

9311010/52
PDRP 488
IAN: 35399

INTERNATIONAL NUTRITION COMMUNICATION SERVICE

CONSULTANT REPORT SERIES

DOMINICAN REPUBLIC

— February and April 10 - 11, 1984 —

**A Nutrition Education Strategy for the Applied
Nutrition Education Project (ANEP),
CRS/Caritas - Dominican Republic.**

by

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This project has been conducted under Contract AID/DSAN-C-0209, Office
of Nutrition, Science and Technology Bureau, United States Agency for
International Development, Washington, D.C.

INTRODUCTION

The small ANEP (Applied Nutrition Education Program) project in the Dominican Republic has large implications for the future of nutrition education. Here is a project that is trying to improve the nutritional status of its target population through family and community action rather than food distribution. Here is a project that is using communications strategies to promote breastfeeding, home hygiene, immunization, and increased local food production.

INCS staff member Marcia Griffiths has been working with the dedicated staff of the ANEP program and its sponsoring agency CRS/Caritas-Dominican Republic for over a year now, helping them conceptualize their educational goals and objectives, design basic messages, and plan a project implementation strategy. Their combined efforts have succeeded in building a sound project design that, over the next two years, ANEP will seek to put into action. If they are successful, they will improve the health and well-being of children in 47 low income, malnourished target communities across the Dominican Republic; and in the process develop a nutrition education model that others will surely want to follow.

Ronald C. Israel
Director, INCS

July, 1984

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ACKNOWLEDGMENTS

The activities and plan summarized in this report reflect a great deal of work: more than could have been done in the two weeks of my assignment with ANEP if I had worked alone. Therefore, I would like to acknowledge the sizable contribution made by the central ANEP staff: Aristides Santana, Juana Maria Mendez, and Joy Miller del Rosso. They had already begun the crucial work of collecting the ideas and opinions of the program's promoters and participants concerning the most critical nutrition problems and potential solutions. This report is the work of the four of us.

In addition to the central ANEP staff, the seven area supervisors contributed extensively--helping order priorities and ensuring that the proposals made by the central staff would be practical for the promoters and communities to carry through. I want to thank them and the promoters, who facilitated our discussions with groups of women in the project communities. Without their guidance, our work would have had much less meaning.

EXECUTIVE SUMMARY

The Dominican Republic's first community nutrition education program to link growth monitoring with education and community action has begun. The CRS/Caritas Applied Nutrition Education Project (ANEP) is working in 47 communities to improve nutritional status through family and community efforts rather than food distribution. With this, the second, consultation with INCS on nutrition education, ANEP has a plan for communications activities--a basic message package, promotional activities, and an implementation plan--and a revised monitoring and evaluation scheme that includes educational concerns.

Although the data from the baseline survey and case studies recommended by the first consultant required finishing for final analysis, they made an adequate base of information at the time of this consultant's visit to broadly identify high-priority groups and to profile project communities in terms of the problems that most affected nutritional status: infant feeding, childhood infections (particularly diarrhea), increased food production, and community organization. These themes will be taken up through two types of educational activities: the first will consist of individual counseling at the growth monitoring sessions and focus on family efforts to better their children's nutritional status. The second will be comprised of group instruction and community projects to make it easier for the families to improve their health and nutrition.

Two days of concept testing with focus groups helped ANEP look at a few problems in more depth than the case studies and as some participants themselves saw them. A set of objectives for the individual counseling was made on the basis of this information.

The educational strategy will address both the educational objectives for the program participants as well as the program's promotional needs. The latter will explain the program to people who might participate and also remind those who work in it of what the program is trying to achieve.

Materials for group instruction are planned as part of the coming year's activities. Further investigation by concept testing will be needed, especially for instruction about weaning foods and oral rehydration. The radio scripts planned for next year can also be part of group instruction. A flexible plan for them would allow the scripts to be recorded on cassettes, which promoters would use in group instruction until it is practical to begin broadcasting.

The monitoring system underwent some revisions to make it useful for evaluating not only improvements in children's nutritional status but also the attitudes and practices of mothers in the program. A new reporting system made it easier for supervisors to give accurate monthly reports on the progress of high-risk children.

The concluding section of this report discusses the potential use of this project as a model for MOH primary health care programs.

BACKGROUND

In May 1983, an Operational Program Grant was given to Catholic Relief Services/DR (CRS) to assist Caritas Dominicana with its Applied Nutrition Education Project (ANEP). This project is unique in the Dominican Republic because it is a small community-based project (currently 47 communities) dedicated to training a cadre of workers to improve the nutrition of their communities through growth monitoring that is closely linked with education and the initiation of community/group activities. ANEP is designed to be completely independent of the food distribution program. It is hoped that ANEP can serve as a prototype community nutrition project for SESPAS and the private voluntary agencies involved in PL-480/Title II food distribution.

Technical assistance is being provided to ANEP by the Office of Nutrition, AID/W in two different areas. One is project monitoring and evaluation and the other nutrition education. The technical assistance in project monitoring and evaluation helped establish a baseline instrument and the training and reporting systems for the area supervisors and community promoters to monitor growth and control community participation. The first technical assistance in nutrition education was provided in August 1983, when a community needs assessment tool and a case study instrument were designed. The former was used immediately by project personnel to identify priorities, and the latter in December/January. (For more on the case studies, see page 2).

This report describes the second nutrition education consultancy, whose purpose was to help the ANEP staff write a comprehensive plan for their nutrition education activities, including messages, an implementation plan, and a radio component. In addition, since the education and the monitoring and evaluation systems must be mutually reinforcing, ANEP personnel asked that the monitoring instruments and activities be reviewed and expanded to include educational concerns.

Appendix A is a list of the people who participated or were consulted during the two-week consultancy.

ESTABLISHING THE EDUCATIONAL PRIORITIES

Rapid Assessment of the Baseline

The baseline, which includes nutritional status information and basic socioeconomic data for the families participating in ANEP, was collected in September 1983. To date, the information has only been hand-tabulated and still has to be computerized, cleaned, retabulated, and analyzed. However, even in rough form, the information was adequate to help identify problem areas in the broadest terms. These were noted:

1. A rate of malnutrition in the project areas ranging from 42 to 60%.
2. A great increase in malnutrition occurring in the second year of life. It is assumed that the decline begins by 7 or 8 months and peaks late in the second year. After 2 years of age, the malnutrition rate remains relatively constant.
3. Incomes are extremely low; most families rely on wages from occasional day labor.
4. The principal problems in food production are water and the amount of land available for cultivation.
5. The families with malnourished children tend not to participate in organized groups.

