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FINAL EVALUATION
WARMI PROJECT
SAVE THE CHILDREN/BOLIVIA

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A

TABLE OF CONTENTS

	Page
EXECUTIVE SUMMARY.....	1-16
I. BACKGROUND.....	17-23
II. METHODOLOGY.....	23-31
III. COMPARISON OF GOALS/OBJECTIVES TO ACHIEVEMENTS.....	32
IV. COMMUNITY ORGANIZATION AND PARTICIPATION.....	33-39
V. INFORMATION, EDUCATION AND COMMUNICATION.....	39-48
VI. TRAINING.....	48-57
VII. SERVICES.....	57-70
VIII. HEALTH INFORMATION SYSTEM.....	70-75
IX. INTERINSTITUTIONAL COORDINATION AND COLLABORATION.....	75-80
X. ADMINISTRATION AND LOGISTICS.....	81-82
XI. BUDGET AND ACTUAL EXPENDITURES.....	83
XII. SUSTAINABILITY.....	83-84
XIII. REPLICABILITY.....	85-86
XIV. CONCLUSIONS.....	87
XV. RECOMMENDATIONS.....	87-88
LIST OF REFERENCE MATERIALS.....	89

TABLES

Project Results

1. Objectives vs Achievement: Mortality
2. Objectives vs Achievement: Women's Groups
3. Objectives vs Achievement: Prenatal Care
4. Objectives vs Achievement: Nutrition
5. Objectives vs Achievement: Delivery
6. Objectives vs Achievement: Post-Partum
7. Objectives vs Achievement: Family Planning
8. Objectives vs Achievement: Materials/Products

Results: Case-Control Studies

9. Community Participation
10. Pregnancy
11. Birth
12. Care of Newborn/Post-Partum

13. Proposed Training Plan for Use of Educational Materials
14. Training Inputs and Achievements
15. Budget versus Actual Expenditures
16. Illustrative Costs of Project Replication

ANNEXES

1. Evaluation Instruments
2. Case-Control Study Questionnaire
3. Bar Graphs of Project Results
4. Timeline of Women's Group and Community Activities
5. Health Information System Instruments
 - A. Women's Health Card
 - B. Vital Events Registration Form
 - C. Original Women's Health Roster
 - D. Revised Women's Health Roster
 - E. Family Registration Card
 - F. Consolidated Women's Health Roster
 - G. National Health Information System Form (SNIS)
6. "Pathway to Survival" Model, A. Bartlett

ACRONYMS & TERMS

ADX	Autodiagnosis
AID	Agency for International Development
AYUFAM	Help for the Family (local NGO)
CIEC	Center for Interdisciplinary Community Studies
FeSO4	Ferrous Sulfate
FP	Family Planning
FSG	San Gabriel Foundation
HIS	Health Information System
IEC	Information, Education and Communication
IMP	Implementation
JSI	John Snow, Inc.
KAP	Knowledge, Attitudes and Practices
MOH	Ministry of Health (sometimes appears as MPSSP)
N/A	Not Available
NGO	Non-governmental Organization
ORG	Organization of women's group
Partera	Community level trained birth attendant (midwives not traditional in Inquisivi)
PROCOSI	Program for the Coordination of Child Survival (PVO umbrella organization)
PT	Planning Together
PVO	Private Voluntary Organization
SC/B	Save the Children/Bolivia
Sindicato	Agrarian Union
SNIS	National Health Information System
TT	Tetanus Toxoid

EXECUTIVE SUMMARY

Save the Children/Bolivia (SC/B) is a Private Voluntary Organization whose primary mission is to improve the quality of life of underprivileged children. SC/B works in a community-based, integrated manner in the sectors of primary health, education, economic development and sustainable agriculture/natural resource management. SC/B initiated the Warmi Project in July, 1990. The three-year project in 50 communities of Inquisivi Province, Bolivia was funded by AID/Washington through the MotherCare Project which was managed by John Snow, Inc. (JSI). The project's objectives as described in SC/B's Field Agreement with JSI follow:

PROJECT OBJECTIVES

A. Affecting Behaviors

1. Increase women's knowledge and understanding of priority maternal and neonatal health and nutrition topics such as nutrition during pregnancy, prenatal care, safe birth practices, postpartum care, sexually transmitted diseases, basic reproductive anatomy and family planning methods.
2. Improve nutrition and other critical practices during pregnancy.
3. Improve neonatal care through increased attention to breast-feeding, keeping the infant warm, awareness of danger signs in the neonate, etc.
4. Increase the knowledge and use of family planning methods that do not interfere with breast-feeding for limiting and spacing births (if this intervention is approved by the Ministry of Health).
5. Establish women's groups capable of identifying and responding to their own and their infants' health needs.

B. Improving Services

1. Strengthen the reproductive health knowledge and skills of health promoters, Ministry of Health (MOH) medical staff, midwives and other "birth attendants" living in the target communities through training and education.
2. Increase the number of clinic visits by women and outreach visits to women for prenatal care and tetanus toxoid immunization during pregnancy.
3. Increase the number of deliveries attended by "trained" birth attendants including midwives, husbands or other health personnel.

C. Enhancing Policy Dialogue

1. Develop a project module which describes the process followed and can serve as a guide for other PVO's that would like to replicate the same type of community-level maternal/neonatal intervention.
2. Education and training materials which are developed through the project will be disseminated to other PVO's working in Bolivia through PROCOSI, an umbrella group for PVO's working in child survival, through collaboration with the MOH, and through other appropriate mechanisms.

PROJECT INTERVENTIONS

In order to achieve the above objectives, SC/B used a community-based, participatory approach working with organized women's groups and other community groups and members. From July, 1990 until June, 1993, SC/B and the communities with which it worked developed and implemented the following interventions:

1. Developed, implemented and analyzed a retrospective maternal and neonatal mortality case-control study in 1990 and repeated the study in April-May, 1993 (end of the project);
2. Organized and strengthened 50 women's groups;
3. Developed and implemented a problem identification and prioritization exercise known as the "autodiagnosis" which was carried out by 50 women's groups;
4. Developed and implemented in 22 communities a "planning together" process to respond to prioritized problems with a formal action plan/community agreement;
5. Developed action protocols based on maternal and neonatal health problems identified by the case-control study and the autodiagnosis which were then used as the basis of technical content for the educational materials produced by the women's groups and parteras¹;

1 "Partera", the Spanish term for empirical midwife, is used to represent those individuals who have been selected by their communities for training in safe/clean birth practices and who have begun to serve as community midwives. In Inquisivi, the husband was traditionally the person most likely to attend births prior to the Warmi Project. The concept of a community midwife/traditional birth attendant was unknown in the community. Additionally, during the Warmi Project period (1990-1993) there was no formal certification program for nurse/midwives in the Bolivian education system.

6. Trained women and men in over thirty communities in safe birth practices;
7. Women's groups prepared 300 safe birth kits;
8. Identified and trained 45 parteras in workshops and in practical visits in the field, trained 42 of these parteras at the San Gabriel Hospital in a one-week in-service practical course and supervised their work in the field;
9. In collaboration with a local NGO, educated 682 women and 207 men in family planning methods and during one year of service delivery for one week every month, provided family planning services to 284 new acceptors in 7 communities (total number of women of reproductive age in these communities is 1380);
10. In collaboration with CIEC (a local NGO), women's groups and parteras: developed and produced a manual for parteras, a series of four booklets for women on reproductive health, and 5 radio programs;
11. In collaboration with women's groups, developed a home-based women's health card;
12. Developed and produced an instruction insert for safe birth kits for family use;
13. SC/B field staff and MOH personnel carried out prenatal care visits, tetanus toxoid vaccination, ferrous sulfate distribution during pregnancy, vitamin A distribution post-partum and referral for pregnant women with complications;
14. Developed and used a Women's Health Roster for data collection (used by SC/B field staff) and a summary sheet for consolidated monthly and quarterly data.

In the area of policy dialogue and advocacy, SC/B disseminated the project methodology and experiences through a number of mechanisms including:

1. Participated as a member of the National Reproductive Health Subcommittee for Information, Education and Communication;
2. Conducted a mid-term and final evaluation of the project with participation of MOH La Paz Health Unit staff staff;

3. With JSI/MotherCare, produced and distributed a working paper on the Autodiagnosis;
4. Presented a paper on the project's methodology at the National Council for International Health Conference in 1991;
5. Presented results of the case-control study and mid-term evaluation to members of PROCOSI, the PVO umbrella network in Bolivia, the MOH and international donors;
6. Participated in the Andean Regional Safe Motherhood Conference;
7. Presented project experience at a USAID/Population Council Workshop on Reproductive Health for PVOs working in Bolivia.

The three year project period proved to be too short to implement all of the activities planned. The women's health card was only recently distributed to women's groups in April, 1993. The educational materials developed by the women's groups and parteras were only just finished and have not been used yet in the communities.

FINAL EVALUATION METHODOLOGY

The evaluation methodology included both qualitative and quantitative methods, and was participatory in design, analysis, and writing. A wide range of persons played key roles in implementing the evaluation methodology and interpreting the results (see evaluation team). Emphasis on participation at all levels allowed the team to capture the explicit and implicit achievements of the program.

Quantitative Methodology

A retrospective case-control study was conducted in November 1990 and was repeated in April-May 1993. The results from the 1993 study were compared with those of the original study in order to identify trends in the project indicators. In the original study, all identified cases of perinatal/neonatal mortality (75) and 151 controls were included. The repeated study included all identified cases of perinatal/neonatal mortality (31) and 136 controls. (Two communities were excluded from the second study because they had not participated in the Warmi Project.)

The manual information system was reviewed and results were compared with project goals and objectives as well as with the results of the study.

Qualitative Methodology

Individual interviews were held with: 8 pregnant women; parteras (27); MOH staff at health posts (4) and hospital (1); SC/B staff (15); husbands; women of reproductive age; and, representatives from PROCOSI, San Gabriel Hospital, CIEC and AYUFAM (SOPACOF).

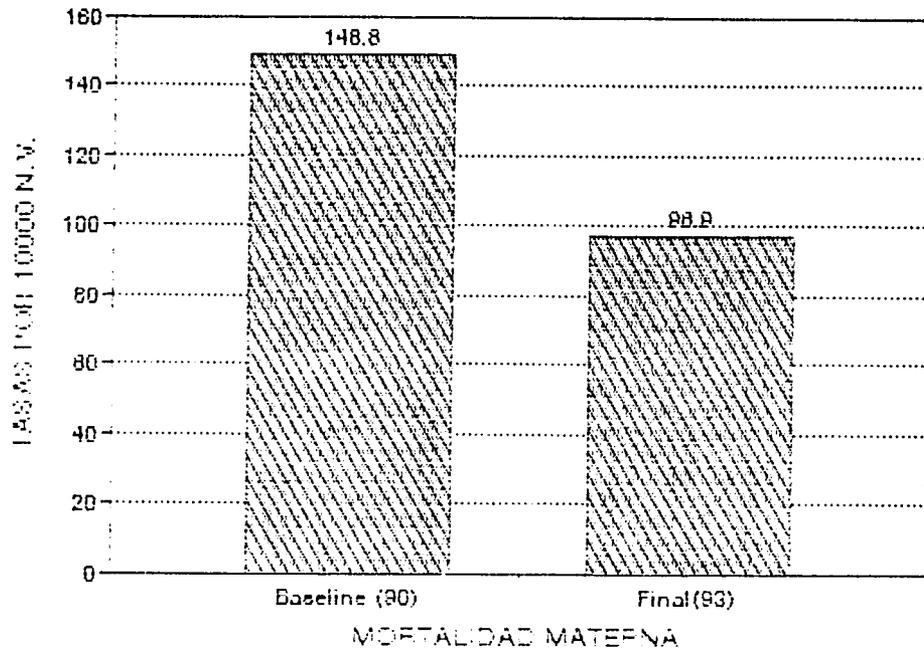
Group discussions were held with: 9 women's groups from the three project zones; parteras at the zonal level; and, local authorities (General Secretaries, etc.) from each zone.

Interview guides were developed by the evaluation team for all interviews. SC/B and MOH staff took a short written exam to determine their level of knowledge regarding several important indicators. The group interviews also utilized several participatory techniques including: a "pile sort" of project intervention cards in small groups; judgments of characters' actions (good, bad, don't know) in stories told by the interviewers; and drawings or written statements of the groups' vision of the future.

RESULTS

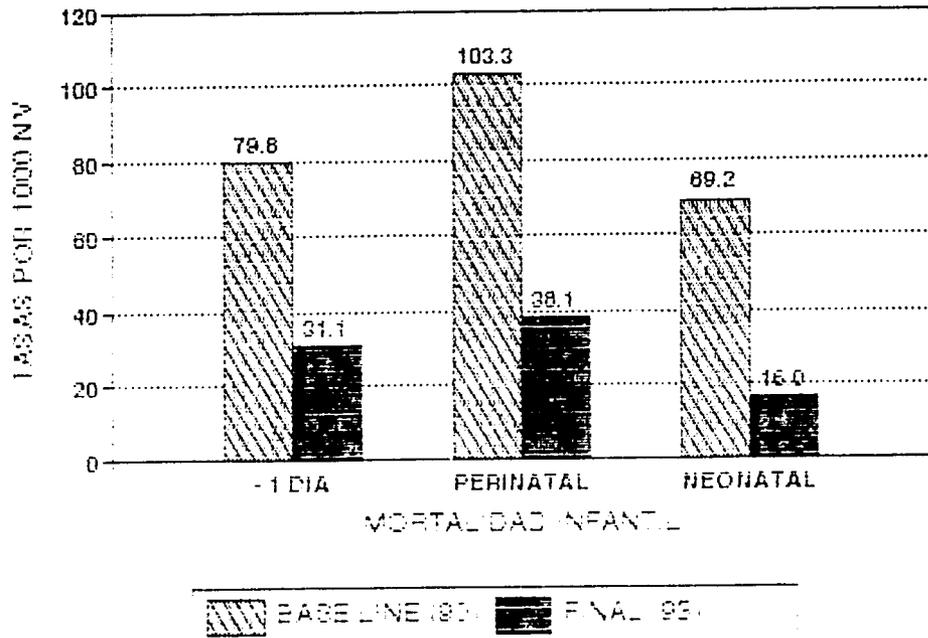
Tables 1-8 present a summary of the results of the final evaluation comparing project objectives as stated in the Project Detailed Implementation Plan with Warmi Project achievements and observations.

MORTALIDAD MATERNA 1990 1993 WARMI - INQUISIVI



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MORTALIDAD INFANTIL 1990 1993 WARMI - INQUISIVI



P R E N A T A L C A R E

OBJECTIVES By June 1993:	RESULTS By June 1993:	ACHIEVED Yes / No	OBSERVATIONS/RECOMMENDATIONS																																
<p>% of pregnant women have 3 prenatal visits the time of delivery.</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="4">Source of data</th> </tr> <tr> <th>No. of visits</th> <th>HIS 7/92-6/93 n=370</th> <th colspan="2">Study 5/93 Cases Controls n=36 n=135</th> </tr> </thead> <tbody> <tr> <td>0</td> <td>23%</td> <td>50%</td> <td>36%</td> </tr> <tr> <td>1</td> <td>42%</td> <td>33%</td> <td>35%</td> </tr> <tr> <td>2</td> <td>15%</td> <td>14%</td> <td>19%</td> </tr> <tr> <td>3</td> <td>15%</td> <td>3%</td> <td>8%</td> </tr> <tr> <td>4</td> <td>5%</td> <td>0%</td> <td>1%</td> </tr> <tr> <td>5</td> <td>0%</td> <td>0%</td> <td>1%</td> </tr> </tbody> </table>	Source of data				No. of visits	HIS 7/92-6/93 n=370	Study 5/93 Cases Controls n=36 n=135		0	23%	50%	36%	1	42%	33%	35%	2	15%	14%	19%	3	15%	3%	8%	4	5%	0%	1%	5	0%	0%	1%	<p>NO</p>	<p style="text-align: right; margin-right: 20px;">55-65%</p> <p>Though the project has not yet achieved its goal of 50% with at least 3 visits, there is a positive trend toward women having contact with health providers. Approx. 65-70% have had at least one visit. Additionally, there was a striking difference between women's perception of the utility of prenatal care as seen in the case-control studies. SC/B should emphasize w/ women, their families and health providers the importance of continuity of care and follow-up.</p>
Source of data																																			
No. of visits	HIS 7/92-6/93 n=370	Study 5/93 Cases Controls n=36 n=135																																	
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3	15%	3%	8%																																
4	5%	0%	1%																																
5	0%	0%	1%																																
<p>% of pregnant women have at least 2 TT vaccines by the time of delivery.</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="4">Source of data</th> </tr> <tr> <th></th> <th>HIS 7/92-6/93 n=370</th> <th>Cases n=30</th> <th>Controls n=136</th> </tr> </thead> <tbody> <tr> <td>TT2 or more</td> <td>79%</td> <td>67%</td> <td>61%</td> </tr> </tbody> </table>	Source of data					HIS 7/92-6/93 n=370	Cases n=30	Controls n=136	TT2 or more	79%	67%	61%	<p>YES</p>	<p>The project should continue to reinforce the importance of TT and continue to strengthen links with the USLP providers so that this intervention remains strong in the long term.</p>																				
Source of data																																			
	HIS 7/92-6/93 n=370	Cases n=30	Controls n=136																																
TT2 or more	79%	67%	61%																																
<p>% of pregnant women identified as high risk will have adequate follow-up care.</p>	<p>___% of high risk pregnant women who received care:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2">Source of data:</th> </tr> <tr> <th>HIS 10/92-6/93 # preg=235 # risk=16</th> <th>Study 5/93 Cases Controls</th> </tr> </thead> <tbody> <tr> <td>31% referred</td> <td>N/A</td> </tr> </tbody> </table>	Source of data:		HIS 10/92-6/93 # preg=235 # risk=16	Study 5/93 Cases Controls	31% referred	N/A	<p>YES</p>																											
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HIS 10/92-6/93 # preg=235 # risk=16	Study 5/93 Cases Controls																																		
31% referred	N/A																																		

N U T R I T I O N

OBJECTIVES By June 1993:	RESULTS By June 1993:	ACHIEVED RECOMMENDATIONS Yes / No								
50% of pregnant women will take iodized salt daily. (changed from 3 doses of iodine during pregnancy, in accordance with MOH)	% who regularly consumed iodized salt <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td>HIS</td> <td>Study (5/93)</td> </tr> <tr> <td>7/92-6/93</td> <td>Case Control</td> </tr> <tr> <td>n=370</td> <td>N/A</td> </tr> <tr> <td>74%</td> <td></td> </tr> </table>	HIS	Study (5/93)	7/92-6/93	Case Control	n=370	N/A	74%		YES Iodized salt appears to be becoming a part of most communities normal diet.
HIS	Study (5/93)									
7/92-6/93	Case Control									
n=370	N/A									
74%										
50% of pregnant women will take 2 three month courses of iron, 1 during pregnancy and 1 postpartum.	% who took iron sulphate <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td>HIS</td> <td>Study (5/93)</td> </tr> <tr> <td>10/92-6/93</td> <td>Case Control</td> </tr> <tr> <td>n=235</td> <td>n=31 n=136</td> </tr> <tr> <td>69%</td> <td>45% 51%</td> </tr> </table>	HIS	Study (5/93)	10/92-6/93	Case Control	n=235	n=31 n=136	69%	45% 51%	YES Only registered those who were pregnant, not post-partum. Difficulty in tracking total number of tablets distributed.
HIS	Study (5/93)									
10/92-6/93	Case Control									
n=235	n=31 n=136									
69%	45% 51%									
50% of postpartum women will receive a megadose Vitamin A capsule within the first postpartum week.	% who received Vitamin A megadose postpartum <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td>HIS</td> <td>Study (5/93)</td> </tr> <tr> <td>7/92-6/93</td> <td>Case Control</td> </tr> <tr> <td>n=197</td> <td>n= n=</td> </tr> <tr> <td>46%</td> <td>N/A N/A</td> </tr> </table>	HIS	Study (5/93)	7/92-6/93	Case Control	n=197	n= n=	46%	N/A N/A	NO This objective is close to being achieved and should be reached within the next year as women become more involved in outreach to women outside the organized groups with the education materials that they developed.
HIS	Study (5/93)									
7/92-6/93	Case Control									
n=197	n= n=									
46%	N/A N/A									
50% of pregnant women will have weight controlled during pregnancy, and 50% of those identified at nutritional risk will be followed up.	Data not available.	N/A Did not implement due to difficulties acquiring scales and measuring tapes. ?								

D E L I V E R Y

OBJECTIVES By June 1993:	RESULTS Avg. % July 1992 - June 1993 according to SC/B Info. System	ACHIEVED Yes / No	OBSERVATIONS / RECOMMENDATIONS
50% of deliveries will be attended by trained person (husbands, TBAs, doctors, other women, pregnant woman herself)	59% of women delivered with trained person (n = 197)	YES	Includes doctors, nurses, asst. nurses, parteras and family members who received training in safe/clean birth.
30% of women identified at risk during delivery will receive care according to protocol.	Data not available	DATA N/A	
No stated objective.	29% of women delivered with safe birth kit (n = 197)	ADDIT ACTIVITY (NOT IN D I P)	Not all communities had prepared safe birth kits. Total available during the project period was 300.

POST - PARTUM / NEONATAL

OBJECTIVES By June 1993:	RESULTS By June 1993:	ACHIEVED Yes / No	OBSERVATIONS / RECOMMENDATIONS									
50% of women who deliver receive at least 2 postpartum visits with partera or supervisor with one taking place within 3 days after delivery.	% of women who delivered who received postpartum care: by source of data: <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%;">No. visits</td> <td style="width:33%;">HIS 7/92-6/93 n=197</td> <td style="width:33%;">Study (5/93)</td> </tr> <tr> <td>0</td> <td>36%</td> <td></td> </tr> <tr> <td>1 +</td> <td>64%</td> <td>N/A</td> </tr> </table>	No. visits	HIS 7/92-6/93 n=197	Study (5/93)	0	36%		1 +	64%	N/A	NO	Objective was not achieved. However, a significant increase in the percentage of women who received at least one visit was achieved.
No. visits	HIS 7/92-6/93 n=197	Study (5/93)										
0	36%											
1 +	64%	N/A										
20% of all women identified with hemorrhage or infection will be managed according to protocol.	% of women with hemorrhage or infection postpartum who received care according to protocol: N/A	N/A	Data collection for this indicator was very difficult and unreliable. <i>Why? This is important for us to understand how to collect such info.</i>									
30% of newborns will be breastfed immediately after delivery (colostrum within 1 hour).	% of newborns who received breastmilk one hour after delivery, by source: <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%;">HIS 7/92-6/93 n=197</td> <td style="width:33%;">Study Cases n=19</td> <td style="width:33%;">5/93 Controls n=135</td> </tr> <tr> <td>61%</td> <td>32%</td> <td>50%</td> </tr> </table>	HIS 7/92-6/93 n=197	Study Cases n=19	5/93 Controls n=135	61%	32%	50%	YES				
HIS 7/92-6/93 n=197	Study Cases n=19	5/93 Controls n=135										
61%	32%	50%										
20% of newborns identified at risk will receive treatment according to protocol.	% of newborns identified at risk who rec'd treatment according to protocol: <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;">HIS 7/92-6/93 N/A</td> <td style="width:50%;">Study 5/93 N/A</td> </tr> </table>	HIS 7/92-6/93 N/A	Study 5/93 N/A	N/A								
HIS 7/92-6/93 N/A	Study 5/93 N/A											

F A M I L Y P L A N N I N G

OBJECTIVES By June 1993:	RESULTS By June 1993:	ACHIEVED Yes / No	OBSERVATIONS/RECOMMENDATIONS															
20% of women in reproductive age will receive training in family planning	681 (27%) WRA trained by AYUFAM in 7 comm. visited	YES	Demand for more information and services is high. This activity should continue.															
* of women who use family planning. (Warmi Project did not fund family planning services.)	<p>% of women 15-49 who use a method of family planning: (n=1380: 7 comm w/ access) HIS (4-12/92) n=1380</p> <table border="1" data-bbox="420 728 752 883"> <tr> <td>IUD</td> <td>80</td> <td>6%</td> </tr> <tr> <td>Condom/Foam</td> <td>124</td> <td>9%</td> </tr> <tr> <td>Pill</td> <td>30</td> <td>2%</td> </tr> <tr> <td>Rhythm</td> <td>50</td> <td>4%</td> </tr> <tr> <td>Total</td> <td>284</td> <td>21%</td> </tr> </table>	IUD	80	6%	Condom/Foam	124	9%	Pill	30	2%	Rhythm	50	4%	Total	284	21%	NO OBJ. SET	Service statistics from April, 1992 to December, 1992 (1 week visit/month). Activities suspended in January, 1993 due to delay in renewal of agreement between AYUFAM and MOH. Services will resume in August with San Gabriel Foundation.
IUD	80	6%																
Condom/Foam	124	9%																
Pill	30	2%																
Rhythm	50	4%																
Total	284	21%																
STDs & Cancer	97 Pap smears tested.	NO	Information not available on STDs due to lack of labs. AYUFAM took 97 PAP smears. Of the 55 smear results that AYUFAM submitted to SC/B, all were normal. The project did not focus on STD detection due to lack of laboratory service and possibilities for treatment.															

WOMEN'S GROUPS

OBJECTIVES	RESULTS	ACHIEVED Yes / No	OBSERVATIONS / RECOMMENDATIONS
By July 1992, 50 women's groups will be established or strengthened.	50 groups	YES	50 groups have been organized in 49 communities (Circuata had 2 groups but have now decided to unite them.)
By December 1992, 50 groups complete ADX	50 groups did ADX	YES 6/93	Delayed, but completed 6/93.
By June 1993, Number of commun. that have designed an action plan	22 commun. have plan	IN PROCESS	Activity continues in remaining groups.
By June 1993, ___% of all women 15-49 participate in a women's group. (No specific goal stated).	32% WRA partic.	NO OBJ. SET	875 women belong to the 50 women's groups. (Total WRA = 2,708)
Of those who attend, ___% attend at least 2x every 6 months.	90%+ attend	NO OBJ. SET	Virtually all participants attend at least 2x every 6 months. All groups meet at least once/month except Huaritolo and Alfajiani.

Data: Life of Project

M A T E R I A L S

OBJECTIVES By June 1993:	RESULTS By June 1993:	ACHIEVED Yes / No	OBSERVATIONS/RECOMMENDATIONS
<p>EDUCATIONAL MATERIALS: Maternal and neonatal health education materials will be developed in Aymara and in Spanish.</p>	<p>List of materials produced:</p> <ul style="list-style-type: none"> - "Reproductive Health: Manual For Community Parteras" - "Pregnancy: Booklet for Women" - "Birth: Booklet for Women" - "Care After Birth: Booklet for Women" - "Care of the Newborn: Booklet for Women" - 5 Radio programs - Instructional insert for safe birth kit - Problem picture cards for the autodiagnosis - Intervention picture cards for use in the final eval 	<p>YES</p>	<p>Materials will be completed by end of project but will not have been implemented in the field. Development took longer than expected but participatory methodology used has led to women's ownership of the materials and to appropriateness. Training curriculum in use of materials is being developed by CIEC for SC/B & MOH staff, parteras and women's groups.</p> <p style="text-align: right;"><i>for other NGOs?</i></p> <p>The materials were produced in Spanish with Aymara when desired by the women/parteras for clarification of some terms.</p>
<p>PVO Manual documenting the project, distributed to members of PROCOSI.</p>	<p>Will be completed 7/93, to be distributed 8-9/93</p>	<p>IN PROCESS</p>	<p>Delay due to length of process to validate methodologies and to document project results (final study, evaluation).</p>
<p>WORKING PAPERS/PUBLICATIONS No specified objective</p>	<p>Written materials completed:</p> <ul style="list-style-type: none"> - "The Autodiagnosis: A Participatory Methodology to Identify and Prioritize Maternal and Neonatal Health Problems in Women's Groups in Rural Bolivia" - "Researching Women's Health Problems Using Epidemiol. and Participatory Methods to Plan the Inquisivi MotherCare Project" 	<p>EXTRA PRODUCTS</p>	<p>Products not contemplated in Warmi Project field agreement.</p>

M A T E R I A L S

OBJECTIVES By June 1993:	RESULTS By June 1993:	ACHIEVED Yes / No	OBSERVATIONS/RECOMMENDATIONS
HIS INSTRUMENTS: By Oct. 1991: Finalized roster for women. Women's home-based card.	HIS instruments finalized and in use: - Women's Health Roster - Women's Home-Based Card - Supervisor's Summary Sheet	YES	The original roster was too complicated. The revised version was recently introduced in the field and should facilitate data collection. The new roster should be evaluated in 3-6 mos. to monitor quality of data and ease of use.
PROTOCOLS: High risk pregnant women Postpartum care High risk deliveries Care of the newborn	Protocols completed, 12/91 by August Burns	YES	The protocols were used as a basis for content of the women's booklets and the partera manual. The health personnel level has not yet been applied in a systematic way for use in training of USLP & SC/B staff. Now that new USLP staff are in place, this training should occur in a systematic fashion.

CONCLUSIONS

In conclusion, the Warmi Project achieved most of its objectives as stated in the Detailed Implementation Plan and the Field Agreement with JSI. All project products were delivered, as well as many that were not originally contemplated.

A new methodology of working with rural women with little access to health services was developed, tested and implemented. Although three years is too short a period to make definitive statements, it appears to be an effective, relatively low cost, although human resource intensive model.

A follow-on project to test the efficacy of the materials just completed at the end of this project and to test the replicability of the model to other areas of Bolivia is recommended.

RECOMMENDATIONS

Many important specific recommendations are made in this report. This section will present general recommendations which attempt to synthesize the essence of the specific points mentioned in the body of the document.

1. The project has worked within the existing Ministry of Health norms and has demonstrated positive trends toward reducing maternal, perinatal and neonatal mortality. However, much more could be done to further reduce the high mortality rates if norms were adapted to the rural context. Parteras could play more of a role in stabilizing patients with life-threatening complications (manual extraction of placenta, use of oxytocin in cases of severe hemorrhage, use of antibiotics for puerperal sepsis, etc.) and could serve as community-based family planning service providers of at least some methods. The revival of "matrona" (nurse/midwife) training and certification is recommended so that this valuable member of the health team can help supervise and support community parteras at the district level.
2. SC/B's participatory, community-based approach (autodiagnosis, planning together, implementation and participatory evaluation) is a simple model that has been effective in increasing women's and their families' awareness of maternal and neonatal health problems and provides a framework within which to generate realistic solutions at the community level. It is recommended that this approach be tested by other PVOs to determine whether it is applicable to other

similar rural areas. This approach can only be effective if donors who fund, and implementors who execute, these efforts are flexible to respond to community needs as identified by community members. The Warmi Project was fortunate to have had this financial and programmatic support from AID/Washington and Bolivia, John Snow, Inc., Save the Children and its local counterpart organizations.

3. Women's self-esteem and empowerment play an important role in whether women, and their families, choose to seek adequate health care--if women value their life/health they are more likely to seek services to save their lives. The process of women's empowerment is an integrated one that involves access to information through education, access to economic resources, etc. Though reduction in maternal mortality requires adequate health services, these services, even when well staffed and equipped are only effective if women arrive. The "Pathway to Survival" model (Annex 6) as developed by Dr. Alfred Bartlett with the SC/B team does not begin at the hospital door, but rather the hospital is nearly the last step in a very long and complicated personal, social and cultural process. Institutions that choose to implement a program to reduce maternal and perinatal mortality should either address these issues directly or should coordinate with other institutions and agencies to help empower women and their families.
4. In developing educational materials and training curricula, health and other field personnel should not approach communities with pre-set messages based on the biomedical model. New and improved practices should be negotiated based on mutual respect for one another's beliefs and practices. It is only when existing beliefs and practices are not only taken into account, but respected that true dialogue can begin and a realistic, "improved" practice be found.
5. SC/B zonal quarterly evaluation and planning meetings were determined to be extremely useful to constantly monitor and reinforce the program vision so that the field staff don't get stuck in the "micro view". The delegation of responsibilities and authority to zonal quality circles helped staff to internalize participatory planning and decision-making processes. These skills are critical not only to smooth functioning of the program, but more importantly, so that field staff can facilitate this process in the communities in which they work.

I. BACKGROUND

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

The rural Province of Inquisivi lies approximately five hours by road southeast of La Paz. The province is characterized by high plains (altiplano), high Andean valleys, and subtropical valleys. The population in the defined project area is approximately 15,000 and is predominantly of Aymara (native American) extraction. Quechua migrants are also found in the lower valleys. The project area encompasses nearly 5,000 square kilometers with difficult access to the population. Roads are poor and many communities can only be reached after several hours on foot. Means of transport are scarce and unpredictable.

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

Health care services in the province are provided by the Ministry of Health. There is one health post in Licoma zone and one in Inquisivi zone. These health posts are staffed by one doctor each carrying out the mandatory one year rural medical service. One auxiliary nurse assists the doctor in each of these posts. Circuata zone is served by one auxiliary male nurse. The posts are stocked with the bare minimum of essential basic medicines and equipment. The reference hospital in Quime does not meet the minimum WHO standards for a health post. It is staffed with 3 doctors (cardiologist, surgeon, pediatrician), 2 nurses, a part-time

dentist and custodian. The hospital cannot cope effectively with major complications which require surgical intervention due to a lack of sterilization and anesthesia equipment. There is an ambulance available for use by the Quime Hospital but it is often out of service due to poor maintenance, lack of spare parts and lack of funds to purchase gasoline. All health facilities are under-utilized by the population, in part due to economic factors, in part due to socio-cultural factors and in part due to the population's justified belief that the services are not equipped to deal with complicated problems. Women who present complications during their pregnancies or labors are usually counter-referred to La Paz or Oruro (4-6 hours by road).

WOMEN IN INQUISIVI, LICOMA AND CIRCUATA COMMUNITIES

As described above, the Warimi Project works in three geographic zones of Inquisivi Province (Inquisivi, Licoma and Circuata) that vary widely in their socio-cultural characteristics. The families in the Inquisivi Zone tend to be older, more well-established and stable than those of the Circuata Zone. Formerly labeled "peons", these families have lived in the Inquisivi Zone for generations. The women tend to be less literate and Spanish speaking than the women of Licoma and Circuata. The majority are Aymara, but a significant minority are Quechua. The people are characterized as "altiplanicos" (i.e. closed, distrusting of outsiders, with very deep seated customs and less desire for change or "progress"). The homes of Inquisivi Zone families are much more dispersed than those in the Circuata communities. These communities, for obvious reasons, offer a great challenge to behavior change.

