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**SAVE THE CHILDREN/MOTHERCARE
BOLIVIA "WARMI" PROJECT
DETAILED IMPLEMENTATION PLAN**

July 15, 1990 - July 15, 1993

by:
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ACRONYMS

AID	Agency for International Development
ARI	Acute Respiratory Infection
C-BIRD	Community-Based Integrated Rural Development
COBREHS	Consultara Boliviana de Reproduccion Humana
CS	Child Survival
GOB	Government of Bolivia
HIS	Health Information System
IDD	Iodine Deficiency Disease
IEC	Information, Education and Communication
IPPF	International Planned Parenthood Federation
JSI	John Snow, Inc.
MC	MotherCare
MCH	Maternal and Child Health
MOH	Ministry of Health
MPSSP	Ministerio de Prevision Social y Salud Publica
NGO	Non-Governmental Organization
ORT	Oral Rehydration Therapy
PVO	Private Voluntary Organization
RPS	Rural Promotor de Salud (Rural Health Promoter)
SC	Save the Children
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid

I. BACKGROUND/LOCATION OF PROJECT

Save the Children (SC) began its permanent legal presence in Bolivia in August, 1985. SC has been implementing a primary health care program directed at children under five and to a small degree pregnant women in the Inquisivi Province (please see appendix 1 for a map) through a Child Survival (CS) I funded project starting in January, 1986 and more recently a Child Survival V funded project. In the Child Survival program, the population has been enrolled in the SC project area where on-going vital event reporting is taking place in addition to promotion of immunization, ORT, nutrition, vitamin A, ARI detection, monitoring of pregnant women, and TBA training. This project area is also where the Save the Children, MotherCare (SC/MC) project is conducting their activities. The SC/MC project is primarily focused on improving the health status of women of fertile age and their infants through community based promotional activities and trainings with the goal of adoption of positive behaviors and development of self reliance.

The Inquisivi province where the SC/MC project is operating is situated in the southeast corner of the Department of La Paz. The province covers 5,430 square kilometers and extends from the high Altiplano (3,900 meters above sea level) to the low sub-tropical regions in the north at 900 meters. This enormous climatological difference has tremendous impact on the productive activities and on the medical pathology of the different areas.

Culturally and linguistically the population is an indigenous mixture of Aymara and Quechua; however, the women's groups appear to predominantly Aymara speaking. Of note there are differing characteristics among the communities within this province. The families in the Inquisivi zone, for example, (in the high Altiplano) represent a more well-established, sparsely populated and closed group. The communities in the Circuata Zone (low sub-tropical regions) and Licoma Zone on the other hand have recently settled in this zone and are considered to be more open to change.

The SC/MC project, started on July 15, 1990 and is funded by a three year subcontract from John Snow Institute (JSI); the project focuses on 73 communities within the Circuata, Inquisivi and Licoma Zones. This represents a total of 15,104 persons including 2754 women of reproductive age (15-45 years old, definition used by the Bolivia Ministry of Health). Please refer to appendix 2 for the population pyramid. Based on the 1989 national statistics, an expected 634 births will take place in this project area annually with an expected 66 deaths before the age of one years old. Based on 11/88-11/90 health information gathered in the SC CS project area there is a neonatal mortality rate of 69 which means with an expected 634 births in this area 43 of the newborns will die within the first 28 days of life. The maternal mortality rate calculated over a four year period in this area is 750 per 100,000 live births (Bolivia's national figure is 480).

The MOH facilities and staff in the area are as follows:

In Quime (please refer to the map in appendix 1), the largest population center in the province (3,500), there is a 15 bed hospital with a poorly equipped, but functioning, surgical unit and X ray equipment. It is staffed by 2 MDs, 1 dentist, 3-4 nurses, a lab technician and an x-ray technician. There is now an additional MD and nurse funded by the COBREHS group.

There is a fairly old ambulance which is often out of order. The hospital occupancy rate is very low. The distance to travel to the hospital can often take up to six hours by car.

In Inquisivi and Licoma there are medical centers, each staffed by one M.D. and a nurse auxiliary.

In Capinata, Circuata, Villa Varrientos and Khora there are health posts staffed by a nurse auxiliary. SC has equipped very basic birthing rooms with hygienic conditions and adequate lighting in Inquisivi and Circuata.

In the province bordering to the north of Inquisivi province, there is a 20 bed MOH hospital in the town of Iruapan, staffed by 2 MDs and several nurses. This hospital is closer and thus draws patients from the northern section of the impact area. It has surgical capability with a blood bank.

Based on these mortality rates, the demands of the community and the minimal health services available this project will focus on improving maternal and neonatal health. Clearly there is a desperate need to focus on improving maternal and neonatal health. During the first nine months of this project, this conclusion has been confirmed through the identification of the health priorities of the women of child bearing age in a retrospective case control study and a process among women's groups referred to as autodiagnosis.

The following detailed implementation plan outlines the specific interventions addressing these felt needs.

II. PROJECT DESIGN

A. **Project goal:**

To improve pregnancy outcome, health and nutrition status of women and neonates in rural target area of Inquisivi Province.

B. **Sub-goals:**

- 1) Decrease perinatal and neonatal mortality and morbidity from preventable causes.
- 2) Decrease maternal mortality and morbidity.

3) Establish 50 viable women's organizations capable of identifying and effectively addressing their own and their families health needs.

C. General Strategies:

1) Train mothers in protective health behavior which affect mother's and neonate's health and nutrition.

2) Strengthen mothers' and others' ability to respond to risk situations and to look for and utilize resources.

3) Strengthen and facilitate the introduction of services which will meet the health and nutrition needs of mothers and neonates.

D. Objectives:

1. WOMEN'S GROUPS

In order to identify and strengthen health behaviors and self reliance among women, by July 15, 1991, at least 25 women's groups (34% of the communities) will be strengthened or established in the impact area of Inquisivi.

By July, 15th, 1992 at least 25 more women's groups will be strengthened or established in the eh Inquisivi impact area.

By 3/92 the first 25 women's groups will have completed all of the steps in the process of autodiagnosis and by 12/92 the second 25 women's groups will have completed a modified version of the autodiagnosis.

2. NUTRITION

In order to monitor the nutritional status of pregnant women, by June, 1993, 50% of pregnant women will have their weight measured at least twice during pregnancy and at least 50% of women identified as at nutritional risk will be followed up over a two year period.

In order to increase iodine and iron intake during pregnancy, by June, 1993, 50% of pregnant women will take two three month courses of iron, one during pregnancy and one postpartum over a two year period.

3. PRENATAL

In order to diminish the risks associated with pregnancy and deliver, by June, 1993, 50% of pregnant women will have

three prenatal visits, and 20% of the mothers identified as high risk will have adequate follow-up care according to the established algorithms over a two year period.

4. DELIVERY

In order to reduce mortality during delivery, by June, 1993, 50% of the deliveries will be attended by a trained person and 20% of the women who are identified as at risk during delivery will have appropriate action taken according to established algorithms over a two year period.

In order to assure safer birthing practices, birth kits will be prepared and 50% of deliveries over a two year period will have used them.

5. POSTPARTUM CARE

In order to reduce the risk associated with the postpartum period, by June, 1993, 20% of pregnant women will have received at least two postpartum visits by the TBA or supervisor with one visit taking place within the first three days after deliver and 20% of all women identified with hemorrhage or infection will be managed appropriately according to set algorithm over a two year period.

6. NEWBORN

In order to ensure early care for every newborn, by June, 1993 30% of newborns will receive immediate attention after birth and be breast-fed within the first hour after birth and 20% of all newborns identified as at work will have taken appropriate steps as defined by the protocol over a two year period.

7. NEONATAL

In order to assure that the mother's family supports her in the care of the infant, by June, 1993 30% of trained TBAs, husbands of pregnant women, 10% of mothers of pregnant women, 25% of pregnant women and 90% of MPSSP staff will be able to identify 3 reasons for starting breast-feeding in the first hour and continuing for a minimum of two years, 3 signs of sepsis and pneumonia, and at least 2 ways to prevent tetanus. 20% of infants identified as at risk will be followed up.

8. GENERAL

In order to protect the life and health of mothers and children, and if an agreement with the MPSSP and another group can be obtained:

By June, 1993, 20% of women of reproductive age will be trained and practice a method of family planning (modern

methods including breast-feeding); this project will only be involved in promotion and training and not service delivery.

In order for mothers to continue their education, the program will support literacy training by July, 1993 through the development of maternal and neonatal health and nutrition educational materials in Aymara and Spanish for maternal literacy program.

In order to monitor and record health behavior practices and impact, by October, 1991 a roster for women of child bearing age and a home based card for women of child bearing age will be finalized.

In order to share the project's experiences, by June, 1993 a curriculum documenting the training in this project will be finalized and distributed to PROCOSI.

C. Strategy and Activities

1) GENERAL STRATEGIES:

- a) Train mothers in protective health behavior which affect mother's and neonate's health and nutrition.
- b) Strengthen mothers' and others' ability to respond to risk situations and to look for and utilize resources.
- c) Strengthen and facilitate the introduction of services which will meet the health and nutrition needs of mothers and neonates.

2) ACTIVITIES:

- a) Use the process of "autodiagnosis" (women identify and prioritize maternal and neonatal health and nutrition problems through a participatory approach in women's groups) with at least 50 women's groups.
- b) Identify risk factors through a retrospective case control study.
- c) Develop high risk protocols for literate and illiterate users.
- d) Develop other educational materials relating to maternal and neonatal health and nutrition (i.e., cue cards, literate training material relating to health, and radio).
- e) Develop a monitoring system, both home (maternal and TBA) and locally based (supervisor and MPSSP).

f) Collaborate closely with the staff of the MPSSP so they can provide service delivery and conduct joint training/supervision.

g) Collaborate with COBREHS so they can provide service delivery (especially family planning).

h) Train husbands of pregnant women, men in men's organizations, women of reproductive age, pregnant women, mothers of pregnant women, TBAs, the SC health team, the health promoters, the staff of the MPSSP and adolescents in protective neonatal and maternal health behaviors.

3) The process of Autodiagnosis and the retrospective case control study have been the primary activities of the first year of the project. Through these two steps a more focused plan for maternal health interventions has been developed in this DIP. The reasons for focusing on different groups for training are a direct result of the findings in the case control study. For instance, 38% of all deliveries are attended by the husbands, therefore they will be one of the major groups focused on for the training. The following sub-headings describe in detail the different activities the project has/will use.

a) "Autodiagnosis"

Please refer to appendix 3 for a description of the steps in the Autodiagnosis and appendix 4 for a summary of the results to date.

The objective of working through the ten steps of the autodiagnosis with each women's group is not only to gather information about women's knowledge, attitudes and practices in relation to maternal and neonatal health, but also to transfer problem solving skills to the members of the women's groups so that with education they can identify their own solutions to their priority problems. The process is time consuming, but the long term impact on the empowerment of the women and its sustainable effect are felt to make this time investment worthwhile.

b) Retrospective case control study

Refer to appendix 5 for a summary of the results to date.

The retrospective case control study has three components:

Case control study:

- * identify characteristics associated with maternal, perinatal and neonatal mortality.
- * identify relationships between delivery practices and practices with the recent newborn and maternal, perinatal and neonatal mortality.

Verbal autopsy:

- * identify events and illnesses that are probable causes of mortality.

Process diagnosis:

- * identify the events around the decision process and who makes decisions and what are the actions associated with the decisions.

The hypothesis is that certain maternal and neonatal characteristics exist which are significantly associated with increased risk of maternal, perinatal and neonatal mortality. A significant relationship exists between certain aspects of delivery practices and practices with the recent newborn and risk of maternal, perinatal and neonatal risk of mortality.

The results of this study have contributed to the focus of this project's objectives.

c) Development of high risk protocols

Protocols or algorithms describing signs for recognition and the steps to be taken in a high risk situation will be developed. A review of existing protocols will facilitate this process. These algorithms will be developed for literate and illiterate users. Additionally, specific steps may be added on to the more general algorithm for each community with a women's group (i.e., solutions for overcoming financial obstacles, plans for ways to be transported or identification of a house in town near the hospital where a mother may stay the last week or two of pregnancy if identified as being at risk for delivery). These steps will be a form of "disaster preparedness."

The algorithm will be developed for those at risk conditions identified in the results of the case control study and the results to date in the "autodiagnosis" process (please refer to appendix 4 for a summary of these results). The high risk conditions to be focused on are listed in appendix 6.

d) Development of educational materials:

(i.e. cue cards laminas, materials for literacy training relating to maternal health, and possibly videos or radio time)

Women's groups will:

- * participate in the development and trial of educational messages.
- * select appropriate educational medium.
- * design and field test educational materials for use with specific target groups in the community.

In order to do this Women's groups may:

- * assemble locally available materials which maybe used or adapted in the project.
- * hold a series of educational material development workshops attended by representatives of women's groups and SC staff responsible for coordinating the development of educational materials.
- * use findings from the "autodiagnosis" and case control study to formulate educational messages.
- * design locally appropriate educational materials and pretest.
- * learn how to use materials and evaluate effectiveness.
- * distribute materials through PROCOSI to PVOs and NGOs working in Bolivia and to MPSSP (maternal and child health division).

e) Develop a home and locally based monitoring system

"Women of reproductive age" health card

This card is being designed to maintain a constant record for the woman about her reproductive cycle and any health interventions which may take place. There is room for recording prenatal care including weight gain for one pregnancy. It is kept by the woman so it gives her a degree of control over information about herself. It additionally serves as a means of communication between the different service providers in the community (i.e., TBAs, promoters, supervisors and the MPSSP staff). If the woman is literate or has a helper who is literate she can monitor her own menstrual

cycle with this card and therefore be more knowledgeable about her reproductive cycle.

TBA record: each TBA will keep a duplicate home based "women of reproductive age" health card for each pregnant woman she is following.

Roster for Women of Reproductive Age: this is a roster of all women of reproductive age (15-45 years old). It is kept by the SC/MC supervisors of each of the three zones. Please refer to appendix 7 for a sample that will be used starting in August, 1991 and appendix 8 for a detailed description of the roster.

These records will provide invaluable information to monitor the project's objectives. Furthermore, they will provide guidance on which areas need improvement. The home based record will remain with the mother and therefore provide health history information for any health care provider in the future.

f) Close collaboration with the MPSSP

Strengthening the service delivery at the different points in the Inquisivi impact area will be a major focus in the training of the MPSSP staff. Emphasis will be placed on detection of high risk during pregnancy, postpartum and neonatal periods and what are the appropriate steps to take if high risk is detected. The MPSSP staff will have refresher courses covering basic maternal health subjects given by the SC/MC team and the MPSSP staff will in turn help facilitate the training sessions for other target groups in this project. Sharing of experiences in regular monthly meetings will also take place.

From the retrospective case control study it was found there was no difference in outcome between cases and controls when distance from the health center was measured. Additionally, over fifty percent of the persons studied were less than two hours away by foot from these centers which indicates that these centers are geographically accessible; therefore, the SC/MC project will focus on strengthening these centers through the training of the personnel.

Additionally, the project staff will work with the MPSSP both locally and nationally when developing the different materials in this program. The local MPSSP has already participated in the design of the women of reproductive age's supervisor roster.

g) Collaboration with COBREHS

International Planned Parenthood Federation (IPPF) now funds COBREHS, a local NGO, to contribute one Obstetrician-gynecologist and one nurse in Quime Hospital. In August, 1991 IPPF will evaluate the effectiveness of the additional personnel and recommendations will be made. It is anticipated that additional personnel will be placed, possibly in the Province's health posts, therefore, making health services more available for this dispersed population.

