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**SAVE THE CHILDREN/US**  
**BOLIVIA FIELD OFFICE**  
**INQUISIVI PROVINCE, BOLIVIA**

**CHILD SURVIVAL V**  
**ANNUAL REPORT FY 93**

Cooperative Agreement No. OTR-O500-A-00-9149-00

**YEAR FOUR**

**Save the Children**  
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## **I. OVERVIEW OF YEAR FOUR**

### **A. Actual accomplishments vs. goals and objectives:**

The indicators through September 1993 are: (Source - manual information system)

The infant mortality rate is 60/1000.

The vaccination coverage (complete series) is 3.8% for children 0-11 months, 49.7% (12-23 months) and 76.4% (24-59 months) and 70% (12-59 months).

Vitamin coverage (2 megadoses) is 26%.

The coverage of TT2 or more vaccinations of women from 15-49 years old is 61%.

The prevalence rate of ARIs is 104/1000.

The prevalence rate of diarrheal episodes is 110/1000.

(The above rates are almost identical to those presented in last year's report. It should be noted that the vaccination coverage rates are likely to be much more sustainable than previously, due to a change in strategy which is described in section II.B below.)

### **B. All training activities for project staff:**

#### **Staff and Executive Committee Meetings**

All-staff meetings and Executive Committee meetings were held weekly. CS 5 was discussed in the regular course of these meetings.

#### **Quality Circles**

At the end of each quarter, senior staff participated in the zonal quality circles for training, review of the past quarter's actual versus expected results, and planning for the coming quarter on the basis of this review. Special emphasis was given to child survival activities during these quarterly quality circles, both for quantitative indicators (children with complete vaccination coverage, women of reproductive age with at least TT2, etc.) and qualitative discussions (how to increase sustainability of the interventions, how to improve effectiveness through better teamwork, etc.)

#### **KPC 30 Clusters Survey Methodology Training**

Staff participating in the CS 3 evaluation in January were trained in the Johns Hopkins statistical methodology of grant evaluation.

### **Project Management Workshop**

A workshop on project management was attended by Dr. Guillermo Seoane, National Health Advisor and by Felix Fernandez, Program Advisor, in January and was later replicated with field staff.

### **"Child-to-Child" Methodology Workshop**

In February, Dr. Seoane attended a workshop sponsored by Save the Children/Canada on the child-to-child methodology and later replicated a part of this workshop in an all-field staff workshop.

### **Child Survival and Maternal Health Workshops**

Dr. Seoane attended a regional workshop on Child Survival sponsored by Project Hope and Johns Hopkins University held in Yacuiba, Bolivia in March.

The start-up workshop for the PROCOSI grant "Child Survival and Maternal Health" was held for all health staff in April. This project builds on the experience gained through the AID-funded CS 3 and CS 5 projects and the John Snow, Inc. funded MotherCare project, to continue and strengthen interventions in child and maternal health. The communities presently participating in Child Survival 5 will continue under this PROCOSI grant at the termination of CS 5.

An informational workshop to exchange experiences with Plan International/Altiplano, which included much discussion on child survival issues, was held in May.

In June a workshop was held with SC/B and MOH staff on the management of ARI cases. This was followed up by another workshop in September to develop a plan of action. These workshops were sponsored by the REACH project.

A joint workshop was held by the La Paz Health Unit of the MOH (USLP) and SC/B in August on women's health.

### **PROMIS Workshop**

Lisa Howard-Grabman, the Co-Director of SC/B and SC/B's Health Information Specialist Pacifico Copa were trained in the PromIS Health Information System at the Save the Children Home Office in August, 1993.

### **C. Technical support**

In the Child Survival 3 final evaluation carried out in January 1993, SC/B received technical support from consultant Victor Lara, MD, MPH in a KAP survey, and from Karen LeBan, Manager of the Save the Children Home Office Health Unit, particularly in the areas of sustainability and pipeline analysis. The results of this evaluation confirmed the strategy in CS 5 to concentrate more on sustainability issues.

**D. Active health committees:**

Health committees *per se* have not been formed, but there is high community involvement in all of the communities through the agrarian unions and/or women's groups.

**E. Linkages with the MOH and other health activities**

**Linkages with MOH**

SC/B coordinated with the "Tres Cruces" District, La Paz Unit, MOH in monthly "Information Analysis Committee" (CAI) meetings. SC/B presented all of its relevant statistics at these meetings for inclusion in the GOB national health information system know as SNIS.

There is a sharing of responsibilities for materials - the District provides the vaccines (donated by UNICEF) and the cold chain, as well as Child Health cards. SC/B provides some transport, gas for cold-chain refrigerators, educational materials. SC/B and MOH staff often coordinated in vaccination and other activities.