Analysis of Case Studies

During December and January, 158 case studies of homes with malnourished children were documented by the area supervisors. The studies were quantitative and covered a variety of themes so that ANEP could learn more about the determinants of malnutrition in project communities. (For more information about the case study questionnaire and methodology, see Kathryn Shack's consultant report, August 1983.) Like the baseline survey data, the case studies data require cleaning, computer tabulation, and analysis. However, with the data hand-tabulated by area, profiles for the project communities were made and trends and obvious factors influencing nutritional status were summarized. This showed the following:

1. Most homes lack potable water.
2. Wage earners are predominantly day laborers (rather than farmers). Wages are approximately 3 pesos (US\$1.50) per day worked. Many families rely on cash, which is scarce. In a number of areas respondents said there was no land for them to grow food. Despite an extensive system of food sharing, hunger exists.
3. Many families turn to traditional health practitioners as well as government and private medical services, although medical services are used only in emergencies and for about 60% of the births. Some of the advice given by the medical services is not always sound: for example, the use of bottles and formulas is still promoted.
4. Vaccination seems sporadic.

5. Although the majority of mothers initiate lactation, in many areas children are taken off the breast, or the frequency of breastfeeding is reduced substantially, by their third month. The most common explanations for the early termination of breastfeeding were insufficient quantity and quality of milk.
6. Mothers feed their infants milk in baby bottles during the babies' first months.
7. Food (bananas, porridge, and bean puree) is introduced in infants' first three months.
8. Many mothers rely on older children to care for younger ones when they have to go out.
9. There is an elevated incidence of upper respiratory infections combined with diarrhea.
10. Many mothers withhold food from children with diarrhea.

Decisions on the Crucial Focuses of ANEP's Education Program

Although the case studies did not provide an exhaustive examination of factors influencing malnutrition, it was possible from the preliminary analysis of the baseline to identify high-priority groups and to ascertain some of the major problems from the case studies.

The central-level team met with the area supervisors to explore the focus of two types of actions:

- Those to be carried out by the families to improve their children's nutritional status.
- Those to be initiated by the community/group to decrease the constraints to families improving their health and nutrition situation.

Before analyzing the information collected from the community, the central staff and area supervisors discussed basic nutrition concepts and desirable practices from a theoretical point of view. Then, a set of questions about nutrition was distributed to stimulate discussion. The questions were answered individually and the responses were reviewed by the group. (For the questions, see Appendix B.) Overall, the group's level of knowledge was high, although confusion existed about the age at which foods should be introduced to a baby; the amount of food an 18-month-old should eat; and feeding during diarrheal episodes.

Once the group agreed about the important nutrition concepts, the results of the baseline and the case studies were reviewed and the following priority areas identified:

- I. Infant Feeding
 - A. Early Weaning
 1. Promote exclusive breastfeeding for the first three months (decrease the use of bottles and the early introduction of food)
 2. Work with lactating women to raise their confidence in the quality and quantity of milk they produce
 - B. Feeding 4-24-Month-Olds
 1. Promote the consumption of more food than usual during this period (look for a few basic combinations to recommend)
- II. Childhood Infections (Particularly Diarrhea)
 - A. Prevention (Hygiene)
 1. Orient child caretakers
 2. Discourage use of feeding bottles
 3. Promote vaccinations
 4. Promote handwashing and the boiling of water
 5. Improve quantity and quality of drinking water
 6. Promote the use of latrines
 - B. Treatment
 1. Promote use of ORT to prevent dehydration
 2. Promote continued feeding during diarrhea
- III. Increased Food Production
 - A. Irrigation
 1. Promote appropriate community water systems
 - B. Garden Projects
 - C. Animal Raising
- IV. Project and Community Organization
 - A. Expansion to Include Families with Malnourished Children
 - B. Strengthen Decision Making and Action Capability of Group

Rapid Concept Testing on Major Themes

To proceed with message formulation for a few priority themes, the group felt that more qualitative information was needed. For example, what did mothers think about current practices? What were their impressions and ideas about how to improve current feeding practices? What did they think about some of the solutions the group was proposing?

Because time was limited, focus group interviews were chosen to test ideas with the mothers in project communities. The focus group interview is informal and usually involves not more than six people per group. A moderator guides the discussion with a question guide (not a questionnaire). Each participant is encouraged to share his/her opinions and to speak up when there are differences in experience. These interviews are open-ended; there are no right or wrong answers to the questions. The responses are analyzed for trends, new ideas, resistance points, and positive factors that may aid in changing practices. Focus groups provide a better idea of the kinds of communications and messages project participants need and want.

Because it was only possible to allot two days to the interviews, their number had to be limited. Two teams convened 13 groups in five of the seven areas covered by the project. The selection criteria for participants in the groups were not rigorous. The women were enrolled in ANEP groups, had children under 3, and had time to participate in the interviews. Thus, the responses may be skewed, since mothers in ANEP have had some nutrition education and may have more resources than others in their communities. Both rural and semiurban ANEP communities were included in the sample.

To keep the length of the focus groups within an hour, only four topics were covered: growth, feeding children 0 to 8 months (in two parts), and the prevention and treatment of diarrhea. A draft of the question guide used by the moderators, Juana Mendez and Aristedes Santana, is in Appendix C. Joy del Rosso and the consultant observed and kept notes, although all the sessions were tape-recorded. The area supervisors and promoters listened, but did not participate.

Analysis of the Focus Group Interviews

The focus group interviews were analyzed to identify: a) current practices that fostered good nutrition; b) practices and ideas detrimental to the nutritional status of mothers and children; c) mothers' willingness to modify certain practices; d) feasible modifications; and e) the reasons they would or would not change current practices.

1. Child Growth

A few mothers measured the health of their children by their growth. But the signs of health most mothers looked for were the absence of disease and the children's activity—"juega" (he plays), "mueve mucho" (he moves around a lot), "come mucho" (he eats a lot). Many mothers gauged their children's growth by visible fat and by whether the children were heavier to lift, were outgrowing clothes, or were becoming taller. Although they firmly believed that frequent illnesses kept children from growing, only a few mothers associated food with growth. They said that children with a noticeable growth problem are taken to the doctor, given more rest, and fed eggs (a few mothers said "more food"), and that the mothers themselves clean feeding bottles more carefully.

In light of these findings, messages about growth monitoring should establish a connection between health, activity, and weight gain, using the mothers' own ideas about children's outgrowing clothes and becoming heavier to lift. The messages should stress that the mothers would know with certainty whether the children grew if the children were weighed. The relationship of food to growth and health will have to be introduced. These messages should emphasize that if a child is not growing, the mother's first action is an easy one: try to feed him or her more food--whatever food is in the house.