COBREHS will also provide family planning services in the Inquisivi Province. SC/MotherCare staff are able to promote family planning, but not provide services. Initial promotion will be for natural family planning methods, i.e., breast feeding. Once services are fully functional, promotion of more effective modern methods will be undertaken (i.e., condoms, pills and IUDs).

The MotherCare project will motivate the community members to use these services.

h) Training

Local Human Resource Development - SC's Traditional Approach

SC follows the belief that human resources and local capacity contribute most to enduring community change. That is why training is the most characteristic activity of our work worldwide. In Inquisivi, in order to achieve the goal, sub-goals and objectives of this health project, a many layered network of local resource people have been and will be activated to work together on various complementary tasks within a complex cultural, social and political context on the family, village and provincial levels. Consequently, organizing, orienting and training these local resource groups is the principal project activity.

Who they are - How they interact

Based on the result of the case control study, the autodiagnosis and the SC/MC staff's perceptions, the following groups will comprise the human resource network:

- * men belonging to the Sindicatos
- * husbands of pregnant women
- * women of reproductive age
- * pregnant women
- * mothers of pregnant women
- * TBAs
- * SC health team
- * Promoters
- * Adolescents
- * MPSSP health team

It is the experience of the SC health team that participation of women is hampered by the presence of men at meetings. Men belonging to Sindicatos, husbands of pregnant women, women of fertile age, mothers of pregnant women, TBAs, Promoters and Adolescents will, therefore, be trained in single sex groups. Pregnant women will be trained on an individual basis during home and service delivery visits. SC staff and the MPSSP staff will be trained in groups. Attention to these social dynamics of learning have been found to be critical to the development of social networks which support use of new skills and knowledge after training.

An On-Going Training Cycle

The autodiagnosis has begun a cycle which is the process of organizing and repeating the steps of the training process for each learning group over time. It is illustrated below:

Project Goal and Objectives

Evaluation

- review of competencies
- assessment of impact

- identification of new training topics

Follow Up

- support to learners after learning events
- supervision, coaching and monitoring

TRAINING

CYCLE

Training Needs

Review

- autodiagnosis - themes and topics
- assessment of specific learning needs per group

Training Planning

- curriculum design
- materials development and testing
- preparation for courses and events

Training Program

- learning events and support

Each year of the project, this cycle is carried out to design, and evaluate the training activities for each resource group. The first cycle has begun with the elaboration of projects goals and objectives, and the autodiagnosis and definition of training themes and topics (see appendix 8 for details).

The advantages of this cycle approach are that it organizes all the complex training activities on all levels into a comprehensive plan; it helps the trainers focus on the specific learning needs of the different resource groups; it helps link training to specific job competencies of each

resource group necessary to achieve project goals; it encourages follow-up support to resource groups after training to increase the likelihood they perform as expected in the field; and it helps trainers re-plan new annual training activities based on the previous year's results.

A Competency - Focus for Measurable Impact

Training begins with a detailed assessment of the current versus desired competency - level of participants from the resource groups in order to identify the competency gaps which exist. This helps busy trainers focus on those areas needing the most attention, and helps learners feel more motivated to learn. Pre - tests can be used for this purpose. Training activities themselves are practical and participatory, allowing participants to demonstrate their new levels of competency on completion of training. This demystifies the learning process and enables trainers to accurately assess the impact of their courses on the learners.

Adult Experiential Learning Philosophy

All of these training methods are based on several key principles of our adult, experiential learning philosophy. They include

- * learners act as subjects not objects in training
- * learning is active, engaging and participatory
- * learners help define the content and process of learning
- * learning is practical, focused on real problems and situations
- * the experience of learners is the main resource for learning
- * the trainer's role is to help learners solve problems and gain new competencies

Documentation and Evaluation - Other Levels of Learning

The Project itself is an on-going learning process, from which it is hoped to learn valuable lessons as a resource network. Each training will have a pre and post test (some verbal and others written, depending on the ability of the participants). The results will be documented for evaluation purposes.

The curriculum and other methods of training will be documented. Some of the core themes in the training will focus on findings from the case control study and "autodiagnosis". The findings of case control and autodiagnosis to date with possible actions to take are documented in appendix 10.

Materials will be developed with the assistance of a consultant with experience in the development of materials for illiterates and in dealing with women's health issues.

B. Target population

Total Population:	15,104
Women 15-45 years:	2,754
Expected births:	634/year

If you assume 10% of pregnancies end in stillbirth then:

No. of pregnant women :	704 in one year
or in two years:	1408

It is estimated by the staff that 70% of pregnancies are detected at any one time: 986 for the two year period

Of note when referring to pregnant women in objectives, inputs and outputs - this pertains to those who are identified as pregnant, i.e. 986.

C. Objectives, planned inputs, outputs and dates

Please note the numbers written in this section refer to cumulative pregnancies calculated for a two year period.

The SC/MC activities compliment but do not duplicate the SC/CS activities. There are a number of interventions which the SC/CS program is already undertaking in the SC/MC project area which focus on maternal and neonatal health. They are the following: promotion of Tetanus Toxoid vaccination, iodine administration during pregnancy, vitamin A administration in the postpartum period, training in culinary practices and promotion of taking iodized salt. Because the CS program is promoting these interventions this project will not propose them as distinct objectives.

The CS program also promotes, TBA training, prenatal care, breastfeeding and attendance by trained personnel during delivery. The MotherCare project, however, when focusing on these areas, is developing curriculums and high risk algorithms, and providing more in depth and comprehensive training and prenatal care than the CS program. The details are presented in the matrix below.

I. WOMEN'S GROUPS

Objective:

In order to identify and strengthen health behaviors and self reliance among women, by July 15, 1991 at least 25 women's groups (34% of the communities) will be strengthened or established in the impact area of Inquisivi.

Inputs:

Select at least 25 communities.

By 9/90

Identify and support existing and/or establish at least 25 women's groups.

By July, 15, 1991

Outputs:

100% of the 25 women's groups will meet at least once a month.

By March, 1992

There will be a minimum of 10 women of childbearing age (9% of all women of fertile age) participating in each women's group who will attend at least two meetings every six months.

By March, 1992

By July, 15th, 1992 at least 25 more women's groups will be strengthened or established in the Inquisivi impact area.

Select at least 25 more communities.

By 8/91

Identify and support existing and/or establish at least 25 more women's groups.

By July 15, 1992

100% of the 25 additional women's groups will meet at least once a month.

By December, 1992

There will be a minimum of 10 women of fertile age (9% of all women of fertile age) participating in each women's group and will attend at least two meetings every six months.

By July, 1992

WOMEN'S GROUPS (continued)

Objective:

By March 1992 the first 25 women's groups will have completed all of the steps in the "Autodiagnosis" and by December 1992 the second 25 women's groups will have completed the steps of a revised Autodiagnosis process.

Inputs:

Develop materials for training health staff in autodiagnosis and train SC health staff in the process of "Autodiagnosis."

By 6/91

Support and motivate members of the 50 women's groups to participate in the steps of the "Autodiagnosis."

By 3/92 for the first 25.

By 12/92 for the second 25 (revised version).

Outputs:

The MotherCare health team will train the CS health team in each zone in the autodiagnosis process.

By 3/92

The 25 groups will have identified priority problems, analyzed them, provided solutions and documented these findings relating to maternal and neonatal health.

By 3/92 for the first 25 groups.

By 12/92 for the second 25 groups.

Development of educational materials with pilot testing and final draft.

By 1/93

II. NUTRITION

Objective:

In order to monitor the nutritional status of pregnant women, by June, 1993, 50% of pregnant women will have their weight measured at least twice during pregnancy and at least 50% of women identified as at nutritional risk will be followed up over a two year period.

In order to increase iodine and iron intake during pregnancy, by June, 1993, 50% (493) of pregnant women will take two three month courses of iron (1 tablet: 200 mgs of sulfato ferroso and 0.25 of folic acid), one during pregnancy and one postpartum, over a two year period.

Inputs:

Train 60 TBAs in techniques of measuring, plotting and interpreting the weight of pregnant women, nutrition counseling and 50% of women detected with poor weight gain will be followed up with two extra prenatal visits, one at the home where the pregnant women will be motivated to consume a balanced diet with emphasis on increased intake, and to be oriented in cooking techniques and good hygiene.

By June, 1993

Train 50% (493) of husbands of pregnant women and pregnant women in proper nutrition during pregnancy and postpartum periods.

By June, 1993

The supervisor of the zone will distribute iron to 50% of the pregnant women.

By June, 1993

Outputs:

50% of pregnant women will have their weight measured at least twice during pregnancy.

By June, 1993

50% (493) of pregnant women will identify 3 major food groups and reasons why they should be consumed during pregnancy and postpartum.

By June, 1993

By June, 1993

50% (493) of pregnant women and lactating women will take two three month courses of iron folate (one pill per day).

By June, 1993

III. PRENATAL

Objective

In order to diminish the risks associated with pregnancy and delivery, by June, 1993, 50% (493) of pregnant women will have three prenatal visits, and 20% of the mothers identified as high risk will have adequate follow-up care (according to the established algorithms) over a 2-year period.

Inputs

Train 60 TBAs representing 82% of the communities (59) in prenatal care, detection of high risk, steps to take for follow up at risk and how to use the women's health card (home based).

By June, 1992

Refresher training
Thirdly

Train 50 Health Promoters (78% of the communities) in promotion of prenatal care.

Annually

Train 100% of CS and local MPSSP health team in how to use the women's roster (women of reproductive age 15-45 y.o.), in prenatal care and signs of at risk and actions to take.

By August, 1991

Outputs

60% of the trained TBAs (36) will be following women during pregnancy and record encounters on the women's health card (with the TBAs keeping a copy).

By June, 1993

60% of the health promoters will promote maternal health in there respective communities (at least one time per year).

Annually

80% of the SC and MPSSP health team can identify 4 activities to take place during prenatal care, 3 signs of at risk during pregnancy and steps to take if identified as at risk.

cont. III. PRENATAL

Objective

Inputs

Educate 20% of women of reproductive age (551) about the signs and symptoms of pregnancy, importance of prenatal care, and the signs of high risk and what should be done if high risk signs are detected.

By June, 1993

Train 60% of pregnant women (591) and 30% (386) of their husbands in the signs and risk factors of pregnancy and the importance in prenatal care and to make appropriate decisions in women identified as at risk.

By June, 1993

The health team and the women's groups will develop specific strategies for women who have been identified as at high risk including solutions and actions to be taken in the zones and communities.

By December, 1991 for Zones

By December, 1992 for all communities with a women's group

Outputs

20% of all women of reproductive age will be able to identify at least two signs of pregnancy (nausea and/or vomiting, sensitive breasts, amenorrhea, easily fatigued), two reasons why prenatal care is necessary (i.e. to take iron/folate supplements, iodine, detect high risk women by evaluating the fetal position, measuring the weight and blood pressure) and two signs and symptoms of at risk (i.e., hemorrhage, constant headache in the third trimester, sepsis/fever).

By June, 1993

30% of pregnant women (386) and 20% of their husbands (197) will be able to identify two signs of pregnancy, reasons for prenatal care and signs of high risk groups

By June, 1993

Documentation and distribution of the strategy for solutions and actions for high risk pregnancies.

By December, 1991 for all of the Zones.

By December, 1992 for each community with a women's group

20% of women detected as high risk will receive adequate follow up according to algorithm.

By June, 1993

IV. DELIVERY:

Objective

In order to reduce mortality during delivery, by June, 1993, 50% (493) of the deliveries will be attended by a trained person and 20% of the women who are identified as at risk during delivery will have appropriate action taken (according to established algorithms) over a 2-year period.

Inputs

Train the following groups in difference between false and real labor, clean delivery techniques, attention to the recent newborn, identification of risk factors and actions to be taken.

100% SC health staff (12) and MPSSP staff (5)

By November, 1991

60 TBAs (82% of the communities)

By June, 1991

Refresher course:
tri-annually

45% (444) of husbands of pregnant women

By June, 1993

20% of women of childbearing age (551)

By June, 1993

50% of pregnant women (444)

By June, 1993

20% of mothers of pregnant women (177)

By June, 1993

Outputs

20% of the high risk women will be managed according to a developed protocol.
By June, 1993

The following persons will be able to identify three clean delivery techniques, 2 reasons for the importance of clean delivery, 2 correct practices for attending the recent newborn, 2 signs of at risk, and define false and real labor:

90% of SC/MPSSP staff (15)

30% of trained TBAs (18)

20% of husbands of pregnant women (197)

60% of trained women of childbearing age (331)

20% of pregnant women (197)

14% of mothers of pregnant women (137)

By June, 1993

cont. IV. DELIVERY

Objectives

In order to assure safer birthing practices, birth kits will be prepared, containing:

- 2 sterile gauzes
- 1 new razor blade
- soap
- string
- large cloth
- small cloth
- erythromycin ointment for the newborn.

And by June 1993, 50% of deliveries will utilize them.

Inputs

Meet with the women's groups and the SC health team to develop strategies and a documented algorithm for high risk cases for the Zones and for each community with a women's group.

By December, 1991
for the subareas and 12/92 for the communities

Prepare birth kits for pregnant women.

By June, 1993

Outputs

A documented strategy for high risk women during delivery will be finalized.
By 12/91 for Zones and by 12/92 for communities

50% of deliveries (493) will utilize the birth kit.

By June, 1993

V. POSTPARTUM CARE

Objective:

In order to reduce the risk associated with the postpartum period, by June, 1993, 50% of postpartum women (493) will have received at least one postpartum visit by the TBA or supervisor within the first week after delivery, and 20% of all women identified with hemorrhage or infection will be managed appropriately (according to the set algorithm) over a period of two years.

Inputs

Train 60 TBAs in postpartum care of the mother including the need for the mother to bathe after delivery, to evaluate for high risk i.e. hemorrhage or infection and to follow a series of steps to take if hemorrhage or infection is detected according to a pre-planned referral protocol.

By, June, 1991
Refresher courses quarterly

Develop in conjunction with the SC health team and the women's groups an algorithm describing the steps to take for postpartum maternal sepsis or hemorrhage postpartum (for the literate and illiterate audiences) for the Zones and communities with women's groups.

By December, 1991
for the Zones
By December, 1992 for the communities

Outputs

60% of the trained TBAs (36) will train women in the postnatal period and will be able to identify two signs of hemorrhage and sepsis and will take appropriate steps.

By June, 1993

An algorithm for illiterate and literate persons will be finalized and documented.

By December, 1991.

20% of postpartum women (197) identified with hemorrhage or infection will be managed appropriately according the algorithm developed.

By June, 1993

cont. V. POSTPARTUM

Objectives

Inputs

Train 60% of pregnant women (591) in appropriate postpartum care including hygiene and identification of sepsis/fever and hemorrhage.

By June, 1993

Train 45% (444) of husbands of pregnant women in proper postnatal hygiene and the signs of maternal hemorrhage or sepsis and steps to take if detected.

By June, 1993

Review with 100% of the MOH local health staff and SC local health staff the proper postpartum care and the signs of sepsis and hemorrhage and steps to be taken if they are detected.

By 11/91 and then biannually

Outputs

The following groups will be able to describe at least two signs of infection and of hemorrhage and identify appropriate post partum hygiene:

50% of pregnant women (493).

By June, 1993

20% of husbands of postpartum women (197)

By June, 1993

80% of MOH staff and of the SC staff will be able to identify two steps in proper postpartum maternal care and identify two signs of hemorrhage and sepsis and describe appropriate steps to be taken and which ones they are responsible for.

By 11/91 and then biannually

VI. NEWBORN

Objective

In order to ensure early care for every newborn, by June, 1993 30% of newborns (380) will receive immediate attention by the birthing attendant after birth and be breast-fed within the first hour after birth and 20% of all newborns identified as at risk will have appropriate treatment steps taken as defined by the protocol.

