

PD-ABF-564
81563

**SAVE THE CHILDREN
BOLIVIA FIELD OFFICE**

**CHILD SURVIVAL 3
FINAL EVALUATION REPORT**

Agency for International Development
Cooperative Agreement #OTR-0535-A-00-7215
February 1990 - January 1993

January 1993

Save the Children
54 Wilton Road
Westport, CT 06880
(203) 221-4000

**CHILD SURVIVAL 3/BOLIVIA
FINAL EVALUATION
TABLE OF CONTENTS**

	page
EXECUTIVE SUMMARY	i
I. INTRODUCTION	
A) Background	1
B) Project Description	2
C) Evaluation Objectives	2
D) Methodology	3
II. RESULTS	
A) Achievements by Interventions	3
1) Immunization	4
2) Diarrheal Management/ORT	6
3) Nutrition/Breastfeeding/Vitamin A	7
4) Maternal Health	9
5) Acute Respiratory Infections	10
B) Project Management	10
1) General Project Management	10
2) Community Participation	12
3) Human Resources Development (Training)	14
4) Inter-Institutional Coordination	15
5) Health Information System	16
6) Sustainability	19
7) Financial Management	22
III. LESSONS LEARNED	22
IV. ANNEXES	
A) AID/W Sustainability Questionnaire	
B) Pipeline Analysis	
C) K&P Survey	
D) Maps of Project Area	
E) List of Persons Interviewed	
F) Questionnaires	
G) Chronology of Final Evaluation	
H) List of Communities and Population	
I) SC/B Organizational Chart	
J) Key Staff Job Descriptions	
K) Description and Copy of HIS Instruments	

GLOSSARY

AID	Agency for International Development
AID/W	AID/Washington D.C.
ARI	Acute Respiratory Infection
BCG	Tuberculosis Vaccine
DIP	Detailed Implementation Plan
DPT	Diphtheria, Pertussis, Tetanus Vaccine
EPI	Expanded Program of Immunization
CIEC	<i>Centro Interdisciplinario de Estudios Comunitarios</i> (a Bolivian Consulting Agency)
CS	Child Survival
FHA	Foreign and Humanitarian Assistance Division of AID
HIS	Health Information System
K&P	Knowledge and Practices
MOH	Ministry of Health
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PROCOSI	<i>Programa de Coordinacion en Supervivencia Infantil</i> (A Bolivian CS Umbrella Organization for PVOs)
PVC	Private and Voluntary Cooperation Division of AID
PVO	Private Voluntary Organization
SC	Save the Children
SC/B	Save the Children/Bolivia
SOPACOF	Bolivian Reproductive Health PVO (also called APSOLCOF and ASHOFAM)
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
USLP	<i>Unidad Sanitaria de LaPaz</i> (District MOH Department)
VHW	Village Health Worker (community based volunteer also referred to as health promoter or RPS - <i>Responsable Popular de Salud</i>)

**SAVE THE CHILDREN/BOLIVIA
CHILD SURVIVAL 3 FINAL EVALUATION
JANUARY 1993**

EXECUTIVE SUMMARY

A final evaluation of the Save the Children/Bolivia child survival project was conducted a little over two and one half years after the project started. The evaluation consisted of a K&P survey of mothers with children under two years and a qualitative analysis of the project strategy, sustainability, management and finances. The team focussed on recommendations for follow-up since SC/B has obtained funding to continue project activities for an additional three to five years, a step necessary to consolidate gains in improved health practices with a focus on long-term sustainability.

The project covered 58 dispersed communities with an Aymara speaking population of 11,000 persons located in the high plains at 3600 to 4000 meters above sea-level in the Department of LaPaz, Inquisivi Province, Areas of Quime, Ichoca and Luruta/Siguas. Primary health care services as well as other basic services did not exist in the majority of these communities prior to the project.

The majority of the project objectives established in the Detailed Implementation Plan were met in spite of the difficulty of the situation. The project was strongest in reaching its EPI objectives with a 52% coverage rate for 12-23 month olds with DPT3, OPV3 and measles, and a 46% coverage rate for women with 2 TT doses. 31% of mothers used ORS, and over 80% of mothers properly nourished the child during a diarrhea episode. At least 50% of children were involved in a growth monitoring program, 59% of mothers breast-fed within the first 8 hours, 43% of children were exclusively breast-fed through the first four to six months and 70% of mothers breast-fed through two years. The project did not fully meet targets for Vitamin A capsule administration, knowledge of safe birthing practices and acute respiratory infection management.

The project used a two-tiered strategy to achieve sustainability - the strengthening of the MOH services and the training of mothers in child protective behaviors. SC/B has established a good foundation, especially in EPI, for continuing to coordinate and work with the Ministry of Health. The team suggests that SC/B use a more systematic planning process with the MOH that includes an action plan consisting of objectives, activities, and indicators to further strengthen this link.

SC/B trained VHWs to train mothers in protective health behaviors. The selection process to recruit VHWs through the agrarian union meetings favored men. Women were not included sufficiently in the decision making process and support for the primarily male VHWs was found to be low. SC/B has begun to address this issue by planning to work more closely with women's groups in the community. A Health information system was used effectively by SC/B to plan and supervise activities. This information needs to be shared with the community so they can analyze their preventive health priorities. It is recommended that SC/B establish objectives and indicators around community level sustainability.

The project spent approximately \$201,600 according to line items established in the DIP for a cost/beneficiary ratio (inclusive of all community members) of \$6.17/person/year.

**SAVE THE CHILDREN/BOLIVIA
FINAL EVALUATION, JANUARY 1993
CHILD SURVIVAL 3
Cooperative Agreement # OTR-0535-A-00-7215**

I. INTRODUCTION

I.A. Background

A Child Survival 3 proposal was initially funded by AID/W in August, 1987 to conduct activities in the jungle area of Yucumo in Ballivian Province of the Department of El Beni. In 1989 after a midterm evaluation the project site was closed due to high operating costs and a very migrant population.

SC/B presented a new proposal to AID/W to transfer the remaining funds to cover 60 communities in the Quime Zone of Inquisivi Province in the Department of LaPaz. This area, located in the high plains and pampas was located next to the Child Survival 5 valley area of Inquisivi Zone and it was felt that lessons learned could be transferred and replicated to this new area. SC/Bolivia began working in Bolivia in the Inquisivi zone in 1986 with a community based integrated rural development approach and had established a good reputation with the community.

In February 1990, Amendment No. 3 was received which authorized spending of \$201,600 in Quime Zone. Project activities began in April, 1990 and ended January 31, 1993, a duration of a little over two and one half years. During this time, child survival was practically the only functioning program in this area in addition to some sponsorship activities, one community micro-irrigation project and a few potato credit projects. SC/Bolivia was the only external agency working in these communities. The Ministry of Health had a few health posts in the area but did not yet have an extended outreach program to the majority of these communities. The program strategy of working only in preventive health was very different from the integrated approach being implemented in the nearby Inquisivi Zone and the integrated approach used in most other SC programs around the world. Due to limited funds, SC/B was unable to incorporate other types of project activities into these areas.

The project covered 60 communities with a population of 11,000 people located in the high plains at 3600 to 4000 meters above sea-level. Please refer to Appendix D for a map of the area and Appendix H for a list of each community and their corresponding population. Quime (a town of 3,500 inhabitants) is located 240 km from LaPaz, a 4 1/2 hour trip by road that is paved for the first 150 km. The 20 communities located near Quime town are reached by dirt road or foot path, the furthest being a 5 hour walk. The 20 communities in the Ichoca Group (Ichoca, Franz Tamayo, and Tablachaca) are located higher on the mountains further to the south and are reached by a 50 km dirt road around mountainsides taking two hours from Quime and then by a walk for 1 1/2 to 5 hours. The 13 communities in the Luruta Group are located an additional 2 1/2 hours south by road from Tablachaca and another walk of 1 1/2 to 5 hours. The 5 communities of the Siguas Group are the farthest from any main towns another 4 hours southwest from Luruta by road and 2-3 hours by foot. As can be seen, these communities are extremely dispersed and isolated due to the geographic terrain and have limited accessibility to the outside world. The primary language spoken in this area is Aymara.

I.B. Project Description

The goal of the Quime Child Survival 3 project was to decrease the morbidity and mortality of children under five years of age in a sustainable manner. The total population was estimated at 11,000-12,000 persons with a direct target population of 1,986 children under five years and 2,952 women of 15-49 years. The project proposal targeted the following CS interventions to reach this goal and established objectives in each:

*Expanded Program of Immunization	15%
*ORT/Diarrheal Control and Prevention	25%
*Nutrition/Breastfeeding/Vitamin A	25%
*Maternal Health	20%
*Acute Respiratory Infections	10%
*Iodine Deficiency	5%

The project approach included the registration of all families through an initial census and the establishment of a health information system to follow-up and track all children under five years of age and women of 15-49 years. Community volunteer promoters, VHWs, were to be selected by community organizations, primarily the local agrarian union, trained and supervised by the project, and given the task of training mothers in child protective behaviors and of managing EPI campaigns. The project was to coordinate activities with the MOH in order to strengthen their managerial capacity and provide logistical support for Primary Health Care services in these communities.

A midterm evaluation was conducted in August 1991 by CIEC, a Bolivian consultant group with participation from SC/Bolivia and Westport staff and representatives from other organizations. The methodology used consisted of a K&P survey, a review of project procedures and an analysis of community opinions. Based on recommendations made at this time, the project changed its operational and monitoring procedures to be more field responsive and began to coordinate activities more directly with the MOH and local organizations. There were several changes in field staff at this time; mid-level staff were let go and job descriptions were changed. Project supervisors were now to spend more time in the communities where they worked.

I.C. Objectives of the Final Evaluation

The evaluation team consisting of the following persons met in LaPaz January 12-14, 1993 to establish the methodology to be used and design the necessary tools for the evaluation:

- *Dr. Victor Lara, Johns Hopkins Consultant
- *Karen LeBan, SC/Westport.
- *Charles LLewellyn, USAID/Bolivia
- *Dr. Hernan Zambrana, MOH, La Paz
- *Dr. Carolina De Hilari, Andean Rural Health Care
- *Arturo Villanueva, PROCOSI
- *Dr. Guillermo Seoane, SC/Bolivia
- *Dr. Luis Amendola, SC/Honduras

The main objectives of the final evaluation were to:

- * Report the success of the project to AID including a survey of the knowledge and practices of mothers with children under 24 months of age, a review of the objectives versus achievements, and analysis of the process used and sustainability of the project.
- * Provide recommendations for the future of the project once AID/W financing ends.
- * Document novel experiences and lessons learned of the project that could benefit other projects both within and outside of Bolivia.
- * Transfer the technology and methodology of the final evaluation to the SC/Bolivia team.

I.D. Methodology

In order to complete the final evaluation within a two week time frame, two work teams with specific responsibilities were formed. Both teams aggregated their information and worked together to come up with the final analysis and conclusions. A chronology of the evaluation events can be found in Appendix G. Surveys, interviews and an analysis of results took place in Quime from January 15-22, 1993. Final discussions were conducted and a draft report produced in LaPaz January 23-26, 1993.

One team used a 30 cluster sampling technique to survey mothers with children under 24 months to ascertain their knowledge and practices in each of the health project interventions. A description of the methodology used and an analysis of the results can be found in Appendix C.

The other team developed interview guides for project personnel, VHWs, mothers, union and mother's club leaders, MOH staff and key LaPaz coordinating institutions. All together, it was only possible to interview 8 promoters, 4 groups of union leaders, 7 women leaders and 7 mothers from different communities. The interview questions included those from the sustainability guide developed by AID/FHA/PVC/CSH. A list of all persons interviewed can be found in Appendix E and a copy of the questionnaires in Appendix F. The Health Information System was analyzed by reviewing project instruments and documents, and by comparing the names of the randomly selected families from the K&P survey with the family registration cards in order to find out the percentage of families actually registered by the project.

II. RESULTS

II.A. Achievements by Intervention

The majority of the project objectives established in the Detailed Implementation Plan have been met. An analysis of each intervention follows based on the objective planned in the DIP. Technical recommendations are provided for each intervention to assist SC/B plan new strategies for the continuation of the project.

The analysis in each of the five health interventions is based on results from the K&P survey, a review of the documents including information from the computerized information system,

PROMIS, and interviews with eight of the currently active 43 VHWs. An assessment was made of the technical knowledge of the VHWs based on the following criteria. This information will only provide tendencies due to the low number of interviews the team was able to make with them.

Adequate Technical Knowledge

- EPI:** Identify each vaccination and the correct age each should be given.
- ORT:** Identify at least two dehydration signs: dry lips, depressed fontanel, fold in the skin, slight urination.
- NUTRITION:** Diagnose problem based on red wool method (below road to health line) or drop in weight and provide minimal advice to mother to increase both the frequency of feeding and to increase the caloric density of the food.
- MATERNAL HEALTH:** Diagnose at least two at-risk signs: hemorrhage, fever, malnutrition, previous premature delivery, swelling and provide nutritional advice to mother, reasons for prenatal visits and reference to the Health Post.
- ARI:** Diagnose at least two of the following signs of pneumonia: rapid breathing, cyanosis, chest indrawing.

II.A.1) Immunization

By January 1993, 30% of children 12-23 months and 40% of children 12-59 months will be completely immunized; 50% of women 15-44 yrs old will be completely immunized with 2 doses of TT; 50% of children 0-59 months will be immunized with BCG.

According to the survey, 51.8% of children 12-23 months of age were completely immunized with BCG, OPV3, DPT3 and measles and 73.2% of the children 12-23 months of age had received a BCG vaccine. According to PROMIS information, 65% of children 12-59 months were completely immunized. All are beyond the objectives set by the project. Of the 50.5% of mothers who had a maternal health card at the time of the interview, 91.2% had at least two TT injections indicated on the card. This indicates that TT coverage is approximately 46%, slightly under the goal set by the project. The health information and supervision system used to follow up defaulters was instrumental in achieving this coverage.

Fifty-seven percent of mothers had an immunization card for their child while 10.3% stated they lost their card. This demonstrates that the project is still not totally capturing new births in a timely manner. Part of the reason is that supervisors have been able to visit these communities and organize immunization campaigns on average three times/year due to the dispersion of the communities.

The drop out rate for DPT was found to be approximately 28.6% while the drop out rate for OPV was 24.8%. This demonstrates the need to diversify the current project strategy to address the causes of drop-outs. Educational activities should also be intensified within the communities.

Technical EPI knowledge of the VHWS was found to be only partially acceptable. Of the eight VHWS interviewed, only two had adequate knowledge, while five had partial understanding and one was unacceptable. Some technical irregularities were also found on the road to health cards. For example, measles vaccines were administered before the correct age. This seems to match knowledge of the mothers; only 33% of the mothers stated that a child should receive the measles vaccine at nine months.

It was found that 64.4% of mothers knew that they needed at least two TT injections to protect the newborn infant from tetanus. However, there is considerable miscommunication on this subject as evidenced by radio broadcasts in the area linking TT with sterilization.

In all of the interviews with community leaders, EPI was felt to be the main activity of the project and one of importance to the community. The MOH stated that EPI was probably the most effective component of the project. They also stated that they did not believe they could sustain the high coverage rates if SC/B were to leave the area.

RECOMMENDATIONS FOR EPI:

- * SC/B should reformulate its EPI objective for the future to reach the group at greatest risk - the under one year olds, and should try to reach a coverage rate of 80%.
- * SC/B should try to increase the involvement of parents or community leaders in the identification of newborns and follow-up of the doses required by the children of each community (ie baby tracking system for EPI).
- * Coordination with the MOH should be reinforced and joint strategies made to reach the most dispersed communities in order to increase access to EPI services. An action plan should also be developed with the MOH to establish their role in maintaining EPI services to these areas when SC/B eventually leaves. Immunization cards should be available for each newborn and for each woman 15-49 years of age.
- * Periodic refresher trainings should be provided for both SC/B and MOH staff, with special emphasis on new personnel.
- * An investigation should be made of the factors affecting the acceptance of TT in the community and plans made to try and change the knowledge and attitudes of mothers. Perhaps social marketing techniques might be an appropriate tool.
- * SC/B should continue to reinforce messages about the timing and benefits of immunizations for both the mother and child.
- * SC/B should initiate community campaigns instead of bringing the services directly to each house in the community. This should increase the community responsibility for organizing the services and provide a more sustainable base for future services.

II.A.2) ORT/Diarrhea Management

55 VHWs will be able to register diarrhea cases, train families in proper management and refer severe and moderate dehydration cases.

40% of families with children under-five years will use ORS and know how to feed a child during and after diarrhea and will recognize when to refer the child for further assistance.

According to the survey, 30.8% of the families used ORS as a method of treatment, showing that the project has met its objective. Management of diarrheal cases appears to be quite good. For example, of the children who had diarrhea two weeks prior to the survey, 82.9% were given more or the same amount of breastmilk and of those mothers providing semi-solid or solid foods, 81.9% of their children were given more or the same amount.

Forty-two percent of mothers with children with diarrhea two weeks prior to the survey sought advice or treatment. Of these only 25.8% went to the VHW while 31.3% went to the health post or a hospital and 42.2% went to relatives for advice. This has improved since the midterm evaluation when only 4.2% went to their VHW for advice. Few mothers (13.7%) stated signs or symptoms related to dehydration that would cause them to seek advice. These findings also reflect the knowledge of the VHWs. While all of the VHWs were trained by the project, only 50% of the eight interviewed were found to have adequate knowledge of dehydration identification and treatment.

One important finding was that 40% of the children in the survey had diarrhea during the past two weeks.

RECOMMENDATIONS FOR ORT/DIARRHEA MANAGEMENT

- * Include other community members besides the VHW in the distribution and management of ORS packets. Reinforce the community-based oral rehydration units that the MOH is now pursuing in other regions.
- * Attempt to find home based traditional recipes that could be used for dietary management of diarrhea.
- * Increase messages to mothers emphasizing signs related to dehydration as the most important signs that a child needs medical help during diarrhea.
- * Reinforce training to VHWs and other community leaders about signs of dehydration, dietary management of diarrhea cases and treatment of dehydration.
- * Investigate why so many children have diarrhea and try to develop basic hygiene and sanitation messages. Try and link up with other agencies involved in potable water and sanitation projects who could assist some of the communities most in need of water/sanitation projects.

II.A.3) Nutrition

a) Growth Monitoring/Promotion

40% of under 5 year old children will be in a growth monitoring program.

50 VHWs will give nutritional advice to mothers based on a child's growth card and refer at-risk children.

30% of mothers with under 5 children will interpret their road to health card by means of colored yarns and will act appropriately.

46 communities and Quime town will have growth monitoring instruments.

According to the survey, 59% of mothers had a growth monitoring card for their child and of these, 85.4% of the children had been weighed at least once in the last four months. This signifies that at least 50% of children under two are involved in a growth/ monitoring program. According to PROMIS information, 74% of children under five years are being weighed, again demonstrating that the project has exceeded its objective. It was interesting to note that 32% of mothers interviewed had lost their child's card. According to project documents, 58 communities have their own scale or share one with a very close neighboring community.

Only 50% of the VHWs interviewed mentioned growth monitoring as one of their principal tasks. Only 50% of the VHWs knew basic information about nutrition and could provide nutritional advice. The nutritional messages given to mothers by the VHWs lacked clarity and appeared to be much too complicated. The evaluation team was not able to check the mother's interpretation of the road to health card.

RECOMMENDATIONS FOR GROWTH MONITORING/PROMOTION:

- * SC/B should focus their efforts on monitoring the growth of the most at-risk population - those children under three years of age.
- * SC/B should increase the training of VHWs or other community leaders in weighing practices and try to have the SC supervisors gradually become less involved.
- * While SC/B has enclosed the cards in plastic and provided thumbtacks to hang the cards on the wall a number of cards are still lost. SC/B should stress the importance of the growth card as an important and educational instrument for the mother.
- * The VHW or community leader should have extra road to health cards and be able to provide the mother with the card for her newborn child as soon as this child is identified by the project or leader and/or enlisted in the family register.
- * SC/B should develop and validate one strong educative strategy and messages for mothers with children who lose weight (ie add one spoonful of oil to each plate).
- * SC/B should focus its activities around growth promotion, assuring that mothers can supplement the diet of their children at-risk.

b) Breast-feeding/Weaning

20% of registered women will administer colostrum to their newborn within the first 24 hours.

75% of mothers will continue to breast-feed for two years.

25% of women will breast-feed exclusively for 4-6 months and initiate supplementary food by the sixth month.

Breast-feeding practices appear quite good. Most of the objectives have been exceeded, and there is only a slight discrepancy in relation to continued breast-feeding through two years. Fifty-nine percent of mothers breast-fed their child within the first eight hours after birth, and 70.4% of mothers continued breast-feeding through two years. Forty-three percent of the children were exclusively breast-fed through the first four months and 74.5% of mothers knew that weaning should begin between four and six months of age.

It appears that mothers are giving their children foods enriched with calories, protein, Vitamin A and iodized salt. However the survey did not measure the quantity and quality of the food given.

RECOMMENDATIONS FOR BREAST-FEEDING/WEANING:

- * SC/B should increase its emphasis on the benefits of exclusive breast-feeding for the first four to six months since over 50% of mothers supplement breastmilk with other foods or fluids during these crucial months.
- * All health workers (staff, VHWs, MOH staff) in the project area should receive instruction on the benefits of breast-feeding for the first two years of a child's life.
- * Additional training should be provided to all health workers in the project area including medical staff on actions mothers could take to ensure a regular supply of breastmilk.
- * SC/B should continue to promote adequate weaning foods of good nutritional value, with messages to increase the frequency and density of the weaning foods. In collaboration with the MOH, recipes that include basic local sources of protein, fat, carbohydrates and other micronutrients should be developed for the 6-9 month olds, 9-12 month olds, and 12-18 month olds.
- * Since adequate food availability is a serious concern in many of these communities, SC/B should try to link the community with other groups that could provide agriculture assistance in the form of seeds, training, and/or credit.

c) Micronutrients

100% of registered pregnant women will receive oral iodized oil if SC/B is able to obtain supplies from the MOH.

50% of children 1-5 years old will receive Vitamin A megadoses every six months.

SC/B was unable to receive supplies for iodized oil from the MOH. The Vitamin A coverage for the first dose according to the survey was approximately 29%, much lower than the objective. The mean age for the first dose was one year; however there are children that have received the first dose as early as one month. Coverage for the second dose was very low (18%). The elapsed time between the first and second dose ranged from 1-10 months with a mean of approximately 6 - 7 months.

RECOMMENDATIONS FOR MICRONUTRIENTS:

- * Supervisors and VHWs should receive refresher training courses in the technical norms, monitoring of logistics and in follow-up of children between an adequate age interval, with emphasis on the dangers of overdosage.
- * SC/B should continue to work with the MOH to ensure that iodized salt, at least, is available in each person's home.

II.A.4) Maternal Health

55 VHWs and 30 TBAs will be trained in safe prenatal and birthing practices, and the identification and referral of high risk cases.

Educate 20% of women of fertile age in reproductive health an concept of obstetrical risk.

Less effort was given to maternal health by the project than the other interventions for a variety of reasons. Attendance at TBA training courses was low because of cultural constraints and because it was found that in many of the dispersed communities TBAs did not exist. According to project documents, 22 VHWS and 10 TBAs received training in maternal health. Only three of the eight VHWs interviewed considered maternal health to be part of their activities. According to the survey 64.3% of all deliveries were attended by a family member. Almost none of the mothers had cards with spaces to record ante-natal visits and almost none had made any ante-natal visits. Knowledge about appropriate maternal nutrition practices was very low. Women leaders and mothers commented that they would prefer to discuss these issues with women VHWs.

RECOMMENDATIONS FOR MATERNAL HEALTH

- * SC/B should use the strategy of the "WARMI" project (organization of women's groups around maternal health issues) in these communities to improve basic maternal health knowledge and practices.
- * An effort should be made to recruit women VHWs in each community or to identify women leaders who could work on issues relating to maternal health.
- * Due to the lack of TBAs in many of these communities, the project should identify ways to train men and other interested family members in basic safe delivery procedures. This could be accomplished through mass media or other social marketing techniques.
- * SC/B should negotiate with SOPACOF to extend their reproductive health work into these communities, educating both male and female groups and providing services for individuals. K&P survey data taken for a current reproductive health baseline indicated

that 87% of mothers did not want to have more children within the two years following the survey, but only 3.1% were using a modern method of family planning.

II.A.5) Acute Respiratory Infections

All VHWs will diagnose ARI, take appropriate measures and register deaths due to ARI.

Establish a distribution system for MOH treatment of ARI pneumonia cases.

According to the survey more than one third of the children had been ill with a cough or difficult breathing. Out of these children almost 75% had symptoms of pneumonia. Only 40% of mothers sought advice and of these, only 29% received any treatment.

Project documents show that 78% of the VHWs had received some type of training in ARI. In the interviews however, only 1 out of the 8 VHWs had adequate knowledge of ARI and its symptoms although 4 out of the 8 knew the correct treatment. The MOH current policy is to charge for Cotrimoxazol and Aspirin, making access difficult.

RECOMMENDATIONS FOR ARI:

- * SC/B should start a serious pneumonia control program in the impact area reinforcing the MOH referral services and training the MOH staff.
- * Basic messages should be developed to reinforce mother's knowledge regarding pneumonia warning signs and identification of places that can be used for referral of children.
- * SC/B should receive further training in ARI diagnosis and management through Project REACH, PAHO or other organizations and develop more quantitative objectives.

II.B. Project Management

II.B.1) General Project Management

Several action steps were taken by SC/B based on recommendations of the midterm evaluation to change the operational procedures of the project. According to the staff, these steps have increased the quality and effectiveness of teamwork; have facilitated team problem solving and have increased outreach to project areas. The following changes were made:

*Instead of dividing personnel by project, quality circle teams of staff were formed by areas; Quime being one of the areas. Included in this team is the Health Coordinator and the six Supervisors. The team is supervised by the Health Advisor, who is based in LaPaz. Midlevel management positions of a Nutritionist and a Technical Assistant were eliminated. Please see Appendix I for the current SC/B organizational chart.

* Each person in the team prepared their own quarterly work plans based on the DIP, and discussed their plans, achievements from the last quarter and problems that arose within the team. A system using "missed targets" for each intervention was used to plan the next quarter's work schedule. Each team meets quarterly as a whole in Quime with the executive

and administrative staff to exchange ideas and problem solve. All staff meetings with personnel from LaPaz, Quime, Licoma and Circuata also took place 2-3 times per year. Supervision, feedback and general understanding of a global SC/Bolivia strategy has been facilitated by this process.

* A job description manual was created which clearly defined the roles of each staff member and criteria for performance appraisal. Examples of key positions can be found in Appendix J.

* Supervisors were asked to stay within their communities from one to three days instead of visiting a community and leaving the same day. A room has been rented for them in each of their zones. This has increased the presence of SC in the area and facilitated the supervision of the volunteer promoters.

* Seven supervisors were hired instead of the original three envisioned in the DIP. This has increased outreach to the communities.

* Since the midterm evaluation the project has begun to hire women supervisors in this area to fill staff vacancies.

* Staff were strengthened in Quime by rotating stronger staff from the other SC/B impact areas to Quime.

Currently there are six supervisors, each with responsibility for six to 12 communities, the average being 8.5 to cover a total of 53 communities. Seven of the original 60 communities currently receive minimal supervision. Community size ranges from 18 to 3190 persons, with an average population of 181 persons. The number of communities assigned to each supervisor depended on the following criteria: accessibility, number of project interventions, and population size. Each supervisor is responsible for the training and supervision of 6 to 17 VHWs, with an average of 9.5. This signifies that each supervisor is responsible for 688 to 4,143 inhabitants with an average of 1,660 persons. Each VHW works with approximately 10 to 90 families, averaging at 42 families (191 persons)/VHW.

Each supervisor is now partially responsible for sponsorship activities (from private funds) in his/her communities. While this has enhanced the coordination between sponsorship and health activities, there is still confusion amongst some community members about the role of sponsorship in this program.

RECOMMENDATIONS FOR PROJECT MANAGEMENT:

- * SC/B should continue to recruit women in key project positions in order to enhance the expertise and institutional quality of program planning and problem solving. This is especially important since the main project beneficiaries are women of fertile age and children under five years of age.
- * SC/B should evaluate the ratio of supervisors to VHWs and also of VHWs to families. An analysis should be made according to the three different zones (Quime, Ichoca and Luruta/Siguas) to take into consideration the different programs planned for these areas and the different job expectations of the supervisors and VHWs in these areas. It might be possible to establish a different ratio (more or less supervisors and VHWs per family) in each zone depending on the planned project activities and the funding available. If not, the VHW job descriptions and strategies for working with them should be tailored according to the project activities undertaken. In other integrated

preventive health care programs with comprehensive activities, a ratio of 1 VHW to 25 families or 90 inhabitants has been more effective. Overall, the project should intensively train several community members per village to assume more responsibility for managing preventive health care activities.

- * It was found that the DIP in Spanish did not totally match the DIP in English. All project documents should be carefully translated and the Spanish documents should be easily accessible to staff. In future projects it is recommended that funds be budgeted to cover translation costs.

II.B.2) Community Participation

a) Who is the Community?

The community is estimated at 10,889 persons according to the computerized information system, PROMIS; of which 5,387 inhabitants are female and 5,502 are male. Direct project beneficiaries included 1,478 children under five years and 2,330 women of fertile age (15-49). Sixty percent of the mothers with children under two years reported in the survey that they had attended primary school and could read and 50% of the mothers reported that they generally worked away from home during the day. Of these working mothers, 80% carried their child with them while they were away from home. Of the 20% who left their children at home, 31% reported that older children watched the younger siblings.

b) How does the community participate?

Based on interviews carried out in the community, it was found that all VHWs were selected in agrarian union meetings with the backing of the community leaders. Criteria for selection was suggested by the project and included literacy, age between 20 and 40 years, and stability within the community. Although in principle this method respected the traditional decision-making channels of the community, it excluded the opinion and participation of the women, who were the direct beneficiaries of the project. While the majority of the women accepted the VHW, they said that they would prefer to confide in and discuss health issues with a VHW of their own gender.

The selection of a female VHW is often done through women's groups. However in this project area it was found that most of the mother's clubs had been organized around the distribution of food by other agencies and once the food had been stopped, the mother's clubs had stopped functioning. An intensive effort would need to be made to re-establish and strengthen these groups. In the Child Survival 5 area of Inquisivi, the project has had success in organizing women's groups through the "WARMI" project. Women have united around issues of maternal health and have actively participated in problem identification and solution of their basic health programs. Plans have already been made by SC/B to begin to work with women's groups in the Quime area.

At the beginning of the project 70 VHWs were trained by the project. There are now only 43 VHWs currently active. Reasons given included migration, following the union tradition of only working in a volunteer capacity for one year, and not having community support or other types of incentives. Throughout the life of the project there has been a relatively high turnover of VHWs.

It was originally planned that the VHWs would be generally responsible for registering the population, reporting vital events (births and deaths), managing vaccination campaigns, and training mothers in diarrheal prevention and management, nutrition, ARI and maternal health.

This was in contrast to what the communities wanted. Their main perceived need was curative health, not preventive health, and confidence was lost in the VHW when they could not meet their community's expectations. In addition, perhaps because of the volunteer nature of the VHW position, at least half of them were not successful (as reported in the earlier technical section of the report) in carrying out all of these activities. Responsibilities remained with the SC/B supervisor.

SC/B has been able to establish a fluid relation with the community and its authorities, which has made it possible for the project to develop its activities without problems. Coordination with community groups has increased significantly since the midterm evaluation, but even still, the community involvement has not reached a level where the community directly intervenes, participates and takes decisions related to the project activities.

The relationship with the authorities has been instrumental in achieving consensus in implementing activities that would benefit women and children. Only two communities out of 60 decided not to participate in the project. The project has also begun to work within the community school system. However, the project has been only able to reach some women and mothers who have remained interested; full participation of the community, especially of the women has not been obtained causing some isolation and absence of key community members.

RECOMMENDATIONS FOR COMMUNITY PARTICIPATION:

- * If the currently inactive women's groups can be resuscitated, the leaders of the women's groups might be an appropriate choice or could help facilitate the process of selection of women VHWs.
- * If SC/B continues to work with the VHWs, they should have clearly defined job expectations that are known by the community, the supervisors and the MOH.
- * A system of supervision should be set up within the community. Natural community leaders and the MOH should be trained to supervise the VHWs.
- * Using the methodology of the "WARMI" project or other appropriate strategies, women's groups should be resuscitated or organized to play a more active role in their own health problem identification and decision making.
- * A child to child program or other program coordinated with the school system should be attempted to train older siblings in basic health knowledge and practices, since many of these children are caretakers of their younger brothers and sisters.
- * SC/B should continue to strengthen its ties with all community groups and to involve the community at all levels in health problem identification and decision making. Indicators for monitoring community participation should be established as a guide.
- * As proposed by SC/B, VHWs should be part of a larger group and receive training within a group context so that skills are more likely to exist within a community context instead of one individual who is likely to abandon the position.
- * SC/B should study reasons VHWs remain motivated to continue working as volunteers and establish ways the community and MOH could motivate and support them in their roles.

II.B.3) Human Resource Development (Training)

In general terms, the education process has reached and benefitted mothers and children as evidenced by the results of the K&P survey. SC/B has established a training system for planning and monitoring the number of training events in specific intervention areas and general themes within the community by the VHW and the supervisor. Training programs also existed for SC/B staff. The majority of the VHWs listed workshops and supervisor visits as one of the motivating reasons for continuation as a VHWs. SC/B has recently begun to conduct community "health fairs" during a supervisor's visit to increase the outreach of messages.

However, the evaluation team did not see an annual training plan for VHWs that included pre and post testing of technical concepts, a plan for follow-up refresher courses, or a plan for the development of adult education concepts. The evaluation team was unable to evaluate the quality of the training program or determine the level of knowledge improvement over time for staff or VHWs because a system of pre and post testing was not in place. Because information on health interventions improves over time, a series of refresher courses for staff and VHWs is considered necessary to keep them updated.

Due to the geographic isolation and dispersion of the communities, the supervisors have not been able to establish frequent schedules of training and supervision visits, nor have these events been of a long enough duration to ensure adequate understanding of technical concepts (Please refer to Section IIA.) On average, community visits by a supervisor generally happen every two to four months.

It appears that a great number of educative messages are given to the VHWs, which are transmitted to the mothers directly by the VHW and also by the supervisor. The evaluation team was not able to perceive a prioritization of messages based on problems of mortality or noticeable lack of prevention. It was observed that the VHWs frequently repeated messages without having the message assimilated into the appropriate cultural context so that they could be better understood. For example, in maternal health, VHWs could say that prenatal control was important, but they could not say why it was important or what should happen during a visit.

Because of the project's focus more on individual talks with mothers, health messages and the need for preventive health has not reached a large part of the community, such as teachers, men's groups, or youth groups who could help reinforce basic health practices, spread information and assist in community health decision making.

There was also a noticeable lack of creative non-formal education techniques being used by the project such as songs, shows, role plays, etc. that could more successfully motivate the community to focus on and discuss issues related to preventive health.

RECOMMENDATIONS FOR HUMAN RESOURCE DEVELOPMENT:

- * Develop a systemized plan to upgrade the staff capacity of the Coordinator and Supervisors in technical and community development themes so that they are familiar with the most up to date information. Include the MOH staff in these trainings when possible.
- * Train the VHWs with a systemized curriculum and plan based on the understanding of the most common causes of mortality and prevention. Use a pre and post test system

for technical information. Provide refresher courses during supervisor visits. Develop an instrument to assist the supervisor to provide training and supervision. Try and incorporate experienced VHWs as trainers of new VHWs.