In contrast, the communities in Circuata Zone are newer, or, if old, have a number of recently immigrated families. In at least three of the communities, the entire population migrated as a unit to found the new villages. Though these new families are also descendents of altiplanic (highlander) people, the fact that they are a self-selected group of immigrants which has initiated change implies that they are more interested in, and accepting of, change, progress or improvement in their lifestyle. They are therefore more anxious to work in projects that they believe will influence their development. They are more open in their praise and criticism. The villages are more concentrated than in Inquisivi Zone. The women are also more apt to be bilingual and have, in general, attained a higher level of formal education than the women of Inquisivi Zone.

Men and women in the Inquisivi Province are bound by a tight family structure and rigid sexual roles. Traditionally, women have not participated in the decision-making process for community activities; it is usually the husband who has

voice and vote in the monthly community meetings and if women attend they are never heard. The village authorities may be elected or may serve in turn; the only time a woman is found in this position is if she is a widow of a former member and if she owns land.

In many of the communities, CARITAS Bolivia stimulated the organization of mother's clubs and carried out health (mostly oral rehydration and growth monitoring) and homemaking activities. The women were given food supplements provided by the US government under the PL-480 program in exchange for their attendance. When food donations stopped in the province in 1989, many of these groups either lost members or disbanded completely. Non-Catholic women, which comprise a significant proportion of the population, have always been excluded from these groups.

Before the Warmi Project began in 1990, 20 women's groups were formed-- 16 responding to SC's strategy of training women's groups in horticulture to increase vitamin A intake and 4 were initiated by women's unions with the support of SC staff.

Not only is the community led exclusively by men, but in the family, it is the man who most often makes all financial decisions. Most SC field staff have witnessed cases of husbands deciding that it would cost too much to send a woman with complications during her labor or pregnancy to the hospital (3-7 hours by road, not including the time spent trying to gain access to transport). The cost of a caesarian, for example, may represent 6 or more months of cash income. The family is then left to make do with the few available local resources. This not uncommon scenario has contributed to the high maternal and perinatal mortality rates in the province.

There are no exact data about the degree of domestic violence found in Inquisivi Province, but a man is expected to beat his partner. The occasional beating is not identified by either man or woman as a problem unless it is continuous or results in serious injury or death. It is done openly and the children and neighbors become silent witnesses to it. Very often, alcohol consumption by the man or the couple is a prelude to violence.

PROJECT INTERVENTIONS

During the three year period from July 1990 to June 1993, the SC/Bolivia Warmi Project:

- here
are your* 
1. Developed, implemented and analyzed a retrospective maternal and neonatal mortality case-control study in 1990 and repeated the study in April-May, 1993 (end of the project);
 2. Organized and strengthened 50 women's groups;
 3. Developed and implemented a problem identification and prioritization exercise known as the "autodiagnosis" which was carried out by 50 women's groups;
 4. Developed and implemented in 22 communities a "planning together" process to respond to prioritized problems with a formal action plan/community agreement;
 5. Developed action protocols based on maternal and neonatal health problems identified by the case-control study and the autodiagnosis which were then used as the basis of technical content for the educational materials produced by the women's groups and parteras;
 6. Trained women and men in over thirty communities in safe birth practices;
 7. Women's groups prepared 300 safe birth kits;
 8. Identified and trained 45 parteras in workshops and in practical visits in the field, trained 42 of these parteras at the San Gabriel Hospital in a one-week in-service practical course and supervised their work in the field;
 9. In collaboration with a local NGO, educated 682 women and 207 men in family planning methods and during one year of service delivery for one week every month, provided family planning services to 284 new acceptors in 7 communities (total number of women of reproductive age in these communities is 1380);
 10. In collaboration with CIEC (a local NGO), women's groups and parteras: developed and produced a manual for parteras, a series of four booklets for women on reproductive health, and 5 radio programs;
 11. In collaboration with women's groups, developed a home-based women's health card;
 12. Developed and produced an instruction insert for safe birth kits for family use;
 13. SC/B field staff and MOH personnel carried out prenatal care visits, tetanus toxoid vaccination,

ferrous sulfate distribution during pregnancy, vitamin A distribution post-partum and referral for pregnant women with complications;

14. Developed and used a Women's Health Roster for data collection (used by SC/B field staff) and a summary sheet for consolidated monthly and quarterly data.

In the area of policy dialogue and advocacy, SC/B disseminated the project methodology and experiences through a number of mechanisms including:

1. Participates as a member of the National Reproductive Health Subcommittee for Information, Education and Communication;
2. Conducted a mid-term and final evaluation of the project with participation of MOH La Paz Health Unit staff staff;
3. With JSI/MotherCare, produced and distributed a working paper on the Autodiagnosis;
4. Presented a paper on the project's methodology at the National Council for International Health Conference in 1991;
5. Presented results of the case-control study and mid-term evaluation to members of PROCOSI, the PVO umbrella network in Bolivia, the MOH and international donors;
6. Participated in the Andean Regional Safe Motherhood Conference;
7. Presented project experience at a USAID/Population Council Workshop on Reproductive Health for PVOs working in Bolivia.

In addition to MotherCare activities, SC/Bolivia is working in the areas of child survival and nutrition, economic development, sustainable agriculture (including micro-irrigation) and education. In FY 92, SC/Bolivia added the "Woman Child Impact Program" (WCI) to its portfolio as a direct outcome of MotherCare Project activities. This program focuses on strengthening existing programs and adds literacy training and credit for women since illiteracy and

the lack of income were identified by women during the autodiagnosis as major contributing factors to their health problems. WCI is complementing the work of the MotherCare Project in many of the same communities.

A shift in SC/B's overall strategy occurred in 1993 based on the results of the final evaluation of a Child Survival Project in Quime zone. The project's strategy of house-to-house vaccination was determined to be unsustainable. Therefore, SC/B changed its strategy to that of "integrated fairs" of two to three days in each community every two to three months. Household visits to educate families about the importance of vaccination, growth monitoring and other preventive health interventions continued. However, there was a noticeable drop in coverage rates during the first two quarters of implementation of the new strategy as staff adjusted to the change. The lower rates are also reflected in the Warmi Project in number of pregnant women and births detected. SC/B believes that the rates will increase again as the new strategy of "integrated fairs" takes hold.

A mid-term evaluation of the project focussing primarily on process indicators was conducted in April, 1992 (see Mid-term evaluation report for details). This report presents the findings of the project final evaluation. In this final evaluation the team studied both quantitative and qualitative data and information in order to review the progress made by the project and to determine to what extent project goals and objectives were met.

THE FINAL EVALUATION TEAM

The evaluation team involved both external and internal evaluators.

External team members provided expertise and knowledge in women's reproductive health and community development in rural Bolivia. They also contributed valuable insights based on their experience with similar programs, provided depth of understanding, and suggestions for improvement. Several external members participated because of their interest in replicating components of the project, enhancing the quality of complementary services, or providing support in the future.

Internal team members included both project staff and members of Warmi women's community groups. For both, it was an opportunity to reflect on program achievements and lessons learned, and to identify areas of improvement. SC/B project staff continuously emphasized the need to be honest, critical, and constructive during the evaluation. Internal team members played a central role in facilitating the logistics and process, but deferred to external members for the final analysis, recommendations and conclusions.

The evaluation was enlightened and benefitted greatly from the involvement of Warmi women's group members. Interestingly, it seemed that it was these women from the community who gained the most from participating in the evaluation. They expressed tremendous interest in the organization and activities of women's groups in the other communities they observed, and were eager and excited to share and apply their findings within their respective communities and women's groups. In this regard, the evaluation served as a useful tool for establishing the basis for the next phase of the project.

The members of the team and their institutional or community affiliations are listed on the page directly after the title cover page. The next section presents the methodology used by the evaluation team.

II. EVALUATION METHODOLOGY

The evaluation methodology included both qualitative and quantitative methods, and was participatory in design, analysis, and writing. A wide range of persons played key roles in implementing the evaluation methodology and interpreting the results (see evaluation team). Emphasis on participation at all levels, allowed the team to capture the explicit and implicit achievements of the program.

During the first evaluation meeting, the core team of evaluators expressed their expectations, decided on the key contents and the evaluation methodology, and assigned the roles and tasks of evaluation team members. A similar meeting was conducted in the field to incorporate the input of field staff and women's group members who assisted with the evaluation. Questionnaires and guides used for the evaluation were developed by various team members, and are included in Annex 1. A schedule of events of the evaluation can also be found in Annex 1.

Methodology: A number of qualitative and quantitative methods were applied and are listed below:

- **Review of key documents:**
 - . Mid-term evaluation report
 - . Proposal and field agreement
 - . Quarterly reports
 - . Detailed Implementation Plan
 - . Documents produced by the project or about the project
- **Analysis of quantitative data:**
 - . Analysis of data from case control studies (baseline and final)
 - . Analysis of data in the manual information system
 - . Analysis of data in the computerized information system.
- **Interviews with beneficiaries:**
 - . Members of women's groups
 - . Husbands of members
 - . Pregnant women
 - . Parteras
 - . Community leaders/authorities
- **Group exercises and discussions with beneficiaries regarding:**
 - . History of community involvement with Project Warmi: group discussion
 - . Change in knowledge and attitudes on practices related to reproductive health: stories (see Annex 1).
 - . Assessment of community priorities: pile sort of priority interventions (see Annex 1)
 - . Presentation of the group's vision of the future of the group (drawings and discussion).

These group exercises were done with:

- . Members of women's groups
- . Parteras
- . Community leaders/authorities

- **Interviews with collaborating organizations including:**
 - . Local health unit doctor and a visit of clinic facilities.
 - . PROCOSI, SOPACOF, CIEC, San Gabriel Foundation
- **Interviews with SC/B staff**
 - . Program administrators / managers
 - . Field staff / implementors
- **Review of educational materials produced by the project**
 - . Manual for Parteras
 - . Four booklets by and for women
 - . Protocols
- **Review of Health Information System tools used by the project**
 - . Woman's health card
 - . Women's roster: old and new
 - . Computerized information system

To evaluate knowledge and practice of individuals:

- analysis of data from case control studies (secondary data);
- analysis of data from monitoring system/HIS;
- questionnaire/interview of individual women who were pregnant or delivered in the past year.
- group discussions with women (adolescents, reproductive age, and elderly women);
- skits with women in women's groups;
- group discussions with husbands/men;
- in women's groups asked them to draw what their group will look like in 5 years, and to describe what steps they will take to get there (sustainability); and,
- group rating of actions taken by characters in stories describing pre-natal care, delivery, etc. using green, red and yellow cards to show respectively whether action was good, bad or the participant was not sure.

To evaluate knowledge and practices of health providers:

- analysis of data from case control studies (secondary data);
- analysis of data from monitoring system/HIS;
- questionnaire/interviews with individual parteras;
- Group discussions at zonal level with parteras using stories and red/yellow/green cards, skits;
- Interviews with MOH staff at hospital and health posts; and,
- Short written exam for MOH and SC/B staff.

To evaluate collaboration with others:

- Group discussion with General Secretaries of the Agrarian Unions (local authorities);
- Interviews with MOH staff;

- Visit to hospital and health posts; and,
- Interviews with key personnel from SOPACOF, San Gabriel Foundation, CIEC and PROCOSI.

To evaluate quality, distribution and use of materials developed:

- Review of materials and documents;
- Two observations of development/validation sessions; and,
- Discussion with women's groups, parteras, CIEC, SC/B staff on the development and use of the materials.

To evaluate the ability of groups to prioritize problems, make decisions, and take actions on their own behalf:

- Observations of women's groups;
- Discussions with groups and individual women;
- Drawing of where women's groups see themselves 5 years from now;
- Review of community organizing process; and,
- Review of project documents.

To evaluate existing maternal and neonatal services:

- Visit to local health facilities;
- Discussion with health care providers; and,
- Evaluation of supplies, equipment, and infrastructure available.

To evaluate administration, budget, costs, personal:

- Discussion with SC/B Co-Director Bob Grabman;
- Review of project financial and administrative documents and systems; and,
- Discussions with Impact Area Manager and Administrator.

To evaluate sustainability and replicability of the project

- Review of project documents;
- Review of evaluation results; and,
- Group discussions with women's groups, parteras, local authorities, MOH and SC/B staff.

To evaluate relative changes in health practices from the beginning of the project to the end of the project, the case-control study that was conducted at the beginning of the project (November, 1990) was repeated at the end (April-May, 1993). A summary of the study methodology follows.

INVESTIGATION: RETROSPECTIVE CASE-CONTROL STUDIES (PRE/POST)

Methodology

At the beginning of the Warmi Project a retrospective case control study of perinatal and neonatal mortality was conducted. The study questionnaire consisted of three parts:

1. Demographic and community characteristics
2. Verbal autopsy of cases to determine probable cause of death
3. "Process diagnosis" to determine where the search for adequate care broke down

The questionnaire also included many questions regarding practices related to pregnancy, birth, post-partum and neonatal care. (See Annex 2 and A. Bartlett Trip Report, March-April, 1991, MotherCare).

This initial study included interviews of families of all identified cases (75) within the previous 2 years and double the number of controls (151) selected randomly from births registered from the same communities during the same time period in the SC/B computerized information system. Cases were identified through the SC/B information system (manual and computerized) and through inquiries in the communities with health promoters, local authorities and MOH health personnel.

The Warmi Project conducted the same study again in preparation for this evaluation. The same methodology and questionnaire were used with one exception: the number of controls for the final study was the same as the number of controls in the baseline study (for example if 8 controls had been interviewed in Canguí Chico during the original study, 8 controls were also interviewed in the final study) except those communities that were not participating in the Warmi Project (2). They were discarded making the control sample size 136 instead of 151. Thirty-one (31) cases were identified using the same methodology as in the first study.

Each variable of the questionnaire was analyzed for pre/post changes (both positive and negative) of statistical significance comparing pre-cases with post-cases and pre-controls with post-controls.

FINDINGS

Tables 9, 10, 11 and 12 present only the pre-post differences related to project indicators that were determined to be statistically significant based on Chi-square and "p" values. In some instances, only cases or only controls are presented because no significant change in the other was observed. The study findings regarding important Warmi Project indicators are presented in bar graph form as Annex 3.

Also include here findings re mortality

Table 9		
COMMUNITY ORGANIZATION/PARTICIPATION/RESOURCES		
Significant Findings From Case-Control Studies Warmi Project		
	Baseline (1990)	Final (1993)
Existence of Women's Groups in the community (cases)	36%	71%
Existence of Women's Groups in the community (controls)	30%	69%
Existence of trained midwives in the community (controls)	65%	83%
Mother belongs to the women's group (cases)	8%	42%
Mother belongs to the women's group (controls)	7%	57%

I find this analysis difficult to interpret given some data for cases, some for controls. Think it might be useful to look at odds ratios of $\frac{\text{cases}}{\text{A control}}$ - will discuss with B. Kwasi

Table 10

PREGNANCY

Significant Findings From Case-Control Studies
Warwi Project

	Baseline (1990)	Final (1993)
Urinary infection during pregnancy (cases)	7%	39%
Urinary infection during pregnancy (controls)	9%	27%
Prenatal care done by auxiliary (cases)	7%	23%
Prenatal care done by auxiliary (controls)	9%	25%
Prenatal care done by SC/B field supervisor (controls)	18%	35%
Believe that prenatal care is useful (controls)	60%	87%
Did not give opinion on prenatal care (cases)	63%	26%
Did not give opinion on prenatal care (controls)	38%	10%
Received ferrous sulfate during pregnancy (cases)	15%	45%
Received ferrous sulfate during pregnancy (cases)	17%	51%
Received teas during pregnancy (cases)	13%	35%
Received abdominal massage during pregnancy (controls)	44%	24%

} how determined (put question in note at bottom)

Some (do you mean controls?)

? during labor?

TABLE 11

BIRTH

Significant Findings From Case-Control Studies
Warmi Project

	Baseline (1990)	Final (1993)
Birth at home (controls)	96%	84%
Birth at mother's house (controls)	1%	8%
Promoter helped at the birth	0%	6%
Pushed when baby was at point of being born (controls)	55%	73%
"Manteo" (rocking) during labor (controls)	50%	30%
Abdominal massage during labor (controls)	53%	27%
Use of "pujante" teas (controls)	15%	4%
Birth position lying on back (controls)	33%	47%
Birth on old and dirty bed (controls)	33%	2%
Birth on bed w/ clean cover/blanket (controls)	31%	53%
Birth on clean plastic (controls)	3%	19%
No help used to expel placenta (controls)	47%	64%

Table 12

CARE OF THE NEWBORN & POST-PARTUM

Significant Findings From Case-Control Studies
Warmi Project

	Baseline (1990)	Final (1993)
Grandmother attended to baby (controls)	24%	9%
Used razor to cut cord (controls)	8%	22%
Washed cutting instrument with water (controls)	17%	33%
Used alcohol to disinfect cord ties (controls)	30%	44%
Washed cord ties with water (controls)	5%	15%
No disinfectant of cord ties (controls)	58%	39%
Resuscitated baby	3%	13%
Breast-fed immediately after birth (controls)	25%	50%
Cases looked for inadequate care Sample is small and not stat. significant, but fact that no one looked for inadequate care is interesting.	7%	0%
Mother was washed after birth (controls)	47%	69%

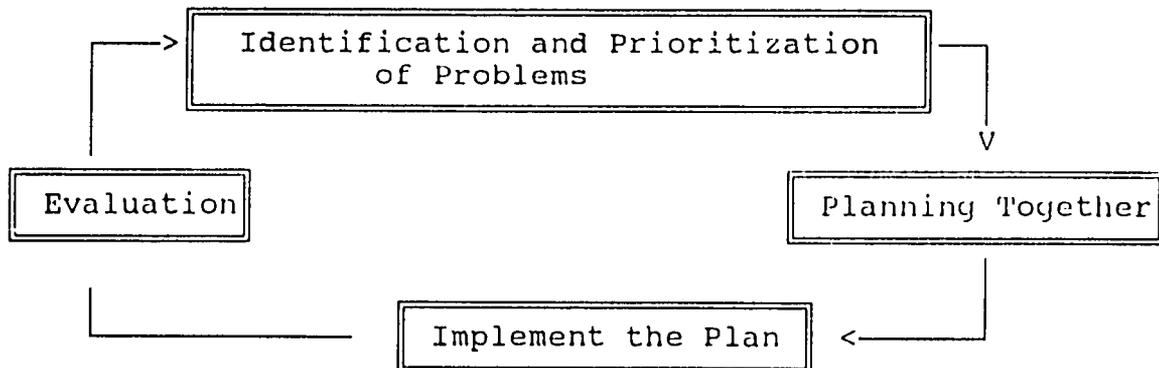
III. COMPARISON OF GOALS/OBJECTIVES TO ACHIEVEMENTS

Tables 1-8 included in the Results section of the Executive Summary present a summary of the quantitative results and products as compared with the objectives per the project's Detailed Implementation Plan. The sources of these results include the case-control studies conducted at the beginning and end of the project and consolidated information from the manual information system during the last year of the project (July, 1992-June, 1993).

The project achieved most of its objectives with the exception of increasing the number of prenatal visits to 3 for 50% of identified pregnant women and increasing the number of post-partum visits to 2 for 50% of identified post-partum women. In both cases, the percentage of women who received at least one visit for prenatal and post-natal care increased significantly, but the percentage of multiple visits did not reach the project's objectives. The project objective that 50% of identified post-partum women will receive a megadose of vitamin A was almost reached with 46% of identified post-partum women having received vitamin A.

Some project objectives were impossible to measure given the time and financial constraints of the evaluation and the limitations of the study and information system data. In these cases, the tables present the indicator and states that the information was not available ("N/A").

The process can be summarized visually in the following manner:



Save the Children clearly structured the steps of this process, first the "Autodiagnosis" and then "Planning Together". The components of these two steps are described below.

The Autodiagnosis

The "Autodiagnosis" constitutes a process that facilitates women in the identification and prioritization of the different maternal and neonatal health problems that affect their lives, the lives of their families and of their community. In addition to facilitating the in-depth analysis of these problems, it leads to exploration of their roles as women in the home and the community.

Steps of the Autodiagnosis

The Warmi Project was promoted in general community meetings and in existing women's groups. In those communities where groups did not already exist, Warmi supported their organization detecting community interest. When a group was organized, SC/B staff promoted the Warmi Project by introducing the theme of maternal and neonatal health in general terms as they affect the community and the personal lives of the women in the group (step 1). The women explored attitudes and knowledge related to: pregnancy, birth and maternity (step 2); they identified maternal and neonatal health problems in the groups, then developed a "dictionary of terms" so that the problems could be identified homogeneously (step 3); the women were then prepared to reflect and ascertain whether other women in the community had the same problems (step 4), motivating them to collect more information and preparing materials to help them carry out individual interviews (step 5). Individually, the women interviewed other women in their communities (step 6), they later shared their experiences and the information that they had collected with the group

IV. COMMUNITY ORGANIZATION AND PARTICIPATION (WOMEN'S GROUPS, AUTODIAGNOSIS AND PLANNING TOGETHER)

Context of the Warmi Project in Inquisivi

In general, community dynamics are different in the communities and the towns. The communities consist of a smaller number of families where access to services and existing infrastructure is reduced in comparison with the towns; because of this, the necessity for organization and participation is greater. The towns have several important advantages: access to health and education services, roads and other basic services. The participation in groups responds to other needs complimentary to daily life, but is not as critical as in the case of the communities.

SC/B works actively in the three zones, using its human resources for promotion, training, supervision and monitoring of the Warmi Project as well as other projects in health, education, economic development and sustainable agriculture.

The Field Coordinator of the project supervises the work of the field supervisors who are responsible for the work with the communities and their organized women's groups; an educator also supports the work by strengthening the women's groups and their training.

Methodology;

The methodology designed and applied by Save the Children was active participatory education, widely accepted by the rural women because it reinforces the cultural experience of Aymara and Quechua whose reference is life in the community.

A strategy was developed to reach the fundamental objective to "reduce maternal and neonatal mortality by affecting the behaviors that impact on pregnancy, birth and the neonatal period". Through the organization of women's groups in the different towns and communities, awareness was created about maternal and neonatal health problems.

This strategy is a cyclical process that enables women and their communities to organize themselves and participate, identify their problems (autodiagnosis); develop together a plan to solve them; put into practice the plan; and finally, conduct an evaluation of the whole process.

(step 7) in order to prioritize the problems based on their frequency, severity and feasibility to be solved (step 8) in the future; they finished with an evaluation of the process (step 9).

Planning Together

When the autodiagnosis ended in a community, "planning together" was begun. (In the first 25 communities there was a lag of 6-8 months between ending the autodiagnosis and beginning the planning together stage, since the methodology guide had not yet been developed--not the optimal situation.) During the preparation phase of "planning together", the women's group analyzed why they prioritized the problems and how they would present this information to the community. In the second phase which takes place in a community meeting, the women presented these problems to the group using skits and other instruments during which time the participants from the community identified barriers and obstacles to receiving adequate care. Once the community had understood the problems, they identified strategies to solve them; they formalized the assignment of responsibilities in a written document that served as a testimony and promise. The activities that the group agreed to should be implemented within a determined time period after which the community should evaluate the process and their results. The cycle begins anew with the identification and prioritization of new problems.

Annex 4 presents a timeline of each community's progress in the cycle described above by quarter and their current status and an example of one community's plan.

Impact of the Process

The Warmi Project realized its goal to organize 50 women's groups and to carry out the autodiagnosis in each of the groups. The "planning together" step was completed in 22 communities in a period of almost 6 months (November, 1992 to June, 1993). The action plans in these communities are currently being implemented and will be evaluated by the communities at the time that they have determined.

According to interviews with women's groups, husbands and authorities in the different communities and using an exercise in prioritizing the interventions of the Warmi Project, the majority of the participants listed the organization and strengthening of women's groups as the most important intervention of the project.

Participatory Evaluation

The Warmi Project has not yet completed the methodological guide to the Participatory Evaluation stage of the cycle, but intends to continue to develop this last stage.

This final evaluation was, in many respects a participatory evaluation of the global project. Nine women representatives elected from their respective women's groups were active participants in the evaluation. They conducted interviews, helped to create and observed various qualitative evaluation methods and assisted in the analysis of the information collected. At the beginning of the evaluation, most of the women were shy and reserved and a little intimidated at the thought of a formal evaluation. By the end of the week of field work, all spoke and laughed freely within the team; they shared their observations openly with the other members of the team. One woman remarked:

"Before the evaluation, I thought that our group was the best one, but now I see that there are others who are better organized than we are. I will go back home and share what I have learned with my group."

The experience of participating in the evaluation and meeting other women leaders was a very positive one. It motivated two women leaders from Licoma zone to borrow their husbands motorcycles to visit other women's groups in Licoma so that they could organize themselves at the zonal level.

What does it mean for women to organize themselves?

The first step for the women was the organization in groups which led to the increasing awareness of their role in the family and the community and the search for a common space in which to share worries, desires and problems.

"The need to organize was latent in the women, we only served as the impulse and they did it". (Elsa Ramos, Field Coordinator of the Project).

The success in the consolidation of the women's groups was motivated by a prime objective identified by the Warmi Project; that of raising awareness in the woman about her health. Before the Warmi Project began, women knew that they and their children were dying. However, not much was done about this because the woman was not subject to decision-making. In addition to not having the economic resources to make decisions, she was ignorant of the importance of the health component of her life and of the possibility to face the danger of mortality through new knowledge that would generate new attitudes and practices.

New expectations were created and this guarantees a better and healthier life.

Positive Aspects

The women realized that they could identify their health problems and that they could improve their quality of life (diet, nutrition, vaccination, prenatal care, safe/clean birth, etc.) and they didn't stop there. Their desire to improve themselves demanded a need to improve their education, to learn how to read and write; to solve nutritional problems by planting family and community gardens; to develop economic strategies through credit in seed and other activities.

Leaders arose who promoted changes and who were encouraged and trained. These leaders took advantage of the opportunity the project offered to identify and train community parteras.

Solidarity of community women grew through shared monitoring networks in the detection and follow-up of maternal and neonatal health problems of community women.

"In Suri, my community, a young woman was going to have her first baby. She was hemorrhaging and her husband didn't want to take her to the doctor because he said they didn't have money. We were checking on and visiting the woman who continued to get worse. Finally, we met in our women's group and we scolded the husband, : "Well, if you're not capable of helping your wife, if you're going to leave her like that, we will take her, we won't leave her to die." The man reacted and took his wife so that she could be treated, and the baby was born after and was fine."
(Conversation with Isabel, partera from Suri).

Once the groups had matured and their presence was noted, the husbands and authorities got involved. In some cases the women's groups maintain formal links with the "sindicatos" (agrarian unions) as in the case of Circuata; in others the groups chose to become mixed such as in Lacayotini.

The men recognized a more protagonistic role of women and became aware of its importance. Now they support their women and note a qualitative change in their lives. Some of the testimonies heard during the evaluation are mentioned below:

"The health of our family depends on the level of training of the woman. She organizes family life and is closer to the children. The man is in the house only as a visitor. (Meeting with husbands and authorities in Licoma.)

"The trained women help their husbands more, in work, in business, even up to doing errands in the city." (Meeting with husbands and authorities in Licoma.)

"The Warmi Project has helped the woman to raise herself up." (Meeting with husbands and authorities in Licoma.)

"The women have strengthened their organizations, now they have voice and vote." (Meeting of authorities in Inquisivi).

The men are conscious that through their wives they now know much more about health and safe/clean birth; they now accept prenatal care. They express an immense desire that approaches that of the women to receive training in these topics.

Included in the positive findings is the women's vision of the future (in the next five years) are:

- Better organization and unity;
- Families which are not numerous, with children who are well educated and healthy;
- A better economic situation;
- A well-equipped health post;
- Homes complete with water, electricity, latrine and shower;
- Better nutrition;
- Less illiteracy; and,
- More training for women in safe/clean birth and family planning.

The SC/B field staff also perceived important changes in the communities in: the participation of the women in the community and the organization as a function of their own needs. "The women aren't timid anymore, they talk, participate." There is communication between groups, they share experiences--the processes of knowledge and training are expanding. In terms of their practices, the staff mentioned that now the women want to educate themselves and improve their lives, they ask for prenatal care and the maternal and neonatal mortality has decreased (Personal interviews with field staff)

Negative Aspects

Save the Children had some difficulties with women's groups that had already been organized. In various communities where the Warmi Project began work other NGOs had already worked there; one case in particular was that of CARITAS whose criteria for work with women was in distribution of food to mothers with children from 0 to 5 years old. The groups were organized in return for food distribution. This conditioning created an initial negative response when SC/B proposed another vision radically different to motivate organization: that of raising awareness about maternal and neonatal health.

The husbands were also conditioned to receiving food, insisting that their wives bring home something after each meeting. "What are you doing in this group, you're wasting your time and not getting anything in return, '... this is what our husbands used to say to us".

(Conversation with Aleja Alejandro from the community of Lacayotini).

The men also exhibited "macho" behavior, hoping that their wives in the women's groups would learn how to weave, sew and knit. They were surprised that they learned other things.

According to interviews held with SC/B field supervisors, at the beginning of the Warmi Project, the husbands would occasionally cause problems by not letting their wives attend women's group meetings. Other identified difficulties were long distances and lack of transport; and the negative attitudes of some community leaders who did not understand or did not agree with the institution's philosophy and created false rumors and comments. (Some of these leaders with negative attitudes wanted SC/B to donate things to them and their communities without a community counterpart).

V. INFORMATION, EDUCATION AND COMMUNICATION

The goal of the Information, Education and Communication (IEC) component of the Warmi Project is to improve knowledge, attitudes and practices of women of reproductive age, husbands and other family members, parteras and health personnel regarding maternal and neonatal health.

The IEC activities of the Project include:

1. Routine interpersonal communication, such as:

1.A. Educational group discussions when there are vaccination campaigns or with women's groups every month.

- 1.B. Home visits for prenatal care or when there is a malnourished child in the home and his/her health card indicates that s/he is at nutritional high risk.

Typical topics covered are nutrition during pregnancy, use of the Women's Health Card, preparation for birth, supplies necessary for the birth, the importance of colostrum, obstetrical complications that can occur and their solutions, post-partum care and family planning. For family planning, the staff used flipcharts and other printed I.E.C. materials produced by the National Reproductive Health Program.

2. The Autodiagnosis

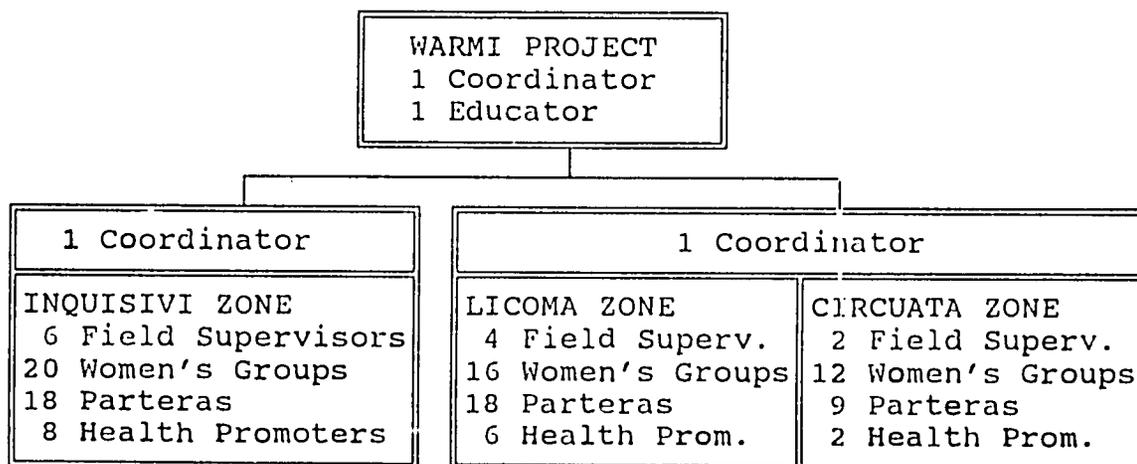
This nine-step maternal and neonatal health problem identification and prioritization exercise was pioneered by the Warmi Project and is described in more detail in the Community Organization and Participation Section of this report and MotherCare Working Paper 16A.

3. Participatory Development of Educational Materials

Community members (women's groups and parteras) participated in the development of educational materials that could be used during group meetings and home visits. These materials are:

- * An insert for the safe birth kit describing how to attend a normal home birth
- * Women's Home-Based Health Card
- * Picture Cards of Problems used in the Autodiagnosis
- * Four Booklets for Women on Pregnancy, Birth, the Post-Partum Period and Care of the Newborn
- * Manual for Parteras and Field Supervisors

The people who participated in the development of these materials are included in the project organigram below:



The advisors who participated directly in these activities were the SC/B Co-Director, the SC/B Health Advisor, and a nurse/midwife based in Licoma. The Women's Health Card and safe birth kit insert were developed by SC/B with women's groups from the three zones. The process of development of the booklets, the Reproductive Health Manual for Parteras and 5 radio programs was coordinated by the Center for Interdisciplinary Community Studies (CIEC), a local NGO under subcontract to SC/B. Comments and suggestions were also made by the SC/Westport medical advisor, the MotherCare Cochabamba Coordinator and the MotherCare/DC staff.

METHODOLOGY

The following methodologies were used to evaluate this component of the project:

- * Responses to story telling in 9 communities in all three zones to demonstrate general knowledge (See Methodology section of this report);
- * Individual interviews with pregnant women, SC/B staff, parteras and MOH staff;
- * Direct observation of the participatory materials development process by CIEC with parteras and women's groups on two occasions (December, 1992 and April, 1993);
- * Observation of "Planning Together" in the community of Charapaxi in April, 1993;
- * Review of supporting documents and drafts of the materials produced by CIEC, SC/B and women; and,
- * Personal interviews with CIEC and SC/B staff who were most directly involved in the development of the materials (December, 1992, April and June, 1993).