Inputs

Train the following groups in the steps for immediate attention of the newborn and in the recognition of the signs of risk and actions to be taken.

60% (591) of husbands of pregnant women.

By June, 1993

60 TBAs

By June, 1991

Refresher courses quarterly

60% of pregnant women (591)

By June, 1993

20% (193) of mothers of pregnant women

By June, 1993

5 MPSSP and 12 SC Health staff

By August, 1991

Outputs

20% of newborns recognized as at risk will have steps followed according to a pre-planned protocol.

By June, 1993

The following persons will know the four basic steps to be taken with the recent newborn (clean phlegm from the airway, cut cord immediately with a sterile instrument, dry newborn/cover and breast feed immediately) and will identify at least 2 signs of at risk.

30% of husbands of pregnant women (386)

By June, 1993

30% (18) of TBAs trained

By June, 1993

50% (493) of pregnant women

By June, 1993

10% (99) of mothers of pregnant women

By June, 1993

90% (15) of MPSSP and SC Health staff

By November, 1991

cont. VI. NEWBORN

Objectives

Inputs

Develop an algorithm with the SC health team and women's groups for actions to be taken if signs indicate the newborn is at risk for the zones and the communities.

By 12/91 for Zones and 12/92 for communities with women's groups

Outputs

A documented protocol will be in place for steps to follow for newborns identified as high risk (for illiterates and literates).

VII. NEONATAL

Objective

In order to assure that the mother's family supports her in the care of the infant, by July, 1993 30% of trained TBAs, husbands of pregnant women, 10% of mothers of pregnant women, 25% of pregnant women and 90% of MPSSP staff will be able to identify 3 reasons for starting breastfeeding in the first hour and continuing for a minimum of two years, 3 signs of sepsis and pneumonia, and at least 2 ways to prevent tetanus. 20% of infants identified as at risk will be followed up.

Inputs

Train the following groups to care for the neonate and detect high risk situations and what steps to take.

60 TBAs

By November, 1991

Refresher trainings quarterly

60% of husbands (591) of pregnant women

By June, 1993

50% of pregnant women (493)

By June, 1993

20% (197) of mothers of pregnant women

By June, 1993

100% of the local MPSSP and SC staff (17)

By November, 1991

(annually)

Outputs

The following persons will be able to identify 3 reasons for starting breast-feeding in the first hour and continuing for a minimum of two years, 3 signs of sepsis, pneumonia and state at least 2 ways to prevent tetanus.

30% of the trained TBAs (18)

By June, 1993

30% of husbands of pregnant women (386)

By June, 1993

25% of pregnant women (246)

By June, 1993

10% of mothers of pregnant women (99)

By June, 1993

90% of MPSSP staff (15)

By November, 1991

cont. VII. NEONATAL

Objectives

Inputs

Develop an algorithm for steps to take for high risk neonatal situations particularly for the Inquisivi community.

By December, 1991 for each zone.

By December, 1992 for communities with women's groups.

Outputs

20% of infants identified as at risk will followed up according to the at risk protocol.

By June, 1993

Algorithm for steps to take for at risk neonatal situations will be finalized and in used.

By January, 1992 for the zones.

By January, 1993 for community specific solutions.

GENERAL

Objective

In order to protect the life and health of mothers and children, and if an agreement with the MPSSP and another group can be obtained:

By June, 1993, 20% (551) of women of reproductive age will be trained and practice a method of family planning (modern methods including breast-feeding); of note this project will only be involved in promotion, training and referral and not service delivery.

Inputs

Train 100% of the SC health and local MPSSP health staff in family planning methods, their contraindications and side effects.

By 11/91

Train the following groups in family planning methods, reproductive cycle and inform them on where to seek services.

25% of women of reproductive age (225).

By 6/93

50% of pregnant women (493).

By 6/93

60 TBAs.

By 6/93

20% (500) of men (20-50 years old).

By 6/93

10% (137) of 15-19 year old men and women.

By 6/93

50% of the teachers in the 73 communities.

By 6/93 (annually)

Outputs

90% of SC and MPSSP local health staff can identify a minimum of three modern methods and one contraindication for each method and two side effects of each method.

By 12/91

The following persons can identify at least three modern methods of family planning and identify where than can receive FP services:

10% (275) of women of reproductive age

By 6/93

40% (394) of pregnant women

By 6/93

50% of trained TBAs (30).

By 6/93

10% (250) of men 20-50 years old.

By 6/93

5% (68) of 15-19 year old women and men.

By 6/93

25% of teachers.

By 6/93

cont. GENERAL

Objective:

Input

Support the Sindicatos, Junta Vecinals and other men's organization through training with particular emphasis on family planning methods and where to go for services in 40 communities.

By July, 1993

Outputs

There will be two meetings per year in 40 different communities where family planning will be discussed.

Annually

In order for mothers to continue their education, the program will support literacy training by July, 1993, through development of maternal and neonatal health and nutrition educational materials in Aymara and Spanish for maternal literacy program.

Develop and validate the maternal neonatal health and nutrition material for literacy training in Spanish and Aymara.

By 8/92

Distribute and utilize the training materials.

By 9/92

VII. HEALTH INFORMATION
SYSTEM

Objective

In order to monitor and record health behavior practices and impact, by October, 1991 a roster for women of childbearing age and a woman's home-based card will be finalized.

Input

Develop and pilot-test roster of women of childbearing age and women's home based card by Sept. 1991.

Outputs

Final versions of cards and implementation of their use by October 1991.

VIII. CURRICULUM

Objective

In order to share the project's experiences, by June, 1993 a curriculum documenting the training in this project will be finalized and distributed to PROCOSI.

Input

Document each training and develop a rough draft of the curriculum by June 1993

Outputs

Finalized curriculum circulated among other PVOs by June 1993.

D. Indicators

The following lists the evaluation indicators for the above objectives:

Objective 1: WOMEN'S GROUPS

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

Objective 2: NUTRITION

- a) Percent of infants born with low birth weights.
- b) Percent of pregnant women with two or more weights plotted during pregnancy.
- c) Percent of women at nutritional risk who are followed up.
- d) Percent of women identified as at nutritional risk who improve after follow up.
- e) Percent of women who are taking two three months courses of iron during pregnancy and postpartum.

Objective 3: PRENATAL

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

Objective 4: DELIVERY

- a) Percent of deliveries attended by trained persons.

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

Objective 5: POSTPARTUM

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

Objective 6: NEWBORN

- a) Perinatal Mortality Rate
- b) Percent of newborns receiving immediate attention after birth.
- c) Percent of newborns breast fed in the first hour of life.
- d) Percent of newborns identified as at risk who are followed up appropriately according to the algorithm.
- e) Percent of husbands, TBAs, mothers of pregnant women, MPSSP/CS local health staff who can identify four basic steps to be taken with the recent newborn, and can identify at least 2 signs of at risk.

Objective 7: NEONATAL

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

Objective 8: GENERAL

- a) Percent of women of reproductive age trained in family planning methods.
- b) Percent of women of reproductive age using at least one modern family planning method.
- c) Percent of MPSSP who can identify a minimum of three modern methods and one contraindication for each method and two side effects of each method.
- d) Percent of women of reproductive age, TBAs, men 20-50, 15-19 year olds, pregnant women and teachers who can identify three modern methods of family planning and identify where they can receive family planning services.

III. HUMAN RESOURCES

A. In country (please refer to appendix 11 for the organogram)

1. SAVE THE CHILDREN IN BOLIVIA:

- a. 1/2 time MotherCare Project Chief's responsibilities (please refer to appendix 12 for a more detailed job description):

Lila Cepedes

- 1) provides overall program guidance to the field staff
- 2) coordinates training and technical assistance
- 3) acts as primary contact with MotherCare Project
- b. Project Coordinator's responsibilities (please refer to appendix 11 for a more detailed job description):

Elsa Sanchez

- 1) provides technical training and follow up
- 2) interfaces with the local MOH officials
- 3) manages data collection and analysis in the communities
- 4) direct supervision of field staff.

- c. Educator's responsibilities:

Yolando Pabon

- 1) organizes groups of women and train them in leadership skills within the groups
- 2) coordinates the development of training materials and methodologies (IEC materials)
- 3) assists in supervision
- 4) trains field supervisors in groups

organization, leadership and supervision

d. Field supervisor's responsibilities (3):

Basilia Laime

Fanny Alavi

Rjomelia Antonio

one additional person is being considered to be hired

- 1) works with the educator to organize women's groups.
- 2) speaks Aymara to the women
- 3) serves as technicians or para professional in health education
- 4) participates in training sessions
- 5) supports individuals and groups in their endeavors.

e. Logistical support:

- 1) full time driver/mechanic based in Inquisivi
- 2) part time secretary
- 3) part time accountant

f. Project team (country director of SC/Bolivia, Project In Charge, Project Coordinator and JSI Representative in Bolivia) meets regularly providing programmatic and administrative direction and coordination to the project.

2. JOHN SNOW INC. IN BOLIVIA

a. Technical Advisor and administrator

Lisa Howard-Grabman gives up to 30% of her time providing assistance to the project staff. She plays an integral part in the design and implementation of the project.

B. External technical assistance

1. SAVE THE CHILDREN IN WESTPORT:

- a) Dr. Warren Berggren provides technical advice.
- b) Dr. Wendy Slusser provides technical and administrative support to the project. She provided support in Bolivia for three weeks during the development of the DIP, HIS forms and outline of the NCIH presentation April-May 1991.

2. JOHN SNOW INC.

a) Dr. Marjorie Koblinsky provides technical and administrative support.

b) Ms. Pat Taylor provides both technical and administrative support to the project. She visited the project in 2/90 to develop the project proposal.

c) Ms. Colleen Conroy provides technical and administrative support.

d) Ms. Marcia Monderroso provides administrative support.

e) Ms. Saipon Vongkitbuncha provides financial administrative support.

3. EXTERNAL CONSULTANTS:

a) Dr. Alfred Bartlett (pediatrician) supports the project technically. He has made two T.A. visits to design, train the staff in the techniques and analyze the results of the retrospective case control study: two weeks in September-October 1990 and two weeks in March-April 1991.

b) Ms. Mona Moore (Manoff consultant) supports the project technically. During a 10 day consultancy she facilitated the initial training of the MotherCare/SC staff and assisted in the development of the six month work plan and focused on the objectives.

c) Anticipated Consultants needed:

One technical advisor (educational advisor with experience working with women's groups) to assist in the development of training materials relating to maternal health including materials for literates and illiterates (with a secondary objective to assist in promoting literacy).

One technical advisor (medical advisor) to assist in the development of the algorithm charts dealing with the subject of at risk women and neonates for illiterates and literates (Al Bartlett ?)

Dates:

July, 1991 (both advisors at the same time)
 November, 1991 for validation of educational materials
 (educational advisor, only)
 July, 1992 (educational advisor)

IV. HEALTH INFORMATION SYSTEM

SC Bolivia has a HIS in place in its CS V impact area which covers this project's "area of operations. This system has been initiated by the staff of the child survival project and is under the supervision of the SC/CS staff. In order to better monitor the SC/MC project, a roster for women of reproductive age is being expanded and a women of reproductive age health card is being developed by the SC/MC staff. These additions to the HIS will be maintained by the SC/CS staff, SC/MC staff, TBAs and the women of CBA. The health information system is supervised by the CS team. The roster for women of child bearing age and the women's health card are the two elements of the system which will be developed and supervised by the SC/MC project. The HIS consists of the following elements:

A. Family Enrollment

A complete household registration which includes data on location of the household, kind of house, members of the family, their position in the family, sex, birth date, education and immunization status. There are also questions on type of land occupancy (e.g. owner, renter or hired hand), occupation of the head of the household, source of family's water, waste disposal and retrospective infant mortality in the past year. The data has been entered into a computerized system in Quime and La Paz. It is anticipated that a new, more sophisticated computerized system, ProMIS, which has been in development over two years will be installed in September, 1991.

B. Manual field system

Rosters are developed based on the family registration for priority groups receiving the health interventions. In the case of the CS V project all children under five are recorded in a separate book so the health information may be recorded for the individual child. These rosters are maintained by the promoters who use them as a guide for their daily activities. These rosters record all the interventions affecting each child, including immunization, growth monitoring activities, iodine and vitamin A treatment, family ORT education, ARI episodes, their treatment and evolution etc. The rosters are a management and monitoring tool for the community and project staff.

C. Rosters for women of reproductive age

A roster listing all women of childbearing age per community has been designed in collaboration with the MPSSP. It will be maintained by the SC/MC supervisors of each zone.

This roster records women's age, parity, previous pregnancy outcomes, pregnancy risk evaluation, new pregnancy, birth and post natal care, iron and iodine administration, and some training and

practice data. Please refer to appendices 7 and 8 for an outline of its content and a sample of the roster.

D. Vital event reporting

On-going reporting by all the SC staff on births, deaths, in-migration and out-migration maintain the family enrollment information.

E. Road to Health Card

A home based card and duplicate by the family and promoter are kept up to date for growth monitoring, immunizations and illnesses of each child. Cards of children considered at nutritional risk are flagged with red or yellow yarn and the ones following normal growth curves are tagged with green yarn.

F. Women's health card

Up until now the only written information kept by the women is a small TT administration register. A more detailed card has been developed and will be kept by the woman and a duplicate by the TBA. It will include information on reproductive cycle, TT, one pregnancy's weight gain, obstetrical history, and risk factors (cards will be flagged with different color ribbons according to risk evaluation). A large portion of the card will be geared toward the illiterate.