MOH staff were always invited to SC/B quality circle meetings to plan logistics and discuss strategies, but unfortunately rarely attended.

After the assumption of power by the new government in August 1993, various social service ministries were combined in a new "Superministry" of Human Development (Health, Education, and Welfare). Under this new structure, the former MOH became a Secretariat under the Ministry of Human Development. Meetings were held in August with the new Minister of Human Development and the Secretary of Education to discuss coordination between SC/B and the Ministry and Secretariat.

**Linkages with Other Health Organizations:**

Membership and active participation in PROCOSI, the coordinating body for 13 NGOs working in Child Health;

Participation as the only international NGO member of the National Reproductive Health subcommittee on IEC. Other members of the subcommittee include the MOH, local NGOs, and donors, including USAID/Bolivia.

Educational materials developed under the MotherCare Project were shared with the MOH and various NGOs.

A workshop to exchange experiences in child survival and other development activities was held with Plan International/Altiplano.

Training of midwives and family planning education and services were carried out in coordination with the San Gabriel Foundation, a local NGO.

SC/B worked with CIEC, a local NGO with extensive experience in materials development and training, on producing educational materials for families, midwives and health personnel. Materials produced included: a home based health card for women of reproductive age; a midwives' manual; four booklets for women of low literacy level on (1) pregnancy and prenatal care, (2) safe birth, (3) postpartum care and family planning, and (4) care of the newborn; and radio dramas on the same topics. (None of these materials were funded by CS 5, but did support CS 5 health activities.)

**F. Names and resumes of professional staff who have the project since last annual report and Organizational Chart**

Professional staff and organizational chart remains the same as in the last CS 5 Annual Report (1992).

**II. CHANGES MADE IN PROJECT DESIGN**

**A. Measurable Objectives:**

No changes were made.

**B. Type or scope of child survival interventions:**

Based on our own perceptions, which were confirmed by the Child Survival 3 evaluation held in January, SC/B no longer goes house-to-house vaccinating children. The search for more sustainable interventions is underway, including community development fairs, which have shown initial success.

**C. Location or number of project beneficiaries:**

No changes were made.

**D. Budget**

In a letter dated March 29, 1993 Save the Children requested a no cost extension of Bolivia CS 5 project activities through March 31, 1994. USAID amendment number 3 approving this change was received on October 1, 1993.

### **III. CONSTRAINTS, UNEXPECTED BENEFITS AND LESSONS LEARNED.**

#### **A. Constraints.**

The major constraint during the previous year was that the change in strategy to one that would be more sustainable in the long run led to a short-term drop in the vaccination coverage rates. SC/B no longer goes house-to-house to vaccinate children or women of childbearing age. This was not sustainable because the communities were not taking the responsibility to look after their own preventative health through use of the health district services. SC/B believes its role is not to supplant the health district, but rather to educate people to use its services. Therefore, SC/B now vaccinates in "Integrated Development Fairs" and, in those communities which have health posts, encourages people to use these services. We believe this strategy to be best in the long run. In this past grant year, coverage rates dropped for the first half of the year, but as the communities became accustomed to the new methodology, rates increased again. By the end of grant year 4 (September 1993), coverage rates had recovered to be essentially equal to those at the end of grant year 3 (September 1992).

One of the principal limitations, and one which made the adoption of the new strategy more difficult, was the poor coordination with the Tres Cruces District of the La Paz Health Unit of the MOH. The project staff placed strong emphasis on improving the coordination with MOH. SC/B attended all meetings held by the District to which it was invited. SC/B invited District personnel to all quality circle planning meetings, but these invitations were seldom accepted. The main cause for this problem was the negative attitude of some of the District staff, who tried to involve SC/B in a conflict between the District and the town of Quime. The situation was aggravated by the refusal of the USLP to sign a working agreement with SC/B for political reasons (these problems occurred around the time of national elections, which were held on June 6).

#### **B. Strategies used to overcome the constraints.**

The problem of vaccination coverage caused by the new, more sustainable strategy has apparently now been solved, since rates are on the rise again after an initial dip.

Relations with the USLP improved somewhat when replacement of key District staff took place. The new government is more committed than the previous one to community-based development; therefore SC/Bolivia staff expects relations to continue to improve.

**C. Circumstances which have facilitated implementation and/or produced unexpected benefits:**

SC/B has remained true to its vision, in spite of problems with the previous government. The assumption of power of a new government more supportive of community-based development will facilitate the implementation of all SC/B projects.

A continued positive relationship with the agrarian unions has allowed for easier implementation of health interventions in the communities. SC/B staff are invited to union meetings which facilitates training of community leaders.

