessness that only grew with my lack of an opportunity to truly immerse myself in a solution to these issues. The effects of the world's unjust distribution of resources seemed insurmountable to me. This disillusionment, guilt, and inactivity created a desire to deny and ignore the existence of these problems.

As a result of the internship I have lost the ability to forget the presence of global poverty and suffering beyond my own comfortable life. Every day I witnessed the effects of impoverishment with my own eyes. It was not on a television that I could simply turn off, or in a book whose cover I could close. The existence of a malnourished child in the flesh cannot be denied like a photograph or story. These images are embedded in my memory. The internship put faces on the issues.

With the loss of the ability to deny the reality of poverty came a new sense of hope. While working with CEMOPLAF, I could do something to better the situation using my own hands and abilities. While I was witness to extremely difficult living conditions, I also saw tangible and effective solutions to alleviate some of the problems. CEMOPLAF cannot save the world, but its workers are contributing to an improvement. I watched and was a part of this endeavor, taking notice of the power of individual actions.

My time in Imbabura clarified poverty. While I cannot pretend to truly understand what it is to be poor, the internship dispelled some of the false stereotypes that are often conveyed through modern mass media. The word "poverty" often elicits an image of an indignant, unhappy and backward man or woman who is utterly helpless. Although the communities around Otavalo were poor, the inhabitants offer us all valuable lessons. I was always so impressed with the

frequent smiles and laughter in spite of the destitute circumstances. In these communities, I saw that families lived happily without the material objects that much of the world would consider absolutely necessary. Life here is looked at on a day by day rather than with a long-term futuristic outlook. While this point of view is often condemned and considered to be the reason for many of the problems, it is also the source of optimism.

These are simply observations. As stated earlier, I cannot say that I truly know poverty. I cannot fathom the feeling of true hunger, or how it would be to lose a child to curable measles. Throughout my days in the communities, I always had the knowledge that my time there was temporary. I had the luxury of witnessing this lifestyle and leaving it when I so desired, while the rest stayed without the possibility of escaping it. Now I am back in my "normal" life a few thousand miles away from Imbabura, living a completely different lifestyle, while the many people I encountered throughout the past spring remain in Ecuador with their situation unchanged.

While my own role with CEMOPLAF was limited and of minor importance, it still resulted in a newfound inspiration to continue making my own difference in the world. I now possess a foundation from which I can continue to study and work in the area of development. In Imbabura I had the opportunity to start a career path that will undoubtedly lead me into both painful frustrations and sweet rewards. This course has no finish line and will be difficult. Single-handedly, I cannot save the world or end poverty. However my actions can be felt by a few, and my difference made. Armed with this newly clarified dedication, I must now search for a situation where my own abilities will be best utilized.

My time as an undergraduate is limited. Since returning to school at Western Washington University, I have been completing the requirements to fulfill my Fairhaven College concentration. With one more academic quarter remaining, the pending question, "what is next?" resounds in my mind. Judging from my time in Ecuador, I know that right now experience is my best teacher. After graduation, I will pursue employment that will hopefully continue my relationship with the social issues of Latin America. There is an abundance of non-profit organizations that conduct health programs both within Latin America and from afar. After graduation, I would like to begin my work with an existing organization to gain valued experience.

I do not undervalue the importance of academic knowledge in this area. My previous classes and independent studies regarding topics such as Latin American family planning, history, and different approaches to poverty alleviation have provided a useful foundation from which I can now move forward. Experience, such as the internship in Imbabura, puts that information to

the test. Family planning, I now realize, is almost unachievable unless the level of children's health drastically improves. The steady combination of both academics and experience is my most effective way of ascertaining realistic solutions to these difficult health problems. Graduate school, possibly with a focus on rural public health, may also be ahead after some years of practice in the field.

While the path that I will take from here is unpredictable, I am always aided by the experience in Ecuador. This internship and cultural immersion created a solid foundation from which I now move forward. My studies became realities in those spring months, and the satisfaction that I gained from participating in this project will act as my compass to guide me where I can continue making my difference.

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