	June 90 - Sept 90		Oct 90 - Sept 91		Oct 91 - Sept 92		Oct 92 - Sept 93		TOTAL		
	Sub-Contract	Primary Contract	Sub-Contract	Primary Contract	Sub-Contract	Primary Contract	Sub-Contract	Primary Contract	Sub-Contract	Primary Contract	
I. Procurement:											
A. Assets < \$ 500											
1. Tape Recorders	500								500	0	500
2. Furniture & Equipment	1.000		300						1.300	0	1.300
Subtotal Assets < \$ 500	1.500	0	300	0	0	0	0	0	1.800	0	1.800
B. Supplies & Materials											
1. Office Supplies & Materials	1.550		3.550		3.735		3.225		12.060	0	12.060
2. Workshop Materials	1.750		5.130		4.290		3.900		15.070	0	15.070
Subtotal Supplies & Materials	3.300	0	8.680	0	8.025	0	7.125	0	27.130	0	27.130
C. Consultants											
1. Local	0		2.000		2.000		1.500		5.500	0	5.500
2. External Tech		1 pers-mo		4 pers-mo		3 pers-mo		3 pers-mo		0 11 pers-mo	11 pers-m
Subtotal Consultants	0	0	2.000	0	2.000	0	1.500	0	5.500	0	5.500
TOTAL PROCUREMENT (I)	4.800	0	10.980	0	10.025	0	8.625	0	34.430	0	34.430
II. Evaluation											
A. Baseline Study											
	500								500	0	500
B. Midterm Evaluation											
			500						500	0	500
C. Final Evaluation											
							1.000		1.000	0	1.000
TOTAL EVALUATION (II)	500	0	500	0	0	0	1.000	0	2.000	0	2.000
III. Other Program Costs											
A. Personnel											
1. Wages, Benefits, Indemnization	10.190		51.916		55.722		42.801		160.629	0	160.629
2. Tuition Reimbursement	3.950		2.220		2.220				8.390	0	8.390
Subtotal Personnel	14.140	0	54.136	0	57.942	0	42.801	0	169.019	0	169.019
B. Travel & Per Diem											
1. Vehicle Op./Maint./Insurance	5.905		5.025		5.250		4.000		21.180	0	21.180
2. Air Fares/Per Diem		0		2.500		6.000		6.325	0	14.825	14.825
Subtotal Travel & Per Diem	6.905	0	5.025	2.500	5.250	6.000	4.000	6.325	21.180	14.825	36.005
C. Other Direct Costs											
1. Workshops - Meeting Costs			1.945		3.105		2.200		7.250	0	7.250
2. Communications & Postage	1.150		2.760		2.780		2.000		8.690	0	8.690
Subtotal Other Direct Costs	1.150	0	4.705	0	5.885	0	4.200	0	15.940	0	15.940
TOTAL OTHER PROGRAM COSTS (III)	22.195	0	63.866	2.500	69.377	6.000	51.001	6.325	206.139	14.825	220.964
TOTAL BEFORE INDIRECT COST RECOVERY (I + II + III)	27.495	0	75.346	2.500	79.192	6.000	60.625	6.325	242.569	14.825	257.394

2 May

Year	TITLE	NAME	SALARY	NO OF	SALARY	YEARLY	FRINGE	SGF SOCIAL	THREE	LEAVING	TOTAL	TOTAL	
			Oct-Mar	MONTHS	June-Sept	SALARY	%	SECURITY	MONTHS	INDEMNITY	BENEFITS	SGF	
			(incl Inas bonus)	# OF MONTHS	(K x F) + (G x H)	(I x J) + (K x L)	(M x N)	(O x P)	(Q x R)	(S x T)	(U x V)	(W x X)	
			K	F	G	H	I	J	K	L	M	N	
FIELD STAFF													
	Proj. Field Coordinator		645.00	9.00	690.00	1.00	8,565.00	128.25	513.90	690.00	690.00	2,322.15	10,857.15
	Educator		749.00	9.00	801.00	4.00	9,945.00	497.25	596.70	801.00	801.00	2,655.95	12,640.95
	Driver/Mechanic		190.00	9.00	205.00	1.00	2,530.00	126.50	151.80	205.00	205.00	688.30	3,218.30
	3 Supervisores de Campo (@ 172 c/u)		516.00	9.00	516.00	4.00	6,708.00	335.40	402.48	516.00	516.00	1,769.88	8,477.38
	SUBTOTAL		2,100.00	36.00	2,212.00	16.00	27,748.00	1,537.40	1,664.88	2,212.00	2,212.00	7,476.23	35,224.23
PROGRAM SUPPORT													
50%	MotherCare Advisor		856.00	9.00	856.00	1.00	11,128.00	556.40	667.68	856.00	856.00	2,936.08	14,054.68
ADMIN SUPPORT													
50%	Accountant		170.00	9.00	182.00	1.00	2,253.00	112.50	135.43	182.00	182.00	612.38	2,870.53
25%	Bilingual Secretary		172.00	9.00	184.00	1.00	2,284.00	114.20	137.04	184.00	184.00	619.24	2,903.24
	Mano de Obra Iventual		55.00	9.00	55.00	1.00	660.00					660.00	
	SUBTOTAL		397.00	26.00	421.00	12.00	5,202.00	227.10	272.52	366.00	366.00	1,231.52	6,433.52
	TOTAL YEAR 3		3,553.00	71.00	3,439.00	32.00	44,078.00	2,170.50	2,505.08	3,434.00	3,434.00	11,643.38	55,721.98
1 Oct 1, 1992 - Mar 31, 1993													
FIELD STAFF													
	Proj. Field Coordinator		690.00	9.00			6,210.00	319.50	372.60	690.00	690.00	2,053.10	8,273.10
	Educator		801.00	9.00			7,209.00	360.45	432.54	801.00	801.00	2,394.99	9,603.99
	Driver/Mechanic		205.00	9.00			1,845.00	92.25	110.70	205.00	205.00	612.95	2,457.95
	3 Supervisores de Campo (@ 185 c/u)		555.00	9.00			4,995.00	249.75	299.70	555.00	555.00	1,659.45	6,654.45
	SUBTOTAL		2,251.00	36.00	0.00	0.00	20,259.00	1,012.95	1,215.54	2,251.00	2,251.00	6,730.49	26,989.49
PROGRAM SUPPORT													
50%	MotherCare Advisor		916.00	9.00			8,244.00	412.20	494.64	916.00	916.00	2,733.84	10,982.34
ADMIN SUPPORT													
50%	Accountant		132.00	9.00			1,658.00	81.90	98.28	132.00	132.00	544.18	2,182.18
25%	Bilingual Secretary		184.00	9.00			1,656.00	82.80	99.36	184.00	184.00	550.16	2,206.16
	Mano de Obra Iventual		55.00	8.00			440.00					440.00	
	SUBTOTAL		421.00	26.00	0.00	0.00	3,734.00	164.70	197.64	366.00	366.00	1,094.34	4,828.34
	TOTAL YEAR 4		3,588.00	71.00	0.00	0.00	32,237.00	1,589.35	1,907.82	3,533.00	3,533.00	10,563.67	42,800.67
GRAND TOTAL													
			19,061.00	213.00	9,045.00	96.00	126,569.00	6,233.45	7,480.14	19,173.00	19,173.00	34,059.59	160,629.59

Notes: (1) Column G includes mandatory Christmas bonus

filename: ac-sal3
 update: ~~27 Feb 90~~
 2/17/90

Year	TITLE	NAME	# OF MONTHS		YEARLY SALARY (12 x F) + (6 x H)	FRINGE %	SCF SOCIAL SECURITY TAXES %	THREE MONTHS PATIENTS	LEAVING INDEMNITY %	TOTAL BENEFITS (J+K+L+M)	TOTAL SCF LIABILITY (I + N)		
			Oct-May	June-Sept									
			F	G	I	J	K	L	M	N	O		
1 June 1, 1990 - Sept 30, 1990													
FIELD STAFF													
	Proj. Field Coordinator	Elsa Sanchez			690.00	4.00	2,400.00	120.00	144.00	0.00	264.00	2,664.00	
	Educator	? ?			760.00	4.00	2,890.00	140.00	168.00	0.00	308.00	3,108.00	
	Driver/Mechanic	? ?			175.00	4.00	700.00	35.00	42.00	0.00	77.00	777.00	
	1 Supervisor de Campo	? ?			150.00	4.00	640.00	32.00	38.40	0.00	70.40	710.40	
	SUBTOTAL				1,635.00	16.00	6,540.00	327.00	392.40	0.00	719.40	7,259.40	
PROGRAM SUPPORT													
20%	Health/Nut Advisor	Emma Otsolienchi			300.00	4.00	1,200.00	60.00	72.00	0.00	132.00	1,332.00	
ADMIN SUPPORT													
50%	Accountant	? ?			155.00	4.00	620.00	31.00	37.20	0.00	68.20	688.20	
25%	Bilingual Secretary	Maria Chouquetari ?			160.00	4.00	640.00	32.00	38.40	0.00	70.40	710.40	
	Mazo de Obra Irentual				50.00	4.00	200.00				200.00		
	SUBTOTAL				365.00	12.00	1,460.00	63.00	75.60	0.00	138.60	1,598.60	
TOTAL YEAR 1					2,300.00	32.00	9,200.00	450.00	540.00	0.00	990.00	10,190.00	
2 Oct 1, 1990 - Sept 30, 1991													
FIELD STAFF													
	Proj. Field Coordinator				690.00	9.00	6,450.00	4.50	7,380.00	399.00	478.80	645.00	8,157.80
	Educator				760.00	9.00	7,140.00	4.00	9,296.00	464.80	557.76	749.00	10,115.56
	Driver/Mechanic				175.00	9.00	1,590.00	4.00	2,335.00	115.75	140.10	190.00	2,971.85
	3 Supervisoras de Campo (# 160 c/u)				480.00	9.00	4,800.00	4.00	6,240.00	312.00	374.40	480.00	7,386.40
	SUBTOTAL				1,955.00	36.00	2,064.00	16.00	25,851.00	1,292.55	1,551.06	2,664.00	32,822.61
PROGRAM SUPPORT													
50%	MotherCare Advisor				800.00	9.00	800.00	4.00	10,400.00	520.00	624.00	800.00	13,144.00
ADMIN SUPPORT													
50%	Accountant				155.00	9.00	170.00	4.00	2,075.00	103.75	124.50	170.00	2,643.25
25%	Bilingual Secretary				160.00	9.00	172.00	4.00	2,128.00	106.40	127.68	172.00	2,706.08
	Mazo de Obra Irentual				50.00	8.00	50.00	4.00	600.00				600.00
	SUBTOTAL				365.00	26.00	392.00	12.00	4,803.00	210.15	252.18	342.00	5,919.33

VII. SUSTAINABLE STRATEGY

SC goals include the health and survival of mothers and their children. The SC/MC project moves towards this health goal by enabling families and communities to protect their members from killing and crippling diseases in new ways. The behaviors promoted in this project complement the community's currently practiced maternal and child protective behaviors.

Behaviors are actions that people tend to repeat or sustain after they have learned them. When a high proportion of families in a community habitually practice a behavior, their example may propagate the behavior among other community members and among new arrivals. In such cases the behavior has succeeded in becoming a community norm.

Practicing some of the behaviors requires access to formal health care services. SC/MC project promotes access to such services by promoting continuing education among the formal health care system's personnel and by enabling communities through training and the Autodiagnosis process to advocate effectively for access to competent service.

Sustaining advocacy and protective behaviors requires high levels of motivation. Motivation levels are determined largely by people's perception of either a danger to be avoided or a value to be gained or persevered. The SC/MC project trains families and communities to inform their perceptions with knowledge of the life, death, health and disease outcomes associated with practice or non-practice of the protective behaviors.

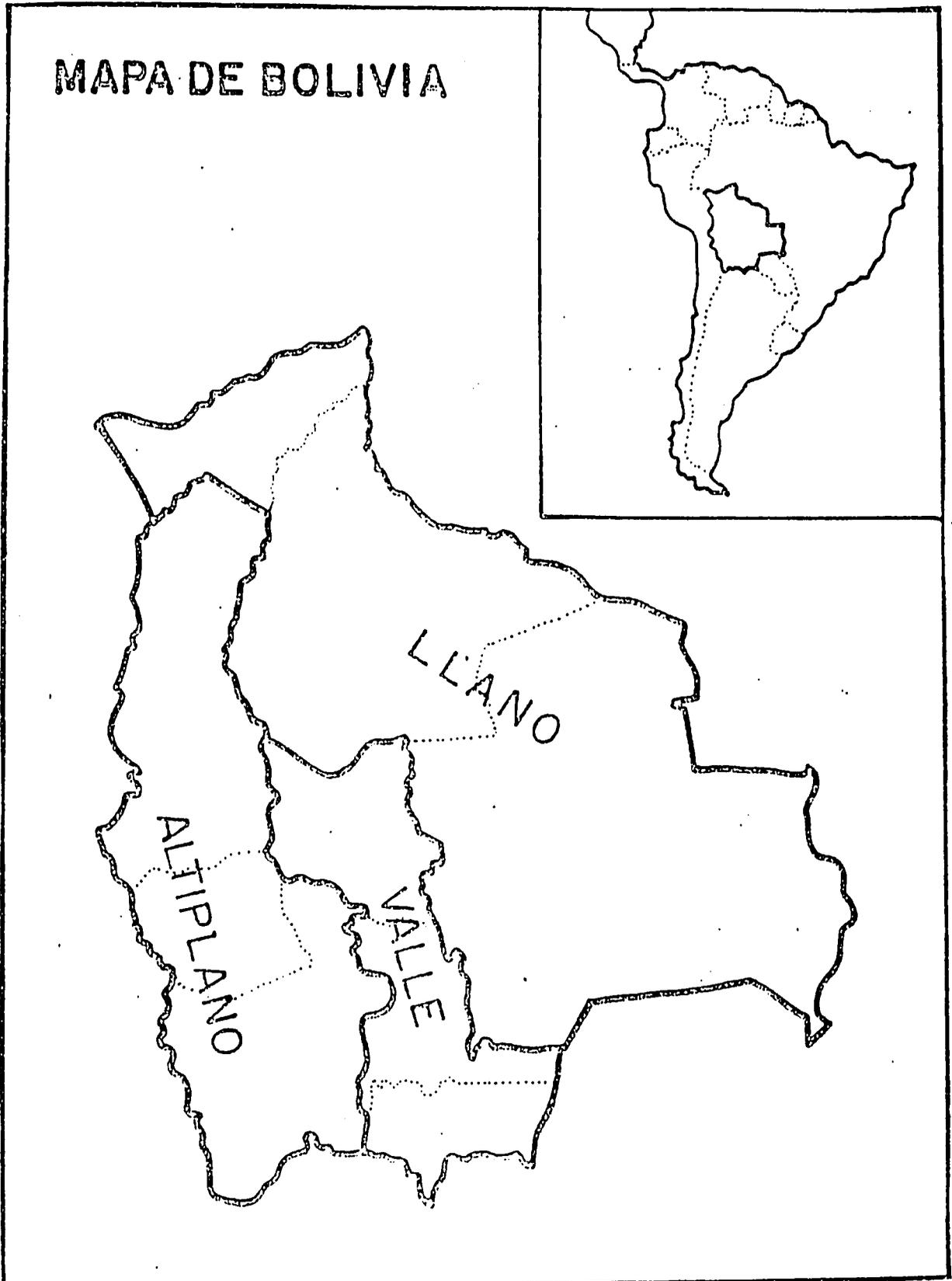
This motivating information comes from family records of behavior (i.e. women's health card) and family reports of births, diseases, deaths or healthy survival. The information, when summarized in the roster for women of reproductive age or in the vital events records will guide health workers in their promotion of protective behaviors. Further summary and comparison to information from other populations or to earliest information from the same population serves as a basis for communities to reassure themselves concerning their progress, advise themselves of any failures, and alert themselves to new problems.

