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**SAVE THE CHILDREN/BOLIVIA MOTHERCARE (WARMI) PROJECT
MID-TERM EVALUATION**

APRIL, 1992

LA PAZ

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LA PAZ, APRIL, 1992.

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EXECUTIVE SUMMARY

Save the Children/Bolivia began MotherCare Project activities in fifty communities in the Inquisivi Province of La Paz Department in July, 1990. The goal of the three year project is to reduce maternal and neonatal mortality and morbidity through affecting the range of behaviors that influence the outcomes of pregnancy, delivery and the neonatal period. A major strategy used to achieve these objectives was the organization of women's groups to increase women's knowledge and awareness of specific maternal and neonatal health problems and the locally available resources that could be accessed to address these problems.

SCF/Bolivia MotherCare Project activities to date include: the development, implementation and analysis of a retrospective maternal and neonatal mortality case-control study; formation and strengthening of women's groups in twenty five communities; the development and implementation of a problem identification and prioritization exercise known to SCF staff as the "autodiagnosis" which was carried out by twenty five women's groups; development of action protocols based on maternal and neonatal health problems identified by the case-control study and the autodiagnosis; training of women and men in twenty five communities on safe birth practices.

The purpose of this mid-term evaluation was to review the progress of project activities to date in terms of compliance with the objectives described in the project Detailed Implementation Plan (DIP), to assess the quality of the work and to recommend ways to strengthen the program during the remaining 16 months.

The methodology used to obtain information during this evaluation consisted of interviews and/or focus groups with different sectors: women who are participating in the project, empirical midwives who have received training, community leaders, project personnel and other key informants.

Some of the most salient (noteworthy) results of the evaluation are presented below in the form of recommendations.

Personnel

In relation to personnel, to facilitate the coordination of health team staff, it is recommended that SC/Bolivia initiate a series of analysis, discussion and training team meetings, focussing on objectives, purposes and strategies common to both the MotherCare and Child Survival projects. This recommendation makes sense every time there is a large staff turn over in the different zones of the project.

On the other hand, due to the specific nature of the Supervisors'

work in the communities, it is recommended to try to standardize their labor, in such a way that the impact achieved in the communities can be compared. Training would play an important role.

The project should choose a series of priority themes identified by the personnel for ongoing training in order to strengthen their abilities. Some themes requested by personnel include Popular Education, Community Development and Cross-cultural communication.

Training

As for training, it was noted that the degree of motivation reached by the women was due in part to their reflections on real needs through the autodiagnosis. Therefore, it is recommended to continue as soon as possible with training sessions which will maintain the collective interest in the subject of maternal health.

Likewise, it was noted that the midwife training course should include alternatives which allow the impact of these training activities to be more carefully monitored. Perhaps it would be interesting to attempt to have the midwives assist in the prenatal care visits in their respective communities, through closer coordination with the health posts in the area. This would allow the midwives to be exposed to additional hands-on training during the prenatal care visits provided by the doctor in the area. The training and the curriculum for midwives should be designed in greater detail, taking into account specific objectives, methodologies, and support materials. It is also recommended outside technical assistance be sought for the design of the curriculum.

The project should seek to develop complementary training activities which include men, or which integrate men into the treatment of aspects which pertain to women.

There are various problems in the community management of the roster. Therefore, it is recommended that the materials and procedures be simplified, even if this means that it is decided that the field supervisors manage the rosters. Practical training is an indispensable prerequisite to assure an adequate performance by those responsible for the HIS.

SC/Bolivia and the project should create a permanent training mechanism to keep area staff up-to-date in information and performance. This recommendation could be extended as well to the personnel of the MPSSP, keeping in mind that they could also enrich the activities of the MotherCare staff.

Methodologically, the project should adopt procedures which are more participatory and geared to adult learning needs. This means going beyond the "talk" as a methodology, which should be replaced

by methodologies which have a broader didactic perspective.

Finally, the educational materials foreseen as part of the project should be produced as soon as possible. This should be done following the participatory spirit of the MotherCare Project.

Autodiagnosis

The following observations can be made about the autodiagnosis. In the first place, the autodiagnosis is not only an instrument to discover community problems, but also constitutes a process which permits the women to identify, prioritize, and manage their various maternal and neonatal health problems. The experience in the first twenty five communities shows that the autodiagnosis raises the women's consciousness of, and interest in, reproductive health. At the same time, it increased the confidence and trust between the women and the project personnel.

Secondly, training in the autodiagnosis methodology is essential for all new personnel. The training should include theoretical and philosophical aspects of the methodology as well as a detailed review of the objectives.

Thirdly, it was evident during the evaluation that the visits to other women is a very important step to build confidence and increase communication among the women. This step was not carried out in many of the communities, because all the women participated, leaving no one to interview. In similar communities, some way should be discovered to ensure that this step is included in the next phase.

During the autodiagnosis, some women asked questions about what they should do if a specific problem occurs. Staff were advised not to enter into education at this point but tell the women that when the autodiagnosis is completed they would begin to analyze what they could do. This left staff and women feeling somewhat uncomfortable at times. One suggestion to deal with this problem was to keep a running list of questions that arise during the autodiagnosis that would be referred to when developing strategies to deal with specific problems. This way, the woman's question is not left hanging without acknowledgement, but is put on the agenda for future discussion.

According to our discussions with women during this evaluation, with one exception, women facilitators were preferred to men facilitators. Women should carry out the autodiagnosis with women's groups whenever possible.

In several groups that were visited, men appeared to be very interested in participating. Though this is positive in the sense that they recognize that maternal and neonatal health are important and that they want to learn more about these things, the end result

may be that women's level of participation is reduced and overall confidence and trust is sacrificed. This would be unfortunate. SC/B staff should carefully study how to deal with this.

Health Information System

The Health Information System (HIS) is an excellent instrument that can be used to identify needs, to set priorities, to plan, to monitor and to evaluate the program, to assist in decision-making, to define the community through baseline/census information, to supervise health workers, to add to the public health literature, to report and satisfy government requirements, to justify expenditures, and for the development of future program proposals. The SC/Bolivia MotherCare Project is using the HIS in many of these ways.

The following recommendations are made to help strengthen the existing HIS:

- * Regarding the Women's Health Roster: The Rosters should be kept and managed by health promoters and TBAs, not by field supervisors. Several variables should be cut from the Roster, definitions of variables need to be clarified, drawings should be added and larger letters should be used. The SC/B team should field test the new format as soon as possible.
- * "Guidelines for Supervision of Field Supervisors" should be used on a continual basis and could be included in the team's monthly activity workplan.
- * The new staff hired to manage ProMis, the computerized SC information system, should be adequately trained. A technical assessment should be carried out to determine which women's health variables should be added to ProMis.
- * SC/B should strengthen feedback of health information in the communities through more regular community meetings. Community Syndicates, women's groups and "juntas vecinales" would be appropriate forums in which to carry out this activity.
- * The "Under 5's" and "Women's Rosters" should be bound under one cover as soon as the women's rosters are modified and field tested.

Detailed Implementation Plan (DIP)

Several members of the evaluation team reviewed the Detailed Implementation Plan and recommend that it should remain as it is. Methods for evaluating the indicators were also recommended. There was some discussion about whether weighing during pregnancy would be feasible given time, budget and other constraints.

The IEC strategy should be implemented as soon as possible. SC/B is planning to hire a local consulting firm to provide technical assistance for this component. Due to cultural factors and gender identification, a strong preference should be given to women professionals when selecting the consulting firm that will provide technical assistance to develop the IEC strategy.

Since there will be several changes in the content and format on the women's roster, a new training session on the modified roster should be planned for SC/B health staff and the local MPSSP health team.

Technical Assistance

In general, technical assistance has been good and useful for the Mothercare project. The weakest part was insufficient time during consultancies to go into deeper detail.

Where possible, consultants should be professionals with experience in Andean countries, who speak Spanish, and who have field experience. Consultants who visit the field should be conscious of the socio-cultural characteristics and educational levels of the beneficiary population.

It is recommended that future technical assistance be oriented toward strengthening field personnel, with consultants bringing innovative ideas, experiences, and educational materials from other places.

Interinstitutional Coordination

Some of the most important recommendations to obtain optimum interinstitutional coordination were the following: Take into account the monitoring and supervisory system already put in place by the MPSSP, which permit the measuring of indicators and progress toward completing project objectives. Instruments and norms should be developed for this purpose.

Planning of related and/or complementary activities should be carried out by representatives of both institutions, to produce a joint action plan.

Monthly health information from the area should be presented to the MPSSP and representatives of the project should participate whenever there are Information Analysis Committee (CAI) or district meetings.

Finally, in order to optimize human resources and logistical support, fundamentally to deliver these to the community, all personnel in the district who work in health should have increased knowledge of the norms and procedures of both the Ministry and the

MotherCare project.

Administration

In spite of an adequate administrative system in the impact area, there is reason to believe that a clarification of the functions of the administrative personnel is necessary to establish limits on their respective responsibilities. This would prevent problems among personnel who perform administrative functions.

Budget

To date, the budget has been underspent. There are several options that SC/B can consider:

- A shift of some funds from the personnel line to the travel line. (This appears to be necessary.)
- Extension of the project for an additional two months (close date September 30, 1993) to allow staff more time to close out the project and to document results.
- Extension of the project for one month and remainder of funds cover costs of a local subcontractor for the IEC component.
- No extension of the project and reallocation of remaining funds to costs of a local subcontractor for the IEC component and additional project-related costs such as basic equipment for health posts or more educational materials, etc.

Sustainability

Special emphasis should be placed on consolidating links with the MPSSP, especially in the impact area, so that the Ministry can gradually take over the functions introduced by the MotherCare project.

Technical assistance to the women's groups should also be stressed, in order to guarantee that they function adequately. It is essential that the groups see themselves as a medium to improve the general conditions of women and their families. No group can survive in the long run if it does not have a practical outlook.

It is also worthwhile for the project to take advantage of the other SC/B projects in the same area, in order to better integrate the work.

Finally, perhaps it would be worthwhile to strengthen the links with the formal authorities in the beneficiary communities of the MotherCare Project, giving the community itself the opportunity to participate in evaluations of the project's progress.

I. BACKGROUND

Save the Children/Bolivia began MotherCare Project activities in fifty communities in the Inquisivi Province of La Paz Department in July, 1990. The goal of the three year project is to reduce maternal and neonatal mortality and morbidity through affecting the range of behaviors that influence the outcomes of pregnancy, delivery and the neonatal period. A major strategy used to achieve these objectives was the organization of women's groups to increase women's knowledge and awareness of specific maternal and neonatal health problems and the locally available resources that could be accessed to address these problems.

The rural Province of Inquisivi lies approximately five hours by road southeast of La Paz. The province is characterized by high plains (altiplano), high Andean valleys, and subtropical valleys. The population in the defined project area is approximately 13,000 and is predominantly of Aymara (native American) extraction. Quechua migrants are also found in the lower valleys. The project area encompasses nearly 5,000 square kilometers with difficult access to the population. Roads are poor in many parts of the province and several communities can only be reached after several hours on foot. Means of transport are scarce and unpredictable.

According to a retrospective case-control study carried out in the province by SCF in 1990, verified mortality rates were extremely high in this population: for a two year period of study, perinatal mortality was 103/1,000 births, neonatal mortality 69/1,000 live births, and maternal mortality 140/10,000 births. The most common probable causes of perinatal death identified by the study were: asphyxia, sepsis, trauma, hemorrhage and hypothermia. Probable causes of maternal death included: hemorrhage, sepsis associated with intrauterine death and puerperal sepsis, and abruptio placenta.

Health care services in the province are provided by the Ministry of Health. Inquisivi and Licoma zones have a health post staffed by one female doctor each carrying out their mandatory one year rural medical service. Circuata zone is served by a health post staffed by one auxiliary male nurse. The posts are stocked with the bare minimum of essential basic medicines and equipment. The reference hospital in Quime does not meet the minimum WHO standards for a health post. It is staffed with two doctors, a nurse, a dentist, two auxiliary nurses and custodian. The hospital cannot cope effectively with major complications which require surgical intervention due to a lack of sterilization and anesthesia equipment and trained staff. The Ministry provides an ambulance for use by the Quime Hospital but it is often out of service due to poor maintenance, lack of spare parts and lack of funds to purchase gasoline. All health facilities are underutilized by the population, in part due to economic factors, in part due to sociocultural factors and in part due to the justified belief that

the services are not equipped to deal with more complicated problems.

SCF/Bolivia MotherCare Project activities to date include: the development, implementation and analysis of a retrospective maternal and neonatal mortality case-control study; formation and strengthening of women's groups in twenty five communities; the development and implementation of a problem identification and prioritization exercise known to SCF staff as the "autodiagnostico" which was carried out by twenty five women's groups; development of action protocols based on maternal and neonatal health problems identified by the case-control study and the autodiagnosis; training of women and men in twenty five communities on safe birth practices; preparation by women's groups of 300 safe birth kits; education of couples in selected Licoma and Circuata Zone communities on family planning methods; and, collaboration with SOPACOF, a local NGO in the delivery of family planning services to over 137 new users in a period of two months prior to this evaluation.

In addition to MotherCare activities, SC/Bolivia is working in the areas of child survival and nutrition, credit, agriculture, micro-irrigation and education. SC/Bolivia has recently added the "Woman Child Impact Program" to its portfolio. This program focuses on strengthening existing programs and will add literacy training and credit for women. It will complement the work of the MotherCare Project in many of the same communities.

The purpose of this mid-term evaluation was to review the progress of project activities to date in terms of compliance with the objectives described in the project Detailed Implementation Plan, to assess the quality of the work and to recommend ways to strengthen the program during the remaining 15 months.

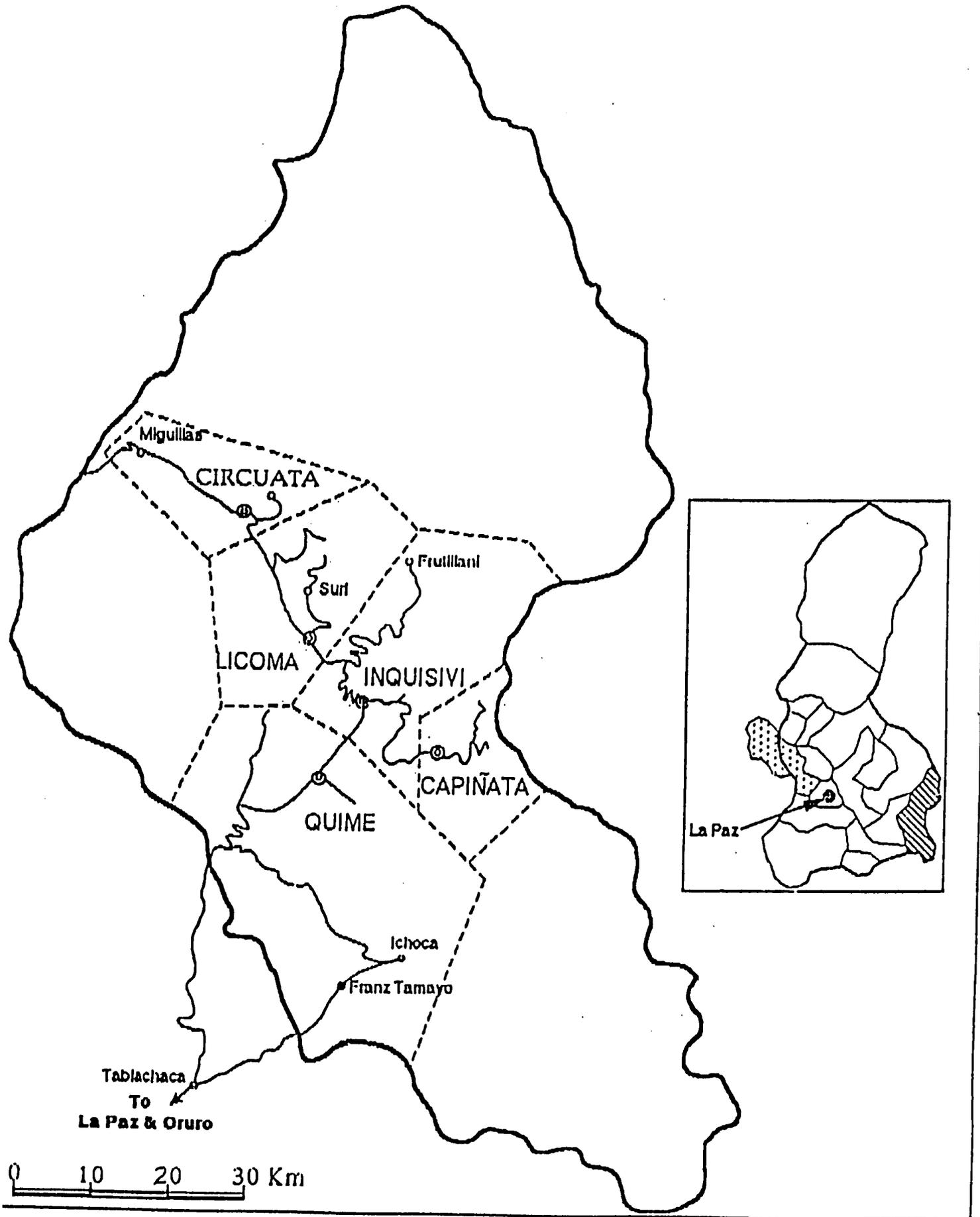


Figure 1. Department of Inquisivi showing location within the Department of La Paz and sub areas in which SCF works. Details of individual subareas are shown in Figures 2 through 6.

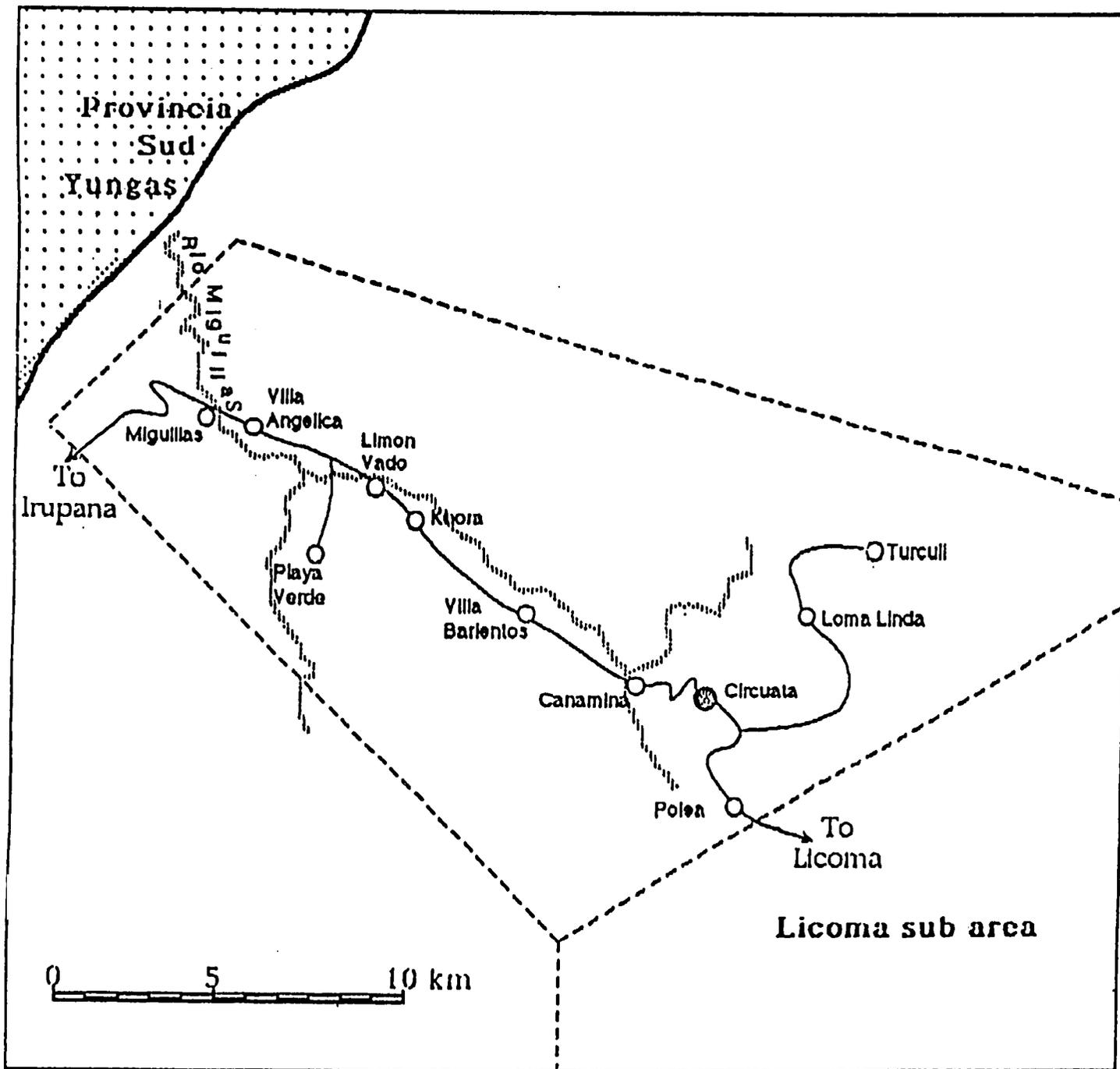


Figure 2. Circuata sub area.

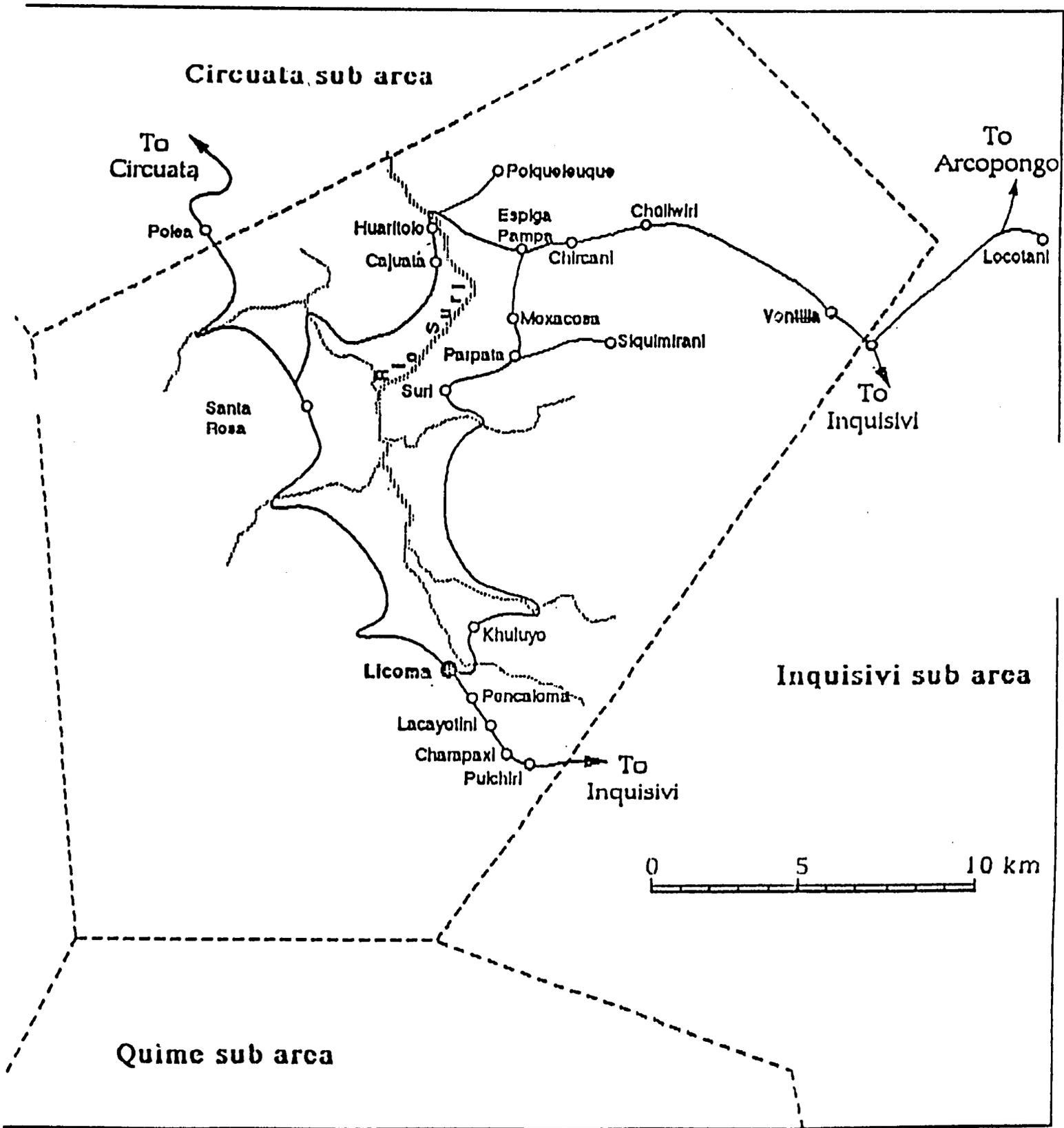


Figure 3. Licoma sub area.