- * Increase the use of mass media and other social marketing and non-formal education techniques. Provide training for staff in these techniques where appropriate. These techniques could perhaps increase attendance at "health fairs" and improve attitudes regarding preventive health.
- * Develop a plan with the MOH to use focus groups to validate and prioritize basic health messages according to the following criteria: that the message is easy to understand, that it implies a change in behavior, that its practice will result in a reduced mortality, and that the message is culturally acceptable. The list of messages should incorporate the results from the K&P survey and should not exceed more than two messages per theme.
- * Taking into consideration that 60% of mothers are at least partially literate and 40% are not, messages and materials should be developed that are acceptable to both audiences.
- * In Bolivia, the educational attainment of mothers has been demonstrated to be powerfully associated with sound health behaviors, utilization of modern health services, and significantly lower mortality and morbidity (1). Based on these findings, an important step for achieving the goal of the project in a sustainable manner would be to integrate health activities with literacy and other educational incentives for women and their children.
- * Develop a supervisory tool, such as a checklist, that the supervisor can use when working with the VHW or the MOH. This should increase the quality assurance of the VHW's work.

II.B.4) Inter-Institutional Coordination

Based on interviews with the MOH (USLP) at the Regional Level, coordination has improved since the midterm evaluation. The MOH felt that the EPI program and the education directed at mothers were the most effective part of the program. EPI campaigns have been carried out together; SC/B assisting with logistics and the MOH providing vaccines, materials, and Road to Health Cards. Project information (vital events, number of persons with specific diseases, EPI statistics and growth monitoring data) have been shared with the MOH. The MOH also reported an increase in referrals to the Hospital and Health Centers from the promoters and supervisors.

The MOH staff felt that coordination could still further improve. They felt that they lacked a general understanding of the project, and that the SC staff did not understand some of the MOH programs and indicators they were using. They suggested more joint training activities, and the establishment of annual plans. They also said that it would be helpful to both parties to establish a more formal set of roles for both organizations.

(1) Bolivia Case Study, A.I.D. Technical Report No. 5, Center for Development Information and Evaluation, 11/92

PROCOSI and SOPACOF both acknowledged excellent relations between their organizations and SC. PROCOSI hoped to be able to visit the project area at least once/year to gain a better understanding of project strategies and achievements. SOPACOF was expecting to begin reproductive health activities with SC in the Quime Zone within the next few months.

RECOMMENDATIONS FOR INTER-INSTITUTIONAL COORDINATION:

- * Given that the MOH frequently changes personnel once a year, SC/B should plan to hold an annual project orientation meeting for the new personnel. At this time, objectives for coordination should be jointly established.
- * SC/B should compare its basic health messages with the MOH and jointly devise a plan for preparing messages standard to both organizations that are applicable to this cultural area.
- * SC/B should increase technical training activities with the MOH so that the MOH and SC share the same technical guidelines and knowledge.
- * SC/B should systematically review with the MOH (*Tres Cruces*) its services, its long-range vision, its staff and jointly develop a plan for strengthening MOH services in key areas that will improve the quality of services and impact the long-term sustainability of project activities.
- * SC/B should alone or in coordination with PROCOSI, document activities and strategies used by the Project so that lessons learned can be shared with other organizations working in Bolivia. Some potential themes might include selection of promoters and results, involvement of women, design of appropriate messages, etc.
- * SC/B should strengthen its relationship with the Medical University in LaPaz so that lessons learned from the project can influence the next generation of primary health care workers in the country.

II.B.5) Health Information System

The objective of the project was to:

Implement an HIS to monitor CS activities; register 100% of families in 47 communities and Quime town.

SC/B is using a fluid Health Information System for programming, supervision and evaluation of project activities. The frequency of information follows a quarterly rhythm that coincides with the Quality Circle Team planning meetings. This system does not seem to overburden the supervisors, links information with decision making, and supports the continual education of the SC/B staff in management of information. Please find a description of the HIS instruments used in the project in Appendix K.

According to the HIS, 58 communities (including Quime) have been registered. Based on a comparison of family registration cards with families interviewed in the K&P survey, it was found that approximately 75% of all families have been registered by the project.

Observations on each of the main instruments used in the HIS follows with recommendations on how they might be able to be used more efficiently:

<u>Instrument</u>	<u>Observation/Specific Recommendations</u>
Family Registration Card	*An easy mechanism to distribute information collected during the census to community leaders does not exist. It is recommended that a short summary of the data from each community be shared with their respective leaders.
Road to Health Card	*This card could be utilized more completely according to the norms of the MOH, i.e. by registering diarrheas and treatment, ARI, etc. in the corresponding month and by coloring the syringes according to the appropriate vaccination. This instrument is one of the few educational instruments for mothers without cost used by the MOH and should be exploited to the maximum.
Roster of Children Under Five Years	*The roster was originally planned to be used and managed by the VHW, but it is primarily used and kept by the supervisor. It is mainly used for the individual follow-up of EPI, Vitamin A and Growth Monitoring activities by the supervisor. It requires a new design in the diarrhea and ARI sections based on how or if SC plans to follow-up these children. The current design is not useful for these two interventions. It is recommended that SC/B design a new instrument that is more graphical and educative and that remains in the community for community identification of EPI follow-up to defaulters and Growth Monitoring (the use of colored bands for different nutritional levels as used in the MotherCare project).
TT Vaccination Card	*SC/B should conduct a technical refresher training with staff and MOH personnel on minimal intervals for TT doses since various vaccinations were found outside of technical norms.
Women's Roster	*This roster should be redesigned to incorporate other aspects of women's health in addition to TT since the project intends to strengthen maternal health interventions. Follow recommendations established by the MotherCare project.

Mortality Record

*This record serves to facilitate the qualitative analysis of the circumstances relating to death. The project is currently only recording and analyzing deaths occurring in children under five years of age. SC/B should decide if it wants to focus its efforts on those diseases found to be most frequent, most debilitating and most preventible. If this is the case, deaths of adults should also be analyzed. An instrument could be designed that would look at annual increases in population (due to births and immigrations) and decreases (deaths and emigrations) by sex, age and community.

SVEN

*SC/B should decide which of the three criteria it wants to focus on to demonstrate actual malnutrition and to be able to have the greatest educational impact: weight in relation to the curve on the road-to-health card, the direction of weight gain/loss in relation to the last recorded weight, or SVEN, the instrument of the MOH. SVEN is the instrument least adequate to educate the community about its state of nutrition nor is it useful to gauge the impact of malnutrition in children. SC/B should discuss this aspect of the HIS with the MOH.

SNIS

No observation

Health Training Record

*This supervisor's instrument is used in quarterly evaluation and planning meetings. Understandably, the project requires an instrument to monitor the activities of the supervisor, but this report does not reflect quality of training, and it creates the illusion that a certain number of VHWs and mothers that listened to a talk were trained in that particular theme. It is suggested that VHWs take some kind of test that reflects their knowledge and actual practice. It would also be interesting to know how many growth monitoring sessions and household visits were conducted by the VHWs independently of the supervisor to get a clear idea of actual work assumed by the VHW.

RECOMMENDATIONS FOR HIS:

- * If SC/B plans for financial reasons to only implement immunization and health education campaigns three times/year with no other project activities in some of the communities, the HIS should be simplified in these areas so that the system can be managed by the community. It is suggested that the project investigate the possibility of establishing a civil system of birth registers with EPI information and a death register in the community. This system could be maintained by union leaders, the VHW or other natural leaders in the community.
- * Since 25% of the families interviewed were found not to be registered in the health information system (ie did not have a family registration card), it is suggested that further studies be conducted to determine the usefulness of the HIS records for the program. It is suggested that a Lot Quality Assessment be conducted to find which

VHWs and supervisors need additional supervision to accurately register at least the vital events and immunizations.

- * Because visits to each community occur only every two to four months, accurate project information is always slightly delayed. Given that this information is then put into the computerized system, PROMIS, by one individual who is responsible for all of the impact areas, the information becomes delayed by approximately six months and in some instances, the information is no longer useful to project staff. It is recommended that the PROMIS information and updating system be reviewed, and that only the most essential information for project decision making be included in the system.
- * In 100% of the interviews made, the community did not know how the information collected by the project was used. It is recommended that a system be developed for feed-back to the community so that they can engage in interpreting the health status of their community and take a more active role in creating solutions to improve the health of the community.
- * It appears that deaths are being under-reported. However the evaluation team did not have time to investigate this. It is recommended that SC/B has technical assistance to analyze the system of recording births and deaths and to analyze the information tabulated to date.

II.B.6) Sustainability

Please refer to Appendix A for the completed AID questionnaire on sustainability which discusses issues related to recurrent costs, sustainability plan proposed in the DIP and its status, monitoring and evaluation of sustainability, community participation, counterpart institution collaboration, efficiency and cost recovery attempts.

This Child Survival Project is one of the few experiences SC has in implementing a preventive health care project that is not complemented by additional activities in education, productivity and agriculture/natural resource management. The project began only two and one half years ago in dispersed communities that had extremely little access to any kind of government or non-governmental services prior to this project. Preventive health was not a prioritized need of the community; curative health services and income generation projects were the felt need. In spite of this, 58 out of 60 communities participated in the project to varying degrees. This project should be reviewed in this light. SC/B has made a modest beginning to address sustainability issues in difficult circumstances and with limited time.

It should also be kept in mind that the process of preventive health has just begun in these communities. Current SC/B plans are to continue project activities for at least an additional five years to consolidate and strengthen achievements made.

It is also important to note that SC/B is reviewing its initial strategy and based on its own internal evaluation already has plans to change the sustainability strategy from one of working exclusively with health promoters to one of working more closely with women's groups, union groups and other groups within the community. Also, education and credit activities will begin in selected communities in Quime under the Women-Child Impact Grant, which continues through September 1996. This change of focus should be recorded accurately and qualitatively so that project findings may be shared with other interested organizations. A general summary of the impact of the current strategy follows.

Given the timeframe of the project, there did not seem to be a reasonable balance between trying to meet quantitative objectives in a short period and implementing a process that could be sustainable. By pushing to reach quantitative objectives, the process that could have maximized community participation and allowed for the internalization of knowledge and practices demonstrated in community decision-making was often given a second place. This is demonstrated by the lack of community decision making that has taken place to date in terms of project activities or based on project information.

On the other hand, one cannot discount the enormous effort expended by the SC/B staff to reach dispersed and isolated communities and to achieve a coordination with the MOH and union organizations. The support given to these local organizations and their staff is a beginning for an increase in and an improvement in preventive health care services over the long-term.

The general conception in the communities about the project is an identification with assistance and support that doesn't cost the community much except for time. None of the communities had made any arrangements or discussed any kind of support system for the VHW.

Additionally, it was noted that there was a very marked relationship of dependency between the SC/B supervisor and the VHW and community. If the SC/B supervisor did not arrive and promote community participation, the communities would probably take very little action themselves around preventive health, especially since this was not a felt community need at the beginning of the project.

The quantity and quality of formal and informal health services in the area are definitely deficient in regards to the needs of the population. The presence of SC/B has contributed to their improvement and it is evident that the strategy used by the project is gradually increasing community awareness of services. More focus needs to be paid to improve the MOH services that exist and should exist in the communities and how these services could be partially sustainable by the communities. An increased use of services and an increase in health preventive behaviors should happen once the value of the preservation, prevention and control of family health is internalized and valued at least as much as curative health.

Another important aspect of sustainability is the acquisition of technical skills by the VHW or other community groups so that these persons serve as a pivotal point to protect the health and prevent diseases in their communities. This objective should be reinforced in the future so that the VHW plays a larger role than the current role of mediator between the community and the MOH or project. This objective could be reached by finding a way to provide additional training to the VHW. For example, SC/B's idea to provide one month of training at the District Hospital for those outstanding VHWs is an excellent beginning.

In the perspective of creating better conditions for the sustainability of preventive health services, a persistent demand exists (within project staff and communities) to introduce complementary productivity projects that could help meet the community need for basic necessities (such as food and water). This would help to motivate the community; an improvement in the family economic situation would permit one to take better care of one's health. If minimal conditions of production and income which cover basic dietary needs don't exist, one cannot expect that preventive health will be a community priority. As also mentioned, literacy and education activities are also very relevant to meeting the goal of the project.

RECOMMENDATIONS FOR SUSTAINABILITY:

- * SC/B should clearly establish process indicators for sustainability so that the impact of the original strategy and of the new strategy can be measured. It might be interesting to involve PROCOSI in the design of these indicators to see what strategies and indicators other projects in Bolivia have already developed. Perhaps funding can be found to hold a workshop on sustainability within child survival programs in Bolivia. Some suggested indicators can be found in the AID sustainability questionnaire. SC/Westport should also be more involved in the distribution of indicators used by other projects and current sustainability strategies.
- * Public health should be viewed as a public event and not an individual service. It is necessary to involve as many people as possible in health discussions (perhaps through plays, songs, women's groups, school groups, union groups or other social events) to engage the community in discussions about their health. This is not to say that individual follow-up should be discontinued, just that it needs to be complemented by activities involving the entire community.
- * It was noted that in some of the communities collections were made for community events. It might be worthwhile to try and collect some minimal funding for community preventive health events in order to establish some degree of community ownership over the project and to place more of a value on these services.
- * It is recommended that the project continue to work with VHWs but to also include other natural community leaders in basic health training. It appears that some VHWs have been more successful than others in terms of their acceptance by the community. The project should consider doing a qualitative study of the role and motivation of the VHW. It might be necessary to develop future plans for the development of key health agents by community or at least by zone in the future and to provide them with adequate training.
- * In some communities, it was stated that a female VHW would be more acceptable to the women than a male VHW, especially in terms of Maternal and Reproductive Health activities. As already mentioned, much work needs to be done within each community to include women as decision makers, rather than only beneficiaries in the program.
- * SC/B set out to work with communities that had very little understanding of preventive health. If SC/B is trying to influence the perceptions of the community around what illnesses can be prevented and the value of preventive services, it would be interesting to develop a system to monitor the changes in these perceptions. Illness is a social and cultural phenomenon, shaped by culturally defined parameters of illness recognition and behavior. An index of self-perceived morbidity could provide critical information on the relevance of disease to the individual. Health priority setting by the community could also then reflect both patterns of observed morbidity and the community's changing rankings of health problems (2).
- * SC/B should evaluate the practicality of training select VHWs in first aid and basic curative health so that community priorities can be met. SC/B should evaluate why many VHWs experienced difficulties in collecting funds from the community for basic

(2)Murray, C.J.L. and L. Chen. *Understanding Morbidity Change*. Population and Development Review vol. 18, no. 3. Sept. 1992.

supplies in their first aid kit, and establish a sustainable plan for keeping basic medicines/supplies within each community.

II.B.7) Financial Management

Please refer to appendix B for a copy of the pipeline analysis. Expenses followed the budget established in the DIP with small changes made in accordance with the guidelines set forth in the cooperative agreement. Changes included a small decrease in funds needed for consultants and a corresponding increase in funds needed for supplies. It is expected that the majority of the funds will be spent by January 31, 1993. Standardized monthly financial procedures were used by the project. These were prepared by two part-time accountants and reviewed by the Co-Directors.

Overall the project spent approximately \$201,600 to work with approximately 10,900 beneficiaries over approximately three years for a cost/beneficiary ratio of \$18.50 over the life of the project or \$6.17/person/year. The direct beneficiary ratio (including only 2,400 women of fertile age and approximately 1,568 children under five years) is \$16.94/person/year. These costs seem reasonable in light of the dispersed and isolated nature of the communities, and the fact that no other basic services exist.

RECOMMENDATIONS FOR FINANCIAL MANAGEMENT

- * SC/B should attempt to develop a system to monitor costs of some of its activities, especially if the project hopes to demonstrate impact of its activities to the MOH or other agencies in Bolivia. This might also help increase project efficiency and reduce some recurrent costs in a phased plan. This is especially important for the EPI campaigns that the MOH will assume in the future.

III. LESSONS LEARNED

In a two and one half year project it is at best difficult to evaluate project impact or sustainability. While significant gains have been made in reaching project objectives, the gains made can only be considered temporary. It is commendable that SC/Bolivia has already secured additional funds to be able to continue basic project activities for an additional three to five years without disrupting or discontinuing current project activities while additional funding was sought.

The K&P survey conducted at this time was a relevant activity that will serve as a useful baseline survey for the remaining years of the project. The tool was useful to help staff re-evaluate some of their perceptions relating to the community and to find out if knowledge of health practices was translated into health practices. This survey was useful for assisting the staff to focus on and plan activities based on the most relevant and important specific health areas.

Conducting a K&P survey simultaneously with a final evaluation proved cumbersome. It is recommended that the K&P survey be completed prior to the final evaluation, so that a final evaluation team could use the quantitative information to evaluate the project objectives and develop the qualitative tools necessary to target on those weakest areas of project content and strategy.

The project developed a two tiered strategy to sustain health activities after the life of the project - the strengthening of the MOH services and the training of mothers in child protective behaviors. While difficulties and delays arose from coordinating activities with the MOH and other local institutions (agrarian unions) at the beginning of the project, the benefits of this approach are beginning to materialize. The project is now in a good position to continue to build on this foundation and increase activities that support and increase the capacity of these institutions so that activities can continue once the project ends. Working with these institutions also aids the transfer of lessons learned and sets the project up to be a "learning experiment" where positive approaches and ideas can hopefully be replicated elsewhere. This approach should cause the project to have a greater impact in Bolivia over the long-term, and should be established and monitored as a project objective.

The second strategy of training mothers in child protective behaviors was a useful strategy as demonstrated by the increased knowledge and practices of mothers in key health preventive areas. The project developed training plans and materials that contributed to this success but could have done this more efficiently through the development of a detailed training cycle plan that included training of staff, MOH personnel, VHWs and community members. Development of culturally specific innovative methodologies and materials could have had an impact beyond the impact area.

Health objectives were in part successfully achieved because of the information system established by the project. The system was used for effective monitoring, supervision and quarterly planning of activities.

Sustainability activities envisioned in the Detailed Implementation Plan are still relevant to the next phase of the project. Activities listed included identifying and analyzing community priorities through participatory research; returning data to the community in a graphic simplified form to analyze and plan future health activities; training VHWs in community perceived high priority areas such as accident prevention and first aid; and assisting the community to link with funds or institutions that can provide their highest perceived needs, such as water, roads, etc. It appears that SC/B focussed on meeting quantitative objectives over and above working with the community on its community development needs. Community support and participation in all aspects of the project was probably low because of this imposed emphasis.

An assumption made by the project in the Detailed Implementation Plan was that community ownership of the project would be fostered by its participation in the selection, monitoring and evaluation of the VHWs and TBAs. While the project ensured that all VHWs were selected by the community leaders through the agrarian unions, it has been found that the key beneficiaries of the project, women and children, were not included in this process since in most cases they were not members of the agrarian union structure that made these decisions. Because women were more passive beneficiaries of project activities instead of key decision makers, support for the role of and use of VHWs (mostly male) was low.

Sustainability in the long term depends on a high level of community involvement and participation and responsibility. Projects which devote initial time for community organization and inclusion of community groups in the project including time for the community to understand their health problems and discuss their possible solutions have a greater chance of changing long-term health behaviors than projects which strive to reach high objectives in a tight timeframe. While the initial costs and timeframe might be greater, in the long term they will lead to more sustainable work.

Constraints listed by the project that were particularly relevant to improved nutritional status were low socio-economic levels, habits and beliefs, language barriers, generally low educational levels particularly of women, lack of hygiene, lack of water, and non-availability of food. All of these constraints still exist and impede project progress since they directly relate to morbidity levels in the community. This raises the question about the relevance and ultimate sustainability of an isolated preventive health project that does not also address these other concerns either directly or through linkages with other institutions, an attainment difficult in this area where other institutions and services are minimal.

A project that sets and monitors sustainability indicators along with health indicators will be in a better position to periodically evaluate its sustainability strategy and re-plan activities in an efficient and timely manner. The indicators will also be useful for monitoring the quality of services. This focus should help balance the dilemma between service delivery and strategy given time and funding constraints.

ANNEX A

AID/W Sustainability Questionnaire

APPENDIX A
BOLIVIA CHILD SURVIVAL 3 FINAL EVALUATION
January 1993

AID/W SUSTAINABILITY QUESTIONNAIRE

The questions about sustainability were answered by SC/Bolivia staff, staff from the Ministry of Health, agrarian union leaders, leaders of mothers' clubs and members of the impact area communities. The following format was designed by the Office of Private Voluntary Cooperation/Bureau for Food and Humanitarian Assistance for use in AID/W centrally funded Child Survival final evaluations.

A. Sustainability Status

A1. At what point does A.I.D. funding for child survival project activities end?

A.I.D. financing of this project ends January 31, 1993.

A2. At what point does the organization plan to cease child survival project activities?

The current plans of SC/Bolivia are to phase-over all child survival activities in this area to local institutions within five years, by Sept. 30, 1997.

A3. How have major project responsibilities and control been phased over to local institutions? If this has not been done, what are the plan and schedule?

The project has and will continue working with the VHWS (community level health promoters within the MOH system) to strengthen their capacity to train families in protective health behaviors and to assist with vaccination campaigns. Health data collected by the project has been shared with the *Tres Cruces* Health District for inclusion in their district wide collection and analysis of health data. The MOH is also responsible for the distribution of ORT packets to the promoters. SC/B plans to coordinate activities more closely with the Quime Hospital which is the District Center in the future, to work more closely with the local unions and mother's clubs, and to form women's groups in communities where they do not now exist. The SC/B current plans are to continue vaccination and health education campaigns coordinated with the MOH three times per year in those communities of the Sigwas/Luruta Zone, continue basic child survival and maternal health activities in the Ichoca Zone, and to intensify child survival and maternal health activities with women's groups in the Quime Zone.

B. Estimated Recurrent Costs and Projected Revenues

- B1. Identify the key child survival activities that project management perceives as most effective and would like to see sustained.

Activities that SC/B management believes are the most effective and should be sustained include community health education and awareness of preventive health behaviors, EPI, rehydration for children with diarrhea and exclusive breast-feeding through the first four to six months and prolonged breast-feeding through two years.

- B2. What expenditures will continue to be needed (ie recurrent costs) if these key child survival activities are to continue for at least three years after child survival funding ends?

SC/B will need to continue to support personnel costs, transport, basic medical supplies, and have access to external assistance. These costs are already guaranteed for the immediate area of Quime (CS3 area) and Inquisivi, Licoma and Circuata (CS5 areas) through funds committed by PROCOSI, a local Bolivian umbrella NGO, through 12/95. Funds donated by a private donor will support activities in the Ichoca Zone through 9/94.

- B3. What is the total amount of money in US dollars the project calculates will be needed each year to sustain the minimum of project benefits for three years after CS funding ends?

SC/B will receive \$225,000 over the next three years to support activities in Quime, Inquisivi, Licoma and Circuata from PROCOSI. Minimal project benefits should continue after the PROCOSI grant ends (12/95) with no additional PVO costs and with continued MOH participation. The costs for activities stated above (B2) in Ichoca and Luruta/Siguas are covered through 9/94. SC/B is currently fundraising to cover additional costs.

- B4. Are these costs reasonable given the environment in which the project operates? (eg local capacity to absorb cost per beneficiary)

Yes, costs in this area are high due to the geographic isolation, and the inaccessibility and dispersed nature of the majority of the communities. They are also reasonable given the fact that there are very few services of any kind to those communities furthest from Quime.

- B5. What are the projected revenues in US dollars that appear likely to fund some child survival activities for at least three years after A.I.D. CS funding ends?

The PROCOSI grant will finance some of the activities in this area from 1/1/93 to 12/31/95.

B6. Identify costs which are not likely to be sustainable.

Costs of personnel, the computerized HIS and transport costs for community visits will not be sustainable.

B7. Are there any lessons to be learned from this projection of costs and revenues that might be applicable to other child survival projects, or to A.I.D.'s support of those projects?

Sustainability in the long term depends on a high level of community involvement and participation and responsibility. Projects which devote initial time for community organization and inclusion of indigenous community groups in the project including time for the community to understand their health problems and discuss their possible solutions have a greater chance of changing long-term health behaviors than projects which strive to reach high objectives in a tight timeframe. While the initial costs and timeframe might be greater, in the long term they will lead to more sustainable work. While difficulties and delays may arise from coordinating activities with the MOH and other local institutions, it is absolutely essential that a project support and increase the capacity of these institutions so that activities can continue once the project ends.

C. Sustainability Plan

C1. Please identify number and position of project staff interviewed, and indicate the extent of their involvement in project design, implementation and/or monitoring/evaluation.

All of the SC/Bolivia management personnel (Co-Directors, Project Advisor, Health Coordinator and the six supervisors) were interviewed as well as several of the community promoters. Since the midterm evaluation, project implementation and monitoring/evaluation was conducted in trimestral planning and evaluation sessions. All staff worked as a team to evaluate their work, analyze data and develop plans for the next three months. Plans for community level activities were shared with the promoters during community visits.

C2. Briefly describe the project's plan for sustainability as laid out in the DIP, or other relevant A.I.D. reports.

The sustainability plan described in the DIP is based on the following points:

- *Community participation and increased capacity of the VHWS
- *Family based preventive health behaviors
- *Collaboration with the MOH and other agencies.

Plans for community participation included the selection and monitoring of the VHWS by the community and community involvement in data analysis. VHWS were to be trained by SC/B and supported

by the community with food allotments, and fees for basic materials that the VHWS would manage. They were to collect health information and share it with the community to aid in problem identification and problem solving. The VHWS were to visit each house in the community, collect health information and follow-up on EPI defaulters, and hold community meetings to train mothers in health preventive behaviors. Coordination with the MOH was to take place via trainings, meetings, increased responsibility for some of the interventions, and a strengthened information system.

C3. Describe what sustainability-promoting activities were actually carried out by the PVO over the lifetime of the project.

Activities in each of the above three categories were carried out, some with more success than others. Success also varied by community. The VHWS were trained and supervised by the project. Their role, credibility and liaison with the union leaders and community members varies from community to community, and their ability to sustain activities when the project ends also varies. Most of the VHWS selected by the agrarian union, an all male group, were male and never really had the confidence of the women. In most of the communities, the VHWS did not receive any direct support from community members other than attendance at events. However, mothers' knowledge and practices of health preventive behaviors have improved as shown by the K&P survey. Coordination with the MOH increased after the midterm evaluation and information from the project was shared in Quime with the Health Center.

C4. Indicate which aspects of the sustainability plan the PVO implemented satisfactorily, and which steps were never initiated. Identify any activities which were unplanned, but formed an important aspect of the PVOs sustainability effort.

The activities listed above were accomplished satisfactorily. More remains to be done however. Most of the VHWS never reached a level where they could manage the information and feed it back to the community. Very little problem solving was accomplished at the community level. More effort is needed to increase the technical and training skills of the VHWS so they have a more credible presence, and to encourage women to become VHWS. The project also needs to work more directly with both women's groups and with other local institutions, such as the agrarian union and the schools so that preventive health is understood as a community issue, not an individual issue. It would help the project if the VHW was a member of a larger group - for example, a women's group and/or community development committee. This would help ensure a continuity of knowledge in case the VHW resigns from this volunteer post. The project needs to continue to coordinate activities with the MOH and other community leaders so that they could be more closely involved in the supervision of

the VHWS or other community leaders when the project ends. Most of the VHWS depend on the presence of SC/B for their supervision and implementation of activities at this time.

C5. Did any counterpart institutions (MOH, development agencies, local NGOs, etc), during the design of the project (proposal or DIP), make a financial commitment to sustain project benefits? If so, have these commitments been kept?

The MOH provided vaccines, Road to Health Cards and ORS packets throughout the life of the project as originally promised. No other financial commitments were made.

C6. What are the reasons given for the success or failure of the counterpart institutions to keep their commitment?

Success can be contributed to the increased coordination with the MOH since the midterm evaluation and the fact that the MOH receives vaccines free from UNICEF.

D. Monitoring and Evaluation of Sustainability

D1. List the indicators the project has used to track any achievements in sustainability outputs and/or outcomes.

The project tracks EPI coverage rates and weight trends of children by community and also number of community members who have received trainings from the project. The project also tracks vital events, ie births and deaths by community.

D2. Do these indicators show any accomplishments in sustainability?

The above indicators are not adequate to track sustainability. It is recommended that the project look for other indicators, such as level of participation by the MOH in supervision of events, number of times community members go to the promoter or health post for support and advice, number of references made to health posts or to the hospital, number of functioning women's groups (if this method is chosen as a strategy) where health is discussed, list of community decisions made in reference to health, participation of women in community health decision making, and technical knowledge of promoters or other community leaders.

D3. What qualitative data does the PVO have indicating a change in the sustainability potential of project benefits?

In the majority of the communities the VHWS either did not exist or were not functioning prior to the project. In some of the communities where the VHWS have received the support and respect of the community, community members go to the house of the VHW for support and advice rather than waiting for the VHW to visit

them.

D4. Identify in-country agencies who worked with the PVO on the design, implementation, or analysis of the midterm evaluation and this final evaluation.

Persons from USAID/B, PROCOSI, Andean Rural Health Care, the Ministry of Health (Unidad Sanitaria de La Paz), Province of Inquisivi agrarian union directors, and Tres Cruces Health Center participated in the implementation and analysis of the final evaluation. During the midterm evaluation, representatives from USAID/B, MOH-USLP, CIEC, and Project Concern participated.

D5. Did the PVO receive feedback on the recommendations regarding sustainability made by the technical reviewers of the proposal and the DIP? Did the PVO carry out those recommendations? If not, why not?

The DIP review pointed out concerns over the high cost per beneficiary and the fact that prospects for sustainability seemed poor at this time due to the complexity of the computer based information system and lack of a cost recovery scheme. Costs of travel in this dispersed area are very high and six supervisors covering 60 communities were felt to be the least number possible. The project decided to focus on the manual HIS while also continuing with the computerized HIS for internal and long-term use. Cost recovery was attempted by giving the VHWS a basic first aid kit to manage. However, very few VHWS were successful in recovering any of the costs.

D6. Did the PVO carry out the recommendations regarding sustainability of the midterm evaluation team? If not, why not?

The midterm evaluation recommended that SC improve its relationship with the MOH in the Tres Cruces Health District, consider providing incentives for the VHWS, and involve local community organizations in health activities. SC has increased the coordination and sharing of information with the MOH although this coordination should be increased even further in the future. A plan should be made with the MOH to clarify the role of the MOH and of SC/B in the future. SC/B works with the agrarian union and has plans to work with women's groups in the future. Staff felt that material incentives for VHWS were not sustainable or desirable in the context of the project area. There is a proposal under consideration with the MOH to provide one month of training for those VHWS with the highest EPI coverage rates in the Tres Cruces health center.

E. Community Participation

E1. Please identify community leaders interviewed and indicate which group(s) they represent.

The names of the leaders of the different committees (Agrarian Union and Mother's Clubs leaders) interviewed and their affiliation can be found in Appendix E.

E2. Which child survival activities do community leaders perceive as being effective at meeting current health needs?

Immunization was mentioned as being the most effective activity of the project in all of the interviews.

E3. What activities did the PVO carry out to enable the communities to better meet their basic needs and increase their ability to sustain effective child survival project activities?

VHWS were trained in basic health messages and information collection, supervised as they made household visits and were accompanied by MOH and SC supervisors during immunization campaigns. One concern of the community was their preference for basic curative services and economic support over and above their perceived need for preventive health services.

E4. How did communities participate in the design, implementation and/or evaluation of child survival activities?

Communities selected their health VHWS and assisted in the logistics of the immunization campaigns. However, in the majority of the communities women were not involved in any of the decision making and selection of their promoters. Information was not shared back with the community so there was little community participation in monitoring of the project and basic decision making over health problems. Members of the agrarian union at both the Province and local level were interested in the project and accompanied the interviewers during the final evaluation and assisted in the analysis of information.

E5. What is the number of functioning health committees in the project area? How often has each met during the past six months? Comment on whether committee members seem representative of their communities.

The project did not form health committees; but worked with local groups such as the agrarian union. Most of these groups were not representative of women in the community. Each community has its own plan for community meetings ranging from monthly meetings to none.

E6. What are the most significant issues currently being addressed by these health committees?

These groups were most frequently involved in vaccination campaigns.

E7. What resources has the community contributed that will encourage continuation of project activities after donor funding ends?

The promoters are volunteer community health workers. Other community members contributed time and energy to project activities.

E8. What are the reasons for the success or failure of the committees to contribute resources for continuation of effective project activities?

The communities have few resources to contribute except their time and energy. In many of the communities, the leaders were eager to increase project activities beyond preventive health care. In some of the areas however, more attempts should be made to encourage some type of financial or basic support for the VHW or other basic project items so that the community places a value on these services.

F. Ability and Willingness of Counterpart Institutions to Sustain Activities

F1. Identify persons interviewed and indicate their organization and relationship to the child survival project.

Dr. Jacinto Perez, medical staff and Theresa Rocaborro, Nurse of the *Tres Cruces* Health Center were interviewed. Thomas Perez, Nurse Auxiliary at the Health Center in Tablachaca was also interviewed.

F2. What linkages exist between the child survival project and the activities of key health development agencies (local/municipal/district/provincial/state level)? Do these linkages involve any financial exchange?

There is no financial exchange but there is coordination of activities and exchange of information with the local health posts, the *Tres Cruces* Health Center and the MOH-USLP in LaPaz. Discussion have taken place with SOPACOF (an indigenous family planning organization) to begin reproductive health activities in Quime during 1993. SOPACOF currently works with SC/B in Inquisivi Province. SC/B also supports some training activities of the Agrarian Union.

F3. What are the key local institutions the PVO expects to take part in sustaining project activities?

The key local institutions include the community agrarian unions, women's groups, the MOH, and the promoters. Other groups include CIEC, PROCOSI and SOPACOF.

F4. Which child survival project activities do MOH personnel and other staff in key local institutions perceive as being effective?

The MOH in Tres Cruces mentioned that the high EPI coverage in the area was due to the work of SC/B. However, they felt that they could not sustain these activities if SC/B were to leave the area and asked for increased coordination in the formation of annual plans and strategies.

F5. What did the PVO do to build skills of local MOH personnel or staff of key counterpart NGOs? Did they teach them to train VHWS, or manage child survival activities once A.I.D. funding terminates?

The MOH has participated in some of the trainings of SC/B and SC/B has participated in MOH trainings. However, no specific trainings have been carried out with the goal of turning the project over to the MOH or to increase their participation. However, project activities are expected to continue for an additional three to five years.

F6. What is the current ability of the MOH or other relevant local institutions to provide the necessary financial, human, and material resources to sustain effective project activities once CS funding ends?

The MOH does not have the material and/or human resources for project follow-up.

F7. Are there any project activities that counterpart organizations perceive as effective?

The counterparts perceive the project as effective. Implementation of the EPI program, promotional activities, and information generation were some of the aspects mentioned by the counterparts as especially effective.

G. Project Expenditures

G1. Attach a pipeline analysis of project expenditures.

Please refer to Appendix B for a pipeline analysis.

G2. Compare the budget for planned expenditures identified in the DIP with the actual expenditures at the end of the project. Were some categories of expenditures much higher or lower than originally planned?

Expenses followed the budget established in the DIP with small changes made in accordance with the guidelines set forth in the cooperative agreement. Changes made included a small decrease in funds needed for consultants and a corresponding increase in funds used for supplies.

G3. Did the project handle the finances in a competent manner?

Yes. The project used standardized monthly financial procedures which are reviewed by the Co-Directors. Two part-time accountants were financed by the project to ensure timely and accurate reporting.

G4. Are there any lessons to be learned regarding project expenditures that might be helpful to other PVO projects, or relevant to A.I.D.'s support strategy?

None.

H. Attempts to Increase Efficiency

H1. What strategies did the PVO implement to reduce costs, increase productivity or make the project more efficient?

After the midterm evaluation, the project eliminated the positions of the mid-level health manager and increased the presence of the supervisors in the communities. Quarterly joint planning sessions among all staff resulted in more focussed energy and improved problem-solving.

H2. What are the reasons for the success or failure of the attempts to reduce costs, increase productivity or efficiency of this project?