2. Breastfeeding

Because most of the mothers preferred breastmilk for its quality and economy, almost all had initiated breastfeeding. Although some said they had been afraid they would have no milk, the most common concern was the pain of initiating breastfeeding, which, they said, new mothers should be assured would subside with time.

The norms for the duration of breastfeeding varied from 4 to 6 months in some areas to 12 to 18 months in others. The younger women tended to breastfeed a shorter time than older women, and they said that if an affordable alternative were available they would not breastfeed at all because it was "a problem." Although mothers had a prevailing sense that it was fine to breastfeed until a child was about 2 years old, doctors had told them that 6 months was the maximum any child should be nursed.

The termination of breastfeeding was often related to mothers feeling that they could not breastfeed any longer, which was expressed in the remarks they made about not having enough milk or having milk of poor quality. Many saw breastfeeding as a personal sacrifice, which was explained by their fear that by not being properly fed, a woman will produce too little milk, and, eventually, if she continues to breastfeed, her baby will suck blood.

Although they believed that heredity determined milk quality, mothers believed there were ways to increase the quantity. Drinking more fluids was the most widely recognized. Chocolate drink, fish (bacalau tail) soup, and grain drinks were also considered helpful. However,

it was generally believed that increasing fluids alone would not help a mother increase the breastmilk she produced if she did not also eat well. The most wholesome foods for this purpose were said to be oatmeal, fish, and pasta.

The relationship between the frequency of breastfeeding and the quantity of the milk was not understood. Mothers believed that frequent breastfeeding could upset a child and that a schedule of feedings once every three to four hours was best. The number of daily feedings tended to decline sharply in the first months and to level off at about three by the third month of life.

In part, this decline can be explained by the prevalent use of feeding bottles. All of the women used them within weeks of delivery, many beginning in the hospital. Mothers said they used the bottle because they did not have enough milk to satisfy their infants. Other reasons for bottle feeding included having something to give infants when mothers left them at home, convenience, and helping babies learn to eat. Although the hygiene problems were recognized, mothers resisted the idea of giving up or postponing the introduction of the bottle.

After analyzing these discussions, it was concluded that educational messages about the benefits of breastfeeding would be unnecessary. But messages to help women gain confidence about their ability to produce "good" milk in quantities sufficient to satisfy their infants in the first months of life are urgently needed. They should reinforce the mothers' ideas about the importance of food quantity and increased fluid consumption while introducing and emphasizing the relationship of frequent feeding to milk production and a satisfied infant. Since mothers strongly oppose the idea, avoidance of feeding bottles should not be mentioned directly.

3. Infant Foods

The introduction of foods to infants takes place within the first months of life. Mothers in the focus groups said this practice was necessary because they must leave something for babies to eat when they go out and because it helps children learn to eat. When babies are at this age, mothers most commonly offer them banana, potato purée, and bean soup, which are made with enough water to pass through a baby bottle.

At about 6 months of age, infants begin to eat foods from the family pot: again, made softer ("more suitable") by adding great quantities of water. Food preferences varied slightly according to the region in which a focus group was held, but crema de habichuela was the choice of all when beans were available. (The crema is sometimes made with the mashed bean, and at others, only with the water from the boiled beans.) In some areas, mothers use mashed rice. Ayuama, a squash, is popularly prepared boiled and mashed for infants. Mothers did not approve of adding oil or coconut milk to food unless the food was well cooked. However, adding oil to infants' rice does not pose a problem, because all the mothers stated that when they prepare rice, it is cooked with as much oil as

they can afford. Generally, children this age are fed one food at a time, not mixed foods. Mothers named three traditional mixed foods for babies this age: cheng-cheng, a mix of cornmeal and beans; locrio, which consists of rice, vegetables, and some meat; and moro, a combination of rice and beans. Their only objection to regularly giving a mixed food to children was that they could not count on having all the ingredients.

It will be necessary to work more with mothers in their homes to finalize infant weaning food messages. The rapidly changing economic situation makes this even more important than it would be ordinarily. However, if household trials are impossible, the messages should focus on the proper time to introduce foods, the consistency of the foods (using more food and less water), and the frequency of feeding.

4. Diarrhea Prevention and Treatment

Mothers knew a variety of ways to prevent diarrhea: covering water, washing hands, boiling water, wearing shoes, and cooking food thoroughly. However, they admitted that they practiced few of these preventive measures. Their experience seems to have shown them that dire consequences do not necessarily ensue when they allow these practices to lapse. For example, about boiling water, mothers said that though children were supposed to get only boiled water, they had given theirs unboiled water and nothing had happened. Some thought boiled water should be resorted to only after a child had diarrhea. They said there were three reasons not to boil water: 1) time, 2) fuel (firewood), and 3) a limited number of cooking pots.

Washing hands is something the mothers said they did easily. But because they forgot about it, they did not wash often enough.

The messages on diarrhea prevention will reinforce handwashing and will also encourage mothers to boil water for infants (the enormous importance of this practice outweighs the mothers' great resistance to it).

The treatment of diarrhea, mothers said, is to do nothing in the first day or two, or to dilute the sick child's milk, or offer him/her tea or sodas. Sometimes coconut oil is given as a purge. If the diarrhea continues, mothers take children to the doctor or buy Elva, an antidiarrheal pill, at the pharmacy. Children with diarrhea are taken off food and put on a liquid diet. If they are being breastfed, their mothers stop or reduce the frequency of the feedings, usually on doctors' orders. The mothers expressed fear of this practice, believing it would either dry up their milk or make children malnourished.

Suero casero and "the packet to cure diarrhea" were mentioned as treatments. Besides their mistaken expectation of what ORS could do, the mothers' recipes for both the homemade and the packaged salts were varied and usually incorrect. A serious problem with all the recipes

is the measurement of a liter: many women use a 650 cc. bottle and call it a liter.

The messages concerning children with diarrhea will center on feeding: continued breastfeeding and the use of soft foods. These practices should be urged as ways to prevent malnutrition, about which the mothers had a justifiable concern. Because doctors are the major obstacle to the mothers feeding children during diarrheal episodes, they will have to be educated or the messages will have little impact. Because no national oral rehydration program exists, messages about treatment will instruct families to go to the promoter immediately when a child has diarrhea. The promoters will be trained to mix the packet or to prepare the sugar-salt solution properly.