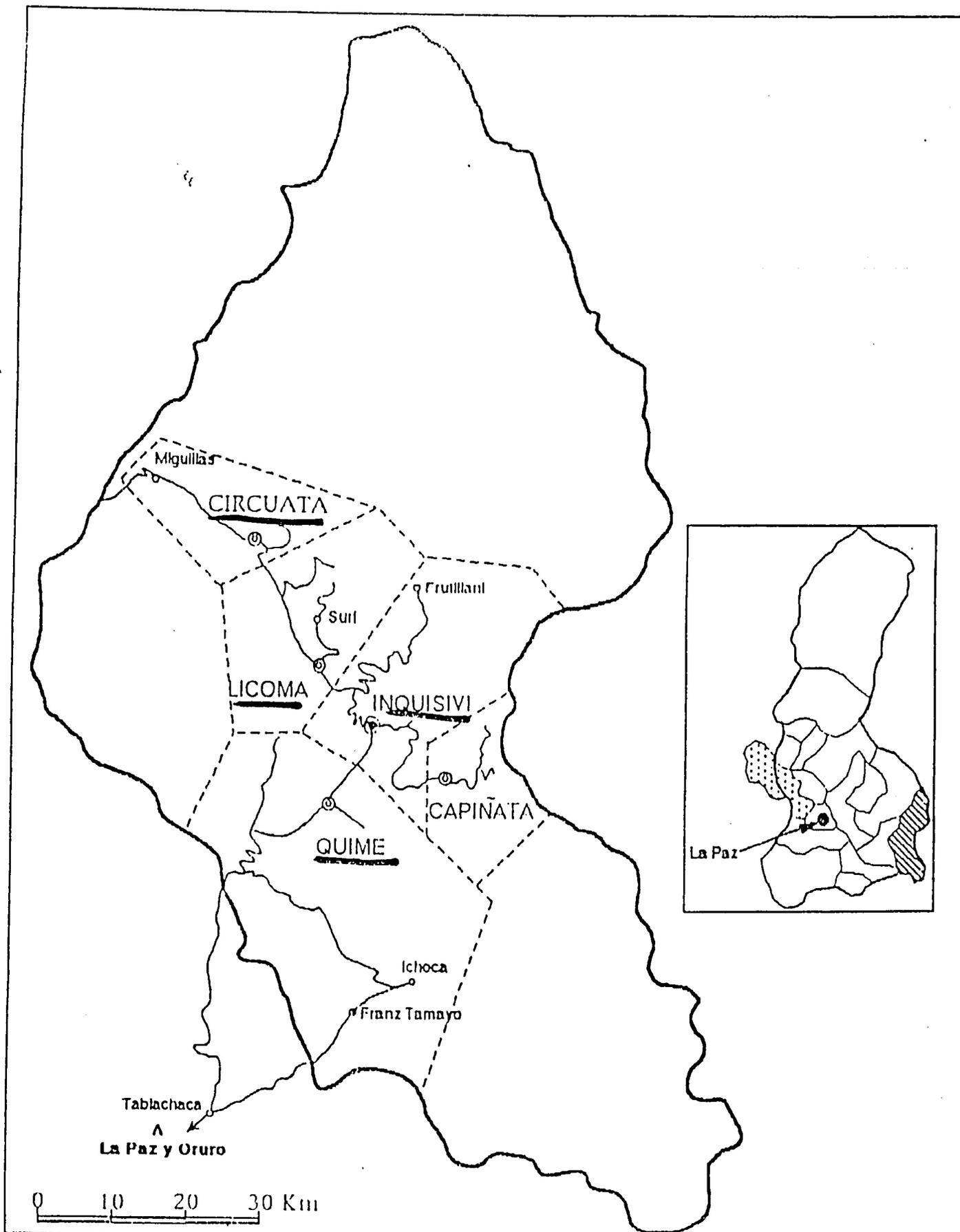
Additionally, the following materials will be developed during the project: educational materials, action protocols for high risk situations, the women of fertile age home based card, and materials for literacy training; it is envisioned that these items will continue to serve the impact area even after the project ends. This will be more likely if the community leaders and the MPSSP staff participate on an ongoing basis with the project team. Additionally a project module will be developed in order to facilitate replicability in other areas through PROCOSI. Its content will include:

- 1) processes used during the project, i.e., what was done and why.
- 2) case studies giving insight into problems encountered and how they were resolved or not resolved.
- 3) educational materials and instructions for their use.
- 4) training curricula and materials.
- 5) results of the project, both positive and negative.

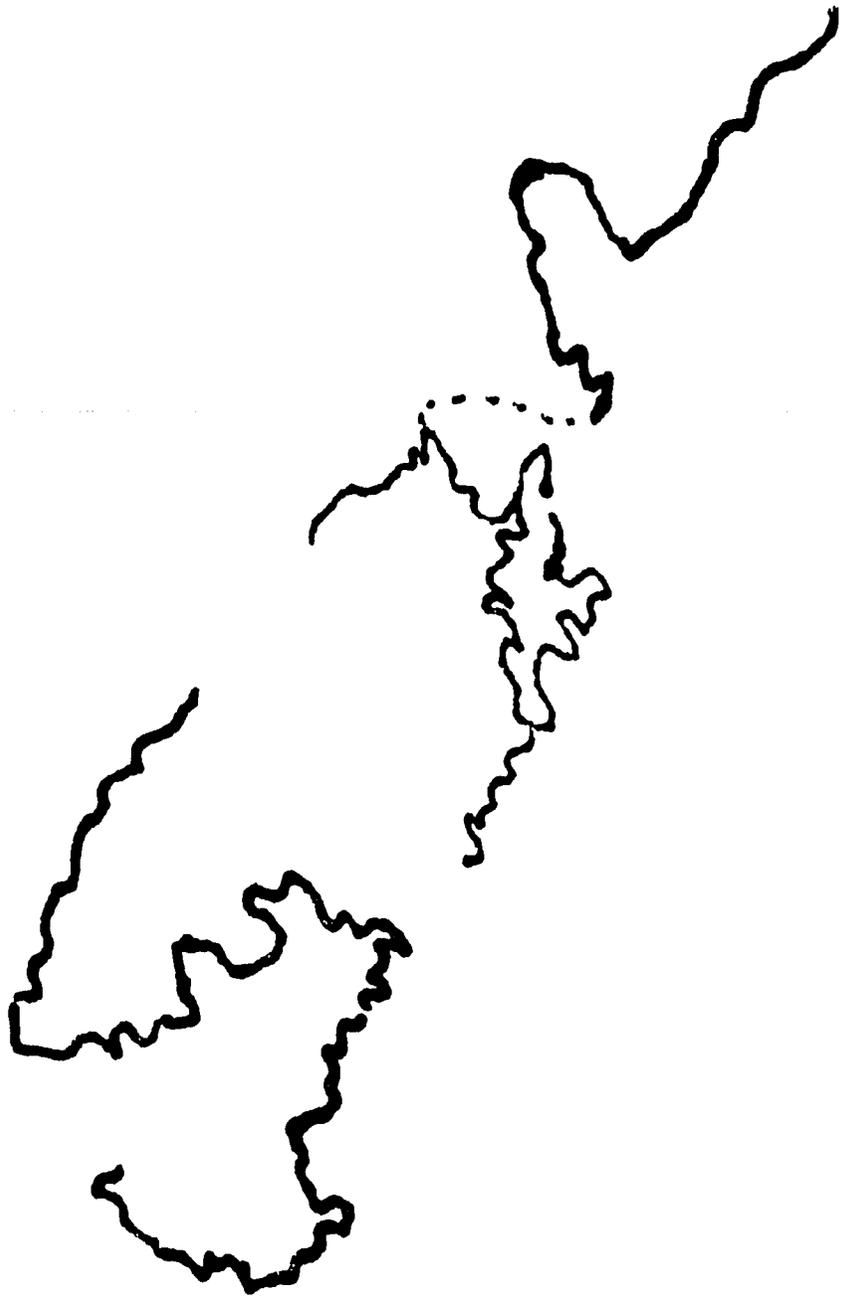
APPENDIX

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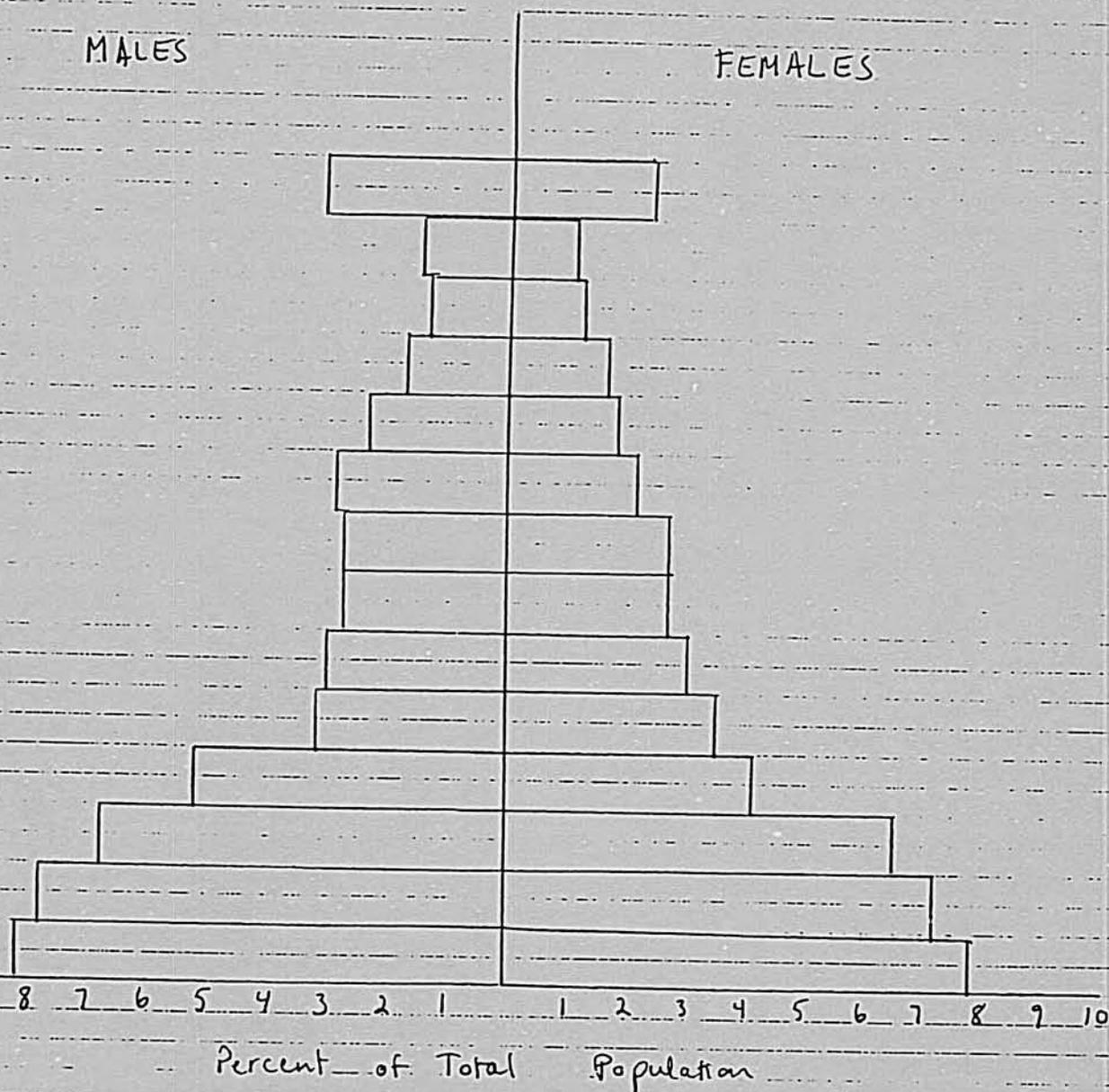
Cuadro 1. Mapa de la Provincia Inquisivi que muestra las zonas donde trabaja DJC. En el recuadro se muestra su ubicación dentro del Departamento La Paz. Los detalles de las sub áreas se ilustran en los Cuadros 2 al 6.



As of March 1991

MALES

FEMALES



65+ year olds
 60-64 year olds
 55-59 year olds
 50-54 year olds
 45-49 year olds
 40-44 year olds
 35-39 year olds
 30-34 year olds
 25-29 year olds
 20-24 year olds
 15-19 year olds
 10-14 year olds
 5-9 year olds
 0-4 year olds

1/1

2

STEPS FOR THE AUTODIAGNOSTICO

1. To explore the attitudes of the women's groups' members about pregnancy and maternity.
2. To orient the group about the "Warmi" project.
3. To learn what they know and do about maternal and neonatal health problems. Work out a "dictionary of words" on maternal and neonatal health problems.
4. To stimulate the group to think of what other women do and know about maternal and neonatal health problems. Do they have the same problems as the group's members do? How can they know it?
5. To explore together with the group, different ways to collect information.
6. Select and design a methodology to obtain information from other women in the community. Practice this methodology within the group.
7. Implementation: The members go out to the community in order to implement the interviews.
8. To share results with the group using the "bandera de la salud" and qualitative questions.
9. To prioritize problems using methods of debate, group discussions, pictures (order pictures according to their priorities) and discussions about factors to be considered, such as:
 - severity of the problem
 - frequency of the problem
 - importance of the problem in the community
 - resources available to solve the problem
 - whether it is possible to face the problem at the community level
10. The group revise the process of the "Autodiagnostico" together with the facilitator (group discussion with questions such as: How was the experience?; What did you learn?; What was difficult, easy, etc?..).

To prepare the group for the next meeting for project's planning.

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GROUP'S WORK

STEP 1: "To explore the women's groups' members attitudes towards pregnancy, birth and maternity.

I. PURPOSE: To know what women think about pregnancy, birth and maternity.

II. FACILITATOR'S AND GROUP'S KNOWLEDGE:

- Terminology used in the community -- language
- To know the women's group
- To know the issue
- To know some habits and traditions of the community

III. MATERIALS NEEDED:

- Educational materials (paper, markers, etc.)
- Tape recorder
- Materials for the "pelota caliente" (literally "hot ball")

IV. POTENTIAL BARRIERS:

- Language
- An unknown issue (facilitator and group)
- Terminology
- Motivation

V. ACTIVITY:

- To elaborate a list of specific questions
- Test the questions
- Prepare women for next step

PASO 2: Introduction about the "Warmi" Project

I. PURPOSE: That women understand what the Warmi project is about.

II. FACILITATOR'S KNOWLEDGE: He (she) knows what the project is about.

III. MATERIALS NEEDED:

- Summary of the project's objectives and other information needed to explain the group what the project is.

- Paper
- Markers

III. FACILITATOR'S RESPONSIBILITIES:

- The facilitator is not familiarized with the project
- The facilitator does not transmit his (her) knowledges
- Women's habits and traditions
- To create unreal expectations
- The group cannot understand what the project is about
- Promotion of the project aside of other DJC projects

V. ACTIVITY:

- Brainstorm about what the project is. The facilitator explains the group what the project is: its objectives, time of execution, etc.

Example for some questions and suggestions:

What do they understand about the "Warmi" Project?

Why do we call this project "Warmi"?

It was noticed that there are many women who die all over the world, but more frequently in poor countries, especially in the rural areas.

In this project we will explore:

Why do mothers believe that they die during the delivery?

Why do they think that their babies are stillborn or die right after birth?

What can we do to avoid the mother's and the just born's deaths?

For this reason the Warmi Project wants to work together with families and mothers' groups because this project is concerned about the mothers and babies deaths. The project will last for three years and is addressed to avoid mothers' and just born's diseases and deaths.

PARO 3: To learn what women faces and do about maternal and neonatal health problems.

f. PURPOSE: To identify and know maternal and neonatal health problems and standardize the terminology within the group.

II. METHODOLOGY:

- Sociodrama
- Cards games
- Open questions with cards

III. ACTIVITY:

- Dictionary of words
- Elaborate drawings to help women to give concepts
- Motivate groups

IV. KNOWLEDGE NEEDED:

The facilitator should know the issue. Should be open to women's knowledge, attitudes and practices. Should be flexible and open to suggestions. Should make women trust him. Should know their language and popular terminology.

V. MATERIALS:

- Paper
- Markers
- Tape recorder
- Franelografos
- Drawings

VI. POTENTIAL BARRIERS:

- Unknown language
- Unknown vocabulary
- The community does not understand
- The community does not understand the terminology
- Lack of reliance

STEP 4: From oneself and the group toward the community

I. PURPOSE: To know if problems and attitudes, knowledge and practices around these problems are common to the whole community.

II. METHODOLOGY:

1. Based on problems elaborated at step 3, analyze within small groups by similarity.

2. Elaborate an issue based on most important problems to analyze them.

3. An informal meeting analyzing problems.

III. FACILITATOR'S KNOWLEDGE:

The facilitator should have enough ability to induce to analysis and the necessary trust with the women's group. The facilitator should also identify one or two women within the group; she will not necessarily be a leader. The selection will be done by the group. This woman will collect opinions about problems from other women.

BEST AVAILABLE COPY

The analysis must include the following:

- How common are the same problems among them (percentage)?
- What do they think is the cause of this problem?
- If they have other problems.

STEP 5: To investigate together with the group different ways to collect information from other women in the community.