The above changes were successful. It is recommended that the project focus more on an overall training scheme and design, from the MOH to the VHW level to increase both technical and training of trainer skills. It is also recommended that the key health messages be reviewed, adapted to community perceptions, taught to supervisors and promoters and other leaders, and shared intensively with the community in groups settings. The training methodology used should also include more non-formal techniques including social marketing techniques and be inclusive of the cultural context of this area. This focus on training should help further with increased efficiency. Given the poverty of the communities, the dispersed nature of the communities and the fact that no services exist in the community, it will not be easy to greatly reduce costs and still be successful.

H3. Are there any lessons to be learned regarding attempts to increase efficiency that might be applicable to other PVO child survival projects or to A.I.D.'s support of these projects?

Team quarterly planning meetings are a successful technique for stimulating new ideas, motivating staff, and arriving at plans synergistically.

Training should not be attempted in an ad-hoc manner but should result from a carefully planned scheme and from messages developed from focus groups that represent the culture of the area. Projects should develop long-term plans for both the development of the institutions in the community as well as for an increase in individual knowledge and practices.

I. Cost Recovery Attempts

I1. What specific cost-recovery mechanisms did the PVO implement to offset project expenditures? If cost recovery was part of the project, who managed implementation?

None.

I2. Estimate the dollar amount of cost recovery obtained during the project. What percent of project costs did this revenue cover? Did the cost recovery mechanisms generate enough money to justify the effort and funds required to implement the mechanisms?

Not applicable.

I3. What effect did any cost recovery activity have on the PVO's reputation in the community? Did the cost recovery venture result in any inequities in service delivery?

Not applicable.

I4. What are the reasons for the success or failure of the household income generating activities of this project?

Not applicable.

I5. Are there any lessons to be learned regarding cost recovery that might be applicable to other PVO child survival projects or to A.I.D.'s support strategy?

Long-term access to health services is essential for the well-being of the community. If preventive health is considered a basic human right, then it is difficult to demand payments for these preventive services in areas as destitute as these. Preventive health projects should be linked with income

generating or credit projects for families so that they have financial resources to contribute.

J. Household Income Generation

J1. Did the project implement any household income-generating activities?

No.

J2. Estimate the dollar amount of income added to a family or household's annual income, as a result of the income-generating activity of the project.

Not Applicable

J3. Did the revenues contribute to meeting the cost of health activities? What percentage of project costs did income generation cover?

Not Applicable

J4. Are there any lessons to be learned regarding household income generation that might be applicable to other PVO child survival projects or to A.I.D.'s support strategy?

Income generating projects and/or credit was a felt need of the community, much more than health. Some type of poverty lending or seed credit program would have been an appropriate entrance into the community to gain their support and would perhaps have contributed to some type of revenue generation.

K. Sustainability Summary

K1. Description of Project Accomplishments, Competence and Lessons Learned

In order to evaluate the overall sustainability of the project one must understand the antecedents of the project. Primary health care services did not previously exist in the majority of these 60 dispersed, isolated and remote communities; this initial phase of the project was only for two and one-half years; preventive health was not a priority community need; this project was the basis for Save the Children's entrance into the community.

Considering the above constraints the achievements have been commendable. Almost all of the indicators stated in the CS3 Detailed Implementation Plan were reached and surpassed in EPI, Nutrition and Exclusive Breast-feeding. Complete EPI coverage for children 12-23 months reached 60%, at least 50% of children under two years were involved in a growth monitoring program, 43% of children were exclusively breast-fed for the first four months

and 70% of mothers continued to breast-feed through two years. While these interventions will require additional follow-up in the next few years, other interventions need much greater emphasis in the future. While diarrhea management was good, only 31% of mothers used ORS as a treatment for dehydration. Maternal health knowledge and practice was extremely low and while one third of the children had some form of ARI, only 29% received some form of treatment.

Systems to achieve sustainability in all primary health care interventions are still in an incipient stage. The project has collaborated with the MOH and did try to resurrect, nominate and train a VHW in every village that would be linked with the MOH. However, given minimal supervision by the community and MOH and lack of women's participation, VHWs were by and far either minimally active, inoperative or had a high turn-over rate. The project needs to be more inclusive of women, work more with group events and trainings and campaigns, include the community in health decision making and tie the VHW with an organized community group. Plans to test this new sustainability strategy have already been formulated by the project staff. The project needs to develop a better balance between striving to reach quantitative objectives and working with the community and the MOH at their pace to ensure that activities will continue once the project ends.

K2. Members of Final Evaluation Team

Members of the final evaluation team included:

- *Dr. Victor Lara, John Hopkins Consultant
- *Dr. Hernan Zambrana, MOH-USLP
- *Dr. Carolina de Itulde, Andean Rural Health Care
- *Arturo Villabuena, PROCOSI
- *Dr. Luis Amendola, ASCH/Honduras
- *Dr. Guillermo Seoane, SC/Bolivia
- *Karen LeBan, SC/Westport
- *Charles Llewellyn, USAID/Bolivia

Additional Members of the final evaluation team in Quime included:

- *Francisco Aruquipa, Secretary Agrarian Union Quime
- *Dr. Adolfo Martinez, SC/Bolivia CS3 Health Coordinator
- *Dr. Jacinto Perez, Director Quime Hospital
- *Gregorio Quispe, SC/Bolivia Supervisor
- *Alicia Tantani, SC/Bolivia Supervisor

ANNEX B

Pipeline Analysis

BUDGET VS. ACTUALS FOR YEAR 6 AND TOTAL EXPENSES TO DATE VS. TOTAL GRANT

	YEAR 1 EXPENSES	YEAR 2 EXPENSES	YEAR 3 EXPENSES	YEAR 4 EXPENSES	YEAR 5 EXPENSES	YEAR 6: EXPENSES VS. PLANNED BUDGET *				LIFE OF GRANT: CUMULATIVE EXPENSES VS. TOTAL GRANT **			
						EXPENSES 09/30/92	PLANNED BUDGET	BALANCE	% EXPENDED	CUMULATIVE ACTUALS	TOTAL PLANNED BUDGET	BALANCE	% OF TOTAL GRANT SPENT
Personnel	0.00	0.00	11,652.11	51,408.54	39,769.22	6,820.76	22,931.13	16,110.37	29.7%	109,650.63	125,761.00	16,110.37	87.2%
Travel	0.00	0.00	539.60	1,308.88	1,271.94	94.66	1,879.58	1,784.92	5.0%	3,215.08	5,000.00	1,784.92	64.3%
Other Direct	0.00	0.00	1,636.98	13,181.00	15,071.01	1,994.80	5,820.01	3,825.21	34.3%	31,883.79	35,709.00	3,825.21	89.3%
SUBTOTAL	0.00	0.00	13,828.69	65,898.42	56,112.17	8,910.22	30,630.72	21,720.50	29.1%	144,749.50	166,470.00	21,720.50	87.0%
Consultants	0.00	0.00	0.00	311.63	1,000.00	0.00	1,000.00	1,000.00	0.0%	1,311.63	2,311.63	1,000.00	56.7%
Supplies	0.00	0.00	655.80	9,872.06	104.90	41.07	2,028.00	1,986.93	2.0%	10,673.83	12,660.76	1,986.93	84.3%
Equipment	0.00	0.00	0.00	(2,972.39)	0.00	0.00	0.00	0.00		(2,972.39)	(2,972.39)		
SUBTOTAL	0.00	0.00	655.80	7,211.30	1,104.90	41.07	3,028.00	2,986.93	1.4%	9,013.07	12,000.00	2,986.93	75.1%
TOTAL	0.00	0.00	14,484.49	73,109.72	57,217.07	8,951.29	33,658.72	24,707.43	26.6%	153,762.57	178,470.00	24,707.43	86.2%

* Field Office, Home Office and Overhead through 09/30/92

** Budget for Ichoca Impact Area is composed of remaining funds of Yucumo Impact Area, transferred per Amendment No. 3; effective February 1, 1990.

NOTE: BOLIVIA PROJECT ENDS AS OF 1/31/93

Year 1 = Aug. 1, 1987 - July 31, 1988

Year 2 = Aug. 1, 1988 - July 31, 1989

Year 3 = Aug. 1, 1989 - July 31, 1990

Year 4 = Aug. 1, 1990 - July 31, 1991

Year 5 = Aug. 1, 1991 - July 31, 1992

Year 6 = Aug. 1, 1992 - January 31, 1993

LINE ITEM FLEXIBILITY: 100% flexibility within each SUBTOTAL.

SUBTOTALS AND TOTALS may not change.

ok

ANNEX C

K&P Survey

**REPORT ON FINAL EVALUATION
SURVEY**

*Save The Children
Quime, Bolivia*

Child Survival III Project

Cooperative Agreement # OTR-0636-A-00-7215

*Guillermo Seoane, M.D., M.P.H.
Health Advisor, SC/Bolivia*

*Victor Lara, M.D., M.P.H.
Survey Trainer Consultant, Johns Hopkins University*

*La Paz - January, 1993
Bolivia*

ACKNOWLEDGEMENTS

The author of this report would like to thank the following persons who participated in the preparation and conduct of this survey:

1. *SC/Bolivia Co-Directors, Robert Grabman and Lisa Howard-Grabman.*
2. *SC/Westport Health Unit Manager, Karen Leban*
3. *La Paz Health Unit (MOH) for their support, Dr. Guido Monasterios and Dr. Hernan Zambrana.*
4. *Inquisivi Impact Area Manager, for his administrative and arrangement of permits for the survey, Ing. Carlos Loayza.*
5. *Head of District Health Services, Dr. Jacinto Perez*
6. *SC/Quime and Inquisivi Supervision and Administrative Team for their day by day coordination and support, particularly to Wilson Rivero and Pacifico Copa.*
7. *SC/Bolivia Staff (all involved), for their invaluable technical collaboration and to Dr. Luis Amendola of SC/Honduras.*
8. *Survey Supervisors*
 - a. *Dr. Adolfo Martinez*
 - b. *Dr. Santiago Medina*
 - c. *Glicerio Quispe*
 - d. *Murcelino Bruñez*
 - e. *Juan Mayta*
 - f. *Basilio Cachi*
9. *Surveyors*
 - a. *Fidelia Quispe*
 - b. *Elizabeth Adriázola*
 - c. *Verónica Salvador*
 - d. *Ana Maria Ramos*
 - e. *Reyna Cerezo Flores*
 - f. *Alfredo Peñaloza Flores*
 - g. *Maria Gonzales Valencia*
 - h. *Raul Prado Bustillos*
 - i. *Marcelina Lopez*
 - j. *Alfredo Estrudu*
 - k. *Celia Quisbert*
 - l. *Ubalдина Condori*
 - m. *Berthu Solares*
 - n. *Gladys Moreno*
 - o. *Vilma Argollo*
 - p. *Basilia Pancara*
 - q. *Bertha Mamani*
 - r. *Fabiola Uriona*

Without their participation and contributions, this survey would not be presented as it is. The author believes that their contributions will have a significant impact on the health development of Quime in particular and Bolivia in general, in order to achieve better living conditions and services for the children.

SC/Bolivia - Quime CSIII: Final Evaluation Survey

TABLE OF CONTENTS

	PAGE
EXECUTIVE SUMMARY	iii
I. INTRODUCTION	1
A. Background information	1
B. Objectives of the survey	2
C. Schedule of activities in La Paz and Quime	3
II. METHODOLOGY	3
A. The questionnaire	3
B. Determination of sample size	4
C. Selection of sample	5
D. Training of supervisors and interviewers	5
E. Conduct of the survey	6
F. Method for data analyses	7
III. RESULTS	7
IV. DISCUSSION AND RECOMMENDATIONS	23
V. BIBLIOGRAPHY	29

ANNEXES

1. Spanish and Aymara (local dialect) translation of questionnaire
2. Population data used for sampling
3. Map of the Impact Area
4. Charts of Selected Indicators

EXECUTIVE SUMMARY

A Knowledge and Practices survey (K&P) was carried out encompassing three local areas, Quime, Tablachaca and Colquiri in the Inquisivi province in northwestern Bolivia between January 11 - 26, 1993. This work was achieved in cooperation between the private voluntary organization Save The Children, AID/FHA/PVC, the Bolivian Ministry of Health and the PVO Child Survival Support Program (PVO CSSP), Institute for International Programs of The Johns Hopkins University School of Hygiene and Public Health.

The objectives of the survey were to obtain information on the knowledge and practices of the mothers of children under two years of age in the Year 3 SC/Bolivia CSIII project areas concerning child survival activities, and to identify health care factors most commonly involved at the household level for childhood illness. The objectives of the survey were accomplished within two weeks. The SC/Bolivia field team discussed the results extensively in order to evaluate project plans as outlined in the proposal and to provide background information for development of the Final Evaluation of the CSIII program.

A Child Survival III project was being implemented by SC/Bolivia, a PVO with the headquarters in the USA. The SC/Bolivia Child Survival Project received a grant from the A.I.D. Bureau for Food and Humanitarian Assistance/Office of Private and Voluntary Cooperation (FHA/PVC). The project was planned to serve a 12,000 potential beneficiary population by implementing CS activities from March 1, 1990 to January 30, 1993, in 60 communities in the Quime sector of the Inquisivi province.

The survey questionnaire was initially designed at the SC/Westport office in Connecticut, in consultation with SC/Bolivia and then refined in La Paz, Bolivia. The SC/Bolivia - Quime staff selected field team participated in a three day training program in conducting a WHO 30 cluster sample survey methodology so that the 24 member group could competently conduct this type of survey as a routine activity to measure project progress. Seven three-person teams of interviewers and a supervisor conducted a 30 cluster survey. Each cluster included 10 cohort household survey interviews of mothers with children less than 2 years of age. A total of 291 households were interviewed.

Major findings include: almost all indicators stated by the SC/Bolivia proposal to AID were reached and surpassed in EPI, Nutrition and Exclusive Breastfeeding. The rate of children with immunization cards recording complete immunization coverage was lower than MOH national targets. Management of children with diarrhea is quite good, more than the half of mothers use ORT recommende fluid, however ORS use is low. Only half of the interveiwed children had growth charts but most of children with cards had been weighed in the four months prior to the survey. Near half of children have been exclusive breastfed. Ante-natal for services and contraceptive use is almost non-existent in the surveyed area.

I. INTRODUCTION

A. Background

Save The Children, a PVO with its headquarters in Westport, Connecticut, implemented a Child Survival III project in 60 rural communities of Quime in northwestern Bolivia. The project has received an A.I.D. grant from the Bureau for Food and Humanitarian Assistance, Office of Private and Voluntary Assistance (FHA/PVC) to implement CS activities from March 1, 1990 to January 30, 1993. This CSIII project, is a continuation of the project started in 1987 in the Beni Province of Bolivia, also funded by AID/FHA/PVC, closed in December 1989 shortly after the Mid-term Evaluation.

Current infant mortality rates (IMR) are not available for Quime and Inquisivi, however, UNICEF estimates Bolivia's IMR to be 102 per 1,000 live births (World State of Children, UNICEF, 1992). A local study developed by PROCOSI, a local "umbrella" project for US PVOs working with USAID funding, estimates an IMR 127 per 1,000 live births for the Inquisivi province (Morales, R. 1992.) The project's ongoing monitoring indicates that diarrhea, acute respiratory infections and malnutrition are the greatest threats to child survival. Full immunization coverage rates for children 12-23 months are estimated at about 20% according to 1991 household survey developed during the Mid-term Evaluation. These surveys also revealed that about 30% of children 0-36 months were malnourished by weight for age.

The project proposal targeted the following CS activities:

ORT	25%
Immunizations	15%
Nutrition: breastfeeding	
Others such as growth monitoring	25%
Maternal Care	20%
Acute respiratory infections	10%
Iodine deficiency	5%

The project approach was to reinforce the community organizations and household ability to prevent basic mother and children health problems increasing their knowledge and modifying their practices. In addition, plans were to strengthen MOH primary health care (PHC) services by providing managerial/logistical support and technical training for MOH personnel and thus improve capacity to implement PHC in concert with communities after project assistance is phased out. PHC, by national policy, is the means through which the extensive health problems of women and children in Bolivia are to be addressed. The national PHC policy delegates main responsibility for the planning, finance, implementation and evaluation of PHC to the Departamental Health Unit. While MOH health personnel are well versed in the theory of PHC, they need to strengthen their managerial capacity, technical experience and resources to effectively implement outreach/service activities.

In 1991, A.I.D. required PVOs with FHA/PVC Child Survival grants to conduct a 30-cluster survey, as part of the Final Evaluation process, using a standardized questionnaire developed by JHU. As part of this required process, the Johns Hopkins University Survey Trainer, Victor Lara, came to Save The Children/Bolivia for three major purposes: (1) to explain to the organization the standardized questionnaire, as well as the purpose of each question, (2) to train SC/Bolivia survey supervisors and interviewers in the conduct of a standard W.H.O. 30-cluster survey, and (3) to train SC/Bolivia staff to manually tabulate, analyze, and develop a report from the completed survey questionnaires. In addition, SC invited one staff member of its office in Honduras to be part of the training process. Additionally, AID/FHA/PVC required that SC pay the costs of the survey trainer's transportation and per diem, while JHU paid the costs of the survey trainer's salary and the trainer's office costs in Peru.

B. Objectives of the Survey

The method of choice for these kind of surveys is a 30 cluster sampling technique. The study population consist of mothers of children under the age of 24 months living in Quime, the SC Bolivia project area. By restricting the sample to mothers of children less than 24 months of age, repeat surveys can ascertain the project's ability to reach children born during the life of the project, and establish whether the project was successful in communicating to the mothers, through village based volunteers, certain action messages about key CS interventions.

A population based sample survey is one method of obtaining rates; i.e. data relative to denominators, which are an important part of project's health information system. The data collected from a sample survey can be used for project design, management information and evaluation purposes.

The objectives of the survey are to provide SC Bolivia with information about the following issues:

- Knowledge of mothers of children under two years of age about: major threats to infant, maternal and child health; ways to prevent immunizable diseases; proper treatment of diarrheal diseases (ORT); the value of growth monitoring; appropriate nutrition/weaning practices; and information about maternal care and child spacing
- Actual practices of mothers with regard to the intervention areas mentioned above
- Target groups for health education action messages
- For children aged 12-23 months: the coverage rates of BCG, DPT3, OPV3, measles vaccines and drop out rates between series antigens

The survey establishes estimates of child survival knowledge and assesses the extent of practices

(K & P) of the project's primary health care interventions. The data collected will help SC do two things: 1) evaluate project plans described in the CSIII proposal in order to develop the Final Evaluation Report; and 2) plan, manage, and assess project activities targeted towards changing behaviors at the household level.

C. Schedule of activities in La Paz and Quime

- Nov-Dec 92 SC staff prepares for the survey, which includes: identification of technical resources and coordination between HQ and Field Office; selecting supervisors and interviewers, determining costs and logistics of both training for and conduct of the survey, and communication and coordination with the survey trainer prior to his arrival at the project site on January 11.
- Jan 93 11-13 Final preparation of the survey, including finalizing Spanish and Aymara translation of the survey questionnaire
- Jan 14 Preparation for survey training
- Jan 15-17 Training of supervisors, survey teams, and field test of the questionnaire
- Jan 18-20 Implementation of the survey in 36 subdistricts of Quime Province, Bolivia.
- Jan 21 Hand tabulation of survey results, and data entry into EPI/INFO5.1b software program
- Jan 22-25 Finalizing of survey draft report
- Jan 26 Feedback to SC program managers in La Paz; Feedback to MOH, USAID, and the PVOs under the PROCOSI project.
- Feb 1993 Feedback by SC program managers to communities surveyed

II. METHODOLOGY

A. The questionnaire

The questionnaire, which contains 55 questions, was designed to collect information from mothers of children under 24 months of age. The questions were based on a standardized survey format which A.I.D. requires of all PVO CSIII projects. The standardized survey instrument was developed by the staff at PVO CSSP, with the assistance of US and international experts for the various intervention areas. SC/Bolivia in cooperation with the PVO CSSP Survey Trainer

Consultant Victor Lara, further customized the standardized survey questionnaire making the finalized questionnaire appropriate to the actual CSIII project interventions and the project area.

The first two questions ask about the age of the respondent (mothers) and her child under 24 months of age; questions 3 - 6 collect data regarding mother's literacy, employment, and who cares for the child when the mother is away from home; questions 7 - 15 deal with breast-feeding and other feeding practices; questions 17 - 20 ask questions concerning the child's attendance at growth monitoring sessions; questions 21 - 30 refer to mother's response to diarrheal disease and management of the child with diarrhea; questions 31 - 35 refer to mother's response to acute respiratory infections management of the child; questions 36 - 41 concern the immunization status of the child; and finally, questions 42 - 55 are about pre-natal care, family planning, and maternal nutrition.

The questionnaire was originally written in English and sent to the SC/Bolivia field office. SC/Bolivia staff translated the questionnaire into Aymara and further customized the questionnaire with the Survey Trainer for the project area. See annex 1 for questionnaire in Spanish and Aymara.

B. Determination of Sample Size

Sample sizes were calculated with the following formula:

$$n = z^2(pq)/d^2$$

where n = sample size; z = statistical certainty chosen; p = estimated prevalence/coverage rate/level to be investigated; $q = 1 - p$; and d = precision desired.

The value of p was defined by the coverage rate that requires the largest sample size ($p = .5$). The value d depends on the precision, or margin of error, desired (in this case $d = .1$). The statistical certainty was chosen to be 95% ($z = 1.96$). Given the above values, the following sample size (n) needed was determined to be:

$$n = (1.96 \times 1.96)(.5 \times .5)/(.1 \times .1)$$

$$n = (3.84)(.25)/.01$$

$$n = 96$$

It takes much time to randomly select an identified individual from the survey population, and then perform this selection 96 times to identify a sample of $n = 96$. Time can be saved by doing a 30 cluster sample survey in which several individuals within each cluster selected to reach the required sample size. However, in order to compensate for the bias which enters the survey from interviewing persons in clusters, rather than as randomly selected individuals, experience has shown that a minimum sample of 210 (7 per cluster) should be used given the values of p , d , and z above (Henderson, et. al., 1982). In general, when using a 30 cluster

44

sample survey, the sample size used should be approximately double the value n , when: $n = (z \times z)(pq)/(d \times d)$. In this case, a sample size of 300 (10 per cluster) was selected so as to ensure that sub-samples would be large enough to obtain useful management type information.

The estimates of confidence limits for the survey results were calculated using the following formula:

$$95\% \text{ confidence limit} = p \pm z(\text{square root of } \{pq/n\})$$

where: p = proportion in population found from survey; z = statistical certainty chosen (if 95% certainty chosen, then $z = 1.96$); $q = 1 - p$; and n = sample size

EXAMPLE: If the proportion of children in the survey who were completely and correctly immunized is 37% and $n = 297$:

$$95\% \text{ confidence limit} = .37 \pm 1.96(\text{square root of } \{.37 \times .63/297\}) \\ (z = 1.96)$$

$$1.96 = .37 \pm .03 \text{ (or, 34\% to 40\%)}$$

In other words, we are 95% sure that the actual proportion of children in the survey area who are completely and correctly immunized is between 34% and 40%.

C. Selection of the Sample

The sample consisted of 300 women with children 0-23 months of age in 8 communities in Siguas and Colquiri; 13 communities around Tablachaca, and in 14 communities in Quime, Bolivia. 10 women were selected in each of 30 randomly selected *communities* (cluster sites) following the process described in The EPI Coverage Survey training manual (WHO, Geneva, Oct. 1988).

Once the survey teams reached the designated *cluster site*, the initial household surveyed within the cluster, as well as the direction from the initial household, was randomly selected. Most of the communities were completely surveyed since the population is extremely dispersed and with a small number of children. Only one community didn't accept to receive the surveyors, in this case interviews were produced in the same cluster, which included other communities, but avoiding the non-participating community.

D. Training of supervisors and interviewers

The SC/ Bolivia staff pre-selected supervisors and interviewers for training. The training of

supervisors and interviewers took place in three days. Prior to the first day of training, the PVO CSSP Survey Trainer and SC/Bolivia staff went over the training curriculum and delegated responsibility for various classes that the SC/Bolivia staff was capable of conducting.

The first training day was dedicated to survey administration, methodology, and understanding the questionnaire. SC staff and the PVO CSSP Survey Trainer conducted the following classes: (a) purpose and objectives of the survey, (b) selection of the sample size, (c) selection of the starting household and survey direction, (d) community protocols and taboos, and (e) review of the customized questionnaire.

The second day of training concentrated on interviewing techniques, familiarization with the questionnaire through role play, and the roles of the supervisor and interviewers. These sessions were conducted by the SC/Bolivia staff with the assistance of the PVO CSSP Survey Trainer.

The final day of training commenced with a field test of the survey questionnaire. A peripheral community of the city of Quime had been pre-selected by SC staff for the test. Each supervisor and surveyor interviewed two mothers of children 0-23 months old.

E. Conduct of the interviews

The survey was conducted over three consecutive days; January 18 -20. Thirty survey areas (group of communities) were randomly selected by SC/Bolivia staff upon arrival of the survey trainer; the teams to survey each area also were selected.

The supervisors of each team were responsible for the selection of the starting household and survey direction. The supervisors observed at least one complete interview by each surveyor each day. Each questionnaire was checked for completeness before the survey team left the survey area, so that, in the case of missing or contradictory information, the mother could be visited again the same day.

In order to ensure consent and confidentiality, a consent form was given to each interviewer to be read to the mother before commencing with the survey. The consent form advised the potential respondent that she was not obligated to participate in the survey, and that no services would be withheld from her if she chose not to participate. The consent form also assured the mother that all information would be held in confidence, and that the information would be used to help health workers plan health activities. The interviewers were required to sign each form verifying that it had been read to the mother, and that she had consented to participate. In order to ensure confidentiality, the PVO CSSP survey trainer urged the SC Project Manager that all identifiers on the questionnaires be discarded/destroyed upon completion of the survey.

F. Method for Data Analysis

January 21 was dedicated to manual data tabulation. The SC/Bolivia Health Advisor and the PVO CSSP Survey Trainer supervised the hand tabulation.

A twenty person team made up of supervisors and interviewers, were available full-time for hand tabulation. Manual tabulation required half day dedicated to tabulation. The hand tabulators sat around large tables in the training rooms and the program officers' office space in the SC office. The questionnaires were organized by sets of 15, and each set of questionnaires was circulated between each of the tabulators. The tabulators each recorded the responses to one question at a time going through each of the 300 survey questionnaires until all the responses to that particular question had been tabulated. The tabulators were organized in analysis teams for each survey module and the teams were trained to analyze the results of the questions they had each tabulated and then write out the analysis tabulation sheets to be reported to the large group.

For the first draft of the survey report, the SC staff obtained frequency distributions for each of the questions and a few key cross tabulations. EPI/INFO was used to cross tabulate the results with the child's age and to complement the hand tabulation.

Immunization coverage was analyzed by looking at children aged 12-23 months. By restricting the sample to children of these ages, we can estimate the percentage of children fully immunized within the first year of life. For example, if only 50% of the children aged 12-23 months in the survey are fully immunized, we can then assume that the percentage of children in the project area who receive the full set of immunizations by age 12 months is 50% or less.

Once the frequency tables and some cross tables were finalized, the results of the survey were discussed between all supervisors, managers and members of the Final Evaluation team which included MOH and other PVO's staff in order to develop the first draft of the survey report. The consensus of the group was recorded and provided the basis for the results and discussion sections of the survey report.

III. RESULTS

The following answers were given for the 55 questions. 291 questionnaires were manually tabulated and entered into EPI/INFO for analysis. No questionnaires were removed from the analysis. Annex 4 includes charts of selected indicators.

Identification Module

1. The mean age reported by mothers surveyed is 29 years. 5.2% of mothers surveyed (15 out of 291) are under 18 years. 15.2% or 65 mothers who were surveyed are over 35 years.
2. 98 (or 33.7%) of children in the survey are under four months of age. 61.5% (179 out of 291) of the children in the survey are under the age on one year; children 0-11 months. 38.5% (112 out of 290) of the children in the survey are 12-23 months of age. The mean age

of children in the survey is 9.25 months.

Mother's Education and Occupation Module

3. 12.4 (36 out of 291) of mothers surveyed reported that they could they had no formal education. 15.5% (45 out of 291) mother reported that they had attended primary school, but could not read. 59.8% (174 mothers) reported that they had attended primary school and could read. 36 mothers (12.4%) reported that they had either a secondary or higher level of education. In sum, 27.8% of mothers stated that they could not read. Of the 210 mothers who stated that they could read, 174 (82.8%) could read only at the primary level.

4. 49.5% of mothers (144) reported that they were generally away from home during the day. The remaining 50.5% stayed close to the home during the day.

5. 59.1% (172 mothers) stated that they had no income generating work. 32.6% (95 mothers) stated that they earn income from harvesting. 14.8% (43 mothers) stated that they earn income from selling handicrafts, and 12.7% reported that they earn income as street vendors. 1.4% (4 mothers) reported earning income selling foods in the streets. 3 mothers earned income working as servants and 13 (4.5%) reported earning income from categories not listed in the questionnaire.

6. 80.1% of mothers (233 out of 291) reported that they took the child with them when they left home. 30.9% reported that older children took care of the child when the mother was away from home. 23 mothers (7.9%) left their children with relatives. 5.5% of mothers took their child to a nursery. 5.2% (15 mothers) left their children with the husband or partner, and only 1% (3 mothers) left their children with neighbor or friend.

Breastfeeding/Nutrition Module

7. 91% (264 mothers) reported that they were breastfeeding their child.

BREASTFEED | Freq Percent Cum.

	Freq	Percent	Cum.
YES	264	91.0%	91.0%
NO	26	9.0%	100.0%
Total	290	100.0%	

Appropriate Infant Feeding Practices: Persistence of Breastfeeding

Of those mothers in the survey with children 20-23 months of age (27 mothers), 19 mothers (70.4%) was still breastfeeding her child.

BREASTFEED	Freq	Percent	Cum.
YES	19	70.4%	70.4%
NO	8	29.6%	100.0%
Total	27	100.0%	

8. Of the 26 mothers who were not breastfeeding their child, 22 (84.6%) reported that they had breastfed the child in the past.

BREASTPAST	Freq	Percent	Cum.
YES	22	84.6%	84.6%
NO	4	15.4%	100.0%
Total	26	100.0%	

9. Appropriate Infant Feeding Practices: Initiation of Breastfeeding

169 mothers (59.3% of 285) reported that they had breastfed their child within one hour after delivery (38.9%) and between one and eight hours after delivery (20.4%). 109 mothers (38.2%) reported breastfeeding more than eight hours after delivery, and 7 mothers (2.5%) stated that they did not remember when they first breastfed their child after delivery.

	Freq	Percent	Cum.
1 hour after delivery	111	38.9%	38.9%
From 1 to 8 hours after delivery	58	20.4%	59.3%
More than 8 hours after delivery	109	38.2%	97.5%
do not remember	7	2.5%	100.0%
Total	285	100.0%	

10. Appropriate Infant Feeding Practices: Exclusive Breastfeeding

Of the children 0, 1, 2 and 3 months of age (84 children), 42.9% were being exclusively breastfed; in other words, they were not being given any of the food/fluid categories listed in question 10 (10a-10i).

EXCLUSV	Freq	Percent	Cum.
NO	48	57.1%	57.1%
YES	36	42.9%	100.0%
Total	84	100.0%	

54'

Appropriate Infant Feeding Practices: Introduction of Foods

Of the children 5, 6, 7 and 8 months of age (43 children), 79.1% had been introduced solid or semisolid foods; in other words, they were being given at least one of the non-fluid categories listed in question 10 (10c - 10i).

WEANING	Freq	Percent	Cum.
NO	9	20.9%	20.9%
YES	34	79.1%	100.0%
Total	43	100.0%	

Of the children in the survey 4 months of age and older (207 children), 78.3% were being given a food enriched with vitamin A, 84.1% were being given a food enriched with protein, 87.9% were given high energy foods and 74.9% were given with iodized salt.

VIT A	Freq	Percent	Cum.
NO	45	21.7%	21.7%
YES	162	78.3%	100.0%
Total	207	100.0%	

PROTEIN	Freq	Percent	Cum.
NO	33	15.9%	15.9%
YES	174	84.1%	100.0%
Total	207	100.0%	

HICAL	Freq	Percent	Cum.
NO	25	12.1%	12.1%
YES	182	87.9%	100.0%
Total	207	100.0%	

IODINE	Freq	Percent	Cum.
NO	52	25.1%	25.1%
YES	155	74.9%	100.0%
Total	207	100.0%	

When children between 4 and 10 months of age are selected almost 40% were not being given

food enriched with vitamin A and almost 35% of them were not being given food enriched with protein, calories and iodized salt.

VIT A	Freq	Percent	Cum.
NO	33	39.3%	39.3%
YES	51	60.7%	100.0%
Total	84	100.0%	

PROTEIN	Freq	Percent	Cum.
NO	26	31.0%	31.0%
YES	58	69.0%	100.0%
Total	84	100.0%	

HICAL	Freq	Percent	Cum.
NO	19	22.6%	22.6%
YES	65	77.4%	100.0%
Total	84	100.0%	

IODINE	Freq	Percent	Cum.
NO	30	35.7%	35.7%
YES	54	64.3%	100.0%
Total	84	100.0%	

11. 32.4% (94 mothers) responded not knowing what to do to continue breastfeeding during the first four days of a child's life.

	Freq	Percent	Cum.
NOT KNOW	94	32.4%	32.4%
YES	196	67.6%	100.0%
Total	290	100.0%	

49% (142 mothers) responded to this question with breastfeeding as soon as possible after delivery as an action to continue breastfeeding during the first days of a child's life. 34.1% (99 mothers) stated that frequent sucking was action a mother could do to continue to breastfeed. 6.9% (20 mothers) reported that care of breasts or nipples was an action a mother could take to continue to breastfeed during the first four days of a child's life. 5.9% (17 mothers) responded with "avoiding bottle feeding".

4

61 mothers (21% of 290) stated an action other than the actions listed in question 11. Of these 61 mothers, 27 (44.26%) stated that "drinking soups" and 16 (26.22%) stated that eating good foods was an action a mother could take to continue to breastfeed during the first four days of life. 12 mothers (19.67% of 61) responded with "drinking teas and liquids".

12. 24.8% (72 mothers) responded not knowing what to do to continue breastfeeding during the first four months of a child's life.

	Freq	Percent	Cum.
NOT KNOWN	72	24.8%	24.8%
YES	218	75.2%	100.0%
Total	290	100.0%	

41% (120 mothers) stated that frequent sucking was action a mother could do to continue to breastfeed and the same number of mothers 41% (120) responded with "exclusive breastfeeding" as actions to take to continue to breastfeed during the first four months of life. 5.9% (17 mothers) responded with "avoiding bottle feeding" and 1.7% (five mothers) stated that relactation was an action of mother could take to keep on breastfeeding during the first four months of life.

121 mothers (41% of 290) stated an action other than the actions listed in question 12. Of these 121 mothers, 89 (71%) stated that "drinking soups and teas" was an action a mother could take to continue to breastfeed during the first four months of life. 31 mothers (28% of 121) responded with "eating foods."

13. When asked when a mother should start giving a child foods in addition to breastmilk, 74.5% (216 out of 290) mothers responded with an age between four and six months. 6.9% (20 mothers) indicated an age earlier than four months, and 16.9% indicated an age six months or later. Five mothers (1.7%) stated that they did not know when. In sum, 25.5% (74) did not know that mothers should give their children food in addition to breastmilk between four and six months of age.

14. When asked what the additional foods to breastmilk should be, 47.6% (138 of 290) responded with a food rich in vitamin A, and 45.2% (131 of 290) stated that a mother should add oil to the child's food. 29.3% (85 mothers) responded with a food rich in iron. 24.1% (70) responded with a category other than those listed in question 14.

15. When asked which vitamins helps to prevent "night blindness", 51.7% (150 mothers) responded correctly, vitamin A, and 48.3% responded incorrectly.