The organization of women's groups through SC/B projects in reproductive health, literacy, and credit has created an outreach mechanism which provides direct access to the community. Mothers are the principal agents of social change in the community and are responsible for the health of the family. Therefore, working closely with the women's groups helps to assure greater application of child survival interventions.

Integrated development fairs capture the attention of those who might not otherwise participate in child survival activities. Some people are initially attracted by SC/B's work in agriculture or education, but end up learning about child survival and preventative health as well.

Training and work in cross-sectoral teams created synergies in which each SC/B development sector (health, education, economic opportunities, and sustainable agriculture) strengthened, and in turn was strengthened by, every other sector.

**D. Lessons learned and steps that have been taken to institutionalize these lessons:**

The principal lesson learned this year was in implementing integrated development fairs, with the field supervisors remaining in the communities 2-3 days. This strategy included the following activities: joint planning of the fair with community members; interventions in various sectors (including primary health); training; monitoring of progress (or lack thereof) since the previous integrated fair; collection and analysis of information by SC/B personnel, community volunteers, and authorities; and the feedback of information to the community in general. We believe that this strategy provides greater chances for sustainability, since it involves the community to a high degree. In the time that remains, we plan to focus on developing simple and effective community-based instruments and mechanisms to manage health information.

#### **IV. PROGRESS IN HEALTH INFORMATION DATA COLLECTION.**

##### **A. Characteristics and Effectiveness of the Health Information System.**

SC/B uses a health information system that enables us to systematically enter information gathered in the impact area into a computerized database called ProMIS.

The information system flow begins with registering the family on a family registration card. This information provides demographic data which enable us to construct population pyramids by community. The following information instruments are also used: the Child Health Card and the Women's Health Card; the Children's Roster and Women's Roster; and the supervisory consolidation forms by community and zone.

Twice a year, the consolidated information from the manual system is entered into the computerized system, which registers demographic information, (births, deaths, migration), immunizations, and growth monitoring in the communities covered by the project.

In this past year various manual HIS instruments have been simplified, including the supervision record, the reproductive health forms, mortality forms, training forms, and the guide for quarterly planning.

##### **B. How and by whom HIS data are being collected and utilized:**

The volunteer promoters (community health workers) and the SC/B field supervisors are responsible for collecting much of the data. The data are used as inputs to make decisions on the next quarter's activities and priorities during the zonal quality circle meetings.

SC/B is moving toward training community groups, especially women's groups, rather than just promoters. In this way basic health knowledge will reside in more than one or two individuals, and will remain in the community even when key community members out-migrate.

Health information should be shared with the communities in the integrated health fairs once every two or three, although this feedback mechanism has not yet been incorporated in all project communities. Data on immunizations, diarrhea, and nutrition are discussed with the staff of the health district Tres Cruces, including the Director, in formal monthly meetings.

All of the above mentioned instruments contribute to information on immunizations, growth monitoring, Vitamin A, acute diarrheal diseases, prenatal care, birth and postpartum care and family planning. The manual instruments enable field supervisors to follow-up on high risk cases. The information is also shared and analyzed with field supervisors during the quarterly quality circle meetings.

The monitoring and analysis of the data are the responsibility of the Health Information Specialist, whose semi-annual reports are reviewed by the National Health and Nutrition Advisor and by the Co-Directors, for use in reports and decision making.

**C. Need for further refinement:**

SC/B suggests the following:

Increase the capacity of the computerized data base to cross-cut sectorially. This would allow staff to see if, for instance, participation in credit by a mother leads to better child survival indicators, or if fertility rates are affected by participation in literacy classes. Since SC/B believes that development is an integrated process, the computerized information system should allow us to measure this integration.

The version II of SC/ProMIS will allow individual field offices to adapt the computerized system to their own needs and provide information from their particular projects (including the above example). The version II will be available to all SC Field Offices in the first quarter of FY 94.

In the CS 5, SC/B will continue using the present ProMIS system to allow for consistency of data interpretation. However, we believe that in the future individual records should be kept at the community level and community members should take the responsibility for assuring that all community children are vaccinated. SC/B should concentrate more on the macro level, perhaps with twice yearly surveys. This is more sustainable than the present system which is extremely labor intensive and will never be maintained by community members after phaseover. This is also necessary if Save the Children is to scale up its activities. In the next 6 months, SC/B plans to explore alternatives to ProMIS in coordination with its home office.

## **V. BUDGET AND EXPENDITURES**

### **A. Major budget revisions since the Cooperative Agreement was signed.**

In 1992, a budget shift among line items for the Bolivia F.O. portion of CS 5 was made due to the under use of funds destined for supplies and consultants and the need for more funds in other direct costs, mostly because of vehicle operation costs due to the distance between communities and the toll the rough roads take on the vehicles.

