



SUPPORTING NUTRITION IN PROJECT DEVELOPMENT IN BOLIVIA:  
THE COMMUNITY AND CHILD SURVIVAL PROJECT PAPER

I. BACKGROUND

The consultant, who was to be in Bolivia providing technical assistance in nutrition to a Child Survival-funded PVO, was requested by the USAID Mission to remain another week to assist in the development of the nutrition component of the Child Survival Project Paper. He had previously, under the OIH Nutrition RSSA, provided technical input in the development of the Project Identification Paper (Jan. 1988). The consultant was also asked to provide followup with potential collaborators of the AED Nutrition Communications Project Assessment Report prepared in March by a team of which he was a member.

II. ACTIVITIES

The team leader of the PP team, Mr. Robert Pratt, requested that the consultant focus his efforts on development of the technical analysis of the nutrition subcomponent of one of the three components ("child survival") of the Community and Child Health Project (CCH). The consultant requested working with Dr. Fernando Rocabado, medical nutritionist of the MOH, and this was made possible. Mr. Pratt also requested that the consultant become involved with both the team (including AED consultant Oscar Bigano) and U.S.A.I.D. in discussions on the relationship between the CCH project and the proposed Nutrition Communications Project.

Meetings were attended with the entire PP Team (up to 12 members), with the child survival and the IEC working groups, and

with Ministry of Health counterparts. A field trip was carried out to the Sanitary Unit in Cochabamba, one of the project departments, and to Capinota, one of the potential Sanitary districts. Here, Bigano and Teller were accompanied by Project Concern, CANSAVE and CEPROCA counterparts to visit an innovative primary health care project. Discussions were held concerning the collaboration between the Ministry of Health, the PVOs, mothers clubs and the new projects (CCH and NCP).

Meetings were also held with the Ministry of Health (Vice-Minister Paz, MCH Chief Bartos), the PVO Child Survival Project team (PVO-REC/OPG), its Health and Nutrition Subcommittee and with individual PVOs (SCF, MMF/FFH, PCI, CARE and CARITAS BOLIVIANA) to followup on their interest in participating in the NCP project which is in its predesign phase.

### III. SUMMARY OF RESULTS

The consultant's recommendations on the nutrition component for the child survival intervention component of the PP are presented in Annex I (Draft Memo to Pratt and Hartenberger). It follows the CCH Memo Technical Analysis Outline and includes:

- A. Nutrition Problem Priorities;
- B. Recent Bolivia Program Experience;
- C. Major Issues/Constraints;
- D. Essential Approaches, Methodologies and Technologies;
- E. Capability of the MOH to Handle These Technologies;
- F. Proposed Nutrition Intervention Plan; and
- G. Results Expected.

These were incorporated by the Mariscal group and the Bigano group into the draft PP.

The key challenge to incorporating nutrition into this Child Survival project was to keep it as simple and low cost as possible, but still have some effectiveness in helping to lower infant mortality and morbidity. It was decided that the CCH will be managed by the MOH and implemented in a few Districts in La Paz, Cochabamba and Santa Cruz. Given the difficult situation in which most Districts find themselves, the CCH would strengthen their capacity to plan and manage key child survival interventions. There are four nutrition activities that are recommended as the minimal essential ones that the MOH could, over time, carry out as a package: 1) growth monitoring/promotion; 2) nutritional surveillance; 3) nutrition education; and 4) treatment and rehabilitation of nutritional deficiencies or acute undernutrition.

An essential issue will be the availability of the minimum essential human resources needed for these nutrition activities at the District, Area, Sector and community levels. The District team should have a public health nutritionist to work alongside the nurse and social worker. Most of the nutrition actions at the health post level can be carried out by auxiliary nurses as part of their routine primary health care activities. She, in turn, will need support at the community level by the health promotor, teachers, and by community organizations. The most important of these for integrated nutrition actions are : Sindicatos Agrarios, Clubes de Madres, Comites de Salud or de Agua, and Comites Escolares de Padres de Familia.

The basis of getting an effective nutrition component into the health program is that the growth monitoring/promotion activity be supported by mobilized community organizations who can ensure full coverage and frequent participation. The other essential elements are that the nurse auxiliaries concentrate their precious time on the more technical aspects of outreach, detection, diagnosis, followup home visits and individualized and community plans of action.

Concerning the relationship between the CCH and the NCP projects, the PP Team was reluctant to consider the nutrition project as part of the child survival package. The team leader suggested that the NCP should avoid working directly at the field implementation stage in the Sanitary Districts selected, but work in other districts in the same department. In this way it can support the CCD project at the Sanitary Unit (regional) level, particularly in the technical aspects of program planning, training, research and materials development. Being small and less complex, the NCP should get off the ground sooner and provide a wealth of timely and useful information. A full-time IEC advisor is proposed for the CCD project and can provide the technical and professional channels for collaboration at the eventual implementation stage.