STRATEGY

When the central level team began to design the strategy, there were two obvious roles for communications in the project:

- To educate families, making concrete recommendations about what they can do at home to improve nutrition practices.
- To promote community projects and educate families about them.

In light of all the program's goals, however, other objectives for the communications component became apparent:

- To promote the program.
- To give visibility and prestige to the work of the community promoter.
- To promote the surveillance and monitoring system.
- To encourage participation in the organized groups.

For each of these objectives, the staff specified: 1) priorities (program targets, if appropriate); 2) audience; 3) action objectives (what the audience should do); 4) resistance points (blocks to undertaking the action); and 5) media and materials.

The first four points were detailed using existing information about the attitudes of program administrators and information collected in the needs assessment, case studies, and focus groups. The media plan for family education is based primarily on using the community promoter for face-to-face education, which will be provided through individual counseling at weighing sessions and group discussions. Radio may also play a role because of its popularity. The material to support the face-to-face education is a portalamina (a package of individual message sheets) and probably a flipchart, which may be accompanied by a cassette for group instruction.

Details of the strategy are provided on the pages that follow.

ESTRATEGIA DE LA COMUNICACION

Propósito de la Comunicación	Prioridades del Programa	Audiencia	Objetivo de Acción	Puntos de Resistencia	Medios/Materiales
Prestigiar el Programa		CARITAS	<ul style="list-style-type: none"> - Dar a conocer el Programa - Lograr aceptación, apoyo y cooperación 	<ul style="list-style-type: none"> - Dicen que ANEP no da algo visible (ej., alimentos) - Piensan que el director diocesano pierde autoridad dentro del programa (pero es otra puerta abierta en la comunidad) - Tiene que encontrar otra persona para Título II 	<u>Medios Masivos</u> <ul style="list-style-type: none"> - Brochur con carta de Pte. de Caritas - Boletín informativo, semestral - Boletín mensual - Audiovisual sobre el Programa <u>Cara-a-Cara</u> <ul style="list-style-type: none"> - Reuniones - Encuentros - Evaluaciones (dentro de PENA)
		<p>Otras instituciones</p> <p>Interior del PENA</p>	<ul style="list-style-type: none"> - Que conozcan el Programa lograr coordinación o cooperación - Conocer y asumir el Programa - Mayor responsabilidad - Consciente con el Programa 	<ul style="list-style-type: none"> - Falta de información - Confusión entre nuevas metas y las del Programa anterior 	

Estrategia de la Comunicación continua...

Propósito de la Comunicación	Prioridades del Programa	Audiencia	Objetivo del Acción	Puntos de Resistencia	Medios/Materiales
Promover el Trabajo del Promoter		Promotores	<ul style="list-style-type: none"> - Que toman el liderazgo necesario 		<u>Medios Masivos</u> <ul style="list-style-type: none"> - Brochur - Audiovisual
		Comunidad/ Grupo	<ul style="list-style-type: none"> - Que conozcan y participen con el Programa - Se identifiquen con el Programa - Que traigan socios nuevos al grupo - Reconozcan valor del Promotor 	<ul style="list-style-type: none"> - Sienten que es un programa desfuera donde viene bienes - Miembros de la comunidad sienten que alguien de la comunidad no tiene autoridad 	<p>Afiche "¿Sabe Si Su Niño Está Sano? Pregunte a Su Promotor"</p> <ul style="list-style-type: none"> - Radio <p><u>Cara-a-Cara</u></p> <ul style="list-style-type: none"> - Reuniones
Promover el Sistema de Vigilancia y Monitoreo		Madres/ Familias	<ul style="list-style-type: none"> - Que participe en el control de ganancia de peso cada mes - Que tengan la gráfica en buen estado - Que puede explicar si su niño está ganando peso - Que se acostumbra a pedir informaciones al Promotor 	<ul style="list-style-type: none"> - "No traen nada" - No se valora lo que se está recibiendo - No tienen experiencia con el sistema de monitoreo 	<u>Medios Masivos</u> <ul style="list-style-type: none"> - Gráfica con mensajes - Afiche con mensaje sobre ganancia de peso - Radio <p><u>Cara-a-Cara</u></p> <ul style="list-style-type: none"> - Consejos individuales en portalamina - Reuniones: rotofolio

Estrategia de la Comunicación continua...

Propósito de la Comunicación	Prioridades del Programa	Audiencia	Objetivo del Acción	Puntos de Resistencia	Medios/Materiales
		Grupo	- Que el grupo reconocen el progreso de la comunidad en cuanto a la nutrición		- Gráficas gigante - Reuniones
Promover la Participación en los Grupos Organizados para Garantizar su Fortalecimiento y Buen Funcionamiento		Promotor	- Se identifique con el grupo y participe regularmente en sus reuniones	- No hay cooperación-- mucho trabajo	<u>Medios Masivos</u> - Audiovisual sobre el Programa - Radio <u>Cara-a-Cara</u> - Reuniones--rotofolio - Encuentros con otros grupos
		Grupos	- Que los grupos se reúnan por lo menos cada 15 días	- Se pierde mucho tiempo--se habla mucho y no se consigue nada - Las únicas que conocen del grupo son los directivos - El grupo no da ningún beneficio a los socios	<u>Proyectos</u>

Estrategia de la Comunicación continua...

Propósito de la Comunicación	Prioridades del Programa	Audiencia	Objetivo del Acción	Puntos de Resistencia	Medios/Materiales
Educar Sobre Algunas Acciones Concretas que Pueden Hacer las Familias, en Sus Casas, para Mejorar los Habitos que Influyen Sobre la Nutrición	Fomentar la lactancia materna solamente 0-4 meses	Madres/ Familias	<ul style="list-style-type: none"> - Dar seno solamente (no usar el biberón) - Que la mamá da el seno con más frecuencia - Que la mamá beba mucho y más líquido de cual quiera clase - Que la mamá coma más de lo usual, de lo que haya en la región 	<ul style="list-style-type: none"> - El niño no quiere el seno - El niño no se llena con solo pecho - La mamá no da suficiente leche - La leche es de baja calidad - Dar mucho seno debilita - Cuando la mamá sale de la casa tiene que dejar un biberón 	<u>Medios Masivos</u> <ul style="list-style-type: none"> - Radio - Radio curso sobre lactancia <u>Cara-a-Cara (Promotor)</u> <ul style="list-style-type: none"> - Consejos individuales utilizando portalamina - Reuniones grupal utilizando el rotofolio
	Alimentacion de Ninos de 5-8 Meses	Madres/ Familias	<ul style="list-style-type: none"> - Que la siga dando seno - En la alimentación del niño usar jarros, cucharas y platos (no biberón) - La comida (de destete) sea suave pero no aguada - Usar habichuelas guandules con cualquier cereal (arroz, maiz), hecho en puree 	<ul style="list-style-type: none"> - Se desperdicia alimentos - No hay tiempo - Niño no puede tragar o digerir estos alimentos - No quiere comer alimentos ligados 	[Igual que arriba menos radio curso]

Estrategía de la Comunicación continua...