OBJECTIVES OF THE IEC COMPONENT

The specific objectives of the Project that relate to IEC are:

1. Increase women's knowledge and understanding of priority maternal and neonatal health and nutrition topics such as nutrition during pregnancy, prenatal care, safe birth practices, postpartum care, sexually transmitted diseases, basic reproductive anatomy and family planning methods.
2. Improve nutrition and other critical practices during pregnancy.

3. Improve neonatal care through increased attention to breast-feeding, keeping the infant warm, awareness of danger signs in the neonate, etc.

4. Increase the knowledge and use of family planning methods that do not interfere with breast-feeding for limiting and spacing births (if this intervention is approved by the Ministry of Health).

5. Establish women's groups capable of identifying and responding to their own and their infants' health needs.

QUANTITATIVE FINDINGS OF THE IEC COMPONENT

1. Routine interpersonal communication

1.a. Prenatal Care Visits

From July, 1992 through June, 1993, 286 prenatal care visits were conducted by SC/B staff to women in the three zones. Due to the small number (8) of interviews conducted with pregnant women during this evaluation it was not possible to adequately assess knowledge level. (Three of the eight women were not participating in women's groups, nor had they received pre-natal check-ups by SC/B supervisors). However, the general impression created by this limited number of interviews was that more needs to be done in one-on-one counseling. It should be noted that two of the major materials to support this counseling (the Women's Health Card and the Women's Booklets) had not been in use yet. Women had just received the card the month before the evaluation and the booklets will not be printed until the end of June.

1.b. Women's Group Meetings (Specific topics)

The 50 Women's Groups meet at least once monthly, some meeting as many as 4 times per month. The "Training" Section of this report presents the topics discussed and number of participants per topic.

2. The Autodiagnosis

Fifty women's groups completed the Autodiagnosis and 21 groups have also completed the "Planning Together" sessions.

3. Participatory Development of Educational Materials

The materials that were completed prior to this evaluation include:

- * The safe birth kit
- * The Women's Health Card
- * The Picture Problem Cards

The materials that were ready (or near ready) for production include:

- * Insert for the safe birth kit
- * 4 Booklets for Women (Pregnancy, Birth, Post-Partum Period and Care of the Newborn
- * Manual for Parteras and Field Supervisors
- * 5 Radio Programs
- * Manual on Participatory Techniques for Field Supervisors.

SC/Bis developing a Manual for PVOs that documents the Warmi Project process and experience. This manual will be completed in August, 1993.

Changes in Knowledge, Attitudes and Practices (KAP) in the Population

The changes in the KAP of the population to date can be attributed to the combination of interventions: 1) routine interpersonal communication between SC/B staff and women and their families; 2) participation in the Autodiagnosis, and/or, 3) participation in the development of educational materials.

Details of these changes are presented in other sections of this report (Services, Organization and Community Participation, General Results, etc.).

QUALITATIVE FINDINGS OF THE IEC COMPONENT

1. Routine interpersonal communications were generally carried out without supporting materials, according to the project Coordinator. In order to make these meetings more participatory, SC/B staff sometimes incorporated the use of games, puzzles, stories, skits and other "dynamics" with picture cards and silhouettes and they also used the flipcharts on Family Planning developed by the National Reproductive Health IEC Subcommittee. Only very recently is the staff beginning to use the new materials such as the Women's Health Card and to develop other local materials with the women. The women's booklets and the partera manual

have only recently been completed and will be ready for distribution in July-August, 1993.

The supervisors felt that there was not enough time to carry out the multiple activities that they programmed: community visits, meetings with different local groups, vaccination campaigns, growth monitoring, speaking with authorities, literacy classes, etc. They hope that with the change in vaccination strategy (eliminating going house-to-house) that they will have more time for IEC activities. They are also awaiting the arrival of the printed materials and training in their use in order to be more effective in their educational work.

2. The Autodiagnosis appears to be the "heart" of the Warmi Project, in the way it brings together the women in the community and awakens their own vision of what they can learn and do in order to improve their health and that of their children. (For more details, see the MotherCare Working Paper on the Autodiagnosis.)

3. The development of educational materials seems to be as important as an active learning process for the women, parteras and field supervisors, as will be the use of the materials in the future. This process was carried out in a highly participatory manner. The CIEC team merits special mention for its excellent staff and for the way in which they respect the women and the parteras, working patiently with them and helping them to create products that truly are their own. All aspects of these materials (format, letter font, size, presentation, contents, text, drawings, etc.) were collective decisions with the complete participation of the women and parteras in the three zones of the project.

A variety of changes in attitudes occurred in the women, parteras and SC/B staff due to the combination of strategies adopted by the project. Some examples follow.

KAP Changes in Women, Parteras and Other Community Members

- * Significant increase in women's appreciation of the value of prenatal care and increased use of prenatal care;
- * The growing strength of the women's groups and the resulting increase in communication among women and respect by men for women in the community.
- * Increased immediate breast-feeding.
- * Increased knowledge and use of family planning methods.

- * Better hygiene for labor and delivery and some acceptance of the safe birth kit.
- * Increased acceptance of the partera as a community resource.

KAP Changes in SC/B Field Staff

- * SC/B staff role changing from traditional "educator" to facilitator.
- * More respect for community women's beliefs and practices.

LESSONS LEARNED

Regarding the routine interpersonal communication activities such as group meetings and home visits:

- Group interest in various maternal/neonatal health themes is greatly increased when the women themselves set the agenda for the discussion.
- Changes in practices are more likely to occur when existing practices and beliefs are respected and incorporated into the negotiation with the group of new, improved practices.
- Home visits by women to other women are generally more effective when the visitor is aided by some type of appropriate educational material to help guide the discussion (i.e. problem cards in the autodiagnosis).

Regarding the process of the Autodiagnosis:

- Though the process requires an investment of at least four sessions to complete, it is worth the time.
- Staff must understand and appreciate the philosophy underlying the process and must be well trained in application of the steps and their role as facilitator. (Staff should not correct "wrong" answers-- this closes the door to trust within the group.)
- Giving up the "expert" role can be difficult for staff.
- The process will likely awaken awareness not only in specific health problems but also in some of the contributing causes such as illiteracy and lack of

access to economic resources. Any program that intends to replicate the autodiagnosis should be prepared to respond to these needs--not necessarily by offering solutions if they do not have the resources, but by being aware of what other organizations exist locally that might be willing to collaborate.

- Women's reproductive health is a very intimate and strongly binding theme that, if treated sensitively and with respect during the autodiagnosis process, can serve to greatly strengthen the ties of trust and support within the group and with field staff.

The development of educational materials with this high level of participation of women's groups and parteras was more complicated than initially expected. The products changed significantly during the process: the women asked for more content, more text, and more drawings because they wanted to learn more! The validation was an iterative and repetitive process, up to 10-15 revisions of the same page, but this was very educational for the participants and assured that the product will be used and understood by the women. Because of this, the work took a long time to complete.

- + Advantages: a high level of commitment was achieved during this process and for the future use of the materials; the people truly feel that these are their materials; the women and parteras are coauthors.
- Disadvantages: the cost and the time required are increased quite a bit; the artist quit under the pressure of so many revisions in so short a time; it's very difficult to work concurrently with participatory methodology and fixed time limits.

Due to administrative reasons (time needed in the office to close the books), the project will end two months before originally anticipated. This caused problems in the final stages of developing the materials. To their credit, all three institutions, CIEC, SC/B and JSI-- were understanding and flexible throughout the entire process.

RECOMMENDATIONS

A. DEVELOPMENT OF EDUCATIONAL MATERIALS: SC/B should finalize the development of the materials and produce them in quantities sufficient to satisfy the expectations of the women, parteras and field supervisors in the project zones, and more for dissemination throughout Bolivia. If possible in the future, the fifth booklet on The Use of Local Health Resources should be developed and produced.

B. IEC TRAINING: Table 13 below presents a proposed training plan for use of the educational materials.

Table 13. Proposed Training Plan

<u>SUBJECTS OF TRAINING</u>	<u>IN THE USE OF...</u>
1. SC/B Field Staff.....	Manual on Participatory Techniques
2. SC/B Field Staff and Parteras.....	Manual for Parteras
3. SC/B Field Staff and Women's Groups.....	Women's Booklets
4. Pregnant Women and Husbands.....	Safe Birth Instruction Insert
5. SC/B Field Staff.....	5 Radio-cassette programs

In this process, the Field Supervisors can train the parteras, and together they can train the women and their husbands.

C. AUTODIAGNOSIS: Follow the Autodiagnosis process in the new zone (Quime) as is programmed.

D. ADAPTABILITY OF THE MATERIALS: SC/B together with other interested institutions, should evaluate the acceptability of the materials (Women's Health Card, Safe Birth Kit and its instruction insert, women's booklets, partera manual, radio programs) in other rural zones of Bolivia.

E. TECHNICAL ASSISTANCE: SC/B should offer technical assistance to other NGO's especially those that work in rural areas, in training of their personnel in participatory techniques, the autodiagnosis process with women's groups, and the use of the materials developed by the project.

LIST OF IEC MATERIALS USED BY THE PROJECT

Autodiagnosis: Picture problem cards and the "health flag" (Warmi Project)

Family Planning: Fabric and paper flipcharts, booklets and posters on contraceptive methods (National Reproductive Health Program)

Safe Birth: kit and instructional insert (to be printed) (Warmi Project/SC/B)

4 Booklets for women: 1) PREGNANCY, 2) BIRTH, 3) CARE OF THE NEWBORN, 4) POST-PARTUM (OR CARE AFTER BIRTH), (to be printed, Warmi Project/CIEC & SC/B)

5 Audio Programs in validation phase (Warmi Project/CIEC)

PAPERS/PUBLICATIONS

Howard-Grabman, L., The Autodiagnosis: A Methodology to Facilitate Maternal and Neonatal Health Problem Identification and Prioritization in Women's Groups in Rural Bolivia, MotherCare Working Paper No. 16A; John Snow, Inc.; May, 1993. (Also available in Spanish)

Sanchez, E., Howard-Grabman, L., Rogers, D., Bartlett, A., Researching Women's Health Problems Using Epidemiological and Participatory Methods to Plan the Inquisivi MotherCare Project, paper presented at NCIH Conference, June, 1991.

VI. TRAINING

Training played a crucial role throughout the Warmi Project. To meet the knowledge, attitudes and practice objectives of the project, training was identified as a general strategy to strengthen mothers' and others' ability to develop positive health behaviors which affect the health of women and neonates, their ability to respond to risk situations, and to look for and utilize resources.

The Detailed Implementation Plan (DIP) identified the content and recipients of a training strategy, as well as specified numeric training inputs to be accomplished by project completion (See Table 13 below). Content was to include nutrition, prenatal care, clean/safe birth, post-partum care, immediate attention to the newborn, neonate

care, and family planning. Recipients of such training were to include SC/B personnel, parteras, health promoters, women's groups (women of reproductive age), pregnant women, husbands, and community leaders.

The evaluation team reviewed quarterly reports and conducted extensive discussions with SC/B staff to explore the extent, content of and quality of training supported by the Warmi Project. Qualitative information collected during the evaluation reinforced the findings regarding the extent of and gaps in knowledge and practice of positive health behaviors. In addition, the family rosters indicate which individuals (women and husbands) received training and of what content. Women's groups' notebooks, kept by the supervisory field staff, indicate the contents and list the participants of general women's groups sessions. However, these last two sources were not consolidated in one location until December 1991. Currently training information is tracked in a more organized fashion, gathered during quarterly evaluation and planning meetings and consolidated within the quarterly report. Information regarding the numbers attending technical health trainings and who the attendees are has improved tremendously. However, information regarding training in all its variations is not collected in a systematized fashion.

Within the Warmi Project, training is a widely-defined concept covering general staff orientation, the autodiagnosis process with women's groups, meetings with community authorities, introduction of technical health concepts, materials validation, and methodology and process training. Every staff discussion, provider meeting, or community gathering is seen as an opportunity to reinforce positive behaviors affecting maternal, perinatal and neonatal health.

TRAINING ACTIVITIES

Training activities within the Warmi Project to date roughly fall within four Phases: project launch activities, the Autodiagnosis process, technical health trainings, and complementary activities conducted by external institutions.

PHASE I

The first activity to launch the project was a three-day maternal health workshop for SC/B staff held in August 1990. It was conducted by outside consultants from the CCH project and Foundation San Gabriel. The following month SC/B held a workshop for Warmi staff to introduce the project and review the project goals and objectives. Later in November, a similar workshop was held to introduce the entire SC/B staff

to the Warmi project. During the Fall of 1990 and early into 1991, the project focused on the development and implementation of the baseline case-control study. This process entailed training field staff in interviewing and collecting data.

PHASE II

SC/B staff involvement in the Autodiagnosis process began in January 1991. A general staff workshop, conducted by the JSI Project Advisor and PROCOSI TA, focused on concept testing, the principles of focus groups and validation of materials. The Autodiagnosis process was launched with a meeting of community authorities to solicit support for the project.

As described in Section III of this report, the development of the Autodiagnosis process was a lengthy participatory process. The first 25 women's groups started the process in February 1991 and completed the process by January 1992. The second set of 25 women's groups started the process in April 1992 and completed the process in March 1993. The revised version of the Autodiagnosis averages two months to complete.

The next step was the training and implementation of the "planning together". A guide to this process was first developed in October and revised November 1992. The guide was further revised in April and completed in May 1993. CIEC plans to conduct a training in its use for SC/B staff during 1993.

PHASE III

As the first set of 25 women's groups completed the Autodiagnosis process, community health needs were clearly identified. In November 1991, the SC/B health team decided to initiate a series of safe birth trainings with the women's groups (including husband participation). These activities continued through April 1992.

Under the direction of a professional nurse-midwife, technical health trainings started in earnest in October 1992. For a period of seven months, she conducted specific trainings for parteras, promoters and SC/B staff. MOH personnel were always invited but rarely attended. She conducted day-long workshops on prenatal care, safe birth, hemorrhage, and retained placenta in each of the three zones. She also held a one-day workshop on care of the newborn in Inquisivi before departing the project. The

technical curricula were based on protocols developed by an external consultant in November 1991. The goal was for these parteras to transmit the knowledge during women's group meetings in their communities and with pregnant women during prenatal care visits.

PHASE IV

About the same time that the nurse-midwife initiated technical health trainings, CIEC began to develop and validate educational materials with women's groups and parteras. CIEC held a general staff workshop in August 1992 to launch the development process. The organization also tested the format of the booklets within three communities. Subsequently one week out of every month CIEC worked with six women's groups to further validate and develop the booklets.

CIEC also worked with the parteras from each zone to validate the parteras' manual.

In January 1992, SOPACOF initiated community education in family planning and began offering services in February during monthly visits of one week each. This local NGO trained the SC/B staff in May at the all-staff training. In October, SOPACOF conducted a sex education talk in the Inquisivi school. This was followed by a second talk in the intermediate school in November by the nurse-midwife and SC/B staff. SOPACOF had served 10-12 communities by the end of its involvement with the Warmi project.

In January 1992, an agreement was reached with the San Gabriel Foundation to train parteras at its hospital in La Paz. The goal was to improve partera skills, improve the referral network, and familiarize the parteras with urban institutional practices. By the end of the project (June 30) 39 parteras were trained, averaging two per week since February 1.

The Autodiagnosis process identified needs far beyond immediate women's health concerns: literacy and access to resources. With funding outside the Warmi project, SC/B initiated literacy programs within 11 communities and added 14 more. Two monitors from each community are trained with the goal that they will replicate literacy groups in their own communities. This project will be expanded to at least 50 communities. SC/B has started a pilot credit program with five communities eligible for group-guaranteed lending. Two representatives from each community have been trained. To date, three communities have taken out loans.

QUANTITATIVE FINDINGS FOR TRAINING COMPONENT

Table 14. Training Inputs and Findings

Objective Area	Training Input	Training Findings
Women's Groups: Autodiagnosis process	SC/B health staff trained	Achieved
	50 women's groups	50 groups
Nutrition: proper nutrition during pregnancy	60 parteras trained in nutrition counseling & weighing pregnant women	In prena- tal care training
	493 pregnant women	Prenatal care visit w/ partera or prom.
	493 husbands of pregnant women	Attend. prenatal care
Prenatal Care: symptoms of pregnancy, importance of prenatal care, detection of high risk signs, steps for follow-up, and use of women's health card	60 parteras	53
	50 health promoters trained in prenatal care promotion	46
	SC/B health team	Achieved
	MOH personnel	16
	551 WRA	643
	591 pregnant women	N/A
	386 husbands of pregnant women	N/A

Table 14. Training Inputs and Findings (Continued)

Objective Area	Training Input	Training Findings
Safe Birth: difference between false and real labor, clean birth techniques, attention to the recent newborn, identification of risk factors, and follow-up actions	12 SC/B personnel	Achieved
	5 MOH personnel	17
	60 parteras	62
	promoters	66
	551 WRA	552
	444 pregnant women	N/A
	444 husbands of preg women	N/A
	177 mothers of preg women	N/A
Postpartum Care: hygiene, identification of sepsis/ fever, hemorrhage	60 parteras	57
	promoters	35
	591 pregnant women	N/A
	444 husbands of preg women	N/A
	SC/B health team	Achieved
	MOH personnel	10
Newborn Care: immediate attention, breast-feeding, identification of risk signs and follow-up action	591 husbands of preg women	N/A
	60 parteras	78
	591 pregnant women	N/A
	193 mothers of preg women	N/A
	5 MOH staff	8
	12 SC/B health team	6
Neonatal: Care of neonate, breast-feeding, risk signs, follow-up actions	60 parteras	With
	591 husbands of preg women	newborn
	197 mothers of preg women	care
	17 local MOH & SC/B staff	training

*does this mean
N/A done or
numbers not
available*

Table 14. Training Inputs and Findings (Continued)

Objective Area	Training Input	Training Findings
Family Planning: methods, contraindications, side effects; reproductive cycle, and where to seek services	SC/B and MOH staff	Achieved
	225 WRA	Achieved
	493 pregnant women	N/A
	60 parteras	45
	500 men	Achieved
	137 adolescents	76
	teachers	N/A
Literacy Training		Initiated in 25 commun.

The figures above represent considerable training with the parteras, women of reproductive age, SC/B health team and MOH personnel. The numbers, however, are quite problematic. It is unclear to what extent the same individuals attended training events twice. For example, the project only has 45 parteras for the three zones, however, the above figures would indicate many more due to multiple training sessions.

The glaring gaps in training are with pregnant women, their husbands and mothers. Pregnant women were difficult to identify as a separate group apart from women of reproductive age. Pregnant women may have attended women's groups meetings and benefitted from the information transmitted. Additionally, they may have attended a prenatal care visit with the community partera or promoter. The information is not gathered for easy analysis; the family rosters note when and where a prenatal visit occurs. The same comment applies to husbands of pregnant women. These men occasionally attend prenatal care visits with their wife. Mothers of pregnant women are even harder to track. They too may have attended women's groups meetings and benefitted from the information presented.

The DIP identified two subject areas not tracked separately by the Warmi Project: nutrition and neonatal care. Nutrition is an integral component not only of the Warmi project but within all of SC/B's activities. Nutrition is incorporated within child survival activities and agricultural projects in addition to the Warmi Project.

Nutrition specific training is not monitored separately within the Warimi Project but the information is incorporated within prenatal care activities. The topic of neonatal care is treated at the same time as newborn care.

QUALITATIVE FINDINGS OF THE TRAINING COMPONENT

Knowledge among the 8 pregnant women interviewed was low. However, knowledge among women of reproductive age interviewed in 9 women's groups was relatively good. There still exists a need to strengthen mechanisms in imparting information. The women want to educate themselves, while the men within the community also recognize the need for further knowledge. Based on answers to the questions asked in the interviews and on the written exam, the level of knowledge varies quite a bit among health providers be they parteras, promoters, SC/B or MOH staff. See the Services section of this report for a more detailed discussion.

In the "planning together" phase, communities have asked for further knowledge and training in a variety of themes including family planning, safe/clean birth practices, hemorrhage, vaginal infection, retained placenta, malpresentation and others.

FUTURE PLANS AND STRATEGIES

In August or September 1993, CIEC will train SC/B staff on the use of the booklets, the manual for parteras and the Autodiagnosis procedures manual. Strategies for materials use will be reviewed. CIEC will also train parteras in the use of their manual and the booklets. These same materials will be used within literacy activities directed to post-literacy groups.

SC/B is thinking of ways to introduce peer counseling with the materials. Through the Autodiagnosis process community women have gained experience in interviewing other women. With these skills women could also introduce and discuss materials with their peers. The goal is to reach women outside the organized women's groups.

In the interests of sustainability, SC/B has identified the need to strengthen the partera's role and communication skills within the community. The partera may take on a larger role in training the women's groups with assistance for curriculum development and under supervision of the SC/B Field Supervisor. The goal would be to build the partera's confidence and strengthen her ability to transfer knowledge.

RECOMMENDATIONS FOR TRAINING

1. Advocate for changes within current MPSSP norms. The norms were written for the urban Bolivian context not the poor, isolated, rural environment of Inquisivi. Some examples of effective interventions to decrease maternal mortality that would imply further training for parteras include:
 - Manual extraction of the placenta;
 - Administration of antibiotics in cases of puerperal and/or neonatal sepsis;
 - Administration of oxytocin in cases of severe hemorrhage;
 - Family planning method counseling for community-based distribution of condoms, foam tablets and pills;
 - Oral rehydration solution preparation for hemorrhage to prevent shock if IV not available;
 - Administration of methergin or other hemorrhage treatments.
2. Advocate for a professional Nurse Midwife ("Matrona") profile within MPSSP services. (See "Services" Section). If this position is to be approved by the MPSSP, it would necessitate training at the University and field levels.
3. Maintain a more accurate record of all the trainings that take place. For example the quarterly evaluation and planning meetings are used as an opportunity to conduct refresher training in technical subjects. The attendance list, used to estimate meal requirements for the day, could be summarized and inserted into the resulting report.
4. Ensure that the "Planning Together" process is completed prior to introducing the technical training. This would ensure that the training meets the needs identified by the community, reinforces "ownership" of the knowledge and would raise the likelihood that the information would be accepted.
5. Explore ways to encourage provider contact with pregnant women. The use of the women's card is a tool for counseling and imparting nutritional information. The parteras and promoters need to be trained in the card's use.
6. Strengthen counseling training for parteras, promoters, SC/B staff: Knowledge appears to be high among these groups but the ability to transfer this knowledge to others, particularly in prenatal care, appears to be low.
7. Improve the supervision of parteras and promoters to ensure that accurate information is transferred. Supervision should not just account for the occurrence of a training event but provide active feedback on the quality of the content and the process.

8. Work with the San Gabriel Foundation to strengthen the content of partera training at that institution. Expectations of practices and techniques appropriate within the poor, rural, isolated context of Inquisivi should be clarified. Coordinate with San Gabriel staff to improve cultural sensitivities on both sides.

VII. SERVICES

In a setting such as Inquisivi Province where the District Hospital cannot yet serve as a secondary referral point: where health posts are poorly equipped and are staffed by recently graduated doctors carrying out their mandatory year in the rural areas who often have little interest in investing their efforts in improving the situation; and where there are serious cultural, social and economic barriers to seeking services, it is a wonder that anyone uses the services. In fact, use of formal health services in the District remains low. Additionally, the process diagnosis section of the initial case control study identified lack of or late recognition of potentially lethal problems as one of the most important barriers to seeking adequate care. This scenario is not unique to Inquisivi, but rather is the prevailing situation in rural areas of Bolivia.

In light of the existing resources and in order to address the extremely high maternal and perinatal mortality rates, the project focussed most of its efforts on improving what could be done at the household level within the community and on families recognizing danger signs and acting rapidly to find transport to La Paz when problems could not be solved in the District. Ministry of Health personnel were trained with SC/B staff in a series of workshops on different aspects of reproductive health (see Training Section) but many of those trained (particularly the doctors) have left the District and have been replaced.

SC/B signed an agreement with San Gabriel Foundation in January, 1993 which identified the San Gabriel Hospital as the La Paz referral point for complicated cases that could not be treated at the District Hospital. Concurrently, San Gabriel began a training course for parteras participating in the Warmi Project. This course was part of the effort to strengthen the links between communities and the referral hospital. It is still too early to assess the results of this strategy. However, interviews with parteras trained at San Gabriel indicate that as a result of the training course they feel more confident with their improved technical skills which will serve them well in their communities. They also remarked that they are much more comfortable in the hospital environment and will refer their patients when necessary.

QUANTITATIVE FINDINGS OF THE SERVICES COMPONENT

These findings are based on two sources:

1. Baseline case-control study versus final case-control study; and,
2. Manual information system (Women's Health Roster, consolidated quarterly reports from July, 1992 to June, 1993).

Indicators:

Bar graph charts of the following results are presented in Annex 3.

Prenatal care visits: The average percent of identified pregnant women during the last year (July, 1992-June, 1993: manual information system) who received at least one prenatal check-up was to 77%. Only 20% received 3 check-ups or more. The goal of 50% of identified pregnant women receiving at least 3 visits was not achieved. More visits were registered in October-December because the MOH was distributing food during the visits at this time. One problem encountered by SC/B staff was that even though they could identify a woman as pregnant, the woman or her husband would not allow a physical exam until her last trimester. One reason for this was that women often deny that they are pregnant until it is obvious to all. Another is that they believe that the exam is only to determine the position of the baby to know whether their delivery will be difficult or not--an early exam will not give them this information. Although it is clear from the baseline/final studies that many more women now know about prenatal care and believe that it is useful, more emphasis needs to be placed on the importance of early and continuous follow-up.

Tetanus Toxoid Vaccine: The percentage of women who delivered who had received at least 2 doses of TT increased from baseline 53% (controls) and 44% (cases) to final 61% (controls) and 67% (cases). The manual information system registered 84%, 83%, 85% and 74% for the last four quarters. The project goal of 50% of detected births with a minimum of 2 doses of TT was surpassed.

Nutrition: not able to assess or monitor weight/diet.

Received Ferrous Sulfate: The percentage of identified pregnant women who received at least 30 tablets of ferrous sulfate in their second or third trimester increased from 17% (baseline-controls) to 51% (final-controls); and, 15% (baseline-cases) to 45% (baseline-controls). The manual

information system confirms this with 83%, 56%, 61% for the last three quarters. (The data from the first quarter, July-October, 1992) were not complete.) The project goal of 50% was surpassed.

Birth Attendants (trained vs untrained): The case-control study could not detect whether family members had been trained in safe birth techniques. The manual information system births registered that 47%, 70%, 52%, and 64% of detected births during the last four quarters respectively were attended by trained birth attendants (trained husbands, mothers, parteras, nurses, doctors, etc.). The project goal of 50% of detected births being attended by trained people was surpassed.

to define
High risk patients referred: The manual information system for the last year registered that 13% of women identified as high risk during pregnancy received referral follow-up care by the formal health system (health post or hospital). The goal of 20% was not achieved. However, with the recent training of parteras at San Gabriel Hospital, SC/B anticipates that referral will increase during the next year.

Place of birth (home vs health facility): The place of birth according to the baseline and final studies was as follows:

	BASELINE		FINAL	
	Cases (n=75)	Controls (n=151)	Cases (n=31)	Controls (n=135)
Woman's Home	89%	96%	77%	84%
Woman's Mother's House	4%	1%	7%	8%
Health Post	0%	2%	3%	2%
Hospital	?*	?*	3%	4%
Other	4%	1%	10%	2%
Missing	3%	0%	0%	0%

* The option "hospital" was not included in the questionnaire. In the 1993 study, hospital was entered in the "other" category and tabulated. In the original study in 1990 the "other" responses were not tabulated for the report and original questionnaires were not available for consultation.

Use of safe birth kits: This activity was not contemplated in the DIP so no project goal was set for this indicator. However, the manual information system indicates that of the women who delivered within the last year, 36%, 33%, 25% and 26% respectively for the last four quarters used a safe birth kit.

Immediate breast-feeding: The percentage of women who delivered who Breast-fed immediately (within one hour) increased from 25% (baseline-controls) to 50% (final-controls). The manual information system confirms this with 41%, 59%, 54%, 62% for the last four quarters. The project goal of 30% was surpassed. Baseline cases who received immediate breast-feeding increased from 11% to 32% (final-cases) but because the sample size was small this change is not statistically significant.

Post-partum visits: The percent of women who delivered who received at least one post-partum visit, according to the manual information system were 77%, 83%, 60% and 55% respectively for the last four quarters. The project goal of 50% with at least two visits was not achieved since only very few women received two visits. The case-control study did not include this question.

Received Vitamin A (post-partum): The percent of women who received a megadose of Vitamin A, according to the manual information system were 48%, 52%, 40% and 55% respectively for the last four quarters. The project goal of 50% of detected post-partum women with a megadose of vitamin A was achieved. The case-control study did not include this question.

QUALITATIVE FINDINGS OF THE SERVICES COMPONENT

The qualitative findings related to the services component are based on:

1. Personal interviews with pregnant women, women of reproductive age, parteras, husbands and MOH personnel;
2. Group discussions with women's groups, local authorities, parteras using a variety of participatory techniques such as story-telling, pile-sort intervention cards, etc. (see Methodology Section).

The findings are presented by type of group interviewed.

a) Pregnant Women

During the evaluation, 8 women between 2 and 8 months pregnant were interviewed (three of the women had not participated in project activities). Of the 8, 5 were in their final trimester. The majority identified their pregnancy because they missed a period and half because of nausea and vomiting. 62.5% of the women reported receiving their TT vaccine 4 or more times and 87% reported 2 times or more. Half of the women interviewed had at least one prenatal visit with the SC/B field supervisor or by the auxiliary nurse in the health post, with an average of 2.5 visits per person. All of the women that had received prenatal care reported that they were satisfied with the quality of the service.

Five of the 8 women interviewed are using the Women's Health Card developed by the project. They use it to "record their vaccinations, for the women's calendar, and to have the person who does their prenatal care fill it in".

When we asked about danger signs during pregnancy only one woman could remember 3 signs; one could remember 2 signs and three could remember one sign. Regarding tetanus prevention in the newborn, one woman of the eight could cite 2 ways; one cited "by giving vaccines to the mother"; and five did not know.

Knowledge of nutrition was very low in the pregnant women who were interviewed. One woman spoke of the 3 food groups and another said that "one should eat fruit, milk and beans". Their present diets were not adequate. An analysis of the foods consumed in the last 24 hours demonstrated a lack of calcium and protein. Almost two thirds of the women also lacked sufficient intake of carbohydrates. One woman indicated that she was taking ferrous sulfate.

In the 8 women interviewed, confusion existed regarding the symptoms of post-partum sepsis in the mother and danger signs during the delivery. Half of the women could not name at least one danger sign during delivery. In the majority of the cases the action that they said they should take is to look for help from the partera or go to the hospital.

The majority of women were able to name at least 2 steps in care of the newborn. Half of the pregnant women recognized pneumonia in the newborn by cough and fever. Almost all of the eight women are planning to give birth at home and one in the hospital. Of those that plan to give birth at home, half indicated that they will be attended by their husband

or mother and half by the auxiliary nurse or the partera (someone trained in safe/clean birth) and one by a doctor from the MOH. Only very few of the women were preparing the necessary things for a clean birth.

b) Community Men and Women

Using stories about maternal and neonatal health problems, we saw that the majority of men and women demonstrated good knowledge in relation to good and bad practices related to delivery, post-partum and care of the newborn practices. In general, the women demonstrated a higher level of knowledge than the men.

The stories indicated that knowledge was the weakest in wrapping the newborn and calling the partera for retained placenta.

The women's and authorities' groups prioritized project interventions using drawings representing 16 activities of the Warmi Project. The following results from 8 communities in the 3 zones were obtained:

Women (n = 161) said that the Organization and Strengthening of women's groups, Family Planning, Clean Birth, Prenatal Care, and Literacy were the five most important project interventions.

The authorities (men = 53 women = 2) indicated that the Organization/Strengthening of women's groups, Family Planning, Clean Birth, and Literacy were the most important project interventions from their point of view.

The husbands (n = 37) said that the most important interventions of the project were the Health Card for Women, Referral System, Safe/Clean Birth and Prenatal Care.

Family Planning

Although no formal baseline exists for the project regarding family planning, studies in other rural areas similar to Inquisivi where no access to "modern" methods existed (DHS, 1989) showed virtually no recognition of FP methods. Individual interviews with husbands, women of reproductive age and parteras during this evaluation demonstrated that the majority knew of at least three methods without prompting and recognized most other methods when they were mentioned. The demand for family planning services is high and when services were available (SOPACOF) 32% who attended educational sessions opted to use a method.

Women of reproductive age and men were interviewed about family planning methods. Of the 14 men and 29 women who were interviewed in the 3 zones:

The methods mentioned most frequently and spontaneously were the IUD, the pill, and condoms. The average number of methods mentioned spontaneously was 3, with more methods mentioned in Licoma.

The methods recognized most frequently were breast-feeding and withdrawal. Rhythm and/or sterilization (masculine or feminine) were recognized by a minority of the persons interviewed.

Of the few people that indicated having used some method at some time, the methods which the man, the woman or the couple have used were the IUD, withdrawal or rhythm, condoms, pills and breast-feeding. In all categories, Licoma zone was the highest.

KNOWLEDGE AND PRACTICES OF HEALTH SERVICE PROVIDERS

a) Parteras

Indicators:

27 parteras (11 men and 16 women) were interviewed. They have between less than 1 and 40 years of experience, most having begun in 1990-1991 with the Warmi Project. The parteras have attended between 1 and 100 births with 16 attending 6 births or more. The majority provide at least 2 prenatal visits per patient.

Training

18 of the parteras that were interviewed had attended training at San Gabriel Hospital. One also said that he had been trained originally several years ago by the MOH. 16 said that they can use what they learned at San Gabriel in their work. For example:

*many of them
trained at
San
Gabriel.*

"They reinforce good hygiene, knowledge, techniques and care of the newborn." Two parteras said that they could not use what they had learned due to lack of equipment. The majority (19) reported that they did not possess a medical kit or that what they had was not complete. There were many recommendations to improve the partera's kit. Among those most often mentioned to add to the kit were gloves, pincers, scissors, bulb aspirator and pinard (fetoscope). (SC/B provided fetoscopes, baby scales and measuring tapes to all participating parteras.)