### **B. Pipeline Analysis. See attached.**

### **C. Quantification of project output**

Five year total budget/CS 5 community children 0-5  
(September 93) = \$ 443,419/2337 = \$ 190/child 0-5 or \$  
38/year/child.

This calculation overstates the cost per beneficiary because it does not take into account children who fell within the 0-5 age range earlier in the project and are now older, nor does it take into account the women of reproductive age, who benefited through project interventions, such as tetanus toxoid immunizations.

### **D. Other pertinent information such as an explanation of cost overruns or higher unit costs.**

Not applicable.

## **VI. FOLLOW-UP MID-TERM EVALUATION:**

The second Annual report addresses the extent to which the project has implemented the MTE recommendations. As a follow-up to the Mid-Term Evaluation, a layer of middle management in the impact area was eliminated, resulting in more efficient use of resources.

## **VII. OTHER SIGNIFICANT INFORMATION**

The recently concluded (June 1993) MotherCare project, which raised consciousness and stimulated community action in the areas of maternal and neonatal health, also had a positive impact on child survival. SC/B believes that family planning, maternal health, neonatal health, and child survival are closely interrelated and that health projects are more successful when they do not attempt to specialize in only one of these areas. The Child Survival and Maternal Health Project, funded by PROCOSI from January 1, 1993 through December 31, 1995 incorporates all of these health aspects in communities previously/now covered by the CS 3, CS 5, and/or MotherCare projects.

BUDGET VS. ACTUALS FOR YEAR 4 AND TOTAL EXPENSES TO DATE VS. TOTAL GRANT \*

Procurement	YEAR 4: EXPENSES VS. PLANNED BUDGET *								LIFE OF GRANT: CUM TOTAL VS. TOTAL GRANT *			
	EXPENSES YEAR 1	EXPENSES YEAR 2	EXPENSES YEAR 3	EXPENSES 07/31/93	PLANNED BUDGET**	BALANCE	% SPENT	BUDGET YEAR 5 (note 3)	CUMULATIVE TOTAL ACTUALS	PLANNED BUDGET***	BALANCE	% SPENT
Supplies***	3,428.00	5,877.98	2,739.05	4,510.77	4,124.88	(385.89)	109.4%	2,889.09	16,555.80	19,059.00	2,503.20	86.9%
Assets***	0.00	0.00	0.00	0.00	0.00	0.00		0.00		0.00	0.00	
Consultants	0.00	757.82	1,000.00	0.00	(0.00)	(0.00)		2,000.18	1,757.82	3,758.00	2,000.18	46.8%
Sub-Total:	3,428.00	6,635.80	3,739.05	4,510.77	4,124.88	(385.89)	109.4%	4,689.27	18,313.62	22,617.00	4,503.38	80.3%
Evaluation	0.00	911.30	1,742.84	0.00	0.00	0.00	0.0%	1,999.86	2,654.14	4,654.00	1,999.86	57.0%
Other Program Costs												
Personnel	67,843.54	86,061.48	82,829.05	71,564.50	86,664.29	15,099.79	82.6%	34,742.64	308,298.57	358,141.00	49,842.43	86.1%
Travel	4,535.66	3,684.44	417.86	2,724.73	3,562.04	837.31	76.5%	1,000.00	11,362.69	13,200.00	1,837.31	86.1%
Other	4,705.87	14,763.91	10,491.23	12,135.58	12,708.47	572.89	95.5%	1,937.52	42,096.59	44,607.00	2,510.41	94.4%
Sub-Total:	77,085.07	104,509.83	93,738.14	86,424.81	102,934.80	16,509.99	84.0%	37,680.16	361,757.85	415,948.00	54,190.15	87.0%
TOTAL	80,513.07	112,058.93	99,220.03	90,935.58	107,059.68	16,124.10	84.8%	44,569.29	382,725.61	443,419.00	60,693.39	86.3%

\*Final Year 3 expenses; Year 4 expenses through: 07/31/93

\*\* Year 2 Planned Budget per F.O.'s Annual Report. Year 4 includes balances from year 3. Revised LOG Budget approved 4/28/92.

\*\*\* Assets are individual items \$500 and over. Supplies are individually under \$500 per item.

(3) Grant year 4 and 5 budgets revised 5/21/93; No-cost extens. to 3/31/94 approved.

Year 1 = Sept. 1, 1989 - Aug. 31, 1990  
 Year 2 = Sept. 1, 1990 - Aug. 31, 1991  
 Year 3 = Sept. 1, 1991 - Aug. 31, 1992  
 Year 4 = Sept. 1, 1992 - Aug. 31, 1993  
 Year 5 = Sept. 1, 1993 - Aug. 31, 1994

LINE ITEM FLEXIBILITY: No flexibility between Procurement, Evaluation and Other.  
 100% flexibility within each group.