	Freq	Percent	Cum.
YES	150	51.7%	51.7%
NOT KNOW	140	48.3%	100.0%
Total	290	100.0%	

51

16. When asked which foods contain vitamin A to prevent "night blindness", 48.3% (140 mothers) responded with yellow type fruits. 30.7% (89 mothers) stated that green leafy vegetables contained vitamin A to prevent "night blindness". 16.2% (47 mothers) responded with eggs yolks, and 14.8% responded meat and fish. 37.2% responded that they didn't know which foods contained vitamin A in order to prevent "night blindness."

Growth Monitoring Module

17. 171 mothers (59% of 290) in the survey had a growth monitoring card for their child. 32.1% (93) stated that they had lost their child's growth monitoring card, and 9% (26) stated that they never had a growth monitoring card for their child.

	Freq	Percent	Cum.
YES	171	59.0%	59.0%
LOST	93	32.1%	91.0%
NO	26	9.0%	100.0%
Total	290	100.0%	

18. Of the 290 mothers who had growth monitoring cards, 171 responses were recorded for this question. 146 children (85.4%) had a card which indicated that they had been weighed in the four months prior to the survey; in other words, 50.34% of the 291 children in the survey had cards which indicated that they had been weighed in the four months prior to the survey.

	Freq	Percent	Cum.
YES	146	85.4%	85.4%
NO	25	14.6%	100.0%
Total	171	100.0%	

19. Of the 290 mothers who had growth monitoring cards, 171 responses were recorded for this question. Only 51 children (29.8%) had a card which included records of vitamin A capsules.

	Freq	Percent	Cum.
YES	51	29.8%	29.8%
NO	120	70.2%	100.0%
Total	171	100.0%	

58

20. Of the 51 children with records of vitamin A the age mean in months at which children receive the first doses of vitamin A was 12.18.

AGE	Freq	Percent	Cum.
1	1	2.0%	2.0%
2	1	2.0%	3.9%
3	2	3.9%	7.8%
7	1	2.0%	9.8%
8	2	3.9%	13.7%
9	1	2.0%	15.7%
10	5	9.8%	25.5%
11	11	21.6%	47.1%
12	4	7.8%	54.9%
13	3	5.9%	60.8%
14	7	13.7%	74.5%
15	2	3.9%	78.4%
16	2	3.9%	82.4%
17	5	9.8%	92.2%
18	2	3.9%	96.1%
19	1	2.0%	98.0%
22	1	2.0%	100.0%
Total	51	100.0%	

Mean = 12.18
 Standard deviation = 4.26

Only nine records included two doses of vitamin A. The elapsed time in months between the first and second doses of vitamin A ranges from 0 to 10 months of age. The age mean was 6.89 months of age.

MONTHS	Freq	Percent	Cum.
0	1	11.1%	11.1%
6	2	22.2%	33.3%
7	3	33.3%	66.7%
9	1	11.1%	77.8%
10	2	22.2%	100.0%
Total	9	100.0%	

Mean = 6.89
 Standard deviation = 3.02

51

Diarrheal Disease Module

21. 40.3% (117 of 290) of the mothers surveyed stated that their child had diarrhea within the two weeks prior to the survey.

DIARRHEA	Freq	Percent	Cum.
YES	117	40.3%	40.3%
NO	173	59.7%	100.0%
Total	290	100.0%	

22. Of the 117 children with diarrhea during the two weeks prior to the survey, 106 were still being breastfed. Of these 106 children, 33 were given more breastmilk than usual and 64 were given the same amount of breastmilk as usual.

Management of Diarrheal Diseases: Continued Breastfeeding

In sum, 97 of 117 (82.9) of children were being given breastmilk more or the same amount as usual during the diarrhea episode. (As recommended by Rapid Child Survival Indicators: $97/(264-9)=97/255=38\%$).

BREASTGAVE	Freq	Percent	Cum.
MORE	33	28.2%	28.2%
SAME	64	54.7%	82.9%
LESS	9	7.7%	90.6%
STOP	2	1.7%	92.3%
NOT BREAST.	9	7.7%	100.0%
Total	117	100.0%	

Nine mothers (7.7% of 117) gave their child less breastmilk than usual during diarrhea, and two mothers (1.7% of 117) stopped giving their child breastmilk completely during the diarrhea episode. In sum, 9.4% (11 of 117) gave less breastmilk or stopped giving breastmilk completely.

23. Of the 117 children with diarrhea during the two weeks prior to the survey, 69 were being given fluids other than breastmilk. Of these 69 children, 50.7% (35 children) were given more fluids than usual and 31.8% were given the same amount of fluids as usual.

Management of Diarrheal Diseases: Continued Fluids

In sum, 82.6% of the 69 children were being given fluids other than breastmilk more or the same amount as usual during the diarrhea episode. (As recommended by Rapid Child Survival Indicators: $57/(117-46)=57/71=80\%$.)

FLUIDSGAVE	Freq	Percent	Cum.
MORE	35	29.9%	29.9%
SAME	22	18.8%	48.7%
LESS	12	10.3%	59.0%
STOP	2	1.7%	60.7%
EXCLUSIV.	46	39.3%	100.0%
Total	117	100.0%	

Twelve mothers (10.3 of 117) gave their child less fluids than usual during diarrhea, and two mothers (1.7% of 117) stopped giving their child fluids completely during the diarrhea episode. In sum, 12% (14 of 117) gave less fluids or stopped giving fluids other than breastmilk completely during their child's diarrhea episode.

24. Of the 117 children with diarrhea during the two weeks prior to the survey, 72 were being given solid or semisolid food. Of these 72 children, 40.2% (29 children) were given more foods than usual, and 41.6% were given the same amount of food as usual.

Management of Diarrheal Diseases: Continued Foods

In sum, 81.9% of the 59 children were being given foods more or the same amount as usual during the diarrhea episode. (As recommended by Rapid Child Survival Indicators: $59/(117-38) = 59/71 = 83\%$).

SOLIDGAVE	Freq	Percent	Cum.
MORE	29	24.8%	24.8%
SAME	30	25.6%	50.4%
LESS	13	11.1%	61.5%
STOP	7	6.0%	67.5%
EXCLUSIV.	38	32.5%	100.0%
Total	117	100.0%	

18 mothers (27.6% of 65) gave their child less food than usual during diarrhea, and six mothers (9.2% of 65) stopped giving their child food completely during the diarrhea episode. In sum, 36.9% (24 of 65) gave less food or stopped giving food completely during their child's diarrhea episode.

25. Management of Diarrheal Diseases: ORT Usage

Of the 117 children with diarrhea during the two weeks prior to the survey: 57 (48.7% of 117) received home fluids, 36 children (30.8% of 117) received an ORS sachet. 25 (21.4%) received a sugar salt solution.

9 mothers (7.7% of 117) gave their child medicine as treatment for their child's diarrhea.

601

29 mothers (24.8%) did not give any treatment for their child's diarrhea, and 23 mothers (19.7%) gave something other than the categories listed in question 25.

26. Of the 112 mothers of children with diarrhea during the two weeks prior to the survey, 42.7% (50 mothers) sought advice or treatment for their child's diarrhea.

ADVICE	Freq	Percent	Cum.
YES	50	42.7%	42.7%
NO	67	57.3%	100.0%
Total	117	100.0%	

27. Of the 50 mothers who sought advice or treatment for their child's diarrhea: 21 mothers (42.2%) sought advice from relatives for their child's diarrhea, 13 mothers (25.8%) went to a community health worker, and 7 (13.7) mothers went to a health center, and nine mothers (17.6%) went to a general hospital. Six mothers went to a private clinic or doctor. Two mothers sought advice or treatment from a traditional healer and one from a traditional birth attendant.

28. 22 mothers (43.1%) stated "fever" as a sign/symptom and 21 mothers (41.2%) stated that weakness or tiredness was a sign/symptom that cause them to seek advice or treatment for their child's diarrhea. 39.2% stated that loss of appetite, and 27.5% (14 mothers) responded to this question with vomiting as a sign/symptom. 14 mothers (27.5%) stated that dehydration and 7 (13.7%) stated prolonged diarrhea as a sign/symptom that would cause them to seek advice or treatment for their child's diarrhea.

29. 152 mothers (52.4%) stated that giving more to drink than usual is an important action, and 45.2% (131 of 290) stated that taking the child to the health center is an important action to take if the child has diarrhea. 52 mothers (17.9%) stated that giving the child smaller more frequent feeds is an important action. 88 mothers stated an action other than the action listed in question 29.

Two mothers stated that withholding fluids is an important action, and two mothers stated that withholding foods is an important action to take if the child has diarrhea.

30. 146 mothers (50.3%) responded to this question by indicating that giving more foods than usual is an important action. 113 mothers (39%) stated that giving the child smaller, more frequent feeds is an important action to take when the child is recovering from diarrhea. 45 mothers (15.5% of 290) responded with giving the child foods with high caloric content as important actions to take when the child is recovering from diarrhea.

76 mothers (26.2%) gave an answer other than the categories listed in question 25. Other actions included giving certain foods or breastfeeding (38% of 76), giving home fluids (30% of 76), and giving "home care" (14% of 76).

62

Pneumonia Control Module

31. 105 of the 290 mothers surveyed (36.2%) reported that their child had been ill with cough or difficult breathing in the two weeks prior to the survey.

	Freq	Percent	Cum.
YES	105	36.2%	36.2%
NO	185	63.8%	100.0%
Total	290	100.0%	

32. Out of 105 children with cough or difficult breathing, 77 (73.3%) experienced rapid (fast) difficult breathing (dyspnea).

33. Out of the 77 children that experienced rapid difficult breathing, 31 mothers (40.39%) seek for treatment when the children were ill with these respiratory problems.

ADVICE	Freq	Percent	Cum.
YES	31	40.3%	40.3%
NO	46	59.7%	100.0%
Total	77	100.0%	

34. Of the 31 mothers that seek for treatment, 16 (51.6%) sought advice from relatives for their child's respiratory problem, 9 mothers (29%) went to a general hospital, 5 (16.%) mothers went to a health center, and six mothers (19.4%) seek for treatment from village health workers. Four mothers went to a private clinic or doctor. Two mothers sought advice or treatment from a pharmacy and one from a traditional healer.

Pneumonia Control: Medical Treatment

In sum, only 29% of the children received medical treatment from health centers or doctors. (As recommended by Rapid Child Survival Indicator: $\{5+4\}/31=29\%$).

35. 173 mothers (59.7% of 290) stated "fever" as a sign/symptom and 135 mothers (46.6%) stated "cough" was a sign/symptom that cause them to seek advice or treatment for their child's respiratory infection. 78 mothers (26.9%) stated fast or difficult breathing, and 52 (17.9%) refer to "loss of appetite" as the sign/symptom that cause them to seek advice. 33 mothers stated an action other than the action listed in question 35. 13 out of 33 (39.9%) stated that "crying and uneasiness" was the sign/symptom that cause them to seek advice for the respiratory infection of their children.

Immunization Module

36. 204 mothers (70.3% of 290) stated that their child had received at least one immunization. (100 of the 112 mothers with children aged 12-23 months (89.3%) reported that their child had received at least one vaccination). 86 mothers (29.7% of 290) stated that their child had not received any immunizations.

37. Immunization Knowledge: Timeliness of Measles

96 mothers (33.1% of 290) stated that a child should receive its measles vaccine at age nine months. 8 mothers (2.8%) stated that a child should receive the measles vaccine at six months of age. 92 mothers (33.4%) gave an age other than nine months or six months, and 91 mothers (31.4%) stated that they did not know when a child should receive the measles vaccine. In sum, 64.8% of mothers did not know that a child should receive the measles vaccine at nine months of age.

38. Immunization Knowledge: Tetanus Toxoid Protection

127 mothers (43.9% of 289) stated that the main reason why pregnant women need to be vaccinated with the tetanus toxoid vaccine is to protect both the mother and child. 5.9% (17 mothers) stated that the main reason for the TT vaccine was to protect the woman against tetanus, and 17% (49 of 289) stated that the main reason was to protect the newborn infant. 96 mothers stated that they did not know.

39. 139 mothers (47.93%) stated that a pregnant woman needs more than two tetanus toxoid injections to protect the newborn infant from tetanus, and 48 mothers (16.6%) stated that a pregnant woman needs two TT injections. In sum, 64.4% of mothers stated that a pregnant woman needs at least two TT injections to protect the newborn infant from tetanus.

84 mothers (29%) stated that they did not know how many TT injections a pregnant woman needs, and 19 mothers (6.6%) stated that one or none TT injection is needed to protect the newborn.

40. 167 mothers (57.6%) had an immunization card for their child. 30 mothers (10.3%) stated that they had lost their child's immunization card, and 93 (32.1%) stated that they never had a card for their child.

41. The immunization status for children 12-23 months of age is based on the immunization card actually seen by the interviewers. There are 112 children in the survey 12-23 months of age. The following are coverage figures for BCG, OPV, DPT, and measles:

Vaccination Coverage (Card): EPI Access

BCG Recorded	EPI Access
82 Children	73.2%

Vaccination Coverage (Card): EPI Coverage

OPV3 Recorded	EPI Coverage
63 Children	56.3%

Vaccination Coverage (Card): Measles Coverage

Measles Recorded	Measles Coverage
64 Children	57.1%

Vaccination Coverage (Card): Overall Drop Out Rate

BCG Coverage	Measles Coverage	Drop Out Rate
73.2%	57.1%	21.9%

BCG Status

AGEGROUP	NO BCG	YES BCG	TOTAL
12-23 MONTHS	30 (26.8%)	82 (73.2%)	112 CHILDREN

OPV Status

OPV 1,2,&3: 112 children 12-23 months of age

OPV 1		OPV 1,2		OPV 1,2,3		Drop Out	
Freq. #	Percent %	Freq. #	Percent %	Freq. #	Percent %	D.O. Frequency (# OPV1 - # OPV3)	D.O. Rate $\frac{\#OPV1 - \#OPV3}{\#OPV1}$
85	72.6%	79	67.5%	63	53.8%	22	24.8%

65

DPT Status

DPT 1,2,&3: 112 children 12-23 months of age

DPT 1		DPT 1,2		DPT 1,2,3		Drop Out	
Freq. #	Percent %	Freq. #	Percent %	Freq. #	Percent %	D.O. Frequency (# DPT1 - # DPT3)	D.O. Rate $\frac{\#DPT1 - \#DPT3}{\#DPT1}$
84	75%	75	66.9%	60	53.5%	24	28.6%

Measles Status

AGEGROUP	NO MEASLES	YES MEASLES	TOTAL
12-23 MONTHS	48 (42.9%)	64 (57.1%)	112 CHILDREN

Fully Immunized Status

(BCG + OPV123 + DPT123 + Measles)

AGEGROUP	NOT FULLY IMMUNIZED	FULLY IMMUNIZED	TOTAL
12-23 MONTHS	54 (48.2%)	58 (51.8%)	112 CHILDREN

Maternal Care Module

42. Maternal Care: Maternal Card

147 mothers (50.5%) surveyed had maternal vaccination cards. 48 (16.5%) reported having lost their maternal health card, while 96 (33%) stated that they did not have a maternal health card.

CARD		Freq	Percent	Cum.
-----+-----				
YES		147	50.5%	50.5%
LOST		48	16.5%	67.0%
NO		96	33.0%	100.0%
-----+-----				
Total		291	100.0%	

43. Maternal Care: Tetanus Toxoid Coverage (Card)

Of the 147 mothers who had a maternal health card, 134 (91.2%) had at least two TT injections indicated on the card. 46% of all mothers in the survey have had more than two doses of TT. 13 mothers (8.8% of 147) had one TT injection indicated on the card.

44. Of the 147 maternal health cards looked at by interviewers in the survey, 8 (5.4%) had a space to record ante-natal care visits; the other 139 cards did not have spaces to record ante-natal visits.

45. Maternal Care: One or More Ante-Natal Visits (Card)

Of the 8 maternal cards with spaces to record ante-natal visits, 6 (75%) indicated that the mother had made at least two ante-natal visits. The remaining two cards indicated that the mothers had made one ante-natal visit. The percent of mothers who had at least one pre-natal visit prior birth of the child is: 2.7%

46. 12 mothers (4.1% of 291) stated that they were pregnant.

47. Of the 279 mothers who stated that they were not pregnant, 240 (86.3%) stated that they did not want to have a child in the next two years. The remaining 48 mothers (13.7%) either did want to have a child in the next two years, or did not know if they did or did not.

48. Maternal Care: Modern Contraceptive Usage

Of the 240 mothers who either did not want to have a child in the next two years, or did not know if they did or did not, 8 (3.1%) stated that they were using a method to avoid/postpone getting pregnant. The remaining 248 mothers stated that they were not using any method (96.9% of 256). The Percent of mothers who desire no more children in the next two years, or are not sure, who are using a contraceptive method is: 3.3%

49. Of the 8 mothers who stated that they were using a method to avoid getting pregnant, 5 (62.5%) were using a modern method; in other words, they indicated one of the first seven methods listed in question 49. Of the 5 mothers using a modern method, two mothers were using contraceptive injections, two mothers were using pills, and one mother was using an IUD.

3 of the 8 mothers (37.5%) were using the rhythm method.

50. Maternal Care Knowledge: Timeliness of Ante-Natal Care

When asked how soon after a woman knows she is pregnant should she see a health professional, 108 mothers (37.1% of 291) indicated a time period within the first trimester of pregnancy, 33 mothers (11.3%) indicated a time period within the second trimester, and 22 mothers (7.6%) indicated a time period within the third trimester. 64 mothers (22%) indicated that there was no need to see a health professional during pregnancy, and 64 mothers (22%) stated that they did not know when a pregnant woman should see a health professional. The percent of mothers who know that pregnant women should start ante-natal care before the third

trimester is: 48.4%

51. When asked what foods are good for a woman to eat to prevent pregnancy anemia, 164 mothers (56.4%) indicated a protein food rich in iron and 144 mothers (49.5%) indicated a green leafy vegetable rich in iron. 55 mothers (19%) indicated a food type other than the categories listed in question 51, and 89 mothers (30.6%) stated that they did not know which foods would help prevent anemia.

52. When asked how much weight should a woman gain during pregnancy, 55 mothers (19.1%) indicated 10-12 kilos, 47 mothers (16.3%) indicated the gain weight of baby, and 172 mothers (59.7%) stated that they did not know how much weight should a woman gain during pregnancy. 14 mothers indicated an answer other than the categories listed in question 51.

53. 83 of 291 mothers (28.5%) stated that they visited a health site for prenatal care and 208 mothers (71.5%) stated that they never visited a health site for prenatal care.

54. 26.8% of mothers surveyed (78 of 291) stated that they ate more food than usual during pregnancy and 100 mothers (34.4%) stated that they ate the same as usual during pregnancy. In sum, 61.2% of mothers stated that they ate either more or the same as usual during pregnancy.

172 mothers (59.7%) stated that they ate less food than usual during pregnancy, and four mothers stated that they did not know.

55. When asked who tied and cut the cord at the child's delivery, 64.3% (187 of 291) indicated a family member, 46 mothers (15.8%) indicated a health professional (physician, nurse or midwife). 33 mothers (11.3%) indicated a traditional birth attendant, 5 mothers (1.7%) indicated and one mother stated that she herself had tied and cut the cord. 16 mothers (5.5%) mothers indicated someone other than the categories listed in this question.

IV. DISCUSSION AND RECOMMENDATIONS

Age Distribution

15.2% of the mothers surveyed were over the age of 35 years. The Bolivia MOH states that the risks of child-bearing are greatest when the mother to be is under 15 years or over 49. However, WHO and UNICEF states that the risks of child-bearing are greatest when to be is under 18 years or over 35.

Over 61.5% of the children in the survey were under 12 months of age. One possible explanation for the large number of infants under 12 months of age is that many mothers are spacing births less than two years apart.

In summary, SC/Bolivia should continue emphasis on birth spacing at least two years apart, and avoiding pregnancies below the age of 18 or above the age of 35 to reduce the dangers of child bearing.

Education and Occupation

Over 70% of the mothers surveyed can read, however, of those the majority (80%) can read only at the primary level. Two different groups could be targeted: those that can read at the primary level and those that cannot read. For those mothers that can read, SC/ Bolivia can develop simple written health messages both in Spanish and Aymara. For those mothers that cannot read, SC/ Bolivia should train VHWs or other community members in counseling techniques. This group could also be reached by the VHWs using adult learning methodologies, for example demonstrations, role plays, pictorial presentations and through discussions. SC/Bolivia could also explore the possibility of using radio messages to reach rural non-readers.

Almost 50% of the mothers are away from home during the day. Many of these mothers leave their children with older siblings and relatives. Other caretakers mentioned by mothers were husbands and nurseries. In order for VHWs to reach mothers, home visits need to take place in the evenings or on "free" days when mothers are at home, since from those who work, almost 80% take their children with them. In order for VHWs to reach relatives, and husbands, VHWs could explore such avenues as market days, elders meetings, church and women's group meetings. In order for health messages to reach older siblings, SC/Bolivia should work with the school health services program.

32.6% of mothers partake in some form of income generating work. SC/Bolivia could assume, therefore, that in general mothers can not afford primary health care (PHC) services. SC/Bolivia Child Survival project, should intensify activities that promote awareness regarding child and maternal care. These activities include: adequate nutrition for mother and child including exclusive breastfeeding, maternal care, immunizations, family planning/child spacing, home management of diarrhea, and growth monitoring.

Breastfeeding/Nutrition

The Bolivian MOH and SC breastfeeding messages state: that mothers should exclusively breastfeed during the first four to six months of life, that mothers should introduce foods in addition to breastmilk between four to six months of age, that infants should start to breastfeed as soon as possible after birth, and that breastfeeding should continue well into the second year of a child's life and for longer if possible.

Breastfeeding practices are quite good. 42.9% of the 84 children in the 0, 1, 2, and 3 month agegroup in the survey were being exclusively breastfed. 79.1% of the 43 children in the 5, 6, 7, and 8 month agegroup had been given solid or semisolid foods. About 74.5% of mothers, when asked, knew that children should be introduced to foods other than breastmilk between four and six months of age; 6.9% indicated an age for food introduction earlier than four months. A problem, therefore, is the early introduction of food and fluids other than breastmilk in the project area in almost half of the infants. SC/Bolivia should emphasize the benefits of exclusive breastfeeding during the first four to six months by targeting mothers, VHWs, TBAs, and professional health workers.

59.3% of mothers breastfed their child within the first eight hours after birth. SC/Bolivia should continue emphasis on benefits of early initiation of breastfeeding after delivery during the training of TBAs, VHWs, and public health workers.

All of the children in the survey had been breastfed at some time, however, at the time of the survey 70.4% were still being breastfed. Of the 23 children in the 20, 21, 22, and 23 month agegroup, 27 were still being breastfed. Mothers will be encouraged to continue breastfeeding up to the child's 24 month of age. SC/Bolivia will reinforce the benefits of prolonged breastfeeding during training of VHWs, TBAs, the communities themselves. All health workers in the project area should receive instruction on the benefits of breastfeeding for the first two years of a child's life.

SC/Bolivia breastfeeding message is that to ensure the regular supply of breastmilk the mother should: breastfeed as soon as possible after birth, care for her breasts/nipples, allow frequent sucking to stimulate production, exclusively breastfeed for the first four months of life, avoid bottle feeding of the baby, and to attempt to relactate if she had stopped breastfeeding. Of these actions to ensure the supply of breastmilk, almost 50% of mothers knew to breastfeed as soon as possible after delivery, 34.1% of mothers knew to allow frequent sucking, and about 25% knew to care for breasts/nipples to stimulate production. Few mothers knew about the other actions to ensure the supply of breastmilk. Many mothers mentioned eating good foods and drinking "sopas y mates" (soups and teas) as actions to ensure the regular supply of breastmilk. Mothers in the project area need to hear and understand the benefits of this health message. VHWs, TBAs as well professional health workers should be encouraged to bring this message to mothers and to the community as a whole.

It appears that most mothers are giving their children foods enriched with calories, protein, vitamin A and iron. It is not clear from the survey, however, the quality and quantity of foods given to the children. SC/Bolivia, therefore, could continue to work towards promoting and encouraging mothers to provide adequate foods of good nutritional value. Strategies should include the tranference of information to mothers (cooking/mixing practices) about the need to increase the frequency and density of weaning stuffs. SC/Bolivia, in collaboration with the MOH should promote the daily administration of simple mixes (three recipes for each of the following groups: 6-9 mo, 9-12 mo, 12 -18 mo.) that include basic local sources of protein, fat, carbohydrates and other micronutrients (iron, vitamin A and iodine).

Growth Monitoring and Vitamin A

Approximately 59% of the mothers in the survey had a growth monitoring card for their child. Of the children with growth monitoring cards, most of them had been weighed in the four months preceding the survey (85.4% of 291). The SC/Bolivia CSIII project objective as stated in the proposal is that at least 40% of children 0-5 years of age in the surveyed communities will be weighed once every four months. Survey data shows that 60% of children have a card and 85.4% of them have been weighted at least once in the last four months.

SC/Bolivia should provide cards to all children under the age of three years in the project areas through community household registration, and will encourage mothers to safeguard the cards. SC/Bolivia also could train health workers and encourage MOH policy makers to ensure that all

children under two years are weighed and that weights are recorded on the child's growth monitoring card. Professional health workers need to be trained to better coordinate PHC activities to assure that children are weighed and that weights are recorded.

The vitamin A coverage for the first dose is around 29%. The age mean for the first dose is 12.18, however there are children that have received the first dose as early as one month. The coverage for the second dose is very low and the elapsed time between the two doses is around 6.89. There is no record with three doses. Special efforts should be devoted to this component in the areas of training of supervisors and VHWs and monitoring of logistics and in follow-up of children between adequate age intervals.

Diarrheal Diseases

SC/Bolivia diarrhea messages stress the importance of giving extra fluids and continued feeding during the diarrhea episode, and providing extra foods when the child is recovering from diarrhea.

More than 40% of the children in the survey had diarrhea. Approximately 28.2% of the children in the survey were given more breastmilk than usual during the diarrhea episode, and close to 30% of the children were given more fluids than usual during diarrhea. 60% of children were given more or the same amount of foods as usual during diarrhea, and 50% of mothers knew that a child should receive more foods or high calorie foods after the diarrhea episode. SC/Bolivia could provide messages for VHWs to bring to mothers in the project areas that stress the importance of giving more fluids and continued feeding during a child's diarrhea.

One of the project objectives outlined in the proposal is that 30% of mothers will use ORS to treat their children's diarrhea. The MOH also stresses the dangers of using medicines to treat diarrhea. Approximately half of the mothers in the survey were giving ORT to their children during diarrhea. Very few of the mothers also were giving their child medicine for the diarrhea. Of those mothers giving ORT about one-third were giving a sugar-salt solution (SSS); the rest were providing ORS or other kinds of home available fluids. In the project areas, SC/Bolivia could place special emphasis on the use of ORS to treat diarrhea and on the dangers of using medicines for diarrhea. Strategies could include to reinforce the Oral Rehydration Units that the MOH have in each community. The logistics and availability of ORS could improve the management of cases with ORT in each community.

Few mothers in the survey (13.7%) stated signs or symptoms related to dehydration as those that would cause them to seek advice or treatment for their child's diarrhea. Signs and symptoms most frequently mentioned were fever (43%). SC/Bolivia and the MOH stresses in order dehydration, fever, loss of appetite, vomiting, passing several watery stools in one or two hours, and blood in the stool as signs that a mother should seek qualified medical help for her child. Health messages could be provided by SC/Bolivia emphasizing signs related to dehydration as the most important signs that a child needs medical help during diarrhea. SC/Bolivia should plan to train VHWs and other community members to emphasize this message to mothers. Strategies could include to reinforce the knowledge of volunteers working in the Oral Rehydration Units in order to transfer the information about alarm signs to mothers when they receive the ORS sachet and instructions of use.

Pneumonia Control

More than one third of surveyed children had been ill with cough or difficult breathing. Out of these children almost 75% had symptoms of pneumonia. Only 40.3% of mothers sought for advice for the illness of their children and only 29% got medical treatment. SC/Bolivia should start a pneumonia control program in the impact area reinforcing the MOH referral services and training the MOH staff. The WHO/PAHO training modules for supervisors and managers could be used to provide up-date information to MOH and SC/Bolivia. Additional efforts should be made to reinforce mothers knowledge regarding the recognition of children with pneumonia and the identification of places that can be used for referral of children.

Immunizations

57.7% of 290 mothers had an immunization card for their child and 10.3% stated that they had lost their child's card. 70.3% of the 290 mothers with children aged 12-23 months (84%) reported that their child had received at least one vaccination.

Antigen-specific immunization coverage rates for the 12-23 month age group are: . These percentages represent population based coverage rates for the surveyed children, as recorded on the immunization card. The rate of children fully immunized (BCG + OPV123 + DPT123 + Measles) in the CSIII Final Evaluation survey (51.8%) is higher than the 40% national EPI coverage estimate of 1992. The national objective for full immunization coverage of children during the first year of life is 80%. The SC/Bolivia CSIII project objective as stated in the proposal is for 30% of children in the each community to be fully immunized by the end of the first year of life.

In the surveyed population, the difference between the first and third OPV is about 24.8%. and between the first and third DPT is approximately 28.6%.

The percentage of mothers who reported that their child had received immunizations and who had in their possession immunization cards for their children relates with the coverage rates found in the survey. This may suggest that vaccinations given during immunization campaigns are not enough for reaching children the number of times required to fully immunize in the first year of life. SC/Bolivia should focus its intervention in the group of children below 11 months and increase the involvement of parents in the identification of newborns and follow-up of the doses required by the children of each community (Baby tracking systems for EPI). SC/Bolivia could work in collaboration with the MOH to provide routine immunization services to those parents groups requesting vaccinations. SC/Bolivia should train health staff of this institution and provide cold chain equipment. Also, SC/Bolivia should train VHWs/TBAs to counsel mothers and reinforce the message on the importance of completion of the EPI schedule during a child's first year of life.

Overall knowledge of mothers about the timing and purpose of immunizations needs to be reinforced. For example, only 33% of mothers stated that a child should receive the measles vaccine at age nine months. SC/Bolivia should continue to reinforce messages about the timing and benefits of immunizations for both the mother and child.

Maternal Care

Around 50% of mothers surveyed had maternal health cards. Of those mothers with cards, however, most had received two TT injections, and almost all had received at least two TT injection. This represents a coverage of 46% of mothers with TT vaccine.

Almost none of mothers had cards with spaces to record ante-natal visits and almost none had made ante-natal visits. In order to better estimate access to ante-natal care and TT coverage of pregnant women all women of child-bearing age in the project should receive primary health care cards.

87% of mothers who did not want to have more children within the two years following the survey, but only 3.1% were using a modern method of family planning. Looking at the 291 mothers in the survey, only 7 are using a modern method of contraception. The CSIII project didn't established objectives for this component and this data could be used as a baseline for future intervention. Use of modern contraceptive could be increased from 3.1% up to 15%.

Mothers' knowledge of appropriate maternal nutrition practices is very low. SC/Bolivia should include in its program to promote maternal nutrition in its PHC activities in order to obtain adequate levels of knowledge and practices regarding appropriate maternal nutrition.

A high percentage of deliveries (64.3%) were attended by a family member. This highlights the importance of incorporating all the adult population (women groups and others) in the communication efforts regarding "safe and clean delivery". In addition CS/Bolivia should include in their PHC activities to reinforce the capability of the MOH in identifying high risk women.

BIBLIOGRAPHY

1. 1989. UNICEF, UNESCO & WHO. Facts for Life - A Communications Challenge. UNICEF, New York NY.
2. 1988. Expanded Programme on Immunization, Training for Mid-Level Managers: Coverage Survey. World Health Organization, Geneva.
3. 1989. Diarrhoeal Disease Control Programme, Household Survey Manual: Diarrhoea Case Management, Morbidity, and Mortality. World Health Organization, Geneva.
4. 1991. USD Incorporated. "Epi Info, Version 5.1b". Stone Mountain, Georgia.
5. 1982. Henderson, R.H. & Sundaresan, T. "Cluster Sampling to Assess Immunization Coverage: A Review of Experience with a Simplified Sampling Method," Bulletin of the World Health Organization. 60 (2): pp. 253-260
6. 1991. Child Survival III Expansion Project Proposal submitted to AID/FHA/PVC Washington. SC/Bolivia, Washington, D.C.
7. 1992. National Child Survival Plan. Ministry of Health of Bolivia. La Paz, Bolivia.

**QUESTIONARIO SOBRE CONOCIMIENTOS Y PRÁCTICAS EN
SUPERVIVENCIA INFANTIL, INQUISIVI 1/18/93**

Las siguientes preguntas son para las madres de niños menores de dos años (24 meses).

Fecha entrevista	___/___/93	Re-entrevista	___/___/93
	(dd/mm)		(dd/mm)
Nombre entrevistador	_____		
Supervisor	_____		

1. Nombre y edad de la madre

Nombre _____ Edad (años) _____

2. Nombre y edad del niño menor de 2 años

Nombre _____

Fecha de nacimiento ___/___/___ Edad (meses) _____
(dd/mm/aa)

Comunidad _____

Educación/ocupación de la madre

3. ¿Cuál fue el grado de educación más alto que alcanzó?
Kuna marakamas escuelas jan ukajj colegion yateqta?

- | | |
|----------------------|-----|
| 1. ninguno | [] |
| 2. primaria y no lee | [] |
| 3. primaria y si lee | [] |
| 4. secundaria o más | [] |

4. ¿Trabaja fuera de su casa?

Trabajiritati?

- | | |
|-------|-----|
| 1. si | [] |
| 2. no | [] |

5. ¿Realiza alguna actividad para "generar ingresos económicos"?

Kuna lurañanakanitas qolla gananiñataki?

- | | |
|---------------------------------------|-----|
| a. no, ninguna | [] |
| b. artesanías, tejidos, etc. | [] |
| c. cosechando (campo) | [] |
| d. vendiendo productos agrícolas | [] |
| e. venta de comidas | [] |
| f. empleada doméstica/otros servicios | [] |
| g. vendedora callejera | [] |
| h. trabajadora asalariada | [] |
| i. otros (especifique) _____ | [] |

15

6. ¿Quién cuida de (nombre del niño) mientras trabaja o está fuera de casa?

Kithis ashu wawar unji? jum trabajaskipan jan ukajj jan utankipanjj khitis ashu wawar unji?

(puede marcar más de una respuesta)

- | | |
|---------------------------|-----|
| a. el niño va con la mamá | [] |
| b. el esposo/compañero | [] |
| c. hermanos mayores | [] |
| d. parientes | [] |
| e. vecinos/amigos | [] |
| f. otros | [] |

Lactancia Materna/Nutrición

7. ¿Está dando de mamar a (nombre del niño)

¿Jisk'a wawar ñuñyasktati?

- | | | |
|-------|-----|-----------------|
| 1. sí | [] | ——> pase a la 9 |
| 2. no | [] | |

8. ¿Le ha dado alguna vez de mamar a (nombre del niño)

¿Jisk'a wawar ñuñ churiritati?

- | | | |
|-------|-----|------------------|
| 1. sí | [] | |
| 2. no | [] | ——> pase a la 10 |

9. Después del parto, ¿cuándo le dió de mamar por primera vez a (nombre del niño)?

Wawachasisinij kunapachas wawamar ñuñ churañ qallt-ta?

- | | |
|---|-----|
| 1. durante la primera hora después del parto | [] |
| 2. durante las primeras 8 horas después del parto | [] |
| 3. más de 8 horas después del parto | [] |
| 4. no se acuerda | [] |

10. a. ¿Le está dando agua (tés/mate) a (nombre del niño)?

Jisk'a wawarojj um churasktati? Jan ukajj kuna mate, te?

- | | |
|------------|-----|
| 1. sí | [] |
| 2. no | [] |
| 3. no sabe | [] |

- b. ¿Le está dando leche en biberón (mamadera) a (nombre del niño)?

Jisk'a wawarojj mamadarant lech churaskta?