Propósito de la Comunicación	Prioridades del Programa	Audiencia	Objetivo del Acción	Puntos de Resistencia	Medios/Materiales
			<ul style="list-style-type: none"> - Dar comida al niño 2 veces/día (4-6 meses) al introducir alimentos. Cuando está acostumbrado a comer y es mayor de 6 meses dar una comida más de lo acostumbrado. 		
	<p>Alimentación del niño de 9-23 meses</p>	<p>Madres/ Familias</p>	<ul style="list-style-type: none"> - La mama debe seguir dando seno - Darle al niño todo lo que coma la familia - Darle al niño comida 3 veces/día y algo más (frituras, yaniqueques, empanadas, jugos, etc.) <p>El niño debe comer una cantidad igual a la mitad de lo que come el papa cuando tiene su 23º meses.</p>	<ul style="list-style-type: none"> - No hay suficiente alimentos - Hay problemas de apetito del niño—no quiere comer 	<p>Igual que arriba</p>

Estrategia de la Comunicación continua...

Propósito de la Comunicación	Prioridades del Programa	Audiencia	Objetivo del Acción	Puntos de Resistencia	Medios/Materiales
	Alimentación del niño de 24-59 meses	Madres/ Familias	<ul style="list-style-type: none"> - Darle al niño de todo lo que coma la familia - Darle comida 4 veces al día y algo más (fritura, yaniqueques...) 	<ul style="list-style-type: none"> - No hay suficiente alimentos 	<u>Medios Masivos</u> Radio <u>Cara-a-Cara</u> Reuniones grupales utilizando el rotofolio
	Prevención de la diarrea (higiene)	Madres/ Familias	<ul style="list-style-type: none"> - Que hiervan el agua para los niños menores 2 años - Que las madres se laven las manos después de hacer sus necesidades y cuando limpien sus niños - Lavar las manos de los niños por lo menos, antes de comer 	<ul style="list-style-type: none"> - No es necesario - No hay tiempo - Olvida 	<u>Medios Masivos</u> Radio <u>Cara-a-Cara</u> <ul style="list-style-type: none"> - Consejos individuales utilizando portalaminas - Reuniones grupales utilizando el rotofolio

Propósito de la Comunicación	Prioridades del Programa	Audiencia	Objetivo del Acción	Puntos de Resistencia	Medios/Materiales
	Tratamiento de Diarrea	Madres/ Familias	<ul style="list-style-type: none"> - Que la madre siga dando pecho - Seguir dándole alimentos suaves al niño - Dar líquidos inmediatamente comienza la diarrea. Un vaso de líquido por cada evacuación - Buscar ayuda donde el Promotor para hacer suero casero 	<ul style="list-style-type: none"> - Piensan que la leche materna y los alimentos les hacen daño (pesado; incrementa la diarrea) - Falta de información 	<u>Medios Masivos</u> Radio <u>Cara-a-Cara</u> - Consejos individuales utilizando portalaminas - Reuniones grupales utilizando el rotfolio
	Vacunación	Madres/ Familias	<ul style="list-style-type: none"> - Llevar los niños al centro de salud o al Promotor para vacunarlos 	<ul style="list-style-type: none"> - Los niños enfermos no debe vacunar - No entienden bien los efectos secundarios de la vacuna 	<u>Medios Masivos</u> Radio <u>Cara-a-Cara</u> - Promotor - Reuniones
Promover y Educar Acerca de los Proyectos Comunitarios para Mejorar el Estado Nutricional, Salud y Bienestar	Será desarrollado cuando está decidido los proyectos				

NEXT STEPS

The development of a few promotional materials, the growth cards, and the portalamina for counseling sessions was given priority. The growth monitoring program is well established in the communities, and the promoters are ready for materials. Materials for group sessions and for radio have been scheduled for Year 2 of the program. (See Appendix D for the chronogram.) The communications materials, which will be ready for distribution by May (about the end of Year 1) are the following:

Promotional: Program logo and slogan
Program brochure
Poster promoting the weighing program
and the work of promoters

Educational: Individual growth card
Large community growth chart
Portalamina (a package of message sheets about
children of different ages who gain and fail to
gain weight)

By mid-April progress on these materials was good. The program had decided on a slogan: "Niños Sanos/Comunidad Fuerte," which represents both the child health and community development interests of the project. Ideas for the logo had been proposed and were awaiting artistic conceptualization. A draft brochure was discussed and the letter of endorsement received from the Archbishop of CARITAS to attach to the brochure. The poster had not been designed, although the idea for one with a promoter weighing a child and the words "Sabe Si Su Niño Está Sano? Pregunta a Tu Promoter" has been proposed. The community growth chart is finished, and the individual chart awaits the artist. A draft of the portalamina has been completed and is being revised. The major problem for the work in the next several months is finding an artist who can conceptualize and draw the ideas of project personnel in a style relevant for the communities. At present, artists are being interviewed and their work reviewed.

Once the draft print materials are ready, the portalamina message sheets will be pretested with a small sample of program participants and printed. Once ready for distribution, the program will hold a two- or three-day training session for the promoters on how to use the portalamina in conjunction with weighing and how to talk with mothers about dietary improvement.

OTHER ISSUES

1. Radio

Included in the original program plan is a radio component, which, if implemented as planned, should be underway now. Only now, however, are listening habits of program participants being studied (see Appendix E).

In the revised program plan, the radio component comes later. It was given a lower priority for the following reasons:

a) The project is only functioning in 47 communities, but these are scattered throughout the country. Radio broadcasts would mean that the program was sending messages to many uninvolved communities whose messages, via community workers, might be inconsistent with those on the broadcasts. Thus, at this time, the amount of work in contracting regional stations and monitoring them would outweigh the benefits.

b) The program's staff know little about radio work, and training at this point would distract from more important tasks.

It is recommended that, once the communications have been linked directly to growth monitoring activities, the person in charge of nutrition education learn more about radio and then contact some stations, recording studios, and writers. A radio plan will have to be made and program messages revised before short scripts can be developed to complement the face-to-face communications.