Complications Experienced by the Parteras

The majority of the parteras (16) had no complications. But those that did experience complications reported the following:

- Retention of the placenta (4)
- Malpresentation (hand or foot) (4)
- Hemorrhage (3)
- Feto-pelvic disproportion or prolonged labor (3)
- Presentation of the umbilical cord (2)

Actions Taken by Parteras In Response to Complications

The actions taken in the majority of cases were correct, but some parteras reported incorrect actions when presented with retention of the placenta, presentation of the hand or cord and prolonged labor, although it is not known if these problems occurred before or after their training in the project. Ten of the parteras had not referred any patients because they had not experienced any complications.

TECHNICAL KNOWLEDGE OF PARTERAS BY THEME

Sepsis

When asked about maternal sepsis, the signs and symptoms indicated most frequently by the parteras were fever and headache. Almost half of the parteras could name 3 symptoms of maternal sepsis.

22 parteras said that the action that they should take in these cases of sepsis is to go to the hospital or the health post.

Neonatal sepsis was often confused with other problems (such as neonatal tetanus).

The signs most frequently indicated were that the newborn won't nurse, doesn't cry loudly, or shivers (fever). Very few could name 3 signs of neonatal sepsis. Again, almost all the parteras indicated the necessity of taking the newborn to the health post.

Family Planning

The parteras also demonstrated knowledge of "modern" methods of family planning. The methods mentioned most often by more than three-fourths of the parteras were the IUD, condoms, or the pill. More than half mentioned all three methods.

The use of family planning methods by parteras or their partners at some time previous to the interview was much less than their knowledge. The methods used at some time are in general natural methods such as rhythm/calendar or withdrawal, but used by very few.

Prenatal Care

Some of the parteras demonstrated a high level of knowledge of what one should ask/counsel during a prenatal visit. Others demonstrated weaknesses that need strengthening through follow-up and/or more training.

Of the 27 parteras interviewed:

- >90% said that it was important to provide counseling on nutrition (ie 3 food groups);
- >80% said that it was important to ask the client about the date of her last period and to tell her that she should get her TT vaccine;
- >70% said that they ask what the client is eating, discuss the importance of iodized salt and symptoms of pregnancy;
- >50% counsel on the importance of breast-feeding, safe/clean birth and recommend ferrous sulfate;
- >40% ask about the age of the pregnancy, number of pregnancies, current problems and referrals; and,
- >Less than 40% ask about who will attend the birth; ask about abortions, previous problems, twins (past or present), fetal movement, edema, hemorrhage, pain on urination or give counsel regarding hygiene.

Partera's fees vary by zone. In Inquisivi zone nobody charged to attend a birth. In Licoma zone, 4 of the 10 parteras charged between 5 and 20 Bolivianos (U.S \$ 1.20 to 4.76). In Circuata zone, the 6 parteras charged between 10 and 25 Bolivianos (U.S. \$ 4.20 to 5.95) per birth.

PARTERAS AND THE REFERRAL SYSTEM

Links with the MOH

23 of the 27 parteras are in contact with the auxiliary nurse or the MOH doctor. Five reported frequent contact, 7

some contact or when the auxiliary is present, and the others infrequently or when there is an emergency.

Almost all of the parteras referred all of their patients for the TT vaccine. The majority of the pregnant women referred received their TT vaccine from the MOH and a minority from SC/B supervisors. Others received vaccinations from the partera or the promoter during campaigns.

The majority of the parteras were not yet using the Women's Health Card because they had not yet received it.

Strengthening the Referral System

The parteras reported that they send their clients for their TT vaccine, generally to the MOH health post or hospital. They also have contact with the auxiliary nurse, although many of these contacts are when emergencies occur.

Four MOH staff (in the 3 zones) were interviewed. They had worked in Inquisivi between 5 months and 26 years. All of them said that the project provides information to the national health information system (SNIS) but that the data vary. All of them receive data regarding prenatal care, TT vaccine and Vitamin A post-partum. The other data including births, training/education of women's groups and reproductive health are received by some but not by all. The majority of the staff had not received the Women's Health Card yet.

Two MOH staff stated that they had received patients with complications referred by the Warmi project. Only one patient's problem was resolved by the health post; 3 were referred to the District Hospital in Quime. They reported the need to refer to Quime "due to the insufficiency of equipment and lack of sterilization". However, the equipment in the Quime Hospital is not adequate to attend many complications. The doctor in charge of the hospital informed us that the Quime Hospital had only attended 10 deliveries (normal and complicated) in the last 12 months.

The recommendations from the interviews with MOH staff for the project were numerous and include:

- "That SC/B always coordinate with the District staff, so that in the future all the health programs come out well."
- "More coordination with the MOH - for example, name someone to assure the coordination and programming."

- "That there be more support in materials, supplies and transport."
- "There has to be interest in coordinating."
- "Give some personal incentives."
- "Dedicate their activities in specific areas either in health or in credit or in education."
- "Promote to the people to come to the health post (with money) and do follow-up of the patients that have been referred, don't just leave them."
- "The parteras should refer to the health post so that the people receive a better orientation. They should inform us of problems in their communities so that we can program better."
- "That they help us with their vehicles for transportation of the patients to the different health centers either in Irupana or to Quime."
- "Development of fairer schedules." (not specified)
- "When authorities come, they say one thing and do another. Help with the vehicles to do visits to the communities."
- "Constant change of personnel, loss of continuity, they don't express the philosophy of SC/B."

The interviews suggested that coordination with the MOH could be much improved. One auxiliary commented that she never attended a meeting of a women's group in his community because she didn't know when a meeting was to take place. She doesn't make promotional visits in the community and commented that very few people go to the hospital for reproductive health services, only to ask about SOPACOF. The Co-Director of SC/B commented that the MOH staff are always invited to the monthly and quarterly planning meetings but often do not attend.

b) SC/B and MOH Staff

Indicators:

As part of the evaluation, 4 MOH staff and 12 SC/B staff took an exam of their knowledge in maternal and neonatal

health. The average score for the MOH staff in the three zones was 69% (range 51% to 88%); of the SC/B staff the average score was 88% (range 52% to 94%).

The areas where knowledge is lacking in the MOH staff are in safe birth techniques, modern methods of family planning, their contraindications and secondary effects, and the difference between true and false labor.

The areas where knowledge is lacking in the SC/B staff are: danger signs during pregnancy and steps to follow to respond to these cases, and modern methods of family planning, their contraindications and secondary effects. Also, on average SC/B staff stated only three activities that one needs to do in prenatal care.

	MOH	SC/B
- 3 practices for safe birth	1 (25%)	11 (92%)
- 2 reasons for the importance of safe/clean birth	2 (50%)	9 (75%)
- 2 correct practices for neonatal care	2 (50%)	10 (83%)
- 2 signs of high risk during pregnancy and birth	3 (75%)	10 (83%)
- the difference between true and false labor	1 (25%)	12 (100%)
- 4 basic steps in the care of the newborn	2 (50%)	8 (75%)

SC/B, THE MOH AND THE REFERRAL SYSTEM

SC/B has experienced many problems in trying to obtain its new agreement with the MOH. The MOH signature has been delayed months. There has also been a lack of coordination between the project and the MOH at the local level. The project wanted to respond to the needs of the communities but the hospitals and health posts did not have the equipment nor the infrastructure to serve its role in the communities.

The inability of the MOH to provide services in reproductive health caused the project to look for other local NGOs to provide these services. SOPACOF was contracted to provide family planning services in the project communities. Although the community expressed much satisfaction with the services (See Final Evaluation of SOPACOF) it was not sustainable; when the contract with SOPACOF ended, the services also ended. SC/B wanted to sign a new contract

with SOPACOF but this was not possible without SC/B's agreement with the MOH. There still exists a high demand and interest expressed by community men and women. To respond to this demand, SC/B is negotiating with the San Gabriel Foundation to continue the services that SOPACOF had provided earlier.

The hospitals and posts in the zones are not equipped for maternal or newborn emergency cases. The project is developing a link with the San Gabriel Hospital in La Paz as a reference hospital because looking for services in La Paz was the only recourse. This strategy has mixed results. This link was made because the MOH could not respond to these complicated cases and in order to have a specific referral point that could give more emphasis to the needs of rural women. However, the need still exists to strengthen the local institutions of the MOH. The project can increase training of the hospital and health posts; the MOH should equip and renovate its hospital and health posts (perhaps with funding from the Social Investment Fund (FIS)). It is very far to the La Paz hospital and for this reason it is important that the District Hospital and zonal health posts which are considerably nearer be able to adequately treat the majority of these cases, sending only the worst cases to La Paz (a distance of approximately 5 hours from the Quime Hospital).

RECOMMENDATIONS

1. Better coordination between the project and the MOH
 - The La Paz Health Unit should sign the agreement with SC/B;
 - The Tres Cruces District staff (MOH) should attend SC/B workshops and meetings to which they are invited;
 - Joint planning of activities, use of vehicles, etc.; and,
 - Joint supervision from the district level to the zonal level, from the zonal level to the health post and from the health post to the community (parteras)
 - Strengthen hospitals and posts -- Equipment and renovation by MOH (FIS) and knowledge/skills by SC/B.
2. Adapt the maternal and perinatal health norms to the reality (morbi-mortality) in the rural areas
 - Train parteras in techniques that can save women's and newborns' lives including:
 - External uterine massage for hemorrhage
 - Application of TT vaccine;

- Application of oxytocin in cases of retention of placenta and/or hemorrhage;
 - Provision of antibiotics in cases of sepsis and then look for help from MOH staff;
 - Community-based distribution of contraceptive methods: pills, condoms, and vaginal foaming tablets;
 - Use of rehydration solution in cases of hemorrhage.
- Train "Matronas" (nurse/midwives) to work at the level of the District Hospital to supervise training and follow-up of parteras, incorporating them into the formal health team of the MOH.
3. Program more time for training of pregnant women, women of reproductive age, men and parteras in the communities and increase follow-up to ensure that they have put into practice their knowledge.
 4. Change the nutritional focus for pregnant women to practical knowledge in the preparation of locally available foods, rather than theoretical training in the 3 food groups. Foods that are available locally should be used in effective combinations. For example, cereals and legumes for a complete protein, eggshells for calcium, dark green leafy vegetables or carrots for vitamin A, etc.
 5. The MOH personnel should promote and provide reproductive health services in their hospitals, health posts and communities.
 6. It is important for all to take advantage of the technical workshops offered by the project to improve their knowledge and the conduct of their work. It is also important for the parteras to be supervised and that all staff receive the same messages and information.

VIII. HEALTH INFORMATION SYSTEM (HIS)

THE SC/D HEALTH INFORMATION SYSTEM

The manual maternal HIS was implemented in November 1991 by the Warmi project personnel in order to detect and respond to women at risk in the communities and to monitor the progress of project indicators. Through this information system it was possible to have more detailed information about, and follow-up in, the communities.

This HIS helped field staff to develop their quarterly plans based on their consolidated reports. Every quarter, individual field supervisors consolidated their data with

those of their zonal co-workers and then presented and discussed them with the SC/B management team (Co-Directors, the Health and Nutrition Advisor, the Program Advisor and the Impact Area Manager). Monthly plans are developed at the end of each month for the next month based on the quarterly planning exercise. These instruments have shown to be effective for planning and implementing the project's activities.

The HIS is also utilized by the community and the women's groups to determine who is in need of vaccination, prenatal care, post-natal care, etc. However, the current instruments (see section below) with the exception of the women's health card, are not appropriate for direct community use. The development of appropriate maternal and neonatal health and child survival instruments for parteras and other community groups/individuals is an area that SC/B would like to focus on in the near future, using the experience gained from development of the women's health card and the educational materials.

THE MANUAL INFORMATION SYSTEM

The manual maternal and perinatal health information system consists of the following instruments:

- Women's Home-Based Health Card (Woman's Home)
- Vital Events Reporting Form (SC/B field sup.)
- Women's Health Roster (SC/B field sup.)
- Family Register Card (Sub-zone office)
- Consolidated Women's Roster (Zonal Coordinator, Co-Director)
- National Information System (MOH District level)

The section below briefly describes each instrument.

Women's Health Card

The women's home-based health card was developed by SC/B with women's groups in 10 communities over a period of one and a half years. The card's content and structure changed enormously based on the numerous validations that it underwent in the communities. The final version was approved by the MOH and was just recently distributed to women's groups in April-May, 1993. (See Annex 5-A).

Since this card must be used by the women in the community, it is necessary to train them in order to obtain the desired result, and to test how it is used by the women and whether its utilization is beneficial or not over an extended period of time.

Vital Events Registration Form

The vital events registration form registers births, deaths and probable causes of mortality. It is simple and complete and should be utilized when a birth or death occurs in the community so that these events are tracked appropriately. (See Annex 5-B.) However, sometimes field supervisors will register a birth or death in their roster and forget to complete the vital events form.

Women's Health Roster

The Women's Health Roster was first implemented in November, 1991. This roster originally contained several pages of indicators for each woman of reproductive age registered (see Annex 5-C). It is managed by the SC/B field supervisors. The roster was reviewed during the mid-term evaluation and was judged to be much too complicated. SC/B revised the roster, cutting it down to one page per woman. The new version (see Annex 5-D) was reviewed by all field staff and was printed and distributed only recently in May, 1993. Therefore, it can not yet be determined how well the new roster responds to some of the difficulties encountered in the earlier version. However, it was clear that a change was needed since the evaluation team encountered many errors in data entry.

Though the roster was intended to be used for follow-up of individual pregnant women, there were numerous cases of detected pregnancies that had no date of birth recorded. In the majority of cases, this is probably because there are many places to register births (vital events form, family register and Child Roster) and the field supervisor did not register the birth in all places. This is a likely explanation, particularly due to the fact that the child rosters that fed into ProMIS (the computerized HIS) registered 708 births in the last 2 years and the Women's Health Roster only showed 336.

Family Register Card

The family register card is initially used in a general census of the impact area (see Annex 5-E). It records family demographic data by household. The cards should be updated as new information is gathered (births, deaths, migrations, etc.). These cards hold information on the population base. In reality, it was observed that the cards are sometimes not updated and are therefore incomplete. This probably occurs because the cards are not held by the field supervisors in the communities and are therefore relatively static.

Consolidated Women's Health Roster

Every quarter, the information from the Field Supervisors' rosters is summarized on the Consolidated Quarterly Roster Sheet. This information is presented and analyzed by zone (Inquisivi, Licoma/Circuata) during the evaluation and planning meetings held in each zone at the end of every quarter. Use of this form was initiated in July, 1992. It greatly improved the accessibility of the information for analysis and led to the identification of problem areas in need of extra programmatic attention. The form is presented as Annex 5-F.

National Health Information System (SNIS)

SC/B field supervisors complete and submit monthly reports required by the MOH to the SC/B zonal coordinator who then consolidates all reports received and presents the consolidated report to the District Director. The information is discussed and analyzed at monthly (zonal/area level) and quarterly (district level) Information Analysis Committee meetings. SC/B zonal coordinators and MOH district staff attend these meetings. The SNIS form is presented as Annex 5-G.

COMPUTERIZED SYSTEM

SC/B manages a computerized health information system known as "ProMIS" which was installed in October 1991. The first cut of system data was completed in July 1992, due to lack of specialized personnel to run it previous to that date. Designed primarily for child survival data, this system allows SC/B to monitor and evaluate only a few of the Warmi Project's indicators (number of women of reproductive age, number of TT vaccines, number of births/deaths and number of prenatal care visits). All other indicators must be consolidated manually.

EFFICIENCY OF THE DATA COLLECTION PROCESS

In spite of the improvements introduced in the instruments for data collection, several problems persist. It appears that there are gaps in data collection/registration evidenced by the blank spaces in the registers. Some of these gaps may have resulted from the supervisor not having access to the information. Others may be the result of inadequate follow-up. In spite of periodic training in the registration of data in the roster, this continues to be problematic.

CONCLUSIONS

The HIS is a good instrument to identify needs; establish priorities; plan, monitor and evaluate the program. It aids decision-making, provides community health information, and facilitates the supervision of health personnel such as supervisors and promoters. However, the system was designed with the intention of monitoring indicators at the field supervisor level and not at the community level. This system will not be sustainable without SC/B presence.

The introduction of zonal quarterly evaluation and planning meetings helped the project to identify needs and establish priorities. This strategy is rendering positive results.

With the hiring of the programmer in July, 1992, to operate the new computerized system, data collection and entry has improved, but there are still some problems with the use of the instruments.

RECOMMENDATIONS

1. Field staff should continue to receive periodic training in how to fill out the rosters and other forms and they should receive feedback on their individual work at least once every quarter.
2. It is important when preparing the quarterly consolidated reports that the information on the women's and children's rosters and family card registration cards coincide.
3. In general, there are too many steps to register health information into the system. This process should be consolidated and simplified. The HIS could combine the information required by three instruments (women's roster, child's roster, vital events form) into one instrument so that data are not lost. For this reason, the HIS should be re-organized.

4. The space given for the date of prenatal care in the women's roster should be larger.
5. Change the term "Puerperal" to "Post-partum" which is more easily understood by the field supervisors who are in charge of filling out the registers.
6. The women's health roster should include a space for the date of death.
7. SC/B should put into practice its vision of developing with the communities simple health status monitoring instruments that can be sustained by the community when SC/B leaves Inquisivi Province in September, 1997.
8. Ongoing supervision of field supervisors is necessary in order to improve the HIS and for staff to have access to more consistent and reliable information.

IX. INTERINSTITUTIONAL COORDINATION AND COLLABORATION

To assess the Warmi Project's coordination and cooperation with other institutions, one should consider how SC/B generally works with other institutions. SC/B's policy is to work in collaboration and coordination with both public and private institutions. The type of work agreement established depends on the projects' objectives and the needs that arise along the road. The Warmi Project needed assistance from a local NGO (AYUFAM) to provide reproductive health services, CIEC for the design and development of educational materials, and the San Gabriel Foundation for training of parteras. SC/B participates in the PROCOSI network of PVOs which promotes child survival and maternal health.

The institutions with which SC/B coordinated activities under the Warmi Project within the private sector are: PROCOSI, AYUFAM, CIEC and the San Gabriel Foundation. In the public sector, SC/B coordinated with the MOH La Paz Health Unit and the District level staff.

PROCOSI

SC/B belongs to the PROCOSI network which groups ten non-profit private voluntary organizations which execute and/or sponsor child survival projects in Bolivia. PROCOSI promotes institutional strengthening of its members through coordination, technical assistance, investigation and channeling of financial resources which support its members' programs to benefit the children, women and communities of Bolivia.

Under a previous AID Operating Program Grant, SC/B rendered legal and administrative support and then supported the consolidation of the PROCOSI network. Now PROCOSI is legally registered as a Bolivian NGO, and SC/B is a regular member.

For PROCOSI, the Warmi Project is considered as "a very good initiative which should be replicated in the country. Women in the rural areas are neglected and exploited; this project is an alternative for women to organize themselves, to improve their maternal and reproductive health." Besides the impact in Inquisivi, the methodology utilized has generated much interest in the PROCOSI network, especially for institutions working in health in the rural areas. The different findings in the network are constantly shared and "the Warmi's methodological experience is surprising and successful".

PROCOSI recognizes SC/B as an important member whose work is responsible and effective.

AYUFAM

AYUFAM (formerly SOPACOF) is a non-profit public institution whose objective is to contribute to improve the quality of life of the family in Bolivia through execution of primary care and reproductive health interventions.

SC/B and AYUFAM established a working Agreement in August, 1991 which also involved the MOH (La Paz Health Unit). The objective was to provide reproductive health services in response to the needs put forward by women in the Warmi Project autodiagnosis. AYUFAM was responsible for offering reproductive health services in Inquisivi, Licoma and Circuata zones; training the SC/B staff; and for giving educational talks and counseling to organized community groups, adolescents in school and individual couples desiring more information.

There were two important achievements in this work from AYUFAM's perspective: the first referred to was "the improvement of community health" and the second "allowed the definition, testing and execution of strategies and reproductive health activities in the rural area, with the possibility of replicability."

The only problem they encountered was with their information system. They were unable to accurately register the number of participants who attended education sessions and had difficulty recording continuing contraceptive method users.

The only recommendation from AYUFAM for the future is that in the "next agreements, activities, objectives, supplies, medical equipment, etc. be defined in conjunction with the MOH La Paz Health Unit in order to avoid unrealistic expectations."

CENTER FOR INTERDISCIPLINARY COMMUNITY STUDIES (CIEC)

CIEC is a non-profit Bolivian NGO that works in the areas of training, education, materials development, investigation and evaluation.

CIEC conducted the mid-term evaluation of SC/B's Warmi Project in April 1992. A much closer working relationship between SC/B and CIEC originated from this initial activity. In August 1992, CIEC and SC/B signed a fixed-price agreement for the development, testing and training in the use of materials for the Warmi Project.

The CIEC Director described the work with SC/B as a tremendous undertaking. As discussed in the IEC section, the participatory process involved in the materials' development was much more intensive and extensive than originally envisioned. The materials were developed and tested with women's groups in each zone as was the Partera's Manual with parteras from each zone. CIEC worked in teams with the women's groups constantly revising the documents. The process is crucial in ensuring the success of the use of the materials. In addition, the time planned for completion of the activities was far too short.

Production of the women's booklets was further delayed due to problems with the graphics designer. It was necessary to find a new professional able to draw similar designs in a similar style.

In general, CIEC had no complaints regarding the administration of funds or lines of communication with SC/B. The two organizations have close relations at both the director and field levels.

Through its involvement with the Warmi Project, CIEC has strengthened its institutional skills in the design of materials for a rural population. The institution acknowledges all that it has gained from the process. CIEC personnel speak very highly of their experience in Inquisivi and are now emphasizing the participatory methodology in materials development with its own personnel.

SAN GABRIEL FOUNDATION

The San Gabriel Foundation (FSG) is a non-profit Bolivian NGO that provides health services and education in one district in the city of La Paz. The Foundation has a tertiary care hospital and nine clinics in the district.

There have been two agreements between FSG and SC/B. The first was to provide technical training within FSG's training center to parteras from Inquisivi and to be a referral center for complicated cases from Inquisivi. The second contract, in negotiation, is to provide family planning services and education in Inquisivi Province.

After some initial problems, the partera's training appears to have gone smoothly. Initially, there were serious cultural conflicts between the parteras and FSG personnel. A lack of understanding of the parteras' experience, beliefs and customs on the part of FSG personnel accounted for the feeling of lack of acceptance by the parteras. FSG has since rectified the problem with internal sensitivity training for its own personnel. There is an attempt to respect the practices that have no impact on pregnant women's health and modify those that do harm. By the third group of trainees, relations had improved considerably. The quality of training varies depending on the number of institutional births a partera is able to assist. The parteras do not practice their profession at FSG but are present to observe every step.

Out of this experience FSG commented on a new awareness raised by the parteras regarding the treatment of women during the birth process. It is customary for a partera to assist with a pregnant woman from the first sign of contractions. In FSG, as in much urban medical practice, the pregnant woman is assigned to a nurse and the doctor is only present to deliver the baby. FSG is initiating an internal dialogue to explore ways to "humanize" the process within its hospital.

Both FSG and SC/B mentioned the conflict between practices based on medical technology and practices in areas with few resources. Early in the training, the midwives came away with raised expectations of all the equipment and accessories necessary for a healthy birth. These would be impossible to sustain in Inquisivi. Discussions between SC/B and FSG brought about a few changes in the training; the curriculum was modified slightly to accommodate a rural reality.

There were no administrative problems between SC/B and FSG and communication appears quite open. FSG is very positive about its linkages with other institutions. The institution

is open to learning from its experience with others, avoiding duplication and using resources efficiently. "Institutional linkages are fundamental."

FSG is currently conducting an internal evaluation of the training experience with SC/B. The institution will be very interested in the findings and their importance for the Training Center. (FSG is one of 6 national reproductive health training centers). Although this training course was initiated by SC/B, FSG foresees further possibilities in strengthening the Training Center and in its ability to offer similar training to other organizations.

LA PAZ HEALTH UNIT (MOH)

The Warmi Project area is a part of the Tres Cruces District of the La Paz Department Health Unit. The MOH has a hospital in Quime and health posts in Inquisivi, Licoma and Circuata. It has a doctor and a nurse auxiliary in Inquisivi and Licoma, a nurse auxiliary in Circuata and some health promoters in the rural communities. Its infrastructure is minimal, with little equipment and supplies.

SC/B has tried to work jointly with the Health Unit but this has not always been possible. In some areas, the Health Unit's personnel and SC/B's personnel are able to coordinate in some activities, such as "integrated fairs" and vaccinations. In the majority of cases, SC/B makes referrals to the Health Unit.

SC/B intended to involve the MOH District staff in interventions which would have an impact on health in the different communities. However, the District's organizational structure is very narrow and its personnel find it difficult to leave the health facilities. With some exceptions, they almost never accompany SC/B on field visits and rarely attend the monthly and quarterly planning and evaluation meetings to which they are invited.

RECOMMENDATIONS FOR INTERINSTITUTIONAL COORDINATION/COLLABORATION

SC/B should:

- Continue its interinstitutional coordination policy within networks and with individual institutions;

- Share the Warmi Project's achievements with institutions with similar characteristics (community focus in rural areas) for replication;
- Search for private institutions which could provide reproductive health services in the impact area until MOH services are able to respond to community demand for these services, and,
- Develop working agreements with other NGOs that can benefit from SC/B's Warmi Project experience (technical assistance, etc.).

X. ADMINISTRATION AND LOGISTICS

The administration of SC/B's projects is based on an organizational chart (see next page) which delegates decision-making to zonal quality circles in which each person has responsibility for the efficient and effective functioning of the whole team in the zone.

The inherent exchange of ideas in the decision-making process among the different persons involved facilitates the work and results in an adequately functioning system. Any improvement or modification can be made and/or implemented in the shortest time possible.

All procurement requests must be received 15 days prior to the date that materials are needed so that three price quotes may be obtained and budget made available for the purchase. The project has not experienced any undue delay in procurement.

Zonal quality circle problems that involve decisions that affect institutional policy and overall institutional functioning must be referred to the La Paz office Executive Committee.

Standard operating procedures have not changed significantly since the mid-term evaluation. For more detail regarding administrative procedures, see the Mid-term Evaluation Report, 1992.

INSERT SC/B ORGANIZATIONAL CHART HERE

XI. BUDGET AND COSTS

The three year life of project budget versus actual expenses is presented in Table 14 below by line item.

Table 15. Budget versus Actual Expenditures

LINE ITEM	APPROVED BUDGET	ACTUAL EXPENDITURES
PERSONNEL	\$ 140,019.00	\$ 137,184.78
LOCAL CONSULTANTS	19,760.00	19,386.53
TRANSPORT	28,180.00	27,843.15
SUPPLIES/MATERIALS	30,630.00	33,116.10
COMMODITIES/EQUIPMENT	1,800.00	1,796.96
EVALUATION	2,000.00	2,544.23
OTHER DIRECT COSTS	20,180.00	20,104.96
TOTAL DIRECT COSTS	242,569.00	241,976.71

Note: Overhead calculated at Home Office in Westport.

XII. SUSTAINABILITY

From the beginning, project staff incorporated activities and strategies to maximize the chances of sustainability.

At the community level, the project strengthened the ability of women's groups, partera associations, and community councils, to identify and prioritize their problems, and to plan together to resolve these problems. Many communities have begun to implement their plans. As each plan is realized their vision expands and their confidence in developing themselves and their communities also expands. This process was clearly reflected when observing these groups in problem prioritization, and in their expressions, drawings, and plans for the future.

The "partera", created in part by Warmi in response to community requests, has become an established and valued member of several communities. Many call her at the time of birth, recognize her training and skills, and pay for her

services. Some community councils are in the process of providing a birthing room where they may practice. Other communities have insisted that there be 2 parteras in each community, (one in training), so that if one dies or moves away, another can play this important role. Commitment in some communities to the objectives of Warmi in the form of providing funds and space to the parteras, was seen by the evaluation team as a strong indicator of sustainability.

The greatest constraint to sustainability is the lack of services to meet the demand created by training and education in maternal and neonatal health. The project, with due consideration to sustainability, did not provide direct services but rather referred to Ministry and Bolivian NGOs to provide these services. However, the quality and accessibility of these services is insufficient to meet the needs of the communities. Family planning supplies are not regularly available, and SC has had difficulty renewing the contract to make these services available through a Bolivian organization. MOH norms prohibit community-based distribution by parteras of all family planning methods, with the exception of condoms. Moreover, the norms also prohibit the partera to use antibiotics, oxytocin, and IV solutions, which restricts the ability of parteras to stabilize women at risk of dying from childbirth before reaching the hospital. Even the administration of TT vaccines is limited to medical staff who are clinic-based.

Existing services for secondary and tertiary referral are inaccessible, due to distance, cost, and a lack of facilities, equipment, drugs, and sometimes qualified medical staff.

In sum, demand and awareness for safe and wanted pregnancy and delivery has been created, yet the resources needed to meet this demand are inadequate.

RECOMMENDATION

Together with other NGOs and perhaps even the communities, Save the Children may try various strategies to increase the quality and access to needed medical services. Strategies may focus on improving community-based access to family planning, drugs which treat sepsis and hemorrhage, and the re-introduction of a "Matrona", who will act as a link between the District Hospital and the community. Such changes in national norms would have a tremendous impact on maternal health, and the sustainability of maternal and neonatal health objectives.

XIII. REPLICABILITY

If funding is secured for phase 2 of the project, SC/B will place greater emphasis in sharing lessons learned and providing assistance to other organizations who have expressed an interest in replicating program components. Moreover, the education materials and monitoring and evaluation systems will also be widely shared.

Already the following groups have expressed interest in replicating parts of the project:

- PLAN Sucre and Altiplano
- CARE
- CARITAS
- Andean Rural Health Project

Moreover, UNICEF has expressed interest in reproducing the Warmi women's health card for wider distribution.

Save the Children plans to work with PROCOSI and the Community Child Health (CCH) Project to identify ways for interested NGOs to collaborate together to replicate project components.

Persons trained by Save the Children in the Warmi project will be great resources for replicating program components. Women community members will be able to train women from other communities. And SC/B technical staff based in the field and La Paz will be excellent resources to provide technical support to others interested in implementing such a project.

The estimated cost of replication is calculated below (Table 15) and is based on a variety of assumptions which are explained. PVOs interested in replicating the project should take into account their own particular population characteristics and institutional operations and make adjustments accordingly.

Perhaps most importantly, if PVOs are to maintain the participative spirit of this project, it is quite possible that other interventions not contemplated below will have to be added or substituted.

Estimated Project Costs

Assumptions:

- 100 communities with women's groups in each community (avg. 20-25 women per group= 2,000 women of reproductive age)

- Amount of materials needed are estimated for both women who are members of groups and women who are not members of groups (total approx. 6,000)

Staff includes:

- 1 Project Coordinator
- 15 Field Supervisors (avg. 1 per 7 groups)
- Travel costs are shared among other projects in same communities

Table 16. Illustrative Cost of Project Replication

COST OF PROJECT REPLICATION IN 100 COMMUNITIES (Illustrative)				
	Year 1	Year 2	Year 3	Total
Salaries/Benefits				
1 Coordinator	\$20,000	21,000	22,050	63,050
15 Field Supervisors	58,500	61,425	64,496	184,421
Admin. Support	5,265	5,528	5,805	16,598
Travel/Per Diem				
Gas (400 kms/mo)	1,800	1,890	1,985	5,675
Vehicle Maintenance	450	475	500	1,425
Per diem: Workshops	3,000	3,150	3,310	9,460
Materials/Supplies				
Women's Health Cards	1,800	0	0	1,800
Women's Booklets	6,000	0	0	6,000
Partera Manuals (200)	3,000	0	0	3,000
Safe Birth Kits (2,000)	2,000	0	0	2,000
Partera Kits (200)	2,000	0	0	2,000
Training Materials	1,000	1,000	1,000	3,000
Other Direct Costs				
Reproduction	1,200	1,260	1,323	3,783
Communications	1,200	1,260	1,323	3,783
Miscellaneous	500	500	500	1,500
Evaluations (mid/final)	0	3,500	3,500	7,000
GRAND TOTAL	\$107,715	100,988	105,792	314,495

XIV. CONCLUSIONS

In conclusion, the Warmi Project achieved most of its objectives as stated in the Detailed Implementation Plan and the Field Agreement with JSI. All project products were delivered, as well as many that were not originally contemplated.

A new methodology of working with rural women with little access to health services was developed, tested and implemented. Although three years is too short a period to make definitive statements, it appears to be an effective, relatively low cost, although human resource intensive model.

A follow-on project to test the efficacy of the materials just completed at the end of this project and to test the replicability of the model to other areas of Bolivia is recommended.

XV. RECOMMENDATIONS

Many important specific recommendations have been made throughout the text of this report. To avoid repetition, this section will only present general recommendations which attempt to synthesize the essence of the specific points mentioned earlier.

1. The project has worked within the existing Ministry of Health norms and has demonstrated positive trends toward reducing maternal, perinatal and neonatal mortality. However, much more could be done to further reduce the high mortality rates if norms were adapted to the rural context and human resources available. Parteras could play more of a role in stabilizing patients with life-threatening complications (manual extraction of placenta, use of oxytocin in cases of severe hemorrhage, use of antibiotics for puerperal sepsis, etc.) and could serve as community-based family planning service providers of at least some methods. The revival of "matrona" (nurse/midwife) training and certification is recommended so that this valuable member of the health team can help supervise and support community parteras at the district level.

2. SC/B's participatory, community-based approach (autodiagnosis, planning together, implementation and participatory evaluation) is a simple model that has been effective in increasing women's and their families' awareness of maternal and neonatal health problems and provides a framework within which to generate realistic solutions at the community level. It is recommended that this approach be tested by other PVOs to determine its replicability to other similar rural areas.

This approach can only be effective if donors who fund and implementors who execute these efforts are flexible to respond to community needs as identified by community members. The Warmi Project was fortunate to have had this financial and programmatic support from AID/Washington and Bolivia, John Snow, Inc., Save the Children and its local counterpart organizations.

3. Women's self-esteem and empowerment play a large role in whether women, and their families, choose to seek adequate health care-- if women value their life/health they are more likely to seek these services to save their lives. The process of women's empowerment is an integrated one that involves access to information through education, access to economic resources, etc. Though reduction in maternal mortality requires adequate health services, these services, even when well staffed and equipped are only effective if women arrive. The "Pathway to Survival" model (see Annex 6) as developed by Dr. Alfred Bartlett with the SC/B team does not begin at the hospital door, but rather the hospital is nearly the last step in a very long and complicated personal, social and cultural process. Institutions that choose to implement a program to reduce maternal and perinatal mortality should either address these issues directly or should coordinate with other institutions and agencies to help empower women and their families.