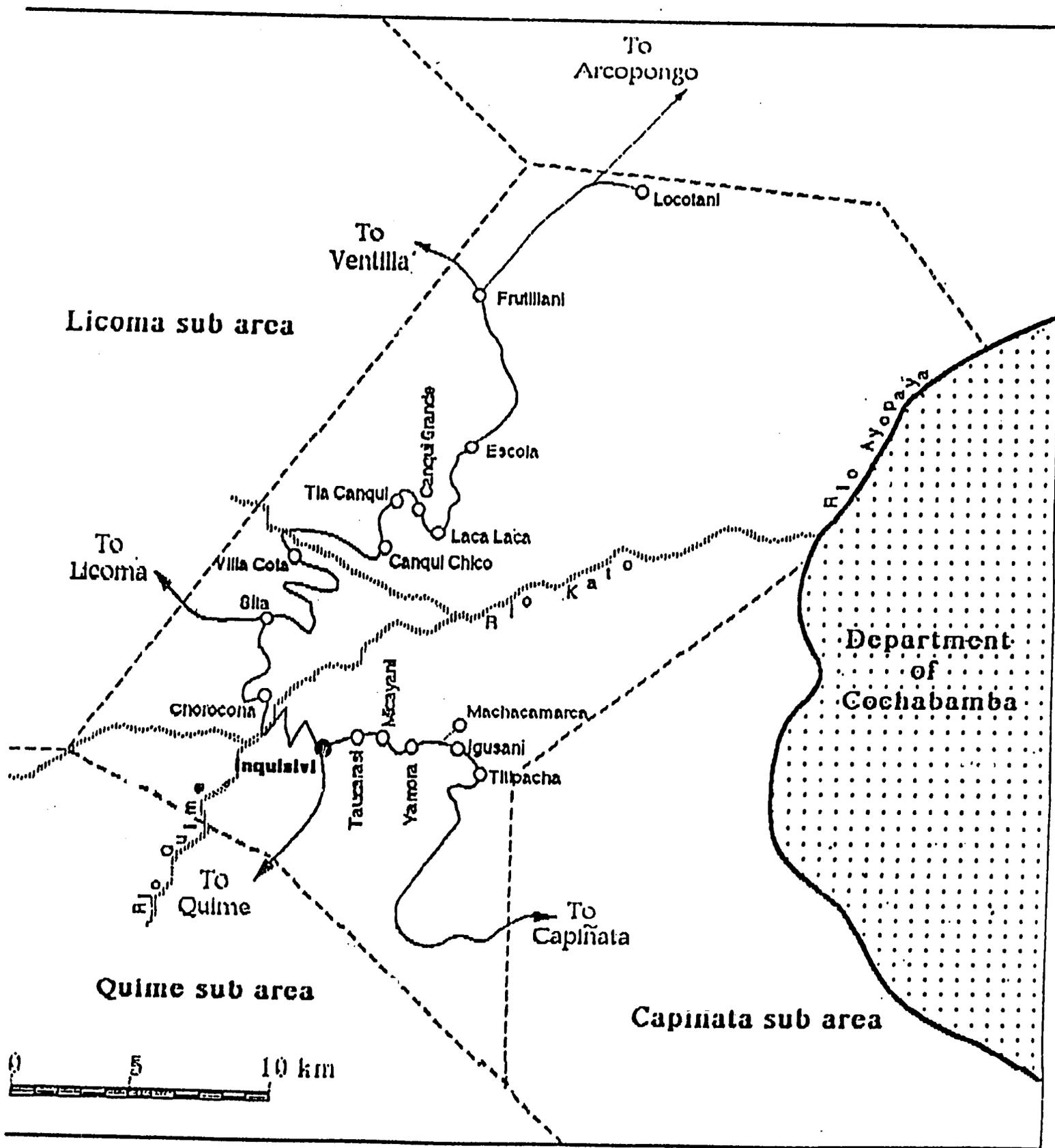


Figure 4. Inquisivi sub area.

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II. METHODOLOGY

The evaluation procedures were agreed upon in the first evaluation meeting, in which the entire project team participated, facilitated by David Rogers, Director of Save the Children/Bolivia.

During this meeting, the following points were considered:

1. Search for an agreement on the objectives of the Mid-Term Evaluation.
2. Development of a strategic work plan to achieve the objectives.
3. Definition of the roles and responsibilities of the different members of the evaluation team.
4. Definition of logistical aspects to aid the evaluation.

The meeting began with the presentation of the team members and the presentation of the MotherCare Project. Objectives of the project, expected results, and successes to date were clarified. Table 1 on the following page presents the results of this analysis.

Table 1. Review of Project Objectives and Achievements to Date

COMPONENT	DESIRED	ACHIEVED	OBSERVATIONS
Autodiagnosis	Execute in 25 communities	Executed in 25 communities	Report pending
Case Control Study	Investigate 73 cases of perinatal mortality, 146 controls and 9 cases of maternal death	All interviews were carried out with the families	Results presented at PROCOSI, in report and at NCIH
Develop High Risk Protocols	Complete development of protocols, & validate them	Protocols were completed for all 3 levels: * Family * Midwives * Services	Have not yet been integrated into IEC. Need to be validated & tested in field.
Develop IEC materials of	Begin production materials	Defined terms of reference needed to contract the appropriate personnel	Lack specification of type of materials
Home Visits	50 % pregnant women with min. 3 prenatal care visits as of 1993	391/527 pregnant women received at least one prenatal care visit registered in 2 years 74 % coverage of at least one visit. 227 with 1 visit (43 %) 123 with 2 visits (23%) 41 with 3 visits (8%)	Data do not exist in the computerized HIS.
	50% WRA receive 2 doses TT	61% of detected pregnant women received 2 doses TT	
	50% pregnant women will receive Ferrous Sulphate	50% of detected pregnancies	Should detect 100% pregnancies (in one year)

Table 1- Continued

COMPONENT	DESIRED	ACHIEVED	OBSERVATIONS
Coordination with MPSSP	Better collaboration	Coordination improved w/ change of Dist. Director	Need to strengthen relationship.
Relations with SOPACOF	Agreements & visits to the project area for training and service delivery	SOPACOF worked w/ Health Posts in family planning. They made 3 visits (179 patients and 137 new users of FP methods).	Some problems w/ religious sects.
Training	29 midwives (100%) & women (60%), husbands (45%), local authorities, SC/B staff & MPSSP	29 parteras (100%) 52% women of reprod. age, 70% of husbands trained in safe birth, SC/B staff in process of training, MPSSP not yet trained.	Optimize training.
Information System	Roster is functioning. Develop the women's health card.	Training in mgmt of roster. Clarify indicators.	Roster must be modified. Implement use of card.

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After this, the team proceeded with the identification of the objectives of the project, its goals, and the strategy of the evaluation, in order to assign roles and responsibilities. Table 2 on the following pages presents the design.

Table 2. Evaluation Goals & Objectives Assigned by Method & Team Members

OBJECTIVES	GOALS	HOW	WHO
Participation in training, coverage of training, results of training	Coverage, type, results, methodologies scope covered; curricula Procedure of follow-up to monitor process. Educational materials, Methods for their development.	Analysis of documents, Interviews (women, midwives, staff, community).	Erick Roth Loren Galvao
Organization - & Participation	Number of women's groups organized. Average # of mtgs. per group. Number of activities on maternal health. Type of traditional women's organiz. Measure results of work of groups (autodiagnosis, safe birth kits, culinary practice, other initiatives, etc.).	Meeting with women: focus gps. Review of notebooks & attendance lists, auto-diagnosis notebooks. Amt. of time group has been functioning. Possession of safe birth kit and its use.	Erick Roth Lisa Howard Willy Seoane Elsa Sanchez
Autodiagnosis	Number of participants (direct & indirect). Results: priorities, indir. (income generation, etc.), quality of the process, definition of solutions. Training.	Review of documents (notebooks) Focus groups with women Interviews w/ SC/B staff. Verification of staff diaries/ notes.	Lisa Howard Loren Galvao Willy Seoane Hernan Zambrana Erick Roth

Table 2- Continued

OBJECTIVES	GOALS	HOW	WHO
Health Information System	<p>Instruments: Women's Health Card, Consolidated Roster. Indicators of use of information in the community. Methodology of collection of information. Use of the information for decision-making. Updating of the information.</p>	<p>Verification of the rosters in the community. Interviews w/ women. Essential and feasible indicators. Review of PROMIS. Relation of the women's health card with MPSSP card.</p>	<p>Willy Seoane Hernan Zambrana Loren Galvao</p>
Administration, Management & Personnel	<p>Strengths & weaknesses of the admin. systems: personnel, inform. flow, decision-making, centralization/decentralization. Supplies & logistics.</p>	<p>Interviews with SC/B staff. Considerations of the Field Director. Review of documents. Criteria for contracting of staff.</p>	<p>Erick Roth Willy Seoane</p>
Inter & Intra-institutional Coordination	<p>Relations w/ the MPSSP, SOPACOF, PROCOSI, CARITAS, Catholic Church, John Snow, Inc.</p>	<p>Referral systems Interviews with MPSSP staff in the District, Areas & Sectors. Influence of SC/B on other institutions.</p>	<p>Hernan Zambrana Erick Roth</p>
Technical Assistance	<p>John Snow, Inc.: Lisa Howard-Grabman, Pat Taylor Other: Mona Moore, Al Bartlett, August Burns, PROCOSI. SCF: Wendy Slusser, Loren Galvao, Monica Ortega, Karen Le Ban</p>	<p>Analyze scopes of work: expectations at central level and at impact area level. Interviews w/ SC/B staff.</p>	<p>Elsa Sanchez Lisa Howard</p>

Based on the previous evaluation design, the following work plan was developed:

Monday	6	Planning Meeting
Tuesday	7	Preparation of work documents
Wednesday	8	Travel to Inquisivi Province. Afternoon meeting with SC/B area staff.
Thursday	9	Visits to the communities of Ventilla, Ojo de Agua, Corachapi and Chiji.
Friday	10	Work in Inquisivi: Interviews with SC/B staff, community authorities, traditional midwives, and MOH staff. Review of indicators and of the DIP.
Saturday	11	Travel to Licoma. Visits to the communities of Espiga Pampa, Pencaloma and Lacayotini. Meeting with Licoma women's group.
Sunday	12	Work in Licoma: interviews with SC/B staff, community authorities, traditional midwives and MOH personnel. Review of manual HIS instruments (Roster, Women's Health Card, Supervisors' Consolidated Roster).
Monday	13	Travel to Circuata. Visits to the community of Lujmani, interviews with traditional midwives, meeting with women's group in Circuata. Return to La Paz.

Information was obtained during the field work in the following manner:

1. Review of Documents and Other Secondary Sources

The review of rosters, work notebooks, register lists, planning documents, and educational protocols allowed an evaluation of the degree of work performed in the project area. This led to the formation of a series of initial suppositions to be confirmed through community visits and/or beneficiary interviews.

2. Focus Groups with Participating Women's Groups

A series of meetings was held with community women who had taken part in the autodiagnosis and training in maternal health. In these meetings the idea was to obtain first hand information on the women's opinions (and later, the opinions of their husbands) on the

process followed since the beginning of the project. In addition, data were obtained on the degree of understanding of basic elements covered during the community training, problems faced during the first phase of the project, and the management of community information. Annex 1 contains the thematic guide prepared to facilitate the Focus Group.

3. Meetings with Traditional Midwives

In each of the zones visited (Inquisivi, Licoma, and Circuata) a meeting was held with midwives trained by the MotherCare project. In these meetings, the objective was to find out the midwives' point of view on the project, as well as the knowledge, attitudes, and practices internalized through the training sessions. This information was complemented with anecdotes and references to their work, and the way in which the new vision had been put into daily practice.

4. Meeting with Local Authorities

The information obtained was complemented by the appraisal of the various community authorities (General Secretaries of the Agrarian Syndicates) on their knowledge of the project, the progress to date, and their suggestions for improvement. Annex 1 contains the guide used to facilitate the meetings with local authorities.

5. Interviews with Project Staff and MPSSP Personnel

Annex 1 contains a semi-structured guide which facilitated the interviews held with team members involved with the MotherCare Project. Information was obtained on group dynamics, their participation in the activities developed in the initial phase, and their opinions and suggestions on to optimize their work. The interviews with MPSSP personnel permitted a characterization of the present state of interinstitutional relations.

6. Selection of Communities Visited

Communities to be visited were selected on the basis of having a sample from each of the three zones in which the project works (Inquisivi, Licoma, and Circuata), and taking into consideration communities where the project was advancing without problems and exhibiting outstanding results, as well as those in which there were reported to be difficulties or not very significant advances. The selection was tentatively made during the first team planning meeting, and finalized during the meeting in Inquisivi with the entire project staff. The following is a map which shows the MotherCare project area, noting the communities visited by the evaluation team.

III. RESULTS

The following are the results of the MotherCare Mid-Term Evaluation presented according to the order established during the planning meeting. The results are summarized in the table that precedes this section.

A. PROJECT STRUCTURE AND CHARACTERISTICS

The organic structure of the MotherCare project has passed through two distinct phases. The first had as its principle characteristic that the project was defined as autonomous from the other SC/B projects carried out in the impact area. Its organic structure responded solely to the demands of MotherCare activities; for this reason its structure was represented in the following manner:

- A half-time MotherCare project director based in La Paz, whose functions were to guide project field personnel, coordinate technical assistance, and serve as the contact person with the MotherCare Project staff in Bolivia and Washington, DC.
- In the impact area, the greater responsibility fell to the Project Coordinator, contracted for full-time work. Her activities were technical training and supervision of field staff; relations with MPSSP authorities in the Tres Cruces District, and the collection and analysis of community health data.
- The field educator, whose responsibilities were the organization of women's groups and the development of leadership abilities within the groups; implementation of training materials and methodologies; and support to field supervisors. These functions were not fulfilled by Sra. Yoland Pabón, who did not develop educational materials; she dedicated herself more to organizing the women's groups and supporting the field supervisors.
- The three field supervisors were responsible for the implementation of the activities in the communities, including organizing the women's groups in the 25 communities with the help of the Educator; facilitating training sessions for the women's groups; and supervising maternal health interventions such as prenatal care visits, T.T. vaccinations, safe birth practices, vitamin A distribution, and family planning visits by SOPACOF.
- Lisa Howard-Grabman provided technical assistance and administrative support for the project staff. She is an integral part of the team in the project design and implementation.

This first stage in the organic structure allowed the start-up of the project, making possible the identification of MotherCare with women's activities related to their reproductive health.

The second phase of the MotherCare project in relation to its organic structure began as a result of the mid-term evaluation of the SC/B Child Survival projects. The resultant recommendations defined a new strategy of "DJC presente" whose principal characteristic is the permanence of SC/B personnel in the communities. To accomplish this, all of the SC/B projects were defined as constituent parts of the whole. This signified that there did not exist isolated projects and that all personnel should participate in the activities of the entire SC/B program. The role of field supervisors was modified to that of integrated supervisors with responsibilities in Child Survival, MotherCare, and Sponsorship. Groups of communities were redivided among the field supervisors and "Health Fairs" were initiated in the communities. Planning was based on the criteria of meeting the "missed goals" with interventions in the communities. As a result of these recommendations, a new organic structure was devised which fit into the new strategy. This consisted of:

- A MotherCare quality circle was formed in La Paz where the follow-up of the project was planned and defined. This quality circle consists of David Rogers, Lisa Howard-Grabman and Guillermo Seoane and meets weekly. A Health and Nutrition Advisor was hired to develop the follow-up for the Child Survival and MotherCare projects.

- In the Impact Area, a second quality circle, consisting of the Impact Area Manager, the Child Survival Coordinator, the MotherCare Coordinator, and Impact Area Administrator, is in charge of implementing all the SC/B programs in the impact area (Child Survival, MotherCare, Sponsorship, Micro-Irrigation, Woman/Child Impact, etc.) The field coordinators are also integrated health coordinators: Elsa Sánchez is the Child Survival/Maternal Health Coordinator for the Circuata and Licoma zones, and Adolfo Martínez for the Guime and Inquisivi zones.

- There is also a quality circle in each zone, made up of integrated field supervisors, who have responsibilities in Child Survival, MotherCare, and Sponsorship. These quality circles implement the programs in the community, where their participation with the community members on a day-to-day basis and should be related to the priority problems. Each supervisor has a number of communities, where (s)he remains for 2 or 3 days bi-monthly, and develops the integrated health fairs together with the community leaders, promoters, and midwives.

Parallel to these activities, the autodiagnosis with women's groups is carried out, as well as training of groups of women of reproductive age in such themes as: breastfeeding, with emphasis on colostrum; nutrition during pregnancy and post-partum; hygiene; clean birth; and immediate attention to the newborn. Training is also given in the preparation and use of safe birth kits.

The principle characteristics of the MotherCare Project to date are:

* The realization of a Case Control Study on Maternal Mortality, Neonatal Mortality, and Perinatal Mortality in the project work area which represents a reliable source of information on the problems and symptoms associated with maternal and neonatal health.

* The autodiagnosis, on the basis of its initial 10 step methodology, made it possible to gather information on the knowledge, attitudes and practices of women in 25 communities with regard to maternal and neonatal health. The transfer of knowledge to community groups of women was done in such a manner that the women themselves can find solutions to their priority health problems. A workshop held at the end of February, 1992, revised the autodiagnosis, reducing it to 9 steps. This new methodology will be used in the next twenty five communities in which the autodiagnosis will be developed this year.

* High risk protocols and algorithms were developed to be used by women and family members, midwives, and health personnel in the communities. The objective is to aid in the identification of women at risk and to provide community and health workers with appropriate actions to take should complications arise. The work done in this area by consultant August Burns was revised and made more consistent.

* As for the development of IEC materials, the autodiagnosis has employed educational materials based on the illustrations and silhouettes used with the "health flag." Videos and sociodramas on clean births have been used. Nevertheless, these do not constitute adequate educational materials, leaving the information, education, and communication activities pending.

* To aid in local home-based health care, the intent was to design a health card for women of reproductive age. This would make it possible to maintain a constant register of the women about their reproductive cycle, which would be used by the women and allow them a certain degree of control over information related to their own reproductive health. The women's health card has passed through two steps. The first design was based on figures, whose intention was to correlate the months of pregnancy with complications during those months, as well as give birth and post-partum information. The validation of this first attempt showed that it was complicated, insufficient, and did not give the woman the idea of the reproductive health process. The second format corrected these errors, having been reformulated on the basis of constant feedback within the quality circle. The validation of this second format, and training the communities in its use, remains to be done.

* The Women's Health Roster is being used in the communities. In spite of promoters and/or midwives having been trained in its use,

the management of this roster has proved to be complicated and in most cases it is the field supervisor who manages it. A consolidated roster has been developed which is being used by the field supervisors.

* The cooperation with the Ministry of Social Welfare and Public Health (MPSSP) on both the local and national levels has followed an uneven path. In the last few months, the follow-up of this activity by the La Paz Health Unit has been more constant since the signing of an agreement with SOPACOF; the participation of the Health Unit in the mid-term evaluation; and the coordination with District Director and MPSSP doctors in the area of maternal health to improve prenatal care, Tetanus Toxoid vaccinations, and patient referrals.

* In regard to family planning, the project has been developing in a steady manner for the past three months; the services that have been delivered have been well received; and this has caused a rising demand among women for family planning services.

Conclusions

In conclusion, it can be said that the organic structure of the MotherCare project fits into the "DJC presente" strategy. It has adapted to the more horizontal structure of the different projects in the impact area. Thus, MotherCare personnel participate in Child Survival and Sponsorship activities. They also participate in quality circles where they discuss and look for solutions to the problems that face the various projects. By observation during the trip to the impact area, this new structure is better adapted to the institutional requirements of SC/B, and makes possible a greater understanding of, and responsibility to, the MotherCare project on the part of SC/B personnel.

The principle characteristics of the MotherCare project have followed the lines laid down in the Detailed Implementation Plan (DIP). The expectations originated in the use of new methodologies - the case control study and the autodiagnosis - identify the MotherCare project as innovative, with possibilities of replication in other institutions. In general, the project has advanced according to the time frame. Nevertheless, the delay in the preparation of educational materials (IEC) is worrisome.

Recommendations

1. Consolidate the integrated relationships among the various projects so that the MotherCare Project can have a broader horizon of possibilities. To do this, it should be integrated with the Child Survival and Woman/Child Impact projects, through the integration of the quality circles (La Paz, Impact

Area Administration, and Integrated Field Supervisors.)

2. It would be worthwhile to train the personnel in the management of total quality circles, to make possible joint and integrated planning of all SC/B activities.
3. All staff should be given the manual of job descriptions and functions, based on the criteria elaborated in a SC/B workshop and specified in the DIP, so that personnel clearly understand their functions.
4. It is essential that a person or team be contracted to advance the design and implementation of the educational materials and methods (IEC).

B. PROJECT PERSONNEL

In order to arrive at a clear understanding of the dynamic among project personnel, a series of interviews was held with each project member in the three zones where the MotherCare Project works. Those interviewed were:

* Carlos Loayza	Impact Area Manager
* Wilson Rivero	Impact Area Administrador
* Adolfo Martínez	Child Survival Coordinator
* Elsa Sánchez	MotherCare Coordinator
* Fanny Alavi	Field Supervisor
* Martha Calla	Field Supervisor
* Adela Calisaya	Field Supervisor
* Bismark Ortiz	Field Supervisor
* Macario Laura	Field Supervisor
* Luis Laime	Field Supervisor
* Máxima Asistiri	Field Supervisor
* Lourdes Checa	Field Supervisor
* Romelia Antonio	Field Supervisor
* Victor Hugo Taboada	Field Supervisor

Firstly, it should be stated that the project personnel have passed through a period of instability that affected the rate of progress at the beginning of the project. The roots of this problem can be traced to the mid-term evaluation of the Child Survival III and V projects, during the second half of 1991. The recommendations regarding personnel that emanated from this evaluation pointed in two different directions. On one hand, it was suggested that the health staff be fused into one health team because at that time, they were found to be working in an isolated manner: one group with Child Survival and one group with the MotherCare Project. This supposedly created additional work and more than a number of times, lack of communication between both teams. The second recommendation had to do with the operations of the field staff in the community. Until this time, the presence of the Field Supervisors in the community was insufficient and this created innumerable problems. The evaluation recommended a change in the strategy so that Field Supervisors would spend more time in their work areas.