- | | |
|------------|-----|
| 1. sí | [] |
| 2. no | [] |
| 3. no sabe | [] |

- c. ¿Le está dando alpi de trigo, quinua, o maíz a (nombre del niño)?

Ashu wawarojj allpi, trigo, quinua, tonqo churasktati?

- | | |
|-------|-----|
| 1. sí | [] |
| 2. no | [] |

- d. ¿Le está dando frutas o jugos a (nombre del niño)?
 Ashu wawarojj fruta jugonak churasktati?
 1. si []
 2. no []
 3. no sabe []
- e. ¿Le está dando zanahorias, zapallo, mangos o papaya a (nombre del niño)?
 Wisk'a wawarojj zanahorias, zapallo, mango, papaya, frutanak churasktati?
 1. si []
 2. no []
 3. no sabe []
- f. ¿Le está dando vegetales verdes, como la acelga a (nombre del niño)?
 Ch'ojjña achinak wawarojj churasktati?
 1. si []
 2. no []
 3. no sabe []
- g. ¿Le está dando carne o pescado a (nombre del niño)?
 Wawarojj aycha jan ukajj chawila aycha churasktati?
 1. si []
 2. no []
 3. no sabe []
- h. ¿Le está dando poroto, lentejas, tarwi, kañawa a (nombre del niño)?
 Wawarojj poroto, lentejas, tarwi, kañawa churasktati?
 1. si []
 2. no []
 3. no sabe []
- i. ¿Le está dando huevos a (nombre del niño)?
 Wawarojj k'awn churasktati?
 1. si []
 2. no []
 3. no sabe []
- j. ¿Le está añadiendo vegetales verdes, como la acelga a los alimentos de (nombre del niño)?
 Wawan manq' anakaparojj acelganaka ch'ojjña vegetalanaka uchasktati?
 1. si []
 2. no []
 3. no sabe []
- k. ¿Le está añadiendo azúcar o chancaca a los alimentos de (nombre del niño)?
 Wawarojj azucarnchasktati manq' asiñanakaparú?
 1. si []
 2. no []
 3. no sabe []

l. ¿Le está añadiendo aceite o manteca a los alimentos de (nombre del niño)?

Wawan manq anakaparojj aceite manteca uchasktati?

- 1. si []
- 2. no []
- 3. no sabe []

m. ¿Le está añadiendo sal yodada a los alimentos de (nombre del niño)?

¿Wawan manq anaparojj jayu (yodompi) uchaktati?

- 1. si []
- 2. no []
- 3. no sabe []

11. Los promotores de salud piensan que es importante amamantar durante el primer año de vida. ¿Qué puede hacer la madre durante los cuatro primeros días de nacido para una buena lactancia?

Salud promotoranakajja "wawar ñuñuñayawa" saaw amryasipijsa Wawan mamapasti, kamachañapas wawar sum ñuñyañatakejj pusi nayraqat urunakana?

(puede marcar más de una respuesta)

- a. no sabe []
- b. dar de mamar inmediatamente después del parto (sin descartar el calostro) []
- c. evitar el biberón (mamadera) []
- d. lactar frecuentemente para estimular la producción []
- e. cuidado de los pechos y pezones []
- f. otros (especifique) _____ []

12. ¿Qué debe hacer una madre, durante los 4 primeros meses, para mantener suficiente leche y amamantar bien?

Jisk'a wawan mamapajj kamachañapasa kims manq asiñapa walja lecheniñapataki nayraqat pusi phajjsinakana wawar sum ñuñyañataki?

(puede marcar más de una respuesta)

- a. no sabe []
- b. dar exclusivamente de lactar, durante los cuatro primeros meses []
- c. evitar la leche en mamadera []
- d. amamantar frecuentemente para la buena producción de leche []
- e. re-amamantar (la madre puede volver a la lactancia exclusiva si la había dejado) []
- f. otros (especifique) _____ []

18

13. ¿A qué edad debería empezar la madre a dar otros alimentos además de su pecho?

Wawan mamapajj kuna mararus jisk'a wawar yaqha manq'asiñanak churañapa, ukch'añkam m̄m̄yaskakipana?

- 1. empezar de los 4 a 6 meses []
- 2. empezar antes de los 4 meses []
- 3. empezar después de los 6 meses []
- 4. no sabe []

14. ¿Qué otros alimentos?

Yaqha manq'asiñinaka?

(puede marcar más de una respuesta)

- 1. no sabe []
- 2. añadir aceite a las comidas []
- 3. dar alimentos ricos en vitamina A []
- 4. dar alimentos ricos en hierro []
- 5. Otros (especifique) _____ []

15. ¿Qué vitamina previene la "ceguera nocturna"?

Kuna vitaminanaka wali, wawan jan arumanak juykh̄m̄apataki?

- 1. la vitamina A []
- 2. no sabe u otras []

16. ¿Qué alimentos contienen vitamina A para la prevención de la "ceguera nocturna"?

Jan arum juykh̄ñapaakejj kuna alimentonakas vitamina A ukan utji?

(puede marcar más de una respuesta)

- a. no sabe u otros []
- b. vegetales verdes []
- c. frutas de color amarillo intenso []
- d. carne/pescado []
- e. lactancia materna []
- f. la yema del huevo []

Control del crecimiento

17. ¿Tiene (nombre del niño) su carnet infantil (o gráfica) para el control del peso?

Jisk'a wawajj Carnet de Saludaniti pesop controlañataki?

- 1. sí [] (¡pida que se lo muestre!)
- 2. no [] ———> paso a la 21
- 3. perdió el carnet [] ———> paso a la 21

18.

Mire la gráfica del niño y registre la siguiente información: ¿ha sido pesado el niño en los últimos 4 meses?

si []

no []

19.

Mire también el carnet de salud del niño y vea si existe un espacio para anotar las cápsulas de vitamina A que recibió.

1. si []

2. no [] -----> pase a la 21

20.

Si es así, anote las fechas en que le dieron cápsulas de vitamina A al niño, en el espacio correspondiente.

(dd/mm/aa)

1ra ___/___/___

2da ___/___/___

3ra ___/___/___

4ta ___/___/___

Contestar preguntas 40 y 41, ahora:

Enfermedades Diarréicas

21. ¿Ha tenido (nombre del niño) diarrea en las dos últimas semanas?

Akapa pauir semananakan wawajj diarreaninti (wichi)?

1. si []

2. no [] -----> pase a la 29

3. no sabe [] -----> pase a la 29

22. Durante la diarrea de (nombre del niño), ¿le dió pecho (lea las opciones a la madre)...

- Jisk'a waw diarreaipanjja ñuñuytati?
- 1. más de lo acostumbrado? []
juk'ampt ñuñuyta?
 - 2. igual a lo acostumbrado []
kipkakiti?
 - 3. menos de lo acostumbrado? []
menosak ñuñuyta
 - 4. dejó de darle completamente? []
janit kums ñuñuyktati
 - 5. ya no recibía pecho []
janit ñuñuyjta

23. Durante la diarrea de (nombre del niño), ¿le dió otros líquidos (además del pecho),

- Jisk'a waw diarreaipanjja ñuñuyakasaj yaqha qolla umanaka churtati?
(lea las opciones a la madre)
- 1. más de lo acostumbrado? []
juk'ampt churta?
 - 2. igual a lo acostumbrado []
kipkakt churta?
 - 3. menos de lo acostumbrado? []
menosakt umayta?
 - 4. dejó de darle completamente? []
janit kums umaykikta?
 - 5. solo pecho []
ñuñukt churta?

24. Durante la diarrea de (nombre del niño), ¿le dió alimentos blandos o purés,

- Diarreaipanjjaa ch'oqe ch'ajjetanaka wawar churtati?
(lea las opciones a la madre)
- 1. más de lo acostumbrado? []
juk'ampt churta?
 - 2. igual a lo acostumbrado []
kipkakiti?
 - 3. menos de lo acostumbrado? []
menosakt churta?
 - 4. dejó de darle completamente? []
janit kuma manq's churta?
 - 5. solo pecho []
ñuñuyaktati?

25. Cuando (nombre del niño) tuvo diarrea, ¿qué tratamiento le dió?

- Jisk'a wawa diarreaipanjjaa junjama qollta?
(puedo marcar más de una respuesta)
- a. nada []
 - b. sobre de rehidratación oral []
 - c. solución de azúcar y sal (suero casero) []
 - d. soluciones a base de cereales []
 - e. líquidos, té o socimientos caseros []
 - f. medicinas antidiarréicas o antibióticos []
 - g. otro (especifique) _____ []

81

26. Cuando (nombre del niño) tuvo diarrea, ¿pidió Ud. consejo o ayuda?

Kunapachatejj wawajj diarreäninjja jumajj amaytawinaka yanapawisa maytati?

1. sí []
2. no [] ———> pase a la 29

27. ¿A quién pidió el consejo o ayuda para la diarrea de (nombre del niño)?

Khitirus uka consejonaka, yapapāawinak mayi, wawan diaarreap gollañataki?

(puede marcar más de una respuesta)

- a. hospital general []
b. centro de salud/puesto de salud []
c. médico []
d. farmacia/botica []
e. promotor de salud []
f. curandero []
g. partera []
h. parientes y amigos []
i. otro (especifique) _____ []

28. ¿Qué signos y síntomas harían que busque ayuda para la diarrea de (nombre del niño)?

Kunjams uñjasispa wawan diarrea usunisp ukajja?

(puede marcar más de una respuesta)

- a. no sabe []
b. vómitos []
c. fiebre []
d. boca seca, ojos hundidos, mollera hundida, orina poco (deshidratación) []
e. diarrea prolongada (más de 14 días) []
f. sangre en las heces []
g. pérdida del apetito []
h. débil o desganado []
i. otros (especifique) _____ []

29. ¿Qué acciones importantes debe seguir una madre si su niño tiene diarrea?

Jisk'a waw diarreanipanjja mamapajj kamachañapasa?

(puede marcar más de una respuesta)

- a. no sabe []
b. lleva al niño al hospital/centro de salud []
c. dá más líquidos de lo usual []
d. dá alimentos más frecuentes y en menor cantidad []
e. suspende líquidos []
f. suspende alimentos []
g. otros (especifique) _____ []

30. ¿Qué acciones importantes debe seguir una madre cuando su niño está recuperando de la diarrea?

Jisk'a waw diarreat waliptasinjja mamapajj kamachañapasa?

(puede marcar más de una respuesta)

- a. no sabe []
- b. dar alimentos con más frecuencia y menor cantidad []
- c. dar más alimentos de lo usual []
- d. dar alimentos con alto contenido calórico []
- e. otros (especifique) _____ []

Infecciones Respiratorias Agudas

31. ¿Ha estado (nombre del niño) enfermo con tos o problemas respiratorios en las dos últimas semanas?

Akapa pasir semanañ jisk'a wawajj ujuminti jan ukajj jikhan usunircha?

- 1. sí []
- 2. no []

32. ¿Ha estado (nombre del niño) con respiración rápida o respiraba como cansado (disnea) cuando enfermó?

Ashu wawajj samsuñataakajj ratukik samsuñ, qaitjamach samsuna?

- 1. sí []
- 2. no [] ———> pase a la 35
- 3. no sabe [] ———> pase a la 35

33. ¿Ha pedido Ud. consejo o ayuda para (nombre del niño) cuando estuvo enfermo con tos y dificultad respiratoria?

Jumajj yanapāwi, jan ukajj kuna consejolak maytati, kunapachatejj jisk'a wawajj ujinina?

- 1. sí []
- 2. no [] ———> pase a la 35

34. ¿De quién recibió consejo o ayuda para la tos y dificultad respiratoria de (nombre del niño)?

Khitis uka yanaapāwi consejonak mayirlta kunapachatejj wawajj uju usuninjja?

(puede marcar más de una respuesta)

- a. hospital general []
- b. centro de salud/puesto de salud []
- c. médico []
- d. farmacia/botica []
- e. promotor de salud []
- f. curandero []
- g. partera []
- h. parientes y amigos []
- i. otro (especifique) _____ []

35. ¿Cuáles son los signos y síntomas que haría que busque ayuda para la enfermedad respiratoria de (nombre del niño)?
Wawajj kimaninsa yanapawi thaqer sarañataki?
 (puede marcar más de una respuesta)
- | | |
|---------------------------------|-----|
| a. no sabe | [] |
| b. respiración rápida y agitada | [] |
| c. retracciones inter-costales | [] |
| d. pérdida de apetito | [] |
| e. fiebre | [] |
| f. tos | [] |
| g. otro (especifique) _____ | [] |

Inmunizaciones

36. ¿(nombre del niño) ha sido vacunado alguna vez?
Jisk'a wawajj kuma vacuna katoqeti?
- | | |
|------------|-----|
| 1. si | [] |
| 2. no | [] |
| 3. no sabe | [] |
37. ¿A qué edad (nombre del niño) debería recibir la vacuna contra el sarampión?
Qawqha phajjsirus wawajj sarampion neutakejj vacuna katoqañapa?
- | | |
|-------------------------|-------------|
| 1. especifique en meses | [___/___] |
| 2. no sabe | [] (99) |
38. ¿Cuál es la razón principal por la que una mujer embarazada debe ser vacunada contra el tétanos?
Kima laykus mā usur warmejj tetano usu contrajj vacuna katoqañapa?
- | | |
|---|-----|
| 1. para proteger a madre y niño contra el tétanos | [] |
| 2. para proteger <u>solo</u> a la mujer contra el tétanos | [] |
| 3. para proteger <u>solo</u> al niño contra el tétanos | [] |
39. ¿Cuántas vacunas contra el tétanos debe recibir una mujer embarazada para proteger al recién nacido?
Qawqha kutis mā usur warmejj tetano usu contrajj vakinanak katoqañapa, a shu wawar usunakat jark ñataki?
- | | |
|---------------|-----|
| 1. una | [] |
| 2. dos | [] |
| 3. más de dos | [] |
| 4. ninguna | [] |
| 5. no sabe | [] |
40. ¿Tiene Ud. el carnet infantil (o el carnet de vacunación) de (nombre del niño)? (Viene de pregunta 17)
Wawan controlap carnetanitati?
- | | | |
|---------------------|-----|----------------------------|
| 1. si | [] | (¡pida que se lo muestre!) |
| 2. perdió el carnet | [] | -----> pase a la 42 |
| 3. no | [] | -----> pase a la 42 |

híre el carnet de vacunación y registre las fechas de las inmunizaciones en el espacio correspondiente:

	(día/mes/año)
BCG	___/___/___
ANTIPOLIO	1a ___/___/___ 2a ___/___/___ 3a ___/___/___
DPT (TRIPLE)	1a ___/___/___ 2a ___/___/___ 3a ___/___/___
ANTISARAMPION	___/___/___ ___/___/___

Regis. el carnet de vacunación

Salud Materna

42. ¿Tiene Ud. carnet de salud/vacunación materna?

Junajj carnetanitati (salud maternata)?

1. si [] (¡pída que se lo muestre!)
 2. perdió el carnet [] -----> PASE A LA 46
 3. no [] -----> PASE A LA 46

43.

híre el carnet de salud/vacunación materna y registre el número de vacuna TT en el espacio correspondiente:

1. una []
 2. dos []
 3. doc o más []

44.

¿Tiene el carnet de salud materna espacio para anotar visitas prenatales?

1. si []
 2. no [] ----> PASE A LA 46

85

45.

Si es así, registre si la madre asistió a
visitas prenatales:

Usur warmejj uka pre-natal visitanakar
sariri:

- | | |
|--------------|-----|
| 1. una | [] |
| 2. dos o más | [] |
| 3. ninguna | [] |

46. ¿Está Ud. embarazada ahora?

Jichbajj jumajj usur warmitati? (waw suryasktati?)

- | | | |
|-------|-----|----------------|
| 1. sí | [] | → PASE A LA 50 |
| 2. no | [] | |

47. ¿Quisiera Ud. tener otro hijo en los próximos dos años?

Jumajj jutir pā maranakanjja yaqha wawaniñ mantati?

- | | | |
|------------|-----|----------------|
| 1. sí | [] | → PASE A LA 50 |
| 2. no | [] | |
| 3. no sabe | [] | |

48. ¿Está Ud. usando ahora algún método para no embarazarse o retrasar el próximo embarazo?

Jan wawaniñatakejja kamaka luraskta?

- | | | |
|-------|-----|----------------|
| 1. sí | [] | |
| 2. no | [] | → PASE A LA 50 |

49. ¿Cuál es el método principal que Ud. o su esposo están usando ahora para que usted no quede embarazada?

Jumamp chachamampejj kamachasiptana jan wawaniñatakejja?

(puedo marcar más de una respuesta)

- | | |
|--------------------------------|-----|
| 1. ligadura de trompas | [] |
| 2. Norplant | [] |
| 3. inyecciones | [] |
| 4. pastillas anticonceptivas | [] |
| 5. dispositivo intra-uterino | [] |
| 6. diafragma | [] |
| 7. condones | [] |
| 8. espumas o gel | [] |
| 9. lactancia materna exclusiva | [] |
| 10. método del ritmo | [] |
| 11. abstinencia | [] |
| 12. coito interrumpido | [] |
| 13. otros _____ | [] |

50. ¿Una vez que la mujer sabe que está embarazada, cuánto tiempo debe pasar para ir a ver a la partera, al sanitario, enfermera, o al médico?

Há kutitejj warmejj umitatap yatini qawqha phajjini pasañapa
partera, sanitario, enfermera, doctorar uñjiri?

- | | |
|--|-----|
| 1. en el primer trimestre, (1-3 meses) | [] |
| 2. en mitad del embarazo, (4-6 meses) | [] |
| 3. en el último trimestre, (7-9 meses) | [] |
| 4. no necesita ir | [] |
| 5. no sabe | [] |

51. ¿Qué alimentos debería ingerir una mujer para evitar la anemia durante el embarazo?
 Jana anemia usamiñatakej j mā usur warmejj kumanakas manq añapa?
 (puede marcar más de una respuesta)
- no sabe []
 - proteínas ricos en hierro(carne/pescado/nuevo) []
 - hojas verdes o vegetales ricos en hierro []
 - otro (especifique) _____ []
52. ¿Cuánto peso debería aumentar una mujer durante el embarazo?
 Gawqha pesos ma usur warmejj jiljjatañapa usur warmiskaginja?
 1. 10-12 kilos []
 2. el peso del bebé []
 3. no sabe []
 4. otro (especifique) _____ []
53. Cuando Ud. estaba embarazada de (nombre del niño), ¿visitó algún centro de salud (clínica u hospital) para el control de su embarazo?
 Kunapachatejj jumajj ashu wawamar suyankayātajja, hospitalar, centro de saludar saririyātati controlayasiñataki?
 1. si []
 2. no []
54. Mientras estuvo embarazada de (nombre del niño), la cantidad de alimentos que Ud. comía era:
 Kunapachatejj jlak'a wawamar suyankayātajja, kuma manq'anaka manq'ayāta? Gawqha manq'ayāta?
 (lea las opciones a la madre)
- más de lo acostumbrado? []
 yaqburunakat sipanj juk'ampi?
 - igual a lo acostumbrado? []
 kipekaki?
 - menos de lo acostumbrado? []
 yaqburunakat menowa?
 - no sabe []
 janiw yatkiti?
55. Cuando nació (nombre del niño), quien amarró y cortó el cordón?
 Wawa yurkam ukajj khithis kururup chint'i, kuchoqo?
- Ud. misma []
 - Un miembro de la familia []
 - partera tradicional []
 - profesional de salud []
 - otro(especifique) _____ []
 - no sabe []

DATOS DE CS-III

Jure Acuña...

FECHA: 3 de diciembre de 1992

No.	COMUNIDAD	POBLACION	NIÑOS < 5 AÑOS	MUJERES E.F. 15-49 AÑOS	Vacc. TT d/2 dosis		
1	JUCUMARINI	129	16	27	15	27	
2	SOPOCARI	72	13	16	2	43	1
3	RAMADA	31	1	5	4	48	
4	WICULLPAYA	82	12	19	0	67	
5	CHOQUETANGA	356	63	83	46	150	2
6	MARQUIRIVI	90	5	21	1	171	
7	CENTRAL HUERTAPATA	94	10	19	5	190	3
8	TUINI	145	20	31	10	221	
9	CALASAYA	156	11	33	8	254	
10	CAMILLAYA	164	26	43	15	297	4
11	HUAYCAMARCA	118	19	22	7	319	
12	HORNUNI	84	13	16	7	335	
13	LIRIUNI CHICO	34	3	8	1	343	
14	QUIÑUMA	18	2	4	3	347	
15	COCHABAMBITA	113	20	24	15	377	5
16	TITIAMAYA	178	19	29	10	400	
17	IRUPAYA	137	15	25	8	425	6
18	PONGO B-2	162	24	45	20	470	
19	VILLA CARMEN	312	34	58	30	528	7
20	HUAÑACOTA	76	15	13	5	541	
21	CIUDAD QUIME	3190	361	737	183	1278	8.9.10.11.12 13.14.15.16.
22	GERMAN BUSCH	119	10	22	0	1300	17
23	PUETUCUNI	119	16	27	13	1327	
24	HUAFACA	135	16	29	9	1356	
25	JUPIRI	180	22	34	11	1390	18
26	AÑAHUAYANI	92	13	19	9	1409	
27	LUJURA	62	11	13	3	1422	
28	SURIPI	62	11	13	2	1435	
29	ICHOCA	417	74	65	23	1500	19
30	QUEÑUANI	143	27	26	10	1526	20
31	MOSTRAPATA	86	16	16	11	1542	
32	MATHA	88	15	17	4	1559	
33	WILLOQUIPIÑA	210	31	49	8	1608	
34	LICOBAMBA	76	16	13	9	1621	21
35	PAMPOCO	136	26	24	11	1665	
36	MATHA-YANGAÑA-W **						

DATOS DE CS-III

FECHA: 3 de diciembre de 1992

No.	COMUNIDAD	POBLACION	NIÑOS < 5 AÑOS	MUJERES E.F. 15-49 AÑOS	Vac. TT c/2 dosis		
37	TABLACHACA	404	43	101	17	1746	22
38	FRANZ TAMAYO	198	36	44	6	1790	23
39	GRAL. ELIODORO CAMACHO	267	34	59	6	1849	24
40	COLLPA	171	27	33	6	1882	
41	TABLACHACA OESTE	258	29	66	12	1948	25
42	GUALBERTO VILLARROEL	125	12	21	0	1969	
43	ANTAWARA	68	12	13	8	1982	
44	IRIPE	84	10	23	7	2005	26
45	LURUTA	211	27	45	0	2050	
46	TIKA	81	11	16	0	2066	27
47	KAKOMA	73	17	14	0	2080	
48	YUNGUMA	133	22	34	0	2114	
49	YAWAROCO	45	3	11	5	2125	
50	SIGUAS	210	45	35	17	2160	28
51	CHOSECA	189	24	43	16	2203	
52	HUMANPATA	47	11	9	5	2212	
53	CHAPIMARCA	98	13	18	7	2230	29
54	HUARAHUARANI	88	24	14	13	2244	
55	CALAJALIRI **						
56	V.S. ANTONIO SIRARANI	124	6	21	0	2265	
57	ALTO SIRARANI	219	36	43	3	2308	30..
58	CHACURI	130	23	22	7	2330	
59	TOTORA **						
60	CHICHIPATA **						
TOTALES		10389	1476	2310	663		

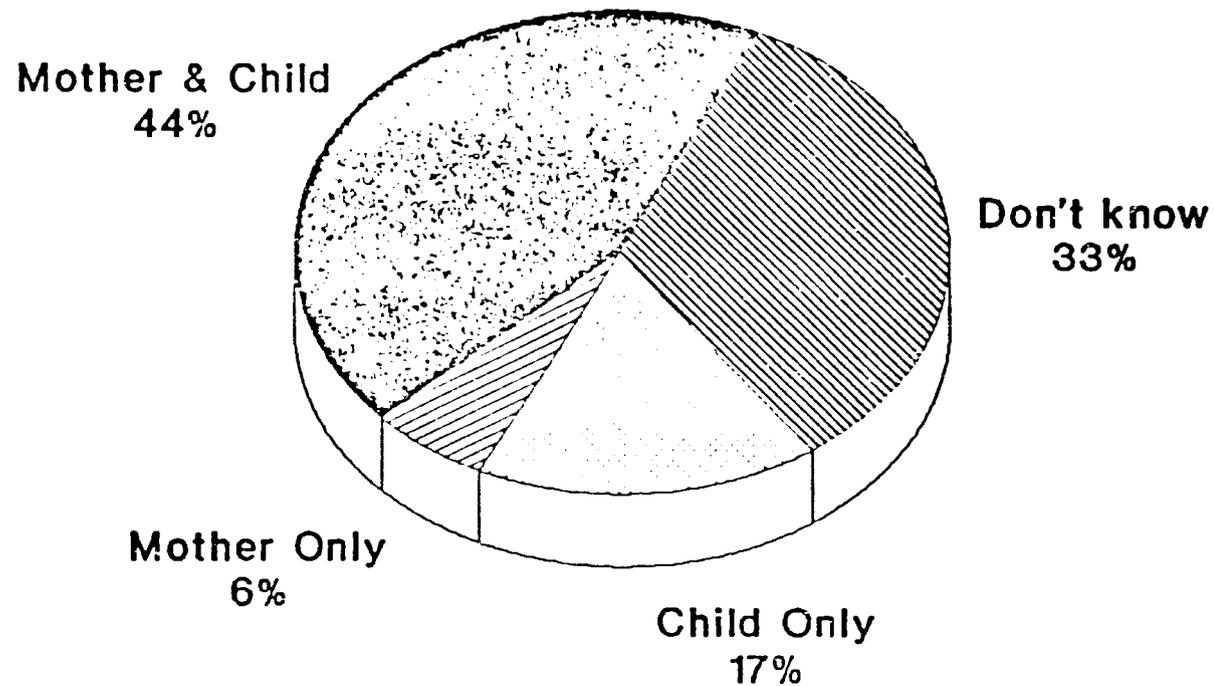
FUENTE: Datos actualizados del PROMIS

** Comunidades con datos estimados.

INDICADOR: $2330 / 30 = 78 \dots (77.66) \dots$

RECURSO: 34 900 TABLA . .

Final Evaluation CSIII Quime
Immunization Knowledge:
Tetanus Toxoid Protection



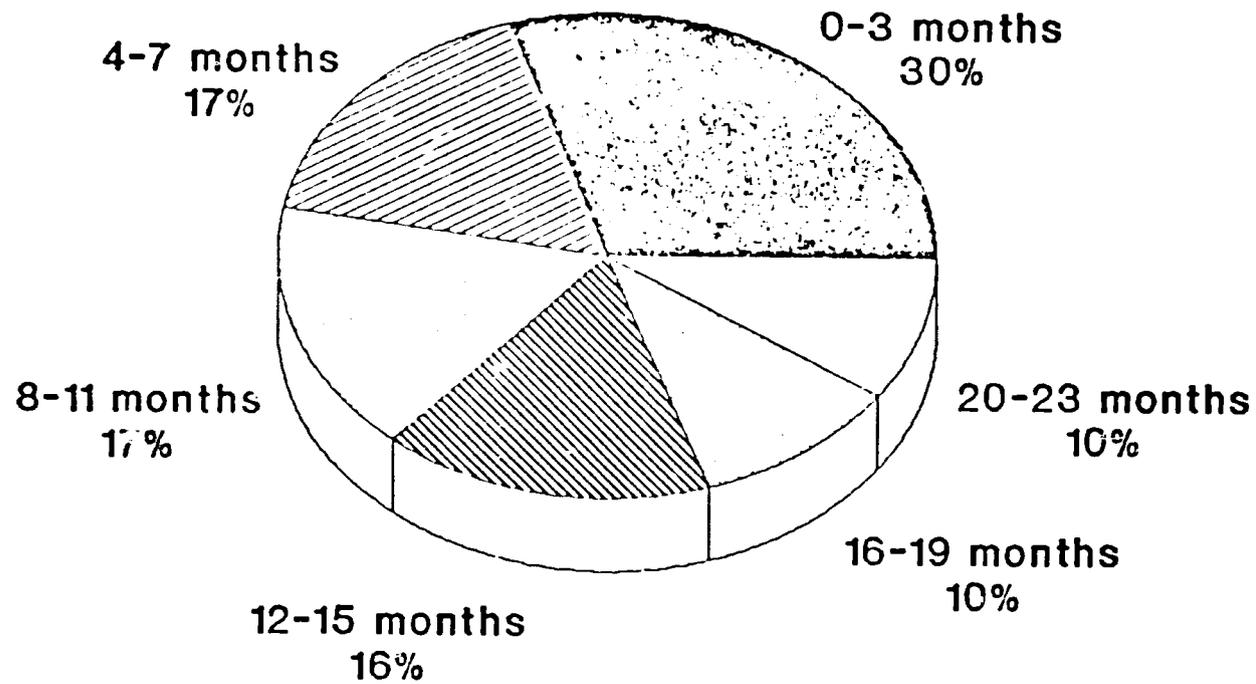
Percent of mothers who know that tetanus
toxoid protects both the child & mother

Final Evaluation Survey, January 1993

Save The Children/Quime, Bolivia

41

Final Evaluation CSIII Quime Children Age Group Distribution



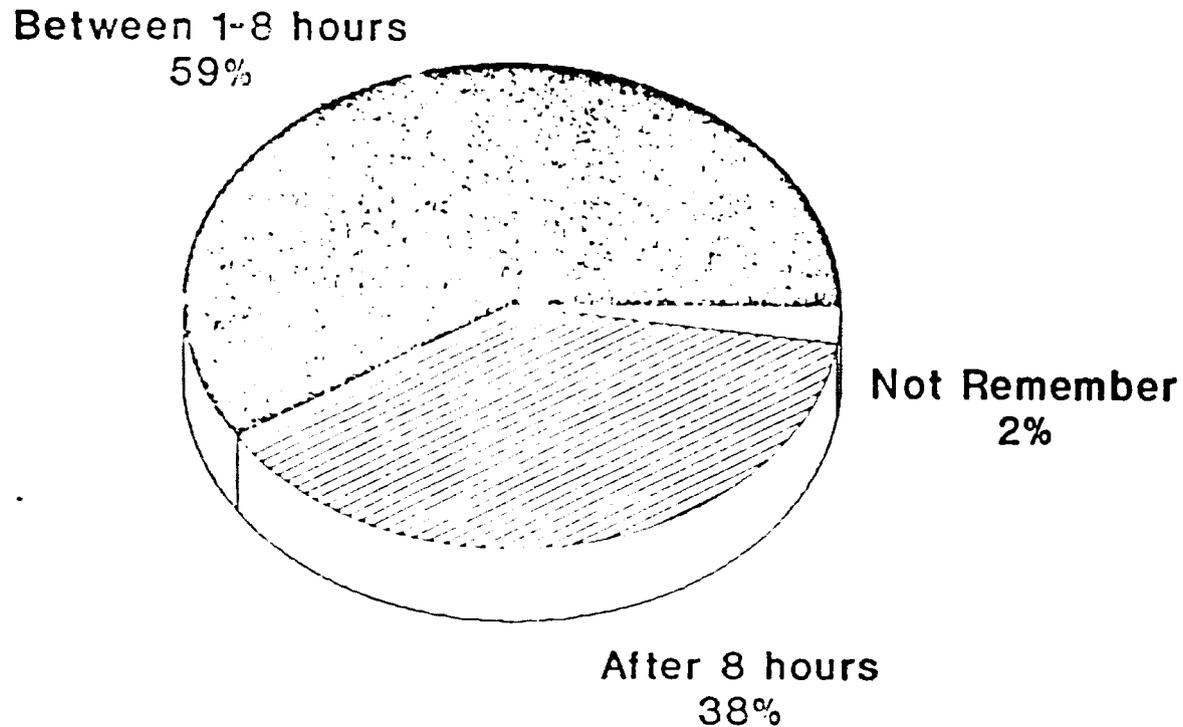
Age Groups

Final Evaluation Survey, January 1993

SC/Bolivia

Handwritten mark

Final Evaluation CSIII SC/Bolivia
Appropriate Infant Feeding Practices:
Initiation of Breastfeeding

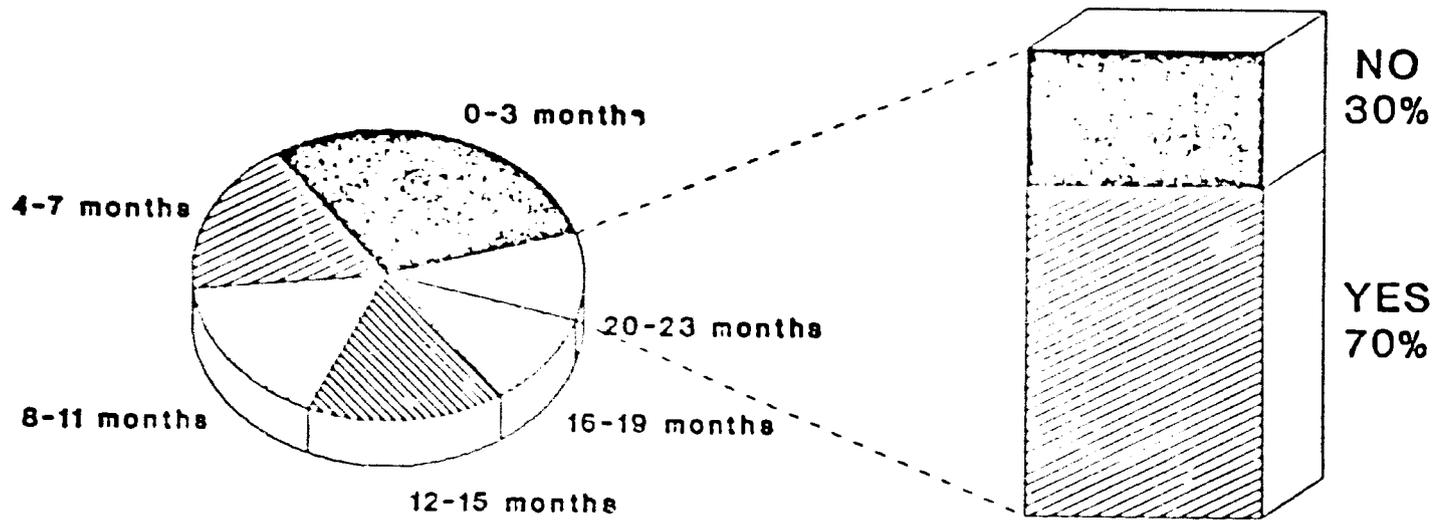


Percent of infants/children who were
breast-fed within the first 8 hours

Final Evaluation Survey, January 1993
Save The Children/Quilme, Bolivia

93

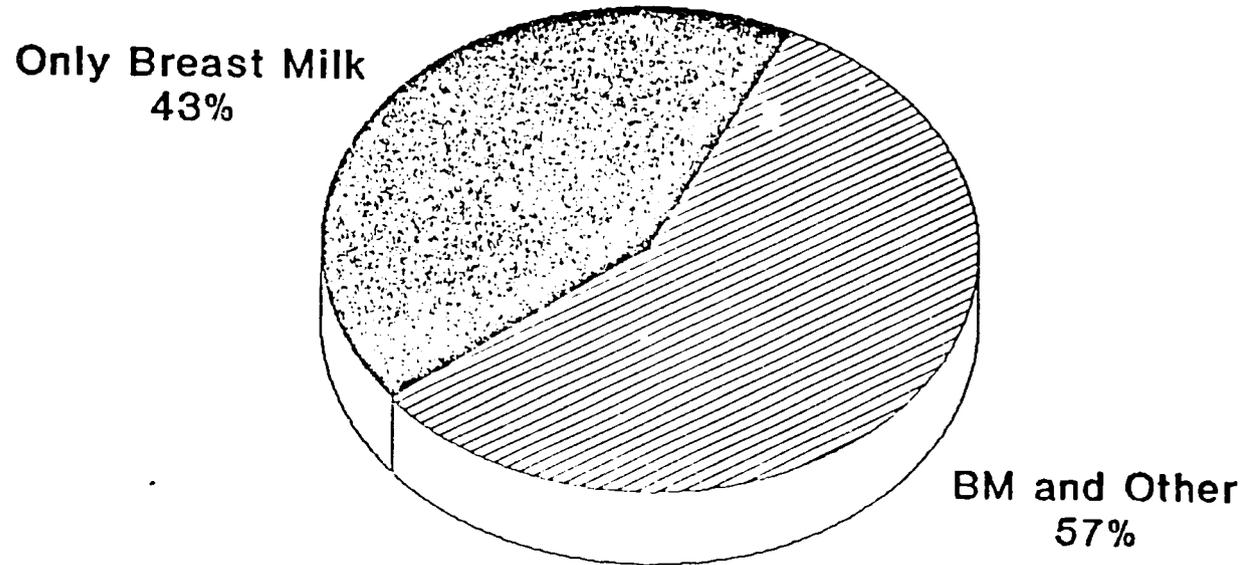
Final Evaluation CSIII SC/Bolivia Appropriate Infant Feeding Practices: Persistence of Breastfeeding