I. PURPOSE: To find strategies to collect data with the women's group.

II. KNOWLEDGE OF THE FACILITATOR:

- Leadership
- Motivation
- Techniques management
- Initiative
- Language

AND THE GROUP:

idem
idem

literacy level

III. MATERIALS:

- Letters with drawings: stories about a woman: little novels: videos?
- Paper: markers
- Tape recorder

IV. POTENTIAL BARRIERS:

- The facilitator is a man
- Not enough time (facilitator and group)
- The weather
- Distance
- Absence due to lack of motivation or tiredness

V. ACTIVITY:

- Materials collection
- Check materials and test them within the group (sociodrama)
- Organize the women's group
- Test materials in the community
- Evaluate the test and modifications

VI. METHODOLOGY:

- Participative: e.g., group discussion
- learn doing: e.g., sociodrama
- Test in the community
- Technique: Using drawings

VII. PARTICIPATION OF THE FACILITATOR:

- To orient the group
- Supervise the process

VIII. TIME NEEDED:

A lot (4 hours)

IX. LANGUAGE: Aymara or Spanish, depends on the group

X. QUESTIONS FOR BOTH: (Facilitator and group)

- About maternal and neonatal health problems

LIST OF CRITERIA FOR ADDRESSING TECHNIQUES PROPOSED BY THE GROUP

- The method should encourage dialogue between interviewer and interviewed.

- The instrument should serve to record basic quantitative information: e.g., record how many women suffered anemia according to what they answered during the interview.

- The method should not take long (no longer than half an hour or one hour maximum).

- The method should stimulate qualitative questions and answers such as: How did she feel when she had an abortion? Why does she think that she had such a problem? etc.

- The method should not cost too much and it should be applicable in the community.

- The administration of the method should be easy for the members of the group.

PASO 6: To design a method for information collection.

I. PURPOSE: To design a method to collect information about maternal and neonatal health problems.

II. ACTIVITIES:

- Select a method among those mentioned in step 5.

- Elaborate steps for the method together with the group

- Elaborate the instrument that will serve to stimulate dialogue and record quantitative results.

- Practice the use of the instrument.

One possibility is:

DRAWING OR PICTURE WITH A SIGN OF DANGER

Other possibilities:

IV. TIME NEEDED: 2 hours (depending on the selection made by the group: if they select the method developed by DJC or not).

STEP 7: Implementation.

I. PURPOSE: The group's members go to the community in order to interview their neighbours. During this step, interviewers and interviewed will think about their own maternal and neonatal health problems.

II. ACTIVITIES:

A. Review together with the group a way to interview women. Clarify if necessary.

Methodology: group discussion

Time: 10-15 minutes

Technician participation: leader, group facilitator

B. The group's members go to the community to interview their neighbours according to the method selected in the previous step.

Methodology: Women-to-women: individual interviews using some instrument to be developed in the workshop or a method developed by the women's group's members. Each woman will interview approximately 5 women and will record their answers in a determined way.

Technician participation: The technician will help during the process of interviewing: will be prepared to answer women's questions and will observe some interviews in order to know if there is any problem. He (she) will NOT correct answers or the interviewers' questions. There is no "wrong" answer.

Materials needed: drawings for all the members, 5 interviews for each member: pens or pencils for each one + extra. Possibly, a tape recorder for the technician to record some interviews.

Language: Aymara or Castellano (depends on which language the interviewed speaks)

Knowledge needed by the facilitator and the group:
Methodology: How to interview women and how to record their answers. What does each drawing mean?

III. Potencial Questions:

During the interviews, interviewers can ask:

1. What does she see on the drawing? What problem does the drawing represent?
2. Did the woman ever have such a problem?
3. When?
4. How did she feel when she had that problem?
5. What happened? Did the problem just go by itself? Did she go to see a doctor? nurse? healer? etc.
6. Why does she think that she had such a problem?
7. What was the family's reaction before the problem?
8. Does she think that it is a common problem?
9. Other questions that the interviewer wants to ask.

IV. TIME NEEDED: 4-5 hours

V. POTENTIAL BARRIERS:

- The members do not want to interview women.
- Women do not want to answer questions.
- The instrument is not clear.
- Other community members do not let interviewers to interview women.

STEP 8: Sharing results.

I. PURPOSE: That participating women can share those results obtained through the information given and can question themselves: additionally, they can prioritize and analyze them.

II. METHODOLOGY:

- Demonstrative, analytical and participative.

Techniques to be used:

- Displaying the information obtained
- Comparing situations
- Open questions

III. ACTIVITY:

- Bandera de la Salud for most common results
- Questions posed to the group in a qualitative way.

IV. LANGUAGE: Aymara or Spanish, depending on the group.

V. OPEN QUESTIONS:

- What do you think of the results obtained?
- What caused the women's death?

Knowledge of the Facilitator

- Motivating techniques
- To know the participative method
- Knowledge about mother-child problems
- Knowledge of the language (Quechua or Aymara)

Debate:

Materials:

- Bandera de la Salud
- Markers
- Paper
- Thumbtacks
- Results and others

Time: 1 hour

Barriers:

- Lack of knowledge about mother-child problems, especially about pregnancy.
- Not to count on the appropriate participative environment for sharing information.

APPENDIX 4

Summary of the findings of the autodiagnosis process

There are 10 steps in the autodiagnosis process. To date three groups of women in the Inquisivi district (groups from Inquisivi, Licoma and Circuata villages) have completed the seventh step in the preliminary trial. These three groups were chosen for the pilot test for the process because:

1. They have regular meeting.
2. They are considered dynamic groups.
3. The members have an interest in maternal health.
4. They represented the three different zones in the district and exhibit unique characteristics.

The following summarizes the results from each step.

Step # 1. Explore the attitudes of the members of the women's groups relating to pregnancy, delivery and postnatal period.

Negative aspects of pregnancy, delivery and postnatal period:

- a. Too many children
- b. No planning of pregnancy
- c. Inability to provide equal opportunities for all the children especially in education because there are too many in the family.
- d. Inability to adequately look after the next to youngest when caring for a newborn.
- e. Difficulty working in the field while pregnant.
- f. Some women hope that their newborn will die (usually the women already has 10-11 children); they will cover the infant with blankets and not attend to it.
- g. Some women do not care if the newborn lives but will not make an active effort to kill it (usually a women who has 5-6 children).
- h. Fearful of difficult delivery and especially if it is prolonged.
- i. Exacerbates the lack of money.
- j. Often very tired during pregnancy.
- k. Occasionally fearful of husband.

Positive aspects:

- a. Happy when it is the first, second or third child or if it is the first son.

Step # 2. Promotion, Motivation, introduction of the health subjects and explanation of the objective of the "Warmi" project.

A total of 26 women's groups have been identified and will have gone through all of the steps of the Autodiagnosis by 3/92.

Steps # 3 and # 4. KAP of members: to learn what the members of women's groups and of the community know and do about maternal and neonatal health problems. Work out a "dictionary of words" on maternal and neonatal health problems.

a. PREGNANCY:

* TBA visits home of pregnant women only when women has a perceived problem.

* Manteo (rocking of the pregnant women in a make-shift hammock) is performed gently by the TBA or the husband

* Rubbing of the women's stomach with grease or cream is traditionally practiced.

* Tea drinking

* No change in content of diet or its quantity

* In Inquisivi, but not in Licoma or Circuata the use of very tight skirts during pregnancy is generally practiced.

* There is generally no attention to proper hygiene.

b. DURING LABOR

* The first contraction (even if false) will be the time the mother will start pushing and not stop (may be up to 3 days).

* Will drink tea with an oxytocin effect.

* Boiled water is prepared and old bedding is used below the mother on the floor of delivery.

* Mother will traditionally kneel or squat when delivering.

* Mother will wear a lot of clothes during delivery and often tightly wrap some clothes around the stomach.

* The birthing room is traditionally poorly ventilated and lit with a small window closed and cloth placed in it with incense burning between the legs of the mother.

c. DELIVERY

* The husband will usually help and will often hold the women from the back grabbing her shoulders or her stomach.

* The infant is not attended to until the placenta is delivered and the cord is not cut (the newborn will often be left in the blood and other possible secretions like meconium or maternal feces until the placenta is delivered).

* After the placenta is delivered the infant will be washed and tightly wrapped with "bedding".

* The infant will only be given tea during the first 2-3 days of life, sometimes the newborn is given urine to drink.

d. POSTPARTUM

* The mother will not clean herself until 7-10 days postpartum.

* The mother can not eat cows meat, vegetables or milk. The diet consists of potatoes, rice and pork.

e. Overall priorities:

Too many children	37/66 = 56%
Malpresentation	31/66 = 46%
Sepsis	25/66 = 38%
Retained placenta	20/66 = 30%
Vaginal infection	19/66 = 28%
Anemia	15/66 = 23%
Bleeding during delivery	14/66 = 21%

f. Reasons for the selection:

1. Too many children:

- * suffer too much during pregnancy
- * suffer during delivery

- * difficult to educate all the children when one has too many.
- * risk of death during pregnancy
- * husbands play little attention to the women during pregnancy.
- * it is a way for some husbands to control women

2. Malpresentation presentation and retained placenta

- * The communities are very far from the service delivery for emergencies.
- * The time is late for cutting the cord of the placenta.
- * The TBAs are not able to deal with these problems
- * These problems are not detected promptly
- * Husbands don't realize the gravity of these problems and so do not seek help from the doctor.

3. Hemorrhage during delivery

- * sometimes the mother dies
- * the mother gets anemic and has therefore very little energy to look after the recent newborn.
- * the recent newborn can die because it is not attended.

4. Vaginal infection

- * the mother has a bad odor
- * it itches and bother the women
- * can cause problems during sexual relations.

5. Sepsis

- * there can be a lot of fever two to three days after delivery
- * abdominal pain
- * headache and feeling poorly
- * difficulty getting out of the bed

g. One of the groups (Chirapaxi) was asked about their priority health problems according to category:

1. During pregnancy:

- * Sepsis
- * Goiter

2. During Delivery:

- * Malpresentation
- * Multiple births
- * Prolonged labor

3. Postpartum:

- * Hemorrhage
- * Vaginal infection
- * Sepsis
- * Retained placenta

4. Neonatal:

- * low birth weight

h. The following outlines the dictionary of terms in Aymara and some of the traditional cures:

TERMS IN AYMARA	TRADITIONAL CURES
<p><u>Preeclampsia:</u></p> <p>phusuntata</p> <p>ladunhasista</p> <p>curmimaritata</p>	<p>drink tea of chocolate or cola caballo (a diuretic)</p> <p>baths of salt water</p> <p>visit the TBA</p> <p>tea of plant with hair or toe nail</p>
<p><u>Hemorrhage during pregnancy:</u></p> <p>Wila apiri</p> <p>lastimado</p> <p>aborto</p>	<p>drink tea of cola caballo</p> <p>massage the body</p> <p>drink tea of lacre with chua chua (oxytocin effect)</p> <p>rock the women in a hammock (made from the poncho of the husband) gently and then throw the women into the air so she lands on her feet and then rests in bed.</p>
<p><u>Vaginal infection:</u></p> <p>janko kana</p> <p>janko apiri</p> <p>phasa</p> <p>resfriago</p> <p>flujo blanco</p> <p>janko regla</p>	<p>friction on the hips</p> <p>drink teas (can cause abortions)</p> <p>avoid lifting weights</p> <p>place items on the spine</p> <p>wash with water</p>
<p><u>Anemia:</u></p> <p>Anemia</p> <p>llaqui usuta</p>	<p>place earth on the body</p> <p>consume plants, intestine and liver</p>
<p><u>Tuberculosis:</u></p> <p>Chojo</p> <p>Tisisanpi</p> <p>Pulmonia</p> <p>tisi usu</p> <p>tisico</p>	<p>treatment with medicine</p>
<p><u>Goiter:</u></p> <p>coto</p> <p>bocio</p>	<p>consumption of iodine</p>

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TERMS IN AYMARA	TRADITIONAL CURES
<u>Multiple Births:</u> ispa wawa ispa gemelos mellizps	no cure
<u>Malpresentation:</u> Kayu wawa	rocking vigorously in a hammock place mothers feet above head
<u>Retained placenta:</u> Paresa walkatata paresa siscktata	breast feed immediately hot chocolate rock vigorously in hammock tea of chua chua (oxytocin effect) induce the vomiting reflex talk to the TBA light an explosive
<u>Postpartum sepsis</u> Recaida	wash with water with hair and toe nails
<u>Low birth weight:</u> Turisito desnutrido	feed with a bottle do not feed colostrum feed water with corn
<u>Premature:</u> K'asito	unknown
<u>Tetanus:</u> diablo	not known
<u>Hemorrhage postpartum:</u>	tea of Chua Chua hot chocolate

Steps # 5- # 6.

- a. Explore with the group ways to collect information and select and design a methodology for gathering information from other women in the community and practice this methodology.

The following steps have been taken:

1. Review materials (laminas: illustrations of various health issues during pregnancy, delivery and postpartum).
2. Revision of materials
3. Organize the women
4. Pilot test materials with women
5. Pilot test materials with the community
6. evaluation of the pilot test

- b. Working with the material in the women's group:

- * Use the laminas as if cards in a deck
- * divide the laminas into the different stages of pregnancy
- * talk about each stage and prioritize problems putting different color strings on each lamina
- * Ask the following questions about the laminas:
 - what do you see in the lamina? what is the problem?
 - have you had this problem?
 - if so when?
 - what have you done when you had this problem?
 - what happened? what is the cure? who is involved in the cure?
 - is this a common problem?
 - why do you think it happened?

- c. Steps for the interviews of the women in the women's group with other women in the community (one member interview two women in the community).

1. The day before the interview the woman in the community will be visited by the member of the women's group and the purpose of the interview explained.
2. During the interview the following illustrate the type of questions asked:
 - * how many children do you have? (use the grains of corn to indicate the number alive and the number dead)
 - * what are your health problems during pregnancy and what are the worse ones?

Steps # 8-# 10 (compare results, prioritize problems and revise problems) will be followed in May for these three pilot groups.

APPENDIX 5

Summary of retrospective case control study

1. Objectives:

a. Case control study:

* Identify characteristics associated with maternal, perinatal and neonatal mortality.

* Identify relationships between delivery practices and practices with the recent newborn and maternal, perinatal and neonatal mortality.

b. Verbal autopsy:

* Identify events and illness that are probable causes of mortality.

c. Process diagnosis:

* Identify the events around the decision process and who makes decisions and what are the actions associated with the decisions.

2. Hypothesis:

Certain maternal and neonatal characteristics exist which are significantly associated with increased risk of maternal, perinatal and neonatal mortality.

A significant relationship exists between certain aspects of delivery practices and practices with the recent newborn and risk of maternal, perinatal and neonatal risk of mortality.

3. Cases:

perinatal and neonatal: 74 in two years
(abortion, 23%; stillborn/first day 46%; and first day to 28 days 31%)

note: perinatal defined as abortion, stillborns or death in the first day of life.

neonatal defined as death in the first week of life after the first day and in the first week to 28 days of life.

maternal: 9 in four years

4. Controls: two to every one case, therefore 148 in two years (same time period and the same ratio per sub-area).

5. Tools: HIS
questionnaires with instructions
EPI-Info

6. Conclusions:

The following reports on the preliminary analysis of the data which are considered pertinent or illustrative of the findings. Plans for more complicated analysis of the data i.e. multivariant analysis will take place in order to deduce more information from the data).