It is noteworthy that SC/B has implemented the suggestions of this evaluation, thereby demonstrating its volition to improve the results of the project and to optimize its human resources in the field. However, this decision had repercussions in the behavior of the staff. Firstly, those who were not in agreement with the idea of reform left the institution, which meant a loss of trained personnel with field experience in the area, and in addition, meant that new staff were needed. Secondly, the new strategy demanded a number of small administrative adjustments that had to do principally with the subsistence of the staff in the communities.

Presently, the health staff form one team in order to execute both activities; those of Child Survival and those of MotherCare. Notwithstanding, the fact remains that those who were involved initially with one project or the other, continue to prioritize their actions in detriment to overall coordination. It should be added that the staff originally assigned to Child Survival did not receive, according to them, sufficient training in order to pick up their new responsibilities in the MotherCare Project. For example, this was the case with the autodiagnosis.

RECOMMENDATION. With the objective of trying to facilitate the internal coordination of the health team, a series of meetings of analysis, discussion and training in program objectives, purposes and strategies that are common to both Child Survival and MotherCare projects. This recommendation is worthwhile following every time there is a good proportion of staff turnover in the different areas.

The predominant work experience of the new project staff is clearly oriented to more clinical work. This observation justifies the realization of systematic educational activities with special emphasis on Primary Health Care.

RECOMMENDATION. The project should select a series of themes considered as priorities by the staff, with the end being to solidify their training through continual training. Some of the themes solicited by the team were: Popular Education, Community Development and Crosscultural Communication.

Likewise, the team has notably increased its presence in the communities. Each Field Supervisor is responsible for a predetermined number of communities (generally between 6 and 8) in which they carry out all of their responsibilities. This strategy, according to the Supervisors, though it signified greater personal sacrifice, has yielded evident advantages to the communities involved in the work.

RECOMMENDATION. Given the specific nature of the work of the Field Supervisor in the communities, his/her job should try to be standardized so that the impact achieved in the communities is basically comparable. Staff training could play an important role in this.

RECOMMENDATION. The institution in general, and the MotherCare Project in particular, should place special emphasis on facilitating solutions to the problems of housing and diet which resulted from the new strategy of permanence of the Supervisors in the communities.

During the interviews with the staff in Inquisivi, one could clearly observe the felt need for more frequent feedback and support from the MotherCare Field Coordinator who is now based in Licoma and who evidently reduced her number of visits to the higher zones.

RECOMMENDATION. The MotherCare Field Coordinator should increase her links with Inquisivi Zone in order to attend to the staff's specific requirements for timely technical assistance and feedback.

SC/Bolivia recently initiated an administrative strategy based on decision-making in work teams called "Quality Circles". These circles permit analysis and solutions to problems at different levels. Although this new form of administrative organization has not yet demonstrated its value, the staff have shown their willingness to work in this mode and are optimistic about this approach.

C. TRAINING/EDUCATION

Although it is certain that the educational component has not yet occupied an outstanding place in the project, it is evident that in this new phase, it will merit special attention. Every time that communities have finished the autodiagnosis they tell of their hopes to take more directed action to find solutions to the identified problems. From this point on, a large part of the solution will come from education and training.

One should say, however, that the actual process of the autodiagnosis carried out by women's groups has played an important educational role because it brought about reflection and debate over topics that are weighted by a series of prejudices, distortions and beliefs that promote troublesome practices.

Training of Women. During the evaluation, ten women's groups were visited and focus groups were conducted in order to ascertain ideas, concepts and knowledge assimilated by the women during the first phase of the project. Although it was evident that the groups that were interviewed showed a heterogeneous benefit probably due to the lack of standardization on the part of the Field Supervisors, it is certain that the women, in general, demonstrated that they possess basic notions about problems of maternal health and about safe birth.

It was clear that they had received some central concepts through one course on safe birth. It was interesting also to note a change in attitude in many of the women and to perceive differences between the conditions that surround their births, before and after the analysis of the treated problems.

Perhaps the most notable effect was the increase in their motivation to continue to learn more about this and other topics related to the daily problems of the peasant woman. This remains reflected in the constant need of the women for a greater and constant provision of courses in order to deepen and broaden the knowledge gained to date.

RECOMMENDATION. It is probable that the level of motivation reached by the women is due in part to the process which permitted a profound reflection on the real need. For this reason, it is advisable to continue as soon as possible with training activities which will prevent the decline of collective interest in the topic of maternal health.

The most striking result of the meetings held with the women was their evident interest in themes related to family planning. This interest extends to their husbands who feign economic reasons in order to justify their interest in the topic.

RECOMMENDATION. It would be advisable to intensify community training in family planning. For this, coordination with SOPACOF should be strengthened and close supervision of the implementation of training should be SC/Bolivia's responsibility.

Training of Empirical Midwives. Complementary to the focus groups held with women, the team also held informational meetings with empirical midwives from different communities. These meetings were conducted in the three zones: Inquisivi, Licoma and Circuata.

The midwives informed the team of their educational experiences with the project and were in agreement that it was very useful, especially in the specific content of prenatal care.

Table 3. Summary of the beneficiaries of safe birth training

SAFE BIRTH TRAINING			
	MIDWIVES	OTHERS	TOTAL
INQUISIVI	6	4	10
LICOMA	6	5	11
CIRCUATA	4	4	8
TOTAL	16	13	29

Table 3 takes into account the information available from the project about the number of people trained in safe birth. Note that included under the category "others" are young women who are interested in becoming midwives.

RECOMMENDATION. The midwife training activities include exercises in theory as well as in practice; however, data are lacking in follow-up of the midwife's actual work. This uncertainty obliges us to recommend that alternatives be sought which permit a more careful monitoring of the impact of these training activities. Perhaps it would be interesting to look at--through better coordination with the Area Health Posts-- whether midwives could bring their pregnant clients from their community to prenatal care at the respective Health Post/Center. This would permit the midwives to be exposed to additional instruction from the area doctor during the process of the prenatal care visit.⁽¹⁾

¹ Vale la pena hacer notar que existe una clara tendencia de las mujeres embarazadas a someterse al control prenatal en el Centro de Salud, debido a la vigencia de un programa de distribución de alimentos a la embarazada, implementado por el

Training of the Husband. Almost invariably the husbands participated in the safe birth training activities planned by the women. The usefulness of this is evident: in all of the visited communities, it is the husband who is usually responsible for attending the delivery of his wife; this is due to the fact that it is the husband who is usually the closest when the moment arrives. There are also other cultural and moral reasons. What is certain is that to involve men in this type of education has been one of the most outstanding initiatives of the MotherCare Project. This involvement, in a sector that is more timid and cautious than others, can also facilitate the treatment of other topics of interest to the family, complementary to that of maternal health or that of family planning.

RECOMMENDATION. The project should look for ways to develop complementary training activities that include men and women or that integrate the treatment of aspects that pertain to women in men's training activities.

Training to Improve the Management of the Roster. The interviews held with midwives to analyze the management of the Health Information System led to the discovery of large deficiencies in training materials for the management of the roster. Although this topic will be discussed in more detail in the chapter which refers to the Health Information System, it is presented here simply to say that in order to be effective, whether it be the Women's Health Card or the Women's Health Roster, the use of these materials must be accompanied by intensive and supervised education and training.

RECOMMENDATION. It would be advisable to simplify the materials and the procedures, even if these materials are to be used by Field Supervisors. Practical training is an indispensable requirement in order to assure good compliance from staff responsible for the HIS.

Training of SC/Bolivia Staff. In the section dedicated to analysis of personnel problems, the staff's need to receive complementary training in diverse topics was discussed. It is important to note that the criteria which were used during the autodiagnosis differed many times by quite a bit from one community to another. This divergence was due basically to the fact that while some Field Supervisors were very well trained to carry out the autodiagnosis, others, especially those who initially worked only with Child Survival, demonstrated an uneven methodological formation.

We have already mentioned the need expressed by many of the staff for complementary training in topics such as Community Development, Nonformal Education, Community Organization and Participation and others that will help to improve the staff's ability to deal with

problems in their assigned communities.

RECOMMENDATION. The institution and the project should create an ongoing mechanism that keeps staff up-to-date on topics that they require given their professional/work circumstances.

Training of MPSSP Staff. The evident improvement of interinstitutional relations between SC/Bolivia and the MPSSP now permits joint planning of numerous activities of common interest. Training is a requirement that was detected in the different Health Posts as well as by SC/Bolivia staff. In other words, the Health Post staff have asked the Field Supervisors for training in certain topics that are not necessarily included in the project's activities, but are of interest to the Health Unit of La Paz. The project is developing activities that are of interest to the doctors as well as to the auxiliary nurses and that are not contemplated as functions of the Health Center, but that are of interest to the staff for personal reasons.

RECOMMENDATION. Given these circumstances, it would be advisable to solicit help from the Health Posts and Hospital for the training activities to be developed for SC/B MotherCare staff. In this way, the area doctors and District Health personnel would be required to analyze the norms and policies of the MPSSP in primary health care, with the objective being to facilitate the work of the Field Supervisors according to the dictates of the Health Sector.

Considerations about Training Methods. The characteristics of the target population for training are sufficiently particular as to select didactic methods used by the project. The majority of the women involved in the working groups are illiterate and there are few who are fluent in Spanish (particularly in the higher zones). Consequently, the methodology that is often reverted to is restricted. Perhaps this is the reason for the prevalence of the "talk" over other more participatory options.

In the talk, the audience passively receives an explanation, usually accompanied by static images presented in a flipchart. The lack of feedback that characterizes this procedure constitutes one of the principal obstacles to learning. Its verbal preeminance favors uniquely verbal learning that has little to do with the expression of knowledge or new behaviors.

In the context of the project, there are few Supervisors who transcend the "talk" as a basic method for training.

RECOMMENDATION. The institution and the project should encourage the adoption of methodologies that are more participatory, aiming to fit the contents to adult learning needs. Adult education should be above all,

learning by discovery through participatory and horizontal actions that value the experience of the learner. Likewise, the adult can learn within the context of his/her daily life or, be able to learn by "doing". These characteristics are far from the "talk", for which the staff responsible for training should substitute with methods of greater didactic utility.

The methodology developed for training should be conditioned by the nature of the indicators of learning. It should be noted that the goals proposed by the evaluation of training in the roster contemplate only the number of trainees, number of training sessions, quantity of workshops imparted, etc., and make no reference to other types of indicators relative to the quality of learning or its impact in the sphere of daily behavior in relation to health.

RECOMMENDATION. Therefore, training objectives should be carefully reviewed, fit into categories of desired behaviors and the training methodology and strategies should be adjusted in order to achieve the new objectives.

One important aspect related to education/training in the project has to do with educational materials and other didactic support. It should be noted that the most adverse part of the evaluation by the project staff themselves was regarding the lack of training materials. This is a recurring need, and constitutes a deficiency that has been able to affect the educational achievements in the sectors involved in the training in maternal health. This deficiency was also mentioned by the community sector (women's groups) and also by the midwives.

RECOMMENDATION. It is necessary to begin the production of educational materials for the project as soon as possible. Above all, staff should insist that this production be carried out in the participatory spirit of the MotherCare Project, in spite of the fact that this may signify delays in implementation.

One should not lose sight of the time that it will take to design, test, validate and produce the didactic materials, the result being so much time as to limit follow-up of the materials before the end of the project. In this case, it would be lamentable not to have precise information about the impact of the materials prepared about women's health and on the work of the midwives.

CURRICULUM REVIEW

Traditional Birth Attendant Curricula

Curriculum No. 1 Nov. 1990 - 2 days
 June 1991 - 2 days

- . Prenatal care
- . Safe birth
- . Follow-up postpartum
- ✓ Detection of high risk

The curriculum should be much more detailed. For example:

- The objective should be more specific.
- The methodology to be used should be described in more detail. If "participatory", how?
- The materials to be used are listed, but how are they used? Did the women understand and like the educational materials?
- The technical content should be more detailed. For example, if nutrition is one topic, what is included in nutrition education? (for example: major food groups, adequate liquid intake, use of locally available foods, etc).

Other topics that could have been included in this session are important, such as: changes in fetal movements, warning signs of preterm labor (be specific here). All the high risk signs stated in this curriculum should be described in more detail, what was actually taught to the women?

At the end of the sessions, the messages given should also include changes in fetal movements, nutrition education, TT immunization, and the importance of breast-feeding. It is during prenatal care that education about breast-feeding should start.

In the safe birth component, specify how the birth kit should be used. How should women be educated about it?

Curriculum No. 2

- . Evaluation,
- . Information about Autodiagnosis,
- . Safe Birth Techniques,
- . High Risk Signs,
- . Family Planning and
- . Roster Management.

The same comments as above for Curriculum Number 1 apply here for objectives, methodology, educational materials and technical contents.

For example:

- **Methodology:** participatory, how?
- **Information about autodiagnosis:** should be more detailed.
- **Family planning:** what kind of information was provided about each contraceptive method?
- **Safe birth techniques:** what kind of information was provided?

RECOMMENDATION: The curricula should be designed in a more detailed format concerning objectives, methodology, educational materials, and technical content. If not possible to contract a volunteer TBA, technical assistance will be required for curriculum development.

D. LOCAL ORGANIZATION AND PARTICIPATION IN THE PROJECT

This section on community organization and participation in the project should consider the following aspects: first, the relationship of the project with the legitimately constituted local authorities; second, the nature of the women's groups that serve as a model for the MotherCare Project; and, finally, it is worth commenting on the situation of the midwives convened by the project.

In relation to the first point, in two of the zones visited (Inquisivi and Licoma), there were formal meetings with the community authorities in order to evaluate the political relations of the project. The background to this evaluation was the mid-term evaluation of the Child Survival Project, in the sense that, on that occasion, the relations of the authorities with the project were not precisely the best. At that time, one noted the lack of knowledge of the authorities about the nature and characteristics of the project. Presently, the situation has reverted noticeably. The General Secretaries of the Agrarian Syndicates demonstrated knowledge of the details of the MotherCare Project and showed their pleasure with the form in which it is developing. The reason for this attitude can be attributed to the initiative of the project to train the authorities in the general aspects and perspectives of the project. Likewise, many of the authorities also participated in the safe birth training, together with their wives.

Being excessively suspicious, one could presume that the information offered by the General Secretaries was biased because no negative or critical points could be found. In this manner, one could argue that by reporting only the positive, the authorities tried to obstruct whatever institutional decision might be made against the continuance of the project. However, we should recognize that whatever action destined to conserve the support of the institution or of the project carries an implicit favorable evaluation of the institution or the project.

RECOMMENDATION. The practice of informing the authorities constitutes a strategy in order to obtain political support for the project and the institution which sponsors it. For this reason, it is advisable to maintain this support, involving on a permanent basis those formal levels of local decision-making.

In relation to the organizational nature of the women, we encountered two clearly different structures: the groups formed with the purpose of working in the project and those already formed from other circumstances that were taken advantage of by the MotherCare Project. The characteristics of the formation of the women's groups has important connotations in the perspective of these groups. A group already formed can guarantee a series of actions and decisions that are favorable to the project; on the

contrary, a new group may pass through seemingly unending difficulties before adapting a solid base to the actions of the project. On the other hand, the stability of the group constitutes a facilitator of sustainability of actions promoted by the project. It is clear that membership participation in the groups is increasing. Table 4 below from Licoma Zone is illustrative of this tendency.

RECOMMENDATION. Strengths and weaknesses of each group should be identified with the purpose of developing support activities oriented at strengthening them. This will reiterate the benefit of the project to have established a firm base upon which to receive its benefits.

Table 4. Participation in Women's Groups in Licoma Zone Beginning of Project and Present

ZONE/COMMUNITY	NO. MEMBERS AT BEGINNING	NO. MEMBERS AT PRESENT	INCREASE (%)
LICOMA ZONE			
Alfagiani			
Charapaxi	11	13	18%
Cheka	28	29	4%
Espiga Pampa	11	15	36%
Lacayotini	24	29	21%
Licoma	13	17	31%
Pencaloma	6	32	433%
Pulchiri	10	23	130%
Rica Rica	13	17	31%

One should also warn, however, that many of the already formed groups come from the tradition of food donation and because of that, they bring with them their particular perspective of community participation. It would be advantageous not to lose sight of this fact, because it can be converted into a great antagonist to the sustainability of the project's actions.

RECOMMENDATION. It is important that the women's groups search for continuity in their actions, evaluating alternative strategies to those of food donations. This would mean that the project would permit careful study of mechanisms for income generation and other strategies with better survival value.

Finally, we should point out that the MotherCare Project is supporting in a positive manner a grassroots organization based in

the zone of Circuata. There, the midwives involved in the project have formed a Syndicate (Association), which has as its main function the defense of the members' interests. Although there are not yet any elements to evaluate, it is recommended that this group's development be closely followed and supported with technical assistance.

E. AUTODIAGNOSIS

The "Autodiagnosis" is a problem identification and prioritization exercise that was developed by SC/Bolivia for the MotherCare Project with technical assistance provided by John Snow, Inc. and the Manoff Group, Inc. It is an on-going activity that allows both the community and SC to learn about how women perceive maternal and neonatal health problems and how they respond to them. Consistent with SC's participatory, community-based methodology, this process draws on basic concepts of facilitating the exploration of experiences, attitudes and practices. Whereas, in the case-control study the interviewers sought specific, quantifiable data, in the autodiagnosis there are no "right answers", only what the women themselves believe and understand. In addition to raising women's awareness of specific maternal and neonatal health problems, a major goal of the process is to foster the women's confidence in their ability to gather information from their neighbors about topics that concern the community and to learn to prioritize the problems that are identified.

For the women, the specific objectives of the autodiagnosis are to:

1. Define, identify and recognize common maternal and neonatal health issues and problems at the community level;
2. Increase women's awareness of and motivation to act upon maternal and neonatal health problems at the community level; and,
3. Prioritize maternal and neonatal health problems as identified by the women in the community. The selected problems should be such that they are able to be addressed at the community level.

For SC Staff the objectives include:

1. Gain a better understanding of whether, how and why women attend to their perinatal health care needs; and,
2. Develop a basis for planning the interventions which will be implemented during the duration of the project.

For the Women and SC Staff together:

- Explore and generate ideas about maternal and neonatal health problems and develop trust and confidence between the staff and the communities.

There are ten steps to carrying out the complete autodiagnosis in a community. A brief summary of these steps follows (for a more comprehensive review, see Appendix 2).

- Step 1:** Explore attitudes of the group members toward pregnancy and maternity. This step orients and motivates the women to begin talking about and sharing their health problems.
- Step 2:** Orientation to Save the Children's Warmi (Woman, in Aymara and Quechua) Project. This step describes to the women's groups how the Warmi Project fits into other existing SC programs. The group members analyze past SC program accomplishments, successes and failures, and their community's participation in the process. The central discussion topic is maternal and neonatal health problems and the community's role in the search for solutions.
- Step 3:** Learn what the group members know and do about maternal and neonatal health problems. Using role play, this step demonstrates current knowledge, attitudes and practices during pregnancy, birth and post-partum. A pictorial dictionary of terms is developed to represent maternal and neonatal health problems. Women identify the specific problem in local Aymara/Quechua/Spanish terminology, what they believe causes the problem, what they do to treat the problem, and what occurs if the problem is not treated.
- Step 4:** Encourage group members to think about what other women in the community know and do in relation to maternal and neonatal health problems. The purpose of this step is to generate a dialogue between members of the group about their experiences by dividing the larger group into smaller groups of 8-10 women where they relate their own problems; judge how common their problems are; and, prioritize their problems as a group. Once again in the larger group, members are asked whether they thought their problems were similar to the problems experienced by other women in the community who did not participate in the group.
- Step 5&6:** To explore and design different ways to collect information from other women in the community. Individual women are encouraged to design ways to elicit more information from additional women in the community. The women's group defines the questions that will be

asked, and learns to use pictorial guides that help record the frequency of the problems. The pictorial "questionnaire" is validated by a trial run in the community, the women practice the interviews, and a calendar for visits is agreed upon.

Step 7: Implementation. The women go out into the community to conduct interviews with the "instrument" they developed in steps 5 & 6, visiting other women who have not participated in the group. The interviewee may be a friend or relative of the interviewer. Some women only conduct one interview, others as many as three or four. The interview is very open and may include some or all of the following questions:

- What do you see in this drawing? (the woman is shown the drawings of maternal and neonatal health problems)
- Have you ever experienced this problem?
- How did you treat it? Where did you go?
- How did your husband help you?
- Are there other women in the community who have had this problem?

Step 8: Share the results with the group. Once the interviews are completed, the women return to the group to share what they have learned. The quantitative results (whether the interviewee experienced the problem or not) are presented using a technique that SC uses in the child survival programs called Health Flag. The flag graphically shows the frequency of an event or intervention by having different colored columns for different results. For example, the red column signifies that a woman experienced a problem, and a small cut-out doll is placed in that column to represent the response. Women who do not experience the problem are represented by cut-out dolls placed in the green column. Qualitative results are also presented in group discussion facilitated by SC staff. (Note: in some communities, the placing of cut-out dolls in red, yellow or green columns was a reflection of interviewees' opinions of what priority problems were, and not necessarily a reflection of whether they themselves experienced the problem or not.)

To close this step, the SC staff presents a quick summary of the results from the case-control study. The women are very interested in learning more about the deaths that have occurred in the neighboring communities.

Step 9: Prioritize the problems. The SC staff discusses with the group what factors are important in prioritizing problems

(frequency, severity, community opinion, etc.). Using the health flag and the conclusions drawn from the discussions during step 8, the group decides which three problems it would like to work on at the community level. The group must reach consensus by the end of this step. A variation of this step was used in several communities: women prioritized problems within the different periods in which they occurred- i.e. during pregnancy, delivery, post-partum and neonatal. The result was four priority problems, one for each stage.

Step 10: Review of the Autodiagnosis Process. The group evaluates what it has learned, what it liked and did not like about the process, how it would change the process the next time, etc. The results from this step are used to improve the process in future communities.

To evaluate the autodiagnosis process and results, the following methods were used:

1. Focussed group discussions with 10 women's groups that had carried out the autodiagnosis in their communities.
2. Individual interviews with SC/Bolivia staff.
3. Review of community "autodiagnosis" notebooks kept by SC/Bolivia staff to document the results of each step.

Results

The autodiagnosis was carried out in the following 25 communities from March, 1991 to January, 1992:

<u>Inquisivi Zone</u>	<u>Licoma Zone</u>	<u>Circuata Zone</u>
Acota	Alfajiani	Circuata (2 groups)
Acutani	Charapaxi	Lujmani
Canqui Chico	Cheka	Miguillas
Caychani	Espiga Pampa	Polea
Chiji	Lacayotini	Villa Khora
Chuallani	Licoma	Villa Barrientos
Corachapi	Pencaloma	
Ojo de Agua	Pulchiri	
Ventilla	Rica Rica	
Yamora		

Table 5 presents the level of women's participation in the autodiagnosis by community and percentage of women of reproductive age participating in each community.