Percent of children between 20 and 23 mo. who are still breastfeeding

Final Evaluation Survey, January 1993
Save The Children/Quime, Bolivia

Final Evaluation CSIII Quime
Appropriate Infant Feeding Practices
Exclusive Breastfeeding



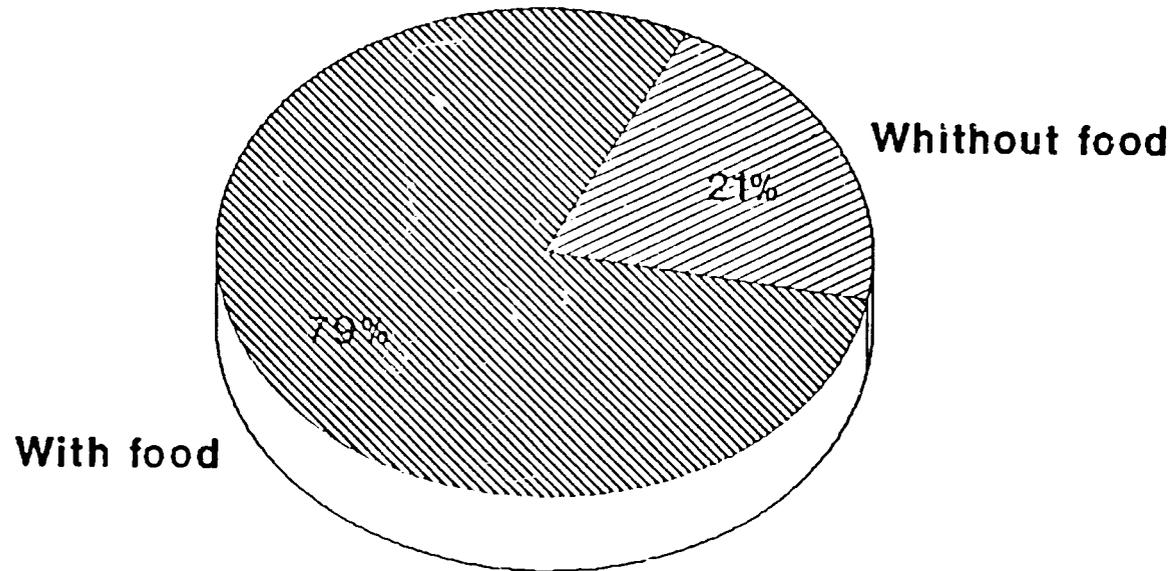
Percent of infants under four months
who are being given only breast milk

Final Evaluation Survey, January 1993

Save The Children/Quime, Bolivia

95

Final Evaluation CSIII Quime
Appropriate Infant Feeding Practices
Introduction of Foods



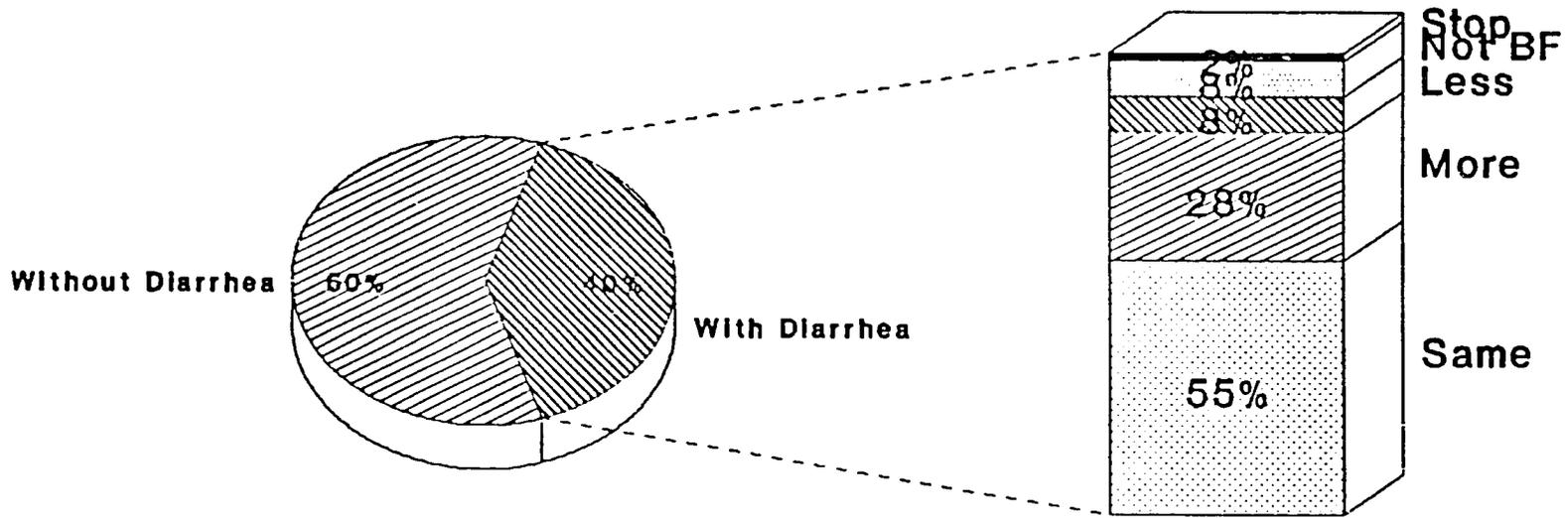
Percent of infants between 5-9mo who are
being given solid or semi-solid foods

Final Evaluation Survey, January 1993

Save The Children/Quime, Bolivia

96

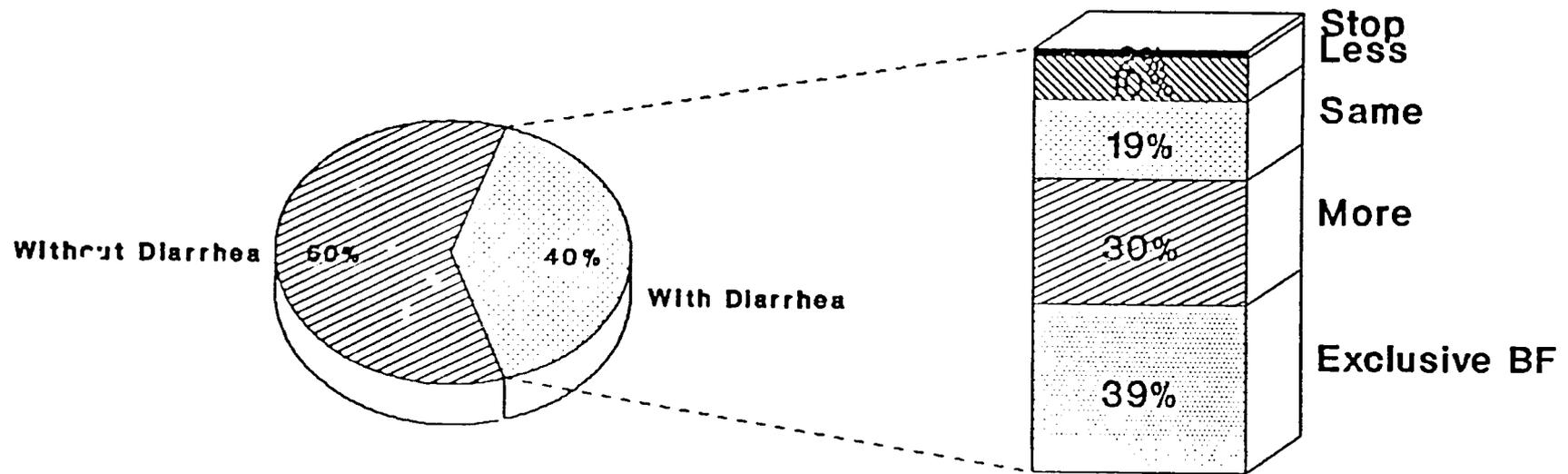
Final Evaluation CSIII SC/Bolivia Management of Diarrheal Diseases: Continued Breastfeeding



% infants/children with Diarrhea
who were given the same or more BM

Final Evaluation Survey, January 1993
Save The Children/Quime, Bolivia

Final Evaluation CSIII SC/Bolivia Management of Diarrheal Diseases: Continued Fluids

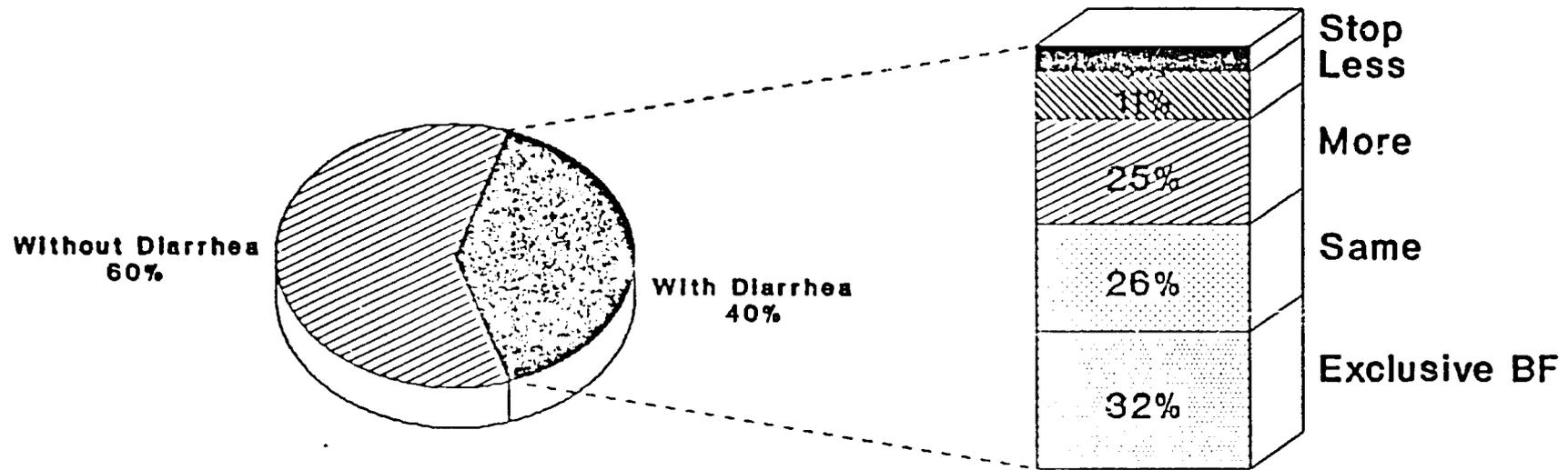


% infants/children with Diarrhea
who were given the same or more fluids

Final Evaluation Survey, January 1993
Save The Children/Quime, Bolivia

98

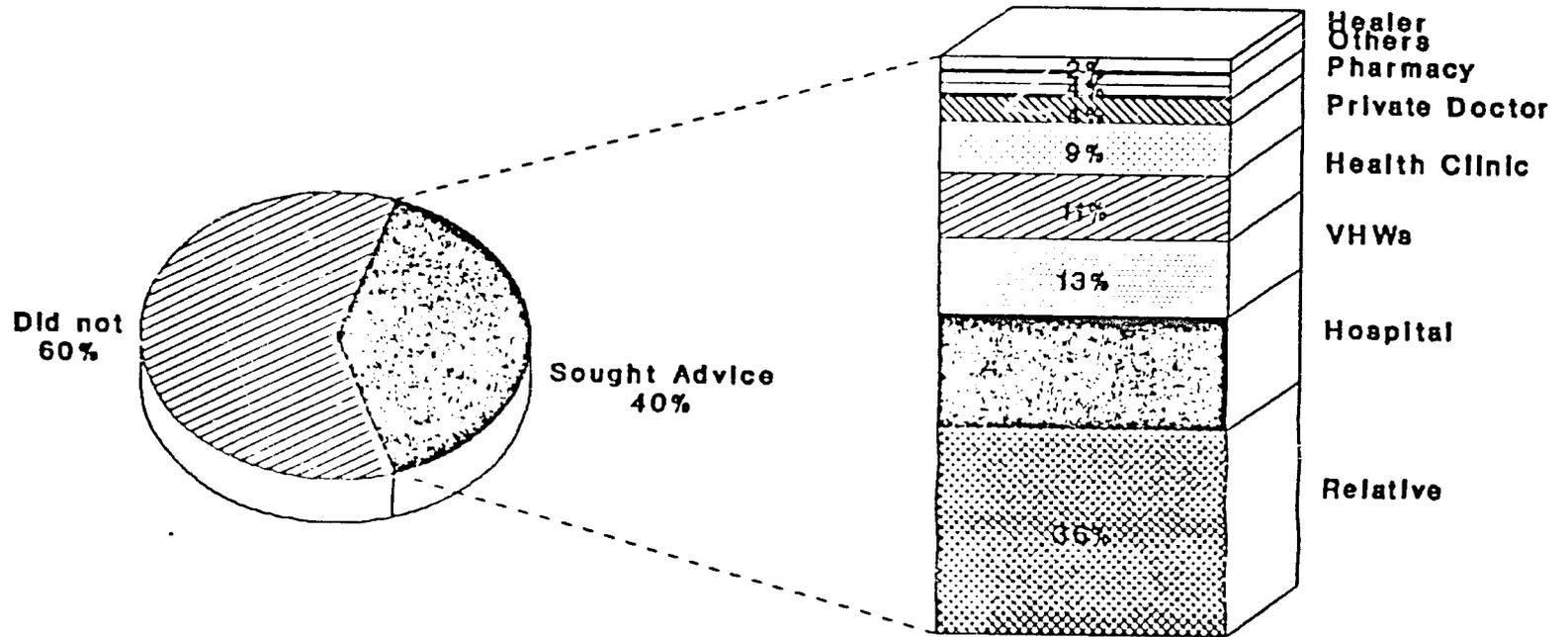
Final Evaluation CSIII SC/Bolivia Management of Diarrheal Diseases: Continued Foods



% infants/children with Diarrhea
who were given the same or more foods

Final Evaluation Survey, January 1993
Save The Children/Quilme, Bolivia

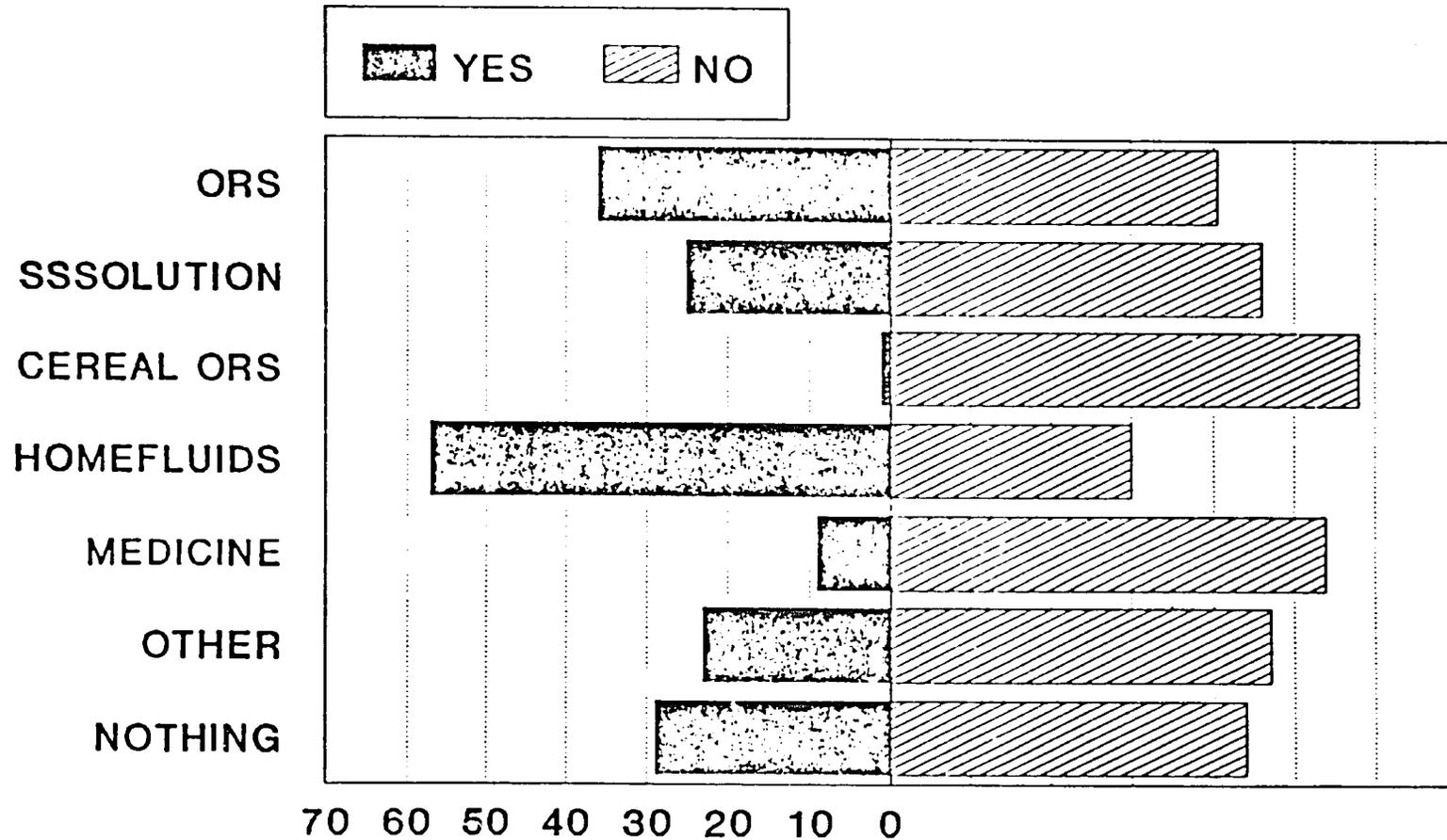
Final Evaluation CSIII SC/Bolivia Pneumonia Control: Medical Treatment



% mothers who sought medical treatment for infant/children w/cough & rapid b.

Final Evaluation Survey, January 1993
Save The Children/Quilme, Bolivia

Final Evaluation CSIII CS/Bolivia
 Management of Diarrheal Diseases:
 ORS Usage

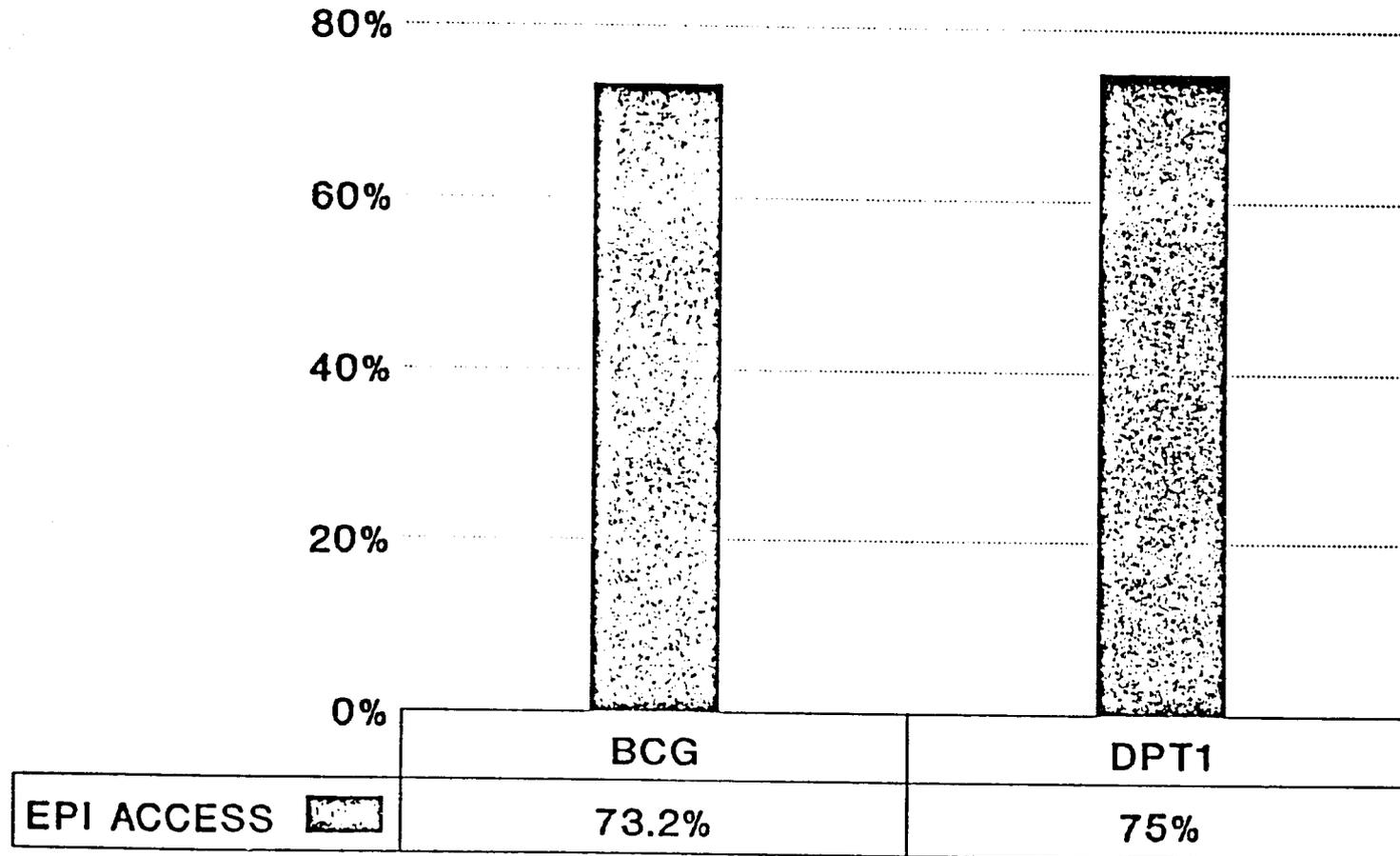


Final Evaluation Survey, January 1993
 Save The Children/Qulme, Bolivia

101

Final Evaluation CSIII CS/Bolivia
Vaccination Coverage (Card):

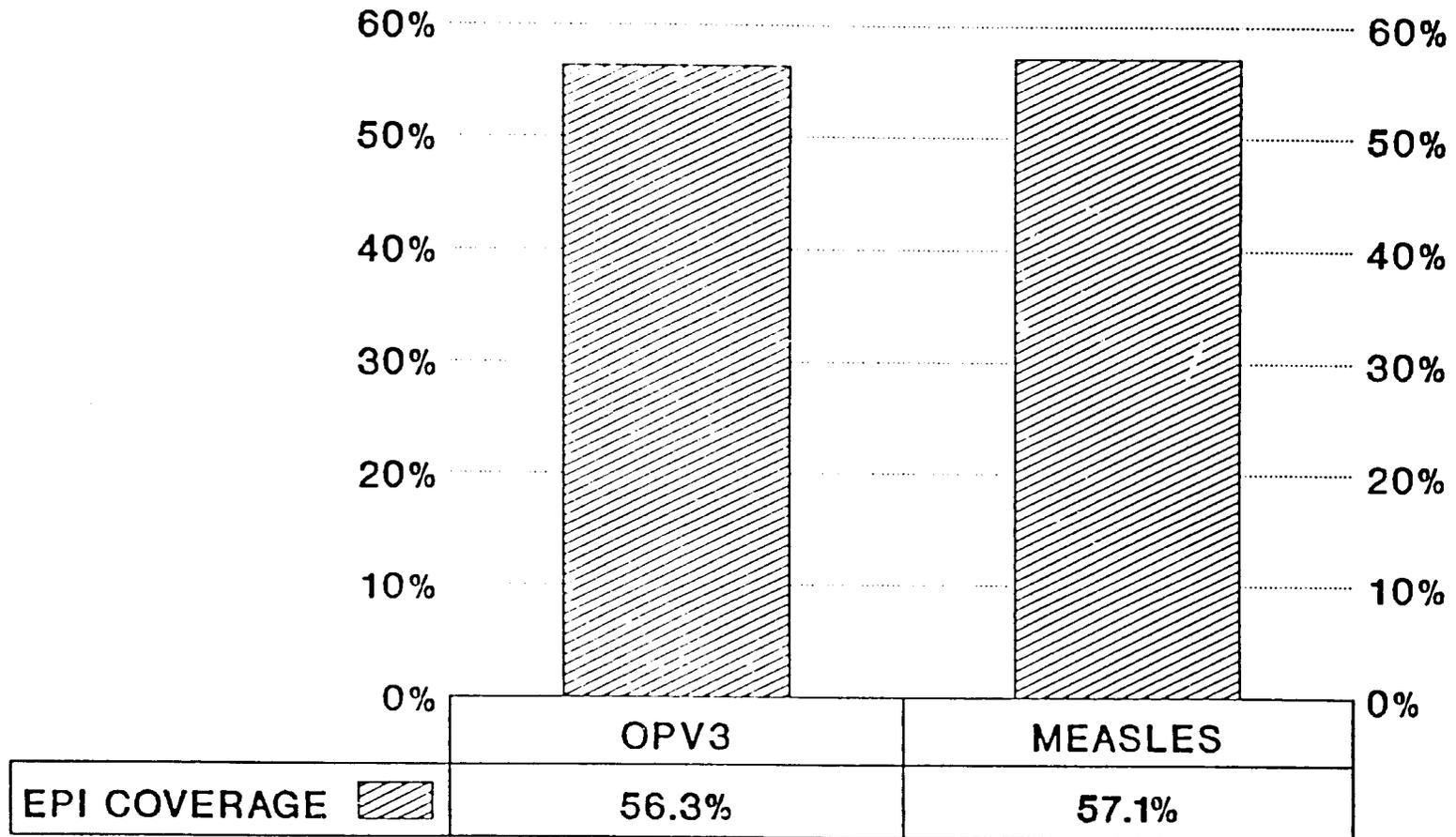
EPI ACCESS (*)



(*) Percent of children 12 to 23 months
Final Evaluation Survey, January 1993
Save The Children/Qulme, Bolivia

- 102

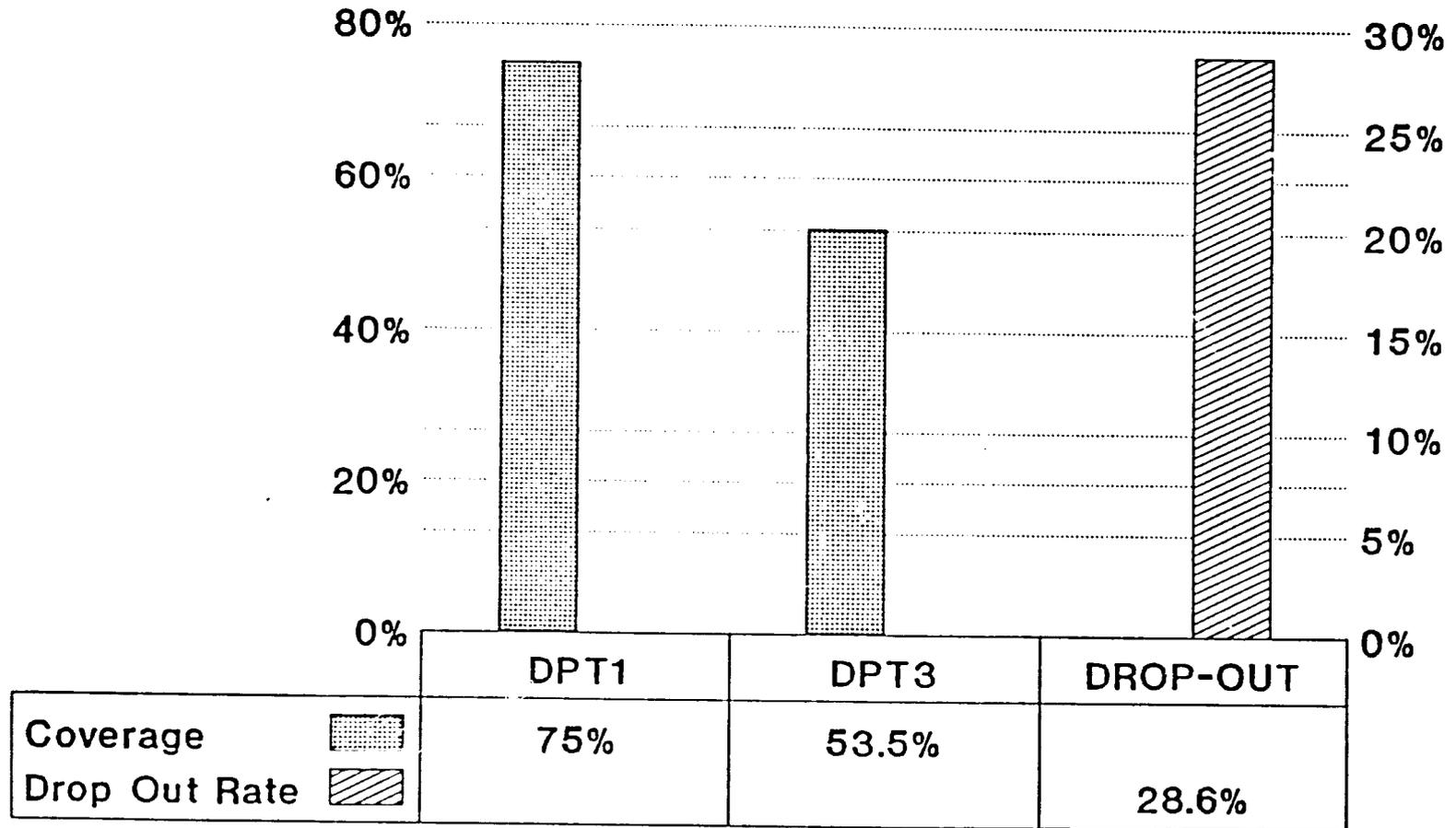
Final Evaluation CSIII CS/Bolivia
 Vaccination Coverage (Card):
EPI & MEASLES COVERAGE (*)



(*) Percent of children 12 to 23 months
 Final Evaluation Survey, January 1993
 Save The Children/Gulme, Bolivia

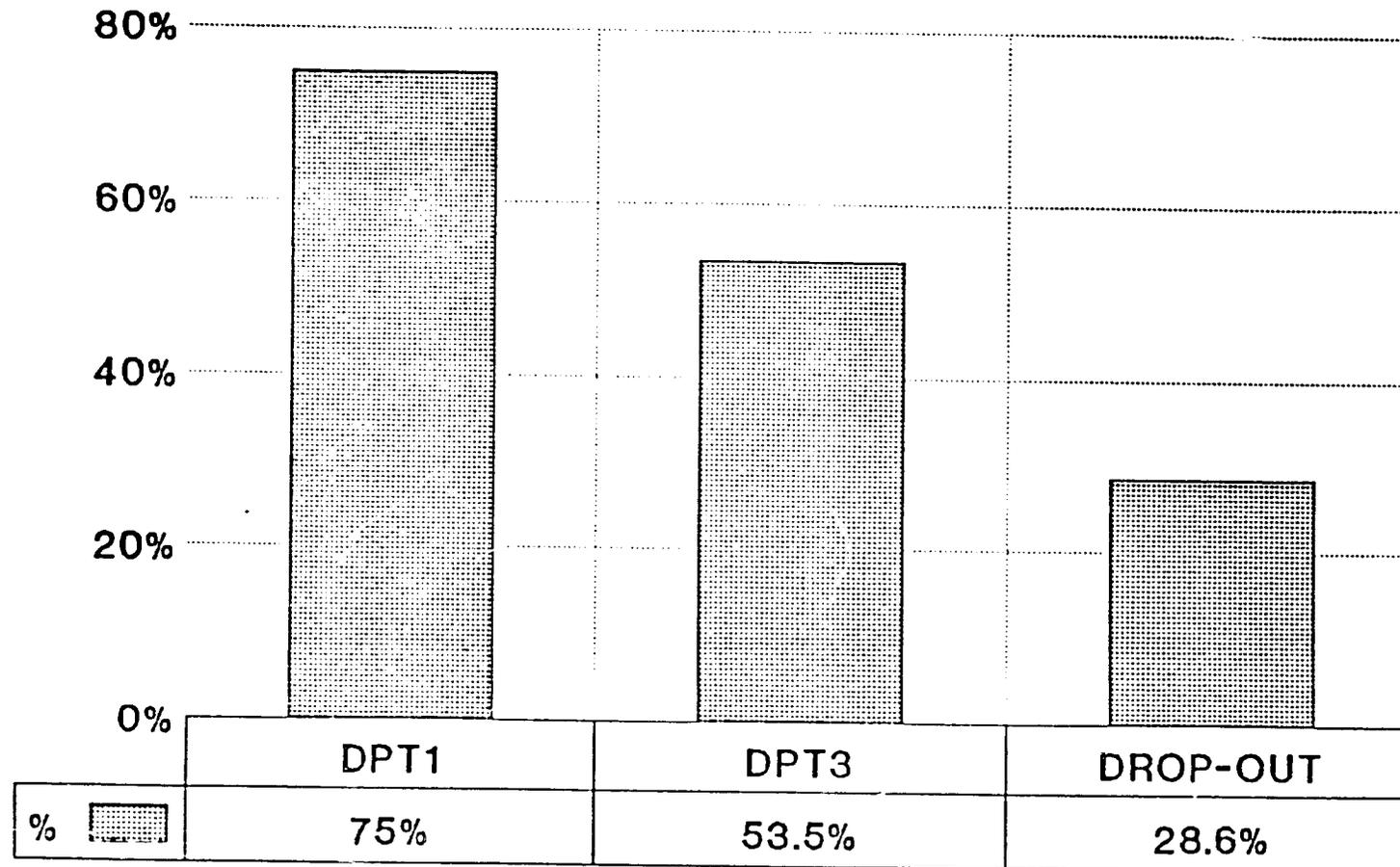
107

Final Evaluation CSIII CS/Bolivia
 Vaccination Coverage (Card):
 Drop Out Rate (*)



(-) Percent of children 12 to 23 months
 Final Evaluation Survey, January 1993
 Save The Children/Quilme, Bolivia