Perinatal and neonatal morality rates are high in the Inquisivi impact area according to the vital events collected in the health information system of the Child Survival project: Perinatal 103/1000
Neonatal 69/1000

There are differences in the neonatal and perinatal rates between subareas within the impact areas:

Death Rates	Circuata	Licoma	Inquisivi
Perinatal	148	95	94
Neonatal	96	63	38

Why are there such high perinatal and neonatal death rates?
(risk refers to death either perinatal or neonatal)

d. CASE CONTROL

1. There was no difference in risk between cases and controls when each of the following were looked at:

- * socioeconomic indicators: occupation of the father, type of agriculture production, and what is sold of the agriculture production and whether owned land or not.
- * maternal participation in groups dealing with health
- * number of family members (average of 5.1 in both cases and control groups)
- * the walking distance to the health center measured in time
- * access to clean water
- * if a school exists in the community.
- * if there is a promoter in the community
- * if there is a trained or untrained TBA in the community.
- * the presence of a community women's organization or the participation of the mother (but an informal observation

- is that many of these groups are made up of women older than the fertile age).
- * between women working in different occupations
 - * amounts of prenatal care although the majority did not receive it. (however, of the 54% of women who gave an opinion about prenatal care, 96% had a positive attitude towards it).
 - * between different age groups (majority of women, 73% gave birth at the ideal age of 18-34 years old) although the primagravidas were most at risk during delivery.
 - * the administration of iron/folate, vitamins, teas or TT vaccine 46% of cases and 52% of controls had two or more TTs at time of delivery, only an average of 16% of women in both groups took iron and only 11% took vitamins during pregnancy).
 - * number of households in the home
 - * presence of community organizations for men

2. There was less of a risk for poor fetal outcome:

- * if the father belongs to a Junta Vecinal, Cooperativa or a Credito (political organizations mostly associated with village living)
- * if the father has an education higher than the third or fourth grade (although in both groups 94% of the men can read and 93% speak Spanish).

3. There is an increased risk:

- * if the mother does not speak Spanish
- * if the mother is illiterate
- * if the mother is a single parent
- * if the pregnant woman has a history of abortion, stillbirth or neonatal death
- * living in smaller communities independent of distance to services

4. Practices during pregnancy:

No difference in risk:

- * "Manteo" (rocking gently back and forth as if in a hammock)
- * "Sobado" (rubbing the entire body with a lotion or a cream)
- * Intent for an abortion by drinking teas or excessive physical force but not by placing foreign objects into the uterus.

Associated with increased risk:

- * Bleeding
- * Constant headache in the third trimester
- * Trauma

- * Sepsis
- * Attempts at manipulating the fetus if malpresentation (not statistically significant, but a practice which should be discouraged)

5. Practices during delivery

Data of note:

- * 94% of deliveries take place at the women's home
- * The order of those most likely to assist at time of delivery is the following: Husband (38%)>TBAs (23%)>mother of pregnant women (13%)
- * Family members most likely to be present at the time of delivery: Husbands (78%)> mothers of pregnant women (20%)>mothers in law (12%)

Not associated with increased risk:

- * "Manteo" but only smoothly not for therapy of hemorrhage or transverse position
- * "sobado"
- * injections (although performed mostly with controls by trained health personnel)
- * vaginal exams (although practiced mostly by trained health personnel)

Associated with increased risk:

- * "Manteo" when used as therapy for hemorrhage or transverse position the pregnant women is thrown into the air and meant to land on her feet.
- * Manipulation of the fetus in an attempt to correct malpresentation
- * Prolonged labor > 12 hours
- * ruptured membranes >12 hours (increased risk but not statistically significant; this could be not significant because it only occurred in 8% of cases)
- * Malpresentation (20% massage stomach, 6% stimulate the nipples of the mother and 12% administer metergonal).
- * hemorrhage
- * maternal fever
- * if retained placenta 48% of birth attendants do nothing
- * trauma

6. Attention to the neonate

Practices with controls:

- * 33% of neonate attended immediately after birth
- * 64% of neonates not attended to until placenta is delivered
- * 59% of neonates have cord of placenta cut only after delivery of placenta
- * 87% use a string to tie the cord

- * 62% use no disinfectant
- * 69% have cord cut with a piece of pottery
- * 32% use alcohol for this step
- * 29% have phlegm removed
- * 99% are bathed after birth
- * 98% get covered tightly
- * 79% are placed at the mother's side not on her
- * 49% will receive colostrum:
 - 25% immediately
 - 40% in the first day
 - 22% in the second day

b. Verbal Autopsy

1. The most likely causes for abortion are the following (n=15):

Trauma (5) > unknown (4) > symptoms of hypertension (3) > maternal death (2) > epilepsy (1)

2. The most likely causes for intrapartum death are the following (n=34):

Asphyxia (18) > Asphyxia and/or trauma (6) > intrapartum hemorrhage (3) > no attention (3) > Unknown (3) > amnionitis (1)

3. Predominant causes associated with intrapartum deaths:

Malpresentation (5) > Prolonged labor (5) > hemorrhage during delivery (3) > not attending the newborn right away (3) > maternal infection (3)

4. The most likely causes of death after the first day (neonatal) n=23:

Sepsis (4) > hemorrhage (4) > pneumonia (3) > tetanus (3) > sepsis/pneumonia (2)

d. Process diagnosis

Results relating to the process of decision making:

prompt response (adequate)	: 27%
Late	: 30%
Did not recognize the problem	: 25%
Did not think the problem was important:	16%

sought adequate attention	: 29%
sought inadequate attention	: 12%
treated problem in the home:	44%
other	: 15%

APPENDIX 6

HIGH RISK CONDITIONS

Maternal conditions:

Pregnancy History: Abortion
Stillborn
Neonatal death

Pregnancy: Sepsis/fever
Trauma
Hemorrhage
Constant headache in the third
trimester/edema (i.e., high blood
pressure)
Premature ruptured membranes
Malpresentation

Delivery: Malpresentation
Ruptured membranes >12 hours
Prolonged labor >12 hours
Hemorrhage
Maternal fever

Postpartum: Sepsis
Retained placenta
Hemorrhage

Infant conditions:

Recent Newborn:
(in the first day) Asphyxia
Hemorrhage
Sepsis

Neonatal:
(2-28 days old) Sepsis
Pneumonia
Low birth weight
Tetanus
Hemorrhage (infant)

ROSTER FOR WOMEN OF REPRODUCTIVE AGE

This Roster is designed for all women of reproductive age (15-45), without taking into account their fertility.

Its purpose is to do a follow-up from the TT immunization status, pregnancy, delivery, newborn care, puerperium, training and FAP, in order to improve the women's health level decreasing the maternal and neonatal morbidity and mortality rates.

Personal Code:

Is the number allocated in the computer for each person and is composed of the Family Card number multiplied by 100 and added to the register's number.

E.g.:

If the card Nr. is 2767 and the personal register Nr. is 2, according to the card's list we get:

Card Nr.	2767	=	276700
	x100		
Register Nr.			2
Personal Code Nr.			276702

Year:

Register the year we are in at that moment of the detection.

House Number:

Use the same number of the birth card.

Current Age:

Estimate the age based on the date of birth

T.T. Vaccine:

The date of each shot of TT will be registered, as well as the number of dose.

I. **Obtetrical History**
(For pregnant women only)

1. **Date of Pregnancy Detection**
The date of the pregnancy detection will be registered: it is very important in order to determine the gestational age
2. **Number of Pregnancies**
Find out the number of pregnancies, abortions, deliveries, premature deliveries, including the current pregnancy.

3. **Date of the last Delivery**
This information will be obtained from the child under 5's roster and/or from the woman herself the day her pregnancy is detected or during the first prenatal control visit.

4. **Number of Abortions**
Also called miscarriage. When a woman loses her baby before the sixth month of pregnancy.

5. **Number of children born alive**
Any fetus which shows a sign of life, even if it dies immediately after birth.

6. **Stillborn**
Any fetus born without any sign of life; these can be classified by:

Intra-Uterine Death: The fetus died before starting the labor. The baby had no movement inside the mother's womb; at birth it looks like drenched and presents a brownish colour, like toasted; the mother will refer to its movement as a block.

Stillbirth: According to the mother, the fetus had movement and signs of life up to the labor and was born without signs of life.

7. **Number of Deliveries:**
Delivery is the product eliminated through the vagina from the sixth month of pregnancy.

8. **How many children are currently alive**
The number of children currently alive at the moment of the detection will be registered.

9. **Perinatal Deaths**

From 0 to 7 Days: any child born alive who died between the day of birth and the seventh day of life.

From the 7th to the 30th Day: any child who had lived until the seventh day of life and then died between the 8th and the 30th day.

II. PRENATAL CONTROL

1. **Date**
Register the day, month and year of the prenatal control visit.

2. L.M.D. (Last Menstruation Date)

"Register the date of the last menstruation.

3. Possible Date of Birth

Ask the pregnant woman when did she have her last menstruation. Add seven days to that date and from the resulting addition or date, count the months of pregnancy.

E.g.:

You visited Ms. Nora Mamani on January 5th, 1991. She had her last menstruation on September 15th, 1990; if you add seven days to that date, the resulting date is September 22nd, 1990. Then you can count the months of pregnancy as follows:

From September 22 to October 22	= 1 month
from October 22 to November 22	= 1 month
from November 22 to December 22	= 1 month
from December 22 to January 22	= 1 month
from January 22 to February 22	= 1 month
from February 22 to March 22	= 1 month
from March 22 to April 22	= 1 month
from April 22 to May 22	= 1 month
from May 22 to June 22	= 1 month
T O T A L	= 9 months

Then we know that the possible date of birth will be June 22nd, 1991.

"A normal pregnancy lasts 40 weeks or 9 months".

4. Weight

Register the pregnant woman's weight: the woman should be weighed wearing the least clothes as possible: for later weight controls, the woman must wear the same clothes as she did the first time. Normally, a pregnant woman gains between 8 and 10 Kg. during the pregnancy.

5. Blood Pressure

Normal blood pressure measurement is 120-80 mm/kg. To measure blood pressure a blood pressure cuff and a Stethoscope must be used.

6. Gestational Age Is the estimation of weeks or months of pregnancy based on:

a) Uterine Height:

It is important to control the uterine height to know if the baby is developing normally: sometimes the mother's belly looks small in relation to the baby's gestational age.

Register the uterine height as follows:

E.g.: Estimating weeks of pregnancy:

If the womb is under the navel, add 4 cm. to the measurement you got. If the womb is below the navel, then add 7 cm.. The result will show us the gestational age:

8-9 cm.	3 months
13 cm.	4 months
17 cm.	5 months
21 cm.	6 months
25 cm.	7 months
29 cm.	8 months
32-34 cm.	9 months

7. **Presentation**

CE=CEFALICA Head comes out first
CP=PODALICA Foot or Arm comes out first
TR=TRANSVERSA The baby is Side-ways

8. **Fetal Beating**

Register the number of the baby's heart beatings per minute.

9. **Risk Factors**

9.a **Low Risk**

Women are considered at low risk when:

They are illiterate, do not know how to read and write, they can only sign.

The mother is undernourished.

9.b **Medium or Middling (?) Risk**

Previous fetal death

Previous cesarian section

Genital bleeding

Birth spacing shorter than 2 years: period between the last pregnancy or abortion and the current pregnancy.

9.c **High Risk**

High Blood Pressure

Hands, feet or face swelling

Cretinism

Heart affections

Age: younger than 17 or older than 40 years.

First pregnancy at more than 35 years of age (Mala presentación)

Twins

10. Iodine
Register the date of iodine administration.
11. Ferrous Sulphate
Register the date of ferrous sulphate administration.

III. DELIVERY

1. Date of Birth
Register the day, month and year of birth.
2. Place
Use the code to indicate the place of birth:

At woman's, husband's or mother in law's house.
Institutional - health or medical post:
general hospital: clinic.
3. The Delivery was Assisted by:
Register the right code to describe the person who assisted the delivery:

Midwife: did not receive institutional training
Traditional Midwife: received institutional training and has the supervisor's follow-up.
Health Promoter
Husband
Health personnel (doctor, nurse, auxiliary)
Others (mother, neighbour)

IV. NEWBORN

1. Born Alive
Any newborn who presented signs of life at the moment of birth is considered alive, even if he (she) dies right after birth.
2. Death
The fetus was born alive and died during the first 28 days of life.
 - 2.a Date
Register the day, month and year of death.
 - 2.b Age
Register the baby's age in days

2.c Cause of Death (0-30 dias)

Intra Uterine Death: The fetus died before starting the labor. The baby had no movement inside the mother's womb: at birth it looks like drenched and presents a brownish colour, like toasted: the mother will refer to its movement as a block.

Stillbirth: According to the mother, the fetus had movement and signs of life up to the labor and was born without signs of life.

Newborn's Infection: A child with infection will suffer temperature, irritability, blisters all over the body, redish navel, bad smelling supuration.

Tetanus: The child will present the following symptoms: muscular spasms: will not suckle: will be irritable: will cry: will not be able to swallow.

Low Body Temperature: One can see that the baby is decaved: lethargic: cries: presents (apnea), which can be the first symptom.

Severe Neumonia One should observe: breathing, if there are more tan 70x1:

Asphixia Can be due to a prolonged labor.

Others: E.g.: prematurity

3. Sex
Register:

M = Male
F = Female

4. Weight
If possible, the child must be weighed after birth.

5. Was fed with Calostrum
Register YES - NO. take into account 48 hours after birth.

6. Survived the First Month of Life

"This information will provide us the datum of the newborn's survival during the first month of life.

V. PUERPERIUM (After Birth - Post-partum)

1. Temperature

During the follow-up visit, control the mother's temperature to make sure that there is no post-partum infection.

2. Discharges (Elimination of a bloody liquid through the vagina)

During the visit to the puerperal woman, make sure that the appearance of the discharge is normal (smelling, colour and quantity), taking into account that at the beginning the discharge will be red, then it will look like bloody (looks like washed meat) and finally will be white. The duration is 45 days.

3. Hemorrhage

After the delivery, one must control especially bleeding, which can for instance be afterbirth leftover.

4. Vitamin A

Vitamin "A" will be administered during the first 7 days of the puerperium. After this period one must not administer Vitamin A.

VI. REFERRAL

Register the date of referral

VII. CROSS-REFERENCE

Register if the referred patient improved, died or if we ignore what happened to her.

Improved

Died

We ignore

VIII. MATERNAL MORTALITY

Maternal Mortality occurred during pregnancy, birth and puerperium will be registered under the following codes:

death during pregnancy
death during birth
death during puerperium

X. TRAINING

Register the code corresponding to the issue the pregnant and/or puerperal woman was trained on:

Pregnancy Risk
Birth and Puerperium Risk
TT Vaccine
Iodine and iodized salt
Safe Birth assistance
Newborn's care
Puerperium control
Colostrum and Breastfeeding
Feeding: pregnancy, birth, puerperium,
breastfeeding
Breastfeeding

XI. OBSERVATIONS

Those observations you consider worthy will be registered.