In terms of the implementation of the NCP, meetings with the PVOs indicated that Save-the-Children and Freedom-from-Hunger in the Department of La Paz, and Project Concern in the Department of Cochabamba, appear to be the most interested and appropriate ones to become involved at first in field projects, and the CARITAS BOLIVIANA Child Survival Project will collaborate where

it can. Preliminary discussions were held on the role of the PVO/OPG in the NCP in both financial and managerial terms, and the PVO-REC was to communicate with AED on its preferences. In general, priority was given by the OPG staff to training workshops during the first year.

ANNEX I

DRAFT MEMO: NUTRITION IN COMMUNITY/CHILD HEALTH PROJECT, BOLIVIA

TO: Robert Pratt, Head, PP Team and Paul Hartenberger, USAID/La Paz

FROM: Charles H. Teller, Consultant in Nutrition, INU/LTS

RE: Nutrition Subcomponent for Child Survival Intervention Component of Project Paper

DATE: May 9, 1988

The consultant was requested by USAID/La Paz (through an I.Q.C. through the Office of Nutrition, A.I.D. Washington) to participate for one week on the Project Paper Team for the Community and Child Health Project (CCH). The general scope of work, which was clarified by the Team Leader upon the consultant's arrival in Bolivia, focussed on development of the technical analysis of the nutrition subcomponent of the Child Survival Intervention component. He also requested inclusion of discussion of the relationship of the CCH project with the proposed A.E.D. Nutrition Communication Project. It was specified that both be very short in order to meet the page limit of the PP. This brief memo deals mainly with the former and is being FAXED down in draft form as a summary of discussions with both the Child Survival group (Mariscal, Rocabado and Velasco) and also the IEC group (Bigano, Quiroga and Bastien). It follows the CCH Memo Technical Analysis Outline by R. Pratt of May 2, 1988.

A. NUTRITION PROBLEM PRIORITIES (See more detailed discussion in AED Bolivia Needs Assessment Report, March 1988)

1. The major public health nutrition problem is energy-protein malnutrition in the 6-23 age group in rural areas of the Altiplano, Puna and High Valleys, and in El Alto. Chronic malnutrition was found in 40.1% of children 0-5 in the National Nutrition Survey of 1981. From our recent analysis of over 1000 growth cards in the rural Altiplano, Valles and Llanos, growth retardation is accentuated in the second half of the first year of life and appears to be a result of both repeated illnesses (infectious and parasitic) and insufficient and inadequate weaning food diet.

2. Endemic goiter is second in importance, affecting some 60% of the population, with the highest rates among teenage and young adult women and in the Valles and Mountainous regions. Its severe manifestation in cretinism is found in 1-2% of the population in some Departments (Chuquisaca, Cochabamba, Tarija).

3. Iron-deficiency anemia appears to be the third most important problem, affecting about 20%, principally in pregnant women and young children. Even using different cut-off points according to altitude, the tropical regions have higher prevalence (eg. Santa Cruz).

Other possible public health nutrition problems where the evidence either suggests lower priority or insufficient documentation are: Vitamin A deficiency, low birth weight, maternal malnutrition and breastfeeding declines in urban areas.

## B. Recent Bolivia Program Experience (see AED Report for details)

1. Growth Monitoring programs are associated mainly with food and milk supplementation programs. They have relatively low coverage, infrequent attendance and over-reliance on CARITAS mothers clubs which are dependent on imported food supplements and often do not reach the highest risk families.
2. A well-planned and financed goiter control program (PRONOCOLRO) financed jointly by UNICEF and WHO (JNSF) which has used oil injections and wants to transfer to distribution of iodized salt.
3. A relatively new anemia (PROLAN) control program with three basic components: information and education on the problem; supplementation of pregnant women with ferrous sulfate and folic acid, and epidemiological surveillance.
4. A Nutritional Surveillance program (SVEN) which is weighing almost 100,000 children under five each year and disseminating the information for planning and programming.
5. A new nutrition education program now, under the restructuring of the MOH, being incorporated into the popular education program based on educational fairs and participation of health promoters.
6. An MCH-Title II food distribution and nutrition education program reaching more than 275,000 mothers and children through the formation of mothers clubs organized by several PVOs. These clubs increase the access to MPSSP services but have never been evaluated for their cost-effectiveness in reducing malnutrition, and it is unlikely that this would be found.
7. Other nutrition interventions, such as community or home gardens and domestic animal production are being tried mainly by PVOs and on a small scale. While the direct nutritional impact is probably minimal, indirect benefit from raising purchasing power and increasing women's group solidarity is likely.