4. In developing educational materials and training curricula, health and other field personnel should not approach communities with pre-set messages based on the biomedical model. New and improved practices should be negotiated based on mutual respect for one another's beliefs and practices. It is only when existing beliefs and practices are not only taken into account, but respected that true dialogue can begin and a realistic, "improved" practice be found.

5. SC/B zonal quarterly evaluation and planning meetings were determined to be extremely useful to constantly monitor and reinforce the program vision so that the field staff don't get stuck in the "micro view". The delegation of responsibilities and authority to zonal quality circles helped staff to internalize participatory planning and decision-making processes. These skills are critical not only to smooth functioning of the program, but more importantly, so that field staff can facilitate this process in the communities in which they work.

LIST OF REFERENCE DOCUMENTS USED DURING THE EVALUATION

Warmi Project Field Agreement with John Snow, Inc., July, 1990.

Warmi Project Detailed Implementation Plan, April, 1991.

Warmi Project Quarterly Reports for Life of Project.

Warmi Project Mid-Term Evaluation, April, 1992.

AYUFAM (SOPACOF) Final Evaluation, February, 1993.

Warmi Project Trip Reports by Mona Moore (1990), Patricia Taylor & Lisa Howard-Grabman (1990), Alfred Bartlett (1990 & 1991) August Burns (1991), Wendy Slusser (1991), Mary McInerney (1993), Marjorie Koblinsky (1993).

Howard-Grabman, L., The Autodiagnosis: A Methodology to Facilitate Maternal and Neonatal Health Problem Identification and Prioritization in Women's Groups in Rural Bolivia, MotherCare Working Paper No. 16A; _John Snow, Inc.; May, 1993. (Also available in Spanish)

Basic Proposal for the Format of the Warmi Project Educational Materials: First Report; Center for Interdisciplinary Community Studies (CIEC); September 8 1992.

Start-up Workshop for the Participatory Production of Educational Materials for the Warmi Project; CIEC: August 31-September 1, 1992.

Sanchez, E., Howard-Grabman, L., Rogers, D., Bartlett, A., Researching Women's Health Problems Using Epidemiological and Participatory Methods to Plan the Inquisivi MotherCare Project, paper presented at NCIH Conference, June, 1991.

Proposal for the Design and Production and Educational Materials on Maternal and Reproductive Health; CIEC, 1992.

Two Contracts for Technical Assistance Services between SC/B and CIEC for the period August 1, 1992 to August 31 1993 (later amended to June 30, 1993).

ANNEX 1: EVALUATION SCHEDULE AND INSTRUMENTS



CALENDARIO DE ACTIVIDADES PARA LA EVALUACION FINAL DEL PROGRAMA WARMI

FECHA:

Lunes 24 de Mayo y Martes 25 de Mayo	Planificación y preparación de la Evaluación por el equipo en La Paz.
Miércoles 26 de Mayo	(Por la mañana) Viaje a Inquisivi
Jueves 27 de Mayo	Reuniones con grupos de Mujeres y esposos de las comunidades de: Ventilla Chiji por la mañana Corachapi Yacopampa por la tarde
Viernes 28 de Mayo	Entrevistas con parteras (en la mañana) y autoridades de la zona de Inquisivi (en la tarde).
Sábado 29 de Mayo	Reunión con Grupo de Mujeres y esposos en Espiga Pampa y Pencaloma en la mañana y Lacayotini y Licoma en la tarde. vally
Domingo 30 de Mayo	Entrevistas con parteras (en la mañana) y autoridades de la zona de Licoma (en la tarde).
Lunes 31 de Mayo	Entrevistas con parteras (en la mañana) y autoridades de la zona de Circuata (en la tarde)
Martes 1ro. de Junio	Reunión con Grupo de Mujeres y esposos en Circuata en la mañana y Lujmani en la tarde. <i>por la mañana</i> Viaje hasta Chulumani.
Miércoles 2 de Junio	Regreso a La Paz desde Chulumani.

CRONOGRAMA DE TRABAJO
Equipo Cuantitativo

Lunes 24 de Mayo

- Hrs. 9:00 - 18:00 Limpieza de Datos
- Hrs. 14:00 Discusion del Plan de Trabajo
- Hrs. 16:00 Presentacion del Plan de Trabajo al Equipo Evaluador

Martes 25 de Mayo

- Hrs. 9:00-18:00 Validacion de Base de Datos y Revisión Final de Datos; Tablas de Frecuencia 22/93, Revis de la Encuesta, Guia de la Encuesta y Resultados Estudio de Casos, y Controles.
- Hrs. 14:30 Depuracion del Plan de Trabajo
- Hrs. 16:30 Discusion del Plan de Trabajo con Equipo Evaluador y Preparacion de Material para el Viaje

Miércoles 26 de Mayo

- Hrs. 8:30 inicio a Impresión
- Hrs. 15:00 Continuacion de Impresion de Tablas; Inicio del analisis de Tablas 22/93

Jueves 27 de Mayo

- Hrs. 8:30 Inicio Programa de Comparacion de Bases de Datos 20/91 y 22/93 y Repuesta Informatica a Demas Reuniones con Grupos de Mujeres y esposos (con todo el Equipo)

Viernes 28 de Mayo

- Hrs. 8:30 Continuacion de la Base de Comparaciones y del analisis de las Tablas
- Hrs. 14:30 Elaboracion del Resumido y Reporte Final

Sábado 29 de Mayo

- Hrs. 8:30 Continuacion del analisis de Comparacion y Reporte Final
- Hrs. 18:00 Salida a El Coma

Domingo 30 de Mayo

Hrs. 8:30 Continuar con Equipo Cualitativo y Reporte Final

Lunes 31 de Mayo

Hrs. 8:30 Continuar con Equipo Cualitativo y Reporte Final

Martes 1 de Junio

Hrs. 8:30 Continuar con Equipo Cualitativo y Reporte Final

Miércoles 2 de Junio

Regreso a La Paz



CONOCIMIENTOS EN SALUD MATERNA Y NEONATAL, EVALUACION FINAL,
Proyecto Warmi, 5/93, Desarrollo Juvenil Comunitario

NOMBRE: _____

INSTITUCION: _____

CARGO: _____

ZONA DE BASE: _____

1. Describe 4 actividades que se deben realizar durante el control prenatal.
 - 1.
 - 2.
 - 3.
 - 4.

2. Describe 3 signos de peligro durante el embarazo y los pasos que se deben seguir para responder a estos casos.
 - 1.
 - 2.
 - 3.

3. Describe 3 técnicas del "parto limpio".
 - 1.
 - 2.
 - 3.

4. Describe 2 razones de la importancia para realizar un parto limpio.
 - 1.
 - 2.

5. Describe 2 prácticas correctas para atender al recién nacido.

1.

2.

6. Describe 2 señales de alto riesgo durante el embarazo o el parto.

1.

2.

7. Describe la diferencia entre el trabajo de parto falso y el trabajo de parto real.

8. Describe 4 pasos básicos que se debe cumplir para atender al recién nacido.

1.

2.

3.

4.

9. Describe 3 métodos modernos de planificación familiar y para cada método, describe una contraindicación para su uso y 2 efectos secundarios.

Método	Contraindicación (1)	Efectos Secund.
--------	----------------------	-----------------

1.

2.

3.



Si la respuesta es no,
¿Porqué? _____

¿Qué paso con la(s) paciente(s)? _____

6.- ¿Que recomendaciones haria para el Proyecto DMC en el futuro?



CUESTIONARIO PARA EL PERSONAL DE DJC

- 1.- ¿Cuál es tu profesión? _____
- 2.- ¿Cuál es tu área de trabajo? _____
- 3.- ¿Hace cuánto tiempo estás trabajando en el Proyecto?
_____ meses/años
- 4.- ¿Cuál es el cambio más grande que has visto en las comunidades en relación al Proyecto WARRI?
- 5.- ¿Cuales son las dificultades o problemas que ha tenido el proyecto?
- 6.- ¿Cómo se puede mejorar el trabajo?
- 7.- ¿Cómo se puede mejorar la coordinación con la Unidad Sanitaria?
- 8.- ¿Cómo modificarías el Proyecto en el futuro? ¿Qué cambiarías?
- 9.- Otros comentarios y sugerencias



EMBARAZADAS: NUTRICION Y T.T.

1a.- ¿Cómo supiste que estabas embarazada?

1b.- ¿Cómo te cuidas durante tu embarazo?

2.- Número de vacunas TT: 1 2 3 4 5 >5

3.- Nutrición

ALIMENTOS

Leche (4 vasos, 4 Onzas de queso)
4 Tazas de sopa cremosa/
budín

Proteínas (3 porciones de carne,
pescado, pollo, porotos,
o 2 huevos)

Cereales/Carbohidratos (5 x ½ taza
o pedazo) cereales,
arroz, pan, fideo)

Fruta/Verdura (½ taza o un pedazo
mediano)

1 zanahoria/vainita,
zapallo, camote (Vit A)

2 repollo, manzana, papa,
plátano, arveja,
durazno, etc.

1 ají, tomate, cítricos,
melón, broccoli (Vit C)

TOTAL

Dosis Diaria Ideal	Cantidades		
	Desayun	Almuerzo	Cena
4			
3			
5			
1			
2			
1			
10			

FALTA: _____



4.- ¿Has asistido al control prenatal alguna vez?

SI ____ NO ____

¿Cuántas veces? _____

¿Dónde? _____ Partera
_____ Puesto Médico
_____ Supervisora de DJC
_____ Hospital
_____ Otro _____

5.- ¿Quedaste satisfecha con el control?

SI ____ NO ____

¿Por qué? _____

6.- ¿Tienes el carnet de la mujer?

SI ____ NO ____

¿Estás usándolo?

SI ____ NO ____

¿Por qué? _____

7.- ¿Puedes recordar 3 signos de peligro durante el embarazo?
¿Cuáles son? ¿Qué tienes que hacer cuando apareciera cada uno de estos signos?

Signo

Acción

1.

2.

3.

8.- ¿Cuáles son 2 acciones para prevenir el tétanos en la madre y la wawita?

1.

2.



PARTERAS - ENTREVISTAS INDIVIDUALES

Nombre: _____

Comunidad: _____

1.- ¿Cuándo empezó su trabajo como partera? _____

2.- ¿Por cada mujer/paciente, ¿Cuántos controles prenatales realizas (promedio)?

_____ No. de CP (promedio)

3.- ¿Cuántos partos ha atendido? _____

4.- ¿Qué complicaciones ha tenido? _____

5.- ¿Qué acciones ha tomado? _____

6.- ¿Cuántas pacientes ha referido? _____

¿A dónde? _____

7.- ¿Ya se capacitó en San Gabriel? SI ___ NO ___

¿Cuándo? _____

8.- ¿La capacitación en San Gabriel se puede usar en su trabajo de campo?

SI ___ NO ___

¿Por qué? _____

9.- ¿Tiene usted contacto con la Auxiliar o el Médico de la Unidad Sanitaria?

SI ___ NO ___

¿Cada cuánto tiempo tiene contacto con ellos? _____

Comentarios _____

10.- ¿Tiene usted un botiquín de partos? SI ___ NO ___



Nombre de la Partera: _____

Comunidad: _____

Parteras Lista de Chequeo de Entrevista Prenatal

- _____ Edad de la embarazada
- _____ Número de embarazos
- _____ Fecha de la última menstruación
- _____ Problemas anteriores
- _____ Problemas actuales
- _____ ¿Qué está comiendo/cómo se está alimentando?
- _____ Consejos sobre nutrición/alimentación
- _____ Consejos sobre aseo
- _____ Sal yodada
- _____ T.T.
- _____ Parto limpio
- _____ Lactancia Materna (primera hora después del nacimiento)
- _____ ¿Quién va a atender el parto?
Capacitado: SI ____ NO ____
- _____ Abortos, fracasos, mortinatos, óbitos, prematuros
- _____ Mellizos (en el pasado o actualmente)
- _____ Referencias
- _____ Síntomas de embarazo
- _____ Movimiento fetal
- _____ Sulfato ferroso
- _____ Aumento de peso
- _____ Edema/hinchazón
- _____ Hemorragia
- _____ Dolor al orinar



CUENTO NO. 1

Historia de Doña Aleja

Doña Aleja era una señora que no asistía a las reuniones, ni a las campañas de vacunación de TT. Pensaba que las reuniones quitaban tiempo, que solo se reunían para chismear y hablar de sus maridos.

¿Es bueno o malo no asistir a las reuniones ni a las campañas de vacunación de TT?

BUENO _____ MALO _____ NO SABE _____
(Anotar el número de respuestas correspondientes a cada opción)

Pero resulta que esta señora estaba embarazada, ya en sus últimos meses. Llegó el momento del parto y nadie pudo ayudarla, ni su marido porque había viajado a la ciudad.

¿Es bueno o malo que una mujer se quede sola cuando está cerca el momento del parto?

BUENO _____ MALO _____ NO SABE _____
(Anotar el número de respuestas correspondientes a cada opción)

Cuando nació el niño, estuvo mucho rato debajo de la madre, llorando.

La madre solo tenía a su hijita mayor, quien hizo todo lo que su madre le indicó. Doña Aleja le dijo que le pasara tijera e hilo de saquillo que estaban sobre la mesa de la cocina.

Doña Aleja, como estaba sola, sin que nadie pudiera ayudarla, se levantó con mucho esfuerzo, vió a su niño que era varón y gordito y llorón; se alegró mucho porque era su primer varón, le limpió la carita, sacó las flemas con un trapo limpio.

¿Es bueno o malo todo lo que la madre hizo cuando nació su wawa?

BUENO _____ MALO _____ NO SABE _____
(Anotar el número de respuestas correspondientes a cada opción)

Le cortó con la tijera el cordón umbilical y lo amarró con el hilo de saquillo.

¿Es bueno o malo lo que hizo la madre con el cordón?

BUENO _____ MALO _____ NO SABE _____
(Anotar el número de respuestas correspondientes a cada opción)



Envolvió a su niño.

¿Es bueno o malo envolver al niño recién nacido?

BUENO _____ MALO _____ NO SABE _____
(Anotar el número de respuestas correspondientes a cada opción)

Le hizo mamar después de 3 días,

¿Es bueno o malo hacer mamar después de 3 días?

BUENO _____ MALO _____ NO SABE _____
(Anotar el número de respuestas correspondientes a cada opción)

no hizo ninguna curación del cordón.

¿Es bueno o malo no curar el cordón?

BUENO _____ MALO _____ NO SABE _____
(Anotar el número de respuestas correspondientes a cada opción)

Pasó una semana y el niño ya no quería mamar, lloraba muchísimo, estiraba mucho hacia atrás.

¿Es bueno o malo que el niño no quiera mamar y que estire hacia atrás?

BUENO _____ MALO _____ NO SABE _____
(Anotar el número de respuestas correspondientes a cada opción)

Como la señora no sabía qué ocurría, porque ella nunca había asistido a las reuniones y servicios de salud, pensaba que solo era algún dolor de estómago; lo envolvió y lo hizo dormir.

¿Es bueno o malo que el niño no quiera mamar y que estire hacia atrás?

BUENO _____ MALO _____ NO SABE _____
(Anotar el número de respuestas correspondientes a cada opción)

Al día siguiente, Doña Aleja quiso amamantar a su niño y se dió cuenta de que había muerto. La señora no sabía qué hacer; lo único que hizo fue llorar desesperadamente y gritar que su niño había muerto, porque era su único hijo varón.

¿Qué le recomendarían a Doña Aleja?



CUENTO NO. 2

Doña María, una mujer joven de 25 años, ya tiene 6 hijos y está embarazada otra vez.

¿Es bueno o malo que una mujer tan joven tenga tantos hijos?

BUENO _____ MALO _____ NO SABE _____
(Anotar el número de respuestas correspondientes a cada opción)

María tiene los pies muy hinchados, pronto va a nacer su wawa y bota un poco de sangre cada día.

¿Es bueno o malo que bote sangre?

BUENO _____ MALO _____ NO SABE _____
(Anotar el número de respuestas correspondientes a cada opción)

Ella piensa: "Ya tengo seis hijos, siempre se me han hinchado los pies, pero nunca botaba sangre; esta vez ¿qué será? Yo creo que ya se me va a pasar. No tengo tiempo de ir al control, ahí te tocan, te miran, te preguntan; feo debe ser".

¿Es bueno o malo que Doña María no quiera ir al control?

BUENO _____ MALO _____ NO SABE _____
(Anotar el número de respuestas correspondientes a cada opción)

A pesar de botar sangre, ella sigue haciendo su trabajo en la casa: limpia, lava y prepara su comida, fideo, arroz, papa; siempre cocina con sal de adobe.

¿Es bueno o malo que Doña María consuma sal de adobe si está embarazada?

BUENO _____ MALO _____ NO SABE _____
(Anotar el número de respuestas correspondientes a cada opción)

Cuando los dolores comienzan, María avisa a su esposo, Juan. El le da mates de orégano y flor de anabán.

¿Es bueno o malo tomar mates cuando los dolores comienzan?

BUENO _____ MALO _____ NO SABE _____
(Anotar el número de respuestas correspondientes a cada opción)



Luego nace el niño, flaquito y decaído: no tiene fuerza ni para llorar.

¿Es bueno o malo que un niño nazca flaquito y decaído?

BUENO _____ MALO _____ NO SABE _____

(Anotar el número de respuestas correspondientes a cada opción)

Doña María tiene un problema: han pasado dos horas y la placenta no baja. Don Juan no sabe qué hacer y decide avisar a Doña Flora, la vecina que es partera.

¿Don Juan ha tomado una decisión buena o mala llamando a Doña Flora?

BUENO _____ MALO _____ NO SABE _____

(Anotar el número de respuestas correspondientes a cada opción)

Doña Flora corre a ayudar a Doña María: le hace masajes, le charla, pone al niño al pecho de la madre para que lacte y logra al fin que la placenta baje.

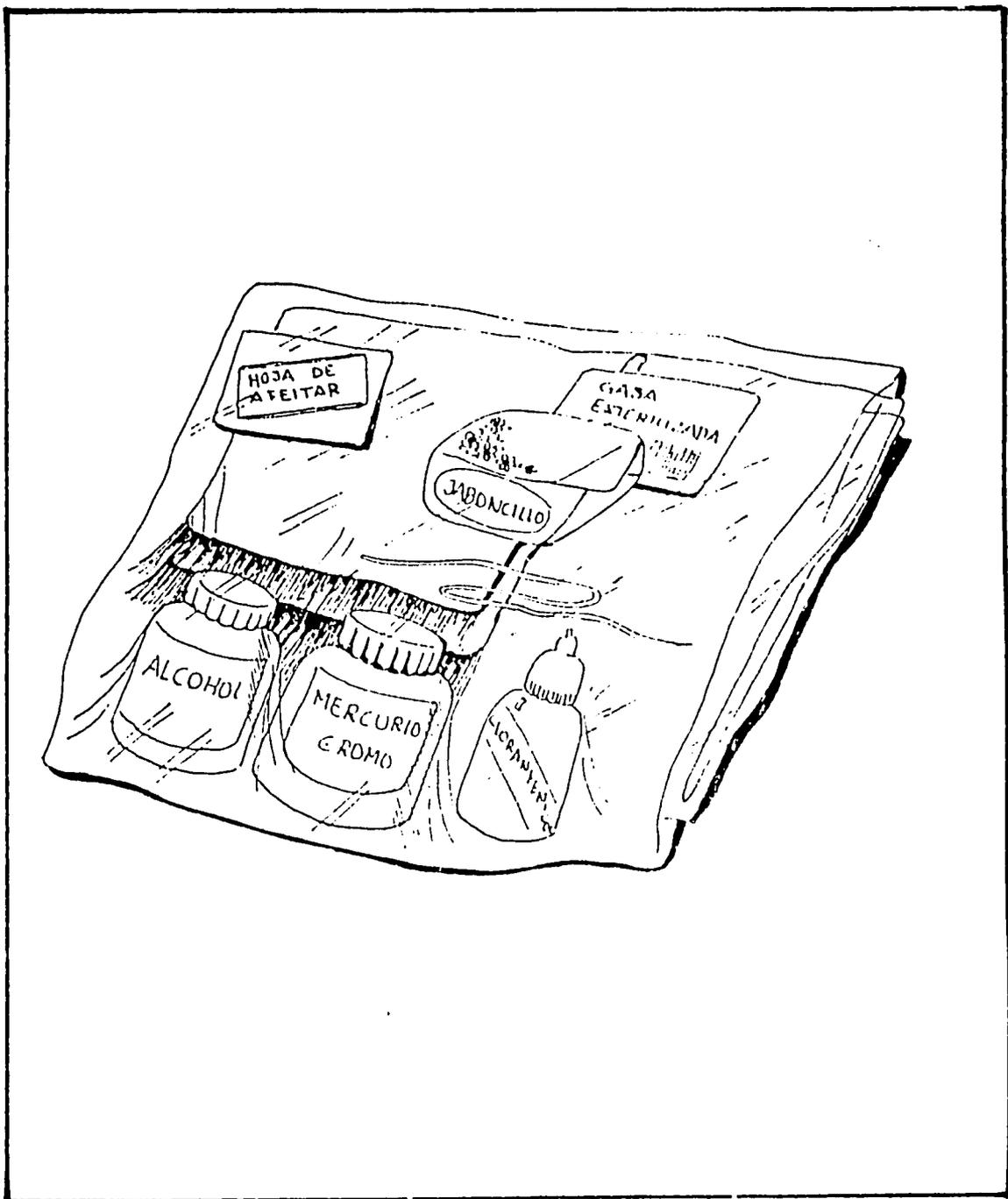
¿Es bueno o malo que una partera ayude cuando se presentan problemas?

BUENO _____ MALO _____ NO SABE _____

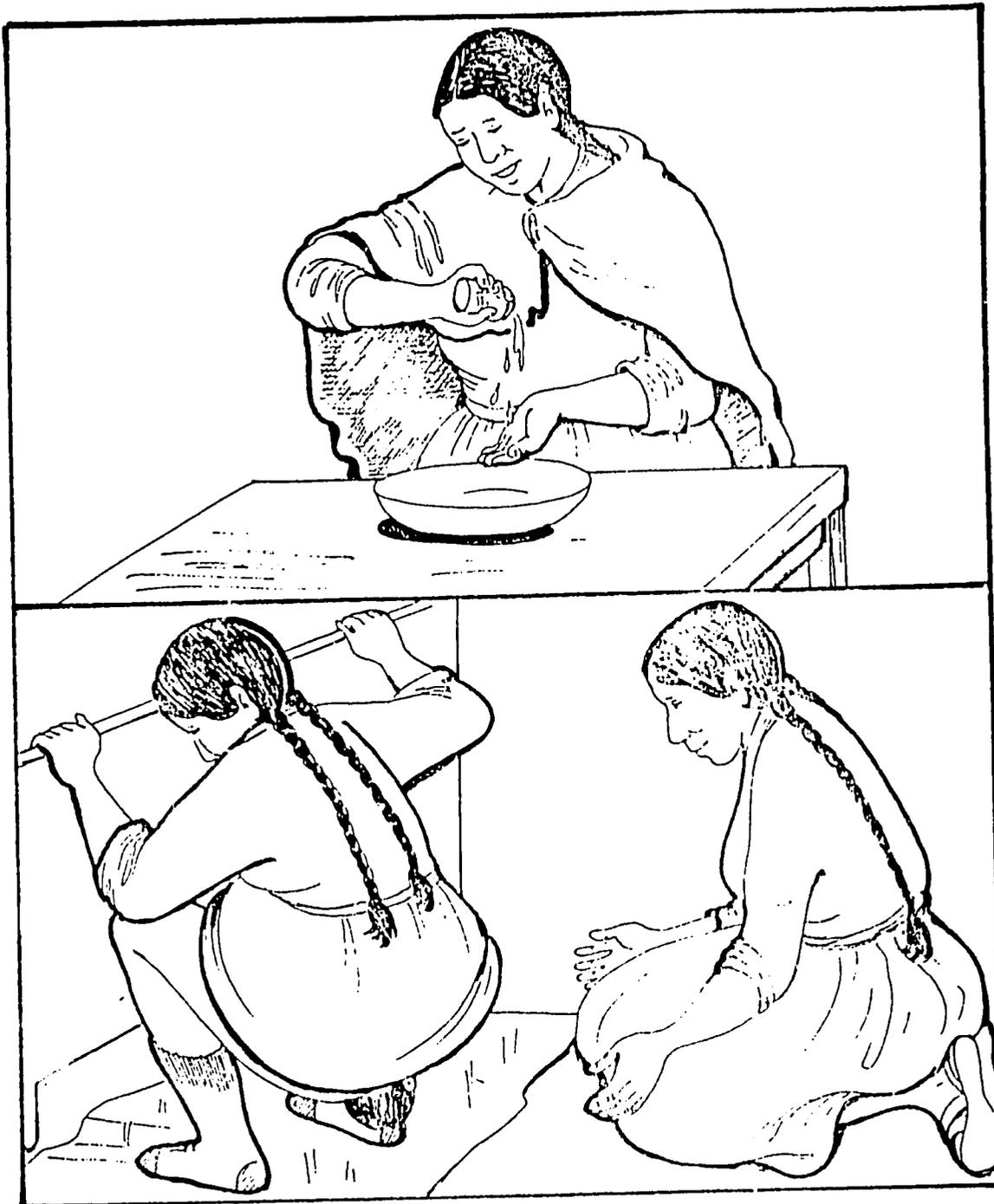
(Anotar el número de respuestas correspondientes a cada opción)