TRAINING MATRIX FOR SC MOTHERCARE PROJECT

PARTICIPANTS	# OF TRAINEES	# OF DAYS	TRAINING CONTENT
SC MOTHERCARE PROJECT STAFF			
Year 1:			
Project In Charge	1	on-going	On-the-job training in: organization of women's groups; supervisory skills; research methodologies; maternal and neonatal health interventions; SC programs and philosophy; MotherCare Project objectives and approaches.
Field Coordinator	1	on-going	
Educator	1	on-going	
Field Supervisor	1	on-going	
Year 2			
New Field Supervisors	2	on-going	Same as above
SC MotherCare Staff	5	on-going	Management; supervision and evaluation; no-formal education techniques; MCH and sex education for largely illiterate and primarily Aymara speaking audiences; data analysis; intervention development adult education methods and materials development training methodologies; MIS form development and use.
OTHER SC STAFF			
Year 2	13	2	Orientation to MotherCare Project and general overview of maternal and neonatal health interventions.
Year 3	13	2	

PARTICIPANTS	# OF TRAINEES	# OF DAYS	TRAINING CONTENT
<hr/> TBAs <hr/>			
Year 2	60	3 (thirdly)	Prenatal care including risk assessment avoidance of medicines, appropriate nutrition hygiene, importance of iron and preparation of birthing (birth kits). Delivery practices including hygienic and safe birthing practices i.e. avoidance of some traditional harmful practices, care of the women in labor and of the recent newborn, cord care, colostrum feeding (within one hour of birth) and risk assessment; postpartum care including risk assessment, postnatal care of the mother and newborn including risk assessment; registration of data on a newly developed maternal health information form. family planning methods (natural methods i.e. breast feeding and if available modern methods).
Year 3	60	3 (thirdly)	Same as above
<hr/> MOH CLINICAL STAFF <hr/>			
Year 2	7	2	High risk pregnancy detection and clinical management
	7	2	Family planning methods and counseling
Year 3	7	2	Same as above
	7	2	

PARTICIPANTS	# OF TRAINEES	# OF DAYS	TRAINING CONTENT
HEALTH PROMOTERS			
Year 2	85	2	Basic prenatal and postpartum care including preparation for delivery, hygiene, review of harmful birthing practices, detection of at risk during each stage of pregnancy, care of the neonate including breast-feeding within the first hour of life and proper cord care.
Year 3	85	2	Same as above
WOMEN'S GROUPS MEMBERS WOMEN OF FERTILE AGE			
Year 1			
25 groups	250	on-going	Organization and self management; techniques in autodiagnosis, including consensus, conflict resolution, needs and resource assessment and prioritization, action planning. Health training topics include prenatal, delivery, postnatal, recent newborn, neonatal, nutrition, family planning and high risk management at all stages of pregnancy and newborn periods.
Year 2			
25 groups whose members will invite other women of fertile age	250	on-going	Same as above
25 additional groups	250	on-going	
Year 3			
50 groups whose members will invite other women of fertile age	500	on-going	Same as above

PARTICIPANTS	# OF TRAINEES	# OF DAYS	TRAINING CONTENT
HUSBANDS AND MOTHERS OF PREGNANT WOMEN, AND PREGNANT WOMEN			
Year 2			
Husbands of pregnant women	200	on-going	Risks of pregnancy, delivery, postpartum, recent newborn and neonatal periods and steps to take if risk is detected; importance and practices of prenatal care, clean delivery techniques and attention to the recent newborn. Nutrition education at each stage of pregnancy and family planning methods and where to find the services..
Mothers of pregnant women	100	on-going	As above
Pregnant women	250	on-going	As above
Year 3			
Husbands of pregnant women	200	on-going	As above
Mothers of pregnant women	100	on-going	As above
Pregnant women	250	on-going	As above
ADOLESCENTS			
Year 2			
	25 males	4	Personal hygiene; reproductive health, sex education, family planning, nutrition, family health including conflict resolution, cooperative lifestyles, paternity and maternity issues and responsibilities, family violence and machismo.
	25 females	4	
Year 3			
	25 males	4	Same as above
	25 females	4	

SUMMARY OF CONCLUSIONS AND
RECOMMENDED ACTIVITIES FROM THE
CASE CONTROL STUDY AND
AUTODIAGNOSIS

PRENATAL

TBAs visit pregnant women usually in their home, but generally only when the woman perceives a problem.

There is a tradition of "manteo" and rubbing the stomach of the mother.

No change in the maternal diet during pregnancy.

Women perceive anemia as a problem during pregnancy.

In Inquisivi the women wear very tight waisted skirts during pregnancy.

"Regla Blanca"

ACTIVITIES/SOLUTIONS

Early detection of pregnancy by women, promoters and TBAs through education of the signs and symptoms and through regular visits by the promoters.

Reinforce the merits of manteo when it is done gently, stressing the dangers of throwing the women into the air but if used for therapy of hemorrhage or an infant in transverse position medical care should be sought.

Education and technical service dealing with the growing, preparing and eating of highly nutritious foods during pregnancy.

Additionally, there should be promotion and provision of iron/folate tabs to be given for a three month course once a day during pregnancy and another course during lactation.

Assess the prevalence of anemia among all women of fertile age and modify target group for iron/folate treatment, accordingly.

Education of the mothers and TBAs about wearing loose clothes especially during the third trimester of pregnancy.

Education of the mothers/husbands/supervisors/TEs and adolescents about proper hygiene and detection of infection and proper referral

Cont. of prenatal

“

Goiter

Hypertension/continuous headache
during the third
trimester/epilepsy

Sepsis/fever

Trauma

Hemorrhage

ACTIVITIES/SOLUTIONS

Education and distribution to all pregnant women about the merits of taking iodine tablets three times during pregnancy and consuming iodized salt.

Train mothers, TBAs, promoters and supervisors about the signs of hypertension and the need and where to seek help.

Monitor BP during the prenatal visits and if high refer and educate about bed rest and appropriate diet.

Train mothers, TBAs, promoters, and supervisors about the signs and symptoms of sepsis and fever including measurement of temperature by the TBAs or promoters and appropriate referral.

Educate mothers and husbands about the risks of trauma and need to be more careful during pregnancy.

Train mothers, TBAs and promoters about the risks of hemorrhage and appropriate referral.

DELIVERY

“
No distinction between false and real labor.

Boiled water is prepared during delivery.

The traditional squatting position during delivery is most commonly practiced.

Clothes are placed tightly around the abdomen.

Majority of births take place in the home and in a room with a small window, little ventilation and incense burning.

Husband>TBAs>Mothers of the pregnant women are present at delivery.

ACTIVITIES/SOLUTIONS DIRECTED TOWARDS THE MOTHER, TBAs AND THE HUSBANDS.

Educate about the difference between false and real labor and when a woman should push.

Reinforce this custom, but stress that the boiled water should be used for washing hands and materials used during delivery and not to wash the newborn.

Reinforce this custom, but stress the need to attend to the infant right away after birth and to use clean materials under the women. Furthermore, the placental cord should be cut immediately, phlegm cleaned from the newborn's mouth and infant dried with a clean cloth.

Tight clothing should not be used during delivery.

Educate about the need for a delivery room which is well ventilated and has sufficient light.

Train in the practical delivery skills and educate in the following:

- * conducting the delivery
- * detection of signs and symptoms of high risk (i.e. prolonged labor >12 hours, ruptured membranes >12 hours, retained placenta, hemorrhage)
- * selection of teas
- * preparation of materials for birth (birth kit)
- * recognition of false labor.
- * immediate attention to the newborn (i.e. clean phlegm, clean infant with dry clean cloth, stimulate infant to cry and observe infant for color, activity and effort in crying)
- * recognize risk factors in the newborn.

cont. DELIVERY

Malpresentation and multiple gestation increases the risk for poor fetal outcomes.

Prolonged labor over 12 hours increases the risk for poor fetal outcome.

Ruptured membranes longer than twelve hours increases the risk for poor fetal outcome, but not significantly.

48% of persons do nothing for a retained placenta.

ACTIVITIES/SOLUTIONS

Education and promotion of prenatal visits, at least three increasing to five if identified as high risk (obstetrical history of an abortion, stillbirth, or neonatal death; hemorrhage during pregnancy, high blood pressure, infection during pregnancy or trauma).

Educate the TBAs and the supervisors in the detection of the position of the fetus and the appropriate steps if there is a malpresentation: 1. identify a home near the hospital that the women can stay in during the last days of pregnancy; 2. help organize women's group to develop a monetary fund which can be used to help women pay for the hospital.

Train fathers, mothers and TBAs about difference between false and real labor and when to push and the risks of labor over 8 hours for multigravida and 16 hours for primagravidas and to seek help from medical personnel.

Train fathers, mothers and TBAs about ruptured membranes (especially the difference between urine and amniotic fluid) and the significance of the risk of infection if membranes are ruptured longer than one day (must make plans to transport mother to medical facility after the twelfth hour of ruptured membranes).

Educate the father, mother and TBA about the risk of placental retention, the risk of pulling and the need to seek prompt medical help. Emphasis on prompt cutting of the cord and attention to the infant is needed.

cont. DELIVERY

There are practices of rough manteo/sabádo and attempts at changing the position of the fetus if there is hemorrhage or malpresentation of the fetus.

Maternal fever increase the risk for poor fetal outcome.

Asfixia>asfixia or trauma>hemorrhage>no attention to the newborn>amnionitis are the most likely causes for perinatal death. Associated causes are malpresentation> prolonged labor> hemorrhage> no attention to the infant> infection.

ACTIVITIES/SOLUTIONS

Education about the risks of manipulation with rough "manteo or trying to manipulate the position of the fetus because of malpresentation. Stress prenatal detection of malpresentation and appropriate plans for referral. If hemorrhage do not perform Manteo, but stress transporting mother with feet up if possible. Promotion of iron/folate intake during pregnancy would improve mothers and fetuses chances if hemorrhage takes place.

Appropriate referral to promote and if truly febrile to the health post. Educate family to look for signs and symptoms of sepsis in the newborn (increase respiratory rate, petechiae, cold/hot, decreased energy)

Training in the appropriate attention to the newborn and prenatal care and management in delivery as described above.

POSTNATAL

Mother does not traditionally wash herself until 7-10 days post partum and women sight vaginal infections as a major problem postpartum.

Poor food intake post partum; women traditionally will avoid vegetables and milk.

Hemorrhage is associated with a high risk of poor fetal outcome and women consider it a major problem.

Infants rarely are fed colostrum, drinking tea for the first couple of days.

Low birth weight is considered a big problem among some women in the groups.

Newborn is traditionally washed after birth and wrapped tightly in dry cloth.

Sepsis, pneumonia, hemorrhage and tetanus are the most common causes of death in the neonate.

ACTIVITIES/SOLUTIONS

Education and training of the mother about appropriate hygiene postpartum (making sure that mother does not immerse herself into water). Stress clean delivery practices. Postpartum visits by the promoter/TBAs (#); referral

Education and promotion of intake of nutritious locally available foods and appropriate preparation.

Vitamin A megadose to the mother within one week postpartum.

Iron/folate three month course.

Iron administration.

Promotion of breast-feeding.

Referral

education and promotion of taking colostrum and promotion of breast-feeding for at least years.

Promotion of proper nutrition during pregnancy. Attention to the newborn with special follow up by the promoter.

Training of drying newborn off but not giving a bath until the second day of life during the daytime hours.

Training about the signs and symptoms of sepsis in the newborn and appropriate referral.

Maintenance of good hygiene by the mother during pregnancy. Attention to clean delivery techniques and cord care.

Promotion of TT administration (at least two).

GENERAL

Major concern among women is that they have too many children and will point out the neglect of a newborn to the fact that they have too many children already.

Illiterate women are at increased risk for poor fetal outcome.

Women who can not speak Spanish are at increased risk for poor fetal outcome.

women living alone are at increased risk for poor fetal outcome.

If the father is a member of Junta Vecinal, Cooperativa Credito or has an education higher than intermediate there is a reduced risk for poor fetal outcome.

ACTIVITIES/SOLUTIONS

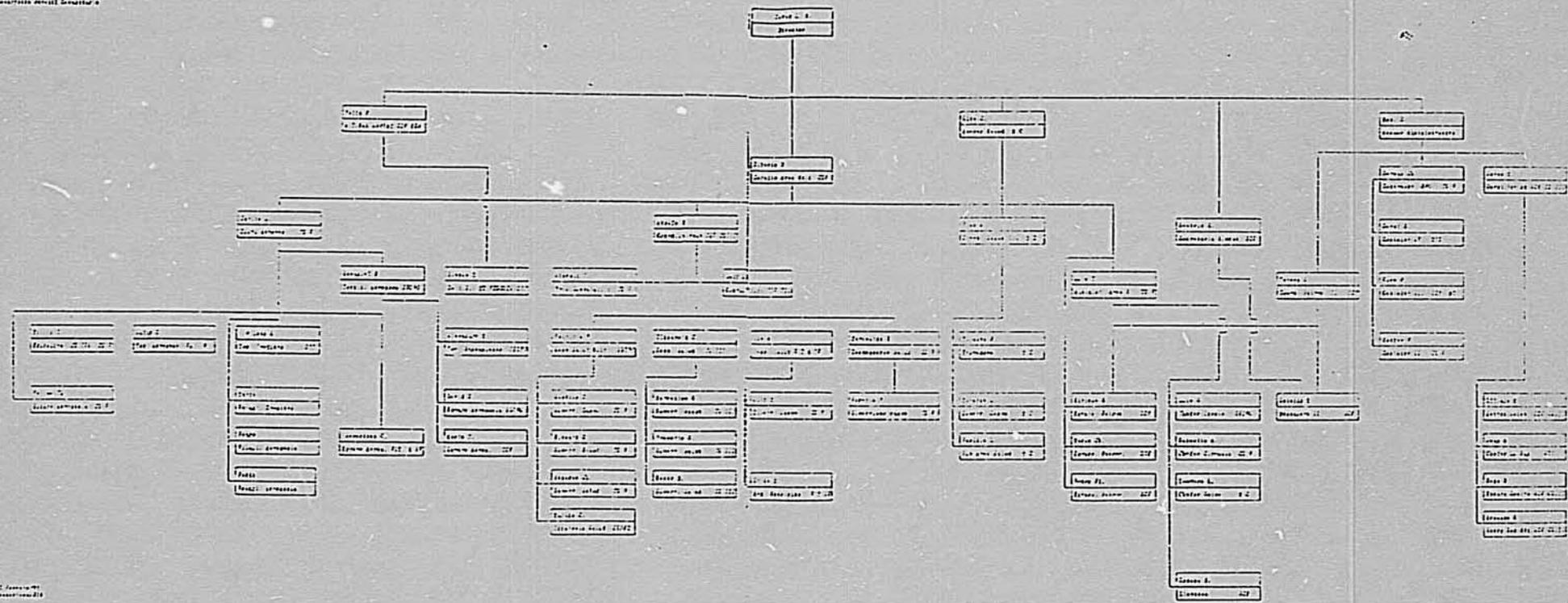
Promotion of family planning and development with another organization of appropriate and available service delivery.

Develop materials about maternal health for education in literacy courses in Spanish and Aymara.

Promotion of family planning.

Reinforce and strengthen men's groups.

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FIELD SUPERVISOR

The Field Supervisor will:

- 1) actively participate in the work of the women's groups under the direction of the Educator;
- 2) participate in the training of TBA's, family members and teenagers;
- 3) provide support to training of MOH personnel;
- 4) supervise and provide continuous training to the TBA's in their communities;
- 5) participate in the monitoring and evaluation of the project through collection of data;
- 6) participate in the implementation of any investigation which is undertaken as part of the project (dietary recall, anemia study, etc.);
- 7) liaise with Child Survival staff to coordinate supervisory visits and programming;
- 8) report to the Project Coordinator and Educator.

PROJECT COORDINATOR

The Project Coordinator will coordinate and supervise all MotherCare Project activities within the project and with the SCF Child Survival and MOH staff. The Project Coordinator will work as a field supervisor in a number of communities so that s/he will be able to monitor progress and difficulties first-hand. S/he will be responsible for collecting the process data from the field supervisors and for writing quarterly project reports.

With the Educator, the Project Coordinator will plan the training events at all levels, including subjects, training modules, ordering materials and evaluating the trainees.

S/he will direct investigational activities such as an anemia prevalence study.

S/he will monitor IEC activities development and activities.

The Project Coordinator will document the activities and experiences, both positive and negative, of the project, so that in the future a complete "How to Work with Rural Bolivian Women on Improving Their and Their Children's Health" manual may be written.