## C. MAJOR ISSUES/CONSTRAINTS

1. Low coverage of families at high risk for malnutrition enrolled in MPSSP growth monitoring programs.
2. Infrequency of attendance of those enrolled in growth monitoring sessions, low quality of the service, and little followup action.
3. Insufficient personnel at the health district, area and health post level to carry out integrated nutrition and other child survival actions, leaving little time for quality nutrition diagnosis, dialogue and followup plan of action.
4. Lack of supervision from the Unidad Sanitaria to improve the quality of the nutrition interventions, and their material and logistic support..
5. Infrequent on-the-job training and refresher courses.
6. Lack of updated norms and unified criteria on growth monitoring.
7. Institutional separation within the MPSSP of the Directorate of Food and Nutrition and the Maternal-Child Division (to be rectified under the restructuring).

8. Lack of a functioning MOH-wide information system for ongoing monitoring, management and evaluation, and for feedback of the nutritional surveillance data to the community and the areas.

9. Cultural, Social and Economic barriers in the utilization of health services, and preference for native healers.

D. Essential approaches, methodologies and technologies proposed to be employed in CCH Project

The basic primary health care approach is to extend coverage to the higher risks and improve the local capacity to deal with these problems in a permanent way. The techniques and methods suggested are: scales, growth cards, surveillance charts, food demonstrations, manuals, radio and T.V. spots, flip charts, iodized salt, iodized oil injections, iron and folic acid tablets. The capacity of the MPSSP now to handle these technologies is severely limited by the shortage of personnel, training, supervision, materials and supplies, and by the lack of mobilization of community participation.

E. Capability of the MPSSP and "other participants" to handle these technologies

The Ministry Division which directs the Growth Monitoring Program, MCH, had acquired this responsibility in 1986-7 and not been able to manage it adequately. It has yet to update the norms and procedures, even after the Jan. 1988 National Seminar in which it said the document would be ready by March. The scheduled merge of the MCH Division with the Directorate of Food and Nutrition (DNNA) should strengthen the capacity of the MOH to plan and support the nutrition program. DNNA is responsible for the goiter and anemia control programs, food supplementation and nutrition education. It has placed in the Sanitary Units nutritionists who are responsible for the programming, training and supervision of the interventions. About half of the Units have vacancies in this slot, and the others receive little support for carrying out their training and supervisory functions. Nutrition education, now included in DNNA, will be strengthened by incorporation into the Community Education (Educacion Popular) Program, which is absorbing the smaller programs of Social Mobilization and Communication. The MOH needs, and has called upon, the larger PVOs to help strengthen the growth monitoring/promotion program, particularly in extending coverage, training, supervision and materials (National Seminar, Hotel Titikaka, Jan. 1988). The Goiter and Anemia control programs receive support from UNICEF and WHO, as does the Nutritional Surveillance program (SVEN). The latter would need additional support in order to expand coverage, ensure data quality control and be useful at the area and community level for planning and program monitoring purposes. The largest outreach group for nutrition, the Mothers Clubs, are receiving support from PRITECH and CARITAS in the Altiplano and Valles, and will need continuing support and closer supervision to ensure that the sequential training program is reaching the promoters and mothers in an effective manner. The capacity for effective nutrition rehabilitation of acutely malnourished children in the health centers and hospitals is considered minimal.

## . F. Proposed Nutrition Intervention Plan

Dr. Rocabado and the consultant have recommended (on Friday, May 5) to the Child Survival Component of the PP Team four nutrition subcomponents:

1- Growth Monitoring/Promotion: this is to be the main entry point for high risk families. It will be used as an education tool, for early detection of growth faltering, and as a basis for followup preventive and curative actions as needed. It will feed data into the program monitoring system and into the SVEN.

The new Directorate of Nutrition and Maternal-Infant Health will soon be in charge of this Program, developing updated norms and more realistic procedure, and the Sanitary Units responsible for programming, training and supervision. Some of the PVOs who have acquired excellent experience in this Program should assist the MOH in adapting their results to the National Program.

2- Nutritional Surveillance- the main purposes are advocacy, promotion, planning and evaluation. Data will come from growth monitoring sessions and the National Height Census carried out in the primary schools. This is important for identifying the ecological zones of greatest need, and as a basis for intersectorial and community planning to address the non-health causes of malnutrition.

3- Nutrition education- supported in part by the IEC component of the PP, this will address the behavioral factors associated with malnutrition. Included are increased diagnostic, interpretive and communication skills during growth monitoring, targeted home visits for dialogue and developing family action plans, dietary management of diarrhea, breastfeeding protection, goiter and anemia prevention, and infant feeding orientations and demonstrations. The IEC component would support these by the content development, design and production of materials, identification of communication channels, and training in appropriate methods and techniques.