Table 5. Participation of Women in the Autodiagnosis

ZONE/COMMUNITY	# WOMEN OF REPRODUCTIVE AGE	# WOMEN PARTICIPATING IN AUTODIAG.	PARTICIPATION (%)
INGUISIVI ZONE			
Acota	49	28	57.14%
Acutani	29	22	75.86%
Canqui Chico	65	30	46.15%
Caychani	29	26	89.66%
Chiji	45	32	71.11%
Chuallani	23	N/A	N/A
Corachapi	31	25	80.65%
Ojo de Agua	25	N/A	N/A
Ventilla	N/A	N/A	N/A
Yamora	39	16	41.03%
LICOMA ZONE			
Alfagiani	21	11	52.38%
Charapaxi	32	16	50.00%
Cheka	31	10	32.26%
Espiga Pampa	32	24	75.00%
Lacayotini	17	10	58.82%
Licoma (Manzana)	35	6	17.14%
Pencaloma	19	8	42.11%
Pulchiri	26	15	57.69%
Rica Rica	25	12	48%
CIRCUATA ZONE			
Circuata 1 & 2	60	10	16.67%
Lujmani	26	15	57.69%
Miguillas	108	18	16.67%
Polea	40	19	47.50%
Villa Barrientos	52	12	23.08%
Villa Khora	94	20	21.28%
TOTAL PARTICIPATION	953	385	46.86%

Generally, the objectives of the autodiagnosis were achieved: common maternal and neonatal health issues and problems at the community level were defined, identified and recognized; women's awareness of and motivation to act upon maternal and neonatal health problems at the community level were increased; and,

maternal and neonatal health problems as identified by the women in the community were prioritized. SC/B Staff gained a better understanding of whether, how and why women attend to their perinatal health care needs; and, developed a basis for planning the interventions which will be implemented during the duration of the project. Women and SC staff did explore and generate ideas about maternal and neonatal health problems and developed trust and confidence.

There were some exceptions due to poor facilitation by new, barely trained staff. The difference in the level of awareness and understanding of the problems and interest in resolving them was striking between groups that had done a complete autodiagnosis with good facilitation and those that had not been facilitated well. When staff were well prepared and well versed in the methodology, the process often exceeded the team's expectations in terms of increased trust and confidence of the women to speak freely about such intimate subject matter. Thorough staff training is therefore extremely important.

The length of the autodiagnosis varied from two sessions of approximately 3 hours each (in communities where virtually all women of reproductive age in the community attended the sessions and therefore home visits were not carried out) to four sessions of approximately 2-3 hours each plus home visits over a period of one to two months. Though some women and staff commented that the process was long, they did not think that any steps should be omitted. During a workshop held in March, 1992 to review the steps, staff agreed that the process could be somewhat shortened by prioritizing only in the 8th step, not in the 4th. Several women commented that they felt that they needed more practice before the home visit interviews to increase their familiarity with the interview methodology and to gain confidence. Overall, results were better when groups met on a weekly basis rather than a biweekly or monthly basis. Weekly meetings helped to maintain the flow of the process and the enthusiasm of the group.

The steps that women particularly liked were the development of the dictionary of terms, home visit interviews and prioritizing problems. Many commented that this was the first time they had ever discussed these problems with other women and that they enjoyed being able to speak openly. This openness is reflected in the staff notebooks that document the process step by step. A sample of the results from several of the communities is included as Annex 3. These results are taken directly from the staff notebooks. Also included in Annex 3 is the newly revised version of the guide to the autodiagnosis.

The problems identified by the groups are fairly consistent with the problems identified by the retrospective case-control study (see Table 6). The demand for family planning services is also quite clear as can be seen in group priorities and in the responses

to questions during the first step when women are asked how they feel when they suspect that they are pregnant (if the baby is their fourth or greater, many hope that it will die). In response to this demand identified in the autodiagnosis, SC/Bolivia has given a small grant to SOPACOF, a local NGO that recently began to provide family planning services in Inquisivi Province in collaboration with the Ministry of Health. (See Interinstitutional Relations in this report.)

Table 6. A summary of the priorities as determined by the groups follows

Zone	Priority #1	Priority #2	Prior.#3
Inquisivi Zone			
Acota,	*	*	*
Acutani	*	*	*
Canqui Chico	(Notebook stayed in community- unavailable)		
Caychani	Too many children	Hemorrhage	Anemia
Chiji	Edema	Anemia	Sepsis
Chuallani	N/A	N/A	N/A
Corachapi	Prolonged labor	LBW	Sepsis
Ojo de Agua	Too many children	Hemorrhage	Sepsis
Ventilla	N/A	N/A	N/A
Yamora	*	*	*
Licoma Zone			
Alfajiani	N/A	N/A	N/A
Charapaxi	Too many children	Prolong labor	Sepsis
Cheka	Ret. of Placenta	Infection	Hemorrhage
Espiga Pampa	Too many children	Malpresent	Ret. Plac.
Lacayotini	Too many children	Hemorrhage	Malpresent
Licoma	Infection	Anemia	LBW
Pencaloma	Ret. Placenta	Edema	LBW
Pulchiri	Malpresentation	Hemorrhage	Edema/LBW
Rica Rica	N/A	N/A	N/A
Circuata Zone			
Circuata (gp.1)	Edema	Anemia	Hypother.
Circuata (gp.2)	Tuberculosis	Edema	Hemorrhage
Lujmani	Hypothermia (newb)	LBW	Tetanus
Miguillas	Too many children	Hemorrhage	Plac Ret
Polea	Edema (pre-eclam)	Hemorrhage	Malpresent
Villa Khora	Hemorrhage	Anemia	Malpresent
Villa Barrientos	Stillborns	Hemorrhage	Infection
* Did not select 3 top priorities, but prioritized by period of reproductive cycle (pregnancy, birth, post-partum, neonate). Top priorities respectively were:			
Acota:	Vaginal Infection, Malpresentation, Puerperal Sepsis, LBW		
Acutani:	Anemia, Malpresentation, Placental Retention, Tetanus		
Yamora:	Edema, Malpresentation, Placental Retention and Neonatal Tetanus		
=====			

The majority of SC staff were pleased with the process and with the results of the autodiagnosis. They commented on:

- the increased sense of trust and confidence that the women demonstrate in their meetings;
- the growing number of participants in the women's groups (e.g. Licoma's group grew from a core of five to over thirty);
- the growing interest of men in the communities in women's health problems;
- the change in focus from the role of "educator" to "facilitator" and how this is affecting their work outside of the autodiagnosis in a positive way, (also the difficulty that they had at first trying to implement the process because of its novelty and their previous training as "dispensers" of information);
- a better understanding of how the women perceive their problems and what they are doing to solve them;
- their belief that a good autodiagnosis serves as a basis for future problem solving and good relations with the community;
- the possibility of using photographs or slides to demonstrate maternal and neonatal health problems instead of the drawings, believing that they would be more realistic (2);
- the need for vigorous staff training in the methodology and philosophy of the autodiagnosis;
- their interest in using the methodology in other areas such as agriculture, etc.

- the fact that previous to the autodiagnosis many women

2 Using photographs or slides of actual cases is likely to be time consuming, costly and might not be culturally appropriate given the women's positions and lack of clothing that would be necessary to accurately portray some problems. The women in several groups commented that the drawings were sometimes "painful" to look at, indicating that they do provoke a reaction and that the women identified with them. In other groups, women asked that the drawings be made larger and that they be colored. This suggestion is more feasible and should be considered by the SC/B staff.

were not interested in learning to read or in income generation activities, but during the autodiagnosis, women perceived the need to learn to read to educate themselves about these problems and to generate income to pay for health services when complications arise (these interests were also stated in the women's group discussions during the evaluation).

Conclusion

The Autodiagnosis is not only a diagnostic tool, but the beginning of a process that enables women to identify and prioritize their community's maternal and neonatal health problems, and to address these problems. In order for the process to be effective, staff must be thoroughly trained in the philosophy and methodology. Experience in the first twenty five communities shows that the autodiagnosis increases women's awareness of, and interest in, their reproductive health problems. It also increases trust and confidence between the women and project staff.

Recommendations

1. Training all new personnel in the autodiagnosis methodology is essential. Previous staff members should also attend this training as a refresher. The training should cover the theoretical and philosophical aspects of the autodiagnosis methodology as well as a step by step review of all objectives and methods. The role of "facilitator" (not "educator") should be stressed. The training should include a practical, in-field component. As an observer/recorder, the new staff member should accompany a previously trained staff member when she carries out each step in a community. The new staff member should serve as the observer/recorder. After she assists with each step the team should reverse roles and the previously trained staff member should serve as the observer/recorder. The new staff member should be briefed on how to improve her performance during each step.
2. During the evaluation, it was evident that the implementation of home visits to interview other women was a key step in confidence building and in increasing the communication network among women. Some of the communities visited did not carry out the home visits because all of the women of reproductive age in the community attended the women's group meetings and there was no one left to visit. One community decided that it was important to visit other women and proposed to visit women from a neighboring community. They did carry out the visits with very positive results. This is one possible strategy, if the women in the group feel comfortable doing this. If a neighboring community is not possible, there are several other options. The women in the

group can break up into pairs and carry out more extensive conversations outside of the group; the women can choose to limit the process to working in smaller groups; a self-selected portion of the group can choose to carry out the interviews and the other women can be the subjects of the interviews. The strategy that a given group chooses will depend upon the particular situation and make-up of the group, but staff should be flexible enough to suggest different alternatives.

3. Though the process is long, women and staff believed that all of the steps should be maintained. One way to shorten the process is to omit the prioritization of problems within the group during the fourth step and do just one prioritization after the home visit interviews. (Small group discussion of problems and sharing of experiences during this step should be maintained as many women found this exercise useful and it appears to have strengthened communication and trust in several cases.) A few women's groups asked that the practice time before the interviews be increased so that they could gain more confidence in their ability to conduct the interviews. Staff should be aware of this possible need and should increase practice time if the women feel the need to do so.
4. Staff should better explain at the beginning the purpose of the autodiagnosis so that unrealistic expectations are avoided and practical guidelines are established. This can be done effectively only if staff themselves are aware of the objectives.
5. During the autodiagnosis, some women asked questions about what they should do if a specific problem occurs. Staff were advised not to enter into education at this point but tell the women that when the autodiagnosis is completed they would begin to analyze what they could do. This left staff and women feeling somewhat uncomfortable at times. One suggestion to deal with this problem was to keep a running list of questions that arise during the autodiagnosis that would be referred to when developing strategies to deal with specific problems. This way, the woman's question is not left hanging without acknowledgement, but is put on the agenda for future discussion.
6. SC/B staff are interested in varying the materials used in the autodiagnosis. Instead of drawings, they have suggested photos or slides that are more realistic. There are several potential problems with this. If real women are to be the subjects, it may take a long time to capture every maternal and neonatal health problem within the local context on film. Though the photos may be more realistic, they may also be more offensive to women, depending on how they are shot. It may

not be worth the time, effort and cost to do this. Instead, what might be more effective is to enlarge the existing drawings and color them.

7. According to our discussions with women during this evaluation, with one exception, women facilitators were preferred to men facilitators. Women should carry out the autodiagnosis with women's groups whenever possible.
8. SC/B will soon begin the autodiagnosis with men's groups in several communities. These sessions should be facilitated by men, given the experience above (#7) with women's groups.
9. In several groups that were visited, men appeared to be very interested in participating. Though this is positive in the sense that they recognize that maternal and neonatal health are important and that they want to learn more about these things, the end result may be that women's level of participation is reduced and overall confidence and trust is sacrificed. This would be unfortunate. SC/B staff should carefully study how to deal with this. One possible strategy would be to include men in specific educational activities on days that they are more likely to be able to meet and to hold women's group meetings exclusively for women on days that men are less likely to be able to attend. There is a delicate balance to be maintained here between support for the program by local authorities and husbands and the objectives of the groups themselves in terms of confidence building and women's empowerment.
10. Sessions of the autodiagnosis should be held as closely together as possible - ideally once a week for a month - in order to maintain the flow of the process.
11. The prioritization of problems was in some cases classified by period of reproductive life (i.e. pregnancy, delivery, post-partum, neonatal). This was done because it was difficult for the group to focus on problems of primary importance. When so many problems had to be considered, this is a good strategy to begin the prioritization process, but the group should proceed to the final step when the group should select the three highest priority problems from the full range of problems investigated.

F. MATERNAL HEALTH INFORMATION SYSTEM

1. Description of the Health Information System (HIS)

SC/Bolivia uses a health information system in its MotherCare Project and Child Survival V Impact Areas. The system consists of the following elements:

a. Family Registration

In February-March 1990- SC/B completed 100% registration in 58 new communities. The data included community, house, members of the family, their position in the family, sex, birth date, education and immunization status. There were also questions related to perinatal and infant mortality. The data were transferred to a computerized system in La Paz in March, 1990. The family registration was extended in February, 1991 and updated again in December, 1991.

b. Manual Field System

- i) **The Children Under 5 Roster.** Children under 5 years of age are registered in rosters which remain in the community and are constantly updated. These rosters are used for the child survival project and they are managed by health promoters. There is also an Under Five Health Card. The field supervisors visit each community periodically to supervise the health promoters' work and to collect vital events data and migrations.
- ii) **Women's Health Roster.** A women's health roster was designed and has been used since July, 1991. This instrument went through several reviews. It was originally designed to be managed by Warmi Project and Child Survival field supervisors. The women's roster records data on women's age, obstetric history, current pregnancy, prenatal, post-natal and newborn problems and care, referrals and educational sessions attended.

This roster has been used since July, 1991, however some problems have arisen with its use. They are the following:

- the women's health roster was originally designed to be managed by community health supervisors, so the literacy level and knowledge required to manage it are not the same as if managed by some illiterate or almost illiterate health promoters or TBAs.
- there is an excessive number of variables.
- some of the variables are not justified because they are not related to a specific indicator.

- definitions of perinatal mortality and neonatal mortality are unclear in the roster.

Presently, the women's roster is managed mostly by health promoters, but with very close supervision by the field supervisors. Some health promoters are actually unable to fill out this roster. In some communities, the TBAs are managing the women's rosters.

Informal interviews with TBAs, health promoters, field supervisors and health coordinators suggest that there is an urgent need to change the format and content of the Women's Roster. The problems most frequently mentioned are that the Roster is "too complicated", there is an excessive number of variables, "letters are too small", and definitions are unclear.

In this Midterm Evaluation, an extensive review of the Women's Roster was conducted with participation of field staff, TBAs and field supervisors. Recommendations for changes were made.

- iii) The Women's Health Card. The women's health card (see appendix 3) was developed in June of 1991 and it has been going through a lengthy review process since then. The evaluation team reviewed the women's health card, suggested some changes and recommended that the card should be field tested as soon as possible.

Furthermore, through focus groups during this evaluation, the women were asked if they thought it was relevant to have a women's card and what they thought would be important to include in the card. The demand for a women's health card was very strong and the variables that the women suggested that should be included were: uterine height, weight monitoring, risk factors in pregnancy and family planning.

- iv) The Supervisors' Tabulation Forms. For most SC/B health activities there are monthly supervisors' tabulation forms (quarterly for child survival project). The supervisors' forms aid in compiling data from individual health worker rosters.

The MotherCare Project recently developed a supervisors' form (February, 1991), which will be used by the supervisors on a quarterly basis.

The supervisors' form was also reviewed during this evaluation and suggestions for some changes were made.

- v) Guidelines for Supervision Instrument. An instrument developed by Dr. Monica Ortega during her last technical assistance visit is very comprehensive in order to help the

health coordinators to supervise the community health field supervisors.

c. The Computerized System

The data collected in the field were entered into a database program in La Paz. ProMIS, a computerized system which allows monitoring and evaluation of the project's progress, was installed in October, 1991. Since December, 1991 there were no staff to run ProMIS, so the system is not active now. Furthermore, the data from women's rosters and supervisors' forms are not included as ProMis variables.

2. Efficiency of the Data Collection Process

As mentioned before, there are several problems related to the data collection instruments. The evaluation team was able to retrieve from the manual system a series of quantitative data on maternal and neonatal health and nutrition that will be mentioned in more detail later. However, the evaluation team cannot know whether the data collection process has been efficient due to the problems with the instruments which are the basis for an efficient data collection. Alterations in the data collection instruments and intensive training of health promoters will be required in order to overcome these problems.

3. Measurement of Health Indicators by HIS

An extensive review of the maternal, neonatal and nutrition indicators that the Warmi project proposes to measure was conducted during this evaluation.

The HIS is able to measure several indicators, including some important impact indicators such as neonatal and perinatal mortality and other process indicators. However, it will not be effective and not possible to measure all the indicators with the HIS. Some indicators, such as knowledge indicators can be measured through a survey.

By reviewing the DIP, the team decided to cut a few indicators which were considered too ambitious to measure given the present constraints of the project.

Appendix 3 includes a list of the indicators that the evaluation team believes are realistic to measure and it also includes the instruments which will be used to measure them (HIS, survey, projects records).

4. Use of the Health Information System

- a) **By SCF.** Since November of 1991, health information collected through the HIS has been actively used by MotherCare Project staff to analyze problems and look for possible solutions. For example, by defining the communities that are at increased risk for a specific problem these communities can be targeted for more intensive attention. Furthermore, the health information has been used to develop quarterly plans based on the community health supervisor's tabulation forms.

Each community health supervisor develops his/her own plan, which includes interventions, expected results, activities, supplies and missed goals.

The health coordinator consolidates the data from the CHSs and develops her/his own trimestral plan. Every three months the health coordinator's quarterly plan is reviewed and discussed with Dr. Willy Seoane, Health and Nutrition Advisor and with Carlos Loayza, Impact Area Manager.

Monthly workplans are also developed from the quarterly plans and they have been proved to be very effective in planning project activities.

Interviews with the health coordinators suggest that since the development of monthly workplans and quarterly plans, a strong coordination among all the project staff (Child survival, sponsorship and MotherCare) has taken place. Furthermore, a greater exchange of information between projects is occurring because of these plans.

The populational pyramid will be developed by May 1992.

- b) **By the communities and women's groups.** Interviews with community health supervisors in Circuata demonstrate that the health information has been actively used by the community and women's groups. The health information here is used to positively reinforce the community, according to one of the promoters. In Circuata, one Saturday every month, community meetings are conducted. Generally, the community chooses a theme to be discussed and the health information on a given subject is shared.

In Inquisivi and in Licoma, according to the health coordinators, meetings to share health information with the community and women's groups are planned according to need approximately every three months.

One of the objectives from the DIP is to train members of syndicates, "juntas vecinales" and other men's organizations with particular emphasis on family planning methods. A few meetings have taken place since the beginning of the project. The next meetings that are planned would be excellent

opportunities to share health information with these community groups.

Annex 4 presents a synthesis of the statistical information collected during the evaluation on the principal indicators of the project.

Conclusions

The HIS is an excellent instrument to identify needs, to set priorities, to plan, to monitor and evaluate the program, to aid in decision-making, to define the community through baseline/census information, to supervise health workers, to add to the public health literature, to report and satisfy government requirements, to justify expenditures to self, agency and others, and to use data for future project proposals. From this extensive list, the MotherCare Project is benefitting from several elements. Some very positive steps were taken in the last months. Through the addition of quarterly plans and workplans, the project is identifying needs, setting priorities, and planning health activities. This activity started a few months ago and it seems that it has been a very positive experience.

The baseline-census information has been used by the project and data have been used to justify expenditures to self, agency and founders. On the other hand, there are some problems with the instruments for data collection, supervision of health promoters and field supervisors that should be dealt with immediately in order to strengthen the HIS. Furthermore, a new programmer was hired to maintain the computerized system.

The following are some recommendations that the evaluation team believes will strengthen the HIS.

Findings and Recommendations

- Finding 1: The women's roster was originally designed to be managed by SC/B field supervisors.
- Finding 2: There is an excessive number of variables in the women's roster.
- Finding 3: Some definitions such as perinatal and neonatal mortality are unclear in the women's roster.

RECOMMENDATION: One member of the team felt that the women's rosters should be managed by health promoters and TBAs, not by field supervisors. Other members believed that the roster should be managed by SC/B field supervisors due to its complexity (even in a

simplified form) and due to the probability that this will not be a sustainable community instrument, but one that will serve the Project's needs.

RECOMMENDATION: The MotherCare Project staff should discuss the suggestions given during this evaluation about alterations in the women's roster and fields test the new format as soon as possible. Suggested changes included the cutting of some variables, clarification of definitions and addition of pictures and bigger letters in the roster.

RECOMMENDATION: Train all the staff in the management of the newly formatted roster.

RECOMMENDATION: Continue to improve birth and death records.

Finding 4: The supervisor's tabulation form was developed in February, 1992. This form was also reviewed and some alterations were suggested.

RECOMMENDATION: To discuss with staff the alterations suggested by this team and to pretest the new form as soon as possible.

Finding 5: The guidelines for supervision of field supervisors have not been used regularly by health coordinators. This is an excellent supervisory instrument that would strengthen the management of the HIS.

RECOMMENDATION: The use of the guidelines for supervision of field supervisors should be a regular activity and could be included in the monthly workplan as one of the activities to be carried out.

Finding 6: Promis is inactive since January, 1992.

RECOMMENDATION: To update the computerized information. Promis should be technically assessed to determine whether and how to add other maternal and neonatal health variables, such as the Women's Roster of the manual system.

Finding 7: There has been some community feedback to share health information, however not on a very regular basis.

RECOMMENDATION: To strengthen community feedback to share health information through more regular community meetings. The team should also use also the syndicate, juntas vecinales and women's groups to share more health information.

Finding B: There was a recommendation from the Child Survival V mid-term evaluation to integrate the under 5's and the women's rosters to facilitate their use. This was not done because the women's roster is in the process of change.

RECOMMENDATION: To combine the under 5's and women's rosters as soon as the women's rosters are modified and field tested.

Additional Comments on the Health Information System

Designed for use by field supervisors, the Women's Health Roster is much too complicated for use at the community level by promoters and midwives. The SC/B team should carefully examine the need for the Roster and the rationale behind it. Other alternatives should be studied for their pros and cons. One possible alternative would be a family health record that would contain all the major family health indicators. This type of instrument would allow the promotor/supervisor/midwife to have a complete record of the family when s/he went to visit the household. There are pros and cons to this method as well. However, the point is to examine other alternatives for information collection and use and not to be committed to the roster merely because it already exists.

The women's health card is problematic. If it is truly to be used by and for women, the card must be simple. The latest version of the card is probably still too complex, though this must be tested. When women were asked what they would like to appear on the card, many asked for their weight gain during pregnancy, uterine height, date of birth of the baby, and monitoring of their menstrual cycles for the rhythm method of family planning. Only one of these appears on the current version of the card--the baby's date of birth. Weighing during prenatal care was the topic of much debate during the evaluation. Though weight monitoring is advisable in programs where food supplementation is available and where women come for prenatal care on a regular basis, it is not clear whether it is worth the investment to purchase the scales and in staff time in this context. If weighing actually acted as an incentive to come regularly to prenatal care, then it might justify the cost, but this also is not clear. One possibility would be to test pilot the concept in several communities to see if weighing makes a difference in overall attendance and satisfaction with prenatal care. If there was more time to study this and if there were fewer other activities to concentrate on, this would be an interesting operations research project. As it is now, this is probably not a priority, but something that might be worth looking at in the future.

5. Review of the Detailed Implementation Plan

An extensive review of the Detailed Implementation Plan was conducted in the field by some members of the evaluation team and field staff in Inquisivi.

There is clearly a need for reorientation of some strategies during the remaining time of the project.

The following are the findings and recommendations that were agreed upon among the evaluation team and field staff. (See Appendix 3 for the Detailed Implementation Plan including the recommended modifications).

OBJECTIVE I: Women's groups

- Finding 1: The autodiagnosis was successfully completed in 25 communities in February 1992. The next 25 women's groups are in the planning process.
- Finding 2: The document about the autodiagnosis is in the process of editing by Lisa Howard-Grabman.
- Finding 3: The IEC Strategy is 3 months behind schedule due to staff turnover and overall project delays.
- Finding 4: The focus groups with women during this evaluation provided the team with strong evidence that the women in the groups feel more comfortable working with women.