A trial of the spots would be appropriate by the end of Year 2, if by then the project has a region of the country where participating communities are more concentrated. Given the current way the communities are scattered, it might make more sense for the project to use the money budgeted for airtime to produce cassettes that could be used by the promoters in their group sessions. An expansion of the program later would signal production of the scripts for radio.

Radio's role in standardizing messages for promoters was also not contemplated in the original program plan. A weekly 10-minute promoter program could serve as a vehicle for continuing education and as a reminder of the important tasks the project relies on them to do.

2. Additional Concept Testing

Though a great deal of survey work with participants has been completed, more should be done as the program develops. At this point, the most fundamental messages have been worked out. Others will be necessary as the materials for the group discussions are designed. Weaning foods and oral rehydration, for example, call for further investigations with the project's participants. The program's accomplishments are considerable in so short a period, but the job is not completed, and with the development of more messages, the qualitative research, or concept testing, methods should be refined.

3. Program Monitoring

Part of the consultancy was spent reviewing the program's monitoring system, ensuring the growth data's usefulness to communities and to area supervisors and the inclusion of educational concerns in the evaluation instrument.

First, we found that the baseline done for the 47 communities now in the program did not include any indicator relevant to education.

The educational priorities established during the February consultancy facilitated the writing of a brief survey (of attitudes and practices) to serve as a baseline for the educational component. Area supervisors administered it at the time of the biannual weighing in March. (A copy of the questionnaire is in Appendix F.) The new questionnaire should be combined with the original baseline instrument and administered in any new communities.

The second finding concerns the program's monitoring system, which is based on trimester reports by the area supervisors and had been used for several months. The supervisors found it cumbersome and confusing, because the reports called for summarizing three months of detailed records on the monthly gains in weight of the most vulnerable children. To accurately follow improvements in this population, however, monthly reports were needed. Thus, the central level team designed a new form (see Appendix G). This should help the supervisors and promoters rapidly assess their progress in promoting weight gain to the high-risk population. The monthly weight report for high-risk children is supplemented by a biannual nutritional status profile of all children under 5.

4. Program Expansion

The positive features of the new plan could make ANEP a model for community nutrition programs in the Dominican Republic: 1) a well-conceived monitoring system whose reporting problems are being worked out; 2) a communications component well integrated with the overall nutrition improvement strategy; 3) independence from costly food distribution systems (although a modest supplementary feeding program could be added where needed).

The program's plan to cover only about 90 communities in the course of its three years is its only drawback, because the low coverage will increase costs and may prejudice expansion on a national level. However, it should be pointed out that many of the developmental costs have been born by this project and that the products, monitoring, and education activities will be ready for implementation on a larger scale.

If "scaling up" could begin before the project is terminated, then by mid-1986 a well-tested community nutrition component would be available for the larger MOH primary health care plan, and the costs for expansion could be estimated more accurately. The MOH/CARE effort to improve the PL-480 maternal-child health program might offer one avenue for expansion. MOH/CARE centers and communities could implement the monitoring and educational activities of ANEP regionally. MOH could adapt implementation wherever necessary to suit its supervision system and workload and could calculate the costs for expansion. Further experimentation in choosing the most sound community nutrition activities would benefit future nutrition programs in the Dominican Republic.

APPENDIX A: PERSONS CONTACTED

Catholic Relief Services

Joy Miller del Rosso, ANEP Manager
Mary Hennigan, Acting Country Representative and Director, CRS PL-480
Title II Program

CARITAS

Ramon Almont Ramirez, CARITAS National Director
Elsa Alcantara, ANEP Coordinator
Juana Maria Mendez, ANEP Nutritionist
Aristides Santana, ANEP Agronomist
Clara Valdez, Administrative Assistant
Reynaldo Santana, Higuey Area Supervisor
Ana Ramona Cabrera, San Francisco Area Supervisor
Augustin Javier, Santo Domingo Area Supervisor
Belkis Mejia, La Vega Area Supervisor
Quisqueya Lora, Santiago Area Supervisor
Angela Rodriguez, Mao Area Supervisor
Virtudes Roa, San Juan Area Supervisor
Promoters and Mothers Clubs in Las Mulas and Biafra, San Juan; Km. 20,
Higuey; and a batay in the Archdiocese

AID/DR

Rose Veith, Program Officer
Rudolph Ellert-Beck, Deputy Program Officer
Lynn Myers, PL-480/Title II Program
Dulce Jimenez, Health Program

APPENDIX B

NUTRITION PRETEST
FOR AREA SUPERVISORS

APPENDIX B: NUTRITION PRETEST

1. Ustedes han visto en los mapas de sus comunidades alguna relación entre la malnutrición y el sector en que viven las familias? Si _____ No _____
Si contesta si, cuál es la relación?

2. Por favor llenar la gráfica para Juanito:

- Nació en Noviembre de 1982
- Se pesó por primera vez en Febrero de 1983: 6 kgs.
- Llegó nuevamente el Promotor a pesarle en Marzo y Juanito pesó 6.5 kgs.
- Pasó tres meses sin pesarse y entonces en Julio, Juanito peso 8 kgs.
- Seguió pesandolo mensualmente el Promotor y mes por mes Juanito pesó:
 - en Agosto 8.2 kgs.
 - Septiembre 8.4 kgs.
 - Octubre 8.5 kgs.
 - Noviembre 8.5 kgs.
- y ahora en Febrero de 1984 pesa 9 kgs. ¿Cuándo en el crecimiento, Juanito empezó a tener problemas?

3. Si un niño tiene 5 meses y no ha ganado peso por dos meses que recomienda usted que haga la mamá?

4. Si una niña tiene 15 meses y no ha gardo peso en dos meses que recomienda usted que haga la mamá?

5. Si un niño tiene 9 meses y parece que ha perdido peso en los últimos tres meses; que recomienda usted que haga la mamá?

6. ¿Qué debe recibir para comer un niño entre 0 y 3 meses de edad?

7. ¿Qué debe recibir para comer un niño entre 4 y 7 meses de edad?

Cuántas veces por día debe comer? _____

8. Cree usted que un niño con 18 meses de edad puede comer la mitad de la cantidad de comida que come el papá? _____

9. Señoras embarazadas y lactantes deben intentar cambiar sus dietas en que forma?

10. Puede hacer algo una madre lactante para incrementar la cantidad de leche que produce? Si _____ No _____

Si contesta si; cómo puede hacer?

11. El papá trajo su niño de 3 meses a mi casa con diarrea. El niño recibe: leche de pecho y harina cocinada. ¿Le va a aconsejar a este papá sobre la dieta de su niño mientras tiene diarrea?