4. Treatment and Rehabilitation- Efforts will be made first at the community and family level to deal with either the nutritional deficiency or with acute undernutrition. EPI, DDC, Anemia and Goiter control programs are available at this level. TB, parasitic control, dengue and malaria programs are also important. Referrals will be made only where the need for short-term intensive care is called for and there are available pediatric wards. The low incidence of acute malnutrition and the poor cost-effectiveness of special rehabilitation centers rule against this consideration.

The human resources needed for the nutrition subcomponent at the Regional, District, Area, sector and community levels are outlined in figure one. The District Team will need to have a public health nutritionist to work alongside the nurse and social worker. Most of the nutrition actions at the Puesto level can be carried out by auxiliary nurses are part of their routine primary health care activities. She will need support at the community by the health promotor (RPS), teachers and by community organizations (organizaciones de bases). The most important organizations for integrated nutrition actions are: Sindicatos Agrarios, Clubes de Madres, Clubes de Mujeres Adolescentes, Comites de Salud o de Agua, y Comites Escolares de Padres de Familia. The key here is that the growth monitoring/promotion program is supported by the community organizations who ensure full coverage and frequent participation, and that the nurse auxiliaries can concentrate their precious time on the more technical aspects of detection, diagnosis, followup home visits and individualized and community plans of action.

6. Results Expected from the Integrated Nutrition and Child Survival Package (in the 3-4 selected pilot Sanitary Districts in La Paz, Cochabamba and Santa Cruz in 4-5 years time):

1- Reduction of the incidence of young child (6-23 months) malnutrition by 10-20%.

2. Reduction of prevalence of goiter in young women by 50-70%.

3. Expansion of coverage of growth monitoring of children under two to 30-50%, and increase in average number of visits per year to three.

4. Protect the positive traditional breastfeeding and weaning practices and improve others, including dietary management of diarrhea, in the regular participants in the growth monitoring program.

5. Contribute significantly to the overall reduction of infant and child mortality and to the case fatality rate from diarrhea and pneumonia.

Note on the interrelationship between the CCH and the AED Nutrition Education/Social Marketing Project: There was an understanding reached between the USAID Mission and the Head of the PP Team on several points: 1- Funds have been allocated for the Nutrition Education Project irrespective of the degree to which this project is integrated with the CCH project; 2- The nutrition project should support the CCD project in the same Regions mutually preselected (La Paz and Cochabamba) at the Sanitary Unit level, particularly in the technical aspects of program planning, training and materials development; 3- It should avoid working directly at the field implementation stage in the Sanitary Districts preselected by the CCH project, but work in other Sanitary Districts in the same department; and 4- The Nutrition project will be working with PVOs at the Sanitary District/Province level in developing effective approaches to changing health/nutrition related behavior, in coordination with the MOH and in ways that, if successful, could be adapted by the MOH in the pilot CCD Districts. Further details on the proposed coordination between the two projects will be developed shortly by AED/Washington in coordination with their PP Team consultant, Mr. Oscar Bigano.

# FIGURE 1

## HUMAN RESOURCES - NUTRITION SUBCOMPONENT CCD PROJECT - BOLIVIA

<u>LEVELS</u>	<u>KEY DIVISIONS/PERSONS</u>
1. CENTRAL	DMI, DNNA, EDU. POP.
2. REGIONAL	Prog. Mat-Inf; Nutrition; Pop. Edu.
3. DISTRICT	Drs, Nurses, Nutritionist, Social Worker
4. AREA	Doctor, Auxiliary Nurses
5. COMMUNITY	Auxiliary Nurse, RPS, Teachers, Healers
Groups	Mother's Club Teenagers Club Sindicato Agrario School Committee Health, Water Committee
6. FAMILY	Mother, caretaker, father, significant others

ANNEX II

I.Q.C. - NUTRITION IN CHILD SURVIVAL

PERSONS CONTACTED

USAID/La Paz

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Ministry of Health

La Paz

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Dr. Andres Bartos, Director, Materno-Infantil  
Licda. Ana Quiroga, Educacion Popular  
Dr. Fernando Rocabado, Director, SVEN  
Dr. Jorge Mariscal, Epidemiologia

Unidad Sanitario, La Paz

Dr. Juan Carlos Carazas, Director, Materno-Infantil

Unidad Sanitario, Cochabamba

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Project Esperanza

Mr. Alonzo Wind, Country Director  
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CODETAR (Corporacion de Desarrollo de Tarija)

Lic. Gabriel Gayte, Director Desarrollo Rural  
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