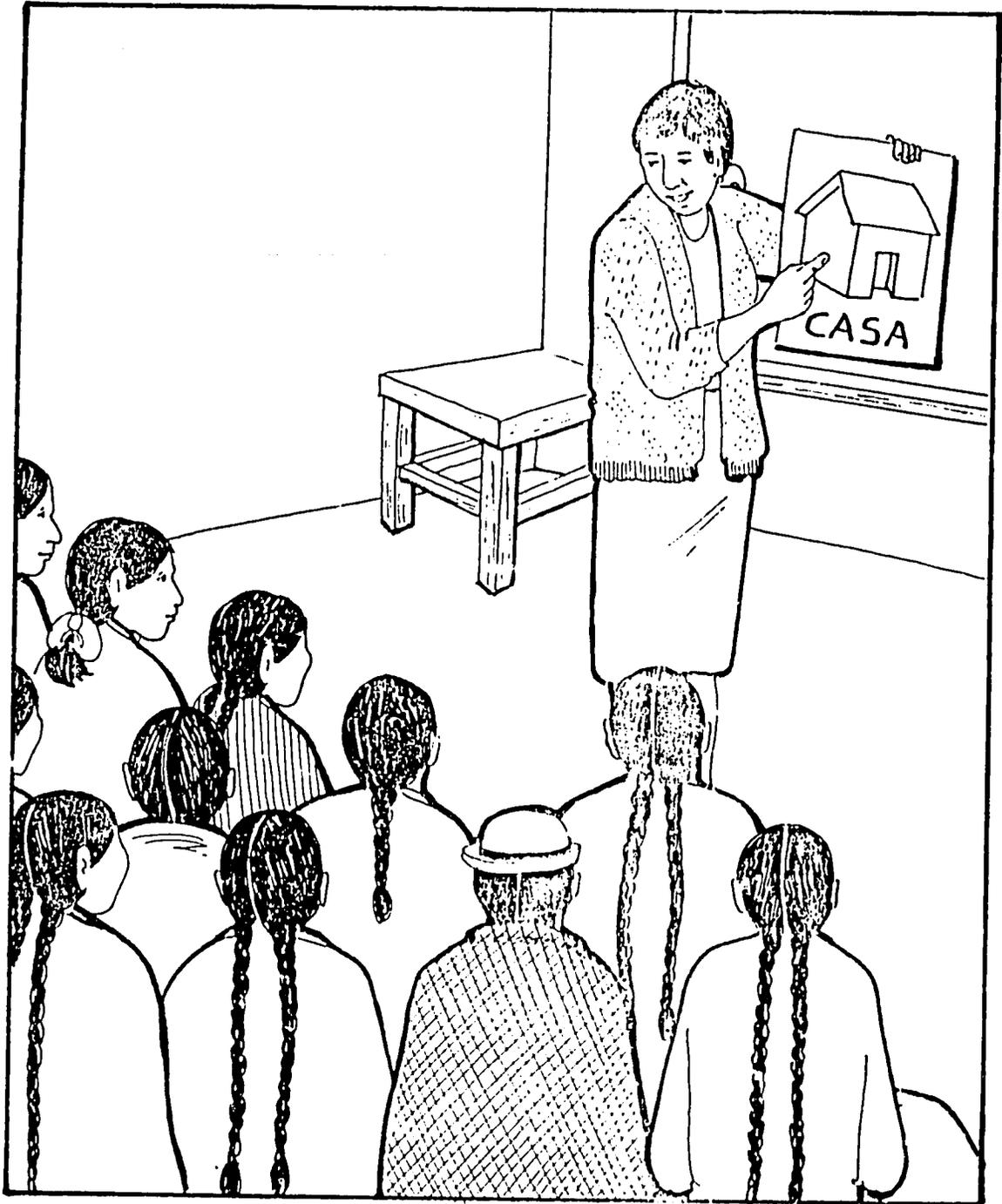
GRUPOS DE AHORROS



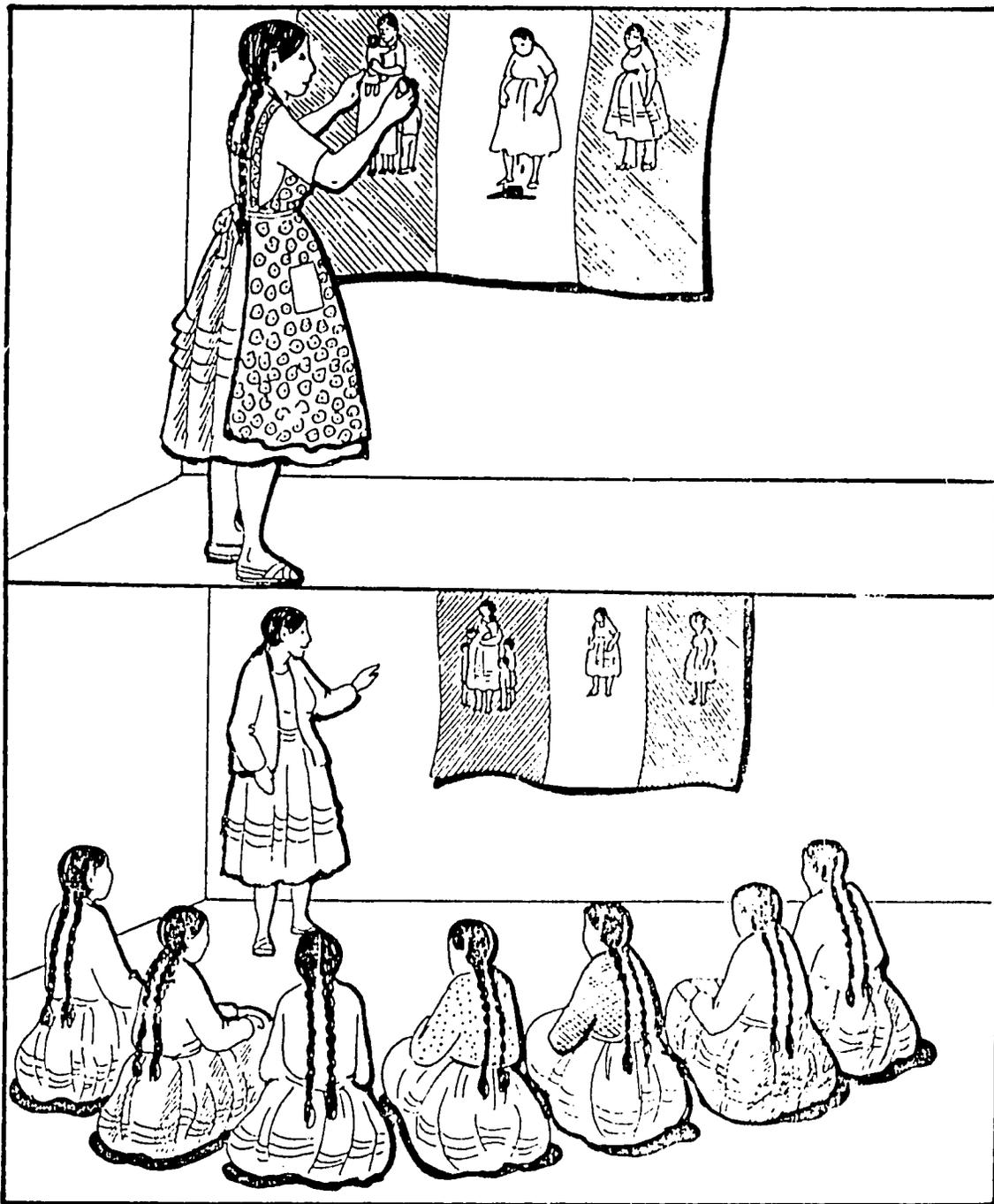
PAQUETES DE PARTO LIMPIO



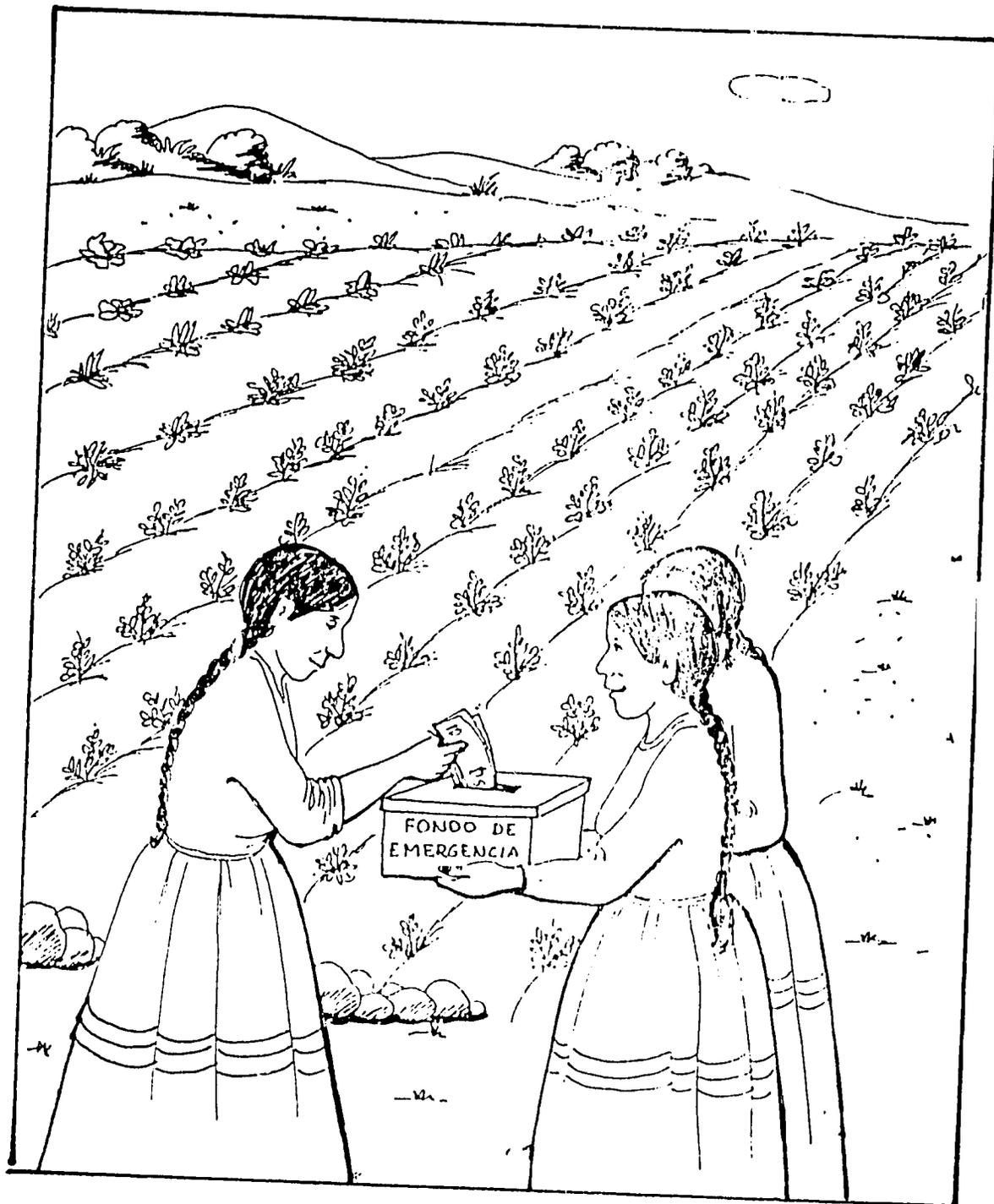
PARTO LIMPIO



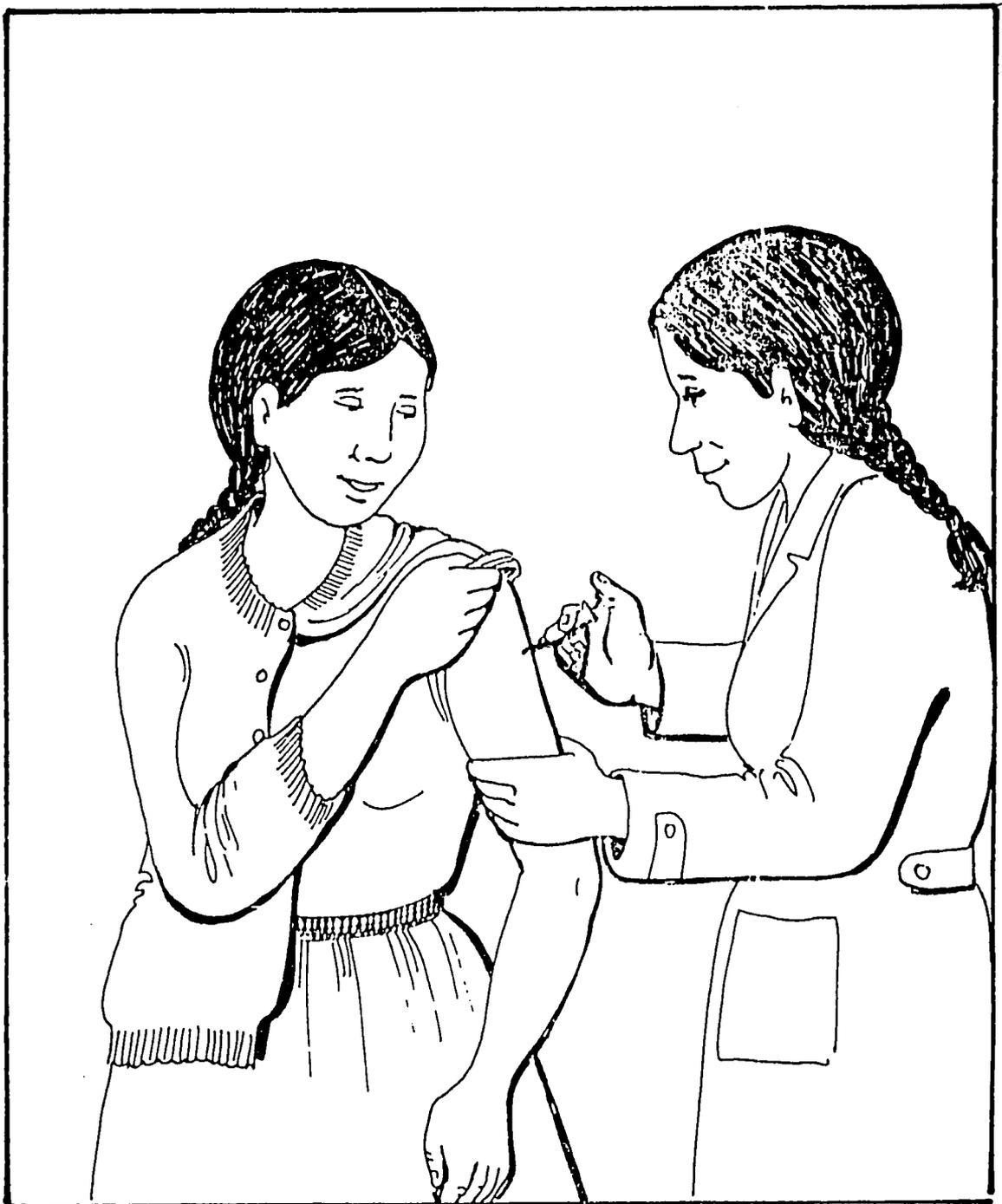
ALFABETIZACION



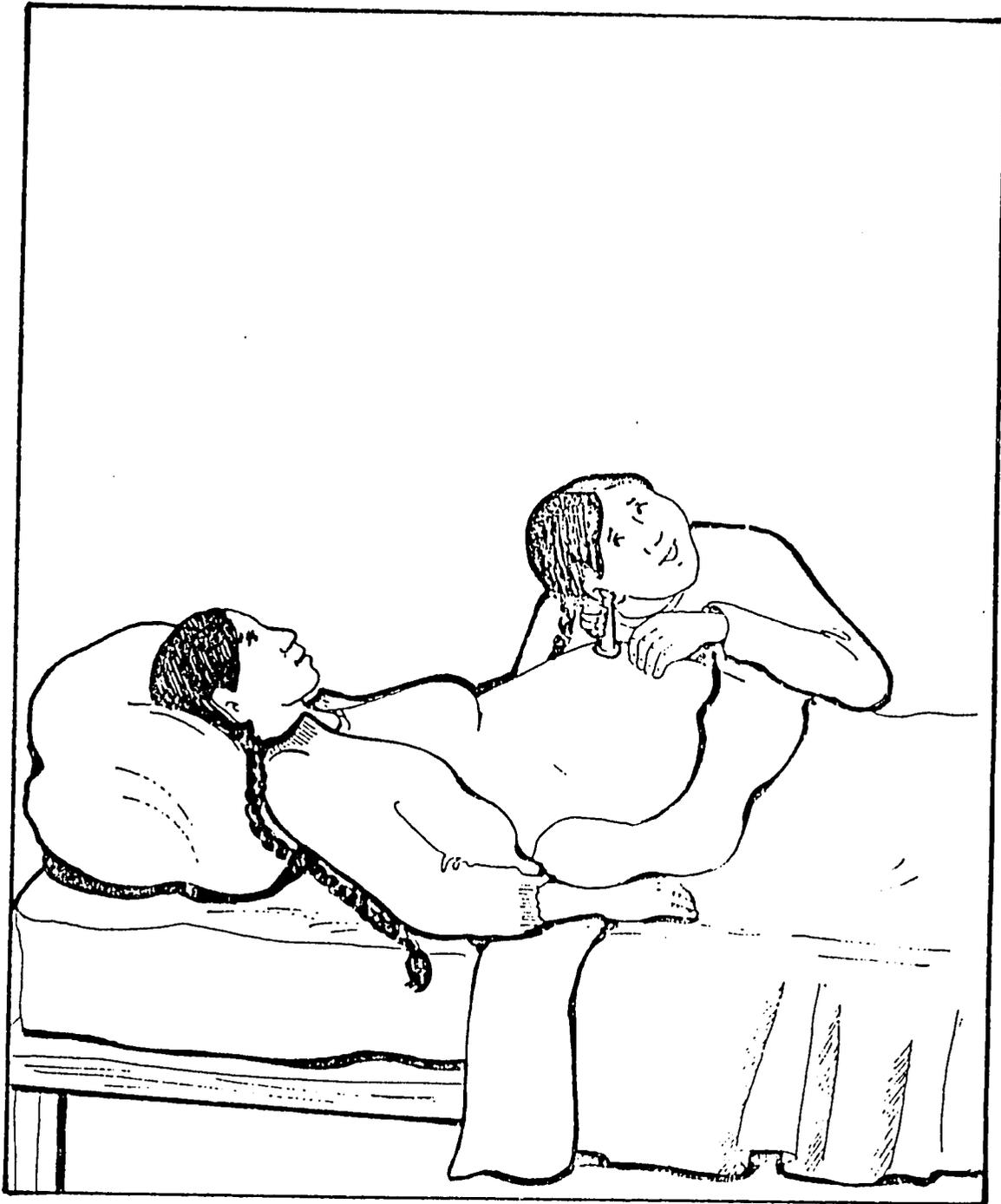
AUTODIAGNOSTICO



FONDO DE EMERGENCIA DE HUERTOS COMUNALES Y OTRAS
ACTIVIDADES PARA GENERAR INGRESOS



TOXOIDE TETANICO



CONTROL PRENATAL

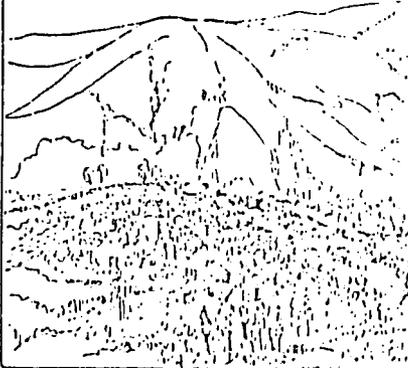
Salud Reproductiva Manual para parteras comunitarias

Save the Children
Proyecto Wamun
CHC

"La salud de la madre es responsabilidad de todos"

Una historia real.

Esta historia ocurrió en Caychani,
una comunidad cerca de Cuzco.



En Caychani hay un centro
de salud, pero hay
problemas para llegar
por la mala carretera.

Pero Caychani tiene también sus
problemas: no tiene un Centro de Salud
y solo se puede llegar a una clínica.

ELABORACION Y PRODUCCION DE LOS MATERIALES
EDUCATIVOS (CARTILLAS, MANUAL PARA PARTIRAS, ETC.).



SULFATO FERROSO



CREDITO PARA LA MUJER

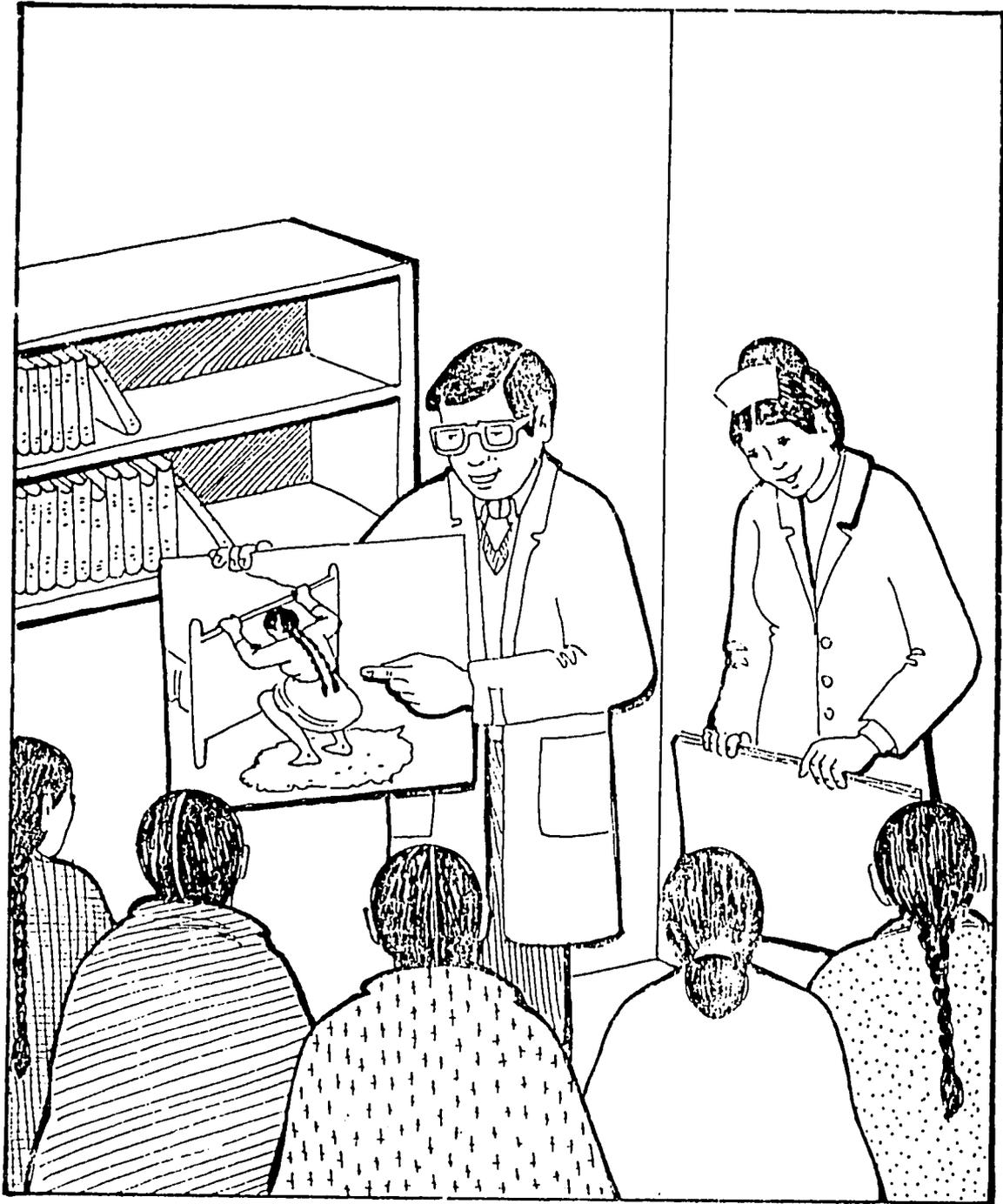


FORTALECIMIENTO DEL SISTEMA DE REFERENCIA (PARTERA
A PUESTO A HOSPITAL DE QUIME A SAN GABRIEL)



ORGANIZACION Y FORTALECIMIENTO DE GRUPOS DE MUJERES

12/11



CAPACITACION Y SERVICIOS DE LAS PARTERAS



PLANIFICACION FAMILIAR

LISTA DE PARTICIPANTES

TALLER DE: EVALUACION WAPHI FECHA: 29 de Mayo.

No.	NOMBRES	CARGO	COMUNID.	FIRMAS
1	Santiago Medina C	Educ.-Coord	Licoma	[Signature]
2	Huanachi Leiona Carera	Sup Campo Salud	Licoma	[Signature]
3	Juan Alberto	chefe	LD	[Signature]
4	Freddy Bezo M.	Tec.-H. O. petib	Licoma	[Signature]
5	Carlos Huancu K	Pro motor.	Lacayo Int.	[Signature]
6	Los Ramos Gonzales	COORD/WAPHI	LICOMA	[Signature]
7	Juanca Loma Chery	aux. Su. L.S. Licoma	Licoma	[Signature]
8	Yvina Mercado	Sup. Campo	Licoma	[Signature]
9	CARLOS LOAYZA	GERENTE	INQUISIVI.	[Signature]
10	Kathleen Dowd	AGRICULTURA	LICOMA	[Signature]
11	CLAUDIA DE LA QUINTANA	Rep. Pop. Council	LICOMA	[Signature]
12	Ysabel Bonce R.	Partera	Chayma	[Signature]
13	Yousompa Cecilia Dolu	Representante	Yousompa	[Signature]
14	Macario Kaura T	sup. Camp	Licoma	[Signature]
15	Luis Gorgui Rio	Representante	Lacayampi	[Signature]
16	Betty Micaela	representante	Circunata	[Signature]
17	Zenia Perea de la	Partera	Circunata	[Signature]
18	Tania Muñoz Mamani	promotora	Lacayampi	[Signature]
19	Isabel Gutierrez	Monitora	Licoma	[Signature]
20	Sebastian Pardo	conductor	Licoma	[Signature]
21	Salustio Aguilar	conductor	Licoma	[Signature]
22	Debo Flores	Petroquímico	Licoma	[Signature]
23	José Luis Mamani	Sadud	Lacayampi	[Signature]
24	Alexis Alejandro	Partera	Lacayampi	[Signature]
25	Delina de Mendoza	USLP	Supiniza	[Signature]
26	Basilio Juicio	E. de W. Comu	Inguruni	[Signature]
27	Adela Culliraya A.	Sup. Campo	Suri	[Signature]
28	Mary	CA - PA	LD - PA	[Signature]
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LISTA DE PARTICIPANTES

TALLER DE: EVALUACION UJRM

FECHA: 30 de mayo.

No.	NOMBRES	CARGO	COMUNID.	FIRMAS
1	Jacón Urbina P.	Coordinador	Juzi	[Signature]
2	María Llanos	STRO general	Maxxoca	[Signature]
3	Alfredo Bellido	STRO de Kela	Maxxoca	[Signature]
4	David Curicaguqui	Sub. Control	Chupaca	[Signature]
5	Adelio Peralta	STRO. general	Chigña	[Signature]
6	Sebastián Pardo Chávez	Tramitador	Wanca	[Signature]
7	Clidy Belmont	Portero	Suri	[Signature]
8	Guillermo Huancu	Portero	Porcota	[Signature]
9	Pamela Pao	Portero	maxxoca	[Signature]
10	Francisco Pao	Portero	Kuluyo	[Signature]
11	Oliver Huancu	prosecretaria	Supanivaca	[Signature]
12	Emiliana Quijada	Portero	Copiza	[Signature]
13	Agustín Rueda	STRO general	Supanivaca	[Signature]
14	Román Álvarez D.	STRO general	Pacayabamba	[Signature]
15	Salustiano Aguilar	Conductor	Secoma	[Signature]
16	Juan Manuel Durán	Portero S. Relación	Palomani	[Signature]
17	Macario Cordón	Secretario Relación	Systaca Rielca	[Signature]
18	Grina Mercado	Sup. Campa	Licoma	[Signature]
19	Macario Pao	Sup. Campa	Chua	[Signature]
20	Angel Quijada	Portero	Soytaq	[Signature]
21	Meliton Llanos	Central Chigña	Chiclayo	[Signature]
22	German Pardo Chuanqui	Organista	Chiclayo	[Signature]
23	Florencia Flores	Sec. Relación	Lagayateji	[Signature]
24	Lorena Rosa Quijada	Munici local	Lagayateji	[Signature]
25	Luis Quijada	Sec. General	Chiclayo	[Signature]
26	Enrique Manani	S. Relación	Chiclayo	[Signature]
27	Pedro Muñoz	Quindicario	Kuluyo	[Signature]
28	Santiago Aruquipa	S. General	San Juan de los	[Signature]
29	Delina de Mendoza	Supanivaca	USLP	[Signature]
30	Claudia de la Quintana	Pop. Pop. Council	LA PAZ	[Signature]
31	KATHLEEN DOWD	AGRICULTURA	LILOMA	[Signature]
32	Betty Mercedes	Representante	Circunata	[Signature]
33	Lucía Huancu	STRO Justicia	Lagayateji	[Signature]

LISTA DE PARTICIPANTES

TALLER DE: EVALUACION WARMI FECHA: 30-05-93

No.	NOMBRES	CARGO	COMUNID.	FIRMAS
1	Felix Aguay Quipe	autoridad	Licoma	[Signature]
2	Alberto Alambi Banqui	Stric. Relacion	Pencaloma.	[Signature]
3	Paulino Mamani E.	Prof. Licoma	Esc. Central	[Signature]
4	Laureano Marca. Condori.	Stric. General.	Pencaloma.	[Signature]
5	Atanacia Muñoz Mamani	promotora	Cochabamba	[Signature]
6	ISABEL GARCIA	Secretaria	Ticacajani	[Signature]
7	Basilio Yume	E. de Warmi	Inguisivi	[Signature]
8	Louder N. Mamani E.	Salud	Pencaloma	[Signature]
9	Zonia Perea de Ah	Partera	Circuta	[Signature]
10	Fra. Romeo Gonzalez	coord. WARMU	Licoma	[Signature]
11	Juan Alberto	[Signature]	"	[Signature]
12	Cristina Quiles	Partera	Chaca	[Signature]
13	Adela Pallacaya A.	Sup. Campo	Suri	[Signature]
14	Carlos Loayza	GERENTE DE BEN	INGUISIVI	[Signature]
15	Ysabel Ponce R.	partera	Chajma	[Signature]
16	Juliago Medina	Coord. Educ	S.J.	[Signature]
17	Yonna Calleja M	partera	Charafari	[Signature]
18	Julia F. Ch.	partera	Isosajutane	[Signature]
19	Alya Alejandra	Partera	Laco y otine	[Signature]
20	Luis Yansuri	Representante	Cochabamba	[Signature]
21	Cecilia Rodriguez Pico	Representante	Yacupampa	[Signature]
22	Atancia Muñoz Mamani	Representante	Cochabamba	[Signature]
23	Ana Juanita Sandozo	B. General.	Inguisivi	[Signature]
24	Dereza Limacachi Licoma	Sup. de Licoma	Licoma	[Signature]
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LISTA DE PARTICIPANTES

TALLER DE: EVALUACION "WAZMI" FECHA: 31-05-93

No.	NOMBRES	CARGO	COMUNID.	FIRMAS
1	Jose Perez L	aux. Enf.	Circuata	J. Perez L
2	Alja Alvarado	Portera	Sacayotine	Alja Alvarado
3	Elsa Ramos G.	Coord. / WAZMI	Sayama	E. Ramos
4	Patricia Lopez	Sitio de Adm.	Guamirina	Patricia Lopez
5	Rosa Bujones	Sup. Tonicos	Circuata	Rosa Bujones
6	Maria Tabares	Exp. Regidos	Circuata	M. Tabares
7	Gene Cipriano	Sitio Gen.	Circuata	G. Cipriano
8	Guillermo Chabali	Sitio Adm.	Circuata	G. Chabali
9	CLAUDIA DE LA QUINTANA	Rep. Pop. Council	LA PAZ	C. Quintana
10	MAX DEL VALLE	Rep. San Gabriel	La Paz	M. Del Valle
11	Carlos Loayza	GERENTE de AREA	FUGUISIVI	C. Loayza
12	Willy Seoana	Asesor	L. P.	W. Seoana
13	Basilio Lopez	Sup. Salud	Circuata	B. Lopez
14	Suzanna Alvarado	Sitio General	San Jose	S. Alvarado
15	Juan Jacobo Arguello	Sitio General	Agua Rica	J. Arguello
16	Lourdes Medina	Coord. Edu.	Pic / cer	L. Medina
17	Cecilia Rodriguez Boza	Representante	Guamirina	C. Rodriguez
18	Betty Alvarado	Representante	Circuata	B. Alvarado
19	Ena Gomez de Rojas	Representante	Agua Rica	E. Gomez
20	Juan Alberto	Asesor	L. P.	J. Alberto
21	Sebastiana Pardo	"	"	S. Pardo
22	Sonia Huiza	"	"	S. Huiza
23	Alia Gabriel	Portera	Limón Uado	A. Gabriel
24	Rosmeri Peña Pae	Portera	Canamino	R. Peña
25	Sonia Perea	Portera	Circuata	S. Perea
26	Lourdes Mamani	Mambora - sala	Puncaboma	L. Mamani
27	Cecilia Laine	E. de Waruwi	Fuguisivi	C. Laine
28	Rosalia Antonia T.	Sup. Campo	Circuata	R. Antonia
29	Maria Zamborano	Portera	Canamino	M. Zamborano
30	Gita Pillai	WCL Program	Oficina Habita	Gita Pillai
31	Lucia Targui	Representante	Corochopi	L. Targui
32	Lucia Aruqipa	Portera	Agua Rica	L. Aruqipa
33	Salvadora Aguilar	Coordinador	Sacayotine	S. Aguilar

LISTA DE PARTICIPANTES

TALLER DE: Evaluación WASH FECHA: 31-05-23

No.	NOMBRES	CARGO	COMUNID.	FIRMAS
1	Lisa Howard-Orbman	Co-Directora	La Paz	<i>[Signature]</i>
2	Delina Mendoza	Supervisora	USHP	<i>[Signature]</i>
3	Isabel Gutierrez	Manutara	Micoyani	<i>[Signature]</i>
4	Atomacia Muñoz	Promotora	Corachapi	<i>[Signature]</i>
5	Isabel Ponce	Portera	CHADMA	<i>[Signature]</i>
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LISTA DE PARTICIPANTES

TALLER DE: FUNDACION WARMI FECHA: 1-06-93

No.	NOMBRES	CARGO	COMUNID.	FIRMAS
1	Basilio Larrea	E. de Warmi	Enquisivi	Basilio Larrea
2	Cladia de la Quintana	Rep. Pop. Comul	LA PAZ	Cladia de la Quintana
3	Santiago Medina	coord-Educ	lic/CIR	Santiago Medina
4	Delina Mendoza	superiora	USLP	Delina Mendoza
5	Juan Alberto	chefe	L.P.	Juan Alberto
6	Yita Pellai	Yita Pellai	Oficina Matina	Yita Pellai
7	Lisa Howard-Orabman	Co-Directora	La Paz	Lisa Howard-Orabman
8	Willy Seoane	AJEDOR	L.P.	Willy Seoane
9	MAX del Valle	Rep. Sr. Gabriel	L. Paz	MAX del Valle
10	Lourdes Mamani	Salud	Potosí	Lourdes Mamani
11	Aleja Alejandro	Portera	L. Cayalini	Aleja Alejandro
12	Lucia Torqui	Representante	Cochabamba	Lucia Torqui
13	Rosmelia Chiriqui	Sup. Grupo	Cochabamba	Rosmelia Chiriqui
14	Sonia Huiza		L.P.	Sonia Huiza
15	Elsa Ramos	coord. WARMI	Lima	Elsa Ramos
16	Lucia Rodriguez Paez	Representante	Yampiza	Lucia Rodriguez Paez
17	Isabel Gutierrez	Manilera	Micayani	Isabel Gutierrez
18	Betty Abreu	Representante	Caracas	Betty Abreu
19	Carlos Loayza	GERENTE de OEA	INQUISIVI	Carlos Loayza
20	Ataricia Ullman	Patrona	Cochabamba	Ataricia Ullman
21	Basilio Cetti P.	Sup. Grupo	Sicoma	Basilio Cetti P.
22	Santiago Paez	Chefe	L. Paz	Santiago Paez
23	Salustio Aguilar	conductor	Sicoma	Salustio Aguilar
24	Sonia Paez	Portera	Cochabamba	Sonia Paez de Cetti
25	Isabel Paez	portera	Orayma	Isabel Paez de Cetti
26				
27				
28				
29				
30				
31				
32				
33				

100

ANNEX 2: CASE CONTROL STUDY QUESTIONNAIRE

COMMUNITY INFORMATION

13. Total population:

- 1 = very small (<100)
- 2 = small (100-199)
- 3 = medium (200-499)
- 4 = large (>500)

Response:

14. Organization: (0 = none 1 = yes)

- Syndicate
- Mothers' Club
- Mothers' Organization
- Cooperatives
- Neighborhood committee
- Other

15. Health resources: (0 = none 1 = yes)

- Health promoter
- Trained empirical birth attendant
- Untrained empirical birth attendant
- Yatiri (**traditional healer**)
- Health post
- Medical post
- Hospital

16. Basic services: (0 = none 1 = yes)

- School
- Water source
- 1 = river
- 2 = well
- 3 = watershed
- 4 = Public faucet
- 5 = Intradomiciliary faucet

FAMILY AND HOUSING INFORMATION

(NOTE: From here on the data refer to the moment the event occurred.)

17. How many families live in the house:
18. How many persons lived in the house:
19. Number of habitable rooms:
20. In case of an emergency, how many hours does it take you to get to the nearest medical center?

Walking hrs.
Transportation

21. Characteristics of the house: (0 = no 1 = yes)

False stucco ceiling
Dubbed out walls
Mixed type
Dirt floor

22. Where do you bring water from for personal use?

1 = river
2 = well
3 = watershed
4 = public water faucet
5 = private intradomiliciary water faucet

Response:

23. Sewage disposal (Drainage system)

1 = open field
2 = latrine

Response:

ECONOMIC CONDITIONS

24. Land holding (0 = no 1 = yes)

Legal ownership
Leasing
Sharing
Dependent (lodging in)
Borrowed

25. What was being produced in the community? (0 = no 1 = yes)

Cereals and grains
Vegetables
Tubers
Fruits
Pastures
Others

26. What was being sold in the community? (0 = no 1 = yes)

Cereals and grains
Vegetables
Tubers
Fruits
Pastures
Others

27. What was being consumed at home? (0 = no 1 = yes)

Cereals and grains
Vegetables
Tubers
Fruits
Pastures
Others

28. Amount of land that was farmed?

1 = small (less than one "cato")
2 = medium (1-3 "catos")
3 = large (more than 3 "catos")

Response:

29. Maternal civil status:

1 = single
2 = formally united (not legally married)
3 = legally married
4 = separated, divorced or widow

Response:

INFORMATION ON FATHER

(If the answer to question No. 29 is 1 or 4, then write down "9").

30. Principal occupation or job:

- 1 = farmer
- 2 = cattle raiser
- 3 = merchant
- 4 = student
- 5 = other occupation

Response:

31. Organizations to which he belongs: (0 = no 1 = yes)

- Agrarian Union
- DJC credit
- Cooperatives
- Neighborhood committed
- Other

32. Level of formal education:

- 0 = none
- 1 = basic
- 2 = intermediate
- 3 = medium
- 4 = technical
- 5 = higher

Response:

33. Does he know how to read?

- 0 = no
- 1 = yes
- 2 = a little

Response:

34. Does he know how to write?

- 0 = no
- 1 = yes
- 2 = only signs his name

Response:

35. What language does he speak? (0 = no 1 = yes)

- Spanish
- Aymara
- Quechua

36. Were the following persons present at the birth (or event)? (0 = no 1 = yes)

Grandmother

Grandfather
Mother-in-law
Father-in-law

37. Was the father present during the child's birth (or event)?

0 = no
1 = yes

Response:

INFORMATION ON MOTHER

38. Principal occupation or job: (0 = no 1 = yes)

Home chores
Helps doing the farming
Artisan
Merchant
Other occupation

39. Organizations to which she belongs:

Agrarian Union
Mothers' Club (CARITAS)
Mothers' Organization
Cooperatives
Neighborhood committee
SC/B credit
Other

40. Level of formal education:

0 = none
1 = basic
2 = intermediate
3 = medium
4 = technical
5 = higher

Response:

41. Does she know how to read?

0 = no
1 = yes
2 = a little

Response:

42. Does she know how to write?

0 = no
1 = yes
2 = only signs her name

Response:

43. What languages does she speak? (0 = no 1 = yes)

Spanish

Aymara

Quechua

OBSTETRIC HISTORY BEFORE THE SUBJECT PREGNANCY

44. Number of previous pregnancies:

45. Number of previous abortions (losses):

46. Number of stillborn children:

47. Number of children born alive:

NOTE: The total sum of 45, 46 & 47 should coincide with 44..

48. Number of premature babies:

a) if there were premature babies, how many stillborn?

b) if there were premature babies, how many died before the first month of life?

49. Number of children born full term with low birth weight?

50. Number of abnormal fetal presentations?

a) if there were abnormal presentations, how many were stillborn?

b) if there were abnormal presentations, how many died during the first day of life?