Después que termine la diarrea?

12. Ha oído usted sobre el suero casero?

Si _____ No _____ . Si contesta si, ¿Qué es y para que se usa?

¿Cómo lo prepara?

13. En la familia está la abuela Julia y su hijo Eddy, su esposa Mariana y los hijos de ellos: Miguel que tiene 7 años, Elena con 5 años y Rosa quien acaba de cumplir 1 año. Ellos acaban de conseguir una gallina. El Lunes la gallina puso un huevo. Mariana, Eddy y Julia no pueden decidir que hacer con el huevo. Qué recomienda usted que hagan con este huevo.

APPENDIX C

GUIA DE PREGUNTAS: ALIMENTACION INFANTIL Y DIARREA

APPENDIX C: Guía de Preguntas: Alimentación Infantil y Diarrea

BORRADOR

ANEP

febrero 1984

Introducción

Estamos con Uds. para discutir sobre el cuidado de los niños.

Esperamos que nos hablan como estamos en familia, con toda sinceridad porque vamos a utilizar sus respuestas para ayudar familias en esta país cuidar a sus hijos mejor.

No estamos buscando una respuesta correcta porque no hay respuestas correctas ni incorrectas a nuestras preguntas, entonces si está o no está de acuerdo con alguna idea que estamos discutiendo, por favor díganos para que podemos conocer la opinión de todos.

I. ¿ Como sabe si su niño está sano?

¿ Como sabe si su niño está creciendo?

En su comunidad ¿ conoce algunos niños pequeños que no están creciendo?

¿ Porqué no crecen?

¿ Que puede recomendar a una mamá cuando ella da cuenta por primera vez que su niño no está creciendo?

II. ¿ Dieron pecho Uds. a sus niños?

¿ Porqué dieron pecho?

¿ Hasta que edad piensa que es bueno dar el pecho? ¿ Porque?

¿ Hasta que edad dió pecho?

¿ Tenia Ud. problemas cuando empezó de dar el pecho? ¿ Cuales?

¿ Que hizo?

¿ Porqué dejó de dar el pecho?

Para cada respuesta:

¿ Que puede hacer una mamá si quiere seguir dando el pecho para sobrar este problema?

Si no ha salido:

¿ Ha dido de mamás que dicen que no tienen suficiente leche?

¿ Que opinas?

¿ Piensa que hay algo que puede hacer una madre para aumentar la cantidad de leche que tiene? ¿ Qué?

Si el/la promotor(a) dijo que debe beber más líquido cuando está dando pecho, ¿ es algo que puede hacer facilmente?

¿ Porqué sí? ¿ Porque no?

Si no ha salido:

- ¿ Conoce una relación entre el número de veces que le da el pecho y la cantidad de leche que tiene? ¿ Qué es?
- ¿ Conoce una relación entre la cantidad de líquido que consume y la cantidad de leche que tiene? ¿ Qué es?

Si el/la promotor(a) dijo que debe beber más líquido cuando está dando pecho, ¿ es algo que puede hacer facilmente? ¿ Porqué sí?

- ¿ Porque no?
- ¿ Cuanto (vasos) puede aumentar?

- III. ¿ Hay algunos de Uds. que utilizen el biberón?
- ¿ A qué edad empezó con el biberón? ¿ Porque?
 - ¿ Cuando empezó con el biberón su niño, ¿ tenía problemas?
 - ¿ Qué tipo de problemas?
 - ¿ Si alguien le dice que no debe utilizar el biberón con su niño, ¿ qué opina?
 - ¿ Qué haría si no puede utilizar el biberón?

Si no ha salido:

- ¿ Puede utilizar una tasa y cuchara en vez de biberón? ¿ Porqué sí?
- ¿ Porque no?

- IV. ¿ Algunos de Uds. han dado alimentos a sus niños durante los primeros tres meses? ¿ Porque dió estos alimentos?
- Hemos oído recientemente que durante los primeros tres meses de vida un niño debe recibir solamente leche del pecho-- ningún alimento ni el biberón. ¿ Qué piensa? ¿ Estará dispuesto ensayar esta recomendación? ¿ Porqué sí? ¿ Porqué no?

- ¿ Cuales son los alimentos buenos para un niño de 4 a 6 meses?
- ¿ Porqué son buenos?

Si no ha salido:

- ¿ Piensa que un niño de este edad puede comer habichuelas y guandules?
- ¿ El grano tanto como la salsa? ¿ Porqué sí? ¿ Porqué no?
- ¿ Debe preparar el grano sin cáscara para el niño?
- ¿ Eso es fácil o difícil hacer?

- ¿ Uds. utilicen la comida cocida para la familia también para su niño a cocina la comida del niño aparte? ¿ Porqué?
- ¿ Cuantos días por semana tienen Uds. habichuelas o guandules?
- ¿ Creen que crema de habichuelas es bueno para un niño de este edad?
- ¿ Porqué sí? ¿ Porqué no?
- ¿ Le dan Uds. esta comida todo los días a su niño de este edad?
- ¿ Como lo prepara?
- ¿ Qué piensan si alguien les recomienda la adición de algunas gotas de aceite a esta crema?

- ¿Cuántos días por semana tienen Uds. arroz?
- ¿Siempre cocina arroz con aceite para la familia?
- ¿Tiene aceite todo los días en la casa?
- ¿Piensan Uds. que un niño de 4 a 6 meses puede comer habichuelas o guandules machucado con arroz (cocido con aceite)?
- ¿Porqué sí? ¿Porqué no?

- ¿Puede dar auyama a un niño de 4 a 6 meses? ¿Porqué sí? ¿Porqué no?
- ¿Cuántos días por semana tiene auyama?
- ¿Qué opinan sobre una comida de auyama y habichuelas machucadas para un niño de 4 a 6 meses?

- ¿Cuántos días por semana utilice leche de coco para cocinar?
- ¿Piensa que un niño puede comer comida cocida en leche de coco?
- ¿Porqué sí? ¿Porqué no?

V. Un problema en las comunidades es que hay niños que tienen diarrea:

- ¿Uds. conocen si hay alguna manera de evitar que los niños tengan diarrea?
- ¿Qué puede hacer?
- ¿Uds. lo hacen?
- ¿Hay problemas en hacerlo?
- ¿Los niños puede utilizar el mismo agua que los adultos? ¿Porqué sí/no?
- ¿Cuales serían los problemas?
- ¿Hay algún dificultad en lavarse las manos cada vez después que hace las necesidades?
- ¿Porqué hay personas que no lo hacen?
- ¿Cuándo su niño tenga diarrea, ¿qué hace Ud. en los primeros dos días?
- ¿Qué hace si dura la diarrea?
- ¿Qué puede hacer en la casa?