RECOMMENDATION: The IEC strategy should be developed as soon as possible. The staff will most likely contract (a) local consultant(s).

RECOMMENDATION: Due to cultural factors and gender identification, a strong preference should be given to women professionals to develop the IEC strategy, since women will be more sensitive to the women's needs.

OBJECTIVE II: Nutrition

- Finding 1: Monitoring the nutritional status of pregnant women by weight measurement and referral of the women identified at risk has not been started yet. The two main reasons are: first, though there are weight scales in the health posts in Licoma, Circuata and Inquisivi, it is geographically not possible for most women to come to the health post to have weight measurements as the communities are very far apart; second, there are no weight scales available in the communities for the health

promoters to use to weigh the women.

Finding 2: The focus groups with women surprised the evaluation team with a frequent demand by the women of the importance they see in having weight measured during pregnancy. Some groups recommended that scales should be bought for each community, so the TBAs and health promoters could weigh them.

Finding 3: The time remaining in the subcontract (14 months) is relatively short. If the team decides to go ahead with this objective, action should be taken as soon as possible.

RECOMMENDATION: Three options could be considered by MotherCare Project staff: 1) scales for 47 communities could be bought (there are 3 already for health posts, though one does not function well) and a weight plot graphic should be added in the women's card. This is the ideal option due to the strong correlation between mother's weight and the newborn's weight. However, the budget may not permit the purchase of the scales depending on overall project priorities and given the amount of time remaining; 2) the objective above mentioned could be replaced by a process oriented objective that would be more realistic to carry out due to the short time left in the subcontract. This objective could entail intensive educational activities on nutrition in pregnancy and use of available local food; or, 3) a pilot study could be conducted in some of the communities to determine whether the act of being weighed is an incentive for women to come to prenatal care.

Finding: The iodine intake objective is stated in the Spanish version but not in the English version of the DIP.

RECOMMENDATION: Add the iodine intake "inputs" and "outputs" in the English version.

OBJECTIVE III: Prenatal

Finding 1: The TT immunization objective is not included in the English version of the DIP.

RECOMMENDATION: Add TT immunization objective to the English version of the DIP.

Finding 2: The SC/B and local MPSSP Health Teams were already

trained in how to use the women's roster.

RECOMMENDATION: Since there will be several changes in the content and format of the women's roster, a new training session on the modified roster should be planned for the SC/B and local MPSSP health teams.

OBJECTIVE IV: Delivery

Finding 1: At the time that the training for men on safe birth was conducted, staff did not register which men were husbands of pregnant women.

RECOMMENDATION: From now on, every training session for men should be conducted for husbands of pregnant women.

Finding 2: The percentage of 20% of the women who are identified at risk during delivery and will have appropriate action was considered too low by the team.

RECOMMENDATION: The percentage should be increased to 30%.

Finding 3: The mothers of pregnant women usually do not live in the same area and generally come a few days before the delivery. This is considered a very hard-to-reach group.

RECOMMENDATION: To decrease the percentage of training on safe delivery to mothers of pregnant women to 10%.

Finding 4: Erytromycin ointment for the newborn has not been included in the birth kits because it is too expensive and the tube sizes available in the market are too big.

RECOMMENDATION: Use the revolving funds for the kits to buy erytromycin and investigate the local market for smaller tubes with lower prices.

Finding 5: Three hundred and five kits were prepared and distributed to TBAs in October, 1991. As of the present, 21 kids have been used. The output of utilizing birth kits for 493 deliveries is too ambitious because the intervention was delayed until October, 1991.

RECOMMENDATION: Due to the delay in this intervention the team recommends that this number should be decreased

to 246 deliveries accordingly to calculations of the expected number of births until the end of the project. This number still reflects 50% of deliveries, it is just over a shorter period of time.

OBJECTIVE V: Post partum care

Finding 1: The Vitamin A objective for women in post partum is not included in the English version of the DIP.

RECOMMENDATION: Add Vitamin A objective from the Spanish version to the English version.

Finding 2: The policy of the MOH is to have 3 post partum visits. The objective in the DIP states 1 visit post partum visits.

RECOMMENDATION: In order to conform with the MOH policies and also due to the strong relevance of the post partum visits, this objective should be changed to state that 50% of the post partum women should receive at least two post natal visits.

OBJECTIVE VIII: HIS

Finding 1: The women's card was developed in June, 1991 and it was being reviewed by staff in order to pretest it in the community.

RECOMMENDATION: Design the final form of the women's card and pretest as soon as possible.

X General Objectives.

Finding 1: The training in family planning methods for the MPSSP was delayed because the agreement between SOPACOF and the MPSSP was delayed until January, 1992. The training workshop is planned for May, 1992.

RECOMMENDATION: Conduct a training workshop for the MPSSP in family planning methods as soon as possible.

Finding 2: Until now, there have been meetings with syndicates, Juntas Vecinales and other men's organizations in 3 communities.

RECOMMENDATION: The team should strengthen the relationship with the syndicates, Juntas Vecinales and

other men's organizations. The evaluation team believes that for the time left in the subcontract it is not realistic to visit 40 communities, two meetings per year, so it recommends at least 1 visit in 30 communities.

Finding 3: The IEC activities have been delayed. The development of literacy materials will also be delayed.

RECOMMENDATION: Coordinate with the Women Child Impact project in the development of literacy materials focused on maternal and neonatal health and nutrition.

G. TECHNICAL ASSISTANCE

Since the project's inception, it has received technical assistance at different levels. In the following section, each technical assistance consultancy is described.

Mona Moore

Collaborated in the process of detailing the objectives and annual workplan for July 1990 to July 1991. The negative side was that Ms. Moore was not convinced of the value of the Autodiagnosis process.

Alfred Barlett

A very positive person, Dr. Bartlett supported the team with his theoretical and practical knowledge in the design of the perinatal and maternal mortality study. The negative side of his consultancies was that his scope of work did not include how to utilize the results of the study in the community.

Wendy Slusser

Very professional and capable, Dr. Slusser collaborated in the development of the Detailed Implementation Plan as an integrated member of the team.

August Burns

A person with much field experience with women's groups and midwives and good knowledge of the rural areas of Bolivia. Her work shed light on the definition of concepts and some treatments at the community level for problems during pregnancy, delivery and post partum. She worked with the team to develop the high risk protocols. Once the protocols were completed, she held a workshop with the health team in Inquisivi to begin the validation process.

Negative: Insufficient time to conclude the protocols for several other problems encountered in the autodiagnosis and case control study. Additionally, because of their absence from the province during Ms. Burns' visit, the Ministry of Health staff did not participate in the design of the protocols for the health post level.

Susana Barrera

Furnished the first steps for the design of the educational materials for the autodiagnosis, the community participation in the design, the validation and the utilization of the process of the autodiagnosis through training the SC/Bolivia

staff in how to lead focus groups and methodology of how to validate materials.

Negative: insufficient time to penetrate and practice the use of the steps and materials in the autodiagnosis.

Lisa Howard-Grabman

A person with a broad range of technical and practical knowledge of public health, collaborated in the development of the proposal and in the implementation of the project in the community, principally in the autodiagnosis. The coordination has been improving steadily during the life of the project.

Negative: She was absent from Bolivia for six months due to her pregnancy.

Conclusion

In general, the technical assistance provided to the project was good and useful for the MotherCare Project. The weakest part was the lack of time to explore in depth the contents/actions of each consultancy.

Recommendations

1. Consultants, whenever possible, should be professionals with experience in Andean countries, who speak Spanish and preferably have field experience.
2. Consultants' recommendations should be written in Spanish and should be based on local reality. They should be discussed with the field team before being implemented.
3. It is necessary for the consultants to know about the project in its totality and that their contracting permits follow-up, principally when their work is to carry out evaluations/studies.
4. The consultants who visit the communities should adapt to the sociocultural and educational characteristics of the beneficiary population.
5. The technical assistance should be oriented toward the strengthening of field staff, facilitating innovative ideas, and sharing experiences and educational materials from other places.

H. INTERINSTITUTIONAL COORDINATION

The MotherCare Project is being carried out in the impact area of Save the Children/Bolivia, Inquisivi Province, in accordance with the regionalization of the Health Unit of La Paz, in the Health District of Tres Cruces. The project consists of a team of professionals who develop their activities according to a geographic distribution in the province.

One of the principal functions of the personnel and specifically those responsible for project coordination, is to serve as the link to local functionaries of the Health Unit and to develop programmed activities in the field.

In the past, the possibilities for coordination between the Health District of Tres Cruces (MPSSP) and SC/Bolivia were many. However, coordination did not occur probably due to the following:

- * In Save the Children, all the projects carried out in the health district of Tres Cruces were developed unilaterally.
- * Supervisory visits were not conducted together with Health Unit personnel.
- * In spite of including contents from the program for women of reproductive age, activities were not developed with representatives of the Health Unit.
- * The information gathered by the project does not arrive at the District with the frequency that the Health Unit and the system require.
- * The field team are not aware of the regionalization of the Health Unit.
- * A large percentage of the project personnel do not know the contents of the health plan of the Ministry, nor do the local representatives of the Ministry of Health know the MotherCare Project.
- * Finally, one could detect that in the past there existed dispositions (at the operational level of the District Director) that impeded coordination.

Recommendations

1. SC/Bolivia should work toward achieving internal coordination between its projects.

2. SC/Bolivia should take into account the already established monitoring and supervisory system of the Ministry which permit one to measure indicators and the effectiveness of achieving project objectives; to this end, instruments and norms should be designed.
3. Achieve planning of related and/or complementary activities with representatives from both institutions with the objective being to establish and carry out a workplan together.
4. SC/Bolivia should deliver monthly information to the area to which it corresponds and have project representatives participate in the Information Analysis Committee meetings in the District every time they are conducted.
5. SC/Bolivia project personnel should learn about the regionalization policy of the MPSSP through Ministry personnel. This will serve to strengthen coordination.
6. In order to optimize human and logistical resources and fundamentally to reach the community with the same, one should broaden the knowledge of the norms and procedures of the Ministry as well as of the project to all health personnel who work in the District.
7. Mechanisms of regular interinstitutional coordination should be established, subject to previously established workplans.
8. Considering that during the first quarter several activities were carried out together with the MPSSP, further strengthening of interinstitutional coordination is recommended.

A recommended graphic scheme of interinstitutional coordination between SC/Bolivia and the different levels of the MPSSP is presented below:

LEVELS OF COORDINATION

National Normative
Level

MPSSP
Central
Level

EXECUTIVE
DIRECTION SC/B

DIRECTOR USLP _____ PROJECT ADVISOR

Regional Level

PROJECT
PLANNING

DISTRICT _____ PROVINCE IMPACT AREA
DIRECTOR

Local Operative
Level

HEALTH AREA _____ OPERATIVE AREA

SECTORS _____ COMMUNITY

I. ADMINISTRATION

Regarding general aspects of project administration, one should consider the following: Firstly, it is necessary to comment on the administrative mechanisms related to decision-making in the field; Secondly, one should assess the procurement systems for the harmonic development and functioning of the project, and finally, one should mention the relations and functions that arise in carrying out administrative activities.

SC/Bolivia has been staffed for some by an administrator who shares his functions with those of a Credit Official. He is located in the organizational hierarchy in strict relation with the administrative office of La Paz and with the Field Director in Inquisivi. His functions are to monitor vehicle use, manage economic resources through petty cash, deal with personnel issues, and procurement of supplies and materials. The Quality Circle is presently the formal forum for interchange and decision-making between the different people linked with administration. In this circle, a series of measures are conceived in order to facilitate the regulation of economic resources for the project; some of these include solicitation of funds, petty cash vouchers, formats for expense vouchers and certification of expenses, and others.

The measures taken by the personnel have made it easier to carry out transactions and have simplified accounting procedures, which have clearly benefitted the project, whose functioning depends on decisions that must be made in La Paz. The only requirement that the technical field staff must comply with in order to avoid administrative obstacles, is to make their requests for supplies and materials according to their programming with a minimum of 15 days notice so that the financial resources are available.

RECOMMENDATION. In spite of the adequate administrative system in the field, there are reasons to think that it may be necessary to clarify the functions of the administrative staff, the purpose being to establish limits and scope of their respective responsibilities.

J. BUDGET ANALYSIS

The total subcontract budget is \$242,569. Unofficial (not yet processed by SCF/Westport) expenses through March 31, 1992 total \$105,085.46 (43% of total budget). The personnel line item has been underspent due to delays in contracting staff to fill several positions. The Consultant line item is underspent but this is likely to change once the mid-term evaluation is completed and external team members are compensated. Travel expenses were almost double the budgeted amount. Supplies and Materials costs were underspent, primarily due to the fact that the educational materials development phase is only just beginning. The Commodities and Equipment line item is completely spent. Other Direct Costs line item spending is on schedule. (For details, see Appendix 6).

Projections were made based on the current level of staffing (including the addition of one volunteer nurse-midwife) and projected annual increases in salaries. These projections show that approximately \$17,600 will remain in the Personnel line item at the current end date of the project (July 31, 1993) assuming a monthly rate of expenditure of approximately \$5,400. The Travel line would be overspent by approximately \$8,400 if the current rate of spending is maintained. It is assumed that the Supplies and Materials line will be spent on educational materials and other project supplies.

There are several options that SC/B can consider:

1. A shift of some funds from the personnel line to the travel line. (This appears to be necessary.)
2. Extension of the project for an additional two months (close date September 30, 1993) to allow staff more time to close out the project and to document results.
3. Extension of the project for one month and remainder of funds cover costs of a local subcontractor for the IEC component.
4. No extension of the project and reallocation of remaining funds to costs of a local subcontractor for the IEC component and additional project-related costs such as basic equipment for health posts or more educational materials, etc.

K. SUSTAINABILITY

By sustainability, we mean the consolidation of the process of innovation, which expresses itself exclusively in terms of its generalization or transference to other subparts or components of the system. In other words, we can say that when change in a concrete aspect of community life begins to affect other aspects, the process acquires a generalness that widens the bases for sustaining itself. The generalization can be noted also through the rising of new merit worthy needs and demands attributable to the assimilated and stabilized innovation.

There are various factors associated with sustainability of the innovation. The most important ones have to do with the institutionalization of change, the development of capacity for community management, the integration of the innovation in the dynamic of the global community, with special emphasis on economic problems, with respect for the local culture and attention to the norms in force for political decision-making.

With regard to the institutionalization of the innovation, we must emphasize the importance of the use of local resources for the development of initiative: the people, their organizations and their raw materials. This supposes the rational use of the local capacity and the need to avoid duplicity or useless additions, creating artificial groups whose purpose it is to implement the innovation.

In regard to the MotherCare Project, the institutionalization of the project is centered on the coordination with the Ministry of Health, at its different levels, but fundamentally in the District Director of Tres Cruces and at the level of Health Centers in the Area. The interinstitutional coordination was interrupted for an extended period of time and only recently has been taken up again with the appointment of the new District Director, and the process must recover and perfect its mechanisms.

RECOMMENDATION. SC/Bolivia must put special emphasis on consolidating its work linkages with the MPSSP, especially in the impact area, in pursuit of a service that assumes little by little the functions introduced by the project.

Regarding the development of management capability, sustainability demands the optimization of local capabilities to administer the innovation adequately and efficiently. One cannot wait for the change to become generalized if the people responsible for its administration do not acquire the knowledge and experience necessary to respond to the administrative and technological demands of the change. In many cases, these demands are foreign to the local culture and its incorporation into the community dynamic supposes an additional effort which complicates the already

difficult panorama of sustainability.

RECOMMENDATION. In this sense, we must recommend that technical assistance to women's groups be stressed with the purpose of guaranteeing adequate management. It is important that the group conceives of itself as a means to improve the general condition of the woman and her family. No working group will be able to survive over time if one does not allow for a practical outlook.

It is important to note however, that almost invariably in all the groups that were visited, one could observe the interest on the part of the women to send representatives of the group to obtain additional training on leadership and group management. This interest points toward more effective management that is, at the same time, more sustainable.

On the other hand, experience has demonstrated the enormous difficulty that exclusively social projects have had in trying to achieve sustainability. Notwithstanding, the feasibility is more probable if structural and functional measures are taken to articulate economic initiatives that provide resources that can subsidize other activities. From here, all innovation should be seen as necessarily tied to greater integrated considerations, above all those which have to do with production processes or transformation. The initiative should not emphasize sectorialized actions; these are enemies of sustainability.

Likewise, it is well known that the dynamic of the communities focuses on development from a more integrated perspective than a sectoral one. The problems of health, production or productivity, education, etc., cannot be considered in an independent manner if pertinent solutions are to be proposed. For this reason, the solutions should also be of an integrated nature. That is to say, one initiative will necessarily impact on other areas and should link diverse activities in order to reduce the amount of overall effort.

RECOMMENDATION. It is worth the effort on the part of the project to take advantage of the other SC/Bolivia projects in the same zones as the MotherCare Project with the aim of achieving more integration in the work.

Another factor which is intimately associated with sustainability is sociocultural. One cannot lose sight of the context of the innovation as much as the characteristics of its receptors are sociocultural in nature. In this manner, when the initiative is culturally identified, the displayed actions can easily be confused with acculturation. In other words, if self determination is diminished in the qualification of the innovation, the risks that it will not be assimilated due to an incongruence with values, attitudes, customs, rituals, beliefs and other local

manifestations, is very high. For this reason, it is recommended that the implantation of the innovation be appropriate to the local cultural demands with the object of being flexible enough to accommodate to local norms.

The MotherCare Project is a project that was conceived to modify standards of popular conduct in relation to maternal health practices. This necessarily supposes a violation of beliefs, values, rituals and other cultural elements. However, the process that has been used in the first phase, as for example the autodiagnosis, supposes the adoption of very participatory and horizontal strategies that demonstrate a cushioning of the undesirable cultural effects of the innovation. It is hoped that during the second phase of implementation, the MotherCare Project will deepen its participatory guidelines which continue to constitute a demonstration of respect for the local culture.

Finally, the innovation should go hand in hand with formal mechanisms of community decision-making. This supposes that sustainability nourishes itself directly from the participation and mutual communication in an organizational framework. The processes oriented at decision-making which are exercised in rural communities are aspects of great importance for the consolidation of change.

The institutionalization of the initiative requires democratization of decision-making. From this point of view, autocratic and vertical styles could interfere with sustainability by trying to put off the collective interest by exercising the personal interests of those in power. This infraction of free determination can avail itself as much from an institutional perspective as from a community group in charge of making decisions.

In those contexts where an authority exercises control over decision making, change is not stabilized outside of the leadership or direction that personally supports it, and generally tends to revert in their absence. For this reason, institutionalization is incomplete when a mechanism of vertical power is in effect, the implantation is usually false, the stabilization is ephemeral, and sustainability, absolutely improbable.

We have already mentioned that the project is favored with good results in terms of its relations with formal community authorities, explicative as well as educational. This favors the stabilization of actions, each time that corresponding political support is given.

RECOMMENDATION. Perhaps it would be worthwhile to further strengthen the links with formal directorates in the communities where the MotherCare Project works, also offering the opportunity to these communities to participate in activities to evaluate the progress of the

project.

IV. CONCLUSIONS AND FINAL COMMENTS

The results arrived at by the evaluation team were presented in the Results section of this report. A brief summary of a series of final comments oriented to reaffirm some of the expressed opinions follows.

Personnel

In relation to personnel, it should be reiterated that a period of great instability has just passed due to programmatic and administrative adjustments in the institution. This problem, obviously has had negative repercussions on the project's progress during this first phase. At present, steps have been taken to resolve this situation, contracting new staff, although the new staff still need to be trained.

Another aspect that should be mentioned is the felt need of the staff to receive in more quality and quantity, complementary training in diverse subjects related to their daily work. In this manner, the requirement is to systematically present training workshops on community development, community education techniques, crosscultural communication and other themes.

Finally, SC/Bolivia should resolve as soon as possible the problems of housing and diet that have arisen as a result of the change in the strategy of permanence of the staff in the community.

Training

The autodiagnosis had a series of gaps in training which led to a heterogeneous treatment of women's groups. This difficulty could be rectified easily through training activities in the management of the autodiagnosis methodology. It is an obvious need for the new staff and would constitute an important refresher for those who already facilitate the process.

The aspect of community education resulted the weakest component of the project. This is perhaps due to the concept of education that is prevalent among the team of field supervisors. There exists the impression that this component is being conceived uniquely to impact on conceptual levels instead of being perceived as a means to arrive at the modification of behaviors. From this point of view, the health "talk" is the educational practice most used and the training indicators refer uniquely to the recounting of training activities, number of people trained and type of topic covered and do not attempt to account for qualitative aspects associated with change in behavior, demand for health services or other indicators linked with new ways of preserving good health.

Finally, there exists a great need expressed by the supervisors for didactic materials that will permit them to be more effective

health educators. It is strongly recommended that the production of materials to support training and education be begun as soon as possible without losing the participatory essence of the project.

Autodiagnosis

The most salient aspects of the autodiagnosis during this first phase are the following. Firstly, it is worthwhile strengthening the knowledge and mastery of the project staff (and especially the rest of the health team) on the methodology employed in order to conduct the autodiagnosis. Secondly, it was evident that the visits that women must make to other women for the collection of information constitutes an important element, as much for the fixation of the technique as for the improvement of the participation of the sector; however, in the experience to date, this step could not be carried out in some communities due to the total participation of all interested women of reproductive age in the community. For this reason, it is important to encounter in the second phase that is now beginning, mechanisms that make possible this additional interchange.

Thirdly, the possibility should be studied that sessions dedicated to the autodiagnosis be administered more closely in time one to the other; this would avoid a "cooling" of the process. Finally, one should reiterate that the autodiagnosis, in addition to being a good instrument for learning about the reality of women, is an educational instrument, that allows women to learn by means of discovery and participation.

Health Information System

The Health Information System has shown that it is a mechanism of great utility for the project. This was demonstrated in the quality and quantity of information that it offers for quarterly programming and planning. However, the instruments (particularly the roster) are sufficiently complicated that they present difficulties to the promoters and midwives who must complete them. This verification should allow a reflection about strategies that could be adopted during the second phase. Some of them could be: the simplification of the instrument (including the women's health card), or the decision to involve the field supervisor more in its management. Likewise, certain doubts exist about the capacity to sustain these instruments after the project is completed.

Detailed Implementation Plan (DIP)

The Detailed Implementation Plan is an excellent working instrument for the project. However, the recommendations pointed out the need to improve the indicators when taking into account the perspective of the final evaluation.

Technical Assistance

The technical assistance received during the life of the project was good and relatively well oriented. However, it was judged also that future assistance should put special emphasis on selecting consultants principally with attention to their knowledge and experience in the context of the national, regional and/or local reality.

Interinstitutional Coordination

It was evident that the coordination with the Health Sector (especially with the District Directorate of Tres Cruces) experienced a great improvement since the change in Directors. Since then, the links have been tightened and a new phase of work with new perspectives has begun. However, the assuagement of relations that was experienced in the impact area is not to say that all difficulties have been resolved. It is evident that one must continue to fill in the gaps of coordination on both sides (SC/Bolivia as well as the MPSSP).

Something that must be insisted upon is the importance of both parties sharing training activities in order to benefit their respective human resources. It is important that the MPSSP transmit the norms and policies to project personnel; it is also as important that the MPSSP personnel receive technical assistance with that which principally benefits the staff of SC/Bolivia.

Finally, the project should share its experience with other local and national institutions that are working in maternal health.