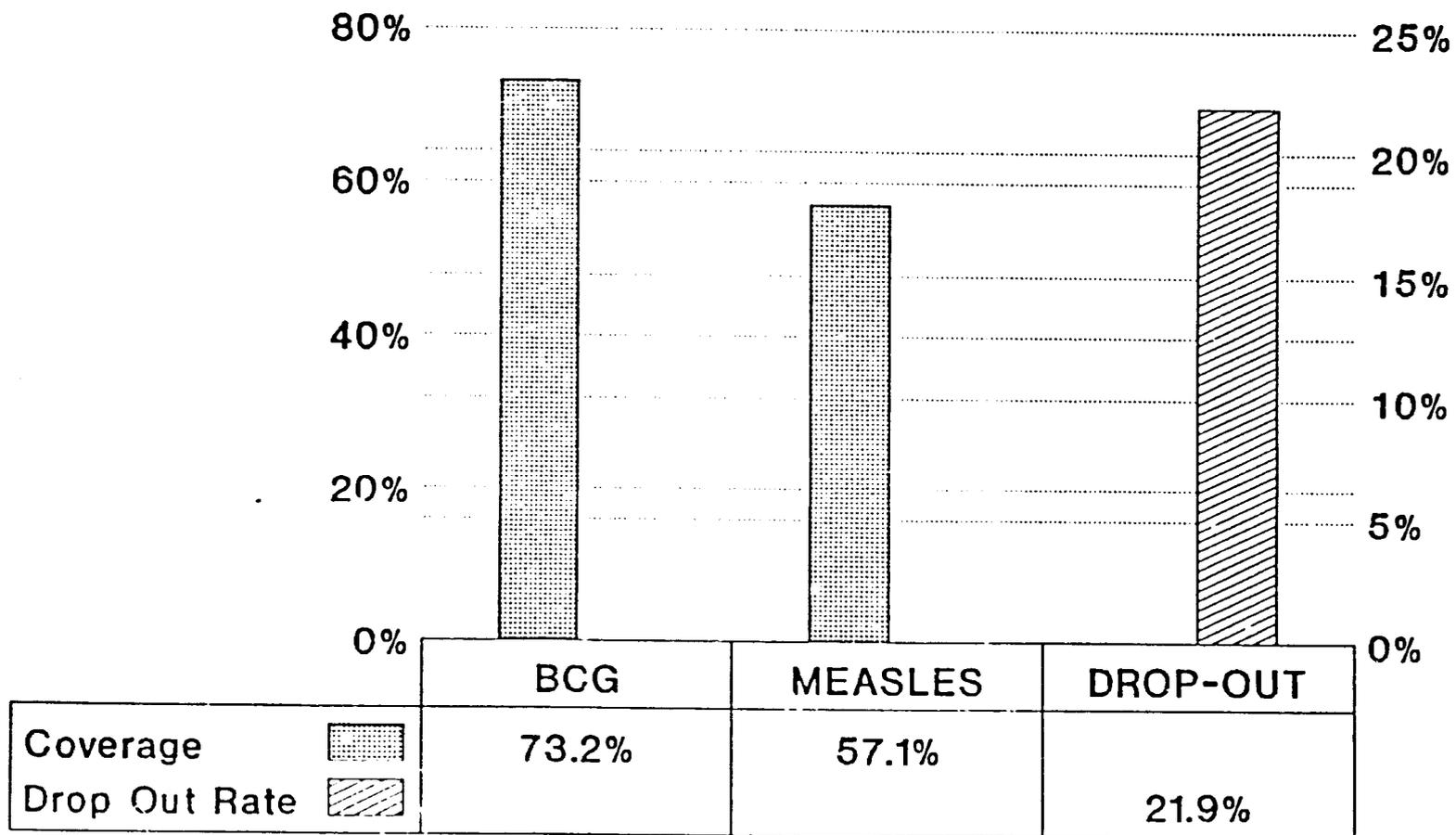
Final Evaluation CSIII CS/Bolivia
 Vaccination Coverage (Card):
 Drop Out Rate (*)



(•) Percent of children 12 to 23 months
 Final Evaluation Survey, January 1993
 Save The Children/Quime, Bolivia

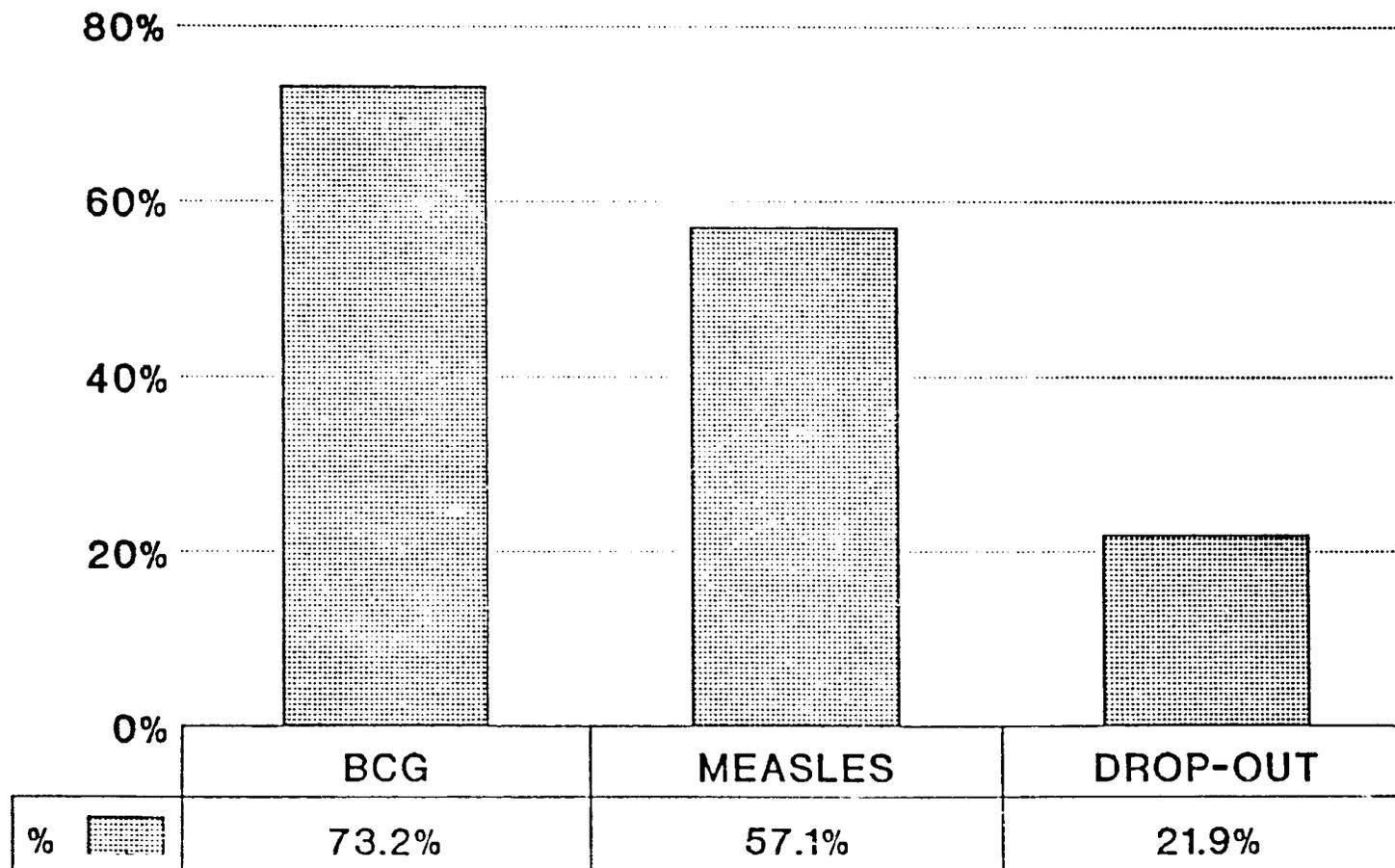
105

Final Evaluation CSIII CS/Bolivia
 Vaccination Coverage (Card):
Overall Drop Out Rate (*)



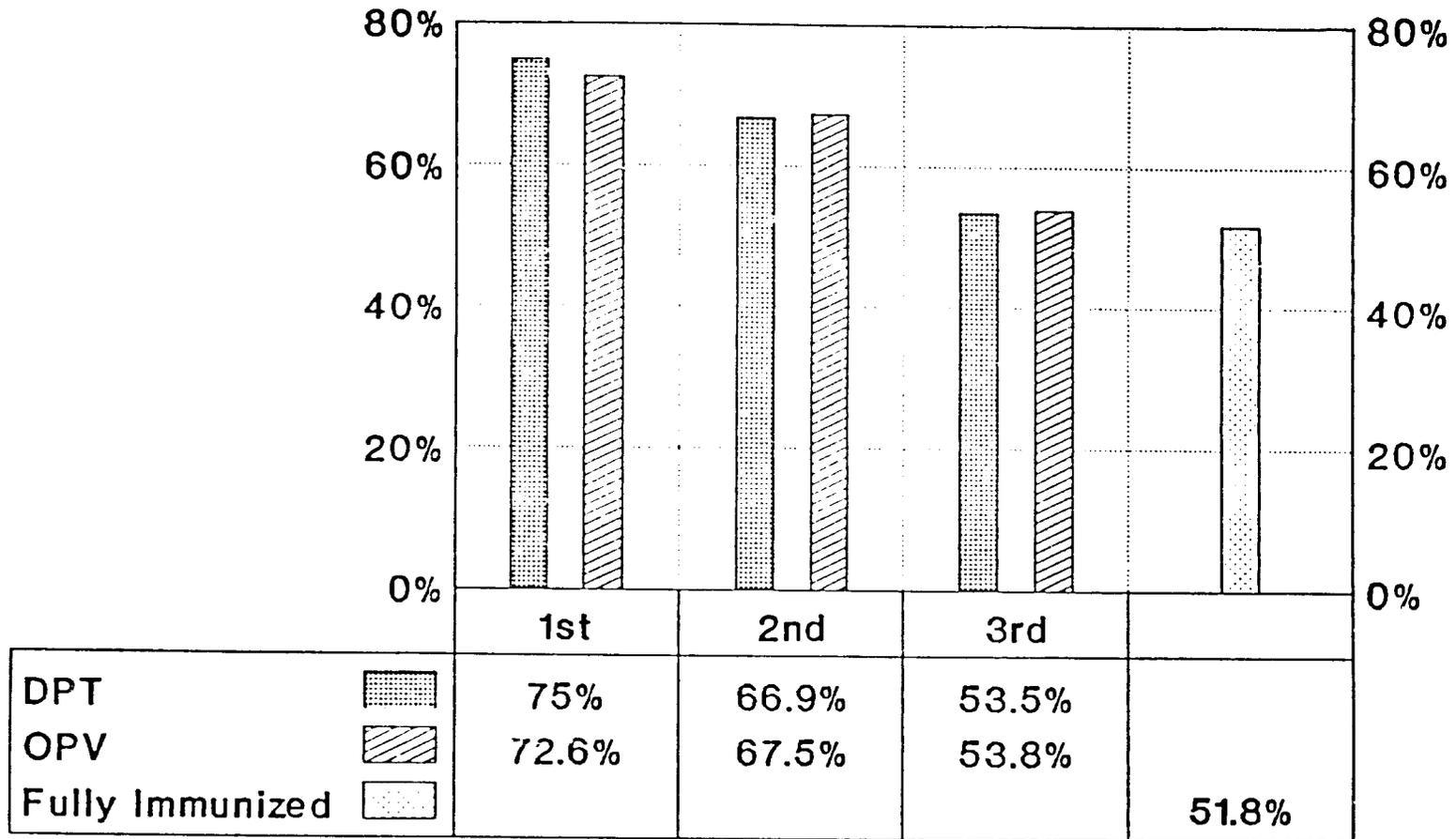
(*) Percent of children 12 to 23 months
 Final Evaluation Survey, January 1993
 Save The Children/Quilme, Bolivia

Final Evaluation CSIII CS/Bolivia
 Vaccination Coverage (Card):
Overall Drop Out Rate (*)



(*) Percent of children 12 to 23 months
 Final Evaluation Survey, January 1993
 Save The Children/Qulme, Bolivia

Final Evaluation CSIII CS/Bolivia
 Vaccination Coverage (Card):
 Fully Immunized Rate (*)

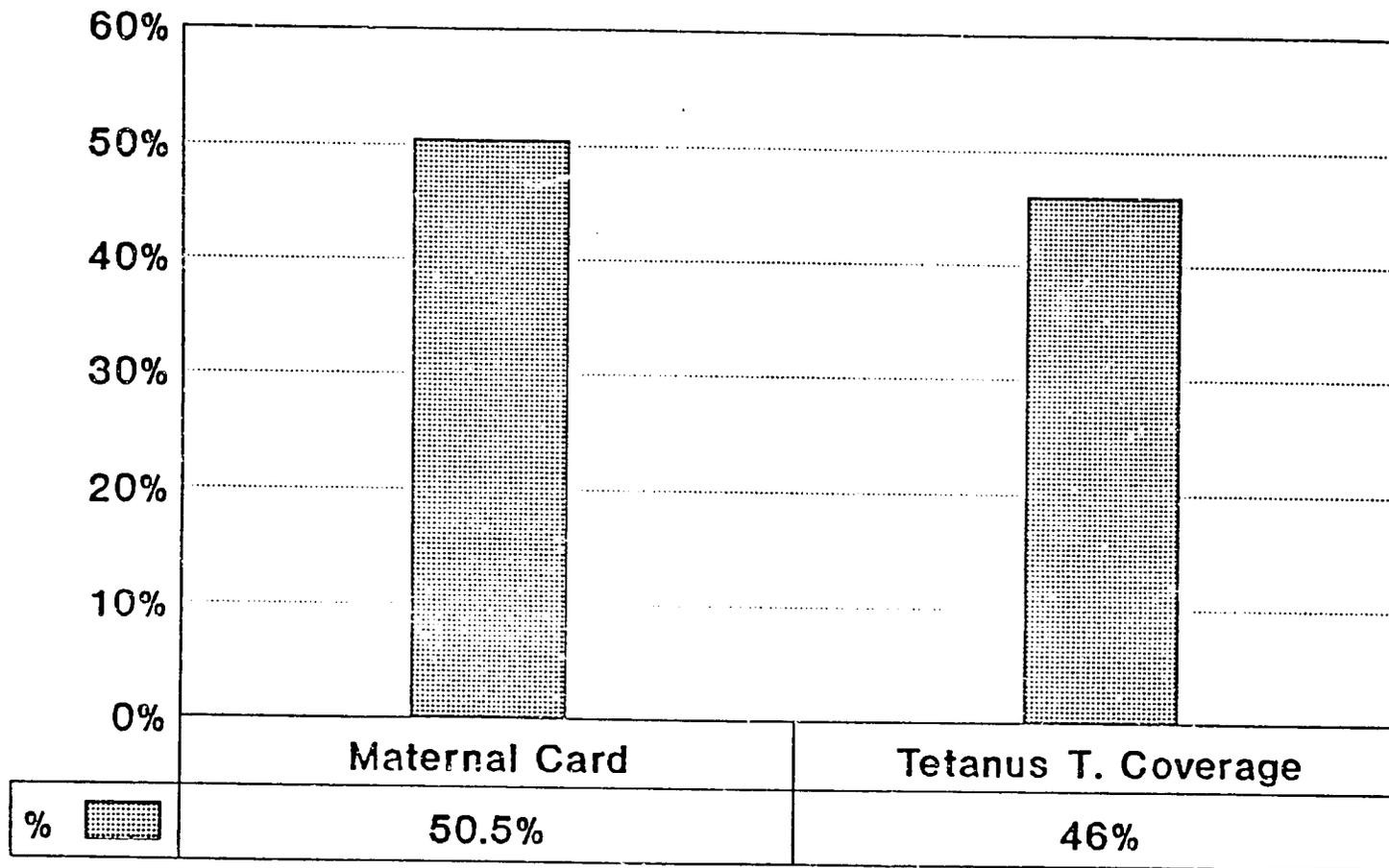


(*) Percent of children 12 to 23 months
 Final Evaluation Survey, January 1993
 Save The Children/Qulme, Bolivia

103

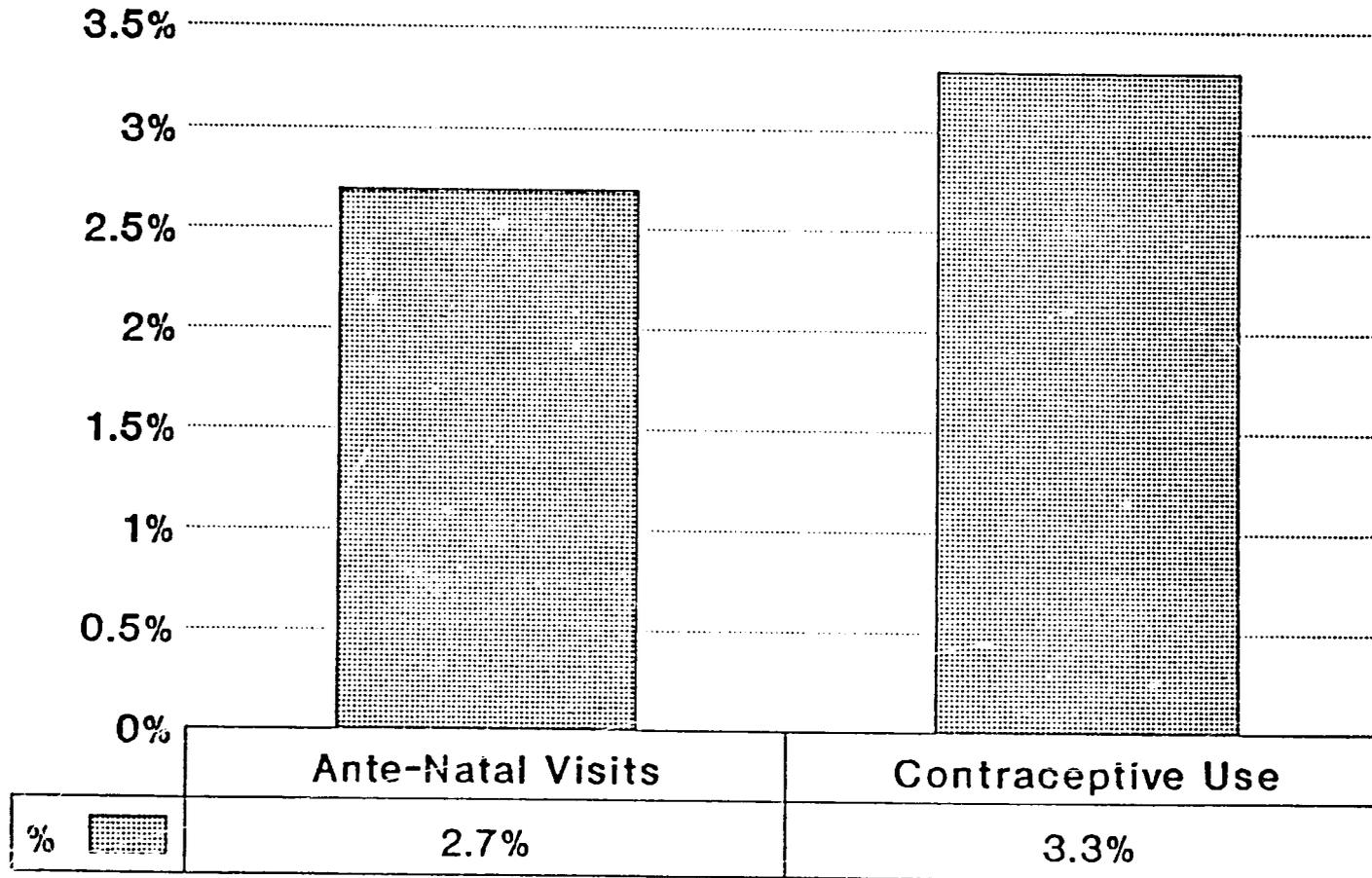
Final Evaluation CSIII CS/Bolivia
Maternal Care:

Maternal Care Card & TT Coverage (Card)*



• Percent of mother with two doses of TT
Final Evaluation Survey, January 1993
Save The Children/Quilme, Bolivia

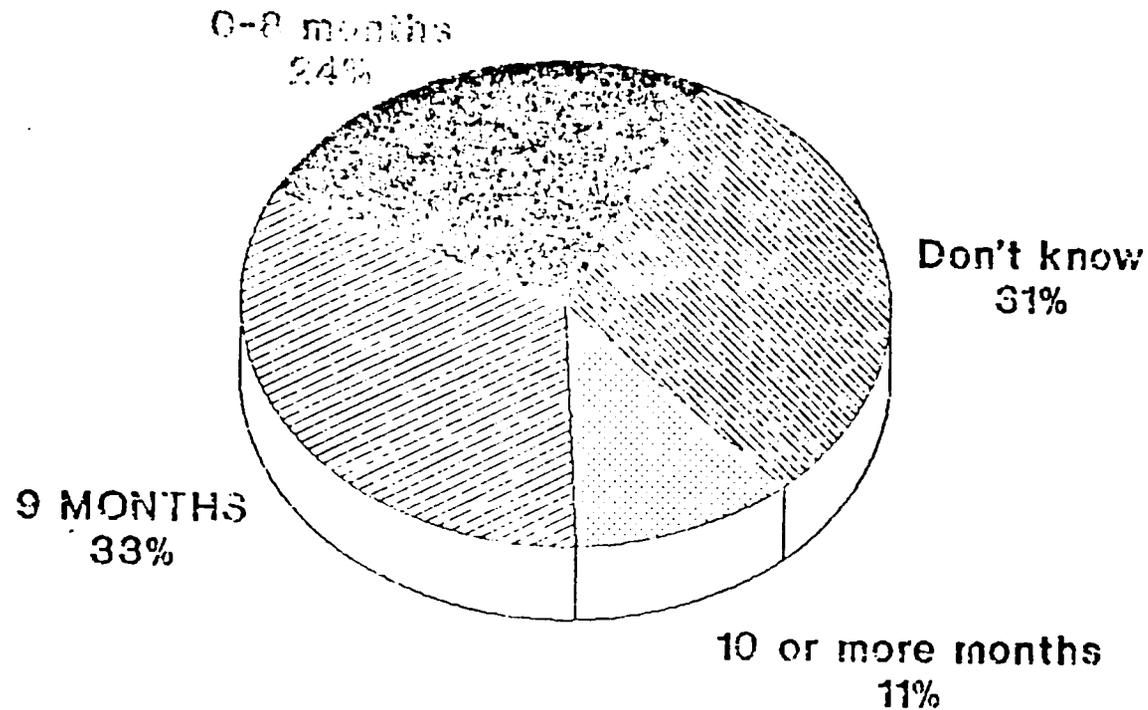
Final Evaluation CSIII CS/Bolivia
 Maternal Care:
Ante-Natal Visits & Contraceptive Usage



Final Evaluation Survey, January 1993
 Save The Children/Quilme, Bolivia

110

Final Evaluation CSIII Quime
Immunization Knowledge:
Timeliness of Measles

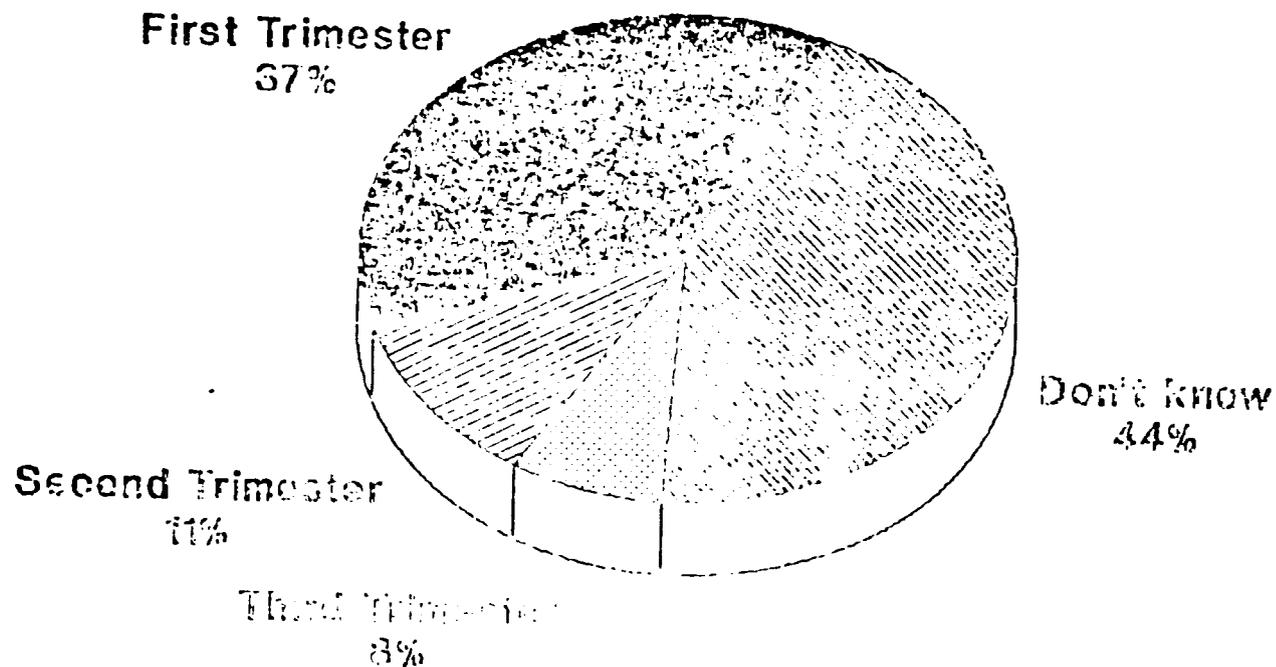


Percent of mothers who know that measles vaccine should be given at nine months

Final Evaluation Survey, January 1993

Save The Children/Quime, Bolivia

Final Evaluation CSIII SC/Bolivia
Maternal Care Knowledge:
Timeliness of Ante-Natal Care



Percent of mothers who know that pregnant women should start before 3rd Trimester

ANNEX D

Maps of Project Area

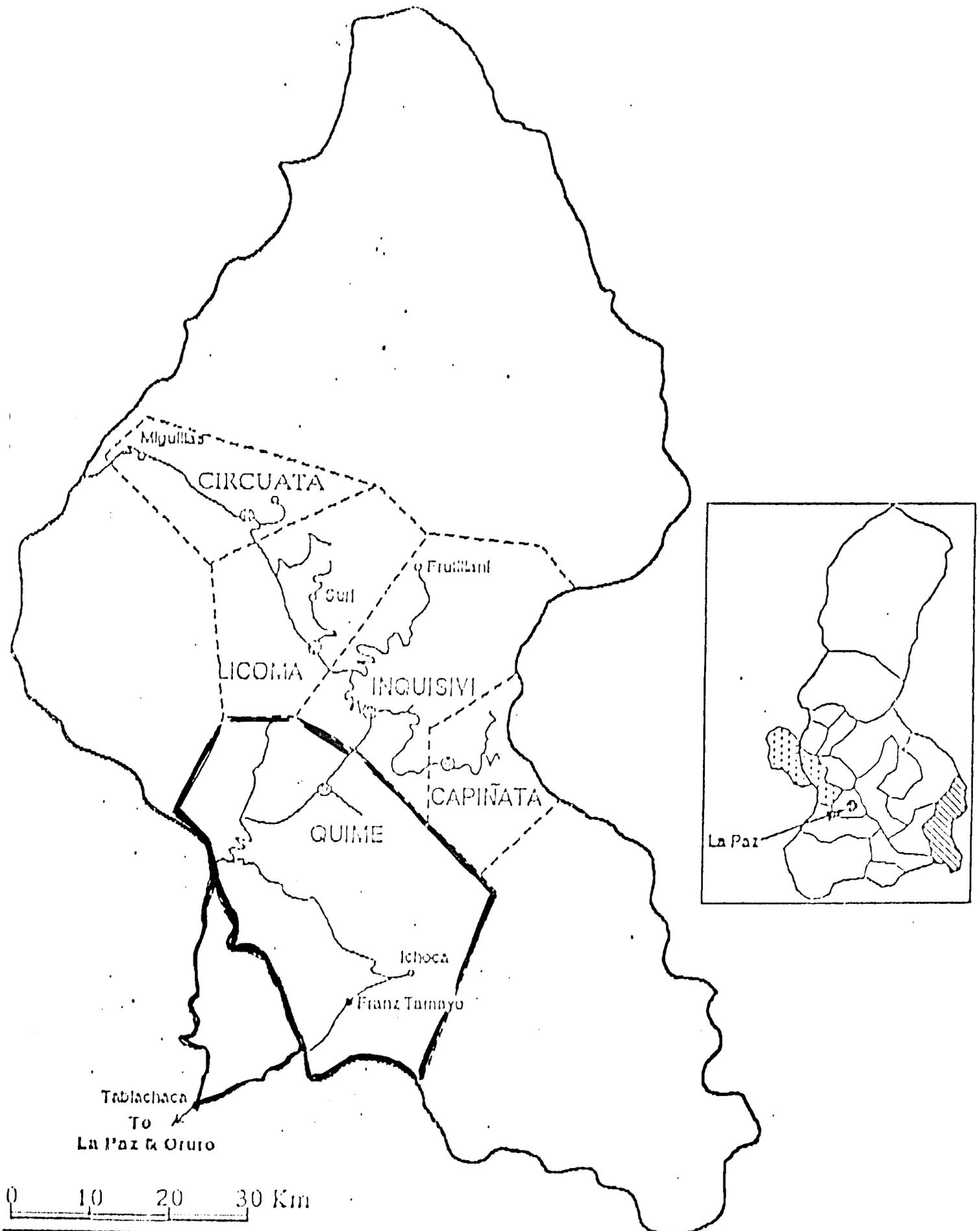
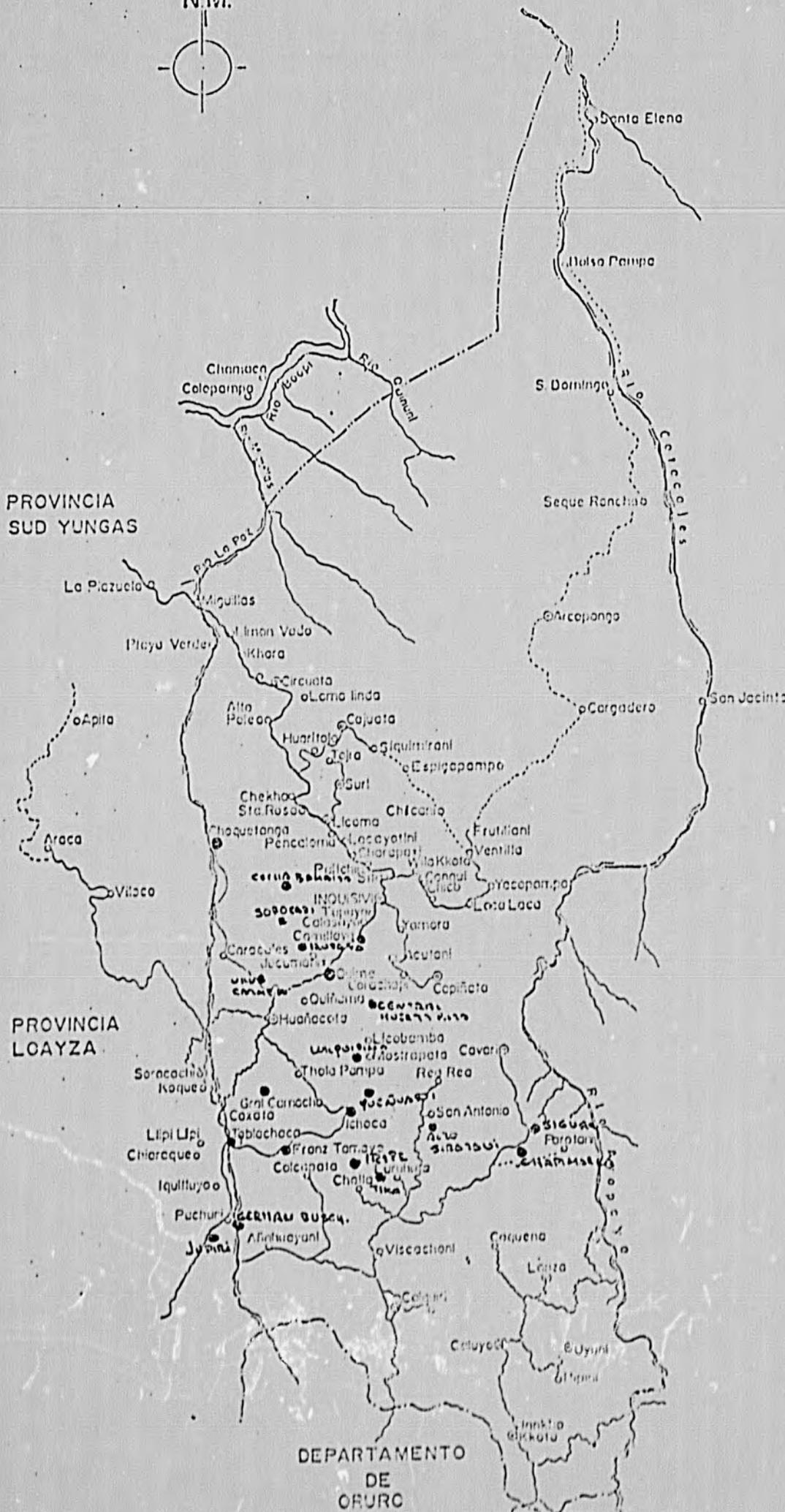
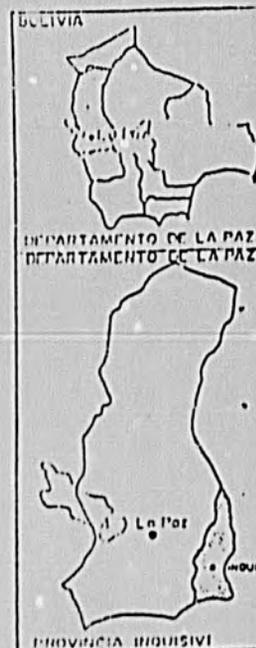
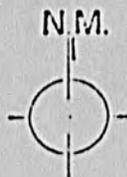


Figure 1. Department of Inquisivi showing location within the Department of La Paz and sub areas in which SCF works. Details of individual subareas are shown in Figures 2 through 6.



DEPARTAMENTO DE COCHABAMBA

DEPARTAMENTO DE ORURO

SAVE THE CHILDREN DESARROLLO JUVENIL COMUNITARIO MAPA DE LA PROVINCIA INQUISIVI AREA DE IMPACTO La Paz Septiembre de 1992

ANNEX E

List of Persons Interviewed

APPENDIX E

PERSONS AND INSTITUTIONS INTERVIEWED DURING THE CHILD
SURVIVAL III EVALUATION IN BOLIVIA

THE INSTITUTIONS INTERVIEWED WERE:

- PROCOSI Dr. Franklin Bustillos
- SOPACOF-ASBOLCOF Dr. Eduardo del Castillo

THE LEADERS/MOTHERS INTERVIEWED WERE:

- Aurelia Choque Quime
- Maruja Vargas de Quispe Quime
- Domitila Choque (head of family) Tablachaca
- Tomás Huanca Tablachaca
- President, Mothers Club
Inmaculada School Quime
- Andrea Castro Quime
- Marina Cosme de Castro Quime
- Juana Flores/Agustina Sarsuri Villa El Carmen
- Felisa Choque de Mamani Jupiri
- Alicia Barreto Huaraca
- Judith Zarate Añamayani
- Elia Argenta Franz Tamayo
- Clemente Colque (General Secretary) Camillaya
- Eduardo Calisaya (Secretary, Meetings) Huaynacota
- David Argollo (Syndicate) Quime
- Eliseo Mamani (Secretary, Meetings)
Agro-economic Commission) Quime
- Gregoria Orellana Ichoca

THE TWO INDIVIDUALS WHO PARTICIPATED IN THE SURVEY WERE:

- Francisco Aruquipa (Secretary, Education)
- Mario Conde (Secretary, Central Agrarian Syndicate
Organizations)

INTERVIEWS OF THE MINISTRY IN THE FIELD:

- Dr. Jacinto Pérez - Doctor CSH San Antonio-Quime
- Tomás Pérez (Auxiliary Nurse) Health Unit, La Paz
C.S. Tablachaca

PROMOTERS WHO PARTICIPATED IN THE SURVEY:

- José Mamani Camillaya
- Nieves Otalora Villa El Carmen
- Enrique Aruquipa Franz Tamayo
- Leandro Fernández Ichoca
- Luis Lima Poma Calasaya
- Albertina Ramos Tablachaca
- Francisco Auna Licobamba
- Máxima Guarachi Huañacota

ANNEX F

Questionnaires

GUIA PARA INSTITUCIONES

Fecha:

Institución:..... Entrevistado:.....