51. Number of previous caesarean sections?

52. Number of children who died during the first 7 days?

53. Number of children who died after the first week but not past the first month?

54. Number of children who died during the first year but after the first month?

55. Number of children who died after the first year of life?

62. Number of tetanus shots received:

Before this pregnancy
During this pregnancy

63. Any treatments or remedies taken during this pregnancy?
(0 = none or no 1 = yes 8 = does not recall)

Vitamins
Ferrous sulfate
Analgesics (sedatives)
Antihypertensives
Infusions

64. Practices (0 = no 1 = yes 8 = does not recall)

Mantling or handling with a mantle
Massage
External fetal rotation

65. Feeding during most of the pregnancy:

1=less than normal
2=normal
3=more than normal
Response:

66. Maternal work during pregnancy: (0 = none 1 = yes)

Farming
Harvest/sowing
Carrying heavy loads over long distances
Commercial
Pastoral

LABOR AND DELIVERY

67. Did the baby move during the days prior to labor?

0 = no
1 = yes
Response:

68. How many months did the pregnancy last?
months weeks

69. Was this a multiple pregnancy?

0 = no
1 = yes
Response:

70. Where was the baby born?

- 1 = at home
- 2 = at the mother's mother's home
- 3 = at a medical post
- 4 = at another place

Response:

71. How did the mother know labor had begun?
(0 = no 1 = yes)

- show
- pulse
- contractions (pain)

72. How many hours did labor (pains) last?

73. How long before labor did the fetal membranes rupture?

- 1 = during delivery
- 2 = less than 6 hours before delivery
- 3 = 6-12 hours before delivery
- 4 = more than 12 but less than 24 hours before delivery
- 5 = more than 24 hours before delivery

74. Who assisted labor? (0 = no 1 = yes)

- TBA
- Mother-in-law
- Mother
- Husband
- Promoter
- Physician
- Nurse/Nurse aid
- Nobody

75. Who assisted during delivery? (0 = no 1 = yes)

- TBA
- Mother-in-law
- Mother
- Husband
- Promoter
- Physician
- Nurse/Nurse aid
- Someone else
- Nobody

76. Who helped assist during delivery of the baby:
(0 = no 1 = yes)

- TBA
- Mother-in-law
- Mother
- Husband
- Promoter
- Physician
- Nurse/Nurse aid
- Someone else
- Nobody

77. Delivery route:

- 1 = vaginal
- 2 = caesarean section
- 3 = was not born

--

78. How long before delivery did you begin to push down?

- 1 = From the very first moment the contraction started (pushing down all through labor).
- 2 = Only when the baby was about to come out (be born)
- 3 = A few hours before birth
- 4 = Started to push but stopped later.
- 5 = She did not push.

--

79. Any problems during labor and delivery:
(0 = none 1 = yes)

- Abnormal breech (buttocks) presentation
- Abnormal breech (podalic) presentation
- Prolapse of extremity(ies) (hand)
- Meconium staining of amniotic fluid: the liquid was dark brown or green
- Transverse lie
- Umbilical cord wrapped around baby's neck
- Umbilical cord prolapse
- Hemorrhage
- Fever
- Seizures
- Other problems

80. Any treatments performed during labor or delivery?
(0 = none received 1 = yes)

Handling the abdomen with a mantle
Massage
Putting the baby back in normal position
(external rotation)
Girdle
Pelvic examination (vaginal)
Oregano, chua-chua, kinsa k'uchu infusions
Pill 1 for pushing (white and gray capsule)
Pill 2 for pushing (yellowish white tablet)
Another "pushing pill" _____

Injection for hastening labor:
 "Peturitina"
 Methergine
 Ignores the name
Large tablet
Other treatment

81. In what maternal position was labor and delivery conducted?

1 = lying down on her back
2 = kneeling down
3 = on hands and knees
4 = squatting down

Response:

--

82. What was the baby born on to?

1 = sheep skin
2 = animal carcass
3 = old and dirty bed
4 = bed or leather plus clean cloth
5 = plastic

Response:

--

DELIVERY OF THE PLACENTA

83. How long before the placenta was ejected?

1 = fast
2 = less than one hour
3 = more than one hour

Response:

--

84. What assistance was performed to help eject the placenta?

1 = blowing, coughing or provoking nausea
2 = other
3 = none

--

85. Was there bleeding immediately after delivery of the placenta?

0 = no

1 = yes

86. How long did the blood loss last? (hours)

87. Approximate amount of blood lost?

0 = nothing

1 = a little

2 = a lot

NEONATAL CARE PROVIDED

88. Birth weight (grams):

89. Was the baby immediately cared for or not until after the placenta came out?

1 = care provided immediately after birth

2 = care provided after the placenta came out

3 = don't remember

90. Baby's condition at birth:

Crying:

0 = none

1 = weak

2 = strongly

3 = cannot tell (cannot remember)

Movements:

0 = none

1 = very little

2 = fairly active

3 = cannot tell (cannot remember)

Skin color:

0 = pale

1 = blue (cyanotic)

2 = pink

3 = cannot tell (cannot remember)

Breathing:

0 = did not breathe

1 = very little

2 = with whining (moaning)

3 = normal

4 = cannot tell (cannot remember)

91. Baby's condition a few moments later (about five minutes after birth).

Crying:
Movements:
Skin color:
Breathing:

92. Were there other abnormalities noticed in the newborn?
(0 = none 1 = yes)

Bad odor (stench)
Bruises: any purple lesions or excoriations derived from trauma
Maceration: the baby with characteristics similar to those found in a "wet baby"
Deformities:
Which? _____

93. Suction reflex immediately after birth:

0 = baby did not nurse
1 = nursed weakly
2 = nursed vigorously
3 = baby was not offered breast

--

94. Who assisted the baby: (0 = no 1 = yes)

TBA
Grandmother
Father
Promoter
Physician
Nurse
Someone else _____
Mother
Nobody

95. How long did it take to have the umbilical cord cut?

1 = immediately
2 = after the placenta was delivered
3 = after burying/disposing of the placenta
4 = don't remember

--

96. What was used to cut the umbilical cord:

1 = a broken piece of new ceramic ("juk'illa)
2 = broken glass
3 = knife or switchblade
4 = scissors

--

97. How was this material disinfected?
(0 = no 1 = yes 8 = cannot recall)

- with alcohol or other antiseptic
- washed with water
- boiled
- with a piece of cloth
- did not disinfect at all
- cannot tell (cannot remember)

98. What was used to tie the cord?

- 1 = sack cloth thread
- 2 = mantle thread
- 3 = nothing
- 4 = other material

--

99. How was this material disinfected?

- 1 = with alcohol or another antiseptic
- 2 = washed with water
- 3 = boiled
- 4 = did not disinfect

--

100. What was used to cure?

- 1 = mercurochrome
- 2 = sulfa
- 3 = alcohol
- 4 = other substance

--

101. Immediate care given to the newborn? (0 = no 1 = yes)

- Bathed
- Clothed
- Stimulated
- Placed beside mother
- Resuscitated
- Pharyngeal aspiration
- Other _____

POST-PARTUM AND PUERPERIUM MATERNAL CARE

102. What was done to control post-partum bleeding?
(0 = no 1 = yes)

- There was no hemorrhage
- Transabdominal uterine massage
- Methergine administration
- Nipple massage
- Other _____

103. What was done to correct placental retention?
(0 = no 1 = yes)

There was no placental retention
Pulling the umbilical cord
Blowing/coughing/provoking nausea
Manual extraction
Other _____

104. Immediate care for the mother after delivery:
(0 = none 1 = yes)

Washed
Changed clothes
Given liquid
Clothed
Girdled (sheep hair belt)

105. Lochia: (0 = none 1 = yes)

How many days did it last?
Bad odor?

106. Fever after delivery: (0 = none 1 = yes)

If yes, how many days after birth did it begin?

107. How long did the fever last?

108. How was the fever treated? (0 = no 1 = yes)

antibiotics
local remedies
putting the baby to the breast
no treatment

109. How many days after birth did the mother
get out of bed?

110. How many days after birth did the mother
wash herself (or was washed)?

NEONATAL CARE DURING THE FIRST MONTH

111. Was the baby given colostrum?
 0 = no
 1 = yes

112. How many days after birth did breast-feeding begin?

 1 = immediately after birth
 2 = on the first day
 3 = on the second day
 4 = on the third day
 5 = after the third day
 6 = never breast-fed

113. Did the mother stop breast-feeding her baby?
 0 = no
 1 = yes

114. What was used to cure the umbilical cord?

 (0 = no 1 = yes)
 mercurochrome
 burned piece of cloth
 "mantizan"
 other substance
 nothing

115. How many days after birth was the baby bathed?

116. How often was the baby bathed or washed?

117. Who was the baby taken to for health check-ups

 during the first month of life? (0 = no 1 = yes)
 TBA
 Promoter
 Traditional healer
 Physician
 Nurse

118. Did the newborn receive a BCG shot during the first
 month?
 0 = no
 1 = yes

CHILD'S VERBAL AUTOPSY

122. At what age (in days) did the child die?

123. Symptoms of the terminal illness or disease:

SYMPTOMS	1 = present 2 = absent	Number of days before death
GENERAL		
stopped nursing		
irritable		
too much crying		
weak crying		
difficulty nursing		
nursed weakly		
depressed		
fever		
hypothermia (cold)		
whining/moaning		
apnea (stopped breathing)		
NEURO MUSCULAR		
could not swallow		
muscular spasms		
rigidity		
convulsions (attacks)		
abnormal movements		
RESPIRATORY		
cough		

SYMPTOMS...cont.	1 = present 2 = absent	Number of days before death
nasal secretions		
nasal flaring		
noisy breathing		
rapid breathing		
breathing fatigue		
chest retractions (caving-in of chest cavity)		
DERMATOLOGICAL		
cyanosis (purple, blue)		
pallid		
jaundiced (yellow)		
erythrodermia (red skin)		
pus on umbilical cord		
bad odor of umbilical cord		
blisters		
blood blisters		
rash		
BLOOD		
hemorrhage		
where? _____		
DIGESTIVE		
abdominal distention		
no bowel movements		

128. Once the problem was detected, what was done about it?

- 1 = looked for adequate care
- 2 = looked for inadequate care
- 3 = did not look for help (tried to treat it at home)
- 4 = other
- 9 = question does not apply

129. If inadequate resources were sought, why did you decide on this? (0 = no 1 = yes 9 = not applicable)

- Because of the cost of adequate care
- Because of transportation costs
- Because we trusted in the inadequate care
- Lack of trust in adequate care
- Because of advice given by someone
- Because of the distance from adequate care
- The person to contact was not in the community
- Other

130. Who participated in deciding on inadequate assistance? (0 = no 1 = yes)

- TBA
- Mother-in-law
- Mother
- Husband
- Promoter
- Physician
- Nurse
- "Yatiri"
- Someone else _____
- Nobody

131. What treatment was administered by the inadequate resource?

- a) _____
- b) _____
- c) _____

132. After using inadequate assistance, was adequate assistance sought?

- 0 = no
- 1 = yes, an adequate person was called
- 2 = the case was taken to health services
- 3 = the individual had already died
- 9 = not applicable

133. If an adequate person was called, what did this person do?

- 1 = adequate response
2 = inadequate response
9 = not applicable

134. When it was decided to look for adequate resources (persons), did you reach them?

- 1 = yes
2 = no, because there was no transport
3 = no; there was transportation but the owner did not think the matter was important.
4 = the individual died before the person came
5 = no/other reason _____
9 = not applicable

135. When you reached the health services, what type of care was given?

- 1 = adequate care
2 = inadequate care
9 = not applicable

MOTHER'S VERBAL AUTOPSY

Maternal Mortality: (all deaths caused by pregnancy, birth or puerperium)

136. The mother died during:

- 1 = pregnancy
2 = birth: labor
3 = giving birth
4 = exit of placenta
5 = post-partum: immediately
6 = after a short time
7 = later

Response:

137. Pregnancy:

- 1 = first trimester
2 = second trimester
3 = third trimester
4 = abortion: induced
5 = spontaneous

Response:

141. Multiple birth (twins)

142. Placenta:

(0 = no 1 = yes 8 = don't remember)

Hemorrhage

Placental retention of more than 45'

143. Post-partum:

(0 = no 1 = yes 8 = don't remember)

fragments of placenta in uterus

fever

general malaise

putrid secretion

puerperal endometritis (white period)

cold sweat

debilitated, bed-ridden

abdominal pain

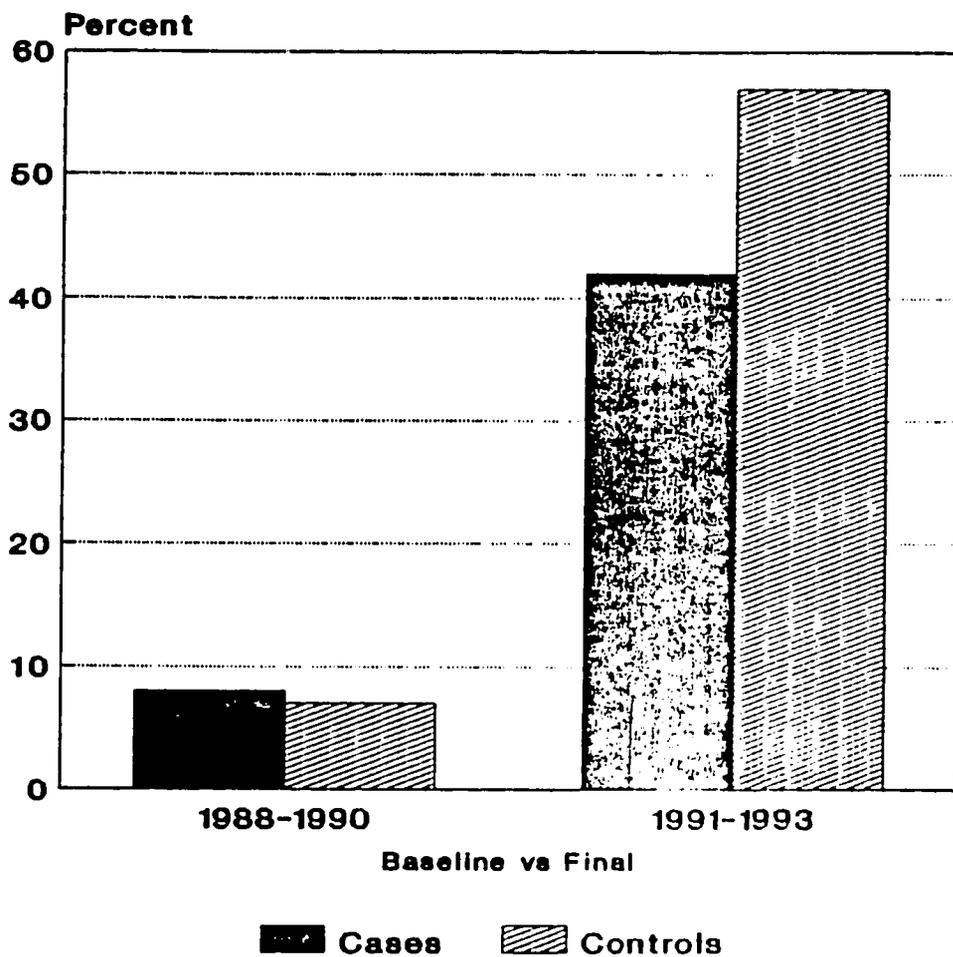
abdominal swelling

puerperal infection

ANNEX 3: BAR GRAPHS OF PROJECT RESULTS

WARMI PROJECT: WOMEN'S GROUPS

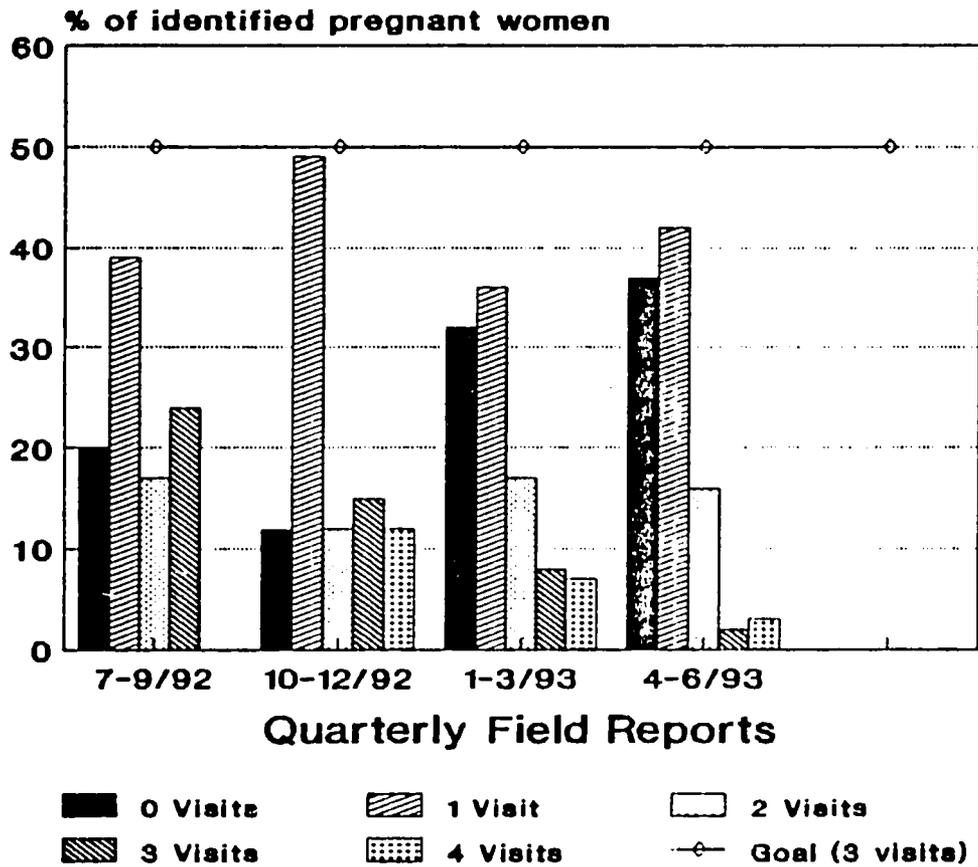
Mother Belonged to Women's Group



Cases (n=74, 31) Controls (n=148, 138)

PRENATAL CARE

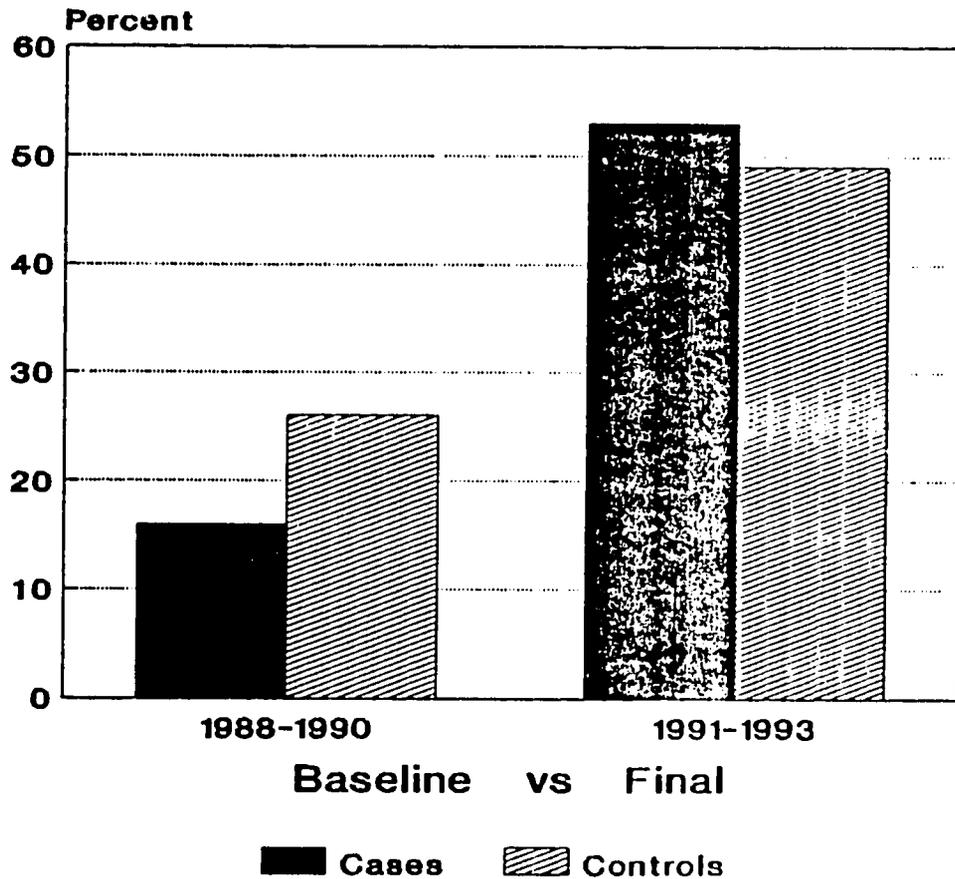
Number of Visits/Woman (%)



Manual Information System

Tetanus Toxoid Vaccine

2 doses before pregnancy

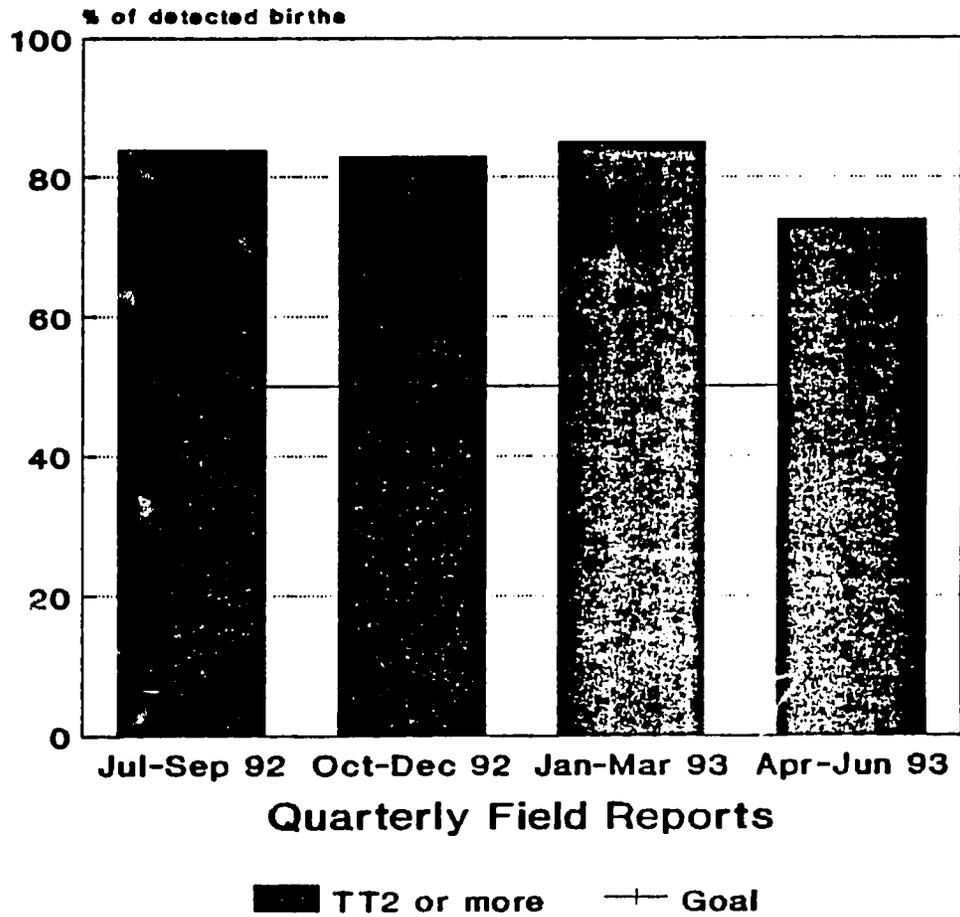


Cases (n=74, 31); Controls (n=148, 136)

16/2

Tetanus Toxoid

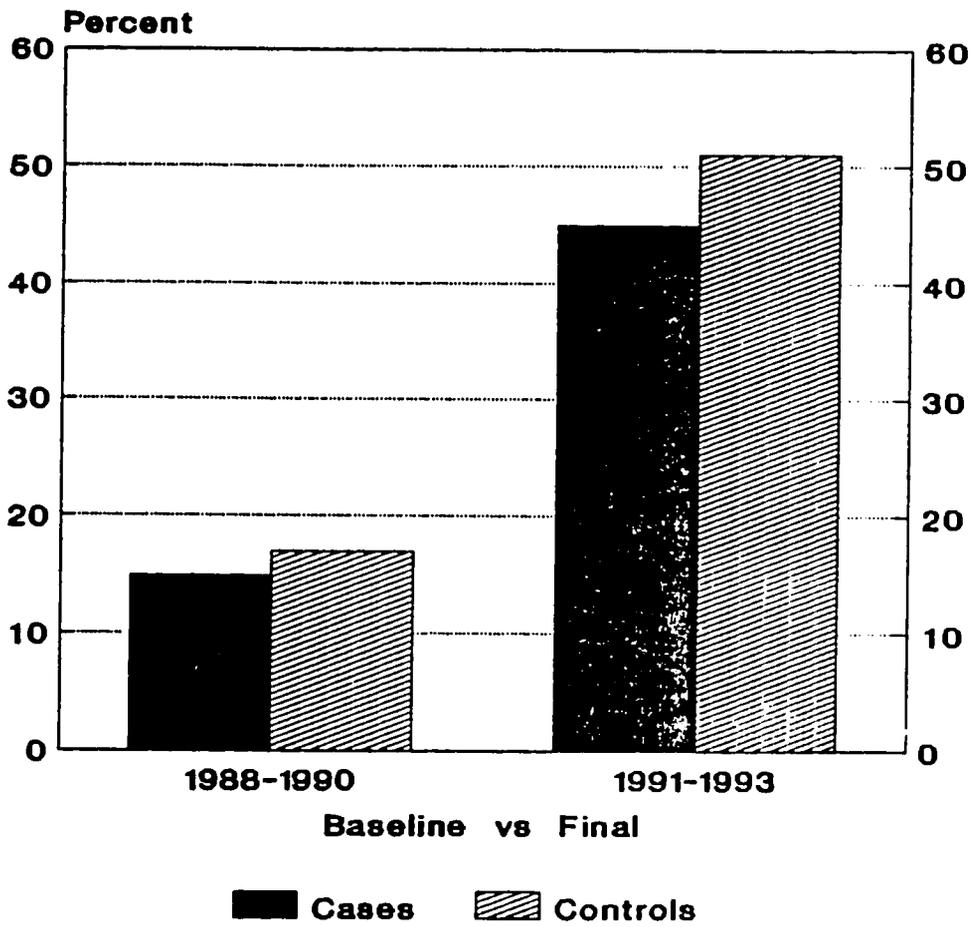
Women who delivered with TT2 or more



Manual Information System

PRENATAL CARE

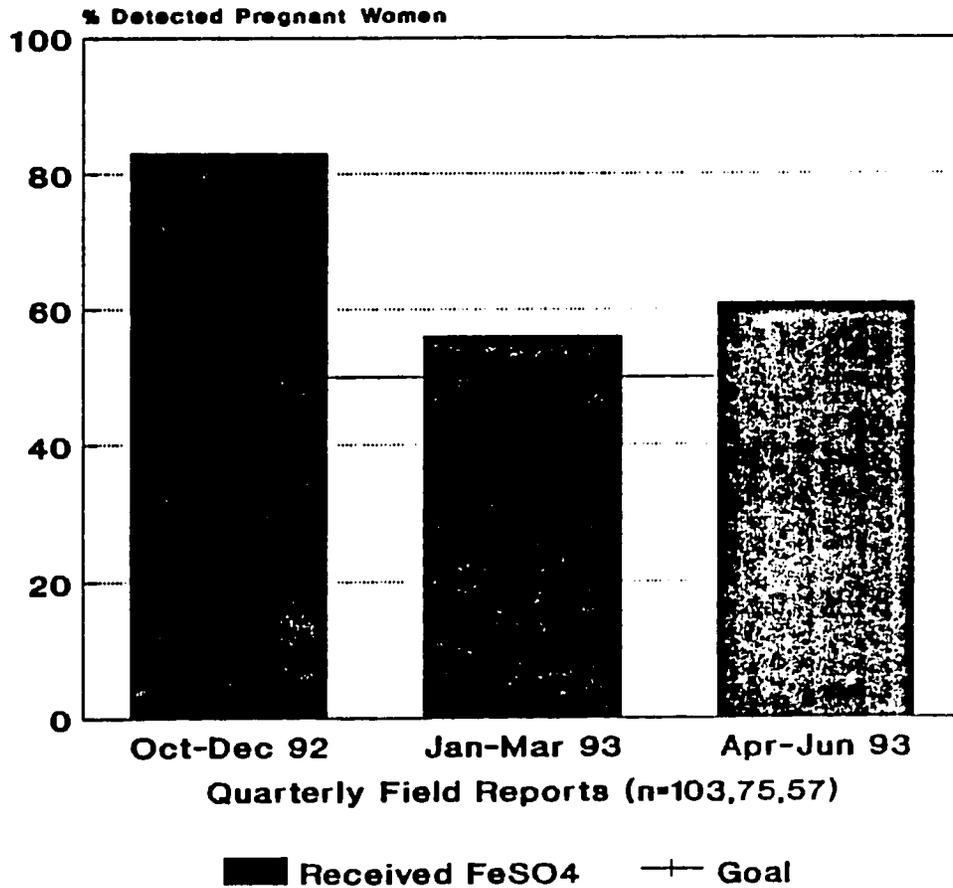
% Pregnant Women who Received FeSO₄



Cases (n=75,91) Controls (n=151,132)

FERROUS SULPHATE

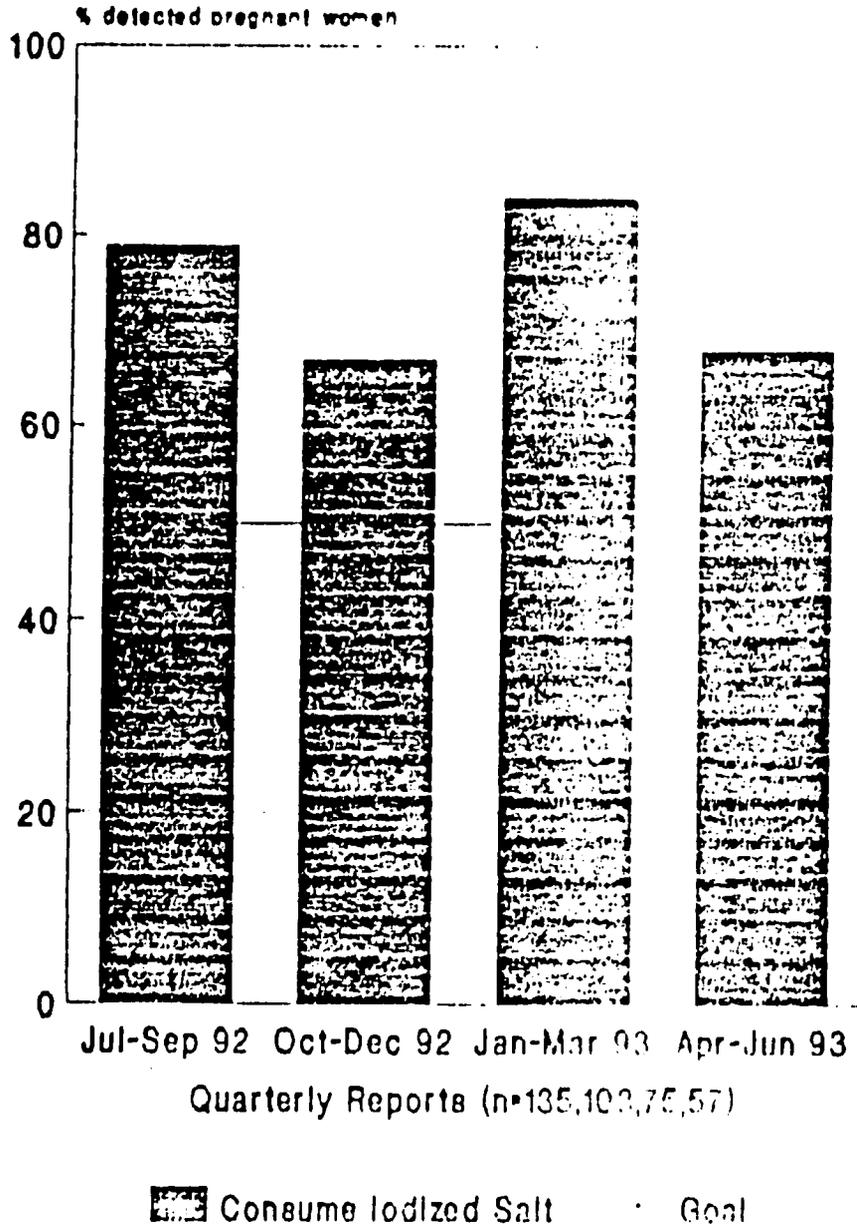
% of Pregnant Women Who Received FeSO₄



Manual Information System
(Data not complete for July-Sept. 1992)

IODIZED SALT

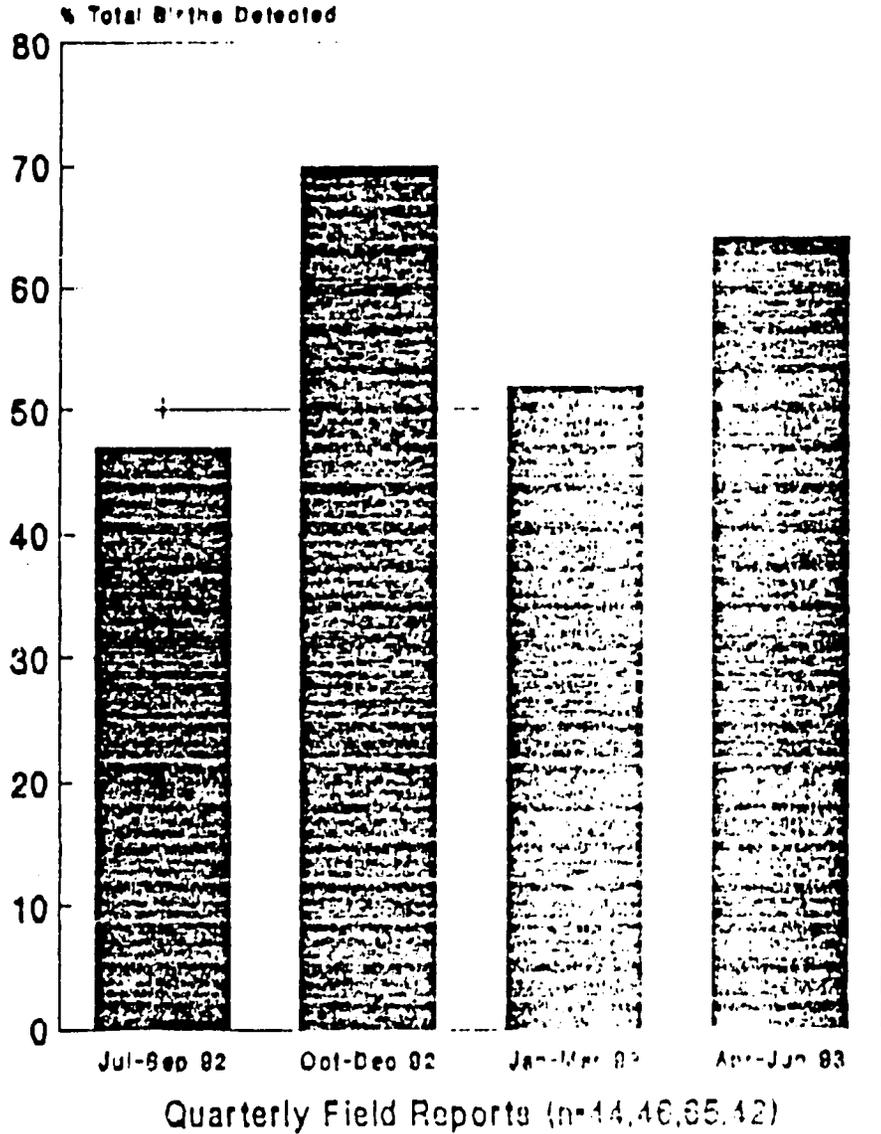
% Pregnant Women Consume Iodized Salt



Manual Information System

BIRTH ATTENDANTS

% of Births Attended by Trained Person

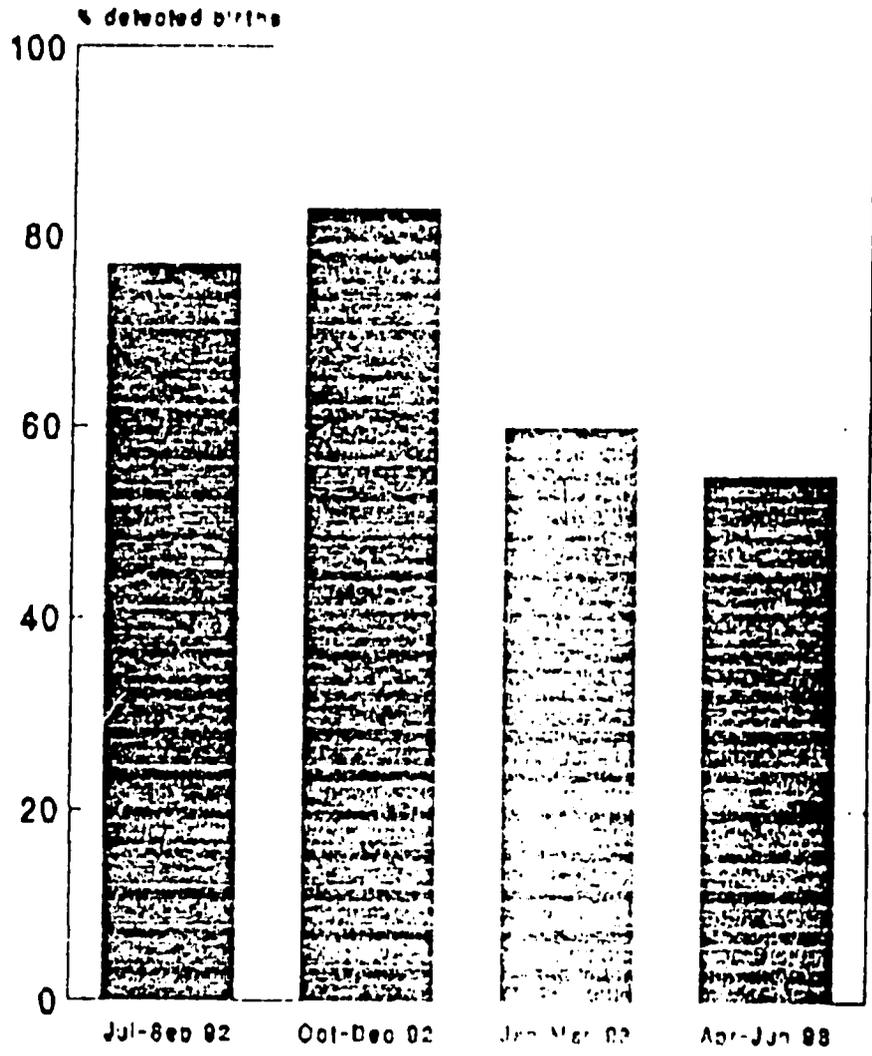


■ Trained Person

Manual Information System

POST-PARTUM CARE

% Women with Post-Partum Check-up



Quarterly Field Reports (n=44,46,65,42)

2003

Manual Information System
Goal of 60% w. 2 visits not achieved.