Administration and Budget

Regarding the administrative component, it is necessary to more clearly define the functions and responsibilities of the personnel who work in administration. This would permit the definition of attributes and above all, staff would know the limits of an individual's responsibilities.

In relation to the budget, a reprogramming is possible. Some possibilities that appear worthwhile are the following: a) increase the amount for travel; b) extend the project for one or two months more; c) increase the quantity of educational material originally budgeted; d) make available funds for contracting an institution that would be responsible for the production of didactic material; or e) provide some equipment to the MPSSP Health Centers in the impact area.

Sustainability

The sustainability of a project should not be considered as a product that happens in an automatic manner at the conclusion of the project; it is a process that is born with the project itself from the time of the proposal. To include the treatment of this process in the evaluation of a project supposes the consideration of real perspectives that have to do with the activities of the project once the project is closed down and discontinued.

From this perspective, the project must take special care in the following aspects. Firstly, it should consider the institutionalization of its actions. This means supporting the potency of local resources (Health Centers, Midwives' Associations) and consolidating already formed women's groups. Secondly, SC/Bolivia should reinforce the administrative capacity and/or the management of the groups with which they work, with the end being to assure their autonomous functioning when the project ends. Thirdly, SC/Bolivia should look for practical (useful) ties of the project with other initiatives that motivate the participation of women (for example, income generation activities). Fourthly, the MotherCare Project should look for-- in its circle of operations-- better integration of action, in order to generate greater reality in its actions. Finally, SC/Bolivia will promote greater sustainability of the project if the capacity of formal groups in the community are strengthened in the processes of legitimate decision-making and in the democratization of the different local power groups. The project will have a better perspective in time if it forms an active part of this participatory process and of consensus.

A N N E X E S

ANNEX 1. GUIDES AND FORMATS FOR INTERVIEWS

A. GUIA DE ENTREVISTA PARA AUTORIDADES

1. Qué conocimiento tiene del proyecto/De donde procede el conocimiento
2. Cómo ha sido iniciado. De quién fue la idea?
3. Cómo se tomó la decisión para que la comunidad participe?
4. Qué papel juega la organización sindical en el proyecto?
5. Ha recibido capacitación? Cuándo? en qué temas? Quienes recibieron, quienes impartieron?
6. Cómo se ha pensado que continúe el proyecto?
7. Cómo se manejará el proyecto cuando termine el financiamiento?
8. Cuáles son las ventajas del proyecto?
9. Cuáles son las desventajas del proyecto?
10. Qué tendría que hacer el proyecto para mejorar?
11. Opinión sobre el trabajo realizado por las mujeres de la comunidad
12. Problemas surgidos por el proyecto: sociales, políticos, etc.
13. Recomendaciones a la institución
14. Análisis de necesidades y expectativas
15. Organizaciones femeninas de base y su relación con las dirigencias comunitarias.

B. GUIA DE ENTREVISTA PARA EL PERSONAL DEL PROYECTO

I. CONFORMACION DEL EQUIPO

1. Historia del Equipo: cambios y modificaciones
2. Experiencia previa en trabajos conjuntos
3. Roles y funciones de cada miembro
4. Responsabilidades y obligaciones. Funciones
5. Toma de Decisiones y Procesos de Planificación
6. Relaciones jerárquicas y relaciones horizontales
7. Capacitación del equipo/ expectativas sobre el proyecto
8. Estrategias para la permanencia.

II. CARACTERISTICAS DEL PROYECTO

1. Análisis de la estructura del Proyecto
2. Historia del Proyecto: Cambios, modificaciones
3. Participación de los Beneficiarios
4. Recursos y medios con que se cuentan
5. Concepto de Integralidad
 - Vinculos con Otros Proyectos en la misma institución
 - Vinculos Intrainstitucionales con otras iniciativas económicas o sociales
6. Vinculos interinstitucionales
 - MPSSP/ COBREH/ CARITAS/PARROQUIA/PROCOSI/J.SNOW
 - Materiales necesarios/ Insumos
 - Coordinación con otras iniciativas productivas o sociales
7. Logística y administración del proyecto en el área.

III. ESTRATEGIA DE IMPLANTACION DEL PROYECTO

1. Estrategias y métodos de implantación utilizada (Asistencia Técnica, capacitación/educación, demostraciones, etc.)
Análisis de pre y posttest. Verificación de cuadernos.
2. Estrategias de evaluación y seguimiento
3. Identificación de necesidades de las comunidades (Autodiagnóstico)
4. Análisis de expectativas comunitarias
5. Evaluación de la capacidad de asimilar la innovación
6. Grado de cohesión comunitaria en torno al proyecto
7. Correcta elección de los puntos de apoyo
8. El rol de la organización comunitaria en el proyecto (decisión, ejecución, evaluación, etc.)
9. Institucionalización de las acciones del proyecto
10. Desarrollo de la capacidad de gestión de los grupos
11. Vinculos con iniciativas productivas de otra índole
12. Vinculos con iniciativas sociales
13. Respeto a la particularidad sociocultural.
14. Calidad del relacionamiento con la comunidad
15. Expectativas del personal del proyecto con respecto al comportamiento de la comunidad.

C. GUIA PARA EL GRUPO FOCAL CON MUJERES

1. Cuándo se conformó el grupo. Forma de organización adoptada. Características de sus miembros/grado de satisfacción con la conformación del grupo/ Opinión sobre su utilidad práctica.
2. Conocimiento de los objetivos, propósitos y estrategias del proyecto.
3. Actividades realizadas por el grupo/ Opinión sobre sus actividades/ Expectativas sobre el proyecto/Necesidad percibida de la utilidad del grupo y el proyecto
4. Capacitación recibida/Temas/Grado de conocimiento/Opiniones y expectativas sobre la capacitación/ Retroalimentación y flujo de información al grupo.
5. Ventajas y desventajas del proyecto/ Sugerencias y Recomendaciones.
6. Utilidad percibida del proyecto
7. Cómo les gustaría participar en la conformación de materiales/Idea sobre materiales y tipo.
8. Qué pasaría con el grupo cuando termine el proyecto.

D. GUIA DE ENTREVISTA CON PERSONAL DE OTRAS INSTITUCIONES.

1. Grado de conocimiento del proyecto
2. Grado de participación conjunta/ Areas de cooperación/
Planificación conjunta/Evaluación conjunta.
3. Opiniones y expectativas sobre el proyecto y personal del
proyecto.
4. Ventajas y desventajas del proyecto/ Recomendaciones y
sugerencias
5. Capacitación recibida o impartida para fines del proyecto.

ANNEX 2. STEPS FOR AUTODIAGNOSIS

PENCALOMA COMMUNITY NOTEBOOKS

REVIEW OF THE AUTODIAGNOSIS METHODOLOGY

FIRST SESSION

STEP 1: Introduction to the Warmi Project--Promotion SC/Bolivia

Purpose: The women will understand what the Warmi Project is and they will be invited to participate in the project and other SC/Bolivia programs.

Knowledge of the facilitator and the group:

- Terminology used in the community; language
- Knows the women's group
- Knows SC/Bolivia's programs
- Knows the objectives of the Warmi Project
- Knows the results of the case-control study of maternal and neonatal mortality and morbidity carried out in Inquisivi by SC/Bolivia staff

Necessary supplies/materials:

- Summary of Warmi Project objectives
- Summary of the case-control study results on cardboard poster
- Flipchart paper
- Markers
- Question guide (below)
- Tape recorder (optional)

Possible barriers:

- Language
- Facilitator doesn't know the project well
- Facilitator doesn't know the local terms and/or customs in the community
- Lack of motivation of the group
- Facilitator lacks experience

Activities:

1. The facilitator asks the group:

Do you know of any women from this community who have died? What caused their death? Did they die during pregnancy? During delivery of their baby? Within one month after they gave birth?

Do you know of any babies who died at birth or during their first month of life? Why do you think they died so suddenly?

2. Brief presentation of the results of the case-control study using photos and/or slides, and posterboard with summary of the results.
3. The facilitator asks the group:
Have you ever heard of the Warmi Project? What is the project? (What do you think it could be?)
4. Brief presentation of the Warmi Project objectives.

Time: 2 hours

STEP 2: Explore group members' attitudes towards pregnancy, birth and maternity

Purpose: To know what the women in the group think about pregnancy, birth and maternity.

Knowledge of the facilitator and the group:

- Terminology of the community; language
- Know the women's group
- Know some of the customs and traditions of the community

Necessary supplies/materials:

- Picture cards of an unhappy pregnant woman and a happy pregnant woman
- Question guide
- Tape recorder (optional) or observer/recorder
- "Hot potato"

Possible barriers:

- Language
- Facilitator's lack of familiarity/knowledge of the topic
- Do not know the terminology
- Lack of motivation of the group
- Lack of experience

Activities:

1. The facilitator shows the picture card of the happy pregnant women and ask the group, "What do we see in this picture?"
The group responds with what they see.
"Why is the woman happy?"
2. The facilitator shows the picture card of the unhappy pregnant woman and asks the group, "What do we see in this picture?"
"Why is the woman sad?"

3. Discussion questions:

How do you feel when you're pregnant?

What do you think when you suspect that you're pregnant?
Why?

How does your husband react when he finds out that you're pregnant? During the pregnancy? During the delivery? After the birth? With the newborn baby?

How do you react to your husband's response?

4. Explanation of what the group will do in the next meeting.

Time: 1 hour

SECOND SESSION

STEP 3: To learn what the women in the group know, do and believe regarding maternal and neonatal health and their related problems

Purpose: To identify and know about maternal and neonatal health problems and to standardize terminology used to describe these problems within the group.

Knowledge of the facilitator and the group:

- Terminology used in the community; language
- Know the women's group

Necessary Supplies/materials:

- Picture cards of problems
- Flipchart paper
- Markers
- Question guide (below)
- Tape recorder (optional) or observer/recorder

Possible barriers:

- Language
- Facilitator doesn't know community's terminology and/or customs and traditions
- Lack of group motivation
- Facilitator's lack of experience

Activities:

1. The group divides into two smaller groups. One group prepares a "sociodrama" about what they do during pregnancy. The other group prepares a "sociodrama" about what they do during delivery, care of the neonate and in the month following birth.

Questions to take into account when preparing the skits:

Pregnancy

- How do you know that you're pregnant?
- What do you eat when you're pregnant?
- How do you take care of yourself when you're pregnant (alcohol, work, hygiene, etc.)?
- Who do you see when you're pregnant? (Doctor, nurse, midwife, mother, etc.)?

Birth/Delivery

- What things do you get ready for the birth?
- Who attends the birth?
- How do you know when you are going to give birth?
- How do you deliver the baby (position, birth place, materials)?

Post partum

- How does the placenta come out? In how much time after the birth does the placenta come out? If it doesn't come out, what do you do? What do you do with the placenta when it comes out?
- How do you take care of yourself after the birth? (hygiene, diet, rest)?
- When do you get out of bed?

Newborn

- What do you do when the baby is born? (mucous, crying, swaddling, drying, cutting the cord)?
- When, with what and how do you cut the umbilical cord?
- After how much time do you put the baby to the breast?

2. The pregnancy group presents its skit. The facilitator leads a discussion after the skit about the practices and to see if all of the women agree with what was presented.
3. The birth/post-partum group presents its skit. The facilitator leads a discussion after the skit about the practices presented and asks whether all the women agree with what was presented.

(If the group does not wish to do a skit, the facilitator can ask whether (a) volunteer(s) would like to tell the group about her pregnancy and birth experiences.)

4. Develop a "Dictionary of Terms".

In this step, the group develops a "dictionary of terms".

A variety of methods can be used for this activity such as:

- The facilitator asks the group what maternal and neonatal problems the women have heard of. Each member of the group gives an answer and the facilitator gives the respondent the picture card that represents her response until all of the picture cards are distributed. (If the problem is not present in a picture card, the respondent can draw her own card.)
- "Card game"- each of the women selects a card from the set of picture cards (without seeing what it is when she selects it) and then describes the problem represented by the picture.
- Put all of the picture cards on the floor and let the women select one that attracts her attention. She then tells the group what problem is represented.
- Less active, but also a possibility is for the facilitator to show the picture cards to the group one by one and ask the group what they see.

The facilitator asks the following questions related to the problems depicted by the picture cards:

Pregnancy

What problems do women experience during pregnancy?

What is the problem called in this community? (Aymara, Spanish, Quechua)

Does it occur in this community?

Why does this problem occur?

How do you treat it?

If you don't treat it, what happens?

Labor/Delivery

What problems do women experience during labor and delivery?

What is the problem called in this community? (Aymara, Spanish, Quechua)

Does it occur in this community?

Why does this problem occur?

How do you treat it?

If you don't treat it, what happens?

Post partum

What problems do women experience within one month after the birth?

What is the problem called in this community? (Aymara, Spanish, Quechua)

Does it occur in this community?

Why does this problem occur?

How do you treat it?

If you don't treat it, what happens?

Newborn/Neonate

What problems do babies experience in their first month of life?

What is the problem called in this community? (Aymara, Spanish, Quechua)

Does it occur in this community?

Why does this problem occur?

How do you treat it?

If you don't treat it, what happens?

To document this step, the observer/recorder can use the following chart:

Problem	What is it called (local terminology)?	What causes the problem?	How is it treated?	If you don't treat it, what happens?	Does it occur here?

Time: 3 hours

STEP 4: Moving from self and group towards thinking about the community

Purpose: Prepare the group psychologically to think about the problems of other women in the community and motivate curiosity to know what other women think.

Activity:

The facilitator asks the group:

1. Do we think that other women in the community have the same problems and experiences during pregnancy, birth and after birth that we in the group have?
2. How can we find out? (Discussion about ways to get more information- interviews, etc.)

Time: 10 minutes

THIRD SESSION

STEP 5: Preparation of materials and methodology for information collection from other women in the community and practice using the methodology and materials

Purpose: To identify strategies to collect information from other women in the community about their maternal and neonatal health experiences and problems, select a strategy appropriate to the needs of the group, develop the materials and practice the methodology.

Activities:

1. The facilitator asks the group:
What information do we need?
How can we collect this information from other women in the community?
What material can help us to collect this information?
(picture cards, etc.)
How are we going to record the information so that we don't forget the answers?
2. The group discusses the options in materials and methodology and selects the most appropriate methodology and material.
3. Several volunteers from the group present a skit showing how to implement the selected strategy. The other members discuss how to improve the process based on the presentation.
4. The group divides into pairs and the women practice the interviews. One woman plays the role of the interviewer and the other the interviewee. Then they change roles. The women practice until they feel comfortable carrying out the interview.

5. The group organizes the home visits. Who will visit whom? Are they going to go first to the house to set a date and time and then return to do the interview? (The group prepares a list of the visits. Each woman should make at least one visit.)

Time: 2 hours

BETWEEN SESSIONS 3 AND 4

STEP 6: Implementation of the interviews

Purpose: To exchange maternal and neonatal health experiences between members of the group and other women in the community and to reflect on these problems. This step is very important for the improvement of communication among women about their problems and also serves to raise self-esteem and self confidence of the interviewers to be able to speak openly with others.

Possible barriers:

- Timidity or lack of confidence of the interviewers
- Refusal of the interviewee or her husband to do the interview
- Lack of sufficient practice to carry out the interview
- Lack of time to carry out the interview
- Husband of interviewer refuses to let her do the interview

Activity:

The women carry out the interviews using the methodology and materials that they prepared in step 5.

Possible questions for the interviews:

1. What does the woman see in the drawing? What problem is represented?
2. Has the woman ever experienced this problem?
3. When?
4. How did she feel when she had the problem?
5. What did she do to solve the problem? Why?
6. What problems does the woman think are the most important to treat in the community? Why?

Time: Depends on the interviewer, but the average interview lasts approximately one hour.

SESSION 4

STEP 7: Share the results of the interviews with the other members of the group

Purpose: The interviewers share the results of their interviews (quantitative and qualitative) with the other members of the group.

Knowledge of the facilitator and the group:

- Terminology of the community; language
- Know the women's group

Necessary materials/supplies:

- Problem "silhouettes" with sandpaper on back
- "Health Flag" (flag made of flannel, stripes of red, yellow and green)
- Flipchart paper
- Markers
- Question guide (below)
- Tape recorder (optional) or observer/recorder

Possible barriers:

- Language
- Facilitator doesn't know local terms and customs
- Lack of motivation of group (didn't do interviews, etc.)
- Facilitator lacks experience

Activities:

1. Each interviewer selects the problems identified during her interview(s) in silhouette form and tacks them onto the health flag according to their level of importance (red is the most important, yellow second most important and green is the third most important). While the interviewer tacks on the silhouette, she describes why the interviewee selected this problem as a priority. Then, the interviewer selects her own three most important problems and tacks them to the flag, explaining why she chose these three. Each interviewer tacks on the results of their interviews and their own priority problems in this manner. At the end of this step, all of the priority problems identified by the participants in the autodiagnosis (interviewees and the interviewers) will be represented on the health flag.
2. The facilitator asks the group:
 - What do you think about the results?
 - How did you feel while doing the interviews?
 - How did the women that you interviewed feel?

- What did you learn from the interviews?

Time: 1 hour

STEP 8: Prioritize the problems

Purpose: The group reaches consensus as to what the three most important maternal and neonatal health problems are that need to be addressed in the community.

Knowledge of the facilitator and the group:

- Local terminology; language
- Know the women's group
- Familiarity with local resources
- Facilitator's ability to facilitate the debate

Necessary materials/supplies:

- Problem silhouettes with sandpaper on back
- "Health Flag" (Flannel flag, stripes of red, yellow and green)
- Flipchart paper
- Markers
- Question guide (below)
- Tape recorder (optional) and/or observer/recorder

Possible barriers:

- Language
- Facilitator doesn't know local terms and/or customs
- Lack of motivation of the group
- Facilitator lacks experience
- Difference of opinion of group members- difficulty arriving at consensus

Activities:

1. The facilitator asks the group:

Of all these problems, how can we decide which three are the most important to try to deal with in the community?

What should we take into account when we prioritize our problems?

(Discussion about **FREQUENCY, SEVERITY, FEASIBILITY**)

What are the most frequent problems that we see on the health flag?

What are the most serious (severe)? Why are they serious?

What are the most important for your health?

Can we deal with these problems in the community? What resources do we have available in the community to deal with these problems? If there are no resources in this community, are there other resources available in other places? Can we access these resources? How?

2. The group divides into two or three small groups and, using one set of the picture cards per group, each group discusses which are the three priority problems in the community and why. When they arrive at a decision, they go on to the next step.
3. Each group presents its conclusions and justifies its priorities. If there is not yet consensus among the groups' priorities, the groups begin a debate to justify their priorities.
4. If the group still does not arrive at a consensus, they can hold an election to determine the three priority problems. (Or, if the group desires, it can choose to adopt four problems if the group agrees to work on all four problems).

Time: 1.5 hours

STEP 9: Evaluation of the Autodiagnosis Process

Purpose: The group evaluates the whole process of the Autodiagnosis in order to improve the process in the future with other groups.

Necessary materials/supplies:

- Markers
- Flipchart paper
- Tape recorder (optional) and/or observer/recorder

Activity:

1. The facilitator asks the group:
 - What did you think of the Autodiagnosis process?
 - Was there enough time?
 - What did you learn?
 - What did you think about the facilitator's participation?
 - How was the women's participation in the community?
 - How was your own participation?

- Was it tiring?
- What did you like? Why?
- What did you not like? Why?

2. The facilitator congratulates the group for its participation in the process and says:

In our next meetings, we will study different strategies and will learn more about how to deal with these priority problems.

Time: 20 minutes to one half hour

Autodiagnostico - Pecaloma Sept 1991

Pecaloma es una comunidad del subarea de Picocha. Tiene poblacion de 104 habitantes y queda a si del pueblo

La comunidad produce: ajios, (naranja, mandarina y limon) tuberculos (yuca, malusa y papa), hortalizas (zanahoria, repollo, tomate, beterraga etc) frutas (papaya, palta, chirimoya, mango) y otros productos como mani.

Infraestructura: cuentan con sede social.

Actualmente la comunidad esta trabajando en un sistema de micro riego y construccion de gallinero para crianza de aves menores.

En las intervenciones de Desarrollo Juvenil comunitario participar la mayor parte de las familias. Las mujeres no tienen habito de reunion al contrario no estan motivadas a organizarse y permanecer organizadas. Inicialmente se trabajo en mujeres en bordado y tejido.

De 22 mujeres en edad reproductiva y sus esposos asisten a las reuniones de 5 a 10 mujeres, el resto no asisten a las reuniones por miedo al esposo y por no poder tiempo.

Para iniciar y motivar a las mujeres para su organización de coordinó con Agrofeminas.

Esta vez el grupo se organizó con el objetivo de guiar a los grupos para la solución de algunos problemas que ellas consideraran importantes.

Una de las actividades fue instalar la tienda comunal en las huellas de hortalizas. Que al final no dio buen resultado por lo que la venta no es continua.

Actualmente las mujeres están algo motivadas para costuras en la comunidad, otras actividades como prácticas culinarias.

Para fortalecer al grupo de mujeres ya existente y para atraer al resto de las mujeres invitamos a una reunión a los esposos para analizar el papel de la mujer en la casa, la importancia de la mujer en el hogar - el papel de la

mujer como madre, la necesidad
de conocimiento en salud.

1º Paso

Explorar las actitudes de los miembros del grupo hacia el embarazo, nacimiento y maternidad.

Propósito: Conocer lo que piensan las mujeres acerca del embarazo, nacimiento y maternidad.

Conocimiento del facilitador y del grupo

- terminología de la comunidad
- conocer el grupo de mujeres
- conocer el tema
- conocer algunas costumbres y tradiciones de la comunidad

Materiales necesarios

- Material didáctico
- Grabadora
- Material de pelota caliente

Posibles barreras

- Idioma
- no conocer el tema
- terminología
- motivación

Actividad

- Elaborar una lista de preguntas específicas

- Prueba de las preguntas
- Preparación de las mi-
seses para el próximo paso

Participantes:

Bertha Uda de Chambi

Luisa Córdova

Surdez Mamani

Juana

Victoria Aguilar

Marguila Aguayo

Facilitadores:

Sra. Bacilia Jaime

Sra. Elsa Sanchez

Fecha: 6 de septiembre 1997

Tiempo: 2 horas.

Preguntas:

- 1: Como se sienten cuando se embarazaron y durante el embarazo?
- 2: Como reacciona el esposo al embarazo?
- 3: Como reaccionaron ilds al parto?
- 4: Cual es el papel del esposo.

durante el parto de la wawa y el parto de la placenta?

5. Cual es el papel del esposo después del parto de la placenta en la cama?

6. Como reaccionan Uds a la respuesta del esposo?

Respuestas de las mujeres al esposo

1. Como se sienten cuando se razan y durante el embarazo?

7. Nos sentimos mal, desgastados con mucho cansancio, con mal estómago, dolor a los costados, dolor en las piernas.

Al principio no sentía nada pero después de 5 meses sentía mucha vergüenza de la gente, me quería que crezca mi barriga, no quería esta wawa por nada del mundo, pero después que nació cambie completamente, lo quería tanto que no quería un año para nada la wawita??

Yo me sentía triste por que estaba embarazada de ocho meses y lo más difícil o es el parto. Sentía mucha dificultad para andar, para trabajar, dolencias que en la vida es muy cara y lloraba mucho, no quería ese hijo primado, no quería nacirme nunca por miedo y por falta de plata dice que es muy caro ??

Cuando los hijos son muchos la gente critica, enojan, hablan y maullan como conejos. Esta pariendo. En este embarazo nuestra única esperanza era que sea mujercita. Cuando hablé con mi esposo sobre mi periodo atrasado se asusto y me dijo que si es embarazo tendremos este unito más chico sea, no se meño enojado, tampoco me dijo que por que no me nazca unido, esto ocurre ??