1. Qué conoce usted del Proyecto de Supervivencia Infantil III de Save the Children? Existe información flúida?

2. Tiene algún tipo de coordinación con Save the Children y/o con el Proyecto?

En qué aspectos?

Tiene usted algunas sugerencias para mejorarlo?

3. Qué opinión tiene usted del Proyecto?

Tiene usted algunas sugerencias para el Proyecto?

4. En su criterio el Proyecto de Supervivencia Infantil III de Save the Children está dentro del marco de la política de Salud?

DESARROLLO JUVENIL COMUNITARIO
EVALUACION FINAL CS3

GUIA PARA EL PERSONAL DE DJC

FECHA: _____
NOMBRE: _____
CARGO: _____
AREA DE TRABAJO: _____
TIEMPO DE TRABAJO: _____

INFORMACION EN SALUD:

1a) Describa el trabajo y las actividades que realiza en el proyecto.

- b) Cómo participa la comunidad en estas actividades?
 - c) La participación es suficiente?
 - d) Qué podría hacer para mejorarla?
- 2) Señale los éxitos/logros que ha alcanzado en su trabajo.
- 3) Señale las limitaciones/deficiencias que ha tenido en el desarrollo de las actividades.
- 4) Qué sugerencias tiene para mejorar su trabajo?
- 5a) Qué tipo de información obtiene usted?

- b) Qué hace usted con esta información?
- c) Qué tipo de informes/documentos produce usted?
- d) Conoce usted toda la información necesaria sobre el proyecto para desarrollar sus actividades?
- e) Qué tipo de decisiones toma usted en base a la información?
- f) Considera usted que falta alguna información para hacer su trabajo?

INFORMACION DEL MANEJO DE PROYECTO

- 6) Cuenta usted con la orientación y la guía necesarias para el desempeño de su trabajo?
- 7a) Cómo planifica usted su trabajo?
- b) Participa usted en la toma de decisiones? en el diseño del proyecto? en la evaluación de actividades?
(continúe...hierarquía y flexibilidad de las organizaciones)
- 8a) Qué le gusta de su trabajo? Qué no le gusta de su trabajo?
- b) El proyecto le da a usted los medios logísticos y materiales necesarios para realizar su trabajo?

c) Qué han hecho ustedes para reducir costos y para mejorar la efectividad del proyecto?

9) Cómo podría mejorar el trabajo del equipo?

CAPACITACION

10) La institución le ofrece a usted una capacitación y actualización adecuada y periódica para hacer un buen trabajo?

SOSTENIBILIDAD

11)Cuál es la estrategia de sostenibilidad del proyecto? Qué indicadores de sostenibilidad usan ustedes?
Es realista? Adecuada?

12) Hasta qué punto se ha logrado algo en esta estrategia?

13a) Cómo cree usted que la comunidad pueda apoyar esta estrategia para asegurar la sostenibilidad del proyecto?

b) Qué podrían hacer ustedes para recuperar los costos del proyecto?

121

COORDINACION

15) Cuál es la coordinación y cuáles son las actividades que desarrolla usted? Con:

- a) Unidad Sanitaria

- b) Distrito de Tres Cruces?

- c) los líderes

- d) los promotores

- e) las madres?

- d) otros proyectos de DJC?

- e) otras instituciones

CONOCIMIENTOS DE SALUD (PARA SUPERVISORES)
Refiere a la encuesta para promotoras.

Desarrollo Juvenil Comunitario

Evaluación Final/CS3

GUIA PARA LIDERES/MADRES

Fecha: _____
Nombre de Comunidad: _____
Nombre de Madre/Líder: _____
Cargo: _____
Entrevistador: _____

1. Conoce usted el proyecto "children" de DJC?
2. Qué actividades realiza este proyecto en su comunidad?

COMPONENTES	SI	PROPOSITO
a) PAI		
b) TRO		
c) Nutrición/Vit A		
d) Salud Materna		
e) IRA		
f) Otras		

3a) Están contentos con este proyecto?

- b) Todas las familias participan?
 - c) Cómo han decidido participar en el proyecto?
 - d) Cómo apoya la comunidad al proyecto?
- 4a) Cuando hay reuniones de la comunidad, de qué actividades del proyecto hablan ustedes?
- b) Con qué frecuencia?
 - c) En qué forma participa el sindicato?
- 5a) Quién es el promotor de su comunidad?
- b) Si es hombre/mujer....Las mujeres/hombres están contentos con su trabajo?
 - c) Qué hace el promotor?
 - d) Cómo fue nombrado?
 - e) Está de acuerdo con su trabajo?
 - f) Quién es el jefe del promotor?
 - g) Cómo le apoya el promotor?
- 6a) Qué tipo de información solicita el personal o promotor del proyecto?
- b) Qué hacen ellos con esta información?
 - c) Ustedes conocen esa información?

- d) Cómo la utilizan?
-
- 7a) Sabe usted hasta cuándo va a durar el proyecto?
 - b) Qué piensa hacer la comunidad cuando termina el proyecto?
 - c) Realizan actualmente algún aporte/contribución para desarrollar el proyecto?
 - d) Cómo van a asegurar la continuación del proyecto?
 - e) En qué puede apoyar la comunidad para mejorar su salud?
-
- 8) Qué se puede hacer para mejorar el proyecto?

DESARROLLO JUVENIL COMUNITARIO
EVALUACION FINAL/CS3

GUIA PARA EL MINISTERIO EN EL CAMPO

Fecha: _____
Nombre: _____
Cargo: _____
Institución: _____

- 1) Qué conoce usted del proyecto de Supervivencia Infantil 3 de Save the Children? Existe información flúida?

- 2) Qué actividades del proyecto han sido más efectivas? o han tenido mayor éxito?

- 3) Cómo coordina su institución con el proyecto? En qué aspectos?

- b) Qué actividades relacionadas con el proyecto realiza en forma conjunta?

- c) Tiene usted algunas sugerencias para mejorarla?

- 4) Ha participado en las programaciones del proyecto? Cómo?

- 5) Qué tipo de apoyo ha brindado el proyecto a su institución?

b) Los eventos de capacitación que realizó el proyecto fueron positivos para su institución?

6) Qué tipo de apoyo ha brindado su institución al proyecto?

7)Cuál es la información que el proyecto entrega al Ministerio?

b)Cuál es el uso que se da a esa información?

c) Tiene usted algunas sugerencias para mejorar el sistema de información?

8) En su criterio, cómo podría asegurar la continuidad del trabajo que ha desarrollado el proyecto una vez que termine el proyecto en su área de trabajo?

9) Existe un plan para integrar los promotores a la red del servicios que tiene el Ministerio?

ANNEX G

Chronology of Final Evaluation

1/1

**DESARROLLO JUVENIL COMUNITARIO
EVALUACION FINAL CS3**

CRONOGRAMA DE TRABAJO

...Equipo A
...Equipo B

MARTES 12 DE ENERO

Reunion Equipo Evaluacion
Definicion Equipos de la Encuesta CYP y Equipos de la Evaluacion

MIERCOLES 13 DE ENERO

Preparacion de Formularios de la Evaluacion
Preparacion de Encuestas/Cuestionario

JUEVES 14 DE ENERO

Entrevistas La Paz/Impresion de Formularios
Impresion de cuestionario encuesta/Documento entrenamiento a
suspervisores

VIERNES 15 DE ENERO

Llegada del Campo/Formar Equipos

Inicio entrevistas supervisores, SC personel y Centro de Madres
en Quime/Revision Documentos
Entrenamiento a supervisores en encuesta/Preparacion logistica
encuesta

SABADO 16 DE ENERO

Entrevista Ministerio/Revision de Documentos
Entrenamiento de supervisores encuestadores: Revision
cuestionario

DOMINGO 17 DE ENERO

Entrevistas con Promotores y Parteras/Revision de Documentos
Prueba de campo para encuestas/Revision de cuestionarios

LUNES 18 DE ENERO

Entrevistas con Lideres, Promotores y Madres
Encuestas/Ingreso de datos

MARTES 19 DE ENERO

Entrevistas con Lideres, Promotores y Madres
Encuestas/Ingreso de datos

MIERCOLES 20 DE ENERO

Analisis y hallazgos/Escribir informe
Encuestas e ingreso de datos

JUEVES 21 DE ENERO

Analisis y hallazgos/Escribir informe/Analisis de encuesta
Tabulacion manual encuestas/Analisis de encuesta

VIERNES 22 DE ENERO

Analisis Global
Regresar a LaPaz

SABADO 23 DE ENERO A MIERCOLES 26

Reportes

ANNEX H

List of Communities and Population

DATOS DE CS-III

FECHA: 3 de diciembre de 1992

	COMUNIDAD	POBLACION	NIÑOS < 5 AÑOS	MUJERES E.F. 15-49 AÑOS
37	TABLACHACA	404	43	101
38	FRANZ TAMAYO	198	36	44
39	GRAL. ELIODORO CAMACHO	267	34	59
40	COLLPA	171	27	33
41	TABLACHACA OESTE	258	29	66
42	GUALBERTO VILLARROEL	125	12	21
43	ANTAWARA	68	12	13
44	IRIPE	84	10	23
45	LURUTA	211	27	45
46	TIKA	81	11	16
47	KAKOMA	73	17	14
48	YUNGUMA	133	22	34
49	YAWAROCO	45	3	11
50	SIGUAS	210	45	35
51	CHOSECA	189	24	43
52	HUMANPATA	47	11	9
53	CHAPIMARCA	98	13	18
54	HUARAHUARANI	88	24	14
55	CALAJALIRI **			
56	V.S.ANTONIO SIRARANI	124	6	21
57	ALTO SIRARANI	219	36	43
58	CHACURI	130	23	22
59	TOTORA **			
60	CHICHIPATA **			
TOTALES		10389	1476	2330

DATOS DE CS-III

FECHA: 3 de diciembre de 1992

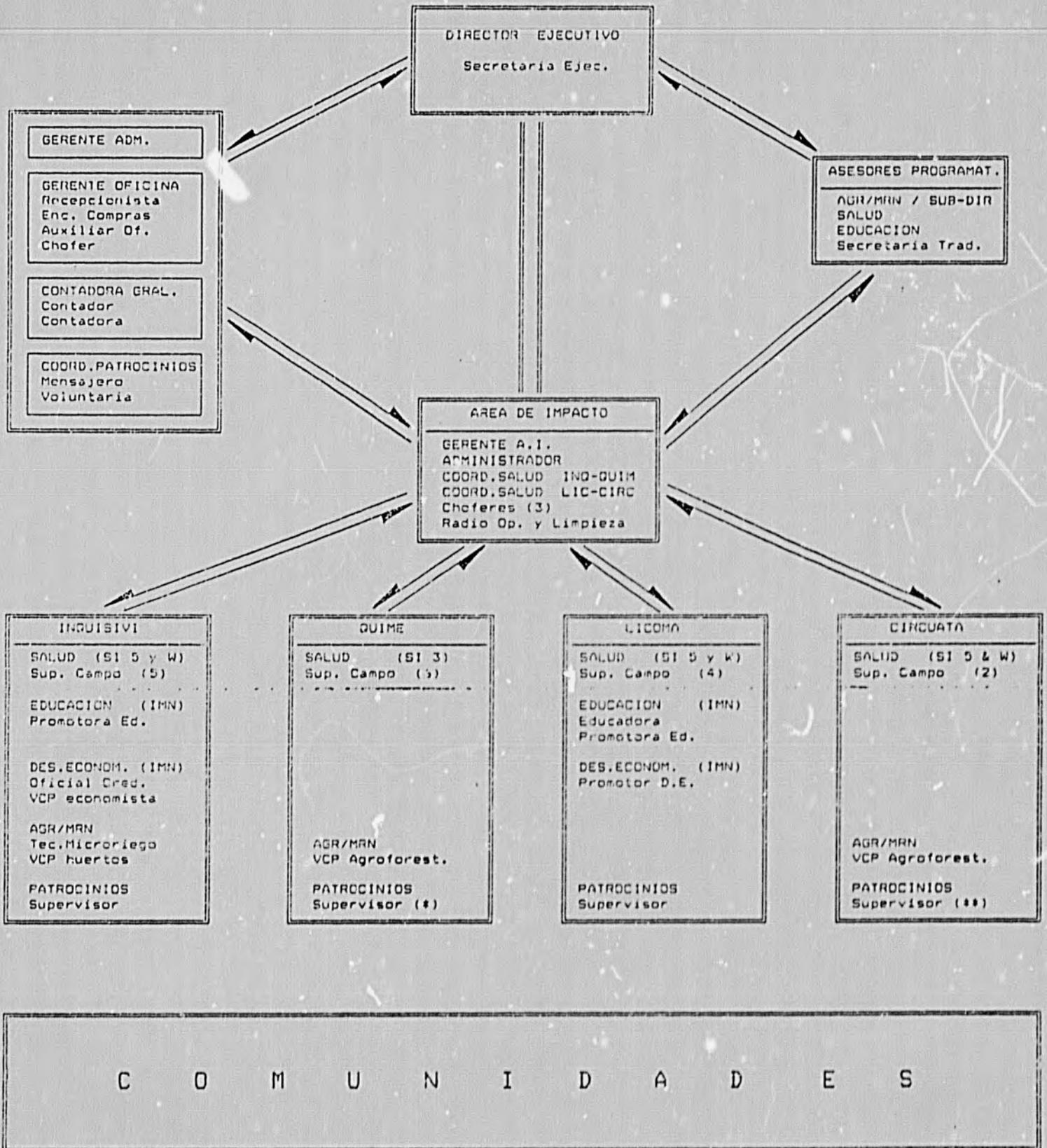
	COMUNIDAD	POBLACION	NIÑOS < 5 AÑOS	MUJERES E.F. 15-49 AÑOS
37	TABLACHACA	404	43	101
38	FRANZ TAMAYO	198	36	44
39	GRAL. ELIODORO CAMACHO	267	34	59
40	COLLPA	171	27	33
41	TABLACHACA OESTE	258	29	66
42	GUALBERTO VILLARROEL	125	12	21
43	ANTAWARA	68	12	13
44	IRIPE	84	10	23
45	LURUTA	211	27	45
46	TIKA	81	11	16
47	KAKOMA	73	17	14
48	YUNGUMA	133	22	34
49	YAWAROCO	45	3	11
50	SIGUAS	210	45	35
51	CHOSECA	189	24	43
52	HUMANPATA	47	11	9
53	CHAPIMARCA	98	13	18
54	HUARAHUARANI	88	24	14
55	CALAJALIRI **			
56	V.S.ANTONIO SIRARANI	124	6	21
57	ALTO SIRARANI	219	36	43
58	CHACURI	130	23	22
59	TOTORA **			
60	CHICHIPATA **			
TOTALES		10889	1476	2330

12/92

ANNEX I

SC/B Organizational Chart

ORGANIGRAMA FUNCIONAL DE DJC



(*) 1 Superv. para Inquisivi y Guime
 (**) 1 Superv. para Licoma y Circuata

ANNEX J

Key Staff Job Descriptions



Desarrollo Juvenil Comunitario

CB

A Save the Children Program

Calle Pedro Salazar 517 (Esq. Plaza Abaroa)

☒ 15120

☎ 325011 - 323845

Telex 591 - 2 - 391455

La Paz, Bolivia

Nombre: Guillermo Seoane F.

Posición: Asesor en Salud y Nutrición

Objetivos:

Contribuir como miembro de un equipo multidisciplinario a la consecución de los objetivos de DJC en el campo del desarrollo integral y específicamente en la implementación de los programas de salud.

Sector

Principal: Salud

Funciones:

- a) Planificar, orientar y supervisar la ejecución de los programas y proyectos de salud proporcionando asesoría y retroalimentación permanente sobre los mismos, velando por la calidad del trabajo en el campo.
- b) Estudiar y proponer políticas y propuestas programáticas en el área de su competencia.
- c) Preocuparse por el mejoramiento y motivación del personal aplicando políticas de capacitación y adiestramiento.
- d) Propiciar y mantener relaciones interinstitucionales con organizaciones públicas y privadas, nacionales e internacionales relacionadas con salud y nutrición.
- e) Mantener información actualizada sobre los programas y proyectos del Área y presentar los informes pertinentes.
- f) Participar en el Comité Ejecutivo
- g) Seguimiento y control presupuestario de los Proyectos de Salud.

Relación:

Supervisión: Director Ejecutivo

Horizontal: Director de Programas, Asesora de Educación, Coordinadores de Salud, Gerente Administrativo, Gerente de Oficina, Gerente de Área y Personal del Campo

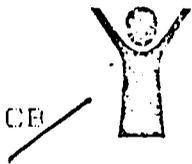
135

Grado
Escala Salarial: G

Indicadores:

- a) Seguimiento y supervisión de los proyectos y programas.
- b) Grado de motivación del personal.
- c) Calidad y oportunidad de la información sobre el desarrollo y ejecución de los proyectos.
- d) Apreciación cualitativa sobre los proyectos y propuestas presentadas a instituciones financieras.

Sede Principal: La Paz



Desarrollo Juvenil Comunitario

A Save the Children Program

Calle Pedro Salazar 517 (Esq. Plaza Abaroa)

☒ 15120

☎ 325011 - 323845

Telefax 591 - 2 - 391455

La Paz, Bolivia

Nombre: Adolfo Martinez

Posición: Coordinador de Salud

Objetivos:

- Dirigir y Supervisar las intervenciones de Salud para el logro de sus Objetivos, asegurando la calidad de las mismas y su integración con los otros sectores.

Sector

Principal: Salud

Funciones:

- a) Ejecutar las actividades de Salud (Warmi y S.I) con las Organizaciones Comunitarias y en coordinación con el Distrito de Salud de Tres Cruces (Subáreas de Inquisivi y Quime).
- b) Supervisar en las comunidades a los Supervisores de Campo.
- c) Elaborar y consolidar el informe trimestral de CSS y CSB y enviar al Asesor de Salud/Nutrición hasta fecha 5 del primer mes del siguiente trimestre.
- d) Revisar los Planes Trimestrales elaborados por los Supervisores de Campo en base a la meta perdida y los PID y entregar al Gerente de Área y al Asesor de Salud.
- e) Apoyar el cumplimiento de las actividades planificadas por los Supervisores de Campo.
- f) Ser responsable directo de la ejecución de las intervenciones de Salud en su área.
- g) Supervisar la capacitación que realizan los Supervisores de Campo a RPS y parteras.
- h) Elaborar el Plan Trimestral de CSS Y CSB de Inquisivi y Quime en base a la consolidación de los Planes Trimestrales de los Supervisores de Campo y el Plan de Implementación Detallado y entregar junto con el informe.
- i) Velar por el cumplimiento de las actividades del PID.

140

- j) Asistir a visitantes del Area de Impacto para cumplir los objetivos de estas visitas.
- k) Elaborar su propio Plan Trimestral y entregar al Gerente de Area junto con el informe de actividades.
- l) Coordinar y cumplir las actividades del programa de patrocinios en la comunidad asignada.
 - 1. Historiales: Recolectar datos, sacar fotografias a los niños que no estan en el Programa.
 - 2. Informe de Progreso: Foto actualizada de niños patrocinados una vez al año.
 - 3. Entregar la correspondencia al niño y asegurarse de la respuesta, enviar a La Paz.
 - 4. Pedidos especiales.

Relación:

Supervisión: Gerente de Area
Asesor de Salud/Nutrición

Horizontal : Equipo de Salud, Administrador A.I

Grado
Escala Salarial: E

Indicadores:

- a) Objetivos y Metas cumplidas.
- b) Calidad y oportunidad de los Informes.
- c) Evolución de las metas perdidas
- d) Resultados del SIS confiables, revisados y actualizados.

Sede Principal: Quime



Desarrollo Juvenil Comunitario

A Save the Children Program

Calle Pedro Salazar 517 (Esq Plaza Abaroa)

☒ 15120

☎ 325011 - 323845

Telefax 591 - 2 - 391455

La Paz, Bolivia

Nombre: Pacifico Copa Cabrera

Posición: Responsable del Sistema de Información

Objetivos:

- Mantener al día el Sistema Manual y computarizado de Información de Salud (PROMIS), determinando el progreso del Programa y ofreciendo retroalimentación oportuna al equipo de Salud.

Sector

Principal: Salud

Funciones:

- a) Operar el SIS computarizado en coordinación con los Supervisores de Campo.
- b) Introducir información dentro del PROMIS.
- c) Verificar la veracidad de la información contenida en los instrumentos de recolección de datos (Rosters, Carnets) y capacitar en el registro manual de los mismos a los supervisores de campo.
- d) Elaborar información específica sobre el cumplimiento de las metas para los supervisores de campo con carácter trimestral, dos semanas antes de la elaboración de los planes trimestrales.
- e) Elaborar informes semestrales en base a los indicadores del programa de salud.
- f) Participar en la capacitación del equipo.
- g) Velar por la seguridad y buen mantenimiento del equipo.
- h) Coordinar y cumplir las actividades del programa de patrocinios en la comunidad asignada.
 1. Historiales: recolectar datos, sacar fotografías a los niños que no están en el Programa.
 2. Informe de Progreso: foto actualizada de niños patrocinados una vez al año.
 3. Entregar la correspondencia al niño y asegurarse de la respuesta, enviar a La Paz.
 4. Pedidos especiales

Relación:

Supervisión: Dr. Guillermo Seoane

Horizontal: Bob, Carlos, Equipo A.I.

Grado

Escala Salarial: "D"

Indicadores:

- a) SIS al día.
- b) Instrumentos manuales verificados
- c) Informes trimestrales y semestrales presentados correcta y oportunamente.



Desarrollo Juvenil Comunitario

A Save the Children Program

Calle Pedro Salazar 517 (Esq. Plaza Abaroa)

☒ 15120

☎ 325011 - 323845

Telefax 591 - 2 - 391455

La Paz, Bolivia

Nombre: Juana Alicia Tantani

Posición: Supervisora de Campo de Salud

Objetivos:

- Ejecutar con la participación de la comunidad el Programa integral de DJC.
- Desarrollar los programas de salud (Supervivencia Infantil, Warmi y otros) y patrociniados en sus comunidades asignadas.

Sector

Principal: Salud

Funciones:

- a) Promover y explicar los programas de salud y de patrociniados a la comunidad y autoridades.
- b) Capacitar a RPS, parteras, líderes comunales en los Programas de Supervivencia Infantil, Warmi, IMN, y otros.
- c) Elaborar el Plan e Informe Trimestral de actividades en base al PID del Programa correspondiente.
- d) Realizar las actividades de Patrociniados de las comunidades que le han sido asignadas.
 - 1. Historiales: recolectar datos, sacar fotografías a los niños que no están en el Programa.
 - 2. Informe de Progreso: foto actualizada de niños patrociniados una vez al año.
 - 3. Entregar la correspondencia al niño y asegurarse de la respuesta, enviar a La Paz.
 - 4. Pedidos especiales.
- e) Organizar y realizar las ferias de salud cada dos meses en cada comunidad de su Área de trabajo.
- f) Visitas de supervisión a las comunidades de acuerdo al plan aprobado con el coordinador de salud.

- g) Promover y organizar grupos de mujeres y fortalecer las ya existentes en la comunidad para las diferentes actividades.
- h) Capacitar en el manejo de los Rosters a los RPS.
- i) Supervisar y consolidar los rosters de las comunidades bimensualmente.
- j) Apoyar las actividades del Distrito de Salud en todas la intervenciones programadas.
- k) Alimentar con información actualizada al ProMIS y utilizar sus datos para planificar las intervenciones.

Relación:

Supervisión: Dr. Adolfo Martinez

Horizontal: Equipo de Salud

Grado

(Escala Salarial): B

Indicadores:

- a) Eficiencia en el trabajo de acuerdo a resultados obtenidos .
- b) Grado de participación comunitaria.
- c) Metas perdidas.

Sede Principal: Quime

ANNEX K

Description and Copy of HIS Instruments

**APPENDIX K
CHILD SURVIVAL 3 / BOLIVIA
FINAL EVALUATION**

INFORMATION SYSTEM ANALYSIS

Completes: whoever fills out the form

User: whoever uses the form

How: how the form is used

Where: where the form is filled (e.g. Supervisor's office:
SC/B Supervisors room in one of the communities)

I. INSTRUMENTS FOR THE FLOW OF INFORMATION FROM THE FAMILY TO THE DJC SUPERVISOR

<u>INSTRUMENT</u>	<u>AREAS COVERED</u>	<u>COMPLETES</u>	<u>USER</u>	<u>HOW</u>	<u>WHERE</u>
Family Register in the Community Folder	Demographic data, EPI and Survey	SUPERVISOR	SUPERVISOR VHW Authorities	Baseline	Supervisor's Office
Road to Health Card	GM, EPI, Vitamin A Diarrhea/ORT, ARI, Breastfeeding	SUPERVISOR some VHWs	SUPERVISOR VHW, mother	Education	In the home
Children's Roster	GM, EPI, Vitamin A Diarrhea/ORT, (ARI)	SUPERVISOR	SUPERVISOR	Monitoring EPI Reports	Supervisor's Office
Vaccination Card	Tetanus Toxoid	SUPERVISOR	SUPERVISOR	Education for mother	In the home
Women's Roster	Tetanus Toxoid	SUPERVISOR	SUPERVISOR	Monitoring	Supervisor's office
Death Record	Death by age and cause	SUPERVISOR	SUPERVISOR COORDINATOR	Analysis of mortality	Supervisor's Office

147

II. SUPERVISORY INSTRUMENTS USED TO PROVIDE INFORMATION FROM THE SUPERVISOR TO THE COORDINATOR, THE SC/B QUALITY CIRCLE TEAM, PROMIS AND THE MOH-USLP DISTRICT LEVEL

INSTRUMENT	AREAS COVERED	COMPLETES	USES	HOW	WHERE
Supervisor's Report *by page of children's roster *by community *by zone and area	EPI, Vitamin A, GM, TT	SUPERVISOR	SUPERVISOR COORDINATOR	Quality team decisions	Supervisor's Office
SVEN	GM	SUPERVISOR	MOH-USLP	Unknown	SC/QUIME and MOH-USLP
SNIS (adapted)	EPI, GM, Tetanus Toxoid	SUPERVISOR	MOH-USLP	Consolidated reports reports	SC/QUIME and MOH-USLP
Death Reports	Deaths under 5 years old	COORDINATOR	COORDINATOR	Focus on weak communities	SC/QUIME
Health Training	Training Number trained according to type of person and community	SUPERVISOR	COORDINATOR	SUPERVISOR	Supervisor's Office

1/12



DESARROLLO JUVENIL COMUNITARIO

"A Save the Children Program"

Encuesta N°

FICHA FAMILIAR

Nombre del encuestador: Comunidad:

Código
Área Zona Comunidad

Fecha de la encuesta
Día Mes Año

Número de casa:

Número de Familia en la casa:

N°	NOMBRES Y APELLIDOS			Sexo	Inclusión familiar (M/F)	FECHA DE NACIMIENTO (d/m/año)	EDUCACION			CONTROL DE INMUNIZACIONES							Tasa 100 por mil 15 días	
	NOMBRES	PATERNO	MATERNO				Letra S/N	Grado de Instrucción B/M/T/U	Ocupación Principal I/A/C/G/M/E/O/L	BCG S/N	DPT 1-2-3	FOLIO 1-2-3	Sarampión S/N	TT 1-2 3-4-5	Fiebre Amarilla S/N	VCCO Año		S/N
1																		
2																		
3																		
4																		
5																		
6																		
7																		
8																		
9																		
10																		
11																		
12																		

¿QUÉ TIPO DE PARTO DE LA MADRE LE HICIE EN MESSES ANTES SU NAC?
 a) Apl. normal vive
 b) Mujo al poco tiempo de nacer
 c) Nado muerto
 Respuesta

¿EN QUE CONDICION CULTIVA LA TIERRA?
 a) Propiedad d) Alquiler
 b) Amistades e) Cooperativa
 c) Comunal f) Armado
 Respuesta

PROVISION DE AGUA
 a) Grifo o pileta domiciliaria
 b) Grifo o pileta colectiva
 c) Pozos
 d) Rio o Nonas
 Respuesta

ELIMINACION DE EXCRETAS:
 a) Campo abierto
 b) Letrina
 c) Servicio Higiénico (baño)
 Respuesta

10

INFORME DE SUPERVISION

INMUNIZACION - VIGILANCIA DE CRECIMIENTO Y VITAMINA "A"

POR PAGINA Y POR CUADERNO

SUPERVISOR DE SALUD: _____
 ZONA: _____ COMUNIDAD: _____

TRIMESTRE: 1ro. 2do. 3er. 4to.

INMUNIZACIONES / PAGINA =====>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	20	TOTALES	
A) TOTAL MENORES DE 5 AÑOS																					
B) TOTAL MENORES DE 1 AÑOS																					
C) TOTAL 12-59 MESES (C=A-B)																					
D) TOTAL 1-5 AÑOS C/ESQ. COMPLETO																					
E) META PERDIDA (E=C-D)																					
F) No NIÑOS COMPLETAN ESQ. EN TRIM.																					
G) TOTAL NIÑOS A VACUNAR (G=B+E)																					
H) COBERT. C. ESQ. COMP. 1-5 AÑOS (H=D/C*100)																					
MONITOREO VIGILANCIA DE CRECIMIENTO :																					
I) NIÑOS C/3 ó MAS PESAJES EN ULT. 12 MESES																					
J) NIÑOS C/MENOS DE 3 PES. EN ULT. 12 MESES																					
K) No. DE NIÑOS QUE TIENEN LANA ROJA																					
ADMINISTRACION VIT. "A" (1-5 AÑOS) :																					
NIÑOS C/DOS MEGADOSIS EN ULTIMOS 12 MESES																					
NIÑOS C/UNA MEGADOSIS EN ULTIMOS 12 MESES																					
NIÑOS SIN MEGADOSIS EN ULTIMOS 12 MESES																					

152

PLAN DE DESARROLLO

SEMESTRE : _____
ANTE LOS MESES Y AÑO

ELABORADO POR : _____
CARGO : _____

SUB AREA _____ ZONA _____
SUPERVISOR INMEDIATO: _____

RESULTADOS ESPERADOS	ACTIVIDADES/LUGAR	CON QUIEN COORDINA	CUANDO			FECHA EN QUE SE CUMPLIO	OBSERVACIONES
			MES	MES	MES		

155

MORTALIDAD DE MENORES DE CINCO AÑOS

SUPERVISOR DE CAMPO _____

ZONA _____

TRIMESTRE _____

ANOTAR LOS MESES Y AÑO

GRUPO ETAREO	TOTAL	DIARREA	DIARREA ASC- CIADA CCN DESNUTRICION	I.R.A.	I.R.A. ASO- CIADA CCN DESNUTRICION	DESNU- TRICION	TETA- NOS	SARAM- PION	TUBER- CULO- SIS	MORTI- NATO	OBITO FETAL	ASFI- XIA	TRAU- MA	SEP- SIS	ACCI- DEN- TE	OTRO-
00 - 28 DIAS																
29 - 11 MESES																
12 - 23 MESES																
24 - 35 MESES																
36 - 59 MESES																
TOTAL																

MORTALIDAD MATERNA

TOTAL	HEMORRAGIA	RETENCION FLACENTARIA	MALA POSICION	ECLAMPSIA	SEPSIS	OTROS
TOTAL						

OBSERVACIONES _____

150

INFECCIONES RESPIRATORIAS AGUDAS
TRIMESTRE _____

ZONA _____

Nº DE COMUNIDADES _____

SUPERVISOR DE CAMPO _____

GRUPO ETARÍO (en meses)	TOTAL CASOS	TIPO DE IRA				ACTITUD DE LA MADRE		
		SIN NEUMONIA	NEUMONIA	NEUMONIA GRAVE	ANSIENTE HUMEDO	HIDRATACION ORAL	ADMINISTRA ASA	ACUDIC AL RES.
0- 11 meses								
12 -23 m.								
24 -35 m.								
36 -59 m.								
T O T A L								

ENFERMEDADES DIARREICAS AGUDAS

GRUPO ETAREO (en meses)	TOTAL EPISO DIOS, DIARR COS.	TIPO DE DIARR.		ACTITUD DE LA MADRE								
		LEVE	MODERADO	HIDRATACION ORAL	ALIMENTOS DURANTE DIARREA	RECIBO	COMIDA NORMAL	COMIDA ESPECIAL	SIN COM.			
0 -11 meses												
12 -23 meses												
24 -35 meses												
36 -59 meses												
T O T A L												

CAPACITACION EN SALUD

PARTICIPANTES	EDA	IRA	VACUNAS	VIGILANCIA NUTRICIONAL	VIT "A"	CONTROL PRENATAL	PARTO	R.N.	PURPERIO
MUJERES									
ESCOLARES									
PROFESORES									
DIRIGENTES									
PARTERAS									
RPS									
PERSONAL DE SALUD									

151

DESARROLLO JUVENIL COMUNITARIO

Save the Children

COMUNIDAD: _____
 SUPERVISOR: _____

No. Ficha _____

REGISTRO DE MUERTE

Código:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Área	Zona	Comunidad	No. de casa	No. Flia.	No. Persona
Nombre del fallecido:	Nombre		Apellido paterno		Apellido materno	
Fecha de muerte:	<input type="text"/>	<input type="text"/>	<input type="text"/>	Edad del fallecido:	<input type="text"/>	<input type="text"/>
	Día	Mes	Año		Años	Meses Días
Para niños menores de 5 años:						
<input type="text"/>			Nombre y Apellidos del Padre			
<input type="text"/>	<input type="text"/>	<input type="text"/>	Sexo:	<input type="text"/>		
Día	Mes	Año	(M - F)	Nombre y Apellidos de la Madre		
Fecha de Nacimiento						
Causa de muerte de < 5 años:			b) Tuberculosis		Causa muerte de madre :	
a) Diarrea	1) Infección		RES-		(embarazo-parto-puerperio)	
b) Diarrea Asoc./Desnut.	1) Utrito fetal		FUES-		a) Hemorragia	
c) IRA	1) Asfixia		IA =		b) Retención placentaria	
d) IRA Asoc./Desnutrición	1) Trauma				c) Mala posición	
e) Desnutrición	m) Sepsis				d) Eclampsia	
f) Tétanos	n) Accidente				e) Sepsis RESP. =	
g) Sarampión	o) Otros				f) Otro _____	
Recibió la atención de:						
Familiares:	<input type="text"/>	RPS:	<input type="text"/>	Par- tera:	<input type="text"/>	Médico:
	<input type="text"/>		<input type="text"/>		<input type="text"/>	<input type="text"/>
	<input type="text"/>		<input type="text"/>		<input type="text"/>	Ninguno:
	<input type="text"/>		<input type="text"/>		<input type="text"/>	<input type="text"/>
Tratamiento recibido:						
Cuero casero:	<input type="text"/>	Sobre F.O.:	<input type="text"/>	Ma- ta:	<input type="text"/>	Medi- cine:
	<input type="text"/>		<input type="text"/>		<input type="text"/>	<input type="text"/>
	<input type="text"/>		<input type="text"/>		<input type="text"/>	Otro:
	<input type="text"/>		<input type="text"/>		<input type="text"/>	<input type="text"/>
	<input type="text"/>		<input type="text"/>		<input type="text"/>	Nin- guno:
	<input type="text"/>		<input type="text"/>		<input type="text"/>	<input type="text"/>
Si la familia no ha llegado al personal de salud (médico, enfermera), la causa fue por razón de:						
a) No dieron importancia al problema			e) Por consejo de otra persona			
b) No han reconocido que había problema			f) Llegó al centro de salud pero no había nadie para atender.			
c) falta de transporte						
d) falta de dinero						
						RESPUESTA =
DESCRIPCION DE LA CAUSA PROBABLE:						
a) DE ACUERDO A LOS FAMILIARES: _____						
b) DE ACUERDO AL RPS: _____						
c) DE ACUERDO AL SUPERVISOR (Diagnóstico probable de muerte): _____						
OBSERVACIONES: _____						

Fecha de Registro (dd/mm/aa): _____

138