ANNEX 4: TIMELINE OF WOMEN'S GROUP ACTIVITIES
(Autodiagnosis, Planning Together, Implementation)

RCSI AVAL AND CONN

ACTIVITIES - WARM PROJECT																											
COMMITTEE	1990				1991				1992				1993		TOTAL STAT'S												
	MEMBERS	JUL	AUG	SEP	ACT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL		AUG	SEP	ACT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	
...																											
...	1																										
...	17																										
...	14																										
...	7																										
...	17																										
...	7																										
...	12																										
...	12																										
...	9																										
...	14																										
...	14																										
...	12																										
...	18																										
...	10																										
...	21																										
...	9																										
...	17-11																										
...	20																										
...	9																										
...	20																										
...	18																										
...	24																										
...	9																										
...	21																										

TOTAL MEMBERS 423

CCCES ORG Organization ADX Aided grass PT Flanking Together

IMP Implementation

1/10

ACTIVITIES - WAFMI PROJECT

COMMUNITIES	1990			1991			1992			1993			ACTUAL STATUS	
	MEMBERS	JUL/AUG/SEP	OCT/NOV/DEC	JAN/FEB/MAR	APR/MAY/JUN	JUL/AUG/SEP	OCT/NOV/DEC	JAN/FEB/MAR	APR/MAY/JUN	JUL/AUG/SEP	OCT/NOV/DEC	JAN/FEB/MAR		APR/MAY/JUN
INDUENT														
Toluca	9				CEB				ADY	ADY	ADY			PT
Miguel Alemán	29	OR 3-1990									ADA	PT		IMP
San Mateo	15					CEB	ADY	ADY						FT
San Mateo	22	OR 3-1990			ADY									FT
San Mateo	25					CEB ADY	ADY	ADY						FT IMP
San Mateo	32	OR 3-1990				ADY	ADY							FT IMP
San Mateo	23	OR 3-1990				ADY	ADY	ADY						FT
San Mateo	30	CEB								ADY				FT
San Mateo	17								CEB		ADY			CT
San Mateo	25	OR 3-1990				ADY	ADY				FT			IMP
San Mateo	27	OR 3-1990				ADY	ADY							CT
San Mateo	12								CEB	ADY	ADY			FT
San Mateo	27								CEB		ADY			FT
San Mateo	21	OR 3-1990			ADY	ADY								FT
San Mateo	11				CEB			ADY						FT IMP
San Mateo	15				CEB			ADY						FT IMP
San Mateo	11										CEB ADY	ADY		FT IMP
San Mateo	17										ADY	ADY		FT
San Mateo	11										ADY ADY	ADY FT		IMP

BEST AVAILABLE COPY

ACTA DE REUNION DE PLANIFICACION CONJUNTA EN MOXACOCA

En la comunidad de Moxacoca, provincia Guaymas del Departamento de la Paz, siendo a las horas quin ... del día domingo once de abril de mil novecientos noventa y tres años. Se han reunido los señores autoridades: Sr. General, Sr. de Relaciones, Sr. de Justicia, Sr. de Actas y Sr. de Educacion; el R.P.S. don Hermiguel Jimenez, la señora Doña Primitiva Peco, Presidenta de la organizacion de mujeres, doña Francisca Mamani; miembros de la organizacion de mujeres, padres de Familias, Promotores de Agro; la señora Adela Callesaya y Don Pacifico Cojra, funcionarios de la "Institucion" Desarrollo Juvenil Comunitario; con el objeto de realizar la "Planificacion Conjunta" previamente citada y acordada con la organizacion de mujeres en la "Fase de Preparacion".

Despues de palabras iniciales de presentacion, se inicio la reunion con los siguientes puntos que a continuacion se detallan:

1. La vision de Salud Reproductiva: Se han organizado de mujeres y tres de varones. Los componentes de los grupos variaban entre cinco a ocho

Despues de la presentacion de los dibujos de cada grupo, se han identificado estos aspectos a manera de lluvia de ideas sobre la vision en "Salud Reproductiva":

- a) Mejoramiento de la Salud de las madres y los niños
- b) Necesidad de medicamentos - tener medicinas
- c) Cobertura en Salud para la madre, el niño y en general para toda la comunidad
- d) Tener buena alimentacion
- e) Ya no tener muchos hijos
- f) Tener posta sanitaria
- g) Familias unidas y sanas

Mediante la participacion de los asistentes, se llego a establecer la vision de "Salud Reproductiva" por consenso y, el camino sigue:

"DESARROLLO COMUNITARIO CON FAMILIAS UNIDAS Y POCOS HIJOS SANOS Y, CAPACITADOS EN SALUD REPRODUCTIVA"

2. Presentación de los problemas por las mujeres: La supervivencia de salud, día

del día. presento a las señoras: Primitiva Paco, Flora Miramón, Francesca Mamani y Luisa Uruña; quienes presentaron en el mismo orden el resultado de la investigación e identificación de algunos problemas que bloquean la visión:

- Prevalencia de lómbos umbilicales
- Retención de la placenta
- Muchos hijos
- Parto gemelar

Tanto los padres de familias como las demás mujeres participantes, ratificaron los problemas anotados al hacer comentarios correspondientes.

3. IDENTIFICAR OBSTACULOS / BARRERAS A LA VISIÓN: Después

de una explicación sobre lo que es un obstáculo, con ejemplos claros de la vida real, se han organizado ocho grupos de trabajo entre varones y mujeres.

Cada grupo presento su dibujo y más que todo en forma escrita sobre los obstáculos de la visión. Luego se han establecido por similitud una lista de los obstáculos:

- a) Poca conciencia sobre control prenatal
- b) No hay transporte (ambulancia)
- c) Poca conciencia y poca participación en las decisiones
- d) No hay suficiente dinero
- e) No hay atención médica
- f) Muchos hijos.

En los comentarios sobre los obstáculos identificados, los participantes reconocieron y ratificaron los mismos como las barreras que entorpecen y bloquean la visión.

4. Identificar estrategias y acciones específicas concretas y realistas. Mediante opiniones, sugerencias e

intercambio de ideas sobre la forma como la comunidad puede hacer frente a los obstáculos en forma real y concreta y, con medios que se cuenta en la comunidad; por consenso se llegó a las estrategias y acciones siguientes:

ESTRATEGIA / ACTIVIDAD	CUANDO	RESPONSABLES
a) Mayor control prenatal	a) El parto de hoy 11/04/93	a) Partera / Dr. de Licoma Sup. Salud DSC / IRPS, Organización de Mujeres
b) Transporte - Buscar otro medio rápido	b) Cuando se presente un caso difícil de parto	b) Esposo / Partera / Organización de Mujeres
c) Asistir a (a) Asesorías de Capacitación - Solicitar la presencia del Dr. de Licoma para capacitación	c) El parto de hoy 11/04/93 - Próxima reunión de la Comunidad (forma Salud-Tud)	c) Autoridades (Stric-General), Organización de Mujeres
d) Apoyo de la comunidad - Atención Familiar	d) En situaciones difíciles - El diagnóstico del parto	d) Las autoridades de la Comunidad - Cada mujer y familia
e) Solicitar atención del médico de Licoma	e) Formas solicitadas en la próxima reunión de la Comunidad	e) Autoridades y Organización de Mujeres
f) Recibir orientación en Planificación Familiar	f) El parto de hoy	f) Dr. Santiago Medina, Sup. Salud DSC, CUPICOF

Por el hecho del tiempo empleado en la reunión, y notando el cansancio de algunos participantes, se hizo indicaciones sobre la necesidad de evaluar la realización de los acuerdos tomados periódicamente, a fin de establecer si están en el camino correcto y los logros alcanzados.

5. Formalizar los acuerdos en un documento escrito. - Para abreviar el tiempo de la reunión, se determinó elaborar el presente documento como testimonio de los acuerdos tomados y que deberá ser firmado por las autoridades y todos los participantes en general previa lectura del contenido (diez y siete personas en total).

Adela Callisaya

Sra. Adela Callisaya
Sup. Salud - DJC

Pacifico Copa

Sr. Pacifico Copa @
Respm "SJS" - DJC

Secretaria de Juntas

SECRETARIA DE JUNTAS
ORGANIZ. MUJERES

Secretaria de Actas

SECRETARIA DE ACTAS
ORGANIZ. MUJERES

Tesorera

TESORERA
ORGANIZ. MUJERES

Vice-Presidenta

VICE-PRESIDENTA
ORGANIZ. MUJERES

Presidenta

PRESIDENTA
ORGANIZ. MUJERES

Sr. Francisco

Sr. FRANCISCO
Secretario Educacion

Sr. Elio Fuentes

Sr. Elio Fuentes
Secretario de Actas

Sr. Gregorio

Sr. Gregorio Fernandez
Secretario de Justicia

Sr. German Santos

Sr. German Santos
Secretario Palacios

Sr. Martin Uruña

Sr. Martin Uruña
Secretario General



(sellu) *[Signature]*

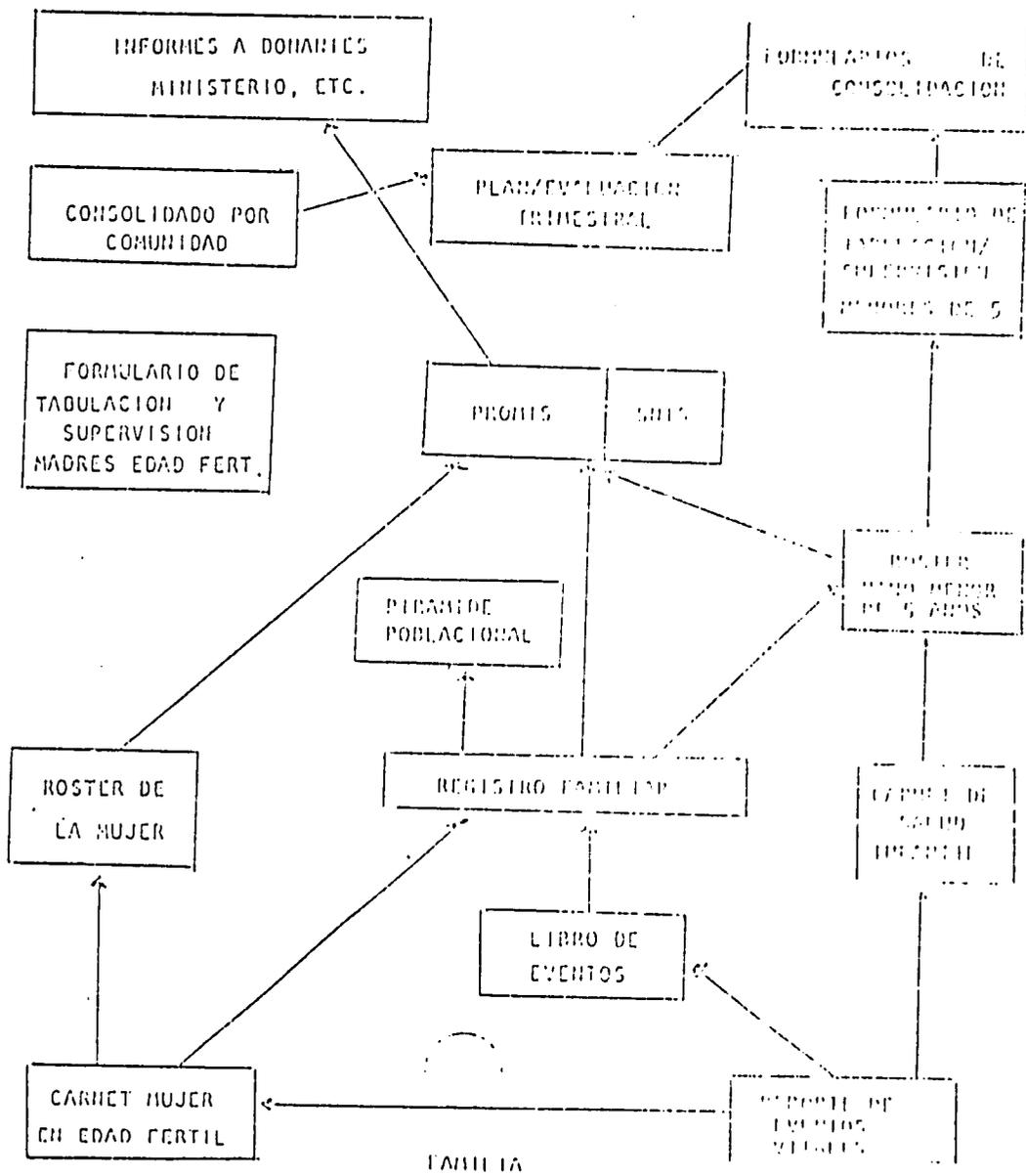
NOMINA DE PARTICIPANTES EN LA REUNION
DE PLANIFICACION CONJUNTA - MUXACOCA

- | | |
|-------------------------|----------------------------|
| 1.- Rosa Bellido | 37.- Santiago Viro - |
| 2.- Celia Calderón | 38.- Macario Pacajes |
| 3.- Cristina Bellido | 39.- Valerio Bellido |
| 4.- Ramona Mamani | 40.- Lucio Apaza |
| 5.- Anna Laura | 41.- Feliciano Apaza |
| 6.- Flora Miranda | 42.- Adela Callisaya (DSC) |
| 7.- Rosa Bellido | 43.- Pacifico Copa (DSC) |
| 8.- Daria Uuspe | |
| 9.- Santusa Marca | |
| 10.- Mercedes Ovando | |
| 11.- Santusa Santos | |
| 12.- Primitiva Pico | |
| 13.- Francisca Mamani | |
| 14.- Emeliana Oaqui | |
| 15.- Gabriela Laura | |
| 16.- Esperanza Huayta | |
| 17.- Mulberla Tintaya | |
| 18.- Bárbara Fernández | |
| 19.- Luisa Uruña | |
| 20.- Mariana Huanca | |
| 21.- Teodora Pacajes | |
| 22.- Teodora Santos | |
| 23.- Damiana Mamani | |
| 24.- Deysi Aguilar | |
| 25.- Justina Tintaya | |
| 26.- Sofía Flores | |
| 27.- Martín Uruña | |
| 28.- Alfredo Bellido | |
| 29.- Luis Fernández | |
| 30.- Juan Mamani | |
| 31.- Gregorio Fernández | |
| 32.- Felipe Uuspe | |
| 33.- Javier Uruña | |
| 34.- Marcos Tintaya | |
| 35.- Pascual Viro | |
| 36.- Hermógenes Huayta | |

ANNEX 5: HEALTH INFORMATION SYSTEM INSTRUMENTS

INSTRUMENTOS 515

FLUJO



MINISTERIO DE PREVISION
SOCIAL Y SALUD PUBLICA



Desarrollo Juvenil Comunitario

CARNET DE LA MUJER



Nombre: _____

Fecha de Nacimiento: _____

Dirección: _____

Número de casa: _____

Comunidad: _____

Fecha de Entrega: _____

El trabajo en el cual se basa este carnet, fue desarrollado por Desarrollo Juvenil Comunitario/Bolivia, un programa de Save the Children dentro del Proyecto MotherCare, bajo Contrato N° DPE-5966-Z-00-8083-00 con la Agencia Norteamericana para el Desarrollo Internacional.
CON AUTORIZACION DEL MINISTERIO DE PREVISION SOCIAL Y SALUD PUBLICA
DINAP con Cite No . 0231

DESARROLLO JUVENIL COMUNITARIO

Save the Children

COMUNIDAD: _____
 SUPERVISOR: _____

REGISTRO DE MUERTE

Código:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>														
	Área	Zona	Comunidad	No. de casa	No. Calle	No. Teléfono														
Nombre del fallecido:	Nombre		Apellido		Apellido Materno															
Fecha de muerte:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>														
	Día	Mes	Año	Hora	Minuto	Segundo														
Para niños menores de 5 años:																				
<table style="width: 100%; border: none;"> <tr> <td style="width: 15%;"><input type="text"/></td> </tr> <tr> <td style="font-size: small;">Día</td> <td style="font-size: small;">Mes</td> <td style="font-size: small;">Año</td> <td style="font-size: small;">(H)</td> <td style="font-size: small;">(M)</td> <td style="font-size: small;">(S)</td> <td style="font-size: small;">(Seg)</td> </tr> </table>							<input type="text"/>	Día	Mes	Año	(H)	(M)	(S)	(Seg)						
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>														
Día	Mes	Año	(H)	(M)	(S)	(Seg)														
Fecha de Nacimiento																				
Causa de muerte de < 5 años:																				
a) Diarrea	b) Intoxicación	Causa muerte de madre:																		
b) Diarrea Asoc./Desnut.	c) Obstrucción	(embarazo-parto-puerperal)																		
c) IRA	d) Trauma	h) Infección																		
d) IRA Asoc./Desnutrición	e) Tronca	i) Bata postparto																		
e) Desnutrición	f) Sepsis	j) Fiebre																		
f) Intoxico	g) Accidente	k) Sepsis																		
g) Sarampión	h) Otrac	l) Sepsis																		
Recibió la atención de:																				
Familiares: <input type="text"/>																				
Tratamiento recibido:																				
Severo <input type="text"/>	Subsevero <input type="text"/>	Leve <input type="text"/>	Medio <input type="text"/>	Grave <input type="text"/>	Extremo <input type="text"/>	Extremo <input type="text"/>														
Letal <input type="text"/>	Letal <input type="text"/>	Letal <input type="text"/>	Letal <input type="text"/>	Letal <input type="text"/>	Letal <input type="text"/>	Letal <input type="text"/>														
Si la familia no ha llegado al personal de salud (médico, enfermera), la causa fue por razón de:																				
a) No hay personal de salud en el área	b) Personal de salud no tiene tiempo para atender																			
b) No han reconocido que haya problema	c) Falta de transporte																			
c) Falta de dinero	d) Falta de dinero																			
DESCRIPCIÓN DE LA CAUSA PROBABLE:																				
a) DE ACUERDO A LOS FAMILIARES: _____																				
b) DE ACUERDO AL SES: _____																				
c) DE ACUERDO AL SUPERVISOR (de acuerdo probable de muerte): _____																				
OBSERVACIONES:																				

Fecha de Registro: _____

ROSTER DE LA MUJER

Nombres y Apellidos
 Código Personal
 Numero de Casa
 Comunidad
 Fecha de Nacimiento (d/m/a)

Vacuna Toxoide Tetanico, fecha de dosis 1:
 Vacuna Toxoide Tetanico, fecha de dosis 2:
 Vacuna Toxoide Tetanico, fecha de dosis 3:
 Vacuna Toxoide Tetanico, fecha de dosis 4:
 Vacuna Toxoide Tetanico, fecha de dosis 5:

I ANTECEDENTES OBSTETRICOS							II EMBARAZO				III PARTO				IV PUERPERIO					V RECIEN NACIDO				VI REFERENCIA		VII MORTALIDAD						
Edad	No	Ultimo	Total	No de	No de	Total	Fecha	Fecha	Fecha	Control Prenatal				Fecha	Lugar	Quien	Causa	Fecha	Temp	Locales	Hemorra	VIA	Nacio	Sexo	Peso	Castro	Fecha	Contra	Materna	R.N.		
Actual	ESTE	DATE	No de	naudos	naudos	No de	delecc	Ultima	delecc	N	fecha	Factor	Sueta	Ser	Fecha	del	atendido	de	de	de	de	de	de	de	de	de	de	de	de	de		
	EMB	EMB	EMB	EMB	EMB	EMB	EMB	EMB	EMB			de	Fetal	biologica		parto	al parto															
										1																						
										2																						
										3																						
										4																						
										1																						
										2																						
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										1																						
										2																						
										3																						
										4																						
										1																						
										2																						
										3																						
										4																						

FACTORES DE RIESGO
 HA Hipertension arterial
 EA Edema
 RM Retardo mental
 ER Enfermedad renal
 EC Enfermedad cardiaca
 ED Menor de 17 años y/o de 40 años
 PM Primigesta mayor de 30 años

MP Malpresentacion
 EG Embarazo gemelar
 CP Cesaria previa

PARTO ATENDIDO POR:
 MD Médico
 ENF Enfermera auxiliar
 PI Parto
 ES Espreso
 OF Otro familiar
 MM Mujer misma
 OT Otro

REFERENCIA:
 Refenido a:
 CS Centro de Salud
 HD Hospital de Distrito (O Home Hospital)
 HEP Hospital EP
 HO Hospital Otro
 Contrareferencia
 MJ Mayor MR Menor

CAUSA: MORTALIDAD FETO/NEONATO
 OF Otulo fetal
 SP Sepsis
 A Asfixia
 IHA Infeccion respiratoria aguda
 D Difteria
 OT Otros
 M Mortuato
 T Tetanos
 ENF Entrenamiento

CAUSA: MORTALIDAD MATERNA
 HM Hemorragia
 RP Retencion placentaria
 MP Malpresentacion
 EC Eclampsia (ataques)
 SP Sepsis infeccion
 OT Otro

187



DESARROLLO JUVENIL COMUNITARIO

"A Save the Children Program"

Encuesta N°

FICHA FAMILIAR

Nombre del encuestador: Comunidad:

Código
Área Zona Comunidad

Fecha de la encuesta
Día Mes Año

Número de casa

Número de Familia en la casa

N° de niño	NOMBRES Y APELLIDOS			SEXO MF	Relación familiar primario	FECHA DE NACIMIENTO día / mes / año	EDUCACION			CONTROL DE INMUNIZACIONES							Fecha de ingreso al hogar día / mes / año	
	NOMBRES	PATERNO	MATERNO				Nivel de estudio S/N	Grado de Instrucción B/M/T/U	Ocupación Principales A/C/M/E/C	BCG S/N	DP 1 2 3	Polio 1 2 3	Sarampión S/N	TT 1 2 3 4 5	Fiebre Amarela S/N	TODOS Año		S/N
1																		
2																		
3																		
4																		
5																		
6																		
7																		
8																		
9																		
10																		
11																		
12																		

SI EL ÚLTIMO PARTO DE LA MADRE FUE HACE 12 MESES ATRAS SUJUNO:
 a) Actualmente vive
 b) Muerto al poco tiempo de nacer
 c) Nació muerto
 Respuesta

¿EN QUE CONDICIÓN CUENTA LA TIERRA?
 a) Propiedad d) Alquiler
 b) A mitades e) Cooperativa
 c) Comunal f) Armada
 Respuesta

PROVISIÓN DE AGUA
 a) Grifo o pileta domiciliaria
 b) Grifo o pileta colectiva
 c) Pozos
 d) Río o Nonas
 Respuesta

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

INFORME MENSUAL DE ACTIVIDADES EN SALUD

UNIDAD SANITARIA.	DISTRITO	AREA
ESTABLECIMIENTO.		MES AÑO

ATENCIÓN A LA MUJER EN EDAD FÉRTIL (De 15 a 49 años)

CONTROL PRE-NATAL					CONTROL DE POST-PARTO	Nº de atenciones de parto domiciliario	
CONSULTAS NUEVAS		CONSULTAS REPETIDAS	CON 4 CONSULTAS	Embarazos de Alto Riesgo 1ª Consulta	1ª Consulta	Personal de Salud	Por Partera Capacitada
Menos de 5 meses	De 5 meses y más						

Toxoide Tetánico (Nº de Dosis)	Con primera dosis		Con segunda dosis		Con tercera dosis o más	
--------------------------------	-------------------	--	-------------------	--	-------------------------	--

ATENCIÓN INTEGRAL AL MENOR DE 5 AÑOS

CONTROL DE CRECIMIENTO Y DESARROLLO					
A NIÑOS MENORES DE DOS AÑOS					A NIÑOS DE 2 A 4 AÑOS
NUEVOS	REPETIDOS	LANA ROJA	LANA AMARILLA	LANA VERDE	

ENFERMEDADES DIARREICAS AGUDAS con signos de DESHIDRATACION		INFECCIONES RESPIRATORIAS AGUDAS con signos de NEUMONIA	
Menores de 2 años	De 2 a 4 años	Menores de 2 años	De 2 a 4 años

ENFERMEDADES INMUNOPREVENIBLES - VACUNAS

DOSIS-->	ANTIPOLIOMIELITICA				D.P.T.			Anti Sarampión	BCG	Nº de Dosis Fiebre Amarilla	Control de Escolares. (1er Curso Básico)	
	1ª	2ª	3ª	Ref.	1ª	2ª	3ª				Controles Nuevos	
A niños < 1 año											c/3ra Aplicación Fluor	
De 1 año a 4 años											Vacunados c/ B C G.	
											Vac c/ dt (2a dosis)	

RELACION CON LA COMUNIDAD

	Club Madres	Comité de Salud		
Nº Reuniones				
Nº Participantes				

ATENCIONES POR LOS R P S Y OTRO PERSONAL COMUNITARIO

Educación en saneamiento	Diarrreas	IRA	Pre-Natal	Post-Natal	Otras Atenciones	Nº Visitas Domiciliarias

SUPERVISIONES RECIBIDAS DE

Unidad Sanitaria	Distrito	Area	

VISITAS DOMICILIARIAS

POR EL PERSONAL DE SALUD		TOTAL DE INGRESOS ECONOMICOS DEL MES

INSTRUCTIVO DE LLENADO DEL INFORME MENSUAL DE ACTIVIDADES EN SALUD

Este formulario deberá ser llenado mensualmente, resumiendo (consolidando) toda la información recolectada de las hojas de tabulación, otros formularios y cuadernos. Los datos a llenarse debe corresponder sólo al mes que se está reportando.

Lo primero que debe hacer es identificar: a) Unidad Sanitaria, b) Distrito, c) Área, d) Establecimiento que corresponde a su servicio.

Anote el mes y año correspondiente al informe.

ATENCIÓN INTEGRAL A LA MUJER EN EDAD FÉRTIL

Control Prenatal - Anote el número de consultas prenatales nuevas, separando las que corresponden a mujeres que están con menos de cinco meses de embarazo de las con cinco meses o más. Anote luego el número de consultas prenatales repetidas.

La consulta prenatal nueva es la primera consulta del embarazo, correspondiendo a la inscripción, consulta repetida significa todas las demás consultas.

Anote el número de las pacientes que cumplieron con 4 consultas durante su embarazo. Anote también el número de embarazos de Alto riesgo detectados en el transcurso del mes.

Anote el número de controles de Post parto. No incluya en este número los controles inmediatos que se dan mientras la parturienta está todavía hospitalizada luego del parto.

Atención de Parto domiciliario - Anote el número de partos domiciliarios atendidos por el personal de salud (Médico, Enfermera, Auxiliar). No incluya los partos atendidos institucionalmente. Ver otra hoja.

Anote de igual manera el número de partos domiciliarios atendidos por parteras capacitadas. No incluya los otros partos domiciliarios atendidos ya sea por familiares o parteras sin capacitación.

Toxide Tetánico - Anote en el casillero correspondiente el número de pacientes que recibieron la 1ra, 2da y 3ra dosis o más del Toxide Tetánico.

ATENCIÓN INTEGRAL AL MENOR DE 5 AÑOS

Control de crecimiento y desarrollo - Anote el número de niños menores de 2 años con controles nuevos y repetidos.

Consulta nueva es la primera consulta de control de crecimiento y desarrollo realizada al niño durante este periodo de su vida. Corresponde a la inscripción al programa.

Consulta repetida significa todas las otras consultas del programa durante el mismo periodo de vida.

Del total de repetidos vistos en el transcurso del mes, anote el número de niños con lana roja, lana amarilla y el número de niños con lana verde.

Anote el número total de niños controlados de 2 a 4 años (Nuevos y Repetidos).

Enfermedades diarreicas agudas (EDA) - Solamente anote el número de casos de diarrea con signos de deshidratación detectados respectivamente en el grupo de niños menores de 2 años y el de 2 a 4 años.

Infecciones Respiratorias Agudas (IRA) - Anote el número de casos de infecciones respiratorias agudas con signos de neumonía en el grupo de niños menores de 2 años y el de 2 a 4 años.

ENFERMEDADES INMUNOPREVENIBLES - VACUNAS

Anote para la vacuna antipoliomelítica, el número de niños menores de 1 año que recibieron su 1ra, 2da, 3ra dosis o dosis de refuerzo. Haga lo mismo para la vacuna DPT (1ra, 2da, 3ra dosis), la vacuna antisarampionosa (dosis única) y la BCG (dosis única), diferenciando entre niños < 1 año y de 1 año a 4 años.

FIEBRE AMARILLA

Anotar el total de dosis administradas sin diferenciar edades.

CONTROL DE ESCOLARES - (1er curso básico)

Escolares controlados - Anote el número de controles nuevos, son nuevos los primeros controles del año en curso.

c/3ra Aplicación Fluor - Anote el número de escolares que recibieron su 3ra aplicación de fluor.

Vacunas c/B C G - Anote el número de escolares que fueron vacunados con BCG.

Vac c/dt (2da dosis) - Anote el número de escolares que fueron vacunados con 2da dosis de dt.

RELACION CON LA COMUNIDAD -

Anote el número de reuniones efectuadas con los Clubes de Madres, Comités de Salud, otras instancias (identificándolas). Para cada tipo de organización, anote el número total de participantes a las reuniones en el mes.

ATENCIÓN DE LOS R.P.S. Y OTRO PERSONAL COMUNITARIO -

Anote el número de actividades de educación en saneamiento, anote el número de casos atendidos de diarreas (EDA), IRA, Atención Pre y Post-Natal, visitas domiciliarias y otras actividades realizadas por Responsables Populares de Salud y otro personal comunitario.

SUPERVISIONES REALIZADAS -

Anote el número de visitas de supervisiones recibidas en el mes identificando su origen: Unidad Sanitaria, Distrito, Área y otro tipo de supervisión (Identificándolo).

VISITAS DOMICILIARIAS POR EL PERSONAL DE SALUD -

Anote el número total de visitas domiciliarias realizadas por el personal de salud.

TOTAL DE INGRESOS ECONÓMICOS DEL MES - Anote el total de ingresos económicos recaudados en el servicio durante el mes (en bolivianos). Este rubro comprende la venta de servicios, medicamentos, etc.

ANNEX 6: THE "PATHWAY TO SURVIVAL" MODEL

By Alfred Bartlett with SC/B staff

PATHWAY TO SURVIVAL

PERINATAL/NEONATAL MORTALITY: INQUISIVI, BOLIVIA