En uno de mis embarazos yo yano quería por nada del mundo, sin avisar le a mi esposo me fui al médico para consulta y él me colocó una inyección y me dijo que si no soluciona el problema, me iba a colocar una sonda, me asusto ya no volví ??

Mi esposo no quiere a los hijos, nunca quiso tener hijos, yo tampoco ahora ya no quiero, algunas esposas no aceptan que nos naculen nacer

el control pre-natal, las mujeres
influyen a veces.

Yo tengo siete hijos y uno lo tengo
en el segundo embarazo ya estaba
preocupada, hasta he llegado a 7 hijos
no sé saber bien como controlarlos
después que me caí durante mi mis-
tración. Mi esposo es muy celoso
manera normal quiere una vez
fue al médico sola sin permiso
en Oruro para hacerme examen, no
quiso el médico, dice que debía
ir con mi esposo, tener permiso de
él, tuve que volver y tener la misma
igual normal?

Mi esposo se preocupa, aunque él
ya no quiere tener más hijos, pero quiere
normal (me) quiere verme embarazada
por que dice que anda mal la mujer
y se vuelven muchas cosas desgracia-
de terminar de lactar las mujeres están
dando un poquito y eso no les gusta.

Yo sé que grave, mis partes son feas
siempre que mi embarazo siempre que
vaya morir. En este último parto me
han sacado me han colocado cables
abajo. En el parto, mi man-
do me sacaba y al mantener no
más parada a parir al dar el
le saca para de pronto, en ese
momento no duele nada, al continuar
los dolores calman?

7.
Si nos embarazamos abusamos recién a los dos meses, una vez a year se atraxó fui al médico o sea abortar y no puede. entonces hablé con mi esposo y él no aceptó, por que dice que el médico manosea a la mujer y se queda enfema y le suena mas todavía al marido. Además dice que yo no soy soltera, tampoco viuda, para abortar.

Durante el parto
El esposo o ayuda, busca ayuda en otras personas, va al médico o a la partera. a veces durante el (habajo) parto el esposo se duele, la suegra o la mamá hasta mientras nace la avada. a veces estamos esperando el parto, se rompe la bolsa y pasan los dolores.

El esposo busca medicinas como chila chila, avila nula, siente que ayuda los dolores. A veces el esposo busca payantén y son unas piedroras que quitas de color blanco y con estas tabletas el dolor aumenta.

Las tabletas consiguen en las tiendas Don Abel y la partera médico.

De mates utilizan comero, azahar, manzanilla, orégano, escamola.

de Uibora un peñacito

En el parto de la wawa no se cura
ma el esposo, a ver lo que sale de la
wawa, ayuda agarrando, ayutandi
a barriga, otra mujer si hay atiende
el parto.

↑ Una vez en uno de mis partos la
pantera metoco sus partes y me
dio mates y atiendio mi parto.
Sobre estas cosas no sabe mi
mairdo, solo prepara mates,
casi siempre el Dr me
atiende o a veces mi suegro;
me toca la barriga, si estoy al
lado o estoy bien, y tambien
busca la cubrecita de la wawa

↑ Mi marido cuando estoy en dolores se encarga o se acuesta y a veces ayuda agarrándose el cuerpo, la cabeza, yo me apoyo en él, me agarro de él para bajar[?]. Mi marido me "cruce"[?] (mantiene), me faja con una faja para que me salve rápido y no se suba la wawa.

↑ Faltando poco tiempo para el parto yo apuro pinto le mando a mi marido de viaje, para que no me vea.[?]

↑ Cuando nace la newborna se pinta la regueta si es hombre o mujercita. Si es mujercita se aleguran por que dice que se suelte. Si es Varón mi marido dice "ese llegalla que se muera"[?]
No le vayan el cordón a la wawa
(cortar el esdm)

hasta que sale la placenta. si
lo cortan el cordón no hay que
amarrar al dedo del pie?

↑ A veces es difícil botar la pla-
centa porque estamos en el sol,
hacemos cazado en sosten, por
cocinar en el fogón, por que el
sol le dio por la espalda. Yo
tuve placenta (se quedó la placenta)
y mi esposo ni siquiera se movió,
ni papá tomar camino de
un lado a otro buscando ayuda?

↑ Una vez cerca a la comunidad
una sra tuvo placenta (R Placenta)
por 1 mes, el cordón se secó hay
mismo, fué al medico a Quine

y hay muy caro y volvió a la
comunidad en su placenta,
ya tenía mal olor, caminaba espaa-
fantando moscas en su mal olor, to-
davía con el cordón colgando y
placenta en matriz. Se peelo todo
el pelo, la mujer ya estaba mal, la
comunidad hizo una recolección de
dinero para llevarla a la paz. De
La Paz volvió sana.

En otro hijo a la muajwa Sra de
Bunio lo mismo por menos tiempo.

En caso de emergencia acudir
al puesto médico.

3er Paso

Conocer qué saben y hacen las mujeres sobre los problemas dentro del grupo

I - Propósito: Identificar y conocer los problemas de salud materna y neonatal; estandarizar la terminología de los problemas dentro del grupo.

II - Metodología: - Sociodrama

- Juego de cartas.

- Preguntas abiertas con juegos.

III - Actividades: - Diccionario de términos

- Elaborar dibujos para que la comunidad de mujeres entienda los conceptos

- motivar a los grupos

IV - Conocimiento necesario: El facilitador tiene que conocer el tema, tiene que estar abierto a

los conocimientos, actitudes y prácticas de las mujeres. Tiene que ser flexible y abierto en sugerencias.

Tiene que ganar confianza de las mujeres.

Tiene que conocer su lenguaje y términos populares de la región.

- II - Material :
- Papeógrafo
 - Marcadores
 - Presidiera
 - Cronómetro
 - Alfileros

III - Posibles barreras :

- No conocer el idioma
- No conocer el vocabulario
- Que la comunidad no entienda
- Que no está al tanto de la terminología
- Falta de confianza

Fecha: 22 de Septiembre de 1991

Facilitadores: Sr. Juan Magta
Sra. Lucía Larne

Participantes:

1. - Soledad Alvarado
2. - Lucía Calle
3. - Martha Yamani
4. - Juanita Vasquez de Cordova
5. - Edmunda Cacho
6. - Asunta Yamani
7. - Bertha Cota de Alvarado
8. - Rocío Fierro
9. - Celina Chacolla

Preguntas:

- Qué era?
- ¿Es problema lo que representa esta lámina o dibujo?
- ¿Ustedes han visto este problema en

La comunidad?

- Cómo se llaman en la comunidad?
- Por qué ocurre esta enfermedad?
- Cómo se curan en su comunidad?
- Qué pasa si no se cura?

Enfermedad

Problema: *Regla leucorrea*

Qué ven?

Una mujer esperando familia, se está divorcián-
do de su esposo, mujer, bien casada.

Paso 21.

Partiendo de una muestra y de los grupos hacer la comunidad.

Pregunta: - Conocer si los problemas comunes y las actitudes, conocimientos y prácticas de estos problemas son comunes en la comunidad.

Conocer si los problemas son comunes del grupo de mujeres.

Metodología

1. En base a los problemas elaborados en el paso 10, se realizó el análisis por grupos requerido por comunidad.
2. Reunión informal a campo abierto o analizando los problemas.

Conocimiento del facilitador

El facilitador debe tener la suficiente habilidad para involucrar al análisis y la comparación necesaria con el grupo de mujeres.

El facilitador debe identificar en el grupo a una o dos mujeres

para de con una de la mujer
electorales en una lista
la función de cada mujer por el
necesitan opiniones de los
de sus comunidades

El siguiente debe consistir en

- Que las comunas por lo
menos representen entre ellas
(Porcentaje)

- Que representen las mujeres que
ocasionan los problemas

En base a estos resultados
proyectar a las otras mujeres de
comunidad para conocer la
situación

- Están de acuerdo en otras
otras mujeres? Por qué?

Si tienen otros problemas
de los no mencionados en el grupo

Participantes al paso 4

- Betna Vda de Chamki
- Irene Mansani
- Guillermina Sumpitegui
- Azanta Ramirez
- Margarita Aguayo
- Eduarda Cachi
- Aurora Luna
- Victoria Aguilar
- Matrina Calle

Facilitadora:

Elsa Sanchez

tiempo: 1 hora y media

Fecha: 14 de octubre 1991

Se trabajó con un solo grupo; las mujeres no tuvieron una facilitadora del grupo como a una líder natural.

Los problemas seleccionados fueron:
los siguientes: según No. de mu.

1 Edema generalizado en los últimos meses de embarazo 6 muje.

2 Hemorragia durante el embarazo 5 muje.

Parto
3 Pseudocoma de mano y pie 4 muje.

Tricéfalos

1 Retención placentaria 9

2 sobre parto 4

Recien nacido

1 Bajo peso al nacer 6

Razones para seleccionar los

el tema generalizado en los últimos me-
ses de embarazo

Este problema no surgió ni
una de las mujeres, sin embar-
go considero que es un proble-
ma que afecta a algunas mujeres
durante un periodo de hasta
de la comunidad que no vea
necesitan conocer por que ocurre
este problema.

Edema durante el embarazo

"Hace poco antes que nazca
mi hijo me inundó con
pletamente no tenía dolor de ca-
baza pero nada de mi ropa me
quedaba."

Hemorragia durante el embarazo

Este problema solo una mujer di-
sustó.

Es un problema gravísimo, no
se puede curar en la comunidad.

la mujer puede morir, hasta
puede quedar muy débil.
dicen que a veces no aguantan
el parto.

Hay que curarse en mates
y con harina preparando con
ropa.

Procedencia de noma

"Este problema se va a dar
en gran parte cuando la mujer
está transada y no se ha hecho
controlar, también en gran parte
levantar pesados, en ayunar al
parto, o cuando los machos in-
terferen."

"La manita no sabe lutar,
con un fin pedacitos y lo malhar
la barriga de la mujer."

"La mujer no tiene curio."

para hacer operas de este problema?
mas bonito resulta visitar a un g-
fici, un medico o partera con mucha
experiencia??

Retención placentaria

En la comunidad hemos visto
a una sea por dos veces a la
misma mujer??

La primera vez, la mujer con
placenta estuvo andando por casi
un mes, recibiendo, en las mos-
cas al rededor y ella no tenia
dinero para hacerse curar??

Que hicieron?

La comunidad recolectó dinero
como donacion y se lo entregaron
para que vaya a La Paz y se
haga curar, hasta el orden ya??

Estaba reco??

Esta mujer perdió todo el pelo de la cabeza, tenía piel alta, aun así caminaba??

¿Su esposo no había nada, lo estaba mirando??

¿A mí no me ha pasado, pero he escuchado de otra Sra??

Sobre punto =

¿Son pocas las mujeres que tienen estos problemas??

¿Se curan con yerba, dicen que es grave??

¿Se usa matito matico, manzanilla, somero para batirse y curar en esto enfermedad??

¿A la mujer dice que se le

quiere la leche y muere con
leche. Hasta la leche se seca cuando
estamos en sobre parto??

Aprendizaje:

El grupo ^{de mujeres} de nuestro título
por la presencia de una persona
desconocida y ajena a la comuni-
dad y al proyecto. Esta persona
fue la Srta. Mary Mac Noni, que
visitaba la área de impacto.

Paso A

Diseño de un método para recolección de información

Propósito

Diseñar un método para recolección de información sobre los problemas de salud materna y neonatal de las mujeres en la comunidad.

Actividades

- Elegir un método
- Elaborar los pasos del método con el grupo
- Elaborar el instrumento que servirá para estimular el diálogo y registrar los resultados cuantitativos
- Practicar el uso del instrumento

Metodología

- Elección del método
- Discusión del grupo
- Sociodrama para practicar el método

Fecha: 20-10-91

Facilitador: Elsa Sánchez

Participantes: 9

Nómina de mujeres

Juisa Cárdenas

Joudle Mamani

Martha Mamani

Victoria Aguilar

Suana Vasquez

Eduarda

Gyllumina Sempitregui

Angélica

Irene Mamani

Asunta

Tiempo 2 horas

Diseño de método para visita
domiciliar y recolección de información
sobre los problemas de salud ma-
terna y neonatal

Un grupo de mujeres utilizaban las láminas, más tarde de vez en cuando para purificar los problemas, los pocos son los siguientes

1- Presentar a la mujer mexicana la razón de la vida

2- Una vez que acepta la mi

A. Mostrar las láminas solo de embolazo si la lámina no es suficientemente comprensible explicar lo que quiere decir

a.) Selecciona la mujer su problema

b.) Se prioriza su problema

c.) Se escucha la razón por lo que indica que es problema

B. Mostrar las láminas (sobre de problemas de parto de mismo seleccionar el problema

C. Muestra las láminas sobre los problemas de pulperío

D. Muestra las láminas sobre nacimiento

En caso que tuviera un problema que no está en las láminas, la SIA puede dibujar, escribir o mencionar verbalmente

Para purificar utilizarán las lanas de color rojo indica problema purificado, amarillo el segundo y verde el tercer problema de nacimiento

Las preguntas posibles durante la entrevista

1. ¿Qué ve la SIA en el dibujo? ¿Qué problema está representando?
2. ¿Si la SIA tenía este problema alguna vez?
3. ¿Cuándo?
4. ¿Cómo se sentía cuando tenía el problema?
5. ¿Qué paso? ¿paso el problema por sí solo?

Un grupo de mujeres utilizarán las láminas, más lanas de color para finalizar los problemas, los puros son los siguientes:

1. Presentarse a la mujer mexicana y explicar la razón de la visita.

2. Una vez que acepta la invitación:

A. Mostrar las láminas solo de simbolismo y si la lámina no es suficientemente comprensible explicar lo que quiere decir.

a.) Selecciona la mujer su problema.

b.) Se prioriza su problema.

c.) Se escucha la razón por la que indica que es su problema.

B. Mostrar las láminas (sobre el problema de punto de vista) y seleccionar el problema.

C. Muestra las laminas sobre los problemas de pulpos.

D. Muestra las laminas sobre nacido.

En caso que hubiera un problema que no esta en las laminas, la Sra puede dibujar, escribir o mencionar verbalmente.

Para asegurar utilizaran las laminas de color: solo un problema purpura, amarillo el segundo y verde el tercer problema de menor importancia.

Las preguntas posibles durante la entrevista.

1. Que ve la Sra en el dibujo? Que problema esta representando?

2. Si la Sra tenia este problema alguna vez?

3. Cuando?

4. Como se sentia cuando tenia el problema?

5. Que paso? Paso el problema por si solo.

6. Por que habría tenido ella el problema?

7. Como reaccionó su familia al problema?

8. Pienso ella que es un problema común?

La práctica del método se lo realiza mediante un sociodrama en grupos pequeños.

Un ejercicio importante antes de utilizar el material es practicar una visita domiciliar y la explicación de la razón de la visita.

Organización de las mujeres para la visita

Nombre	Visitará	Día
Irené	✓	20-10-97
Inés	✓	
Martha		

	Viollana u sra. Aldertina (su cunada)	Fecha
Angelica		
Victoria	Sra. Angelica (su tía)	
Louises	Sra. Aurora Luna Sra. Clotilde Corpus	
Bertha	Sra. Juana Vasquez Martha Mamani	
Guillemina	Sonia Escobar	

3 mujeres del grupo no se animan y la comunidad de yunca loma tiene pocas mujeres en edad fértil (que) no asisten a la reunión.

ANECDOTA DEL PROCESO DEL AUTO DIAGNOSTICO

Durante el proceso del auto diagnóstico en la motivación las mujeres que participaban contaron una historia impresionante de una mujer que sufrió retención placentaria en dos ocasiones.

Como respuesta a los problemas del auto diagnóstico se empezó con un taller sobre parto limpio a la que se invitó a todas las parejas de la comunidad con una invitación escrita para cada uno a dicho taller asistió a insistencia de otras mujeres.

La Ema. que sufrió retención placentaria por dos ocasiones consecutivas y ella vivió personalmente su experiencia en la reunión de señoras y fue así.

En uno de mis partos la placenta se me
quedó en mi vientre por un mes
yo me preocupaba con mi cordón balanceando:
cada día se iba recamando entre mis piernas
con mal olor con las moscas a mi alrededor
Caminaba por el camino con mi Winka cargada
al trabajo, de paso pediendo ayuda. Por mis veci-
nos.

Yutenti botan soplando botellas, venieron
mis vecinos me llamaron con ajei, lo que que
me hacían tener fuerte y mucho mi ajei
no salía

En esa época no había médicos y me
marido iba a licuma rogaba a los dueños
del cururo, hasta hasta quitándose el sobobro
ellos no aceptaron
por que yo estaba soliendo y al final
un Sr. que decían lo que me hizo llevar

en el Hospital me hicieron dormir y no me
dormí más.

La segunda vez me paró igual, pero
releí pedazo por pedazo la placenta de
color verde y edemato, me llevaron en un
camión a Yaguajay, no me hicieron nada
y se volvió a Lima y nuevamente me fui
a pongo en hay me hicieron el resto. El Doct
me mostró como carne verde y edemato
desde eso me he quedado con regla blanca
y hormigueo dolor de espalda.

Organisasi perusahaan
visi & misi

Tujuan :
- Meningkatkan produktivitas
- Meningkatkan efisiensi
- Meningkatkan kualitas
- Meningkatkan daya saing

Misi :
- Meningkatkan kinerja (output)

Visi :
- Meningkatkan daya saing

Misi :
- Meningkatkan kinerja

Misi :
- Meningkatkan kualitas

Misi :
- Meningkatkan efisiensi

Misi :
- Meningkatkan daya saing

Misi :
- Meningkatkan produktivitas

Misi :
- Meningkatkan efisiensi

Historia del Proceso del Autoexamen

Durante el proceso del autoexamen, la motivación de las personas que participan en él es una de las más importantes y se basa en una mujer en edad fértil en la comunidad por las condiciones

Durante el proceso del autoexamen, la motivación de las mujeres que participan en él es una de las más importantes y se basa en una mujer en edad fértil que quiere mantenerse saludable en sus condiciones.

Como se muestra a los jóvenes del autoexamen se le empezó con un taller como un tiempo a la que se invitó a todas las personas de la comunidad.

Madrid era una hermosa ciudad.
Esta fue una gran ciudad.

Aunque el arte antiguo de España
era de otros tiempos, la
España que había de alcanzar su
centro por las ocasiones que
ocurrieron y ella mismo
sonaba mucho en España.
La nación de España. y fue
F

En una de mis jornadas la
falta me quedo por un momento
en el momento de entrar en
con un mal día. En un momento
ocurrió con un viento muy fuerte
Intenté salir corriendo volando,
me hice un viento que me
me hacia hacia el viento, ni
no salía

En esa época no había médicos
y mi marido iba a licencias y
trabaja el asunto se
remiten a los deudos de
caro, pero no aceptaban
por que yo estaba enferma
y al final un Sr. que le dice
el Sr. de la casa o de la
me hicieron un servicio y no me
cuentan nada.

La familia era muy pobre
y yo iba a pedir cosas
de la plaza de los deudos y
edificios, me llevaban una cosa
a la iglesia, pero la hacían
y se volvía a la casa y me
daban de la casa y me
me iba a la casa. El

desde eso me he quedado con
con una buena idea de los
que es de cada uno de los

**ANNEX 3. HEALTH INFORMATION SYSTEM
INFORMATION FLOWCHART
WOMEN'S HEALTH CARD**

ANTECEDENTES GINECO OBSTETRICOS

Número de embarazos: _____
 Número de abortos: _____
 Número de nacidos vivos: _____
 Número de nacidos muertos: _____
 Vivos actuales: _____

PARTOS ANTERIORES

Número de Parto		Fecha del Parto	
Sexo	Problema		

Número de Parto		Fecha del Parto	
Sexo	Problema		

Número de Parto		Fecha del Parto	
Sexo	Problema		

VACUNA TT

	1	2	3	4	5
FECHA					

MINISTERIO DE PREVISION
SOCIAL Y SALUD PUBLICA

Desarrollo Juvenil Comunitario



Nombre: _____
 Fecha de Nacimiento: _____
 Dirección: _____
 Número de Casa: _____
 Comunidad: _____
 Fecha de Entrega: _____

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EMBARAZO N°			
Número de control	1	2	3
Fecha de control			
Edad de embarazo			
Presión arterial			
Altura uterina			
Presentación			
Latido fetal	Sí No	Sí No	Sí No
Sal yodada	Sí No	Sí No	Sí No
Sulf. ferroso	Sí No	Sí No	Sí No
Hemorragia Wila apiri		Sí No Fecha: / / Acción:	
Edema Phusuntata		Sí No Fecha: / / Acción:	
Vómitos		Sí No Fecha: / / Acción:	
Embarazo Gemelar		Sí No Fecha: / / Acción:	

EMBARAZO N°			
Número de control	1	2	3
Fecha de control			
Edad de embarazo			
Presión arterial			
Altura uterina			
Presentación			
Latido fetal	Sí No	Sí No	Sí No
Sal yodada	Sí No	Sí No	Sí No
Sulf. ferroso	Sí No	Sí No	Sí No
Hemorragia Wila apiri		Sí No Fecha: / / Acción:	
Edema Phusuntata		Sí No Fecha: / / Acción:	
Vómitos		Sí No Fecha: / / Acción:	
Embarazo Gemelar		Sí No Fecha: / / Acción:	

EMBARAZO N°			
Número de control	1	2	3
Fecha de control			
Edad de embarazo			
Presión arterial			
Altura uterina			
Presentación			
Latido fetal	Sí No	Sí No	Sí No
Sal yodada	Sí No	Sí No	Sí No
Sulf. ferroso	Sí No	Sí No	Sí No
Hemorragia Wila apiri		Sí No Fecha: / / Acción:	
Edema Phusuntata		Sí No Fecha: / / Acción:	
Vómitos		Sí No Fecha: / / Acción:	
Embarazo Gemelar		Sí No Fecha: / / Acción:	

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CALENDARIO DE LA MUJER

Código de Métodos de Planificación Familiar

E=Embarazo
D=Diú

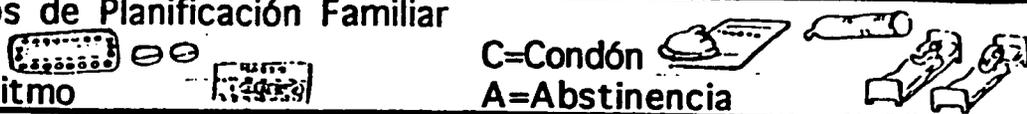
3 J 7

P=Pastilla

N=Natural/Ritmo

C=Condón

A=Abstinencia



	AÑO		AÑO		AÑO		AÑO		AÑO	
	Menstruación	Método								
ENERO	Sí No									
FEBRERO	Sí No									
MARZO	Sí No									
ABRIL	Sí No									
MAYO	Sí No									
JUNIO	Sí No									
JULIO	Sí No									
AGOSTO	Sí No									
SEPTIEMBRE	Sí No									
OCTUBRE	Sí No									
NOVIEMBRE	Sí No									
DICIEMBRE	Sí No									

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PARTO

Lugar, fecha y Quién atendió	_____ / _____
Retención de placenta	 Sí No Acción:
Mala posición Ladunquiwa	 Sí No Acción:
Prolongado Jayawas t'alaya	 Sí No Acción:
Hemorragia Wila apiri	 Sí No Acción:

DESPUES DEL PARTO

Disminución del tamaño del útero	Normal <input type="checkbox"/> Anormal <input type="checkbox"/>
Características de los loquios	Normal <input type="checkbox"/> Anormal <input type="checkbox"/>
Fiebre Calenturan-piwa	Sí No Fecha: / / Acción:
Sobreparto Sobrepartu-piwa	 Sí No Fecha: / / Acción:
Hemorragia Wila apiri	 Sí No Fecha: / / Acción:

RECIEN NACIDO

Nacido	<input type="checkbox"/> <input type="checkbox"/>	
Sexo	<input type="checkbox"/> <input type="checkbox"/>	
Peso		
Calostro	<input type="checkbox"/> <input type="checkbox"/>	
Problema	Fecha: / /	Acción:

PARTO

Lugar, fecha y Quién atendió	_____ / _____
Retención de placenta	 Sí No Acción:
Mala posición Ladunquiwa	 Sí No Acción:
Prolongado Jayawas t'alaya	 Sí No Acción:
Hemorragia Wila apiri	 Sí No Acción:

DESPUES DEL PARTO

Disminución del tamaño del útero	Normal <input type="checkbox"/> Anormal <input type="checkbox"/>
Características de los loquios	Normal <input type="checkbox"/> Anormal <input type="checkbox"/>
Fiebre Calenturan-piwa	Sí No Fecha: / / Acción:
Sobreparto Sobrepartu-piwa	 Sí No Fecha: / / Acción:
Hemorragia Wila apiri	 Sí No Fecha: / / Acción:

RECIEN NACIDO

Nacido	<input type="checkbox"/> <input type="checkbox"/>	
Sexo	<input type="checkbox"/> <input type="checkbox"/>	
Peso		
Calostro	<input type="checkbox"/> <input type="checkbox"/>	
Problema	Fecha: / /	Acción:

PARTO

Lugar, fecha y Quién atendió	_____ / _____
Retención de placenta	 Sí No Acción:
Mala posición Ladunquiwa	 Sí No Acción:
Prolongado Jayawas t'alaya	 Sí No Acción:
Hemorragia Wila apiri	 Sí No Acción:

DESPUES DEL PARTO

Disminución del tamaño del útero	Normal <input type="checkbox"/> Anormal <input type="checkbox"/>
Características de los loquios	Normal <input type="checkbox"/> Anormal <input type="checkbox"/>
Fiebre Calenturan-piwa	Sí No Fecha: / / Acción:
Sobreparto Sobrepartu-piwa	 Sí No Fecha: / / Acción:
Hemorragia Wila apiri	 Sí No Fecha: / / Acción:

RECIEN NACIDO

Nacido	<input type="checkbox"/> <input type="checkbox"/>	
Sexo	<input type="checkbox"/> <input type="checkbox"/>	
Peso		
Calostro	<input type="checkbox"/> <input type="checkbox"/>	
Problema	Fecha: / /	Acción:

ANNEX 4. QUANTITATIVE DATA/TABLES

I. NUMBER OF WOMEN WHO RECEIVED PRENATAL CARE = 391

II. PREGNANCIES REGISTERED WITH 1, 2 OR 3
PRENATAL CARE VISITS IN MOTHERCARE PROJECT

INQUISIVI PROVINCE - BOLIVIA
JULY 1990 - MARCH 1992

SUBAREAS	NUMBER OF PREGNANCIES REGISTERED	PREGNANCIES WITH PRENATAL CARE			
		1	2	3	TOTAL
Inquisivi	152	90	39	21	150
Licoma	206	80	39	18	137
Circuata	169	57	45	41	143
Total	527	227	123	80	430

Source: 1 Manual system of information

Average number of visits per pregnancy = $713/527 = 1.35$

III. PRENATAL CARE ACTIVITIES

- 1) Historical Information
 - a) Medical History
 - b) Obstetric History
 - . High Risk Detection
- 2) Physical Exam
 - a) Physical Examination
 - b) Dental Examination
 - c) Obstetric Examination
 - . Breast Examination
 - . Leopold Maneuvers
 - . Check for MMII Edema

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IV.

PREGNANCIES AND BIRTHS
WITH 2 DOSES OF T.T.

JULY 1990 - MARCH 1992
IMPACT AREA

	REGISTERED PREGNAN- CIES	PREG. WOMEN W/ 2 DOSES		TOTAL # REGISTERED BIRTHS	NO. BIRTHS W/ 2 DOSES OF TT.	
		No.	%		No.	%
Inquisivi	152	91	60	173	121	70
Licoma	206	142	69	123	138	
Circuata	169	86	50	152	73	48
Total	527	319	61	448	332	74

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V.

NUMBER AND PERCENT OF PREGNANCY WITH
IRON - MOTHERCARE PROJECT

JULY 1990 - MARCH 1992

SUB-AREA	NUMBER OF REGISTERED PREGNANCIES	PREGNANCIES WITH IRON	%
Inquisivi	152	150	97
Licoma	206	120	58
Circuata	169	111	66
Total	527	381	72

Source: Manual Information System

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VI.

MOTHERS WHO GIVE COLOSTRUM IN THE FIRST
24 HOURS AFTER BIRTH

IMPACT AREA (MOTHERCARE) - INQUISIVI
JULY 1990 - MARCH 1992

SUBAREA	No. OF POST-PARTUM	MOTHERS WHO GIVE CALOSTRUM	
		No.	%
Inquisivi	173	31	18
Licoma	123	51	41
Circuata	152	70	46
Total	448	152	34

Source: Manual Information System

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VII.

BIRTHS ATTENDED BY UNTRAINED AND
TRAINED MIDWIVES, WHPS AND HEALTH
INSTITUTION PERSONNEL

INQUISIVI PROVINCE - BOLIVIA
MOTHERCARE PROJECT

JULY 1990 - MARCH 1992

SUB-AREAS	BIRTHS ATTENDED BY TRAINED PERSONNEL			BIRTHS ATTENDED BY UNTRAINED PERSONNEL
	VHPs	TBAs	HEALTH PERSONNEL	HUSBANDS
Inquisivi	0	36	7	130
Licoma	2	36	11	63
Circuata	34	35	40	34
Total	36	107	58	227

Source: Manual System of Information

1. Includes nurses, doctors and nurse auxiliaries

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IX.

NUMBER AND PERCENTAGE
OF MATERNAL, PERINATAL AND
NEONATAL DEATHS

INQUISIVI PROVINCE - BOLIVIA
MOTHERCARE PROJECT

JULY 1990 - MARCH 1992

	N u m b e r	R a t e s
Number of Maternal Deaths	6	537/100.000
Number of Perinatal Deaths	22	51,4/10.00
Number of Neonatal Deaths	3	58/1000
T O T A L	31	

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REGISTERED COMPLICATIONS
INQUISIVI PROVINCE - BOLIVIA
MOTHERCARE PROJECT

JULY 1990 - MARCH 1992

	- Abortion - Pregnancy - Over 35 - Multipar. - Anemia - Neonatal death	Pre- Eclamsia	Placenta Previa	Malpre- sentation	Placental Retention	Puer- peral Sepsis
Inquisivi	2	1	0	0	1	1
Licoma	6	1	3	0	2	3
Circuata	4	3	2	3	3	2
Total	12	5	5	3	6	6

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REGISTERED COMPLICATIONS
THAT RECEIVED SOME TREATMENT AND THE RESULTS

INQUISIVI PROVINCE - BOLIVIA
JULY 1990 - MARCH 1992

	Total Cases	Detected		Solution at Home	R e m i s s i o n			Results	
		Early	Late		Health Post	Quime Hospital	Irupana Hospital	Woman Lived	Woman Died
Inquisivi	5	5	0	5	0	0	0	5	0
Licoma	15	12	3	5	5	3	2	11	4
Circuata	17	17	0	13	3	0	1	17	0
	37	34	3	23	8	3	3	33	4

Of 37 registered women at high risk, 14 were referred to a health center; 1 died. 23 women received home treatment with positive results.

3 women were detected late (with problems of fetal death, placental retention and endometritis). All 3 women died.

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LIST OF COMM

No.	COMMUNITY	WOMEN OF REP. AGE	TOTAL INHABITANTS	SUB AREA
1	CORACHAPI	36	188	INQUISIVI
2	ACOTA	53	291	INQUISIVI
3	QUINCU SUYO	53	284	INQUISIVI
4	UPUÑA	102	522	INQUISIVI
5	CAYCHANI	32	185	INQUISIVI
6	ESCOLA	33	177	INQUISIVI
7	OJO DE AGUA	30	156	INQUISIVI
8	CHUALLANI	25	115	INQUISIVI
9	VENTILLA	38	198	INQUISIVI
10	FRUTILLANI	27	119	INQUISIVI
11	CHALWIRI	41	170	INQUISIVI
12	CHILCANI	63	325	INQUISIVI
13	SITA	95	493	INQUISIVI
14	VILACOTA	31	123	INQUISIVI
15	CANQUI CHICO	70	405	INQUISIVI
16	INQUISIVI	66	327	INQUISIVI
17	TAUCARASI	62	274	INQUISIVI
18	YAMORA	45	244	INQUISIVI
19	TITIPACHA	33	164	INQUISIVI
20	ACUTANI	35	174	INQUISIVI
TOTAL SUB AREA:		970	4934	
1	PULCHIRI	31	206	LICOMA
2	CHARAPAXI	38	214	LICOMA
3	HARITOLO	76	361	LICOMA
4	RICA RICA	49	233	LICOMA
5	LACAYOTINI	23	102	LICOMA
6	PENCALOMA	21	104	LICOMA
7	KULUYO	31	106	LICOMA
8	LICOMA	162	785	LICOMA
9	KHARA	35	145	LICOMA
10	SANTA ROSA	22	116	LICOMA
11	CHECA	34	178	LICOMA
12	ALFAGIANI	26	122	LICOMA
13	SURI	43	213	LICOMA
14	CHAJNA	31	189	LICOMA
15	PARPATA	13	80	LICOMA
16	MOXACOCA	32	158	LICOMA
17	ESPIGA PAMPA	35	174	LICOMA
18	LOMA LINDA	50	232	LICOMA
19	TURCULI	54	265	LICOMA
20	CAJUATA	91	386	LICOMA
21	SIQUIMIRANI	68	314	LICOMA
22	PUENTE ALEGRE	38	174	LICOMA
TOTAL SUB AREA:		1003	4857	

ANNEX 5. NEW STRUCTURE OF THE DETAILED IMPLEMENTATION PLAN

INDICATORS.

The following lists the evaluation indicators that the evaluation team decided to maintain to be evaluated by the end of the Warmi Project. Furthermore, for each indicator, the methodology for the evaluation is specified.

Objective 1: WOMEN'S GROUPS

- a) Percent of communities with mother's groups
- b) Percent of women's groups meeting once a month
- c) Percent of women of reproductive age participating in women's groups
- d) Percent of women attending two or more meetings every six months
- e) Percent of health personnel trained in autodiagnosis
- f) Percent of women's groups participating in the autodiagnosis process
- g) Educational material developed and distributed

The above indicators will be evaluated through internal documents such as quarterly reports.

Objective 2: NUTRITION

- a) Percent of infants born with low birth weight
- b) Percent of pregnant women with two or more weights plotted during pregnancy
- c) Percent of women at nutritional risk who are followed up
- d) Percent of women who are taking two three-month courses of iron during pregnancy and postpartum
- e) Percent of women who consume iodized salt. Indicators a, d and e, can be evaluated through the HIS.
Indicators b and c, can be evaluated through a survey.

Objective 3: PRENATAL

- a) Percent of pregnant women who had three prenatal visits
- b) Percent of pregnant women followed by TBAs who have encounters recorded on their women's health card
- c) Percent of staff on the SC and MPSSP health teams who can identify four activities that take place during prenatal care, three signs of at risk during pregnancy and routine steps to take if a woman is identified as at risk
- d) Percent of women of reproductive age, pregnant women and husbands of pregnant women who can identify two signs of pregnancy, two reasons why prenatal care is necessary and two signs of at risk.

Indicator a, can be evaluated through the HIS. Indicators b, c and d, can be evaluated through a survey.

Objective 4: DELIVERY

- a) Percent of deliveries attended by trained persons.
- b) Percent of deliveries where clean delivery techniques were practiced
- c) Percent of deliveries where the newborn is attended to immediately and appropriately
- d) Percent of women of reproductive age, husbands, TBAs and mothers of pregnant women who can identify two reasons for the importance of a clean delivery, two ways to have a clean delivery, two correct practices for attending to the recent newborn and two signs of at risk
- d) Percent of pregnant women who can define false and real labor, prepares for a clean delivery, able to identify two reasons why the newborn needs to be attended to immediately after birth and can identify at least two high risk situations during delivery that require action
- e) Percent of deliveries where a birth kit is utilized

Indicators a and f, can be evaluated through the HIS.
Indicators b, c, d and e can be evaluated through a survey.

Objective 5: POSTPARTUM

- A) Percent of pregnant women who receive one or more postpartum visits (one in the first week postpartum)
- b) Percent of women identified with hemorrhage or infection who are managed appropriately
- c) Percent of pregnant women, TBAs, husbands and percent of MOH and SC health staff who can identify two steps in proper postpartum maternal care and identify two signs of hemorrhage and sepsis and describe appropriate steps to be taken and which ones they are responsible for.

Indicator a, can be evaluated through the HIS; indicator b, through a survey or the HIS and indicator c, through a survey.

Objective 6: NEWBORN

- a) Perinatal Mortality Rate
- b) Percent of newborns receiving immediate attention after birth
- c) Percent of newborns breastfed in the first hour of life
- d) Percent of husbands, TBAs, mothers of pregnant women, MPSSP/CS local health staff who can identify four basic steps to be taken with the recent newborn, and can identify at least signs of at risk.

Indicators a and c, can be evaluated through the HIS. Indicators b and d, through a survey.

Objective 7: NEONATAL

- a) Neonatal mortality rate
- b) Percent of TBAs, husbands, mothers of pregnant women, pregnant women, CS and MPSSP staff who can identify three reasons to start breastfeeding in the first hour and continue for a minimum of two years, three signs of sepsis, pneumonia and state at least two ways to prevent tetanus.

Indicator a, can be evaluated through the HIS. Indicator b, can be evaluated through a survey.

Objective 8: GENERAL

- a) Percent of women of reproductive age trained in family planning methods
- b) Percent of women of reproductive age using at least one modern family planning method
- c) Percent of MPSSP who can identify a minimum of three modern methods and one contraindication for each method and two side effects of each method
- d) Percent of women of reproductive age, TBAs, men 2-50, 15-19 years old, pregnant women and teachers who can identify three modern methods of family planning and identify where they can receive family planning services

Indicators a and b, can be evaluated through the reports presented by SOPACOF. Indicators c and d, can be evaluated through a survey

ANNEX 6. BUDGET

ANEXO 6. PRESUPUESTO

SALARIES--MOTHERCARE	Apr-Dec	Jan-Jul	Benefits	Total	
	Monthly Salary				
Salustio Aguilar (30%)	54.30	488.70	399.105	314.15	1,201.96
Adolfo Martinez (20%)	189.00	1,701.00	1389.15	1,093.46	4,183.61
Juan Alberto (30%)	67.50	607.50	496.125	390.52	1,494.15
Victor Sanjinez (30%)	120.00	1,080.00	882	694.26	2,656.26
Teodoro Lozano (20%)	35.00	315.00	257.25	202.49	774.74
Maria Alavi (60%)	123.00	1,107.00	904.05	711.62	2,722.67
Romelia Antonio (60%)	123.00	1,107.00	904.05	711.62	2,722.67
Martha Calla (30%)	61.50	553.50	452.025	355.81	1,361.33
Macario Laura (30%)	64.80	583.20	476.28	374.90	1,434.38
Bismark Ortiz (20%)	41.00	369.00	301.35	237.21	907.56
Luis Quisbert (45%)	81.45	733.05	598.66	471.23	1,802.94
Elsa Sanchez (80%)	520.00	4,680.00	3,822.00	3,008.46	11,510.46
Guillermo Seoane (50%)	650.00	5,850.00	4,777.50	3,760.58	14,388.08
Daysi Beltran (50%)	300.00	2,700.00	2,205.00	1,735.65	6,640.65
Blanca Gumucio (25%) Feb.	147.50	1,327.50	1,069.38	851.30	3,248.17
Rene Apaza (40%) March	68.40	615.60	492.48	394.29	1,502.37
Adela Callisaya (60%) March	102.60	923.40	738.72	591.44	2,253.56
Lourdes Checa (60%) March	102.60	923.40	738.72	591.44	2,253.56
Luis Laine (60%) March	102.60	923.40	738.72	591.44	2,253.56
Educator (90%) May	360.00	3,240.00	2,574.00	2,072.70	7,886.70
Volunteer (90%) May	405.00	3,645.00	2,895.75	2,331.79	8,872.54
TOTAL	3,719.25	33,473.25	27,112.31	21,486.34	82,071.89

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SECTOR: Primary Health (2)

GASTOS AÑO 1	GASTOS AÑO 2	GASTOS AÑO 2	PRESUPUESTO AÑO 4 (per M.O.)	GASTOS AÑO 4 (per M.O.)	GASTOS AÑO 4 (per Bol FO)	TOTAL GASTOS AÑO 4 (AC+AD)	SALDO AÑO 4 (AD-AE)	% GASTADO AÑO 4 (AE/AD)	PRESUPUESTO AÑO 5 (10 months)	PRESUPUESTO VIDA DEL PROYECTO	GASTOS NASTA 31-Mar-92	SALDO VIDA DEL PROYECTO 31-Mar-92 (AK-AL)	% VIDA DEL PROYECTO GASTADO NASTA (AL/AK)	MESES QUE FALTAN (1 Mar 92 - 14 July 93)	GASTOS PERMITIDOS POR MES (AM/AN)	PROMEDIO GASTOS POR MES FY 92 (E/G)	DIFERENCIA (AG-AR)
PERSONNEL	0.00	5,230.84	41,183.48	67,264.68	11,436.04	11,433.20	22,909.24	44,335.44	34.1%	55,348.00	169,019.00	69,323.36	99,695.44	16			
CONSULTANTS	0.00	0.00	14.87	3,483.13	292.06	0.00	292.06	3,193.07	8.4%	2,000.00	5,500.00	306.93	5,193.07		6,230.97	3,818.21	2,412.76
TRAVEL EXPENSES	0.00	249.19	8,425.26	8,030.35	2,120.90	3,627.04	3,747.94	2,282.61	71.6%	4,475.00	21,180.00	14,422.39	6,757.61		422.35	957.99	(535.64)
SUPPLIES & MATERIALS	0.00	35.91	8,383.07	11,416.02	660.46	816.21	1,476.67	9,969.35	12.9%	7,265.00	27,130.00	9,895.65	17,234.35		1,077.15	179.78	897.37
COMMODITIES/EQUIPMENT (Assets > 500)	0.00	150.94	1,646.03	3.03	0.00	0.00	0.00	3.03	0.0%	0.00	1,800.00	1,796.97	3.03		0.19	0.00	0.19
EVALUATION	0.00	0.00	0.00	1,500.00	0.00	0.00	0.00	1,500.00	0.0%	500.00	2,000.00	0.00	2,000.00		125.00	0.00	125.00
OTHER DIRECT COSTS	0.00	131.93	6,814.79	3,493.26	421.84	1,971.40	2,393.24	1,090.04	48.7%	3,510.00	15,940.00	9,339.96	6,600.04				
TOTAL SPENT	0.00	5,752.61	66,467.50	93,212.69	14,951.30	17,867.85	32,819.15	62,393.54	34.3%	75,090.00	242,569.00	105,085.46	137,483.54		412.50	398.87	13.63
															6,552.72	5,403.33	3,289.20

*Year 4 = 1 Oct, 1991 - 30 Sept, 1992
 *Year 5 = 1 Oct, 1992 - 14 July, 1993

3/12 = 25.02

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SAVE THE CHILDREN
 Monthly Expense Statement
 Month of: MARCH, 1992

SECTOR: Primary Health (2)

	Code	Budget	Expenses This Month	Total FY 92 Expenses	FY 92 Balance	Percent Spent	Oct 91	Nov 91	Dec 91	Jan 92	Feb 92	Mar 92
A. PERSONNEL (CC 030)												
Salaries Paid by F.O.	30-2-030-702	47,000.00	3,002.70	10,063.12	20,136.08	40.12%	2,597.44	2,694.00	5,006.09	2,645.20	2,036.01	3,002.70
Casual Labor	30-2-030-705	0.00	0.00	(37.21)	37.21	ERR	10.97			(36.18)		
Fringe Benefits Paid by F.O.	30-2-030-717	5,000.00	(130.47)	907.44	4,012.56	19.72%	16.25	16.17	700.03		296.66	(130.47)
Indemnizations	30-2-030-721	9,000.00	2,050.53	2,050.53	6,941.47	22.92%						2,050.53
Taxes Paid by F.O.	30-2-030-734	4,044.68	214.02	1,037.36	3,007.32	25.62%	155.05	161.64		209.45	216.40	214.02
Tuition Reimbursement	30-2-030-723	2,220.00	0.00	0.00	2,220.00	0.02%						
Subtotal Personnel		67,264.68	5,224.70	22,909.24	44,355.44	34.12%						
B. CONSULTANTS (CC 012)												
	30-2-012-772	3,485.13	0.00	292.06	3,193.07	8.42%	26.03	265.23				
C. TRAVEL EXPENSES (CC 031)												
Travel	30-2-031-660	1,030.55	63.50	316.14	714.41	30.72%	3.62	22.10	65.25	59.24	102.27	63.50
Vehicle Op./Maint.	30-2-031-861	7,000.00	1,032.01	5,431.00	1,569.20	77.62%	1,316.00	503.00	210.77	461.40	1,400.54	1,032.01
Subtotal Travel		8,030.55	1,095.59	5,747.94	2,282.61	71.62%						
D. SUPPLIES & MATERIALS (CC 011)												
Office Supplies and Materials	30-2-011-785	5,700.00	189.19	611.30	5,088.62	10.72%	200.20	1.62		126.22	86.07	169.19
Training Supplies and Materials	30-2-011-740	5,746.02	88.71	467.29	5,278.73	8.12%	40.95		11.61	326.02		89.71
Subtotal Supplies & Materials		11,446.02	277.90	1,078.67	10,367.35	9.42%						
E. COMMODITIES/EQUIPMENT (010)												
(Assets < \$ 500)	30-2-010-787	3.03	0.00	0.00	3.03	0.02%						
F. EVALUATION (020)												
Evaluation Materials	30-2-020-740	750.00	0.00	0.00	750.00	0.02%						
Evaluation Travel	30-2-020-860	750.00	0.00	0.00	750.00	0.02%						
Subtotal Evaluation		1,500.00	0.00	0.00	1,500.00	0.02%						
G. OTHER DIRECT COSTS (CC 032)												
Telecommunications	30-2-032-795	600.00	100.60	268.66	331.34	44.87%	27.10		27.95	105.01		100.60
Postage	30-2-032-804	600.00	0.66	33.33	566.67	9.61%	4.53	2.83	2.01	0.75	14.53	0.66
Miscellaneous	30-2-032-890	490.00	167.95	315.56	(25.56)	105.22%	54.20	75.46	25.04	56.84	96.07	167.95
Workshops - Meeting Costs	30-2-032-860	1,443.20	179.33	1,430.64	4.64	99.72%	10.16		152.66	312.07	761.20	179.33
Loss in conversion	30-2-032-975	350.00	39.21	137.05	212.95	39.22%			39.26	50.00	7.90	39.21
Subtotal Other Direct Costs		3,483.20	495.95	2,393.24	1,090.04	68.72%						
TOTAL		95,212.69	7,094.22	32,421.15	62,791.54	34.12%						

* FY 92 budget now coincides with grant Year 4 budget as per Caroen Weder.

15/92