Si no menciona suero casero:

- ¿Han oído de suero casero? ¿Para qué se usa? ¿Como lo prepara?
- ¿Qué es su experiencia con suero casero?
- ¿Una madre debe seguir dando de mamar a su niño con diarrea?
- ¿Porqué sí/no?
- ¿Un niño con diarrea puede seguir comiendo? ¿Porqué sí/no?
- ¿Hay alguna comida que puede seguir recibiendo?
- ¿Qué opinan si su promotor(a) recomienda que le da a su niño con diarrea puré de batata/sopa de arroz/puré de guineo?

CHRONOGRAM

CHRONOGRAM MAY - DECEMBER 1984

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ACTIVITIES	MAY	JUNE	JULY	AUGUST	SEPT.	OCT.	NOV.	DEC.
<u>Nutritional Surveillance</u>								
-Introduce new grafica								
-Incorporate new info-system								
-Introduce new system for data collection								
-Plot baseline on large grafica (in training)								
-Plot 6mo. weighing on large grafica (in communities)								
-Plot 1yr. weighing								
<u>Communication Materials</u>								
-Prepare brochure								
-Print program emblem								
-Print/distribute brochure								
-Prepare bulletin #1								
-Print 6mo. bulletin #1								
-Prepare bulletin #2								
-Print 12mo. bulletin #2								
-Prepare audiovisual about program								
-Print audiovisual about program								
-Prepare afiche								
-Print afiche								
-Prepare portalaminas								

ACTIVITIES	MAY	JUNE	JULY	AUGUST	SEPT.	OCT.	NOV.	DEC.
-Test portalaminas		-----						
-Revise portelaminas		-----						
-Prepare for training in nutrition education #1			-----					
-Print/train in use of portalaminas (encuentro nacional)				-----				
-Plan and elaborate group nutr. educ. materials				-----				
Test group nutr. mat.					-----			
Revise group nutr. educ. material						-----		
Prepare for training nutr. educ. #2						-----		
-Train in use of group nutr. educ. material							-----	
-Radio Program								
<u>Projects</u>								
-Establish criteria	-----							
-Prepare for training	-----							
-Train in project promotion	-----							
Project promotion		-----						
Feasibility studies		-----	-----					
Implementation			-----	-----				

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APPENDIX E

MEDIA USAGE QUESTIONNAIRE

ANEP

PROGRAMA DE EDUCACION NUTRICIONAL APLICADA

Encuesta - El uso de medios de comunicación disponibles

1. ¿Cuáles "medios" están en la casa en este momento?

Televisión _____ Funciona Si _____ NO _____

Radio _____ Funciona Si _____ NO _____

Periódico _____

Otro material escrito de información _____ ¿Cuál? _____

Calendario _____

Otro _____

2. Si no hay radio en casa:

¿Escucha radio? Si _____ NO _____

¿Dónde? _____

3. Si escuchan radio:

¿Cuántas horas al día? 1 ó 2 horas _____

La mitad del día _____

Siempre está prendido _____

¿Cuál emisora escucha más? 1. _____

2. _____

3. _____

¿Cuáles programas le gusta más? 1. _____ hora _____

2. _____ hora _____

3. _____ hora _____

Ha oído programas de salud o nutrición? Si _____ NO _____ ¿Cuáles? _____

Le gustó? Si _____ NO _____ ¿Por qué? _____

NUTRITION EDUCATION BASELINE QUESTIONNAIRE

PROGRAMA DE EDUCACION NUTRICIONAL APLICADA

Diócesis _____ Comunidad _____

Nombre del niño _____ Nombre de la madre _____

PREGUNTAS PARA LAS MADRES - (Pesaje de los 6 meses)

1. ¿Si un niño no está ganando peso, qué debe hacer la mamá?

2. ¿Qué recibió su niño en los primeros 3 meses? _____

3. ¿Cómo se debe alimentar un niño de 0 - 3 meses? _____

4. ¿Utiliza biberón? Si _____ NO _____ ¿A qué edad comenzó? _____
5. ¿Le está dando o le dió el pecho al niño? Le está dando? _____
Le dió el pecho? _____ ¿cuánto tiempo? _____
6. ¿En el primer mes, cuántas veces por día dió pecho a su niño? _____

7. ¿Qué edad tenía el niño cuando comenzó a darle alimentos además de leche?

8. ¿Cuándo su niño tenía 6 meses de nacido, cuántas veces comía por día?

9. ¿Cuándo su niño tiene diarrea que hace en el primer día? _____

10. ¿Cómo se debe alimentar un niño con diárrrea? _____

AREA SUPERVISOR'S MONTHLY REPORT

PROGRAMA DE EDUCACION NUTRICIONAL APLICADA

INFORME MENSUAL DE SUPERVISORES

atos de vigilancia y participación	C O M U N I D A D E S				
Niños 0-5 años (según censo)					
Niños pesados					
Alto riesgo (2 años y II y III grado 2 años)					
Alto riesgo pesados					
No ganando peso					
Niños salieron de alto riesgo					
Ingresaron nuevos al programa					
Niños salieron del program (5 años)					
Familias con niños en alto riesgo					
Familias con niños en alto riesgo que estan participando en grupos					

FICHA DE VIGILANCIA

Están completas y correctas todas las fichas de sus promotores? Sí _____ No _____

Si la respuesta es No, explique por qué y qué piensa hacer.

SISTEMA DE VIGILANCIA

¿Todos sus promotores están pesando regularmente y en la misma fecha cada uno?

Sí _____ No _____ Si la respuesta es No, explique por qué y qué piensa hacer. _____

CURVA DE GANANCIA

¿Todas las madres entienden las gráficas y las tienen completas para cada niño

Sí _____ No _____ Si la respuesta es No, explique por qué y que piensa hacer. _____

GRUPOS

¿Cómo va el funcionamiento de los grupos? Bien _____ Regular _____ Mal _____

Si no va Bien, explique por qué y qué piensa hacer. _____

¿Han usado materiales del Programa con el grupo? Sí _____ No _____

Si la respuesta es No, explique por qué y qué piensa hacer. _____

PROYECTOS PRODUCTIVOS

Si existe en algún proyecto una dificultad mayor, señáela para ser tratada de manera particular. _____

OTROS TRABAJOS

¿Qué otros trabajos ha realizado en su diócesis? (Fuera o dentro del programa)